TennCare Quarterly Report

July – September 2017

Submitted to the Members of the General Assembly

Status of TennCare Reforms and Improvements

Demonstration Amendment 32: Medication Therapy Management. On September 6, 2017, the Division of TennCare submitted Demonstration Amendment 32 to the Centers for Medicare and Medicaid Services (CMS). Consistent with Public Chapter No. 363 passed by the 110th General Assembly, Amendment 32 would establish a two-year pilot project in which certain TennCare enrollees receive a medication therapy management (MTM) benefit in addition to the traditional TennCare benefits package. MTM is a clinical service provided by licensed pharmacists, the aim of which is to optimize drug therapy and improve therapeutic outcomes for patients. MTM services include medication therapy reviews, pharmacotherapy consults, monitoring efficacy and safety of medication therapy, and other clinical services. Amendment 32 proposes to make MTM available to TennCare members enrolled in the State's health home program, and to members whose primary care providers are participants in the State's patient-centered medical home (PCMH) program. The pilot program would last from January 1, 2018, through December 31, 2019, and received initial funding in the Fiscal Year 2018 budget approved by the General Assembly this year.

Stakeholder engagement and public input processes that informed the design and development of Amendment 32 include—

- A series of Technical Advisory Group meetings held between November 2016 and June 2017 with a focus on operational design (i.e., model, reimbursement, evaluation, and quality metrics);
- A public notice and comment period on Amendment 32 held by TennCare from July 28 through September 1, 2017.

Additional information about the State's proposal may be found on the TennCare website at http://www.tn.gov/assets/entities/tenncare/attachments/ComprehensiveNotice.pdf.

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. During the July-September 2017 quarter, Deloitte Consulting, LLP—TennCare's systems integrator partner—presented formal design documents for review by the

State. TennCare approved these materials during the last week of August, and Deloitte subsequently began development of the system. The State's attention has now turned to—

- Finalizing test scripts, which will be used to verify that TEDS performs according to expectations;
- Organizational Change Management, which involves development of training materials and actual training of TennCare staff on use of TEDS; and
- Working on ancillary services, such as the Master Person Index and Access Identity Management.

Implementation of the TEDS system is planned for late 2018.

Payment Reform. Tennessee's Health Care Innovation Initiative is changing health care payment to reward providers for high-quality and efficient treatment of medical conditions, and to help in maintaining people's health over time.

One strategy being used to reform health care payment in Tennessee is Episodes of Care. Episode-based payment is applicable for most procedures, hospitalizations, acute outpatient care (e.g., broken bones), as well as some forms of treatment for chronic health conditions (e.g., cancer) and behavioral health conditions (e.g., ADHD). Episodes encompass care delivered by multiple providers in relation to a specific health care event. Each episode has a principal accountable provider (sometimes referred to as the "quarterback") who is in the best position to influence the cost and quality of the episode. Eighteen episodes covering orthopedics, hospitalist medicine, gynecological surgery, and general surgery are expected to be implemented in the spring of 2018.

Stakeholder input from Tennessee providers, payers, patients, and employers is central to the design of episodes of care and the other value-based payment strategies that are part of Tennessee's Health Care Innovation Initiative. The Initiative organizes Technical Advisory Groups (TAGs) composed of experts in the field to provide clinical feedback on each episode's design. Episode TAG meetings are held in the spring and fall.

The Episode Design Feedback Sessions are another opportunity for stakeholders to provide input on existing episodes of care. On May 16, 2017, 160 providers from across Tennessee convened to comment on aspects of the program that are working well, as well as on areas for improvement in the design of the first 20 Episodes of Care. The meetings were held simultaneously in six cities across Tennessee (Chattanooga, Jackson, Johnson City, Knoxville, Memphis, and Nashville) and were connected via videoconference to make it easier for providers across the state to participate.

Based on the feedback received, the State is making over 35 changes to the design of these Episodes of Care for calendar year 2018. These changes will first be reflected in reports released in August of 2018. Commercial and Medicare Advantage carriers may also choose to implement these changes, but there may be differences in the clinical design of commercial episodes.

Attached to this report is an appendix that contains the feedback from the Annual Feedback Sessions and the State's response to each comment.

Employment and Community First CHOICES. Designed and implemented in partnership with people with intellectual and developmental disabilities, their families, advocates, providers, and other stakeholders, 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.

Data drawn from the first five quarters of the program's implementation indicate that Employment and Community First CHOICES is successfully enrolling eligible individuals. Participation in the program has increased to 1,891 individuals, a total representing 70 percent of program capacity for the first two years of operation (July 1, 2016, through June 30, 2018). In the July-September 2017 quarter alone, overall enrollment increased 36 percent, with more than 90 percent of new enrollees entering the program through one of the seven employment-related priority groups.

The success of Employment and Community First CHOICES is evident not solely in growing enrollment but also in employment gains for members. Over 17 percent of working-age enrollees already have competitive integrated employment after an average of only seven months of enrollment. This rate is 30 percent higher than the national average for individuals with intellectual and developmental disabilities, even though the average length of program enrollment in other states is typically much longer. Average wages for Employment and Community First CHOICES members are $8.60 per hour, and the average number of hours worked per week exceeds 17. Furthermore, nearly 150 enrollees who thought they did not want to work completed an Exploration process (i.e., a service that helps individuals make an informed choice about working), and 86 percent of the enrollees subsequently chose to pursue employment.

Additional details about Employment and Community First CHOICES, including instructions for individuals interested in enrolling in the program, are available on the TennCare website at http://www.tn.gov/tenncare/topic/employment-and-community-first-choices.

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 of 2009. The purpose of the program is to provide financial incentives to Medicaid providers[1] to replace outdated, often paper-

[1] CMS allows two types of providers to participate in the Medicaid EHR Incentive Program: medical professionals (medical and osteopathic physicians, nurse practitioners, certified nurse midwives, dentists, and physician assistants who meet certain criteria) and hospitals (acute care hospitals, critical access hospitals, and children's hospitals).

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 funding for administrative costs.

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

- First-year payments (through the 2016 Program Year) to eligible hospitals or practitioners who had submitted an attestation by April 30, 2017, the deadline for enrollment and first-time submission, and 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 a 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, fifth-year, and sixth-year payments to providers who continue to demonstrate meaningful use of certified EHR technology.

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 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 July-September 2017 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 (Jul-Sept 2017)	Cumulative Amount Paid to Date[2]
First-year payments	22[3]	$446,250	$181,556,067
Second-year payments	106	$892,501	$57,678,166
Third-year payments	137	$1,798,450	$32,301,505
Fourth-year payments	96	$799,002	$5,383,344
Fifth-year payments	100	$847,167	$2,776,668
Sixth-year payments	28	$238,000	$824,500

Technical assistance activities, outreach efforts, and other EHR-related projects conducted by TennCare staff during the quarter included the following:

[2] Audits performed during the July-September 2017 quarter identified past payments to eligible hospitals and an eligible practitioner to be recouped. The cumulative totals associated with first-year and second-year payments reflect these recoupments.

[3] Of the 22 providers receiving first-year payments in the July-September 2017 quarter, 8 earned their incentives by successfully attesting to meaningful use of EHR technology.

