TN Division of TennCare

MEMO: 2019 Episode Changes

Date: September 2018 (updated November 1, 2018)
Subject: Update on the Tennessee Health Care Innovation Initiative

This memo discusses the recommendations and corresponding improvements made to the Episodes of Care program in Tennessee for the 2019 performance period.

We greatly appreciate the feedback we have received from stakeholders over the past year, and especially those stakeholders who attended the Annual Episodes Design Feedback Session meetings held on May 22, 2018. The meetings were an opportunity for stakeholders from across Tennessee to comment on what is working well and how to improve the clinical design of the first 27 episodes of care. The meetings were held simultaneously in six cities across Tennessee (Chattanooga, Jackson, Johnson City, Knoxville, Nashville, and Memphis) and connected via videoconference to make it easier for the public to participate. Members of the public were also able to submit their feedback electronically.

This year we are pleased to present substantial changes to address issues that stakeholders have raised for multiple years. One of these changes is a low-volume exclusion for quarterbacks with a minimal number of episodes (see comment "**Create a low-volume exclusion for all episodes**"). Another recommendation that has been accepted for 2019 is an overlapping episode exclusion to only hold a quarterback accountable for one episode if two of their episodes have the same patient and overlapping spend (see comment "**Create overlapping episodes exclusion**"). There will also be a pharmacy spend adjustment in 2019 for preferred medications, in order to ensure that the medications that are preferred on the TennCare Preferred Drug List (PDL) are incentivized in episode spend (see comment "**Adjust pharmacy costs to reflect medication rebates**").

Based on the feedback received, we are making 31 changes to the design of these episodes for calendar year 2019 performance period. These changes will first be reflected in the interim performance reports released in August 2019 that cover the first quarter of the performance period (January – March 2019).

Stakeholder input from Tennessee providers[1], payers, patients, and employers has shaped the design of episodes of care and the other value-based payment strategies that make up Tennessee's Health Care Innovation Initiative. The Initiative has held over a thousand meetings with stakeholders to date and continues to regularly seek stakeholder input. Each episode's design is initially informed by a Technical Advisory Group (TAG) composed of expert clinicians representing a diversity of relevant specialties, provider types, and urban and rural practices from across Tennessee.

The state received approximately one hundred pieces of feedback this year and worked diligently to review all recommendations. The feedback is organized by episode in alphabetical order. Each episode contains two sections: 1) Design Changes Made in Response to Feedback and 2) No Changes to Design. Recommendations within the "Design Changes Made in Response to Feedback" section refers to feedback that has resulted in changes that will be incorporated and reflected in the 2019 Detailed Business Requirements (DBRs) and Configuration Files. Please note that some feedback may be accepted with modifications (where indicated). "No Changes to Design" reflects feedback that was received but did not result in a change for 2019.

For more information about episodes of care in Tennessee, and for all of the episode DBRs and configuration files, go to https://www.tn.gov/tenncare/health-care-innovation/episodes-of-care.html.

[1]Throughout the memorandum, references to "providers" can be substituted with individual providers, provider groups or facilities. The provider, provider group or facility quarterbacks are identified by the Tax ID or Contracting ID.

All Episodes

Design Changes Made in Response to Feedback

Comment: Create a low-volume exclusion for all episodes.

Response – Accepted: Providers recommended that quarterbacks with a low volume of episodes should not be held financially accountable for Episodes of Care. We understand that focusing on the quarterbacks with more episodes will reduce the burden for providers whose primary practice differs from the services covered by the episode or who do not regularly treat TennCare members. Starting in 2019, the state will introduce a low-volume episode exclusion. Quarterbacks with fewer than five valid episodes of a particular episode type (e.g., Perinatal Episode) in a given performance year with a particular Managed Care Organization (MCO) will not be considered for gain or risk sharing by that MCO. Should the provider have five or more valid episodes of the same episode type with another MCO, they will continue to be considered for gain or risk sharing by that MCO.

Please note that low-volume quarterbacks will continue to receive quarterly reports because the quarterback's total number of valid episodes is determined at the end of the performance period.

Comment: Create overlapping episodes exclusion.

Response – Accepted: We received and accepted this feedback last year for the 2018 performance period. The overlapping episodes exclusion is reflected in the 2018 Detailed Business Requirements (DBRs) for the episodes in a performance period during 2018. We are continuing with this exclusion for the 2019 performance period. In the DBRs, we provide detail on the application of the overlapping episodes exclusion to the additional episodes in the 2019 performance period, which are the episodes in waves 1-8.

Providers were concerned that overlapping episodes, i.e. episodes that share some of the same services and treat the same patient within the episode window, may lead to a provider being held accountable twice for the same health care services in some cases. To avoid duplicative accountability, episodes with overlapping included services where the quarterback provider is the same and the patient is the same will be considered "overlapping." The overlapping episodes exclusion will apply to the episodes that are in a performance period. Episodes in a preview period are not considered for the overlapping episode exclusion because they do not affect

financial accountability. One of the overlapping episodes will be excluded based on a predetermined hierarchy (see Table 1 below). The logic is outlined in more detail in the Detailed Business Requirements (DBR) for 2019.

In calendar year 2018, the episodes in a performance period are the episodes in waves 1-6[2]. The hierarchy of episodes used to determine precedence for this exclusion for 2018 is shown in Table 1.

Table 1 – Episode Hierarchy by Exclusion Condition for 2018 Performance Period

Episodes in 2018 Performance Period	Rank
Perinatal	1
HIV	2
Valve Repair and Replacement	3
Coronary Artery Bypass Graft (CABG)	4
Total Joint Replacement (Hip & Knee)	5
Non-acute Percutaneous Coronary Intervention (PCI)	6
Acute Percutaneous Coronary Intervention (PCI)	7
Bariatric surgery	8
Outpatient and Non-Acute Inpatient Cholecystectomy	9
Tonsillectomy	10
Breast biopsy	11
Screening and Surveillance Colonoscopy	12
Upper GI Endoscopy (Esophagogastroduodenoscopy (EGD))	13
Oppositional Defiant Disorder (ODD)	14
Attention Deficit and Hyperactivity Disorder (ADHD)	15
Pancreatitis	16
Congestive Heart Failure (CHF) Acute Exacerbation	17
Diabetes Acute Exacerbation	18
Urinary Tract Infection (UTI) – Inpatient	19
Gastrointestinal Hemorrhage (GIH)	20
Chronic Obstructive Pulmonary Disease (COPD) Acute Exacerbation	21
Pneumonia (PNA)	22
Asthma Acute Exacerbation	23
Skin and Soft Tissue Infection	24
Otitis media	25
Urinary Tract Infection (UTI) – Outpatient	26
Respiratory infection	27

[2] https://www.tn.gov/tenncare/health-care-innovation/episodes-of-care/episodes-by-wave.html

Similarly, in calendar year 2019 all of the episodes in a performance period will be considered for the overlapping episodes exclusion (these are waves 1-8 episodes) The hierarchy of episodes used to determine precedence for this exclusion is shown in Table 2.

