TennCare Quarterly Report

Submitted to the Members of the General Assembly

July 2016

Status of TennCare Reforms and Improvements

Naming of New TennCare Director. As detailed in TennCare's previous Quarterly Report to the General Assembly, Darin Gordon decided to step down from his roles as TennCare Director and Deputy Commissioner of Health Care Finance and Administration (HCFA) at the end of June. On April 6, 2016, Governor Haslam announced that Dr. Wendy Long would succeed Mr. Gordon in both of these roles beginning on July 1.

Dr. Long's experience in public sector healthcare is extensive. Prior to her tenure at TennCare, she held a variety of positions of increasing responsibility within the Tennessee Department of Health, including Assistant Commissioner and Medical Director for the Bureau of Health Services. Dr. Long has also served in several key roles at TennCare and HCFA, including Interim TennCare Director (from March 1998 to January 1999), Medical Director, Chief Medical Officer, and—since 2013—Deputy Director and Chief of Staff. In the role of Deputy Director, she has provided leadership in all areas of operation, including oversight of contracts between TennCare and its network of Managed Care Contractors.

Dr. Long received her undergraduate and medical degrees from the Ohio State University and completed a preventive medicine residency and Master of Public Health program at the University of South Carolina.

Application to Renew the TennCare Demonstration. On December 22, 2015, the Bureau of TennCare submitted an application to renew the TennCare Demonstration to the Centers for Medicare and Medicaid Services (CMS). The application requested that the approval period for the Demonstration—which was scheduled to end on June 30, 2016—be extended through June 30, 2021.

Throughout the April-June 2016 quarter, the State and CMS negotiated the terms of a renewal. The State requested no substantive changes to the TennCare Demonstration; however, CMS identified a number of topics it wished to discuss, including supplemental pool payments to Tennessee hospitals and the methodology by which the TennCare program remains "budget-neutral" (i.e., does not spend more than would be expended to operate Tennessee's Medicaid program in the absence of the Demonstration). While considerable progress was made in these negotiations, the State and CMS

ultimately determined that more time was needed to come to final agreement and complete the approval process. The parties therefore agreed to a temporary extension of the Demonstration through August 31, 2016. The purpose of the two-month extension is to allow for further discussion of any remaining issues with the hope of finalizing the Special Terms and Conditions (STCs) that will govern the operations of the TennCare program during the next approval period. A copy of CMS's June 30 letter granting the temporary extension is available at http://www.tn.gov/assets/entities/tenncare/attachments/tennessee1115TemporaryExtensionLetter.pdf.

Employment and Community First CHOICES. Employment and Community First CHOICES is the first managed long-term services and supports program in the nation that is focused on promoting and supporting integrated, competitive employment and independent community living as the first and preferred option for people with intellectual and other types of developmental disabilities.

ECF CHOICES offers three different benefit packages:

- Essential Family Supports for families caring for a loved one with an intellectual or developmental disability;
- Essential Supports for Employment and Independent Living for adults with an intellectual or developmental disability who are transitioning out of school or who need support to achieve employment and independent living goals; and
- Comprehensive Supports for Employment and Community Living for adults with an intellectual or developmental disability who have more intense needs and require more comprehensive supports to achieve their employment and community living goals.

This tiered benefit structure based on the needs of people supported and their families, with appropriate cost caps and expenditure controls, will help TennCare to begin serving people with intellectual disabilities in Tennessee more cost-effectively, allowing more Tennesseans who need these services to receive them. This includes people currently on the waiting list for services and people with other kinds of developmental disabilities.

After a year and a half of intensive work with stakeholders, TennCare submitted a formal proposal for Employment and Community First CHOICES to CMS in June 2015, and CMS ultimately approved the proposal in February 2016. With federal approval secured and implementation activities well underway, the Bureau devoted several additional months to readiness, ensuring that the implementation scheduled for July 1, 2016, would proceed as seamlessly as possible. During the April-June 2016 quarter, these preparations included provider training and outreach activities, as well as readiness review tasks related to TennCare's Managed Care Organizations (MCOs), including desk deliverables, systems testing, and systems-related demonstrations. By the conclusion of the quarter, final preparations were complete, and the MCOs had been cleared to proceed with program implementation.

As importantly, during the quarter, the Tennessee General Assembly approved funding to serve up to 1,700 people in the first year, offering long needed supports to many Tennesseans with intellectual and developmental disabilities and their families.

Payment Reform. In February 2013, Governor Haslam launched Tennessee's Health Care Innovation Initiative to change the way that health care is paid for in Tennessee. The desired direction is to move from paying for volume to paying for value by rewarding health care providers for high-quality and efficient treatment of medical conditions, and to help in maintaining people's health over time.

The Tennessee Health Care Innovation Initiative is co-located with TennCare in HCFA. Although its goals transcend Medicaid, there is much emphasis on Medicaid and TennCare as playing a pivotal role in meeting the Initiative's goals. All of TennCare's providers are included in the Initiative.

Two strategies being used to reform health care payment approaches are Tennessee Health Link and episodes of care:

- As part of the primary care transformation strategy, Tennessee Health Link is working with providers to improve integrated and value-based behavioral and primary care services for people with significant behavioral health needs. These TennCare members have higher rates of asthma, congestive heart failure, chronic obstructive pulmonary disease (COPD), coronary artery disease, diabetes, hypertension, and stroke. Furthermore, on average, a TennCare member with significant behavioral health needs uses the Emergency Department (ED) more than twice as often as a TennCare member who does not have these needs. The State will leverage an enhanced federal match to offer value-based payments for care coordination and case management for two years, coupled with provider training and capacity building, and quarterly cost and quality reporting. While TennCare has already taken significant steps to integrate behavioral health and primary care within the services delivered by the MCOs, the development of Tennessee Health Link will help providers integrate care and build their practices' capacity to transition to value-based payment and delivery.
- Episodes of care focuses on health care delivered in acute health care events, such as a surgical procedure or an inpatient hospitalization. Episodes encompass care delivered by multiple providers in relation to a specific health care event. Each episode has a principal accountable provider (or "quarterback") who is in the best position to influence the cost and quality of the episode. Episodes of care are implemented in groups or—in the terminology of the program—"waves." The fifth wave ("Wave 5") is the most recent.

