



Governor's Office of  
Health Transformation

# Transforming Payment for a Healthier Ohio

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May 15, 2015

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

## 2011 Ohio Crisis

- \$8 billion state budget shortfall
- 89-cents in the rainy day fund
- Nearly dead last (48<sup>th</sup>) 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)

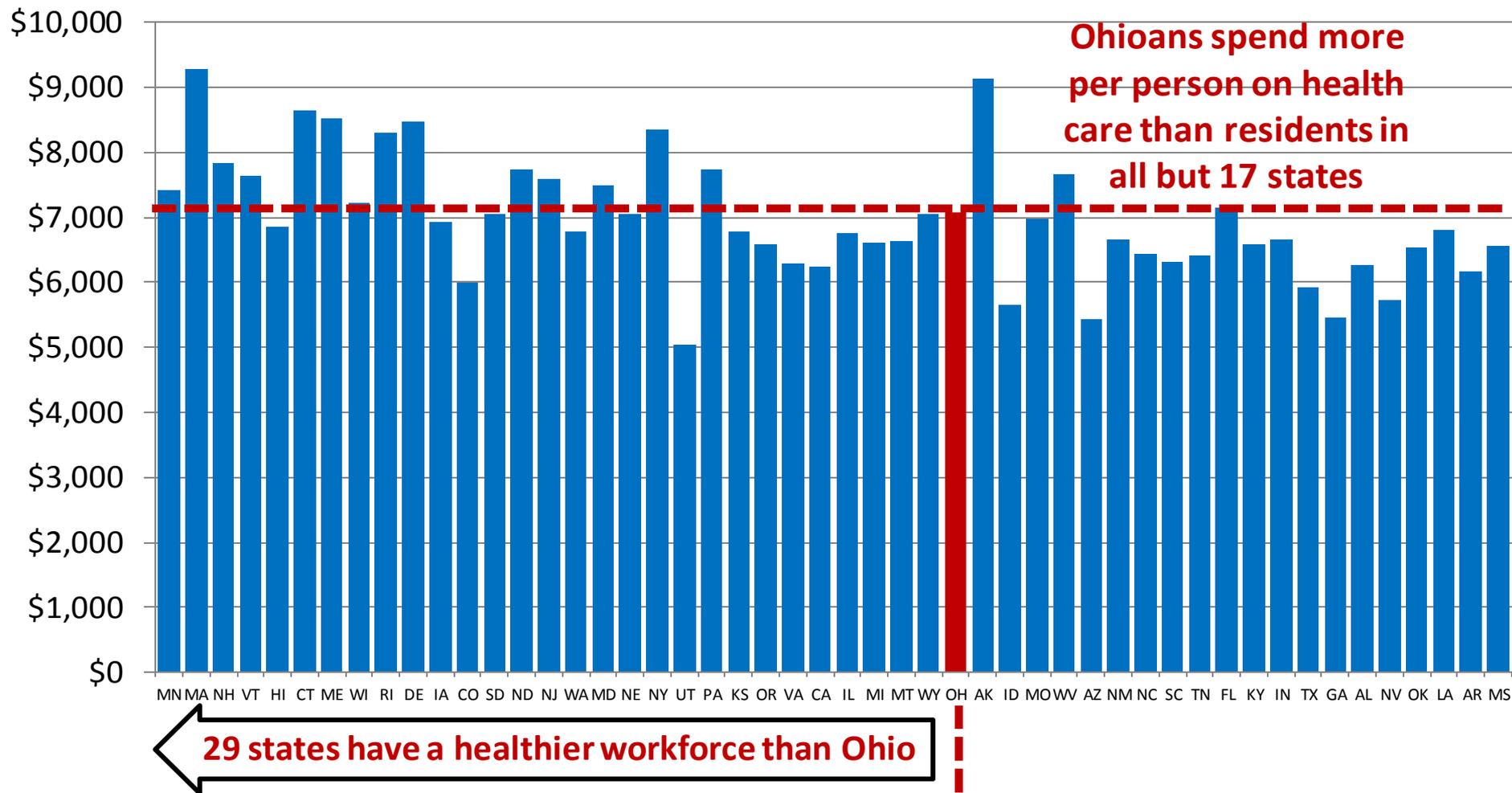
## 2011 Ohio Crisis

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> |
|--|---|

# 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



# 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)

- State leads design of six episodes: asthma acute exacerbation, COPD exacerbation, perinatal, acute and non-acute PCI, and joint replacement

## Year 2

- Collaborate with payers on design decisions and prepare a roll-out strategy

- State leads design of seven new episodes: URI, UTI, cholecystectomy, appendectomy, GI hemorrhage, EGD, and colonoscopy

## Year 3

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

- 20 episodes defined and launched across payers, including behavioral health

## 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:



# 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)

**Regional Data Transparency + Engaged Physicians = National Leaders in Primary Care Transformation**

220,000 Beneficiaries

250 Providers

9 Health Plans

**Key Functions**

-  Patient Experience
-  24/7 Access to Medical Record
-  Shared Decision Making
-  Clinical Quality Improvement
-  Care Management

