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

<table>
<thead>
<tr>
<th>Fee for Service</th>
<th>Incentive-Based Payment</th>
<th>Transfer Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payment for services rendered</td>
<td>Payment based on improvements in cost or outcomes</td>
<td>Payment goes to a local provider entity responsible for all of the health care and related expenditures for a defined population of patients</td>
</tr>
<tr>
<td>Payment for services rendered</td>
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</tr>
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<td>Payment for Performance in outcomes or cost for all of the services needed by a patient, across multiple providers, for a specific treatment condition</td>
<td>Payment goes to a local provider entity responsible for all of the health care and related expenditures for a defined population of patients</td>
</tr>
</tbody>
</table>

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

Anthem
aetna
Care Source
PARAMOUNT
ADVANTAGE
Medical Mutual
United Healthcare
Molina Healthcare
Buckeye Health Plan
Ohio payment innovation progress to-date

Comprehensive Primary Care (CPC) program

- **1M+ unique patients** included in the CPC model for 2018
- **$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 CPC
- **1,800+ reports** sent to CPC practices capturing patient panel, cost and quality measures

Episodes of care program

- **1M+ unique patients** covered in 43 episodes
- **13,000+ Medicaid providers** receiving reports as an episode principle accountable provider (PAPs)
- **56,000+ reports** delivered including episode performance on cost and quality measures

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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

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

1. Patients seek and providers deliver care as they do today

   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

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

   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

Ohio’s episode model is retrospective, building on the current FFS infrastructure already in place.
Provider cost distribution  (average risk-adjusted reimbursement per provider)

- **Negative incentive**: No incentive payment
- **No change**: No change
- **No Change**: Eligible for positive incentive payment based on cost, but did not pass quality metrics
- **Positive incentive**: 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.
Ohio’s reporting and performance years by episode wave

<table>
<thead>
<tr>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>W1</td>
<td>• Acute PCI, <strong>Asthma exacerbation</strong>, COPD exacerbation, Non-acute PCI, Perinatal, Total joint replacement</td>
<td>Reporting only</td>
<td>Performance Y1</td>
<td>Performance Y2</td>
<td>Performance Y3</td>
<td>Performance Y4</td>
<td></td>
</tr>
<tr>
<td>W2</td>
<td>• Appendectomy, <strong>Cholecystectomy</strong>, Colonoscopy, EGD, GI bleed, URI, UTI</td>
<td>Reporting only</td>
<td>Performance Y1</td>
<td>Performance Y2</td>
<td>Performance Y3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>W3</td>
<td>• Ankle sprain/strain, ADHD, Breast biopsy, Breast cancer surgery, Breast medical oncology, CABG, Cardiac valve, CHF exacerbation, Dental: tooth extraction, Diabetic ketoacidosis (DKA) / hyperosmolar hyperglycemic state, Headache, Hip/pelvic facture procedure, HIV, Hysterectomy, Knee arthroscopy, Knee sprain/strain, Low back pain, Neonatal (high-risk), Neonatal (low-risk), Neonatal (moderate-risk), ODD, Otitis media, Pancreatitis, Pediatric acute lower respiratory infection, Shoulder sprain/strain, Skin and soft tissue infection, Spinal decompression (without fusion), Spinal fusion, Tonsillectomy, Wrist sprain/strain</td>
<td>Reporting only²</td>
<td></td>
<td>Performance Y1</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

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

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
Contents

- Episodes overview
- 2018 episode updates
- Episode reporting
- 2019 episodes updates
- Next steps and questions
Update on the episodes program

- 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

- 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

- 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
### Updated quality measures tied to payment (1/2)

<table>
<thead>
<tr>
<th>Quality Measure</th>
<th>CY2016 rate</th>
<th>CY2017 rate</th>
<th>CY2018 rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma exacerbation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Controller medication prescription fill rate</td>
<td>≥ 26%</td>
<td>≥ 29%</td>
<td>≥ 31%</td>
</tr>
<tr>
<td>▪ Follow-up visit rate</td>
<td>≥ 28%</td>
<td>≥ 33%</td>
<td>≥ 38%</td>
</tr>
<tr>
<td>COPD</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Follow-up visit rate</td>
<td>≥ 50%</td>
<td>≥ 54%</td>
<td>≥ 58%</td>
</tr>
<tr>
<td>Perinatal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ HIV screening rate</td>
<td>≥ 50%</td>
<td>≥ 51%</td>
<td>≥ 61%</td>
</tr>
<tr>
<td>▪ C-section rate</td>
<td>≤ 50%</td>
<td>≤ 41%</td>
<td>≤ 38%</td>
</tr>
<tr>
<td>▪ Post-partum follow-up visit rate</td>
<td>≥ 45%</td>
<td>≥ 55%</td>
<td>≥ 66%</td>
</tr>
<tr>
<td>▪ Group-B strep screening rate</td>
<td>≥ 50%</td>
<td>≥ 58%</td>
<td>None</td>
</tr>
</tbody>
</table>
### Updated quality measures tied to payment (2/2)

