



Governor's Office of  
Health Transformation

# Transforming Payment for a Healthier Ohio

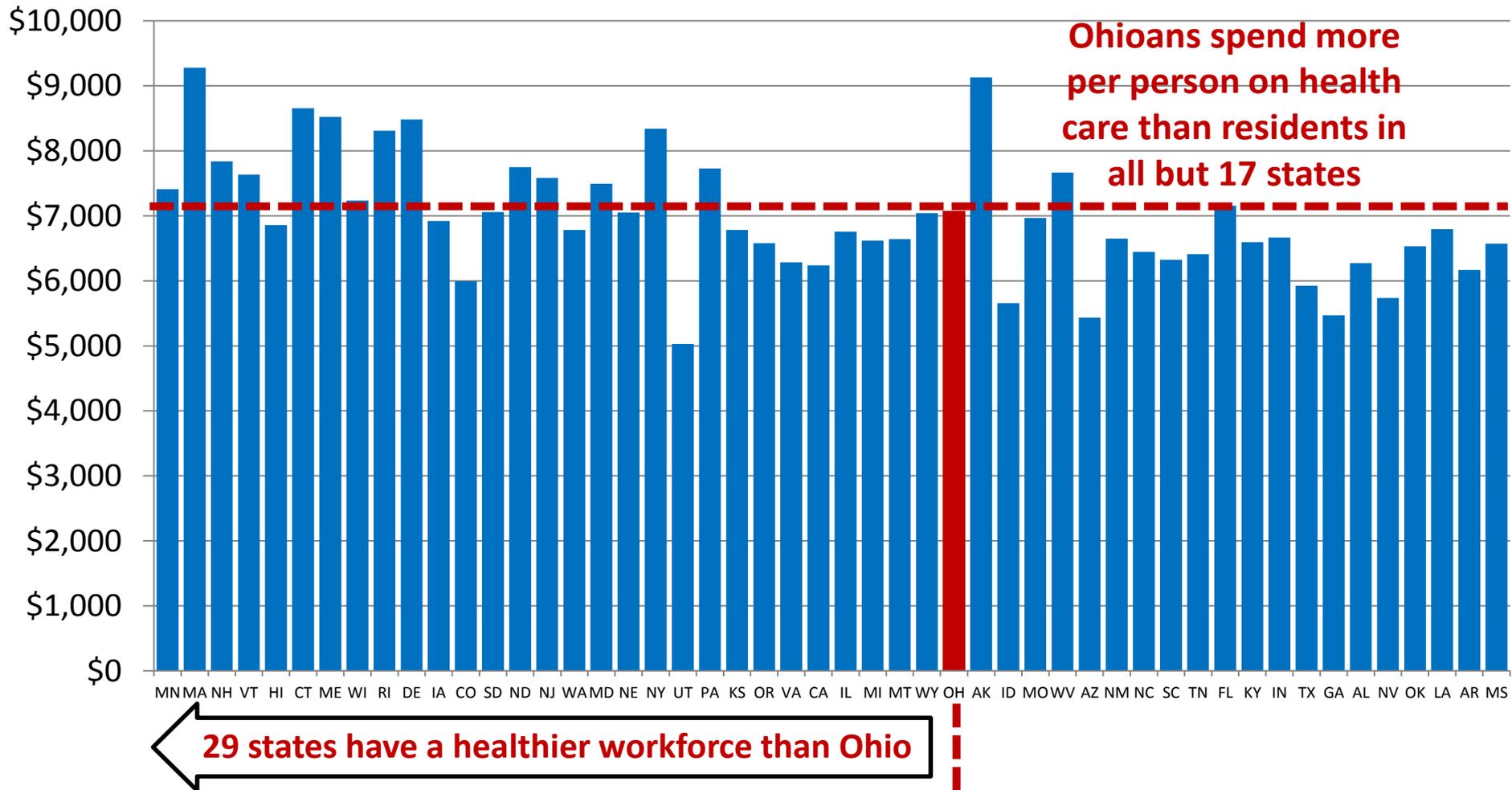
Greg Moody, Director  
Governor's Office of Health Transformation

