



Governor's Office of
Health Transformation

State Innovation Models Round 2 Model Test: Ohio Operational Plan

UPDATED DECEMBER 16, 2015

Project Summary

Ohio's health care delivery system, like the nation's, is fragmented in ways that lead to disrupted relationships, poor information flows, and misaligned incentives. As a result, nearly 30 percent of all health care spending is wasted (IOM 2009) and Americans receive only 55 percent of recommended treatments for preventive, acute, and chronic care (NEJM 2003).

As a result of the State Innovation Model (SIM) design process, Ohio achieved multi-payer agreement across Medicaid, state employee, and commercial health plans to launch episode-based payments statewide in November 2014, and to adapt Southwest Ohio's Comprehensive Primary Care Initiative (CPCI) for a statewide roll-out of patient-centered medical homes (PCMH). Together these models reset the basic rules of health care competition so the incentive is to deliver better care and keep people as healthy as possible.

The Governor's Office of Health Transformation manages the SIM test for the state. The Governor's Advisory Council on Payment Innovation, which represents purchasers, plans, providers, and consumers, aligns public and private payment innovation priorities. A multi-payer Core Team (Aetna, Anthem, Buckeye, CareSource, Medical Mutual, Molina, Paramount, United and Medicaid) oversees implementation of the PCMH and episode models.

Through these efforts, Ohio aims to enroll 80-90 percent of the state's population (10.1 million Americans) in some value-based payment model (combination of episode- and population-based payments) within the four-year grant period. By the end of the grant period, Ohio's goal is to launch up to 50 episodes in a multi-payer environment and enroll 80 percent of Ohio's population in PCMH care delivery and payment models statewide.

Governor's Office of Health Transformation

5-Year Goal for Payment Innovation

Goal	80-90 percent of Ohio's population in some value-based payment model (combination of episodes- and population-based payment) within five years
State's Role	<ul style="list-style-type: none"> ▪ Shift rapidly to PCMH and episode model in Medicaid fee-for-service ▪ Require Medicaid MCO partners to participate and implement ▪ Incorporate into contracts of MCOs for state employee benefit program

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

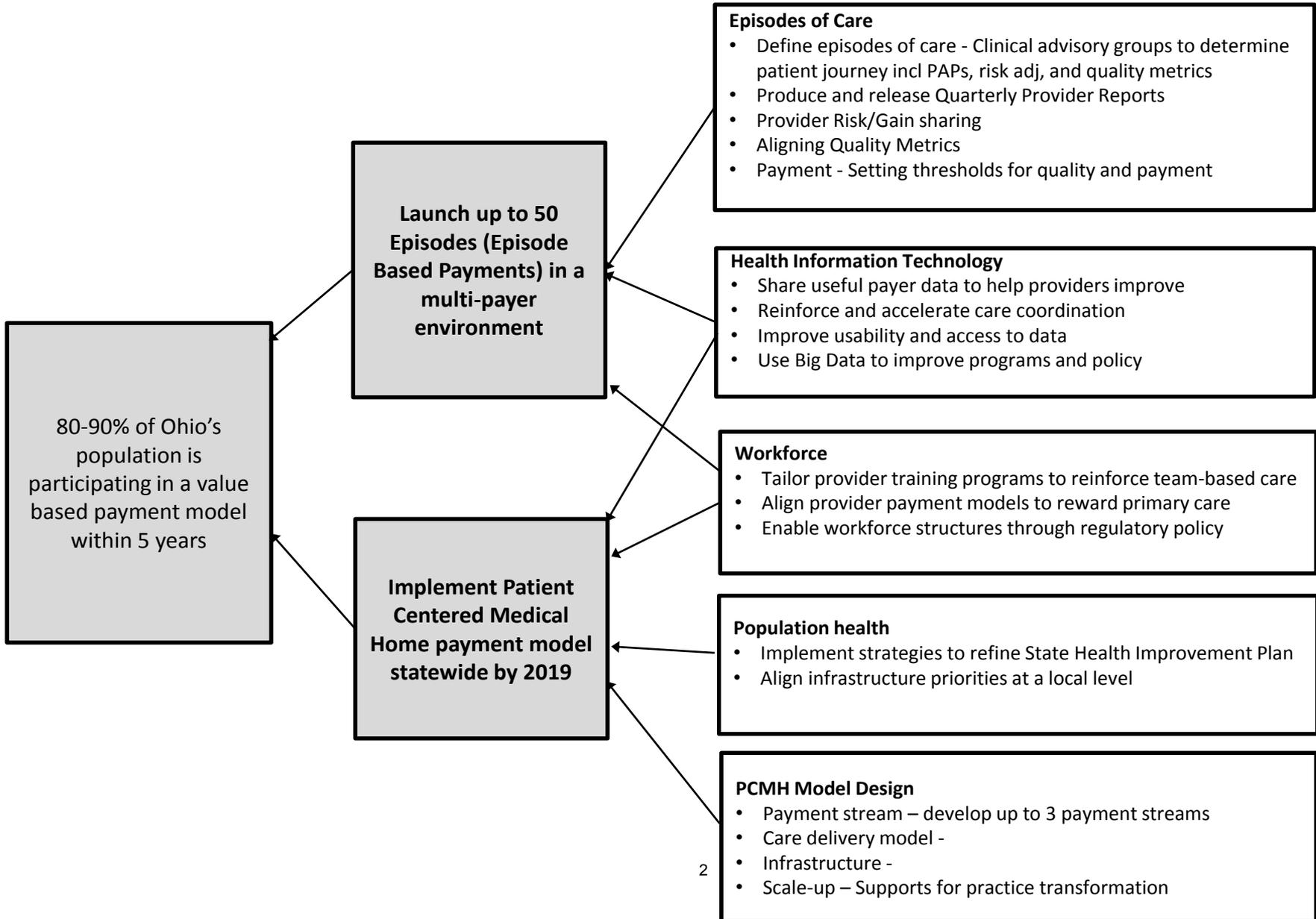
updated August 27, 2015

Key Driver Diagram: SIM

Aim

Key Drivers

Secondary Drivers



SIM Component/Project Implementation Gantt Chart (Year 1)																			
SIM Component/Project Area	Project Lead	Pre-Imp Year				Year 1				Year 2				Year 3				Milestone(s) with Due Dates	
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4		
Episode Based Payments - Wave 1																			
Provider Reports on 6 episodes	ODM	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	Quarterly Ongoing	
Detailed Business Requirements Development/Updates	ODM	■	■	■	■													as needed	
Thresholding Evaluation	ODM		■	■	■													complete	
Report Development	ODM		■	■	■													complete	
Stakeholder engagement	OHT	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	ongoing	
OAC rule changes	ODM		■	■	■													4/30/2016	
State plan amendment	ODM																	Submit Q1 2016	
payment	ODM											■	■			■	■	first payment in Q3 2017	
Episode Based Payments - Wave 2																			
Diagnostic/Episode Selection	ODM/OHT	■	■	■	■													complete	
Clinical Advisory Groups	ODM		■	■	■													complete	
Detailed Business Requirements Development/Updates	ODM		■	■	■			■	■									IC-10 updates in 2016	
Provider Reports on 7 episodes	ODM					■	■	■	■	■	■	■	■	■	■	■	■	quarterly ongoing	
Thresholding	ODM																	Q3	
Stakeholder engagement	OHT/ODM		■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	ongoing	
payment	ODM																■	first payment Q3 2018	
Episode Based Payments - Wave 3																			
Diagnostic/Episode Selection	ODM/MHAS/OHT					■	■	■	■									Q1 BH and medical episodes	
Clinical Advisory Groups	ODM/MHAS					■	■	■	■									complete Q2	
Detailed Business Requirements Development/Updates	ODM							■	■			■	■					Build by Q3 and updates as needed	
Provider reports	ODM									■	■	■	■	■	■	■	■	start Q1 2018	
Thresholding	ODM											■	■					2017	
Stakeholder engagement	OHT/ODM					■	■	■	■	■	■	■	■	■	■	■	■	ongoing	
Episode Based Payments - Wave 4																			
Diagnostic/Episode Selection	ODM/OHT									■	■	■	■					TBD	
Clinical Advisory Groups	ODM									■	■	■	■					TBD	
Detailed Business Requirements Development/Updates	ODM											■	■					TBD	
Provider Reports on 7 episodes	ODM													■	■	■	■	TBD	
Thresholding	ODM													■	■	■	■	TBD	
Stakeholder engagement	OHT/ODM									■	■	■	■	■	■	■	■	TBD	

Patient Centered Medical Homes																		
Diagnostic/Care Delivery Model Design	OHT/ODM																	complete
Payment model design	ODM/OHT																	Q2 2016
Enrollment	ODM																	annually Q3
Develop provider reports	ODM																	Q2 2016
Thresholding	ODM																	Q4 2016
Provider Reports	ODM																	Q2 2017
Practice Support/Provider Engagement																		TBD
Activities Payment	ODM																	TBD
Practice Transformation Payment	ODM																	TBD
Outcome-based payment	ODM																	TBD
stakeholder engagement	OHT																	ongoing
OAC rule changes	ODM																	6/30/2016
State plan amendment	ODM																	submit Q2 2016

2016 Operational Plan

Project Overview

Ohioans spend more per person on health care than residents in all but 17 states (CMS 2012) but higher spending does not correlate to better value – 41 states have a healthier population than Ohio (CMWF 2014). Ohio’s predominantly FFS system encourages providers to deliver more care instead of better care. Despite broad agreement FFS should be abandoned, finding an alternative is challenging, particularly in a state as diverse as Ohio, with 11.5 million residents in seven metropolitan areas and 50 rural counties, no health plan with more than 20 percent market share, and multiple competing health systems within seven regional markets. This diversity is what makes Ohio a go-to state for consumer research companies to test new products – and why it is an ideal state to test innovative payment and service delivery models.

In 2011, Ohio Governor John Kasich issued an Executive Order to “engage private sector partners to set clear expectations for better health, better care, and cost savings through improvement.” He instructed the Office of Health Transformation to reset the basic rules of health care competition so the incentive is to keep people as healthy as possible, pay for what works to improve and maintain health, and shift from FFS to population- and value-based payments that reward patient-centered care coordination and better health outcomes.

For SIM, the State of Ohio, along with its Medicaid managed care plans (Buckeye, CareSource, Molina, Paramount, and UnitedHealthcare) and a multi-payer coalition that includes four private payers with 80 percent of the commercial market (Aetna, Anthem, Medical Mutual, and UnitedHealthcare) are launching two models statewide: a patient-centered medical home (PCMH) model and an episode-based payment model. After four years, the PCMH and episode models together will cover 50-60 percent of the state’s medical spend and expect at scale, will cover 80 percent of medical spend and 80-90 percent of Ohio’s total population.

Patient-Centered Medical Home Model. PCMHs 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, as well as total cost and quality. PCMHs help manage patients’ overall care, ensuring they receive timely, high-quality, cost-effective care tailored to their specific needs that goes beyond today’s fragmented, visit-focused approach. PCMHs engage patients to maintain health and wellness, reduce health costs by managing chronic conditions, and prevent unnecessary emergency department visits and admissions.

During SIM Design, Ohio’s multi-payer coalition created a [PCMH Charter](#) outlining desired levels of payer alignment across four elements of the PCMH model: care delivery (target patients, care delivery improvements, target sources of value), payment model (technical requirements, attribution, quality measures, payment incentives, patient incentives), infrastructure (technology, data systems, and people to administer the model), and scale-up and

practice performance improvement (support, resources and activities to enable practices to adopt and sustain the PCMH model). Payers agreed to align in principle on the four elements of the model but will implement their own specific designs.

In 2015, payers along with providers, population health experts, and patient advocates participated in detailing the PCMH model. Overall, the proposed PCMH model is designed to be flexible and able to meet the different needs of different types of providers and geographies (e.g., rural, urban, underserved areas) as well as encourage participation by as many practices and patients as possible. This goal of inclusiveness is reflected in the proposed care delivery model, which outlines transformation to a PCMH for both the least advanced and most advanced practices, and the payment model, which allows all practices—regardless of current level of performance—access to the payment model.

On December 14, 2015, OHT and ODM made a decision to accelerate the timeframe originally proposed for the PCMH Model Test implementation and instead of a three-year regional roll-out, implement the PCMH model statewide in 2016. Given the diverse provider environment and the goal to include as many practices as possible, Ohio is considering the best way to provide targeted capability-building support (“Practice transformation”) to some providers for a limited time to serve as temporary support for the initial investments required to begin the path to becoming a PCMH. As model design details are confirmed, PCMH implementation processes will be decided.

Episode-Based Payment Model. The episode-based payment model encourages high-quality, patient-centered, cost-effective care by holding a single provider or entity accountable (Principle Accountable Provider, or PAP) for care across all services in a specific episode. It aligns provider incentives to 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 an episode of care rather than simply focusing on specific visits or procedures.

For SIM, Ohio’s multi-payer coalition created an [Episode-Based Payment Charter](#) outlining desired levels of payer alignment across four elements of the Ohio episode model: (1) accountability (PAP, cost normalization), (2) payment model (retrospective design, payment incentives, quality measures), (3) performance management (gain sharing, risk adjustment, exclusions), and (4) timing (reporting period, synchronizing performance periods). From October 2013 to May 2014, the multi-payer coalition, with extensive provider input, completed six [episode definitions](#) on which the state began reporting in March of 2015. Calendar year 2016 marks the first performance period for the first six episodes meaning that episodes ending during that timeframe will be used to determine whether or not a provider receives a positive or negative incentive. This past year, Ohio designed 7 additional episodes. Reporting for this second set of episodes will begin in early 2016. In 2016, Ohio will design a new wave of episodes that will include both behavioral and physical health journeys.

Linkages between PCMH and episode-based models. PCMH and episode-based payment models are more powerful in combination. Medical homes provide the foundation for total cost and quality accountability, while episodes create joint accountability for total cost of care across providers by increasing coordination for specific, defined procedures or chronic acute exacerbations. 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 incented to work with episode accountable providers to increase quality and manage costs, as well as community-based and public health resources to address social determinants of health. Episodes extend incentives to improve cost and quality to specialists and hospitals responsible for managing specific medical events, defined procedures, or acute exacerbations of chronic conditions. Both models allow a portion of any savings generated be reinvested in infrastructure (e.g., HIT), practice transformation, and meaningful patient education and engagement.

Importantly, the PCMH and episode models leave enough room for variation to stimulate innovation among payers and providers that want to refine the model for competitive advantage. They do not preclude payers and providers from moving faster to more integrated total cost of care models (e.g., ACOs), and actually complement the transformation by aligning incentives and providing actionable performance data. In particular, these models can potentially accelerate improved outcomes through Accountable Care Communities, CMS Bundled Payments for Care Improvement, Medicare Shared Savings Programs, and the Medicare-Medicaid Financial Alignment Program. For providers not yet ready to fully transition to an ACO model, the PCMH and episode models serve as "building blocks" to develop the systems and capabilities necessary to support more integrated care models.

1. SIM Governance, Management Structure and Decision-making Authority

Governor Kasich made strengthening health care in Ohio one of his top priorities and created the Office of Health Transformation (OHT) in 2011 to pursue 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 produced widespread momentum among the government, consumer advocates, payers, physicians, hospitals, communities and other stakeholders, and provided a strong basis for collaboration through SIM.

