Division of
Health Care
Finance & Administration

Health Care
Innovation Initiative

Provider Stakeholder Group
June 29, 2016

Agenda

- Updates
- Episodes reports released
- Wave 4 TAG recommendations of episode design
- Update to Colonoscopy and EGD DBR – Qualified Clinical Data Registry quality metric
- Updated episode sequencing
- Wave 6 episodes TAG- Call for nominations to be released soon

Updated PCMH application and selection timeline

Release PCMH application	PCMH applications due back to State	Selection of Wave 1 practices	Wave 1 practices activities begin
By July 1, 2016	*By August 1, 2016*	*By September 1, 2016*	*January 1, 2017*
• Finalize PCMH application • Publish supporting information on website to provide context for potential applicants • Open application to potential respondents	• Practices to submit applications, with State fielding questions as needed	• State to synthesize results of application and announce Wave 1 PCMHs to practices and other stakeholders	• 20 – 30 practices begin Wave 1 of the TennCare PCMH Program

The application window for Tennessee's PCMH program has been shifted to accommodate the CPC+ schedule. CMS will announce selected regions for the CPC+ program on July 15. This does not affect the program's launch date of January 1, 2017.

State SIM Population Health Improvement Update

- 6/7 – State Health Plan Draft sent out to stakeholders for comment
- 6/15 – Met with Department of Mental Health and Substance Abuse to further integrate mental and behavioral health into the Plan
- 6/23 – All comments received
- 6/24 – State Health Plan Final Draft submitted to Dr. Dreyzehner, Commissioner of Health
- **7/1 – State Health Plan submitted to Governor Haslam**

- Next steps:
  - Develop Tennessee-specific set of Vital Signs metrics to measure health and progress in the state
    - Held a workshop with TDH Executive Leadership Team on 6/22
    - Currently designing approach for additional public stakeholder engagement
  - Create plan of action to expand upon PHIP foundation for future updates to the State Health Plan (including the incorporation of Physical Activity Plan and Oral Health Plan)

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Episodes reports released

- MCOs sent performance reports for Wave 1 episodes last week.
  - These reports are for calendar year 2015 and allow for three months of claims runout.
- Preview reports for Waves 2, 3 and 4 episodes were also sent last week.
- The Wave 1 final reports will be released in August 2016 for the same calendar year 2015 period.
  - The August final report will allow for six months of claims runout.
  - Any shared savings rewards or shared risk penalties will be based on the August 2016 report.

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Wave 4 TAG Recommendations

Wave 4 Episodes include:

- Attention deficit and hyperactivity disorder (ADHD)
- Oppositional defiant disorder (ODD)
- Bariatric surgery
- Coronary artery bypass graft (CABG)
- Heart valve replacement and repair
- Congestive heart failure (CHF) acute exacerbation

DBRs and code sheets will be available on the website http://tn.gov/hcfa/topic/episodes-of-care

