



Department of
Medicaid

Ohio Payment Innovation Program Update

Webinar

August 27th 2019

Contents

- **Background on payment innovation in Ohio**
- Program updates
 - Overall summary
 - CPC impact
 - Episodes impact
- Next steps and questions

Looking back: Original five-year plan to launch a PCMH and episode model at scale

Goal	80-90% of Ohio's population in some value-based payment model (combination of episodes- and population-based payment) within 5 years
State's role	<ul style="list-style-type: none"> ▪ Shift rapidly to PCMH & episode model in Medicaid FFS ▪ Require Medicaid MCO partners to participate / implement ▪ Incorporate into contracts of MCOs for state employee benefit program

	Patient centered medical homes	Episode-based payments
Year 1	<ul style="list-style-type: none"> ▪ In 2014 focus on CPCi ▪ Payers agree to participate in design for elements where standardization and / or alignment is critical ▪ Multi-payer group begins enrollment strategy for one additional market 	<ul style="list-style-type: none"> ▪ State leads design of 5 episodes – perinatal, asthma (acute exacerbation), COPD exacerbation, PCI, and joint replacement ▪ Payers agree to participate in design process, launch reporting on at least 3 of 5 episodes in 2014 and tie to payment within year
Year 3	<ul style="list-style-type: none"> ▪ Model rolled out to all major markets ▪ 50% of patients are enrolled 	<ul style="list-style-type: none"> ▪ 20 episodes defined and launched across payers
Year 5	<ul style="list-style-type: none"> ▪ Scale achieved state-wide ▪ 80% of patients are enrolled 	<ul style="list-style-type: none"> ▪ 50+ episodes defined and launched across payers

Primary objectives for the CPC and Episodes programs

CPC

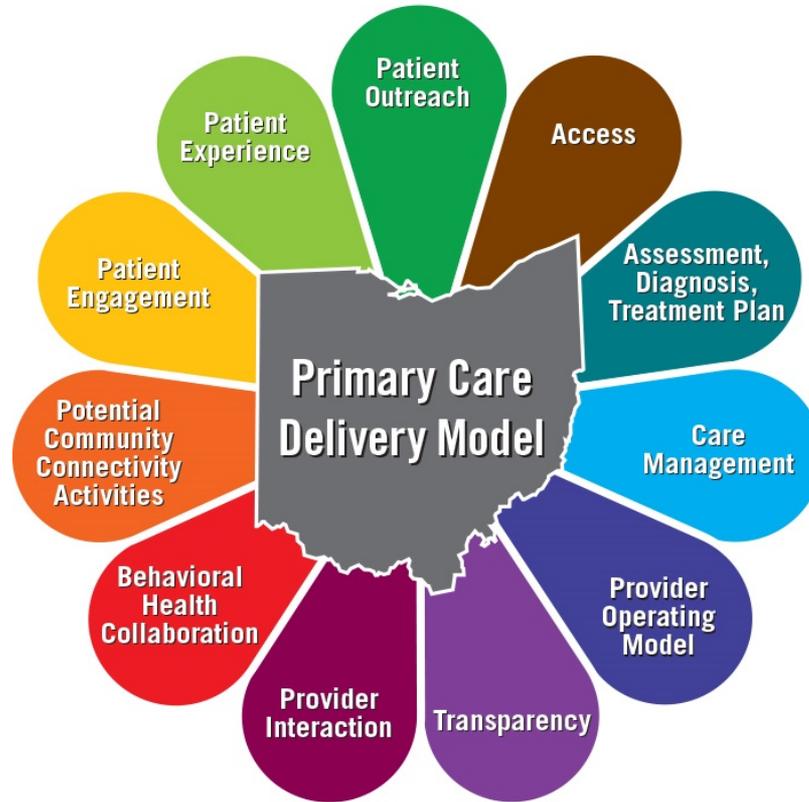
- Goal: Improving **access** to care, improving **quality**, and reducing the **total cost** of patient care
- Mechanism: Providing financial incentives to primary care practices for **keeping the population healthy** and to providing **more coordinated care**

Episodes

- Goal: Driving **more efficient, higher quality** care across specific patient journeys
- Mechanism: Providing financial incentives to providers for better managing quality and efficiency for **acute conditions and procedures**

Ohio CPC is a PCMH program designed 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

