Ohio | Governor's Office of Health Transformation

Patient-Centered Medical Home State Model Design Team

August 27, 2015

www.HealthTransformation.Ohio.gov

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PCMH Design Team Agenda

1. Update on progress to date
2. Detailed review of model design decisions
3. Approach to receiving your input
4. Alignment with other reform goals
5. Appendix (Ohio PCMH Charter)

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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	▪ 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	▪ In 2014 focus on Comprehensive Primary Care Initiative (CPCi)	▪ State leads design of six episodes: asthma acute exacerbation, COPD exacerbation, perinatal, acute and non-acute PCI, and joint replacement
2015	▪ Collaborate with payers on design decisions and prepare a roll-out strategy	▪ State leads design of seven new episodes: URI, UTI, cholecystectomy, appendectomy, GI hemorrhage, EGD, and colonoscopy
2016	▪ Model rolled out to at least two major markets	▪ 20 episodes defined and launched across payers, including behavioral health
2017-2018	▪ Model rolled out to all markets ▪ 80% of patients are enrolled	▪ 50+ episodes defined and launched across payers, including behavioral health

updated August 27, 2015

Significant progress implementing episode-based payment model …

Principles for selection:

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

Ohio's episode selection:

Episode	*Principal Accountable Provider*
WAVE 1 (launched March 2015)	
1. Perinatal	Physician/group delivering the baby
2. Asthma acute exacerbation	Facility where trigger event occurs
3. COPD exacerbation	Facility where trigger event occurs
4. Acute Percutaneous intervention	Facility where PCI performed
5. Non-acute PCI	Physician
6. Total joint replacement	Orthopedic surgeon
WAVE 2 (launch January 2016)	
7. Upper respiratory infection	PCP or ED
8. Urinary tract infection	PCP or ED
9. Cholecystectomy	General surgeon
10. Appendectomy	General surgeon
11. Upper GI endoscopy	Gastroenterologist
12. Colonoscopy	Gastroenterologist
13. GI hemorrhage	Facility where hemorrhage occurs
WAVE 3 (launch January 2018)	
14-19. Package of behavioral health episodes to be determined	

This is an example of the reports the plans listed above made available to providers beginning in March 2015

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EPISODE of CARE PAYMENT REPORT

PERINATAL — Jul 1, 2013 to Jun 30, 2014

Reporting period covering episodes that ended between July 1, 2013 and June 30, 2014

PAYER NAME: Ohio – Medicaid FFS PROVIDER CODE: 1234567 PROVIDER NAME: XYZ Women's Health Center

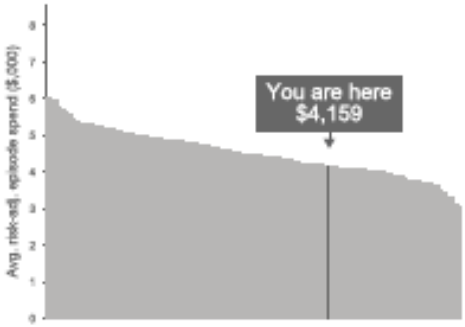
You would be eligible for gain or risk sharing of N/A[1]

Episodes inclusion and exclusion

Total episodes: 154

Risk adjusted average spend per episode

Distribution of provider average episode spend (risk adj.)



Episodes risk adjustment

95% of your episodes have been risk adjusted

Quality metrics

Your performance on quality metrics that will be ultimately linked to gain sharing

HIV screening	53%
GBS screening	71%
C-section	31%
Follow-up visit	30%

Potential gain/risk share

N/A[1]

1 Not applicable during reporting-only period

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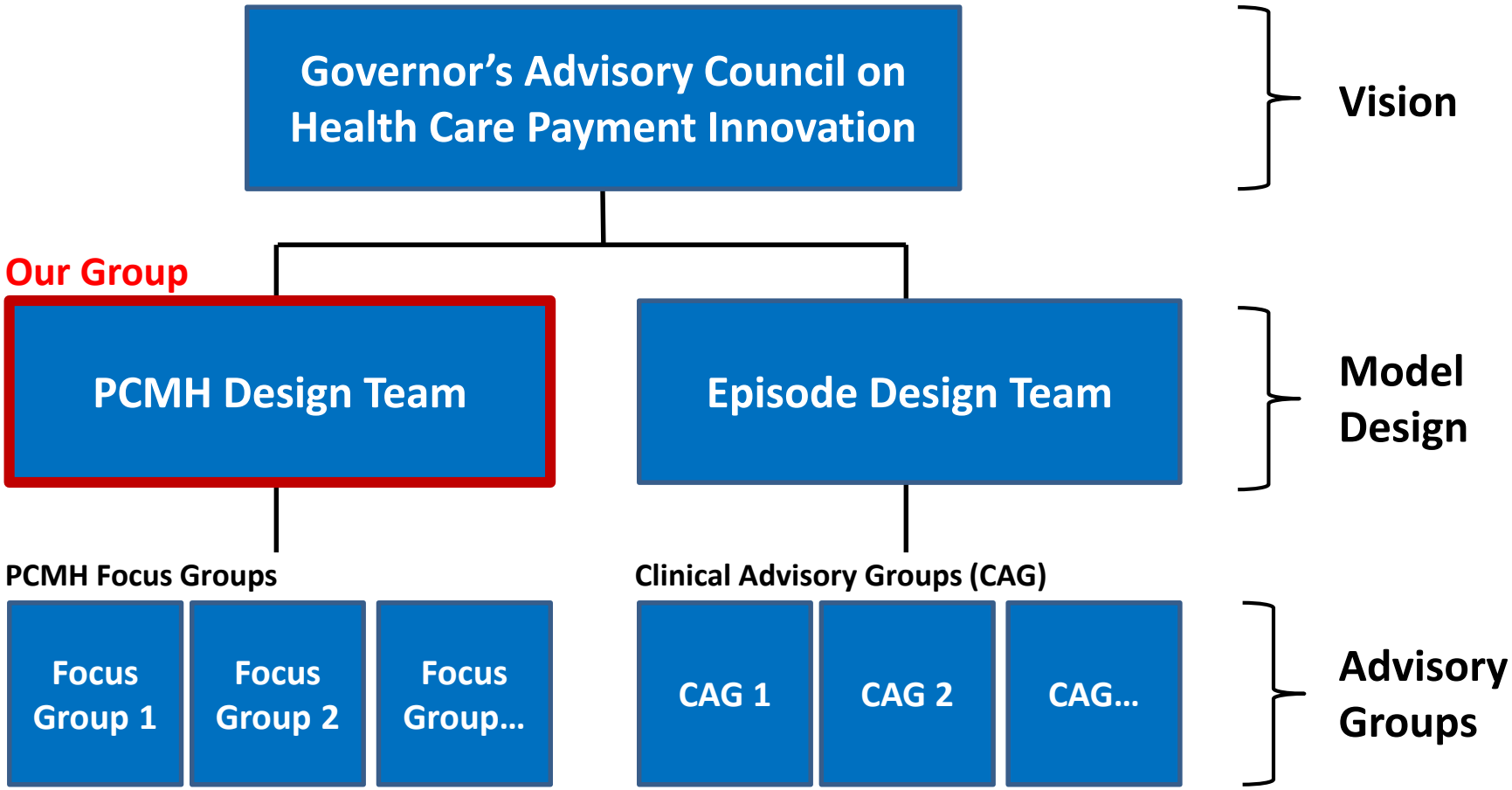
Ohio's payment innovation design team structure



