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Transforming Payment for a Healthier Ohio

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Joint Medicaid Oversight Committee
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1. **Ohio's approach to paying for value instead of volume**
2. Episode-Based Payment Model
3. Patient-Centered Medical Home Model

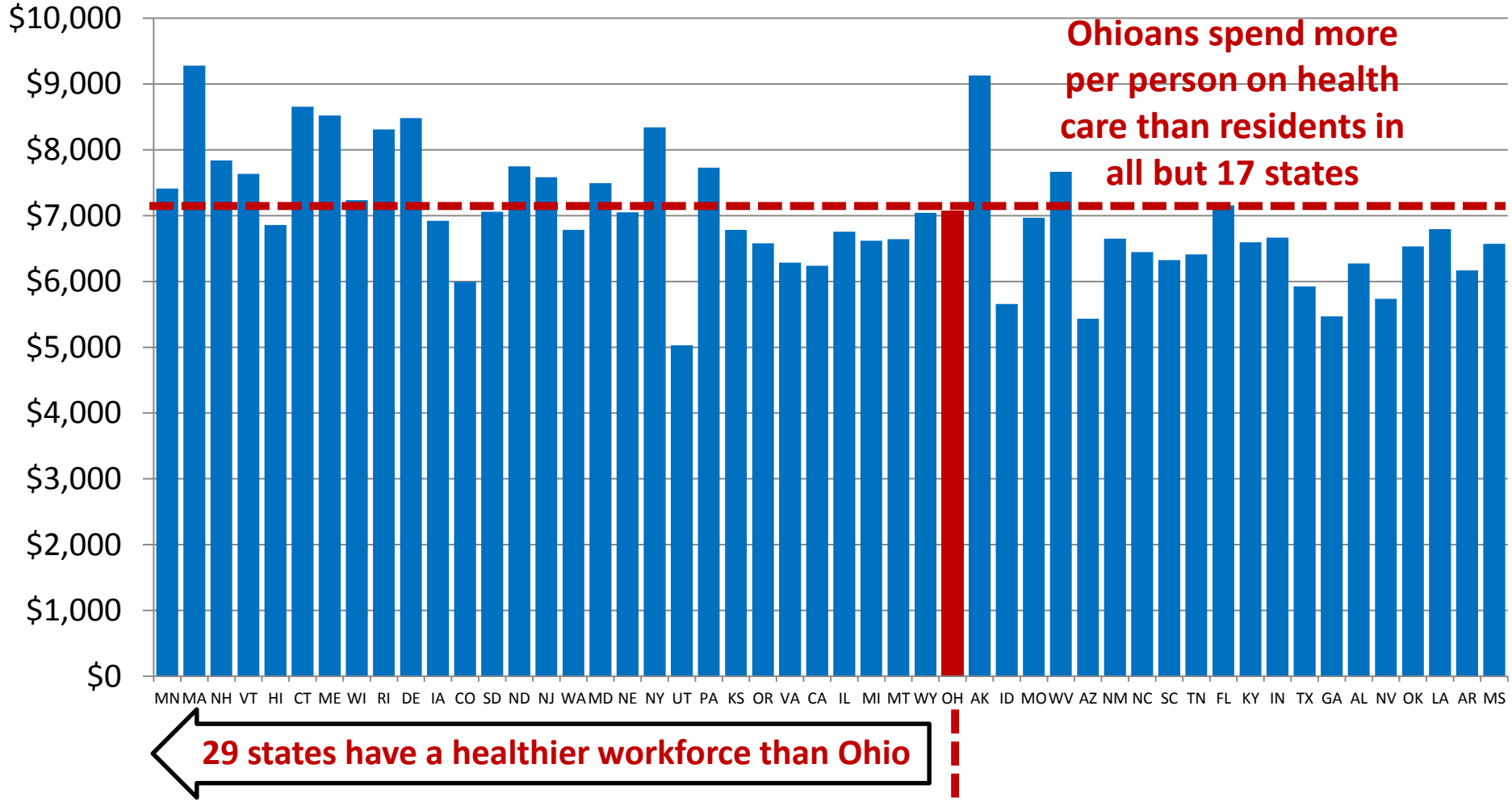
In fee-for-service, we get what we pay for

- **More volume** – to the extent fee-for-service payments exceed costs of additional services, they encourage providers to deliver more services and more expensive services
- **More fragmentation** – paying separate fees for each individual service to different providers perpetuates uncoordinated care
- **More variation** – separate fees also accommodate wide variation in treatment patterns for patients with the same condition – variations that are not evidence-based
- **No assurance of quality** – fees are typically the same regardless of the quality of care, and in some cases (e.g., avoidable hospital readmissions) total payments are greater for lower-quality care

Source: UnitedHealth, *Farewell to Fee-for-Service: a real world strategy for health care payment reform* (December 2012)

Ohio can get better value from what is spent on health care

Health Care Spending per Capita by State (2011) in order of resident health outcomes (2014)



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Sources: CMS *Health Expenditures by State of Residence* (2011); The Commonwealth Fund, *Aiming Higher: Results from a State Scorecard on Health System Performance* (May 2014).

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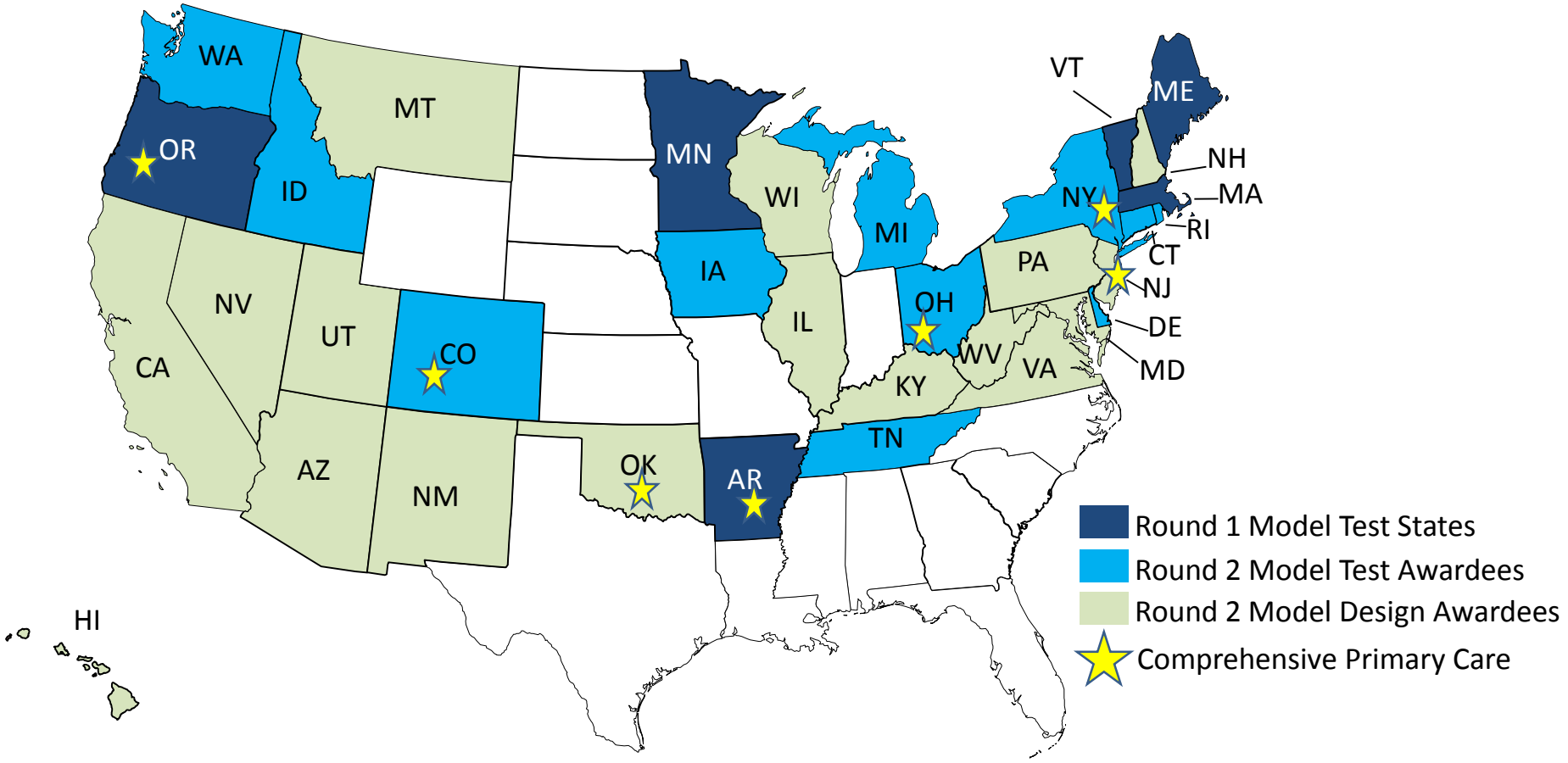
Ohio's Path to Value

