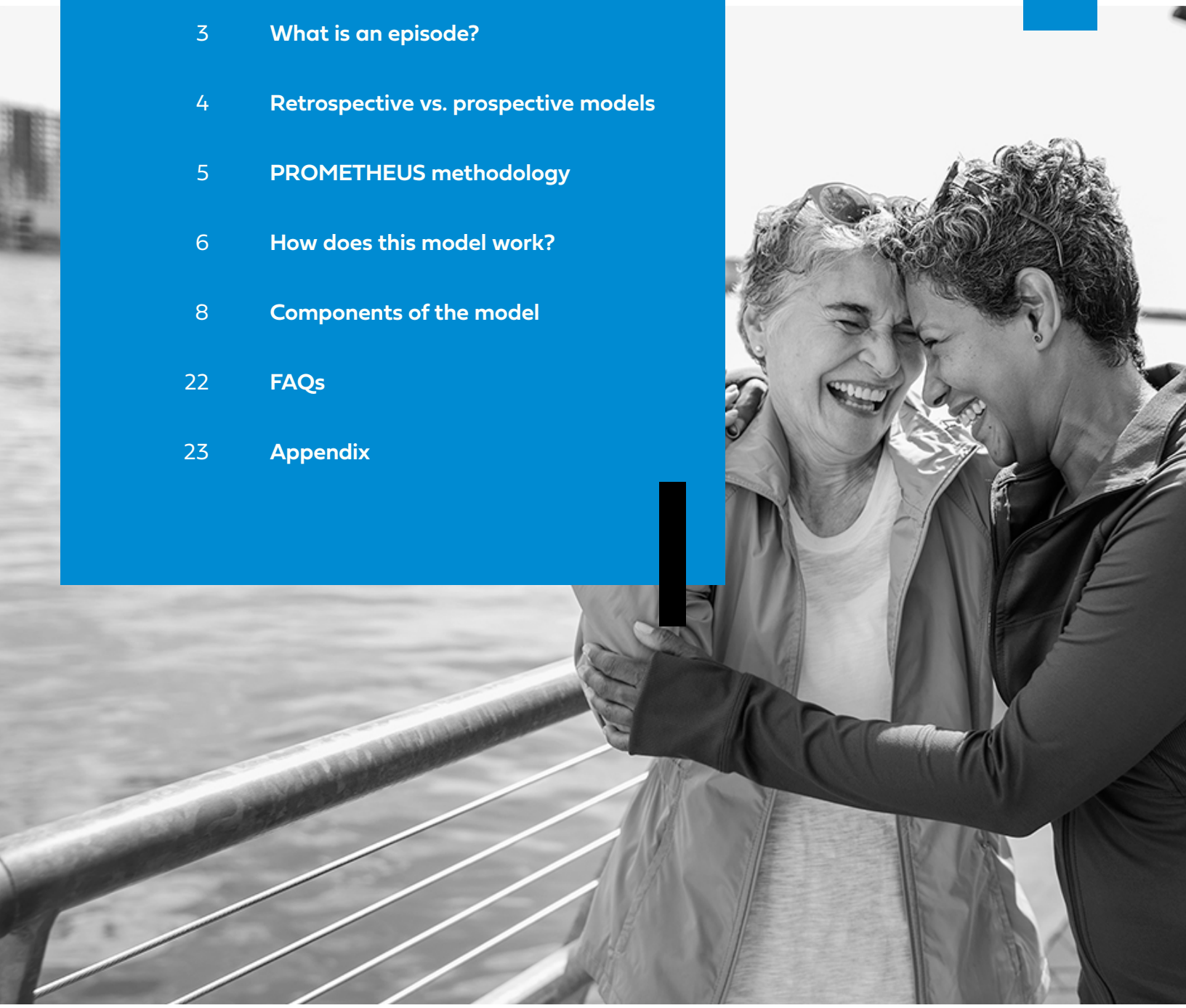
Gastrointestinal Episodes of Care Payment Model Manual