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Laying the groundwork to move quickly …

2013-2014	May	June/July	August	Sept-Dec
Preliminary Model Design	**Model Design Team Kick-Off**	**RFP for design support**	**Design work begins**	**Develop the model**
• Adopt a PCMH Charter for Payers to align public and commercial PCMH payment priorities • Follow lessons learned from Comprehensive Primary Care Initiative (CPCi) • Submitted State Health Improvement Plan with key PCMH milestones	• Ohio's approach to paying for value • Ohio PCMH Charter for Payers • Arkansas PCMH Model Design • Comprehensive Primary Care Initiative (CPCi) PCMH Model Design	• State RFP for comprehensive design and implementation support • McKinsey chosen as support vendor	• Design team convenes to develop and share design and roll-out plan by the end of 2015	• Focus groups convene to provide input on design decisions • Design team meets every other month to review focus group results and provide input on multiple design dimensions • Ohio develops the model based on design team input

PCMH pilots and planning are underway in Ohio …

Care delivery model	• Regional activities promoting care coordination are underway (e.g., Better Health Partnership, Healthcare Collaborative of Greater Columbus, The Health Collaborative, CPCi) • Ohio Patient-Centered Primary Care Collaborative (OPCPCC) Patient Engagement Learning Center is working with providers on ways to engage patients in their healthcare
Payment model	• CPCi pilot sites in Cincinnati include payment reforms (e.g., PMPM fee for care coordination, shared savings) and metrics linked to incentive payments • Limited pilots including payment model reforms elsewhere (e.g., OSU Family Practice sites negotiating PMPMs with payers)
Infrastructure	• Organizations like HealthBridge and OHIP develop tools and services to help health care organizations adopt technologies (e.g., HER, HIE, registry, IP admit alerts) • OHT preliminary HIT strategy sets priorities for state action • No mandatory infrastructure has been rolled out statewide
Scale-up and practice performance improvement	• Education pilots to train practicing and student providers • No statewide set of metrics identified yet; CPCi and other pilots require metrics collection as part of participation • OHT, working with payers across Ohio, has established the goal of covering 80 percent of the state's population in PCMHs by 2018

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PCMH Design Decisions

Care delivery model	A. Target patients and scope B. Target sources of value C. Care delivery improvements	Vision for a PCMH's role in the healthcare eco system, including who they should target, how care should be delivered (including differences from today), and which sources of value to prioritize over time.
Payment model	D. Technical requirements for PCMH E. Attribution/assignment F. PCMH activities G Quality/efficiency/total cost of care (TCOC) H. Payment streams/incentives I. Risk adjustment	Holistic approach to use payment (from payers) to encourage the creation of PCMHs, ensure adequate resources to fund transformation from today's model, and reward PCMH's for improving in outcomes and total cost of care over time
Infrastructure	J. Provider infrastructure K. Payer infrastructure L. State system infrastructure	Technology, data, and people required to enable changes in payment, reporting, and HIE
Scale-up and practice performance improvement	M. Scale-up target N. Practice transformation support O. Patient engagement P. Workforce/human capital Q. Legal/regulatory environment R. Network/contracting S. ASO contracting/participation T. Performance transparency U. Ongoing PCMH support V. Evidence/pathways/research W. Multi-payer collaboration X. Stakeholder engagement	Support, resources, or activities to enable practices to adopt the PCMH delivery model, sustain transformation and maximize impact

Agree on degrees of standardization within each model

"Standardize"

Standardize approach (i.e., identical design) only when:

- Alignment is critical to provider success or significantly eases implementation for providers (e.g., lower administrative burden)
- Meaningful economies of scale exist
- Standardization does not diminish potential sources of competitive advantage among payers
- It is lawful to do so
- In best interest of patients (i.e., clear evidence base)

Example: Quality Measures

"Align in principle"

Align in principle but allow for payer innovation consistent with those principles when:

- There are benefits for the integrity of the program for payers to align
- It benefits providers to understand where payers are moving in same direction
- Differences have modest impact on provider from an administrative standpoint
- Differences are necessary to account for legitimate differences among payers (e.g., varied customers, adm. systems)

Example: Gain Sharing

"Differ by design"

Differ by design when:

- Required by laws or regulations
- An area of the model is substantially tied to competitive advantage
- There exists meaningful opportunity for innovation or experimentation

Example: Amount of Gain Sharing

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Over the remainder of 2015, your input will help shape our approach

