



Governor's Office of  
Health Transformation

# Patient-Centered Medical Home Charter for Payers

Governor Kasich's Advisory Council on  
Health Care Payment Innovation

October 18, 2013

[www.HealthTransformation.Ohio.gov](http://www.HealthTransformation.Ohio.gov)



## Ohio's SIM Grant Activities

- Governor's Office of Health Transformation convened experts to provide detailed input on State Innovation Model (SIM) design
  - 100+ experts from 40+ organizations deeply engaged
  - 50+ multi-stakeholder meetings to align across payers and providers
  - Top 5 payers aligned on overall strategy
- Ohio selected McKinsey & Company to assist in producing:
  - State of Ohio Healthcare Diagnostic Report
  - PCMH and Episode "Charters" to align payer decisions
  - Analytics and implementation plans to support the models
  - Ohio's Healthcare Innovation Plan (to submit October 30, 2013)

# PCMH Model Design Team

## Providers

- Michael Rothberg, MD, Cleveland Clinic
- Jeff Biehl, AccessHealth Columbus
- Richard Shonk, MD, Cincinnati Health Collaborative
- Ken Bertka, MD, Catholic Health Partners
- William Wulf, MD, Central Ohio Primary Care
- Bruce Vanderhoff, MD, OhioHealth
- Will Groneman, TriHealth Cincinnati
- Randy Wexler, MD, Ohio State University
- Jim Misak, MD, MetroHealth
- Randall Cebul, MD, Better Health Greater Cleveland
- Rita Horwitz, RN, Better Health Greater Cleveland
- Deborah Southard, Family Practice of SW Ohio
- William Washington, MD, Linden Medical Center
- Pamela Oatis, MD, St. Vincent Mercy Children's
- Susan Miller, PriMed Physicians
- Nick Lashutka, Ohio Children's Hospital Assoc.
- Robert Falcone, MD, Ohio Hospital Assoc.
- Berna Bell, Ohio Hospital Assoc.

## Payers

- Robin Dawson, Medical Mutual
- Donald Wharton, MD, CareSource
- Randy Montgomery, Aetna
- Kelly Owen, Anthem
- Pam Schultz Anthem
- Richard Gajdowski, MD, United Healthcare
- Craig Osterhues, GE (*representing purchasers*)

## State

- Ted Wymyslo, MD, ODH (*PCMH Team Chair*)
- Heather Reed, ODH
- Amy Bashforth, ODH
- Robyn Colby, Medicaid
- Debbie Saxe, Medicaid
- Angela Dawson, Minority Health Commission
- Angie Bergefurd, MHAS
- Afet Kilinc, MHAS
- Greg Moody, OHT
- Rick Tully, OHT
- Monica Juenger, OHT
- Marc Molea, Aging
- Rebecca Susteric, BWC
- McKinsey: Razili Stanke-Koch, Caroline Cross, Brendan Buescher, Kara Carter, Thomas Latkovic, Amit Shah, MD



# 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

# Agree on degrees of standardization within each model

## “Standardize approach”

Standardize approach (i.e., identical design) only when:

- Alignment is critical to provider success or significantly eases implementation for providers (e.g., lower administrative burden)
- Meaningful economies of scale exist
- Standardization does not diminish potential sources of competitive advantage among payers
- It is lawful to do so
- In best interest of patients (i.e., clear evidence base)

## “Align in principle”

Align in principle but allow for payer innovation consistent with those principles when:

- There are benefits for the integrity of the program for payers to align
- It benefits providers to understand where payers are moving in same direction; it's beneficial to know payers are not moving in different direction
- Differences have modest impact on provider from an administrative standpoint
- Differences are necessary to account for legitimate differences among payers (e.g., varied customers, members, strategy, administrative systems)

