



Governor's Office of
Health Transformation

Quicker to Value:

How Ohio and its health plans are partnering to reform health purchasing

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Governor's Office of Health Transformation

Medicaid Innovations Conference
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www.HealthTransformation.Ohio.gov



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What do states need from health plan partners?

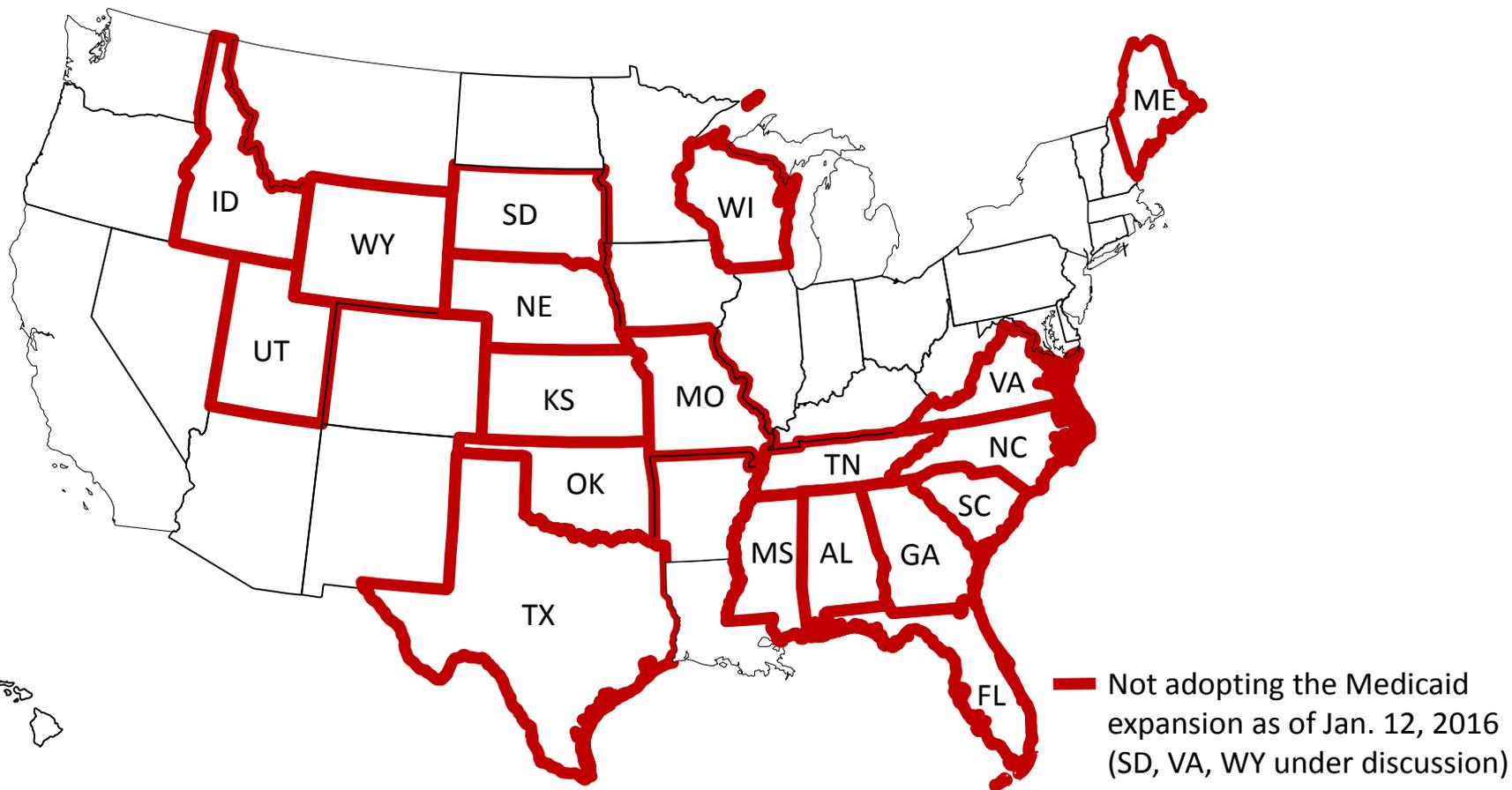
- 1. Improve Medicaid Performance**
2. Improve Population Health Outcomes
3. Pay for Value
 - Episode-Based Payment Model
 - Patient-Centered Medical Home Model

**In Ohio, we repealed the
outdated, government-run, fee-
for-service Medicaid program and
replaced it with private-sector
health plans**

Clear benefits from extending Medicaid coverage ...

- Cut Ohio's uninsured rate in half – 650,000 otherwise uninsured Ohioans now covered, including 400,000 with a behavioral health need, and 38,000 veterans and family members
- The rate of employer-sponsored insurance remained constant before and after expansion (55 percent in Ohio)
- Support for expansion created an opportunity to insist on bringing new populations and benefits into managed care
- Provided significant general fund relief when Medicaid coverage offset costs previously covered by local mental health boards and public health services for uninsured populations
- Created new opportunities to reduce health disparities