■ Details follow

	Description	Design deliverables by end of 2015
1 **Care delivery model**	*Vision for a PCMH's role in the health care ecosystem*	A Target patients and scope B Target sources of value C Care delivery improvements
2 **Payment model**	*Model to encourage and finance transformation, fund new care and operations, reward value*	D Technical requirements for PCMH E Attribution/assignment F PCMH activities G Quality, efficiency, and total cost of care H Payment streams/incentives I Financial risk adjustment and risk mitigation
3 **Infrastructure**	*Technology, data, and people required to enable changes in payment, reporting, and HIE*	J Provider infrastructure K Payer infrastructure L State system infrastructure
4 **Scale-up and practice performance improvement**	*Support, resources, or activities to enable practices to adopt the PCMH delivery model, sustain transformation and maximize impact*	M Scale-up target N Practice transformation support O Patient engagement P Workforce/human capital Q Legal/regulatory environment R Network/contracting to increase participation S ASO contracting/participation T Performance transparency U Ongoing PCMH support V Evidence, pathways, & research W Multi-payer collaboration X Stakeholder engagement

Reminder – principles behind PCMH design decisions

	Description	Design deliverables by end of 2015
1 **Care delivery model**	*Vision for a PCMH's role in the health care ecosystem*	A Target patients and scope B Target sources of value C Care delivery improvements
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Principles that we have agreed upon as we work through care delivery model design decisions

- Identify the scope of people and changes to activities, and services, using real evidence to create better health outcomes for Ohio

1A Example design decisions: target patients and scope (1/2)

	Issue	Options[1]	Considerations / open questions
Target patient population	Age of patient population	▪ Adults only ▪ Pediatrics only ▪ Adults and pediatrics	▪ Breadth and potential impact of program ▪ Demonstrated value in adult and pediatrics in other successful models
	Health profile inclusion	▪ Include all patients, both healthy and chronically ill ▪ Include chronic or high risk patients only	▪ Breadth and potential impact of program ▪ Precedent of full inclusion in other models (i.e., 17 of 19 NASHP models address full patient population)[2]
	Approach to high-need behavioral health members	▪ Exclude patients with specific behavioral health conditions ▪ Include patients with specific behavioral health conditions, but exclude their costs ▪ Include all patients and all costs	▪ Support mechanisms available to BH members (i.e., health homes) ▪ Open question on whether PCP can effectively coordinate patient care and be responsible for total cost
	Approach to duals population	▪ Include all duals ▪ Include only duals in MCOs ▪ Exclude all duals	▪ Only include members where MCO has total cost of care responsibility and data ▪ Consider including broader population as more data becomes available
	Approach to LTSS population (including I/DD population)	▪ Exclude all LTSS members ▪ Include some LTSS members (and none, some[3], or all of LTSS costs) ▪ Include all LTSS members (and none, some[3], or all of LTSS costs)	▪ Answer could differ for LTSS members in nursing facilities / HCBS ▪ Open questions of whether PCP can effectively coordinate patient care and be responsible for total cost, and whether to include total medical or LTSS core costs

1 Many options have sub-choices to be discussed in upcoming working sessions, and all require a separate decision on degree of alignment needed across payers
2 Pennsylvania and Rhode Island address only high-risk patients
3 E.g., PCMH responsible for all costs associated with home and community based services and for the first portion of a nursing facility stay (e.g., first 90 days)

1A Example design decisions: target patients and scope (2/2)

	Issue	Options[1]	Considerations / open questions
Service exclusions	Service exclusion	▪ Include all services ▪ Exclusion of dental and vision ▪ Exclusion of transportation services ▪ Exclusion of LTSS services (described on previous page)	▪ Exclude costs for which PCP does not have direct control ▪ TBD if provision of coverage is consistently available ▪ Exclude non-medical costs / may want to encourage some use
Geographic exclusions	Patient geographic exclusion	▪ None ▪ Rural communities ▪ Pilot in a single region	▪ Goals for focus of effort ▪ Consider time/pace to get to scale ▪ Test if / how program may differ by geographies

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1B Example design decisions: sources of value

	Issue	Options[1]	Considerations / open questions
Sources of value	Area of patient focus	▪ Equal focus on all patients ▪ Focus PCMH activities on high-risk patients (e.g., through payment, training, reporting metrics, and required PCMH activities)	▪ Channel state efforts toward a focused common goal ▪ Maximize potential impact of program and value for investment ▪ Modeled after successful examples in other settings
	Identified sources of value that align to focus areas	▪ Appropriateness of care setting – Reduction in unnecessary ED visits and inpatient admissions – Shift to lower cost facilities ▪ Appropriateness of treatment or care – Appropriate BH counseling / meds – Minimize length of stay – Improved medication management (i.e., improved reconciliation, appropriate utilization, use of generics) – Resource utilization (e.g., imaging) ▪ Improved treatment compliance ▪ Referrals to high-value providers ▪ Reduction in readmissions ▪ Population health and wellness – Preventative screening – Vaccinations ▪ Other	▪ Prioritize sources of value that address target population of high-risk patients ▪ Open questions include further sources of value (to be identified through diagnostic) and balance across identified sources of value, e.g., – Distribution of ED visits / IP visits across practices – Distribution of costs and utilization by chronic condition – Alignment of PCP attendance (e.g., outside of assigned practice) with utilization – “ER frequent flyers” by practice type, region, etc. – Costs / utilization by practice type, region, etc. ▪ Use sources of value to drive decisions on metrics for provider performance reporting, required/desired PCMH activities

1 Many options have sub-choices to be discussed in upcoming working sessions, and all require a separate decision on degree of alignment needed across payers

Reminder – principles behind PCMH design decisions

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Principles that we have agreed upon as we work through payment model design decisions

- Provide time-limited support for business model transformation
- Compensate PCMH for new activities (care coordination, population health management, etc.)
- Reward PCMHs for delivering efficient care through bonus payments, shared savings, or capitation

2D Example design decisions: technical requirements for PCMH (1/2)

