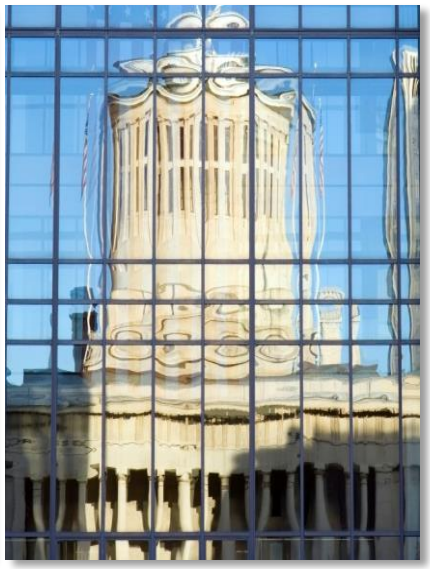


How to read your referral report – for PAPs

OFFICE OF THE GOVERNOR
STATE OF OHIO

Ohio | Governor's Office of Health Transformation

How to read your referral report – for PAPs

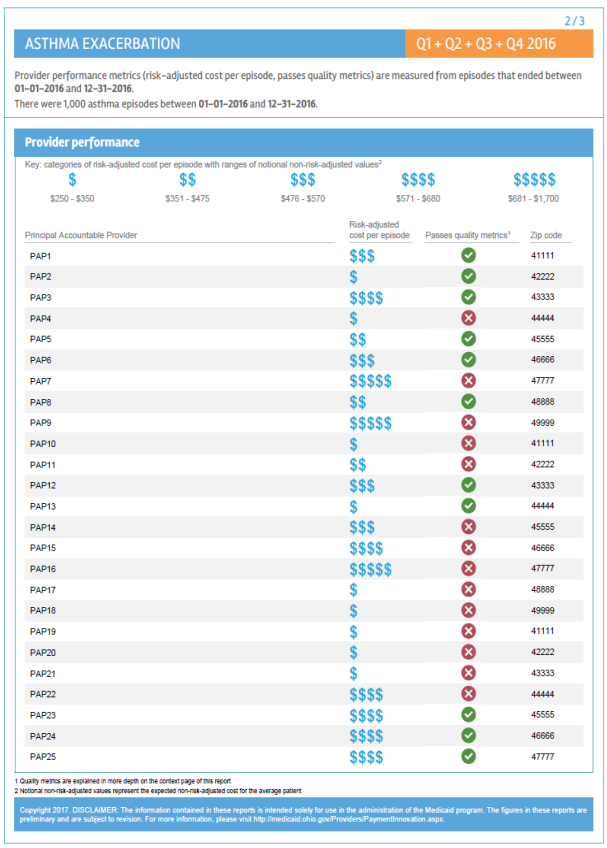
This guide explains how to read the referral report using illustrative examples. Principal Accountable Providers (PAPs) are the target audiences for this guide. The PAP referral report, which has two sections, aims to:

- Offer PAPs an understanding of both individual and peer cost and quality performance for distinct episodes
- Help identify potential areas for improvement (e.g., increased collaboration between PAPs)

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

PAP referral report sections

Section 1: provider performance



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Provider performance metrics (risk–adjusted cost per episode, passes quality metrics) are measured from episodes that ended between **01–01–2016** and **12–31–2016**.
There were 1,000 asthma episodes between **01–01–2016** and **12–31–2016**.

