



Governor's Office of
Health Transformation

Ohio SIM: Episode-based payments update

Webinar

June 7, 2016

www.HealthTransformation.Ohio.gov

Ohio's State Innovation Model (SIM) Partners



Objectives for today's conversation

- **Update on SIM progress to date & model recap**
- **Review thresholds for first performance period for Wave 1**
- **Provide an update on episode reporting, including launch of Wave 2 reports**
- **Share plans for Wave 3 episode design in 2016**

Ohio's State Innovation Model (SIM) progress to date

Episode-Based Payment

- **13 episodes** designed across seven clinical advisory groups (CAGs), with **30+ additional episodes** under development to launch in 2017
- **Nine payers** released performance reports on first wave of 6 episodes
- State set **thresholds for performance** payments across Medicaid FFS and MCPs on first wave of episodes
- State released **performance reports** aggregated across Medicaid FFS and MCPs on second wave of 7 episodes
- **Executive Order** signed by Governor established a rule that requires Medicaid provider participation

Patient Centered Medical Home

- **Care model and payment model** design in place for model to reach 80 percent of Ohio's population
- **Statewide provider survey** gauged readiness for PCMH (570 responses)
- **Infrastructure plan** in place for attribution, enrollment, scoring, reporting, and payment
- **PCMH performance report** designed with provider/payer input
- **State provided a template for payers to apply for CPC+** (a similar template is under development for providers)

Ohio's PCMH Requirements and Payment Streams

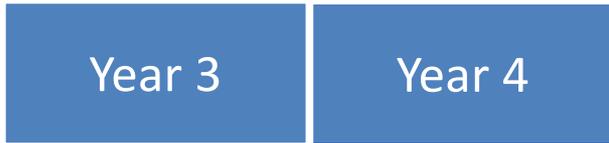
Requirements	1 8 activity requirements <ul style="list-style-type: none"> ▪ Same-day appointments ▪ 24/7 access to care ▪ Risk stratification ▪ Population management ▪ Team-based care management ▪ Follow up after hospital discharge ▪ Tracking of follow up tests and specialist referrals ▪ Patient experience 	2 5 Efficiency measures <ul style="list-style-type: none"> ▪ ED visits ▪ Inpatient admissions for ambulatory sensitive conditions ▪ Generic dispensing rate of select classes ▪ Behavioral health related inpatient admits ▪ Episodes-linked metric 	3 20 Clinical Measures <ul style="list-style-type: none"> ▪ Clinical measures aligned with CMS/AHIP core standards for PCMH 	4 Total Cost of Care
Payment Streams PMPM	<p style="text-align: center;"><i>Scoring weight shifts from standard processes and activities... ...to efficiency and clinical quality over time</i></p>			
Shared Savings	<i>Must meet activity and efficiency targets</i>	<i>Quality gate</i>	<i>Based on self-improvement & performance relative to peers</i>	

Enhanced payments begin January 1, 2018 for any PCP that meets the requirements

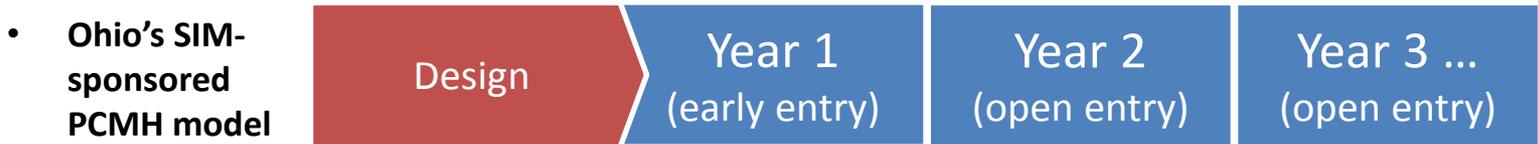
Ohio's Comprehensive Primary Care Timeline



CPCi "Classic"



CPC Statewide



- Ohio's SIM-sponsored PCMH model

CPC+



- Medicare-sponsored
- Payers apply by region
- Practices apply within regions

Application Process for CPC+



April 15 – June 8

Payers submit applications

- Preference given to CPCi and MAPCP participants, and Medicaid SIM states
- States may need additional waivers/ SPAs to apply
- **State created a template for payers to apply**

June 8 – July 15

20 Regions Selected

- CMS evaluates payers and selects regions based on payer footprint
- 20 regions to be selected – intent to award to the 7 current CPCi regions plus 13 new regions
- Regional size and boundaries to be determined

July 15 – Sept. 1

Practices submit applications

- Practices in selected regions eligible to apply
- Application includes program integrity check, questions regarding care model, and letters of support including from IT vendor
- **State will create a template for practices to apply**

Sept. 1 – Dec. 31

5,000 practices selected

- Evaluation based on practice diversity (e.g., size, location)
- CMS-selected practices eligible for CPC+ Medicare payments beginning January 1, 2017

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Retrospective episode model mechanics