Spring 2022
Blue Shield of California

blue california

Contents

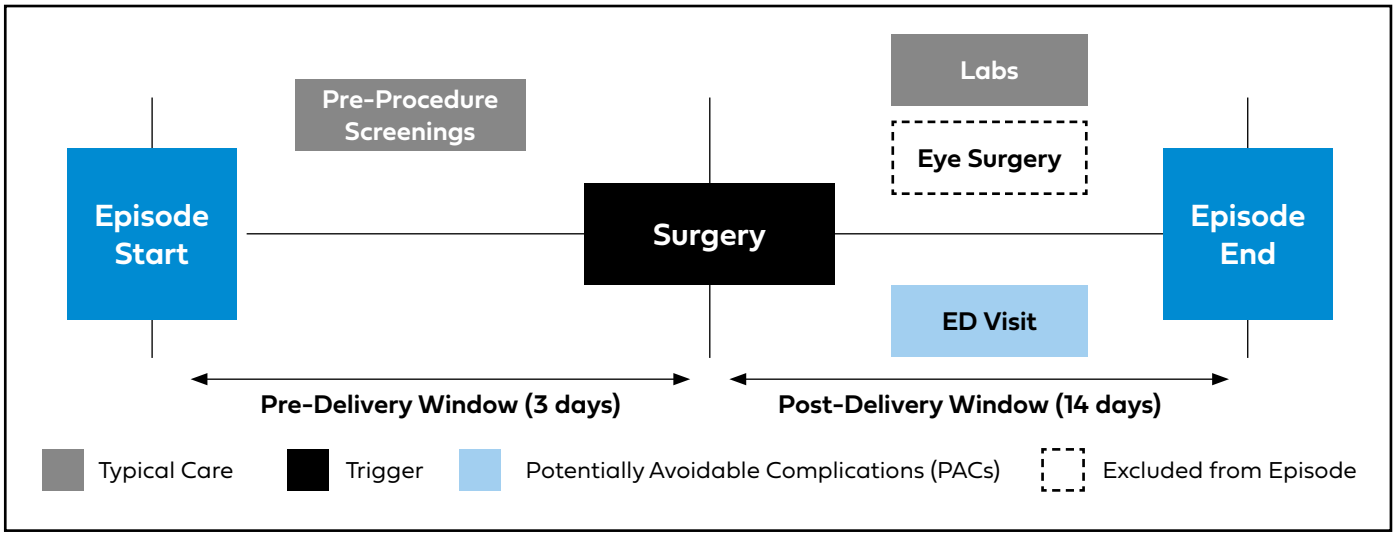


Why episodes of care?

Blue Shield of California's episode of care program aims to transform how specialty health care services are delivered by shifting away from traditional fee-for-service (FFS) to value-based care in an episode of care arrangement. The focus of an episode of care arrangement is providing coordinated, collaborative care across the health care continuum to ensure that patients receive the highest quality and most comprehensive care.

What is an episode?

Episodes of care encompasses the full spectrum of services related to a given procedure during a specific time frame. The episode can include services from multiple providers and facilities, but the episode is designed to only include costs relevant to that procedure.



Based on PROMETHEUS episode definitions
Professional + Facility + Labs + Rx

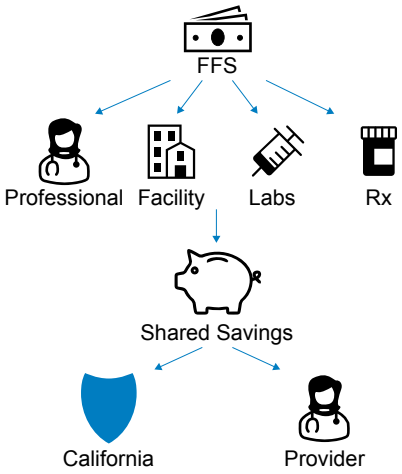
Example of a Colonoscopy Episode

Retrospective vs. prospective models

To minimize operational challenges in modifying the current claims adjudication system and to ensure providers can participate in our payment model (regardless of the size of the practice or organizational structure) Blue Shield is offering a retrospective payment model. It is important to understand the differences between retrospective and prospective.

Retrospective

In a retrospective model, providers are paid on a FFS basis for services related to the episode during the defined time frame. At the end of performance period, there is a financial reconciliation with the potential for shared savings depending on whether the FFS claims costs were above or below the pre-defined established target.



