Ohio | Department of Medicaid

John R. Kasich, Governor
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Updates for performance year 2019

Webinar
December 5, 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

Fee for service	Pay for Performance	Patient-Centered Medical Home	Episode-Based Payment	Accountable Care Organization
Payment for services rendered	Payment based on improve-ments in cost or outcomes	Payment encourages primary care practices to organize and deliver care that broadens access while improving care coordination, leading to better out-comes and a lower total cost of care	Payment based on performance in outcomes or cost for all of the services needed by a patient, across multiple providers, for a specific treatment condition	Payment goes to a local provider entity responsible for all of the health care and related expenditures for a defined population of patients

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 2018[1]

$66.5 million in enhanced payment delivered to support primary care practices[2]

145 CPC practices in program year 2018 (up from 111 in 2017)

~10,000 primary care practitioners (PCPs) participating in CPC[1]

1,800+ reports sent to CPC practices capturing patient panel, cost and quality measures[4]

Episodes of care program

1M+ unique patients covered in 43 episodes in 2018

13,000+ Medicaid providers receiving reports as an episode principle accountable provider (PAPs)[3]

56,000+ reports delivered including episode performance on cost and quality measures[3]

1 Information as of September 1, 2017.
2 Includes PMPM payments made to participating practices in CY2017 and Q1, Q2 and Q3 of 2018.
3 All PAPs must have at least 1 valid episode to receive a report.
4 From launch through January 2018.

SOURCE: Ohio Medicaid claims data; valid and invalid episodes ending in Jan – Jun 2017

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The Ohio episodes program will transition 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 principal accountable providers

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 an 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	▪ Thresholds set at **all-Medicaid level**	▪ No change
Performance Assess providers on quality and episode spend	▪ PAP performance is assessed at **payer-level**	▪ PAP performance is assessed at **all-Medicaid level**
Incentive payment distribution	▪ PAP receives/owes incentive payment(s) based on **performance with payer(s)** ▪ PAP may receive/owe multiple payments based on incentive payment attributed to individual payers	▪ PAP receives/owes incentive payment(s) based **performance at all-Medicaid level** ▪ PAP may receive/owe multiple payments based on share of incentive payment attributed to individual payers

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	Current approach	Pooled approach
A Clearer understanding of episode performance	▪ **Variation in performance incentive asseessments** across payers ▪ For example, **3 positive, 1 neutral and 2 negative**	▪ **Single assessment** of spend and quality performance per episode ▪ **Note:** You may still receive/ owe incentive payments with up to **6 payers**
B Simplified episode reports	▪ Up to **6 reports** (e.g., 1 per payer) with more than **30 pages** in total	▪ Reports focused on **all-Medicaid performance** ▪ **Shorter length reports** (potentially ~5 – 10 pages)
C Increased potential participation	▪ **5 episodes with an individual payer** required for participation	▪ **5 episodes** at the **All-Medicaid level** required for participation
D Greater number of episodes used to assess incentives	▪ **Variation in the number of episodes** used to assess incentives with each individual payer	▪ **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