2019 Ohio Comprehensive Primary Care (CPC) Program Requirements and Payment Streams

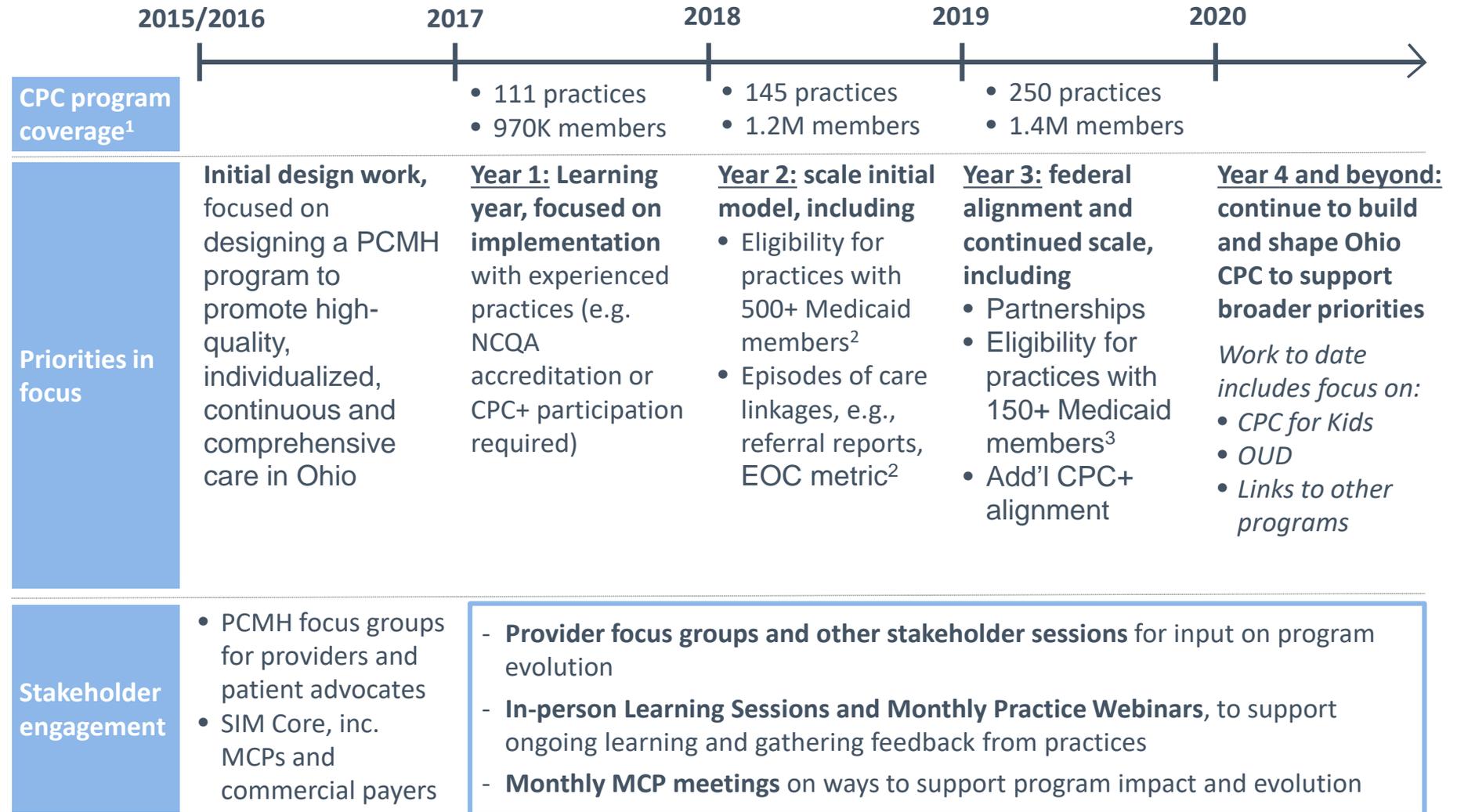
Requirements

8 activity requirements	20 Clinical quality metrics	5 Efficiency metrics	Total Cost of Care
<ul style="list-style-type: none"> • 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 <p style="text-align: center;">Must pass 100%</p>	<ul style="list-style-type: none"> • Clinical measures aligned with CMS/AHIP core standards for PCMH <p style="text-align: center;">Must pass 50%</p>	<ul style="list-style-type: none"> • ED visits • Inpatient admissions for ambulatory sensitive conditions • Generic dispensing rate of select classes • Behavioral health related inpatient admits • Episodes-related metric <p style="text-align: center;">Must pass 50%</p>	<div style="border: 1px dashed black; height: 100%;"></div>

Payment Streams

PMPM	All required	
Shared Savings	All required	Based on self-improvement & performance relative to peers

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



Source: program operational work to date.

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 Information only in 2018

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

Ohio's Episodes of Care program is designed to improve care quality and reduce healthcare costs



Goals



Progress
to-date

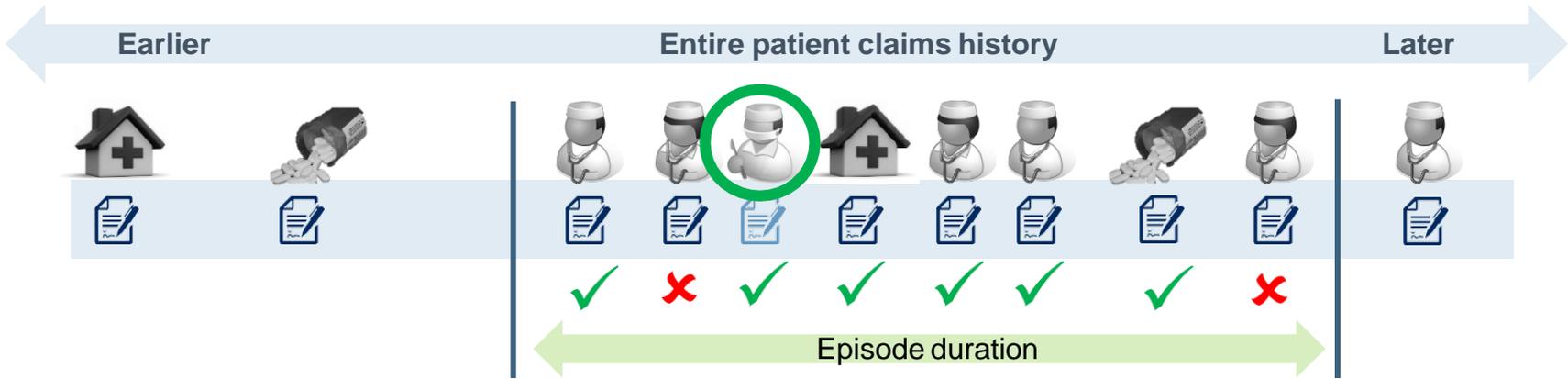


How it
works

- The goal of the Episodes of Care program is to give providers **greater visibility** into their own performance through **improved transparency** on spend and quality
- Ohio has launched **43 unique episodes** since the program first began; 18 of these are currently tied to payment
- Episodes tied to payment are evaluated on spend and quality performance with respect to a set of **peer-defined thresholds**, which are specific to each type of episode
- Providers receive **payment incentives** based on a combination of these spend and quality measures, which are assessed on an annual basis

Anatomy of an episode bundle

- An episode of care (“episode” or “EOC”) is defined as the set of **services provided to treat a clinical condition or procedure** for a defined duration
- These services occur **across the continuum of care** and can include: Extended care, Acute hospital care, Ambulatory care, Home care, Community Outreach, Wellness, etc.



Episode Parameters

Example of service

	Claim for significant medical “trigger” event	Hip replacement procedure
	Time period before and after the significant medical event where related claims will be included	30 days prior to 60 days post-op
	Claims that are related to the significant medical event and will be included in the episode	IP admission, physical therapy, medications
	Claims that are unrelated to the significant medical event and will not be included	Vaccinations, chronic condition medications
	Provider that will be accountable for the episode	Orthopedic surgeon

Ohio's episode model is retrospective, building on the current FFS infrastructure already in place

Patients seek and providers 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 

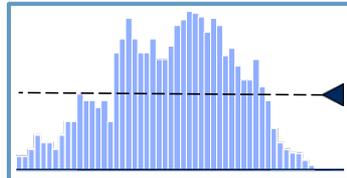
Payers reimburse for all services as they do today

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

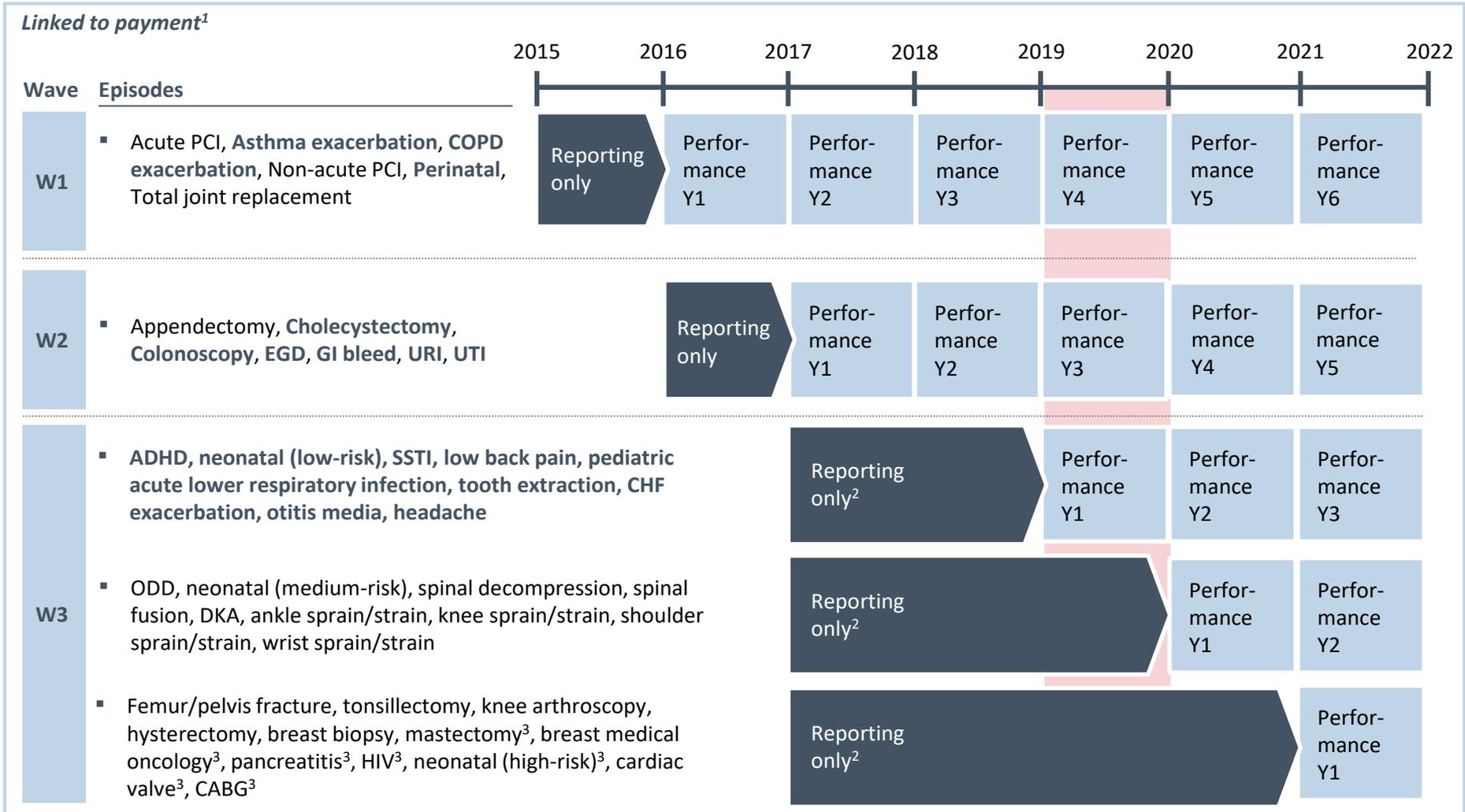
5 Payers calculate average risk-adjusted reimbursement per episode for each PAP



