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Transforming Payment for a Healthier Ohio

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Governor's Office of Health Transformation

HPIO: Paying for value over volume
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Ohio's Path to Value

Modernize Medicaid	Streamline Health and Human Services	Pay for Value
Initiate in 2011	***Initiate in 2012***	***Initiate in 2013***
Advance Governor Kasich's Medicaid modernization and cost containment priorities	***Share services to increase efficiency, right-size capacity, and streamline governance***	***Engage private sector partners to set clear expectations for better health, better care and cost savings through improvement***
• Extend Medicaid coverage to more low-income Ohioans • Eliminate fraud and abuse • Prioritize home and community based (HCBS) services • Reform nursing facility payment • Enhance community DD services • Integrate Medicare and Medicaid • Rebuild community behavioral health system capacity • Restructure behavioral health system financing • Improve Medicaid managed care plan performance	• Create the Office of Health Transformation (2011) • Implement a new Medicaid claims payment system (2011) • Create a unified Medicaid budget and accounting system (2013) • Create a cabinet-level Medicaid Department (2013) • Consolidate mental health and addiction services (2013) • Simplify and integrate eligibility determination (2014) • Refocus existing resources to promote economic self-sufficiency	• Join Catalyst for Payment Reform • Support regional payment reform • Pay for value instead of volume (State Innovation Model Grant) – Provide access to medical homes for most Ohioans – Use episode-based payments for acute events – Coordinate health information infrastructure – Coordinate health sector workforce programs – Report and measure system performance

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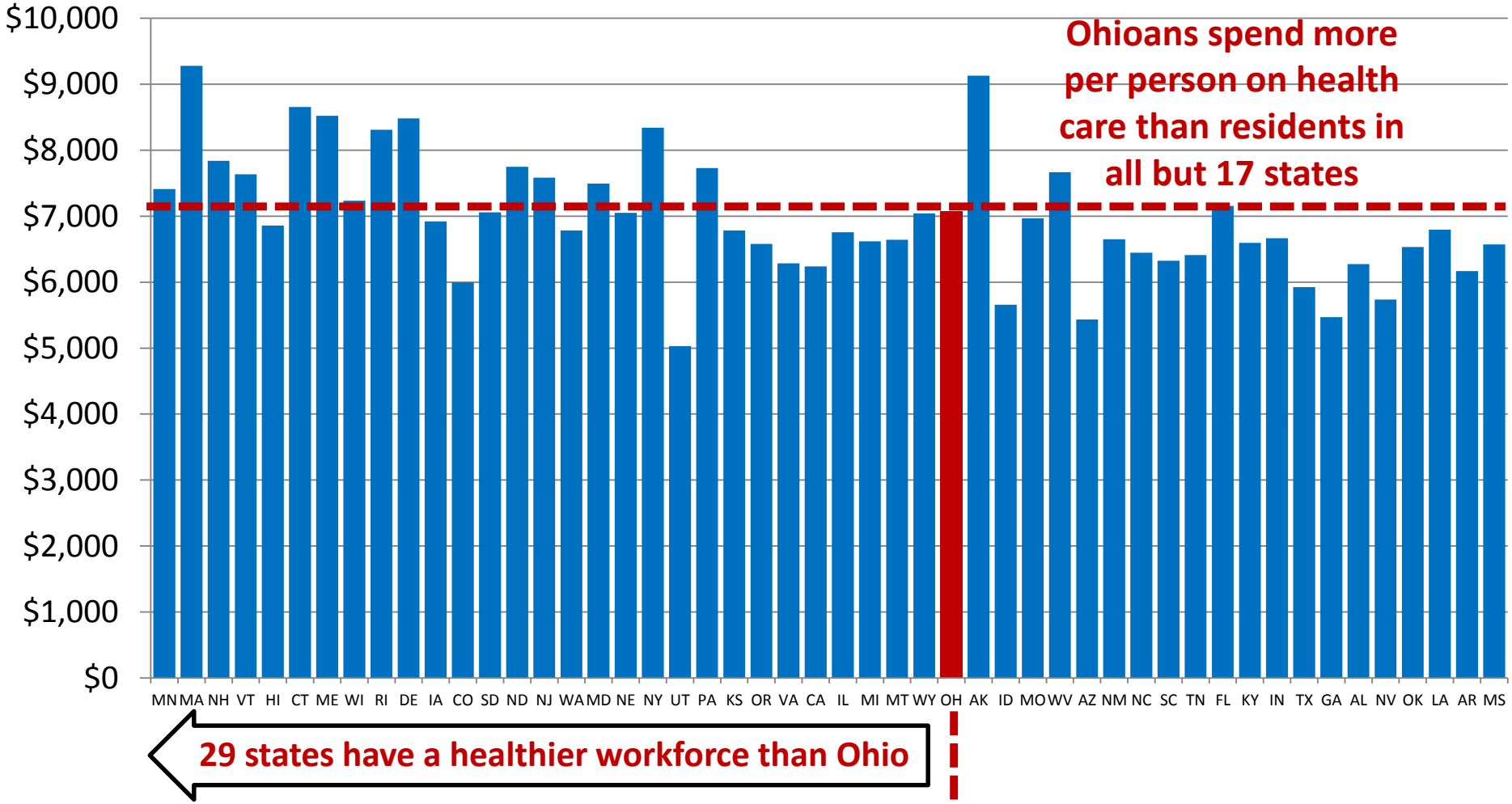
1. **Ohio's approach to paying for value instead of volume**
2. Patient-Centered Medical Home (PCMH) Model
3. Episode-Based Payment Model

