Ohio | Governor's Office of Health Transformation

Episode-Based Payment Charter for Payers

Governor Kasich's Advisory Council on Health Care Payment Innovation

October 18, 2013

www.HealthTransformation.Ohio.gov

Ohio's SIM Grant Activities

- Governor's Office of Health Transformation convened experts to provide detailed input on State Innovation Model (SIM) design
  - 100+ experts from 40+ organizations deeply engaged
  - 50+ multi-stakeholder meetings to align across payers and providers
  - Top 5 payers aligned on overall strategy
- Ohio selected McKinsey & Company to assist in producing:
  - State of Ohio Healthcare Diagnostic Report
  - PCMH and Episode "Charters" to align payer decisions
  - Analytics and implementation plans to support the models
  - Ohio's Healthcare Innovation Plan (to submit October 30, 2013)

SOURCE: www.healthtransformation.ohio.gov

Episode-Based Payment Model Design Team

Providers

- David Bronson, MD, Cleveland Clinic
- Tony Hrudka, MD, Cleveland Clinic
- Michael McMillan, Cleveland Clinic
- John Corlett, MetroHealth
- Steve Marcus, ProMedica
- Terri Thompson, ProMedica
- John Kontner, OhioHealth
- Jennifer Atkins, Catholic Health Partners
- Ken Bertka, MD, Catholic Health Partners
- Richard Shonk, MD, Cincinnati Health Collaborative
- Mary Cook, MD, Central Ohio Primary Care
- Randall Cebul, MD, Better Health Greater Cleveland
- Rita Horwitz, RN, Better Health Greater Cleveland
- Uma Kotegal, MD, Cincinnati Children's Hospital
- Mary Wall, MD, North Central Radiology
- Michael Barber, MD, National Church Residences
- Todd Baker, Ohio State Medical Assoc.
- Nick Lashutka, Ohio Children's Hospital Assoc.
- Ryan Biles, Ohio Hospital Assoc.
- Alyson DeAngelo, Ohio Hospital Assoc.

Payers

- Wendy Payne, Medical Mutual
- Jim Peters, CareSource
- Ron Caviness, Aetna
- Barb Cannon, Anthem
- Meredith Day, Anthem
- Tammy Dawson, Anthem
- Mark DiCello, United Healthcare
- Rick Buono, United Healthcare
- Tim Kowalski, MD, Progressive *(representing purchasers)*

State

- John McCarthy, Medicaid *(Episode Team Chair)*
- Robyn Colby, Medicaid
- Patrick Beatty, Medicaid
- Debbie Saxe, Medicaid
- Ogbe Aideyman, Medicaid
- Mary Applegate, MD, Medicaid
- Katie Greenwalt, Medicaid
- Amy Bashforth, ODH
- Anne Harnish, ODH
- Mark Hurst, MD, MHAS
- Greg Moody, OHT
- Rick Tully, OHT
- Monica Juenger, OHT
- Rebecca Susteric, BWC
- McKinsey: Razili Stanke-Koch, Christa Moss, Brendan Buescher, Kara Carter, Tom Latkovic, Amit Shah, MD

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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) ▪ Payers agree to participate in design for elements where standardization and/or alignment is critical ▪ Multi-payer group begins enrollment strategy for one additional market	▪ State leads design of five episodes: asthma (acute exacerbation), perinatal, COPD exacerbation, PCI, and joint replacement ▪ Payers agree to participate in design process, launch reporting on at least 3 of 5 episodes in 2014 and tie to payment within year
Year 3	▪ Model rolled out to all major markets ▪ 50% of patients are enrolled	▪ 20 episodes defined and launched across payers
Year 5	▪ Scale achieved state-wide ▪ 80% of patients are enrolled	▪ 50+ episodes defined and launched across payers

Agree on degrees of standardization within each model

"Standardize approach"

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)

"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; it's beneficial to know payers are not moving in different 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, members, strategy, administrative systems)

