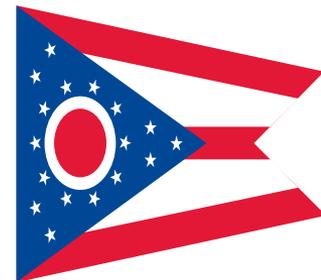


Transforming Payment for a Healthier Ohio

Roundtable Advisory Group

Mary Applegate, MD, FAAP, FACP,
Medical Director, Ohio Department of Medicaid
July 2015

**MAKING
OHIO
BETTER**





Governor's Office of
Health Transformation

CURRENT INITIATIVES

BUDGETS

NEWSROOM

CONTACT

VIDEO



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

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 Health Insurance Exchange

Ohio's State Innovation Model (SIM) Test Grant Application:

- Population Health Plan
- Delivery System Plan
- Payment Models
- Regulatory Plan
- HIT Plan
- Stakeholder Engagement
- Quality Measurement

Payment Models:

- PCMH Charter
- Episode Charter
- Overview Presentation



Governor's Office of
Health Transformation

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



Governor's Office of Health Transformation

Payment Innovation Partners

John R. Kasich
Governor

Governor's Senior Staff

State of Ohio Health Care Payment Innovation Task Force

Office of Health Transformation

- Project Management Team:** Executive Director, Communications Director, Stakeholder Outreach Director, Legislative Liaison, Fiscal and IT Project Managers

Participant Agencies

- Administrative Services, Development, Health, Insurance, JobsOhio, Ohio Medicaid, Rehabilitation and Corrections, Taxation, Worker's Compensation, Youth Services, Public Employee and State Teachers Retirement Systems

Governor's Advisory Council on Health Care Payment Innovation

- Purchasers** (Bob Evans, Cardinal Health, Council of Smaller Enterprises, GE Aviation, Procter & Gamble, Progressive)
- Plans** (Aetna, Anthem, CareSource, Medical Mutual, UnitedHealthcare)
- Providers** (Akron Children's Hospital, Catholic Health Partners, Central Ohio Primary Care, Cleveland Clinic, North Central Radiology, Ohio Health, ProMedica, Toledo Medical Center)
- Consumers** (AARP, Legal Aid Society, Universal Health Care Action Network)
- Research** (Health Policy Institute of Ohio)

State Implementation Teams

Patient-Centered Medical Homes

Episode-Based Payments

Workforce and Training

Health Information Technology

Performance Measurement

State Innovation Model Core Team

HIT Infrastructure Core Team

Public/Private Workgroups

Ohio Patient-Centered Primary Care Collaborative

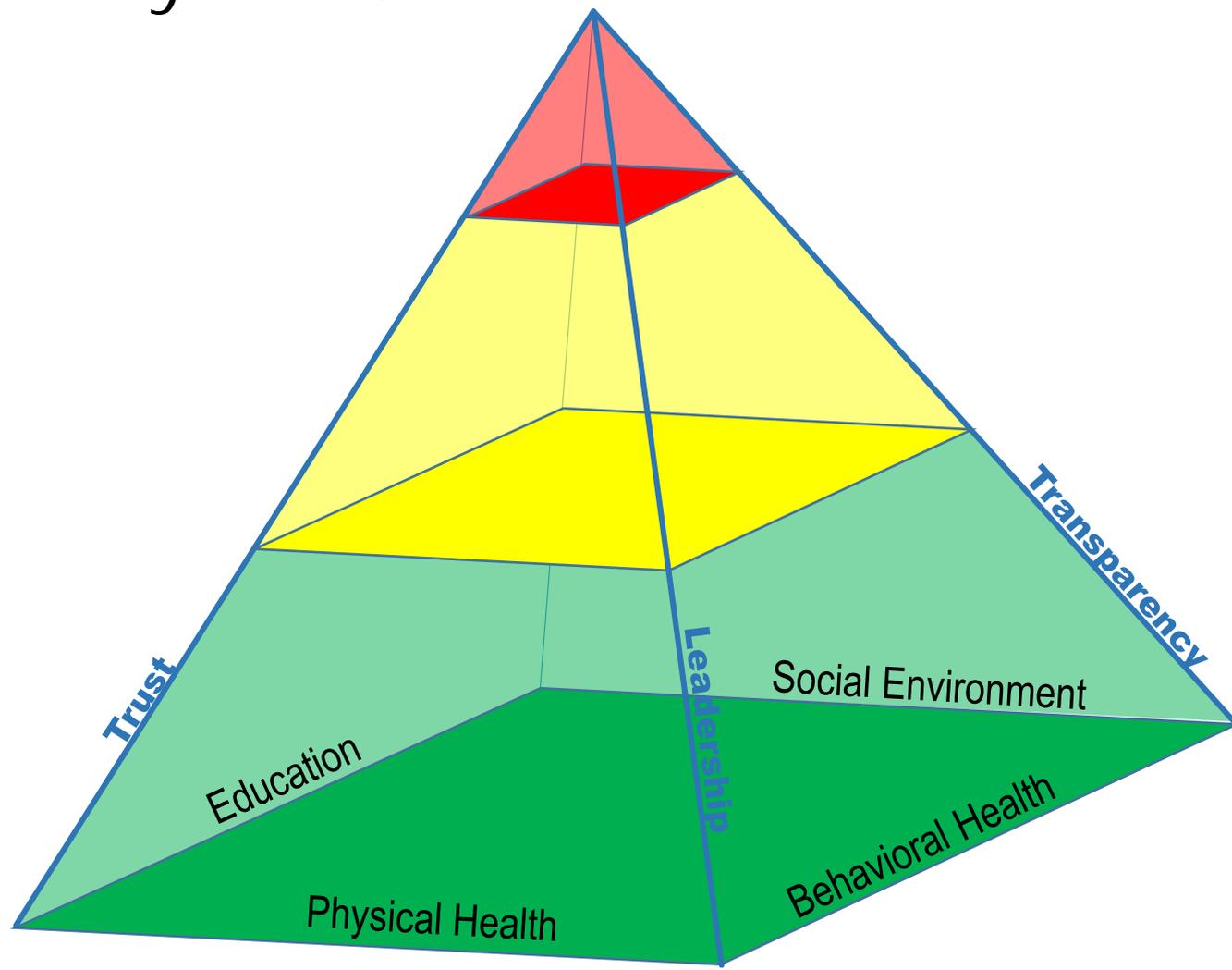
External Expert Teams for specific episodes

