Bundled Episode Payment and Gainsharing Demonstration*

Maternity and Women's Health Episode Definitions

	Episode Definitions
1.	Maternity – Delivery Only
2.	Maternity – Pregnancy and Delivery
3.	Hysterectomy

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Bundled Episode Payment and Gainsharing Demonstration*
Delivery Case Rate Definition

Component	Description
Summary Description	This episode definition covers all facility and professional services rendered during a woman's hospitalization for labor and delivery. A single case rate will be paid, regardless of whether delivery is vaginal or C-section.
Episode Structure	Episode begins on date of admission for triggering DRG and ends on hospital discharge date for delivery stay. Includes Postpartum Complications within 60 days of discharge (see below.)
Clinical Conditions (DRGs)	**Episode is triggered by one of the following DRGs:** • MS DRG 765: Cesarean section w CC/MCC • MS DRG 766: Cesarean section w/o CC/MCC • MS DRG 767: Vaginal delivery w sterilization &/or D&C • MS DRG 768: Vaginal delivery w O.R. procedures except sterilization &/or D&C • MS DRG 774: Vaginal delivery w complicating diagnoses • MS DRG 775: Vaginal delivery w/o complicating diagnoses

Standard Services	**Services expected within the episode period (may not be separately billed), include all facility charges for:**
	• Hospital inpatient stay for DRG's above
	• Professional charges during the inpatient stay
	
	Services which, if they occur within the episode period, may not be separately billed:
	• Postpartum Complications within 60 days of discharge:
	  ○ DRG 769 Postpartum Diagnoses with OR procedure
	  ○ DRG 776 Postpartum Diagnoses without OR procedure
	
	Services excluded from Standard Definition, may be separately billed:
	• Outpatient prescription drugs

Patient Qualification	**For inclusion in the pilot, patient must be:**
	• Covered by participating health plan during complete episode period
	• Over age 13 and under age 50
	Patients are excluded from the pilot if:
	• Discharge status is:
	  ○ Left against medical advice
	  ○ Transferred during labor
	• Clinical history demonstrates:
	  ○ Active Cancer
	  ○ AIDS
	  ○ Fetal Surgery
	  ○ Gestational Age Less than 37 weeks
	  ○ Multi-Gestation 3+ (or twins that share one amniotic sac)
	  ○ Multiple Sclerosis
	  ○ Pulmonary Embolism
	  ○ Renal Dialysis
	  ○ Rupture of Uterus
	  ○ Transplant

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<table>
<tr><th>Component</th><th>Description</th></tr>
<tr><td>Payment Mechanism</td><td>Single case rate to be determined based on weighted average blend of C-section rate and vaginal delivery rate. The blend will be set to reflect a reasonable target rate of cesarean sections, such as 25%, which has been achieved by many hospitals today, but which represents a decrease from California’s overall rate of 32%. May be subject to risk adjustment (see subsequent section).</td></tr>
<tr><td>Severity Markers/Risk Adjustment</td><td>No prospective risk adjustment.
Recommend reviewing experience on annual basis for following potential severity markers for population-based risk adjustment vs. risk-adjusting every episode.

<table>
<tr><th>Complications</th></tr>
<tr><td>Anesthetic complications during pregnancy</td></tr>
<tr><td>Hemorrhage in pregnancy</td></tr>
<tr><td>Pregnancy, with shock</td></tr>
</table>

<table>
<tr><th>Comorbidities</th></tr>
<tr><td>Abnormalities of genital tract in pregnancy</td></tr>
<tr><td>Anemia in pregnancy</td></tr>
<tr><td>Asthma</td></tr>
<tr><td>Bipolar disorder</td></tr>
<tr><td>Breech pregnancy</td></tr>
<tr><td>Cerebrovascular disorders of pregnancy</td></tr>
<tr><td>Diabetes (pre-existing)</td></tr>
<tr><td>Drug dependence in pregnancy</td></tr>
<tr><td>Eclampsia</td></tr>
<tr><td>Fetal complication in pregnancy</td></tr>
<tr><td>Gestational diabetes</td></tr>
<tr><td>Heart disease in pregnancy</td></tr>
<tr><td>Hemorrhage in pregnancy</td></tr>
<tr><td>Hypertension</td></tr>
<tr><td>Hypertension in pregnancy</td></tr>
<tr><td>Liver disease in pregnancy</td></tr>
<tr><td>Major depression</td></tr>
<tr><td>Morbid obesity</td></tr>
<tr><td>Other infectious diseases in pregnancy</td></tr>
<tr><td>Pregnancy, with deep vein thrombosis</td></tr>
<tr><td>Pregnancy, with mild preeclampsia</td></tr>
<tr><td>Pregnancy, with severe preeclampsia</td></tr>
<tr><td>Previous C-section</td></tr>
<tr><td>Pyelonephritis</td></tr>
<tr><td>Renal disease in pregnancy</td></tr>
<tr><td>Rheumatologic diagnosis</td></tr>
<tr><td>Schizophrenia</td></tr>
<tr><td>Sickle cell disease</td></tr>
<tr><td>Twins with two amniotic sacs</td></tr>
</table>
</td></tr>
</table>

