



Governor's Office of
Health Transformation

Appendix A: Ohio's State Health Care Innovation Plan Exhibits

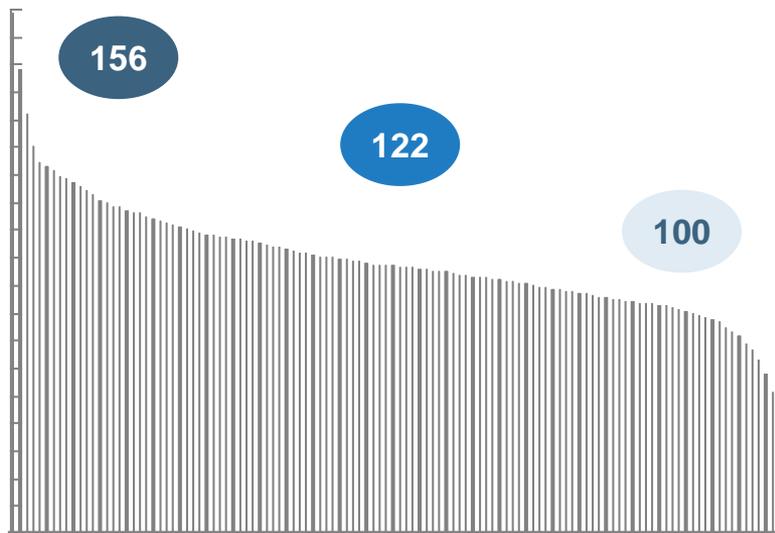
Average cost per episode varies across providers

Comparison of risk adjusted average episode costs for performing providers and facilities

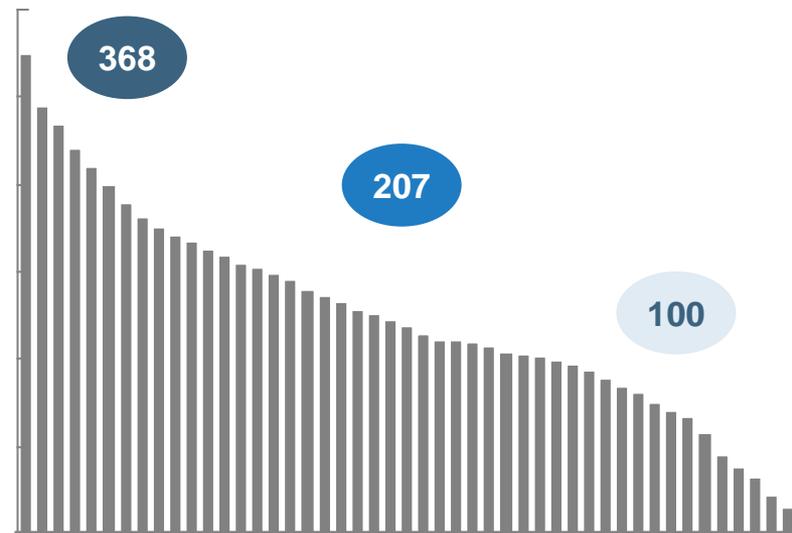
PRELIMINARY



Perinatal



Asthma acute exacerbation

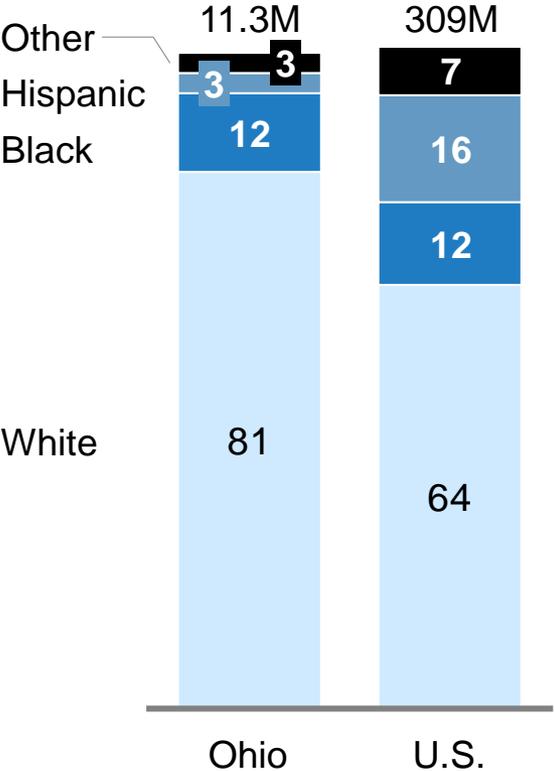


Each bar represents total average cost per episode across five accountable providers. For both perinatal and asthma acute exacerbation, individual episode costs were risk-adjusted for clinical drivers of severity based on historically derived multipliers. Percentiles are calculated with respect to the 10th percentile across average episode costs for all providers.

Ohio population demographics (1/2)

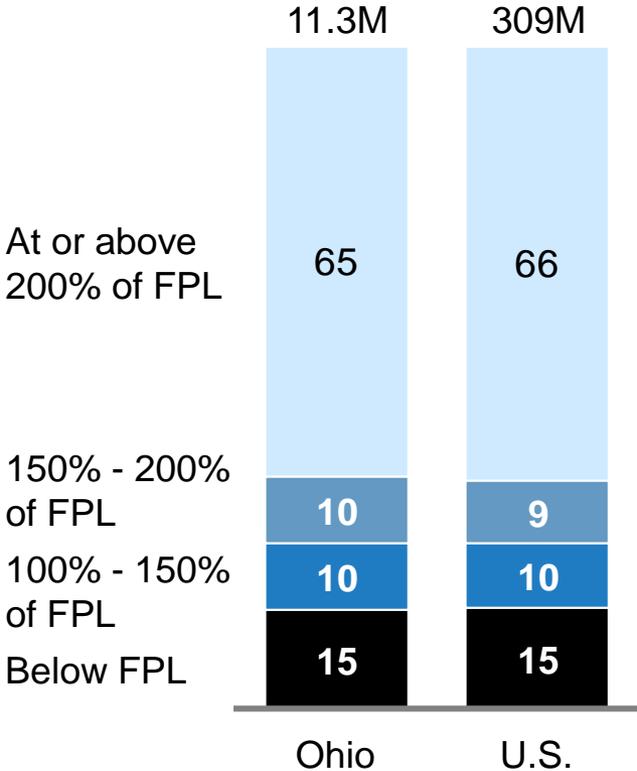
Ohio population by race/ethnicity; 2011

Percent of population



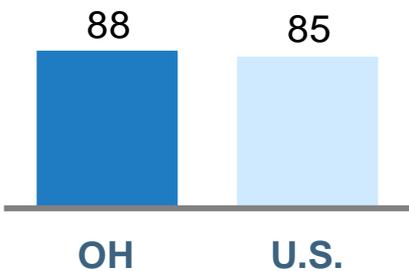
Ohio population by poverty status; 2011

Percent of population



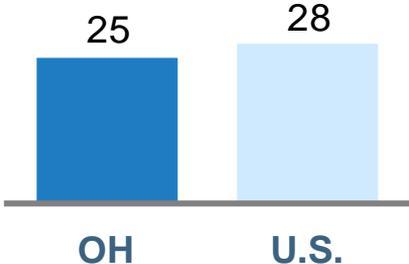
Attained high school degree or higher

Percent of people age >25



Attained bachelor's degree or higher

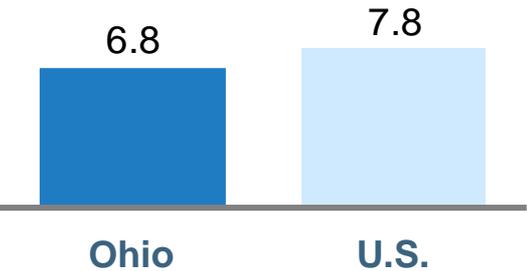
Percent of people age >25



Ohio population demographics (2/2)

