



Governor's Office of  
Health Transformation

# **Introduction to the Ohio Patient-Centered Medical Home Care Delivery and Payment Model**

January 2016

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



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Health Transformation

## 1. Ohio's approach to pay for value instead of volume

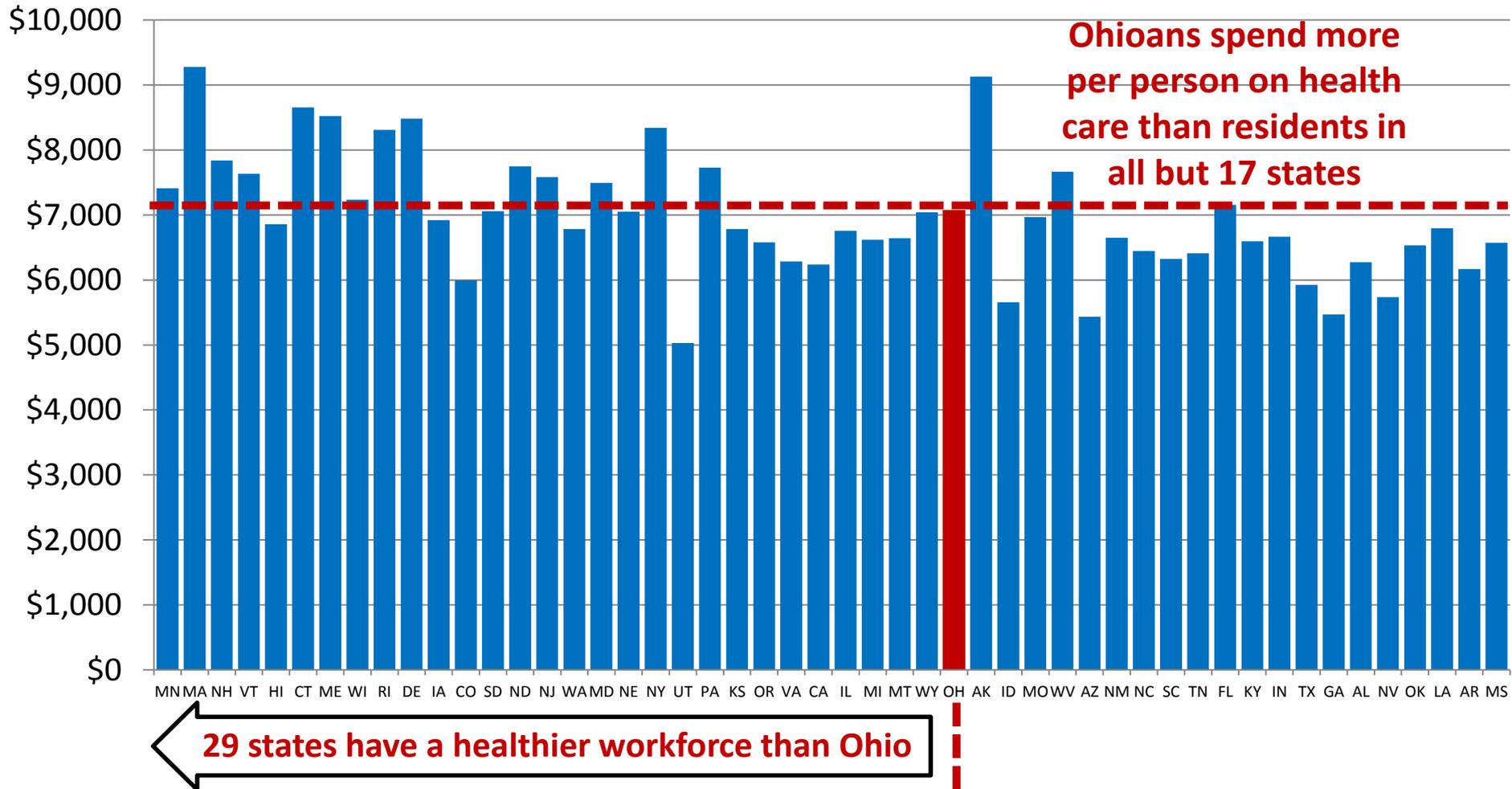
2. What is a Patient-Centered Medical Home?
3. How would care delivery change?
4. How would payment change?
5. How do providers earn enhanced payments?
6. Want to learn more?

## 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

# Ohio can get better value from what is spent on health care

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).



# Ohio's Path to Value

<b>Modernize Medicaid</b>	<b>Streamline Health and Human Services</b>	<b>Pay for Value</b>
<i>Initiate in 2011</i>	<i>Initiate in 2012</i>	<i>Initiate in 2013</i>
<i>Advance Governor Kasich's Medicaid modernization and cost containment priorities</i>	<i>Share services to increase efficiency, right-size capacity, and streamline governance</i>	<i>Engage private sector partners to set clear expectations for better health, better care and cost savings through improvement</i>
<ul style="list-style-type: none"> <li>• Extend Medicaid coverage to more low-income Ohioans</li> <li>• Eliminate fraud and abuse</li> <li>• Prioritize home and community based (HCBS) services</li> <li>• Reform nursing facility payment</li> <li>• Enhance community DD services</li> <li>• Integrate Medicare and Medicaid</li> <li>• Rebuild community behavioral health system capacity</li> <li>• Restructure behavioral health system financing</li> <li>• Improve Medicaid managed care plan performance</li> </ul>	<ul style="list-style-type: none"> <li>• Create the Office of Health Transformation (2011)</li> <li>• Implement a new Medicaid claims payment system (2011)</li> <li>• Create a unified Medicaid budget and accounting system (2013)</li> <li>• Create a cabinet-level Medicaid Department (2013)</li> <li>• Consolidate mental health and addiction services (2013)</li> <li>• Simplify and integrate eligibility determination (2014)</li> <li>• Refocus existing resources to promote economic self-sufficiency</li> </ul>	<ul style="list-style-type: none"> <li>• Join Catalyst for Payment Reform</li> <li>• Support regional payment reform</li> <li>• Pay for value instead of volume (State Innovation Model Grant) <ul style="list-style-type: none"> <li>– Provide access to medical homes for most Ohioans</li> <li>– Use episode-based payments for acute events</li> <li>– Coordinate health information infrastructure</li> <li>– Coordinate health sector workforce programs</li> <li>– Report and measure system performance</li> </ul> </li> </ul>

