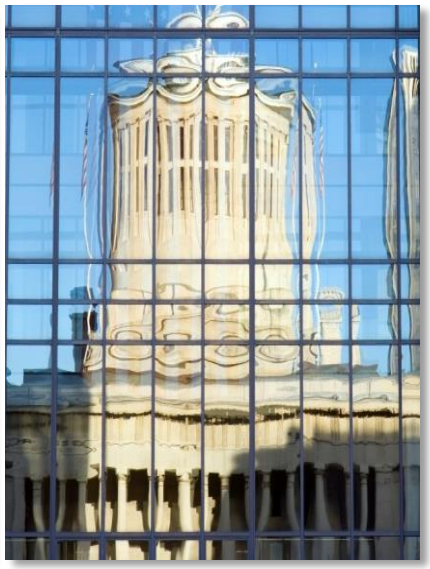


How to Read Your Ohio CPC Referral Reports

August, 2017

Ohio | Governor's Office of Health Transformation

Overview and contact information

This guide serves as an informational companion for reading and interpreting the Ohio CPC Referral Reports shared with practices on a quarterly basis.

This document is intended for users of the reports, as well as those interested in the technical details of the information contained within the reports.

Further information is available at:
http://www.medicaid.ohio.gov/

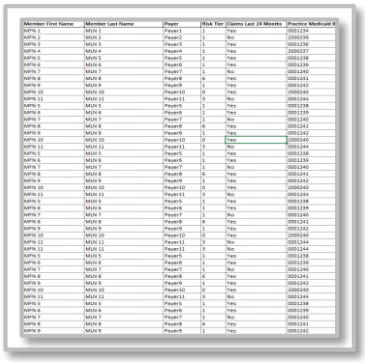
For questions and feedback, please contact the Medicaid provider hotline at:
(800) 686-1516

Overview of quarterly Ohio CPC Reports

Focus of this guide

Attribution and payment file

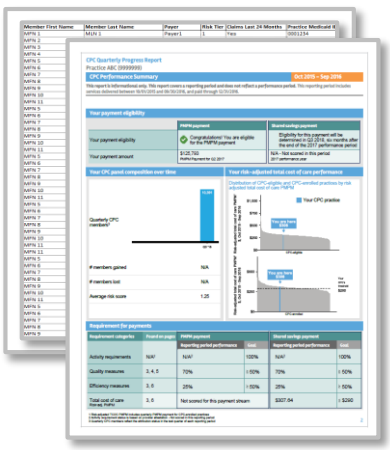
Contains attributed members and associated PMPM payments for each quarter



1 quarterly (.csv) file

Ohio CPC Practice Reports

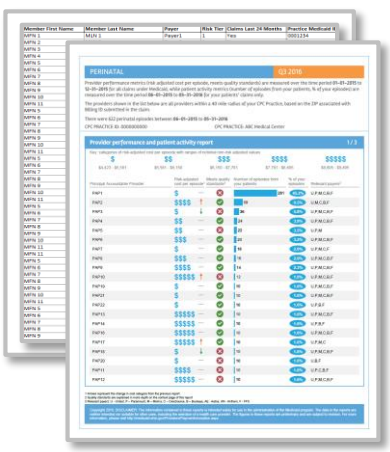
Contains practice-level summary and a member-level detail of Ohio CPC performance over a rolling 12-month period



1 quarterly (PDF) file
1 quarterly (.csv) file

Ohio CPC Referral Reports

Contains practice-level summary and member-level detail of COPD, perinatal, and asthma episodes over a rolling 12-month period for your CPC attributed members



1 quarterly (PDF) file
1 quarterly (.csv) file

How to Access your Ohio CPC Reports on the MITS Portal

All CPC Reports are located in the MITS Provider Portal under the Reports Section

- Your CPC Practice's MITS Portal Administrator can access all of the reports shared as part of the CPC program
- Your MITS Portal Administrator can also assign a designated Agent the **new role of Reports**, allowing any Agent assigned the Reports Role to also access your CPC Reports

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

- 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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How to read your referral report – for CPC practices