Practice Transformation Network (PTN) Collaborative

External Expert Team TBD

External Expert Team TBD

Pyramid of Health



HIGHEST:
Individual effort,
Complexity,
Cost

LOWEST:
Impact

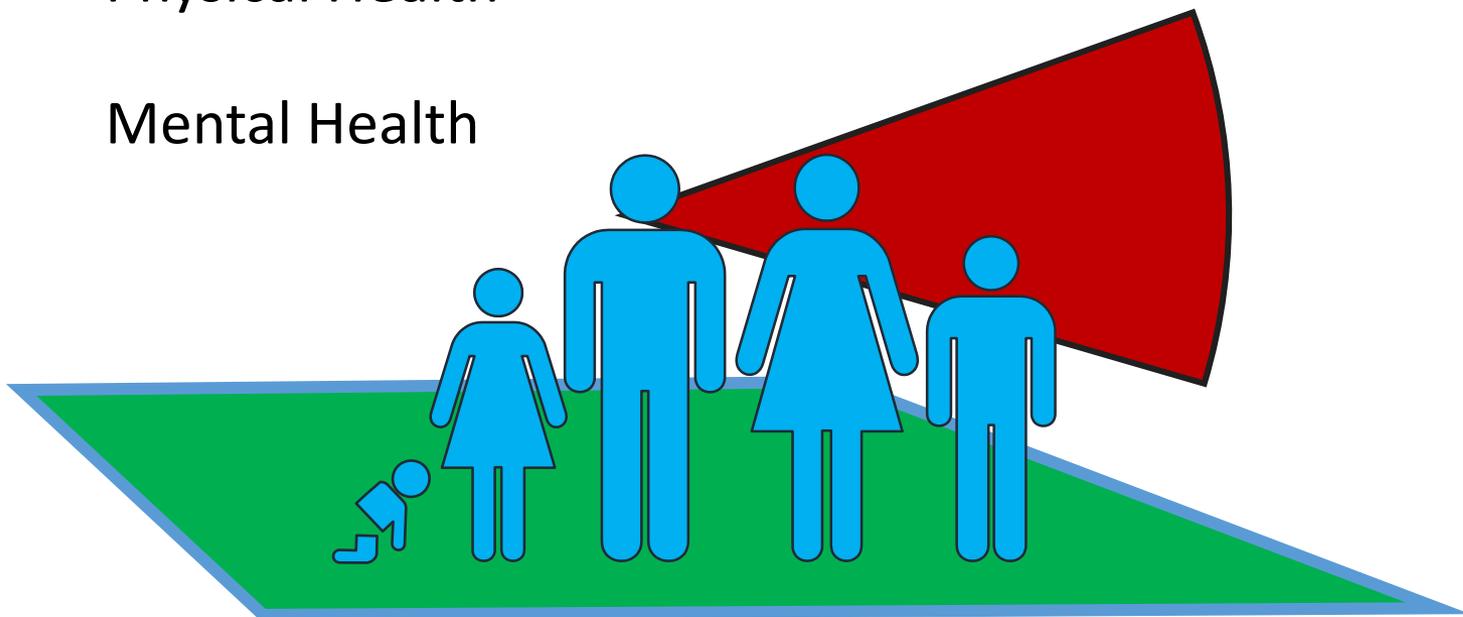
