Ohio | Department of Medicaid
John R. Kasich, Governor
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Ohio Episode-Based Payments Frequently Asked Questions

Updated January 2020

EPISODE OVERVIEW

Questions	Answers
What are Episodes of Care?	Episodes of care include all the care related to a defined medical event (e.g., a procedure, an acute condition), including the care for the event itself (e.g., procedures, professional claims, pharmacy), any pre-cursors to the event (e.g., diagnostic tests, pre-operative visits), and follow-up care (e.g., follow-up visits, medications, rehab, readmissions). They are built from the perspective of a "patient journey" through the health system, providing a more comprehensive view of care involved in treating a condition for a patient. For a given episode type, a principal accountable provider (PAP) is defined and held accountable for the quality and cost of care delivered to the patient for the entire episode.
Why is Ohio implementing an Episodes of Care program?	The episodes of care model can reduce health care costs and improve quality of care. By providing transparency on healthcare spend and quality of care across the entire episode, providers can see how they perform as compared to their peers. The transparency gained through the episodes-based payment model gives providers information needed to better understand the sources of costs and where to improve quality of care. For episodes that are linked to payment, the episodes of care model incentivizes providers to keep healthcare costs down by rewarding them with positive incentive payments if their average cost for a certain episode falls below a predetermined 'commendable' threshold and they meet specific quality measures. Providers whose average episode spend is above a predetermined 'acceptable' threshold will be held responsible by incurring a negative incentive payment.
What Episodes of Care have been implemented in Ohio?	43 episodes have been implemented in Ohio and, as of January 2020, 23 of those episodes are currently linked to payment. 11 episodes have been retired starting the 2019 program year and two additional in 2020. The full list of episodes by Wave, Source of Value and details for each episode – including whether they are tied to financial incentives- can be found on the Ohio Medicaid website.

How will an Episode-based payment model work with fee-for-service?	Providers continue to have the same administrative and financial relationships with payers as before, but the incentive payments are structured to better align incentives to promote high-quality and efficient care. All providers continue to provide care, bill payers, and receive reimbursement as they do today. Based on a look-back at claims data (retrospective), the principal accountable provider (PAP) for an episode is identified, and the episode cost and select quality measures are calculated based on episode-specific definitions and algorithms. Each PAP receives quarterly reports summarizing their quality and cost results across all their episodes in a reporting period. For some episodes, this performance data is shared as information-only, however for those episodes that are tied to financial incentives, the information in the quarterly reports provides important information to providers before financial incentives are assessed.
Who has been involved in the design of Ohio's Episode-based payment model?	Episodes were designed with input from multiple stakeholders. The Episode Design Team, including providers, payers, employers, and other stakeholders, provided input to the overall Ohio episode model. In addition, approximately 200+ providers in Ohio participated in 13 separate Clinical Advisory Groups (CAGs) that met multiple times to review episode definitions (including PAP selection, types of cost to include/exclude, risk factors, and quality metrics) and detailed analyses for select sets of episodes. For later episodes that were designed in an accelerated fashion, clinical input was sought from providers through clinical feedback sessions. The core team of participating payers also met regularly to contribute to the design process and developed a charter outlining how the multiple payers in the state would align on this model, and in what areas they would develop their own strategy.
Will there be changes to the model in the future?	While the overall approach is expected to remain stable, the State will continue to test the model as designed, collect feedback, and assess the need for updates, in the spirit of continuous improvement.

