Division of TennCare | Health Care Innovation

MEMO: 2021 Episode Changes

Table of Contents

TABLE OF CONTENTS 1

INTRODUCTION 2

SUMMARY OF PROGRAM CHANGES TAKING EFFECT IN 2021 4

GENERAL EPISODES FEEDBACK 6

EPISODE-SPECIFIC FEEDBACK 9

- ACUTE GASTROENTERITIS 9
- ACUTE PANCREATITIS 10
- ASTHMA ACUTE EXACERBATION 10
- ATTENTION DEFICIT AND HYPERACTIVITY DISORDER (ADHD) 10
- BACK AND NECK PAIN 11
- BARIATRIC SURGERY 12
- BREAST BIOPSY 12
- ESOPHAGOGASTRODUODENOSCOPY (EGD) 12
- HYSTERECTOMY 12
- KNEE ARTHROSCOPY 14
- OPPOSITIONAL DEFIANT DISORDER (ODD) 14
- OTITIS MEDIA 14
- PERINATAL 15
- RESPIRATORY INFECTION 16
- TONSILLECTOMY 16

MEMO: 2021 Episode Changes

Introduction

Date: September 2020
Subject: Updates to TennCare's Episodes of Care program

This memorandum discusses the recommendations and state responses made to TennCare's Episodes of Care program in Tennessee for the 2021 performance period that begins January 1, 2021.

The state greatly appreciates the feedback we have received from stakeholders over the past year, and especially those stakeholders who attended the Episodes of Care Annual Feedback Session, held on May 20, 2020. To maintain the safety of all participants, this year was the first ever virtual feedback session. The WebEx event was an opportunity for stakeholders from across Tennessee to comment on what is working well and how to improve upon the clinical design of all 48 episodes of care that are in performance in 2020. Members of the public were also able to submit their feedback electronically, before the event via email and online form, and during the event via the live chat feature with the state.

The state is making 13 changes to the design of the episodes program for the 2021 performance period. These changes will first be reflected in the interim performance reports released in August 2021 that cover the first quarter of the 2021 performance period (January through March 2021).

The feedback is organized by episode in alphabetical order. The table "Summary of Program Changes Taking Effect in 2021" is also provided to highlight feedback that resulted in episode design changes for the 2021 performance year.

Episodes of Care's Response to COVID-19

The state recognizes that COVID-19 has created an unprecedented health and economic crisis for the provider community, including financial pressures on many providers. In order to continue to support providers during this difficult time, the state announced on July 17, 2020, that the three TennCare Managed Care Organizations (MCOs) will waive all episodes of care risk-sharing payments in the final reports for the 2019 performance period. MCOs will still pay out gain-sharing payments as planned.

The state is in the process of analyzing the impact of this pandemic on the 2020 episodes of care performance period and beyond. We welcome input from stakeholders regarding potential future adjustments to episodes design during this uniquely difficult time.

Five Episode Types Shifting to Informational Only Reporting

Beginning in January 2021, there are five episode types that will shift to informational only reporting. The five episode types are Coronary Artery Bypass Graft (CABG), Femur/Pelvic Fracture, Human Immunodeficiency Virus (HIV) Infection, Non-acute Percutaneous Coronary Intervention (PCI), and Valve Repair and Replacement (Valve). The 2019 performance period was the first year that the low volume episode exclusion was implemented, which waives accountability for quarterbacks with fewer than five episodes of a particular episode type. This change significantly impacted the number of valid episodes in certain episode types. Therefore, CABG, Femur/Pelvic Fracture, Non-acute PCI, and Valve will shift to

informational only reporting due to impacts of the low volume episode exclusion. The HIV episode type is also shifting to informational only reporting because of data limitations to capture a source of value. Although there will be no financial accountability for performance within these episode types, providers will continue to receive quarterly reports on cost and quality.

A Primer on the Episodes of Care Program

How are episodes designed?

