



Governor's Office of
Health Transformation

Transforming Payment for a Healthier Ohio

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Governor's Office of Health Transformation

TriHealth Physician Hospital Organization
March 8, 2016

www.HealthTransformation.Ohio.gov



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

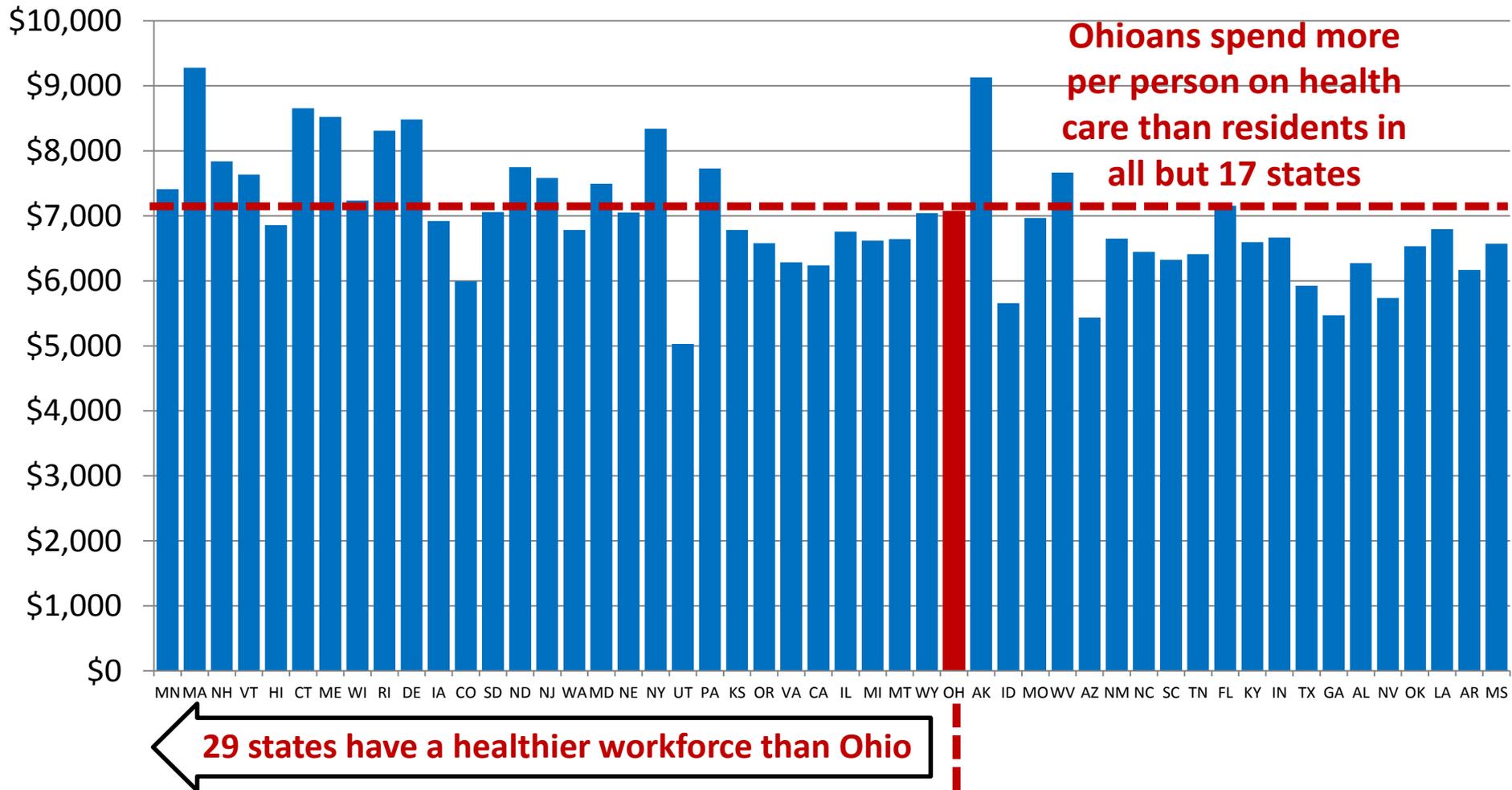
2. Patient-Centered Medical Home (PCMH) Model
3. Episode-Based Payment Model
4. Detailed Example: Perinatal Episode

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)

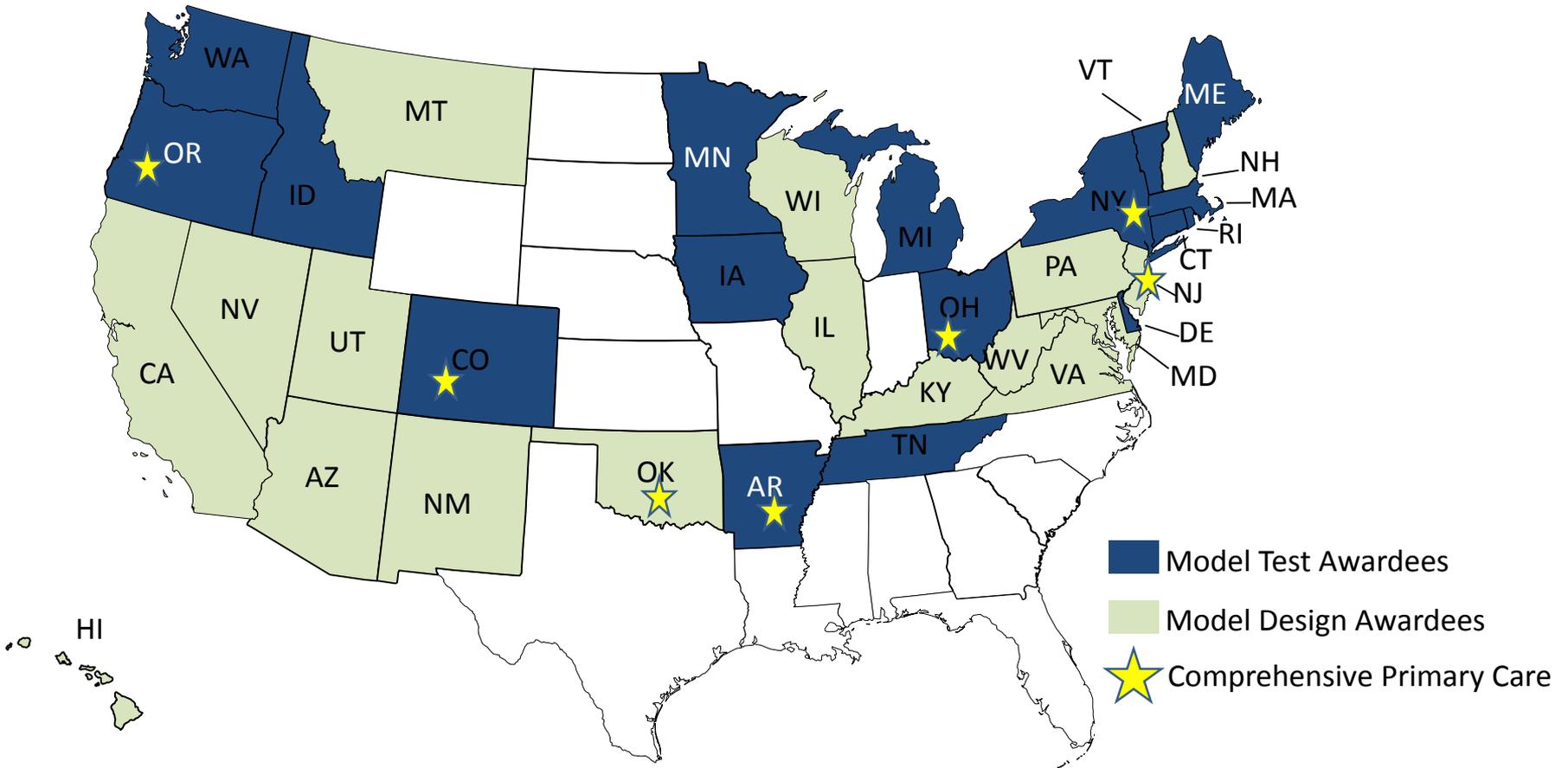


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Sources: CMS *Health Expenditures by State of Residence* (2011); The Commonwealth Fund, *Aiming Higher: Results from a State Scorecard on Health System Performance* (May 2014).



Ohio is one of 17 states awarded a federal grant to test payment innovation models



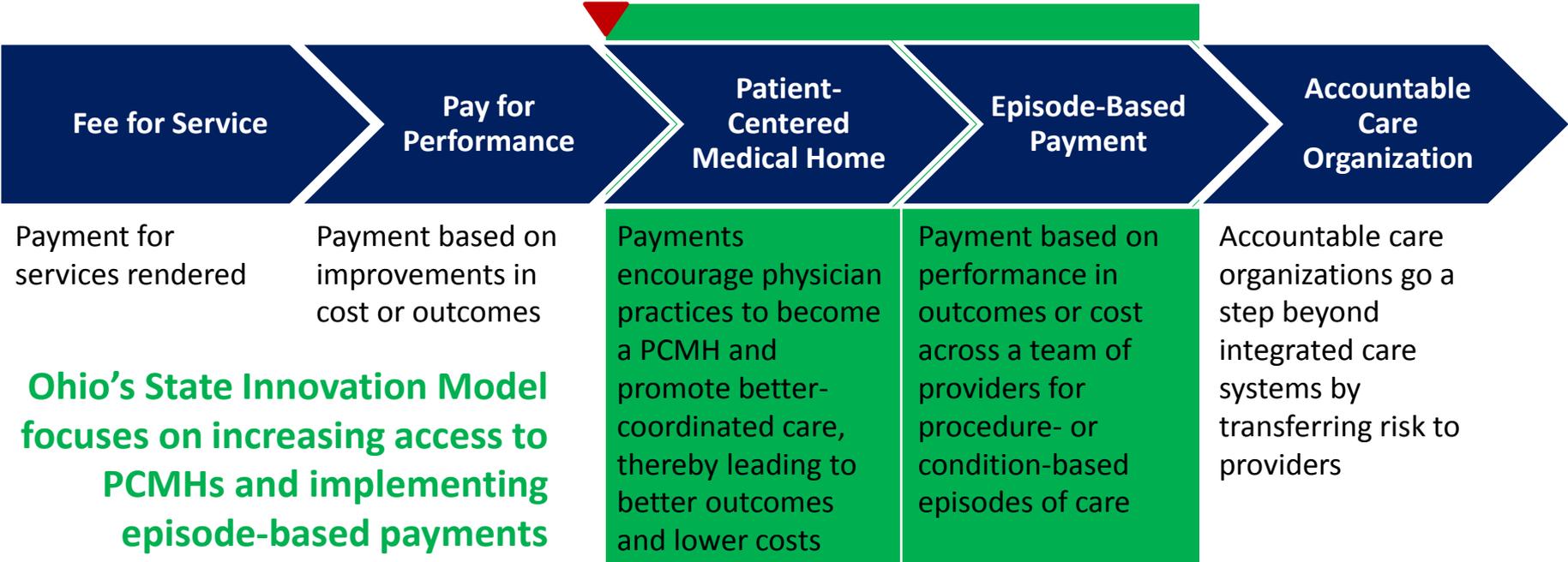
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SOURCE: [State Innovation Models](#) and [Comprehensive Primary Care Initiative](#), U.S. Centers for Medicare and Medicaid Services (CMS).