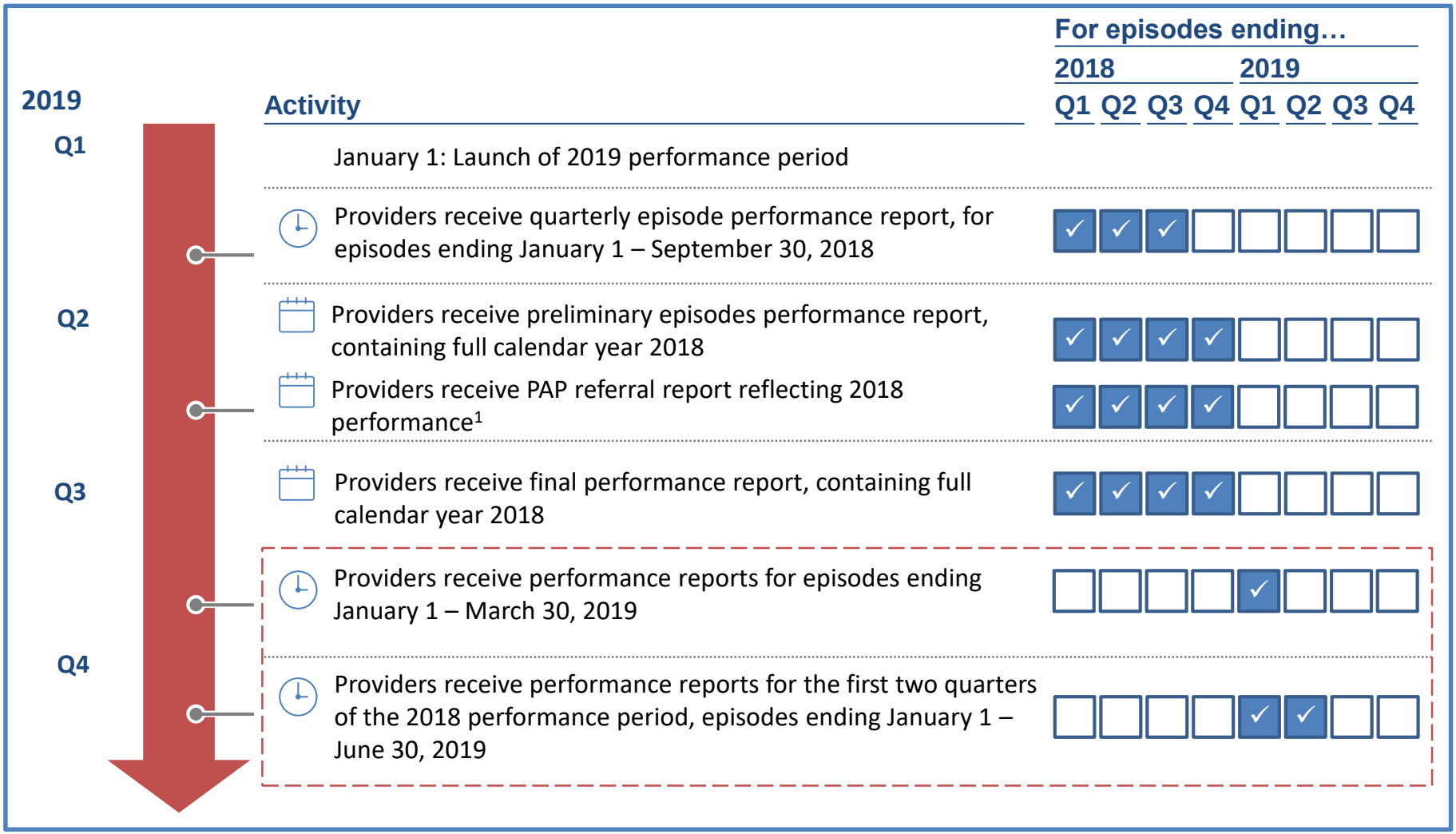
- The format of Episode Reports will look very similar to what you receive today, with the following exceptions:
  - The All-Medicaid view will now reflect PAP performance relevant for assessment of incentives
  - Reports will likely be shorter, as focus shifts to the all-Medicaid view and away from the payer-level information
  - New report components that provide a performance summary with Payer-Level Detail
- Practices will still receive both a summary PDF and patient-detail CSV file each quarter

Pooled performance assessment will be reflected in reports beginning late 2019

Quarterly report

Annual report

Reports reflect pooled performance



1 Report is not created for information-only episodes

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Timeline to link select episodes 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
- Headache

