Ohio | Governor's Office of Health Transformation

We get what we pay for: Ohio's plan to transform payments to improve health

Greg Moody, Director
Office of Health Transformation

The Pay for Performance Summit
March 3, 2015

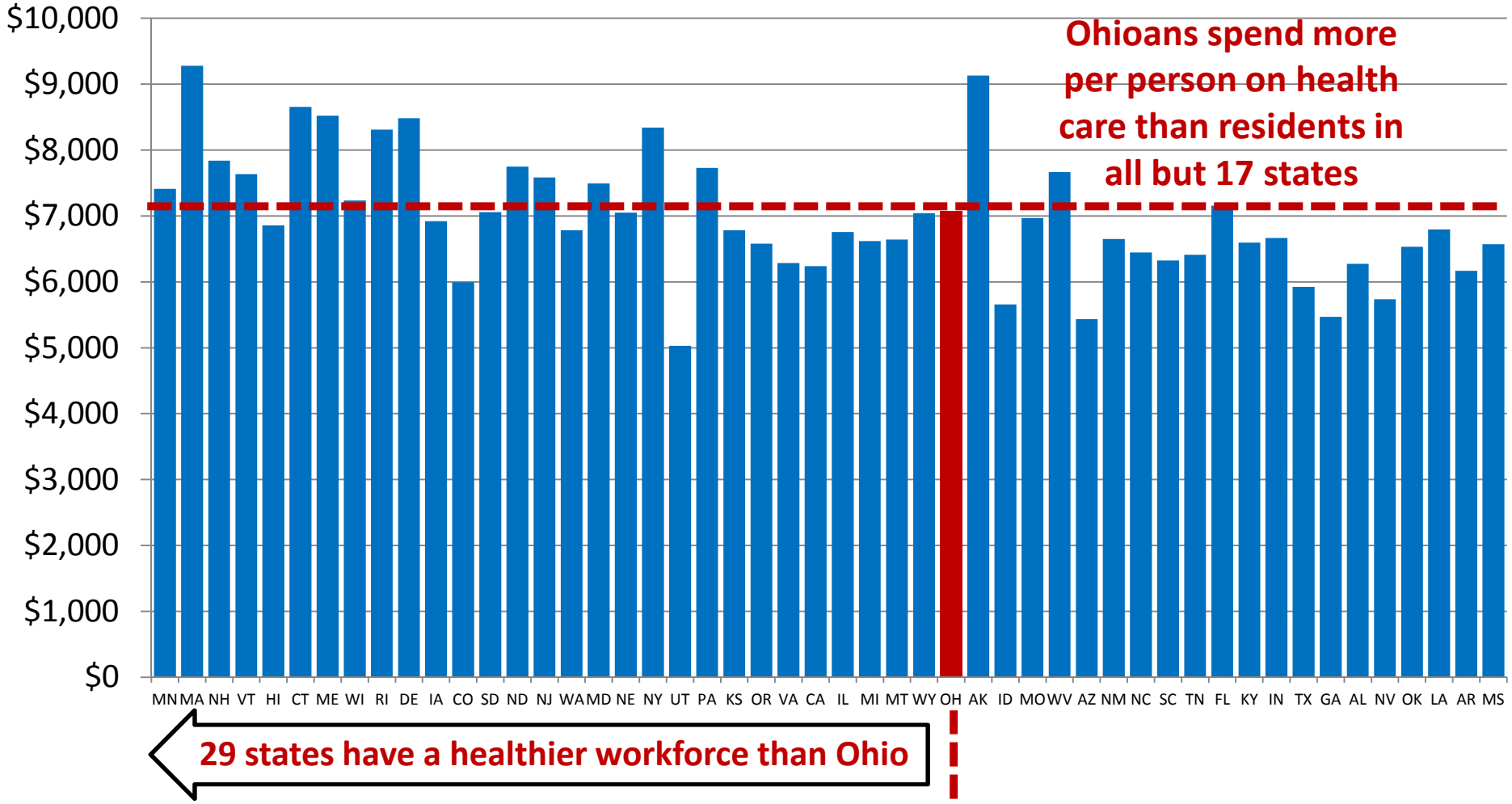
www.HealthTransformation.Ohio.gov

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

Source: UnitedHealth, *Farewell to Fee-for-Service: a real world strategy for health care payment reform* (December 2012)

Health Care Spending per Capita by State (2011) in order of resident health outcomes (2014)



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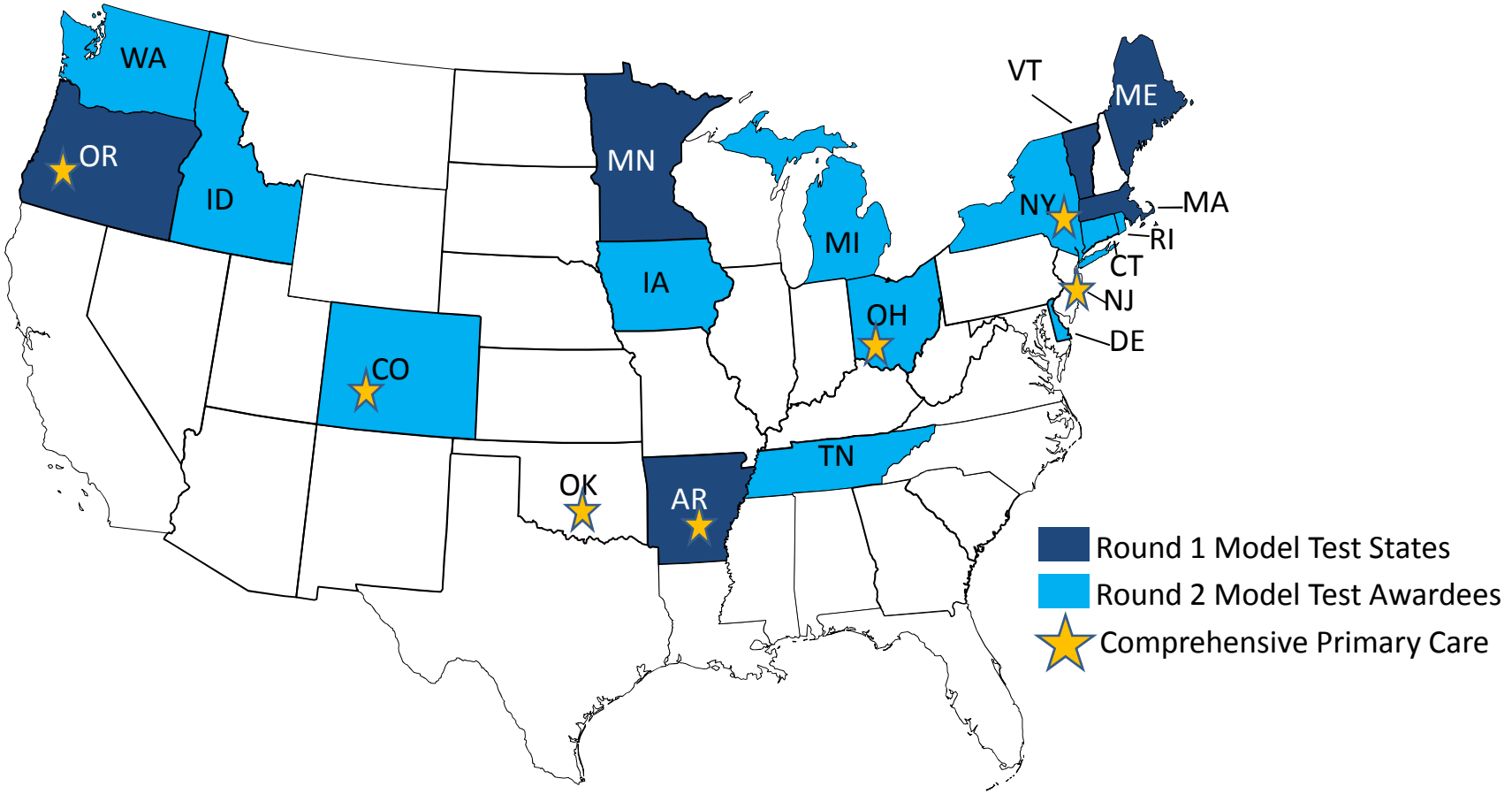
Sources: CMS *Health Expenditures by State of Residence* (2011); The Commonwealth Fund, *Aiming Higher: Results from a State Scorecard on Health System Performance* (May 2014).

State Innovation Model (SIM) grants awarded to 17 test states



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SOURCE: State Innovation Models and Comprehensive Primary Care Initiative, U.S. Centers for Medicare and Medicaid Services (CMS).

