



Governor's Office of  
Health Transformation

# Transforming Payment for a Healthier Ohio

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



# Ohio's Path to Value

<b>Modernize Medicaid</b>	<b>Streamline Health and Human Services</b>	<b>Pay for Value</b>
<i>Initiate in 2011</i>	<i>Initiate in 2012</i>	<i>Initiate in 2013</i>
<i>Advance Governor Kasich's Medicaid modernization and cost containment priorities</i>	<i>Share services to increase efficiency, right-size 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>

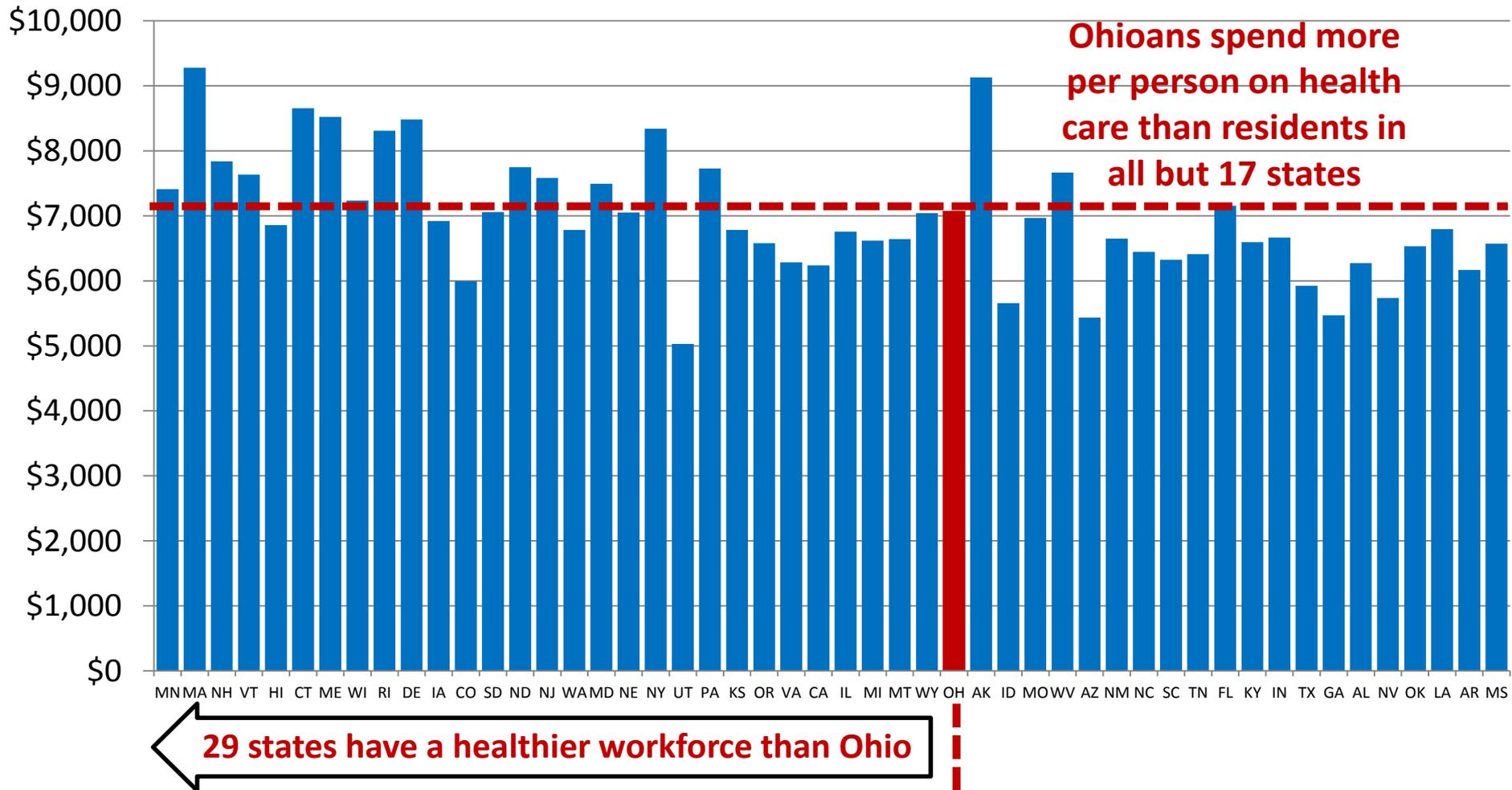


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- 1. Ohio's approach to paying for value instead of volume**
2. Patient-Centered Medical Home (PCMH) Model
3. Episode-Based Payment Model