Table 2 – Episode Hierarchy by Exclusion Condition for 2019 Performance Period

Episodes in 2019 Performance Period	Rank
Perinatal	1
HIV	2
Valve Repair and Replacement	3
Coronary Artery Bypass Graft (CABG)	4
Spinal Fusion	5
Total Joint Replacement (Hip & Knee)	6
Femur/pelvic fracture	7
Non-acute Percutaneous Coronary Intervention (PCI)	8
Acute Percutaneous Coronary Intervention (PCI)	9
Bariatric surgery	10
Spinal decompression (without spinal fusion)	11
Hysterectomy	12
Outpatient and Non-Acute Inpatient Cholecystectomy	13
Appendectomy	14
Hernia Repair	15
Knee Arthroscopy	16
Tonsillectomy	17
Breast biopsy	18
Screening and Surveillance Colonoscopy	19
Upper GI Endoscopy (Esophagogastroduodenoscopy (EGD))	20
Colposcopy	21
Oppositional Defiant Disorder (ODD)	22
Attention Deficit and Hyperactivity Disorder (ADHD)	23
Gastrointestinal (GI) Obstruction	24
Pancreatitis	25
Congestive Heart Failure (CHF) Acute Exacerbation	26
Diabetes Acute Exacerbation	27
Urinary Tract Infection (UTI) – Inpatient	28
Gastrointestinal Hemorrhage (GIH)	29
Chronic Obstructive Pulmonary Disease (COPD) Acute Exacerbation	30
Acute Seizure	31
Pneumonia (PNA)	32

Bronchiolitis	33
Pediatric Pneumonia	34
Asthma Acute Exacerbation	35
Acute Gastroenteritis	36
Back / Neck pain	37
Syncope	38
Shoulder non-operative injuries	39
Knee non-operative injuries	40
Ankle non-operative injuries	41
Wrist non-operative injuries	42
Skin and Soft Tissue Infection	43
Otitis media	44
Urinary Tract Infection (UTI) – Outpatient	45
Respiratory infection	46

Comment: Adjust pharmacy costs to reflect medication rebates.

Response – Accepted, with modifications: The cost of preferred medications that is included in the episode will be adjusted to reflect more accurately the medication costs incurred by TennCare. There can be a substantial difference between the list price of a preferred brand or preferred generic medication on TennCare's Preferred Drug List (PDL) and the price that the state pays after rebates. Federal policies prevent Medicaid agencies from disclosing the post-rebate price of medications.

Therefore, the episodes will use a proxy for the post-rebate price. If a pharmacy claim contains a medication that is a preferred brand or preferred generic medication as identified on the TennCare PDL, the included spend of that medication for episodes will be set at $10. This adjustment will be made at the national drug code (NDC) level. If a pharmacy claim contains a medication that is not listed as a preferred brand or preferred generic medication on the PDL, there will be no adjustment to the pharmaceutical manufacturer's published price of that medication in episodes.

Please note that the adjusted pharmacy cost which will be shown on episode reports will be a proxy and not the exact cost to the state of pharmaceuticals in the episode.

The PDL is available on https://tenncare.magellanhealth.com/static/docs/Preferred_Drug_List_and_Drug_Criteria/TennCare_PDL.pdf.

Comment: Add CPT code 99024 for post-surgical follow-up to the "Follow-up care within the post-trigger window" quality metric definition.
Response – Accepted: To ensure this quality metric was capturing all post-surgical follow-up care, CPT code 99024 was added for the 2018 performance period to the quality metric definition of the Bariatric Surgery, CABG and Valve Repair and Replacement episodes. This CPT code is a zero amount, global spend code.

No Changes to Design

Comment: Make payment thresholds the same across MCOs.
Response – Not Accepted: Two types of episode spend thresholds are applicable in the Episodes of Care program: acceptable and commendable thresholds.

- *The commendable threshold*: If a quarterback achieves an average risk-adjusted episode spend for the performance period that is less than the commendable threshold and the quarterback's performance on quality metrics linked to gain sharing exceeds those quality metric thresholds, that provider is eligible to receive a gain sharing reward payment.

- *The acceptable threshold*: If a quarterback's average risk adjusted episode spend for the performance period is greater than the acceptable threshold, the quarterback is responsible for a risk sharing payment equal to half of the excess spend above the threshold.

More information can be found in the following document https://www.tn.gov/content/dam/tn/tenncare/documents2/EpisodesThresholds2018.pdf. The acceptable threshold, used to assess risk sharing payments, is determined by the state and is the same across TennCare Managed Care Organizations (MCOs) for a particular episode type. This was a design change early in the implementation of episodes to respond to providers who were particularly concerned about MCOs setting the acceptable threshold because it is used to calculate risk sharing.

The commendable threshold, used to calculate gain sharing payments, is set by each MCO individually, but each MCO uses the same method: the most recent previous year's data is used to model the thresholds so that there is a balance of risk sharing and gain sharing incentives at the MCO level.

TennCare MCOs are fully at risk for the payments they make to providers, including episode gain sharing payments. There are differences between MCO's cost structures. One MCO may have a lower average spend for a certain episode and a higher average spend for another episode compared to the other MCOs.

We believe that the current compromise approach responds to stakeholder's concerns about the acceptable threshold without leading to outcomes where some MCOs are paying out much more gain sharing payments than others. Therefore, the current approach will remain in place.

Comment: Display greater level of detail on medication costs.
Response – Not Accepted: Several providers requested additional transparency on medication-level costs in reports to facilitate management of their episode performance. We believe that this concern from providers will be eased by adjusting pharmacy costs to reflect medication rebates as discussed above (see comment "**Adjust pharmacy costs to reflect medication rebates**"), so an additional change to the reports is not needed.