Comprehensive Primary Care Initiative

- Dayton/Cincinnati is one of only seven CPC sites nationally
- Bonus payments to primary care doctors who better coordinate care
- Multi-payer: Medicare, Medicaid, nine commercial insurance plans
- 75 primary care practices (261 providers) serving 44,500 Medicare enrollees in 14 Ohio and 4 Kentucky counties

The goal is to learn from CPC in developing an approach to roll out PCMH statewide

- Practices were selected based on their use of HIT, advanced primary care recognition, and participation in practice improvement activities
- Supported by a unique regional collaborative:

Creating connections. Improving care.

Better information. Better care. Better outcomes.

Ohio's Innovation Model Partners:

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

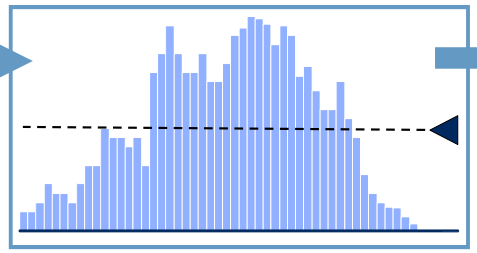
Payers reimburse for all services as they do today

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



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

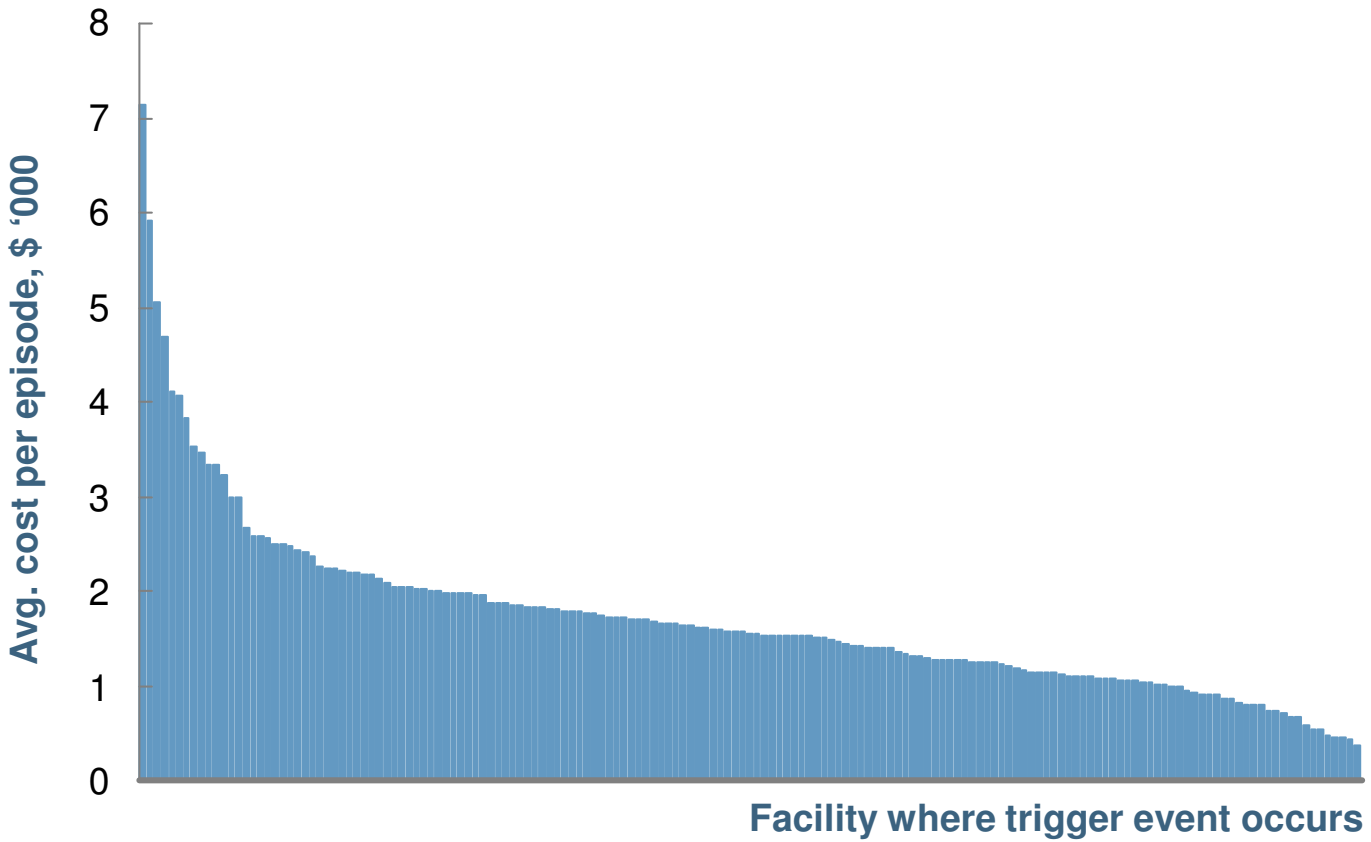
6 **Providers may:**

- **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

Asthma Acute Exacerbation: Provider Performance

Distribution of provider average episode cost

$ in thousands



- **Unadjusted episode cost, no exclusions**
- Average cost after episode exclusions (e.g., clinical, incomplete data)
- Average cost after removal of impact of medical education and capital
- Average cost after risk adjustment and removal of high cost outliers

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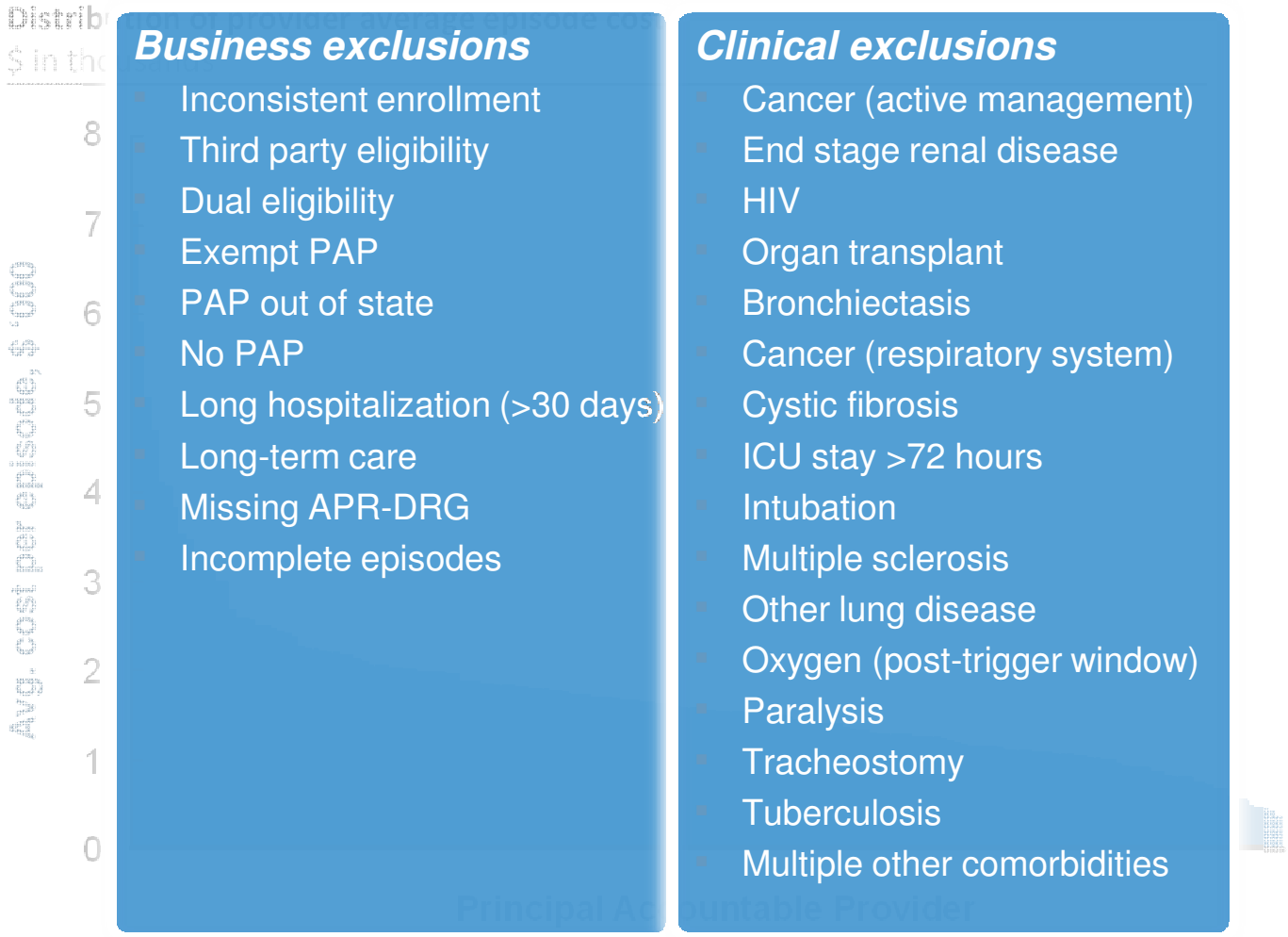
SOURCE: Ohio Medicaid claims data, 2011-12.

