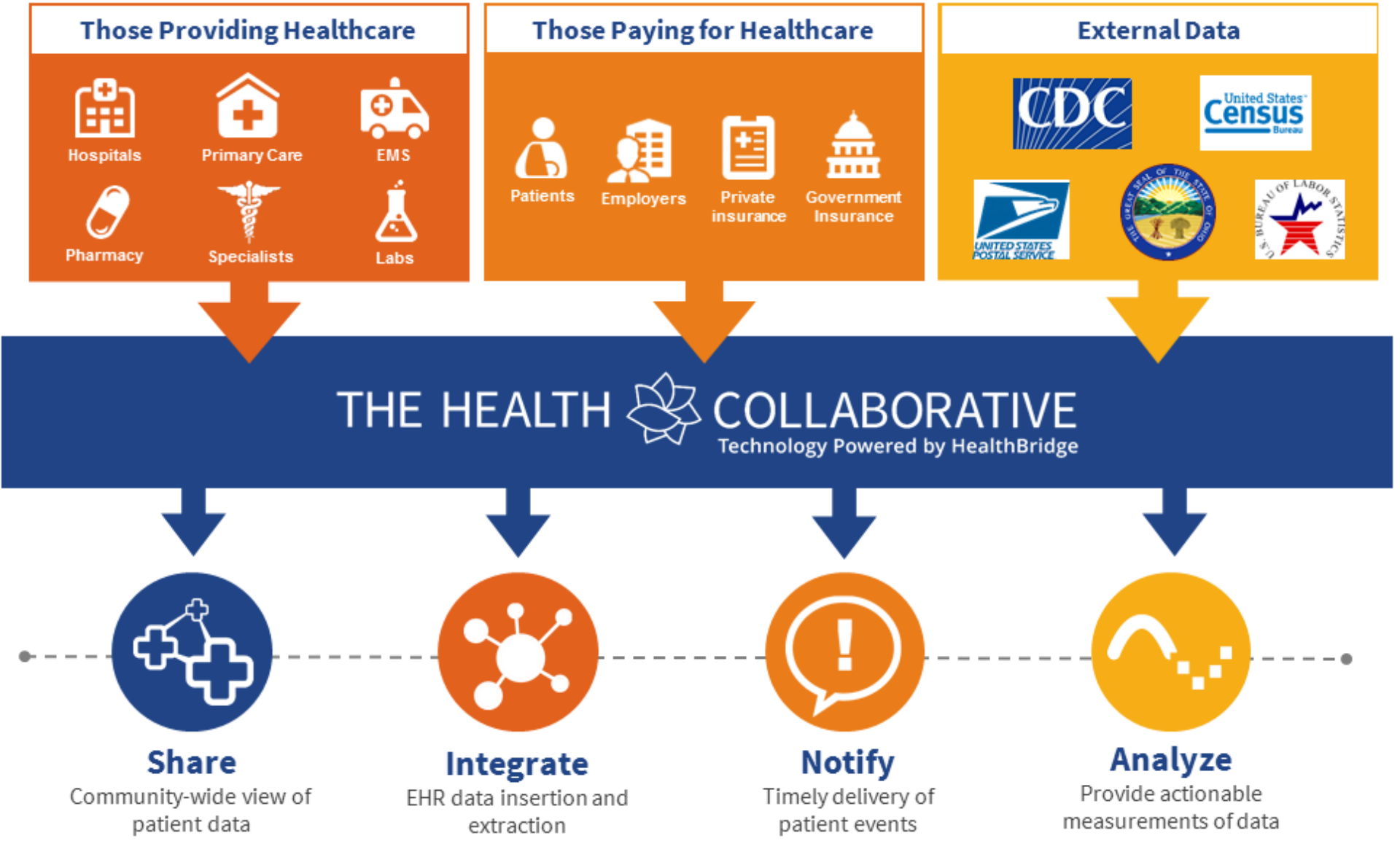
THE HEALTH COLLABORATIVE

Recognizing & Rewarding Value

National Trends. Local Action.

Dr. Richard Shonk
Chief Medical Officer


Those Providing Healthcare
Hospitals
Primary Care
EMS
Pharmacy
Specialists
Labs
Those Paying for Healthcare
Patients
Employers
Private insurance
Government Insurance
External Data
CDC
United States Census Bureau
UNITED STATES POSTAL SERVICE
U.S. BUREAU OF LABOR STATISTICS
THE HEALTH COLLABORATIVE
Technology Powered by HealthBridge
Share
Community-wide view of patient data
Integrate
EHR data insertion and extraction
Notify
Timely delivery of patient events
Analyze
Provide actionable measurements of data

How we got Here?

- Form follows Function
- Proof of Concept
- Keep adding Value
- Grow it organically
- Keep it Actionable
- Keep it Affordable
- Keep It!

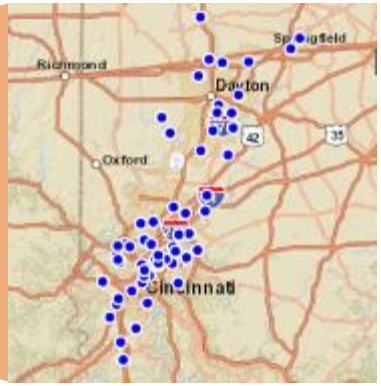
CPC
Comprehensive Primary Care

PCMH + Payment Reform

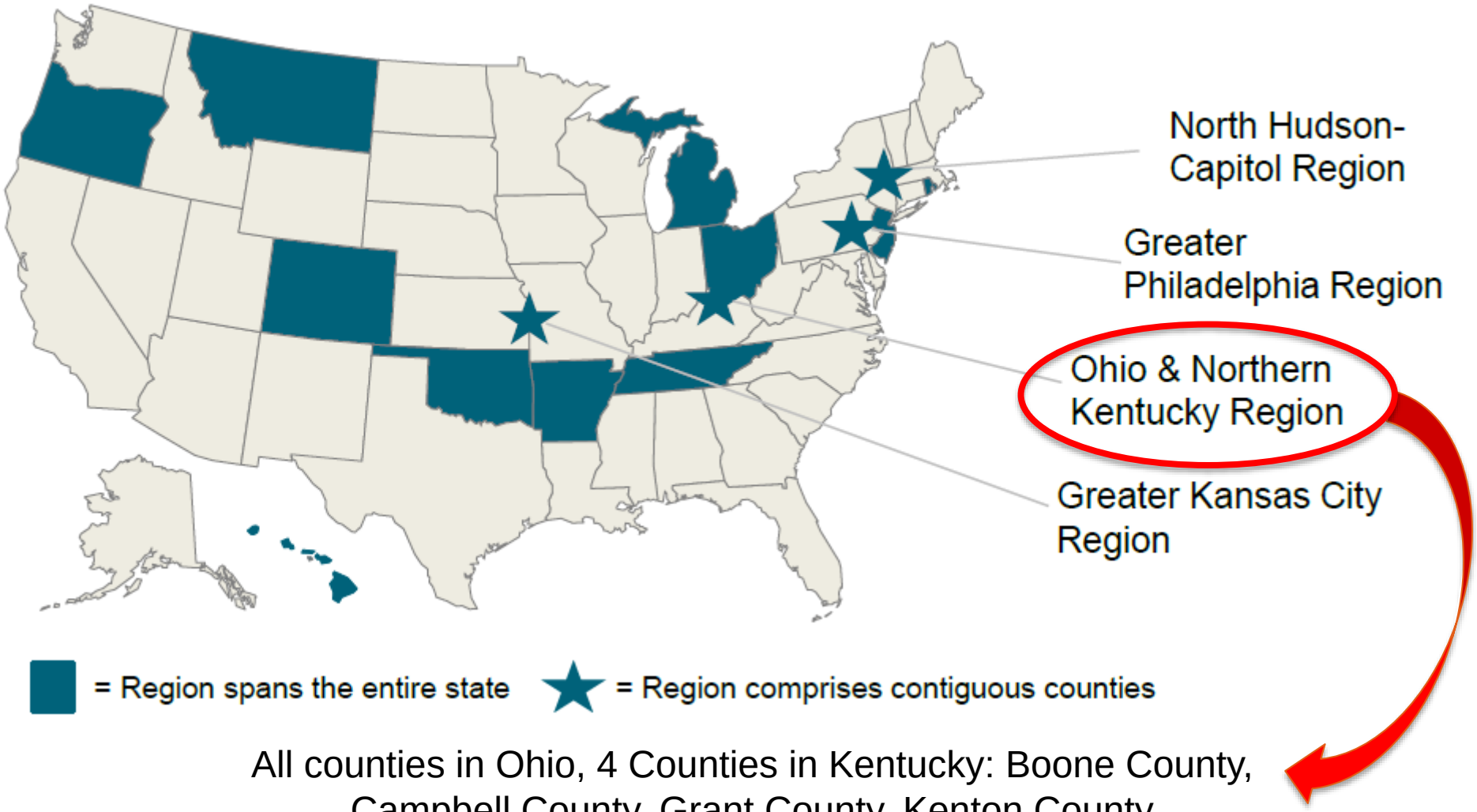
Greater Cincinnati
1 of only 7
chosen sites nationally

- **75** practices and **350** providers
- **Multi- payer:** 9 health plans + Medicare
- **500,000** estimated commercial, Medicaid and Medicare enrollees

65 miles from
Williamstown, KY to Piqua, OH



14 Selected Regions



All counties in Ohio, 4 Counties in Kentucky: Boone County, Campbell County, Grant County, Kenton County

