



Governor's Office of
Health Transformation

Transforming Payment for a Healthier Ohio

Greg Moody, Director
Office of Health Transformation

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www.HealthTransformation.Ohio.gov



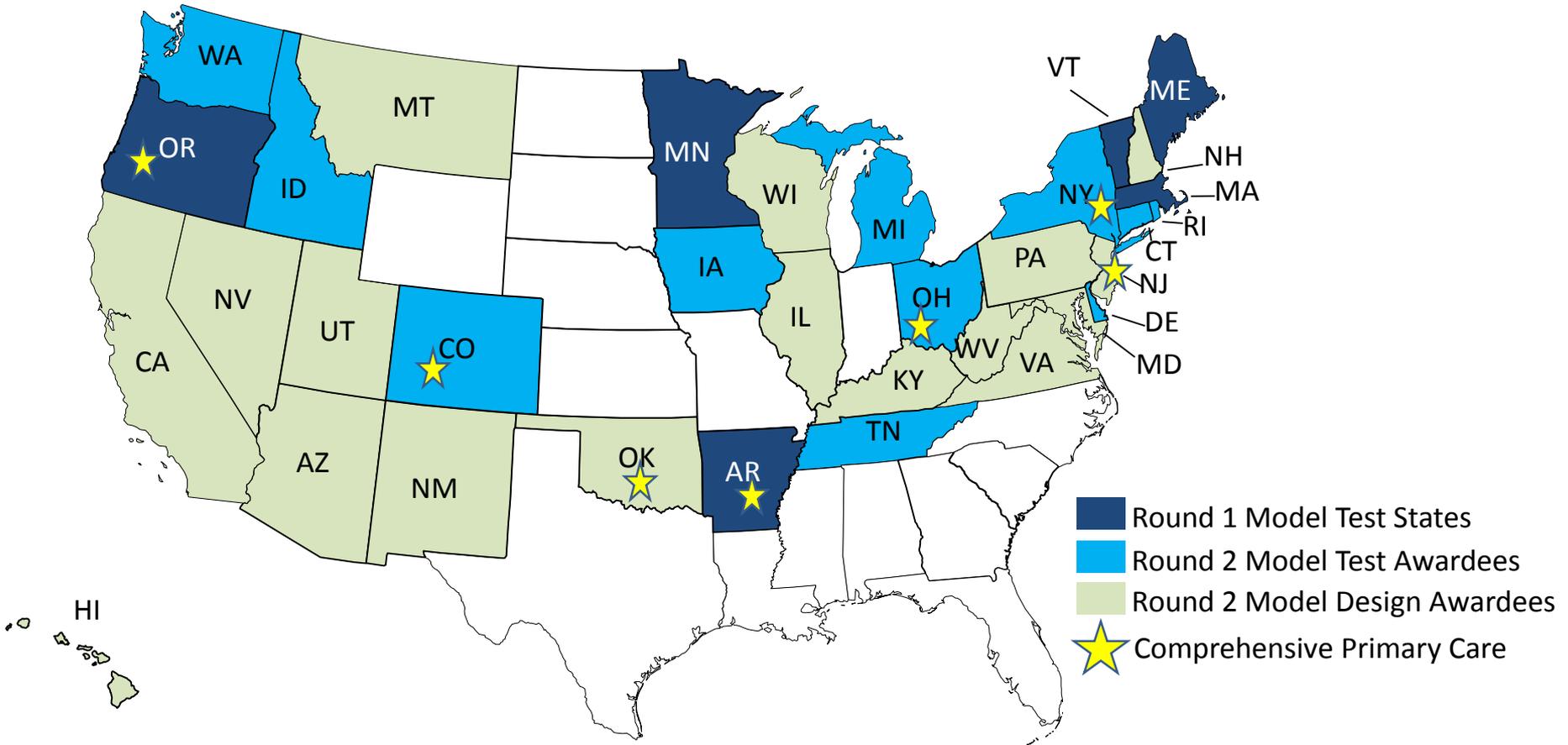
Modernize Medicaid	Streamline Health and Human Services	Pay for Value
<i>Initiate in 2011</i>	<i>Initiate in 2012</i>	<i>Initiate in 2013</i>
<i>Advance the Governor Kasich's Medicaid modernization and cost containment priorities</i>	<i>Share services to increase efficiency, right-size state and local 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"> • Extend Medicaid coverage to more low-income Ohioans • Eliminate fraud and abuse • Prioritize home and community based (HCBS) services • Reform nursing facility payment • Enhance community DD services • Integrate Medicare and Medicaid • Rebuild community behavioral health system capacity • Restructure behavioral health system financing • Improve Medicaid managed care plan performance 	<ul style="list-style-type: none"> • Create the Office of Health Transformation (2011) • Implement a new Medicaid claims payment system (2011) • Create a unified Medicaid budget and accounting system (2013) • Create a cabinet-level Medicaid Department (2013) • Consolidate mental health and addiction services (2013) • Simplify and integrate eligibility determination (2014) • Refocus existing resources to promote economic self-sufficiency 	<ul style="list-style-type: none"> • Join Catalyst for Payment Reform • Support regional payment reform • Pay for value instead of volume (State Innovation Model Grant) <ul style="list-style-type: none"> – Provide access to medical homes for most Ohioans – Use episode-based payments for acute events – Coordinate health information infrastructure – Coordinate health sector workforce programs – Report and measure system performance