**Population Health**



**84,000**  
Patients Received  
Care Management

**42,000**  
Discussed Smoking  
Cessation Treatment  
Options

**8,700**  
Discussed Advance  
Care Plan Options

**Evidence-Based Care**

**Medicare Outcomes to Date**

	Overall Hospital Admissions	-8%
	Primary Care Treatable Admissions	-10%
	Readmissions	-3%
	Overall Expenditures	-3.4%

Data-Driven Improvement

# Elements of an Episode-Based Payment Strategy

## Program-level design decisions

<b>Participation</b>	Provider participation Payer participation	} Related to 'scale-up' 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	

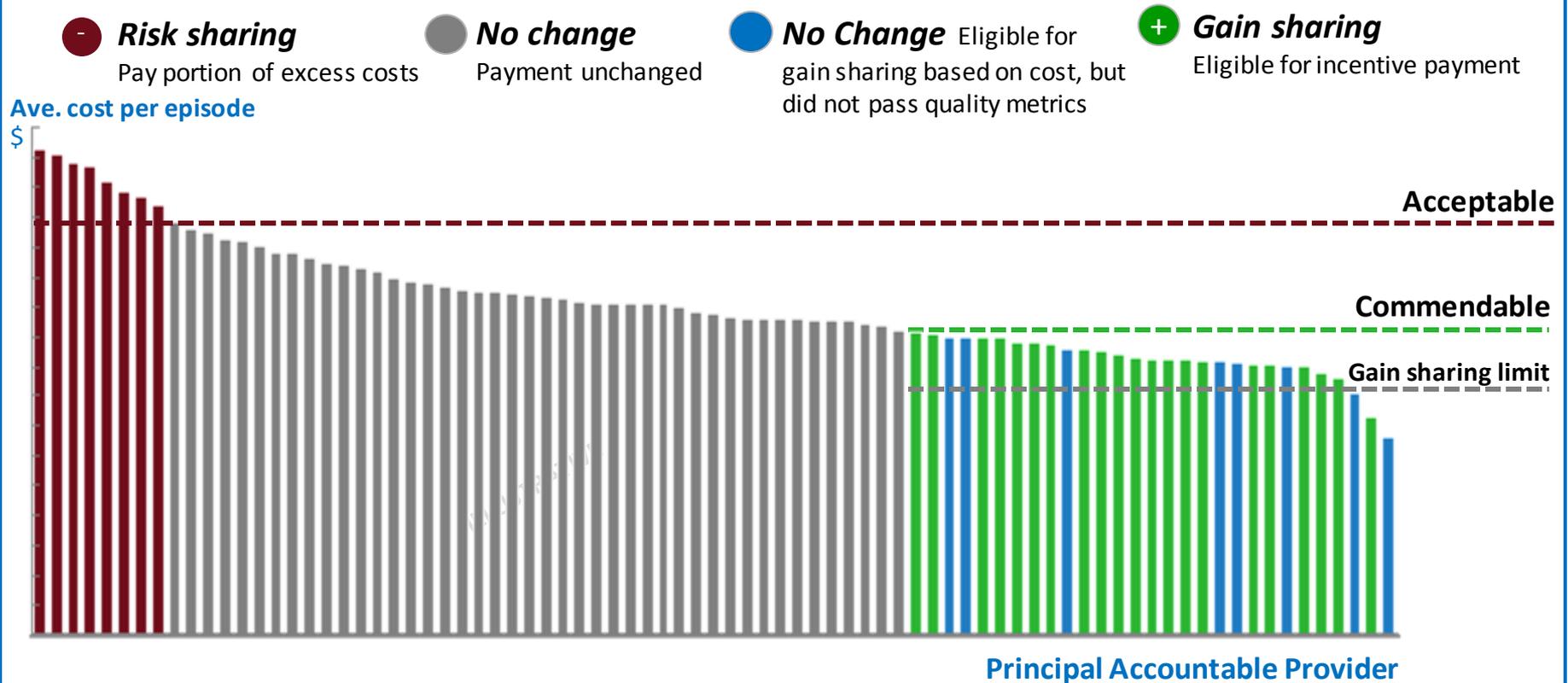
## Payment Model Mechanics:

- 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

## Provider cost distribution (average episode cost per provider)



# Elements of the episode definition

Category	Description
1 Episode trigger	<ul style="list-style-type: none"><li>Diagnoses or procedures and corresponding claim types and/or care settings that characterize a potential episode</li></ul>
2 Episode window	<ul style="list-style-type: none"><li><b>Pre-trigger window:</b> Time period prior to the trigger event; relevant care for the patient is included in the episode</li><li><b>Trigger window:</b> Duration of the potential trigger event (e.g., from date of inpatient admission to date of discharge); all care is included</li><li><b>Post-trigger window:</b> Time period following trigger event; relevant care and complications are included in the episode</li></ul>
3 Claims included	
4 Principal accountable provider	<ul style="list-style-type: none"><li>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</li></ul>
5 Quality metrics	<ul style="list-style-type: none"><li>Measures to evaluate quality of care delivered during a specific episode</li></ul>
6 Potential risk factors	<ul style="list-style-type: none"><li>Patient characteristics, comorbidities, diagnoses or procedures that may potentially indicate an increased level of risk for a given patient in a specific episode</li></ul>
7 Episode-level exclusions	<ul style="list-style-type: none"><li>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</li></ul>