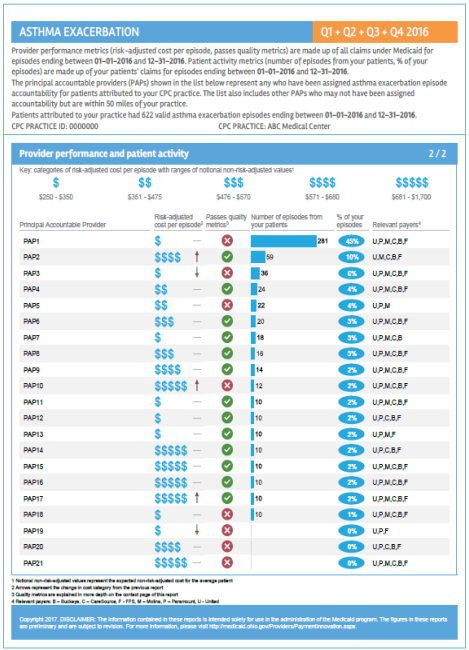
This guide explains how to read the Comprehensive Primary Care (CPC) referral report and understand detailed patient-level data using illustrative examples. The report and the detailed patient file aim to:

- Offer an understanding of provider variation in cost and quality of care for distinct episodes
- Help identify potential areas for improvement (e.g., increased provider collaboration)

The guide assumes some knowledge of the episode-based payment model. To learn more, please visit: medicaid.ohio.gov/PROVIDERS/PaymentInnovation.aspx

CPC referral report files:

Provider performance and patient activity PDF



ASTHMA EXACERBATION — Q1 + Q2 + Q3 + Q4 2016

Provider performance metrics (risk-adjusted cost per episode, passes quality metrics) are made up of all claims under Medicaid for episodes ending between **01–01–2016** and **12–31–2016**. Patient activity metrics (number of episodes from your patients, % of your episodes) are made up of your patients' claims for episodes ending between **01–01–2016** and **12–31–2016**.
The principal accountable providers (PAPs) shown in the list below represent any who have been assigned asthma exacerbation episode accountability for patients attributed to your CPC practice. The list also includes other PAPs who may not have been assigned accountability but are within 50 miles of your practice.
Patients attributed to your practice had 622 valid asthma exacerbation episodes ending between **01–01–2016** and **12–31–2016**.
CPC PRACTICE ID: 0000000 CPC PRACTICE: ABC Medical Center

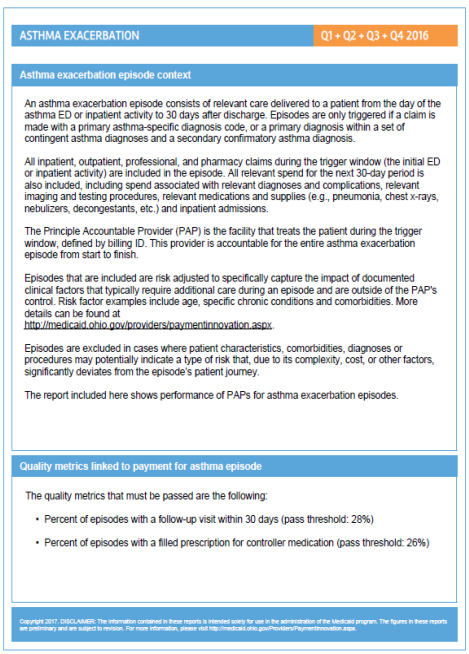
Provider performance and patient activity 2 / 2

Key: categories of risk-adjusted cost per episode with ranges of notional non-risk-adjusted values[1]

$	$$	$$$	$$$$	$$$$$
$250 - $350	$351 - $475	$476 - $570	$571 - $680	$681 - $1,700

