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Introduction to the Ohio Episode-Based Payment Model

December 2015

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1. **Ohio's approach to paying for value instead of volume**
2. Episode-Based Payment Model
3. Specific episode example
4. Want to learn more?

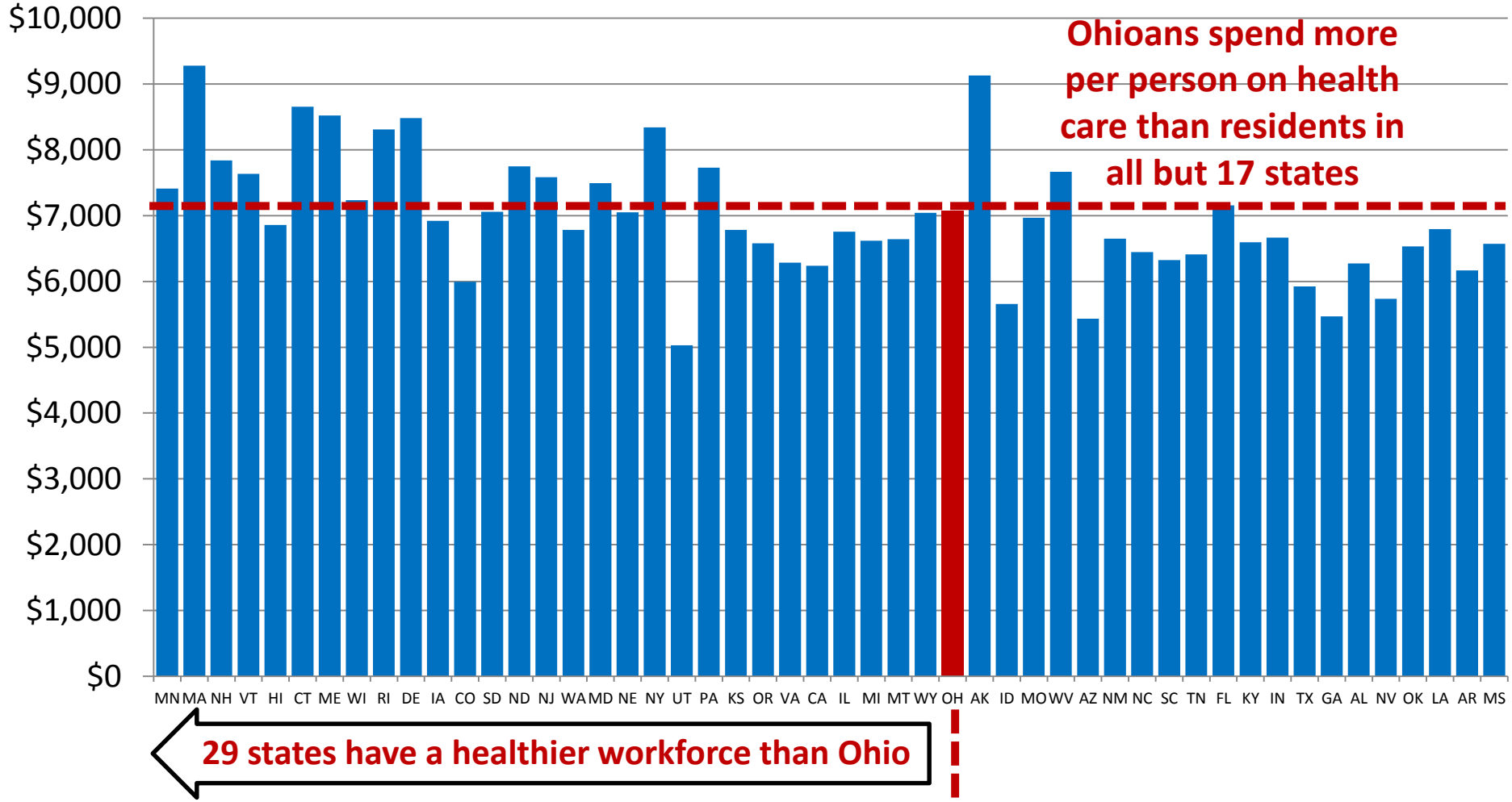
In fee-for-service, we get what we pay for

- **More volume** – to the extent fee-for-service payments exceed costs of additional services, they encourage providers to deliver more services and more expensive services
- **More fragmentation** – paying separate fees for each individual service to different providers perpetuates uncoordinated care
- **More variation** – separate fees also accommodate wide variation in treatment patterns for patients with the same condition – variations that are not evidence-based
- **No assurance of quality** – fees are typically the same regardless of the quality of care, and in some cases (e.g., avoidable hospital readmissions) total payments are greater for lower-quality care

Source: UnitedHealth, *Farewell to Fee-for-Service: a real world strategy for health care payment reform* (December 2012)

Ohio can get better value from what is spent on health care

Health Care Spending per Capita by State (2011) in order of resident health outcomes (2014)



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Sources: CMS *Health Expenditures by State of Residence* (2011); The Commonwealth Fund, *Aiming Higher: Results from a State Scorecard on Health System Performance* (May 2014).

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Ohio's Path to Value

Modernize Medicaid	Streamline Health and Human Services	Pay for Value
Initiate in 2011	***Initiate in 2012***	***Initiate in 2013***
Advance Governor Kasich's Medicaid modernization and cost containment priorities	***Share services to increase efficiency, right-size capacity, and streamline governance***	***Engage private sector partners to set clear expectations for better health, better care and cost savings through improvement***
• Extend Medicaid coverage to more low-income Ohioans • Eliminate fraud and abuse • Prioritize home and community based (HCBS) services • Reform nursing facility payment • Enhance community DD services • Integrate Medicare and Medicaid • Rebuild community behavioral health system capacity • Restructure behavioral health system financing • Improve Medicaid managed care plan performance	• Create the Office of Health Transformation (2011) • Implement a new Medicaid claims payment system (2011) • Create a unified Medicaid budget and accounting system (2013) • Create a cabinet-level Medicaid Department (2013) • Consolidate mental health and addiction services (2013) • Simplify and integrate eligibility determination (2014) • Refocus existing resources to promote economic self-sufficiency	• Join Catalyst for Payment Reform • Support regional payment reform • Pay for value instead of volume (State Innovation Model Grant) – Provide access to medical homes for most Ohioans – Use episode-based payments for acute events – Coordinate health information infrastructure – Coordinate health sector workforce programs – Report and measure system performance

In 2013, Ohio won a federal innovation grant to adopt two payment models that reward higher-quality, value-based care

Goal	80-90 percent of Ohio's population in some value-based payment model (combination of episodes- and population-based payment) within five years
State's Role	▪ Shift rapidly to PCMH and episode model in Medicaid fee-for-service ▪ Require Medicaid MCO partners to participate and implement ▪ Incorporate into contracts of MCOs for state employee benefit program

	Patient-centered medical homes	Episode-based payments
2014	▪ In 2014 focus on Comprehensive Primary Care Initiative (CPCi)	▪ State leads design of six episodes: asthma acute exacerbation, COPD exacerbation, perinatal, acute and non-acute PCI, and joint replacement
2015	▪ Collaborate with payers on design decisions and prepare a roll-out strategy	▪ State leads design of seven new episodes: URI, UTI, cholecystectomy, appendectomy, GI hemorrhage, EGD, and colonoscopy
2016	▪ Model rolled out to at least two major markets	▪ 20 episodes defined and launched across payers, including behavioral health
2017-2018	▪ Model rolled out to all markets ▪ 80% of patients are enrolled	▪ 50+ episodes defined and launched across payers, including behavioral health

updated August 27, 2015

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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

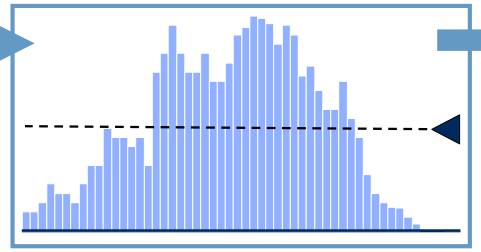
Payers reimburse for all services as they do today

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

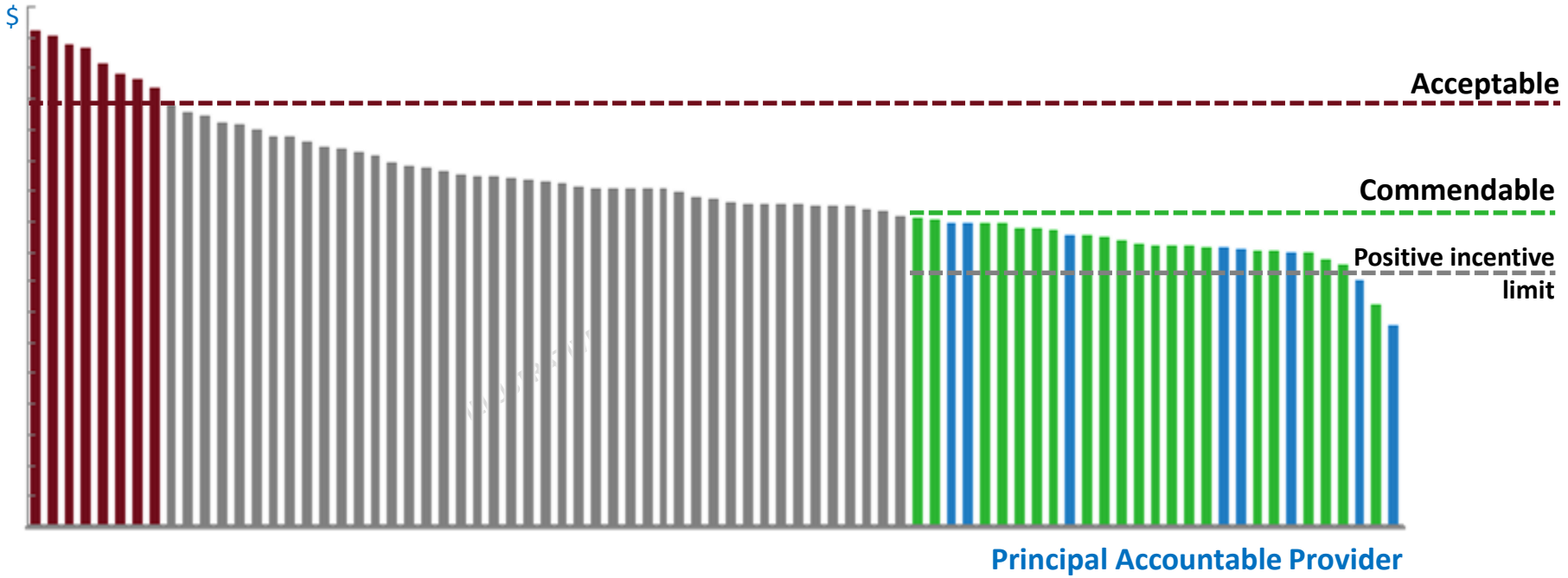
6 **Providers may:**

- **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)