Episode name

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

Episode name

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

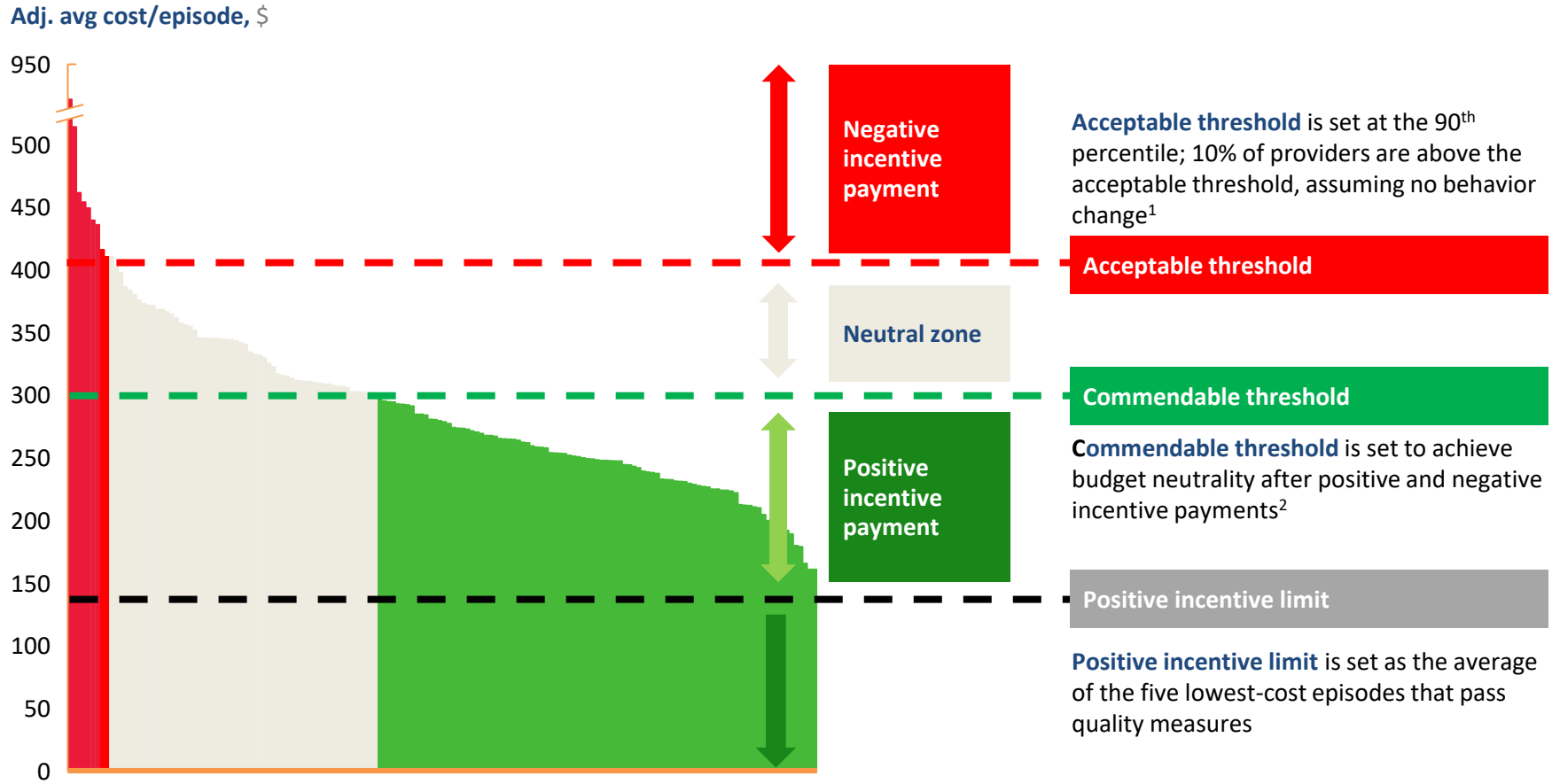
Note: Implementation of Oppositional defiant disorder for payment has been delayed from 2019 to 2020

Episode Spend Thresholds

Medicaid spend thresholding methodology

PAP average episode cost

Provider risk-adjusted cost distribution



Acceptable threshold is set at the 90th percentile; 10% of providers are above the acceptable threshold, assuming no behavior change[1]

Commendable threshold is set to achieve budget neutrality after positive and negative incentive payments[2]

Positive incentive limit is set as the average of the five lowest-cost episodes that pass quality measures

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; assumes all providers pass quality measures tied to payment

SOURCE: OH Medicaid FFS and encounter data, CY2017

Spend thresholds for episodes newly tied to payment in 2019

Episode		Acceptable threshold	Commendable threshold	Positive incentive limit
ADHD	Value, $	$1,460	$1,031	$32
	All-Medicaid percentile	90th	61st	N/A
Neonatal- low	Value, $	$1650	$1141	$329
	All-Medicaid percentile	90th	15th	N/A
Skin and Soft Tissue Infections	Value, $	$197	$102	$3
	All-Medicaid percentile	90th	31st	N/A
Low Back Pain	Value, $	$241	$117	$17
	All-Medicaid percentile	90th	24th	N/A
Pediatric Acute LRI	Value, $	$650	$600	$13
	All-Medicaid percentile	90th	89th	N/A
Tooth Extraction	Value, $	$210	$156	$10
	All-Medicaid percentile	90th	64th	N/A
Congestive Heart Failure exacerbation	Value, $	$4,049	$1,708	$112
	All-Medicaid percentile	90th	14th	N/A
Otitis Media	Value, $	$136	$87	$10
	All-Medicaid percentile	90th	32nd	N/A
Headache	Value, $	$265	$139	$17
	All-Medicaid percentile	90th	45th	N/A