- Completing more than 100 technical assistance calls, 35 of which related to Meaningful Use;
- Responding to over 300 emails received in the EHR Incentive mailbox, and to over 300 emails received in the EHR Meaningful Use mailbox;
- Attendance at the 2017 Medicaid HITECH Multi-Regional Conference in Philadelphia, Pennsylvania, in August 2017;
- Making a presentation at the TriMED Healthcare Education Summit in Nashville in September 2017;
- Participation throughout the quarter in several Southeast Regional Collaboration for HIT/HIE (SERCH) calls;
- Mailing of reminder notices to eligible professionals whose attestations were incomplete; and
- Newsletters and alerts distributed by TennCare's EHR ListServ.

Although enrollment of new providers concluded on April 30, 2017, TennCare's EHR Incentive Program team continues to work with a variety of provider organizations to maintain the momentum of the program. The focus of outreach efforts has shifted from new enrollments to providers who attested to EHR requirements only once or who have not attested in recent years. To advance this strategy, TennCare staff made preparations to attend a variety of events in the months ahead, including statewide meetings hosted by the Tennessee Medical Association; the 69th Annual Scientific Assembly of the Tennessee Academy of Family Physicians; and regional workshops hosted by United HealthCare.

Pharmacy Benefits Manager Procurement. Following a competitive bidding process in which multiple companies submitted proposals, TennCare named OptumRx the program's new Pharmacy Benefits Manager (PBM) on August 25, 2017. OptumRx is scheduled to replace Magellan Health Services, which has held the role since 2013. On September 1, 2017, Magellan Health Services protested the award of the contract to OptumRx. As of the end of the July-September 2017 quarter, the protest was ongoing, but a decision in the matter was expected by November 1, 2017.

If the protest is resolved in TennCare's favor, OptumRx will begin preparations this fall. Although OptumRx would not begin processing claims for TennCare until June 1, 2018, priorities during this period of transition would include the following:

- Establishing a pharmacy network;
- Building a claims processing system and loading it with enrollee information and with edits specific to TennCare's preferred drug list, prior authorization program, and clinical/quantity requirements;
- Creating a call center and a website to assist patients and providers; and
- Processing, invoicing, and collecting supplemental rebates.

OptumRx's experience in managing pharmacy benefits for millions of individuals, working with hundreds of health plans, and partnering with dozens of governmental entities is a positive indication of the

company's ability to fulfill the requirements of TennCare's pharmacy program. TennCare's contract with OptumRx is scheduled to last through May 31, 2021, and contains an option for four one-year extensions.

Essential Access Hospital (EAH) Payments. The Division of TennCare continued to make EAH payments during the July-September 2017 quarter. EAH payments are made from a pool of $100 million ($34,395,000 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 53.a. 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 first quarter of State Fiscal Year 2018 (for dates of service during the fourth quarter of State Fiscal Year 2017) are shown in the table below.

Essential Access Hospital Payments for the Quarter

Hospital Name	County	EAH First Quarter FY 2018
Vanderbilt University Hospital	Davidson County	$3,432,915
Regional One Health	Shelby County	$3,169,454
Erlanger Medical Center	Hamilton County	$2,588,947
University of Tennessee Memorial Hospital	Knox County	$1,542,189
Johnson City Medical Center (with Woodridge)	Washington County	$1,201,426
Parkridge Medical Center (with Parkridge Valley)	Hamilton County	$888,939
LeBonheur Children's Medical Center	Shelby County	$731,246
Metro Nashville General Hospital	Davidson County	$565,069
Jackson – Madison County General Hospital	Madison County	$554,396
East Tennessee Children's Hospital	Knox County	$518,754
TriStar Centennial Medical Center	Davidson County	$468,191
Methodist Healthcare – Memphis Hospitals	Shelby County	$467,472
Saint Jude Children's Research Hospital	Shelby County	$438,580
Methodist Healthcare – South	Shelby County	$391,029
Parkridge East Hospital	Hamilton County	$366,501

Hospital Name	County	EAH First Quarter FY 2018
TriStar Skyline Medical Center (with Madison Campus)	Davidson County	$330,238
Parkwest Medical Center (with Peninsula)	Knox County	$313,712
Baptist Memorial Hospital – Memphis	Shelby County	$288,813
Methodist Healthcare – North	Shelby County	$279,227
University Medical Center (with McFarland)	Wilson County	$257,541
Saint Francis Hospital	Shelby County	$252,781
Saint Thomas Rutherford Hospital	Rutherford County	$238,691
Lincoln Medical Center	Lincoln County	$234,738
Baptist Memorial Hospital for Women	Shelby County	$217,868
Wellmont – Holston Valley Medical Center	Sullivan County	$213,281
Fort Sanders Regional Medical Center	Knox County	$211,885
Saint Thomas Midtown Hospital	Davidson County	$210,726
Wellmont – Bristol Regional Medical Center	Sullivan County	$207,292
Cookeville Regional Medical Center	Putnam County	$206,384
Maury Regional Hospital	Maury County	$190,697
Pathways of Tennessee	Madison County	$183,584
Tennova Healthcare – Newport Medical Center	Cocke County	$174,389
Ridgeview Psychiatric Hospital and Center	Anderson County	$164,734
TriStar StoneCrest Medical Center	Rutherford County	$152,953
Tennova Healthcare	Knox County	$151,419
Blount Memorial Hospital	Blount County	$147,676
TriStar Horizon Medical Center	Dickson County	$128,624
TriStar Summit Medical Center	Davidson County	$127,178
Gateway Medical Center	Montgomery County	$126,323
TriStar Southern Hills Medical Center	Davidson County	$125,949
Sumner Regional Medical Center	Sumner County	$124,465
Skyridge Medical Center	Bradley County	$119,741
Rolling Hills Hospital	Williamson County	$119,729
TriStar Hendersonville Medical Center	Sumner County	$113,303
Dyersburg Regional Medical Center	Dyer County	$111,930
NorthCrest Medical Center	Robertson County	$108,170
Morristown – Hamblen Healthcare System	Hamblen County	$105,478
LeConte Medical Center	Sevier County	$101,744
Methodist Medical Center of Oak Ridge	Anderson County	$94,806
Jellico Community Hospital	Campbell County	$86,133
Takoma Regional Hospital	Greene County	$85,081
Tennova Healthcare – Harton Regional Medical Center	Coffee County	$75,730
Tennova Healthcare – LaFollette Medical Center	Campbell County	$68,412
Indian Path Medical Center	Sullivan County	$64,210
Sycamore Shoals Hospital	Carter County	$61,306
Starr Regional Medical Center – Athens	McMinn County	$60,582
Skyridge Medical Center – Westside	Bradley County	$58,241