Comment: Exclude patients who are incurring costs out of state in episodes.
Response – Not Accepted: Some providers expressed concern about episodes that involve care for patients out of the state due to the higher expected costs. They proposed excluding such episodes. The state will continue to keep such episodes in the program because:

- Many such episodes involve physicians in the states adjacent to Tennessee. Given the MCOs' network arrangements that include providers in neighboring states where utilization patterns indicate the need, the episodes with incurred spend with these out-of-state in-network providers should not be treated differently than other in-network providers.

- MCOs may additionally have access to national networks that extend beyond providers in the communities immediately adjacent to Tennessee state boundaries.

Comment: Providers do not have control over the lab spend.
Response – Not Accepted: Providers are encouraged to discuss individual cases with the MCOs and ensure they are utilizing the in-network lab for each MCO, in addition to appropriately manage laboratory testing utilization.

Comment: Risk adjustment does not take into account complexity of patients. Providers cannot indicate multiple diagnoses/conditions as primary even though they could be equally important.
Response – Not Accepted: Every provider reports diagnoses with a single primary diagnosis. The stakeholders concern is not specific to episodes or to TennCare. Instead the provider's concern relates to national and international standards for recording and reporting diagnoses. There are many examples of value based payments program with risk adjustment based on the standard reporting of risk adjustment.

In fact, risk adjustment for episodes in Tennessee takes into account diagnosis codes whether they are in the primary or secondary position on the claim form.

Comment: Doctors cannot predict the development of complications and should not be penalized for increased costs associated with complications that develop in an episode.
Response – Not Accepted: While all providers will have episodes that include a complication, providers have the ability to prevent the development of some complications through high quality, evidence-based care. Preventing avoidable complications is a key source of value in all episodes. Episodes use risk adjustment, exclusions, and other design elements to adjust for patient variation that could lead to complications and other drivers of high cost care. Therefore, complications will continue to be included in the episode spend.

Comment: Extend appeals period to a minimum of 60 days.
Response – Not Accepted: The current appeals (reconsideration) periods will be maintained. The reconsideration periods range from 20 business days to 60 days. Although the state has worked with payers to create alignment in episodes to a much greater degree than other interactions between providers and the MCOs, the length of reconsideration periods is specified in MCOs' payment appeals processes and we do not see the need for alignment. Providers are encouraged to communicate with MCOs throughout the performance period in the event of any questions or concerns.

Acute diabetes exacerbation

Design Changes Made in Response to Feedback

Comment: Education visits from Certified Diabetes Educators (CDEs) should be included in "follow-up care" quality metric.
Response – Accepted: To account for diabetes management education comprehensively, including care delivered by non-physicians, the following HCPCS/CPT codes will be added to the "Follow-up care" quality metric definition:

- S9460 Diabetic management program, nurse visit
- S9465 Diabetic management program, dietitian visit
- S9141 Diabetic management program, follow-up visit to MD provider
- S9140 Diabetic management program, follow-up visit to non-MD provider
- S9145 Insulin pump initiation, instruction in initial use of pump (pump not included)
- S9455 Diabetic management program, group session
- G0108 Diabetes outpatient self-management training services, individual, per 30 minutes
- G0109 Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes
- 97802 Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes
- 97803 Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes
- 97804 Medical nutrition therapy; group (2 or more individual(s)), each 30 minutes

Comment: Make new-onset, or newly-diagnosed, diabetes a new risk factor, which would appropriately adjust the diabetes acute exacerbation episode.
Response – Accepted: New onset and/or newly diagnosed diabetes will be tested in the risk adjustment model.

No Changes to Design

Comment: Patients with Type 1 and Type 2 diabetes represent differing patient journeys, and should be treated in separate episodes. In addition, pediatric patients represent a different patient journey, in particular pediatric patients with Type 2 diabetes, and should be assessed separately.
Response – Not Accepted: Risk adjusted spend and resource utilization are not meaningfully different for Type 1 vs Type 2 diabetes episodes, as discussed in detail with the Technical Advisory Group (TAG) during episode design. In addition, the episodes risk adjust for patient age. Providers are therefore not disadvantaged by the inclusion of patients of different ages and with Type 1 vs Type 2 diabetes. All of these patient types will continue to be included in the episode.

Type 2 diabetes and age flags will be tested, or retested, as risk factors in the risk adjustment models to ensure continued fair assessment of quarterback performance.

Attention Deficit and Hyperactivity Disorder (ADHD)

Design Changes Made in Response to Feedback

Comment: Patients under six years old should not receive long acting stimulants.
Response – Accepted: The "long-acting stimulants for members aged 4 and 5" gain sharing quality metric is designed to measure the percentage of valid episodes where long-acting stimulants are prescribed for children under age six when a stimulant medication is prescribed. While there are benefits to long-lasting stimulants particularly among school-children with ADHD, there are concerns about the side effects on preschoolers' growth and development rates. Due to mixed guidance on prescribing long-acting stimulants for children under age six, this metric will be removed.

The long acting stimulants quality metric was created because some stakeholders were concerned that the higher cost of long-acting stimulants would cause providers to inappropriately use short-acting stimulants. With the adjustment of preferred pharmacy costs to $10 (see comment "**Adjust pharmacy costs to reflect medication rebates**"); this concern has been addressed in a different way.

Comment: Keep the Level I Case management exclusion.
Response – Accepted: The intent of the Level I Case Management temporary clinical exclusion was to give providers an additional year to improve their coding to more accurately capture clinical exclusions and risk factors. Improved coding will allow higher risk patients to be excluded based on a diagnosis (e.g. bipolar disorder) rather than the treatment. However, while Level I Case Management will not be made a permanent exclusion, the episode will continue to have a Level I Case Management clinical exclusion for ADHD in performance year 2019. It will be revisited for performance period 2020.

