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GREATER CINCINNATI HEALTH COUNCIL

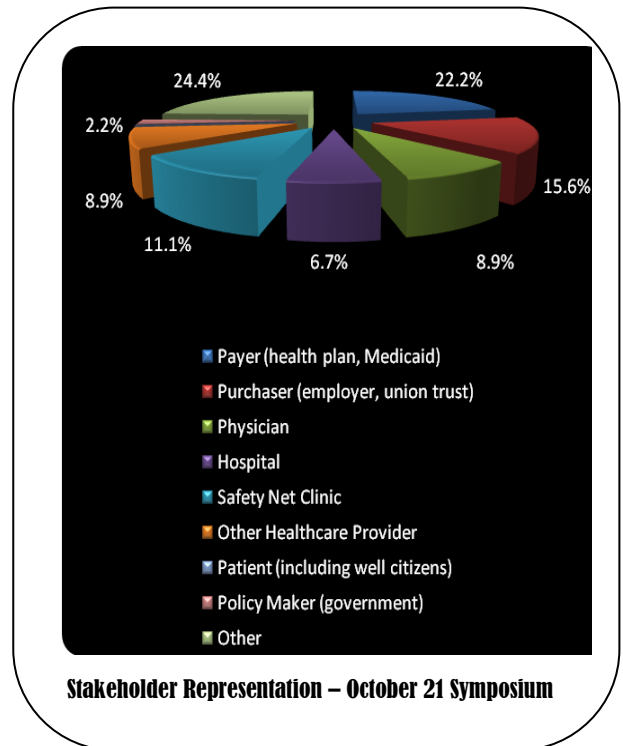
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Greater Cincinnati Health Care Payment Reform Symposium October 21, 2011 Executive Summary

Stakeholders agree that the Cincinnati region - a leader in health care transformation - is poised to take a bold step toward payment innovation. On October 21, 2011, at the Greater Cincinnati Health Care Payment Reform Symposium (Symposium) - an invitation only event - nearly 50 health care leaders convened to discuss how health care payment systems, benefit designs, and delivery systems could be changed to achieve better health, better care, and lower costs. As the pie chart on the right displays, stakeholder involvement was broad, crossing provider and payer sectors. The convening organizations, represented by their logos above, include:

- Employers Health
- Greater Cincinnati Health Council
- Health Care Access Now
- Health Collaborative
- HealthBridge



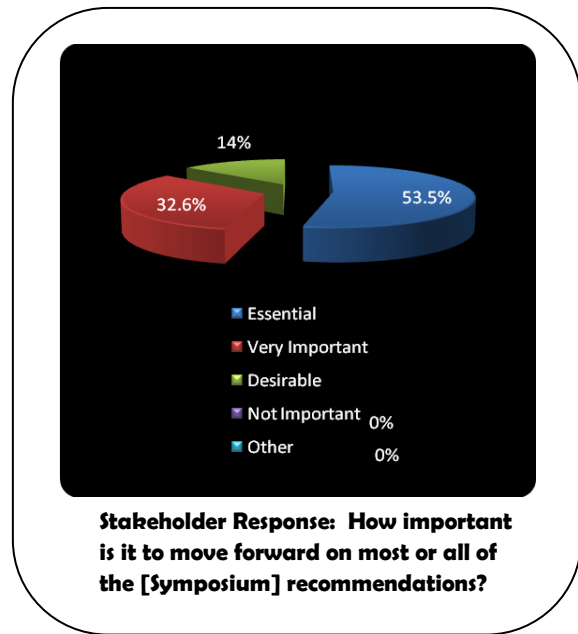
Greater Cincinnati Health Care Payment Reform Symposium

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Representatives of the convening organizations report they are encouraged by the engagement and enthusiasm of participating stakeholders. In particular, stakeholders recommended that it is essential or very important for the region to move forward with bold goals designed to

reshape the ways in which we pay for primary care and major acute care within the next five years.



With respect to moving forward with payment innovation efforts, the majority of symposium participants were clear that local payment reform efforts should move forward on the regional level, regardless of participation in federal or other broader initiatives. However, if possible, seventy-two percent of participants want to see an effort that includes pursuit of both local reforms and collaboration with other regions. Moreover, 95 percent of stakeholders indicated that Cincinnati should have transitional payment

models implemented within a period of 6 months to 2 years (48 percent indicated that payment reforms should be implemented by the end of 2012).