Both of these strategies have benefitted from the input of Technical Advisory Groups (TAGs) composed of subject matter experts. TAG recommendations related to Tennessee Health Link span a variety of topics, including member identification criteria, physical and behavioral quality measures, eligibility, workforce and personnel qualifications, primary care physician (PCP) collaboration, patient engagement, staffing roles and ratios, provider reporting, and training curriculum and support. TAG recommendations concerning episodes of care are similarly comprehensive, addressing such topics as

the patient journey and care pathways, the definition of the principal accountable provider (i.e., the quarterback), any aspects of care delivery unique to Tennessee, the components of the episode of care, and appropriate quality measures.

Attached to this report are two appendices. Appendix A consists of TAG recommendations for the Tennessee Health Link program. Appendix B comprises TAG recommendations related to Wave 5 episodes of care, which are Breast Cancer Mastectomy, Breast Cancer Medical Oncology, Breast Biopsy, Tonsillectomy, Otitis Media, Anxiety, and Non-Emergent Depression.

Tennessee Eligibility Determination System. Tennessee Eligibility Determination System (or "TEDS") is the name of the system that will be used by the State to process applications and identify persons who are eligible for TennCare and CoverKids.

Instead of consolidating all aspects of the project under one vendor, the Bureau opted to procure three separate contracts to address the following functions:

- Technical advisory services;
- Strategic Program Management Office (SPMO) services; and
- Systems integration services.

By the end of Calendar Year 2015, two of the three contracts had been awarded and implemented. KPMG, LLP successfully bid on the technical advisory services contract, which went into effect on September 1, 2015. The contract for SPMO services was awarded to Public Consulting Group, Inc. and took effect on November 1, 2015.

During the April-June 2016 quarter, procurement of the third contract for systems integration services neared completion. The State issued a Request for Qualifications on April 1, 2016, and, by the end of the quarter, responses from vendors had been received and evaluated. As of June 30, 2016, the State planned to announce the successful bidder in July.

Wilson v. Gordon. *Wilson v. Gordon* is a class action lawsuit filed against the Bureau of TennCare by the Tennessee Justice Center, the Southern Poverty Law Center, and the National Health Law Program. The suit alleges federal noncompliance in the Medicaid application and appeals process TennCare has been using since implementation of the Affordable Care Act.

Two separate courts have heard arguments in the case. One is the U.S. District Court for the Middle District of Tennessee, where Plaintiffs originally filed suit in July 2014. The District Court granted class action status to the case and issued a preliminary injunction requiring the State to provide an opportunity for a fair hearing on any delayed adjudications of applications for TennCare coverage. TennCare took immediate action to comply with these rulings but also filed an appeal of the preliminary injunction with a second court, the U.S. Court of Appeals for the Sixth Circuit in Cincinnati.

On May 23, 2016, a three-judge panel for the Sixth Circuit affirmed the District Court's decision to issue a preliminary injunction. The panel majority's opinion held that the actions taken by the State to address the needs of the named plaintiffs in the suit did not render the case moot and, therefore, that the preliminary injunction was properly issued. The dissenting opinion reached a very different conclusion, noting, "The plaintiffs asked and now have received. Because the plaintiffs received all of their requested injunctive relief before class certification, the case is moot."[1]

On June 6, 2016, the State responded to the ruling by filing a petition for rehearing en banc with the Sixth Circuit. If granted, the petition would allow the State's appeal to be heard by all of the Sixth Circuit judges instead of by a small panel. The rehearing request is based on the premise that the three-judge panel reached a determination at odds with relevant decisions issued by other courts, including other circuit courts (the Fourth, Fifth, and Eighth Circuits) and the Supreme Court. As of the end of the April-June 2016 quarter, the Plaintiffs' response to the State's petition was expected to be filed in July.

Incentives for Providers to Use Electronic Health Records. The Electronic Health Records (EHR) Incentive Program is a partnership between federal and state governments that grew out of the Health Information Technology for Economic and Clinical Health (HITECH) Act. The purpose of the program is to provide financial incentives to Medicaid providers[2] to replace outdated, often paper-based approaches to medical record-keeping with electronic systems that meet rigorous certification criteria and that can improve health care delivery and quality. The federal government provides 100 percent of the funding for the incentive payments and 90 percent of the administrative costs.

Currently, Medicaid providers may qualify for the following types of payments:

- First-year payments to providers (eligible hospitals or practitioners) who either—
  - Adopt, implement, or upgrade to certified EHR technology capable of meeting "meaningful use" in accordance with CMS standards, or
  - Achieve meaningful use of certified EHR technology for any period of 90 consecutive days;
- Second-year payments to providers who have received first-year payments and who achieved meaningful use for a subsequent period of 90 consecutive days;
- Third-year, fourth-year, and fifth-year payments to providers who continue to demonstrate meaningful use.

Eligible practitioners who successfully attest may receive incentive payments in up to six program years. With CMS approval, TennCare chose to divide the full amount of incentive payments available to eligible

[1] A copy of the panel's ruling is available at http://www.opn.ca6.uscourts.gov/opinions.pdf/16a0127p-06.pdf.
[2] CMS allows two types of providers to participate in the Medicaid EHR Incentive Program: medical professionals (physicians, nurse practitioners, certified nurse midwives, dentists, and certain kinds of physician assistants) and hospitals (acute care hospitals, critical access hospitals, and children's hospitals).

hospitals among three program years. Eligible hospitals must continue to attest annually beyond the three years of payments in order to avoid Medicare payment adjustments.

EHR payments made by TennCare during the April-June 2016 quarter as compared with payments made throughout the life of the program appear in the table below:

Payment Type	Number of Providers Paid During the Quarter	Quarterly Amount Paid (Apr-Jun 2016)	Cumulative Amount Paid to Date
First-year payments	207[3]	$3,199,262	$167,413,648
Second-year payments	82	$2,162,404	$53,312,597
Third-year payments	82	$1,621,542	$25,285,091
Fourth-year payments	96	$810,334	$2,516,007
Fifth-year payments	56	$476,000	$620,500

The Bureau's technical assistance activities, outreach efforts, and other EHR-related projects remained robust during the quarter, due in part to recently implemented "Modified Stage 2" meaningful use measures. These activities included the following:

- Evaluation of more than 1,000 meaningful use attestations;
- Holding 72 technical assistance calls;
- Responding to 778 emails received in the EHR meaningful use mailbox;
- Attendance at the "MedTenn 2016" convention, a statewide meeting of physicians and medical professionals sponsored by the Tennessee Medical Association;
- Attendance at regional workshops hosted by Amerigroup and UnitedHealthcare Community Plan;
- Participation throughout the quarter in several Southeast Regional Collaboration for HIT/HIE (SERCH) calls;
- Monthly newsletters and occasional alerts distributed by the Bureau's EHR ListServ; and
- A quarterly reminder to Tennessee providers who had registered at the federal level but who have not registered or attested at the state level.