No Changes to Design

Comment: Create low-volume cutoff for sub-population quality measures.
Response – Not Accepted: A recommendation was made to establish a minimum volume threshold for sub-population metrics to minimize the impact of random statistical variation on quarterbacks' performance for providers with low sub-population volumes. Analysis suggests that variation in size by age bracket is already reduced through the implementation of the low volume exclusion (See comment "**Create a low-volume exclusion for all episodes**"). Additionally, the "long-acting stimulant for members aged 4 and 5" metric, which shows the most significant volume volatility of the sub-population quality metrics, will be removed (see comment "**Patients under six years old should not receive long acting stimulants**"). Therefore, a low-volume cut-off will not be introduced for subpopulation quality metrics.

Comment: Treat CMHC quarterbacks separately from non-CMHC quarterbacks.
Response – Not Accepted: Community Mental Health Centers (CMHCs) typically focus on a predominantly Medicaid population, and some stakeholders deemed these providers to have unique characteristics requiring separate treatment in episodes. Analysis indicates that the average episode spend of CMHC quarterbacks is not consistently higher than that of non-CMHC quarterbacks. Furthermore, both CMHC and non-CMHC quarterbacks were found to be amongst high performers; similarly, both provider types were found among low performers.

Additionally, significant differences between patient populations are addressed by risk adjustment and exclusions.

Comment: Clarify rationale for a five visit minimum care requirement. It might not be necessary for patients with well-controlled ADHD.
Response – Not Accepted: Some providers expressed a concern that an ADHD patient may not require five physician visits to control their condition effectively. However, the visits that define the relevant quality metric are defined in the DBR as "five visits or pharmacy claims that are included in episode spend. These may be a combination of Level I Case Management visits included in episode spend, E&M and medication management visits included in episode spend, therapy visits included in episode spend, and pharmacy claims for the treatment of ADHD included in episode spend." The Technical Advisory Group (TAG) also agreed that this level of care was appropriate for ADHD patients. Given the broad definition of minimum care, the state will continue to include this quality metric in the episode assessment.

Bariatric Surgery

No Changes to Design

Comment: Change the quarterback from the physician or the physician group to the facility.
Response – Not Accepted: The Technical Advisory Group (TAG) recommended the physician or physician group to be the quarterback for the Bariatric episode. The physician group is in the best position to influence the cost and quality of a bariatric episode, and also generally advises the patient on which facility the surgery should be performed. For this reason, in elective procedural episodes created to date, the physician performing the procedure has typically been assigned as the quarterback. The Bariatric episode will continue to have the physician or physician group as the quarterback.

Colonoscopy (Screening and Surveillance)

Design Changes Made in Response to Feedback

Comment: Remove Lisinopril from included spend.
Response – Accepted: There is a concern that this medication is not closely related to the management of the colonoscopy procedure. The state will remove this medication from episode spend. Additionally, medication related to the cardiovascular system (e.g. antihypertensives) will also be removed from episode spend because it is not related to the colonoscopy episode.

HIV

No Changes to Design

Comment: Split at least one of the quality metrics into separate categories by race.
Response – Not Accepted: While the state appreciates that academic literature comparing subpopulation measures in the HIV pathway exist, we have not pursued such measures based on specific demographic sub-populations.

Oppositional Defiant Disorder (ODD)

No Changes to Design

Comment: Treat CMHC quarterbacks separately from non-CMHC quarterbacks.
Response – Not Accepted: Community Mental Health Centers (CMHCs) typically focus on a predominantly Medicaid population, and some stakeholders claimed these providers have unique characteristics requiring different treatment within the Episodes program. State analysis indicates that CMHC quarterbacks have a comparable (slightly lower) episode average spend than non-CMHC quarterbacks.

Additionally, significant differences between patient populations are addressed by risk adjustment and exclusions. The state welcomes further feedback on refining the risk adjustment model and the list of exclusions.

Otitis Media

Design Changes Made in Response to Feedback

Comment: Account for patients with tympanostomy tube insertion during the episode.
Response – Accepted: In CY 2016 TennCare data, only a small percentage of valid episodes include tympanostomy. The spend associated with a tympanostomy will be removed due to the higher cost of such episodes, which is not a result of variation in the efficiency of providers.

Comment: Include the following criteria in total cost: total number of Acute Otitis Media (AOMs) per year, hospital visits (ED and inpatient), and tympanostomies.
Response – Accepted, with modifications: To reflect potentially increased complexity associated with recurrent otitis media, previous episodes of otitis media are included as risk factors:

- Otitis media in the 6 months before episode window, and
- Recurrent acute otitis media, three episodes in six months or four episodes in one year.

The design of the otitis media episode reflects key elements including relevant ED visits during the trigger and post-trigger windows, and relevant inpatient spend in the post-trigger window. Relevance is established by the presence of appropriate diagnoses on inpatient and ED claims. The intent of the post-trigger spend inclusion is to capture care for and complications of the initial condition that triggered the episode that the quarterback is in a position to influence by providing high-value care.

The inclusion of tympanostomies was addressed above (see comment "**Account for patients with tympanostomy tube insertion during the episode**").

No Changes to Design

Comment: Link non-Otitis Media Effusion (non-OME) episodes without macrolides filled to gain sharing.
Response – Not Accepted: The state will keep the "non-OME episodes without macrolides filled" as an information only metric because a limited number of providers have a score on this metric. In addition, variation by quarterbacks in performance on this metric may be in some cases clinically indicated.

Comment: Remove the criteria for prescribing amoxicillin.
Response – Not Accepted: The provider concern was many patients with OME do not develop infections, and non-OME patients could have had previous treatment failures with amoxicillin. The quality metric related to the prescribing of amoxicillin is "Non-OME episodes with amoxicillin filled". The state will not remove this quality metric because:

- This metric is limited to non-OME episodes, addressing the concern about patients with OME who do not develop infections, and
- Patients may have had previous treatment failures with amoxicillin, patients who have had a pharmacy claim for amoxicillin in the 30 days before the episode start date are excluded from the evaluation of the quality metric.

Perinatal

Design Changes Made in Response to Feedback

Comment: Exclude patients who had a previous C-section from the C-section quality metric.
Response – Accepted, with modifications: The state will add an informational quality metric of primary C-section rate that excludes previous C-sections from the denominator.

The state is keeping the C-section rate gain sharing quality metric that includes previous C-sections. While it may in some cases be clinically indicated to perform a

C-section for patients with a history of C-section, a vaginal birth may be possible for many women after a prior C-section[3].

