



Governor's Office of
Health Transformation

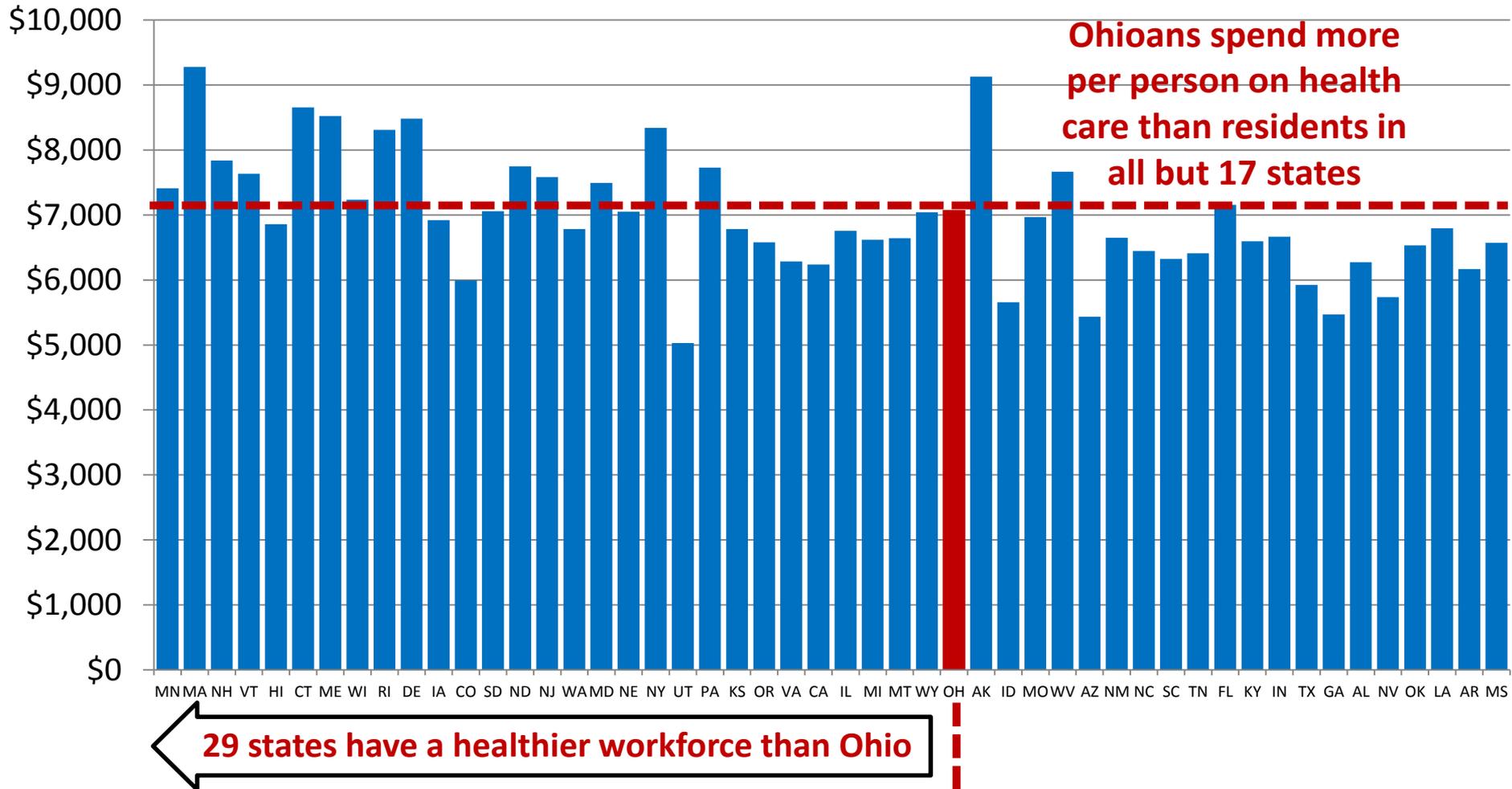
Transforming Payment for a Healthier Ohio

July 2016

www.HealthTransformation.Ohio.gov

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).