TennCare continues to schedule EHR workshops with a variety of provider organizations to maintain the momentum of the program. The Bureau is also making every effort to alert eligible professionals and eligible hospitals that 2016 is the last year in which they may enroll in the EHR program and begin attesting (as specified by the HITECH Act).

Demonstration Amendment 30: Program Modifications. During March and April 2016, TennCare held a public notice and comment period concerning a demonstration amendment that was being developed. Amendment 30 was based on demonstration amendments from prior years that outlined program

[3] Of the 207 providers receiving first-year payments in the April-June 2016 quarter, 10 earned their incentives by successfully attesting to meaningful use of EHR technology in their first year of participation in the program.

reductions to be made if the Tennessee General Assembly did not pass or renew a one-year hospital assessment fee. The reductions contemplated in Amendment 30 included limits on inpatient hospital services, outpatient hospital visits, health care practitioners' office visits, and lab and X-ray services, as well as the elimination of certain kinds of therapy.

By the time the public notice period concluded on April 18, 2016, the State had received two sets of comments, each of which expressed concern about the impact that the potential reductions could have on TennCare enrollees (especially those with serious and/or chronic conditions). As was the case in previous years, however, the General Assembly renewed the hospital assessment fee, thereby eliminating the need for Amendment 30 to be submitted to CMS.

Essential Access Hospital (EAH) Payments. The TennCare Bureau continued to make EAH payments during the April-June 2016 quarter. EAH payments are made from a pool of $100 million ($34,965,000 in State dollars) appropriated by the General Assembly and funded by the hospital assessment fee.

The methodology for distributing these funds, as outlined in Special Term and Condition 56.e. of the TennCare Demonstration Agreement with CMS, specifically considers each hospital's relative contribution to providing services to TennCare members, while also acknowledging differences in payer mix and hospitals' relative ability to make up TennCare losses. Data from the Hospital Joint Annual Report is used to determine hospitals' eligibility for these payments. Eligibility is determined each quarter based on each hospital's participation in TennCare. In order to receive a payment for the quarter, a hospital must be a contracted provider with TennCare Select and at least one other Managed Care Organization (MCO), and it must have contracted with TennCare Select for the entire quarter that the payment represents. Excluded from the Essential Access Hospital payments are Critical Access Hospitals, which receive cost-based reimbursement from the TennCare program and, therefore, are not included, and the four State mental health institutes.

The Essential Access Hospital payments made during the fourth quarter of State Fiscal Year 2016 (for dates of service during the third quarter) are shown in the table below.

Essential Access Hospital Payments for the Quarter

Hospital Name	County	EAH Fourth Quarter FY 2016
Regional Medical Center at Memphis	Shelby County	$3,494,251
Vanderbilt University Hospital	Davidson County	$3,333,176
Erlanger Medical Center	Hamilton County	$2,561,577
University of Tennessee Memorial Hospital	Knox County	$1,457,096
Johnson City Medical Center (with Woodridge)	Washington County	$1,093,472
Parkridge Medical Center (with Parkridge Valley)	Hamilton County	$727,861
LeBonheur Children's Medical Center	Shelby County	$715,194
Jackson – Madison County General Hospital	Madison County	$601,213
Metro Nashville General Hospital	Davidson County	$560,428

Hospital Name	County	EAH Fourth Quarter FY 2016
Methodist Healthcare – Memphis Hospitals	Shelby County	$554,639
East Tennessee Children's Hospital	Knox County	$534,806
Saint Jude Children's Research Hospital	Shelby County	$437,376
Methodist Healthcare – South	Shelby County	$425,871
Parkwest Medical Center (with Peninsula)	Knox County	$330,343
Methodist Healthcare – North	Shelby County	$323,680
TriStar Centennial Medical Center	Davidson County	$312,774
TriStar Skyline Medical Center (with Madison Campus)	Davidson County	$303,559
Wellmont – Holston Valley Medical Center	Sullivan County	$292,106
University Medical Center (with McFarland)	Wilson County	$258,774
Parkridge East Hospital	Hamilton County	$255,721
Saint Francis Hospital	Shelby County	$254,063
Saint Thomas Rutherford Hospital	Rutherford County	$253,534
Lincoln Medical Center	Lincoln County	$252,730
Saint Thomas Midtown Hospital	Davidson County	$237,410
Maury Regional Hospital	Maury County	$223,108
Baptist Memorial Hospital for Women	Shelby County	$217,064
Wellmont – Bristol Regional Medical Center	Sullivan County	$209,423
Cookeville Regional Medical Center	Putnam County	$201,709
Fort Sanders Regional Medical Center	Knox County	$194,648
Pathways of Tennessee	Madison County	$191,254
Ridgeview Psychiatric Hospital and Center	Anderson County	$184,156
Tennova Healthcare – Physicians Regional Medical Center	Knox County	$167,018
Blount Memorial Hospital	Blount County	$145,171
Delta Medical Center	Shelby County	$142,885
TriStar Summit Medical Center	Davidson County	$137,731
TriStar StoneCrest Medical Center	Rutherford County	$129,912
Skyridge Medical Center	Bradley County	$124,643
Rolling Hills Hospital	Williamson County	$124,590
Southern Hills Medical Center	Davidson County	$122,047
NorthCrest Medical Center	Robertson County	$121,223
Gateway Medical Center	Montgomery County	$120,066
TriStar Horizon Medical Center	Dickson County	$118,465
Sumner Regional Medical Center	Sumner County	$114,231
Morristown – Hamblen Healthcare System	Hamblen County	$110,774
Dyersburg Regional Medical Center	Dyer County	$104,231
Baptist Memorial Hospital – Tipton	Tipton County	$93,824
Methodist Medical Center of Oak Ridge	Anderson County	$88,728
TriStar Hendersonville Medical Center	Sumner County	$88,552
Jellico Community Hospital	Campbell County	$87,628
LeConte Medical Center	Sevier County	$86,613
Harton Regional Medical Center	Coffee County	$82,479