"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

Episode design elements – Program level included in charter

Category	Program level design decision to make	
Participation	1 Provider participation	Related to 'scale-up' plan for episodes
	2 Payer participation	
Account-ability	3 Providers at risk – Number	
	4 Providers at risk – Type of provider(s)	
	5 Providers at risk – Unique providers	
	6 Cost normalization approach	
Payment model mechanics	7 Prospective or retrospective model	
	8 Risk-sharing agreement – types of incentives	
	9 Approach to small case volume	
	10 Role of quality metrics	
	11 Provider stop-loss	
	12 Absolute vs. relative performance rewards	
Performance manage-ment	13 Absolute performance rewards – Gain sharing limit	
	14 Approach to risk adjustment	
	15 Exclusions	
Payment model timing	16 Preparatory/"reporting-only" period	
	17 Length of "performance" period	
	18 Synchronization of performance periods	
Payment model thresholds	19a Approach to thresholds	
	19b How thresholds change over time	
	20 Specific threshold levels	
	21 Degree of gain / risk sharing	
	22 Cost outliers	

Category	Episode specific design decision to make
Core Episode definition	1 Quarterback selection
	2 Triggers
	3a Episode timeframe – Type/length of pre-procedure/ event window
	3b Episode timeframe – Type/length of post-procedure/ event window
	4a Claims in- or excluded: pre-procedure/event window
	4b Claims in- or excluded: during procedure/event
	4c Claims in- or excluded: post procedure/event (incl. readmission policy)
Episode cost adjustment	5 Risk adjustors
	6a Unit cost normalization - Inpatient
	6b Unit cost normalization - Other
	7 Adjustments for provider access
	8 Approach to cost-based providers
	9 Clinical exclusions
Quality metric selection	10 Approach to non-claims-based quality metrics
	11 Quality metric sampling
	12 Quality metrics linked to payment
	13 Quality metrics for reporting only

Ohio episode model charter with potential degrees of standardization by component

	"Standardize approach"	"Align in principle"	"Differ by design"
Accountability	▪ Single accountable provider will be identified for majority of episodes ▪ Type of provider may vary, but payers align on accountable providers for each episode	▪ Common vision to not categorically exclude unique providers	▪ Adjustments to episode cost (e.g., cost normalization) may vary by payer
Payment model mechanics	▪ Model follows a retrospective approach; episode costs are calculated at the end of a fixed period of time ▪ Payers adopt common set of quality metrics for each episode	▪ Model includes both upside and downside risk sharing ▪ Aligned principle of linking quality metrics to incentives ▪ Agree to evaluate providers against absolute performance thresholds	▪ Payers may choose to have min number of episodes for provider participation ▪ Type and degree of stop loss may vary
Performance management	▪ Commitment to launch reporting period prior to tying payment to performance	▪ Aligned approach to have episode-specific risk adjustment model ▪ Aligned approach to exclude episodes with factors not addressable through risk adjustment	▪ Payers independently determine method and level for gain sharing ▪ Risk adjustment methodologies may vary across payers
Payment model timing and thresholds		▪ Performance period length for each episode and launch timings aligned where possible	▪ Start / end dates for each episode may vary ▪ Payers each determine approach to thresholding (incl. level of gain/risk sharing) ▪ Outlier determinations will be at discretion of each payer

Accountability

"Standardize approach"

3 ▪ Payers agree that there will be a **single accountable provider** for majority of episodes

4 ▪ Type of provider (e.g., surgeon, facility) may vary by episode; payers **align on** the accountable **provider** for **each specific episode** (e.g., physician delivering baby for perinatal)

"Align in principle"

5 ▪ Common vision to **not categorically exclude unique providers**

"Differ by design"

6 ▪ Specific adjustments to average episode cost calculations may be warranted; the type of **adjustment** (e.g., unit cost normalization) may differ by payer

Payment model mechanics

"Standardize approach"

- 7 Episode model follows **retrospective** approach; episode costs are calculated at the end of a fixed period of time known as a performance period (e.g., one year)
- 10 Payers adopt a common set of quality metrics for each episode for reporting

