Key Findings and Next Steps of the Ohio Payment Reform Summit

A Report Prepared for the
Ohio Health Care Coverage and Quality Council and the Ohio Department of Insurance

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Executive Summary

In order to facilitate the process of health care reform in Ohio, the Ohio Health Care Coverage and Quality Council (HCCQC) held a statewide health care Payment Reform Summit on December 4, 2010. The Summit's 139 participants included consumers, physicians, hospitals, other health care practitioners, employers, and public and private health plans staff.

The Summit's goals were to:

- Create a common understanding of the health care system's payment reform needs, challenges, and opportunities;
- Discuss and refine payment options to promote improved quality and outcomes, while bending the growth of health care spending;
- Develop ideas on how to move payment reform forward in Ohio; and
- Foster relationships among different parties at the state and regional levels to further health care improvement conversations.

Summit participants, divided into eight regional breakout groups, addressed policy options and local and state action steps under two general themes:

- Advancing patient-centered primary care in Ohio by supporting practice transformation, including consumer engagement and the integration of behavioral health in the primary care home; and
- Aligning payment to achieve improved health outcomes and better value across health care settings, included but not limited to strategies such as bundled or global payments and episode of care reimbursement.

Based on the breakout group discussions, the participants agreed that:

- The payment system needs to move away from the existing fee-for-service model because it rewards quantity over quality;
- Moving to a patient-centered primary care home model is a worthwhile goal; requiring payment reform to support practice transformation and team-based care;
- Payment reform to promote medical homes should include either a large monthly care management fee or a per-patient partial comprehensive care payment for outpatient services, along with financial incentives to reduce the overall rate of hospital readmissions;
- Either of these payments should be risk-adjusted and applied to all patients;
- Cost sharing should encourage patients to select and use a primary care home and appropriately use medications and/or other treatments for managing their health conditions;
- Any payment structure should ensure effective integration of behavioral and physical health services, including support for telemedicine;

- Payment for major acute care events should become a single, prospectively-defined payment to cover the cost of hospital care, all physician and other health care practitioner services, and any short-term care following discharge;
- Payment reform should promote the reduction of preventable adverse events, including no additional payments for events that should not occur, and should support the reduction of avoidable hospital readmissions;
- Payment reform should be accompanied by greater transparency and public reporting of data;
- Information gleaned from the Summit should be shared with their peers, patients, and others, as well as begin or continue local payment reform discussions; and
- Continued state leadership on payment and delivery system reform is needed, including Medicaid participation in any multi-payer initiatives.

Participants also raised some important challenges to consider and address when moving forward with payment reform, including:

- Because providers will transform their entire practice or not transform at all, they must have multiple payers participate in payment reform and the reform changes must cover all of their patients;
- Because the costs of practice transformation will require that providers get some upfront financial and technical assistance to facilitate this transformation, funds that will need to come from public and private health plans;
- Practice transformation will require continued support for the adoption of electronic health records and the exchange of health information;
- Practice transformation will require much better coordination across health care settings and involvement of a much wider range of health care practitioners. This transformation requires technical assistance, including changes in workforce development. Payment structures must support this new approach to practice;
- A "free rider" concern is that many plans will hold off on making payment reform changes hoping to benefit from the investment of a few plans;
- The State must assist with any anti-trust concerns related to regional or state collaborative meetings associated with payment reform; and
- Payment reform requires flexibility because providers are at different points of readiness for change and resources will differ for small practices and practiced in rural and underserved areas.

According to the evaluations and discussions with participants, the Summit met its goals. The participants expressed interest in continuing the work on payment reform. Next steps include:

- Share this report with a workgroup from the Council's Payment Reform Taskforce and Enhanced Patient Centered Home Steering Committee to build upon the Summit results and propose specific action steps for regions and for the state;
- Include the report in the transition materials related to health care reform;
- Share the report with members of the Ohio General Assembly;
- Share participant contact information with all Summit participants to facilitate continuing regional meetings; and
- Share the report with all Summit participants so that they can build upon the agreements and discussions they had at the Summit and share the information with their peers and other people in their regions.

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Introduction

This report entitled "Key Findings and Next Steps of the Ohio Payment Reform Summit" is the culmination of many months of planning and discussions initiated by the Ohio Health Care Coverage and Quality Council (HCCQC). In order to facilitate the process of health care reform in Ohio, the HCCQC decided last summer to hold a Payment Reform Summit of key health care stakeholders. The Summit's 139 participants included consumers, physicians, hospitals, other health care practitioners, employers, and public and private health plans staff. The statewide health care Payment Reform Summit was held on Saturday, December 4, 2010. The Summit attracted 139 participants who spent the day considering reform strategies to improve the quality and cost of health care for all Ohioans. This report summarizes the key outcomes of the Summit.

The goals for the Summit were to:

- Create a common understanding of the health care system's payment reform needs, challenges, and opportunities;
- Discuss and refine payment options to promote improved quality and outcomes while bending the growth of health care spending;
- Develop ideas on how to move payment reform forward in Ohio; and
- Foster relationships among different parties at the state and regional level to further health care improvement conversations.

The Summit participants addressed policy options under two general themes:

- Advancing patient-centered primary care in Ohio by supporting practice transformation, including consumer engagement and the integration of behavioral health in the primary care home; and
- Aligning payment to achieve improved health outcomes and better value across health care settings, included but not limited to strategies such as bundled or global payments and episode of care reimbursement.

Participants also identified at least one local and one state action that would advance the work of payment reform.

The following report outlines the steps leading up to the Summit, explains the rationale for focusing on payment reform, and captures the outcomes from the work of the participants.

Road to the Summit

A series of Ohio public and private sector activities over the past four years led to the Ohio Payment Reform Summit. The public sector activities began with Ohio participating in a national effort sponsored by the Robert Wood Johnson Foundation called the State Coverage Initiative (SCI). Ohio's SCI project created a multi-stakeholder advisory group of 45 individuals to identify policy options to reduce the number of uninsured Ohioans. Many of the participants on this advisory group noted that it was equally important to identify strategies to reform the payment and delivery of health care services to create an affordable and sustainable health system. Therefore, Ohio's final SCI report included a recommendation for a follow-up advisory group to work on such strategies, as well as a recommendation to support the development of medical homes.[1]

Following the SCI work, Ohio participated in the national State Quality Improvement Initiative (SQII). Ohio was one of nine states selected to participate in SQII. The purpose of the SQII project, sponsored by the Commonwealth Fund, was to assist participating states in developing health quality improvement plans. The three priority areas for these plans were: 1) delivery and financing systems reform, 2) care coordination/chronic care management, and 3) data integration/transparency.[2]

Ohio's SQII leadership team decided that the best way to create a meaningful state quality improvement plan that would be practical, feasible, and broadly supported was to include the diversity of Ohio stakeholders in its development. The Ohio Health Quality Improvement Summit (OHQIS) took place between November 17th and November 19th 2008, with 160 individuals participating for all three days.

OHQIS participants identified four critical building blocks needed to advance health quality improvement in Ohio. These building blocks were payment reform, health information technology, consumer engagement, and medical homes. The participants also identified some objectives and next steps for each of these areas. Many of the action steps in the areas of HIT, consumer engagement, and medical homes required payment reforms. The participants also called for creation of an ongoing statewide health coverage and quality advisory group to provide leadership.[3]

Based on OHQIS, Governor Strickland created the Ohio Health Care Coverage and Quality Council by Executive Order in 2009. The Ohio General Assembly codified the Council into state law.[4]

At its inception in 2009, the HCCQC created several task forces, including a Payment Reform Task Force and a Medical Homes Taskforce. It charged the Payment Reform Task Force to identify payment reform changes and strategies to foster adoption of the OHQIS recommendations in the public and private sector. Based on recommendations from these two groups, the Council invested funds to support an avoidable hospital readmission initiative and a multi-payer primary care home initiative.

The Payment Reform Task Force also concluded that these initiatives required a more concentrated discussion of payment reform options. It concluded that implementation of these options required the active engagement of all parties that such recommendations would affect. To obtain this

engagement, the Task Force decided to hold an Ohio Payment Reform Summit.

During this same time, several private sector-led initiatives also took place aimed at improving health quality and outcomes and finding ways to slow the growth of health spending. These initiatives included the following:

- Ohio Business Roundtable's roadmap for improving Ohio's health system. This report, entitled "Improving Ohio's Health System", identified 18 priority areas for reform.[5] Payment reform was identified as an important action step to advance reform in several priority areas;
- Two Robert Wood Johnson Aligning Forces for Quality demonstration projects, one in Cincinnati and one in Cleveland. Both of these projects identified the need for payment reform to make their quality improvement successes sustainable[6];
- Ohio employer health purchasing organization-led activities, such as promoting LeapfrogGroup[7] standards and participating in Bridges to Excellence[8];
- Several community-based medical home development efforts; and
- Several health plan led efforts to promote payment reform to support medical homes and pay for performance.

Why Payment Reform in Ohio?

An assumption underlying the ongoing national and Ohio health quality improvement efforts is that payment reform is needed to create incentives that reward health outcomes and efficient, effective care because the current fee-for-service system (FFS) does the opposite. That is, the current FFS system pays for volume and units of service and does not reward quality and reducing unnecessary treatment.

The impetus behind all of this work is the realization that the current way of paying for and delivering health care is: 1) not sustainable or affordable; 2) not providing the best value for consumers and employers; and 3) cannot improve quality and outcomes while slowing the rate of growth in health spending. The Ohio Business Roundtable's 2009 analysis of Ohio's health system concluded that without any changes, total health spending in Ohio will increase from $89 billion in 2006 to $200 billion by 2018. The report also concluded that a series of reforms in 18 opportunity areas could reduce spending growth, while improving outcomes, by $41 to $59 billion by 2018.[9]

Examples of opportunities to improve outcomes and appropriate use of health services in Ohio that would benefit from payment reform mentioned in the Summit's keynote presentation include:

- 68% of practices in the Cleveland area are meeting good control for high blood pressures and 82% are providing good high blood pressure care.[10] This quality of care varies between practices ranging from 46% to 80% on the good control measures and 77% to 88% on the good care measure;
- Only 9% of the Cincinnati region's patients with diabetes achieve all five goals of good care management[11];
- Ohio ranks 45th out of 50 states in people receiving care in the ER[12] , with more than 40% of these ER visits being preventable[13];
- Ohio has the 10th highest hospitalization rate in the U.S.[14];
- Ohio has the 8th highest rate of preventable hospitalizations, hospitalizations that would likely not occur if patients received appropriate ambulatory care[15];
- More than 10% of heart failure patients in Ohio do not get proper care[16]; and
- Twenty-five percent (25%) of Ohio patients who were hospitalized return to the hospital within 30 days of discharge.[17]

In addition to data from the Henry J. Kaiser Family Foundation's Statehealthfacts.org, Ohio has the 12th highest rate of hospital readmissions within 30 days of discharge for its fee-for-service Medicare patients[18].

According to the Commonwealth Fund's 2009 State Scorecard, Ohioans could live longer and spend less money if Ohio performed at the same rate as the best performing state on different measures[19]. For example, there would be:

- 44,865 fewer preventable hospitalizations for ambulatory care sensitive conditions among Medicare beneficiaries (age 65 and older) which would save $276,103,274 from the reduction in hospitalizations;
- 13,124 fewer hospital readmissions among Medicare beneficiaries (age 65 and older) which would save $162,254,116 from the reduction in hospital readmissions;
- 6,630 fewer long-stay nursing home residents being hospitalized which would save $49,213,233 from the reduction in hospitalizations;
- 4,438 fewer premature deaths before age 75; and
- 200,731 more adults (ages 18 and older) with diabetes getting all three of the recommended services (eye exam, foot exam, and hemoglobin A1c test) to help prevent or delay disease complications.