# Selection of episodes

## Principles for selection:

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

## Ohio’s episode selection:

### *Episode*

### *Principal Accountable Provider*

#### **WAVE 1 (launched March 2015)**

- |                                    |                                     |
|------------------------------------|-------------------------------------|
| 1. Perinatal                       | Physician/group delivering the baby |
| 2. Asthma acute exacerbation       | Facility where trigger event occurs |
| 3. COPD exacerbation               | Facility where trigger event occurs |
| 4. Acute Percutaneous intervention | Facility where PCI performed        |
| 5. Non-acute PCI                   | Physician                           |
| <b>6. Total joint replacement</b>  | <b>Orthopedic surgeon</b>           |

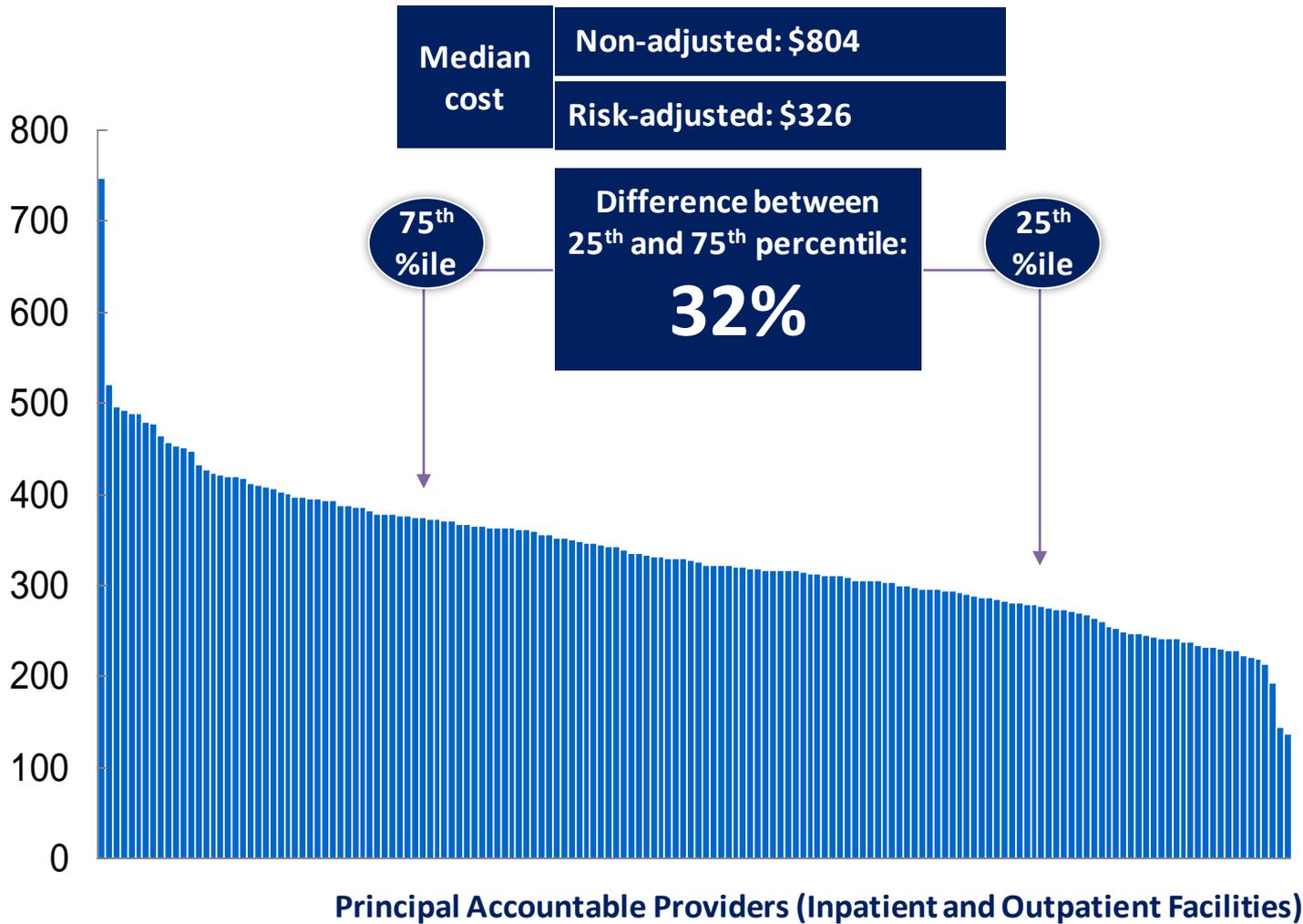
#### **WAVE 2 (launch January 2016)**

- |                                |                                  |
|--------------------------------|----------------------------------|
| 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

# Variation across the Asthma Exacerbation episode



## Impact:

- 160 PAPs
- 21,994 Episodes
- \$19.4 million Spend

## Select Quality Measures:

- 50% Episodes where x-ray is performed
- 38% Episodes where patient fills prescription for asthma controller

