Oklahoma State Department of Health

Oklahoma State Innovation Model (OSIM)

OSIM Health Finance
8/6/2015 Workgroup Meeting

Agenda

Section			Presenter
Introductions			Isaac L.
OSIM Overview &Triple Aim	5 min	2:00	Alex M.
Deliverable Review & Discussion: Market Effects on Health Care Transformation	60 min	2:05	Milliman
Payment & Delivery Models: Overview	45 min	3:05	Isaac L.
Additional Discussion Items and Future Meetings	15 min	3:50	Isaac L.

Overview of the State Innovation Model project

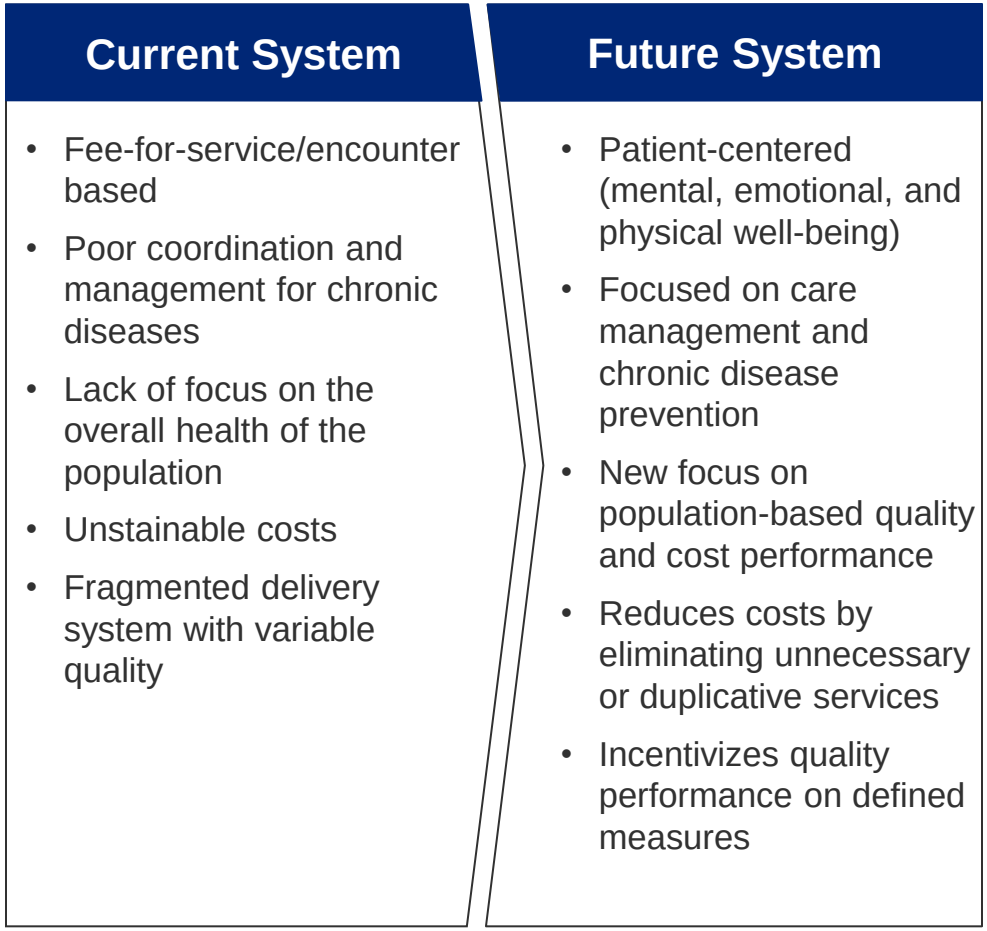
The mission of the State Innovation Model (SIM) project aligns to the CMS Triple Aim Strategy to improve care, population health, and costs.

The SIM project, launched by the CMS Center for Medicare and Medicaid Innovation (CMMI), tests the ability of state governments to use regulatory and policy levers to **accelerate health transformation**.

CMMI is providing financial and technical support to states for developing and testing **state-led, multi-payer health care payment and service delivery models** that will impact all residents of the participating states.