In the most recent biennial budget signed by Governor Kasich in June 2015, there is a provision in Ohio Revised Code 5167.33 that requires the Medicaid managed care plans (MCPs) to implement 50 percent of payments as value based by 2020. The language codifies the authority for the ODM Director to adopt rules to implement this provision including rules that specify the following: (1) The value received from a provider's services; (2) A provider's success in reducing waste in the provision of services; (3) The percentage of a Medicaid MCPs aggregate net payments to providers that are based on the value received from the providers' services.

SIM state leadership is organized through the SIM Directors Group, including leaders of OHT, the Ohio Department of Medicaid (ODM), the Ohio Department of Health (ODH) and the Ohio Department of Mental Health and Addiction Services (MHAS). OHT leads Ohio's SIM initiative, providing overall oversight on behalf of the Governor. OHT convenes state agencies and multi-stakeholder teams, provides coordination across related state health initiatives, and sets healthcare regulatory and budgetary priorities for the Governor's office. ODM is responsible for the development, implementation and operation of the Medicaid episode and PCMH models (both for FFS and managed care plans). This role is critical to move this population into value-based models and to catalyze similar efforts in the private sector as the state leads by example. ODM administers the SIM Model Test funding. ODH connects the SIM efforts to other population health strategies and leads many of the state's ongoing PCMH efforts while MHAS connects these efforts as a track of work in the state's behavioral health redesign initiative.

Key personnel from these offices and agencies are listed below. The SIM initiative is a top priority for OHT, and the team dedicates about 80 percent of its time to this effort. ODM is deeply involved in building payment models for episode based payments and patient centered medical homes. The work of all Medicaid employees includes components of SIM, with 30 percent of time, on average dedicated to this initiative. There have been 5 trainings for all ODM staff to learn more about this effort, a webinar has been recorded for staff to learn more at their convenience, and ODM will continue to provide updates to staff on a regular bases. Further an additional 50 ODM staff representing fiscal, research, legal, policy, legislation, communications and managed care are engaged in operationalizing the two payment models.

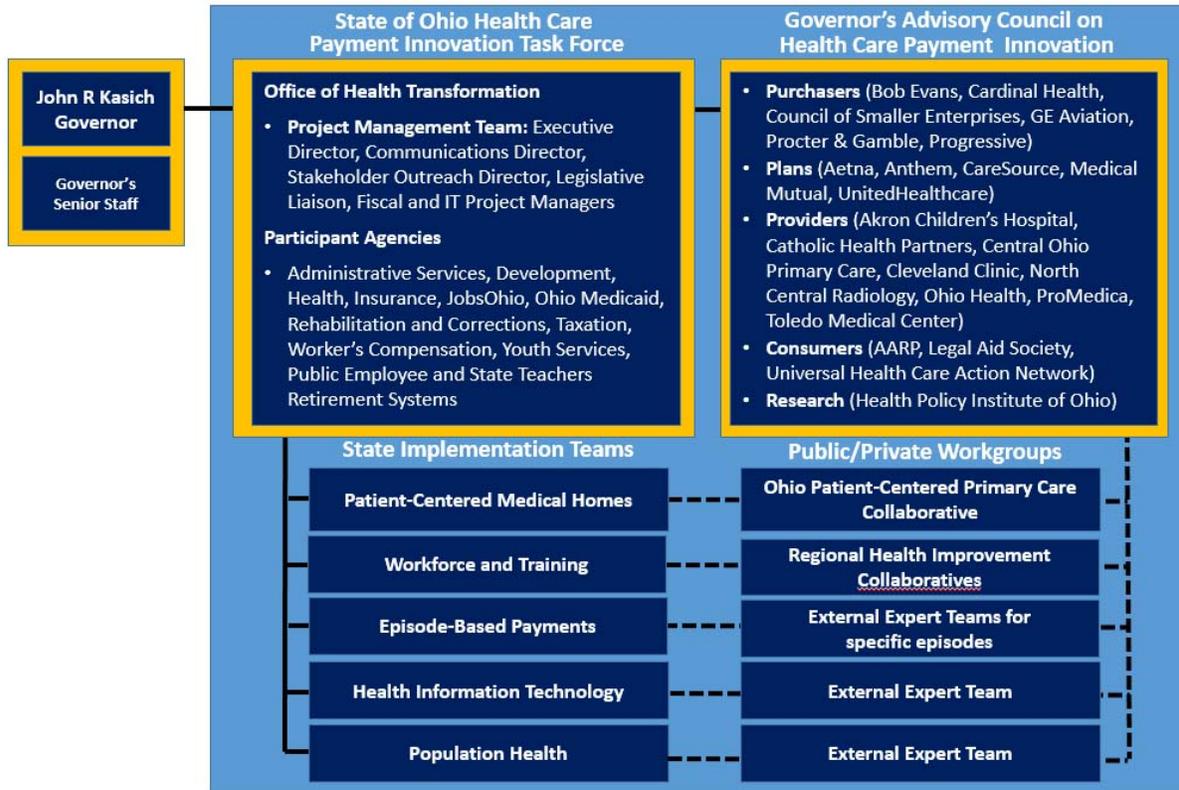
In addition, the Department of Administrative Services is represented on the SIM core team, providing connections for the extension of SIM models to state employee plans and to statewide data and IT initiatives.

Key State Personnel

SIM Component/Project Area Key Staff Directory					
SIM Component/Project Area	Component/Project Lead			Contact Information	
	Position/Title	First Name	Last Name	Phone Number	Email Address
Governor's Office of Health Transformation	Director	Greg	Moody	614-752-2784	greg.moody@governor.ohio.gov
Governor's Office of Health Transformation	Director of Stakeholder Relations	Monica	Juenger	614-752-2784	monica.juenger@governor.ohio.gov
Governor's Office of Health Transformation	Portfolio Manager	Rex	Plouck	614-752-2784	rex.e.plouck@governor.ohio.gov
Governor's Office of Health Transformation	Office Manager	Theresa	Hatton	614-752-2784	theresa.hatton@governor.ohio.gov
Ohio Department of Medicaid	Director	John	McCarthy	614-752-3786	john.mccarthy@medicaid.ohio.gov
Ohio Department of Medicaid	Medical Director	Mary	Applegate	614-752-3786	mary.applegate@medicaid.ohio.gov
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Ohio Department of Medicaid	Innovation Development and Payment Reform	Karin	Hoyt	614-752-5044	karin.hoyt@medicaid.ohio.gov
Ohio Department of Medicaid	Chief of Staff	Jennifer	Demory	614-752-3786	Jennifer.demory@medicaid.ohio.gov
Ohio Department of Medicaid	Chief Operating Officer	Roger	Fouts	614-752-3786	roger.fouts@medicaid.ohio.gov
Ohio Department of Medicaid	Chief Financial Officer	Michelle	Horn	614-752-3786	michelle.horn@medicaid.ohio.gov
Ohio Department of Medicaid	Chief Legal Counsel	Brianne	Brown	614-752-3786	brianne.brown@medicaid.ohio.gov
Ohio Department of Health	Director	Richard	Hodges	614-752-9452	rick.hodges@odh.ohio.gov
Ohio Department of Health	Medical Director	Mary	Diorio	614-752-9452	Mary.Diorio@odh.ohio.gov
Ohio Department of Health	Chief Legal Counsel	Lance	Himes	614-752-9452	Lance.Himes@odh.ohio.gov
Ohio Department of Health	Deputy Director	Brandi	Robinson	614-752-9452	Brandi.Robinson@odh.ohio.gov
Ohio Department of Mental Health & Addiction Services	Director	Tracy	Plouck	614-466-2337	Tracy.Plouck@mha.ohio.gov
Ohio Department of Mental Health & Addiction Services	Assistant Director	Angie	Bergefurd	614-466-2337	Angie.Bergefurd@mha.ohio.gov
Ohio Department of Administrative Services	State CIO	Stu	Davis	614-644-6446	Stu.Davis@das.ohio.gov
Ohio Department of Administrative Services	Fiscal Specialist	Kevin	Binckerhoff	614-466-2942	Kevin.Brinckerhoff@das.ohio.gov
Ohio Department of Insurance	Assistant Director of Health Policy	Carrie	Haughawout	614-728-1015	carrie.haughawout@insurance.ohio.gov
McKinsey & Co	Consultant	Brendan	Buescher	216-274 4000	brendan_buescher@mckinsey.com
McKinsey & Co	Consultant	Tom	Latkovic	216-274 4000	thomas_latkovic@mckinsey.com
McKinsey & Co	Consultant	Adi	Kumar	216-274 4000	adi_kumar@mckinsey.com
McKinsey & Co	Consultant	Bryony	Winn	216-274 4000	bryony_winn@mckinsey.com

Further, the State of Ohio, through two separate procurement processes has contracted with McKinsey and Company to assist the State with the development of its episode based payment and patient centered medical home models.

The state's private sector partners play critical leadership roles in SIM through participation in the Governor's Advisory Council on Payment Innovation, the multi-payer SIM core team, and the SIM episodes and PCMH planning teams. These stakeholders are committing substantial time and resources to participate in the SIM process. In particular, the participating payers (both commercial and managed Medicaid) are investing in the technology and other infrastructure to implement and operate the SIM models. The next chart demonstrates the number of organizations involved as well as the infrastructure for model development with stakeholders.



2. Stakeholder Engagement

The challenge engaging stakeholders in health reform is that many see themselves as victims within a system where they have lost control. Health care purchasers, payers, providers and patients tend to blame each other, even as they themselves make decisions that run counter to better health. At the root of this conflict is the financial incentive to provide more care and more expensive care instead of preventing illness and injury before they occur and providing better care with improved health outcomes.

Ohio's approach to stakeholder engagement is grounded in the belief that we all share responsibility in what has gone wrong with the health care system, which means we all have a role in making it better. The purpose of stakeholder engagement is to give voice to diverse views, build trust, and create an environment where constructive disruption in the status quo is understood in the broader context of improving overall population health outcomes.

Since 2011, OHT has engaged many diverse stakeholders in the design, implementation, and ultimate participation in multiple new models of care. Ohio's decision to expand Medicaid, for example, triggered the formation of an unprecedented grass-roots coalition of stakeholders spanning chambers of commerce, faith-based organizations, consumer advocacy groups, local governments, and health care providers and systems. OHT relies on this large, well-organized coalition to quickly share information and seek feedback on emerging policy priorities, like SIM.

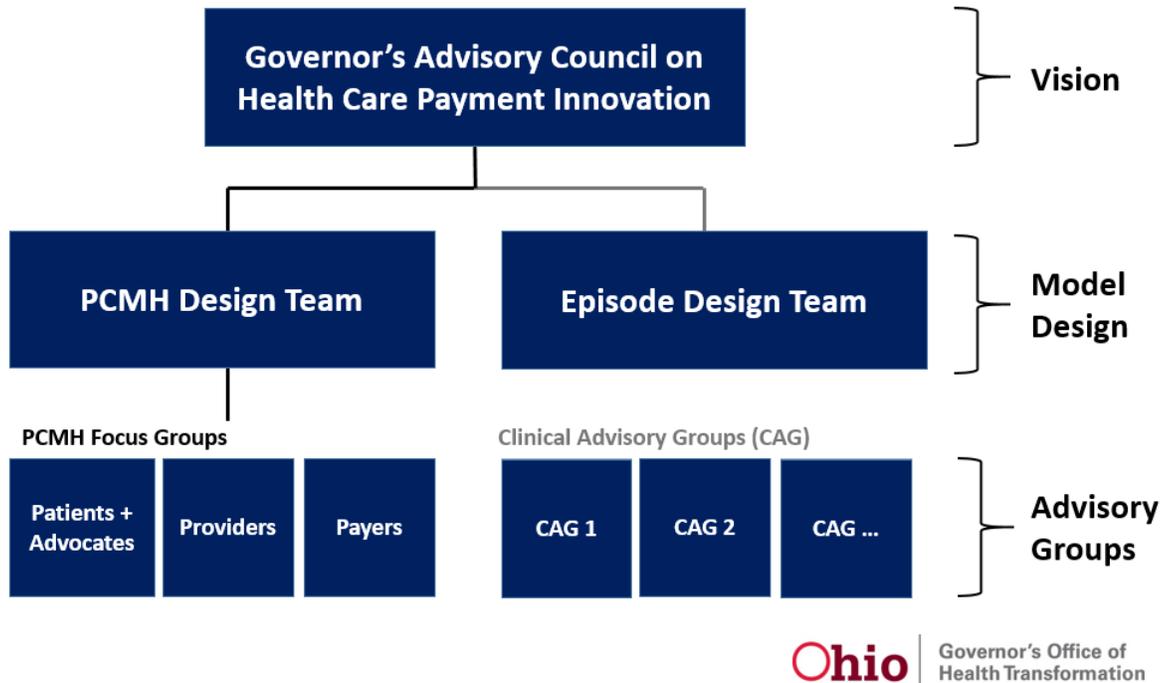
In January 2013, prior to SIM, Governor Kasich convened an Advisory Council on Payment Innovation comprised of purchasers, plans, providers, consumers, and researchers to prioritize and coordinate multi-payer health care payment innovation activities statewide. The Advisory Council identified experts to participate on three leadership teams related to SIM design: a multi-payer core team, PCMH design team, and episode design team. The SIM core team (Aetna, Anthem, Buckeye, CareSource, Medical Mutual, Molina, Paramount and United) aligns overall strategy across payers. The CEOs of these plans have committed to the Governor they will help design and implement the episode and PCMH models in Ohio.

During the SIM Design grant, the episode and PCMH design teams were convened to review detailed analysis and form recommendations for PCMH and episode-based payment model design. The teams met on a weekly basis over six months and included over 100 participants, including representatives from OHT and the Ohio Departments of Medicaid, Health, Aging, Mental Health and Addiction Services, Administrative Services, Insurance and others; provider organizations representing various geographies and levels of scale and integration (e.g., large health systems, academic medical centers, multi-specialty, independent practice); purchasers representing self-insured employers interested in payment innovation; payer experts identified by the SIM core team; and payment innovation leaders from across the state (e.g., community leaders, local collaboratives, HIE experts, research organizations).

For the SIM Test grant, OHT continues to rely on the core team and PCMH/episode design teams to coordinate implementation, pressure-test approaches, share lessons learned, and inform continuous improvement. However, the specific meeting cadence and membership of these groups changes as needs change. On the episode side, specific Clinical Advisory Groups (CAG), composed of relevant physician experts (e.g., OB/GYNs and nurse midwives for perinatal), are convened at the start of each episode design phase. To date there have been seven CAGs to develop Ohio's 13 episodes.

For PCMH, three specific focus groups were convened – high functioning primary care providers, patient/advocates, and payers to provide expertise in developing the models. Other existing stakeholder groups were leveraged to provide feedback on the care delivery model including the Regional Health Improvement Collaboratives (RHIC) which led to two regional meetings – Cleveland and Cincinnati – and the Ohio Patient Centered Primary Care Collaborative. These focus groups all played a role in designing the Ohio PCMH program. Further, Ohio conducted a survey of primary care clinicians and practice administrators in Ohio to understand how practices are delivering patient-centered care today and seek input on key PCMH model design decisions. With over 500 survey respondents, we are eager to aggregate responses and learn what the data tells us about provider readiness and other insights into the care delivery model.