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

Timeline of Episodes of Care: Episode launch timeline



1 Payment episode status already determined for W1 and W2; W3 episodes will be tied to payment through 3-stage implementation with 9 episodes in the first stage in 2019
 2 Reporting for Wave 3 episodes extended through CY18 given need to incorporate physician feedback through reactive clinical process into episode design prior to performance periods
 3 Episodes staying in 'reporting-only' for a period to-be-determined, or indefinitely by design.

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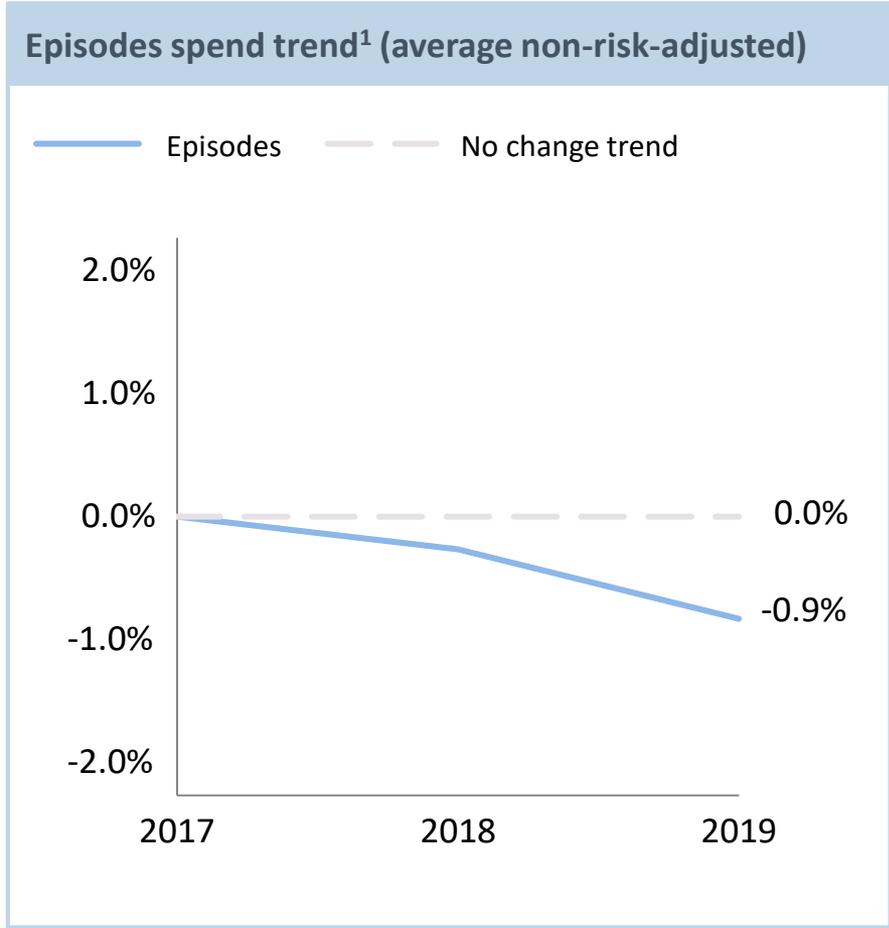
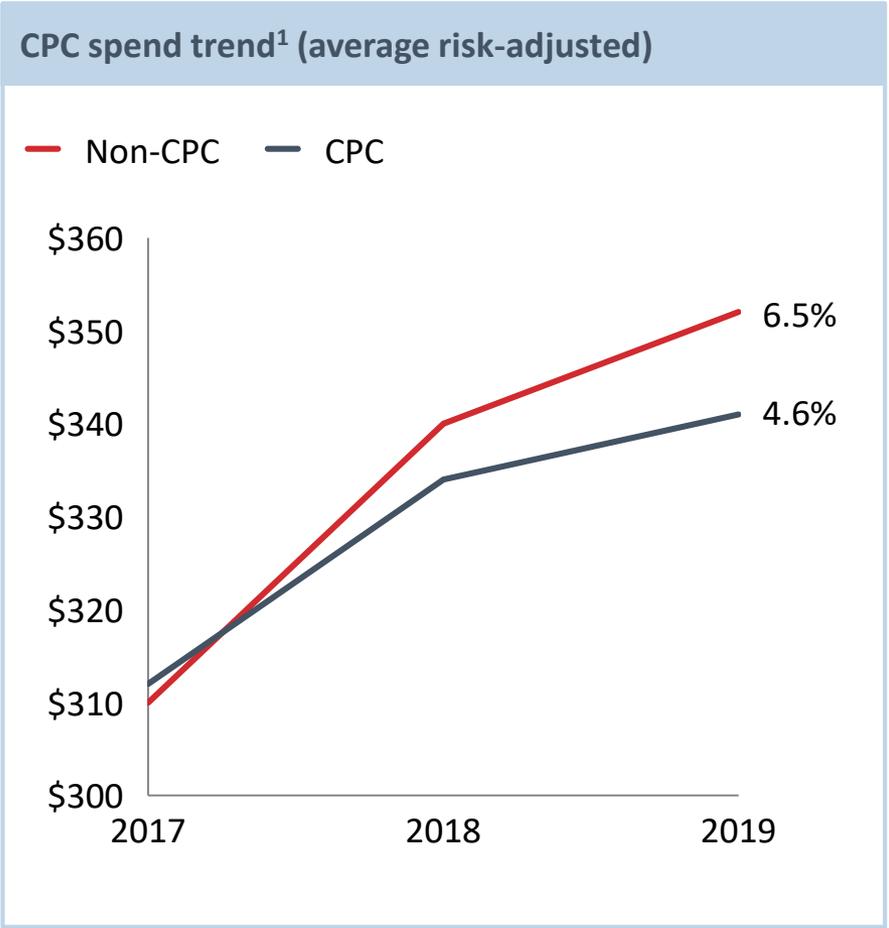
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Across CPC and Episodes, there is evidence of improvement on the goals for transformation in Ohio’s healthcare delivery system