Every episode is designed with recommendations from Tennessee clinicians, who formed a Technical Advisory Group (TAG). These design recommendations include the episode trigger, the type of quarterback for the episode, included spend, episode duration, exclusions, risk factors, and quality metrics. For every episode that has been designed in Tennessee, clinicians' recommendations were incorporated into the episode design before implementation.

TAGs were composed of Tennessee clinicians with expertise in relevant specialties who volunteer their time to make recommendations on the clinical aspects of the episode design. Members were selected through a nomination process. TAGs met in person multiple times as part of the episode design process.

How does the Episodes of Care program make fair comparisons across episodes?

Episode design has exclusions in place for episodes with a different care pathway. There are several types of exclusions applied to all episodes (e.g., business exclusions, clinical exclusions, overlapping episode exclusions). After all exclusions have been applied, a set of valid episodes remain that are used for financial accountability.

The Episodes of Care program also includes many components to make fair comparisons among providers. Risk adjustment is a method used to scale the episode spend up or down to account for higher patient costs due to greater patient complexity. This adjustment is done on the basis of the comorbidities coded in the claims. Quarterbacks are held accountable for their risk-adjusted episode spend.

Who determines the risk factors for each episode?

TAG members recommended a clinically appropriate list of risk factors for each episode. After the conclusion of the TAG, the list of risk factors was sent to the Managed Care Organizations (MCOs). The MCOs test each risk factor, in addition to other diagnoses that are identified in their models, for statistical significance based on their data. The risk factors that are statistically significant in terms of episode spend for each MCO are used as risk factors for that episode type.

For more information about the TennCare Episodes of Care program, including all the episode detailed business requirements (DBRs) and configuration files, go to: https://www.tn.gov/tenncare/health-care-innovation/episodes-of-care.html.

MEMO: 2021 Episode Changes

Summary of Program Changes Taking Effect in 2021

Episode Type(s) Impacted	Change to Episode Design	Page
Coronary Artery Bypass Graft (CABG); Femur/Pelvic Fracture; Human Immunodeficiency Virus (HIV) Infection; Non-acute Percutaneous Coronary Intervention (PCI); Valve Repair and Replacement	Shift episodes to informational only reporting beginning with the 2021 performance period	2
All episodes	Update the FQHC/RHC exclusion from an episode-level exclusion to a quarterback-level exclusion	6
Attention Deficit Hyperactivity Disorder (ADHD)	Update the attribution logic to increase specificity in identifying the quarterback	9
Attention Deficit Hyperactivity Disorder (ADHD)	Continue the temporary level 1 case management exclusion	10
Breast Biopsy	Extend the Appropriate Diagnostic Workup Rate quality metric pre-trigger window to overlap with the trigger window	11
Hysterectomy	Update the denominator of the Alternative Treatments quality metric to exclude those women who have a history of uterine prolapse (N81.3)	12
Hysterectomy	Update the Related follow-up care quality metric to include additional related diagnoses that count towards the quality metric (Z09 and Z48.816)	12
Hysterectomy	Update the denominator of the Alternative Treatments quality metric to remove uterine polyps (N84.1)	12
Hysterectomy	Update the Alternative Treatments quality metric to include LEEP, cold knife conization, and colposcopy procedures	12
Knee Arthroscopy	Change the duration of the pre-trigger opioid window to days 1 - 60 prior to the trigger window start date	13

Perinatal	Update the code list for episode triggers in the perinatal episode	14
Perinatal	Remove Screening for Hepatitis B Specific Antigens informational quality metric	14
Perinatal	Add Screening for Hepatitis C as an informational quality metric	14

General Episodes Feedback

Comment: Improve the method of identifying Federally Qualified Health Centers and Rural Health Centers.

Response: The state is updating the FQHC and RHC exclusion from an episode-level exclusion, based on "Place of Service" coding, to a quarterback-level exclusion. FQHCs and RHCs will need to ensure their FQHC and RHC certification letters are forwarded to the Tennessee State Comptroller of the Treasury office. These providers will continue to receive episodes reporting, but they will be exempt from financial accountability.[1]

Comment: Make it easier for providers to access reports using a single portal for all MCOs.