Symposium keynote speaker, Harold Miller, was well-received by the audience. A major theme of Mr. Miller’s talk was that increasing health system value, which includes quality improvement, has to happen at the local level in areas such as (1) prevention and wellness; (2) avoiding hospitalizations; and (3) efficient, successful treatment. He provided compelling Cincinnati-specific data illustrating areas where the region has room for systemic improvement, for example in preventable ER visits and high rates of hospitalization. Mr. Miller then level-set stakeholders around specific innovative payment reform and quality improvement models and benefits designed to offer value-based consumer choice.

After Mr. Miller’s presentation, Symposium participants split into two breakout sessions. The first was focused on: “How Greater Cincinnati should pay for primary care within five years.”

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The second breakout session focused on: “How Greater Cincinnati should pay for major acute care within five years.” A summary of participant’s recommendations is provided as Appendix 1 to this executive summary.

Symposium participants identified an immediate next step with about 95% support. The recommendation was that we move forward with the goal of participating in the Center for Medicare and Medicaid Innovation (CMMI) “Comprehensive Primary Care Initiative” (CPCI). (Forty-four percent of attendees reported participation should be a top priority, 51 percent reported it was a desirable priority, and about 5 percent reported it could be a distraction.) The full CPCI solicitation is available at:

http://innovations.cms.gov/documents/pdf/cpc_initiative_solicitation.pdf.

As the accompanying Milestone & Timeline document indicates, convening organizations have moved forward with stakeholder recommendations. The CPCI Letter-of-Intent, to be submitted to CMMI by health plans, was due on November 15, 2011. Given the short turn-around time between the Symposium and this due date, convening organizations set their sights on providing health plans and self-funded employers the information they needed to: (1) choose to apply; and (2) to include Cincinnati-Dayton within its designated choice of CPCI markets. Convening organizations are pleased to report robust support from the health plans on both fronts, as well as the enthusiastic support of self-funded employers agreeing to participate in application discussions. (See the list of health plans and self-funded employers below.) In

The following health plans submitted letters-of-interest to CMMI for the CPCI and included Cincinnati-Dayton in the market definition.

- **Anthem Blue Cross & Blue Shield**
- **Aetna**
- **Buckeye Community Health Plan**
- **HealthSpan**
- **Humana**
- **Medical Mutual of Ohio**
- **Molina Healthcare of Ohio**
- **Ohio Medicaid**
- **UnitedHealthcare**

The following self-funded employers indicated to their plan administrators an interest in CPCI participation.

- **Cincinnati Children’s Hospital Medical Center**
- **Frisch’s Restaurants**
- **GE Aviation**
- **Ethicon Endo-Surgery, a division of Johnson & Johnson**
- **Procter & Gamble**
- **TriHealth**
- **St. Elizabeth Health Care**
- **UC Health**
- **Western & Southern Insurance**

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addition, the state of Ohio also submitted a letter-of-intent, indicating that Ohio Medicaid will participate in the initiative. A full “CPCI Update” is attached as Appendix 2 to this report.

Now that the letters-of-intent are submitted to CMMI, next steps will include developing a timeline of stakeholder meetings based on application items that require regional stakeholder agreement. The work we started with technical assistance from the Brookings Institution and continued at the Symposium, including the break-out session recommendations, will likely serve us well as we undertake community-wide discussions on what our local payment innovation model will look like.

Should you have any questions or concerns regarding this executive summary, please contact Lisa Sloane at (513) 746-7839 or lisa@lrsloane.com . Ms. Sloane has been retained to manage our post Symposium multi-stakeholder coordination and communications.

Very truly yours,



Christopher D. Goff, JD, MA, CEO & General Counsel
Employers Health



Keith W. Hepp, Interim CEO
HealthBridge



Judith Warren, Executive Director
Health Care Access Now



Gregory L. Ebel, Executive Director
Health Collaborative



Colleen O'Toole, PhD, President
Greater Cincinnati Health Council

RECOMMENDATIONS OF THE GREATER CINCINNATI PAYMENT REFORM SYMPOSIUM October 21, 2011

On October 21, 2011, a multi-stakeholder group of approximately 50 healthcare leaders convened at the request of the Employers Health Coalition, the Greater Cincinnati Health Council, Health Care Access Now, The Health Collaborative, and HealthBridge to discuss how healthcare payment systems, benefit designs, and delivery systems should be changed in order to improve the quality and reduce the cost of healthcare in the Greater Cincinnati region. Their recommendations are summarized below.