Ohio can get better value from what is spent on health care

Health Care Spending per Capita by State (2011) in order of resident health outcomes (2014)



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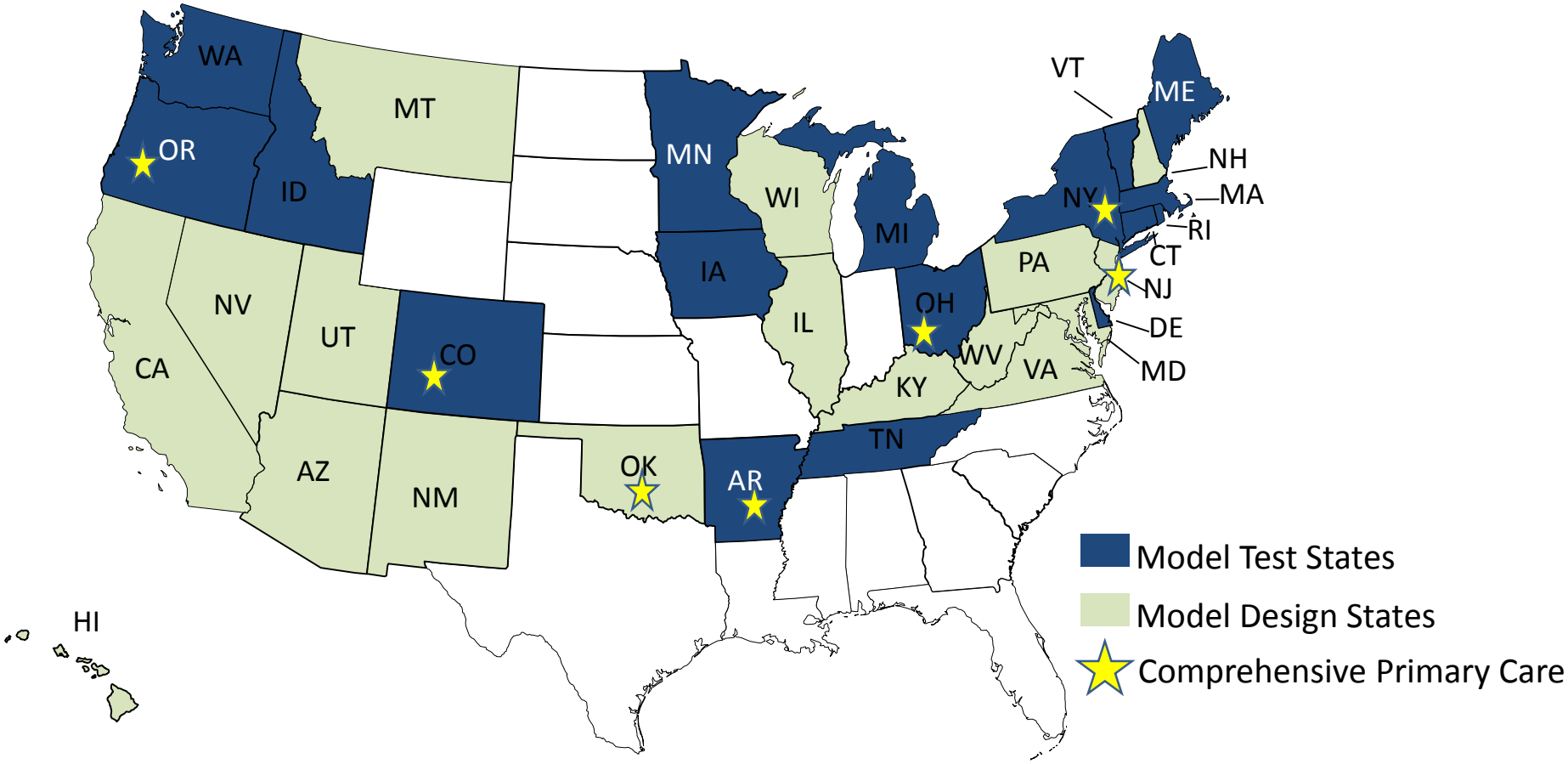
Sources: CMS *Health Expenditures by State of Residence* (2011); The Commonwealth Fund, *Aiming Higher: Results from a State Scorecard on Health System Performance* (May 2014).

