THE HEALTH COLLABORATIVE

Payment Reform

June 2022

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what we do

Serving the Greater Cincinnati-Northern Kentucky Region

We bring healthcare stakeholders together.

We act as a facilitator to **bring all the healthcare stakeholders** in our region **to the table.**

We work for the good of the community.

We bring healthcare stakeholders **together** to work for a **common good.**

We provide actionable data.

We provide **real-time information** to healthcare providers so they will know immediately when a patient has been hospitalized, discharged, or taken to an emergency room.

strategic priorities

2022-2024 Focus Areas

01.

Collective Health Agenda

Facilitate a collective health agenda for the region with a focus on equity.

02.

Workforce Pipeline & Diversity

Expand pipeline and diversity of health workforce.

03.

Regional Health Data Utility

Bring together siloed data sets as a community asset.

04.

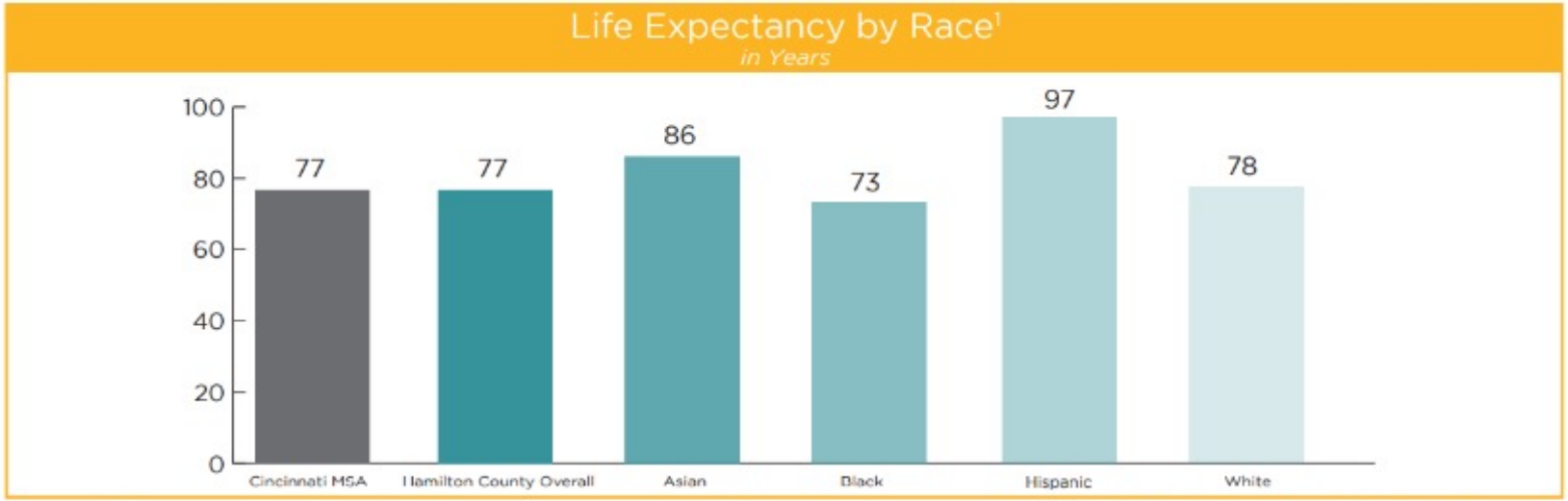
Innovation & Growth

Prioritize data solutions delivering greatest value to partners and/or community health

collective health agenda

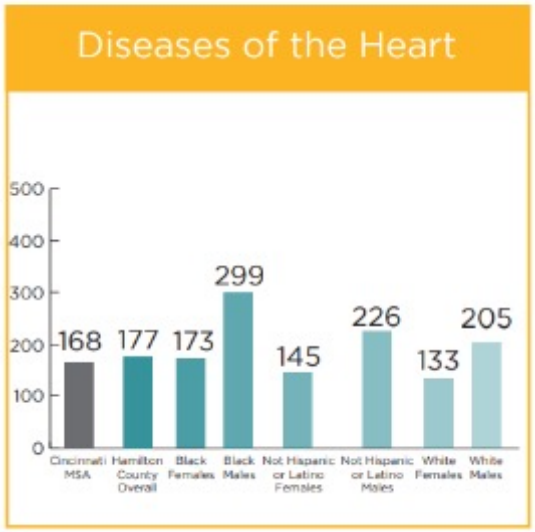
regional health challenges

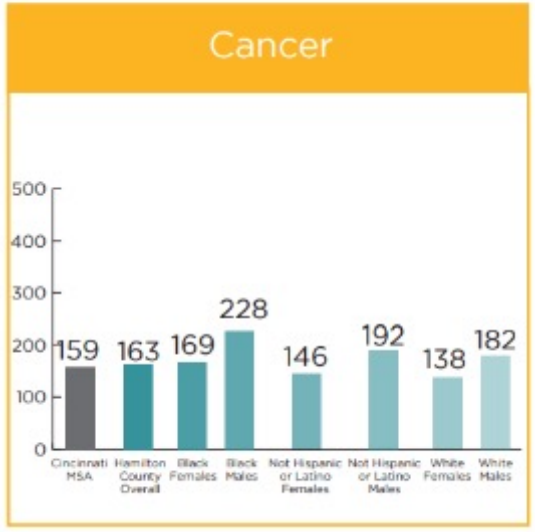
Exceptional Healthcare, but Less Than Exceptional Health Outcomes

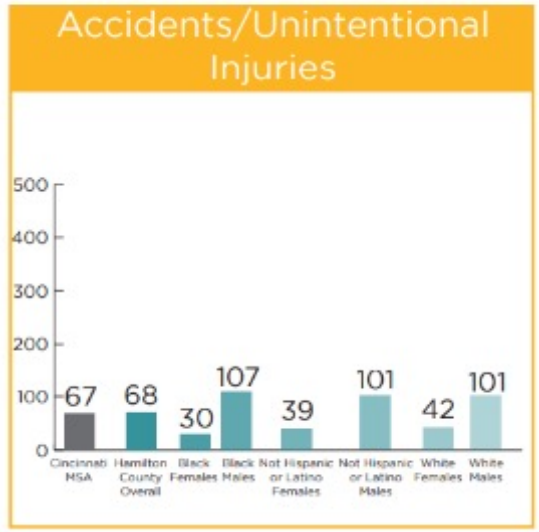


Cause of Death Summary (by Race) Age-adjusted Mortality Rates[1]

Rates per 100,000







Greater Cincinnati is in a critical situation when it comes to our community's health.

Healthcare alone can't fix it.

We are fortunate to have exceptional healthcare resources, but our health outcomes continue to tell a story of inequity and rank amongst the unhealthiest in the nation.

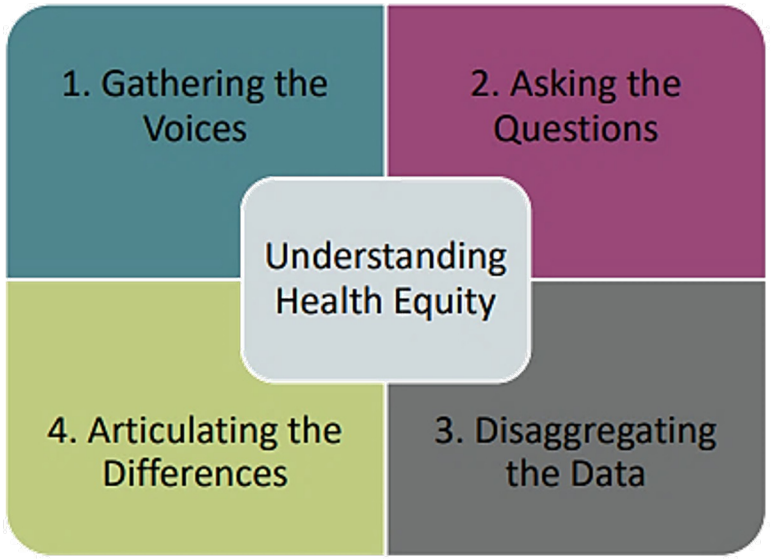
CHNA overview

Bringing Together Healthcare and Public Health in a Collaborative Effort

The exercise moved beyond what was is known through secondary data and explored the **comprehensive drivers** of health outcomes.

"THC is a very, very important partner connecting us all – the center of the wheel."
-Congregate Care Stakeholder

Health equity means everyone has a fair and just opportunity to be as healthy as possible.[i] To achieve an understanding of health equity, each data collection strategy included mechanisms to:



1. **Hear the voices of community members** and be intentional about engaging community members who are historically underrepresented in community data.

2. **Ask questions** about health experiences, outcomes, barriers, and solutions.

3. **Disaggregate the data** by region, age, race, and gender and other characteristics with sufficient sample sizes.

4. Using the data to clearly **identify the unique experiences** of community members.

OVER 10,000 voices heard

community health improvement plan

Regional Community Health Improvement Plan (CHIP) – the “how”

Top Priorities:

- **Access to services** for the region’s top health needs: **behavioral health, cardiovascular disease, dental and vision.**
- **Access to and Use of Resources** for most critical health related social needs (HRSNs): **food security and housing**, with a focus on the development and **strengthening of partnerships.**
- **Healthcare Workforce pipeline and diversity**, including cultural competence.