An informational quality metric will be added for additional transparency; it will measure the C-section rates amongst patients without a previous C-section ("Primary C-section"), using the following codes to define patients with a history of C-section:

- O34.211 Low Transverse Scar from previous C-section
- O34.212 Vertical scar from previous C-section
- O34.29 Uterine Scar from other previous surgery.

The state will monitor performance on this quality metric, including the comparison to the gain sharing quality metric, which will not exclude patients with a previous C-section.

Comment: Exclude patients who deliver prior to 35 weeks from the Group B streptococcus screening quality metric, or update the Group B streptococcus screening quality metric to capture births that occurred before 35 weeks.
Response – Accepted: Stakeholders were concerned that patients who deliver earlier than 35 weeks are less likely to receive a Group B streptococcus screening since the test is not as accurate earlier in the pregnancy. The concern was that the outcome of the quality metric may be impacted by the presence of more deliveries before 35 weeks in the quarterback's patient population. The numerator and denominator of this quality metric will be adjusted to exclude episodes with a delivery before 35 weeks, as indicated by the appropriate diagnosis code on the trigger delivery claim (e.g., Z3A32, 32 weeks gestation of pregnancy).

Comment: Exclude genetic testing from episode spend.
Response – Accepted, with modifications: There was concern about the high cost of genetic testing, as quarterbacks may be incentivized to withhold this testing inappropriately. However, in the CY2016 TennCare data, quarterbacks' comparative performance is not strongly correlated with genetic testing rate, and removal of genetic testing spend is estimated to have very limited impact on risk-adjusted episode spend across quarterbacks. There is significant variability in genetic testing rates among quarterbacks, and both high- and low-performing providers see high

[3] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3624716/

rates of genetic testing. Similarly, both high- and low-performing providers see low rates of genetic testing. Therefore, genetic testing will not be excluded from episode spend as it is a source of value.

However, genetic testing utilization will be added as an informational quality metric to create additional transparency around quarterback performance. This quality metric will track the utilization of fetal chromosomal aneuploidy analysis[4] among patients 35 years or older.

Additionally, to account further for clinically appropriate genetic testing, additional risk factors will be tested in the risk model, including the following conditions recorded in the claims data:

- Family history of mental retardation or autism,
- Family history of congenital malformations and chromosomal abnormalities,
- Peripheral neuropathy, unexplained myopathy, progressive ataxia, early onset dementia, or a familial movement disorder, or other progressive neurologic condition known to be genetically determined,
- Abnormal findings on antenatal screening of mother,
- Maternal care for known or suspected fetal abnormality and damage by radiation,
- Personal history of pregnancy complications, and
- Pregnancy complicated by alcohol use, drug use, and/or smoking.

Comment: Remove all spend related to Maternal Fetal Medicine (MFM) specialists from the episode.

Response – Accepted, with modifications: Maternal Fetal Medicine (MFM) services are frequently included in perinatal episodes. Additionally, quarterbacks' comparative performance is not strongly correlated with MFM referral rate. The state will continue to include MFM services in the episode spend as it is a source of value.

[4] CPT 81420: Fetal chromosomal aneuploidy (eg, trisomy 21, monosomy X) genomic sequence analysis panel, circulating cell-free fetal DNA in maternal blood, must include analysis of chromosomes 13, 18, and 21.

However, MFM services utilization for episodes with diabetes will be added as an informational quality metric to create additional transparency around quarterback performance.

Additionally, to account further for clinically appropriate MFM services utilization, additional risk factors will be tested in the risk model, including the following conditions recorded in the claims data:

- Obstetric complications:
    - Meconium complications
    - Malpresentation and malposition
    - Shoulder dystocia
    - Abnormal third stage of labor
    - Pre-existing hypertension with pre-eclampsia
    - Postpartum hemorrhage
    - Amniotic fluid embolism
- Maternal complications:
    - Arrhythmias
    - Valve disease
    - Pulmonary hypertension
    - Acute myocardial infarction
    - Pulmonary edema
    - Respiratory tuberculosis
    - Hypoparathyroidism
    - Hyperparathyroidism and other disorders of parathyroid gland
    - Benign neoplasm of other and unspecified endocrine glands
    - Hyperemesis gravidarum
    - Eating disorders
    - Intrahepatic cholestasis
    - Inflammatory bowel disease (ulcerative colitis; Crohn's disease)
    - Maternal anemia and hemoglobinopathies
    - Thrombotic thrombocytopenia purpura/hemolytic uremic syndrome
    - Renal disease
        - Acute nephritic syndrome
        - Chronic nephritic syndrome
        - Unspecified nephritic syndrome
        - Glomerular disorders in diseases classified elsewhere

        - Acute kidney failure
        - Chronic kidney disease (CKD)
        - Unspecified kidney failure
        - Calculus of kidney and ureter
        - Calculus of lower urinary tract
        - Calculus of urinary tract in diseases classified elsewhere
        - Disorders resulting from impaired renal tubular function
        - Unspecified contracted kidney
        - Small kidney of unknown cause
        - Other disorders of kidney and ureter, not elsewhere classified
        - Other disorders of kidney and ureter in diseases classified elsewhere
    - AV malformation/berry aneurysm
    - Myasthenia gravis
    - Spinal cord injury
    - Diabetes insipidus
    - Domestic violence
    - Systemic lupus erythematosus
    - Rheumatoid arthritis
    - Other autoimmune disease
    - Venous thromboembolism and anticoagulation
    - Inherited thrombophilia
    - Viral hepatitis infection
    - Syphilis
    - Maternal skeletal dysplasia
    - Dermatoses
- Gynecologic issues related to pregnancy:
    - Adnexal mass

Comment: Exclude episodes with no or minimal prenatal care.

Response – Accepted: The concern amongst providers was that episodes with no or limited prenatal care may result in higher complication rates and therefore higher costs. Based on the state's analysis, on average, episodes where the patient seeks care late in the pregnancy, or only at delivery, have lower risk adjusted episode spend than other episodes.

The state will accept the recommendation to exclude episodes with no prenatal care (defined as no attributable medical spend in the pre-trigger window). Although most providers with these types of episodes are not being negatively impacted, this exclusion will prevent any provider from being negatively impacted from a high cost, no prenatal care episode.

