



# Transforming Payment for a Healthier Ohio

Greg Moody, Director  
 Governor's Office of Health Transformation  
 Mount Carmel Practice Management Forum  
 September 22, 2015

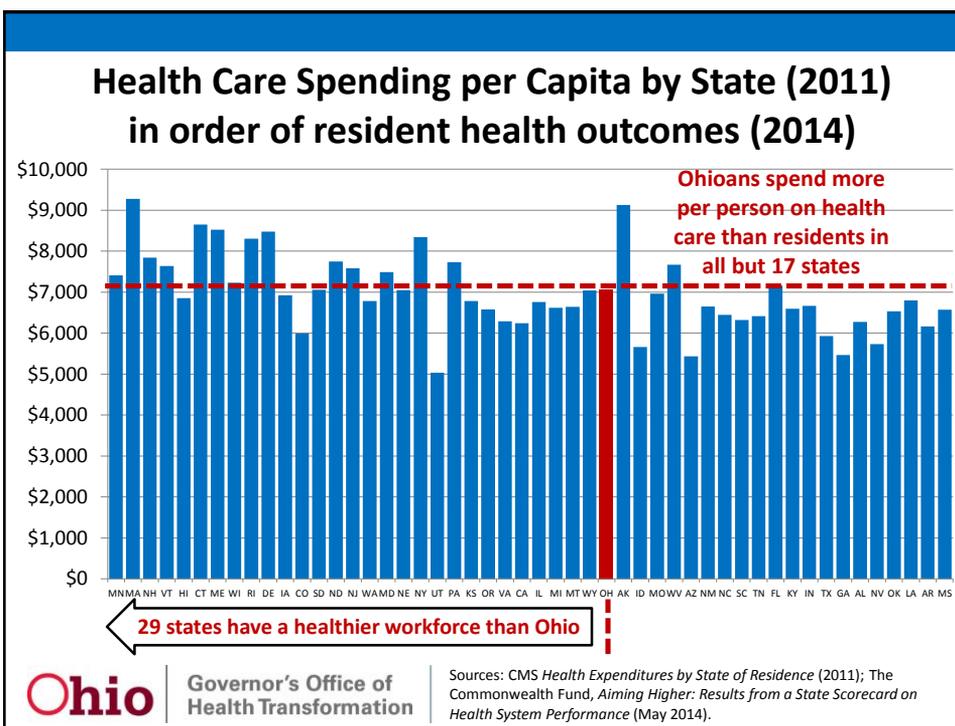
[www.HealthTransformation.Ohio.gov](http://www.HealthTransformation.Ohio.gov)



## 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>
<i>Advance the Governor Kasich's Medicaid modernization and cost containment priorities</i>	<i>Share services to increase efficiency, right-size state and local service capacity, and streamline governance</i>	<i>Engage private sector partners to set clear expectations for better health, better care and cost savings through improvement</i>
<ul style="list-style-type: none"> <li>Extend Medicaid coverage to more low-income Ohioans</li> <li>Eliminate fraud and abuse</li> <li>Prioritize home and community based (HCBS) services</li> <li>Reform nursing facility payment</li> <li>Enhance community DD services</li> <li>Integrate Medicare and Medicaid</li> <li>Rebuild community behavioral health system capacity</li> <li>Restructure behavioral health system financing</li> <li>Improve Medicaid managed care plan performance</li> </ul>	<ul style="list-style-type: none"> <li>Create the Office of Health Transformation (2011)</li> <li>Implement a new Medicaid claims payment system (2011)</li> <li>Create a unified Medicaid budget and accounting system (2013)</li> <li>Create a cabinet-level Medicaid Department (2013)</li> <li>Consolidate mental health and addiction services (2013)</li> <li>Simplify and integrate eligibility determination (2014)</li> <li>Refocus existing resources to promote economic self-sufficiency</li> </ul>	<ul style="list-style-type: none"> <li>Join Catalyst for Payment Reform</li> <li>Support regional payment reform</li> <li>Pay for value instead of volume (State Innovation Model Grant)                             <ul style="list-style-type: none"> <li>Provide access to medical homes for most Ohioans</li> <li>Use episode-based payments for acute events</li> <li>Coordinate health information infrastructure</li> <li>Coordinate health sector workforce programs</li> <li>Report and measure system performance</li> </ul> </li> </ul>