Summit Planning

To create a successful Summit, the Payment Reform Taskforce created a Summit planning workgroup that included participants representing providers, consumers, employers, and payers (see Appendix 1 for a full list of workgroup members). The Council contracted with the Government Resource Center (GRC) at the Ohio State University to assist the workgroup in developing the structure and process for the Summit. Key decisions that this group made included:

- The development of payment reform questions and policy option discussion topics (see Appendix 2 for a list of the policy options by topic area);
- The selection of the representative stakeholder groups – including providers, consumers, employers, and private and public payers, (see Appendix 3 for a list of Summit participants);
- The setting of workgroups by geographic areas (eight regional workgroups corresponding to the Medicaid managed care regions, as shown by the map in Appendix 4);
- Identification of a set of pre-reading materials for Summit participants; and
- Selection of a national payment reform expert to assist in the development of the Summit and to serve as the Summit's keynote speaker.

The group selected Harold Miller to be Ohio's national expert. Mr. Miller is the Executive Director of the Center for Healthcare Quality and Payment Reform and the President and CEO of the Network for Regional Healthcare Improvement in Pittsburgh. He also has been one of the technical assistance experts for the State Quality Improvement Initiative and has worked with several states on the issue of payment reform (see Appendix 5 for his full biography).

To ensure that the Summit had a diverse group of participants, the planning team asked different provider, consumer, payer, and employer associations to select individuals to receive an invitation to attend the Summit (see Appendix 6 for list of association asked to send recommend participants). These associations identified individuals from each of the eight regions that were familiar with the issue of payment reform and were willing to participate in the dialogue at the Summit and beyond. The associations were receptive to this request and identified the majority of the Summit's participants.

As a result, a total of 139 people participated in the Summit, including 83 providers, three individuals from existing Enhanced Primary Care Home initiatives, 16 payers, five employers, 22 consumers, and three researchers. In addition, eight people from the Council and four people from the Office of Health Plans (Medicaid) participated in the Summit.

Summit Outcomes

The Summit began with a keynote address by Harold Miller. After the keynote, the participants moved into regional discussion groups to address the two major payment reform themes of the conference and to identify potential local and state action steps. This section summarizes the major outcomes for these different activities, the challenges and opportunities identified in moving payment reform forward, findings from the online evaluations, and overall observations from the event.

Keynote Remarks

The purpose of the keynote address was to provide a common understanding of the basics of payment reform ideas to facilitate effective discussion. It is available for viewing at: (http://grc.osu.edu/projects/paymentreformsummit/presentationmaterials/index.cfm).

Major points of the keynote presentation included:

- The fee-for-service payment method prevents achieving an affordable, sustainable, quality health system because it pays for units of services, rather than outcomes, and it negatively rewards outcomes and more efficient processes;
- Payment reform can work; it is working in some existing states, communities, and organizations;
- Payment reform only works by promoting quality improvement activities;
- Only payment reform can prevent strict health care rationing and across-the-board fee cuts to reduce health spending;
- The two most promising payment reform options are: 1) episode payments when there is a hospital event; and 2) comprehensive care payments;
- Comprehensive care payments are, and need to be, different from the old form of capitation to work effectively. It is possible to retain the positive aspect of capitation, while improving on its weaknesses;
- Payment reform will be a process that will take time to complete, but it is critical to identify where we want to be in five and ten years;
- Payment reform can only work with the active engagement of providers, consumers, employers, and payers;
- Improved outcomes will require transformation in the practice of medicine. This transformation will require upfront dollars;
- Providers will need to benefit from the financial rewards that come from cost improvements;
- Providers will change how they practice for all of their patients or none of them. Therefore, for payment reform to succeed it must involve multiple payers; and
- Payment reform efforts will benefit from the leadership of an independent entity at the state and the regional levels.

Regional Discussions

The charge to the Summit participants was to consider the health care system over the next five years and identify realistic reforms that could be implemented during that time period.

The morning session focused on the theme: ***Advancing patient-centered primary care in Ohio by supporting practice transformation, including consumer engagement and the integration of behavioral health in the primary care home.***

The afternoon session focused on the theme: ***Aligning payment to achieve improved health outcomes and better value across health care settings, included but not limited to strategies such as bundled or global payments and episode of care reimbursement.***

Both sessions included four policy questions for discussion. Under each policy question the participants had three to eight policy options to consider, with the possibility of altering, combining, or creating an additional option (see Appendix 2). Appendix 7 contains a table that compares the major findings for each policy question by policy question and by region. Appendix 8 provides a summary of the general consensus for all the regions by question, outstanding issues, and any minority viewpoints. Appendix 9 lists the issues that participants raised that were put into the "Parking Lot" for consideration at a later time.

Morning Session: Advancing patient-centered primary care in Ohio

In all the regional breakout sessions, the participants actively engaged in small group discussions in order to address the first four policy questions (see Appendix 2). The major conclusions from each region on all of the questions were similar. The conclusions included:

- It is a worthwhile goal to move forward with the implementation of a patient-centered primary care home model;
- This model will require support for practice transformation and an emphasis on team-based care;
- Practices will need a change in payment to support this practice transformation;
- The five year goal should be to modify primary care payment toward either the option to pay the primary care home a large monthly care management payment for certain patients in lieu of most fees with a requirement to meet specific results (1.4), or the option to pay the primary care home a monthly per-patient, severity-adjusted partial comprehensive care payment to cover the costs of all outpatient services with the home being required to reduce the rate of hospitalization below specified targets (1.5);
- Because it will take time for the health care system to incorporate payment options 1.4 or 1.5, the groups concluded that it would be good to begin with either the option to pay the primary care home a small monthly care management payment for certain patients to primary care homes that meet accreditation standards (1.2), or preferably the option to pay the primary care home a large monthly care management payment for certain patients with a reduction in individual service fees and pay-for-performance bonuses rather than for meeting accreditation standards (1.3);
- The care management payments should be made for all patients on a risk-adjusted basis because:
    - Providers who change their practice will change it for all patients or none;
    - Everyone can benefit from a level of care management, from a low level management to help someone maintain their health, to a moderate level of management to keep someone at the low level of a chronic condition, to a higher level of care management for someone with multiple conditions or a severe case of a chronic condition; and
    - Providing care management to all patients reinforces its importance and value.

- The risk adjustment factor should include geographic and socio-demographic factors, along with clinical risk factors;
- Consumer engagement is critical to effective health outcomes, but there was no one best policy option among the choices;
- Patient cost sharing and incentives should encourage patients to use their primary care home, including medications and other treatments prescribed to help them manage their health conditions (options 3.3, 3.6, and 3.7);
- The integration of behavioral and physical health does not work well in today's payment structure and needs to occur, though there was not one best policy option among the choices;
- Payment for telemedicine is important (option 4.8), but not sufficient to achieve integration of behavioral and physical health care;
- Payment to the primary care home should cover the costs for behavioral health providers needed to serve the primary care home's patients;
- The primary care home for patients with severe mental disorders should be the behavioral health provider, with integration support from physical health providers; and
- Co-location of behavioral health and physical health providers is a worthy goal.

The groups did not reach consensus on a couple of consumer engagement issues, including:

- Whether patients should have to pay a higher fee for using the emergency department, especially if their primary care provider sent them there for care;
- Whether patients should be required to select a primary care provider or pay a penalty for changing primary care providers (PCPs) more than once during a year; and
- Whether compelling patients to pick a primary care provider undermines their support and engagement for the primary care health home.

Afternoon Session: Aligning payment across health care settings

Similar to the morning session, participants actively engaged in their regional small discussion groups to address the last four payment policy questions (see Appendix 2). The major conclusions from each region on all of the questions were similar. The conclusions included:

- Regarding payment reform for major acute care of patients, the groups supported the policy option which would create a single, prospectively-defined payment to cover the cost of hospital care, all physician and health care practitioners involved in the patient's care in the hospital, and any short-term care following discharge (1.6);
- Some participants in two of the regions expressed concern about the ability to align all providers together as called for under this payment approach and how to assure a fair distribution of the payment to all parties involved in the provision of care;
- Because it will take time to move to option 1.6, the groups supported starting with the option to pay hospital, physicians, and other health care practitioners separately with hospital having the ability to make additional payments to specific providers if they help the hospital reduce its cost or improve quality (1.3);
- Many groups suggested that a possible starting place for acute care payment reform could be to focus on high volume services or conditions identified by the Geisinger Health System model[20];
- All the regions support the need for greater transparency, public reporting, and peer reporting to promote the desired outcomes from this payment reform. This transparency would provide patients, providers, payers, and employers with better information from which to make care selection choices;

- Regarding payment for preventable adverse events, the groups supported, for those events that truly should never happen, the option that providers should get no additional payment for care needed to address such a preventable event (2.3);
- Group discussions did insist on the need of creating a clear definition of the exact events that fall under this designation;
- For those events that should occur at lower rates, the groups supported the policy that would pay providers for the additional costs of treating a preventable adverse event, but they should receive bonuses or penalties based on the rate at which such adverse events occur (2.2);
- All the regions struggled to find an acceptable payment strategy for hospitals related to paying for care when patients need to be readmitted shortly after discharge, though they generally agreed there needed to be some payment reform to address this issue. The group discussion raised the following issues:
    - How to actually determine what is an avoidable readmission;
    - Many readmissions, up to one-third according to one payer, are to different hospitals. Therefore, the groups wondered how can one punish this new hospital when it was not part of the original care; and
    - Avoidable hospital readmissions often relate to challenges with the transition of care for a patient from one setting to another. Given that many different organizations are part of that transition, the groups questioned how best to promote effective transitions and how to determine who to hold accountable.
- On how to pay physicians when patients needed to be readmitted after discharge, seven of the eight regions agreed with the use of financial bonuses or penalties to the patient's medical home based on the home's overall rate of hospital readmission (4.8).

Afternoon Session: Local and State Action Steps

The last step of the afternoon session was to identify at least one regional and one state action step to move payment reform forward. The table in Appendix 8 also contains the identified local and state action steps by each region.

Local action steps

The regional groups identified two consistent action steps mentioned across the regions were:

- Share the Summit results with peers, patients, and local organizations; and
- Begin or continue local conversations to move payment reform and delivery system reform forward at the local level, potentially leading to the creation of regional collaboratives.

Different regional groups identified some additional local action steps, including:

- Create more local public reporting;
- Raise awareness with employers on the importance of payment reform;
- Get more consumer engagement in what they want from a medical home;
- Identify sources of start up funds to help practices with practice transformation;
- Move forward on getting electronic connectivity for exchange of health information; and
- Get more provider participation in local patient centered medical home efforts.

State action steps

The regional groups identified five state action steps, including:

- Continue state leadership under the direction of incoming Governor John Kasich, on the issues of health system reform, including payment and delivery system reform;
- Bring all payers together to create a common approach to payment reform and medical homes;
- Ensure active, engaged Medicaid participation in multi-payer payment reform, medical home, and health information technology initiatives;
- Continue to convene stakeholders at the state level; and
- Assist local areas without existing regional meetings to convene such meetings, while continuing to help those areas where such meetings are already taking place.