- ***Negative incentive***
- ***No change***
  No incentive payment
- ***No Change***
  Eligible for positive incentive payment based on cost, but did not pass quality metrics
- ***Positive incentive***



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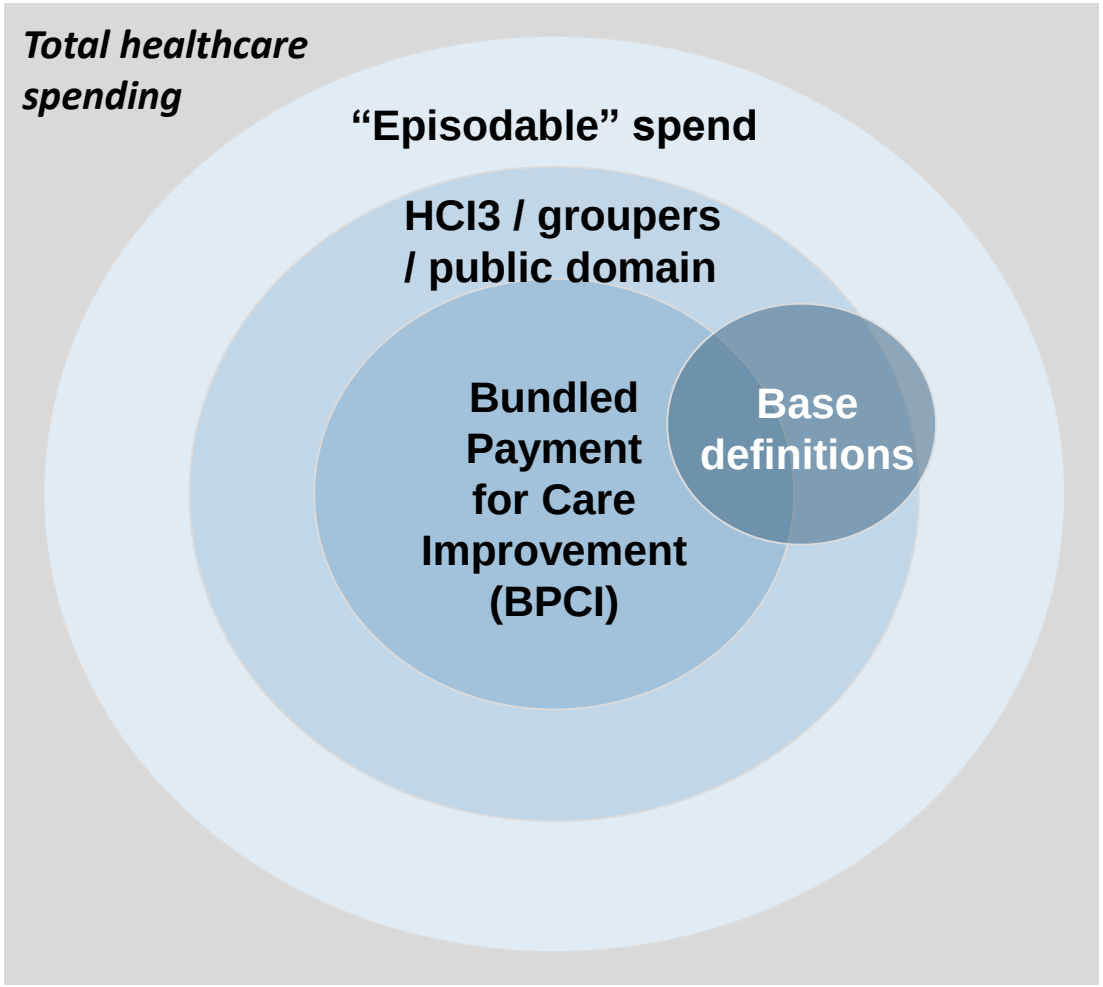
NOTE: Each vertical bar represents the average cost for a provider, sorted from highest to lowest average cost

Elements of the Episode Definition

Category	Description
1 Episode trigger	▪ Diagnoses or procedures and corresponding claim types and/or care settings that characterize a potential episode
2 Episode window 3 Claims included	▪ **Pre-trigger window:** Time period prior to the trigger event; relevant care for the patient is included in the episode ▪ **Trigger window:** Duration of the potential trigger event (e.g., from date of inpatient admission to date of discharge); all care is included ▪ **Post-trigger window:** Time period following trigger event; relevant care and complications are included in the episode
4 Principal accountable provider	▪ Provider who may be in the best position to assume principal accountability in the episode based on factors such as decision making responsibilities, influence over other providers, and portion of the episode spend
5 Quality metrics	▪ Measures to evaluate quality of care delivered during a specific episode
6 Potential risk factors	▪ Patient characteristics, comorbidities, diagnoses or procedures that may potentially indicate an increased level of risk for a given patient in a specific episode
7 Episode-level exclusions	▪ Patient characteristics, comorbidities, diagnoses or procedures that may potentially indicate a type of risk that, due to its complexity, cost, or other factors, should be excluded entirely rather than adjusted

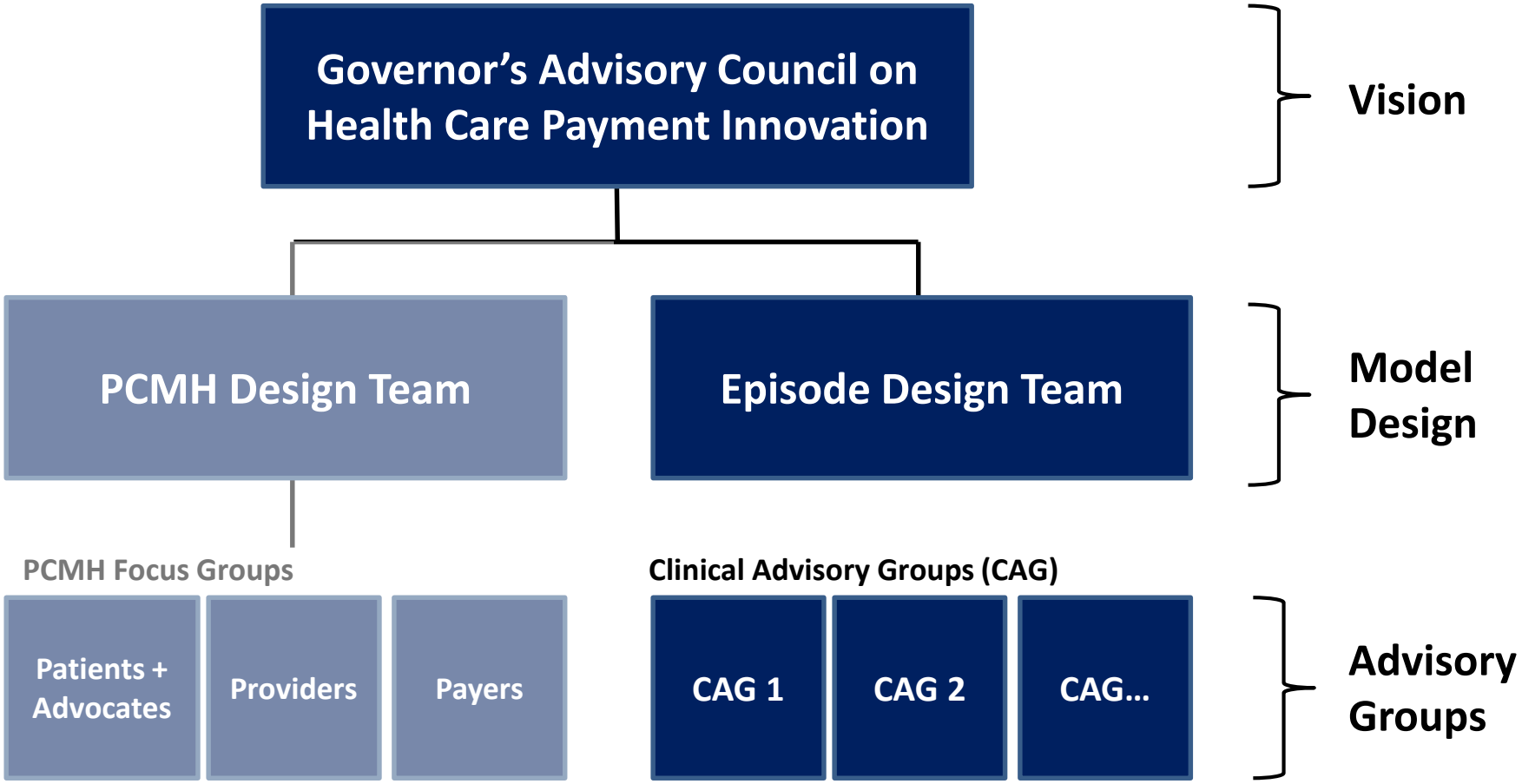
Base definition incorporates work from pilots nationwide



Base definitions incorporate work from multiple episode initiatives, including

- Work in other states (e.g., Arkansas)
- Prometheus
- Bundled payment for care improvement

Ohio's payment innovation design team structure is on track to deliver 5-7 new episodes annually



