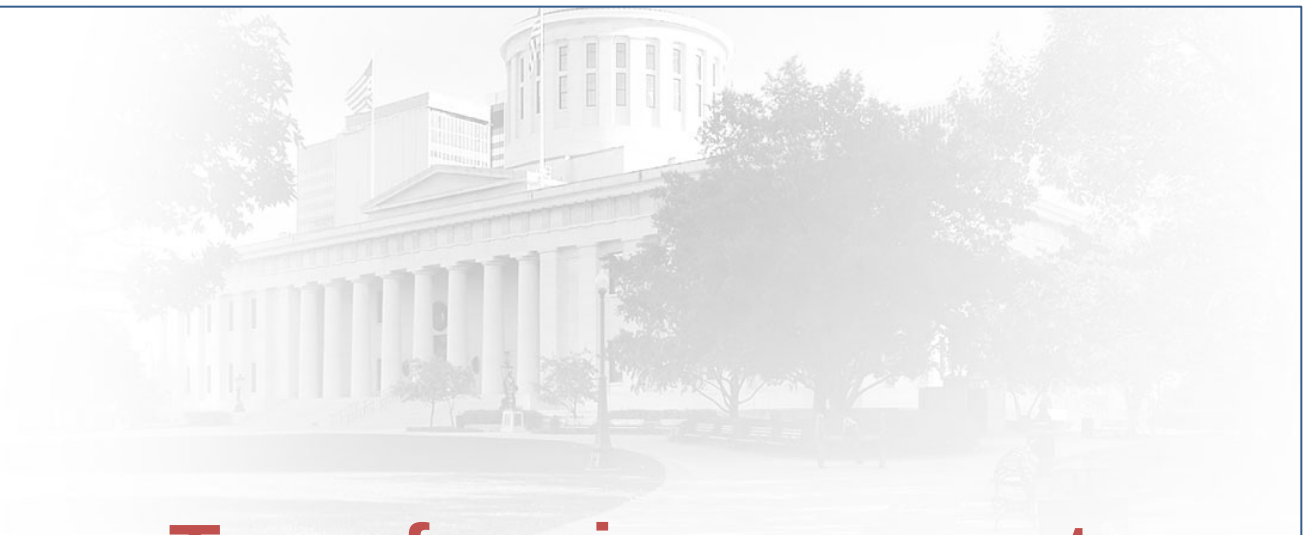


Transforming payment for a healthier Ohio

Ohio's State Health Care Innovation Plan

October 30, 2013

Ohio | Governor's Office of Health Transformation

www.HealthTransformation.Ohio.gov

Contents

A. State goals 1

B. Description of state health care environment 6

C. Report on design process deliberations 19

D. Health system design and performance objectives 25

E. Payment and delivery models 28

F. Health information technology 42

G. Workforce development 47

H. Financial analysis 50

I. Evaluation plans 54

J. Roadmap for health system transformation 57

A. State Goals

Governor John R. Kasich, with extensive support from multiple payers, providers and community leaders, has made strengthening health care in Ohio one of his top priorities. In 2011, he created the Office of Health Transformation (OHT), which pursues three aims: modernizing Medicaid; streamlining Health and Human Services; and improving Ohio's overall health system performance. As part of the third initiative, the Governor issued an Executive Order to "Engage private sector partners to set clear expectations for better health, better care and lower costs through improvement". The energy behind these initiatives has produced widespread momentum among the government, consumer advocates, payers, physicians, hospitals, communities and other stakeholders, and provided a strong basis for collaboration throughout the State Innovation Model (SIM) design phase.

Ohio is currently ranked 10th among the 25 SIM states in terms of its level of existing innovation[1], with an aspiration to do even better. Stakeholders are highly engaged in the governance structure of OHT and the momentum behind SIM. The state has held regular working meetings since June 2013 involving over 100 stakeholders representing payers, providers and payment innovation experts. These form a strong foundation for change with widespread commitment to both patient-centered medical home and episode-based payment models.

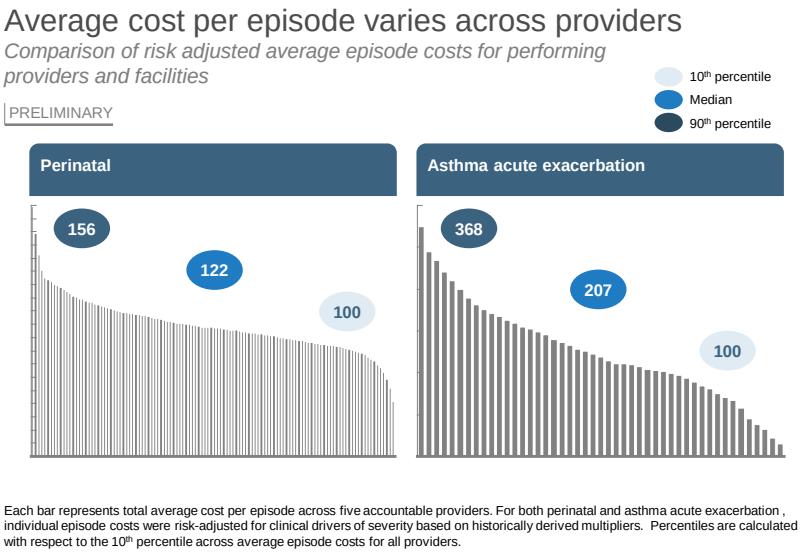
[1] SHADAC rankings based on combination of percentage of physicians with electronic health records, 2011; all payer claims database, 2012; and number of delivery system transformation initiatives.

The need for change

The need for change is clear. Despite the fact that Ohioans spend more per person on health care than residents in 32 other states[2], 36 states have a healthier population[3]. When key health outcomes are measured against other states with State Innovation Model design grants, Ohio ranks 24th out of 25. When compared against national averages, Ohio ranks very low on key health measures. For example, Ohio's preventable hospitalizations (78.5/1,000 Medicare enrollees)[4] and infant mortality (7.7 deaths/1,000 births) place the state 42nd and 47th out of 50 respectively.

In addition, patients experience far too much variance in the cost of their provider care. As shown in Exhibit 1 below, an exploration of two potential episodes of care, asthma acute exacerbation and perinatal, revealed significant differences in average cost across providers. (Note: each exhibit is included in a larger, easier-to-read format in Appendix A.)

EXHIBIT 1



[2] CMS *Health Expenditures by State of Residence* (2011),: America's Health Rankings (2012).

[3] The Commonwealth Fund, *Aiming Higher: Results from a State Scorecard on Health System Performance* (October 2009).

[4] Healthcare Cost and Utilization Project (HCUP) data. Calculated using Agency for Healthcare Research and Quality and Pediatric Quality Indicators.

Current state

Ohio's expensive and fragmented health care system makes it difficult to improve performance and demonstrate value.

- **A historically fragmented payer, provider and state system:** There are over 60 active health plans across the state of Ohio, many with very small market share. These plans currently pursue a wide range of payment innovation, creating mixed incentives for providers. Patients often face a disjointed provider system with inadequate coordination and accountability. Similarly, Ohio health and human services policy, spending and administration have historically been split across multiple state and local government jurisdictions, impeding innovation and lacking accountability.
- **Growth in health care spending:** Health care spending is growing at an unsustainable rate. When Governor Kasich took office in 2011, Medicaid spending was growing four times faster than the Ohio economy and now consumes 30 percent of total state spending and 3.6 percent of the Ohio economy (2011). Similarly, Ohio's commercial health care premiums (per member per month, or PMPM) have grown 8.6 percent per year over the past three years.
- **Spending not correlated with better outcomes:** Higher spending in Ohio does not correlate to better value. Ohioans spend more per person on health care than residents in all but 17 states, yet higher spending has not resulted in better outcomes; The Commonwealth Fund's 2011 State Scorecard on Health System Performance ranked Ohio #37 in health outcomes.
- **Ohio's public health and health care systems are disconnected:** Population level public health strategies such as the National Diabetes Prevention Program (DPP), community health worker approaches, and assessing population risk and disease prevalence for population health management all lack integration with clinical care. Referrals to evidence-based interventions in the community often are not made or are rarely followed up. Additionally, patients receiving community-based services often are not connected back into the health system, further fragmenting care.

Despite these challenges, providers across the state are independently making strides towards improving cost efficiency and quality. For instance, the Cleveland Clinic has implemented bundled payments for cardiac and joint care with large employer groups (e.g., Wal-Mart, Kohl's), and the Children's Hospital Association has formed a council on Payment Innovation and has been collaborating on initiatives to improve health outcomes in targeted areas (e.g., asthma).

In addition, multiple providers in Ohio have received Health Care Innovation Award (HCIA) funding and used this to pursue innovative pilots and other projects. For example, Partners for Kids, a physician hospital organization located in Columbus and Akron is experimenting with a capitated payment model for children on Medicaid. Ohio is also proactively building and learning from existing CMMI innovations, including the Comprehensive Primary Care Initiative (CPCI) in Southwest Ohio, the Bundled Payments for Care Improvement (BPCI) in each of the four major markets (Toledo, Cleveland, Columbus and Cincinnati) and an Advance Payment Accountable Care Organization (ACO) in Sandusky, Ohio.

Vision, models and methods

To address these issues and capture the priorities, the state will create a sustainable, patient-centered delivery and payment system over the next three to five years. During this time, the state, along with its Medicaid managed care organizations (Molina, United Healthcare, CareSource, Paramount and Buckeye) and a multi-payer coalition that includes the four private payers who represent 80 percent of the commercial market (Aetna, Anthem Blue Cross and Blue Shield, Medical Mutual of Ohio and United Healthcare) will launch two models statewide: a patient-centered medical home (PCMH) model and an episode-based payment model. Ohio also proposes that Medicare support this effort, at least by producing total cost of care reports for providers and ideally by fully adopting the PCMH and episode-based payment models in the testing phase of implementation.

The proposed payment models will lay a solid foundation for Ohio's transition to increased provider accountability, improved quality and sustained cost efficiency. These models will shift today's fragmented care, which focuses on individual visits with little coordination, to coordinated, patient-centered care that addresses patients' ongoing needs. Health care will also become more cost-effective as pure fee-for-service incentives that reward over utilization are replaced by value-based payments that reward successful coordination and care outcomes (e.g., quality, costs). After five years, these models will together cover 80 percent of the state's medical spend and 80-90 percent of Ohio's population.

Patient-Centered Medical Homes

Patient-centered medical homes (PCMH) will take a person-centered approach to coordinate care for all patients. Where clearly designed and properly incented, multi-payer PCMH models have been shown to have demonstrable impact for improved population health management, particularly for those with chronic conditions or significant medical needs.

Medical homes provide part of the foundation for total cost management and quality accountability. By engaging patients, they significantly improve the quality of health and reduce health care costs by managing chronic disease more effectively and preventing more expensive events (e.g., ED visits). The accountability they introduce helps shift the mindset of providers, payers and patients. For example, integration between primary care and public health will connect clinicians with community services, build community health teams to empower patients to successfully manage illness and maximize resources, improve the use of clinical data to assess and monitor population health, and create greater capacity to reach into more neighborhoods and improve health outcomes in whole populations.

Providers in patient-centered medical homes will have to shift their practice patterns and build capabilities to succeed in a payment model that tracks total cost of care and rewards value rather than volume. Our goal is to reach at least 50 percent of the population in selected markets within three years and 80-90 percent of Ohio's population with some value-based payment model within five years.

Episode-based payment model

The episode-based payment model creates value by establishing clear accountability for both outcomes and cost of care, rewarding providers for delivering high quality, guideline concordant care.

The foundation of the model is provider accountability – each episode of care will have a clearly defined Principal Accountable Provider, who has the most influence over end-to-end care. Because the model is designed to work within the existing provider delivery system and market structure (it is retrospective by design, encouraging coordination and accountability but not requiring ownership or formal governance changes among providers), providers of all sizes and administrative capabilities are able to participate.

The clearly demonstrable opportunities for improvement (e.g., reduce unnecessary admissions, increase guideline concordant care) and the fact that episodes can be implemented regardless of market structure and capabilities means it can provide material impact near term.

Given the diversity of providers that can participate, Ohio will start by implementing three to five episodes statewide for Medicaid and the private payer partners. The state's vision is to design and launch 20 episodes over the first three years and continue building scale by increasing care covered under the episode model in subsequent years. Episodes to pursue early on will cross categories of inpatient admissions, acute procedures and behavioral health, and engage a broad subset of provider types (e.g., specialists, inpatient facilities). Linkages to primary care and local public health will increase the likelihood of success by improving care of illness exacerbations and preventing future illness and injury, further reducing health system cost and utilization.

Performance measurement

The state will capitalize on existing in-state data and Health Information Technology (HIT) to regularly assess the progress of the models toward their specific goals of improving quality and patient care and lowering costs. These measures will, unlike now, be standardized to a much greater degree across payers and providers throughout the state and tracked on a more regular basis to evaluate the state's performance across three main categories:

- Goal achievement in overall program components: tracking the state's progress toward reaching scale in PCMH and episodes;
- Specific program outcomes: achieving improvement in health system transformation, and improved risk reduction; and,
- Stakeholder engagement: measuring satisfaction and level of involvement.

The performance measurement process, along with regular reviews and communication, will help to inform the state's future strategies, reinforce accountability and increase transparency in health system performance across patients, providers, purchasers and payers.

Integrated care delivery

Initiatives are also underway to provide better-integrated and coordinated care through programs like MyCare Ohio (the state's Medicare-Medicaid Integrated Care Delivery System), the Balancing Incentives Program (BIP), and the introduction of Health Homes for individuals with severe and persistent mental illness (SPMI). As these models are developed and launched, we will continue to identify linkages with the PCMH and episode-based payment models to further increase the effectiveness of the care delivery system.

Why Ohio is well positioned to succeed

We believe Ohio is well positioned to succeed in this effort and has the responsibility to deliver better value to Ohioans, CMS and to other states that are undertaking similar tasks. Our current team's experience in working on health care issues, our strengths in health care innovation and our demographic profile as a "test case" for the U.S. create a tremendous opportunity to produce insights not only for ourselves but also for other states.

Ohio's unique governance structure creates a strong platform for state leadership. Through the Governor's Office of Health Transformation, the state has convened experts and generated a broad base of support from public and private sector partners, which have provided input on a weekly basis throughout the duration of the design phase. The Governor's Advisory Council on Health Care Payment Innovation, which serves as an advisory board for the initiative, includes representatives from 14 different state agencies and over 25 public and private organizations. The five largest health plans in the state have not only publicly voiced their commitment to this initiative but have also dedicated resources to co-create a multi-payer model for payment innovation.

In addition, Ohio's public health system is aligning around common priorities and goals to improve health for all Ohioans. The Ohio Injury Prevention Partnership, Ohio Adolescent Health Partnership, Ohio Collaborative to Prevent Infant Mortality and newly formed chronic disease collaborative are all working toward a coordinated approach to improve health outcomes and reduce illness and injury at the state level.

As the seventh most populated state, Ohio is a diverse testing ground for payment innovation. Ohio's population and delivery system is representative of the entire country, with four unique major metropolitan areas and over 20 percent of its population residing in rural areas of the state. Ohio also has one of the most complex and fragmented payer landscapes in the country, with over 50 health plans participating in the commercial, Medicaid and Medicare Advantage markets. Transforming health care in Ohio can provide a roadmap to transform health care in the United States.

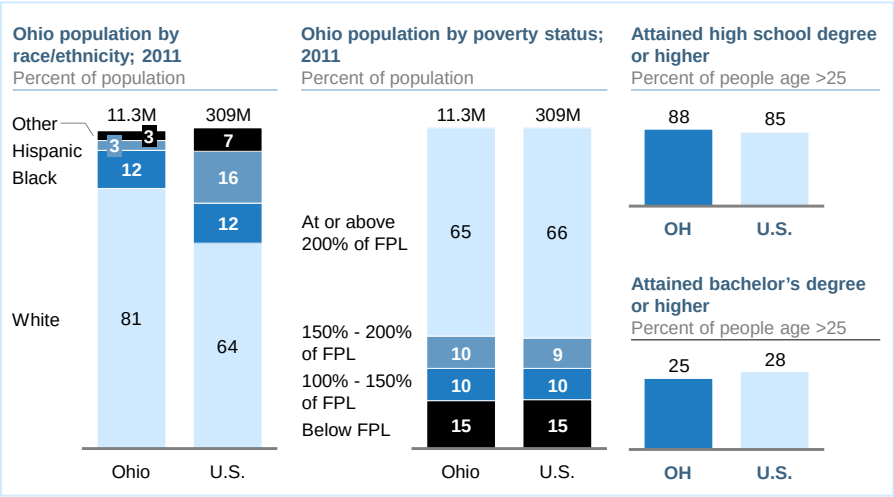
B. Description of State Health Care Environment

Description of population demographics and profiles of major payers in the state

Ohio's ~11.5 million residents have a demographic profile that mirrors the U.S. average across multiple dimensions; with 22 percent of the population residing in rural areas of the state (see Exhibits 2 and 3).

