



Transforming Payment for a Healthier Ohio

Governor Kasich's Advisory Council on
Health Care Payment Innovation
April 28, 2015

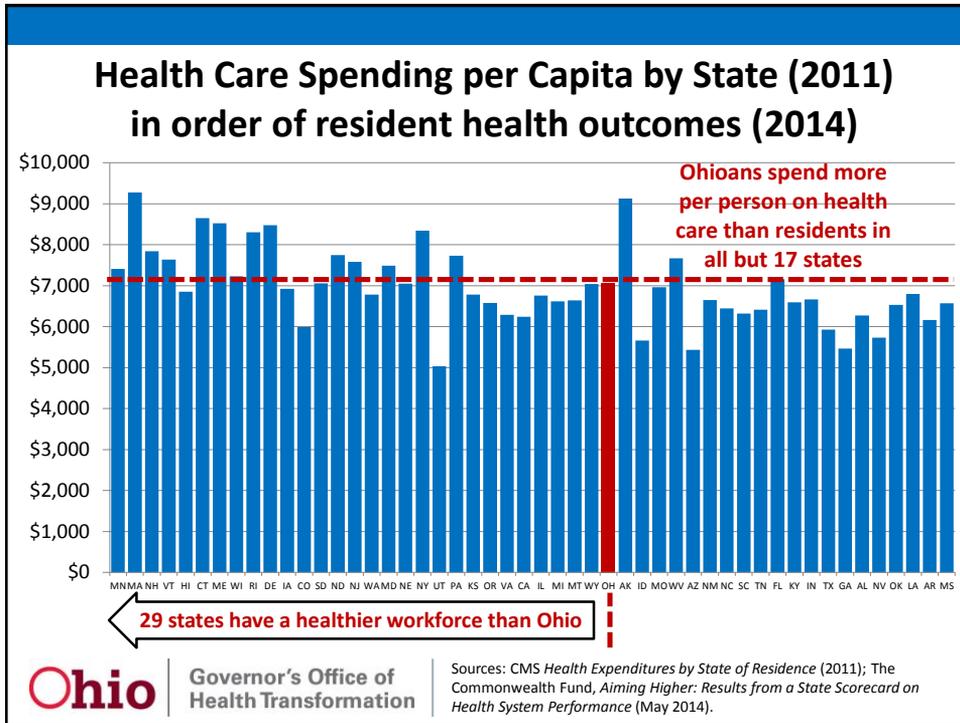
www.HealthTransformation.Ohio.gov



1. Ohio Approach to Paying for Value Instead of Volume
2. Patient-Centered Primary Care Model
3. Episode-Based Payment Model
4. Next Steps

2011 Ohio Crisis	vs.	Results Today
<ul style="list-style-type: none"> • \$8 billion state budget shortfall • 89-cents in the rainy day fund • Nearly dead last (48th) in job creation (2007-2009) • Medicaid spending increased 9% annually (2009-2011) • Medicaid over-spending required multiple budget corrections • Ohio Medicaid stuck in the past and in need of reform • More than 1.5 million uninsured Ohioans (75% of them working) 		<ul style="list-style-type: none"> • Balanced budget • \$1.5 billion in the rainy day fund • One of the top ten job creating states in the nation • Medicaid increased 4.1% in 2012 and 2.5% in 2013 (pre-expansion) • Medicaid budget under-spending was \$1.9 billion (2012-2013) and \$2.5 billion (2014-2015) • Ohio Medicaid embraces reform • Extended Medicaid coverage

Ohio Governor's Office of Health Transformation Innovation Framework		
Modernize Medicaid	Streamline Health and Human Services	Pay for Value
<i>Initiate in 2011</i>	<i>Initiate in 2012</i>	<i>Initiate in 2013</i>
<p><i>Advance the Governor Kasich's Medicaid modernization and cost containment priorities</i></p> <ul style="list-style-type: none"> • 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 	<p><i>Share services to increase efficiency, right-size state and local service capacity, and streamline governance</i></p> <ul style="list-style-type: none"> • 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 	<p><i>Engage private sector partners to set clear expectations for better health, better care and cost savings through improvement</i></p> <ul style="list-style-type: none"> • Join Catalyst for Payment Reform • Support regional payment reform • Pay for value instead of volume (State Innovation Model Grant) <ul style="list-style-type: none"> – 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



In fee-for-service, we get what we pay for

- **More volume** – to the extent fee-for-service payments exceed costs of additional services, they encourage providers to deliver more services and more expensive services
- **More fragmentation** – paying separate fees for each individual service to different providers perpetuates uncoordinated care
- **More variation** – separate fees also accommodate wide variation in treatment patterns for patients with the same condition – variations that are not evidence-based
- **No assurance of quality** – fees are typically the same regardless of the quality of care, and in some cases (e.g., avoidable hospital readmissions) total payments are greater for lower-quality care



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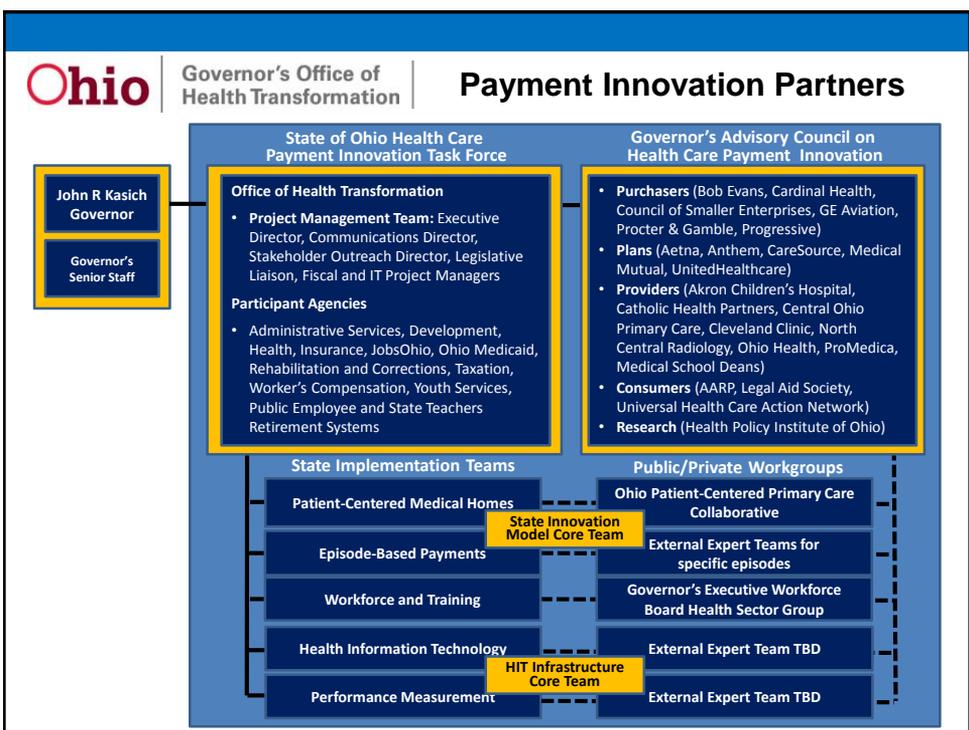
Source: UnitedHealth, *Farewell to Fee-for-Service: a real world strategy for health care payment reform* (December 2012)

Center for Medicare & Medicaid INNOVATION

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

Ohio Governor's Office of Health Transformation

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



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Goal 80-90 percent of Ohio's population in some value-based payment model (combination of episodes- and population-based payment) within five years

State's Role

- Shift rapidly to PCMH and episode model in Medicaid fee-for-service
- Require Medicaid MCO partners to participate and implement
- Incorporate into contracts of MCOs for state employee benefit program