PROVIDER PARTICIPATION

Questions	Answers
What is a principal accountable provider (PAP), and how are they determined?	The principal accountable provider, or PAP, is the clinician, practice, or institution in the best position to ensure that a patient is treated in a high-quality, cost-efficient manner. The PAP is usually the provider that has most closely followed the patient through his or her treatment journey and has had the most decision-making responsibility over that patient's care. The PAP will receive an episode performance report that compares performance on cost and quality metrics for a given episode to other PAPs. Though many providers, from radiologists to physical therapists, may be involved in treating one patient, the PAP is the one ultimately responsible for ensuring that efficient, high quality care is delivered. The PAP for each episode can be found in the Episode quick reference table on the Ohio Department of Medicaid website.
How will providers be impacted by Episodes of Care?	PAPs will continue to interact with patients, bill, and receive payments just as they do today. For providers who are identified as a PAP for a given episode, positive and negative incentive payments may be used to discourage inefficient and low-quality care, and also reward providers for high-quality, efficient care. PAPs are held responsible for all relevant care provided during the episode duration, therefore, providers will be rewarded for coordinating care with high-quality, efficient providers. Providers other than the PAPs will play a role in many of the episodes. We refer to these providers as "participating providers." The episode model encourages PAPs to coordinate closely with these participating providers to ensure high value care is being delivered. Participating providers will not be subject to any direct changes in payment or incentives. For some episodes, the State has decided that they will not be directly linked to incentive payments. PAPs for these episodes will primarily benefit from the episodes of care program through increased transparency on cost and quality performance.
How can providers participate in Episode of Care design process?	For episodes launched during the first few years of the program, multiple rounds of Clinical Advisory Group (CAG) meetings were held prior to the release of episodes. Providers shared their thoughts regarding those episodes, and changes were incorporated into both the initial release of episodes, as well as subsequent revisions. For episodes designed in an accelerated fashion, provider input was sought both before and after the initial launch of reports. Through a similar clinical feedback process, clinical input will be routinely considered for design changes to be implemented in time for future rounds of reports. ODM welcomes feedback for all episodes.

Questions	Answers
Who should providers contact for questions about OH Episode-based payment model specific questions?	For all episodes, providers can 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.

EPISODE DESIGN AND DEFINITION

Questions	Answers
What dimensions are included in Episode of Care design?	Episodes are designed across the following dimensions: – Trigger: diagnoses or procedures and corresponding claim types and/or care settings that characterize a potential episode – Duration: fixed window relevant to trigger events, which consists of the time period when most relevant service occurs – Claims included: claims with relevant diagnoses or procedures that will be included in episode spend calculation – PAP: principal accountable provider (PAP) who has the most control over how care is being delivered over the episode window; usually identified from trigger claim – Exclusion: identification of episodes that meet certain business and/or clinical criteria, and have a significantly different patient journey that are not comparable to other episodes that will be included – Risk adjustment: as patients with certain comorbidities and an overall more significant risk profile can have higher episode spend, risk adjustment is performed to ensure variation in episode spend comes from variation in care utilization instead of patients' characteristics; this allows PAPs to be compared on an equal basis – Quality metric: a set of metrics measuring quality of care for a given episode, focusing on both care utilization and health outcomes
What measures are used to ensure fair comparison across providers?	Recognizing that there is variation in patients' characteristics, multiple measures are taken to ensure providers who see particularly high-risk or complex patients are not disadvantaged in an episode compared to their peers: – Episode specific risk adjustment models are used to adjust for higher spend across episodes with multiple clinically-validated risk factors – Episodes with certain comorbidities that lead to substantially different patient journeys will be excluded from determination of average episode spend Episodes with adjusted episode spend higher than three standard deviations from the mean will be excluded to ensure outliers are not included

Where can I find the definition for a certain Episode of Care?	Definitions for all 43 episodes that Ohio has launched into reporting (as of January 2020) are posted on the Medicaid website. Any future episodes that are designed and launched will also be posted at the same website location. For a given episode, the following documents are provided: – Definition / concept paper: summary of key design dimensions for an episode, along with views on the patient journey and sources of value; a concept paper will also provide additional background and analysis on the episode design Detailed Business Requirement (DBR): technical guide for implementation of the episode in quarterly reports, including comprehensive business context and detailed logic for each design dimension – Code sheet: Excel workbook that provides details on medical codes and parameters important for all episode design dimensions; designed to be used in conjunction with the DBR – Thresholds: for episodes linked to payment, provides details on the thresholds for both episode spend and quality metric performance

