



Division of  
**Health Care  
Finance & Administration**

Health Care  
Innovation Initiative

EPISODE DESIGN FEEDBACK SESSION

MAY 16, 2017



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**GASTROINTESTINAL EPISODES**

# Episodes Included in the Gastrointestinal Session

Screening and Surveillance  
Colonoscopy

Upper GI Endoscopy  
(Esophagogastroduodenoscopy  
(EGD))

Outpatient and Non-Acute  
Inpatient Cholecystectomy

Gastrointestinal Hemorrhage  
(GIH)

# Approach to the feedback session and objectives for today's discussion

## Approach & Process

1. **May 2017:** Gather feedback from Stakeholders across the state on the first 20 episodes implemented
2. **May-June 2017:** Conduct analysis to inform decision of how to incorporate feedback
3. **Fall 2017:** Release memo to public with all episode changes
4. **January 2018:** Incorporate selected changes into program for calendar year 2018

## Objectives & Scope for Today

1. Briefly review the background and objectives of the Tennessee Health Care Innovation Initiative & Episodes of care
2. Review feedback received prior to the meeting regarding the gastrointestinal episodes
3. Listen to and capture feedback *specific* to the gastrointestinal episodes
4. Capture feedback on the program overall

**The primary purpose of today's session is listening; the state will respond to and incorporate feedback as appropriate over the coming months**

# Tennessee Health Care Innovation Initiative



We are **deeply committed** to reforming the way that we pay for healthcare in Tennessee

Our goal is to **pay for outcomes and for quality care**, and to reward strongly performing providers

We plan to have value-based payment account for the **majority of healthcare spend** within the next three to five years

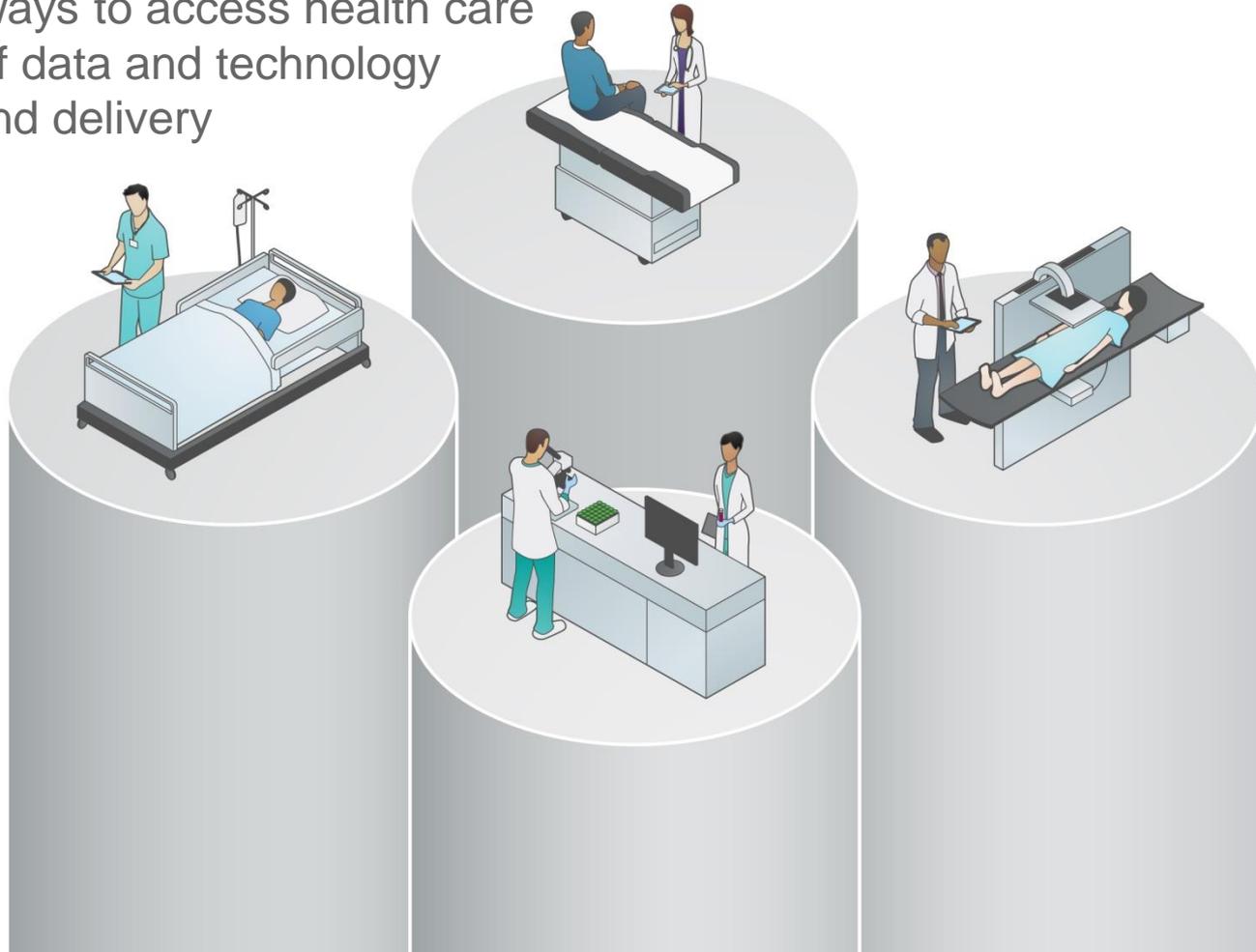
By **aligning on common approaches** we will see greater impact and ease the transition for providers