Anthem Client Meeting  
April 19, 2016

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

## 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

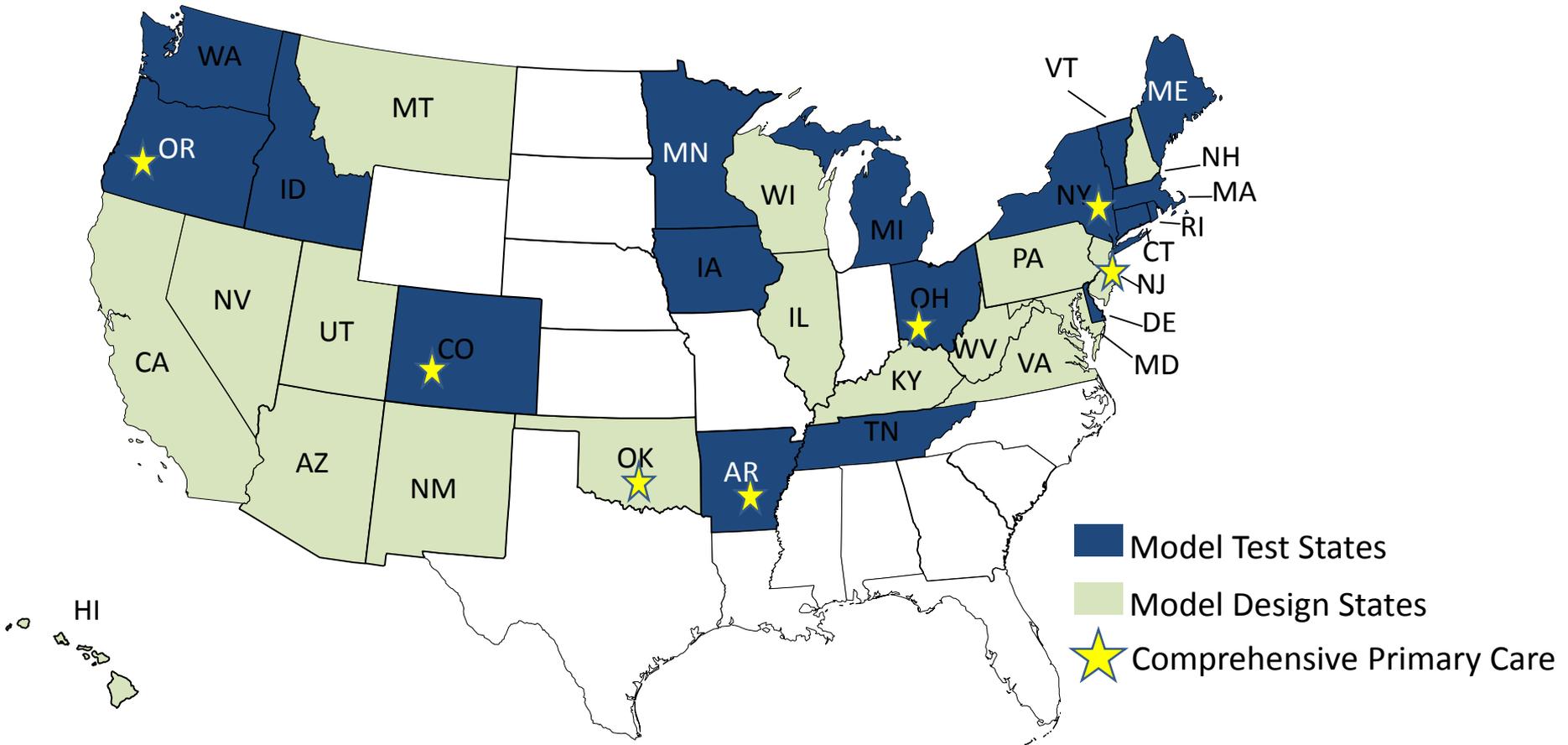


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- 1. Ohio's approach to paying for value instead of volume**
2. Episode-Based Payment Model
3. Comprehensive Primary Care Model



# 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

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Pay for Performance

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





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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

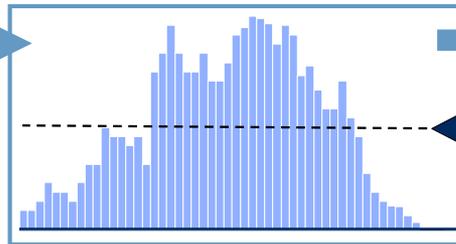
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Review claims from the performance period to identify a **'Principal Accountable Provider'** (PAP) for each episode