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



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).



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:



Agree on degrees of standardization within each model

“Standardize”

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

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

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

Participation	Provider participation Payer participation	} Related to 'scale-up' plan for episodes
Accountability	Providers at risk – Number Providers at risk – Type of provider(s) Providers at risk – Unique providers Cost normalization approach	
Payment model mechanics	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	
Performance management	Absolute performance rewards – Gain sharing limit Approach to risk adjustment Exclusions	
Payment model timing	Preparatory/"reporting-only" period Length of "performance" period Synchronization of performance periods	
Payment model thresholds	Approach to thresholds How thresholds change over time Specific threshold levels Degree of gain / risk sharing Cost outliers	

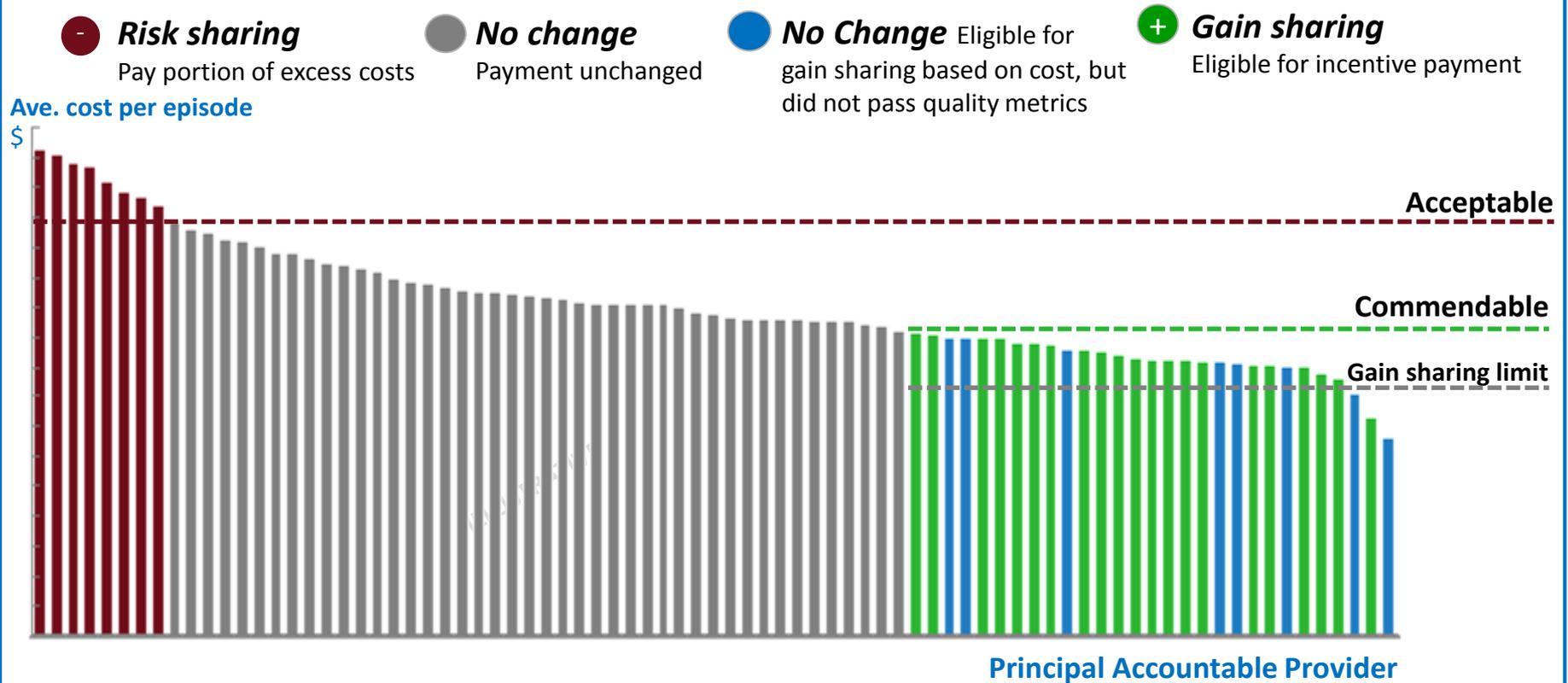
Payment Model Mechanics:

- 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)



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 |

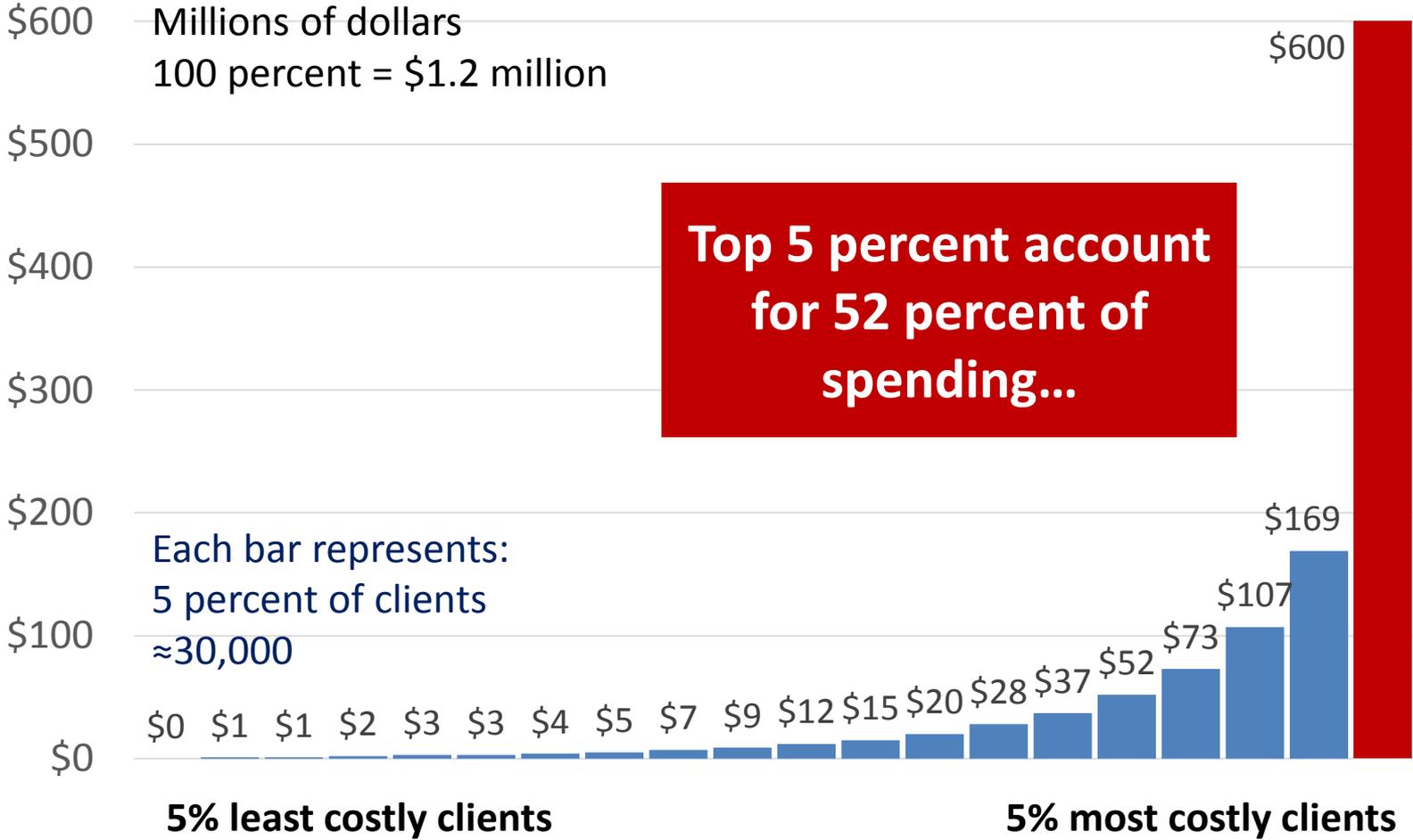
WAVE 2 (launch January 2016)

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

WAVE 3 (launch January 2017)

