

## Episode-Based Payment Model Frequently Asked Questions

(updated September 2014)

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## Episode-Based Payment Model Frequently Asked Questions

*(updated September 2014)*

### OHIO'S HEALTH CARE PAYMENT INNOVATION INITIATIVE OVERVIEW

#### **What is Ohio's payment innovation initiative?**

Ohio's payment innovation initiative, led by the Governor's Office of Health Transformation (OHT), brings together payers, providers, and other healthcare stakeholders to broadly transform the Ohio health delivery system to achieve better health, better care, and cost savings. In February 2013, OHT was awarded a federal State Innovation Model (SIM) grant to design payment models that increase access to patient-centered medical homes (PCMHs) and support episode-based payments for acute medical events. In July 2014, the state submitted an application for a federal State Innovation Model Test award through the Center for Medicare and Medicaid Innovation (CMMI), to implement both models over the next 4 years. As an initial step, Medicaid and participating commercial plans are launching performance reports for 6 episodes of care. An overview of Ohio's payment innovation initiative can be found [here](#).

#### **Why is this happening now?**

Health care spending across state and commercial payers in Ohio is growing at an unsustainable rate, leading to higher premiums and higher spend for the state. Even so, health care outcomes for Ohioans are poor: Across all 50 states, Ohio has the 18<sup>th</sup> highest healthcare spend per person, but ranks 36<sup>th</sup> in terms of population health. This initiative is being implemented now to replace the trend of growing costs and consistently poor health outcomes with vastly improved population health and more stable costs.

#### **What new payment and delivery models will be part of this initiative?**

Ohio's payment innovation will ultimately include both implementing episodes of care and patient centered medical homes. Both models will include payment incentives to reward high quality, low cost care (i.e., gain-sharing for PCMH, gain/risk-sharing for episodes), performance reporting, and additional provider support.

#### **What is the timing for implementation?**

An overview of the five-year strategy can be found [here](#). Medicaid and participating commercial payers are starting with performance reporting for an initial set of 6 episodes – asthma, chronic obstructive pulmonary disease (COPD), perinatal, total joint replacements (TJR), and acute and non-acute percutaneous coronary interventions (PCI) – with the first performance reports to be shared with providers in November 2014. For PCMH, the Comprehensive Primary Care Initiative

(CPCI) in Southwest Ohio is on-going and will inform the design of the broader statewide PCMH model to be rolled out in SIM implementation.

### **Which health care payers are participating?**

Four commercial payers are participating in Ohio: including Aetna, Anthem, Medical Mutual of Ohio, and United HealthCare. Medicaid fee-for-service (FFS) and all five Medicaid managed care plans: Buckeye, CareSource, Molina, Paramount, and UnitedHealth are also participating. These payers cover about 90% of Ohio's population.

### **Is provider participation mandatory for Medicaid?**

Medicaid will start by automatically sharing episode performance reports- with all Principal Accountable Providers without any associated changes in payment/incentives. All providers who meet the qualifications to receive an episode report (see below) will receive the reports. Changes to incentives will occur in future phases of the initiative.

### **How will the episode and patient-centered medical home (PCMH) models interact?**

Episodes and PCMHs are complementary care delivery and payment approaches. PCMHs provide the foundation for total cost and quality accountability and primarily target the primary care community, particularly in caring for the chronically ill and improving overall population health. Episode based performance measurement and payment encourage high value care for acute situations and some specific conditions and are more applicable to the specialists and facilities that deliver acute care. It will be easier for a PCMH to succeed if the acute care providers it interacts with assume greater accountability for acute events. Similarly, providers that lead an episode of care will find it easier to be successful if a patient has a strong PCMH that will coordinate care across multiple episodes and care types. While some larger health systems that own primary care, specialists, and facilities may participate in both models, most clinicians in Ohio will likely end up participating in one or the other.

### **What about providers who are in or developing accountable care organizations (ACOs)?**

While the state is developing episode and PCMH models, this is not designed to preclude providers from moving towards even more aggressive value-based payment models, such as capitation or full risk bearing ACOs. The goal of the episodes and PCMH models is to provide the building blocks for a healthcare system founded on quality of health outcomes, rather than quantity of treatments. For example, episode performance reporting can provide data that will help an ACO understand some of its cost drivers and target areas to improve performance.