	Patient-centered medical homes	Episode-based payments
Year 1	<ul style="list-style-type: none"> ▪ In 2014 focus on Comprehensive Primary Care Initiative (CPCI) 	<ul style="list-style-type: none"> ▪ State leads design of six episodes: asthma acute exacerbation, COPD exacerbation, perinatal, acute and non-acute PCI, and joint replacement
Year 2	<ul style="list-style-type: none"> ▪ Collaborate with payers on design decisions and prepare a roll-out strategy 	<ul style="list-style-type: none"> ▪ State leads design of seven new episodes: URI, UTI, cholecystectomy, appendectomy, GI hemorrhage, EGD, and colonoscopy
Year 3	<ul style="list-style-type: none"> ▪ Model rolled out to all major markets ▪ 50% of patients are enrolled 	<ul style="list-style-type: none"> ▪ 20 episodes defined and launched across payers, including behavioral health
Year 5	<ul style="list-style-type: none"> ▪ Scale achieved state-wide ▪ 80% of patients are enrolled 	<ul style="list-style-type: none"> ▪ 50+ episodes defined and launched across payers

Ohio's Health Care Payment Innovation Partners:

















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Agree on degrees of standardization within each model		
“Standardize”	“Align in principle”	“Differ by design”
<p>Standardize approach (i.e., identical design) only when:</p> <ul style="list-style-type: none"> Alignment is critical to provider success or significantly eases implementation for providers (e.g., lower administrative burden) Meaningful economies of scale exist Standardization does not diminish potential sources of competitive advantage among payers It is lawful to do so In best interest of patients (i.e., clear evidence base) 	<p>Align in principle but allow for payer innovation consistent with those principles when:</p> <ul style="list-style-type: none"> There are benefits for the integrity of the program for payers to align It benefits providers to understand where payers are moving in same direction Differences have modest impact on provider from an administrative standpoint Differences are necessary to account for legitimate differences among payers (e.g., varied customers, adm. systems) 	<p>Differ by design when:</p> <ul style="list-style-type: none"> Required by laws or regulations An area of the model is substantially tied to competitive advantage There exists meaningful opportunity for innovation or experimentation
<p>Example: Quality Measures</p>	<p>Example: Gain Sharing</p>	<p>Example: Amount of Gain Sharing</p>
		

	
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Elements of a Patient-Centered Medical Home Strategy

Care delivery model	Target patients and scope Care delivery improvements e.g., <ul style="list-style-type: none"> ▪ Improved access ▪ Patient engagement ▪ Population management ▪ Team-based care, care coordination Target sources of value
Payment model	Technical requirements for PCMH Attribution / assignment Quality measures Payment streams/ incentives Patient incentives
Infrastructure	PCMH infrastructure Payer infrastructure Payer / PCMH infrastructure PCMH/ Provider infrastructure System infrastructure
Scale-up and practice performance improvement	Clinical leadership / support Practice transformation support Workforce / human capital Legal / regulatory environment Network / contracting to increase participation ASO contracting/participation Performance transparency Ongoing PCMH support Evidence, pathways, & research Multi-payer collaboration

Payment Model Mechanics:

- Payers agree to provide resources to support business model transformation for a finite period of time, particularly for small, less capitalized practices
- Agree to provide resources to compensate PCMH for activities not fully covered by existing fee schedules (care coordination, non-traditional visits like telemedicine, population health)
- Agree to reward PCMHs for favorably affecting risk-adjusted total cost of care over time by offering bonus payments, shared savings, or capitation

Source: Ohio PCMH Multi-Payer Charter (2013)

Build on existing projects and leadership ...

From payers:



From providers:

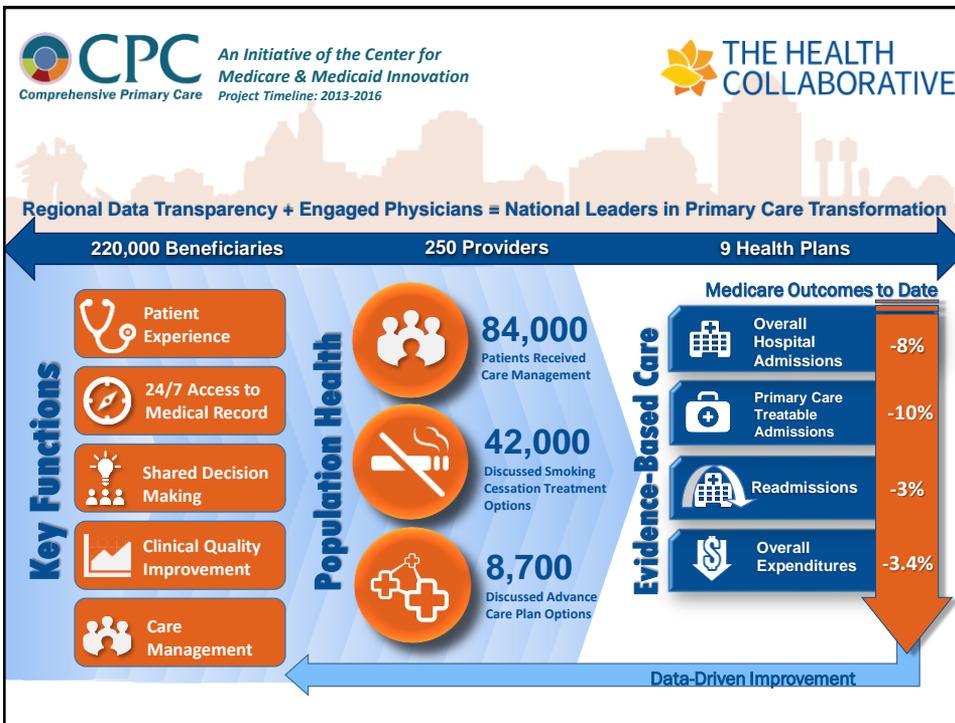


From collaboration:

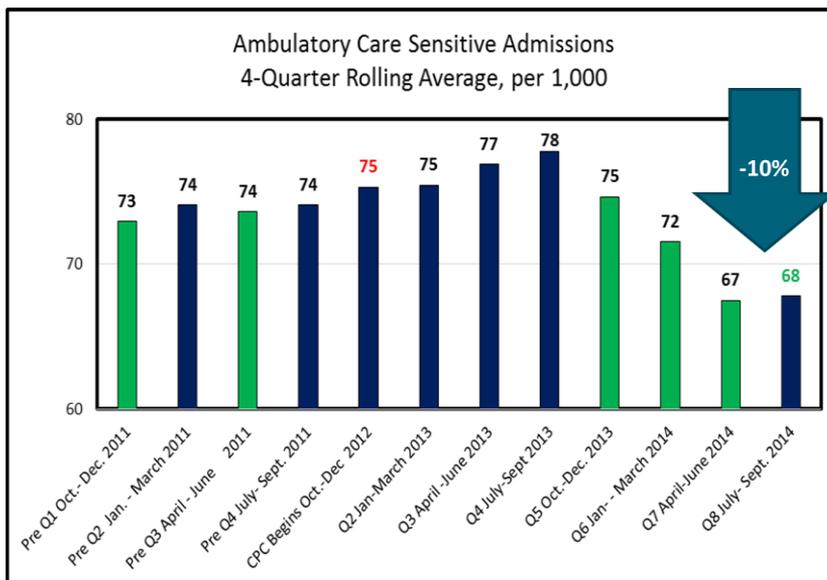




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OH/KY Medicare Ambulatory Care Sensitive Admissions



Comprehensive Primary Care Drivers

Five Essential Elements:

1. Prospective Care Management Payment
2. Aggregation of Clinical and Claims Data
3. Avoiding administrative overload of practices
4. Physician/Provider/Practice Culture
5. Care Coordination and Care Management

Comprehensive Primary Care Drivers

Five Important Elements:

1. Timely Access
2. Action-able tools
3. A Supportive Medical Neighborhood
4. Electronic Health Record Capability
5. Structured programs for budgeting and process improvement



