



Division of  
**Health Care  
Finance & Administration**

Health Care  
Innovation Initiative

WAVE 1 AND 2 FEEDBACK SESSIONS

July 19, 2016



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**Health Care  
Finance & Administration**

Health Care  
Innovation Initiative

WAVE 1 AND 2 FEEDBACK SESSIONS

Acute Asthma Exacerbation Episode and COPD Acute Exacerbation Episode  
July 19, 2016

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

## Approach

- Gather feedback from Stakeholders across the state on each of the episodes implemented in wave 1 and 2 of the Tennessee Health Care Innovation Initiative
- Conduct analysis to inform decision of how to incorporate feedback
- Incorporate selected changes into program for calendar year 2017

## Objectives for Today

1. Briefly review the background and objectives of the Tennessee Health Care Innovation Initiative
2. Discuss the current implemented asthma and COPD episodes and definitions
3. Review program-level feedback and asthma/COPD episode-specific feedback received prior to the meeting
4. Listen to and capture feedback on the asthma and COPD episodes across each of the primary design dimensions
5. 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



"It's my hope that we can provide quality health care for more Tennesseans while transforming the relationship among health care users, providers and payers. If Tennessee can do that, we all win."

– Governor Haslam's address to a joint session of the state Legislature, March 2013

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

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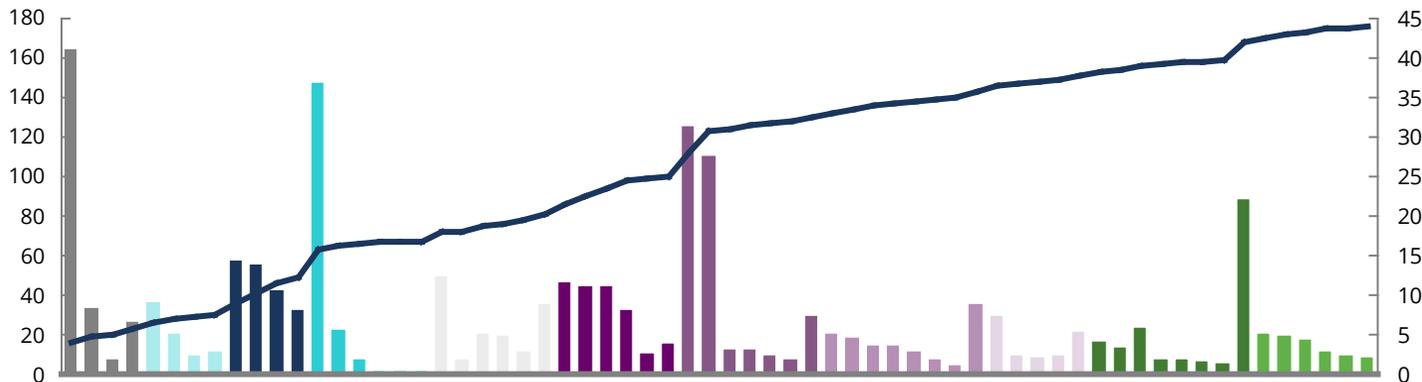
By working together, we can make significant progress toward **sustainable medical costs and improving care**

# Episodes of care program in Tennessee

Episodes of care: 75 in 5 years

Episode spend, \$M

Cumulative share of total spend, %



Wave

Design Year

1	2	3	4	5	6	7	8	9	10	11
2013	2014	2015	2015	2016	2016	2017	2017	2018	2018	2019

## Overview

- A review and planning process identified 75 episodes to develop over the coming 5 years
- Episodes were chosen and sequenced based on opportunities to improve patient health, improve quality of patient experiences, and to deliver care more efficiently
- Recently finished the design of the wave 5 episodes

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Source: TennCare and State Commercial Plans claims data, episode diagnostic model

# Status of the episodes of care program by wave

- In the performance period
- In the preview period

	First Preview Report Sent	Start of performance period (if currently in preview)
<b>Wave I</b> (perinatal, asthma, TJR)	<ul style="list-style-type: none"> <li>▪ Mid-2014</li> </ul>	<ul style="list-style-type: none"> <li>▪ Currently in second performance period</li> </ul>
<b>Wave II</b> (COPD, cholecystectomy, non-acute & acute PCI, colonoscopy)	<ul style="list-style-type: none"> <li>▪ Mid-2015</li> </ul>	<ul style="list-style-type: none"> <li>▪ Currently in first performance period</li> </ul>
<b>Wave III</b> (GIH, EGD, respiratory infection, pneumonia, inpatient & outpatient UTI)	<ul style="list-style-type: none"> <li>▪ Mid-2016</li> </ul>	<ul style="list-style-type: none"> <li>▪ First performance period begins in January 2017</li> </ul>
<b>Wave IV</b> (ADHD, CHF, ODD, CABG, valve repair & replacement, bariatric surgery)	<ul style="list-style-type: none"> <li>▪ Mid-2016</li> </ul>	<ul style="list-style-type: none"> <li>▪ First performance period begins in January 2017</li> </ul>

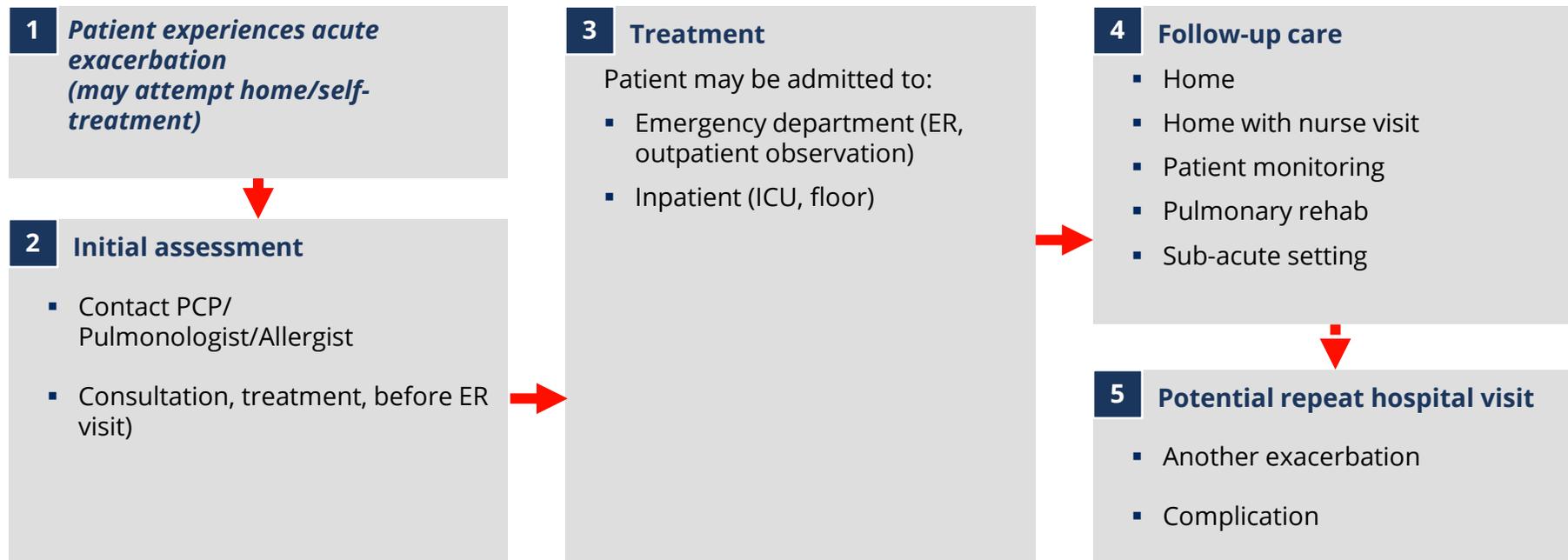


# Agenda and contents

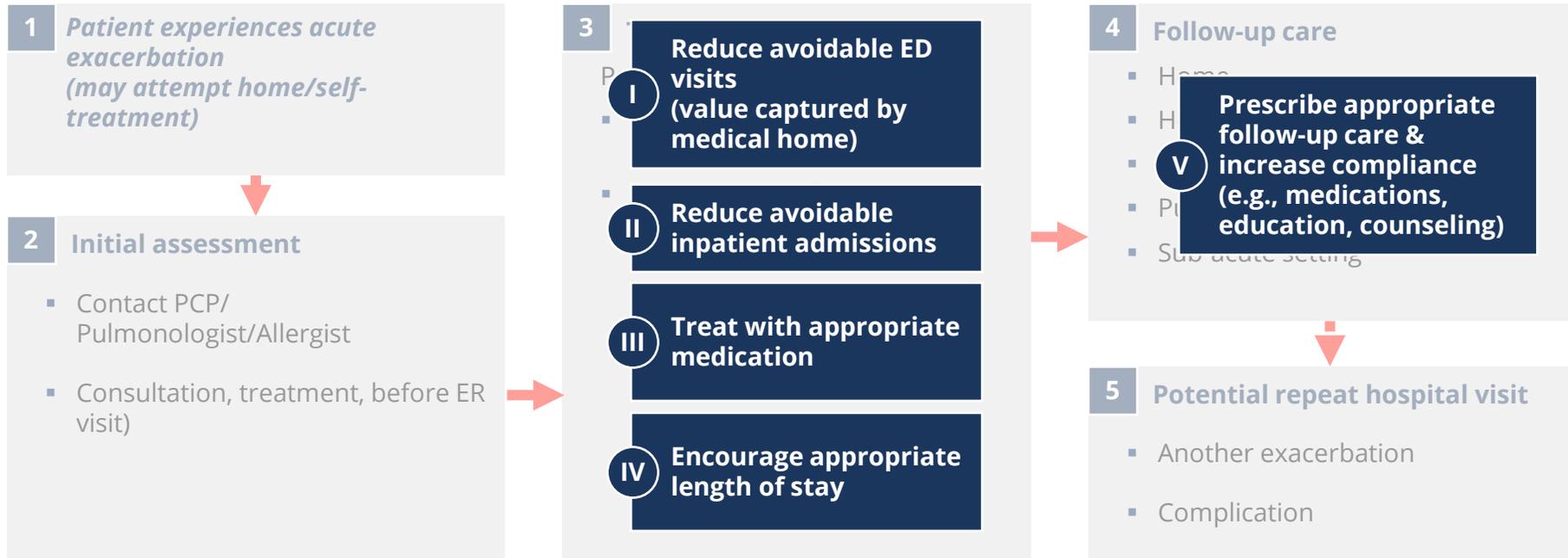
## Agenda

<u>Time</u>	<u>Activity</u>
8:00-8:30 AM	<b>A</b> Overview of the asthma and COPD episodes
8:30-8:40 AM	<b>B</b> Changes based on last year's feedback session
8:40-8:50 AM	<b>C</b> Feedback received to date
8:50-9:10 AM	<b>D</b> Today's feedback

# A Asthma and COPD patient journey



# A Asthma and COPD sources of value



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# A Asthma episode definition