- 14-19. Package of behavioral health episodes to be determined

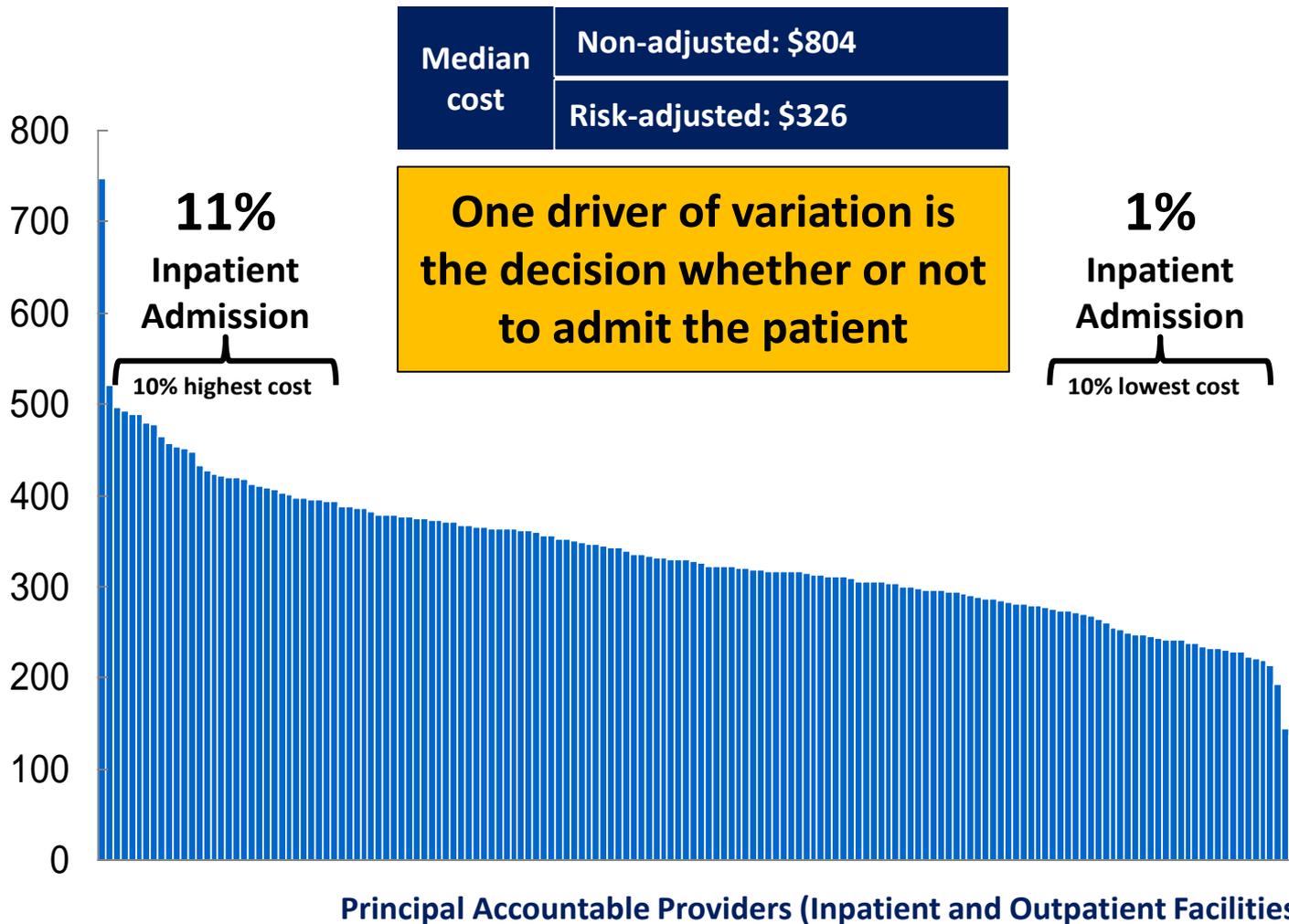
Distribution of Behavioral Health Clients by Spending



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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).

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:

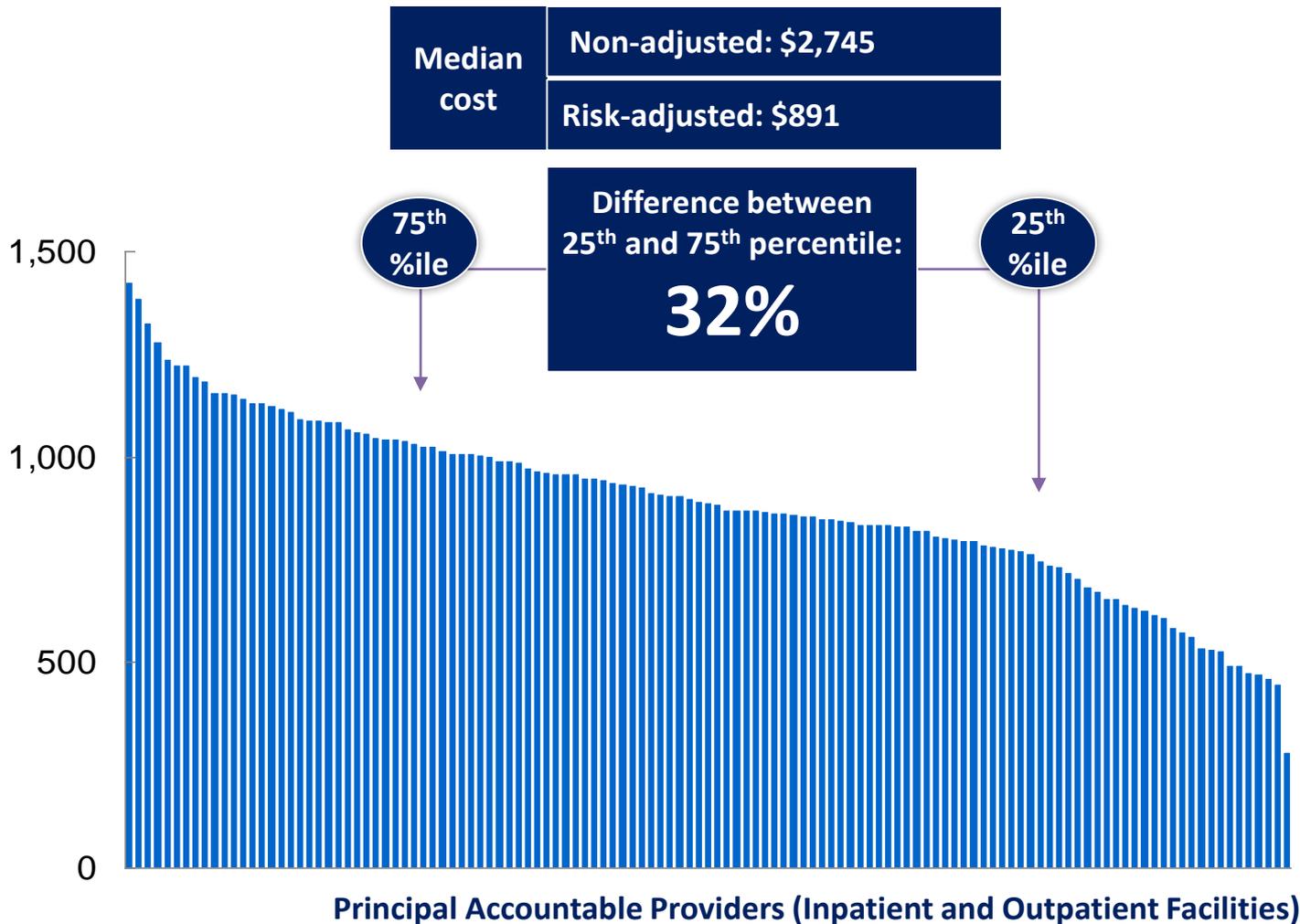
- Age <2 and >64
- Inconsistent enrollment
- ICU stay > 72 hours