Building the Foundations

Social Stability

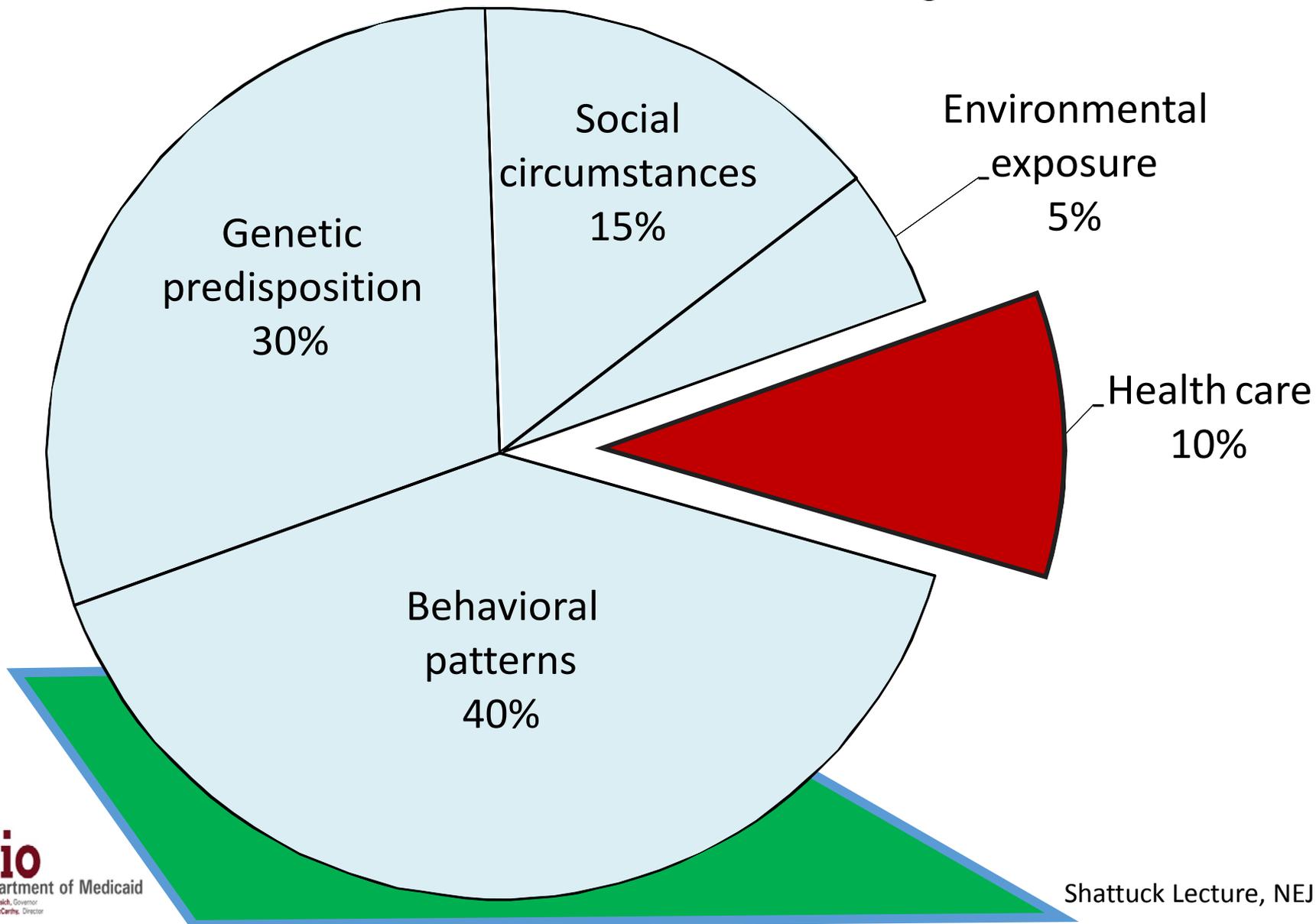
Education and Health Literacy

Physical Health

Mental Health

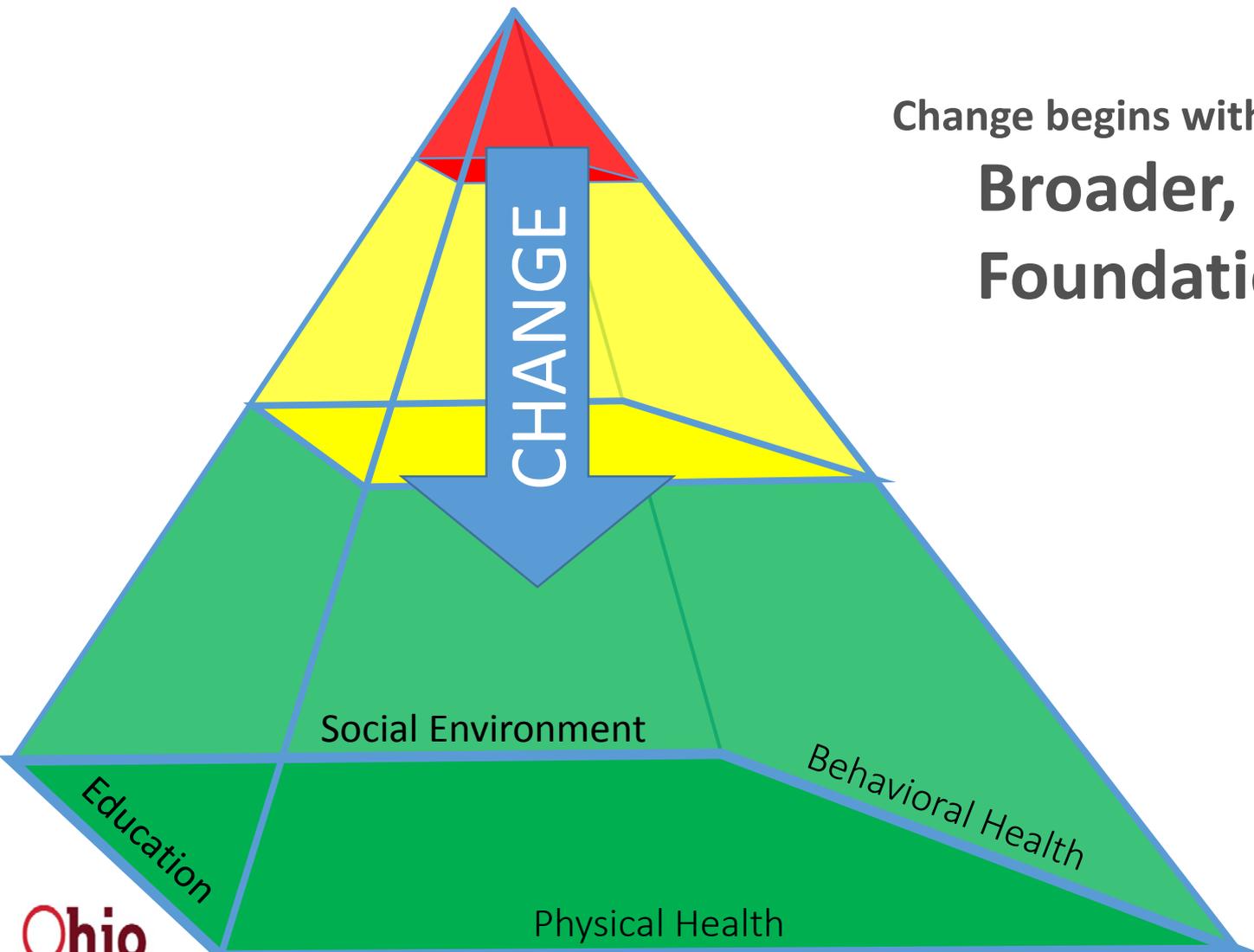