Area	Episode definition
<p><b>1</b> Identifying episode triggers</p>	<ul style="list-style-type: none"> <li>An <b>emergency department, observation room, or inpatient visit for an acute exacerbation of asthma, bronchospasm, or wheezing</b><sup>1</sup></li> </ul>
<p><b>2</b> Attributing episodes to quarterbacks</p>	<ul style="list-style-type: none"> <li>The PAP is the <b>facility</b> of the trigger claim</li> </ul>
<p><b>3</b> Identifying services to include in episode spend</p>	<ul style="list-style-type: none"> <li>Episode <b>begins with the acute exacerbation</b> and <b>ends 30 days after discharge</b></li> <li><b>During the trigger event:</b> All medical and prescription drug claims included</li> <li><b>After discharge:</b> Claims for related services only (with a Primary Dx code related to asthma)                             <ul style="list-style-type: none"> <li>Readmissions: Related care 0-30 days after discharge including possible related complications</li> <li>Medications: Relevant medications</li> </ul> </li> </ul>
<p><b>4</b> Risk-adjusting and excluding episodes</p>	<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 65 or older)</li> <li>Clinical exclusions: Patient's care pathway is different for clinical reasons</li> <li>High cost outlier exclusions: Episode's risk adjusted spend is three standard deviations above the mean</li> </ul> </li> </ul>
<p><b>5</b> Determining quality metrics performance</p>	<p>Tied to gain sharing</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> <li>Percent of patients on <b>appropriate medications</b> determined by an administration of or filled prescription for <b>oral corticosteroids and/or injectable corticosteroids</b> within the post-trigger window</li> </ul> <p>Not tied to gain sharing</p> <ul style="list-style-type: none"> <li>Percent of valid episodes where the patient has a <b>repeat asthma acute exacerbation</b> within the post-trigger window</li> <li>Percent of valid episodes where the <b>acute exacerbation</b> during the trigger window is treated in an <b>inpatient setting</b></li> <li>Percent of valid episodes where <b>smoking cessation counseling</b> for the patient and/or family was offered</li> <li>Percent of valid episodes where <b>education on proper use of medication, trigger avoidance, or asthma action plan</b> was discussed</li> <li>Percent of valid episodes where the patient receives a <b>chest x-ray</b></li> </ul>

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<sup>1</sup> The ICD-9 code 786.07 (wheezing) is a potential trigger if the code is present in the primary diagnosis field of an emergency department, observation room, or inpatient facility and if at least one asthma or bronchospasm code is present in any diagnostic field of an inpatient, emergency department, outpatient, or professional claim within 365 days prior to the potential trigger event

# A COPD episode definition

Area	Episode definition
<b>1 Identifying episode triggers</b>	<ul style="list-style-type: none"> <li>▪ Facility visit (ER or inpatient) for <b>acute exacerbation of COPD</b>. Primary diagnosis or other diagnosis indicating condition related to COPD</li> <li>▪ No ambulatory surgical centers, no PCP, other settings. Episode should occur at a hospital or extended care facility.</li> </ul>
<b>2 Attributing episodes to quarterbacks</b>	<ul style="list-style-type: none"> <li>▪ The Quarterback is the <b>facility</b> of the trigger claim.</li> </ul>
<b>3 Identifying services to include in episode spend</b>	<ul style="list-style-type: none"> <li>▪ The episode does not have a pre-trigger window. The <b>trigger window begins on the first day of the final facility</b> during the first COPD acute exacerbation encounter of an episode and <b>ends day of discharge</b> from that admission. The <b>post-trigger window begins on discharge</b> from the final hospital in the initial trigger window and <b>continues to the later of the 30 days or the last day of discharge from any readmission</b> that starts within that 30 day post-trigger period</li> <li>▪ <b>Trigger window:</b> All claims included (starting from the final transfer facility during the trigger window). <ul style="list-style-type: none"> <li>– Trigger must be preceded by 30-day period clean of any claim or combination thereof that would trigger an COPD acute exacerbation episode</li> <li>– All medications included</li> </ul> </li> <li>▪ <b>Post-trigger window:</b> Claims for related services only (with a Primary Dx code related to COPD) <ul style="list-style-type: none"> <li>– Readmissions: All costs relating to related readmissions</li> <li>– Relevant medications included</li> </ul> </li> </ul>
<b>4 Risk-adjusting and excluding episodes</b>	<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 65 or older)</li> <li>– Clinical exclusions: Patient's care pathway is different for clinical reasons</li> <li>– High cost outlier exclusions: Episode's risk adjusted spend is three standard deviations above the mean</li> </ul> </li> </ul>
<b>5 Determining quality metrics performance</b>	<p>Tied to gain sharing</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, <p>Not tied to gain sharing</p> <ul style="list-style-type: none"> <li>▪ Percent of valid episodes where the patient has a <b>repeat COPD acute exacerbation</b> within the post-trigger window</li> <li>▪ Percent of valid episodes where the <b>acute exacerbation</b> during the trigger window is treated in an <b>inpatient setting</b></li> <li>▪ Percent of valid episodes where <b>smoking cessation counseling</b> for the patient and/or family was offered</li> </ul> </li></ul>

## B Changes made based on last year's feedback session: Asthma

- 1
  - **Updated the corticosteroid quality measure to include Decadron from hospital claims in the list of codes for the quality metric and broadened the window for scripts to 90 days from 30 days to allow for 90 day refills**
    - The intent of the corticoid steroid quality metric could better be captured by focusing on the patient population that requires systemic corticosteroids for asthma acute exacerbations. Therefore, all inhaled corticosteroids were removed from the numerator, leaving only oral and injectable systemic corticosteroids within 30 days of the end of the trigger window as contributing to acceptable performance

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- 2
  - **Removed code 493.00 from the list of trigger codes**
    - Code 493.00 (Extrinsic asthma unspecified) should not normally be placed in the primary position. In the few cases where the code is used in the primary diagnosis field, the treatment pathway is similar to an asthma acute exacerbation. To ensure that the episodes included do indeed clinically represent an asthma acute exacerbation, the state changed the episode logic so that episodes with 493.00 are only triggered in the event that a confirming asthma acute exacerbation-related diagnosis code appears within one year prior to the episode. This approach is the same as the TAG-recommended trigger logic used for wheezing.

# C Program feedback received to date

## Area

## Feedback received

### General program design and integrity

- The way the new system is designed, it is far too complex. Keep it simple. Physicians submit a bill, TennCare pays it.
- Redefine episodes as journeys, including episodes that were prevented, using counterfactual analysis. Update risk assessment at each point where the provider can change the trajectory of the journey.
- Extend episodes technology into information production for Patient Centered Medical Home journey
- Provide more information on sources of value in order to help providers improve care, e.g.:
  - Specify how efficiency is determined and group spend by the specific sources of value
  - Find ways to compare performance of quarterbacks and PCMH
  - Find ways to compare journeys among patients that had the episode to patients that were not in the episode

## C Episode feedback received to date

Area	Feedback received
<b>General design</b>	<ul style="list-style-type: none"> <li>Provide ICD-10 codes</li> </ul>
<b>Provider reports</b>	<ul style="list-style-type: none"> <li>Ensure that facilities receive reports in a timely manner and in a more user friendly format (e.g., excel)</li> </ul>
<b>Determining quality metrics performance</b>	<ul style="list-style-type: none"> <li>Follow up care – ensure ability to sort by those who did not receive in order to better target improvement strategies</li> <li>Appropriate medications – ensure that corticosteroids given while in the hospital setting (ED, Obs, and/or inpatient) are counted; expand definition to include corticosteroids given or filled during trigger window, not only during post-trigger window (ex: patient seen in ED, given decadron and discharged same day)</li> <li>Patient education – communicate when to expect metric will be tied to gain sharing; consider methods to obtain the data beyond coding</li> <li>Best practice is moving from 3-5 day courses of steroids towards a one-time ED dose of dexamethasone (with potentially a second dose, patient dependent):             <ul style="list-style-type: none"> <li>Quarterback should receive credit for the single dose of decadron administered to patient</li> <li>Prior authorization is required before filling the commercially available form of liquid decadron - this barrier should be lifted</li> </ul> </li> </ul>

## **D** Today's feedback

Area	Feedback
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Identifying episode triggers	▪ ...
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Attributing episodes to quarterbacks	▪ ...
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Identifying services to include in episode spend	▪ ...
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Risk adjusting and excluding episodes	▪ ...
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Determining quality metrics performance	▪ ...
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## 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 fall
- **Incorporate** changes that need to be made for the 2017 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)



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WAVE 1 AND 2 FEEDBACK SESSIONS

Total Joint Replacement (TJR) Episode  
July 19, 2016

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

## Approach

- Gather feedback from Stakeholders across the state on each of the episodes implemented in wave 1 and 2 of the Tennessee Health Care Innovation Initiative
- Conduct analysis to inform decision of how to incorporate feedback
- Incorporate selected changes into program for calendar year 2017

## Objectives for Today

1. Briefly review the background and objectives of the Tennessee Health Care Innovation Initiative
2. Discuss the current implemented TJR episode and definition
3. Review program-level feedback and TJR episode-specific feedback received prior to the meeting
4. Listen to and capture feedback on the TJR episode across each of the primary design dimensions
5. 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



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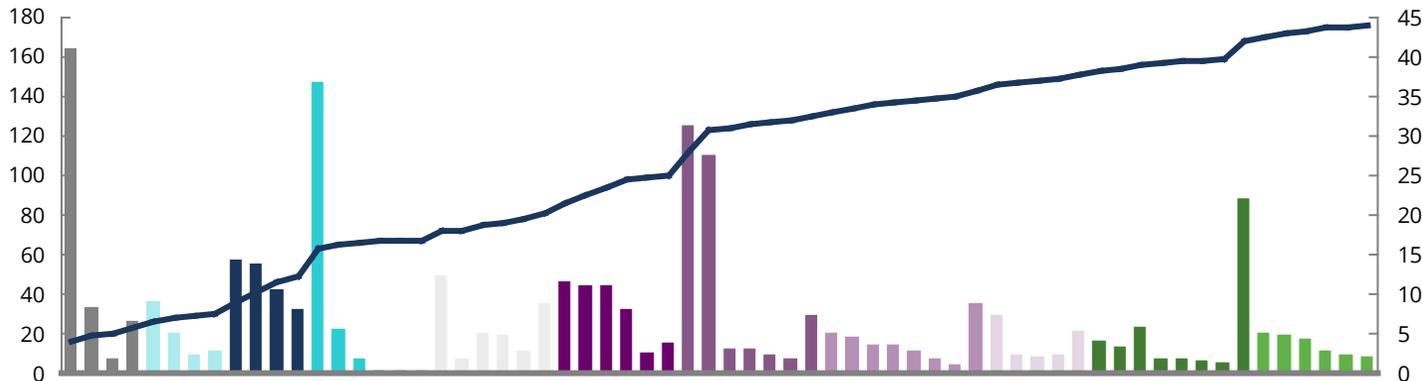
By working together, we can make significant progress toward **sustainable medical costs and improving care**

# Episodes of care program in Tennessee

Episodes of care: 75 in 5 years

Episode spend, \$M

Cumulative share of total spend, %



Wave

Design Year

1	2	3	4	5	6	7	8	9	10	11
2013	2014	2015	2015	2016	2016	2017	2017	2018	2018	2019

## Overview

- A review and planning process identified 75 episodes to develop over the coming 5 years
- Episodes were chosen and sequenced based on opportunities to improve patient health, improve quality of patient experiences, and to deliver care more efficiently
- Recently finished the design of the wave 5 episodes

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Source: TennCare and State Commercial Plans claims data, episode diagnostic model

# Status of the episodes of care program by wave

- In the performance period
- In the preview period

	First Preview Report Sent	Start of performance period (if currently in preview)
<b>Wave I</b> (perinatal, asthma, TJR)	<ul style="list-style-type: none"> <li>▪ Mid-2014</li> </ul>	<ul style="list-style-type: none"> <li>▪ Currently in second performance period</li> </ul>
<b>Wave II</b> (COPD, cholecystectomy, non-acute & acute PCI, colonoscopy)	<ul style="list-style-type: none"> <li>▪ Mid-2015</li> </ul>	<ul style="list-style-type: none"> <li>▪ Currently in first performance period</li> </ul>
<b>Wave III</b> (GIH, EGD, respiratory infection, pneumonia, inpatient & outpatient UTI)	<ul style="list-style-type: none"> <li>▪ Mid-2016</li> </ul>	<ul style="list-style-type: none"> <li>▪ First performance period begins in January 2017</li> </ul>
<b>Wave IV</b> (ADHD, CHF, ODD, CABG, valve repair & replacement, bariatric surgery)	<ul style="list-style-type: none"> <li>▪ Mid-2016</li> </ul>	<ul style="list-style-type: none"> <li>▪ First performance period begins in January 2017</li> </ul>