Response: The state will not make this change due to security, privacy, and technical concerns. The state intends to standardize the provider's access to reports as much as possible. For example, reports for all MCOs are released on the same day (the third Thursday of the release month). The state prescribes standard templates that each MCO follows regarding provider reports, and these reports provide quarterly information for each episode type. Due to differences in contracting between the MCOs and their providers, some discrepancies exist in terms of reporting by MCO. However, all MCOs follow the same episode design logic and report the same episode information in the same format to quarterbacks.

Comment: Allow individual physicians to access reports when the Quarterback is a large facility (e.g., a hospital).

Response: The state continually strives to increase the information available to quarterbacks. We provide as much transparency as possible within the legal constraints of contractual and privacy considerations. Provider reports contain confidential information, such as the contracted rates between a provider and MCO, that the state cannot share with other entities outside of that contract. If a quarterback would like to further investigate specific episodes data, that quarterback can reach out to the respective MCO representatives for more details.

Comment: The MCOs need to create an executive summary report for the leadership at large facilities (e.g., a hospital) and providers with multiple TINs.

Response: The state continually strives to provide reports that are easy to analyze and understand. Due to differences in contracting between the MCOs and their partners, it is difficult to create an additional, standardized method to aggregate reports across large facilities and providers with multiple TINs. If a quarterback would like to gain further performance insights across large facilities or multiple TINs, the quarterback can discuss improved care with other community providers or reach out to the respective MCO representatives for more details.

Comment: Continue providing reimbursement to all Delivery System Transformation programs (PCMH, THL, and Episodes of Care) to provide telehealth visits.

[1] Update April 2021: FQHC and RHC providers will not receive episodes reporting unless they voluntarily opt-in to receiving reports. Each MCO will manage the process for providers to request episodes reports. Please contact your MCO representative for more information.

Response: The episodes program does not change a provider's existing reimbursement model. The program is retrospective and collects data from claims without changing reimbursement rates. The episodes program already includes telehealth follow-up visits in the follow-up quality metric if appropriate telehealth codes are submitted for an evaluation and

management (E&M) visit. For more information about telehealth in primary care, please see https://www.tn.gov/tenncare/health-care-innovation/primary-care-transformation.html or write to Payment.Reform@tn.gov.

Comment: Rural physicians should be exempt from the episodes program.

Response: Each episode type was initially informed by a TAG composed of expert clinicians based on data representing a diversity of relevant specialties, provider types, and urban and rural practices from across Tennessee. Under this design, both rural and urban quarterbacks have been successful across all episodes, and there is no need to create such an exemption. The episodes program currently offers financial incentives for providers to provide high quality, cost effective care in all communities, regardless of location.

Comment: Create more specialized educational materials that apply to providers in the acute setting (e.g., emergency department), such as additional guidance and best practices for success in episode types in the acute setting.

Response: On the state's recently redesigned episodes webpage, there are several new provider engagement materials. We continually strive to create new content that explains the program, and we will work on creating new educational materials in response to this feedback.

Comment: Change provider reports to include the cost of outpatient laboratory tests.

Response: The patient-level spreadsheet that is distributed to providers through the MCO portals every quarter provides cost information by patient and by cost category. One of the cost categories is outpatient laboratory. By taking a closer look at individual patients with a high cost in the outpatient laboratory care category, a provider can identify which lab tests are driving the increased costs. Another best practice for providers is to confirm they are using an outpatient laboratory that is currently in-network for their MCO, as out-of-network laboratory testing is typically more expensive.

Comment: Exclude testing for COVID-19 because it may be duplicative for other testing (e.g., flu and strep tests).

Response: The episodes program was designed to include only those costs that are relevant to the episode type. While some costs are explicitly noted as being excluded in the configuration file, an episode's cost will not include anything outside the configuration file. Therefore, novel testing like COVID-19 diagnostics is not intended to be captured in an episode's cost. The state is looking carefully to see what impact COVID-19 is having on program-wide data for 2020, and individual episode types may have future changes to the configuration file to exclude any COVID-19 testing as a related cost.