# In 2013, Ohio won a federal innovation grant to adopt two payment models that reward higher-quality, value-based care

## 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
2014	<ul style="list-style-type: none"> <li>▪ In 2014 focus on Comprehensive Primary Care Initiative (CPCi)</li> </ul>	<ul style="list-style-type: none"> <li>▪ State leads design of six episodes: asthma acute exacerbation, COPD exacerbation, perinatal, acute and non-acute PCI, and joint replacement</li> </ul>
2015	<ul style="list-style-type: none"> <li>▪ Collaborate with payers on design decisions and prepare a roll-out strategy</li> </ul>	<ul style="list-style-type: none"> <li>▪ State leads design of seven new episodes: URI, UTI, cholecystectomy, appendectomy, GI hemorrhage, EGD, and colonoscopy</li> </ul>
2016	<ul style="list-style-type: none"> <li>▪ Model rolled out to at least two major markets</li> </ul>	<ul style="list-style-type: none"> <li>▪ 20 episodes defined and launched across payers, including behavioral health</li> </ul>
2017-2018	<ul style="list-style-type: none"> <li>▪ Model rolled out to all markets</li> <li>▪ 80% of patients are enrolled</li> </ul>	<ul style="list-style-type: none"> <li>▪ 50+ episodes defined and launched across payers, including behavioral health</li> </ul>

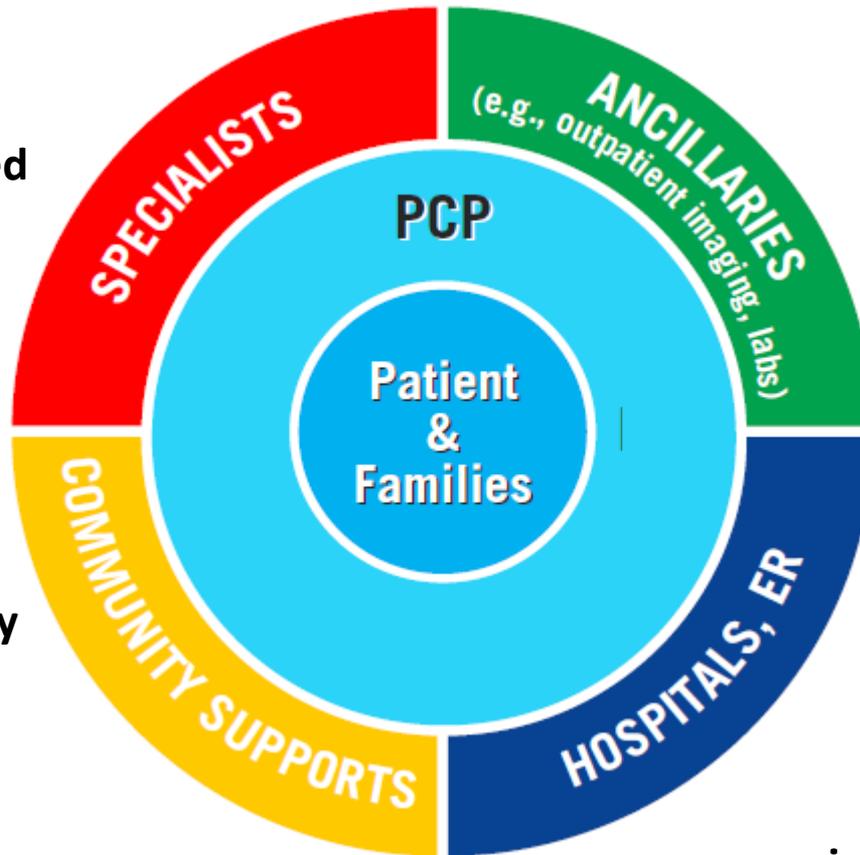


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1. Ohio's approach to pay for value instead of volume
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# What is a Patient-Centered Medical Home (PCMH) and why focus on primary care?

PCMH is a team-based care delivery model led by a primary care provider who comprehensively manages a patient's health needs with an emphasis on health care value and quality



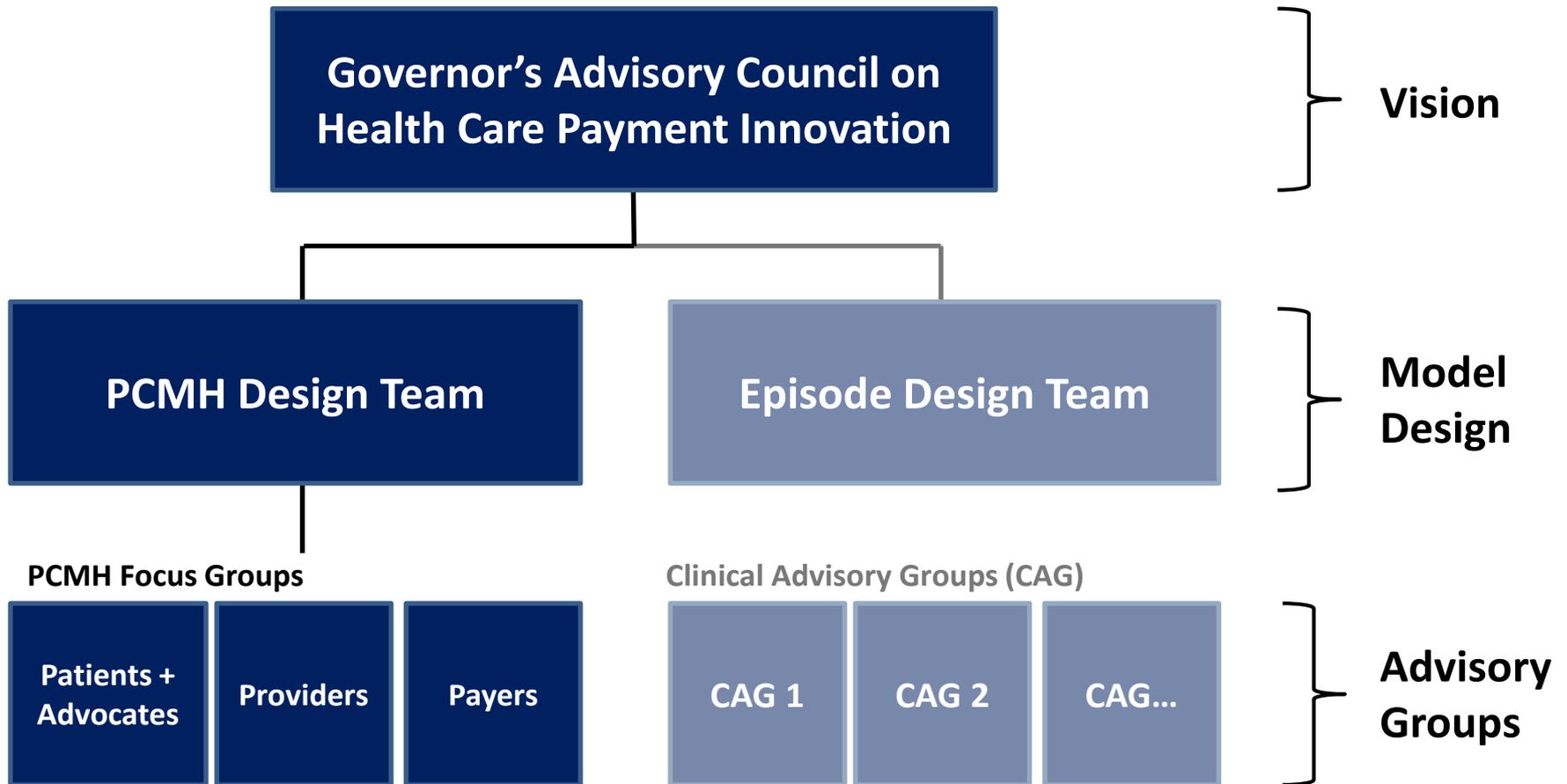
Most medical costs occur outside of the office of a primary care physician (PCP), but PCPs can guide many decisions that impact those broader costs, improving cost efficiency and care quality