SOURCE: Ohio Medicaid CY 2017

Medicaid incentive payment methodology

Overview: methodology to set spend thresholds

- All thresholds are set before the performance year begins; for episodes tied to payment in CY2019, thresholds are calculated using CY2017 performance data
- Thresholds are set based on historic data and are set so the thresholds are budget neutral at the All-Medicaid view
- PAP incentive payments are also determined at the All-Medicaid level and 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 and PAP passes quality measures tied to payment

Episode Quality Metric Thresholds

Medicaid quality measure thresholding methodology

Methodology to set quality thresholds

- Quality Metric (QM) thresholds are set to encourage delivery of high quality care and a provider must meet quality metrics to be eligible to receive a positive incentive payment
- Quality thresholds are set using historical data. For episodes tied to payment in 2019, QM pass rates were determined using CY2017 performance data
  - Each episode typically has between 1 and 3 quality measures tied to payment; additional quality metrics are informational only
  - **QM pass rates are set such that approximately 75% of providers pass all quality metrics tied to payment, based on historical data**
  - QM pass rates for subsequent performance years are ramped up to encourage higher quality performance over time

Quality measure definitions and targets (1/2)

Episode	OH quality metric linked to payment	Definition	Target
ADHD	Minimum care requirements (5 visits or prescription refills)	Percentage of valid episodes that meet the minimum care requirement of five visits or claims during the episode window.	High
	Antipsychotics in non-comorbid episodes	Percentage of valid episodes with no coded behavioral health comorbidity for which the patient received antipsychotics.	Low
Neonatal- Low	Pediatric visit within 5 days of discharge	Percent of valid episodes with a pediatric visit within five days of discharge.	High
Skin and soft tissue Infections	Bacterial cultures when I&D performed	Of the valid episodes that had an incision and drainage, the percentage in which bacterial cultures were obtained.	High
	First-line antibiotic was filled	Of the valid episodes with an antibiotic prescription filled within the seven days after initial diagnosis, the percentage in which a first-line antibiotic was filled.	High
Low Back Pain	30-day physician follow-up visit rate	Percent of episodes with an office visit follow-up during the 30 days after the trigger.	High
	Imaging rate(CT scans and MRIs)	Percent of episodes with an imaging procedure during the episode window.	Low
	Difference in MED/day	Average difference in morphine equivalent dose (MED)/day during the post-trigger opioid window and the pre-trigger opioid window, across valid episodes with at least one opioid prescription	Low
PALRI	Follow-up rate (7 days)	Percent of valid episodes with a relevant follow-up care visit within the first seven days of the post-trigger window.	High
Otitis Media	Decongestant fill rate	Percentage of valid episodes that have a filled prescription for decongestants.	Low

Quality measure definitions and targets (2/2)

Episode	OH quality metric linked to payment	Definition	Target
Tooth extraction	Difference in average MED/day	Average difference in morphine equivalent dose (MED)/day between the post-trigger opioid window (0 - 30 days after the trigger start) and the pre-trigger opioid window (1 - 30 days prior to the trigger start), across valid episodes with at least one opioid prescription during the episode window.	Low
	Related post trigger emergency department visits	Percentage of valid episodes with an included ED visit during the post-trigger window.	Low
Congestive Heart Failure	Follow up care rate (within 30 days)	Percent of valid episodes with relevant follow-up care within 30 days of discharge.	High
	Beta blocker prescription	Percent of valid episodes with filled Beta blocker during the episode window and 30 days before the episode.	High
	ACE inhibitor prescription	Percent of valid episodes with filled ACE-inhibitor during the episode window and 30 days before the episode.	High
Headache	New barbiturate prescription fill rate	Percent of episodes with a filled prescription for barbiturates during the episode window among patients that did not have a filled prescription for barbiturates during the 90 days before the episode.	Low
	Difference in MED/day	Average difference in morphine equivalent dose (MED)/day during the post-trigger opioid window and the pre-trigger opioid window, across valid episodes with at least one opioid prescription	Low
	Imaging rate(CT scans and MRIs)	Percent of episodes with a computed tomography or magnetic resonance imaging procedure during the episode window.	Low