 Negative trend  Neutral trend  Positive trend

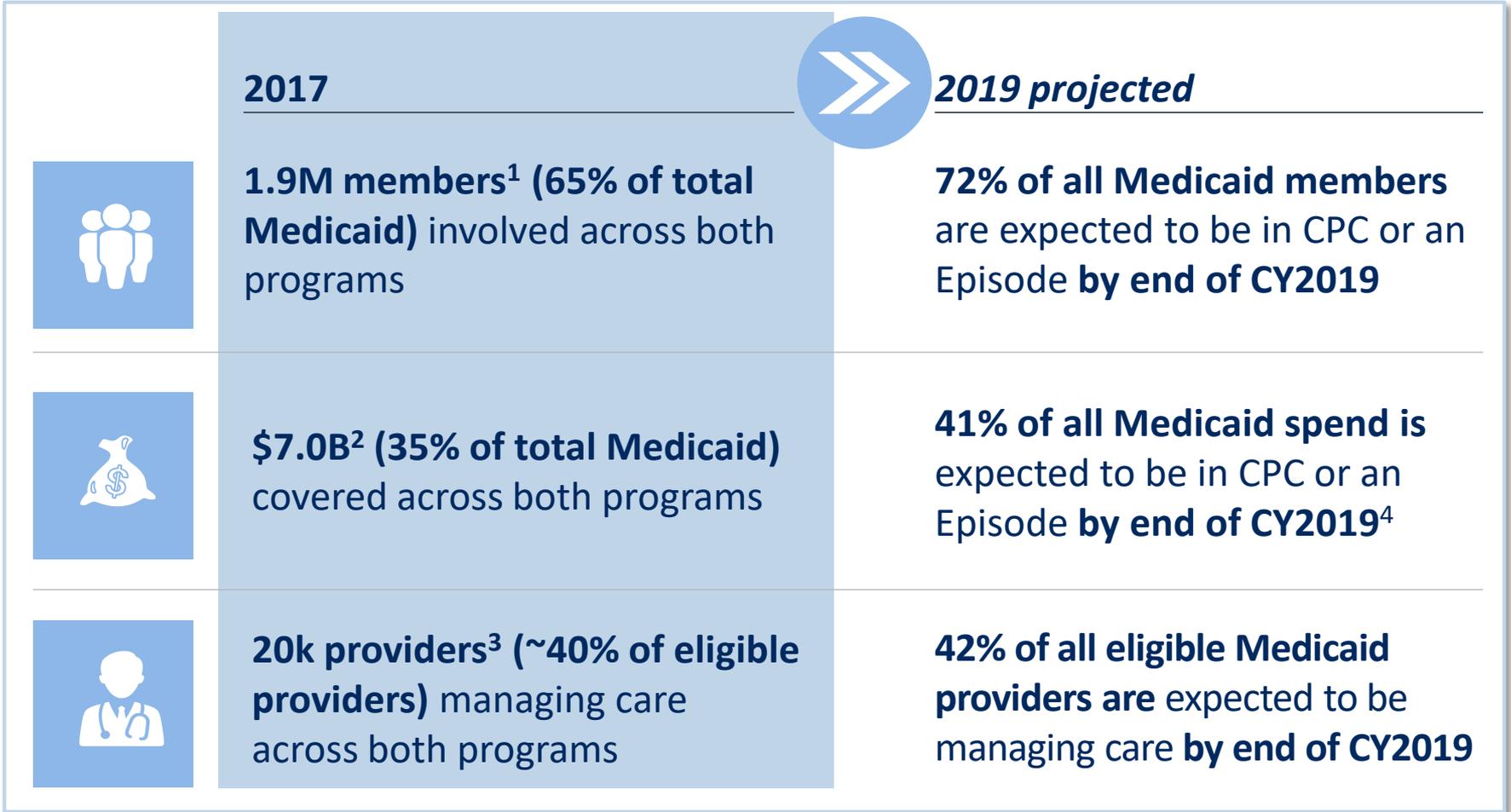
Program	Key results
CPC	<ul style="list-style-type: none">  Overall quality performance of CPC practices improved by ~2.2% annually from 2015 to 2017  CPC had a negative 1.9% cost trend compared with the non-CPC control group for risk-adjusted total cost of care  This cost trend resulted in \$78.1M in net annual savings across the program
Episodes	<ul style="list-style-type: none">  Average performance across all episode quality metrics held largely steady for the first two years of the program  Average non-risk-adjusted spend decreased by 0.9% annually from 2015 to 2017, which translates to a negative spend trend of ~2.8% to ~7.7%  This cost trend resulted in ~\$31.6-92.4M in annual savings for the program

CPC outperformed the non-CPC control group on cost growth, while Episodes achieved a negative spend trend over time



¹ All spend trends are annualized

In 2017, the CPC and Episodes programs covered a significant portion of Ohio Medicaid, and are expected to grow



1 Total Medicaid members defined as avg monthly members for CY2017 from the June 2018 caseload report. CPC members defined as members with at least 6 member months attributed to a CPC practice in 2017 with exclusions applied. Episode members defined as members with at least one episode in 2017 with no exclusions applied.

2 Spend for CPC and Episodes is non risk-adjusted and includes all CPC members and all Episodes with no exclusions. Program-eligible spend is restricted to just claims and encounters, and excludes outside payments to MCPs, off-claims Dept. of Aging, Medicare, supplemental payments to providers, and administrative costs. 4 This number includes all billing providers with a claim in 2017, excluding those that would never be eligible for CPC or Episodes (e.g. out of state, labs, ancillary, DME, etc.).

3 All CPC billing provider IDs are assigned as episode PAPs for URI during CY2017

4 2019 Projected spend assumes the same overlap of claim-level data across multiple episode or across episodes and CPC in 2017

Early impact across CPC and episodes programs

CPC practices have lower spend trend than a comparison group...

4.6%
CPC Increase

6.5%
Non-CPC Increase

in annualized risk-adjusted spend PMPM trend (CAGR 2015-2017, %)

... which represents net savings over shared savings payments...

\$89M

\$11M

Gross savings for CY2017 and ...

... in shared savings payment to CPCs

... with improvement in quality performance consistently increasing

2.2%
CPC Increase

3.6%
Higher than non-CPC

in annualized composite quality score (CAGR 2015-2017, %)

percentage points nominal composite quality score (2017)

Episode spend trend (for the 9 episodes in payment for 2017) was negative for the first two years of the program...

0.9%
decrease

in annualized average non-risk-adjusted episode spend trend (CAGR 2015-2017, %)

... which represents net savings over positive incentive payments...

\$32-91M

\$4M

Gross savings for CY2017¹ and...

... in positive incentive payments to PAPs²

...with no adverse impact on quality...