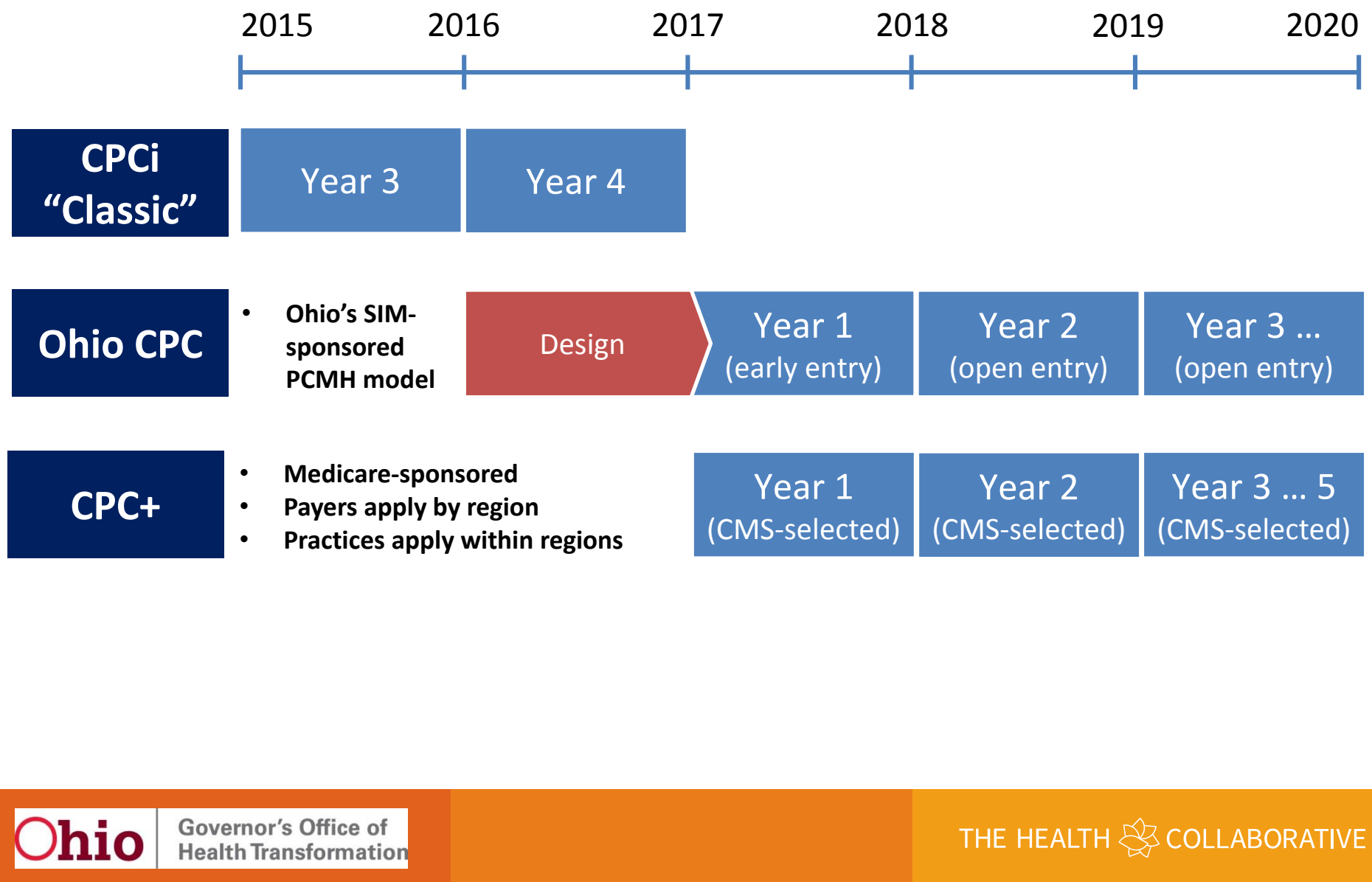
Payer Participation in OH/KY Region

In addition to Medicare:

- *Aetna*
- *Anthem*
- Aultman Health Foundation
- *Buckeye Health Plan*
- *CareSource*
- Gateway Health Plan of Ohio
- *Medical Mutual of Ohio*
- *Ohio Medicaid*
- Molina
- Paramount Health Care
- SummaCare, Inc.
- The Health Plan
- *UnitedHealthcare*

CPC Comprehensive Primary Care

Ohio's Comprehensive Primary Care Timeline



THE HEALTH COLLABORATIVE
Technology Powered by HealthBridge

CPC
Comprehensive Primary Care

An Initiative of the Center for Medicare & Medicaid Innovation
Project Timeline: 2013-2016

Population Health | **471,815 Empaneled Patients** | **Evidence-Based Care**

Critical Elements

Data
Transparency & aggregation have informed changes & helped guide improvements.

Trust
Collaboration enabled the trust necessary for establishing data transparency; *a first in CPC.*

Relationships
Provider & practice collaboration supported continued learning and innovation.

Data-Driven Improvement

Utilization	% Change 2013-2015
ED Visits	-2.8%
Inpatient Bed Days	-17.8%
Inpatient Discharges	-17%
Primary Care Visits	-9.1%
Specialist Visits	-10.7%
Quality	
CHF Admissions	-28.4%
COPD Admissions	-13.3%
ACSC Composite	-23%

*OH/KY Risk-Adjusted All Payer Aggregate Data

Outcomes through 3 years: All Payer Claims Data Aggregation

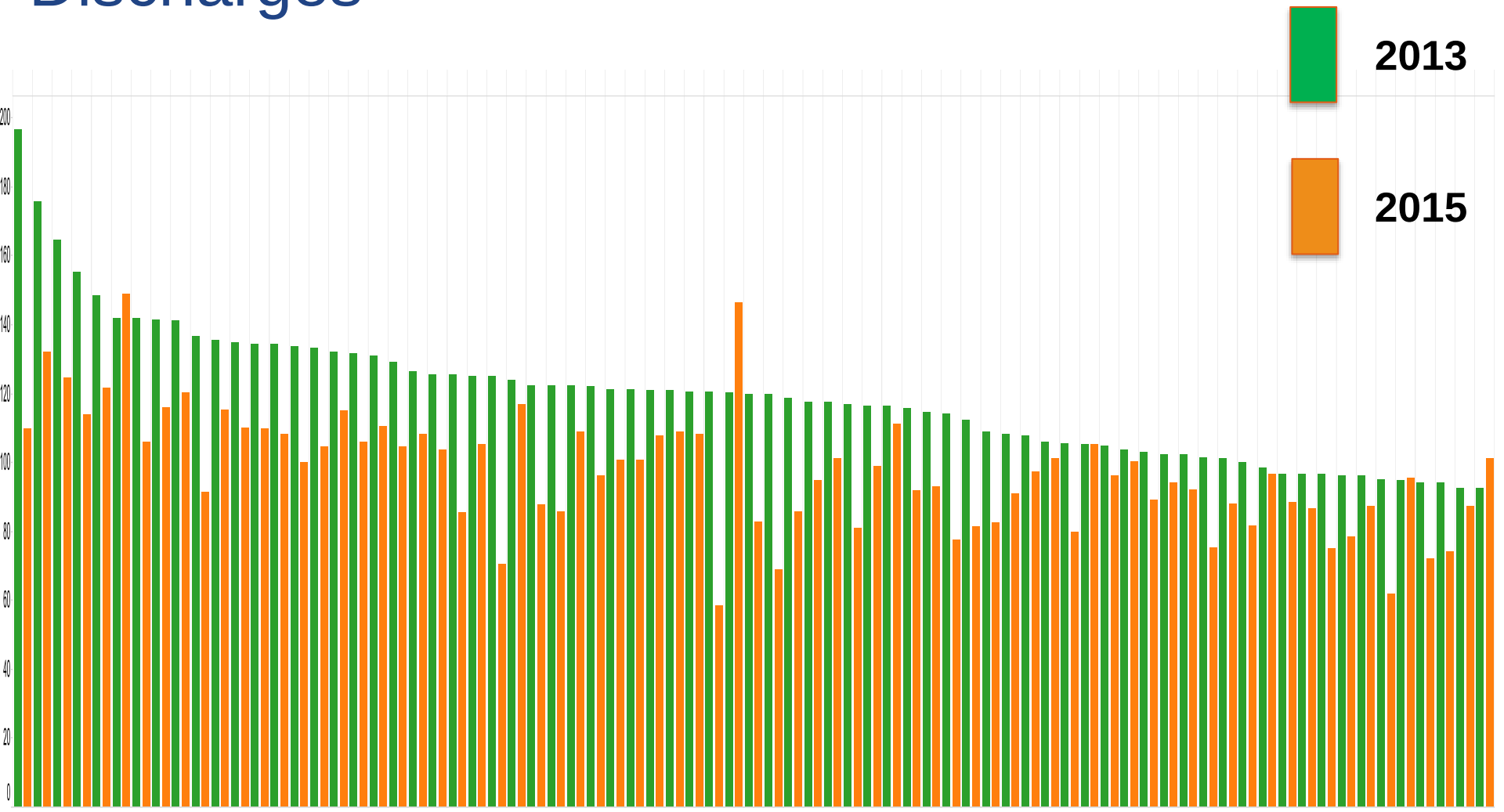
Risk-Adjusted Utilization Rates per 1,000 *OH/KY CPC Region: All Payer Aggregate*				
Measure	**2013**	**2014**	**2015**	**% Change from 2013**
ED Visits	302.8	301.8	**294.3**	**-2.8%**
Inpatient Bed Days	578.2	**507.0**	**475.5**	**-17.8%**
Inpatient Discharges	121.5	**107.9**	**100.9**	**-17%**
Primary Care Visits	2593.9	**2544.4**	**2357.5**	**-9.1%**
Specialist Visits	2487.6	**2265.8**	**2222.5**	**-10.7%**
Risk-Adjusted Quality Measure Rates per 1,000				
PQI CHF	6.2	**5.6**	**4.4**	**-28.4%**
PQI COPD	5.7	**5.0**	**4.9**	**-13.3%**
PQI Composite	21.0	**18.0**	**16.2**	**-23.0**
PCR(30-day readmits)	0.9	0.9	1.0	