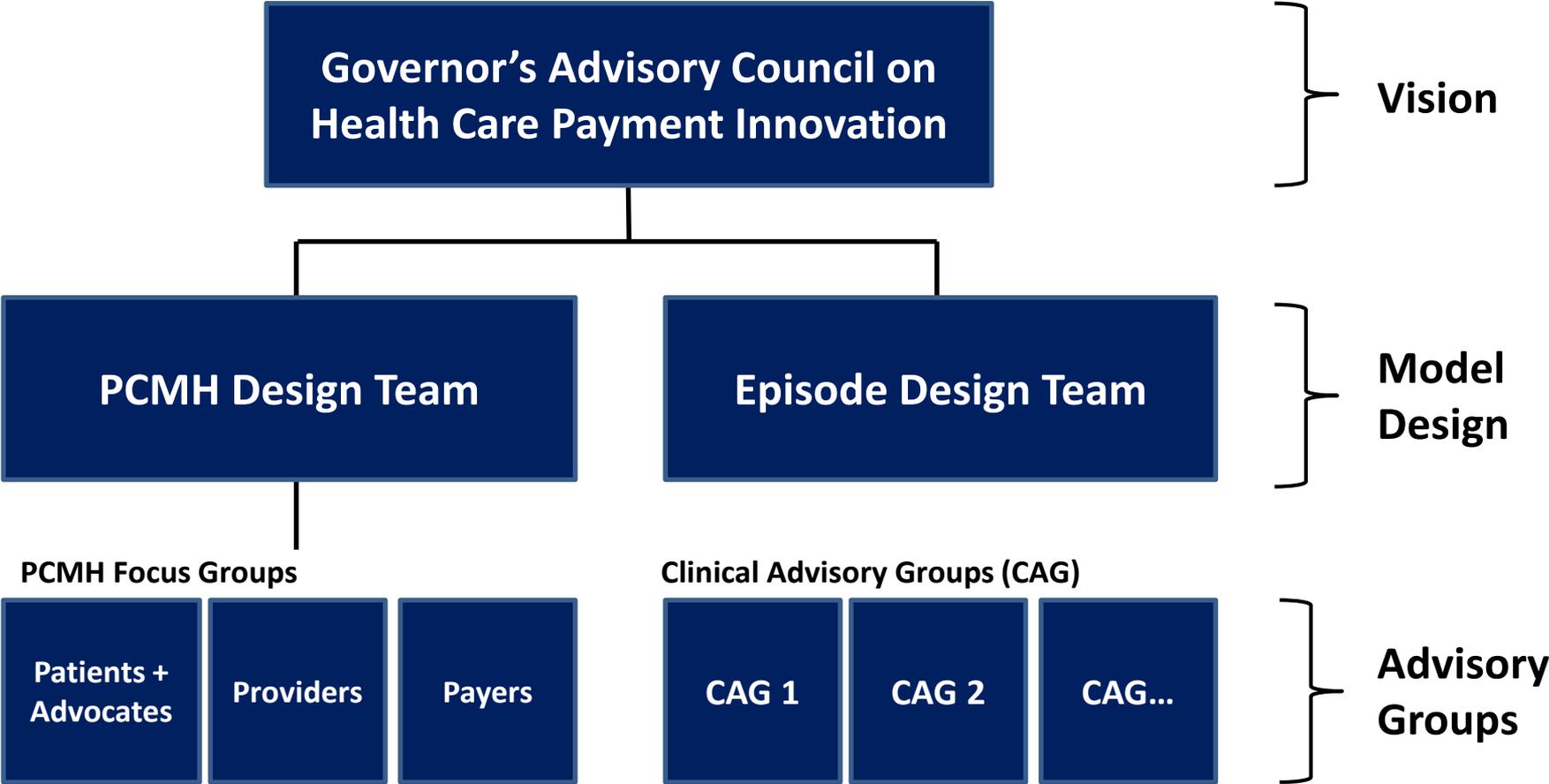
Value-Based Alternatives to Traditional Fee-for Service Payments



Most payers fall here on this continuum – implemented some form of pay for performance and at least begun to consider or rollout PCMH, episode and ACO initiatives



Payment model design decisions have been shaped by meaningful input from 800+ stakeholders across Ohio



Ohio's largest health plans have committed to help design and implement PCMH and episode-based payment models



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- 2. Patient-Centered Medical Home Model**
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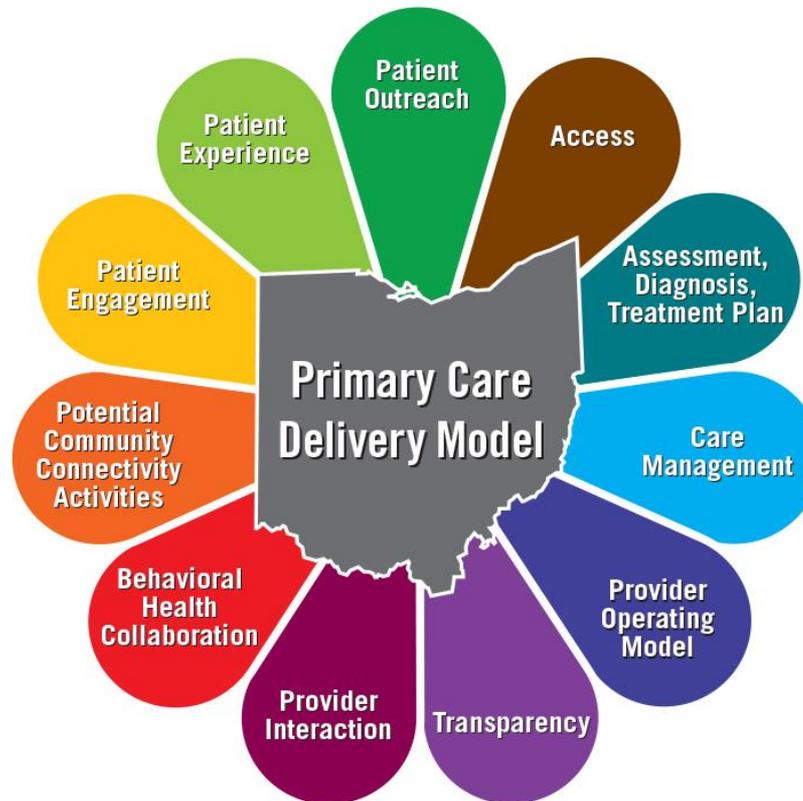
“Health care homes save Minnesota \$1 billion”

State-certified patient-centered health care home performance (2010-2014) compared to other Minnesota primary care practices ...

- Better quality of care for diabetes, vascular, asthma (child and adult), depression, and colorectal cancer screening
- Significantly smaller racial disparities on most measures
- Better care coordination for low-income populations
- Major decrease in the use of hospital services
- Saved \$1 billion over four years, mostly Medicaid (\$918 million), but also Medicare (\$142 million)

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

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

Beginning of the journey

Reactive, presentation-based prioritization

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

Early PCMH

Proactive, targeting patients with chronic conditions and existing PCP/team relationship

Behavioral Health Collaboration

Provider Interaction

Transparency

Patient Experience

Patient Outreach

Access

Maturing PCMH

Proactive, targeting patients with chronic conditions but no clear PCP relationship, and prioritizing patients at-risk of developing a chronic condition

Provider Operating Model

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:
Creative ways to engage with patients (e.g., extended hours)

Transformed PCMH

Proactive, with broader focus on all patients including healthy individuals

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

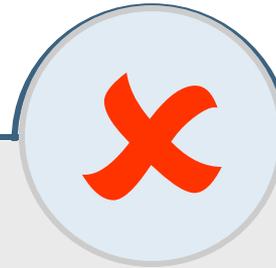
Provider enrollment requirements

Required



- **Eligible provider type and specialty** (details to follow)
- **Minimum size:** 500 attributed/ assigned Medicaid eligible members within a contracted entity
- **Commitment**
 - To sharing data with payers/ the state
 - To participating in learning activities¹
 - To meeting “standard processes” requirements in 6 months

Not required



- **Accreditation:** (e.g., NCQA or URAC)
- **Planning** (e.g., develop budget, plan for care delivery improvements, etc.)
- **Tools** (e.g., e-prescribing capabilities, EHR, etc.)