We appreciate that hospitals, medical providers, and payers have all demonstrated a **sincere willingness** to move toward payment reform

By working together, we can make significant progress toward **sustainable medical costs and improving care**

# What changes do we see for the health care system?

- Silos are starting to come down
- Growth in new ways to access health care
- Increased use of data and technology
- New payment and delivery models



# Over 40 episodes of care have been designed over the last 4 years

Design year & wave	Episode	Design year & wave	Episode	Design year & wave	Episode			
2013	1	Perinatal	2016	5	Breast biopsy			
	Asthma acute exacerbation	Breast cancer, medical oncology						
	Total joint replacement	Breast cancer, Mastectomy						
2014	2	COPD acute exacerbation			Otitis media	2017	7	Spinal fusion
		Colonoscopy			Tonsillectomy			Spinal decompression (without spinal fusion)
		Cholecystectomy	Anxiety	Femur/pelvis fracture				
		PCI - acute	Non-emergent depression	Knee arthroscopy				
		PCI - non acute	2015	3	Skin and soft tissue infections			Ankle sprains, strains, and fractures
GI hemorrhage	Neonatal (Age 31 weeks or less)	Wrist sprains, strains, and fractures						
EGD	Neonatal (Age 32 to 36 weeks)	Shoulder sprains, strains, and fractures						
Respiratory Infection	Neonatal (Age 37 weeks or greater)	Knee sprains, strains, and fractures						
Pneumonia	2016	6	HIV	Back/neck pain				
UTI - outpatient			Pancreatitis					
UTI - inpatient			Diabetes acute exacerbation					
2015			4	ADHD				
				CHF acute exacerbation				
				ODD				
				CABG				
	Valve repair and replacement							
	Bariatric surgery							

# Results for First Three Episodes

- ❖ Perinatal, total joint replacement and acute asthma exacerbation episodes showed total costs were reduced while quality was maintained in CY 2015.