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Selection of episodes

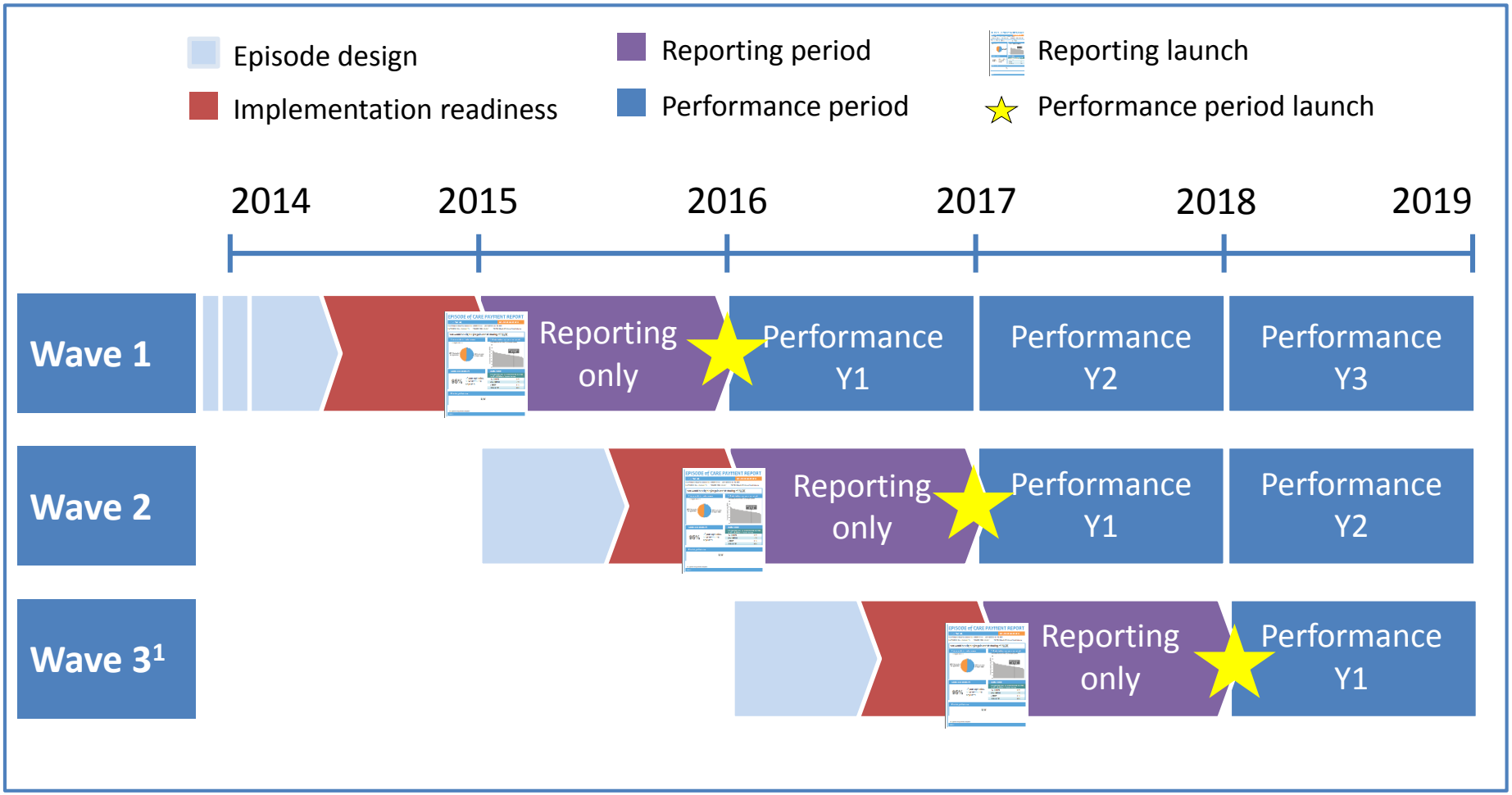
Principles for selection:

- Leverage episodes in use elsewhere to **reduce time to launch**
- Prioritize meaningful **spend across payer populations**
- Look for opportunities with **clear sources of value** (e.g., high variance in care)
- Select episodes that incorporate a **diverse mix** of accountable **providers** (e.g., facility, specialists)
- Cover a **diverse set of "patient journeys"** (e.g., acute inpatient, acute procedural)
- Consider **alignment with current priorities** (e.g., perinatal for Medicaid, asthma acute exacerbation for youth)

Ohio's episode selection:

Episode	*Principal Accountable Provider*
WAVE 1 (launched March 2015)	
1. Perinatal	Physician/group delivering the baby
2. Asthma acute exacerbation	Facility where trigger event occurs
3. COPD exacerbation	Facility where trigger event occurs
4. Acute Percutaneous intervention	Facility where PCI performed
5. Non-acute PCI	Physician
6. Total joint replacement	Orthopedic surgeon
WAVE 2 (launch January 2016)	
7. Upper respiratory infection	PCP or ED
8. Urinary tract infection	PCP or ED
9. Cholecystectomy	General surgeon
10. Appendectomy	General surgeon
11. Upper GI endoscopy	Gastroenterologist
12. Colonoscopy	Gastroenterologist
13. GI hemorrhage	Facility where hemorrhage occurs
WAVE 3 (launch January 2017)	
14-19. Package of episodes including some related to behavioral health	

Ohio's episode timeline



1 Expected timing for Wave 3

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This is an example of the performance report format that will be released in 2016 with the launch of the performance period for Wave 1 and used for both Wave 1 and Wave 2 episodes in 2016

EPISODE of CARE PROVIDER REPORT

EPISODE NAME | Q1 + Q2 YYYY

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

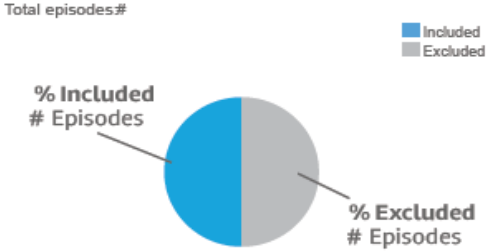
PAYER: Payer Name | PROVIDER ID: PAP ID | PROVIDER: Provider Name

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.
- **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

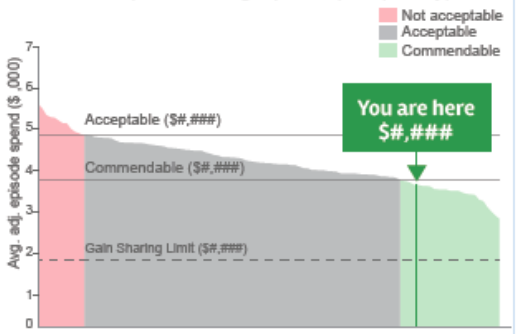
Total episodes#



% of your episodes have been risk adjusted

Risk adjusted average spend per episode

Distribution of provider average episode spend (risk adj.)



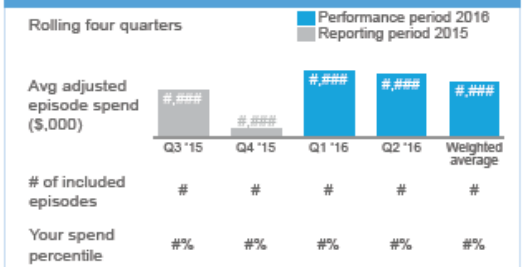
Quality metrics

You achieved # of # quality metrics linked to gain sharing

Quality metric 01	#% ✓
Quality metric 02	#% ✓
Quality metric 03	#% ✗
Quality metric 04	#% ✗

Key performance

Rolling four quarters



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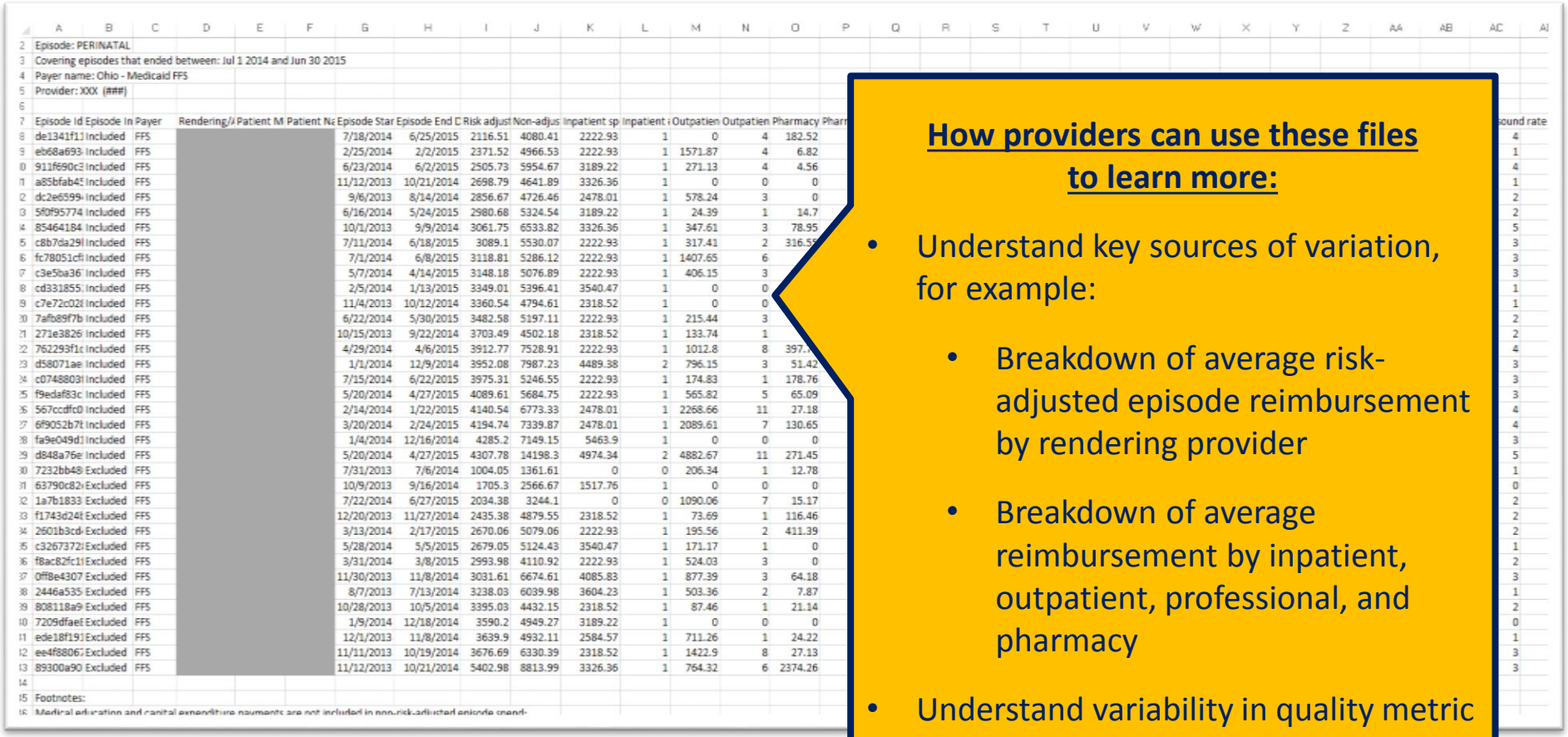
Detailed file delivered to each Principal Accountable Provider to complement quarterly provider reports



Episode: PERINATAL
Covering episodes that ended between: Jul 1 2014 and Jun 30 2015
Payer name: Ohio - Medicaid FFS
Provider: XXX (###)

