



# Cardiac Episodes of Care Payment Model Manual

Winter 2023  
Blue Shield of California

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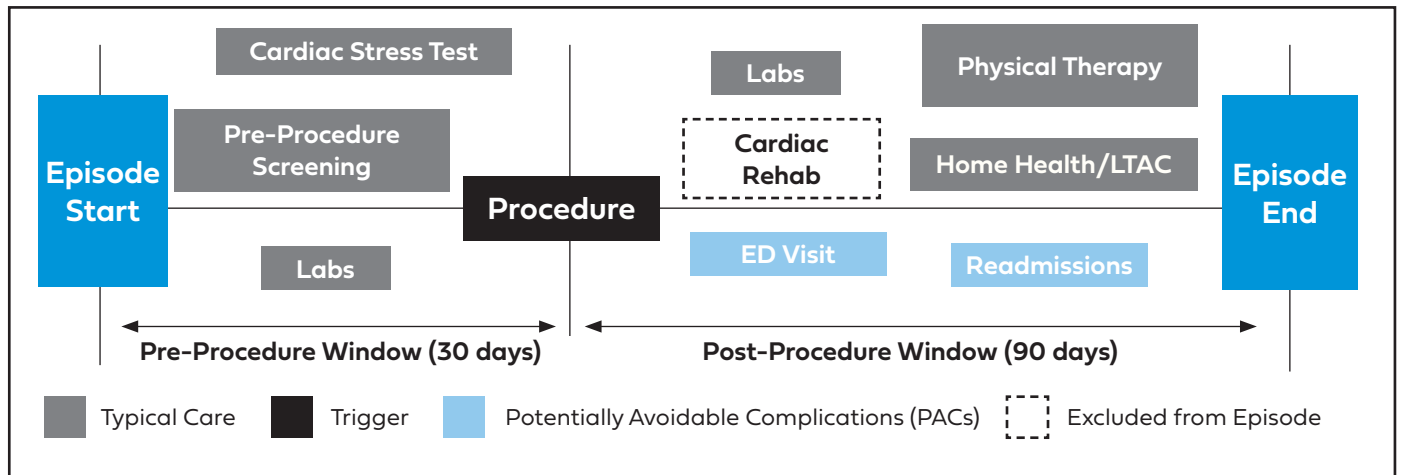
# Why episodes of care?

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?

An episode of care encompasses the full spectrum of services related to Coronary Angioplasty (PCI) and CABG &/or Valve Procedures (CXCABG) during a given time frame, including typical care, services, and complications.



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

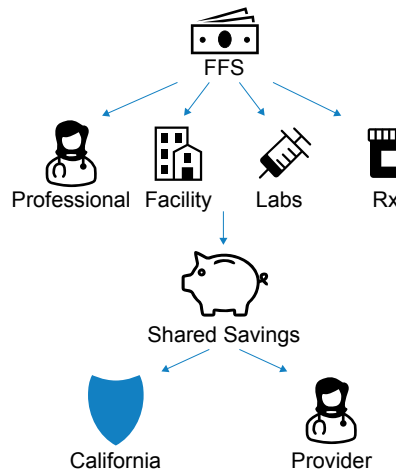
Example of a Cardiac Episode

# Retrospective vs. prospective models

To minimize the operational challenges of 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 will offer a retrospective payment model. Below is a high-level description of 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 continues receiving FFS payments

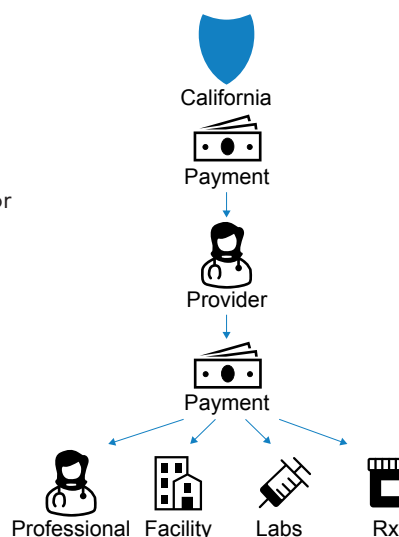
Does not require modification to existing claims adjudication system

Shared savings reimbursement after services rendered and reconciled

Providers receive upfront negotiated payment at the start

Requires additions and/or modifications to existing claims adjudication

Provider savings 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 PROMETHEUS Analytics® for episodes of care logic.

