Division of
Health Care
Finance & Administration

MEMO

Date: October 2016
Subject: Update on the Tennessee Health Care Innovation Initiative

This memo discusses the feedback received during the episodes of care feedback session meetings held on July 19, 2016, and changes to episodes as a result of the feedback received. 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 episodes in Wave 1 (perinatal, total joint replacement, and asthma exacerbation) and Wave 2 (COPD acute exacerbation, colonoscopy, cholecystectomy, acute PCI, and non-acute PCI). The meetings were held simultaneously in six cities across Tennessee (Chattanooga, Jackson, Johnson City, Knoxville, Nashville, and Memphis) 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. The State, and our insurance carrier partners have reviewed this feedback, and plan to incorporate these changes into the design of these episodes of care that are used for TennCare beginning in calendar year 2017. 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 859 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. A similar episodes feedback session was held in the summer of 2015 as well.

For more information about episodes of care in Tennessee in general, go to http://tn.gov/hcfa/section/strategic-planning-and-innovation-group.

Wave 1 Episodes

Asthma Acute Exacerbation episode of care:

Comment: Expand the definition of the appropriate medications quality metric to include oral and/or injectable corticosteroids filled during the trigger window in the hospital setting (e.g. Emergency Department, Observation and/or inpatient stay) and the post-trigger window rather than just in the post-trigger window.
Response: Guidelines for medication use during an acute asthma exacerbation now 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. These medications are often prescribed in the hospital setting and therefore should be included in the quality metric for appropriate medications. The appropriate medications will be included in the quality metric during both the trigger and post-trigger window.

Perinatal episode of care:

Comment: Exclude patients who had a previous C-Sections from the quality metric.
Response: The NQF endorsed measure for C-sections excludes previous C-section, but the measure is not based on claims data. The State is interested in including a non-claims-based measure in future years, and is procuring a vendor to facilitate the collection of non-claims-based measures. For calendar year 2017, that vendor will not be in place and so the C-section measure will continue to include patients who have had a previous C-section. Since the quality metric for C-section rate is set at 41.0%, there is room for providers to meet the quality metric and perform C-sections when necessary.

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: Patients who deliver earlier than 35 weeks are less likely to receive a Group B streptococcus screening, which may impact the outcome of the quality metric. Currently, there is no data available to show the gestational age of the baby at time of delivery. In future years it may be possible to link the mother's and baby's claims data. The quality metric threshold for Group B streptococcus screening is set

at 85.0% to give providers room to meet the quality metric even if the screening is cannot be performed under certain circumstances, such as a premature birth. For these reasons, the logic for the Group B streptococcus screening quality metric will not change for calendar year 2017.

Comment: Exclude episodes from screening quality measures if the patient changes Managed Care Organizations (MCOs) during the episode window.
Response: Stakeholders were concerned that prenatal care such as screenings delivered prior to the MCO switch were not included in the claims and would negatively impact the Quarterback's quality metrics. Each of the quality measures has room for providers who are providing group B step screenings and HIV screenings but have some patients for whom the associated claims data is not available. The thresholds for each of those two quality measures are 85 percent, so if a provider has patients who change MCOs in 15 percent of the episodes, the provider would still pass the quality measure. Patients who switched MCOs during the episode window will continue to be included as valid episodes.

Comment: Remove the inconsistent enrollment business exclusion that excludes episodes with gaps in coverage totaling more than 45 days during the episode window.
Response: The inconsistent enrollment business exclusion for the perinatal episode states that an episode is excluded if there are gaps in coverage totaling more than 45 days during the episode window. To create a fair policy, TennCare will remove the 45 day gap in coverage exclusion starting in 2017.

Total Joint Replacement episode of care:

Comment: Exclude codes not directly related to the hip and knee replacement from the episode spend in the post-trigger window.
Response: The Total Joint Replacement (TJR) episode is designed to capture the care provided to a patient after discharge from the hospital following the procedure. While some complications not directly related to the knee and hip are important to include within the post-trigger window, ICD-10 codes relating to "Diseases of the musculoskeletal system and connective tissue" and "Congenital anomalies" that affect the spine and upper extremities (i.e. above the hip and pelvis) will no longer be included in the episode spend in the post-trigger window.