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

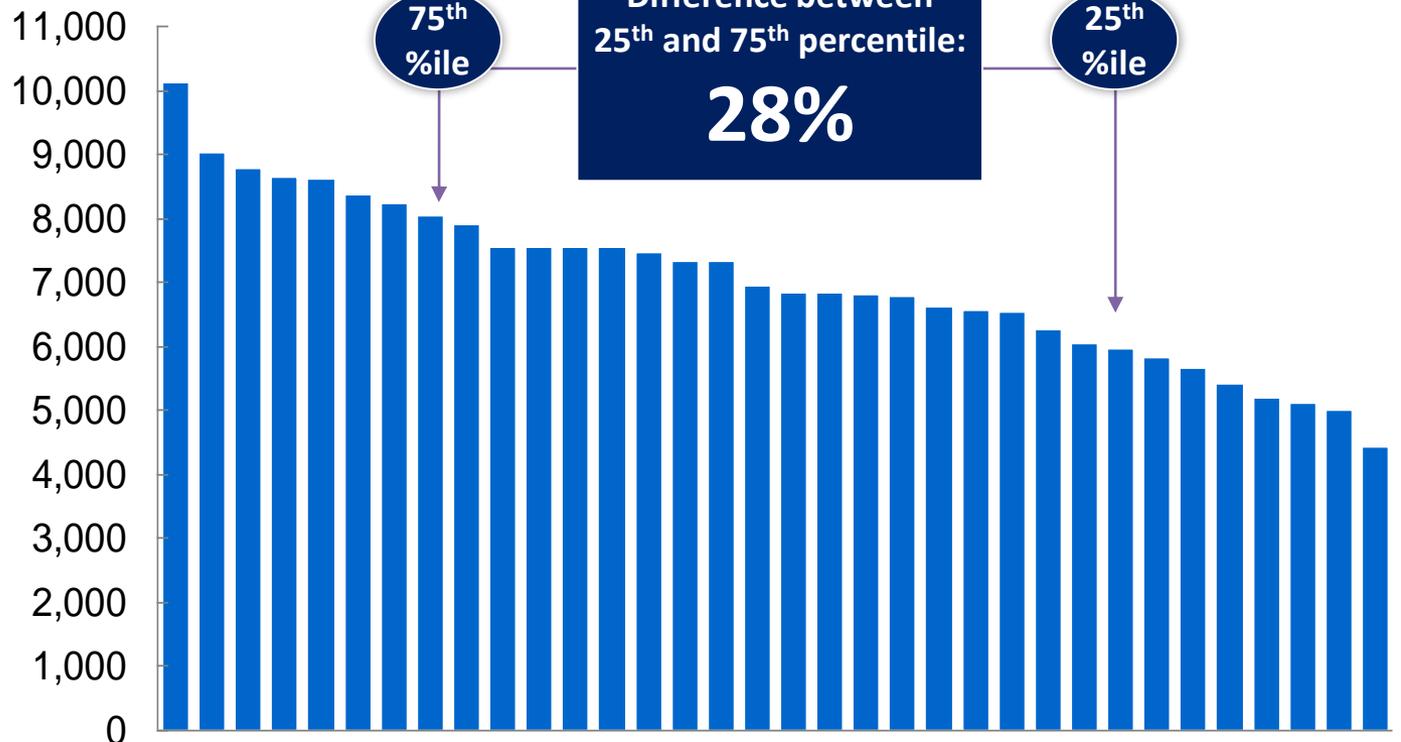
Variation across the Acute PCI episode

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

75th %ile

Difference between 25th and 75th percentile: **28%**

25th %ile



Principal Accountable Providers (Inpatient and Outpatient Facilities)

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:

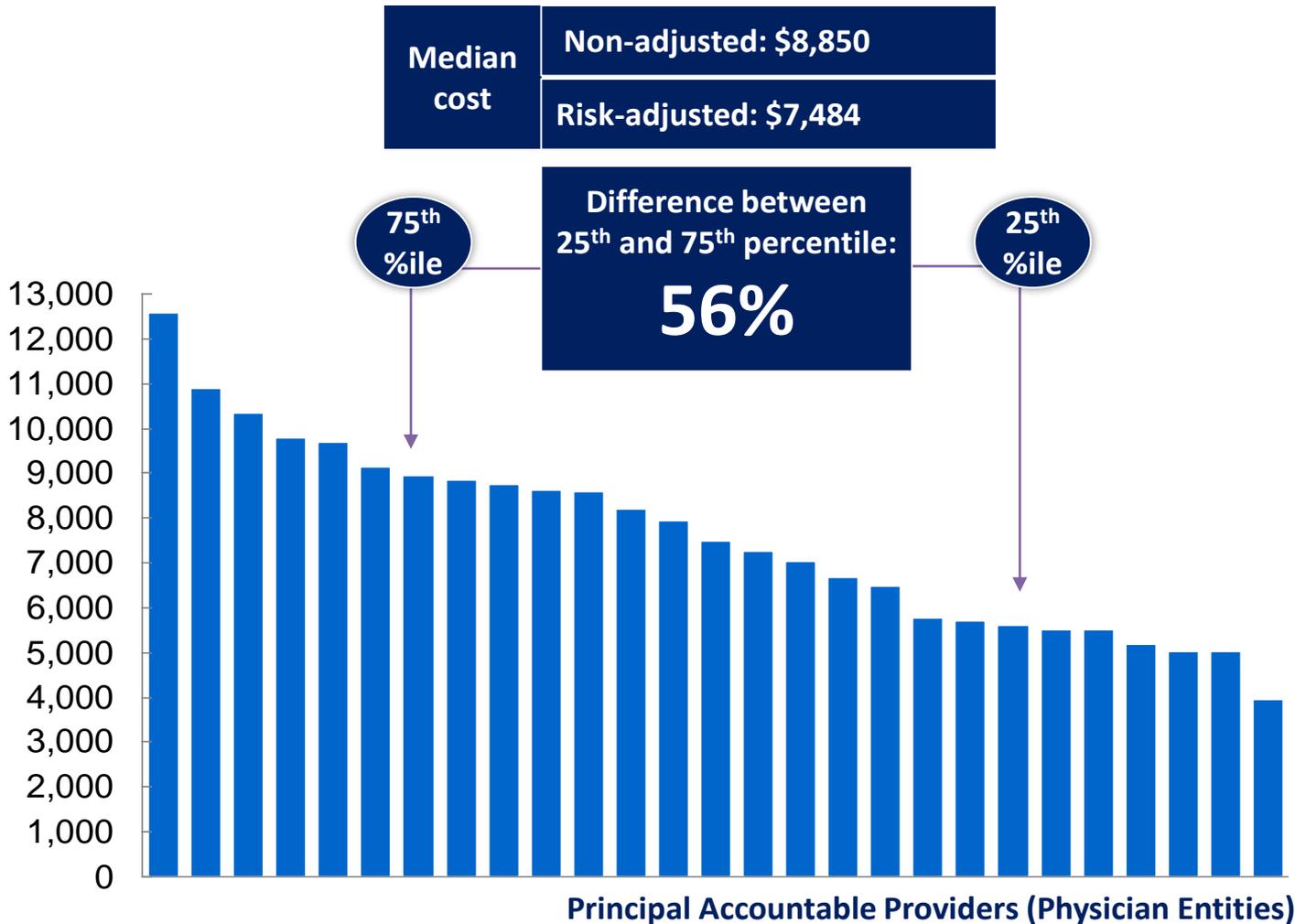
- Diagnostic work-up
- Setting of care
- Complications
- Readmissions