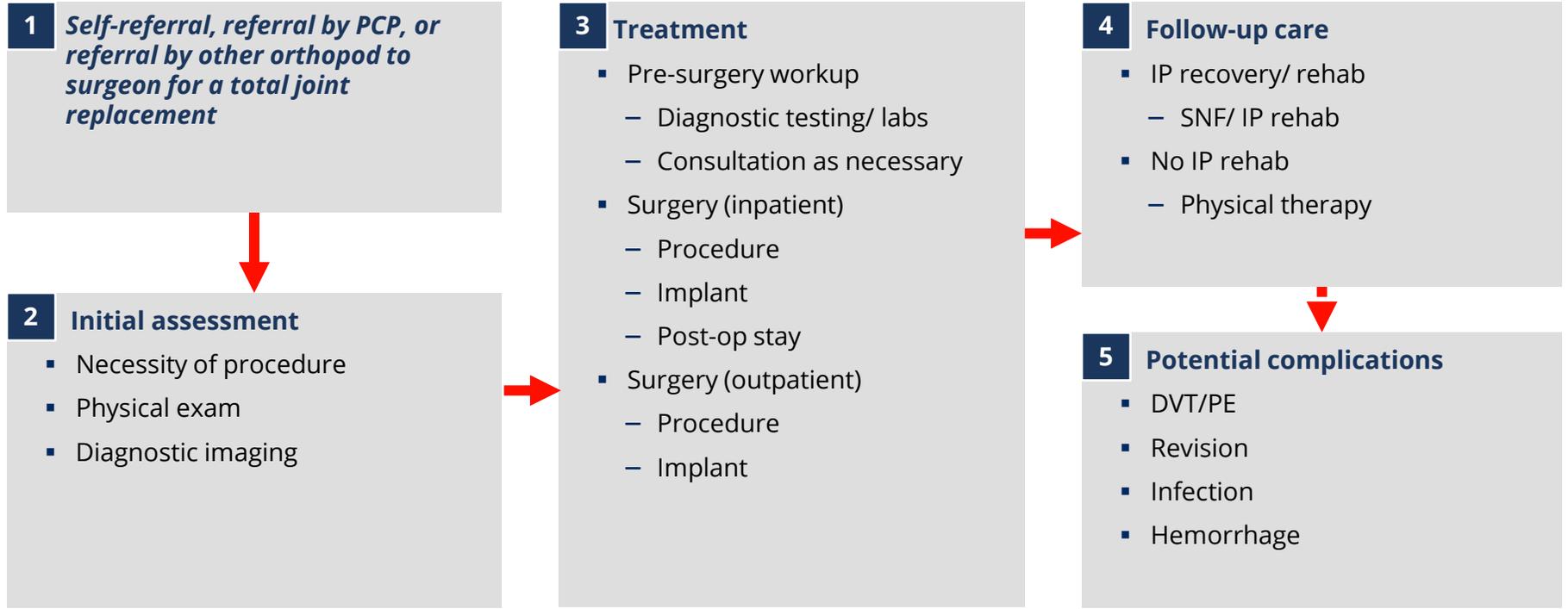


# Agenda and contents

## Agenda

Time	Activity
9:15-9:45 AM	<b>A</b> Overview of the TJR episode
9:45-9:55 AM	<b>B</b> Changes based on last year's feedback session
9:55-10:05 AM	<b>C</b> Feedback received to date
10:05-10:25 AM	<b>D</b> Today's feedback

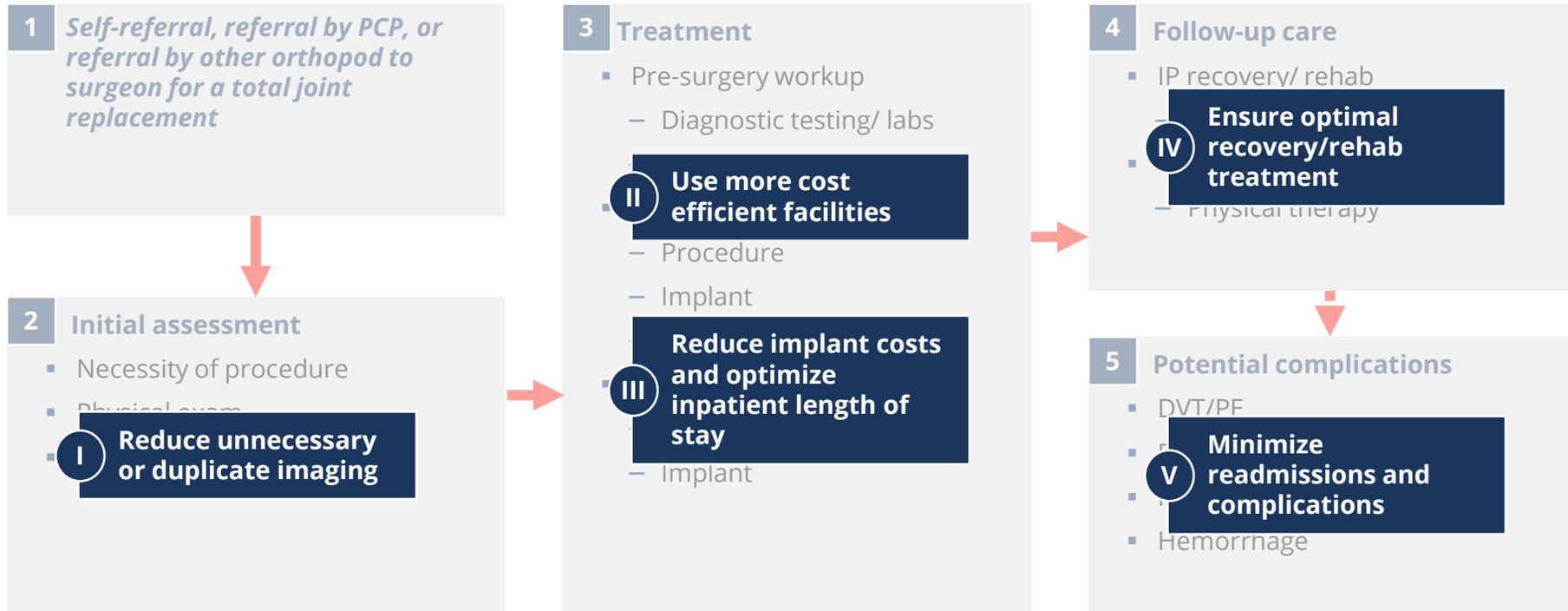
# A Total joint replacement patient journey



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# A Total joint replacement sources of value



# A Total joint replacement episode definition

Area	Episode definition
1 Identifying episode triggers	<ul style="list-style-type: none"> <li>A <b>surgical procedure for total hip replacement or total knee replacement</b> unless accompanied by a procedure modifier exclusion code</li> </ul>
2 Attributing episodes to quarterbacks	<ul style="list-style-type: none"> <li>For each episode, the Principal Accountable Provider (PAP), or quarterback, is the <b>orthopedic surgeon</b> (by Tax ID) performing the total joint replacement procedure</li> </ul>
3 Identifying services to include in episode spend	<ul style="list-style-type: none"> <li>Episode begins <b>45 days prior to date of admission</b> for the inpatient hospitalization for the total joint replacement surgery and <b>end 90 days after the date of discharge</b></li> <li><b>Prior to admission for surgery:</b> Related labs and claims filed by the Quarterback</li> <li><b>During surgery admission:</b> All claims included</li> <li><b>After discharge from surgery:</b> <ul style="list-style-type: none"> <li>Related claims only (radiology claims, claims filed by quarterback, all claims associated with a hip/knee ICD-9 diagnosis code)</li> <li>Readmissions: Readmissions 0-30 days after discharge for related care including care due to infections and complications, and follow-up evaluation &amp; management, therapy and labs/imaging/other outpatient procedures 31-90 after discharge</li> <li>Medications: Relevant medication including anticoagulants, analgesics, iron, stool softener, anti-nausea, NSAID, and antibiotics</li> </ul> </li> </ul>
4 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 65 or older)</li> <li>Clinical exclusions: Patient's care pathway is different for clinical reasons</li> <li>High cost outlier exclusions: Episode's risk adjusted spend is three standard deviations above the mean</li> </ul> </li> </ul>
5 Determining quality metrics performance	<p>Not tied to gain sharing</p> <ul style="list-style-type: none"> <li>30-day <b>all cause readmission rate</b> (after applying readmission exclusions)</li> <li>Percent of patients with <b>post-op Deep Venous Thrombosis (DVT)/Pulmonary Embolism (PE)</b> within 30 days post-surgery</li> <li>Percent of patients with <b>post-op wound infection rate</b> within the post-trigger window</li> <li>Percent of patients with <b>dislocations or fractures</b> within the post-trigger window</li> <li>Average <b>inpatient length of stay</b> based on Medicaid covered days for episodes</li> </ul>

## B Examples of changes made based on last year's feedback session

1

- **Episode: Asthma**
- **Updated the corticosteroid quality measure to include Decadron from hospital claims in the list of codes for the quality metric and broadened the window for scripts to 90 days from 30 days to allow for 90 day refills**
  - The intent of the corticoid steroid quality metric could better be captured by focusing on the patient population that requires systemic corticosteroids for asthma acute exacerbations. Therefore, all inhaled corticosteroids were removed from the numerator, leaving only oral and injectable systemic corticosteroids within 30 days of the end of the trigger window as contributing to acceptable performance

2

- **Episode: Perinatal**
- **Updated group B strep metrics to account for patient history**
  - The state updated the metric definition to include specific diagnosis codes that specify a history of or active group B streptococcus into the list of acceptable codes to satisfy the quality metric.

3

- **Episode: Perinatal**
- **Removed transportation cost from the perinatal episode.**
  - The state agreed with the concern that structural barriers such as transportation can potentially limit access to care, both in the prenatal and postnatal periods.

# C Program feedback received to date

## Area

## Feedback received

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### General program design and integrity

- The way the new system is designed, it is far too complex. Keep it simple. Physicians submit a bill, TennCare pays it.
- Redefine episodes as journeys, including episodes that were prevented, using counterfactual analysis. Update risk assessment at each point where the provider can change the trajectory of the journey.
- Extend episodes technology into information production for Patient Centered Medical Home journey
- Provide more information on sources of value in order to help providers improve care, e.g.:
  - Specify how efficiency is determined and group spend by the specific sources of value
  - Find ways to compare performance of quarterbacks and PCMH
  - Find ways to compare journeys among patients that had the episode to patients that were not in the episode

## Episode feedback received to date

### Area

### Feedback received

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#### Identifying services to include in episode spend

- Provide more transparency on drivers of episode cost per provider in order to help providers understand where cost-reduction improvements can be made. For instance, inpatient professional includes any and all professional services provided in an inpatient setting and inpatient facility includes all services provided in an inpatient facility – both hospital and SNF. Some payers are sending additional claims information but no costs are associated so it is impossible to make decisions related to most cost effective selections from this information.
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#### Risk adjusting and excluding episodes

- We continue to struggle with the variance of the way risk adjustment is applied by payer. This continues to vary significantly by payer making it difficult to manage a population of patients appropriate.