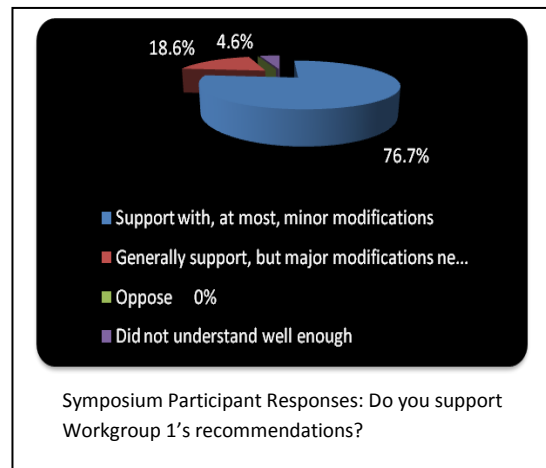
I. HOW GREATER CINCINNATI SHOULD PAY FOR PRIMARY CARE WITHIN FIVE YEARS

A. How Primary Care Practices Should Be Paid

A primary care practice should be paid a monthly per-patient Partial Comprehensive Care Payment to cover the costs of all outpatient services needed by its patients for treatment of their conditions, whether the services are provided by the practice itself or by other providers, e.g., diagnostic testing, specialty consultation, behavioral health, outpatient procedures, and emergency room use. The practice should no longer receive any fees for individual services provided to those patients, and it should be responsible for using the Partial Comprehensive Care Payment to pay other outpatient providers for services they provide to patients.

The amount of the payment should be set at the current average per patient costs of outpatient care for those patients, and should be increased each year by the consumer price index. The payment amount should also be condition/severity adjusted, i.e., the payment would be increased if the practice's patients in future years had more severe diseases or more health conditions.

Hospital costs and other institutional care (e.g., long-term care or inpatient rehabilitation) would continue to be paid separately, but the practice should be required to reduce the rate of hospitalizations for patients below specified target levels; if it did not achieve the target levels, its Partial Comprehensive Care Payment would be reduced; if it reduced utilization below the target levels, it would receive an increase in the Payment.



In addition, pay-for-performance bonuses should be paid based on the practice's performance on quality measures for care of patients.

B. How Specialists Treating Patients With Chronic Disease Should Be Paid

Specialists should partner with primary care practices in order to jointly accept the Partial Comprehensive Care Payment for managing the care of patients with chronic disease, rather than being paid individual fees for services. Specialists should also be accountable for helping the primary care practice to control utilization of services and reduce hospitalizations.

C. Changes That Should Be Made in Benefit Structures

A number of changes should be made to enable and encourage patients to better manage their health conditions in cooperation with their primary care practice:

- Patients should be required to designate a primary care provider (or appropriate specialist) as their medical home. Although they should be permitted to switch primary care providers, they should be required to pay a one-time fee for switching primary care providers more frequently than once per year unless there are appropriate justifications (e.g., a change in the consumer's residence or the provider's location, poor quality ratings of the provider, etc.)
- Patients should have low or zero copayments/co-insurance for visits to their medical home.
- Patients should be required to pay a greater share of the cost of their care (e.g., through higher cost-sharing for hospitalizations) if they do not select a medical home or otherwise use a consistent provider for their care.
- Patients should be required to pay more to go to emergency rooms for non-urgent care that they could have received from their medical home.
- Patients should have low or zero copayments for medications, tests (other than high-tech diagnostics), and treatments their medical home prescribes to help them manage their conditions.
- Patients should receive financial incentives (e.g., reduced insurance premiums or cash awards) for improving their health and adhering to treatment plans developed with their medical home.

In addition, in order to encourage patients to choose high-quality primary care practices and specialists, primary care practices and specialists should be grouped into cost/quality tiers and patients should be informed about the tiers that the physician practices are in. Some employers or health plans may wish to require patients to pay higher amounts if they use a physician practice in a lower-value tier if there are higher-value practices available in the community.

D. How the Greater Cincinnati Region Should Transition to Improved Payment for Primary Care

Health plans should pool their claims data in a common database that community organizations can use to help physician practices identify ways of improving care for their patients. Physician practices

**Greater Cincinnati Payment
Reform Symposium
Appendix 1**

should receive technical assistance in how to analyze data from EHRs and claims data in order to identify ways of improving quality and reduce costs for their patients.