States not adopting the Medicaid expansion





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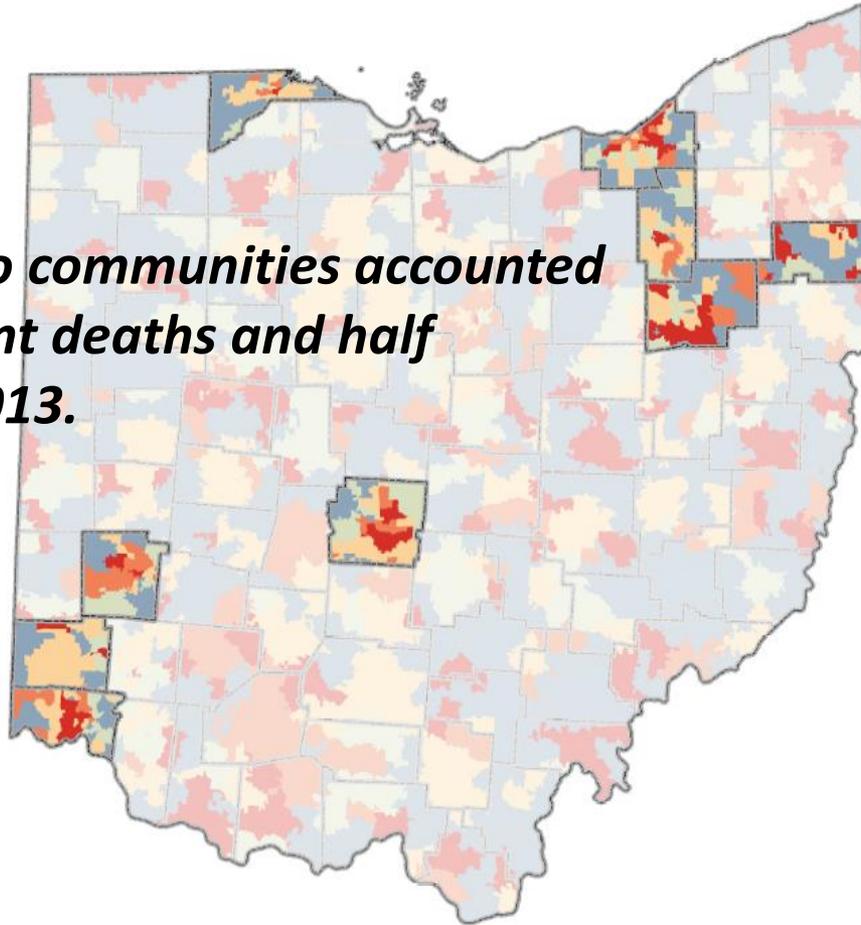
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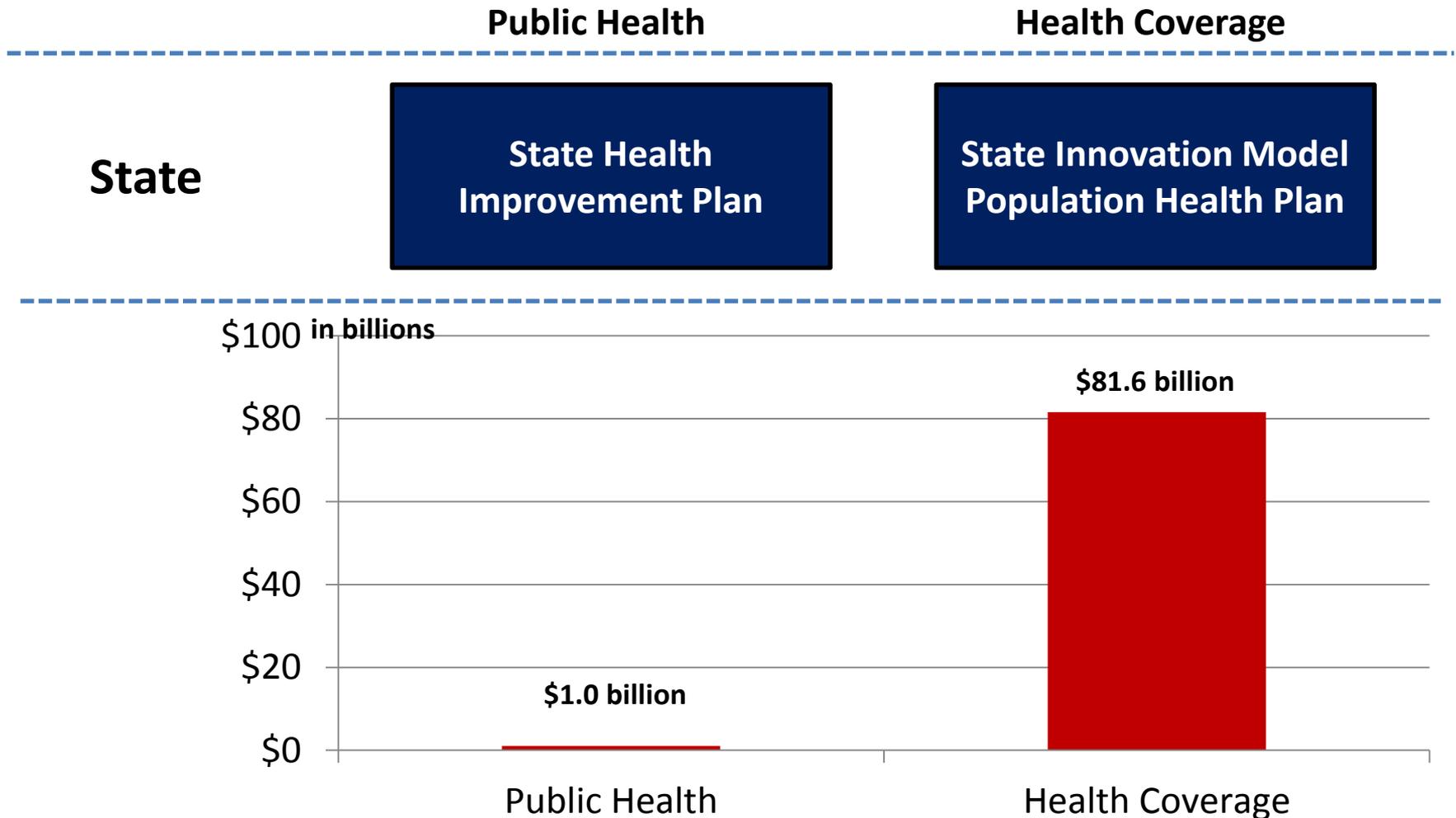
Ohio has significant disparities for many health outcomes by race, income and geography

Neighborhoods in nine Ohio communities accounted for 95 percent of black infant deaths and half of white infant deaths in 2013.

SOURCE: 2014 Ohio Infant Mortality Data



Public health strategies alone are not sufficient



Ohio is aligning public health and coverage strategies

Public Health

Health Coverage

State

State Health Improvement Plan

State Innovation Model Population Health Plan

**Example:
Reduce
Infant
Mortality**

Use vital statistics to identify at-risk women
Align maternal and child health programs
Promote safe sleep, folic acid, etc.
Discourage smoking, etc.

Require enhanced care management
Extend Medicaid to cover more women
Financially reward improved infant health
Reduce scheduled deliveries prior to 39 wks

- Identify at-risk neighborhoods
- Enhance care management for every woman in those neighborhoods
- Plans directly engage leaders in at-risk communities
- Surge resources to greatest need

Coverage raises some interesting questions ...

- What is the role of entities that serve uninsured populations? (FQHCs, free clinics, public health clinics)
- What public health services are now unnecessary because they are covered? (vaccinations, special eligibility programs)
- Who is accountable for care coordination? Do plans duplicate what already exists? Or assign accountability, to a PCMH for example? Or provide “air traffic control” across settings?



What do states need from health plan partners?