Comment: Include social determinants of health in episode risk adjustment.

Response: Behavioral health episode types already include episode exclusions for factors such as homelessness within the configuration file. Further, each MCO develops their own risk adjustment model to make fair comparisons between patients with different costs along a similar care pathway. The state is open to considering future program changes that take coding for social factors into account. The program is designed around claims data, so changes to include social factors will require consistent coding for social determinants of health by all providers. Additionally, each MCO

will need to test each proposed risk factor to determine if the social risk factor has a statistically significant impact on episode cost.

Comment: Do not hold providers accountable for patient choices.

Response: All episodes include patient and business exclusions that minimize provider risk for decisions made by the patient. For example, an episode is excluded if a patient has a discharge status of "left against medical advice or discontinued care" on any inpatient or outpatient claim during the episode window. The goal of the episodes program, however, is to better coordinate care and educate patients to improve quality of care and reduce inappropriate, preventable care. While patient non-compliance or over-utilization can be an issue, providers do have the opportunity to positively influence patient behavior.

Comment: All MCOs should use the same thresholds to eliminate variation.

Response: The state sets the acceptable threshold, which is a single state-wide dollar amount that delineates quarterbacks who owe a risk-sharing payment and quarterbacks who have no change in payment. Each MCO sets its own commendable threshold based on contractual differences, which is the dollar amount that delineates quarterbacks who could earn a gain-sharing payment (if they also pass quality metrics tied to gain-sharing) and quarterbacks who have no change in payment, based on their data. Each MCO sets its commendable threshold such that gain-sharing and risk-sharing payments are projected to be equal.

Comment: The state should publish a list of all the quarterbacks for each episode.

Response: The state strives to provide as much transparency about the program's data as possible within the legal constraints of contractual and privacy considerations. Provider reports contain confidential information, including the name of the accountable provider. The state values the privacy of providers and therefore does not share the identify of other entities outside of that provider's MCO contract. Providers are welcome to self-identify themselves as an episodes quarterback to other participants in the program, and we encourage peer-to-peer sharing about episodes of care.

Episode-Specific Feedback

Acute Gastroenteritis

Comment: Pediatric facilities have a disadvantage because children are more expensive to treat for acute gastroenteritis.

Response: 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. All proposed risk factors are tested, or retested, as risk factors in the risk adjustment models to continue making fair assessments of quarterback performance. For the acute gastroenteritis episode, the risk adjustment process accounts for the differences in cost between pediatric versus adult patients.

Acute Pancreatitis

Comment: Create an episode exclusion for inpatient detox from alcohol.

Response: A new exclusion for acute pancreatitis patients who are receiving inpatient treatment for detox from alcohol will not be created. For the 2020 performance period, the state introduced a new low-volume exclusion that exempts providers from financial accountability if they have four or fewer valid episodes for the performance year. The low-volume exclusion was designed in part to address scenarios that are infrequent and atypical, such as acute pancreatitis patients receiving inpatient alcohol detox at the time of the episode. The state conducted a data analysis and concluded that almost all episodes where an acute pancreatitis patient was also receiving inpatient alcohol detox would be exempted under the low-volume exclusion.

Asthma Acute Exacerbation

Comment: Test mild, moderate, and severe asthma codes for risk factors in asthma.

Response: These proposed risk factors will be tested, or retested, by the MCOs in the risk adjustment models. The aim of risk adjustment is to adjust episode spend based on patient complexity where possible.

Attention Deficit and Hyperactivity Disorder (ADHD)

Comment: Improve the ADHD episode design for assigning episodes to an accountable provider. Some provider types are being assigned ADHD episodes inappropriately, such as laboratories and school nurses.

Response: The state is updating the attribution logic for the ADHD episode. The new logic will continue to look at the plurality of visits to determine the accountable provider for each episode. However, the new logic will use a hierarchy of provider types to help ensure that only the most appropriate provider type is identified as the quarterback.

Comment: Change the calculation for the Long-Acting Stimulants for Members Aged 6 to 11 and Long-Acting Stimulants for Members Aged 12 to 20 quality metrics. For some patients, it is appropriate to prescribe the more expensive short-acting stimulants and that action counts against this gain-sharing quality metric.