Asthma Acute Exercerbation: Provider Performance



Business exclusions

- Inconsistent enrollment
- Third party eligibility
- Dual eligibility
- Exempt PAP
- PAP out of state
- No PAP
- Long hospitalization (>30 days)
- Long-term care
- Missing APR-DRG
- Incomplete episodes

Clinical exclusions

- Cancer (active management)
- End stage renal disease
- HIV
- Organ transplant
- Bronchiectasis
- Cancer (respiratory system)
- Cystic fibrosis
- ICU stay >72 hours
- Intubation
- Multiple sclerosis
- Other lung disease
- Oxygen (post-trigger window)
- Paralysis
- Tracheostomy
- Tuberculosis
- Multiple other comorbidities

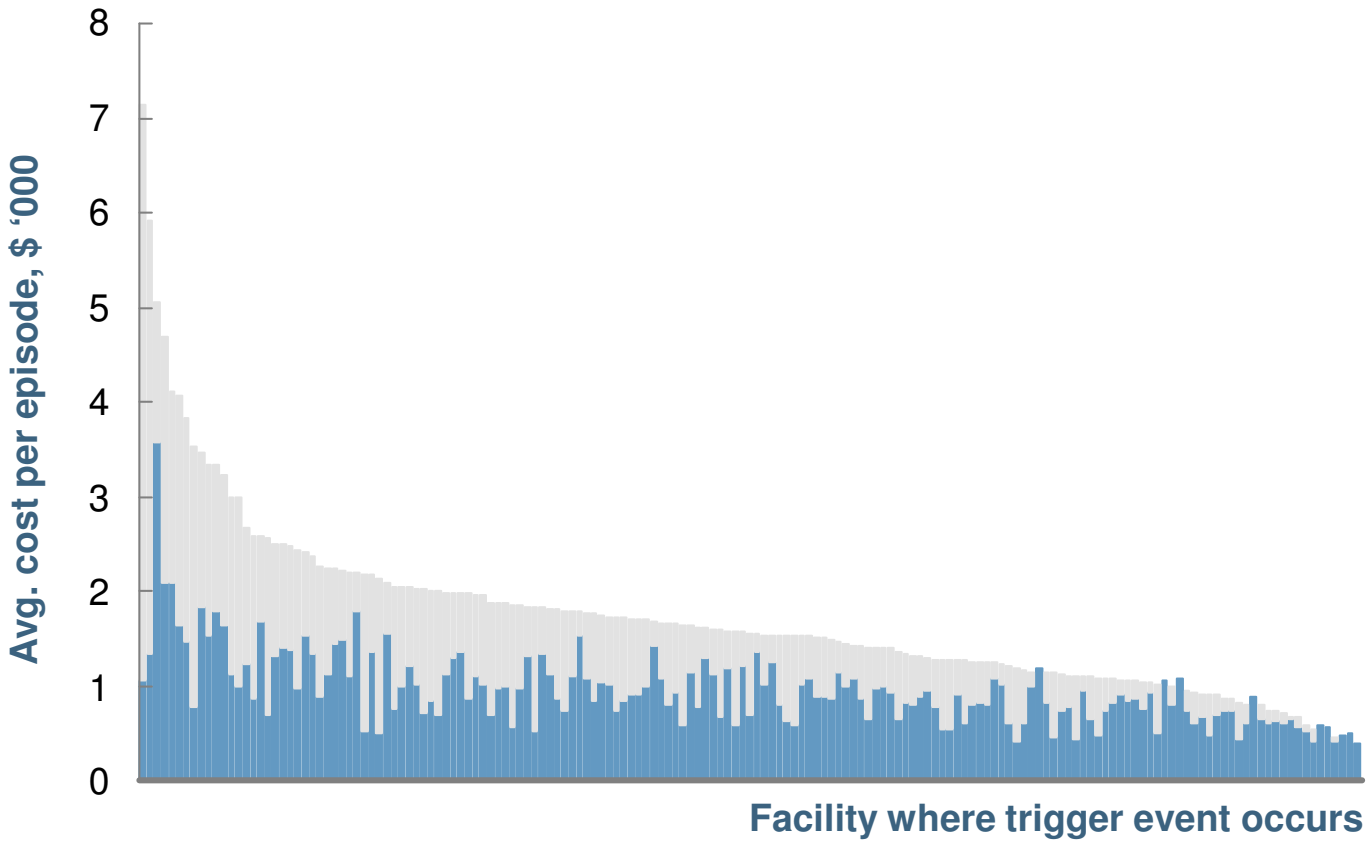
- Unadjusted episode cost, no exclusions
- Average cost after episode exclusions (e.g., clinical, incomplete data)
- Average cost after removal of impact of medical education and capital
- Average cost after risk adjustment and removal of high cost outliers

SOURCE: Ohio Episode-Based Payment Model Clinical Design Team definitions.

Asthma Acute Exacerbation: Provider Performance

Distribution of provider average episode cost

$ in thousands



- Unadjusted episode cost – no exclusions
- **Average cost after episode exclusions (e.g., clinical, incomplete data)**
- Average cost after removal of impact of medical education and capital
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SOURCE: Ohio Medicaid claims data, 2011-12.

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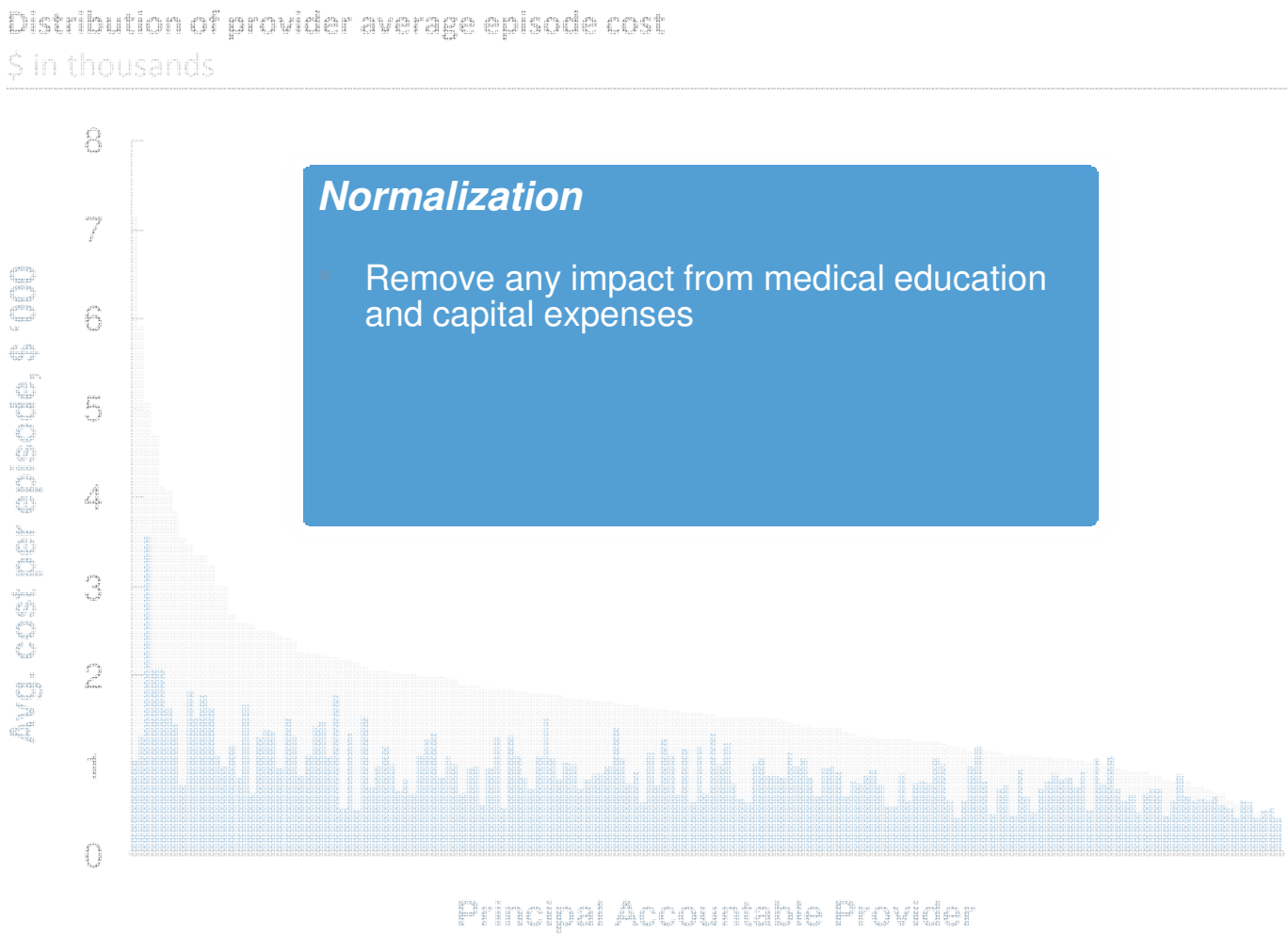

Normalization

- Remove any impact from medical education and capital expenses

- Unadjusted episode cost, no exclusions
- Average cost after episode exclusions (e.g., clinical, incomplete data)
- Average cost after removal of impact of medical education and capital
- Average cost after risk adjustment and removal of high cost outliers

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SOURCE: Ohio Episode-Based Payment Model Clinical Design Team definitions.