## **EPISODES OVERVIEW**

### **What are episodes of care?**

Episodes of care include all the care related to a defined medical event (e.g., a procedure, an acute exacerbation of a chronic condition), including the care for the event itself (e.g., procedures, professional claims, pharmacy), any pre-cursors to the event (i.e., 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. (See examples [here](#).) For a given episode type, a principal accountable provider is defined who is held accountable for both the quality and cost of care delivered to the patient for the entire episode.

### **What episodes are being implemented in Ohio?**

The initial set of episodes being implemented in Ohio includes asthma, chronic obstructive pulmonary disease (COPD), perinatal, total joint replacements (TJR), and acute and non-acute percutaneous coronary interventions (PCI). Medicaid fee-for-service and managed care plans are implementing this full set of episodes. Participating commercial plans are each selecting three episodes to implement.

### **How will Ohio’s retrospective episode model work?**

All providers will 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 will be identified, and the episode cost and select quality measures will be calculated based on [episode-specific definitions](#) and [algorithms](#). Each PAP will receive quarterly reports summarizing their quality and cost results across all their episodes in a reporting period. Initially, performance data will be shared with providers for information only. Ultimately, a payment model will be included with gain-sharing for providers who, on average, have lower costs – and meet quality thresholds – across their episodes, and with risk-sharing for providers who have very high average episode costs.

### **What about prospective “bundled payment” approach?**

The State’s model for episodes is retrospective, as described above. An alternative approach is a prospective model, in which the principal accountable provider received a set payment, or a “bundle” for an episode cost upfront. A main factor in the State’s decision to implement retrospective episodes is that the prospective model requires the provider receiving the prospective payment to enter contracting relationships to reimburse other providers participating in the episode (i.e., facility, imaging, pharmacy), which can be much more complex to implement at-scale across the state. The State’s model, however, is not intended to preclude individual payers and providers from agreeing to specific prospective bundled contracts. In particular, in the near term, the information provided in the episode performance reports being implemented across payers could also help inform a prospective episode arrangement.

### **When are these episodes going into effect for reporting? For payment?**

Episode performance reports will be delivered in or around November 2014. Initially, episodes will be in a “reporting-only period,” to inform and educate providers on their performance but with no changes to provider payment tied to episode performance. For Medicaid fee-for-service, this “reporting-only period” is anticipated to last approximately 12 months. After the “reporting-only period” ends, a “performance-period” will begin. The episodes attributed to a principal accountable provider (PAP) during the performance period will be used to calculate any gain or risk-sharing payments once that performance period ends. Commercial payers will

be contracting separately with PAPs with the intent of following similar timelines and methodology as outlined in this document.

### **How will this model reduce health care costs?**

This model incentivizes providers to keep healthcare costs down by rewarding them with gain sharing payments if their average cost for a certain episode falls below a predetermined threshold. Providers whose average episode spend is above a predetermined high-cost threshold will be held responsible for this cost by paying back a portion of the excess cost. This payment will not come into effect until after approximately one year of reporting, to ensure that providers are fully informed of the cost of the healthcare they provide relative to other providers. Starting in November 2014, providers will receive quarterly reports informing them of their cost performance relative to other providers and highlighting areas for improvement on both cost and quality metrics. In this way, providers have a chance to improve their performance before gain and risk sharing begins.

### **How does this model improve quality of care?**

The episode model includes a targeted set of quality metrics, which track a provider's performance in areas like screening for diseases and arranging follow-up visits after any important health events such as surgeries or ED visits. It also rewards desired health outcomes such as decreased re-hospitalization. (See specific quality measures for each episode in the [episode definition](#). A provider who has low average episode costs will not be eligible for gain-sharing payments unless they also meet standards for certain quality measures.

### **How does an episode-based payment model work with the fee-for-service (FFS) model?**

Under the episode payment model, providers are still paid fee-for-service (FFS) in the same way they do today, but they are held to a greater level of accountability for the cost of care that they deliver. The gain and risk-sharing incentives encourage PAPs to coordinate between different providers to ensure that the care a patient receives is appropriate and of a high quality. In short, providers continue to have the same administrative and financial relationships with the payers as before, but the payments are structured to better align incentives to promote high-quality and efficient care.