Modernize Medicaid	Streamline Health and Human Services	Pay for Value
Initiate in 2011	***Initiate in 2012***	***Initiate in 2013***
Advance Governor Kasich's Medicaid modernization and cost containment priorities	***Share services to increase efficiency, right-size 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 based (HCBS) services • Reform nursing facility payment • Enhance community DD services • Integrate Medicare and Medicaid • Rebuild community behavioral health system capacity • 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 (2013) • Consolidate mental health and addiction services (2013) • Simplify and integrate eligibility determination (2014) • Refocus existing resources to promote economic self-sufficiency	• Join Catalyst for Payment Reform • Support regional payment reform • 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

Ohio is one of 17 states awarded a federal grant to test payment innovation models



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SOURCE: State Innovation Models and Comprehensive Primary Care Initiative, U.S. Centers for Medicare and Medicaid Services (CMS).

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Ohio's Payment Innovation Strategy

Goal

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

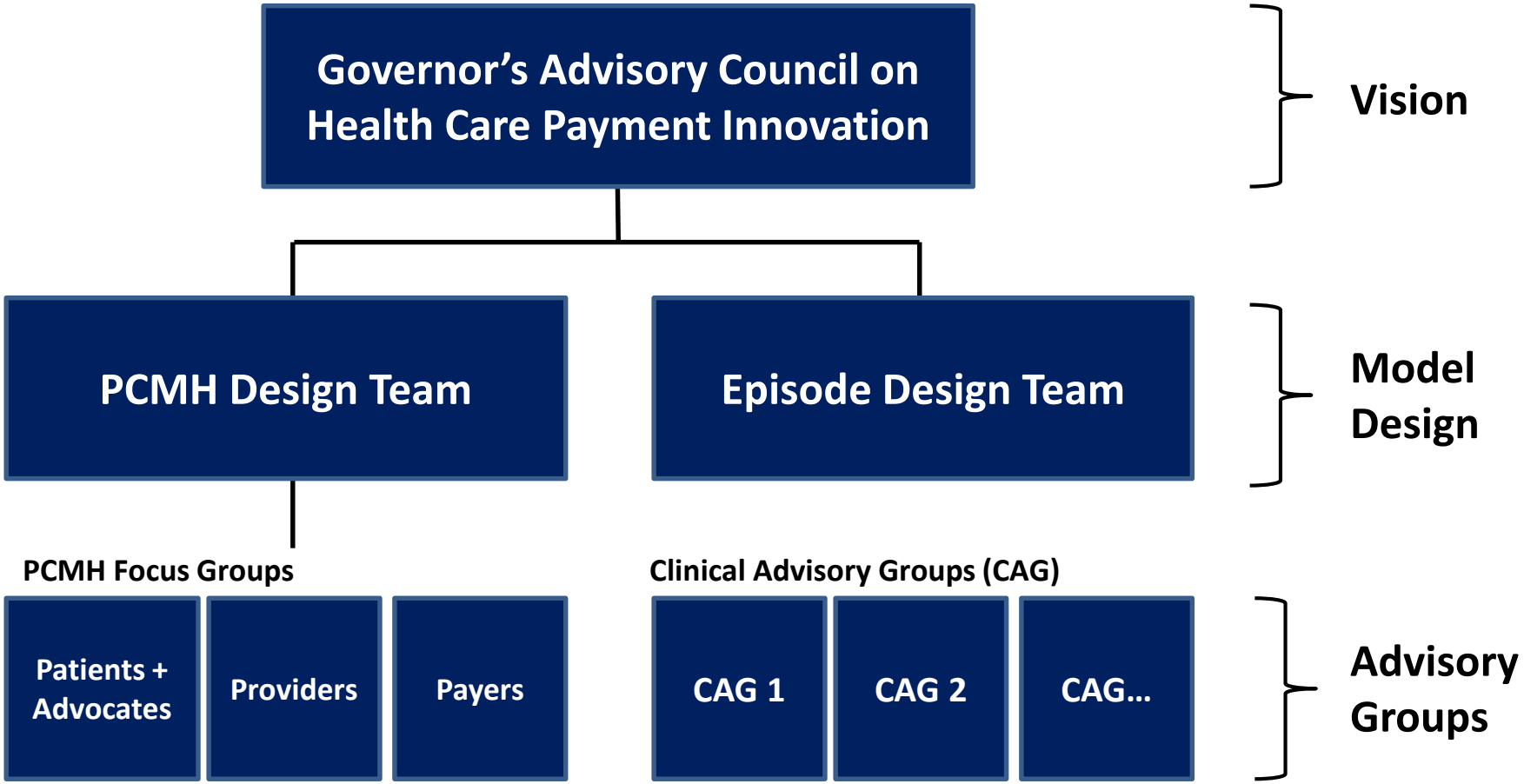
State's Role

- Shift rapidly to PCMH and episode model in Medicaid fee-for-service
- Require Medicaid MCO partners to participate and implement
- Incorporate into contracts of MCOs for state employee benefit program

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

updated August 27, 2015

Payment model design decisions have been shaped by meaningful input from 800+ stakeholders across Ohio



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Ohio's largest health plans have committed to help design and implement PCMH and episode-based payment models

Anthem

MEDICAL MUTUAL

aetna

UnitedHealthcare

CareSource

MOLINA HEALTHCARE

Buckeye Community Health Plan

PARAMOUNT ADVANTAGE

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50-percent value-based by 2020

- The Ohio General Assembly enacted ORC 5167.33 to require Medicaid managed care plans (MCOs) to pay providers based on the value received from the providers' services
  - *"Not later than July 1, 2018, each Medicaid MCO shall implement strategies that base payments to providers on the value received…*
  - *"Not later than July 1, 2020, each Medicaid MCO shall ensure that at least fifty percent of the aggregate net payments it makes to providers are based on the value received…"*
- The Medicaid director is required to adopt rules under ORC 5167.02 as necessary to implement ORC 5167.33

Source: *Main Operating Budget of the 131st General Assembly* (House Bill 64, effective June 30, 2015).

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1. Ohio's approach to paying for value instead of volume
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3. Patient-Centered Medical Home Model

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

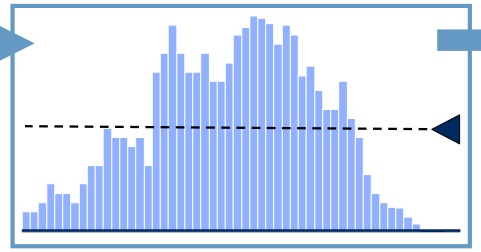
Payers reimburse for all services as they do today

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 risk-adjusted reimbursement per episode** for each PAP