Summary of TAG recommendations – ADHD episode

Area	Episode design summary
1 Identifying episode triggers	▪ An ADHD episode is triggered by a professional claim that has: – A **primary diagnosis of ADHD** (ICD-9 diagnosis code 314 – Hyperkinetic syndrome of childhood), or – A **secondary diagnosis of ADHD and a primary diagnosis of a symptom of ADHD**[1] ▪ This professional visit must also have a procedure code that is for assessment, therapy, case management, or physician services
2 Attributing episodes to quarterbacks	▪ The quarterback is the **provider or group with the plurality of ADHD-related visits** during the episode ▪ The contracting entity ID with the plurality of ADHD visits will be used to identify the quarterback
3 Identifying services to include in episode spend	▪ The length of the ADHD episode is **180 days**. During this time period the following services are included in episode spend: – All inpatient, outpatient, professional, and long-term care claims with a **primary diagnosis of ADHD** – All inpatient, outpatient, professional, and long-term care claims with a **secondary diagnosis of ADHD and a primary diagnosis of a symptom of ADHD** – Pharmacy claims with **eligible therapeutic codes**
4 Risk adjusting and excluding episodes	▪ Episodes affected by **factors that make them inherently more costly than others are risk adjusted.** ▪ Episodes which are **not comparable** or affected by factors that make them inherently more costly but that **cannot be risk adjusted for are excluded**. There are three types of exclusions: – Business exclusions: Available information is not comparable or is incomplete[2] – Clinical exclusions: Patient's care pathway is different for clinical reasons: ▫ These include age (<4 or >20), attempted suicide, autism, bipolar, BPD, conduct disorder, delirium, dementia, dissociative disorders, homicidal ideation, intellectual disabilities, manic disorders, psychoses, PTSD, schizophrenia, specific psychosomatic disorders (e.g. factitious disorder) and substance abuse – High cost outlier exclusions: Episode's risk adjusted spend is three standard deviations above the mean
5 Determining quality metrics performance	▪ Quality metrics **tied to gain sharing** are: – Percentage of valid episodes that meet the minimum care requirement. The minimum care requirement is set at 5 visits/claims with a related diagnosis code during the episode window. These may be a combination of physician visits, therapy visits, level I case management visits, or pharmacy claims for treatment of ADHD ▪ Quality metrics **not tied to gain sharing** are: – Average number of physician visits per valid episode – Average number of therapy visits per valid episode – Average number of level I case management visits per valid episode – Percentage of valid episodes with medication by age group (4 and 5, 6 to 11, and 12 to 20) – Percentage of valid episodes for which the patient has a physician, therapy, or level I case management visit within 30 days of the triggering visit

1 Symptoms of ADHD are identified by ICD-9 diagnosis codes 312.30 – Impulse control disorder and 312.9 - Unspecified disturbance of conduct)

2 Episodes with inconsistent enrollment, third-party liability, or dual eligibility; episodes where triggering procedure occurs in a Federally Qualified Health Center or Rural Health Clinic; episodes that cannot be associated with a quarterback ID; episodes with zero triggering professional spend; episodes where total non-risk-adjusted spend is within the bottom 2.5% of all episodes; and episodes where patients expired in the hospital or left against medical advice

Summary of TAG recommendations – ODD episode

Area	Episode design summary
1 **Identifying episode triggers**	▪ An ODD episode is triggered by a professional claim that has: – A **primary diagnosis of ODD** (ICD-9 diagnosis code 313.81 – Oppositional defiant disorder), or – A **secondary diagnosis of ODD and a primary diagnosis of a symptom of ODD**[1] ▪ This professional visit must also have a procedure code that is for assessment, therapy, case management, or physician services
2 **Attributing episodes to quarterbacks**	▪ The quarterback is the **provider or group with the plurality of ODD-related visits** during the episode ▪ The contracting entity ID with the plurality of ODD visits will be used to identify the quarterback
3 **Identifying services to include in episode spend**	▪ The length of the ODD episode is **180 days**. During this time period the following services are included in episode spend: – All inpatient, outpatient, professional, and long-term care claims with a **primary diagnosis of ODD** – All inpatient, outpatient, professional, and long-term care claims with a **secondary diagnosis of ODD and a primary diagnosis of a symptom of ODD** – Pharmacy claims with **eligible therapeutic codes**
4 **Risk adjusting and excluding episodes**	▪ Episodes affected by **factors that make them inherently more costly than others are risk adjusted.** ▪ Episodes which are **not comparable** or affected by factors that make them inherently more costly but that **cannot be risk adjusted for are excluded**. There are three types of exclusions: – Business exclusions: Available information is not comparable or is incomplete[2] – Clinical exclusions: Patient's care pathway is different for clinical reasons: ▫ These include age (<4 or >18), antisocial personality disorder, attempted suicide, autism, BPD, conduct disorder, delirium, dementia, disruptive mood dysregulation disorder, dissociative disorders, homicidal ideation, intellectual disabilities, manic disorders, psychoses, PTSD, schizophrenia, specific psychosomatic disorders (e.g. factitious disorder) and substance abuse – High cost outlier exclusions: Episode's risk adjusted spend is three standard deviations above the mean
5 **Determining quality metrics performance**	▪ Quality metrics **tied to gain sharing** are: – Percentage of valid episodes that meet the minimum care requirement. The minimum care requirement is set at 6 therapy and/or level I case management visits with a related diagnosis code during the episode window ▪ Quality metrics **not tied to gain sharing** are: – Percentage of valid episodes with no coded behavioral health comorbidities for which the patient received behavioral health medications – Percentage of valid episodes that had a claim with ODD as the primary diagnosis in the prior year – Average number of visits (physician, therapy, and case management) per valid episode – Average number of therapy or level I case management visits per valid episode