Link to the CHNA complete report and Executive Summary

Community Health Needs Assessment | The Health Collaborative

collective health agenda: screening for social determinants of health

- Hamilton
- Butler
- Warren

SW Ohio's AHC Model

The Accountable Health Communities (AHC) Model will assess whether systematically identifying the health-related social needs of community-dwelling Medicare and Medicaid beneficiaries (CDB's), including those who are dually eligible, and addressing their identified needs, impacts those CDBs' total healthcare cost and their inpatient and outpatient healthcare utilization.

- 11 Clinical Delivery Sites
- 3 Community Partners
- 3 Payer Partners

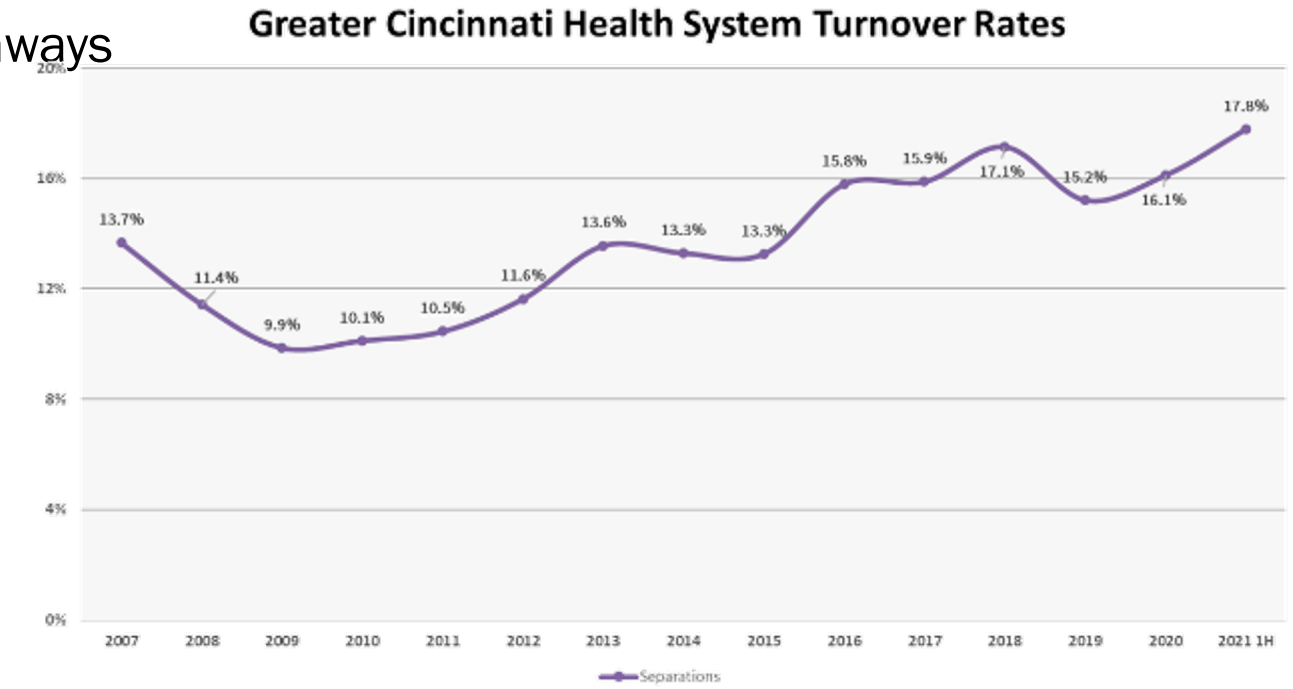
31,000 patients screened!

workforce pipeline

workforce innovations

A centralized hub for healthcare workforce initiatives in the Greater Cincinnati medical community

- Regional Workforce Collaboration
- Job Quality - Attract, Retain, Engage and Advance Workforce
- Healthcare Talent Pipeline and Career Pathways
- HR Business Intelligence Market Data
- Employer Peer-to-Peer Diversity Learning



tap.hc

Experiences for students exploring **healthcare career** paths: clinical, administrative, & health IT fields

tap.md

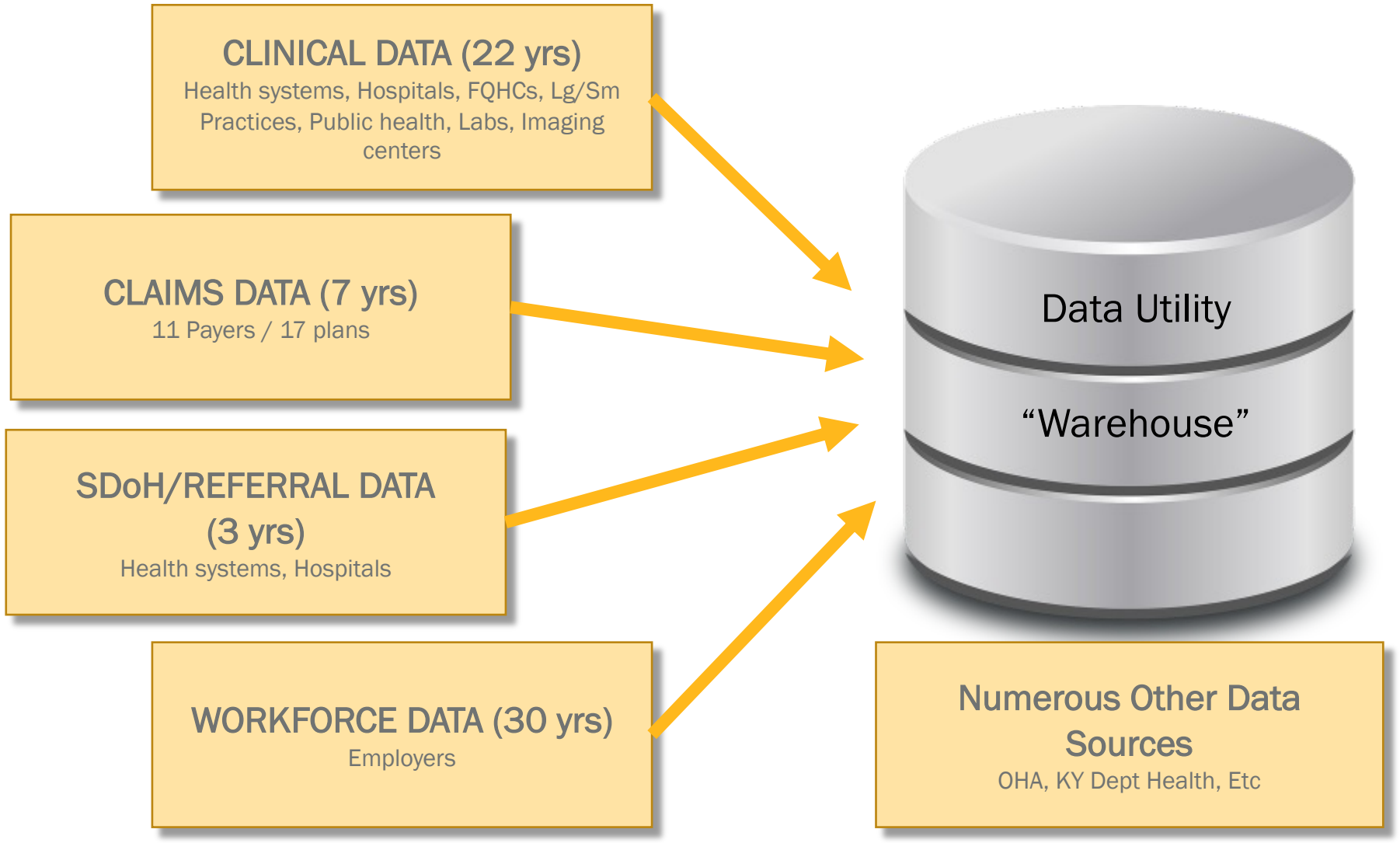
Experiences for students interested in pursuing a **physician career**, exploring a variety of specialties

healthFORCE

A bi-annual **healthcare career expo** for high school students to learn about a wide variety of health careers

health data utility

what data does THC already capture?



what does THC do with that data?

CLINICAL DATA (22 yrs)
Patient results,

- Patient Results
- Realtime Alerts
- Longitudinal Records

CLAIMS DATA (7 yrs)
CPC+, CPC Classic, CPC-OH, PCF,

- CPC+
- CPC-OH
- Employer Analysis

SDoH/REFERRAL DATA (3 yrs)
Health systems, Hospitals

- SDoH Stats
- CHNA

WORKFORCE DATA
Employers

- Workforce Stats
- Turnover

by the numbers: the health collaborative

14.9 million

Clinical results processed monthly

10.4 million

Unique patients in Master Patient Index (MPI)