Ohio's payment innovation design team structure



In 2016, there will continue to be a robust outreach to stakeholders for both PCMH and episodes. As Ohio brings up the next wave of seven episodes, still to be determined, there will be a set of no more than four new clinical advisory groups to develop the patient journey, definitions, and quality indicators from which to build an episode. We have indicated that the next set of episodes will include behavioral health which is a new set of stakeholders needed to participate in the detailed discussions. We will continue to do outreach, especially with principle accountable providers (PAP) as well as payers, on the first seven episodes as it moves from informational reporting to performance reports tied to positive and negative incentive payments and PAPs for the second wave of seven episodes, which will launch informational reports both of which will launch in early 2016.

For PCMH, there is a great deal of activity planned with stakeholders as the state prepares to launch with PMCH enrollment beginning in 2016. First, the PCMH design team and all three focus groups will continue to refine the care delivery model and make decisions about the payment model. After gaining insights from the PCMH survey, Ohio will conduct a select

number of primary care on-site visits to see in-person how practices are currently operating, better understand challenges and how best we can shape the model to help transform practices to PCMHs. Ohio will engage in an intensive awareness effort to educate current practices on the model as we move into an enrollment period.

In 2016, additional focus will be given to support practice transformation. We are utilizing a multitude of approaches in our transformation, and keeping on task is critical to our success. As no health systems or practices in Ohio were direct recipients of Transforming Clinical Practices Initiative (TCPI) awards through CMMI, the conversation in Ohio has shifted from how to best disburse grant funds to support direct practice transformation to a conversation focused on leveraging existing resources both within the state, and outside of it. For example, as a part of our SIM work, we have engaged Ohio's three RHICs in conversation about what supports will best support practices across Ohio. We will continue this conversation well into grant year 2.

As always, the state will continue its general outreach with availability of information on the OHT and ODM websites, conduct and record webinars for posting on the websites, and large stakeholder meetings. This is in addition to any one-on-one meetings as needed, ongoing one-on-one meetings with each payer, and a monthly meeting with both commercial and Medicaid MCPs.

In terms of alignment, participating payers have agreed on the OHT [Multi-Payer Charter](#) for both episodes and PCMH. The design of each payment model follows the levels of alignment, including elements on which to “standardize,” “align in principle,” or “differ by design.” One of the core elements for standardization across all payers is quality metrics for both PCMH and episodes. Additionally, based on provider input, the Medicaid managed care plans are standardizing a number of additional design elements including –

- Cost and quality thresholds for episode-based payments
- Episode-based payment reporting (state selected vendor will send provider reports for all Medicaid managed care plans)
- Requirements tied to payment streams for PCMH
- Payment model and structure for both episodes and PCMH

The Medicaid provider agreement with the managed care plans specifically covers participation and alignment with SIM and payment innovation in order to ensure consistency across all of the plans. In Governor's Advisory Council on Payment Innovation meetings, all plan CEOs (including commercial payers) have committed to participation in SIM and the specific asks by OHT related to episodes and PCMH.

3. Plan for Improving Population Health

Our current health care payment system rewards medical care for individuals but neglects activities outside the doctor's office that contribute to better health where people live, learn, play and work. This systemic underrepresentation of population health in care delivery and coverage programs has contributed to the U.S. ranking below many countries in life expectancy, infant mortality, and other indicators of healthy life. This is particularly true in Ohio, which ranks 42 among states in the overall health of its population (CMWF 2014).

Ohio is taking steps to increase the number of residents who are healthy at every stage of life, with a goal of being the healthiest place to live, work, and raise a family. The state's current focus is to incorporate population health measures into regulatory and payment systems, and use those measures to align population health priorities across clinical services, public health programs, and community-based initiatives.

The state is working to align community health needs assessment and population health planning. Currently, Ohio's 124 local public health districts and multiple hospital systems are performing Community Health Assessments and Community Health Needs Assessments with varying levels of coordination. The State is pursuing better coordination of these plans, with the goals of identifying clear population health priorities across regions, facilitating stronger relationships among public health districts and health care delivery systems (e.g., PCMH), and explicitly tying hospital community benefit requirements to addressing regional population health priorities.

In 2015, ODM and ODH contracted with the Health Policy Institute of Ohio (HPIO) to: 1) assist the State in identifying population health priority areas and align with patient centered medical home model; and 2) analyze the population health planning infrastructure at the state, regional and local levels and make recommendations for improving the State Health Improvement Plan process while aligning the local and hospital community benefit plans.

Between October and November 2015, HPIO convened six meetings with 48 organizations representing local health districts, providers, payers, patient advocates, employer groups, Regional Health Improvement Collaboratives, ODM, ODH, MHAS and OHT. While HPIO's final report will not be submitted to the State until January 2016, HPIO did an extensive amount of data collection and analysis in identifying health priority areas in the state including 10 state-level health improvement plans, 110 local health assessments and improvement plans and 170 hospital community assessments and implementation plans. Utilizing a methodology that takes into consideration the nature of the problem, impact on healthcare costs, potential for impact and clinical alignment and available data, HPIO recommended the State focus in ten population health priorities:

1. Obesity
2. Physical activity
3. Nutrition
4. Substance abuse treatment/prevention
5. Infant mortality
6. Tobacco use
7. Mental health
8. Diabetes
9. Cancer
10. Heart disease

When compared to the proposed clinical quality requirements for PCMH (as of 12/16/15 see the chart below) there is a great deal of synergy between the clinical measures selected for quality and the health priority areas to address to improve overall population health. Throughout the SIM design, a high priority was given to selecting measures that efficiently serve cross-functional needs including population-level health reporting (e.g., aligned with the National Quality Strategy), ease of provider reporting (e.g., available in electronic health records), program performance measures (e.g., Medicaid MCO pay-for-performance programs), and payment innovation (e.g., PCMH, episode-based payments). Selecting measures in this way ties population health priorities directly into health care payment and delivery system performance, and begins the process of replacing financial incentives that only reward more health care with incentives that reward better health.

Clinical quality requirements

Category	Measure Name	Population	Population health priority	Data Type	NQF #
Preventive Care	Adult BMI	Adults	Obesity	Claims or Hybrid	1690
	Well-Child Visits in the First 15 Months of Life	Pediatrics		Claims or Hybrid	1392
	Well-Child visits in the 3rd, 4th, 5th, 6th years of life	Pediatrics		Claims or Hybrid	1516
	Adolescent Well-Care Visit	Pediatrics		Claims or Hybrid	N/A
	Breast Cancer Screening	Adults	Cancer	Claims	2372
	Weight assessment and counseling for nutrition and physical activity for children/adolescents: BMI assessment for children/adolescents	Pediatrics	Obesity, physical activity, nutrition	Claims or Hybrid	0024
	Timeliness of prenatal care	Adults	Infant Mortality	Claims or Hybrid	1517
	Postpartum care	Adults	Infant Mortality	Claims or Hybrid	1517
	Live Births Weighing Less than 2,500 grams	Pediatrics	Infant Mortality	State Records	N/A
	Appropriate Care	Controlling high blood pressure ¹	Adults	Heart Disease	Hybrid
Med management for people with asthma		Both		Claims	1799
Comprehensive Diabetes Care: HgA1c poor control (>9.0%)		Adults	Diabetes	Claims or Hybrid	0059
Statin Therapy for patients with cardiovascular disease		Adults	Heart Disease	Claims	HEDIS SPC
Behavioral Health	Antidepressant medication management	Adults	Mental Health	Claims	0105
	Follow up after hospitalization for mental illness	Both	Mental Health	Claims	0576
	Preventive care and screening: tobacco use: screening and cessation intervention	Both	Substance Abuse	Claims or Hybrid	0028

In addition to aligning clinical and population health priorities, the HPIO process also generated recommendations for improving Ohio's State Health Assessment (SHA) and State Health Improvement Plan (SHIP) and coordinating local population health planning. The fundamental component of the population health meetings, however, was improving population health infrastructure and planning.

Currently, Ohio's 124 local public health districts and multiple hospital systems are performing Community Health Assessments and Community Health Needs Assessments with varying levels of coordination. Based on the outcome of the population health meetings, in 2016 the state will pursue better coordination of these plans, with the goals of identifying clear population health priorities across regions, facilitating stronger relationships among public health districts and health care delivery systems (e.g., PCMH), and explicitly tying hospital community benefit requirements to addressing regional population health priorities.

Specifically, in 2016 the State will seek to further align the State SHA/SHIP with local health district and hospital assessments and plans timing to every three years to make it consistent with IRS requirements of hospitals' community benefit plans. To improve transparency of plans improving population health the State will seek to require tax-exempt hospitals and local health departments submit their assessments and plans to the State and make them publicly available through an online repository. Further, the State will seek to require tax-exempt hospitals to submit their Schedule H and corresponding attachments including reporting on each category of expenditures that demonstrates community benefit spend and to make this information also publicly available via an online repository.

4. Health Care Delivery System Transformation Plan

Ohio's health care delivery system, like the nation's, is fragmented in ways that lead to disrupted relationships, poor information flows, and misaligned incentives. As a result, nearly 30 percent of all health care spending is wasted (IOM 2009) and Americans receive only 55 percent of recommended treatments for preventive, acute, and chronic care (NEJM 2003).

In 2011, Ohio adopted an aggressive plan to systematically convert all of the state's health care delivery systems to person-centered models that engage patients in decisions about their care, engage providers in more integrated delivery models, hold providers accountable for quality and cost of care, and link payment to value.

Since 2011, OHT has consistently demonstrated its capability to design and implement delivery system reforms that improve care and hold down costs ([Ohio Governor's Office of Health Transformation Strategic Framework](#)). The focus has been to integrate care across traditionally disconnected providers for target populations (e.g., dual eligibles, mental health, developmental disabilities). For each population, the state is moving to models that take a person-centered approach to manage total care and reduce fragmentation. For example, in May 2014, Ohio Medicaid began enrolling 60 percent of the state's Medicare-Medicaid population in *MyCare Ohio* managed care plans. *MyCare* plans use person-centered care coordination to integrate services across both programs, and support Ohio's already strong commitment to create community alternatives to institutions (Ohio participates in the federal *Balancing Incentive Program* and the state's *Money Follows the Person* Demonstration is ranked second overall – and first for Medicaid recipients with mental illness – in the number of Medicaid beneficiaries transitioned to a home setting). The benefit of Ohio's aggressive reforms has accrued to Medicaid, Medicare, and throughout the system. For example, Ohio Medicaid reduced average annual program growth from 8.9 percent (2009-11) to 3.3 percent (2012-14) and saved taxpayers \$3.0 billion in the first two years of reform. This early success built momentum for Governor Kasich to extend Medicaid coverage to an additional 563,000 low-income Ohioans, simplify enrollment, and implement a new integrated eligibility system.

At the same time, Ohio's private sector health plans and providers have made significant investments to shift toward better-integrated, value-based systems of care. For example, some of

the most clinically integrated large systems in the country are located in Ohio (e.g., Cleveland Clinic, Catholic Health Partners, OhioHealth, Premier Health Partners, Tri-Health), there is a high level of support for patient-centered medical homes (e.g., 494 recognized or accredited PCMH practices serving 3.7 million Ohioans as of June 2014, two Aligning Forces for Quality sites, at least three commercial health plan PCMH incentive programs, 700+ active stakeholder participants in Ohio’s Patient-Centered Primary Care Collaborative), there are several bundled payment initiatives (e.g., Cleveland Clinic bundled contracts with employers, commercial health plan bundled payment tests for transplants, ED use, and hip replacements), and several nascent accountable care organizations (e.g., Children’s Hospital Partners for Kids, ten Medicare Shared Savings ACOs). Altogether, these activities create an ideal environment to align payment innovation priorities, refine models to efficiently scale, and expand the benefits of value-based payment and service delivery models to more Ohioans.

For SIM, Ohio adopted a goal to enroll 80-90 percent of the total population in value-based payment models that support health care delivery system transformation. Ohio’s SIM-designed PCMH and episode-based payment models support a transition to paying for value, aligning provider incentives, providing data and supports to transform practices and empower patients, and connecting public health efforts with health care delivery systems. The interdependent cost and quality incentives in the two models also encourage better care coordination and integration across providers and care settings.

Throughout the Operational Plan, we detail how the following care delivery characteristics have been, and will continue to be, addressed through our SIM and related work. Ohio’s plans for health information technology, workforce development, stakeholder engagement, and quality measurement are critical to enabling the new payment models and supporting health care delivery system transformation. The following table represents a quick glance at each characteristic.

CHARACTERISTIC	OHIO SIM COMPONENT
<i>1. Providers across the state and across the care continuum participate in integrated or virtually integrated delivery models</i>	PCMH – In Project Year 1, we anticipate 2 – 5% of practices participating in Ohio’s PCMH Initiative. Analysis of PCMH survey results collected in December 2015 will allow us to be more specific; EBP – In Project Year 1, the performance year for six Wave 1 episodes begins, covering roughly 10% of providers; seven Wave 2 episodes will launch for informational reporting, covering roughly an additional 15% of providers; up to 7 Wave 3 episodes will be developed, which are projected to engage an additional 10% of providers in episodes.
<i>2. Over 80% of payments to providers from all payers are in</i>	Financial modeling projects that in the first two Project Years, 15 – 30% of payments will be covered through

<i>fee-for-service alternatives that link payment to value</i>	the PCMH model across all payers. In addition, Ohio’s Medicaid MCPs (representing 80% of Medicaid covered lives) are required, through statutory requirement, to achieve at least 50% of payments in a value-based setting. Coupled with the SIM efforts, Ohio is well on its way to achieving 80% by the end of the grant.
3. Every resident of the state has a primary care provider who is accountable both for the quality and for the total cost of their health care	Early financial modeling for PCMH suggests that by CY2020, nearly 90% of beneficiaries will receive care through a PCMH.
4. Care is coordinated across all providers and settings	Care coordination is embedded in the care delivery model for PCMH. Transformed PCMHs will integrate BH specialists into patient’s full care, oversee successful transitions of care, ensure adequate follow up of care and increase access to care. Care coordination will also be a critical element to the payment model. More details in Appendix A. The episode based payment model works synergistically with the PCMH model to provide joint accountability for care coordination.
5. There is a high-level of patient engagement and quantifiable results on patient experience	Patient engagement and patient experience are embedded in the proposed care delivery model for PCMH. Transformed PCMHs will promote patient activation and self-management, and actively work to improve patient literacy levels. Achieving greater cultural competences through training, awareness, and access to appropriate services, like translation, will also be a top priority for practices that are in later phases of the journey. More advanced practices will also have forums and tools to regularly solicit and incorporate the feedback of patients into individual care.
6. Providers leverage the use of health information technology to improve quality	As detailed in section ten, Ohio aligned existing initiatives and assets to seven themes. Examples include: Ohio’s SIM initiative is directly related to Rewarding Value, Ohio’s high adoption of EHRs and HIEs supports Care Coordination.
7. There is an adequate health care workforce to meet state residents’ needs	ODM will take the recommendation from the GME Study Committee and develop a new formula that will better align state funding to teaching hospitals toward the Administration’s priorities to support primary care.
8. Providers perform at the top of their license and board certification	For practice transformation, there continues to be a discussion about provider performing at the top of their license in addition to appropriate staff roles in a team-based environment (e.g. clinical vs social work).