Hospital Name	County	EAH Fourth Quarter FY 2016
Takoma Regional Hospital	Greene County	$81,797
Tennova Healthcare – LaFollette Medical Center	Campbell County	$78,205
Grandview Medical Center	Marion County	$76,479
Skyridge Medical Center – Westside	Bradley County	$73,248
Southern Tennessee Regional Health System – Winchester	Franklin County	$66,037
United Regional Medical Center and Medical Center of Manchester	Coffee County	$63,642
Sycamore Shoals Hospital	Carter County	$63,216
Indian Path Medical Center	Sullivan County	$62,582
Lakeway Regional Hospital	Hamblen County	$61,337
Roane Medical Center	Roane County	$59,394
Laughlin Memorial Hospital	Greene County	$59,012
Starr Regional Medical Center – Athens	McMinn County	$58,102
Regional Hospital of Jackson	Madison County	$58,072
Hardin Medical Center	Hardin County	$57,172
Crockett Hospital	Lawrence County	$54,869
Henry County Medical Center	Henry County	$54,731
Stones River Hospital	Cannon County	$52,962
Wellmont Hawkins County Memorial Hospital	Hawkins County	$51,837
Saint Thomas River Park Hospital	Warren County	$48,886
Jamestown Regional Medical Center	Fentress County	$46,344
Hillside Hospital	Giles County	$44,719
Livingston Regional Hospital	Overton County	$43,699
Heritage Medical Center	Bedford County	$43,182
Baptist Memorial Hospital – Union City	Obion County	$42,731
McNairy Regional Hospital	McNairy County	$39,796
Claiborne County Hospital	Claiborne County	$39,097
McKenzie Regional Hospital	Carroll County	$35,097
Erlanger Health System – East Campus	Hamilton County	$31,344
Henderson County Community Hospital	Henderson County	$28,628
Volunteer Community Hospital	Weakley County	$27,238
Wayne Medical Center	Wayne County	$25,639
DeKalb Community Hospital	DeKalb County	$21,953
Decatur County General Hospital	Decatur County	$18,179
Baptist Memorial Hospital – Huntingdon	Carroll County	$17,300
Southern Tennessee Regional Health System – Sewanee	Franklin County	$9,647
TOTAL		**$25,000,000**

Number of Recipients on TennCare and Costs to the State

During the month of June 2016, there were 1,521,024 Medicaid eligibles and 28,453 Demonstration eligibles enrolled in TennCare, for a total of 1,549,477 persons.

Estimates of TennCare spending for the fourth quarter of State Fiscal Year 2016 are summarized in the table below.

Spending Category	Fourth Quarter FY 2016*
MCO services**	$1,084,603,900
Dental services	$40,220,600
Pharmacy services	$303,356,800
Medicare "clawback"***	$51,257,700

**These figures are cash basis as of June 30 and are unaudited.*

***This figure includes Integrated Managed Care MCO expenditures.*

****The Medicare Part D clawback is money states are required to pay to the federal government to help offset costs the federal government incurs by covering the prescription benefit for enrollees who have both Medicare and Medicaid.*

Viability of MCCs in the TennCare Program

Claims payment analysis. TennCare's prompt pay requirements may be summarized as shown below.

Entity	Standard	Authority
MCOs (non-CHOICES services)	90% of clean claims for payment for services delivered to TennCare enrollees are processed and, if appropriate, paid within 30 calendar days of the receipt of such claims. 99.5% of all provider claims are processed, and, if appropriate, paid within 60 calendar days of receipt.	TennCare contract and in accordance with T.C.A. § 56-32-126(b)
MCOs (CHOICES services)	90% of clean electronically submitted Nursing Facility and applicable Home and Community Based Services claims[4] are processed and paid within 14 calendar days of receipt. 99.5% of clean electronically submitted Nursing Facility and applicable Home and Community Based Services claims[5] are processed and paid within 21 calendar days of receipt.	TennCare contract

[4] Excludes Personal Emergency Response Systems (PERS), assistive technology, minor home modifications, and pest control claims. Claims for delivery of these services are handled like general MCO claims.

[5] Ibid.

Entity	Standard	Authority
DBM	90% of clean claims for payment for services delivered to TennCare enrollees are processed, and, if appropriate, paid within 30 calendar days of the receipt of such claims. 99.5% of all provider claims are processed, and, if appropriate, paid within 60 calendar days of receipt.	TennCare contract and in accordance with T.C.A. § 56-32-126(b)
PBM	100% of all clean claims submitted by pharmacy providers are paid within 10 calendar days of receipt.	TennCare contract

The MCOs, the DBM, and the PBM are required to submit monthly claims data files of all TennCare claims processed to the Tennessee Department of Commerce and Insurance (TDCI) for verification of statutory and contractual prompt pay compliance. The plans are required to separate their claims data by claims processor (e.g., MCO, vision benefits manager, etc.). Furthermore, the MCOs are required to identify separately non-emergency transportation (NEMT) claims in the data files. Finally, the MCOs are required to submit separate claims data files representing a subset of electronically submitted Nursing Facility and applicable Home and Community Based Services claims for CHOICES enrollees. TDCI then performs an analysis and reports the results of the prompt pay analyses by NEMT and CHOICES claim types, by claims processor, and by total claims processed for the month.

If an MCO does not comply with the prompt pay requirements based on the total claims processed in a month, TDCI has the statutory authority to levy an administrative penalty of $10,000 for each month of non-compliance after the first instance of non-compliance was reported to the plan. The TennCare Bureau can also assess liquidated damages pursuant to the terms of the TennCare Contract. If the DBM and PBM do not meet their contractual prompt pay requirements, only the TennCare Bureau can assess applicable liquidated damages against these entities.

Net worth and company action level requirements. According to Tennessee's "Health Maintenance Organization Act of 1986" statute (T.C.A. § 56-32-101 *et seq.*), the minimum net worth requirement for each TennCare MCO is calculated based on premium revenue reported on the National Association of Insurance Commissioners (NAIC) Annual Financial Statement for the most recent calendar year, as well as any TennCare payments made to the MCO that are not reported as premium revenue.

During the April-June 2016 quarter, the MCOs submitted their NAIC First Quarter 2016 Financial Statements. As of March 31, 2016, TennCare MCOs reported net worth as indicated in the table below.[6]

MCO	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$29,016,782	$153,385,375	$124,368,593
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community	$55,361,026	$419,602,706	$364,241,680

[6] The "Net Worth Requirement" and "Reported Net Worth" figures in the table are based on the MCOs' company-wide operations, not merely their TennCare operations.

MCO	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
Plan)			
Volunteer State Health Plan (BlueCare & TennCare Select)	$43,251,806	$346,137,825	$302,886,019

During the April-June 2016 quarter, the MCOs were also required to comply with Tennessee's "Risk-Based Capital for Health Organizations" statute (T.C.A. § 56-46-201 *et seq.*). Risk-based capital (RBC) involves a method of calculating the minimum amount of capital necessary for a health entity to support its overall business operations depending on its size and risk profile. A health entity with a higher amount of risk is required to hold a higher amount of capital. The RBC statute gives TDCI the authority and mandate to use preventive and corrective measures that vary depending on the amount of capital deficiency indicated by the RBC calculations. A "Company Action Level" deficiency (defined at T.C.A. § 56-46-203(a)) would require the submission of a plan to correct the entity's capital deficiency.