The earlier regional group discussions also identified one other commonly called for state action step. That action step was to create more transparency and public reporting to assist consumers, providers, payers, and employers with health care decisions.

Different regional groups identified some other potential state action steps, including:

- Continue the work of the Ohio Health Information Partnership (OHIP) to increase the adoption of electronic health records (EHRs) and electronic connectivity to foster health information exchange (HIE);
- Push for standardization across regions for certain activities, such as public reporting;
- Consider the need for a greater state role to push forward change; and
- Provide advice and assistance to reduce any anti-trust concerns over local meetings that bring together stakeholders to discuss these issues.

Challenges for Payment Reform

The regional discussions raised several concerns and needs related to achieving payment reform. The participants agreed that these concerns and needs do not change the necesity for payment reform. However, they are issues that payment reform efforts must take into consideration and work to overcome. Efforts that need to be taken into account include:

- Consumers and providers need to be engaged in payment reform and delivery system reform development: Participants with experience from earlier managed care and cost containment efforts cautioned that those efforts failed in part because consumers did not accept the requirements and providers did not find the reforms easy to implement. Therefore, they advise that this effort must include consumers and providers in the design of the reforms to increase their acceptance and feasibility to adopt (as was demonstrated at the Summit);
- Health plans face a free rider problem: Because providers are going to change their entire practice or not at all, health plans worry about a free rider problem related to payment reform. These health plans note that some payers, especially self-insured plans, will benefit from practice changes created by payment reforms from a few plans. This concern could lead even the most forward thinking payer to resist being a leader in making payment reform changes where they would pay the entire or major cost for the changes and other payers would benefit from the changes without investing any money into the changes;
- Change the practice for all or for none: Providers noted that they only will run their practice in one way. The practices need payment changes for enough of their patients to make it worth their while to transform their practice. Therefore, they need multiple payers to participate in payment reform or it will not work;
- Multi-payer approach needed: The providers need a common, consistent payment reform approach to make it easier to transform their whole practice;
- Role of Medicare: Participants noted that Medicare is an important payer outside of the control of state government and regional efforts. They also pointed out that Medicare has yet to decide if it wants to support the medical home approach. For practices that see Medicare patients, these patients are often a high user of their services. Therefore, Medicare needs to be part of the common payment reform solution;
- Providers are at different points of readiness for practice change: The participants pointed out that there is great variability in the ability of providers to make practice changes today. This variability speaks to the reality that payment reform will need to occur overtime and at different a pace for different providers;
- Payers need to agree on what they want to pay for first: One payer participant noted that during payment reform discussion with providers, one provider kept asking what payers wanted to pay for. This person realized that it is essential to make that decision and then build a reformed payment approach. He suggested that what payers, consumers, and employers should want is a payment approach that engages patients and providers, improves quality, improves health outcomes, and is self sustaining;

- Providers need up front dollars and technical assistance: Provider participants argued that practice transformation requires up front investments, including the need for technical assistance on how best to do practice transformation. Providers will also need training on how to provide open access to patients and tools, such as patient registries. Many providers lack the capital to finance those investments. Therefore, they want payment reform to include such financial support;
- Electronic health records must have the tools to support practices in meeting new practice expectations: Practice transformation will require the use of electronic health records (EHRs). However, EHRs vary in their tools and support for achieving some of these expectations. Therefore, providers need OHIP, HealthBridge and the other regional extension centers to identify EHRs that will work for medical homes and other emerging practice expectations;
- Anti-trust challenges to regional payment reform discussions: Harold Miller advised that regional groups can meet around the issue of payment reform as long as the meetings do not discuss specific amounts that payers will pay for services. Mr. Miller will provide additional information that the regions can review on this issue. He noted that an advantage of having a state-led group is that it can discuss issues that others cannot discuss;
- Improved health outcomes is a team sport: As the participants discussed different health delivery issues, such as avoidable hospital readmissions or integration of behavioral and physical health, they noted that the solution to these issues requires much better coordination across all health care settings, more inclusion of community-based resources, and a more team and systems-based approach. They noted that this way of practicing health care requires a major change in approach, from an individual orientation to a team orientation. However, current payment approaches reward the individual approach and punish the team approach; and
- What works in urban areas may not work in rural areas: Many participants expressed concern about the ability of rural areas to meet the expectations of payment and delivery system reform. They cautioned that designers of these reforms need to consider how to tailor them to the geographic realities of different parts of Ohio.

While the Summit participants raised these challenges, they did not see them as insurmountable. The reality that some Ohio payers are already doing payment reform pilots demonstrated that it is possible to address many of these challenges.

Conclusions and Next Steps

Based on the output generated by the Summit participants, the evaluation responses, and statements by participants after the Summit, the Summit did meet its goals. For example, over 85% of participants rated their overall satisfaction with the Summit at an 8 or above (on a scale of 1-10). Appendix 10 provides the complete evaluation results for each question. In addition, Summit participants who also participated in the December meetings of the Payment Reform Task Force, the Enhanced Primary Care Management Steering Committee, and the Council underscored the value and success of the Summit and its ability to advance payment reform forward in Ohio.

The following are a set of overall conclusions that came out of this Summit:

- Participants were engaged and wanting action with over 80% wanting to get together with others within their region and also with wanting to meet again with other Summit participants to work on payment reform;
- While the Summit was a great success, participants need to see concrete action steps in the future or momentum and willingness to meet will go away;
- Over 70% of participants expect and believe that payment reform is coming and is possible within their region;
- Participants need and want state leadership to continue at same or a greater level;
- Participants strongly supported the need to move from fee-for-service system to an alternative way of payment, but they are unclear on how to make this change. Almost 40% of the evaluation respondents reported being uncertain about the next steps to move payment reform forward;
- Provider engagement is essential. That participation requires that providers benefit from cost improvements or they will be unlikely to participate in the changes. Only half of practitioners reported on their evaluations that they agreed or strongly agreed that they change their practices;
- Consumer engagement is also essential. Consumers want and need to be actively engaged in development of activities to ensure that reforms will work for consumers;
- More employer participation is needed in future meetings;
- Regional collaborative efforts got support, but may require state assistance in getting going, such as in Northwest Ohio;
- Strong endorsement for integrating behavioral health and physical health care through payment reform;
- Strong agreement that there is a need and ability to reduce preventable hospital readmissions, though these actions require payment reforms;
- Strong agreement that providers should not get additional payments for costs associated with clearly preventable adverse events and the consumer should get no additional charges for such work;
- Strong support for greater transparency and public reporting; and
- Strong agreement on need for effective risk adjustment for payment incentives.

The work on payment reform will not end with the Summit. As noted in the evaluations, the participants want this work to continue. The immediate next steps include to:

- Share this report with a workgroup of people from the Council's Payment Reform Taskforce and Enhanced Patient Centered Home Steering Committee to build upon the Summit results and propose specific action steps for regions and for the state. One possible action step could be to host additional learning sessions related to payment reform, such as hearing from states, regions, or practice organizations that are successfully moving forward with payment and delivery reforms;
- Include the report in the transition materials for the incoming Kasich Administration related to health care reform;
- Share the report with members of the Ohio General Assembly;
- Share participant contact information with all Summit participants to facilitate continuing regional meetings; and
- Share the report with all Summit participants so that they can build upon the agreements and discussions they had at the Summit and so they can share the information with their peers and other people in their regions.

End Notes

[1] Covering Ohio's Uninsured: The SCI Team's Final Report to Governor Ted Strickland. July 2008. http://www.insurance.ohio.gov/Legal/Reports/Documents/SCIReportFINAL.pdf

[2] More information on the national State Quality Institute Initiative is available on AcademyHealth's website at: http://www.academyhealth.org/Programs/ProgramsDetail.cfm?ItemNumber=3148&navItemNumber=2502

[3] The Ohio Health Quality Improvement Plan: An Action Plan based on the Recommendations of the Ohio Health Quality Improvement Summit is available at http://ah.cms-plus.com/files/SQII/OHQIPFinal.pdf

[4] More detailed information about the Ohio Health Care Coverage and Quality Council, including links to the Executive Order and Statute creating the Council, are available on the Council's website at: http://www.hccqc.ohio.gov/pages/hccqcabout.aspx

[5] The Ohio Business Roundtable's full report, Improving Ohio's Health System, is available online at: http://www.ohiomeansbusiness.com/docs/OBRT_Health_Report.pdf

[6] The Robert Wood Johnson's Aligning Forces for Quality (AF4Q) initiative is operating in 17 communities across the country, including Cincinnati and Cleveland. For more information on the AF4Q initiative go to: http://www.rwjf.org/qualityequality/af4q/about.jsp. For information on the Cincinnati project go to: http://www.rwjf.org/qualityequality/af4q/communities/cincinnati.jsp or http://www.the-collaborative.org/AligningForcesforQuality/tabid/926/Default.aspx. For information on the Cleveland project go to: http://www.rwjf.org/qualityequality/af4q/communities/cleveland.jsp or http://www.betterhealthcleveland.org/

[7] The LeapfrogGroup is a voluntary program aimed at mobilizing employer purchasing power to alert America's health industry that big leaps in health care safety, quality and customer value will be recognized and rewarded. Among other initiatives, Leapfrog works with its employer members to encourage transparency and easy access to health care information as well as rewards for hospitals that have a proven record of high quality care. More information on the LeapfrogGroup is available at http://www.leapfroggroup.org/

[8] Bridges to Excellence programs recognize and reward clinicians who deliver superior patient care. Physicians, nurse practitioners and physician assistants who meet its performance benchmarks can earn a range of incentives, sometimes including substantial cash payouts. Insurers and employers fund these payouts from the savings they achieve through lower health care costs and increased employee productivity. For more information about Bridges to Excellence go to: http://www.bridgestoexcellence.org/

[9] Ohio Business Roundtable. Improving Ohio's Health System. March 2009. page 103.

