Ohio | Department of Medicaid

Ohio CPC

Program updates for 2020

June 2019

Timeline of Ohio CPC: groundwork laid to date and continued work to build and scale for impact

PRELIMINARY

	2015/2016	2017	2018	2019	2020
CPC program coverage[1]		• 111 practices • 970K members	• 145 practices • 1.2M members	• 250 practices • 1.4M members	
Priorities in focus	**Initial design work,** focused on designing a PCMH program to promote high-quality, individualized, continuous and comprehensive care in Ohio	**<u>Year 1:</u> Learning year, focused on implementation** with experienced practices (e.g. NCQA accreditation or CPC+ participation required)	**<u>Year 2:</u> scale initial model, including** • Eligibility for practices with 500+ Medicaid members[1] • Episodes of care linkages, e.g., referral reports, EOC metric[2]	**<u>Year 3:</u> federal alignment and continued scale, including** • Partnerships • Eligibility for practices with 150+ Medicaid members[3] • Add'l CPC+ alignment	**<u>Year 4 and beyond:</u> continue to build and shape Ohio CPC for impact in Ohio**
Stakeholder engagement	• PCMH focus groups for providers and patient advocates • SIM Core, inc. MCPs and commercial payers	- **Provider focus groups and other stakeholder sessions** for input on program evolution - **In-person Learning Sessions and Monthly Practice Webinars**, to support ongoing learning and gathering feedback from practices - **Monthly MCP meetings** on ways to support program impact and evolution			

Source: ODM working group conversations and stakeholder input.

1 Practices defined at the Medicaid Billing ID level. Point-in-time attribution as of June 1, 2018 for the practices enrolled in Ohio CPC for each program year respectively.

2 Informational only in 2018.

3 Claims-based attributed members. Practices with 150-500 members must participate through a practice partnership.

2020 Ohio CPC requirements for payment

PRELIMINARY

Program requirements

10 activity requirements

- 24/7 and same-day access to care
- Risk stratification
- Population management
- Team-based care delivery
- Care management plans
- Follow up after hospital discharge
- Tracking follow up tests and specialist referrals
- Patient experience
- **Community Services and Supports Integration**
- **Behavioral Health Integration**

Must pass 100%

4 efficiency metrics

- ED visits
- Inpatient admissions for ambulatory sensitive conditions
- ~~**Generic dispensing rate of select classes**~~
- Behavioral health related inpatient admits
- Episodes-related metric

Must pass 50%

20 Quality metrics

- Clinical measures aligned with CMS/AHIP core standards for PCMH

Note: Includes update from IET-AD: Initiation to IET-AD: Engagement

Must pass 50%

Payment Streams

PMPM	**All required**
Shared Savings	**All required**

Source: ODM working group conversations and stakeholder input.

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2020 CPC activity requirements

New in 2020, detail follows

PRELIMINARY

	Requirements
Community services and supports integration	The practice uses screening tools to identify patients in need of community services and supports, and implements and maintains a process to connect patients to necessary services.
Behavioral health integration	Practice identifies, refers, and tracks follow-ups for patients in need of behavioral health services; practice has planned improvement strategy for behavioral health outcomes.
24/7 and same-day 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, including providing same-day access (within 24 hours of initial request) and regularly offering at least one alternative to traditional office visits to increase access to care team and clinicians in a way that best meets the needs of the population.
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 delivery	Practice defines care team members, roles, and qualifications; practice provides various care management strategies in partnership with payers and ODM (and behavioral health qualified entities, as applicable) for patients in specific patient segments.
Care management plans	Practice creates care plans for all high-risk patients as identified by risk stratification system, 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 use of a Patient and Family Advisory Council or other quantitative or qualitative means, and integrates additional data sources into its assessment where available; 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; and the practice has process in place to honor relationship continuity throughout the entire care process.

Source: ODM working group conversations, informed by stakeholder input.

Additional detail: community services and supports integration activity requirement

PRELIMINARY

Rule	The practice uses screening tools to identify patients in need of community services and supports, and implements and maintains a process to connect patients to necessary services.
Provider requirement	• Practice identifies patients in need of community services and supports through the use of screening tools or other means (e.g., Screening, Brief Intervention, and Referral to Treatment (SBIRT), adverse childhood experiences screening (ACES), social determinants of health questionnaire) • Practice has a systematic approach to refer and link patients to necessary community services and supports, including validating that services recommended were received with a provision to close gaps in care if necessary • Practice integrates community services and supports activities into broader practice systems, including risk stratification, care management plan, population health management • Practice has planned improvement strategy for outcomes with community services and supports

Source: ODM working group conversations and stakeholder input.