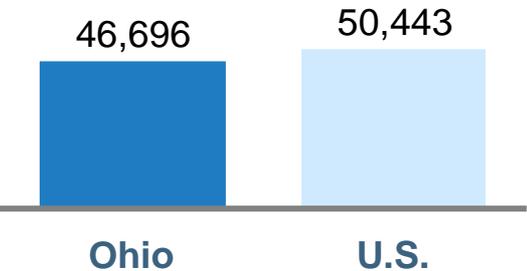
Unemployment rate

Percent unemployed, November 2012



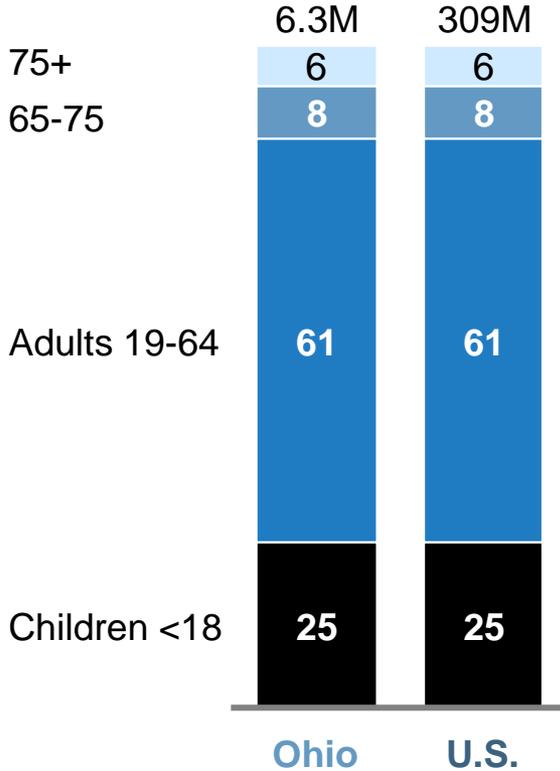
Median Annual Income

\$ Household income, 2009-2011



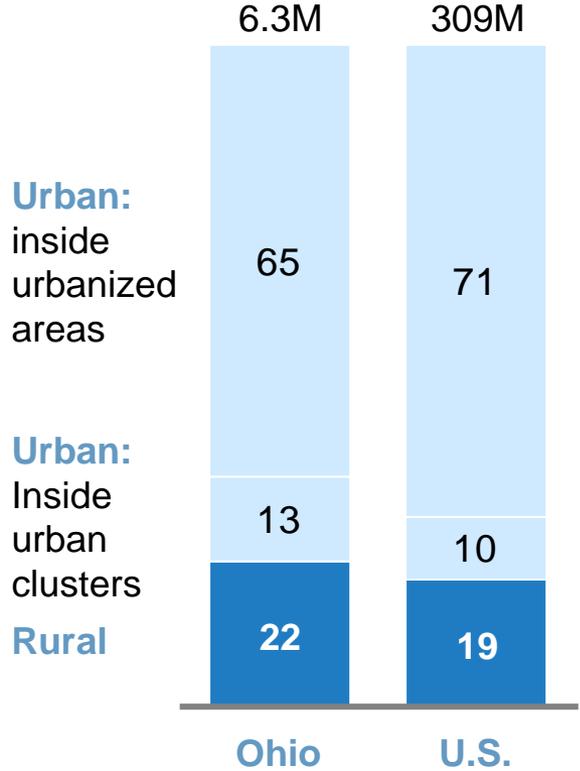
Population by age

Percent of population, 2011



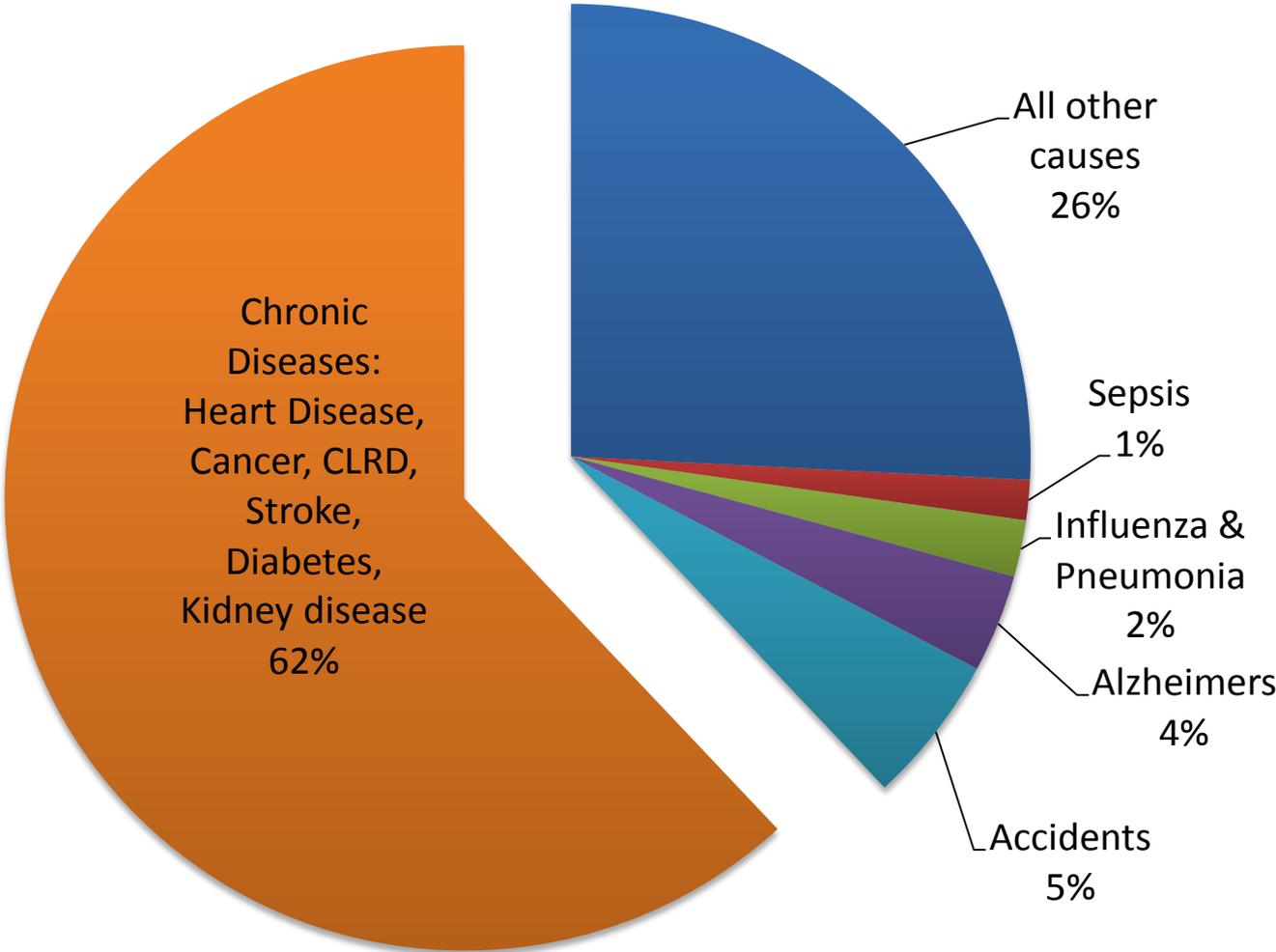
Population by urban/rural

Percent of population, 2010



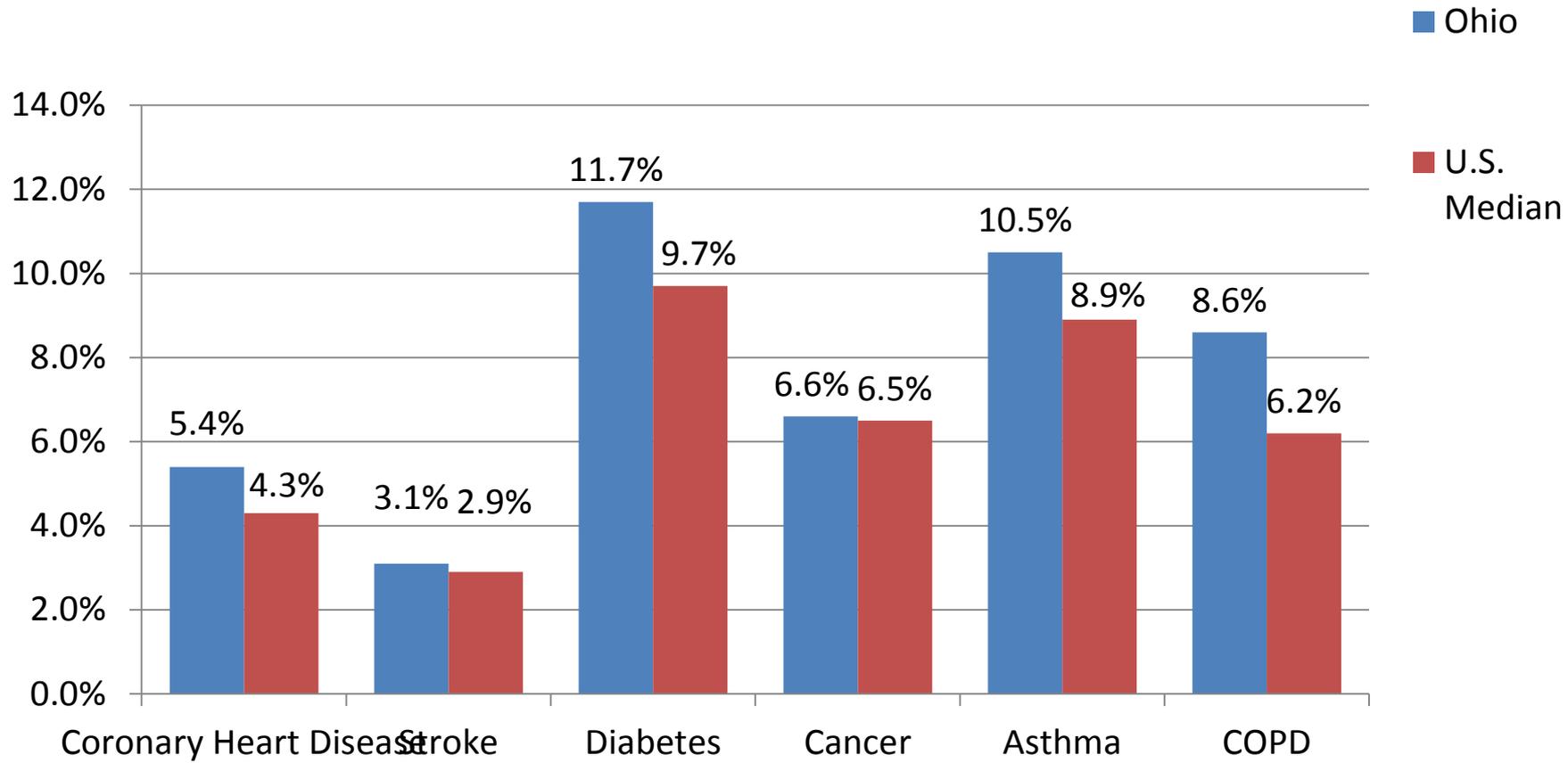
SOURCE: Kaiser State Health Facts, U.S. Census Bureau, 2010 Census