	Issue	Options[1]	Considerations / open questions
Initial eligibility require-ments	Minimum panel size to join program	▪ Require minimum panel size for participation (i.e., eligibility to receive practice transformation and care coordination support and reports) ▪ Require minimum panel size for only PT and CC support (not reporting) ▪ No minimum panel size requirement	▪ Resources allocated to practices need to impact a minimum number of patients to be valuable ▪ Provide reporting to smaller practices to encourage movement toward participation ▪ Question remains whether to consider size of patient panel within a given payer or across MCOs
	Specialties eligible for attribution to the PCMH model	▪ Family medicine ▪ Internal medicine ▪ Geriatrics ▪ Pediatrics ▪ Other	▪ Primary care-focused ▪ To extent possible, accommodate MCOs' current definition of primary care providers ▪ Open question whether to include mid-levels (e.g., advanced registered nurses, physician assistants, etc.)
Ongoing participa-tion require-ments	Minimum perso-nnel requirements	▪ Primary care provider (PCP) ▪ Clinical care coordinator / case manager for practices above certain size ▪ Other	▪ Literature indicates that clinical care coordinators enable success of PCMH program ▪ Supported by learnings from payers ▪ Open question of defining size requirements for care coordinator
	Additional tools or vendor adoption required for care coordination	▪ Adoption of a care coordination tool ▪ Commitment toward EHR over time ▪ Other	▪ Maximize and standardize data sharing across payers and providers and ensure that all PCMHs have a base level of health record functionality ▪ Open question of whether and how to monitor usage of tool
	Third party accreditation	▪ NCQA ▪ Multiple[2] ▪ None	▪ Provide mechanism to encourage common approach to PCMH transition ▪ Precedent in over half of other states' programs ▪ Open questions remain impact of NCQA recognition redesign (e.g., cost)

1 Many options have sub-choices to be discussed in upcoming working sessions, and all require a separate decision on degree of alignment needed across payers
2 E.g., AAAHC, TJC, URAC

2D Example design decisions: technical requirements for PCMH (2/2)

	Issue	Options[1]	Considerations / open questions
Practice require-ments to achieve incentive payments	Panel size required to be eligible for incentive payments	▪ Minimum of 5,000 patients per MCO for shared savings payments ▪ Enable practices with < 5,000 members per MCO to achieve incentive payments through pooling	▪ Literature indicates 5,000 minimum for receiving shared savings payments ▪ Balance between need to eliminate noise in year-to-year variation in TCOC from small panel sizes with including the maximum possible number of practices
	Quality metric performance	▪ Use quality as a gate to both care coordination payments and shared savings (e.g., must hit 5 of 10 core measures) ▪ Create multiplier for quality beyond gate for shared savings (e.g., 50% of total for 5/10, 60% for 6/10, etc.) ▪ No quality gate	▪ By including quality as a gate for shared savings in addition to other payments, emphasizes the value-based nature of the program (i.e., not just cost-based) to providers ▪ Multiplier creates an element of fairness, though may have increased volume of providers on the border requesting to move up a tier, given that there will be more 'borders', i.e., 60% + or - 1
Patient eligibility	Time with practice	▪ Set minimum time with practice as prerequisite to eligibility for shared savings (e.g., 6-9 months) ▪ No time requirement	▪ Ensure that practices have sufficient time to enable meaningful change in care delivery ▪ Open question on specific time requirement, to be informed by patient churn rates and impact of specific time requirements on panel size
	Time with payer	▪ Set minimum time for coverage to be attributed, included in reporting/payment ▪ No time requirement	▪ For sufficient claims history
	Practice exclusion of patients	▪ Allow PCPs to exclude select few outliers from patient panel ▪ None	▪ Potential choice to allow physicians some discretion re: very complicated or non-compliant patients (i.e., don't create incentive for PCP not to see them by including in payment model)

1 Many options have sub-choices to be discussed in upcoming working sessions, and all require a separate decision on degree of alignment needed across payers

2G For discussion – quality/efficiency metrics

Example HEDIS-based metrics aligned to sources of value

- Adolescent well-care visits
- Antibiotics for acute bronchitis
- Antidepressant medication management
- Diabetes: Hemoglobin A1c (HbA1c) testing, HbA1c poor control (>9.0%), LDL–C screening, LDL–C <100 mg/dL
- Diabetes: Nephropathy, retinal exam, and BP <140/90
- Follow-up care for children prescribed ADHD medication (initiation phase)
- Follow-up care for children prescribed ADHD medication (continuation phase)
- Hyperlipidemia control
- Hypertension control
- Immunizations for adolescents
- Medication management for people with asthma
- Persistent medication monitoring

Example STARs metrics[1]

- Customer service
- Improving or maintaining physical health
- Obtaining appointments and care quickly
- Patient perception of coordinated care
- Rating of healthcare quality

Considerations

- What metrics are **already being reported on** today? Frequency and timing of reporting?
- Is there any metrics
  - Known to be effective in bringing **low-attendance patients** into the door
  - Known to **cut cross disease states** for high-risk patients
  - Shown to have **significant variation** between high vs low performers
  - Shown to **correlate especially highly with overall cost / quality improvement** for high-risk patients

1 Examples given are from CAHPS (Consumer Assessment of Healthcare Providers and Systems) and from HOS (Health Outcomes Survey). HEDIS measures are also included in STARs metric set

2G Example design decisions: quality metrics

	Issue	Options[1]	Considerations / open questions
Quality measures and approach for PCMH	Approach to identify common core metrics	▪ Use of existing core metrics tailored for high impact populations in OH[2] ▪ Incorporate HEDIS measures associated with care for high risk individuals, and selected others that further goals of model (e.g., share of LTSS population in HCBS settings) ▪ Additional core metrics could be drawn from other sources to further programs' goals (e.g., CAHPS, HOS)	▪ Take advantage of existing common set of metrics currently in use that aligns with identified OH needs ▪ Address program sources of value with targeted metrics, including for LTSS population ▪ Open question: Supplement with additional metrics (e.g., CAHPS) to more fully align with STARs for MA
	Usage of common core set of quality metrics amongst payers (for PMPM and incentive payments)	▪ Single set of common metrics aligned across payers[3] ▪ Small menu of options ▪ Large menu of options	▪ Ensure standardization to best compare providers to one another statewide ▪ Streamline set of required metrics
	Additional menu of optional metrics to supplement core	▪ Yes ▪ No	Ensure optionality for payers and providers to customize metric set ▪ Minimize rework for contracts already in place ▪ Enable commercial participation ▪ Learn from best approaches currently taken by payers and providers