[10] Data on high blood pressure in the Cleveland area comes from Better Health Greater Cleveland's website at: http://www.betterhealthcleveland.org/Systems-and-Practices/High-Blood-Pressure-Practice-Comparison.aspx

[11] From the Health Improvement Collaborative of Greater Cincinnati's YourHealth Matters initiative, "Understanding diabetes performance scores" at http://yourhealthmatters.org/search_practices.php

12 From the Henry J. Kaiser Family Foundation's Statehealthfacts.org website. Hospital Emergency Room Visits per 1,000 Population, 2008 at http://www.statehealthfacts.org/comparebar.jsp?yr=63&typ=1&ind=388&cat=8&sub=94&rankbyind=1&o=a

13 Data calculated by Harold Miller from FFY 2009 Medicaid claims and for his keynote presentation for the Ohio Payment Reform Summit, December 4, 2010, slide 16. http://grc.osu.edu/projects/paymentreformsummit/presentationmaterials/index.cfm

14 From the Henry J. Kaiser Family Foundation's Statehealthfacts.org website. Hospital Admissions per 1,000 Population, 2008 at statehealthfacts.org/comparebar.jsp?yr=63&typ=1&ind=386&cat=8&sub=94&rankbyind=1&o=a

15 Data from America's Health Rankings Ohio 2010 at http://www.americashealthrankings.org/yearcompare/2009/2010/OH.aspx

16 Data calculated by Harold Miller from the Hospital Compare dataset for his keynote presentation at the Ohio Payment Reform Summit, December 4, 2010, slide 19. http://grc.osu.edu/projects/paymentreformsummit/presentationmaterials/index.cfm

17 Data calculated by Harold Miller from Hospital Compare dataset for his keynote presentation at the Ohio Payment Reform Summit, December 4, 2010, slide 20. http://grc.osu.edu/projects/paymentreformsummit/presentationmaterials/index.cfm

18 From the Henry J. Kaiser Family Foundation's Statehealthfacts.org website. Medicare Fee-for-Service Patients who were Rehospitalized within 30 Days after Hospital Discharge, 2004 at http://www.statehealthfacts.org/comparebar.jsp?typ=2&ind=688&cat=6&sub=80&cha=1563&o=a

19 Ohio data comes from The Commonwealth Fund's 2009 State Scorecard Ohio section at http://www.commonwealthfund.org/Maps-and-Data/State-Scorecard-2009/DataByState/State.aspx?state=OH

20 The Geisinger Health System calls its model Geisinger Health System ProvenCareSM It consists of a single payment for an entire 90 day period including: all related pre-admission care; all inpatient physician and hospital services; all related post-acute care; and all care for any related complications or readmissions. It offers this payment method for the following eight types of conditions/treatments: Cardiac Bypass Surgery; Cardiac Stents; Cataract Surgery; Total Hip Replacement; Bariatric Surgery; Perinatal Care; Low Back Pain; and Treatment of Chronic Kidney Disease (from Harold Miller's keynote presentation, slide 24).

Appendix

Appendix 1: HCCQC Payment Reform Summit Planning Committee

Ohio | Ohio Health Care Coverage and Quality Council

Ted Strickland, Governor
Mary Jo Hudson, Council Chair / Director, Ohio Department of Insurance
Cynthia Burnell, Executive Director, OHCCQC

50 West Town St
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Payment Reform Summit Planning Group
Member List

Col Owens
Senior Attorney
Legal Aid Society of Southwest Ohio, LLC

Carrie Haughawout
Director, Ohio Small Business Council
Ohio Chamber of Commerce

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Assistant to the President for Public Policy
MetroHealth Medical Center

Kelly McGivern
President and CEO
Ohio Association of Health Plans

Sean McGlone
Associate General Counsel and Director of Health Policy
Ohio Hospital Association

Michael Bird
Vice President for Medical Services, Patient Safety Officer, Akron Childrens Hospital

Ann Spicer
Executive Vice President
Ohio Association of Family Physicians

Ted Backus
Vice President & Chief Operating Officer
Health Policy Institute of Ohio

Angie Bergefurd
Assistant Deputy Director and Chief
Office of Medicaid

Cathy Levine
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UHCAN Ohio

Christine Williams
The Ohio Association of Advanced Practice Nurses

D. Brent Mulgrew
Executive Director
Ohio State Medical Association

Lisa Bateson
Director of Government Relations
Anthem Blue Cross & Blue Shield of Ohio

Ernest Boyd
Executive Director
Ohio Pharmacists Association

Debbie Saxe
Office of Health Plans
Ohio Department of Job and Family Services

Martin McGann
Director Government Relations
Cleveland Clinic

Jerry Friedman
Advisor for Health Policy &
Director, External Relations & Advocacy
The Ohio State University Medical Center

Kyrsten Chambers
Staff Member
Health Care Coverage and Quality Council

Appendix 2: Policy Questions and Policy Options

Ohio Health Care Coverage and Quality Council
Payment Reform Summit Goals and Work Group Discussion Topics

I. Goals of the Summit

The HCCQC Payment Reform Summit will bring together health system payers (public/private), providers, employers and consumers for a day-long discussion of health care payment reform. Through regional work groups, participants will consider payment reform strategies to improve quality and cost, identify challenges, and assist in designing a process for payment reform. The participants will identify potential payment and delivery reforms that they could pursue in their own communities as well as produce recommendations for review and further action by Ohio's Health Care Coverage and Quality Council to support reform efforts across the state. The HCCQC Payment Reform Summit will focus on action steps to reform payment to encourage the effective use of patient-centered primary care homes and services, improve the coordination of care, and avoid preventable utilization of more intensive or duplicative services.

Using specific questions and options, work group discussions will focus on:

- Advancing patient-centered primary care in Ohio by supporting practice transformation, including consumer engagement and the integration of behavioral health in the primary care home;
- Aligning payment to achieve improved health outcomes and better value across health care settings, including but not limited to strategies such as bundled or global payments and episode of care reimbursement.

II. Work Group Session #1 Discussion Focus:

Advancing patient-centered primary care in Ohio by supporting practice transformation, including consumer engagement and the integration of behavioral health in the primary care home.

1. What modifications to the fee-for-service payment system for primary care will be most effective in advancing patient-centered primary care in Ohio and supporting of practice transformation? (Choose one of the options below.)

1.1 Separate fees should continue to be paid for all services delivered by primary care practices that are separately defined under the Medicare fee schedule (CPT4+HCPCs). Evaluation and management (E&M) fee levels should be increased and new service fee codes should be added in order to (1) enable primary care providers to spend more time counseling patients; (2) compensate primary care providers for time spent responding to patient phone calls, coordinating with specialists, etc.; and (3) pay for non-physicians to provide patient education and self-management support. The primary care home would receive pay-for-performance bonuses based on performance on quality measures for care of patients.

1.2 The primary care home should be paid under the current fee-for-service structure, but it should also receive a small monthly care management payment for certain types of patients (see issue group 2) to provide flexible funds that the medical home can use for services that are not covered by fees, or to enable the primary care provider to spend more time with patients than fee levels would justify. Primary care homes should meet accreditation standards in order to receive the care management payment.

1.3 The primary care home should be paid a large monthly care management payment for certain types of

patients to cover the costs of all services the practice provides to those patients (e.g., primary care provider visits, screenings, immunizations, etc.). Fees paid for individual services to those patients would be significantly reduced or eliminated, such that the practice is receiving equivalent or slightly higher revenue than in the past, but in a more predictable and flexible fashion. Pay-for-performance bonuses would be paid based on the primary care home's performance on measures of the quality of care given to the patients, rather than on accreditation standards.

1.4 The primary care home should be paid a large monthly care management payment for certain types of patient in place of most or all fees, as in option 1.3. However, in addition, the primary care home should be required to reduce the rate of non-urgent ER visits, ambulatory care sensitive hospitalizations, and/or high-tech diagnostic imaging for those patients below specified target levels; if it did not achieve the target levels, its care management payment would be reduced; if it exceeded target levels, it would receive an increase in the care management payment. In addition, pay-for-performance bonuses would be paid based on the primary care home's performance on measures of the quality of care for those patients.

1.5 The primary care home should be paid a monthly per-patient partial comprehensive care payment to cover the costs of all outpatient services needed by certain types of patients, whether the services are provided by the practice itself or by other providers, e.g., diagnostic testing, specialty consultation, and outpatient procedures. The amount of the payment would be condition/severity adjusted, i.e., the payment would be higher for a patient with more severe conditions or multiple health conditions. Hospital costs and other institutional care (e.g., long-term care or inpatient rehabilitation) would be paid separately, but the primary care home would be required to reduce the rate of hospitalizations for the patients below specified target levels; if it did not achieve the target levels, its comprehensive care payment would be reduced; if it exceeded target levels, it would receive an increase in the payment. In addition, pay-for-performance bonuses would be paid based on the primary care home's performance on quality measures for care of the patients.

1.6 The primary care home should be paid a monthly per-patient comprehensive care payment to cover the costs of all services needed by certain types of patients, including both outpatient care and hospitalizations. The amount of the payment would be condition/severity adjusted, i.e., the payment would be higher for a patient with more severe conditions or multiple health conditions, and there would be a cap on how much the primary care home would required to spend on any one patient. In addition, pay-for-performance bonuses would be paid based on the primary care home's performance on quality measures for care of patients.

1.7 Other: _____

2. For which patients should care management payments be paid? (Choose one of the options below.)

2.1 The care management payment should be paid for all patients seen by the primary care practice.

2.2 The care management payment should only be paid for patients with chronic diseases.

2.3 The care management payment should be paid for patients who are identified by a health plan as being at risk for high utilization of services.

2.4 Other: _____

3. What changes in benefit structures are needed to enable/encourage patients to better manage their

health conditions? (Choose one of the options below.)

3.1 Patients should be required to designate a primary care provider as their primary care home, but should be permitted to switch primary care providers as often as necessary.

3.2 Patients should be required to pay a one-time fee for switching primary care providers more frequently than once per year unless there are appropriate justifications (e.g., a change in the consumer's residence or the provider's location, poor quality ratings of the provider, etc.)

3.3 Patients should have low or zero copayments/co-insurance for visits to their primary care home.

3.4 Patients should be required to pay a greater share of the cost of their care (e.g., through higher cost-sharing for hospitalizations) if they do not select a primary care home or otherwise use a consistent provider for their care.

3.5 Patients should be required to pay more to go to emergency rooms for non-urgent care they could have received from their primary care home.

3.6 Patients should have low or zero copayments for medications and other treatments (e.g., cardiac rehabilitation) their primary care home prescribes to help them manage their conditions.

3.7 Patients should receive financial incentives (e.g., reduced insurance premiums or cash awards) for improving their health and adhering to treatment plans developed with their primary care home.

3.8 Other: _____

4. What payment structure will best support the integration of physical and behavioral health services? (Choose one of the options below.)

4.1 A separate fee should be paid to the primary care providers for behavioral health screening, including screening for depression, anxiety, and substance use disorders.

4.2 A practice should be required to perform behavioral health screening if it receives a care management payment under issue 1.

4.3 A separate evaluation and management fee should be paid to a primary care practice for an extended visit for diagnostic assessment and treatment (including counseling and medication therapy) for behavioral health care.

4.4 The care management payment should be increased for patients who test positive on the behavioral health screening instrument.

4.5 For individuals who require specialized behavioral health care, a fee should be paid to the behavior health provider to coordinate care with the patient's primary care home.

4.6 Licensed or certified practitioners, including psychiatrists, psychologists, psychiatric nurse practitioners, clinical social workers, and pharmacists should be paid for their services through the enhanced primary care home.

4.7 Enhanced primary care homes and behavioral health providers should each receive bonuses/penalties based on the rate of ED visits and inpatient hospitalizations.

4.8 Payment should be provided for telemedicine services between psychiatrists and enhanced primary care homes in underserved areas.

4.9 Other: _____

III. Work Group Session #2 Discussion Focus:

Aligning payment to achieve improved health outcomes and better value across health care settings, including but not limited to strategies such as bundled or global payments and episode of care reimbursement.

1. How should hospitals, physicians and other health care practitioners, be paid for major acute care of patients? (Choose one of the options below.)

1.1 Hospitals, physicians, and other health care practitioners involved with hospital care should continue to be paid separately, as they are today.

1.2 Hospitals, physicians and other health care practitioners involved with hospital care should continue to be paid separately, but each should receive incentive payments from health plans based on the total cost of their services for individual episodes compared to other providers.

1.3 Hospitals, physicians and other health care practitioners should continue to be paid separately, but hospitals should have the ability to make additional payments to specific providers if they help the hospital reduce its costs or improve quality ("gain-sharing").