Compare to predetermined "commendable" and "acceptable" levels

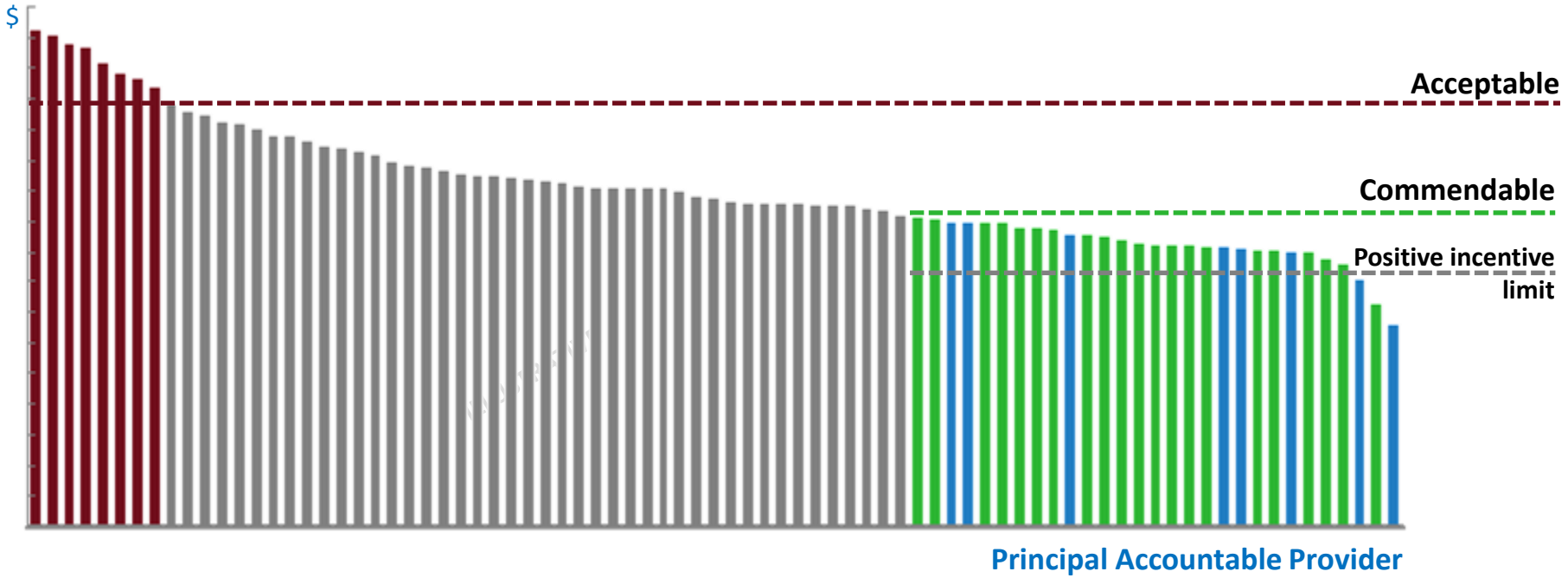
6 **Providers may:**

- **Share savings**: if average costs below commendable levels and quality targets are met
- **Pay negative incentive:** if average costs are above acceptable level
- **See no impact:** if average costs are between commendable and acceptable levels

Retrospective thresholds reward cost-efficient, high-quality care

Provider cost distribution (average risk-adjusted reimbursement per provider)

- ***Negative incentive***
- ***No change***
  No incentive payment
- ***No Change***
  Eligible for positive incentive payment based on cost, but did not pass quality metrics
- ***Positive incentive***



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

Elements of the Episode Definition

Category	Description
1 Episode trigger	▪ Diagnoses or procedures and corresponding claim types and/or care settings that characterize a potential episode
2 Episode window 3 Claims included	▪ **Pre-trigger window:** Time period prior to the trigger event; relevant care for the patient is included in the episode ▪ **Trigger window:** Duration of the potential trigger event (e.g., from date of inpatient admission to date of discharge); all care is included ▪ **Post-trigger window:** Time period following trigger event; relevant care and complications are included in the episode
4 Principal accountable provider	▪ Provider who may be in the best position to assume principal accountability in the episode based on factors such as decision making responsibilities, influence over other providers, and portion of the episode spend
5 Quality metrics	▪ Measures to evaluate quality of care delivered during a specific episode
6 Potential risk factors	▪ Patient characteristics, comorbidities, diagnoses or procedures that may potentially indicate an increased level of risk for a given patient in a specific episode
7 Episode-level exclusions	▪ Patient characteristics, comorbidities, diagnoses or procedures that may potentially indicate a type of risk that, due to its complexity, cost, or other factors, should be excluded entirely rather than adjusted

Selection of episodes

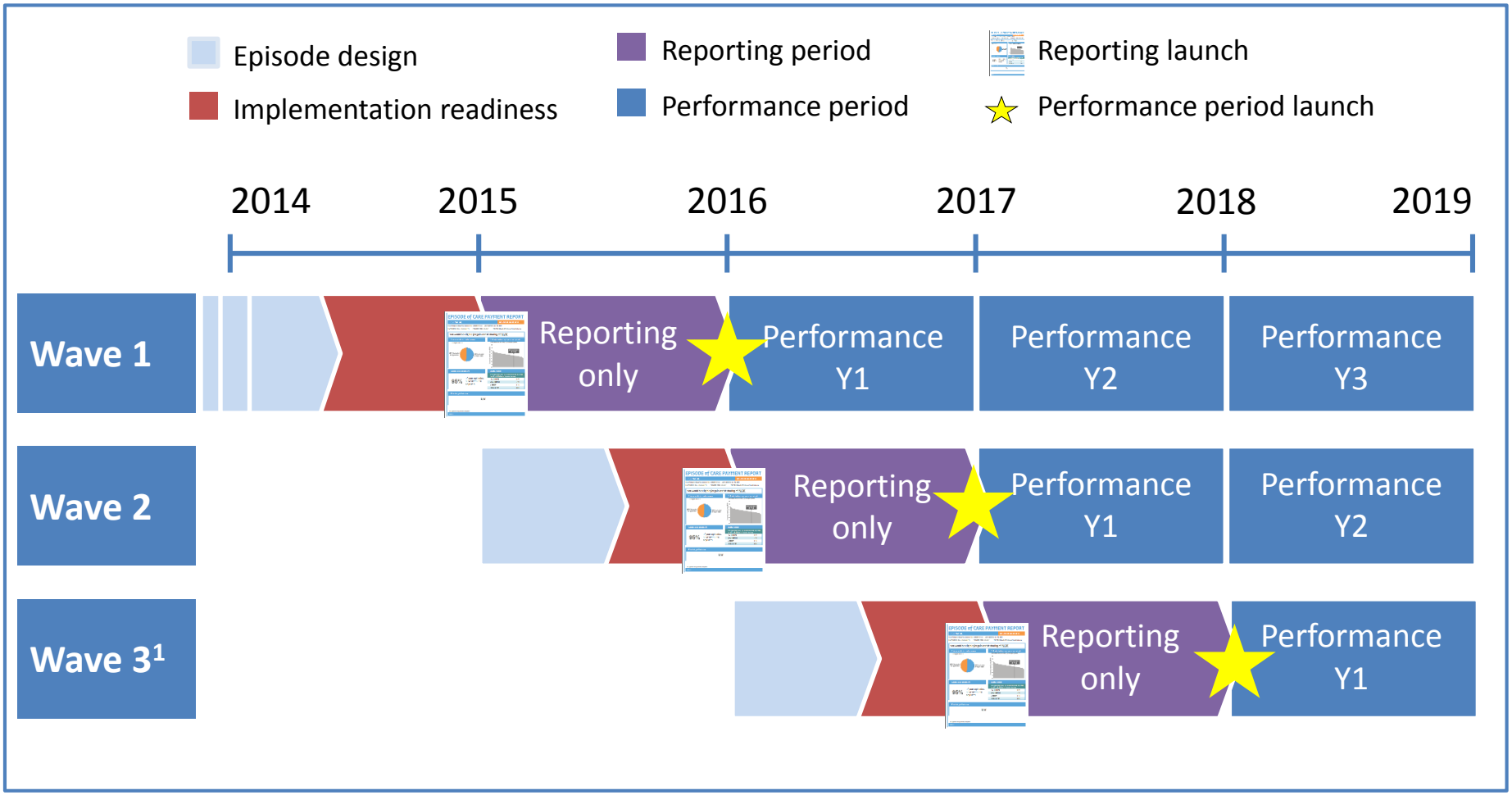
Principles for selection:

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

Ohio's episode selection:

Episode	*Principal Accountable Provider*
WAVE 1 (launched March 2015)	
1. Perinatal	Physician/group delivering the baby
2. Asthma acute exacerbation	Facility where trigger event occurs
3. COPD exacerbation	Facility where trigger event occurs
4. Acute Percutaneous intervention	Facility where PCI performed
5. Non-acute PCI	Physician
6. Total joint replacement	Orthopedic surgeon
WAVE 2 (launch January 2016)	
7. Upper respiratory infection	PCP or ED
8. Urinary tract infection	PCP or ED
9. Cholecystectomy	General surgeon
10. Appendectomy	General surgeon
11. Upper GI endoscopy	Gastroenterologist
12. Colonoscopy	Gastroenterologist
13. GI hemorrhage	Facility where hemorrhage occurs
WAVE 3 (launch January 2017)	
14-19. Package of episodes including some related to behavioral health	

Ohio's episode timeline



1 Expected timing for Wave 3

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This is an example of the performance report format that will be released in 2016 with the launch of the performance period for Wave 1 and used for both Wave 1 and Wave 2 episodes in 2016

EPISODE of CARE PROVIDER REPORT

EPISODE NAME | Q1 + Q2 YYYY

Reporting period covering episodes that ended between **Start Date to End Date**

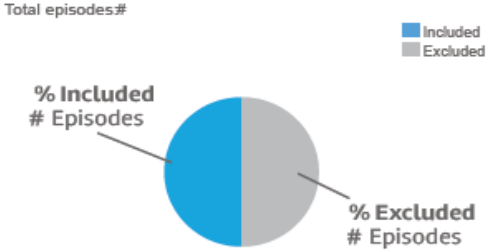
PAYER: Payer Name | PROVIDER ID: PAP ID | PROVIDER: Provider Name

Eligibility requirements for gain or risk-sharing payments

- **Episode volume:** You have at least 5 episodes in the current performance period.
- **Spend:** Your average risk-adjusted spend per episode is below the commendable threshold.
- **Quality:** You are not currently eligible for gain-sharing because you have not passed all quality metrics linked to gain-sharing.
- **This report is informational only.** Eligibility for gain or risk-sharing will be determined at the end of the performance period and any applicable payments will be calculated at that time.