5

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



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

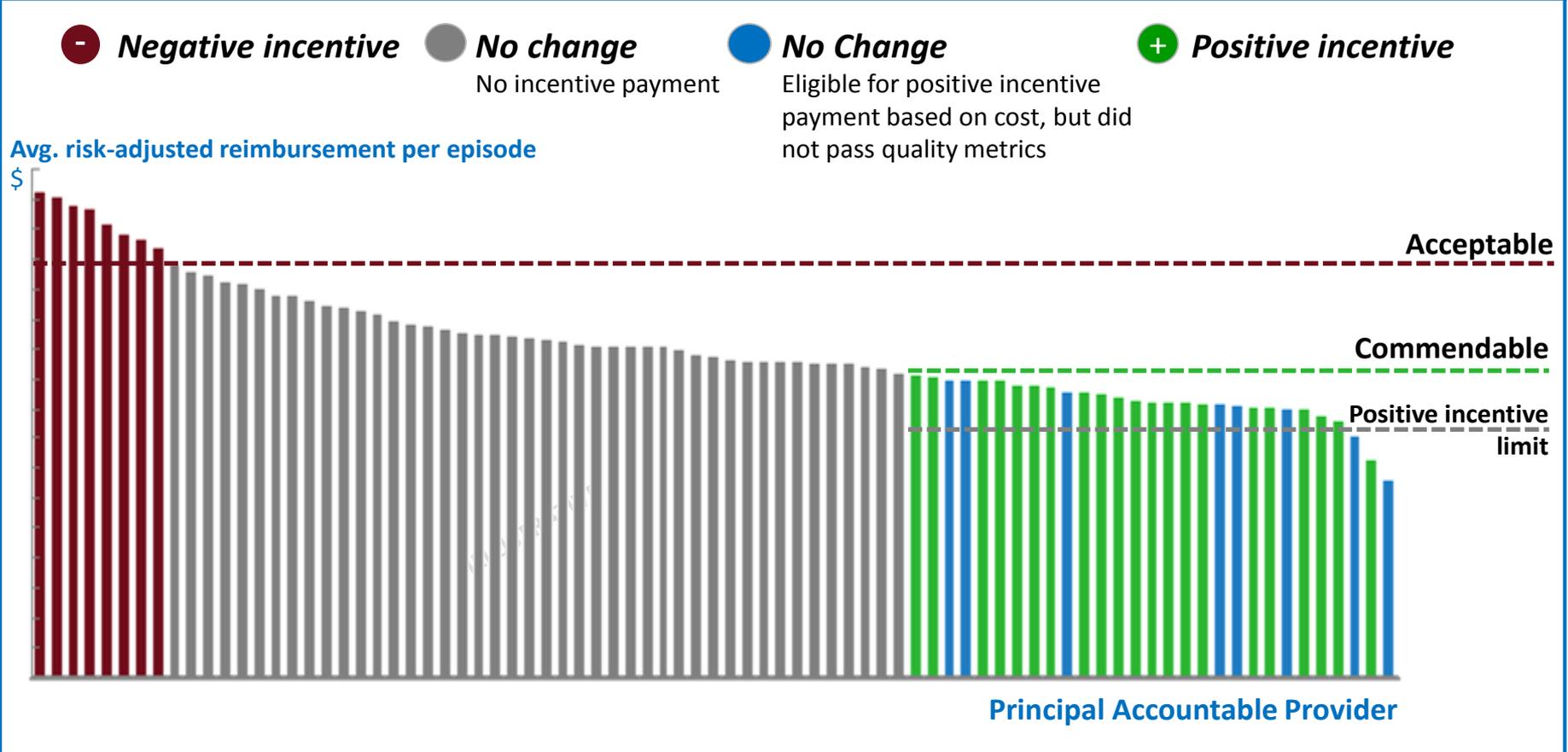
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**Providers may:**

- **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)



# Ohio's episode timeline



**Wave 1** | Perinatal, asthma exacerbation, COPD exacerbation, Acute PCI, Non-acute PCI, total joint replacement

Design (2015) | Reporting only (2016) | Performance Y1 (2017) | Performance Y2 (2018) | Performance Y3 (2019)

**Wave 2** | URI, UTI, cholecystectomy, appendectomy, upper GI endoscopy, colonoscopy, GI hemorrhage

Design (2016) | Reporting only (2017) | Performance Y1 (2018) | Performance Y2 (2019)

**Wave 3** | *Preliminary:* 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

Design (2017) | Reporting only (2018) | Performance Y1 (2019)

**Wave 4** | Design work begins on behavioral health episodes in July 2016 ...

Design (2017-2018) | Reporting Only (2019)