Center for Medicare & Medicaid INNOVATION

Ohio is one of 17 states awarded a federal grant to test payment innovation models



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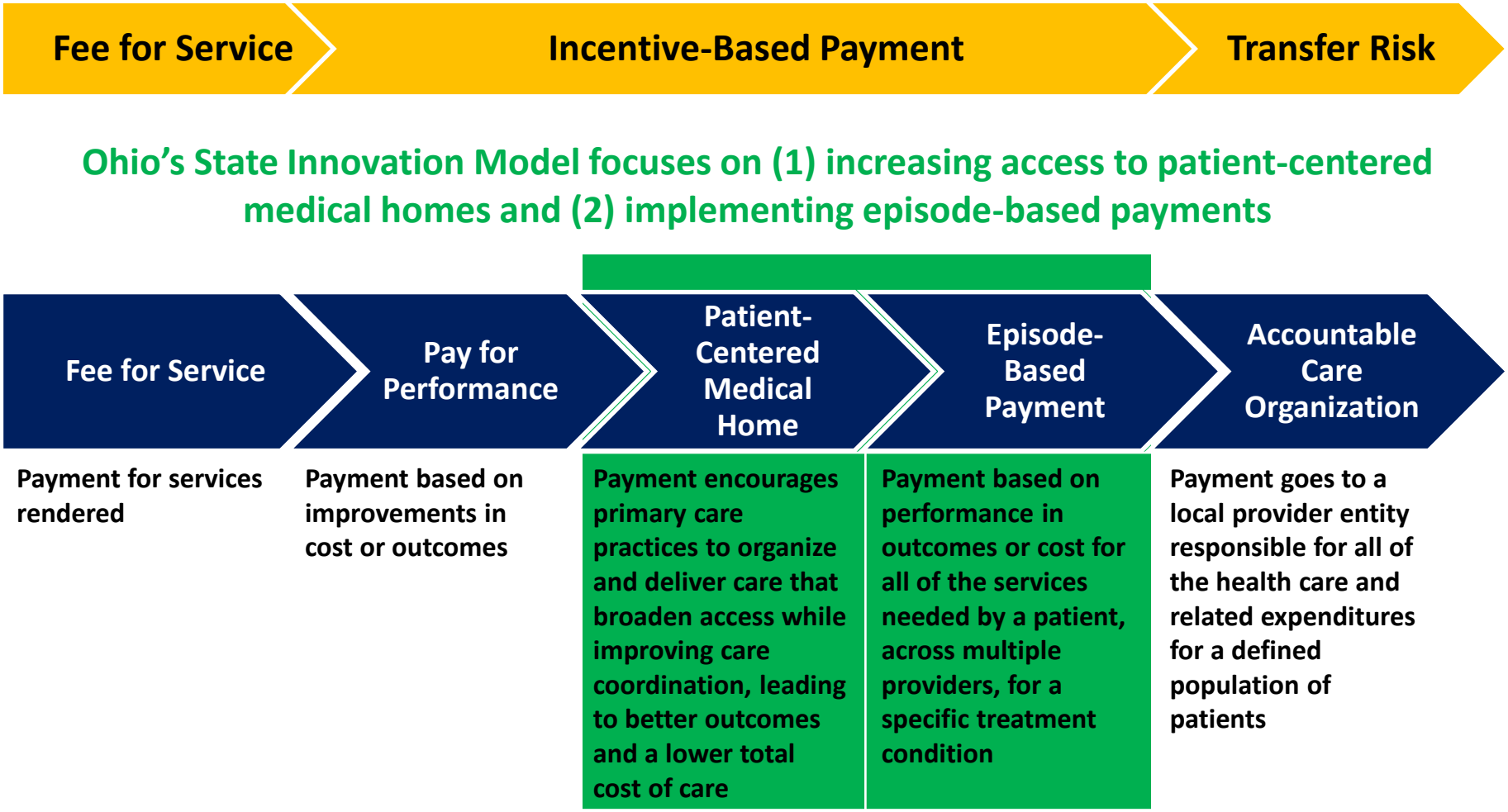
SOURCE: State Innovation Models and Comprehensive Primary Care Initiative, U.S. Centers for Medicare and Medicaid Services (CMS).