The **overall goals** of the SIM project are to:

- Achieve the Triple Aim: improve care, improve population health, and decrease total per capita health spending
- Establish public and private collaboration with multi-payer and multi-stakeholder engagement
- Transform health care payment and delivery systems



Source: CMS SIM Round Two Funding Opportunity Announcement Webinar

OSIM Deliverable Roadmap

***Bolded items indicate deliverables for CMS Review**

	QUARTER 2 MAY – JULY	QUARTER 3 AUGUST – OCTOBER	QUARTER 4 NOVEMBER - JANUARY
OSDH Program Staff	• **CMS Quarterly Report 1 Final** • **CMS Population Health Plan** • **CMS Driver Diagrams**	• **CMS Quarterly Report 2 Final** • **CMS Value-Based Delivery and Payment Methodology Transformation Plan** • CMS Health Information Technology Plan : HIT Workgroup Review	• **CMS Quarterly Report 3 Final** • **CMS Operational & Sustainability Plan** • **CMS Health Information Technology Plan** • **Final SHSIP: CMS Review**
Technical Assistance	• CMS Quarterly Report 1: OSDH Review • SHSIP Roadmap	• CMS Quarterly Report 2: OSDH Review • SHSIP Draft 1: OSDH Review	• CMS Quarterly Report 3: OSDH Review • **SHSIP Draft 2: Public Comment Period and CMS Optional Review** • Final SHSIP: OSDH Review
Stakeholder Engagement	• Statewide Stakeholder Meeting • Quarterly Stakeholder Engagement Report 1 • CMS Stakeholder Engagement Plan	• Monthly Statewide Stakeholder Meeting • Quarterly Stakeholder Engagement Report 2 • Stakeholder Engagement Narrative	• Monthly Statewide Stakeholder Meetings • Quarterly Stakeholder Engagement Report 3
Health Efficiency and Effectiveness	• CMS Value-Based Delivery and Payment Methodology Transformation Plan: OSDH Review	• Evaluation Plan with Quality Metrics Draft • Evaluation Plan with Quality Metrics Final	
Health Workforce	• Health Workforce Assessment: Landscape • Health Workforce Assessment: Provider Organizations • Health Workforce Assessment: Providers • Health Workforce Assessment: Gap Analysis • Health Workforce Assessment: Environmental Scan (Policy Levers)	• Health Workforce Assessment: Emerging Trends • Health Workforce Assessment: Policy Prospectus • Health Workforce Assessment Final Report	
Health Finance	• Market Effects on Health Care Transformation	• Oklahoma Care Delivery Model Assessment • High-Cost Delivery Services • Financial Forecast of New Payment Delivery Models	
Health Information Technology	• Electronic Health Records Survey Completion • Electronic Health Records Adoption Analysis • Health Information Exchange Environmental Scan (Policy Levers)	• CMS Health Information Technology Plan : OSDH Review • **Value-Based Analytics Roadmap**	

Health Finance Workgroup Meeting Objectives

Topic	Description	Section Objectives
Deliverable Review & Discussion: *Market Effects on Health Care Transformation*	▪ Assess market effects on health care transformation for the Federal Exchanges, Medicaid, EGID, Medicare, and private insurance groups.	▪ Engage and understand the process and key findings of the deliverable ▪ Discuss implications of results for overall Health Finance Workgroup process

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Market Effects on Health Care Transformation

Market Effects Considerations & Discussion Questions

Considerations

- Potential future insurance market shifts
  - Emergence or disappearance of insurance payers
  - Insurance premium price increases on the Federally Facilitated Marketplace (FFM) and its effects on enrollment
- Markets are both complementary and competitive
  - The FFM and Insure Oklahoma serve many of the same low income population
- Reliability and availability of data sources for private markets
  - Price transparency

Discussion Questions

- Does this accurately reflect the insurance market in Oklahoma?
- Does Oklahoma have network adequacy to effectively cover everyone?

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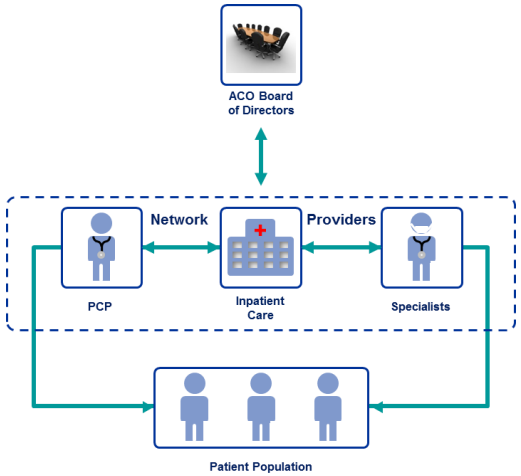
Accountable Care Organizations

Overview	▪ Networks of providers that collectively accept accountability for the cost and quality of a patient's care ▪ Emphasizes coordination of care
Scope	▪ Provider organizations including hospitals, primary care, specialists, and other supportive care institutions and services
Care Model	▪ Integrated care delivery efforts on behalf of networked providers – ACO assumes primary accountability for overall outcomes and costs for a patient's care ▪ Patients are not limited to providers within the ACO network
Payment Model	▪ ACOs can operate through a variety of payment models ▪ Their networked nature positions them well to handle episodes of care and bundled payments designs
Attribution	▪ Patients are attributed prospectively based on prior claims information and retroactively based on volume of contacts – Provider must notify patients that it is an ACO