In addition, the state will restrict the GBS screening quality metric to episodes where the gestational age of the baby is above 34 weeks in order to fairly account for instances where the provider is unable to perform appropriate GBS screening due to the patient seeking care too late (see comment "**Exclude patients who deliver prior to 35 weeks from the Group B streptococcus screening quality metric, or update the Group B streptococcus screening quality metric to capture births that occurred before 35 weeks**").

Comment: Exclude patients with opioid use disorder.
Response – Accepted, with modifications: The state will not exclude patients with opioid use from the episode as the care for these patients is a source of value.

Additionally, in the CY2016 TennCare data, quarterbacks' comparative performance is not strongly correlated with opioid use rate, and exclusion of episodes with opioid use will have limited impact on risk-adjusted episode spend.

The original broad substance abuse risk factor will be split into two risk factors to improve the performance of the risk adjustment model:

- Opioid use will be tested as a risk factor in the risk adjustment models, separate from other substance abuse, and
- Other substance abuse (e.g., alcohol abuse) will remain as a risk factor to be tested.

Comment: Account for impact of facility fee on perinatal episode spend.
Response – Accepted: The provider concern was around provider's ability to control facility spend in the case of delivering at a high-cost, isolated facility. In Tennessee it is rare for a provider to deliver at an especially high cost facility where there is not another lower cost facility nearby. This is because the highest cost facilities tend to be in urban areas where there are more reasonable alternatives nearby.

Providers who believe that they have a risk sharing payment that is due to the high cost of where they are delivering may contact their MCO to ask for reconsideration. This new level of reconsideration is targeted to provide an opportunity for relief for perinatal providers with a risk sharing payment on their final performance report that is due to high inpatient facility negotiated rates.

MCOs will handle reconsideration requests on a case-by-case basis to determine the extent that the high cost inpatient facility spend is contributing to a risk sharing payment[5]. If part of a risk sharing payment is due to another category of care then the provider will remain responsible for that part of the risk sharing payment.

This reconsideration process for high-cost, isolated inpatient facility spend is limited to the perinatal episode. In all other episodes, the provider is either a facility (and therefore directly responsible for facility rates) or else the episodes is a non-emergent type and the physician has the opportunity to send patients to lower-cost facilities.

Comment: Exclude unrelated spend and spend on the baby e.g., spend before pregnancy, NICU and other neonatal charges.
Response – Accepted: Only spend with pregnancy-related diagnoses is included in current episode design. NICU spend is excluded from episode spend by each MCO.

Comment: HIV and GBS testing rates are not always captured correctly.
Response – Accepted: The providers have the opportunity to code for HIV and Group B Strep (GBS) testing rates using a variety of codes including Category II codes, which can be used to report testing not tied to reimbursement.

Comment: There is a need to educate patients as sometimes they use high-cost services without the quarterback's input. Some have been incurring inpatient costs before visiting the quarterback.
Response – Accepted: We agree that patient education is a source of value in the episode and are supportive of providers' efforts in this domain. Every provider will have some patients who don't listen to their advice. However some providers are better than others at using various methods of communication to increase the likelihood that their patients will use appropriate services. These providers should be rewarded with shared savings to recognize their effective approaches.

[5] See page 32 for additional guidance on the reconsideration process for inpatient facility spend.

Comment: Exclude fetal abnormality diagnoses

Response – Accepted: The MCOs exclude specific in-utero procedures from episode spend, for example in-utero fetal shunt placement, given the cost of such procedures.

Comment: Gross outliers for medical tests, and questionable diagnoses and services, should be explored.

Response – Accepted: The state agrees that providers should seek to understand patterns of overutilization of testing. To this end, the state is adding an additional quality metric in the perinatal episode, "Genetic testing utilization", given the potential cost of genetic testing.

Also note that there are multiple mechanisms to ensure fairness in the episode, including risk adjustment and exclusions. An episode is excluded if the risk-adjusted episode spend is greater than the high outlier threshold. The high outlier threshold is set at three standard deviations above the average risk-adjusted episode spend for valid episodes. Should a provider consider the data on their episode spend inaccurate, the state invites them to proceed via the standard reconsideration process.

No Changes to Design

Comment: Remove GBS and HIV screening metrics as quarterbacks are already performing well.

Response – Not Accepted: GBS and HIV screening will remain as gain sharing quality metrics given performance variation across providers. Two refinements will be made to these quality metrics:

- To ensure providers have sufficient time to intervene, patients who deliver earlier than 35 weeks will be excluded from the quality metric "GBS screening" (see comment "**Exclude patients who deliver prior to 35 weeks from the Group B streptococcus screening quality metric, or update the Group B streptococcus screening quality metric to capture births that occurred before 35 weeks**").
- To ensure quality metric "HIV screening rate" is capturing all relevant HIV screening, the CPT code 87906 and the HCPCS code G0475 will be added to the definition of the quality metric.

Comment: Exclude patients who have not been under the care of the quarterback physician for the entire episode.

Response – Not Accepted: Concern was expressed about the ability of providers to control episode costs before they become involved with the care for the patient. The state will continue to include episodes where the patient was not under the care of the provider throughout the duration of the pregnancy for the following reasons:

- One of the objectives of Episodes of Care is to incentivize better coordination and continuity of care across all providers involved in the patient journey. It is a source of value for quarterbacks to seek early intervention in the patient journey and maintain good continuity of care.
- In CY 2016 TennCare data, risk-adjusted episode spend is not strongly correlated with limited quarterback involvement. Quarterbacks whose episodes include more care provided by other providers and quarterbacks with higher rates of late involvement in patient care do not have higher risk-adjusted episode spend compared to their peers on average.
- Episodes with no medical pre-natal care will be excluded (see comment "**Exclude episodes with no or minimal prenatal care**").

Comment: Remove Emergency Department (ED) spend from episode as provider does not have control over patients visiting ED.

Response – Not Accepted: The episode will continue to include related ED spend since ED visits are a key source of value in the episode, and can in many cases be prevented by effective care management, care coordination and patient education.

Comment: Remove accountability for duplicative tests ordered by hospitals.

Response – Not Accepted: The episode will continue to include all relevant testing, including duplicative testing, as the quarterback has accountability for all related care and duplicative testing is a source of value that can be reduced by effective care coordination between providers.

Comment: Change pre-trigger window.