Hospital Name	County	EAH First Quarter FY 2018
Grandview Medical Center – Jasper	Marion County	$57,058
Heritage Medical Center	Bedford County	$55,618
Bolivar General Hospital	Hardeman County	$55,228
Regional Hospital of Jackson	Madison County	$54,670
Southern Tennessee Regional Health System – Winchester	Franklin County	$54,216
Henry County Medical Center	Henry County	$50,978
Baptist Memorial Hospital – Union City	Obion County	$50,949
Henderson County Community Hospital	Henderson County	$49,708
Saint Thomas River Park Hospital	Warren County	$48,651
Hardin Medical Center	Hardin County	$46,989
Roane Medical Center	Roane County	$46,605
Lakeway Regional Hospital	Hamblen County	$46,057
Southern Tennessee Regional Health System – Lawrenceburg	Lawrence County	$42,438
Hillside Hospital	Giles County	$36,653
Claiborne County Hospital	Claiborne County	$36,103
PremierCare Tennessee, Inc.	Putnam County	$31,953
McKenzie Regional Hospital	Carroll County	$31,394
Erlanger Health System – East Campus	Hamilton County	$30,605
Saint Thomas DeKalb Hospital	DeKalb County	$28,299
Jamestown Regional Medical Center	Fentress County	$27,258
Saint Thomas Stones River Hospital	Cannon County	$25,669
Volunteer Community Hospital	Weakley County	$24,287
Wayne Medical Center	Wayne County	$20,338
United Regional Medical Center and Medical Center of Manchester	Coffee County	$16,973
Southern Tennessee Regional Health System – Sewanee	Franklin County	$10,431
TOTAL		**$25,000,000**

Number of Recipients on TennCare and Costs to the State

During the month of September 2017, there were 1,419,700 Medicaid eligibles and 14,297 Demonstration eligibles enrolled in TennCare, for a total of 1,433,997 persons.

Estimates of TennCare spending for the first quarter of State Fiscal Year 2018 are summarized in the table below.

Spending Category	First Quarter FY 2018*
MCO services**	$1,442,218,900
Dental services	$35,681,200
Pharmacy services	$225,995,100
Medicare "clawback"***	$37,657,000

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

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

****The Medicare Part D clawback is money that 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 Managed Care Contractors (MCCs) in the TennCare Program

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

Entity	Standard	Authority
MCOs (services other than CHOICES and ECF CHOICES)	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 and ECF 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
Dental Benefits Manager (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)
Pharmacy Benefits Manager (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 and ECF CHOICES enrollees. TDCI then performs an analysis and reports the results of the prompt pay analyses by NEMT and CHOICES and ECF 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 Division of TennCare may 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 TennCare may 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 July-September 2017 quarter, the MCOs submitted their NAIC Second Quarter 2017 Financial Statements. As of June 30, 2017, TennCare MCOs reported net worth as indicated in the table below.[6]

MCO	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$33,420,759	$190,479,457	$157,058,698

[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)
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$57,158,856	$414,834,966	$357,676,110
Volunteer State Health Plan (BlueCare & TennCare Select)	$46,879,872	$431,219,175	$384,339,303

During the July-September 2017 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 June 30, 2017:

MCO	Company Action Level	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$122,877,816	$190,479,457	$67,601,641
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$205,480,268	$414,834,966	$209,354,698
Volunteer State Health Plan (BlueCare & TennCare Select)	$148,059,416	$431,219,175	$283,159,759

All TennCare MCOs met their minimum net worth requirements and Company Action Level requirements as of June 30, 2017.

Success of Fraud Detection and Prevention

The mission of the Tennessee Office of Inspector General (OIG) is to identify, investigate, prosecute, and arrest 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 Division of TennCare, Health Related Boards (HRB), the Department of Human Services (DHS), other State agencies, health care providers, MCCs, and the general public via the OIG website, fax, written correspondence, and phone calls to the OIG hotline. Cases adjudicated during a particular fiscal year may have no relationship to dates of arrest during the same year. Selected statistics for the first quarter of Fiscal Year 2018 are as follows:

Fraud and Abuse Complaints	First Quarter FY 2018
Fraud Allegations	986
Abuse Allegations*	669
Arrest/Conviction/Judicial Diversion Totals	**First Quarter FY 2018**
Arrests	37
Convictions	25
Judicial Diversions	11

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

Criminal Court Fines and Costs Imposed	First Quarter FY 2018
Court Costs & Taxes	$7,567
Fines	$12,600
Drug Funds/Forfeitures	$448
Criminal Restitution Ordered	$191,990
Criminal Restitution Received[7]	$19,819
Civil Restitution/Civil Court Judgments	**First Quarter FY 2018**
Civil Restitution Ordered[8]	$0
Civil Restitution Received[9]	$5,897

Recommendations for Review	First Quarter FY 2018
Recommended TennCare Terminations[10]	107
Potential Savings[11]	$391,234

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.

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

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

[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

Episodes of Care Design Feedback Memorandum

Division of TennCare

2018 MEMO

Date: September 2017

Subject: Update on the Tennessee Health Care Innovation Initiative

The following memo discusses the recommendations and corresponding improvements made to the Episodes of Care program in Tennessee for the 2018 performance period.

We greatly appreciate the feedback we have received from stakeholders over the past year, and especially those stakeholders who attended the Episodes Design Feedback Session meetings held on May 16, 2017. The meetings were an opportunity for members of the public from across Tennessee to comment on what is working well and areas for improvement in the design of the first 20 Episodes of Care. The meetings were held simultaneously in six cities across Tennessee (Chattanooga, Jackson, Johnson City, Knoxville, Memphis, and Nashville) and connected via videoconference to make it easier for the public to participate. Members of the public were also able to submit their feedback by email.

Based on the feedback received, we are making over 35 changes to the design of these Episodes of Care for calendar year 2018. These changes will first be reflected in reports released in August of 2018. Commercial and Medicare Advantage carriers may also choose to implement these changes, but there may be differences in the clinical design of commercial episodes.

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

The State received over one hundred pieces of feedback and worked diligently to address all recommendations. The feedback is organized by episode in alphabetical order. Each episode can contain two sections: 1) Feedback Accepted and 2) Feedback Not Accepted. Recommendations within the "Feedback Accepted" section refer to feedback that will be incorporated and reflected in the 2018 Detailed Business Requirements (DBRs) and Configuration Files. Please note that

some feedback may be accepted with modifications. Additionally, "Feedback Not Accepted" reflects feedback that was either not accepted as a change or will not be ready for implementation for the 2018 performance period.

For more information about Episodes of Care in Tennessee in general, go to http://tn.gov/tenncare/section/health-care-innovation.

All Episodes

Feedback Accepted

Comment: Protect the Quarterback from paying high penalties by revising the Stop-loss policy.

Response: The Stop-loss policy is in place to protect providers and provider groups[1] from paying back more than they are reimbursed by creating a high-cost cap to penalties. While this policy currently exists, the State is changing the rule from "A quarterback's penalty cannot exceed 100% the amount paid to the quarterback for all valid episodes in the performance period" to "A quarterback's penalty cannot exceed *25%* the amount paid to the quarterback for all valid episodes in the performance period." This means if a provider group is reimbursed $1,000 for all valid episodes, the provider group is only at risk to pay a maximum $250 penalty.

Comment: Quarterbacks should not have patients in more than one episode at a time.

Response: Throughout the Feedback Session, multiple comments were made regarding two or more episodes running concurrently for the same patient. For example, we had recommendations to exclude one of the two episodes for the following situations: cholecystectomy and appendectomy, cholecystectomy and esophagogastroduodenoscopy (EGD), colonoscopy and EGD, perinatal and skin and soft tissue infection, and attention deficit and hyperactivity disorder (ADHD) and oppositional defiant disorder (ODD). We have made some of these changes as suggested; please see the relevant episode for more information. In addition, we are working to create a general approach to multiple episodes running concurrently that will be effective for the 2018 performance period.