1.4 A single prospectively-defined payment (a "bundled DRG payment") should be made to cover the cost of hospital care and the services of the physician managing the patient's care in the hospital, but other consulting physicians (e.g., anesthesiologists, consulting specialists) and other health care practitioners should continue to be paid fees separately. Additional outlier payments should be made for patients who require an unusually high number of hospital or physician services.

1.5 A single, prospectively-defined payment should be made to cover the cost of hospital care and the services of all physicians and health care practitioners involved in the patient's care in the hospital. Additional outlier payments should be made for patients who require an unusually high number of hospital or physician services.

1.6 A single, prospectively-defined payment should be made to cover the cost of hospital care, all physicians and health care practitioners involved in the patient's care in the hospital, and any short-term care following discharge (e.g., home health care, rehabilitation, etc.). Additional outlier payments should be made for patients who require an unusually high number of hospital, physician, or post-acute care services.

1.7 Other: _____

2. How should hospitals, physicians and other health care practitioners be paid when preventable adverse events (e.g., hospital-acquired infections, medical errors, etc.) occur during major acute care? (Choose one of the options below.)

2.1 Hospitals, physicians, and other health care practitioners should be paid for the additional costs of treating a preventable adverse event which occurs during care of patient, but the rate at which such adverse events occur should be reported publicly to encourage patients to use higher-quality providers.

2.2 Hospitals, physicians, and other health care practitioners should be paid for the additional costs of treating a preventable adverse event which occurs during care of patient, but the hospital, primary care provider and health care practitioner involved in the adverse event should receive bonuses or penalties based on the rate at which such adverse events occur.

2.3 No additional payment should be made for care needed to address a preventable adverse event (i.e., the payment to the hospital/primary care provider/health care practitioner would include an "inpatient warranty"). (If providers are paid separately, those not involved in the care leading up to the adverse event who are needed to treat the result of the adverse event would still be paid.)

2.4 Other: _____

3. How should hospitals be paid when patients need to be readmitted after discharge? (Choose one of the options below.)

3.1 Hospitals should be paid for treating a patient during a readmission, but the rate at which readmissions occur for reasons similar or related to the initial admission should be reported publicly to encourage hospitals to reduce such readmissions and to encourage patients to use hospitals with lower rates of readmissions.

3.2 Hospitals should be paid for treating a patient during a readmission, but the hospital should receive financial bonuses or penalties based on the rate of readmissions for reasons similar or related to the initial admission.

3.3 Hospitals should receive a reduced payment for treating a patient who is readmitted within 30 days for reasons similar or related to the initial admission.

3.4 No additional payment should be made to hospitals for treating a patient who is readmitted within 30 days for reasons similar or related to the initial admission.

3.5 No additional payment should be made to hospitals for treating a patient who is readmitted within 30 days for reasons similar or related to the initial admission, but the payment for the initial admission should be increased to reflect the fact that not all readmissions can be prevented.

3.6 Hospitals should be paid for treating a patient during a readmission, but the hospital's payment for the original admission should be retroactively reduced if the patient is readmitted within 30 days for reasons similar or related to the initial admission.

3.7 Other: _____

4. How should physicians be paid when patients need to be readmitted after discharge? (Choose one of the options below.)

4.1 Physicians should be paid for treating a patient during a readmission, but the rate at which readmissions occur for reasons similar or related to the initial admission should be reported publicly to encourage physicians

to reduce such readmissions and to encourage patients to use physicians with lower rates of readmissions.

4.2 Physicians should be paid for treating a patient during a readmission, but the physicians should receive financial bonuses or penalties based on the rate of readmissions for reasons similar or related to the initial admission.

4.3 Physicians should receive a reduced payment for treating a patient who is readmitted within 30 days for reasons similar or related to the initial admission.

4.4 No additional payment should be made to physicians treating a patient who is readmitted within 30 days for reasons similar or related to the initial admission.

4.5 Physicians who treated the patient during their initial stay should not receive any additional payment for treating a patient who is readmitted within 30 days for reasons similar or related to the initial admission.

4.6 No additional payment should be made to physicians for treating a patient who is readmitted within 30 days for reasons similar or related to the initial admission, but their payment for the initial admission should be increased to reflect the fact that not all readmissions can be prevented.

4.7 Physicians should be paid for treating a patient during a readmission, but the physicians' payment for the original admission should be retroactively reduced if the patient is readmitted within 30 days for reasons similar or related to the initial admission.

4.8 The patient's medical home should receive financial bonuses or penalties based on the rate of readmissions for reasons similar or related to the initial admission.

4.9 Other: _____

Appendix 3: Summit Participants

Central Region

Facilitator: Deb Helber deb@dhelber.com		
Steven	Atwood	Southeast, Inc.
Joan	Beitman	Ohio State University Medical Center
Jeff	Biehl	Access HealthColumbus
Ernest	Boyd	Ohio Pharmacists Association
William	Cotton	Nationwide Children's Hospital
Robin	Dawson	Medical Mutual
Steven	Gabbe	Ohio State University Medical Center
Sky	Gettys	Fairfield Medical Center
Charles	Hickey	Columbus Ophthalmology Associates Inc.
Linda	Hondros	Hondros College
Bobby	Jones	CareSource
Eugene	King	Ohio Poverty Law Center
Christine	Kozobarich	Service Employees International Union 1199
Clint	Kuntz	Fairfield Community Health Center
Janice	Lanier	Private Contracting
Cathy	Levine	Universal Health Care Action Network Ohio
Chris	Moore	Ohio Dental Association
Brian	Pack	Ohio Public Employee Retirement System
David	Paugh	Berger Health System
Patrina	Queen	Southeastern Ohio Legal Services
Sarah	Sams	Private Practice
Richard	Snow	Ohio Osteopathic Association
Victor	Trianfo	Memorial Hospital of Union County
Judy	Tse	Ohio Department of Administrative Service
Jon	Wills	Ohio Osteopathic Association
Mel	Bourkin	Ohio Medicaid
Jerry	Friedman	Ohio State University Medical Center

East Central Region

Facilitator: Maurice Stevens stevens.368@osu.edu		
Marie	Curry	Community Legal Aid Services, Inc.
Jennifer	Dwyer	Akron Children's Hospital
Matt	Fettman	Davies Drugs Pharmacy
Patricia	Galon	University of Akron
Janet	Grant	CareSource
Martin	Hauser	SummaCare
Doreen	Kuster	Child Guidance and Family Solutions
Joe	Novak	AultCare
Joan	Picone	American Cancer Society
Jon	Seager	Private Practice
Tim	Teynor	Aultman Hospital

Eugene	Thorn	Union Hospital
Julie	Tome	Anesthesia Associates of Mansfield Inc.
Annette	Welker	Ohio Association of Advanced Practice Nurses
Kara	Williams	Ohio State Legal Services Association
Mark	Wright	Aultman Hospital
Doug	Anderson	Ohio Department of Insurance

Northeast Region

Facilitator: Tuesday Ryan-Hart
Tuesday@tryanhart.com

Randy	Runyon	Ohio CHC
Gary	Benjamin	UHCAN Ohio
Karen	Butler	Health CMR
Brent	Carson	University Hospitals Case Medical Center
John	Corlett	MetroHealth System
Peter	DeGolia	Center for Geriatric Med. / University Hosp.
Andrew	Garner	University Hospital/ case western
Jeff	Harwood	New London Family Practice LLC
Mary	Hull	Center for Families and Children
Teresa	Koenig	SummaCare
Christopher	Loyke	Private Practice
Martin	McGann	Cleveland Clinic
Deborah	Nebel	LEAP
Don	Pirc	Medical Mutual of Ohio
Mark	Rood	South Russell Family Practice Inc.
J.B.	Silvers	Case Western Reserve University
Jean	Therrien	Neighborhood Family Practice
Jay	Timm	Aetna
Susan	Tullai-McGuinness	Case Western Reserve University
William	Watson	WellCare
Howard	Waxman	General Podiatric Medicine
Christine	Williams	Metrohealth Hospital System/ OAAPN
James	Misak	Case Western Reserve University
Diane	Solov	Better Health Greater Cleveland
Debbie	Saxe	Ohio Medicaid
Teresa	Koenig	SummaCare

Northeast Central Region

Facilitator: Amy Watson

Charles	Alderson	Wadsworth-Rittman Hospital
Jeffrey	Corzine	Unison
Douglas	Harley	Akron General
Lon	Herman	Northeastern Ohio Universities College of Medicine
Melissa	Long	Alliance for Retired Americans
Martin	McGann	Cleveland Clinic Foundation

Jim	Porterfield	Venture Practice Services
Cathy	Saluga	Humility of Mary Health Partners
Mike	Sevilla	Private Practice
Patty	Starr	Council of Smaller Enterprises
Marianne	Steger	AFSCME 8
Linda	Warino	District 3-Ohio Nurses Association
Michael	Winiarski	East Liverpool City Hospital
Ken	Frisof	MetroHealth System
Joshua	Anderson	Ohio Medicaid

Northwest Region

Facilitator: Malcolm Porter malcolmjporter@aol.com		
David	Amerine	Buckeye
Robert	Applebaum	Miami University of Ohio
Berna	Bell	Ohio Hospital Association
Ken	Bertka	Private Practice
Kathryn	Boehm	Adolescent and Young Adult Health Service
Ken	Erdmann	IBEW
Timothy	Gaspar	University of Toledo
David	Koeninger	Advocates for Basic Legal Equality, Inc.
Russell	Korb	Paramount
Jennifer	Moses	Zepf Center
Randall	Myers	Harry's Pharmacy
Emilie	Owens	Area Office on Aging of NWO
Cliffton	Porter	Provider
Mark	Ridenour	Ohio State University Medical Center
Richard	Shonk	United
Janis	Sunderhaus	Health Partners of Western Ohio
Craig	Warren-Marzola	Provider
Hubert	Wirtz	The Ohio Council of Behavioral Health and Family Services Providers
Linda	Young	Provider
Marc	Molea	Ohio Department of Aging
Joseph	Doodan	Ohio Medicaid

Southeast Region

Facilitator: Phil Cass pcass@goodhealthcolumbus.org		
Catherine	Bishop	Private Practice
Robin	Bozian	Voices for Ohio's Children
Mark	Bridenbaugh	Family Healthcare, INC
Amy	Clubbs	Molina
Sandy	Erb	Voices of Ohio's Children
Larry	Kidd	Reliable Staffing Services, LLC
Jacqueline	Lather	Provider
NEAL	NESBITT	Provider
Robbin	Sizemore	Provider

J. Craig	Strafford	Holzer Clinic
Don	Thacker	Shawnee Mental Health
Andrew	Wapner	Ohio Department of Health
Ron	Weiner	Genesis Health System
Norman	Wernet	Alliance for Retired Americans in Ohio
Bibi	Manev	Ohio Medicaid
Col	Owens	Legal Aid Society of Southwest Ohio, LLC