OH/KY Aggregate Payer Data: Blinded Payer Data

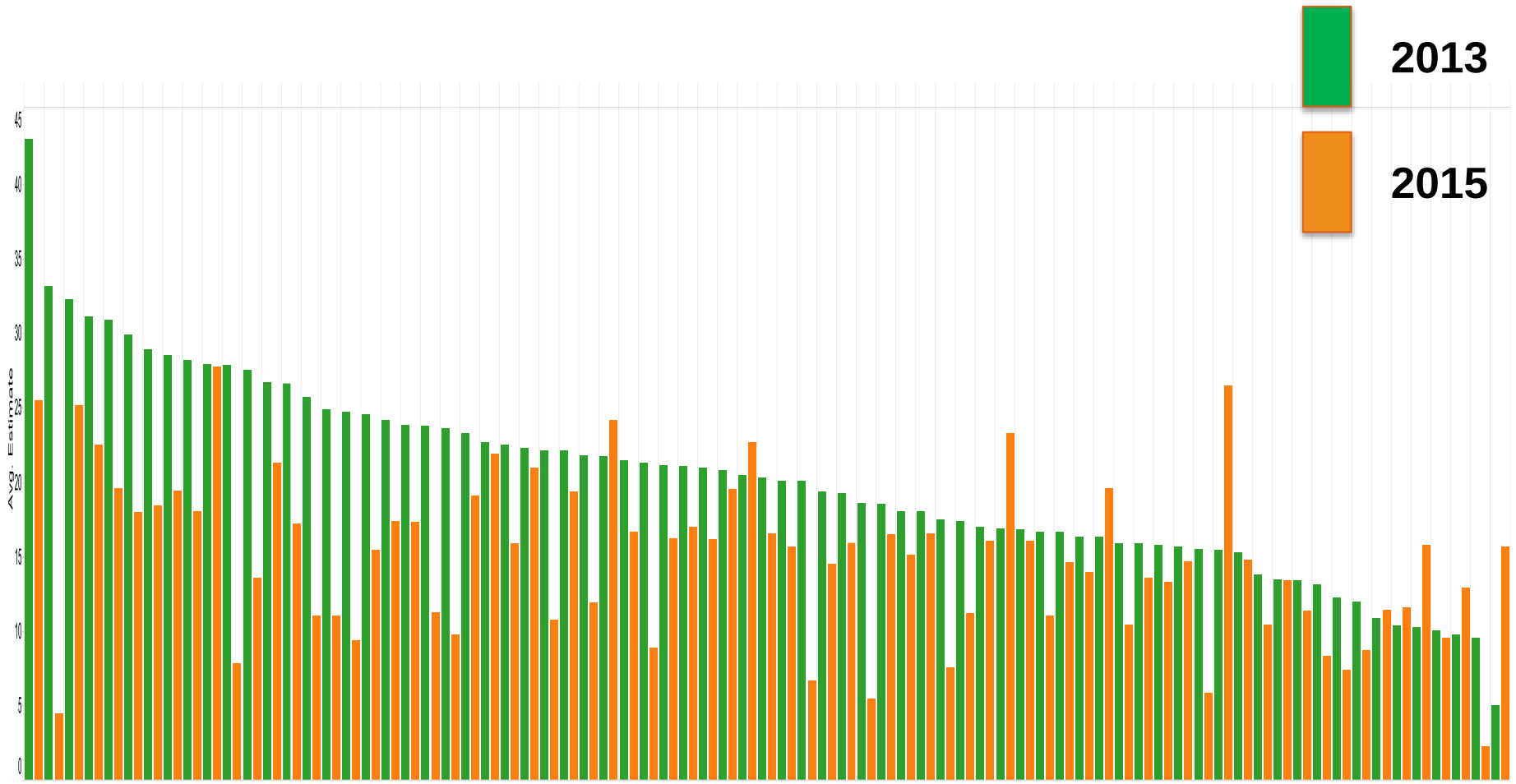
CPCi % Change from 2013 (risk-adjusted)
OH/KY Region: Commercial Plans
Risk Adjusted Utilization Rates per 1,000

Measure	Blinded Health Plan	% Change from 2013-2015
Inpatient Discharges	All Payers	**-17.0%**
	Health Plan 05	**-41.3%**
	Health Plan 17	**-14.9%**
	Health Plan 31	**-17.6%**
	Health Plan 77	**-15.1%**
	Health Plan 81	**-29.8%**
PQI Composite	All Payers	***-23.0%***
	Health Plan 05	-49.3%
	Health Plan 17	-34.0%
	Health Plan 31	***-27.2%***
	Health Plan 77	***-38.0%***
	Health Plan 81	***-32.6%***

OH/KY Aggregate Payer Data: Risk Adjusted - Inpatient Discharges



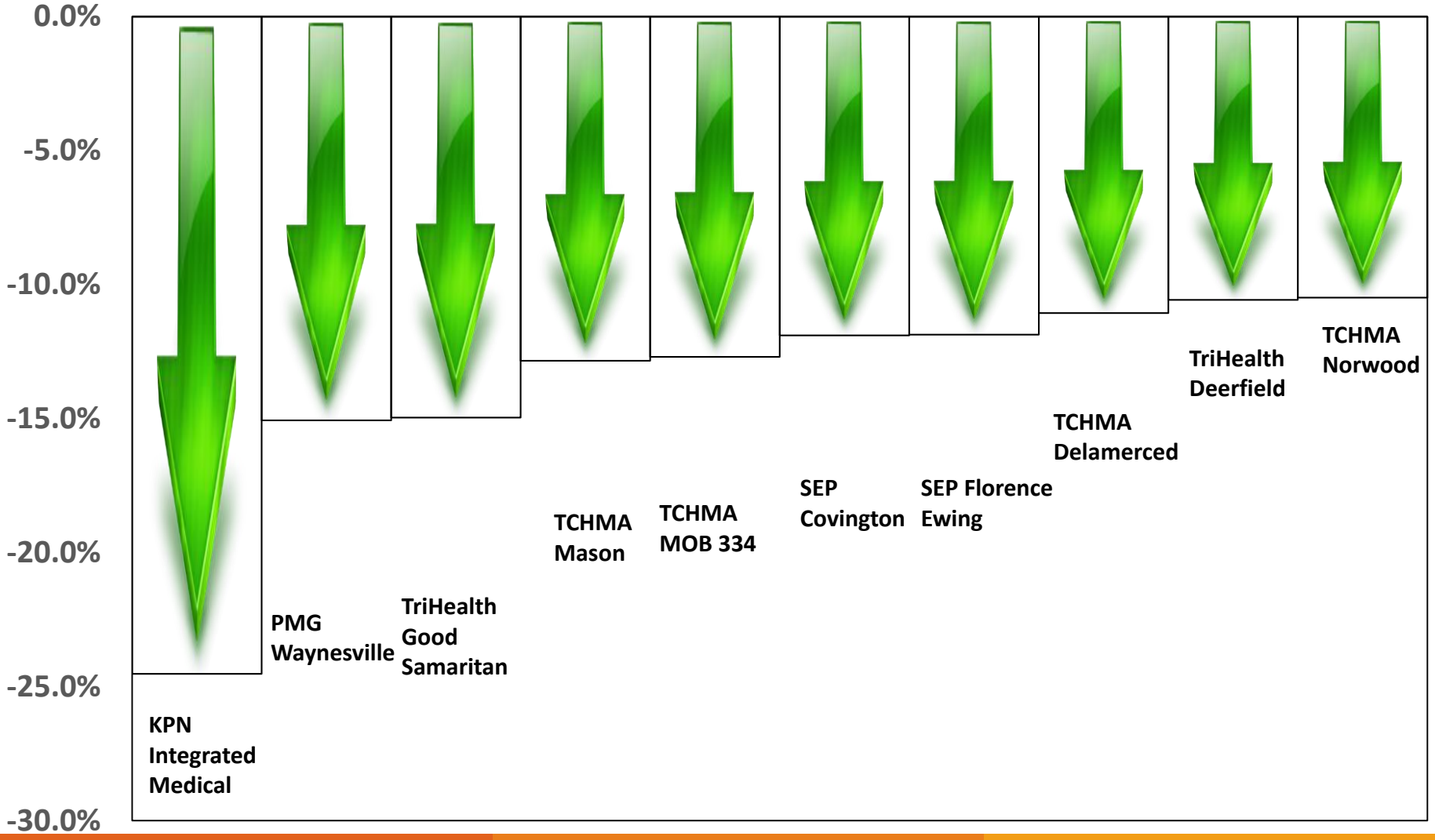
OH/KY Aggregate Payer Data: Risk Adjusted – PQI Composite (ACSC)



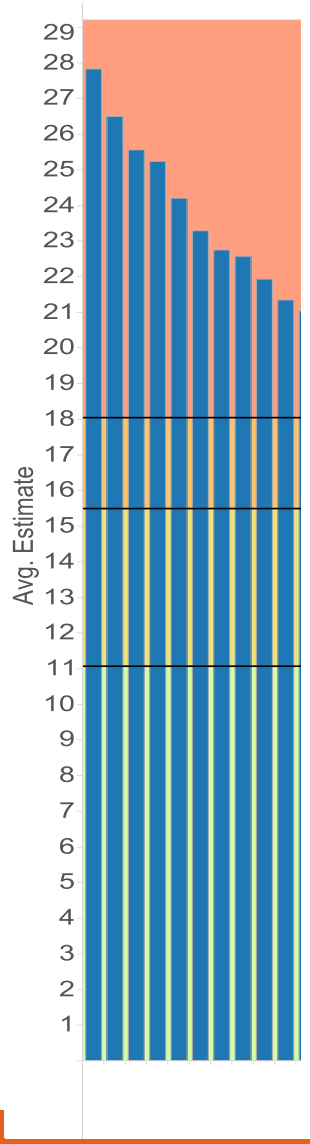
OH/KY Aggregate Payer Data: TOP TEN
Total Cost (risk-adjusted)