Accountable Care Organizations

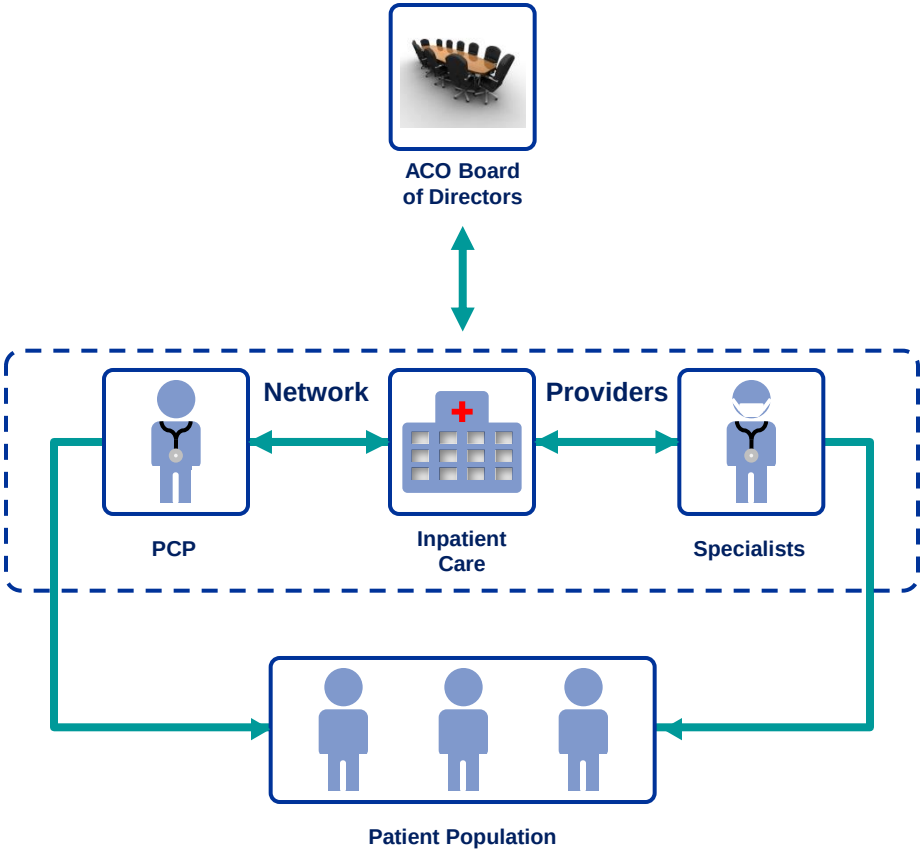


Results & Considerations

- Preliminary results from the 243 Medicare ACOs indicate that 25% achieved significant cost savings
  - Total of $817M in 2014 (.2% of total Medicare A&B budget)
- Patients are not limited to in-network physicians, which complicates provider coordination and outcomes
- All participating providers need to have some level of access to HIT in order to best coordinate patient care
  - Health IT interoperability is a critical component of high level care coordination

Accountable Care Organizations – Care Model Design

ACOs help to shift the emphasis from volume to value in care delivery by networking the providers together to facilitate care coordination and financial incentive realignment



- Board of directors develops treatment and care coordination protocols
- ACO governing body recruits providers and institutions to be involved in the network
- The ACO assumes full accountability for the patient
  - Care delivered
  - Clinical outcomes
  - Cost expenditures
- Providers coordinate to optimize the care delivered and costs incurred for patient care

- Note: Patients can see any provider, not necessarily just those in network

Accountable Care Organizations – Model Implications Discussion

Considerations

- Preliminary results from the 243 Medicare ACOs indicate that 25% achieved significant cost savings
  - To date, MSSP and Pioneers have generated $817M of savings with $372M returned in savings
- Patients are not limited to in-network physicians, which complicates provider coordination and outcomes
- All participating providers need to have some level of access to HIT in order to best coordinate patient care
  - Health IT interoperability is a critical component of high level care coordination

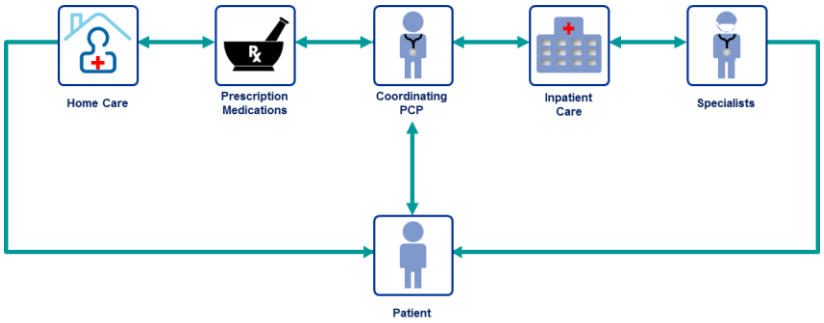
Discussion Questions

- Does shared savings adequately incentivize providers to deliver quality care to their patients?
- What is necessary for ACOs to evolve into a multi-payer initiative?

