



Governor's Office of
Health Transformation

Transforming Payment for a Healthier Ohio

February 20, 2015

www.HealthTransformation.Ohio.gov



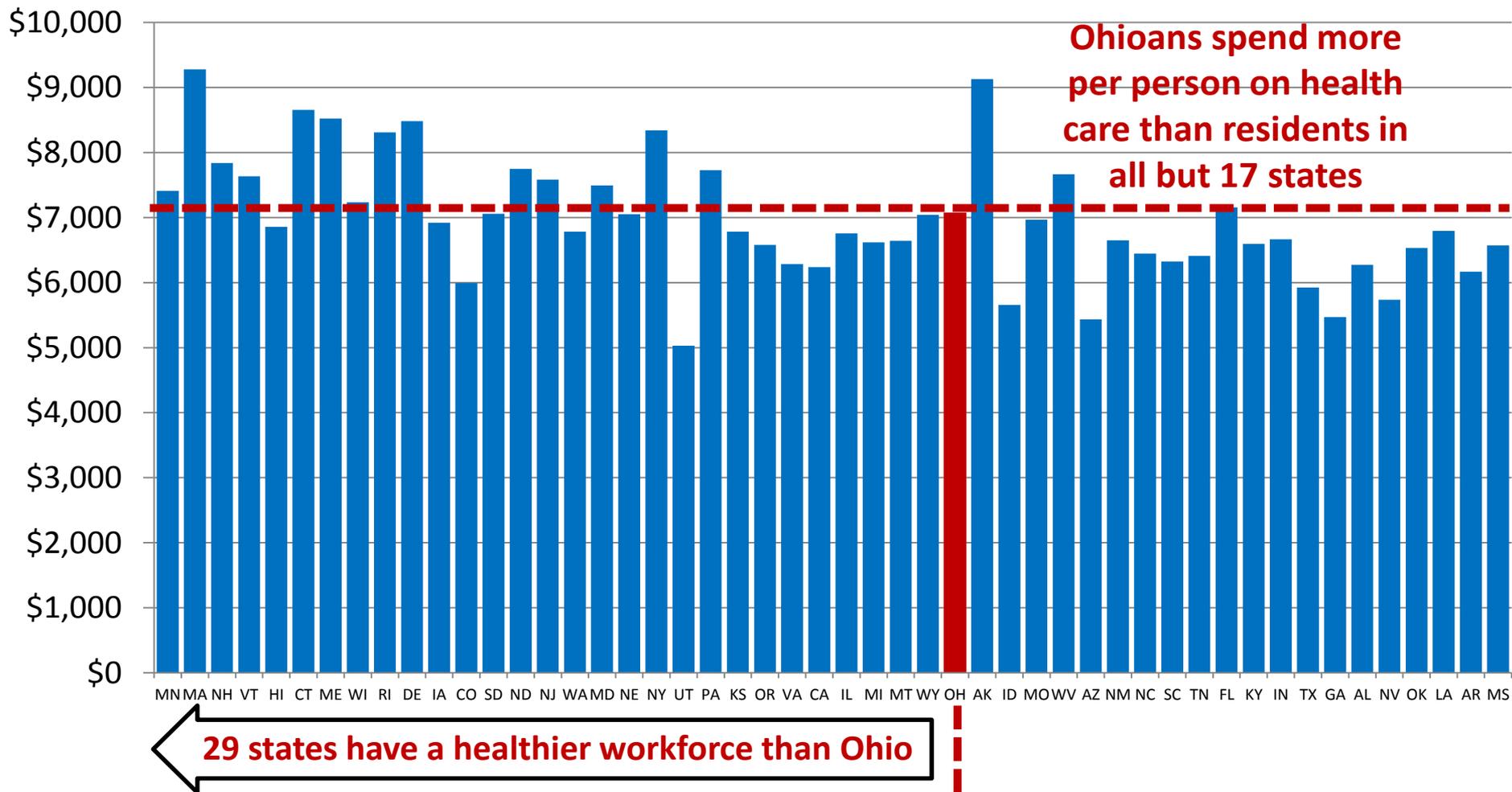
- Governor Kasich created the Office of Health Transformation to improve overall health system performance
- Pay for health care value instead of volume across Medicaid, state employee, and commercial populations
 - Launch episode based payments in Q1 2015
 - Take Comprehensive Primary Care to scale in 2015
- Partners include Anthem, Aetna, CareSource, Medical Mutual, and UnitedHealthcare, covering ten million Ohioans
- Build on momentum from extending Medicaid coverage, Medicare-Medicaid Enrollee project, etc.
- Comprehensive, complementary strategies for health sector workforce development and health information technology
- Active stakeholder participation: 150+ stakeholder experts, 50+ organizations, 60+ workshops, 20 months and counting ...



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1. Ohio Approach to Paying for Value Instead of Volume
2. Patient-Centered Medical Home Model
3. Episode-Based Payment Model
4. Episode Example

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



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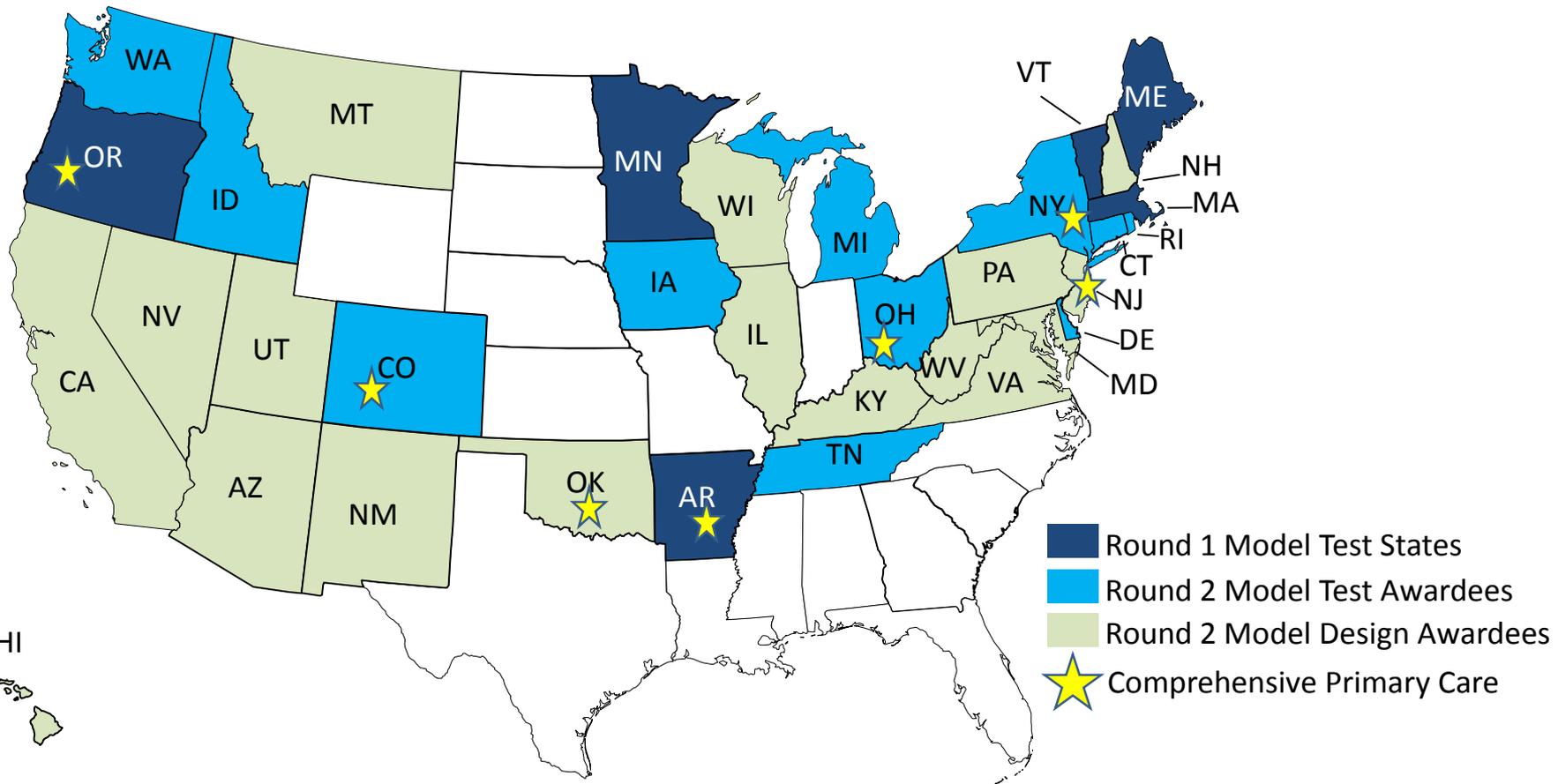
Sources: CMS *Health Expenditures by State of Residence* (2011); The Commonwealth Fund, *Aiming Higher: Results from a State Scorecard on Health System Performance* (May 2014).

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



17 states received federal grants 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).

Shift to population-based and episode-based payment

Payment approach

Population-based
(PCMH, ACOs, capitation)

Episode-based

Fee-for-service

(including pay for performance)

Most applicable

- Primary prevention for healthy population
- Care for chronically ill (e.g., managing obesity, CHF)
-
- Acute procedures (e.g., CABG, hips, stent)
- Most inpatient stays including post-acute care, readmissions
- Acute outpatient care (e.g., broken arm)
-
- Discrete services correlated with favorable outcomes or lower cost



5-Year Goal for Payment Innovation

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

- In 2014 focus on Comprehensive Primary Care Initiative (CPCi)
- Payers agree to participate in design for elements where standardization and/or alignment is critical
- Multi-payer group begins enrollment strategy for one additional market

- State leads design of five episodes: asthma acute exacerbation, perinatal, COPD exacerbation, PCI, and joint replacement
- Payers agree to participate in design process, launch reporting on at least 3 of 5 episodes in 2014 and tie to payment within year

Year 3

- Model rolled out to all major markets
- 50% of patients are enrolled

- 20 episodes defined and launched across payers

Year 5

- Scale achieved state-wide
- 80% of patients are enrolled

- 50+ episodes defined and launched across payers

Ohio's Health Care Payment Innovation Partners:



Agree on degrees of standardization within each model

“Standardize approach”

Standardize approach (i.e., identical design) only when:

- 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)

Example:
Quality Measures

“Align in principle”

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

- 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)

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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Ohio PCMH Model Design Team

Providers

- Michael Rothberg, MD, Cleveland Clinic
- Jeff Biehl, AccessHealth Columbus
- Richard Shonk, MD, Cincinnati Health Collaborative
- Ken Bertka, MD, Catholic Health Partners
- William Wulf, MD, Central Ohio Primary Care
- Bruce Vanderhoff, MD, OhioHealth
- Will Groneman, TriHealth Cincinnati
- Randy Wexler, MD, Ohio State University
- Jim Misak, MD, MetroHealth
- Randall Cebul, MD, Better Health Greater Cleveland
- Rita Horwitz, RN, Better Health Greater Cleveland
- Deborah Southard, Family Practice of SW Ohio
- William Washington, MD, Linden Medical Center
- Pamela Oatis, MD, St. Vincent Mercy Children's
- Susan Miller, PriMed Physicians
- Nick Lashutka, Ohio Children's Hospital Assoc.
- Robert Falcone, MD, Ohio Hospital Assoc.
- Berna Bell, Ohio Hospital Assoc.