Patients and providers continue to deliver care as they do today



1 **Patients** seek care and select providers as they do today



2 **Providers** submit claims as they do today



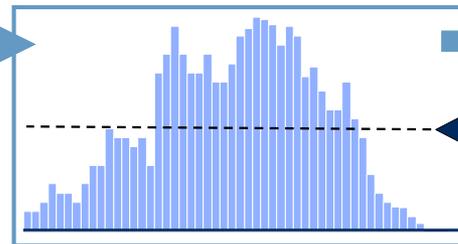
3 **Payers** reimburse for all services as they do today

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



4 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

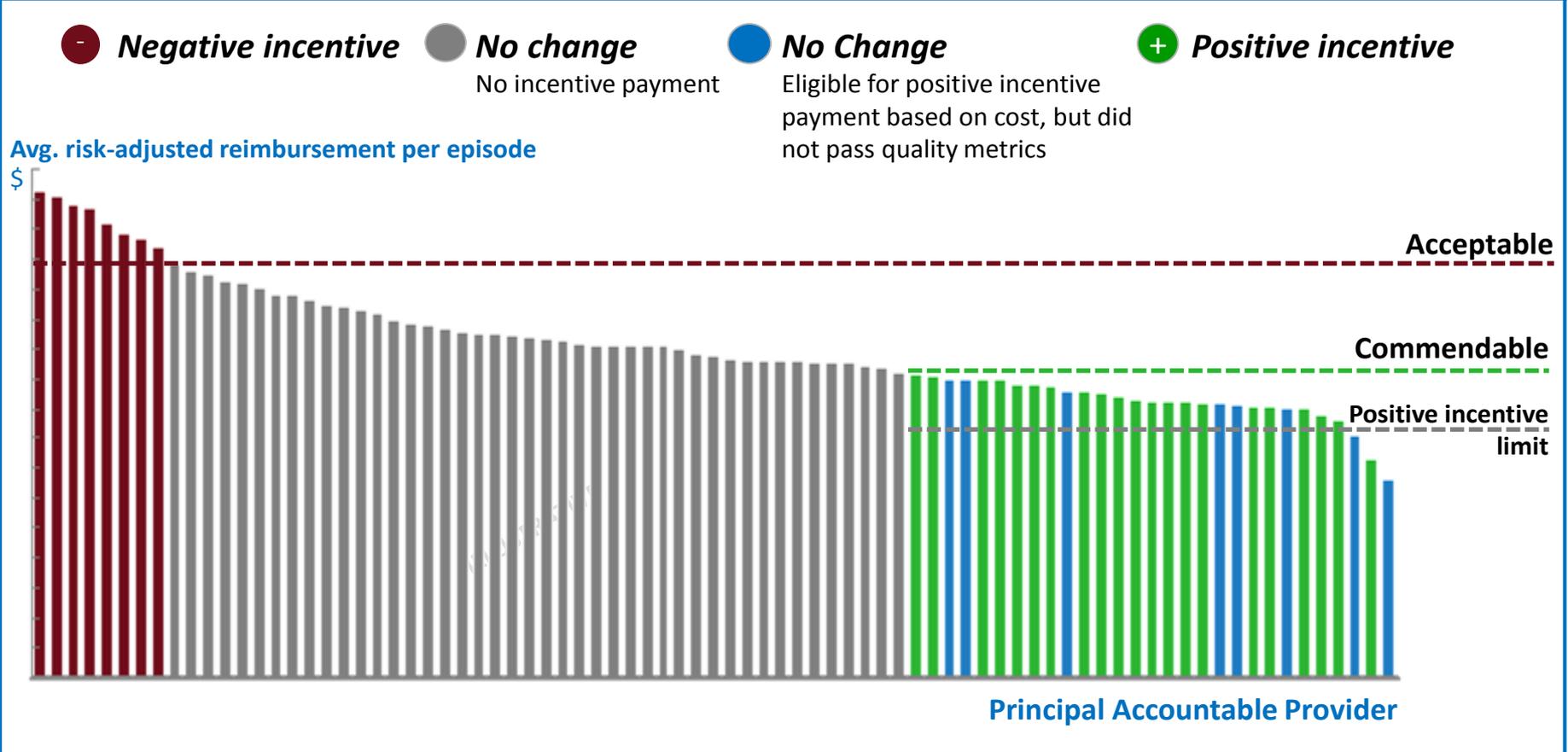


Compare to predetermined "commendable" and "acceptable" levels

- 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

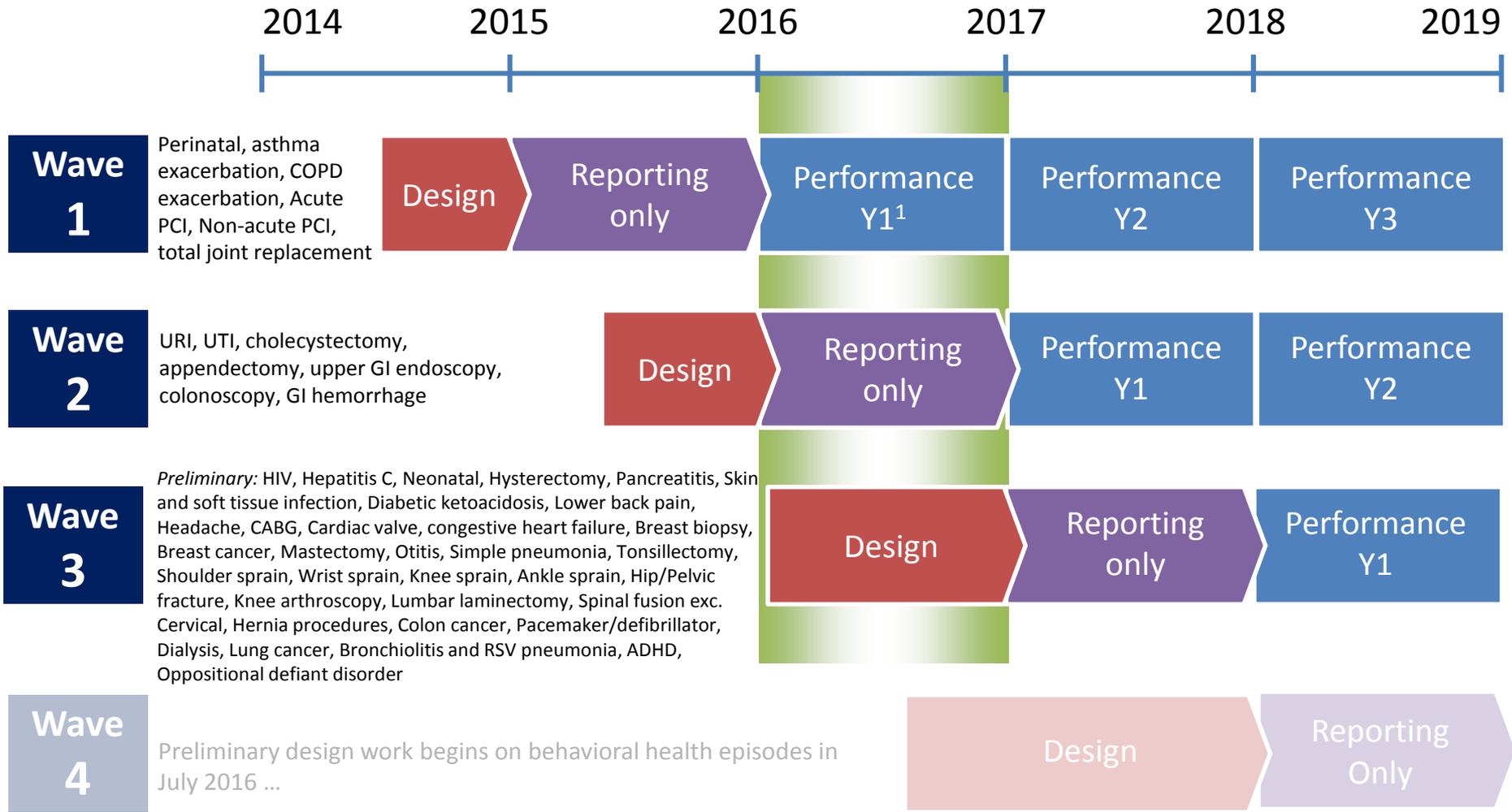
Retrospective thresholds reward cost-efficient, high-quality care

Provider cost distribution (average risk-adjusted reimbursement per provider)



Ohio's episode timeline

 Focus for today's discussion



Governor's Office of Health Transformation

¹ For three episodes linked to payment for Medicaid program: Asthma exacerbation, COPD exacerbation and Perinatal

Objectives for today's conversation

- Update on progress to date & model recap
- **Review thresholds for first performance period for Wave 1**
- Provide an update on episode reporting, including launch of Wave 2 reports
- Share plans for Wave 3 episode design in 2016

Three of the six Wave 1 episodes are linked to payment for Medicaid, with 2016 as first performance period