# Designing Ohio's PCMH model requires input on many decisions

<b>Care delivery model</b>	<ul style="list-style-type: none"> <li>A. Target patients and scope</li> <li>B. Target sources of value</li> <li>C. Care delivery improvements</li> </ul>	<p>Vision for a PCMH's role in the healthcare eco system, including who they should target, how care should be delivered (including differences from today), and which sources of value to prioritize over time.</p>
<b>Payment model</b>	<ul style="list-style-type: none"> <li>D. Technical requirements for PCMH</li> <li>E. Attribution/assignment</li> <li>F. PCMH activities</li> <li>G. Quality/efficiency/total cost</li> <li>H. Payment streams/incentives</li> <li>I. Risk adjustment</li> </ul>	<p>Holistic approach to use payment (from payers) to encourage the creation of PCMHs, ensure adequate resources to fund transformation from today's model, and reward PCMH's for improving in outcomes and total cost of care over time</p>
<b>Infrastructure</b>	<ul style="list-style-type: none"> <li>J. Provider infrastructure</li> <li>K. Payer infrastructure</li> <li>L. State system infrastructure</li> </ul>	<p>Technology, data, systems, and people required to enable creation of PCMH, administer new payment models, and support PCMHs in making desired changes in care delivery</p>
<b>Scale-up and practice performance improvement</b>	<ul style="list-style-type: none"> <li>M. Scale-up target</li> <li>N. Practice transformation support</li> <li>O. Patient engagement</li> <li>P. Workforce/human capital</li> <li>Q. Legal/regulatory environment</li> <li>R. Network/contracting</li> <li>S. ASO contracting/participation</li> <li>T. Performance transparency</li> <li>U. Ongoing PCMH support</li> <li>V. Evidence/pathways/research</li> <li>W. Multi-payer collaboration</li> <li>X. Stakeholder engagement</li> </ul>	<p>Support, resources, or activities to enable practices to adopt the PCMH delivery model, sustain transformation and maximize impact</p> <p>SOURCE: Ohio PCMH Charter for Payers (October 2013)</p>



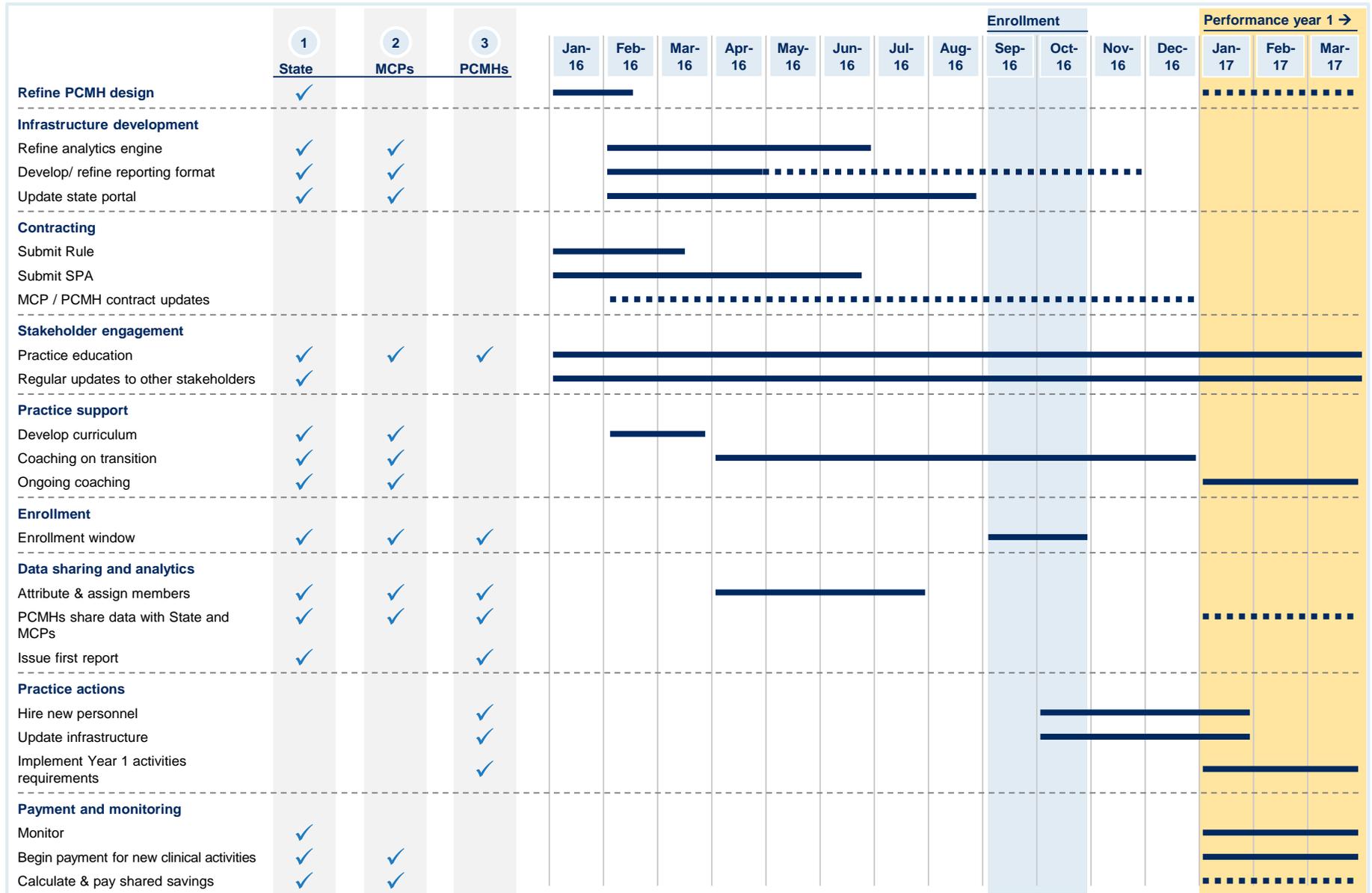
# Ohio's payment innovation design team structure delivered a PCMH care delivery and payment model framework in 2015