Episode Id	Episode In	Payer	Rendering/A	Patient M	Patient Na	Episode Star	Episode End D	Risk adjust	Non-adjus	Inpatient sp	Inpatient :	Outpatien	Outpatien	Pharmacy	Pharr	sound rate
de1341f13	Included	FFS				7/18/2014	6/25/2015	2116.51	4080.41	2222.93	1	0	4	182.52		4
eb68a693	Included	FFS				2/25/2014	2/2/2015	2371.52	4966.53	2222.93	1	1571.87	4	6.82		1
911f690c3	Included	FFS				6/23/2014	6/2/2015	2505.73	5954.67	3189.22	1	271.13	4	4.56		4
a85bfab45	Included	FFS				11/12/2013	10/21/2014	2698.79	4641.89	3326.36	1	0	0	0		1
dc2e6599	Included	FFS				9/6/2013	8/14/2014	2856.67	4726.46	2478.01	1	578.24	3	0		2
5f0f95774	Included	FFS				6/16/2014	5/24/2015	2980.68	5324.54	3189.22	1	24.39	1	14.7		2
85464184	Included	FFS				10/1/2013	9/9/2014	3061.75	6533.82	3326.36	1	347.61	3	78.95		5
c8b7da29	Included	FFS				7/11/2014	6/18/2015	3089.1	5530.07	2222.93	1	317.41	2	316.5		3
fc78051cf	Included	FFS				7/1/2014	6/8/2015	3118.81	5286.12	2222.93	1	1407.65	6			3
c3e5ba36	Included	FFS				5/7/2014	4/14/2015	3148.18	5076.89	2222.93	1	406.15	3			3
cd331855	Included	FFS				2/5/2014	1/13/2015	3349.01	5396.41	3540.47	1	0	0			1
c7e72c02	Included	FFS				11/4/2013	10/12/2014	3360.54	4794.61	2318.52	1	0	0			1
7afb89f7b	Included	FFS				6/22/2014	5/30/2015	3482.58	5197.11	2222.93	1	215.44	3			2
271e3826	Included	FFS				10/15/2013	9/22/2014	3703.49	4502.18	2318.52	1	133.74	1			2
762293f1c	Included	FFS				4/29/2014	4/6/2015	3912.77	7528.91	2222.93	1	1012.8	8	397.7		4
d58071ae	Included	FFS				1/1/2014	12/9/2014	3952.08	7987.23	4489.38	2	796.15	3	51.42		3
c0748803	Included	FFS				7/15/2014	6/22/2015	3975.31	5246.55	2222.93	1	174.83	1	178.76		3
f9edaf83c	Included	FFS				5/20/2014	4/27/2015	4089.61	5684.75	2222.93	1	565.82	5	65.09		3
567ccdfc0	Included	FFS				2/14/2014	1/22/2015	4140.54	6773.33	2478.01	1	2268.66	11	27.18		4
6f9052b7f	Included	FFS				3/20/2014	2/24/2015	4194.74	7339.87	2478.01	1	2089.61	7	130.65		4
fa9e049d1	Included	FFS				1/4/2014	12/16/2014	4285.2	7149.15	5463.9	1	0	0	0		3
d848a76e	Included	FFS				5/20/2014	4/27/2015	4307.78	14198.3	4974.34	2	4882.67	11	271.45		5
7232bb48	Excluded	FFS				7/31/2013	7/6/2014	1004.05	1361.61	0	0	206.34	1	12.78		1
63790c82	Excluded	FFS				10/9/2013	9/16/2014	1705.3	2566.67	1517.76	1	0	0	0		0
1a7b1833	Excluded	FFS				7/22/2014	6/27/2015	2034.38	3244.1	0	0	1090.06	7	15.17		2
f1743d24	Excluded	FFS				12/20/2013	11/27/2014	2435.38	4879.55	2318.52	1	73.69	1	116.46		2
2601b3cd	Excluded	FFS				3/13/2014	2/17/2015	2670.06	5079.06	2222.93	1	195.56	2	411.39		2
c3267372	Excluded	FFS				5/28/2014	5/5/2015	2679.05	5124.43	3540.47	1	171.17	1	0		1
f8ac82fc1	Excluded	FFS				3/31/2014	3/8/2015	2993.98	4110.92	2222.93	1	524.03	3	0		2
0ff8e4307	Excluded	FFS				11/30/2013	11/8/2014	3031.61	6674.61	4085.83	1	877.39	3	64.18		3
2446a535	Excluded	FFS				8/7/2013	7/13/2014	3238.03	6039.98	3604.23	1	503.36	2	7.87		1
808118a9	Excluded	FFS				10/28/2013	10/5/2014	3395.03	4432.15	2318.52	1	87.46	1	21.14		2
7209dfae	Excluded	FFS				1/9/2014	12/18/2014	3590.2	4949.27	3189.22	1	0	0	0		0
ede18f19	Excluded	FFS				12/1/2013	11/8/2014	3639.9	4932.11	2584.57	1	711.26	1	24.22		1
ee4f8806	Excluded	FFS				11/11/2013	10/19/2014	3676.69	6330.39	2318.52	1	1422.9	8	27.13		3
89300a90	Excluded	FFS				11/12/2013	10/21/2014	5402.98	8813.99	3326.36	1	764.32	6	2374.26		3

Footnotes:
Medical education and capital expenditure payments are not included in non-risk-adjusted episode spend.

How providers can use these files to learn more:

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

Wave 1 performance period launch: Proposed 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**

	Quality metric	Threshold
Asthma	QM1: Follow-up visit rate	28%
	QM2: Controller medication prescription fill-rate	26%
COPD	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%

SOURCE: Ohio Medicaid claims data, CY 2014

Wave 1 performance period launch: Medicaid spend threshold methodology

Determining…

Threshold levels

- Ohio Medicaid will set cost and quality thresholds for all MCPs
- Ohio Medicaid will set one acceptable threshold for all of Medicaid so that ~10 percent of providers are above the acceptable threshold, assuming no behavior change[1]
- Ohio Medicaid will set 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 curve[2]
- 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 percent
- 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: Proposed Medicaid spend thresholds[1]

		Acceptable	Commendable	Positive incentive limit
Asthma	Value, $	$372	$292	$24
	'All Medicaid' percentile	90th percentile	55th percentile	N/A
COPD	Value, $	$1,087	$683	$58
	'All Medicaid' percentile	91st percentile	21st percentile	N/A
Perinatal	Value, $	$4,405	$3,169	$1,235
	'All Medicaid' percentile	90th percentile	12th percentile	N/A

1 Subject to inflationary adjustment based on actuarial review; final adjusted thresholds will be posted in 2016 and included on all reports in 2016

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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, CY 2014

All Medicaid PAP curve (used to set thresholds) - Perinatal

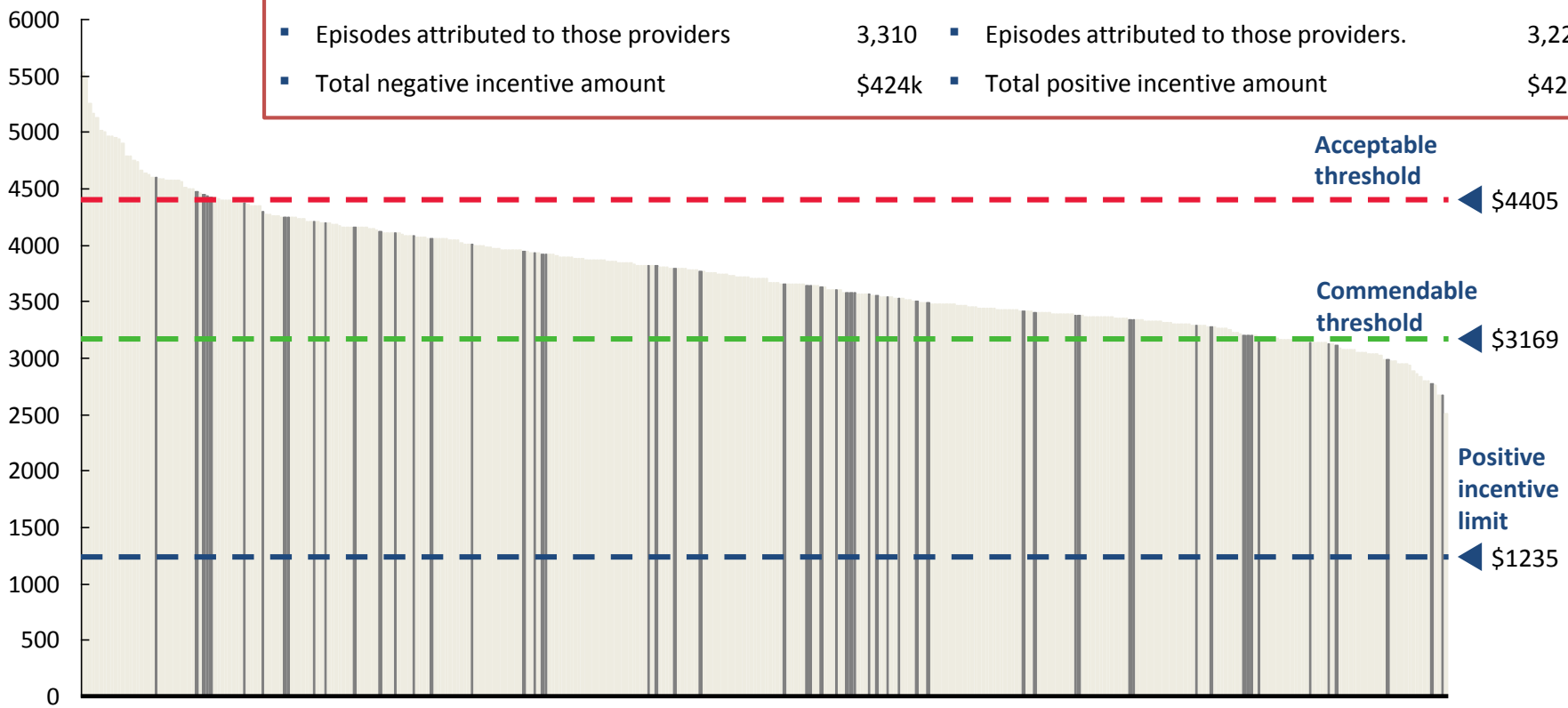
Provider risk-adjusted cost distribution

PAP average episode cost

Low volume High volume[1]

'All Medicaid' summary statistics

Negative incentive payments		Positive incentive payments[2]	
Providers above acceptable threshold	38	Providers below commendable threshold	45
Episodes attributed to those providers	3,310	Episodes attributed to those providers.	3,220
Total negative incentive amount	$424k	Total positive incentive amount	$424k