- Asthma acute exacerbation
- COPD acute exacerbation
- Perinatal

Linked to
payment

- Acute PCI
- Non-acute PCI
- Total joint replacement

Reporting only
'All Medicaid' view

This is an example of the performance report format released in 2016

For reporting only episodes, format is similar but there are no thresholds included

Note: An updated 'How to read your report' document is available on the Medicaid website

EPISODE of CARE PROVIDER REPORT

EPISODE NAME

Q1 + Q2 YYYY

Reporting period covering episodes that ended between Start Date to End Date

PAYER: Payer Name

PROVIDER ID: PAP ID

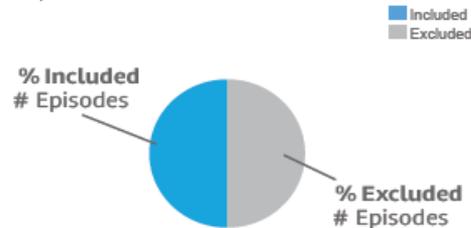
PROVIDER: Provider Name

Eligibility requirements for gain or risk-sharing payments

- ✔ **Episode volume:** You have at least 5 episodes in the current performance period.
- ✔ **Spend:** Your average risk-adjusted spend per episode is below the commendable threshold.
- ! **Quality:** You are not currently eligible for gain-sharing because you have not passed all quality metrics linked to gain-sharing.
- i **This report is informational only.** Eligibility for gain or risk-sharing will be determined at the end of the performance period and any applicable payments will be calculated at that time.

