



Governor's Office of  
Health Transformation

# Transforming Payment for a Healthier Ohio

Greg Moody, Director  
Governor's Office of Health Transformation

Ohio Health Care Association

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

## 2011 Ohio Crisis

vs.

## Results Today

- |  |   |
|--|---|
| <ul style="list-style-type: none"><li>● \$8 billion state budget shortfall</li><li>● 89-cents in the rainy day fund</li><li>● Nearly dead last (48<sup>th</sup>) in job creation (2007-2009)</li><li>● Medicaid spending increased 9% annually (2009-2011)</li><li>● Medicaid over-spending required multiple budget corrections</li><li>● Ohio Medicaid stuck in the past and in need of reform</li><li>● More than 1.5 million uninsured Ohioans (75% of them working)</li></ul> | <ul style="list-style-type: none"><li>● Balanced budget</li><li>● \$1.5 billion in the rainy day fund</li><li>● One of the top ten job creating states in the nation</li><li>● Medicaid increased 4.1% in 2012 and 2.5% in 2013 (pre-expansion)</li><li>● Medicaid budget under-spending was \$1.9 billion (2012-2013) and \$2.5 billion (2014-2015)</li><li>● Ohio Medicaid embraces reform</li><li>● Extended Medicaid coverage</li></ul> |
|--|---|

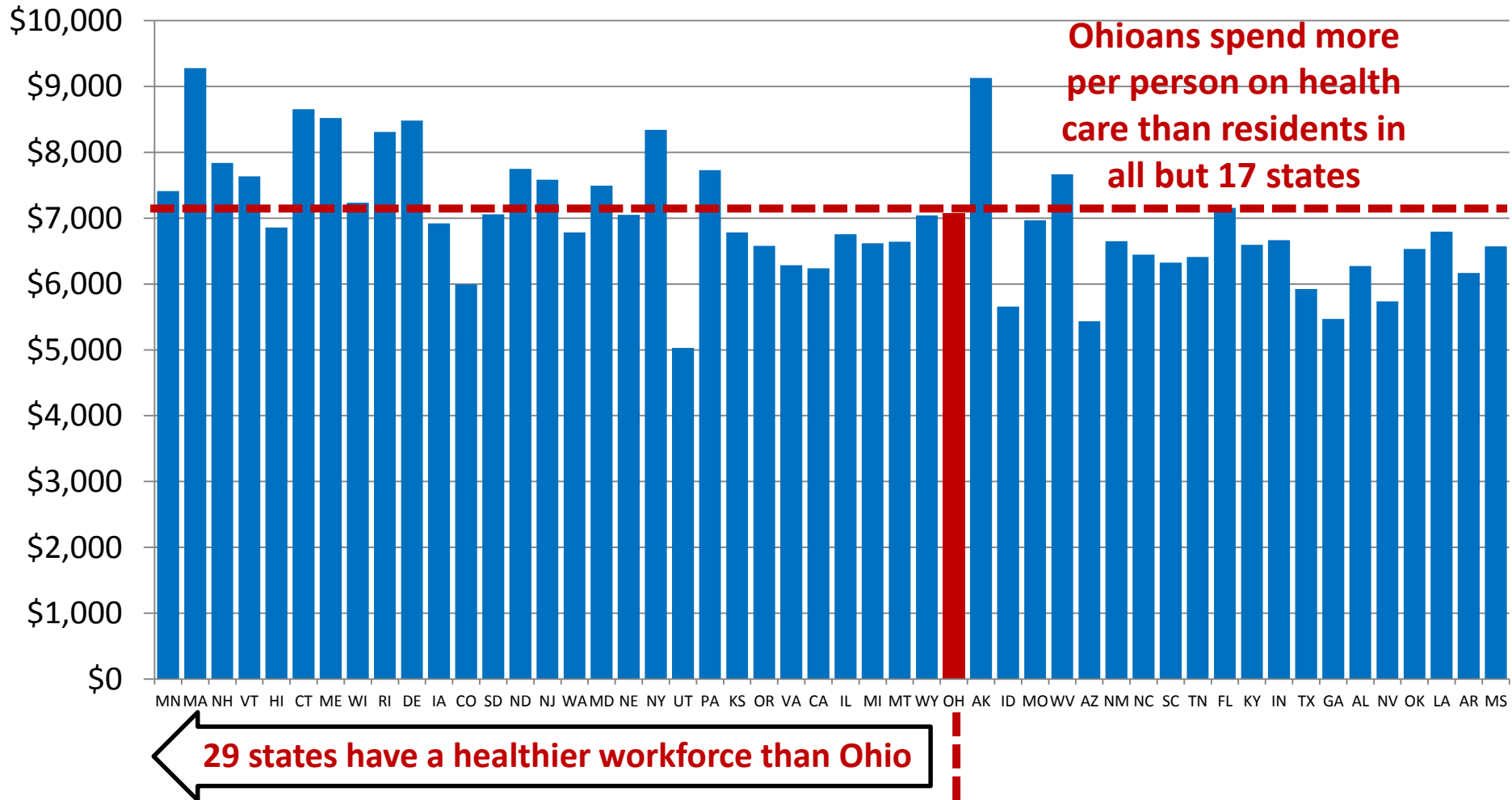


# Ohio's Path to Value

<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>

# 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

# In 2013, Ohio won a federal innovation grant to adopt two payment models that reward higher-quality, value-based care

## 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

#### 2014

- In 2014 focus on Comprehensive Primary Care Initiative (CPCi)

