Transforming Payment for a Healthier Ohio

Ohio Patient-Centered Primary Care Collaborative
Fall Conference

November 8, 2013

www.HealthTransformation.Ohio.gov

Health Care Spending per Capita by State (2011) in order of resident health outcomes (2009)

$10,000
$9,000
$8,000
$7,000
$6,000
$5,000
$4,000
$3,000
$2,000
$1,000
$0

MN HI CT UT CA MA IA VT WI ND CO ID WA NH NE WY NY OR NJ RI AZ TX ME MD MT FL AK VA NM SD KS IL PA DE MI IN GA NV NC MO OH SC OK KY LA AL AR TN WV MS

Ohioans spend more per person on health care than residents in all but 17 states

36 states have a healthier workforce than Ohio

Governor's Office of Health Transformation

Sources: CMS *Health Expenditures by State of Residence* (2011); The Commonwealth Fund, *Aiming Higher: Results from a State Scorecard on Health System Performance* (October 2009).

Innovation Framework

Modernize Medicaid	Streamline Health and Human Services	Pay for Value
Initiate in 2011	***Initiate in 2012***	***Initiate in 2013***
Advance the Governor Kasich's Medicaid modernization and cost containment priorities	*Share services to increase efficiency, right-size state and local service capacity, and streamline governance*	*Engage private sector partners to set clear expectations for better health, better care and cost savings through improvement*
• Extend Medicaid coverage to more low-income Ohioans • Eliminate fraud and abuse • Prioritize home and community services • Reform nursing facility payment • Enhance community DD services • Integrate Medicare and Medicaid benefits • Rebuild community behavioral health system capacity • Create health homes for people with mental illness • Restructure behavioral health system financing • Improve Medicaid managed care plan performance	• Create the Office of Health Transformation (2011) • Implement a new Medicaid claims payment system (2011) • Create a unified Medicaid budget and accounting system (2013) • Create a cabinet-level Medicaid Department (July 2013) • Consolidate mental health and addiction services (July 2013) • Simplify and replace Ohio's 34-year-old eligibility system • Coordinate programs for children • Share services across local jurisdictions • Recommend a permanent HHS governance structure	• Participate in Catalyst for Payment Reform • Support regional payment reform initiatives • Pay for value instead of volume (State Innovation Model Grant) – Provide access to medical homes for most Ohioans – Use episode-based payments for acute events – Coordinate health information infrastructure – Coordinate health sector workforce programs – Report and measure system performance

Governor's Office of Health Transformation

Payment Innovation Partners

John R Kasich
Governor

Governor's Senior Staff

State of Ohio Health Care Payment Innovation Task Force

Office of Health Transformation

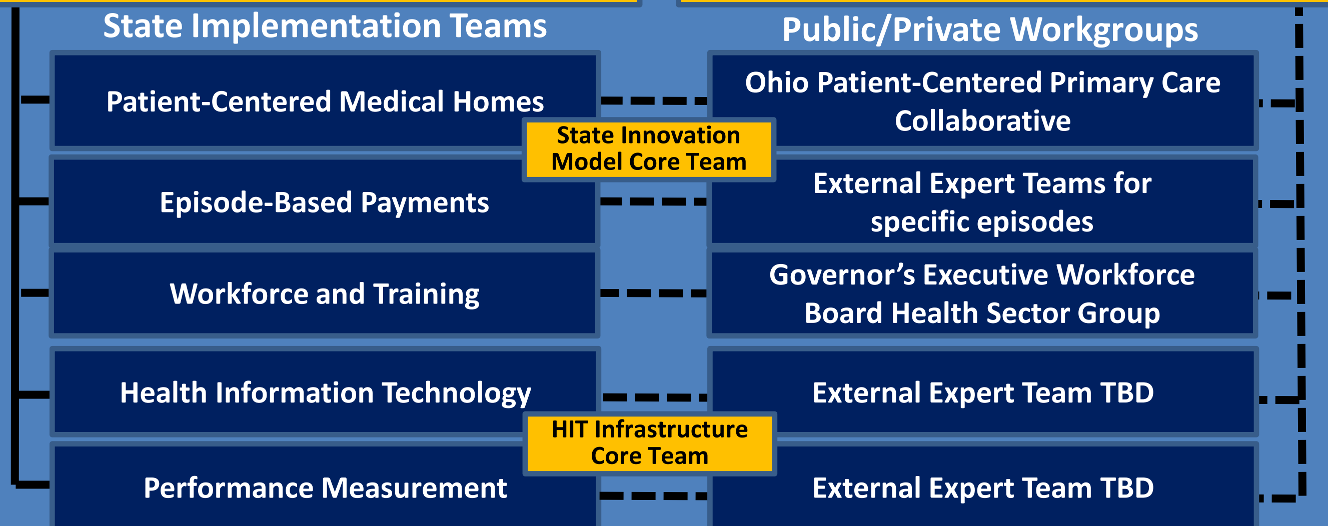
- **Project Management Team:** Executive Director, Communications Director, Stakeholder Outreach Director, Legislative Liaison, Fiscal and IT Project Managers