<p><i>9. Performance in quality and cost measures is consistently high</i></p>	<p>Year 1 analyses for setting episode thresholds yielded information related to our current state of quality metrics for episodes of care. In order to balance plan and provider participation with the need for improving quality care, we have set Year 1 episode thresholds lower than originally intended. Over the next five years, we will increase quality thresholds in each of the episodes so as to move the needle on achieving quality. Ultimately, Ohio will set quality metrics such that the top quartile of providers will be eligible for positive incentive payments through episode based payments.</p>
<p><i>10. Population health measures are integrated into the delivery system</i></p>	<p>As demonstrated through our proposed quality metrics for PCMH, Ohio continues to embed population health measures in our SIM initiatives.</p>
<p><i>11. Data is used to drive health system processes</i></p>	<p>Synergies across the seven HIT themes have a data driven focus that allows for monitoring of both process and outcomes.</p>

Practice Transformation Support

In 2016, additional focus will be given to support practice transformation. We are utilizing a multitude of approaches in our transformation, and keeping on task is critical to our success. As no health systems or practices in Ohio were direct recipients of Transforming Clinical Practices Initiative (TCPI) awards through CMMI, the conversation in Ohio has shifted from how to best disburse grant funds to support direct practice transformation to a conversation focused on leveraging existing resources both within the state, and outside of it. For example, as a part of our SIM work, we have engaged Ohio’s three Regional Health Improvement Collaboratives in conversation about what supports will best support practices across Ohio. We will continue this conversation well into grant year 2.

Additionally, in 2016, Ohio will finalize data collection through a comprehensive patient-centered medical homes survey. Nearly 600 surveys were completed by physicians and practice administrators. We will analyze and build from the results of this survey, using it to focus our efforts on geographic areas of need, practice capacity determination, and assessing the return on investment in practice transformation.

As mentioned in *Section 5. Payment and/or Service Delivery Models*, care coordination is a critical element in our patient-centered medical homes care delivery model. As the PCMH model rolls out in 2016, we will finalize enhanced per member per month payment for coordinated care along with additional new activities provided at a practice level. We will continue to be engaged with and learn from existing efforts aimed at strengthening the effects of care coordination, such as the Comprehensive Primary Care Initiative (CPCi) operating in southwest Ohio. Early learning from CPCi suggests that a proper balance must be struck between enhanced care coordination payment amounts and achieving intended quality outcomes, all the while, keeping cost-effectiveness in mind.

Further, Ohio has recently engaged in conversations with the National Rural Accountable Care Consortium (NRACC), a non-profit organization that supports health care transformation. NRCC, a TCPI awardee, is developing practice transformation networks across the country. They plan to assist hundreds of practices implementing value-based models through their engagement. Ohio is excited about the continued conversation with NRACC and similar entities.

5. Payment and/or Service Delivery Model(s)

Overall of scale-up approach

Ohio's goal is to transform the state's health care system by rapidly scaling the use of PCMH and episode-based models and developing the cross-cutting infrastructure to support implementation and sustain operations. By the end of the Model Test, Ohio will have launched up to 50 episodes of care and implemented PCMHs statewide. Each episode will be implemented statewide, with the number of episodes scaling over time. Informational reporting for the first six episodes launched in March of 2015. An additional seven episodes were designed in 2015; informational reporting for these episodes will begin in 2016. Design and development of the next round of seven episodes will begin in 2016. While our initial approach was to scale PCMH geographically, the plan is now to launch statewide in 2016, achieving scale more quickly.

Overview of operating model

Activities to reach scale fall into four main categories: design, implementation, operation, and evaluation/refinement. Design includes specifying the details of each payment model and its associated activities to enable implementation. Implementation includes the set of one-time activities needed to launch a model. Operations are the ongoing activities to maintain the models. Evaluation allows for continuous improvement, both to update models that have already been launched and to improve designs for later phases.

Episodes – activities and detailed timeline

Episode activities prior to start of SIM Test. After submitting the State Health Innovation Plan, Ohio and its SIM partners began defining an initial set of episodes. Asthma, chronic obstructive pulmonary disease (COPD), acute and non-acute percutaneous coronary intervention (PCI), perinatal, and total joint replacement (TJR) were the first episodes chosen, based on meaningful spend across payer populations, clear sources of value, a diverse mix of accountable providers, and existing definitions to use as a baseline to reduce time to launch.

The design of these episodes follows the levels of alignment set out in the OHT [Multi-Payer Episode Charter](#). The base episode definitions, including elements to “standardize” as defined in the charter (e.g., principal accountable provider, quality metrics) and “align in principle” (e.g., claims to include, episode time frames) were developed through Clinical Advisory Groups (CAGs). These included a diverse set of clinical leaders from across the state (e.g., large health systems, individual practitioners, payers). Over 100 clinicians participated in 4 working sessions for each episode to review prototype definitions and detailed claims-based analyses, and to provide extensive clinical input into the definitions. The episodes are consistent

across the Medicaid managed care plans; each commercial payer customized the base definitions based on their respective populations (e.g., risk adjustment, specific exclusions).

During this time, prototype performance reports were designed and tested with providers on the episode working team. Additionally, all payers (Medicaid and Commercial) invested to develop the production algorithms and infrastructure to run episode analytics, generate performance reports, and share reports with providers. For the first Wave of episodes, initial reports for Medicaid launched in March of 2015. To date, ALL plans have released provider reports for episodes.

2015: Episode Model Test pre-implementation period. In 2015, Ohio continued to design and launch new episodes, and also prepared for launch of the first performance period for the initial set of episodes, during which episode performance is linked to payment.

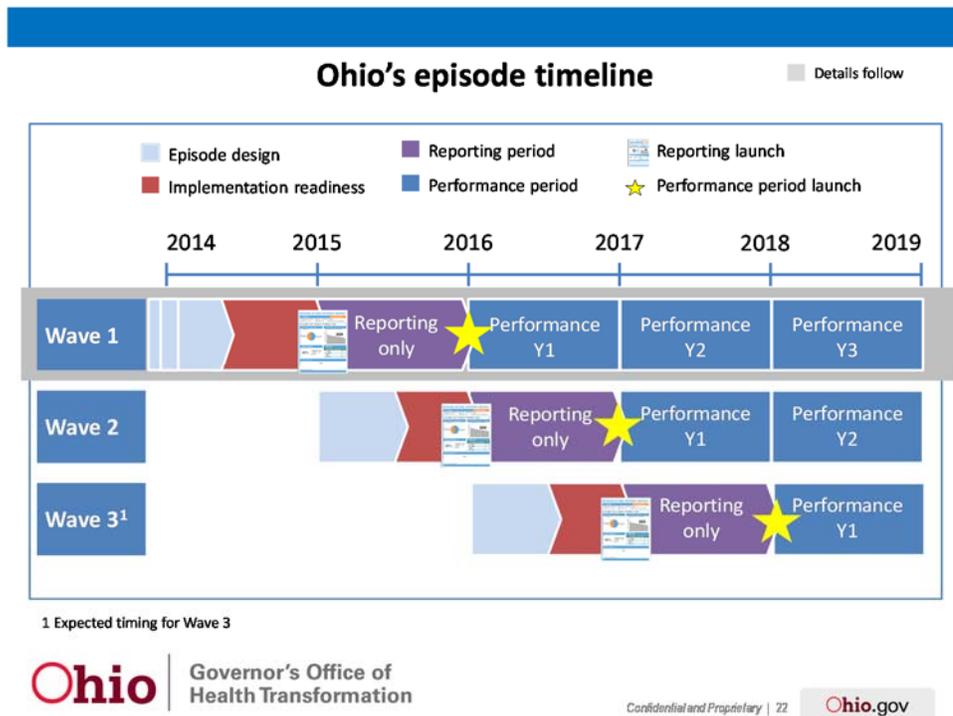
Seven new episodes were defined and implemented (following similar processes as for the first six). The episodes selected and designed include appendectomy, cholecystectomy, colonoscopy, esophagogastroduodenoscopy, gastrointestinal bleed, upper respiratory infection and urinary tract infection. Three additional CAGs were convened to design these episodes and the plan is to launch informational reports in early 2016. Based on feedback from the Medicaid managed care plans as well as providers, the state is pursuing an option to run the episode analytics and generate performance reports for all of the Medicaid managed care plans. This will ensure that episode algorithms, reporting structures, and timelines are aligned for the Medicaid program. Detailed episode definitions and business requirements (necessary to code the algorithms) are also shared with the commercial plans.

For the initial six episodes, 2015 was a reporting-only period for Medicaid, without positive or negative incentive payments tied to providers' performance. This reporting only period allowed Medicaid and its payer partners to test the model, build provider awareness, and undertake an analytics-driven process to set incentive payment thresholds. For Medicaid, a single value was identified for each threshold for the three episodes Medicaid is linking to payment – asthma acute exacerbation, COPD exacerbation, and perinatal. This provides a consistent message for providers involved with multiple Medicaid managed care plans. The thresholds were set based on historical performance. Initially, the acceptable threshold was set such that 10% of the providers with at least 5 valid episodes were above the acceptable threshold (based on data from calendar year 2014 from Medicaid FFS and all of the Medicaid managed care plans). Next, the commendable threshold was set such that positive incentives balanced the negative incentives, ultimately resulting in impact that is budget neutral to the program. Threshold methodology as well as specific threshold values for the three episodes that Medicaid is linking to payment starting in 2016 are posted on ODM's website.

Additionally, to prepare for the launch of the first performance period, Medicaid followed a legislative approach, submitting a Rule and drafting a State Plan Amendment (SPA) for submission in early 2016 in order to enable linking episode performance to positive and negative incentive payments in 2016. The Rule requires participation in episodes for all Medicaid providers, streamlining participation in the new payment model with both FFS and the Medicaid managed care plans.

2016: Episode Model Test year 1 of implementation. In 2016, Ohio payers will continue to operate episodes 1-6, producing quarterly performance reports and applying both positive and

negative incentive payments after a year-long performance period closes on December 31, 2016. Reporting will launch for episodes 7-13, starting with a reporting-only period; the performance period will begin in calendar year 2017. The figure below shows the timeline associated with design, implementation, and launch of the first three waves of episodes. In addition, Ohio will design and implement episodes 14-20. Ongoing operations will include production and distribution of quarterly reports, stakeholder engagement including targeted outreach to support providers in how to understand and act on their reports, continued provider and MCO contracting, and additional regulatory approval activities. Episode refinements will be identified and implemented based on stakeholder feedback and insights from evaluation and monitoring activities.



2017: Episode Model Test year 2 of implementation. In 2017, Ohio payers will operate and evaluate episodes 1-20 and design and implement episodes 21-35. This assumes the pace of scale-up for episode design accelerates due to increased experience with the process, ability to adopt existing episode definitions, and selection of some families of related episodes.

2018: Episode Model Test year 3 of implementation. By 2018, episode 1-35 will be in operation and episodes 36-50 will be designed and implemented. Figure 1 lays out the full set of activities required for episode scale-up.

Figure 1. Episode Operating Model

	Design	Implement	Operate	Evaluate & improve
1 Episode design, analytics and delivery	<ul style="list-style-type: none"> Select launch sequencing Define base episode and quality metrics Customize model Execute thresholds 	<ul style="list-style-type: none"> Build analytics engine Define/QA production algorithms 	<ul style="list-style-type: none"> Gather/integrate all claims and non-claims data Execute production of episodes 	<ul style="list-style-type: none"> Maintain & update base definition Manage program evaluation Report on program impact Make refinements
2 Reporting	<ul style="list-style-type: none"> Design report templates Develop strategy to gather non-claims data 	<ul style="list-style-type: none"> Develop/purchase reporting software 	<ul style="list-style-type: none"> Gather data Generate reports 	<ul style="list-style-type: none"> Execute refinements/additions to reports
3 Payer / provider connectivity	<ul style="list-style-type: none"> Plan for report generation/quality metric entry 	<ul style="list-style-type: none"> Build/modify "portal" 	<ul style="list-style-type: none"> Distribute reports Gather clinical data for analytics 	<ul style="list-style-type: none"> Monitor & report on provider report viewing
4 Payment	<ul style="list-style-type: none"> Define consistent payment approach 	<ul style="list-style-type: none"> Develop API to payment systems with modifications for gainsharing payments" 	<ul style="list-style-type: none"> Manage bonus payment or risk Audit/reconcile payments 	<ul style="list-style-type: none"> Manage updates to payment system
5a Provider support outbound	<ul style="list-style-type: none"> Design provider education strategy & approach for outbound support 	<ul style="list-style-type: none"> Develop/obtain provider education material 	<ul style="list-style-type: none"> Distribute education materials Engage/consult to individual providers 	<ul style="list-style-type: none"> Update provider education strategy & materials
5b Provider support inbound	<ul style="list-style-type: none"> Develop approach & capabilities to respond to provider inquiries 	<ul style="list-style-type: none"> Train staff to answer inquiries Modify provider appeals process 	<ul style="list-style-type: none"> Field inbound inquiries and appeals 	<ul style="list-style-type: none"> Update and advance training materials
6 MCO contracting	<ul style="list-style-type: none"> Develop contracting approach 	<ul style="list-style-type: none"> Execute re-contracting/addendums 	<ul style="list-style-type: none"> Manage amendment process 	<ul style="list-style-type: none"> Monitor program integrity Manage re-contracting
7 Provider contracting	<ul style="list-style-type: none"> Develop provider re-contracting approach 	<ul style="list-style-type: none"> Execute provider re-contracting/addendums 	<ul style="list-style-type: none"> Manage amendment process, as needed 	<ul style="list-style-type: none"> Manage re-contracting process
8 Client & regulatory filings/activities	<ul style="list-style-type: none"> Develop regulatory strategy Develop ASO contracting plan 	<ul style="list-style-type: none"> Execute regulatory approval (e.g., SPA) ASO re-contracting/addendums 	<ul style="list-style-type: none"> Monitor changes to payment model to ensure compliance 	<ul style="list-style-type: none"> Obtain new regulatory approvals, as needed

PCMH – activities and detailed timeline

PCMH Activities prior to start of SIM Test. During Model Design, the SIM core team and PCMH working team laid out a vision and overall design for a statewide PCMH model, including building alignment around the [Multi-Payer PCMH Charter](#) to specify areas of design for multi-payment standardization. In parallel, Southwest Ohio participated in CPCI, and multiple other PCMH pilots continued in the state.

2015: PCMH Model Test pre-implementation period. In 2015, the ODM went through a competitive bid process to procure a vendor with subject matter expertise in the design and implementation of PCMH. McKinsey & Co was awarded a four year contract to assist the State with its PCMH work. OHT convened the PCMH Model Design Team and subsequent focus groups to define the statewide PCMH approach in detail and plan for implementation. The groups met to specify the model elements upon which payers can agree to a standard approach:

technical requirements, milestones to qualify as a PCMH, and quality metrics. For relevant state populations (Medicaid, state employees), attribution and empanelment logic and payment model details were also defined. The SIM teams used already existing definitions (e.g. CPCi) as a baseline and then modified as needed. In particular, changes reflected adaptations to make the PCMH model accessible to primary care practice types with different baseline capabilities in care coordination and population health management. Proposed model elements were also informed by extensive claims-based analytics to test the impact of proposed definition, particularly for attribution and payment (*Details of the proposed PCMH care delivery and payment model in Appendix A*).

On December 14, 2015, OHT and ODM made a decision to accelerate the timeframe originally proposed for the PCMH Model Test implementation and instead of a three-year regional roll-out, implement the PCMH model statewide in 2016.