**Perinatal: 3.4%  
decrease in cost**

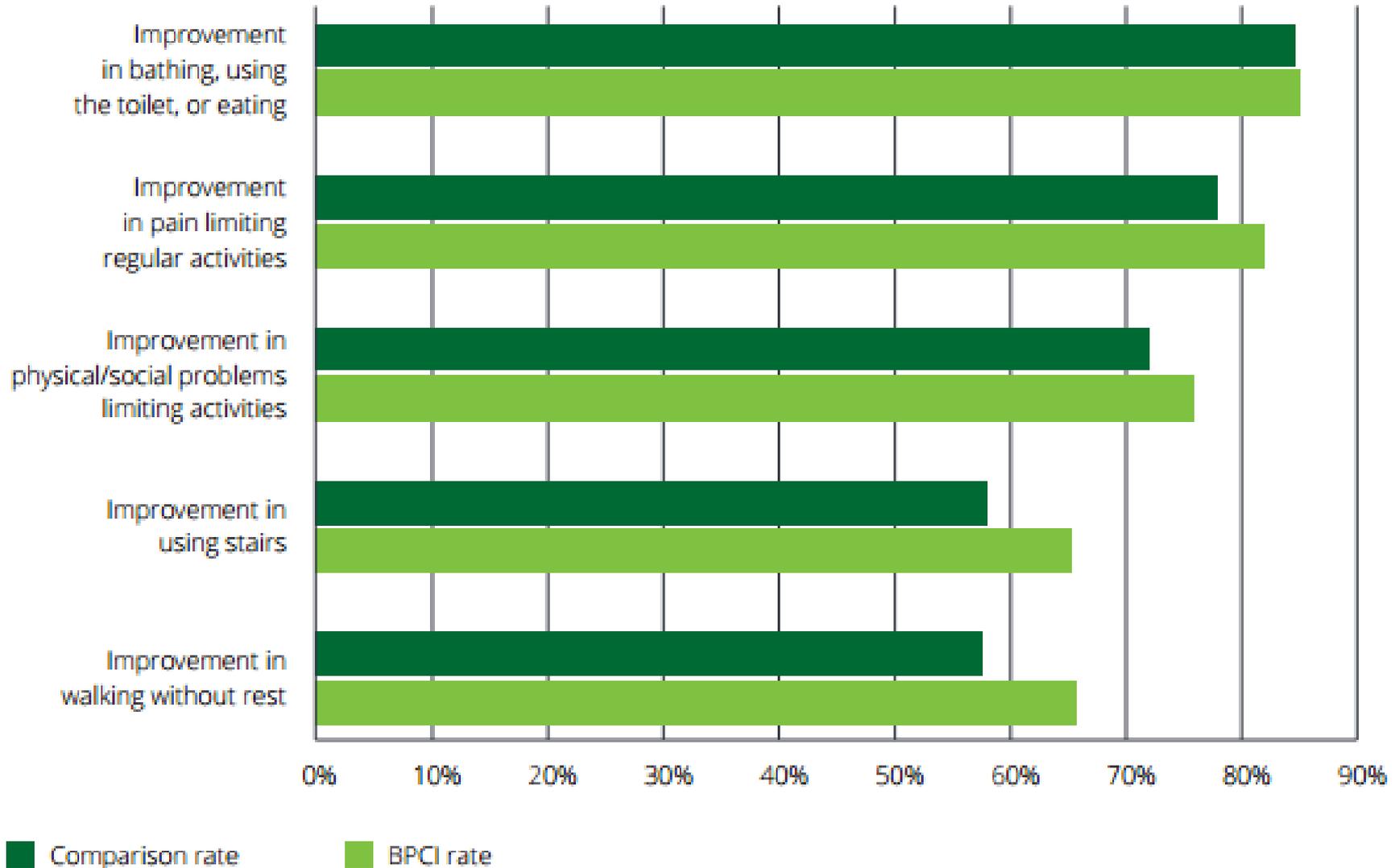
**Acute asthma  
exacerbation: 8.8%  
decrease in cost**

**Total joint  
replacement: 6.7%  
decrease in cost**

**Doctors and hospitals  
reduced costs while  
maintaining quality of  
care**

**Wave 1 episodes  
reduced costs by \$11.1  
million**  
(assuming a 3 percent increase  
would have taken place in the  
absence of this initiative)

# Bundled services for major joint replacement of the lower extremity showed improvement in mobility measures for patients



Source: CMS Bundled Payments for Care Improvement Initiative Models 2-4: Year 2 Evaluation & Monitoring Annual Report, 2016.

# Status of the launched Gastrointestinal Episodes

	First Preview Report Sent	Performance Period
<b>Cholecystectomy &amp; Colonoscopy (Wave II)</b>	2015	1st: CY 2016 2nd: CY 2017
<b>Gastrointestinal Hemorrhage &amp; EGD (Wave III)</b>	Spring 2016	1 <sup>st</sup> : CY 2017