The following table compares the MCOs' net worth to the Company Action Level requirements as of March 31, 2016:

MCO	Company Action Level	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$104,759,436	$153,385,375	$48,625,939
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$189,545,450	$419,602,706	$230,057,256
Volunteer State Health Plan (BlueCare & TennCare Select)	$133,523,082	$346,137,825	$212,614,743

All TennCare MCOs met their minimum net worth requirements and Company Action Level requirements as of March 31, 2016.

Success of Fraud Detection and Prevention

The mission of the Tennessee Office of Inspector General (OIG) is to identify, investigate, and prosecute persons who commit fraud or abuse against the TennCare program and to recoup money owed to the State of Tennessee. The OIG receives case information from a variety of sources, including local law enforcement, the TennCare Bureau, Health Related Boards (HRB), the Department of Human Services (DHS), other State agencies, health care providers, Managed Care Contractors (MCCs), and the general public via the OIG website, fax, written correspondence, and phone calls to the OIG hotline. Selected statistics for the fourth quarter of Fiscal Year 2016 are as follows:

TennCare Fraud & Abuse Complaints

	Fourth Quarter FY 2016
Fraud Allegations	859
Abuse Allegations*	740

***** *Abuse cases may be referred to the appropriate Managed Care Contractor (MCC), the TennCare Bureau, or DHS for further review/action.*

Arrests, Convictions, and Judicial Diversion*

	Fourth Quarter FY 2016
Arrests	90
Convictions	44
Instances of Judicial Diversion	8

***** *Cases adjudicated during a particular fiscal year may have no relationship to dates of arrest during the same year.*

Criminal Court: Fines & Costs Imposed

	Fourth Quarter FY 2016
Court Costs & Taxes	$1,220
Fines	$23,710
Drug Funds/Forfeitures	$315
Criminal Restitution Ordered	$172,435
Criminal Restitution Received[7]	$63,301

Civil Restitution & Civil Court Judgments

	Fourth Quarter FY 2016
Civil Restitution Ordered[8]	$0
Civil Restitution Received[9]	$17,422

Recommendations for Review

	Fourth Quarter FY 2016
Recommended TennCare Terminations[10]	174

[7] Restitution may have been ordered in a fiscal year other than the one in which payment was actually received.

[8] This total reflects dollars identified for recoupment by the OIG in such non-criminal contexts as civil cases, administrative hearings, and voluntary reimbursements to TennCare.

[9] A recoupment may be received in a quarter other than the one in which it is ordered.

[10] Recommendations that enrollees' TennCare coverage should be terminated are sent to the TennCare Bureau for review and determination of appropriate action. These recommendations are based on information received and reviewed by the OIG. The Bureau determines whether these referrals meet the criteria for termination. In reviewing these recommendations, TennCare must factor in some limitations, such as the inability to disenroll individuals in certain federally protected categories.

	Fourth Quarter FY 2016
Potential Savings[11]	$636,212

Statewide Communication

In an effort to stay connected with local law enforcement and achieve the OIG's mission, Special Agents continue to meet in person with sheriffs and police chiefs throughout the state. These meetings further collaborative relationships and aid the mutual goal of stopping TennCare fraud and prescription drug diversion.

[11] Potential savings are determined by multiplying the number of enrollees whose coverage would be terminated, assuming all of the State's criteria for termination are met, by the average annual cost per enrollee for MCO, pharmacy, and dental services (currently estimated by TennCare to be $3,656.39).

Appendix A

TAG Recommendations for Tennessee Health Link

Tennessee Health Link TAG recommendation summary

The Health Link TAG recommended the following areas as **sources of value** for the Health Link program: appropriateness of care setting and forms of delivery, increased access to care, improved treatment adherence, medication reconciliation, medication management, referrals to high-value behavioral health providers, appropriateness of treatment for physical health conditions, enhanced chronic condition management, and reduced readmissions through effective follow-up and transition management

The Health Link TAG recommended specific criteria for **Health Link member identification** based on three categories: 1) diagnostic criteria only (claims based), 2) diagnostic and utilization criteria (claims based), and 3) functional need (provider referral). For category 1, diagnostic criteria only, member identification criteria included a new or existing diagnosis code of attempted suicide or self-injury, bipolar disorder, homicidal ideation, or schizophrenia. For category 2, diagnostic and utilization criteria, member identification criteria included one or more behavioral health-related (a) inpatient admissions or (b) crisis stabilization unit admissions (18 or over), ED admissions (under 18), or residential treatment facility admissions; WITH a diagnosis of the following: abuse and psychological trauma, adjustment reaction, anxiety, conduct disorder, emotional disturbance of childhood and adolescence, major depression, other depression, other mood disorders, personality disorders, psychosis, psychosomatic disorders, PTSD, somatoform disorders, substance use or other / unspecified. For category 3, functional need, member identification criteria varied by date. Until October 1, 2016, member identification criteria will include a receipt of two or more Level 2 case management services. After October 1, 2016, there will need to be provider documentation of functional need, which is to be determined by the provider and verified by the Managed Care Organization (MCO). This is designed to align with Level 2 case management medical necessity criteria.

Quality metrics will be used to assess the quality of the Health Link providers. The TAG recommended the following behavioral health quality measures: 7-day and 30-day psychiatric hospital / RTF readmission rate, follow-up after hospitalization for mental illness within 7 days or within 30 days, initiation/engagement of alcohol and drug dependence treatment, antidepressant medication management, and use of multiple concurrent antipsychotics in children and adolescents. The TAG also recommended the following physical health quality measures: BMI and weight composite metric, immunization

composite metric, comprehensive diabetes care, EPSDT screening rate, and asthma medication management.

TAG members recommended a set of **activity requirements for providers** participating in Health Link. These requirements are grouped into seven categories: comprehensive care management, care coordination, referral to social supports, patient and family support, transitional care, health promotion, and population health management.