Asthma Acute Exacerbation: Provider Performance

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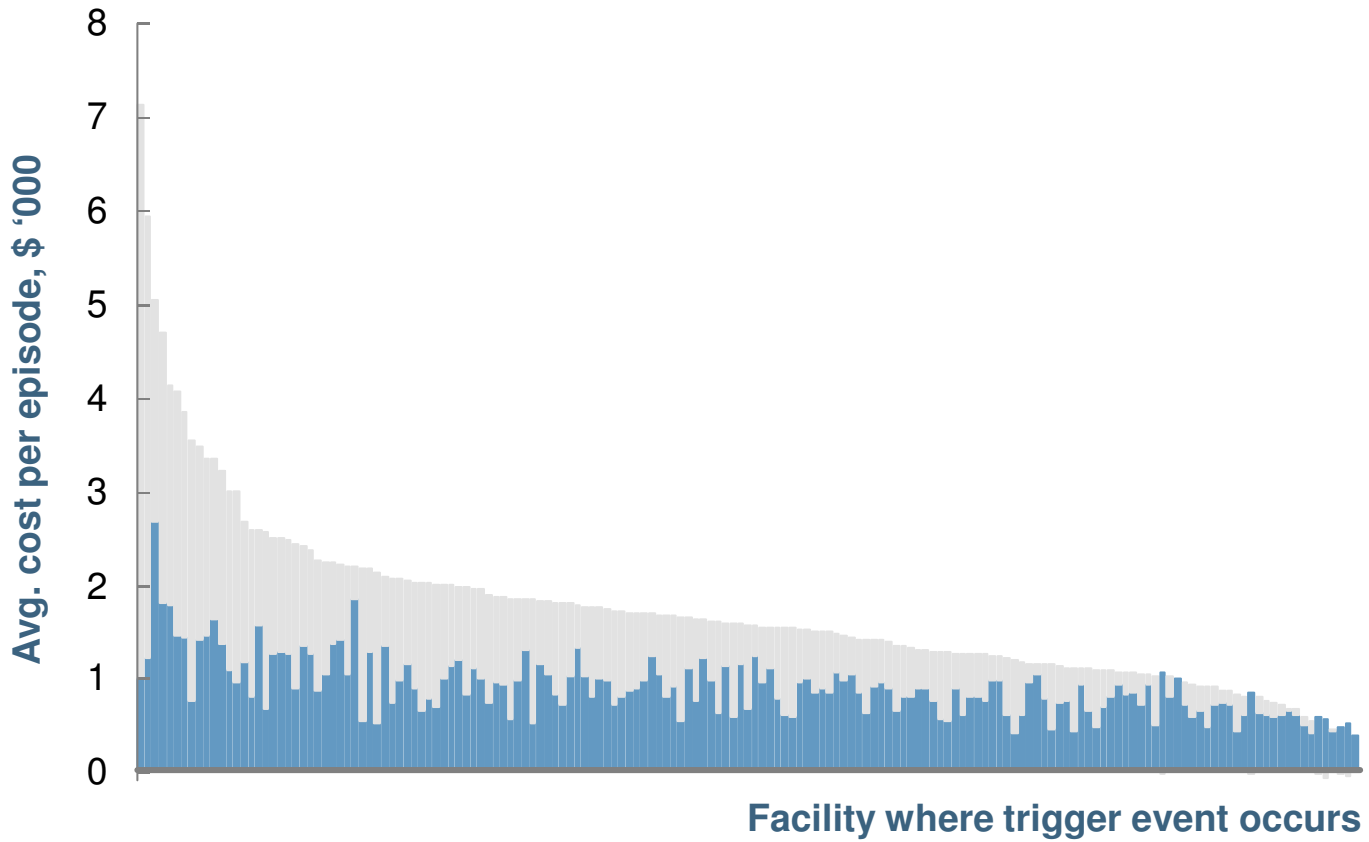

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- Average cost after episode exclusions (e.g., clinical, incomplete data)
- **Average cost after removal of impact of medical education and capital**
- Average cost after risk adjustment and removal of high cost outliers

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SOURCE: Ohio Medicaid claims data, 2011-12.

Asthma Acute Exacerbation: Provider Performance

Risk adjustment

- Adjust average episode cost down based on presence of clinical risk factors including:
  - Heart disease
  - Heart failure
  - Malignant hypertension
  - Obesity
  - Pneumonia
  - Pulmonary heart disease
  - Respiratory failure (specific)
  - Respiratory failure, insufficiency, and arrest
  - Sickly cell anemia
  - Substance abuse

High cost outliers

- Removal of any individual episodes that are more than three standard deviations above the *risk-adjusted* mean

- Unadjusted episode cost – no exclusions
- Average cost after episode exclusions (e.g., clinical, incomplete data)
- Average cost after removal of impact of medical education and capital
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SOURCE: Ohio Episode-Based Payment Model Clinical Design Team definitions.

Asthma Acute Exacerbation: Provider Performance

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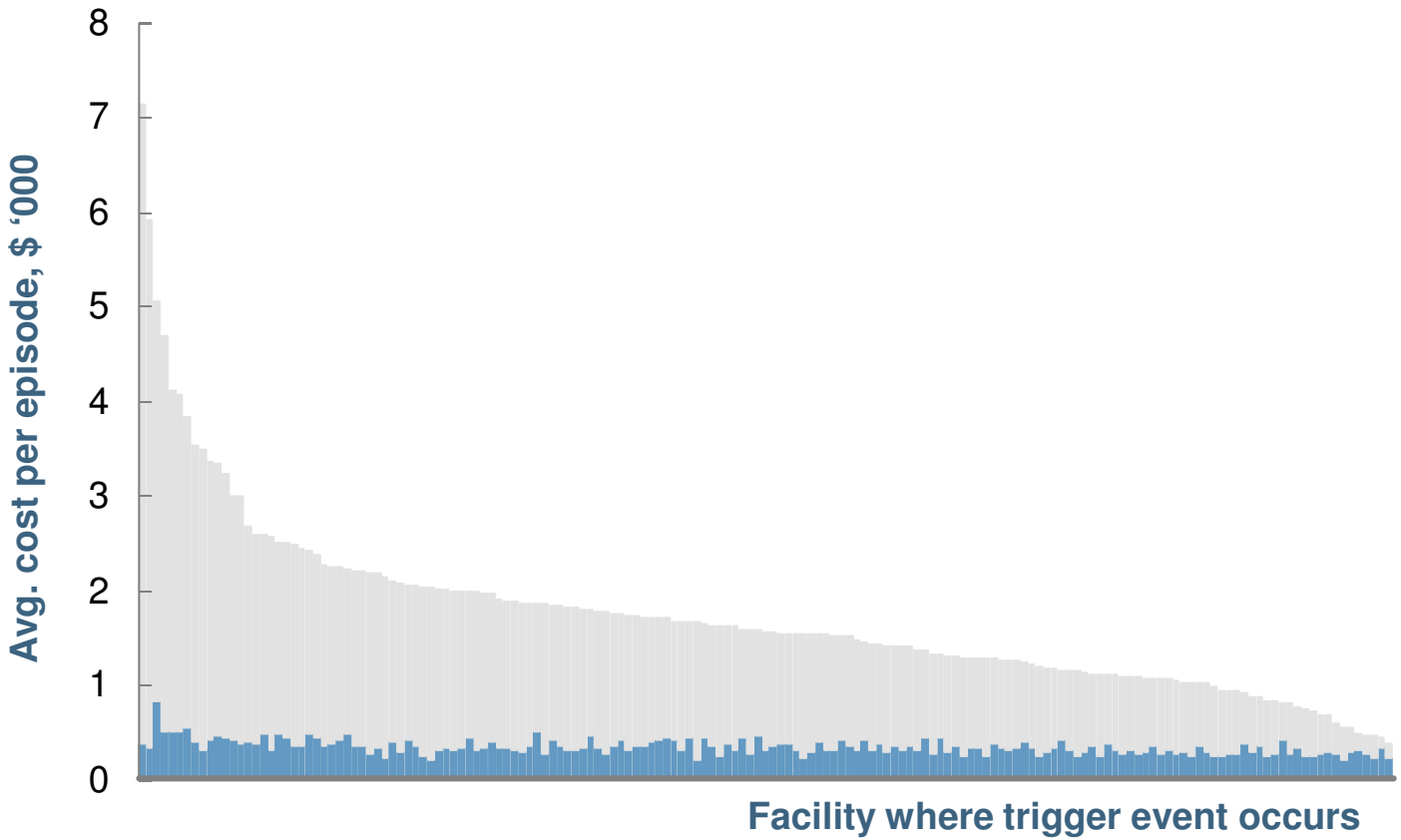