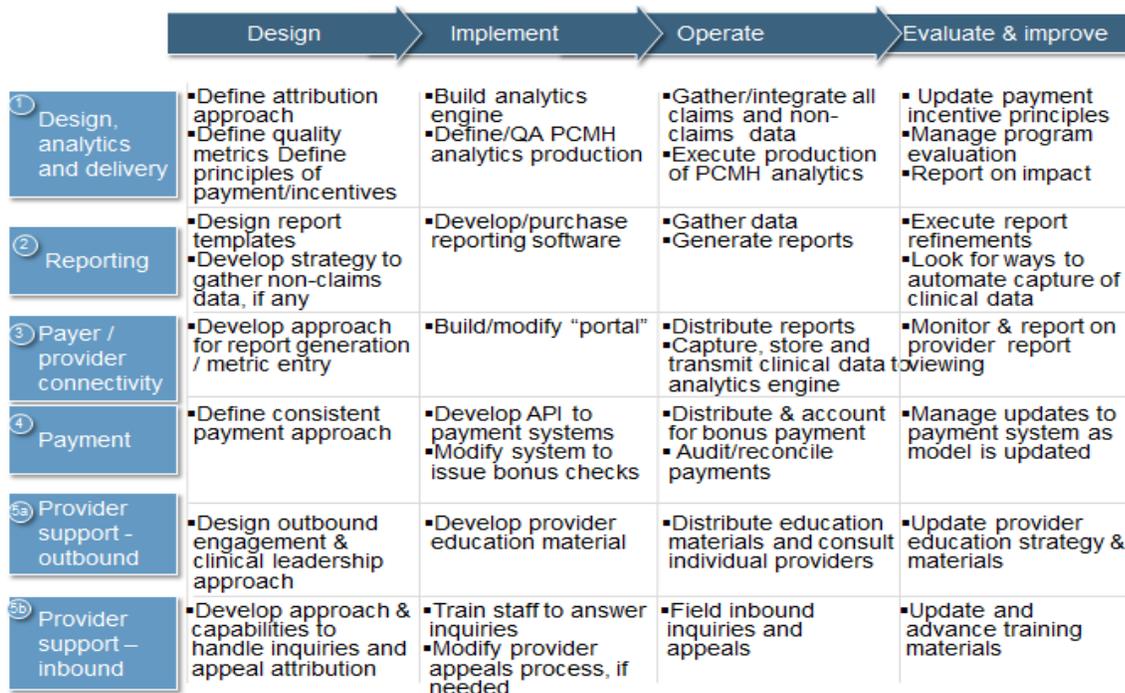
2016: PCMH Model Test year 1 of implementation: As model design details are confirmed, PCMH implementation processes will be decided. The SIM core team, with input from the PCMH design team and focus groups, will determine which of these would benefit from being shared functions across payers (as in CPCi) or conducted independently. Figure 2 shows the full set of activities required for PCMH scale-up. Provider engagement materials, to raise awareness of the PCMH model and educate providers on how to enroll, will also be developed.

In 2016, the PCMH model will begin statewide; practices will not be restricted by region. This will start with provider enrollment, including any review of eligibility to participate, sharing initial empanelment and attribution data, and any contracting requirements with commercial and Medicaid managed care plans. The state also will submit its PCMH shared savings SPA for approval. OHT will continue to convene the PCMH Design team, focus groups, and other stakeholders to understand the on-the-ground impact and identify opportunities for improvement. Refinements will be incorporated into the PCMH model as practices continue to enroll.

2017: Model Test year 2 of implementation. In 2017, the PCMH model will continue operating with the initial enrolled PCMHs and open enrollment to more practices. During the year, providers will be expected to meet milestones (similar to CPCi) and will receive quarterly performance reports, and payment incentives as defined in the pre-implementation phase. In 2017, a major focus will be on provider support, to enable providers to act on opportunities identified in performance data, and on continuous improvement, to refine reports, requirements, and types of provider support provided.

2018: Model Test year 3 of implementation. By 2018, enrollment will be accessible to all providers and the PCMH model will be operational statewide, across all elements identified in Figure 2. Model refinements will continue based on stakeholder feedback and the evaluation and measurement plan.

Figure 2. PCMH Operating Model



6. Leveraging Regulatory Authority

The state’s initial PCMH and episode-based payment models are designed to fit within existing state regulations for Medicaid and private health insurers. For Medicaid, these models build on the Catalyst for Payment Reform (CPR) principles that have already been incorporated into all Medicaid managed care plan contracts. In addition, OHT engages the Ohio Department of Insurance to identify further opportunities to align regulations with the PCMH and episode-based payment models.

In the most recent biennial budget signed by Governor Kasich in June 2015, there is a provision in Ohio Revised Code 5167.33 that requires the Medicaid managed care plans (MCPs) that 50 percent of payment is value based by 2020. The language codifies the authority for the ODM Director to adopt rules to implement this provision including rules that specify the following: 1) The value received from a provider's services; (2) A provider's success in reducing waste in the provision of services; (3) The percentage of a Medicaid MCPs aggregate net payments to providers that are based on the value received from the providers' services.

As Ohio moves to implementation there are regulatory actions being taken both for episode based payments and patient centered medical homes. Ohio convened an internal regulatory working team that meets bi-monthly to work through the different regulatory components. ODM made changes to the managed care plan provider agreement to strengthen the state’s authority to require provider participation in these models. The new language will go into effect in January 2016. Further, there are plans to completely revise the MCP provider agreement in July 2016 to add more detail to the value-based purchasing models in which the MCPs will be required to participate.

Regulatory preparations are well underway for episode based payments. ODM, together with OHT, is coordinating with the Governor's Office, Ohio Department of Insurance, Common Sense Initiative Office (CSIO) and the legislative Joint Committee for Agency Rule Review (JCARR) to submit parallel actions to make changes to Ohio Administrative Code 5160-1-70 that will set the Medicaid policy and reimbursement structure for episode based payments. An Executive Order from the Governor's Office is required so the rule will be in effect for 120 days starting January 1, 2016, the beginning of the performance period for the first wave of episodes – perinatal, asthma, COPD, total joint replacement, and acute/non-acute PCI. Concurrent with the Executive Order, ODM will go through a process to file permanent rules with CSIO and JCARR to go into effect by March 2016.

The ODM team also started conversations with CMS to lay the groundwork for a state plan amendment (SPA) in first quarter 2016. The SPA will seek the approval to provide positive and negative incentive payments for a number of defined episodes of care as an incentive to improve care quality, efficiency, and economy. The SPA will be effective January 1, 2016, with the State making incentive adjustments for episodes of the first six types having ending dates January 1 – December 31, 2016, and for episodes of an additional seven types ending dates January 1 – December 31, 2017. While we are including time for CMS review, it is critical that the SPA process be efficient as this impacts the timing for implementation.

In 2016, there will be a similar regulatory process to implement patient-centered medical homes. By the end of the first quarter, ODM will submit a permanent Ohio Administrative Rule change through the CSI Office and JCARR. This rule will set the Medicaid policy and payment infrastructure for PCMHs. At this time, we are not planning to submit an executive order as we are confident the CSI and JCARR process will be complete ahead of the start of the performance period for PCMH. Concurrently, ODM will be submitting a SPA to CMS to seek approval to provide payments to compensate practices for activities that improve care, outcomes-based payment for achieving total cost of care savings and meeting pre-determined quality targets, and some practices a one-time practice transformation support to help them successfully begin the transition to a PCMH. Again, while we are including time for CMS review, it is critical that the SPA process be efficient as this impacts the timing for implementation.

7. Quality Measure Alignment

The challenge in quality measurement is not a lack of data but an overwhelming abundance, which makes it difficult for decision makers to see what is important within what is available. This is made worse because the system generates data primarily to pay claims, not deliver quality or improve outcomes. Even when quality measures are used as a starting point (e.g., NQF, HEDIS), stakeholder preferences must be balanced to reach a smaller, targeted list of metrics for any given purpose. On a practical level, access to different types of data (e.g., EHR, claims) and varying uses of data fields across organizations create further challenges to consistent quality measurement. As a result, the health care provided often depends most on what is paid, not what is clinically appropriate or even desired by an informed patient.

Ohio is following the National Quality Strategy to focus on fewer but more meaningful core quality measures. The goal is to define, measure, track, and pay for quality in ways that create value for all stakeholders, reduce the reporting burden for providers, bring sharper focus to population health outcomes, and enable value purchasing across all payers.

Since 2011, the State of Ohio has been working with CDC, NQF, AHRQ and other partners to align quality measurement across multiple measure stewards and delivery system layers (e.g., payer, hospital, clinician, and patient). CDC is a particularly important partner as OHT increasingly focuses state resources on achieving better health: being born healthy, staying or getting healthy after an acute episode, preventing and controlling chronic conditions across a person's lifespan, and influencing the social determinants of health that underlie much of the health disparity in Ohio.

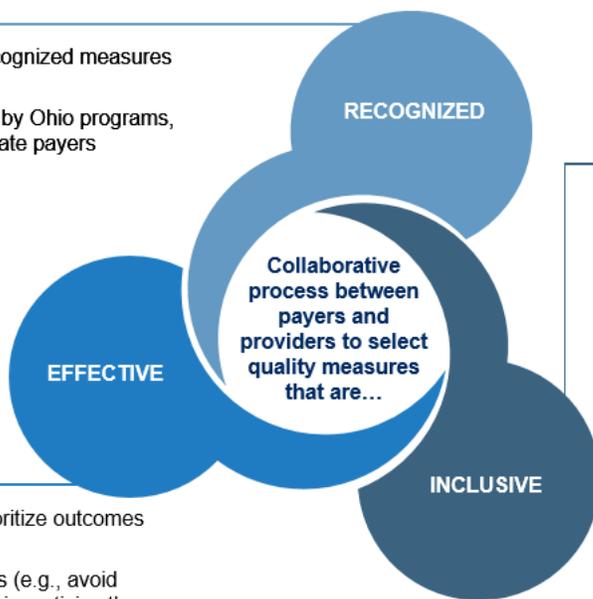
For SIM, OHT has made significant progress aligning quality measures across multiple payers for PCMH and episode-based payment models. During SIM Design, the core team of payers identified quality metrics as an area where standardization would be critical and committed to using a common set of quality metrics for each episode. The first six episodes were designed through a series of Clinical Advisory Group (CAG) meetings in which clinicians provided input on the selection of a targeted set of quality metrics specific to each episode. For simplicity in the initial rollout of episodes, only metrics that could be measured through claims data were selected. Example metrics include rate of follow-up visit after an acute exacerbation for COPD and asthma or C-section rate for perinatal. Participating commercial payers and Medicaid plans are already delivering provider reports for the first wave of episodes with the quality metrics that were determined by the CAG meetings. The second set of episodes (7 – 13) was designed with a similar approach and quality metrics are consistent across involved plans. Reporting for the next Wave of episodes is set to launch in 2016.

In parallel to work on episodes, OHT has worked to build cross-payer alignment on PCMH quality metrics. A quality metric working team consisting of Medicaid FFS, MCP, and commercial payers was formed to discuss what it would take to achieve alignment, to agree on the guiding principles that would inform the selection of requirements, and finally, to create a core set of requirements. To achieve alignment, the quality metric working team agreed that the process would be a collaborative process between payers and providers and such, the core set of requirements was created over the course of three meetings with payers, two meetings with providers and a forum with population health experts.

The quality metric working team and the provider focus groups agreed on a set of guiding principles (see figure below) to inform the selection of requirements. The purposes of the guiding principles was to steer the working team towards choosing impactful yet minimally burdensome measures.

RECOGNIZED

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



INCLUSIVE

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

EFFECTIVE

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

The proposed PCMH clinical quality measures (as of 12/16/15) (*Medicaid and MCPs*) are listed below. The list includes measures that address preventive care, appropriate care, and behavioral health. The measures cover both pediatrics and adults as well as all types of populations—both the health and the chronically ill. For simplicity in the initial rollout of PCMH, only metrics that can be measured through claims data will be used. Over time, as the PCMH matures, hybrid measures will be required.

Clinical quality requirements

Category	Measure Name	Population	Population health priority	Data Type	NQF #
Preventive Care	Adult BMI	Adults	Obesity	Claims or Hybrid	1690
	Well-Child Visits in the First 15 Months of Life	Pediatrics		Claims or Hybrid	1392
	Well-Child visits in the 3rd, 4th, 5th, 6th years of life	Pediatrics		Claims or Hybrid	1516
	Adolescent Well-Care Visit	Pediatrics		Claims or Hybrid	N/A
	Breast Cancer Screening	Adults	Cancer	Claims	2372
	Weight assessment and counseling for nutrition and physical activity for children/adolescents: BMI assessment for children/adolescents	Pediatrics	Obesity, physical activity, nutrition	Claims or Hybrid	0024
	Timeliness of prenatal care	Adults	Infant Mortality	Claims or Hybrid	1517
	Postpartum care	Adults	Infant Mortality	Claims or Hybrid	1517
	Live Births Weighing Less than 2,500 grams	Pediatrics	Infant Mortality	State Records	N/A
	Appropriate Care	Controlling high blood pressure ¹	Adults	Heart Disease	Hybrid
Med management for people with asthma		Both		Claims	1799
Comprehensive Diabetes Care: HgA1c poor control (>9.0%)		Adults	Diabetes	Claims or Hybrid	0059
Statin Therapy for patients with cardiovascular disease		Adults	Heart Disease	Claims	HEDIS SPC
Behavioral Health	Antidepressant medication management	Adults	Mental Health	Claims	0105
	Follow up after hospitalization for mental illness	Both	Mental Health	Claims	0576
	Preventive care and screening: tobacco use: screening and cessation intervention	Both	Substance Abuse	Claims or Hybrid	0028

These initial successes in building cross-payer alignment on episode and PCMH quality metrics are the first steps in working toward a broader vision for cost and quality transparency. In 2016, during the SIM test, OHT will convene a quality measurement leadership team to coordinate a broader, statewide quality measurement plan. This plan will be used to coordinate activities across the state's population health plan, HIT plan, and existing quality measurement activities.

8. SIM Alignment with State and Federal Initiatives

The State of Ohio is engaged in multiple federally-supported health care innovation activities, representing a considerable federal investment in Ohio. Like CMMI, Ohio recognized the importance of "air traffic control" across multiple reforms and in 2011 created the Office of Health Transformation (OHT) to align public and private sector health innovation activities in

Ohio. For example, Ohio will rely on its experience with CPCi to roll out multi-payer PCMHs statewide, and the multi-payer PCMH and episode models will be designed to complement CMS/CMMI initiatives that target Medicare patients only.

OHT will ensure that SIM funding does not duplicate or supplant current initiatives (*see the Budget Narrative for more detail*) and align SIM objectives consistent with other federal investments and CMMI initiatives in Ohio, including the following:

CPCi –

In addition to engaging with Ohio's Comprehensive Primary Care initiative (CPCi) as a part of the PCMH care delivery design, Ohio participates in CPCi as a payer. There are roughly 376 Medicaid enrolled people across 76 practices in the CPCi demonstration in southwest Ohio. As mentioned previously, OHT and ODM continue to engage those involved in CPCi as a continued learning opportunity for PCMH care delivery and payment models, as well as practice transformation.

MPIP –

Ohio Medicaid continues to work with doctors, hospitals and other health care providers to convert paper-based medical records to electronic formats. The shift to an electronic standard allows for more efficient sharing of information among patients, insurers and providers. Ohio Medicaid has become a national leader in its assistance to medical professionals making the transition to electronic health records. The need to migrate paper-based records to electronic platforms is growing, but the process is expensive and time-consuming for providers. In order to meet the demand for modernization, Ohio Medicaid has been aggressive in getting Ohio's share of federal Medicaid Provider Incentive Program (MPIP) grants to help health care providers make a successful transition.