# Ohio's PCMH model design decisions have been shaped by meaningful input from 800+ stakeholders across Ohio

<b>PCMH Design Team</b>	<ul style="list-style-type: none"><li>▪ 3 meetings with a broad group of stakeholders (<i>payers, providers, RHICs, patient advocates, and population health experts</i>) involved in development of the PCMH charter and PCMH design</li></ul>
<b>Providers</b>	<ul style="list-style-type: none"><li>▪ 4 meetings of a provider focus groups with over 30 primary care physicians and PCMH clinical managers</li><li>▪ 2 regional health collaborative meetings in Cleveland and Cincinnati with over 200 attendees</li><li>▪ 574 responses to a statewide provider and clinician manager survey</li></ul>
<b>Payers</b>	<ul style="list-style-type: none"><li>▪ 6 meetings with over 40 representatives from commercial payers, Medicaid MCPs, OHT, ODM, ODH and DAS</li><li>▪ 20+ one on one calls with commercial payers and Medicaid MCPs</li></ul>
<b>Patient advocates</b>	<ul style="list-style-type: none"><li>▪ 2 focus groups with over 20 patient advocates</li><li>▪ Additional one on one meetings and presentations</li></ul>
<b>Population health experts</b>	<ul style="list-style-type: none"><li>▪ 6 meetings organized by the Health Policy Institute of Ohio with over 40 payer, provider, employer, local health district, and patient advocate representatives to discuss population health priorities</li></ul>

# Early view on timeline for statewide PCMH launch



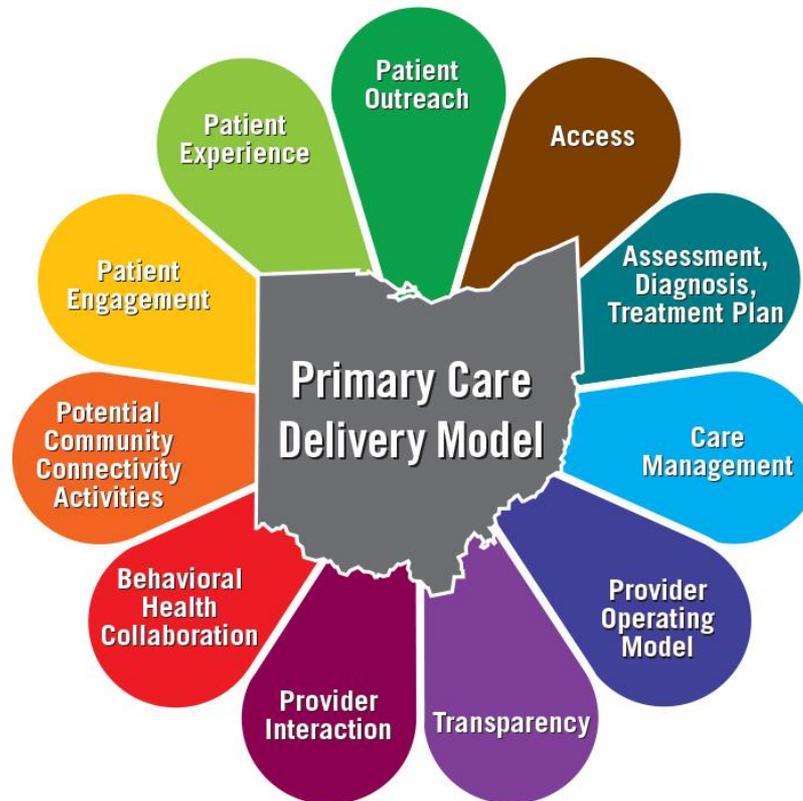


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# Ohio's vision for PCMH is to promote high-quality, individualized, continuous and comprehensive care

- Patient Experience:**  
Offer consistent, individualized experiences to each member depending on their needs
- Patient Engagement:**  
Have a strategy in place that effectively raises patients' health literacy, activation, and ability to self-manage
- Potential Community Connectivity Activities:**  
Actively connect members to a broad set of social services and community-based prevention programs (e.g., nutrition and health coaching, parenting education, transportation)
- Behavioral Health Collaboration:**  
Integrate behavioral health specialists into a patients' full care
- Provider Interaction:**  
Oversee successful transitions in care and select referring specialists based on evidence-based likelihood of best outcomes for patient
- Transparency:**  
Consistently review performance data across a practice, including with patients, to monitor and reinforce improvements in quality and experience



- Patient Outreach:**  
Proactive, targeting patients with focus on all patients including healthy individuals, those with chronic conditions, and those with no existing PCP relationship
- Access:**  
Offer a menu of options to engage with patients (e.g., extended hours to tele-access to home visits)
- Assessment, Diagnosis, Care Plan:**  
Identify and document full set of needs for patients that incorporates community-based partners and reflects socioeconomic and ethnic differences into treatment plans
- Care Management:**  
Patient identifies preferred care manager, who leads relationship with patients and coordinates with other managers and providers of specific patient segments
- Provider Operating Model:**  
Practice has flexibility to adapt resourcing and delivery model (e.g., extenders, practicing at top of license) to meet the needs of specific patient segments

# Vision for Ohio's primary care delivery model (1 of 4)

UPDATED 12/10/2015



	Beginning of the journey	Early PCMH	Maturing PCMH	Transformed PCMH
<b>Patient outreach</b>	<ul style="list-style-type: none"> <li>Reactive, presentation-based prioritization</li> </ul>	<ul style="list-style-type: none"> <li>Proactive, targeting patients with <b>chronic conditions and existing PCP/ team relationship</b></li> </ul>	<ul style="list-style-type: none"> <li>Proactive, targeting patients with <b>chronic conditions but no clear PCP relationship<sup>1</sup></b>, and prioritizing <b>patients at-risk</b> of developing a chronic condition</li> </ul>	<ul style="list-style-type: none"> <li>Proactive, with broader focus on all patients including healthy individuals</li> </ul>
<b>Access</b>	<ul style="list-style-type: none"> <li>Offer <b>limited access</b> beyond office/ regular hours</li> </ul>	<ul style="list-style-type: none"> <li>Expand channels for <b>direct patient PCMH interaction for at-risk patients</b> with an existing PCP/ team relationship through phone/ email/ text consultation</li> <li>Provide <b>24/7 access</b> to PCMH-linked resources for at-risk patients with an existing PCP/team relationship</li> </ul>	<ul style="list-style-type: none"> <li>Provide appropriately resourced <b>same-day appointments</b></li> <li>Ensure appropriate site of visit for <b>at-risk patients</b> (e.g., home, safe/ convenient locations in the community)</li> <li>Offer a <b>menu of communication options</b> (e.g., encrypted texts, email) to all patients for ongoing care management</li> <li>Provide <b>full accessibility for patients with disabilities</b> and achieve ADA compliance (e.g., exam tables for patients in wheel chairs, facility ramps)</li> </ul>	<ul style="list-style-type: none"> <li>Offer <b>remote clinical consultation</b> for broader set of members, where appropriate and only if practice has capability to share medical records with and receive medical records from tele-health provider</li> <li>Increase time spent in locations that represent <b>key points of aggregation</b> for the community (e.g., churches, schools), meeting patients' needs in the most appropriate setting</li> </ul>
<b>Assessment, diagnosis, treatment plan</b>	<ul style="list-style-type: none"> <li>Diagnose and develop treatment plan for <b>presenting condition</b>, with emphasis on pharmaceutical treatment</li> </ul>	<ul style="list-style-type: none"> <li>Identify and document <b>full set of needs</b> for at-risk patients with an existing PCP/ team relationship (e.g., barriers to access health care and to medical compliance)</li> <li>Develop evidence-based care plans with <b>recognition of physical and BH needs</b> (e.g., medications), customized based on benefits considerations</li> <li>Identify and close <b>gaps in preventive care</b> for at-risk patients with an existing PCP/ team relationship</li> </ul>	<ul style="list-style-type: none"> <li>Systematically incorporate patient <b>socio-economic status, gender, sexual orientation, sex, disability, race, language, religion, and ethnic-based differences</b> into treatment (e.g., automatic screening flags for relevant groups)</li> <li>Assess gaps in both primary and secondary preventive care across the broader patient panel and <b>prioritize member outreach</b> accordingly</li> <li>Include <b>BH needs</b> (e.g., psycho-social treatment) into care plan through regular communication with BH provider</li> <li>Identify and incorporate <b>improvements to care planning process</b></li> </ul>	<ul style="list-style-type: none"> <li>Agree on <b>shared agenda with patients to best meet their acute and preventive needs</b> with a multi-generational lens and leveraging the result of predictive modeling, where appropriate</li> <li><b>Collaborate meaningfully with other key community-based partners</b> (e.g., schools, churches) for input into a treatment plan and share relevant information on an ongoing basis with patient consent where appropriate</li> </ul>



