

Oklahoma State Department of Health



Oklahoma State Innovation Model
Tribal Consultation
January 28, 2016



Introduction to the State Innovation Model Grants

State Innovation Model

- **State Innovation Model (SIM):** The SIM is a grant that was awarded to States by the Centers for Medicare and Medicaid Services (CMS).
 - The grant provides technical and financial support to states to develop state-led, multi-payer healthcare service delivery and payment models. The SIM is part of a growing portfolio of CMS projects that seek to achieve the goals of the Triple Aim.



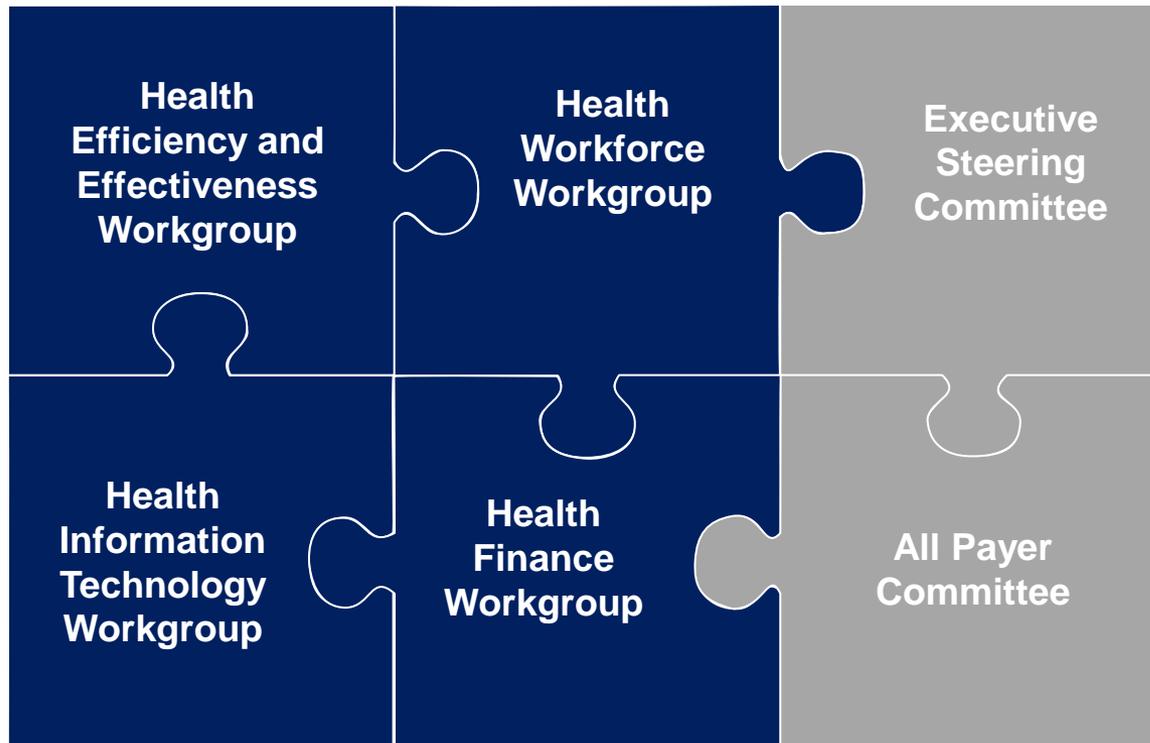
- **Oklahoma SIM Project:** Oklahoma was awarded \$2,000,000 for a SIM Model Design Grant. The grant period runs from February 2015 to March 2016.
 - **State Health System Innovation Plan (SHSIP):** By March 2016, the Oklahoma SIM Project Team will use stakeholder input and subject matter expertise to develop a detailed plan for state-wide health system transformation, called the SHSIP.



Oklahoma State Innovation Model Grant: Overview and Status Update

Committees and Workgroups

The four OHIP/OSIM Workgroups, along with the Executive Steering Committee and All Payer Committee, have guided the OSIM model development and Innovation Plan deliverables.



Stakeholder Engagement

The Oklahoma SIM Project Team has been engaging Oklahoma stakeholders across the healthcare spectrum, including providers, payers, and public health and consumer groups.



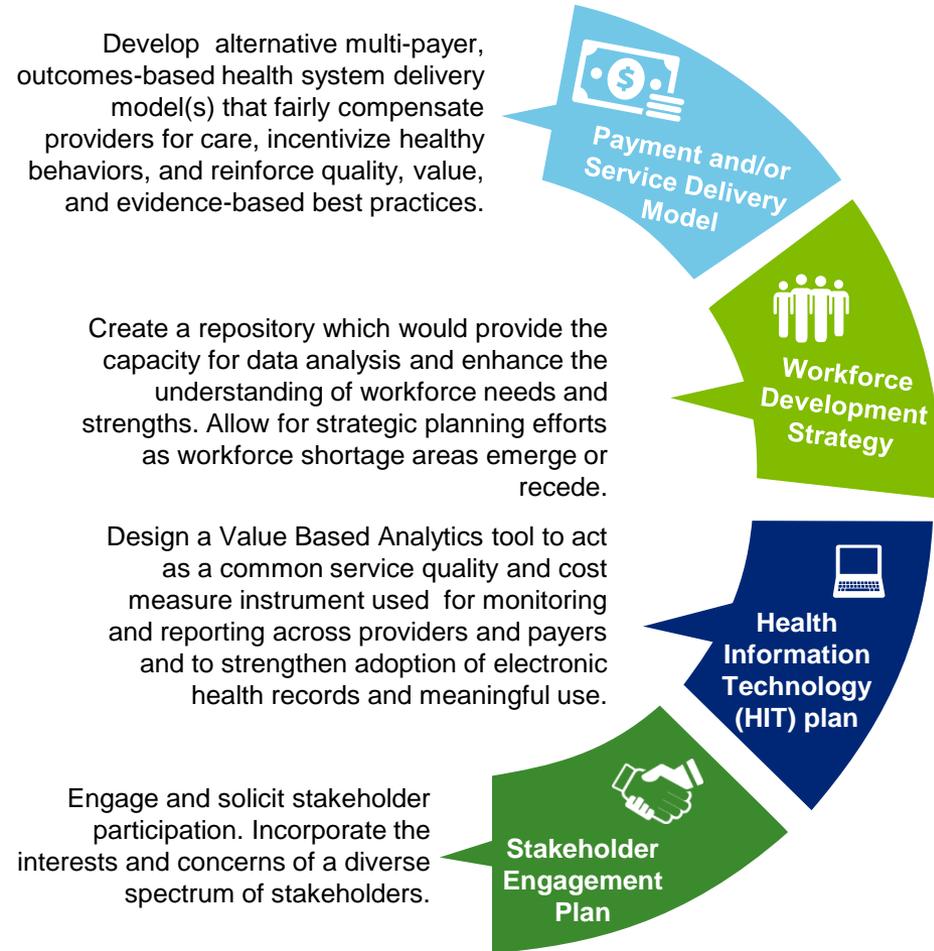
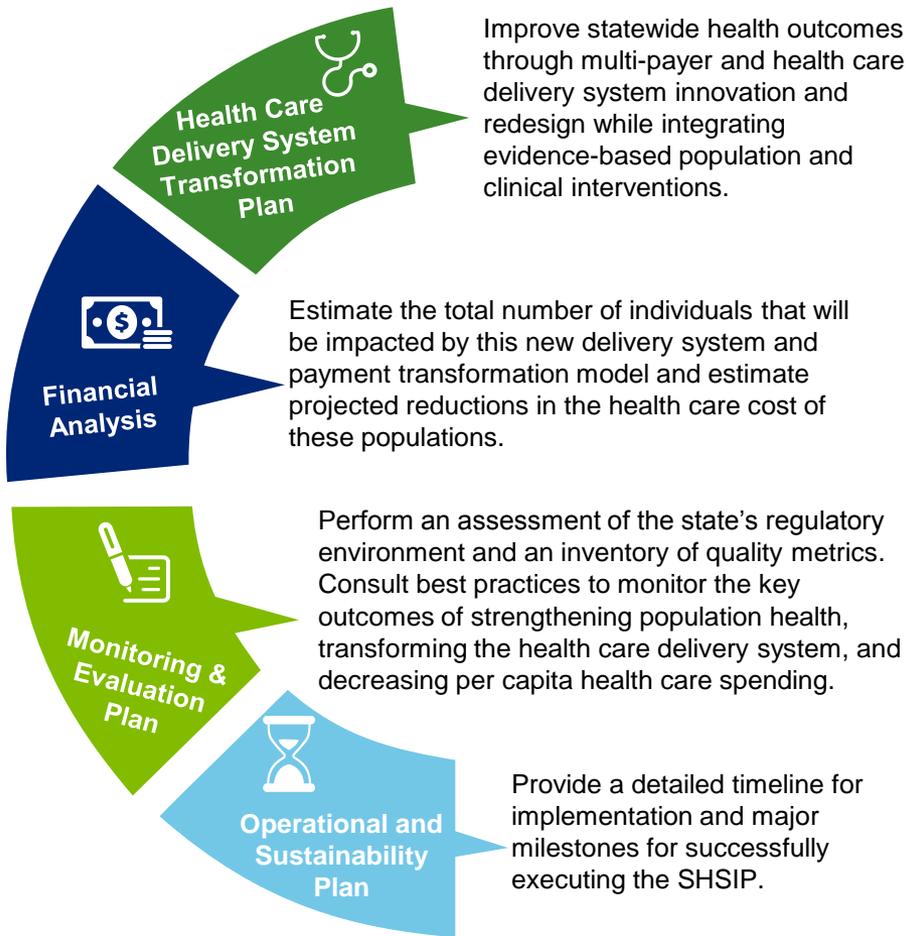
Stakeholder Engagement