Value-Based Alternatives to Fee-for Service

Most payers have implemented some form of pay for performance and at least begun to consider PCMH, episode or ACO alternatives

Fee for Service	Pay for Performance	Patient-Centered Medical Home	Episode-Based Payment	Accountable Care Organization
Payment for services rendered	Payment based on improvements in cost or outcomes	Payment encourages primary care practices to organize and deliver care that broaden access while improving care coordination, leading to better outcomes and a lower total cost of care	Payment based on performance in outcomes or cost for all of the services needed by a patient, across multiple providers, for a specific treatment condition	Payment goes to a local provider entity responsible for all of the health care and related expenditures for a defined population of patients

Value-Based Alternatives to Fee-for Service



Multi-payer participation is critical to achieve the scale necessary to drive meaningful transformation

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Ohio's approach to multi-payer alignment

"Standardize"

Standardize approach with an identical design only when:

- In the best interest of patients
- Alignment is critical to provider success or significantly eases implementation for providers
- There are meaningful economies of scale
- Standardization does not diminish sources of competitive advantage among payers
- It is lawful to do so

Example:
Quality Measures

"Align in principle"

Align in principle but allow for payer innovation consistent with those principles when:

- It benefits providers to understand where payers are moving in same direction
- Differences have modest impact on providers from an administrative standpoint
- Differences are necessary to account for legitimate differences among payers (varied enrollees, etc.)

Example:
Gain Sharing

"Differ by design"

Differ by design when:

- Required by laws or regulations
- An area of the model is substantially tied to competitive advantage
- There exists meaningful opportunity for innovation or experimentation

Example:
Amount of Gain Sharing

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1. Ohio's approach to paying for value instead of volume
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Ohio's vision for PCMH is to promote high-quality, individualized, continuous and comprehensive care

Patient Experience:
Offer consistent, individualized experiences to each member depending on their needs

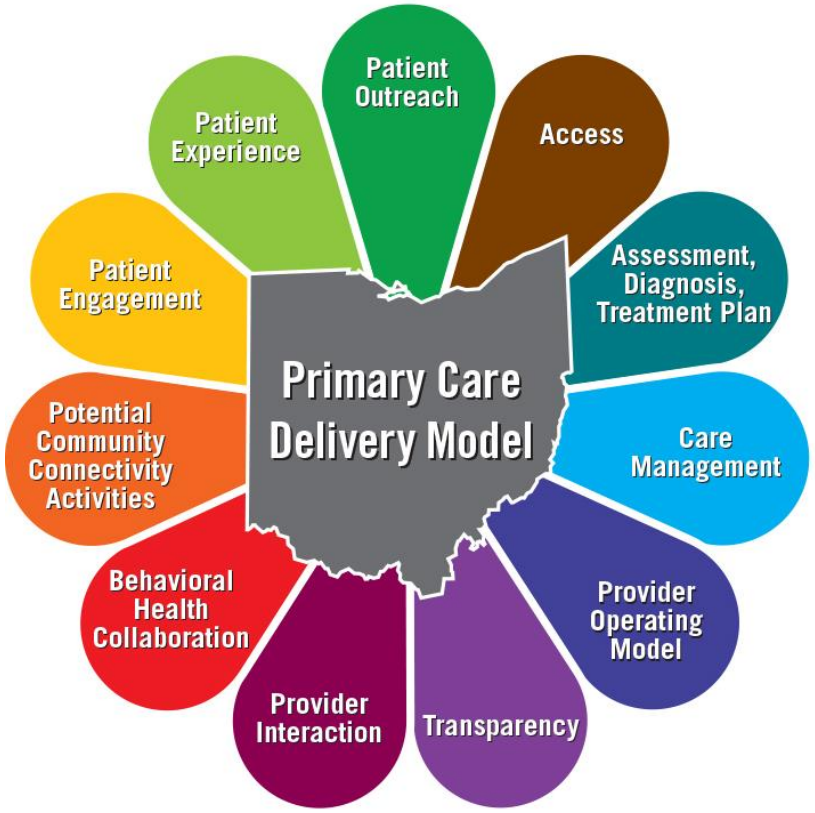
Patient Engagement:
Have a strategy in place that effectively raises patients' health literacy, activation, and ability to self-manage

Potential Community Connectivity Activities:
Actively connect members to a broad set of social services and community-based prevention programs (e.g., nutrition and health coaching, parenting education, transportation)

Behavioral Health Collaboration:
Integrate behavioral health specialists into a patients' full care

Provider Interaction:
Oversee successful transitions in care and select referring specialists based on evidence-based likelihood of best outcomes for patient

Transparency:
Consistently review performance data across a practice, including with patients, to monitor and reinforce improvements in quality and experience



Patient Outreach:
Proactive, targeting patients with focus on all patients including healthy individuals, those with chronic conditions, and those with no existing PCP relationship

Access:
Offer a menu of options to engage with patients (e.g., extended hours to tele-access to home visits)

