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2018 CPC Program Performance and 2019 CPC Activity Requirement Reviews

February 27, 2020
Revised February 28, 2020

Agenda

- 2018 Program Performance
- 2018 Practice Monitoring Results
- 2019 Practice Monitoring Updates
- What's Next and Reminders

2018 Program Performance

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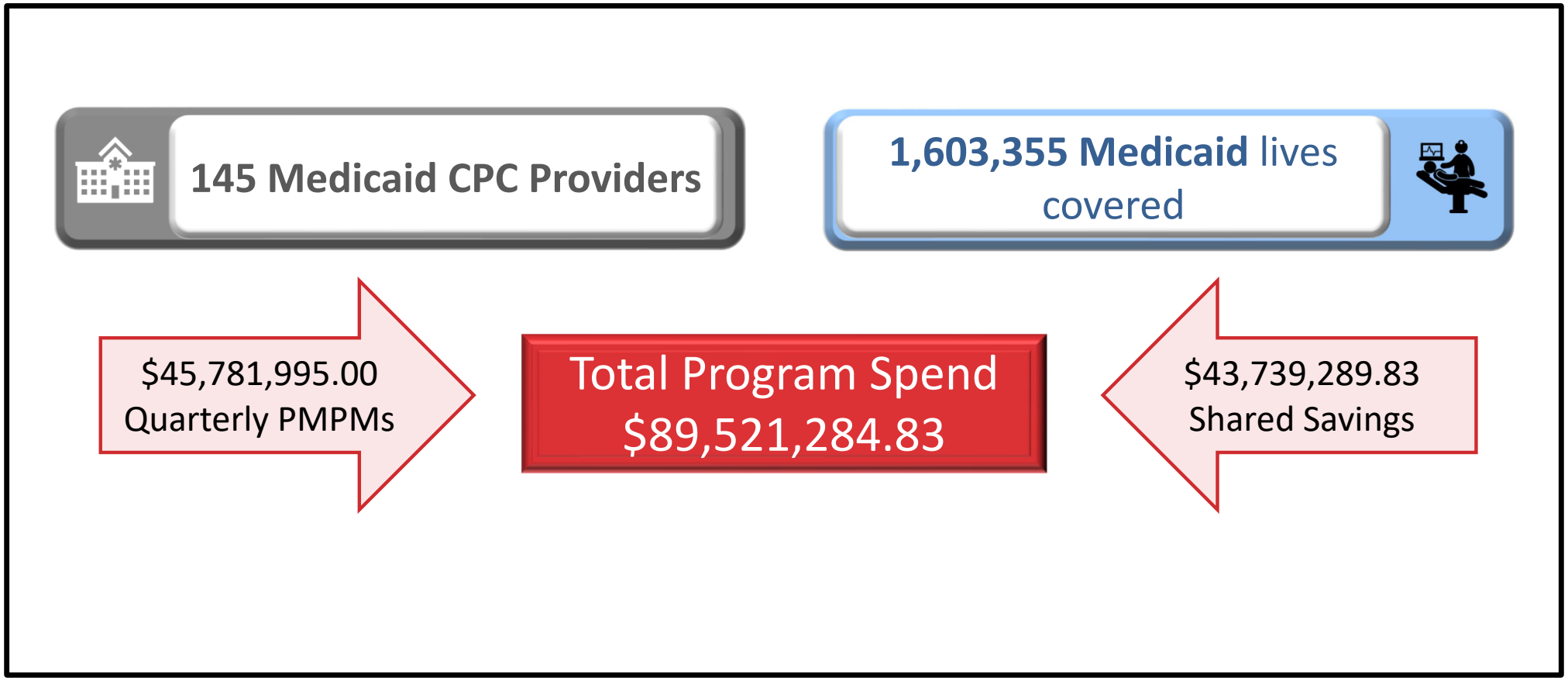
Provider Recap

A total of 145 CPC providers enrolled in CPC for 2018 program year

Provider Types (PT)	Number of Providers
Hospital (01)	03
FQHC (12)	70
Clinic (50)	06
Professional Medical Group (21)	66
Total	145

2018 Breakdown of Spend



1 Projected based on current attribution for 2019 enrolled practices based on 2017 average spend

Shared Savings Relative to Peers

Lowest 10% Total Cost of Care (TCOC) Threshold: $317.41

Practice Name	Risk Adjusted TCOC PMPM (with quarterly PMPMs)	Shared Savings Payment
METROHEALTH SYSTEM	$305.60	$451,518.75
ADENA MEDICAL GROUP LLC	$316.82	$69,418.33
TOTAL		**$520,937.08**