Stakeholders have been engaged through individual meetings and the OHIP/OSIM Workgroups.

State/Local Agency	Tribal Nation/ Association	Payer	Provider/Health Association	Academic Institution/Vendor
<ul style="list-style-type: none">• Oklahoma Health Care Authority (OHCA)• Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS)• Oklahoma Employment Security Commission (OESC)• Oklahoma Department of Human Services (OKDHS)	<ul style="list-style-type: none">• Chickasaw Nation• Absentee Shawnee Tribe• NE Tribal Health Systems• Muscogee Creek Nation• Choctaw Nation• Cherokee Nation• Tribal Public Health Advisory Committee	<ul style="list-style-type: none">• Oklahoma Health Care Authority (OHCA)• Blue Cross Blue Shield (BCBS) of Oklahoma• CommunityCare of Oklahoma Health Insurance Plans• Employees Group Insurance Division (EGID)• GlobalHealth INC.	<ul style="list-style-type: none">• Variety Care, Inc.• Oklahoma State Medical Association• Oklahoma Hospital Association• Oklahoma Primary Care Association• Oklahoma Association of Health Plans• Oklahoma Nurses Association• Mental Health Association of Oklahoma• Alliance for the Uninsured	<ul style="list-style-type: none">• University of Oklahoma Health Sciences Center (OUHSC)• Oklahoma State University (OSU)• Oklahoma Foundation for Medical Quality (OFMQ)• INTEGRIS• MyHealth• Yeaman Plus Associates

State Health System Innovation Plan: Detailed Overview

The final product of Oklahoma SIM Project will be the State Health System Innovation Plan. The SHSIP includes various sections centered around a population health improvement plan.



State Health System Innovation Plan: Status Update

Section	CMS Review Status	Contractor Review Status	Stakeholder Review Timeline
1. Description of the State Healthcare Environment	Yes	Yes	2/1/16
2. Report on Stakeholder Engagement	Yes	Yes	2/1/16
3. Health System Design and Performance Objectives	Yes	Yes	2/1/16
4. Value Based Payment and Service Delivery Model	No	Yes	2/1/16
5. Plan for Healthcare Delivery System Transformation	Yes	Yes	2/1/16
6. Plan for Improving Population Health	Yes	Yes	2/1/16
7. Health Information Technology Plan	Yes	Yes	In Review
8. Workforce Development Strategy	Yes	Yes	In Review
9. Financial Analysis	No	No	2/15/16
10. Monitoring and Evaluation Plan	No	No	2/15/16
11. Operational and Sustainability Plan	Yes-Draft	Yes-Draft	2/15/16

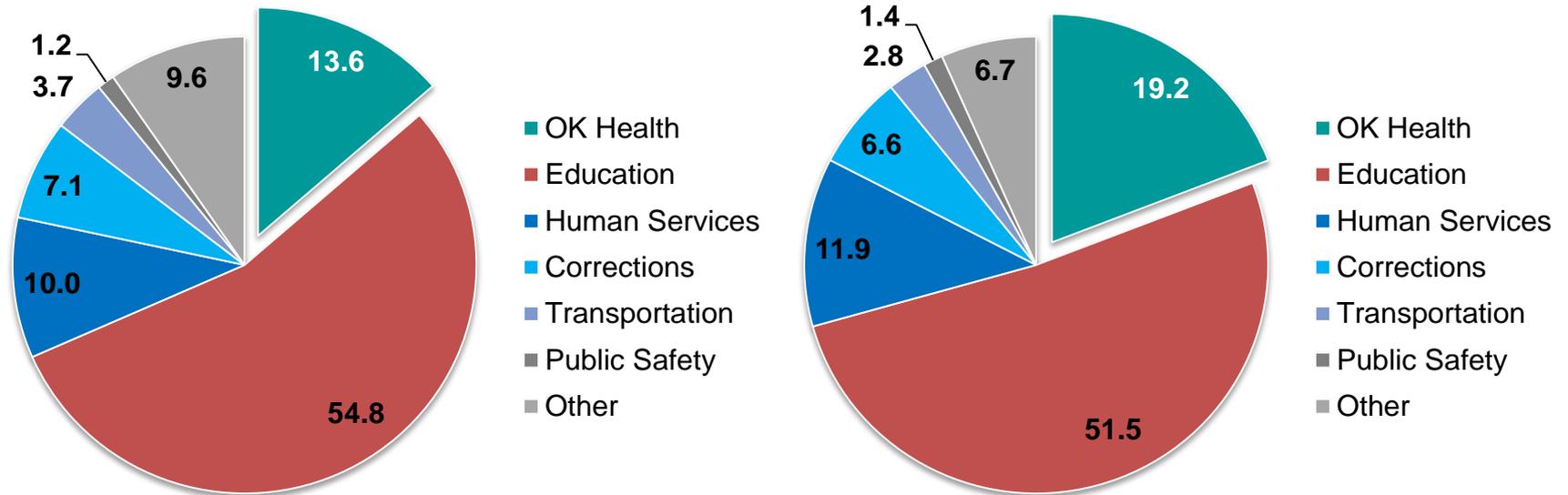


Oklahoma State Innovation Model: Current Healthcare Environment and New Model Proposal

Oklahoma Department Spending Share 2005-15

Oklahoma's health spending has increased its share of the total state budget by 5.6 percentage points, from 13.6% to 19.2%, since 2005

Percentage Department Spending (%), 2005 Percentage Department Spending (%), 2015