## **D** Today's feedback

Area	Feedback
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Identifying episode triggers	▪ ...
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Attributing episodes to quarterbacks	▪ ...
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Identifying services to include in episode spend	▪ ...
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Risk adjusting and excluding episodes	▪ ...
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Determining quality metrics performance	▪ ...
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## Next steps following this feedback session

- **Review** all feedback received both prior and during the feedback session
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WAVE 1 AND 2 FEEDBACK SESSIONS

Perinatal Episode  
July 19, 2016

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

## Approach

- Gather feedback from Stakeholders across the state on each of the episodes implemented in wave 1 and 2 of the Tennessee Health Care Innovation Initiative
- Conduct analysis to inform decision of how to incorporate feedback
- Incorporate selected changes into program for calendar year 2017

## Objectives for Today

1. Briefly review the background and objectives of the Tennessee Health Care Innovation Initiative
2. Discuss the current implemented perinatal episode and definition
3. Review program-level feedback and perinatal episode-specific feedback received prior to the meeting
4. Listen to and capture feedback on the perinatal episode across each of the primary design dimensions
5. Capture feedback on the program overall

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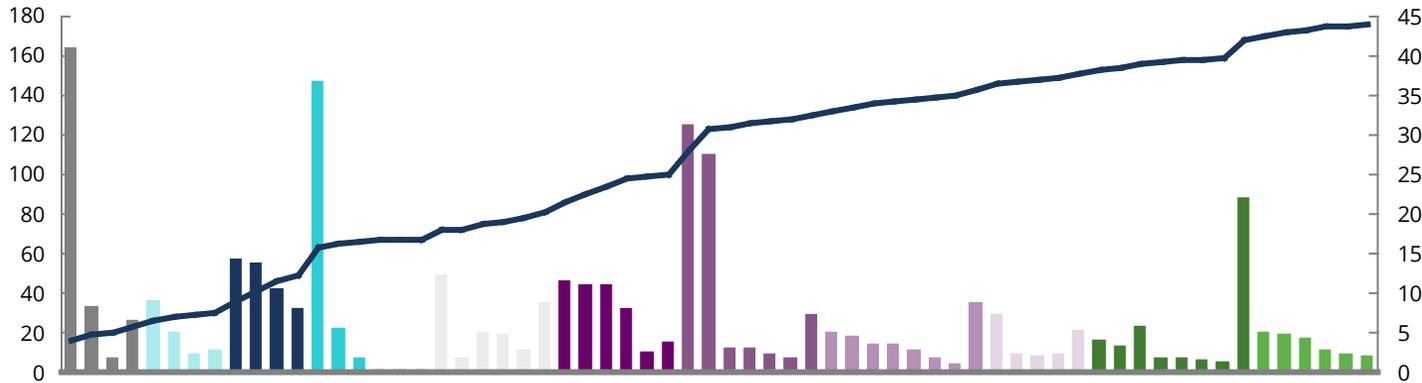
By working together, we can make significant progress toward **sustainable medical costs and improving care**

# Episodes of care program in Tennessee

Episodes of care: 75 in 5 years

Episode spend, \$M

Cumulative share of total spend, %



Wave	1	2	3	4	5	6	7	8	9	10	11
Design Year	2013	2014	2015		2016		2017		2018		2019

- Perinatal
- Asthma acute exac.
- Total joint replacement
- COPD acute exac.
- Colonoscopy
- Cholecystectomy
- PCI (multiple)
- GI hemorrhage
- EGD
- Respiratory Infection
- Pneumonia
- UTI (multiple)
- ADHD
- CHF acute exacerbation
- ODD
- CABG
- Valve repair and replacement
- Bariatric surgery
- Breast cancer (multiple)
- Breast biopsy
- Tonsillectomy
- Otitis
- Anxiety
- Non-emergent depression
- Outpatient skin and soft tissue infection
- Neonatal Part II
- Neonatal Part I
- HIV
- Pancreatitis
- Diabetes acute exacerbation
- Medical non-infectious orthopedic
- Schizophrenia
- Spinal fusion exc. cervical
- Lumbar laminectomy
- Hip/Pelvic fracture
- Knee arthroscopy
- Hemophilia & other coagulation disorders
- Anal procedures
- Colon cancer
- Coronary artery disease & angina
- Hernia procedures
- Cardiac arrhythmia
- Sickle cell
- Pacemaker/Defibrillator
- Depression - acute exacerbation
- Lung cancer
- Female reproductive cancer
- Other major bowel
- PTSD
- Fluid electrolyte imbalance
- Renal failure
- Liver & pancreatic cancer
- Hepatitis C
- GERD acute exacerbation
- Drug dependence
- GI obstruction
- Rheumatoid arthritis
- Bipolar (multiple)
- Conduct disorder
- Epileptic seizure
- Hypotension/Syncope
- Kidney & urinary tract stones
- Other respiratory infection
- Dermatitis/Urticaria

## Overview

- A review and planning process identified 75 episodes to develop over the coming 5 years
- Episodes were chosen and sequenced based on opportunities to improve patient health, improve quality of patient experiences, and to deliver care more efficiently
- Recently finished the design of the wave 5 episodes

Last Modified 7/15/2016 5:25 PM Eastern Standard Time

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Source: TennCare and State Commercial Plans claims data, episode diagnostic model

# Status of the episodes of care program by wave

- In the performance period
- In the preview period

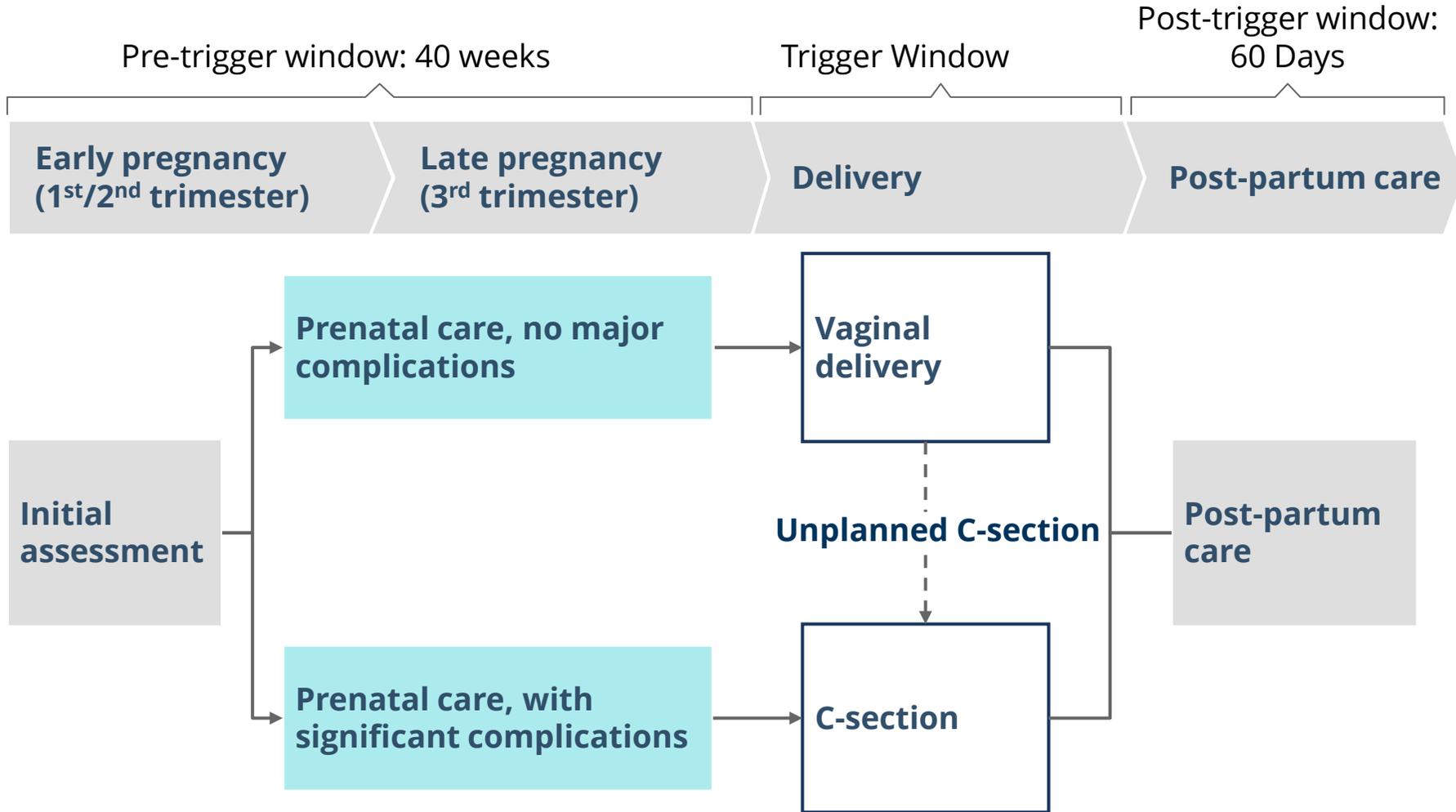
	First Preview Report Sent	Start of performance period (if currently in preview)
<b>Wave I</b> (perinatal, asthma, TJR)	<ul style="list-style-type: none"> <li>▪ Mid-2014</li> </ul>	<ul style="list-style-type: none"> <li>▪ Currently in second performance period</li> </ul>
<b>Wave II</b> (COPD, cholecystectomy, non-acute & acute PCI, colonoscopy)	<ul style="list-style-type: none"> <li>▪ Mid-2015</li> </ul>	<ul style="list-style-type: none"> <li>▪ Currently in first performance period</li> </ul>
<b>Wave III</b> (GIH, EGD, respiratory infection, pneumonia, inpatient & outpatient UTI)	<ul style="list-style-type: none"> <li>▪ Mid-2016</li> </ul>	<ul style="list-style-type: none"> <li>▪ First performance period begins in January 2017</li> </ul>
<b>Wave IV</b> (ADHD, CHF, ODD, CABG, valve repair & replacement, bariatric surgery)	<ul style="list-style-type: none"> <li>▪ Mid-2016</li> </ul>	<ul style="list-style-type: none"> <li>▪ First performance period begins in January 2017</li> </ul>