Facing the Evidence on Quality

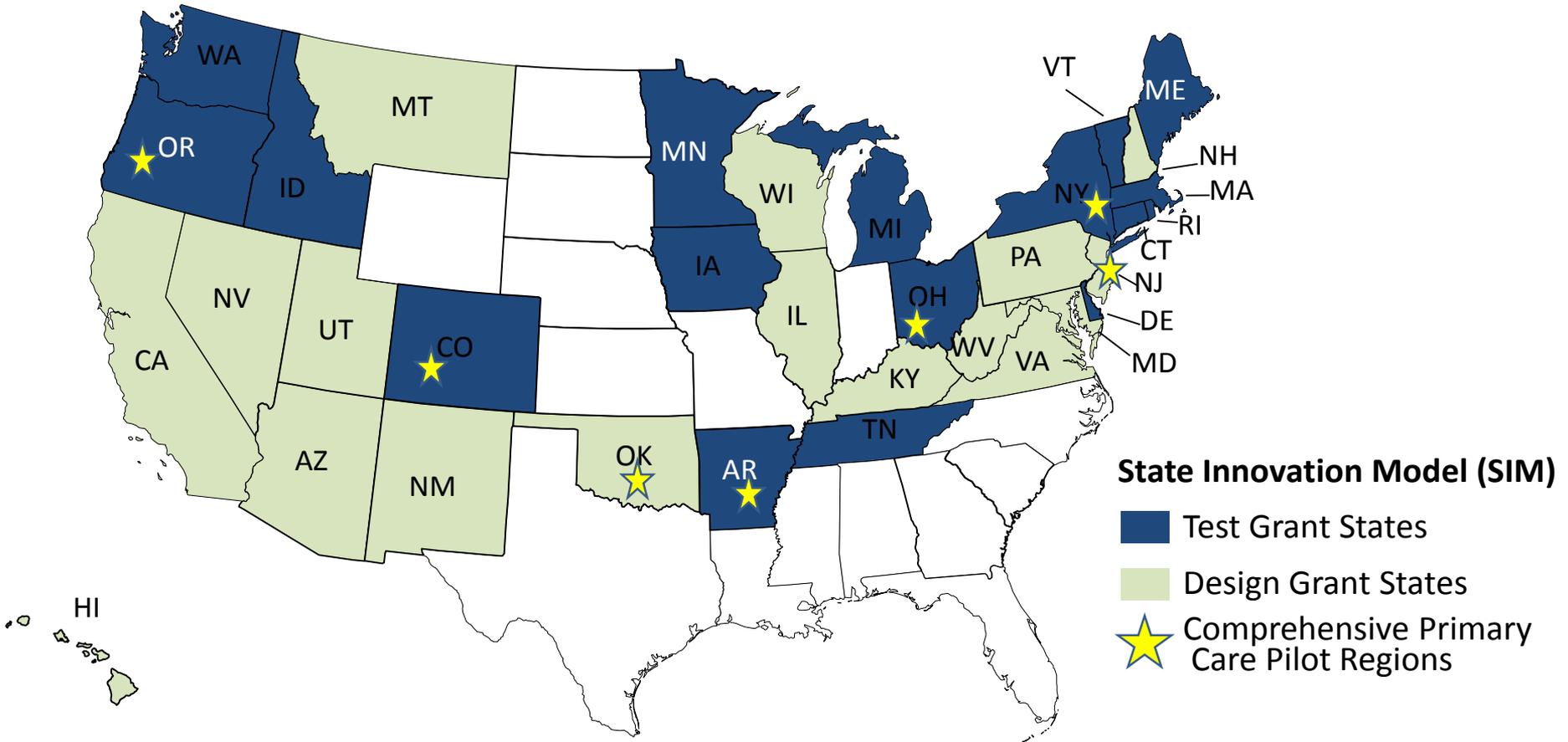
- **Not safe** – Between one-fifth and one-third of hospital patients are harmed during their stay and much of that harm is preventable (IOM 2012)
- **Not timely** – The U.S. ranks last among 19 industrial nations related to preventable deaths with timely and effective care (Commonwealth 2008)
- **Not effective** – Americans receive only 55% of recommended treatments for preventive care, acute care, and chronic care management (NEJM 2003)
- **Not efficient** – Nearly 30% of all health care spending is wasted, much of it on unnecessary or inefficiently delivered services (IOM 2009)
- **Not patient-centered** – Half of all Americans feel their doctor does not spend enough time with them (Commonwealth 2005)
- **Not equitable** – racial and ethnic minorities receive care that often is of lower quality compared to the care received by whites (NEJM 2004)

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

- **More volume** – fee-for-service payments 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
- **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



Ohio was awarded a federal grant to test multi-payer, value-based payment 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

Fee for Service

Incentive-Based Payment

Transfer Risk

Most payers have implemented some form of pay for performance but otherwise only just started to consider other value-based 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 broadens access while improving care coordination, leading to better outcomes and a lower total cost of care