## Episode triggers

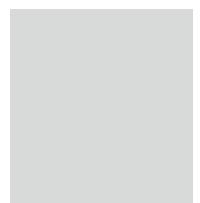
For each episode of care, PROMETHEUS Analytics® defines sets of trigger codes (ICD-9/10 diagnoses and procedures, CPT, HCPCS) along with target sequence (i.e., principal or any), type of claim with which code should be associated (i.e., inpatient or outpatient facility claims, or professional claim) 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.

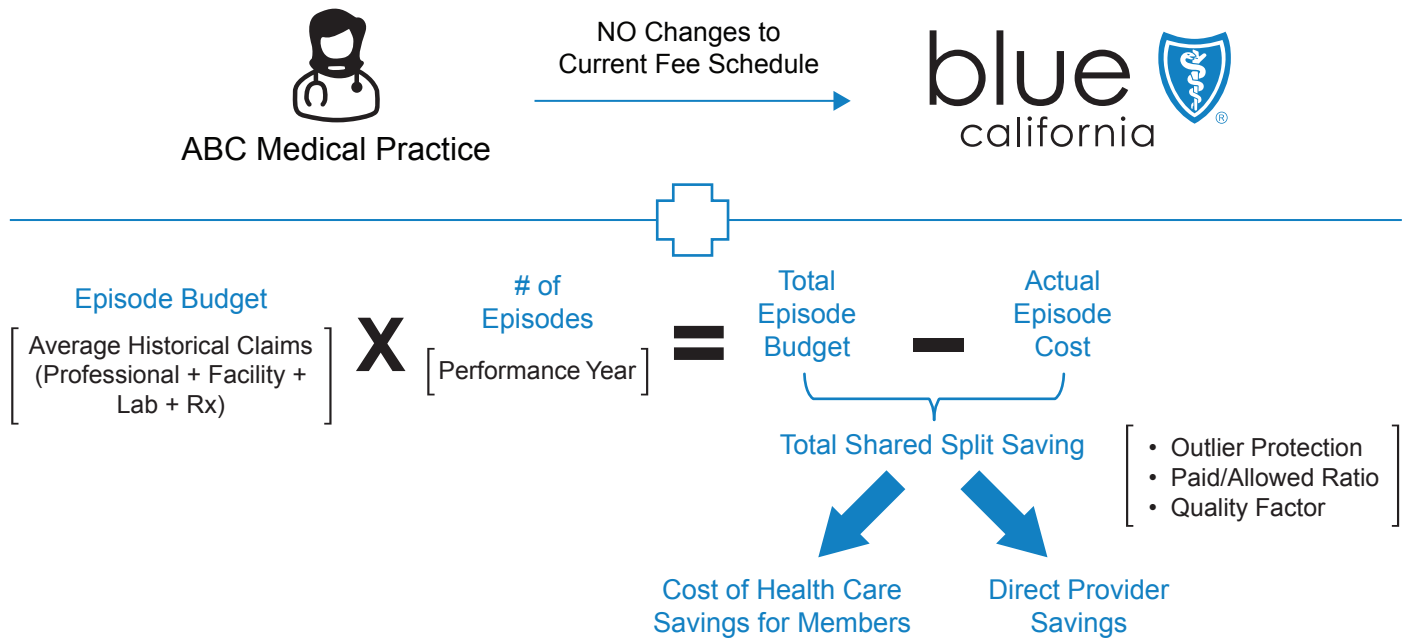
## Services included

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 performance 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. 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., Coronary Angioplasty (PCI) and CABG &/or Valve Procedures (CXCABG), individual episode budgets will be set.

1.

**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.

2.

**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 provide 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 maximize savings while in the program.

Data will be aggregated at the practice level per episode as well as individually by physician to allow full transparency in how performance is utilized. Refer to the monitoring reports overview for additional details on how to view and use these 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 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 will be adjusted by a quality score to generate the net shared savings. If your practice participates in multiple procedural episodes (i.e., Coronary Angioplasty (PCI) and CABG &/or Valve Procedures (CXCABG), etc) each individual episode's performance and shared savings will be calculated separately.

