

Episodes of Care 201

Webinar

July 2019

Contents

- **Goals**
- Understanding threshold setting methodology
 - Quality and spend thresholds
 - 2019 update: shifting to pooled performance
- Reading episodes provider reports
- Next steps and questions

Context and objectives for this webinar

Context



- In 2015, the State of Ohio introduced an **episode-based payment model** to reduce health care costs and improve care quality
- The subset of Episodes tied to payment are evaluated on spend and quality performance with respect to a set of **peer-defined thresholds**, which are specific to each type of episode
- Just for the Episodes tied to payment providers may receive **payment incentives** based on a combination of these spend and quality measures, which are assessed on an annual basis
- This webinar builds off an introductory webinar, **Episodes 101**, which reviews the conceptual framework and design dimensions that define an episode

Goals for today's discussion



- Understand the methodology behind how thresholds are calculated (including the new pooled performance approach)
- Become comfortable with the content and layout of episode provider reports

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Positive and Negative Incentive Payments

In order to be eligible for incentive a PAP must have 5 or more valid episodes.

A PAP will receive Negative Incentive if:

The PAP's average risk adjusted spend is above the acceptable threshold.

A PAP will receive Positive Incentive if:

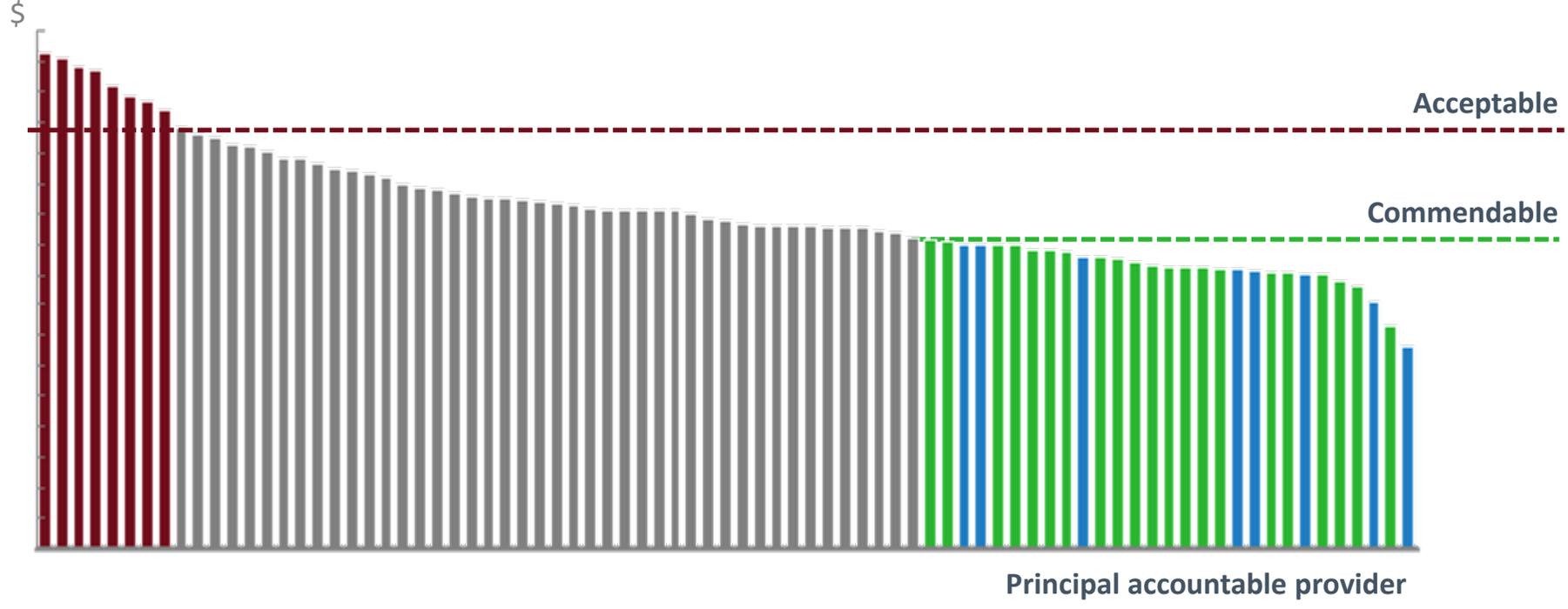
1. The PAPs average risk adjusted spend is below the commendable threshold
2. The PAP passes all the quality metrics tied to payment.