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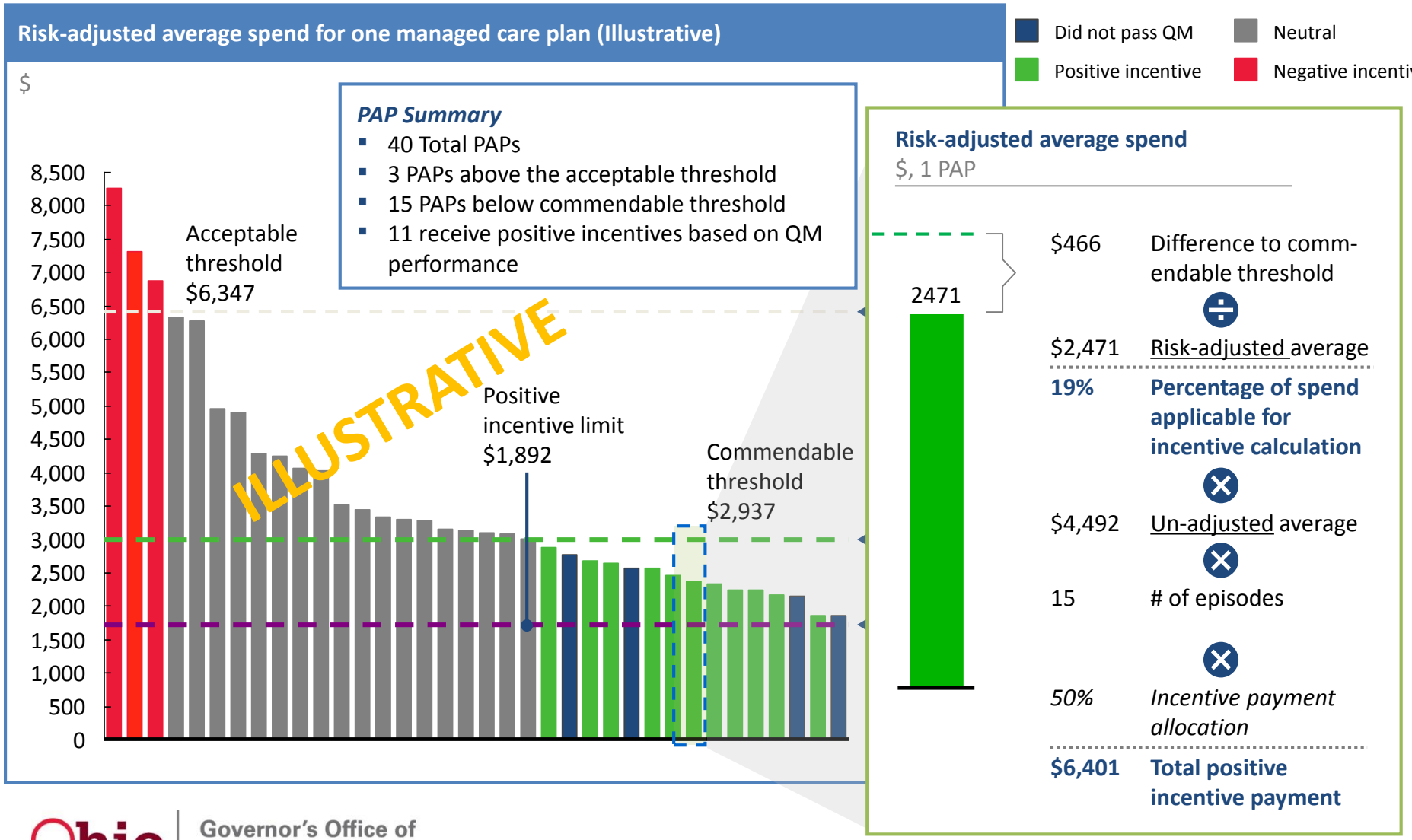
1. Top 10 percent of providers by volume
2. Assumes all providers pass quality metrics tied to incentive payments

SOURCE: Ohio Medicaid FFS and encounter data, CY 2014

Positive incentive payments are based on average risk-adjusted episode reimbursement for providers that pass quality metrics



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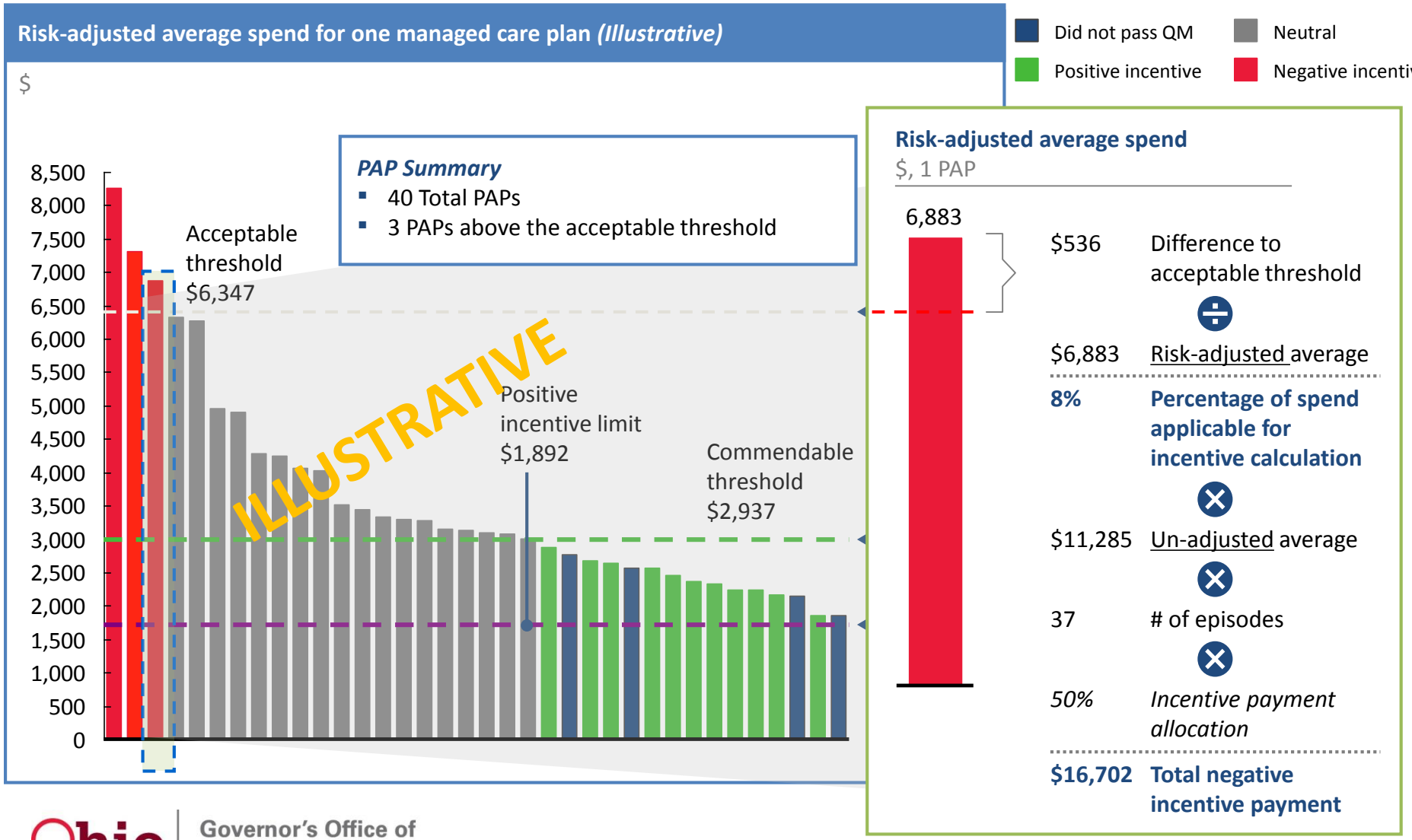
Negative incentive payment is calculated based on average episode spend within each payer



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Wave 2 materials now available online

Summary definitions

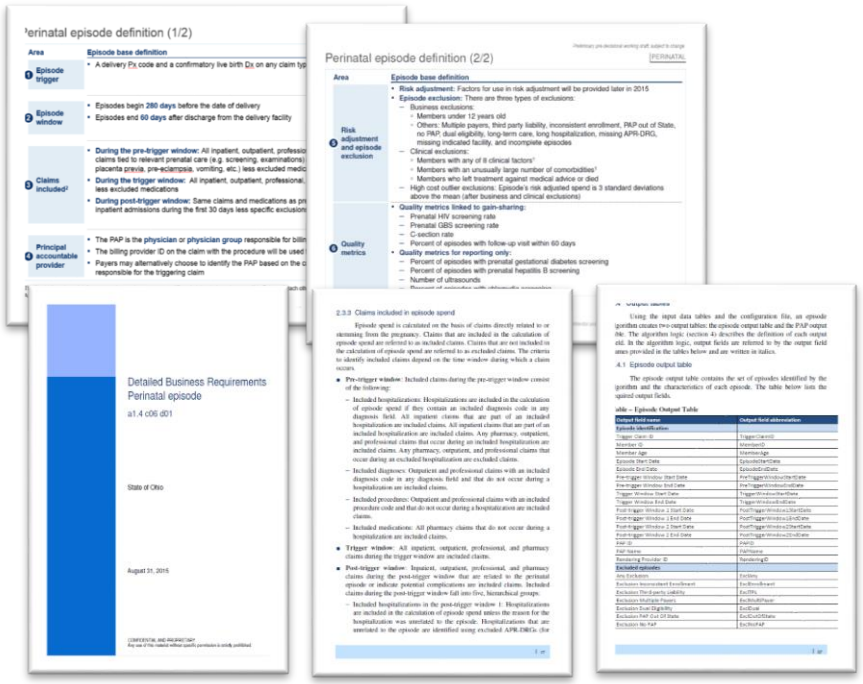
- Overview of definitions resulting from CAG process
- '2 page' view of all design elements

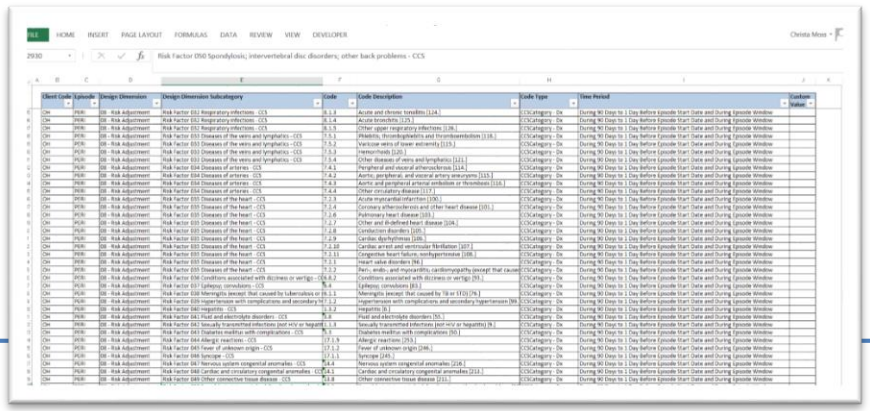
Detailed business requirements

- Detailed word file including all of the specifics required to code an algorithm

Code sets

- Excel file containing specific diagnosis and procedure codes used for trigger, included claims, exclusions, risk adjustment, etc.