Comment: Exclude health departments that are Federally Qualified Health Clinics (FQHCs).

Response: An episode will be excluded if a trigger diagnosis occurs in a Federally Qualified Health Clinic (FQHC). Exclusions for FQHCs are based on Place of Service and Billing type. If coding is correct, all FQHCs will not be included in the Episodes of Care program.

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

Comment: Only include specific medications in all episodes.

Response: Some stakeholders were concerned that unrelated medications are being included in the cost of episodes. The Detailed Business Requirements (DBRs) for all episodes define what medications to include based on type of medication and time of fill. For example, inpatient episodes include all medications during the triggering visit or hospitalization, which is appropriate because the medications are part of the treatment that the patient is receiving. Outpatient episodes, on the contrary, include only specific medications as defined in the configuration file. Section 2.3.4 of the DBR for each episode documents the types of medications included in the pre-trigger, trigger, and post-trigger window. These distinctions are generally based on feedback from the Technical Advisory Group (TAG). It is important to note that all medications prescribed for that patient that match the DBR rules will be included in spend regardless of the provider that prescribed the medications.

In addition to general concern about included medications, the State received feedback about inclusion of specific types of medications. We have made changes based on some of these recommendations, which are included in the specific episode section.

Feedback Not Accepted

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

Response: It was recommended that Quarterbacks with a low volume of episodes should not be held financially accountable under the Episode of Care model. The State believes that providers should be held accountable for all care under the Episode of Care model.

However, if a provider or provider group has a penalty at the end of the year and feels that they have special circumstances, such as only a few valid episodes or believes that one of more of their episodes cannot be fairly compared to others and contributed to the penalty, then that provider or provider group can ask the respective TennCare Managed Care Organization (MCO) for reconsideration for the penalty. On a case-by-case basis, the MCOs can review the situation and decide whether there is a reason not to collect the penalty.

Please also note, beginning in 2016 performance period, providers or provider groups with risk sharing payment of less than $100 are not penalized. All providers

/ provider groups will continue to receive reports, but only those providers / provider groups with a final risk sharing payment in excess of $100 will be required to make a shared risk payment back to the MCO. Providers / provider groups with a shared savings reward of any amount will continue to receive the reward payment.

Comment: Display greater level of detail on the specific diagnosis codes that comprise a patient's risk score.

Response: In Tennessee, carriers are sharing more information about their risk adjustment model for episodes than is available for many other risk adjustment models in use elsewhere. Providers can go to carriers' websites and see how variation in episode cost due to a patients' demographic information (such as age and sex) and comorbidities are accounted for in the model. This information includes a list of the demographic categories and comorbidities and the factor by which the cost will be adjusted. Here is how to view that information:

- **Amerigroup:** https://providers.amerigroup.com/pages/tn-2012.aspx [Under the "Tennessee Episodes of Care" tab].
- **BlueCross BlueShield of Tennessee:** https://bluecare.bcbst.com/forms/Provider%20Information/Risk_Factors_and_Weights.pdf
- **United Healthcare:** http://www.uhccommunityplan.com/health-professionals/tn/Episodes-of-Care-PCMH-TN-Health-Link.html
- **Cigna:** 615-595-3663 or email Megan.Higdon@Cigna.com

Some stakeholders would like to see the specific diagnosis codes (e.g., ICD-10) that define the comorbidities in the carriers' risk adjustment model. These diagnosis codes are generally proprietary to the model developers, and by contract they cannot be shared. We believe that the level of transparency from the carriers is the best balance of giving the providers the information that they need while allowing the carriers to use the best available risk adjustment models.

Overall, the level of detail in these reports allows providers to know what diagnosis or condition is included in risk adjustment without revealing proprietary information.

Comment: Exclude non-compliant patients from all episodes.
Response: All episodes include patient and business exclusions that aim to protect the provider from being held responsible for decisions made by the patient. For example, an episode is excluded if a patient has a discharge status of "left against medical advice or discontinued care" on any inpatient or outpatient claim during the episode window. The goal of the Episodes program, however, is to better coordinate care and educate patients to improve quality care and reduce expensive, preventable care. While patient non-compliance is frequently an issue, providers do have the opportunity to positively influence patient behavior. Creating a separate exclusion on patient non-compliance could lead to perverse incentives.

Acute Asthma Exacerbation

Feedback Accepted

Comment: Exclude episodes with a diagnosis of sickle cell disease.
Response: Clinical experts and recent studies have shown that asthma may complicate a patient's sickle cell disease leading to more complex care. Since the patient journey for acute asthma exacerbation is unique for a patient with this condition, sickle cell disease will be excluded from the acute asthma exacerbation episode.

Comment: Include inpatient claims for the "appropriate medications within the trigger and post-trigger window" quality metric in addition to outpatient and professional claims.
Response: The goal of the "appropriate medications within the trigger and post-trigger window" quality metric is to determine the percent of episodes where an oral and/or injectable corticosteroid is administrated or filled during the triggering visit or stay and/or 30-days after the index visit or stay. As discussed in the 2016 Episodes Design Feedback Session memorandum, the guidelines for medication use during an acute asthma exacerbation recommend giving early systematic glucocorticoids (e.g., prednisone, prednisolone, methylprednisolone, beclomethasone, betamethasone, dexamethasone, hydrocortisone, and triamcinolone) to all patients who have a moderate or severe exacerbation. Since these medications are often prescribed in an inpatient hospital setting, inpatient

professional claims will be included in the quality metric to better capture appropriate oral and/or injectable corticosteroids.

Attention Deficit and Hyperactivity Disorder (ADHD)

Feedback Accepted

Comment: Change the current temporary Level I Case Management clinical exclusion to a permanent clinical exclusion.
Response: The intent of the Level I Case Management temporary clinical exclusion was to give providers an additional year to improve their coding to more accurately capture clinical exclusions and risk factors. Improved coding will allow higher risk patients to be excluded based on a diagnosis (e.g., bipolar disorder) rather than the treatment. However, while Level I Case Management will not be made a permanent exclusion, the episode will continue to have a Level I Case Management clinical exclusion for ADHD in calendar year 2018. It will be revisited for performance period 2019.

Comment: Improve the Disruptive Mood Dysregulation Disorder (DMDD) clinical exclusion by adding additional diagnosis codes to the definition.
Response: To ensure the Disruptive Mood Dysregulation Disorder (DMDD) clinical exclusion is correctly excluding patients with this diagnosis, additional codes were added to the configuration file. This improvement also makes the DMDD exclusion the same for the ADHD and ODD episodes.

Comment: Exclude patients with a diagnosis of Tourette's Disorder from the ADHD episode.
Response: Since a diagnosis of Tourette's Disorder does not change the patient journey for ADHD care, Tourette's Disorder will not be a clinical exclusion. However, to account for higher cost due to Tourette's Disorder, the diagnosis is listed as a proposed risk factor for the ADHD episode.

Feedback Not Accepted

Comment: Incorporate non-claims-based data, such as school data, into quality metrics for the ADHD episode.

