TN Division of TennCare

MEMO: 2022 Episode Changes

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Introduction

Date: September 2021 – *Updated November 2021*
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 2022 performance period that begins January 1, 2022.

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 19, 2021. 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 2021. Members of the public were able to share their feedback live during this year's event, as well as submit their feedback electronically prior to the event via email and an online form.

The state is making 45 changes to the design of the episodes program for the 2022 performance period. The feedback is organized by episode in alphabetical order. The table "Summary of Program Changes Taking Effect in 2022" is also provided to highlight feedback that resulted in episode design changes for the 2022 performance year.

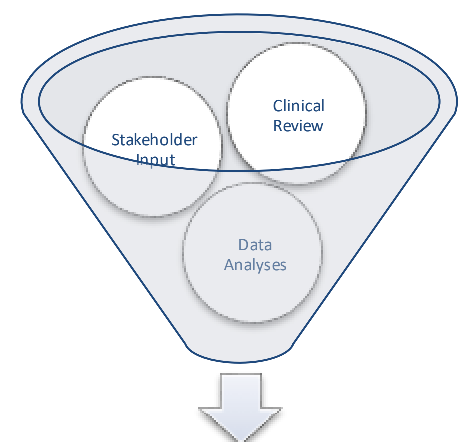
Episodes of Care's Response to COVID-19

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 May 12, 2021, that the three TennCare Managed Care Organizations (MCOs) will waive all episodes of care risk-sharing payments in the final reports for the 2020 performance period. Providers who have gain-sharing payments will receive those payments as planned, with no changes.

The state welcomes input from stakeholders regarding potential future adjustments to episodes design during this uniquely difficult time.

What Does the State Do with Your Feedback?

The state highly values stakeholder feedback. TennCare works on your proposed changes throughout the year, with efforts focused during the summer between the spring feedback session and the fall release of this memo. The state conducts data analyses and solicits clinical input. All of these perspectives are taken into account as the state determines its response to each item of feedback received.



State response to stakeholder feedback

When Will Providers See These Changes Reflected in Their Reports?

Episode design changes in this memo will take effect on January 1, 2022, for the 2022 performance year. Providers will first see their performance data reflecting these changes in the interim performance reports released in August 2022 that cover the first quarter of the 2022 performance period (January through March 2022).

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 that cannot be fairly compared. Some exclusions are business exclusions (e.g., incomplete data, dual eligibility), clinical exclusions (e.g., active cancer management, triplet pregnancy), patient exclusions (e.g., left against medical advice, death), and high-cost outlier exclusions (i.e., the risk-adjusted cost for an episode makes it an outlier relative to other valid episodes). 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 other 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 based on comorbidities or other factors shown in the data to be significantly higher cost. 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 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 2022[1]

Providers will first see these changes reflected in their interim performance reports released in August 2022 that cover the first quarter of the 2022 performance period (January through March 2022).

Episode Type(s) Impacted	Change to Episode Design	Page
All Episodes	An episode is excluded if the patient has a diagnosis code related to COVID-19 (U071) or pneumonia due to COVID-19 (J1282).	12
All Episodes	Removal of invalidated codes and the addition of new or revised codes related to configuration file maintenance.	12
Acute Gastroenteritis	The Difference in Average MED/day informational quality metric will be updated to the percentage of valid episodes that have a difference in MED that is less than or equal to zero (0.0) as opposed to the average difference across all valid episodes.	14
Acute Kidney and Ureter Stones	The Difference in Average MED/day gain-sharing quality metric will be updated to the percentage of valid episodes that have a difference in MED that is less than or equal to three (3.0) as opposed to the average difference across all valid episodes.	14
Acute Pancreatitis	The time period for the Follow-up Care gain-sharing quality metric will be expanded from 14 days to 30 days.	14
Acute Pancreatitis	The Difference in Average MED/day informational quality metric will be updated to the percentage of valid episodes that have a difference in MED that is less than or equal to zero (0.0) as opposed to the average difference across all valid episodes.	14
Acute Percutaneous Coronary Intervention (PCI)	The Difference in Average MED/day informational quality metric will be updated to the percentage of valid episodes that have a difference in MED that is less than or equal to zero (0.0) as opposed to the average difference across all valid episodes.	15
Asthma Acute Exacerbation	The asthma acute exacerbation episode will have a new informational quality metric added for Follow-up Care for Newly-diagnosed Asthma Cases.	15

[1] Table updated November 2021 to reflect updated calculation of the Difference in Average MED/day informational quality metrics.