Patient-Centered Medical Home (PCMH)

Overview	▪ Primary care delivery model that focuses on care coordination, communication, and the patient experience
Scope	▪ Single primary care provider ▪ Appropriate patients vary by program
Care Model	▪ One primary care physician serves as the first point of contact for the patient and provides comprehensive, coordinated care ▪ The PCMH encompasses five attributes: – Comprehensive, team-based care – Patient-centered care – Coordinated care – Accessible services – Quality and safety
Payment Model	▪ Payment can include fee-for-service (FFS), with a modest additional per member per month payment for coordinating care
Attribution	▪ Patient eligibility determined by payer organization

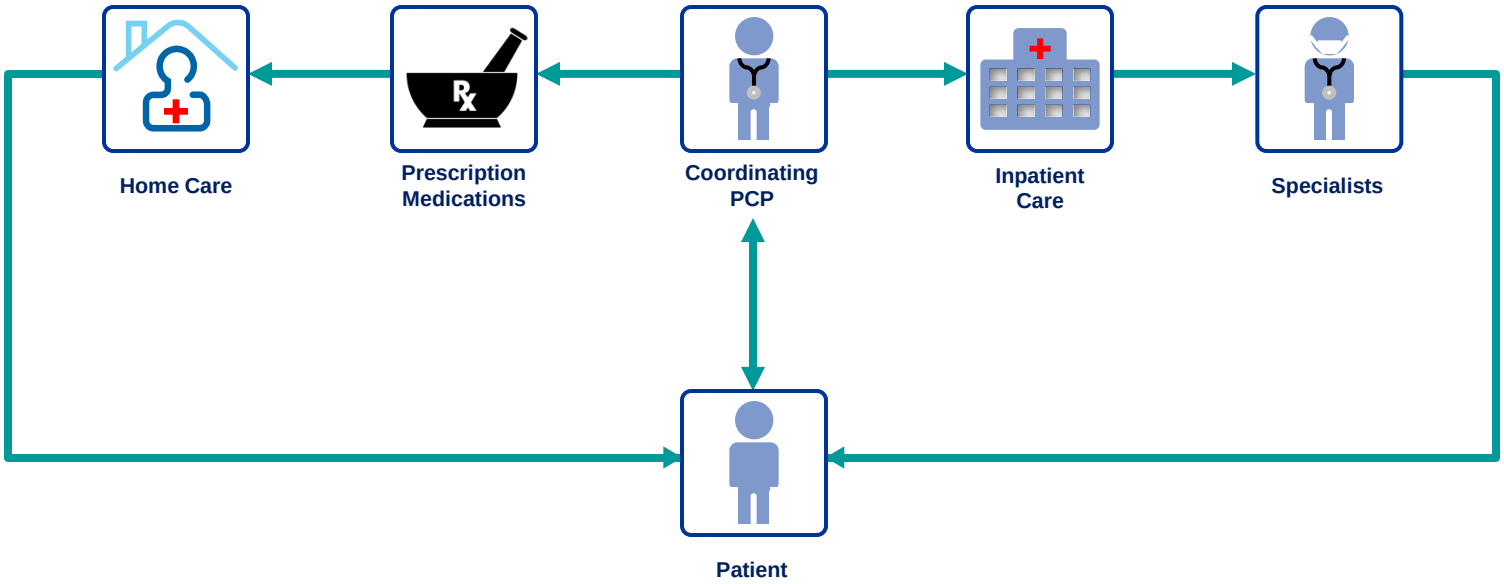
Patient Centered Medical Home



Results & Considerations

- All participating providers need to have some level of access to HIT in order to best coordinate patient care
  - Health IT interoperability is a critical component of high level care coordination
- Management of PCMH, at its ideal level, can place a significant burden on an individual practitioner. Providers may require additional IT systems, support, or personnel to succeed

Patient-Centered Medical Home (PCMH) – Care Model Design



- One primary care physician serves as the first point of contact for the patient and provides comprehensive, coordinated care
  - Helps to ensure that patients understand and execute their medical instructions, referrals, and follow up appointments
- Coordinating PCP need not have formal or official network or institutional relationships with other care providers involved in the care of the patient
- Payment can include fee-for-service (FFS), with a modest additional per member per month payment for coordinating care