- Unadjusted episode cost, no exclusions
- Average cost after episode exclusions (e.g., clinical, incomplete data)
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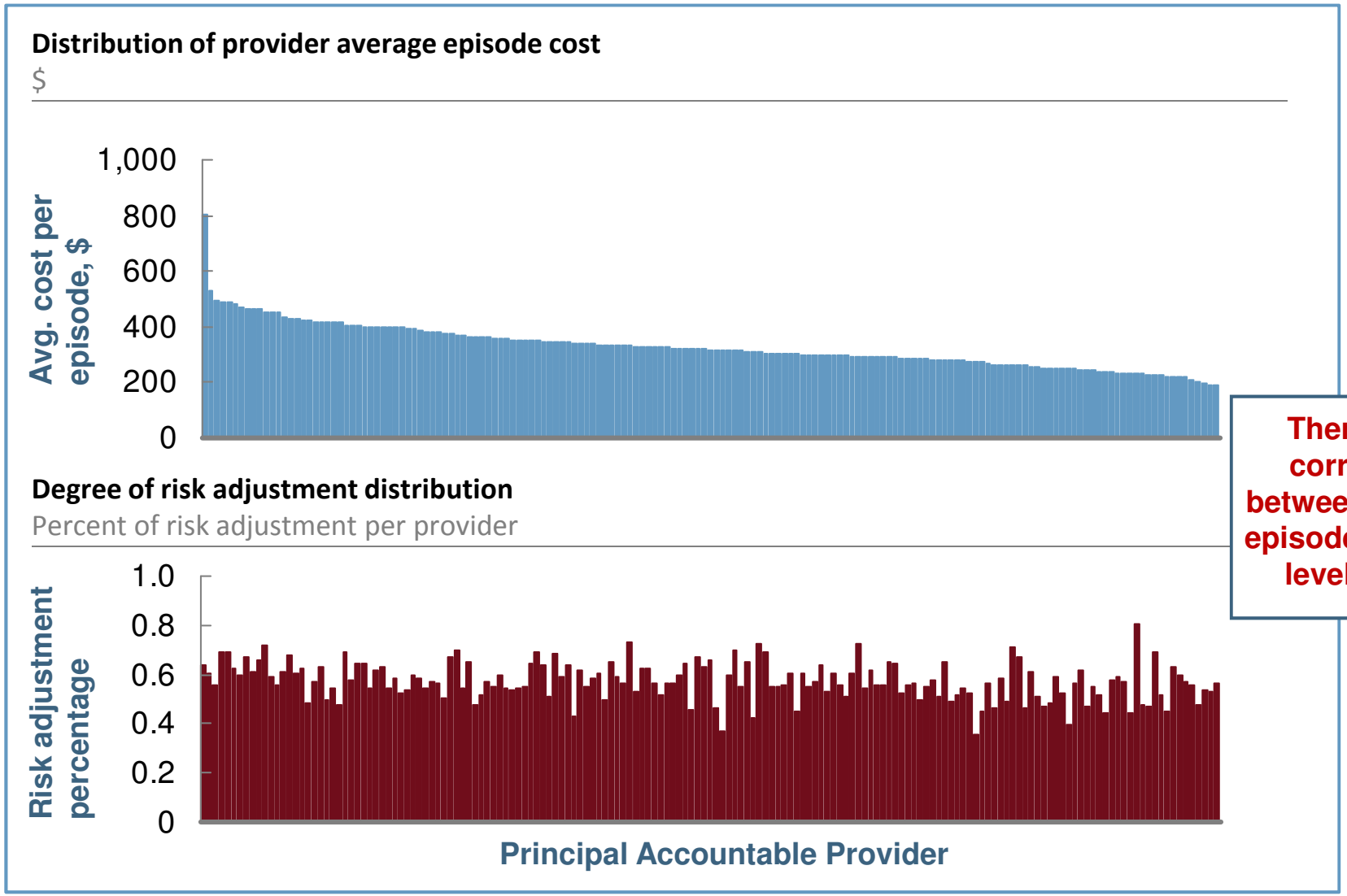
SOURCE: Ohio Medicaid claims data, 2011-12.

Asthma Acute Exacerbation: Provider Performance



There is no correlation between average episode cost and level of risk

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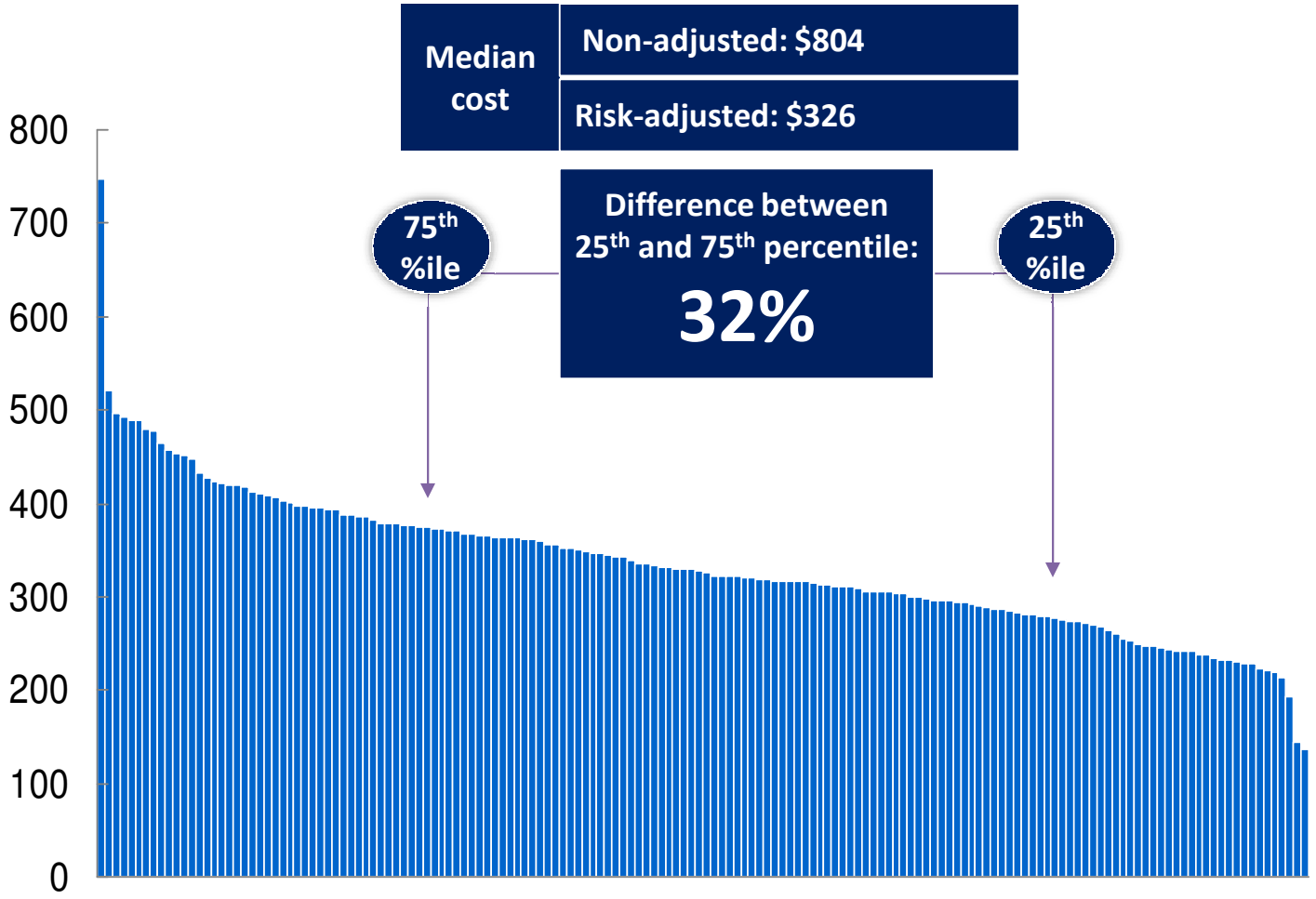
SOURCE: Ohio Medicaid claims data, 2011-12.