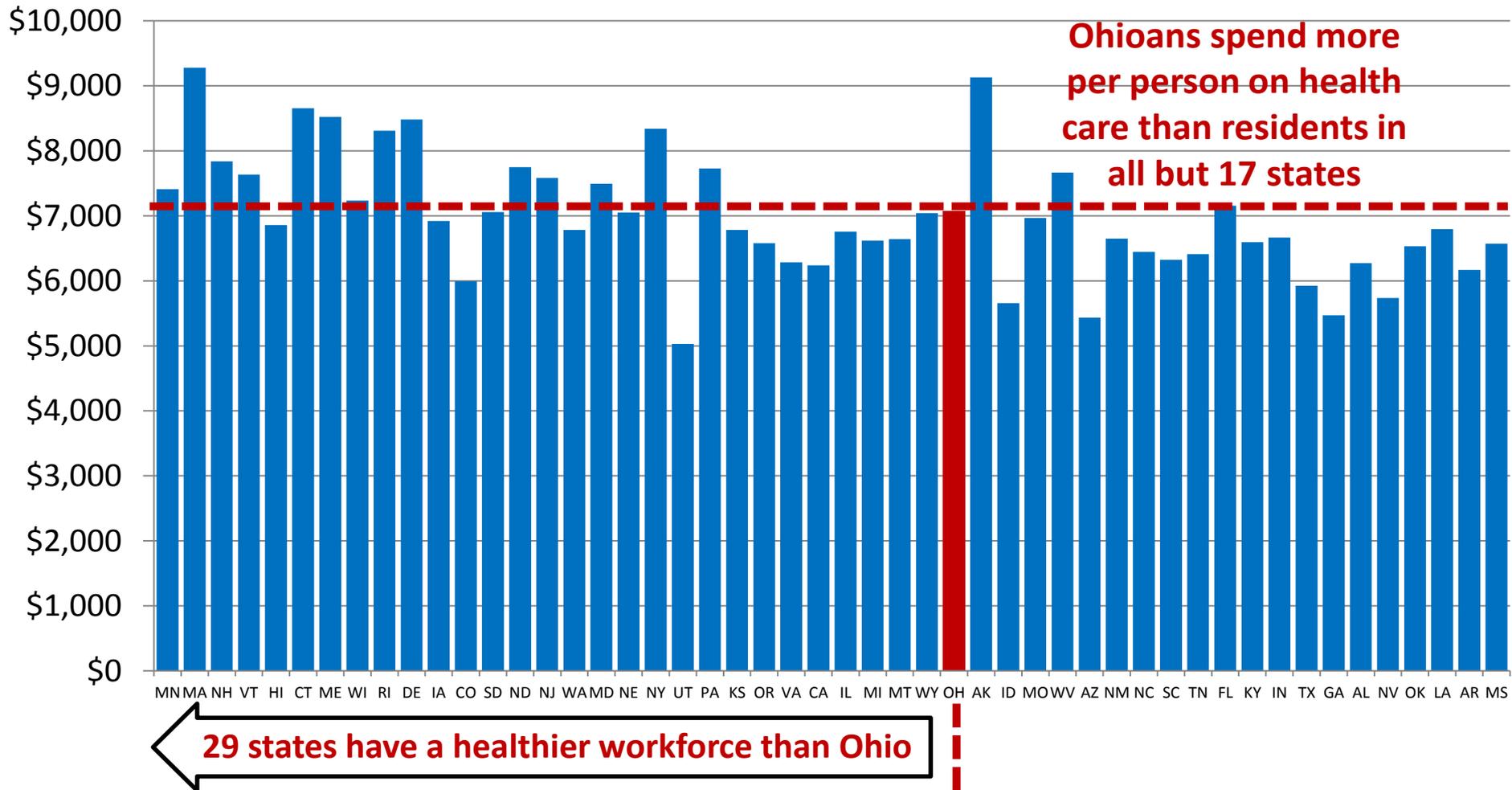
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Ohio can get better value from what is spent on health care

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).

In 2014, Ohio was awarded a State Innovation Model (SIM) grant to test two value-based payment models

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

2014

- In 2014 focus on Comprehensive Primary Care Initiative (CPCi)

2015

- Collaborate with payers on design decisions and prepare a roll-out strategy

2016

- Model rolled out to at least two major markets

2017-2018

- Model rolled out to all markets
- 80% of patients are enrolled

Episode-based payments

- State leads design of six episodes: asthma acute exacerbation, COPD exacerbation, perinatal, acute and non-acute PCI, and joint replacement

- State leads design of seven new episodes: URI, UTI, cholecystectomy, appendectomy, GI hemorrhage, EGD, and colonoscopy

- 20 episodes defined and launched across payers, including behavioral health

- 50+ episodes defined and launched across payers, including behavioral health

Selection of episodes

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)

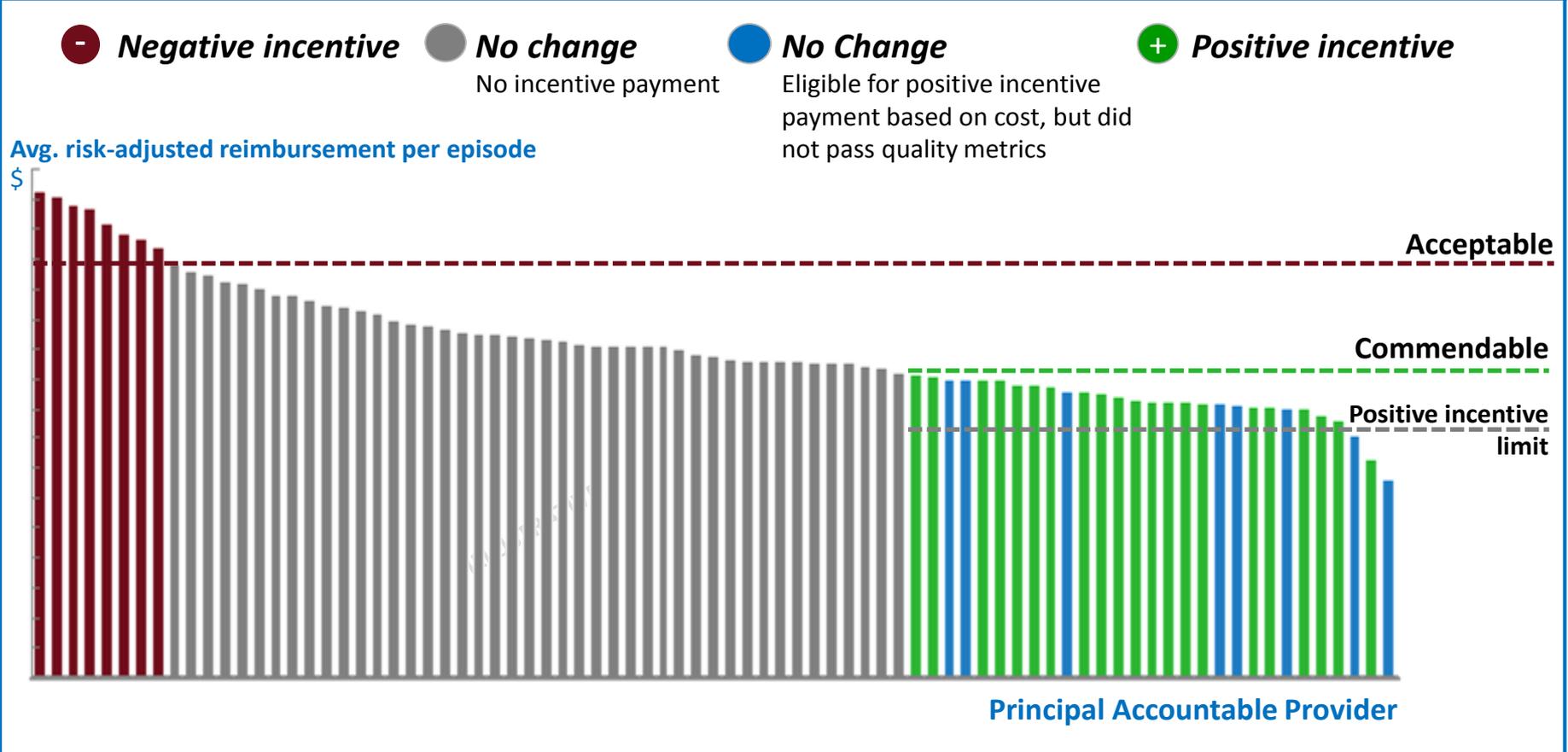
- | | |
|--------------------------------|----------------------------------|
| 7. Upper respiratory infection | PCP or ED |
| 8. Urinary tract infection | PCP or ED |
| 9. Cholecystectomy | General surgeon |
| 10. Appendectomy | General surgeon |
| 11. Upper GI endoscopy | Gastroenterologist |
| 12.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