# Agenda and contents

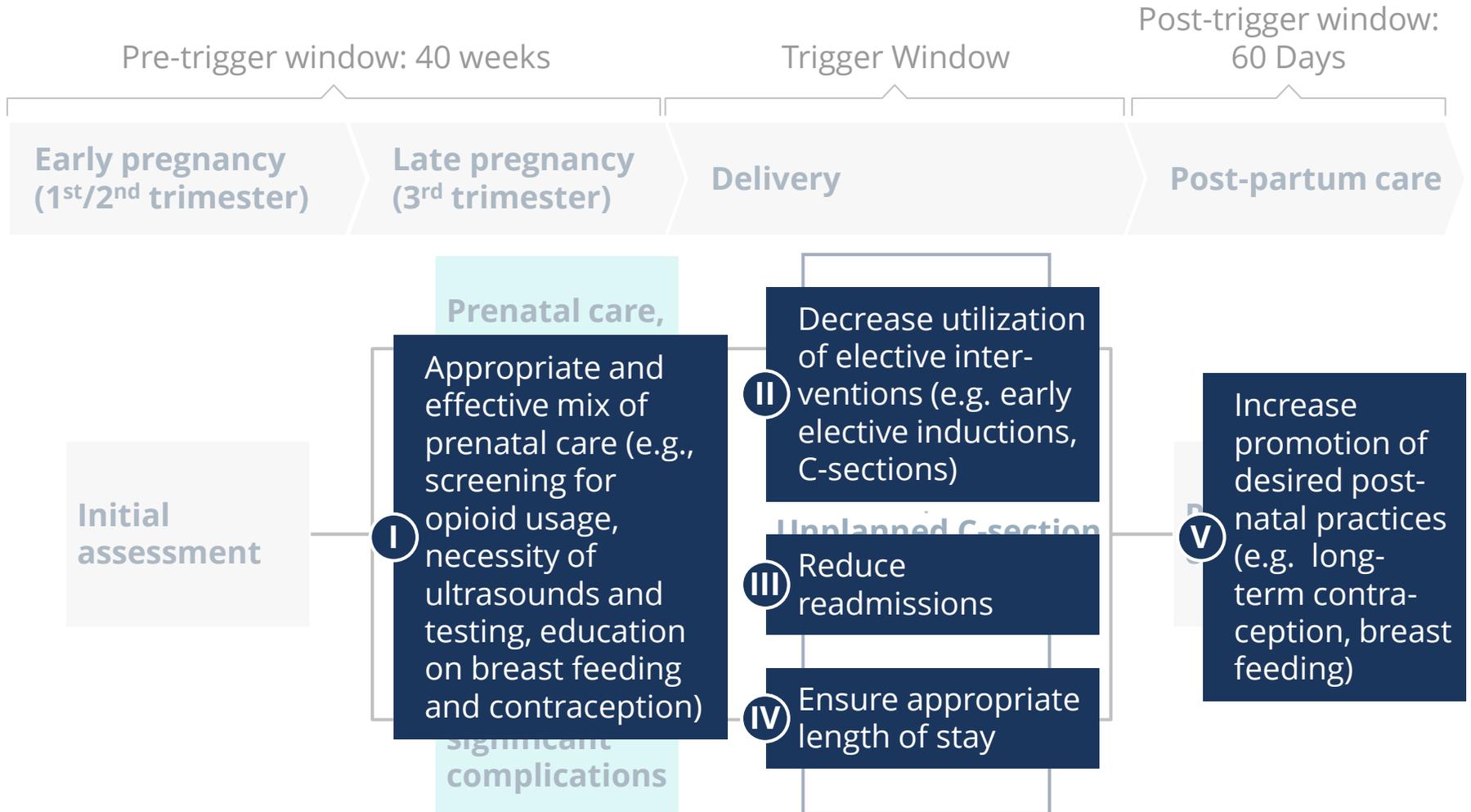
## Agenda

<u>Time</u>	<u>Activity</u>
10:30-11:00 AM	<b>A Overview of the perinatal episode</b>
11:00-11:10 AM	<b>B Changes based on last year's feedback session</b>
11:10-11:20 AM	<b>C Feedback received to date</b>
11:20-11:40 AM	<b>D Today's feedback</b>

# A Perinatal patient journey



# A Perinatal sources of value



# A Perinatal episode definition

Area	Episode definition
<b>1 Identifying episode triggers</b>	<ul style="list-style-type: none"> <li>▪ <b>Live birth diagnosis code or delivery procedure code</b> in any claim type and any care setting unless accompanied by a procedure modifier exclusion code</li> </ul>
<b>2 Attributing episodes to quarterbacks</b>	<ul style="list-style-type: none"> <li>▪ For each episode, the PAP, or quarterback, is the <b>provider or provider group</b> (by Tax ID) that performs the delivery</li> </ul>
<b>3 Identifying services to include in episode spend</b>	<ul style="list-style-type: none"> <li>▪ Episode begins <b>40 weeks prior to day of admission for delivery</b> and <b>ends 60 days after discharge</b></li> <li>▪ <b>Prior to admission for delivery:</b> All care associated with a pregnancy-related ICD-9 diagnosis code is included (unless explicitly excluded), including all ED claims. All medications claims for mother are included (unless explicitly excluded e.g., biologics)</li> <li>▪ <b>During delivery admission:</b> All claims included</li> <li>▪ <b>After discharge:</b> <ul style="list-style-type: none"> <li>– Readmissions: Related care from 0-30 days after discharge and relevant claims 31-60 days after discharge.</li> <li>– All ED claims during 0-30 days after discharge and relevant ED claims 31-60 days after discharge not previously excluded based on readmission exclusions outlined above.</li> <li>– All other care associated with a pregnancy-related ICD-9 diagnosis code is included (unless explicitly excluded).</li> <li>– Medications: All claims for mother are included (unless explicitly excluded e.g., biologics)</li> </ul> </li> <li>▪ <b>All care related to neonatal care is not included</b></li> </ul>
<b>4 Risk-adjusting and excluding episodes</b>	<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 65 or older)</li> <li>– Clinical exclusions: Patient's care pathway is different for clinical reasons</li> <li>– High cost outlier exclusions: Episode's risk adjusted spend is three standard deviations above the mean</li> </ul> </li> </ul>
<b>5 Determining quality metrics performance</b>	<p>Tied to gain sharing</p> <ul style="list-style-type: none"> <li>▪ Percent of valid episodes where the patient is <b>screened for HIV</b> within the episode window</li> <li>▪ Percent of valid episodes where the patient is <b>screened for Group B streptococcus</b> within the episode window</li> <li>▪ Percent of valid episodes where the patient undergoes a <b>C-Section</b> within the trigger window</li> </ul> <p>Not tied to gain sharing</p> <ul style="list-style-type: none"> <li>▪ Percent of valid episodes where the patient is <b>screened for gestational diabetes</b> within the episode window</li> <li>▪ Percent of valid episodes where the patient is <b>screened for asymptomatic bacteriuria</b> during the episode window</li> <li>▪ Percent of valid episodes where the patient is <b>screened for Hepatitis B specific antigens</b> within the episode window</li> <li>▪ Percent of valid episodes where the patient is <b>given a Tdap vaccination</b> within the episode window</li> </ul>

## B Changes made based on last year's feedback sessions: Perinatal (1/3)

- 1 **Appropriately account for the increased cost of delivering multiple gestations**
  - As there may be differences in risk and care delivered across the different types of multi-fetal gestations, the state excluded episodes with three or more gestations.

---

- 2 **Removed IUDs and contraceptive implants from episode spend**
  - The perinatal episode definition was updated to remove all intrauterine devices and implantable contraceptives from episode spend.

---

- 3 **Included only related emergency department visits in the pre-trigger window.**
  - The perinatal episode definition was updated to require a confirming pregnancy-related diagnosis code for all emergency department visits to ensure that they are related to the episode. This means that ED visits prior to the start of pregnancy are not included in the episode spend.

---

- 4 **Updated the Tdap vaccination rate to include revenue codes 0636 and 0771, as well as exclude members who are eligible for Tennessee's Vaccines for Children (VFC) program**
  - The perinatal episode definition was updated to include revenue codes 0636 and 0770, but did not exclude members eligible for Tennessee Vaccines for Children (VFC) program as those member's vaccination status can be accurately captured.

## B Changes made based on last year's feedback sessions: Perinatal (2/3)

- 5 **Removed transportation cost from the perinatal episode.**
  - The state agreed with the concern that structural barriers such as transportation can potentially limit access to care, both in the prenatal and postnatal periods.

---

- 6 **Developed risk weights for prior pregnancy complications that affect the management of subsequent pregnancies**
  - The state will include diagnosis codes that account for a history of complications during pregnancy in the list of recommended risk factors for each payer to test.

---

- 7 **Excluded MFMs as potential quarterbacks for the episode**
  - The state is working on excluding MFMs as quarterbacks.

---

- 8 **Include newborn care costs in OB/GYN episodes**
  - The state is convening a neonatal episode TAG in the fall of 2016 and will at that time consider whether some of the neonatal costs can be included in the perinatal episode as well.

---

- 9 **Updated group B strep metrics to account for patient history**
  - The state updated the metric definition to include specific diagnosis codes that specify a history of or active group B streptococcus into the list of acceptable codes to satisfy the quality metric.

# C Program feedback received to date

## Area

## Feedback received

### General program design and integrity

- The way the new system is designed, it is far too complex. Keep it simple. Physicians submit a bill, TennCare pays it.
- Redefine episodes as journeys, including episodes that were prevented, using counterfactual analysis. Update risk assessment at each point where the provider can change the trajectory of the journey.
- Extend episodes technology into information production for Patient Centered Medical Home journey
- Provide more information on sources of value in order to help providers improve care, e.g.:
  - Specify how efficiency is determined and group spend by the specific sources of value
  - Find ways to compare performance of quarterbacks and PCMH
  - Find ways to compare journeys among patients that had the episode to patients that were not in the episode

# C Episode feedback received to date (1/2)

Area	Feedback received
<b>Provider reports</b>	<ul style="list-style-type: none"> <li>▪ Based on preliminary reports, what percentage of Obstetricians will receive gain sharing and what percent will receive risk sharing?</li> <li>▪ Based on preliminary reports, what percentage of Maternal Fetal Medicine specialists will receive risk sharing and what percent will receive gain sharing?</li> <li>▪ If the payment reform process was not in effect until 1/1/15, how can a patient who delivered in 2014 (be justified as included in the payment reform episode?</li> </ul>
<b>TAG meetings</b>	<ul style="list-style-type: none"> <li>▪ Will there be another Perinatal Tag Group meeting? If so, when will it be and will it be open to obstetricians and maternal fetal medicine specialists?</li> </ul>
<b>Identifying services to include in episode spend</b>	<ul style="list-style-type: none"> <li>▪ If the physician is concerned that choosing a cesarean or allowing his/her patient to choose a cesarean may impact the bottom line, the opportunity to intervene in a timely manner may have adverse consequences for the fetus and/or the mother.</li> </ul>
<b>Risk adjustment</b>	<ul style="list-style-type: none"> <li>▪ Some patients are averaged back down into the penalty zone once the risk adjustment process is made. We are concerned about this considering we only treat the sickest patients out there.</li> </ul>

## C Episode feedback received to date (2/2)

### Area

### Feedback received

#### Risk adjusting and excluding episodes

- There are several instances where multiple conditions with varying acuities are represented by the same diagnosis code. Therefore, when one of the diagnosis codes are reported, it is hard to determine for which condition the diagnosis was actually coded for. This makes it hard for MCOs to assign the correct risk adjustment factor weights based solely on the diagnosis code.

#### Determining quality metrics performance

- Is there an easy way to determine "During episode window" time period? Please give me the gestational age time frame for each Quality Metrics.
- The quality metric around C-Section rates is currently calculated based on all C-Sections performed, which discourages providers from seeing patients that have had previous C-Sections, because these patients have a greater likelihood of having a C-Section again (many patients opt for a repeat C-Section when counseled about the relative risks of VBAC versus Repeat C-Sections). Therefore, patients with previous C-Sections should be excluded from this metric.
- The quality metric around measuring Group B strep screening currently only measures any screening that happened between weeks 35-37, but Group B Strep screening can either be given during weeks 35-37 of gestation, or prior to 35 weeks. The quality metric should either:
  - Be updated for the Category II Code to capture patients that receive Group B Strep screening prior to 35 weeks OR
  - Be updated to exclude inclusion of patients who end their pregnancies prior to 35 weeks

## **D** Today's feedback

### Area Feedback

**Identifying episode triggers**

- ...

**Attributing episodes to quarterbacks**

- ...

**Identifying services to include in episode spend**

- ...

**Risk adjusting and excluding episodes**

- ...

**Determining quality metrics performance**

- ...