What It Takes To Be Healthy

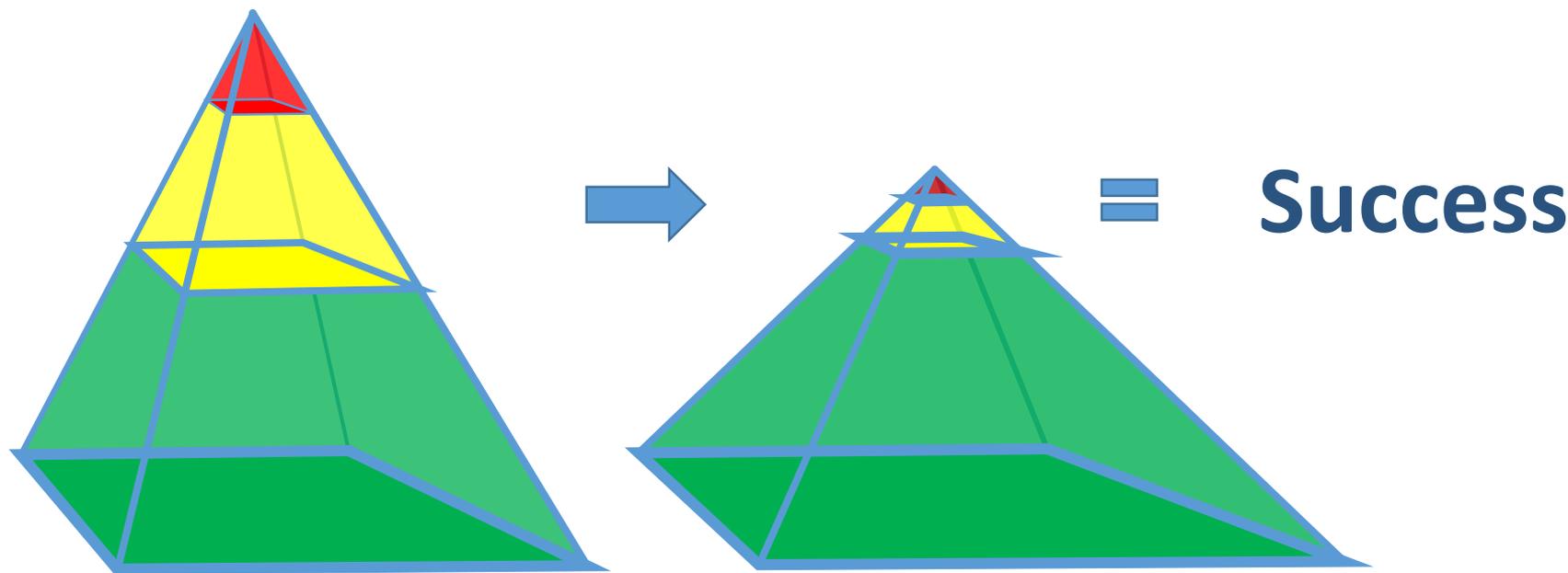


Driving Change: Improved Well-being

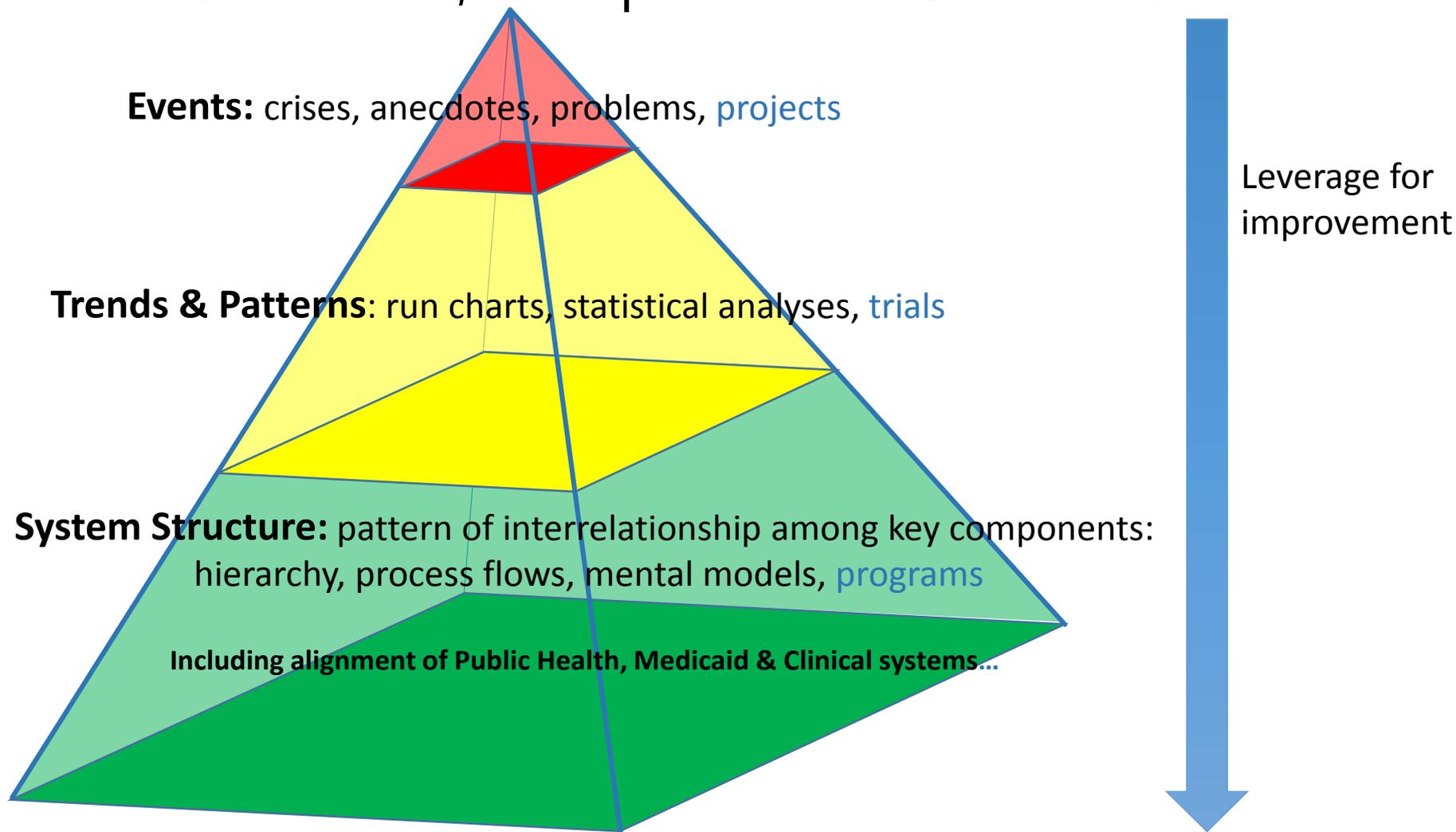
Change begins with
**Broader, Stronger
Foundations**