¹ Examples include sharing best practices with other PCMHs, working with existing organizations to improve operating model, participating in state led PCMH program education at kickoff

Patients and services included in total cost of care

Inclusions



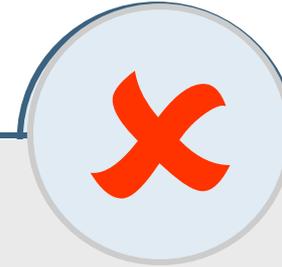
Patients

- All adults and pediatrics¹
- All behavioral health members
- Members with exclusively dental or vision TPL coverage

Services

- All non-excluded medical and prescription spend including:
 - Case management
 - DME
 - Home health
 - First 90 days of nursing facility spend²

Exclusions



- Duals (*included as operationally feasible, priority for MyCare population*)
- Members with limited benefits (e.g., family planning)
- All other members with TPL coverage

- Waiver
- Currently underutilized services (dental, vision, and transportation)
- Nursing facility spend after 90 days in institution
- All spend for a member after first ICF/IID claim

¹ All PFK members are included in PCMH model

² May be reconsidered due to effect on panel size and other technical considerations

Attributing patients to providers

Members are attributed/assigned to PCPs based on ...

- Claims, for existing members
- Member choice, for new members
- Non-claims methodology (geography, capacity, age), for members not attributed/assigned based on first two methodologies

Changes can be made based on ...

- Member preference
- Member behavior, as assessed through claims

Payment streams will be tied to specific requirements

Requirements	1 Standard processes <ul style="list-style-type: none"> Risk stratification Same day appointments 24/7 access Practice uses a team Care management Relationship continuity 	2 Activities <ul style="list-style-type: none"> Risk stratification Population management Care plans Follow up after hospital discharge Tracking of follow up tests and specialist referrals Patient experience 	3 Efficiency <ul style="list-style-type: none"> ED visits Inpatient admissions for ambulatory sensitive conditions All-cause readmission rate Generic dispensing rate of select classes 	4 Clinical quality <ul style="list-style-type: none"> 16-20 measures aligned with CMS/AHIP core standards for PCMH 	5 Total Cost of Care
PCMH operational activities PMPM	<p>Scoring weight shifts from standard processes and activities... <i>...to efficiency and clinical quality over time</i></p>				
Quality and financial outcomes-based payment	<i>"Must have" processes targeting access to care</i>			<i>Quality gate</i>	<i>Based on self-improvement</i>

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
	Live Births Weighing Less than 2,500 grams	Pediatrics	Infant Mortality	State Records	N/A
Appropriate Care	Controlling high blood pressure (beginning year 3)	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
	Statin Therapy for patients with cardiovascular disease	Adults	Heart Disease	Claims	HEDIS SPC
Behavioral Health	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
	Initiation and engagement of alcohol and other drug dependence treatment	Adults	Substance Abuse	Claims	0004

Final clinical requirements will align with CMS/AHIP Core Quality Measures for PCMH

<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Co-re-Measures.html>

Ohio's statewide PCMH rollout

- Spring 2016 – finalize PCMH care delivery and payment model
- Throughout 2017 – recruit primary care practices to commit to the PCMH model and support practice transformation
- January 1, 2018 – performance period begins for:
 1. Operational activities PMPM
 2. Quality and financial-outcomes based payment
 3. One-time practice transformation support for some practices
- Fall 2016 – exploring an early enrollment process for some already-accredited PCMHs for a performance period beginning January 1, 2017



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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

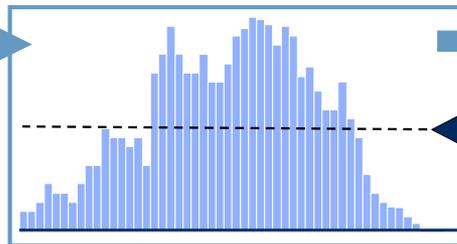
4



Review claims from the performance period to identify a **'Principal Accountable Provider'** (PAP) for each episode

5

Payers calculate **average risk-adjusted reimbursement per episode** for each PAP



Compare to predetermined "commendable" and "acceptable" levels

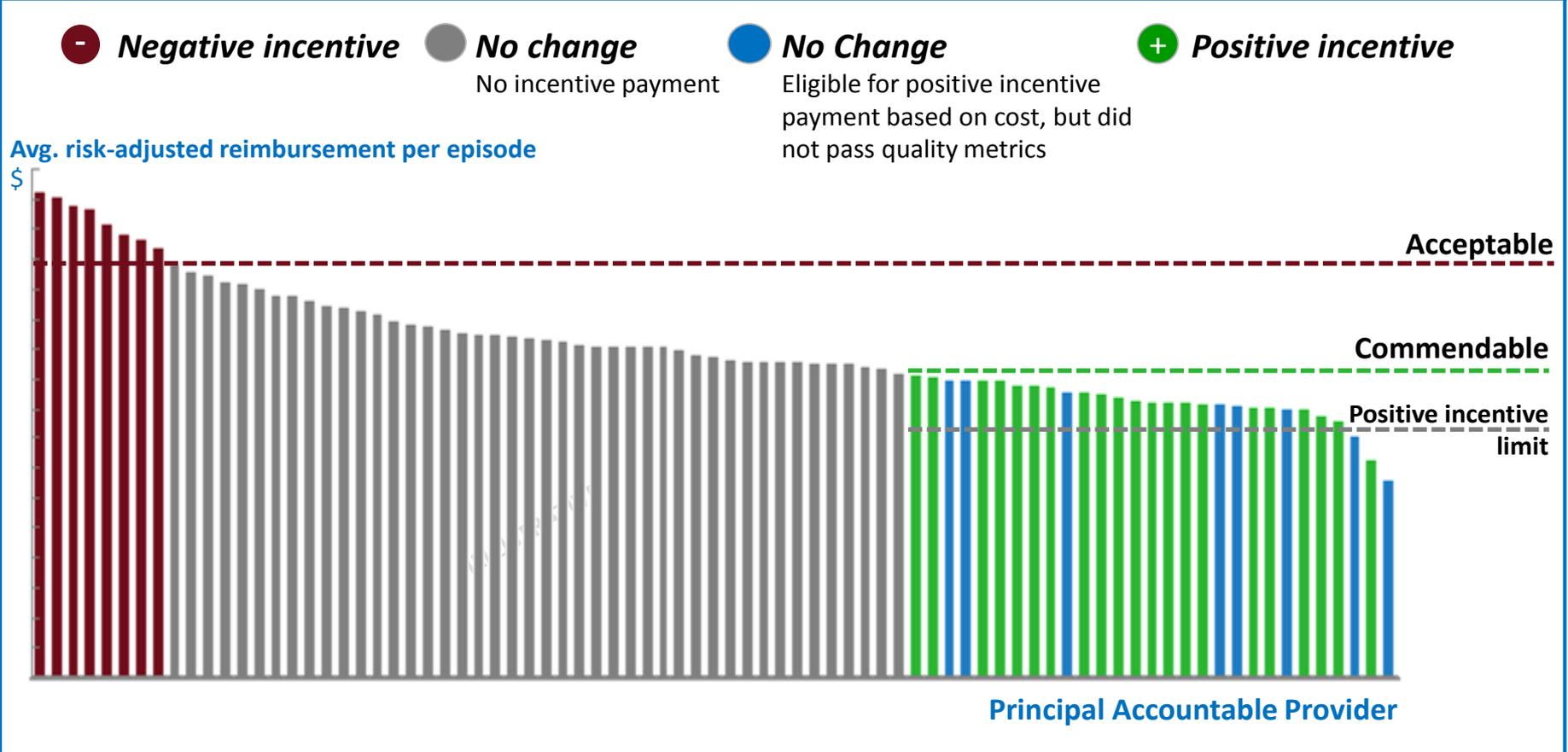
6

Providers may:

- **Share savings:** if average costs below commendable levels and quality targets are met
- **Pay negative incentive:** if average costs are above acceptable level
- **See no impact:** if average costs are between commendable and acceptable levels

Retrospective thresholds reward cost-efficient, high-quality care

Provider cost distribution (average risk-adjusted reimbursement per provider)



Elements of the Episode Definition

Category	Description
1 Episode trigger	<ul style="list-style-type: none">Diagnoses or procedures and corresponding claim types and/or care settings that characterize a potential episode
2 Episode window	<ul style="list-style-type: none">Pre-trigger window: Time period prior to the trigger event; relevant care for the patient is included in the episodeTrigger window: Duration of the potential trigger event (e.g., from date of inpatient admission to date of discharge); all care is includedPost-trigger window: Time period following trigger event; relevant care and complications are included in the episode
3 Claims included	
4 Principal accountable provider	<ul style="list-style-type: none">Provider who may be in the best position to assume principal accountability in the episode based on factors such as decision making responsibilities, influence over other providers, and portion of the episode spend
5 Quality metrics	<ul style="list-style-type: none">Measures to evaluate quality of care delivered during a specific episode
6 Potential risk factors	<ul style="list-style-type: none">Patient characteristics, comorbidities, diagnoses or procedures that may potentially indicate an increased level of risk for a given patient in a specific episode
7 Episode-level exclusions	<ul style="list-style-type: none">Patient characteristics, comorbidities, diagnoses or procedures that may potentially indicate a type of risk that, due to its complexity, cost, or other factors, should be excluded entirely rather than adjusted

Selection of episodes (1 of 2)

Principles for selection:

- Leverage episodes in use elsewhere to **reduce time to launch**
- Prioritize meaningful **spend across payer populations**
- Look for opportunities with **clear sources of value** (e.g., high variance in care)
- Select episodes that incorporate a **diverse mix** of accountable **providers** (e.g., facility, specialists)
- Cover a **diverse set of “patient journeys”** (e.g., acute inpatient, acute procedural)
- Consider **alignment with current priorities** (e.g., perinatal for Medicaid, asthma acute exacerbation for youth)

Ohio’s episode selection:

Episode

Principal Accountable Provider

WAVE 1 (launched March 2015)