WAVE 3 (launch January 2017)

- 14-19. Package of episodes including some related to behavioral health

Retrospective thresholds reward cost-efficient, high-quality care

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



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

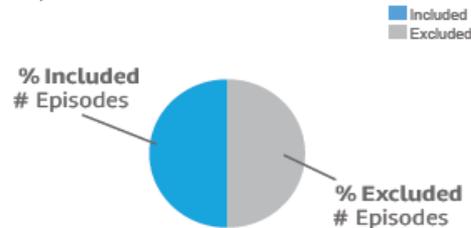
PROVIDER: Provider Name

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

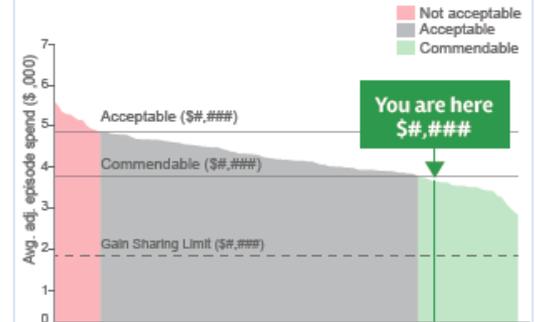
Quality metrics

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 in use now for both Wave 1 and Wave 2 episodes in 2016

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>.



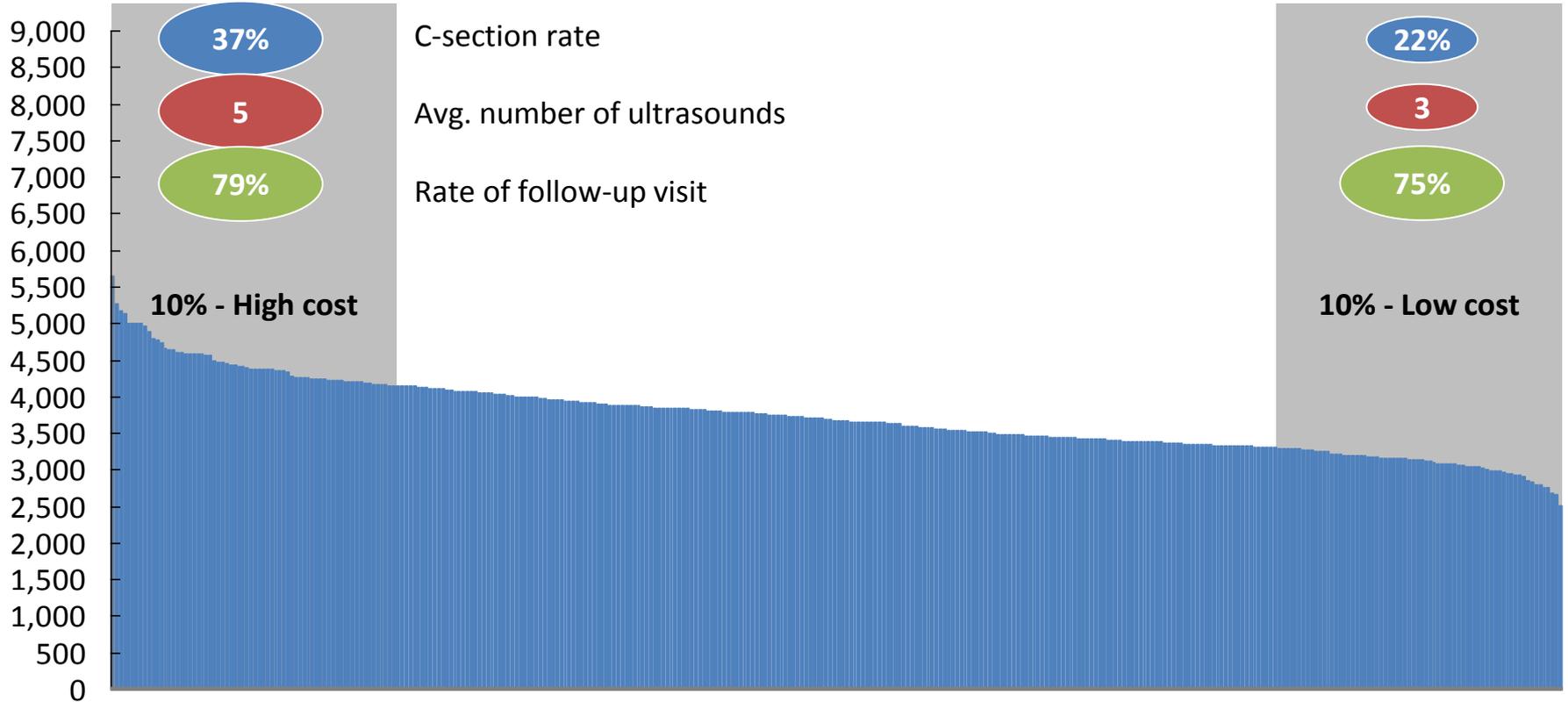
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Variation across the Perinatal episode

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.

In 2014, Ohio was awarded a State Innovation Model (SIM) test grant to implement two value-based payment models

Goal

80-90 percent of Ohio's population in some value-based payment model (combination of episodes- and population-based payment) within five years