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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

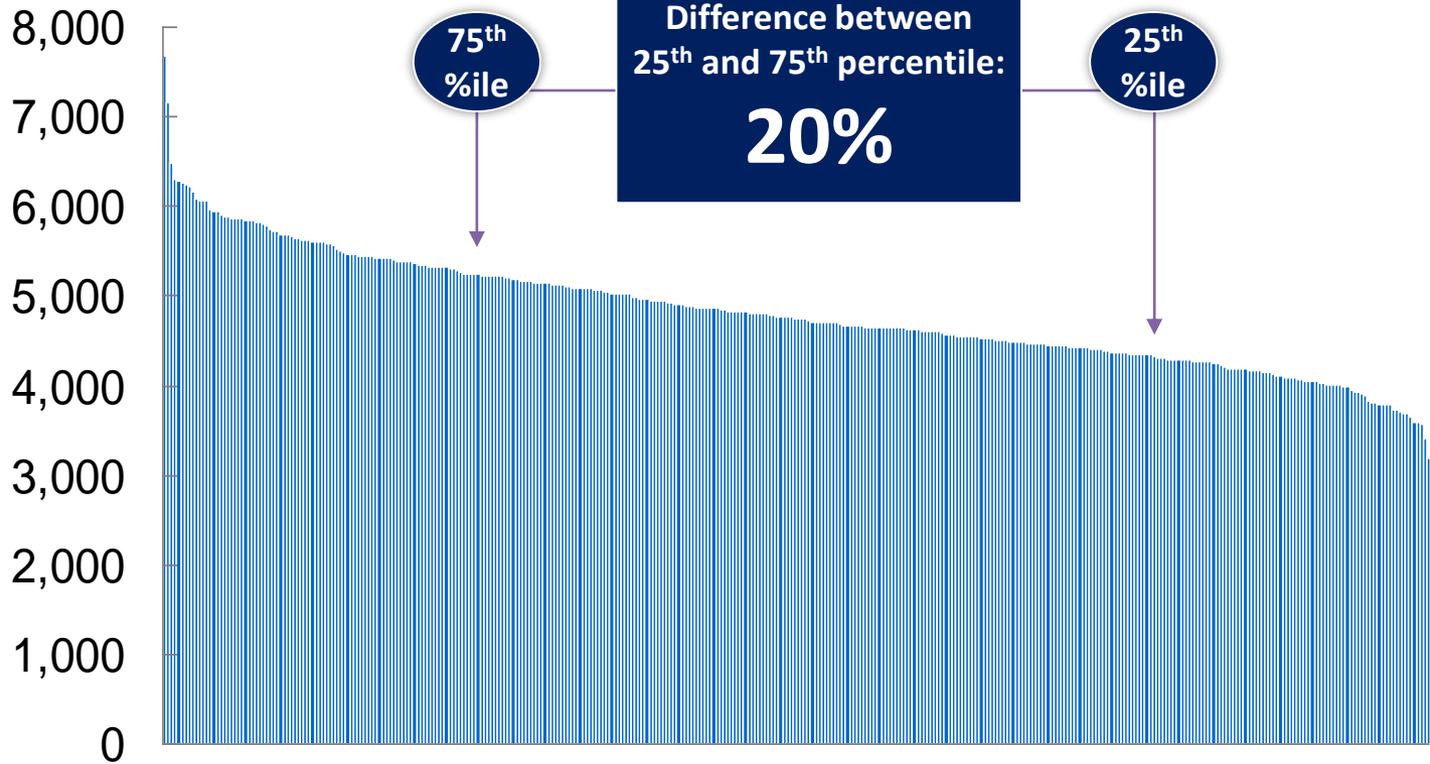
Variation across the Perinatal episode

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

Difference between 25th and 75th percentile: **20%**

75th %ile

25th %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 3rd party liability
- Cystic fibrosis
- Inconsistent enrollment