Retrospective thresholds reward cost-efficient, high-quality care

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

- Negative incentive payment**
- No change No incentive payment**
- No change Eligible for positive incentive payment based on cost, but did not pass quality metrics**
- + Positive incentive payment**

Avg. risk-adjusted reimbursement per episode



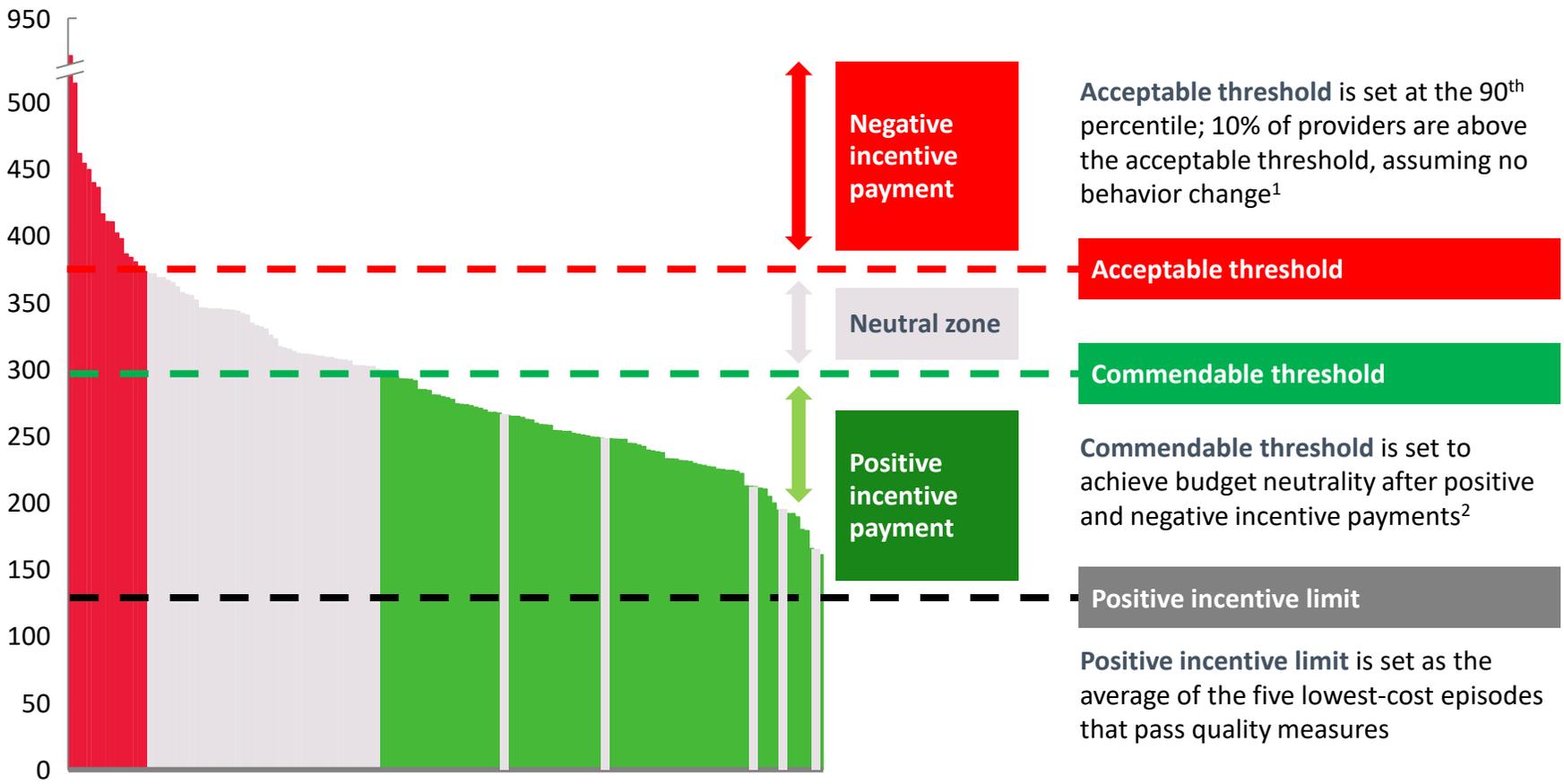
NOTE: Each vertical bar represents the average cost for a provider, sorted from highest to lowest average cost

