Transforming Payment for a Healthier Ohio

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Governor’s Office of Health Transformation

HPIO: Paying for value over volume
March 17, 2016

# Ohio’s Path to Value

<table>
<thead>
<tr>
<th>Modernize Medicaid</th>
<th>Streamline Health and Human Services</th>
<th>Pay for Value</th>
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<tbody>
<tr>
<td><strong>Initiate in 2011</strong></td>
<td><strong>Initiate in 2012</strong></td>
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<tr>
<td><strong>Advance Governor Kasich’s Medicaid modernization and cost containment priorities</strong></td>
<td><strong>Share services to increase efficiency, right-size capacity, and streamline governance</strong></td>
<td><strong>Engage private sector partners to set clear expectations for better health, better care and cost savings through improvement</strong></td>
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</tbody>
</table>
| • 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 | • 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 | • Join Catalyst for Payment Reform  
• Support regional payment reform  
• Pay for value instead of volume (State Innovation Model Grant)  
  - 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 |
1. Ohio’s approach to paying for value instead of volume

2. Patient-Centered Medical Home (PCMH) Model

3. Episode-Based Payment Model
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)

Ohioans spend more per person on health care than residents in all but 17 states

29 states have a healthier workforce than Ohio

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).
Ohio is one of 17 states awarded a federal grant to test payment innovation models

Value-Based Alternatives to Fee-for-Service

Most payers have implemented some form of pay for performance and at least begun to consider PCMH, episode or ACO alternatives.

**Fee for Service**
- Payment for services rendered

**Pay for Performance**
- Payment based on improvements in cost or outcomes

**Patient-Centered Medical Home**
- 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

**Episode-Based Payment**
- 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

**Accountable Care Organization**
- Payment goes to a local provider entity responsible for all of the health care and related expenditures for a defined population of patients
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
### Ohio’s approach to multi-payer alignment

#### “Standardize”
- Standardize approach with an identical design only when:
  - In the best interest of patients
  - Alignment is critical to provider success or significantly eases implementation for providers
  - There are meaningful economies of scale
  - Standardization does not diminish sources of competitive advantage among payers
  - It is lawful to do so

**Example:** Quality Measures

#### “Align in principle”
- Align in principle but allow for payer innovation consistent with those principles when:
  - It benefits providers to understand where payers are moving in the same direction
  - Differences have modest impact on providers from an administrative standpoint
  - Differences are necessary to account for legitimate differences among payers (varied enrollees, etc.)

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

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Ohio’s vision for PCMH is 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
“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)

Source: University of Minnesota School of Public Health Evaluation of the State of Minnesota’s Health Care Homes Initiative, 2010-2014 (December 2015).
# Payer alignment on PCMH requirements in Ohio

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<th>“Align in principle”</th>
<th>“Differ by design”</th>
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| 1 6 process requirements            | An ongoing stream of **new funds to support clinical and operational activities** that are currently not compensated or undercompensated
| 2 6 activity requirements           | - Sufficient to compensate for the new clinical activities required by PCMH
| 3 4-8 efficiency measures           | - At risk based on performance on standard processes and activities, clinical quality, and efficiency metrics
| 4 20 clinical quality measures      | A stream of gain-sharing payment to **award PCMHs for lowering total cost of care**
|                                     | **Attribution** model that aligns all members with a PCMH                          | **Payment levels** for new payment streams
|                                     | **Thresholds and risk adjustment methodology** for payment streams                  |
Payment streams will be tied to specific requirements

<table>
<thead>
<tr>
<th>Requirements</th>
<th>Payment Streams</th>
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<tr>
<td>1 6 Process Measures</td>
<td>PCMH operational activities PMPM</td>
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<tr>
<td>Risk stratification</td>
<td>Quality and financial outcomes-based payment</td>
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<tr>
<td>Same day appointments</td>
<td>“Must have” processes targeting access to care</td>
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<tr>
<td>24/7 access</td>
<td>Scoring weight shifts from standard processes and activities...</td>
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<tr>
<td>Practice uses a team</td>
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<tr>
<td>Care management</td>
<td></td>
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<tr>
<td>Relationship continuity</td>
<td></td>
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<td>Efficiency Measures</td>
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<td>Risk stratification</td>
<td>ED visits</td>
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<td>Population management</td>
<td>Inpatient admissions for ambulatory sensitive conditions</td>
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<tr>
<td>Care plans</td>
<td>All-cause readmission rate</td>
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<tr>
<td>Follow up after hospital discharge</td>
<td>Generic dispensing rate of select classes</td>
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<tr>
<td>Tracking of follow up tests and specialist referrals</td>
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<tr>
<td>Patient experience</td>
<td></td>
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<tr>
<td>3 Efficiency Measures</td>
<td>20 Clinical Measures</td>
</tr>
<tr>
<td>ED visits</td>
<td>16-20 measures aligned with CMS/AHIP core standards for PCMH</td>
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<tr>
<td>Inpatient admissions for ambulatory sensitive conditions</td>
<td>Quality gate</td>
</tr>
<tr>
<td>All-cause readmission rate</td>
<td>Based on self-improvement and performance relative to peers</td>
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<td>Generic dispensing rate of select classes</td>
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Ohio Governor’s Office of Health Transformation
Ohio’s statewide PCMH rollout

