MEMO: 2020 Episode Changes

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Introduction

Date: September 2019
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 2020 performance period that begins January 1, 2020.

The state greatly appreciates 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 21, 2019. 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 45 episodes of care that are in performance in 2019. The meetings were held simultaneously in six cities across Tennessee (Memphis, Jackson, Chattanooga, Nashville, Knoxville, and Johnson City) 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.

Based on the feedback received, the state is making 41 changes to the design of the episodes program for the 2020 performance period. These changes will first be reflected in the interim performance reports released in August 2020 that cover the first quarter of the 2020 performance period (January through March 2020).

The feedback is organized by episode in alphabetical order. The table "Summary of Program Changes Taking Effect in 2020" is also provided to highlight feedback that resulted in episode design changes for the 2020 performance year.

A Primer on the Episodes of Care Program

How are episodes designed?

Every episode is designed with recommendations from Tennessee clinicians, who form 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 are 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 are selected through a nomination process. TAGs meet in person multiple times as part of the episode design process.

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

The Episodes of Care program 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 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.

Episode design also 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.

Who determines the risk factors for each episode?

TAG members recommend a clinically appropriate list of risk factors for each episode. After the conclusion of the TAG, the list of risk factors is 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.

Summary of Program Changes Taking Effect in 2020

Episode Type(s) Impacted	Change to Episode Design	Page
All	Add an additional list of global clinical exclusions that apply to all episodes. This list will exclude episodes where patients have rare, high-cost conditions, such as paralysis and coma.	8
All	Update the overlapping episode exclusion hierarchy for 2020 to include episodes new to a performance period in 2020: acute gastroenteritis, cystourethroscopy, and acute kidney and ureter stones.	8
All episodes with facility quarterbacks	Update the episode transfer logic across all episode types with facility quarterbacks for 2020.	8
Acute Percutaneous Coronary Intervention (PCI)	Add an informational quality metric (not tied to gain-sharing) for "Difference in MED/day".	12
Acute Seizure	Add an episode exclusion for head trauma.	12
Appendectomy	Add an episode exclusion for abdominal trauma.	12
Attention Deficit and Hyperactivity Disorder (ADHD)	Extend the temporary level 1 case management exclusion.	13
Back and Neck Pain	Add episode exclusions for traumatic brain injury and other trauma related to the head, neck, and spine.	14
Bariatric Surgery	Add an informational quality metric (not tied to gain-sharing) for "Difference in MED/day".	14
Breast Biopsy	Add an informational quality metric (not tied to gain-sharing) for "Difference in MED/day".	14
Cholecystectomy	Add an informational quality metric (not tied to gain-sharing) for "Difference in MED/day".	14
Chronic Obstructive Pulmonary Disease (COPD) Acute Exacerbation	Expand the "follow-up care" quality metric to include hospice visits.	15
Colonoscopy	Add an informational quality metric (not tied to gain-sharing) for "ED visit within the post-trigger window".	15

Colonoscopy	Add an informational quality metric (not tied to gain-sharing) for "Difference in MED/day".	15
Congestive Heart Failure (CHF) Acute Exacerbation	Expand the "follow-up care" quality metric to include hospice visits.	16
Coronary Artery Bypass Graft (CABG)	Remove the informational metric "Participation in a Qualified Clinical Data Registry (QCDR)".	16
Coronary Artery Bypass Graft (CABG)	Add an informational quality metric (not tied to gain-sharing) for "Difference in MED/day".	16
Esophagogastroduodenoscopy (EGD)	Change the existing "ED visit within the post-trigger window" quality metric to be tied to gain-sharing.	17
Esophagogastroduodenoscopy (EGD)	Add an informational quality metric (not tied to gain-sharing) for "Difference in MED/day".	17
Femur and Pelvic Fracture	Add an episode exclusion for head trauma related to the hip, pelvis, and femur.	17
Gastrointestinal (GI) Obstruction	Add episode exclusions for abdominal trauma, bowel disorders, spinal cord injuries, spine trauma, and spine fractures.	17
Hernia Repair	Add an episode exclusion for abdominal trauma.	17
Hysterectomy	Update the "alternative treatments" quality metric to include birth control use.	18
Hysterectomy	Update the "alternative treatments" quality metric to exclude episodes with enlarged uteruses.	18
Hysterectomy	Add CPT code 58558 to the list of accepted alternative treatments for the hysterectomy episode.	18
Hysterectomy	Add ICD-10 codes to the configuration file for family history of uterine cancer and referrals to genetic counseling/genetic testing for genes associated with uterine cancer.	18
Knee Arthroscopy	Add episode exclusions for burns or systemic trauma.	19
Non-acute Percutaneous Coronary Intervention (PCI)	Add an informational quality metric (not tied to gain-sharing) for "Difference in MED/day".	19
Non-operative Ankle Injury	Add an episode exclusion for systemic trauma in addition to the joint injury.	19