## Select Risk Adjustments:

- Pneumonia
- Heart disease
- Obesity

## Select Exclusions:

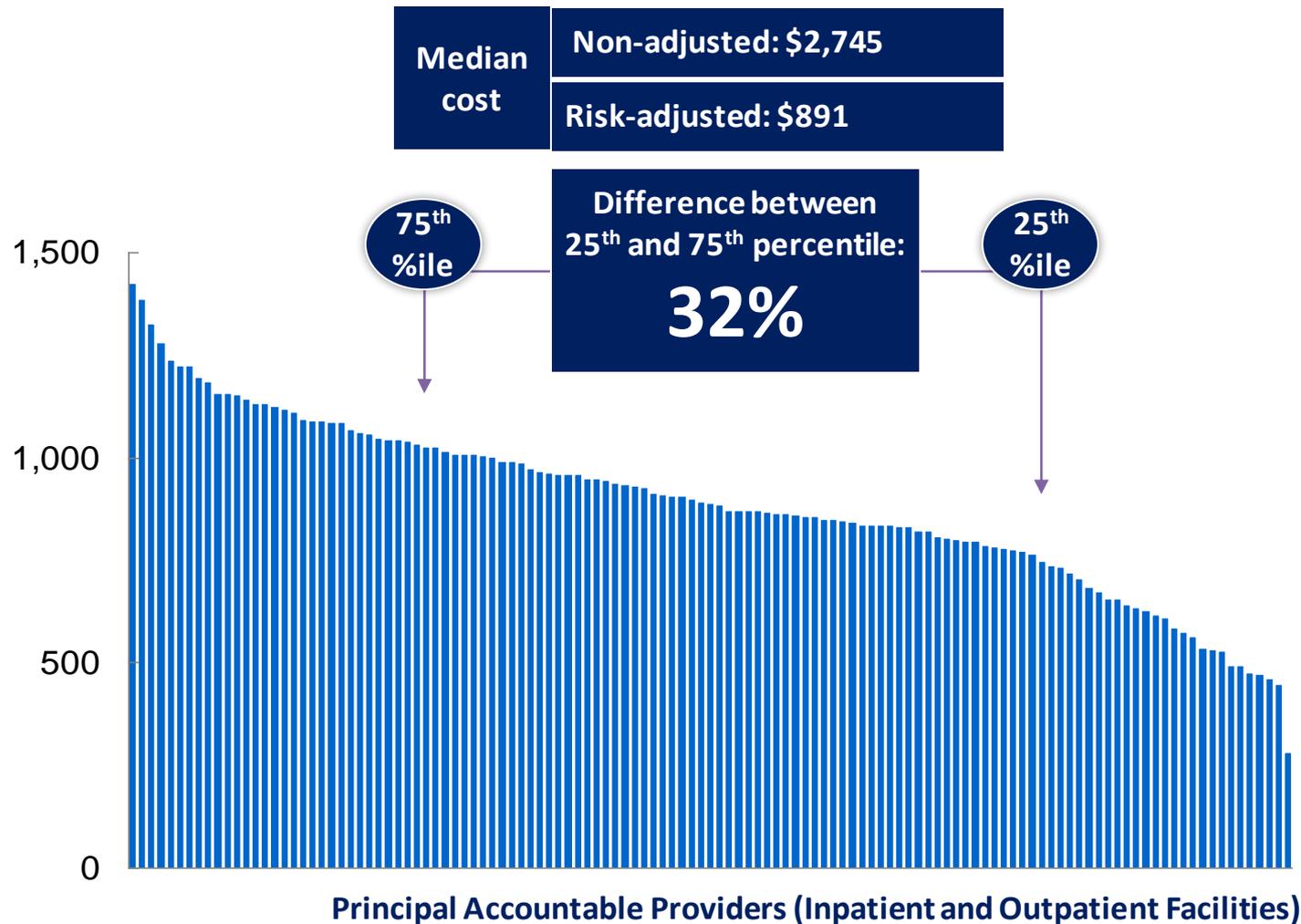
- Age <2 and >64
- Inconsistent enrollment
- ICU stay > 72 hours

## Sources of variability/value:

- Medications
- Inpatient admissions
- Complications



# Variation across the COPD episode



## Impact:

- 123 PAPs
- 4,533 Episodes
- \$13.7 million Spend

## Select Quality Measures:

- 89% Episodes where x-ray is performed
- 61% Episodes where patient receives follow-up visit