Response: In 2018, the state announced a pharmacy cost adjustment for all episode types. 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 is made at the national drug code (NDC) level.

Comment: Make the Level 1 Case Management exclusion for ADHD permanent.

Response: The temporary Level I Case Management exclusion will be continued through the 2021 performance period. The intent of the Level I Case Management temporary clinical exclusion was to give providers additional time 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 Level I Case Management service. The ADHD episode will continue to have a Level I Case Management clinical exclusion for performance year 2021. This action will be reassessed for performance year 2022.

Comment: The Minimum Care Requirement quality metric is problematic because the ADHD episode accounts for care that occurs on a rolling basis.

Response: The state is following guidance from the TAG, and the TAG intentionally created an episode that accounted for care provided on a rolling basis. In terms of ensuring there is appropriate quarterback accountability in managing ADHD, there is a benefit to capturing the minimum care being provided every 180 days to ADHD patients. The TAG considered the ability to capture this information as a source of value in ADHD's episode design. The state is open to considering any specific design changes that stakeholders believe can improve upon this design.

Back and Neck Pain

Comment: Separate the episode into two separate episode types, a back pain episode and a neck pain episode.

Response: The state is following guidance from the TAG. TAG feedback indicated that back and neck pain follow a similar patient journey and share common opportunities for improved outcomes, quality, and cost effectiveness. The state accepted the TAG recommendation that the episode's design should trigger on neurologic conditions (e.g., radiculopathy) for information purposes, but these episodes should be excluded. The state also evaluated the average episode cost for both neck and back pain and the two conditions are comparable after appropriate clinical exclusions and risk adjustment. Therefore, it is appropriate for the Back and Neck Pain episode to continue as a single episode in design.

Comment: Change the way the Back and Neck Pain episode assigns the quarterback to avoid holding providers accountable for treatment that occurred before seeing the patient.

Response: The quarterback assignment varies by episode type based on TAG feedback. Some episodes have quarterback assignment based on plurality of visits, and some episodes have quarterback assignment based on the trigger diagnosis or procedure. In this case, the TAG designed the back and neck pain episode so that quarterback assignment was based on plurality of visits. Accountability for an episode is assigned to the provider who is in the best position to influence the overall cost and quality of a patient's treatment within the episode, even if another physician under another TIN also provides care to the patient.

Bariatric Surgery

Comment: Quarterbacks are being held accountable for factors outside of their control, such as high outpatient facility fees or patients opting for surgery at high-cost hospitals.

Response: The goal of the episodes program is to better coordinate care to improve quality of care and reduce expensive, preventable care. While patient non-compliance can be an issue, providers do have the opportunity to positively influence patient behavior. Likewise, providers also have the opportunity to work with more cost-effective facilities. If a quarterback believes it is still being held accountable inappropriately, the quarterback can reach out to the respective MCO representative to assess the specific details regarding the situation.

Comment: Introduce a minimum number of cases to be held accountable for an episode.

Response: For the 2020 performance period, the state introduced a new low-volume exclusion that exempts providers from financial accountability if they have fewer than five valid episodes for the performance year.

Breast Biopsy

Comment: Update the Appropriate Diagnostic Workup Rate quality metric to include claims occurring within the trigger window.

Response: The state is extending the Appropriate Diagnostic Workup Rate pre-trigger window to overlap with the trigger window. This allows providers who perform the diagnostic imaging and breast biopsy procedure in the same day to capture their quality metric performance.

Esophagogastroduodenoscopy (EGD)

Comment: Add age as a risk factor to the EGD episode.

Response: Age will be re-tested as a risk factor for the EGD episode. 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.

Hysterectomy

Comment: Attach a $10 to $20 administrative fee to the follow-up visit so that it is identified in claims data and will be reflected in measuring Follow-Up Care quality metric performance.