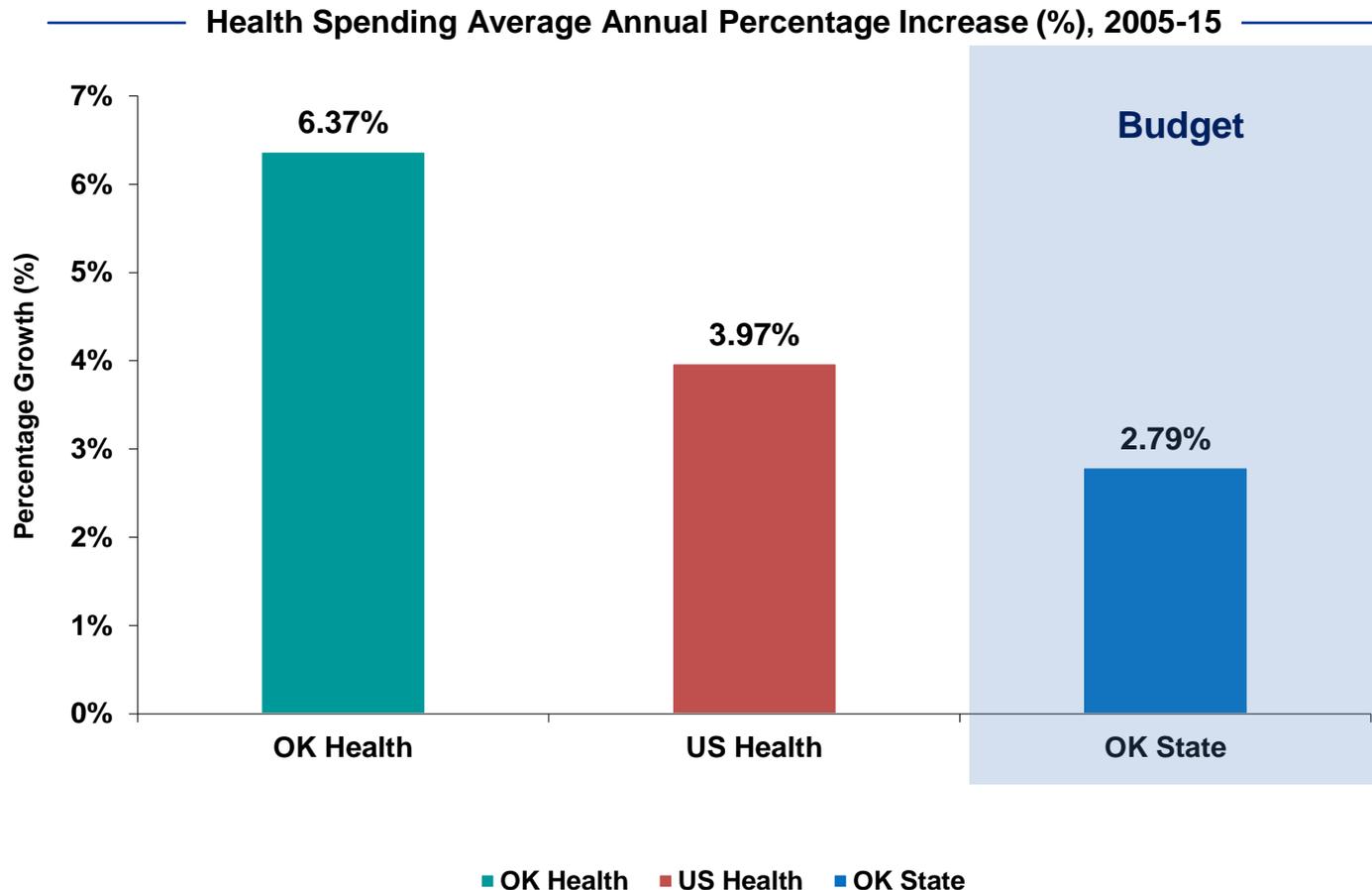


Source: Oklahoma Comprehensive Annual Financial Reports, CHIE Analysis



Oklahoma Health Spending Average Annual Increase 2005-15

Oklahoma's health spending has increased twice as fast as the state budget and one and a half times as fast as US total healthcare expenditures



Source: Oklahoma Comprehensive Annual Financial Reports, CMS National Health Expenditure Data, CHIE Analysis



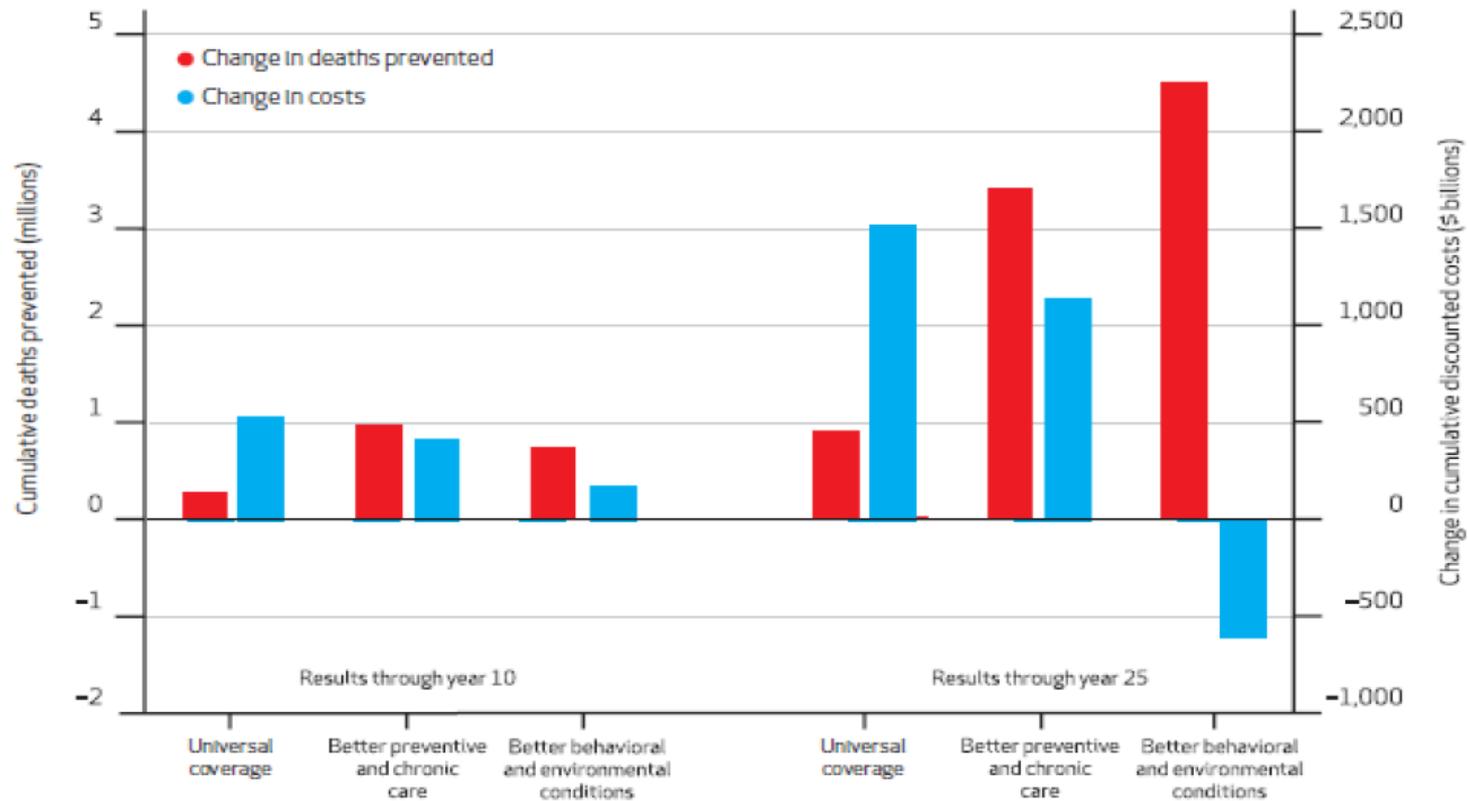
Oklahoma Healthcare Costs

State of Oklahoma High-Cost Condition Relative Cost		
	% Increase	Average Annual Cost
Entire Population	100%	\$4,993
Diabetes	349%	\$17,426
Obesity	343%	\$17,126
Tobacco Usage	345%	\$17,226
Behavioral Health	313%	\$15,628
Hypertension	283%	\$14,130



Primary Prevention Strategies Needed

Figure 3. A comparison of changes in deaths prevented and costs associated with expanding health coverage, improving care and investing in community primary prevention.