<table>
<thead>
<tr>
<th>Quality Measure</th>
<th>CY2017 rate</th>
<th>CY2018 rate</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cholecystectomy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infection rate</td>
<td>≤ 5%</td>
<td>≤ 4%</td>
</tr>
<tr>
<td>Severe adverse outcome rate</td>
<td>≤ 20%</td>
<td>≤ 7%</td>
</tr>
<tr>
<td><strong>Colonoscopy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ED visit rate</td>
<td>≤ 6%</td>
<td>≤ 5%</td>
</tr>
<tr>
<td><strong>EGD</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ED visit rate</td>
<td>≤ 10%</td>
<td>≤ 8%</td>
</tr>
<tr>
<td><strong>GI bleed</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30-day office visit rate</td>
<td>≥ 41%</td>
<td>≥ 45%</td>
</tr>
<tr>
<td><strong>URI</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antibiotics fill rate in absence of strep test</td>
<td>≤ 79%</td>
<td>≤ 70%</td>
</tr>
<tr>
<td><strong>UTI</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advanced imaging rate</td>
<td>≤ 13%</td>
<td>≤ 10%</td>
</tr>
</tbody>
</table>
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- Next steps and questions
Providers receive two types of reports for the episodes program

<table>
<thead>
<tr>
<th><strong>Episode report</strong></th>
<th><strong>PAP referral report</strong></th>
</tr>
</thead>
</table>

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

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

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:

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](http://medicaid.ohio.gov/provider/PaymentInnovation/episodes)
### Episode Report Corrections

#### Context

<table>
<thead>
<tr>
<th>Third Party Liability (TPL)</th>
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<tbody>
<tr>
<td>▪ Episodes with TPL paid claims are excluded from a PAP’s total number of valid episodes.</td>
</tr>
<tr>
<td>▪ A change in how the claims processing system treated TPL claims resulted in over-identification of episodes with TPL paid claims</td>
</tr>
<tr>
<td>▪ This affected quarterly episode reports posted September and December 2017</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Perinatal Risk-adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Risk-adjustment coefficients were applied incorrectly for perinatal episode reports</td>
</tr>
<tr>
<td>▪ This affected December 2017 perinatal episode reports</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preliminary incentive amounts</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ 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</td>
</tr>
<tr>
<td>▪ Reports also showed incentive payment values at the all-Medicaid view</td>
</tr>
</tbody>
</table>

#### Status

| ▪ 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 |

| ▪ 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 |

| ▪ 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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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 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:

- **Year 2019**
  - First stage
  - 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

- **Year 2020**
  - Second stage
  - Episode name:
    - Spinal fusion
    - Neonatal - Medium
    - Spinal decompression
    - Diabetic ketoacidosis
    - Ankle Sprain/Strain
    - Knee Sprain/Strain
    - Shoulder Sprain/Strain

- **Year 2021**
  - Third stage
  - Episode name:
    - Femur and pelvis fracture
    - Tonsillectomy
    - Knee arthroscopy
    - Hysterectomy
    - Breast biopsy

The subset of episodes to roll out each year
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
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## Upcoming episodes webinars

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<th>Dates</th>
<th>Topics</th>
</tr>
</thead>
<tbody>
<tr>
<td>August 29th</td>
<td>Update on the Episodes program</td>
</tr>
<tr>
<td>September 26th</td>
<td>Understanding your episode and PAP referral reports</td>
</tr>
<tr>
<td>October 23th</td>
<td>Update on episodes launched in 2017</td>
</tr>
<tr>
<td>November 28th</td>
<td>Updates relevant for the 2019 performance year</td>
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</tbody>
</table>
Episode information can be found on the ODM website

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

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