Full region-wide implementation of the desired payment system should be planned for a specific date no more than five years from now (i.e., 2016). The payment system should then be changed in multiple steps over the next several years in order to allow primary care practices and specialists a more gradual approach to evolving their care delivery processes. For example, initially, primary care practices could be paid a monthly Care Management Payment instead of some fees for services, along with bonus or penalty payments based on the rate at which the practices' patients use the emergency room for non-urgent reasons, are hospitalized for ambulatory care sensitive conditions, use high-tech diagnostic imaging, etc. In addition, the desired payment system should be pilot-tested with selected physician practices and selected patient populations in order to work out the details before it is implemented on a widespread basis.

E. Implementation Barriers That Will Need to Be Overcome

Due to competitive pressures, health plans will likely resist implementing common payment systems, although it is clearly desirable for healthcare providers to have a single payment system to implement. Health plans will have to be discouraged from being "free riders," i.e., benefiting from the improvements in cost and quality without investing in making the changes needed to support those improvements.

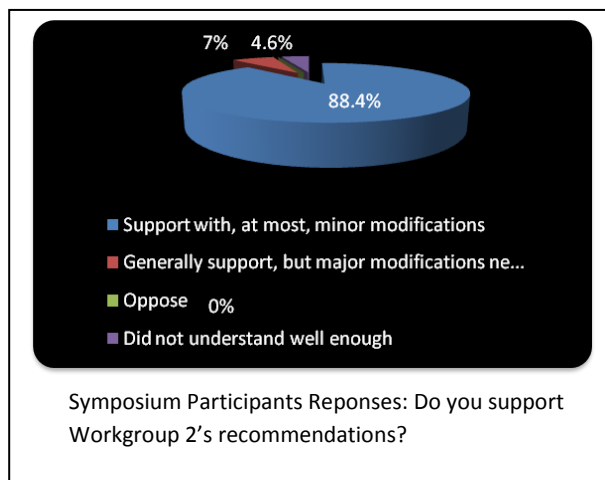
Multi-state regions such as Cincinnati may be hurt if the federal government is only willing to support payment reform projects within single states.

II. HOW GREATER CINCINNATI SHOULD PAY FOR MAJOR ACUTE CARE WITHIN FIVE YEARS

A. What Payments for Major Acute Conditions Should Cover

When a patient has a major acute condition, treatment of the condition should be paid for through a single, comprehensive bundled payment. This payment should include (1) all payments to the hospital or other facility where treatment is rendered, (2) all fees for physicians involved in the treatment, including all consultants and hospital based specialists, and (3) any payments for post-discharge or rehabilitative care, including facilities and home health care, that occurs within 90 days after discharge.

Costs would vary depending on the needs of the patient, and so payment amounts should be acuity-



adjusted to prevent encouraging providers to choose only relatively healthy patients and penalizing those caring for sicker patients.

B. How Payments Should Be Modified When Preventable Adverse Events Occur

No additional payments would be made to either hospitals or physicians to cover the costs of treating preventable adverse events, i.e., the bundled payment would include a “warranty” for the cost of such events. If complications occurred and care or expertise was needed from physicians or hospitals which were not part of the original treatment, payments would still be made to those physicians and hospitals, but the cost of those payments would be deducted from the bundled payment for the original care.

Not all complications may be preventable, and so the payment amount should not assume that there will be no complications, but rather should incorporate the costs of treating an “acceptable rate” of complications based on current best practices. All complications and outcomes of care should be publicly reported

This new joint accountability among hospitals, physicians, and other providers will require an understanding among them about how to allocate responsibility when problems arise, in order to avoid litigation among the providers.

C. How Prices for Acute Care Payments Should Be Set

The market is the best mechanism for determining the actual prices of acute care payment bundles, even with all of the complexities involved, rather than having prices set or recommended by the federal government, the state, or a multi-stakeholder collaborative. Although reference pricing (i.e., agreeing to pay only for the lowest price offered by quality providers and then asking patients to pay any difference between that price and the price of the provider they use) has advantages for encouraging competition on prices, this and other issues related to benefit design should be left to employers, providers, and health plans, i.e., plans should have the ability to design benefit packages as the market asks for them.

The disparity in rates between public and private payers is a concern, since it can result in cost shifting. Ideally, public and private rates will converge, so that the true cost of an episode of care could be judged and compared transparently, rather than obfuscated as a result of cost shifting. Negotiating rates in the news media is counter-productive and should be discouraged.