Patient-Centered Medical Home (PCMH) – Model Implications Discussion

Considerations

- All participating providers need to have some level of access to HIT in order to best coordinate patient care
  - Health IT interoperability is a critical component of high level care coordination
- Management of PCMH, at its ideal level, can place a significant burden on an individual practitioner. Providers may require additional IT systems, support, or personnel to succeed

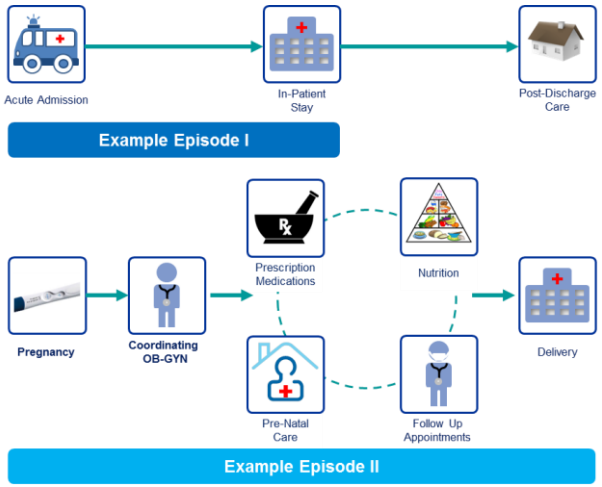
Discussion Questions

- Does capitation adequately incentivize providers to deliver quality care to their patients?
- What is necessary for PCMHs to evolve into a multi-payer initiative?

Episodes of Care

Overview	▪ Payment model in which services related to a condition or procedure are grouped into “episodes” that provide benchmarks for both costs and quality of care
Scope	▪ Principle Accountable Provider (PAP) is assigned and is responsible for the episode's outcome ▪ Episodes may include acute, chronic, or behavioral health conditions
Care Model	▪ Encourage provider efficiency and care coordination to avoid the need for further intervention or complications
Payment Model	▪ PAP are assigned by the carrier and initially paid on a fee-for-service basis. They are retroactively evaluated against a set of benchmarks for the average cost of care delivered over the episode’s performance period ▪ PAPs are rewarded with a percentage of savings or charged a portion of costs in excess of the benchmarks
Attribution	▪ Patient has a triggering event or certain number of claims related to an episode with a participating provider