## 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 fall
- **Incorporate** changes that need to be made for the 2017 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)



Division of  
**Health Care  
Finance & Administration**

Health Care  
Innovation Initiative

WAVE 1 AND 2 FEEDBACK SESSIONS

Outpatient and Non-Acute Inpatient Cholecystectomy Episode  
July 19, 2016

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

## Approach

- Gather feedback from Stakeholders across the state on each of the episodes implemented in wave 1 and 2 of the Tennessee Health Care Innovation Initiative
- Conduct analysis to inform decision of how to incorporate feedback
- Incorporate selected changes into program for calendar year 2017

## Objectives for Today

1. Briefly review the background and objectives of the Tennessee Health Care Innovation Initiative
2. Discuss the current implemented cholecystectomy episode and definition
3. Review program-level feedback and cholecystectomy episode-specific feedback received prior to the meeting
4. Listen to and capture feedback on the cholecystectomy episode across each of the primary design dimensions
5. 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



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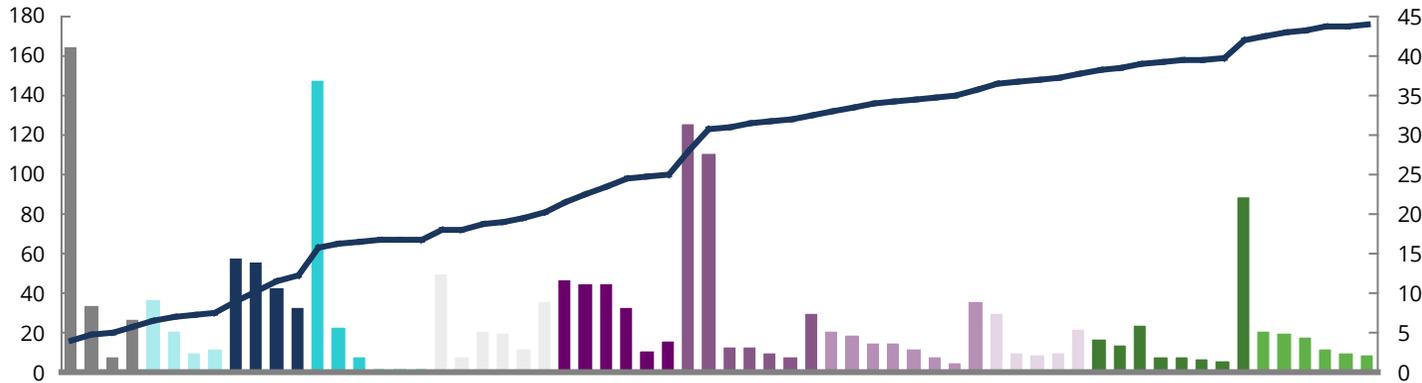
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Episodes of care: 75 in 5 years

Episode spend, \$M

Cumulative share of total spend, %



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Design Year	2013	2014	2015		2016		2017		2018		2019

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- Colonoscopy
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- PCI (multiple)
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- CABG
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- Rheumatoid arthritis
- Bipolar (multiple)
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- Epileptic seizure
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- Kidney & urinary tract stones
- Other respiratory infection
- Dermatitis/Urticaria

## Overview

- A review and planning process identified 75 episodes to develop over the coming 5 years
- Episodes were chosen and sequenced based on opportunities to improve patient health, improve quality of patient experiences, and to deliver care more efficiently
- Recently finished the design of the wave 5 episodes



Source: TennCare and State Commercial Plans claims data, episode diagnostic model

Last Modified 7/15/2016 5:25 PM Eastern Standard Time  
Printed 7/8/2016 12:02 PM Eastern Standard Time

# Status of the episodes of care program by wave

- In the performance period
- In the preview period

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<b>Wave I</b> (perinatal, asthma, TJR)	<ul style="list-style-type: none"> <li>▪ Mid-2014</li> </ul>	<ul style="list-style-type: none"> <li>▪ Currently in second performance period</li> </ul>
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# Agenda and contents

## Agenda

<u>Time</u>	<u>Activity</u>
12:15-12:45 PM	<b>A Overview of the cholecystectomy episode</b>
12:45-12:55 PM	<b>B Examples of changes based on last year's feedback session</b>
12:55-1:05 PM	<b>C Feedback received to date</b>
1:05-1:25 PM	<b>D Today's feedback</b>

# A Cholecystectomy patient journey

## 1 Patient has clinical indications that require a cholecystectomy

## 2 Initial assessment

- Initial assessment is done by either a primary care provider (PCP), general surgeon (non-acute presentation) or emergency department (ED) physician (acute presentation)
- Patient may receive diagnostic testing, labs, imaging and prophylactic antibiotics

## 3 Procedure

- Procedure ideally is performed as quickly as possible, e.g., within 24 to 48 hours
- Patient is prepared for procedure and given general anesthesia
- Procedure is performed by laparoscope or open surgery as an inpatient or outpatient (conversion may occur from laparoscope to open surgery)
- Gallstones may be removed
- Potential complications such as common bile duct injury may happen

## 4 Follow-up care

- Patient recovers same-day if laparoscopic, or inpatient for 2-3 days if open surgery
- Patient may be discharged home or to home health care
- Medications to alleviate pain may be prescribed

## 5 Potential complications

- Infection
- Abdominal injury
- Post-operative bile leak



# A Cholecystectomy episode definition

Area	Episode definition
<b>1 Identifying episode triggers</b>	<ul style="list-style-type: none"> <li>A professional and a facility claim for cholecystectomy trigger the episode</li> </ul>
<b>2 Attributing episodes to quarterbacks</b>	<ul style="list-style-type: none"> <li>The physician who performs the cholecystectomy is the Quarterback</li> </ul>
<b>3 Identifying services to include in episode spend</b>	<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 30 days prior to procedure (or admission if inpatient) and ends 90 days after procedure (or discharge if inpatient)</li> </ul>
<b>4 Risk-adjusting and excluding episodes</b>	<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 65 or older)</li> <li>Clinical exclusions: Patient's care pathway is different for clinical reasons</li> <li>High cost outlier exclusions: Episode's risk adjusted spend is three standard deviations above the mean</li> </ul> </li> </ul>
<b>5 Determining quality metrics performance</b>	<p>Tied to gain sharing</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>Not tied to gain sharing</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>

## B Examples of changes made based on last year's feedback session

1

- **Episode: Asthma**
- **Updated the corticosteroid quality measure to include Decadron from hospital claims in the list of codes for the quality metric and broadened the window for scripts to 90 days from 30 days to allow for 90 day refills**
  - The intent of the corticoid steroid quality metric could better be captured by focusing on the patient population that requires systemic corticosteroids for asthma acute exacerbations. Therefore, all inhaled corticosteroids were removed from the numerator, leaving only oral and injectable systemic corticosteroids within 30 days of the end of the trigger window as contributing to acceptable performance

2

- **Episode: Perinatal**
- **Updated group B strep metrics to account for patient history**
  - The state updated the metric definition to include specific diagnosis codes that specify a history of or active group B streptococcus into the list of acceptable codes to satisfy the quality metric.

3

- **Episode: Perinatal**
- **Removed transportation cost from the perinatal episode.**
  - The state agreed with the concern that structural barriers such as transportation can potentially limit access to care, both in the prenatal and postnatal periods.

# C Program feedback received to date

## Area

## Feedback received

### General program design and integrity

- The way the new system is designed, it is far too complex. Keep it simple. Physicians submit a bill, TennCare pays it.
- Redefine episodes as journeys, including episodes that were prevented, using counterfactual analysis. Update risk assessment at each point where the provider can change the trajectory of the journey.
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  - Find ways to compare journeys among patients that had the episode to patients that were not in the episode

# C Episode feedback received to date

## Area

## Feedback received

---

### Identifying services to include in episode spend

- Address the concern regarding potential challenges that providers have in:
  - Influencing cost of care for patients before a patient's first visit with the provider
  - Influencing care outside of the provider's hands-on care of the patient, especially when the care is geographically remote from the provider

# Today's feedback

## Area Feedback

**Identifying episode triggers**

- ...

**Attributing episodes to quarterbacks**

- ...

**Identifying services to include in episode spend**

- ...

**Risk adjusting and excluding episodes**

- ...

**Determining quality metrics performance**

- ...

## Next steps following this feedback session

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Division of  
**Health Care  
Finance & Administration**

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Innovation Initiative

WAVE 1 AND 2 FEEDBACK SESSIONS

Acute and Non-Acute Percutaneous Coronary Intervention (PCI) Episodes  
July 19, 2016

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

## Approach

- Gather feedback from Stakeholders across the state on each of the episodes implemented in wave 1 and 2 of the Tennessee Health Care Innovation Initiative
- Conduct analysis to inform decision of how to incorporate feedback
- Incorporate selected changes into program for calendar year 2017

## Objectives for Today

1. Briefly review the background and objectives of the Tennessee Health Care Innovation Initiative
2. Discuss the current implemented acute and non-acute PCI episodes and definitions
3. Review program-level feedback and acute/non-acute PCI episode-specific feedback received prior to the meeting
4. Listen to and capture feedback on the acute and non-acute PCI episodes across each of the primary design dimensions
5. Capture feedback on the program overall

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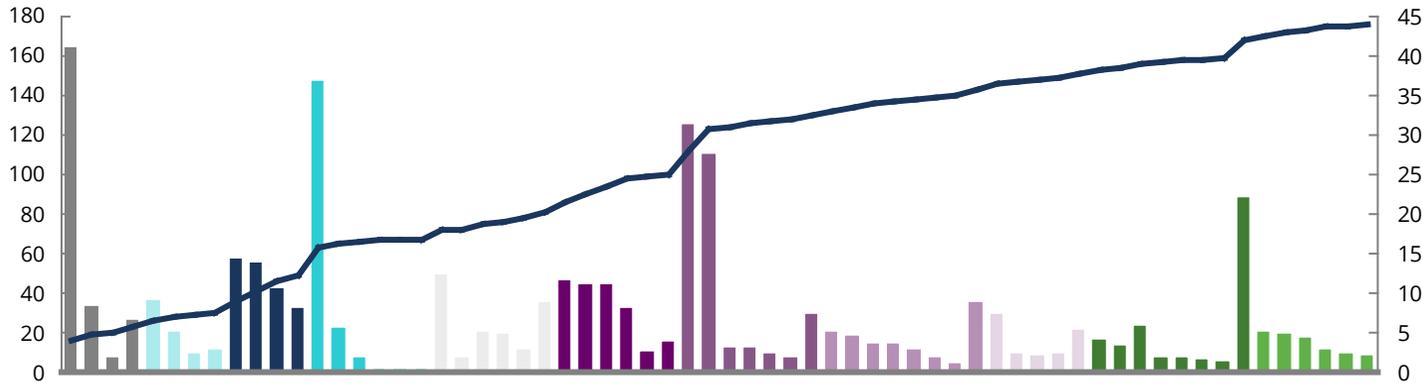
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- UTI (multiple)
- ADHD
- CHF acute exacerbation
- ODD
- CABG
- Valve repair and replacement
- Bariatric surgery
- Breast cancer (multiple)
- Breast biopsy
- Tonsillectomy
- Otitis
- Anxiety
- Non-emergent depression
- Outpatient skin and soft tissue infection
- Neonatal Part II
- Neonatal Part I
- HIV
- Pancreatitis
- Diabetes acute exacerbation
- Medical non-infectious orthopedic
- Schizophrenia
- Spinal fusion exc. cervical
- Lumbar laminectomy
- Hip/Pelvic fracture
- Knee arthroscopy
- Hemophilia & other coagulation disorders
- Anal procedures
- Colon cancer
- Coronary artery disease & angina
- Hernia procedures
- Cardiac arrhythmia
- Sickle cell
- Pacemaker/Defibrillator
- Depression - acute exacerbation
- Lung cancer
- Female reproductive cancer
- Other major bowel
- PTSD
- Fluid electrolyte imbalance
- Renal failure
- Liver & pancreatic cancer
- Hepatitis C
- GERD acute exacerbation
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- Rheumatoid arthritis
- Bipolar (multiple)
- Conduct disorder
- Epileptic seizure
- Hypotension/Syncope
- Kidney & urinary tract stones
- Other respiratory infection
- Dermatitis/Urticaria

Wave	1	2	3	4	5	6	7	8	9	10	11
Design Year	2013	2014	2015		2016		2017		2018		2019

## Overview

- A review and planning process identified 75 episodes to develop over the coming 5 years
- Episodes were chosen and sequenced based on opportunities to improve patient health, improve quality of patient experiences, and to deliver care more efficiently
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Source: TennCare and State Commercial Plans claims data, episode diagnostic model