Leading causes of death in Ohio, 2011



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

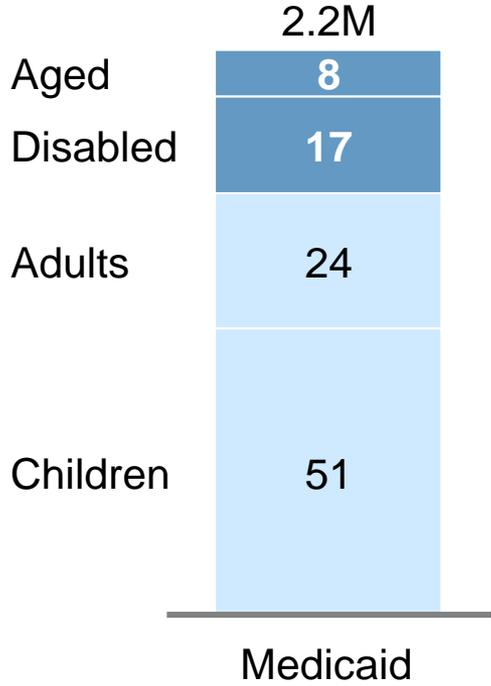
Prevalence of selected chronic diseases, Ohio compared to the U.S. Median, 2012



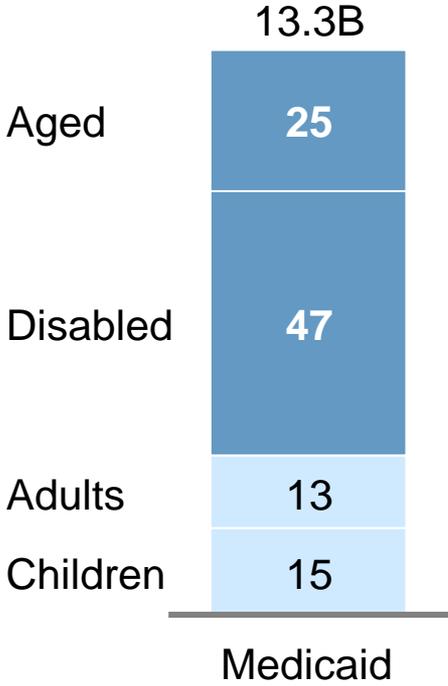
SOURCE:
2012 Ohio Behavioral Risk Factor Surveillance System, Ohio Department of Health, 2013.
2012 Behavioral Risk Factor Surveillance System, Centers for Disease Control and Prevention, 2013.

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

Percent of Medicaid covered lives



Percent of total Medicaid payments



SOURCE: Kaiser State Health Facts

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

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

State of Ohio Health Care Payment Innovation Task Force

Governor's Advisory Council on Health Care Payment Innovation

**John R
Kasich
Governor**

**Governor's
Senior Staff**

Office of Health Transformation

- **Project Management Team:** Executive Director, Communications Director, Stakeholder Outreach Director, Legislative Liaison, Fiscal and IT Project Managers

Participant Agencies

- Administrative Services, Development, Health, Insurance, JobsOhio, Ohio Medicaid, Rehabilitation and Corrections, Taxation, Worker's Compensation, Youth Services, Public Employee and State Teachers Retirement Systems

- **Purchasers** (Bob Evans, Cardinal Health, Council of Smaller Enterprises, GE Aviation, Procter & Gamble)
- **Plans** (Aetna, Anthem, CareSource, Medical Mutual, UnitedHealthcare)
- **Providers** (Akron Children's Hospital, Catholic Health Partners, Central Ohio Primary Care, Cleveland Clinic, North Central Radiology, Ohio Health, ProMedica, Toledo Medical Center)
- **Consumers** (AARP, Legal Aid Society, Universal Health Care Action Network)
- **Research** (Health Policy Institute of Ohio)

State Implementation Teams

Patient-Centered Medical Homes

Episode-Based Payments

Workforce and Training

Health Information Technology

Performance Measurement

Public/Private Workgroups

Ohio Patient-Centered Primary Care Collaborative

External Expert Team TBD

Governor's Executive Workforce Board Health Sector Group

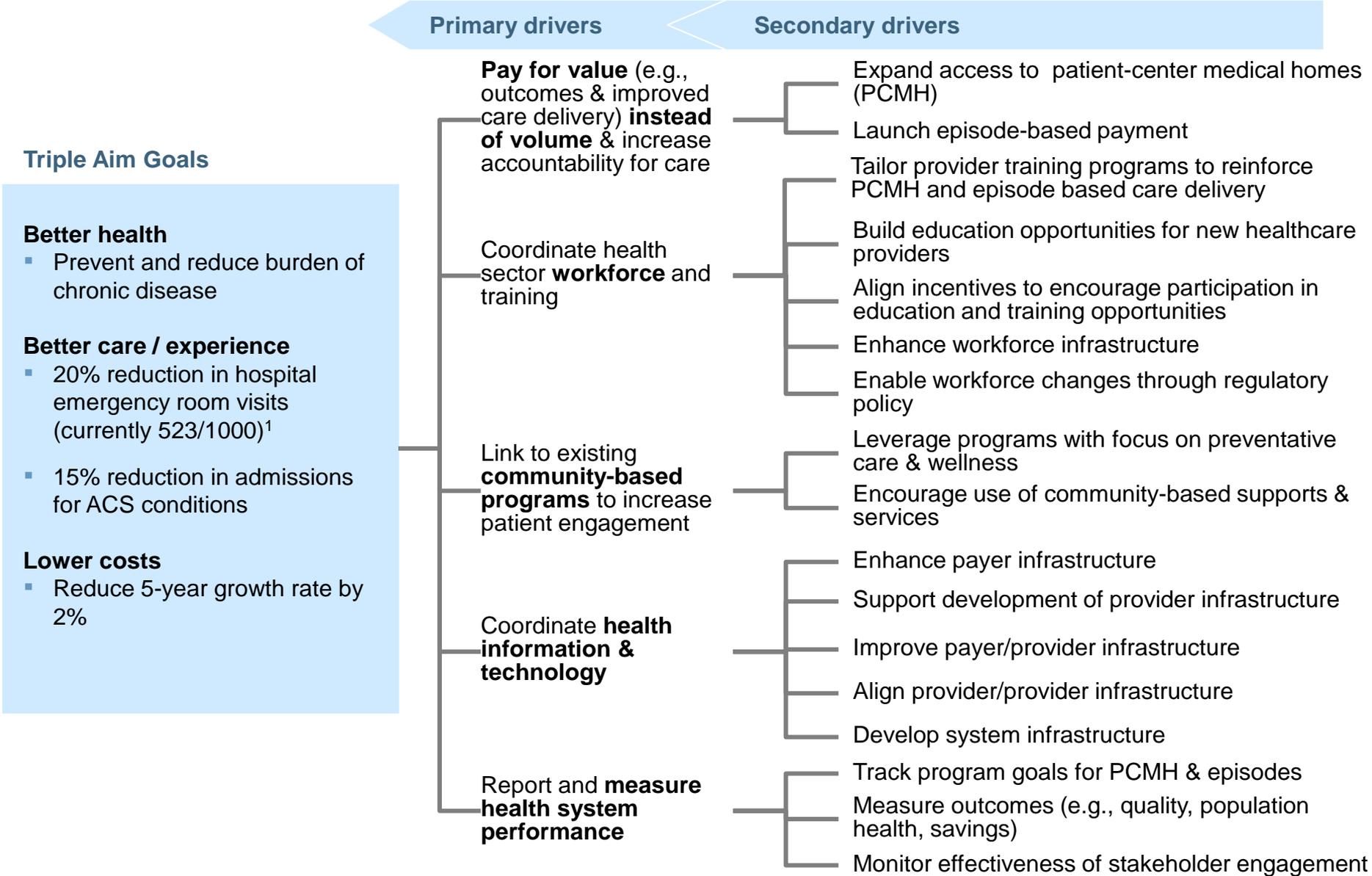
External Expert Team TBD

External Expert Team TBD

SIM Core Team

**HIT
Infrastructure
Core Team**

Ohio SIM driver diagram



Primary drivers

Secondary drivers

Triple Aim Goals

Better health

- Prevent and reduce burden of chronic disease

Better care / experience

- 20% reduction in hospital emergency room visits (currently 523/1000)¹
- 15% reduction in admissions for ACS conditions

Lower costs

- Reduce 5-year growth rate by 2%

Pay for value (e.g., outcomes & improved care delivery) **instead of volume** & increase accountability for care

Coordinate health sector **workforce** and training

Link to existing **community-based programs** to increase patient engagement

Coordinate **health information & technology**

Report and **measure health system performance**

Expand access to patient-center medical homes (PCMH)

Launch episode-based payment

Tailor provider training programs to reinforce PCMH and episode based care delivery

Build education opportunities for new healthcare providers

Align incentives to encourage participation in education and training opportunities