# 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)

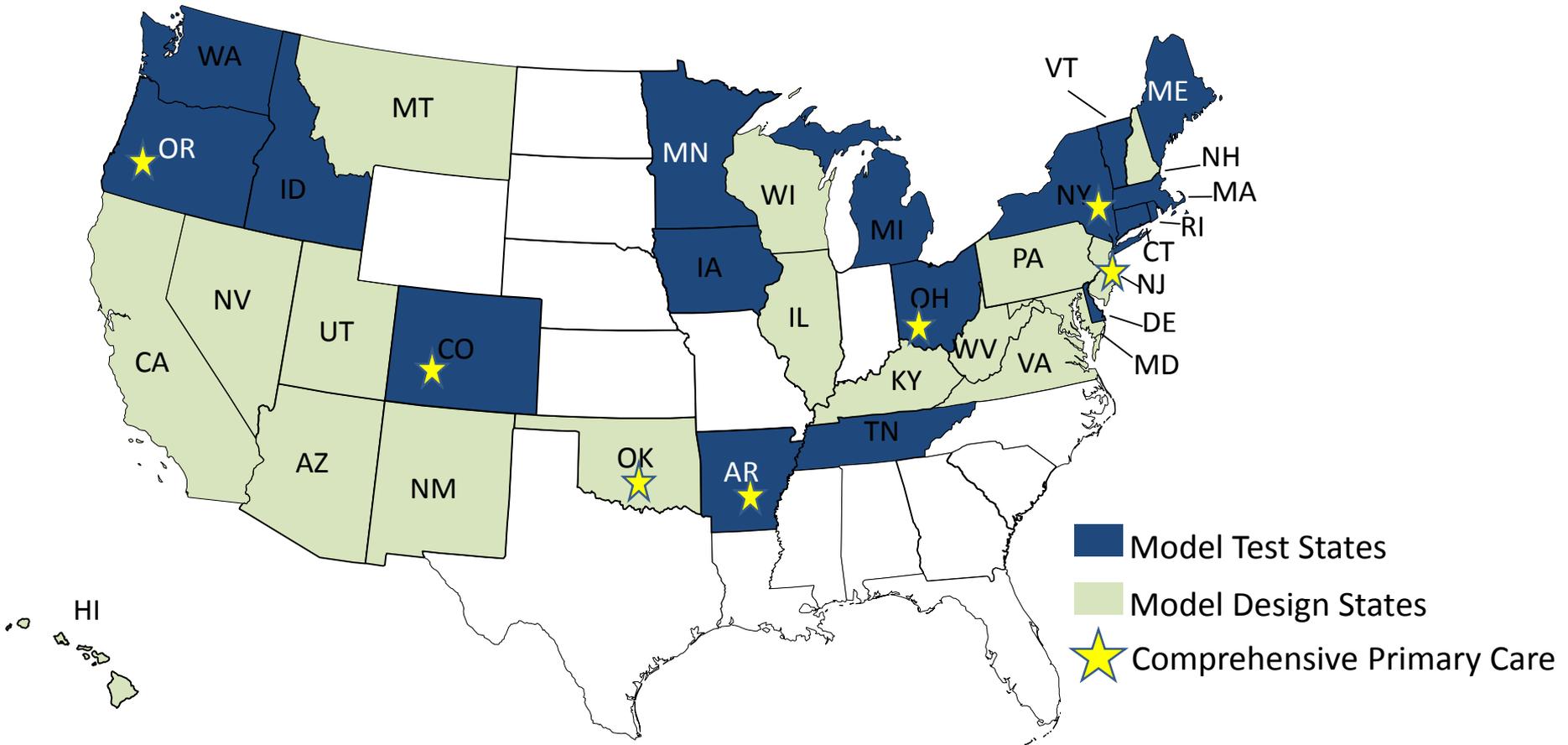


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Sources: CMS *Health Expenditures by State of Residence* (2011); The Commonwealth Fund, *Aiming Higher: Results from a State Scorecard on Health System Performance* (May 2014).