386,714

hb/notify care alerts monthly

18,177

Connected providers*

1,597

Connected practices*

70

Connected hospitals*

18

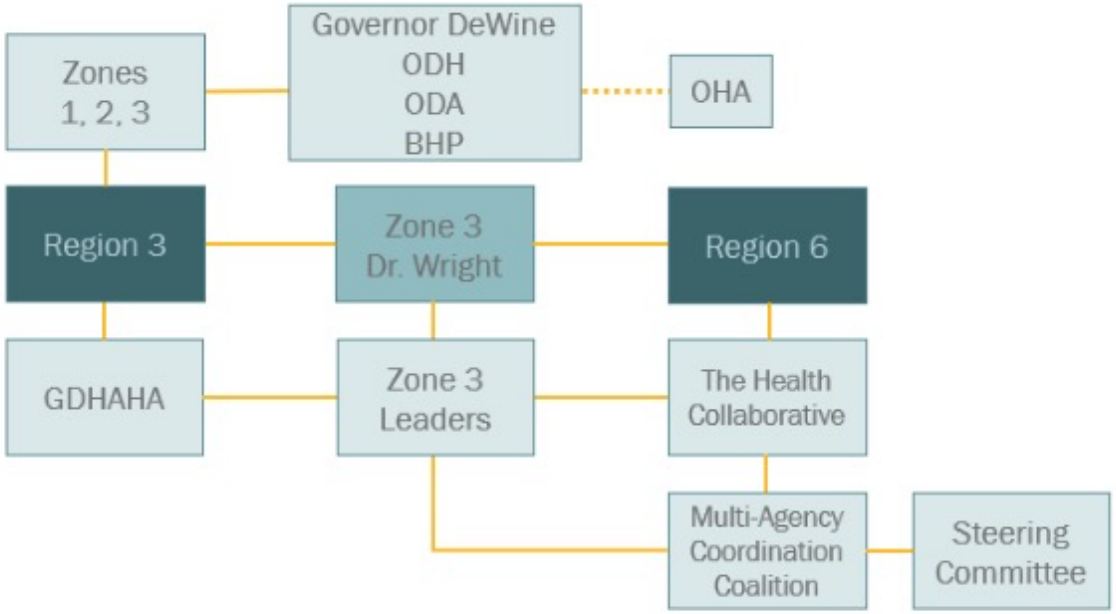
Connected independent laboratories/ radiology centers*

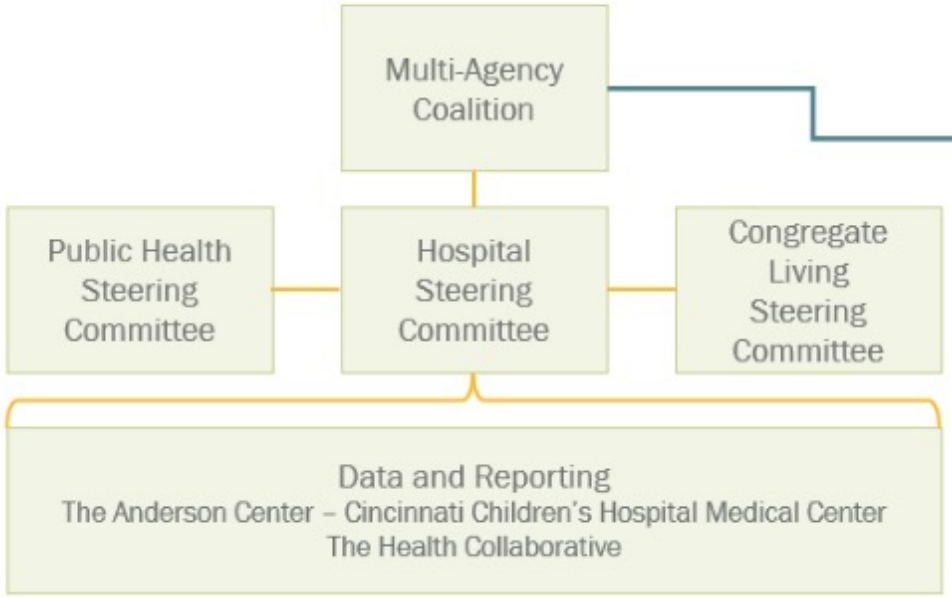
22

Connected health systems*

**Actively using THC products and services*

COVID response

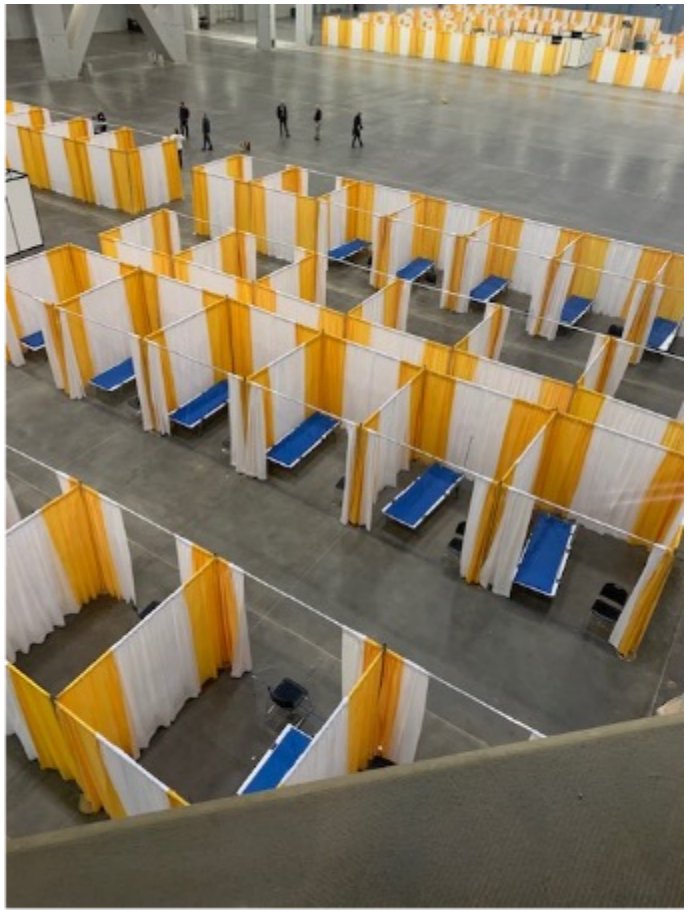




MULTI-AGENCY COALITION

- Zone 3 Lead – Dr. Wright
- CCHMC Epidemiology Data Team
- Ohio Department of Health
- Ohio EMA
- Steering Committee Chairs
- Public Information Officer
- Federally Qualified Health Centers
- Tristate Disaster Preparedness Coalition
- The Health Collaborative
- Infectious Disease

surge planning



- Bed Capacity/Expansion
- Staffing
- Load balancing
- Triage & Transport
- Mechanical Resources
- Pharmaceutical Resources
- PPE
- Modes of decompression
- Testing
- Vaccination

care innovation
CPC plus

comprehensive primary care plus (cpc+)

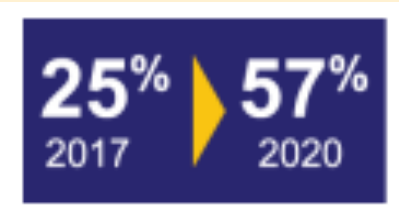
- Largest and most ambitious primary care payment and delivery model ever **TESTED**
- 3,070 Primary Care Practices & over 17 million patients

Did we pass the TEST?

CPC Plus results for Y4 2020

Access

Care improved for beneficiaries with behavioral health needs



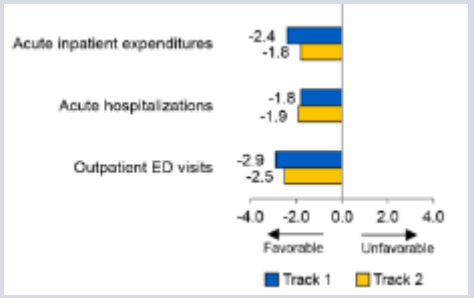
Quality

Increased hospice use, diabetes protocol and breast cancer screening

1.5% increase in diabetes protocol

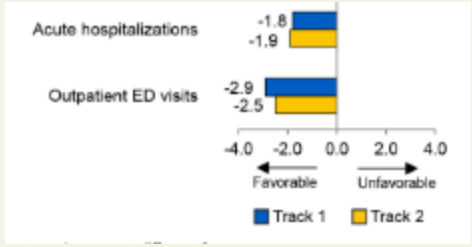
Efficiency

Reduced acute hospitalization and outpatient ED visits



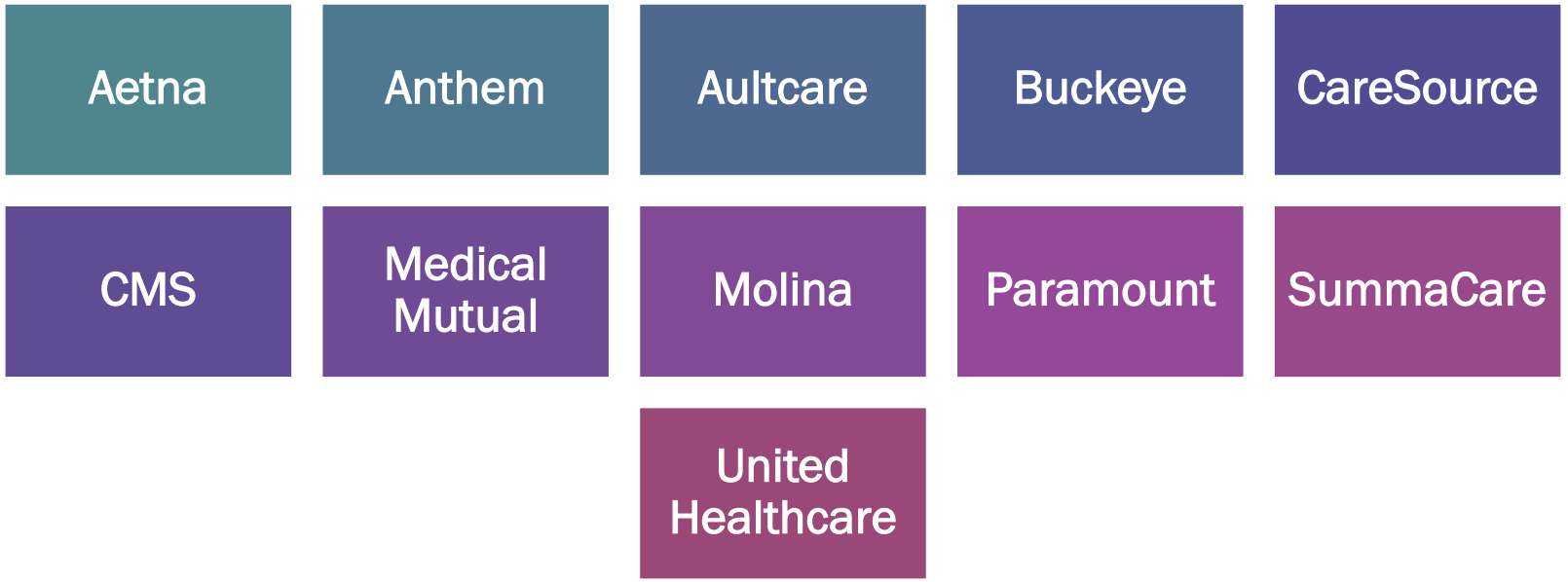
Lower cost

Reduced expenditure without enhanced payment and increased expenditure with enhanced payment



