STATE OF TENNESSEE
DIVISION OF HEALTH CARE FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE
310 Great Circle Road
NASHVILLE, TENNESSEE 37243

MEMORANDUM

TO: TennCare Managed Care Organizations

FROM: Keith Gaither, Director Managed Care Operations

Date: September 2, 2014

Subject: Tennessee Health Care Innovation Initiative and Episodes of Care

---

This letter serves as official notice of programmatic changes to be made by the TennCare MCOs. Each MCO will implement three retrospective episodes of care on January 1, 2015:

- Total joint replacement (hips and knees) including diagnostics (e.g. imaging and laboratory tests), professional and facility fees, medical device(s), physical therapy and other forms of post-acute care, pharmaceuticals, and treatment of any complications and/or related readmissions.
- Hospitalization for acute asthma exacerbation including professional and facility fees, post-acute care, care management through the transition to ongoing outpatient care, pharmaceuticals, and treatment of any complications and/or related readmissions.
- Pregnancy including prenatal care, delivery, postpartum care, and treatment of any complications or related readmissions of the mother.

The state's goal is to design and implement 75 episodes over the next five years. A description of restrospective episodes of care is included in Attachment A of this memo.

The episode of care model is part of the Tennessee Health Care Innovation Initiative, which was launched in 2013 as a state-wide initiative to transition its healthcare payment system to better reward patient-centered, high-quality, high-value health care outcomes for all Tennesseans. Several commercial and Medicare advantage insurance carriers are participating in the initiative as well, but Attachment A of this memo specifically describes the details of episodes of care for TennCare MCOs. More information on the initiative is available at: http://www.tn.gov/HCFA/strategic.shtml

Attachment A: Retrospective Episodes of Care

Retrospective episode-based payment rewards providers who successfully achieve high quality and efficient outcomes during an "episode of care," a clinical situation with start and end points that may involve multiple independent providers. This approach rewards high-quality care, promotes the use of clinical pathways and evidence-based guidelines, encourages coordination, and reduces ineffective and/or inappropriate care. The design of the episode is aligned for all MCOs. Episode of care rewards and penalties are in addition to and will not have an impact on the normal claims payment arrangements between an MCO and a provider. Detailed definitions of each episode are available at http://www.tn.gov/HCFA/strategic.shtml.

Benefits of Episodes of Care

Today, most healthcare payment from payers to providers in Tennessee is "fee for service", meaning that a healthcare provider is paid to perform a specific activity or task. Fee-for-service payment fails to reward providers who achieve higher quality, more efficient, integrated and coordinated care. Following a thorough review of outcomes-based payment strategies and with the input of stakeholders, Tennessee is implementing episodes of care to reward providers for providing high-quality and efficient care for acute medical and behavioral treatments and conditions.

For each episode of care, the state convened expert Tennessee clinicians who specialize in care related to that episode. Based on clinical advice from Tennessee healthcare providers, each episode was designed to include:

A Principle Accountable Provider: Each episode design includes a definition of a Principal Accountable Provider (PAP), or quarterback. The PAP is the type of provider that has the best opportunity to influence the quality and cost of a type of episode. The PAP will receive quarterly reports from the payer showing how the PAP performed on episode cost and quality results. The reports will includes key information including the number of episodes, average risk-adjusted episode cost, quality metric results, and details on each episode the PAP treats. The episode cost will include relevant claims for all providers who submitted claims related to the episode, not just those associated with the PAP.