Shared Savings Relative to Self

Practice	Shared Savings TCOC PMPM Target (with Adjustment Factor and Minimum Savings Rate)	Risk Adjusted TCOC PMPM (with Quarterly PMPMs)	Shared Savings Payment
THE CLEVELAND CLINIC FOUNDATION	$396.72	$347.74	$16,151,937.09
CHILDRENS HOSP MED CTR	$461.02	$421.98	$7,382,004.23
METROHEALTH SYSTEM	$310.68	$305.60	$6,698,825.94
PROVIDENCE MEDICAL GROUP INC	$423.29	$373.13	$5,285,358.35
CHILDRENS HOSP MED CTR-ARKON	$396.09	$380.70	$3,778,618.80
PREMIER PHYSICIANS CENTERS INC	$367.07	$343.35	$2,042,280.68
PARTNERS PHYSICIAN GROUP	$373.35	$365.15	$1,232,018.20
UNIVERSITY OF TOLEDO PHYSICIANS, LLC	$390.46	$386.85	$444,145.50
FIVE RIVERS HEALTH CENTERS	$355.04	$351.59	$203,163.96
TOTAL			**$43,218,352.75**

CPC Program Clinical Quality Measures

Category	Measure	2017	2018	Improved in 2018
Pediatric Health	Well-Child Visits in First 15 Months of Life	56.88%	62.43%	✓ 5.55%
	Well-Child Visits in the 3rd, 4th, 5th, 6th years of life	68.43%	70.71%	✓ 2.28%
	Adolescent Well-Care Visit	45.53%	45.24%	! -0.29%
	Weight assessment and counseling for nutrition and physical activity for children/adolescents	24.21%	37.96%	✓ 13.75%
Women's Health	Timeliness for prenatal care	70.65%	75.13%	✓ 4.48%
	Live Births Weighing Less than 2,500 grams	9.84%	10.11%	! 0.27%
	Postpartum Care	55.27%	57.02%	✓ 1.76%
	Breast Cancer Screening	57.64%	55.89%	✗ -1.75%
	Cervical Cancer Screening	57.37%	58.72%	✓ 1.35%
Adult Health	Adult BMI	29.30%	40.25%	✓ 10.95%
	Controlling high blood pressure	11.01%	11.17%	! 0.16%
	Med management for people with asthma	33.46%	41.85%	✓ 8.40%
	Statin therapy for patients with cardiovascular disease	74.55%	77.09%	✓ 2.54%
	Comprehensive diabetes care: HbA1c poor control (>9.0%)	93.41%	82.43%	✓ -10.98%
	Comprehensive diabetes care: HbA1c testing	84.89%	87.86%	✓ 2.98%
	Comprehensive diabetes care: eye exam	45.24%	47.85%	✓ 2.60%
Behavioral Health	Antidepressant medication management	51.67%	52.24%	✓ 0.57%
	Follow up after hospitalization for mental illness	49.71%	31.74%	✗ -17.97%
	Preventive care and screening: tobacco use: screening and cessation intervention	15.39%	32.06%	✓ 16.67%
	Initiation and engagement of alcohol and other drug dependence treatment	41.48%	44.83%	✓ 3.36%

Threshold Met

Threshold Not Met

⊘ N/A – minimum denominator not met

✓ Improved

✗ Need Improvement

! Within +/- 0.5 % for measures counted as percentage.
Within +/- 0.1 for measures counted as # per 1000 member months.

- Improved in **15 of 20** measures
- Remained within +/- 0.5% in **3** measures
- Need improvement in **2** measures

CPC Program Efficiency Metrics

Metric	2017	2018	Improved in 2018
Emergency Department Visits / 1,000 Member Months	90.50	87.20	-3.30
Behavioral health-related inpatient admits / 1,000 Member Months	1.58	1.67	0.09
Ambulatory care-sensitive inpatient admits /1,000 Member Months ages 18 years and older	1.47	1.50	0.03
Generic dispensing rate	80.00%	86.00%	6.00%

- Improved in Emergency Department (ED) Visits
  - Decreased by 3.30 Visits/1,000 Member Months **39,187** ED Visits avoided in 2018
- Improved in Generic Dispensing Rate
- Remained within +/- 0.1 in the remaining two measures

Threshold Met
Threshold Not Met
N/A – minimum denominator not met
Improved
Need Improvement
Within +/- 0.5 % for measures counted as percentage.
Within +/- 0.1 for measures counted as # per 1000 member months.