Provider continue receiving FFS payments

Does not require modification to existing claims adjudication system

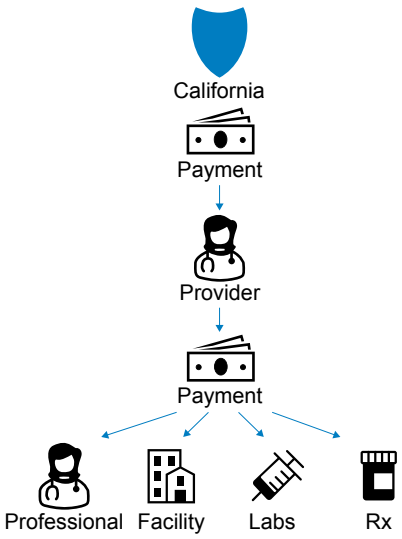
Shared saving reimbursement after services rendered and reconciled

---

Providers receive upfront negotiated payment at the start

Requires new, or modifications to existing claims adjudication

Provider saving obtained by managing downstream cost



Prospective

In a prospective model, a fixed price for services that are covered within the episode are paid out prior to any services being rendered. The fixed amount covers the total cost of care associated with that episode and providers are responsible for managing cost and facilitating payment to the various providers and facilities. If costs go beyond the fixed amount, the provider is at risk and responsible for those costs. However, if the cost of care is below the fixed amount, the provider benefits from any savings achieved.

PROMETHEUS methodology

PROMETHEUS Analytics® is a standardized grouping methodology developed to bundle claims data to create episodes of care that can be used to design and operationalize value-based payment models. PROMETHEUS supports performance evaluations in order to improve the quality of care and patient outcomes. Blue Shield utilizes PROEMTHEUS analytics for episodes of care logic.

Episode triggers

For each episode of care, PROMETHEUS Analytics defines sets of trigger codes (ICD-9/10 diagnoses and procedures, CPT, HCPCS) along with target sequence (i.e., principal or any), type of claim with which code should be associated (i.e., inpatient or outpatient facility claims, or professional claim) and any temporal relationship among combinations of claims (e.g., relevant professional claim within a predefined number of days of facility claim).

Episode window

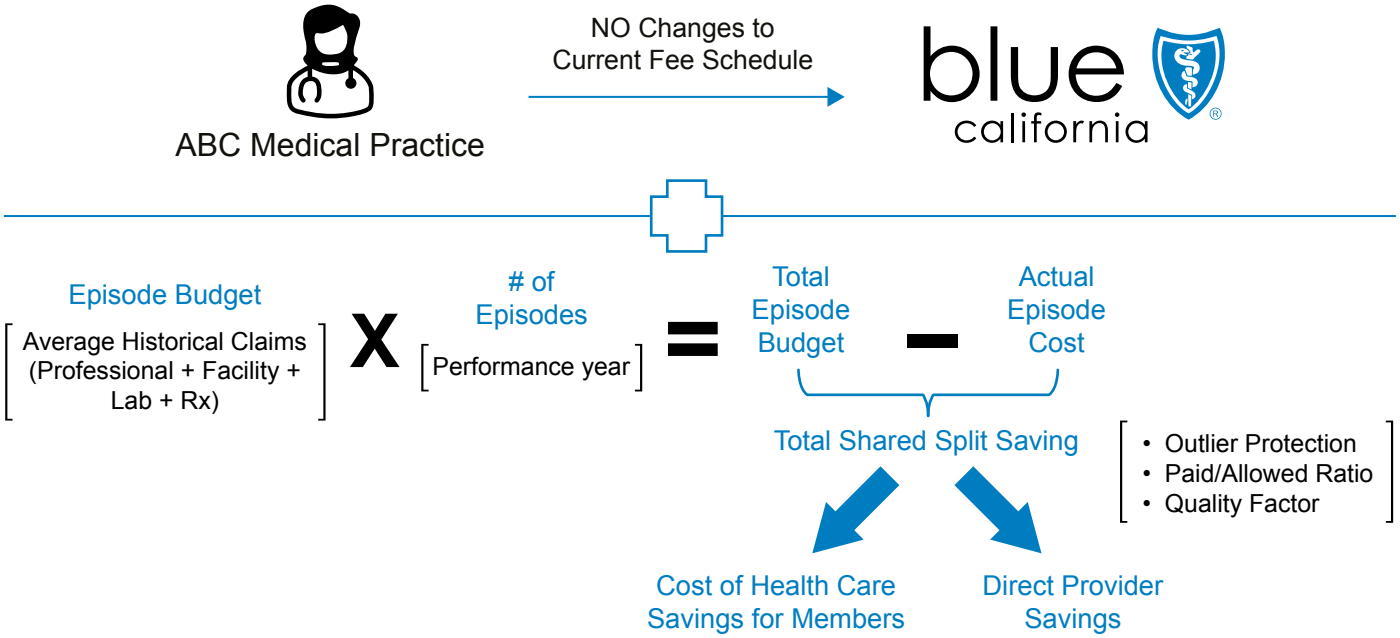
For each episode of care, PROMETHEUS Analytics® defines the default duration of the pre- and post-trigger windows. Additionally, system-related failure and most acute medical condition episodes have no pre-trigger window, and most procedural episodes have suggested 30, 60 or 90 day post-trigger windows. Specific parameters can be provided upon request.