Non-operative Knee Injury	Add an episode exclusion for systemic trauma in addition to the joint injury.	19
Non-operative Shoulder Injury	Add an episode exclusion for systemic trauma in addition to the joint injury.	19
Non-operative Wrist Injury	Add an episode exclusion for systemic trauma in addition to the joint injury.	19
Pancreatitis	Add an informational quality metric (not tied to gain-sharing) for "Difference in MED/day".	20
Respiratory Infection	Change the existing quality metric "ED visit within the post-trigger window" to be tied to gain-sharing.	22
Respiratory Infection	Add an informational quality metric (not tied to gain-sharing) for "Antibiotic use".	22
Spinal Decompression	Add an episode exclusion for trauma related to the head, neck, and spine.	22
Tonsillectomy	Add an informational quality metric (not tied to gain-sharing) for "Difference in MED/day".	22
Total Joint Replacement	Change the existing quality metric "Admission within post-trigger window" to be tied to gain-sharing.	23
Total Joint Replacement	Add an informational quality metric (not tied to gain-sharing) for "Difference in MED/day".	23
Valve Repair and Replacement	Add an informational quality metric (not tied to gain-sharing) for "Difference in MED/day".	23
Valve Repair and Replacement	Remove the informational metric "Participation in a Qualified Clinical Data Registry (QCDR)".	23

General Episodes Feedback

Comment: Exclude patients who have high-cost comorbidities.
Response: In addition to the episode-specific clinical exclusions, there will be an additional list of global clinical exclusions that apply to all episodes. This list will exclude episodes where patients have rare, high-cost conditions, such as paralysis and coma.

Comment: Update the overlapping episode exclusion.
Response: The overlapping episode exclusion hierarchy will be updated for 2020 to include episodes new to a performance period in 2020: acute gastroenteritis, cystourethroscopy, and acute kidney and ureter stones.

Comment: Update the transfer logic for all episodes with a facility quarterback.
Response: Based on TAG recommendations, the receiving facility is assigned as the quarterback for all episodes currently in performance when the patient is transferred within the first two days of the episode from the transferring facility. The episode transfer logic will be updated across all episode types with facility quarterbacks for 2020.

Comment: Standardize the provider reports across all three MCOs.
Response: The state continually strives to standardize the provider reports. 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: Standardize the dispute resolution and reconsideration process across all three MCOs.
Response: There is alignment across all MCOs in the reconsideration process. For example, the process for all MCOs begins with the provider submitting a written request to appeal a final performance report; the timeline for filing a request for reconsideration begins at the same point in time for all MCOs (i.e., when final performance reports are released); and providers may file a request with the Tennessee Department of Commerce & Insurance for an independent review. Differences between MCO reconsideration processes are due to differences with internal MCO processes.

Comment: Develop a reporting system that provides more information and allows a provider to have the opportunity to understand how the system is working. Hospitals should get the same information on reports that a provider/quarterback receives.
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: Improve measurement of follow-up care quality metrics.
Response: The existing follow-up quality metric measures relevant patient visits in the post-trigger window, and in prior years the follow-up quality metric has been improved by the addition of codes to better measure this metric. This year, codes for follow-up care occurring in the hospice or home health setting will be added to several episodes. Quarterbacks can influence this metric by educating patients and working with outpatient providers to arrange appropriate follow-up care. These quality metrics were included in episode design based on TAG recommendations.

Comment: Align quality metrics across all value-based payment payors.
Response: The state works to maintain as much consistency as possible with other existing payment reform programs. For instance, quality metrics are completely aligned between TennCare and commercial episodes within Tennessee. Further, the episodes program is also approved as an Advanced Alternative Payment Model (APM) with CMS.

Comment: Only hold providers accountable for costs that are related to the episode.
Response: The episodes were designed to include relevant spend in episode costs. Each episode was designed in consultation with a TAG to identify what spend is relevant to include in the episode. Episode designs have evolved with clinical and coding changes over time.

Comment: Remove the emergency department as a possible episode quarterback.
Response: The state is following guidance from the TAGs. TAG feedback indicates that there is an opportunity for hospitals and emergency departments to appropriately educate and inform patients to encourage appropriate follow-up care. Therefore, it is appropriate for the hospital and emergency departments to be accountable for specific episodes.