Response: The State recently secured the capacity to integrate non-claims-based data into the quality metrics and is working with various organizations to add additional non-claims-based quality measures. School-based data is one area that we will investigate.

Comment: Expand the types of treatments and programs (e.g., Regional Intervention Program (RIP)) that are included in the Minimum Care Requirement and Utilization of Therapy quality metrics.

Response: The overarching goal of the Minimum Care Requirement and Utilization of Therapy quality metrics is to hold providers and provider groups accountable for providing appropriate and effective care. While community interventions are important forms of treatment for patients with ADHD, they are often not provided by licensed professionals or physicians, and patients still require other forms of treatment. Additionally, these programs are not captured in claims. For these reasons, community-based treatments, such as RIP, will not be included in the quality metric definitions.

Comment: Revise the "long-acting stimulants" and "utilization of therapy" quality metrics for children ages 4 and 5 years to prevent perverse incentives.

Response: Stakeholders were concerned that the "long-acting stimulants" and "utilization of therapy" quality metrics for 4 and 5 year olds were incentivizing both medication and therapy, therefore creating confusion for the Quarterbacks. This is not the case, however. As discussed by the Technical Advisory Group (TAG) in November 2016, most children aged 4 or 5 years old receive only therapy to treat ADHD. If this is the case and no medication is prescribed, the denominator of the "long-acting simulants" quality metric will be zero and will not be counted against the Quarterback for gain share eligibility. On the other hand, if the child does need medication, the "long-acting stimulants" quality metric will be activated. The percentage of "long-acting stimulants" quality metric was added to avoid rewarding short-acting stimulants over long-acting stimulants due to lower costs when medication is appropriate. Overall, these quality metrics do not interact and correctly capture different types of care.

Comment: Include diagnoses from Mobile Crisis Units for exclusions and/or risk adjustment for the ADHD episode.

Response: We are further investigating this recommendation to use diagnoses from Mobile Crisis Units. Information from Mobile Units could be used to capture

diagnoses for exclusion and risk adjustment if these diagnoses are not captured by a different provider. It is important to note that this may impact a limited set of episodes and Mobile Crisis Units may not be credentialed to render a diagnosis.

Additionally, the data from Mobile Crisis Units could be accessed either through claims or other data sources. While claims data would be easier to integrate and Mobile Crisis Units are required to submit claims to the Managed Care Organizations (MCOs), not all Mobile Crisis teams consistently submit claims. TennCare is working with the Department of Mental Health and Substance Abuse Services to determine the feasibility of incorporating Mobile Crisis data into episodes.

Comment: Exclude patients from the ADHD episode who have an encounter with a Mobile Crisis Unit.
Response: In addition to the limitations with the Mobile Crisis Unit data discussed above, the Episodes of Care program does not typically exclude on the provision of a service since that service does not directly signal a unique patient journey. For example, acute episodes are not excluded if a patient needed an ambulance. Therefore, the fact that a patient saw a Mobile Crisis Unit is not a reason for a clinical exclusion.

Comment: Remove Family Support Services from Quarterback attribution for the ADHD episode.
Response: A stakeholder was concerned that Family Support Service (FSS) specialists were being attributed as Quarterbacks for the ADHD episode. Since FSS specialists are usually unlicensed and serve as community support, the State agrees that these specialists are not in the best position to influence care and therefore should not be Quarterbacks. After analysis, however, there has been no evidence that FSS specialists have ever been assigned as Quarterbacks. The problem will be addressed if it arises.

Bariatric Surgery

Feedback Accepted

Comment: Add CPT code 99024 for post-surgical follow-up to the "Follow-up care within the post-trigger window" quality metric definition.

Response: To ensure the quality metric was capturing all post-surgical follow-up care, CPT code 99024 was added to the quality metric definition. This CPT code is a zero amount, global spend code.

Comment: Decrease the duration of the post-trigger window from 90 days.
Response: The post-trigger window of the Bariatric episode is 30 days, not 90 days. The Technical Advisory Group (TAG) recommended a post-trigger window duration of 30 days to accurately capture the follow-up period in which a Quarterback is responsible for influencing care and reducing costs.

Feedback Not Accepted

Comment: Change the Quarterback from the physician or the physician group to the facility.
Response: The TAG recommended the physician or physician group to be the Quarterback for the Bariatric episode. The physician group is in the best position to influence the cost and quality of a bariatric episode, and also generally advises the patient in which facility the surgery should be performed. For this reason, in all elective procedural episodes created to date, the physician performing the procedure has been assigned as the Quarterback. The Bariatric episode will continue to have the physician or physician group as the Quarterback.

Comment: Request that the "Appropriate procedural choice" quality metric be changed from informational to gain sharing for calendar year 2018.
Response: The "Appropriate procedural choice" quality metric measures the percentage of valid episodes where patients with metabolic and/or diabetes receive Roux-en-Y gastric bypass (RYGB). Based on the first preview period for Bariatric Surgery, a low percentage of Quarterbacks had data for this quality metric. Due to the lack of data, it is currently not recommended to change this metric to gain sharing. In the future, we will seek further discussion from multiple Bariatric providers about possibly moving this metric to being tied to gain sharing.

Cholecystectomy

Feedback Not Accepted

Comment: Exclude the episode or the related spend if the patient is diagnosed with one or more sexually transmitted diseases (STDs).
Response: Some providers were concerned that the development of a STD should be excluded because it could lead to more costly treatment. An STD does not meet the standard of creating a different patient pathway. An STD is one of many factors that could have some impact on the cost of an episode, but the potential for a provider group to have a patient with one of these many factors is about the same. There are several aspects of the episode program design that mitigate these types of risk for the provider group. One aspect is that the provider group is being held accountable for the average of all episodes in a year, mitigating the impact of any one episode. Another element is that very high-cost episodes are excluded if the total adjusted cost of the episode is more than three standard deviations above the adjusted mean. For these reasons, STDs will not be a clinical exclusion or excluded from spend.

Colonoscopy (Screening and Surveillance)

Feedback Accepted

Comment: Split the "prior colonoscopy" quality metric into two metrics: 1) "prior screening colonoscopy" and 2) "prior diagnostic colonoscopy."
Response: For calendar year 2017 and earlier, the "prior colonoscopy" quality metric measured the percent of valid episodes with a prior screening, surveillance, or diagnostic colonoscopy within 365 days before the triggering colonoscopy. A stakeholder recommended creating two separate quality metrics: "prior screening and surveillance colonoscopy" and "prior diagnostic colonoscopy." This allows Quarterbacks to better pinpoint potential sources of overutilization within care. Overall, the "prior colonoscopy" quality metric will be replaced with a "prior screening and surveillance colonoscopy" quality metric and "prior diagnostic colonoscopy" quality metric.

Comment: Remove all codes unrelated to a colonoscopy from the configuration file.

Response: The screening and surveillance colonoscopy episode is designed to capture care before, during, and after the colonoscopy procedure. To more accurately fulfill the episode's intended goal, codes unrelated to the colonoscopy process were removed from the configuration file (code sheet). For example, codes related to systems other than the gastrointestinal system are no longer included in the episode logic. While inclusion of these unrelated codes will most likely not impact the overall cost as they rarely occur concurrently with a screening and surveillance colonoscopy, the codes were removed to improve clarity and intent of the episode.