# Ohio is one of 17 states awarded a federal grant 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).

# 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 and at least begun to consider PCMH, episode or ACO 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 broaden 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

# Value-Based Alternatives to Fee-for Service

Fee for Service

Incentive-Based Payment

Transfer Risk

Ohio's State Innovation Model focuses on (1) increasing access to patient-centered medical homes and (2) implementing episode-based payments

Fee for Service

Pay for Performance

Patient-Centered Medical Home

Episode-Based Payment

Accountable Care Organization

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



# Ohio's approach to multi-payer alignment

## "Standardize"

Standardize approach with an identical design only when:

- In the best interest of patients
- Alignment is critical to provider success or significantly eases implementation for providers
- There are meaningful economies of scale
- Standardization does not diminish sources of competitive advantage among payers
- It is lawful to do so

**Example:**  
**Quality Measures**

## "Align in principle"

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

- It benefits providers to understand where payers are moving in same direction
- Differences have modest impact on providers from an administrative standpoint
- Differences are necessary to account for legitimate differences among payers (varied enrollees, etc.)

**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**

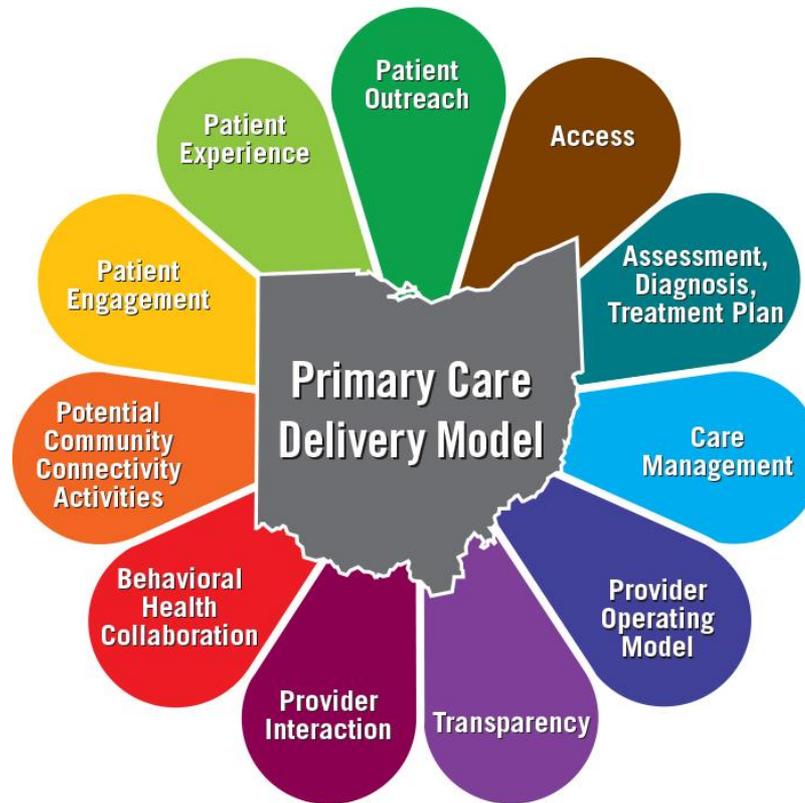


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1. Ohio's approach to paying for value instead of volume
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# Ohio's vision for PCMH is to promote high-quality, individualized, continuous and comprehensive care

- **Patient Experience:**  
Offer consistent, individualized experiences to each member depending on their needs
- **Patient Engagement:**  
Have a strategy in place that effectively raises patients' health literacy, activation, and ability to self-manage
- **Potential Community Connectivity Activities:**  
Actively connect members to a broad set of social services and community-based prevention programs (e.g., nutrition and health coaching, parenting education, transportation)
- **Behavioral Health Collaboration:**  
Integrate behavioral health specialists into a patients' full care
- **Provider Interaction:**  
Oversee successful transitions in care and select referring specialists based on evidence-based likelihood of best outcomes for patient
- **Transparency:**  
Consistently review performance data across a practice, including with patients, to monitor and reinforce improvements in quality and experience



- **Patient Outreach:**  
Proactive, targeting patients with focus on all patients including healthy individuals, those with chronic conditions, and those with no existing PCP relationship
- **Access:**  
Offer a menu of options to engage with patients (e.g., extended hours to tele-access to home visits)
- **Assessment, Diagnosis, Care Plan:**  
Identify and document full set of needs for patients that incorporates community-based partners and reflects socioeconomic and ethnic differences into treatment plans
- **Care Management:**  
Patient identifies preferred care manager, who leads relationship with patients and coordinates with other managers and providers of specific patient segments
- **Provider Operating Model:**  
Practice has flexibility to adapt resourcing and delivery model (e.g., extenders, practicing at top of license) to meet the needs of specific patient segments

# “Health care homes save Minnesota \$1 billion”

State-certified patient-centered health care home performance (2010-2014) compared to other Minnesota primary care practices ...