### **Who was involved in the design of Ohio's episode-based payment model?**

Episodes were designed with input from many stakeholders. The Episode Design Team (slides 3-4 [here](#)), including providers, payers, employers, and other stakeholders, provided input to the overall Ohio episode model. In addition, approximately 110 providers in Ohio participated in clinical advisory groups that met multiple times to review baseline episode definitions and detailed analyses. They provided clinical input into the creation of the episode definitions (i.e. PAP selection, types of costs to include/exclude, risk factors, quality metrics.) The list of clinical advisory group participants is available here at the website referenced above. In addition, the core team of participating payers 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.

### **How consistent is the episode model across payers?**

Medicaid fee-for-service and the Medicaid managed care plans are applying the same episode [definitions and algorithms](#), though each plan is implementing the episodes on its own claims data and will be delivering separate reports to providers. The commercial plans on the core team aligned on an [episode charter](#), identifying areas where the design will be consistent or customized for its business. Questions on the specific payer's episode definitions should be directed to that payer.

### **Where else has this model been used? How is it working for them?**

Payers and large providers in Ohio have experimented with episode-based payments via the Medicare Bundled Payment for Care Improvement (BPCI) initiative. Commercial plans (i.e. United Health Care) have piloted episode programs in specific areas such as cancer care. Other states such as Arkansas and Tennessee have also implemented episodes as part of their State Innovation Model initiatives. Studies of episodes initiatives have shown savings between 3-29%. These savings have been captured due to improved appropriateness of care (Health Affairs 2008), reduced pharmacy and imaging costs, and a reduction of hospital admissions, readmissions, and average length of stay, for which one study reported a 16% decrease after 1 year of implementation.

### **What are Ohio's plans for episodes going forward?**

As described in Ohio's five-year [strategy for payment innovation](#) and [application](#) for CMS State Innovation Model Test funding, the state intends to continue to work with participating payers to launch 20 episodes over the next three years and up to 50 episodes over the next 5 years. The next set of episodes to develop has not yet been determined.

### **Will there be changes to the model in the future?**

While the overall approach is expected to remain stable, the next 6-12 months of reporting period will provide an opportunity to test the model as designed, collect feedback, and assess the need for updates, in the spirit of continuous improvement.

## **EPISODE PROVIDER ACCOUNTABILITY**

### **What is a principal accountable provider (PAP) and how are they determined?**

The principal accountable provider, or PAP, is the clinician, practice, or institution most responsible for ensuring 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 a report comparing his or her performance on cost and quality metrics for a particular episode compare 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 treatment is of a high quality and an appropriate cost.

**How do I know if I am a PAP?**

Each episode has a clearly defined attribution methodology to connect a patient's episode of care to a specific PAP. To find out which provider is the PAP for any given episode, refer to the episode definitions found [here](#). The definition of the PAP for each episode was decided by a clinical advisory group and takes into account which provider will have the most decision making responsibility, ability to coordinate or direct other providers delivering care, and responsibility for a meaningful share of costs or volumes of care.

**Do providers choose if they want to be a PAP? Is participation required?**

A provider cannot opt in or out of being a PAP. PAPs are identified according to the [episode definitions](#), retrospectively, on claims data. The PAP will receive a report showing how his or her performance on a set of quality metrics (found in the episode definitions) and costs compares to other providers.

**Will non-physicians be eligible to participate?**

Yes, in two ways. For some episodes the PAP will be a facility or mental health provider. In other cases providers other than the PAP will play some role in 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. That said participating providers will not be subject to any direct changes in payment or incentives.

**What happens if another provider drives up the episode cost? Will the PAP be responsible for this cost?** In any one case, another provider may contribute to greater expense for patients being cared for by a PAP. Even so, PAPs remain accountable for the average cost of care across all of their episodes. This is intended to reward providers for coordinating care with high-quality, efficient providers.