Enhance workforce infrastructure

Enable workforce changes through regulatory policy

Leverage programs with focus on preventative care & wellness

Encourage use of community-based supports & services

Enhance payer infrastructure

Support development of provider infrastructure

Improve payer/provider infrastructure

Align provider/provider infrastructure

Develop system infrastructure

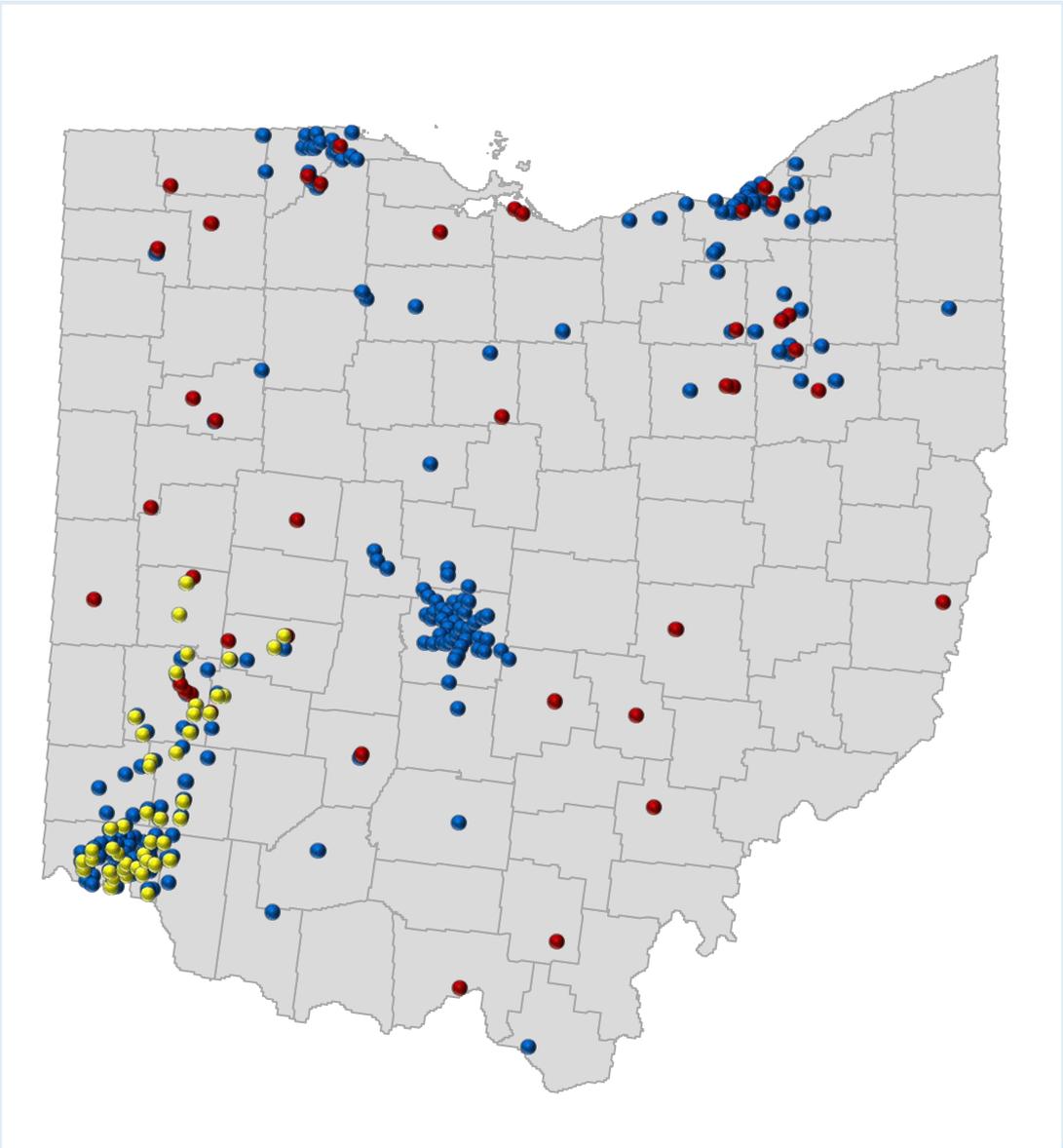
Track program goals for PCMH & episodes

Measure outcomes (e.g., quality, population health, savings)

Monitor effectiveness of stakeholder engagement

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

PCMH activity in Ohio



- HP 198 Education Pilot Sites (48 sites)
- PCMH AAAHC & NCQA accredited¹ (314 sites)
- Cincinnati / Dayton CPCi (61 sites)

In addition, PCMH efforts are being developed and piloted by private payers, employers, and primary care group practices

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

Elements of a comprehensive PCMH Strategy

Care delivery model	Target patients and scope
	Care delivery improvements e.g., <ul style="list-style-type: none"> ▪ Improved access ▪ Patient engagement ▪ Population management ▪ Team-based care, care coordination
	Target sources of value
Payment model	Technical requirements for PCMH
	Attribution / assignment
	Quality measures
	Payment streams/ incentives
	Patient incentives
Infrastructure	PCMH infrastructure
	Payer infrastructure
	Payer / PCMH infrastructure
	PCMH/ Provider infrastructure
	System infrastructure
Scale-up and practice performance improvement	Clinical leadership / support
	Practice transformation support
	Workforce / human capital
	Legal / regulatory environment
	Network / contracting to increase participation
	ASO contracting/participation
	Performance transparency
	Ongoing PCMH support
	Evidence, pathways, & research
	Multi-payer collaboration

Ohio PCMH model charter with potential degrees of standardization by component

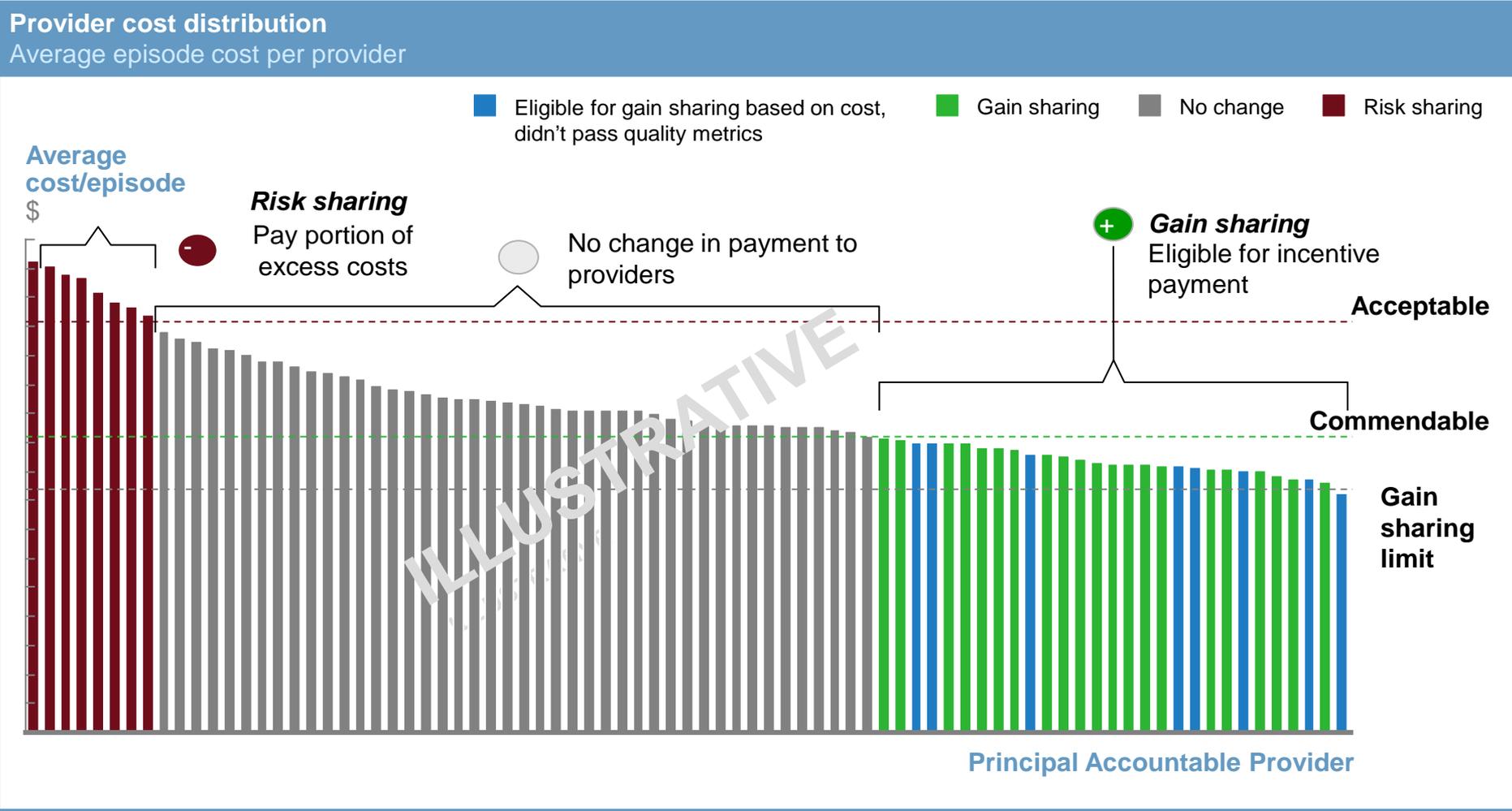
		“Standardize approach”	“Align in principle”	“Differ by design”
Care delivery model	Target patients and scope		<ul style="list-style-type: none"> All patients included Strive for TCOC accountability 	
	Care delivery improvements		<ul style="list-style-type: none"> Aligned vision / vocabulary of care delivery model 	<ul style="list-style-type: none"> Payers, practices champion unique care delivery models
	Target sources of value		<ul style="list-style-type: none"> Align on near-term and longer term sources of value 	<ul style="list-style-type: none"> Payers set unique targets to realize sources of value
Payment model	Technical requirements for PCMH	<ul style="list-style-type: none"> Standard set of requirements and milestones 	<ul style="list-style-type: none"> Payers do not pose additional barriers to participation 	<ul style="list-style-type: none"> Payers separately design link of requirements & milestones to payment
	Attribution / assignment		<ul style="list-style-type: none"> Attribute to provider that can be held accountable for TCOC Provide transparency 	<ul style="list-style-type: none"> Payers maintain unique attribution methodologies
	Quality measures	<ul style="list-style-type: none"> Standard “menu” of metrics & definitions 	<ul style="list-style-type: none"> Agree to have link between quality and payment 	<ul style="list-style-type: none"> Payers separately design how metrics link to payment)
	Payment streams/ incentives		<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> Payers will have unique <ul style="list-style-type: none"> – Payment levels – Risk adjustment – Shared savings methodology
	Patient incentives		<ul style="list-style-type: none"> Agree to create incentives, communication to engage patients 	<ul style="list-style-type: none"> Incentives, benefit design, etc.

