

Transforming Payment for a Healthier Ohio

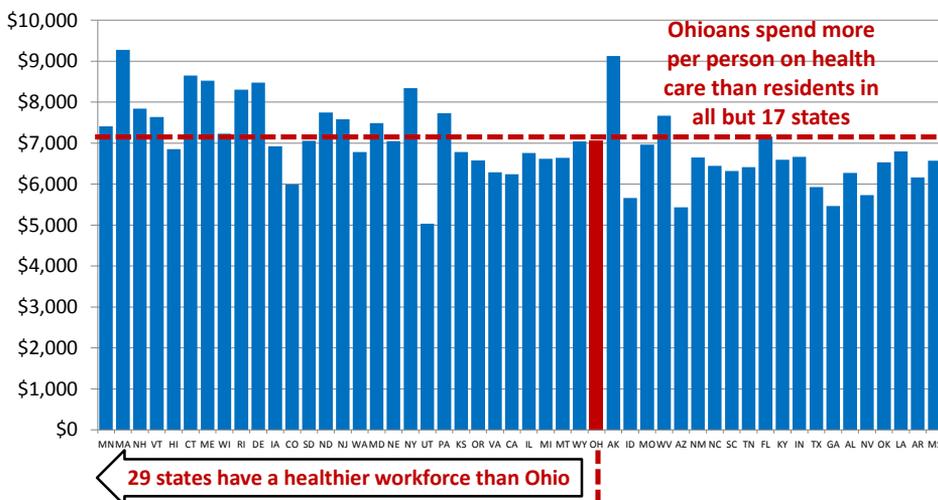
Greg Moody, Director
Governor's Office of Health Transformation

Common Sense Initiative Small Business Advisory Group
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www.HealthTransformation.Ohio.gov

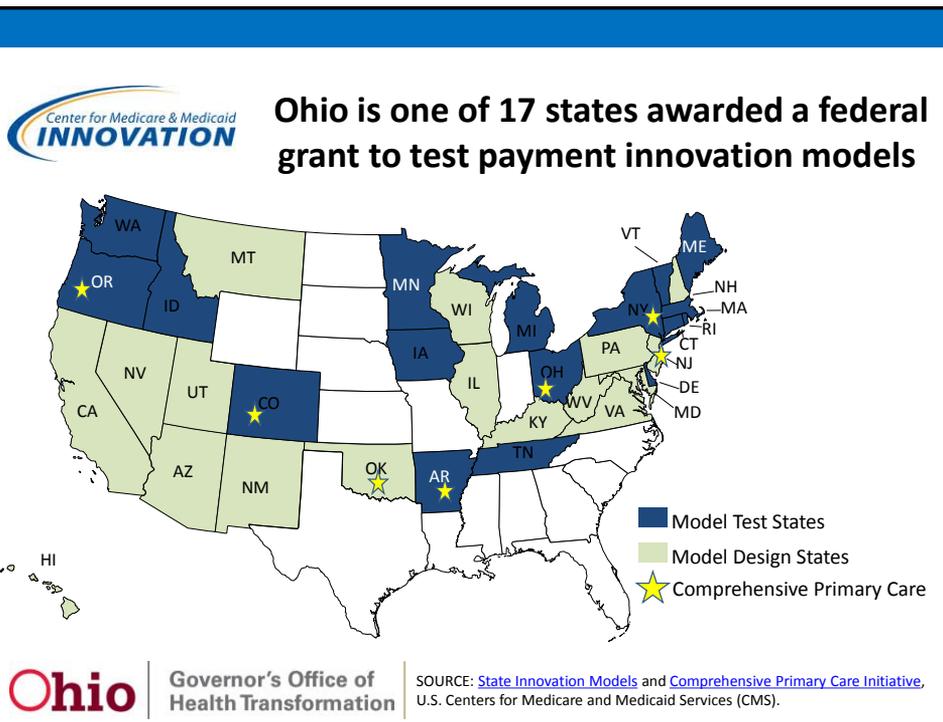
Ohio can get better value from what is spent on health care

Health Care Spending per Capita by State (2011) in order of resident health outcomes (2014)



1. Ohio's approach to paying for value instead of volume

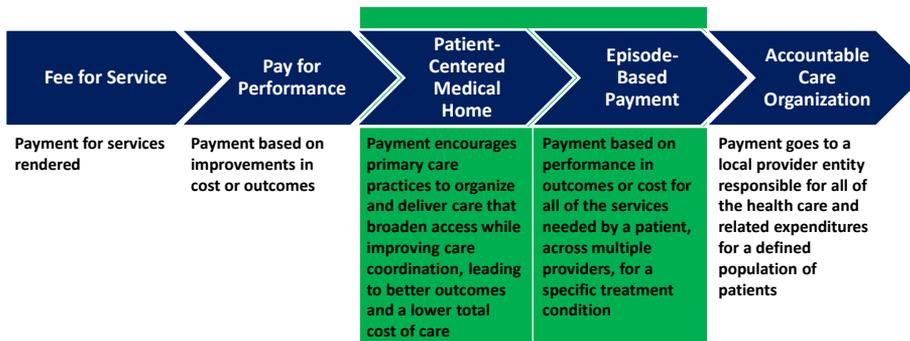
2. Episode-Based Payment Model
3. Comprehensive Primary Care (CPC) Model