Payers

- Robin Dawson, Medical Mutual
- Donald Wharton, MD, CareSource
- Randy Montgomery, Aetna
- Kelly Owen, Anthem
- Pam Schultz Anthem
- Richard Gajdowski, MD, United Healthcare
- Craig Osterhues, GE (*representing purchasers*)

State

- Ted Wymyslo, MD, ODH (*PCMH Team Chair*)
- Heather Reed, ODH
- Amy Bashforth, ODH
- Robyn Colby, Medicaid
- Debbie Saxe, Medicaid
- Angela Dawson, Minority Health Commission
- Angie Bergefurd, MHAS
- Afet Kilinc, MHAS
- Greg Moody, OHT
- Rick Tully, OHT
- Monica Juenger, OHT
- Marc Molea, Aging
- Rebecca Susteric, BWC
- McKinsey: Razili Stanke-Koch, Caroline Cross, Brendan Buescher, Kara Carter, Thomas Latkovic, Amit Shah, MD

Ohio already has various PCMH projects underway

-  Major focus of pilots
-  Some focus
-  Minimal or no focus

HB 198 Education Pilot Sites

- 42 pilot sites target underserved areas

NCQA, AAAHC, Joint Commission

- 511 NCQA-recognized sites
- 51 Joint Commission accredited sites
- 7 AAAHC-accredited

Comprehensive Primary Care Initiative

- 61 sites in OH (14 in KY), incl. Tri-Health, Christ Hospital, PriMed, Providence, St. Elizabeth (KY)

Private Payer Pilots

- Vary in scope by pilot, but tend to focus on larger independent or system-led practices

	HB 198 Education Pilot Sites	NCQA, AAAHC, Joint Commission	Comprehensive Primary Care Initiative	Private Payer Pilots
Care delivery model				
Payment model				
Infrastructure				
Scale-up and practice performance improvement				



Comprehensive Primary Care Initiative

- Dayton/Cincinnati is one of only seven CPC sites nationally
- Bonus payments to primary care doctors who better coordinate care
- Multi-payer: Medicare, Medicaid, nine commercial insurance plans
- 75 primary care practices (261 providers) serving 44,500 Medicare enrollees in 14 Ohio and 4 Kentucky counties
- Practices were selected based on their use of HIT, advanced primary care recognition, and participation in practice improvement activities
- Supported by a unique regional collaborative: The Greater Cincinnati Health Council, the Health Collaborative, and HealthBridge

The goal is to learn from CPC in developing an approach to roll out PCMH statewide



Regional Health Improvement Collaboratives



Elements of a Patient-Centered Medical Home Strategy

<p>Care delivery model</p>	<p>Target patients and scope</p> <p>Care delivery improvements e.g.,</p> <ul style="list-style-type: none"> ▪ Improved access ▪ Patient engagement ▪ Population management ▪ Team-based care, care coordination <p>Target sources of value</p>	<p>Vision for a PCMH's role in the healthcare eco system, including who they should target, how care should be delivered (including differences from today), and which sources of value to prioritize over time.</p>
<p>Payment model</p>	<p>Technical requirements for PCMH</p> <p>Attribution / assignment</p> <p>Quality measures</p> <p>Payment streams/ incentives</p> <p>Patient incentives</p>	<p>Holistic approach to use payment (from payers) to encourage the creation of PCMHs, ensure adequate resources to fund transformation from today's model, and reward PCMH's for improving in outcomes and total cost of care over time</p>
<p>Infrastructure</p>	<p>PCMH infrastructure</p> <p>Payer infrastructure</p> <p>Payer / PCMH infrastructure</p> <p>PCMH/ Provider infrastructure</p> <p>System infrastructure</p>	<p>Technology, data, systems, and people required to enable creation of PCMH, administer new payment models, and support PCMHs in making desired changes in care delivery</p>
<p>Scale-up and practice performance improvement</p>	<p>Clinical leadership / support</p> <p>Practice transformation support</p> <p>Workforce / human capital</p> <p>Legal / regulatory environment</p> <p>Network / contracting to increase participation</p> <p>ASO contracting/participation</p> <p>Performance transparency</p> <p>Ongoing PCMH support</p> <p>Evidence, pathways, & research</p> <p>Multi-payer collaboration</p>	<p>Support, resources, or activities to enable practices to adopt the PCMH delivery model, sustain transformation and maximize impact</p>

Elements of a Patient-Centered Medical Home Strategy

<p>Care delivery model</p>	<p>Target patients and scope Care delivery improvements e.g.,</p> <ul style="list-style-type: none"> ▪ Improved access ▪ Patient engagement ▪ Population management ▪ Team-based care, care coordination <p>Target sources of value</p>	<ul style="list-style-type: none"> • Risk-stratified care management (care plans, patient risk-stratification registry) • Access and continuity of care (team-based care, multi-channel access, 24/7 access, same day appointments, electronic access) • Planned care for chronic conditions and preventive care • Patient and caregiver engagement (shared decision-making, more time discussing patient's conditions and treatment options) • Coordination of care across the medical neighborhood (follow up on referrals, integrate behavioral and physical health needs, coordinate with all forms of insurance including BWC) <p>Source: Ohio PCMH Multi-Payer Charter (2013)</p>
<p>Payment model</p>	<p>Technical requirements for PCMH Attribution / assignment Quality measures Payment streams/ incentives Patient incentives</p>	
<p>Infrastructure</p>	<p>PCMH infrastructure Payer infrastructure Payer / PCMH infrastructure PCMH/ Provider infrastructure System infrastructure</p>	
<p>Scale-up and practice performance improvement</p>	<p>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</p>	

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

- 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, capitation, or sub-capitation.
- Source: [Ohio PCMH Multi-Payer Charter \(2013\)](#)



Ohio Practice Transformation Network

- Statewide collaborative application seeking \$28.6 million in federal grant funds to support transformation for 6,400 clinicians
- Goal is to work with practices to establish a team-based approach to care and prepare to adopt payment reform models
- OPTN will recruit practices to achieve the following milestones:
 - ***Practice Sets Goals and Develops Basic Capabilities:*** onsite practice transformation consultation will assist practices in choosing and implementing transformation goals and plan.
 - ***Practice Uses Data to Lower Costs, Improve Health:*** leverage technology to improve care coordination for high risk and chronic care patients.
 - ***Practice is Prepared for Payment Reform:*** The goal is for at least 75 percent of participating clinicians to accomplish the transformation to team-based care that prepares them for value-based payment models.



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4. Episode Example

Ohio Episode-Based Payment Model Design Team

Providers

- David Bronson, MD, Cleveland Clinic
- Tony Hrudka, MD, Cleveland Clinic
- Michael McMillan, Cleveland Clinic
- John Corlett, MetroHealth
- Steve Marcus, ProMedica
- Terri Thompson, ProMedica
- John Kontner, OhioHealth
- Jennifer Atkins, Catholic Health Partners
- Ken Bertka, MD, Catholic Health Partners
- Richard Shonk, MD, Cincinnati Health Collaborative
- Mary Cook, MD, Central Ohio Primary Care
- Randall Cebul, MD, Better Health Greater Cleveland
- Rita Horwitz, RN, Better Health Greater Cleveland
- Uma Kotegal, MD, Cincinnati Children's Hospital
- Mary Wall, MD, North Central Radiology
- Michael Barber, MD, National Church Residences
- Todd Baker, Ohio State Medical Assoc.
- Nick Lashutka, Ohio Children's Hospital Assoc.
- Ryan Biles, Ohio Hospital Assoc.
- Alyson DeAngelo, Ohio Hospital Assoc.

Payers

- Wendy Payne, Medical Mutual
- Jim Peters, CareSource
- Ron Caviness, Aetna
- Barb Cannon, Anthem
- Meredith Day, Anthem
- Tammy Dawson, Anthem
- Mark DiCello, United Healthcare
- Rick Buono, United Healthcare
- Tim Kowalski, MD, Progressive
(representing purchasers)

State

- John McCarthy, Medicaid *(Episode Team Chair)*
- Robyn Colby, Medicaid
- Patrick Beatty, Medicaid
- Debbie Saxe, Medicaid
- Ogbe Aideyman, Medicaid
- Mary Applegate, MD, Medicaid
- Katie Greenwalt, Medicaid
- Amy Bashforth, ODH
- Anne Harnish, ODH
- Mark Hurst, MD, MHAS
- Greg Moody, OHT
- Rick Tully, OHT
- Monica Juenger, OHT
- Rebecca Susteric, BWC
- McKinsey: Razili Stanke-Koch, Christa Moss, Brendan Buescher, Kara Carter, Tom Latkovic, Amit Shah, MD

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



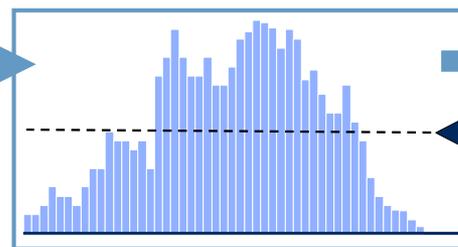
3 **Payers** reimburse for all services as they do today

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 cost per episode** for each PAP

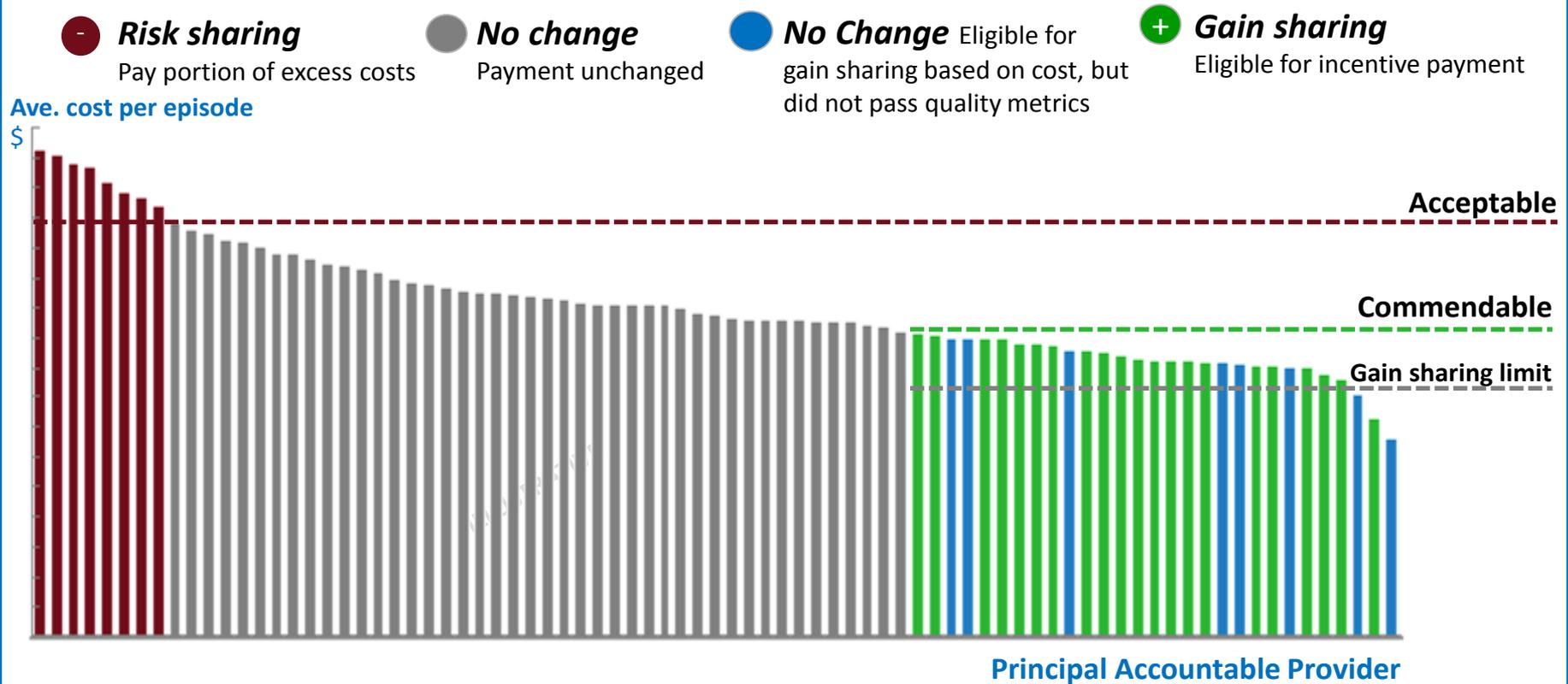


Compare average costs to predetermined "commendable" and "acceptable" levels

- 6** **Providers may:**
- **Share savings:** if average costs below commendable levels and quality targets are met
 - **Pay part of excess cost:** if average costs are above acceptable level
 - **See no change in pay:** if average costs are between commendable and acceptable levels

Retrospective thresholds reward cost-efficient, high-quality care

Provider cost distribution (average episode cost per provider)