Population Perspective

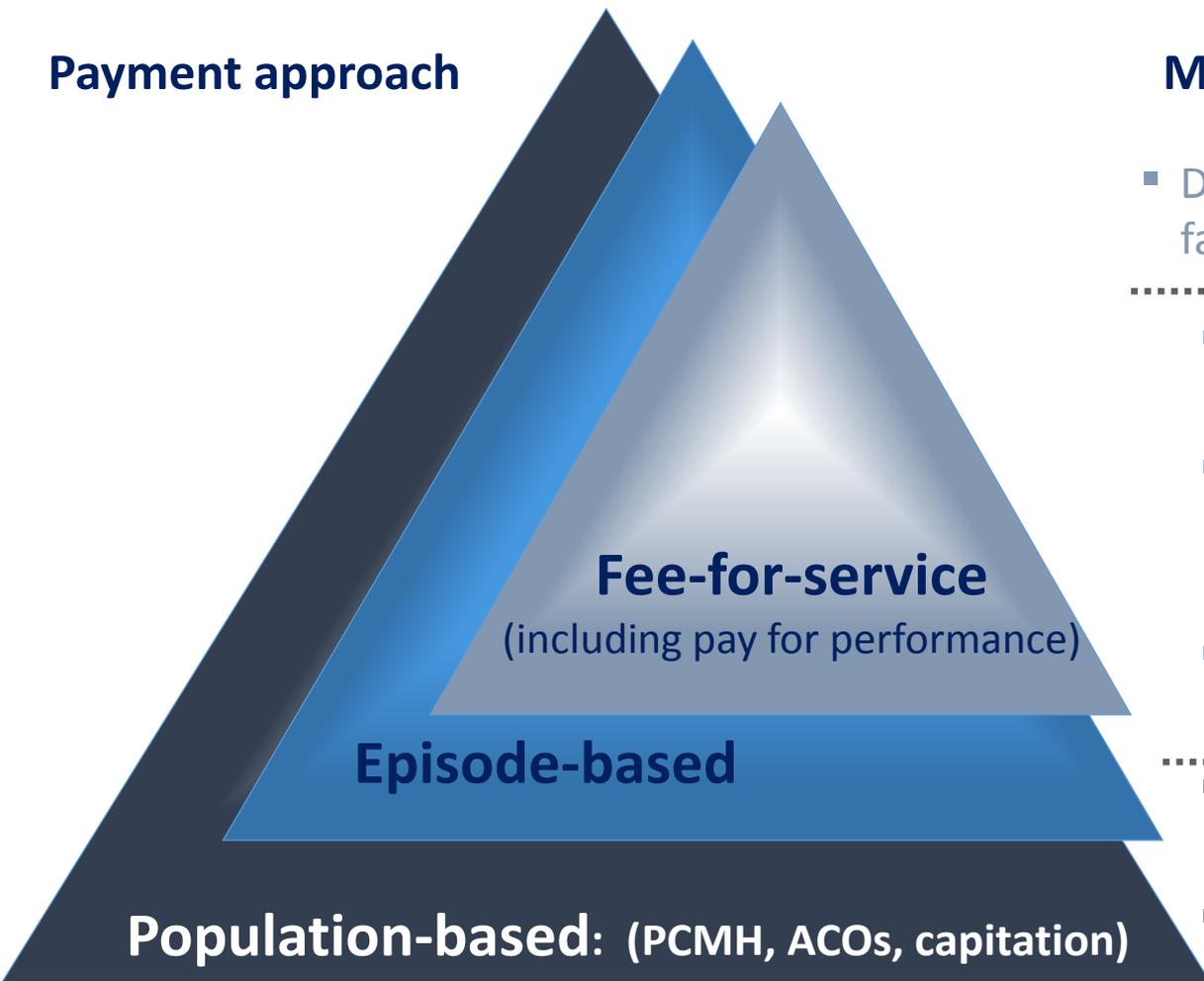


Collaboration, Cooperation & Coordination



Shift to population- and episode-based payment

Payment approach



Most applicable for

- Discrete services correlated with favorable outcomes or lower cost
-
- Acute procedures (e.g., CABG, hips, stent)
 - Most inpatient stays including Newborn deliveries, post-acute care, readmissions
 - Acute outpatient care (e.g., broken arm)
-
- Primary prevention for healthy population
 - Care for chronically ill (e.g., managing obesity, CHF)

Elements of the episode definition

Category	Description
1 Episode trigger	<ul style="list-style-type: none"> Diagnoses or procedures and corresponding claim types and/or care settings that characterize a potential episode
2 Episode window	<ul style="list-style-type: none"> Pre-trigger window: Time period prior to the trigger event; relevant care for the patient is included in the episode Trigger window: Duration of the potential trigger event (e.g., from date of inpatient admission to date of discharge); all care is included Post-trigger window: Time period following trigger event; relevant care and complications are included in the episode
3 Claims included	
4 Principal accountable provider	<ul style="list-style-type: none"> 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
5 Quality metrics	<ul style="list-style-type: none"> Measures to evaluate quality of care delivered during a specific episode
6 Potential risk factors	<ul style="list-style-type: none"> Patient characteristics, comorbidities, diagnoses or procedures that may potentially indicate an increased level of risk for a given patient in a specific episode
7 Episode-level exclusions	<ul style="list-style-type: none"> 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