Value-Based Alternatives to Fee-for Service



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

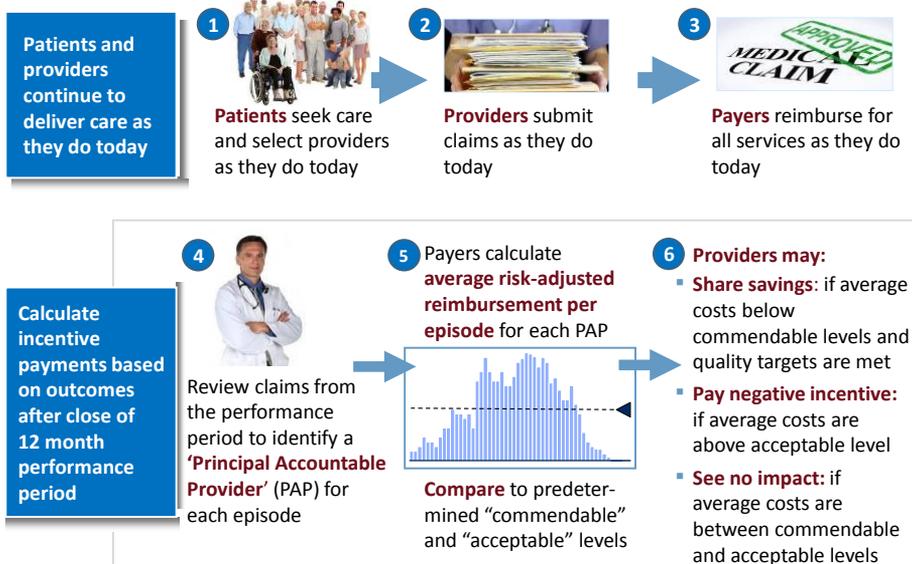


Multi-payer participation is critical to achieve the scale necessary to drive meaningful transformation

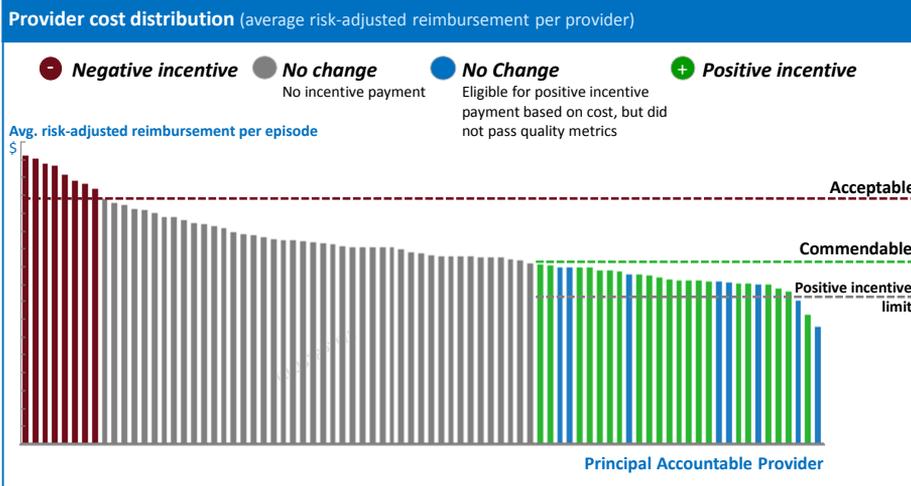


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Retrospective episode model mechanics



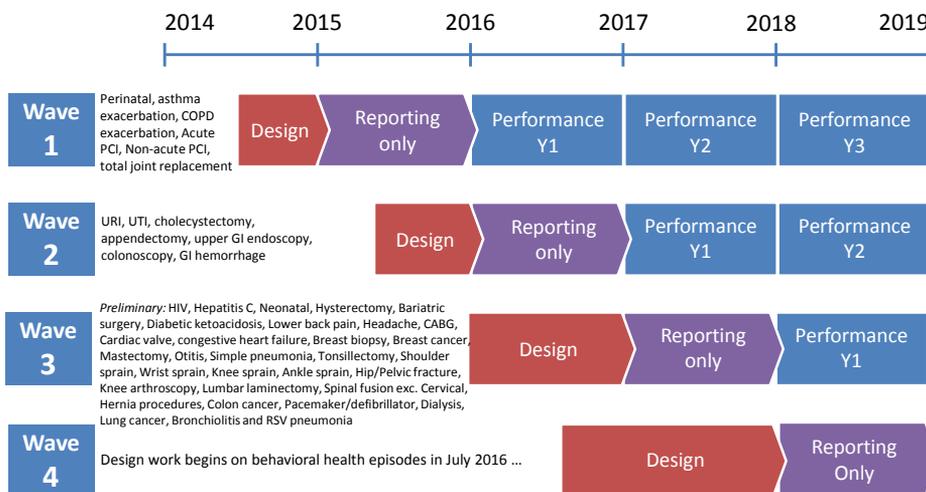
Retrospective thresholds reward cost-efficient, high-quality care



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NOTE: Each vertical bar represents the average cost for a provider, sorted from highest to lowest average cost

Ohio's episode timeline



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



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

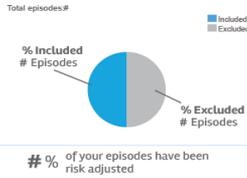
PROVIDER ID: PAP ID

PROVIDER: Provider Name

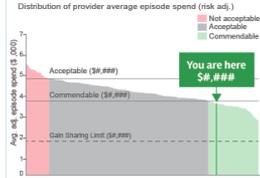
Eligibility requirements for gain or risk-sharing payments

- ✔ **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



Risk adjusted average spend per episode



Quality metrics

You achieved # of # quality metrics linked to gain sharing

Quality metric	Value	Status
Quality metric D1	#%	✔
Quality metric D2	#%	✔
Quality metric D3	#%	✘
Quality metric D4	#%	✘

Key performance



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/ProvidersPaymentInnovation.aspx>.



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

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

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Payment streams tied to specific requirements

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

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“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)



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Source: University of Minnesota School of Public Health *Evaluation of the State of Minnesota's Health Care Homes Initiative, 2010-2014* (December 2015).

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



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