Ohio | Governor's Office of Health Transformation

Ohio's Vision for Health Care Payment Innovation

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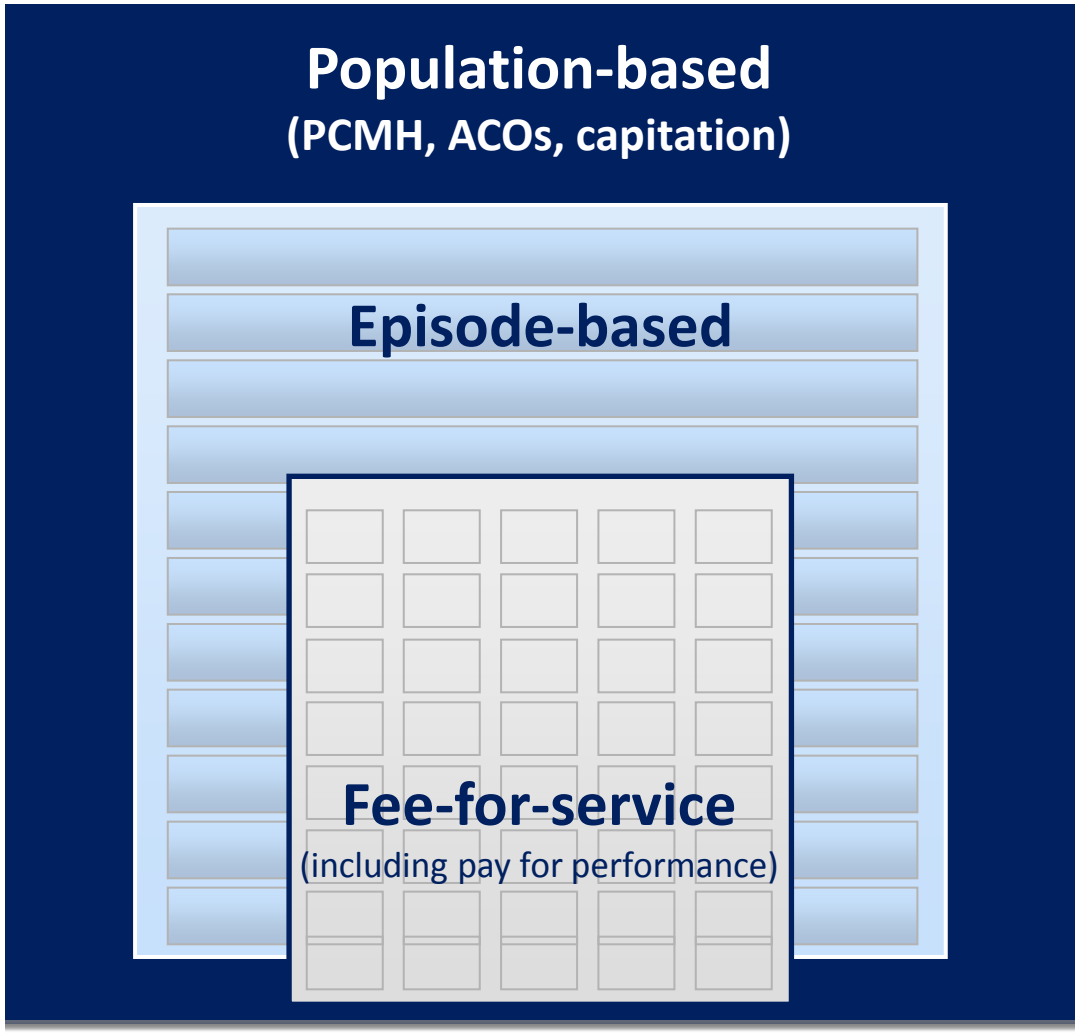
Shift to population-based and episode-based payment

Payment approach



Most applicable

- Primary prevention for healthy population
- Care for chronically ill (e.g., managing obesity, CHF)

- Acute procedures (e.g., CABG, hips, stent)
- Most inpatient stays including post-acute care, readmissions
- Acute outpatient care (e.g., broken arm)

- Discrete services correlated with favorable outcomes or lower cost

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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

Aligning on goals of PCMH / population-based models in Ohio

I. By region, Ohio will roll out a portfolio-based approach to population-based care delivery and payment models across multiple payers and all books of business, with aspiration to reach
   A. At least 50% of population in selected markets within 3 years of roll-out
   B. Reach 80-90% of Ohio's population in some value-based payment model (combination of episodes- and population-based payment) within 5 years

II. To the extent permissible, payers should coordinate provider targeting strategy so that providers can smoothly transition their entire panel to population-based care delivery and payment models

III. Participation criteria will be consistent across payers and structured so that participation is accessible to most providers, but providers must also meet aspirational milestones for continued participation in the program

IV. In order to meet the varied needs and current capabilities of different types of providers and geographies, the transition to population-based care could take the form of a mix of models (e.g., PCMH, ACO), so long as models are aligned on a common set of principles

V. Medicare will participate in expansion, at a minimum by supporting production of "shadow" total cost of care reports for providers that enroll; ultimate goal is full Medicare participation, including payment