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



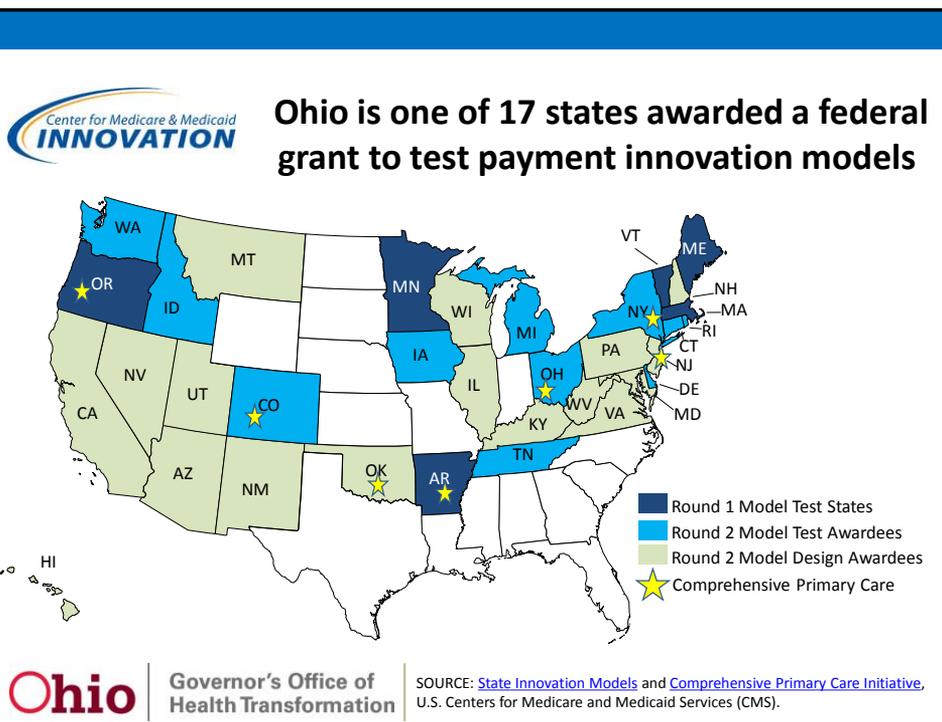
## In fee-for-service, we get what we pay for

- **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)



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

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

## Ohio's Health Care Payment Innovation Partners:



















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## Elements of a Patient-Centered Medical Home Strategy

<b>Care delivery model</b>	Target patients and scope Care delivery improvements e.g., <ul style="list-style-type: none"> <li>▪ Improved access</li> <li>▪ Patient engagement</li> <li>▪ Population management</li> <li>▪ Team-based care, care coordination</li> </ul> Target sources of value
<b>Payment model</b>	Technical requirements for PCMH Attribution / assignment Quality measures Payment streams/ incentives Patient incentives
<b>Infrastructure</b>	PCMH infrastructure Payer infrastructure Payer / PCMH infrastructure PCMH/ Provider infrastructure System infrastructure
<b>Scale-up and practice performance improvement</b>	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)

## Elements of an Episode-Based Payment Strategy

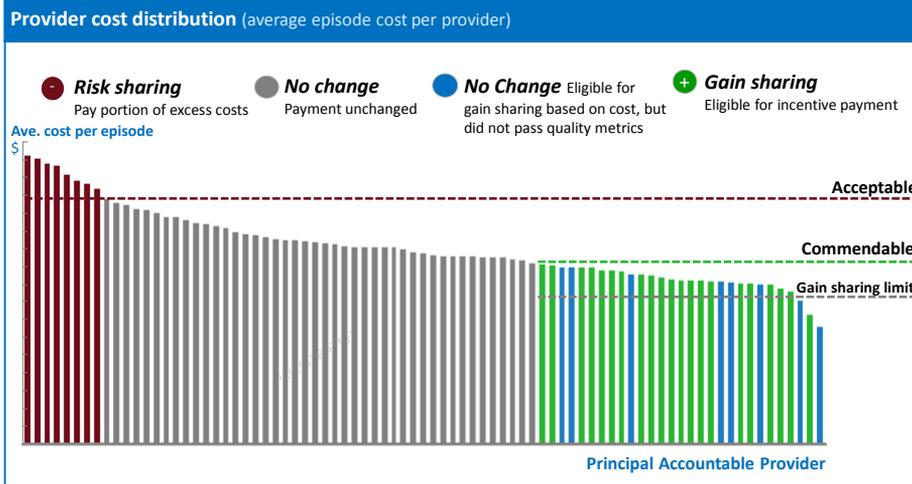
<b>Program-level design decisions</b>	
<b>Participation</b>	Provider participation } Related to 'scale-up' Payer participation } plan for episodes
<b>Accountability</b>	Providers at risk – Number Providers at risk – Type of provider(s) Providers at risk – Unique providers Cost normalization approach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