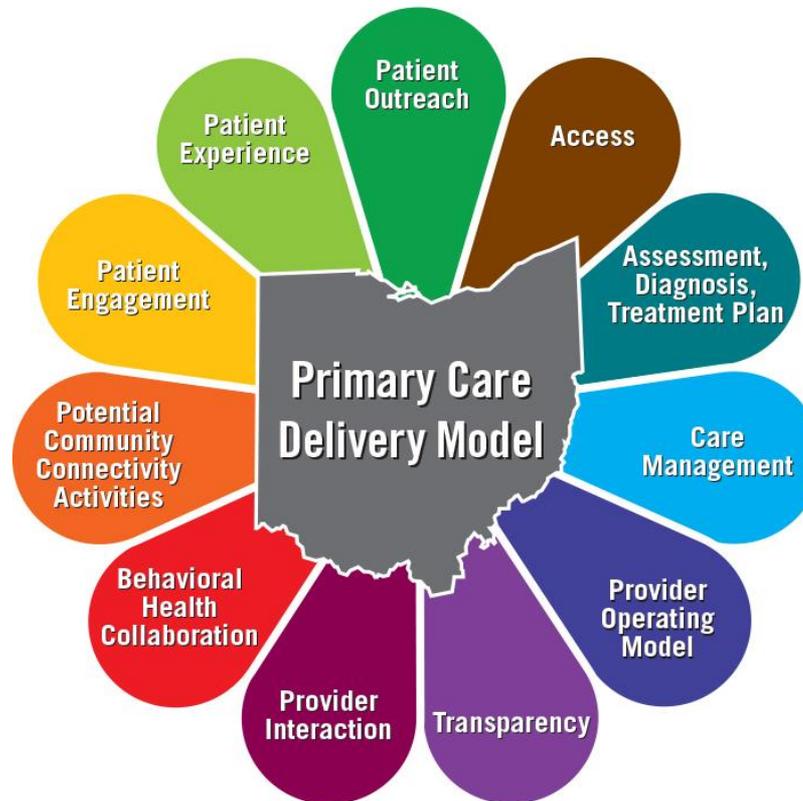
State's Role

- Shift rapidly to PCMH and episode model in Medicaid fee-for-service
- Require Medicaid MCO partners to participate and implement
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	Patient-centered medical homes	Episode-based payments
2014	<ul style="list-style-type: none"> ▪ In 2014 focus on Comprehensive Primary Care Initiative (CPCi) 	<ul style="list-style-type: none"> ▪ State leads design of six episodes: asthma acute exacerbation, COPD exacerbation, perinatal, acute and non-acute PCI, and joint replacement
2015	<ul style="list-style-type: none"> ▪ Collaborate with payers on design decisions and prepare a roll-out strategy 	<ul style="list-style-type: none"> ▪ State leads design of seven new episodes: URI, UTI, cholecystectomy, appendectomy, GI hemorrhage, EGD, and colonoscopy
2016	<ul style="list-style-type: none"> ▪ Model rolled out to at least two major markets 	<ul style="list-style-type: none"> ▪ 20 episodes defined and launched across payers, including behavioral health
2017-2018	<ul style="list-style-type: none"> ▪ Model rolled out to all markets ▪ 80% of patients are enrolled 	<ul style="list-style-type: none"> ▪ 50+ episodes defined and launched across payers, including behavioral health

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

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

Financial incentives for meeting PCMH model requirements:

- *Some* practices may be eligible for one-time **Practice Transformation Support** to help them begin the transition to a PCMH care delivery model
- **PCMH Operational Activities Payments** to compensate practices for activities that improve care and are currently under-compensated
- **Quality and Financial Outcomes-Based Payment** for achieving total cost of care savings and meeting pre-determined quality targets

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 an 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

4

Aligning population health priorities and PCMH measures

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 ¹	Adults	Heart Disease	Hybrid
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

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

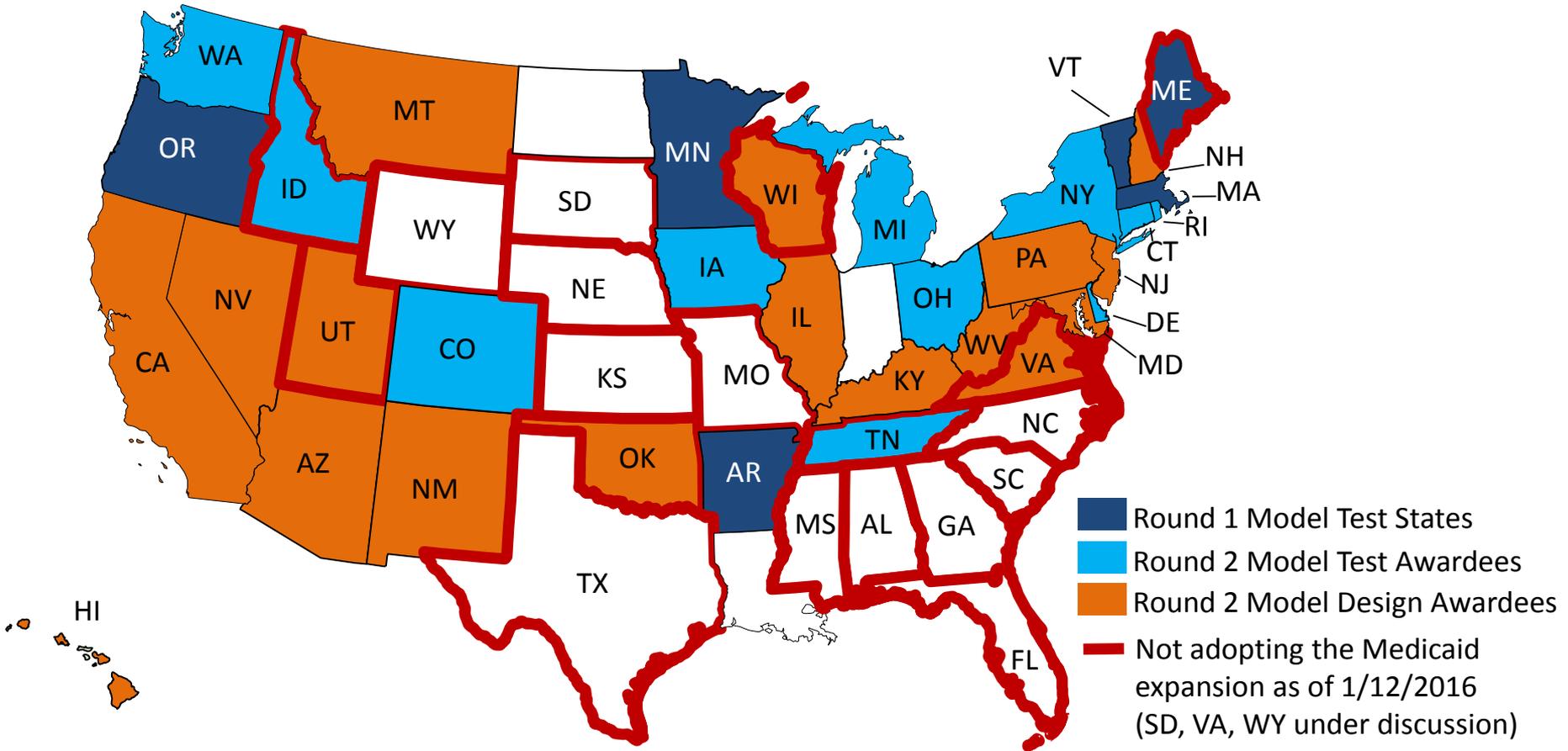
1 Scored beginning in year 3

Ohio's largest health plans have committed to help the state design and test PCMH and episode models





Ohio is one of 34 states awarded a State Innovation Model (SIM) design or test grant



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SOURCE: [State Innovation Models](#), U.S. Centers for Medicare and Medicaid Services (CMS) and [Kaiser Family Foundation State Health Facts](#).