5.

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

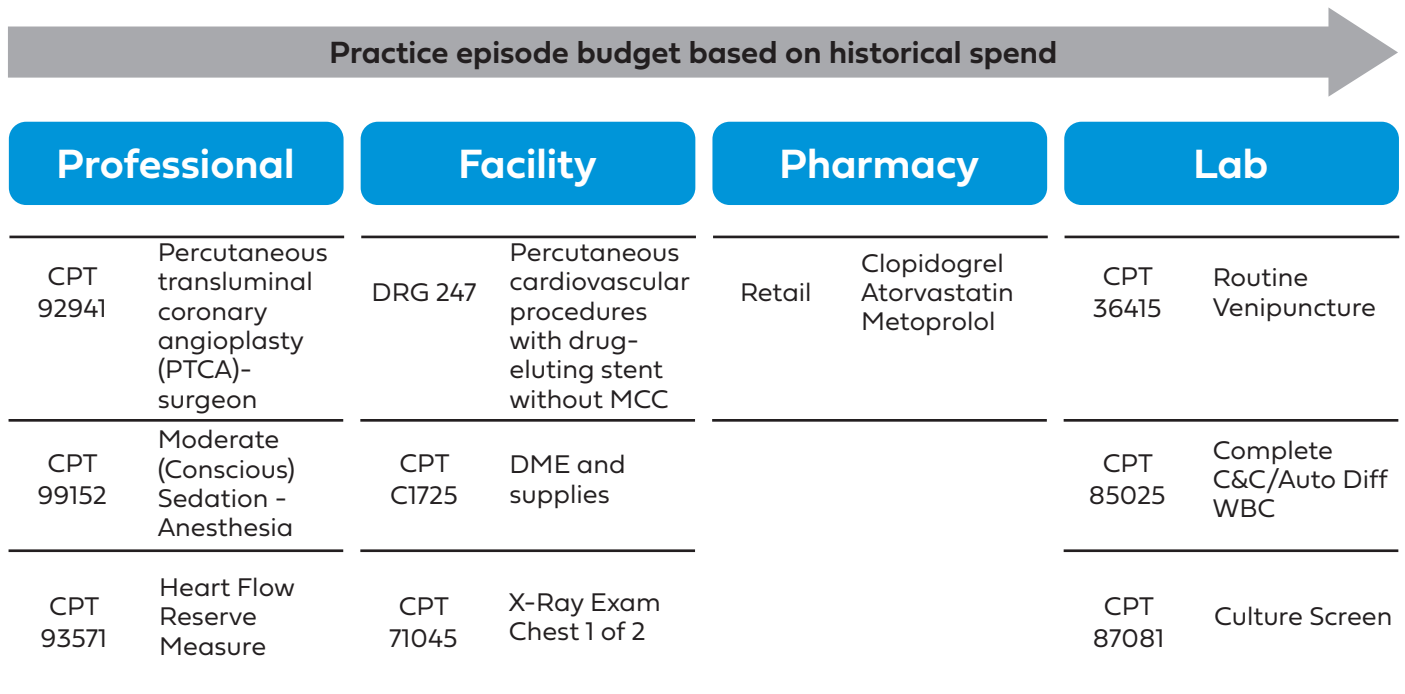
6.



# Components of the model:

## Budget setting:

Each episode budget will be calculated based on your practice’s historical performance. Per the PROMETHEUS methodology, all claims associated with the episode will be included in the budget.



PROMETHEUS can differentiate between claims that are directly associated with an episode and those that are not. If there are claims outside the realm of an 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 practice will have separate budgets by line of business.

- IFP: Health insurance coverage purchased by individuals/families directly from Blue Shield or through an agent, broker, or on the exchange.
- Group: Blue Shield health insurance coverage typically purchased by employers for employees.

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.