Principal Accountable Provider	Risk-adjusted cost per episode[2]	Passes quality metrics[3]	Number of episodes from your patients	% of your episodes	Relevant payers[4]
PAP1	$ —	✗	281	45%	U,P,M,C,B,F
PAP2	$$$$ ↑	✓	59	10%	U,M,C,B,F
PAP3	$ ↓	✗	36	6%	U,P,M,C,B,F
PAP4	$$ —	✓	24	4%	U,P,M,C,B,F
PAP5	$$ —	✗	22	4%	U,P,M
PAP6	$$$ —	✓	20	3%	U,P,M,C,B,F
PAP7	$ —	✓	18	3%	U,P,M,C,B
PAP8	$$$ —	✓	16	3%	U,P,M,C,B,F
PAP9	$$$$ —	✓	14	2%	U,P,M,C,B,F
PAP10	$$$$$ ↑	✗	12	2%	U,P,M,C,B,F
PAP11	$ —	✓	10	2%	U,P,M,C,B,F
PAP12	$ —	✓	10	2%	U,P,C,B,F
PAP13	$ —	✓	10	2%	U,P,M,F
PAP14	$$$$$ —	✓	10	2%	U,P,C,B,F
PAP15	$$$$$ —	✓	10	2%	U,P,M,C,B,F
PAP16	$$$$$ —	✓	10	2%	U,P,M,C,B,F
PAP17	$$$$$ ↑	✓	10	2%	U,P,M,C,B,F
PAP18	$ —	✗	10	1%	U,P,M,C,B,F
PAP19	$ ↓	✗		0%	U,P,F
PAP20	$$$$ —	✗		0%	U,P,C,B,F
PAP21	$$$$$ —	✗		0%	U,P,M,C,B,F

1 Notional non-risk-adjusted values represent the expected non-risk-adjusted cost for the average patient
2 Arrows represent the change in cost category from the previous report
3 Quality metrics are explained in more depth on the second page of this report
4 Relevant payers: B – Buckeye, C – CareSource, F – FFS, M – Molina, P – Paramount, U – United



ASTHMA EXACERBATION — Q1 + Q2 + Q3 + Q4 2016

Asthma exacerbation episode context

An asthma exacerbation episode consists of relevant care delivered to a patient from the day of the asthma ED or inpatient activity to 30 days after discharge. Episodes are only triggered if a claim is made with a primary asthma-specific diagnosis code, or a primary diagnosis within a set of contingent asthma diagnoses and a secondary confirmatory asthma diagnosis.

All inpatient, outpatient, professional, and pharmacy claims during the trigger window (the initial ED or inpatient activity) are included in the episode. All relevant spend for the next 30-day period is also included, including spend associated with relevant diagnoses and complications, relevant imaging and testing procedures, relevant medications and supplies (e.g., pneumonia, chest x-rays, nebulizers, decongestants, etc.) and inpatient admissions.

The Principle Accountable Provider (PAP) is the facility that treats the patient during the trigger window, defined by billing ID. This provider is accountable for the entire asthma exacerbation episode from start to finish.

Episodes that are included are risk adjusted to specifically capture the impact of documented clinical factors that typically require additional care during an episode and are outside of the PAP's control. Risk factor examples include age, specific chronic conditions and comorbidities. More details can be found at http://medicaid.ohio.gov/providers/paymentinnovation.aspx.

Episodes are excluded in cases where patient characteristics, comorbidities, diagnoses or procedures may potentially indicate a type of risk that, due to its complexity, cost, or other factors, significantly deviates from the episode's patient journey.

The report included here shows performance of PAPs for asthma exacerbation episodes.

Quality metrics linked to payment for asthma episode

The quality metrics that must be passed are the following:

- Percent of episodes with a follow-up visit within 30 days (pass threshold: 28%)
- Percent of episodes with a filled prescription for controller medication (pass threshold: 26%)

Detailed patient file

PAP Performance and Patient Activity Report - Patient Episode Detail
Episode(s): ASTHMA, COPD, and PERI
Covering episodes that ended between Jan 1 2016 and Dec 31 2016
Payer name: All
CPC Practice Name: ABC Medical Center (1234567)