# Vision for Ohio's primary care delivery model (2 of 4)

UPDATED 12/10/2015



## Care management

- Beginning of the journey**
  - Most patients lack **connection to a care manager** while others are subject to many, overlapping care coordination efforts
- Early PCMH**
  - Foster **communication between care managers** for patients
  - Identify who, within the practice, is in charge of care management activities for at-risk patients
- Maturing PCMH**
  - Coordinate between care managers to ensure clarity over which manager has lead responsibility when and reduce duplications of outreach to patients
  - Establish **initial links with community-based partners** for at-risk patients
- Transformed PCMH**
  - Patient identifies **preferred care manager**, who leads relationship with patient and coordinates with other managers and providers
  - Collaborate meaningfully with other key community-based partners** (e.g., schools, churches) to exchange information with patient consent where appropriate

## Provider operating model

- Beginning of the journey**
  - Primarily focus on managing **patient flow/volume**
- Early PCMH**
  - Improve **operational efficiency** through process redesign and standardization, harnessing improvement tools (e.g., standardized use of clinical practice guidelines)
- Maturing PCMH**
  - Optimize staff mix (e.g., extenders, community health worker, cultural diversity), redesign processes and leverage technology, where appropriate, to maximize practice's operational efficiency (e.g., practice at top of license)
- Transformed PCMH**
  - Practice has **flexibility to adapt resourcing and delivery model** to meet the needs of specific patient segments as appropriate

## Transparency

- Beginning of the journey**
  - Review **performance data irregularly**, if at all, to identify and pursue opportunities for improvement
- Early PCMH**
  - Bi-directionally exchange performance data** with payers using a standard format and with a high degree of timeliness that can lead to improvements in treatment
  - Consistently review performance data** within the practice to monitor quality and prioritize outreach efforts
  - Leverage standard process to ensure that data leads to **identification of opportunities and changes to practice patterns**, working with payers where appropriate
  - Share **priorities from patient survey** with members and staff (e.g., post findings in the office)
- Maturing PCMH**
  - Discuss **performance data with other providers**, sharing learnings, receiving "second opinion" on challenging cases and advice on opportunities for improvement
  - Share **relevant performance data with public health agencies**
  - Implement changes based on **priorities resulting from patient satisfaction survey**
- Transformed PCMH**
  - Share **relevant performance data with members and communities** through website and in-office communication (e.g., information about providers' specialty areas and training and practice wait times)

# Vision for Ohio's primary care delivery model (3 of 4)

UPDATED 12/10/2015

	Beginning of the journey	Early PCMH	Maturing PCMH	Transformed PCMH
<b>Provider interaction</b>	<ul style="list-style-type: none"> <li>Select specialists for referrals based on <b>prior experience</b></li> <li>Do not consistently leverage all available resources during <b>transitions in care</b></li> </ul>	<ul style="list-style-type: none"> <li>Proactively reach out to patients <b>after an ED visit/hospitalization</b></li> <li><b>Track and follow-up</b> on specialist referrals and diagnostic testing</li> <li>Information is shared bi-directionally between PCP and specialist</li> </ul>	<ul style="list-style-type: none"> <li>Select specialists for referrals also based on <b>likely connectivity</b> with member</li> <li>Select <b>specialists</b> for referrals based on <b>risk-adjusted data on outcomes and cost</b>, potentially leveraging data from episodes of care</li> <li>Proactively reach out to patients <b>before and after any planned transition in care</b></li> </ul>	<ul style="list-style-type: none"> <li><b>Match type of care with member needs</b>, as jointly identified by member and provider (e.g., regular in-person interactions with multi-disciplinary team only when needed)</li> <li><b>Proactively manage urgent needs, to the extent possible</b> (e.g., <b>reach out to the ED</b> to anticipate arrival of patients that have sought care from the practice first, to accelerate provision of care and ensure that it is targeted)</li> <li>Ensure <b>access and integration</b> to all capabilities needed (e.g., clinical pharmacy, dental providers, community health workers)</li> </ul>
<b>Behavioral health collaboration</b>	<ul style="list-style-type: none"> <li>Do not consider undiagnosed BH cases a priority</li> </ul>	<ul style="list-style-type: none"> <li>Integrate presenting behavioral health needs <b>into care plans</b></li> <li><b>Refer BH cases</b> to appropriate providers</li> <li>Collaborate 'at a distance' with BH providers for most at-risk patients</li> </ul>	<ul style="list-style-type: none"> <li>Focus on diagnosing and addressing <b>undiagnosed BH needs</b></li> <li><b>Track and follow-up</b> on BH referrals and ensure ongoing communication with BH specialist – onsite where possible</li> <li>Provide <b>more coordinated care between primary and BH</b> providers (e.g., same-day scheduling, co-location, system integration)</li> </ul>	<ul style="list-style-type: none"> <li><b>Integrate behavioral specialists</b> in the practice, where scale justifies it</li> <li><b>Fully integrated systems and regular formal and informal meetings between BH and PCP/team to facilitate integrated care</b></li> <li><b>Build competencies</b> to directly provide select BH services on site, when scale justifies it</li> <li>Collaborate with <b>community-based resources</b> to manage BH needs</li> </ul>
<b>Potential community connectivity activities</b>	<ul style="list-style-type: none"> <li>Have <b>limited community connectivity</b> outside of office, or relationships with social services</li> </ul>	<ul style="list-style-type: none"> <li><b>Inform patients of social services and community-based prevention programs</b> that can improve social determinants of health (e.g., provide list of helpful resources, including local health districts)</li> </ul>	<ul style="list-style-type: none"> <li>Facilitate connectivity to <b>social services and community-based prevention programs</b> by identifying targeted list of relevant services geographically accessible to the member, covered by member benefits, and with available capacity (e.g., Community Health Nursing, employment, recreational centers, nutrition and health coaching, tobacco cessation, parenting education, removal of asthma triggers, services to support tax return filings, transportation)</li> </ul>	<ul style="list-style-type: none"> <li><b>Actively connect members</b> to broader set of social services and community-based prevention programs (e.g., scheduling appointments and addressing barriers like transportation to ensure appointment happens)</li> <li><b>Ensure ongoing bi-directional communication with social services and community-based prevention programs</b> (e.g., follow up on referrals to ensure that the member used the service, incorporate insights into care plan, provide support during transitions in care)</li> <li><b>Collaborate meaningfully</b> (e.g., through formal financial partnerships) with partners based on achievement of health outcomes</li> <li><b>Actively engage in advocacy and collaborations</b> to improve basic living conditions and opportunities for healthy behaviors<sup>1</sup></li> </ul>