Metrics		Weight
<b>CABG &amp;/or Valve Procedures (CXCABG)</b>	<ul style="list-style-type: none"><li>• Patient Experience</li><li>• Post-Surgical Readmissions</li><li>• Potentially Avoidable Complications: General</li><li>• Potentially Avoidable Complications: Infections</li><li>• Potentially Avoidable Complications: Cardiovascular</li></ul>	10% 45% 15% 15% 15%
<b>Coronary Angioplasty (PCI)</b>	<ul style="list-style-type: none"><li>• Patient Experience</li><li>• Post-Surgical Readmissions</li><li>• Potentially Avoidable Complications: General</li><li>• Potentially Avoidable Complications: Infections</li><li>• Potentially Avoidable Complications: Cardiovascular</li></ul>	10% 45% 15% 15% 15%



## **Baseline and target setting approach**

Blue Shield will use your practice's average historical performance for 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.

## Patient Experience

Blue Shield will administer a patient experience survey to the member. Members will be contacted by mail and/or email 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.

Question #	Category	Question
1	<b>Someone at office gave test results</b>	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	<b>Got urgent-care appointment as soon as needed</b>  <b>Get routine-care appointment as soon as needed</b>	In the last 6 months, when you contacted your 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 check-up or routine care with this provider, how often did you get an appointment as soon as you needed?
3	<b>Saw provider within 15 minutes of appointment time</b>	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 minutes of your appointment time?
4	<b>Rating of Personal Doctor</b>	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.
5	<b>Provider explained things in an easily understandable way</b>	In the last 6 months, how often did this provider explain things in a way that was easy to understand?

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## Shared savings calculations

### Savings cap

A savings cap is the limit of the total dollar amount of savings 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.