Selection of episodes in the first year

Guiding 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)

First six episodes selected:

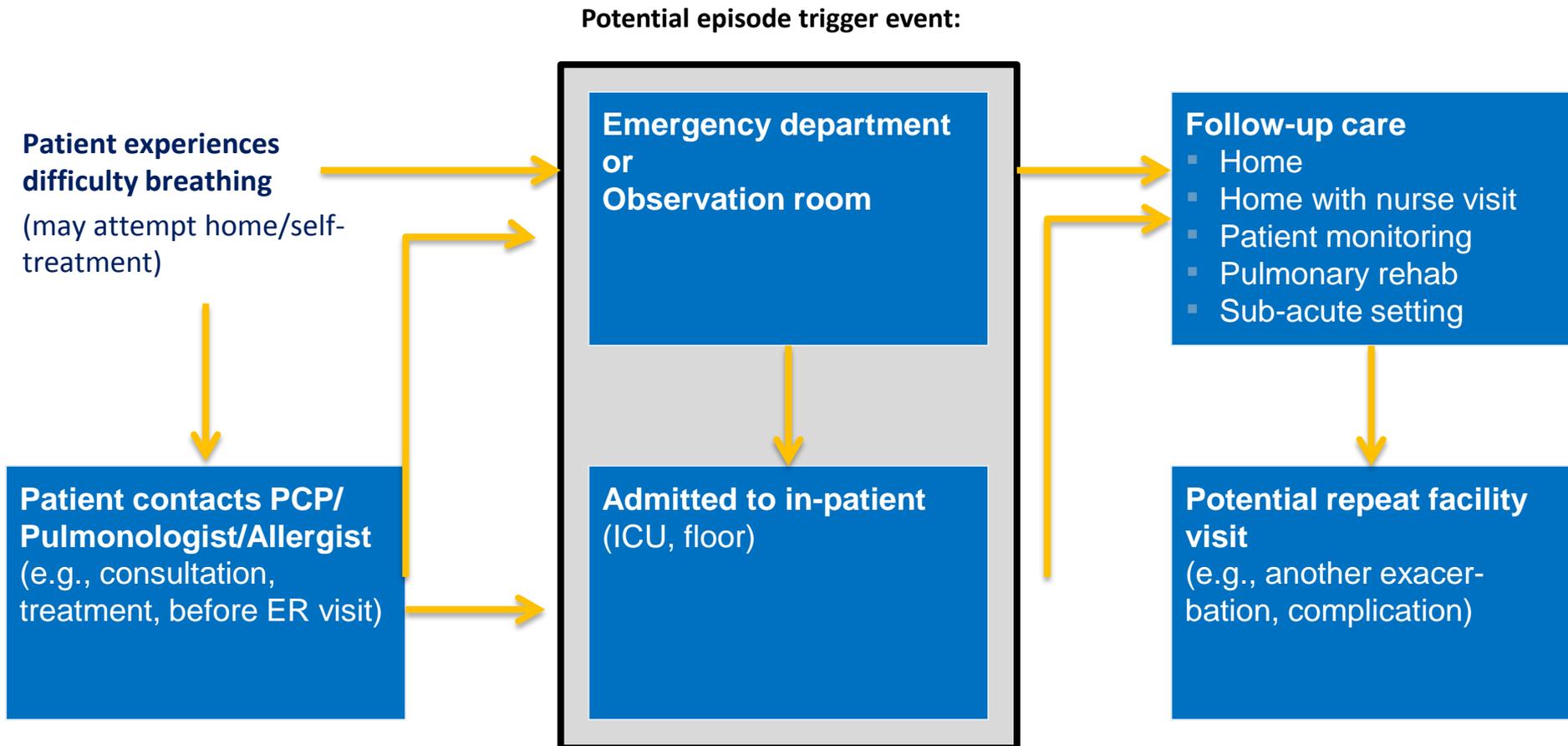
Episode	Principal Accountable Provider (PAP)
▪ Perinatal	Physician/group delivering the baby
▪ Asthma acute exacerbation	Facility where trigger event occurs
▪ COPD exacerbation	Facility where trigger event occurs
▪ Percutaneous coronary intervention (PCI)	Facility where PCI performed (acute) OR physician (non-acute)
▪ Total joint replacement	Orthopedic surgeon performing the total joint replacement procedure



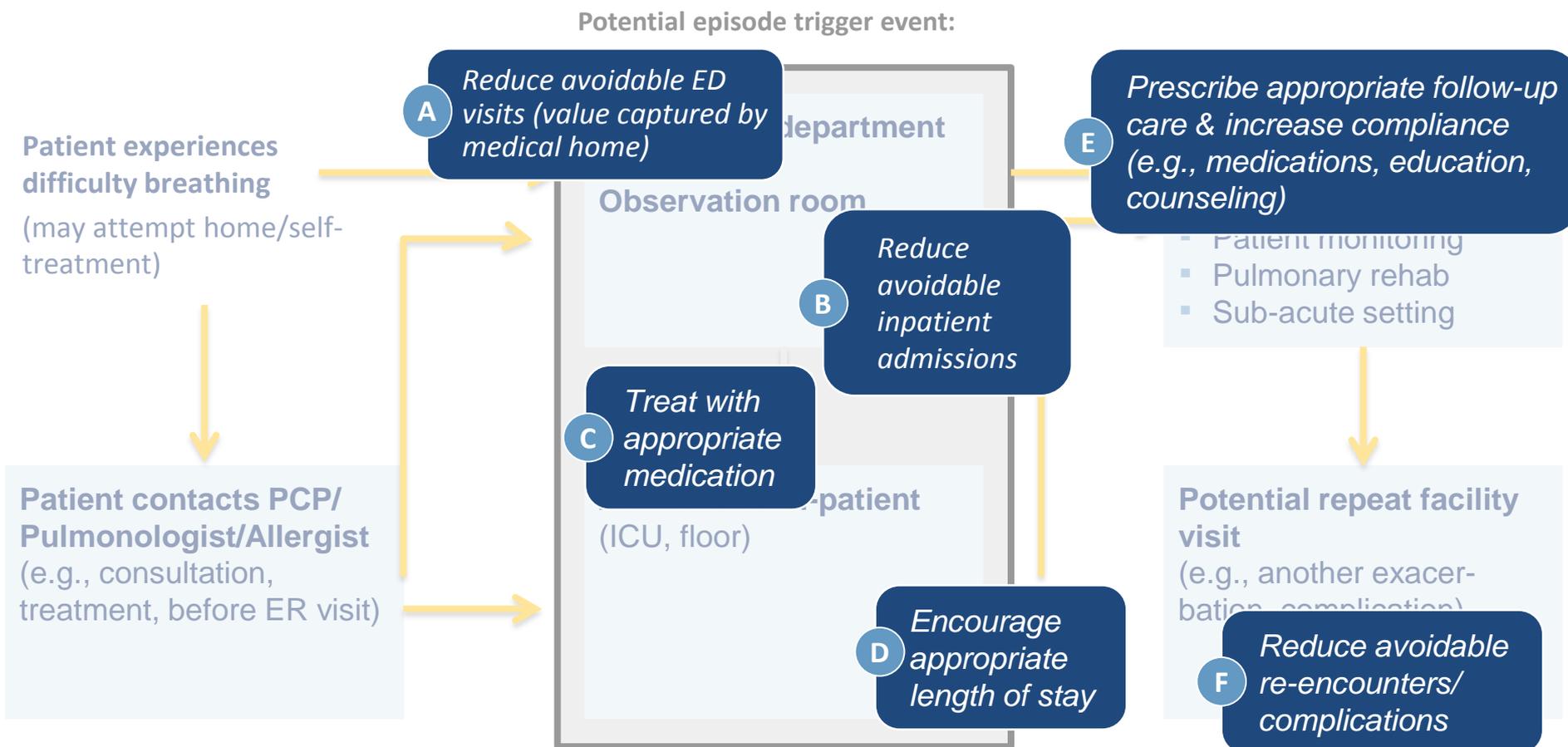
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- 4. Episode Detail: Asthma Acute Exacerbation**

Asthma Acute Exacerbation: Patient Journey



Asthma Acute Exacerbation: Sources of Value



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 episodeTrigger window: Duration of the potential trigger event (e.g., from date of inpatient admission to date of discharge); all care is includedPost-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

Asthma Acute Exacerbation: Definitions (1/5)

Category	Episode base definition
1 Episode trigger	<p>An inpatient, outpatient ED visit (revenue codes 045x) or outpatient observation room visit (revenue codes 076x) with a diagnosis from the following list:</p> <p><i>ICD-9 Dx asthma-specific trigger codes:</i></p> <ul style="list-style-type: none">493.00-493.02 – Extrinsic asthma, unspecified, with status asthmaticus and with (acute) exacerbation, respectively493.10-493.12 – Intrinsic asthma, unspecified, with status asthmaticus and with (acute) exacerbation, respectively493.20-493.22 – Chronic obstructive asthma, unspecified, with status asthmaticus and with (acute) exacerbation, respectively493.81 – Exercise induced bronchospasm493.82 – Cough variant asthma493.90-493.92 – Asthma, unspecified type, unspecified, with status asthmaticus and with (acute) exacerbation, respectively519.11 – Acute bronchospasm <p><i>ICD-9 Dx contingent trigger codes:</i></p> <ul style="list-style-type: none">786.00 – Respiratory abnormality, unspecified786.05 – Shortness of breath786.07 – Wheezing786.09 – Dyspnea and respiratory abnormalities; other786.90 – Other symptoms involving resp. system and chest519.8,9 – Respiratory disease NECRespiratory failure – 518.8
2 Episode window	<p>The start of the trigger window through 30 days after the end of the trigger window</p> <ul style="list-style-type: none"><i>Trigger window:</i> the day of admission for the trigger through the day of discharge from the trigger facility. When the trigger doesn't occur in an inpatient setting, the trigger window begins and ends on the day of the trigger<i>Post-trigger window:</i> 1 day after the end of the trigger window through 30 days after the end of the trigger window

Contingent trigger codes only act as a trigger if the patient had an asthma-specific trigger code on any claim within 365 days prior to or up to 30 days after the trigger claim

Asthma Acute Exacerbation: Definitions (2/5)

Category	Episode base definition
3 Claims included	<p>Included claims vary by time window</p> <p><i>Trigger window:</i> All claims</p> <p><i>Post-trigger window¹:</i></p> <ul style="list-style-type: none">▪ Relevant diagnoses<ul style="list-style-type: none">— Examples include pneumonia, acute sinusitis, laryngitis, hyperventilation, apnea, cough, throat pain, acute respiratory failure, emphysema▪ Relevant labs<ul style="list-style-type: none">— Examples include chest x-rays, chest CT, chest MRI, lung function tests▪ Relevant DME<ul style="list-style-type: none">— Examples include oxygen delivery systems, nebulizers, ventilators, humidifiers, spirometers▪ Relevant pharmacy<ul style="list-style-type: none">— Examples include decongestants, antihistamines, smoking deterrents, analgesics, narcotics, glucocorticoids, proton-pump inhibitors▪ Hospitalizations, except exclusions<ul style="list-style-type: none">— Exclusion list includes cardiovascular, pulmonary, dermatological, ophthalmological, orthopedic, otolaryngological, digestive, renal, i.e., diagnoses and procedures not directly related to the asthma acute exacerbation or common complications thereof
4 Principal accountable provider	<p>Facility where the trigger event occurs</p> <ul style="list-style-type: none">▪ In case of a transfer, the first facility (i.e., the one from which the patient is transferred) is the PAP

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

Asthma Acute Exacerbation: Definitions (3/5)

Category

Episode base definition

Linked to gain sharing:

- Percent of episodes with a follow-up visit within 30 days
- Percent of episodes with a filled prescription for controller medication (based on HEDIS list)

For reporting only:

- Percent of episodes with a repeat exacerbation within 30 days
 - Same codes as trigger
- Percent of episodes in IP vs. ED/Obs treatment setting
 - IP identified by bill types
 - ED/Obs identified by revenue codes and bill types
- Percent of episodes with smoking cessation counseling
- X-ray utilization rate¹
- Percent of episodes with a follow-up visit within 7 days