The TAG also provided recommendations regarding **Health Link provider eligibility requirements**. These requirements include: stated commitment to collaboration with primary care, being part of a Community Mental Health Center or other qualified Health Link provider (i.e., mental health clinic, FQHC, PCP, or BH specialty) with at least 250 assigned Health Link members across all MCOs, commitment to the adoption of the state care coordination tool, and a documented plan to progress toward CMS e-prescribing requirements by October 2017. For personnel specifically, eligibility requirements include one individual designated as Health Link point of contact, identification of a care team, and capability to provide behavioral health services onsite. The care team includes lead clinical care coordinator(s), such as a Registered Nurse, to coordinate with medical professionals as well as case manager(s) to be the primary point of contact for the patient and family. To be considered capable of providing behavioral health services onsite, a psychiatrist, or a licensed master-level mental health professional and a primary care physician, or a psychologist and a primary care physician must be on staff or accessible through affiliation.

The TAG made recommendations for the **training and technical supports** for Health Link providers. For Health Link leaders, training and technical supports should focus on business support, workflow management, patient access, and workforce management. Supports for clinical care coordinators should include management training, clinical workflows training and patient engagement training including individual and organization-level methods. For case managers, this training should include patient education and support training, family and community engagement training, and clinical workflows training. Last, training and technical supports for direct clinical service providers should focus on clinical workflows and patient engagement.

Key practice transformation services were also recommended by the TAG members and include three stages: 1) pre-transformation assessment, 2) practice transformation support curriculum, 3) semi-annual assessment.

1. The pre-transformation assessment is an initial, rapid, standardized assessment to develop a tailored curriculum for each site to establish baseline level of readiness for transformation. The assessment will focus on the strengths and gaps in workforce, infrastructure, and workflows as they relate to capabilities and transformation milestones, prioritizing areas for improvement.

2. The practice transformation support curriculum is a standard curriculum that can be tailored for each Health Link site based on the needs identified in the pre-transformation assessment. The curriculum will cover first and second years of transformation including frequency and structure of learning activities. Curriculum may include content structured through the following: learning collaboratives, large format in-person trainings, live webinars, recorded trainings, and on-site coaching.

3. The semi-annual assessment is designed to assess the progress toward each provider transformation milestone every six months and to document this progress.

TAG members made the following recommendations to encourage **patient engagement** in Health Link: skill building on health literacy and self-care, motivational interviewing, peer support and/or peer recovery services, scheduling, follow-up and reminders, in-person accompaniment to appointments, facesheets or dashboards to support patient recognition and relationship, incentives where possible, and training curriculum to address patient engagement including standard materials for physical health. The TAG also recommended patient actions to reinforce and encourage participation, such as adherence to primary care, behavioral health, and specialist appointments, adherence to medication, reduced risk factor activity (e.g., exercise, less smoking), and enhanced reliance on crisis support. Health Links will have the flexibility to innovate on how they will engage patients.

The Health Link TAG recommended that **provider reports** include the following sections of information: Health Link overview, quality performance report, efficiency performance report, and reporting-only measures (e.g., total costs of care). The Health Link overview section will include basic information such as assigned members and training milestones. The quality performance report will track progress against previous performance and compare to peer organizations and state and national benchmarks (where available). The efficiency performance report will similarly track progress against previous performance and compare peer organizations and state and national benchmarks (where available).

Appendix B

TAG Recommendations for Wave 5 Episodes of Care

Breast Biopsy episode design summary

Identifying episode triggers

A breast biopsy episode is triggered by a professional claim with one of the defined procedure codes for a punch biopsy, core needle biopsy, or open biopsy, and an inpatient or outpatient facility claim with a primary diagnosis code of breast cancer or symptoms, except when the biopsy is performed in an office setting.

Attributing episodes to quarterbacks

The quarterback is the physician or physician group that performed the triggering procedure. The contracting entity ID will be used to identify the quarterback. Quarterback reports should provide the information needed to better manage variation in diagnostic workup leading up to biopsy.

Identifying services to include in episode spend

Services to include in episode spend are: specific evaluation and management, imaging, and testing up to 90 days before the triggering procedure; all medical services and specific medications during the stay or visit where the triggering procedure is performed; specific care after discharge, procedures, evaluation and management, imaging, testing, pathology, anesthesia, and medications up to 30 days after the triggering procedure. Services to exclude from episode spend are: sentinel lymph node biopsy, axillary lymphadenectomy, mastectomy, radiation therapy, breast reconstruction, port placement, and antineoplastic therapy (including hormonal therapy) procedures up to 30 days after the triggering procedure is performed.

Excluding episodes

There are three types of exclusions. Business exclusions: available information is not comparable or is incomplete. Clinical exclusions: patient's care pathway is different for clinical reasons. These include patients receiving a mastectomy during the same stay or visit as the triggering biopsy and patients receiving a sentinel lymph node biopsy, axillary lymphadenectomy, mastectomy, radiation therapy, antineoplastic therapy administration, or oral antineoplastics (except hormonal therapy) up to 30 days after the biopsy. High cost outlier exclusions: episode's risk-adjusted spend is three standard deviations above the mean.

Determining quality metrics performance

Quality metrics tied to gain sharing are: percentage of valid episodes with diagnostic imaging up to 90 days prior to the biopsy; percentage of valid episodes triggered on core needle biopsies; percentage of valid and invalid episodes with complete patient-level clinical factor reporting to the Tennessee Cancer Registry within four months for patients receiving a breast cancer diagnosis within 30 days of procedure.

Quality metrics not tied to gain sharing are: percentage of valid episodes with surgical complications up to 30 days after the biopsy; percentage of valid episodes with a subsequent breast biopsy or excision up to 30 days after the biopsy; percentage of valid episodes with genetic testing where patient has documented family history of breast, ovarian, tubal, or peritoneal cancer; percentage of valid episodes where a BI-RADS4 or 5 mammogram is followed up by biopsy within seven to ten days; percentage of valid episodes with a follow-up visit within 30 days of procedure; percentage of valid and invalid episodes with biopsy pathology results including pTcategory, pNcategory, and histologic grade.

<u>Breast Cancer Mastectomy episode design summary</u>

Identifying episode triggers

The mastectomy episode is triggered by a professional claim with one of the defined procedure codes for a sentinel lymph biopsy, axillary lymphadenectomy, partial mastectomy, total mastectomy, or radical mastectomy and an inpatient or outpatient facility claim with a primary diagnosis code of breast cancer or symptoms.

Attributing episodes to quarterbacks

The quarterback is the physician or physician group that performed the triggering procedure. The contracting entity ID will be used to identify the quarterback.