Variation across the Asthma Exacerbation episode



Impact:
- 160 PAPs
- 21,994 Episodes
- $19.4 million Spend

Select Quality Measures:
- 50% Episodes where x-ray is performed
- 38% Episodes where patient fills prescription for asthma controller

Select Risk Adjustments:
- Pneumonia
- Heart disease
- Obesity

Select Exclusions:
- Age <2 and >64
- Inconsistent enrollment
- ICU stay > 72 hours

Sources of variability/value:
- Medications
- Inpatient admissions
- Complications

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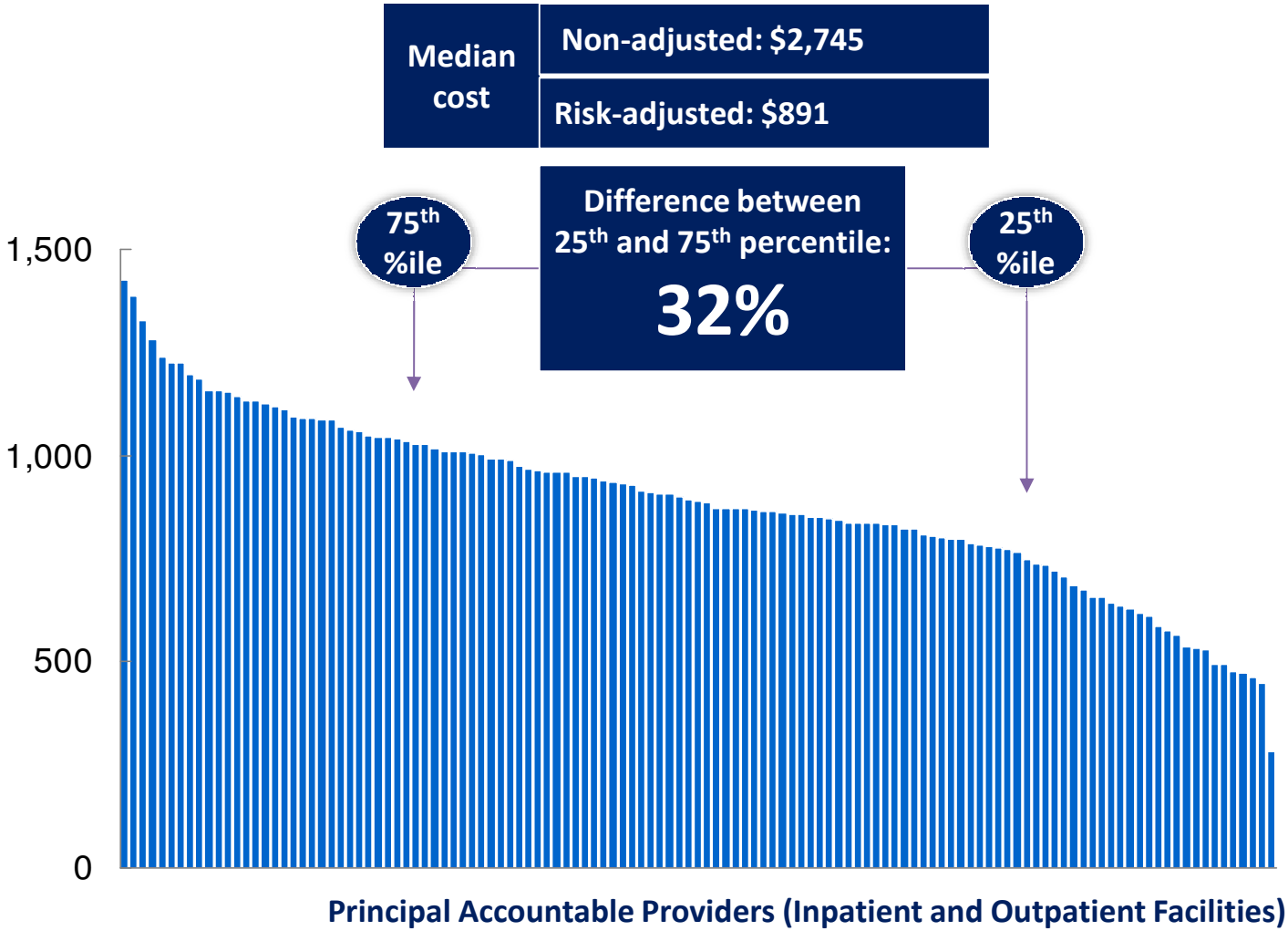
NOTES: Each vertical bar represents the average risk adjusted cost in dollars per episode (including outliers) for one provider across Medicaid FFS and five Medicaid MCOs; data covers period from July 1, 2013 to June 30, 2014.

Variation across the COPD episode



Impact:
- 123 PAPs
- 4,533 Episodes
- $13.7 million Spend

Select Quality Measures:
- 89% Episodes where x-ray is performed
- 61% Episodes where patient receives follow-up visit

Select Risk Adjustments:
- Cardiac dysrhythmias
- Blood disorders and anemia
- Respiratory failure

Select Exclusions:
- ICU stay > 72 hours
- Inconsistent enrollment
- Intubation of patient

Sources of variability/value:
- Medications
- Inpatient admissions
- Follow-up care

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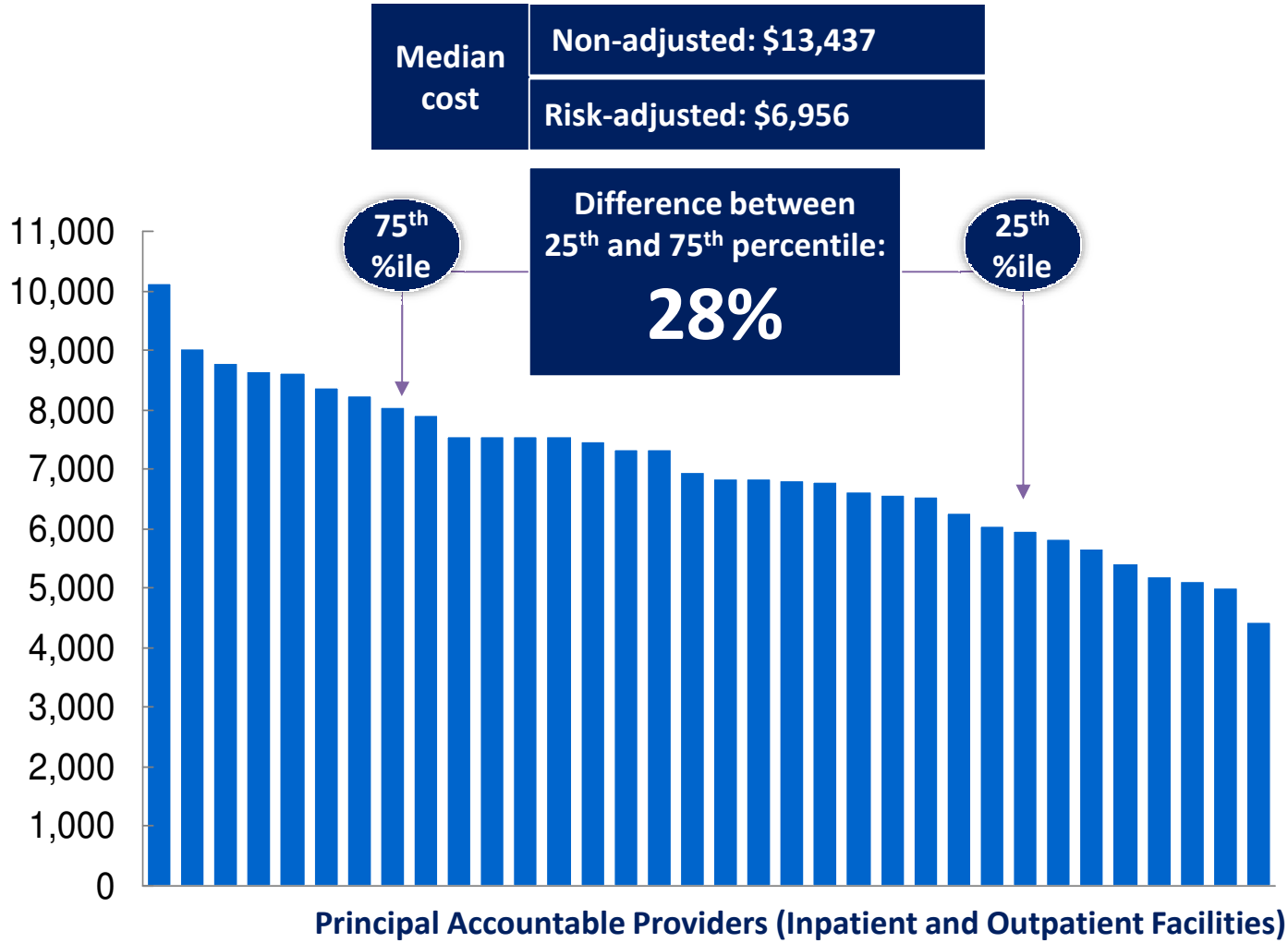
Variation across the Acute PCI episode



Impact:
- 34 PAPs
- 311 Episodes
- $4.3 million Spend

Select Quality Measures:
- 10% repeat PCI
- 1% post-operative hemorrhage

Select Risk Adjustments:
- STEMI
- Fluid and electrolyte disorders

Select Exclusions:
- Inconsistent enrollment
- Cardiogenic shock
- Age <18 and >64