Comment: Reconvene TAGs to review quality metrics for episode types that have been active for several years.
Response: The state currently has no plans to reconvene the TAGs that initially designed the episodes. The state is open to specific suggestions for quality metrics, and there are multiple venues for physicians and other providers to give feedback on specific quality metrics. The state has accepted many of the recommended changes to the quality metrics, both from the TAGs during episode design and from subsequent provider feedback.

Comment: Exclude the cost of well-care visits from episode spend.
Response: Episodes are designed to include relevant spend. Costs associated with well-care visits that are not part of follow-up care for an episode are generally excluded from episode spend.

Comment: The program needs to allow greater flexibility for clinical judgment.
Response: The episodes program allows quarterbacks to maintain flexibility in treating their patients, while providing incentives to improve quality and cost effectiveness. Flexibility is built into the program model by adjusting or excluding episodes based on comorbid conditions and different patient journeys. Episode design is not prescriptive about how a provider should render care.

Comment: Standardize drug costs across all pharmacy claims within episodes.
Response: For the 2019 performance period, the state implemented a change to adjust pharmacy spend in all episodes for preferred brand and preferred generic drugs from the TennCare Preferred Drug List (PDL) to $10. This pharmacy spend adjustment helps ensure that the medications that are preferred on the TennCare PDL are incentivized in episode spend.

For more information about this change, see Memo: 2019 Episodes Changes at
https://www.tn.gov/content/dam/tn/tenncare/documents2/Memo2019EpisodesChanges.pdf.

Comment: Improve quarterback assignment to prevent a quarterback from being assigned to a patient who is primarily treated by another physician under another tax identification number (TIN).
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. 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.

Comment: Patients should be held accountable for over-utilization of services (for example, a patient's choice to go to the emergency department (ED) for a head cold that does not improve in 3 days).
Response: All episodes include patient and business exclusions that aim to protect the provider from being held responsible 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 expensive, preventable care. While patient non-compliance or over-utilization can be an issue, providers do have the opportunity to positively influence patient behavior.

Comment: Any "N/A" for a gain-sharing quality metric should not count towards the formula for determining if the quarterback passed that metric.
Response: For gain-sharing quality metrics that measure a subset of the episodes, the provider will only be held accountable for those gain-sharing quality metrics that apply to them. For example, the ADHD episode contains the gain-sharing quality metric "long-acting stimulants for members aged 6 to 11". If a quarterback for the ADHD episode does not have any patients aged 6 to 11, then that provider will see an "N/A" next to that quality metric on his or her report. Any gain-sharing quality metric with a value of "N/A" does not count towards the formula for determining if the quarterback met all gain-sharing quality metrics.

Comment: TennCare should provide additional compensation to Memphis providers to help the region's most vulnerable communities.
Response: The episodes program currently offers financial incentives for providers to provide high-quality, cost-effective care in all communities, regardless of location. Both rural and urban quarterbacks have been successful across all episodes. In addition to the episodes program, TennCare also has other initiatives to incentivize care coordination and quality of care.

Comment: Remove the follow-up care quality metric from all wave 7 orthopedic episodes.
Response: Follow-up care quality metrics will not be removed from wave 7 orthopedic episodes. For the majority of these episodes, the follow-up care quality metric is informational only and not tied to gain-sharing. The state continually tracks and reviews these metrics for additional transparency. Of the wave 7 orthopedic episodes, "related follow-up care" is only a quality metric tied to gain-sharing for the femur and pelvic fracture episode. Due to the emergent nature of the episode, it is important to track related follow-up care to ensure appropriate steps are taken to manage patient care of this acute event.

Comment: Aggregate all lines of business into a unified report instead of providing provider reports broken out by MCO.
Response: Episode reports need to be separated by MCO because each MCO contracts separately with providers. For legal and privacy reasons, contractual information needs to remain separate.

Comment: Provide quarterbacks with additional ways to give real time feedback on episode design.
Response: The state will continue to host the Annual Episodes Design Feedback Session and continue to accept feedback any time through its payment.reform@tn.gov e-mail. The state continually accepts feedback on the episodes program throughout the year and reviews recommended design changes to the program every year.

Comment: Improve episode design to prevent holding providers accountable for costs they do not control in the episode.
Response: The TAG determined who should be the quarterback or principal accountable provider for each episode. The quarterback is provided information via the provider reports to help influence the cost and quality associated with patient care. The state has researched areas where quarterbacks have had difficulty influencing costs and has adjusted program design accordingly, such as implementing automatic reconsideration in the perinatal episode for high inpatient facility spend for providers without a low-cost, nearby alternative beginning with the 2017 performance period. The state continues to evaluate specific suggestions related to other concerns.