The State's role in working together

I. Working in collaboration with public and private partners, the State (e.g., OHT, Medicaid, ODH) will lead development of a "charter" in which payers will voluntarily agree to align certain aspects of the PCMH model over time, most prominently
   - A. Common expectations to qualify and operate as a PCMH (with potential that State designates a provider a PCMH so that other payers would honor)
   - B. Alignment on principles of payment (e.g., rewarding improvement in total cost of care, material level of compensation on table) but not standardization
   - C. Minimum level / standards for metrics and reporting
   - D. Plan for scale-up (likely geographical roll-out)

II. Ohio Medicaid will lead by example by implementing PCMH model(s), requiring its MCO partners to participate for Medicaid business, and encouraging MCO implementation for other books of business. The State will also encourage State Employee Benefit Plans to implement PCMH or other population-based models

III. The State will further enable growth of medical home model by supporting HIT infrastructure, workforce development, and continuing to coordinate and align many ongoing activities

IV. The State will provide guidance and work with stakeholders to resolve legal and regulatory barriers

V. The State will gather data and feedback from the multi-payer group and provider sites to measure overall program performance

Principles for how the multi-stakeholder group will continue to work together

Ongoing PCMH and population-based model work will rely on regular meetings of the multi-stakeholder groups. Where possible, group will leverage governance from SIM Design phase and Cincinnati CPCi pilot

I. Payers will be added to multi-payer group upon agreeing to the "Charter." Multi-payer group will continue to meet at regular intervals to:
   - A. Refine model design and "Charter" on an ongoing basis, as necessary
   - B. Finalize regional roll-out plan
   - C. Create plans to maximize employer adoption of and provider participation in population-based models
   - D. Identify and resolve practical barriers to successful scale-up

II. Major providers will be added to Clinical workgroup as population-based models are expanded to their geographies. Clinical workgroup will continue to meet at regular intervals to:
   - A. Provide feedback on model design and "Charter" including suggestions for model components that need greater consistency across payers and general appetite for providers to opt-in to these models
   - B. Serve as conduits for frontline providers transitioning to PCMH and other population-based models, in order to fine-tune or course-correct the program
   - C. Form task-force groups to resolve critical barriers to scale, as necessary (e.g., research and make recommendations on how to refine model for small practices)

Strategy for implementation of episode-based payments

Goal: Multi-payer episode model, state-wide, covering ~50 - 60% of total healthcare spend in 5 years

I. Five-year plan for multi-payer adoption of >50 episodes across inpatient admissions, acute inpatient, acute outpatient, procedures, and behavioral health; ~20 episodes launch in first three years

II. Episodes selected are relevant across payer populations & model encompasses most books of business for public and most private payers with emphasis on fully insured populations & Medicare Advantage

   A. Certain design elements are consistent across payers (e.g., base episode definitions, provider reporting format); others remain at each payer's discretion (e.g., performance thresholds)

   B. Multi-payer team, convened by the state, collaborates on implementation and roll-out with aim to synchronize launch, where possible, across episodes

III. At launch, max possible potential accountable providers across the state participate; scale-up approach involves increasing number of episodes over time with design tailored to accelerate provider adoption

   A. Model incorporates diverse group of providers early on, evolving to cover critical mass of each provider type (e.g., orthopedic surgeon, facility, obstetrician)

   B. Individual episode definition has reasonable list of patient and episode exclusions to ensure focus on clinically comparable situations

   C. Transitional strategies included in Medicaid model, and at discretion of each private payer, give providers time to adjust to new model (e.g., stop-loss, cost normalization)

   D. Medicaid initial threshold strategy focused on supporting providers to win, with risk sharing focused on providers meaningfully out-of-step with clinically recommended best practices (other payers to develop individual approaches)

Role of the state in episode implementation

Goal: **State leads by example with Medicaid program, supports co-development with stakeholders of standardized elements for implementation, and takes point on messaging to providers**

I. Where it has influence, State implements episode-based model to move meaningful spend into value-based payments

   A. For Medicaid, shift rapidly to episodes for FFS and include as component in MC contracts

   B. Encourage state employee benefit program to incorporate into contracts for MC vendors

II. State continues to convene multi-payer coalition, and encourages payers (including Medicaid MCOs) to implement episodes in other books of business, engaging providers at more substantive level:

   A. Works through multi-payer coalition to design base definition (e.g. triggers, exclusions, accountable providers, quality metrics) for all episodes, with input from providers and payers across the state

   B. Develops common provider reporting format with potential to support private payer reporting in testing phase, including multi-payer report as comprehensive view of episode-based payment performance across all payers

   C. Takes point on provider messaging by convening working teams for each episode design as well as public workgroups to educate and receive feedback

Near term plan for episode implementation

I. State leads multi-payer coalition and provider workgroups in design of base definition for 5 episodes

II. State begins reporting for its FFS business and the MCOs; Medicaid and MCOs synchronize transition to linking performance to payment on early wave of episodes in first year

III. Private payers begin reporting on some or all of designed episodes within first half of 2014 with agreement to tie to payment within 12 months