Medicaid spend thresholding methodology

Provider risk-adjusted cost distribution

PAP average episode cost

Adj. avg cost/episode, \$

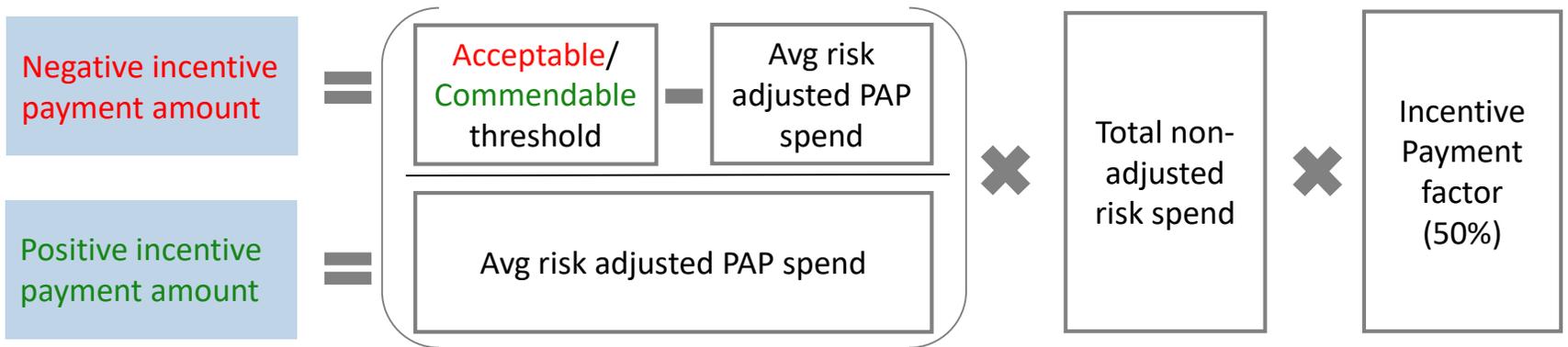


1 The threshold will be set midway between the avg. cost for the last provider above acceptable and the first one not. Including 10% of providers means including the minimum number of providers such that at least 10% of providers are included
 2 Based on historical performance; only providers that pass quality measures tied to payment will receive positive incentive payments