Assessment, Diagnosis, Care Plan:
Identify and document full set of needs for patients that incorporates community-based partners and reflects socioeconomic and ethnic differences into treatment plans

Care Management:
Patient identifies preferred care manager, who leads relationship with patients and coordinates with other managers and providers of specific patient segments

Provider Operating Model:
Practice has flexibility to adapt resourcing and delivery model (e.g., extenders, practicing at top of license) to meet the needs of specific patient segments

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"Health care homes save Minnesota $1 billion"

State-certified patient-centered health care home performance (2010-2014) compared to other Minnesota primary care practices …

- Better quality of care for diabetes, vascular, asthma (child and adult), depression, and colorectal cancer screening
- Significantly smaller racial disparities on most measures
- Better care coordination for low-income populations
- Major decrease in the use of hospital services
- Saved $1 billion over four years, mostly Medicaid ($918 million), but also Medicare ($142 million)

Source: University of Minnesota School of Public Health *Evaluation of the State of Minnesota's Health Care Homes Initiative, 2010-2014* (December 2015).

Payer alignment on PCMH requirements in Ohio

"Standardize"

1 **6 process requirements**

2 **6 activity requirements**

3 **4-8 efficiency measures**

4 **20 clinical quality measures**

Consistent public **messaging** of Ohio's PCMH model

Commitment to 30-40% patient volume in the PCMH model **by 2018**, and >80% when fully implemented

- PCMH enrollment does not require EHR or accreditation

"Align in principle"

An ongoing stream of **new funds to support clinical and operational activities** that are currently not compensated or undercompensated

- Sufficient to compensate for the new clinical activities required by PCMH
- At risk based on performance on standard processes and activities, clinical quality, and efficiency metrics

5 A stream of gain-sharing payment to **award PCMHs for lowering total cost of care**

Attribution model that aligns all members with a PCMH

"Differ by design"

Payment levels for new payment streams

Thresholds and risk adjustment methodology for payment streams

Payment streams will be tied to specific requirements

Requirements	1 6 Process Measures	2 6 Activity Measures	3 Efficiency Measures	4 20 Clinical Measures	5 Total Cost of Care
	▪ *Risk stratification* ▪ *Same day appointments* ▪ *24/7 access* ▪ *Practice uses a team* ▪ *Care management* ▪ *Relationship continuity*	▪ *Risk stratification* ▪ *Population management* ▪ *Care plans* ▪ *Follow up after hospital discharge* ▪ *Tracking of follow up tests and specialist referrals* ▪ *Patient experience*	▪ *ED visits* ▪ *Inpatient admissions for ambulatory sensitive conditions* ▪ *All-cause readmission rate* ▪ *Generic dispensing rate of select classes*	▪ *16-20 measures aligned with CMS/AHIP core standards for PCMH*	
Payment Streams					
PCMH operational activities PMPM	*Scoring weight shifts from standard processes and activities…*			*…to efficiency and clinical quality over time*	
Quality and financial outcomes-based payment	*"Must have" processes targeting access to care*			*Quality gate*	*Based on self-improvement and performance relative to peers*

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Ohio's statewide PCMH rollout

- Spring 2016 – finalize PCMH care delivery and payment model
- Throughout 2017 – recruit primary care practices to commit to the PCMH model and support practice transformation
- January 1, 2018 – performance period begins for:
  1. Operational activities PMPM
  2. Quality and financial-outcomes based payment
  3. One-time practice transformation support for some practices
- Fall 2016 – exploring an early enrollment process beginning January 1, 2017 for some already-accredited PCMHs

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1. Ohio's approach to paying for value instead of volume
2. Patient-Centered Medical Home Model
3. **Episode-Based Payment Model**

Retrospective episode model mechanics

Patients and providers continue to deliver care as they do today

1

Patients seek care and select providers as they do today

2

Providers submit claims as they do today

3

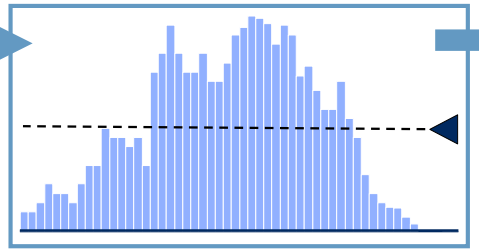
Payers reimburse for all services as they do today

Calculate incentive payments based on outcomes after close of 12 month performance period

4

Review claims from the performance period to identify a **'Principal Accountable Provider'** (PAP) for each episode