Response – Not Accepted: The provider concern is that the pre-trigger window is 280 days, while many pregnant women are pregnant for a shorter period time, which is taken to mean that part of the spend incurred before the patient is

pregnant. However, claims included in spend in the pre-trigger window must have a diagnosis of pregnancy. Should providers encounter individual cases that do not adhere to this rule, they should contact their Managed Care Organization (MCO) representative as part of the reconsideration process.

Comment: Add neonatal and maternal mortality quality metric

Response – Not Accepted: We support the idea of closely tracking mortality in maternal and neonatal care. However, the state believes that the episode construct is not the most effective mechanism for tracking these metrics. The Department of Health tracks maternal mortality, which is a more thorough approach and a better way to consider this rare but very important occurrence.

Comment: Refine risk adjustment, such as adding risk factors for lack of prenatal care, previous number of children, etc.

Response – Not Accepted: The state is supportive of refining the risk adjustment model to enable fair comparisons between quarterbacks. The current risk model includes a range of factors with the accessible data. However,

- Information such as previous number of children is not available at this stage. Furthermore, it may be co-linear with a number of risk factors that do exist in current models.
- Lack of prenatal care will not be added as a risk factor. Per response to the comment "**Exclude episodes with no or minimal prenatal care**", episodes with no medical prenatal care are being excluded.

To review all risk factors included in each episode, please visit the website for each TennCare MCO:

- **Amerigroup:** https://providers.amerigroup.com/pages/tn-2012.aspx [Under the "Tennessee Episodes of Care" tab].
- **BlueCross BlueShield of Tennessee:**
- https://bluecare.bcbst.com/forms/Provider%20Information/Risk_Factors_and_Weights.pdf
- **United Healthcare:** https://www.uhccommunityplan.com/health-professionals/tn/Episodes-of-Care-PCMH-TN-Health-Link-MTM.html

Comment: Exclude pharmacy, hospital cost (Inpatient, ED, Outpatient), and high-risk obstetrician cost.

Response – Not Accepted: Episode design includes the spend within the quarterback's influence. Quarterbacks have influence over the aforementioned costs by applying high-quality care management, care coordination with other providers, judicious prescribing and referrals. Therefore, relevant spend on pharmacy and relevant hospital cost (Inpatient, ED, Outpatient) will continue to be included in the episode.

For high-risk obstetrician costs, see comment "**Remove all spend related to Maternal Fetal Medicine (MFM) specialists from the episode**."

Comment: Share cost data on services provided by other providers in the episode.

Response – Not Accepted: Episode reports include spend at the individual patient level broken into categories such as inpatient facility, pharmacy, laboratory, etc. This gives providers a good sense of the costs of various providers. However, exact negotiated rates for other providers cannot be shared because they are proprietary and confidential. If providers have questions about which of the providers they work with are the most efficient, they can reach out to the MCOs using the contact details below or by contacting their individual representative.

TennCare Managed Care Organizations (MCOs):

- **Amerigroup:** 615-232-2160
- **BlueCross BlueShield of Tennessee:**
  - 800-924-7141 (Option 4)
  - Contact your PRC: http://www.bcbst.com/providers/mycontact/?nav=calltoaction.
- **United Healthcare:** 615-372-3509

Cigna: 615-595-3663 or email Megan.Higdon@Cigna.com

Comment: Exclude out-of-network costs from the episode.

Response – Not Accepted: The concern is that out-of-network costs have a disproportionate impact on episode spend. Out-of-network costs will continue to be included in the episode. Out-of-network care typically requires prior authorization, therefore mitigating the impact on the average episode spend.

Providers are incentivized to use in-network services, such as labs. Providers have the opportunity to raise concerns during the reconsideration process.

Comment: Thresholds should be different for providers with a large volume of Medicaid patients.
Response – Not Accepted: The intent is for all providers with sufficient data to be incentivized to provide high-value care, including those with large episode volumes. All eligible quarterbacks will continue to be included in the episode. Also, quarterbacks with a small volume of episodes will not be eligible for risk sharing or gain sharing payments (see comment "**Create overlapping episodes exclusion**").

Comment: Exclude patients if a physician was under two different tax IDs during the episode window.
Response – Not Accepted: The physician's tax identification number (TIN) change does not affect the quarterback's accountability during the episode. Should the quarterback's TIN change during the course of an episode, the TIN on the trigger claim will continue to be used for attribution purposes. The state will continue to include the quarterbacks with changing TINs in the program.

Respiratory Infection

Design Changes Made in Response to Feedback

Comment: Remove diabetes medications from the configuration file.
Response – Accepted: Diabetes medications will be removed from episode spend as they are not closely related to the respiratory infection.

Comment: Fairly account for episodes with Gram negative and/or Gram positive infections.
Response – Accepted: Concern was expressed that the treatment of bacterial infections, especially Gram negative infections, is more costly, and quarterbacks treating a high number of such cases may be disadvantaged. Two additional risk factors will be tested in the risk adjustment model, in order to better account for complexity of treatment:

- Gram positive bacterial infection, and
- Gram negative bacterial infection.

Comment: Remove deviated septum surgery and nasal endoscopy from episode spend.

Response – Accepted: Due to limited clinical relationship with the episode, the state will exclude both deviated septum surgery and nasal endoscopy from the episode.

Comment: During the episode window, a patient can be treated for other related conditions, such as asthma. Pharmacy costs will increase since both conditions are treated as one episode.

Response – Accepted: Many patients will have chronic conditions that may alter the patient journey to an extent. The episodes program addresses this issue in multiple ways:

- Risk adjustment: Patients with risk factors that predispose them to require higher-cost treatment may have their episodes risk adjusted. The aim of risk adjustment is to adjust episode spend based on patient complexity where possible. An example of a common risk factor is asthma.
- Clinical exclusions: Patients whose patient journey significantly differs from the majority of the patient population for reasons outside of the quarterback's control may be excluded from the episode if risk adjustment is not sufficient to account for the differences in cost. In the Respiratory Infection episode, examples of such exclusions are acute epiglottitis, cystic fibrosis and admission during the trigger window or one day after.
- Business exclusions: If the episode spend cannot be reliable established, e.g., because the patient did not have consistent enrollment or third-party payers were involved, the episode may be excluded.
- Patient exclusions: Episodes may be excluded if the patient does not satisfy certain criteria e.g., age. An episode is also excluded if the risk-adjusted episode spend is greater than the high outlier threshold. The high outlier threshold is set at three standard deviations above the average risk-adjusted episode spend for valid episodes.
- Overlapping episode exclusion: If a quarterback is accountable for two concurrent episodes that share spend, additional exclusions may apply (see comment "**Create overlapping episodes exclusion**").