Since work began in 2011, Ohio Medicaid ranks fourth in the nation for the total number of Medicaid incentive payments (11,931) distributed to providers and sixth in the nation for total amount paid by the Medicaid Incentive Program (more than \$386 million). In State Fiscal Year (SFY) 2015, Ohio Medicaid distributed 3,169 payments totaling nearly \$72.8 million. The work completed to date complements the infrastructure and support portions of the PCMH development and roll-out scheduled for 2016, and beyond.

MyCare –

MyCare Ohio is a three-year demonstration project aimed at coordinating health care delivery for individuals served by both Medicare and Medicaid. The demonstration is a collaborative effort between Ohio Medicaid, CMS, and five private managed care plans, integrating and coordinating health care delivery. MyCare Ohio is a fully capitated program that provides comprehensive services to Medicare-Medicaid enrollees. Initial Medicaid enrollment began on May 1, 2014 and continued, by region, through July 1, 2014. The Medicare passive enrollment period began on January 1, 2015, and beneficiaries maintain the freedom to 'opt-out' of the Medicare benefits if they choose. Since its implementation, the average monthly enrollment for MyCare Ohio is approximately 95,000 (45% of Ohio's dual population) individuals in 29 Ohio counties. Approximately 70% of MyCare Ohio enrollees are enrolled for

both Medicare and Medicaid benefits, optimizing the benefits of care coordination. Duals are an important population when considering payment reform. As mentioned in Section 5. *Payment and/or Service Delivery Models*, the initial statewide roll-out of PCMH will not include either FFS or MyCare populations due to some limitations in achieving comprehensive total cost of care. However, Ohio aims to include the dual population as soon reliable cost of care data is available.

Medicare Bundled Payment Efforts –

Ohio continues to keep abreast of other federal initiatives aimed at supporting better and more efficient care provided. For example, analysis of Medicare’s Comprehensive Care for Joint Replacement (CCJR) episode indicates Ohio and Medicare are well aligned in approach to episode development. As the model rolls out to markets, Ohio will continue to monitor Medicare alternative payment models. It is important to note that based on Ohio’s model for episodes, the presence of TPL excludes an episode from the model. Specifically, the following factors would exclude an episode:

- An inpatient, outpatient, or professional claim that is assigned to the episode window is associated with a third-party liability amount, or
- A patient who was enrolled with a relevant source of third party liability during the episode window.

Therefore, there will be no duplication or overlap between the episodes.

BIP –

In June 2013, Ohio was awarded more than \$169 million in enhanced federal medical assistance percentage (FMAP) for its participation in the Balancing Incentive Program (BIP). Ohio’s work to achieve balance in long-term care funding became a reality in SFY 15. On September 10, 2014, the Department of Medicaid announced that it had reached the 50-percent spending target to direct half of all Medicaid long-term care funding to home and community-based services. Beginning in 2014 and lasting well into 2015, work was underway to design and launch an online, single-entry point for obtaining information about long-term care services and supports available throughout Ohio. Another component of BIP, the online portal is intended to assist residents in their search for nearby health care and service options.

Money Follows the Person –

HOME Choice, Ohio’s Money Follows the Person effort, hit a new milestone in August 2014 as it successfully completed its 5,000th transition. By the fiscal year’s conclusion, the total number of transitions since the program’s 2008 inception reached 6,500 – more than tripling its initial goal of 2,000 transitions. Ohio also received a federal grant totaling \$12 million to implement an 811 Project Rental Assistance Demonstration program. The effort was a collaboration between the Ohio Department of Medicaid, the Ohio Housing Finance Agency, the Ohio Department of Developmental Disabilities, and the Ohio Department of Mental Health and Addiction Services.

CMMI Transforming Clinical Practices Initiative –

Ohio has recently engaged in conversations with the National Rural Accountable Care Consortium (NRACC), a non-profit organization that supports health care transformation. NRCC, a TCPI awardee, is developing practice transformation networks across the country. They plan to assist hundreds of practices implementing value-based models through their engagement. Ohio is excited about the continued conversation with NRACC and similar entities.

9. Workforce Capacity Monitoring

OHT is developing a comprehensive workforce development and training plan that will support SIM objectives. Ohio has approximately the national average number of primary care physicians, but more than 1.1 million Ohioans reside in rural or low-income urban areas underserved by these physicians. The shift to a population-based model will increase demand for primary care providers (PCPs), particularly those trained in team-based care. To support these models, Ohio will need to increase access to PCPs, build its workforce in underserved areas, enable all clinicians to practice at the top of their license, increase productivity through technology, and improve the effectiveness of interdisciplinary and community-based teams.

In 2013 OHT adopted a comprehensive plan to align Ohio’s health sector workforce programs to support advanced primary care and recruitment and retention of minorities into health professions. The plan has four components: (1) identify needs (increase reporting to the national Minimum Data Set (MDS) for primary care, enhance Ohio’s MDS data to identify health profession shortages, and develop an advanced primary care workforce forecasting model), (2) retain talent (target scholarship and loan repayment), (3) reform training (refocus \$100 million in Medicaid direct graduate medical education to support health sector workforce priorities and support training in promising models of care, including funding for 50 PCMH Education Pilot sites and 50 Pediatric Education Pilot sites), and (4) align payment (coordinate workforce policy priorities with PCMH and episode-based payment models).

To tackle the issue of aligning State funding to teaching hospitals toward the Administrations priorities to support primary care, Section 327.320 of the 2016-2017 of the State’s biennial budget (Am. Sub. H.B. 64) established a “Graduate Medical Education Study Committee” to study Medicaid payments to hospitals for the costs of graduate medical education (GME). The Committee is required to compile recommendations into a report it submits to the Governor and Ohio General Assembly not later than December 31, 2015.

The formula used to calculate GME payments to teaching hospitals was developed in 1987 and has never been revised. As a result, Ohio Medicaid subsidizes hospitals \$39,000 on average annually for each graduate medical intern or resident the hospital trains. However, some hospitals receive as much as \$385,000 per resident while others receive nothing at all.

In October and November 2015, the Office of Health Transformation convened the GME study Committee and invited public testimony on recommendations to (1) update the GME formula (e.g., recognize changes since the program was created in 1987) and achieve fairness in training program support, (2) promote state health policy priorities (e.g., recruit and retain more

physicians into primary care and specialties with shortages, and strengthen and improve minority training programs), and (3) create a comprehensive approach to medical education (e.g., repurpose medical school earmarks, loan forgiveness programs). ODM will take the first half of 2016 to work on a new formula with consideration from recommendations received. ODM will proceed to enter into an Ohio Administrative Rule change via CSIO and JCARR process by July 1, 2016 with implementation of a new formula July 1, 2017. Additional considerations will be made for a transition period of the new formula for teaching hospitals.

ODM intends to bring in national experts in the second quarter of 2016 to provide insights around the clinical workforce needed to meet the demands of both population health and patient-centered care.

10. Health Information Technology

HIT Plan Development

During 2015, Ohio crafted a visionary HIT plan based on market-based principles and focused on key healthcare objectives. While providing a vision for long term value, Ohio's plan delivers concrete, value-driven accomplishments in the very near term. This combined approach provides both the private sector and state government guidance for investments while the near term accomplishments adds immediate value and proof of the long term vision.

National Input, Ohio Focus

Ohio has an outstanding inventory of success in the HIT. From long existing HIEs (HealthBridge) to groundbreaking healthcare providers (Cleveland Clinic) to innovative payers (CareSource), Ohio has a strong knowledge base to leverage. However, Ohio also sought national leaders to develop our HIT plan. Following is a brief overview of the scope of input Ohio solicited to build our HIT plan.

Conducted interviews with experts and stakeholders within and outside of Ohio including:

- Individuals across 4 state agencies: Medicaid, Health, Mental Health, and Administrative Services
- Federal agencies including: former National Coordinators for HIT and current ONC executives
- Ohio payers and executives from non-Ohio payers (e.g., CTO, Sr. Medical Director, Business Architect)
- Provider executives from within and outside of Ohio, including CTOs, CIOs, senior business leaders, and practice managers
- Global IT consulting experts in the business technology, healthcare value analytics, and healthcare practices
- HIE / APCD executives from 4 different HIEs and 2 state-run APCDs
- Technology companies' executives from EHR, analytics, IT services, and associated vendors in the HIT value chain

Market Driven, Value Principles

Ohio established guiding principles to ensure we developed a plan consistent with the State's broader healthcare approach. Our overarching principles include being market driven, value based and leveraging existing assets.

These guiding principles helped steer the HIT plan:

- Act to affect private sector only where risk of market failure is very high (e.g., barriers to sharing necessary data)
- Lead by example and use ongoing efforts to further accelerate the technology outcomes that the market will not otherwise solve
- Clear regulatory barriers, if necessary
- Make full use of state assets (e.g., data, Universities, etc.)
- Accelerate private sector innovation
- Leverage other health reform and innovation efforts (e.g., SIM)
- Avoid actions that will undermine or delay innovation (e.g., being overly prescriptive in data or infrastructure standards)
- Do not "pick winners"; stay disciplined to letting the market resolve competitive issues wherever possible
- Avoid onerous mandates to participate in or contribute to an unproven concept in the absence of compelling business case (e.g., require all payers to submit claims to a statewide database with uncertain return on investment)
- Avoid very long projects with unclear objectives
- Invest in improving state's performance where potential value is greatest

The State's Role

We built our plan acknowledging the State cannot control or fix every challenge facing the healthcare industry. However, the State can play two important roles: catalyzer and or actor.

As a catalyzer, the state prioritizes action in areas where both the market will not solve an issue and successful SIM efforts will not create sufficient incentives to move the market. As an actor, value accrues by directly improving quality or lowering costs for state programs such as Medicaid.

Understanding and acknowledging the State's role was important when developing a plan that can successfully be implemented.

Key Healthcare Themes and Objectives

Ohio identified 7 non-IT themes to organize our plan. Leveraging non-IT themes ensured our HIT plan was directly connected to improving healthcare outcomes and adding value. For each theme, we identified an end state objective to ensure our plan was focused on valuable outcomes.

The 7 key healthcare themes and associated objectives are:

1. **Rewarding Value:** Providers are rewarded for delivering patient outcomes and cost-effectiveness,
2. **Performance Transparency:** Patients, providers, and other stakeholder have clear understanding of performance,
3. **Care Coordination:** Different types of clinicians have unfettered access to necessary patient records and collaborate to deliver care,
4. **Operational Efficiency:** Cost reduced through out value chain via process streamlining, automation, etc,
5. **Non-clinical Decision-making:** Policy and business decisions driven by a full understanding of relevant information and consistent use of advanced analytics,
6. **Clinical Decision-making:** Clinicians have robust set of support – data, tools, coaching, etc. available to consistently make optimal decisions, and
7. **Patient Engagement and Behavior Change:** Most patients empowered, enabled, or incented to make value-conscious decisions around their healthcare choices.

Technology Outcomes

To help narrow scope and focus on the opportunities with the most value add potential, Ohio identified technology-oriented outcomes to each of the 7 themes. Subsequently, we identified each outcome where the state had a role as catalyzer, actor or both. The chart below summarize the data in a visual format.

Recap: Technology-oriented outcomes

Potential focus area: state as catalyzer Potential focus area: state as actor Potential focus area: state as both roles PRELIMINARY

A Rewarding value	B Performance transparency	C Care coordination	D Operational efficiency	E Non-clinical decision-making	F Clinical decision-making	G Patient engagement/behavior change
1 Needed payer infrastructure, tools and data	1 Stakeholder alignment on metrics	1 Data formats enable sharing	1 Digitization	1 Integration, curation of internal data	1 Researchers can access needed data	1 Infrastructure, tools, data to monitor patients
2 Channels to share data	2 Useable data captured	2 Needed data capture	2 Workflow automation	2 Access to external data	2 Researchers capable of analyzing data	2 Infrastructure, channels for patients/provider communication
3 Providers can accept payments	3 Providers have data to self-evaluate	3 Infrastructure to communicate	3 Automation of manual activities	3 Analytic infrastructure	3 Clinicians can access needed data	3 Consumers have control over medical record
4 Common use of capabilities across payers where needed	4 Payers have data to evaluate providers	4 Channels to access data	4 Tech spend optimized	4 Analytic tools and talent	4 Channels, tools to support clinical decisions	4 Consumers have access to health info to make decisions
	5 Consumers have data to evaluate providers	5 Data owners provide data	5 Intermediation cost reduced	5 Robust advanced analytics for program assessment	5 Clinicians equipped to use tools, data	
	6 Sufficient analytic capacity	6 Providers use data				
	7 Channels to access data	7 Bi-directional communications				
		8 Transitions of care enabled				

Ohio then aligned existing initiatives and assets to the 7 themes. Examples include:

- Ohio’s SIM initiative is directly related to Rewarding Value,
- Ohio’s high adoption of EHRs and HIEs supports Care Coordination, and
- Ohio State University’s big data partnership with IBM could be leveraged to support Clinical Decision-making.

The Plan

In the state’s role as catalyzer, 9 potential focus areas emerged across 7 themes:

- Nearly half of these outcomes are related to having or using the right data, including providers having data to self-evaluate, consumers having data to evaluate providers, consumers accessing their own records, providers having the data to better coordinate care and make clinical decisions
- Other prioritized outcomes relate to rewarding performance through access to common capabilities across payers, improving care coordination during transitions, lower intermediation costs, and access to tools and talent to perform advanced analytics for non-clinical decision-making.

In the state's role as actor, several outcomes emerged as strategic priorities for consideration within two themes: improving non-clinical decision making (primarily through the robust use of advanced analytics for program assessment) and improving performance transparency. In addition, as an actor the state could choose to execute operational improvements that are critical to a well-performing and efficient state healthcare program; these may be considered distinctly from the strategic priorities (e.g. through automation of manual activities, optimization of technology spend across state agencies).

A set of best practices helped define a preliminary set of 4 strategies address many of these desired outcomes for both state as catalyzer and actor:

1. **Share useful payer data to help providers improve:** design and deliver multi-payer data and reports to PAPs, PCMHs, and key participating providers, including actionable performance data,
2. **Reinforce and accelerate care coordination:** encourage or require PAPs, PCMH, and other providers to develop stronger clinical (e.g., ADT) and administrative (e.g., appointment scheduling) linkages with other providers,
3. **Improve usability and access to state data:** continue and accelerate efforts to integrate data sets, expand access to data to internal and external stakeholders and create potential for other parties to add data, and
4. **Use big data to improve programs:** Create partnerships to apply big data and advanced analytics to the state's most pressing policy issues.

2016 Execution Plan

2016 will be a year of execution on Ohio's HIT Plan. Initiatives will be started in each of the 4 strategies. For each strategy, Ohio has identified some key Objectives and specific initiatives we will be launching.

Share Useful Payer Data To Help Provider Improve

Deliver data to providers so they can:

- Assess their own performance against peers and know what actions to take to improve the cost and quality of their care,
- Assess the quality and value of referral options, and
- Assess the quality and value of services and facilities for patient care.

Ohio will develop a suite of reports to meaningfully improve provider performance. Options include:

- Enhancing existing episode reports to include multi-payer data on a single report giving providers a complete overview of their performance for a specific episode. Ohio is investigating incorporating the following data on episode reports: Medicaid FFS, Medicaid managed care, Medicare, and some commercial payer data.
- Developing referral reports to allow providers visibility into the performance and quality of their referral partners.