**Will the PAP be held responsible for decisions beyond their reach, for example, if a patient is non-compliant?** Ultimately, it is the role of the PAP to encourage behaviors that are best for their patients. This includes educating patients about the best treatment plans for them, and informing them of how the most appropriate treatment plan also leads to the best health outcomes. Even so, a certain level of patient non-compliance may still occur. In that case, the comparative nature of this model ensures that the average episode spend across all PAPs includes a certain level of non-compliance, so no one provider should feel singled out. Furthermore, risk-adjustment and high-cost outliers have been designed based on historical claims data which reflects some level of non-compliance.

**Will this model penalize doctors who take on particularly sick or complex patients?**

No. In this model, the cost of an episode is risk-adjusted to compare doctors' performance relative to others' in a way that takes patient health risk factors and other health complications into consideration. If a doctor takes on a patient who incurs a higher cost of care due to a noted risk factor, the spend for that episode will be adjusted downward to reflect what the cost of that episode would have been for a much healthier patient. Details of the risk adjustment methodology can be found [here](#). If complications arise for any patient that drive the cost of

care up to a level far beyond the average spend for that episode (e.g. 3 standard deviations above the mean), the episode will be excluded. These two safeguards, risk-adjustment and excluding high-cost outliers, are put in place to protect patients from being denied care by any provider for reasons of cost, and to protect providers from being penalized for taking on sick patients.

**Why does this payment model affect all providers, both those who are high and low performing today?** The goal of this health transformation initiative is not only to discourage inefficient and low-quality care, but also to reward providers for high-quality, efficient care. Our aim is to transform the way that all providers in the state think about care delivery. Rather than quantity of care, this model rewards high-quality and better health outcomes, while encouraging providers to use resources efficiently.

## **EPISODE DESIGN AND DEFINITION**

### **What types of costs are included in an episode?**

Episodes are defined to include relevant claims for care around a specific “trigger event” that defines an episode (i.e., delivery for perinatal, knee or hip replacement procedure for total joint replacement). This includes all the claims generated during the actual trigger event (i.e., inpatient admission), specific types of claims related to the trigger event that occur beforehand (i.e., prenatal visits, ultrasounds for perinatal) in the pre-trigger window, and any follow-up care that occurs in a post-trigger window. Costs included in the post-trigger window can include planned care (i.e., post-discharge follow-up visits, medications), or care resulting from complications in the episode (i.e., readmissions). Types of costs included may include professional claims, procedures (inpatient or outpatient), labs and imaging (inpatient or outpatient), rehabilitation or long term care, pharmacy, etc. A summary of the types of costs included for each episode are in the [episode definitions](#) and further details can be found in the episode detailed [business requirements and code sheets](#).

### **What do the different windows for an episode mean: pre-trigger, trigger, post-trigger?**

The “trigger event” is the diagnosis or procedure code that indicates a potential episode has occurred. For some episodes, there is a “pre-trigger window.” This defines the period of time before the trigger event in which claims related to the episode will be included in the episode cost. The “post-trigger window” is the set time period for each episode in which relevant claims related to the episode which occur after the trigger event will be included in the episode cost.

### **What does it mean for an episode to be excluded?**

An excluded episode is not taken into account when the PAP’s performance is measured (i.e., average episode spend, quality metrics.) The episodes not excluded, or valid episodes, are used to calculate PAP performance on episodes. All claims in an excluded episode will still be billed under FFS, and the provider(s) who make the claims will be reimbursed and paid as usual. Each episode report will indicate the total number of episodes identified during the period, and the number of those that are excluded or valid on the summary report file. Episode-level details for

both valid and excluded episodes (including the reason for exclusion) are included in the detailed report file.

### **What factors can cause an episode to be excluded?**

Episodes can be excluded for a number of reasons, all aimed at ensuring the remaining episodes used to measure performance are comparable to each other and allow fair comparisons between patient panels. Some of these are business exclusions, i.e., if there are gaps in insurance enrollment during the episode window, if there are multiple payers, or incomplete billing data. Others are clinical exclusions, i.e., the patient is outside the defined age range for an episode, the patient left the hospital against medical advice, the episode is a high-cost outlier (even after risk adjustment has been applied), or the patient has co-morbidities identified in the [episode definitions](#). The full list of exclusion factors for each episode is available in the episodes' detailed [business requirements](#).