- | | |
|------------------------------------|-------------------------------------|
| 1. Perinatal | Physician/group delivering the baby |
| 2. Asthma acute exacerbation | Facility where trigger event occurs |
| 3. COPD exacerbation | Facility where trigger event occurs |
| 4. Acute Percutaneous intervention | Facility where PCI performed |
| 5. Non-acute PCI | Physician |
| 6. Total joint replacement | Orthopedic surgeon |

WAVE 2 (launch January 2016)

- | | |
|--------------------------------|----------------------------------|
| 7. Upper respiratory infection | PCP or ED |
| 8. Urinary tract infection | PCP or ED |
| 9. Cholecystectomy | General surgeon |
| 10. Appendectomy | General surgeon |
| 11. Upper GI endoscopy | Gastroenterologist |
| 12. Colonoscopy | Gastroenterologist |
| 13. GI hemorrhage | Facility where hemorrhage occurs |

Selection of episodes (2 of 2)

Principles for selection:

- Leverage episodes in use elsewhere to **reduce time to launch**
- Prioritize meaningful **spend across payer populations**
- Look for opportunities with **clear sources of value** (e.g., high variance in care)
- Select episodes that incorporate a **diverse mix** of accountable **providers** (e.g., facility, specialists)
- Cover a **diverse set of “patient journeys”** (e.g., acute inpatient, acute procedural)
- Consider **alignment with current priorities** (e.g., perinatal for Medicaid, asthma acute exacerbation for youth)

Ohio’s episode selection:

Episode

WAVE 3 (launch January 2017)

The following is a preliminary list of potential episodes to design in 2016:

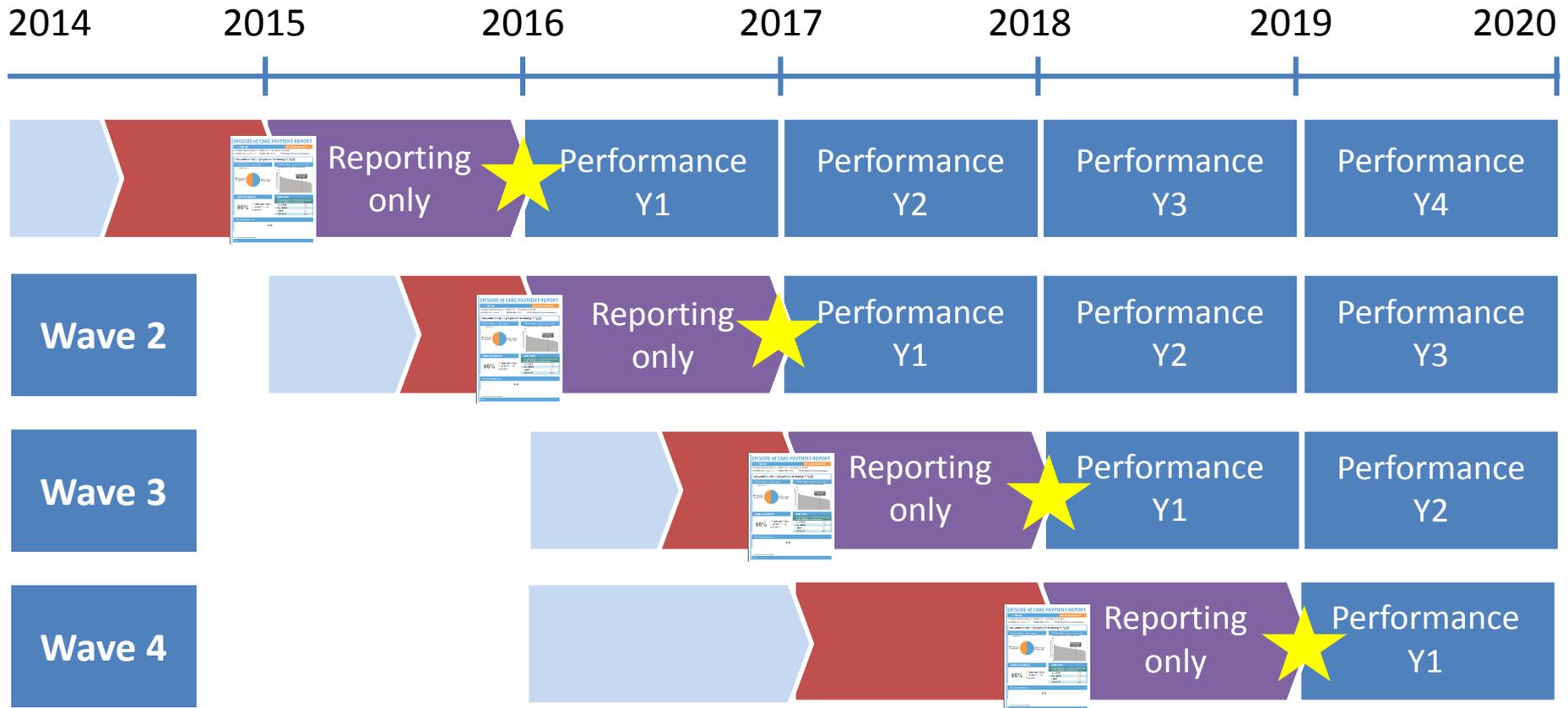
HIV	Hepatitis C	Neonatal
Hysterectomy	Bariatric surgery	Diabetic ketoacidosis
Lower back pain	Headache	CABG
Cardiac valve	congestive heart failure	Breast biopsy
Breast cancer	Mastectomy	Otitis
Simple pneumonia	Tonsillectomy	Shoulder sprain
Wrist sprain	Knee sprain	Ankle sprain
Hip/Pelvic fracture	Knee arthroscopy	Lumbar laminectomy
Spinal fusion exc. cervical	Hernia procedures	Colon cancer
Pacemaker/defibrillator	Dialysis	Lung cancer
Bronchiolitis and RSV pneumonia		

WAVE 4 (launch January 2018)

Behavioral episodes (design work begins June 2016)

Ohio's episode timeline

- Episode design
- Reporting period
- Reporting launch
- Implementation readiness
- Performance period
- Performance period launch



EPISODE of CARE PROVIDER REPORT

EPISODE NAME

Q1 + Q2 YYYY

Reporting period covering episodes that ended between Start Date to End Date

PAYER: Payer Name

PROVIDER ID: PAP ID

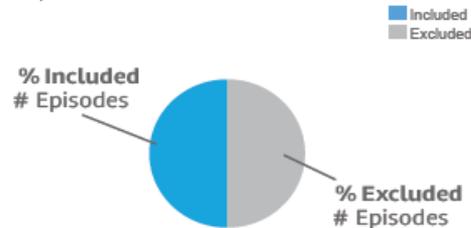
PROVIDER: Provider Name

Eligibility requirements for gain or risk-sharing payments

- ✓ **Episode volume:** You have at least 5 episodes in the current performance period.
- ✓ **Spend:** Your average risk-adjusted spend per episode is below the commendable threshold.
- ⚠ **Quality:** You are not currently eligible for gain-sharing because you have not passed all quality metrics linked to gain-sharing.
- ⓘ **This report is informational only.** Eligibility for gain or risk-sharing will be determined at the end of the performance period and any applicable payments will be calculated at that time.

Episodes included, excluded & adjusted

Total episodes#



% of your episodes have been risk adjusted

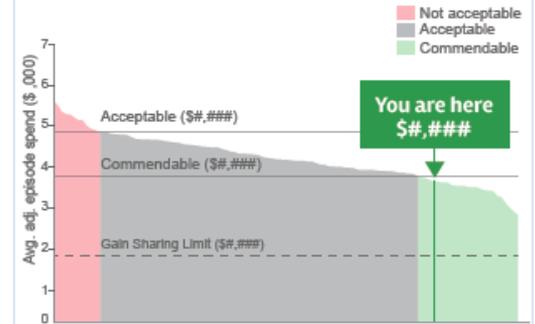
Quality metrics

You achieved # of # quality metrics linked to gain sharing

Quality metric 01	##%	✓
Quality metric 02	##%	✓
Quality metric 03	##%	✗
Quality metric 04	##%	✗

Risk adjusted average spend per episode

Distribution of provider average episode spend (risk adj.)



Key performance

Rolling four quarters

	Performance period 2016		Reporting period 2015		
	Q3 '15	Q4 '15	Q1 '16	Q2 '16	Weighted average
Avg adjusted episode spend (\$,000)	###	###	###	###	###
# of included episodes	#	#	#	#	#
Your spend percentile	##%	##%	##%	##%	##%

This is an example of the performance report format released in 2016



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DISCLAIMER: The information contained in these reports is intended solely for use in the administration of the Medicaid program. The data in the reports are neither intended nor suitable for other uses, including the selection of a health care provider. The figures in these reports are preliminary and are subject to revision. For more information, please visit <http://medicaid.ohio.gov/Providers/PaymentInnovation.aspx>.