Medicaid spend thresholding methodology

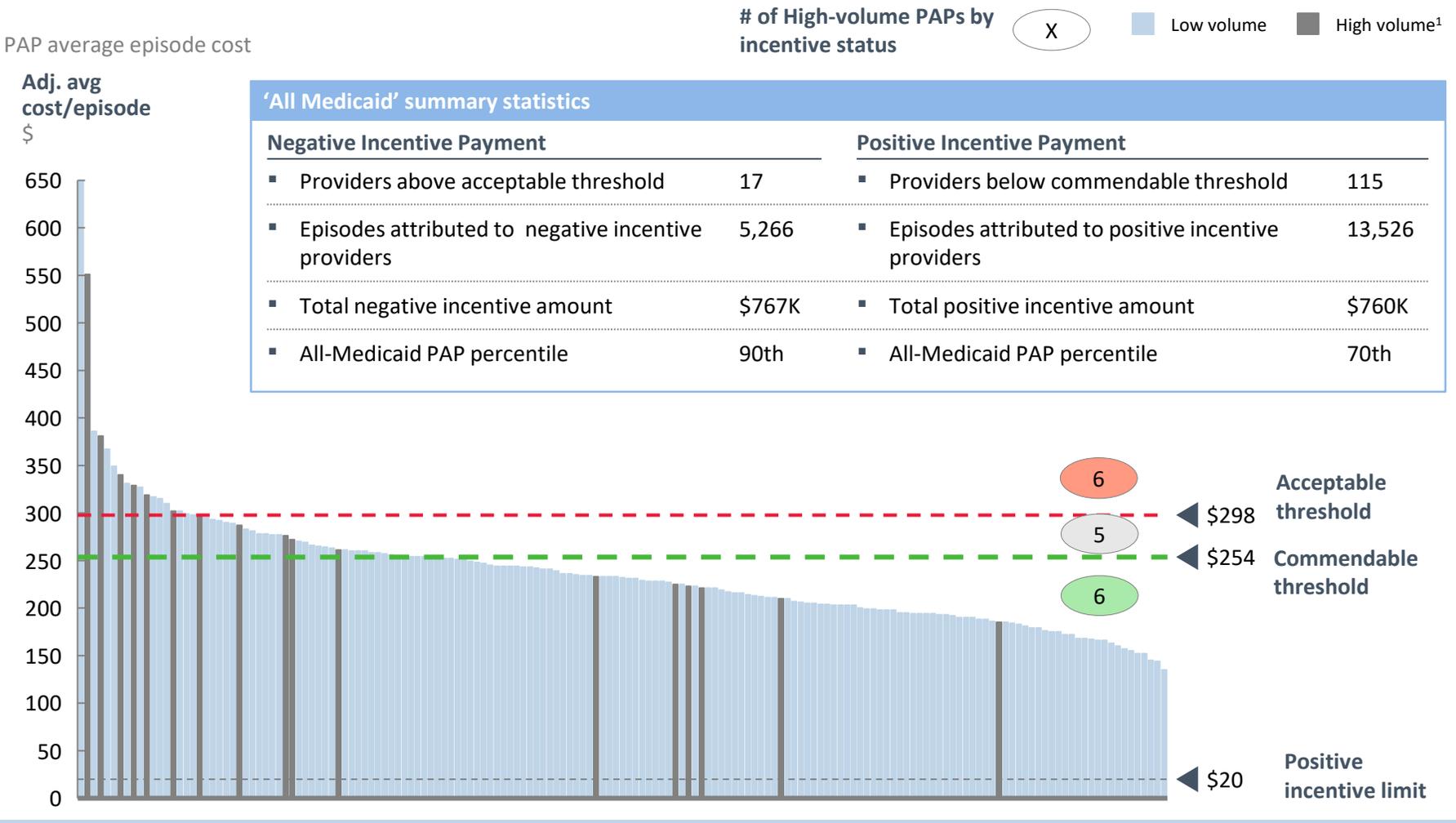
Overview: methodology to set spend thresholds

- All thresholds are set before the performance year begins. E.g., for Wave 3 episodes tied to payment in CY2019, thresholds are calculated using CY2017 performance data, adjusted for inflation
- Thresholds are set based on projections that result in program budget neutrality across All-Medicaid view (i.e. equivalent total rewards and penalties)
- PAP incentive payments can result in 3 outcomes:
 - **Negative incentive payment:** PAP’s average risk-adjusted cost is above the Acceptable threshold
 - **Neutral:** PAP’s average risk-adjusted cost is between the Acceptable and Commendable threshold
 - **Positive incentive payment:** PAP’s average risk-adjusted cost is below the Commendable threshold
- Calculating incentive payment amounts:



Example: Asthma exacerbation - All-Medicaid PAP curve to set thresholds

Provider risk-adjusted cost distribution



1 Top 10% of providers by volume 2 Assumes all providers pass quality metrics tied to gain sharing

Medicaid quality thresholding methodology

Overview: methodology to set quality thresholds

- Quality Metric (QM) thresholds are set to determine eligibility for positive incentive payments
- Quality thresholds are set at the beginning of each performance period
 - Each episode typically has between 1 and 3 quality measures tied to payment
 - QM pass rates are set such that 75% of providers pass all quality metrics tied to payment during the first performance year, and are ramped up in each year that follows to achieve top quartile performance by the fifth performance year
- For certain episodes, actual performance data used to set thresholds poses difficulty achieving desired overall pass rates, particularly for episodes with more than 1 QM tied to payment
 - In such cases, the State will review varying combinations of individual metric pass rates to achieve an appropriate overall pass rate given actual performance data

Example episode: Asthma (Wave 1)

Quality metric	Threshold			
	CY2016	CY2017	CY2018	CY2019
QM1: Follow-up visit rate	≥28%	≥33%	≥38%	≥38%
QM2: Controller medication prescription fill-rate	≥26%	≥29%	≥31%	≥31%

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The Ohio episodes program is transitioning to pooled performance measurement for PAPs beginning performance year 2019

Context

- Historically, the Ohio episodes program has set **thresholds based on the all-Medicaid view but assessed PAP incentive payments at the individual MCP-level**
- Since the program's launch, the state has shifted to a **consolidated reporting** approach and implemented the **CPC program with an all-Medicaid** view of practice performance
- The state has decided to **adopt a pooled approach** to assess providers at the all-Medicaid view as part of the process to finalize model design changes prior to 2019

Pooled performance assessment has several benefits for PAPs

Benefits to providers

- A** Clearer understanding of episode performance for each PAP
- B** Simplified reports for each episode, focused on All-Medicaid
- C** Increased potential for **participation for providers** with lower volumes
- D** Greater number of episodes used to assess incentives, resulting in a more robust evaluation a provider's overall Medicaid performance

The pooled performance approach will assess providers on quality and episode spend at the all-Medicaid view

	Current approach	Pooled approach
Thresholds Set thresholds for spend and quality performance	<ul style="list-style-type: none"> ▪ Thresholds set at all-Medicaid level 	<ul style="list-style-type: none"> ▪ No change
Performance Assess providers on quality and episode spend	<ul style="list-style-type: none"> ▪ PAP performance is assessed at payer-level 	<ul style="list-style-type: none"> ▪ PAP performance is assessed at all-Medicaid level
Incentive payment distribution	<ul style="list-style-type: none"> ▪ Based on performance with each payer(s) PAP may receive/owe multiple incentive payments 	<ul style="list-style-type: none"> ▪ Based performance at all-Medicaid level PAP may receive/owe multiple payments based on Payer's share of incentive payment
Increasing simplicity of performance feedback & incentives that providers receive		

What the shift to pooled performance means for providers in the Episodes program

Pooled performance benefits

A Clearer understanding of episode performance

B Simplified episode reports

C Increased potential participation

D Greater number of episodes used to assess incentives

Current approach
<ul style="list-style-type: none"> Variation in performance incentive assessments across payers For example, 3 positive, 1 neutral and 2 negative
<ul style="list-style-type: none"> Up to 6 reports (e.g., 1 per payer) with more than 30 pages in total
<ul style="list-style-type: none"> 5 episodes with an individual payer required for participation
<ul style="list-style-type: none"> Variation in the number of episodes used to assess incentives with each individual payer

Pooled approach
<ul style="list-style-type: none"> Single assessment of spend and quality performance per episode Note: You may still receive/ owe incentive payments with up to 6 payers
<ul style="list-style-type: none"> Reports focused on all-Medicaid performance Shorter length reports (potentially ~5 – 10 pages)
<ul style="list-style-type: none"> 5 episodes at the All-Medicaid level required for participation
<ul style="list-style-type: none"> All valid episodes attributed to a PAP used to assess incentives at the All-Medicaid level