Quality metric thresholds for episodes newly tied to payment in 2019 (1/2)

↑ Higher rate indicates passing

↓ Lower rate indicates passing

Episode	OH quality metric linked to payment	Year 1: CY 2019	
ADHD	Minimum care requirements (5 visits or Rx refills)	63%	↑
	Antipsychotics in non-comorbid episodes	4%	↓
Neonatal- Low	Pediatric visit within 5 days of discharge	64%	↑
Skin and soft tissue Infections	Bacterial cultures when I&D performed	10%	↑
	First-line antibiotic was filled	80%	↑
Low Back Pain	Difference in MED/day	10.0	↓
	30-day physician follow-up visit rate	7%	↑
	Imaging rate (CT scans and MRIs)	50%	↓
PALRI	Follow-up rate (7 days)	26%	↑
Tooth extraction	Difference in average MED/day	20.0	↓
	Related post trigger emergency department visits	10%	↓
Headache	Difference in MED/day	5.0	↓
	Imaging rate(CT scans and MRIs)	30%	↓
	New barbiturate fill rate	10%	↓

Quality metric thresholds for episodes newly tied to payment in 2019 (2/2)

↑ Higher rate indicates passing

↓ Lower rate indicates passing

Episode	OH quality metric linked to payment	Year 1: CY 2019	
Congestive Heart Failure	Follow up care rate (within 30 days)	95%	↑
	Beta blocker prescription	50%	↑
	ACE inhibitor prescription	26%	↑
Otitis Media	Decongestant fill rate	32%	↓

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Re-calculating 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 has updated spend thresholds for these episodes for performance year 2019
- Going forward, ODM will assess episodes for re-thresholding on the following cadence:
  - First evaluation 3 years after episode is initially tied to payment
  - Subsequent evaluation every 2 years for mature episodes

Updated thresholds for episodes tied to payment in 2016

'All Medicaid' summary statistics

	2019 threshold		Original	
Asthma exacerbation	**Value**	**%ile**	**Value**	**%ile**
▪ Acceptable threshold	$298	90th	$383	90th
▪ Commendable threshold	$254	70th	$294	55th
▪ Positive incentive limit	$20	-	$25	-
COPD exacerbation				
▪ Acceptable threshold	$887	90th	$1,115	90th
▪ Commendable threshold	$535	21st	$690	55th
▪ Positive incentive limit	$29	-	$49	-
Perinatal				
▪ Acceptable threshold	$4,689	90th	$4,473	90th
▪ Commendable threshold	$3,309	8th	$3,210	11th
▪ Positive incentive limit	$894	-	$1,284	-

SOURCE: OH Medicaid FFS and encounter data, CY2017 for 2019 thresholds, CY2014 for Original thresholds