Warning Letters

- **Efficiency Metrics**
  - 5 CPC entities did not pass 50%
  - Warning notices have been issued
- **Quality Metrics**
  - System updates for 2018 HEDIS value sets has caused delay on these results
  - At least one practice did not have at least a 50% pass rate
  - Warning notice(s) will be issues once final results are reviewed

2018 Practice Monitoring Results

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CPC Activity Requirements

Must pass 100%

Same-day appointments	The practice provides same-day access, within 24 hours of initial request, including some weekend hours to a PCMH practitioner or a proximate provider with access to patient records 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 primary care physician, primary care physician assistant or a primary care nurse practitioner with access to the patient's medical record
Risk stratification	Providers use risk stratification from payers in addition to all available clinical and other relevant information to risk stratify all of their patients, and integrates this risk status into records and care plans
Population health management	Practices identify patients in need of preventative or chronic services and implements an ongoing multifaceted outreach effort to schedule appointments; practice has planned improvement strategy for health outcomes
Team-based care management	Practice defines care team members, roles, and qualifications; practice provides various care management strategies in partnership with payers and ODM for patients in specific patient segments; practice creates care plans for all high-risk patients, which includes key necessary elements
Follow up after hospital discharge	Practice has established relationships with all EDs and hospitals from which they frequently get referrals and consistently obtains patient discharge summaries and conducts appropriate follow-up care
Tests and specialist referrals	The practice has a documented process for tracking referrals and reports, 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 experience and cultural competence at least once annually through quantitative or qualitative means; information collected by the practice covers access, communication, coordination and whole person care and self-management support; the practice uses the collected information to identify and act on improvement opportunities to improve patient experience and reduce disparities. The practice has process in place to honor relationship continuity

Practice Monitoring Breakdown

100 CPC practices participated in desk reviews

All new practices participated in desk reviews, in addition to others chosen to reflect diverse practice characteristics, including:

- High, middle, and lower practice performance on program elements
  - Activity requirements (from 2017 practice monitoring)
  - Clinical quality and efficiency metrics
- Practice attributes
  - Geographic location
  - Practice size
  - School-based health care participation

30 of the 100 CPC practices interviewed participated in on-site visits

Variety of practices chosen to reflect diverse practice characteristics, including

- Accreditation (NCQA, Joint Commission)
- Other PCMH program participation (e.g., CPC+, SBHC, 2017 Ohio CPC)
- Prior on-site review during 2017 program year
- Practice specialty (e.g., pediatric, BH - integrated)
- Practice characteristics (e.g., size, location)

Statewide Results Summary

- The **majority of CPC practices met all of the activity requirements** for the program in 2018
  - 94% of practices scored at least "1" for every element
- Four providers created and successfully performed improvement performance plans
- On several activity requirements, practices had **room for improvement**
  - Risk stratification – most practices performed some kind of risk stratification but did not incorporate payer data or use risk scores in the patient care plan
  - Tests and specialist referrals – most practices performed proactive communication and follow-up but performed less well on the tracking element
  - Follow-up after hospital discharge – practices had room for improvement in the "admissions, discharges, and transfers data" element, which requires that they proactively and consistently obtain ADT summaries from hospitals and other facilities
- There was variation on performance within certain activities
  - Lower average score on the "weekend hours" element of the same-day appointments activity

Statewide Summary Report Results

Activity #1 Example:

Same-day appointments

Practices perform better on some elements than on others

- **Higher performance on "same day appt" and "appt within 24 hours of request"**
- **Lowest average score on "weekend hours"**

	Min	Max	Average	Median	Practices scoring "0"
Same day appointment	3	5	4.07	4	0
Appointment within 24 hours of request	3	5	4.07	4	0
After hours access	0	5	4.04	4	1
Weekend hours	0	5	3.93	4	3

Practice Innovations From 2018 Practice Monitoring

Same-day appointments

One CPC practice used a virtual system that **allowed patients to have virtual appointments 24/7 over the phone** or through video conferencing

- Included diagnosing, treatment recommendations, and prescribing for non-emergency medical issues.
- Patient simply needed a laptop, tablet, or smartphone

Follow-up after hospital discharge

One CPC practice employs two **patient advocates** who visit patients in ED to **help coordinate post-discharge plans and care coordination**

