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Patient-Centered Medical Home State Model Design Team

May 19, 2015

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Agenda

1. Ohio's approach to paying for value
2. Ohio Patient Centered Medical Home (PCMH) Charter
3. Arkansas PCMH Model Design
4. Comprehensive Primary Care PCMH Model Design
5. Discussion and next steps

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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 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

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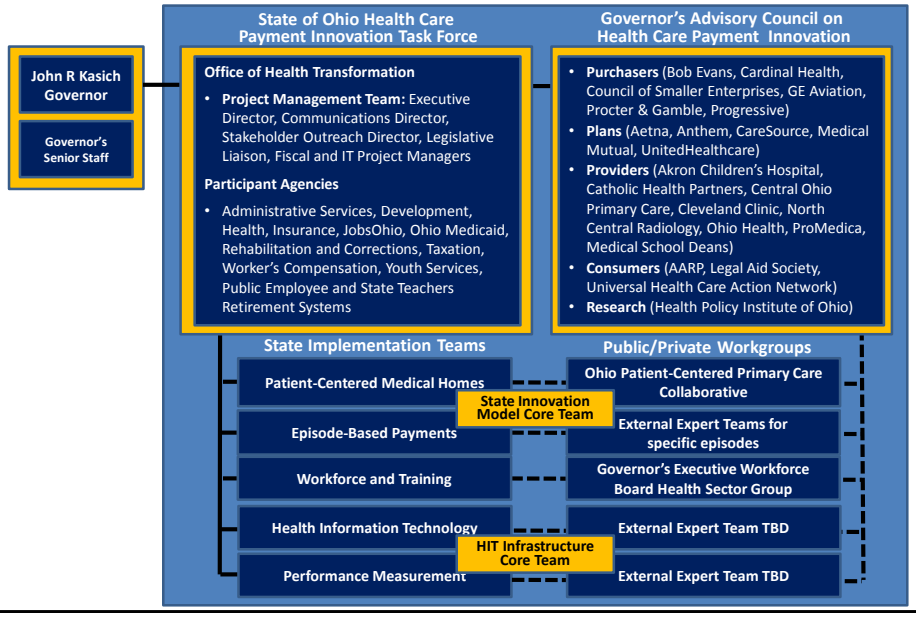
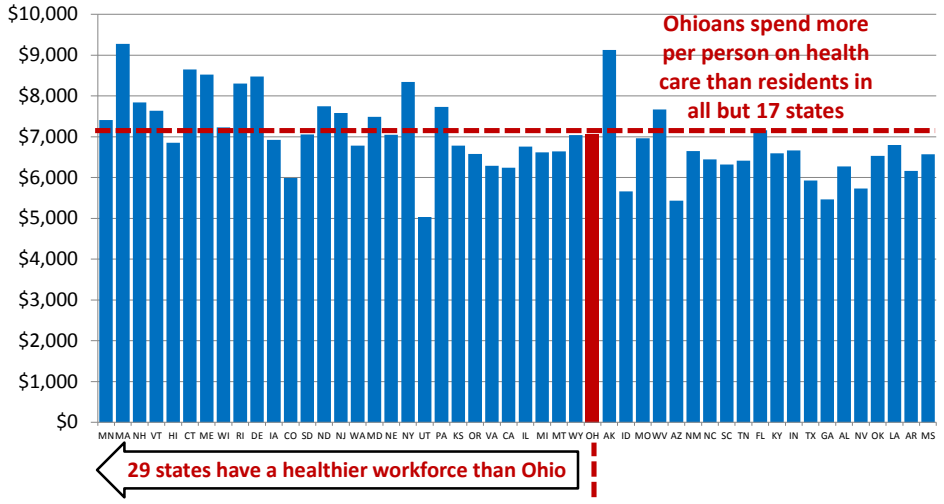
Payment Innovation Partners



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).

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

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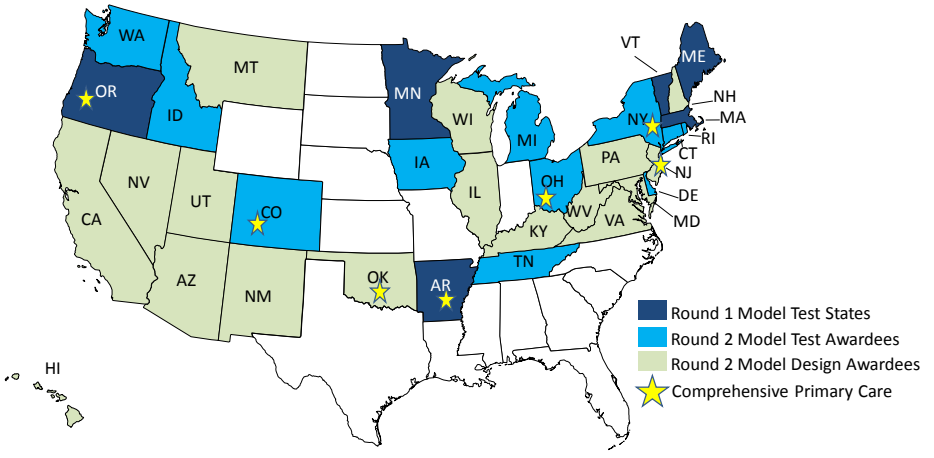
Source: UnitedHealth, *Farewell to Fee-for-Service: a real world strategy for health care payment reform* (December 2012)