Reinforce and Accelerate Care Coordination

Support and encourage the sharing of data between providers to improve the quality and efficiency in transitions of care.

As part of Ohio's PCMH rollout we attempt to design programs and structure incentives to optimize use of health IT to improve care coordination. Examples:

- Include requirement to share all necessary clinical data with PCPs and specialists involved in patient care
- Require hospitals with value-based Medicaid contracts to meet process metrics for data sharing
- Tie incentives for PCPs to directly schedule appointments with specialists and receive notifications when patients attend

Improve Usability and Access to State Data

Integrate existing, siloed state data to facilitate comprehensive analysis for program assessment, provider performance evaluation, and population health reporting.

Ohio will expand its enterprise data warehouse to integrate: Medicaid FFS and managed care data, Medicare data, population health data and early childhood data. We will improve the access to the integrated data to a broader range of state agencies and look for opportunities to enable commercial payers to contribute data.

Use Big Data to improve Programs

Ohio will look to create partnerships with the private sector to quickly take advantage of developing big data tools and capabilities without having to invest time and money in costly tools. Additionally, these partnerships will allow Ohio to augment its existing knowledge base with industry experts on an as-needed basis. Our first partnership will likely be focused on lowering the infant mortality rate in Ohio.

In addition, Ohio will look to leverage new technologies to give all providers access to state data in more dynamic and efficient manner. One potential opportunity is to connect the episode reports to live data allowing providers to drill down to source data to better understand and improve their performance.

11. Program Monitoring and Reporting

Ohio views the SIM Model Test as an opportunity for continuous improvement, to use data throughout the test period to assess progress, identify factors driving the observed results, and refine the models on an ongoing basis to improve long-term success and sustainability. This approach requires a comprehensive evaluation and monitoring plan focused on providing actionable insights to multiple stakeholders. This plan outlines the questions to be addressed and metrics that inform the answers, data sources and processes that different stakeholders will use to measure these factors, and processes to apply results for continuous improvement.

Ohio’s SIM Test will address four main questions: (1) Is the program achieving its end outcomes of strengthening population health, improving patient experience, and reducing the per capita cost of care? (2) Before improved population outcomes can be realized, what are the early signals of success? (3) Are implementation processes timely and effective? (4) What balancing measures are needed to address inadvertent negative consequences?

(1) Population level metrics change slowly over decades, beyond the duration of the SIM test. However, early indicators of program effectiveness may be seen in proximate measures, including cost, utilization, unit price, or site of care shifts (e.g., rates of ED visits) and quality (e.g., screening rates, rates of follow-up visits after inpatient stays). (2) To monitor the impact of Ohio’s SIM Test Ohio will track and report to CMS the following utilization, cost, quality, and population model performance metrics

<i>Impact area</i>	<i>Measure</i>	<i>Comments</i>
<i>Hospital readmission rates</i>	Plan All-Cause Readmissions	
<i>Emergency department visits</i>	ED visits/1000	
<i>Patient Experience</i>	% of participating PCMH providers who obtain patient feedback through either a	Ohio model strives to encourage innovation and minimize prescriptiveness, so providers have

	CAHPS survey or a patient family advisory council	option to perform CAHPS survey but can also obtain patient feedback in another way
Diabetes Care	Comprehensive Diabetes Care: HgA1c > 9%*	
Tobacco use	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	
Obesity	Adult BMI	Claims based, so preferred over the hybrid “Preventive care and screening: BMI screening and follow up” measure
Total cost of care per member per month	Total cost of care post member and service exclusions	
Behavioral health	Antidepressant medication management	The Ohio PCMH model only uses claims based measures so this measure was chosen in favor of “Preventive Care and Screening: Screening for Clinical Depression and Follow-up Plan”

Evaluation will include aggregate assessments at state and regional levels by population (Medicaid, Medicare, commercially insured) with performance analyses for providers participating in the PCMH model to assess impact over time. Although the PCMH model provides the best opportunity to track population health metrics, providers participating in the episode model will also be assessed on a set of quality metrics. Some of these metrics are aligned with the metrics listed above (*e.g., the asthma and COPD episode measures both include smoking cessation counseling.*)

Standard project management tools will be used to monitor adherence to the timeline of the transformation effort. For episodes, these include the number of principal accountable providers (PAPs) receiving a report, the number of PAPs eligible for incentive payments (minimum volume of valid episodes), the percent of PAPs who are reviewing their reports, and the number of PAPs participating in provider engagement activities (*i.e., webinars, best-practice sharing sessions*). For PCMHs, examples include the number of providers enrolled, the number of patients attributed to PCMHs, and providers’ status in meeting milestones set out by the

program (anticipated to be similar to those for CPCI, e.g., meeting meaningful use). Qualitative feedback on program effectiveness will also be gathered through PCMH and episodes planning teams (e.g. regional collaboratives, consumer advocates, others) and other forums for stakeholder engagement (e.g., regional meetings, questions received through customer support lines).

Finally, evaluation and monitoring processes will identify unintended consequences of the SIM models and opportunities for refinements throughout the course of the Model Test. Stakeholder feedback during implementation will be a critical source of this input. In addition, system metrics to identify practice pattern anomalies (i.e., shifts in coding practices) will be defined and regularly monitored. Combined, these system metrics, process metrics, and early indicators of success can highlight opportunities to make the SIM model more effective.

12. Data Collection, Sharing and Evaluation

Ohio is well-positioned to work collaboratively with the federal evaluation team, led by Dr. Joshua Wiener, Distinguished Fellow, Aging, Disability and Long-Term Care, RTI International. The first federal evaluation visit will be in Spring 2016. OHT, ODM and the federal evaluation team are already working through logistical items for the visit, so that it will be productive for all involved.

1. Collecting, securing, and providing the necessary Medicaid data, private payer data and/or Medicare data (e.g. identifiers) in such a manner, including file specification, that CMS and its contractors can perform the federal evaluation.

We believe that the majority of the evaluation effort will center on metrics that will be derived from claims data. In regards to claims data:

- We have access to all Medicaid claims data, both claims data for our fee for service book of business and claims data for the Medicaid Managed Care plans in Ohio.
- Being a duals demonstration state, Ohio also has access to data for a large portion of the Ohio duals population, but would like to work with Medicare to fill data gaps where they exist.
- We have yet to gain access to Medicare data for the non-duals population that resides in Ohio, but have expressed the desire to CMS to acquire the claims data for this population, and we have a high interest in working with CMS to set up a process by which Ohio will be able to access or acquire this data.
- Finally, while Ohio has worked in concert with commercial partners in the development of existing episodes and the early development of PCMH care delivery and payment models, Ohio has yet to formalize a process with commercial payers by which claims data will be transferred, or acquire higher level outputs derived from claims data to compute program evaluation metrics. In 2016, we will continue conversations with all payers.

To the extent that there are certain non-claims based metrics (e.g. certain forms of monitoring in our PCMH program may rely on provider attestations and other submissions) that are relevant for evaluation purposes, Ohio will set up a collection process that will to the best of our ability centralize and make accessible these data elements to CMS and its contractors for federal evaluation purposes.

2. Providing data for all patients covered by the SIM program (public, and commercial), including baseline and historical data for three years prior to the Project Period.

As stated above, Ohio believes that most of the metrics used for evaluation purposes will be derived from administrative claims data. Ohio, through sole action taken by the state, should have the ability to provide federal evaluators and their contractors with data for the Medicaid and Duals populations. Where Ohio will still need to build a process of data collection is for commercial and Medicaid (non-Duals) patients.

3. Creating an identifier for those affected by the SIM program, regardless of payer, as well as sufficient data to identify a comparison group.

As stated above, we will be able to create an identifier for those affected by SIM for the Medicaid and Duals populations. Based on the reports we get from commercial payers (e.g. on the number of reports released, on the provider outreach being performed), we believe they, too, will be able to create identifiers for those affected by the SIM program. However, we still need to work with commercial payers to ensure they fully operationalize the creation of the unique identifier.

Ohio would like to work in concert with Medicare to align and further engage in the Ohio SIM efforts. For example, knowledge of Medicare recipients who are being treated by providers participating in Ohio SIM efforts would be incredibly valuable to Ohio, and we assume for the federal evaluation process as well. This very gradual start would not require CMS to immediately send reports or tie payment to Ohio SIM program elements, but rather just to provide transparency on patient flows.

4. Providing CMS and its contractor(s) with identifying and contact information for beneficiaries who receive services under the model to examine patient care experience under this initiative.

- *The state will coordinate and facilitate any sampling and data collection on behalf of CMS among, but not limited to, state payers, private sector payers, and health care providers*

Ohio is currently reviewing, and will continue to work with the federal evaluation team in order to provide them with the necessary information in order to evaluate our SIM efforts. The ODM data team, including the ODM Privacy Board, will work to address needs related to beneficiary identification and contact information, sampling and data collection from payers and providers, and appropriate measures of patient care experience.

5. Cooperating with primary data collection efforts such as, but not limited to, surveys, focus groups, and key informant interviews.

The state of Ohio will be happy to cooperate with primary data collection efforts, and can help CMS and its contractors navigate the necessary pathways specific to Ohio that will help get this work done. Of note, the state of Ohio has already engaged in primary data collection efforts in the design of the SIM payment models. One example is a PCMH survey launched to providers across the state of Ohio.

6. Ensuring that the necessary legal mechanisms, authorities, and/or agreements are in place to ensure timely delivery of data to CMS and/or CMS contractors.

As identified in initial conversations with the federal evaluation team, Ohio will review existing governance to ensure that the necessary legal mechanisms, authorities, and/or agreements are in place to ensure timely delivery of data to CMS and/or CMS contractors. The state is committed to working to help make provide the clearances required to ensure a timely delivery of data to CMS. In the months to come, the state may require additional information from CMS in regards to the actual data elements that are most necessary for CMS and its contractors to perform the evaluation work, the level of disaggregation sought, the frequency of timeliness of the data being sought, etc. The State looks forward to working with CMS on these elements.

7. Cooperating with the federal evaluation contractor and CMS for any other needs/requirements for the evaluation.

Ohio is eager to continue building on our initial conversations with the federal evaluation team. We look forward to establishing a cadence of conference calls in 2016 and beyond.

8. Agreeing not to receive additional reimbursement for providing data or other reasonable information to CMS or another government entity or contractor.

Yes, we agree not to receive additional reimbursement for providing data or other reasonable information to CMS or another government entity or contractor.

13. Fraud and Abuse Prevention, Detection and Correction

The Ohio Department of Medicaid's Bureau of Program Integrity, made up of over 70 dedicated staff, includes auditors, nurses, and data analysts who focus on preventing and detecting fraud, waste, and abuse across a wide spectrum of services. The group coordinates with operational units on program integrity policy, and works to improve quality of care and

program compliance by providing technical assistance and monitoring providers, managed care plans, and subrecipients.

Further, the Ohio Medicaid Program Integrity Group (PIG) is a collaborative initiative that brings together Ohio Medicaid; the Ohio Auditor of State; and the Ohio Attorney General – all of whom operate complementary Medicaid integrity sections. Together, the respective entities craft data mining algorithms aimed at identifying fraudulent Medicaid providers and plan coordinated response to these findings. This coordinated approach to program integrity has been nationally recognized as a best practice in program integrity. The PIG continued to refine its efforts in SFY 15 and increased coordination with other program integrity partners. The success of the PIG model led to similar groups being created. One sub-group is aimed at ensuring program integrity in managed care organizations and the other explores creative ways to find patterns of abuse in prescription drugs.

In order to guard against new fraud and abuse exposures introduced under the new payment models, a series of measures will be evaluated historically and tracked annually to assess potentially fraudulent changes in practice patterns. For the episode model, potential measures to track include number of episodes, number and percentage of business and clinical exclusions (broken out by specific cause for exclusion, e.g., inconsistent enrollment), the distribution of included diagnosis and procedure codes within an episode, and the number and percentage of episodes with each risk factor. Potential fraudulent activities include an increase in coding of exclusions to avoid the episode, changes in coding practices to decrease claims included in the episode, and/or an increase in coding of specific risk factors in order to lower a provider's average episode cost. Additionally, there may be specific measures identified for each episode, such as the number or procedures performed in an inpatient vs. outpatient setting. These measures will be finalized in 2016 and evaluated in 2017 to assess impact of the first performance period for the first set of episodes.

For the PCMH model, potential measures include coding distributions by population and by member with a specific focus on codes related to risk-adjustment and total spend at the population, provider, and patient level. As the PCMH model is finalized over the next year, additional measures will be identified for assessment in 2017 – 2018.

For both models, where possible, quality measures are implemented to also guard against potentially fraudulent activities. One example is need for a follow-up visit in the asthma, COPD, and perinatal episodes within the first set that have already launched. Not performing a follow-up, or waiting to do so until after the episode has ended would lower the cost of the episode. However, follow-up is critical to delivering high quality care and preventing potential downstream exacerbations or admissions; hence each episode include follow-up within a specific timeframe as a quality metric.

Should the results of any ODM review lead the agency to believe that an incident of fraud has occurred in the Medicaid program, ODM refers the case to the Attorney General's Medicaid Fraud Control Unit (MFCU). ODM then proceeds to support the Attorney General by providing supporting documentation and resources as needed, while also protecting the privacy rights of those covered by the Medicaid program. Conversely, Ohio Medicaid also accepts referrals from

the Attorney General that may lead to the ultimate recovery of improper payments made to providers. The PIG also engages representatives from the Centers for Medicare and Medicaid Services (CMS) to discuss procedures, investigations, and provider areas that are at a heightened risk for fraud or abuse. In SFY 15, the Medicaid Fraud Control Unit of the Attorney General recorded:

- » 154 indictments,
- » 157 convictions; and,
- » \$15.8 million in recovery.

Annually, the U.S. Department of Health and Human Services, Office of Inspector General issues an annual report that highlights statistical achievements from the investigations and prosecutions conducted by 50 MFCUs nationwide. The latest issuance covers Federal Fiscal Year 2014 and Ohio was number one in fraud indictments and convictions.

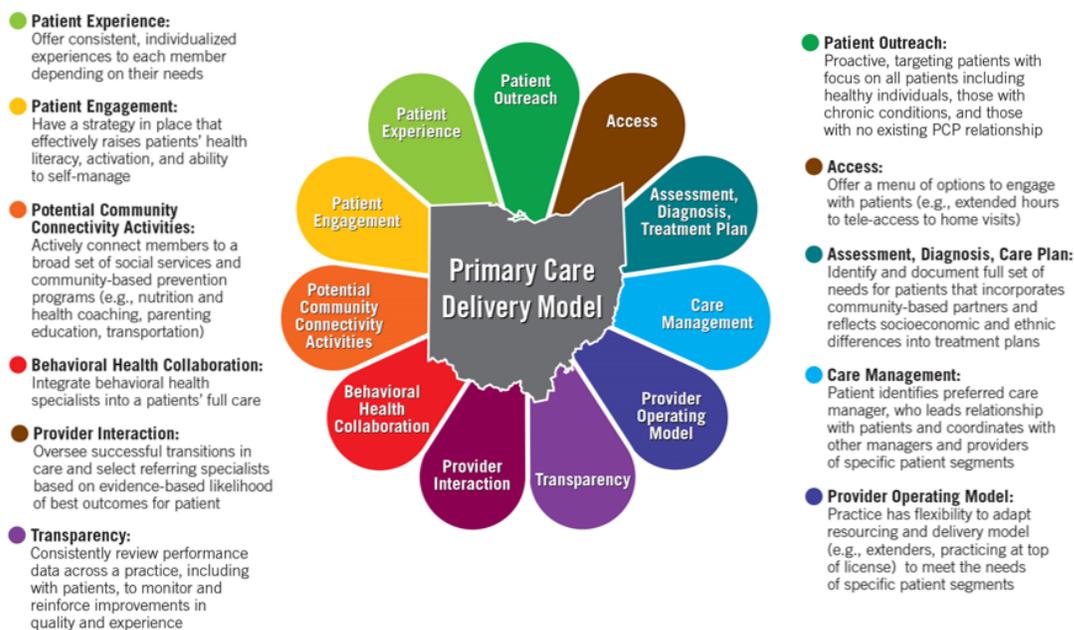
Currently, no current fraud or protection measures have been identified that interfere with implementation of the new payment models. ODM's Bureau of Program Integrity will be involved in evaluation of measures identified above and hence acutely aware of implementation needs for the activities laid out both in Ohio's Testing Grant Application and this operational plan. If any limitations arise, OHT and Medicaid will work closely to overcome these barriers as needed.