5 Payers calculate **average risk-adjusted reimbursement per episode** for each PAP



Compare to predeter-mined "commendable" and "acceptable" levels

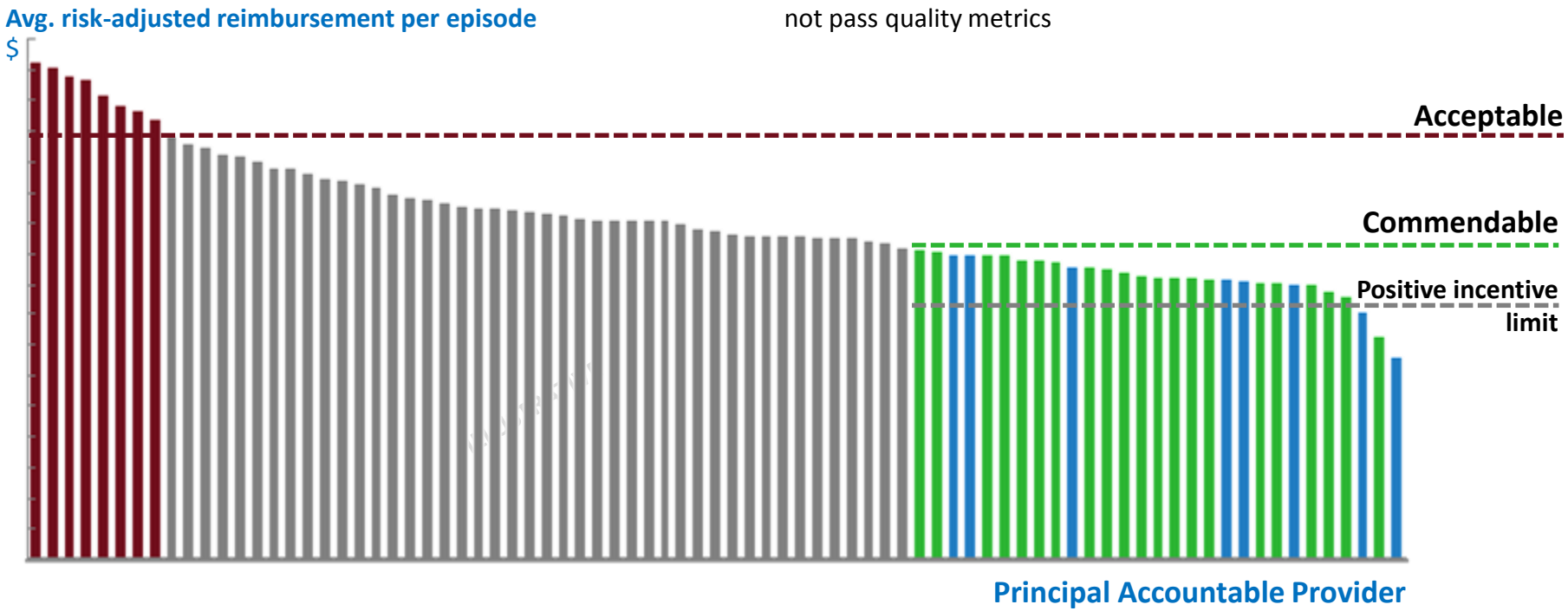
6 **Providers may:**

- **Share savings**: if average costs below commendable levels and quality targets are met
- **Pay negative incentive:** if average costs are above acceptable level
- **See no impact:** if average costs are between commendable and acceptable levels

Retrospective thresholds reward cost-efficient, high-quality care

Provider cost distribution (average risk-adjusted reimbursement per provider)

- ***Negative incentive***
- ***No change*** — No incentive payment
- ***No Change*** — Eligible for positive incentive payment based on cost, but did not pass quality metrics
- ***Positive incentive***



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NOTE: Each vertical bar represents the average cost for a provider, sorted from highest to lowest average cost

Selection of episodes

Principles for selection:

- Leverage episodes in use elsewhere to **reduce time to launch**
- Prioritize meaningful **spend across payer populations**
- Look for opportunities with **clear sources of value** (e.g., high variance in care)
- Select episodes that incorporate a **diverse mix** of accountable **providers** (e.g., facility, specialists)
- Cover a **diverse set of "patient journeys"** (e.g., acute inpatient, acute procedural)
- Consider **alignment with current priorities** (e.g., perinatal for Medicaid, asthma acute exacerbation for youth)

Ohio's episode selection:

Episode	*Principal Accountable Provider*
WAVE 1 (launched March 2015)	
1. Perinatal	Physician/group delivering the baby
2. Asthma acute exacerbation	Facility where trigger event occurs
3. COPD exacerbation	Facility where trigger event occurs
4. Acute Percutaneous intervention	Facility where PCI performed
5. Non-acute PCI	Physician
6. Total joint replacement	Orthopedic surgeon
WAVE 2 (launch January 2016)	
7. Upper respiratory infection	PCP or ED
8. Urinary tract infection	PCP or ED
9. Cholecystectomy	General surgeon
10. Appendectomy	General surgeon
11. Upper GI endoscopy	Gastroenterologist
12. Colonoscopy	Gastroenterologist
13. GI hemorrhage	Facility where hemorrhage occurs