Episodes included, excluded & adjusted

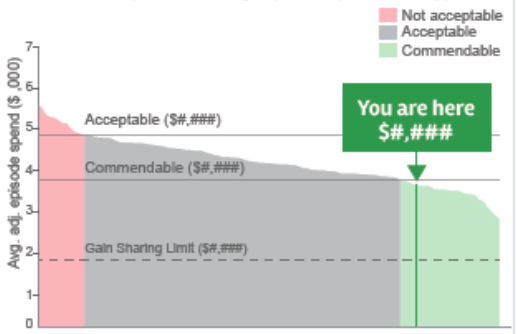
Total episodes#



% of your episodes have been risk adjusted

Risk adjusted average spend per episode

Distribution of provider average episode spend (risk adj.)



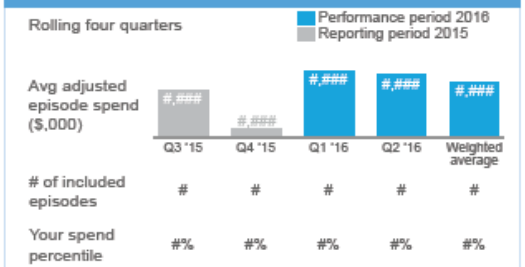
Quality metrics

You achieved # of # quality metrics linked to gain sharing

Quality metric 01	#% ✓
Quality metric 02	#% ✓
Quality metric 03	#% ✗
Quality metric 04	#% ✗

Key performance

Rolling four quarters



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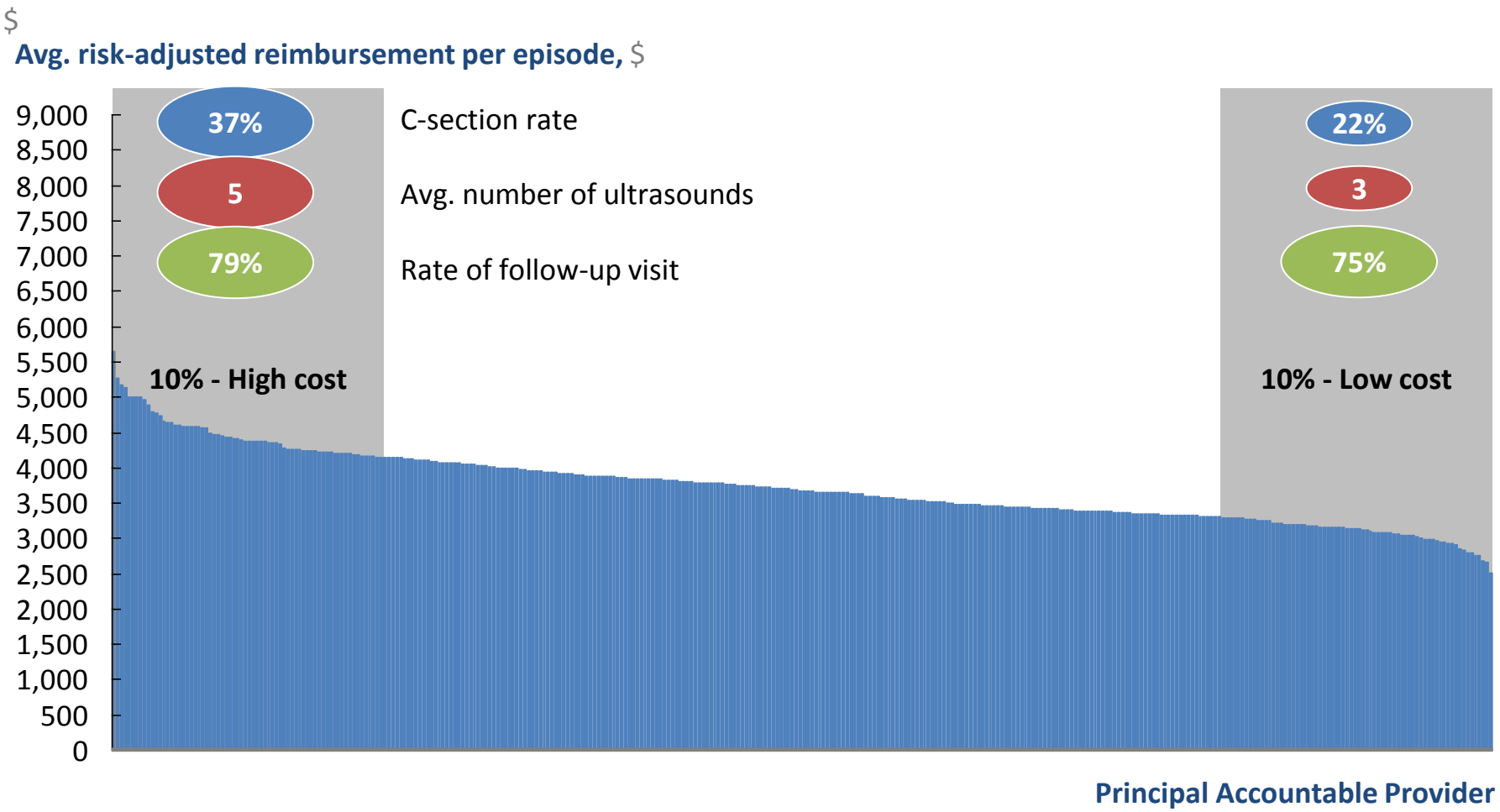
Variation across the Perinatal episode

Distribution of provider average episode cost



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NOTES: Average episode spend distribution for PAPs with five or more episodes; each vertical bar represents the average spend for one PAP.
SOURCE: Analysis of Ohio Medicaid claims data, CY2014.

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1. Ohio's approach to paying for value instead of volume
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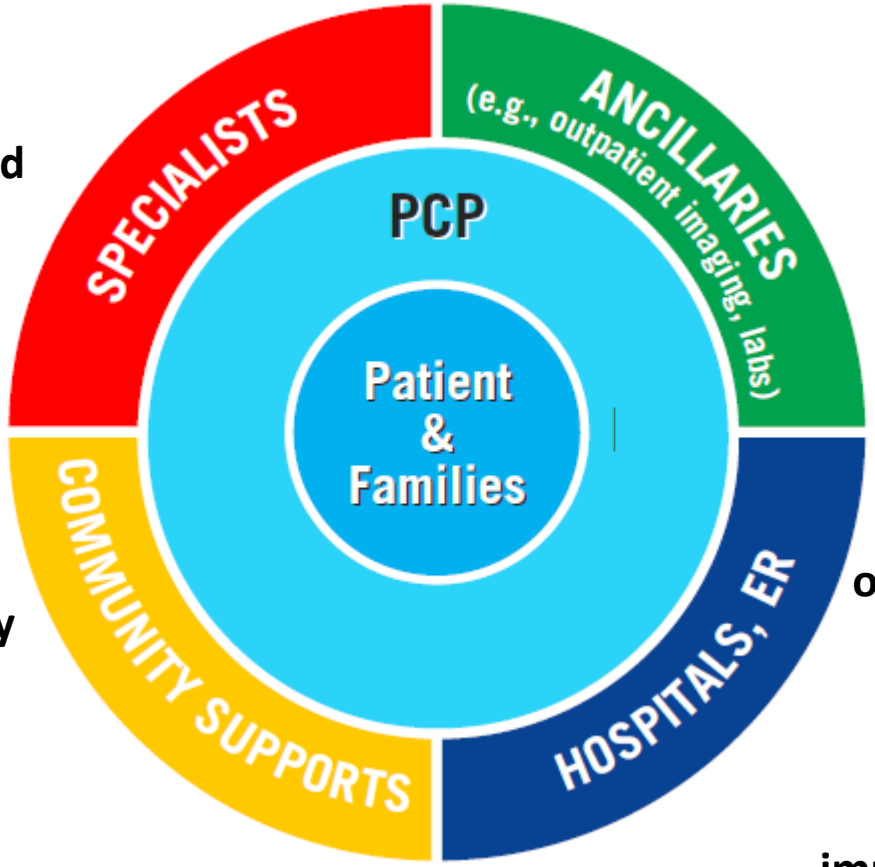
3. **Patient-Centered Medical Home Model**

What is a Patient-Centered Medical Home (PCMH) and why focus on primary care?