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Perinatal episode definition

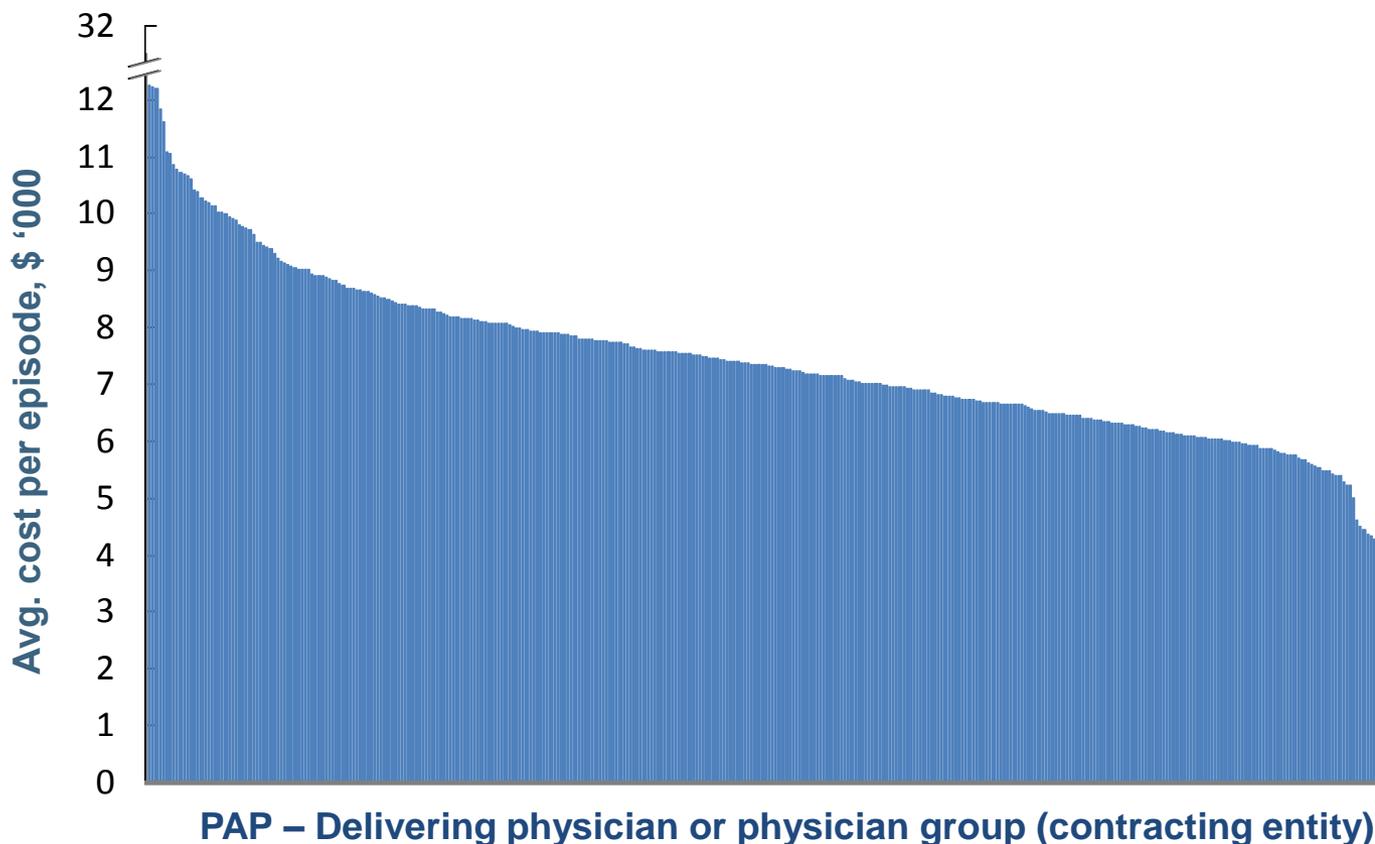
Category	Episode definition	
1 Episode trigger	<ul style="list-style-type: none"> A delivery Px code with a confirmatory live birth Dx on any claim type¹ 	
2 Episode window	<ul style="list-style-type: none"> <i>Pre-trigger</i>: Begins 280 days before delivery and ends on day prior to trigger window start <i>Trigger</i>: Starts on day of admission and ends on day of discharge <i>Post-trigger</i>: Begins day after discharge from delivery admission and ends 60 days later 	
3 Claims included	<ul style="list-style-type: none"> <i>Pre-trigger window</i>: Relevant prenatal care and complications (except excluded medications) <i>Trigger window</i>: All <i>Post-trigger window</i>: <ul style="list-style-type: none"> Relevant care and complications including diagnoses, procedures, labs, and pharmacy Readmissions (except those not relevant to episode) 	
4 Principal accountable provider	<ul style="list-style-type: none"> Physician or physician group responsible for the delivery (billing provider or contracting entity) 	
5 Quality metrics	<p><i>Linked to positive incentive payment:</i></p> <ul style="list-style-type: none"> Prenatal HIV screening rate Prenatal GBS screening rate C-section rate Percent of episodes with follow-up visit within 60 days 	<p><i>For reporting only:</i></p> <ul style="list-style-type: none"> Percent of episodes with prenatal gestational diabetes screening Percent of episodes with prenatal hepatitis B screening Percent of episodes with chlamydia screening Ultrasound rate
6 Potential risk factors	<ul style="list-style-type: none"> Comorbidities (e.g., hypertension, diabetes, substance abuse, obesity, prior C-section) 	
7 Exclusions	<ul style="list-style-type: none"> Clinical (e.g., cystic fibrosis, cancer, end stage renal disease, HIV, paralysis) Business (e.g., dual coverage, inconsistent eligibility) Patients < 12 years old and > 49 years old Death in hospital, left AMA 	

1 The live birth code and delivery procedure code can occur on different claims but must occur within 7 days of each other

Perinatal: Provider Performance

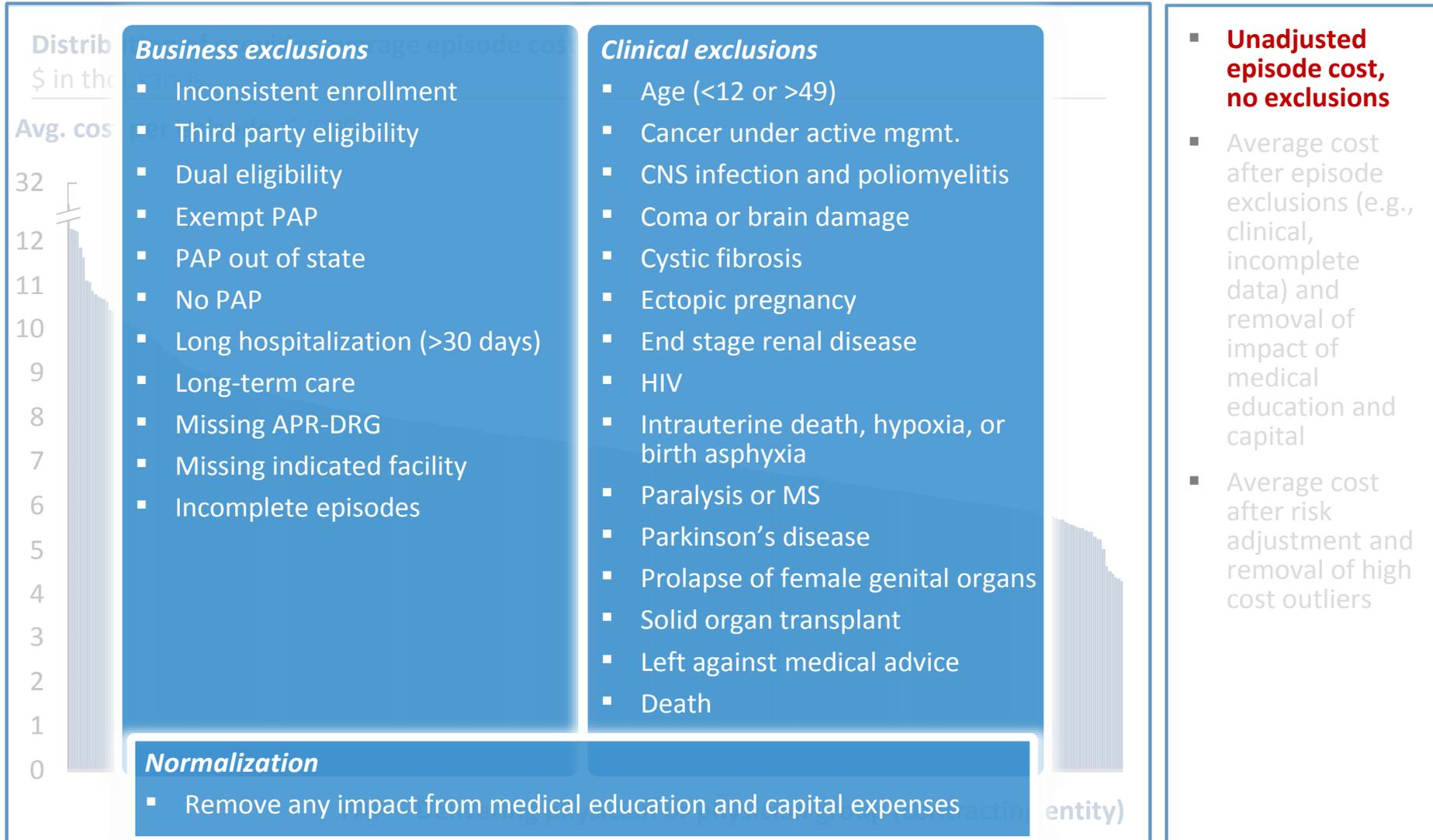
Distribution of provider average episode cost