All of the details to run the first 13 episodes are available online

Summary definitions

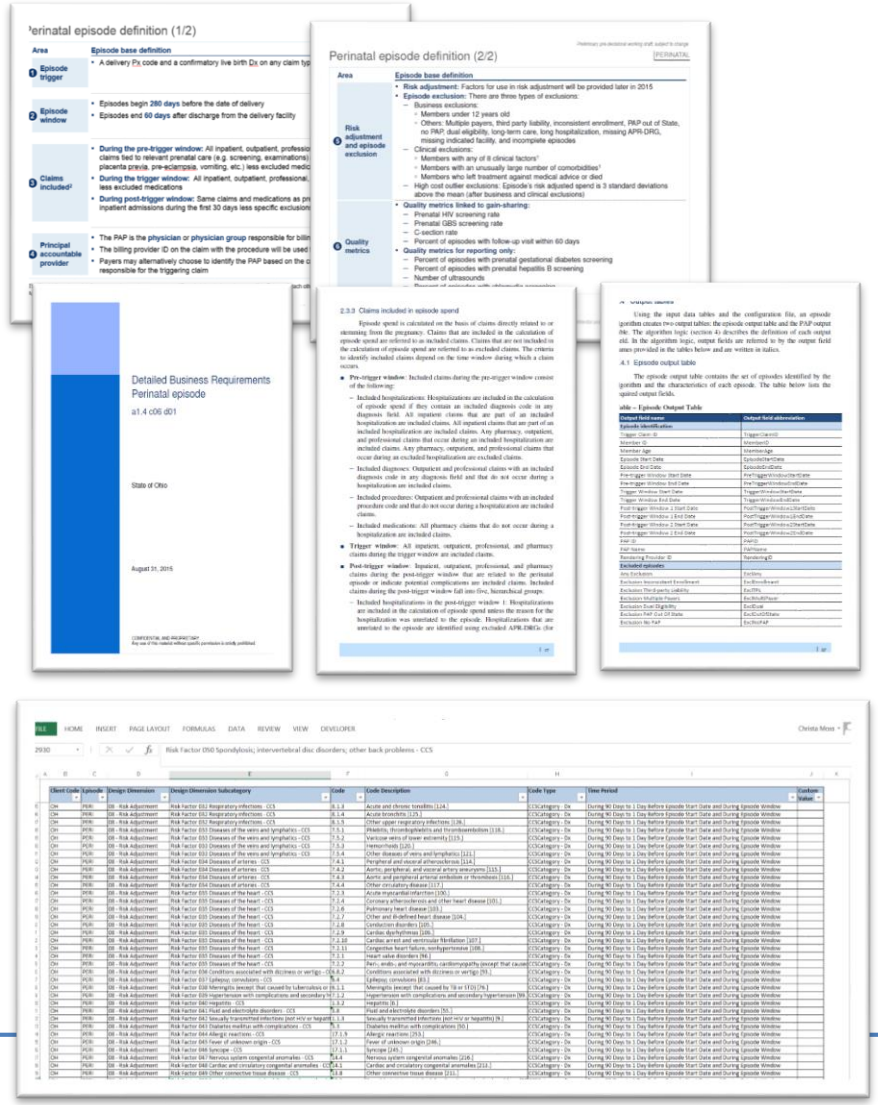
- Overview of definitions resulting from clinical advisory group process
- 2-page overview of all design elements

Detailed business requirements

- Detailed word file including all of the specifics required to code an algorithm

Code sets

- Excel file containing specific diagnosis and procedure codes used for trigger, included claims, exclusions, risk adjustment, etc.



http://medicaid.ohio.gov/providers/PaymentInnovation.aspx

This is an example of the multi-payer performance report format released in 2016

EPISODE of CARE PROVIDER REPORT

EPISODE NAME

Q1 + Q2 YYYY

Reporting period covering episodes that ended between **Start Date to End Date**

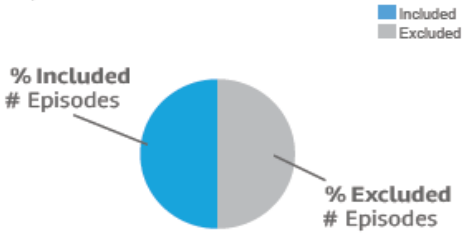
PAYER: Payer Name | PROVIDER ID: PAP ID | PROVIDER: Provider Name

Eligibility requirements for gain or risk-sharing payments

- **Episode volume:** You have at least 5 episodes in the current performance period.
- **Spend:** Your average risk-adjusted spend per episode is below the commendable threshold.
- **Quality:** You are not currently eligible for gain-sharing because you have not passed all quality metrics linked to gain-sharing.
- **This report is informational only.** Eligibility for gain or risk-sharing will be determined at the end of the performance period and any applicable payments will be calculated at that time.