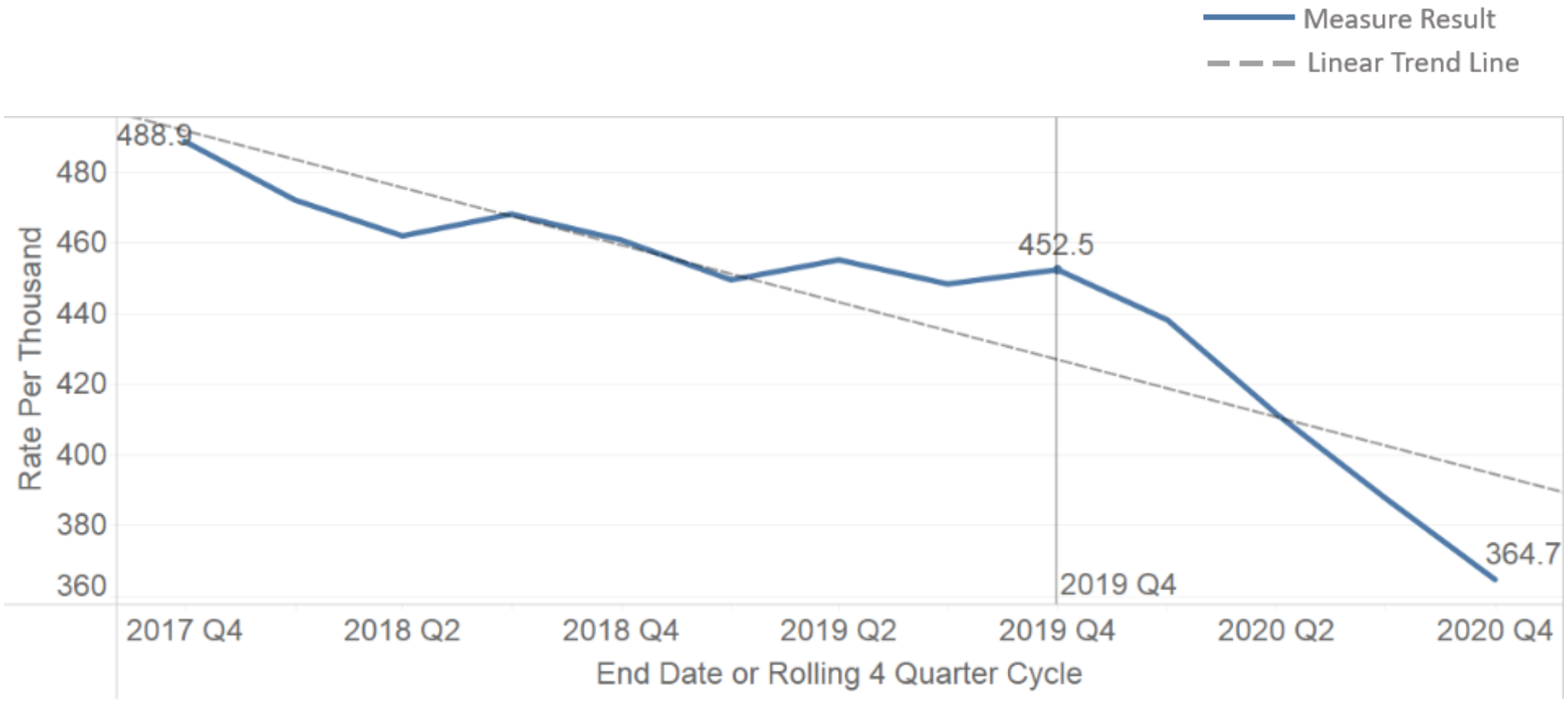
OH-NKY aggregated claims data

% Change in Rate per 1000 from 2017-2019	
Outpatient ED Visits (per 1000)	-7.5%
Inpatient Discharges (per 1000)	-6.5%
Ambulatory Care Sensitive Conditions (ACSC)	-12.3%



Source: Ohio-Northern Kentucky Aggregated Claims Data; The Health Collaborative

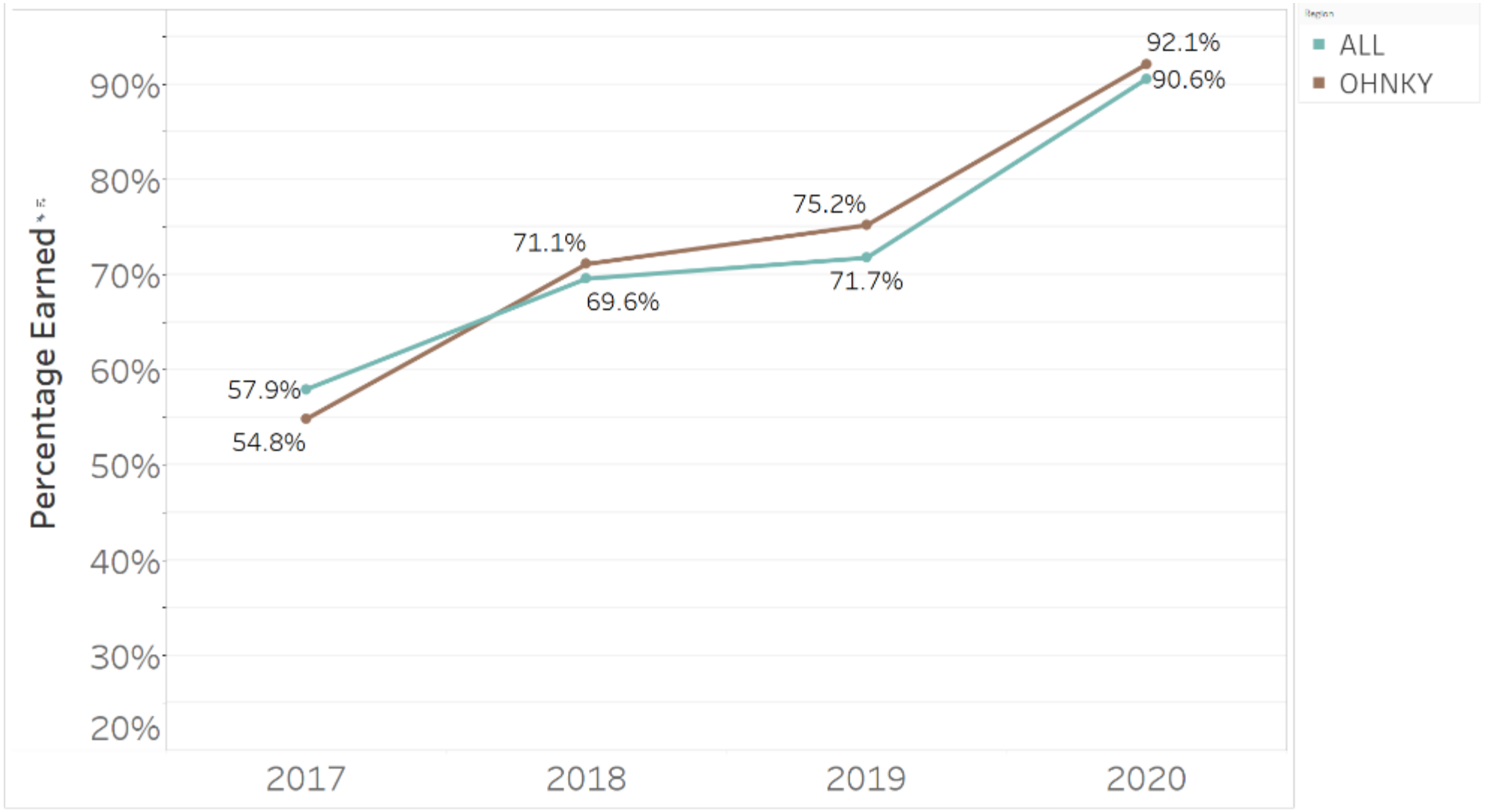
OH-NKY aggregated claims data: emergency visits