Episodes included, excluded & adjusted

Total episodes#



% of your episodes have been risk adjusted

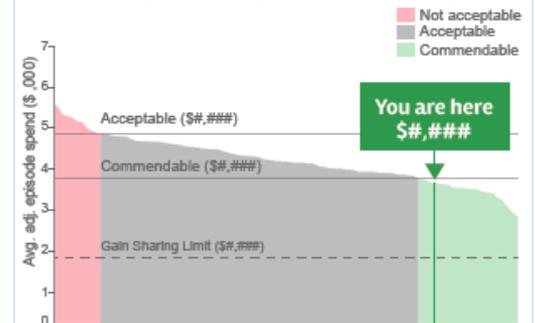
Quality metrics

You achieved # of # quality metrics linked to gain sharing

Quality metric 01	##%	✔
Quality metric 02	##%	✔
Quality metric 03	##%	✘
Quality metric 04	##%	✘

Risk adjusted average spend per episode

Distribution of provider average episode spend (risk adj.)



Key performance

Rolling four quarters

	Q3 '15	Q4 '15	Q1 '16	Q2 '16	Weighted average
Avg adjusted episode spend (\$,000)	#,###	#,###	#,###	#,###	#,###
# of included episodes	#	#	#	#	#
Your spend percentile	##%	##%	##%	##%	##%

Legend: ■ Performance period 2016, ■ Reporting period 2015

DISCLAIMER: The information contained in these reports is intended solely for use in the administration of the Medicaid program. The data in the reports are neither intended nor suitable for other uses, including the selection of a health care provider. The figures in these reports are preliminary and are subject to revision. For more information, please visit <http://medicaid.ohio.gov/Providers/PaymentInnovation.aspx>.



Governor's Office of Health Transformation

Wave 1 performance period launch: Medicaid quality metric thresholds

- The State’s goal is to set quality metric thresholds at the **top quartile of current performance** to encourage delivery of high quality care
- However, to ensure a majority of providers eligible for incentives can participate, in **Year 1**, the quality metric thresholds will be at a level where **75% of providers pass all metrics tied to incentive payments**
- Quality metric thresholds will **ramp up to top quartile performance level over the next 5 years**

	<u>Quality metric</u>	<u>Threshold</u>
Asthma exacerbation	QM1: Follow-up visit rate	28%
	QM2: Controller medication prescription fill-rate	26%
COPD exacerbation	QM1: Follow-up visit rate	50%
Perinatal	QM1: HIV screening rate	50%
	QM2: GBS screening rate	50%
	QM3: C-section rate	45%
	QM4: Post-partum visit rate	50%

Wave 1 performance period: Medicaid spend threshold methodology

Determining...

Threshold
levels

- Ohio Medicaid sets cost & quality thresholds for all MCPs
- Ohio Medicaid sets one acceptable threshold for all of Medicaid so that ~10% of providers are above the acceptable threshold, assuming no behavior change¹
- Ohio Medicaid sets one commendable threshold for all of Medicaid such that it would be budget neutral after positive and negative incentive payments, assuming no change in the PAP curve²
- Ohio Medicaid is using the same methodology to set thresholds across all Wave I episodes

Payments

- For Ohio Medicaid, including the managed care plans, the incentive payment allocation for PAPs will be 50%
- Payments will be proportional to the non-risk adjusted payment for each PAP

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 Assumes all providers pass the quality measures

Wave 1 performance period launch: Medicaid spend thresholds w/ inflationary adjustment

		<u>Acceptable</u>	<u>Commendable</u>	<u>Positive incentive limit</u>
Asthma exacerbation	Value, \$	\$383	\$294	\$25
	'All Medicaid' percentile	90 th percentile	55 th percentile	N/A
COPD exacerbation	Value, \$	\$1,115	\$690	\$49
	'All Medicaid' percentile	90 th percentile	16 th percentile	N/A
Perinatal	Value, \$	\$4,473	\$3,210	\$1,284
	'All Medicaid' percentile	90 th percentile	11 th percentile	N/A

NOTE: Thresholds are based on risk-adjusted episode reimbursement and should be used in tandem with average risk-adjusted episode reimbursement delivered on quarterly provider reports.