Services included

PROMETHEUS Analytics® defines service assignment rules that determine to which episode(s) each service is associated, and whether these services should be considered typical or a potential complication. These rules are comprised of both episode-specific diagnosis and/or procedure code sets to identify and classify relevant claims, as well as a hierarchical set of logic rules that take into account claim type, episode type and temporal relationships among services. Specific code sets can be provided upon request.

How does this model work?

This payment model works by setting a total episode budget at the start of the performance year and comparing that to what was paid traditionally FFS. If a practice comes in under budget while meeting quality metrics, Blue Shield and the practice receive a share of the savings.



Step 1: Blue Shield sets the episode budget. To calculate the episode budget, Blue Shield takes the average cost per episode, using historical claims (professional, facility, pharmacy, labs, etc.) associated with your practice per episode. By considering your practice's historical claims, the episode budget assumes an equivalent demographic mix of patients that your practice would serve. The episode budget is shared upfront and included in the contract. If your practice participates in multiple procedural episodes (i.e., endoscopy, colonoscopy) individual episode budgets will be set.

1.

2.

Step 2: Blue Shield sets your clinical quality targets. To ensure health care quality is maintained during the program, Blue Shield will be monitoring quality throughout the program. Shared savings will be directly tied to quality performance. Quality targets will be based on your practice historical performance.

Step 3: Blue Shield continues to pay your contracted rate. Throughout the performance year, Blue Shield will continue paying the contracted rate as it relates to your base agreement.

3.

Step 4: Blue Shield will provide detailed data. Monthly monitoring reports will be available to share valuable insights on how your practice is performing while in the payment model. Critical components include:

- Financial performance against episode budget
- Quality performance
- Potential areas of opportunity to explore to maximize savings while in the program.

Data will be aggregated at the practice level per episode as well as detailed by physician to allow full transparency in how performance is utilized. Refer to the monitoring reports overview for additional details on how to utilize monitoring reports.

4.

Step 5: Blue Shield performs reconciliation. A final episode budget will be calculated at the end of the performance year to incorporate actual episode utilization for the performance year and reconcile the difference between the final episode budget and actual cost paid according to your contracted rate throughout the performance year. After the total risk limits and adjustment factors have been applied, the resulting gross shared savings shall be adjusted by a quality score to generate the net shared savings. If your practice participates in multiple procedural episodes (i.e., endoscopy, colonoscopy) each individual episode's performance and shared savings will be calculated separately.

5.

6.

Step 6: Payments. If there is a surplus in the net shared savings, Blue Shield will share those savings directly back to your practice.

Components of the model:

Budget setting:

Each episode budget will be calculated based on your practice's historical performance. All claims associated with the episode per PROMETHEUS methodology will be included in budget cost.

Practice episode budget based on historical spend

Professional		Facility		Pharmacy		Lab	
CPT: 45378	Diagnostic Colonoscopy	CPT: 45385	Colonoscopy w/Lesion Removal	Retail	Omeprazole Amoxicillin Pantoprazole	CPT: 88305	Tissue Exam by Pathologist
CPT: 96365	THER/PROPH /DIAG IV INF	CPT: 43259	EGD US EXAM Duodenum			CPT: 82270	Occult Blood Feces
		CPT: 73560	X-Ray Exam of Knee 1 or 2			CPT: 74246	X-Ray XM UPR GI Track 2 CNTRST

Example based on PROMETHEUS episode definitions
Detailed inclusions/exclusion can be provided upon request

PROMETHEUS can differentiate between claims that are directly associated with the Episode. If there are claims outside the realm of that Episode, those claims will not be included in the budget as well as calculations for that performance year.