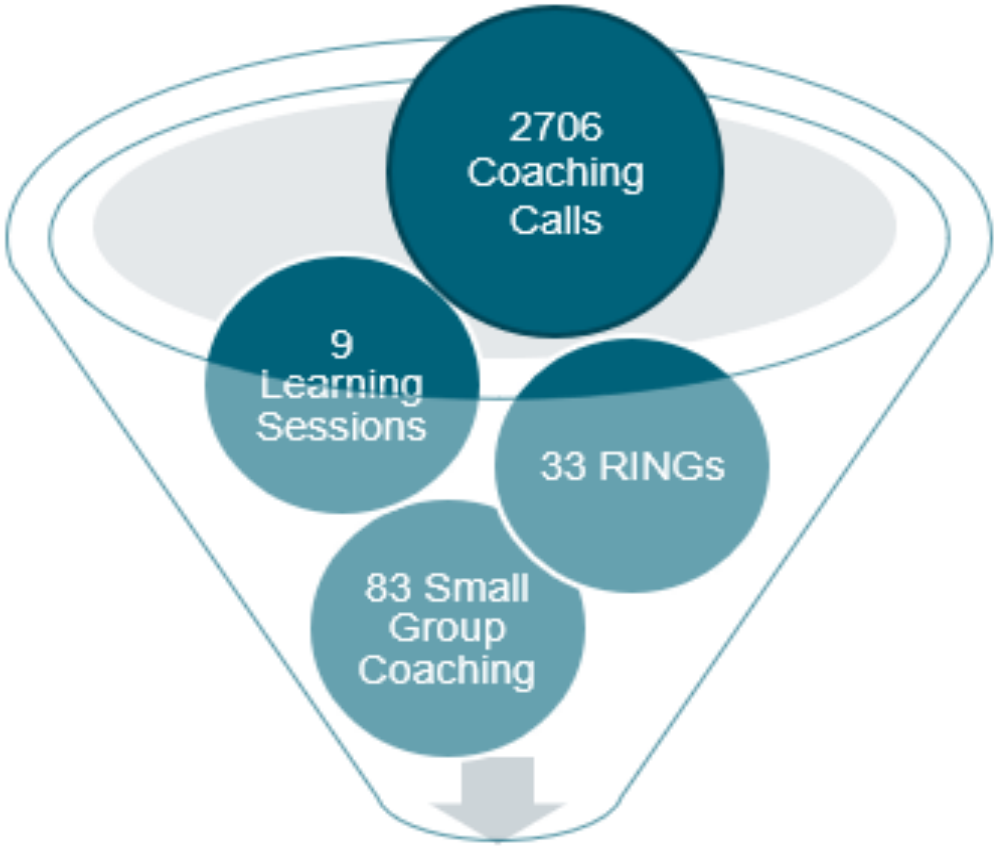
Payers included in this view: Aetna, Anthem, Aultcare, Buckeye, CareSource, CMS, Medical Mutual, Molina, Paramount, SummaCare, and United Healthcare

Source: Ohio-Northern Kentucky Aggregated Data; The Health Collaborative

percent of PBIP retained: OH-NKY & all regions



THC led CPC+ activities over the years



Total of 2821 Interactions

Nationally, CPC+ practices widely found that CPC+ payment learning and data feedback supports to be useful in improving primary care

Nationally, CPC+ practices reported that they plan to continue the processes they put in place for CPC+ after the model ends but need ongoing support to continue many aspects

Payment Reform

- Pandemic Pandemonium
- Addressing Equity and the Individual
- Primary Care Is the Foundation

CMMI vision for the next 10 years

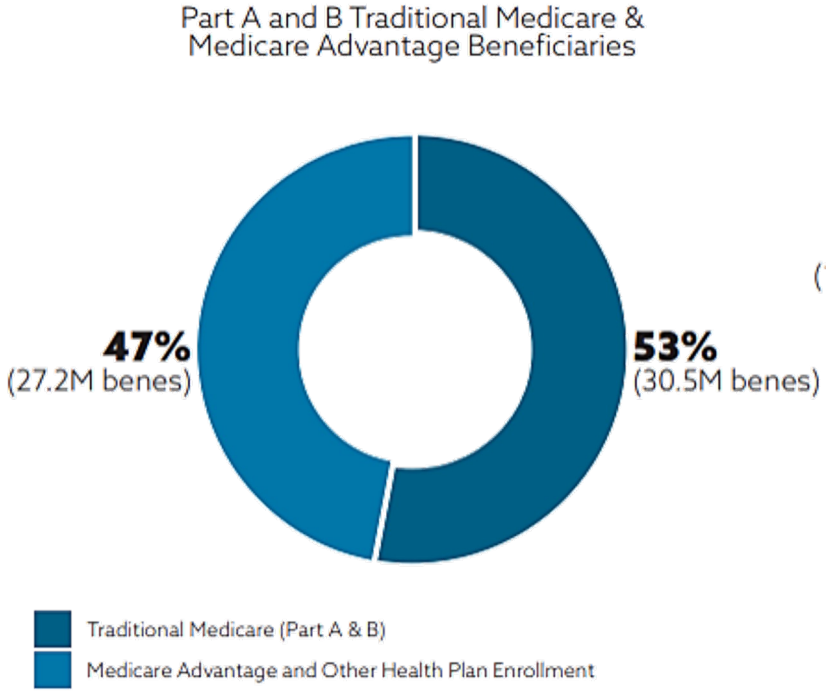
CMMI has created MORE than 50 alternative payment models since it was formed in 2010

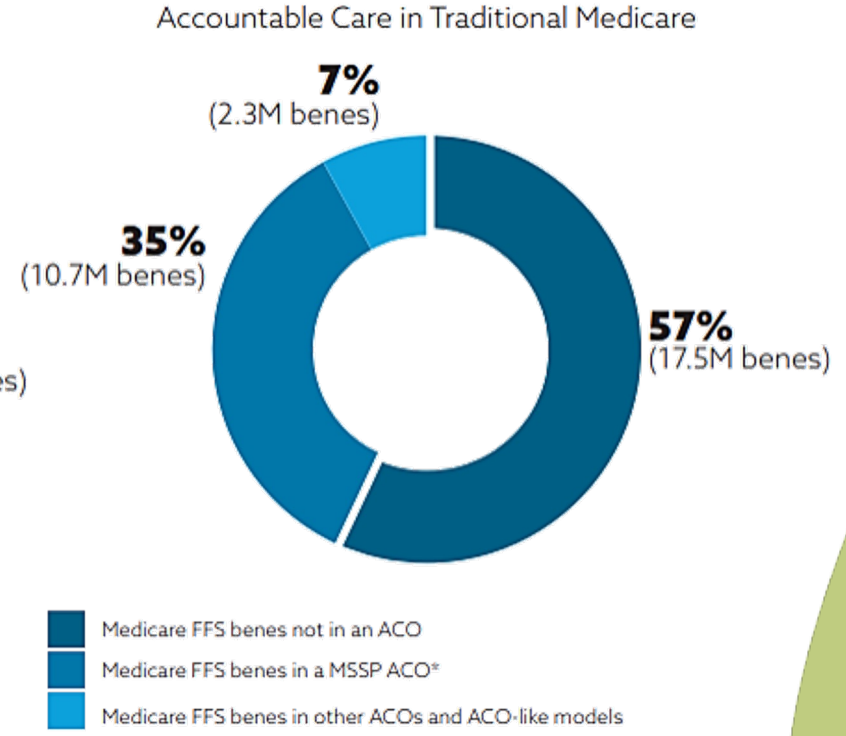
Reflecting on over a decade of work to create a vision for the future:

- Innovation models have been primarily focused on Medicare
- Too many models make it overly complex
- Incentive models need to ensure meaningful provider participation
- Challenging to take to accept downside risk if providers don't have the tools to enable change
- Financial benchmarks undermine model frameworks
- CMMI needs to define success as long lasting transformation not individual program result