SOURCE: Ohio Medicaid claims data, CY2014

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Reporting overview by episode for Medicaid

	Reports distinct for each Medicaid plan	Reports aggregated across Medicaid data for all plans	Reports released by ¹ ...
Wave 1	Asthma exacerbation	✓	Ohio Department of Medicaid via MITS portal
	COPD exacerbation		
	Perinatal		
	Acute PCI		
	Non-acute PCI		
Wave 2	TJR	✓	Ohio Department of Medicaid via MITS portal
	Appendectomy	<div style="border: 1px dashed blue; padding: 10px; display: inline-block;">  </div>	
	Cholecystectomy		
	Colonoscopy		
	EGD		
	GI hemorrhage		
	URI		
UTI			

One single pdf comprised of reports for each individual MCP, available on Medicaid portal

Wave 2 cross-MCP reports include a cover page with a hyperlinked table of contents, including an 'All Payers' view followed by a report for each MCP where the PAP has at least one valid episode in the reporting period

NOTE: Working to eventually align Wave 1 and Wave 2 reports on the same quarterly schedule



EPISODE of CARE PROVIDER REPORT

COLONOSCOPY

Jan 1, 2015 to Sep 30, 2015

Reporting period covering episodes that ended between **January 1, 2015 to September 30, 2015**

PROVIDER CODE: 00000000

PROVIDER NAME: ABC Gastroenterologist

Report contents:

Page 3 All Payers

Page 8 BUCKEYE

Page 13 CARESOURCE

Page 18 FFS

Page 23 MOLINA

Page 28 PARAMOUNT



Governor's Office of
Health Transformation

FAQs: How do I access my report(s)?

Ohio
Department of Medicaid

Welcome, [redacted] Wednesday 06/17/2015 10:41:10 AM

Super User Providers Account Claims Eligibility Prior Authorization **Reports** Publications

Provider Reports

*Report EPISODE REPORTS SUMMARY (PDF) AND PATIENT DETAIL DATA(CSV)

Date Available From

Date Available To

EPISODE REPORTS SUMMARY (PDF) AND PATIENT DETAIL DATA(CSV)
EPISODE REPORTS SUMMARY DATA(PDF) ONLY
REMITTANCE ADVICE

search clear

- Reports for Ohio Medicaid are available on the MITS portal
- MITS administrators have access to the portal and can pull down to share with others in a practice

FAQs: What content is available on the portal?

In addition to pdf reports, there is a detailed csv file delivered to each PAP to complement provider reports

1	Episode Id	Included/Excluded	Payer	Rendering/Attending Physician	Medicaid ID	Patient Name	Episode Start Date	Episode End Date	Days	Risk adjusted spend	Non-adjusted spend	Dif: Adjusted/Total	IP spend (non-adj.)	IP # claims	OP spend (non-adj.)	OP # claims	Rx spend (non-adj.)	Rx # claims	Prof spend (non-adj.)	Prof # claims	Exclusion (if applicable)
2		Excluded	FFS				7/30/2012	7/7/2013	342	\$ 6,426.12	\$ 7,891.59	\$ (1,465.47)	\$2,169.63	1	\$4,170.06	12	\$ 22.22	4	\$ 1,529.68	13	Inconsistent Eli
3		Included	FFS				10/25/2012	10/3/2013	343	\$ 5,774.63	\$ 7,319.85	\$ (1,545.22)	\$3,505.12	1	\$ 76.95	1	\$ 10.96	2	\$ 3,726.82	28	
4		Excluded	FFS				1/1/2013	12/11/2013	344	\$ 5,326.18	\$ 7,931.76	\$ (2,605.58)	\$4,294.85	1	\$1,696.95	5	\$ 48.68	4	\$ 1,891.28	13	Inconsistent Eli
5		Excluded	FFS				8/24/2012	8/3/2013	344	\$ 5,036.81	\$ 7,318.82	\$ (2,282.01)	\$4,754.21	1	\$ 760.31	6	\$ 15.81	3	\$ 1,788.49	12	TPL Exclusion
6		Included	FFS				2/5/2013	1/13/2014	342	\$ 4,945.62	\$ 4,945.62	\$ -	\$2,200.73	1	\$ 101.86	1	\$ 52.25	1	\$ 2,590.78	14	
7		Excluded	FFS				8/13/2012	7/22/2013	343	\$ 4,894.99	\$ 6,150.26	\$ (1,255.27)	\$4,904.34	1	\$ -	0	\$ -	0	\$ 1,245.92	10	TPL Exclusion
8		Included	FFS				8/9/2012	7/17/2013	342	\$ 4,844.63	\$ 4,844.63	\$ -	\$3,685.38	1	\$ -	0	\$ -	0	\$ 1,159.25	6	
9		Excluded	FFS				9/13/2012	8/22/2013	343	\$ 4,815.96	\$ 7,335.82	\$ (2,519.85)	\$4,594.69	1	\$ 183.88	3	\$ 60.86	6	\$ 2,496.39	30	Comorbidity Ex
10		Excluded	FFS				5/16/2013	4/23/2014	342	\$ 4,748.90	\$ 11,189.69	\$ (6,440.79)	\$8,716.48	4	\$ 672.26	4	\$ -	0	\$ 1,800.95	15	Inconsistent Eli
11		Included	FFS				9/13/2012	8/21/2013	342	\$ 4,652.56	\$ 5,482.64	\$ (830.07)	\$2,378.98	1	\$ 946.16	8	\$ 89.67	9	\$ 2,067.83	22	
12		Excluded	FFS				9/1/2012	8/10/2013	343	\$ 4,606.32	\$ 5,463.55	\$ (857.23)	\$4,754.21	1	\$ -	0	\$ -	0	\$ 709.34	1	TPL Exclusion
13		Included	FFS				5/7/2013	4/14/2014	342	\$ 4,566.38	\$ 5,482.64	\$ (916.26)	\$2,378.98	1	\$ 274.11	2	\$ 8.81	1	\$ 1,376.63	23	
14		Included	FFS				10/18/2012	9/26/2013	343												
15		Excluded	FFS				7/11/2013	6/17/2014	341												
16		Excluded	FFS				3/29/2013	3/7/2014	343												
17		Excluded	FFS				11/15/2012	10/24/2013	342												
18		Included	FFS				12/20/2012	11/27/2013	342												
19		Excluded	FFS				10/24/2012	10/1/2013	342												
20		Included	FFS				7/28/2012	7/5/2013	342												
21		Included	FFS				11/23/2012	11/1/2013	342												
22		Excluded	FFS				7/3/2013	6/11/2014	342												
23		Included	FFS				11/12/2012	10/21/2013	343												
24		Excluded	FFS				7/19/2013	6/28/2014	344												