EXHIBIT 2

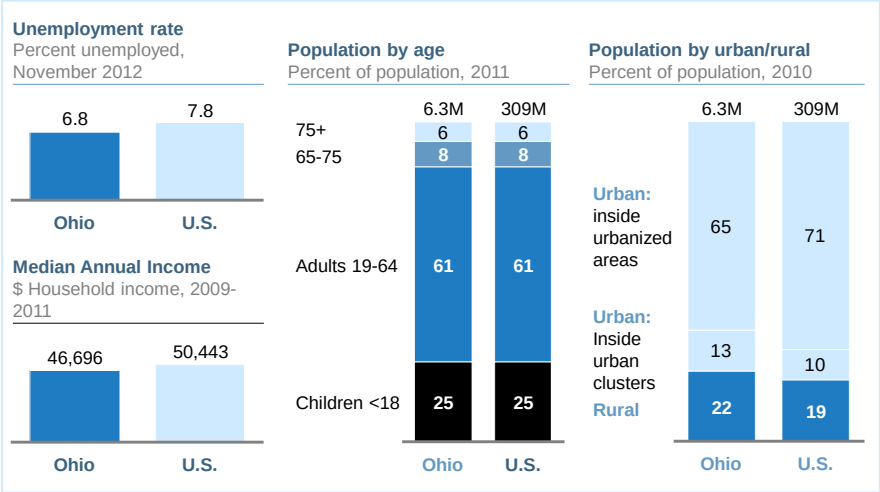
Ohio population demographics (1/2)



SOURCE: U.S. Census Bureau

EXHIBIT 3

Ohio population demographics (2/2)



SOURCE: Kaiser State Health Facts, U.S. Census Bureau, 2010 Census

Ohio has one of the most fragmented and complex payer landscapes in the country. Ohio's residents receive health care through Medicaid (1.7 million), Medicare (1.6 million), and commercial (6.5 million) plans. However, ~1.6 M residents are currently uninsured. Ohio's Medicaid program is a blend of fee-for-service (FFS) and managed care. In 2012, approximately 80 percent of lives and just under 50 percent of spend is managed by Medicaid's managed care plans. As of July 1, 2013, members enrolled in managed care are able to choose from five health plans: Buckeye, CareSource, Molina, Paramount and United Healthcare.

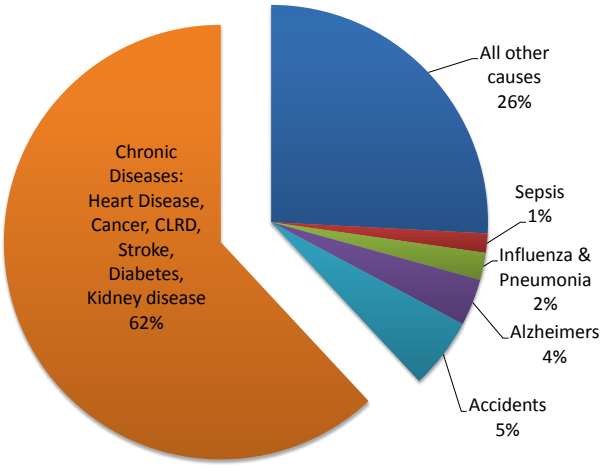
The commercial landscape is highly fragmented with a diverse array of regional and national health plans active in the state. The top four health plans represent 80 percent of total commercial lives and no single plan holds more than 30 percent of the market. Ohio also has a higher than average proportion of administrative services only (ASO) business, with 66 percent of lives covered through an employer who is self-insured. The Medicare market is similarly complex. Approximately 38 percent of lives are enrolled in a Medicare Advantage plan, with ~80 percent of lives distributed across four different payers.

Description of population health status and issues or barriers

Chronic disease mortality represents a significant burden among Ohioans. In 2011, six of the ten leading causes of death in Ohio were attributed to heart disease, cancer, chronic lower respiratory disease (CLRD), stroke, diabetes and kidney disease, accounting for more than three out of five (62 percent) deaths among Ohio residents (Exhibit 4).

EXHIBIT 4

Leading causes of death in Ohio, 2011

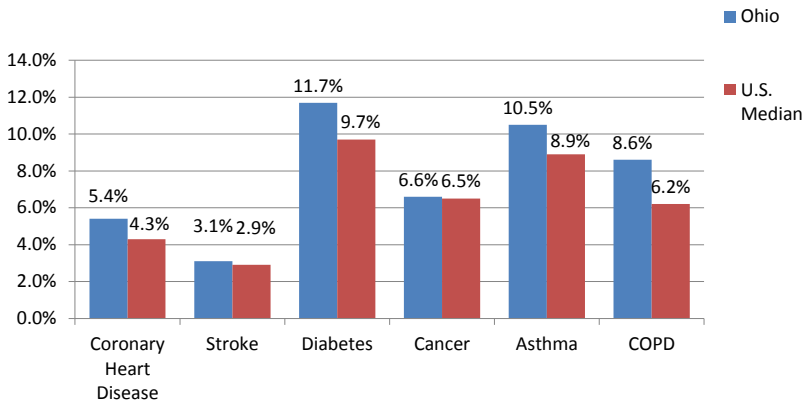


SOURCE: 2011 Ohio Certificates of Death, Ohio Office of Vital Statistics, Ohio Department of Health, 2012.

In addition to high rates of chronic disease mortality, Ohio has a higher prevalence of chronic disease morbidity, compared to the U.S. According to 2012 data from the Ohio Behavioral Risk Factor Surveillance System (BRFSS), Ohioans age 18 and older had a higher prevalence of coronary heart disease (5.4 percent), stroke (3.1 percent), diabetes (11.7 percent), cancer (6.6 percent), asthma (10.5 percent) and COPD (8.6 percent), compared to the U.S. median (Exhibit 5).

EXHIBIT 5

Prevalence of selected chronic diseases, Ohio compared to the U.S. Median, 2012



SOURCE:
2012 Ohio Behavioral Risk Factor Surveillance System, Ohio Department of Health, 2013.
2012 Behavioral Risk Factor Surveillance System, Centers for Disease Control and Prevention, 2013.

More than one third (36.7 percent) of Ohio residents suffer from more than one of ten common chronic diseases and conditions (arthritis, asthma, cancer, COPD, diabetes, heart disease, high blood pressure, high cholesterol, kidney disease and stroke). Ohioans with lower education and household income and those 65 and older are more likely to have four or more chronic diseases and conditions.[5] Aside from the substantial impact on quality of life, care for people with multiple chronic conditions accounts for 66 percent of health care spending.[6]

In Ohio, nearly one in four (23.3 percent) adults, more than one in four (26.1 percent) high school students and nearly one in ten (9.4 percent) middle school students were current smokers, according to 2012 data from the Ohio BRFSS and 2010 data from the Ohio Youth Tobacco Survey (YTS) for adults and students, respectively. Nearly four in five (78.6 percent) adults in Ohio do not meet guidelines for aerobic and muscle strengthening physical activity, and three in four (74.6 percent) high school students do not engage in at least 60 minutes of physical activity per day, according to data from the 2011 BRFSS and 2011 Ohio Youth Risk Behavior Survey.[7] Fruit and vegetable consumption as part of a healthy diet is also lacking among Ohioans; only 26.7 percent of high school students consume two or more fruits/fruit juices per day, and only 11.2 percent consume three or more vegetables per day. In 2012, an estimated 30.1 percent of Ohio adults were obese, and in 2011, 14.7 percent of Ohio high school students in grades 9-12 were obese.

Nearly two out of five (38.9 percent) Ohio adults have high cholesterol, and more than three out of ten (32.7 percent) have high blood pressure. Control of high blood pressure, high cholesterol and Hemoglobin A1C is therefore essential to reducing the mortality and increasing the quality of life for Ohioans with chronic disease. Data from the 2012 Healthcare Effectiveness Data and Information Set (HEDIS) reveal that only 65.4 percent of at risk adults in Ohio had achieved high blood pressure control (<140/90), one in four (23.2 percent) at risk adults had high LDL cholesterol (>100 mg/dl) and more than one in four (27.4 percent) diabetic adults had poor Hemoglobin A1C control (>9.0).

While all Ohioans are at risk, chronic disease mortality, prevalence and associated risk factors are disproportionately higher among several populations. Similar to national trends, rates of heart disease, stroke, high blood pressure and diabetes in Ohio are higher among males, African Americans, people age 65 and older, residents of Appalachian and rural counties, those with the lowest income and education, and those who are disabled. Similar disparities in associated health behaviors/conditions (i.e., lack of physical activity, insufficient fruit and vegetable consumption and overweight/obesity) were identified among these same populations. These disparities are often due to differences in access to health care and other social services, availability of community resources (e.g., safe places to be active, healthy food options, etc.) and economic and educational opportunities.

[5] 2012 & 2011 Ohio Behavioral Risk Factor Surveillance System, Ohio Department of Health, 2013.

[6] Anderson G. Chronic Care: Making the Case for Ongoing Care. Princeton, NJ: Robert Wood Johnson Foundation, 2010.

[7] 2011 Ohio Youth Risk Behavior Survey, Ohio Department of Health, 2013.

To address this significant burden, Ohio is developing a cross-cutting approach to improve health and reduce disease. Developed by more than 40 statewide partners, the plan will leverage activities ongoing through the state's expansion of PCMH, adoption of HIT, integration of clinical services and population health and development of connections between community health and primary care.

Ohio's infant mortality rate in 2011 was 7.7 (per 1000 births) compared to the national rate of 6.05, ranking Ohio 47th in the country. For black babies, the rate is 15.8, more than double the rate for white babies, ranking Ohio 49th in the nation. The three primary drivers for these high rates include prematurity (47 percent of infant deaths), birth defects (14 percent) and sleep-related deaths (13 percent).

To address these issues, Ohio is working across public and private agencies and partners to implement a 28-point agenda for addressing the most common and preventable causes for infant mortality. These efforts tie in closely to the state's efforts to improve care through the PCMH model and increase efficiency through a perinatal episode of care model.

Opportunities and challenges in health information exchange (HIE)

Ohio has two main HIEs: HealthBridge and The Ohio Health Information Partnership (The Partnership). In addition, Ohio has several hospital-based HIE networks sharing information within their own system.

Formed in 1997, HealthBridge is a non-profit community-based organization that provides services in southwest Ohio, northwest Kentucky, and southeast Indiana. HealthBridge provides connectivity to more than 28 hospitals, 5,500 physician users, 17 local health departments, 700 physician offices and clinics, as well as nursing homes, independent labs and radiology centers. Its clinical messaging system delivers around three million messages to 5,500 physicians each month. HealthBridge received a $13.8 million Beacon Community cooperation agreement in September 2010 to enhance the use of technology and collaboration among providers in the greater Cincinnati region. HealthBridge is also the lead organization for the Tri-State Regional Extension Center, which serves Southwest Ohio as well as parts of Kentucky and Indiana. HealthBridge is also the technology partner for the Greater Dayton Area Health Information Network. Experts from HealthBridge have been involved throughout the SIM design phase.

The Partnership was created in 2009 as a public/private not-for-profit collaborative with participation from state government, Bio-Ohio, the Ohio State Medical Association, the Ohio Hospital Association, and the Ohio Osteopathic Association. The Partnership received $44.8 million in federal funding through two federal grants. The HIE grant of $14.9 million is for the creation of a technological infrastructure (CliniSync) that allows hospitals, physicians, clinicians, laboratories and others involved in a patient's care to communicate electronically and share patient data. The second grant includes $29.4 million for regional extension centers (RECs) and $558,000 for 31 critical access and rural hospitals (CAHs) so at least 6,000 physicians can be assisted in the adoption of electronic health records. The Partnership is funded through the Office of the National Coordinator and U.S. Department of Health and Human Services. The purpose of The Partnership is to advance HIT within Ohio's health care providers. It operates a statewide HIE under the brand name CliniSync and, in December 2011, began connecting Ohio's hospital systems. Currently, 141 hospitals and their employed physicians are committed to connect with

CliniSync with 38 currently live and 52 in implementation. More than 1,500 independent physicians also are connecting to CliniSync with more than 800 lives within the network. According to The Partnership, 6,512 primary care physicians signed up to receive REC services, the highest of any single REC in the nation. When combined with HealthBridge services, more than 7,500 primary care physicians are receiving REC assistance.

The Partnership's structure delivers REC services through regional partners in seven geographic regions around the state. This collaborative — joining hospital, physician groups, and universities — allows The Partnership to outreach to physicians and hospitals across Ohio. Its regional partners have held numerous information outreach sessions, educating health care providers not only on the Medicare and Medicaid electronic health records incentive programs, but also on the development of HIEs in their regions, the state, and nationally. In cooperation with HealthBridge, the Ohio Department of Health, the Ohio Department of Medicaid and the Office of the National Coordinator for HIT, more than 17,500 Ohio physicians, hospitals and other eligible providers have received $659.6 million in Medicare and Medicaid electronic health records dollars since the program's inception, ranking Ohio sixth in the nation for total payments received.

Meaningful use of electronic health record (EHR)

The Ohio Departments of Medicaid and Health, The Partnership and HealthBridge collaborate closely on strategies to expand EHR adoption and participation in Ohio's Medicaid Provider Incentive Program (MPIP); all of which have significant common interest in the promotion and adoption of certified EHRs and implementation of HIE.

MPIP was launched in June 2011. It provides incentive payments to eligible professionals and eligible hospitals that adopt, implement, or upgrade to certified EHR technology and use this technology in a meaningful manner.

Ohio's recognition of the tremendous value of EHR to transform the state's health care delivery system has resulted in the aggressive and effective development of the MPIP program. Prior to launching the program, the state estimated that of the more than 75,000 providers in the Medicaid network, 3,000-4,000 providers would likely qualify for the Medicaid incentive payments. As of December 31, 2012, the state has exceeded this estimate, with approximately 4,800 eligible professionals and hospitals enrolled in the program and more than 4,300 providers receiving incentive payments. Ohio has been recognized by CMS as a top performing state for our successful implementation of MPIP. The most recent CMS reports show Ohio is one of the top five states providing incentive payments to Medicaid providers, with CMS reporting a total of $217,328,773 paid to Ohio providers from January 2011 to April 2013.

The Ohio Department of Medicaid tracks participation in the MPIP by provider and hospital types. Table 1 below provides a breakdown of MPIP enrollment and incentive payments by provider type as of the end of 2012.

Table 1. Medicaid Provider Incentive Program (MPIP) Summary

Provider Type	# of providers registered at CMS & known to ODM	Disbursed payments	Disbursed payment amounts
Eligible Hospitals			
Acute care hospitals	145	173	$95,139,286
Children's hospitals	7	9	$18,808,294
EH totals	**152**	**182**	**$113,947,581**
Eligible Providers			
Certified nurse midwives	94	92	$1,738,250
Dentists	246	141	$2,932,500
Nurse practitioners	859	678	$13,183,500
PA practicing in a FQHC or RHC led by a PA	1	0	$0
Physicians	3,497	3,288	$61,763,899
EP totals	**4,697**	**4,199**	**$79,618,149**
EH and EP TOTALS	**4,849**	**4,381**	**$193,565,730**

Potential strategies to improve use and deployment of HIT

A central element of OHT's strategy to improve overall health system performance is to coordinate health information infrastructure across the state.

A key component of this strategy is to accelerate the adoption and use of health information technology and electronic health information exchange. OHT priorities include:

- Updating Ohio's privacy laws and policies if necessary to encourage electronic HIE and address conflicts with federal law,
- Leveraging Medicaid payment incentives for health care providers to accelerate their adoption and meaningful use of electronic HIE,

- Engaging the federal Office of the National Coordinator to advocate policies that are good for Ohio, and
- Aligning strategies within state government to efficiently and effectively connect to electronic HIE networks.

Since the creation of the Office of Health Transformation (OHT) in 2011, the office has accomplished much to help accelerate use and deployment of HIT across the state. Recent accomplishments include:

- 2011: Launch of MPIP (as described above) to encourage EHR adoption;
- 2011: Launch of Medicaid Information Technology System (MITS), which replaced Ohio's outdated, 25-year-old Medicaid Management Information System. MITS automates and transforms existing business processes to allow providers to submit claims through the web and get instant feedback on whether their claims were approved or denied, lowering administrative costs for the state and for health care providers. MITS also offers enhanced claims decision support to the Ohio Department of Medicaid and its sister state agencies;
- 2012: Accelerate the adoption of electronic health information exchange through HB 487, which harmonizes state law with the standards adopted in the federal HIPAA privacy rule with respect to individual access to protected health information, proper safekeeping of protected health information and the use and disclosure of protected health information; and
- 2013: Launch of Integrated Eligibility System, an eligibility modernization project to simplify client eligibility based on income, streamline state and local responsibility for eligibility determination, and modernize eligibility systems technology. The new system went live on October 1, 2013, and over the next two years will replace Ohio's 32-year-old Client Registry Information System (CRIS-E). The goal is for most enrollees to learn of their eligibility for Medicaid and other programs based on income tax information without needing to undergo any additional eligibility tests.

Even with much yet to achieve, Ohio's success related to HIT adoption combined with the leadership of OHT positions the state to leverage the full potential of electronic data sharing to improve health outcomes for Ohioans.