1 Hyde Park FM
2 TriHealth Deerfield
3 TCHMA Mason
4 TriHealth Finneytown
5 SEP Covington
6 TriHealth Good Sam
7 TCHMA Norwood
8 TCHMA Walnut
9 TCHMA Rookwood IM
10 SEP Walton

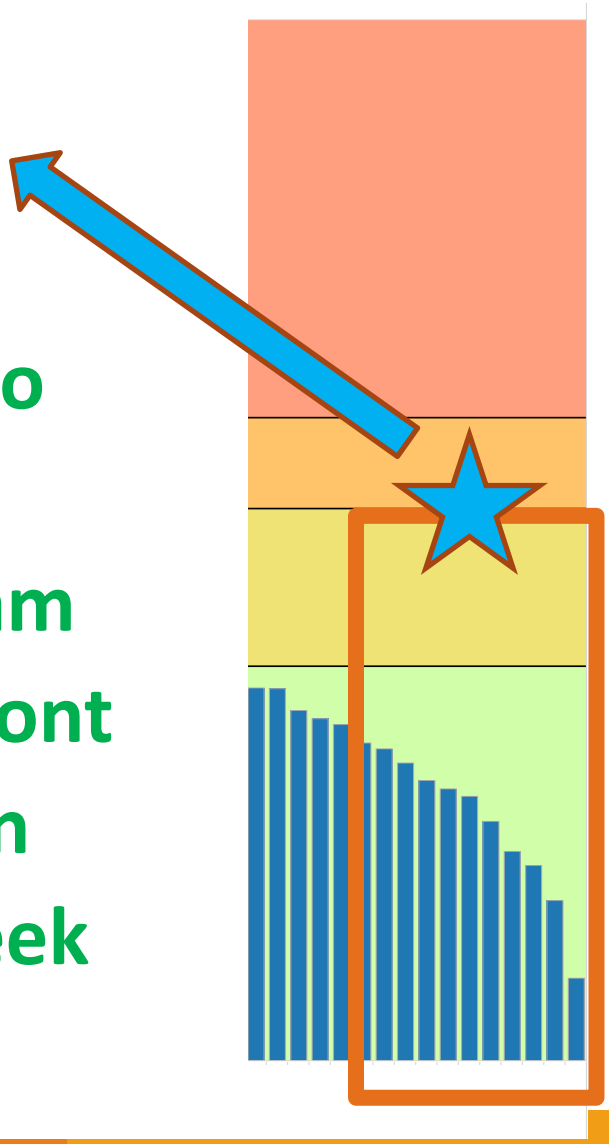
OH/KY Aggregate Payer Data: TOP TEN Most Improved 2013 to 2015 Total Cost (risk-adjusted)



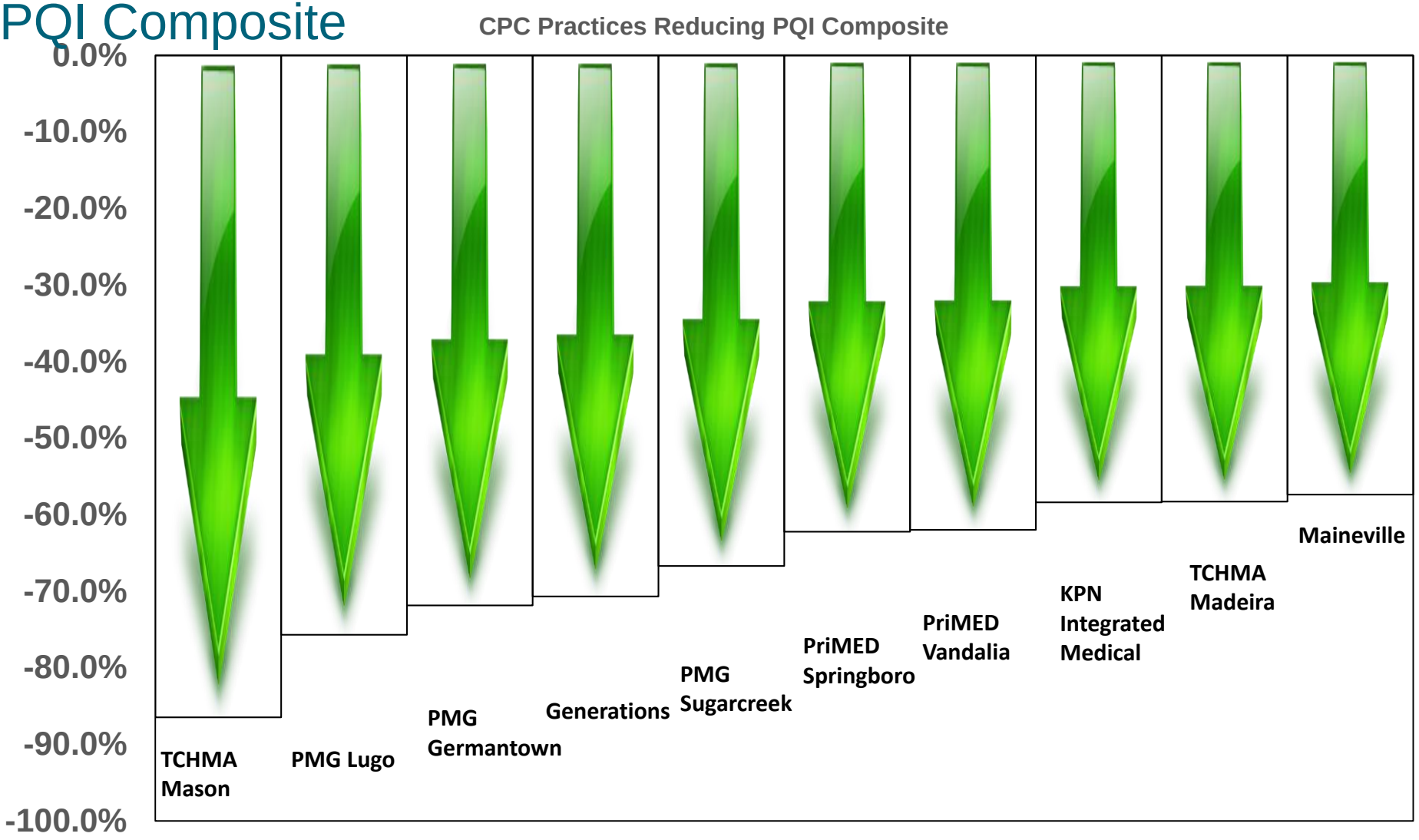
OH/KY Aggregate Payer Data: TOP TEN
PQI Composite



1. PMG Lugo
2. TCHMA Mason
3. Generations
4. PriMED Springboro
5. PMG Sugarcreek
6. TriHealth Good Sam
7. TriHealth Mariemont
8. PMG Germantown
9. PriMED Beavercreek
10. PMG Waynesville



OH/KY Aggregate Payer Data: TOP TEN Most Improved 2013 to 2015 PQI Composite



TriHealth: Looking for Value in Data Aggregation

- Directional and strategic – Aggregated data giving clues to interventions
- 3M CRG risk methodology as a jumpstart for risk stratification process
- Validate coding
- Potential use for physician compensation model
- Best practices: Who is performing well?

Maineville: How we use the reports.

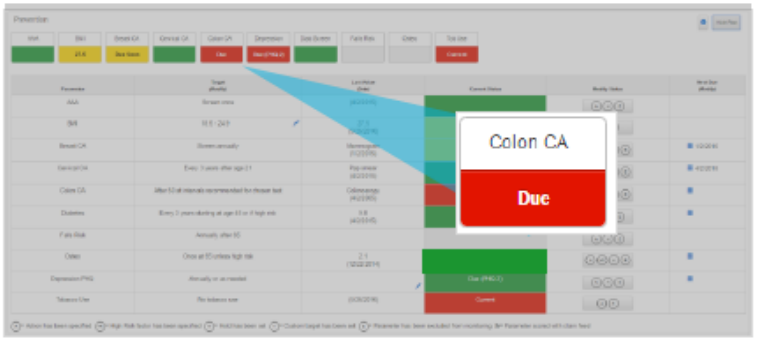
- Data Aggregation – checks and balances
  - Looking for holes in practice system with regard to high cost and high utilization patients
- Attribution
  - Checking for gaps
- Tracking patient health status over time

The Christ Hospital: Incorporating data into the workflow

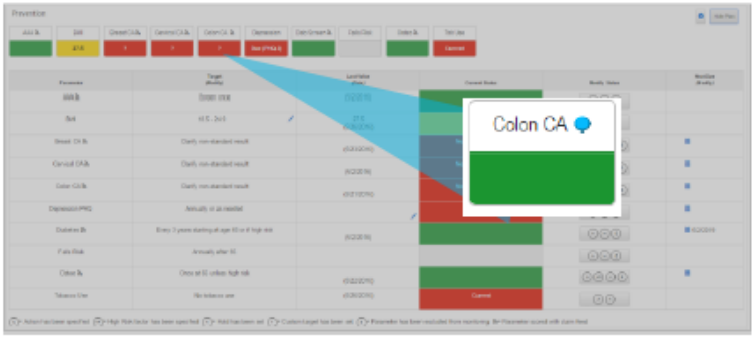
- Care Management Point of Care Software
- Patient health over time with 3M CRG risk categories
- Looking for patterns of best practice