Individual family plan (IFP) vs group plans

Your budget will be broken down by two separate budgets per line of business.

- IFP: insurance health plans that is purchased individually or family basis, as opposed to obtaining through an employer
- Group: insurance health plans that provide coverage to a group of members, usually comprised of company employers or members of an organization

Different budgets represent different contracted rates set per line of business.

Clinical quality

Clinical quality is a critical component of episodes of care. Each episode will have its own set of quality metrics and applicable weight distribution to incentivize improvement and reward continued high performance. Improvement towards achieving quality targets will be translated to an overall "quality score" that is used to adjust the practice portion of the final net shared savings result.

Colonoscopy	Endoscopy	Weight
• Member Experience • Episodes with Emergency Department Visits	• Member Experience • Episodes with Emergency Department Visits	10% 90%

Baseline and target setting approach

Blue Shield will take your practice's average historical performance of each metric to determine your baseline. Quality targets will be set at your historical baseline to assume the same equivalent acuity of patients that your practice would serve. If your historical baseline is at 0%, the target will be increased to allow for potential deviations from your historical experience.

Quality supplemental data

To minimize additional administrative workstreams, all quality metrics used will be claims-based measures and no additional supplemental data will be required. Regular reporting on performance relative to quality metrics will be included in monthly monitoring reports as they become available.

Member Experience

Blue Shield will administer a member experience survey to members who have participated in the episode. Members will be contacted by mail, email, or phone and asked to complete/return the survey. All responses are anonymous. Only questions from the categories noted below will be utilized for the purpose of incentive payment. Blue Shield reserves the right to modify questions annually.

Category	Question	shared savings weight
Rating of personal doctor	Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?	**2%**
Getting care quickly composite	In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed? In the last 6 months, when you made an appointment for a checkup or routine care with this provider, how often did you get an appointment as soon as you needed?	**2%**
Someone at office gave test results	In the last 6 months, when your doctor ordered a blood test, X-ray or other test for you, how often did someone from your doctor's office follow up to give you those results as soon as you needed them?	**2%**
Saw provider within 15mins of appointment time	Wait time includes time spent in the waiting room and exam room. In the last 6 months, how often did you see this provider within 15 mins of your appointment time?	**2%**
Provider explained things in an easily understandable way	In the last 6 months, how often did this provider explain things in a way that was easy to understand?	**2%**

Shared savings calculations

Savings cap

A savings cap is the limit of the total dollar amount of savings that your practice would be able to collect of all potential shared savings based off a percentage of the episode budget calculated annually across eligible episodes of care.

Outlier protection

Outlier protection is the limit of total dollar amount of eligible expenses that your practice would be responsible for above and beyond the episode budget calculated for each individual episode of care.

Paid/allowed ratio

When calculating the episode budget "allowed" cost is used versus "paid" cost because the "paid" cost is variable as it incorporates the member's benefit. If "paid" costs were used for the budget, then the member benefits would skew the budget. Since the "paid" cost is the final cost paid out from the plan, we need to adjust for the member's responsibility, which is why the paid/allowed ratio will be included. This adjustment will accurately reflect the actual saving accumulated from the model to be shared back with your practice.

Share savings illustrative example

An example, for illustrative purposes only, of how provider's final earned shared savings is calculated is included below to demonstrate the application of the savings cap and provider's shared savings with the quality score applied.

EXAMPLE: Shared Savings Calculations			Definitions / Calculations
A	Episode Budget	$25,000	Based on historic total episode cost (includes all professional, facility & pharmacy claims)
B	# of Episodes	100	# of Episodes during the Performance Year
C	Total Episode Budget	$2,500,000	(C) = (A) x (B)
D	Average Allowed Episode Cost	$22,000	Actual cost of Allowed Episode cost (includes all professional, facility & pharmacy claims)
E	# of Episodes	100	# of Episodes during the Performance Year
F	Total Allowed Episode Cost	$2,200,000	(F) = (D) x (E)
G	Gross Shared Savings	$300,000	(G) = (C) - (F)
H	40% Savings Cap	$1,000,000	(H) = (C) x 40%
I	Capped Gross Saving	$300,000	(I) = lesser of (G), (H)
J	Paid / Allowed Ratio	83%	Adjustment factor to account for member benefit
K	Adjusted Gross Shared Savings	$249,000	(K) = (I) x (J)
L	Quality Score	100%	Aggregated per metric quality score
M	Providers Shared Savings Split	50%	
N	Providers Share in Savings	$124,500	(N) = (K) x (L) x (M)
O	**Final Providers Net Shared Savings**	**$124,500**	(O) ≤ (I)