Appendectomy	The Difference in Average MED/day gain-sharing quality metric will be updated to the percentage of valid episodes that have a difference in MED that is less than or equal to zero (0.0) as opposed to the average difference across all valid episodes.	15
Attention Deficit and Hyperactivity Disorder (ADHD)	The temporary Level 1 Case Management exclusion will be permanently removed for the 2022 performance period.	15
Attention Deficit and Hyperactivity Disorder (ADHD)	The state will add new clinical exclusions that are based on diagnosis codes found on Level 1 Case Management claims in excluded ADHD episodes.	17
Attention Deficit and Hyperactivity Disorder (ADHD)	The state will remove the informational quality metric Utilization of Level 1 Case Management from the ADHD episode.	17
Attention Deficit and Hyperactivity Disorder (ADHD)	The Long-acting Stimulants for Members Aged 6 to 11 Years quality metric will be moved from gain-sharing to informational.	17
Attention Deficit and Hyperactivity Disorder (ADHD)	The Long-acting Stimulants for Members Aged 12 to 20 Years quality metric will be moved from gain-sharing to informational.	17
Back and Neck Pain	The Difference in Average MED/day gain-sharing quality metric will be updated to the percentage of valid episodes that have a difference in MED that is less than or equal to zero (0.0) as opposed to the average difference across all valid episodes.	17
Bariatric Surgery	The Difference in Average MED/day informational quality metric will be updated to the percentage of valid episodes that have a difference in MED that is less than or equal to zero (0.0) as opposed to the average difference across all valid episodes.	18
Breast Biopsy	The Difference in Average MED/day informational quality metric will be updated to the percentage of valid episodes that have a difference in MED that is less than or equal to zero (0.0) as opposed to the average difference across all valid episodes.	18

Cholecystectomy	The Difference in Average MED/day informational quality metric will be updated to the percentage of valid episodes that have a difference in MED that is less than or equal to zero (0.0) as opposed to the average difference across all valid episodes.	18
Colonoscopy	The Difference in Average MED/day informational quality metric will be updated to the percentage of valid episodes that have a difference in MED that is less than or equal to zero (0.0) as opposed to the average difference across all valid episodes.	18
Colposcopy	The Difference in Average MED/day informational quality metric will be updated to the percentage of valid episodes that have a difference in MED that is less than or equal to zero (0.0) as opposed to the average difference across all valid episodes.	19
Coronary Artery Bypass Graft (CABG)	The Difference in Average MED/day informational quality metric will be updated to the percentage of valid episodes that have a difference in MED that is less than or equal to zero (0.0) as opposed to the average difference across all valid episodes.	19
Cystourethroscopy	The Difference in Average MED/day gain-sharing quality metric will be updated to the percentage of valid episodes that have a difference in MED that is less than or equal to zero (0.0) as opposed to the average difference across all valid episodes.	19
Diabetes Acute Exacerbation	The time period for the Follow-up Care gain-sharing quality metric will be expanded from 14 days to 30 days.	19
Esophagogastroduodenoscopy (EGD)	The Difference in Average MED/day informational quality metric will be updated to the percentage of valid episodes that have a difference in MED that is less than or equal to zero (0.0) as opposed to the average difference across all valid episodes.	19
Femur/Pelvic Fracture	The Difference in Average MED/day informational quality metric will be updated to the percentage of valid episodes that have a difference in MED that is less than or equal to zero (0.0) as opposed to the average difference across all valid episodes.	20

GI Obstruction	The Difference in Average MED/day gain-sharing quality metric will be updated to the percentage of valid episodes that have a difference in MED that is less than or equal to zero (0.0) as opposed to the average difference across all valid episodes.	20
Hernia Repair	The Difference in Average MED/day gain-sharing quality metric will be updated to the percentage of valid episodes that have a difference in MED that is less than or equal to zero (0.0) as opposed to the average difference across all valid episodes.	20
Hysterectomy	The look-back period for the Alternative Treatments gain-sharing quality metric will be extended from 180 days to 690 days.	20
Hysterectomy	The ICD-10 diagnosis codes related to personal history of contraception (Z92.0) will be added to the Alternative Treatments quality metric of the hysterectomy episode.	20
Hysterectomy	The ICD-10 diagnosis codes related to post-endometrial ablation syndrome (N99.85) will be added to the Alternative Treatments quality metric of the hysterectomy episode.	20
Hysterectomy	The Difference in Average MED/day informational quality metric will be updated to the percentage of valid episodes that have a difference in MED that is less than or equal to zero (0.0) as opposed to the average difference across all valid episodes.	21
Knee Arthroscopy	The Difference in Average MED/day gain-sharing quality metric will be updated to the percentage of valid episodes that have a difference in MED that is less than or equal to zero (0.0) as opposed to the average difference across all valid episodes.	21
Non-Acute Percutaneous Coronary Intervention (PCI)	The Difference in Average MED/day informational quality metric will be updated to the percentage of valid episodes that have a difference in MED that is less than or equal to zero (0.0) as opposed to the average difference across all valid episodes.	21