Also, there are multiple mechanisms to make fair comparisons across episodes, including risk adjustment and exclusions. Should a provider question the accuracy of the data in their episode report, the provider can follow the reconsideration process for each MCO.

Comment: The state should set commendable thresholds consistently by disease (and not by MCO).
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, 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.

Episode-Specific Feedback

Acute Percutaneous Coronary Intervention (PCI)

Comment: Add opioid-related quality metrics to the acute PCI episode.
Response: A new informational quality metric (not tied to gain-sharing) will be added for "Difference in MED/day" to measure the usage of opioids for all procedural episodes.[1] Appropriate prescribing of opioids is a strategic initiative for all TennCare programs and a priority for the entire state.

Acute Seizure

Comment: Change the trigger logic for the acute seizure episode to allow neurology consults to trigger the episode.
Response: Episode logic will not be changed to allow neurology consults to trigger the acute seizure episode. Neurology consults frequently occur after the acute seizure has ended and is no longer an acute event. Episodes triggered by a neurology consult may include a complex seizure disorder and a different patient journey than episodes triggered by a patient admitted to the ED for an acute seizure event.

Comment: Exclude acute seizure episodes where the patient has head trauma.
Response: An episode exclusion for head trauma will be added to the acute seizure episode.

Appendectomy

Comment: Exclude appendectomy episodes where patient has abdominal trauma.
Response: An episode exclusion for abdominal trauma will be added to the appendectomy episode.

Comment: Exclude episodes that involve trauma (e.g. an appendectomy performed pursuant to a cholecystectomy and is required because of the cholecystectomy trauma).
Response: In the 2018 performance period, the state implemented an overlapping episode exclusion based on stakeholder feedback. To avoid duplicative accountability, episodes with overlapping spend where the quarterback is the same and the patient is the same will be considered "overlapping." The overlapping episode exclusion hierarchy would remove accountability for an appendectomy episode that has an episode window overlapping with a cholecystectomy episode window. The remaining cholecystectomy episode would then be subject to risk adjustment.

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[1] MED stands for morphine equivalent dose. The quality metric "difference in average MED/day" measures the average difference in morphine equivalent dose per day before the procedure and for a defined period of time after the procedure (refer to each episode's Detailed Business Requirements for the defined period of time). A lower value is indicative of better performance.

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.

Comment: Exclude all services provided in public schools for the asthma episode.
Response: Some school-based services will still be included in episode spend, when appropriate. The episode is designed to exclude medication administration by a school employee (e.g., a school nurse).

Attention Deficit and Hyperactivity Disorder (ADHD)

Comment: Make the Level 1 Case Management exclusion for ADHD permanent.
Response: The temporary Level 1 Case Management exclusion will be extended through the 2020 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 1 Case Management service. The ADHD episode will continue to have a Level I Case Management clinical exclusion for performance year 2020. It will be revisited for performance period 2021.

Comment: Quality metrics for medication in the ADHD episode conflict with the costs of the medications, as the most effective ADHD medications to prescribe are also the most expensive. Recommend updating quality metrics to align with these medications' costs.
Response: For the 2019 performance period, the state implemented a change to adjust pharmacy spend in all episodes for preferred brand and preferred generic drugs from the TennCare Preferred Drug List (PDL) to $10. This pharmacy spend adjustment helps ensure that the medications that are preferred on the TennCare PDL are incentivized in episode spend.

Comment: Exclude all services provided in public schools for the ADHD episode.
Response: The state will continue to allow some school-based services to be included in episode spend when appropriate. The episode is designed to exclude medication administration by a school employee (e.g., a school nurse).

Comment: Due to the chronic nature of mental health conditions, recommend that TennCare consider that the design of Episodes of Care is generally better suited for physical health conditions and not behavioral health conditions.
Response: Sources of value have been identified in both behavioral health and physical health episodes. For example, episodes in which children received unnecessary medication in the oppositional defiant disorder (ODD) episode has decreased from 24.6% to 3.7% from 2015 to 2017. Further, for both behavioral health and physical health episodes alike, the TAGs defined the length of each episode, and

the design of each episode includes risk factors and exclusions that account for various clinical circumstances.

Back and Neck Pain

Comment: Exclude back and neck pain episodes where the patient has traumatic brain injury and other trauma related to the head, neck, and spine.
Response: An episode exclusion for traumatic brain injury and other trauma related to the head, neck, and spine will be added to the back and neck pain episode.