#### 2015

- Collaborate with payers on design decisions and prepare a roll-out strategy

#### 2016

- Model rolled out to at least two major markets

#### 2017-2018

- Model rolled out to all markets
- 80% of patients are enrolled

### Episode-based payments

- State leads design of six episodes: asthma acute exacerbation, COPD exacerbation, perinatal, acute and non-acute PCI, and joint replacement

- State leads design of seven new episodes: URI, UTI, cholecystectomy, appendectomy, GI hemorrhage, EGD, and colonoscopy

- 20 episodes defined and launched across payers, including behavioral health

- 50+ episodes defined and launched across payers, including behavioral health

# 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

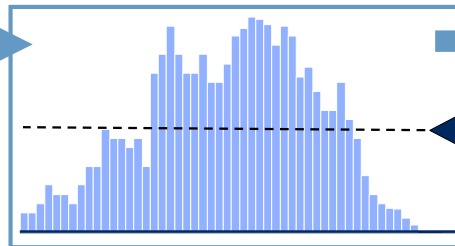
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Review claims from the performance period to identify a **'Principal Accountable Provider'** (PAP) for each episode

5

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



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

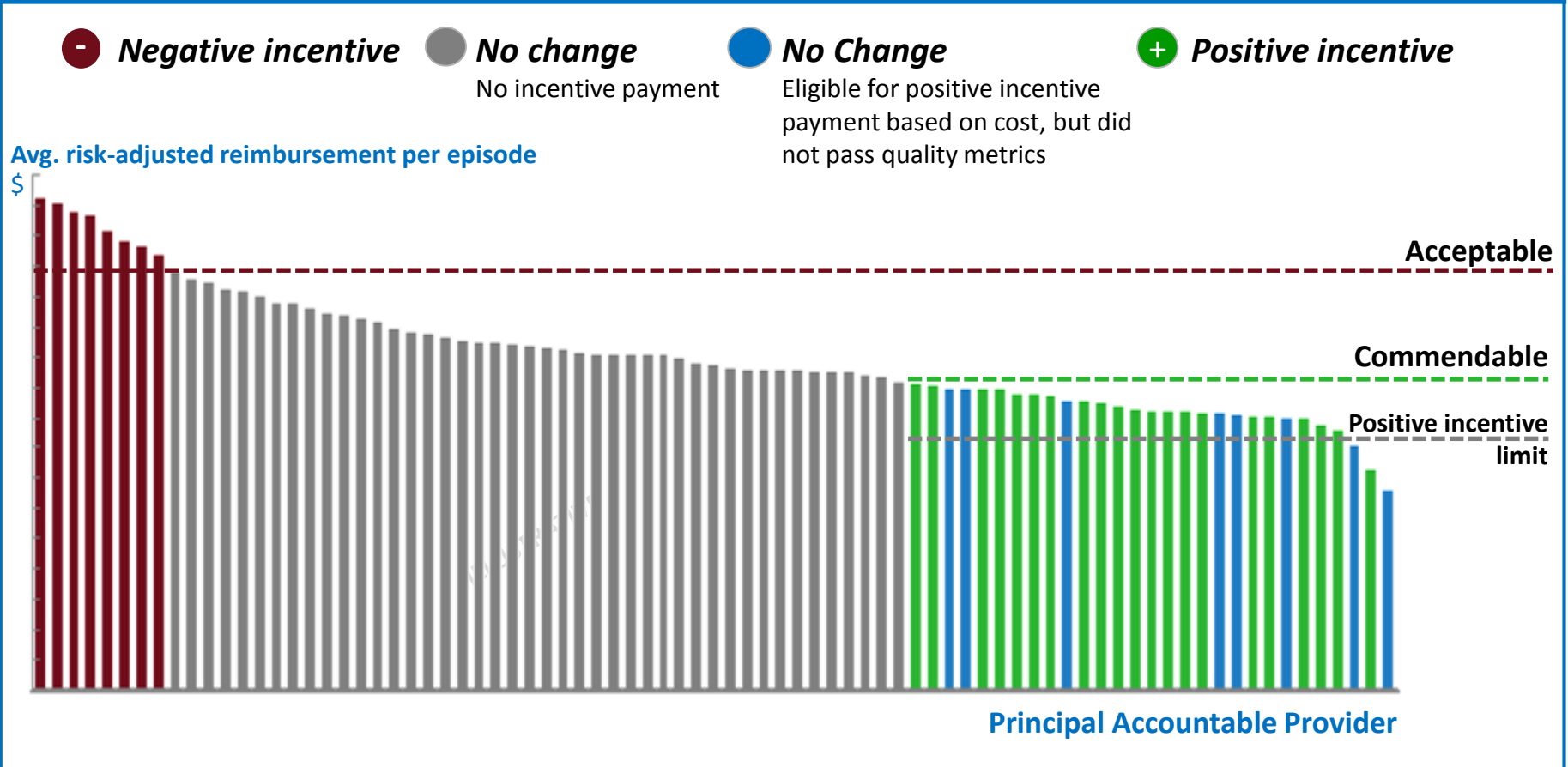
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**Providers may:**