Milstein et al. (2011) Why Behavioral and Environmental Interventions are needed to Improve Health at Lower Costs. *Health Affairs*. 30, No. 5 (2011): 823-832.



The Case for Change

The fee-for-service system incentivizes volume, making it difficult to contain costs

Fee-for-service payments do not incentivize investment in innovative delivery methods or systems

Patients too often viewed by system as diagnoses instead of whole persons with need for coordinated care

Providers ability to deliver person-centered care inhibited by ever-expanding mandates

Current system does not emphasize primary prevention efforts that can lead to better population health and reduced costs



SIM Model Goal

To move the purchasing of health care services from a fee-for-service system to a population-based payment structure that incentivizes quality and value while emphasizing primary prevention strategies.



By moving to value-based care coordination model and focusing on the SIM flagship issues, we will improve population health, increase the quality of care, and contain costs.

Obesity

Diabetes

Tobacco Use

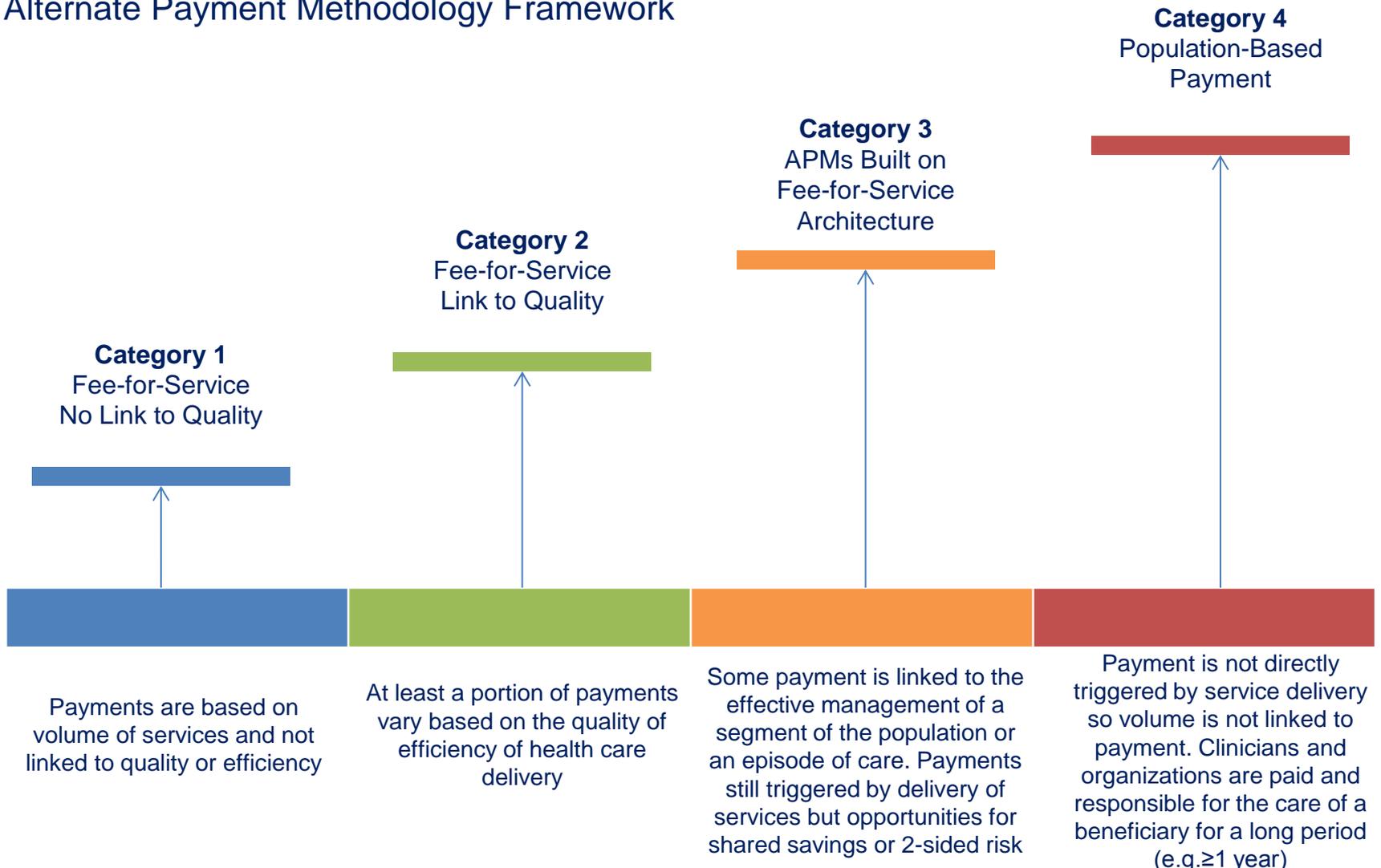
Hypertension

Behavioral Health



Where Are We Going?

Health Care Payment Learning & Action Network Alternate Payment Methodology Framework



How Did We Get Here?

The Oklahoma SIM project began in February 2015 and has used the expertise of our OHIP/OSIM workgroups, the SIM All Payer and Executive Committees, technical assistance contractors, and dozens of stakeholders from our communities and health systems.

- OHIP/OSIM Workgroups
- Executive Steering Committee
 - After reviewing stakeholder feedback, the Executive Steering Committee directed the SIM team to proceed with the development of a model concept similar to a Care Coordination Organization.
- Technical Assistance
 - Deloitte Consulting
 - Milliman Healthcare Consulting
 - SIM and Non-SIM States
 - Centers for Medicare and Medicaid Innovation
 - SHADAC
 - ONC
- Other Oklahoma Stakeholders
 - Turning Point, Rural Health Association, OKPCA, OHA, et al



OSIM Model Proposals – Conceptual Design Tenets

Through this process the OSIM team identified several key tenets to build the OSIM model

Incorporate What Drives Health Outcomes

- Expand from an integrated clinical view of patients to include social determinants of health and associated health enabling elements
 - Address behavioral health needs
 - Develop stronger relationships with social services and community resources

Integrate The Delivery Of Care

- Ensure that various aspects of patient care are integrated and managed collectively, rather than in an isolated fashion
 - Leverage Care Coordination practices already in place
 - Enhance and expand use of health information technology
 - Fully integrate primary care and behavioral health

Drive Alignment To Reduce Provider Burden

- Engage with external stakeholders to align quality metrics from OSIM
 - Foster buy-in from private payers
 - Work with Medicare to synchronize evaluative metrics

Move Toward VBP With Realistic Goals

- Understand that value-based purchasing will need a transition period
- This is a large commitment that needs to be collaborative to allow for transformation to occur at the practice level



SIM Goal:

To move payments to providers from a fee-for-service system to a value-based payment structure