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

Governor's Advisory Council on Health Care Payment Innovation

- **Purchasers** (Bob Evans, Cardinal Health, Council of Smaller Enterprises, GE Aviation, Procter & Gamble, Progressive)
- **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 Innovation Model Grants

- Federal funding for states to design and test comprehensive State Health Care Innovation Plans. Innovation plans must:
  - Be Governor-led and multi-payer
  - Improve health, improve health care, and reduce costs
  - Incorporate a broad range of stakeholder input
- Significant funding pool
  - 16 design grants of $1-3 million each
  - 6 testing grants of $20-60 million each and Medicare participates
  - Ohio received a $3 million design grant ($4.1 million in kind) and will apply for a second round of testing grants early in 2014

SOURCE: www.innovation.cms.gov/initiatives/state-innovations

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)

Governor's Office of Health Transformation

5-Year Goal for Payment Innovation

Goal

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

State's Role

- 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

Shift to population-based and episode-based payment

Payment approach

Population-based
(PCMH, ACOs, capitation)

Episode-based

Fee-for-service
(including pay for performance)

Most applicable

- Primary prevention for healthy population
- Care for chronically ill (e.g., managing obesity, CHF)

- Acute procedures (e.g., CABG, hips, stent)
- Most inpatient stays including post-acute care, readmissions
- Acute outpatient care (e.g., broken arm)

- Discrete services correlated with favorable outcomes or lower cost

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

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)*

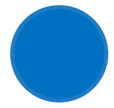
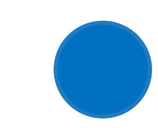
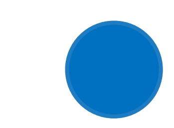
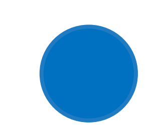
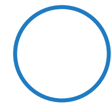
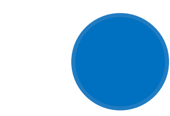
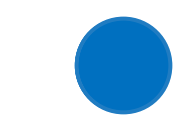
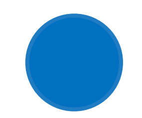
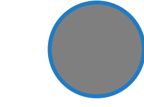
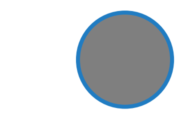
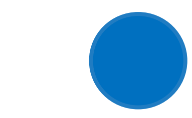
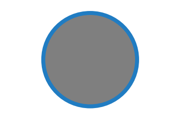
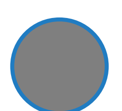
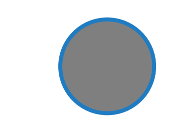
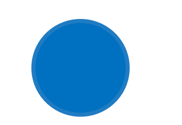
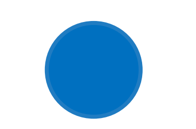
State

- 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

Elements of a Patient-Centered Medical Home Strategy

Element	Components	Description
Care delivery model	Target patients and scope Care delivery improvements e.g., ▪ Improved access ▪ Patient engagement ▪ Population management ▪ Team-based care, care coordination Target sources of value	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	Technical requirements for PCMH Attribution / assignment Quality measures Payment streams/ incentives Patient incentives	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	PCMH infrastructure Payer infrastructure Payer / PCMH infrastructure PCMH/ Provider infrastructure System infrastructure	Technology, data, systems, and people required to enable creation of PCMH, administer new payment models, and support PCMHs in making desired changes in care delivery
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	Support, resources, or activities to enable practices to adopt the PCMH delivery model, sustain transformation and maximize impact