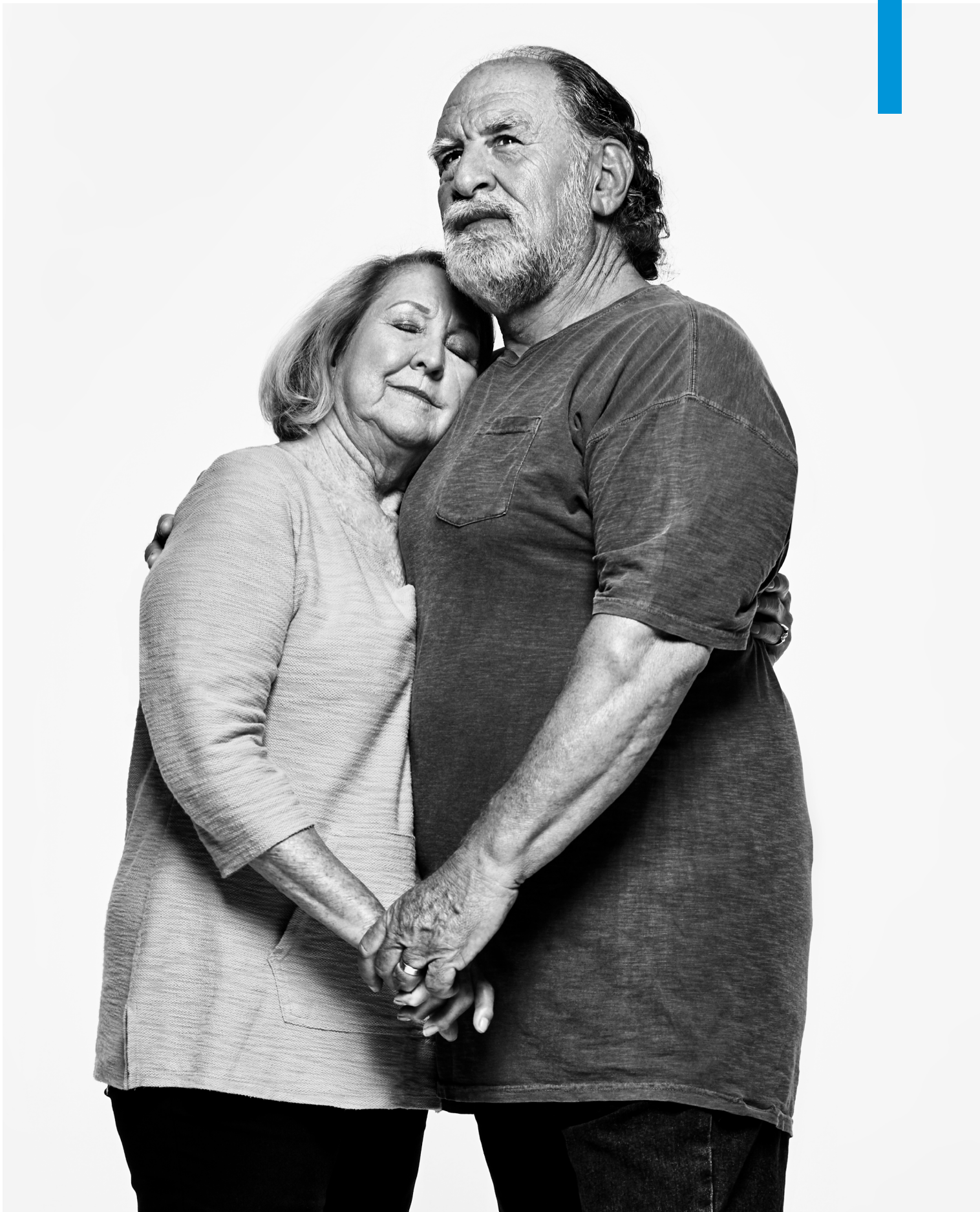
### Outlier protection

Outlier protection is the limit of the 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

To calculate the final portion of your shared savings, a "paid/allowed" ratio will be applied. This ratio is used to incorporate the member benefit. Since the paid cost is the final cost distributed to the provider by Blue Shield, we need to adjust for the member's responsibility by applying this "paid/allowed" ratio. The adjustment will accurately reflect the actual savings accumulated from the model to be shared back with your practice.

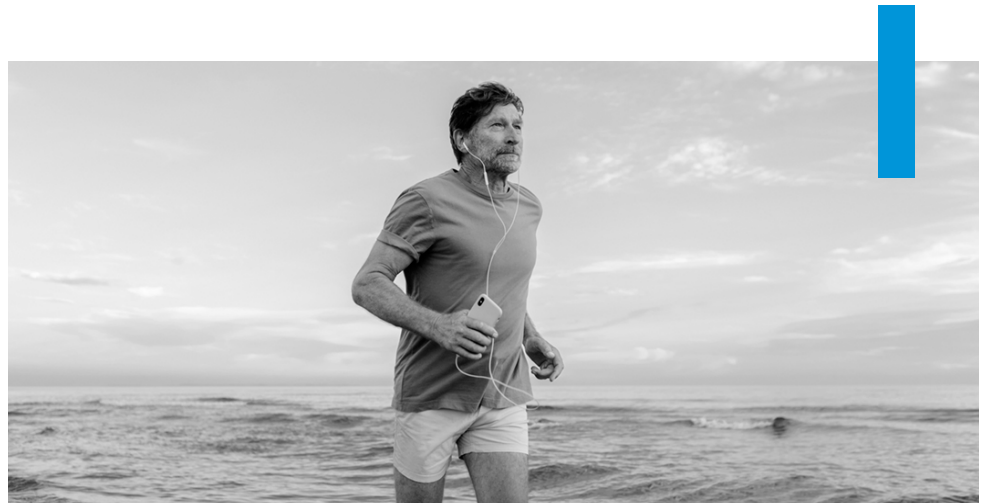




## Share savings illustrative example

Below is an example of how a provider's final earned shared savings will be calculated. The example includes application of the savings cap and the provider's shared savings, with the quality score applied. The table is for illustrative purposes only.

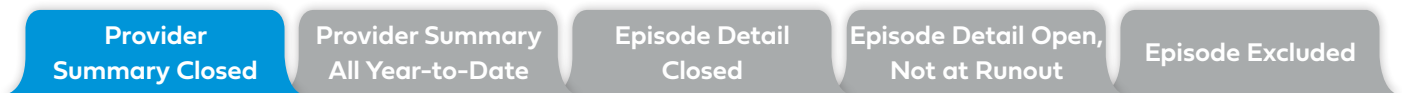
EXAMPLE: Shared Savings Calculations			Definitions / Calculations
A	Episode Budget	\$25,000	Based on historic total episode cost (includes all professional, facility & pharmacy claims)
B	# of Episodes	100	# of Episodes during the Performance Year
C	Total Episode Budget	\$2,500,000	(C) = (A) x (B)
D	Average 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	40%	
N	Providers Share in Savings	\$99,600	(N) = (K) x (L) x (M)
O	<b>Final Providers Net Shared Savings</b>	<b>\$99,600</b>	(O) ≤ (I)