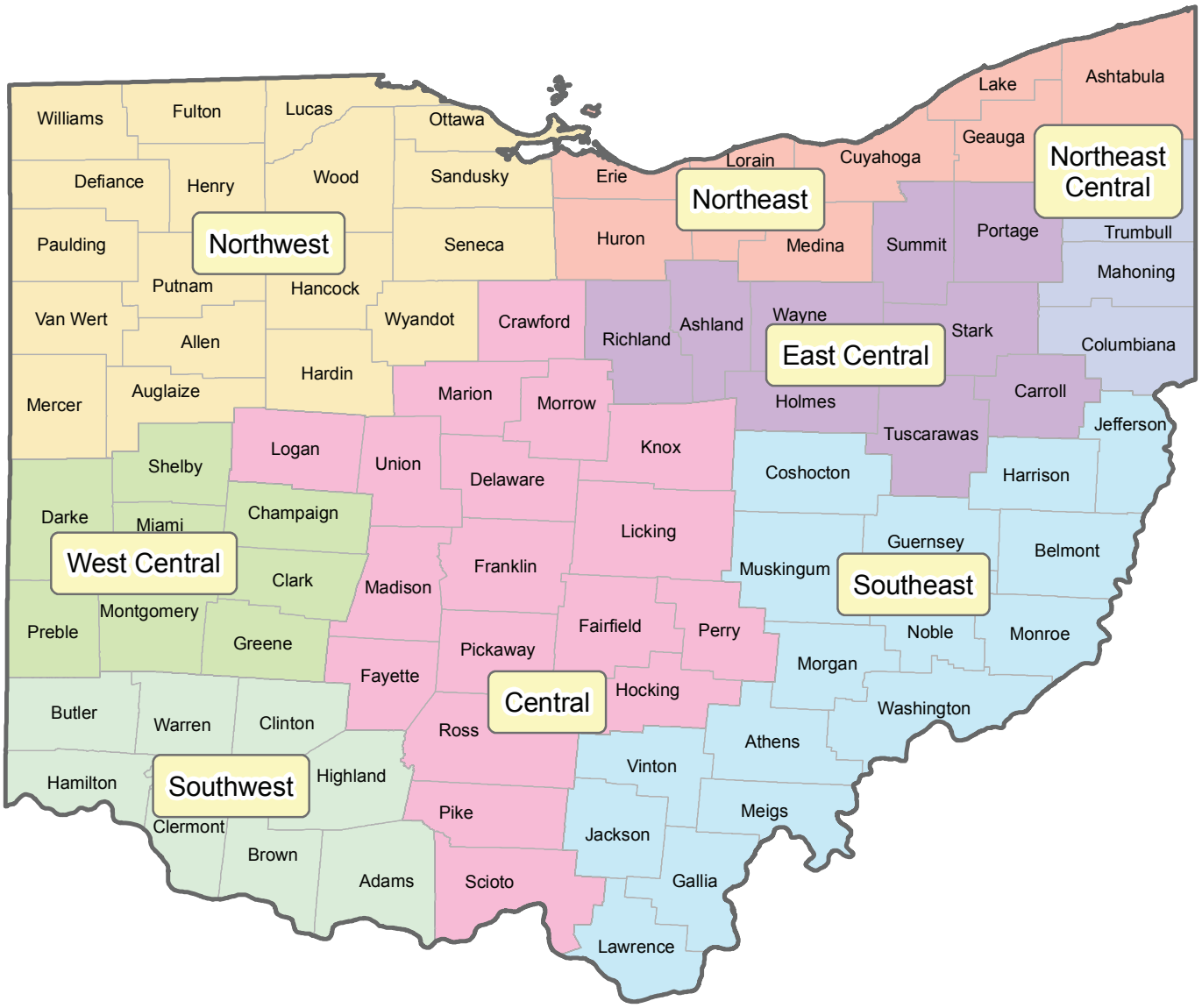
Southwest Region

Facilitator: Jewell Garrison jgarrison@ohiograntmakers.org		
Jim	Baer	Highland District Hospital
Karen	Bell	Provider
Rosemary	Bootes	UC Health/ University Hospital
Robyn	Chatman	Private Practice
tony	Dattilo	Greater Cincinnati Behavioral Health
Marianne	Farmer	American Cancer Society
Joe	Gay	Health Recovery Services Inc
Robert	Graham	University of Cincinnati College of Med.
Randal	Lennartz	Highland District Hospital
Barry	Malinowski	Anthem
Robert	Matthews	Medisync
Margie	Namie	Mercy Health Partners
Col	Owens	Legal Aid
Holly	Saelens	Amerigroup
Ruth	Schwallie	Trihealth, Inc.
Michael	Vallee	Ohio Valley Home Health
Maureen	Corcoran	Ohio Medicaid
Lisa	Bateson	Anthem

West Central Region

Facilitator: Marc Parnes m.parnes@att.net		
Dominic	Bartone	Hock's Pharmacy
Angie	Bergefurd	Ohio Department of Mental Health
Julie	DiRossi-King	OACHC
Margaret	Dunn	Wright State University
Robert	Hunter	Buckeye Family Practice
Larke	Recchie	Ohio A4A
Candy	Rinehart	Provider
Matt	Schueren	Molina
Ted	Wymyslo	Miami Valley Hospital FPR
Kimberly	Storck	Ohio Medicaid
Amy	McGee	Health Policy Institute of Ohio

The Payment Reform Summit Regional Map



Health Care Coverage and Quality Council
Ohio Department of Insurance
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Appendix 5: Harold Miller's Biography

Harold D. Miller is the Executive Director of the Center for Healthcare Quality and Payment Reform and the President and CEO of the Network for Regional Healthcare Improvement. Miller has been working at both the regional and national levels on initiatives to improve the quality of healthcare services and to change the fundamental structure of healthcare payment systems in order to support improved value. Miller also serves as Adjunct Professor of Public Policy and Management at Carnegie Mellon University's Heinz School of Public Policy and Management, where he was Associate Dean from 1987-1992.

Miller organized the Network for Regional Healthcare Improvement's national Summits on Healthcare Payment Reform in 2007 and 2008. His report Creating Payment Systems to Accelerate Value-Driven Health Care: Issues and Options for Policy Reform which was prepared for the 2007 Summit was published by the Commonwealth Fund in September, 2007,and his summary of the recommendations from the 2008 Payment Reform Summit, From Volume to Value: Transforming Healthcare Payment and Delivery Systems to Improve Quality and Reduce Costs, was published in November 2008 by NRHI and the Robert Wood Johnson Foundation. His paper "From Volume to Value: Better Ways to Pay for Healthcare" appeared in the September 2009 issue of Health Affairs. He also authored the Center for Healthcare Quality and Payment Reform's report How to Create Accountable Care Organizations, the Massachusetts Hospital Association's report Creating Accountable Care Organizations in Massachusetts, and the American Medical Association's report Pathways for Physician Success Under Healthcare Payment and Delivery Reforms.

Miller's work with the Pittsburgh Regional Health Initiative (PRHI) demonstrating the significant financial penalties that hospitals can face if they reduce hospital-acquired infections was featured in Modern Healthcare magazine in December, 2007. He designed and is currently leading a multi-year PRHI initiative to reduce preventable hospital admissions and readmissions through improved care for chronic disease patients. In 2007 and early 2008, he served as the Facilitator for the Minnesota Health Care Transformation Task Force, which prepared the recommendations that led to passage of Minnesota's path-breaking healthcare reform legislation in May, 2008. He is currently working with regional health improvement collaboratives in several states to design and implement payment and delivery system reforms.

Appendix 6: Associations Asked to Participant In Summit

Employer Representatives	
	Ohio Chamber of Commerce
	County Commissioners Association of Ohio
	Ohio Public Employees Retirement System
	Department of Administrative Services
	Interuniversity Council of Ohio
	Business Round Table
Payer Representative	
	Medical Mutual of Ohio
	Ohio Association of Health Plans
	Ohio Medicaid
Consumer Representative	
	Universal Health Care Action Network of Ohio
	AARP
	Legal Aid Society
Provider Representatives	
	Ohio Hospital Association
	Ohio Children's Hospital Association
	Ohio State Medical Association
	Ohio Association of Family Physicians
	American Academy of Pediatrics
	Ohio Osteopathic Association
	ODADAS
	Ohio Department of Mental Health
	Ohio Association of Community Health Centers
	Ohio Dental Association
	Ohio Pharmacists Association
	Ohio Association of Advance Practice Nurses
	Ohio Nurses Association

Appendix 7: Summary Findings by Region, by Question

Summary of Workgroup Findings by Policy Question

Question	Majority View	Concerns	Minority View
What modifications to the fee-for-service payment system for primary care will be most effective in advancing patient-centered care in Ohio and supporting of practice transformation?	5 year goal is to pay primary care home a severity adjusted care management fee (1.4) or per-patient partial comprehensive care payment for all outpatient services (1.5) with outcome requirements. Starting point either a small monthly care management payment for certain patients (1.2) or a large care management paymnt that costs costs of all services provided to these patients (1.3), though option 1.3 is a bolder first step. New payment method must not be procedure driven.	Payments should be on all patients; Option 1.6 would require hospital/ physician integration which may not be a good goal; Should be outcomes payment (incentive/penalty) on top of care management payment; Risk adjustment needs to begin at the starting point; Are resources issues in certain areas that could affect this effort, such as Southeast Ohio. Some areas not moving as fast on practice improvements, such as EHRs, as other areas. Providers will need upfront funds to support transition to primary care home model. How handle payment for other providers that are part of total care, such as pharmacists.	Some support within regions for option 1.1, increasing E&M codes for cognitive tasks; Groups did not decided whether to start at 1.2 or 1.3 or whether final goal should be 1.4 or 1.5
For which patients should care management payments be paid?	Care management payments should be paid for all patients on a risk adjusted basis	Risk adjustment should include geography and social demographic factors, along with clinical factors; Fee should promote wellness, too.	If can't start with all, begin with high cost patients
What changes in benefit structures are needed to enable/encourage patients to better manage their health conditions?	Policy options were not mutually exclusive. General agreement for financial incentives for use of services. Strongest preference for options that encourage use of primary care home and for taking medications and following treatments for health conditions through low or no cost sharing for these services. Support for some combination of policy options 3.3, 3.5, 3.6, and 3.7. Patients need a medical home.	Disagreement over how strongly to force and enforce patients selecting a PCP. Some worry that too much direct requirements will create patient backlash. Also, concern that patients should not pay high cost share for use of ER or urgent care if PCP told them to go there. Need to consider what patients have control over when designing incentives and disincentives. People in rural areas may face different access issues that could affect how to set up cost sharing	While overall agreement on need for cost sharing, no final agreement on rate of incentives and disincentives.
What payment structure will best support the integration of physical and behavioral health services?	All agree better integration is needed, which current payment system does not foster. All supported paying for telemedicine (4.8). Most favored practitioners providing behavioral health services get paid through enhanced primary care home (4.6) as a 5 year goal. All want BH assessment support. Broad support that the health home for people with severe mental disorders should be the behavioral health setting with integration of physicial health services taking place there. Co-location of providers also a long-term goal	While agreeing on the need to set appropriate measures for financial incentives, some doubted that ED visits is a good measure for this population. Need for different integration strategies for people with severe mental disorders and others with less severe behavioral health issues. Substance abuse needs to be included as a behavioral health service need. Need whole person assessment, that includes behavioral health screening, and whole person care. Should location of health home depend on severity of behavioral health condition?	While no minority view, much work on details to be done