- Provided information to patients on appropriate ED usage and same-day appointments
- Helped schedule follow-up appointments with PCP (including for patients who did not have an established PCP)

2019 Practice Monitoring Updates

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Overview of Practice Monitoring

- When practices join CPC, they **must attest to meeting the CPC activity requirements**
  - The activity requirements focus on practice processes and activities that lead to **coordinated and patient-centered primary care**
  - Unlike the clinical quality and efficiency metrics, CPC practices **must meet 100% of the CPC activity requirements**
- **Practice monitoring is the process ODM uses to assess CPC entity performance** on the CPC activity requirements
  - Along with assessing performance, practice monitoring gives practices the **opportunity to receive technical assistance** to improve their execution of the activity requirements
  - ODM also uses practice monitoring to **identify practices using innovative strategies** to care for their patients

ODM selects a vendor to perform practice monitoring

In 2018, ODM worked with HSAG to complete practice monitoring. In 2019, ODM worked with QSource

Practice Monitoring Process

This process is designed to assess whether a practice is meeting activity requirements

- Structured assessment questionnaire
- Phone discussion and review of relevant documents

- Written report from each desk review
- Detailed discussion of how activity requirements are or are not being implemented

- Lower-scoring practices on the onsite reviews must submit a performance improvement plan
- Practices may contest results of monitoring reports through reconsideration process

- Opportunity to observe and learn from innovative practices, or observe activities for practices where desk reviews indicate improvement is needed

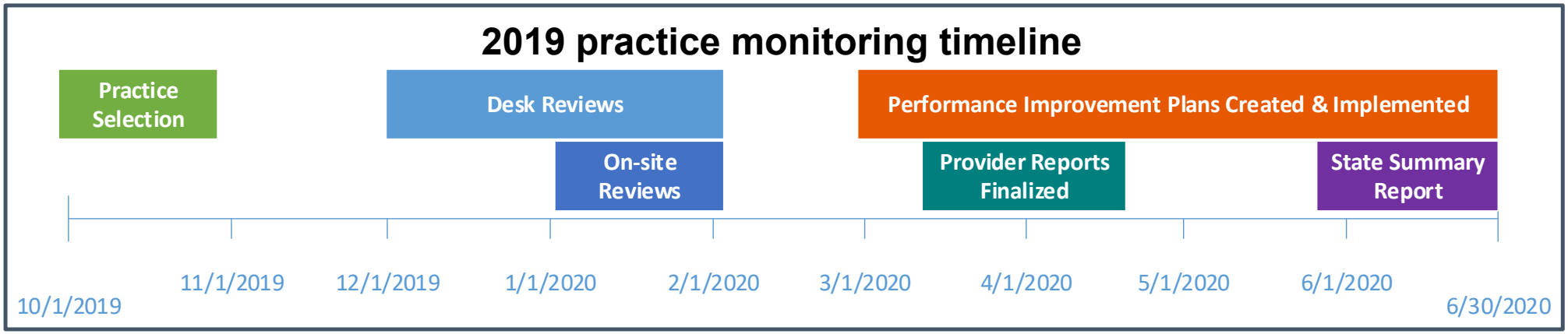
Practice Monitoring Updates

ODM partnered with a new vendor, QSource, for practice monitoring in 2019, beginning in August

- QSource is a private, nonprofit healthcare quality improvement and IT consultancy
- This organization will analyze and evaluate aggregated information on quality and access to health care services for Medicaid members

Evaluation methodology was refined for CPC practices for the 2019 practice monitoring

- QSource completed 157 Desk reviews and 74 on-site reviews
- Timeline for 2019 was pushed back due to delays in the state budget



Activity Requirement Elements Breakdown

Activity 2: Risk Stratification example

Providers use risk stratification from payers in addition to all available clinical and other relevant information to risk stratify all their patients and integrates this risk status into records and care plans:

Element	Blue	Green	Yellow	Red
Systemic Process	Evidence of Community Commitment or Innovation	Systemic process and criteria for identifying patients who need care management that is integrated with patient record using risk stratification from ODM or MCPs and other relevant information.	Process is inconsistent and not integrated to the patient record.	No regular risk stratification is done to identify high-risk patients.
Element Examples		***-List of additional factors considered in supplementing risk stratification information from payers.***		
Monitoring	Evidence of Community Commitment or Innovation	The practice monitors the percent of the total population identified through its process and criteria and updates results when significant change to patient status occurs.	Results are monitored but changes in patient status are not documented in risk status in medical record.	Results are not monitored.
Element Examples	***Quarterly deep dive meetings with each practitioner to evaluate empanelment and identify the highest-risk patients***			
Documentation	Evidence of Community Commitment or Innovation	Practice creates care plans for all high-risk patients as identified by risk stratification system, which includes key necessary elements, including at minimum patient preferences and functional/lifestyle goals, treatment goals, potential barriers to meeting goals, self-management plan; and is easy to understand and provided in writing to the patient/family/caregiver.	Sparse documentation in the care plan that does not include all key necessary elements.	No documentation or evidence of care plan in patient medical record.
Element Examples		***-Care plans for high-risk patients, showing explicitly how risk status was used in their development.*** ***-Health Records showing risk status incorporated***		

Each activity has several elements

The score sheet defines different levels of performance for each element, in addition to any innovative solutions practices may be using

Blue	5 Points	High Performing Practice
Green	3 – 4 Points	Meeting Expectations
Yellow	1 – 2 Points	Opportunity for Improvement
Red	0 Points	Improvement Needed

Practice Monitoring Reports

Practices who undergo practice monitoring will receive reports on their performance

Reports will show overall performance on each activity requirement

- The **heat map table** shows performance on each element of each activity requirement
- The **general comments section** shows how practices are meeting acceptable evidence for each requirement

Reports also **reflect innovative practice activities and practice feedback**

- Reports highlight activities where **practices are using innovative methods** to meet the activity requirements
- The general comments section **gives practices a chance to offer feedback** on feasibility and implementation of program requirements

What's Next and Reminders

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Upcoming Key Dates

2020 PMPM Payments

Q2 Payments will go out by the end of:

April 2020

2020 Attribution

Q2 Files will post on the MITS Portal in:

April 2020

Don't Forget

In-Person Learning Sessions coming

Around July/August 2020

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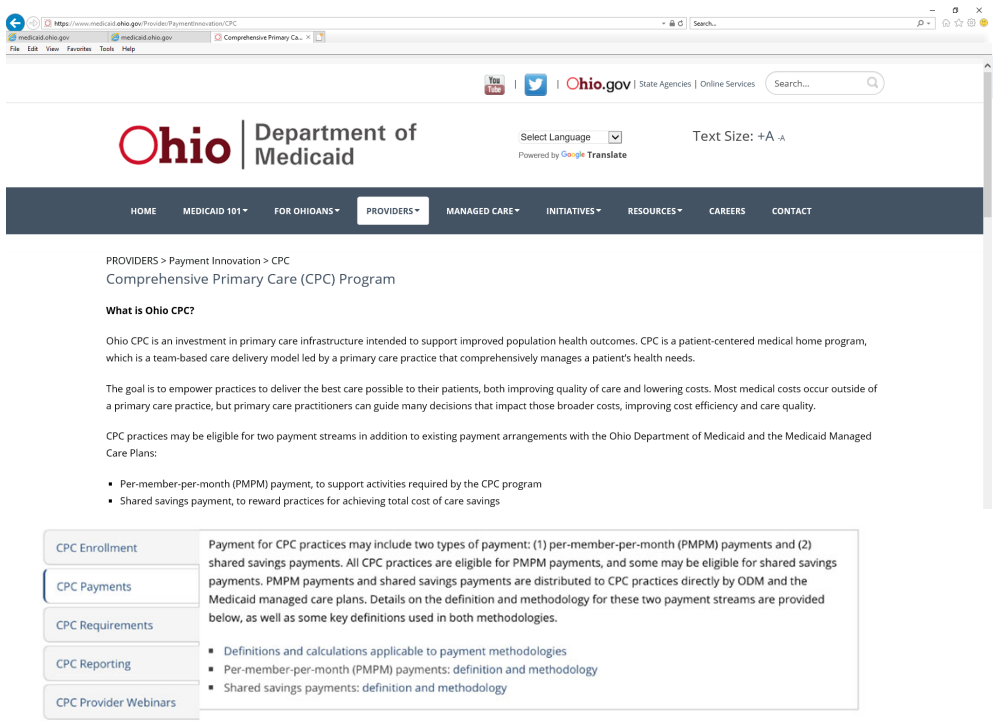
CPC 2020
WEBSITE INFORMATION



Additional detail on the CPC program available on the CPC website:
http://medicaid.ohio.gov/Providers/PaymentInnovation/CPC.aspx

Learn more about:

- CPC enrollment
- CPC payment
- CPC requirements
- CPC reporting
- CPC provider webinars

Don't Forget to Signup for our CPC Listserv to receive all the important communication for the 2020 program year.