Center for Medicare & Medicaid INNOVATION

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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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)	▪ State leads design of six episodes: asthma acute exacerbation, COPD exacerbation, perinatal, acute and non-acute PCI, and joint replacement
Year 2	▪ 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
Year 3	▪ Model rolled out to all major markets ▪ 50% of patients are enrolled	▪ 20 episodes defined and launched across payers, including behavioral health
Year 5	▪ Scale achieved state-wide ▪ 80% of patients are enrolled	▪ 50+ episodes defined and launched across payers

Ohio's Health Care Payment Innovation Partners:

Anthem

MEDICAL MUTUAL

aetna

UnitedHealthcare

CareSource

MOLINA HEALTHCARE

Buckeye Community Health Plan

PARAMOUNT ADVANTAGE

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Agree on degrees of standardization within each model

"Standardize"	"Align in principle"	"Differ by design"
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 but allow for payer innovation consistent with those principles when: ▪ There are benefits for the integrity of the program for payers to align ▪ It benefits providers to understand where payers are moving in same direction ▪ Differences have modest impact on provider from an administrative standpoint ▪ Differences are necessary to account for legitimate differences among payers (e.g., varied customers, adm. systems)	Differ by design when: ▪ Required by laws or regulations ▪ An area of the model is substantially tied to competitive advantage ▪ There exists meaningful opportunity for innovation or experimentation
Example: Quality Measures	**Example: Gain Sharing**	**Example: Amount of Gain Sharing**

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PCMH Model Design Team (2013)

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

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Elements of a Patient-Centered Medical Home Strategy

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
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

<u>Payment Model Mechanics</u>:

- Payers 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 PCMH for activities not fully covered by existing fee schedules (care coordination, non-traditional visits like telemedicine, population health)
- Agree to reward PCMHs for favorably affecting risk-adjusted total cost of care over time by offering bonus payments, shared savings, or capitation

Source: Ohio PCMH Multi-Payer Charter (2013)

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Patient-Centered Medical Home Charter for Payers

Governor Kasich's Advisory Council on
Health Care Payment Innovation

October 18, 2013

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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.

Care delivery model

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 model

Care delivery improvements

Notable departure from CPCi

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

Care delivery model

Target sources of value

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

Payment model

Technical requirements for PCMH

Notable departure from CPCi

"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

Payment model

Attribution / assignment

Notable departure from CPCi

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

Payment model

Quality measures

Notable departure from CPCi

"Standardize approach"	"Align in principle"	"Differ by design"
▪ 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)	▪ 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	▪ 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 model

Payment streams / incentives

Notable departure from CPCi

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

Payment model

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

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2015 Priorities

Patient-Centered Medical Homes

- Convene a PCMH model design team to decide what elements of CPC to keep/modify and make statewide design decisions about the Medicaid payment model, attribution methodology, quality metrics, etc.
- Decide the PCMH rollout sequence and enroll primary care practices beginning in January 2016

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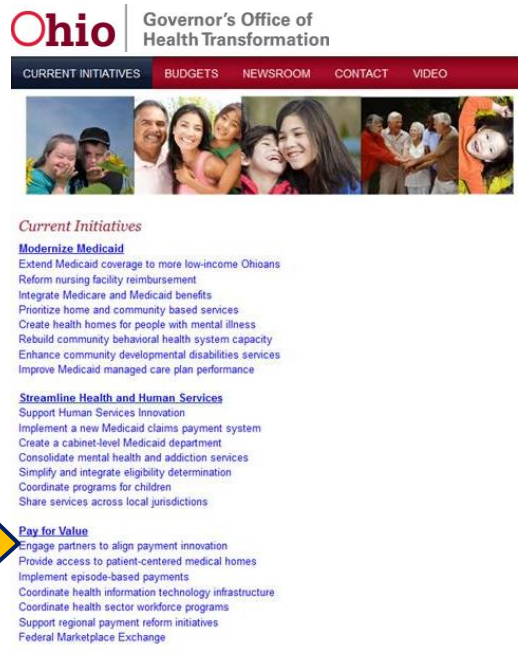

Payment Models:

- **Overview Presentations**
- **PCMH Charter**
- **Episode Charter**
- **Detail for Providers**
  - **Episode Definitions**
  - **Code Tables**
  - **Risk Adjustment**