Description of the current health care cost performance trends and factors affecting cost trends

Ohio has seen relatively modest growth in per-capita Medicaid spend on adults and non-dual people who are aged, blind or disabled (ABDs) from 2008-2010. PMPM growth for duals has been restrained, and child PMPMs have shown marginal contraction. Growth in Medicaid spend was driven primarily by a large expansion in beneficiaries due to the recession (~8 percent compound annual growth rate [CAGR] 2008-10). Enrollment growth has been highest among adults and children – categories most sensitive to economic conditions. Pressure on enrollment growth was expected to decline with an improving economy and declining unemployment. Ohio Medicaid enrollment growth has slowed dramatically in 2011 with 2011 beneficiary-months growing at ~2.5 percent.

Ohio's performance relative to other states varies considerably by category. Ohio ranks sixth in Child PMPMs, 26th in Adult, 45th for Aged and 33rd for Disabled (first = lowest PMPM). Ohio's high per capita spend on ABD (including duals) is directly reflected in total spend – in fiscal year 2012, ABD accounted for ~20 percent of enrollees and ~62 percent of the total spend.[8]

Ohio continues to embrace managed care and over 80 percent of eligible children and parents receive services through an MCO. Ohio ranks eighth in Comprehensive Managed Care.

Growth in individual (6.9 percent CAGR) and family (7.0 percent CAGR) premiums for Ohio from 2008-2010 are comparable to those observed nationally (individual – 6.1 percent, family – 6.2 percent). The growth in 2011 for individual (7.6 percent) and family (9.5 percent) premiums in Ohio mirror a nationwide spike in premiums, attributed to Affordable Care Act changes and expectations of increased utilization driven by economic recovery.

Table 2. PMPM estimates by payer and category for Ohio beneficiaries (from Design grant application)

Per capita health care cost and health care cost trend estimates		Est. PMPM cost CY2010 $ Dollars	Est. most recent annual trend rate Percent
Medicaid/CHIP	Adult	406.02	4.2
	Child	193.42	-0.5
	Duals (only)	2,118.51	1.1
	Disabled/Elderly (without duals)	1,874.26	3.3
Private/ Other	Individual	389.08	6.9
	Family	1,090.25	7.0
Medicare	Dual Eligible	1,376.80	0.5
	Medicare FFS	809.59	4.1
	Medicare Part D	239.00	1.5
	Medicare Advantage	822.28	2.0

Description of the current quality performance by key indicators (for each payer type) and factors affecting quality performance

A full description of performance indicators can be found in Sections D and I.

Description of specific special needs populations and factors impacting care, health, and cost

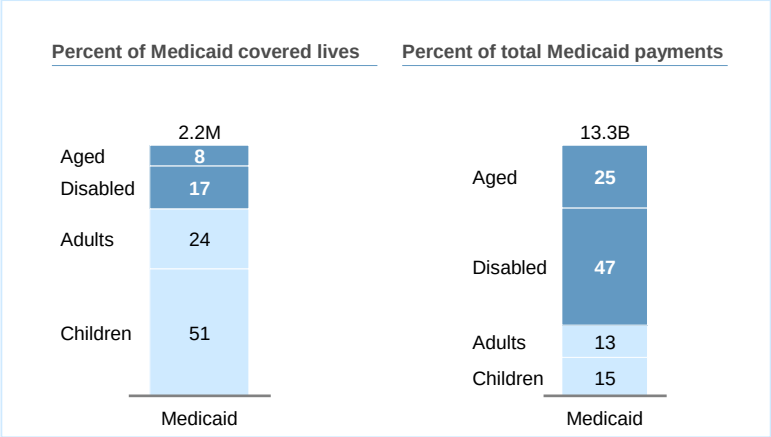
Ohio recognizes there is an opportunity to improve health care for special needs populations and has been working to improve care delivery as well as overall quality of life for these individuals. In Ohio, 25 percent of Medicaid covered lives

[8] Kaiser State Health Facts.

and 72 percent of spend is for the aged population and individuals with disabilities.

EXHIBIT 6

Breakdown of covered lives and costs by sub-population, 2009



SOURCE: Kaiser State Health Facts

In fiscal year 2011, Ohio spent a disproportionate share of Medicaid funds on long-term care. In Ohio, 39 percent of Medicaid dollars were spent on long-term care verses a national average of 30 percent; almost 45 percent of those funds covered care in a nursing facility. Additionally, while Ohio represents 3.8 percent of the total national Medicaid population, it accounts for 5.1 percent of all nursing home days nationally[9] and is third in the country for highest number of persons with mental illness in nursing facilities. The state has focused priorities in long-term supportive services overall as well as two specific populations – mental health and developmental disabilities.

There are currently more than 180,000 individuals in Ohio eligible for coverage through Medicare and Medicaid. On March 1, 2014, Ohio plans to launch an integrated care delivery system (ICDS) for more than 60 percent of the dual eligible population. Ohio is only the second state to pursue a managed care model with their duals population. The ICDS will address the fragmented nature of services offered through the two separate entities by taking a person-centered approach to care coordination and providing a single point of contact across both Medicare and Medicaid.

Specifically for Medicaid, Ohio has made a large push to transition individuals out of institutions and back into the community. The state is participating in the Balancing Incentive Program (BIP), which means that Ohio will shift to 50 percent of long-term care dollars going towards home and community based services (HCBS) by 2015. Launched in 2008, Ohio's Money Follows the Person

[9] Kaiser State Health Facts.

Demonstration (the HOME Choice Program) is ranked second overall in terms of number of Medicaid beneficiaries transitioned back to the home setting and is ranked first for Medicaid recipients with mental illness. Also, Ohio is launching a health home model for individuals with severe and persistent mental illness (SPMI). To date, SPMI health homes have launched in five counties. For these high needs individuals, health homes integrate behavioral, medical, and long-term care. The goal is to roll the model out statewide in 2014.

For the past ten years, Ohio has been undergoing a developmental disabilities system redesign that has enabled thousands more individuals to live and work in the community. Most recently, the Ohio Department of Developmental Disabilities (DODD) has gained additional authority to supervise the programs and really tailor them to seamlessly transition individuals with developmental disabilities back into the community. To date nearly 30,000 individuals receive home and community-based services waivers. Despite these advances, this population still faces substantial challenges in health care support. Ohio has more people living in private facilities than anywhere else in the nation and ranks seventh in terms of public intermediate care facilities.

Description of current federally-supported program initiatives under way in the state, including those supported by but not limited to CDC, CMMI, CMCS, ONC, HRSA and SAMHSA

In addition to the ICDS, BIP and SPMI Health Home initiatives described above, the state is actively engaged in a variety of other federally supported programs.

Ohio is engaged in various Center for Medicare and Medicaid Innovation pilots, including the CPC initiative, BPCI, Health Care Innovation Awards (HCIA), Federally Qualified Health Centers (FQHC) Advanced Primary Care Practice Demonstration, Community-Based Care Transitions Program. As mentioned above, the state is also actively engaged in the MPIP program for EHR development. The state plans to work with representatives from these efforts to ensure that State Innovation Models are complementary and to identify opportunities to collaborate.

The Ohio Department of Health administers several federally funded grant programs that directly support the delivery system efforts outlined in this plan. Those dollars largely come from the Centers for Disease Control and Prevention and Health Resources and Services Administration.

The Title V Maternal and Child Health Services Block Grant Program seeks to do the following:

- Assure access to quality care, especially for those with low-incomes or limited availability of care;
- Reduce infant mortality;
- Provide and ensure access to comprehensive prenatal and postnatal care to women (especially low-income and at risk pregnant women);
- Increase the number of children receiving health assessments and follow-up diagnostic and treatment services;
- Provide and ensure access to preventive and child care services as well as rehabilitative services for certain children;
- Implement family-centered, community-based, systems of coordinated care for children with special health care needs; and

- Provide toll-free hotlines and assistance in applying for services to pregnant women with infants and children who are eligible for Medicaid.

Administered by ODH, the Preventive Health and Health Services Block Grant (PHHSBG) goals are to: achieve health equity and eliminate health disparities by impacting social determinants of health; decrease premature death and disabilities due to chronic diseases and injuries by focusing on the leading preventable risk factors; support local health programs, systems, and policies to achieve healthy communities; and provide opportunities to address emerging health issues and gaps. ODH's programs build capacity statewide and at the local level to improve health through systems changes, partnerships, resource sharing and implementation of proven evidence-based public health programs. All activities with the PHHSBG work achieve the National Health Promotion and Disease Prevention Objectives set in Healthy People 2020. The PHHSBG targets emerging needs and fills voids in current public health funding for chronic disease and injury prevention.

Ohio is also a recipient of two Community Transformation Grants (CTG) and one Community Transformation Small Communities Grant (CTSCG). Awarded to Public Health-Dayton and Montgomery County and the Austin BioInnovation Institute in Akron, the two CTG awards are working to improve the prevention and management of chronic diseases and risk factors in multiple settings and to develop a first-of-its-kind Accountable Care Community to better integrate public health and health systems, respectively. Awarded to the Lima Family YMCA, the CTSCG is pulling together city and county officials, public health, health care, planning and education leaders to identify community needs, assets and strategies to improve health across the lifespan.

The State Office of Rural Health (SORH) in Ohio serves as an institutional framework that links communities with state and federal resources to help develop long-term solutions to rural health problems. The Ohio SORH focuses its efforts on five core functions, the overarching goal being to improve access to care in the state's rural areas. Promoting the recruitment and retention of a competent health care workforce is one of its key focus areas.

The Ohio Primary Care Office (PCO) provides assistance to communities seeking Health Professional Shortage Area (HPSA) designations and funding for health centers (e.g. FQHCs). Ohio's PCO also coordinates all of the state and federally supported recruitment and retention programs (e.g. Ohio Physician Loan Repayment Program, National Health Service Corps programs) and works collaboratively with others to increase access to primary care and improve the health status of underserved and vulnerable populations.

Description of existing demonstration and waivers granted to the state by CMS

EXHIBIT 7

Current Medicaid Home and Community-Based Services (HCBS) waivers

	Program description
Ohio-MetroHealth Care Plus	Demonstration provides coverage to up to 30,000 uninsured adults, ages 19 through 64 who have family income at or below 133 percent of the FPL, who are not otherwise eligible for comprehensive Medicaid benefit coverage under the Medicaid state plan or Medicare, and who reside in Cuyahoga County
OH Home Care	Provides adult day health center services, personal care aide, emergency response services, home care attendant, home delivered meals, home mods, out-of-home respite, supplemental adaptive and assistive device services, supplemental transportation, waiver nursing services for individuals w/ physical disabilities ages 0-59
OH Passport	Provides adult day, homemaker, personal care, chore, community transition, emergency response system, enhanced community living services, home delivered meals, home medical equipment and supplies, independent living assistance, minor home mods-maintenance and repair, non-medical transportation ,nutritional consultation, social work counseling, transportation for aged individuals ages 65 (no maximum age) and physically disabled ages 60-64
OH Individual Options	Provides homemaker/personal care, respite, adaptive and assistive equipment, adult family living, adult foster care, community respite, environmental accessibility adaptations, hab-adult day support, hab-vocational hab, home delivered meals, interpreter, non-medical transportation, etc. for individuals with Mental Retardation./Developmental Disability
OH Choices	Provides adult day, alternative meals service, emergency response system, home care attendant, home delivered meals, home medical equipment and supplies, minor home mods/maintenance and repair services, pest control for physically disabled individuals ages 60-64 and over 65
OH Assisted Living	Provides assisted living services and community transition services for physically disabled individuals ages 21-64 and over the age of 65
OH Transitions II Aging Carve out	Provides adult day health center services, personal care aide services, emergency response services, home care attendant services, home delivered meal services, home mods, out-of-home respite, supplemental adaptive and assistive device services, supplemental transportation, waiver nursing services for aged individuals over 65 and for disabled individuals 60-64
OH Transitions DD	Provides adult day health center services, personal care aide services, emergency response, home delivered meals, home mods, out-of-home respite, supplemental adaptive and assistive devices, supplemental transportation, waiver nursing services for individuals with autism, mental retardation, developmental disabilities
OH Level One	Provides community inclusion, residential respite, supported employment-enclave, participant-directed foods and services, participant/family stability assistance, support brokerage, clinical/therapeutic intervention, community respite, function behavioral assessment, integrated employment, etc. for individuals with mental retardation and developmental disability
Self Empowered Life Funding (SELF)	Participant-directed waiver for people with developmental disabilities who are : children and adults, Medicaid-eligible, in need of an Intermediate Care Facility (ICF) Level of Care, willing and able to perform duties associated with participant direction, able to have their health and welfare needs met through SELF and are in need of at least one SELF service

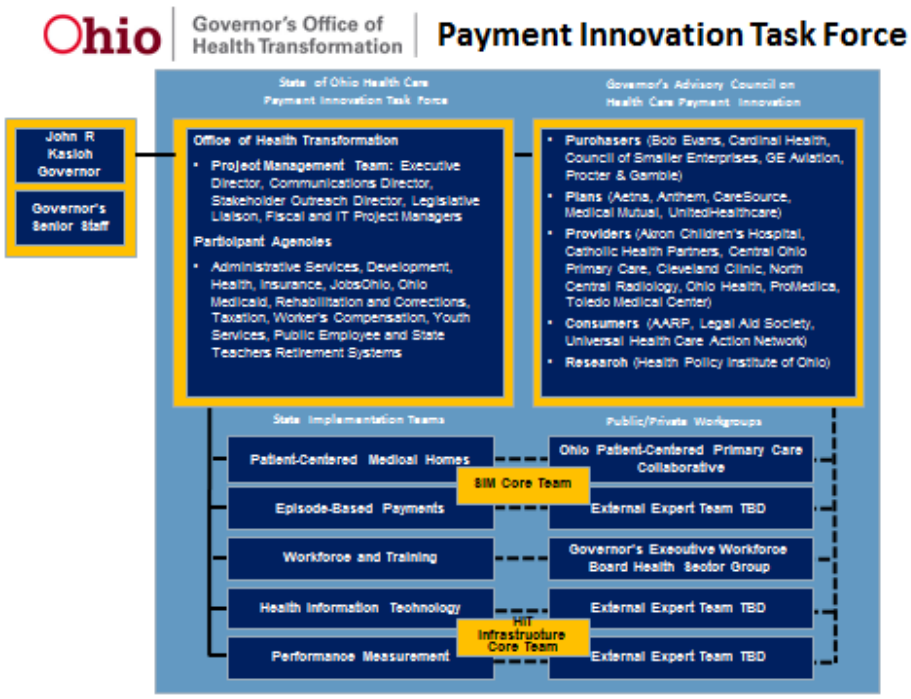
SOURCE: Medicaid.gov: Waivers.

C. Report on design process deliberations

Stakeholder engagement process

In 2012, Governor Kasich formed the Payment Innovation Task Force to support the state's goal to engage private sector partners to set clear expectations for better health, better care, and lower costs through improvement. The state leveraged this task force (Exhibit 8) to form the foundation of the governance structure and stakeholder engagement model for the SIM design phase.

EXHIBIT 8



The state convened the Governor's Advisory Council on Health Care Payment Innovation in January 2013 to pull together key stakeholders (spanning purchasers, plans, providers, consumers and research partners) and reinforce the key problem statement and overall leadership and vision. A specific ask was launched at this time for each stakeholder group to identify exerts in patient-centered medical homes and episode-based payment.

After receiving the notification of award for the SIM design grant, the state quickly convened the core management team (steering committee) which includes members of Office of Health Transformation (OHT), Medicaid and Ohio Department of Health (ODH), to align on an ongoing operating model and refine

the stakeholder engagement plan. This plan initially included three teams (in addition to the steering committee).

- **SIM Core team:** A multi-payer coalition to drive leadership alignment on overall strategy. This group included representatives from Medicaid, Department of Administrative Services (which controls the state employee benefit plan), Bureau of Workers' Compensation and the 5 participating health plans (Aetna, Anthem, CareSource, Medical Mutual and United Healthcare), which cover over 80 percent of commercially insured lives in Ohio.
- **PCMH working team:** A multi-stakeholder group to review detailed analysis and form recommendations for PCMH design. See Appendix B (slide 3) for full list of participating organizations.
- **Episode working team:** A multi-stakeholder group to review detailed analysis and form recommendations on episode-based payment. See Appendix C (slide 3) for full list of participating organizations.

The PCMH and Episode teams met on a weekly basis and included over 100 participants collectively, including:

- **State Officials:** Representatives from OHT, Medicaid, Ohio Departments of Health, Aging, Mental Health and Addiction Services, Administrative Services, Insurance, and Bureau of Worker's Compensation;
- **Provider organizations:** Clinical experts representing various geographies and levels of scale and integration (e.g., large health systems, AMCs, multi-specialty groups, independent practitioners) and representatives from related provider associations / boards;
- **Purchasers:** Representatives from self-insured employers that are interested in payment innovation;
- **Payers:** Experts identified by the SIM core team multi-payer coalition; and
- **Payment innovation leaders**: Experts from throughout the state (e.g., community leaders, learning collaboratives, HIE experts, research organizations).

The participants in the PCMH and Episode working sessions provided detailed input and recommendations to form the model design and strategies outlined in Sections E-J.

Process deliberations and consideration of levers

Options for creating multi-payer strategies to move away from payment based on volume toward payment based on outcomes

The multi-payer coalition aligned on a strategy to launch PCMH and episodes over a five-year timeframe, with the goal of shifting 80-90 percent of volume into these value-based models. Details of these models can be found in Section E.