Patient journey: *Total Joint Replacement*

Patient suffers from limited joint functionality



Initial assessment by surgeon or other orthopedic physician

- Appropriateness (e.g., medical, social, BMI, suitability of risk, timing)
- Objective evidence (e.g., x-ray imaging)



Pre-surgical care

- Patient receives further diagnostic testing/labs, medications, and consultation (e.g., cardiologist, PCP, comorbidity management, rehab planning, education) as needed

Surgery

- Patient receives a hip or knee implant to replace non-functioning joint
- Surgery is performed in either an outpatient or inpatient setting
 - Factors influencing quality include: surgery time, anesthesia and wound closure (e.g., staples, stitches, glue)
 - Sources of variation include: implant choice, length of stay, medications prescribed

■ Potential episode trigger event

Follow-up care

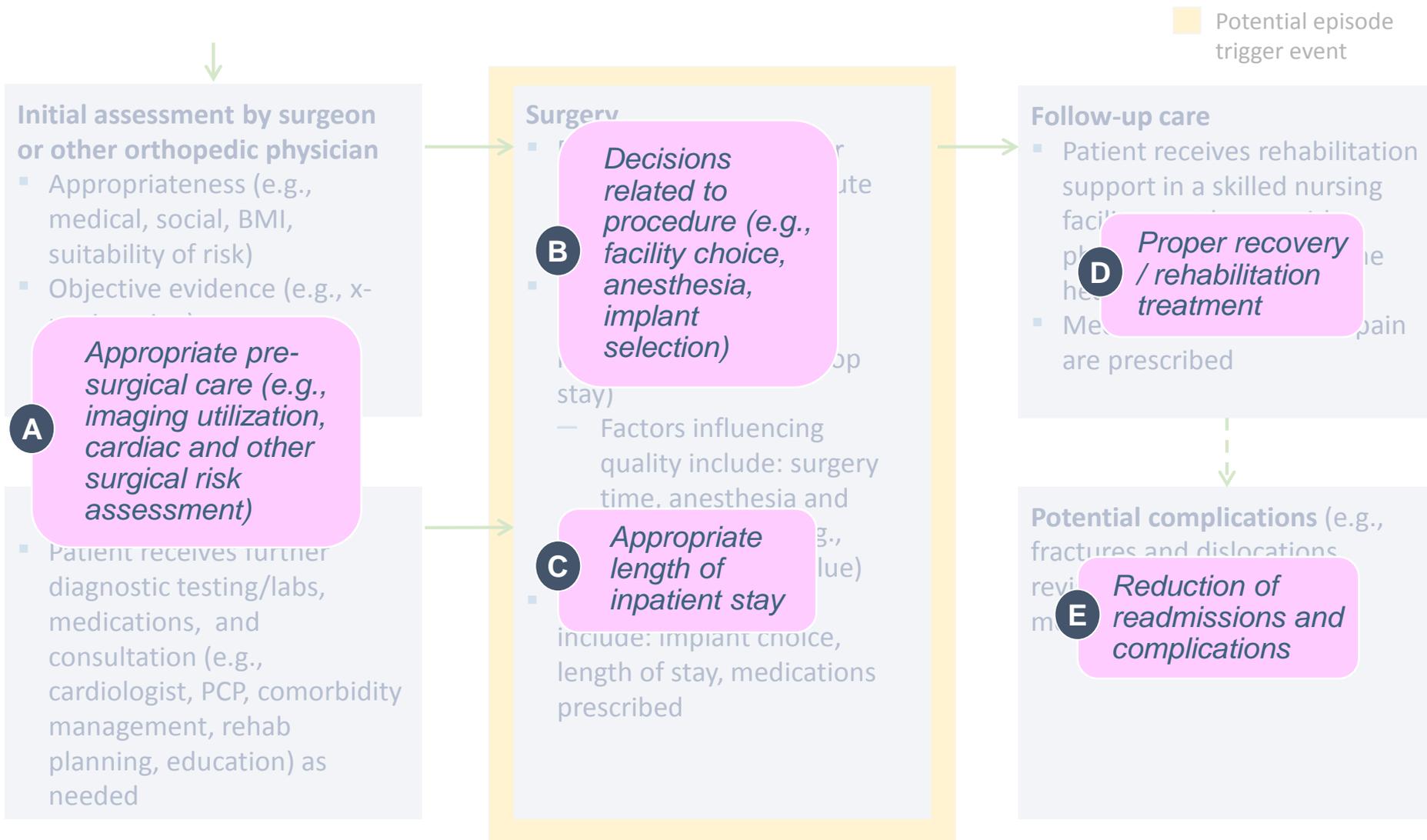
- Patient receives rehabilitation support in a skilled nursing facility or at home with physical therapy and home health
- Medications to alleviate pain are prescribed



Potential complications

- (e.g., fractures and dislocations, revision, DVT, PE, infection, mechanical complications)