REPORT

Questions	Answers
Where can I access reports?	Reports are available to the system administrator on the MITS portal. The system administrator is responsible for sharing the information with the individual clinicians, departments, and other appropriate staff within a healthcare provider organization. System administrators should work with their organizations to ensure that these reports are delivered to the right providers in a timely manner. A guide for accessing reports can be found on the Medicaid website.
When will reports be released?	Episode provider reports are released quarterly. PAP referral reports for those episodes that are linked to payment are released annually in June/July of each calendar year.
How to read my report?	Episode quarterly performance reports include information regarding episode counts, episode spend, quality metric performance, and trends in performance over time. A guide to interpreting the episode performance report can be found on the Medicaid website. Annual PAP referral reports provide an overview of cost and quality performance on PAPs for a given episode and enable providers to see how they are performing as compared to their peers. PAP referral reports only include information about episodes linked to payment and as new episodes are linked to payment in the future, additional episodes will be included in this report. A guide to read PAP referral report can be found on the Medicaid website.
How can I use my reports?	For most PAPs, the quarterly reports mark the first time that they will have access to information about cost, quality and utilization for an overall episode and not just the component of care they delivered. This can help providers to understand the sources of costs and quality of care – and therefore to better coordinate care between providers. PAPs can reference their episode performance reports as a snapshot of their performance. They can also access detailed information, such as the cost distribution across all patients for a particular episode, that inform which practice patterns are delivering care at high quality and low costs, or where there are potential opportunities for improvement. The annual PAP referral reports offer a high-level overview of how a given provider's cost and quality performance compares to peers.
Who do I contact if I have questions about my report?	Please contact ODM at 1.800.686.1516 for any questions regarding episode reports. For payer-specific questions, please find the appropriate contact information on the cover letter of the report.

PAYMENT

Questions	Answers
Which Episodes of Care are tied to payment, and when will each Episode of Care be tied to payment?	Twenty Three episodes are currently linked to payment: Ankle sprain/strain/non-operative fracture, Asthma exacerbation, Cholecystectomy, Colonoscopy, COPD exacerbation, Dental tooth extraction, Femur and pelvis fracture, Perinatal, Cholecystectomy, Colonoscopy, EGD, GI Bleed, Headache, Knee arthroscopy, Knee sprain/strain/non-operative fracture, Low back pain, Neonatal (low-risk), Neonatal (moderate-risk), Otitis media, Pediatric acute lower respiratory infection, Shoulder sprain/strain/non-operative fracture, Skin and soft tissue infections, URI, UTI and Wrist sprain/strain/non-operative fracture. 11 episodes have been retired starting the 2019 program year and two additional in 2020*: Appendectomy, Breast cancer surgery, Breast medical oncology, Diabetic ketoacidosis/ hyperosmolar hyperglycemic state, HIV, Hysterectomy, Oppositional defiant disorder, Pancreatitis, Spinal decompression without fusion, Spinal fusion, and Tonsillectomy; and for 2020* ADHD and CHF. The State plans to continue to link additional episodes to payment using a staged approach over the next couple years. Not all Episodes of Care will ultimately be tied to payment.
Where can I find positive / negative incentive payments, and how are they calculated?	For episodes linked to payment, positive and/or negative incentive payment amounts can be found on end-of-year payment reports. These reports are available via the MITS provider portal, with preliminary reports released approximately June of each calendar year, and final reports released approximately September. These reports will be released after sufficient 6-months claims runout (e.g. reports on CY2016 Performance Year came out in June 2017 and September 2017). To be eligible for a positive incentive payment, a PAP must have at least 5 valid episodes ending in the performance period, have an average risk-adjusted valid episode spend that falls below the commendable threshold, and pass all quality metrics linked to performance. To be eligible for a negative incentive payment, a PAP must have at least 5 valid episodes ending in the performance period and have an average risk-adjusted valid episode spend that is above the acceptable threshold, regardless of quality metric performance. The methodology used to determine incentive payment amounts can be found on DBR section 2.3.9 for any given episode.

How are cost and quality thresholds determined?	Episode spend and quality metric performance thresholds are set for all episodes linked to payment. Thresholds are set based on historical performance with a focus on the top 10% of providers with spend above the acceptable threshold; the commendable threshold is then set so projected positive and negative incentive payments are approximately budget neutral. The methodology used to determine thresholds can be found on the Medicaid website. Historic and current thresholds for a given episode can also be found on the Medicaid website.
How are payments processed?	While episode analytics are run by ODM across all payers (both FFS and managed care plans), payments are processed by each individual payer. PAPs that contract with multiple payers may see multiple positive and/or negative incentive payments from those payers, each of which will be processed separately. Beginning in the 2019 program year: The risk and gain share amount assessed at the all payer level for a PAP, will be split among the payers using a methodology based on volume and risk. Each payer is attributed a portion of the risk or gain share based on the ratio of their risk adjusted valid episodes to total risk adjusted episodes. Where risk adjusted episodes are the number of episodes attributed to the payer for a PAP divided by the payer risk adjusted ratio for that PAP.

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