Episode	PAP nam	PAP ID	PAP ZIP	Valid PAP	Good PA	QM pass	Risk-adjusted cost category	Change in risk-adjusted cost categor	PAP risk-adjusted spend	PAP non-risk-adjusted spend	Rendering physician	Episode	Patient f	Patient f	Excludec	Episode	Episode	Episode	Episode	Payer	Asthma	Asthma	COPD h	HIV s
ASTHM	PAP1	1E+06	41111	1	0	1	5		XX	YY	R1	E1			No	XXYYY2	XXYYY2	XX	YY	Payer1	1	1	NA	NA
ASTHM	PAP2	2E+06	42222	1	0	1	4		XX	YY	R2	E2			No	XXYYY2	XXYYY2	XX	YY	Payer2	0	0	NA	NA
ASTHM	PAP2	2E+06	42222	1	0	0	2		XX	YY	R3	E3			No	XXYYY2	XXYYY2	XX	YY	Payer1	0	1	NA	NA
COPD	PAP1	1E+06	41111	1	0	1	4		XX	YY	R4	E4			No	XXYYY2	XXYYY2	XX	YY	Payer3	NA	NA	0	NA
COPD	PAP3	3E+06	43333	1	0	1	3		XX	YY	R5	E5			No	XXYYY2	XXYYY2	XX	YY	Payer2	NA	NA	1	NA
COPD	PAP4	4E+06	44444	1	1	1	1		XX	YY	R6	E6			No	XXYYY2	XXYYY2	XX	YY	Payer1	NA	NA	1	NA
COPD	PAP4	4E+06	44444	1	0	1	3		XX	YY	R7	E7			No	XXYYY2	XXYYY2	XX	YY	Payer3	NA	NA	1	NA
COPD	PAP4	4E+06	44444	1	0	0	3		XX	YY	R8	E8			No	XXYYY2	XXYYY2	XX	YY	Payer4	NA	NA	0	NA
PERI	PAP5	6E+06	45555	1	0	0	5		XX	YY	R9	E9			No	XXYYY2	XXYYY2	XX	YY	Payer2	NA	NA	NA	
PERI	PAP5	6E+06	45555	1	0	0	3		XX	YY	R10	E10			No	XXYYY2	XXYYY2	XX	YY	Payer3	NA	NA	NA	
PERI	PAP5	6E+06	45555	1	0	1	4		XX	YY	R11	E11			No	XXYYY2	XXYYY2	XX	YY	Payer2	NA	NA	NA	
PERI	PAP5	6E+06	45555	1	0	1	3		XX	YY	R12	E12			No	XXYYY2	XXYYY2	XX	YY	Payer1	NA	NA	NA	

Footnotes:
Medical education and capital expenditure payments are not included in non-risk-adjusted episode spend.