Patient journey & sources of value: TJR



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

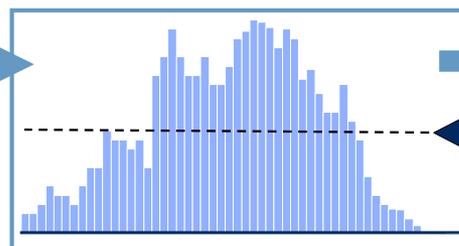
4



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



Compare average costs to predetermined "commendable" and "acceptable" levels

6

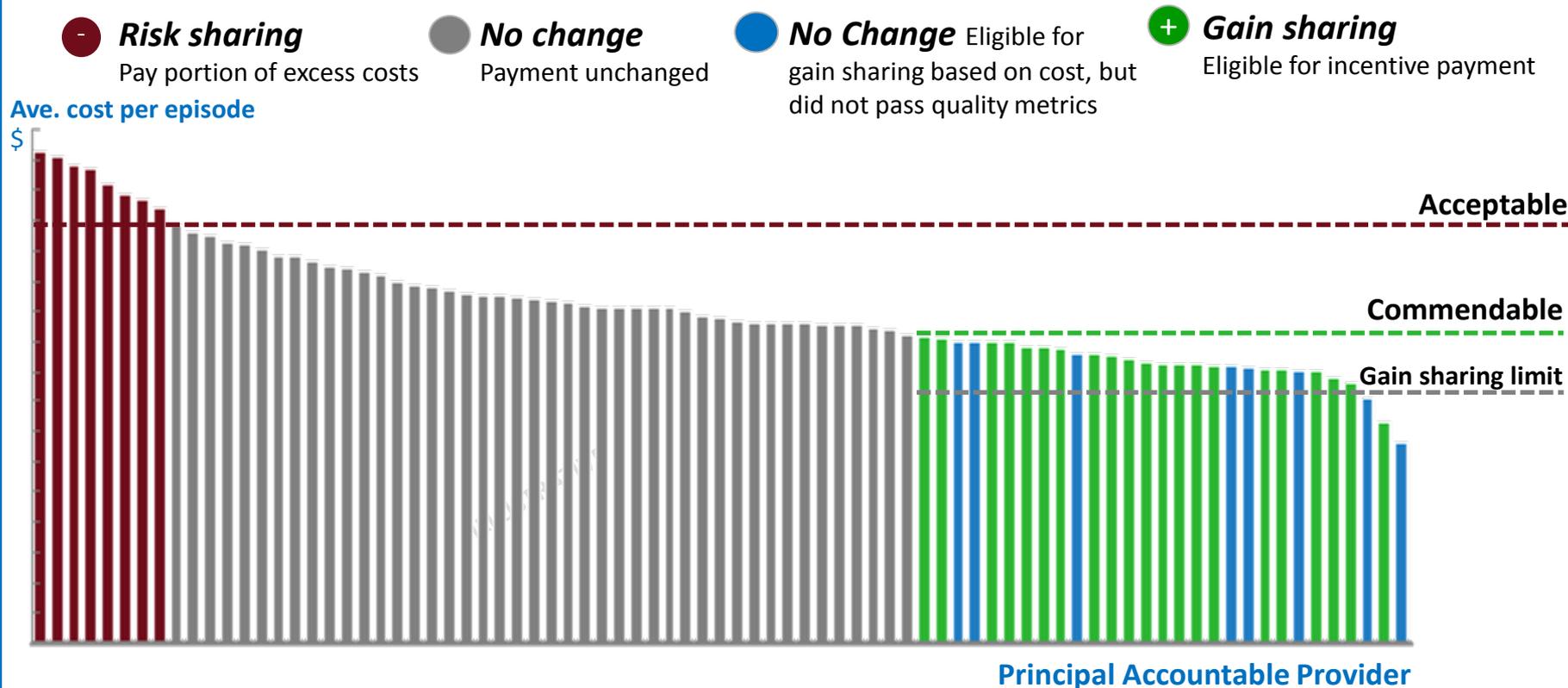
Providers may:

- **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

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 episode cost per provider)



Anthem 

aetna SM

UnitedHealthcare

 MEDICAL
MUTUAL TM

 CareSource

 MOLINA
HEALTHCARE

Buckeye 
Community Health Plan

 PARAMOUNT
ADVANTAGE

This is a sample report; actual reports will be released in 2015

Ohio

Governor's Office of
Health Transformation

EPISODE of CARE PAYMENT REPORT

PERINATAL

Jul 1, 2013 to Jun 30, 2014

Reporting period covering episodes that ended between July 1, 2013 and June 30, 2014

PAYER NAME: Ohio - Medicaid FFS

PROVIDER CODE: 1234567

PROVIDER NAME: XYZ Women's Health Center

You would be eligible for gain or risk sharing of **N/A¹**

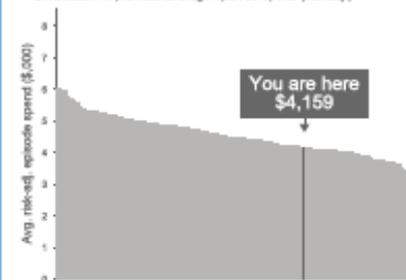
Episodes inclusion and exclusion

Total episodes: 154



Risk adjusted average spend per episode

Distribution of provider average episode spend (risk adj.)



Episodes risk adjustment

95% of your episodes
have been risk
adjusted

Quality metrics

Your performance on quality metrics that will be ultimately linked to gain sharing