1 Many options have sub-choices to be discussed in upcoming working sessions, and all require a separate decision on degree of alignment needed across payers
2 High risk pregnancy/ premature births, behavioral health, cardiovascular disease, diabetes, asthma, upper respiratory infections
3 With variations tailored to specific provider types (e.g., pediatrics, family)

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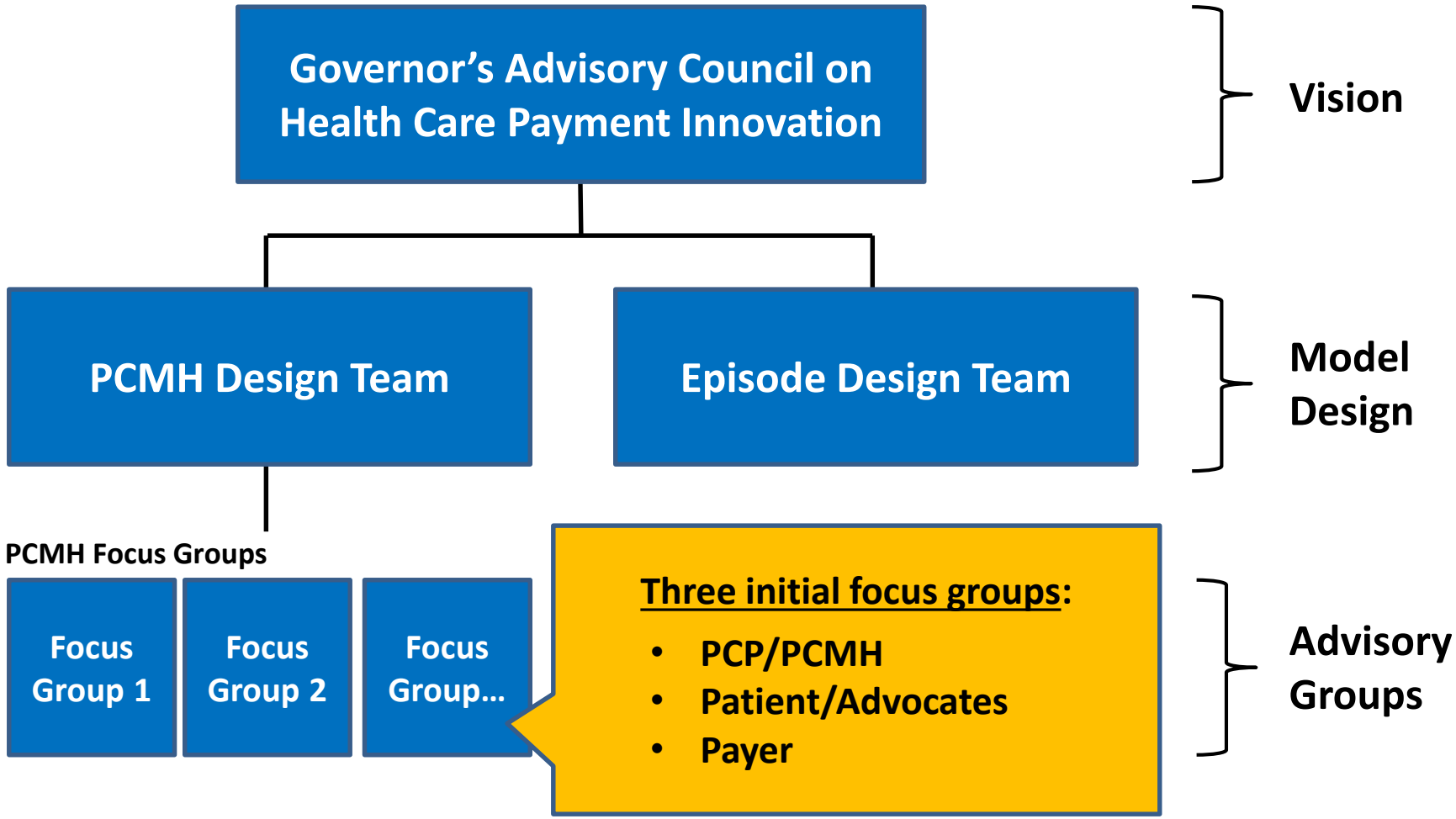
Ohio's payment innovation design team structure



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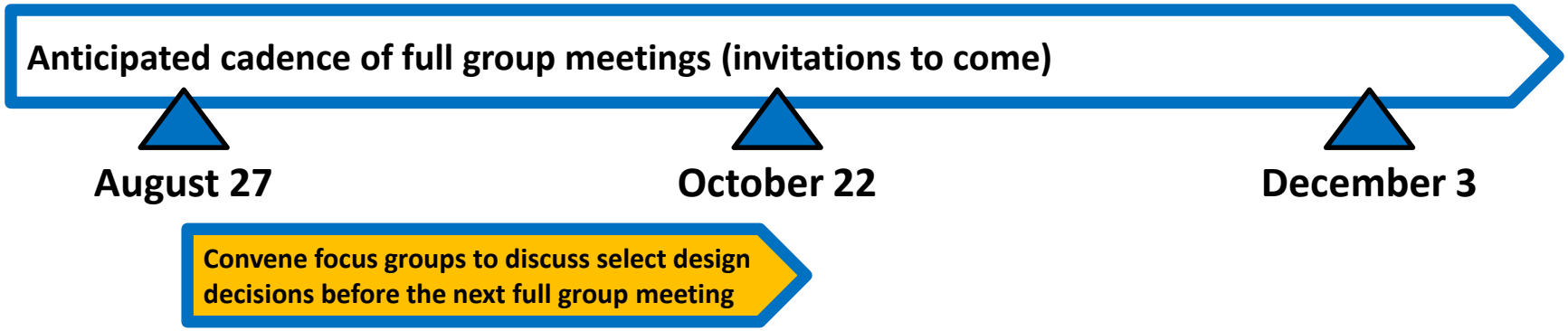
Over the next several months, the PCMH Design Team and its focus groups will meet to provide input as the model takes shape