PCMH is a team-based care delivery model led by a primary care provider who comprehensively manages a patient's health needs with an emphasis on health care value and quality



Most medical costs occur outside of the office of a primary care physician (PCP), but PCPs can guide many decisions that impact those broader costs, improving cost efficiency and care quality

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"Health care homes save Minnesota $1 billion"

State-certified patient-centered health care home performance (2010-2014) compared to other Minnesota primary care practices …

- Better quality of care for diabetes, vascular, asthma (child and adult), depression, and colorectal cancer screening
- Significantly smaller racial disparities on most measures
- Better care coordination for low-income populations
- Major decrease in the use of hospital services
- Saved $1 billion over four years, mostly Medicaid ($918 million), but also Medicare ($142 million)

Source: University of Minnesota School of Public Health *Evaluation of the State of Minnesota's Health Care Homes Initiative, 2010-2014* (December 2015).

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

Patient Experience:
Offer consistent, individualized experiences to each member depending on their needs

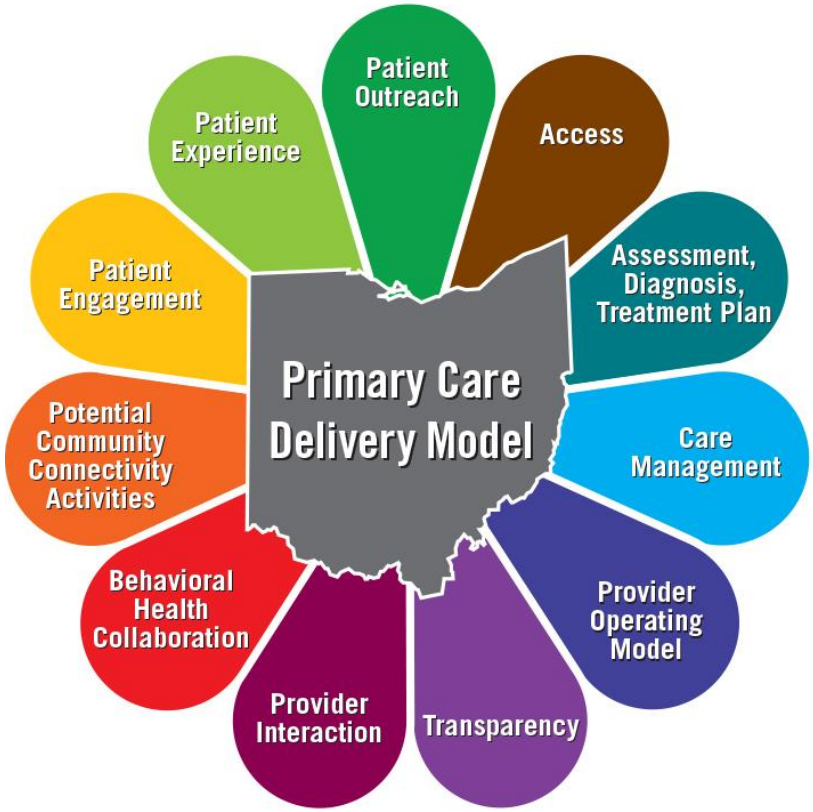
Patient Engagement:
Have a strategy in place that effectively raises patients' health literacy, activation, and ability to self-manage

Potential Community Connectivity Activities:
Actively connect members to a broad set of social services and community-based prevention programs (e.g., nutrition and health coaching, parenting education, transportation)

Behavioral Health Collaboration:
Integrate behavioral health specialists into a patients' full care

Provider Interaction:
Oversee successful transitions in care and select referring specialists based on evidence-based likelihood of best outcomes for patient

Transparency:
Consistently review performance data across a practice, including with patients, to monitor and reinforce improvements in quality and experience



Patient Outreach:
Proactive, targeting patients with focus on all patients including healthy individuals, those with chronic conditions, and those with no existing PCP relationship

Access:
Offer a menu of options to engage with patients (e.g., extended hours to tele-access to home visits)

Assessment, Diagnosis, Care Plan:
Identify and document full set of needs for patients that incorporates community-based partners and reflects socioeconomic and ethnic differences into treatment plans

Care Management:
Patient identifies preferred care manager, who leads relationship with patients and coordinates with other managers and providers of specific patient segments

Provider Operating Model:
Practice has flexibility to adapt resourcing and delivery model (e.g., extenders, practicing at top of license) to meet the needs of specific patient segments

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Vision for Ohio's primary care delivery model (1 of 4)

UPDATED 12/10/2015

	Beginning of the journey	Early PCMH	Maturing PCMH	Transformed PCMH
Patient outreach	▪ **Reactive**, presentation-based prioritization	▪ **Proactive**, targeting patients with **chronic conditions and existing PCP**/ team **relationship**	▪ **Proactive**, targeting patients with **chronic conditions but no clear PCP relationship**[1], and prioritizing **patients at-risk** of developing a chronic condition	▪ **Proactive, with broader focus on all patients** including healthy individuals
Access	▪ Offer **limited access** beyond office/ regular hours	▪ Expand channels for **direct patient PCMH interaction for at-risk patients** with an existing PCP/ team relationship through phone/ email/ text consultation ▪ Provide **24/7 access** to PCMH-linked resources for at-risk patients with an existing PCP/team relationship	▪ Provide appropriately resourced **same-day appointments** ▪ Ensure appropriate site of visit **for at-risk** patients (e.g., home, safe/ convenient locations in the community) ▪ Offer a **menu of communication options** (e.g., encrypted texts, email) to all patients for ongoing care management ▪ Provide **full accessibility for patients with disabilities** and achieve ADA compliance (e.g., exam tables for patients in wheel chairs, facility ramps)	▪ Offer **remote clinical consultation** for broader set of members, where appropriate and only if practice has capability to share medical records with and receive medical records from tele-health provider ▪ Increase time spent in locations that represent **key points of aggregation** for the community (e.g., churches, schools), meeting patients' needs in the most appropriate setting
Assessment, diagnosis, treatment plan	▪ Diagnose and develop treatment plan **for presenting condition**, with emphasis on pharmaceutical treatment	▪ Identify and document **full set of needs** for at-risk patients with an existing PCP/ team relationship (e.g., barriers to access health care and to medical compliance) ▪ Develop evidence-based care plans with **recognition of physical and BH needs** (e.g., medications), customized based on benefits considerations ▪ Identify and close **gaps in preventive care** for at-risk patients with an existing PCP/ team relationship	▪ Systematically incorporate patient **socio-economic status, gender, sexual orientation, sex, disability, race, language, religion, and ethnic-based differences** into treatment (e.g., automatic screening flags for relevant groups) ▪ Assess gaps in both primary and secondary preventive care across the broader patient panel and **prioritize member outreach** accordingly ▪ Include **BH needs** (e.g., psycho-social treatment) into care plan through regular communication with BH provider ▪ Identify and incorporate **improvements to care planning process**	▪ Agree on **shared agenda with patients to best meet their acute and preventive needs** with a multi-generational lens and leveraging the result of predictive modeling, where appropriate ▪ **Collaborate meaningfully with other key community-based partners** (e.g., schools, churches) for input into a treatment plan and share relevant information on an ongoing basis with patient consent where appropriate

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Vision for Ohio's primary care delivery model (2 of 4)