Sources of variability/value:

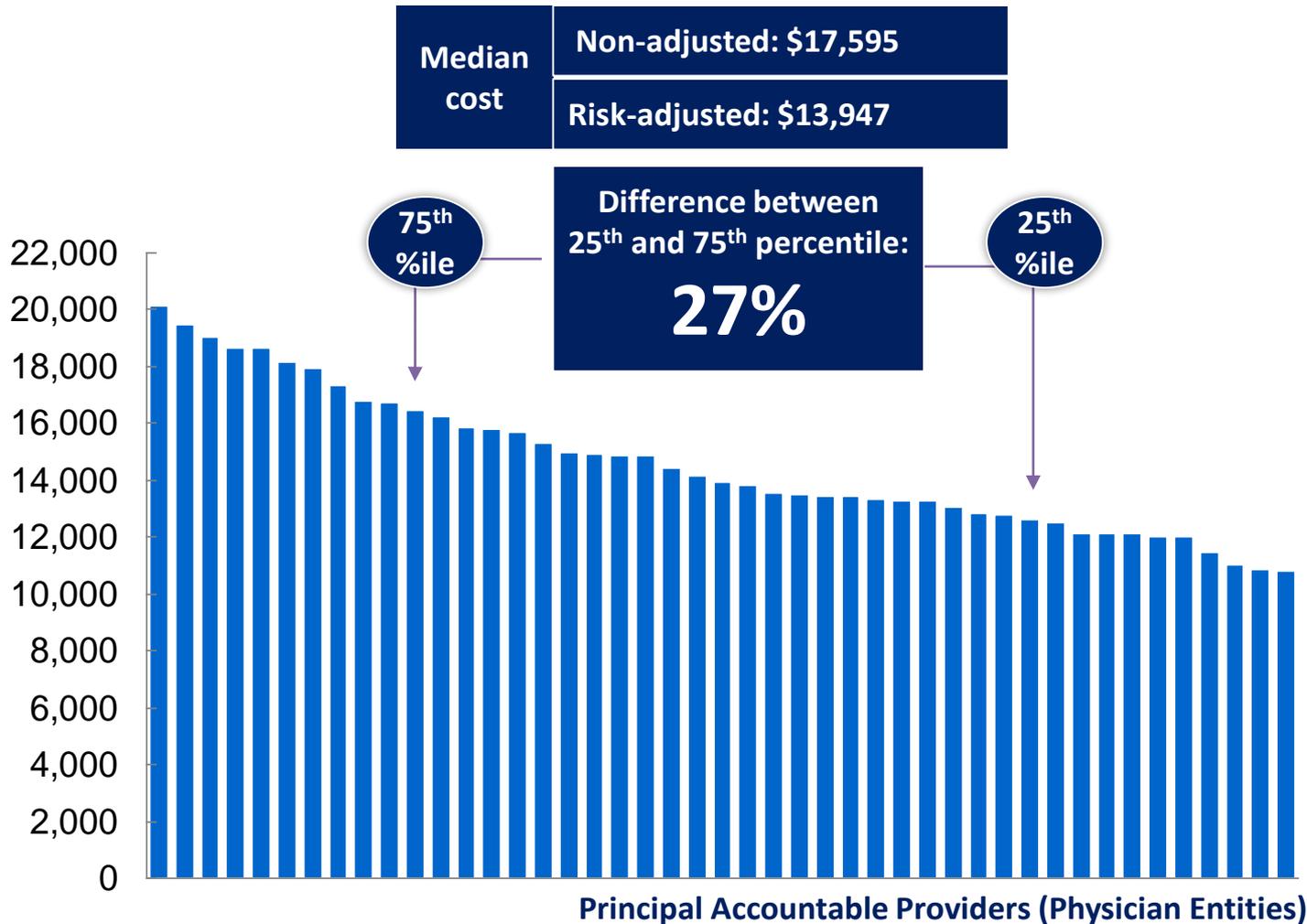
- Elective interventions
- Readmissions



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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



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 3rd 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.

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

Additional Information

- [Overkill](#) by Atul Gawande in *The New Yorker*
- [Payment Innovation Partners](#)
- [Patient-Centered Medical Home Model Details](#)
- [Episode-Based Payment Model Details](#)