



Department of
Medicaid

John R. Kasich, Governor
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Update on the Episodes Program

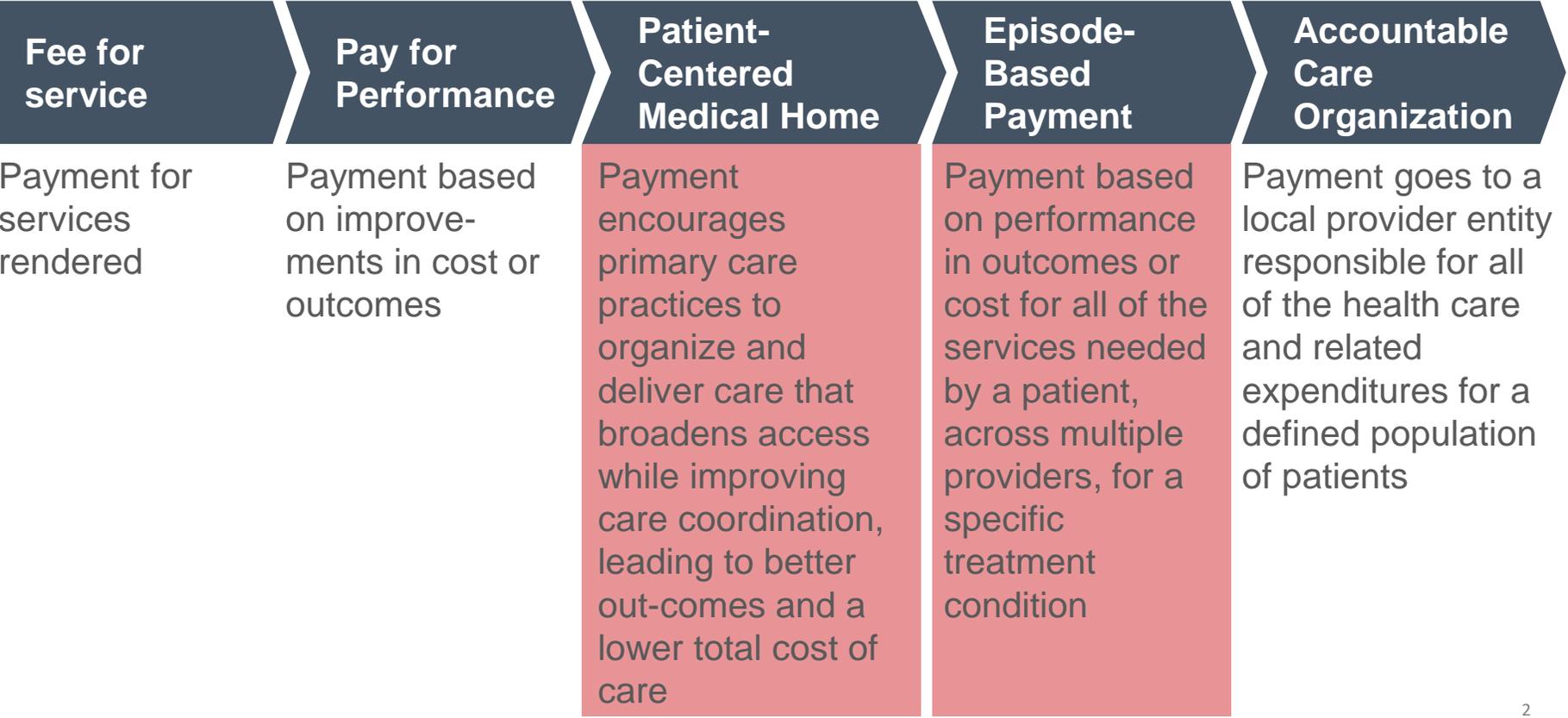
Webinar
August 29, 2018

<http://medicaid.ohio.gov/provider/PaymentInnovation/episodes>

Ohio's Value-Based Alternatives to Fee-for Service



Ohio's State Innovation Model (SIM) focuses on (1) increasing access to comprehensive primary care and (2) implementing episode-based payments