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

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 Episode-Based Payment Model Detail

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

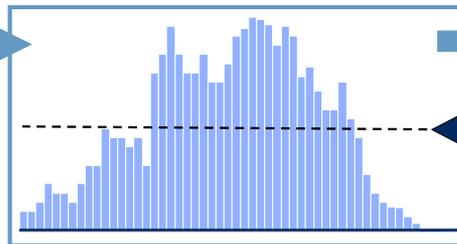
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Review claims from the performance period to identify a **'Principal Accountable Provider'** (PAP) for each episode

5

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



Compare to predetermined "commendable" and "acceptable" levels

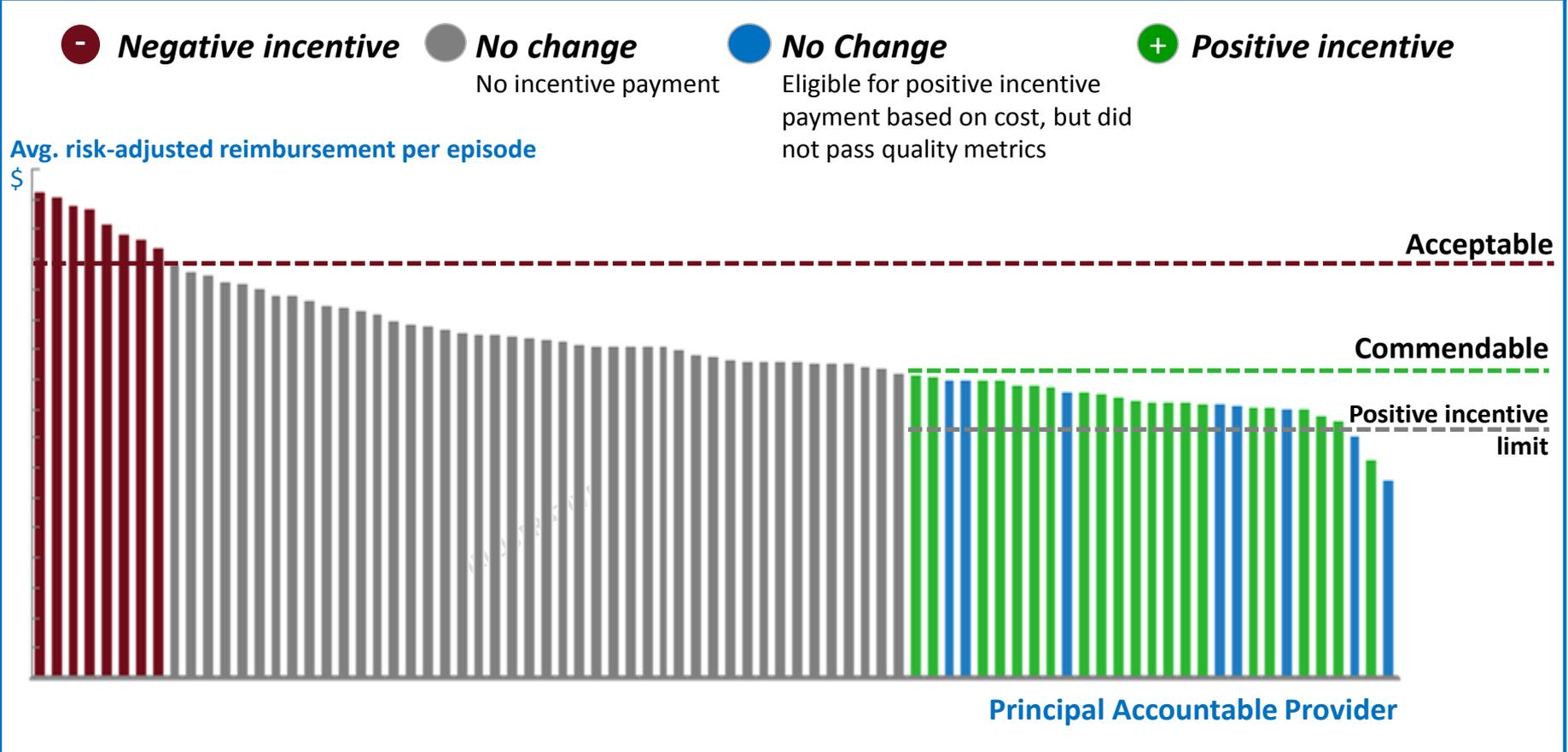
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Providers may:

- **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

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)

- | | |
|------------------------------------|-------------------------------------|
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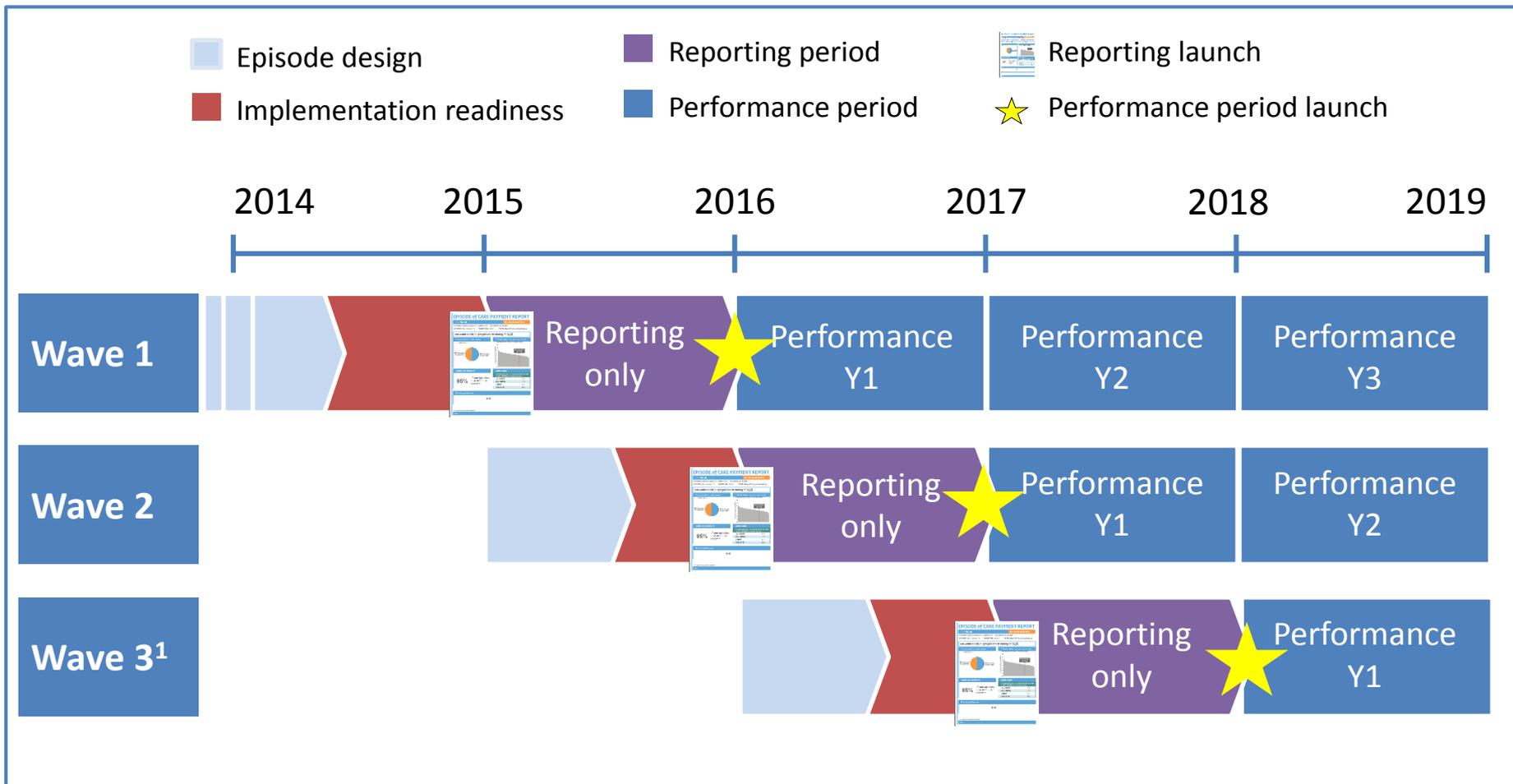
WAVE 2 (launch January 2016)