## Retrospective thresholds reward cost-efficient, high-quality care



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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

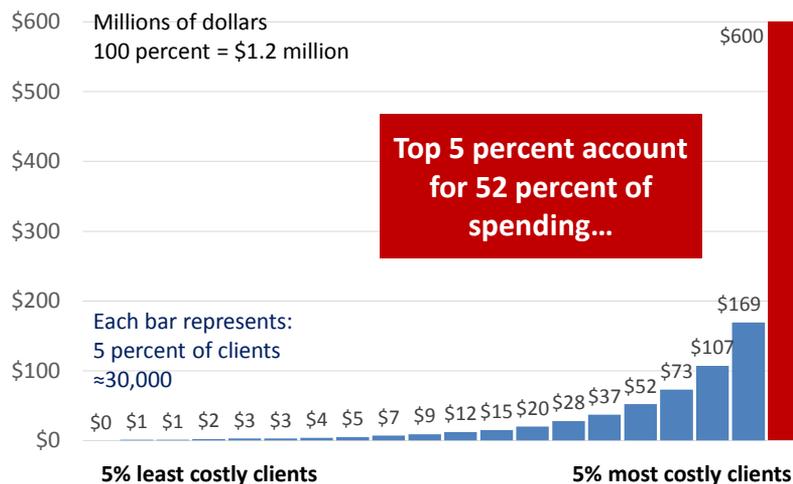
### Principles for selection:

- 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:

<i>Episode</i>	<i>Principal Accountable Provider</i>
<b>WAVE 1 (launched March 2015)</b>	
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
<b>WAVE 2 (launch January 2016)</b>	
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
<b>WAVE 3 (launch January 2017)</b>	
14-19. Package of behavioral health episodes to be determined	

## 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).

Anthem

aetna

UnitedHealthcare

MEDICAL MUTUAL

CareSource

MOLINA HEALTHCARE

Buckeye Community Health Plan

PARAMOUNT ADVANTAGE

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

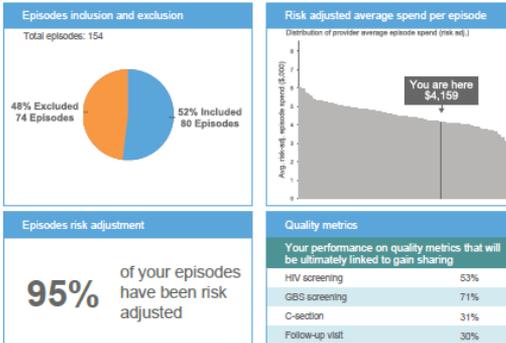


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## EPISODE of CARE PAYMENT REPORT

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/A<sup>1</sup>**



Potential gain/risk share  
**N/A<sup>1</sup>**

<sup>1</sup> Not applicable during reporting-only period  
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## 2015 Priorities