Feedback Not Accepted

Comment: Remove all inpatient claims from the cost for the colonoscopy episode.
Response: The screening and surveillance colonoscopy episode is not intended to capture diagnostic colonoscopies. However, some inpatient services can be related to a screening and surveillance colonoscopy. For example, some patients have screening and surveillance colonoscopies performed in an inpatient hospital setting. To avoid creating an incentive not to use inpatient facilities when appropriate, spend associated with inpatient claims are *not* included on the day of the procedure (also called the episode trigger window).

Inpatient cost should also be included in the episode to hold providers and provider groups accountable for complications from the colonoscopy, such as perforation or bleeding. Therefore, inpatient claims filed after the procedure day (post-trigger window) will continue to be included in the episode cost. Overall, the colonoscopy will continue to capture inpatient spend when appropriate.

Coronary Artery Bypass Grafting (CABG)

Feedback Accepted

Comment: Add CPT code 99024 for post-surgical follow-up to the "Follow-up care within the post-trigger window" quality metric definition.
Response: To ensure the quality metric was capturing all post-surgical follow-up care, CPT code 99024 was added to the quality metric definition. This CPT code is a zero amount, global spend code.

Feedback Not Accepted

Comment: Revise the "Admission within the post-trigger window" quality metric to require a confirming diagnosis related to the CABG procedure.
Response: The current logic only includes readmissions with a relevant diagnosis to the CABG procedure in the calculation of the quality metric. No change will be made to the quality metric.

Endoscopy (Esophagogastroduodenoscopy (EGD))

Feedback Accepted

Comment: Exclude either the EGD or Colonoscopy episode if they overlap during the trigger window.
Response: If appropriate, providers may perform a screening and surveillance colonoscopy and an EGD at the same time since it is preferred by the patient and provider. For example, the patient only needs to be put under anesthesia once rather than twice for each procedure. About 20 percent of colonoscopy episodes overlap with an EGD episode during the trigger window. Therefore, a screening and surveillance colonoscopy will be a clinical exclusion for the EGD episode if it occurs during the trigger window. The Quarterback will still be held accountable for the colonoscopy episode, but not the EGD episode.

GI Hemorrhage

Feedback Accepted

Comment: Add CPT code 99024 for post-surgical follow-up to the "Follow-up care within the post-trigger window" quality metric definition.
Response: To ensure the quality metric was capturing all post-surgical follow-up care, CPT code 99024 was added to the quality metric definition. This CPT code is a zero amount, global spend code.

Comment: Revise the "Admission within the post-trigger window" quality metric to require a confirming diagnosis related to the GI hemorrhage.

Response: The intent of the "Admission within the post-trigger window" quality metric is to include only readmissions with a diagnosis relating to a GI hemorrhage in the calculation of the metric. Therefore, the quality metric logic for "Admission within the post-trigger window" will be revised to require a confirming diagnosis of a GI hemorrhage. This change matches the logic used in CABG and Valve Repair and Replacement episodes.

Oppositional Defiant Disorder (ODD)

Feedback Accepted

Comment: Improve the Disruptive Mood Dysregulation Disorder (DMDD) clinical exclusion by adding additional diagnosis codes to the definition.
Response: To ensure the Disruptive Mood Dysregulation Disorder (DMDD) clinical exclusion is correctly excluding patients with this diagnosis, additional codes were added to the configuration file. This improvement also makes the DMDD exclusion the same for the ODD and ADHD episodes.

Comment: Exclude patients with a diagnosis of Tourette's Disorder from the ODD episode.
Response: Since a diagnosis of Tourette's Disorder does not change the patient journey for ODD care, Tourette's Disorder will not be a clinical exclusion. However, to account for higher cost due to Tourette's Disorder, the diagnosis is listed as a proposed risk factor for the ODD episode.

Feedback Not Accepted

Comment: Include diagnoses from Mobile Crisis Units for exclusions and/or risk adjustment for the ODD episode.
Response: We are further investigating this recommendation to use diagnoses from Mobile Crisis units. Information from Mobile Units could be used to capture diagnoses for exclusion and risk adjustment if these diagnoses are not captured by a different provider. It is important to note that this may impact a limited set of episodes and that Mobile Crisis Units may not be credentialed to render a diagnosis.

Additionally, the data from Mobile Crisis units could be accessed either through claims or through other data sources. While claims data would be easier to integrate and Mobile Crisis Units are required to submit claims to the Managed Care Organizations (MCOs), not all Mobile Crisis teams consistently submit claims. TennCare is working with the Department of Mental Health and Substance Abuse Services to determine the feasibility of incorporating Mobile Crisis data into episodes.

Comment: Exclude patients from the ODD episode who have an encounter with a Mobile Crisis Unit.

Response: In addition to the limitations with the Mobile Crisis Unit data discussed above, the Episodes program does not typically exclude on the provision of a service since that service does not directly signal a unique patient journey. For example, acute episodes are not excluded if a patient needed an ambulance. Therefore, the fact that a patient saw a Mobile Crisis Unit is not a reason for a clinical exclusion.

Comment: Remove Family Support Services from Quarterback attribution for the ODD episode.

Response: A stakeholder was concerned that Family Support Service (FSS) specialists were being attributed as Quarterbacks for the ODD episode. Since FSS specialists are usually unlicensed and serve as community support, the State agrees that these specialists are not in the best position to influence care and therefore should not be Quarterbacks. After analysis, however, there has been no evidence that FSS specialists have ever been assigned as Quarterbacks. The problem will be addressed if it ever does arise.

Comment: Exclude episodes with cannabis and alcohol abuse from the ODD episode.

Response: Patients with behavioral health conditions often have comorbid substance abuse. To ensure providers and provider groups are still accountable for the care of these patients, substance abuse will not be a clinical exclusion. However, various forms of substance abuse (e.g., alcohol, cannabis, tobacco) are proposed risk factors.

Comment: Include Tennessee Health Link (THL) services as part of the Minimum Care Requirement quality metric.

Response: The Minimum Care Requirement quality metric aims to capture specific treatment provided to the patient. While THL helps to coordinate care for patients with significant behavioral health needs, it is not a treatment in itself. Since THL is a service provided, it will not be included in the Minimum Care Requirement for the ODD episode.

Perinatal

Feedback Accepted

Comment: Update the Gestational Diabetes screening Quality Metric to include the ICD-10 diagnosis code O24 for Diabetes mellitus in pregnancy, childbirth and the puerperium.
Response: Currently, the gestational diabetes screening quality metric contains Endocrine or "E" ICD-10 diagnosis codes indicating a diagnosis of diabetes mellitus. In addition to "E" codes, there are "O" ICD-10 diagnosis codes that define diabetes mellitus in pregnancy, childbirth and puerperium. To ensure that patients with existing diabetes, who will not be screened for gestational diabetes, are captured in this quality metric, the ICD-10 diagnosis code, O24, and ICD-9 diagnosis code 648.0 will be added to the quality metric definition under "gestational diabetes diagnoses."