Approaches to improve the effectiveness, efficiency and appropriate mix of the health care work force and align regulatory policies

The state leveraged recommendations from OHT, the Office of Workforce Transformation, and the Department of Health to form its workforce development strategy (outlined in Section G). These recommendations were formed with input from a variety of stakeholders including government agencies as well as educational, medical and nursing organizations.

Options for aligning state regulatory authorities to reinforce accountable care and delivery

The state's initial PCMH and episode-based payment models are designed to fit within existing state regulations. Over time, the state will work with the appropriate authorities to align regulations where necessary to support broader implementation of the payment models.

Options for restructuring Medicaid supplemental payment programs

The multi-payer coalition did not focus on specific funding mechanisms. However, there was alignment that the concept of value as a result of reduced total cost of care and improved quality will be reflected in each payer's strategy. Medicaid as a payer is already moving to tie the supplemental payment for Children's Hospitals to quality improvement.

Options for creating opportunities to align regulations and requirements for health insurers

The multi-payer coalition has designed payment models that fit with the existing regulations and requirements for health insurers. For Medicaid, these models build on the Catalyst for Payment Reform (CPR) principles that have already been incorporated into all Medicaid MCO contracts. OHT has already engaged the Ohio Department of Insurance to identify further opportunities to align regulations with the PCMH and episode based payment models.

Creating mechanisms to develop community awareness and engagement

One of OHT's guiding principles is to "make information about price and quality transparent, and get the right information to the right place at the right time to improve care and cut costs." OHT has worked to increase community awareness and engagement by creating the OHT website, which has been an outlet for the state to share SIM and other payment innovation related materials. OHT also regularly distributes a newsletter, which reaches over 4,000 Ohioans, to provide updates on the progress of related initiatives.

As outlined in Section I, the state is developing a robust evaluation plan. As part of this, the state will leverage the output of the Health Policy Institute of Ohio Health Measurement Initiative, which will be developing a publically accessible dashboard of key statewide indicators to track statewide public health and health system performance, social, economic and environmental measures, overall population health and health system costs. The dashboard of indicators is projected to be completed in early 2014 and will help increase transparency for decision makers and health consumers.

Options for coordinating state-based Health Insurance Marketplace activities with broader health system transformation efforts

As discussed in Sections E and F, the state will ensure its new models are coordinated with the federally facilitated Health Insurance Exchange. One example will be the direct linkage between Ohio's new integrated eligibility system and the federal Exchange and data hub.

Integration of public health services and community-based initiatives

To improve population health, the Ohio Department of Health (ODH) discussed opportunities to build on successful strategies to integrate primary care and public health. Leadership from state public health, local public health, advocacy groups and community organizations have been developing a coordinated approach to chronic disease prevention and health promotion. Conversations with providers in southwest Ohio and the Ohio Research Association for Public Health Improvement (RAPHI) have also centered around advancing public health and primary care integration. Approaches considered include the development of community health teams to connect patients with community resources to reduce risk and improve disease management for illnesses and injuries related to episodes of care. Expanding collaboration among providers, public health, community organizations and health care insurers through the Ohio Patient-Centered Primary Care Collaborative (OPCPCC) was also discussed as a means to develop integrated community health approaches.

Plan to leverage community stabilization development initiatives

Ohio is actively seeking partnerships to build strong communities that not only increase economic assets but also improve the health and safety of all Ohioans. The state has awarded funding to programs focused on improving health outcomes. Examples of this include:

- Two million dollars in state funds to Ohio's children's hospitals for collaborative research innovations. These efforts have focused on Asthma and Neonatal Abstinence Syndrome (NAS) Research; and
- Funding for improving maternal and infant health outcomes among disadvantaged minority populations in Ohio.

Health Impact Assessments have also played a role in helping to inform the impact of local legislation on overall health and safety in the community. Ohio has three active assessments underway throughout the state. Another example of local innovation is Cuyahoga County Board of Health's Place Matters grant, which has enabled them to develop a multi-sector collaborative to reduce the disparity between health outcomes across the city of Cleveland. This initiative has demonstrated success in partnering with community development to improve and support health.

Integration of adolescent and early childhood prevention strategies

Ohio is committed to improving health outcomes across the lifespan. Risk for disease and disability typically begins in early childhood, and efforts across the state are working in several areas to:

- Help expecting mothers have healthy pregnancies through perinatal interventions to reduce low birth weight;

- Reduce birth complications and infant mortality rates through a statewide partnership of health care providers, public health experts and public and private organizations;
- Increase access to healthy and safe early learning environments through state standards (discussed below) and organization policies that include health and wellness;
- Work with schools to consider the non-academic barriers to success, such as poor health, in school improvement efforts; and
- Develop the state's first comprehensive approach to adolescent health, including an emphasis on behavioral health, injury and violence prevention, reproductive health, nutrition, physical activity and sleep.

To advance care in the pediatric setting, Ohio is planning to pilot a Pediatric Medical home Project to expand the model to more high-need children. This effort will model the PCMH transformation projects on going in the state, but is currently being developed by leaders in pediatric patient-centered care to recognize the unique needs of children from basic preventive care to care for children with special health care needs. ODH will continue to find opportunities throughout this project period to align and expand these efforts, especially through PCMH expansion.

In addition to the $2.2 billion in funds that Ohio invests in Early Childhood, the state competed for and won a $70 million dollar Early Learning Challenge Federal grant. The implementation of this grant accelerated improvements that the state had made over many years to improve the early learning system and to enable 37,000 additional high-need young children to enter a system that will prepare them cognitively, socially, emotionally and physically for kindergarten.

Integration with behavioral health and long term services and supports

The PCMH and episode-based payment models are designed to complement and build activities to increase integration of behavioral health, substance abuse and long term services (e.g., health homes, BIP). These existing programs are outlined in Section B. Representatives from Department of Mental Health and Addiction Services and Department of Aging played an integral role in creating the model design and launch strategy and identifying potential linkages with existing community-based programs.

Options for leveraging health information technology

The state formed an internal working group with representatives from OHT and the Ohio Departments of Medicaid and Administrative Services to outline information technology capabilities required to support the new payment and delivery models. Details of this plan can be found in Section F.

As it relates to both health care innovation and the adoption of HIT, communications with stakeholders has been and continues to be a focus. Stakeholders include state agencies and entities, providers, provider groups, provider associations, consumer associations, and consumer advocates.

Options for using other policy levers that can support delivery system transformation

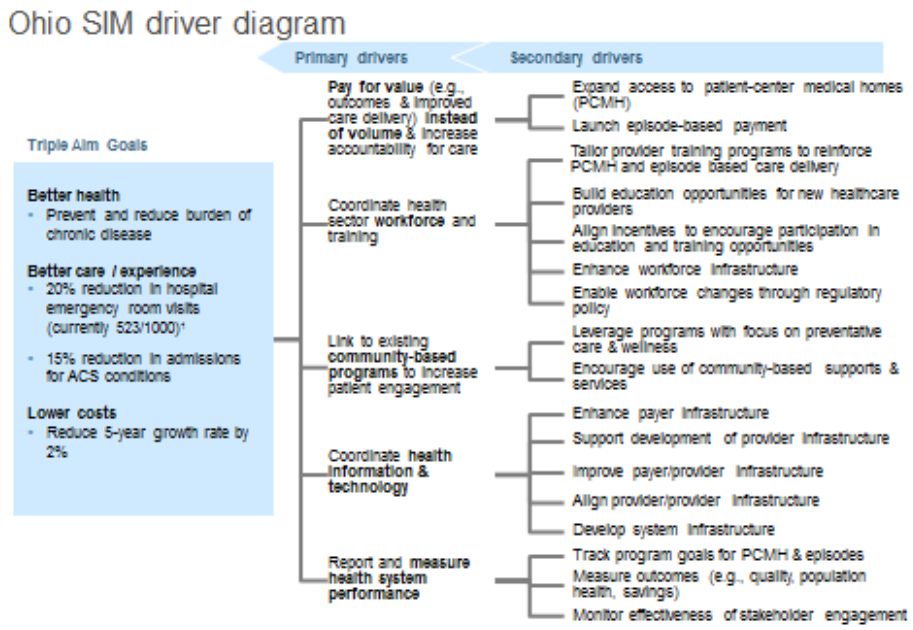
OHT is in a unique position to coordinate across the many agencies responsible for health care policy in the state. Through this role, OHT will continue to identify potential policy actions that may be required to support PCMH and episode-

based payment. For example, OHT has a comprehensive performance measurement plan (outlined in Section I) that is intended to increase transparency throughout the community. The measures are aligned with guidance from ongoing efforts within Ohio and on a national scale (e.g., the Million Hearts Campaign, National Quality Strategy and National Prevention Strategy). Also, OHT has aligned the state's coordinated chronic disease plan 2020 indicators with Healthy People 2020 objectives and will be measuring short and intermediate progress associated with improved health outcomes.

D. Health system design and performance objectives

Ohio has developed a set of goals aligned with Governor Kasich's executive order for Improved Health System Performance: Engage private sector partners to set clear expectations for better health, better care, and lower costs through improvement. As outlined in Exhibit 9, the state has set clear targets for each goal and has identified a series of primary and secondary drivers to achieve these goals.

EXHIBIT 9



SOURCE: (1) Commonwealth Fund 2009 Scorecard on State Health System Performance

Goals

Better health

Improving the health of all Ohioans is a goal shared by partners and stakeholders across the state. As a starting point to measure population-level health improvements, Ohio will follow the recommendations of the Health Policy Institute of Ohio (HPIO) Health Measurement Advisory Committee. The state will select a set of population health core indicators that will be used to assess and track changes over time. An example of these metrics can be found in Table 3.

Table 3. HPIO Health Measurement Initiative Population Health Metrics (draft list as of October 23, 2013).

Category	Recommended metric (source)
Overall health and wellbeing	1. Overall health status (adults reporting fair or poor health) (BRFSS) 2. Limited activity due to physical, mental, or emotional problems (BI 3. Premature death (Years of Potential Life Lost before age 75; CDC analysis of vital stats)
Health equity	4. Life expectancy at birth by race/ethnicity (vital stats as reported by RWJF DataHub)
Health behaviors	5. Adult binge drinking (SAMHSA) 6. Adult physical inactivity (BRFSS) 7. Youth all-tobacco use (YRBS)
Conditions and diseases	8. Infant mortality (vital stats) 9. Cardiovascular disease mortality rate (vital stats) 10. Youth obesity (YRBS) 11. Adult diabetes (BRFSS) 12. Poor mental health days- adults (BRFSS)* 13. Suicide deaths (vital stats) 14. Unintentional drug overdose deaths (vital stats) 15. Adults who have lost teeth due to decay, infection, or disease (BRF

Better care

Ohio has set targets for reduced emergency department utilization and reduced inpatient admissions for ambulatory care sensitive (ACS) conditions. The state has chosen targets within the range of performance improvement experienced by PCMH programs highlighted in the Patient-Centered Primary Care Collaborative report "Summary of Patient-Centered Medical Home Cost and Quality Results 2010-2013."

In addition, each episode launched will have a unique set of quality metrics that will be monitored over time. Example metrics for the first wave may include measures such as percent of patients with appropriate outpatient follow-up, percent of patients with appropriate medications filled, percent of patients with necessary testing (e.g., HIV screening for perinatal).

Lower costs

Through successful implementation of PCMH and episode-based payment, the state aims to reduce its five-year medical spend growth rate by 2 percent. The methodology and details behind this target can be found in Section H.

Primary Drivers

The state has identified five primary drivers to help achieve its goals to improve health, care and cost, as outlined above. These drivers include:

- **Pay for value** (e.g., outcomes and improved care delivery) instead of volume and increase accountability for care. Details for the PCMH and episode-based payment model can be found in Section E,
- **Coordinate health sector workforce and training.** Detailed initiatives are listed in Section G,

- **Increase patient engagement** by linking to existing community-based programs. Examples of this can be found in Section C,
- **Coordinate health information and technology.** Specific capabilities and initiatives are outlined in Section F, and
- **Measure and report health system performance.** Additional measures and methods are outlined in Section I.

E. Payment and delivery models

Proposed payment and service delivery models

The state has set a goal to have 80-90 percent of Ohio's population in some value-based payment model (combination of episodes- and population-based payment) within five years. In addition to the Ohio-based, multi-payer coalition that is already committed to testing these models, Ohio also proposes that Medicare support this effort, at least by producing total cost-of-care reports for providers and ideally by fully adopting the PCMH and episode-based payment models in the testing phase of implementation.

By pursuing PCMH and episode-based payment in tandem, the state aims to create increased accountability across the entire care delivery system. PCMH is an approach to increase coordination of care and drive long-term impact through a focus on prevention and chronic disease management. It also serves as a critical leader for the integration of primary care and public health and connection to community-based health and social services. Episodes, nested within the total cost of care accountability of the PCMH program, extends incentives to specialists and hospitals who are responsible for specific, defined procedures or chronic exacerbations.

Ohio's primary goal is to help all primary care providers succeed as they transition to value-based payment models. However, fragmented or conflicting program design across payers is one of the most significant barriers to successful transition. Therefore, the multi-payer coalition, with input from the PCMH and episode teams, identified the extent to which their payment strategies will be the same, align in principle, or differ by design.

- **"Standardize approach"** (i.e., use an identical design) only when alignment is:
    - Critical to provider success or significantly eases provider implementation (e.g., due to lower administrative burden);
    - Meaningful economies of scale exist;
    - Standardization does not diminish potential sources of competitive advantage among payers;
    - It is lawful to do so; and
    - It is in the best interest of patients (i.e., clear evidence base).
- **"Align in principle"** but allow for provider innovation consistent with those principles when:
    - There are benefits for the integrity of the program for payers to align;
    - It benefits providers to understand where payers are moving in same direction with model design;
    - Differences have modest impact on providers administrative process; and

    - Adjustments are necessary to account for legitimate differences among payers (e.g., varied customers, members, strategy, systems).

- **"Differ by design"** when:
    - Required by laws or regulations;
    - An area of the model is substantially tied to competitive advantage; and
    - There exists meaningful opportunity for innovation or experimentation.

The remainder of this section will describe each model in detail, including an overview of the model, the opportunity to scale in Ohio, core components of the model, approach to multi-payer collaboration on model design, the state's role in getting to scale, and a proposed approach to rolling out statewide.

Patient-centered medical homes (PCMH)

Overview

Patient-Centered Medical Homes (PCMH) improve quality, outcomes and cost of care by holding a single entity, the medical home, accountable for the coordination of care for patients across the health care delivery system. The PCMH helps manage the patient's overall care, ensuring that they receive high-quality, cost-effective care tailored to his/her specific needs that goes beyond today's fragmented, visit-focused approach.

Medical homes provide a significant part of the foundation for total cost management and quality accountability. Medical homes engage patients to maintain health and wellness, reducing health care costs by managing chronic conditions and preventing unnecessary emergency department visits and admissions.

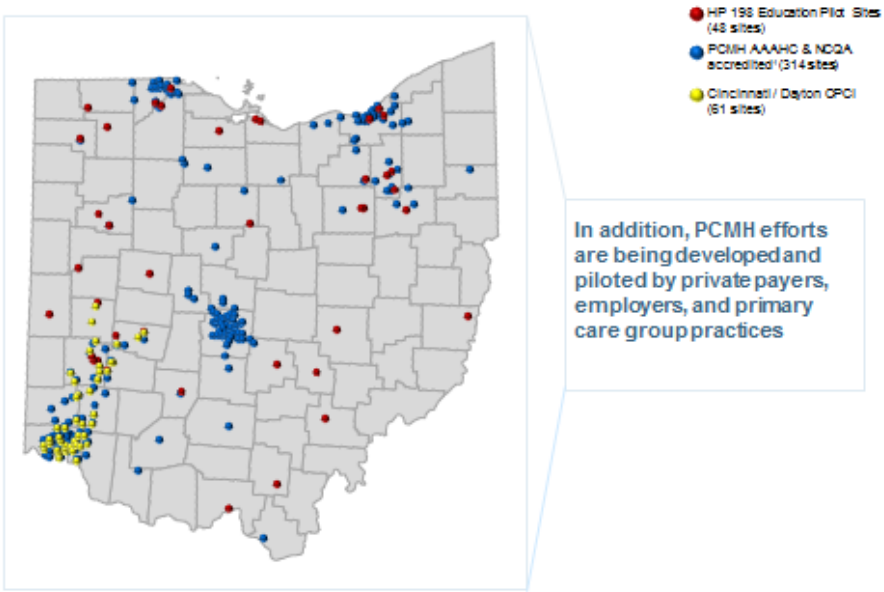
By rolling out the population-based care delivery and payment model across multiple payers and books of business, Ohio will reach 80-90 percent of the population within five years.

Why PCMH can succeed in Ohio

PCMH pilots and activities in Ohio have already laid the groundwork for the implementation of this value-based, patient-centered model (Exhibit 10). This activity has created a surge of momentum among both providers and payers. Ohio can leverage this momentum as it rolls out a PCMH model that is both aspirational and implementable over the next three to five years.