No Changes to Design

Comment: Unrelated spend is included in the episode.
Response – Not Accepted: The concern expressed was that the window for the episode is two weeks, and within that time frame other unrelated issues could occur that may be included in cost for this episode. We would like to clarify that the intent of episode design is to only include spend related to the episode, by designing specific spend inclusion rules based on appropriate diagnosis and/or procedure codes. The state welcomes specific feedback from providers on specific codes for reassessment. Additionally, providers have the opportunity to raise specific concerns about their episode performance during the reconsideration process.

Skin and Soft Tissue Infection (SSTI)

Design Changes Made in Response to Feedback

Comment: Exclude episodes with chemotherapy.
Response – Accepted: The provider concern was the higher complexity of patients who are undergoing chemotherapy. Given the different clinical pathway, episodes with active cancer management (including chemotherapy) with appropriate diagnosis codes within one year before the episode starts or during the episode window will be excluded.

No Changes to Design

Comment: Not all cases of I&D require cultures to be collected.
Response – Not Accepted: The objective of the "bacterial cultures when I&D is performed" quality metric is to ensure clinical best practices and protocols are appropriately adopted. Additional clinical review suggests that care and treatment of skin and soft tissue conditions without sufficient fluid should not require an incision and/or drainage. As a result, this quality metric will remain as a gain sharing metric.

Tonsillectomy

Design Changes Made in Response to Feedback

Comment: Add risk factors (Obstructive sleep apnea, Obesity) and exclusions (ASA 3 and ASA 4; Down Syndrome and other congenital abnormalities; micrognathia, innominate artery compression; bleeding concerns, such as hemophilia, sickle cell, factor deficiencies, leukemia; co-morbidity such as, cardiac, Pulmonary edema, Bronchopulmonary dysplasia; Congenital laryngomalacia; Acute respiratory failure with hypoxia; Hyperglycemia; Hypertension; Compression of brain; Epilepsy; Dependence on supplemental oxygen; Cerebral palsy, Spina Bifida; BMI pediatric, greater than or equal to 95th percentile for age).
Response – Accepted: Based on clinical feedback and review of historical episode costs, new risk factors will be tested and exclusion rules will be added.

Risk factors to be tested, or retested, include:

- BMI pediatric, greater than or equal to 95th percentile for age,
- Obstructive sleep apnea,
- Cerebral palsy,
- Hemophilia, sickle cell, factor deficiencies, leukemia,
- Cardiac comorbidity,
- Pulmonary edema,
- Bronchopulmonary dysplasia,
- Congenital laryngomalacia,
- Acute respiratory failure with hypoxia,
- Hyperglycemia,
- Epilepsy, and
- Dependence on supplemental oxygen.

The following conditions will become excluded:

- Compression of brain,
- Micrognathia,
- Innominate artery compression, and
- Any episodes triggered in an ED-setting will be excluded to ensure valid episodes can be fairly compared.

Urinary Tract Infection (UTI) – Inpatient

Design Changes Made in Response to Feedback

Comment: Exclude Tamiflu medication from episode spend.
Response – Accepted: There is a concern that this medication is not closely related to the management of the UTI – Inpatient episode. The state will remove Tamiflu from episode spend.

Urinary Tract Infection (UTI) – Outpatient

Design Changes Made in Response to Feedback

Comment: Exclude Tamiflu medication from episode spend.
Response – Accepted: There is a concern that this medication is not closely related to the management of the UTI – Inpatient episode. The state will remove Tamiflu from episode spend.

No Changes to Design

Comment: Include more risk factor codes to indicate social circumstances beyond a physician's control.
Response – Not Accepted: While the state is supportive of refining the risk adjustment models, data limitations prevent socioeconomic factors from being included.

Additional Guidance

The following is additional guidance relating to the Comment: "**Account for impact of facility fee on perinatal episode spend**" published in September 2018 (see page 21). This supplemental guidance is effective for 2017 performance period and future performance periods.

MCOs will proactively identify the perinatal quarterbacks who meet the specific criteria described below and perform an adjustment and recalculation of risk sharing payment automatically, without providers submitting a request for reconsideration. Please note that eligibility for this inpatient facility spend adjustment for the perinatal episode must be assessed for each year's final results.

STEP 1: MCOs will screen perinatal quarterbacks for eligibility to receive inpatient facility spend reconsideration.[6]

To be eligible for inpatient facility reconsideration, the perinatal quarterback must meet both of the following criteria:

1. Quarterback has a risk-sharing payment for the perinatal episode; and
2. Quarterback's average adjusted perinatal episode spend remains above the acceptable threshold after all other care categories are set to the provider average.

STEP 2: MCOs will perform analysis for reconsideration on the quarterbacks identified as eligible in Step 1.

The inpatient facility spend reconsideration analysis is as follows:

- Are there any lower-cost delivering facilities[7] within a thirty minute drive?
  - Yes – If there is a lower-cost option, the MCO will make no adjustment to the quarterback's risk sharing payment.
  - No – If there are no lower-cost delivering facilities within a thirty minute drive, the MCO will adjust the quarterback's inpatient facility spend to the provider average inpatient facility spend and recalculate their perinatal average adjusted episode spend.

[6] This will not include perinatal episode quarterbacks who are part of the same business entity as the facility with the high inpatient costs.
[7] A "lower-cost facility" is one that has a cost that allows an average provider to avoid a risk sharing payment.

<u>STEP 3</u>: MCOs will automatically adjust the quarterbacks' risk sharing payment based on the updated perinatal average adjusted episode spend identified in Step 2.

- After this adjustment, a quarterback may have no risk sharing payment or may have a reduced risk sharing payment.
    - As a reminder, a provider's risk adjustment and all other care categories can still impact episode performance.
- MCOs will not pay a gain sharing payment to a quarterback who had a perinatal average adjusted episode spend above the acceptable threshold prior to the inpatient facility spend reconsideration.
- By contacting the quarterbacks proactively, the MCOs will be able to reach providers who are not aware that their inpatient facility spend is driving their perinatal average adjusted episode spend above the acceptable threshold.