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2015 Priorities

Patient-Centered Medical Homes

- Convene a PCMH model design team to decide what elements of CPC to keep/modify and make statewide design decisions about the Medicaid payment model, attribution methodology, quality metrics, etc.
- Decide the PCMH rollout sequence and enroll primary care practices beginning in January 2016

Ohio PCMH Model Design Team (Preliminary)

Providers

- Michael Rothberg, MD, Cleveland Clinic
- Jeff Biehl, Health Care Collaborative of Columbus
- Richard Shonk, MD, Cincinnati Health Collaborative
- Ken Bertka, MD, Mercy Health
- William Wulf, MD, Central Ohio Primary Care
- Bruce Vanderhoff, MD, OhioHealth
- David Applegate, MD, OhioHealth
- Will Groneman, TriHealth Cincinnati
- Randy Wexler, MD, Ohio State University
- Jim Misak, MD, MetroHealth
- Barb Tobias, MD, UC Health
- Randall Cebul, MD, Better Health Greater Cleveland
- Rita Horwitz, RN, Better Health Greater Cleveland
- Deborah Southard, Family Practice of SW Ohio
- Steve Ulrich, MD, Perry County Family Practice
- Sean Gleeson, MD, Nationwide Children's Hospital
- Paul Martin, DO, Providence Medical Group
- Brian Bachelder, MD, Akron General Medical Center
- Ted Wymyslo, MD, OACHC
- Robert Falcone, MD, Ohio Hospital Association

Payers

- Craig Osterhues, GE
- Lisa Kaiser, Health Action Council
- Robin Dawson, Medical Mutual
- Kelly Owen, Anthem
- Randy Montgomery, Aetna
- Guy Shrake, MD, United Healthcare
- Donald Wharton, MD, CareSource
- Holly Saelens, Molina
- Jeff Martin, Paramount
- John Wiley, Buckeye

Patients

- Cathy Levine, UHCAN
- Angela Dawson, Minority Health Commission

State

- Rick Hodges, ODH
- Mary DiOrio, MD, ODH
- John McCarthy, Medicaid
- Mary Applegate, MD, Medicaid
- Karin Hoyt, Medicaid
- Rebecca Susteric, BWC
- Angie Bergefurd, MHAS
- Mark Hurst, MD, MHAS
- Greg Moody, OHT (*Chair*)
- Rick Tully, OHT
- Monica Juenger, OHT

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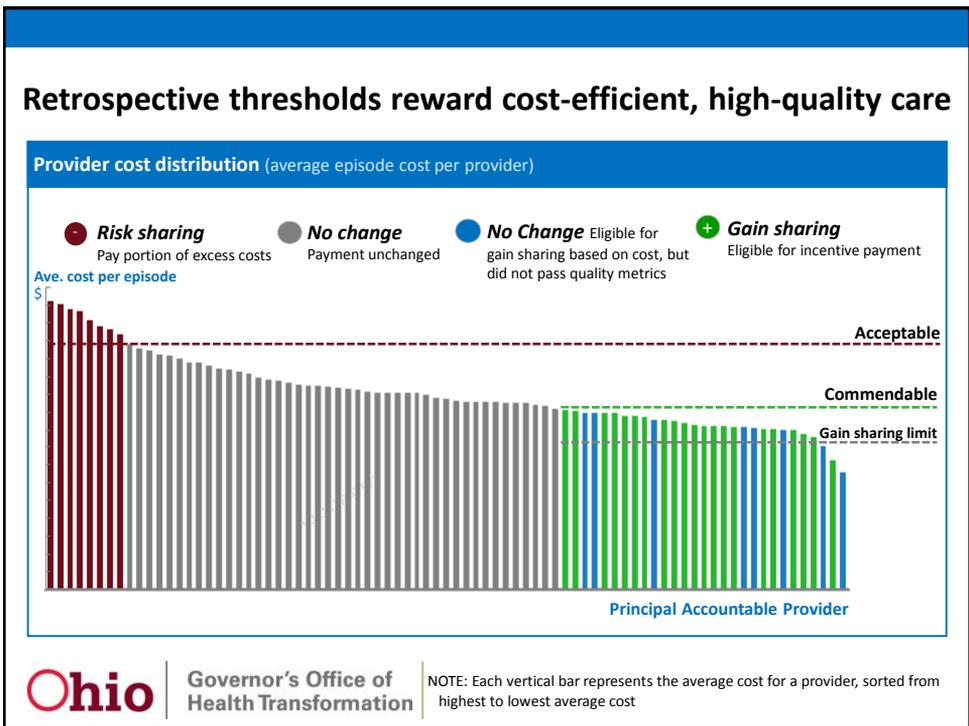
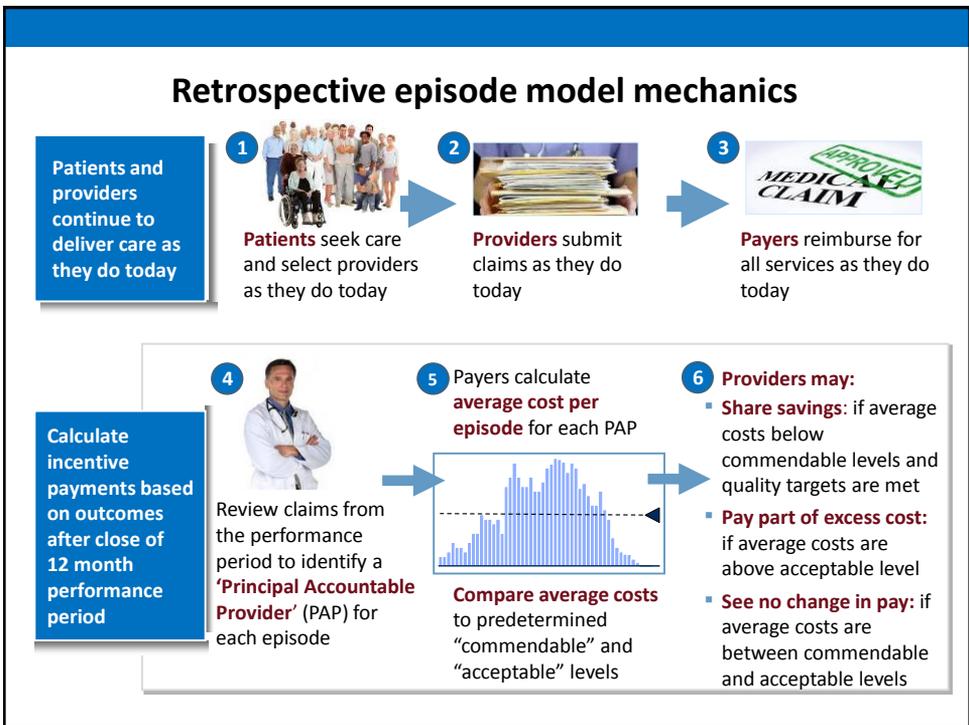
Elements of an Episode-Based Payment Strategy

Program-level design decisions	
Participation	Provider participation } Related to 'scale-up' plan for episodes
	Payer participation }
Accountability	Providers at risk – Number
	Providers at risk – Type of provider(s)
	Providers at risk – Unique providers
Payment model mechanics	Cost normalization approach
	Prospective or retrospective model
	Risk-sharing agreement – types of incentives
	Approach to small case volume
	Role of quality metrics
	Provider stop-loss
Performance management	Absolute vs. relative performance rewards
	Absolute performance rewards – Gain sharing limit
	Approach to risk adjustment
Payment model timing	Exclusions
	Preparatory/"reporting-only" period
	Length of "performance" period
Payment model thresholds	Synchronization of performance periods
	Approach to thresholds
	How thresholds change over time
	Specific threshold levels
	Degree of gain / risk sharing
	Cost outliers

Payment Model Mechanics:

- Episode costs are calculated at the end of a fixed period of time (retrospective performance period)
- Payers adopt a standard set of quality metrics for each episode and link payment incentives
- Payers agree to implement both upside gain sharing and downside risk sharing with providers
- Evaluate providers against absolute performance thresholds, which are set by and may vary across payers
- Type and degree of stop-loss arrangements may vary across payers

Source: Ohio Episode Multi-Payer Charter (2013)



Elements of the episode definition

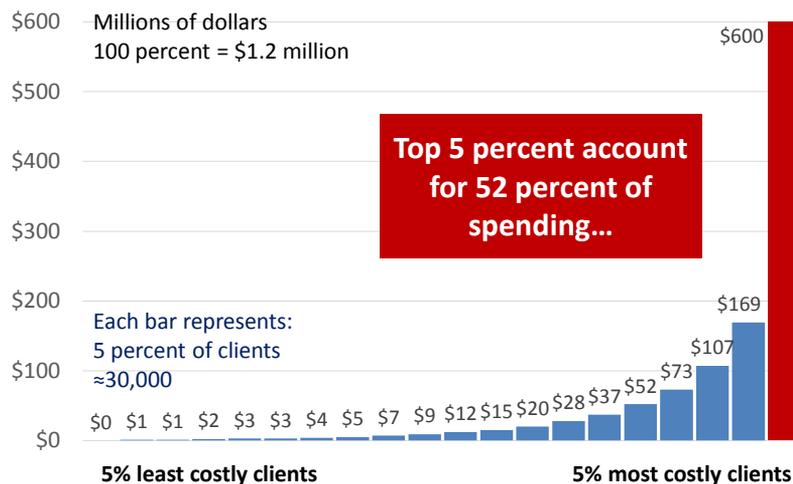
Category	Description
1 Episode trigger	<ul style="list-style-type: none"> Diagnoses or procedures and corresponding claim types and/or care settings that characterize a potential episode
2 Episode window	<ul style="list-style-type: none"> Pre-trigger window: Time period prior to the trigger event; relevant care for the patient is included in the episode Trigger window: Duration of the potential trigger event (e.g., from date of inpatient admission to date of discharge); all care is included Post-trigger window: Time period following trigger event; relevant care and complications are included in the episode
3 Claims included	
4 Principal accountable provider	<ul style="list-style-type: none"> Provider who may be in the best position to assume principal accountability in the episode based on factors such as decision making responsibilities, influence over other providers, and portion of the episode spend
5 Quality metrics	<ul style="list-style-type: none"> Measures to evaluate quality of care delivered during a specific episode
6 Potential risk factors	<ul style="list-style-type: none"> Patient characteristics, comorbidities, diagnoses or procedures that may potentially indicate an increased level of risk for a given patient in a specific episode
7 Episode-level exclusions	<ul style="list-style-type: none"> Patient characteristics, comorbidities, diagnoses or procedures that may potentially indicate a type of risk that, due to its complexity, cost, or other factors, should be excluded entirely rather than adjusted



Selection of episodes

Principles for selection:	Ohio's episode selection:																																				
<ul style="list-style-type: none"> 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) 	<table border="1" style="width: 100%;"> <thead> <tr> <th style="text-align: left;"><i>Episode</i></th> <th style="text-align: left;"><i>Principal Accountable Provider</i></th> </tr> </thead> <tbody> <tr> <td colspan="2">WAVE 1 (launched March 2015)</td> </tr> <tr> <td>1. Perinatal</td> <td>Physician/group delivering the baby</td> </tr> <tr> <td>2. Asthma acute exacerbation</td> <td>Facility where trigger event occurs</td> </tr> <tr> <td>3. COPD exacerbation</td> <td>Facility where trigger event occurs</td> </tr> <tr> <td>4. Acute Percutaneous intervention</td> <td>Facility where PCI performed</td> </tr> <tr> <td>5. Non-acute PCI</td> <td>Physician</td> </tr> <tr> <td>6. Total joint replacement</td> <td>Orthopedic surgeon</td> </tr> <tr> <td colspan="2">WAVE 2 (launch January 2016)</td> </tr> <tr> <td>7. Upper respiratory infection</td> <td>PCP or ED</td> </tr> <tr> <td>8. Urinary tract infection</td> <td>PCP or ED</td> </tr> <tr> <td>9. Cholecystectomy</td> <td>General surgeon</td> </tr> <tr> <td>10. Appendectomy</td> <td>General surgeon</td> </tr> <tr> <td>11. Upper GI endoscopy</td> <td>Gastroenterologist</td> </tr> <tr> <td>12. Colonoscopy</td> <td>Gastroenterologist</td> </tr> <tr> <td>13. GI hemorrhage</td> <td>Facility where hemorrhage occurs</td> </tr> <tr> <td colspan="2">WAVE 3 (launch January 2017)</td> </tr> <tr> <td colspan="2">14-19. Package of behavioral health episodes to be determined</td> </tr> </tbody> </table>	<i>Episode</i>	<i>Principal Accountable Provider</i>	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	WAVE 3 (launch January 2017)		14-19. Package of behavioral health episodes to be determined	
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Distribution of Behavioral Health Clients by Spending



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Source: Ohio Medicaid claims, including claims with diagnosis code of ICD9 290-314 excluding 299 and dementia codes in 294; does not include pharmacy claims (August 2012-July 2013).



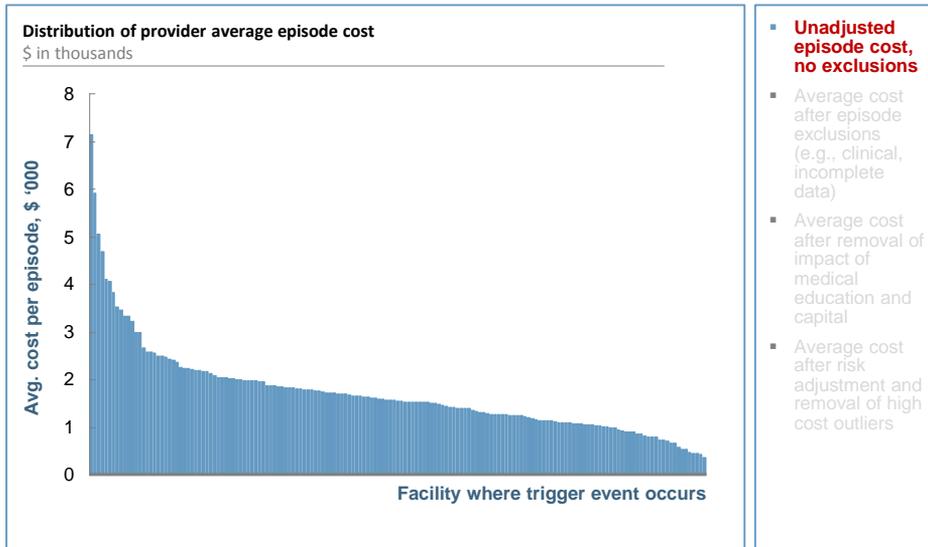
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1. Ohio Approach to Paying for Value Instead of Volume
2. Patient-Centered Primary Care Model
- 3. Episode-Based Payment Model: Asthma Example**
4. Next Steps