Response: The episodes program does not modify reimbursement rates for any claims. However, claims submitted for $0 can be included in episode quality metrics. There are appropriate codes to submit in the post-operative period to document visits in the global period. CPT code 99024 is included for episodes with a global period for procedures to capture follow-up care visits.

Comment: Exclude women who have a history of uterine prolapse from the Alternative Treatments quality metric.

Response: The state will update the denominator of the Alternative Treatments quality metric to exclude those women who have a history of uterine prolapse, as defined by ICD-10 code N81.3. The state recognizes that there is a lack of viable alternative treatments for uterine prolapse, and women with a diagnosis of uterine prolapse can receive a hysterectomy without first attempting alternative treatments.

Comment: Update the Related Follow-Up Care quality metric to include ICD-10 codes Z09 and Z48.816.

Response: The state will add ICD-10 codes Z09 (Encounter for follow-up examination after completed treatment for conditions other than malignant neoplasm) and Z48.816 (Encounter for surgical aftercare following surgery on the genitourinary system) to the related diagnoses subdimension of the Hysterectomy configuration file. This will expand the included diagnoses that count towards the Follow-Up Care quality metric.

Comment: Update the Alternative Treatments quality metric to remove polyp of the cervix (ICD-10 code N84.1).

Response: The state will remove ICD-10 code N84.1 from the related diagnosis subdimension of the Hysterectomy configuration file. This change to the Alternative Treatments quality metric is based on clinical guidance that polyp of the cervix should not be included in the Alternative Treatments quality metric.

Comment: Update the Alternative Treatments quality metric to exclude patients with uterine masses that range between 20 centimeters to 35 centimeters, because masses in this size range are frequently cancerous.

Response: The state is following guidance from the TAG. TAG feedback indicates that alternative treatments prior to hysterectomy are clinically appropriate for patients with uterine masses in the 20 centimeters to 35 centimeters range. Additionally, the state implemented a global clinical exclusions list (effective with the 2020 performance year) that applies to all episodes which excludes episodes where the patient has a rare, high-cost condition, such as cancer. There is also a clinical exclusion for uterine cancer within the Hysterectomy episode's design.

Comment: Update the Alternative Treatments quality metric to include LEEP, cold knife conization, and colposcopy procedures.

Response: The state will update the Hysterectomy episode's configuration file to include LEEP, cold knife conization, and colposcopy procedures in the list of codes for alternative treatments that satisfy the episode's quality metric.

Comment: Exclude high cost, minimally invasive surgeries (e.g., robotic procedures) from the Hysterectomy episode.

Response: The episodes program uses several mechanisms to make fair comparisons between episodes, such as risk adjusting for patient complexity. The higher cost of procedures involving newer technologies are captured to ensure accountability for the quarterback's choice of technique when not related to patient complexity. If more expensive techniques, such as robotic surgery, are providing greater value they will lead to lower costs in other areas such as decreased complications

or shorter hospitalizations and therefore will lead to lower risk adjusted episode costs overall. Robotic surgeries will not be excluded from the Hysterectomy episode to ensure continued transparency and accountability for patient outcomes, as well as cost.

Comment: Exclude patients with a history of prior ablation that occurred greater than 180 days before the episode trigger from the Alternative Treatments quality metric.

Response: The state is following TAG recommendations to ensure alternative treatments are attempted prior to Hysterectomy. Each episode was designed in consultation with a TAG to identify what quality metrics would be appropriate for each episode. The Hysterectomy episode's design includes a 12-month lookback for prior ablation(s) that would meet the Alternative Treatments quality metric.

Comment: Expand the perinatal inpatient facility adjustment to include the hysterectomy episode.

Response: The Perinatal episode's reconsideration process for high-cost facilities without a low-cost, nearby alternative facility is limited to the perinatal episode because it is the only episode that has a professional quarterback and an emergency component to the episode. In all other episodes, either the quarterback is a facility (and therefore directly responsible for facility rates) or the episode is nonemergent and the provider has the opportunity to send patients to lower-cost facilities.

Knee Arthroscopy

Comment: Change the duration of the pre-trigger opioid window from days 31 to 60 prior to the trigger window start date to days 1 to 60 prior to the trigger window start date.