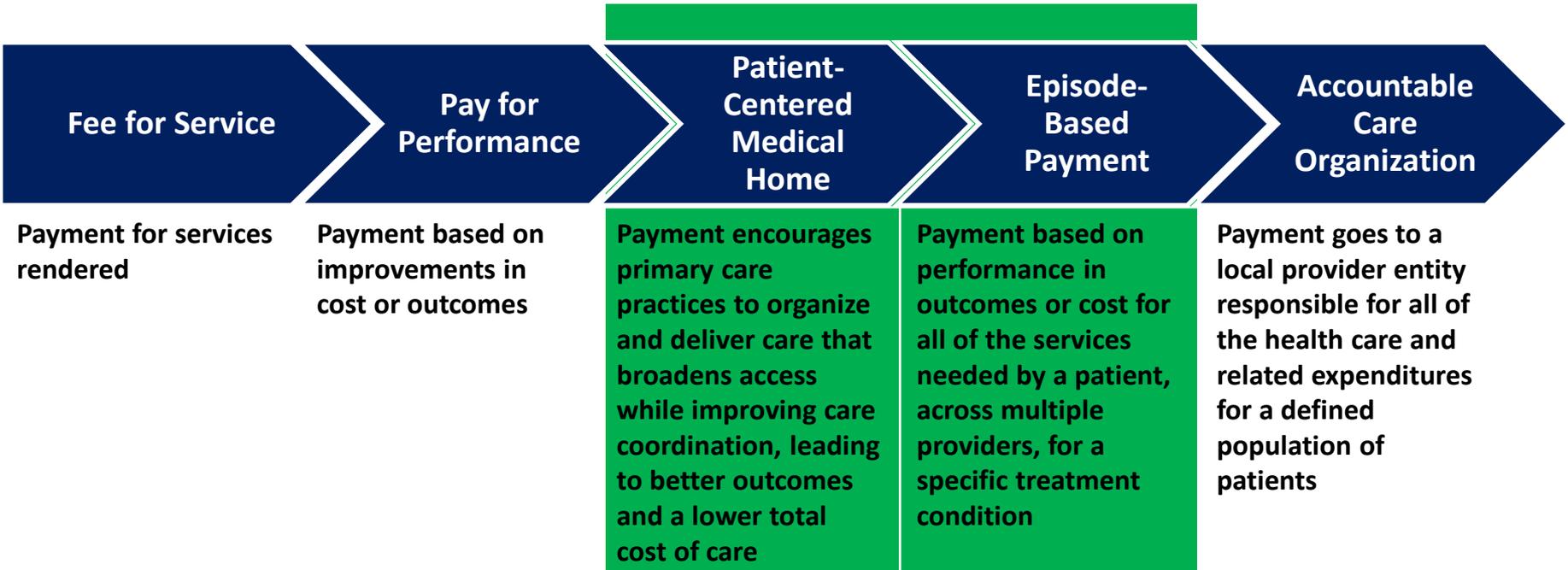
Payment based on performance in outcomes or cost for all of the services needed by a patient, across multiple providers, for a specific treatment condition

Payment goes to a local provider entity responsible for all of the health care and related expenditures for a defined population of patients

Ohio's Value-Based Alternatives to Fee-for Service



Ohio's State Innovation Model (SIM) focuses on (1) increasing access to comprehensive primary care and (2) implementing episode-based payments