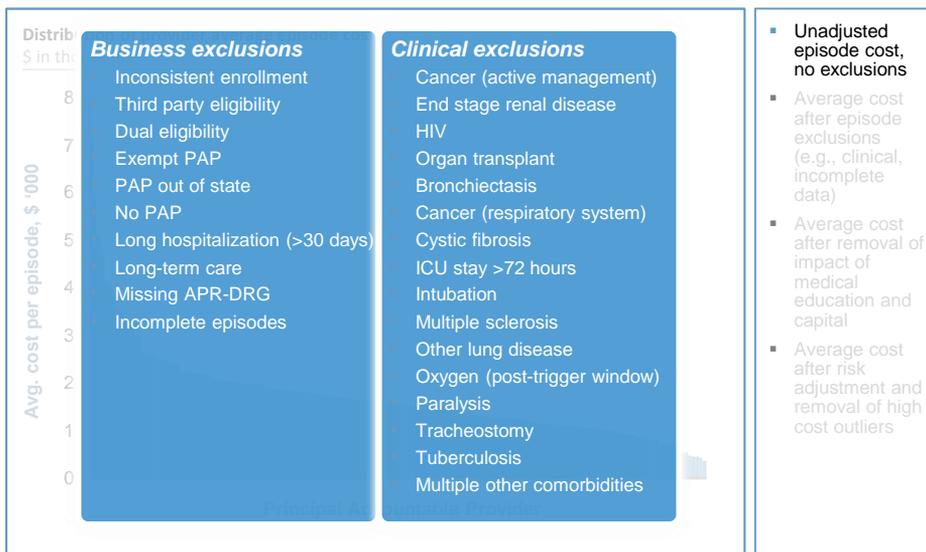
Asthma Acute Exacerbation: Definitions

Category	Episode definition		
1 Episode trigger	<ul style="list-style-type: none"> Asthma specific diagnosis on an ED, observation or IP facility claim Contingent code with confirming diagnosis 		
2 Episode window	<ul style="list-style-type: none"> <i>Trigger:</i> Starts on day of admission and ends on day of discharge <i>Post-trigger:</i> Begins day after discharge and ends 30 days later 		
3 Claims included	<ul style="list-style-type: none"> <i>Trigger window:</i> All <i>Post-trigger window:</i> <ul style="list-style-type: none"> Relevant care and complications including diagnoses, procedures, labs, DME and pharmacy Readmissions (except those not relevant to episode) 		
4 Principal accountable provider	<ul style="list-style-type: none"> Facility where the trigger event occurs In case of transfer, PAP is first facility 		
5 Quality metrics	<table border="0" style="width: 100%;"> <tr> <td style="vertical-align: top;"> <p><i>Linked to gain sharing:</i></p> <ul style="list-style-type: none"> Follow-up visit within 30 days Filled prescription for controller medications (based on HEDIS list) </td> <td style="vertical-align: top;"> <p><i>For reporting only:</i></p> <ul style="list-style-type: none"> Repeat exacerbation within 30 days IP vs. ED/Obs treatment setting Smoking cessation counseling X-ray utilization rate Follow-up visit within 7 days </td> </tr> </table>	<p><i>Linked to gain sharing:</i></p> <ul style="list-style-type: none"> Follow-up visit within 30 days Filled prescription for controller medications (based on HEDIS list) 	<p><i>For reporting only:</i></p> <ul style="list-style-type: none"> Repeat exacerbation within 30 days IP vs. ED/Obs treatment setting Smoking cessation counseling X-ray utilization rate Follow-up visit within 7 days
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6 Potential risk factors	<ul style="list-style-type: none"> Comorbidities (e.g., pneumonia, obesity); age 		
7 Exclusions	<ul style="list-style-type: none"> Clinical (e.g., cystic fibrosis, end stage renal disease, intubation, MS, oxygen during post-trigger window) Business (e.g., dual coverage, inconsistent eligibility) Patients < 2 years old and > 64 years old Death in hospital, left AMA 		

Asthma Acute Exacerbation: Provider Performance



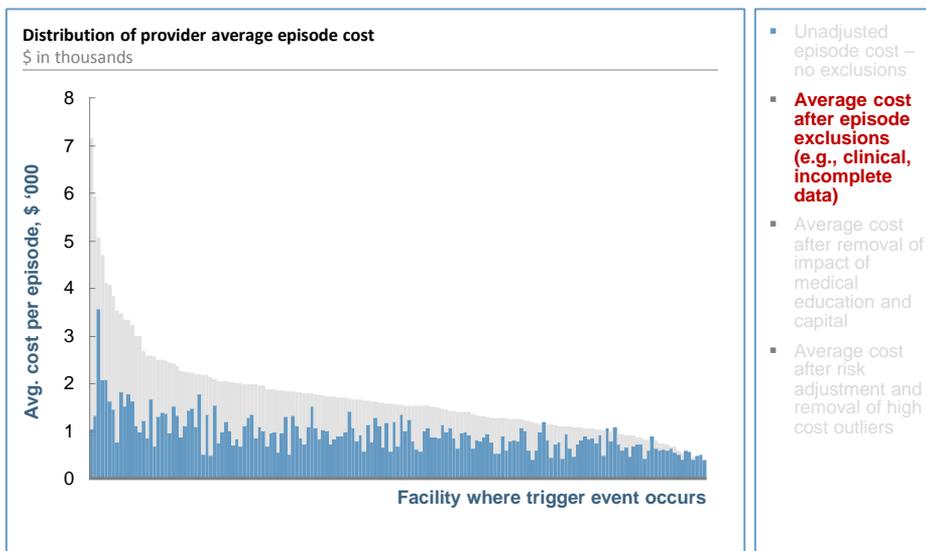
Asthma Acute Exacerbation: Provider Performance



Governor's Office of Health Transformation

SOURCE: Ohio Episode-Based Payment Model Clinical Design Team definitions.

Asthma Acute Exacerbation: Provider Performance

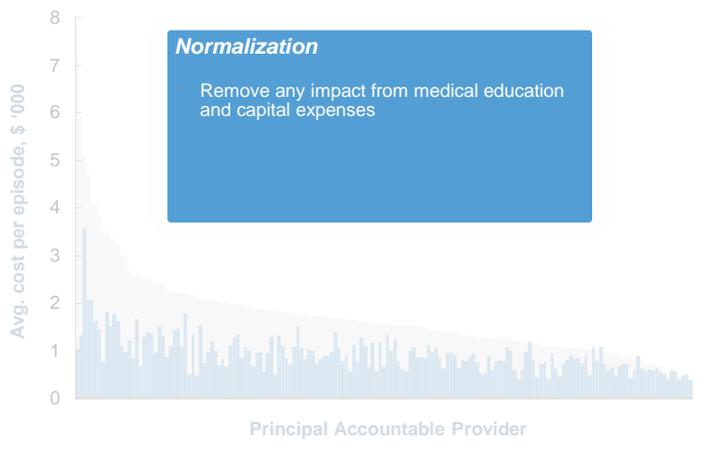


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SOURCE: Ohio Medicaid claims data, 2011-12.

Asthma Acute Exacerbation: Provider Performance

Distribution of provider average episode cost
\$ in thousands



- Unadjusted episode cost, no exclusions
- Average cost after episode exclusions (e.g., clinical, incomplete data)
- Average cost after removal of impact of medical education and capital
- Average cost after risk adjustment and removal of high cost outliers

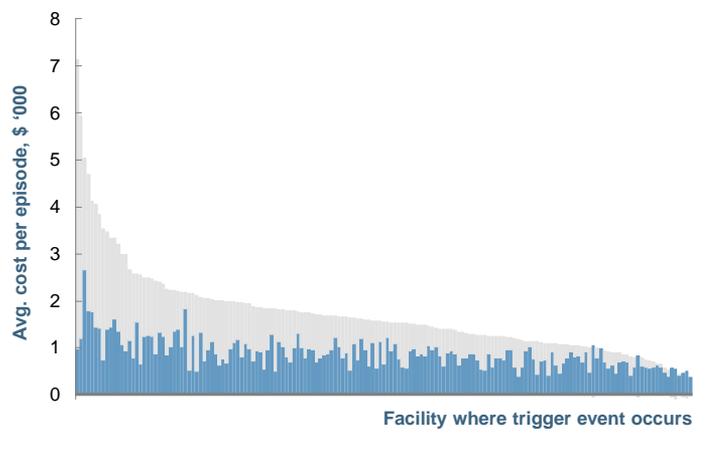


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SOURCE: Ohio Episode-Based Payment Model Clinical Design Team definitions.

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SOURCE: Ohio Medicaid claims data, 2011-12.