How should hospital, physicians, and other health care pracitioners, be paid for major acute care of patients?	5 year goal is to create a single prospectively-defined payment that includes services in the hospital and following discharge (1.6). Starting point should be paying each provider separately, but allowing hospitals to use incentive payments to specific providers to reduce hospital costs and improve quality (1.3); Need for greater transparency to promote desired outcomes.	Some doubt on the ability to get all providers aligned and working together. Worry over how to assure a fair distribution of the payment to all parties involved in the provision of care. Suggestion to start payment reform with a few high volume services or conditions, such as identified by the Geisinger health system	Some preference for pament option that did not include short-term care (1.5) because not sure hospital can control actions in post discharge setting
How should hospital, physicians, and other health care pracitioners, be paid when preventable adervse events (e.g. hospital-based infections, medical erros, etc.) occur during major acute care?	For those events that are truly preventable and should never occur, do not make any additional payment (2.3). For those event that less clearly able to be prevented in all case, then use financial mechanisms to reduce the rate of such events (2.2). There is a need for greater transparency, peer reporting, and public reporting on these events by provider.	Need clear determination of what events meet the truly preventable, should never occur category. Worry that many events fall into a gray area that is not so easy to classify. How to handle payment for additional care if it occurs in another care giving setting, such as at a different hospital. Who will get the benefit of the dollars saved from reduced readmissions? How to use or share those savings? Need for appeals process.	Some tables in regions or region favor only option 2.2
How should hospitals be paid when patients need to be readmitted after discharge?	No consensus on how best to pay hospitals for hopsital readmissions. General agreement that there is a need for a different payment approach that promotes actions to reduce avoidable hospital readmissions. All supported increased transparency and public reporting related to hospital readmission rates.	How to determine what is an avoidable readmission. How to handle payment when many readmissions, perhaps as much as one-third, occur a different hospital from the initial hospital. How to handle responsibility for readmission when much of the challenge occurs after discharge and relates to actions of practitioners outside of the hospital. Need for a payment approach to foster better patient transition of care from one setting to another. Should the payment focus be on reducing the overall rate or on a per event basis?	Two regions supported policy option 3.5, no additional payment for a readmission though a higher initial payment for the initial readmission
How should physicians be paid when patients need to be readmitted after discharge?	The primary care home should receive financial payments tied to hospital readmission rate. Should be transparency and public reporting on readmission rate by medical home. Hospitalist or physician not part of a medical homes requires use of payment with incentives based on readmission rate (4.2)	This payment approach requires patients to be part of medical home. Some worry about how much of hospital readmission is under control of medical home and how much under control of the hospital. Regions that supported 4.8, also supported either 4.2 or 4.3 as a first step Need better end-of-life care support for patients and providers.	One region preferred 4.6. Was lot of variation within regions on best option.

Appendix 8: Summary Findings Across ALL Regions, by Question

Summary of Findings By Region By Policy Question

Option	Central	WC	EC	NE	NEC	NW	SW	SE
What modifications to the fee-for-service payment system for primary care will be most effective in advancing patient-centered care in Ohio and supporting of practice transformation?	1.2 to 1.3 to start with transition to 1.4 or 1.5; should be for all patients with severity adjustment, possible primary care provider salary	1.4 and 1.5 of greatest interest, 1.6 assumes hospital integration which is a concern; need severity adjustment, maybe way to combine 1.3, 1.4, and 1.5	FFS + risk adjusted care management fee, and incentives for quality and appropriate utilization; like to move to 1.4	shoot for 1.4 or 1.6 in 5 years; use 1.2 to 1.3 to get there, 1.3 more serious first step. Need method that is not procedure driven	mix of 1.4 and 1.5; liked pay for performance bonus if increased quality, reduced hospitalization, with care management payment decreaed if targets not met and increased if targets exceeded	split between 1.4 and 1.5, both seen as long term goal with start at 1.2 or 1.3; any payment needs risk adjustment; need blend of financial and quality metrics that have both short term and long term focus; need to include wellness and prevention cost factors	hybrid, care management fee for entire population, with risk adjusted incuding behavioral health and performance requirements to earn fee; some kind of start up support; graduated P4P and increase in evaluation and management codes	combination of 1.3 and 1.4 with large capitation fee; are resource issues in SE area and cost sharing limits for poor people
For which patients should care management payments be paid?	2.1 but tiered payment based on patient assessment	2.1 with risk adjustment	2.1 ideal, but not see as feasible in 5 years, especially for rural practices	2.1 with risk adjustment and focus on wellness	2.1	2.1 with severity adjustments; may take time to get to 2.1	some baseline care management payment necessary for all patients; higher payment for certain populations based on disease burden, geography; if necessary can start payment with chronic patients and then move to all patients	case management for all patients tiered on severity, coupled with accountability and incentives
What changes in benefit structures are needed to enable/encourage patients to better manage their health conditions?	all should have "skin in the game" including patients; need to consider what patients have control over when designing incentives and disincentives	all liked 3.7, though saw many of the other options as also being good	like mix of 3.7, with 3.2 (selection of PCP); 3.5 (appropriate use of services) and 3.6 (reduced cost sharing for certain things)	see value in many of the options, thus created hybrid, want to incent patients go to MH and not to ER and incent preventive care and healthy behavior, big disagreement on 3.2	need patient engagement, like idea of removing copays for things patients need and financial payments for things don't really need	no final agreement; most saw 3.1 as essential, see many options as mutually supporting and important; prefer start with carrots before sticks	options are not mutually exclusive, landed on hybrid option to promote medical home, remove barriers for doing right things and employ financial incentives and payments for other things	combination of 3.3, 3.5, 3.6. and 3.7 - low copayments for PCP visits, more for ED visit that could have received with PCP, low or zero copayment for chronic care medications and treatments; patient financial incentives for adhering to treatment plan
What payment structure will best support the integration of physical and behavioral health (BH) services?	all groups but one liked 4.2, all liked 4.8; no one liked 4.1; risk stratification should include BH; payment structure should support coordinated care and telemedicine; want whole person assessment and whole person care	all thought 4.6 was good, though it would require having BH specialization in practices; need to address risks and severities and have outcomes emphasis; should encourage telemedicine	need to pay for BH under any scenario; location of BH treatment be appropriate for the population, perhaps at a community mental health center for people with severe mental disorders; need telemedicine option; should pay for BH in same way as for physcial health condition	need lot of change to entire system; created hybrid option; pushed for integrated model with co-location of providers; support option 4.6 as down the road as goal	fees should be paid both ways for consultation; mutual support of assessment; collaboration key for payment	Not pick one of the specific options; want strategy that promotes integration of BH, promotes use of a network of providers, and has severity adjustment; how work BH into medical home - is BH provider the home for some?	4.2 and 4.8; recommended that in designation of health home BH provider could be the home for SMD group with PCMH home for others	strong preference for a combination option of at least 4.6 and 4.8, most not like 4.5; important to have telemedicine option in underserved areas; higher care management fee from some with positive BH; some may get care through PCMH led by medical staff, others to get PCMH led by BH staff

Option	Central	WC	EC	NE	NEC	NW	SW	SE
How should hospital, physicians, and other health care pracitioners, be paid for major acute care of patients?	1.6 with caveats, need for transparency	like to get to 1.6, which saw as a stretch, likely need to start at 1.3, maybe 1.2	1.6 with initial focus on high volume services, perhaps using Geisinger examples	start at 1.3 move quickly to 1.5, 1.6 ultimate goal	two tables support version of 1.4, one 1.5; final conclusion supports bundled idea with concern over how it is implemented	3 of 4 tables supported some kind of global payment; other table unsure can align all providers	1.3 using a PHO to handle payments; pay parts separately but hospital can pay some more if it helps reduce cost **AND** improve quality; found it hard tochoose one option when all are similar and intertwined.	1.6 favored by 3 of 4 tables, other table worried about administrative complexity for determining division of payments as reason to not support 1.6
How should hospital, physicians, and other health care pracitioners, be paid when preventable adervse events (e.g. hospital-based infections, medical erros, etc.) occur during major acute care?	2.2 short term move to 2.3, need public reporting, need for determining what is preventable by whom	2.3	2.3 for never events; 2.2 for other events, with transparency and public reporting, bonuses for improvement, and no consumer cost for avoidable events not caused by their behavior	need better list of what is truly preventable; need peer and public reporting, need appeals process; split between 2.2 and 2.3	2.2, with need to define what constitutes preventable adverse event; prefer penalty over bonus	2.3 if preventable is properly defined and event is truly preventable one; and only for those providers who are responsible, 2.2 otherwise	2.3 with need to effectively define what is a preventable adverse event	3 tables favor 2.3, 1 table favor2.2; all favor reporting; see warranty as too strong a word
How should hospitals be paid when patients need to be readmitted after discharge?	3.5 final consensus; want public reporting	two tables support 3.3, one 3.6; need figure out how to handle readmissions to another hospital, which can be upwards of 1/3 of all readmissions	split between 3.3 and 3.5; need transparency and better public reporting; should be lower payment to hospital for avoidable readmission	3.2 and 3.4; agreed on public reporting and hospitals still getting paid if rehospitalizatio n is legitimate	no agreement on specific option; not want to cut off payments completely; payment needs to be sensitive to all variables that affect rehospitlizations	can live with 3.5 if appropirate after care is in place and with good definition of what is a preventable readmission	3.1+3.2, with bonuses and penalities only tied to controllable actions, such as effective discharge planning AND case management to help patients connect with needed community-based resources to avoid rehospitalization	no consensus, with two tables wanting a different option; concern over how define what is a preventable readmission; support for public reporting; support for a lesser amount for preventable readmissions, as long as risk factor considered
How should physicians be paid when patients need to be readmitted after discharge?	see doctors having less control than hospital and that all are somewhat responsible; general support for 4.2 and 4.8	4.8	4.3 and 4.8 with transparency; similar incentives and penalties should apply to physicians that apply to hospitals; did consider 4.6	consensus on 4.8 for medicla home and 4.2 for; what role of ER docs; want address trends or individual incidents?	2 tables supported 4.8, one table supported 4.2; bonuses should be in place; needs case-by-case review	most tables could accept 4.8, but must deal with issue of join accountability including that of the hospital	4.1 and 4.8; public reporting; penalties and bonus need to be over things under control of physician	2 tables for 4.6, one for new option that reduces payment if physician fails to follow well-recognized evidence-based care that results in readmission; need medical home to have incentive and good communication with hospital

Option	Central	WC	EC	NE	NEC	NW	SW	SE
Suggested local action steps	more public reporting; advocate for action among own groups; raise awareness with employers; continue mutlistakeholder process and get participation in PCMH effort	communicate learning among other providers and patients; need move on electronic connectivity; value in learning what consumers want in PCMH	local needs to meet more; worried on legality of such meetings; individuals and groups need to communicate continued support for this work with new Administration	work through existing mechanisms to create regional collaborative that works on payment reform	continue conversation; NEOUCOM to coordinate	take back info to others and set up meeting in region	some ready to move forward, some not; doctors need funds from payers; payers worried to pay upfront; work with Alinging Forces project to move things forward; need up front dollars to support practice transformation costs	create intentional pilot to test some of these ideas
Suggested state action steps	get Medicaid to participate in multi-payer projects; continue to convene stakehodlers; get new administration to support this work	get all payers to support medical home work and help with up front investments in PCMH, continue OHIP work on EHRs and connectivity; be leader	guide discussions; encourage private sector engagement and solutions; put substance behind concepts; help reduce liability concerns over local meetings	continue conversation at state level; work to create innovations that remove barriers to payment reform	create incentive to promote regional efforts; push standardization with regional areas on things such as reporting; get Medicaid invovled in this work	given competitive hopsital environment need state to help convene regional meeting	see need for greater state demand that things moves forward among all parties, as in Vermont or Pennsylvania; value in statewide reporting	lead reform payment change efforts starting with state controlled plans, such as Medicaid and state employees

Appendix 9: "Parking Lot" Issues

During the regional sessions individual participants raised the following issues which the groups put into a "parking lot" for future consideration:

1. Where is malpractice insurance reform in any/all of this? Professional liability and risk management.

2. Trying to maintain costs will call on providers to be innovative and change their mode of operation. Professional liability risk and cost need to be addressed in Ohio.