# Screening and Surveillance Colonoscopy episode definition

Area	Episode definition
<b>1</b> Identifying episode triggers	<ul style="list-style-type: none"><li>A <b>professional claim for colonoscopy</b> triggers the episode</li></ul>
<b>2</b> Attributing episodes to quarterbacks	<ul style="list-style-type: none"><li>The <b>physician or physician group</b> who performs the colonoscopy is the Quarterback</li></ul>
<b>3</b> Identifying services to include in episode spend	<ul style="list-style-type: none"><li>All related services before, during, and 14 days after the procedure e.g. anesthesia, relevant radiology, labs, pathology, office visits, medications, and care for complications are included</li><li>Repeat colonoscopy or similar procedures up to 60 days after the procedure are included</li><li>The episode <b>begins 30 days before the procedure</b> (or admission if inpatient) and <b>ends 60 days after the procedure</b> (or discharge if inpatient)</li></ul>
<b>4</b> Risk-adjusting and excluding episodes	<ul style="list-style-type: none"><li>Episodes affected by <b>factors that make them inherently more costly than others are risk adjusted.</b></li><li>Episodes which are <b>not comparable</b> or affected by factors that make them inherently more costly but that <b>cannot be risk-adjusted for are excluded.</b> There are three types of exclusions:<ul style="list-style-type: none"><li>Business exclusions: Available information is not comparable or is incomplete (e.g., third party liability, non-continuous eligibility, left against medical advice, age less than 18 years and age greater than 64)</li><li>Clinical exclusions: Cancer under active management, colonoscopy through stoma, colonoscopy via colotomy, colonoscopy with stent, colostomy, coma, cystic fibrosis, end stage renal disease, ileostomy and enterostomy, inflammatory bowel disease, multiple sclerosis, organ transplant, paralysis and Parkinson's</li><li>High cost outlier exclusions: Episode's risk adjusted spend is three standard deviations above the mean</li></ul></li></ul>
<b>5</b> Determining quality metrics performance	<p><b>Tied to gain sharing:</b></p> <ul style="list-style-type: none"><li>Percent of valid <b>episodes performed in a facility participating in a Qualified Clinical Data Registry</b> that captures the following measures within the registry: adenoma detection rate, adequate bowel prep, incidence of perforation and average withdrawal time (e.g., GIQuIC)</li></ul> <p><b>Not tied to gain sharing:</b></p> <ul style="list-style-type: none"><li>Percent of valid episodes with a <b>perforation of the colon</b> during the trigger or post-trigger windows</li><li>Percent of valid episodes with <b>post polypectomy/biopsy bleeding</b> during the trigger or post-trigger windows</li><li>Percent of valid episodes with a <b>screening, surveillance, or diagnostic colonoscopy within 1 year prior</b> to the triggering colonoscopy</li><li>Percent of valid episodes with a <b>screening, surveillance, or diagnostic colonoscopy within 60 days after</b> the triggering colonoscopy</li></ul>

# Outpatient and non-acute Cholecystectomy episode definition

Area	Episode definition
<b>1</b> Identifying episode triggers	<ul style="list-style-type: none"> <li>A professional and a facility claim for cholecystectomy trigger the episode</li> </ul>
<b>2</b> Attributing episodes to quarterbacks	<ul style="list-style-type: none"> <li>The <b>physician or physician group</b> who performs the cholecystectomy is the Quarterback</li> </ul>
<b>3</b> Identifying services to include in episode spend	<ul style="list-style-type: none"> <li>All services during the procedure and relevant radiology, labs, pathology, office visits, and medications before and after the procedure as well as care related to complications are included</li> <li>The episode begins <b>90 days prior to procedure (or admission if inpatient) and ends 30 days after procedure</b> (or discharge if inpatient)</li> </ul>
<b>4</b> Risk-adjusting and excluding episodes	<ul style="list-style-type: none"> <li>Episodes affected by <b>factors that make them inherently more costly than others are risk adjusted.</b></li> <li>Episodes which are <b>not comparable</b> or affected by factors that make them inherently more costly but that <b>cannot be risk-adjusted for are excluded.</b> There are three types of exclusions:             <ul style="list-style-type: none"> <li>Business exclusions: Available information is not comparable or is incomplete (e.g., third party liability, non-continuous eligibility, left against medical advice, age less than 18 years and age greater than 64)</li> <li>Clinical exclusions: Chronic pancreatitis, Acute pancreatitis, cancer under active management, cirrhosis, cholangitis, cystic fibrosis, end stage renal disease, laparotomy, multiple sclerosis, organ transplant, pregnancy</li> <li>High cost outlier exclusions: Episode's risk adjusted spend is three standard deviations above the mean</li> </ul> </li> </ul>
<b>5</b> Determining quality metrics performance	<p><b>Tied to gain sharing:</b></p> <ul style="list-style-type: none"> <li>Percent of valid episodes with an <b>included inpatient admission</b> in the post-trigger window</li> </ul> <p><b>Not tied to gain sharing:</b></p> <ul style="list-style-type: none"> <li>Percent of valid episodes with an <b>intraoperative cholangiography</b> during the trigger window</li> <li>Percent of valid episodes with <b>ERCP within 3 to 30 days after procedure</b></li> <li><b>Average duration</b> of the trigger window</li> </ul>