"Align in principle"

- 8 Payers agree on implementation of both **upside** gain sharing and **downside** risk sharing with providers when performance is tied to payment
- 10 Payers align the principle of linking performance on **quality metrics** to incentives in order to ensure providers continue to deliver high quality care
- 12 All align on evaluating providers against **absolute performance thresholds**; individual thresholds vary across payers

"Differ by design"

- 9 Implementation of a **minimum number of episodes** for provider participation may vary by episode and across payers
- 11 Type and degree of **stop-loss** arrangement may differ across payers

Performance management

"Standardize approach"

16

- Each payer commits to launching **reporting** on episode performance prior to tie to payment

"Align in principle"

- To ensure fair evaluation across providers, payers align on approach for:
  - **Risk adjustment** – Payers agree to have episode specific risk factors (tailored to their population) for each episode

14

  - **Exclusions** – Payers align on approach to exclude episodes with factors / complications that cannot be properly addressed through risk adjustment

15

"Differ by design"

13

- The exact method and level at which gain sharing is set may vary across payers

14

- Specifics of risk adjustment (e.g., exact mathematical model) may not be the same for each payer

Payment model timing and thresholds

"Standardize approach"	"Align in principle"	"Differ by design"
▪ N/A	17 18 ▪ Payers collaborate to determine appropriate **performance period lengths** for each episode and align launch timing where possible to ease provider adaptation	18 ▪ Detailed start / end dates for reporting and performance periods may vary across payers 19 20 ▪ The **approach to thresholding** as well as threshold levels relate directly to pricing, impact competitive advantage and hence specifics may differ across payers 21 ▪ Likewise, the **degrees of gain / risk sharing** (e.g., what percentage of gains are given as incentive to providers) may vary across payers 22 ▪ Outlier determination relates directly to pricing and will be different across payers

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

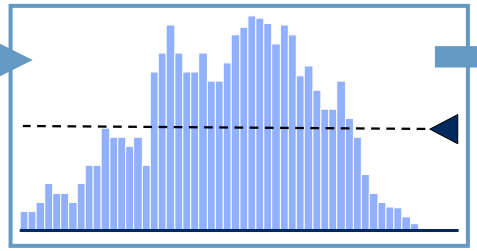
Payers reimburse for all services as they do today

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 cost per episode** for each PAP[1]