What you can expect in your first pooled performance report

- The format of Episode Reports will look very similar to what you receive today, with the following exceptions:
 - The All-Medicaid view will now reflect PAP performance relevant for assessment of incentives
 - Reports will be shorter, the individual payer sections will no longer appear.
 - New report component for those episodes tied to payment that provides the Payer-Level incentive information
- Practices will still receive both a summary PDF and patient-detail CSV file each quarter

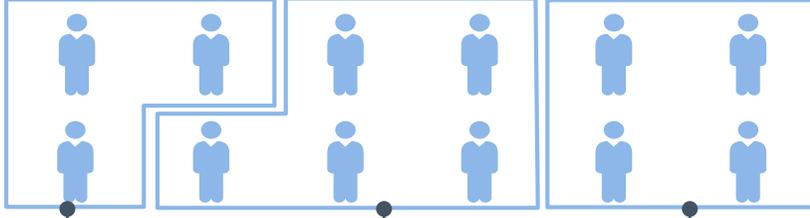
Distributing incentive payments under pooled approach

PAP all-Medicaid view:

Provider receives **\$542 positive incentive payment** based on **all-Medicaid performance** across 12 episodes

MCP-level calculation based on volume and risk:

- $[(\text{MCP valid episode count} / \text{risk score}) / \text{total across MCPs}] * (\text{All Payer Calculated Incentive})$



Current approach ¹	Incentive payment amount	MCP 1	MCP 2	MCP 3
		\$0	\$155	\$0
Distribution to MCP based on volume and risk	Episode count, MCP	3	5	4
	Risk score	0.7	0.5	0.6
	Volume, adjusted for risk	$3/0.7 = 4.3$	$5/0.5 = 10$	$4/0.6 = 6.7$
	MCP share of incentive payment	$4.3/21 = 20\%$	$10/21 = 48\%$	$6.7/21 = 32\%$
	Incentive payment amount	$20\% \times \$542 = 108.40$	$48\% \times \$542 = \260.16	$32\% \times \$542 = \173.44

¹ Under current approach, PAP does not meet minimum episode count with 2 MCPs

New Page For Those Episodes Tied to Payment

Note: Data will not appear in this table until the end of the program year.

CONGESTIVE HEART FAILURE

Q1 2019

Reporting period covering episodes that ended between **January 1, 2019** and **March 31, 2019**

PAYER NAME: ALL PAYERS

MEDICAID BILLING ID:

PROVIDER NAME:

Distribution of Incentive Payment under Pooled Methodology

The following table contains your total gain/risk share amount distributed among each payer based on risk and volume. You will receive/owe the respective amount from each of the payers.

<u>Payer</u>	<u>Gain/Risk Share Amount¹</u>
Buckeye	N/A
CareSource	N/A
FFS	N/A
Molina	N/A
Paramount	N/A
United Health Care	N/A

¹ This report is informational only. Eligibility for financial incentives will be determined at the end of the performance period and any applicable payments will be calculated at that time.

Pooled performance assessment will be reflected in reports beginning late 2019

 Quarterly report
 Annual report

 Reports reflect pooled performance

2019	Activity	For episodes ending...								
		2018				2019				
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
Q1	January 1: Launch of 2019 performance period									
Q2	 Providers receive quarterly episode performance report, for episodes ending January 1 – September 30, 2018	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Q3	 Providers receive preliminary episodes performance report, containing full calendar year 2018 and initial PAP referral report ¹ .	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	 Providers receive final performance report, containing full calendar year 2018	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Q4	 Providers receive performance reports for episodes ending January 1 – March 30, 2019	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2020	Q1	 Providers receive performance reports for the first two quarters of the 2018 performance period, episodes ending January 1 – June 30, 2019	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