Non-Operative Ankle Injury	The Difference in Average MED/day gain-sharing quality metric will be updated to the percentage of valid episodes that have a difference in MED that is less than or equal to zero (0.0) as opposed to the average difference across all valid episodes.	21
Non-Operative Knee Injury	The Difference in Average MED/day gain-sharing quality metric will be updated to the percentage of valid episodes that have a difference in MED that is less than or equal to zero (0.0) as opposed to the average difference across all valid episodes.	21
Non-Operative Shoulder Injury	The Difference in Average MED/day gain-sharing quality metric will be updated to the percentage of valid episodes that have a difference in MED that is less than or equal to zero (0.0) as opposed to the average difference across all valid episodes.	22
Non-Operative Wrist Injury	The Difference in Average MED/day gain-sharing quality metric will be updated to the percentage of valid episodes that have a difference in MED that is less than or equal to zero (0.0) as opposed to the average difference across all valid episodes.	22
Oppositional Defiant Disorder (ODD)	The evaluation and management (E&M) and medication management codes currently listed under the Utilization (excluding medication) informational quality metric will be added to count towards the Minimum Care Requirement gain-sharing quality metric.	22
Perinatal	The state will update the episode trigger logic in the episode to capture more invalid episodes. This change will identify episodes with an incomplete trigger (for example, a delivery claim with no associated facility claim) and count these episodes as invalid.	22
Perinatal	The state is changing the Primary C-section quality metric that is informational to align with the Agency for Healthcare Research and Quality (AHRQ) definition of primary C-section delivery rate. This design change will add exclusions for deliveries with complications (such as abnormal presentation, breech, etc.).	23

Spinal Decompression	The Difference in Average MED/day gain-sharing quality metric will be updated to the percentage of valid episodes that have a difference in MED that is less than or equal to zero (0.0) as opposed to the average difference across all valid episodes.	24
Spinal Fusion	The Difference in Average MED/day gain-sharing quality metric will be updated to the percentage of valid episodes that have a difference in MED that is less than or equal to eight (8.0) as opposed to the average difference across all valid episodes.	24
Tonsillectomy	The Difference in Average MED/day informational quality metric will be updated to the percentage of valid episodes that have a difference in MED that is less than or equal to zero (0.0) as opposed to the average difference across all valid episodes.	25
Total Joint Replacement	The Difference in Average MED/day informational quality metric will be updated to the percentage of valid episodes that have a difference in MED that is less than or equal to zero (0.0) as opposed to the average difference across all valid episodes.	25
Valve Repair and Replacement	The Difference in Average MED/day informational quality metric will be updated to the percentage of valid episodes that have a difference in MED that is less than or equal to zero (0.0) as opposed to the average difference across all valid episodes.	25

General Episodes Feedback

Comment: Consider an episode exclusion for COVID-19.

Response: The state will implement a program-wide exclusion for COVID-19. An episode is excluded if the patient has a diagnosis code related to COVID-19 (U071) or pneumonia due to COVID-19 (J1282) at any time during the episode window.

Comment: Make it easier for providers to access reports.

Response: The state attempts to standardize and streamline the provider's access to reports as much as possible. For example, the state requires each MCO to provide a way for providers to login to a secure portal and download their performance reports. The format of the report is also standardized between the MCOs. The state is open to reviewing any specific suggestions stakeholders may have that may make access to reports easier.

Comment: Review the configuration file codes for each episode.

Response: The state did review and will make necessary changes to the configuration file of each episode type. TennCare reviews the configuration files on a regular basis to update codes, including removal of invalidated codes and the addition of new or revised codes related to configuration file maintenance.

Comment: MCOs should follow CCS or HHS risk adjustment coding guidelines since that is what providers are most comfortable using.

Response: The MCOs are responsible for developing and implementing the risk adjustment process for the episodes program. The risk adjustment process for episodes of care focuses on adjusting for patients with a significantly higher cost. This process is based on specific aspects of the TennCare program that are not captured by other coding guidelines.

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: The state should provide educational materials for patients explaining the process of episodes and providing health information about their medical conditions, available resources, etc.