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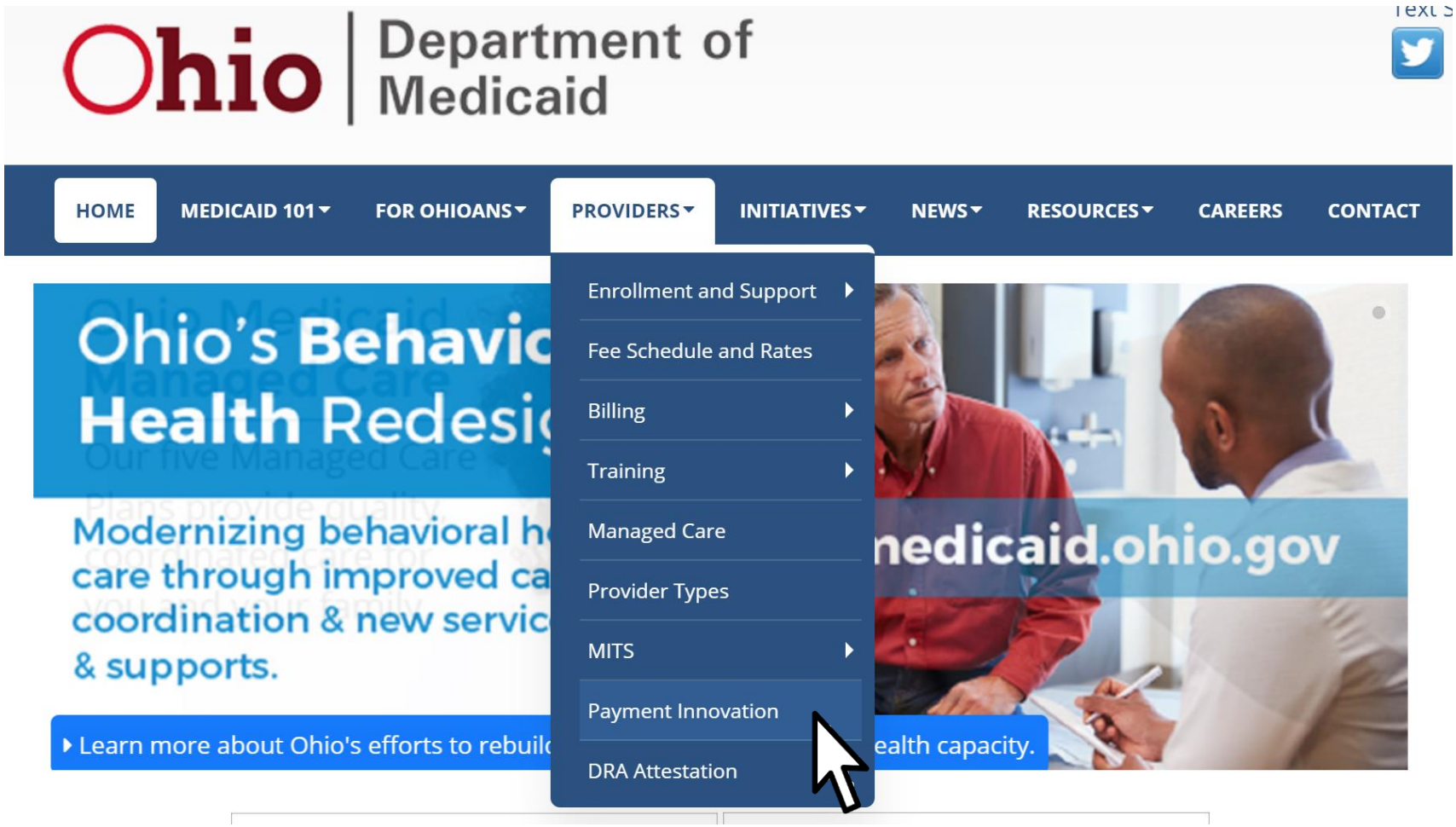
Update on the timing of 2017 Annual Episode Reports