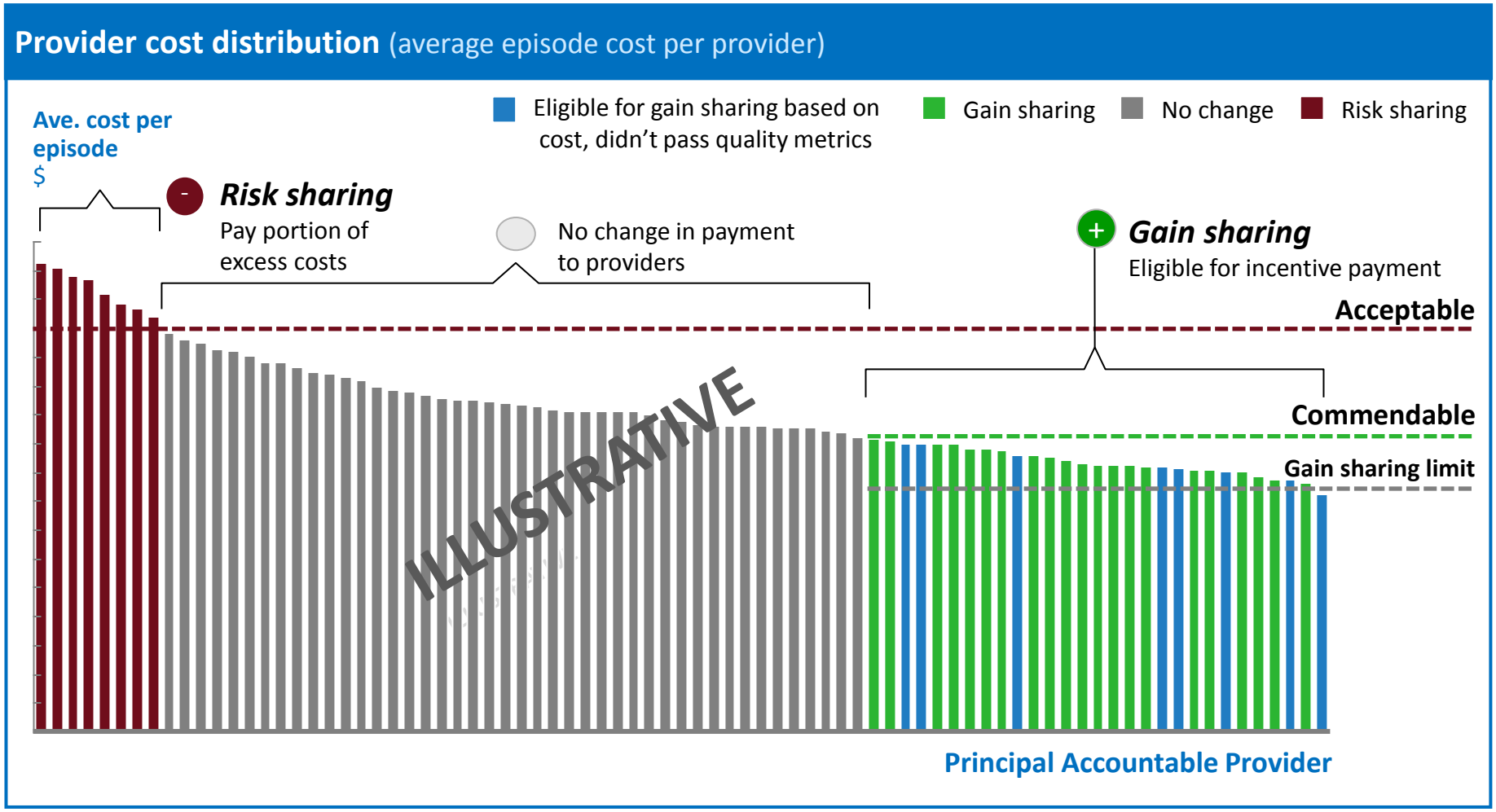
Compare average costs to predetermined ''commendable' and 'acceptable' levels[2]

6 **Providers may:**

- **Share savings**: if average costs below commendable levels and quality targets are met
- **Pay part of excess cost:** if average costs are above acceptable level
- **See no change in pay:** if average costs are between commendable and acceptable levels

SOURCE: Arkansas Payment Improvement Initiative

Retrospective thresholds reward cost-efficient, high-quality care



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SOURCE: Arkansas Payment Improvement Initiative; each vertical bar represents the average cost for a provider, sorted from highest to lowest average cost

Episode Algorithm Design Elements

*Example: Asthma Acute Exacerbation**

- *Trigger*
  - ED visit
  - IP admission
- *Pre-Trigger (none)*
- *Post-Trigger (30 days) includes relevant:*
  - Office visits
  - Labs
  - Medications
  - Readmissions
- ED facility or admitting facility
- Specific comorbidities
- Use of a vent
- ICU more than 72 hours
- Left AMA
- Death in hospital
- Under 5 years old
- Eligibility
- 9 risk factors
- Uses coefficients from AR model
- *Linked to gain sharing:*
  - Corticosteroid and/or inhaled corticosteroid use
  - Follow-up visit within 30 days
- *For reporting:*
  - Repeat acute exacerbation rate

Each episode algorithm is jointly developed with input from key stakeholders including providers (e.g., pulmonologists in this example) and payers

* Algorithm currently in use by the Arkansas Payment Improvement Initiative

Selection of episodes in the first year

Guiding 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)

Working hypothesis for episodes in the first year:

- Perinatal
- Asthma acute exacerbation
- Chronic obstructive pulmonary disease (COPD) exacerbation
- Joint replacement
- Percutaneous coronary intervention (PCI)