# Status of the episodes of care program by wave

- In the performance period
- In the preview period

	First Preview Report Sent	Start of performance period (if currently in preview)
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# Agenda and contents

## Agenda

Time	Activity
1:30-2:00 PM	<b>A</b> Overview of the acute and non-acute PCI episodes
2:00-2:10 PM	<b>B</b> Examples of changes based on last year's feedback session
2:10-2:20 PM	<b>C</b> Feedback received to date
2:20-2:40 PM	<b>D</b> Today's feedback

# A Non-acute and acute PCI patient journey

■ Acute PCI

■ Non-acute PCI

■ Both episodes

**1** *Patient has clinical indications that require an ACUTE PCI*

**2** **Initial assessment**

- Initial assessment is done by an emergency department physician
- Patient receives rapid assessment according to protocol including EKG, labs, IV, oxygen, medication, and appropriate diagnostics

**1** *Patient has clinical indications that require a NON-ACUTE PCI*

**2** **Initial assessment**

- Initial assessment is done by either a primary care physician, cardiologist and/or by other physician depending on where the patient arrives
- Diagnostic procedures are done (e.g. ECG, imaging, blood tests, angiogram)

**3** **Procedure**

- For acute-PCI, procedure is performed as quickly as possible, i.e. within minutes
- Patient is prepared for procedure and given medications (e.g. anticoagulant, low-dose aspirin)
- Patient is given sedative medication to relax and local anesthesia at the insertion site
- Catheter is inserted and balloon inflated to improve blood flow
- Physician may take measurements, pictures, or angiograms to make sure the artery is opened sufficiently
- Insertion site may be closed with a closure device, by use of sutures, or by applying manual pressure over the area
- Potential complications such as abrupt coronary artery closure may happen

**4** **Follow-up care**

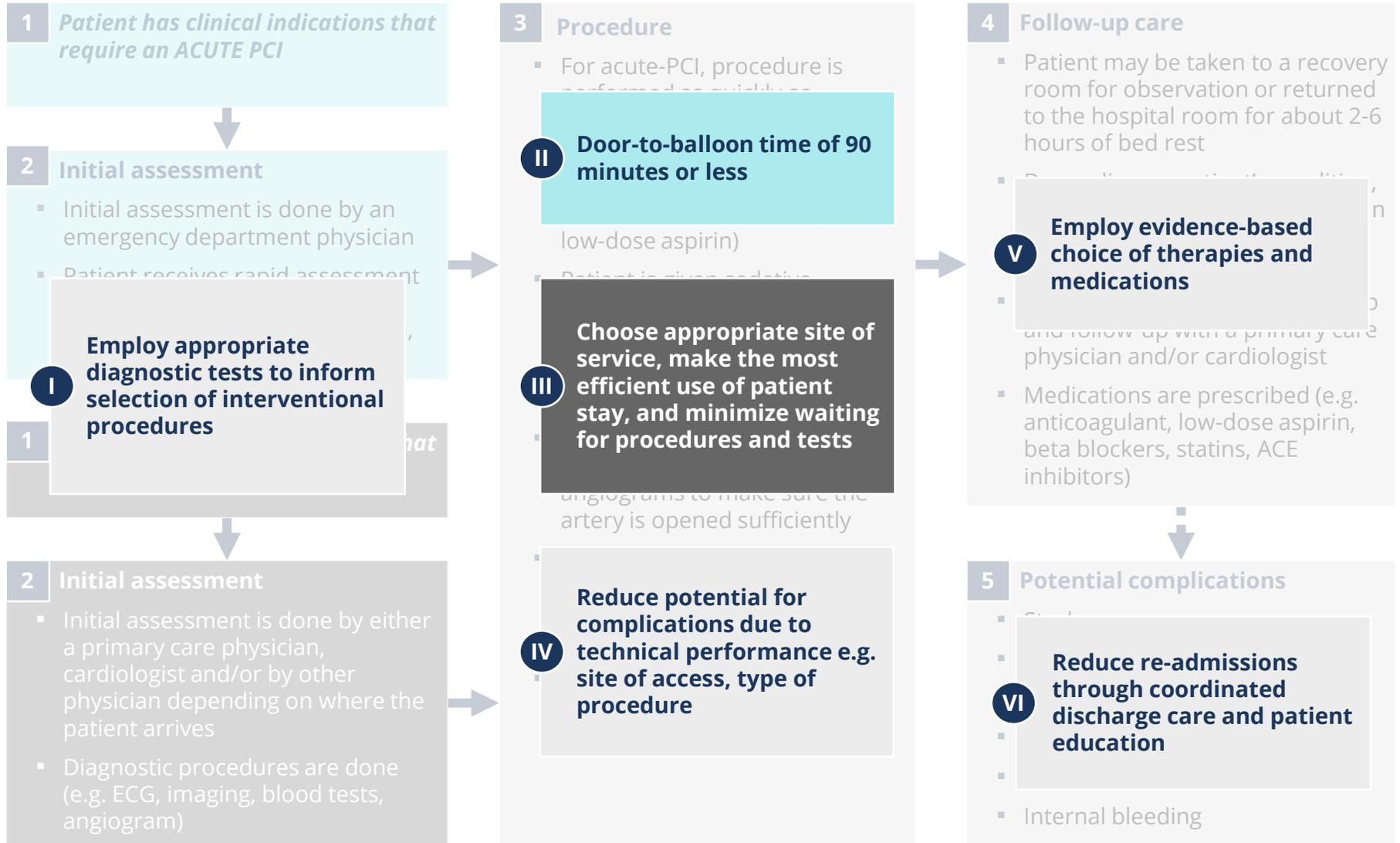
- Patient may be taken to a recovery room for observation or returned to the hospital room for about 2-6 hours of bed rest
- Depending on patient's condition, he/she is discharged the next or in a few days or transferred to a skilled nursing facility
- Patient may receive cardiac rehab and follow-up with a primary care physician and/or cardiologist
- Medications are prescribed (e.g. anticoagulant, low-dose aspirin, beta blockers, statins, ACE inhibitors)

**5** **Potential complications**

- Stroke
- Myocardial infarction
- Vessel dissection
- Embolism
- Infection
- Internal bleeding

# A Non-acute and acute PCI sources of value

■ Acute PCI ■ Non-acute PCI ■ Both episodes



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# A Non-acute and acute PCI episode definitions

**A** Acute PCI  
**N** Non-acute PCI

Area	Episode definition
<b>1 Identifying episode triggers</b>	<ul style="list-style-type: none"> <li>A professional and a facility claim for <b>PCI</b> trigger the episodes</li> <li>Acute and non-acute episodes are distinguished from each other based on <b>two acute indicators</b></li> </ul>
<b>2 Attributing episodes to quarterbacks</b>	<p><b>A</b> For acute episodes, the Quarterback of the episode is the <b>facility</b> where the procedure is performed</p> <p><b>N</b> For non-acute episodes, the Quarterback of the episode is the <b>interventionalist</b> who performed the procedure</p>
<b>3 Identifying services to include in episode spend</b>	<ul style="list-style-type: none"> <li>All services during the procedure and relevant radiology, labs, pathology, office visits and medications before (for non-acute episodes) and after the procedure as well as care related to complications are included</li> <li><b>A</b> For acute episodes, the episode <b>begins on the day of the procedure</b> (or admission if inpatient) and ends <b>30 days after</b> the procedure (or discharge if inpatient)</li> <li><b>N</b> For non-acute episodes, the episode <b>begins 30 days prior to the procedure</b> (or admission if inpatient) and ends <b>30 days after</b> the procedure (or discharge if inpatient)</li> </ul>
<b>4 Risk-adjusting and excluding episodes</b>	<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 65 or older)</li> <li>Clinical exclusions: Patient's care pathway is different for clinical reasons</li> <li>High cost outlier exclusions: Episode's risk adjusted spend is three standard deviations above the mean</li> </ul> </li> </ul>
<b>5 Determining quality metrics performance</b>	<p>Tied to gain sharing</p> <ul style="list-style-type: none"> <li>Percent of valid episodes with an <b>included hospitalization</b> in the post-trigger window</li> </ul> <p>Not tied to gain sharing</p> <ul style="list-style-type: none"> <li>Percent of valid episodes where the <b>professional trigger claim involves multiple vessels</b> (including multiple branches)</li> <li>Percent of valid episodes with a <b>repeat PCI</b> in the post-trigger window</li> </ul>

## B Examples of changes made based on last year's feedback session

1

- **Episode: Asthma**
- **Updated the corticosteroid quality measure to include Decadron from hospital claims in the list of codes for the quality metric and broadened the window for scripts to 90 days from 30 days to allow for 90 day refills**
  - The intent of the corticoid steroid quality metric could better be captured by focusing on the patient population that requires systemic corticosteroids for asthma acute exacerbations. Therefore, all inhaled corticosteroids were removed from the numerator, leaving only oral and injectable systemic corticosteroids within 30 days of the end of the trigger window as contributing to acceptable performance

2

- **Episode: Perinatal**
- **Updated group B strep metrics to account for patient history**
  - The state updated the metric definition to include specific diagnosis codes that specify a history of or active group B streptococcus into the list of acceptable codes to satisfy the quality metric.

3

- **Episode: Perinatal**
- **Removed transportation cost from the perinatal episode.**
  - The state agreed with the concern that structural barriers such as transportation can potentially limit access to care, both in the prenatal and postnatal periods.

# C Program feedback received to date

## Area

## Feedback received

---

### General program design and integrity

- The way the new system is designed, it is far too complex. Keep it simple. Physicians submit a bill, TennCare pays it.
- Redefine episodes as journeys, including episodes that were prevented, using counterfactual analysis. Update risk assessment at each point where the provider can change the trajectory of the journey.
- Extend episodes technology into information production for Patient Centered Medical Home journey
- Provide more information on sources of value in order to help providers improve care, e.g.:
  - Specify how efficiency is determined and group spend by the specific sources of value
  - Find ways to compare performance of quarterbacks and PCMH
  - Find ways to compare journeys among patients that had the episode to patients that were not in the episode

# Today's feedback

## Area Feedback

**Identifying episode triggers**

- ...

**Attributing episodes to quarterbacks**

- ...

**Identifying services to include in episode spend**

- ...

**Risk adjusting and excluding episodes**

- ...

**Determining quality metrics performance**

- ...

## 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 fall
- **Incorporate** changes that need to be made for the 2017 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)



Division of  
**Health Care  
Finance & Administration**

Health Care  
Innovation Initiative

WAVE 1 AND 2 FEEDBACK SESSIONS

Screening and Surveillance Colonoscopy Episode  
July 19, 2016

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

## Approach

- Gather feedback from Stakeholders across the state on each of the episodes implemented in wave 1 and 2 of the Tennessee Health Care Innovation Initiative
- Conduct analysis to inform decision of how to incorporate feedback
- Incorporate selected changes into program for calendar year 2017

## Objectives for Today

1. Briefly review the background and objectives of the Tennessee Health Care Innovation Initiative
2. Discuss the current implemented colonoscopy episode and definition
3. Review program-level feedback and colonoscopy episode-specific feedback received prior to the meeting
4. Listen to and capture feedback on the colonoscopy across each of the primary design dimensions
5. 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



"It's my hope that we can provide quality health care for more Tennesseans while transforming the relationship among health care users, providers and payers. If Tennessee can do that, we all win."