Ohio.gov

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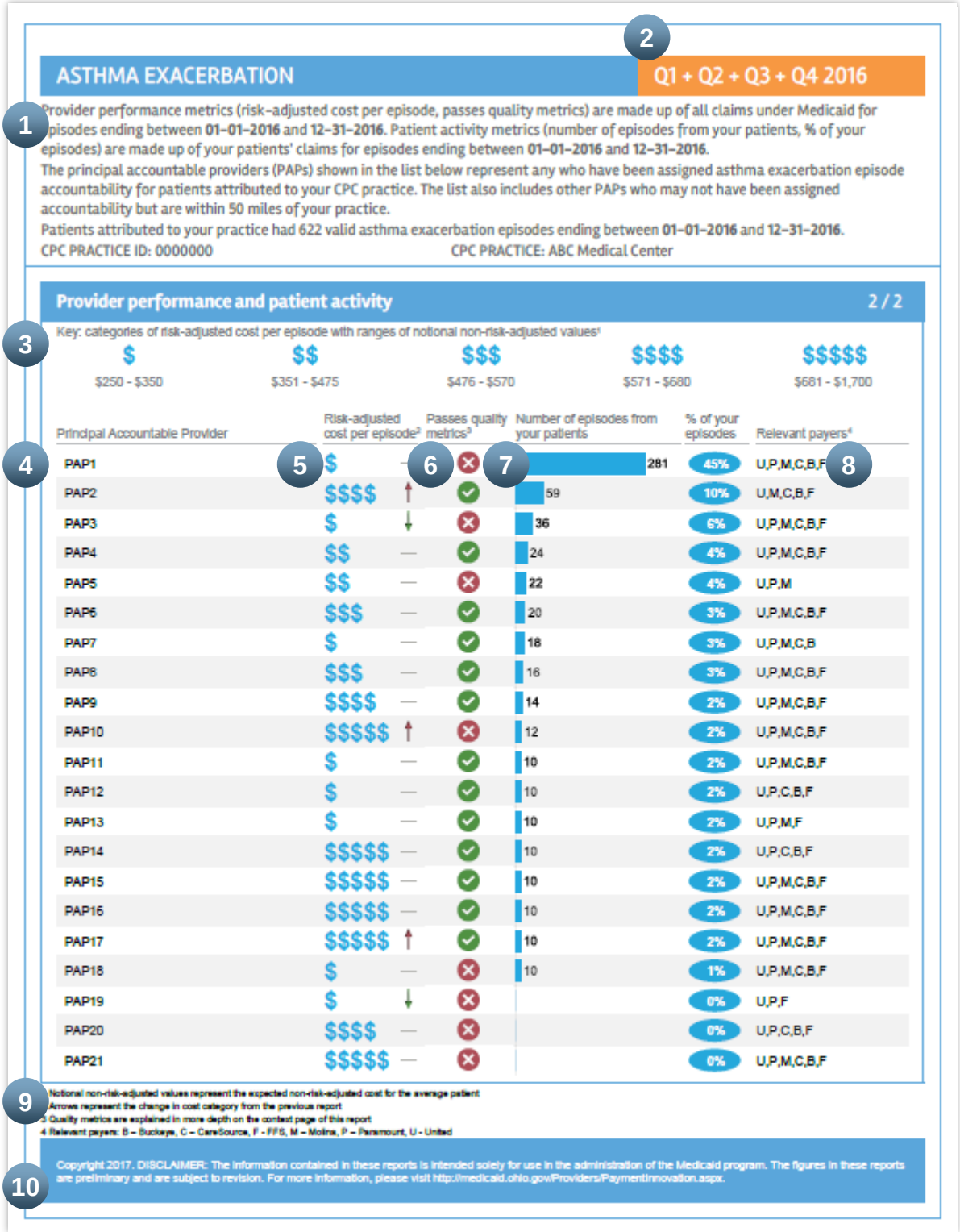
Provider performance and patient activity (PDF)



ASTHMA EXACERBATION

Q1 + Q2 + Q3 + Q4 2016

1 Provider performance metrics (risk-adjusted cost per episode, passes quality metrics) are made up of all claims under Medicaid for episodes ending between **01-01-2016** and **12-31-2016**. Patient activity metrics (number of episodes from your patients, % of your episodes) are made up of your patients' claims for episodes ending between **01-01-2016** and **12-31-2016**.

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CPC PRACTICE ID: 0000000 CPC PRACTICE: ABC Medical Center

Provider performance and patient activity 2 / 2

3 Key: categories of risk-adjusted cost per episode with ranges of notional non-risk-adjusted values[1]

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$250 - $350	$351 - $475	$476 - $570	$571 - $680	$681 - $1,700

4 Principal Accountable Provider	5 Risk-adjusted cost per episode[2]	6 Passes quality metrics[3]	7 Number of episodes from your patients	% of your episodes	8 Relevant payers[4]
PAP1	$ —	✗	281	45%	U,P,M,C,B,F
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PAP8	$$$ —	✓	16	3%	U,P,M,C,B,F
PAP9	$$$$ —	✓	14	2%	U,P,M,C,B,F
PAP10	$$$$$ ↑	✗	12	2%	U,P,M,C,B,F
PAP11	$ —	✓	10	2%	U,P,M,C,B,F
PAP12	$ —	✓	10	2%	U,P,C,B,F
PAP13	$ —	✓	10	2%	U,P,M,F
PAP14	$$$$$ —	✓	10	2%	U,P,C,B,F
PAP15	$$$$$ —	✓	10	2%	U,P,M,C,B,F
PAP16	$$$$$ —	✓	10	2%	U,P,M,C,B,F
PAP17	$$$$$ ↑	✓	10	2%	U,P,M,C,B,F
PAP18	$ —	✗	10	1%	U,P,M,C,B,F
PAP19	$ ↓	✗		0%	U,P,F
PAP20	$$$$ —	✗		0%	U,P,C,B,F
PAP21	$$$$$ —	✗		0%	U,P,M,C,B,F