## Select Risk Adjustments:

- Cardiac dysrhythmias
- Blood disorders and anemia
- Respiratory failure

## Select Exclusions:

- ICU stay > 72 hours
- Inconsistent enrollment
- Intubation of patient

## Sources of variability/value:

- Medications
- Inpatient admissions
- Follow-up care

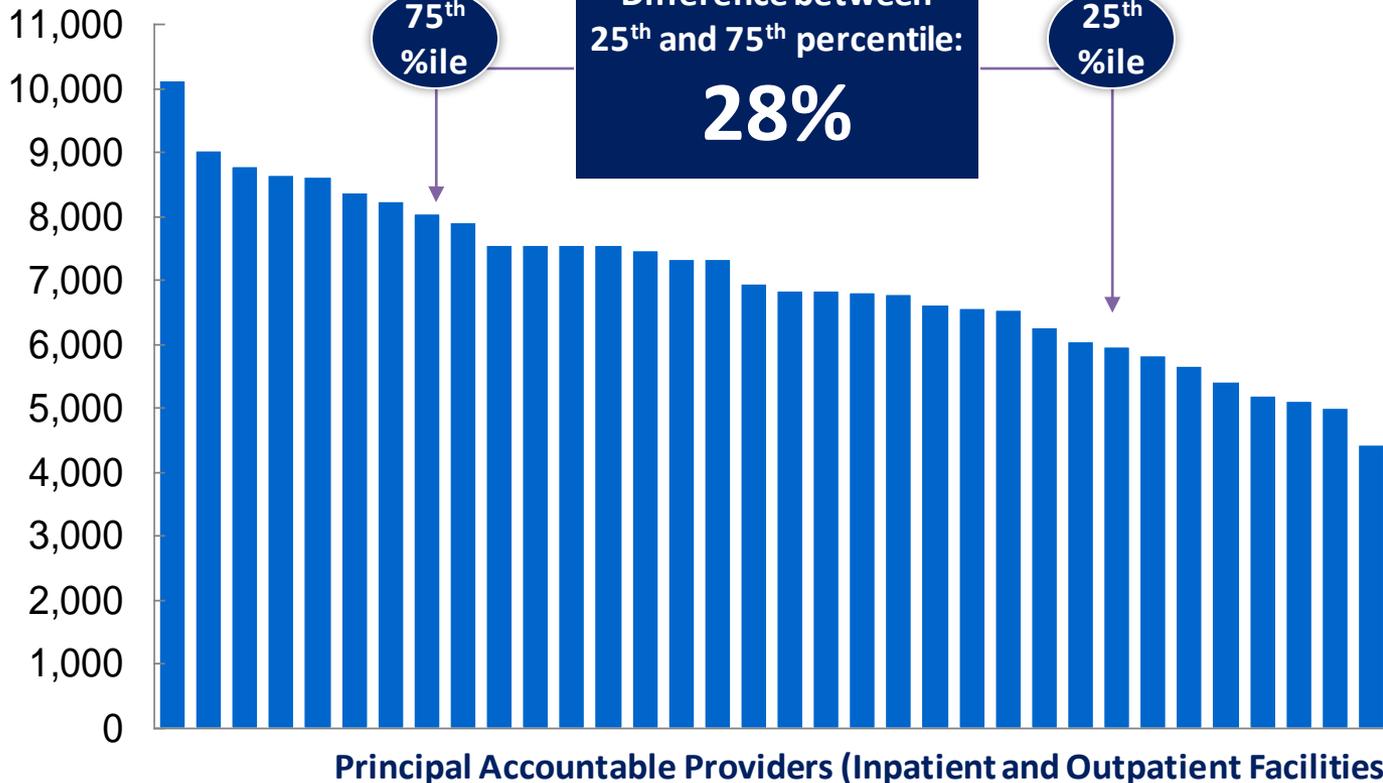
# Variation across the Acute PCI episode