¹ Report is not created for information-only episodes

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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: 4th quarter 2018, posted Aug/Sep 2019



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 in a given performance year

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: 4th quarter 2018, posted Aug/Sep 2019



For episodes tied to payment
 2 PDF files (4th quarter and annual-appended to the end of the Episodes report)

Episode report – summary

EPISODE of CARE PROVIDER REPORT

EPISODE NAME
Q1 + Q2 2016 1

Reporting period covering episodes that ended between Start Date to End Date

PAYER: Payer Name PROVIDER ID: PAP ID PROVIDER: Provider Name

2 **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 are not currently eligible for gain-sharing because you have not passed all quality metrics linked to gain-sharing.
- i **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.

3 **Episodes included, excluded & adjusted**

Total episodes#

■ Included
■ Excluded

% of your episodes have been risk adjusted

4 **Risk adjusted average spend per episode**

Distribution of provider average episode spend (risk adj.)

5 **Quality metrics**

You achieved # of # quality metrics linked to gain sharing

Quality metric 01	#%	✔
Quality metric 02	#%	✔
Quality metric 03	#%	✘
Quality metric 04	#%	✘

6 **Key performance**

Rolling four quarters

	Q3 '15	Q4 '15	Q1 '16	Q2 '16	Weighted average
Avg adjusted episode spend (\$,000)	\$,###	\$,###	\$,###	\$,###	\$,###
# of included episodes	#	#	#	#	#
Your spend percentile	#%	#%	#%	#%	#%

Episode report – performance



Episode report – quality

EPISODE of CARE PROVIDER REPORT
3 / 4

EPISODE NAME
Q1 + Q2 2016

Reporting period covering episodes that ended between Start Date to End Date

PAYER: Payer Name PROVIDER ID: PAP ID PROVIDER: Provider Name

1
Quality and utilization metrics comparison to threshold and other providers

Metrics linked to gain sharing

<Quality metric 01 name>	-<Quality metric 01 description>	
<Quality metric 02 name>	-<Quality metric 02 description>	
<Quality metric 03 name>	-<Quality metric 03 description>	
<Quality metric 04 name>	-<Quality metric 04 description>	

2
Metrics for information only

<Quality metric 05 name>	-<Quality metric 05 description>	
<Quality metric 06 name>	-<Quality metric 06 description>	
<Quality metric 07 name>	-<Quality metric 07 description>	
<Quality metric 08 name>	-<Quality metric 08 description>	

Episode report – cost types



The MITS portal also contains CSV files to complement PDF-based episode reports

In addition to PDF reports, each PAP receives a detailed csv file with episode-level data to complement higher-level insights in episode reports