UPDATED 12/10/2015

	Beginning of the journey	Early PCMH	Maturing PCMH	Transformed PCMH
Care management	▪ **Most patients lack connection to a care manager** while others are subject to many, overlapping care coordination efforts	▪ **Foster communication between care managers** for patients ▪ Identify who, within the practice, is in charge of care management activities for at-risk patients	▪ **Coordinate between care managers** to ensure clarity over which manager has lead responsibility when and reduce duplications of outreach to patients ▪ Establish **initial links with community-based partners** for at-risk patients	▪ **Patient identifies preferred care manager**, who leads relationship with patient and coordinates with other managers and providers ▪ **Collaborate meaningfully with other key community-based partners** (e.g., schools, churches) to exchange information with patient consent where appropriate
Provider operating model	▪ Primarily focus on managing **patient flow/ volume**	▪ Improve **operational efficiency** through process redesign and standardization, harnessing improvement tools (e.g., standardized use of clinical practice guidelines)	▪ Optimize staff mix (e.g., extenders, community health worker, cultural diversity), redesign processes and leverage technology, where appropriate, to maximize practice's operational efficiency (e.g., practice at top of license)	▪ Practice has **flexibility to adapt resourcing and delivery model** to meet the needs of specific patient segments as appropriate
Transparency	▪ **Review performance data irregularly**, if at all, to identify and pursue opportunities for improvement	▪ **Bi-directionally exchange performance data** with payers using a standard format and with a high degree of timeliness that can lead to improvements in treatment ▪ **Consistently review performance data** within the practice to monitor quality and prioritize outreach efforts ▪ Leverage standard process to ensure that data leads to **identification of opportunities and changes to practice patterns,** working with payers where appropriate ▪ Share **priorities from patient survey** with members and staff (e.g., post findings in the office)	▪ **Discuss performance data with other providers**, sharing learnings, receiving "second opinion" on challenging cases and advice on opportunities for improvement ▪ **Share relevant performance data with public health agencies** ▪ Implement changes based on **priorities resulting from patient satisfaction survey**	▪ **Share relevant performance data with members and communities** through website and in-office communication (e.g., information about providers' specialty areas and training and practice wait times)

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Vision for Ohio's primary care delivery model (3 of 4)

UPDATED 12/10/2015

	Beginning of the journey	Early PCMH	Maturing PCMH	Transformed PCMH
Provider interaction	▪ Select specialists for referrals based on **prior experience** ▪ Do not consistently leverage all available resources during **transitions in care**	▪ Proactively reach out to patients **after an ED visit/ hospitalization** ▪ **Track and follow-up** on specialist referrals and diagnostic testing ▪ Information is shared bi-directionally between PCP and specialist	▪ Select specialists for referrals also based on **likely connectivity** with member ▪ Select **specialists** for referrals based on **risk-adjusted data on outcomes and cost**, potentially leveraging data from episodes of care ▪ Proactively reach out to patients **before and after any planned transition in care**	▪ **Match type of care with member needs**, as jointly identified by member and provider (e.g., regular in-person interactions with multi-disciplinary team only when needed) ▪ **Proactively manage urgent needs, to the extent possible** (e.g., **reach out to the ED** to anticipate arrival of patients that have sought care from the practice first, to accelerate provision of care and ensure that it is targeted) ▪ Ensure **access and integration** to all capabilities needed (e.g., clinical pharmacy, dental providers, community health workers)
Behavioral health collabora-tion	▪ Do not consider undiagnosed BH cases a priority	▪ Integrate presenting behavioral health needs **into care plans** ▪ **Refer BH cases** to appropriate providers ▪ Collaborate 'at a distance' with BH providers for most at-risk patients	▪ Focus on diagnosing and addressing **undiagnosed BH needs** ▪ **Track and follow-up** on BH referrals and ensure ongoing communication with BH specialist – onsite where possible ▪ Provide **more coordinated care between primary and BH** providers (e.g., same-day scheduling, co-location, system integration)	▪ **Integrate behavioral specialists** in the practice, where scale justifies it ▪ **Fully integrated systems and regular formal and informal meetings between BH and PCP/team to facilitate integrated care** ▪ **Build competencies** to directly provide select BH services on site, when scale justifies it ▪ Collaborate with **community-based resources** to manage BH needs
Potential community connec-tivity activities	▪ Have **limited community connectivity** outside of office, or relationships with social services	▪ **Inform patients of social services and community-based prevention programs** that can improve social determinants of health (e.g., provide list of helpful resources, including local health districts)	▪ Facilitate connectivity to **social services and community-based prevention programs** by identifying targeted list of relevant services geographically accessible to the member, covered by member benefits, and with available capacity (e.g., Community Health Nursing, employment, recreational centers, nutrition and health coaching, tobacco cessation, parenting education, removal of asthma triggers, services to support tax return filings, transportation)	▪ **Actively connect members** to broader set of social services and community-based prevention programs (e.g., scheduling appointments and addressing barriers like transportation to ensure appointment happens) ▪ **Ensure ongoing bi-directional communication with social services and community-based prevention programs** (e.g., follow up on referrals to ensure that the member used the service, incorporate insights into care plan, provide support during transitions in care) ▪ **Collaborate meaningfully** (e.g., through formal financial partnerships) with partners based on achievement of health outcomes ▪ **Actively engage in advocacy and collaborations** to improve basic living conditions and opportunities for healthy behaviors[1]

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

Vision for Ohio's primary care delivery model (4 of 4)

UPDATED 12/10/2015

	Beginning of the journey	Early PCMH	Maturing PCMH	Transformed PCMH
Patient engagement[1]	▪ Have standard fliers and **educational material available in the office**	▪ Assess patient's **level of health literacy, engagement, and self-management** and have a defined plan to provide appropriate materials and improve over time ▪ Ask patients how they wish to be engaged (e.g., email, phone calls, language), consistent with the resources and infrastructure the practice currently has ▪ Offer **"patient navigator"** support to at-risk patients, to help them find and access healthcare resources	▪ Adopt means that practice did not previously provide to engage with patients and meet patient's preferences (e.g., text messaging) ▪ Use individualized techniques to **activate patients** (e.g. motivational language) ▪ Leverage tools such as remote monitoring devices **to promote patient activation and self-management** ▪ Provide **targeted educational** resources (e.g., online video/guides, printed materials) to all members	▪ **Consistently measure improvement in patient activation and health literacy**, increasing share of patients at appropriate level to achieve optimal care outcomes ▪ **Actively engage with patients to motivate appropriate degree of self-management** ▪ **Connect** at-risk members with other members with similar needs, to help create an additional support system for members and families
Patient experience[2]	▪ **Do not explicitly focus** on patient experience	▪ **Prioritize continuity of relationship** with provider and team for patient ▪ Regularly **solicit and incorporate targeted feedback** from patients into overall patient experience (e.g., quarterly survey, patient family advisory council)	▪ Achieve greater **cultural competence** through training, awareness, and access to appropriate services (e.g., translation, community health workers) ▪ Regularly solicit and incorporate the **feedback of patients into individual care**	▪ Offer **consistent, individualized experiences to each member** depending on their needs (based on age, gender, ethnicity, socio-economic situation) ▪ **Integrate patients into the practice management team** to provide feedback on overall patient experience ▪ Participate in **online patient rating sites** (if relevant to practice population)

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

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Patients and services included in total cost of care

	Inclusions	Exclusions
Patients	• All adults and pediatrics[1] • All behavioral health members • Members with exclusively dental or vision TPL coverage	• Duals *(included as operationally feasible, priority for MyCare population)* • Members with limited benefits (e.g., family planning) • All other members with TPL coverage
Services	• All non-excluded medical and prescription spend including: – Case management – DME – Home health – First 90 days of nursing facility spend[2]	• Waiver • Currently underutilized services (dental, vision, and transportation) • Nursing facility spend after 90 days in institution • All spend for a member after first ICF/IID claim

1 All PFK members are included in PCMH model
2 May be reconsidered due to effect on panel size and other technical considerations

Provider enrollment requirements

Required

- **Eligible provider type and specialty** (details to follow)
- **Minimum size:** 500 attributed/ assigned Medicaid eligible members within a contracted entity
- **Commitment**
  - To sharing data with payers/ the state
  - To participating in learning activities[1]
  - To meeting “standard processes” requirements in 6 months

Not required

- **Accreditation:** *(e.g., NCQA or URAC)*
- **Planning** *(e.g., develop budget, plan for care delivery improvements, etc.)*
- **Tools** *(e.g., e-prescribing capabilities, EHR, etc.)*

1 Examples include sharing best practices with other PCMHs, working with existing organizations to improve operating model, participating in state led PCMH program education at kickoff