Response: Both TennCare and the MCOs provide educational materials for patients. In particular, the MCOs develop new materials every year to educate patients on various aspects of their healthcare. The episodes of care program does not dictate how providers render care, and patient education is ultimately the responsibility of the provider. Additionally, patients are not aware that they are in an episode, and, due to the retrospective nature of the program, an episode is not identified and deemed valid until after the care has been rendered.

Comment: Do not penalize a quarterback for a patient who is primarily treated or prescribed medication 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. A principle of the program is that the quarterback is able to influence the care of other providers involved in the episode.

Comment: Quarterbacks do not always get enough feedback on their results.

Response: The MCOs have developed many resources to support providers in interpreting their episodes performance reports. One of the key elements of support the MCOs provide is individual engagement from provider representatives trained to provide feedback on episodes of care performance. Providers can reach out to their MCO representative to schedule a meeting.

Comment: Attach a $10 to $20 administrative fee to the post-operative visits 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 zero dollars ($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. For example, CPT code 99024 is included for episodes with a global period for procedures to capture follow-up care visits. Reimbursement for post-operative visits is already included in global payments.

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.

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. There are also concerns about confidential contract provisions between contracted providers that cannot be shared. 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: The information in our provider reports is more than a year old. Our sample size is also small. This makes it difficult to get any value out of our performance reports data.

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. Additionally, beginning with 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.

Episode-Specific Feedback

Acute Gastroenteritis

Comment: Update the existing Difference in Average MED/day quality metric to better account for the impact of outliers.

Response: The Difference in Average MED/day informational quality metric will be updated to the percentage of valid episodes that have a difference in MED that is less than or equal to zero (0.0) as opposed to the average difference across all valid episodes. The opioid windows, which are specific to an episode type, will remain the same.

Acute Kidney & Ureter Stones

Comment: Update the existing Difference in Average MED/day quality metric to better account for the impact of outliers.

Response: The Difference in Average MED/day gain-sharing quality metric will be updated to the percentage of valid episodes that have a difference in MED that is less than or equal to three (3.0) as opposed to the average difference across all valid episodes. The opioid windows, which are specific to an episode type, will remain the same.

Acute Pancreatitis

Comment: Expand the time period for the Follow-up Care Quality Metric.

Response: The time period for the Follow-up Care gain-sharing quality metric will be expanded from 14 days to 30 days.

Comment: Update the existing Difference in Average MED/day quality metric to better account for the impact of outliers.

Response: The Difference in Average MED/day informational quality metric will be updated to the percentage of valid episodes that have a difference in MED that is less than or equal to zero (0.0) as opposed to the average difference across all valid episodes. The opioid windows, which are specific to an episode type, will remain the same.

Acute Percutaneous Coronary Intervention (PCI)

Comment: Update the existing Difference in Average MED/day quality metric to better account for the impact of outliers.

Response: The Difference in Average MED/day informational quality metric will be updated to the percentage of valid episodes that have a difference in MED that is less than or equal to zero (0.0) as opposed to the average difference across all valid episodes. The opioid windows, which are specific to an episode type, will remain the same.

Asthma Acute Exacerbation

Comment: Add a new informational quality metric to the asthma acute exacerbation episode.

Response: The asthma acute exacerbation episode will have a new informational quality metric added for Follow-up Care for Newly-diagnosed Asthma Cases.

Appendectomy

Comment: Update the existing Difference in Average MED/day quality metric to better account for the impact of outliers.

Response: The Difference in Average MED/day gain-sharing quality metric will be updated to the percentage of valid episodes that have a difference in MED that is less than or equal to zero (0.0) as opposed to the average difference across all valid episodes. The opioid windows, which are specific to an episode type, will remain the same.

Attention Deficit and Hyperactivity Disorder (ADHD)

Comment: Do not use "hyperactivity" as an episode trigger for ADHD.

Response: An ADHD episode is triggered by a professional claim with an ADHD primary *diagnosis* code and a procedure code that is for assessments and testing, case management, E&M and medication management, or therapy services. In addition, an ADHD episode may be triggered by a professional claim with a primary *diagnosis* of ADHD specific symptoms with a secondary diagnosis code and a procedure code that is for assessments and testing, case management, E&M and medication management, or therapy services. An ADHD episode is not triggered by coding for hyperactivity as a symptom; diagnosis of ADHD must be included. The codes determined to trigger an ADHD episode are based on specific TAG feedback.

Comment: Remove the Level 1 Case Management exclusion for ADHD.

Response: The temporary Level 1 Case Management exclusion will be removed beginning with the 2022 performance period.

Comment: Some patients are treated with non-stimulant medications and prescribed a 3-month supply. This only generates a single claim for multiple months of medication.