- Better quality of care for diabetes, vascular, asthma (child and adult), depression, and colorectal cancer screening
- Significantly smaller racial disparities on most measures
- Better care coordination for low-income populations
- Major decrease in the use of hospital services
- Saved \$1 billion over four years, mostly Medicaid (\$918 million), but also Medicare (\$142 million)

# Payer alignment on PCMH requirements in Ohio

## “Standardize”

- 1 4 start-up requirements
- 2 8 ongoing requirements
- 3 4-6 efficiency measures
- 4 20 clinical quality measures

Consistent public **messaging** of Ohio’s PCMH model

Commitment to 30-40% patient volume in the PCMH model **by 2018**, and >80% when fully implemented

- PCMH enrollment does not require EHR or accreditation

## “Align in principle”

An ongoing stream of **new funds to support clinical and operational activities** that are currently not compensated or undercompensated

- Sufficient to compensate for the new clinical activities required by PCMH
- At risk based on performance on standard processes and activities, clinical quality, and efficiency metrics

- 5 A stream of gain-sharing payment to **award PCMHs for lowering total cost of care**

**Attribution** model that aligns all members with a PCMH

## “Differ by design”

**Payment levels** for new payment streams

**Thresholds and risk adjustment methodology** for payment streams

# PCMH payment streams tied to specific requirements

## Requirements

### 1 4 start-up requirements

- Risk stratification methodology
- Practice uses a team
- Care management infrastructure
- Relationship continuity process

### 2 8 ongoing requirements

- 24/7 access
- Same-day appointments
- Risk stratification used
- Population management
- Care plans developed and updated
- Follow up after hospital discharge
- Tracking of follow up tests and specialist referrals
- Patient experience assessed

### 3 Efficiency Measures

- ED visits
- Inpatient admissions for ambulatory sensitive conditions
- Generic dispensing rate of select classes
- Behavioral health related inpatient admits
- Episodes-linked metric

### 4 20 Clinical Measures

- Clinical measures aligned with CMS/AHIP core standards for PCMH

### 5 Total Cost of Care

## Payment Streams

PCMH  
PMPM

*Scoring weight shifts from standard processes and activities...*

*...to efficiency and clinical quality over time*

PCMH  
Shared  
Savings

*"Must have" processes target access to care*

*Quality gate*

*Based on self-improvement & performance relative to peers*

## Ohio's statewide PCMH rollout

- Spring 2016 – finalize PCMH care delivery and payment model
- Throughout 2017 – recruit primary care practices to commit to the PCMH model and support practice transformation
- January 1, 2018 – performance period begins for:
  1. Operational activities PMPM
  2. Quality and financial-outcomes based payment
  3. One-time practice transformation support for some practices
- Fall 2016 – exploring an early enrollment process beginning January 1, 2017 for some already-accredited PCMHs





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# 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

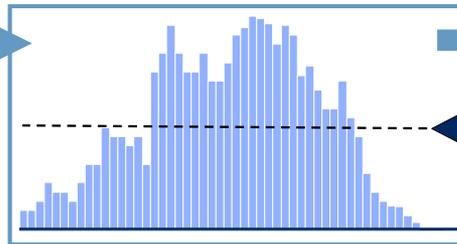
4



Review claims from the performance period to identify a **'Principal Accountable Provider'** (PAP) for each episode

5

Payers calculate **average risk-adjusted reimbursement per episode** for each PAP