Provider types and specialties eligible for enrollment

PCP definition by provider type and specialty

Provider Type	Provider Type Description	Provider Specialty	Provider Specialty Description
01	Hospital	001	General Hospital
01	Hospital	005	Children's Hospital
01	Hospital	006	Major Teaching Hospital
01	Hospital	010	Critical Access Hospital
05	Rural Health Clinic	050	Rural Health Clinic Medical
20	Physician/Osteopath Individual	207	Family Practice
20	Physician/Osteopath Individual	201	General Practice
20	Physician/Osteopath Individual	263	General Preventive Medicine
20	Physician/Osteopath Individual	209	Internal Medicine
20	Physician/Osteopath Individual	215	Pediatric
20	Physician/Osteopath Individual	342	Public Health & Gen Preventive Med
20	Physician/Osteopath Individual	274	Internal Medicine/Pediatrics
20	Physician/Osteopath Individual	216	Geriatric
21	Professional Medical Group	021	Professional Medical Group
24	Physician Assistant	240	Physician Assistant
50	Clinic	500	Primary Care Clinic
50	Clinic	501	Public Health Clinic
65	Clinical Nurse Specialist Individual	215	Pediatric
65	Clinical Nurse Specialist Individual	651	Adult Health
65	Clinical Nurse Specialist Individual	216	Geriatric
72	Nurse Practitioner Individual	651	Adult Health
72	Nurse Practitioner Individual	207	Family Practice
72	Nurse Practitioner Individual	216	Geriatric
72	Nurse Practitioner Individual	215	Pediatric
12	Federally Qualified Health Center	121	FQHC Medical
20	Physician/Osteopath Individual	200	Physician/Osteopath Individual
20	Physician/Osteopath Individual	239	ACA Primary Care[1]
65	Clinical Nurse Specialist Individual	650	Clinical Nurse Specialist
72	Nurse Practitioner Individual	720	Nurse Practitioner

Professional medical groups affiliated with a hospital billing under hospital ID should be considered eligible for Ohio's PCMH program

Urgent Care Centers are considered ineligible for attribution

A billing provider with >50% of E&M claims having Urgent Care Facility as Place of Service (i.e., Place of Service = 20) is identified as an Urgent Care Center and is excluded from attribution

Provider type and specialty pulled from provider master file (all 9 columns)

Must have any of the primary eligible specialties above to be considered as PCP

1 Note that provider specialty 239 sometimes appears as "Clinical biochemical genetics" – potentially a legacy description in provider master file

The role of plans to support enrolled providers

Critical activities payers are uniquely positioned to deliver

Data and insights

- Provide all data in timeliest possible manner
- Inform providers of members in their panel
- Help practices identify high-priority members and opportunities to improve quality/cost of care
- Provide detailed care histories on select patients
- Provide accurate and timely reporting of performance using a standard
- Provide information to support provider decision making (e.g., high-
- Share materials on best practices and lessons learned by high-perf

Reimbursement

- Provide incentives for meeting model requirements
- Limit administrative burden for providers, also ensuring standardization of requirements and forms/ processes to verify that requirements are met
- Continue refining the incentive model to encourage innovation

Benefit design

- Ensure physicians and patients are aware of eligible benefits and patient in
- Consider introducing reimbursement for/ promoting community-based pre programs, such as diabetes prevention program at YMCAs

Care management resources

- Coordinate with providers on care management activities that are being pr to/ targeted at members in the providers' panel: create clarity over who ha responsibility for what aspects of care management, for what patients, and
- Bi-directionally exchange relevant information with providers on a regular

Network/ Access

- Develop a network of culturally diverse high quality providers with capacity access to serve members
- Recognize high-performing PCMHs with preferential position in network
- Ensure that high performing specialists are in network/ in preferred tier

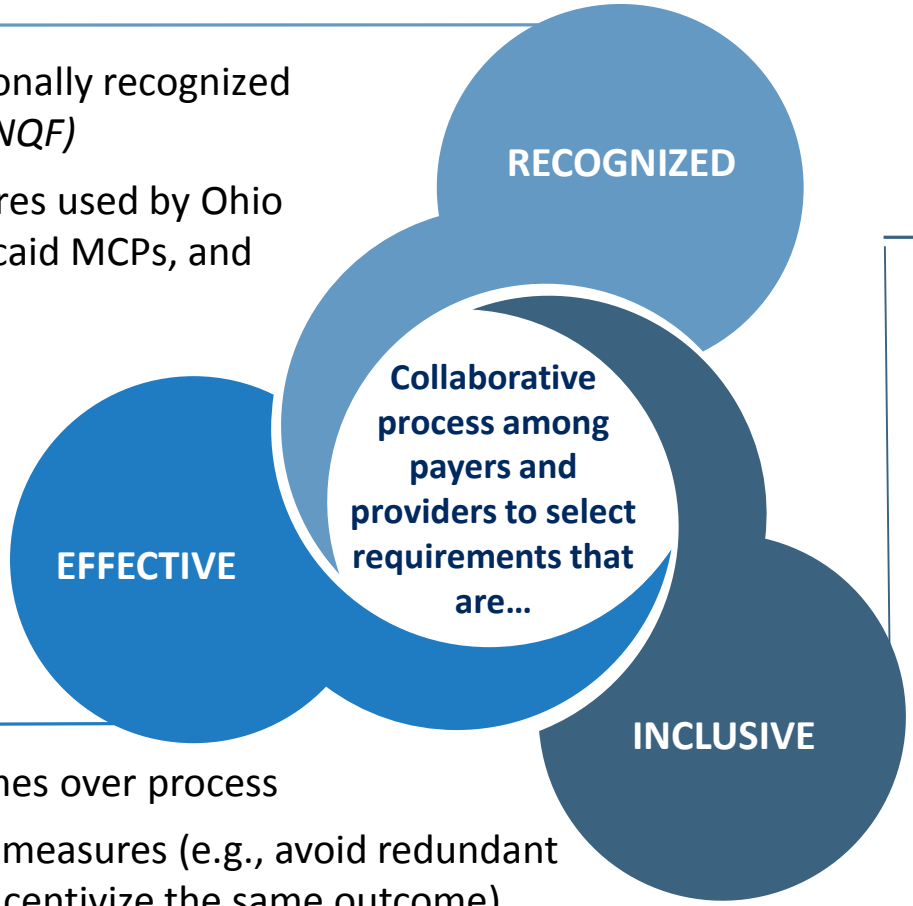
Financial incentives for meeting PCMH model requirements:

- **PCMH Operational Activities Payments** to compensate practices for activities that improve care and are currently under-compensated
- **Quality and Financial Outcomes-Based Payment** for achieving total cost of care savings and meeting pre-determined quality targets
- *Some* practices may be eligible for one-time **Practice Transformation Support** to begin the transition to a PCMH care delivery model

Guiding principles to select performance requirements

RECOGNIZED

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



INCLUSIVE

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

EFFECTIVE

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

Payment streams will be tied to specific requirements…

Standard Processes	▪ Risk stratification ▪ Same day appointments ▪ 24/7 access to care ▪ Practice uses a team ▪ Care management ▪ Relationship continuity	1
Activities	▪ Risk stratification ▪ Population management ▪ Care plans ▪ Follow up after hospital discharge ▪ Tracking of follow up tests an specialist referrals ▪ Patient experience	2
Efficiency	▪ ED visits/1000 ▪ Inpatient admission for ambulatory sensitive conditions ▪ All cause readmission rate ▪ Generic dispensing of select classes	3
Clinical Quality	▪ Claims based metrics ▪ Hybrid measures	4
Total Cost of Care	▪ Total Cost of Care	5

1 Standard processes requirements

	Requirements
Process for Risk Stratification	▪ The practice uses a methodology to assign a risk status in accordance with criteria aligned across payers **Who provides risk stratification to be finalized in 2016**
Same day appointments	▪ The practice provides same-day access to a practitioner connected to the PCMH who can diagnose and treat
24/7 access to care	▪ The practice provides and attests to 24 hour, 7 days a week patient access to a practitioner connected to the PCMH who will diagnose and treat
Practice uses a team	▪ The practice uses a team to provide a range of patient care services by: – Defining roles for clinical and nonclinical team members – Designating a lead for quality improvement efforts – Holding scheduled patient care team meetings or a structured communication process focused on individual patient care
Care management	▪ The practice indicates who provides care management services for high priority members
Relationship continuity	▪ The practice has a process to orient all patients to the PCMH