Ohio already has various PCMH projects underway

● Major focus of pilots ◐ Some focus ○ Minimal or no focus	HB 198 Education Pilot Sites	NCQA, AAAHC, Joint Commission	Cincinnati/Dayton CPCi	Private Payer Pilots
	▪ 47 pilot sites target underserved areas ▪ Potential to add 50 pediatric pilots	▪ 291 NCQA-recognized sites ▪ 18 Joint Commission accredited sites ▪ 5 AAAHC-accredited	▪ 61 sites in OH (14 in KY), incl. Tri-Health, Christ Hospital, PriMed, Providence, St. Elizabeth (KY)	▪ Vary in scope by pilot, but tend to focus on larger independent or system-led practices
Care delivery model				
Payment model				
Infrastructure				
Scale-up and practice performance improvement				

Governor's Office of Health Transformation

Source: Ohio Patient-Centered Primary Care Collaborative ; as of Oct. 2013.

Comprehensive Primary Care (CPC) Initiative

- Ohio is one of only seven CPC sites nationally
- Multi-payer: Medicare, Medicaid, nine commercial insurance plans
- Bonus payments to primary care doctors who better coordinate care
- 75 primary care practices (261 providers) serving 44,500 Medicare enrollees in 4 Kentucky and 14 Ohio counties (Dayton to Cincinnati)
- Practices were selected based on their use of HIT, advanced primary care recognition, and participation in practice improvement activities
- Supported by a unique regional collaborative:

CPC Informed Ohio's PCMH Model Design

		Standardize	Align in Principle	Differ by Design
Care Delivery Model	Target patients and scope		✓	
	Care delivery improvements		✓	
	Target sources of value		✓	
Payment Model	Technical require-ments for PCMH	✓		
	Attribution / assignment		✓	
	Quality measures	✓		
	Payment streams / incentives			✓
	Patient incentive		✓	

Check-mark indicates whether most design decisions will need to be standardized, aligned in principle, or differ by design. However, within any component of the model, there may be individual design decisions that fall into each bucket

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

Elements of an Episode-Based Payment Strategy

Program-level design decisions

Participation
- Provider participation
- Payer participation

(Related to 'scale-up' plan for episodes)

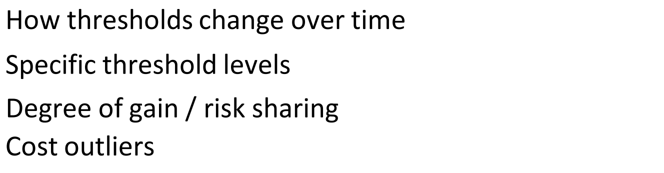
Account-ability
- Providers at risk – Number
- Providers at risk – Type of provider(s)
- Providers at risk – Unique providers
- Cost normalization approach

Payment model mechanics
- Prospective or retrospective model
- Risk-sharing agreement – types of incentives
- Approach to small case volume
- Role of quality metrics
- Provider stop-loss
- Absolute vs. relative performance rewards

Performance management
- Absolute performance rewards – Gain sharing limit
- Approach to risk adjustment
- Exclusions

Payment model timing
- Preparatory/"reporting-only" period
- Length of "performance" period
- Synchronization of performance periods

Payment model thresholds



- Approach to thresholds
- How thresholds change over time
- Specific threshold levels
- Degree of gain / risk sharing
- Cost outliers

Episode-specific design decisions

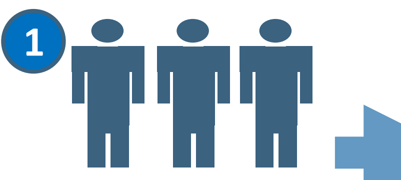
Core Episode definition
- Quarterback selection
- Triggers
- Episode timeframe – Type/length of pre-procedure/ event window
- Claims in- or excluded: pre-procedure/event window
- Claims in- or excluded: during procedure/event
- Claims in- or excluded: post procedure/event (incl. readmission policy)

Episode cost adjustment
- Risk adjustors
- Unit cost normalization - Inpatient
- Unit cost normalization - Other
- Adjustments for provider access
- Approach to cost-based providers
- Clinical exclusions

Quality metric selection
- Approach to non-claims-based quality metrics
- Quality metric sampling
- Quality metrics linked to payment
- Quality metrics for reporting only