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

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

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

ILLUSTRATIVE



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

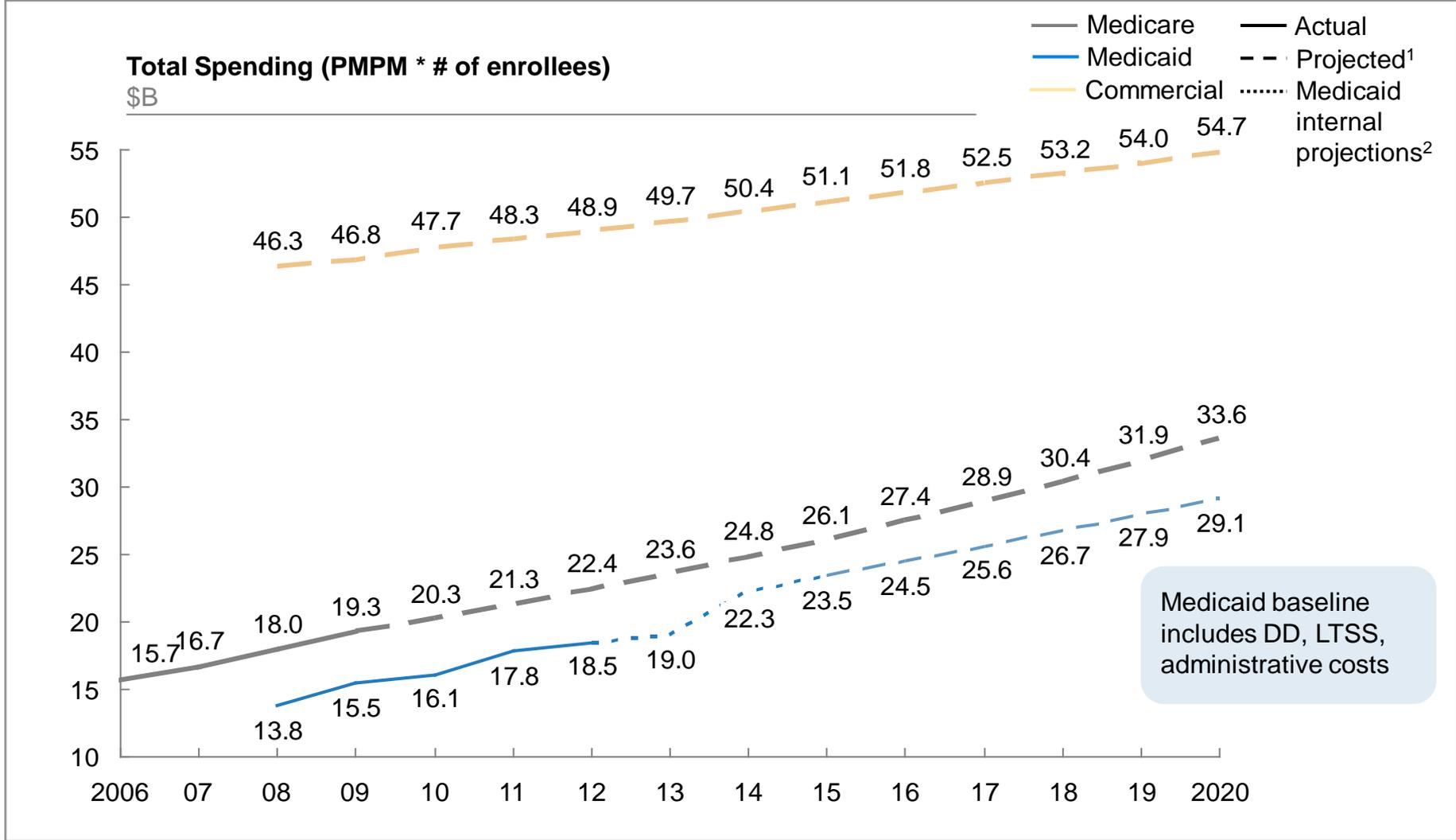
SOURCE: Arkansas Payment Improvement Initiative

Ohio episode model charter with potential degrees of standardization by component

	“Standardize approach”	“Align in principle”	“Differ by design”
Accountability	<ul style="list-style-type: none"> Single accountable provider will be identified for majority of episodes Type of provider may vary, but payers align on accountable providers for each episode 	<ul style="list-style-type: none"> Common vision to not categorically exclude unique providers 	<ul style="list-style-type: none"> Adjustments to episode cost (e.g., cost normalization) may vary by payer
Payment model mechanics	<ul style="list-style-type: none"> Model follows a retrospective approach; episode costs are calculated at the end of a fixed period of time Payers adopt common set of quality metrics for each episode 	<ul style="list-style-type: none"> Model includes both upside and downside risk sharing Aligned principle of linking quality metrics to incentives Agree to evaluate providers against absolute performance thresholds 	<ul style="list-style-type: none"> Payers may choose to have min number of episodes for provider participation Type and degree of stop loss may vary
Performance management	<ul style="list-style-type: none"> Commitment to launch reporting period prior to tying payment to performance 	<ul style="list-style-type: none"> Aligned approach to have episode-specific risk adjustment model Aligned approach to exclude episodes with factors not addressable through risk adjustment 	<ul style="list-style-type: none"> Payers independently determine method and level for gain sharing Risk adjustment methodologies may vary across payers
Payment model timing and thresholds		<ul style="list-style-type: none"> Performance period length for each episode and launch timings aligned where possible 	<ul style="list-style-type: none"> Start / end dates for each episode may vary Payers each determine approach to thresholding (incl. level of gain/risk sharing) Outlier determinations will be at discretion of each payer