1 Symptoms of ODD are identified by ICD-9 diagnosis codes 312.9 - Unspecified disturbance of conduct, 313.89 - Other emotional disturbances, and 93 ICD-9 codes for substance-related disorders

2 Episodes with inconsistent enrollment, third-party liability, or dual eligibility; episodes where triggering procedure occurs in a Federally Qualified Health Center or Rural Health Clinic; episodes that cannot be associated with a quarterback ID; episodes with zero triggering professional spend; episodes where total non-risk-adjusted spend is within the bottom 2.5% of all episodes; and episodes where patients expired in the hospital or left against medical advice

Summary of TAG recommendations – Bariatric surgery episode

Area	TAG recommendation
1 Identifying episode triggers	▪ A bariatric surgery episode is triggered by: – A **professional claim** that has one of the **defined procedure codes** for **bariatric surgery** – A **facility claim** that has a diagnosis code relevant to severe obesity or indicated comorbidities of obesity
2 Attributing episodes to quarterbacks	▪ The quarterback is the **physician or physician group** that performed the procedure ▪ The contracting entity ID of the physician (or group) on the professional claim will be used to identify the quarterback
3 Identifying services to include in episode spend	▪ Services to include in episode spend are: – All medical services and medications **during the bariatric procedure** – Specific evaluation and management, medications, procedures, imaging, testing, anesthesia, pathology, and care after discharge **up to 30 days after discharge** from the facility where the bariatric procedure was performed
4 Risk adjusting and excluding episodes	▪ Episodes affected by **factors that make them inherently more costly than others are risk adjusted.** The TAG has recommended a specific list of factors for testing. ▪ Episodes which are **not comparable** or affected by factors that make them inherently more costly but that **cannot be risk adjusted for are excluded**. There are three types of exclusions: – Business exclusions: Available information is not comparable or is incomplete[1] – Clinical exclusions: Patient's care pathways is different for clinical reasons ▫ These are **BPD/BPD-DS, adjustable gastric band placement,** and **revision procedures** – High cost outlier exclusions: Episode's risk adjusted spend is three standard deviations above the mean
5 Determining quality metrics performance	▪ Quality metrics tied to gain sharing are: – Percent of valid episodes where the patient receives relevant follow-up care within 30 days of discharge ▪ Quality metrics not tied to gain sharing are: – Percent of total episodes performed in an accredited facility, e.g. through MBSAQIP – Percent of valid episodes with relevant admission or observation care within 30 days of discharge – Percent of valid episodes with relevant ED visits within 30 days of discharge – Percent of valid episodes with relevant reoperations, including major abdominal procedures and wound debridement, within 30 days of discharge

1 Episodes with inconsistent enrollment, third-party liability, or dual eligibility; episodes where triggering procedure occurs in a Federally Qualified Health Center or Rural Health Clinic; episodes that cannot be associated with a quarterback ID; episodes with zero triggering professional spend; episodes where total non-risk-adjusted spend is within the bottom 2.5% of all episodes; and episodes where patients expired in the hospital or left against medical advice