Potential quality metrics for v2

- Asthma action plan
- Reporting on utilization of spacers and peak flow meters
- Link to PCP / PCMH

5

Quality metrics

Asthma Acute Exacerbation: Definitions (4/5)

Category

Episode base definition

Model to be consistent across all Medicaid plans, may vary for commercial

- Age less than 10
- Age between 10 and 19 (inclusive)
- Age between 40 and 49 (inclusive)
- Age between 50 and 59 (inclusive)
- Age greater than 59
- Atelectasis
- Blood disorders and anemia
- Cardiac dysrhythmias
- Developmental and intellectual disabilities
- Diabetes
- Epilepsy
- Esophageal disorders
- Heart disease
- Heart failure
- Malignant hypertension
- Obesity
- Pneumonia
- Pulmonary heart disease
- Respiratory failure (specific)
- Respiratory failure, insufficiency, and arrest
- Sickle cell anemia
- Substance abuse
- Suicide and intentional self-harm

6

Potential
risk factors

Asthma Acute Exacerbation: Definitions (5/5)

Category

Episode base definition

Clinical exclusions:

- Death
- Left against medical advice
- Age < 2 ; age > 64
- Comorbidities¹
 - Cancer under active management
 - End stage renal disease
 - HIV
 - Organ transplant
 - Bronchiectasis
 - Cancer of respiratory system
 - Cystic fibrosis
 - ICU stay >72hrs
 - Intubation
 - Multiple sclerosis
 - Other lung disease
 - Oxygen during post-trigger window
 - Paralysis
 - Tracheostomy
 - Tuberculosis
 - Multiple other comorbidities

Business exclusions:

- Inconsistent enrollment
- Third party liability
- Dual eligibility
- Exempt PAP
- PAP out of state
- No PAP
- Long hospitalization (>30 days)
- Long-term care
- Missing APR-DRG
- Incomplete episodes (non-risk-adjusted spend is less than the low cost threshold)

Outliers:

- High outlier (risk-adjusted spend is greater than the high outlier threshold)

7

Episode
level
exclusions

1 Comorbidities are identified in claims during the episodes and up to 365 prior to the episode start

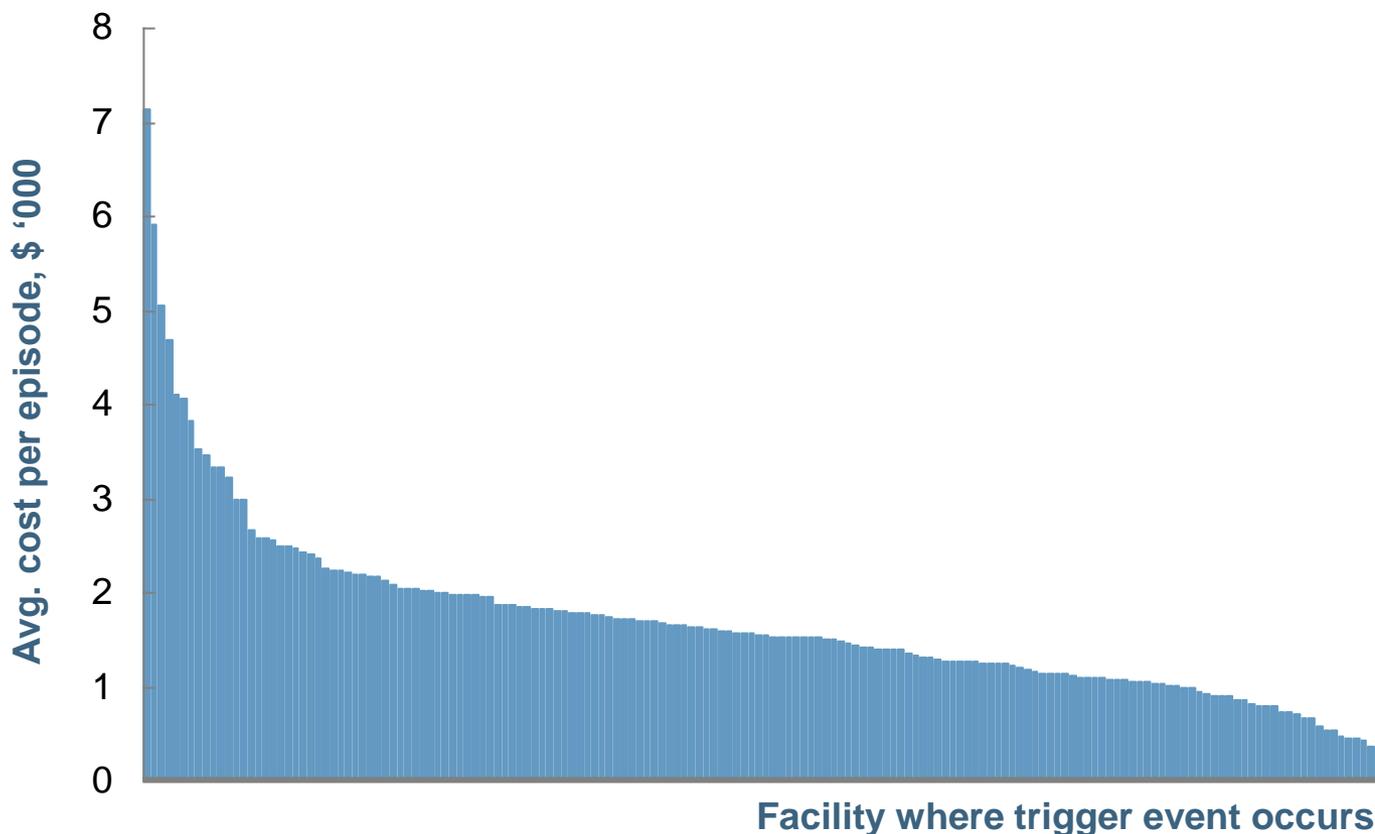
2 Intubation and ICU stay are only an exclusion if occurring during the trigger window

3 Oxygen is only an exclusion in the post-trigger window

Asthma Acute Exacerbation: Provider Performance

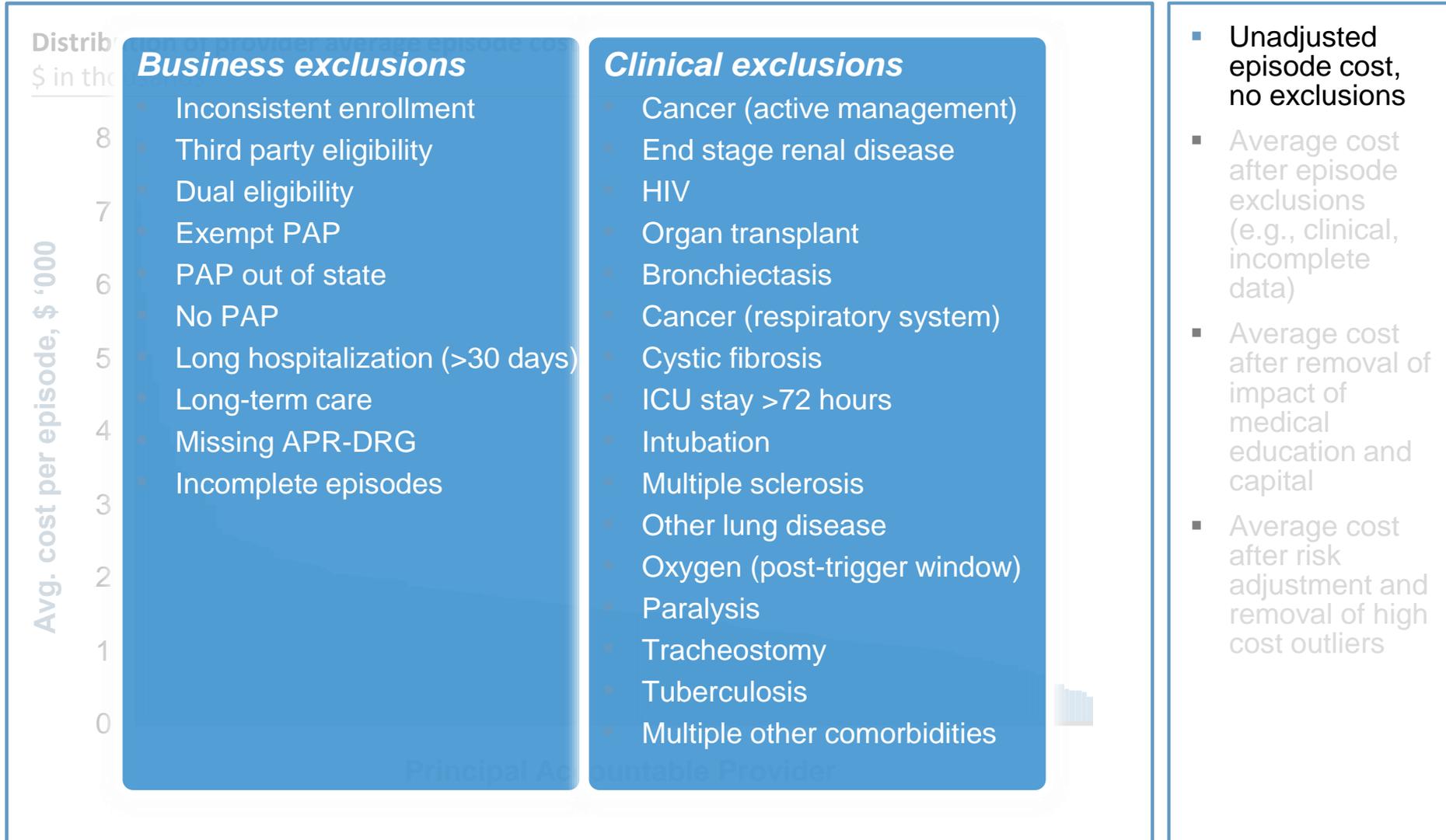
Distribution of provider average episode cost

\$ 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

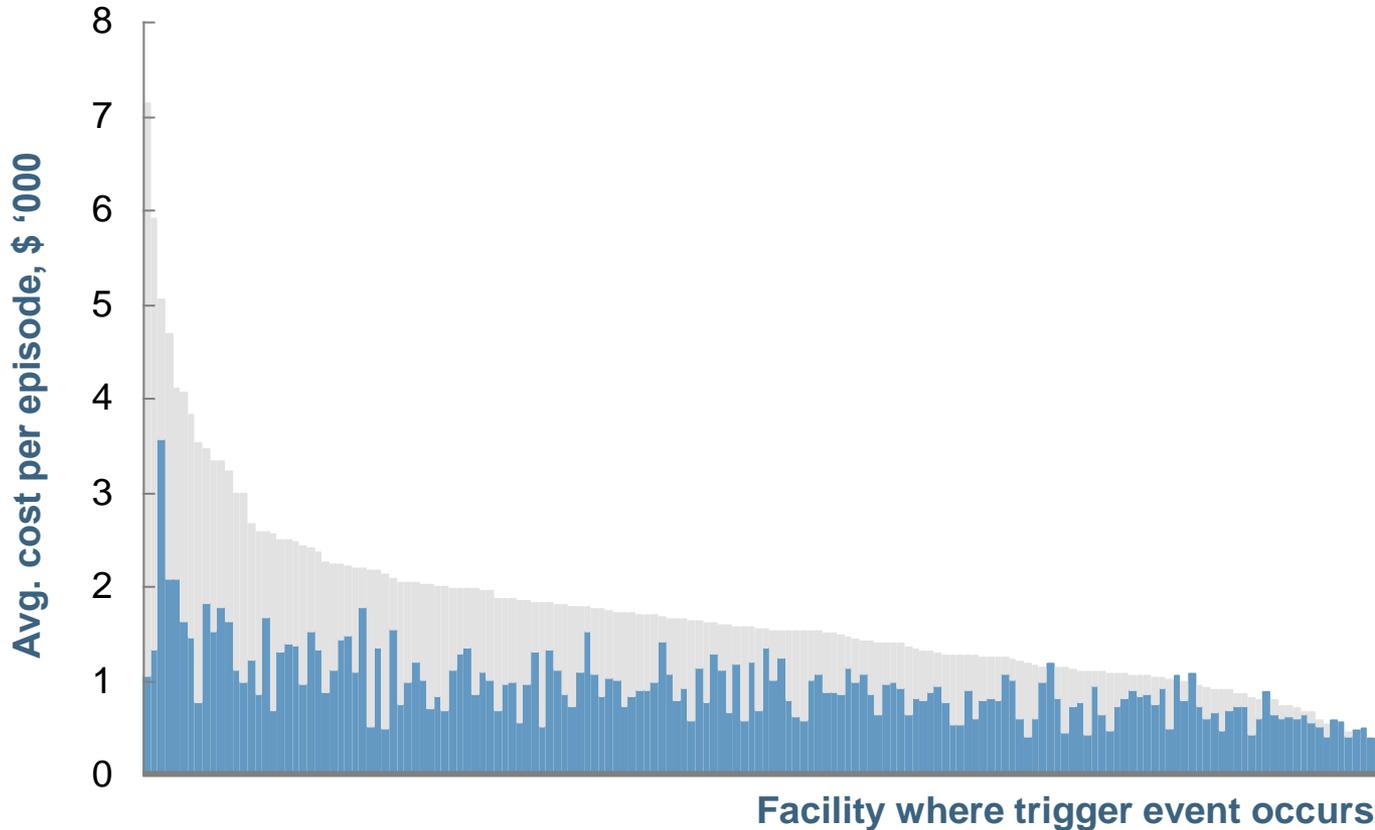
Asthma Acute Exacerbation: Provider Performance