- Including today's meeting, we will plan to meet three times as a full group in 2015
- In the interim, we will convene focus groups for detailed work in target areas
  - Accepting suggestions from anyone on the PCMH Design Team
  - For PCMH, ideal to have 8-10 PCPs or practice managers who are currently designated as a PCMH, and preferably some who the nominating party believes has shown results. Also, ideally from different parts of Ohio, recognizing that several may be from Southwest Ohio
- Focus group participation and meeting dates will be communicated as they arise
- **Notify Monica.Juenger@governor.ohio.gov by September 2, 2015 if you want to participate in a focus group or suggest someone to participate in a focus group**

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Aligning reform goals to support PCMH model design

Care delivery model	A. Target patients and scope
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Payment model	D. Technical requirements for PCMH
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	S. ASO contracting/participation
	T. Performance transparency
	U. Ongoing PCMH support
	V. Evidence/pathways/research
	W. Multi-payer collaboration
	X. Stakeholder engagement

Health Information Technology Plan

Behavioral Health System Redesign

State Population Health Improvement Plan

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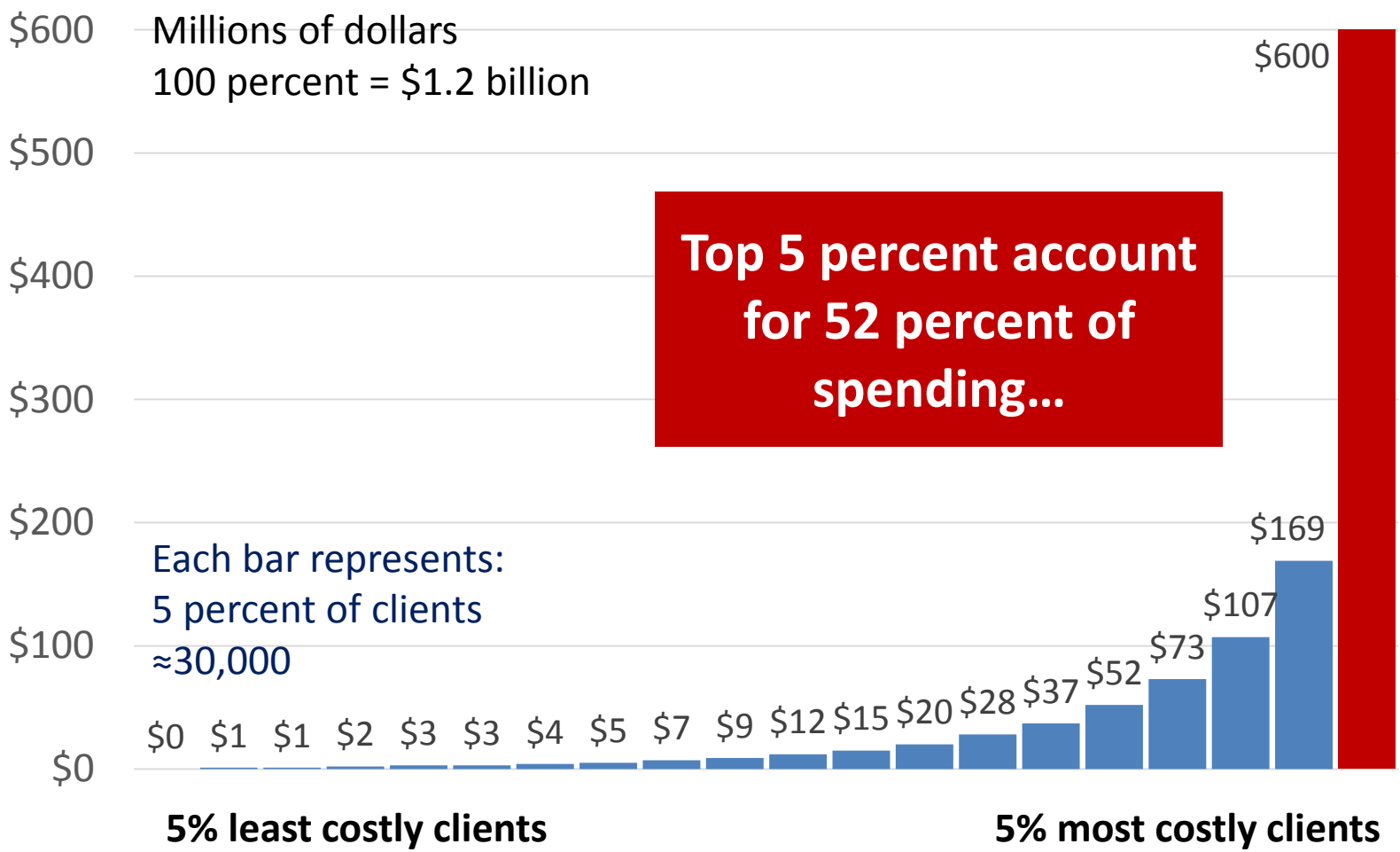
Health IT Plan: Four Priorities for State Action