Summary of TAG recommendations – Coronary artery bypass graft episode

Area	TAG recommendation
1 Identifying episode triggers	A CABG episode is triggered by: ▪ A **professional claim** that has one of the **defined primary procedure codes for CABG** ▪ An inpatient **facility claim** that has a diagnosis code relevant to CABG (e.g., coronary occlusion) *CABG procedures that are concurrent with heart valve replacement or repair procedures will not trigger episodes*
2 Attributing episodes to quarterbacks	The quarterback is the **facility where the CABG was performed** ▪ The contracting entity ID of the facility on the inpatient facility claim will be used to identify the quarterback
3 Identifying services to include in episode spend	▪ Services to include in episode spend are: – All medical services and medications **during the facility stay where the CABG is performed** – Specific evaluation and management, medications, anesthesia, pathology, procedures, imaging, testing, and care after discharge **up to 30 days after discharge** from the facility where the procedure was performed
4 Risk adjusting and excluding episodes	▪ Episodes affected by **factors that make them inherently more costly than others are risk adjusted.** The TAG has recommended a specific list of factors for testing. ▪ Episodes which are **not comparable** or affected by factors that make them inherently more costly but that **cannot be risk adjusted for are excluded**. There are three types of exclusions: – Business exclusions: Available information is not comparable or is incomplete[1] – Clinical exclusions: Patient's care pathways is different for clinical reasons ▫ These are **emergent procedures, pre-existing endocarditis,** and **pre-existing pneumonia** – High cost outlier exclusions: Episode's risk adjusted spend is three standard deviations above the mean
5 Determining quality metrics performance	▪ Quality metrics tied to gain sharing are: – Percent of valid episodes performed by a surgeon participation in a Qualified Clinical Data Registry – Percent of valid episodes where the patient receives relevant follow-up care within 30 days of discharge ▪ Quality metrics not tied to gain sharing are: – Percent of valid episodes with relevant readmission or observation care within 30 days of discharge – Percent of total episodes with patient mortality within the episode window – Percent of valid episodes where the patient has a major morbidity[2] within the episode window

1 Episodes with inconsistent enrollment, third-party liability, or dual eligibility; episodes where triggering procedure occurs in a Federally Qualified Health Center or Rural Health Clinic; episodes that cannot be associated with a quarterback ID; episodes with zero triggering professional spend; episodes where total non-risk-adjusted spend is within the bottom 2.5% of all episodes; and episodes where patients expired in the hospital or left against medical advice

2 Stroke/cerebrovascular event; renal failure; cardiac reoperation; deep sternal wound infection; prolonged ventilation or intubation

Summary of TAG recommendations – Heart valve replacement and repair episode

Area	TAG recommendation
1 Identifying episode triggers	A heart valve replacement and repair episode is triggered by: ▪ A **professional claim** that has one of the **defined procedure codes for heart valve replacement or repair** ▪ An inpatient **facility claim** that has a diagnosis code relevant to heart valve replacement or repair episode *Heart valve replacement and repair that is concurrent with CABG will trigger a heart valve episode*
2 Attributing episodes to quarterbacks	The quarterback is the **facility where the heart valve replacement or repair procedure was performed** ▪ The contracting entity ID of the facility on the inpatient facility claim will be used to identify the quarterback
3 Identifying services to include in episode spend	▪ Services to include in episode spend are: – All medical services and medications **during the facility stay where the heart valve replacement or repair procedure is performed** – Specific evaluation and management, medications, anesthesia, pathology, procedures, imaging, testing, and care after discharge **up to 30 days after discharge** from the facility where the procedure was performed
4 Risk adjusting and excluding episodes	▪ Episodes affected by **factors that make them inherently more costly than others are risk adjusted.** The TAG has recommended a specific list of factors for testing. ▪ Episodes which are **not comparable** or affected by factors that make them inherently more costly but that **cannot be risk adjusted for are excluded**. There are three types of exclusions: – Business exclusions: Available information is not comparable or is incomplete[1] – Clinical exclusions: Patient's care pathways is different for clinical reasons ▫ These are **acute ischemia-related admissions, pre-existing endocarditis,** and **pre-existing pneumonia** – High cost outlier exclusions: Episode's risk adjusted spend is three standard deviations above the mean
5 Determining quality metrics performance	▪ Quality metrics tied to gain sharing are: – Percent of valid episodes performed by a surgeon participation in a Qualified Clinical Data Registry – Percent of valid episodes where the patient receives relevant follow-up care within 30 days of discharge ▪ Quality metrics not tied to gain sharing are: – Percent of valid episodes with relevant readmission or observation care within 30 days of discharge – Percent of total episodes with patient mortality within the episode window – Percent of valid episodes where the patient has a major morbidity[2] within the episode window