**Episode-Based Payments**

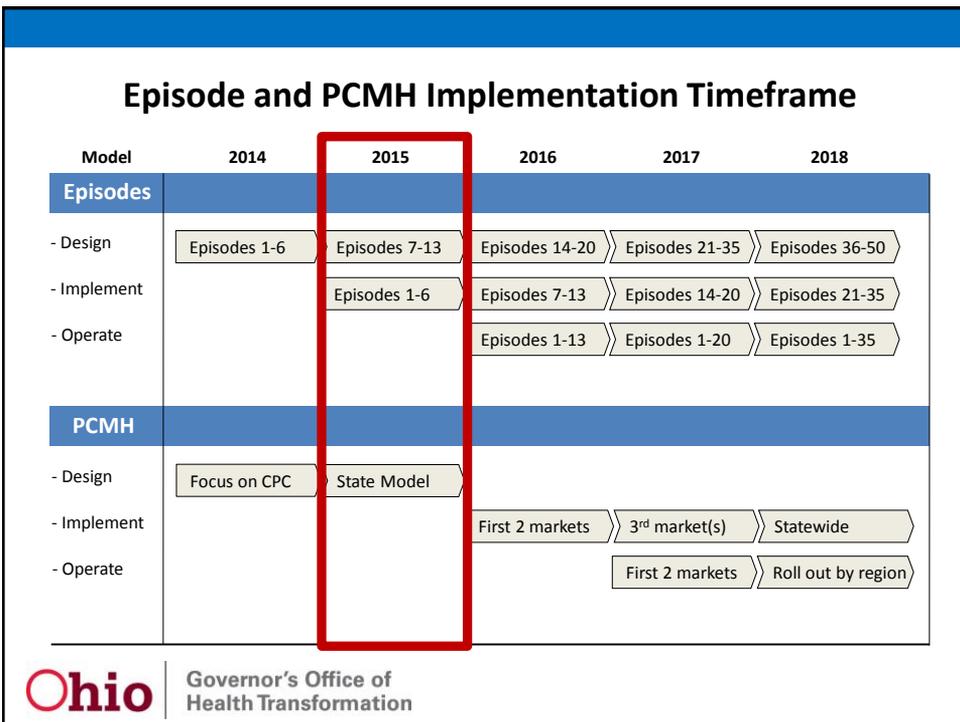
- Wave 1: release episode reports quarterly, set performance thresholds, and start the first performance period that links to payment in January 2016
- Wave 2: convene clinical advisory groups to design the next seven episodes, with first reports to launch in January 2016
- Wave 3: begin work on behavioral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



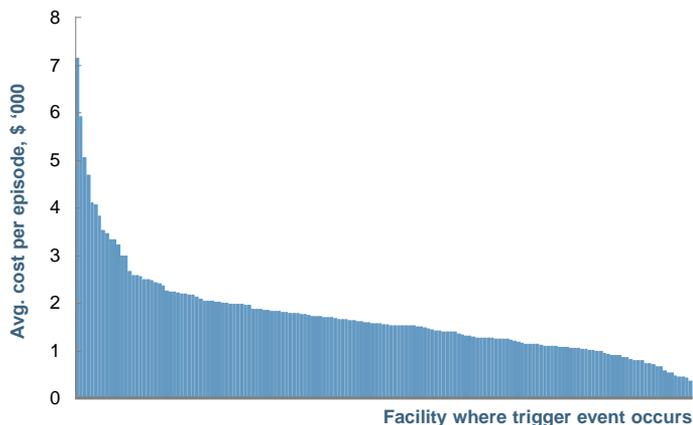
## Detailed episode-based payment model example: asthma acute exacerbation

### Asthma Acute Exacerbation: Definitions

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

## 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 Medicaid claims data, 2011-12.

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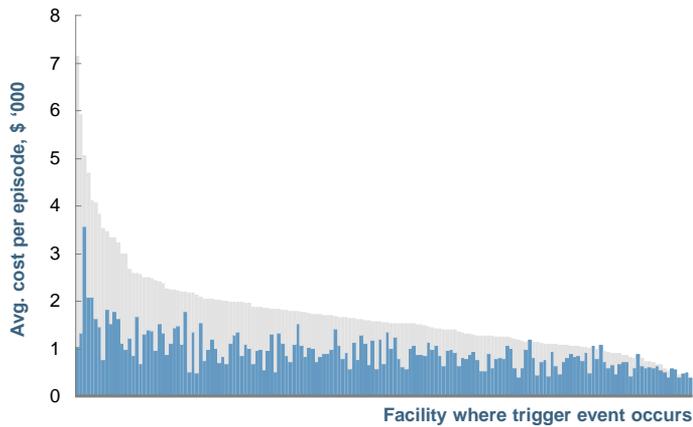


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SOURCE: Ohio Episode-Based Payment Model Clinical Design Team definitions.