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## Monitoring Reports Overview:

### Provider Summary Closed Tab



#### Retrospective Monitoring Report - Contract Entity Summary, Closed Episodes Only

Contract Entity Name: ABC Cardiac Associates

Episode Name(s): CABG &/or Valve Procedures, Coronary Angioplasty

Measurement Period: 1/1/2021-12/31/2021

Report Run Date: 11/19/2021

Date Through: 10/31/2021

**Purpose:** This report captures episodes 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.

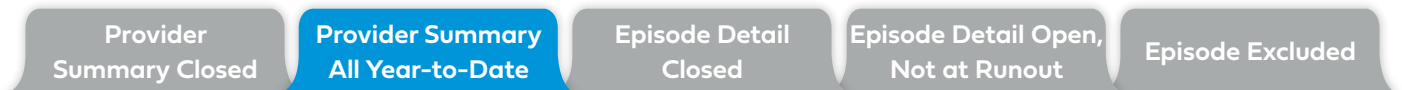
Closed episodes are defined as any episode in which the end date is 90 days or longer from the latest date in the current data set to allow for adequate claims runout.



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## Monitoring Reports Overview:

### Provider Summary All Year-to-Date



#### Retrospective Monitoring Report - Contract Entity Summary

**Contract Entity Name:** ABC Cardiac Associates

**Episode Name(s):** CABG &/or Valve Procedures, Coronary Angioplasty

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). It can be used to understand care patterns at the group and physician level and/or to assess over-utilization of services. In addition, this report can give providers a preview of any episodes that may be going over-budget before they have closed. Finally, the "Opportunities" column at the end of the individual provider table 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.

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## Monitoring Reports Overview:

### Episode Detail Closed Tab



#### Retrospective Monitoring Report - Member Detail for Completed Episodes

**Contract Entity Name:** ABC Cardiac Associates

**Episode Name(s):** CABG &/or Valve Procedures, Coronary Angioplasty

Measurement Period: 1/1/2021-12/31/2021

Report Run Date: 11/19/2021

Date Through: 10/31/2021

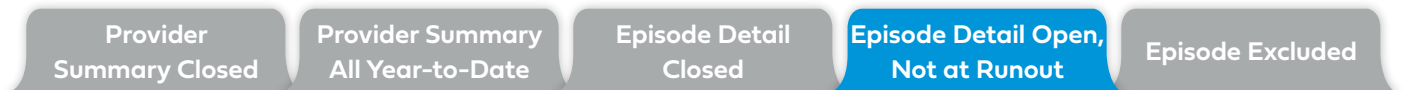
**Purpose:** This report displays the same information as the tab “Provider Summary Closed tab,” but each line represents information for a single episode. Episodes on this tab are closed with administrative claims runout. The financial calculations on this tab are final and provide additional insights 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

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## 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 Cardiac Associates

**Episode Name(s):** CABG &/or Valve Procedures, Coronary Angioplasty

Measurement Period: 1/1/2021-12/31/2021

Report Run Date: 11/19/2021

Date Through: 10/31/2021

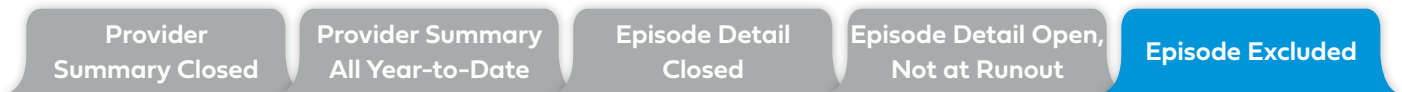
**Purpose:** This report captures episodes that are not yet closed, nor at administrative claims runout. It can be used to provide additional episode-level detail to support the “Provider Summary All YTD” tab. The financial and quality calculations are a snapshot of current performance and should be 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

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## Monitoring Reports Overview:

### Episode Excluded Tab



#### Retrospective Monitoring Report - Member Detail for Excluded Episodes

Contract Entity Name: ABC Cardiac Associates

Episode Name(s): CABG &/or Valve Procedures, Coronary Angioplasty

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 Cardiac Associates	EP0509 - CXCABG	Group	\$5,000	2.5%	1.0%	5.0%
ABC Cardiac Associates	EP0509 - CXCABG	IFP	\$5,000	2.5%	1.0%	5.0%
ABC Cardiac Associates	EP0520 - PCI	Group	\$5,000	6.0%	3.0%	13.0%
ABC Cardiac Associates	EP0520 - PCI	IFP	\$5,000	6.0%	3.0%	13.0%