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Bundled Episode Payment and Gainsharing Demonstration*
Pregnancy and Delivery (Mother only) Definition

Component	Description
Summary Description	This episode definition covers all facility and professional services rendered during a woman's pregnancy, labor and delivery, including care following delivery and services related to complications (including readmissions).
Episode Structure	Episode begins 270 days prior to triggering DRG and ends 60 days after the hospital discharge date for delivery stay.
Clinical Conditions (DRGs)	**Episode is triggered by one of the following DRGs:** • MS DRG 765: Cesarean section w CC/MCC • MS DRG 766: Cesarean section w/o CC/MCC • MS DRG 767: Vaginal delivery w sterilization &/or D&C • MS DRG 768: Vaginal delivery w O.R. procedures except sterilization &/or D&C • MS DRG 774: Vaginal delivery w complicating diagnoses • MS DRG 775: Vaginal delivery w/o complicating diagnoses

Standard Services	**Services expected within the episode period (may not be separately billed), include all professional and facility charges for:**
	• Amniocentesis
	• Antepartum Admission
	• Antepartum Care Only
	• Chorionic Villus Sampling
	• C-section Delivery
	• External Cephalic Version
	• Fetal Test
	• OB Lab
	• OB Ultrasound
	• Postpartum Curettage
	• Removal Cerclage Suture
	• Tocolytic Therapy
	• Tubal Ligation
	• Vaginal Delivery
	
	Services which, if they occur within the episode period, may not be separately billed:
	• Postpartum Complications within 60 days of discharge:
	  ○ DRG 769 Postpartum Diagnoses with OR procedure
	  ○ DRG 776 Postpartum Diagnoses without OR procedure
	
	Services excluded from Standard Definition, may be separately billed:
	• Outpatient prescription drugs

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Component	Description

Patient Qualification	**For inclusion in the pilot, patient must be:**
	• Covered by participating health plan during complete episode period
	• Over age 13 and under age 50
	Patients are excluded from the pilot if:
	• Discharge status is:
	  ○ Left against medical advice
	  ○ Transferred during labor
	• Clinical history demonstrates:
	  ○ Active Cancer
	  ○ AIDS
	  ○ Fetal Surgery
	  ○ Multi-gestation 3+ (or twins that share one amniotic sac)
	  ○ Multiple Sclerosis
	  ○ Pulmonary Embolism
	  ○ Renal Dialysis
	  ○ Rupture of uterus
	  ○ Transplant

Payment Mechanism	TBD

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<tr><th>Component</th><th>Description</th></tr>
<tr><td>Severity Markers/Risk Adjustment</td><td>No prospective risk adjustment.
Recommend reviewing experience on annual basis for following potential severity markers for population-based risk adjustment vs. risk-adjusting every episode.

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<tr><th>Complications</th></tr>
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<tr><td>Pregnancy, with deep vein thrombosis</td></tr>
<tr><td>Pregnancy, with mild preeclampsia</td></tr>
<tr><td>Pregnancy, with severe preeclampsia</td></tr>
<tr><td>Pre-term labor</td></tr>
<tr><td>Previous C-section</td></tr>
<tr><td>Pyelonephritis</td></tr>
<tr><td>Renal disease in pregnancy</td></tr>
<tr><td>Rheumatologic diagnosis</td></tr>
<tr><td>Schizophrenia</td></tr>
<tr><td>Sickle cell disease</td></tr>
<tr><td>Threatened labor</td></tr>
<tr><td>Twins with two amniotic sacs</td></tr>
</table>
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Bundled Episode Payment and Gainsharing Demonstration*
Hysterectomy Definition