How to use these files to learn more:

- Understand key sources of variation, for example:
 - Breakdown of avg. risk-adjusted episode reimbursement by rendering provider
 - Breakdown of avg. reimbursement by inpatient, outpatient, professional, & pharmacy
- Understand variability in quality metric performance and relationship to average episode reimbursement

FAQs: Additional questions

Questions

Response

Who do I reach out to if I have questions about my report?

- Please reach out to either Medicaid (Provider hotline – (800) 686.1516) or the plan from which you received the report
- Contact information will be added to the cover letter for Wave 2 reports moving forward with plan-specific contact

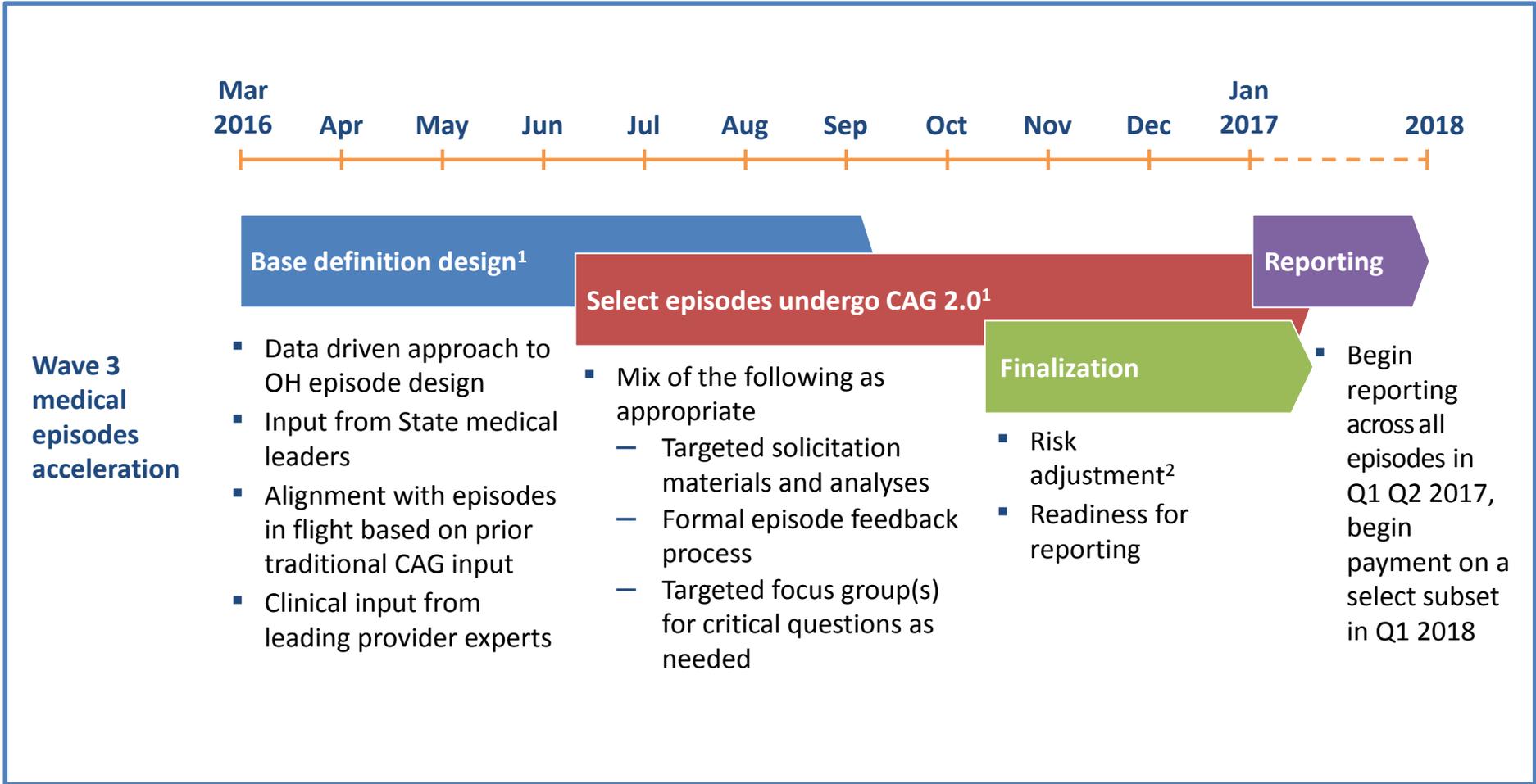
***Will Wave 1 reports continue to come from different sources?
What will happen for Wave 3?***