- **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 largest health plans have committed to help design and implement PCMH and episode-based payment models



# Elements of the Episode Definition

Category	Description
1 Episode trigger	<ul style="list-style-type: none"><li>Diagnoses or procedures and corresponding claim types and/or care settings that characterize a potential episode</li></ul>
2 Episode window	<ul style="list-style-type: none"><li><b>Pre-trigger window:</b> Time period prior to the trigger event; relevant care for the patient is included in the episode</li><li><b>Trigger window:</b> Duration of the potential trigger event (e.g., from date of inpatient admission to date of discharge); all care is included</li><li><b>Post-trigger window:</b> Time period following trigger event; relevant care and complications are included in the episode</li></ul>
3 Claims included	
4 Principal accountable provider	<ul style="list-style-type: none"><li>Provider who may be in the best position to assume principal accountability in the episode based on factors such as decision making responsibilities, influence over other providers, and portion of the episode spend</li></ul>
5 Quality metrics	<ul style="list-style-type: none"><li>Measures to evaluate quality of care delivered during a specific episode</li></ul>
6 Potential risk factors	<ul style="list-style-type: none"><li>Patient characteristics, comorbidities, diagnoses or procedures that may potentially indicate an increased level of risk for a given patient in a specific episode</li></ul>
7 Episode-level exclusions	<ul style="list-style-type: none"><li>Patient characteristics, comorbidities, diagnoses or procedures that may potentially indicate a type of risk that, due to its complexity, cost, or other factors, should be excluded entirely rather than adjusted</li></ul>