Asthma Acute Exacerbation: Provider Performance

Risk adjustment

Average episode cost

Adjust average episode cost down based on presence of clinical risk factors including:

- Heart disease
- Heart failure
- Malignant hypertension
- Obesity
- Pneumonia
- Pulmonary heart disease
- Respiratory failure (specific)
- Respiratory failure, insufficiency, and arrest
- Sickly cell anemia
- Substance abuse

Principal Accountable Care Organization

High cost outliers

Removal of any individual episodes that are more than three standard deviations above the *risk-adjusted* mean

- Unadjusted episode cost – no exclusions
- Average cost after episode exclusions (e.g., clinical, incomplete data)
- Average cost after removal of impact of medical education and capital
- Average cost after risk adjustment and removal of high cost outliers

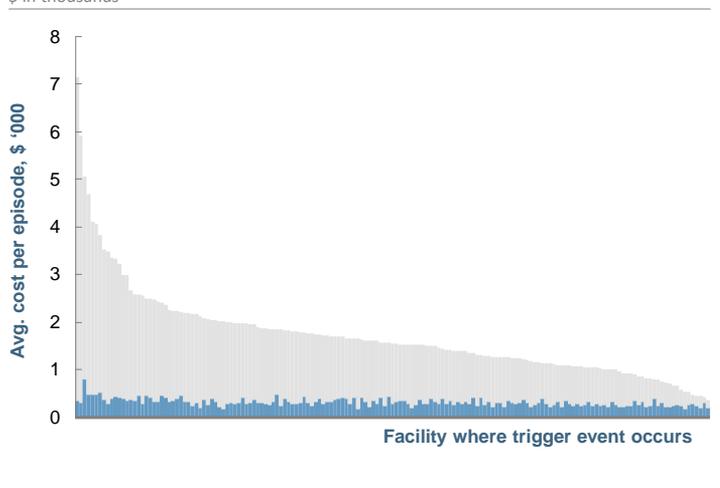


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SOURCE: Ohio Episode-Based Payment Model Clinical Design Team definitions.

Asthma Acute Exacerbation: Provider Performance

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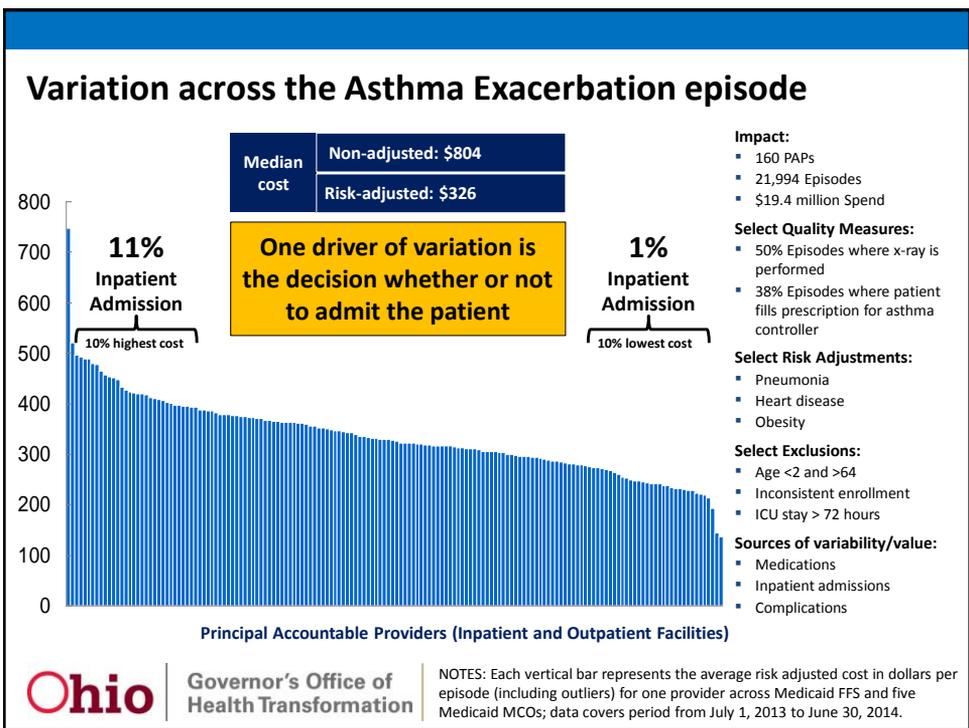
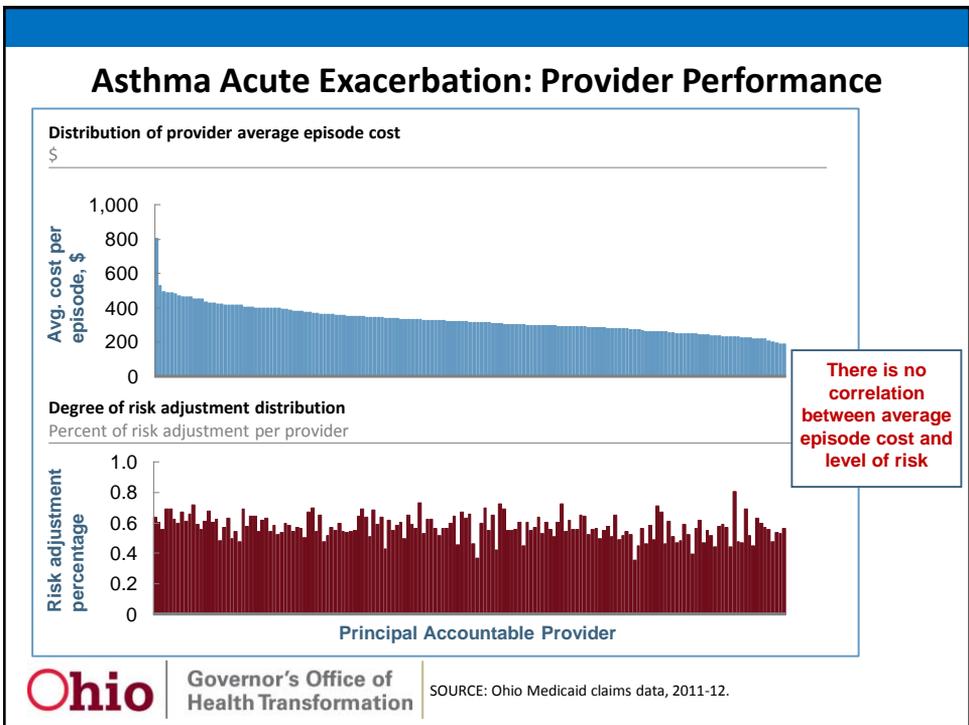