9 Notional non-risk-adjusted values represent the expected non-risk-adjusted cost for the average patient
Arrows represent the change in cost category from the previous report
3 Quality metrics are explained in more depth on the context page of this report
4 Relevant payers: B – Buckeye, C – CareSource, F - FFS, M – Molina, P – Paramount, U - United

10 Copyright 2017. DISCLAIMER: The information contained in these reports is intended solely for use in the administration of the Medicaid program. The figures in these reports are preliminary and are subject to revision. For more information, please visit http://medicaid.ohio.gov/Providers/PaymentInnovation.aspx.

Provider performance and patient activity (PDF)

ASTHMA EXACERBATION | **Q1 + Q2 + Q3 + Q4 2016**

Asthma exacerbation episode context

11

An asthma exacerbation episode consists of relevant care delivered to a patient from the day of the asthma ED or inpatient activity to 30 days after discharge. Episodes are only triggered if a claim is made with a primary asthma-specific diagnosis code, or a primary diagnosis within a set of contingent asthma diagnoses and a secondary confirmatory asthma diagnosis.

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The Principle Accountable Provider (PAP) is the facility that treats the patient during the trigger window, defined by billing ID. This provider is accountable for the entire asthma exacerbation episode from start to finish.

Episodes that are included are risk adjusted to specifically capture the impact of documented clinical factors that typically require additional care during an episode and are outside of the PAP's control. Risk factor examples include age, specific chronic conditions and comorbidities. More details can be found at http://medicaid.ohio.gov/providers/paymentinnovation.aspx.

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The report included here shows performance of PAPs for asthma exacerbation episodes.

Quality metrics linked to payment for asthma episode

12

The quality metrics that must be passed are the following:

- Percent of episodes with a follow-up visit within 30 days (pass threshold: 28%)
- Percent of episodes with a filled prescription for controller medication (pass threshold: 26%)

Patient care report for CPC practices (PDF)

1. This section displays an overview of the data included in the report and describes the performance period used.
2. The date label corresponds to the performance period used.
3. The number of “dollar signs” correspond to quintiles of PAP cost performance for a given episode. The dollar value ranges below represent the expected non-risk-adjusted cost for the average patient.
4. Names of principal accountable providers (PAPs) will be shown, ordered in the report using the following logic: number of your patients with an episode attributed to the PAP, quality metric pass, and risk-adjusted cost category.
5. Risk-adjusted cost categories correspond to the legend above (3). A trend indicator is shown next to the dollar signs to represent a change in cost category from the previous quarter’s report to this quarter’s report. An up arrow signifies movement to a more expensive cost category, a down arrow shows movement to a less expensive cost category, while no arrow means staying in the same cost category. No arrows will be present for the first quarter of reports.
6. Quality metrics linked to payment are represented with a single check mark or cross. All metrics linked to payment must be passed in order to receive a check mark. A full list of measures linked to payment is located on the last page of the report.
7. The “number of episodes from your patients” field shows the reported episodes triggered by the CPC’s patients at the given PAP. The “% of your episodes” metric shows this number as a proportion of all patient episodes attributed to the practice.
8. Relevant payers provides a list of plans that each PAP has episodes for. Historical claims data from the latest performance period is used to determine the links between PAPs and payers.
9. Explanatory footnotes for the report are displayed at the bottom of the page. Brief descriptions of the risk-adjusted cost per episode trend arrows, the quality metrics, and the relevant payer abbreviations are shown here.
10. A disclaimer is written at the very bottom of the page along with a link to the Medicaid website for further information.
11. A description of the episode is shown on the back page of the report. This text provides an overview of the key elements of the episode – the triggers, duration, inclusions and exclusions. The PAP is defined and the risk-adjustment process is briefly described along with a link to the Medicaid website for further information.
12. The quality metrics linked to payment are displayed along with current pass thresholds. All quality metrics shown here must be passed in order to receive a check mark on the provider performance and patient activity page.