State Action	Description
1. **Share useful payer data to help providers improve**	▪ Design and deliver multi-payer (Medicaid, Medicare, commercial) data/reports to primary accountable providers (PAPs), Patient-Centered Medical Homes (PCMHs), and key participating providers, including actionable performance data and data about other providers that interact with patients; add commercial payer data as interested
2. **Reinforce and accelerate care coordination**	▪ Encourage/require PAPs and/or PCMH to develop stronger clinical (e.g., admission, discharge, transfer notifications) and administrative (e.g., appointment scheduling) linkages with other providers
3. **Improve usability and access to data**	▪ Continue/accelerate efforts to integrate data sets (e.g., Medicaid FFS, Medicaid encounter), expand access to data to internal and external stakeholders (e.g., researchers, providers, etc.) , and create potential for other parties (e.g., private health plans) to add data over time
4. **Use Big Data to improve programs and policy**	▪ Create (or repurpose) a public-private partnership to apply Big Data and Advanced Analytics to the state's most pressing policy issues

Behavioral Health System Redesign

- Add new services to the Medicaid behavioral health benefit
- High intensity services are available for those most in need
- All providers follow National Correct Coding Initiative (NCCI)
- All providers practice at the top of their scope of practice
- Behavioral health and physical health integration opportunities are maximized
- All behavioral health services in managed care by January 2018
- Implement value-based payment methodologies (e.g., episode-based and PCMH payment models) by January 2018
- Coordination of benefits across payers

Distribution of Behavioral Health Clients by Spending



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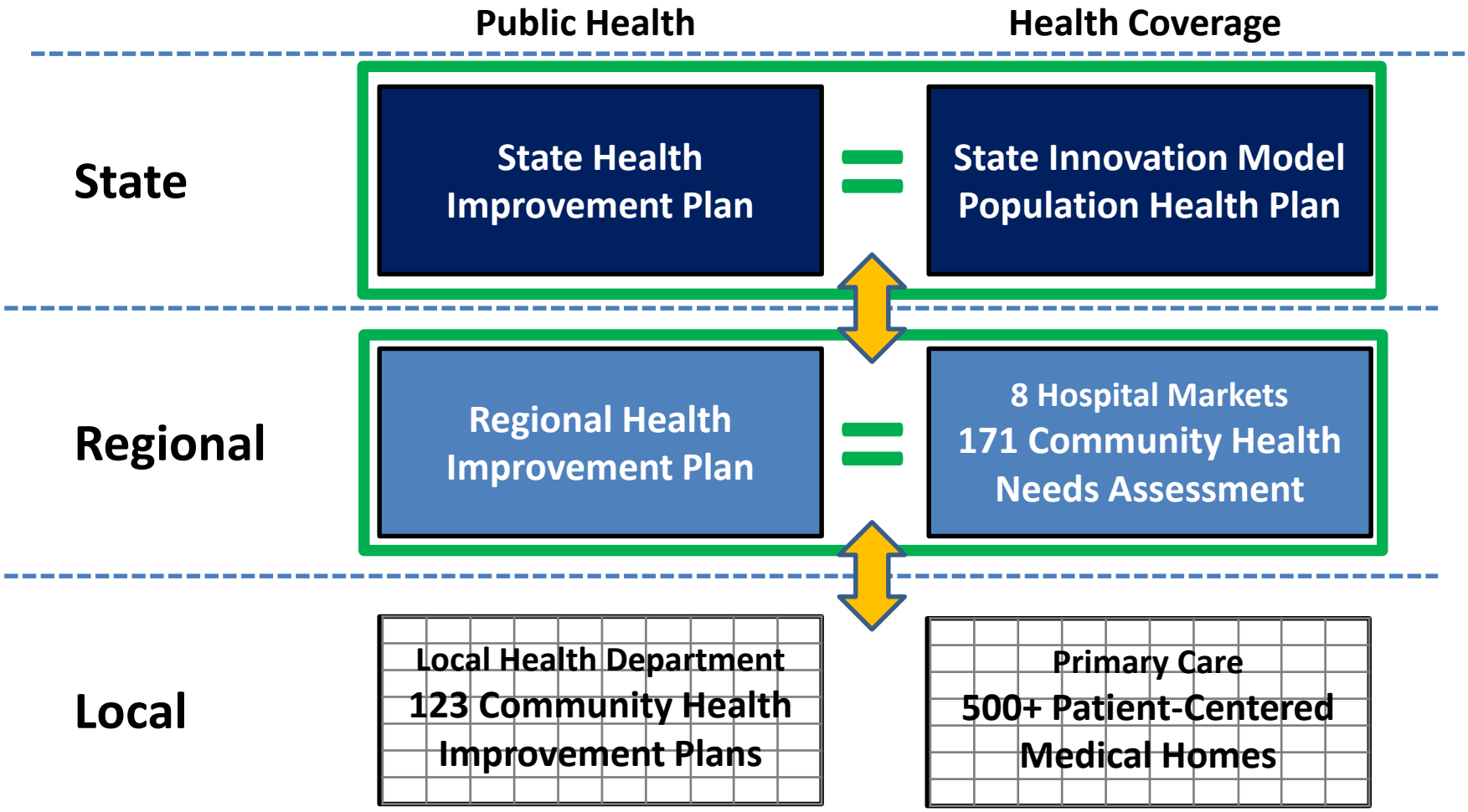
Source: Ohio Medicaid claims, including claims with diagnosis code of ICD9 290-314 excluding 299 and dementia codes in 294; does not include pharmacy claims (August 2012-July 2013).