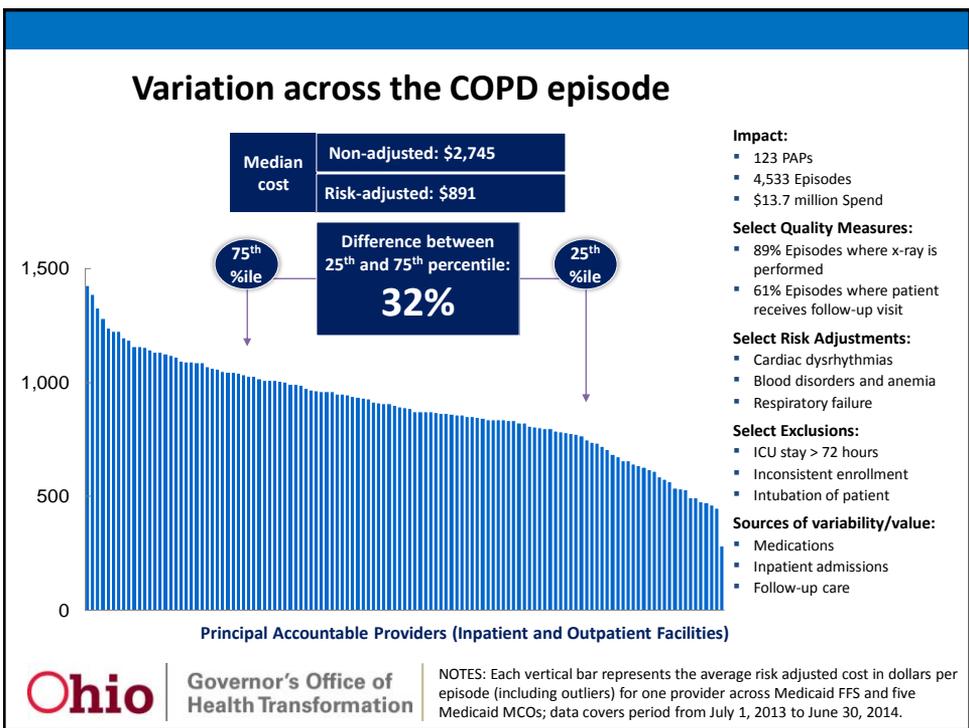
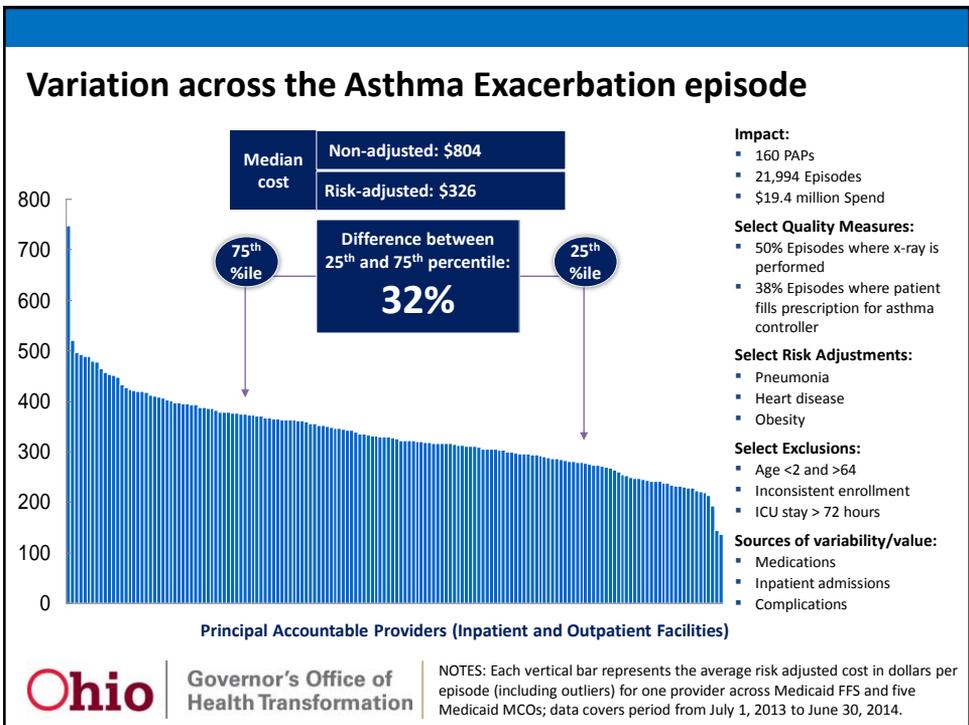
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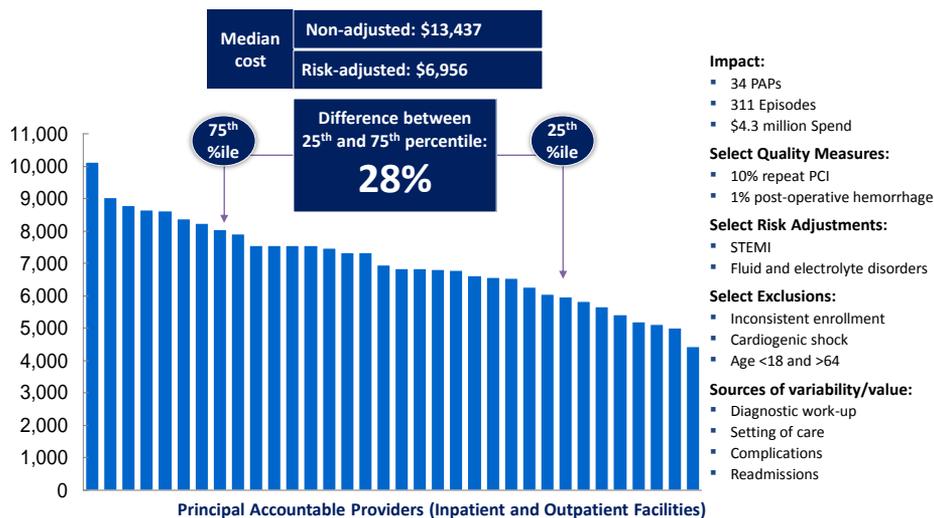
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SOURCE: Ohio Medicaid claims data, 2011-12.