\$ in thousands



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

Perinatal: Provider Performance

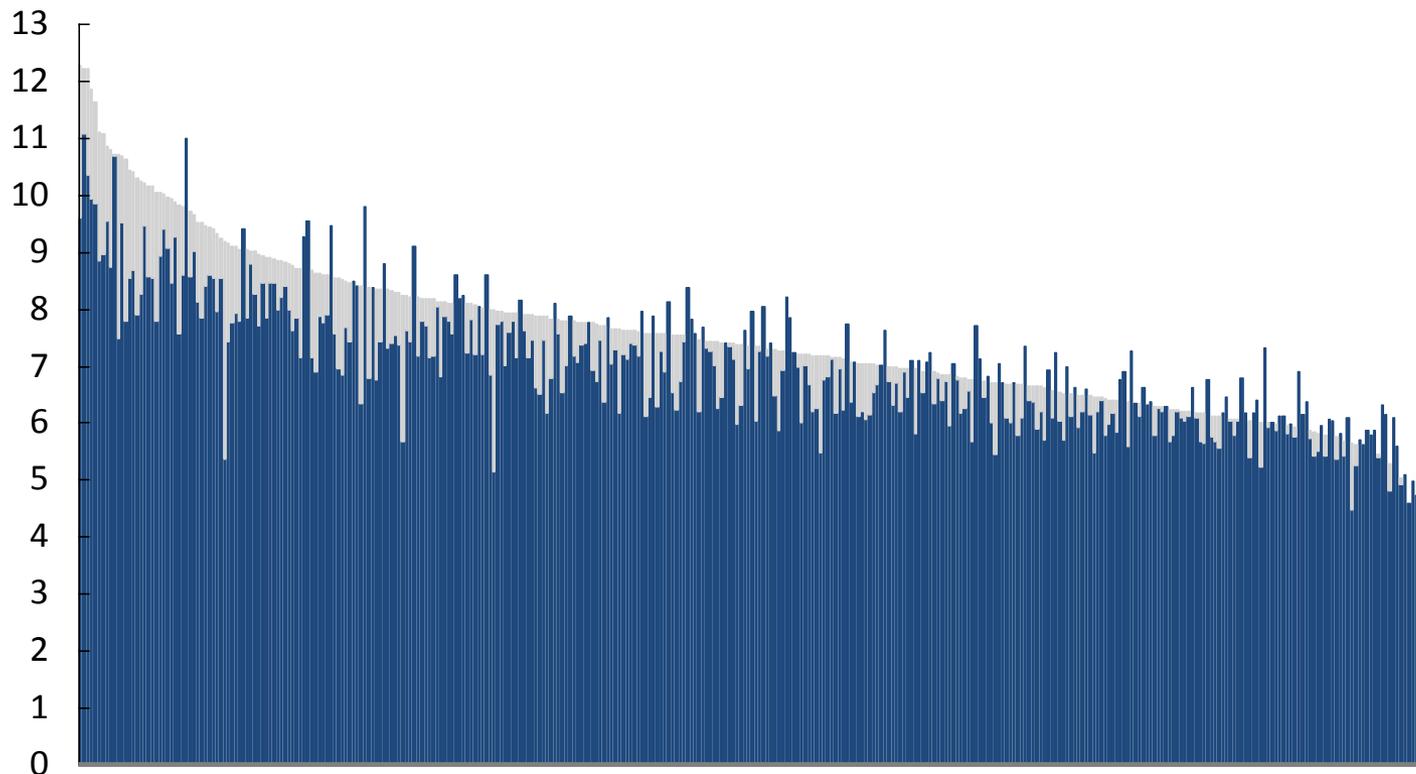


Perinatal: Provider Performance

Distribution of provider average episode cost

\$ in thousands

Avg. cost per episode, \$ '000



PAP – Delivering physician or physician group (contracting entity)

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

Perinatal: Provider Performance

Risk adjustment

Provider average episode cost

\$ in thousands

Adjust average episode cost down based on presence of 70+ clinical risk factors including:

Avg. cost per episode, \$ '000

- 13 ■ Hypertension
- 12 ■ Prior C-section
- 11 ■ Obesity
- 10 ■ Diabetes
- 9 ■ Diseases of the central nervous system
- 8 ■ Substance related mental or behavioral illness
- 7 ■ Emotional and behavioral mental illnesses
- 6 ■ Non-anemic blood diseases
- 5 ■ Viral infections
- 4 ■ Anemia
- 3 ■ Congenital anomalies
- 2 ■ Abortion related disorders
- 1 ■ Complications mainly related to pregnancy
- 0 ■ Diseases of the urinary system
- 0 ■ Diseases of the respiratory system
- 0 ■ Diseases of the heart

PAP – Delivering physician or physician group (contracting entity)

High cost outliers

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

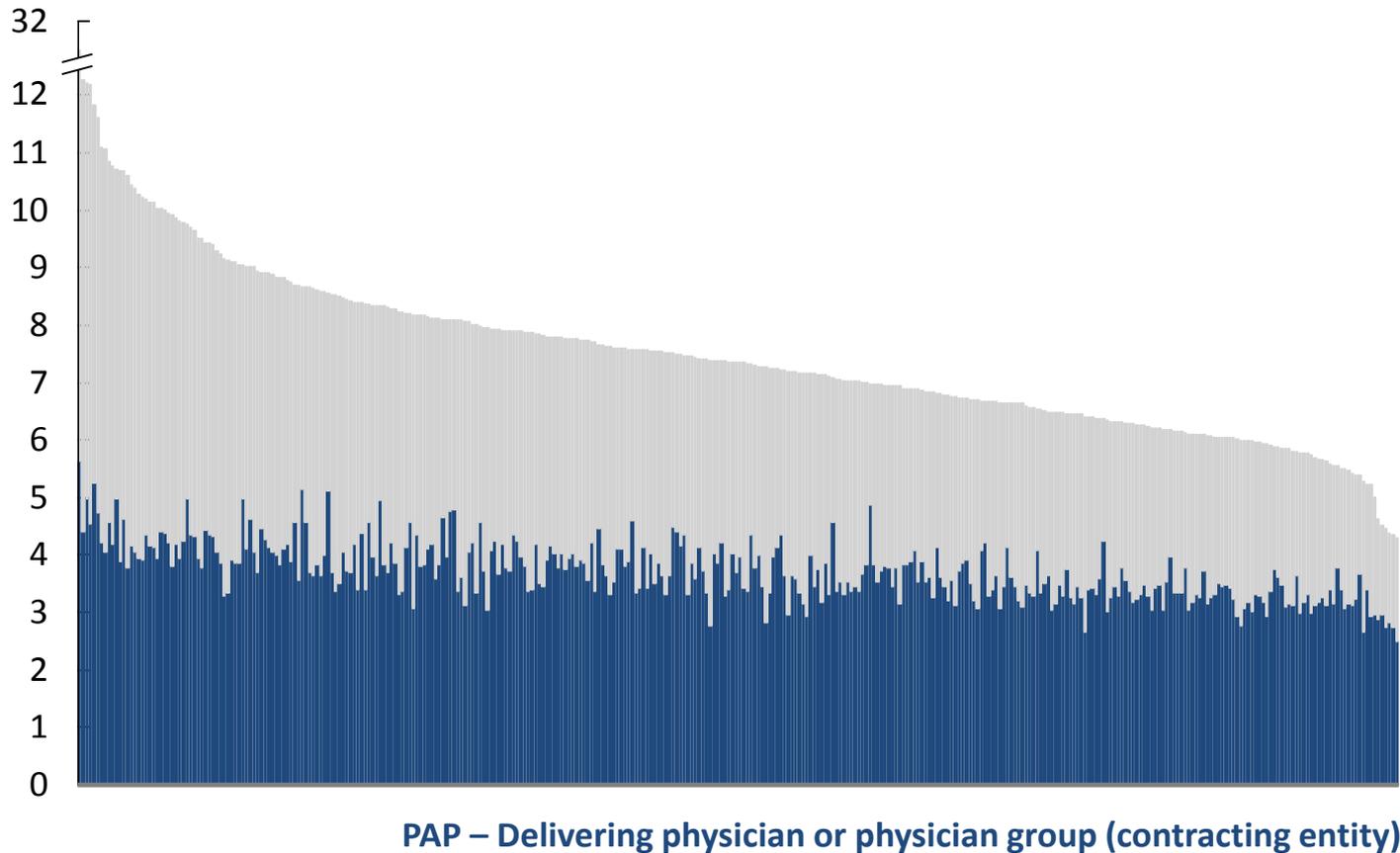
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Perinatal: Provider Performance

Distribution of provider average episode cost

\$ in thousands

Avg. risk-adjusted reimbursement per episode, \$ '000



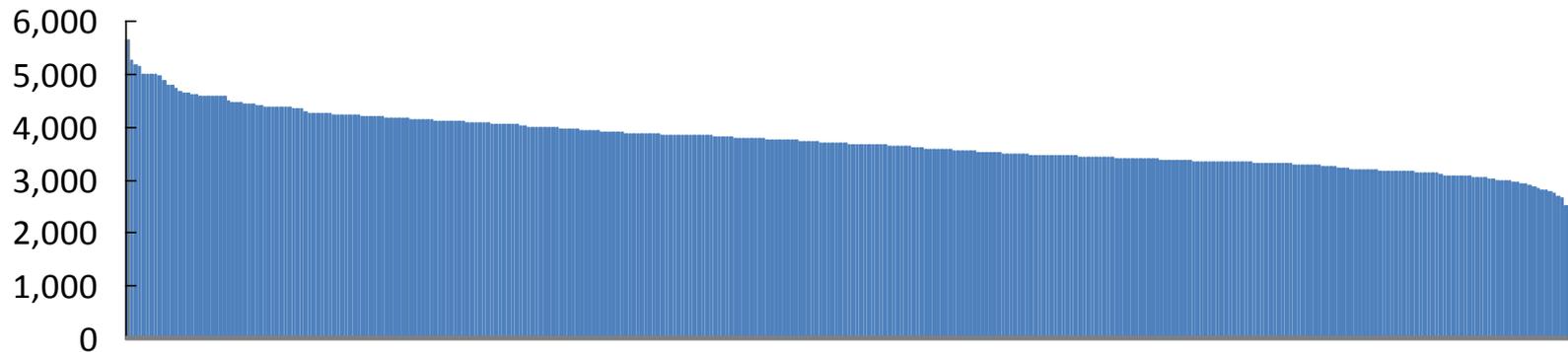
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Perinatal: Provider Performance

Distribution of provider average episode cost

\$

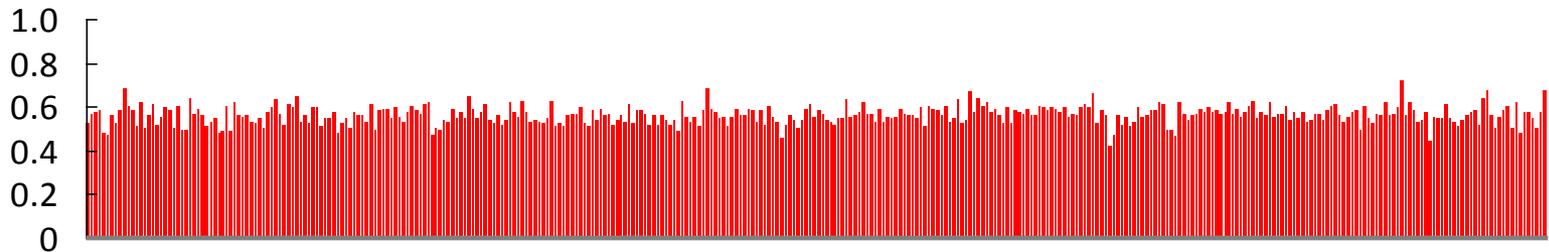
Avg. risk-adjusted reimbursement per episode, \$