**Compare** to predetermined "commendable" and "acceptable" levels

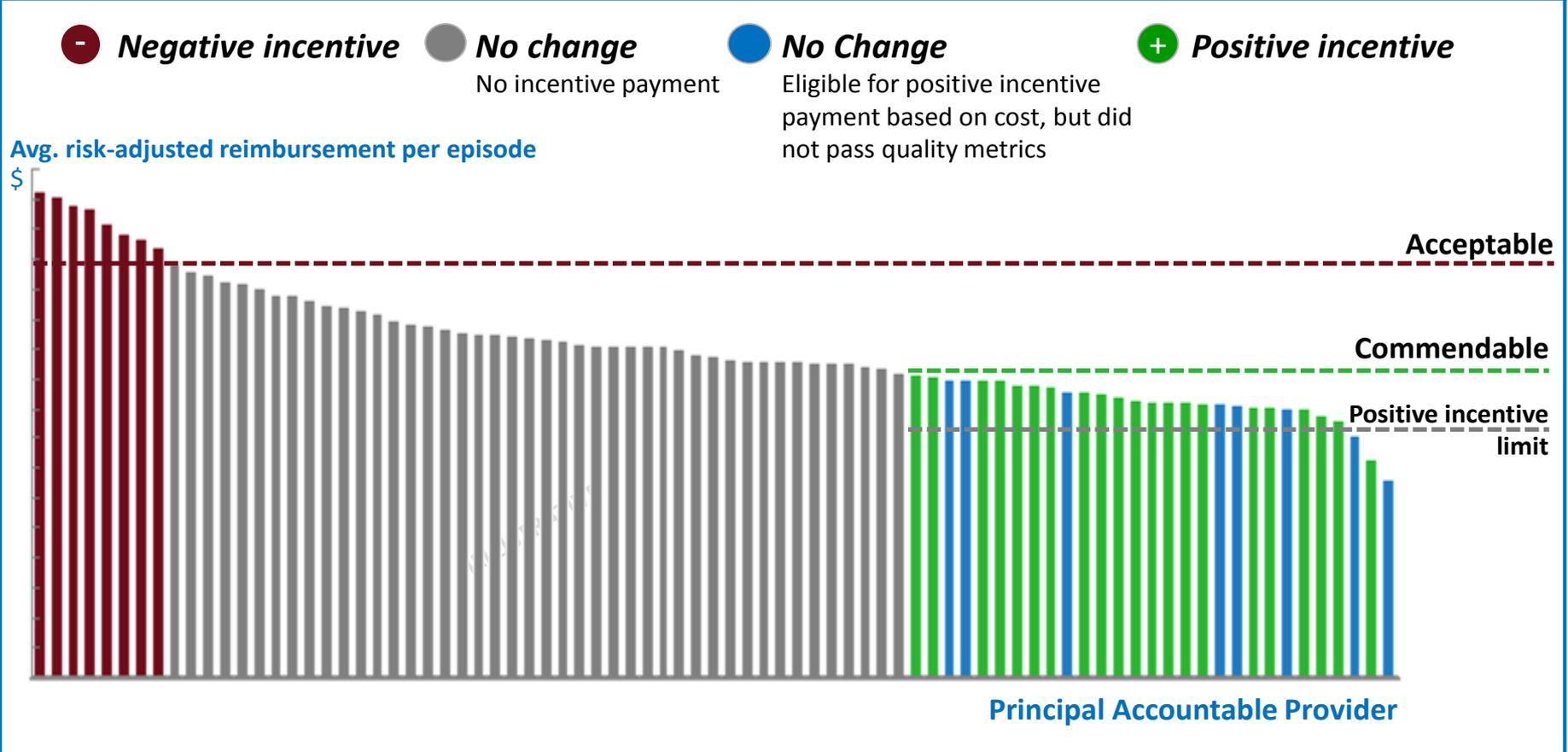
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**Providers may:**

- **Share savings:** if average costs below commendable levels and quality targets are met
- **Pay negative incentive:** if average costs are above acceptable level
- **See no impact:** if average costs are between commendable and acceptable levels

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

## Provider cost distribution (average risk-adjusted reimbursement per provider)



# 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                           |
| 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 |

# All of the details to run the first 13 episodes are available online

## Summary definitions

- Overview of definitions resulting from clinical advisory group process
- 2-page overview of all design elements

## Detailed business requirements

- Detailed word file including all of the specifics required to code an algorithm

## Code sets

- Excel file containing specific diagnosis and procedure codes used for trigger, included claims, exclusions, risk adjustment, etc.

The collage displays several key documents:

- Perinatal episode definition (1/2):** A document defining the episode base definition, episode trigger (A delivery Pk code and a conatory live birth Dx on any claim by), episode window (episodes begin 280 days before the date of delivery, episodes end 60 days after discharge from the delivery facility), claims included (during pre-trigger window, trigger window, and post-trigger window), and principle accountable provider.
- Perinatal episode definition (2/2):** A document detailing risk adjustment factors for use in risk adjustment, episode exclusions (business, clinical, and quality metrics), and quality metrics for reporting.
- Detailed Business Requirements Perinatal episode:** A word document (dated 8/14/2016) providing specific requirements for code an algorithm, including definitions for pre-trigger, trigger, and post-trigger windows, and rules for included and excluded claims.
- Excel spreadsheet:** A table with columns for ICD-10 code, design element, design dimension, design subcategory, date, code description, code type, and time period. It lists various medical conditions and their corresponding codes used in the algorithm.