1 Episodes with inconsistent enrollment, third-party liability, or dual eligibility; episodes where triggering procedure occurs in a Federally Qualified Health Center or Rural Health Clinic; episodes that cannot be associated with a quarterback ID; episodes with zero triggering professional spend; episodes where total non-risk-adjusted spend is within the bottom 2.5% of all episodes; and episodes where patients expired in the hospital or left against medical advice

2 Stroke/cerebrovascular event; renal failure; cardiac reoperation; deep sternal wound infection; prolonged ventilation or intubation

Summary of TAG recommendations – CHF acute exacerbation episode

Area	TAG recommendation
1 Identifying episode triggers	A congestive heart failure acute exacerbation episode is triggered by an **inpatient admission or ED/Observation/IV infusion center outpatient claim,** where either: ▪ The primary diagnosis is one of the **defined acute or unspecified CHF trigger codes**; ▪ The primary diagnosis is one of the **defined chronic CHF codes, with a secondary diagnosis code from the acute or unspecified CHF trigger or signs and symptom codes**; or ▪ The primary diagnosis is one of the **defined CHF signs and symptom codes, with a secondary diagnosis code from the acute, chronic, or unspecified CHF trigger codes**
2 Attributing episodes to quarterbacks	The quarterback is the **facility where the patient is treated** ▪ The contracting entity ID on the facility claim will be used to identify the quarterback
3 Identifying services to include in episode spend	▪ Services to include in episode spend are: – All medical services and medications **during the trigger window**[1] – Specific anesthesia, evaluation and management, medications, procedures, imaging, testing, and care after discharge **up to 30 days after discharge** from facility where the CHF acute exacerbation was treated
4 Risk adjusting and excluding episodes	▪ Episodes affected by **factors that make them inherently more costly than others are risk adjusted.** The TAG has recommended a specific list of factors for testing. ▪ Episodes which are **not comparable** or affected by factors that make them inherently more costly but that **cannot be risk adjusted for are excluded**. There are three types of exclusions: – Business exclusions: Available information is not comparable or is incomplete[2] – Clinical exclusions: Patient's care pathways is different for clinical reasons ▫ These are **active cancer, ESRD, heart transplant, pregnancy, history of and/or concurrent ECMO, and presence or placement of VAD** – High cost outlier exclusions: Episode's risk adjusted spend is three standard deviations above the mean
5 Determining quality metrics performance	▪ Quality metrics tied to gain sharing are: – Percent of valid episodes where the patient receives relevant follow-up care within 30 days of discharge ▪ Quality metrics not tied to gain sharing are: – Percent of valid episodes where the patient receives relevant follow-up care within 7 days of discharge – Percent of valid episodes with relevant admission or observation care within 30 days of discharge – Percent of valid episodes with relevant ED visit within 30 days of discharge – Percent of total episodes with patient mortality within the episode window – Percent of total episodes where patients received quantitative symptom/activity assessment during episode window