Response: Patients prescribed multiple months of medication for the treatment of ADHD must still refill monthly, which should generate three touchpoints for the ADHD episode. The original TAG recommendation was to include prescriptions for more than a month of medication as a source of value for the ADHD episode.

Comment: Phone calls to parents to engage them in their child's treatment for ADHD (for example, appointment reminders) should count towards the minimum care requirement rate.

Response: The Minimum Care Requirement quality metric is intended to capture visits/claims that occur for the purposes of providing treatment to patients. Phone calls to the parent of a patient may provide valuable engagement that results in the improvement of the patient's care (for example, attending more appointments), but those touchpoints are outside the scope of the metric.

Comment: COVID-19 has impacted patients' ability to book and attend therapy appointments, especially as new patients. That is impacting provider's ability to meet the Utilization of Therapy for 4-to-5 year-olds quality metric.

Response: The state will be implementing a global exclusion for COVID-19 diagnosis and treatment. Further, net risk-sharing payments for both the 2019 and 2020 performance periods will be waived in response to COVID-19. The state will continue to analyze data and monitor the system-wide impacts of the pandemic on providers.

Comment: The ADHD quality metrics do not support providers who limit the use of medication during weekends and summer medication holidays.

Response: The original TAG recommendation was to capture the sources of value related to medication management during holidays, weekends, etc. The appropriate use of medications throughout the year is a source of value for all providers to manage in the treatment of ADHD.

Comment: Add code 96127 (Brief emotional/behavioral assessment (e.g., depression inventory, attention deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument) to the minimum care requirement for ADHD.

Response: The Minimum Care Requirement quality metric is intended to capture visits/claims that occur for the purposes of providing treatment to patients. Developmental/behavioral screenings may be an important part of a provider's overall care of patients with ADHD, but this screening tool is outside the scope of the metric.

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 ADHD TAG identified school-based services as a source of value within the ADHD episode.

Comment: Add additional clinical exclusions based on excluded ADHD episodes with Level 1 Case Management claims

Response: The state will add additional clinical exclusions that are based on diagnosis codes found on Level 1 Case Management claims in excluded ADHD episodes.

Comment: Remove the Utilization of Level 1 Case Management quality metric.

Response: The state will remove the informational quality metric Utilization of Level 1 Case Management from the ADHD episode.

Comment: Exclude ADHD episodes that have instances of attempted treatment, specialized treatments, parent refusal, etc.

Response: The original ADHD TAG recommendation is to include episodes that contain patient compliance, medication management, or other challenges because they are a source of value for the episode. All ADHD quarterbacks have a similar patient population, and providers are compared with their peers to determine ADHD episode performance.

Comment: Shift the Long-acting Stimulant for Age 6 to 11 Year Olds quality metric from gain-sharing to informational.

Response: The Long-acting Stimulants for Members Aged 6 to 11 Years quality metric will be moved from gain-sharing to informational.

Comment: Shift the Long-acting Stimulant for Age 12 to 20 Year Olds quality metric from gain-sharing to informational.

Response: The Long-acting Stimulants for Members Aged 12 to 20 Years quality metric will be moved from gain-sharing to informational.

Comment: Providers are disadvantaged when prescribing medically necessary long-acting stimulants to patients who need them.

Response: The Long-Acting Stimulants for Members Aged 6 to 11 Years and Long-Acting Stimulants for Members Aged 12 to 20 Years quality metrics will be moved from gain-sharing to informational for the 2022 performance period. Additionally, 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 Preferred Drug List (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.

Back and Neck Pain

Comment: Update the existing Difference in Average MED/day quality metric to better account for the impact of outliers.

Response: The Difference in Average MED/day gain-sharing quality metric will be updated to the percentage of valid episodes that have a difference in MED that is less than or equal to zero (0.0) as opposed to the average difference across all valid episodes. The opioid windows, which are specific to an episode type, will remain the same.

Bariatric Surgery

Comment: Update the existing Difference in Average MED/day quality metric to better account for the impact of outliers.

Response: The Difference in Average MED/day informational quality metric will be updated to the percentage of valid episodes that have a difference in MED that is less than or equal to zero (0.0) as opposed to the average difference across all valid episodes. The opioid windows, which are specific to an episode type, will remain the same.

Breast Biopsy

Comment: Exclude patients younger than 21 years old from the Core Needle Biopsy Rate quality metric.

Response: The breast biopsy TAG recommendation is to capture core needle biopsies on all valid episodes as a source of value. The TAG recommendation is that all breast biopsy episodes on patients 13 years old and above be included as valid episodes. The state will not remove younger patients from this quality metric.