CMMI strategy refresh – strategy for the CMS innovation center's second decade

drive accountable care

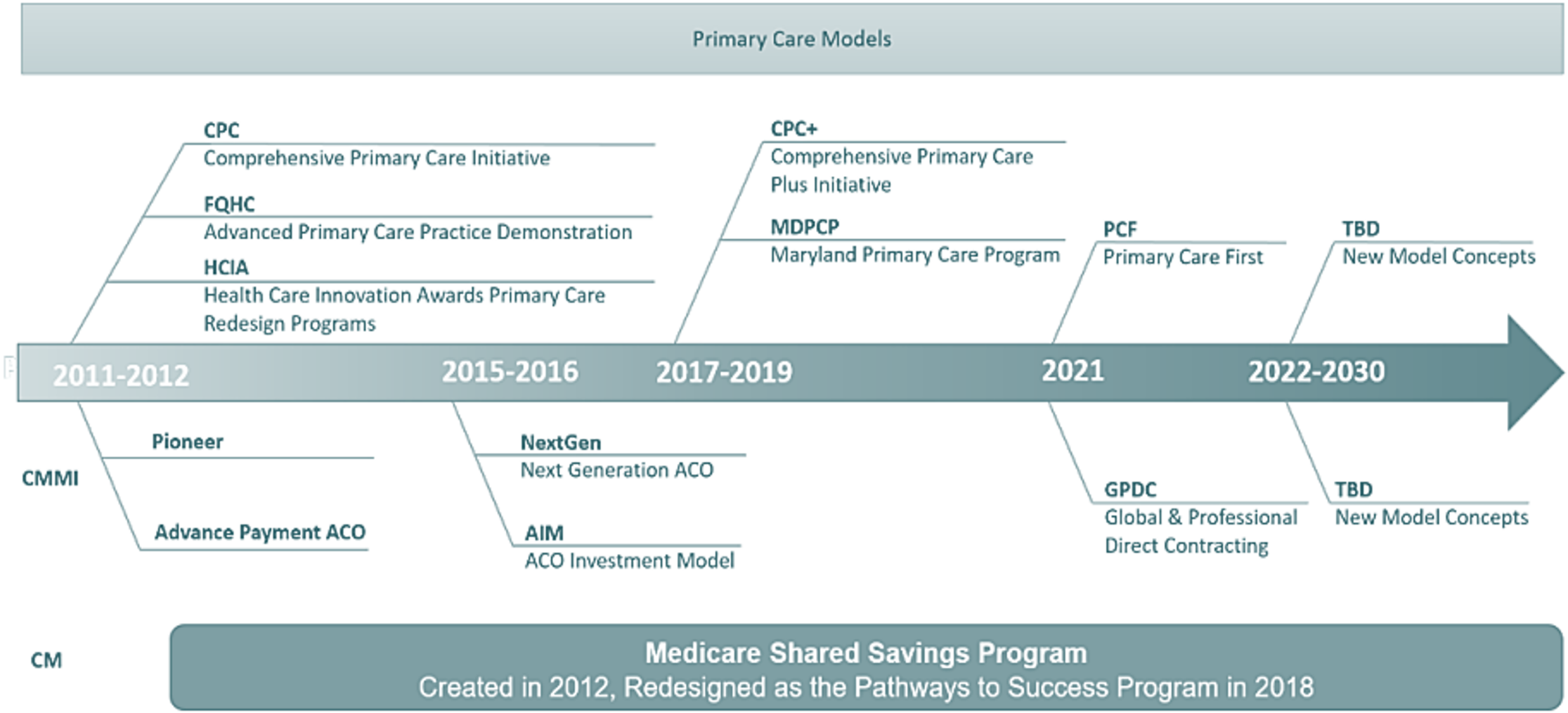




Measuring Progress

- All Medicare beneficiaries with Part A and B will be in a care relationship with accountability for quality and total cost of care by 2030
- Vast majority of Medicaid beneficiaries will be in a care relationship with accountability for quality and total cost of care by 2030.

primary care models



additional objectives and measures

- Collect and report demographic data on social needs and social determinate of health.
- Include patients from historically underserved populations population and safety net providers.
- Identify areas for reducing inequalities.

- Improve patient experience, shared decision making, health promotion and care coordination.
- Include patient-reported outcomes as part of performance management.

- Set targets to reduce % of beneficiaries that forgo care due to cost by 2030.
- Include opportunities to improve affordability of high value care by beneficiaries.

- Where applicable, all new models will make multi-payer alignment available by 2030.
- All new models will collect and integrate patient perspectives across the life cycle.

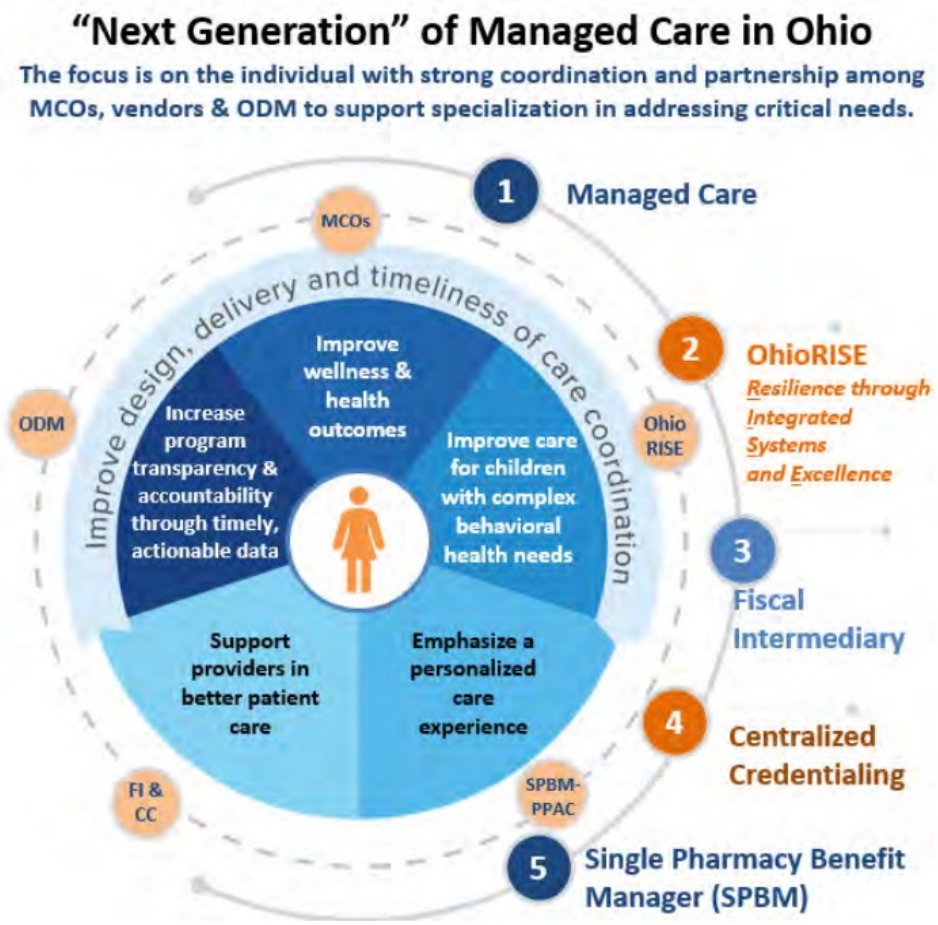
global and professional direct contracting redesigned = ACO REACH

	GPDC	ACO REACH
Governance	Provider are 25% Consumer advocate and beneficiary representative - can be same person and not required to hold voting rights	Provider are 75% Consumer advocate and beneficiary representative - can not be same person and are required to hold voting rights
Health Equity	No policies explicitly promoting health equity	Develop Health Equity Plan Introduce health equity benchmark Collect beneficiary-reported and social needs data Increase range of services ordered by Nurse Practitioners.
Discount	2021 – 2% / 2022 – 2% / 2023 – 3% / 2024 – 4% / 2025 – 5% / 2026 – 5%	2021 – 2% / 2022 – 2% / 2023 – 3% / 2024 – 3% / 2025 – 5% / 2026 – 3.5%
Quality Withhold	5%	2%

Made changes to:

1. Advance Health Equity to bring benefits of Accountable Care to underserved communities
2. Promoting provider leadership and governance
3. Protecting beneficiaries

Next Generation Medicaid



OhioRISE

aetna

Aetna Better Health® of Ohio

Single Pharmacy Benefit Manager (SPBM)

gainwell

Gainwell Technologies

AmeriHealth Caritas

Care is the heart of our work

AmeriHealth Caritas Ohio, Inc.

Anthem

Anthem Blue Cross and Blue Shield

buckeye health plan

Buckeye Health Plan

CareSource

CareSource Ohio, Inc.

Humana.

Humana Health Plan of Ohio, Inc.

MOLINA HEALTHCARE

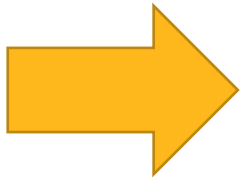
Molina Healthcare of Ohio, Inc.

UnitedHealthcare Community Plan

United Healthcare Community Plan of Ohio, Inc.

Next Generation – Driving Alignment & Accountable Care

MCOs must design and implement value based care and payment reform initiatives to drive the transformation of the health care delivery system to improve individual and population health outcomes, improve member experience, and contain the cost of health care through the reward of innovation and results over volume of services provided.



- Episode Based Payments
- Comprehensive Primary Care Practice Requirements
- Behavioral Health Care Coordination Requirement
- Comprehensive Maternal Care Requirements
- Care Innovation and Community Improvement Program Requirements

The HCP LAN Alternative Payment Model Categories

CATEGORY 1

FEE FOR SERVICE NO LINK TO QUALITY & VALUE

CATEGORY 2

FEE FOR SERVICE - LINK TO QUALITY & VALUE

A

Foundational Payments for Infrastructure & Operations

(e.g., care coordination fees and payments for HIT investments)

B

Pay for Reporting

(e.g., bonuses for reporting data or penalties for not reporting data)

C

Pay-for-Performance

(e.g., bonuses for quality performance)

CATEGORY 3

APMs BUILT ON FEE-FOR-SERVICE ARCHITECTURE

A

APMs with Shared Savings

(e.g., shared savings with upside risk only)

B

APMs with Shared Savings and Downside Risk

(e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk)

CATEGORY 4

POPULATION-BASED PAYMENT

A

Condition-Specific Population Based Payment

(e.g., per member per month payments, payments for specific services, such as oncology or mental health)

B

Comprehensive Population-Based Payment

(e.g., global budgets or full/percent of premium payments)

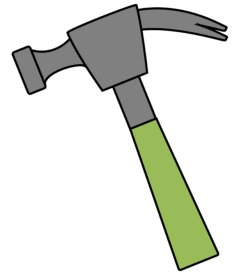
C

Integrated Finance and Delivery System

(e.g., global budgets for full/percent of premium payments in integrated systems)

Next Generation – Driving Accountability

	Small Providers (< 150 Medicaid Members)		Large Providers (≥ 150 Medicaid Members)	
	APM LAN Category 3A	APM LAN Category 3B	APM LAN Category 3A	APM LAN Category 3B
CY 2022	60%	0%	50%	20%
CY 2023	70%	0%	50%	30%
CY 2024	80%	0%	50%	40%
CY 2025	90%	0%	50%	50%



MCO's failure to meet alternative payment methodology (APM) targets may, at ODM's discretion, result in:

1. A reduction in member assignments to the MCO through ODM's auto assignment algorithm; and/or

2. The requirement that the MCO must invest profits in excess of 1% of the MCO's profit margin in primary care providers (PCPs). If ODM requires MCO investment of profits in excess of 1%, the MCO must submit a written plan to ODM for ODM's approval that describes the MCO's proposed expenditures and the associated rationale. The MCO must submit associated financial reporting as directed by ODM.