## “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

# Ohio PCMH model charter with potential degrees of standardization by component

		“Standardize approach”	“Align in principle”	“Differ by design”
Care delivery model	Target patients and scope		<ul style="list-style-type: none"> <li>All patients included</li> <li>Strive for TCOC accountability</li> </ul>	
	Care delivery improvements		<ul style="list-style-type: none"> <li>Aligned vision / vocabulary of care delivery model</li> </ul>	<ul style="list-style-type: none"> <li>Payers, practices champion unique care delivery models</li> </ul>
	Target sources of value		<ul style="list-style-type: none"> <li>Align on near-term and longer term sources of value</li> </ul>	<ul style="list-style-type: none"> <li>Payers set unique targets to realize sources of value</li> </ul>
Payment model	Technical requirements for PCMH	<ul style="list-style-type: none"> <li>Standard set of requirements and milestones</li> </ul>	<ul style="list-style-type: none"> <li>Payers do not pose additional barriers to participation</li> </ul>	<ul style="list-style-type: none"> <li>Payers separately design link of requirements &amp; milestones to payment</li> </ul>
	Attribution / assignment		<ul style="list-style-type: none"> <li>Attribute to provider that can be held accountable for TCOC</li> <li>Provide transparency</li> </ul>	<ul style="list-style-type: none"> <li>Payers maintain unique attribution methodologies</li> </ul>
	Quality measures	<ul style="list-style-type: none"> <li>Standard “menu” of metrics &amp; definitions</li> </ul>	<ul style="list-style-type: none"> <li>Agree to have link between quality and payment</li> </ul>	<ul style="list-style-type: none"> <li>Payers separately design how metrics link to payment)</li> </ul>
	Payment streams/ incentives		<ul style="list-style-type: none"> <li>Support for practice transformation</li> <li>Compensation for activities not fully covered by current fee schedule</li> <li>Shared savings or other TCOC incentives / payment</li> <li>Approach to include small practices</li> </ul>	<ul style="list-style-type: none"> <li>Payers will have unique                             <ul style="list-style-type: none"> <li>Payment levels</li> <li>Risk adjustment</li> <li>Shared savings methodology</li> </ul> </li> </ul>
	Patient incentives		<ul style="list-style-type: none"> <li>Agree to create incentives, communication to engage patients</li> </ul>	<ul style="list-style-type: none"> <li>Incentives, benefit design, etc.</li> </ul>

# Target patients and scope

 Notable departure  
from CPCi

## “Standardize approach”

- N/A

## “Align in principle”

- Ultimately aim to include all beneficiaries in PCMH or some other population-based model
- Common vision for shared accountability for all medical costs, most behavioral or mental health costs, and long-term supports and services
- In the near term, payers may provide specific guidance on target patients for high focus (e.g., highest cost, diagnosed or at-risk for chronic conditions)

## “Differ by design”

- N/A

# Care delivery improvements

 Notable departure from CPCi

## “Standardize approach”

- N/A

## “Align in principle”

- Payers will generally align on a similar vocabulary / framework for the PCMH model. For example, in CPCi, care delivery model oriented around a five part framework:
  - Risk-stratified care management (e.g., care plans, patient risk-stratification registry)
  - Access and continuity of care (e.g., team-based care, multi-channel access, 24/7 access, same-day appointments, electronic access)
  - Planned care for chronic conditions and preventive care (e.g., appropriate and timely delivery of preventive care)
  - Patient and caregiver engagement (e.g., shared decision-making, more time discussing patient’s conditions and treatment options, medication adherence, greater awareness of cultural / linguistic / other unique patient needs)
  - Coordination of care across the medical neighborhood (e.g., follow-ups on referrals, integrating behavioral and physical health needs, evidence-based care)

## “Differ by design”

- Each payer can champion or promote its own unique or proprietary PCMH care delivery model
- Ultimately, practices execute PCMH care delivery model as they see fit and in accordance with their needs / capabilities within the confines of the technical requirements

# Target sources of value

## “Standardize approach”

- N/A

## “Align in principle”

- Initial focus for the first 3-5 years is to reduce total cost of care and increase quality. For example,
  - Reduced inappropriate ER use and hospital admissions
  - Reduced unnecessary readmits within 30 days of an inpatient stay
  - Appropriate use of generic Rx
  - Improved adherence to treatment plan
  - Recognition of high-value providers and appropriate settings of care
- Over time, additional value will be accrued from
  - Lower incidence of chronic illness
  - Prevention and early detection from better screening, preventative care, etc.