Design Concept: Point of Care Display Augmented with Claims Data

Before claim feed information

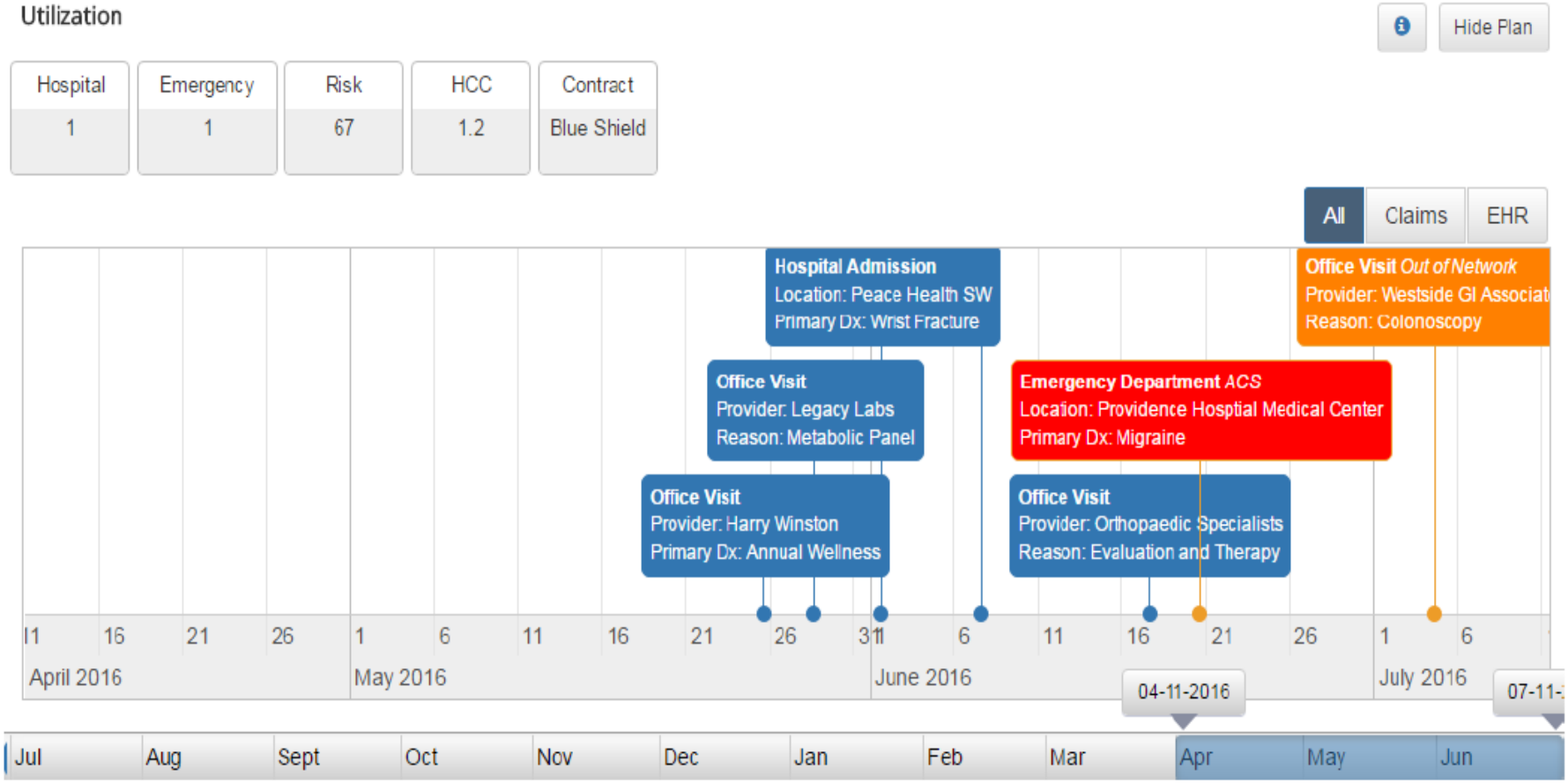


After claim feed information

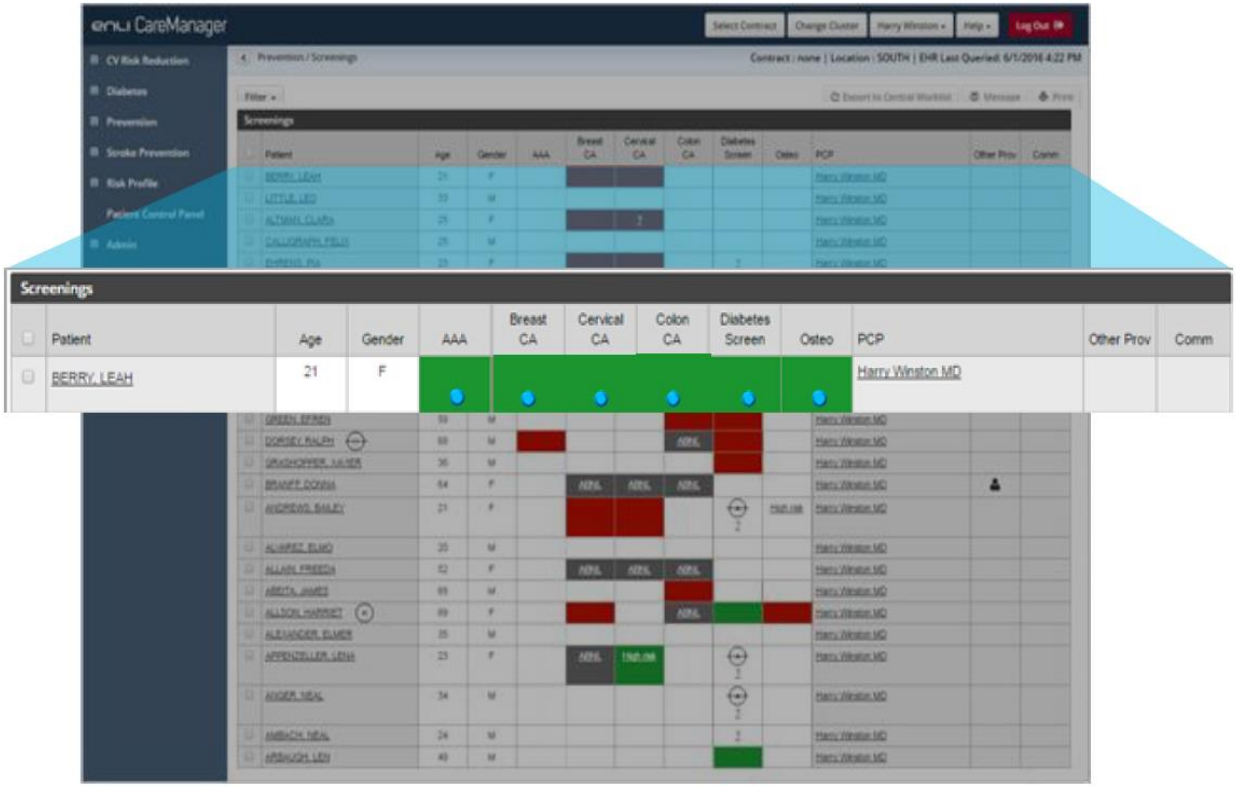


UTILIZATION DATA AT THE POINT OF CARE

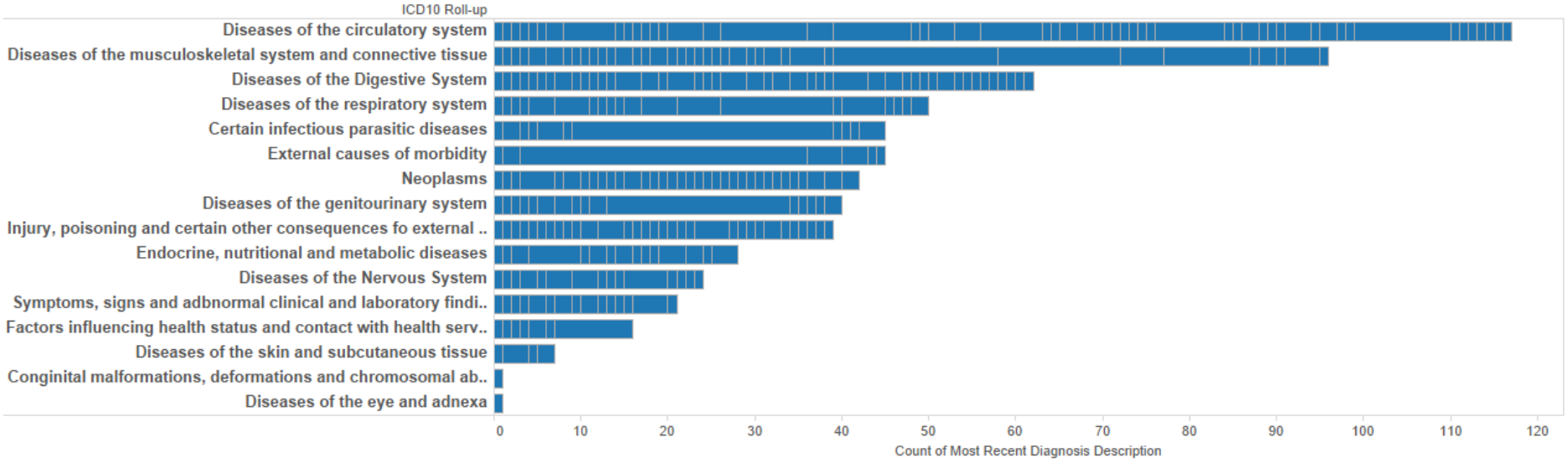
Design Concept: Displaying Where Else My Patient Has Been



Design Concept: Augmenting Clinical Service Gaps with Claims Data in the Registry