Asthma Acute Exacerbation: Provider Performance

Distribution of provider average episode cost

\$ in thousands

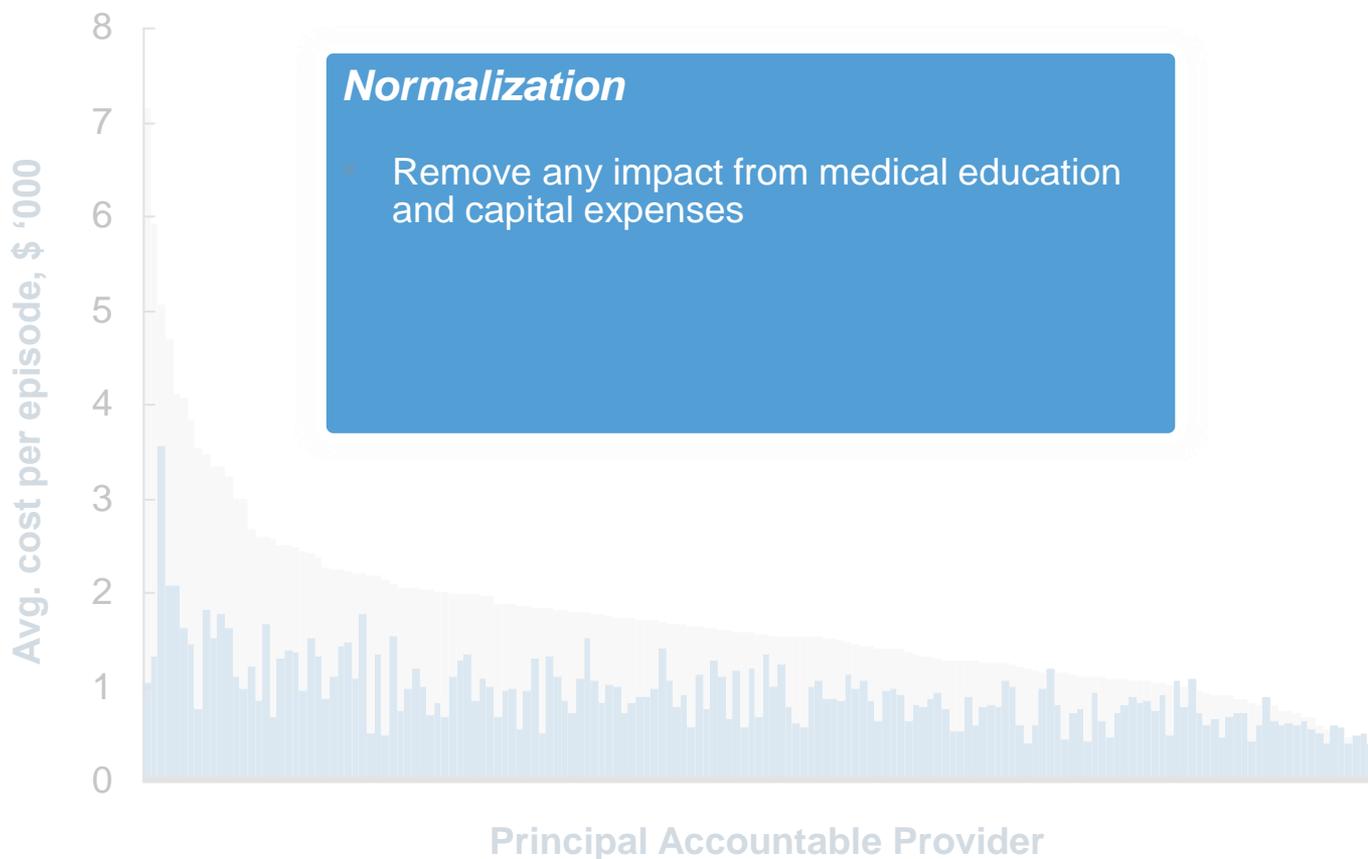


- Unadjusted episode cost – no exclusions
- **Average cost after episode exclusions (e.g., clinical, incomplete data)**
- Average cost after removal of impact of medical education and capital
- Average cost after risk adjustment and removal of high cost outliers

Asthma Acute Exacerbation: Provider Performance

Distribution of provider average episode cost

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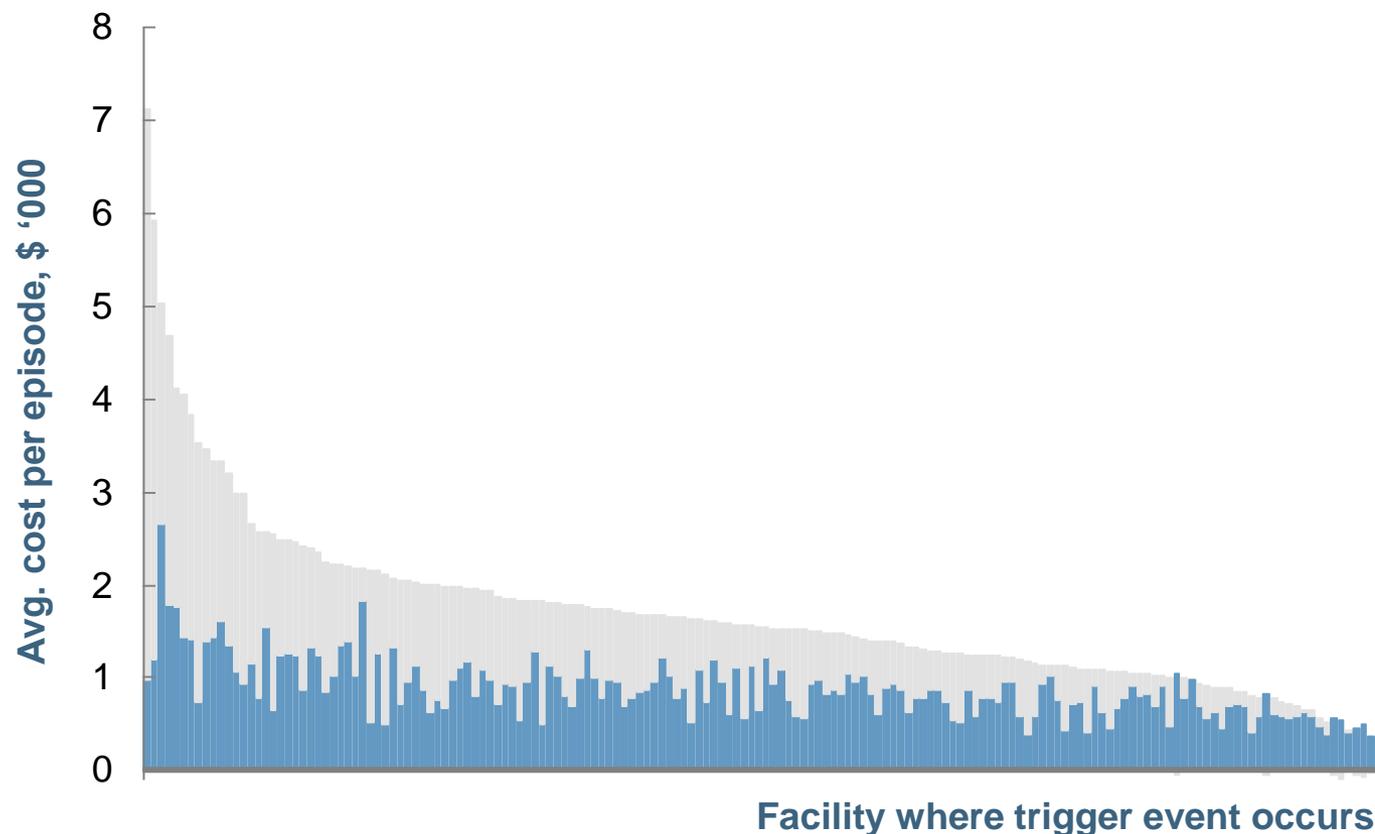


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Asthma Acute Exacerbation: Provider Performance

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- **Average cost after removal of impact of medical education and capital**
- Average cost after risk adjustment and removal of high cost outliers

Asthma Acute Exacerbation: Provider Performance

Risk adjustment

- 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
 - Sickle cell anemia
 - Substance abuse

High cost outliers

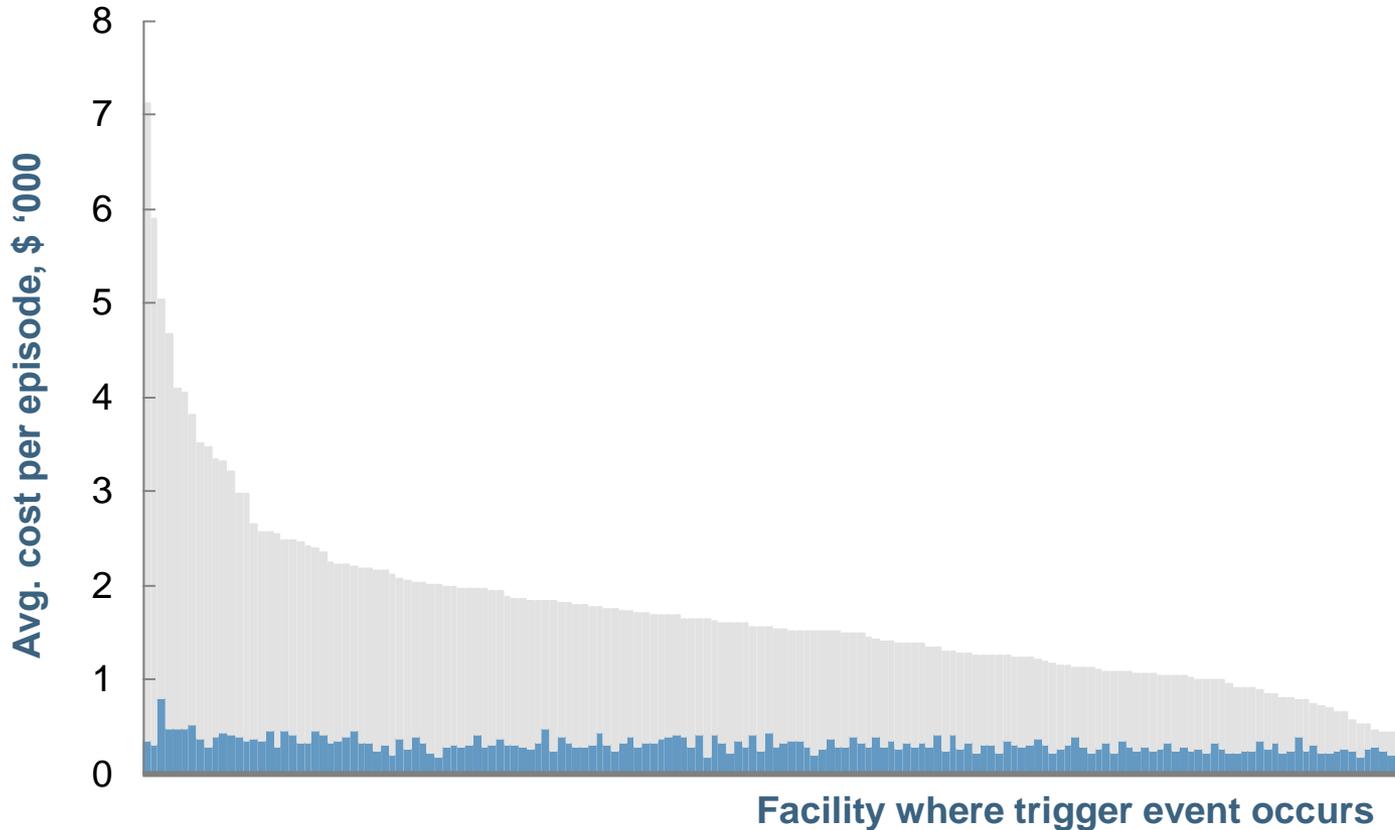
- Removal of any individual episodes that are more than three standard deviations above the *risk-adjusted* mean