Appendix A

In 2015, Ohio began to develop the care delivery and payment models as well as other elements how practices can participate (enrollment, attribution, and pooling), and practice transformation, an additional support for select practices. Design decisions will continue to be refined in 2016 with stakeholder input as the State begins to operationalize the model. The design of these elements reflect the PCMH strawman as of December 16, 2015 **Primary care delivery model:** The Ohio PCMH care delivery model depicts four stages a practice may go through in its journey to become a transformed PCMH: beginning of journey, early, maturing, and transformed PCMH. The journey was organized around eleven domains that span across different areas of care delivery [EXHIBIT 1]

EXHIBIT 1

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



The Ohio PCMH care delivery model is intended to serve as a transformation guide for participating practices. Practices in Ohio currently span the spectrum with some practices operating as early PCMHs and other, more advanced practices, operating as transformed PCMHs. There is no timeline associated with the care delivery model (i.e, a practice does not need to become a “maturing PCMH” within 2 years) and there is no formal distinction between PCMHs at different stages. More transformed practices will be rewarded financially for their better outcomes. To gain access to these payments, practices will be required to pass a set of requirements inspired by the care delivery model.

Enrollment: Consistent with Ohio’s objective to include 80 - 90 percent of the state population (approximately 10.1 million Americans) in value-based payment models within five years, Ohio’s PCMH model has been designed to allow a broad provider participation through limited requirements for enrollment. At the same time, practices in the program will have to meet escalating performance requirements to keep qualifying for incentive payment over time.

To be eligible to participate in Ohio’s PCMH program, providers will have to meet the following enrollment requirements: 1) Be considered a primary care provider for the purpose of Ohio’s PCMH model, 2) Have at least 500 attributed Ohio Medicaid beneficiaries post exclusions, and 3) Commit to behaviors considered foundational for the success of the program (e.g., *commit to sharing data with the State and MCPs*)

To preserve the inclusiveness of the model, Ohio made an explicit decision not to include external accreditations or tools (e.g., EHR) as requirements for enrollment. This is in direct contrast to the CPCi model which highly preferred practices who were already recognized for advanced primary care and strong use of EHRs and other HIT.

Attribution: Only a subset of Medicaid recipients will be attributed to providers in Ohio’s PCMH model. These are recipients for whom the State and Managed Care Plans have visibility into total cost of care. Due to lack of visibility into total cost of care for others, duals, members with limited benefits, and members with TPL coverage beyond dental or vision services will be excluded at the outset, but Ohio intends to include duals once access to accurate and timely Medicare data is available.

This subset of included Medicaid recipients will be attributed to individual primary care providers based primarily on claims. In addition, new members can choose their PCP, and members remaining unattributed will be attributed based on non-claims methodology like geography or age. Members can make changes to their PCP, and changes will be made to reflect claims data (e.g., *if a member has three consecutive visits with a different PCP*).

INCLUSIONS

<u>Members included in TCOC spend</u>	<u>Services included in TCOC spend</u>
All adults and pediatrics	All non-excluded medical and prescription spend including case management, DME, home health
All behavioral health members	The first 90 days of nursing facility spend
Members with exclusively dental or vision TPL coverage	

EXCLUSIONS

<u>Members excluded from TCOC spend</u>	<u>Services excluded from TCOC spend</u>
Beneficiaries that have been attributed to that entity's practice(s) for less than 9 months of the performance period.	Waivers
Beneficiaries for whom Ohio Medicaid has identified another payer that is legally liable for all or part of the cost of Medicaid care and services provided to the beneficiary (e.g., dual-eligible population).	Dental services
Beneficiaries with limited benefits (e.g., family planning)	Transportation services
All other members with TPL coverage	Vision services
	Nursing facility spend after 90 days in institution
	All spend for a member after their first ICF/IID claim
	Other costs as determined by ODM.

Pooling: Upon enrollment and annually thereafter, practices will have the opportunity to pool with other practices to meet the minimum pool size of 5,000 attributed beneficiaries required to gain access to quality & financial outcomes based payments. Considerations for pooling activity will not be implemented till 2017.

Payment requirements: To earn payment there are capability requirements that measure what the practice has (e.g., *does the practice have 24/7 access to care*), activity requirements that measure what the practice does (e.g., *does the practice perform population management and see patients not recently seen*) and performance requirements that measure what the practice achieves (e.g., *does the practice decrease total cost of care, ED visits per thousand, or the number of patients with a HgA1c >9%?*)

Overview: Upon enrollment, all practices could have the opportunity to access two payment streams, PCMH operational activities payments and quality and financial outcomes based payment. The PCMH operational activities payment stream is intended to cover the ongoing costs associated with the new activities which PCMHs are expected to deliver such as ongoing infrastructure changes and staffing. The quality and financial outcomes based payments are payments intended to reward PCMHs who effectively manage total cost of care. Only

practices with 5,000 or more Medicaid members are eligible for outcome based payments. Practices with fewer than 5,000 members can become eligible for outcome based payments by pooling with other practices of under 5,000 members to reach the 5,000 threshold (pooling will not be implemented in 2016). Each payment stream is contingent on eligibility and ongoing requirements.

Payment stream—PCMH operational activities: All practices enrolled as PCMHs maybe eligible for operational activity PMPMs. PCMH operational activity payments are intended to provide ongoing support to practices as they commit to the key elements of transformation, including but not limited to care coordination, increasing patient access, creating care plans, and several other elements believed to be central to transformation.

PMPMs are contingent upon meeting a set of standard processes, activities, clinical quality and efficiency requirements. Requirements evolve over time, with greater long-term emphasis on measures assessing changes in performance (vs. processes/ activities).

The PCMH operational activities payment is in the form of a risk adjusted PMPM. The PCMH operational activities PMPM is intended to support both new activities and activities for which they were not previously reimbursed.

Risk adjustment will be performed using a standardized risk adjustment methodology based on factors that may include patient demographics, diagnoses, and utilization. Ohio’s goal is to have a single risk adjustment tool used across all MCPs to create consistency in risk stratification and payment, improve the overall statistical quality, and provide greater support to MCPs. The tool will be determined in conjunction with MCPs and payers in 2016.

Payment stream: quality & financial outcomes based payment: Quality & financial outcomes-based payments are intended to reward practices that effectively manage total cost of care for their populations while delivering on quality and utilization outcomes. Ohio’s current discussion about minimum panel size suggests that in order to be eligible for shared savings, there must be 5,000 members attributed across MCOs and FFS within a single practice, or in a provider pool. This minimum panel number is consistent with other shared savings programs including the Medicare shared savings program and the Arkansas PCMH program. The Anthem PCMH program requires a minimum of 7,500 attributed members. CPCi calculates shared savings at a regional level.

5. Practice transformation: Practice transformation payment is intended to serve as temporary support for the initial time, energy, and infrastructure investments (due to its time-limited nature, it is not meant to be used to fund additional personnel) required to begin the path to becoming a PCMH. Practice support is not intended to provide incremental margin for the practice, but rather to cover costs that practices would face to “transform.”

Care delivery model

Preliminary pre-decisional working draft; subject to change

HIGHLY PRELIMINARY

Vision for Ohio’s primary care delivery model (1/4)

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

Vision for Ohio’s primary care delivery model (2/4)

	Beginning of the journey	Early PCMH	Maturing PCMH	Transformed PCMH
Care management	<ul style="list-style-type: none"> Most patients lack connection to a care manager while others are subject to many, overlapping care coordination efforts 	<ul style="list-style-type: none"> Foster communication between care managers for patients Identify who, within the practice, is in charge of care management activities for at-risk patients 	<ul style="list-style-type: none"> Coordinate between care managers to ensure clarity over which manager has lead responsibility when and reduce duplications of outreach to patients Establish initial links with community-based partners for at-risk patients 	<ul style="list-style-type: none"> Patient identifies preferred care manager, who leads relationship with patient and coordinates with other managers and providers Collaborate meaningfully with other key community-based partners (e.g., schools, churches) to exchange information with patient consent where appropriate
Provider operating model	<ul style="list-style-type: none"> Primarily focus on managing patient flow/volume 	<ul style="list-style-type: none"> Improve operational efficiency through process redesign and standardization, harnessing improvement tools (e.g., standardized use of clinical practice guidelines) 	<ul style="list-style-type: none"> Optimize staff mix (e.g., extenders, community health worker, cultural diversity), redesign processes and leverage technology, where appropriate, to maximize practice’s operational efficiency (e.g., practice at top of license) 	<ul style="list-style-type: none"> Practice has flexibility to adapt resourcing and delivery model to meet the needs of specific patient segments as appropriate
Transparency	<ul style="list-style-type: none"> Review performance data irregularly, if at all, to identify and pursue opportunities for improvement 	<ul style="list-style-type: none"> Bi-directionally exchange performance data with payers using a standard format and with a high degree of timeliness that can lead to improvements in treatment Consistently review performance data within the practice to monitor quality and prioritize outreach efforts Leverage standard process to ensure that data leads to identification of opportunities and changes to practice patterns, working with payers where appropriate Share priorities from patient survey with members and staff (e.g., post findings in the office) 	<ul style="list-style-type: none"> Discuss performance data with other providers, sharing learnings, receiving “second opinion” on challenging cases and advice on opportunities for improvement Share relevant performance data with public health agencies Implement changes based on priorities resulting from patient satisfaction survey 	<ul style="list-style-type: none"> Share relevant performance data with members and communities through website and in-office communication (e.g., information about wait times)

Vision for Ohio’s primary care delivery model (3/4)

	Beginning of the journey	Early PCMH	Maturing PCMH	Transformed PCMH
Provider interaction	<ul style="list-style-type: none"> Select specialists for referrals based on prior experience Do not consistently leverage all available resources during transitions in care 	<ul style="list-style-type: none"> Proactively reach out to patients after an ED visit/hospitalization Track and follow-up on specialist referrals and diagnostic testing Information is shared bi-directionally between PCP and specialist 	<ul style="list-style-type: none"> Select specialists for referrals also based on likely connectivity with member Select specialists for referrals based on risk-adjusted data on outcomes and cost, potentially leveraging data from episodes of care Proactively reach out to patients before and after any planned transition in care 	<ul style="list-style-type: none"> Match type of care with member needs, as jointly identified by member and provider (e.g., regular in-person interactions with multi-disciplinary team only when needed) Proactively manage urgent needs, to the extent possible (e.g., reach out to the ED to anticipate arrival of patients that have sought care from the practice first, to accelerate provision of care and ensure that it is targeted) Ensure access and integration to all capabilities needed (e.g., clinical pharmacy)
Behavioral health collaboration	<ul style="list-style-type: none"> Do not consider undiagnosed BH cases a priority 	<ul style="list-style-type: none"> Integrate presenting behavioral health needs into care plans Refer BH cases to appropriate providers Collaborate ‘at a distance’ with BH providers for most at-risk patients 	<ul style="list-style-type: none"> Focus on diagnosing and addressing undiagnosed BH needs Track and follow-up on BH referrals and ensure ongoing communication with BH specialist – onsite where possible Provide more coordinated care between primary and BH providers (e.g., same-day scheduling, co-location, system integration) 	<ul style="list-style-type: none"> Integrate behavioral specialists in the practice, where scale justifies it Fully integrated systems and regular formal and informal meetings between BH and PCP/team to facilitate integrated care Build competencies to directly provide select BH services on site, when scale justifies it Collaborate with community-based resources to manage BH needs
Potential community connectivity activities	<ul style="list-style-type: none"> Have limited community connectivity outside of office, or relationships with social services 	<ul style="list-style-type: none"> Inform patients of social services and community-based prevention programs that can improve social determinants of health (e.g., provide list of helpful resources, including local health districts) 	<ul style="list-style-type: none"> Facilitate connectivity to social services and community-based prevention programs by identifying targeted list of relevant services geographically accessible to the member, covered by member benefits, and with available capacity (e.g., Community Health Nursing, employment, recreational centers, nutrition and health coaching, tobacco cessation, parenting education, removal of asthma triggers, services to support tax return filings, transportation) 	<ul style="list-style-type: none"> Actively connect members to broader set of social services and community-based prevention programs (e.g., scheduling appointments and addressing barriers like transportation to ensure appointment happens) Ensure ongoing bi-directional communication with social services and community-based prevention programs (e.g., follow up on referrals to ensure that the member used the service, incorporate insights into care plan, provide support during transitions in care) Collaborate meaningfully (e.g., through formal financial partnerships) with partners based on achievement of health outcomes Actively engage in advocacy and collaborations to improve basic living conditions and opportunities for healthy behaviors¹

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

Vision for Ohio’s primary care delivery model (4/4)

	Beginning of the journey	Early PCMH	Maturing PCMH	Transformed PCMH
Patient engagement ¹	<ul style="list-style-type: none"> Have standard fliers and educational material available in the office 	<ul style="list-style-type: none"> Assess patient’s level of health literacy, engagement, and self-management and have a defined plan to provide appropriate materials and improve over time Ask patients how they wish to be engaged (e.g., email, phone calls, language), consistent with the resources and infrastructure the practice currently has Offer “patient navigator” support to at-risk patients, to help them find and access healthcare resources 	<ul style="list-style-type: none"> Adopt means that practice did not previously provide to engage with patients and meet patient’s preferences (e.g., text messaging) Use individualized techniques to activate patients (e.g. motivational language) Leverage tools such as remote monitoring devices to promote patient activation and self-management Provide targeted educational resources (e.g., online video/guides, printed materials) to all members 	<ul style="list-style-type: none"> Consistently measure improvement in patient activation and health literacy, increasing share of patients at appropriate level to achieve optimal care outcomes Actively engage with patients to motivate appropriate degree of self-management Connect at-risk members with other members with similar needs, to help create an additional support system for members and families
Patient experience ²	<ul style="list-style-type: none"> Do not explicitly focus on patient experience 	<ul style="list-style-type: none"> Prioritize continuity of relationship with provider and team for patient Regularly solicit and incorporate targeted feedback from patients into overall patient experience (e.g., quarterly survey) 	<ul style="list-style-type: none"> Achieve greater cultural competence through training, awareness, and access to appropriate services (e.g., translation) Regularly solicit and incorporate the feedback of patients into individual care 	<ul style="list-style-type: none"> Offer consistent, individualized experiences to each member depending on their needs (based on age, gender, ethnicity, socio-economic situation) Integrate patients into the practice management team to provide feedback on overall patient experience Participate in online patient rating sites (if relevant to practice population)

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