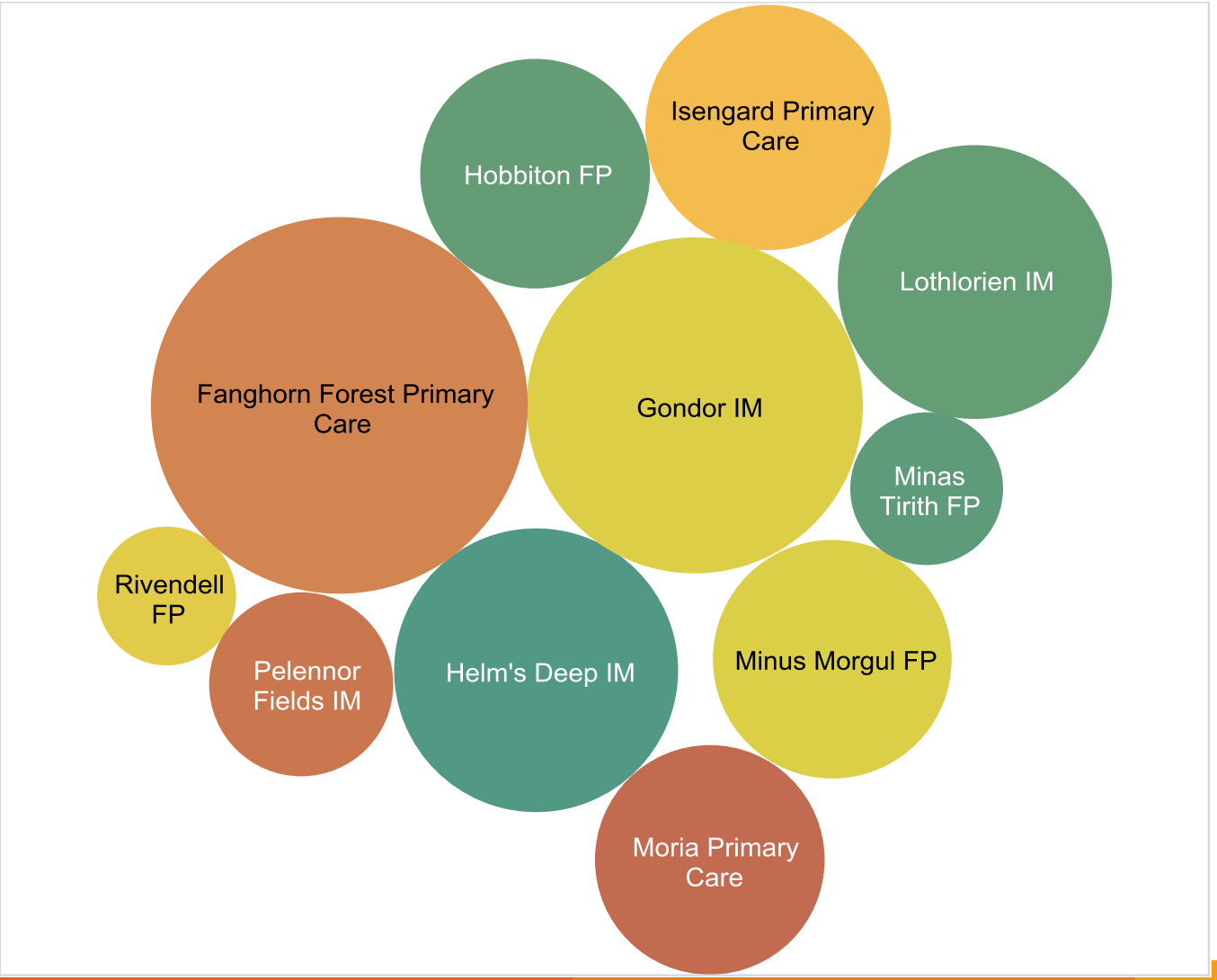


Interventions to Outcomes:
ICD 10 Category Roll-up



Inpatient Discharges, Readmissions, and ED Visits can be viewed and ranked by frequency.

Allocate Care Management and practice resources



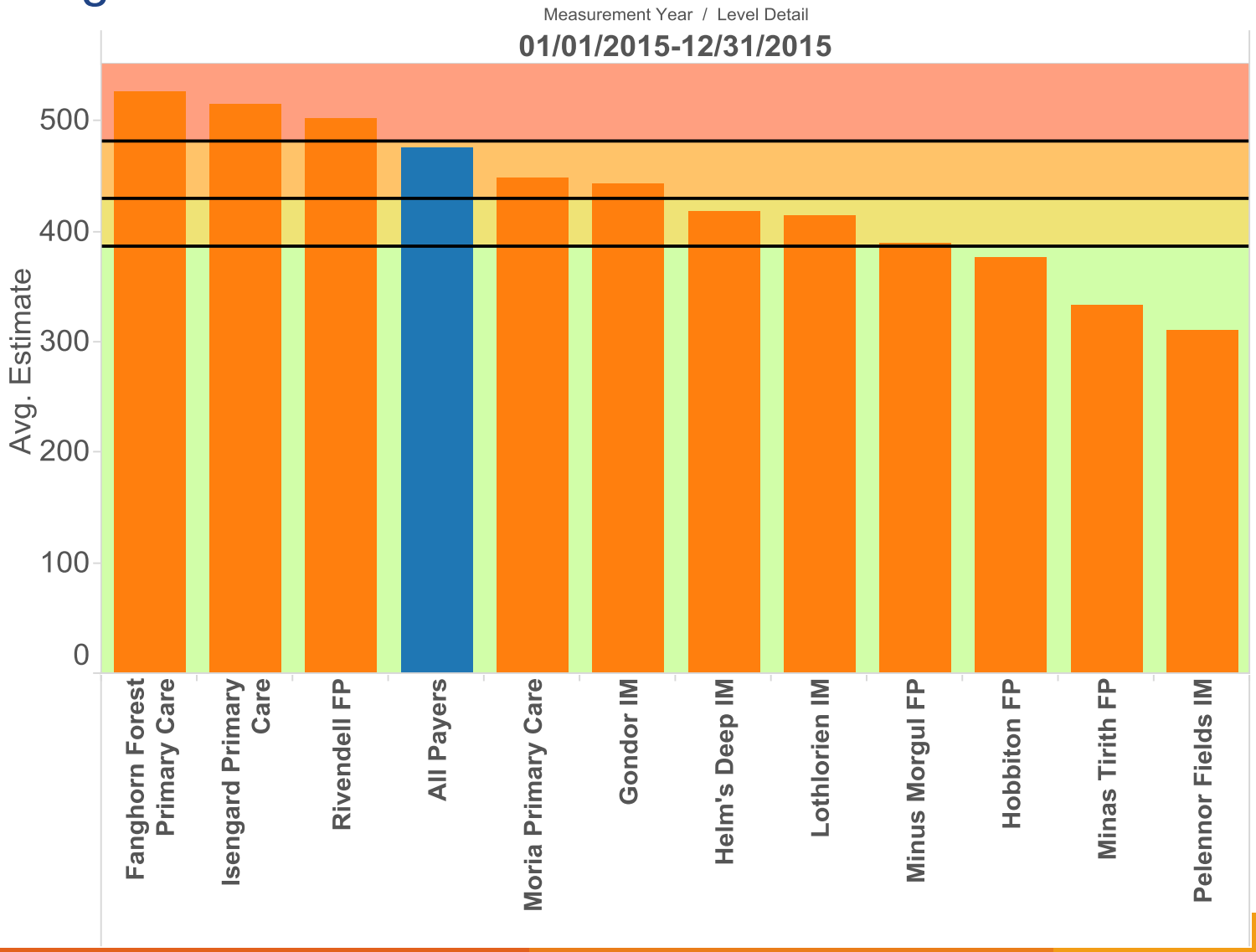
Utilization: ED Visits (lower utilization is green and transitions to red as value increases)

Circle Size: Size of practice by distinct member count (lower patient volume is a smaller circle

Allocating Resources:
Where are your patients going?

	Practice A Hospital Admissions	=	Practice A ED Visits
1	Hospital One		Hospital Eleven
2	Hospital Two		Hospital One
3	Hospital Three		Hospital Five
4	Hospital Four		Hospital Twelve
5	Hospital Five		Hospital Thirteen
6	Hospital Six		Hospital Ten
7	Hospital Seven		Hospital Fourteen
8	Hospital Eight		Hospital Fifteen
9	Hospital Nine		Hospital Sixteen
10	Hospital Ten		Hospital Seventeen