Monitoring Reports Overview:

Provider Summary Closed Tab

Retrospective Monitoring Report - Contract Entity Summary, Closed Episodes Only
Contract Entity Name: ABC Gastroenterology Associates
Episode Name(s): Colonoscopy, Endoscopy

Measurement Period: 1/1/2021-12/31/2021
Report Run Date: 11/19/2021
Date Through: 10/31/2021

Purpose: This report captures episodes that are closed with administrative claims runout. The aggregate financial calculations on this tab are final and provide insights into cost and quality performance for the group and for individual physicians.

Closed episodes are defined as any episode in which the end date is 90 days or longer from the latest date in the current dataset, to allow for adequate claims runout.

Monitoring Reports Overview:

Provider Summary All Year-to-Date

Provider Summary Closed	Provider Summary All Year-to-Date	Episode Detail Closed	Episode Detail Open, Not at Runout	Episode Excluded

Retrospective Monitoring Report - Contract Entity Summary

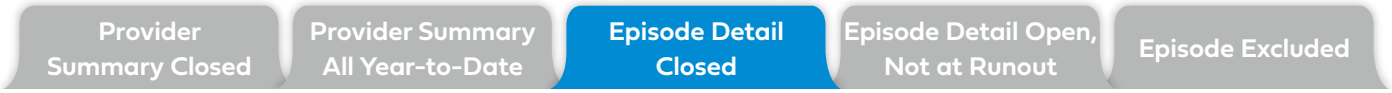
Contract Entity Name: ABC Gastroenterology Associates
Episode Name(s): Colonoscopy, Endoscopy

Measurement Period: 1/1/2021-12/31/2021
Report Run Date: 11/19/2021
Date Through: 10/31/2021

Purpose: This report captures all episodes year-to-date (YTD) and should be used to understand care patterns at the group and physician level, to assess over-utilization and/or unnecessary services. In addition, this report can give providers a preview of any episodes that may be going over-budget before they have closed. Finally, there is a column at the end of the individual provider table – "Opportunities" – that provides insights into individual physician opportunities relative to the group. The financial and quality calculations on this tab are a snapshot of current performance and should be reviewed with the knowledge that the episodes may be missing services due to timing.

Monitoring Reports Overview:

Episode Detail Closed Tab



Retrospective Monitoring Report - Member Detail for Completed Episodes
Contract Entity Name: ABC Gastroenterology Associates
Episode Name(s): Colonoscopy, Endoscopy

Measurement Period: 1/1/2021-12/31/2021
Report Run Date: 11/19/2021
Date Through: 10/31/2021

Purpose: This report displays the same information as the tab "Provider Summary Closed," but each line represents information for a single episode. Episodes on this tab are closed with administrative claims runout. The financial values on this tab are final and provide additional insights into cost and quality performance for individual episodes.

- Identifies details of closed episodes including provider, member, and trigger location information
- Metrics include:
    - Savings/loss summary
    - Quality measures
    - Count of visits for post-acute services

Monitoring Reports Overview:

Episode Detail Open, Not At Runout Tab

Retrospective Monitoring Report - Member Detail for Open, Not at Runout Episodes
Contract Entity Name: ABC Gastroenterology Associates
Episode Name(s): Colonoscopy, Endoscopy

Measurement Period: 1/1/2021-12/31/2021
Report Run Date: 11/19/2021
Date Through: 10/31/2021

Purpose: This report captures episodes that are not yet closed, nor at administrative claims runout, and should be used to provide additional episode-level detail to support the "Provider Summary All YTD" tab. The financial and quality calculations are a snapshot of current performance and should be reviewed with the knowledge that the episodes may be missing services due to timing.