Comment: Update the existing Difference in Average MED/day quality metric to better account for the impact of outliers.

Response: The Difference in Average MED/day informational quality metric will be updated to the percentage of valid episodes that have a difference in MED that is less than or equal to zero (0.0) as opposed to the average difference across all valid episodes. The opioid windows, which are specific to an episode type, will remain the same.

Cholecystectomy

Comment: Update the existing Difference in Average MED/day quality metric to better account for the impact of outliers.

Response: The Difference in Average MED/day informational quality metric will be updated to the percentage of valid episodes that have a difference in MED that is less than or equal to zero (0.0) as opposed to the average difference across all valid episodes. The opioid windows, which are specific to an episode type, will remain the same.

Colonoscopy

Comment: Update the existing Difference in Average MED/day quality metric to better account for the impact of outliers.

Response: The Difference in Average MED/day informational quality metric will be updated to the percentage of valid episodes that have a difference in MED that is less than or equal to zero (0.0) as opposed to the average difference across all valid episodes. The opioid windows, which are specific to an episode type, will remain the same.

Colposcopy

Comment: Update the existing Difference in Average MED/day quality metric to better account for the impact of outliers.

Response: The Difference in Average MED/day informational quality metric will be updated to the percentage of valid episodes that have a difference in MED that is less than or equal to zero (0.0) as opposed to the average difference across all valid episodes. The opioid windows, which are specific to an episode type, will remain the same.

Coronary Artery Bypass Graft (CABG)

Comment: Update the existing Difference in Average MED/day quality metric to better account for the impact of outliers.

Response: The Difference in Average MED/day informational quality metric will be updated to the percentage of valid episodes that have a difference in MED that is less than or equal to zero (0.0) as opposed to the average difference across all valid episodes. The opioid windows, which are specific to an episode type, will remain the same.

Cystourethroscopy

Comment: Update the existing Difference in Average MED/day quality metric to better account for the impact of outliers

Response: The Difference in Average MED/day gain-sharing quality metric will be updated to the percentage of valid episodes that have a difference in MED that is less than or equal to zero (0.0) as opposed to the average difference across all valid episodes. The opioid windows, which are specific to an episode type, will remain the same.

Diabetes Acute Exacerbation

Comment: Update the existing Difference in Average MED/day quality metric to better account for the impact of outliers.

Response: The time period for the Follow-up Care gain-sharing quality metric will be expanded from 14 days to 30 days.

Esophagogastroduodenoscopy (EGD)

Comment: Update the existing Difference in Average MED/day quality metric to better account for the impact of outliers.

Response: The Difference in Average MED/day informational quality metric will be updated to the percentage of valid episodes that have a difference in MED that is less than or equal to zero (0.0) as opposed to the average difference across all valid episodes. The opioid windows, which are specific to an episode type, will remain the same.

Femur/Pelvic Fracture

Comment: Update the existing Difference in Average MED/day quality metric to better account for the impact of outliers

Response: The Difference in Average MED/day gain-sharing quality metric will be updated to the percentage of valid episodes that have a difference in MED that is less than or equal to zero (0.0) as opposed to the average difference across all valid episodes. The opioid windows, which are specific to an episode type, will remain the same.

GI Obstruction

Comment: Update the existing Difference in Average MED/day quality metric to better account for the impact of outliers.

Response: The Difference in Average MED/day gain-sharing quality metric will be updated to the percentage of valid episodes that have a difference in MED that is less than or equal to zero (0.0) as opposed to the average difference across all valid episodes. The opioid windows, which are specific to an episode type, will remain the same.

Hernia Repair

Comment: Update the existing Difference in Average MED/day quality metric to better account for the impact of outliers.

Response: The Difference in Average MED/day gain-sharing quality metric will be updated to the percentage of valid episodes that have a difference in MED that is less than or equal to zero (0.0) as opposed to the average difference across all valid episodes. The opioid windows, which are specific to an episode type, will remain the same.

Hysterectomy

Comment: Extend the Alternative Treatments quality metric window to capture alternative treatments attempted further back in time.

Response: The look-back period for the Alternative Treatments gain-sharing quality metric will be extended from 180 days to 690 days.

Comment: Add diagnosis codes related to personal history of contraception (Z92.0) to the Alternative Treatments gain-sharing quality metric.

Response: The ICD-10 diagnosis codes related to personal history of contraception (Z92.0) will be added to the Alternative Treatments quality metric of the hysterectomy episode.

Comment: Add diagnosis codes related to post-endometrial ablation syndrome (N99.85) to the Alternative Treatments gain-sharing quality metric.