### **Why are some high-cost episodes risk adjusted and others excluded as high-cost outliers?**

Risk adjustment and high-cost outlier exclusions are both components of the episode algorithm designed to ensure that providers who treat patients with higher episode costs due to more complex cases are not penalized when cost performance is compared across PAPs. Statistical modeling was applied to identify the set of risk factors for each episode most predictive of episode spend and to calculate adjustment coefficients for each factor. See the [risk adjustment methodology paper](#) for details of approach of the approach used. The cost of any episode with one or more risk factors present is adjusted down based on the appropriate risk adjustment coefficients. After all episodes have been risk adjusted, high cost outliers (total risk-adjusted episode cost greater than 3 standard deviations above the mean) are also excluded. This step recognizes that complications outside of the PAPs control may still occur and to take out the highest cost cases.

**Where can I find a comprehensive list of relevant diagnoses, risk factors, and exclusions for each episode? The episode definitions only provide a list of examples.** An exhaustive list of relevant diagnoses which would be included in the pre-trigger, trigger, and post-trigger windows can be found in the [code sheets](#).

**Where can I find a summary of the episode design parameters (e.g., PAP, trigger window, quality metrics) for each episode?** A summary table of the major components for the six initial episodes is available [here](#).

## **EPISODE QUALITY MEASURES**

**What measures are in place to ensure that patients receive a high quality of care, even as providers aim to reduce overall costs?** Each episode will have a set of quality metrics on which providers are evaluated. These quality metrics reflect certain standards of care, such as patient education or episode-relevant screenings which act as a benchmark to ensure that a patient is receiving adequate care for his or her episode. These quality metrics act as a useful source of

information for providers about their performance relative to other PAPs and how they can improve patient care.

### **How were quality metrics determined?**

Quality metrics were developed through a process of close collaboration between providers, clinical advisors, and other stakeholders in clinical advisory groups. The current set of quality metrics can all be measured based on claims data. This was an explicit decision in the design process to avoid the need for providers to report additional clinical data to the payers. Analysis of claims data was also used to assess quality and costs. The clinical advisory groups aligned on these quality metrics as being good indicators of a high quality of care which leads to improved health outcomes for patients.

### **Why are some quality measures linked to gain-sharing and others for reporting only?**

A small, targeted set of quality metrics, determined by the clinical advisory groups to be most critical, will be linked to gain-sharing. While aiming to limit the metrics included in total to a manageable number, the clinical advisory groups also identified a set of additional metrics for each episode that could help provide insights into PAPs care patterns and help identify opportunities for improvement, without tying financial consequences to these measures.

### **What are the thresholds for quality metrics? Are there “passing grades”?**

For the reporting period, there are no thresholds set for quality metrics. PAPs will see their performance on a quality measure across all their valid episodes, relative to the average performance across all PAPs. Reports released for this period are meant to inform providers of their performance on quality relative to others and to highlight areas for improvement in care. Once the reporting period is complete and the performance period begins, thresholds will be set for the metrics tied to gain-sharing, to ensure that a minimum standard of quality is met by all providers who receive gain-sharing payments.

## **ACCESSING EPISODE PERFORMANCE REPORTS (Medicaid FFS)**

### **How often will episode reports be released?**

Episode reports will be released quarterly. The first set of reports will be released in November 2014.

### **Where can I access my report?**

For episodes paid for by Medicaid FFS, reports can be accessed on the Medicaid MITS portal. (Each payer will send reports out separately, so questions about access to other payer’s reports should be directed to those payers.) Reports will be available to the system administrator on the MITS portal. The system administrator will be responsible for sharing the information with the individual clinicians, departments, and other appropriate staff (e.g., administrators). System administrators should work with their organizations to make sure that these reports can be delivered to the right providers in a timely manner. A guide for accessing reports will soon be able to be found [here](#).

**Who in my practice or institution will receive the reports?**

Reports will initially be available to the system administrator through the Medicaid MITS portal. The system administrator will be responsible for sharing the reports with the appropriate staff.