- Identifies details of all open episodes including provider, member, and trigger location information
- Metrics include:
    - Savings/loss summary
    - Quality measures
    - Count of visits for post-acute services

Monitoring Reports Overview:

Episode Excluded Tab

Retrospective Monitoring Report - Member Detail for Excluded Episodes
Contract Entity Name: ABC Gastroenterology Associates
Episode Name(s): Colonoscopy, Endoscopy

Measurement Period: 1/1/2021-12/31/2021
Report Run Date: 11/19/2021
Date Through: 10/31/2021

Purpose: Identifies individual episodes excluded from the savings/loss totals as well as the reason for the exclusion.

Raw Data Tab: Detailed episode medical claim information, excluding financials.

RX Raw Data Tab: Detailed episode pharmacy claim information, excluding financials.

Glossary Tab: List of terms found in the report and their definitions.

Tab Sections: Seen in Provider Summary Closed Tab & Providers Summary ALL YTD Tab.

Contract Entity Contract Terms: Overview of contract terms:

- Episode Contract Target [Budget]

Contract Entity Contract Terms						
Contract Entity	**Episode Name**	**Product**	**Episode Contract Target**	**ER %**	**Readmission %**	**Complications %**
ABC Gastroenterology Associates	EP0811 - Endoscopy	Group	$6,000	2.5%	1.0%	5.0%
ABC Gastroenterology Associates	EP0811 - Endoscopy	IFP	$5,000	2.5%	1.0%	5.0%
ABC Gastroenterology Associates	EP0811 - Colonoscopy	Group	$6,000	9.0%	6.0%	6.0%
ABC Gastroenterology Associates	EP0811 - Colonoscopy	IFP	$5,000	9.0%	6.0%	6.0%

- Quality Baseline Metrics

Contract Entity Performance Statistics: Contract performance for the practice at the product level for closed episodes.

Metrics include:

- Average episode savings/loss summary

Contract Entity Performance Statistics					
Contract Entity	**Episode Name**	**Product**	**Episodes**	**Episode Average Savings/Loss to Date**	**Total Quality %**
ABC Gastroenterology Associates	EP0811 - Endoscopy	Group	3	$2,000	90
ABC Gastroenterology Associates	EP0811 - Colonoscopy	IFP	11	$1,000	90
ABC Gastroenterology Associates	EP0811 - Colonoscopy	Group	4	$2,000	90
ABC Gastroenterology Associates	EP0811 - Colonoscopy	IFP	10	$1,000	90

- Breakdown of quality metric proportions during trigger

- Percentage of episodes by trigger type location and total cost associated with each trigger type location

Contract Entity Performance Statistics					
Contract Entity	**Episode Name**	**% Performed Inpatient**	**% Performed Outpatient**	**% Performed in ASC**	**Average Office Physical Therapy Visits**
ABC Gastroenterology Associates	EP0811 - Endoscopy	0	0	67	9.0
ABC Gastroenterology Associates	EP0811 - Colonoscopy	0	0	73	7.7
ABC Gastroenterology Associates	EP0811 - Colonoscopy	0	50	50	0.0
ABC Gastroenterology Associates	EP0811 - Colonoscopy	10	70	10	8.5

- Average count, cost, and visits of post-acute period services

Individual Performance Statistics: Provider performance at the product level for closed episodes, which allows for assessment of how the provider is performing compared to the risk bearing entity.

Metrics include:

- Average episode savings/loss summary

Individual Performance Statistics								
Provider Name	**Episode Name**	**Product**	**Completed Episodes**	**Episode Contract Target**	**Average Episode Allowed**	**Average RX Allowed**	**Episode Average Savings/ Loss**	**Total Quality %**
Provider 1	EP0811 - Endoscopy	IFP	1	$5,000	$4,000	$50	$1,000	90
Provider 2	EP0811 - Colonoscopy	IFP	4	$5,000	$4,000	$50	$1,000	90
Provider 3	EP0811 - Colonoscopy	Group	1	$6,000	$4,000	$50	$2,000	90
Provider 4	EP0811 - Colonoscopy	Group	1	$6,000	$4,000	$50	$2,000	90

- Breakdown of quality metric proportions during trigger period

- Percentage of episodes by trigger type location and total cost associated with each trigger type location