EXHIBIT 10

PCMH activity in Ohio



SOURCE: Ohio Department of Health website, as of May 2013

Some of the most prominent PCMH activities and pilots in Ohio include:

- **CMMI's Comprehensive Primary Care (CPC) initiative:** A multi-payer pilot for PCMH care delivery and payment models in 61 Ohio primary care practices in the Cincinnati-Dayton region;
- **The PCMH Education Pilot Project:** Supports PCMH recognition in 47 primary care practices in Ohio, including those in underserved areas. The Pilot Project includes an Education Advisory Group (EAG) that has reformed curricula at medical and nursing schools related to delivering care in the PCMH model;
- **The Ohio Patient-Centered Primary Care Collaborative (OPCPCC):** A coalition of primary care providers, insurers, employers, consumer advocates, government officials and public health professionals. Among other accomplishments, the OPCPCC established public Learning Centers to discuss the advancement of patient-centered primary care. These centers cover payment reform, communications and education, HIT, patient engagement and metrics; and
- **Connections between public health and primary care:** There are several community collaborations that are working to maximize use and efficacy of community-based resources in Ohio. For example, the Health Collaborative in Cincinnati is a group of diverse stakeholders, including local public health, health care providers and public and private organizations, working together to improve health for the Greater Cincinnati region.

The core elements of a PCMH

A comprehensive, successful Patient-Centered Medical Home model contains four components:

- **Care delivery model:** The vision for a PCMH's role in the health care ecosystem, including which populations to target, how care should be delivered and which sources of value to prioritize;
- **Payment model:** The holistic approach where payers use payments to encourage PCMH formation, to ensure adequate resources are available for practice transformation and to reward PCMHs for improving outcomes and achieving total cost-of-care savings over time;
- **Infrastructure:** The technology and data systems required to support necessary changes to the care delivery model, to track and report provider performance and to administer payments. Infrastructure is discussed in more detail in Section F; and
- **Scale-up and practice performance improvement:** Additional support, resources or activities which equip practices to adopt the PCMH delivery model, sustain transformation and maximize impact.

These components are outlined in more detail in Exhibit 11, which provides a thorough picture of the specific decision points embedded in each core element.

EXHIBIT 11

Elements of a comprehensive PCMH Strategy

Care delivery model	Target patients and scope
	Care delivery improvements e.g., ▪ Improved access ▪ Patient engagement ▪ Population management ▪ Team-based care, care coordination
	Target sources of value
Payment model	Technical requirements for PCMH
	Attribution / assignment
	Quality measures
	Payment streams/ incentives
	Patient incentives
Infrastructure	PCMH infrastructure
	Payer infrastructure
	Payer / PCMH infrastructure
	PCMH/ Provider infrastructure
	System infrastructure
Scale-up and practice performance improvement	Clinical leadership / support
	Practice transformation support
	Workforce / human capital
	Legal / regulatory environment
	Network / contracting to increase participation
	ASO contracting/participation
	Performance transparency
	Ongoing PCMH support
	Evidence, pathways, & research
	Multi-payer collaboration

Approach to multi-payer collaboration for PCMH design

Included below in Exhibit 12 are the model details classified by the multi-payer coalition across the three levels of alignment. Full details as defined by the multi-stakeholder workgroup can be found in Appendix B.

EXHIBIT 12

Ohio PCMH model charter with potential degrees of standardization by component

		"Standardize approach"	"Align in principle"	"Differ by design"
Care delivery model	Target patients and scope		▪ All patients included ▪ Strive for TCOC accountability	
	Care delivery improvements		▪ Aligned vision / vocabulary of care delivery model	▪ Payers, practices champion unique care delivery models
	Target sources of value		▪ Align on near-term and longer term sources of value	▪ Payers set unique targets to realize sources of value
Payment model	Technical require-ments for PCMH	▪ Standard set of requirements and milestones	▪ Payers do not pose additional barriers to participation	▪ Payers separately design link of requirements & milestones to payment
	Attribution / assignment		▪ Attribute to provider that can be held accountable for TCOC ▪ Provide transparency	▪ Payers maintain unique attribution methodologies
	Quality measures	▪ Standard "menu" of metrics & definitions	▪ Agree to have link between quality and payment	▪ Payers separately design how metrics link to payment)
	Payment streams/ incentives		▪ Support for practice transformation ▪ Compensation for activities not fully covered by current fee schedule ▪ Shared savings or other TCOC incentives / payment ▪ Approach to include small practices	▪ Payers will have unique – Payment levels – Risk adjustment – Shared savings methodology
	Patient incentives		▪ Agree to create incentives, communication to engage patients	▪ Incentives, benefit design, etc.

Payment model details

As outlined in the exhibit above, the PCMH model will include three types of payment streams or incentives:

- Support business model transformation for a finite period of time, particularly for small, less capitalized practices;
- Resources to compensate PCMHs for activities not fully covered by existing fee schedules (care coordination, non-traditional visits, population health management); and
- Rewards for favorably affecting risk- adjusted total cost of care over time by offering bonus payments, shared savings, or capitation.

While the PCMH payment model is designed to be flexible to meet the different needs of different types of providers and geographies (e.g., rural, urban, underserved areas), the aim is that over time, models will increase the emphasis on total cost of care accountability (e.g., shared savings or other total cost of care incentives).

While the state has chosen to focus on developing and launching PCMH, Ohio is encouraging payers and providers to continue experimenting with other

population-based models (such as full capitation or ACO models), as long as these satisfy the requirement of total cost-of-care accountability. The state also recognizes that not all providers are prepared to take on total cost of care accountability at present. Recognizing the diversity of the provider environment, Ohio will provide targeted capability-building support to some providers for a limited time. This support could include EHR implementation or performance measurement education.

Integration of community health

Extensive evidence has shown the effectiveness of community-based approaches to improve self-management and prevention of chronic diseases, falls and associated risk factors. Furthermore, patients in high-risk communities often lack access to social, environmental and health care related resources, making even an efficient and effective health care delivery system deficient in meeting the needs of the community. Integration of community-based health and social services with care provided by a PCMH and streamlined through episode-based payments can further empower patients to improve their quality of life.

Given Ohio's success in building PCMH networks and integrating them with HIE, as in the CPC initiative in southwest Ohio, connecting community resources to these providers would allow for a more integrated approach than might be possible in other parts of the state..

With the successful integration of primary care, public health and community health, Ohio hopes to encourage:

- Efficient resolution of specific episodes,
- Prevention of additional costly episodes,
- Community and institutional change to support health behaviors,
- Improved community capacity to meet patients' needs, and
- Connected systems which allow for monitoring success of community programs and referrals.

Ohio's role

Ohio Medicaid will lead by example, implementing PCMH for its fee-for-service business and requiring managed care organization (MCO) partners to participate with their Medicaid business. Ohio will also encourage MCOs to implement population-based models for other areas of business. The state will also encourage state employee benefit plans to implement PCMH or other population-based models that meet the state's aspiration for care delivery and payment reform.

Ohio also proposes that Medicare support this effort, whether by helping to produce total cost of care reports for providers that enroll (a minimum level of support) or by fully adopting the PCMH model including payment, and participating in and contributing to Ohio specific PCMH working groups (the preferred level of support).

The state will also provide multiple types of ongoing support throughout the program's implementation. By coordinating activities focused on building enabling infrastructure (e.g., HIT, workforce developments such as the PCMH Education pilot project). The state will also work with stakeholders to resolve

legal or regulatory issues and take the lead on submitting necessary State Plan Amendments (SPAs).

To ensure continuous improvement of the program Ohio will gather data and other feedback from multiple payers and providers on the performance of the health care system and the program. Additional details are listed in Section I.

Reaching scale statewide

To ensure that the patient-centered, multi-payer PCMH rollout goes smoothly in both the near- and mid-term, Ohio will implement it in three waves over the next five years.

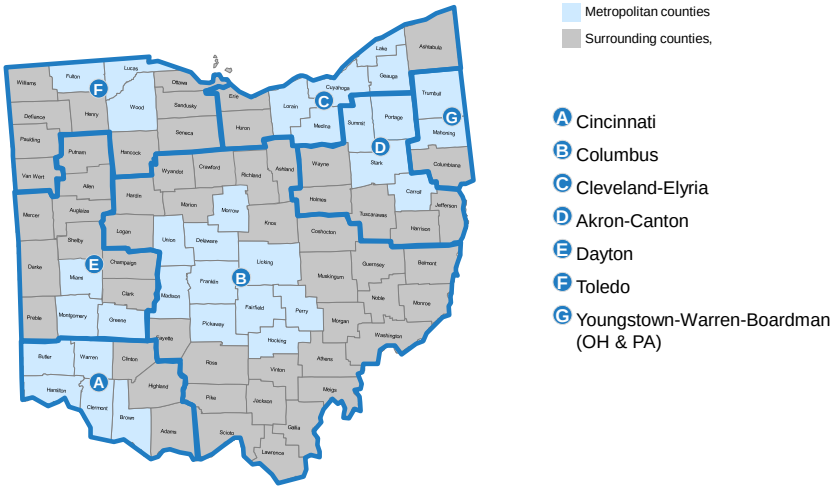
The seven major markets we are targeting (Exhibit 13) all cover both metropolitan and rural/non-metropolitan areas. These markets were identified by combining the hospital referral regions (from the Dartmouth Atlas) and definitions of the Ohio Metropolitan Statistical Areas (from the Ohio Development Services Agency).

Wave 1 has already begun. It is working the CPC initiative to implement the PCMH model in the Cincinnati-Dayton region.

After the Wave 1 model design is refined, Wave Two is expected to begin around mid-year 2014. The multi-payer PCMH in the Cincinnati-Dayton region will expand to take in all willing providers. It will also enroll all willing providers in a second market (to be identified). Rural counties within the referral regions of these markets will be included when sufficient scale can be achieved in the near-term (i.e., at least 50 percent of their providers are prepared to participate).

EXHIBIT 13

Potential regions for PCMH roll-out



1 Includes Harrison and Jefferson counties, which largely align with Pittsburgh referral region

SOURCE: MSA definitions from Office of Research, Ohio Development Services Agency, April 2013, Hospital Referral Regions (HRR) used for "halo" around each MSA from Dartmouth Atlas 2011

In advance of this wave, payers will recruit providers in the Wave 2 geographies. They will also launch the payment model for all providers who meet the minimum technical requirements for participation. Providers from other geographies can also opt into PCMH or other population-based models, at the discretion of the payer and provider involved.

Wave Three will start mid-year 2015 and will complete the rollout to all Ohio markets, both urban and rural.

By launching the rollout in three waves, Ohio aspires to quickly achieve scale among both metropolitan and rural populations while also having the opportunity to refine and improve the process as it moves forward towards engagement of providers statewide.

Episode-based payment model

Overview

The episode-based payment model encourages high-quality, patient-centered, cost-effective care by holding a single provider or entity accountable for care across all services in a specific episode definition. It also aligns provider incentives to promote and reinforce this behavior, as well as discourage under-utilization. By creating a common view of the patient journey, it encourages providers to coordinate patient care throughout the duration of an episode rather than simply focusing on specific visits or procedures.

The episode-based model complements population-based models, including PCMH. While PCMHs manage overall health and wellness in complex, multi-provider situations, this model creates joint accountability between multiple providers by increasing coordination for specific, defined procedures or chronic exacerbations. As shown in Exhibit 14; the model may cover a variety of conditions, ranging from inpatient medical (e.g., pneumonia, renal failure) to acute procedures (e.g., hip replacement, coronary artery bypass graft). Addressing acute exacerbations of chronic conditions through episodes highlights how the PCMH and episode models can work in tandem to hold providers jointly accountable for delivery of cost-efficient, quality care across the continuum of care delivery. Because population health measures include quality measures which may be applicable to episodes and total episode costs are accounted for as part of the PCMH total cost of care calculation, PCMH's are incentivized to work with episode accountable providers to increase quality and manage costs.

EXHIBIT 14

Approximately ~50 – 70% of spend may be addressable through episodes

NATIONAL

	Examples	Percent of total spend: Commercial	Medicaid	Medicare	
Prevention	Routine health screenings	~5	~5	~3-5	Addressed through population-based model (e.g., PCMH)
Chronic care (medical)	Diabetes, chronic CHF, CAD	~15-25	~10-15	~20-30	
Acute outpatient medical	Ambulatory URI, sprained ankle	~5-10	~5-10	~5-10	Potentially addressable through episodes (e.g., discrete, defined goal, clear guidelines)
Acute inpatient medical	CHF, pneumonia, AMI, stroke	~20-25	~5-15	~20-30	
Acute procedural	Hip/knee, CABG PCI, pregnancy	~25-35	~15-25	~20-25	
Cancer	Breast cancer	~10	<5	~10	
Behavioral health	ADHD, depression	~5	~15-20	~5	
Supportive care	Develop. disability, long-term care	N/A	~20-30	N/A	

For each episode, a single provider is identified as the "quarterback" or accountable provider for all elements of care included in the episode cost. Accountable providers can be physicians (e.g., specialists), physician practices or facilities. They will be selected specifically for each episode (e.g., obstetrician for perinatal). Accountable providers will be eligible for incentives based on delivery of high quality, cost-effective care.

Ohio will begin initially with a set of episodes to define and launch statewide. The scale up approach for episodes is to increase the number over time; with the long-term goal of encompassing 50-60 percent of Ohio's total health care spend. The episodes to pursue near term, which cover a mix of acute procedures and inpatient conditions, have been carefully chosen so they are relevant across both private and public payer populations.

Why the episodes model will succeed in Ohio

While the episode model is not as established nationally or statewide as PCMH, there are providers and payers engaged in episode-based payment pilots. Seven different systems in Ohio that expressed interest were selected for participation in the Bundled Payment for Care Improvement (BPCI) initiative. The most frequently selected episodes across providers include joint replacement, chronic obstructive pulmonary disease (COPD), bronchitis/ asthma, simple pneumonia, and coronary artery bypass graft (CABG).

Additionally, the Cleveland Clinic has been a pioneer in contracting directly with employers for bundled services. In 2010, they launched a bundled payment program for cardiac care with Lowes. Since then, other large employers (e.g., Boeing, Wal-Mart) have made similar agreements for cardiac care. Recently they expanded their program to include major joint procedures.

On the payer side, United Healthcare is experimenting with an episode-type payment for cancer care. They have partnered nationally with five oncology

groups, including one based in Dayton. The bundled payment covers four months of chemotherapy care.

Initiatives underway highlight interest across the state from both the provider and payer perspective in increasing accountability and offering providers incentives for delivering high-quality, cost-effective care. Working with payer and provider stakeholders, the state has solicited feedback from individuals involved in these novel episode-based pilots. Ohio's high level of innovation positions both providers and payers well for transition to episode-based payments.

The core elements of the episode model

Developing the state's episode model involves determining the design of the overall, "cross-episode" model as well as the specific definitions for each episode to implement in Ohio (e.g., perinatal). The cross-episode design elements are integral to the payment model structure and have been the focus of the multi-payer coalition's work to define what episodes will look like in Ohio. The state is convening clinical workgroups, one for each specific condition or procedure, to aid in determining the episode definition. These clinical groups will include both payer and provider stakeholders with specialties related to the episode in question.

There are four core components of cross-episode model design.

- **Accountability:** The number of providers accountable for an episode of care and types of providers that may be selected as a "quarterback" or accountable provider.
- **Payment model mechanics:** Overview of payment model including whether it's retro- or prospective; type of gain / risk sharing; and method by which providers are measured to determine performance outcomes (e.g., absolute vs. relative thresholds).
- **Performance management:** Describes components integral to determining provider performance in episode model (e.g., risk adjustment, patient-specific exclusions to calculation of average cost per episode).
- **Payment model timing and thresholds:** Average cost is calculated across all episodes for an accountable provider in a given time window; payment model timing includes the time window for average episode cost calculation and dates for launch and link to payment. Thresholds are levels to which a provider's average cost is compared.

Approach to multi-payer collaboration for episode design

Given Ohio's long-term goal to transition 50 percent of spend to episode-based payments, the multi-payer team sees real value in collaboration on the cross-episode design elements. Additionally, input from provider stakeholders highlighted items where standardization or alignment is critical for them to participate in a model across Ohio's fragmented payer landscape. Like the PCMH charter, the episode charter lays out components of the model where payers agree to align on specifics or in approach. Please see above section "Approach to multi-payer collaboration for PCMH design" for definitions behind the three specific levels of alignment.

The episode charter highlights design elements for standardization across the four main components of the model: accountability, payment model mechanics, performance management, and payment model timing.