Comment: Update the list of diagnoses to test for in the risk adjustment process.
Response: Stakeholders recommended adding additional risk factors to test for in the perinatal episode to better account for sources of variation between patient journeys and make fair comparisons. For example, such risk factors include abnormal findings on antenatal screening of mother and infections of the genitourinary tract in pregnancy. These risk factors will be tested for statistical significance in the risk adjustment model by each of the Managed Care Organizations (MCOs) on an annual basis. However, since factors such as reimbursement rates and the patient population can impact the significance of a suggested risk factor, the risk factors may vary between MCOs.

Comment: Exclude the episode for patients who are victims of rape or statutory rape.
Response: While the State agrees that patients with a history of rape or statutory rape may have more medical needs, the perinatal episode aims to hold providers

and provider groups accountable for appropriate prenatal care. To ensure that valid episodes can be fairly compared in terms of both cost and patient journey, rape was added as risk factor for the MCOs to test.

Comment: Exclude the spend related to a Skin and Soft Tissue Infection (SSTI) episode from the Perinatal episode.
Response: It is possible that the Quarterback of a perinatal episode, usually the OBGYN, will also diagnose a skin and soft tissue infection (SSTI). While it is important to hold the Quarterback accountable for the care around the SSTI, allowing both episodes to trigger can lead to duplicate rewards or penalties. Therefore, a live birth 60 days prior to the SSTI trigger or during the episode window will cause the SSTI episode to be excluded or invalid.

Comment: Remove 58 ICD-10 codes related to malignant neoplasms and neoplasms for male patients from the perinatal episode.
Response: The current version of the perinatal episode specifies codes for malignant neoplasms and neoplasms of male anatomy as "Malignant Cancer" and "Active Cancer Management" clinical exclusions. While diagnoses of cancer for males are not part of the perinatal patient journey, these codes are in the episode logic as *exclusions* to ensure they are not incorrectly captured in episode spend. Therefore, we will not remove the codes from the exclusion list as a safeguard for the episode. Additionally, male diagnosis codes related to genetic testing will remain included in the episode spend as they are important for informing the health of the mother and baby.

Comment: Risk adjust the perinatal episode for patients with obesity.
Response: Obesity is considered a risk factor for complications in pregnancy. Currently, all three Managed Care Organizations (MCOs) risk adjust for obesity in the perinatal episode. Since this recommendation is currently implemented, no change will be made. To review all risk factors included in each episode, please visit the website for each TennCare MCO and Cigna:

- **Amerigroup:** https://providers.amerigroup.com/pages/tn-2012.aspx [Under the "Tennessee Episodes of Care" tab].
- **BlueCross BlueShield of Tennessee:** https://bluecare.bcbst.com/forms/Provider%20Information/Risk_Factors_and_Weights.pdf

- **United Healthcare:** http://www.uhccommunityplan.com/health-professionals/tn/Episodes-of-Care-PCMH-TN-Health-Link.html
- **Cigna:** 615-595-3663 or email Megan.Higdon@Cigna.com

Feedback Not Accepted

Comment: Exclude patients who had a previous C-section from the C-section quality metric. It was also recommended that the quality metric exclude patients from the quality metrics based on scars (O34.211 Low Transverse Scar from previous C-section, O34.212 Vertical scar from previous C-section, and O34.29 Uterine Scar from other previous surgery).
Response: While a previous C-section is one of many reasons a patient may be at higher risk for a second C-section, the quality metric for C-section rate is set to allow for a relatively high proportion of C-sections (41 percent in 2017); therefore, the provider has the ability to still meet the quality metric and perform C-sections when clinically necessary.

Furthermore, while a stakeholder's recommendation to exclude on codes for scarring is an interesting approach, it may not consistently capture patients who have had previous C-sections.

Comment: Exclude the episode if the patient had a previous C-section.
Response: The patient journey of a woman in the perinatal episode is a low to medium-risk pregnancy with the birth of a live baby. The episode contains exclusions and risk factors to ensure that patients with unique patient journeys are not included in the episode and that fair comparisons can be made across episodes. However, since a woman with a previous C-section does not have a unique overall patient journey, the Quarterback should continue to be held accountable for the care they provide. Therefore, a woman with a previous C-section will continue to be a valid episode when appropriate risk adjustment can be made.

Comment: Exclude patients who deliver prior to 35 weeks from the Group B streptococcus screening quality metric or update the Group B streptococcus screening quality metric to capture births that occurred before 35 weeks.
Response: Stakeholders are concerned that patients who deliver earlier than 35 weeks are less likely to receive a Group B streptococcus screening since the test is

not as accurate 5 weeks before term, and that the outcome of the quality metric may be impacted. Currently, there is no data available to show the gestational age of the baby at time of delivery since the mother's and baby's claims cannot be linked. To account for early delivery, the threshold for the quality metric is not set at 100 percent to allow quarterbacks to still pass the quality metric without all patients receiving the screening. In future years, it may be possible to link the mother's and baby's claims data and therefore make this change to the quality metric.

Comment: Exclude genetic testing from episode spend.
Response: A stakeholder was concerned that since genetic testing is expensive, providers or provider groups will not provide genetic testing in order to reduce episode costs. There is evidence, however, that genetic testing is overutilized. Therefore, not holding providers or provider groups accountable for such services will be a loss of a significant source of value. Additionally, since gain and risk sharing is determined by relative spend between other Quarterbacks with perinatal episodes, a provider will not be at risk of a penalty if they perform a clinically appropriate amount of genetic testing. For these reasons, genetic testing will remain as an included service in the perinatal episode.

Comment: Change the perinatal episode trigger from live birth to positive pregnancy test.
Response: Stakeholders were concerned that since the episode assumes a 40-week gestation due to the length of the pre-trigger window, spend may be included from time before the woman was pregnant if she delivered prior to 40 weeks. While it is possible that the pre-trigger window may be longer than the pregnancy, spend is only included if it is directly related to pregnancy. Therefore, if the woman is not pregnant, she should not have a diagnosis for pregnancy, and the associated costs would then not be included in the episode.

Additionally, it is not feasible to trigger on the first positive pregnancy test since that event is not always captured in medical records and/or claims.

Comment: Change the Quarterback from the physician or the physician group to the facility.

Response: The Technical Advisory Group (TAG) recommended the provider or provider group to be the Quarterback since they are in the best position to influence the cost and quality of care in the perinatal episode. The perinatal episode will continue to have the provider or provider group as the Quarterback.

Comment: Include the outcome of the baby in the perinatal episode as a quality metric, exclusion, or other aspect of the episode's design.

Response: It was recommended that the health of the baby should be captured in the perinatal episode. In future years, when it may be possible to link the mother's and baby's claims data, the State plans to integrate the perinatal and neonatal episodes to create aligned accountability between the perinatal and neonatal quarterbacks.

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

Response: Maternal Fetal Medicine (MFM) services are frequently included in perinatal episodes. In fact, about 40 percent of the perinatal episodes had MFM services included in the CY 2016 TennCare data. If MFM costs were excluded from spend, the episodes would still not be comparable to episodes where no services were excluded. In future years, the State plans to integrate the perinatal and neonatal episodes to better align the incentives across the MFMs, OB/GYNs, and neonatologists. Overall, MFM spend will continue to be included in the episode spend.