1 During the day or days of the facility stay (if any) where the CHF is treated

2 Episodes with inconsistent enrollment, third-party liability, or dual eligibility; episodes where triggering procedure occurs in a Federally Qualified Health Center or Rural Health Clinic; episodes that cannot be associated with a quarterback ID; episodes with zero triggering professional spend; episodes where total non-risk-adjusted spend is within the bottom 2.5% of all episodes; and episodes where patients expired in the hospital or left against medical advice

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Update to Colonoscopy and EGD DBR – Qualified Clinical Data Registry quality metric

- In order to meet gain sharing for the Colonoscopy and EGD episodes, a provider must have a percent of valid episodes performed in a facility participating in a Qualified Clinical Data Registry (e.g., GIQuIC).
- The State will give a one year grace period to allow providers more time to begin using a registry.
- As a result, TennCare MCOs will move the quality metric "Participation in a qualified clinical data registry" to an information-only measure for the 2016 performance period for the Colonoscopy and EGD episodes.
- The quality metric will be moved back to gain share for the 2017 performance period.

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Updated episode sequencing

Edits highlighted in red

Design year & wave		Episode
2013	1	Perinatal Asthma acute exacerbation Total joint replacement
2014	2	COPD acute exacerbation Colonoscopy Cholecystectomy PCI - acute PCI – non acute
2015	3	GI hemorrhage EGD Respiratory Infection Pneumonia UTI - outpatient UTI – inpatient
	4	ADHD CHF acute exacerbation ODD CABG Valve repair and replacement Bariatric surgery
2016	5	Breast biopsy Breast cancer, mastectomy Breast cancer, medical oncology Otitis media
2016	5	Tonsillectomy Non-emergent depression Anxiety
2016	6	Outpatient skin and soft tissue infection Neonatal (multiple) HIV Pancreatitis Diabetes acute exacerbation
2017	7	Medical non-infec. orthopedic Schizophrenia (multiple) Spinal fusion exc. cervical Lumbar laminectomy Hip/Pelvic fracture Knee arthroscopy
	8	Hemophilia & other coag. dis. Anal procedures Colon cancer CAD & angina Hernia procedures Cardiac arrhythmia Sickle cell Pacemaker / Defibrillator
2018	9	Depression – acute exacerbation Lung cancer (multiple) Female reproductive cancer Other major bowel (multiple) PTSD
	10	Fluid electrolyte imbalance Renal failure Liver & pancreatic cancer Hepatitis C GERD acute exacerbation Drug dependence GI obstruction Rheumatoid arthritis
2019	11	Bipolar - chronic Bipolar – acute exacerbation Conduct disorder Epileptic seizure Hypotension/Syncope Kidney & urinary tract stones Other respiratory infection Dermatitis/Urticaria

Updated June 14, 2016

Updated episode sequencing

- Wave 5
  - Expanded the names of the breast cancer episodes. Previously stated “Breast cancer (multiple)”. Updated to “Breast cancer, mastectomy” and “Breast cancer, medical oncology”
  - “Chronic depression” was updated to state “non-emergent depression” per the TAG’s recommendation

- Wave 6
  - Diabetes acute exacerbation moving from Wave 7 to Wave 6
  - Pancreatitis moving from Wave 10 to Wave 6
  - Hepatitis C moving from Wave 6 to Wave 10
  - Bronchiolitis/RSV removed from list as these were included as triggers in the Pneumonia episode

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Wave 6 episodes TAG- Call for nominations to be released soon

- In July 2016, the Tennessee Health Care Innovation Initiative will begin seeking nominees for clinical experts to advise on the design of Wave 6 episodes of care.

- We will be looking for clinicians who are thought leaders in their fields, representative of practicing providers, enthusiastic about improving care delivery, and available to attend all TAG meetings (for the topic they are nominated) in Nashville.

- Wave 6 episodes of care include:
  - Outpatient skin and soft tissue infection
  - HIV
  - Neonatal (multiple)
  - Pancreatitis
  - Diabetes acute exacerbation

- Wave 6 TAG meetings will be held from September – November 2016.