Identifying services to include in episode spend

The services to include in episode spend are: specific evaluation and management, imaging, testing, procedures, and pathology up to 30 days before the triggering procedure; all medical services and specific medications during the stay where the triggering procedure is performed; specific evaluation and management, medications, pathology, procedures, imaging, testing, anesthesia, and care after discharge up to 30 days after the triggering procedure; neo-adjuvant radiation therapy up to 180 days before the triggering procedure for patients without locally advanced and unresponsive to chemotherapy and

ipsilateral cancer recurrence following a lumpectomy. Services to exclude from episode spend are: reconstruction procedures, radiation therapy, and antineoplastic therapy during the entire episode; open, core needle, fine needle aspiration (FNA), or punch biopsies up to 180 days before the triggering procedure.

Excluding episodes

There are three types of exclusions. Business exclusions: available information is not comparable or is incomplete. Clinical exclusions: patient's care pathway is different for clinical reasons. High cost outlier exclusions: episode's risk-adjusted spend is three standard deviations above the mean.

Determining quality metrics performance

Quality metrics tied to gain sharing are: percentage of valid episodes that undergo a partial mastectomy; percentage of valid episodes with a surgical complication within 30 days of the mastectomy; percentage of valid and invalid episodes with complete Tennessee Cancer Registry reporting within four months of episode. Quality metrics not tied to gain sharing are: percentage of valid episodes that had repeat surgery for positive margins; percentage of valid episodes referred for breast reconstruction following a mastectomy; percentage of valid episodes referred to a medical oncologist for neo-adjuvant therapy prior to surgery; percentage of valid episodes stage I, II, or III, receiving breast conserving surgery and radiation therapy within one year of diagnosis; percentage of valid episodes with biopsy pathology results that include pTcategory, pNcategory, and histologic grade; percentage of valid episodes with documentation of hormone receptor status; percentage of valid episodes receiving neo-adjuvant radiation therapy up to 180-days before surgery; percentage of valid episodes with proper orientation of specimen.

<u>Breast Cancer Medical Oncology episode design summary</u>

Identifying episode triggers

A medical oncology episode is triggered by a professional claim with one of the defined procedure codes for antineoplastic therapy infusion administration with either: a primary diagnosis code of breast cancer, or a primary diagnosis code of encounter for antineoplastic therapy and a confirming claim with a primary diagnosis code of breast cancer within six months; and a pharmacy claim with one of the defined medication codes for antineoplastic therapy and a confirming claim with a primary diagnosis code of breast cancer within six months.

Attributing episodes to quarterbacks

The quarterback is the physician or physician group with the plurality of antineoplastic therapy infusion administrations. If the patient does not have any antineoplastic therapy infusion administrations during the episode, the quarterback is the provider or group with the most visits. The contracting entity ID will be used to identify the quarterback.

Identifying services to include in episode spend

The length of the medical oncology episode is 180 days. Services to include in episode spend are: specific evaluation and management, medications, pathology, procedures, imaging, testing, anesthesia, and care after discharge. Services to exclude from episode spend are mastectomy procedures, radiation therapy, and breast reconstruction.

Excluding episodes

There are three types of exclusions. Business exclusions: available information is not comparable or is incomplete. Clinical exclusions: patient's care pathway is different for clinical reasons. High cost outlier exclusions: episode's risk-adjusted spend is three standard deviations above the mean.

Determining quality metrics performance

Quality metrics tied to gain sharing are percentage of valid and invalid episodes with complete Tennessee Cancer Registry reporting within four months of the episode. Quality metrics not tied to gain sharing are: percentage of valid episodes with hospitalizations for therapy-related adverse events; percentage of valid episodes that are estrogen receptor (ER) or progesterone receptor (PR) positive breast cancer who were prescribed tamoxifen or aromatase inhibitors (AI); percentage of valid episodes receiving aromatase therapy for breast cancer who had a central dual energy X-ray absorptiometry (DXA) performed or pharmacologic therapy prescribed; average number of ED visits per episode; percentage of valid episodes that are HER2/neu3negative who are not administered trastuzumab; percentage of valid episodes that are HER2/neu3positive who are administered trastuzumab; percentage of valid episodes that receive HER23testing; percentage of valid episodes that have non-metastatic breast cancer and also receive a biomarker assay; percentage of valid episodes that do not receive chemotherapy within the 30 days before death; percentage of valid episodes that are re-biopsied once diagnosed with metastatic disease.

Otitis Media episode design summary

Identifying episode triggers

An otitis media episode is triggered by a professional claim for an outpatient visit where either the primary diagnosis is one of the defined otitis media trigger codes, or the primary diagnosis is one of the defined otitis media contingent codes (including signs, symptoms, and EPSDT visits) with a secondary diagnosis code from the defined otitis media trigger codes.

Attributing episodes to quarterbacks

The quarterback is the physician or physician group that diagnosed the patient. The contracting entity ID will be used to identify the quarterback.

Identifying services to include in episode spend

Services to include in episode spend are: specific visits, procedures, anesthesia, imaging and testing, pathology, and medications during the trigger and up to 30 days after the trigger; care related to complications of otitis media up to 30 days after the trigger. Services to exclude from episode spend are specific visits (when EPSDT visit is concurrent with a specific evaluation and management—or "E&M"—visit) and procedures (e.g., mastoidectomy) during the trigger and up to 30 days after the trigger.

Excluding episodes

There are three types of exclusions. Business exclusions: available information is not comparable or is incomplete. Clinical exclusions: patient's care pathway is different for clinical reasons. These include episodes triggered in inpatient or observation room settings, or age (patients under 6 months or over 20 years old). High cost outlier exclusions: episode's risk adjusted spend is three standard deviations above the mean.

Determining quality metrics performance

Quality metrics tied to gain sharing are: percentage of valid episodes triggered by otitis media with effusion that did not have antibiotics filled; percentage of valid non-effusive otitis media episodes with antibiotics filled that are filled by amoxicillin. Quality metrics not tied to gain sharing are: percentage of valid episodes triggered by otitis media with effusion that did not have corticosteroids filled; percentage of valid and invalid episodes with tympanostomy performed that had tympanostomy indications; percentage of valid and invalid episodes with tympanostomy performed; percentage of valid episodes without follow-up visit up to 30 days after triggering visit; percentage of valid episodes that have

antibiotics filled that do not have macrolides filled among non-effusive otitis media episodes; percentage of valid non-effusive otitis media episodes where antibiotics are filled within the first seven days after initial diagnosis; percentage of valid episodes that have pneumococcal vaccine administered within the episode window.

Tonsillectomy episode design summary

Identifying episode triggers

A tonsillectomy episode is triggered by a professional claim that has one of the defined procedure codes for tonsillectomy and/or adenoidectomy.

Attributing episodes to quarterbacks

The quarterback is the physician or physician group that performed the triggering procedure. The contracting entity ID will be used to identify the quarterback.