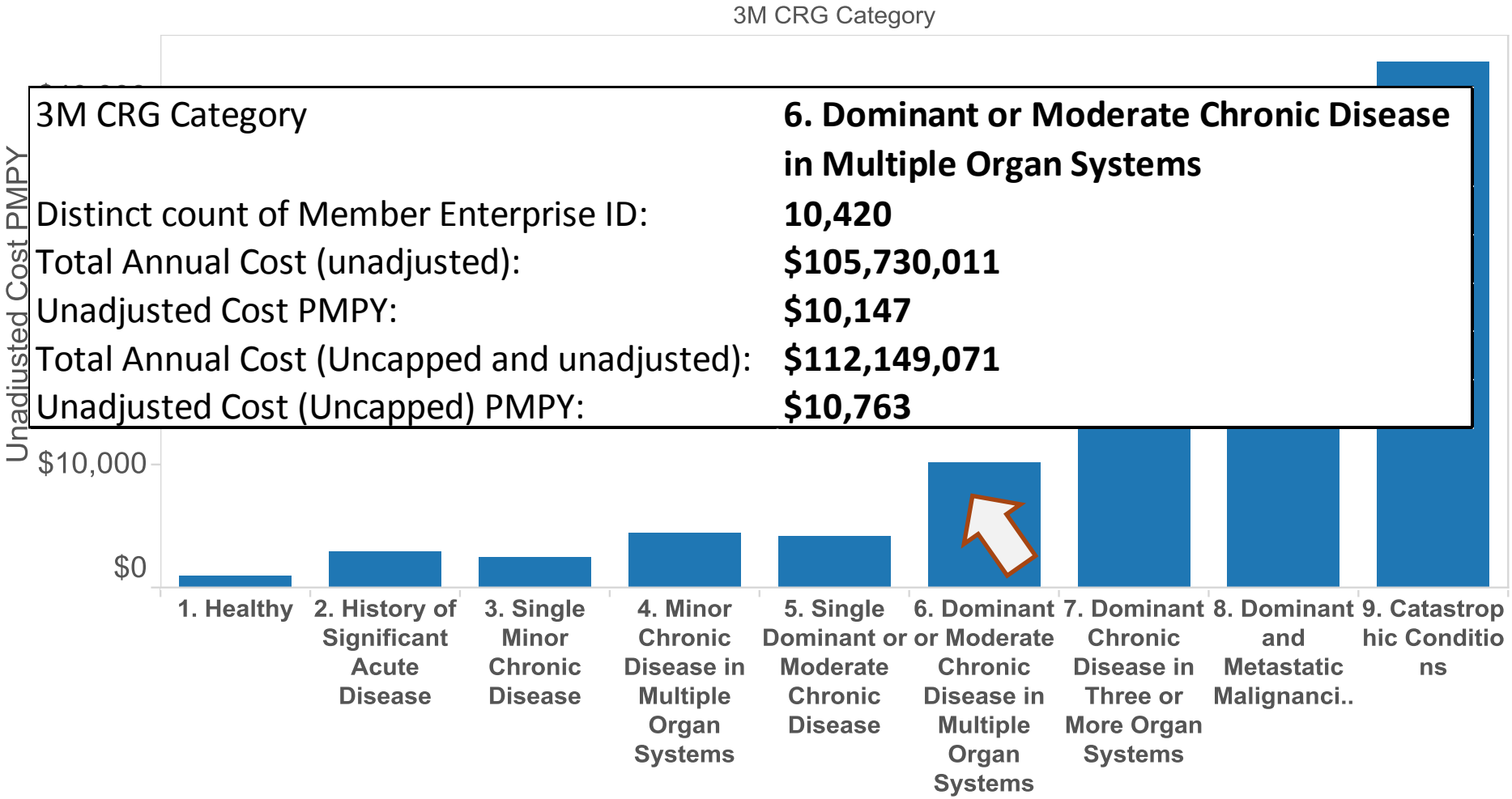
Benchmarking: 2015 Risk-Adjusted Total Cost: Provider Group vs the Region



Tolkien practices

ALL OH/KY CPC Practices

Rising Risk:
Cost PMPY per 3M CRG Category

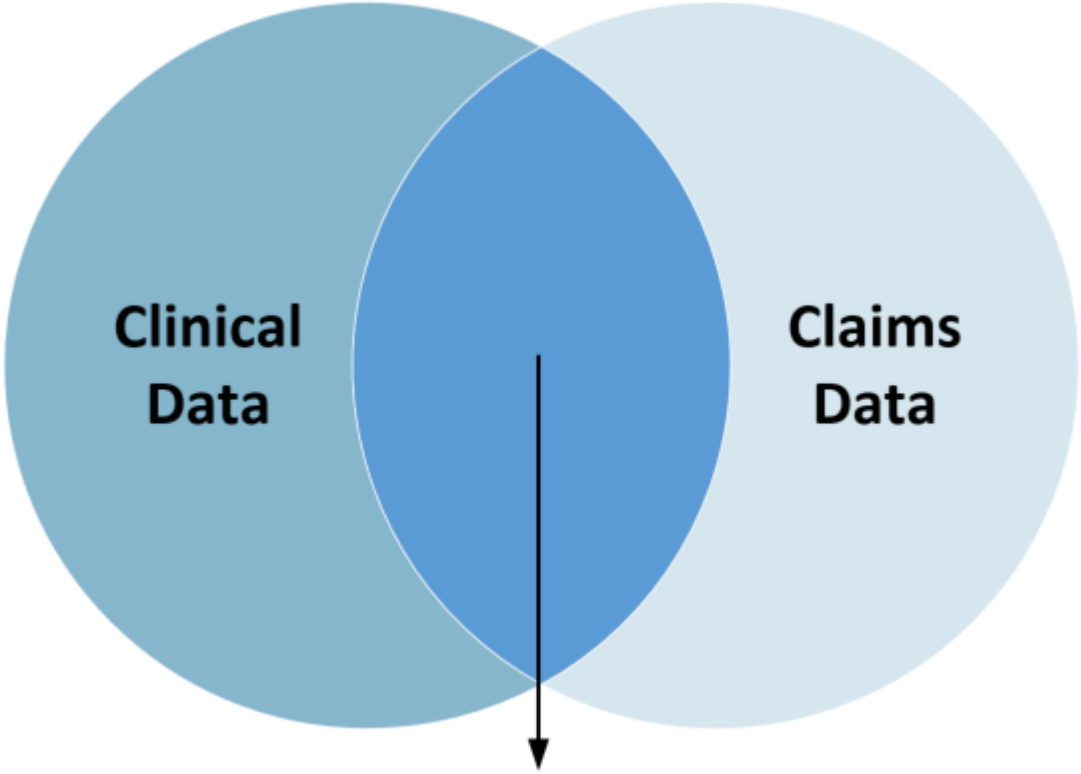


3M CRG Category	**6. Dominant or Moderate Chronic Disease in Multiple Organ Systems**
Distinct count of Member Enterprise ID:	**10,420**
Total Annual Cost (unadjusted):	**$105,730,011**
Unadjusted Cost PMPY:	**$10,147**
Total Annual Cost (Uncapped and unadjusted):	**$112,149,071**
Unadjusted Cost (Uncapped) PMPY:	**$10,763**

Coming Attractions

- Clinical Impact: Actionable data
  - ED: Visits/1000
    - By Day of Week
    - By Diagnosis
    - ENS Impact
  - PQI 90: Events/1000
    - By Diagnosis
  - Specialists visits
    - By Diagnosis
    - By Provider Name
    - By Severity Score

Cost & Clinical Data Combination



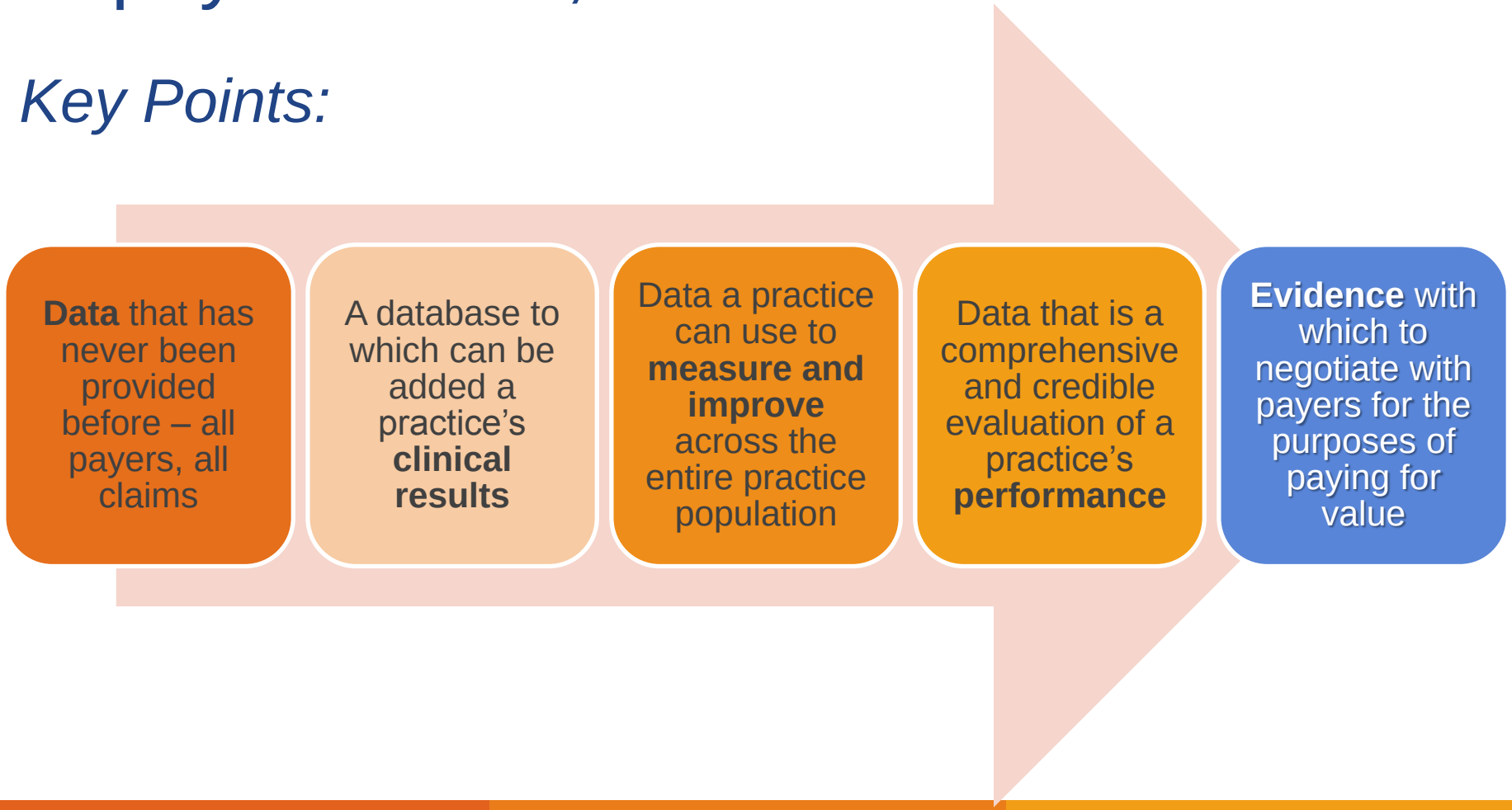
Combined data set tied together via master patient and provider index

Clinical Data Core Services:

- Clinical Results Delivery
- Meaningful Use
- Encounter Notifications
- Admission Analysis
- HEDIS
- Quality & Cost Measurement

To pay for value, one must measure value!