Bariatric Surgery

Comment: Align the quality metrics in the bariatric episode to those posted by the Bariatric Medical Society.
Response: Quality metrics for the bariatric episode are based on recommendations by the TAG, which considered input from existing standards. Some quality metrics that are consistent with the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) bariatric surgery accreditation standards are included. We are open to other specific suggestions for quality metrics.

Comment: Add opioid-related quality metrics to the bariatric surgery episode.
Response: A new informational quality metric (not tied to gain-sharing) will be added for "Difference in MED/day" to measure the usage of opioids for all procedural episodes. Appropriate prescribing of opioids is a strategic initiative for all TennCare programs and a priority for the entire state.

Breast Biopsy

Comment: Add opioid-related quality metrics to the breast biopsy episode.
Response: A new informational quality metric (not tied to gain-sharing) will be added for "Difference in MED/day" to measure the usage of opioids for all procedural episodes. Appropriate prescribing of opioids is a strategic initiative for all TennCare programs and a priority for the entire state.

Cholecystectomy

Comment: Add opioid-related quality metrics to the cholecystectomy episode.
Response: A new informational quality metric (not tied to gain-sharing) will be added for "Difference in MED/day" to measure the usage of opioids for all procedural episodes. Appropriate prescribing of opioids is a strategic initiative for all TennCare programs and a priority for the entire state.

Chronic Obstructive Pulmonary Disease (COPD) Acute Exacerbation

Comment: Exclude patients discharged into hospice care from the 30-day follow-up care quality metric for the COPD episode.
Response: In response to stakeholder feedback, hospice visits will be allowed to count towards the follow-up care quality metric. The relevant hospice codes for the follow-up care quality metric will be added to the COPD episode. The state supports allowing any relevant follow-up care to apply to the quality metric, inclusive of hospice care.

Comment: Create an exclusion for patients discharged into hospice care.
Response: A new exclusion for patients who are discharged into hospice care will not be created. One of the objectives of the episodes program 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 coordinate care with hospice providers for patients discharged into hospice following a COPD acute exacerbation episode.

Colonoscopy

Comment: Add additional quality metrics for the colonoscopy episode.
Response: "ED visit within the post-trigger window" and "Difference in MED/day" will be added as new informational quality metrics to the colonoscopy episode.

Comment: Add opioid-related quality metrics to the colonoscopy episode.
Response: A new informational quality metric (not tied to gain-sharing) will be added for "Difference in MED/day" to measure the usage of opioids for all procedural episodes. Appropriate prescribing of opioids is a strategic initiative for all TennCare programs and a priority for the entire state.

Colposcopy

Comment: Exclude obstetrical panel costs from the colposcopy episode.
Response: Obstetrical panel costs will not be excluded from the colposcopy episode. Appropriate lab testing is a source of value for the colposcopy episode. For instance, accountability for typically inappropriate lab spending, such as an obstetrical panel, is a source of value. In cases where lab spending on an obstetrical panel is deemed appropriate for a colposcopy episode (i.e. the patient receiving the colposcopy is pregnant), the episode would be subject to the overlapping episode exclusion and counted as invalid because it overlaps with a perinatal episode.

Comment: Shorten the 90-day post trigger window for the colposcopy episode.
Response: The state will not shorten the post trigger window for the colposcopy episode. The 90-day post-trigger window only includes spend relevant to the colposcopy episode. The TAG recommended a 90-day post trigger window to allow for appropriate follow-up and definitive treatment.

Congestive Heart Failure (CHF) Acute Exacerbation

Comment: Lower the follow-up care quality metric threshold for CHF to 40% to match the COPD episode.
Response: For each gain-sharing quality metric, the benchmark for that metric is based on data specific to each episode. The threshold for the CHF episode will remain at 60%.

Comment: Exclude patients discharged into hospice care from the 30-day follow-up care quality metric for the CHF episode.
Response In response to stakeholder feedback, hospice visits will be allowed to count towards the follow-up care quality metric. The relevant hospice codes for the follow-up care quality metric will be added to the CHF episode. The state supports allowing any relevant follow-up care to apply to the quality metric, inclusive of hospice care.

Comment: Create an exclusion for patients discharged into hospice care.
Response: A new exclusion for patients who are discharged into hospice care will not be created. One of the objectives of the episodes program 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 coordinate care with hospice providers for patients discharged into hospice following a CHF acute exacerbation episode.