Wave 2 Episodes

Cholecystectomy episode of care:

Comment: Exclude episodes with chronic pancreatitis in the trigger window.
Response: The cholecystectomy episode is intended as a non-emergent cholecystectomy episode and to capture non-acute cholecystectomy procedures. Since patients with acute pancreatitis may undergo an emergent cholecystectomy, patients with acute pancreatitis are excluded from the cholecystectomy episode. However, the cholecystectomy episode is still capturing some patients with chronic pancreatitis that have an acute exacerbation and as a result, undergo an emergent cholecystectomy procedure. To ensure a comparable patient population and to reflect the original intent of the episode definition as much as possible, patients with chronic pancreatitis during the trigger window will now also be excluded from the cholecystectomy episode. Patients with chronic pancreatitis are identified as a diagnosis code for chronic pancreatitis on either an inpatient, outpatient or a profession claim during the trigger window of the cholecystectomy episode.

Comment: Exclude episodes that penalize providers for care that happens outside of the Quarterback's influence, especially when care is geographically remote from the provider.
Response: The cholecystectomy episode attempts to capture the span of care provided to a patient that is related to the cholecystectomy procedure. While service not related to the cholecystectomy are not included in spend, in some cases services delivered by another provider will be included in the episode if they are related. The accountable "Quarterback" provider will be rewarded for influencing the other providers of services related to the cholecystectomy, whether it be through conversations with the patient or other providers. The goal of the program is to encourage coordination of care between the Quarterback, the patient, and other providers that could be involved in caring for a patient undergoing a cholecystectomy. Therefore, all care related to the cholecystectomy will remain in the episode.

Comment: Exclude Emergency Department (ED) visits from the pre-trigger window.
Response: The pre-trigger window of procedural episodes is meant to capture preoperative work-up and care related to the upcoming procedure and therefore

ED visits before the procedure are not included. The State will maintain the current pre-trigger window spend inclusion rules, which does not include ED visits.

Comment: Concern around influencing cost of care before a patient's first visit with the provider.
Response: The pre-trigger window of procedural episodes is important in capturing preoperative work-up and care related to the procedure. Using targeted inclusion prevents holding providers accountable for care that is unrelated to the procedure. It is possible for cholecystectomy related services from a provider who is not the Quarterback to be included in the episode. One goal of the Episodes of Care program is to encourage coordination and communication among the different providers involved in a patients' care, and in part to encourage the Quarterback to coordinate with providers who may be interacting with patients before their first visit with the Quarterback.

Screening and surveillance colonoscopy episode of care:

Comment: Exclude diagnostic colonoscopies from the colonoscopy episode.
Response: As a result of input from the colonoscopy TAG, diagnostic colonoscopies are not included in the screening and surveillance colonoscopy episode. The current codes and logic used to identify colonoscopies are specific to screening and surveillance colonoscopies.

Comment: Revise post-polypectomy/biopsy bleeding quality metric so providers are not discouraged to remove large polyps.
Response: This quality metric is implemented as an informational quality metric recognizing that there may be multiple drivers of variation, such as patient variation. Thus, this quality metric is not tied to gain-sharing and does not affect payment. Additionally, this quality metric was incorporated based on feedback from the TAG. Therefore, the current quality metric will remain as an information-only measure.

Comment: Track repeat colonoscopies that happen outside of the episode window to monitor patients receiving inappropriate second procedures.
Response: The colonoscopy episode has a quality metric that tracks repeat colonoscopies occurring both within and outside the episode spend window. While the post-trigger window for tracking spend in the colonoscopy episode is only 14-

days, the quality metric tracks colonoscopies in the 60-day window following the triggering colonoscopy. The current quality measure is therefore responsive to the comment and will remain the same.