Provider performance

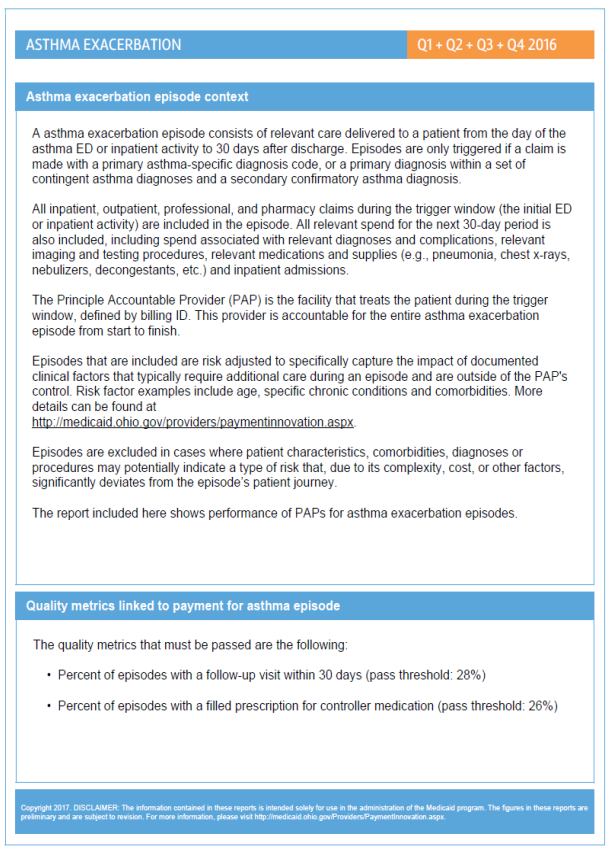
Key: categories of risk-adjusted cost per episode with ranges of notional non-risk-adjusted values[2]

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

Principal Accountable Provider	Risk-adjusted cost per episode	Passes quality metrics[1]	Zip code
PAP1	$$$	✓	41111
PAP2	$	✓	42222
PAP3	$$$$	✓	43333
PAP4	$	✗	44444
PAP5	$$	✓	45555
PAP6	$$$	✓	46666
PAP7	$$$$$	✗	47777
PAP8	$$	✓	48888
PAP9	$$$$$	✗	49999
PAP10	$	✗	41111
PAP11	$$	✗	42222
PAP12	$$$	✓	43333
PAP13	$	✓	44444
PAP14	$$$	✗	45555
PAP15	$$$$	✗	46666
PAP16	$$$$$	✗	47777
PAP17	$	✗	48888
PAP18	$	✗	49999
PAP19	$	✗	41111
PAP20	$	✗	42222
PAP21	$	✗	43333
PAP22	$$$$	✗	44444
PAP23	$$$$	✓	45555
PAP24	$$$$	✓	46666
PAP25	$$$$	✓	47777

1 Quality metrics are explained in more depth on the context page of this report
2 Notional non-risk-adjusted values represent the expected non-risk-adjusted cost for the average patient

Section 2: episode context



ASTHMA EXACERBATION | Q1 + Q2 + Q3 + Q4 2016

Asthma exacerbation episode context

A 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%)

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PAP referral report

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Provider performance metrics (risk-adjusted cost per episode, passes quality metrics) are measured from episodes that ended between **01-01-2016** and **12-31-2016**.

There were 1,000 asthma episodes between **01-01-2016** and **12-31-2016**.

Provider performance

3

Key: categories of risk-adjusted cost per episode with ranges of notional non-risk-adjusted values[2]

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

4 5 6 7

Principal Accountable Provider	Risk-adjusted cost per episode	Passes quality metrics[1]	Zip code
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PAP23	$$$$	✓	45555
PAP24	$$$$	✓	46666
PAP25	$$$$	✓	47777

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1 Quality metrics are explained in more depth on the context page of this report

2 Notional non-risk-adjusted values represent the expected non-risk-adjusted cost for the average patient

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PAP referral report

ASTHMA EXACERBATION | Q1 + Q2 + Q3 + Q4 2016

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Asthma exacerbation episode context

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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.

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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%)

PAP referral report

1. This section displays an overview of the data included in the report and 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 represent the expected non-risk-adjusted cost for the average patient.
4. Names of principal accountable providers (PAPs) will be shown and ordered in the report alphabetically.
5. Risk-adjusted cost categories correspond to the legend above (3).
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. Zip code for the episode PAP.
8. Explanatory footnotes for the report are displayed at the bottom of the page. It refers the reader to the context page of the report for quality measure details.
9. A disclaimer is written at the very bottom of the page along with a link to the Medicaid website for further information.
10. A description of the episode is shown on the context page of the report. This text provides an overview of the key elements of the episode – the triggers, claims window, 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
11. 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 section.

Contact

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