## Asthma Acute Exacerbation: Provider Performance

Distribution of provider average episode cost  
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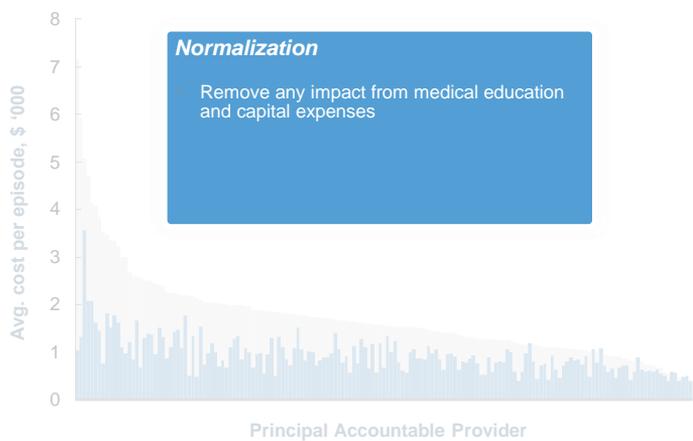


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SOURCE: Ohio Medicaid claims data, 2011-12.

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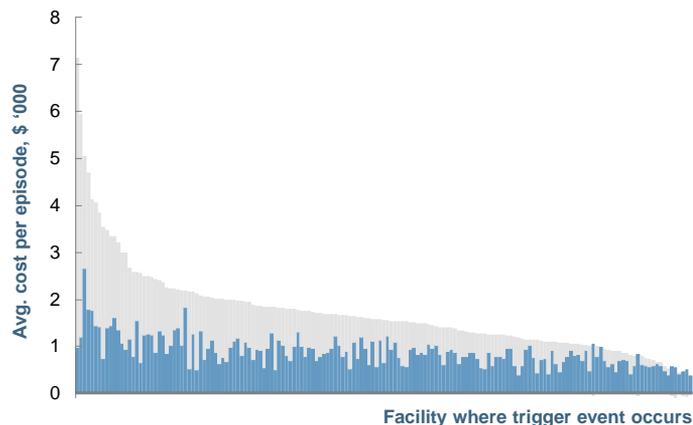


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SOURCE: Ohio Episode-Based Payment Model Clinical Design Team definitions.

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SOURCE: Ohio Medicaid claims data, 2011-12.

## Asthma Acute Exacerbation: Provider Performance

### Risk adjustment

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

### 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

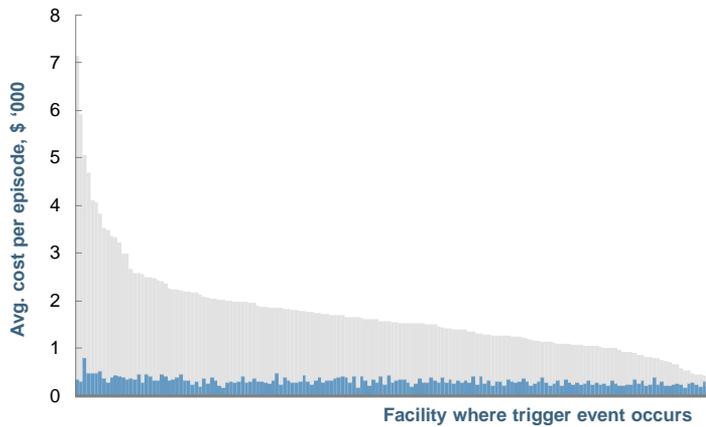


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SOURCE: Ohio Episode-Based Payment Model Clinical Design Team definitions.

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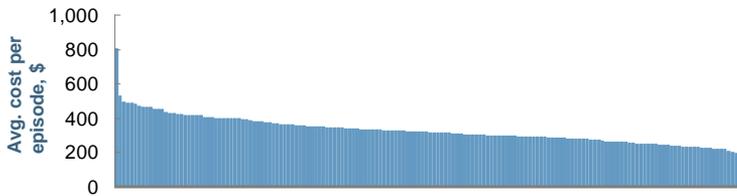


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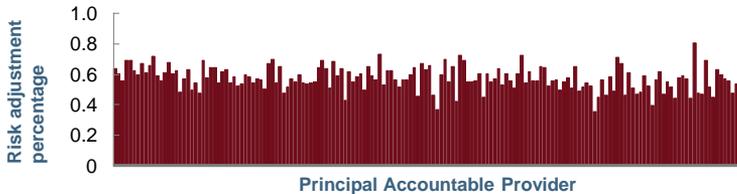
SOURCE: Ohio Medicaid claims data, 2011-12.

## 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**



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SOURCE: Ohio Medicaid claims data, 2011-12.