HIV screening	53%
GBS screening	71%
C-section	31%
Follow-up visit	30%

Potential gain/risk share

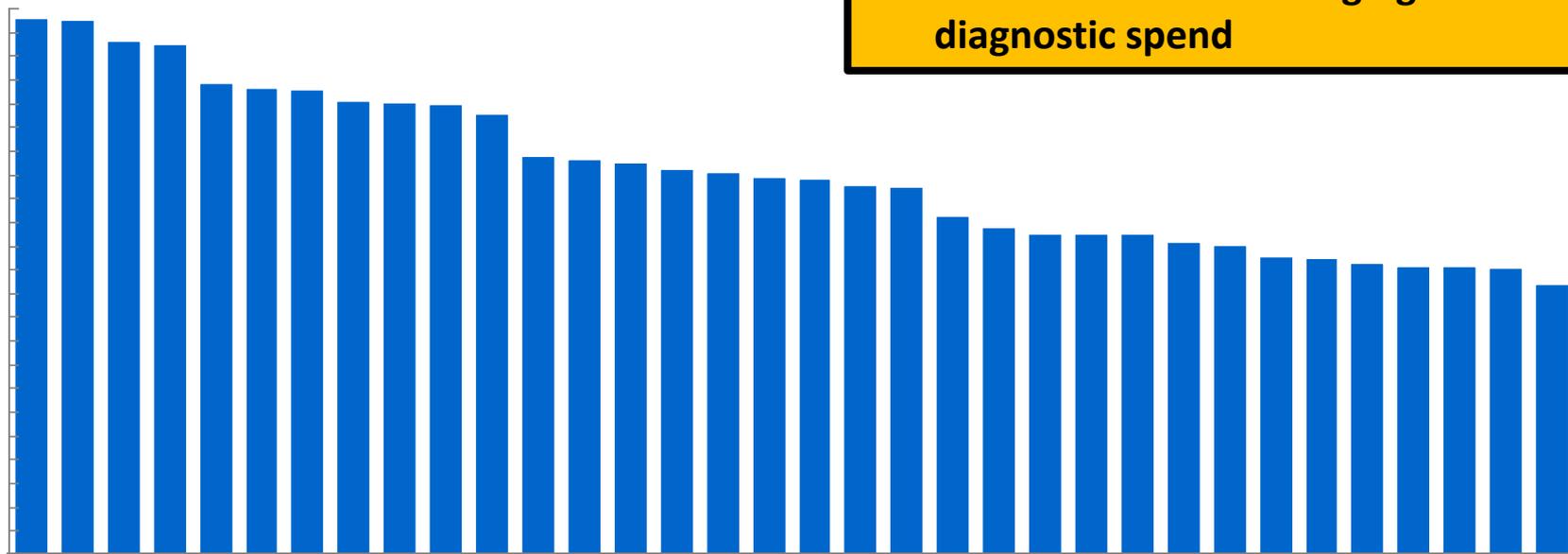
N/A¹

¹ Not applicable during reporting-only period

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Variation across the Total Joint Replacement episode

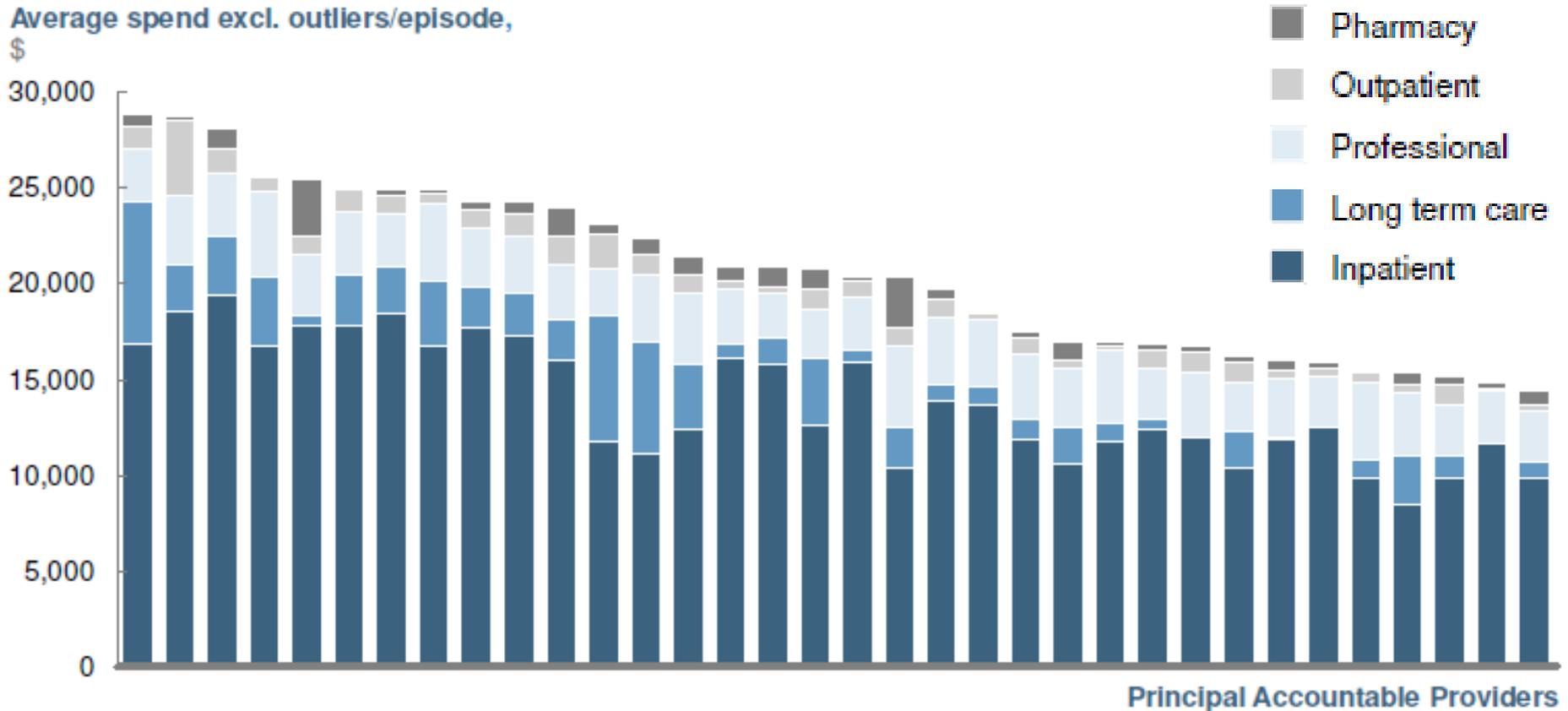
Average cost per episode, risk adjusted, excluding outliers



- Readmission rate within 30 days varies from 0% to 33%
- >200% variation in imaging and diagnostic spend

Orthopedic surgeon performing the TJR procedure

Total Joint Replacement Episode Distribution by Claim Type



Episodes of Care Developed To Date

- **Wave I**

- » Total joint replacement (hip and knee)
- » Asthma & COPD
- » Percutaneous cardiac intervention (heart catheterization with stents etc..)
- » Perinatal (newborn delivery)

- **Wave II**

- » Upper respiratory & urinary tract infection
- » Appendectomy & cholecystectomy
- » Upper and lower endoscopy & gastrointestinal Bleed

- **Wave III**

- » tbd but behavioral health a priority

How can we get to win:win:win?

How can you/we add additional value to patients?

What else might we consider?

Other Questions? Comments?

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