Communities of
Care Organizations

Multi-Payer
Quality Measures

Multi-Payer
Episodes of Care



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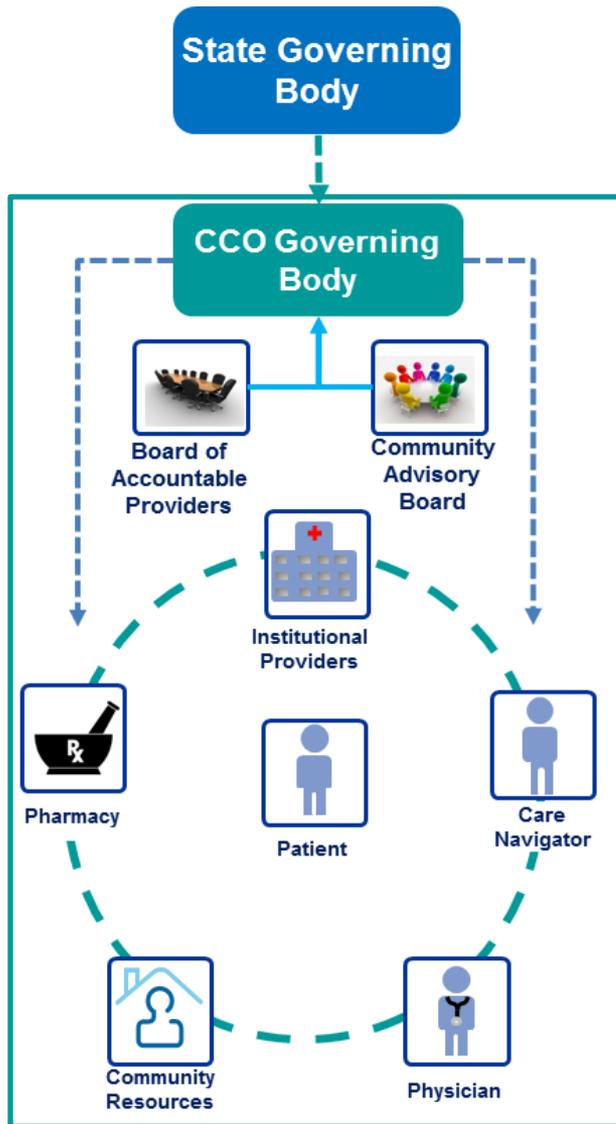
I. Communities of Care Organizations: Overview

What are Communities of Care Organizations?

- CCOs are local, risk-bearing care delivery entities that are accountable for the total cost of care for patients within a particular region of the state
- Governed by a partnership of health care providers, community members, and other stakeholders in the health systems to create shared responsibility for health
- CCOs focus on primary care and prevention strategies, using care coordination and the integration of social services and community resources into the delivery of care
- Utilize global, capitated payments with strict quality measure accountability to pay for outcomes and health
- Reimburse non-traditional health care workers and services, such as community health workers, peer wellness specialists, housing, et al
- Initially, this model is proposed for all state purchased health care, which comprises a quarter of the state's population
 - Medicaid (SoonerCare): 805,757 members
 - Public Employees: 225,861 members



I. Communities of Care Organization



- Geographically distinct, provider and community-led care delivery entities that are each accountable for the total cost of care for patients within their geography
- Receive a capitated payment from the State Governing Body to cover total cost of member services
- CCOs create a network of providers and community resources that will deliver care to the attributed members
 - CCOs will have to show they have assembled an adequate network of providers to deliver patient-centered care
- CCOs will organize a governance structure that incorporates the providers and community they serve

I. CCO Overview- Who could be a CCO?

There are many different organizations already operating within the healthcare system that could be a CCO or join together to be a CCO.

Example CCOs:

- **Integrated System partnership with Health Plan – Example is Hypothetical**
 - Plan administered by system providers and health plan leadership
 - Ownership: Those within integrated system, key community partners, and health plan
- **Provider and System Partnerships – Example: Eastern Oregon Care Organization**
 - Plan administered by: Greater Oregon Behavioral Health, Inc. (GOBHI) and Moda Health
 - Ownership: GOBHI, Moda Health, Good Shepard Health Care System (NFP Hospital), Grand Ronde Hospital, Inc., Saint Alphonsus Health System Inc., St. Anthony Hospital, Pendleton IPA Inc., Yakima Valley Farm Workers Clinic (FQHC)
 - Joined through LLC
- **Independent Physician Association – Example: AllCare CCO**
 - Governance: AllCare is actively governed by a 21-member board composed of eleven practicing physicians and 10 stakeholders including: one representative from each of our three Community Advisory Councils, a public member at large, two local hospital representatives, a representative of a Federally Qualified Health Center, a local pediatric dentist, a representative of a local Addictions Recovery program, and a representative of a local mental health provider. The ten stakeholders have no financial interest in the company. Each person on the board has an equal vote.



II. Payment Methodology – CCO

- CCOs will receive a fully capitated, risk-adjusted per member per month payment
- Incentives paid through a Community Quality Incentive Pool
 - X% of capitated rate will be withheld for a community quality incentive pool that pays for meeting performance and quality benchmarks
 - The percent of withhold will increase over time to accelerate move toward outcome-based payments
- If savings are accrued, a portion must be reinvested in the community to serve human needs affecting health (e.g., transportation, housing, mold remediation, food access).
- A percentage of the capitated rate will be paid to a Health Information Network for interoperability and data infrastructure (see Health Information Technology Plan)



II. Payment Methodology – CCO to Network Providers

- The CCO will implement an Alternate Payment Arrangement (APA) with the providers in their networks
 - Allowing CCOs to choose the payment arrangements gives the model flexibility to meet providers and regions where they are in their practice transformation
 - Strict interpretation of what constitutes an APA is needed
- The CCOs will work to meet the following targets:
 - 80% of payments made to providers will be value-based by 2020 to align with Medicare;
 - Participation with the Multi-Payer Episodes of Care;
 - At least one additional Alternative Payment Arrangement must be utilized; and
 - APAs must include mechanisms to encourage both cost savings and high quality care
- Alternate payment arrangements include, but are not limited to:
 - Pay for Performance
 - Payment Penalties
 - Shared Savings
 - Shared Savings and Shared Risk
 - Full Capitation
 - CPCI



III. Integration of Social Determinants

- A Community Advisory Board will serve as the mechanism for formal integration of the social determinants of health within the proposed model.
 - Their guidance will address population needs outside of the normal scope of healthcare to help the CCO create better care and cost savings

- Oklahoma will negotiate with CMS to pursue the use of flexible spending arrangements to assist in addressing social determinants.
 - Purpose is to give providers and patients access to non-medical services that can have a direct, positive impact on their health

- At enrollment members will complete a human needs survey which analyzes patient social needs
 - Used in risk stratification of member
 - Proactively identify needs before seeking care

- Quality metrics include a social determinant aspect

- All CCOs will create and maintain a regional asset database of community resources for easy referral



IV. Delivery Model

- The CCO will be required to articulate back to the governing body the mechanisms by which they will deliver patient-centered care (e.g., care coordination strategies, primary care provider role, creation of care teams, etc.)

- Delivery model designs should show how the CCO will:
 - Focus on comprehensive primary care and prevention
 - Integrate behavioral health and primary care
 - Integrate Federally Qualified Health Centers, County Health Depts., and other existing entities
 - Use non-traditional healthcare workers
 - Role of a centralized (among providers) multi-specialty care coordinator
 - Integrate telemedicine

- The best practices of the current Medicaid PCMH and HAN model will be part of the CCO quality metrics
 - 24 hour availability, expanded clinic hours
 - Co-Management and integrated health plans among healthcare disciplines
 - Use of EHR and e-Prescribing, supporting patient with educational materials and patient reminders for tests/screenings

- Other best practices and quality metrics will be set out so that each CCO must show how they achieve a high degree of patient-centered team-based care.