Median cost	Non-adjusted: \$13,437
	Risk-adjusted: \$6,956

75<sup>th</sup> %ile

Difference between 25<sup>th</sup> and 75<sup>th</sup> percentile: **28%**

25<sup>th</sup> %ile



## Impact:

- 34 PAPs
- 311 Episodes
- \$4.3 million Spend

## Select Quality Measures:

- 10% repeat PCI
- 1% post-operative hemorrhage

## Select Risk Adjustments:

- STEMI
- Fluid and electrolyte disorders

## Select Exclusions:

- Inconsistent enrollment
- Cardiogenic shock
- Age <18 and >64

## Sources of variability/value:

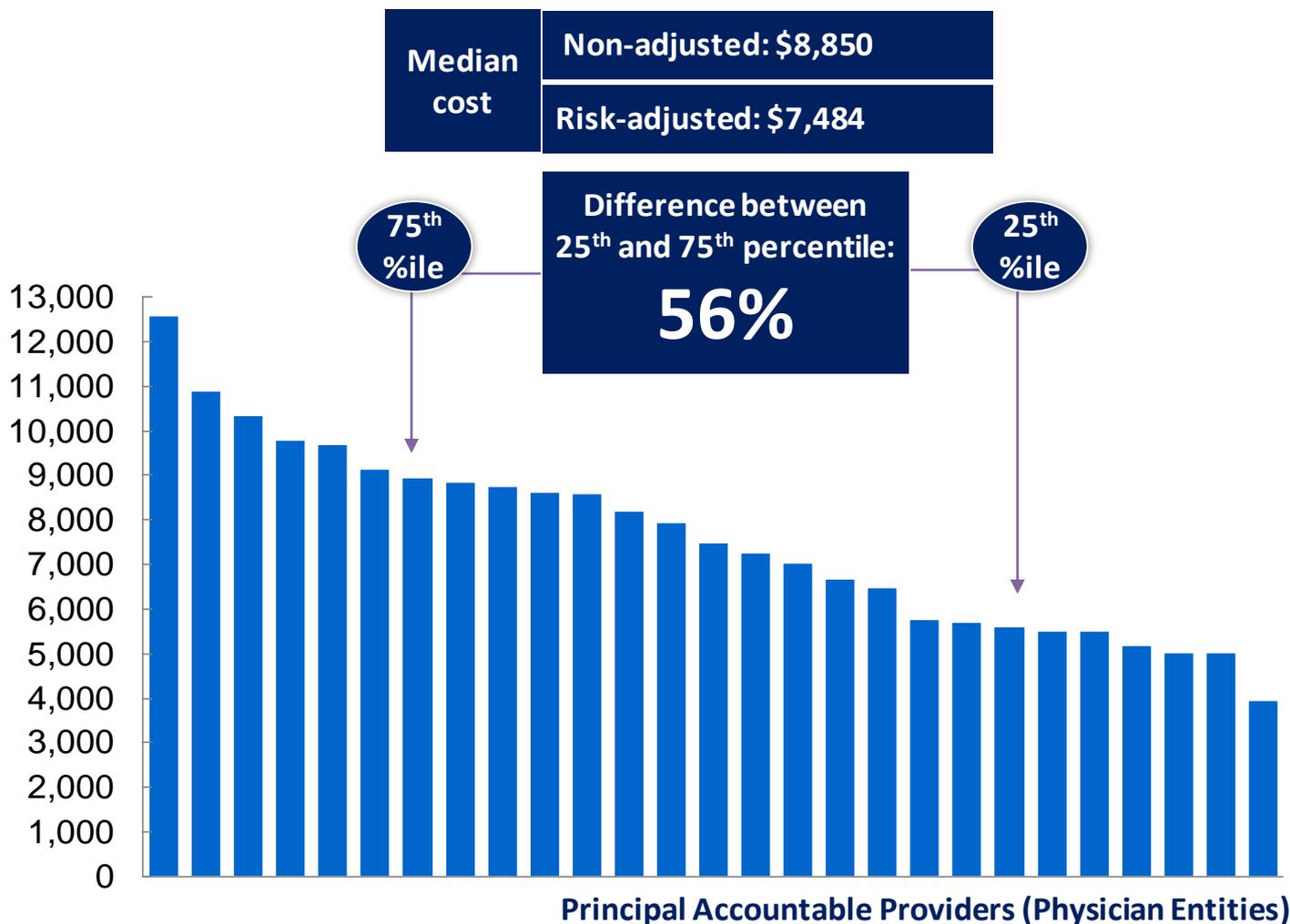
- Diagnostic work-up
- Setting of care
- Complications
- Readmissions



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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



## Impact:

- 27 PAPs
- 273 Episodes
- \$2.4 million Spend

## Select Quality Measures:

- 10% repeat PCI
- 1% post-operative hemorrhage

## Select Risk Adjustments:

- Fluid/electrolyte disorders
- Multiple vessel procedures
- Complex hypertension

## Select Exclusions:

- Inconsistent enrollment
- Age <18 and >64
- HIV comorbidity

## Sources of variability/value:

- Diagnostic work-up
- Setting of care
- Complications
- Readmissions

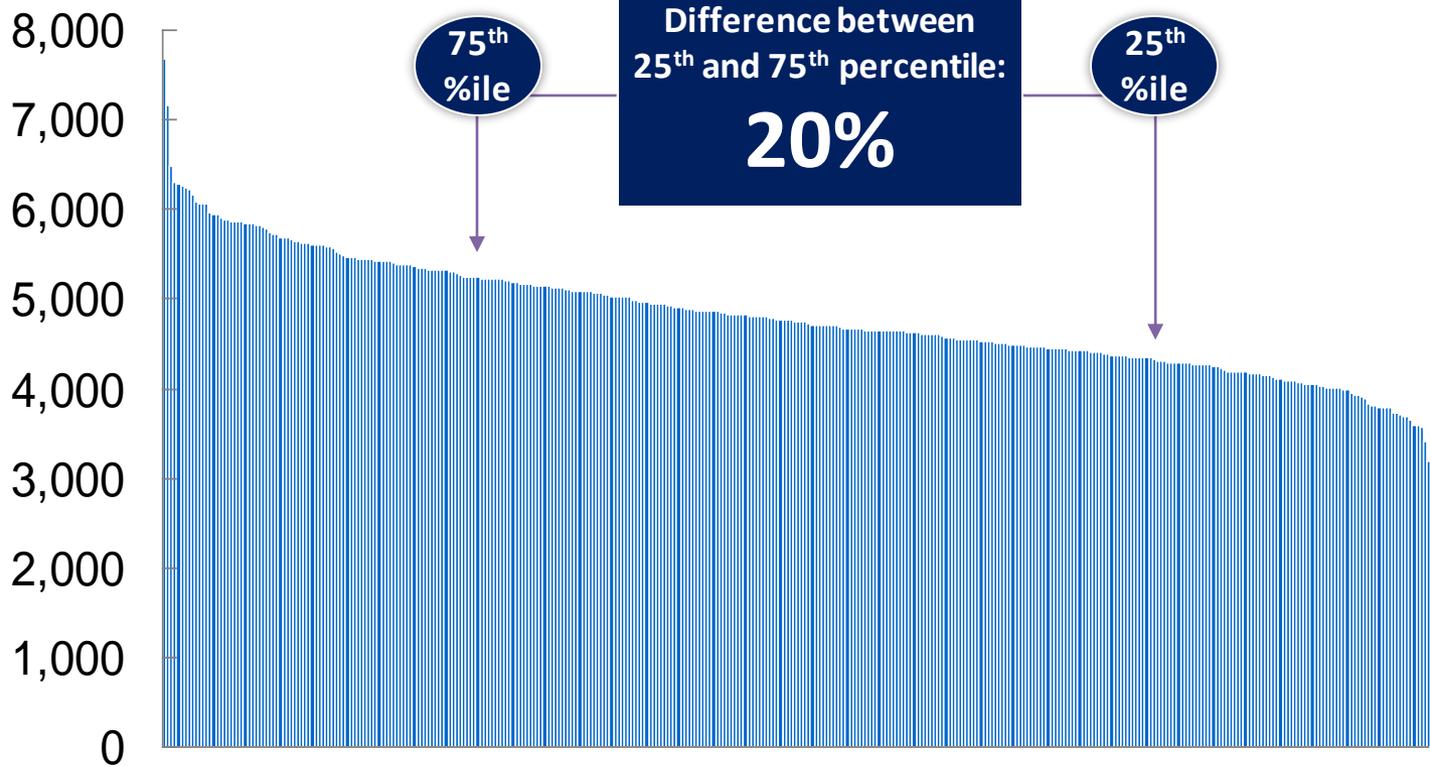
# Variation across the Perinatal episode