- For the remainder of 2016, Wave 1 reports will continue to be generated by each plan
- Wave 3 is likely to follow a similar approach to the Wave 2 episodes

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Timeline for episode design in 2016



1 Base definition design and risk adjustment will be performed in 5 staggered batches of episodes

2 Risk adjustment for all batches could be performed together in last ~2 months of 2016

Rationale for accelerated approach to episode design

- Building on momentum, we have an opportunity to accelerate episode design and reporting to increase transparency to providers in parallel to PCMH launch
- Operational changes in implementation (e.g., state reporting for MCPs) truly enable an accelerated, streamlined approach to accelerated episode reporting
- Scaling effectively requires adhering to the same core guiding principles we have aligned on while innovating and evolving our design approach, including the way we seek provider input
- An accelerated approach includes a streamlined 'Clinical Advisory Group (CAG) 2.0' process to leverage the design work completed to date, be responsive to provider feedback regarding cumbersome mid-day 'in-person' meetings, and continue to get Ohio specific input critical to the model
- Accelerating the design process not only increases projected impact due to an earlier launch, but also creates scale efficiencies and greater value, which secondarily creates option value for Ohio to be able to do additional activities with SIM funds

Episodes can be classified across six distinct archetypes

	A Planned procedures	B Acute procedures	C Acute emergent condition	D Acute non-emergent condition	E Acute symptomatic condition	F Chronic condition
						
Notes	<ul style="list-style-type: none"> May or may not be specific to a condition 	<ul style="list-style-type: none"> General ED or IP 	<ul style="list-style-type: none"> Unplanned, require immediate care 	<ul style="list-style-type: none"> Spectrum of sites of care from office to ED 	<ul style="list-style-type: none"> Symptom with broad differential 	<ul style="list-style-type: none"> Long-term disease mgmt.
Typical PAP	<ul style="list-style-type: none"> Provider 	<ul style="list-style-type: none"> Provider or facility 	<ul style="list-style-type: none"> Facility 	<ul style="list-style-type: none"> Provider 	<ul style="list-style-type: none"> Provider of facility 	<ul style="list-style-type: none"> Provider
Examples	<ul style="list-style-type: none"> CABG Hip/knee replacement 	<ul style="list-style-type: none"> Acute PCI Perinatal 	<ul style="list-style-type: none"> Acute asthma GI hemorrhage 	<ul style="list-style-type: none"> URI, UTI, Otitis Acute anxiety 	<ul style="list-style-type: none"> Lower back pain Headache 	<ul style="list-style-type: none"> ADHD / ODD Depression HIV

■ First episodes for external clinical input

Proposed episodes by archetype

Archetype	Episodes	Archetype	Episodes						
Planned procedures	<ul style="list-style-type: none"> Non-acute percutaneous coronary intervention Total joint replacement Cholecystectomy Colonoscopy Upper endoscopy (EGD) Hysterectomy¹ CABG¹ Cardiac valve replacement/repair¹ Breast biopsy Mastectomy Tonsillectomy Knee arthroscopy Lumbar laminectomy Spinal fusion exc. cervical Hernia procedures Pacemaker/defibrillator 	Acute emergent condition	<ul style="list-style-type: none"> GI hemorrhage Pancreatitis CHF Bronchiolitis & RSV pneumonia DKA/HHS² Simple pneumonia Shoulder sprain Wrist sprain Knee sprain Ankle sprain 						
	Acute procedures		<ul style="list-style-type: none"> Acute percutaneous coronary intervention Perinatal Appendectomy Hip/Pelvic fracture Neonatal 	Acute non-emergent condition	<ul style="list-style-type: none"> Upper respiratory infection Urinary tract infection Otitis Skin and soft tissue infection 				
			Acute procedures		<ul style="list-style-type: none"> Acute percutaneous coronary intervention Perinatal Appendectomy Hip/Pelvic fracture Neonatal 	Acute symptomatic condition	<ul style="list-style-type: none"> Low back pain Headache 		
					Acute procedures		<ul style="list-style-type: none"> Acute percutaneous coronary intervention Perinatal Appendectomy Hip/Pelvic fracture Neonatal 	Chronic condition	<ul style="list-style-type: none"> HIV ADHD ODD Breast cancer Hep C³ Dialysis Colon cancer Lung cancer (with surgery) Lung cancer (without surgery)

