The MetroHealth System

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The MetroHealth System

- 550 bed tertiary care academic medical center with 27 satellite facilities and an additional 20 sites served through community partnerships
- 142 primary care physicians
- 459 specialty physicians
- 193 advanced practice nurses
- 37 physician assistants
- 300+ resident/fellow physicians
- 1,200 nurses
- 26,735 discharges in 2015
- 106,000 ED visits in 2015
- Over 1,000,000 outpatient visits in 2015

- Affiliated with Case Western Reserve University School of Medicine
- Special Population Health Expertise: Medicaid, school-based health, corrections, foster care populations, value-based risk-sharing models

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Transition to a Value-Based World

When entering the payment reform environment and converting from fee-for-service to value-based reimbursement, it is important that providers:

- Carefully study their book of business
- Hone their population management approaches
- Enhance their investments in data analytics and patient engagement resources
- Transform their business model
- Continually assess their company culture

Larger organizations do not fare any better than smaller entities in adopting these significant changes

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MetroHealth's Payment Reform Experience

The MetroHealth System has hands-on experience with Medicaid payment reform through multiple initiatives:

- One of Ohio's largest Medicaid providers
- Caring for uninsured patients not yet enrolled in Medicaid
- Operating a successful pre-expansion Medicaid Waiver, MetroHealth Care Plus
- Supporting the State's exploration of risk-based evolution
- Designing advanced provider-payer collaborations
- Managing Medicaid HMO Value Based Total Cost of Care initiatives for CareSource's population

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Key MetroHealth Payment Reform Factors

Technology and Informatics

- Single electronic medical record across providers
- Patients actively using MyChart
- Among the “Most Wired” health systems nationally with HIMSS level 7 certification for ambulatory services

Patient Centered Medical Home (PCMH) Level III NCQA Recognized Primary Care locations

- Operational focus on primary care, ambulatory outreach, and the delivery of preventive and chronic disease services
- Care Coordination interventions tailored to identify and remove multi-source barriers to care for Medicaid beneficiaries
- Inherent metrics to monitor clinical, quality, and process results

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MetroHealth and CareSource Partnership

Organizations committed to re-balanced incentives

- Total Cost of Care contract with first dollar shared savings
- Population management investments
- Shared commitment to and shared financial reward for improving selected quality performance improvement measures, e.g. HEDIS

Essential layers of collaboration

- Executive leadership support and expectation of risk evolution
- Data transparency for population health analysis and planning
- Co-managed teams focused on making existing initiatives more effective and creating new ones for attributed beneficiaries' needs

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Realities to Payment Reform Implementation

Recognize multi-faceted provider-payer relationships

- Adding risk-based financials alone will not change the history
- Essential for provider/payer partners to get re-acquainted for the collaboration's necessary trust and dependencies to occur
- Leverage collective resources
- Align incentives between the organizations

Expect constant lessons-learned moments and retooling

Critical to assist patients with their real-life environments

Requires unwavering investment in population health and effective community partnerships

Active listening to Medicaid patients & their families as Advisors

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How Can The State of Ohio Offer Payment Reform Assistance?

1. **Continued support of Office of Health Transformation SIM initiatives:** PCMH roll out, Episodes of Care Payment
2. **Relieve providers with advanced value based proprietary risk contracts from competing reporting obligations**
3. **Ensure continuous coverage of Medicaid enrollees to achieve "triple aim" of improved care, improved population health, lower cost of care**
4. **Consider legislation requiring minimum percentage of payments from payers to providers be value based, as opposed to traditional fee-for-service payments**
5. **Facilitate payers' claims data-sharing with providers**
6. **Support of statewide health information exchange**

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Thank You. Questions or Comments?

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