Individual Performance Statistics							
Provider Name	**Episode Name**	**% Performed Inpatient**	**% Performed Outpatient**	**% Performed in ASC**	**Average SNF Days**	**Average Home Health Visits**	**Average Office Physical Therapy Visits**
Provider 1	EP0811 - Endoscopy	100	0	0	0.0	0.0	24.0
Provider 2	EP0811 - Colonoscopy	0	0	50	0.0	0.0	3.7
Provider 3	EP0811 - Colonoscopy	100	0	0	0.0	0.0	0.0
Provider 4	EP0811 - Colonoscopy	100	0	0	0.0	0.0	0.0

- Average count, cost, and visits of post-acute period services

Capped Closed Episodes: Provider performance at the product level for capped closed episodes. Episodes are identified as capped when the total episode allowed exceeds twice the contract target rate.

Metrics include:

- Average episode savings/loss summary

Capped Episodes								
Provider Name	**Episode Name**	**Product**	**Completed Episodes**	**Episode Contract Target**	**Average Episode Allowed**	**Capped Episode Allowed**	**Episode Average Savings/ Loss**	**Complications %**
Provider 1	EP0811 - Endoscopy	Group	1	$6,000	$15,000	$15,000	($26,700)	0
Provider 2	EP0811 - Colonoscopy	IFP	1	$5,000	$10,000	$15,000	($12,300)	0

- Breakdown of quality metric proportions during trigger period

- Percentage of episodes by trigger type location

Capped Episodes					
Provider Name	**Episode Name**	**% Performed Inpatient**	**% Performed Outpatient**	**% Performed in ASC**	**Average IP LOS**
Provider 1	EP0811 - Endoscopy	100	0	0	5.0
Provider 2	EP0811 - Colonoscopy	100	0	0	2.0

Final Year-to-Date Closed (YTD) with Runout - Total savings/loss, by episode type, for closed episodes.

Final Year-to-Date Closed (YTD) with Runout			
Provider Name	**Episode Name**	**Completed Episodes**	**Total YTD Savings***
ABC Gastroenterology Associates	EP0811 - Endoscopy	6	$2,346
ABC Gastroenterology Associates	EP0811 - Colonoscopy	8	$85,011

Frequently Asked Questions

How and when will I know my final shared savings?

After the performance year is complete, all of the episodes are closed, and time is allowed for claims run out. Blue Shield will share the final reconciliation report which will aggregate your practice performance against the set episode budget. Payment of shared savings will vary depending on the duration of the post trigger period of each episode. After the post trigger period is closed, allow for a 3 month claims run out, and another 1 month to finalize processing the shared savings.

What if you have questions about reporting?

If you have questions about monitoring reports, please check the Monitoring reports overview section. If that does not answer your question, please email CareReImagined@blueshieldca.com.

What if I have questions about the program?

Please email questions about the program to CareReImagined@blueshieldca.com. Someone from our team will respond promptly.

Appendix

Colonoscopy	
Episode Summary	
Full Name	Colonoscopy
Abbreviation	COLOS
Description	Most colonoscopies are currently done in an outpatient setting, either in a doctor's office or in an ambulatory surgery center, so these are the ones intended to be captured in the COLOS episode. The COLOS episode focuses on screening, surveillance and diagnostic colonoscopies. Services and costs associated with a procedure of colonoscopy (COLOS) are grouped together to include the index event during which the procedure was performed, a 3-day look back period to capture pre-operative diagnostic workup leading to the colonoscopy and a 14-day post-discharge period.
Default Parameters	
Age Range	18 - 65
Pre-Trigger Window	3 days
Post-Trigger Window	14 days

Upper GI Endoscopy	
Episode Summary	
Full Name	Upper GI Endoscopy
Abbreviation	EGD
Description	Most upper GI endoscopies are currently done in an outpatient setting, either in a doctor's office or in an ambulatory surgery center, so these are the ones intended to be captured in the EGD episode. Services and costs associated with a procedure of Esophagogastroduodenoscopy Upper GI (EGD) are grouped together to include the index event during which the procedure was performed, a 3-day look back period to capture pre-operative diagnostic workup leading to the endoscopy and a 14-day post-discharge period.
Default Parameters	
Age Range	18 - 65
Pre-Trigger Window	3 days
Post-Trigger Window	14 days


blue
california