1 Procedure can be planned or emergent; intention is to limit episode inclusion to subset that are planned
 2 Diabetic ketoacidosis and hyperosmolar hyperglycemic state
 3 Reporting episode only

Key components of CAG 2.0 approach

15 – 30 clinicians per CAG 2.0

- 15-30 clinicians, with participants suggested by payers, large provider systems on the Governor’s Advisory Council, related clinical associations, Medicaid; with introductory webinar to learn about the episode model

Concept paper + key questions

- Materials for review will be a brief “concept paper” (e.g., 4-8 pages) that summarizes an episode’s design + a set of key questions. (Concept papers will be developed as an informational piece for all episodes in acceleration, not just those undergoing the CAG 2.0 approach.)

Clinician review

- Introductory webinar and call for clarifying questions followed by a formal episode review process, where clinicians review materials and provide feedback ~2 – 3 weeks after receiving the concept paper

Targeted clinician engagement as needed

- Focus group(s) / interview(s) conducted as needed over a 1-2 week period when feedback is collated and reviewed, based on design discussions and feedback received in the clinician review process

Follow-up / syndication

- Updates to the definition will be made as appropriate, and then an updated concept paper will be shared back with participating clinicians ~4 - 6 weeks following the end of the offline review period

Timeline for CAG 2.0 for the Neonatal and HIV episodes

	<u>Timing</u>	<u>Activity</u>
June	June 7 th	▪ Episode design team webinar; final request for participants
	Mid-June	▪ CAG 2.0 invitations sent out
	TBD	▪ <i>Introductory webinar on episode model (live & available online)</i>
July	Early July	▪ CAG 2.0 materials delivered
	TBD	▪ <i>Clarification call to answer any questions; episode specific</i>
	~2 - 3 wks after material release	▪ Feedback on materials due back to state
Aug.	~End of July	▪ As needed follow-up on targeted questions
	~Mid-August	▪ Syndicate updated concept paper with involved providers

Looking for recommendations for:

- Neonatologists
- Infectious disease specialists

And in behavioral health:

- Community mental health professionals
- Psychologists & psychiatrists
- Pediatricians with experience treating ADHD & ODD

Please submit names by June 13th

Specific ask of participants -

- Attend introductory webinar or watch recording online
- Review targeted materials (e.g., concept paper and related analyses)
- Provide structured feedback on key design elements
- 3 in-person meetings July/Aug ADHD/ODD CAG

Information for Providers

[Episode quick reference tables](#) - A summary of key episode definition components for all episodes.

Detailed episode information

Definitions, Detailed Business Requirements (DBR), and code tables for all episodes. DBRs include a more detailed definition as well as the associated coding algorithm. The code tables refer to an excel spreadsheet with the code detail for each episode.

Wave 1: Reporting for the initial set of episodes began in March of 2015. For Medicaid, the performance period for asthma, COPD, and perinatal begins January 1st, 2016. Episodes ending during the 12- month performance period will be used to determine whether or not a provider is eligible for an incentive payment. Reporting will continue for all episodes.

- [Asthma \(definition, DBR, code sheet\)](#)
- [COPD \(definition, DBR, code sheet\)](#)
- [Perinatal \(definition, DBR, code sheet\)](#)
- [Acute percutaneous coronary intervention episodes \(definition, DBR, code sheet\)](#)
- [Non-acute percutaneous coronary intervention episodes \(definition, DBR, code sheet\)](#)
- [Total joint replacement \(definition, DBR, code sheet\)](#)

Wave 2: Reporting will begin for the episodes listed below in 2016. The performance period for Wave 2 begins January 1st, 2016.

- [Appendectomy \(definition, DBR, code sheet\)](#)
- [Cholecystectomy \(definition, DBR, code sheet\)](#)
- [Colonoscopy \(definition, DBR, code sheet\)](#)
- [Esophagogastroduodenoscopy \(definition, DBR, code sheet\)](#)
- [Gastrointestinal bleed \(definition, DBR, code sheet\)](#)
- [Upper respiratory infection \(definition, DBR, code sheet\)](#)
- [Urinary tract infection \(definition, DBR, code sheet\)](#)

[Risk Adjustment Document](#): Detailed description of principles and process of risk adjustment for episode

Details for Providers:

- **Episode quick reference tables**
- **Frequently Asked Questions**
- **“Wave 1 & 2” episode definitions, business requirements, code sets, and risk adjustment – *soon to be updated to include ICD10 codes***
- **Risk adjustment methodology**