



Division of
**Health Care
Finance & Administration**

Health Care
Innovation Initiative



Executive Summary

Coronary Artery Bypass Graft (CABG) Episode

Corresponds with DBR and Configuration file V1.2

Updated: January 11, 2017

OVERVIEW OF A CORONARY ARTERY BYPASS GRAFT (CABG) EPISODE

The coronary artery bypass graft (CABG) episode revolves around patients who receive a CABG. The trigger event is an inpatient admission or observation, emergency department, outpatient, or office visit with a CABG procedure. If there is a concurrent heart valve replacement or repair procedure within a potential triggering event, the potential trigger is disqualified. All related care – such as anesthesia, imaging and testing, evaluation and management, and medications – is included in the episode. The quarterback, also called the principal accountable provider or PAP, is the facility where the CABG was performed. The CABG episode begins on the day of the triggering procedure and ends 30 days after discharge.

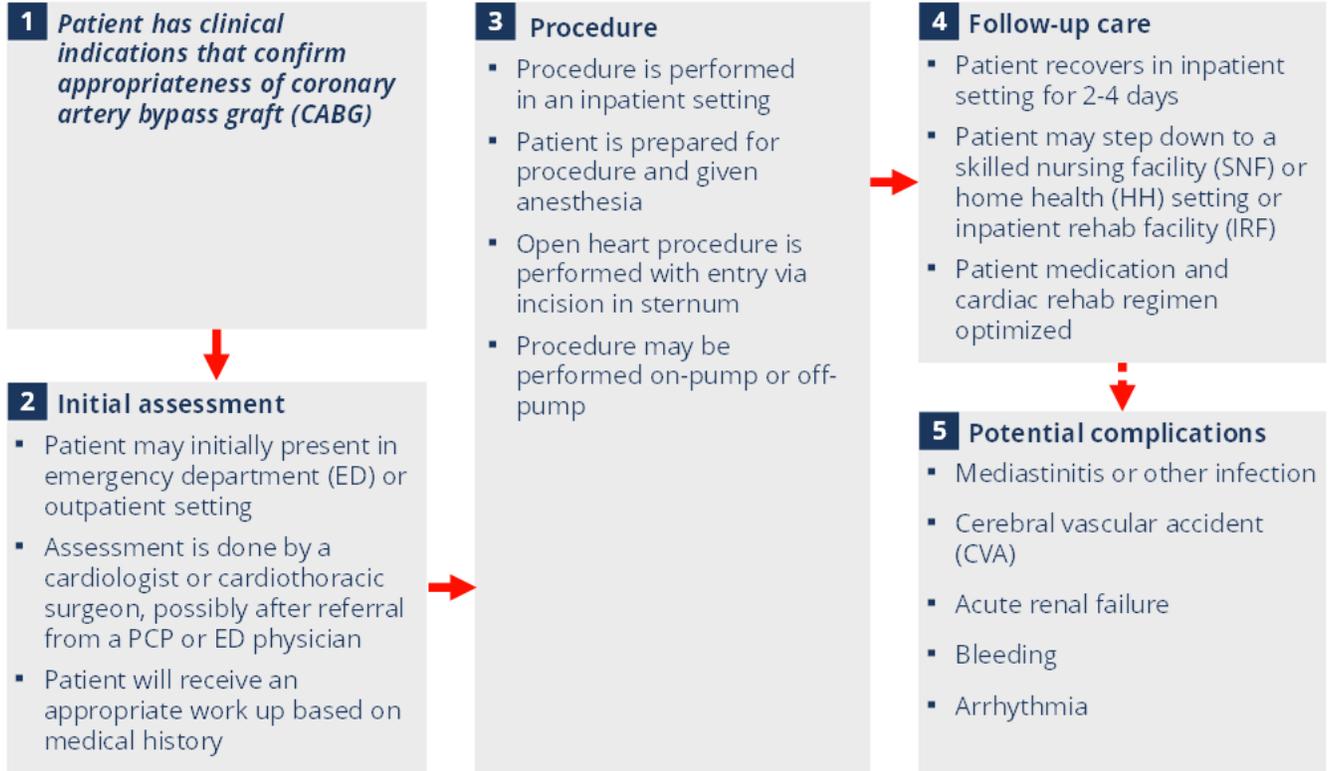
CAPTURING SOURCES OF VALUE

Providers have multiple opportunities during a CABG to improve the quality and cost of care. Example sources of value include increased operative efficiency and selection of the appropriate source of grafts for the patient. In addition to increased operative efficiency, providers can select an appropriate length of stay for the procedure, while also reducing in-hospital complications and infections. Furthermore, providers can choose appropriate post-acute care, efficient follow-up imaging, and appropriate use of medications. Overall, the provider can bring about a reduction in readmissions and complications.

To learn more about the episode's design, please reference the following documents on our website at www.tn.gov/hcfa/topic/episodes-of-care:

- *Detailed Business Requirements: Complete technical description of the episode*
<http://www.tn.gov/assets/entities/hcfa/attachments/CoronaryArteryBypassGraft.pdf>
- *Configuration File: Complete list of codes used to implement the episode*
<http://www.tn.gov/assets/entities/hcfa/attachments/CABG.xlsx>

Illustrative Patient Journey



- Exclusion of episodes when clinical circumstances create the likelihood that the case will deviate substantially from the typical care path or when claims data is likely to be incomplete.
- Risk adjusting episode spend to account for the cost of more complicated patients.

The CABG episode has no pre-trigger window. During the trigger window, all services and all medications are included. The post-trigger window includes specific care after discharge, specific anesthesia, specific evaluation and management visits, specific imaging and testing, specific medications, specific pathology, and specific surgical and medical procedures.