## “Differ by design”

- Payers will set unique targets / thresholds aimed at realizing these sources of value

# Technical requirements for PCMH

## “Standardize approach”

- Payers will agree to fully standardized requirements to participate as “OH PCMH”
- Payers will agree to fully standardized milestones for continued participation that will be measured/ monitored over time (e.g., performing care plans)
- Payers may determine the need for multiple sets of requirements or milestones to accommodate the needs of different geographies or types of providers (e.g., all practices must meet requirement set A, with large practices also needing to meet requirements in set B)

## “Align in principle”

- Where not possible to apply standardized participation criteria (e.g., due to pre-existing contracting or network constraints), the participation criteria should maintain the intent of the standard set and should not pose additional barriers to provider participation

## “Differ by design”

- The extent to which and how meeting these requirements affect payment

# Attribution / assignment

 Notable departure  
from CPCi

## “Standardize approach”

- N/A

## “Align in principle”

- Principles of attribution or assignment, namely:
  - Payers (or providers / patients) identify members for whom PCMH can be reasonably expected to share accountability for members’ health and costs over time
  - Where payers are attributing patients (instead of patient assignment)
    - Provide transparency on methodology and outcomes of attribution, including general alignment on cadence and format of reporting list of attributed patients to PCMHs
    - Make transparent to patients to which PCMH they have been attributed
- Align some elements of attribution process
  - Minimum frequency with which to refresh attribution (e.g., quarterly)
  - Format of reporting
- Consider aligning on minimum level of robustness or accuracy expected of payer attribution models

## “Differ by design”

- Specific attribution or assignment methodology will vary by payer and network configuration (e.g., some will assign, some will attribute)

# Quality measures

 Notable departure  
from CPCi

## “Standardize approach”

- Develop standardized “menu” of measures, i.e.,
  - Claims-based quality, cost, and utilization metrics to track/measure
  - Set of non-claims-based clinical data (e.g., from provider records, patient satisfaction surveys) that providers submit to payers
- Ensure “menu” of metrics takes into consideration the aspiration / requirements for provider infra (e.g., if not requiring EHR, choose metrics that can be reported manually)

## “Align in principle”

- Develop aligned approach to incorporating small practices in quality measurement (e.g., payers create virtual pooling based on provider ZIP code) in order to minimize complexity
- Payers agree to link a set of quality metrics to payment

## “Differ by design”

- How quality measures affect payment streams, including but not limited to
  - Methodology for linking metrics to payments
  - Relative emphasis on particular metrics
  - Quality targets or thresholds that determine degree of provider eligibility for payments

# Payment streams / incentives

## “Standardize approach”

- N/A

## “Align in principle”

- Agree to provide resources to support business model transformation for a finite period of time, particularly for small, less capitalized practices
- Agree to provide resources to compensate PCMHs for activities not fully covered by existing fee schedules (care coordination, non-traditional visits like telemedicine, population health management)
- Agree to reward PCMHs for favorably affecting risk-adjusted total cost of care over time by offering bonus payments, shared savings, capitation, or sub-capitation
  - Payers should align balance / emphasis on absolute performance or relative improvement
  - Agree to goal that as shared savings / TCOC payments ramp up, other payments may be reevaluated and potentially ramped down over time in order to create a self-sustaining model
- Agree to goal that providers assume greater risk over time
- Develop aligned approach to small practices (e.g., TCOC accountability) in order to minimize complexity

## “Differ by design”

- Duration and level of payments for practice transformation and activities not covered under existing fee schedules
- Risk adjustment methodologies both for assessment of TCOC and other payments (e.g., PMPMs)
- Level and method of reward TCOC performance

# Patient incentives

 Notable departure  
from CPCi

## “Standardize approach”

- N/A

## “Align in principle”

- Agree in principle to create incentives (e.g., value-based benefit design), communication, etc. that engage patients in PCMH care delivery model

## “Differ by design”

- Specific benefit designs (e.g., co-pay differentials, bonus payments) to be determined by individual payers