- 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

Asthma Acute Exacerbation: Provider Performance

Distribution of provider average episode cost

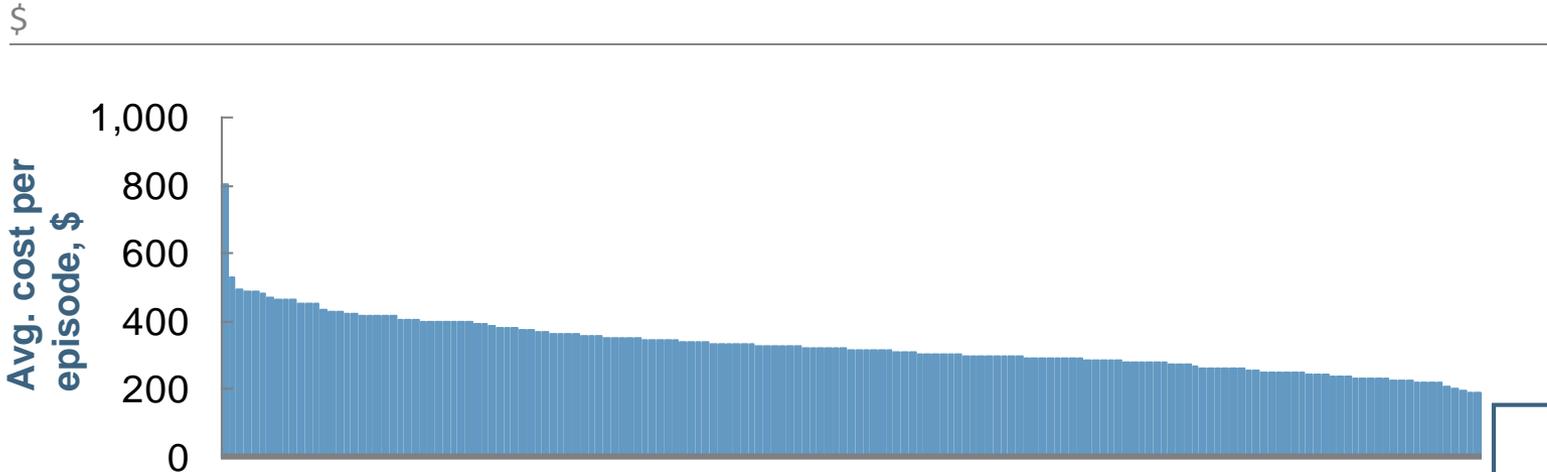
\$ in thousands



- 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**

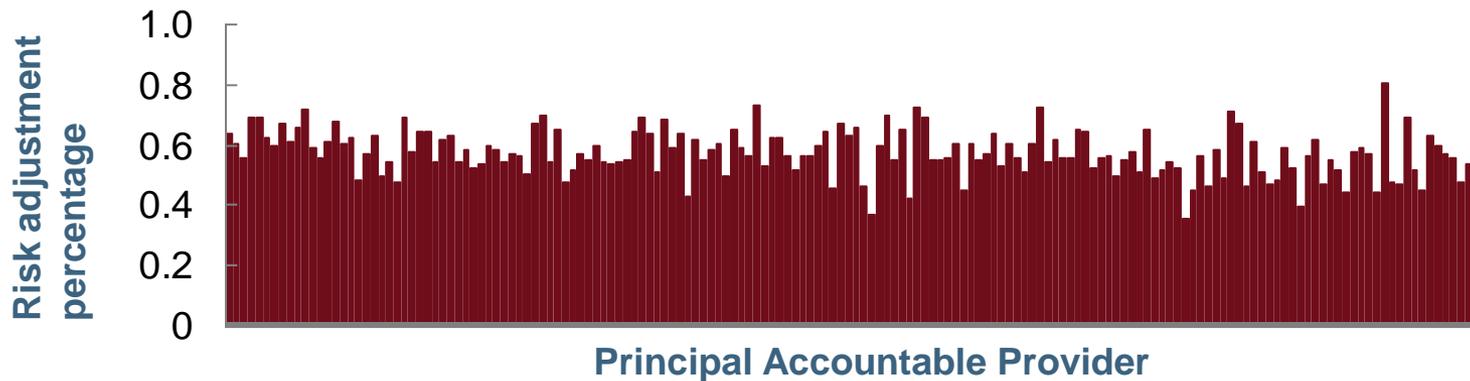
Asthma Acute Exacerbation: Provider Performance