Comment: Since QCDR only measures if a bowel preparation was performed, include an additional quality metric for inadequate bowel preparation in order to hold providers accountable.
Response: QCDR has a metric for adequacy of bowel preparation. In addition to the QCDR metric, providers are also being held accountable for poor bowel preparation through the repeat colonoscopy quality metric and inclusion of colonoscopy procedure spend in the 14 days following the triggering colonoscopy. Since providers are being held accountable for poor bowel preparation through QCDR, quality metrics, and spend, an additional quality metric will not be added.

Comment: Shorten pre-trigger window from one month to two weeks and lengthen the post-trigger window from two weeks to one month.
Response: Our current design was based on the advice of our colonoscopy TAG. Accountability in the pre-trigger window for the colonoscopy episode is limited to office visits, relevant imaging and testing, and relevant medications. In the post-trigger window accountability is limited to specific complications, anesthesia, imaging and testing, medications, procedures, and office visits. In data presented to the TAG, these services generally occurred within one month pre-trigger and two week post-trigger. Therefore, the current pre-trigger and post-trigger window lengths will remain.

Comment: Shorten the 60 day post-trigger window.
Response: The colonoscopy episode has a single 14 day post-trigger window for spend inclusion. The 60 day window does not include any spend, but is used solely to capture repeat colonoscopies for the repeat colonoscopy quality metric.

Comment: Concern around holding providers accountable for high facility costs.
Response: The cost of facility services is one of several sources of variation and sources of value within episodes, alongside professional services, imaging services, laboratory services, post-acute services, and others. In the past there has been no reward for providers who engage with their facilities on efforts to improve quality and reduce costs of the overall care associated with a procedure. Facility cost will

remain a key component of the total cost of the episodes in which it is relevant, including colonoscopy.

Comment: Do not hold providers accountable for concurrent procedures (e.g. EGD and colonoscopy).
Response: Based on the current spend inclusion, providers are not being held accountable for unrelated concurrent procedures. Although concurrent procedures may occasionally occur, concurrent procedures that are not screening and surveillance colonoscopies are not included within the colonoscopy episode. Spend inclusion rules are intended to only capture care that is related to a screening and surveillance colonoscopy.

Comment: Exclude Emergency Department (ED) visits in the post-trigger window.
Response: While all ED visits are not included in the episode, relevant ED visits are included within the episode post-trigger window. Relevant ED visits are included with the intent of capturing colonoscopy complications that result in an ED visit and encouraging necessary post-procedure follow-ups that may prevent ED visits. The goal of the program is encourage appropriate provider involvement and care coordination in a patient's care, before, during, and after the procedure.

Comment: Only include medications that are prescribed by the Quarterback.
Response: To ensure that providers are appropriately being held accountable for care related to the colonoscopy, only medications associated with the colonoscopy procedure are included in spend. Since medications related to the colonoscopy may not always be prescribed by the Quarterback, it is important to include medications regardless of the prescribing physician.

All Episodes

During the July 19th meeting, some stakeholders recommended changes that would apply to all episodes. This section describes those comments.

Comment: Episodes of care program should be modeled after the CMS PQRS system.
Response: During the formation of the episodes of care program, the Initiative strived to incorporate lessons learned from the best practices of various payment innovation programs around the country. For example, the post-trigger window lengths of several hospital-based episodes reflect those used in the CMS BPCI program. In addition to modeling after the CMS BPCI program, the Initiative also references the CMS PQRS program in determining the quality measures to be incorporated into the episodes of care program. While the CMS PQRS program only addresses quality, the episodes of care program addresses both quality and cost. By sourcing best practices from each program, the Episodes of Care program is able to take a more holistic approach for payment innovation and targeting improvements in healthcare. The State will continue to follow this type of approach in the future design of the episodes of care program.