2 Activity requirements

	Requirements
Application of Risk Stratification	▪ Percentage of a practice's at risk beneficiaries–defined in accordance with criteria aligned across payers– who are seen by attributed PCP at least twice in past 12 months
Population management	▪ At least annually the practice proactively identifies patients not recently seen by the practice and reminds them, or their families/caregivers, of needed care based on personal treatment plan
Care plans	▪ At least 80% of high priority beneficiaries have a treatment plan in the medical record defined with accordance with a set of key elements aligned across payers[1]. Care plan must be updated at least 2x/year and with significant changes in conditions
Follow up after hospital discharge	▪ Percentage of high priority beneficiaries who had an acute inpatient hospital stay and had follow up contact within 1 week
Tracking of follow up tests and specialist referrals	▪ The practice has a documented process for and demonstrates that it: — Asks about **self-referrals** and requests reports from clinicians — Tracks **lab tests and imaging tests** until results are available, flagging and following up on overdue results — Tracks **referrals** until the **consultant or specialist's** report is available, flagging and following up on overdue reports — Tracks **fulfillment of pharmacy prescriptions** where data is available
Patient experience	▪ The practice assesses their approach to patient centeredness and cultural competence to improve overall patient experience and reduce disparities in patient experience *(e.g., by creating a patient/family advisory council, by administering and assessing a CAHPS survey)* **Practices will be required to prove they both assess and act on patient feedback**

1 E.g., documentation of a beneficiary's current problem that includes barriers to care. Plan of care integrating contributions from health care team (including BH). Modifications of treatment goals in conjunction with patient and family priorities. Instructions for follow up. Assessment of progress to date

3 Efficiency requirements

- ED visits
- Inpatient admissions for ambulatory sensitive conditions
- All-cause readmission rate
- Generic dispensing rate of select classes

To be refined in 2016 for 2017 performance period

4 Clinical Quality Requirements

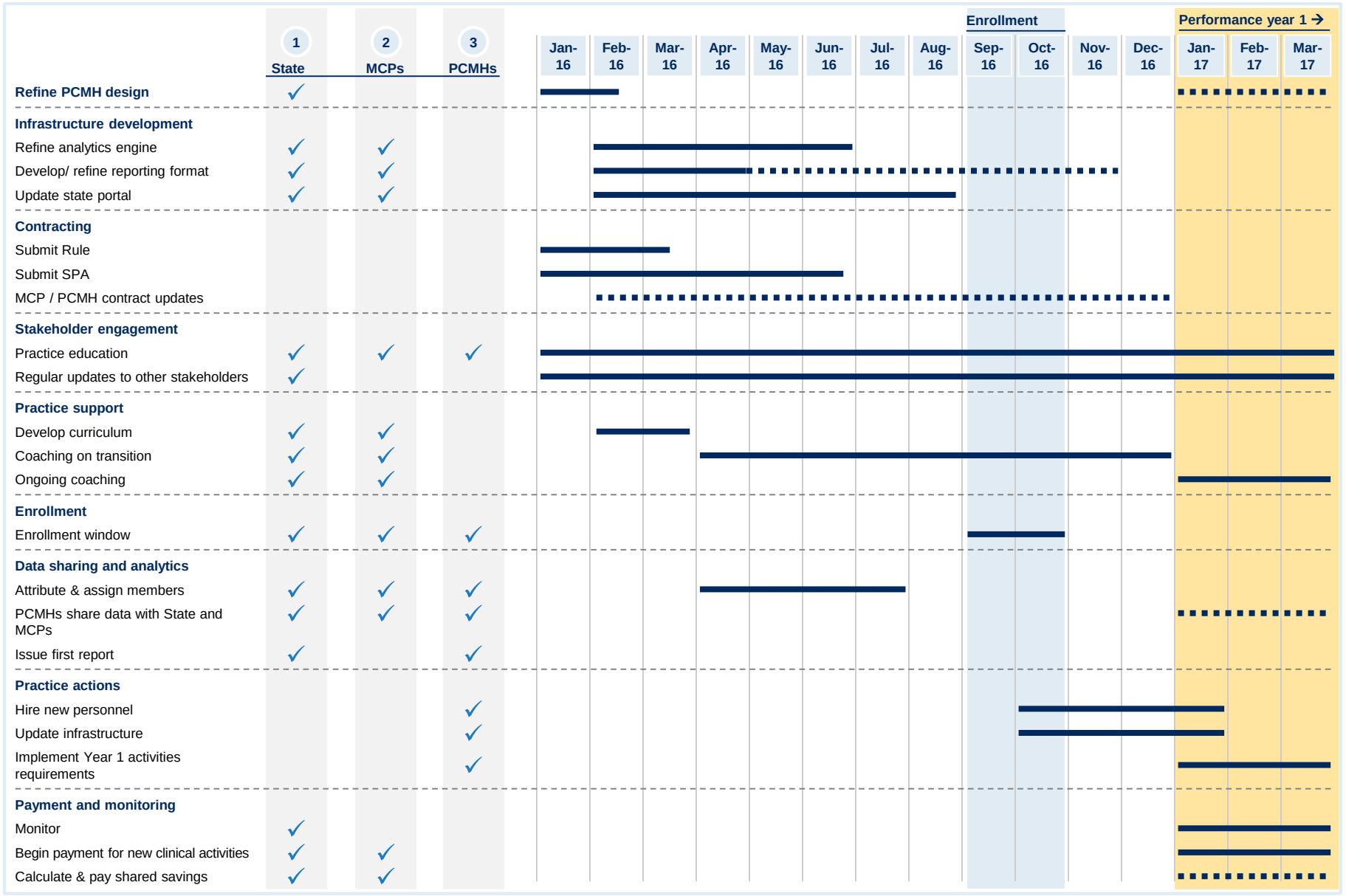
Category	Measure Name	Population	Population health priority	Data Type	NQF #
Preventive Care	Adult BMI	Adults	Obestiy	Claims or Hybrid	HEDIS ABA
	Well-Child Visits in the First 15 Months of Life	Pediatrics		Claims or Hybrid	1392
	Well-Child visits in the 3rd, 4th, 5th, 6th years of life	Pediatrics		Claims or Hybrid	1516
	Adolescent Well-Care Visit	Pediatrics		Claims or Hybrid	HEDIS AWC
	Breast Cancer Screening	Adults	Cancer	Claims	2372
	Weight assessment and counseling for nutrition and physical activity for children/adolescents: BMI assessment for children/adolescents	Pediatrics	Obesity, physical activity, nutrition	Claims or Hybrid	0024
	Timeliness of prenatal care	Adults	Infant Mortality	Claims or Hybrid	1517
	Postpartum care	Adults	Infant Mortality	Claims or Hybrid	1517
	Live Births Weighing Less than 2,500 grams	Pediatrics	Infant Mortality	State Records	N/A
Appropriate Care	Controlling high blood pressure (beginning year 3)	Adults	Heart Disease	Hybrid	0018
	Med management for people with asthma	Both		Claims	1799
	Comprehensive Diabetes Care: HgA1c poor control (>9.0%)	Adults	Diabetes	Claims or Hybrid	0059
	Statin Therapy for patients with cardiovascular disease	Adults	Heart Disease	Claims	HEDIS SPC
Behavioral Health	Antidepressant medication management	Adults	Mental Health	Claims	0105
	Follow up after hospitalization for mental illness	Both	Mental Health	Claims	0576
	Preventive care and screening: tobacco use: screening and cessation intervention	Both	Substance Abuse	Claims or Hybrid	0028
	Initiation and engagement of alcohol and other drug dependence treatment	Adults	Substance Abuse	Claims	0004

To be finalized in 2016

Note: measures are expected to evolve over time

- Measures will be refined based on learnings from initial roll-out
- Hybrid measures that require EHR may be added to the list of core measures
- Hybrid measures may replace some of the core measures
- Reduction in variability in performance between different socioeconomic demographics may be included as a PCMH requirement

Early view on timeline for statewide PCMH launch



Ohio has the critical mass necessary to reset health care competition to reward value instead of volume …

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CURRENT INITIATIVES | BUDGETS | NEWSROOM | CONTACT | VIDEO

Current Initiatives

Modernize Medicaid
Extend Medicaid coverage to more low-income Ohioans
Reform nursing facility reimbursement
Integrate Medicare and Medicaid benefits
Prioritize home and community based services
Rebuild community behavioral health system capacity
Enhance community developmental disabilities services
Improve Medicaid managed care plan performance

Streamline Health and Human Services
Implement a new Medicaid claims payment system
Create a cabinet-level Medicaid department
Consolidate mental health and addiction services
Simplify and integrate eligibility determination
Coordinate programs for children
Share services across local jurisdictions

Pay for Value
Engage partners to align payment innovation
Provide access to patient-centered medical homes
Implement episode-based payments
Align population health planning
Coordinate health information technology infrastructure
Coordinate health sector workforce programs
Support regional payment reform initiatives

State Innovation Model:

- Patient-Centered Medical Home
- Episode-Based Payment Model
- Population Health Plan