Ohio's State Innovation Model (SIM) progress to date

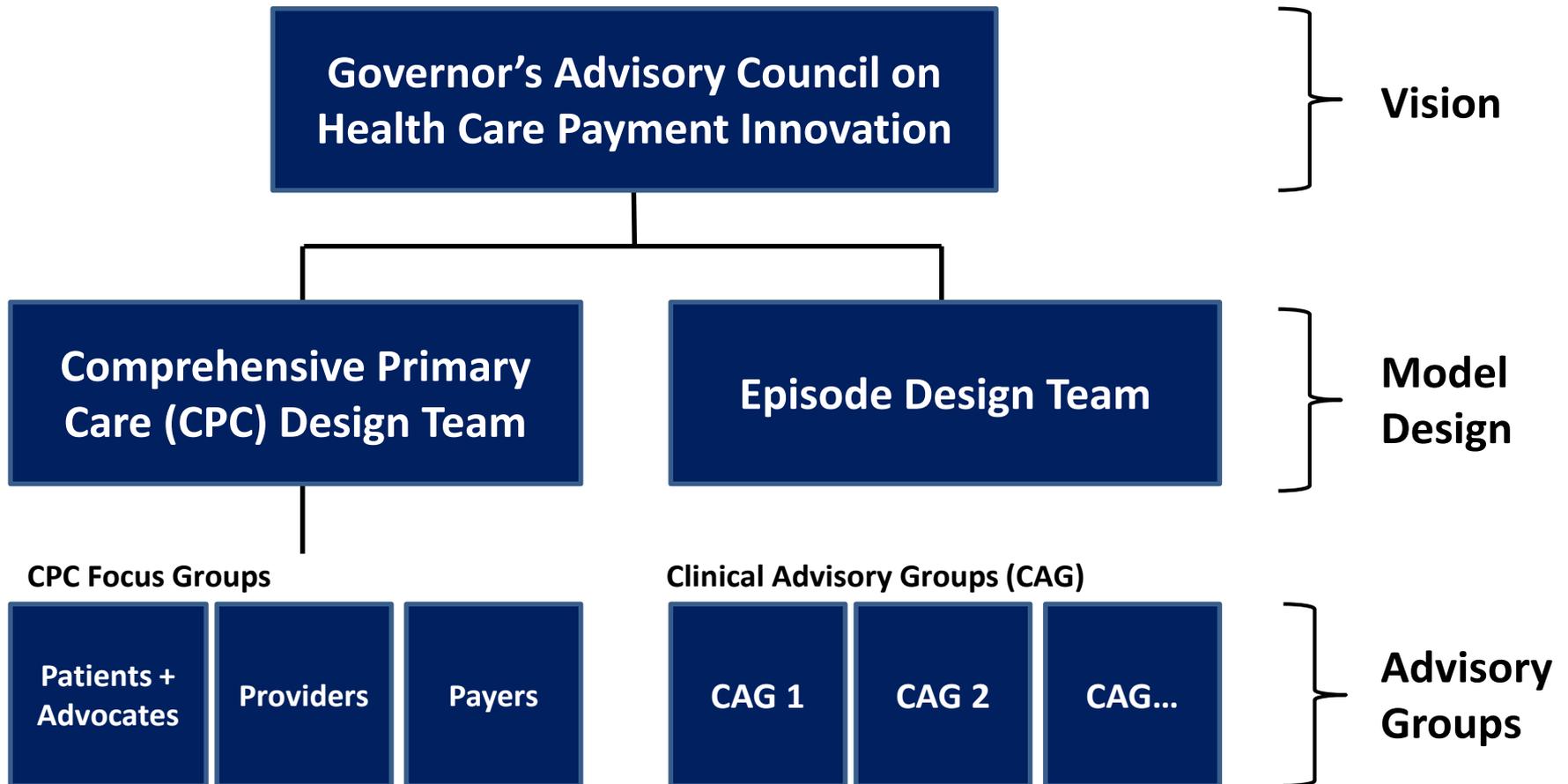
Comprehensive Primary Care

- **Care model and payment model** design in place for model to reach 80 percent of Ohio's population
- **Statewide provider survey** gauged readiness
- **Infrastructure plan** in place for attribution, enrollment, scoring, reporting, and payment
- **Ohio CPC performance report** designed with provider/payer input
- **All payers applied for Ohio to be a statewide Medicare CPC+ region**

Episode-Based Payment

- **13 episodes** designed across seven clinical advisory groups (CAGs)
- **30 additional episodes** under development to launch in 2017
- **Nine payers** released performance reports on first wave of 6 episodes
- State set **thresholds for performance** payments across Medicaid FFS and MCPs on first wave of episodes
- State released **performance reports** aggregated across Medicaid FFS and MCPs on second wave of 7 episodes
- **Executive Order** and rule require Medicaid provider participation

Payment model design decisions have been shaped by meaningful input from 1,000+ stakeholders across Ohio



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





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
- Rebuild community behavioral health system capacity
- Enhance community developmental disabilities services
- Improve Medicaid managed care plan performance

Streamline Health and Human Services

- 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 comprehensive primary care
- Implement episode-based payments
- Align population health planning
- Coordinate health information technology infrastructure
- Coordinate health sector workforce programs
- Support regional payment reform initiatives

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Recently Added

- Simplify disability determination
- 2015 Year in Review

Related Topics

- Medicaid Reforms
- Strategic Framework
- Guiding Principles
- Human Services Inventory

Ohio's Strategy to Pay for Value:

- **State Innovation Model (SIM) Overview**
- **Comprehensive Primary Care (CPC) Program**
- **Episode-Based Payment Model**
- **Population Health Plan**
- **Health IT Plan**