D. How Hospitals with Special Situations (Teaching Hospitals, Critical Access Hospitals, Safety Net Providers, Etc.) Should Participate

Market negotiation should account for the higher cost of operating facilities with special characteristics, such as teaching hospitals and safety net providers. Rather than trying to impose a special assessment on health plans that would equalize the contribution between public and private payers, or a regional tax to cover the costs that are viewed as a public good, it should be recognized that the payment rates for these facilities already include a premium based on their special characteristics, and so there is no need to mandate special payments through other financing vehicles.

E. How Patients Should Be Engaged

Patients should be informed of the relative cost and quality of providers which offer equivalent services, and plans should design benefits in a way that encourages the use of the highest value providers. A variety of options for doing this (tiering, network exclusion, patient coinsurance differentials, excluding non-preferred providers from the out-of-pocket maximum payments by patients, etc.) could be used, but there is not enough experience to dictate use of a single approach.

Although some have concerns about whether the highest value providers would run out of capacity to serve all patients if value-based incentives are provided, providers feel they could scale up to meet whatever demand they are fortunate enough to gain through such value-based incentives.

F. How the Greater Cincinnati Region Should Transition to Improved Payment for Acute Care

The recommended changes in payment would need to be phased-in in a stepwise fashion, rather than trying to move to the new payment structure all at once. The new payment model should be piloted with patients who have specific conditions, since it would be easier for providers to change protocols on all patients with a particular condition or procedure. Common approaches are needed across payers, however, since it would be hard for providers to implement two ways of doing things, e.g., if there were one payment system for Medicare patients and another for commercial patients,

There is a need for a regional organization to coordinate these condition-specific pilots. There will also be a need to find ways to work with employers whose national headquarters are not located in Ohio and to find ways to incent providers to participate in such pilots.

G. Implementation Barriers That Will Need to Be Overcome

There will need to be a shared infrastructure for measurement and reporting within the region. Cincinnati should study best practices from other regions to understand which models work best. A convening organization is needed to gather stakeholders to decide on these measures and reports, drawing upon national quality organizations' existing definitions where possible. The Health Collaborative is well-placed to serve as the convener, but it should be cautious not to decide on the measures without consensus from a broad range of stakeholders.

There are concerns about how the federal Affordable Care Act (ACA) may impact Cincinnati's ability to implement these recommended steps, e.g., ACA requirements for minimum benefit packages, inability to tier providers in the small group market, and additional taxes/fees on plans and providers under ACA.

III. STRATEGIES FOR IMPLEMENTING THE RECOMMENDATIONS

The vast majority (86%) of the participants at the Symposium felt that it was Essential Very Important to move forward in implementing the recommendations above.

Most (69%) felt that at least transitional reforms should be in place by the end of 2012, if not sooner; all agreed that they should be in place within two years.

The group overwhelmingly agreed that the leadership for implementation should come from a collaborative effort of government, health systems, employers, patient advocacy groups, health plans, and others in the community.

There was general support for making an effort to collaborate with other parts of Ohio in order to develop statewide approaches, but it was also generally agreed that this should not impede efforts to make reforms locally. Most participants (72%) felt that the Cincinnati region should simultaneously pursue reforms on its own and seek to collaborate with other regions in the state.

Since the Center for Medicare and Medicaid Innovation (the Innovation Center) had issued solicitations for both a Bundled Payment Initiative and a Comprehensive Primary Care Initiative shortly before the Symposium was held, the participants discussed how important it was for the Cincinnati region to participate. Most participants felt that it would be desirable to participate in both of the Innovation Center projects, but the broadest support (95%) was for participation in the Comprehensive Primary Care Initiative. In both cases, most participants felt that while participation in the federal initiatives was desirable, it was less important than getting region-wide multi-payer payment reforms for all primary care practices and for the acute care conditions that represented the highest costs for commercial payers and Medicaid.

IV. NEXT STEPS

The participants agreed on the following as next steps:

- Obtain and analyze claims and clinical data to identify the best categories of patients and procedures for initial efforts at primary care and acute care payment reforms;
- Organize workgroups to flesh out the details of each of the two recommended payment models and organize implementation efforts;
- Request that all health plans and the state Medicaid program submit Letters of Intent to the Innovation Center by November 15 expressing their interest in participating in the Medicare Comprehensive Primary Care Initiative;
- Designate a lead organization in the region to coordinate implementation efforts and obtain necessary staff/consulting support; and
- Reconvene the participating stakeholders in 6 months (i.e., by April, 2012) to assess progress.