Response: The state is changing the knee arthroscopy pre-trigger opioid window to align with other non-spinal orthopedic episodes. The pre-trigger opioid window for Knee Arthroscopy will change to Days 1 to 60 prior to the trigger window start date.

Oppositional Defiant Disorder (ODD)

Comment: Providers need resources to help patients locate a therapy provider for children with ODD.

Response: The MCOs have many resources that can assist providers treating patients with ODD with locating therapists accessible to their patients. For help connecting patients with therapy providers, please contact your MCO representative.

Otitis Media

Comment: Exclude patients who have a diagnosis for an otitis media infection (e.g., with purulence) during the post-trigger window from the denominator for the quality metric for otitis media with effusion (OME).

Response: The state is following guidance from the TAG. TAG feedback indicates that one source of value for the treatment of otitis media with effusion is the prevention of the development of a purulent otitis media infection that requires antibiotics. Therefore, it is appropriate to hold

providers accountable for antibiotic use when a purulent infection develops after the diagnosis of otitis media with effusion.

Comment: Allow providers to document a reason for choosing a stronger antibiotic, which is often more expensive.

Response: Effective in the 2019 performance year, the state implemented a pharmacy spend adjustment across all episode types. 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 will be included in the provider episode report as $10. Additionally, the quality metrics have thresholds set to allow some percentage of episodes to include antibiotic prescriptions. The state acknowledges that it is clinically appropriate for some patients to have an antibiotic prescription for Otitis Media.

Comment: Remove the Follow-up Encounter quality metric.

Response: The state is following TAG recommendations. Each episode was designed in consultation with a TAG to identify what quality metrics would be appropriate for each episode, and the TAG for the Otitis Media episode determined that the Follow-up Encounter quality metric provided an important source of value in the episode. Please note that the Follow-up Encounter quality metric is informational only, which means that quality metric performance is not tied to any financial accountability.

Perinatal

Comment: Consider twin birth as a risk factor for the perinatal episode.

Response: The proposed risk factor will be tested, or retested, as a risk factor for the perinatal episode. Twin births are a common enough occurrence that the MCOs have enough data to evaluate their cost in the risk adjustment process.

Comment: Update the list of trigger codes in the perinatal configuration file.

Response: The state will review and update the code list for episode triggers in the Perinatal episode.

Comment: Remove Screening for Hepatitis B Specific Antigens quality metric.

Response: The state will remove the informational quality metric Screening for Hepatis B Specific Antigens as a quality metric from the Perinatal episode, and the state is considering the measurement of other quality metrics which may provide more value to providers.

Comment: Add Screening for Hepatitis C as a quality metric.

Response: The state will add a new informational quality metric, Screening for Hepatitis C, to the Perinatal episode.

Comment: Change the C-section quality metric to have a denominator that excludes C-sections performed for medically necessary reasons.

Response: The state is following original TAG recommendations. TAG feedback indicated that a C-section rate with a denominator of all valid episodes is clinically appropriate to measuring a provider's performance. The threshold is not set at zero because the state acknowledges that some C-sections are medically necessary, and the quality metric threshold takes this into account.

Respiratory Infection

Comment: Providers should not be held accountable when a patient chooses to visit the ED during the respiratory infection episode window.

Response: There is appropriate accountability for the quarterback of the respiratory infection episode to encourage access and avoid unnecessary ED visits. Therefore, the associated cost accountability will continue to be included in the Respiratory Infection episode.

Tonsillectomy

Comment: Add readmission rate as an informational quality metric and subdivide the metric into readmissions due to bleeding and readmissions due to dehydration.

Response: The Tonsillectomy episode already has two quality metrics that measure bleeding: Bleeding Up To Two Days Following the Procedure (tied to gain-sharing) and Bleeding Rate Between the 3rd and 14th Days (informational only). Based on an analysis of the data for the Tonsillectomy episode, the readmission rate for the last two performance years is determined to be at an acceptable level. Therefore, it is not necessary to introduce a new readmission quality metric at this time.