Coronary Artery Bypass Graft (CABG)

Comment: Remove Qualified Clinical Data Registry (QCDR) informational quality metrics.
Response: The "participation in a Qualified Clinical Data Registry (QCDR)" quality metric will be removed from the CABG episode. There have been challenges with measuring a quarterback's participation in a QCDR for the episode and with moving beyond participation to more meaningful measurements in the long term. There continues to be a benefit for providers and facilities to use registries to promote data-driven quality improvement efforts.

Comment: Add opioid-related quality metrics to the CABG episode.
Response: A new informational quality metric (not tied to gain-sharing) will be added for "Difference in MED/day" to measure the usage of opioids for all procedural episodes. Appropriate prescribing of opioids is a strategic initiative for all TennCare programs and a priority for the entire state.

Esophagogastroduodenoscopy (EGD)

Comment: Add a quality metric tied to gain-sharing to the EGD episode.
Response: The existing quality metric "ED visit within the post-trigger window" will be changed to gain-sharing.

Comment: Add opioid-related quality metrics to the EGD episode.
Response: A new informational quality metric (not tied to gain-sharing) will be added for "Difference in MED/day" to measure the usage of opioids for all procedural episodes. Appropriate prescribing of opioids is a strategic initiative for all TennCare programs and a priority for the entire state.

Femur and Pelvic Fracture

Comment: Exclude episodes where the patient has trauma related to the hip, pelvis, and femur.
Response: An episode exclusion for head trauma related to the hip, pelvis, and femur will be added to the femur and pelvic fracture episode.

Gastrointestinal (GI) Obstruction

Comment: Exclude GI obstruction episodes where patient has abdominal trauma, bowel disorders, spinal cord injuries, spine trauma, and spine fractures.
Response: An episode exclusion for abdominal trauma, bowel disorders, spinal cord injuries, spine trauma, and spine fractures will be added to the GI Obstruction episode.

Hernia Repair

Comment: Exclude hernia repair episodes where patient has abdominal trauma.
Response: An episode exclusion for abdominal trauma will be added to the hernia repair episode.

Hysterectomy

Comment: Add additional risk factors to the hysterectomy episode, such as vomiting with dehydration (e.g. need for fluids, need for antiemetic medications), anemia (e.g. need for blood work, need for blood transfusions), and infections secondary to the surgery.
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. An example of a common risk factor is asthma. These proposed risk factors will be tested, or retested, as risk factors in the risk adjustment models to continue making fair assessments of quarterback performance in the hysterectomy episode.

Comment: Add additional risk factors to the hysterectomy episode relevant to medical complications to the procedure, such as pneumonia, pleurisy, and urinary tract infection.

Response: Medical complications that are a part of the hysterectomy procedure are not considered risk factors. An episode risk factor is a clinical or patient factor (such as age, gender, diagnoses, and disease comorbidities) that has a statistically significant impact on episode spend. A medical complication subsequent to treatment is important to include in episode design because it is a source of value that is an indication of the quality of care the patient received.

Comment: Follow-up visits in the hysterectomy episode are not being captured because they are a $0 charge. Recommend attaching a $10 to $20 administrative fee to the follow-up visit so that it is attached in claims data and will be reflected in measuring quality metric performance.
Response: 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: Add codes to the configuration file for history of birth control use in the hysterectomy episode for the alternative treatment quality metric.
Response: The ICD-10 codes for birth control use will be added to the hysterectomy episode quality metric for alternative treatments. Birth control is a clinically appropriate alternative treatment prior to a hysterectomy, and therefore it meets the quality metric for alternative treatments.

Comment: Remove women with enlarged uteruses from the denominator of the alternative treatment quality metric in the hysterectomy episode.
Response: Women with an enlarged uterus will be removed from the denominator of the alternative treatment quality metric for the hysterectomy episode, as it may be appropriate for these women to receive a hysterectomy without prior alternative treatments.

Comment: Add CPT code 58558 to the list of included alternative treatment spend in the hysterectomy episode.
Response: The CPT code 58558 will be added to the list of accepted alternative treatments for the hysterectomy episode.

Comment: Add ICD-10 codes to the hysterectomy configuration file that indicate a family history of uterine cancer and referrals to genetic counseling or genetic testing for genes associated with uterine cancer.
Response: A list of ICD-10 codes will be added to the configuration file for family history of uterine cancer and referrals to genetic counseling/genetic testing for genes associated with uterine cancer. These proposed risk factors will be tested, or retested, as risk factors in the risk adjustment models to continue making fair assessments of quarterback performance in the hysterectomy episode.