Less than
0.1%
decrease

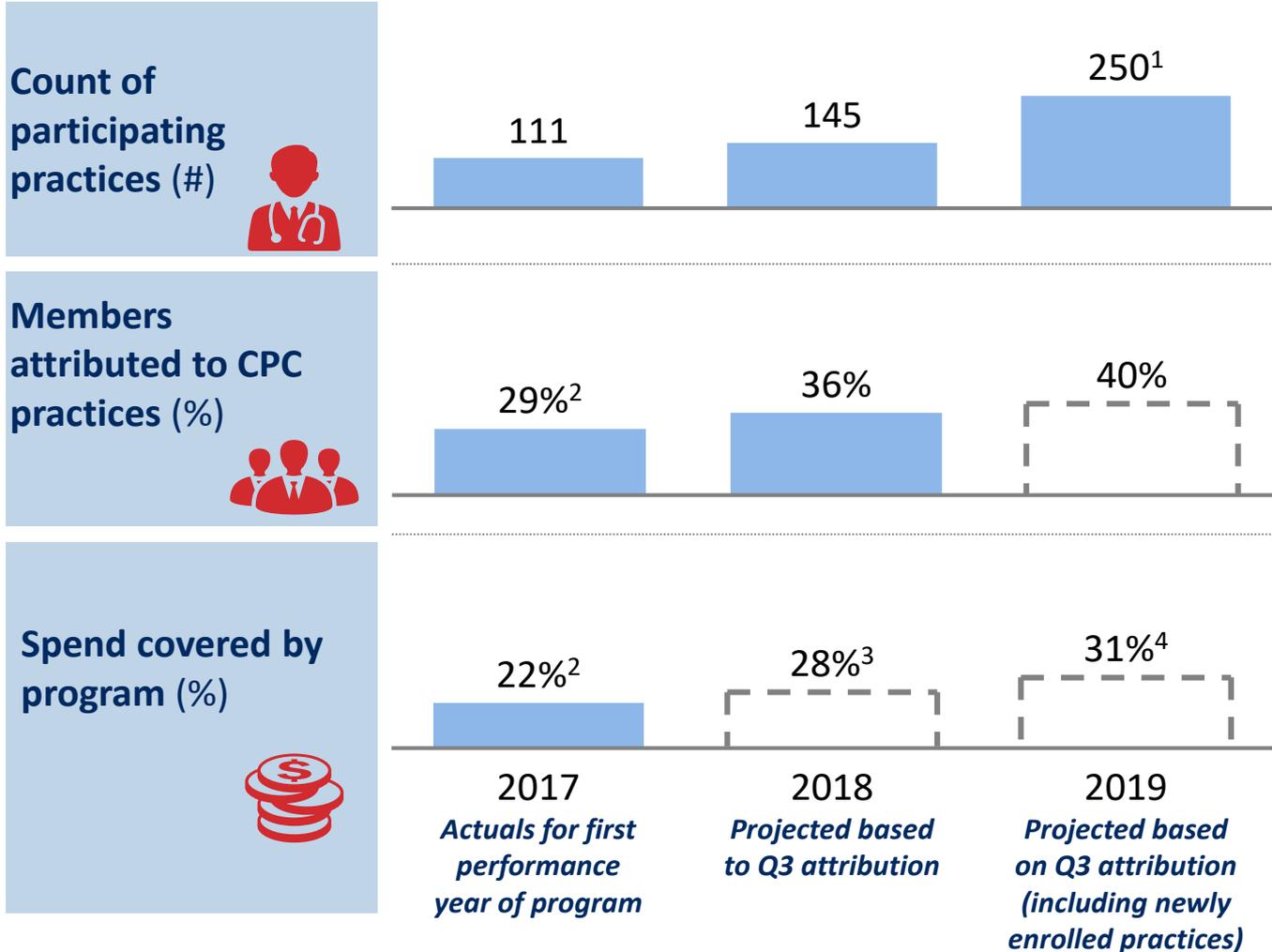
in annualized composite quality score (CAGR 2015-2017, %)

¹ Range of savings across all 9 episodes in payment for 2017 is calculated using a lower bound estimate based on a historical Medicaid spend trend benchmark and an upper bound estimate based on a claim type-weighted expected trend for each episode using claim type trend values. ² Based on 2017 Episodes Annual Reports; does not include Paramount.

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After its first performance year, CPC covered one third of OH Medicaid population and could grow to cover up to 40% by end of 2019



Key takeaways

- In first two years, many large practices enrolled shifting much of the Medicaid population under CPC program
- Program increased scale with 2019 enrollment open to smaller practices (150 members)



1. Represents 250 individual practices enrolling across 163 entities (including practice partnerships)
 2. Based on actual data from 111 practices enrolled in 2017
 3. Projected based on 2017 average spend for 145 practices enrolled in 2018
 4. Projected based on current attribution for 2019 enrolled practices based on 2017 average spend
 SOURCE: Ohio Medicaid claims data CY2015-17

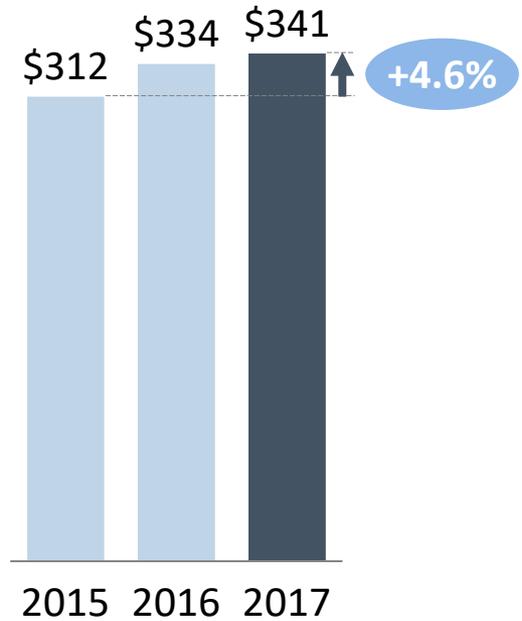
PRELIMINARY

Program spend is growing at a slower rate than spend by members outside the program

CPC¹

Risk-adjusted total cost of care PMPM

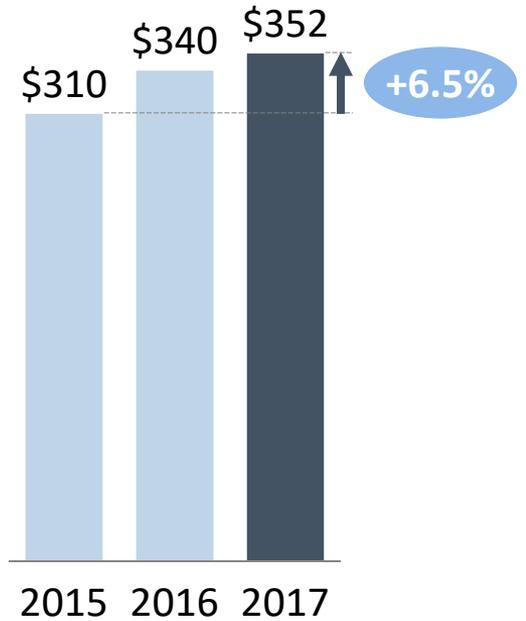
Annualized spend trend '15-'17



Non-CPC^{1,2}

Risk-adjusted total cost of care PMPM

Annualized spend trend '15-'17



■ First performance year of CPC program

Key takeaways

- CPC saw spend increase of 4.6% compared to 6.5% in non-CPC annualized trend 2015-17
- Preliminary effect of CPC program seen in 2016-17 (Y1) trend where PMPM growth rate is down from:
 - 7% in 2015-2016 to 2% in 2016-2017 for CPC
 - Nearly 10% in 2015-2016 to 3.5% in 2016-2017 for non-CPC