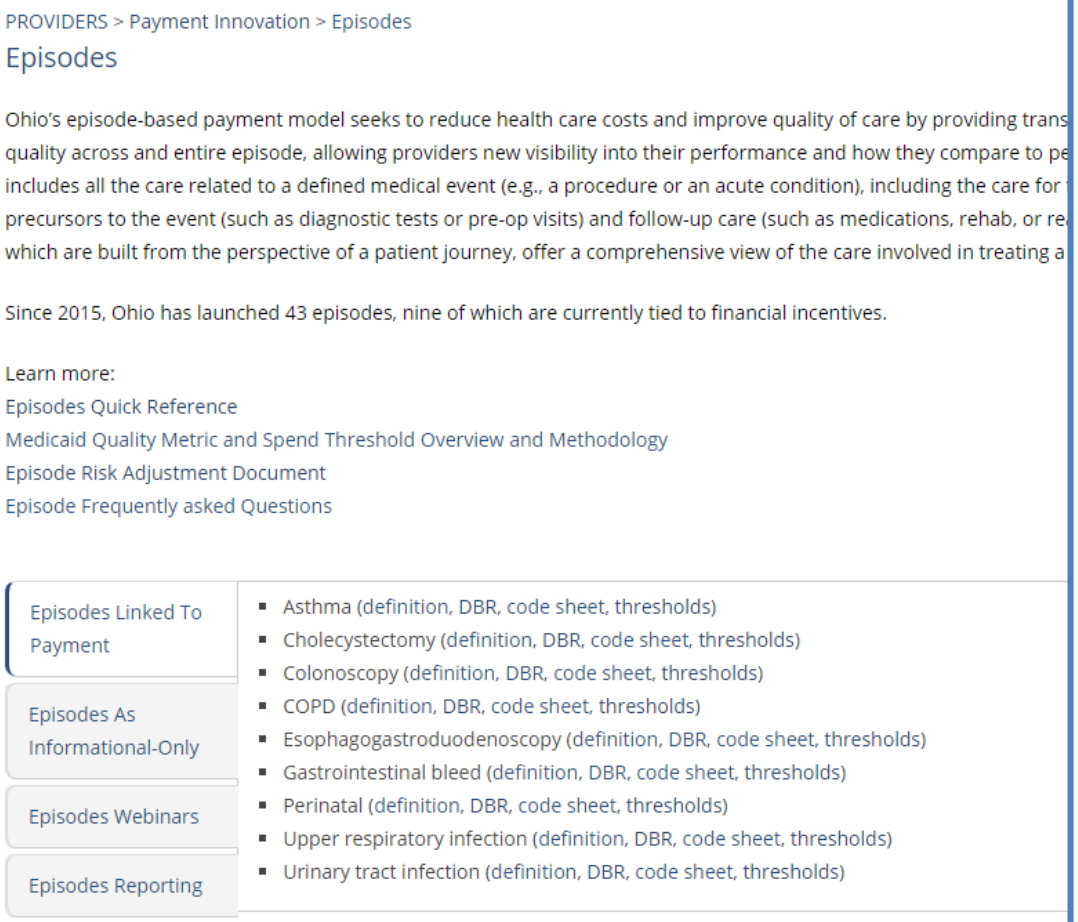
- Episode Final Performance Reports show final episode performance and include final incentive payment assessments and quality performance for PAPs in each episode
- These reports are typically posted in October following the performance period, however the 2017 reports were delayed
- These reports are now expected to be released **mid-December** in the MITS portal
- You will receive an automated email from MITS when the 2017 Final Performance Reports are posted

Episode information can be found on the ODM website



SOURCE: Ohio Department of Medicaid website:http://medicaid.ohio.gov/provider/PaymentInnovation/episodes

Additional episode details can be found on the updated Episodes page online



PROVIDERS > Payment Innovation > Episodes

Episodes

Ohio's episode-based payment model seeks to reduce health care costs and improve quality of care by providing trans
quality across and entire episode, allowing providers new visibility into their performance and how they compare to pe
includes all the care related to a defined medical event (e.g., a procedure or an acute condition), including the care for
precursors to the event (such as diagnostic tests or pre-op visits) and follow-up care (such as medications, rehab, or re
which are built from the perspective of a patient journey, offer a comprehensive view of the care involved in treating a

Since 2015, Ohio has launched 43 episodes, nine of which are currently tied to financial incentives.

Learn more:
Episodes Quick Reference
Medicaid Quality Metric and Spend Threshold Overview and Methodology
Episode Risk Adjustment Document
Episode Frequently asked Questions

Episodes Linked To Payment
Episodes As Informational-Only
Episodes Webinars
Episodes Reporting

- Asthma (definition, DBR, code sheet, thresholds)
- Cholecystectomy (definition, DBR, code sheet, thresholds)
- Colonoscopy (definition, DBR, code sheet, thresholds)
- COPD (definition, DBR, code sheet, thresholds)
- Esophagogastroduodenoscopy (definition, DBR, code sheet, thresholds)
- Gastrointestinal bleed (definition, DBR, code sheet, thresholds)
- Perinatal (definition, DBR, code sheet, thresholds)
- Upper respiratory infection (definition, DBR, code sheet, thresholds)
- Urinary tract infection (definition, DBR, code sheet, thresholds)

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 and design dimensions, patient journey, and sources of value
- **Detailed business requirements (DBR)**: Detailed technical definition by design dimension
- **Code sheet**: Medical, pharmacy, and other related codes that define the episode, to be referenced with the DBR
- **Thresholds**: Spend thresholds and quality metric targets (available for episodes that are linked to payment)

Additional tabs include information from past Episodes Webinars as well as Episodes Reporting materials such as how to read your episode reports

SOURCE: Ohio Department of Medicaid website:http://medicaid.ohio.gov/provider/PaymentInnovation/episodes

Additional Questions?