Ohio Payer Partners in Payment Innovation



Ohio payment innovation progress to-date



Comprehensive Primary Care (CPC) program

1M+ unique patients included in the CPC model for 2018¹

\$43.1 million in enhanced payment delivered to support primary care practices



145 CPC practices in program year 2018

~10,000 primary care practitioners (PCPs) participating in CPC¹



1,800+ reports sent to CPC practices capturing patient panel, cost and quality measures³

Episodes of care program

1M+ unique patients covered in 43 episodes

13,000+ Medicaid providers receiving reports as an episode principle accountable provider (PAPs)²

56,000+ reports delivered including episode performance on cost and quality measures²

¹ Information as of September 1, 2017

² All PAPs must have at least 1 valid episode to receive a report

³ From launch through January 2018

Contents

- **Episodes overview**
- 2018 episode updates
- Episode reporting
- 2019 episodes updates
- Next steps and questions

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

Patients seek and providers deliver care as they do today

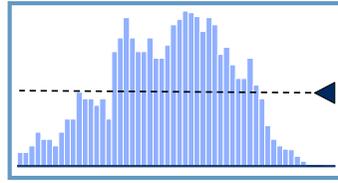
1  Patients seek care and select providers as they do today

2  Providers submit claims as they do today

3  Payers reimburse for all services as they do today

Calculate incentive payments based on outcomes after close of 12 month performance period

4  Review claims from the performance period to identify a 'Principal Accountable Provider' (PAP) for each episode

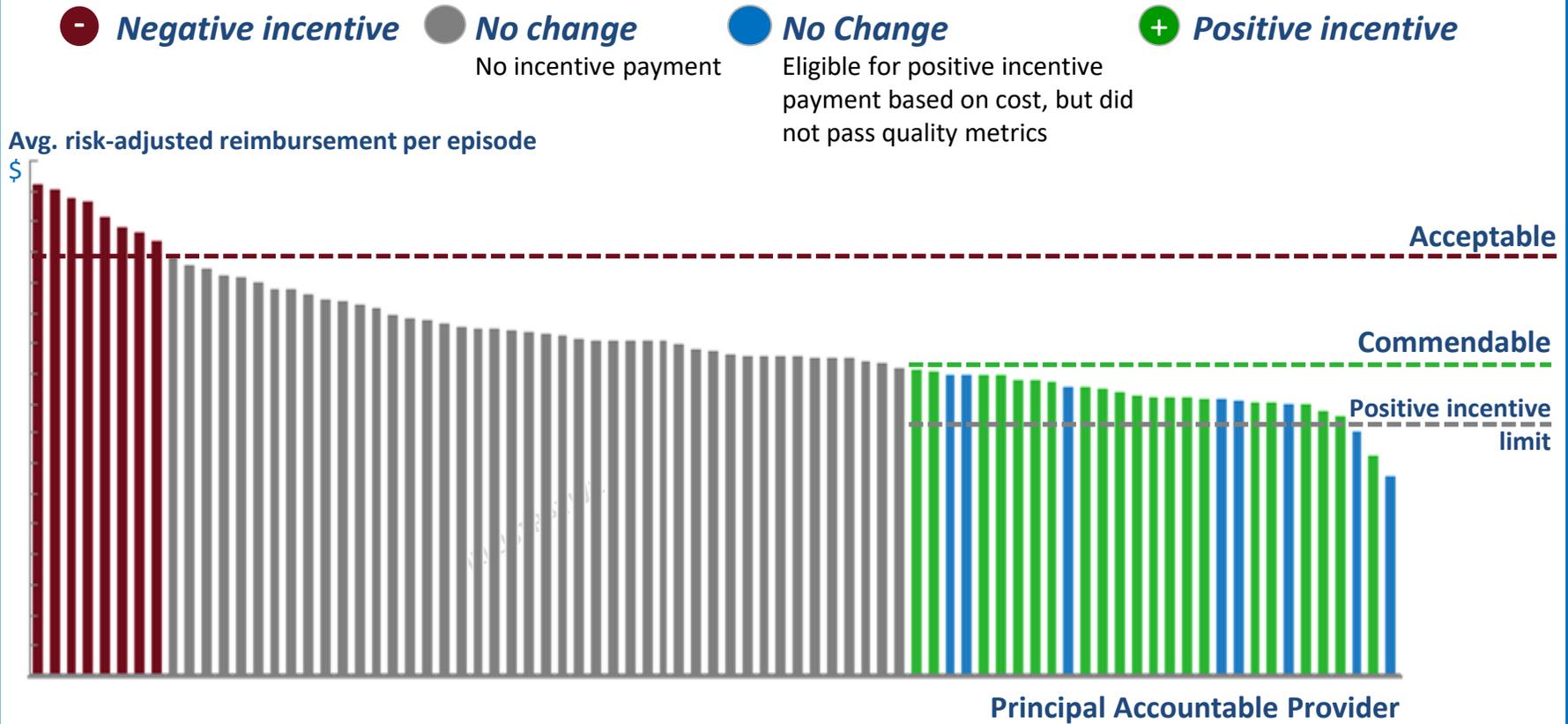
5 Payers calculate average risk-adjusted reimbursement per episode for each PAP  Compare to predetermined "commendable" and "acceptable" levels