- | | |
|--------------------------------|----------------------------------|
| 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 |

WAVE 3 (launch January 2017)

- 14-19. Package of episodes including some related to behavioral health

Ohio's episode timeline



¹ Expected timing for Wave 3

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

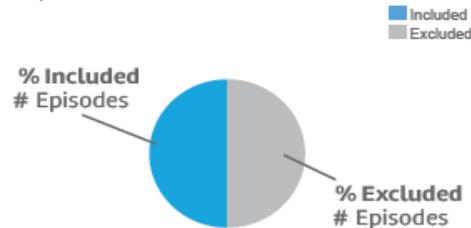
PROVIDER: Provider Name

Eligibility requirements for gain or risk-sharing payments

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Episodes included, excluded & adjusted

Total episodes#



% of your episodes have been risk adjusted

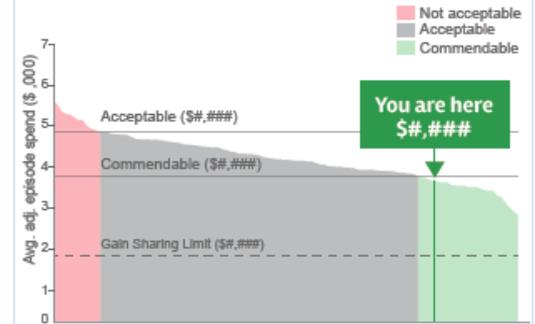
Quality metrics

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	##%	##%	##%	##%	##%

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This is an example of the performance report format that will be released in 2016 with the launch of the performance period for Wave 1 and used for both Wave 1 and Wave 2 episodes in 2016



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Detailed file delivered to each Principal Accountable Provider to complement quarterly provider reports

Episode Id	Episode In	Payer	Rendering P	Patient M	Patient N	Episode Star	Episode End	C Risk	adjust	Non-adjus	Inpatient sp	Inpatient i	Outpatient	Outpatient	Pharmacy	Pharm	Sound rate
de1341f1	Included	FFS				7/18/2014	6/25/2015	2116.51	4080.41	2222.93	1	0	4	182.52			4
eb68a693	Included	FFS				2/25/2014	2/2/2015	2371.52	4966.53	2222.93	1	1571.87	4	6.82			1
911f690c	Included	FFS				6/23/2014	6/2/2015	2505.73	5954.67	3189.22	1	271.13	4	4.56			1
a85bfab4	Included	FFS				11/12/2013	10/21/2014	2698.79	4641.89	3326.36	1	0	0	0			1
dc2e6599	Included	FFS				9/6/2013	8/14/2014	2856.67	4726.46	2478.01	1	578.24	3	0			2
5f0f95774	Included	FFS				6/16/2014	5/24/2015	2980.68	5324.54	3189.22	1	24.39	1	14.7			2
85464184	Included	FFS				10/1/2013	9/9/2014	3061.75	6533.82	3326.36	1	347.61	3	78.95			3
c8b7da29	Included	FFS				7/11/2014	6/18/2015	3089.1	5530.07	2222.93	1	317.41	2	316.53			5
fc78051cf	Included	FFS				7/1/2014	6/8/2015	3118.81	5286.12	2222.93	1	1407.65	3				3
c3e5ba36	Included	FFS				5/7/2014	4/14/2015	3148.18	5076.89	2222.93	1	406.15	6				3
cd331855	Included	FFS				2/5/2014	1/13/2015	3349.01	5396.41	3540.47	1	0	0				1
c7e72c02	Included	FFS				11/4/2013	10/12/2014	3360.54	4794.61	2318.52	1	0	0	0			1
7af889f7b	Included	FFS				6/22/2014	5/30/2015	3482.58	5197.11	2222.93	1	215.44	3				2
271e3826	Included	FFS				10/15/2013	9/22/2014	3703.49	4502.18	2318.52	1	133.74	1				2
762293f1c	Included	FFS				4/29/2014	4/6/2015	3912.77	7528.91	2222.93	1	1012.8	8	397.7			4
d58071ae	Included	FFS				1/1/2014	12/9/2014	3952.08	7987.23	4489.38	2	796.15	3	51.42			3
c0748803f	Included	FFS				7/15/2014	6/22/2015	3975.31	5246.55	2222.93	1	174.83	1	178.76			3
f9eda83c	Included	FFS				5/20/2014	4/27/2015	4089.61	5684.75	2222.93	1	565.82	5	65.09			3
567ccdfc0	Included	FFS				2/14/2014	1/22/2015	4140.54	6773.33	2478.01	1	2268.66	11	27.18			4
6f9052b7f	Included	FFS				3/20/2014	2/24/2015	4194.74	7339.87	2478.01	1	2089.61	7	130.65			4
fa9e049d	Included	FFS				1/4/2014	12/16/2014	4285.2	7149.15	5463.9	1	0	0	0			3
d848a76e	Included	FFS				5/20/2014	4/27/2015	4307.78	14198.3	4974.34	2	4882.67	11	271.45			5
7232bb48	Excluded	FFS				7/31/2013	7/6/2014	1004.05	1361.61	0	0	206.34	1	12.78			1
63790c82	Excluded	FFS				10/9/2013	9/16/2014	1705.3	2566.67	1517.76	1	0	0	0			0
1a7b1833	Excluded	FFS				7/22/2014	6/27/2015	2034.38	3244.1	0	0	1090.06	7	15.17			2
f1743d24f	Excluded	FFS				12/20/2013	11/27/2014	2435.38	4879.55	2318.52	1	73.69	1	116.46			2
2601b3cd	Excluded	FFS				3/13/2014	2/17/2015	2670.06	5079.06	2222.93	1	195.56	2	411.39			2
c3267372f	Excluded	FFS				5/28/2014	5/5/2015	2679.05	5124.43	3540.47	1	171.17	1	0			1
f8ac82fc1	Excluded	FFS				3/31/2014	3/8/2015	2993.98	4110.92	2222.93	1	524.03	3	0			2
0ff8e4307	Excluded	FFS				11/30/2013	11/8/2014	3031.61	6674.61	4085.83	1	877.39	3	64.18			3
2446a535	Excluded	FFS				8/7/2013	7/13/2014	3238.03	6039.98	3604.23	1	503.36	2	7.87			1
808118a9	Excluded	FFS				10/28/2013	10/5/2014	3395.03	4432.15	2318.52	1	87.46	1	21.14			2
7209dfaef	Excluded	FFS				1/9/2014	12/18/2014	3590.2	4949.27	3189.22	1	0	0	0			0
ede18f19f	Excluded	FFS				12/1/2013	11/8/2014	3639.9	4932.11	2584.57	1	711.26	1	24.22			1
ee4f8806f	Excluded	FFS				11/11/2013	10/19/2014	3676.69	6330.39	2318.52	1	1422.9	8	27.13			3
89300a90	Excluded	FFS				11/12/2013	10/21/2014	5402.98	8813.99	3326.36	1	764.32	6	2374.26			3