Sources of variability/value:
- Diagnostic work-up
- Setting of care
- Complications
- Readmissions

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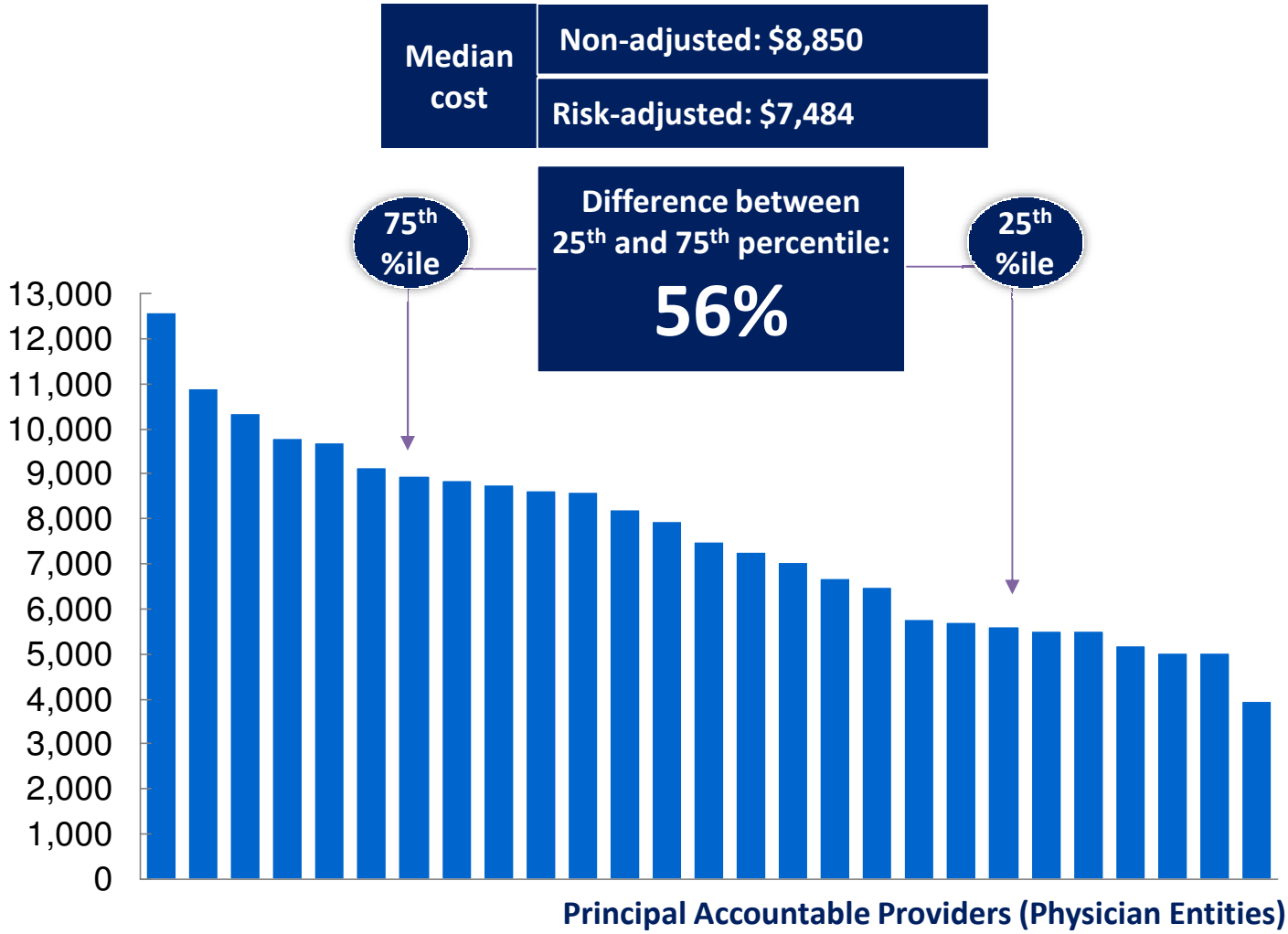
Variation across the Non-Acute PCI episode



Impact:
- 27 PAPs
- 273 Episodes
- $2.4 million Spend

Select Quality Measures:
- 10% repeat PCI
- 1% post-operative hemorrhage

Select Risk Adjustments:
- Fluid/electrolyte disorders
- Multiple vessel procedures
- Complex hypertension

Select Exclusions:
- Inconsistent enrollment
- Age <18 and >64
- HIV comorbidity

Sources of variability/value:
- Diagnostic work-up
- Setting of care
- Complications
- Readmissions

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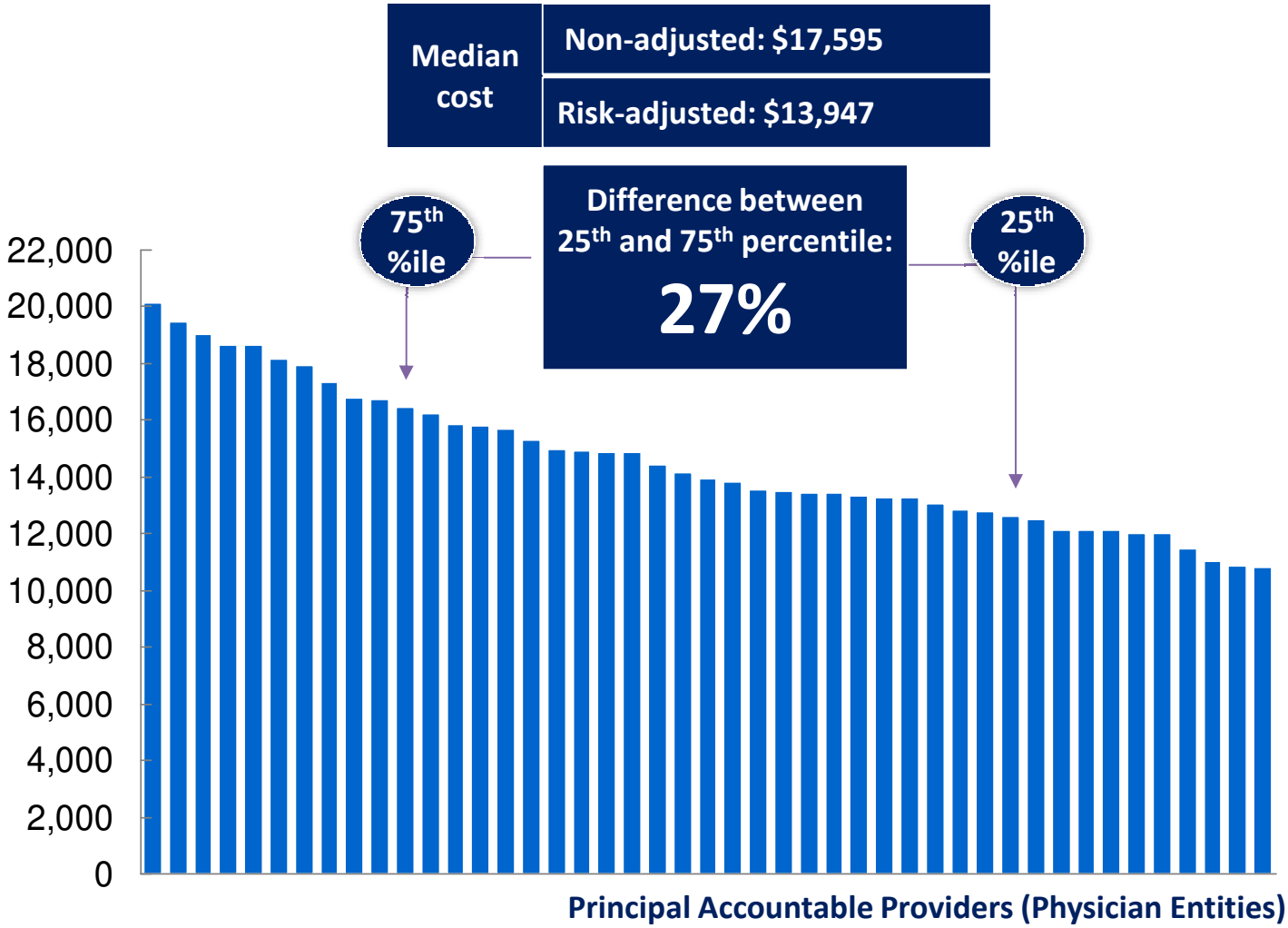
Variation across the Total Joint Replacement episode



Impact:

- 45 PAPs
- 574 Episodes
- $10.7 million Spend

Select Quality Measures:

- 10% Episodes where patient receives one or more blood transfusions
- 1% Episodes where patient develops pulmonary embolism

Select Risk Adjustments:

- Anemia
- Obesity

Select Exclusions:

- Inconsistent enrollment
- Presence of 3rd party liability
- Lower leg open wounds, fracture or dislocation