Episode Id	Included/Excluded	Payer	Rendering/Attending Physician	Medicaid ID	Patient Name	Episode Start Date	Episode End Date	Days	Risk adjusted spend	Non-adjusted spend	Dif: Adjusted/Total	IP spend (non-adj.)	IP # claims	OP spend (non-adj.)	OP # claims	Rx spend (non-adj.)	Rx # claims	Prof spend (non-adj.)	Prof # claims	Exclusion (if applicable)	
2	Excluded	FFS				7/30/2012	7/7/2013	342	\$ 6,426.12	\$ 7,891.59	\$ (1,465.47)	\$2,169.63	1	\$4,170.06	12	\$ 22.22	4	\$ 1,529.68	13	Inconsistent Eli	
3	Included	FFS				10/25/2012	10/3/2013	343	\$ 5,774.63	\$ 7,319.85	\$ (1,545.22)	\$3,505.12	1	\$ 76.95	1	\$ 10.96	2	\$ 3,726.82	28		
4	Excluded	FFS				1/1/2013	12/11/2013	344	\$ 5,326.18	\$ 7,931.76	\$ (2,605.58)	\$4,294.85	1	\$1,696.95	5	\$ 48.68	4	\$ 1,891.28	13	Inconsistent Eli	
5	Excluded	FFS				8/24/2012	8/3/2013	344	\$ 5,036.81	\$ 7,318.82	\$ (2,282.01)	\$4,754.21	1	\$ 760.31	6	\$ 15.81	3	\$ 1,788.49	12	TPL Exclusion	
6	Included	FFS				2/5/2013	1/13/2014	342	\$ 4,945.62	\$ 4,945.62	\$ -	\$2,200.73	1	\$ 101.86	1	\$ 52.25	1	\$ 2,590.78	14		
7	Excluded	FFS				8/13/2012	7/22/2013	343	\$ 4,894.99	\$ 6,150.26	\$ (1,255.27)	\$4,904.34	1	\$ -	0	\$ -	0	\$ 1,245.92	10	TPL Exclusion	
8	Included	FFS				8/9/2012	7/17/2013	342	\$ 4,844.63	\$ 4,844.63	\$ -	\$3,685.38	1	\$ -	0	\$ -	0	\$ 1,159.25	6		
9	Excluded	FFS				9/13/2012	8/22/2013	343	\$ 4,815.96	\$ 7,335.82	\$ (2,519.85)	\$4,594.69	1	\$ 183.88	3	\$ 60.86	6	\$ 2,496.39	30	Comorbidity Ex	
10	Excluded	FFS				5/16/2013	4/23/2014	342	\$ 4,748.90	\$ 11,189.69	\$ (6,440.79)	\$8,716.48	4	\$ 672.26	4	\$ -	0	\$ 1,800.95	15	Inconsistent Eli	
11	Included	FFS				9/13/2012	8/21/2013														
12	Excluded	FFS				9/1/2012	8/10/2013														
13	Included	FFS				5/7/2013	4/14/2014														
14	Included	FFS				10/18/2012	9/26/2013														
15	Excluded	FFS				7/11/2013															
16	Excluded	FFS				3/29/2013															
17	Excluded	FFS				11/15/2012	10/1/2013														
18	Included	FFS				12/20/2012	11/27/2013														
19	Excluded	FFS				10/24/2012	10/1/2013														
20	Included	FFS				7/28/2012	7/5/2013														
21	Included	FFS				11/23/2012	11/1/2013														
22	Excluded	FFS				7/3/2013	6/11/2014														
23	Included	FFS				11/12/2012	10/21/2013														
24	Excluded	FFS				7/19/2013	6/28/2014														

How to use these files to learn more:

- Understand key sources of variation, for example:
 - Breakdown of avg. risk-adjusted episode reimbursement by rendering provider
 - Breakdown of avg. reimbursement by inpatient, outpatient, professional, & pharmacy
- Understand variability in quality metric performance and relationship to average episode reimbursement

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, or visit the following link: <https://medicaid.ohio.gov/Portals/0/Providers/PaymentInnovation/Episodes/Access-Your-Report.pdf>
- Visit the Ohio Department of Medicaid website Provider tab, and click on the blue box in the right corner, “Access the MITS Portal”: <https://portal.ohmits.com/Public/Providers/tabId/43/Default.aspx>



For more information on how to read your report, please visit “How to read your report” under Episodes Reporting on <http://medicaid.ohio.gov/provider/PaymentInnovation/episodes>

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Coming up later....

Perinatal Episode Refinement

- Focus on closing gaps in care for high-risk women, such as mothers with SUD, advanced behavioral health problems, or risk of pre-term birth
- Improved methods for comparing providers, including the addition of statistically significant clinical and social factors to the risk-adjustment model
- Additional transparency into neonate outcomes (e.g. gestational age, birth weight, mortality, spend) to create awareness and a sense of responsibility among OB/GYNs

The perinatal update and information on other program changes for 2020 (new thresholds, new episodes tied to payment) will be covered in the next webinar:

Episodes of Care 2020 Program Year Changes

Date: Thursday, December 5th, 2019

Time: 12:30pm-1:30pm

Please register at:

<https://attendee.gotowebinar.com/register/4140439033548412173>

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

Additional Questions?