Median cost	Non-adjusted: \$7,013
	Risk-adjusted: \$4,753

Difference between 25<sup>th</sup> and 75<sup>th</sup> percentile: **20%**

75<sup>th</sup> %ile

25<sup>th</sup> %ile



Principal Accountable Providers (Physician or Physician Entities)

## Impact:

- 360 PAPs
- 30,939 Episodes
- \$223.7 million Spend

## Select Quality Measures:

- 86% Episodes where patient receives screening for Group B streptococcus
- 76% Episodes where patient receives HIV screening

## Select Risk Adjustments:

- Menstrual disorders
- Umbilical cord complication
- Eclampsia
- Anemia

## Select Exclusions:

- Presence of 3<sup>rd</sup> party liability
- Cystic fibrosis
- Inconsistent enrollment

## Sources of variability/value:

- Elective interventions
- Readmissions



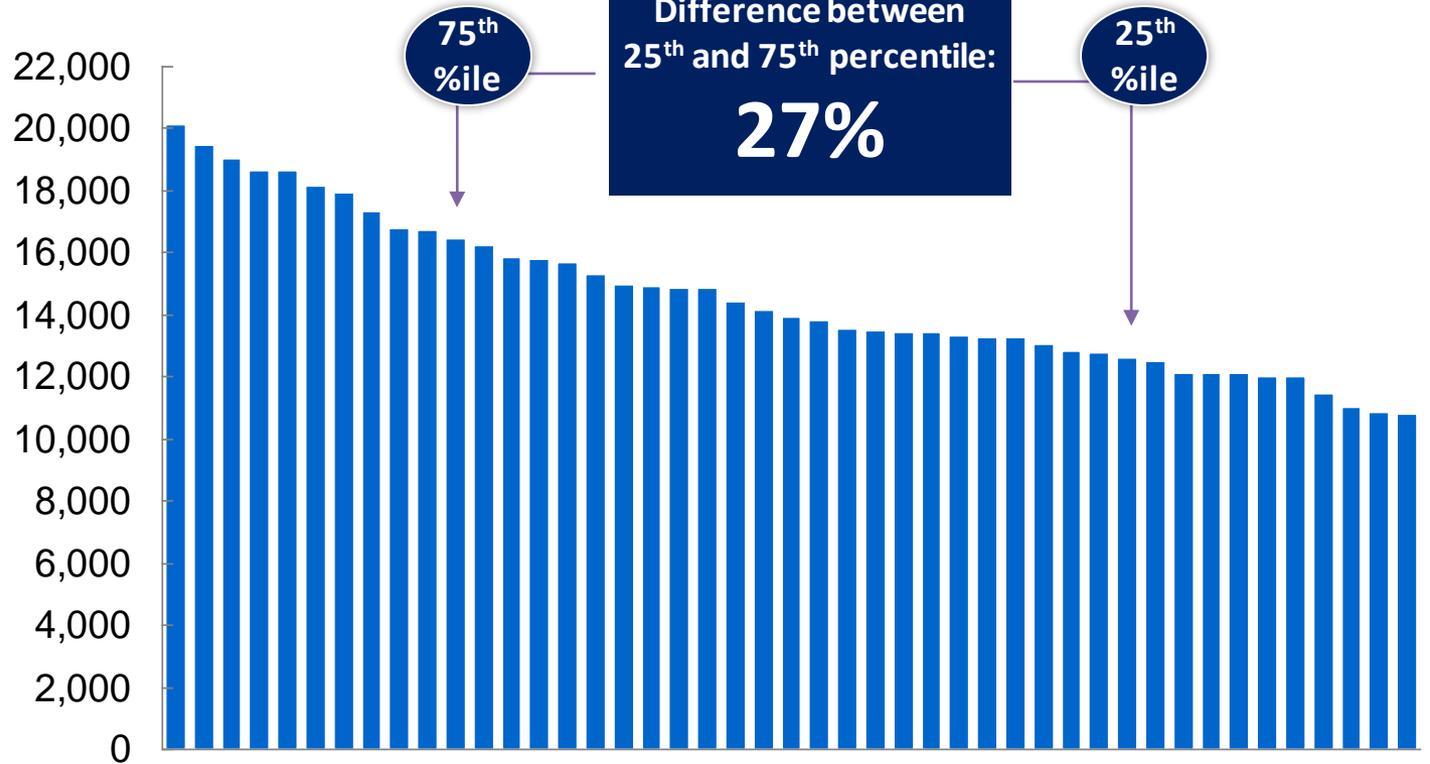
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NOTES: Each vertical bar represents the average risk adjusted cost in dollars per episode (including outliers) for one provider across Medicaid FFS and five Medicaid MCOs; data covers period from July 1, 2013 to June 30, 2014.