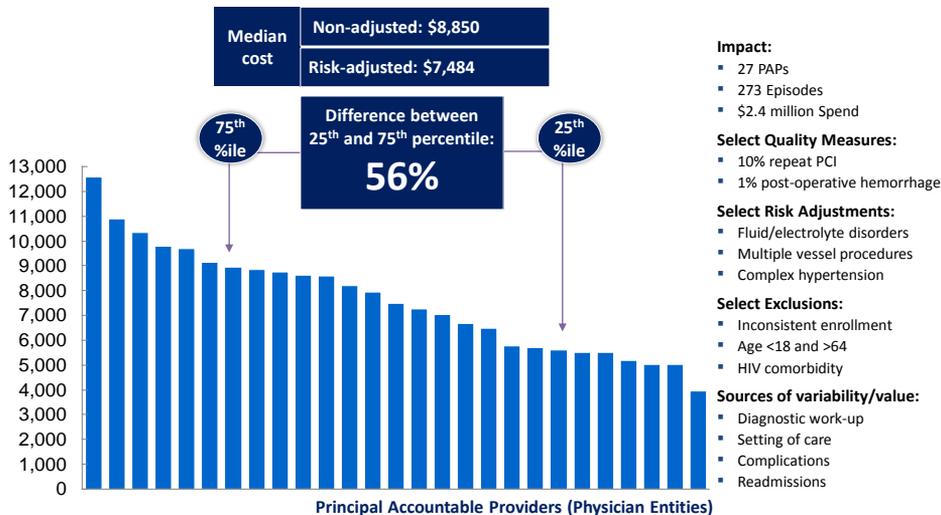
Variation across the Acute PCI episode



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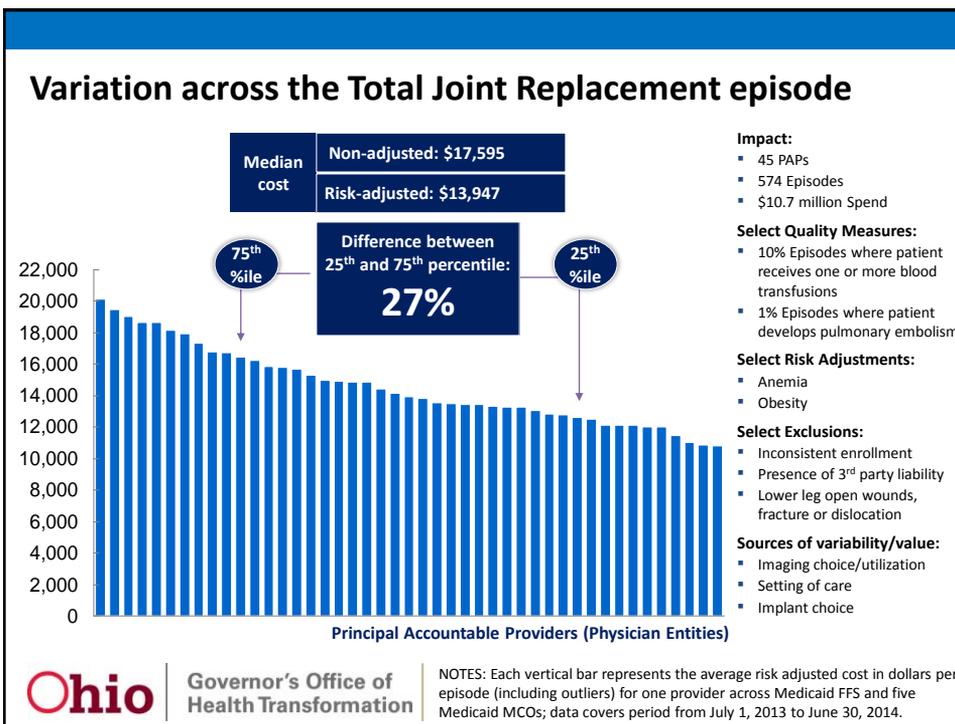
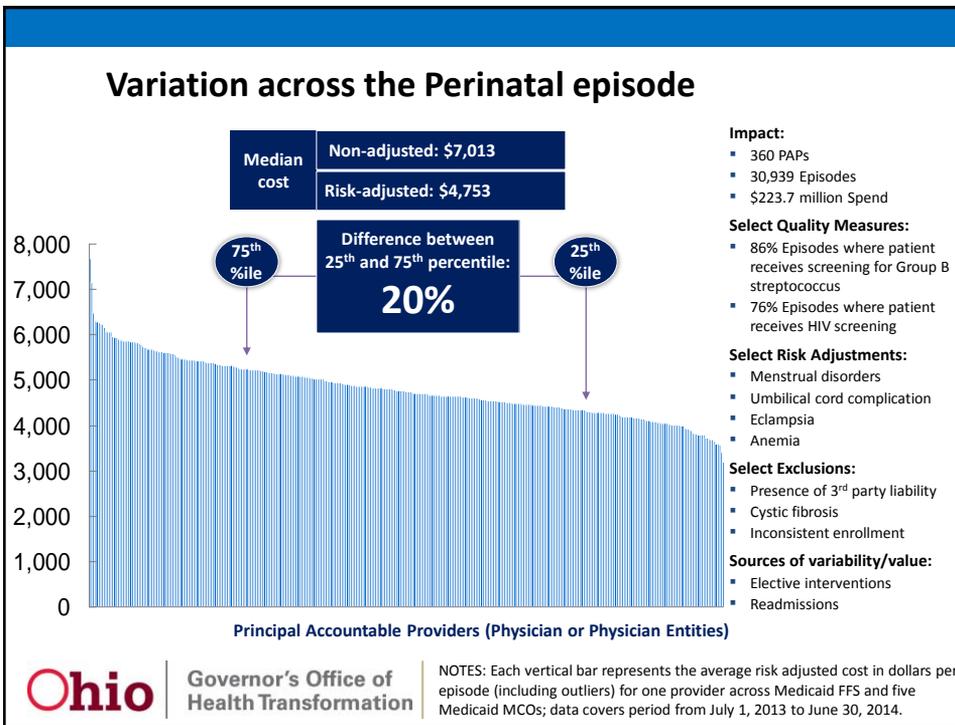
NOTES: Each vertical bar represents the average risk adjusted cost in dollars per episode (including outliers) for one provider across Medicaid FFS and five Medicaid MCOs; data covers period from July 1, 2013 to June 30, 2014.

Variation across the Non-Acute PCI episode



Governor's Office of Health Transformation

NOTES: Each vertical bar represents the average risk adjusted cost in dollars per episode (including outliers) for one provider across Medicaid FFS and five Medicaid MCOs; data covers period from July 1, 2013 to June 30, 2014.





This is an example of the reports the plans listed above made available to providers beginning in March 2015

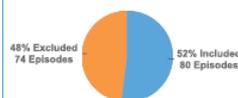


EPISODE OF CARE PAYMENT REPORT

PERINATAL Jul 1, 2013 to Jun 30, 2014

Reporting period covering episodes that ended between July 1, 2013 and June 30, 2014
 PAYER NAME: Ohio - Medicaid FFS PROVIDER CODE: 1234567 PROVIDER NAME: XYZ Women's Health Center

You would be eligible for gain or risk sharing of N/A¹

Episodes inclusion and exclusion	Risk adjusted average spend per episode								
Total episodes: 154  <p>48% Excluded 74 Episodes</p> <p>52% Included 80 Episodes</p>	Distribution of provider average episode spend (risk adj.)  <p>8 7 6 5 4 3 2 1 0</p> <p>0 1 2 3 4 5 6 7 8</p>								
Episodes risk adjustment	Quality metrics								
<p style="font-size: 2em; font-weight: bold; color: #0070C0;">95%</p> of your episodes have been risk adjusted	Your performance on quality metrics that will be ultimately linked to gain sharing <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td>HIV screening</td><td style="text-align: right;">53%</td></tr> <tr><td>GBS screening</td><td style="text-align: right;">71%</td></tr> <tr><td>C-section</td><td style="text-align: right;">31%</td></tr> <tr><td>Follow-up visit</td><td style="text-align: right;">30%</td></tr> </table>	HIV screening	53%	GBS screening	71%	C-section	31%	Follow-up visit	30%
HIV screening	53%								
GBS screening	71%								
C-section	31%								
Follow-up visit	30%								
Potential gain/risk share									
N/A ¹									

¹ Not applicable during reporting-only period
 © 2014

Leveraging episodes into more accountable care ...

Payers:



Providers:



Discussion ...



1. Ohio Approach to Paying for Value Instead of Volume
2. Patient-Centered Primary Care Model
3. Episode-Based Payment Model
- 4. Next Steps**

Episode and PCMH Implementation Timeframe

Model	2014	2015	2016	2017	2018
Episodes					
- Design	Episodes 1-6	Episodes 7-13	Episodes 14-20	Episodes 21-35	Episodes 36-50
- Implement		Episodes 1-6	Episodes 7-13	Episodes 14-20	Episodes 21-35
- Operate			Episodes 1-13	Episodes 1-20	Episodes 1-35
PCMH					
- Design	Focus on CPC	State Model			
- Implement			SW + 2 nd market	3 rd market(s)	Statewide
- Operate				SW + 2 nd market	Roll out by region



Governor's Office of
Health Transformation

2015 Priorities

Episode-Based Payments

- Wave 1: release episode reports quarterly, set performance thresholds, and start the first performance period that links to payment in January 2016
- Wave 2: convene clinical advisory groups to design the next seven episodes, with first reports to launch in January 2016
- Wave 3: begin work on behavioral health episodes to launch in January 2017

Patient-Centered Medical Homes

- Convene a PCMH model design team to decide what elements of CPC to keep/modify and make statewide design decisions about the Medicaid payment model, attribution methodology, quality metrics, etc.
- Decide the PCMH rollout sequence and enroll PCPs beginning in January 2016

Accelerate Adoption

- Seek Medicare participation (with Arkansas and Tennessee)
- Engage large employers to accelerate the demand for payment reform

Self-Insured Employer Partners (Preliminary)

Employer	Ohio Advisory Council	Health Action Council Ohio	Catalyst for Payment Reform
American Greetings		✓	
Progressive	✓	✓	
Nationwide Insurance		✓	
OhioHealth	✓	✓	
Cardinal Health	✓		
Procter & Gamble	✓		
General Electric	✓	✓	✓
WalMart			✓
FedEx			✓
Ohio Public Employee Retirement	✓	✓	✓
Ohio Employee Benefits	✓	✓	

Discussion

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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

Payment Models:

- Overview Presentations
- PCMH Charter
- Episode Charter
- Detail for Providers
 - Episode Definitions
 - Code Tables
 - Risk Adjustment