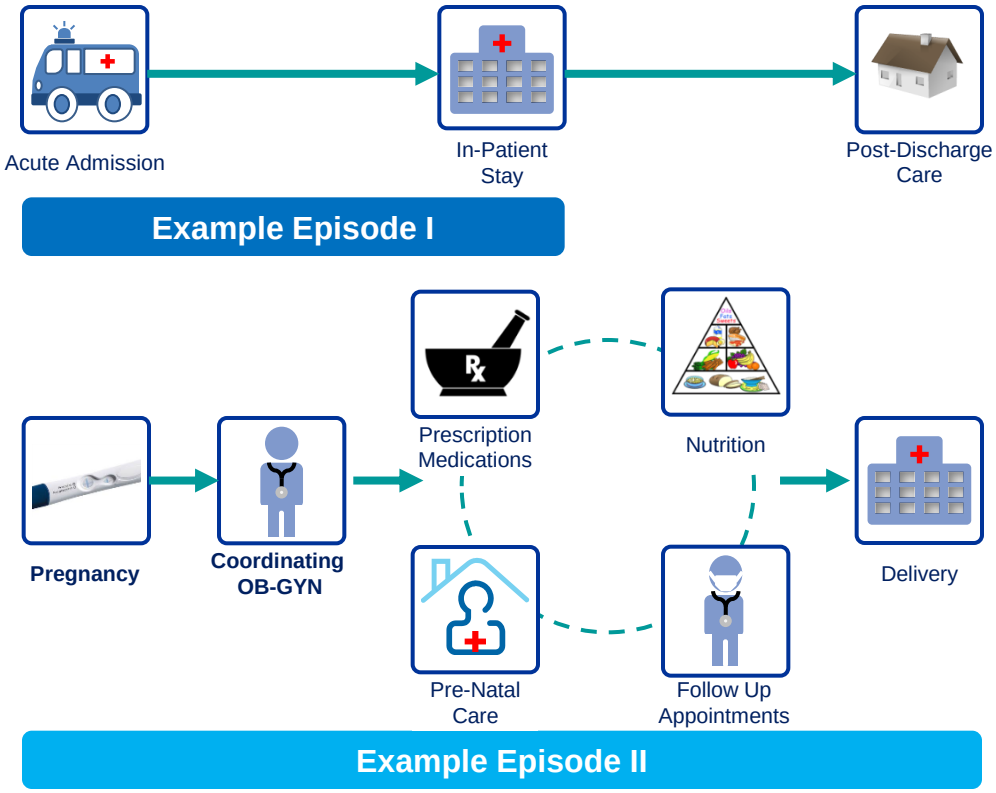
Example Episodes of Care



Results & Considerations

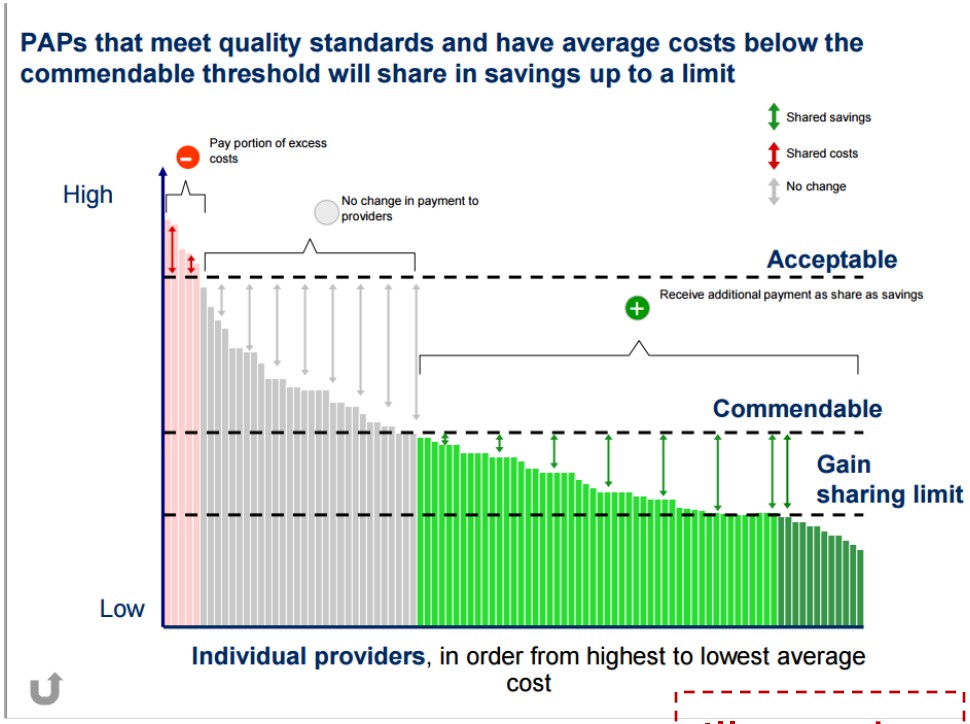
- Episodes can be difficult to define, and changes in best practices or technology can render even well designed episodes obsolete
- Pricing episodes correctly can require significant data
- Costs can vary based on inherent risk within patient population
  - Patient volume considerations to ensure appropriate distribution of risk

Episodes of Care – Payment Model Design



- Episodes begin with a triggering event
  - E.g. Acute admission to a hospital
  - E.g. Confirmation of pregnancy
- Episode lasts until a pre-determined duration elapses
  - E.g. 60 day postpartum upon completion or termination of pregnancy
- Episodes define which related services and patients will be considered within the episode's performance year
  - E.g. Certain patients with complex conditions may be excluded and non-related services would also be excluded for episode
- PAPs are initially paid on a fee for service basis and then retroactively evaluated against a set benchmarks for the average cost of the care delivered per episode

Episodes of Care – Payment Model Design (continued)



Source: http://www.paymentinitiative.org/

Illustrative

- Each episode for a particular condition has an overall performance year in which all patient episodes for that condition are aggregated and evaluated against benchmarks for cost and quality of care
- PAPs that come in under the cost benchmarks receive a percentage of the savings as a bonus, provided they also meet quality benchmarks
- PAPs that exceed the acceptable level of costs may have to pay a portion of the overrun as a penalty
  - Penalties are capped to ensure provider viability

Episodes of Care – Model Implications Discussion

Considerations

- Episodes can be difficult to define, and changes in best practices or technology can render even well designed episodes obsolete
- Pricing episodes correctly can require significant data
- Costs can vary based on inherent risk within patient population
  - Patient volume considerations to ensure appropriate distribution of risk