SOURCE: Ohio Medicaid website

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Perinatal episode definition

Category	Episode definition
1 Episode trigger	• A delivery Px code with a confirmatory live birth Dx on any claim type[1]
2 Episode window	• *Pre-trigger:* Begins 280 days before delivery and ends on day prior to trigger window start • *Trigger:* Starts on day of admission and ends on day of discharge • *Post-trigger:* Begins day after discharge from delivery admission and ends 60 days later
3 Claims included	• *Pre-trigger window:* Relevant prenatal care and complications (except excluded medications) • *Trigger window:* All • *Post-trigger window:* – Relevant care and complications including diagnoses, procedures, labs, and pharmacy – Readmissions (except those not relevant to episode)
4 Principal accountable provider	▪ Physician or physician group responsible for the delivery (billing provider or contracting entity)
5 Quality metrics	*Linked to positive incentive payment:* • Prenatal HIV screening rate • Prenatal GBS screening rate • C-section rate • Percent of episodes with follow-up visit within 60 days *For reporting only:* • Percent of episodes with prenatal gestational diabetes screening • Percent of episodes with prenatal hepatitis B screening • Percent of episodes with chlamydia screening • Ultrasound rate
6 Potential risk factors	• Comorbidities (e.g., hypertension, diabetes, substance abuse, obesity, prior C-section)
7 Exclusions	• Clinical (e.g., cystic fibrosis, cancer, end stage renal disease, HIV, paralysis) • Business (e.g., dual coverage, inconsistent eligibility) • Patients < 12 years old and > 49 years old • Death in hospital, left AMA

1 The live birth code and delivery procedure code can occur on different claims but must occur within 7 days of each other

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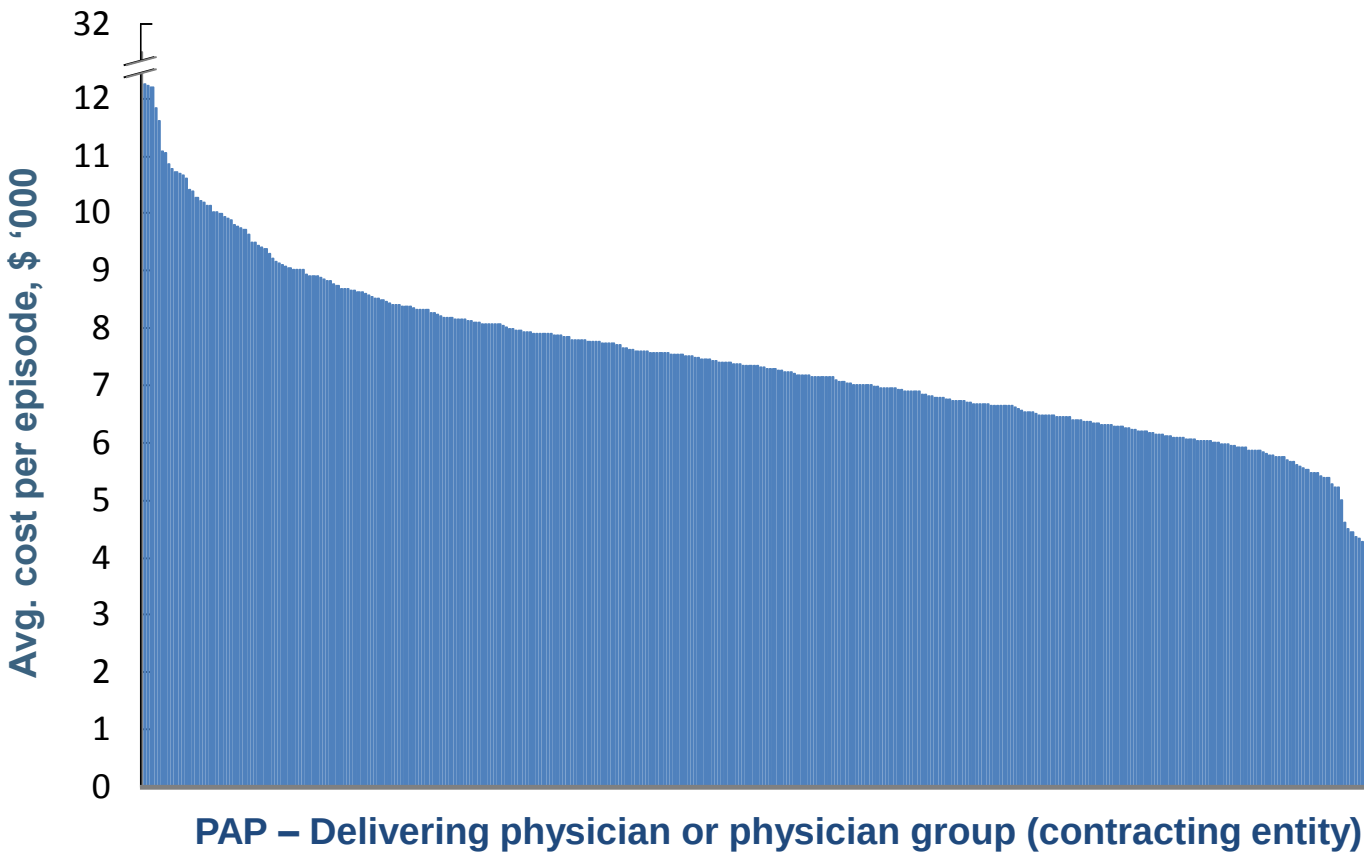
Perinatal: Provider Performance

Distribution of provider average episode cost

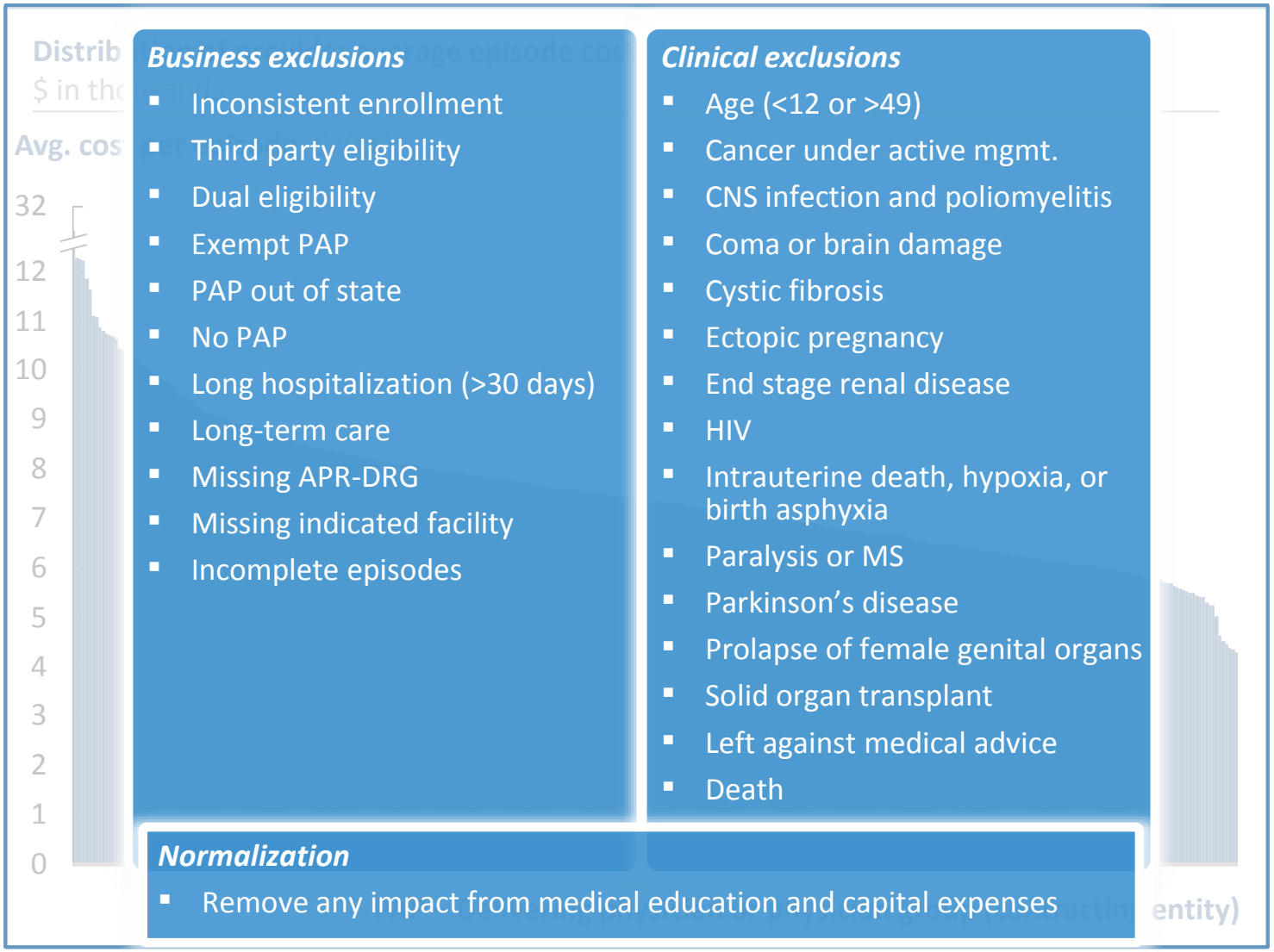
$ in thousands



- **Unadjusted episode cost, no exclusions**
- Average cost after episode exclusions (e.g., clinical, incomplete data) and removal of impact of medical education and capital
- Average cost after risk adjustment and removal of high cost outliers

SOURCE: Ohio Medicaid claims data, CY2014

Perinatal: Provider Performance



Business exclusions

- Inconsistent enrollment
- Third party eligibility
- Dual eligibility
- Exempt PAP
- PAP out of state
- No PAP
- Long hospitalization (>30 days)
- Long-term care
- Missing APR-DRG
- Missing indicated facility
- Incomplete episodes

Clinical exclusions

- Age (<12 or >49)
- Cancer under active mgmt.
- CNS infection and poliomyelitis
- Coma or brain damage
- Cystic fibrosis
- Ectopic pregnancy
- End stage renal disease
- HIV
- Intrauterine death, hypoxia, or birth asphyxia
- Paralysis or MS
- Parkinson's disease
- Prolapse of female genital organs
- Solid organ transplant
- Left against medical advice
- Death