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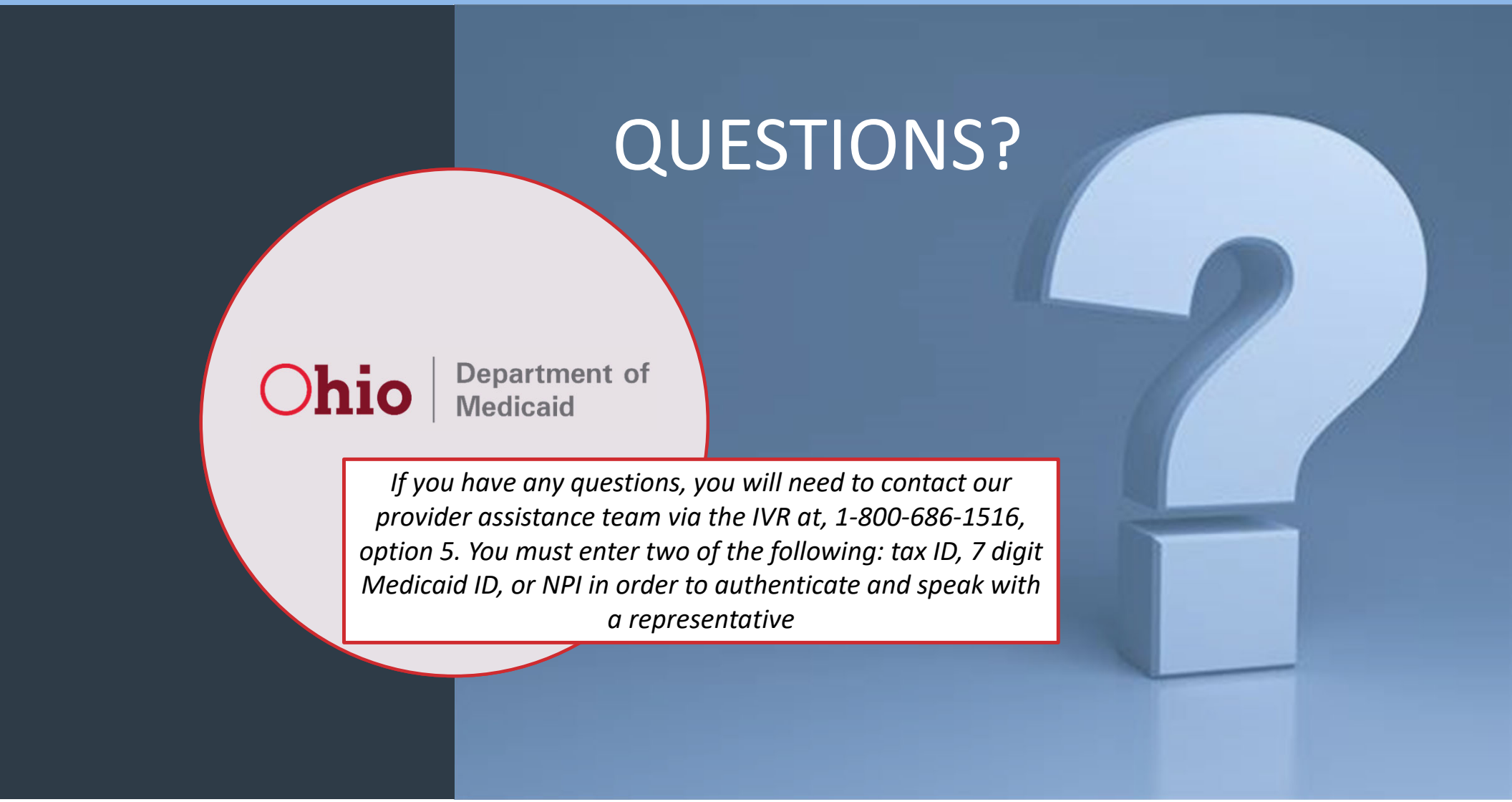
QUESTIONS?



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If you have any questions, you will need to contact our provider assistance team via the IVR at, 1-800-686-1516, option 5. You must enter two of the following: tax ID, 7 digit Medicaid ID, or NPI in order to authenticate and speak with a representative