Ohio baseline costs by payer

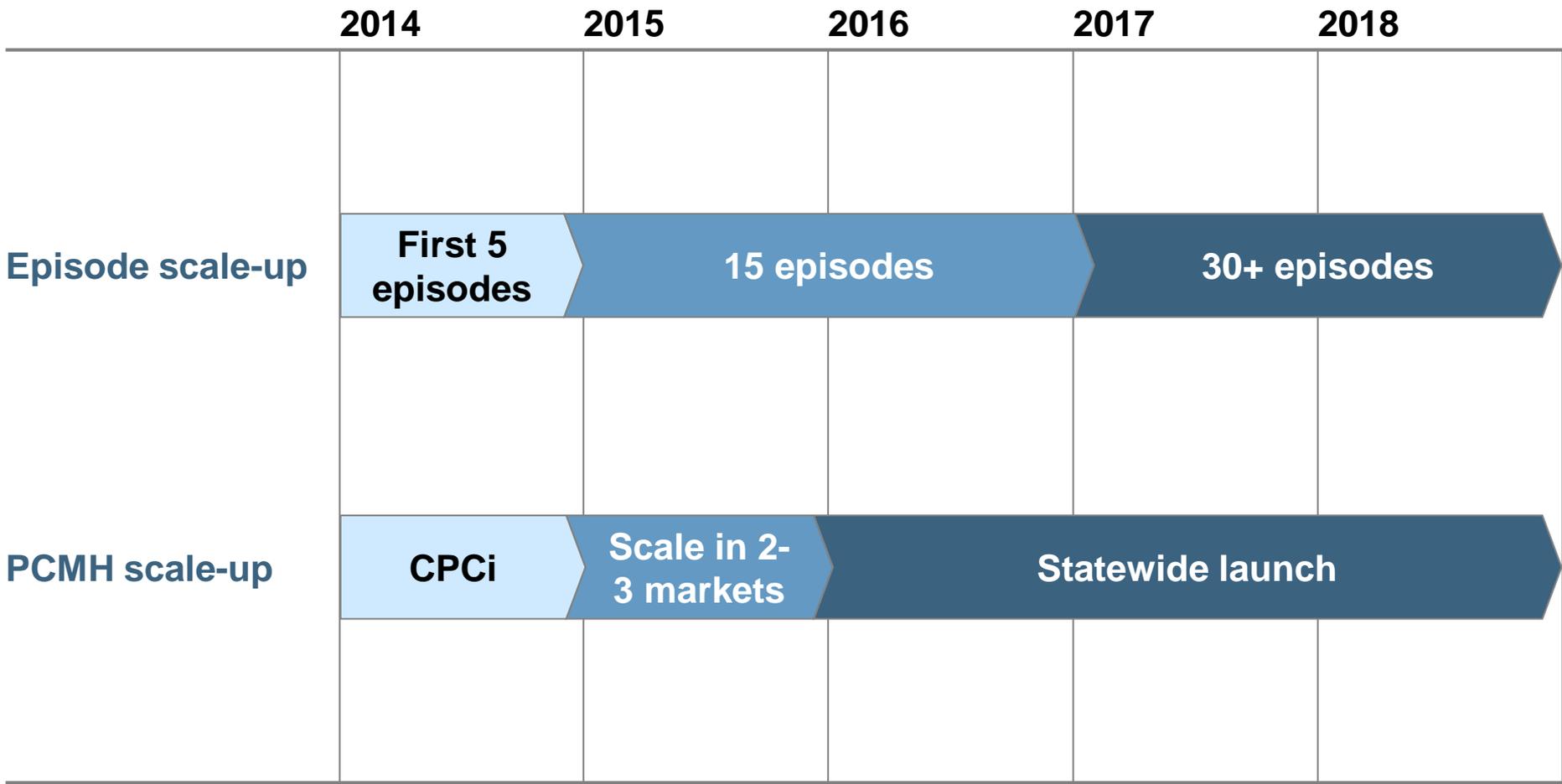
PRELIMINARY



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

Timeline for transformation

- Phase I
- Phase II
- Scale-up



Episodes and PCMH operating models

Episodes operating model



PCMH operating model



Episode operating model

	Design	Implement	Operate	Evaluate & improve
1 Episode model design, analytics and delivery	<ul style="list-style-type: none"> Select and determine launch sequencing Develop base definition: trigger, inclusions, risk adjustment, etc. Customize model: patient exclusions, stop loss, normalization, etc. Define quality metrics Execute thresholding 	<ul style="list-style-type: none"> Build analytics engine/capabilities Define/QA production algorithms 	<ul style="list-style-type: none"> Gather/integrate all claims and non-claims (e.g., portal) data Execute production of episodes 	<ul style="list-style-type: none"> Maintain and update base definition Manage program evaluation: actuarial, economic, clinical, etc. Report on program impact Refinements/additions to algorithms Define/execute refinements
2 Reporting	<ul style="list-style-type: none"> Design report templates Develop strategy to gather non-claims data, if any 	<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"> Develop approach for report generation / quality metric entry 	<ul style="list-style-type: none"> Build/modify "portal" 	<ul style="list-style-type: none"> Distribute reports Capture, store and transmit clinical data to analytics engine 	<ul style="list-style-type: none"> Monitor and report on provider utilization / report viewing
4 Payment	<ul style="list-style-type: none"> Define consistent payment approach (e.g. withhold approach) 	<ul style="list-style-type: none"> Develop API to payment systems Modify system to issue bonus checks or "withholds" 	<ul style="list-style-type: none"> Distribute and account for bonus payment or risk Regularly audit/reconcile payments 	<ul style="list-style-type: none"> Manage updates /modifications to payment system resulting from changes to payment model
5a Provider support - outbound	<ul style="list-style-type: none"> Design general provider education/engagement strategy and approach for outbound support 	<ul style="list-style-type: none"> Develop/obtain provider education material, videos, curriculum, etc. 	<ul style="list-style-type: none"> Distribute education materials Engage/consult to individual providers 	<ul style="list-style-type: none"> Update and advance provider education / engagement strategy and marketing materials
5b Provider support - inbound	<ul style="list-style-type: none"> Develop approach and capabilities to respond to provider inquiries 	<ul style="list-style-type: none"> Train staff to answer inbound provider inquiries Modify current provider appeals process, if needed 	<ul style="list-style-type: none"> Field inbound provider inquiries, episode design inquiries and appeals 	<ul style="list-style-type: none"> Update and advance training materials based on changes to payment model, reporting and/or payments
6 MCO contracting	<ul style="list-style-type: none"> Develop MCO/contracting strategy/ approach 	<ul style="list-style-type: none"> Execute MCO re-contracting/addendums 	<ul style="list-style-type: none"> Manage amendment process, as needed 	<ul style="list-style-type: none"> Monitor program integrity Manage re-contracting process
7 Provider contracting	<ul style="list-style-type: none"> Develop provider contracting strategy/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/approach Develop ASO contracting strategy/approach 	<ul style="list-style-type: none"> Execute regulatory approval (SPA, promulgation, etc.) Execute ASO re-contracting/addendums 	<ul style="list-style-type: none"> Monitor changes to payment model /incentives to ensure all changes fall within previously approved filings 	<ul style="list-style-type: none"> Initiate and execute new regulatory approval process, as needed based on changes to payment model

PCMH operating model – (1/2)

	Design	Implement	Operate	Evaluate & improve
1 PCMH model design, analytics and delivery	<ul style="list-style-type: none"> Define attribution methodology & approach Define quality metrics to be tracked and/or reported by PCMHs Define principles of payment/incentives including: shared savings, risk-adjustment, TCOC & approach to pooling 	<ul style="list-style-type: none"> Build analytics engine/capabilities Define/QA PCMH analytics production including: total-cost-of-care calculation, risk adjustment, risk stratification and attribution 	<ul style="list-style-type: none"> Gather/integrate all claims and non-claims data (e.g., portal, quality metrics, etc.) Execute production of PCMH analytics 	<ul style="list-style-type: none"> Maintain and update principles of payment/incentives Manage program evaluation: actuarial, economic, clinical, etc. Report on program impact
2 Reporting	<ul style="list-style-type: none"> Design report templates Develop strategy to gather non-claims data, if any Define reporting approach for pooled providers 	<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 Look for ways to automate capture of clinical data (e.g., connection to HIE)
3 Payer / provider connectivity	<ul style="list-style-type: none"> Develop approach for report generation / quality metric entry 	<ul style="list-style-type: none"> Build/modify "portal" 	<ul style="list-style-type: none"> Distribute reports Capture, store and transmit clinical data to analytics engine 	<ul style="list-style-type: none"> Monitor and report on provider utilization / report viewing
4 Payment	<ul style="list-style-type: none"> Define consistent payment approach (e.g. withhold approach) 	<ul style="list-style-type: none"> Develop API to payment systems Modify system to issue bonus checks 	<ul style="list-style-type: none"> Distribute and account for bonus payment Regularly audit/reconcile payments 	<ul style="list-style-type: none"> Manage updates/modifications to payment system resulting from updates to principles of payment / incentives
5a Provider support - outbound	<ul style="list-style-type: none"> Design approach for outbound engagement and clinical leadership 	<ul style="list-style-type: none"> Develop/obtain provider education material, videos, curriculum, etc. 	<ul style="list-style-type: none"> Distribute education materials Engage/consult to individual providers 	<ul style="list-style-type: none"> Update provider education / engagement strategy and marketing materials
5b Provider support – inbound	<ul style="list-style-type: none"> Develop approach and capabilities to respond to provider inquiries Develop process for providers to appeal attribution 	<ul style="list-style-type: none"> Train staff to answer inbound provider inquiries Modify current provider appeals process, if needed 	<ul style="list-style-type: none"> Field inbound provider inquiries, episode design inquiries and appeals 	<ul style="list-style-type: none"> Update and advance relevant training materials based on changes to payment model, reporting, and /or payments

PCMH operating model – (2/2)

	Design	Implement	Operate	Evaluate & improve
6 Provider enrollment and contracting	<ul style="list-style-type: none"> Develop strategy/approach for provider recruitment & enrollment Define PCMH technical requirements & qualifications Develop strategy/approach for provider contracting Develop plan for scale-up 	<ul style="list-style-type: none"> Execute provider recruitment strategy Build / modify infrastructure for provider to enroll and qualify as a PCMH Execute provider re-contracting/addendums 	<ul style="list-style-type: none"> Roll-out PCMH across state and execute scale-up plan Qualify, enroll and contract with new PCMHs on an ongoing basis, as needed Revisit and/or amend contracts regularly based on monitoring and enforcement mechanism 	<ul style="list-style-type: none"> Manage re-contracting process
7 PCMH monitoring and enforcement	<ul style="list-style-type: none"> Develop strategy/approach for verifying and enforcing technical requirements and milestones post enrollment 	<ul style="list-style-type: none"> Monitor provider eligibility and compliance with PCMH technical requirements and milestones 	<ul style="list-style-type: none"> Develop performance improvement plans and/or expel practices that do not comply with eligibility and technical requirements 	<ul style="list-style-type: none"> Manage re-certification process
8 Practice transformation	<ul style="list-style-type: none"> Define role of payer in providing both one-time and on-going support for practice transformation 	<ul style="list-style-type: none"> Provide support & training to transform practices' business / administrative functions Provide support & training to ensure successful implementation of care coordination efforts 	<ul style="list-style-type: none"> Provide ongoing support to practices as necessary and/or deemed appropriate Convene and collaborate with multi-payer group to ease implementation and minimize administrative burden for providers 	<ul style="list-style-type: none"> Report on efficacy of practice transformation efforts Share best practices for successful practice transformation
9 MCO contracting	<ul style="list-style-type: none"> Develop MCO/contracting strategy/ approach 	<ul style="list-style-type: none"> Execute MCO re-contracting/addendums 	<ul style="list-style-type: none"> Manage amendment process, as needed 	<ul style="list-style-type: none"> Monitor program integrity Manage re-contracting process
10 Client & regulatory filings / activities	<ul style="list-style-type: none"> Develop regulatory strategy/approach Develop ASO contracting strategy/approach 	<ul style="list-style-type: none"> Execute regulatory approval (SPA, waiver, rule change, etc.) Execute ASO re-contracting/addendums 	<ul style="list-style-type: none"> Monitor changes to payment model /incentives to ensure all changes fall within previously approved filings 	<ul style="list-style-type: none"> Initiate and execute new regulatory approval process, as needed based on changes to payment model / incentives
11 Workforce	<ul style="list-style-type: none"> Define workforce needs to support success of PCMH model Integrate PCMH workforce needs into ODH's Ohio Primary Care Workforce Plan (OPCWP) 	<ul style="list-style-type: none"> Implement initiatives in OPCWP and integrate with efforts aimed at transforming care delivery system 	<ul style="list-style-type: none"> Collaborate with OWT to coordinate workforce efforts across 16 state agencies 	<ul style="list-style-type: none"> Report on program impact Examine status of primary care workforce to determine if additional and supplemental action is required



Governor's Office of
Health Transformation

Appendix B: Patient-Centered Medical Home Charter for Payers

Governor Kasich's Advisory Council on
Health Care Payment Innovation

October 18, 2013

www.HealthTransformation.Ohio.gov



Ohio's SIM Grant Activities

- Governor's Office of Health Transformation convened experts to provide detailed input on State Innovation Model (SIM) design
 - 100+ experts from 40+ organizations deeply engaged
 - 50+ multi-stakeholder meetings to align across payers and providers
 - Top 5 payers aligned on overall strategy
- Ohio selected McKinsey & Company to assist in producing:
 - State of Ohio Healthcare Diagnostic Report
 - PCMH and Episode "Charters" to align payer decisions
 - Analytics and implementation plans to support the models
 - Ohio's Healthcare Innovation Plan (to submit October 30, 2013)

PCMH Model Design Team

Providers

- Michael Rothberg, MD, Cleveland Clinic
- Jeff Biehl, AccessHealth Columbus
- Richard Shonk, MD, Cincinnati Health Collaborative
- Ken Bertka, MD, Catholic Health Partners
- William Wulf, MD, Central Ohio Primary Care
- Bruce Vanderhoff, MD, OhioHealth
- Will Groneman, TriHealth Cincinnati
- Randy Wexler, MD, Ohio State University
- Jim Misak, MD, MetroHealth
- Randall Cebul, MD, Better Health Greater Cleveland
- Rita Horwitz, RN, Better Health Greater Cleveland
- Deborah Southard, Family Practice of SW Ohio
- William Washington, MD, Linden Medical Center
- Pamela Oatis, MD, St. Vincent Mercy Children's
- Susan Miller, PriMed Physicians
- Nick Lashutka, Ohio Children's Hospital Assoc.
- Robert Falcone, MD, Ohio Hospital Assoc.
- Berna Bell, Ohio Hospital Assoc.