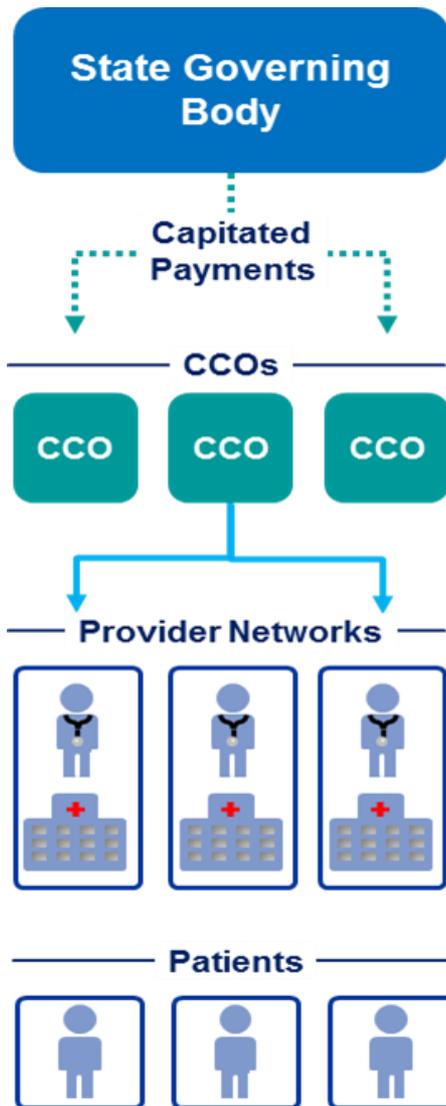


V. Health Information Technology Integration

- All CCOs must establish connection to an interoperable Health Information Exchange
 - An interoperable Health Information Exchange (HIE) is an HIE that is interoperable with any other HIE exchanging the health data of Oklahoma residents
 - Due to the necessity of interoperability for model success a percentage of the capitated rate will be paid to the HIN for maintenance and upkeep of interoperability
- HIE views will be required to be established for the care team
- CCOs must demonstrate how providers will be supported in actively managing the patient's care with patient- and panel-level data analysis
- Data analytics for payment will be done with a VBA tool using data that will be available within the HIN
- Ensure access to a consumer-friendly patient portal



VI. Oklahoma Communities of Care Organization: Governance



State CCO Governing Body

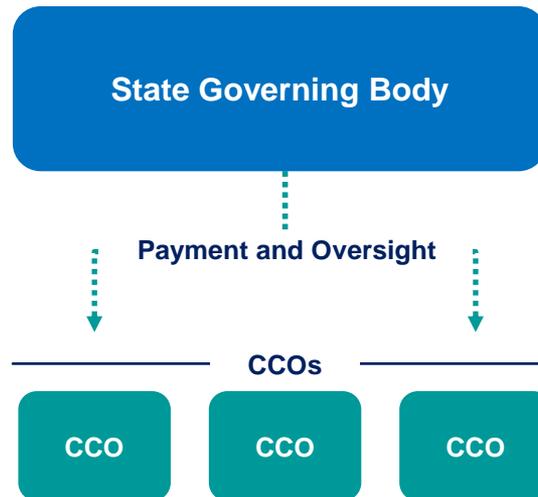
- Governing body consisting of members of health and human service agencies, paying institutions, and providers
- Sets and monitors contracting requirements
- Uses data-driven methods to evaluate CCOs performance
- Sustains key activities for plan maintenance

Communities of Care Organization

- Must show they have network adequacy and population size to support model
- Must meet Oklahoma Insurance Department requirements to be a risk bearing entity and sell insurance products in Oklahoma or contract with a partner to provide these services

Structure and Function of the State Governing Body

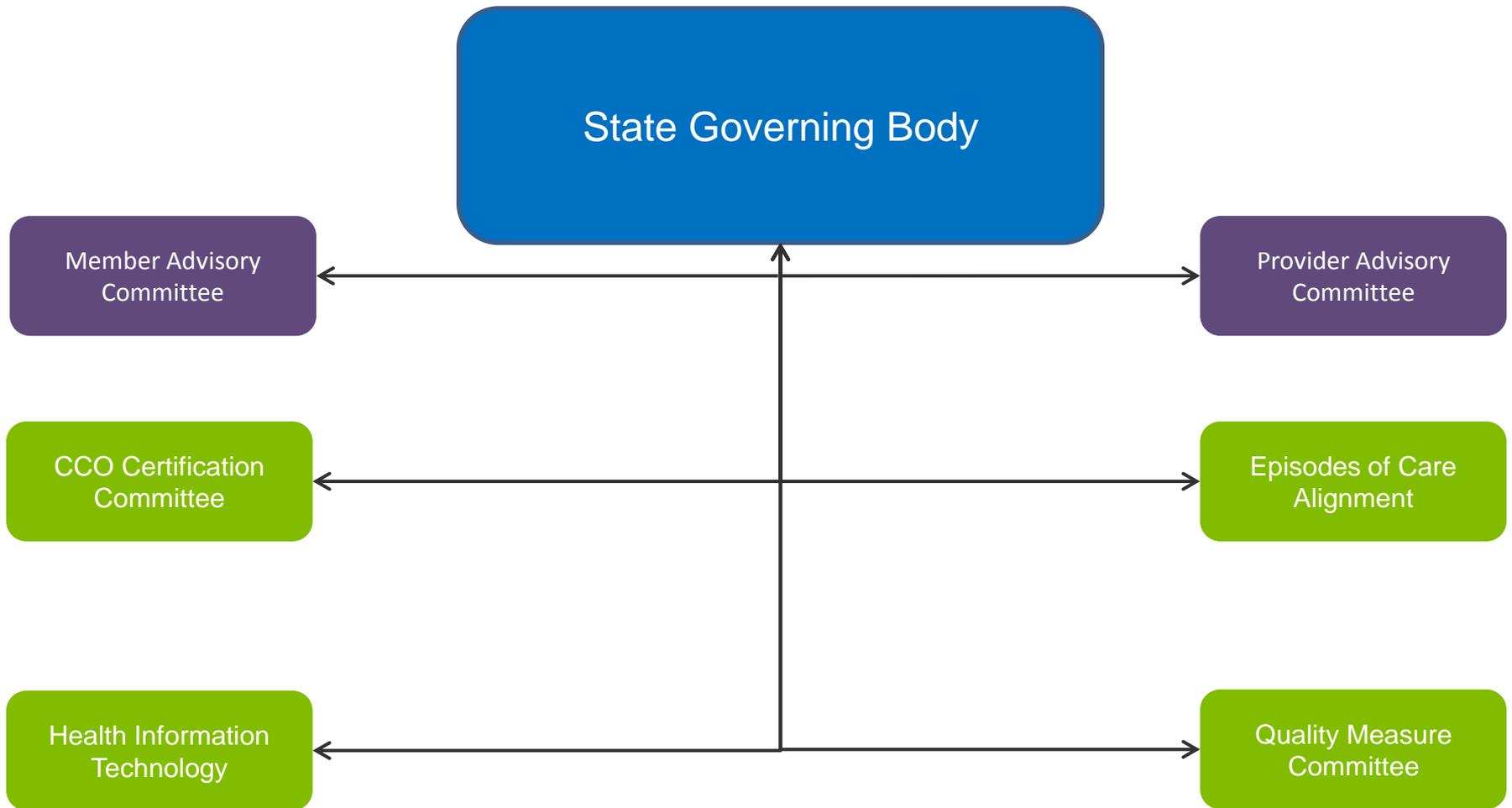
The State Governing Body will serve as the payer for state purchased health care and be responsible for providing oversight of the CCOs through certification and a continuous quality monitoring process.