Some exclusions apply to any type of episode, i.e., are not specific to a CABG episode. For example, an episode would be excluded if more than one payer was involved in a single episode of care, if the patient was not continuously insured by the payer during the duration of the episode, or if the patient had a discharge status of 'left against medical advice'. Other examples of exclusion criteria specific to the CABG episode include a patient who has an emergent CABG procedure or who has pre-existing endocarditis on admission. These patients have significantly different clinical courses that the episode does not attempt to risk adjust. Furthermore, there may be some factors with a low prevalence or significance that would make accurate risk adjustment difficult and may be used to exclude patients completely instead of adjusting their costs.

For the purposes of determining a quarterback's cost of each episode of care, the actual reimbursement for the episode will be adjusted to reflect risk factors captured in recent claims data in order to be fair to providers caring for more complicated patients. Examples of patient factors likely to lead to the risk adjustment of CABG episodes include acute ischemia-related admissions, cardiac dysrhythmias, or a history of acute myocardial infarctions. Over time, a payer may adjust risk factors based on new data.

MEASURING QUALITY

The episode reimbursement model is designed to reward providers who deliver cost effective care AND who meet certain quality thresholds. A quarterback must

meet or exceed all established benchmarks for any quality metric tied to gain sharing in order to be eligible to receive monetary rewards from the episode model. Other quality metrics may be tracked and reported for quality improvement purposes but may not be tied directly to gain sharing.

The quality metric linked to gain sharing for the CABG episode is:

- **Follow-up care within the post-trigger window:** Percent of valid episodes where the patient receives relevant follow-up care within the post-trigger window (higher rate indicative of better performance).

The quality metrics that will be tracked and reported to providers but that are not tied to gain sharing are:

- **Participation in a QCDR:** Percent of valid episodes performed by a surgeon participating in a Qualified Clinical Data Registry (e.g., Society of Thoracic Surgeons National Database) (higher rate indicative of better performance).
- **Admission within the post-trigger window:** Percent of valid episodes with an included admission or relevant observation care within the post-trigger window (lower rate indicative of better performance).
- **Major morbidity:** Percent of valid episodes where the patient has a major morbidity within the episode window (lower rate indicative of better performance).
- **Mortality:** Percent of total episodes with patient mortality within the episode window (lower rate indicative of better performance).

It is important to note that quality metrics are calculated by each payer on a per quarterback basis across all of a quarterback's episodes covered by that payer. Failure to meet all quality benchmarks tied to gain sharing will render a quarterback ineligible for gain sharing with that payer for the performance period under review.