• Spring 2016 – finalize PCMH care delivery and payment model
• Throughout 2017 – recruit primary care practices to commit to the PCMH model and support practice transformation
• January 1, 2018 – performance period begins for:
  1. Operational activities PMPM
  2. Quality and financial-outcomes based payment
  3. One-time practice transformation support for some practices
• Fall 2016 – exploring an early enrollment process beginning January 1, 2017 for some already-accredited PCMHs
1. Ohio’s approach to paying for value instead of volume
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3. Episode-Based Payment Model
Retrospective episode model mechanics

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

4. 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

6. **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

Calculate incentive payments based on outcomes after close of 12 month performance period
Retrospective thresholds reward cost-efficient, high-quality care

Provider cost distribution (average risk-adjusted reimbursement per provider)

- **Negative incentive**
  - No incentive payment

- **No change**
  - Eligible for positive incentive payment based on cost, but did not pass quality metrics

- **No Change**

- **Positive incentive**

Avg. risk-adjusted reimbursement per episode

$\

Acceptable

Commendable

Principal Accountable Provider

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

**WAVE 1 (launched March 2015)**

1. Perinatal
2. Asthma acute exacerbation
3. COPD exacerbation
4. Acute Percutaneous intervention
5. Non-acute PCI
6. Total joint replacement

**Principal Accountable Provider**

- Physician/group delivering the baby
- Facility where trigger event occurs
- Facility where trigger event occurs
- Facility where PCI performed
- Physician
- Orthopedic surgeon

**WAVE 2 (launch January 2016)**

7. Upper respiratory infection
8. Urinary tract infection
9. Cholecystectomy
10. Appendectomy
11. Upper GI endoscopy
12. Colonoscopy
13. GI hemorrhage

**Principal Accountable Provider**

- PCP or ED
- General surgeon
- General surgeon
- Gastroenterologist
- Gastroenterologist
- Facility where hemorrhage occurs
All of the details to run the first 13 episodes are available online

- **Summary definitions**
  - Overview of definitions resulting from clinical advisory group process
  - 2-page overview of all design elements

- **Detailed business requirements**
  - Detailed word file including all of the specifics required to code an algorithm

- **Code sets**
  - Excel file containing specific diagnosis and procedure codes used for trigger, included claims, exclusions, risk adjustment, etc.

http://medicaid.ohio.gov/providers/PaymentInnovation.aspx
This is an example of the multi-payer performance report format released in 2016.
Selecting the next waves of episodes

**Principles for selection:**

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**Ohio’s episode selection:**

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<tr>
<td><strong>WAVE 3 (launch January 2017)</strong></td>
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<tr>
<td><strong>Preliminary list of potential episodes to design in 2016:</strong></td>
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<tr>
<td>HIV</td>
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<td>Hysterectomy</td>
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<td>Lower back pain</td>
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<tr>
<td>Cardiac valve</td>
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<tr>
<td>Breast cancer</td>
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<tr>
<td>Simple pneumonia</td>
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<tr>
<td>Wrist sprain</td>
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<tr>
<td>Hip/Pelvic fracture</td>
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<tr>
<td>Spinal fusion exc. cervical</td>
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<tr>
<td>Pacemaker/defibrillator</td>
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<tr>
<td>Bronchiolitis and RSV pneumonia</td>
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**WAVE 4 (launch January 2018)**

*Design work begins on behavioral episodes in June 2016 ...*
State Innovation Model:

- Overview Presentations
- Patient-Centered Medical Home (PCMH) payment model
- Episode-based payment model
- Population health plan
- Health IT plan