6 Providers may

- **Share savings:** if average costs below commendable levels and quality targets are met
- **Pay negative incentive:** if average costs are above acceptable level
- **See no impact:** if average costs are between commendable and acceptable levels

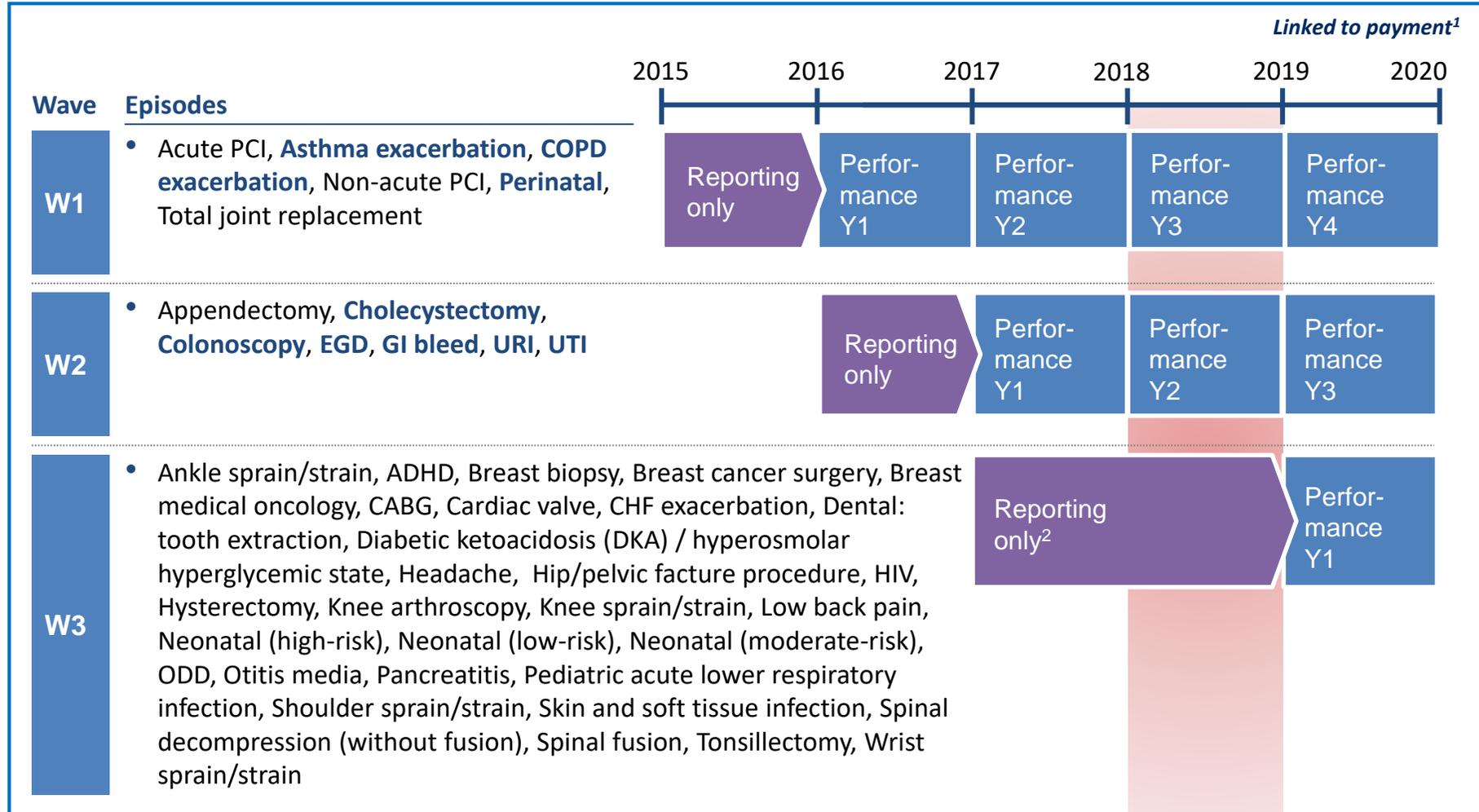
Retrospective thresholds reward cost-efficient, high-quality care