Members

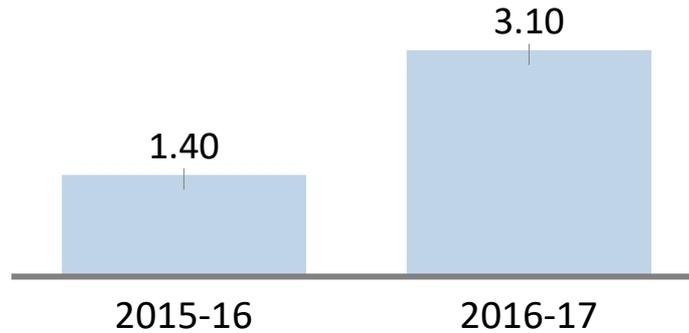
¹ Includes all medical costs including quarterly PMPM payments made to practices for CPC participation and excluding CPC standard member exclusions (i.e., duals, TPL, foster care, limited benefits, in transition, discontinuous enrollment, with NICU stay, with 90+ days of LTC, CRG-based outliers) and spend exclusions (i.e., dental, vision, waiver-based services, transportation). Does not include programmatic adjustment factors

² Includes CPC-eligible practices (i.e., CPC-eligible provider type/specialty codes) that did not enroll in the CPC program

Quality of care has improved, particularly during performance year 2017, with all practices meeting program quality requirements

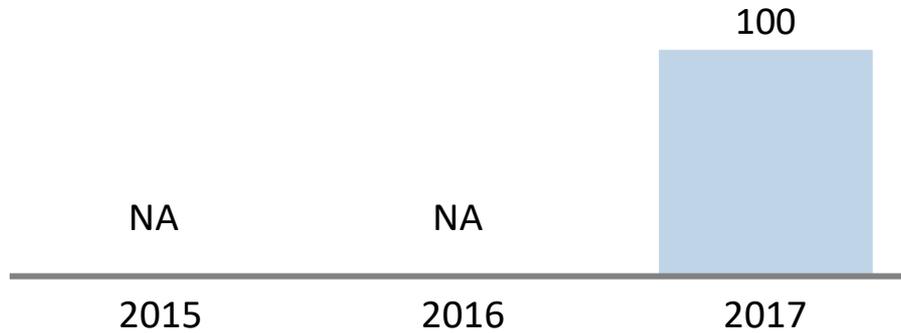
CPC quality trend¹

Change in quality composite score (%)



Program quality requirements performance

Percent practices passing 50% of quality metrics (%)



Key takeaways

- Program-wide performance on composite of metrics tied to payment consistently improved 2015-17
- All practices met quality requirements in 2017 with thresholds set based on historical performance



¹ Average of program-wide performance across all 20 QMs used for payment (adjusted so higher is always better) for all QMs used for payment weighted evenly
SOURCE: Ohio Medicaid claims data CY2015-17

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PRELIMINARY

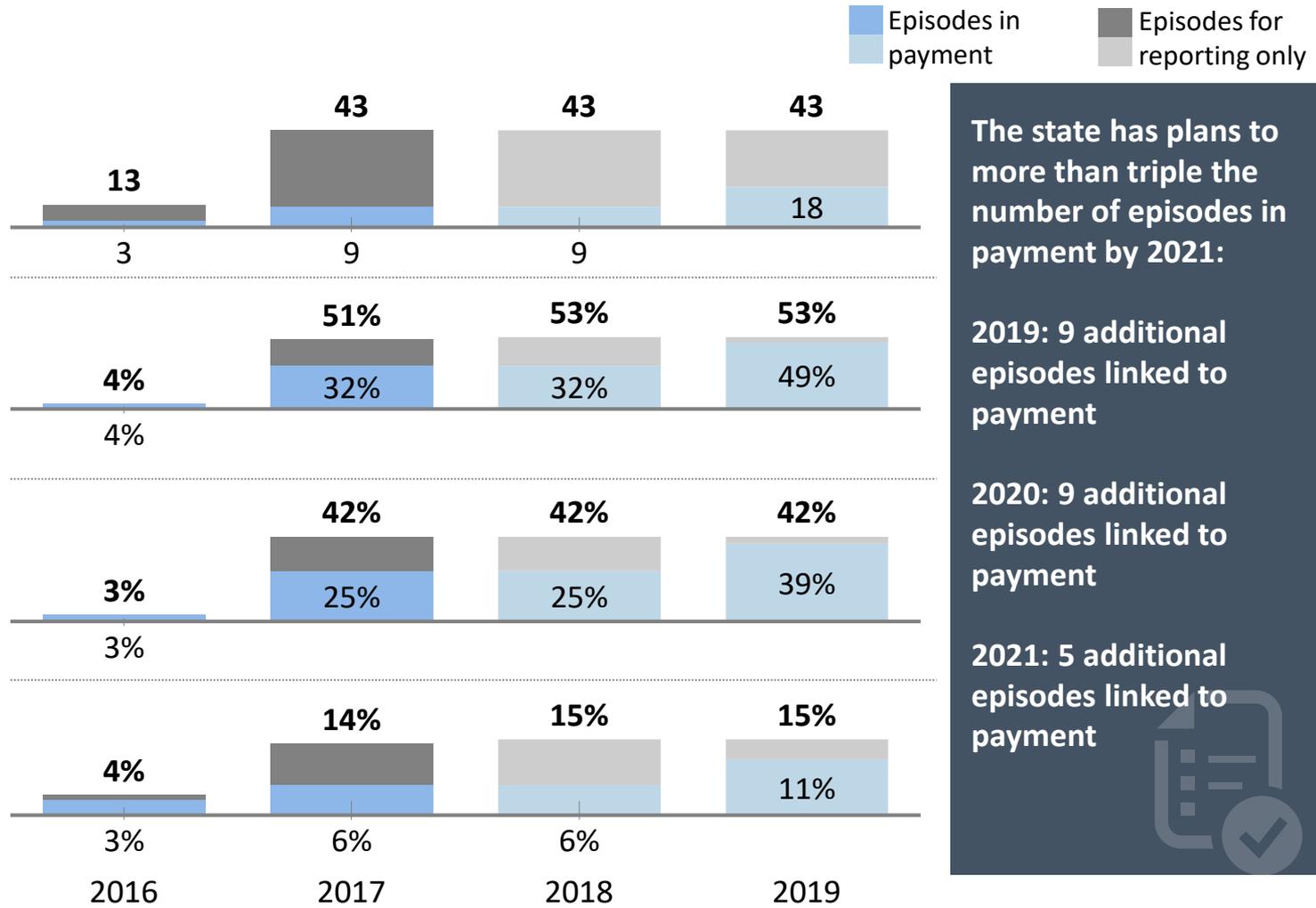
In 2017, episodes covered 52% of members with 31% in episodes tied to payment and 15% of spend with 6% in episodes tied to payment

Episodes in payment (#)

Unique members with an episode (%)¹

Unique PAPs (%)²

Spend covered by Episodes program (%)³



The state has plans to more than triple the number of episodes in payment by 2021:

2019: 9 additional episodes linked to payment

2020: 9 additional episodes linked to payment

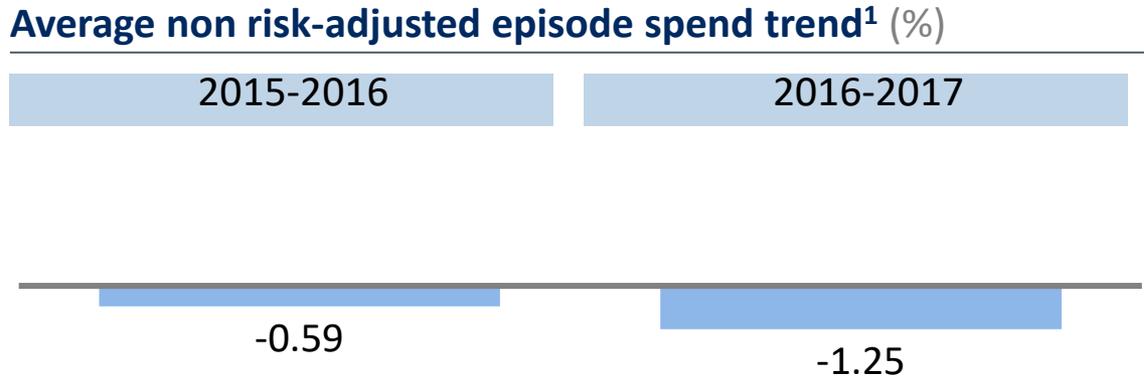
2021: 5 additional episodes linked to payment



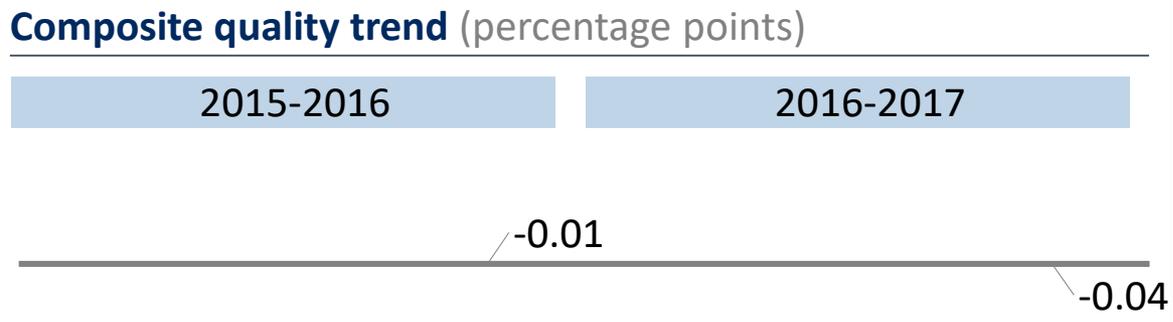
¹ Denominator is total Medicaid members defined as avg monthly members for CY2017 from the June 2018 caseload report. Numerator is unique episode members defined as members with at least one episode in 2017 with no exclusions applied. ² Denominator is all eligible providers, defined as Medicaid billing providers with a claim in 2017, excluding those that would never be eligible for CPC or Episodes (e.g. out of state, labs, ancillary, DME, etc.). Numerator is unique PAPs, defined by Medicaid billing id ³ Denominator is Medicaid program-eligible spend defined as total claims and encounters spend, which excludes outside payments to MCPs, off-claims Dept. of Aging, Medicare, supplemental payments to providers, and administrative costs. Numerator is spend for Episodes, which is non risk-adjusted and includes all Episodes with no exclusions.

For the past two years, the nine episodes linked to payment in 2017 achieved a negative spend trend with no adverse impact on quality

Episode spend trend
(all episodes non risk-adjusted)



Episodes quality trend



Insights

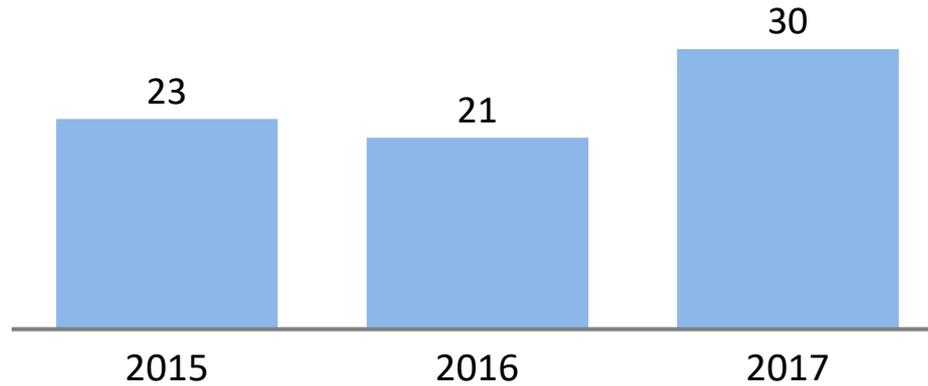
- The first 3 episodes linked to payment saw even lower spend trend (-2.4% annualized 2015-2017)
- Low performance on asthma exacerbation metrics kept quality trend from being positive overall



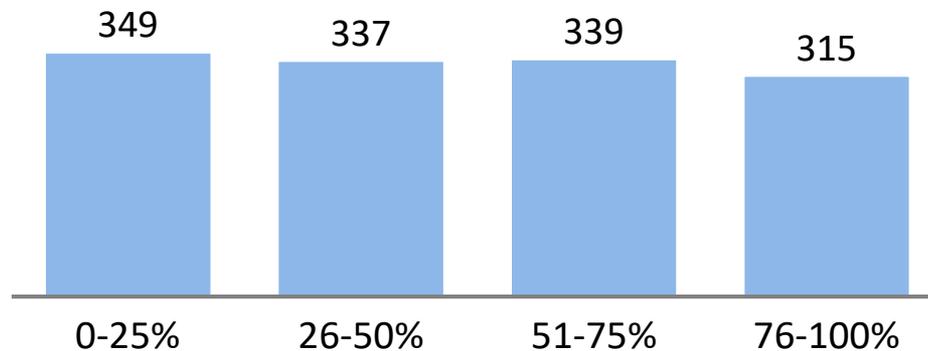
¹ Trend is for the 9 episodes in payment for 2017 with no exclusions applied using all episodes and non risk-adjusted spend

Episodes for CPC attributed members are increasingly with highly efficient PAPs and show a positive correlation with practice-level spend

Trend in % of episodes by CPC members with highly efficient PAPs¹, 2015-17 (%)



CPC risk-adjusted total cost of care PMPM³ by % of episodes by members with highly efficient PAPs¹, 2017 (\$)



Key takeaways

- In CPC’s first performance year, episodes with highly efficient PAPs increased from 21% to 30%
- Correlation between lower risk-adjusted total cost of care and highly efficient PAPs is driven by other aspects of practice behavior, as episode spend accounts for small portion of total cost of care



1 Includes Principal Accountable Providers (PAPs) participating in asthma, COPD, and perinatal episodes with spend performance ranking in the top 2 quintiles (\$ and \$\$)

2 Based on MCP assignment at time of episode occurrence.

3 Includes all medical costs for members including quarterly PMPM payments made to practices for CPC participation and excluding CPC standard member and spend exclusions after applying risk adjustment divided by total number of member months for attributed members.