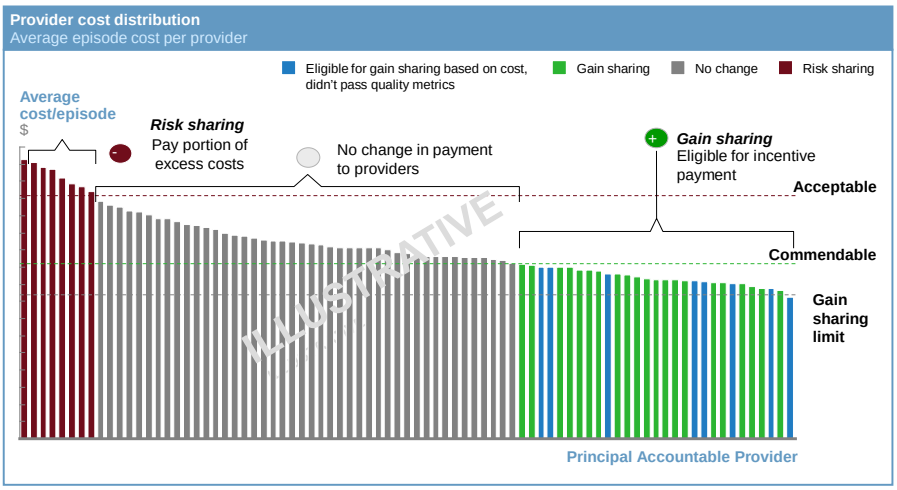
Accountability: For the majority of episodes, a single provider / entity will be held accountable for care; the specific type of accountable provider (e.g., physician type) will vary across episodes. A single provider / entity on point for the episode allows for clear accountability and incentive to influence the full range of care covered in an episode. Accountable providers may include physicians (e.g., specialists), physician practices, or facilities and will be selected for each episode. No types of providers (e.g., cost-based) will be categorically excluded; payers may incorporate adjustments to ensure they are fairy evaluating unique providers and not limiting access to care.

Payment model mechanics: The episode model Ohio is pursuing is retrospective, building on the FFS payment structure already in place. Providers will continue to deliver services, submit claims, and receive payments FFS as they do today. Providers will be evaluated over a performance period (e.g., one year) during which average cost is calculated across all episodes and compared to absolute threshold levels for performance evaluation, as shown in Exhibit 15. Additionally, Exhibit 15 highlights that the model incorporates both up and downside risk. Providers above the acceptable level of spend risk share a portion of excess costs. Providers below the commendable level are eligible to receive an incentive payment for delivering cost-effective care. All threshold decisions related to pricing will vary across payers.

EXHIBIT 15

Retrospective threshold model rewards providers for delivering cost-efficient, high-quality care

ILLUSTRATIVE



1 Each vertical bar represents the average cost for a provider, sorted from highest to lowest average cost

SOURCE: Arkansas Payment Improvement Initiative

Performance management: The overarching episode model design incorporates elements to support fair evaluation of provider performance and accelerate provider adoption. Payers are aligning in principle to ensure a strong focus on clinically comparable situations. Each episode will incorporate a reasonable list of patient and episode exclusions. Additionally, episodes will

be risk adjusted to account for differences in patient panels. The average episode cost for each provider reflects these exclusions and adjustments.

Additionally, each episode will have a set of quality metrics for reporting, with a subset linked to payment to help ensure that providers continue to deliver high-quality health care. Providers that are eligible for gain sharing based on average-cost must also pass quality metrics to receive the incentive payment (Exhibit 15). A minimum cost for high-quality care may also be used to cap gain sharing for each episode; this is done to discourage providers from under-delivering care. Remaining metrics, not tied to payment, are included in reports given regularly to providers to offer insights into performance.

Payment model timing. Different episode performance period start / end dates may present a challenge for providers serving Ohio's fragmented payer landscape. To ease provider adoption, the multi-payer team agrees on principle to align timing for launch and performance periods where possible.

The multi-payer coalition discussed opportunities for collaboration and laid out a working hypothesis across design elements on which to take a consistent approach. Outlined below in Exhibit 16 are the model components across the four main categories. The full details of the episode charter can be found in Appendix C.

EXHIBIT 16

Ohio episode model charter with potential degrees of standardization by component

	"Standardize approach"	"Align in principle"	"Differ by design"
Accountability	▪ Single accountable provider will be identified for majority of episodes ▪ Type of provider may vary, but payers align on accountable providers for each episode	▪ Common vision to not categorically exclude unique providers	▪ Adjustments to episode cost (e.g., cost normalization) may vary by payer
Payment model mechanics	▪ Model follows a retrospective approach; episode costs are calculated at the end of a fixed period of time ▪ Payers adopt common set of quality metrics for each episode	▪ Model includes both upside and downside risk sharing ▪ Aligned principle of linking quality metrics to incentives ▪ Agree to evaluate providers against absolute performance thresholds	▪ Payers may choose to have min number of episodes for provider participation ▪ Type and degree of stop loss may vary
Performance management	▪ Commitment to launch reporting period prior to tying payment to performance	▪ Aligned approach to have episode-specific risk adjustment model ▪ Aligned approach to exclude episodes with factors not addressable through risk adjustment	▪ Payers independently determine method and level for gain sharing ▪ Risk adjustment methodologies may vary across payers
Payment model timing and thresholds		▪ Performance period length for each episode and launch timings aligned where possible	▪ Start / end dates for each episode may vary ▪ Payers each determine approach to thresholding (incl. level of gain/risk sharing) ▪ Outlier determinations will be at discretion of each payer

Ohio's role

In collaboration with Medicaid, the OHT will continue to drive the multi-payer effort for design and implementation of the episode-based payment model. The multi-payer coalition developed the draft charter, identifying elements of the model to align across payers. Additionally, as described above, the multi-payer team collaborated on a working hypothesis for the cross-episode model components that are consistent across payers. The state will continue to lead

payer and provider stakeholders across the state throughout the shift towards implementation. Specifically, OHT and Medicaid will:

- Convene clinical workgroups specific to the five episodes to pursue in the first year; clinical workgroups will include payer and provider representatives with a focus related to the episode in question (e.g., obstetricians / midwives for perinatal, chief medical officers for private payer organizations). Episode workgroups will leverage episode definitions in use elsewhere (e.g., Arkansas Payment Improvement Initiative, Prometheus, BPCI) and provide recommendations on how to tailor, for Ohio, the base definition (e.g., timeframe, care included in episode cost, exclusions, quality metrics) to the multi-payer coalition. Episode definitions will be standardized across payers to ease provider adaptation to the new model;
- Lead the multi-payer team in design of a common reporting format with the potential to support private payer reporting near term. State support of reporting may include a multi-payer report as a comprehensive view of episode-based payment performance to providers; and
- Coordinate with providers across the state to ensure all involved have a solid understanding of new payment models as well as an opportunity to provide feedback.

Additionally, the State will lead by example and implement episode-based models, and where it has influence, encourage other payers to move meaningful spend to value-based payments. Medicaid FFS plans to launch reporting (e.g., providers receiving regular information on performance) in 2014. Episodes will be included as a component of contracts for its MCO partners and the state will encourage MCOs to implement episodes for other books of business. The state will also encourage the state employee benefit program to incorporate the episode-based payment model into contracts for managed care vendors.

While payers and providers in Ohio have been looking independently at bundled models, they see the value of collaborating to ensure new payment models are implemented at scale across the state. The support and alignment across the multi-payer coalition thus far illustrates not only the momentum of the broader group but the fact that others are looking to the state to lead by example and play a substantial role in model design.

Building scale statewide

Ohio's vision is to eventually encompass approximately 50 percent of spend in the episode model. Given this goal, the state plans to define, with input from payers and providers, five episodes to launch in the first year. The state, with feedback from the multi-payers, has selected these first five episodes. Private payers are committed to launching a subset (e.g., three of five) in tandem with the implementation of episodes for Medicaid.

A set of guiding principles were used to select the initial set of episodes to define. These principles include:

- 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 delivery);

- 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, etc.); and
- Consider **alignment with current priorities** (e.g., perinatal for Medicaid, asthma acute exacerbation for youth).

With these in mind, the five episodes identified include: perinatal, asthma acute exacerbation, COPD exacerbation, joint replacement, and percutaneous coronary intervention.

Ohio's plan is to design, with payer and provider input, 20 episodes over the next three years. The same guiding principles will apply as the state looks toward the next wave of episodes to pursue and learnings from episodes in flight within the state will offer additional insights for selection down the line.

Alignment of multiple players

The state leveraged the Governor's Advisory Council for Health Care Payment Innovation to develop a broad set of stakeholder groups to participate in the SIM design process. The SIM core team, which included representatives from the five largest health insurance companies in the state met on a bi-weekly basis to ensure multi-payer alignment on key design dimensions. The PCMH and Episode design teams, which also met on a bi-weekly basis, had representatives from providers, payers, purchasers and other payment innovation experts. These teams provided recommendations to the multi-payer coalition, and had a crucial role in forming the design of each model. Additional details on the stakeholder model can be found in Section B.

To further bring stakeholders into alignment with the new population and episode-based models, Ohio will implement a variety of workforce initiatives (described more specifically in Section G, Workforce Development). These will engage multiple stakeholders, including providers (e.g., through licensing and scope of practice), academic medical centers and graduate medical educators and institutions and acute and post-acute health care facilities.

The state also will submit necessary State Plan Amendments or Waiver applications to support the PCMH and episode-based models and align strategy, where possible, with health insurance regulation and activities in the health insurance marketplace.

Linkages between the PCMH and episode-based payment models

Ohio's objective in pursing PCMH and episode-based payment models simultaneously is our belief that each is more powerful in combination with the other. Pursuing the two payment reform strategies will create opportunities to link incentives between specialists and primary care physicians to address gaps that are inherent in the hand-off process. Transitions of care are recognized as danger zones for issues such as readmissions, patient safety, medication errors, and increased cost. Constructing jointly owned payment incentives for the proper transition of care will go a long way toward addressing these challenges.

F. Health Information Technology

As described in previous sections of this document (section B), Ohio's success with the MPIP program and statewide leadership has positioned the state to use HIT/HIE to align health care strategies and share comprehensive information across state government and private payer networks. Coordinated use of such infrastructure is critical to achieving Ohio's goal of improving overall health system performance and achieving better health outcomes for Ohioans. This is aligned with Ohio's broader HIT Plan and roadmap, which includes four cornerstone objectives:

- Alignment of public health and human service strategies through the Enterprise Data Warehouse;
- Public and private electronic health records linked through secure, trusted health information exchange networks;
- The meaningful use of advanced HIT tools not only as part of the practice of MPIP eligible providers and hospitals, but through a broader array of technologies and providers in Ohio's health care continuum; and
- Technology support for innovative health care models based on value instead of volume.

Investing in business intelligence

Breaking down data silos and moving to a person-centric view of Ohioans receiving government services is the core of Ohio's business intelligence strategy. The business intelligence strategy will allow Ohio to develop better policy and objectively measure the outcomes of those policies. The business intelligence strategy is the combination of an enterprise data warehouse and the application of advanced analytic tools. The enterprise data warehouse will pull together data from across the HHS program spectrum. The initial data in the enterprise data warehouse will include eligibility data from Medicaid, the Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF). Additionally, all Medicaid claims data will be transported directly from Ohio's MMIS system into the enterprise data warehouse. This eligibility and claims data will be essential to the development and analysis of the value-based payment models.

Providing access to state data (where appropriate and legal) is a critical component of the business intelligence strategy. The state government data hub will provide non-governmental entities secure access to data in the data warehouse and other state systems. The data hub will improve security and efficiency when access to data is warranted. For entities to share and access data with the state, the data hub will provide for a single, consistent access point. As a single access point, the data hub will make data collaboration with the state simple and efficient.

Both the HealthBridge and CliniSync HIEs (and any future HIE) will be able to contribute and exchange data via the state's data hub with Medicaid for care

management and the Ohio Department of Health for public health for reporting and surveillance. CMS and the State of Ohio will be able to leverage the existing health IT and HIE infrastructure and will not need to create a separate HIE infrastructure to share data with providers across the state.

Using HIT to support value-based payments

As Ohio advances toward innovative, value-based payment models, the need for timely and relevant data sharing becomes not just a vision, but a practical requirement. Supported by Governor Kasich's Office of Health Transformation and with the goal of improving Ohio's overall health system performance, the Ohio Department of Medicaid has developed an HIT roadmap to develop HIT/HIE infrastructure to support health care innovation and value-based payments. Additional details on Ohio's HIT roadmap can be found in Section B.

Successful implementation of the episode and PCMH models described in section E will require the state to leverage its investment in their Enterprise Data Warehouse and integrate key technologies.

- **Analytics engine:** An analytical tool used to analyze claims and produce payment-related analytics, including metrics for health outcomes, quality and cost for each provider and/or patient. Within the PCMH model, such a tool would run claims-based analytics to attribute patients to a PCMH and adjust payments to the PCMH based on an attributed patients' claims history. Within the episodes model, the tool would process claims to construct episodes and determine performance metrics for each provider. The state will continue to convene the multi-payer coalition to work through the base definitions of the episode and PCMH model, which will be a major input into the technical requirements for the analytic engine. Each payer will then customize the requirements and develop the capabilities independently. The state will likely work with a vendor to develop this solution, and will make its selection public so payers may choose to contract with the same vendor.
- **Report creation and data visualization:** An IT system and/or technology that captures the analytics and performance metrics produced by the analytics engine and translates the data into easy-to-read provider reports. The technology will have the ability to both create static reports for providers and visualize underlying data claims and / or clinical data dynamically. Again, similarly to the analytic engine, the state will lead design through the multi-payer coalition, and work to make its vendor selection public so that payers may leverage the same solution if desired.
- **Provider portal:** A web-based, HIPAA-compliant mechanism for providers to access and submit information required to support innovative care delivery and payment models. This includes the ability for providers to view performance information and share clinical data with payers. With input from the multi-payer coalition, the state will look to leverage an existing portal as a starting point for developing this capability.

The state will begin to develop and implement these capabilities in the second quarter of 2014 in order to support Wave 1 activities for episodes and PCMH.

Plan to reach providers in rural areas, small practices and behavioral health providers

Already about 18,000 eligible providers in Ohio have received $659.6 million in meaningful use EHR incentive payments from Medicare and Medicaid. However, there are many more health care providers along the care continuum that do not have access to electronic records, are not connected through HIE, and cannot effectively participate in a connected medical neighborhood without IT support. In order to increase adoption of EHR, HIT and HIE across the state and further increase enrollment in the MPIP program, Ohio has implemented targeted communications to "priority" groups who may be eligible for MPIP. The state is working in collaboration with the regional extension centers (RECs)—the Ohio Health Information Partnership (The Partnership) and HealthBridge—to identify strategies to ensure that eligible providers receive incentive payments to support HIT adoption. As the state continues our collaboration with the RECs, it is our goal to have as many eligible providers as possible receive an incentive payment.

The Ohio Department of Medicaid (ODM) engages frequently with the RECs to coordinate ongoing initiatives, including provider and hospital incentive expansion. Among other activities, ODM and the RECs collaborate on strategies to help eligible providers achieve Medicaid "adopt, implement or upgrade" incentive payments and Stage 1 meaningful use. As frequent co-presenters at educational events, ODM and the RECs work together to provide the most up-to-date information to providers on requirements for the MPIP, how to apply for incentive payments, and the registration process. These and other outreach efforts resulted in Ohio not only meeting its federal REC goal of signing up 6,000 primary care physicians for REC services, but exceeding it with at least 7,500 providers signing up.

The state recognizes that key provider partners in the vision to achieve greater health outcomes through community care coordination have not been eligible to participate in the federal MPIP program. While many non-eligible providers are finding other ways to finance and leverage information sharing technology, most continue to find the capital investment prohibitive. As part of the SIM process, Ohio plans to explore options to provide HIE connectivity to behavioral health, long-term care facilities, and patient-centered medical homes with a particular emphasis on exchanging clinical data between hospitals, practices and other providers during transitions of care.

In addition to the state's activities, HealthBridge and CliniSync are each seeking to expand their capabilities to exchange both clinical and administrative data and improve the value of information that is available for decision making by providers. This infrastructure will link the financial and clinical data to present a more complete picture of a patient's care.

Cost allocation plan and methodology for information technology system solutions

Whenever information technology system solutions benefit multiple federal and non-federal programs, OHT will ensure compliance with federal cost allocation principles. Also, whenever possible, Ohio will leverage previous investments and other funding sources to develop and enhance its HIT tools. For example, the new enterprise data warehouse is being developed as part of the state's new integrated eligibility system.

Impact on Medicaid Management Information System (MMIS)

Historical data from the MMIS system has been integral to the design of both the episode and PCMH models. MMIS data supported the team in building a fact base to inform design decisions around the two new payment methods.

Episodes

Developing episodes involves both designing the overarching 'cross-episode' model as well as the detailed definitions to implement for specific procedures or conditions. During design of the 'cross-episode' model, the multi-payer coalition utilized algorithms in use elsewhere with historical Medicaid data. The algorithms, which run on claims data, will be able to provide insight into the number of episodes, as well as the cost of potential episodes.

A broad set of claims and associated data fields are necessary to accurately run episode analyses on historical claims data. The algorithms rely on inputs from professional, inpatient facility, outpatient facility and pharmacy claims. In terms of specific data required, given the main output is cost for each episode, it is critical to understand the proper fields used to determine the cost of each claim. Working through a blend of FFS data and managed care encounters for spend adds additional confounding factors to the analysis. Along with spend detail, diagnosis and procedure codes were necessary to determine whether or not specific claims should be included into an episode cost. In addition to basics like patient identification, service date, and eligibility, the other important piece is billing provider identification. Provider identification on claims with specific procedure and /or diagnosis codes aid in the identification of the accountable provider for each episode.

Exhibit 1, included in the first section, illustrates the output of example episode algorithms run on Ohio specific episode data. Working through these types of analyses with a detailed fact base supported the development of the episode charter and the working hypothesis for common elements across payers (as discussed in Section E).