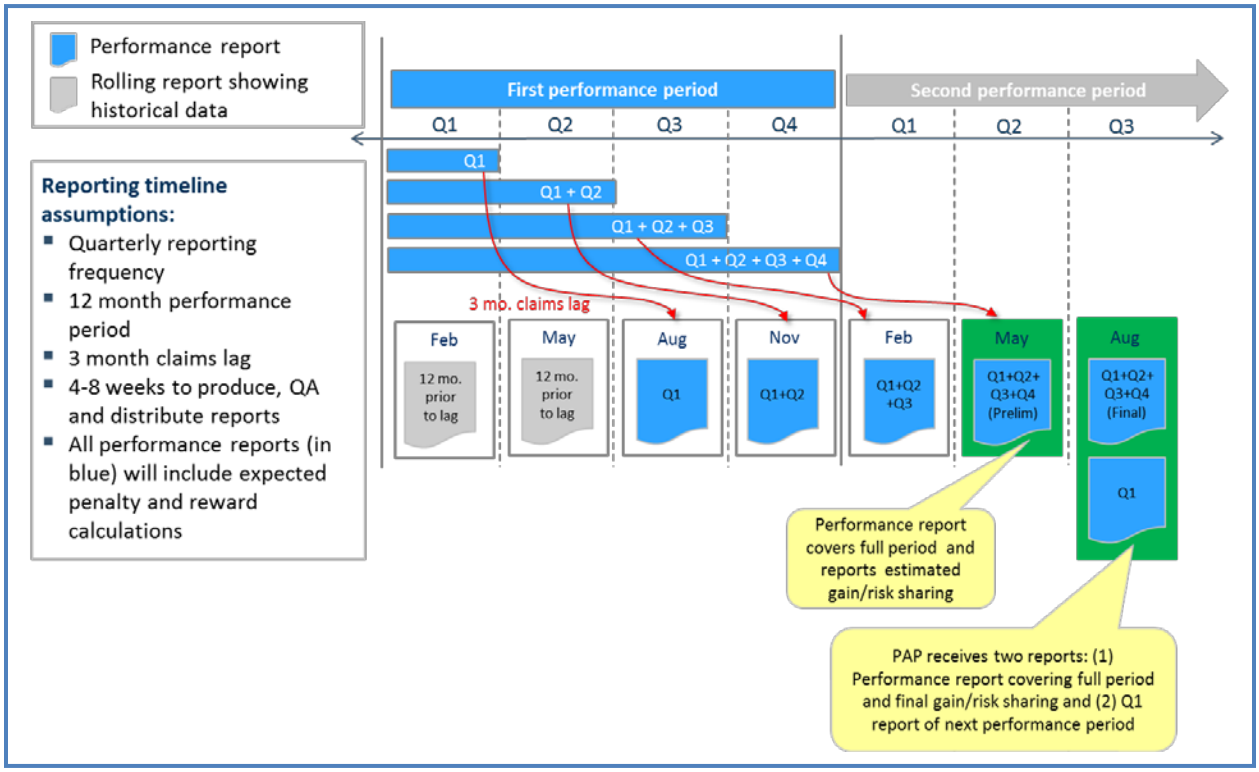
Fairness:The costs of an episode are risk-adjusted so that providers who deliver effective and efficient care to more complex patients are appropriately rewarded. Some episodes with patients whose co-morbidities, age or other characteristics demand a different care pathway altogether will be excluded from the model, and other episodes with extremely high or low costs are removed from the PAP's average cost calculation.

Performance measurement and transparency: The initiative will provide PAPs with significant data and information related to episodes of care for which they are accountable, to enable greater understanding of the drivers of performance. With actionable information, PAPs should have transparency into underlying costs and quality indicators for their episodes, and should be able to assess their performance relative to all other PAPs for that episode type.

Reports

Each quarter the PAP will receive a cost and quality report on their episodes. Report include an estimated gain/risk sharing calculation. The gain/risk sharing calculation will change over the year as new episodes are included in the reports and provider behavior shifts. The final gain/risk sharing calculation will be included in the 5th report for the performance period. Figure 2 outlines the reporting timeline in detail.