3. The requirement that nurse practitioners have a standard care agreement with a physician is an unnecessary restriction as we search for qualified primary care providers in rural areas of Ohio.

4. Health care coverage changes are important to promote improved health outcomes and greater patient engagement. Coverage concerns raised included:

    a. Allow patients to purchase and own their own health insurance
    b. Coverage for all, and adequate payment for all coverage
    c. Provide financial incentive to provide free preventative care to patients.

5. Workforce issues will be critical, especially in resource challenged areas, including:

    a. Increase the number of primary care providers, such as in Southeast Ohio.
    b. Role of physician extenders (number and scope of practice).

Appendix 10: Summary Findings from the Evaluation

I am a(an):		
Answer Options	**Response Percent**	**Response Count**
Actively Practicing Physician	26.4%	23
Non-Practicing/ Retired Physician	0.0%	0
Nurse	9.2%	8
Pharmacist	3.4%	3
Other Healthcare Professional	18.4%	16
Consumer	11.5%	10
Payer	9.2%	8
Employer	3.4%	3
Other _____	18.4%	16
	answered question	87
	skipped question	0

I participated in region:		
Answer Options	**Response Percent**	**Response Count**
Central	18.4%	16
West Central	8.0%	7
Southwest	11.5%	10
East Central	16.1%	14
Northeast Central	3.4%	3
Northeast	20.7%	18
Southeast	10.3%	9
Northwest	11.5%	10
	answered question	87
	skipped question	0

Presentation -- Harold Miller The information presented was relevant to my practice or daily work.		
Answer Options	**Response Percent**	**Response Count**
Strongly Disagree	1.2%	1
Disagree	0.0%	0
Neutral	3.5%	3
Agree	40.7%	35
Strongly Agree	52.3%	45
N/A	2.3%	2
Comments		7
	answered question	86
	skipped question	1

Presentation -- Harold Miller The presenter displayed knowledge, clarity and enthusiasm; kept the audience's interest high.		
Answer Options	**Response Percent**	**Response Count**
Strongly Disagree	1.2%	1
Disagree	0.0%	0
Neutral	0.0%	0
Agree	23.3%	20
Strongly Agree	74.4%	64
N/A	1.2%	1
Comments		2
	answered question	86
	skipped question	1

Presentation -- Harold Miller The format of the presentation allowed me to ask questions.		
Answer Options	**Response Percent**	**Response Count**
Strongly Disagree	0.0%	0
Disagree	7.0%	6
Neutral	15.1%	13
Agree	55.8%	48
Strongly Agree	19.8%	17
N/A	2.3%	2
Comments		2
	answered question	86
	skipped question	1

Presentation -- Harold Miller I was satisfied with the presentation.		
Answer Options	**Response Percent**	**Response Count**
Strongly Disagree	0.0%	0
Disagree	0.0%	0
Neutral	3.5%	3
Agree	39.5%	34
Strongly Agree	55.8%	48
N/A	1.2%	1
Comments		3
	answered question	86
	skipped question	1

Overall Program Evaluation The pre reading list helped prepare me for participating in the conference.		
Answer Options	**Response Percent**	**Response Count**
Strongly Disagree	0.0%	0
Disagree	1.2%	1
Neutral	9.4%	8
Agree	64.7%	55
Strongly Agree	22.4%	19
N/A	2.4%	2
Comments		10
	answered question	85
	skipped question	2

Overall Program Evaluation The regional breakout group format was conducive to conversation with the other Summit participants.		
Answer Options	**Response Percent**	**Response Count**
Strongly Disagree	0.0%	0
Disagree	1.2%	1
Neutral	2.4%	2
Agree	37.6%	32
Strongly Agree	57.6%	49
N/A	1.2%	1
Comments		11
	answered question	85
	skipped question	2

Overall Program Evaluation The regional breakout group included participants from diverse interests (e.g., providers, consumers, payers and employers).		
Answer Options	**Response Percent**	**Response Count**
Strongly Disagree	0.0%	0
Disagree	2.4%	2
Neutral	8.2%	7
Agree	52.9%	45
Strongly Agree	35.3%	30
N/A	1.2%	1
Comments		12
	answered question	85
	skipped question	2

Overall Program Evaluation The facilitators were helpful to the discussion and ensured that each individual had an opportunity to represent his/her viewpoint.		
Answer Options	**Response Percent**	**Response Count**
Strongly Disagree	0.0%	0
Disagree	0.0%	0
Neutral	3.5%	3
Agree	42.4%	36
Strongly Agree	52.9%	45
N/A	1.2%	1
Comments		11
	answered question	85
	skipped question	2

Overall Program Evaluation As a result of the Payment Reform Summit I better understand the complexities of payment reform.		
Answer Options	**Response Percent**	**Response Count**
Strongly Disagree	0.0%	0
Disagree	3.5%	3
Neutral	9.4%	8
Agree	51.8%	44
Strongly Agree	34.1%	29
N/A	1.2%	1
Comments		7
	answered question	85
	skipped question	2

Overall Program Evaluation I understand the next steps that need to be taken in order to ensure meaningful payment reform change.		
Answer Options	**Response Percent**	**Response Count**
Strongly Disagree	1.2%	1
Disagree	17.6%	15
Neutral	20.0%	17
Agree	38.8%	33
Strongly Agree	20.0%	17
N/A	2.4%	2
Comments		14
	answered question	85
	skipped question	2

Overall Program Evaluation I would recommend this event format to others.		
Answer Options	Response Percent	Response Count
Strongly Disagree	1.2%	1
Disagree	3.5%	3
Neutral	3.5%	3
Agree	42.4%	36
Strongly Agree	48.2%	41
N/A	1.2%	1
Comments		4
	answered question	85
	skipped question	2

Overall Program Evaluation Was there any evidence of commercial bias or influence in this presentation?		
Answer Options	Response Percent	Response Count
Yes	5.9%	5
No	89.4%	76
Don't Know	4.7%	4
Comments		7
	answered question	85
	skipped question	2

Overall Program Evaluation On a scale of 1 - 10 with 1 = extremely dissatisfied and 10 = extremely satisfied, overall how satisfied were you with this event?		
Answer Options	Response Percent	Response Count
1	1.2%	1
2	1.2%	1
3	1.2%	1
4	1.2%	1
5	0.0%	0
6	2.4%	2
7	7.1%	6
8	32.9%	28
9	36.5%	31
10	16.5%	14
Comments		10
	answered question	85
	skipped question	2

Measure of Change in Competence and Performance This activity helped me to identify strategies I can use to evaluate the policy considerations for payment reform in Ohio		
Answer Options	**Response Percent**	**Response Count**
Strongly Disagree	0.0%	0
Disagree	6.1%	5
Neutral	15.9%	13
Agree	59.8%	49
Strongly Agree	12.2%	10
N/A	6.1%	5
	answered question	82
	skipped question	5

Measure of Change in Competence and Performance This activity helped me to identify strategies I can use to recognize the strengths and weaknesses of resource allocation.		
Answer Options	**Response Percent**	**Response Count**
Strongly Disagree	0.0%	0
Disagree	6.1%	5
Neutral	22.0%	18
Agree	52.4%	43
Strongly Agree	13.4%	11
N/A	6.1%	5
	answered question	82
	skipped question	5

Measure of Change in Competence and Performance This activity helped me to identify strategies I can use to recognize the strengths and weaknesses of the state's access		
Answer Options	**Response Percent**	**Response Count**
Strongly Disagree	1.2%	1
Disagree	7.3%	6
Neutral	30.5%	25
Agree	45.1%	37
Strongly Agree	9.8%	8
N/A	6.1%	5
	answered question	82
	skipped question	5

Measure of Change in Competence and Performance This activity helped me to identify strategies I can use to clarify domains of payment reform for medical and healthcare		
Answer Options	**Response Percent**	**Response Count**
Strongly Disagree	0.0%	0
Disagree	8.5%	7
Neutral	19.5%	16
Agree	51.2%	42
Strongly Agree	14.6%	12
N/A	6.1%	5
answered question		82
skipped question		5

Measure of Change in Competence and Performance This activity helped me to identify strategies I can use to inform healthcare stakeholders of the potential impact of payment		
Answer Options	**Response Percent**	**Response Count**
Strongly Disagree	0.0%	0
Disagree	2.4%	2
Neutral	18.3%	15
Agree	58.5%	48
Strongly Agree	18.3%	15
N/A	2.4%	2
answered question		82
skipped question		5

Measure of Change in Competence and Performance Please identify new strategies you will take away from this activity.	
Answer Options	**Response Count**
	82
answered question	82
skipped question	5

Measure of Change in Competence and Performance As a result of this activity, I foresee making changes in my practice sometime in the future.

Answer Options	Response Percent	Response Count
Strongly Disagree	3.7%	3
Disagree	6.1%	5
Neutral	22.0%	18
Agree	24.4%	20
Strongly Agree	11.0%	9
N/A	32.9%	27
Please Explain		17
answered question		82
skipped question		5

Future Activities I would like to participate in payment reform activities in my region within the next year.

Answer Options	Response Percent	Response Count
Yes	85.2%	69
No	3.7%	3
Don't Know	11.1%	9
Comments		4
answered question		81
skipped question		6

Future Activities I would like to meet again in the near future with other Summit participants to continue discussing and working to advance payment reform.

Answer Options	Response Percent	Response Count
Strongly Disagree	3.7%	3
Disagree	0.0%	0
Neutral	12.3%	10
Agree	46.9%	38
Strongly Agree	35.8%	29
N/A	1.2%	1
Comments		5
answered question		81
skipped question		6

Future Activities I believe meaningful payment reform is possible in my region.

Answer Options	Response Percent	Response Count
Strongly Disagree	0.0%	0
Disagree	4.9%	4
Neutral	21.0%	17
Agree	55.6%	45
Strongly Agree	17.3%	14
N/A	1.2%	1
Comments		10
answered question		81
skipped question		6

Future Activities Attending the conference helped me generate new ways of thinking about payment reform.		
Answer Options	**Response Percent**	**Response Count**
Strongly Disagree	0.0%	0
Disagree	1.2%	1
Neutral	14.8%	12
Agree	65.4%	53
Strongly Agree	17.3%	14
N/A	1.2%	1
Comments		3
	answered question	81
	skipped question	6

Future Activities I will be following payment reform activities at the state level.		
Answer Options	**Response Percent**	**Response Count**
Strongly Disagree	0.0%	0
Disagree	0.0%	0
Neutral	1.2%	1
Agree	40.7%	33
Strongly Agree	55.6%	45
N/A	2.5%	2
Comments		2
	answered question	81
	skipped question	6

Future Activities I believe the payment reform activities that will occur at the state level will benefit:		
Answer Options	**Response Percent**	**Response Count**
Consumers	56.8%	46
My Practice/Business	6.2%	5
Providers Overall	19.8%	16
Employers	1.2%	1
Health Plans	16.0%	13
Comment		29
	answered question	81
	skipped question	6

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