How providers can use these files to learn more:

- Understand key sources of variation, for example:
 - Breakdown of average risk-adjusted episode reimbursement by rendering provider
 - Breakdown of average reimbursement by inpatient, outpatient, professional, and pharmacy
- Understand variability in quality metric performance and relationship to average episode reimbursement



Wave 1 and 2 materials now available online

Summary definitions

- Overview of definitions resulting from CAG process
- '2 page' view of all design elements

Detailed business requirements

- Detailed word file including all of the specifics required to code an algorithm

Code sets

- Excel file containing specific diagnosis and procedure codes used for trigger, included claims, exclusions, risk adjustment, etc.

The collage displays several key documents:

- Perinatal episode definition (1/2):** A document defining the episode trigger, window, claims included, and principle accountable provider.
- Perinatal episode definition (2/2):** A document detailing risk adjustment factors, business and clinical exclusions, quality metrics, and reporting requirements.
- Detailed Business Requirements Perinatal episode:** A word document providing specific rules for including or excluding claims based on hospitalization status, diagnosis codes, and medication use.
- Excel file:** A spreadsheet with columns for Design Dimension, Design Subcategory, Code, Code Description, and Date, listing various medical codes and their effective dates.





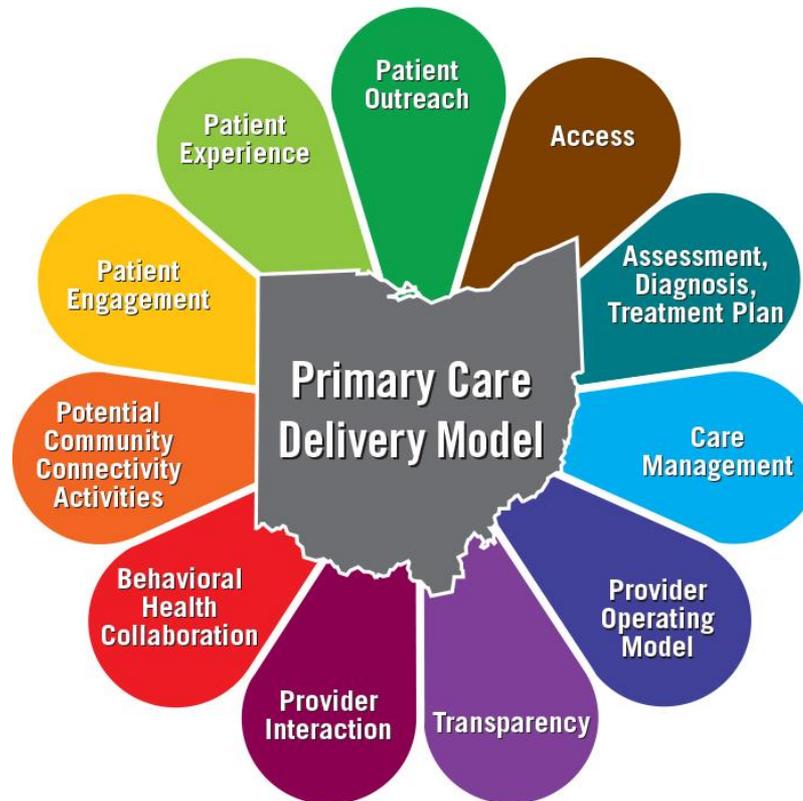
Governor's Office of
Health Transformation

Appendix B:

Ohio's Patient-Centered Medical Home (PCMH) Care Delivery and Payment Model Detail

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



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
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

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)

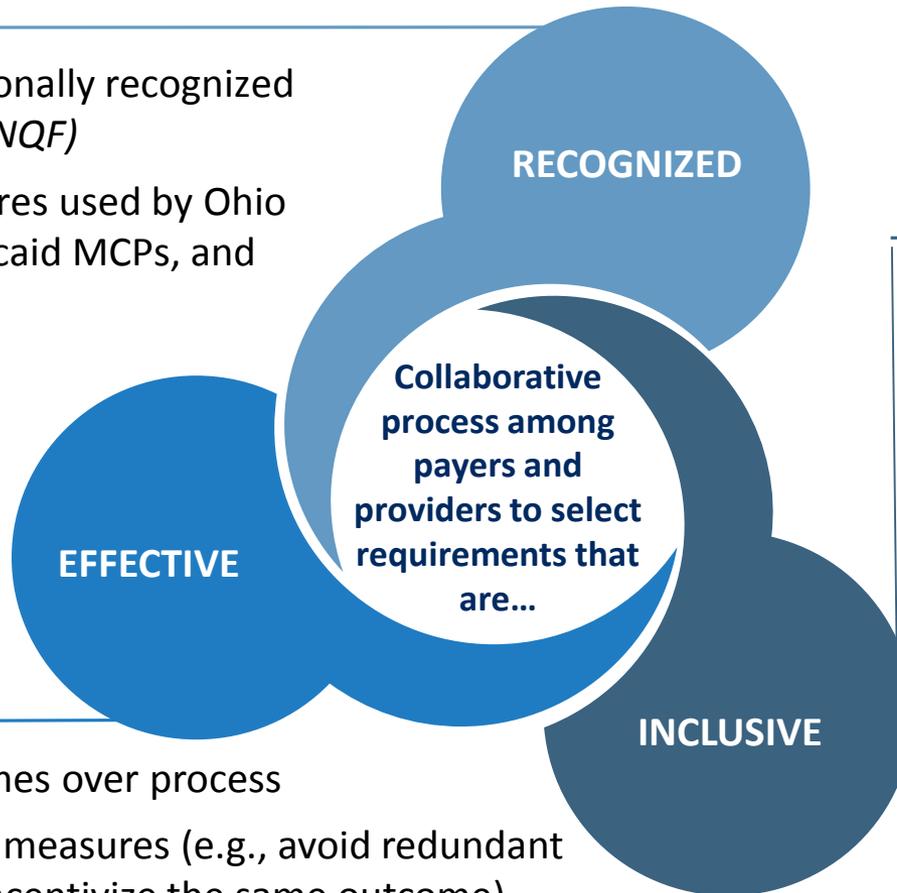
How would practices access PCMH payments?

- 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

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 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 ¹	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

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			