Normalization

- Remove any impact from medical education and capital expenses

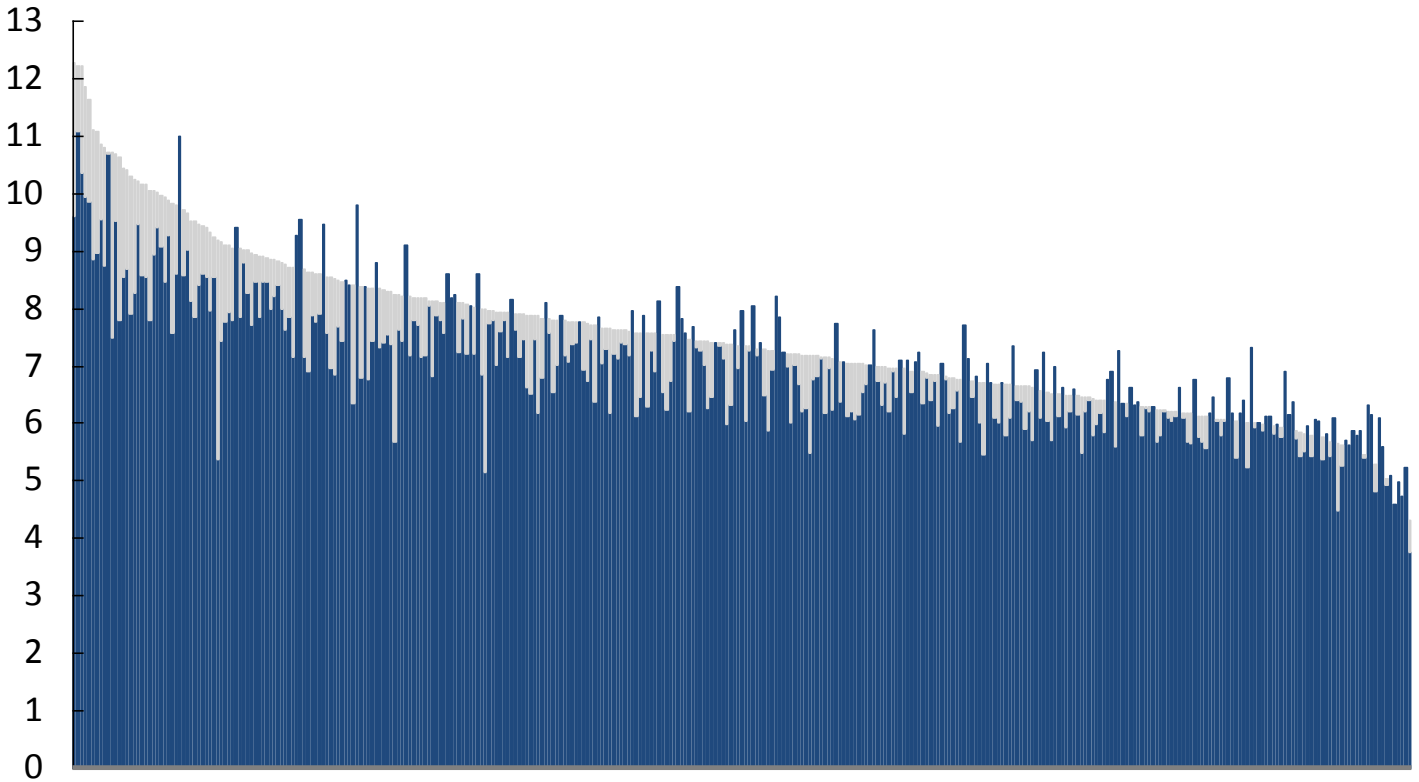
- **Unadjusted episode cost, no exclusions**
- Average cost after episode exclusions (e.g., clinical, incomplete data) and removal of impact of medical education and capital
- Average cost after risk adjustment and removal of high cost outliers

SOURCE: Ohio Medicaid claims data, CY2014

Perinatal: Provider Performance

Distribution of provider average episode cost
$ in thousands

Avg. cost per episode, $ '000



PAP – Delivering physician or physician group (contracting entity)

- Unadjusted episode cost, no exclusions
- **Average cost after episode exclusions (e.g., clinical, incomplete data) and removal of impact of medical education and capital**
- Average cost after risk adjustment and removal of high cost outliers

SOURCE: Ohio Medicaid claims data, CY2014

Perinatal: Provider Performance

Risk adjustment

Adjust average episode cost down based on presence of 70+ clinical risk factors including:

- Hypertension
- Prior C-section
- Obesity
- Diabetes
- Diseases of the central nervous system
- Substance related mental or behavioral illness
- Emotional and behavioral mental illnesses
- Non-anemic blood diseases
- Viral infections
- Anemia
- Congenital anomalies
- Abortion related disorders
- Complications mainly related to pregnancy
- Diseases of the urinary system
- Diseases of the respiratory system
- Diseases of the heart

High cost outliers

- Removal of any individual episodes that are more than three standard deviations above the *risk-adjusted* mean

- Unadjusted episode cost, no exclusions
- **Average cost after episode exclusions (e.g., clinical, incomplete data) and removal of impact of medical education and capital**
- Average cost after risk adjustment and removal of high cost outliers

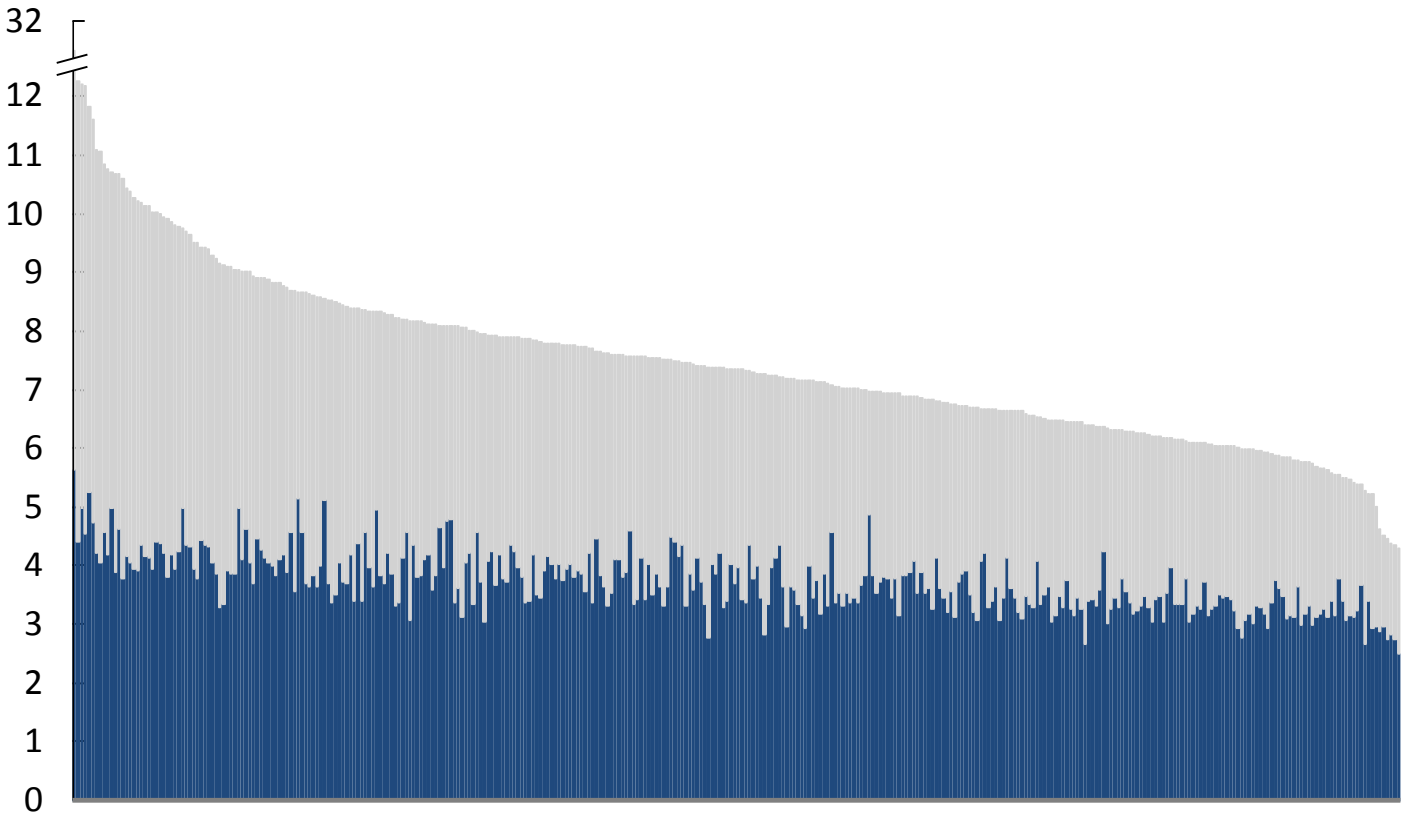
SOURCE: Ohio Episode-Based Payment Model Clinical Design Team definitions.

Perinatal: Provider Performance

Distribution of provider average episode cost

$ in thousands

Avg. risk-adjusted reimbursement per episode, $ '000



PAP – Delivering physician or physician group (contracting entity)

- Unadjusted episode cost, no exclusions
- Average cost after episode exclusions (e.g., clinical, incomplete data) and removal of impact of medical education and capital
- **Average cost after risk adjustment and removal of high cost outliers**

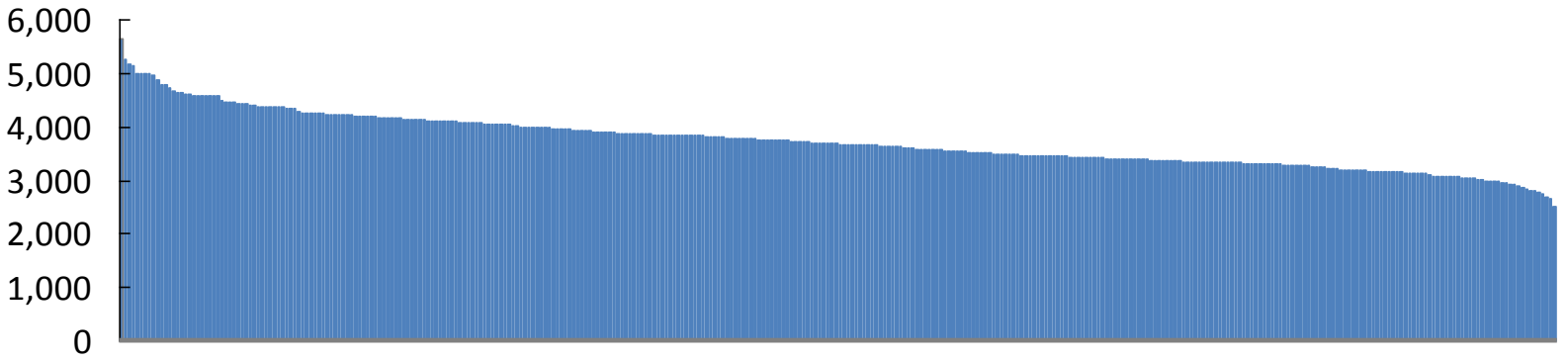
SOURCE: Ohio Medicaid claims data, CY2014