<sup>1</sup> E.g., encourage children to walk to school as part of a coordinated Safe Routes to School initiative

# Vision for Ohio's primary care delivery model (4 of 4)



## Patient engagement<sup>1</sup>

- | Beginning of the journey   | Early PCMH  | Maturing PCMH  | Transformed PCMH  |
|--|---|--|---|
| <ul style="list-style-type: none"> <li>Have standard fliers and <b>educational material available in the office</b></li> </ul> | <ul style="list-style-type: none"> <li>Assess patient's <b>level of health literacy, engagement, and self-management</b> and have a defined plan to provide appropriate materials and improve over time</li> <li>Ask patients how they wish to be engaged (e.g., email, phone calls, language), consistent with the resources and infrastructure the practice currently has</li> <li>Offer "<b>patient navigator</b>" support to at-risk patients, to help them find and access healthcare resources</li> </ul> | <ul style="list-style-type: none"> <li>Adopt means that practice did not previously provide to engage with patients and meet patient's preferences (e.g., text messaging)</li> <li>Use individualized techniques to <b>activate patients</b> (e.g. motivational language)</li> <li>Leverage tools such as remote monitoring devices to <b>promote patient activation and self-management</b></li> <li>Provide <b>targeted educational</b> resources (e.g., online video/guides, printed materials) to all members</li> </ul> | <ul style="list-style-type: none"> <li><b>Consistently measure improvement in patient activation and health literacy</b>, increasing share of patients at appropriate level to achieve optimal care outcomes</li> <li><b>Actively engage with patients to motivate appropriate degree of self-management</b></li> <li><b>Connect</b> at-risk members with other members with similar needs, to help create an additional support system for members and families</li> </ul> |

## Patient experience<sup>2</sup>

- |  |   |  |  |
|--|---|--|--|
| <ul style="list-style-type: none"> <li><b>Do not explicitly focus</b> on patient experience</li> </ul> | <ul style="list-style-type: none"> <li><b>Prioritize continuity of relationship</b> with provider and team for patient</li> <li>Regularly <b>solicit and incorporate targeted feedback</b> from patients into overall patient experience (e.g., quarterly survey, patient family advisory council)</li> </ul> | <ul style="list-style-type: none"> <li>Achieve greater <b>cultural competence</b> through training, awareness, and access to appropriate services (e.g., translation, community health workers)</li> <li>Regularly solicit and incorporate the <b>feedback of patients into individual care</b></li> </ul> | <ul style="list-style-type: none"> <li>Offer <b>consistent, individualized experiences to each member</b> depending on their needs (based on age, gender, ethnicity, socio-economic situation)</li> <li><b>Integrate patients into the practice management team</b> to provide feedback on overall patient experience</li> <li>Participate in <b>online patient rating sites</b> (if relevant to practice population)</li> </ul> |
|--|---|--|--|

<sup>1</sup> Promoting individual activation, health literacy, and self-management  
<sup>2</sup> Quality of patient's interaction with providers in and out of the traditional office setting

# Proposed role of payers to support PCMHs

## Critical activities payers are uniquely positioned to deliver

### Data and insights

- Provide all data in timeliest possible manner
- Inform providers of members in their panel
- Help practices identify high-priority members and opportunities to improve quality/cost of care
- Provide detailed care histories on select patients
- Provide accurate and timely reporting of performance using a standardized format
- Provide information to support provider decision making (e.g., high-value referrals)
- Share materials on best practices and lessons learned by high-performing PCMHs

### Reimbursement

- Provide incentives for meeting model requirements
- Limit administrative burden for providers, also ensuring standardization of requirements and forms/ processes to verify that requirements are met
- Continue refining the incentive model to encourage innovation

### Benefit design

- Ensure physicians and patients are aware of eligible benefits and patient incentives
- Consider introducing reimbursement for/ promoting community-based prevention programs, such as diabetes prevention program at YMCAs

### Care management resources

- Coordinate with providers on care management activities that are being provided to/ targeted at members in the providers' panel: create clarity over who has responsibility for what aspects of care management, for what patients, and when
- Bi-directionally exchange relevant information with providers on a regular basis

### Network/ Access

- Develop a network of culturally diverse high quality providers with capacity and access to serve members
- Recognize high-performing PCMHs with preferential position in network
- Ensure that high performing specialists are in network/ in preferred tier

## Critical activities multiple actors could deliver

- Identify tools to improve population health across providers
- Align with other stakeholders on small number of health priorities (e.g., diabetes, COPD, CHF, asthma, etc.)
- Provide access to data through centralized portal
- Push data to providers, when appropriate to avoid informational overload
- Collect and share additional information (i.e., REAL – Race, Ethnicity, Primary language), so all providers can use it to ensure more appropriate care delivery

- Educate physicians on and/or directly provide community resources that help address social determinants of health
- Incentivize patient behavior to drive health and lifestyle choices (e.g. weight loss, smoking, prevention)

- Adapt care management model depending on provider needs (e.g., care coordinator in the practice, additional resources – like supplemental RN hotlines – to support smaller practices)

# What health plans are partnering with the state to align PCMH requirements and payment incentives?





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# How would practices access PCMH payments?