Degree of risk adjustment distribution

Percent of risk adjustment per provider

Risk adjustment percentage



There is no correlation between average episode risk-adjusted reimbursement and level of risk

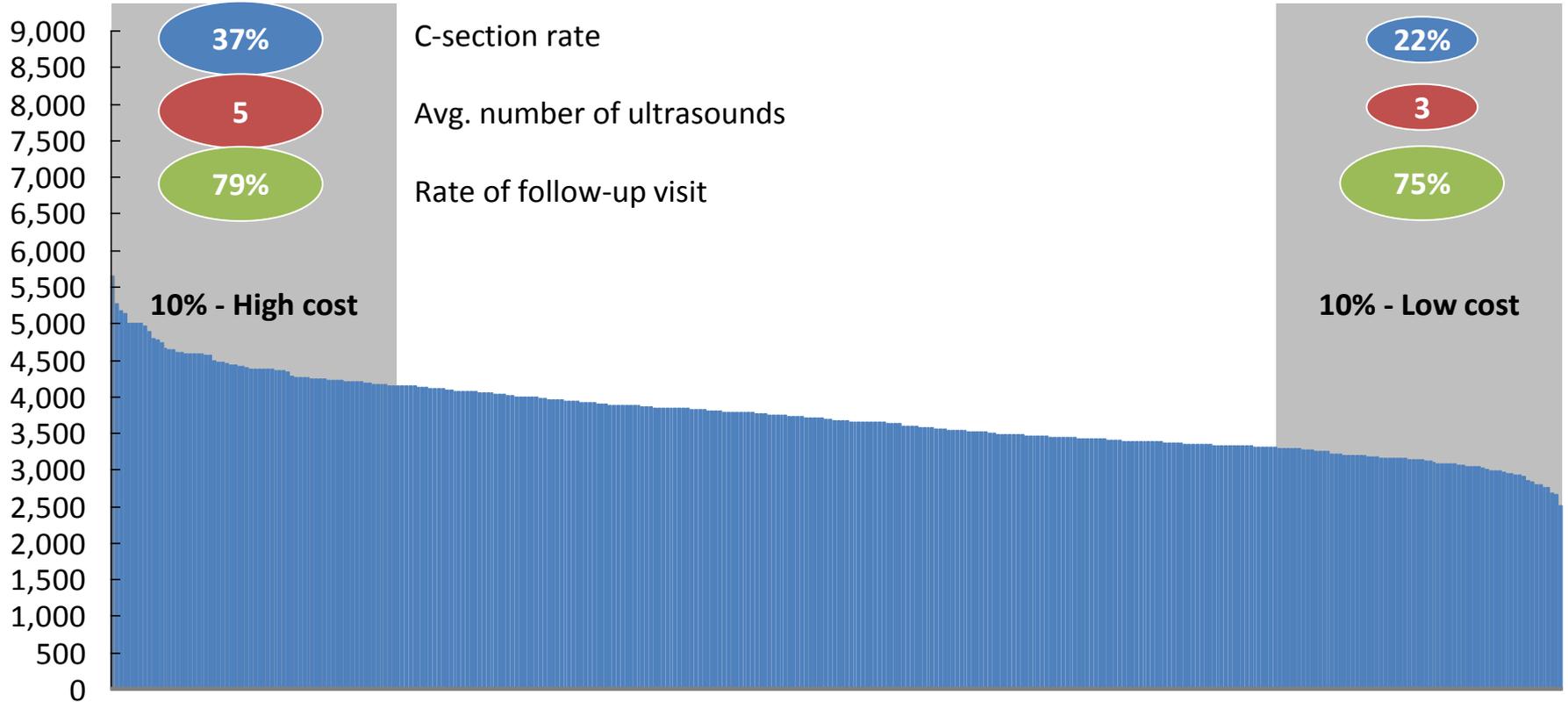
Principal Accountable Provider

Variation across the Perinatal episode

Distribution of provider average episode cost

\$

Avg. risk-adjusted reimbursement per episode, \$



Principal Accountable Provider



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NOTES: Average episode spend distribution for PAPs with five or more episodes; each vertical bar represents the average spend for one PAP.
SOURCE: Analysis of Ohio Medicaid claims data, CY2014.

www.HealthTransformation.Ohio.gov

CURRENT INITIATIVES

BUDGETS

NEWSROOM

CONTACT

VIDEO



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
- Create health homes for people with mental illness
- Rebuild community behavioral health system capacity
- Enhance community developmental disabilities services
- Improve Medicaid managed care plan performance

Streamline Health and Human Services

- Support Human Services Innovation
- 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
- Coordinate health information technology infrastructure
- Coordinate health sector workforce programs
- Support regional payment reform initiatives
- Federal Marketplace Exchange

State Innovation Model:

- Overview Presentations
- Patient-Centered Medical Home (PCMH) payment model
- Episode-based payment model
- Population health plan
- Health IT plan



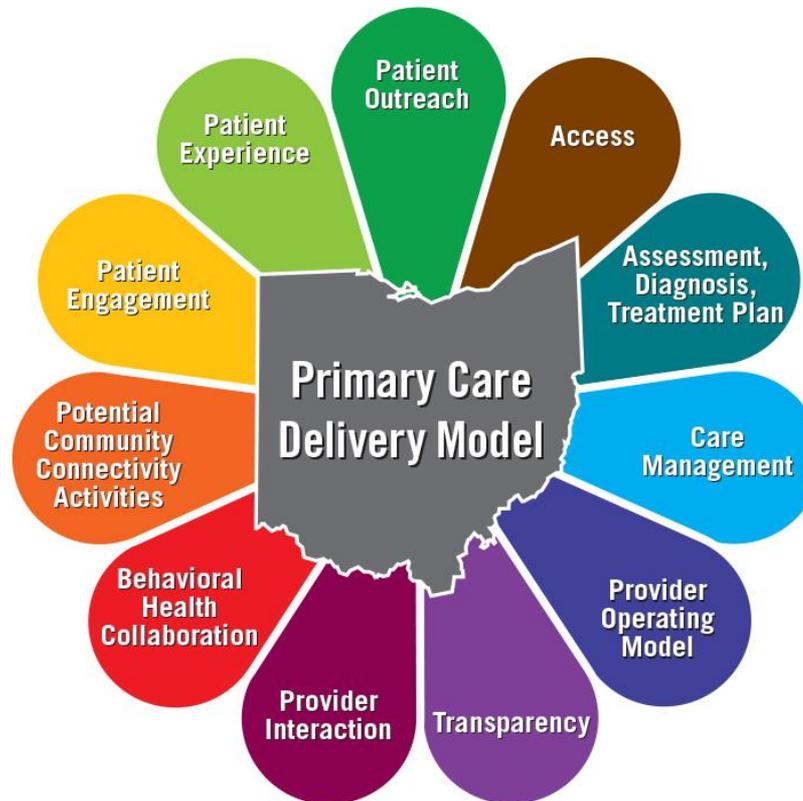
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Appendix A:

Ohio's Patient-Centered Medical Home (PCMH) care delivery and payment model

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
Patient outreach	<ul style="list-style-type: none"> Reactive, presentation-based prioritization 	<ul style="list-style-type: none"> Proactive, targeting patients with chronic conditions and existing PCP/ team relationship 	<ul style="list-style-type: none"> Proactive, targeting patients with chronic conditions but no clear PCP relationship¹, and prioritizing patients at-risk of developing a chronic condition 	<ul style="list-style-type: none"> Proactive, with broader focus on all patients including healthy individuals
Access	<ul style="list-style-type: none"> Offer limited access beyond office/ regular hours 	<ul style="list-style-type: none"> Expand channels for direct patient PCMH interaction for at-risk patients with an existing PCP/ team relationship through phone/ email/ text consultation Provide 24/7 access to PCMH-linked resources for at-risk patients with an existing PCP/team relationship 	<ul style="list-style-type: none"> Provide appropriately resourced same-day appointments Ensure appropriate site of visit for at-risk patients (e.g., home, safe/ convenient locations in the community) Offer a menu of communication options (e.g., encrypted texts, email) to all patients for ongoing care management Provide full accessibility for patients with disabilities and achieve ADA compliance (e.g., exam tables for patients in wheel chairs, facility ramps) 	<ul style="list-style-type: none"> Offer remote clinical consultation 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 Increase time spent in locations that represent key points of aggregation for the community (e.g., churches, schools), meeting patients' needs in the most appropriate setting
Assessment, diagnosis, treatment plan	<ul style="list-style-type: none"> Diagnose and develop treatment plan for presenting condition, with emphasis on pharmaceutical treatment 	<ul style="list-style-type: none"> Identify and document full set of needs for at-risk patients with an existing PCP/ team relationship (e.g., barriers to access health care and to medical compliance) Develop evidence-based care plans with recognition of physical and BH needs (e.g., medications), customized based on benefits considerations Identify and close gaps in preventive care for at-risk patients with an existing PCP/ team relationship 	<ul style="list-style-type: none"> Systematically incorporate patient socio-economic status, gender, sexual orientation, sex, disability, race, language, religion, and ethnic-based differences into treatment (e.g., automatic screening flags for relevant groups) Assess gaps in both primary and secondary preventive care across the broader patient panel and prioritize member outreach accordingly Include BH needs (e.g., psycho-social treatment) into care plan through regular communication with BH provider Identify and incorporate improvements to care planning process 	<ul style="list-style-type: none"> Agree on shared agenda with patients to best meet their acute and preventive needs with a multi-generational lens and leveraging the result of predictive modeling, where appropriate Collaborate meaningfully with other key community-based partners (e.g., schools, churches) for input into a treatment plan and share relevant information on an ongoing basis with patient consent where appropriate