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Upcoming program changes for 2020

CPC program

Episodes program

Update	Description
<p>New CPC program requirements</p>	<ul style="list-style-type: none"> Two new activity requirements for 2020 performance year: community services and support integration, and behavioral health integration Generic dispensing rate removed as efficiency metric Initiation and Engagement of AOD Treatment (IET-AD) clinical quality metric modified from measuring treatment <i>initiation</i> to measuring treatment <i>engagement</i>
<p>CPC for Kids</p>	<ul style="list-style-type: none"> CPC for Kids is a new optional “track” for practices with at least 150 pediatric members¹, designed to improve wellness for children statewide using CPC as a foundation Program involves additional pediatric quality metrics, enhanced PMPM payments for pediatric members, and bonus payment eligibility based on other care activities
<p>Perinatal episode refinement</p>	<ul style="list-style-type: none"> Increased focus on closing gaps in care for high-risk women, such as mothers with SUD, advanced behavioral health problems, or risk of pre-term birth Improved methods for comparing providers, including the addition of statistically significant clinical and social factors to the risk-adjustment model Additional transparency into neonate outcomes (e.g. gestational age, birth weight) to create awareness and a sense of responsibility among OB/GYNs

¹ Entities may be practices participating independently or practice partnerships. Pediatric members defined as members under age 21; claims-only attributed members will be used to determine eligibility for participation in CPC for Kids

Additional CPC details can be found online



<p>HOME MEDICAID 101 ▾ FOR OHIOANS ▾ PROVIDERS ▾ MANAGED CARE ▾</p>	
CPC Enrollment	There are three types of requirements that practices must meet in order to receive payments through the CPC program: activity requirements, clinical quality metrics, and efficiency metrics. Practices must meet all activity requirements, 50% of applicable quality metrics, and 50% of applicable efficiency metrics in order to be eligible for payment.
CPC Payments	
CPC Requirements	Definitions and specifications all requirements are found below. Specifications include numerator and denominator requirements, exclusions, and time frame. Detailed codesheets, which outline the specific codes included in each metric, will be available to practices who are enrolled in the CPC program.
CPC Reporting	
CPC Provider Webinars	<ul style="list-style-type: none"> ▪ Activity requirements (definitions) (2019 CPC activity requirements) ▪ Quality metrics (definitions and detailed specifications) ▪ Efficiency metrics (definitions and detailed specifications) <ul style="list-style-type: none"> ▪ Updated methodology for episode-based efficiency metric ▪ CPT II and other Billing Codes for Quality Metric Compliance ▪ Thresholds for quality and efficiency metrics (thresholds)

The Ohio Department of Medicaid website includes links to additional CPC program information (<https://medicaid.ohio.gov/Provider/PaymentInnovation/CPC>), including:

- **CPC program updates for 2020**
- **Ohio’s Vision for Primary Care**
- **Provider Assistance**
- **Medicare Comprehensive Primary Care Plus (CPC+)**
- **Ohio CPC 2019 Practice List**
- In addition, instructions on how to read your episode reports and general FAQs are available on the website

Additional episode-specific details may also be found online



Wave 3: The following episodes are also planned for release in 2017:

- Attention deficit and hyperactivity disorder (concept paper, DBR, code sheet)
- Breast biopsy (concept paper, DBR, code sheet)
- Breast cancer surgery (concept paper, DBR, code sheet)
- Breast medical oncology (concept paper, DBR, code sheet)
- Coronary artery bypass graft (concept paper, DBR, code sheet)
- Cardiac valve (concept paper, DBR, code sheet)
- Congestive heart failure exacerbation (concept paper, DBR, code sheet)
- Diabetic ketoacidosis/ hyperosmolar hyperglycemic state (concept paper, DBR, code sheet)
- Headache (concept paper, DBR, code sheet)
- HIV (concept paper, DBR, code sheet)
- Hysterectomy (concept paper, DBR, code sheet)
- Low back pain (concept paper, DBR, code sheet)
- Neonatal (high-risk) (concept paper, DBR, code sheet)
- Neonatal (low-risk) (concept paper, DBR, [code sheet](#))
- Neonatal (moderate-risk) (concept paper, DBR, code sheet)
- Oppositional defiant disorder (concept paper, DBR, code sheet)

The Ohio Department of Medicaid website includes links to the following documents for each episode (<http://www.medicaid.ohio.gov/Providers/PaymentInnovation/Episodes.aspx>)

- **Concept paper:** Overview of episode definition including clinical rationale for the episode, patient journey, sources of value, and episode design dimensions
- **Detailed business requirements (DBR):** Description of episode design details and technical definitions by design dimensions
- **Code sheet:** Medical, pharmacy, and other related codes needed to build the episode, to be referenced with the DBR
- **Thresholds:** Spend thresholds and quality metric targets are available for episodes that are linked to payment.

In addition, instructions on how to read your episode reports and general FAQs are available on the website

Additional program performance information may also be found online



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Payment Innovation

The Ohio Department of Medicaid continues to engage public and private sector partners in designing a new health care delivery payment system that rewards the value of services – not the volume.

The Ohio Department Medicaid is also working closely with payer partners, including all Medicaid managed care plans (MCPs: Buckeye Health Plan, CareSource, Molina Healthcare, Paramount Health Care, and UnitedHealthcare) and four commercial payers (Aetna, Anthem, Medical Mutual of Ohio, and UnitedHealthCare).

Ohio’s State Innovation Model (SIM) grant proposal centers on testing payment models that increase access to comprehensive primary care and support retrospective episode-based payments for acute medical events.

Learn more about these initiatives:

[Comprehensive Primary Care](#)

[Episode-based payments](#)

[State Innovation Model \(SIM\) Information](#)

[SIM Grant Final Report](#)

Additional Questions?

Appendix

2019 Ohio CPC Activity Requirements

Must pass 100%

24/7 and same-day access to care	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<p>The practice has a documented process for tracking referrals and reports, and demonstrates that it:</p> <ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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.

2019 Ohio CPC per member per month (PMPM) payments

The PMPM payment for a given CPC practice is calculated by multiplying the **PMPM for each risk tier** by the **number of members attributed to the practice in each risk tier**

	Health statuses	Example	CPC PMPM
CPC PMPM Tier 1	Healthy	Healthy (no chronic health problems)	\$1.80
	History of significant acute disease	Chest pains	
	Single minor chronic disease	Migraine	
CPC PMPM Tier 2	Minor chronic diseases in multiple organ systems	Migraine and benign prostatic hyperplasia (BPH)	\$8.55
	Significant chronic disease	Diabetes mellitus	
	Significant chronic diseases in multiple organ systems	Diabetes mellitus and CHF	
CPC PMPM Tier 3	Dominant chronic disease in 3 or more organ systems	Diabetes mellitus, CHF, and COPD	\$22.00
	Dominant/metastatic malignancy	Metastatic colon malignancy	
	Catastrophic	History of major organ transplant	

- Practices and MCPs receive payments prospectively and quarterly
- Risk tiers are updated quarterly, based on 24 months of claims history with 3 months of claims run-out
- Quarterly PMPM payments are meant to support practices in conducting the activities required by the CPC program

Ohio CPC total cost of care shared savings payment calculation

- **Annual retrospective payment** based on total cost of care (TCOC)
- **Activity requirements and quality and efficiency metrics must be met** for the CPC entity to receive this payment
- CPC entities must have **60,000 member months** to be eligible for TCOC
- CPC entities may receive **either or both** of two payments

1**Total Cost of Care
relative to self**

Payment based on an **entity's improvement on total cost of care** for all their attributed patients, **compared to their own baseline** total cost of care

2**Total Cost of Care
relative to peers**

Payment **based on an entity's low total cost of care** relative to other CPC entities

Elements of the episode definition

Category	Description
1 Episode trigger	<ul style="list-style-type: none"> Diagnoses or procedures and corresponding claim types and/or care settings that characterize a potential episode
2 Episode window	<ul style="list-style-type: none"> 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
3 Claims included	
4 Principal accountable provider	
5 Quality metrics	<ul style="list-style-type: none"> Measures to evaluate quality of care delivered during a specific episode
6 Potential risk factors	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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