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Detailed patient file (.csv)

PAP Performance and Patient Activity Report - Patient Episode Detail
Episode(s): ASTHMA, COPD, and PERI
Covering episodes that ended between Jan 1 2016 and Dec 31 2016
Payer name: All
CPC Practice Name: AB[illegible] l Center (1234567)

1 2 3

Episode name	PAP name	PAP ID	PAP ZIP	Valid PAP	Efficient PAP	QM pass	Risk-adjusted cost	Change in risk-adjusted cost	PAP risk-adjusted spend	PAP non-risk-adjusted spend	Rendering physician
ASTHMA	PAP1	1E+06	41111	1	0	1	5		XX	YY	R1
ASTHMA	PAP2	2E+06	42222	1	0	1	4		XX	YY	R2
ASTHMA	PAP2	2E+06	42222	1	0	0	2		XX	YY	R3
COPD	PAP1	1E+06	41111	1	0	1	4		XX	YY	R4
COPD	PAP3	3E+06	43333	1	0	1	3		XX	YY	R5
COPD	PAP4	4E+06	44444	1	1	1	1		XX	YY	R6
COPD	PAP4	4E+06	44444	1	0	1	3		XX	YY	R7
COPD	PAP4	4E+06	44444	1	0	0	3		XX	YY	R8
PERI	PAP5	6E+06	45555	1	0	0	5		XX	YY	R9
PERI	PAP5	6E+06	45555	1	0	0	3		XX	YY	R10
PERI	PAP5	6E+06	45555	1	0	1	4		XX	YY	R11
PERI	PAP5	6E+06	45555	1	0	1	3		XX	YY	R12

Footnotes:
Medical education and capital expenditure payments are not included in non-risk-adjusted episode spend.

4 5 6 7

Episode ID	Patient name	Patient Medicaid ID	Excluded episode	Episode start	Episode end	Episode risk-adjusted spend	Episode non-risk-adjusted spend	Payer	Asthma follow-up visit
E1			No	XX/YY/2016	XX/YY/2016	XX	YY	Payer1	1
E2			No	XX/YY/2016	XX/YY/2016	XX	YY	Payer2	0
E3			No	XX/YY/2016	XX/YY/2016	XX	YY	Payer1	0
E4			No	XX/YY/2016	XX/YY/2016	XX	YY	Payer3	NA
E5			No	XX/YY/2016	XX/YY/2016	XX	YY	Payer2	NA
E6			No	XX/YY/2016	XX/YY/2016	XX	YY	Payer1	NA
E7			No	XX/YY/2016	XX/YY/2016	XX	YY	Payer3	NA
E8			No	XX/YY/2016	XX/YY/2016	XX	YY	Payer4	NA
E9			No	XX/YY/2016	XX/YY/2016	XX	YY	Payer2	NA
E10			No	XX/YY/2016	XX/YY/2016	XX	YY	Payer3	NA
E11			No	XX/YY/2016	XX/YY/2016	XX	YY	Payer2	NA
E12			No	XX/YY/2016	XX/YY/2016	XX	YY	Payer1	NA

Each PDF report made available to a CPC practice is accompanied by a .csv file that contains the underlying episodes behind the patient activity shown on the report. This episode level detail can be used to determine the following:

1. Physician or hospital PAP for the episode trigger event, along with the associated billing ID, service zip code, and efficient PAP as defined by passing quality measures tied to gain sharing and being in lowest quintile of cost.
2. Change in risk-adjusted cost category from previous quarter. Will be blank for the first quarter of reports.
3. PAP spend is calculated across all valid episodes. PAP spend will not correspond to the average of episode spend in the detailed patient file because episode spend is shown only for members attributed to the CPC practice.
4. List of patients attributed to the CPC practice who received care from the episode PAPs.
5. Date that the patients' episodes take place and the associated durations.
6. Reported cost of each episode in terms of both risk-adjusted cost and non-risk-adjusted cost.
7. Breakdown of quality measure performance for QMs tied to gain-sharing for each episode.