Component	Description
Summary Description	This episode definition covers all facility and professional services for an abdominal, vaginal or laparoscopic hysterectomy, including care following the procedure related to complications (including readmissions).
Episode Structure	Episode begins concurrent with the triggering CPT and ends 90 days after the date of procedure or hospital discharge date for the procedure.
Clinical Conditions	**Episode is triggered by one of the following CPT codes:** • Abdominal Hysterectomy: 58150, 58152, 58180 • Vaginal Hysterectomy: 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58290-58294 • Laparoscopic Hysterectomy: 58541-58544, 58550, 58552-58554, 58570-58573

Standard Services	**Services expected within the episode period (may not be separately billed), include all professional and facility charges within 90 days of trigger procedure unless otherwise noted:**
	• Abdominal Hysterectomy
	• Vaginal Hysterectomy
	• Laparoscopic Hysterectomy
	• Cystourethroscopy, Diagnostic
	• Drainage of Ovarian Abscess, Pelvic Abscess
	• Incision and Drainage of Vaginal Hematoma
	• Radiologic Exams and Procedures of Pelvis – CT, MRI, Ultrasound, Plain Films
	• Robotic Assistance (within 1 day of trigger procedure)
	• Transfusion (within 7 days of trigger procedure)
	• Urodynamics
	
	Services which, if they occur within the episode period stated below, may not be separately billed:
	• Admission Complications or Readmissions:
	  ○ Within 7 days of trigger:
	  ▪ GI Obstruction
	  ▪ Major and Minor Small & Large Bowel Procedures
	  ▪ Major GI Disorders and Peritoneal Infections
	  ▪ Peritoneal Adhesiolysis
	  ▪ Other Digestive System OR Procedures
	  ○ Within 30 days of trigger:
	  ▪ Admission for Complications of Gynecological Surgery
	  ▪ Admission for Urinary System Complication
	  ▪ Deep Vein Thrombosis
	  ▪ Post-Operative Infection
	  ○ Within 90 days of trigger:
	  ▪ Vesico Vaginal Fistula
	
	Services excluded from Standard Definition, may be separately billed:
	• Outpatient prescription drugs

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<table>
<tr><th>Component</th><th>Description</th></tr>
<tr><td>Patient Qualification</td><td>For inclusion in the episode, patient must be:
Covered by participating health plan during complete episode period
Over age 18
Not pregnant
Patients are excluded from the episode if:
Discharge status is:
Left against medical advice
Transferred to another facility
Clinical history demonstrates:
Active Cancer (other than Endometrial Cancer)
AIDS
Renal Dialysis</td></tr>
<tr><td>Payment Mechanism</td><td>TBD</td></tr>
<tr><td>Severity Markers/Risk Adjustment</td><td>No prospective risk adjustment.
Recommend reviewing experience on annual basis for following potential severity markers for population-based risk adjustment vs. risk-adjusting every episode.<table><tr><th colspan="2">Comorbidities</th></tr><tr><td>Appendectomy</td><td>Patients with BMI 40 to 49</td></tr><tr><td>Asthma</td><td>Patients with BMI 50 or greater</td></tr><tr><td>Bipolar Disorder</td><td>Pelvic Inflammatory Disease</td></tr><tr><td>BMI 35 to 39.9</td><td>Peripheral Vascular Disease</td></tr><tr><td>Cerebral Vascular Disease</td><td>Personal History of Smoking</td></tr><tr><td>Chronic Renal Failure Moderate To Severe</td><td>Schizophrenia</td></tr><tr><td>Cirrhosis</td><td>Transplant</td></tr><tr><td>Coagulopathy</td><td>Urinary Incontinence</td></tr><tr><td>COPD</td><td>Uterus Greater Than 250 gms</td></tr><tr><td>Coronary Artery Disease</td><td>Uterus Less Than 250 gms</td></tr><tr><td>Cystoscopy</td><td></td></tr><tr><td>Depression</td><td></td></tr><tr><td>Diabetes</td><td></td></tr><tr><td>Drug and Alcohol Abuse</td><td></td></tr><tr><td>End Stage Renal Disease</td><td></td></tr><tr><td>Endometrial Cancer</td><td></td></tr><tr><td>Endometriosis</td><td></td></tr><tr><td>Heart Failure</td><td></td></tr><tr><td>Low BMI</td><td></td></tr><tr><td>Lysis of Adhessions</td><td></td></tr></table></td></tr>
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