# 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                  |

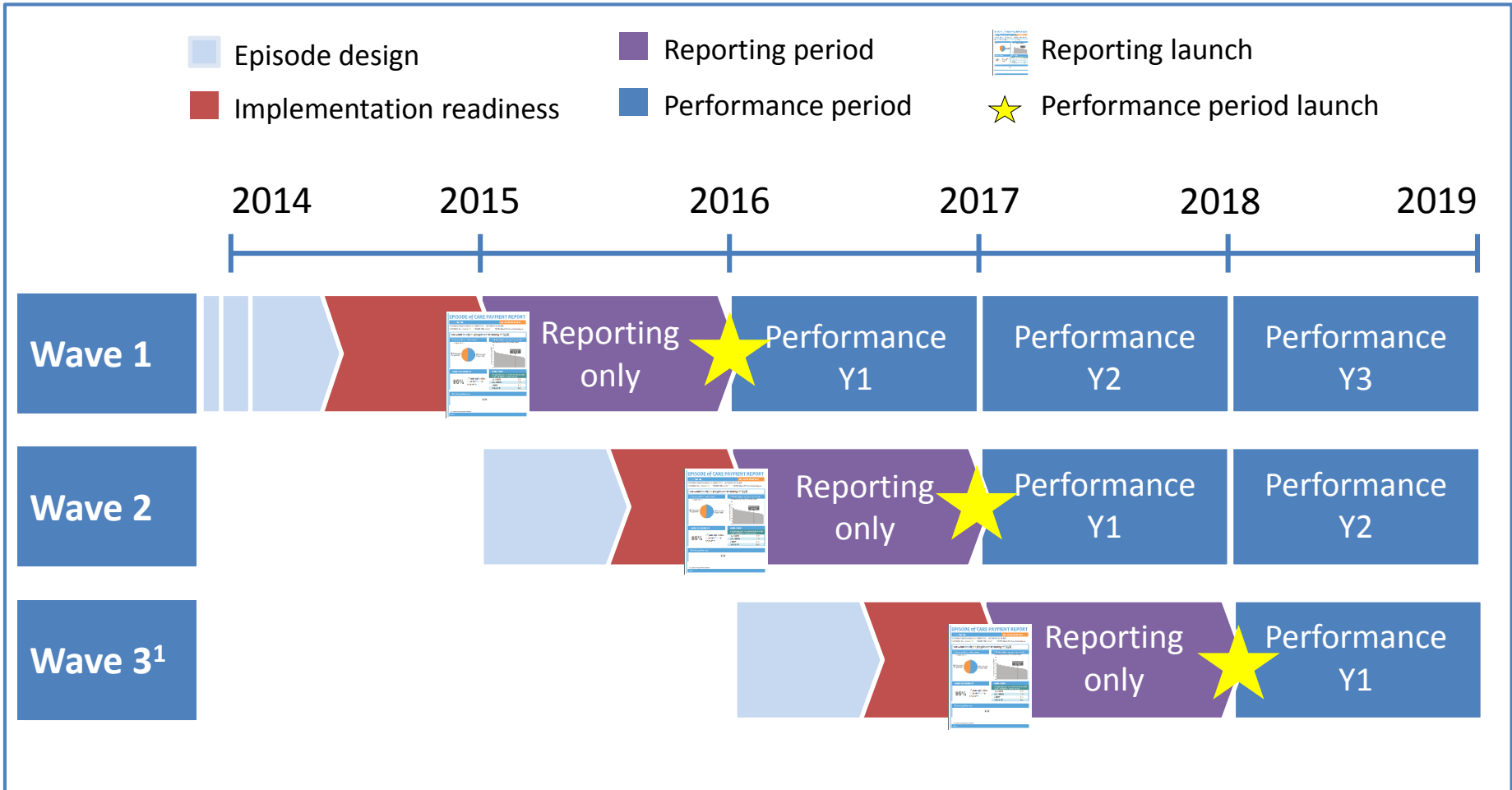
#### **WAVE 2 (launch January 2016)**

- |                                |                                  |
|--------------------------------|----------------------------------|
| 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 episodes including some related to behavioral health

# Ohio's episode timeline



<sup>1</sup> Expected timing for Wave 3

# 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

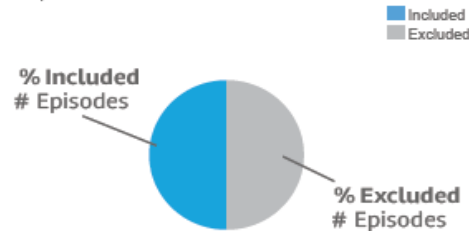
PROVIDER: Provider Name

## 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.
- 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

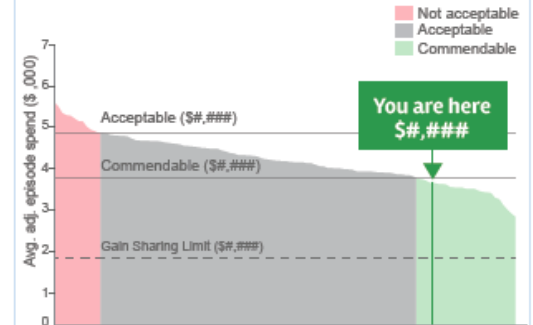
## Quality metrics

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	##%	##%	##%	##%	##%

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>.

*This is an example of the performance report format that was released in 2016 with the launch of the performance period for Wave 1 and used for both Wave 1 and Wave 2 episodes in 2016*



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### ***Episode-Based Payments***

- Provide incentive payments to principal accountable providers (PAPs) on three episodes of care based on performance on those episodes in 2016
- Provide performance reports on a second wave of seven episodes and then tie those episodes to incentive payments based on performance in 2017
- Identify and design a third wave of episodes for performance reports in 2017 and incentive payments based on performance in 2018

### ***Patient-Centered Medical Home Payments***

- Finalize the PCMH care delivery and payment model early in 2016
- Develop a strategy to support ongoing practice transformation
- Begin enrolling primary care practices in the PCMH program in 2016 and provide enhanced payments based on performance in 2017

## How payment innovation changes the landscape ...

- Creates demand for high-value partners that can help the principal accountable provider hold down costs
  - We are seeing an acceleration of value-based contracting between health plans and nursing facilities and health systems and nursing facilities
  - Episode-based payment and PCMH payment models sweeten the financial incentive to enter into value-based contracts
  - Provider associations are in a strong position to provide technical assistance and facilitate the transition to value-based contracting
- Creates an opportunity to become a principal accountable provider and manage teams that keep quality high and costs low
  - Ohio Medicaid is working now to identify the next wave of episodes for performance reporting in 2017 and incentive payments in 2018

# Want to learn more?

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



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CURRENT INITIATIVES

BUDGETS

NEWSROOM

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VIDEO



## State Innovation Model:

- Overview Presentations
- Patient-Centered Medical Home Charter for Payers
- Episode-Based Payment Charter for Payers
- Links to detailed definitions and code sets for providers
- Population health plan
- Health IT plan

### *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