Comment: Extend the post-trigger window for the hysterectomy episode to include the 42-day follow-up care quality metric.
Response: The hysterectomy post-trigger window will not be extended beyond 30 days. The post-trigger window is only related to episode spend, and follow-up care quality metrics that fall outside the post-trigger window will still be counted. Based on the TAG recommendations, the appropriate level of cost accountability is 30 days, and the appropriate window of time for follow-up care is 42 days.

MEMO: 2020 Episode Changes

Knee Arthroscopy

Comment: Exclude episodes where patient has burns or trauma related to the knee.
Response: An exclusion will be added to the knee arthroscopy episode for burns or systemic trauma.

Non-acute Percutaneous Coronary Intervention (PCI)

Comment: Add opioid-related quality metrics to the non-acute PCI episode.
Response: A new informational quality metric (not tied to gain-sharing) will be added for "Difference in MED/day" to measure the usage of opioids for all procedural episodes. Appropriate prescribing of opioids is a strategic initiative for all TennCare programs and a priority for the entire state.

Non-operative Ankle Injury

Comment: Exclude episodes where patient has trauma related to the joint.
Response: An exclusion will be added to the non-operative ankle injury episode for systemic trauma in addition to the joint injury.

Non-operative Knee Injury

Comment: Exclude episodes where patient has trauma related to the joint.
Response: An exclusion will be added to the non-operative knee injury for systemic trauma in addition to the joint injury.

Non-operative Shoulder Injury

Comment: Exclude episodes where patient has trauma related to the joint.
Response: An exclusion will be added to the non-operative shoulder injury episode for systemic trauma in addition to the joint injury.

Non-operative Wrist Injury

Comment: Exclude episodes where patient has trauma related to the joint.
Response: An exclusion will be added to the non-operative wrist injury episode for systemic trauma in addition to the joint injury.

Oppositional Defiant Disorder (ODD)

Comment: Due to the chronic nature of mental health conditions, recommend that TennCare consider that the design of Episodes of Care is generally better suited for physical health conditions and not behavioral health conditions.
Response: Sources of value have been identified in both behavioral health and physical health episodes. For example, episodes in which children received unnecessary medication in the oppositional defiant disorder (ODD) episode has decreased from 24.6% to 3.7% from 2015 to 2017. Further, with both behavioral health and physical health episodes alike, the TAGs defined the length of each episode, and the design of each episode includes risk factors and exclusions that account for various clinical circumstances.

Otitis Media

Comment: Exclude otitis media episodes that require antibiotics.
Response: The otitis media episode quality metrics distinguish otitis media externa, which does not require antibiotics, from non-otitis media externa. Feedback from the TAG was that otitis media externa should not require antibiotics. Appropriate utilization of antibiotics is a source of value in the otitis media episode.

Pancreatitis

Comment: Add opioid-related quality metrics to the pancreatitis episode.
Response: A new informational quality metric (not tied to gain-sharing) will be added for "Difference in MED/day" to measure the usage of opioids for all procedural episodes. Appropriate prescribing of opioids is a strategic initiative for all TennCare programs and a priority for the entire state.

Perinatal

Comment: Add bipolar diagnosis as a clinical exclusion for the perinatal episode.
Response: The patient journey for individuals with bipolar disorder through the perinatal episode is similar to other patients. While this behavioral health condition may make their care more complicated and therefore potentially more expensive, these differences can be addressed through risk adjustment. High-quality, cost-effective care for patients with a bipolar diagnosis is both a source of value and an opportunity for improved outcomes, and therefore patients with a bipolar diagnosis will not be excluded from the perinatal episode. Additionally, the state implemented a change for the 2019 performance period to adjust pharmacy spend in all episodes for preferred brand and preferred generic drugs from the TennCare Preferred Drug List (PDL) to $10.

Comment: Exclude C-sections secondary to emergent or medical necessity from the gain-sharing quality metric in the perinatal episode.
Response: C-sections secondary to emergent or medical necessity will not be excluded from the gain-sharing quality metric. At the advice of the TAG, the state has decided to use a combined rate that

measures all C-sections, regardless of the cause or clinical circumstances. The state also added an informational quality metric to the perinatal episode for primary C-section rate, which allows providers to see the data on the different C-section rates.

Comment: Exclude pregnant women with Opioid Use Disorder (OUD).
Response: Accountability for quarterbacks treating pregnant women with OUD will be maintained. There is opportunity for sources of value and improved outcomes for women with OUD in the perinatal episode which the quarterback can influence. The state seeks to optimize this treatment, and therefore these patients will not be excluded from the perinatal episode. The state has removed cost accountability for Medication Assisted Therapy (MAT) treatment in the perinatal episode to encourage appropriate treatment for this population.