<http://medicaid.ohio.gov/providers/PaymentInnovation.aspx>

# EPISODE of CARE PROVIDER REPORT

EPISODE NAME

Q1 + Q2 YYYY

Reporting period covering episodes that ended between Start Date to End Date

PAYER: Payer Name

PROVIDER ID: PAP ID

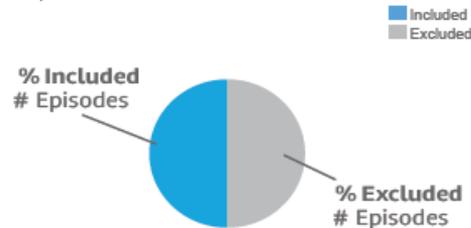
PROVIDER: Provider Name

## Eligibility requirements for gain or risk-sharing payments

- ✔ **Episode volume:** You have at least 5 episodes in the current performance period.
- ✔ **Spend:** Your average risk-adjusted spend per episode is below the commendable threshold.
- ⚠ **Quality:** You are not currently eligible for gain-sharing because you have not passed all quality metrics linked to gain-sharing.
- i **This report is informational only.** Eligibility for gain or risk-sharing will be determined at the end of the performance period and any applicable payments will be calculated at that time.

## Episodes included, excluded & adjusted

Total episodes#



# % of your episodes have been risk adjusted

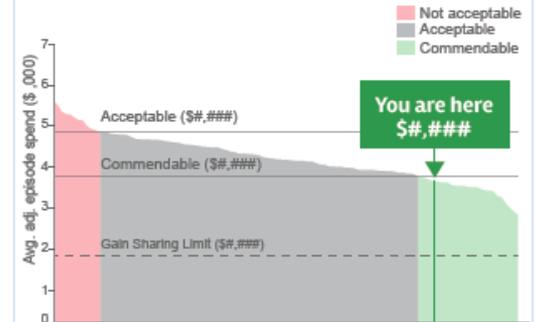
## Quality metrics

You achieved # of # quality metrics linked to gain sharing

Quality metric 01	#%	✔
Quality metric 02	#%	✔
Quality metric 03	#%	✘
Quality metric 04	#%	✘

## Risk adjusted average spend per episode

Distribution of provider average episode spend (risk adj.)



## Key performance

Rolling four quarters

	Performance period 2016		Reporting period 2015		
	Q3 '15	Q4 '15	Q1 '16	Q2 '16	Weighted average
Avg adjusted episode spend (\$ ,000)	#,###	#,###	#,###	#,###	#,###
# of included episodes	#	#	#	#	#
Your spend percentile	#%	#%	#%	#%	#%

*This is an example of the multi-payer performance report format released in 2016*

DISCLAIMER: The information contained in these reports is intended solely for use in the administration of the Medicaid program. The data in the reports are neither intended nor suitable for other uses, including the selection of a health care provider. The figures in these reports are preliminary and are subject to revision. For more information, please visit <http://medicaid.ohio.gov/Providers/PaymentInnovation.aspx>.



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# Selecting the next waves 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*

### ***WAVE 3 (launch January 2017)***

### ***Preliminary list of potential episodes to design in 2016:***

HIV	Hepatitis C	Neonatal
Hysterectomy	Bariatric surgery	Diabetic ketoacidosis
Lower back pain	Headache	CABG
Cardiac valve	congestive heart failure	Breast biopsy
Breast cancer	Mastectomy	Otitis
Simple pneumonia	Tonsillectomy	Shoulder sprain
Wrist sprain	Knee sprain	Ankle sprain
Hip/Pelvic fracture	Knee arthroscopy	Lumbar laminectomy
Spinal fusion exc. cervical	Hernia procedures	Colon cancer
Pacemaker/defibrillator	Dialysis	Lung cancer
Bronchiolitis and RSV pneumonia		

### ***WAVE 4 (launch January 2018)***

***Design work begins on behavioral episodes in June 2016 ...***



## 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

## State Innovation Model:

- Overview Presentations
- Patient-Centered Medical Home (PCMH) payment model
- Episode-based payment model
- Population health plan
- Health IT plan