Distribution of provider average episode cost



Degree of risk adjustment distribution

Percent of risk adjustment per provider

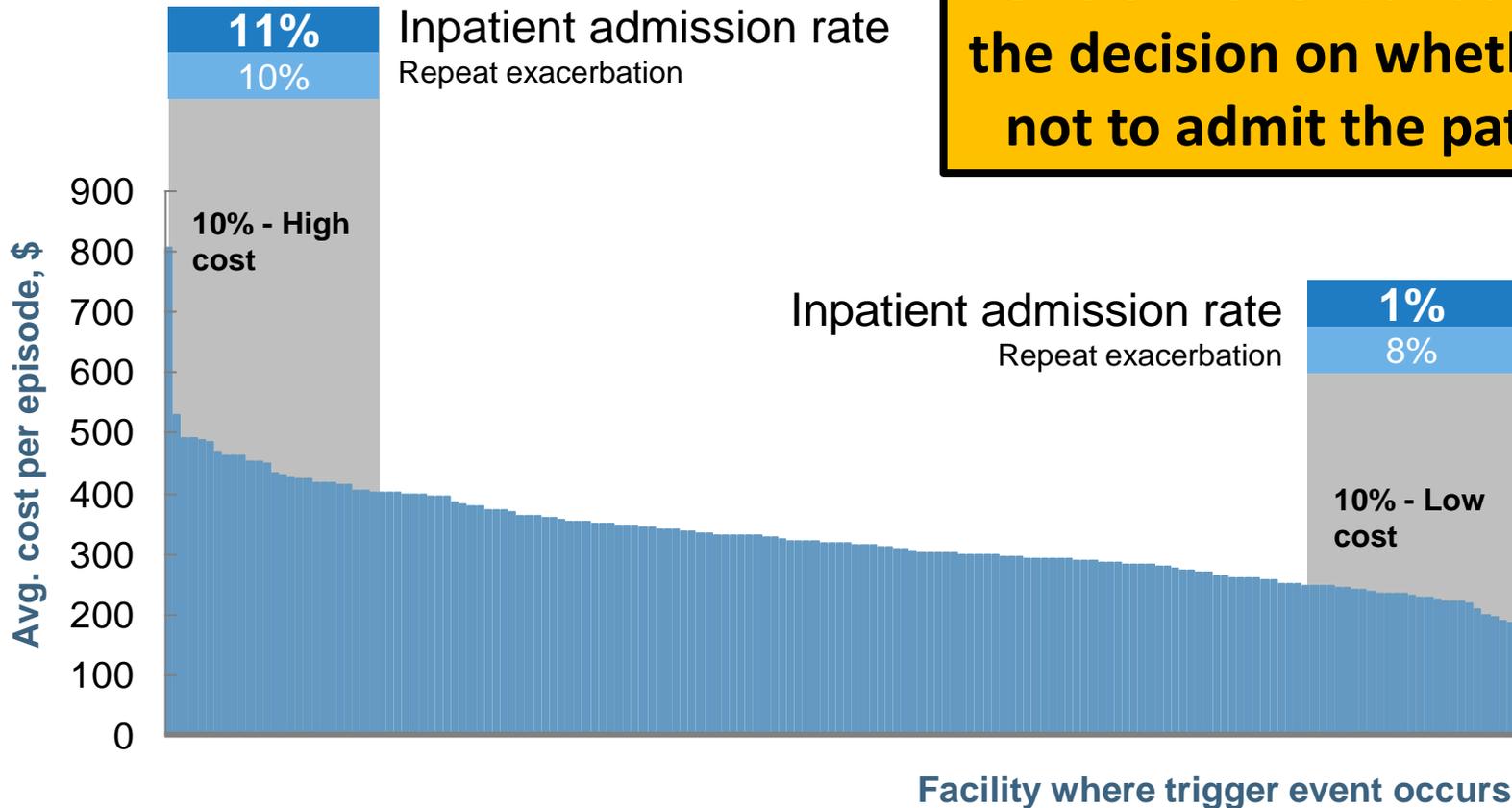


There is no correlation between average episode cost and level of risk

Variation across the Asthma Acute Exacerbation episode

Distribution of provider average episode cost

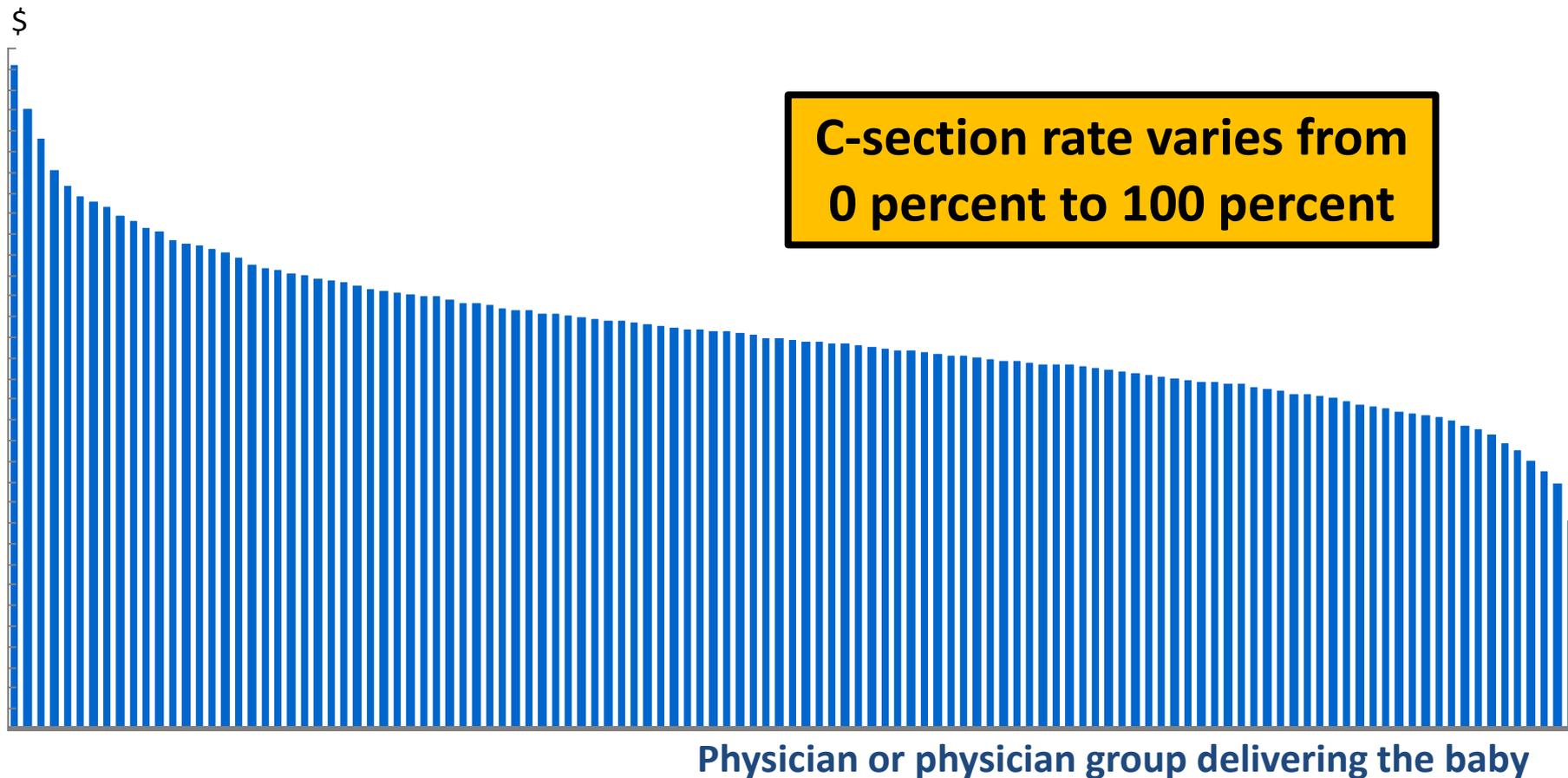
\$



One driver of variation is the decision on whether or not to admit the patient

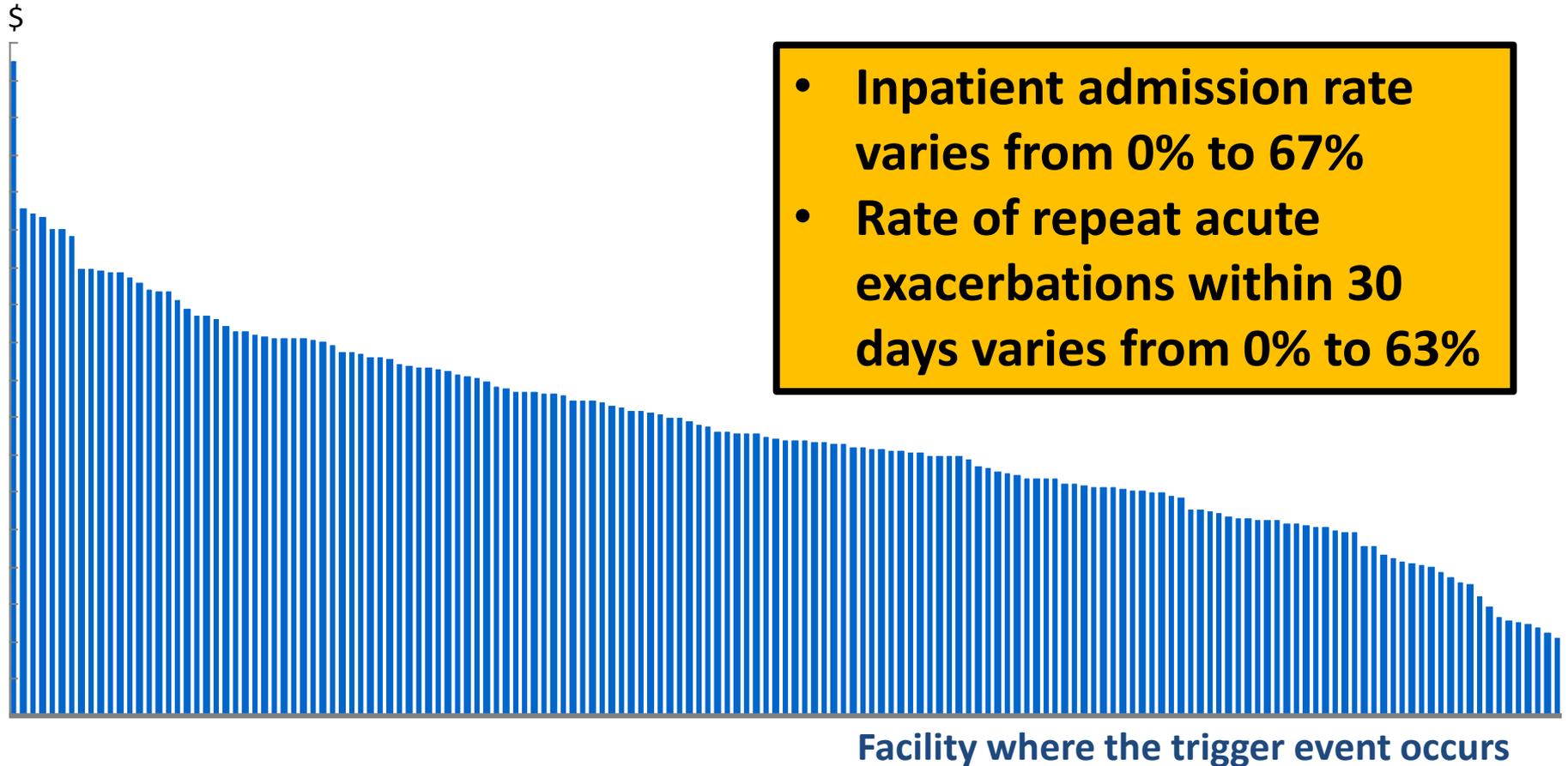
Variation across the perinatal episode

Average cost per episode, risk adjusted, excluding outliers



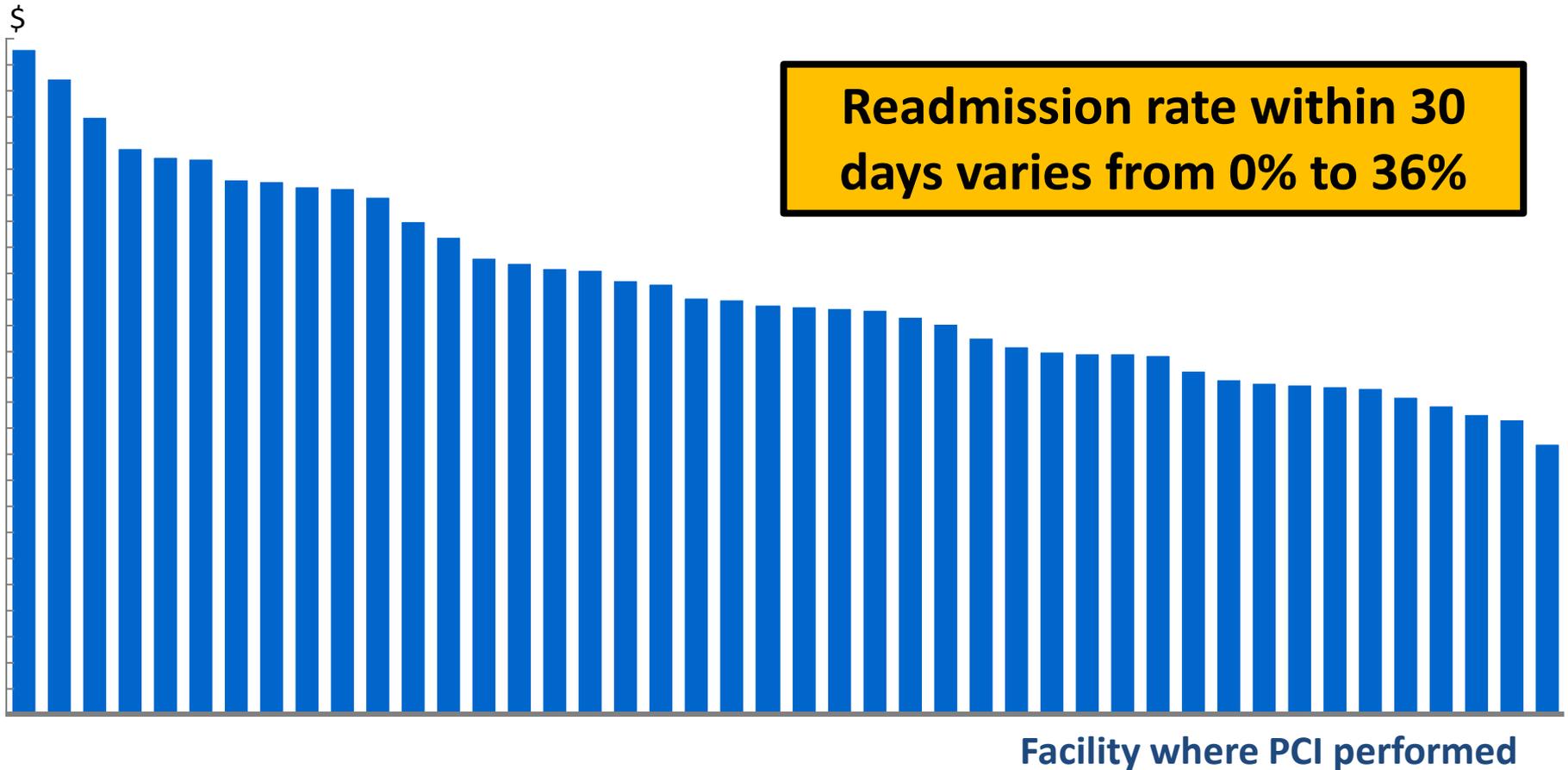
Variation across the COPD Acute Exacerbation episode