Employer Sponsored Health Insurance Payment reform

- Investing in Mental Health
- Investing in Primary Care
- Investing in Digital Access
- Direct Contracting - ASC
- Direct Contracting – Primary Care
- Direct Contracting – Maternity

THE HEALTH COLLABORATIVE

thank you!

The Health Collaborative brings healthcare stakeholders together for the good of the community and provides them with the actionable data they need.

OACHC
Ohio Association of Community Health Centers

All Access:

Ohio's Community Health Centers

Federally Grown :: *State Sustained* :: *Locally Cultivated*

www.ohiochc.org

- Non-Profit membership organization representing Ohio's Federally Qualified Health Centers (FQHCs) & FQHC Look-Alikes (FQHCLAs) – commonly referred to as **Community Health Centers**
- **Mission:** To ensure access to high-quality affordable health care for all Ohioans through the growth and development of Ohio's Community Health Centers

What is a Community Health Center?

- Community-based and patient-directed organization, delivering comprehensive, culturally competent, high-quality primary health care services
- The **Largest primary care network in Ohio.** Provides comprehensive care to **1 in 15 Ohioans** and **1 in 7 Medicaid beneficiaries**
  - → In 75 of Ohio's 88 counties

Mission Driven

CHC Mission: To provide accessible, comprehensive, and quality primary health care services to medically underserved communities and vulnerable populations

CHC Cornerstones

- Governed by the community (>50% board members must be patients)
- Independent, non-profit or public community-based
- High-quality and affordable primary care and preventive services
- Open to all regardless of insurance status or ability to pay
- Must serve a high-need, medically underserved area or population (MUA/MUP)

Accessible & Patient-Centered Care

57 Community Health Center organizations

- **478+** locations
- **87** School-Based Health Center sites
- **100+** Dental sites

Healthcare home and family doctor for **~890,333 Ohioans** annually (2021 UDS data)

~3.5 Million patient visits (2020 UDS data)

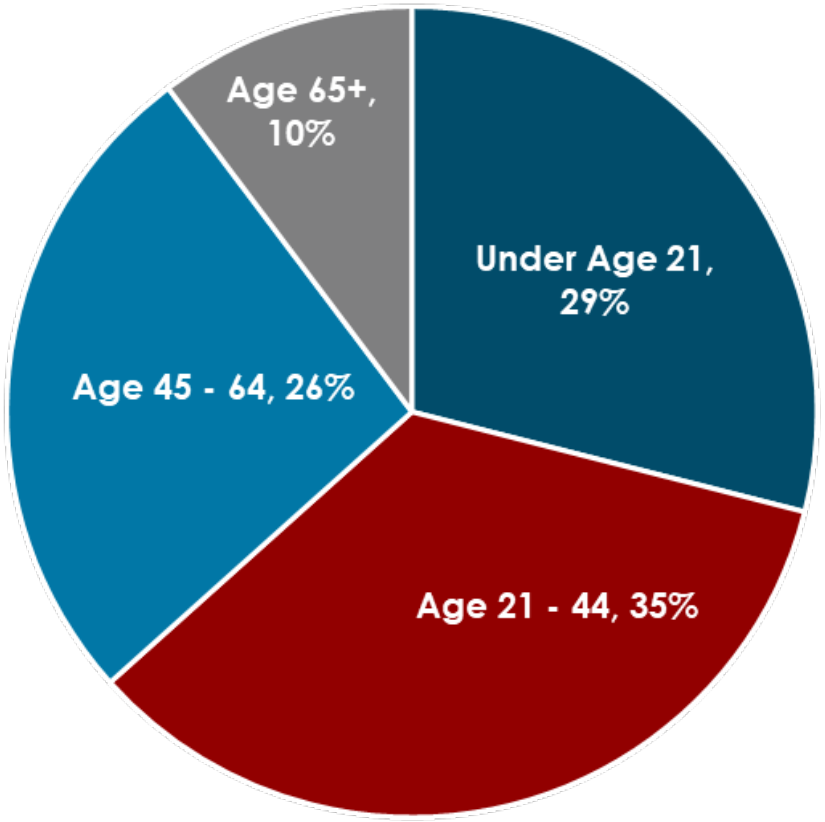
Sliding Fees: Accessible & Affordable Care

- CHCs must have a system in place to determine eligibility for patient discounts adjusted based on the patient's ability to pay
- No patient will be denied health care services due to an individual's inability to pay

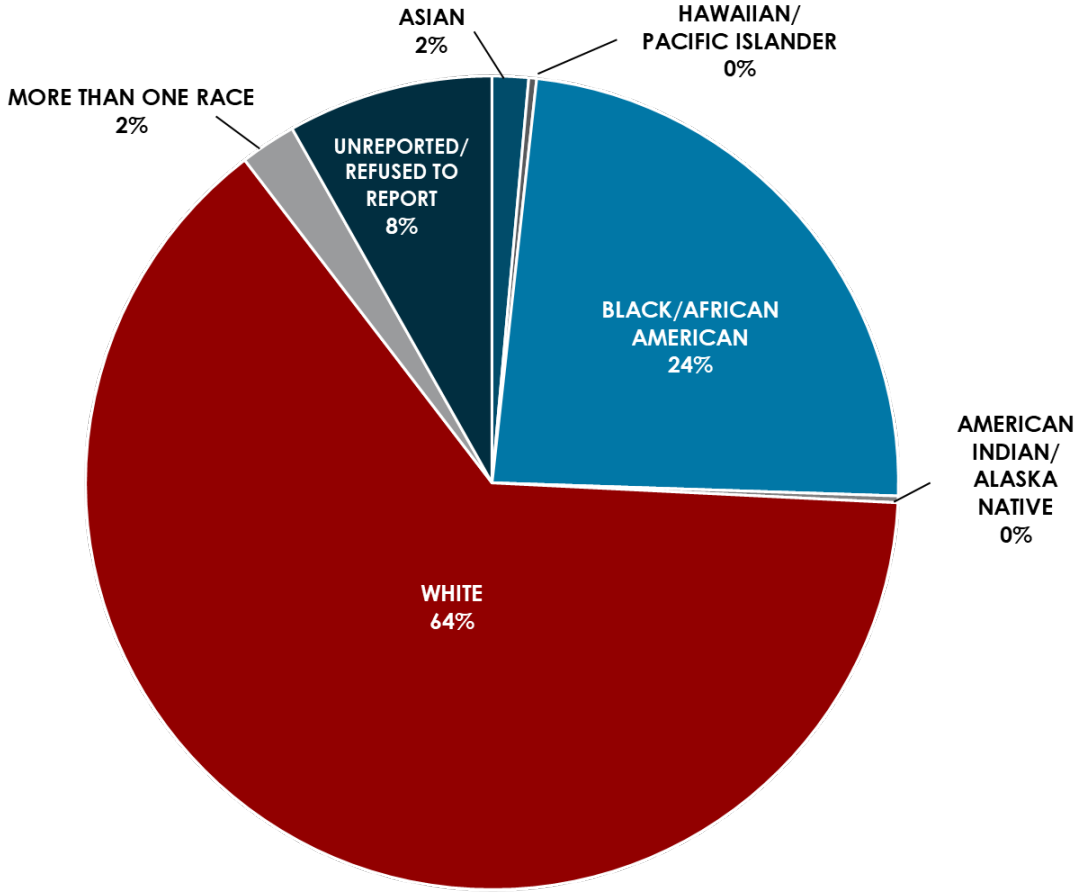
100% or below	Full discount (only nominal fees may be charged)
100% - 200%	Fees must be charged based on sliding fee scale based on family size and income (determined by the Board)
200% or higher	No discounts

In 2022, 100% FPL for an individual is $13,590 | A family of four is $27,750

Ohio Patient Demographics (2020)