# EGD episode definition

Area	Episode definition
<b>1</b> Identifying episode triggers	<ul style="list-style-type: none"> <li>An EGD episode is triggered by a <b>professional claim</b> that has one of the <b>defined procedure codes for EGD</b></li> </ul>
<b>2</b> Attributing episodes to quarterbacks	<ul style="list-style-type: none"> <li>The quarterback is the <b>physician or physician group</b> that performed the EGD</li> </ul>
<b>3</b> Identifying services to include in episode spend	<ul style="list-style-type: none"> <li><b>All related care</b> – such as imaging and testing, follow-up visits and medications – is included in the <b>episode spend</b></li> <li>The episode <b>starts 7 days before the triggering EGD</b> and <b>ends 14 days after the procedure</b></li> </ul>
<b>4</b> Risk adjusting and excluding episodes	<ul style="list-style-type: none"> <li>Episodes affected by <b>factors that make them inherently more costly than others are risk adjusted.</b></li> <li>Episodes which are <b>not comparable</b> or affected by factors that make them inherently more costly but that <b>cannot be risk-adjusted for are excluded.</b> There are three types of exclusions:             <ul style="list-style-type: none"> <li>Clinical: Cancer under active management, coma, cystic fibrosis, end stage renal disease, endoscopic ultrasound, gastrointestinal hemorrhage, multiple sclerosis, organ transplant, Parkinson's</li> <li>Business/Patient: Inconsistent enrollment, TPL, dual eligibility, FQHC/RHC trigger, no PAP ID, incomplete episode, Age &lt;1 or &gt;64, death in hospital, LAMA, high cost outlier</li> </ul> </li> </ul>
<b>5</b> Determining quality metrics performance	<p><b>Tied to gain sharing:</b></p> <ul style="list-style-type: none"> <li>None</li> </ul> <p><b>Not tied to gain sharing:</b></p> <ul style="list-style-type: none"> <li>Participation in a QCDR: Percent of valid episodes performed in a facility <b>participating in a Qualified Clinical Data Registry</b> (e.g., GIQuIC)</li> <li>Emergency department visit within the post-trigger window: Percent of valid episodes with a <b>relevant ED visit</b> within the post-trigger window.</li> <li>Admission within the post-trigger window: Percent of valid episodes with a <b>relevant admission or relevant observation</b> care within the post-trigger window.</li> <li>Perforation within upper gastrointestinal tract: Percent of valid episodes with a <b>perforation</b> within the upper gastrointestinal tract within the trigger or post-trigger window.</li> <li>Biopsy specimens in cases of gastrointestinal ulcers or suspected Barrett's esophagus: Percent of valid episodes with a <b>biopsy specimen</b> in cases of gastrointestinal ulcers or suspected Barrett's esophagus within the trigger window.</li> </ul>

1 EGD episodes can be triggered in any care setting, but are excluded if emergent. Emergent episodes are those that include a primary diagnosis code of GIH, or those that are triggered in inpatient, ED, or observation settings