Governor's Office of Health Transformation

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

UPDATED 12/10/2015

	Beginning of the journey	Early PCMH	Maturing PCMH	Transformed PCMH
Care management	<ul style="list-style-type: none"> Most patients lack connection to a care manager while others are subject to many, overlapping care coordination efforts 	<ul style="list-style-type: none"> Foster communication between care managers for patients Identify who, within the practice, is in charge of care management activities for at-risk patients 	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Primarily focus on managing patient flow/volume 	<ul style="list-style-type: none"> Improve operational efficiency through process redesign and standardization, harnessing improvement tools (e.g., standardized use of clinical practice guidelines) 	<ul style="list-style-type: none"> 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) 	<ul style="list-style-type: none"> Practice has flexibility to adapt resourcing and delivery model to meet the needs of specific patient segments as appropriate
Transparency	<ul style="list-style-type: none"> Review performance data irregularly, if at all, to identify and pursue opportunities for improvement 	<ul style="list-style-type: none"> 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) 	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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
Provider interaction	<ul style="list-style-type: none"> Select specialists for referrals based on prior experience Do not consistently leverage all available resources during transitions in care 	<ul style="list-style-type: none"> Proactively reach out to patients after an ED visit/hospitalization Track and follow-up on specialist referrals and diagnostic testing Information is shared bi-directionally between PCP and specialist 	<ul style="list-style-type: none"> Select specialists for referrals also based on likely connectivity with member Select specialists for referrals based on risk-adjusted data on outcomes and cost, potentially leveraging data from episodes of care Proactively reach out to patients before and after any planned transition in care 	<ul style="list-style-type: none"> Match type of care with member needs, as jointly identified by member and provider (e.g., regular in-person interactions with multi-disciplinary team only when needed) Proactively manage urgent needs, to the extent possible (e.g., reach out to the ED to anticipate arrival of patients that have sought care from the practice first, to accelerate provision of care and ensure that it is targeted) Ensure access and integration to all capabilities needed (e.g., clinical pharmacy, dental providers, community health workers)
Behavioral health collaboration	<ul style="list-style-type: none"> Do not consider undiagnosed BH cases a priority 	<ul style="list-style-type: none"> Integrate presenting behavioral health needs into care plans Refer BH cases to appropriate providers Collaborate 'at a distance' with BH providers for most at-risk patients 	<ul style="list-style-type: none"> Focus on diagnosing and addressing undiagnosed BH needs Track and follow-up on BH referrals and ensure ongoing communication with BH specialist – onsite where possible Provide more coordinated care between primary and BH providers (e.g., same-day scheduling, co-location, system integration) 	<ul style="list-style-type: none"> Integrate behavioral specialists in the practice, where scale justifies it Fully integrated systems and regular formal and informal meetings between BH and PCP/team to facilitate integrated care Build competencies to directly provide select BH services on site, when scale justifies it Collaborate with community-based resources to manage BH needs
Potential community connectivity activities	<ul style="list-style-type: none"> Have limited community connectivity outside of office, or relationships with social services 	<ul style="list-style-type: none"> Inform patients of social services and community-based prevention programs that can improve social determinants of health (e.g., provide list of helpful resources, including local health districts) 	<ul style="list-style-type: none"> Facilitate connectivity to social services and community-based prevention programs 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) 	<ul style="list-style-type: none"> Actively connect members to broader set of social services and community-based prevention programs (e.g., scheduling appointments and addressing barriers like transportation to ensure appointment happens) Ensure ongoing bi-directional communication with social services and community-based prevention programs (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) Collaborate meaningfully (e.g., through formal financial partnerships) with partners based on achievement of health outcomes Actively engage in advocacy and collaborations to improve basic living conditions and opportunities for healthy behaviors¹

¹ 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 engagement¹

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

Patient experience²

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

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

Provider enrollment requirements

Required



- **Eligible provider type and specialty** (details to follow)
- **Minimum size:** 500 attributed/ assigned Medicaid eligible members within a contracted entity
- **Commitment**
 - To sharing data with payers/ the state
 - To participating in learning activities¹
 - To meeting “standard processes” requirements in 6 months

Not required



- **Accreditation:** (e.g., NCQA or URAC)
- **Planning** (e.g., develop budget, plan for care delivery improvements, etc.)
- **Tools** (e.g., e-prescribing capabilities, EHR, etc.)

¹ Examples include sharing best practices with other PCMHs, working with existing organizations to improve operating model, participating in state led PCMH program education at kickoff

Provider types and specialties eligible for enrollment

PCP definition by provider type and specialty

Provider Type	Provider Type Description	Provider Specialty	Provider Specialty Description
01	Hospital	001	General Hospital
01	Hospital	005	Children's Hospital
01	Hospital	006	Major Teaching Hospital
01	Hospital	010	Critical Access Hospital
05	Rural Health Clinic	050	Rural Health Clinic Medical
20	Physician/Osteopath Individual	207	Family Practice
20	Physician/Osteopath Individual	201	General Practice
20	Physician/Osteopath Individual	263	General Preventive Medicine
20	Physician/Osteopath Individual	209	Internal Medicine
20	Physician/Osteopath Individual	215	Pediatric
20	Physician/Osteopath Individual	342	Public Health & Gen Preventive Med
20	Physician/Osteopath Individual	274	Internal Medicine/Pediatrics
20	Physician/Osteopath Individual	216	Geriatric
21	Professional Medical Group	021	Professional Medical Group
24	Physician Assistant	240	Physician Assistant
50	Clinic	500	Primary Care Clinic
50	Clinic	501	Public Health Clinic
65	Clinical Nurse Specialist Individual	215	Pediatric
65	Clinical Nurse Specialist Individual	651	Adult Health
65	Clinical Nurse Specialist Individual	216	Geriatric
72	Nurse Practitioner Individual	651	Adult Health
72	Nurse Practitioner Individual	207	Family Practice
72	Nurse Practitioner Individual	216	Geriatric
72	Nurse Practitioner Individual	215	Pediatric
12	Federally Qualified Health Center	121	FQHC Medical
20	Physician/Osteopath Individual	200	Physician/Osteopath Individual
20	Physician/Osteopath Individual	239	ACA Primary Care ¹
65	Clinical Nurse Specialist Individual	650	Clinical Nurse Specialist
72	Nurse Practitioner Individual	720	Nurse Practitioner

Professional medical groups affiliated with a hospital billing under hospital ID should be considered eligible for Ohio's PCMH program

Urgent Care Centers are considered ineligible for attribution

A billing provider with >50% of E&M claims having Urgent Care Facility as Place of Service (i.e., Place of Service = 20) is identified as an Urgent Care Center and is excluded from attribution

Provider type and specialty pulled from provider master file (all 9 columns)

Must have any of the primary eligible specialties above to be considered as PCP

¹ Note that provider specialty 239 sometimes appears as "Clinical biochemical genetics" – potentially a legacy description in provider master file

Patients and services included in total cost of care

Inclusions



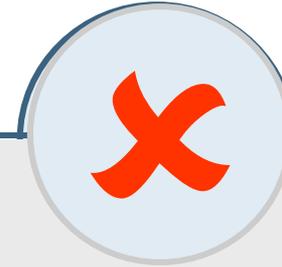
Patients

- All adults and pediatrics¹
- All behavioral health members
- Members with exclusively dental or vision TPL coverage

Services

- All non-excluded medical and prescription spend including:
 - Case management
 - DME
 - Home health
 - First 90 days of nursing facility spend²

Exclusions



- Duals (*included as operationally feasible, priority for MyCare population*)
- Members with limited benefits (e.g., family planning)
- All other members with TPL coverage

- Waiver
- Currently underutilized services (dental, vision, and transportation)
- Nursing facility spend after 90 days in institution
- All spend for a member after first ICF/IID claim

¹ All PFK members are included in PCMH model

² May be reconsidered due to effect on panel size and other technical considerations

Attributing patients to providers

Members are attributed/assigned to PCPs based on ...

- Claims, for existing members
- Member choice, for new members
- Non-claims methodology (geography, capacity, age), for members not attributed/assigned based on first two methodologies

Changes can be made based on ...

- Member preference
- Member behavior, as assessed through claims

Payment streams will be tied to specific requirements

Requirements	1 Standard processes <ul style="list-style-type: none"> Risk stratification Same day appointments 24/7 access Practice uses a team Care management Relationship continuity 	2 Activities <ul style="list-style-type: none"> Risk stratification Population management Care plans Follow up after hospital discharge Tracking of follow up tests and specialist referrals Patient experience 	3 Efficiency <ul style="list-style-type: none"> ED visits Inpatient admissions for ambulatory sensitive conditions All-cause readmission rate Generic dispensing rate of select classes 	4 Clinical quality <ul style="list-style-type: none"> 16-20 measures aligned with CMS/AHIP core standards for PCMH 	5 Total Cost of Care
PCMH operational activities PMPM	<p>Scoring weight shifts from standard processes and activities... <i>...to efficiency and clinical quality over time</i></p>				
Quality and financial outcomes-based payment	<i>"Must have" processes targeting access to care</i>			<i>Quality gate</i>	<i>Based on self-improvement¹</i>

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 payers¹. 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
	Live Births Weighing Less than 2,500 grams	Pediatrics	Infant Mortality	State Records	N/A
Appropriate Care	Controlling high blood pressure (beginning year 3)	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
	Statin Therapy for patients with cardiovascular disease	Adults	Heart Disease	Claims	HEDIS SPC
Behavioral Health	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
	Initiation and engagement of alcohol and other drug dependence treatment	Adults	Substance Abuse	Claims	0004

Final clinical requirements will align with CMS/AHIP Core Quality Measures for PCMH

<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Co-re-Measures.html>

Early view on timeline for statewide PCMH launch