Provider cost distribution (average risk-adjusted reimbursement per provider)



NOTE: Each vertical bar represents the average cost for a provider, sorted from highest to lowest average cost

Ohio's reporting and performance years by episode wave



¹ Payment episode status only determined for W1 and W2; W3 episodes will be tied to payment through 3-stage implementation with 10 episodes in the first stage in 2019

² Reporting for Wave 3 episodes extended to CY2018 given need to incorporate physician feedback through reactive clinical process into episode design prior to performance periods

Wave 1 episode overview and select outcomes

PRELIMINARY

	Asthma	COPD	Perinatal
Number of Valid Episodes	30,535	11,345	37,846
Number of PAPs	160	153	324
Total Episode Cost¹	\$23,924,507	\$24,750,478	\$300,658,181
Average Episode Cost¹	\$784	\$2,181	\$7,944
Total Positive Incentive Payments²	\$1,350,000	\$728,000	\$51,000
Total Negative Incentive Payments²	\$102,000	\$61,000	\$1,576,000
# of PAPs assessed positive or negative incentive payment	142	133	92

¹ Non-risk adjusted spend

² Positive and negative incentive payment amounts includes 50% risk-share factor between FFS, MCPs, and PAPs

SOURCE: Ohio Medicaid claims data, valid episodes where PAP has >4 valid episodes CY2016

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Update on the episodes program

A

**Updated
cholecystectomy
quality measure
tied to payment**

- The severe adverse outcomes metric code list in cholecystectomy has been updated to more narrowly target severe outcomes as a result of the cholecystectomy, effective performance year 2018

B

**Changed
perinatal quality
measure tied to
payment**

- Group B strep screening quality measure is now informational only, no longer tied to payment
- This change resulted from analysis of performance patterns and was initiated based on feedback from the provider community

C

**Spend and quality
measure targets
for performance
year 2018**

- All commendable, acceptable, and positive incentive limit thresholds remain constant in 2018
- Quality measures for episodes tied to payment were updated for Performance Year 2018, as originally stated in the methodology to tie quality measures to payment
- Updated quality thresholds are posted online

C Updated quality measures tied to payment (1/2)

	<u>Quality Measure</u>	<u>CY2016 rate</u>	<u>CY2017 rate</u>	<u>CY2018 rate</u>
Asthma exacerbation	▪ Controller medication prescription fill rate	≥ 26%	≥ 29%	≥ 31%
	▪ Follow-up visit rate	≥ 28%	≥ 33%	≥ 38%
COPD	▪ Follow-up visit rate	≥ 50%	≥ 54%	≥ 58%
Perinatal	▪ HIV screening rate	≥ 50%	≥ 51%	≥ 61%
	▪ C-section rate	≤ 50%	≤ 41%	≤ 38%
	▪ Post-partum follow-up visit rate	≥ 45%	≥ 55%	≥ 66%
	▪ Group-B strep screening rate	≥ 50%	≥ 58%	None

C Updated quality measures tied to payment (2/2)

	<u>Quality Measure</u>	<u>CY2017 rate</u>	<u>CY2018 rate</u>
Cholecystectomy	▪ Infection rate	≤ 5%	≤ 4%
	▪ Severe adverse outcome rate	≤ 20%	≤ 7%
Colonoscopy	▪ ED visit rate	≤ 6%	≤ 5%
EGD	▪ ED visit rate	≤ 10%	≤ 8%
GI bleed	▪ 30-day office visit rate	≥ 41%	≥ 45%
URI	▪ Antibiotics fill rate in absence of strep test	≤ 79%	≤ 70%
UTI	▪ Advanced imaging rate	≤ 13%	≤ 10%

