Question and Answer Log

1. **How are the CCO rates affected, positively or negatively, around care delivery when a CCO makes an evidenced based service authorization based upon CMS or HERC guidance?**

   While utilization in general can impact the statewide base data pool that is the foundation of CCO capitation rates, individual CCO capitation rates are not directly impacted by any results from the episode of care analytics.

   You would not expect these services to be labeled as Adverse Actionable Events in the episode of care modeling.

2. **It is excellent to hear about the change to C-sections, can you explain how this actually impacts results?**

   In the historical Prometheus model, all C-sections related costs were considered Potentially Avoidable Costs (PAC) when subsumed by the pregnancy episode. In the Signify grouper logic, not all C-sections costs are considered PAC when subsumed by the pregnancy episode. Each service is evaluated individually and designated as either an Adverse Actionable Event (AAE) or typical care. The consequence of this logic difference is that (when holding all other factors constant) the aggregate complication rate for the pregnancy episode will be lower in the current grouper version than in the past grouper version.

3. **Is there a simple explanation for defining an episode end or is that not simple/straight forward?**

   Episodes end based on a predefined episode window length. For most procedural episodes, the episode window extends 90 days past the triggering event. For chronic episodes, the episodes end at the end of the data sample. In the event that a person is admitted to the hospital within an episode window, but is discharged outside of the episode window, the episode window is extended to capture the full admission.

4. **Are there any instances of addressing exclusions from the episodes?**

   The Signify grouper logic does include episode specific exclusions. There are two types of exclusions, clinical and business rules. Clinical exclusions include cases where an individual has a specific condition that would likely result in the episode of care having inflated complication rates or costs. For example, if an individual has cancer or HIV or if they are outside of the age group of interest for the episodes, certain episodes will be filtered out of the analysis for that member. Business rule exclusions include cases such as when the data sample period does not cover the entire episode span. When either type of exclusion is triggered, the episode is entirely removed from the analysis.

As Signify staff noted in the training, future versions of the grouper will include service level exclusions. This will allow for individual services to be excluded from an episode of care rather than excluding entire episodes.

Optumas would welcome the opportunity to discuss exclusion logic with the CCO clinical staff in the future. Depending on how the CCOs are using the data, it may be appropriate to stop applying certain exclusions, or to develop and apply new ones.

5. Do you remove episodes if clinical issues mandate a C-section, such as previa or breech?

Episodes are not removed from the analysis in these cases, but many conditions that mandate a C-section are not classified as complications.

The episode definition for C-sections can be found here.

For the current CCO use case, we try to limit exclusions. Our objective is to provide as much information as possible while providing the necessary tools to filter results to the subsets of information that each CCO finds most useful.

As CCOs explore additional use cases, it will be important to think through what modifications need to be applied to the data to have the most appropriate clinical interpretation for the specific use case. This is particularly true when the grouper is tied to payment (CCO or even downstream providers).

6. How might investment in intervention impact the statewide mandate on primary care expenditures?

SB 934 (2017) requires that by January 1, 2023, CCOs must spend at least 12% of their expenditures for physical and mental health care on primary care services. Investment in primary care to reduce downstream complications identified in the episode of care analysis is likely to be an effective strategy in complying with the statutory requirement. As primary care spend increases and the total cost of care decreases, the amount of primary care spend as a percent of total cost of care increases.

7. Can you please share any published outcomes from states or others that have implemented strategies as a result of this tool? Vermont and CO were mentioned.

Yes, we will survey the evidence base for episode of care analysis and bundled payments and provide this summary in the near future.

8. **Since Prometheus and Signify/Optumas diverged, who is now creating episode rules, code handling, clinical logic, etc.?**

   The Signify grouper logic will be maintained, developed, and updated by Signify Health. To the extent that CCOs would like to modify the logic based on Oregon-specific circumstances, Optumas can make these changes to the program directly. Recommendations for modifications can be submitted to OHA Actuarial Services for consideration and implementation.

9. **How would we submit these recommendations?**

   Please submit clinical questions, comments, and feedback to the actuarial services inbox at Actuarial.Services@dhsoha.state.or.us; they will be routed by the Actuarial Services Unit to the appropriate people.

10. **How can this system be used to optimize equity for the populations we serve?**

    This question illustrates how the investment Oregon has made to provide CCOs with interactive dashboards and analytics with a clinical overlay can advance policy from a variety of perspectives.

    Data from the dashboards can be exported and merged with CCO data sets to stratify results based on any member, provider, or community characteristics available.

    Having the ability to stratify the episode of care analysis results, by geographic divisions and population demographic characteristics, provides CCOs with insights into which specific types of disease states and complications that disproportionally affect their community with a level of detail on the populations they serve. This functionality allows for CCOs to craft clinically and culturally appropriate intervention strategies that optimize equity for different populations to meet their communities' needs.

11. **Risk adjustment – how can we protect institutions that select for highly complex and vulnerable patients and populations?**

    The current use case for the tool is to gain greater insight into the delivery system that allows for strategic interventions to reduce costs and improve outcomes. There is currently no risk adjustment applied. This avoids distorting actual costs experienced in the delivery system.

    Should CCOs begin to rank providers or hold providers financially accountable for results (e.g. bundled payments or performance-based rewards that incorporate

complication rates), risk adjustment will be critically important. One initial step to consider is exporting dashboard data and merging it with CCO member risk data.

OHA and Optumas are also open to collaboration on identifying appropriate risk adjustment methodologies for specific use cases.