# 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

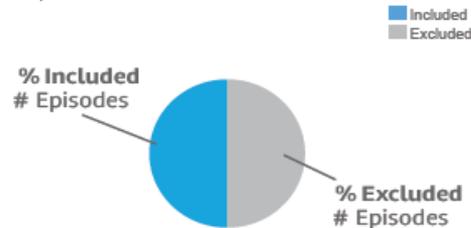
PROVIDER: Provider Name

## 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

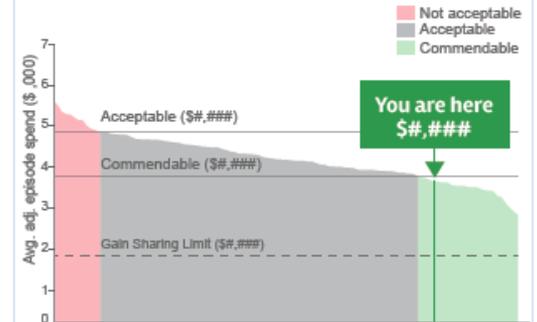
## Quality metrics

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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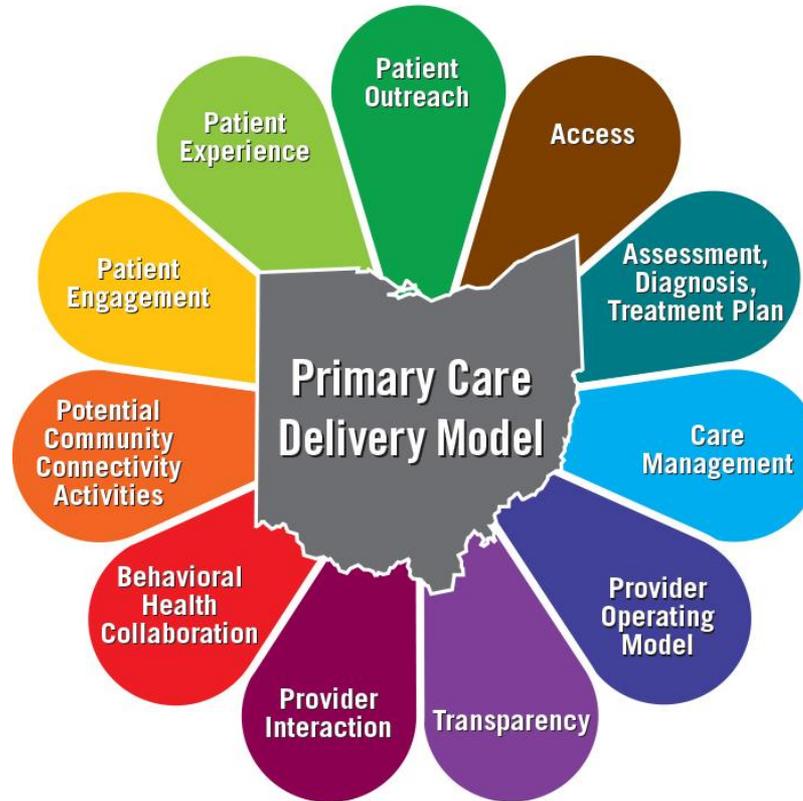


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# Ohio's vision for primary care practices to promote high-quality, individualized, continuous and comprehensive care

- 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

# Payment streams tied to specific requirements

Requirements	<b>1</b> 8 activity requirements <ul style="list-style-type: none"> <li>▪ Same-day appointments</li> <li>▪ 24/7 access to care</li> <li>▪ Risk stratification</li> <li>▪ Population management</li> <li>▪ Team-based care management</li> <li>▪ Follow up after hospital discharge</li> <li>▪ Tracking of follow up tests and specialist referrals</li> <li>▪ Patient experience</li> </ul>	<b>2</b> 5 Efficiency measures <ul style="list-style-type: none"> <li>▪ ED visits</li> <li>▪ Inpatient admissions for ambulatory sensitive conditions</li> <li>▪ Generic dispensing rate of select classes</li> <li>▪ Behavioral health related inpatient admits</li> <li>▪ Episodes-linked metric</li> </ul>	<b>3</b> 20 Clinical Measures <ul style="list-style-type: none"> <li>▪ Clinical measures aligned with CMS/AHIP core standards for PCMH</li> </ul>	<b>4</b> Total Cost of Care
<b>Payment Streams</b>  <b>PMPM</b>	<p style="text-align: center;"><i>Scoring weight shifts from standard processes and activities... ..to efficiency and clinical quality over time</i></p>			
<b>Shared Savings</b>	<p style="text-align: center;"><i>“Must have” activity and efficiency targets</i></p>	<p style="text-align: center;"><i>Quality gate</i></p>	<p style="text-align: center;"><i>Based on self-improvement &amp; performance relative to peers</i></p>	

# “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)

## Ohio's comprehensive primary care rollout

- Spring 2016 – finalize PCMH care delivery and payment model
- Throughout 2017 – recruit primary care practices to commit to Ohio's comprehensive primary care (CPC) model
- January 1, 2018 – performance period begins for:
  1. Activity-based PMPM
  2. Shared Savings
  3. One-time transformation support for some practices
- Fall 2016 – explore an early enrollment process to coincide with the January 1, 2017 start of the Medicare CPC+ program