# Variation across the Total Joint Replacement episode

Median cost	Non-adjusted: \$17,595
	Risk-adjusted: \$13,947

Difference between 25<sup>th</sup> and 75<sup>th</sup> percentile: **27%**



Principal Accountable Providers (Physician Entities)

## Impact:

- 45 PAPs
- 574 Episodes
- \$10.7 million Spend

## Select Quality Measures:

- 10% Episodes where patient receives one or more blood transfusions
- 1% Episodes where patient develops pulmonary embolism

## Select Risk Adjustments:

- Anemia
- Obesity

## Select Exclusions:

- Inconsistent enrollment
- Presence of 3<sup>rd</sup> party liability
- Lower leg open wounds, fracture or dislocation

## Sources of variability/value:

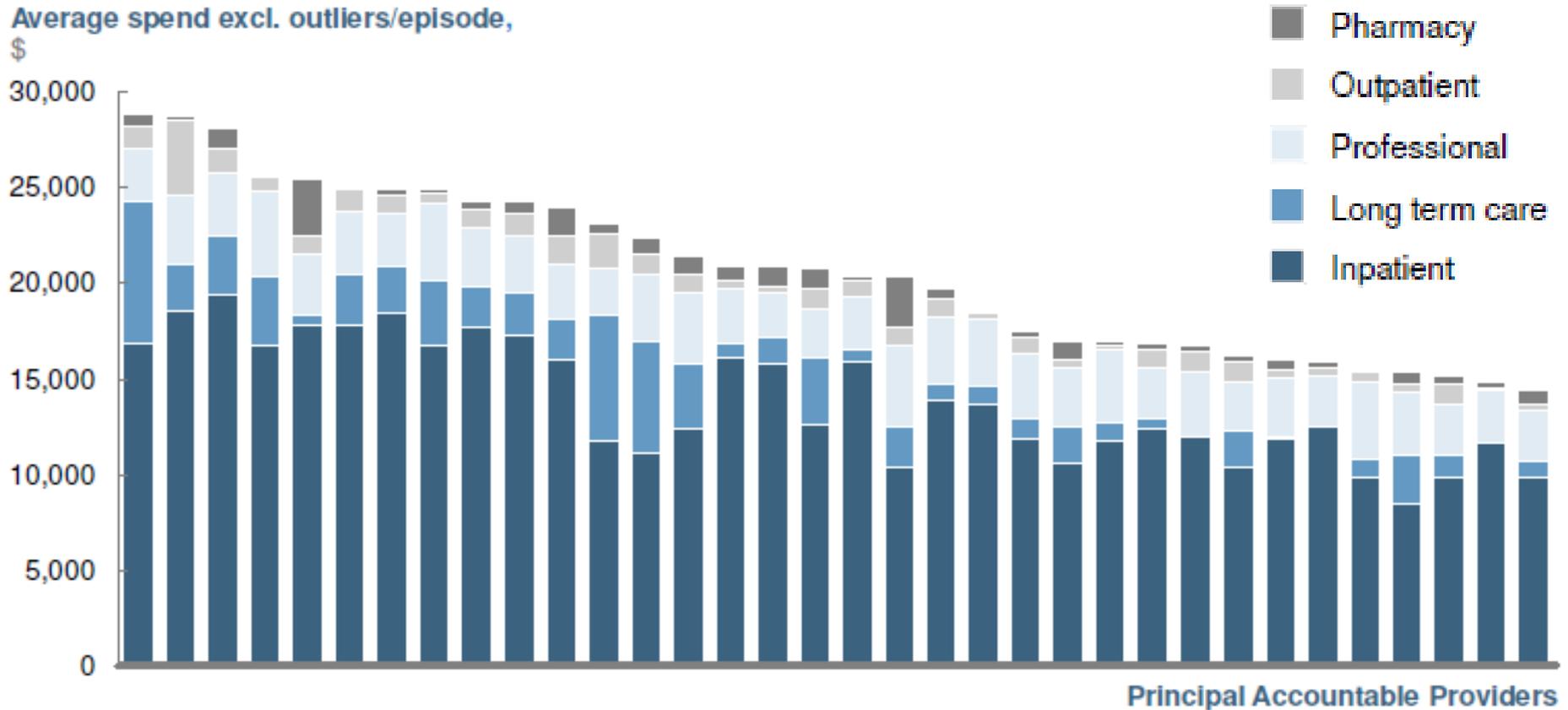
- Imaging choice/utilization
- Setting of care
- Implant choice



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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.

# Total Joint Replacement Episode Distribution by Claim Type



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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.



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

## 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/A<sup>1</sup>

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



### *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