Better Planning for Better Health in Ohio



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PCMH Design Team Next Steps

- Prepare and run a population health diagnostic to help inform design decisions
- Assemble and convene focus groups to provide further input on design decisions
- Create a state end-to-end straw man of design decisions
- Determine how to best incorporate field research
- Begin assessing most important elements for PCMH performance reporting
- Organize PCMH activities to compliment and benefit from other reform priorities

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Patient-Centered Medical Home Charter for Payers

October 18, 2013

www.healthtransformation.ohio.gov/CurrentInitiatives/EncouragePatientCenteredMedicalHomes.aspx

Ohio PCMH model charter with potential degrees of standardization by component

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

Target patients and scope

Notable departure from CPCi

"Standardize approach"	"Align in principle"	"Differ by design"
▪ N/A	▪ Ultimately aim to include all beneficiaries in PCMH or some other population-based model ▪ Common vision for shared accountability for all medical costs, most behavioral or mental health costs, and long-term supports and services ▪ In the near term, payers may provide specific guidance on target patients for high focus (e.g., highest cost, diagnosed or at-risk for chronic conditions)	▪ N/A

Care delivery improvements

Notable departure from CPCi

"Standardize approach"	"Align in principle"	"Differ by design"
▪ N/A	▪ Payers will generally align on a similar vocabulary / framework for the PCMH model. For example, in CPCi, care delivery model oriented around a five part framework: – Risk-stratified care management (e.g., care plans, patient risk-stratification registry) – Access and continuity of care (e.g., team-based care, multi-channel access, 24/7 access, same-day appointments, electronic access) – Planned care for chronic conditions and preventive care (e.g., appropriate and timely delivery of preventive care) – Patient and caregiver engagement (e.g., shared decision-making, more time discussing patient's conditions and treatment options, medication adherence, greater awareness of cultural / linguistic / other unique patient needs) – Coordination of care across the medical neighborhood (e.g., follow-ups on referrals, integrating behavioral and physical health needs, evidence-based care)	▪ Each payer can champion or promote its own unique or proprietary PCMH care delivery model ▪ Ultimately, practices execute PCMH care delivery model as they see fit and in accordance with their needs / capabilities within the confines of the technical requirements

Target sources of value

"Standardize approach"	"Align in principle"	"Differ by design"
▪ N/A	▪ Initial focus for the first 3-5 years is to reduce total cost of care and increase quality. For example, – Reduced inappropriate ER use and hospital admissions – Reduced unnecessary readmits within 30 days of an inpatient stay – Appropriate use of generic Rx – Improved adherence to treatment plan – Recognition of high-value providers and appropriate settings of care ▪ Over time, additional value will be accrued from – Lower incidence of chronic illness – Prevention and early detection from better screening, preventative care, etc.	▪ Payers will set unique targets / thresholds aimed at realizing these sources of value

Technical requirements for PCMH

Notable departure from CPCi

"Standardize approach"

- Payers will agree to fully standardized requirements to participate as "OH PCMH"
- Payers will agree to fully standardized milestones for continued participation that will be measured/ monitored over time (e.g., performing care plans)
- Payers may determine the need for multiple sets of requirements or milestones to accommodate the needs of different geographies or types of providers (e.g., all practices must meet requirement set A, with large practices also needing to meet requirements in set B)

"Align in principle"

- Where not possible to apply standardized participation criteria (e.g., due to pre-existing contracting or network constraints), the participation criteria should maintain the intent of the standard set and should not pose additional barriers to provider participation

"Differ by design"

- The extent to which and how meeting these requirements affect payment

Attribution / assignment

Notable departure from CPCi

"Standardize approach"	"Align in principle"	"Differ by design"
▪ N/A	▪ Principles of attribution or assignment, namely: – Payers (or providers / patients) identify members for whom PCMH can be reasonably expected to share accountability for members' health and costs over time – Where payers are attributing patients (instead of patient assignment) ▫ Provide transparency on methodology and outcomes of attribution, including general alignment on cadence and format of reporting list of attributed patients to PCMHs ▫ Make transparent to patients to which PCMH they have been attributed ▪ Align some elements of attribution process – Minimum frequency with which to refresh attribution (e.g., quarterly) – Format of reporting ▪ Consider aligning on minimum level of robustness or accuracy expected of payer attribution models	▪ Specific attribution or assignment methodology will vary by payer and network configuration (e.g., some will assign, some will attribute)

Quality measures

Notable departure from CPCi

"Standardize approach"

- Develop standardized "menu" of measures, i.e.,
  - Claims-based quality, cost, and utilization metrics to track/measure
  - Set of non-claims-based clinical data (e.g., from provider records, patient satisfaction surveys) that providers submit to payers
- Ensure "menu" of metrics takes into consideration the aspiration / requirements for provider infra (e.g., if not requiring EHR, choose metrics that can be reported manually)

"Align in principle"

- Develop aligned approach to incorporating small practices in quality measurement (e.g., payers create virtual pooling based on provider ZIP code) in order to minimize complexity
- Payers agree to link a set of quality metrics to payment

"Differ by design"

- How quality measures affect payment streams, including but not limited to
  - Methodology for linking metrics to payments
  - Relative emphasis on particular metrics
  - Quality targets or thresholds that determine degree of provider eligibility for payments

Payment streams / incentives

Notable departure from CPCi

"Standardize approach"	"Align in principle"	"Differ by design"
▪ N/A	▪ Agree to provide resources to support business model transformation for a finite period of time, particularly for small, less capitalized practices ▪ Agree to provide resources to compensate PCMHs for activities not fully covered by existing fee schedules (care coordination, non-traditional visits like telemedicine, population health management) ▪ Agree to reward PCMHs for favorably affecting risk-adjusted total cost of care over time by offering bonus payments, shared savings, capitation, or sub-capitation – Payers should align balance / emphasis on absolute performance or relative improvement – Agree to goal that as shared savings / TCOC payments ramp up, other payments may be reevaluated and potentially ramped down over time in order to create a self-sustaining model – Agree to goal that providers assume greater risk over time ▪ Develop aligned approach to small practices (e.g., TCOC accountability) in order to minimize complexity	▪ Duration and level of payments for practice transformation and activities not covered under existing fee schedules ▪ Risk adjustment methodologies both for assessment of TCOC and other payments (e.g., PMPMs) ▪ Level and method of reward TCOC performance

Patient incentives

Notable departure from CPCi

"Standardize approach"	"Align in principle"	"Differ by design"
▪ N/A	▪ Agree in principle to create incentives (e.g., value-based benefit design), communication, etc. that engage patients in PCMH care delivery model	▪ Specific benefit designs (e.g., co-pay differentials, bonus payments) to be determined by individual payers