Perinatal: Provider Performance

Distribution of provider average episode cost

$

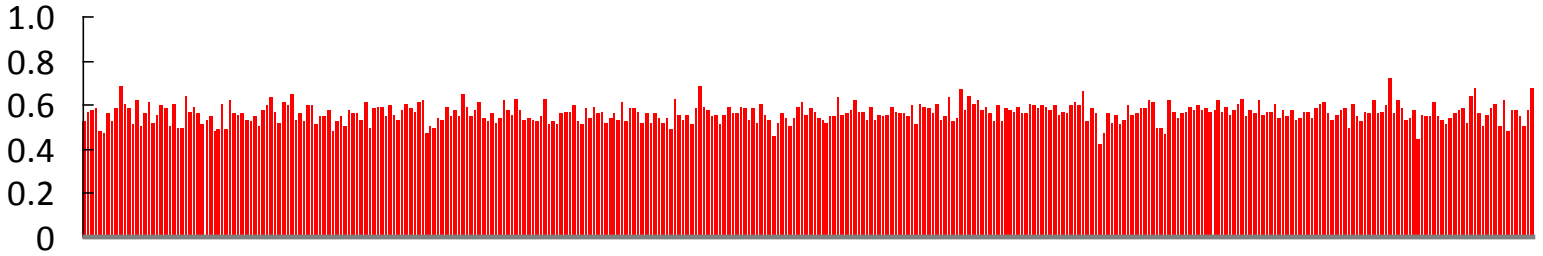
Avg. risk-adjusted reimbursement per episode, $



Degree of risk adjustment distribution

Percent of risk adjustment per provider

Risk adjustment percentage



Principal Accountable Provider

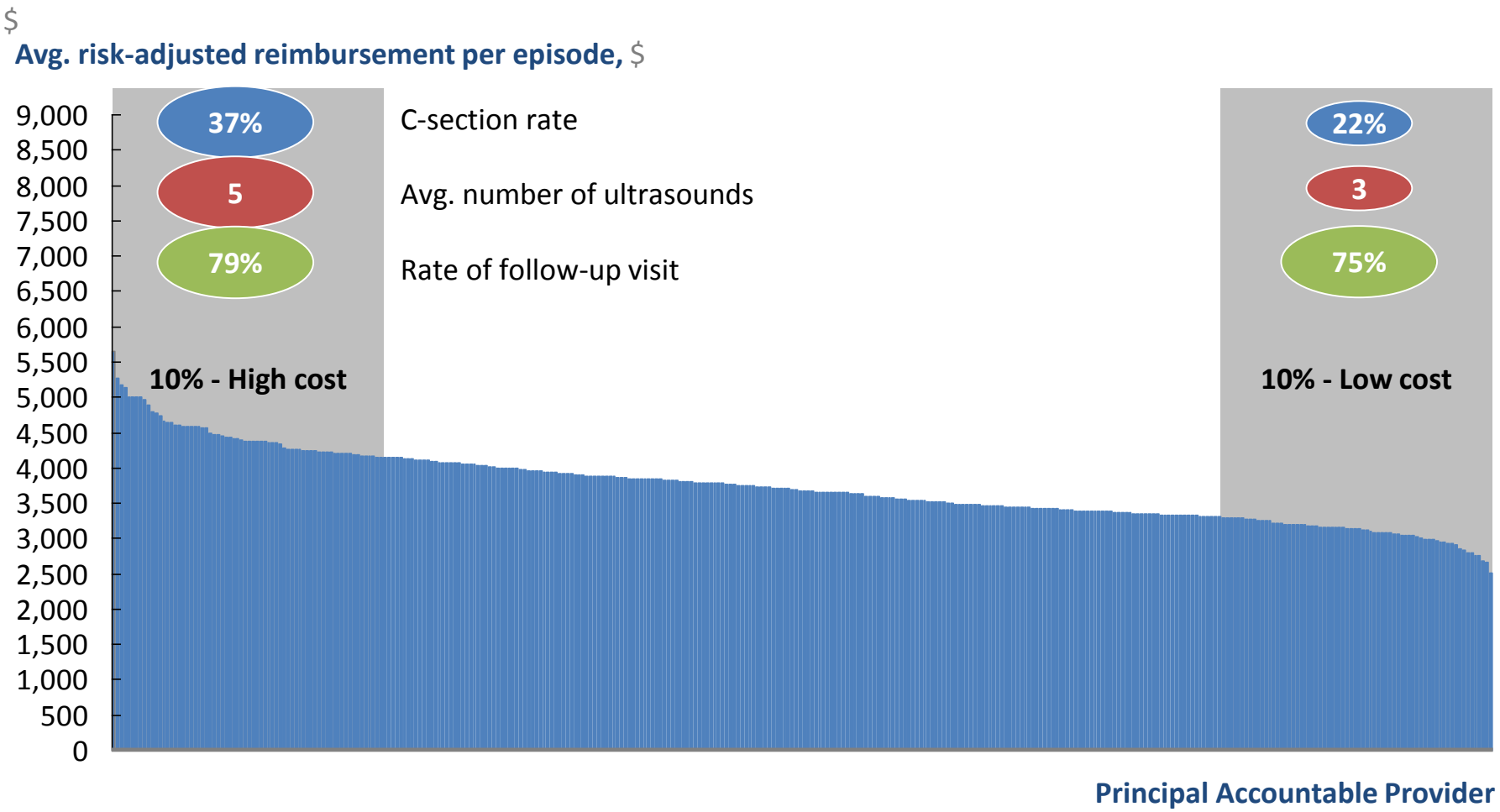
There is no correlation between average episode risk-adjusted reimbursement and level of risk

Ohio | Governor's Office of Health Transformation

SOURCE: Ohio Medicaid claims data, CY2014

Variation across the Perinatal episode

Distribution of provider average episode cost



Ohio | Governor's Office of Health Transformation

NOTES: Average episode spend distribution for PAPs with five or more episodes; each vertical bar represents the average spend for one PAP.
SOURCE: Analysis of Ohio Medicaid claims data, CY2014.

Ohio | Governor's Office of Health Transformation

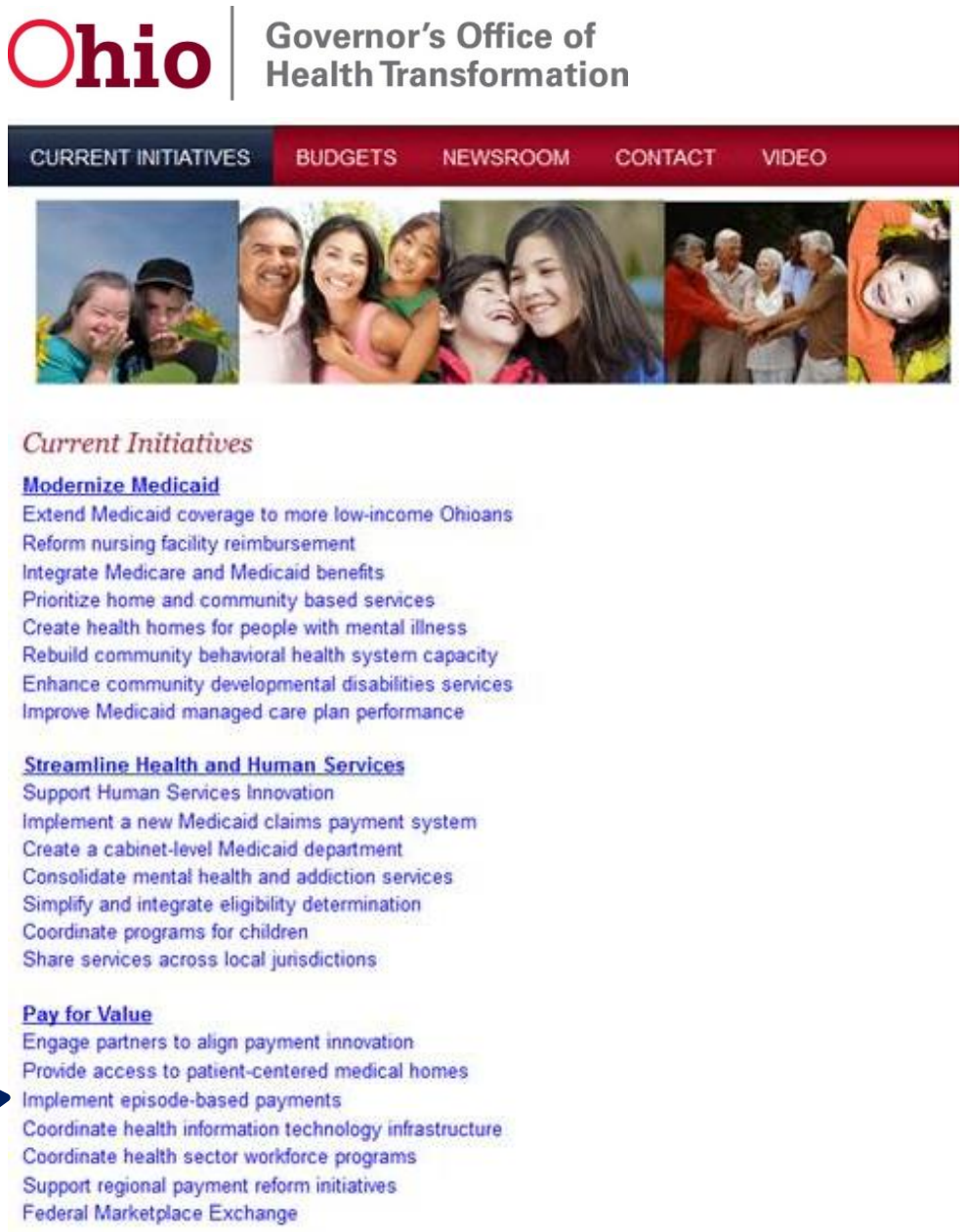
1. Ohio's approach to paying for value instead of volume
2. Episode-Based Payment Model
3. Specific episode example
4. **Want to learn more?**

Want to learn more?

www.HealthTransformation.Ohio.gov

Episode-Based Payment Model:

- **Overview Presentations**
- **Charter for Payers**
- **State Innovation Model Test Grant Detail**



www.Medicaid.ohio.gov/providers/paymentinnovation.aspx

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 reach 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 s
- Non-acute percutaneous coronary intervention episodes (definition
- Total joint replacement (definition, DBR, code sheet)

Wave 2: Reporting will begin for the episodes listed below in 2016. The perfo

- 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 ris

Details for Providers:

- **Episode quick reference tables**
- **Frequently Asked Questions**
- **"Wave I & 2" episode definitions, business requirements, code sets, and risk adjustment**
- **Risk adjustment methodology**