Figure 1: Reporting and payment timeline

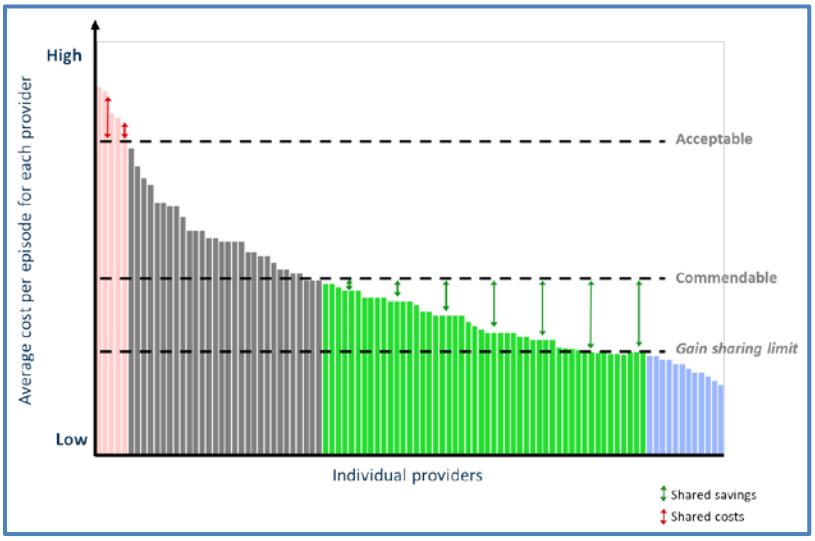


How Episode of Care Payments are Calculated

Episodes are grouped into performance periods based on the calendar year. Claims received prior to July 1st of the year after the performance period will be included in the calculation of gain and risk sharing. In the two months after July 1 of the year after the performance period, the MCO will:

- Categorize claims into episodes of care ending during the performance period for which the provider is the principle accountable provider ,
- Exclude some episodes based on clinical and cost-based exclusion criteria,
- Calculate the rate of each quality measure associated with the episode,
- Adjust the cost of each episode based on comorbidities, demographic factors, and other indicators of patient variation,
- Calculate the average risk-adjusted costs for each PAP, and
- Compare the PAPs risk-adjusted average to the three cost thresholds: Acceptable, Commendable, and Gain Sharing Limit.

Figure 2: Illustration of provider costs and cost thresholds



If a PAP achieves an average risk-adjusted episode cost for the performance period that is less than the Commendable threshold and the PAP's performance on quality measures linked to gain sharing exceeds those quality measure thresholds, that provider is eligible for gain-sharing. The MCO will pay the provider a gain sharing reward payment equal to 50% of difference between the commendable threshold and the provider's risk adjusted average episode cost for the annual performance period times the number of non-excluded episodes the provider had in the performance period. PAPs that have performance on at least one quality metric linked to gain sharing that is less than the threshold for that measure are not eligible for any gain-sharing reward payment.

If a PAP achieves an average risk-adjusted episode cost for the performance period that is less than both the Commendable Threshold and the Gain Sharing Limit, and the PAP's performance on quality measures linked to gain sharing exceeds those quality measure thresholds, the MCO will pay the provider a gain sharing reward payment equal to 50% of difference between the Commendable threshold and the Gain Sharing Limit multiplied by the number of non-excluded episodes the provider had in the performance period.

If the PAP achieves an average risk-adjusted episode cost for the performance period that is less than the Acceptable threshold but greater than the Commendable threshold, the PAP will not be eligible to for gain-share rewards, nor will the provider be responsible for risk-sharing penatlties. Providers in this area will have no difference in payment.

If the PAP achieves an average risk adjusted episode cost for the performance period that is greater than the Acceptable threshold, the PAP is responsible for 50% of the costs that fall above that level. The PAP will pay the MCO a penality equal to 50% of difference between the Acceptable threshold and the PAP's risk adjusted average episode cost for the annual performance period multiplied by the number of episodes the provider had in the performance period. The PAP's performance on quality measures has no impact on the PAP's responsibility for risk sharing penalties.