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Providers receive two types of reports for the episodes program

1 Episode report

Contains provider performance summary as well as details at the episode-level

Latest report on MITS: preliminary CY 2017 report, posted July 2018



For all episodes:
 4 quarterly (PDF) files
 4 quarterly (.csv) files

For episodes tied to payment
 1 annual (PDF) file
 1 annual (.csv) file

2 PAP referral report *For episodes linked to payment only*

Contains PAP-level summary of risk-adjusted cost indicator, quality indicator, and zip code as well as episode and quality metric summary annually

Latest report on MITS: annual 2017 PAP report, posted July 2018



For episodes tied to payment
 1 annual (PDF) file
 1 annual (.csv) file

Updated episode report model

Contains hyperlinks to initiate deep-dive search within the episode:

--- Demonstration Powered by HP Exstream 08/01/2017, Version 9.5.201 32-bit ---

EPISODE of CARE PROVIDER REPORT

COPD **Q1 2017**

Reporting period covering episodes that ended between January 1, 2017 and March 31, 2017

PAYER NAME: All Payers PROVIDER CODE: PROVIDER NAME: HOSP

Eligibility requirements for gain or risk-sharing payments

- Episode volume:** You have at least 5 episodes in the current performance period.
- Spend:** Your average risk-adjusted spend per episode is below the commendable threshold.
- Quality:** You have passed all quality metrics linked to gain-sharing.

This report is informational only. Eligibility for gain or risk-sharing will be determined at the end of the performance period and any applicable payments will be calculated at that time.

Episodes included, excluded & adjusted

Total episodes: 19

- 58% Excluded (11 Episodes)
- 42% Included (8 Episodes)

100% of your episodes have been risk adjusted

Risk adjusted average spend per episode

Distribution of provider average episode spend (risk adj.)

Avg. risk-adj. episode spend (\$,000)

Not Acceptable (>\$1,115)
Acceptable (\$690 - \$1,115)
Commendable (<\$690)

Gain Sharing Limit (\$49)

You are here \$472

Quality metrics

You achieved 1 of 1 quality metrics linked to gain

Key performance

Rolling four quarters

Reporting period 2016 Performance period 2017

--- Demonstration Powered by HP Exstream 08/01/2017, Version 9.5.201 32-bit ---

EPISODE of CARE PROVIDER REPORT

COPD **Q1 2017**

Reporting period covering episodes that ended between January 1, 2017 and March 31, 2017

PAYER NAME: All Payers PROVIDER CODE: PROVIDER NAME:

Your episode spend distribution (risk adjusted)

Each bar represents one episode

Episodes included: 24

Not Acceptable
Acceptable
Commendable

Your Average \$472

Gain/risk sharing calculation

Gain / risk sharing component	You	Description
1. Total spend across included episodes	\$7,921	Total of all associated claims submitted and paid during cycle, excluding medical education and capital portions of the hospital base rates
2. Total # of included episodes	24	Net of episodes excluded for clinical or operational considerations
3. Avg. episode spend (non adj.)	\$990	Average spend before risk adjustment; Equals line (1) divided by line (2)
4. Risk adjustment ratio (avg.)	0.4768	Average adjustment to raw claims to account for clinical variability (set by payers)

For information on how to read your report, please visit "How to read your report" under Guides on <http://medicaid.ohio.gov/provider/PaymentInnovation/episodes>