- 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 Cardiac Associates	EP0509 - CXCABG	Group	3	\$1,000	90
ABC Cardiac Associates	EP0509 - CXCABG	IFP	11	\$1,000	90
ABC Cardiac Associates	EP0520 - PCI	Group	2	\$1,000	90
ABC Cardiac Associates	EP0520 - PCI	IFP	6	\$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	Average Office Physical Therapy Visits
ABC Cardiac Associates	EP0509 - CXCABG	0	0	9.0
ABC Cardiac Associates	EP0509 - CXCABG	0	0	7.7
ABC Cardiac Associates	EP0520 - PCI	0	0	14.0
ABC Cardiac Associates	EP0520 - PCI	33	33	22.6

- 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	EP0509 - CXCABG	IFP	1	\$5,000	\$4,000	\$1,000	\$1,000	90
Provider 2	EP0509 - CXCABG	IFP	4	\$5,000	\$4,000	\$1,000	\$1,000	70
Provider 3	EP0520 - PCI	Group	1	\$5,000	\$6,000	(\$1,000)	\$2,000	40
Provider 6	EP0520 - PCI	IFP	1	\$5,000	\$4,000	\$1,000	\$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	EP0509 - CXCABG	100	0	0	13	30	24.0
Provider 2	EP0509 - CXCABG	100	0	0	8	15	3.7
Provider 3	EP0520 - PCI	50	50	0	4	10	0.0
Provider 6	EP0520 - PCI	100	0	0	17	14.0	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	EP0520 - PCI	Group	1	\$6,000	\$13,000	\$12,000	(\$12,000)	0
Provider 2	EP0520 - PCI	IFP	1	\$5,000	\$11,000	\$10,000	(\$9,000)	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	EP0509 - CXCABG	100	0	0	5.0
Provider 2	EP0520 - PCI	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 Cardiac Associates	EP0520 - PCI	6	\$2,000
ABC Cardiac Associates	EP0509 - CXCABG	5	\$50
ABC Cardiac Associates	EP0509 - CXCABG	2	(\$10,000)

# Frequently Asked Questions

## **How and when will I know my final shared savings?**

After the performance year is complete, all episodes will be closed, and time will be allowed for claims run out. Blue Shield will share the final reconciliation report that aggregates 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 three month claims run out, and another one month to finalize the 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](mailto:CareReImagined@blueshieldca.com).

## **What if I have questions about the program?**

Please email questions about the program to [CareReImagined@blueshieldca.com](mailto:CareReImagined@blueshieldca.com). Someone from our team will respond promptly.



# Appendix

Coronary Angioplasty	
Episode Summary	
<b>Full Name</b>	Coronary Angioplasty
<b>Abbreviation</b>	PCI
<b>Description</b>	Services and costs associated with a procedure of percutaneous coronary intervention (PCI) are grouped together to include the index stay during which the procedure was performed, a 30-day look back period to capture pre-operative diagnostic workup leading to the surgery and a 90-day post-discharge period to capture post-operative care.
Default Parameters	
<b>Age Range</b>	18 - 75
<b>Pre-Trigger Window</b>	30 days
<b>Post-Trigger Window</b>	90 days

CABG &/or Valve Procedures	
Episode Summary	
<b>Full Name</b>	CABG &/or Valve Procedures
<b>Abbreviation</b>	CXCABG
<b>Description</b>	Services and costs associated with a procedure of coronary artery bypass grafting, with or without valve surgery, arrhythmia surgery, or other related open-heart procedures, are grouped together into a complex coronary artery bypass graft (Cx CABG) episode. The episode includes the index stay during which the procedure was performed, a 30-day look back period to capture the pre-operative diagnostic workup leading to the surgery and a 90-day post-discharge period to capture post-operative care.
Default Parameters	
<b>Age Range</b>	18 - 75
<b>Pre-Trigger Window</b>	30 days
<b>Post-Trigger Window</b>	90 days