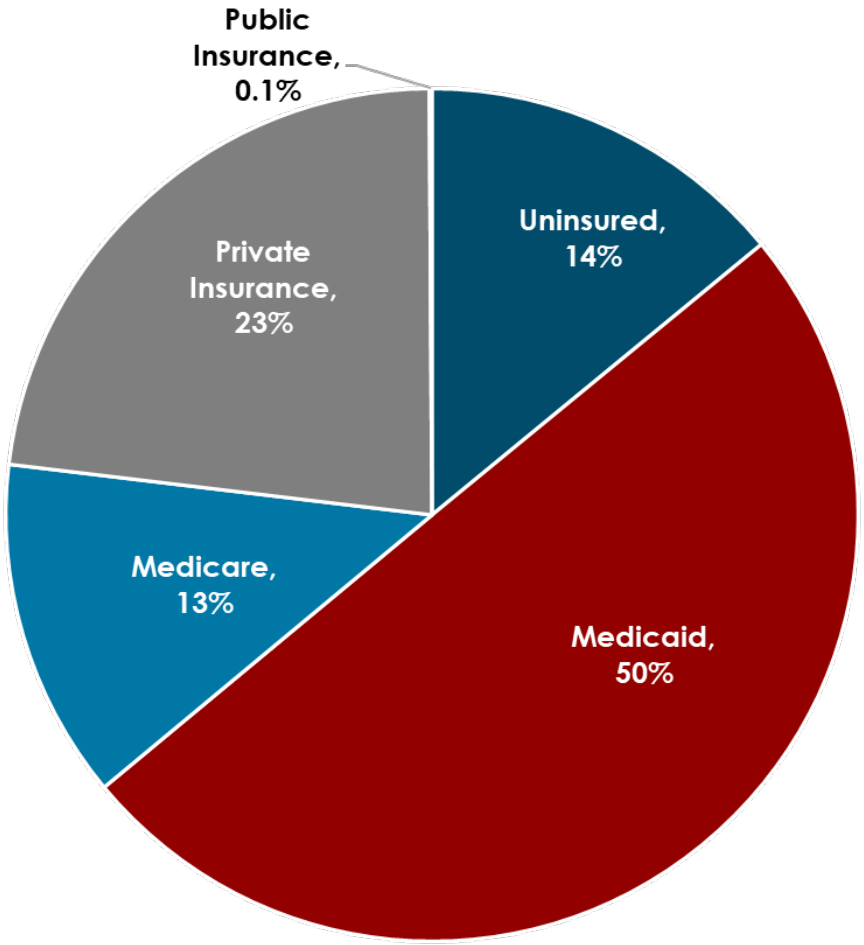
Ages Served



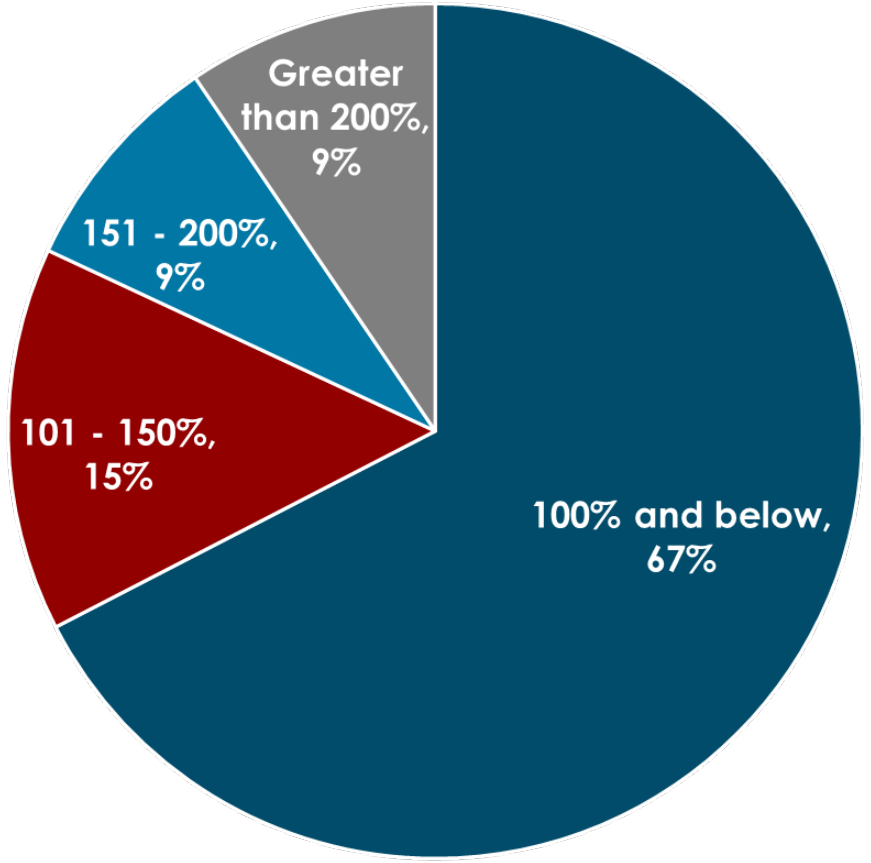
Races Served

Source: 2020 UDS

Ohio Patient Demographics (2020)



Patient Coverage



Income Levels

Source: 2020 UDS

Ohio FQHC Growth: 2002-2022

Year	Organizations	Sites
2002	23	110
2006	30	140
2009	35	158
2011	38	170
2012	41	180
2013	43	200
2016	46	258
2020	56	420
2021	**57**	**452**
2022	**57**	**478**

Over the past 20 years, access increased (sites) by 334%

Source: HRSA

Required Services

- **Primary, Preventive, Enabling**: Provided onsite or through established written agreements and referrals

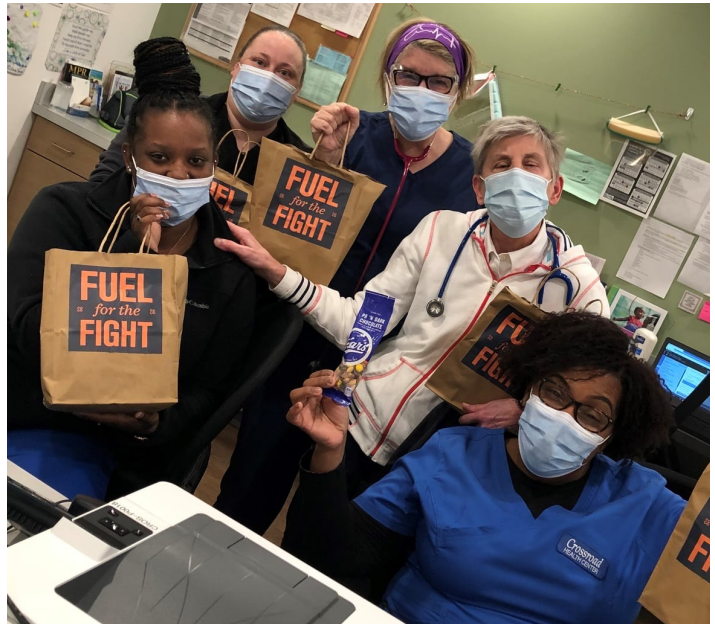
Mental Health
Substance Abuse
Pharmacy
Immunizations
Well Child
Gynecology
Obstetrics
Family Planning
Pre/perinatal
Preventive Dental

Diagnostics
Screenings
Specialty
Case Management
Health Education
Outreach
Transportation
Translation
Emergency Medical Services

Types of Providers & Visits

- Providers
  - Primary Care Physicians
  - OB/GYNs & Certified Nurse Midwives
  - Pediatricians
  - Nurse Practitioners
  - Physicians Assistants
  - Dentists
  - Psychiatrists
  - Optometrists
  - Pharmacists
  - Behavioral Health Providers
  - Nurses
  - Dental Hygienists
- Visits
  - Medical
  - Dental
  - Mental Health
  - Substance Use Disorders (SUD) including Opiates
  - Pharmacy
  - Vision
  - Enabling (care coordination, translation, transportation, financial eligibility)

Ohio CHCs currently employ more than 7,000 FTE staff: that represents a 139% increase from 2013-2020!



Additional Community-Driven Services

- Occupational Therapy
- Podiatry
- Chiropractic
- Vision
- Community Health Workers
- Food/Clothes Pantry
- Grocery Store
- Spiritual Care
- Curbside services/prescription home delivery
- Community Gardens
- CenteringPregnancy/Parenting

Brief History: Value Based Care and FQHCs

- Originally plans for Ohio Medicaid Comprehensive Primary Care Program (CPC) did not include FQHCs
  - → Pleasantly surprised to find out otherwise day of the program launch
  - → CPC continues today and FQHC participation represents at least half of all participants
  - → ODM since launched CPC Kids

- CPC
  - → Per Member Per Month (PMPM)
  - → Shared Savings on total cost of care

CPC FQHC Takeaways

Clean up attribution lists (approximately 60% of attributed pts on average are seen in our centers today)

Ensure risk stratifications scores are correct – strictly claims based!

Won’t get to appropriate risk stratifications scores (nor quality parameters) without enhanced coding skills

Value Based Care and OACHC

OACHC simultaneously was devising an alternative strategy focused on forming an **Independent Practice Association (IPA)**

- Initially to start, one contract with about 60% of membership
- After two years, secured a smaller contract for 8 health centers from same payer
- Currently 2 agreements

Common Elements of Value Based Agreements

- Shared savings elements split with managed care organization
- Payments for improving access to care (PCMH)
- Payments based on improving quality of care
- Payment for other tasks including completing HRAs, contacting unseen patients, improving attribution

Who is a Patient/Member?

- FQHC: any individual patient seen in the calendar year
- Ohio CPC: Member assigned to a FQHC provider except for certain ineligible CPC participants (dual eligible, participants in waiver programs etc. are excluded from CPC)
- Ohio Medicaid MCO: Member assigned to FQHC minus the members carved out for Partners for Kids or other ACO

Avoiding Anti-Trust

- Sherman Anti-Trust Act and Clayton Anti-Trust Act

- Many actions involving more than one health care entity could result in violating anti-trust laws
  - → including joint negotiation with managed care entities or
  - → almost any activity limiting competition such as dividing up a service area

- Limited guidance in avoiding anti-trust activity can be found in a joint DOJ/FTC publication from 1996 including the creation of “safety zones”

Anti-Trust "Safety Zones"

- Clinically and/or financially integrated models (CIN, FIN)
- Independent Practice Associations or IPA
- "Messenger Model"
- Accountable Care Organization or ACO

Why We Chose Messenger Model

- Simplicity for PCA and members (member readiness and capacity)
- Low Cost
- No Risk
- Information on health center cost/performance from payer perspective
- Comparison with other health centers

Drawbacks of Messenger Model

No negotiation – take it or leave it

Modest rewards, if any

Looking For Even More Access?

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Connect via email: info@ohiochc.org