Episode Report Corrections

	Context	Status
Third Party Liability (TPL)	<ul style="list-style-type: none"> Episodes with TPL paid claims are excluded from a PAP's total number of valid episodes. A change in how the claims processing system treated TPL claims resulted in over-identification of episodes with TPL paid claims This affected quarterly episode reports posted September and December 2017 	<ul style="list-style-type: none"> April 2018 reports correct the TPL issue. As a result, episodes formerly identified with TPL will now appropriately be included for Q1-Q3 2017 on the April reports
Perinatal Risk-adjustment	<ul style="list-style-type: none"> Risk-adjustment coefficients were applied incorrectly for perinatal episode reports This affected December 2017 perinatal episode reports 	<ul style="list-style-type: none"> April 2018 perinatal reports correct the application of risk-adjustment. Average risk-adjusted spend for Q1-Q3 2017 on the April report reflects corrected risk-adjustment for all quarters
Preliminary incentive amounts	<ul style="list-style-type: none"> Episode reports posted July 2018 included an incorrect application of the multiplication factor to valid episodes, resulting in overstated positive and negative incentive share values Reports also showed incentive payment values at the all-Medicaid view 	<ul style="list-style-type: none"> Updates have been made to address both issues with incentive payment calculations Episode reports will be reissued – exact delivery dates to be confirmed in a future webinar

How to access your episode and PAP referral reports on the MITS portal

- **The episode and PAP referral reports are located in the MITS Provider Portal under the Reports Section**
- Your MITS Portal Administrator can access your episode reports
- Your MITS Portal Administrator can assign their designated Agent the **new** Role of **Reports**. Then any Agent assigned the Reports Role can access your episode reports

For Assistance accessing your reports, identifying your MITS Portal Administrator, or with Agent set up:

- Call Medicaid Providers Services @ 1-800-686-1516 and speak with a representative
- Visit the Ohio Department of Medicaid website Provider tab, and click on the blue box in the right corner, “Access the MITS Portal”

<http://medicaid.ohio.gov/PROVIDERS.aspx>



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QPP Announcement

- Ohio Medicaid has been approved for the episodes-based payments program for QPP qualification as an “Other payer advanced alternative payment model” as it qualifies for MACRA
- Of note, the model itself has been approved, however only episodes tied to payment qualify for MACRA – as additional episodes are tied to payment, PAPS in those episodes will also be eligible
- CMS will post this information to the [QPP.cms.gov](https://www.cms.gov) website on or near September 1
- Providers interested in becoming Qualifying APM Participants (QPs) under MACRA can count the Ohio Medicaid episodes-based payment program towards the All-Payer Combination Option beginning 2019

Planned program update: Timeline to link select episodes launched in 2017 to payment

The State will implement a **phased approach** to tie episodes launched in 2017 to payment from 2019-2021:



Episode name

- ADHD
- Neonatal - Low
- Skin and soft tissue infections
- Low Back Pain
- Pediatric acute LRI
- Tooth Extraction
- Congestive heart failure acute exacerbation
- Otitis Media
- Oppositional defiant disorder
- Headache

Episode name

- Spinal fusion
- Neonatal - Medium
- Spinal decompression
- Diabetic ketoacidosis
- Ankle Sprain/Strain
- Knee Sprain/Strain
- Shoulder Sprain/Strain

Episode name

- Femur and pelvis fracture
- Tonsillectomy
- Knee arthroscopy
- Hysterectomy
- Breast biopsy

Re-thresholding spend thresholds for episodes

- Spend thresholds for episodes first tied to payment in 2016 (asthma exacerbation, COPD, and perinatal) have not changed since they were originally set based on historical 2014 claims
- These episodes have been through 2 performance years to-date; ODM will update spend thresholds for these episodes for performance year 2019
- We will provide updates on the specific spend thresholds for these episodes in a future webinar this year

Contents

- Episodes overview
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- **Next steps and questions**