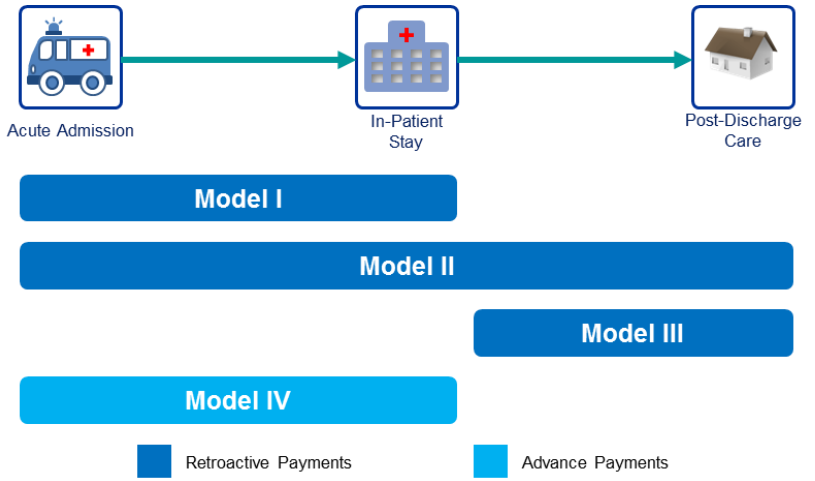
Discussion Questions

- Does shared savings adequately incentivize providers to deliver quality care to their patients?
- What is necessary for Episodes of Care to evolve into a multi-payer initiative?

Medicare Bundled Payments Care Initiative (BPCI)

Overview	▪ Series of opt-in payment model pilot programs from CMS ▪ Designed to align incentives across fee for service providers to improve patient outcomes and decrease costs in tandem
Scope	▪ Networks of providers ▪ Programs encompass some or all of a subset of 48 DRGs
Care Model	▪ Care coordination is up to participating provider networks
Payment Model	▪ Providers receive fee-for-service payments as usual, then at the close of the year, those payments are reconciled with the bundle benchmarks, except for Model IV, which provides prospective payments ▪ All episodes begin with an acute hospitalization by a patient but then vary: – Initiation and duration of episode of care – Applicable DRG – Timing of payments
Attribution	▪ CMS guidance does not specify attribution protocol, so it is assumed that this can vary by participating institutions

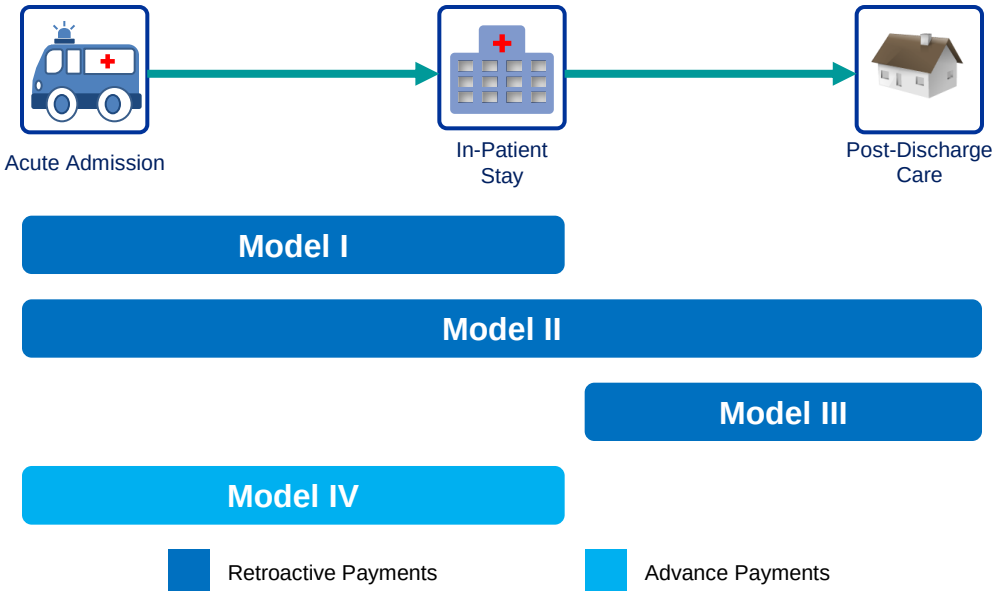
Medicare Bundled Payments Model Structure