Identifying services to include in episode spend

Services to include in episode spend are: specific evaluation and management, imaging, and testing up to 30 days prior to the triggering procedure; all medical services and specific medications during the stay or visit where the triggering procedure is performed; specific evaluation and management, medications, anesthesia, pathology, procedures, imaging, testing, and care after discharge up to 30 days after the triggering procedure.

Excluding episodes

There are three types of exclusions. Business exclusions: available information is not comparable or is incomplete. Clinical exclusions: patient's care pathway is different for clinical reasons. These include Down syndrome, muscle dystrophy, oral pharyngeal cancer, transplant, peritonsillar abscess, and age (patients under 6 months or over 20 years old). High cost outlier exclusions: episode's risk adjusted spend is three standard deviations above the mean.

Determining quality metrics performance

There are no gain sharing metrics recommended by the TAG. Quality metrics not tied to gain sharing are: percentage of valid episodes triggered by sleep apnea and/or tonsil/adenoid hypertrophy with sleep study performed up to 30 days before procedure; percentage of valid episodes with sore throat as primary diagnosis on triggering procedure with strep test performed up to 30 days before procedure; percentage of valid episodes with dexamethasone administered during procedure; percentage of valid episodes with

tympanostomy concurrent with adenoidectomy for children with history of recurrent otitis media among patients who are four years of age and above; percentage of valid episodes with no antibiotics filled during trigger and up to three days after trigger; percentage of valid episodes with post-operative visit(s) up to 30 days after procedure; percentage of valid episodes with post-operative bleeding up to two days after procedure; percentage of valid episodes with post-operative bleeding between the third day and the fourteenth day (inclusive) after procedure.

Non-Emergent Depression episode design summary

Identifying episode triggers

A non-emergent depression episode is triggered by two or more depression visits or one anxiety visit followed by two or more depression visits. Depression visits are identified by professional encounters with a primary diagnosis of depression, OR a secondary diagnosis of depression and a primary diagnosis of attempted suicide or self-injury, poisoning, anorexia, bulimia, or personality disorder. An anxiety visit is identified by a professional encounter with a primary diagnosis of anxiety. The trigger visits must not be in the emergency department or inpatient setting

Attributing episodes to quarterbacks

The quarterback is the provider or group with the plurality of depression or anxiety visits during the episode. The contracting entity ID will be used to identify the quarterback.

Identifying services to include in episode spend

The length of the non-emergent depression episode is 180 days. During this time period, the following services are included in spend: all inpatient, outpatient, professional, and long-term care claims with a primary diagnosis for depression, or a secondary diagnosis of depression and a primary diagnosis of attempted suicide or self-injury, poisoning, anorexia, bulimia, or personality disorder, or a primary diagnosis of anxiety, and pharmacy claims with eligible therapeutic codes.

Excluding episodes

There are three types of exclusions. Business exclusions: available information is not comparable or is incomplete. Clinical exclusions: patient's care pathway is different for clinical reasons. These include age (patients under the age of 7 and over the age of 64), bipolar, dementia, gender identity disorder, major depression with psychotic features, manic disorder, pregnancy, psychosis, schizophrenia, and traumatic brain injury. High-cost

outlier exclusions: episode's spend is three standard deviations above the mean (after business and clinical exclusions).

Determining quality metrics performance

Quality metrics tied to gain sharing are: percentage of valid episodes that meet the minimum care requirement. The minimum care requirement is set at five visits/claims during the episode window. These may be a combination of E&M and medication management visits, therapy visits, Level 1 case management visits, or pharmacy claims for treatment of depression or anxiety; percentage of valid episodes where the patient is under 18 and being prescribed benzodiazepines. Quality metrics not tied to gain sharing are: percentage of valid episodes with a depression or anxiety-related inpatient (IP) admission or ED visit; percentage of valid episodes with a follow-up visit within seven days after a depression or anxiety-related IP admission or ED visit; percentage of valid episodes that include medication related to the condition; average number of therapy or Level 1 case management visits per valid episode; percentage of valid episodes that include an assessment or testing; percentage of valid episodes where the patient is 18 years or older and has six or more prescriptions for benzodiazepines during the episode and did not have benzodiazepines prescribed in the year prior to the episode start.

Anxiety episode design summary

Identifying episode triggers

An anxiety episode is triggered by two or more professional visits that have a primary diagnosis of anxiety. The list of triggering codes includes anxiety disorders in childhood/adolescence; anxiety with other medical cause; generalized anxiety disorder; generalized anxiety with agoraphobia; other and unspecified anxiety; other anxiety-related disorders; panic disorder; panic disorder with agoraphobia; selective mutism; social and developmental disorders in childhood/adolescence; stimulus-related anxiety (stress and phobias). The trigger visits must not be in the ED or IP setting.

Attributing episodes to quarterbacks

The quarterback is the provider or group with the plurality of anxiety visits during the episode. The contracting entity ID will be used to identify the quarterback

Identifying services to include in episode spend

The length of the anxiety episode is 180 days. During this time period, the following services are included in spend: all inpatient, outpatient, professional, and long-term care

claims with a primary diagnosis for anxiety and pharmacy claims with eligible therapeutic codes.

Excluding episodes

There are three types of exclusions. Business exclusions: available information is not comparable or is incomplete. Clinical exclusions: patient's care pathway is different for clinical reasons. These include age (patients under the age of 7 and over the age of 64), bipolar, dementia, gender identity disorder, manic disorder, pregnancy, psychosis, schizophrenia, and traumatic brain injury. High-cost outlier exclusions: episode's spend is three standard deviations above the mean (after business and clinical exclusions).

Determining quality metrics performance

Quality metrics tied to gain sharing are: percentage of valid episodes that meet the minimum care requirement. The minimum care requirement is set at five visits/claims during the episode window. These may be a combination of E&M and medication management visits, therapy visits, Level 1 case management visits, or pharmacy claims for treatment of anxiety; percentage of valid episodes where the patient is under 18 and being prescribed benzodiazepines. Quality metrics not tied to gain sharing are: percentage of valid episodes with an anxiety-related IP admission or ED visit; percentage of valid episodes with a follow-up visit within seven days after an anxiety-related IP admission or ED visit; percentage of valid episodes that include medication related to the condition; average number of therapy or Level 1 case management visits per valid episode; percentage of valid episodes that include an assessment or testing; percentage of valid episodes where the patient is 18 years or older and has six or more prescriptions for benzodiazepines during the episode and did not have benzodiazepines prescribed in the year prior to the episode start.