As the state determines the Ohio specific technical definitions of episodes, it will use similar analyses to tailor existing algorithms for use in Ohio. All of the claims and data fields mentioned above across Medicaid FFS and managed care are necessary. Multiple numbers of diagnosis codes per claim will be critical to help the group align on both patient specific risk factors as well as comorbidities that may remove an episode from a provider's average cost calculation. Updated claims data files will continually be pulled to ensure Ohio is building a fact base from the most up-to-date data sets available.

Once the multi-payer coalition has aligned on the base definitions for the five episodes to pursue in the first year, payers will work to independently customize and set thresholds for each episode. The enterprise data warehouse will supply data for Medicaid FFS to use in analyses to determine threshold levels for each episode. Each participating payer will have to use a similar data set from their own claims engine.

PCMH

Design of the PCMH model, like episodes, is built on a solid fact base, drawing on claims data in designing the preliminary models for attribution and total cost of care calculation. The analysis to support attribution methodology requires detailed provider information (both rendering and billing level as well as

specialty codes). Like in episode cost calculations, understanding both claim types as well as the amount paid is critical for total cost of care calculation. Risk adjustment also plays a role here as well. In early analyses, diagnosis and procedure code information at the claims level were used with a standard risk-adjustment model (e.g., 3M) to consider variability across risk adjusted total cost of care numbers for Medicaid recipients.

Moving forward, current claims data will also be helpful in determining quality metrics. Looking at performance historically will shed light on gaps in care that may be mended through quality metrics as well as the potential number of providers that may be eligible for financial incentives. Leveraging historical data received through the enterprise data warehouse offers a test bed for PCMH design elements as the state looks to expand the model outside providers already included in the CPC initiative.

Modifications to MMIS

In selecting and designing care delivery and payment models for Ohio, the state sought to provide all payers (including Medicaid) with the opportunity to significantly leverage their existing capabilities and HIT infrastructure. The state did this in hopes that it would help accelerate time to impact and improve the likelihood of broad commercial-payer participation. Thus, as a beneficiary of this policy, the state will be able to fully leverage the existing MMIS with only minor modifications to enhance functionality. These simple modifications will allow the system to support bonus payments and withholds resulting from data/outputs supplied by the analytics engine.

G. Workforce development

Successfully transforming Ohio's health care delivery system requires a well-equipped health care workforce that practices at top of their license. However, the state currently faces a potential health professional shortage. Ohio has about the national average number of primary care physicians, but over 1.1 million people reside in areas (e.g., rural or low-income urban communities) underserved by these physicians. In addition, 55.6 percent of physicians trained in the state leave to practice elsewhere.[10]

The shift to a population-based model will increase the importance of and need for primary care providers. To support these models, Ohio will increase its number of primary care providers, improve the effectiveness of its interdisciplinary heath care teams and build its health care workforce in underserved areas. The new model will also require support from the entire health care community.

Several initiatives are already underway to meet workforce goals. In 2012, Governor Kasich created the Office of Workforce Transformation (OWT), which convenes industry and policy leaders to design strategies that align Ohio's workforce education, training and delivery with job and business needs. Some of these address the recruitment and development of health professionals from underrepresented minorities. The Office of Health Transformation has outlined a series of strategies and recommendations to address these needs in its budget white paper "Coordinate Health Sector Workforce Programs." The Ohio Department of Health (ODH) is developing detailed initiatives to strengthen the primary care workforce, primarily through the Ohio Primary Care Workforce Plan. OHT, ODH and the Governor's Office of Workforce Transformation (OWT) are coordinating these efforts across 16 state agencies.

In addition, the Ohio Board of Regents supports the design and implementation of programs in medical education. It can build on the state's rich medical training record; Ohio has one of the highest per capita rates of training in the country - 48.2 residents and fellows in programs per 100,000 people.[11] The state has already developed an advanced PCMH interdisciplinary curriculum.

In order to build and retain a sufficient healthcare workforce that practices at the top of their license and that can consistently deliver quality-driven, team-based, patient-centered care, the state will[12]:

- **Tailor training** through PCMH educational projects like the 47-practice PCMH Education Pilot Project that Ohio created with input from the statewide Education Advisory Group (EAG). Its stakeholders include government agencies as well as educational, medical and nursing organizations. The state will also introduce new training programs for integrated behavioral health care, in addition to a

[10] AAMC 2011 State Workforce Data Book, Center for Workforce Studies, Table 19.

[11] AAMC 2011 State Workforce Data Book, Center for Workforce Studies, Table 12.

[12] Office of Health Transformation workforce white paper, "Coordinate Health Sector Workforce Programs" (January 2013).

proposed 50-practice pediatric PCMH project building on the current education pilot. The current project involves primarily family and internal medicine practices with the majority of patients being adults. There are unique aspects of pediatric care and practices regarding the patient-centered medical home that require a focused project.

- **Increase education opportunities** through expanded mentorship programs, community-based residency opportunities for medical students and enhanced primary care education and recruiting for students from areas with primary care shortages. Medicaid will target direct medical education (DME) funding to support workforce priorities. Beginning July 1, 2014, Medicaid will allocate DME payments according to rules that support all of the following: a workforce trained in comprehensive primary care and committed to serve all Ohioans; dollars that follow residents into community practices; primary care placements in recognized PCMHs; a residency mix that recognizes and supports Ohio's needs; and strategies that mitigate the state's underserved areas. Medicaid will look for stakeholder input, including guidance from the Council of Medical School Deans, in developing these rules.
- **Align incentives** to encourage primary care and PCMH participation. Expanding primary care medical and nursing scholarship programs like Choose Ohio First or by altering and/or expanding loan repayment options could accomplish this. Coordinating priorities and resources across existing scholarship and training programs is a critical initiative. Example programs could include Choose Ohio First Scholarships for primary care, the Medicaid Technical Assistance and Policy Program (MEDTAPP) Healthcare Access Initiative, the combined Board of Regents line items for family medicine, geriatric medicine and primary care residencies and the Area Health Education Center program.

  Ohio also will align loan and loan repayment policies with workforce priorities. For example, licensure boards in eligible disciplines provide matching funds for the State Loan Repayment Program grant in order to support additional primary team members. These disciplines include physician assistants, nurse practitioners, certified nurse midwives, psychiatric nurse specialists, health service psychologists, licensed professional counselors, licensed clinical social workers, marriage and family therapists and registered dental hygienists, pharmacists, and community health workers. Another effort will revise the loan repayment program application scoring criteria to increase opportunities for underrepresented minorities and support advanced primary care practices. Lastly, revisions to Ohio's Physician and Dentist Loan Repayment programs would address the large educational debt incurred by many providers and help to facilitate community-based training.
- **Enhance the workforce infrastructure** through a centralized data collection system with the national Minimum Data Set (MDS), workforce forecasting model, updated e-licensing and a strengthened, facilitative HIT system. OWT, OHT and ODH will collaborate to: (1) collect the nationally recognized MDS for all primary care disciplines by using the Department of Administrative Services e-licensure system; (2) add data elements to Ohio's MDS that are required for the designation of federal Health Professional Shortage Areas; and (3) develop an advanced primary care workforce forecasting model to

assist in planning education programs that meet the needs of Ohioans and support statewide recruitment and retention strategies.

- **Enable workforce changes through regulatory policy** that would use a variety of techniques, e.g., defining core competencies that would require additional training for health professions and facilitating Medicaid reimbursement for that education. The state will also streamline educational credit and licensure processes for veterans and connect to Federal efforts to attract more veterans into the Advanced Practice Registered Nurses (APRN) and Physician's Assistant fields, per the Governor's Executive Order 2013-05K.

Moving forward, Ohio will implement the initiatives outlined in the OHT workforce white paper and will integrate them with other efforts to transform the care delivery system. As initiatives are implemented, the state will examine the status of the primary care workforce to verify that these initiatives are succeeding and sufficient to address Ohio's health care workforce needs, both then and in the future. The state will also ensure that initiatives complement the implementation of PCMH and episode-based payment (outlined in Section J).

H. Financial analysis

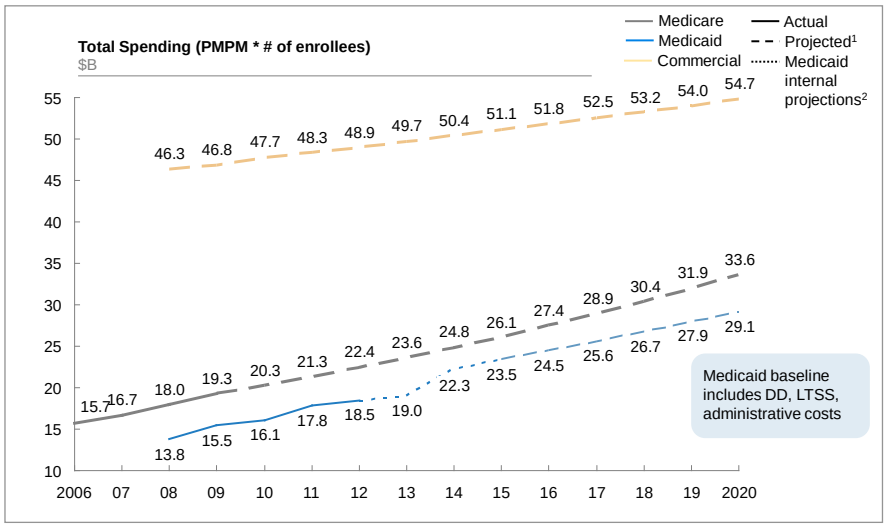
Target populations and respective costs

In terms of current health care costs, Ohio ranked seventh nationally overall with total expenditures near $82 billion in 2011 and sixth across all states for Medicaid expenditures alone. Ohio's Medicaid spending ($18.962 billion in 2013) is projected to grow at an average CAGR of 7.4 percent until 2015 – the fastest of any Ohio payer population (see Exhibit 17). Its current per-member-per month (PMPM) cost of $664 will increase to $744 by 2015 without payment reform. Medicare's 2013 spend ($23.582 billion) is also projected to grow, although more slowly, with an average CAGR of 3.4 percent until 2015. Its PMPM cost of $981 will increase to $1250 by 2015 without payment reform. Finally, commercial payers' 2013 spending (estimated at $49.671 billion, the largest figure) is projected to grow at an average CAGR of .9 percent until 2015. Its PMPM cost of $633 is expected to increase to $691 by 2015 without payment reform.

EXHIBIT 17

Ohio baseline costs by payer

PRELIMINARY



1 Medicare projection based on 5.2% CAGR, assumes linear growth rates for PMPM and enrollees. Commercial back calculated from total healthcare spend from 2008-2010 then projected based on 1.4% CAGR. Medicaid projection 2016-2020 based on 4.4% CAGR from Mercer Ohio Medicaid study
2 Projection from latest Medicaid internal data
SOURCE: OHT, Kaiser Foundation, team analysis

Estimated input costs

Ohio plans to make a sizeable investment to launch and support both PCMH and episode-based payment models. Investments include the infrastructure required for payment innovation as well as provider incentive dollars and funds for provider support as they shift care delivery to succeed under new models.

Infrastructure costs fall into two categories: upfront investment to take design to implementation and continued funds for ongoing support. Initial funds will cover design and implementation of elements including analytics, provider reporting, and development of required payer and provider communication. Continued infrastructure investments include the operational costs of the new models as well as funds to help scale the payment models across the state, maximizing value and financial return. Combined, the state is estimating projected costs to range from $35–75 million, depending on the path forward for implementation.

Expected cost savings will be reinvested in the model in the form of incentives for providers delivering cost-efficient, high quality and well-coordinated treatment. The episode model includes both up and downside gain/risk sharing. Providers with an average cost per episode below a certain threshold have the potential to gain share a percentage of savings while providers with an average cost above a different threshold may be responsible for paying back a portion of the excess cost. For PCMH, dollars reinvested include providers sharing a portion of savings based on total cost of care for their patient panel. Additionally in the PCMH model, like in the CPC initiative, providers may receive up-front funds to support care coordination.

Cost savings

Successful implementation of both PCMH and episodes across payer populations will impact two primary drivers of health care spend – medical waste (e.g., unnecessary tests and procedures) and medical inflation (e.g., use of new, more expensive medications despite lack of evidence for improved clinical outcomes). Both the models can have impact on each driver to improve cost efficiency.

Reducing medical waste in the health care delivery model will lower unnecessary spend. The pure FFS model, which pays providers for volume rather than value, incentivizes providers to perform additional tests or procedures. Offering monetary incentives (such as upside gain sharing on reduced total cost of care in the PCMH model) is critical to encourage delivery of high-quality, cost-efficient care. Similarly, the episode model rewards providers for reducing waste such as avoidable readmissions. Additional waste-reducing practices include the use of lower-cost, effective technology and generic drugs as well as coordinating a recipient's overall care so they do not experience unnecessary medical visits or procedures.

Slowing medical inflation can help to level off the steep trajectory of Ohio's rapidly increasing costs per insured life. Reductions in medical inflation require that both the provider and the recipient adopt better practices; for instance, the provider keeps better records and focuses on quality-centric care that reduces the number of readmissions and ER visits while the care recipient takes steps to maintain his or her health and improve overall wellness. In particular, the person-centered approach of the medical home will increase accountability and encourage practices to improve patient engagement as well.

Expected total cost savings and return on investment (ROI)

Projected reductions in the health care spend will result in significant savings across all payers and produce substantial returns on initial and continued investments. Savings and ROI projections are based reaching a potential savings of 1-2 percent in medical inflation and 4-10 percent in medical waste for

PCMH over a 4-7 year timeframe. Episodes have the potential to impact spending more in the near term: over a 2-4 year timeframe projected savings are 0.5-1.5 percent in medical inflation and 6-12 percent in medical waste.

Across all payer populations, projected three-year savings total between $1-2.4 billion. After reinvestment to providers, projected net savings may total from $230 million to $1.4 billion. Savings are expected to ramp up over time, with a relatively neutral balance between savings and investment in 2015. As more spending is covered through both the PCMH and episode models, next savings is projected to grow to more than $700 million in fiscal year 2017.

Specific numbers and savings rates differ across payer populations; each will see most benefit as the models reach scale in the respective groups. With the state taking the lead, the Medicaid program is projected to realize the largest and fastest savings: approximately $400 million in savings net provider reinvestment over the first three years, reducing the five-year spending growth rate by approximately 2 percent. Projections for both the Medicare and commercial payers assume later timelines and hence, lower numbers in terms of overall savings. By leading with the Medicaid population, the state has the ability to demonstrate the power of the models and build upon work across the state today.

Specifically with the Medicaid population, Ohio projects an anticipated return between 5-10 times upfront costs. The state's plan to take the lead on payment model design with support of the multi-payer coalition allows the commercial payers and Medicare to build on the work for Medicaid, accelerating the path to scale statewide. Given less funds upfront will be required to transition additional populations, the state projects a return 7-15 times investment costs across all payers (e.g., commercial, Medicare, Medicaid) in the first three years. This also accounts for delayed timelines in the commercial and Medicare populations; suggesting that impact may be even greater as the models take traction across all groups over a five-year timeline.

Projected savings numbers used for analyses were based on case studies for population- and episode-based models as well as data sources (including benchmarks) and experiences in other states and projects.

Some of the relevant case studies for the PCMH model include:

- Group Health pursued two initiatives, Seattle and Puget Sound. Seattle, which targeted all insured populations and covered 600,000 residents, achieved a 150 percent ROI. Puget Sound covered 580,000 residents and achieved eight percent total savings.
- Community Care of North Carolina, which implemented a Medicaid-centric PCMH model covering 60 percent of its insured lives, has already captured $300 million in utilization management savings.

Episode-based case studies and research include:

- An Agency for Healthcare Research and Quality (AHRQ) report examined 58 episode-based payment models and found that the models could potentially offer total savings of up to ten percent of total health costs.
- Geisinger ProvenCare implemented an initiative that covered 210,000 enrollees; it also reduced readmissions and utilization while improving compliance by nearly 70 percent within 18 months of program launch.

- Arkansas, with CMS funding, is implementing a statewide episode payment initiative that is projected to save the state between 6.5-13.5 percent of its total health system spending over the first seven years of implementation.

Sustaining the model over time

Ohio and its payers and providers have already started to demonstrate the commitment needed to sustain these models in the longer-term. The multitude of innovations, both regional and statewide, and the substantial capital investments payers and providers are making will not only sustain but also expand Ohio's shift to the value-based payment models. These investments also reflect payers' and providers' willingness to adopt value-based payment and align their incentives with the delivery of cost-effective, patient-centered care. We expect such payer and provider investments to continue past the funding period of three to five years.

Ohio's commitment to the proposed models will not end after they reach scale in five years – it will continue indefinitely. The PCMH and episode-based models will continue to expand over time. The models' payment design, which are complementary to existing payment systems, means that the PCMH and episode models can be implemented quickly and flexibly for as long as the rollout lasts. They will also be adaptable in the long-term as changes occur in Ohio's payer and provider landscape.

I. Evaluation plans

Evaluation and identification of data sources

Ohio will evaluate the impact of PCMH and episode-based payment in improving health care quality, enhancing patient care and lowering health care spend by rigorously examining three key areas:

- Track program goals for reaching scale in PCMH and episodes,
- Measure outcomes related to achieving improvement in health system transformation, and
- Monitor effectiveness of stakeholder engagement.