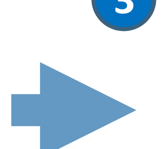
Retrospective episode model mechanics

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

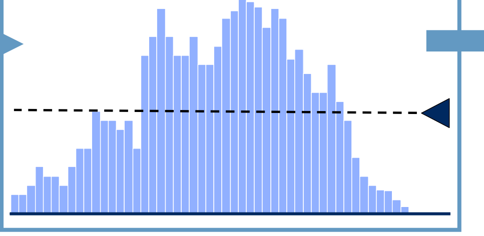


3 **Payers** reimburse for all services as they do today

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 PAP[1]



Compare average costs to predetermined ''commendable' and 'acceptable' levels[2]

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

SOURCE: Arkansas Payment Improvement Initiative

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

Up to 70% of spend may be addressed 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	Potentially addressable through episodes (e.g., discrete, defined goal, clear guidelines)
Acute inpatient medical	CHF, pneumonia, AMI, stroke	~20-25	~5-15	~20-30	
Acute procedural	Hip/knee, CABG PCI, pregnancy	~25-35	~15-25	~20-25	
Cancer	Breast cancer	~10	<5	~10	
Behavioral health	ADHD, depression	~5	~15-20	~5	
Supportive care	Develop. disability, long-term care	N/A	~20-30	N/A	

NOTE: National data

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)

Next Steps

1. Convene clinical workgroups to create Ohio specific technical definitions for five episodes (next 3 months)
2. Continue CPCi efforts in SW Ohio (ongoing)
3. Submit a State Healthcare Innovation Plan to CMMI (by October 30, 2013)
4. Apply for a federal SIM Testing Award (early 2014)

www.HealthTransformation.Ohio.gov

Reactions Overall – PCMH & Episode

1. Supports the Triple Aim - better service/quality, population health management, bend the cost curve
2. Stakeholder leadership
3. Common pathway for transition to value-based payment models
    - — all communities
    - — all size/complexity of practices
    - — major payers
    - — diverse populations
4. Challenge - Requires a strong multi-payer commitment
5. Does NOT interfere with health systems & payers who are ready to go further - such as an Accountable Care Organization
6. Commitment to move ahead with or without the CMS SIM grant

PCMH Comments

1. Expands on existing strengths
   - CPCI
   - House Bill 198 PCMH practices
   - Health system efforts
2. Standard set of quality metrics build upon EHR MU, ACO and CPCI measures
3. Standard set of technical requirements and milestones
4. Agreement on need for patient incentives
5. Agreement on need for compensation for services not adequately covered by fee-for-service today

Episode Comments

1. Gives clinical integration agreed upon starting points for care across the continuum
2. Common set of quality metrics for each episode
3. Commitment to a reporting period before the payment model is changed
4. Episode-specific risk adjustment & inclusion/exclusion criteria
5. "Accountable Provider" will be aligned across the state

Questions?

www.HealthTransformation.Ohio.gov

Patient-Centered Medical Home Charter for Payers

Governor Kasich's Advisory Council on Health Care Payment Innovation

October 18, 2013

www.HealthTransformation.Ohio.gov

Governor's Office of Health Transformation

5-Year Goal for Payment Innovation

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

State's Role:
- 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

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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

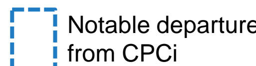
		"Standardize approach"	"Align in principle"	"Differ by design"
Care delivery model	Target patients and scope		▪ All patients included ▪ Strive for TCOC accountability	
	Care delivery improvements		▪ Aligned vision / vocabulary of care delivery model	▪ Payers, practices champion unique care delivery models
	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



"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"

- N/A

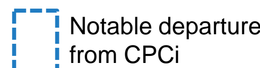
"Align in principle"

- 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"

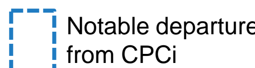
- Payers will set unique targets / thresholds aimed at realizing these sources of value

Technical requirements for PCMH



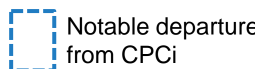
"Standardize approach"	"Align in principle"	"Differ by design"
▪ Payers will agree to fully standardized requirements to participate as "OH PCMH" ▪ Payers will agree to fully standardized milestones for continued participation that will be measured/ monitored over time (e.g., performing care plans) ▪ 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)	▪ 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	▪ The extent to which and how meeting these requirements affect payment

Attribution / assignment



"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



"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)

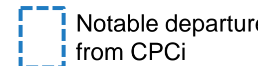
"Align in principle"

- 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"	"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