Sources of variability/value:

- Imaging choice/utilization
- Setting of care
- Implant choice

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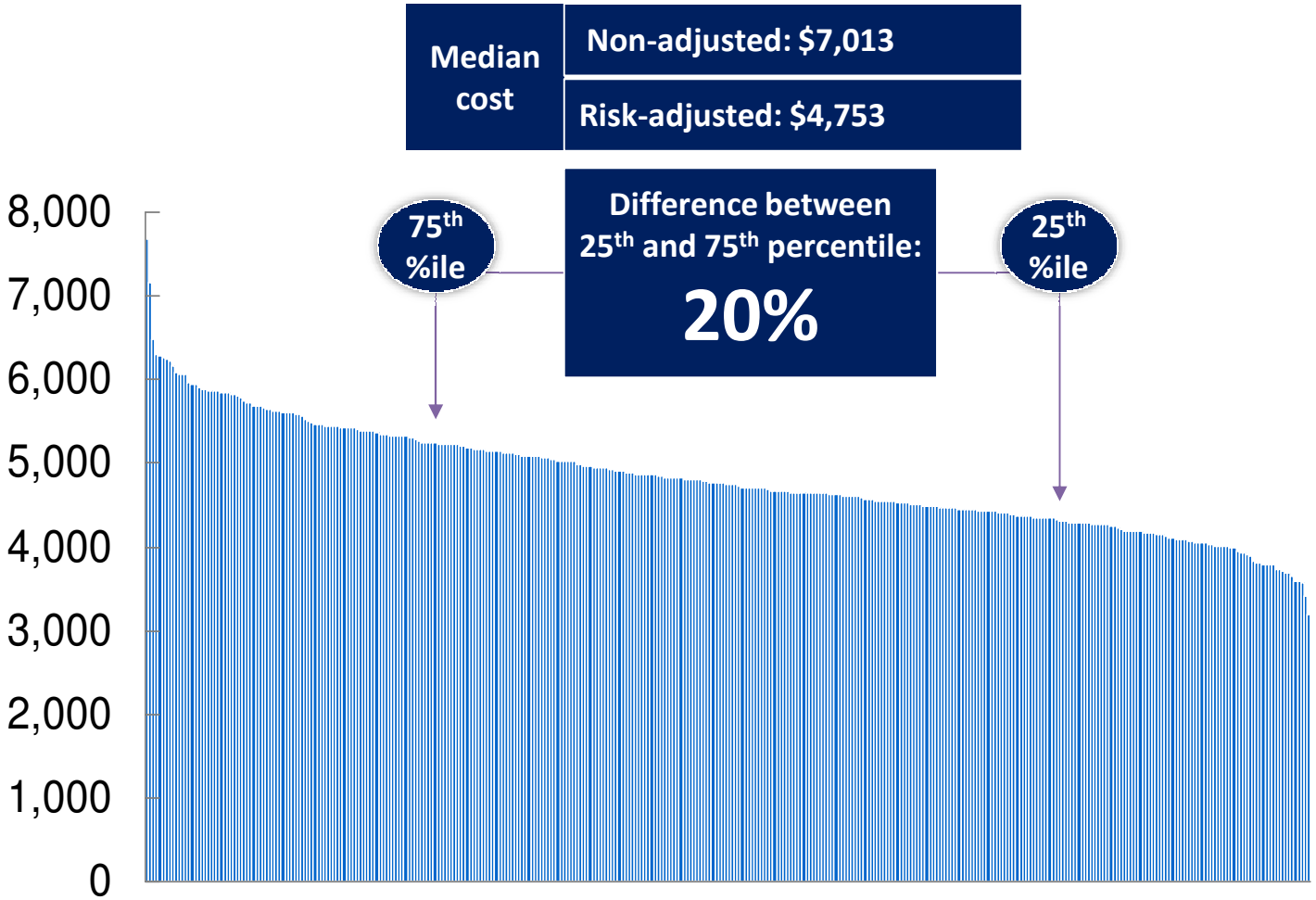
Variation across the Perinatal episode



Impact:

- 360 PAPs
- 30,939 Episodes
- $223.7 million Spend

Select Quality Measures:

- 86% Episodes where patient receives screening for Group B streptococcus
- 76% Episodes where patient receives HIV screening

Select Risk Adjustments:

- Menstrual disorders
- Umbilical cord complication
- Eclampsia
- Anemia

Select Exclusions:

- Presence of 3rd party liability
- Cystic fibrosis
- Inconsistent enrollment

Sources of variability/value:

- Elective interventions
- Readmissions

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Anthem

UnitedHealthcare

MEDICAL MUTUAL

CareSource

MOLINA HEALTHCARE

Buckeye Community Health Plan

PARAMOUNT ADVANTAGE

This is an example of the reports the plans listed above will make available to providers beginning in March 2015

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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/A[1]

Episodes inclusion and exclusion

Total episodes: 154

Risk adjusted average spend per episode

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%

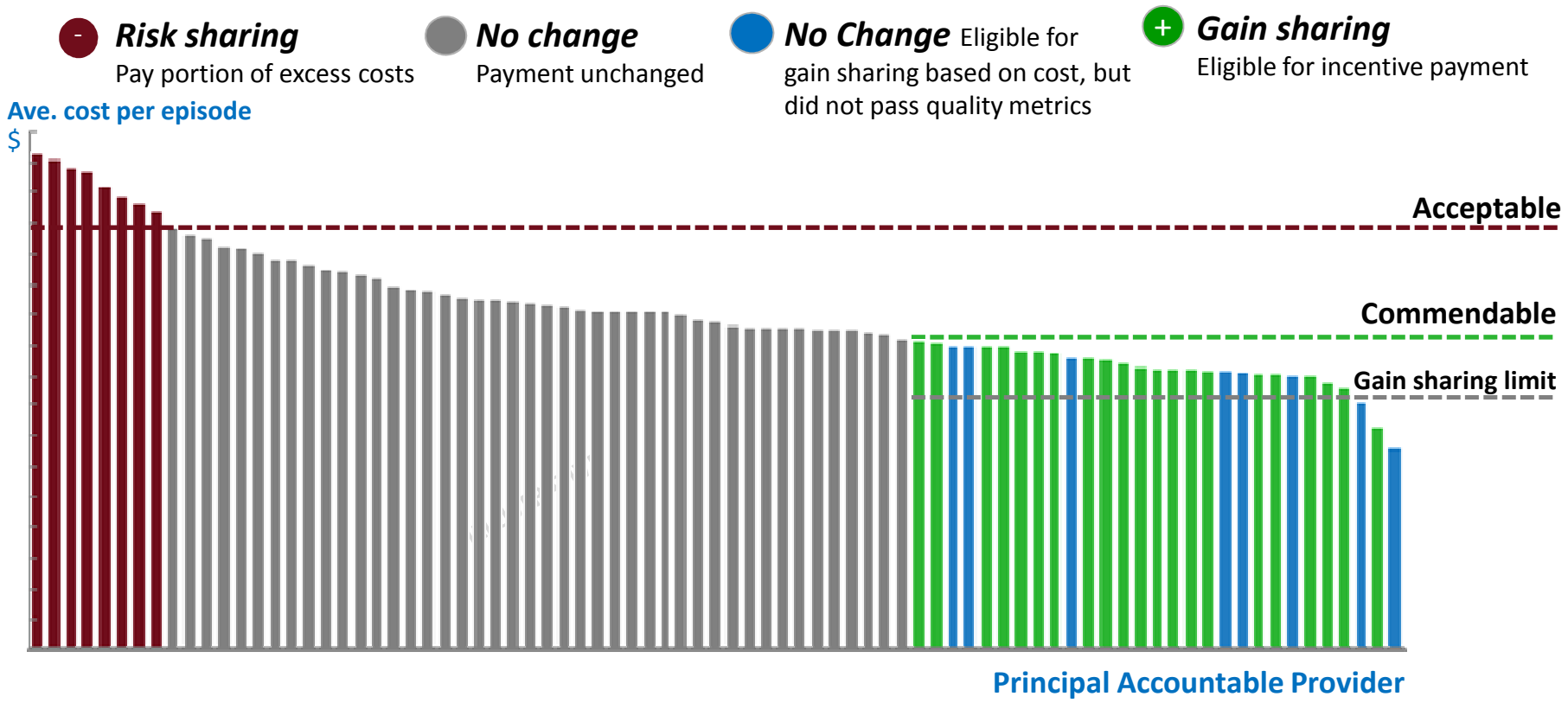
Potential gain/risk share

N/A[1]

1 Not applicable during reporting-only period

Ohio's next step is to link financial incentives to performance

Provider cost distribution (average episode cost per provider)



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

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Payment Models:

- **Overview Presentation**
- **PCMH Charter**
- **Episode Charter**
- **Detail for Providers**
  - **Episode Definitions**
  - **Code Tables**
  - **Risk Adjustment**