**If I am a provider who is not the PAP, but I still want to see how I perform on cost, can I get access to reports?** Reports are only provided to the PAPs. However, if providers would like to find out how the cost of the care they provide affects overall episode cost, they are encouraged to start a dialogue with the PAP and other providers involved in the episode to better understand how the group of providers involved in the episode can coordinate on the quality of care they are delivering to their patients, and explore ways to make this care more cost efficient.

**If the PAP is a facility, who reads the report and informs providers about its contents?**

The system administrator will be responsible for receiving reports and ensuring that the information they provide is passed on to everyone within the facility to whom it is relevant. This may include clinicians, department heads, coordinators, and business managers.

**USING EPISODE PERFORMANCE REPORTS****Who gets to see the reports?**

At this stage, reports will only be provided to the PAPs. However, if providers would like to find out how the cost of the care they provide affects overall episode cost, they are encouraged to start a dialogue with the PAP and other providers involved in the episode to better understand how the group of providers involved in the episode can coordinate on the quality of care they are delivering to their patients, and explore ways to make this care more cost efficient.

**What information is included in the reports?**

The reports, provided to PAPs who have at least 5 valid episodes, will contain information about that PAP's performance on cost and quality in comparison to other PAPs for the same episode. PAPs will be able to see their average cost for the episode and how they performed on a set of quality metrics. PAPs will receive a pdf summary report, with cost and quality data for their episodes and comparisons to other PAPs. They will also receive an excel (.csv) file with details for each episode attributed to the PAP. Once performance becomes linked to payment, reports will also indicate what threshold of spend the PAP falls into for that episode, whether or not the PAP met the minimum standards for quality metrics, and what, if any, the PAP's subsequent gain or risk sharing payment will be. A guide for accessing reports will soon be able to be found [here](#).

**How can PAPs use their reports?**

PAPs can reference their 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. For most PAPs, the 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. A guide to understanding reports will soon be able to be found [here](#).

### **How can PAPs identify ways to improve their performance?**

The cost and quality metric data in the reports can provide high-level guidance of areas where a PAP's care patterns may differ than the average across PAPs, and where there may be opportunities for improvement. In addition, the [sources of value across the patient journey](#) for an episode identify common points at which decisions can influence cost and quality outcomes for an episode. Providers are also encouraged to use the reports as a basis for discussions with colleagues, to share best practices and learn from the other's approaches.

### **How does the reporting differ by episode?**

Each episode type (e.g. perinatal, total joint replacement) will generate a separate report. The format of the report will remain consistent across episodes, but the relevant quality metrics and cost data will differ. A PAP will receive a different report for each episode type in which he or she has at least 5 valid episodes.

### **What period of data is used to calculate reports?**

Each report will include a 12 month period, with calculations applied to data three months after the 12-month period concludes to allow for claim submissions. The 12-month period will be rolling as additional reports are released. Any episode that ends within this 12-month period will be accounted for in the episode report.

### **When will the results published in the reports be tied to payment?**

For all episodes, there will be a "reporting only" period, during which providers are informed of their cost and quality performance relative to other PAPs. PAPs will not be held accountable for their performance during this "reporting only" period. At the end of this "reporting only" period, the performance period will start. During the performance period, payers will periodically, likely every year, retrospectively assess the performance of PAPs for that prior year. Payment will be calculated based on average risk-adjusted episode costs, as well as quality performance, calculated from claims data during the performance year.

## **EPISODE PAYMENT APPROACH**

### **Does the PAP also still bill fee for service (FFS)?**

Yes. The PAP still bills for the care that he or she delivers and will be reimbursed in the same way as today. Any gain or risk sharing payments will be calculated after the performance period closes.

**Will this model have any effect on payments to providers who aren't the PAP?**

No. All providers who deliver services submit fee for service claims and get paid as they do today. Episode spend calculation happens retrospectively and is intended to act as a guide showing PAPs how they perform relative to other providers and highlight areas where they can improve on cost and quality measures. Gain or risk sharing will only apply to the PAP, not any other provider whose costs are included in the episode.

**What are the cost thresholds for gain or risk sharing?**

Medicaid's cost thresholds to determine levels at which gain or risk sharing will apply have not yet been determined for the initial set of episodes.