Members of the State Governing Body will include: the Oklahoma Health Care Authority, the Employee Group Insurance Division, the Oklahoma State Department of Health, the Department of Mental Health and Substance Abuse Services, and the Oklahoma Insurance Department, a Representative from the Member Advisory Committee and Provider Advisory Committee



State Governing Body – Example Advisory Boards and Committees



Quality Measures Committee

The Quality Measures Committee will set CCO quality measure benchmarks and reporting requirements. A proposed committee will be composed of 12 members, including:

- 6 providers from different practice settings and populations served
e. g. MD, DO, Pharm.D., Nurse, PA, Behavioral Health Specialist
- 2 quality measure specialists, consultants, or experts
- 1 HIT/data reporting specialist
- 1 public health specialist
- 1 patient advocate
- 1 practice transformation consultant



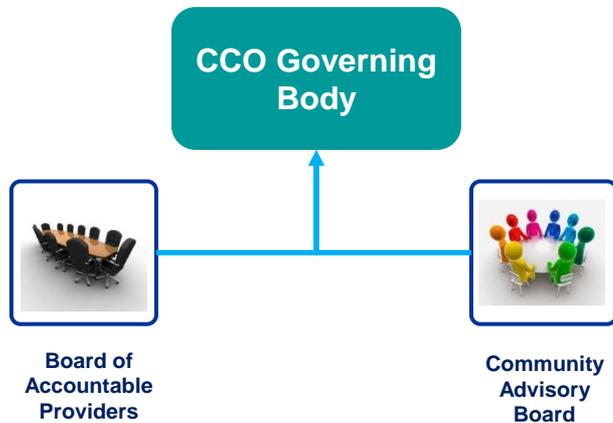
Episodes of Care Committee

The Episodes of Care Committee will propose episodes of care and episode framework, including needed, identified alterations to existing episodes of care. Proposed membership of this committee include:

- A representative from each participating payer
- Provider representatives relevant to each episode of care (PAP)
- A data reporting specialist
- A patient advocate
- Oklahoma Insurance Department



VI. CCO Governing Body



- A Board of Accountable Providers and a Community Advisory Board will be established by the CCO. If the CCO operates in multiple regions, they will set up a separate board in each region
- Each CCO must establish a governance structure that reflects the coordination of care delivery and community services and resources in a single integrated model
- To ensure the organizations decision-making is consistent with community members' values, the CCO governing board must include relevant stakeholders who will be impacted by the CCO, including community members and providers

Proposed CCO Certification Requirements

The State Governing Body will certify CCOs, indicating they have the capacity and plans for meeting the goals and requirements of SIM. The criteria by which the Governing Body certifies CCOs will include:

- Measures of financial capacity
- Determination of network adequacy
- Ability to implement alternative payment arrangements
- Health equity and member protection policies and procedures
- Community and provider engagement
- HIT capability
- Governance structure makeup



Please Refer to Handout



SIM Goal:

To move payments to providers from a fee-for-service system to a value-based payment structure

Communities of Care
Organizations

Multi-Payer
Quality Measures

Multi-Payer
Episodes of Care



Multi-Payer Quality Measures

Why Are These Important?

- Quality measures allow healthcare payers and providers to gauge the quality of care being delivered
- These can help assure cost-effectiveness is not achieved at the expense of quality care
- Multi-payer quality measures will reduce provider burden and create synergy around achieving a high level of performance on selected measures

How Are They Incorporated?

- Participating payers will be asked to make the measures a requirement to report from all applicable providers they contract with
- Participating payers will be asked to form APM strategies around measures with as much alignment among plans as possible
- These measures will be among those asked to be reported by the CCOs



Multi-Payer Quality Metrics

Sources

- Clinical Metrics:
 - Clinical Data
 - Claims Data
- Quality Assurance:
 - Independently reported via CCO
- Population Health Metrics:
 - Clinical Data
 - BRFSS
 - Death Data

Criteria

- Utilized and endorsed by a national authority on healthcare quality metrics
- Related to the core OHIP 2020 goals
 - The OHIP 2020 and Oklahoma SIM target obesity, diabetes, hypertension, tobacco use, and behavioral health as areas for improvement
- Links to clinical outcomes
- Aligned to State and National initiatives
- Included in initiatives such as:
 - CPCI, SoonerVerse, PQRS, Healthy Hearts for Oklahoma, Meaningful Use, eCQMs, FFM QRS, ACO metrics, FQHCs, GPRA



Required Clinical Metrics

Required Clinical Metrics

- NQF 0028: Tobacco Use Screening & Cessation Intervention
- USPTF: Abnormal Blood Glucose and Type 2 Diabetes: Screening - Adults Aged 40 to 70 Years who are Overweight or Obese
- NQF 0018: Controlling High Blood Pressure
- NQF 0024: Weight Assessment and Counseling for nutrition and physical activity
- NQF 0418: Depression Screening
- NQF 0576: Follow-Up after Hospitalization (within 30 days) (BH primary diagnosis)
- NQF: 0275 PQI 05: Chronic Obstructive Pulmonary Disease Admission Rate
- NQF: 0272 PQI 01: Diabetes, Short Term Complication Admission Rate
- CAHPS Composite: Satisfaction With Care
- NQF: 1517 Prenatal And Postpartum Care: Timeliness Of Prenatal Care
- NQF 0059: Comprehensive Diabetes Management/Diabetes Poor Control
- NQF 1932: Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications
- NQF 0421: Body Mass Index Screening & Follow-Up
- NQF 105: Anti – Depressant Medication Management
- NQF 0004: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- HEDIS: Ambulatory Care: Emergency Department Utilization
- NQF: 0277 PQI 08: Congestive Heart Failure Admission Rate
- NQF: 0283 PQI 15: Adult Asthma Admission Rate
- NQF: 1448 Developmental Screening In The First 36 Months Of Life



Required Quality Metrics: Quality Assurance

Required Quality Metrics: Quality Assurance

- % Of population with co-located behavioral health care provider
- % Of primary care practices in network with 24-hour availability
- % Of population assigned to a care coordinator with an elevated risk score
- Electronic resource guide available to care coordinator/staff
- % Of primary care practices in network with expanded hours (after 5pm/weekends)
- % Of population with an assigned risk score/stratification
- % Of network with HIE access
- Provider Satisfaction Survey



Required Quality Metrics: Population Health

Required Quality Metrics: Population Health

- | | |
|--|--|
| • % Of population who screened yes to being a current tobacco user under 18 years of age | • % Of population who screened yes to being a current tobacco user 18 years of age and older |
| • % Of population with a current BMI over 25 who are under 18 years of age | • % Of population with current BMI over 25 who are 18 years of age and older |
| • % Of population diagnosed with diabetes (type I and II) under 18 years of age | • % Of population diagnosed with diabetes (type I and II) 18 years of age and older |
| • % Of population diagnosed with hypertension under 18 years of age | • % Of population diagnosed with hypertension 18 years of age and older |
| • % Of population with a positive screening for depression under 18 years of age | • % Of population with a positive screening for depression 18 years of age and older |
| • Infant Mortality Rate | • Deaths Due to Heart Disease |
| • Suicide Deaths | • Diabetes Deaths |



Optional Bonus Metrics

Optional Bonus Metrics

- NQF 0032: Cervical Cancer Screening
- NQF 0039: Influenza Immunization (50 years and older)
- NQF 1516: Well Child Visits
- Effective Contraceptive Use
- NQF 0541: Portion of Days Covered
- NQF 0041: Influenza Immunization (6 months and older)
- NQF 0038: Childhood Immunization Status
- Dental Sealants for Children
- NQF 0034: Colorectal Cancer Screening
- NQF 0031: Breast Cancer Screening
- NQF 1768: Plan All-Cause Readmission
- NQF 0074: Chronic Stable Coronary Artery Disease – Lipid Control
- Screening, Brief Intervention, and Referral to Treatment
- NQF 0569: Adherence to Statins
- USPTF: Cholesterol Abnormalities Screening



Future Updates

The proposed multi-payer quality metrics are being refined with the support of technical assistance.