Pneumonia (PNA)

Feedback Accepted

Comment: Exclude episodes with a diagnosis of sickle cell disease.

Response: Clinical experts and recent studies have shown that patients with sickle cell disease may require more complex care for pneumonia. Since the patient journey for pneumonia is unique for a patient with this condition, sickle cell disease will be excluded from the pneumonia episode.

Comment: Exclude episodes with a diagnosis of bronchiolitis.

Response: Stakeholders were concerned that bronchiolitis and pneumonia cannot be fairly compared since they are unique disease processes. A diagnosis of bronchiolitis is not made in a patient over the age of 2 years, whereas pneumonia can be diagnosed in both pediatric and adult populations. Since the patient journey for bronchiolitis cannot be fairly compared to pneumonia, the age parameters will be revised to exclude patients under the age of 18 years old. This will ensure that bronchiolitis will be excluded from the pneumonia episode. However, since bronchiolitis is a high-volume episode and includes various sources of value for cost and quality, a new episode called "pediatric acute lower respiratory infection" will be designed in the fall of 2017 (wave 8) to capture bronchiolitis.

Feedback Not Accepted

Comment: Include the cost related to Synagis (Palivizumab) in the pneumonia episode.

Response: One provider gave the recommendation to remove the cost associated with Synagis, an injection used to prevent respiratory syncytial virus (RSV), from the pneumonia episode. After deeper analysis, it was determined that this vaccination was clinically appropriate at times and should be included in spend. By including the cost related to Synagis in the pneumonia episode, providers are incentivized to only administer such injection when medically appropriate.

Respiratory Infection

Feedback Accepted

Comment: Remove all codes unrelated to a respiratory infection, especially medications, from the configuration file.

Response: The respiratory infection episode is designed to capture care during and two weeks after diagnosis. Therefore, medications unrelated to a respiratory infection will be removed from the spend inclusion logic. For example, codes related to chemotherapeutic agents will no longer be included in the episode spend. All codes in the configuration file were reviewed by clinical experts and changes were made when appropriate.

Feedback Not Accepted

Comment: Include the cost related to Synagis (Palivizumab) in the respiratory infection episode.
Response: One provider gave the recommendation to remove the cost associated with Synagis, an injection used to prevent respiratory syncytial virus (RSV), from the respiratory infection episode. After deeper analysis, it was determined that this vaccination was clinically appropriate at times and should be included in spend. By including the cost related to Synagis in the respiratory infection episode, providers are incentivized to only administer such injection when medically appropriate.

Total Joint Replacement (TJR)

Feedback Accepted

Comment: Update the "Dislocations or Fractures" quality metric to include only codes related to the lower extremities.
Response: The Total Joint Replacement (TJR) episode is designed to capture the care provided to a patient before and after receiving a total knee or hip replacement. To accurately capture the quality metric "Dislocations or Fractures," which measures the percentage of valid episodes with a dislocation or fracture in the post-trigger window, codes that affect the spine and upper extremities (i.e., above the hip and pelvis) will no longer be included in the definition of the quality metric.

Comment: Remove codes from the "Dislocations or Fractures" quality metric that were not related to dislocations or fractures.
Response: To further improve the accuracy of the "Dislocations or Fractures" quality metric for the TJR episode, codes not related to a dislocation or fracture were removed from the definition. For example, arthritic conditions are no longer included in this metric.

Urinary Tract Infection (UTI) – Inpatient

Feedback Accepted

Comment: Exclude episodes with a diagnosis of sickle cell disease.

Response: Clinical experts and recent studies have shown that patients with sickle cell disease may require more complex care for inpatient urinary tract infections (UTI). Since the patient journey for inpatient UTI is unique for a patient with this condition, sickle cell disease will be excluded from the inpatient UTI episode.

Feedback Not Accepted

Comment: Ensure that the UTI inpatient episode contains inpatient related facility and professional charges.

Response: There was concern that the UTI inpatient episode was not correctly capturing spend associated with inpatient care. Based on our analysis, it was determined that the UTI inpatient episode is correctly capturing inpatient facility and professional charges and therefore, no change will be made. It is possible, however, that miscoding of claims can lead to errors in calculating the spend associated with the "inpatient" care category on the reports. If providers are seeing extremely low inpatient spend on their reports and are concerned, please contact the respective Managed Care Organization (MCO):

TennCare Managed Care Organizations (MCOs):

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

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

Urinary Tract Infection (UTI) – Outpatient

Feedback Accepted

Comment: Exclude allergy medications from the episode spend for a UTI outpatient episode.

Response: Since the UTI outpatient episode captures only outpatient care, there is a defined list of specific included medications both within the trigger and post-trigger

window. Multiple pharmacists reviewed the list of medications and determined that though antihistamines traditionally are used to treat allergies, they have local pain-relieving and anti-itch properties and can be used in combination with medications to treat a urinary tract infection. While those combination medications will not be removed from the included spend list, oral medicinal mouthwashes, commonly known as "magic mouthwash," that contain a combination of antifungal and/or antibiotics and an antihistamine are removed from the included spend list (HIC3 codes: W3E, W3G, W3F).

Comment: Exclude patients diagnosed with spina bifida and/or paralysis from the UTI outpatient episode.

Response: There was concern from providers that patients with spina bifida and paralysis have a unique patient journey and have more complex urinary tract infections due to indwelling catheterization. Since diagnoses of spina bifida and paralysis can range from mild to severe, a patient may not require an indwelling catheter and therefore will not have a unique patient journey for a UTI. However, to account for the complexity of treating patients with indwelling catheters, the presence or complication of an indwelling catheter is now a clinical exclusion from the UTI outpatient episode.

Comment: Remove codes unrelated to a diagnosis of an outpatient UTI from the list of included "Pathology and laboratory" spend under the "Imaging and Testing" spend subdimension.

Response: To further improve the episode, pathology and laboratory codes not related to the UTI diagnosis were removed from spend. For example, CPT codes related to coagulation time of the blood are no longer included in spend.

Comment: Ensure that only claims with a UTI confirming diagnosis are included in spend for the "Imaging and Testing" subdimension.

Response: Since a UTI is a common primary care diagnosis, providers often perform additional unrelated tests and services during the same visit as the UTI diagnosis. For example, a provider might do a wellness examination on the patient and diagnose a UTI during the examination. Therefore, in addition to removing specific codes as described above, the "Imaging and Testing" codes will now require a confirming diagnosis of a UTI to be included in spend. This logic will function similarly to the "Evaluation and Management" spend inclusion rules.

Valve Repair and Replacement

Feedback Accepted

Comment: Add CPT code 99024 for post-surgical follow-up to the "Follow-up care within the post-trigger window" quality metric definition.
Response: To ensure the quality metric was capturing all post-surgical follow-up care, CPT code 99024 was added to the quality metric definition. This CPT code is a zero amount, global spend code.

Feedback Not Accepted

Comment: Revise the "Admission within the post-trigger window" quality metric to require a confirming diagnosis related to the Valve Repair and Replacement.
Response: The current logic only includes readmissions with a relevant diagnosis to the Valve Repair and Replacement procedure in the calculation of the quality metric. No change will be made to the quality metric.