- There is **one PCMH model in which all practices participate**, no matter how close to an ideal PCMH they are today. The program is designed to encourage practices to improve how they deliver care to their patients over time
- In order to join the program, practices will have to **submit an application and meet enrollment requirements** (e.g. eligible provider type, minimum size, and commitment to PCMH practice transformation)
- All practices in the PCMH program **could have access to two non-financial benefits**:  
(1) being *recognized as a state-designated PCMH*, which can help attract new members;  
and (2) *access to data and reporting* that will provide the actionable, timely information that practices need to make better decisions about outreach, care and referrals
- All practices **could have the opportunity to access two payment streams**:
  1. **PCMH Operational Activities Payments** to compensate practices for activities that improve care and are currently under-compensated
  2. **Quality and Financial Outcomes-Based Payment** for achieving total cost of care savings and meeting pre-determined quality targets
  - Additionally, *some* practices also may be eligible for one-time **Practice Transformation Support** to help them begin the transition to a PCMH

# What activities do the enhanced payments support?

	Objective	Available for	Support type
<b>PCMH Operational Activities Payments</b>	<ul style="list-style-type: none"> <li>Compensate for activities that are currently under-compensated for, and are expected to lead to better clinical quality, patient experience and total cost of care</li> </ul>	<ul style="list-style-type: none"> <li>All practices in the PCMH program</li> </ul>	<ul style="list-style-type: none"> <li>Risk-adjusted PMPM payment, based on performance on standard processes, activities, clinical quality and efficiency</li> </ul>
<b>Quality and Financial Outcomes-Based Payment<sup>1</sup></b>	<ul style="list-style-type: none"> <li>Reward improvement in total cost of care achieved without compromising on clinical quality</li> </ul>	<ul style="list-style-type: none"> <li>All practices in the PCMH program that meet minimum member threshold, independently or by partnering with other practices</li> </ul>	<ul style="list-style-type: none"> <li>Annual shared savings payment based on performance on total cost of care and clinical quality, along with presence of fundamental standard processes</li> </ul>
<b>Practice Transformation Support</b> <i>(only available for select practices)</i>	<ul style="list-style-type: none"> <li>Support initial investment in practice changes, including infrastructure and process redesign</li> </ul>	<ul style="list-style-type: none"> <li>Practices in the program that need support to begin the journey and don't have access to other resources</li> </ul>	<ul style="list-style-type: none"> <li>Time limited support, with potential restrictions on use</li> <li>Likely in the form of PMPM (still being finalized)</li> </ul>

<sup>1</sup> Only available for practices with more than ~5,000 eligible members. Practices that do not meet the minimum member threshold will have the opportunity to pool with other practices to qualify for quality and financial outcomes-based payment



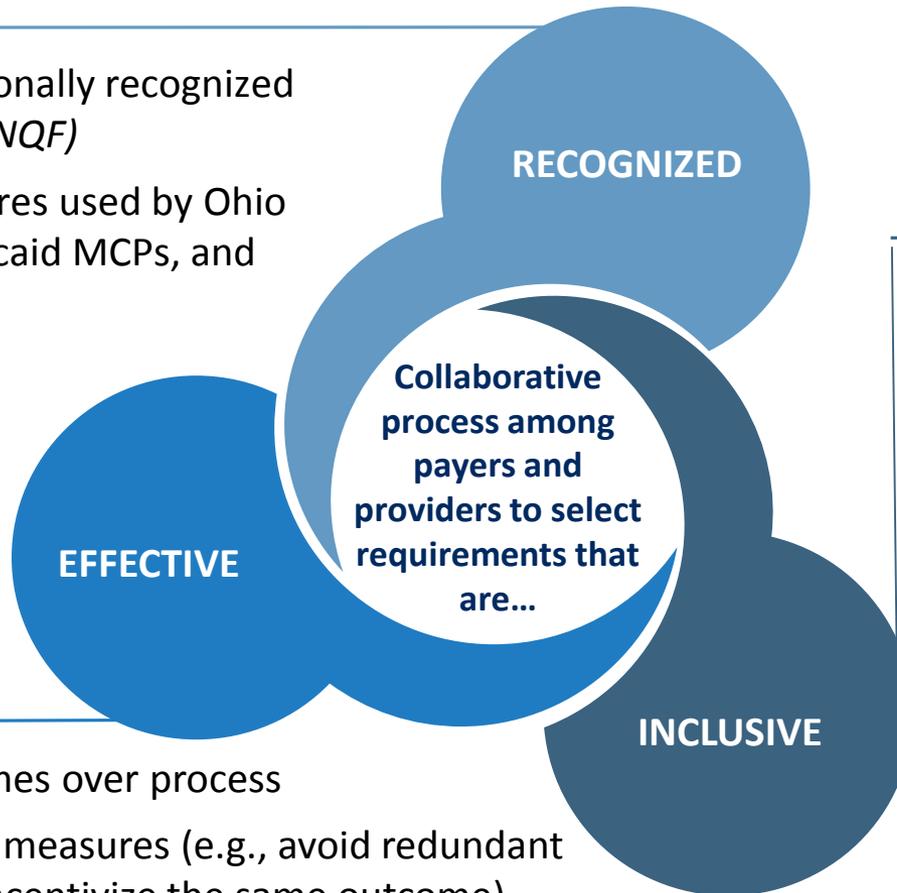
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# Guiding principles to select performance requirements

## RECOGNIZED

- Select from nationally recognized measures (e.g., NQF)
- Prioritize measures used by Ohio programs, Medicaid MCPs, and private payers



## EFFECTIVE

- Prioritize outcomes over process
- Limit number of measures (e.g., avoid redundant measures that incentivize the same outcome)
- Minimize the reporting and monitoring burden to the providers and payers (e.g., prioritize claims-based measures)

## INCLUSIVE

- Align measures with Ohio population health priorities that the Ohio system is ready to address and that the PCMH can impact
- Select measures that are relevant for all practice types
- Select measures that cover all age groups (pediatrics and adults), populations (healthy, with chronic conditions, behavioral health), and consumer segments

# Payment streams will be tied to specific requirements...

## Standard Processes

- Risk stratification
- Same day appointments
- 24/7 access to care
- Practice uses a team
- Care management
- Relationship continuity

1

## Activities

- Risk stratification
- Population management
- Care plans
- Follow up after hospital discharge
- Tracking of follow up tests and specialist referrals
- Patient experience

2

## Efficiency

- ED visits/1000
- Inpatient admission for ambulatory sensitive conditions
- All cause readmission rate
- Generic dispensing of select classes

3

## Clinical Quality

- Claims based metrics
- Hybrid measures

4

## Total Cost of Care

- Total Cost of Care

5

# 1 Standard processes requirements

## Requirements

### Process for Risk Stratification

- The practice uses a methodology to assign a risk status in accordance with criteria aligned across payers **Who provides risk stratification to be finalized in 2016**

### Same day appointments

- The practice provides same-day access to a practitioner connected to the PCMH who can diagnose and treat

### 24/7 access to care

- The practice provides and attests to 24 hour, 7 days a week patient access to a practitioner connected to the PCMH who will diagnose and treat

### Practice uses a team

- The practice uses a team to provide a range of patient care services by:
  - Defining roles for clinical and nonclinical team members
  - Designating a lead for quality improvement efforts
  - Holding scheduled patient care team meetings or a structured communication process focused on individual patient care