Payers

- Robin Dawson, Medical Mutual
- Donald Wharton, MD, CareSource
- Randy Montgomery, Aetna
- Kelly Owen, Anthem
- Pam Schultz Anthem
- Richard Gajdowski, MD, United Healthcare
- Craig Osterhues, GE (*representing purchasers*)

State

- Ted Wymyslo, MD, ODH (*PCMH Team Chair*)
- Heather Reed, ODH
- Amy Bashforth, ODH
- Robyn Colby, Medicaid
- Debbie Saxe, Medicaid
- Angela Dawson, Minority Health Commission
- Angie Bergefurd, MHAS
- Afet Kilinc, MHAS
- Greg Moody, OHT
- Rick Tully, OHT
- Monica Juenger, OHT
- Marc Molea, Aging
- Rebecca Susteric, BWC
- McKinsey: Razili Stanke-Koch, Caroline Cross, Brendan Buescher, Kara Carter, Thomas Latkovic, Amit Shah, MD



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

Year 1

- In 2014 focus on Comprehensive Primary Care Initiative (CPCi)
- Payers agree to participate in design for elements where standardization and/or alignment is critical
- Multi-payer group begins enrollment strategy for one additional market

- State leads design of five episodes: asthma (acute exacerbation), perinatal, COPD exacerbation, PCI, and joint replacement
- Payers agree to participate in design process, launch reporting on at least 3 of 5 episodes in 2014 and tie to payment within year

Year 3

- Model rolled out to all major markets
- 50% of patients are enrolled

- 20 episodes defined and launched across payers

Year 5

- Scale achieved state-wide
- 80% of patients are enrolled

- 50+ episodes defined and launched across payers

Agree on degrees of standardization within each model

“Standardize approach”

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)

“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; it's beneficial to know payers are not moving in different 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, members, strategy, administrative systems)

“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

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		<ul style="list-style-type: none"> All patients included Strive for TCOC accountability 	
	Care delivery improvements		<ul style="list-style-type: none"> Aligned vision / vocabulary of care delivery model 	<ul style="list-style-type: none"> Payers, practices champion unique care delivery models
	Target sources of value		<ul style="list-style-type: none"> Align on near-term and longer term sources of value 	<ul style="list-style-type: none"> Payers set unique targets to realize sources of value
Payment model	Technical requirements for PCMH	<ul style="list-style-type: none"> Standard set of requirements and milestones 	<ul style="list-style-type: none"> Payers do not pose additional barriers to participation 	<ul style="list-style-type: none"> Payers separately design link of requirements & milestones to payment
	Attribution / assignment		<ul style="list-style-type: none"> Attribute to provider that can be held accountable for TCOC Provide transparency 	<ul style="list-style-type: none"> Payers maintain unique attribution methodologies
	Quality measures	<ul style="list-style-type: none"> Standard “menu” of metrics & definitions 	<ul style="list-style-type: none"> Agree to have link between quality and payment 	<ul style="list-style-type: none"> Payers separately design how metrics link to payment)
	Payment streams/ incentives		<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> Payers will have unique <ul style="list-style-type: none"> – Payment levels – Risk adjustment – Shared savings methodology
	Patient incentives		<ul style="list-style-type: none"> Agree to create incentives, communication to engage patients 	<ul style="list-style-type: none"> Incentives, benefit design, etc.

Target patients and scope

 Notable departure
from CPCi

“Standardize approach”

- N/A

“Align in principle”

- 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)

“Differ by design”

- N/A

Care delivery improvements

 Notable departure
from CPCi

“Standardize approach”

- N/A

“Align in principle”

- 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)

“Differ by design”

- 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”

- N/A

“Align in principle”

- 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.

“Differ by design”

- 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”

- N/A

“Align in principle”

- 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

“Differ by design”

- 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

“Standardize approach”

- N/A

“Align in principle”

- 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

“Differ by design”

- 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”

- N/A

“Align in principle”

- Agree in principle to create incentives (e.g., value-based benefit design), communication, etc. that engage patients in PCMH care delivery model

“Differ by design”

- Specific benefit designs (e.g., co-pay differentials, bonus payments) to be determined by individual payers



Governor's Office of
Health Transformation

Appendix C: Episode-Based Payment Charter for Payers

Governor Kasich's Advisory Council on
Health Care Payment Innovation

October 18, 2013

www.HealthTransformation.Ohio.gov



Ohio's SIM Grant Activities

- Governor's Office of Health Transformation convened experts to provide detailed input on State Innovation Model (SIM) design
 - 100+ experts from 40+ organizations deeply engaged
 - 50+ multi-stakeholder meetings to align across payers and providers
 - Top 5 payers aligned on overall strategy
- Ohio selected McKinsey & Company to assist in producing:
 - State of Ohio Healthcare Diagnostic Report
 - PCMH and Episode "Charters" to align payer decisions
 - Analytics and implementation plans to support the models
 - Ohio's Healthcare Innovation Plan (to submit October 30, 2013)

Episode-Based Payment Model Design Team

Providers

- David Bronson, MD, Cleveland Clinic
- Tony Hrudka, MD, Cleveland Clinic
- Michael McMillan, Cleveland Clinic
- John Corlett, MetroHealth
- Steve Marcus, ProMedica
- Terri Thompson, ProMedica
- John Kontner, OhioHealth
- Jennifer Atkins, Catholic Health Partners
- Ken Bertka, MD, Catholic Health Partners
- Richard Shonk, MD, Cincinnati Health Collaborative
- Mary Cook, MD, Central Ohio Primary Care
- Randall Cebul, MD, Better Health Greater Cleveland
- Rita Horwitz, RN, Better Health Greater Cleveland
- Uma Kotegal, MD, Cincinnati Children's Hospital
- Mary Wall, MD, North Central Radiology
- Michael Barber, MD, National Church Residences
- Todd Baker, Ohio State Medical Assoc.
- Nick Lashutka, Ohio Children's Hospital Assoc.
- Ryan Biles, Ohio Hospital Assoc.
- Alyson DeAngelo, Ohio Hospital Assoc.

Payers

- Wendy Payne, Medical Mutual
- Jim Peters, CareSource
- Ron Caviness, Aetna
- Barb Cannon, Anthem
- Meredith Day, Anthem
- Tammy Dawson, Anthem
- Mark DiCello, United Healthcare
- Rick Buono, United Healthcare
- Tim Kowalski, MD, Progressive
(representing purchasers)

State

- John McCarthy, Medicaid *(Episode Team Chair)*
- Robyn Colby, Medicaid
- Patrick Beatty, Medicaid
- Debbie Saxe, Medicaid
- Ogbe Aideyman, Medicaid
- Mary Applegate, MD, Medicaid
- Katie Greenwalt, Medicaid
- Amy Bashforth, ODH
- Anne Harnish, ODH
- Mark Hurst, MD, MHAS
- Greg Moody, OHT
- Rick Tully, OHT
- Monica Juenger, OHT
- Rebecca Susteric, BWC
- McKinsey: Razili Stanke-Koch, Christa Moss, Brendan Buescher, Kara Carter, Tom Latkovic, Amit Shah, MD



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

Year 1

- In 2014 focus on Comprehensive Primary Care Initiative (CPCi)
- Payers agree to participate in design for elements where standardization and/or alignment is critical
- Multi-payer group begins enrollment strategy for one additional market

- State leads design of five episodes: asthma (acute exacerbation), perinatal, COPD exacerbation, PCI, and joint replacement
- Payers agree to participate in design process, launch reporting on at least 3 of 5 episodes in 2014 and tie to payment within year

Year 3

- Model rolled out to all major markets
- 50% of patients are enrolled

- 20 episodes defined and launched across payers

Year 5

- Scale achieved state-wide
- 80% of patients are enrolled

- 50+ episodes defined and launched across payers

Agree on degrees of standardization within each model

“Standardize approach”

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)

“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; it's beneficial to know payers are not moving in different 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, members, strategy, administrative systems)

“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

Ohio episode model charter with potential degrees of standardization by component

	“Standardize approach”	“Align in principle”	“Differ by design”
Accountability	<ul style="list-style-type: none"> Single accountable provider will be identified for majority of episodes Type of provider may vary, but payers align on accountable providers for each episode 	<ul style="list-style-type: none"> Common vision to not categorically exclude unique providers 	<ul style="list-style-type: none"> Adjustments to episode cost (e.g., cost normalization) may vary by payer
Payment model mechanics	<ul style="list-style-type: none"> Model follows a retrospective approach; episode costs are calculated at the end of a fixed period of time Payers adopt common set of quality metrics for each episode 	<ul style="list-style-type: none"> Model includes both upside and downside risk sharing Aligned principle of linking quality metrics to incentives Agree to evaluate providers against absolute performance thresholds 	<ul style="list-style-type: none"> Payers may choose to have min number of episodes for provider participation Type and degree of stop loss may vary
Performance management	<ul style="list-style-type: none"> Commitment to launch reporting period prior to tying payment to performance 	<ul style="list-style-type: none"> Aligned approach to have episode-specific risk adjustment model Aligned approach to exclude episodes with factors not addressable through risk adjustment 	<ul style="list-style-type: none"> Payers independently determine method and level for gain sharing Risk adjustment methodologies may vary across payers
Payment model timing and thresholds		<ul style="list-style-type: none"> Performance period length for each episode and launch timings aligned where possible 	<ul style="list-style-type: none"> Start / end dates for each episode may vary Payers each determine approach to thresholding (incl. level of gain/risk sharing) Outlier determinations will be at discretion of each payer