Response: The ICD-10 diagnosis codes related to post-endometrial ablation syndrome (N99.85) will be added to the Alternative Treatments quality metric of the hysterectomy episode.

Comment: Update the existing Difference in Average MED/day quality metric to better account for the impact of outliers.

Response: The Difference in Average MED/day informational quality metric will be updated to the percentage of valid episodes that have a difference in MED that is less than or equal to zero (0.0) as opposed to the average difference across all valid episodes. The opioid windows, which are specific to an episode type, will remain the same.

Knee Arthroscopy

Comment: Update the existing Difference in Average MED/day quality metric to better account for the impact of outliers.

Response: The Difference in Average MED/day gain-sharing quality metric will be updated to the percentage of valid episodes that have a difference in MED that is less than or equal to zero (0.0) as opposed to the average difference across all valid episodes. The opioid windows, which are specific to an episode type, will remain the same.

Non-Acute Percutaneous Coronary Intervention (PCI)

Comment: Update the existing Difference in Average MED/day quality metric to better account for the impact of outliers.

Response: The Difference in Average MED/day informational quality metric will be updated to the percentage of valid episodes that have a difference in MED that is less than or equal to zero (0.0) as opposed to the average difference across all valid episodes. The opioid windows, which are specific to an episode type, will remain the same.

Non-Operative Ankle Injury

Comment: Update the existing Difference in Average MED/day quality metric to better account for the impact of outliers.

Response: The Difference in Average MED/day gain-sharing quality metric will be updated to the percentage of valid episodes that have a difference in MED that is less than or equal to zero (0.0) as opposed to the average difference across all valid episodes. The opioid windows, which are specific to an episode type, will remain the same.

Non-Operative Knee Injury

Comment: Update the existing Difference in Average MED/day quality metric to better account for the impact of outliers.

Response: The Difference in Average MED/day gain-sharing quality metric will be updated to the percentage of valid episodes that have a difference in MED that is less than or equal to zero (0.0) as opposed to the average difference across all valid episodes. The opioid windows, which are specific to an episode type, will remain the same.

Non-Operative Shoulder Injury

Comment: Update the existing Difference in Average MED/day quality metric to better account for the impact of outliers.

Response: The Difference in Average MED/day gain-sharing quality metric will be updated to the percentage of valid episodes that have a difference in MED that is less than or equal to zero (0.0) as opposed to the average difference across all valid episodes. The opioid windows, which are specific to an episode type, will remain the same.

Non-Operative Wrist Injury

Comment: Update the existing Difference in Average MED/day quality metric to better account for the impact of outliers.

Response: The Difference in Average MED/day gain-sharing quality metric will be updated to the percentage of valid episodes that have a difference in MED that is less than or equal to zero (0.0) as opposed to the average difference across all valid episodes. The opioid windows, which are specific to an episode type, will remain the same.

Oppositional Defiant Disorder (ODD)

Comment: Allow Tennessee Health Link case management contacts to count towards the Minimum Care Requirement quality metric for the ODD episode.

Response: The Minimum Care Requirement quality metric is intended to capture visits/claims that occur for the purposes of providing treatment to patients. Tennessee Health Link case management contacts do not provide treatment during the contact, and therefore they are outside the scope of this quality metric.

Comment: Update the Minimum Care Requirement quality metric for the ODD episode to include additional visits.

Response: The evaluation and management (E&M) and medication management codes currently listed under the utilization (excluding medication) informational quality metric will be added to count towards the Minimum Care Requirement gain-sharing quality metric.

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. Higher-order multiple gestations (>2) are already a perinatal episode exclusion.

Comment: Update the perinatal episode trigger logic to capture episodes with an incomplete trigger.

Response: The state will update the episode trigger logic in the episode to capture more invalid episodes for informational purposes only. This change will identify episodes with an incomplete

trigger (for example, a delivery claim with no associated facility claim) and count these episodes as invalid. The current design does not trigger an episode if the trigger is incomplete. Only a provider's valid episodes are used for financial accountability.

Comment: Change the Primary C-section quality metric to have a denominator that excludes C-sections performed for medically necessary reasons (e.g., breech or transverse fetus).

Response: The state is changing the Primary C-section quality metric that is informational to align with the Agency for Healthcare Research and Quality (AHRQ) definition of primary C-section delivery rate. This design change will add exclusions for deliveries with certain complications (such as abnormal presentation, multiple gestation, etc.).

Comment: Revisit the idea of using a universal Group B strep culture quality metric.