Comment: Increase transparency around the types of services being included in the care categories shown in reports.
Response: Providers can learn which types of services are included in the care categories using the care category definitions in the glossary of the Detailed Business Requirements, which are available on the Initiative's website (http://tn.gov/hcfa/section/strategic-planning-and-innovation-group). For each reporting care category, the glossary offers definitional information on the bill form, bill type, place of service, and revenue codes. By offering patient level data by category instead of specific codes, the reports provide actionable information without overwhelming providers or releasing confidential negotiated rates.

Comment: Update providers on if a finalized payment reform appeals process has been finalized with BlueCross BlueShield and Amerigroup.
Response: The appeals process for TennCare MCOs has two levels. The first step is with the MCO, and the second step is with the Tennessee Department of Commerce and Insurance (TDCI). In the case that providers would like to dispute or appeal an episode report, the providers should contact the appropriate MCO. In the

case the MCOs are unable to address the provider's complain regarding the episode value-based payments, then providers next step in the appeals process is with TDCI. Providers should contact MCOs to resolve disputes regarding episodes as they occur during the quarterly reporting periods. Providers can contact MCOs at the following phone numbers:

Amerigroup: 615-232-2160;
BCBST: 800-924-7141 (Option 4)
United: 615-372-3509

Comment: Limited access may negatively impact providers if facility is high cost.
Response: Facility cost is one of several sources of variation and sources of value within episodes. Providers may improve their performance through a variety of methods, and the method chosen by any given provider will depend on the particular nature of that provider's practice and performance. Providers may choose to engage with facilities on ways to improve efficiency and quality. Providers may also improve on other aspects of the episode such as professional services, imaging services, laboratory services, post-acute services, and many others.

Comment: Include cost of each line item in the provider claim level detail reports to help providers identify line items for appeal.
Response: The reports that providers receive include patient-level detail with costs broken into categories. The reports balance containing enough actionable information so that providers know what areas they should look at to improve versus displaying other providers' negotiated rates, which are often confidential.

Comment: Incorporate a more comprehensive set of risk factors by extending the risk factor look back period.
Response: To ensure a robust risk adjustment model that captures relevant conditions, risk factors have customized time frames, during which potential risk factors are flagged. The longest lookback period is usually a year. While the length of the look back does not always capture the entirety of a patient's comorbidities, the intent is to balance extending the lookback to capture the most comprehensive set of factors, and the timing of the risk factors to ensure statistical significance as a driver of cost of care being provided. For the next calendar year, the lookback periods will remain the same.

Comment: Difference in MCO risk adjustment methods should be accounted for.
Response: There is no off-the-shelf risk adjustment tool available for episodes, and so insurance carriers have created different formulas, although all have the same general approach. Also, inherent differences between MCOs necessitate some difference between risk adjustment specifics to ensure fairness. For example, the various MCOs have different reimbursement policies, which then impacts the risk factors that may be flagged as significant, and are in the final model. The differences in risk adjustment ensure that risk adjustment is being tailored toward each MCO's specific policies and reimbursement policies. In addition, accurate coding by providers will ensure fairness in risk adjustment.

Comment: Do not utilize ICD-10 diagnosis codes that map to multiple conditions in risk-adjustment since it makes it difficult to accurately predict risk.
Response: While some ICD-10 codes may map to multiple diagnoses, it is beneficial to incorporate these into risk adjustment, because with each additional diagnosis code, we have a more comprehensive profile of the patient. To further specify a primary diagnosis that may map to multiple diagnoses, providers should code a secondary diagnoses since secondary diagnoses are considered in risk adjustment as well.

Comment: Concern around providers being disadvantaged by the populations they choose to care for.
Response: Different providers care for different patient populations in some cases. In order to achieve a fair comparison in episode spend across Quarterbacks, risk adjustment and episode exclusions are employed. Episode exclusions ensures that the remaining episodes are comparable by excluding episodes based on business (e.g. a dual eligibility exclusion) and clinical exclusions (e.g.: if patient has conditions that may lead to a different care pathway). Risk adjustment takes into account the various comorbidities or conditions that a patient may have.