Average cost per episode, risk adjusted, excluding outliers



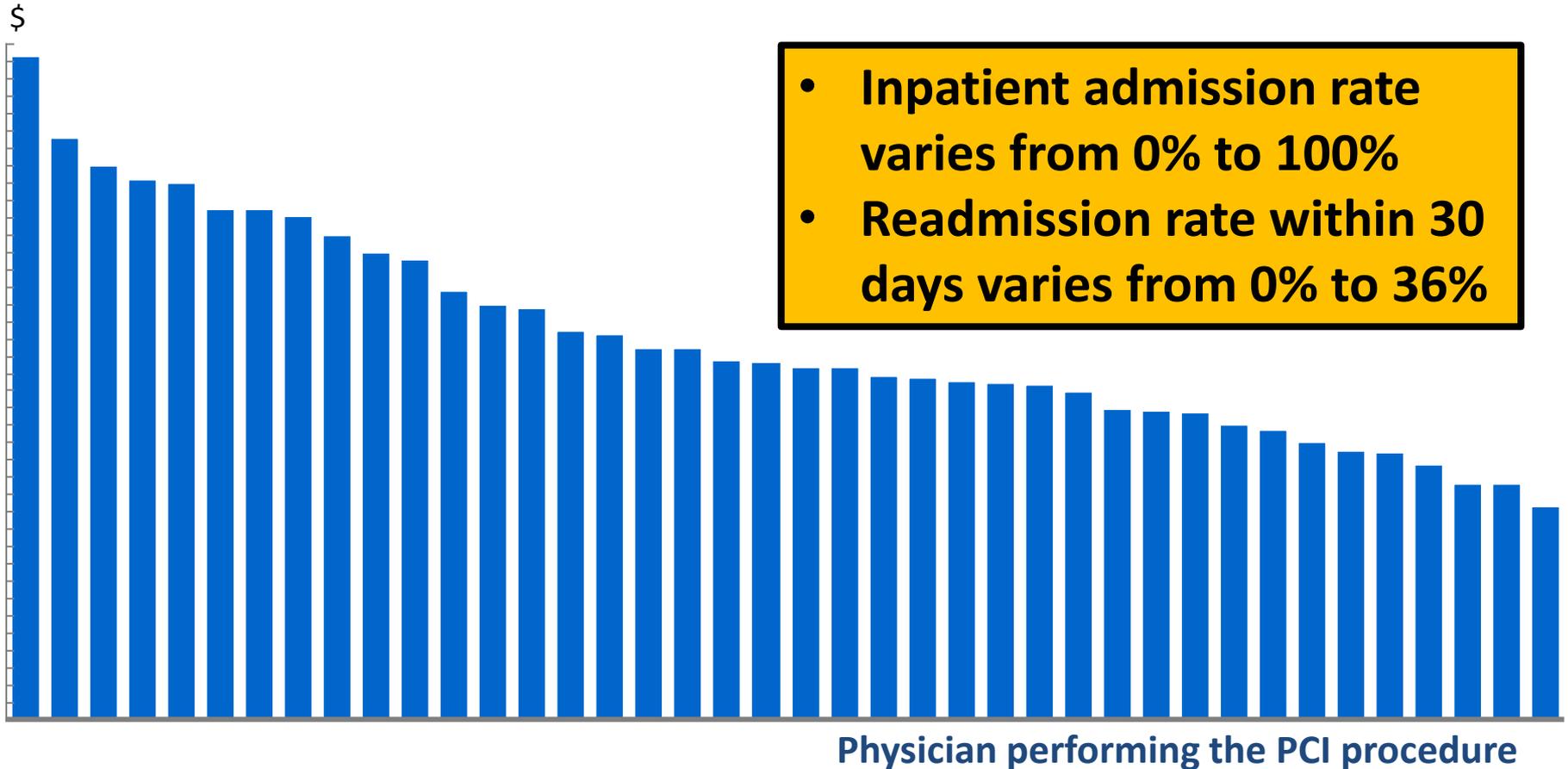
Variation across the Acute PCI episode

Average cost per episode, risk adjusted, excluding outliers



Variation across the Non-Acute PCI episode

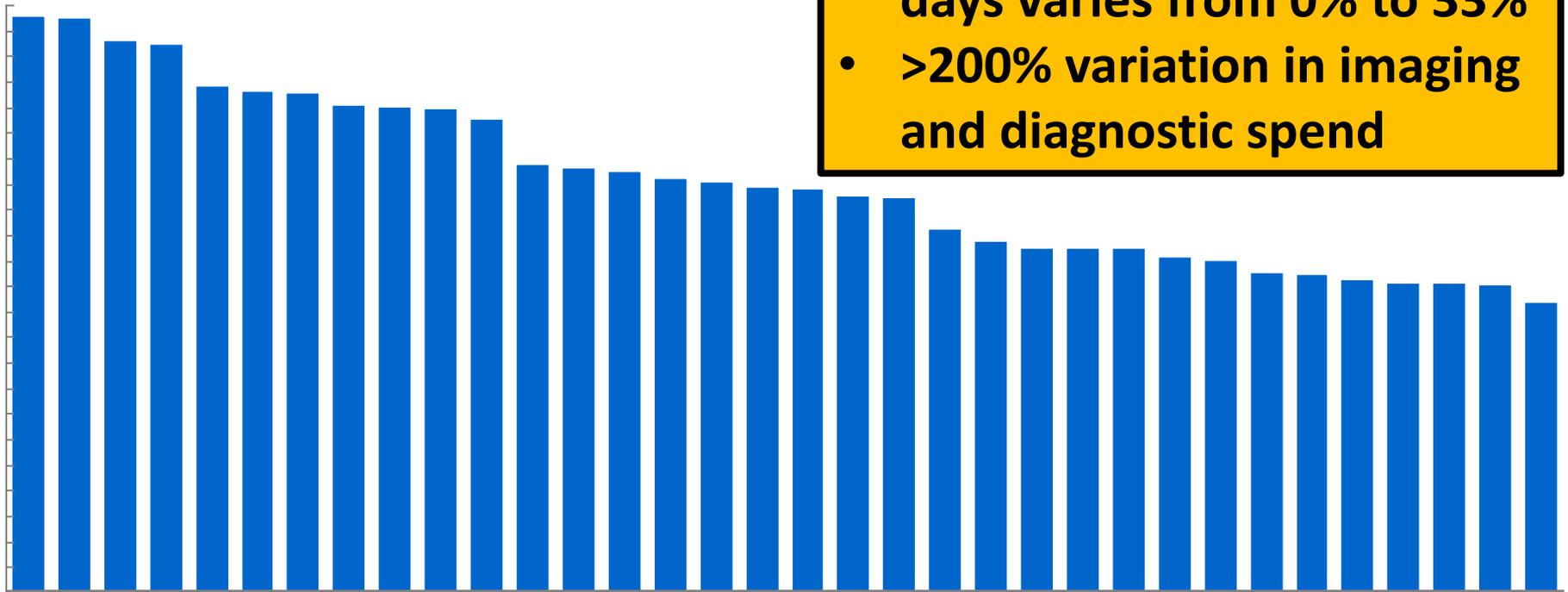
Average cost per episode, risk adjusted, excluding outliers



Variation across the Total Joint Replacement episode

Average cost per episode, risk adjusted, excluding outliers

\$



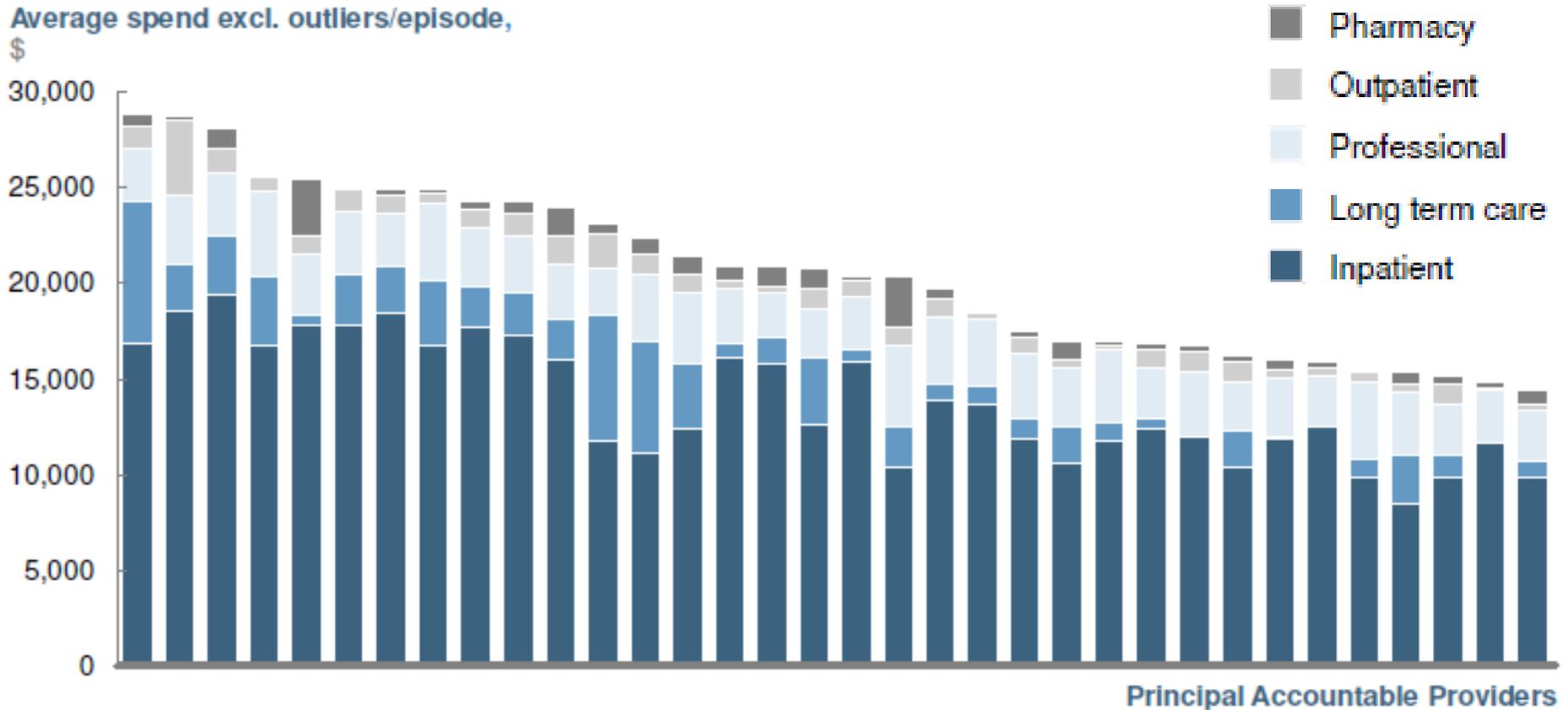
Orthopedic surgeon performing the TJR procedure



Governor's Office of
Health Transformation

NOTES: Average episode spend distribution for PAPs with five or more episodes; each vertical bar represents the average spend for one PAP.
SOURCE: Analysis of Ohio Medicaid claims data, 2011-12.

Total Joint Replacement Episode Distribution by Claim Type



Governor's Office of Health Transformation

NOTES: Average episode spend distribution by claim type for PAPs with five or more episodes; each vertical bar represents the average spend for a PAP.
SOURCE: Analysis of Ohio Medicaid claims data, 2011-2012.



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

Total episodes: 154



Risk adjusted average spend per episode

Distribution of provider average episode spend (risk adj.)



Episodes risk adjustment

95% of your episodes have been risk adjusted

Quality metrics

Your performance on quality metrics that will be ultimately linked to gain sharing

HIV screening	53%
GBS screening	71%
C-section	31%
Follow-up visit	30%

Potential gain/risk share

N/A¹

¹ Not applicable during reporting-only period

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



Who sends and who receives episode reports?

- **Ohio Medicaid will release one Medicaid-wide report** that aggregates FFS and health plan claims for three episodes that are infrequent in Medicaid:
 - Acute PCI (facility where the PCI procedure is performed)
 - Non-acute PCI (physician performing the procedure)
 - Total Joint Replacement (orthopedic surgeon performing the TJR procedure)
- **Ohio Medicaid FFS and five Medicaid health plans will each release a report** on their own Medicaid claims for:
 - Asthma Acute Exacerbation (facility where the trigger event occurs)
 - COPD Exacerbation (facility where the trigger event occurs)
 - Perinatal (physician or physician group delivering the baby)
- **Participating commercial plans will each release a report** on their own claims for at least three of the episodes listed above
- **Reporting will occur quarterly for one year** and payment will not be tied to reports until at least January 2016.

Health Transformation Next Steps

Episode-Based Payments

- March 2 – performance reports available for first six episodes
- Convene payers to identify the next seven episodes, and then convene clinical advisory groups to design each episode

Patient-Centered Medical Homes

- Convene a PCMH planning team to review lessons learned from CPC, define a PCMH approach to roll out statewide, and make recommendations for regional implementation



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:

- PCMH Charter
- Episode Charter
- Overview Presentation



Department of Medicaid

John R. Kasich, Governor
John B. McCarthy, Director

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Payment Innovation

The Ohio Department of Medicaid has joined the Governor's Office of Health Transformation to engage public and private sector partners in designing a new health care delivery payment system that rewards the value of services – not the volume.

In early 2013, the Governor's Advisory Council for Payment Reform was convened to seek input and set clear expectations for better health, better care, and cost savings through improved payment. As part of the effort, Ohio applied and received a State Innovation Model (SIM) design grant from the Center for Medicare and Medicaid Innovation (CMMI). The State of Ohio's proposal centers around design payment models that increase access to patient-centered medical homes and support retrospective episode-based payments for acute medical events.

[Transforming Payment for a Healthier Ohio](#)

Information for Providers

Episode Definitions:

Detailed definitions for perinatal, asthma, chronic obstructive pulmonary disease, total joint replacement, and percutaneous coronary intervention episodes.

Detailed Business Requirements - Detailed definitions of and associated coding algorithms

- [Perinatal](#)
- [Asthma and Chronic Obstructive Pulmonary Disease](#)
- [Total Joint Replacement](#)
- [Percutaneous coronary intervention \(acute and non-acute\) episodes](#)

Code Tables - Excel spreadsheets of code detail for:

- [Perinatal](#)
- [Asthma](#)
- [Chronic Obstructive Pulmonary Disease](#)
- [Total Joint Replacement](#)
- [Percutaneous Coronary Intervention \(acute and non-acute\) episodes](#)

Risk Adjustment Document:

Detailed description of principles and process of risk adjustment for episode-based payment model.

[Episode Frequently Asked Questions](#)

Details for Providers:

- **Episode Definitions**
- **Business Requirements**
- **Code Tables**
- **Risk Adjustment**