### Care management

- The practice indicates who provides care management services for high priority members

### Relationship continuity

- The practice has a process to orient all patients to the PCMH

## 2 Activity requirements

### Requirements

#### Application of Risk Stratification

- Percentage of a practice's at risk beneficiaries—defined in accordance with criteria aligned across payers— who are seen by attributed PCP at least twice in past 12 months

#### Population management

- At least annually the practice proactively identifies patients not recently seen by the practice and reminds them, or their families/caregivers, of needed care based on personal treatment plan

#### Care plans

- At least 80% of high priority beneficiaries have a treatment plan in the medical record defined with accordance with a set of key elements aligned across payers<sup>1</sup>. Care plan must be updated at least 2x/year and with significant changes in conditions

#### Follow up after hospital discharge

- Percentage of high priority beneficiaries who had an acute inpatient hospital stay and had follow up contact within 1 week

#### Tracking of follow up tests and specialist referrals

- The practice has a documented process for and demonstrates that it:
  - Asks about **self-referrals** and requests reports from clinicians
  - Tracks **lab tests and imaging tests** until results are available, flagging and following up on overdue results
  - Tracks **referrals** until the **consultant or specialist's** report is available, flagging and following up on overdue reports
  - Tracks **fulfillment of pharmacy prescriptions** where data is available

#### Patient experience

- The practice assesses their approach to patient centeredness and cultural competence to improve overall patient experience and reduce disparities in patient experience (*e.g., by creating a patient/family advisory council, by administering and assessing a CAHPS survey*)

**Practices will be required to prove they both assess and act on patient feedback**

1 E.g., documentation of a beneficiary's current problem that includes barriers to care. Plan of care integrating contributions from health care team (including BH). Modifications of treatment goals in conjunction with patient and family priorities. Instructions for follow up. Assessment of progress to date

### **3** Efficiency requirements

- ED visits
- Inpatient admissions for ambulatory sensitive conditions
- All-cause readmission rate
- Generic dispensing rate of select classes

To be refined in 2016 for 2017 performance period

# 4 Clinical Quality Requirements

Category	Measure Name	Population	Population health priority	Data Type	NQF #
Preventive Care	Adult BMI	Adults	Obesity	Claims or Hybrid	HEDIS ABA
	Well-Child Visits in the First 15 Months of Life	Pediatrics		Claims or Hybrid	1392
	Well-Child visits in the 3rd, 4th, 5th, 6th years of life	Pediatrics		Claims or Hybrid	1516
	Adolescent Well-Care Visit	Pediatrics		Claims or Hybrid	HEDIS AWC
	Breast Cancer Screening	Adults	Cancer	Claims	2372
	Weight assessment and counseling for nutrition and physical activity for children/adolescents: BMI assessment for children/adolescents	Pediatrics	Obesity, physical activity, nutrition	Claims or Hybrid	0024
	Timeliness of prenatal care	Adults	Infant Mortality	Claims or Hybrid	1517
	Postpartum care	Adults	Infant Mortality	Claims or Hybrid	1517
Appropriate Care	Live Births Weighing Less than 2,500 grams	Pediatrics	Infant Mortality	State Records	N/A
	Controlling high blood pressure <sup>1</sup>	Adults	Heart Disease	Hybrid	0018
	Med management for people with asthma	Both		Claims	1799
	Comprehensive Diabetes Care: HgA1c poor control (>9.0%)	Adults	Diabetes	Claims or Hybrid	0059
Behavioral Health	Statin Therapy for patients with cardiovascular disease	Adults	Heart Disease	Claims	HEDIS SPC
	Antidepressant medication management	Adults	Mental Health	Claims	0105
	Follow up after hospitalization for mental illness	Both	Mental Health	Claims	0576
	Preventive care and screening: tobacco use: screening and cessation intervention	Both	Substance Abuse	Claims or Hybrid	0028

## Measures will evolve over time

- Measures will be refined based on learnings from initial roll-out
- Hybrid measures that require EHR may be added to the list of core measures
- Hybrid measures may replace some of the core measures
- Reduction in variability in performance between different socioeconomic demographics may be included as a PCMH requirement

## To be finalized in 2016

1 Scored beginning in year 3

# Timing to earn PCMH Operational Activities PMPM Payments

		6 months	Year 1	Year 2	Year 3 +
Standard Processes	▪ Risk stratification				
	▪ Same day appointments				
	▪ 24/7 access to care				
	▪ Practice uses a team				
	▪ Care management				
	▪ Relationship continuity				
Activities	▪ Risk stratification				
	▪ Population management				
	▪ Care plans				
	▪ Follow up after hospital discharge				
	▪ Tracking of follow up tests an specialist referrals				
	▪ Patient experience		Lower initial bar		
Efficiency	▪ ED visits/1000		Lower initial bar		
	▪ Inpatient admission for ambulatory sensitive conditions		Lower initial bar		
	▪ All cause readmission rate		Lower initial bar		
	▪ Generic dispensing of select classes				
Clinical Quality	▪ Claims based metrics				
	▪ Hybrid measures				
Total Cost of Care	▪ Total Cost of Care				

# Timing to earn Quality and Financial Outcome-Based Payment

		Year 1	Year 2	Year 3 +
Standard Processes	▪ Risk stratification			
	▪ Same day appointments			
	▪ 24/7 access to care			
	▪ Practice uses a team			
	▪ Care management			
	▪ Relationship continuity			
Activities	▪ Risk stratification			
	▪ Population management			
	▪ Care plans			
	▪ Follow up after hospital discharge			
	▪ Tracking of follow up tests an specialist referrals			
	▪ Patient experience			
Efficiency	▪ ED visits/1000			
	▪ Inpatient admission for ambulatory sensitive conditions			
	▪ All cause readmission rate			
	▪ Generic dispensing of select classes			
Clinical Quality	▪ Claims based metrics			
	▪ Hybrid measures			
Total Cost of Care	▪ Total Cost of Care			

# Requirements will evolve over time as payers and providers gain capabilities

## Next round of design

## Current phase

- 
- Some requirements are more prescriptive (*process focused*) in an effort to more explicitly guide practices toward transformation
  - Requirements are designed to maximize participation in the program
  - No specific requirements on tools
  - Clinical quality measures are claims based
- Requirements are primarily outcome based to encourage innovation, but process focused measures with proven impact remain as requirements
  - Requirements will raise over time as practices increase capabilities
  - Tools are catalysts to successfully completing requirements (e.g., EHR)
  - Clinical quality measures are both claims and hybrid based



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# Want to learn more?

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

CURRENT INITIATIVES

BUDGETS

NEWSROOM

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## *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  
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  
Align population health planning  
Coordinate health information technology infrastructure  
Coordinate health sector workforce programs  
Support regional payment reform initiatives

## PCMH Payment Model:

- Overview Presentations
- Charter for Payers
- State Innovation Model (SIM)  
Test Grant Detail