Monitoring these measures closely and adjusting course when needed will help ensure that the plan's execution stays on track, that the desired health care payment innovation goals are achieved and that the experiences of affected patients, payers and providers are constantly considered.

Program goals

Tracking each of the components of the overall reform plan against its established targets will help ensure their successful integration. The metrics and data sources below focus on the four components.

Table 4. Evaluation Plan Program Goals.

Component	Metric	Data Source
Episodes	▪ Number of episodes implemented over time	▪ Reporting from multi-payer coalition
PCMH	▪ Number of providers participating in the model ▪ Percent of beneficiaries attributed to a PCMH	▪ Reporting from multi-payer coalition
Infrastructure	▪ Percent of providers with portal log-on information ▪ Percent of providers accessing reports	▪ Statistics from provider portal ▪ Reporting from multi-payer coalition
Workforce	▪ Launch of initiatives in the OHT Health Sector Workforce Programs white paper ▪ Filled gaps/met needs for the health care workforce	▪ Health professions licensure board data ▪ Board of Regents/educational data and state workforce modeling

Outcomes

As new payment models are implemented, the state will track their progress toward improved quality, better population health and lower costs. It will examine four types of metrics related to each payment model:

- Quality of care,
- Population health,
- Savings targets, and
- System monitoring.

Table 5. Evaluation Plan Outcome Metrics.

Program outcome	Metric	Data source
Quality ▪ Episodes ▪ PCMH	▪ Rates of certain screenings or tests ▪ Rates of follow-up visits ▪ Key prescription rates ▪ Rates of adverse events ▪ ED utilization ▪ Inpatient readmits ▪ Generic prescription sales ▪ Key prescriptions ▪ Rates of adverse events	▪ Payer and provider data
Population health	▪ Comm. Health referral utilization and completion ▪ Outcomes associated with engagement ▪ CMMI core measures	▪ Payer, provider data ▪ CMS and Health Policy Institute of Ohio (HPIO) data ▪ Research partners
Savings targets ▪ Episodes ▪ PCMH	▪ Costs for episodes ▪ Total cost of care	▪ Payer, provider data ▪ CMS
System monitoring	▪ Instances of program avoidance	▪ Payer, provider data ▪ CMS

Stakeholder engagement

The state will continue gathering the input of patients, purchasers, payers and providers about their individual experiences and practices as it implements the new models. By doing so, Ohio can monitor the effect of the plan on those most directly impacted by it.

Ohio will deploy many of the same techniques used in the model design stage to gather feedback on the process. Consumer focus groups and public meetings that align with program rollout will help Ohio understand patient experiences

and check for any unintended consequences. The state will also explore methods to perform regular assessments of provider and payer customer satisfaction data to round out the program evaluation efforts.

Continuous improvement

Ohio will partner with an independent, credible research group to ensure that its health care delivery system undergoes continuous improvement and evaluation, particularly around Medicaid and CHIP. This partner would be responsible for objectively and consistently collecting and analyzing quantitative and qualitative data and setting and refining benchmarks at different times. They would also use this information to identify and report trends that help the state assess its performance and consider its policies.

The partner will have extensive knowledge of Ohio's situation and of payment innovation; ideally, it will be located in state. To carry out the duties outlined above, it needs to be able to access data from multiple sources (e.g., various commercial payers), perform advanced analytics and generate sophisticated reports and act as a trusted, independent resource for payers, providers and consumers.

The state will review solicit and review proposals from local organizations (e.g., academic institutions, research organization, nonprofits, IT firms) in order to select an appropriate partner. Together they will develop the detailed plan for executing an effective performance measurement program. As part of this program, the state will outline a potential plan. and identify a plan for sharing performance reports with key stakeholders (including CMS, providers, payers, purchasers and patients).

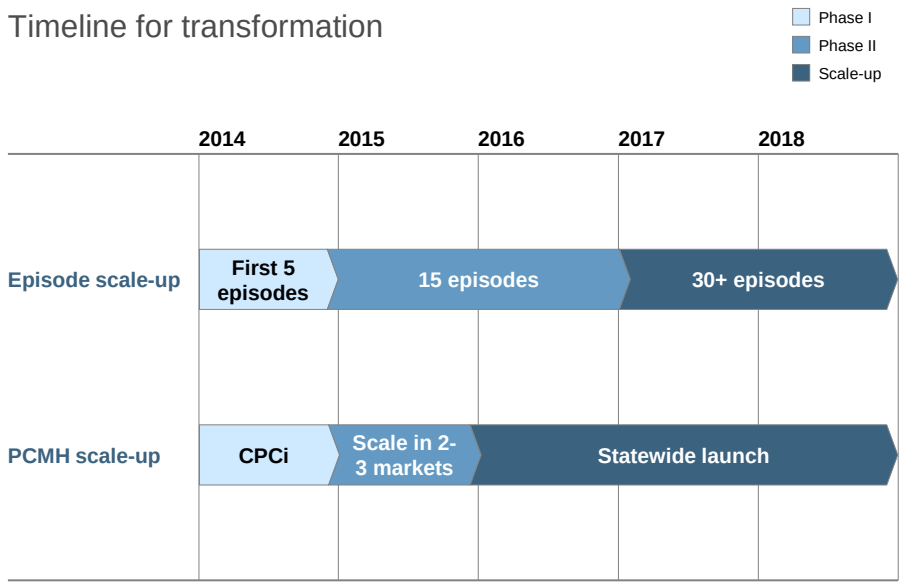
J. Roadmap for health system transformation

Timeline for transformation

Over the next five years, Ohio has set a goal to transform the state's health care system through rapidly scaling the use of PCMH and episode-based payment and care delivery models. Through a combination of episodes- and population-based payment, 80-90 percent of Ohio's population will be in some value-based payment model within five years.

In reaching these goals, the models will be launched in three phases over the next five years:

EXHIBIT 18



- **Phase I *(Year 1)*** – The first six months will involve: (a) detailed design of five episodes including perinatal, asthma, COPD, PCI and joint replacement; (b) rapid-cycle implementation of the basic capabilities necessary to support the launch of the initial wave(s) of both the PCMH and the episode-based payment models defined in the design phase of the initiative; and (c) initiation of development of the long-term, scalable infrastructure and processes necessary to support scale-up of the new models across the substantial majority of primary care providers and episodes. In the second half of the first year, the state and multi-payer coalition (ideally with Medicare participation) will launch reporting on at least three of five episodes and tie to payment

within a year. As it relates to PCMH, the state and multi-payer coalition will focus on the CPC initiative and begin enrollment strategy for one additional market.

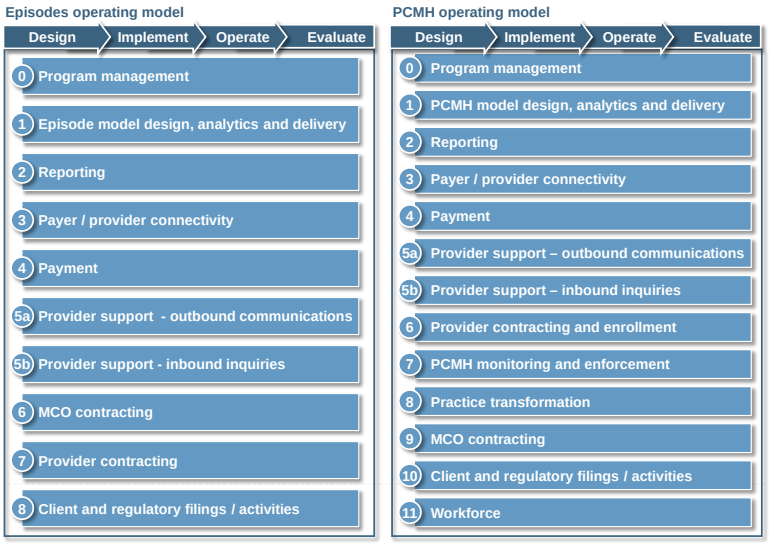
- **Phase II *(Years 2-3)*** – Years 2-3 involve the continued launch of the new payment models and further development of the supporting infrastructure for PCMH and episodes. By year three, the PCMH model will be rolled out to all major markets across the state, including the majority of primary care providers, covering 50 percent of patients. By this time, the state will have also defined and launched no less than 20 episodes across payers (15 additional from Phase I). Additionally, the state will implement provider engagement strategies to support provider understanding of performance data and adoption of new clinical practice patterns. This will include collecting and operationalizing provider feedback processes to refine and improve both the technical design of the new payment models as well as the supporting infrastructure. Lastly, the state will continue to complete implementation of the infrastructure required to support scale-up of the new payment models.
- **Scale-up *(Years 3-5)*** – Over the course of the third through fifth years of the transformation roadmap, the state will implement patient-centered medical homes and episode-based payments statewide. By year five, the PCMH model will achieve full, statewide scale sufficient to create total cost of care accountability for 80 percent of the Ohio population. Concurrently, Ohio will have defined and launched more than 50 episodes across payers.

Milestones and opportunities

In addition to the timeline outlined above, the State of Ohio has also developed a detailed operating model for both PCMH and episodes that defines how the state will work to achieve the strategic goals of each model. Exhibit 19 below describes the key elements of each operating model.

EXHIBIT 19

Episodes and PCMH operating models



Having defined the key elements of each operating model the state then detailed the key activities, processes and milestones required to successfully reach the goal of covering 80-90 percent of Ohio's population in some value-based payment model within five years. From start to finish, Ohio identified four stages of work that applied to each element of the operating models. These stages include: design, implement, operate and; evaluate and improve.

Each of the operating models, including key activities and milestones across each stage of work, is described in further detail below:

EXHIBIT 20

Episode operating model

	Design	Implement	Operate	Evaluate & improve
1 Episode model design, analytics and delivery	▪ Select and determine launch sequencing ▪ Develop base definition: trigger, inclusions, risk adjustment, etc. ▪ Customize model: patient exclusions, stop loss, normalization, etc. ▪ Define quality metrics ▪ Execute thresholding	▪ Build analytics engine/ capabilities ▪ Define/QA production algorithms	▪ Gather/integrate all claims and non-claims (e.g., portal) data ▪ Execute production of episodes	▪ Maintain and update base definition ▪ Manage program evaluation: actuarial, economic, clinical, etc. ▪ Report on program impact ▪ Refinements/additions to algorithms ▪ Define/execute refinements
2 Reporting	▪ Design report templates ▪ Develop strategy to gather non-claims data, if any	▪ Develop/purchase reporting software	▪ Gather data ▪ Generate reports	▪ Execute refinements/additions to reports
3 Payer / provider connectivity	▪ Develop approach for report generation / quality metric entry	▪ Build/modify "portal"	▪ Distribute reports ▪ Capture, store and transmit clinical data to analytics engine	▪ Monitor and report on provider utilization / report viewing
4 Payment	▪ Define consistent payment approach (e.g. withhold approach)	▪ Develop API to payment systems ▪ Modify system to issue bonus checks or "withholds"	▪ Distribute and account for bonus payment or risk ▪ Regularly audit/reconcile payments	▪ Manage updates /modifications to payment system resulting from changes to payment model
5a Provider support - outbound	▪ Design general provider education/engagement strategy and approach for outbound support	▪ Develop/obtain provider education material, videos, curriculum, etc.	▪ Distribute education materials ▪ Engage/consult to individual providers	▪ Update and advance provider education / engagement strategy and marketing materials
5b Provider support - inbound	▪ Develop approach and capabilities to respond to provider inquiries	▪ Train staff to answer inbound provider inquiries ▪ Modify current provider appeals process, if needed	▪ Field inbound provider inquiries, episode design inquiries and appeals	▪ Update and advance training materials based on changes to payment model, reporting and/or payments
6 MCO contracting	▪ Develop MCO/contracting strategy/ approach	▪ Execute MCO re-contracting/addendums	▪ Manage amendment process, as needed	▪ Monitor program integrity ▪ Manage re-contracting process
7 Provider contracting	▪ Develop provider contracting strategy/approach	▪ Execute provider re-contracting/addendums	▪ Manage amendment process, as needed	▪ Manage re-contracting process
8 Client & regulatory filings / activities	▪ Develop regulatory strategy/approach ▪ Develop ASO contracting strategy/approach	▪ Execute regulatory approval (SPA, promulgation, etc.) ▪ Execute ASO re-contracting/addendums	▪ Monitor changes to payment model /incentives to ensure all changes fall within previously approved filings	▪ Initiate and execute new regulatory approval process, as needed based on changes to payment model

EXHIBIT 21

PCMH operating model – (1/2)

	Design	Implement	Operate	Evaluate & improve
1 PCMH model design, analytics and delivery	▪ Define attribution methodology & approach ▪ Define quality metrics to be tracked and/or reported by PCMHs ▪ Define principles of payment/incentives including: shared savings, risk-adjustment, TCOC & approach to pooling	▪ Build analytics engine/ capabilities ▪ Define/QA PCMH analytics production including: total-cost-of-care calculation, risk adjustment, risk stratification and attribution	▪ Gather/integrate all claims and non-claims data (e.g., portal, quality metrics, etc.) ▪ Execute production of PCMH analytics	▪ Maintain and update principles of payment/incentives ▪ Manage program evaluation: actuarial, economic, clinical, etc. ▪ Report on program impact
2 Reporting	▪ Design report templates ▪ Develop strategy to gather non-claims data, if any ▪ Define reporting approach for pooled providers	▪ Develop/purchase reporting software	▪ Gather data ▪ Generate reports	▪ Execute refinements/ additions to reports ▪ Look for ways to automate capture of clinical data (e.g., connection to HIE)
3 Payer / provider connectivity	▪ Develop approach for report generation / quality metric entry	▪ Build/modify "portal"	▪ Distribute reports ▪ Capture, store and transmit clinical data to analytics engine	▪ Monitor and report on provider utilization / report viewing
4 Payment	▪ Define consistent payment approach (e.g. withhold approach)	▪ Develop API to payment systems ▪ Modify system to issue bonus checks	▪ Distribute and account for bonus payment ▪ Regularly audit/reconcile payments	▪ Manage updates/modifications to payment system resulting from updates to principles of payment / incentives
5a Provider support - outbound	▪ Design approach for outbound engagement and clinical leadership	▪ Develop/obtain provider education material, videos, curriculum, etc.	▪ Distribute education materials ▪ Engage/consult to individual providers	▪ Update provider education / engagement strategy and marketing materials
5b Provider support – inbound	▪ Develop approach and capabilities to respond to provider inquiries ▪ Develop process for providers to appeal attribution	▪ Train staff to answer inbound provider inquiries ▪ Modify current provider appeals process, if needed	▪ Field inbound provider inquiries, episode design inquiries and appeals	▪ Update and advance relevant training materials based on changes to payment model, reporting, and /or payments

EXHIBIT 22

PCMH operating model – (2/2)

	Design	Implement	Operate	Evaluate & improve
6 Provider enrollment and contracting	▪ Develop strategy/approach for provider recruitment & enrollment ▪ Define PCMH technical requirements & qualifications ▪ Develop strategy/approach for provider contracting ▪ Develop plan for scale-up	▪ Execute provider recruitment strategy ▪ Build / modify infrastructure for provider to enroll and qualify as a PCMH ▪ Execute provider re-contracting/addendums	▪ Roll-out PCMH across state and execute scale-up plan ▪ Qualify, enroll and contract with new PCMHs on an ongoing basis, as needed ▪ Revisit and/or amend contracts regularly based on monitoring and enforcement mechanism	▪ Manage re-contracting process
7 PCMH monitoring and enforcement	▪ Develop strategy/approach for verifying and enforcing technical requirements and milestones post enrollment	▪ Monitor provider eligibility and compliance with PCMH technical requirements and milestones	▪ Develop performance improvement plans and/or expel practices that do not comply with eligibility and technical requirements	▪ Manage re-certification process
8 Practice transforma-tion	▪ Define role of payer in providing both one-time and on-going support for practice transformation	▪ Provide support & training to transform practices' business / administrative functions ▪ Provide support & training to ensure successful implementation of care coordination efforts	▪ Provide ongoing support to practices as necessary and/or deemed appropriate ▪ Convene and collaborate with multi-payer group to ease implementation and minimize administrative burden for providers	▪ Report on efficacy of practice transformation efforts ▪ Share best practices for successful practice transformation
9 MCO contracting	▪ Develop MCO/contracting strategy/ approach	▪ Execute MCO re-contracting/addendums	▪ Manage amendment process, as needed	▪ Monitor program integrity ▪ Manage re-contracting process
10 Client & regulatory filings / activities	▪ Develop regulatory strategy/approach ▪ Develop ASO contracting strategy/approach	▪ Execute regulatory approval (SPA, waiver, rule change, etc.) ▪ Execute ASO re-contracting/addendums	▪ Monitor changes to payment model /incentives to ensure all changes fall within previously approved filings	▪ Initiate and execute new regulatory approval process, as needed based on changes to payment model / incentives
11 Workforce	▪ Define workforce needs to support success of PCMH model ▪ Integrate PCMH workforce needs into ODH's Ohio Primary Care Workforce Plan (OPCWP)	▪ Implement initiatives in OPCWP and integrate with efforts aimed at transforming care delivery system	▪ Collaborate with OWT to coordinate workforce efforts across 16 state agencies	▪ Report on program impact ▪ Examine status of primary care workforce to determine if additional and supplemental action is required