- Metrics are being evaluated based on several of the following:
 - Data sources
 - Clinical Care Process
 - Evidence based best practices
 - Alignment across populations and payers
 - Integration of the social determinants/primary prevention strategies



Goal:

To move payments to providers from a fee-for-service system to a value-based payment structure

Communities of
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Multi-Payer Episodes of Care

Why is this important?

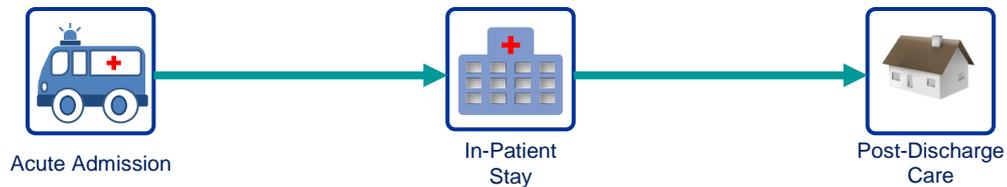
- Episodes have been shown to be effective tools to contain cost and improve quality and outcomes
- These episodes can help providers become accustomed to bearing risk within the delivery of healthcare
- Multi-payer episodes reduce provider burden by focusing the attention of the provider on the patient instead of who the patient's carrier might be

How is this part of the Model?

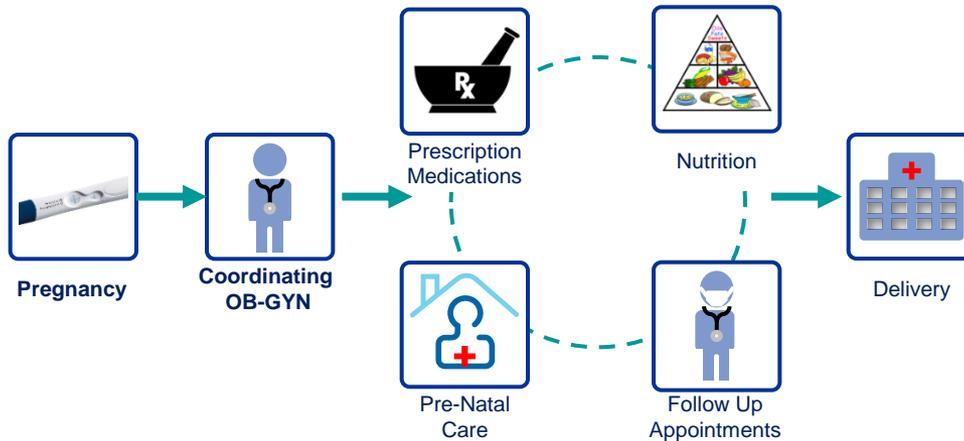
- Participating payers will be asked to make the episodes a requirement to report from all applicable providers they contract with



Episodes of Care – Payment Model Design



Example Episode I

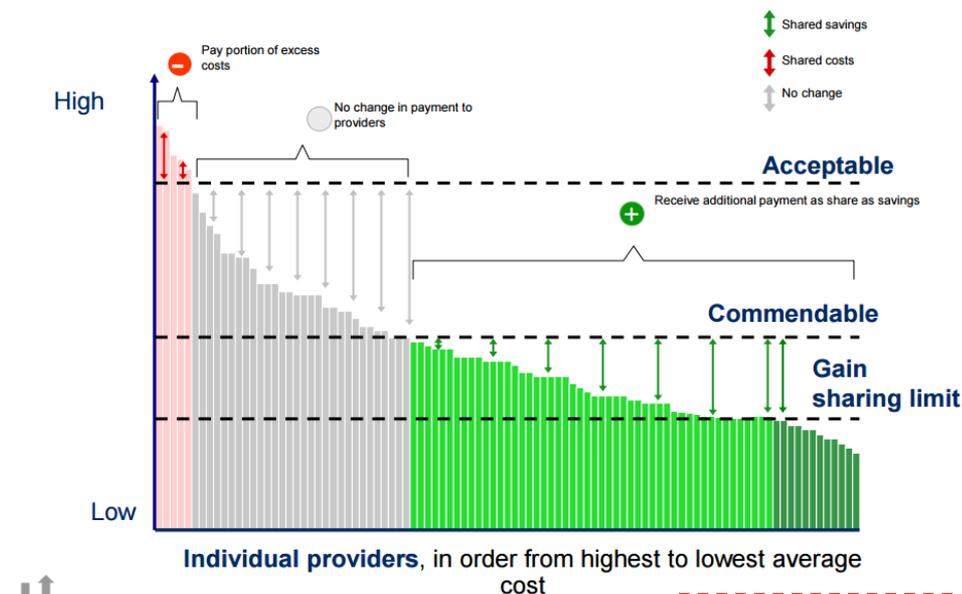


Example Episode II

- Episodes begin with a triggering event
 - E.g. Acute admission to a hospital
 - E.g. Confirmation of pregnancy
- Episode lasts until a pre-determined duration elapses
 - E.g. 60-day postpartum upon completion or termination of pregnancy
- Episodes define which related services and patients will be considered within the episode's performance year
 - E.g. Certain patients with complex conditions may be excluded and non-related services would also be excluded for episode
- PAPs are initially paid on a fee for service basis and then retroactively evaluated against a set benchmark for the average cost of the care delivered per episode

Episodes of Care – Payment Model Design (continued)

PAPs that meet quality standards and have average costs below the commendable threshold will share in savings up to a limit



Source: <http://www.paymentinitiative.org/>

Illustrative

- Each episode for a particular condition has an overall performance year in which all patient episodes for that condition are aggregated and evaluated against benchmarks for cost and/or quality of care
- PAPs that come in under the cost benchmarks receive a percentage of the savings as a bonus, provided they also meet quality benchmarks
- PAPs that exceed the acceptable level of costs may have to pay a portion of the overrun as a penalty
 - Penalties are capped to ensure provider viability

Proposed Episodes of Care

1. Asthma (acute exacerbation)

Overview: Covers care for 30 days following an asthma related trigger (typically an asthma diagnosis on an emergency department or inpatient facility claim). This episode typically covers physician visits, medication, care coordination, and can include hospital readmissions and post-acute care.

2. Perinatal

Overview: The aim of the perinatal episode is ensuring a healthy pregnancy and follow-up care for mother and baby. Perinatal episodes include all pregnancy-related care including: prenatal care, labs, medications, ultrasounds, labor and delivery, and postpartum care. The triggering event for this episode is a live birth and delivery diagnosis code and the episode covers 40 weeks of care prior to the delivery and up to 60 days after delivery.



Proposed Episodes of Care

3. COPD (acute exacerbation)

Overview: Covers care for 30 days following a COPD related trigger (typically a COPD diagnosis on an emergency department or inpatient facility claim). This episode typically covers physician visits, medication, care coordination, and can include hospital readmissions and post-acute care.

4. Total Joint Replacement

Overview: The purpose of a joint replacement (TJR) episode of care is to reduce duplication of services and increased costs through better care coordination. This episode covers 30 days prior to triggering event – total joint replacement – and 90 days postoperatively. This episode typically covers all orthopedic related costs during the episode.

5. Congestive Heart Failure

Overview: Episodic care for congestive heart failure (CHF) is aimed at reducing preventable hospitalizations and improving care coordination. The triggering event for this episode is a hospitalization for congestive heart failure; the episode typically covers the admission day and 30 days after. Episodes include facility services, inpatient services, emergency department visits, observation, and post-acute care; can also cover outpatient services: labs, diagnostics, and medications.



Timeline