Results & Considerations

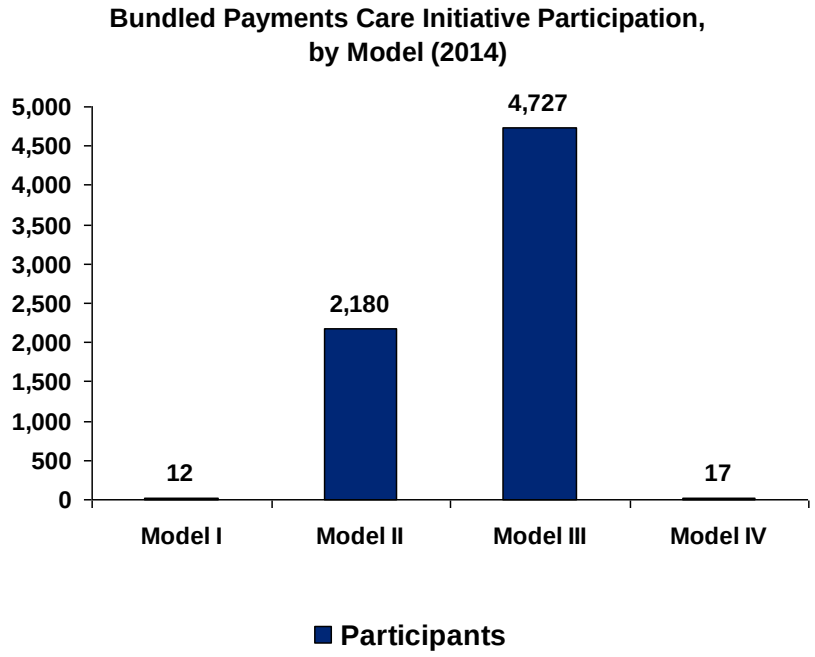
- Initial quantitative results are not yet available within the 2014 status report
  - Limited enrollment for the initial 2013 year limits usefulness of any statistics
  - Subsequent reports should contain much more information
- Challenges coordinating across multiple providers can create tension
  - Disparities in the level of quality of various providers across the care delivery chain
  - Patient preference and the desire of the institution to focus on its preferred quality providers can be at odds
- Timing of payments can create cash flow issues

Medicare Bundled Payments Care Initiative (BPCI) – Payment Model Design



- All episodes begin with acute an hospitalization by a patient but then vary:
  - Initiation and duration of episode of care
  - Applicable DRG
  - Timing of payments; retrospective as usual or prospective
- Payments are reconciled retrospectively for all models, except Model IV
  - Model IV is identical to Model I otherwise
- Participating institutions had to apply to be admitted to the pilot program for these models
  - Participation may continue to grow as the programs evolve and expand

Medicare Bundled Payments Care Initiative (BPCI) – Program Status & Participation



- CMS launched these programs in early 2013, and while each is ongoing with active institutional members, participation numbers vary greatly between programs
- BPCI participants stand to benefit financially if they provide services within the bundle more efficiently, and they can be at risk if their costs are higher than CMS benchmarks
- Additionally, each program has reasonably wide geographic coverage, with the notable exception of Model I, which is concentrated primarily in medical centers on the Northeast coast

Medicare Bundled Payments Care Initiative (BPCI) – Model Implications Discussion

Considerations

- Initial quantitative results are not yet available within the 2014 status report
  - Limited enrollment for the initial 2013 year limits usefulness of any statistics
  - Subsequent reports should contain much more information
- Challenges coordinating across multiple providers can create tension
  - Disparities in the level of quality of various providers across the care delivery chain
  - Patient preference and the desire of the institution to focus on its preferred quality providers can be at odds
- Timing of payments can create cash flow issues

Discussion Questions

- Do bundled payments adequately incentivize providers to deliver quality care to their patients?
- What infrastructure is necessary for bundled payments to evolve into a value-based, multi-payer initiative?

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Next Meetings

- **Statewide Webinar: August 13: 1:00-2:00pm**
  - Call-in information emailed and available on OSIM website
  - osim.health.ok.gov

- **Joint workgroup meeting with Health E&E**
  - August 28: 9:00-11:00am at Oklahoma Health Care Authority

- **Value-Based Analytics and Model Design Workshops**
  - September 9 in Oklahoma City
    - SAMIS Center, OU Health Sciences Center: 2:00-5:00pm
  - September 11 in Tulsa
    - Tulsa Chamber of Commerce: 1:00-3:00pm

Members from all OHIP/OSIM Workgroups are invited

Health Workforce Redesign

Governor's Health Workforce Action Plan Strategy Session

September 2nd, 9:00am-3:00pm

- Action Plan contains high level goals and strategies to ensure Oklahoma's health workforce is able to support the transition to value-based care
- Session will be facilitated by National Governor's Association Consultants
- Attendees from each workgroup will be invited
- Outcomes will be included in an issue brief that will inform the newly created *"Health Workforce Subcommittee"* of the Governor's Council for Workforce and Economic Development

Contact Jana Castleberry at JanaC@health.ok.gov or at 405-271-9444 ext. 56520.

- **Outcomes:**
  - Input on the development of a health workforce plan which incorporates a care coordination model, encourages patient-centered care, and supports the needs of a value-based system
  - Recommendations for descriptions and core competencies for "emerging health professions" in Oklahoma
  - Recommendations that support "Team-Based Care for a Transformed System of Care" in Oklahoma