Key Points:



The Case for Claims Data Aggregation

Comprehensive View

Measurable Value

Standard Approach

Sustainability

Value for Payers

Paying for Value is Enhanced by Comprehensive Practice Level Measurement

Statistical Validity of Aggregated Data Improves the Accuracy of Performance Comparisons

Adoption of a Standard National Measure Set is Reliable and Valued by Stakeholders

Accurate, Co-Owned Data Gives Confidence to pay for Value in a Sustainable and Scalable Approach

Value for Providers

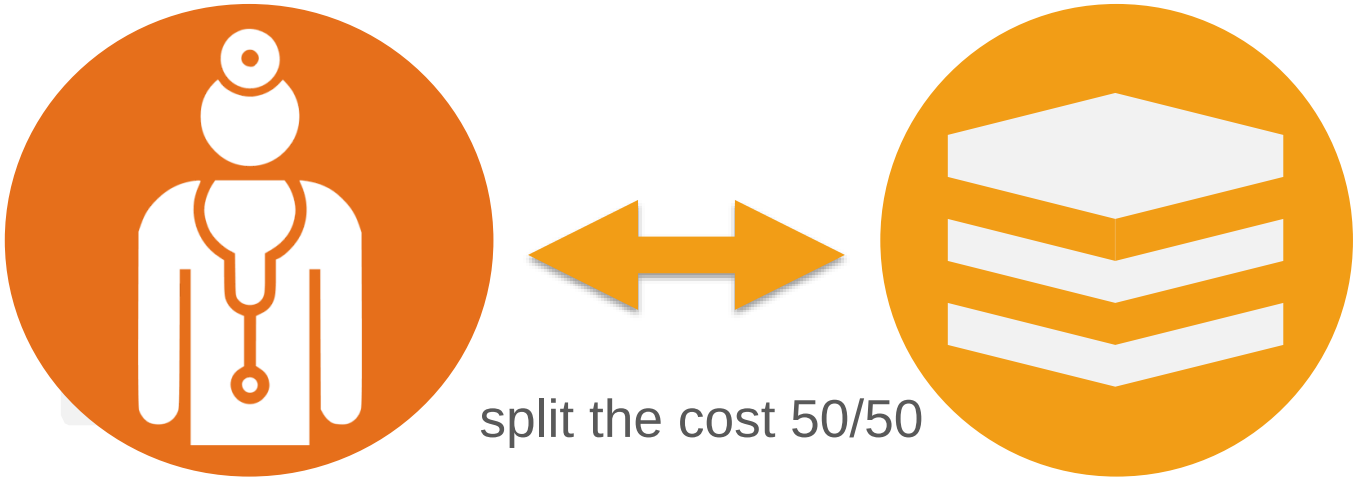
Comprehensive Reports Provide a One Stop Shop for Practice-Wide Data at Patient Level Detail

Aggregated Data Reports Provide a "Third Party" vetted Value of the Provider's Performance

Improvement Efforts are More Efficient with Reductions in Variability and "Drill Down" Capabilities

Sustained Engagement is Made Possible With Co-Owned, Trusted, & Transparent Data

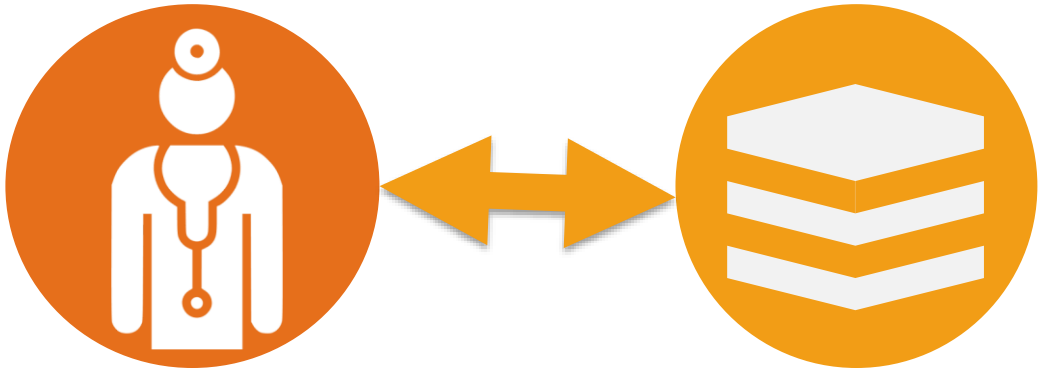
Business Model: Co-Ownership



Providers

Health Plans

Business Model: “Claims Data Co-Op”



- Co-Own the Process
- Look into the “Black Box”
- Ownership of the results
- “Their data” = “Our data”
- Nothing engages like paying for it
- Knowing who to call

CONTINUE THE MOMENTUM

- **Sustainability**: Reap the rewards for the years of work to create an aggregated payor report.
- **Simplicity**: No one wants to go back to receiving separate reports from each payor.
- **Service**: We are continually making the reports more user friendly and actionable.
- **Utility**: Beyond benchmarking against other practices, we are learning together new ways to make the reports more actionable.
- **Shared ownership**: When both providers and payors are engaged in paying for a shared data reporting process there is added credibility.
- **Partnering/Convening**: The reports serve as a focus for working together in CPC+, providing a venue for broader discussions.

Considerations:

If we…

- Preserve the investment of time and effort by building on present agreements and infrastructure…
- Demonstrate an ongoing use of claims data aggregation by practices in managing pay-for-value arrangements…
- Are successful in recruiting practices to bear a majority (60% or greater) of the aggregation cost…
- Keep the costs for health plans within +/-10% of the pro-rated costs (per member rate) incurred for CPC Classic…
- Incorporate into our cost structure the ability to convene the payers in CPC+ as requested by CMMI…

Will you…

- Continue with claims data submission
- Pay your pro-rated portion of the aggregation (and convening) costs
- Consider adding Control Groups
- Consider monthly submissions to allow 30 and 60 day run-outs

Key Strategies

- Demonstrate Value to Practices and Payers
- Continue claims aggregation in CPC+
- Continue to refine the tool
  - Make the data more timely
  - Provide better trending capability
- Add Tri-State Medicare FFS claims (QE)
- Add Clinical Data
- Expand Private Health Plans to State wide

The Near Future…

- To avoid MACRA, PCP's will migrate to alternative payment methodologies
- Comprehensive Primary Care Plus will be very attractive as one of those APMs
- SIM PCMH will add State of Ohio and Medicaid as payers to the incentive to join CPC +
- Medicaid lives will be part of the bargain
- Medicaid and Medicare become more sustainable for the practices as long as care management fees are risk adjusted
- Pay for Value will require fair and accurate measurement of Value

THE HEALTH COLLABORATIVE

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Thank You!

Sample Practice Activities

CPC+ Functions	Track 1	Track 2 (Includes and builds on Track 1)
Access and Continuity	• 24/7 Patient Access • Assigned Care Teams	• E-Visits • Expanded Office Hours
Care Management	• Risk-Stratify patient population • Short and long-term care management	• Care Plans for high-risk chronic disease patients
Comprehensive-ness and Coordination	• Identify high volume/cost specialists serving population • Follow-up on patient hospitalizations	• Behavioral Health Integration • Psychosocial needs assessment and inventory resources and supports
Patient and Caregiver Engagement	• Convene a Patient and Family Advisory Council	• Support patients' self-management of high-risk conditions
Planned Care and Population Health	• Analysis of payer reports to inform improvement strategy	• At least weekly care team review • of all population health data

CMS' Three Payment Innovations Supporting Practice Transformation

	Care Management Fee (PBPM)	Performance-Based Incentive Payment (PBPM)	Underlying Payment Structure
Objective	Invest in practice capability to deliver comprehensive primary care	Reward practice performance on utilization and quality of care	Reduce dependence on fee for service to offer flexibility in care setting
Track 1	$15 average	$2.50 opportunity	Standard FFS Claims Payment
Track 2	$28 average; including $100 to support patients w/ complex needs	$4.00 opportunity	Reduced FFS with prospective "Comprehensive Primary Care Payment" (CPCP)
Payment	Paid prospectively on a quarterly basis.	Paid prospectively on an annual basis. Must meet quality and utilization metrics to keep incentive payment.	**T1**: Regular FFS Claims Payment **T2**: CPCP paid prospectively on a quarterly basis; Medicare FFS claim is submitted normally but paid at reduced rate

Ohio Comprehensive Primary Care (CPC) per member per month (PMPM) payment calculation

The PMPM payment for a given CPC practice is calculated by multiplying the **PMPM for each risk tier** by the **number of members attributed to the practice in each risk tier**

	3M CRG health statuses	Example of 3M CRG	2017 CPC PMPM (Estimated)
CPC PMPM Tier 1	▪ Healthy	▪ Healthy (no chronic health problems)	$1
	▪ History of significant acute disease	▪ Chest pains	
	▪ Single minor chronic disease	▪ Migraine	
CPC PMPM Tier 2	▪ Minor chronic diseases in multiple organ systems	▪ Migraine and benign prostatic hyperplasia (BPH)	$8
	▪ Significant chronic disease	▪ Diabetes mellitus	
	▪ Significant chronic diseases in multiple organ systems	▪ Diabetes mellitus and CHF	
CPC PMPM Tier 3	▪ Dominant chronic disease in 3 or more organ systems	▪ Diabetes mellitus, CHF, and COPD	$22
	▪ Dominant/metastatic malignancy	▪ Metastatic colon malignancy	
	▪ Catastrophic	▪ History of major organ transplant	

- Practices and MCPs receive payments **prospectively and quarterly**
- Risk tiers are **updated quarterly**, based on 24 months of claims history with 6 months of claims run-out
- Finalized 2017 **PMPM values will be determined Q3 2016**

Detailed requirement definitions are available on the Ohio Medicaid website:
http://medicaid.ohio.gov/Providers/PaymentInnovation/CPC.aspx#1600562-cpc-payments

Ohio | Governor's Office of Health Transformation