Comment: Create a new geographic adjustment for the perinatal episode to account for differences in rural versus urban hospital costs.
Response: A geographic cost adjustment will not be created. There are advantages and disadvantages to practicing in different locations. For example, the state has analyzed cost differences between urban and rural providers in numerous episodes, including perinatal, and we have not found that a systemic disadvantage exists when practicing in either setting. There are high performing quarterbacks in both settings.

Comment: Add more exclusions for high-risk patients.
Response: The perinatal TAG recommended that obstetrician-gynecologists (OBGYNs) work with maternal fetal medicine (MFM) specialists to coordinate care and reduce costs. Patients with a different care pathway or who are too high risk to be fairly compared are already excluded from the perinatal episode. These patients represent a significant source of value to the episode.

Comment: Add reporting on neonatal outcomes to measure the full impact of the perinatal episode.
Response The cost and quality of neonatal care is important. The state is investigating if there is a way to reliably and consistently capture this data and report it to providers.

Comment: Add methadone to the Medication Assisted Therapy (MAT) spend exclusion in the perinatal episode.
Response: TennCare does not currently pay for methadone. When TennCare begins to reimburse for methadone, those costs will be added to the MAT spend exclusion.

Comment: Emergency department visit costs should not be included in the perinatal episode.
Response: There is appropriate accountability for the quarterback of the perinatal episode to encourage access and avoid unnecessary ED visits. There is also an episode exclusion for the perinatal episode for no prenatal care. Therefore, the associated cost accountability will continue to be included in the perinatal episode.

Comment: TennCare should provide resources and patient access to treatment options to enable patients to continue treatment for substance and mental health disorders from 43 days to one year after pregnancy.

Response: Apart from the Episodes of Care program, TennCare currently partners with the MCOs to provide a comprehensive network of providers who offer specific treatment for members of opioid use disorder. To promote the use of MAT to treat at-risk pregnant women, TennCare excluded MAT-related spend from the perinatal episode starting with the 2019 performance period. Providers will not be financially accountable for these services. Separate from the episodes program, the state and the MCOs have multiple programs to optimize treatment for pregnant women with substance and mental health disorders. For more information about TennCare's opioid strategy, see https://www.tn.gov/tenncare/tenncare-s-opioid-strategy.html.

Respiratory Infection

Comment: Add a quality metric tied to gain-sharing.

Response: The existing quality metric "ED visit within the post-trigger window" will be changed to gain-sharing.

Comment: Add a new quality metric for antibiotic use to the respiratory infection episode.

Response: A new informational quality metric (not tied to gain-sharing) will be added for "Antibiotic use" to the respiratory infection episode.

Spinal Decompression

Comment: Exclude episodes where patient has trauma related to the head, neck, and spine.

Response: An exclusion will be added to the spinal decompression episode for trauma related to the head, neck, and spine.

Tonsillectomy

Comment: Add opioid-related quality metrics to the tonsillectomy episode.

Response: A new informational quality metric (not tied to gain-sharing) will be added for "Difference in MED/day" to measure the usage of opioids for all procedural episodes. Appropriate prescribing of opioids is a strategic initiative for all TennCare programs and a priority for the entire state.

Total Joint Replacement (TJR)

Comment: Add a quality metric tied to gain-sharing.
Response: The existing quality metric "Admission within post-trigger window" will be changed to gain-sharing.

Comment: Add opioid-related quality metrics to the TJR episode.
Response: A new informational quality metric (not tied to gain-sharing) will be added for "Difference in MED/day" to measure the usage of opioids for all procedural episodes. Appropriate prescribing of opioids is a strategic initiative for all TennCare programs and a priority for the entire state.

Valve Repair and Replacement

Comment: Add opioid-related quality metrics to the valve repair and replacement episode.
Response: A new informational quality metric (not tied to gain-sharing) will be added for "Difference in MED/day" to measure the usage of opioids for all procedural episodes. Appropriate prescribing of opioids is a strategic initiative for all TennCare programs and a priority for the entire state.

Comment: Remove Qualified Clinical Data Registry (QCDR) informational quality metrics.
Response: The "participation in a Qualified Clinical Data Registry (QCDR)" quality metric will be removed from the valve repair and replacement episode. There have been challenges with measuring a quarterback's participation in a QCDR for the episode and with moving beyond participation to more meaningful measurements in the long term. Note that there continues to be a benefit for providers and facilities to continue using registries to promote data-driven quality improvement efforts.