Episodes included, excluded & adjusted

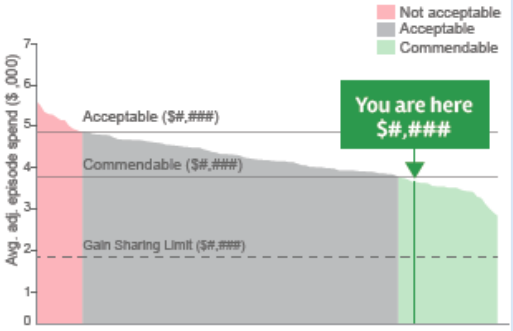
Total episodes#



% of your episodes have been risk adjusted

Risk adjusted average spend per episode

Distribution of provider average episode spend (risk adj.)



Quality metrics

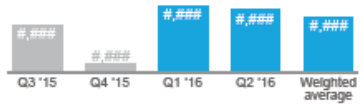
You achieved # of # quality metrics linked to gain sharing

Quality metric 01	#%	✓
Quality metric 02	#%	✓
Quality metric 03	#%	✗
Quality metric 04	#%	✗

Key performance

Rolling four quarters

Performance period 2016
Reporting period 2015



	Q3 '15	Q4 '15	Q1 '16	Q2 '16	Weighted average
Avg adjusted episode spend ($,000)	#,###	#,###	#,###	#,###	#,###
# of included episodes	#	#	#	#	#
Your spend percentile	#%	#%	#%	#%	#%

DISCLAIMER: The information contained in these reports is intended solely for use in the administration of the Medicaid program. The data in the reports are neither intended nor suitable for other uses, including the selection of a health care provider. The figures in these reports are preliminary and are subject to revision. For more information, please visit http://medicaid.ohio.gov/Providers/Paymentinnovation.aspx.

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Selecting the next waves of episodes

Principles for selection:

- Leverage episodes in use elsewhere to **reduce time to launch**
- Prioritize meaningful **spend across payer populations**
- Look for opportunities with **clear sources of value** (e.g., high variance in care)
- Select episodes that incorporate a **diverse mix** of accountable **providers** (e.g., facility, specialists)
- Cover a **diverse set of "patient journeys"** (e.g., acute inpatient, acute procedural)
- Consider **alignment with current priorities** (e.g., perinatal for Medicaid, asthma acute exacerbation for youth)

Ohio's episode selection:

Episode

WAVE 3 (launch January 2017)

Preliminary list of potential episodes to design in 2016:

HIV	Hepatitis C	Neonatal
Hysterectomy	Bariatric surgery	Diabetic ketoacidosis
Lower back pain	Headache	CABG
Cardiac valve	congestive heart failure	Breast biopsy
Breast cancer	Mastectomy	Otitis
Simple pneumonia	Tonsillectomy	Shoulder sprain
Wrist sprain	Knee sprain	Ankle sprain
Hip/Pelvic fracture	Knee arthroscopy	Lumbar laminectomy
Spinal fusion exc. cervical	Hernia procedures	Colon cancer
Pacemaker/defibrillator	Dialysis	Lung cancer
Bronchiolitis and RSV pneumonia		

WAVE 4 (launch January 2018)

Design work begins on behavioral episodes in June 2016 …

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CURRENT INITIATIVES | BUDGETS | NEWSROOM | CONTACT | VIDEO

Current Initiatives

Modernize Medicaid
Extend Medicaid coverage to more low-income Ohioans
Reform nursing facility reimbursement
Integrate Medicare and Medicaid benefits
Prioritize home and community based services
Create health homes for people with mental illness
Rebuild community behavioral health system capacity
Enhance community developmental disabilities services
Improve Medicaid managed care plan performance

Streamline Health and Human Services
Support Human Services Innovation
Implement a new Medicaid claims payment system
Create a cabinet-level Medicaid department
Consolidate mental health and addiction services
Simplify and integrate eligibility determination
Coordinate programs for children
Share services across local jurisdictions

Pay for Value
Engage partners to align payment innovation
Provide access to patient-centered medical homes
Implement episode-based payments
Coordinate health information technology infrastructure
Coordinate health sector workforce programs
Support regional payment reform initiatives
Federal Marketplace Exchange

State Innovation Model:

- **Overview Presentations**
- **Patient-Centered Medical Home (PCMH) payment model**
- **Episode-based payment model**
- **Population health plan**
- **Health IT plan**