Accountability

“Standardize approach”

- 3 Payers agree that there will be a **single accountable provider** for majority of episodes

- 4 Type of provider (e.g., surgeon, facility) may vary by episode; payers **align on** the accountable **provider** for **each specific episode** (e.g., physician delivering baby for perinatal)

“Align in principle”

- 5 Common vision to **not categorically exclude unique providers**

“Differ by design”

- 6 Specific adjustments to average episode cost calculations may be warranted; the type of **adjustment** (e.g., unit cost normalization) may differ by payer

Payment model mechanics

“Standardize approach”

- 7 ▪ Episode model follows **retrospective** approach; episode costs are calculated at the end of a fixed period of time known as a performance period (e.g., one year)
- 10 ▪ Payers adopt a common set of quality metrics for each episode for reporting

“Align in principle”

- 8 ▪ Payers agree on implementation of both **upside** gain sharing and **downside** risk sharing with providers when performance is tied to payment
- 10 ▪ Payers align the principle of linking performance on **quality metrics** to incentives in order to ensure providers continue to deliver high quality care
- 12 ▪ All align on evaluating providers against **absolute performance thresholds**; individual thresholds vary across payers

“Differ by design”

- 9 ▪ Implementation of a **minimum number of episodes** for provider participation may vary by episode and across payers
- 11 ▪ Type and degree of **stop-loss** arrangement may differ across payers

Performance management

“Standardize approach”

- 16 ■ Each payer commits to launching **reporting** on episode performance prior to tie to payment

“Align in principle”

- To ensure fair evaluation across providers, payers align on approach for:
 - 14 – **Risk adjustment** – Payers agree to have episode specific risk factors (tailored to their population) for each episode
 - 15 – **Exclusions** – Payers align on approach to exclude episodes with factors / complications that cannot be properly addressed through risk adjustment

“Differ by design”

- 13 ■ The exact method and level at which gain sharing is set may vary across payers
-
- 14 ■ Specifics of risk adjustment (e.g., exact mathematical model) may not be the same for each payer

Payment model timing and thresholds

“Standardize approach”

- N/A

“Align in principle”

- 17 ▪ Payers collaborate to determine appropriate **performance period lengths** for each episode and align launch timing where possible to ease provider adaptation
- 18

“Differ by design”

- 18 ▪ Detailed start / end dates for reporting and performance periods may vary across payers

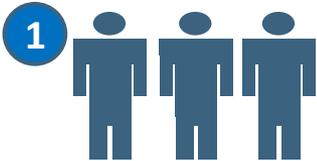
- 19 ▪ The **approach to thresholding** as well as threshold levels relate directly to pricing, impact competitive advantage and hence specifics may differ across payers
- 20

- 21 ▪ Likewise, the **degrees of gain / risk sharing** (e.g., what percentage of gains are given as incentive to providers) may vary across payers

- 22 ▪ Outlier determination relates directly to pricing and will be different across payers

Retrospective episode model mechanics

Patients and providers continue to deliver care as they do today



1 **Patients** seek care and select providers as they do today



2 **Providers** submit claims as they do today



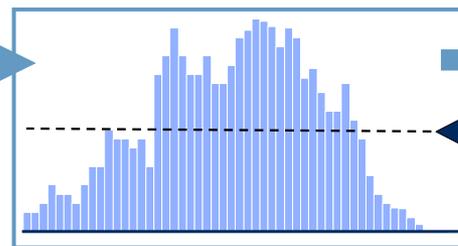
3 **Payers** reimburse for all services as they do today

Calculate incentive payments based on outcomes after close of 12 month performance period



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

5 Payers calculate **average cost per episode** for each PAP¹

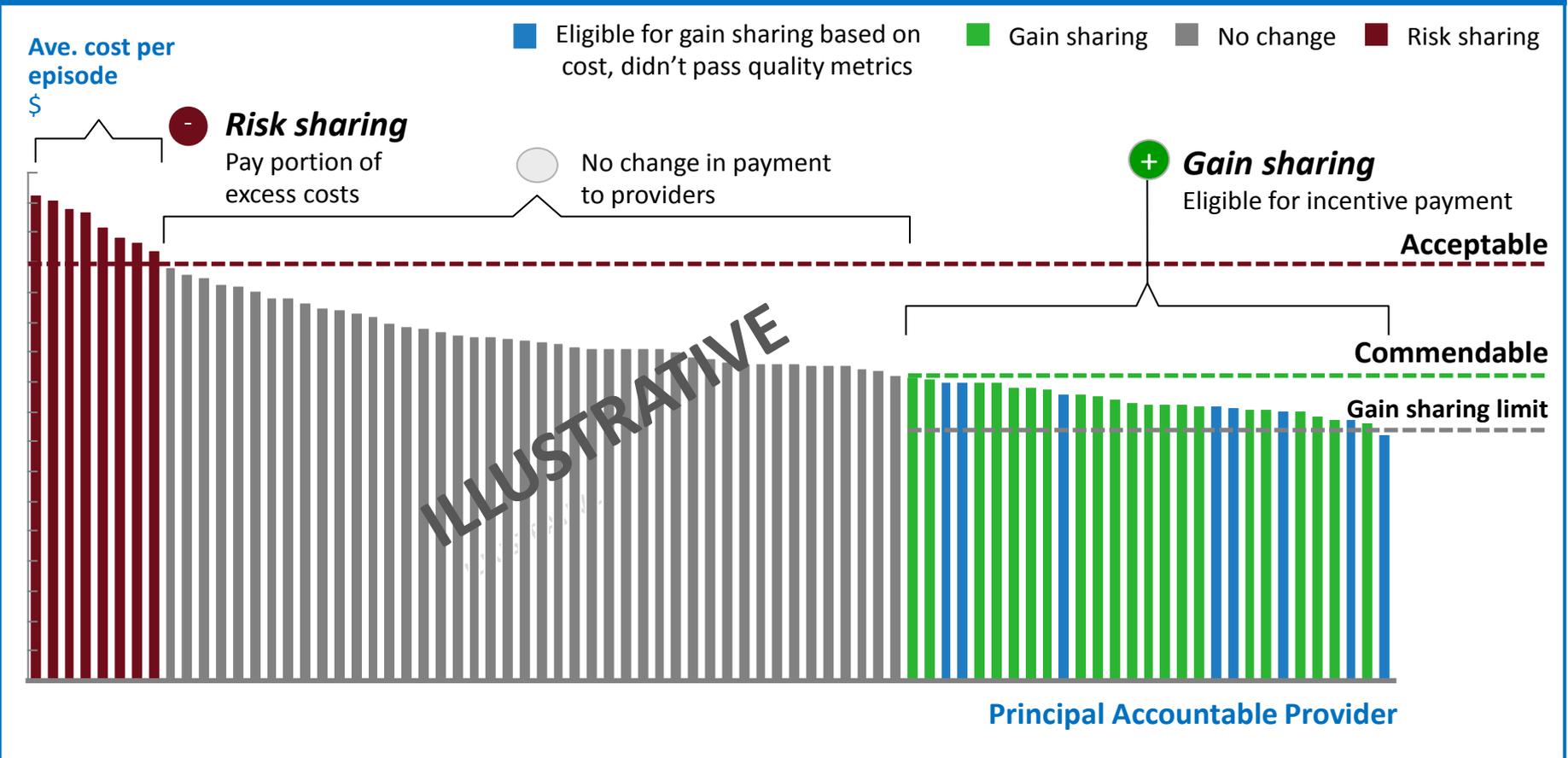


Compare average costs to predetermined "commendable" and "acceptable" levels²

- 6** **Providers may:**
- **Share savings:** if average costs below commendable levels and quality targets are met
 - **Pay part of excess cost:** if average costs are above acceptable level
 - **See no change in pay:** if average costs are between commendable and acceptable levels

Retrospective thresholds reward cost-efficient, high-quality care

Provider cost distribution (average episode cost per provider)



Governor's Office of Health Transformation

SOURCE: Arkansas Payment Improvement Initiative; each vertical bar represents the average cost for a provider, sorted from highest to lowest average cost

Episode Algorithm Design Elements



Example: Asthma Acute Exacerbation*

- *Trigger*
 - ED visit
 - IP admission
- *Pre-Trigger (none)*
- *Post-Trigger (30 days)*
includes relevant:
 - Office visits
 - Labs
 - Medications
 - Readmissions
- ED facility or admitting facility
- Specific comorbidities
 - Use of a vent
 - ICU more than 72 hours
 - Left AMA
 - Death in hospital
 - Under 5 years old
 - Eligibility
- 9 risk factors
- Uses coefficients from AR model
- *Linked to gain sharing:*
 - Corticosteroid and/or inhaled corticosteroid use
 - Follow-up visit within 30 days
- *For reporting:*
 - Repeat acute exacerbation rate

Each episode algorithm is jointly developed with input from key stakeholders including providers (e.g., pulmonologists in this example) and payers

Selection of episodes in the first year

Guiding 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)



Working hypothesis for episodes in the first year:

- Perinatal
- Asthma acute exacerbation
- Chronic obstructive pulmonary disease (COPD) exacerbation
- Joint replacement
- Percutaneous coronary intervention (PCI)