**CPCI Update
Prepared for the ESC, Payment Innovation Subgroup
By Lisa R. Sloane LLC**

Following is an update on Comprehensive Primary Care initiative developments from October 24-
November 14, 2011. Thanks to our many engaged stakeholders, we have made terrific progress.

Following are the highlights:

1. Health plans submitted letters-of-intent to CMMI on November 15, 2011.
2. Payment Innovation Subgroup members have heard from the following health plans, which have indicated they will submit letters-of-intent to CMMI and will include Cincinnati-Dayton as a market they would like to consider including during the application preparation phase:
 - Anthem/Wellpoint
 - Aetna
 - Buckeye Community Health Plan
 - HealthSpan
 - Humana
 - Medical Mutual of Ohio
 - Molina Healthcare of Ohio
 - Ohio Medicaid
 - UnitedHealthcare
3. The following self-funded employers report that they have contacted their plan administrator to encourage the submission of a letter-of-intent:
 - Cincinnati Children's Hospital Medical Center
 - Frisch's
 - GE
 - Johnson & Johnson
 - Procter & Gamble
 - TriHealth
 - St. Elizabeth Health Care
 - UC Health
 - Western & Southern Insurance
4. Lisa Sloane has made contact with the CPCI Project Officer at CMMI. The Project Officer has been briefed on the wide-ranging stakeholder interest throughout the Cincinnati-Dayton market and has been very forthcoming with LOI and application related information.

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5. We asked CMMI if they would consider initiatives that cross state lines. They answered that they would consider such a proposal if a health plan makes a compelling argument for doing so in their application. CMMI indicated that plans would be permitted to reconfigure the markets they identified in their letters-of-intent during the application preparation phase. Because the answer to this question came in on Thursday, November 10th, we determined that it would not be feasible to request plans to include Northern Kentucky in their letters-of-intent. However, we will of course give consideration to market configurations during discussions in the coming weeks, should we be selected to move on to the next phase.
6. Lisa Sloane will field critical questions stakeholders may have regarding the application. Lisa can be reached by e-mail at lisa@lrsloane.com or by telephone at 513-746-7839.
7. To date, we have posed multiple stakeholder questions to CMMI regarding CPCI. Below are the questions and CMMI's responses (unedited):

a. Are there exceptions to the multi-state rule, such as in communities where markets typically cross state lines?

Answer: While page 8 of our solicitation states that "the final boundary of a partnership market will remain within one state," we will consider proposed markets from payers that span multiple states as long as they can provide a compelling reason for doing so in their application.

b. If health plans that serve a similar region select market boundaries that are not exactly the same – will that negatively affect a market's chance of being selected? Do health plans within a region have to have coordinated LOIs and/or applications that so that they all define a market with the same boundaries?

Answer: Markets will be selected based on where a preponderance of health care payers apply, are selected, and agree to participate. The goal is to have diverse geographic representation. Payers are free to list different markets that are not contiguous with each other, but the final definition of a market will be based on the overlapping, contiguous geographic service areas of participating payers. To discern those geographic areas, applicants are asked to propose a market using a combination of Metropolitan Statistical Areas (MSAs), counties, and/or zip codes as descriptors. We are interested in selecting diverse areas, including urban communities, rural communities, and a mix of urban and rural communities, and both large and small geographic areas.

CPCI Update
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By Lisa R. Sloane LLC

c. Self-funded employers in our market are writing letters to their health plans and encouraging them to submit an LOI. The assumption is that self-funded employers are better served by being included by the plans that administer their health insurance programs, rather than submitting LOIs themselves. Is this a fair assumption?

Answer: CMS looks forward to partnering with employers in the CPC initiative. Because payment reform requires TPAs/ASOs to execute the payment agreement described in the Memorandum of Understanding, we would like the TPA/ASO to apply on behalf of one or multiple employers in a market. The TPA/ASO should identify the employer(s) in its application. We would encourage participation of employers in the market discussions.

d. We have a self-funded employer that would like to encourage a plan to submit an LOI. They have a new plan administrator as of 1/1/12. For the purposes of the CPCI, should they consider themselves a part of the plan that will administer their insurance program as of 1/1/12?

Answer: Yes, the employer should consider themselves a part of the plan that will administer their insurance program as of 1/1/12.

e. Are pediatric practices excluded from the CPC initiative?

Answer: It is unlikely that pediatric practices will be eligible to participate due to the requirement that primary care practices must have at least 200 eligible non-institutionalized Medicare fee for service beneficiaries to be eligible for this initiative. The Innovation Center is considering other initiatives to address the health care needs of children.