Response: The current quality metric design does not measure a universal screening for Group B Strep. The Screening for Group B Streptococcus (GBS) gain-sharing quality metric only captures episodes with gestational age of 35 weeks or greater at the time of delivery. The current quality metric design also gives metric performance credit when the patient is documented as a carrier of GBS.

Comment: Allow providers to bill for additional hospital rounds when the patient has a complicated delivery requiring a longer than normal hospital stay.

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. If a patient has a longer hospital stay due to a complicated delivery, then the risk adjustment process will account for the higher cost and complexity of that episode.

Comment: Quarterbacks are being held accountable for factors outside of their control, such as high facility costs.

Response: 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. A principle of the program is that the quarterback is able to influence the care of other providers involved in the episode.

Comment: Is there a reason why TennCare is exclusive to Quest Labs?

Response: TennCare is not exclusive to Quest Labs. The MCOs set both the provider network and the contracted rates with each facility, lab, or provider. TennCare does not control which labs are in-network for each MCO. In-network labs may vary between MCOs, and selecting a lab that is in-network and lower cost for each MCO is a source of value that the perinatal TAG included as a part of the episode's design.

Respiratory Infection

Comment: Exclude acute tonsilitis from the respiratory infection episode.

Response: The respiratory infection TAG recommendation is to include acute tonsilitis as a complication in the post-trigger window for the respiratory infection episode. The state will not exclude acute tonsilitis because managing that complication is a source of value in the respiratory infection episode.

Comment: Do not hold providers accountable for patient choices in the post-trigger window for the respiratory infection episode.

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.

Spinal Decompression

Comment: Update the existing Difference in Average MED/day quality metric to better account for the impact of outliers.

Response: The Difference in Average MED/day gain-sharing quality metric will be updated to the percentage of valid episodes that have a difference in MED that is less than or equal to zero (0.0) as opposed to the average difference across all valid episodes. The opioid windows, which are specific to an episode type, will remain the same.

Spinal Fusion

Comment: Update the existing Difference in Average MED/day quality metric to better account for the impact of outliers.

Response: The Difference in Average MED/day gain-sharing quality metric will be updated to the percentage of valid episodes that have a difference in MED that is less than or equal to eight (8.0) as opposed to the average difference across all valid episodes. The opioid windows, which are specific to an episode type, will remain the same.

Tonsillectomy

Comment: Exclude patients younger than three years old from the tonsillectomy episode because they are higher cost than older patients (for example, post-operative dehydration in patients younger than three years old typically results in an inpatient admission).

Response: The tonsillectomy TAG recommendation is to include patients between six months and three years old in the episode because this population is a source of value for the episode. The state conducted a data analysis and concluded that patients between six months and three years old

comprise a significant amount of the episode's volume, but these younger patients are not significantly higher in cost. 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, such as post-operative complications. While patient non-compliance or over-utilization can be an issue, providers do have the opportunity to positively influence patient behavior.

Comment: Multiple tonsillectomy procedures are not accounted for correctly within the episode.

Response: The tonsillectomy TAG considered factors such as adenoidectomy, septoplasty, use of pressure equalizing (PE) tubes, etc., when designing the episode. The risk adjustment process will account for the higher cost associated with co-occurring procedures. Providers are not systematically disadvantaged as all providers treat a similar tonsillectomy population, and provider performance is compared to peers within TennCare.

Comment: Hospital charges vary between the three MCOs for the same location.

Response: The MCOs set both the provider network and the contracted rates with each facility. TennCare does not determine the negotiated rates between an MCO and a facility, and episodes reporting is produced by each MCO to reflect their specific costs.

Comment: Update the existing Difference in Average MED/day quality metric to better account for the impact of outliers.

Response: The Difference in Average MED/day informational quality metric will be updated to the percentage of valid episodes that have a difference in MED that is less than or equal to zero (0.0) as opposed to the average difference across all valid episodes. The opioid windows, which are specific to an episode type, will remain the same.

Total Joint Replacement

Comment: Update the existing Difference in Average MED/day quality metric to better account for the impact of outliers.

Response: The Difference in Average MED/day informational quality metric will be updated to the percentage of valid episodes that have a difference in MED that is less than or equal to zero (0.0) as opposed to the average difference across all valid episodes. The opioid windows, which are specific to an episode type, will remain the same.

Valve Repair and Replacement

Comment: Update the existing Difference in Average MED/day quality metric to better account for the impact of outliers.

Response: The Difference in Average MED/day informational quality metric will be updated to the percentage of valid episodes that have a difference in MED that is less than or equal to zero (0.0) as opposed to the average difference across all valid episodes. The opioid windows, which are specific to an episode type, will remain the same.