Upcoming episodes webinars

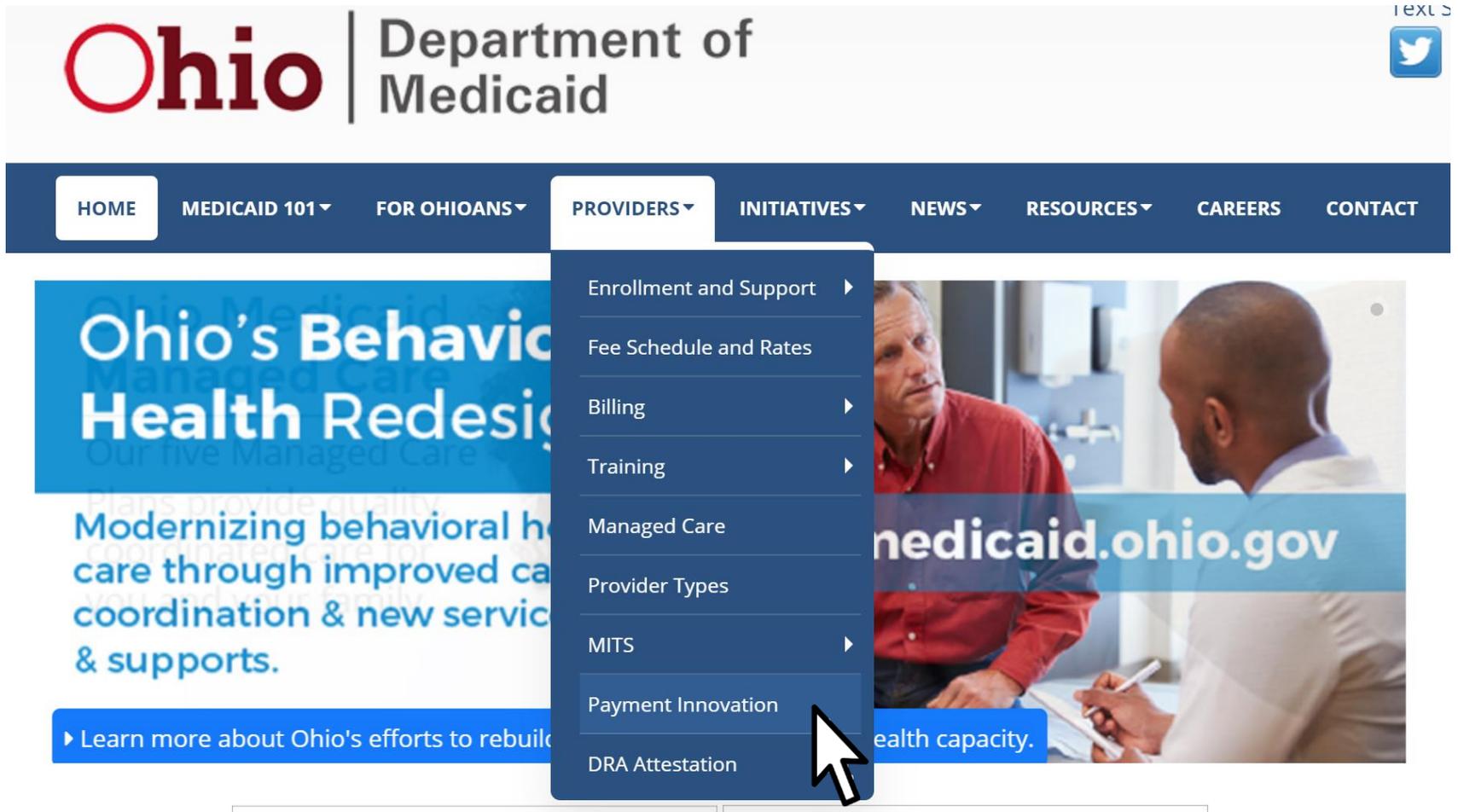
Dates

- August 29th
- September 26th
- October 23th
- November 28th

Topics

- Update on the Episodes program
- Understanding your episode and PAP referral reports
- Update on episodes launched in 2017
- Updates relevant for the 2019 performance year

Episode information can be found on the ODM website



Additional episode details can be found online



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

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

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

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

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

FAQs asked during prior episodes webinars

Q: Who should providers contact for questions regarding the Ohio episodes of care program?

A: For all episodes, providers can ask questions and provide feedback via multiple channels, including phone calls, webinars, and in-person sessions. Please contact ODM at 1.800.686.1516 for any questions regarding the episodes of care program.

Q: Which episodes are tied to payment, and when will episodes be tied to payment?

A: There are 9 episodes currently linked to payment: Asthma exacerbation, COPD exacerbation, Perinatal, Cholecystectomy, Colonoscopy, EGD, GI Bleed, URI, UTI. Ten additional episodes will be linked to payment beginning CY2019: ADHD, Neonatal – Low, Skin and soft tissue infections, low back pain, pediatric acute LRI, tooth extraction, congestive heart failure acute exacerbation, otitis media, oppositional defiant disorder, and headache.

Additional Questions?