Additional detail: behavioral health integration activity requirement

PRELIMINARY

Rule	Practice identifies, refers, and tracks follow-ups for patients in need of behavioral health services; practice has planned improvement strategy for behavioral health outcomes.
Provider requirement	• Practice identifies patients in need of behavioral health services through regular use of specific tools and processes designed for anticipatory diagnosis • Practice has a systematic approach to timely referral and ongoing follow-up for members with behavioral health needs, including validating that services recommended were received with a provision to close gaps in care if necessary • Practice integrates behavioral health activities into broader systems, including care plans, risk stratification, and team based care delivery • Practice has planned improvement strategy for behavioral health outcomes

Source: ODM working group conversations and stakeholder input.

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2020 Ohio CPC efficiency metrics

PRELIMINARY

Metric	Rationale
Ambulatory care-sensitive inpatient admits per 1,000	▪ Strong correlation with total cost of care for large practices ▪ Metric that PCPs have stronger ability to influence, compared to all IP admissions
Emergency room visits per 1,000	▪ Limited range of year over year variability for smaller panel sizes ▪ Aligned with change in providers' behavior that the program wants to incentivize
Behavioral health-related[1] inpatient admits per 1,000	▪ Reinforces desired provider practice patterns, with focus on the behavioral health population ▪ Relevant for a significant number of smaller practices ▪ Stronger correlation to total cost of care than other BH-related metrics
Episodes-related metric	▪ Links CPC program to episode-based payments ▪ Incentivizes primary care providers to refer their patients to higher-performing providers

Note: efficiency metrics for CPC in 2020 do not include Generic Dispensing Rate; no changes have been made to remaining four efficiency metrics in CPC

1 Defined using HEDIS logic- Mental Health Utilization.

Note: CPC efficiency metrics in program year 2020 are all metrics used in previous program year.
Source: ODM working group conversations and stakeholder input.

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2020 Ohio CPC clinical quality metrics

PRELIMINARY

Update for 2020; detail follows

Category	Measure Name
Pediatric Health (4)	Well-Child Visits in the First 15 Months of Life
	Well-Child visits in the 3rd, 4th, 5th, 6th years of life
	Adolescent Well-Care Visits
	Weight assessment and counseling for nutrition and physical activity for children/adolescents: BMI assessment for children/adolescents
Women's Health (5)	Timeliness of prenatal care
	Live Births Weighing Less than 2,500 grams
	Postpartum care
	Breast Cancer Screening
	Cervical cancer screening
Adult Health (7)	Adult BMI Assessment
	Controlling high blood pressure[1]
	Medication management for people with asthma
	Statin Therapy for patients with cardiovascular disease
	Comprehensive Diabetes Care: HgA1c poor control (>9.0%)
	Comprehensive diabetes care: HbA1c testing
	Comprehensive diabetes care: eye exam
Behavioral Health (4)	Antidepressant medication management
	Follow up after hospitalization for mental illness
	Preventive care and screening: tobacco use: screening and cessation intervention
	Initiation of alcohol and other drug dependence treatment: Engagement

Source: ODM working group conversations and stakeholder input.

Note: All CMS metrics in relevant topic areas were included in list except for those for which data availability poses a challenge (e.g.,, certain metrics requiring EHR may be incorporated in future years).

Additional detail: Modification of Initiation and Engagement of AOD treatment (IET-AD) in CPC quality metrics for 2020

PRELIMINARY

No change from current CPC
New in 2020

	Current CPC program	Program update for 2020
Metric	IET-AD: Initiation	IET-AD: **Engagement**
Numerator	Members with **initiation of AOD treatment** through an inpatient admission, outpatient visit, intensive outpatient, or partial hospitalization	Members with **initiation of AOD treatment** through an inpatient admission, outpatient visit, intensive outpatient, or partial hospitalization **and who had two or more additional AOD services or medication treatment within 34 days of the initiation visit**
Denominator	Members who had a new episode of AOD during the intake period	Members who had a new episode of AOD during the intake period

Source: ODM working group discussions, CPC website, and HEDIS quality metric publications.