# Gastrointestinal hemorrhage episode definition

Area	Episode definition
<b>1</b> Identifying episode triggers	<ul style="list-style-type: none"> <li>▪ A gastrointestinal hemorrhage (GIH) episode is triggered by an <b>inpatient admission or ED/Observation outpatient claim</b> where either             <ul style="list-style-type: none"> <li>— The primary diagnosis is one of the <b>defined GIH trigger codes</b>, or</li> <li>— The primary diagnosis is one of the <b>defined GIH symptom codes</b>, with a <b>secondary diagnosis code from the GIH trigger codes</b></li> </ul> </li> </ul>
<b>2</b> Attributing episodes to quarters	<ul style="list-style-type: none"> <li>▪ The quarterback is the <b>facility</b> that treated the GIH</li> </ul>
<b>3</b> Identifying services to include in episode spend	<ul style="list-style-type: none"> <li>▪ <b>All related care</b> – such as imaging and testing, follow-up visits and medications – is included in the <b>episode spend</b></li> <li>▪ The episode <b>starts the day of the triggering GIH</b> and <b>ends 30 days after discharge</b></li> </ul>
<b>4</b> Risk adjusting and excluding episodes	<ul style="list-style-type: none"> <li>▪ Episodes affected by <b>factors that make them inherently more costly than others are risk adjusted</b>.</li> <li>▪ Episodes which are <b>not comparable</b> or affected by factors that make them inherently more costly but that <b>cannot be risk-adjusted for are excluded</b>. There are three types of exclusions:             <ul style="list-style-type: none"> <li>— Clinical: Cancer under active management, coma, cystic fibrosis, end stage renal disease, multiple sclerosis, organ transplant, and Parkinson's</li> <li>— Business/Patient: Inconsistent enrollment, TPL, dual eligibility, FQHC/RHC trigger, no PAP ID, incomplete episode, Age &lt;1 or &gt;64, death in hospital, LAMA, high cost outlier</li> </ul> </li> </ul>
<b>5</b> Determining quality metrics performance	<p><b>Tied to gain sharing:</b></p> <ul style="list-style-type: none"> <li>▪ Percent of valid episodes where the patient receives <b>relevant follow-up care</b> within the post-trigger window</li> </ul> <p><b>Not tied to gain sharing:</b></p> <ul style="list-style-type: none"> <li>▪ Percent of valid episodes where the patient receives <b>relevant follow-up care within the first seven days</b> of the post-trigger window.</li> <li>▪ Percent of valid episodes with a relevant <b>ED visit</b> within the post-trigger window.</li> <li>▪ Percent of valid episodes with a <b>relevant admission or relevant observation care</b> within the post-trigger window.</li> <li>▪ Percent of valid episodes with the first visit being a <b>relevant follow-up visit</b> within the post-trigger window, for valid episodes that had any post-trigger window visits.</li> <li>▪ Percent of valid episodes with <b>pseudomembranous colitis</b> occurring within the post-trigger window.</li> <li>▪ Percent of total episodes with <b>patient mortality</b> within the episode window.</li> </ul>

# Examples of Changes made based on previous Episode Design Feedback Sessions

## 1 ▪ All Episode Feedback

- *Aligning readmission logic with future waves of episodes.*

In 2015, all wave one episodes of care included readmissions based on an exclusionary logic. Following the Feedback Session, readmissions were based on an inclusionary logic, meaning that only specifically related admissions are now included.

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## 2 ▪ Episode: Outpatient and Non-Acute Inpatient Cholecystectomy

- *Exclude episodes with chronic pancreatitis in the trigger window.*

To ensure a comparable patient population and to reflect the original intent of the episode definition as much as possible, patients with chronic pancreatitis during the trigger window will now also be excluded from the cholecystectomy episode

# Gastrointestinal Episode feedback received to date

Area	Feedback
<b>Identifying episode triggers</b>	<ul style="list-style-type: none"> <li>▪ None</li> </ul>
<b>Attributing episodes to quarterbacks</b>	<ul style="list-style-type: none"> <li>▪ None</li> </ul>
<b>Identifying services to include in episode spend</b>	<ul style="list-style-type: none"> <li>▪ Ensure that all inpatient claims are removed from the Colonoscopy episode.</li> <li>▪ Remove unrelated complications and codes from the Colonoscopy episode design.</li> </ul>
<b>Risk adjusting and excluding episodes</b>	<ul style="list-style-type: none"> <li>▪ Review the relationship between the EGD and Colonoscopy episode and possibly exclude one from spend if occurring simultaneously.</li> <li>▪ Exclude appendicitis and/or appendectomy from Cholecystectomy episode.</li> <li>▪ Exclude sexually transmitted diseases from the Cholecystectomy episode.</li> </ul>
<b>Determining quality metrics performance</b>	<ul style="list-style-type: none"> <li>▪ Revise the “percent of colonoscopies 1 year prior to triggering event” quality metric in the Colonoscopy episode to be two separate quality metrics: 1) “prior screening” and 2) “prior diagnostic”.</li> <li>▪ Include CPT code 99024 in follow-up quality metric to account for post-surgical follow-up with provider.</li> </ul>

# Topics for Discussion

## Design Dimensions

1

Identifying episode triggers

2

Attributing episodes to  
quarterbacks

3

Identifying services to include in  
episode spend

4

Risk adjusting and excluding  
episodes

5

Determining quality metrics  
performance

## General Episode Feedback

# Next steps following this feedback session

- **Review** all feedback received both prior and during the feedback session
- **Analyze** the potential changes and possible impact on episode design
- **Release** memo summarizing changes to episode design in the late-summer
- **Incorporate** changes that need to be made for the 2018 performance period

Thank you for participating!

Please contact [payment.reform@tn.gov](mailto:payment.reform@tn.gov) with any questions or visit our website at: [www.tn.gov/hcfa/topic/episodes-of-care](http://www.tn.gov/hcfa/topic/episodes-of-care)