– Governor Haslam's address to a joint session of the state Legislature, March 2013

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 physicians

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

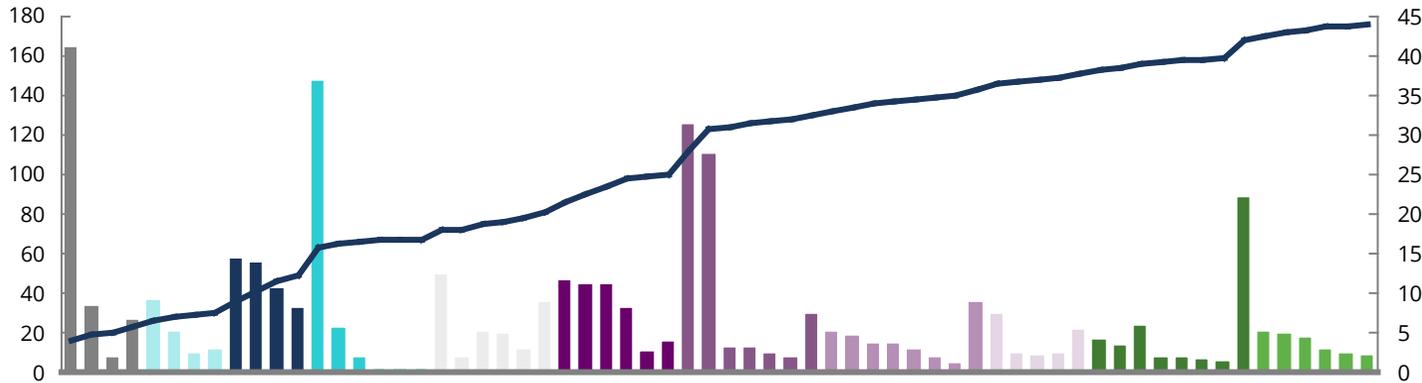
By working together, we can make significant progress toward **sustainable medical costs and improving care**

# Episodes of care program in Tennessee

Episodes of care: 75 in 5 years

Episode spend, \$M

Cumulative share of total spend, %



Wave	1	2	3	4	5	6	7	8	9	10	11
Design Year	2013	2014	2015		2016		2017		2018		2019

- Perinatal
- Asthma acute exac.
- Total joint replacement
- COPD acute exac.
- Colonoscopy
- Cholecystectomy
- PCI (multiple)
- GI hemorrhage
- EGD
- Respiratory Infection
- Pneumonia
- UTI (multiple)
- ADHD
- CHF acute exacerbation
- ODD
- CABG
- Valve repair and replacement
- Bariatric surgery
- Breast cancer (multiple)
- Breast biopsy
- Tonsillectomy
- Otitis
- Anxiety
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Source: TennCare and State Commercial Plans claims data, episode diagnostic model

# Status of the episodes of care program by wave

- In the performance period
- In the preview period

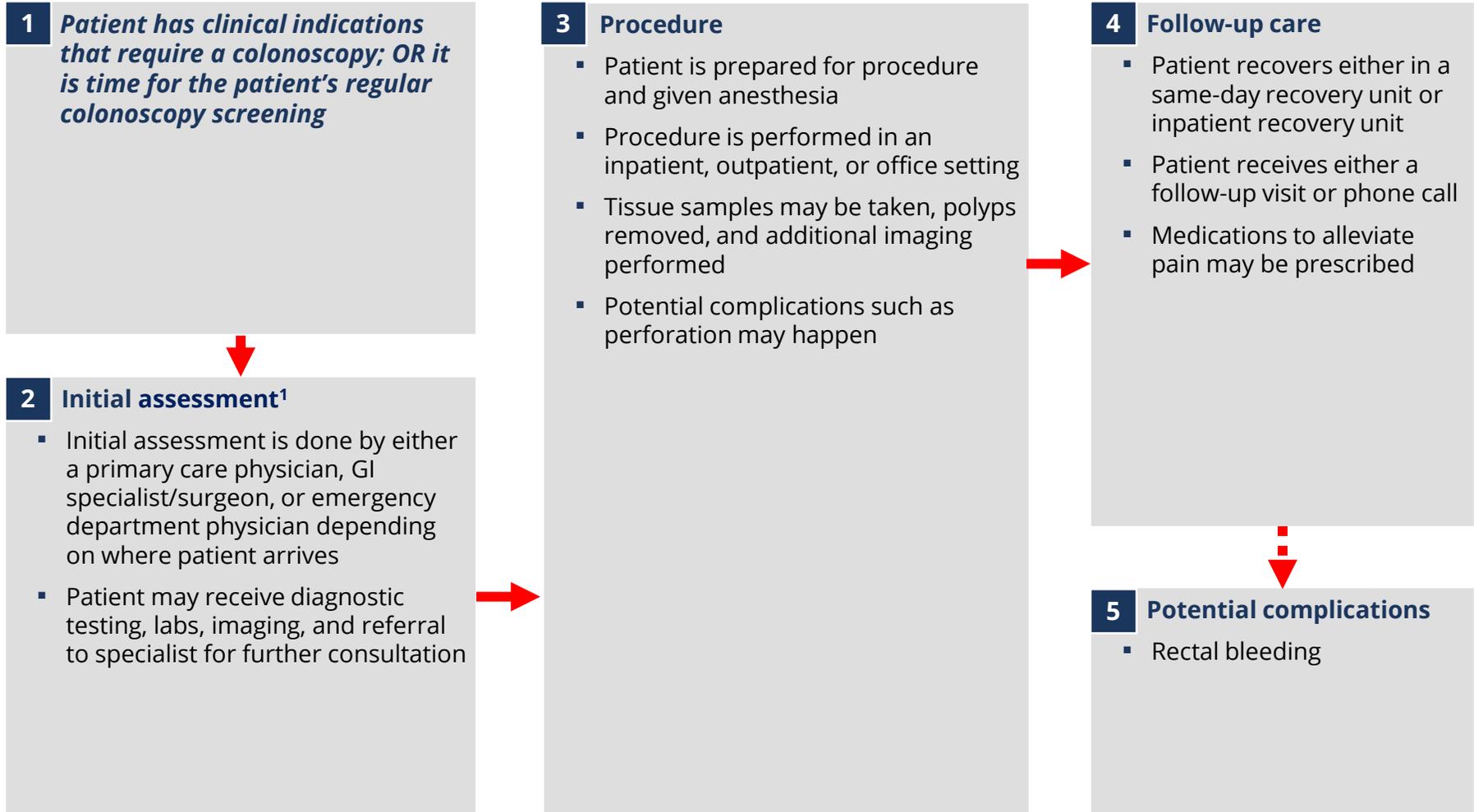
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# Agenda and contents

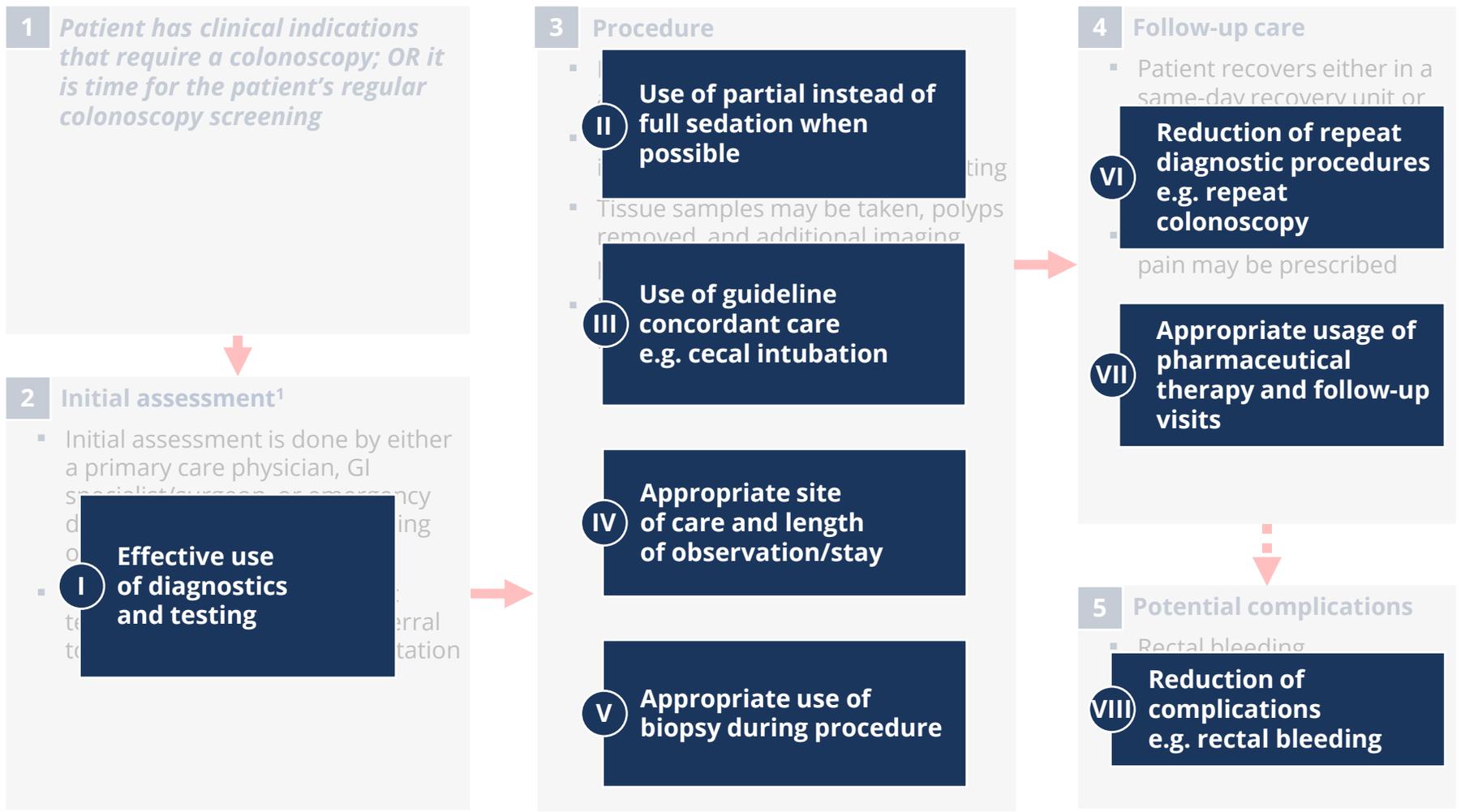
## Agenda

<b>Time</b>	<b>Activity</b>
2:45-3:15 PM	<b>A Overview of the colonoscopy episode</b>
3:15-3:25 PM	<b>B Examples of changes based on last year's feedback session</b>
3:25-3:35 PM	<b>C Feedback received to date</b>
3:35-3:55 PM	<b>D Today's feedback</b>

# A Colonoscopy patient journey



# A Colonoscopy sources of value



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1 For screening colonoscopies initial assessment may vary

# A Colonoscopy episode definition

Area	Episode definition
<p><b>1</b> Identifying episode triggers</p>	<ul style="list-style-type: none"> <li>A <b>professional claim for colonoscopy</b> triggers the episode</li> </ul>
<p><b>2</b> Attributing episodes to quarterbacks</p>	<ul style="list-style-type: none"> <li>The <b>physician</b> who performs the colonoscopy is the Quarterback</li> </ul>
<p><b>3</b> Identifying services to include in episode spend</p>	<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>
<p><b>4</b> Risk-adjusting and excluding episodes</p>	<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 65 or older)</li> <li>Clinical exclusions: Patient's care pathway is different for clinical reasons</li> <li>High cost outlier exclusions: Episode's risk adjusted spend is three standard deviations above the mean</li> </ul> </li> </ul>
<p><b>5</b> Determining quality metrics performance</p>	<p>Not tied to gain sharing</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> <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>

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# C Episode feedback received to date

## Area

## Feedback received

---

**Determining  
quality metrics  
performance**

- How is participation in the Registry being reported?

# Today's feedback

## Area Feedback

**Identifying episode triggers**

- ...

**Attributing episodes to quarterbacks**

- ...

**Identifying services to include in episode spend**

- ...

**Risk adjusting and excluding episodes**

- ...

**Determining quality metrics performance**

- ...

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