Division of TennCare

MEMO: 2023 Episode Changes

Table of Contents

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Introduction

Date: September 2022; Updated January 2023
Subject: Updates to TennCare's Episodes of Care program

This memorandum describes stakeholder feedback, TennCare responses, and a summary of changes to the Episodes of Care program for the 2023 performance period that begins January 1, 2023.

The state greatly appreciates the feedback we have received from stakeholders over the past year, and especially those stakeholders who attended the Episodes of Care Annual Feedback Session, held on May 11, 2022. The virtual feedback session was an opportunity for stakeholders from across Tennessee to comment on what is working well and how to improve upon the clinical design of all 48 episodes of care for performance year 2023. Members of the public were able to share their feedback live during this year's event, as well as submit their feedback electronically prior to the event via email and an online form.

This memo shares the feedback received and is organized by episode type in alphabetical order. After reviewing all feedback for performance period 2022, the state is making 13 changes to the design of the episodes program for the 2023 performance period. The table "Summary of Program Changes Taking Effect in 2023" is also provided to highlight feedback that resulted in episode design changes for the 2023 performance year.

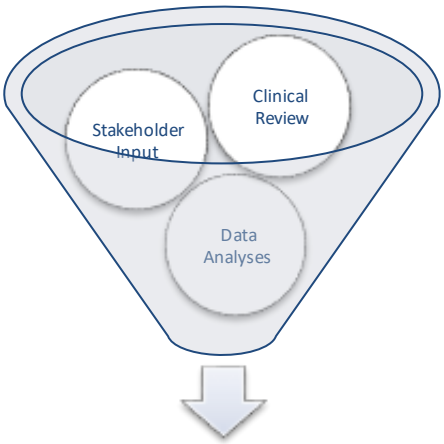
Episodes of Care's Response to COVID-19

The state recognizes that COVID-19 has created an unprecedented health and economic crisis for the provider community. To continue to support providers during this difficult time, the state announced on December 20, 2021, that the three TennCare Managed Care Organizations (MCOs) will waive all episodes of care risk-sharing payments in the final reports for the 2021 performance period. Providers who have gain-sharing payments will receive those payments as planned, with no changes.

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

What Does the State Do with Your Feedback?

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



State response to stakeholder feedback

When Will Providers See These Changes Reflected in Their Reports?

Episode design changes in this memo will take effect on January 1, 2023, for the 2023 performance year. Providers will first see their performance data reflecting these changes in the interim performance reports released in August 2023 that cover the first quarter of the 2023 performance period (January through March 2023).

A Primer on the Episodes of Care Program

How are episodes designed?

Every episode is designed with recommendations from Tennessee clinicians, who formed a Technical Advisory Group (TAG). These design recommendations include the episode trigger, the type of accountable provider for the episode, included spend, episode duration, exclusions, risk factors, and quality metrics. For every episode that has been designed in Tennessee, clinicians' recommendations were incorporated into the episode design before implementation.

TAGs were composed of Tennessee clinicians with expertise in relevant specialties who volunteered their time to make recommendations on the clinical aspects of the episode design. Members were selected through a nomination process. TAGs met in person multiple times as part of the episode design process.

How does the Episodes of Care program make fair comparisons across episodes?

Episode design has exclusions in place for episodes that cannot be fairly compared. Some exclusions are business exclusions (e.g., incomplete data, dual eligibility), clinical exclusions (e.g., active cancer management, triplet pregnancy), patient exclusions (e.g., left against medical advice, death), and high-cost outlier exclusions (i.e., the risk-adjusted cost for an episode makes it an outlier relative to other valid episodes). After all exclusions have been applied, a set of valid episodes remain that are used for financial accountability.

The Episodes of Care program also includes other components to make fair comparisons among providers. Risk adjustment is a method used to scale the episode spend up or down to account for higher patient costs based on comorbidities or other factors shown in the data to be significantly higher cost. This adjustment is done on the basis of the comorbidities coded in the claims. Quarterbacks are held accountable for their risk-adjusted episode spend.

Who determines the risk factors for each episode?

TAG members recommended a clinically appropriate list of risk factors for each episode. After the conclusion of the TAG, the list of risk factors was sent to the MCOs. The MCOs test each risk factor, in addition to other diagnoses that are identified in their models, for statistical significance based on their data. The risk factors that are statistically significant in terms of episode spend for each MCO are used as risk factors for that episode type.

For more information about the TennCare Episodes of Care program, including all the episode detailed business requirements (DBRs) and configuration files, go to: https://www.tn.gov/tenncare/health-care-innovation/episodes-of-care.html.

General Episodes Feedback

Comment: Will providers be held retroactively accountable for episodes performance from 2019-2022?

Response: No. Providers will not be financially accountable for retroactive performance during the state's suspension of risk-sharing payments in response to the COVID-19 pandemic. The state announced that MCOs will waive risk-sharing payment for the 2019, 2020, and 2021 performance years, and that decision is final. The program will return to financial accountability for the 2022 performance period. Episodes of Care risk-sharing payments will resume for the 2022 performance year in order to continue incentivizing high-quality, cost-effective care in the Episodes of Care program.

Comment: The episodes change from year to year; please explain what goes into the change process.

Response: The state strives to continually refine episode design. The state works on stakeholder feedback throughout the year, with efforts focused during the summer between the spring Episodes of Care Feedback Session and the fall release of this memo. The state conducts data analyses and solicits clinical input to inform the change review process. Episode design changes in this memo will take effect on January 1, 2023, for the 2023 performance year.

Comment: Are the configuration files codes reviewed and updated for each episode?

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

Comment: Send provider reports by mail in addition to posting them electronically.

Response: The MCOs are responsible for provider reports in the Episodes of Care program. Each MCO utilizes their provider portal for posting provider reports online for viewing or downloading by providers. The Episodes of Care program includes more than 2,000 accountable providers; therefore, electronic report releases are the most efficient way to release reports. Providers can reach out to their MCO representative to request assistance accessing provider reports.

Comment: Increase the cost allowed for COVID-19 testing. For example, rapid PCR testing is more costly than the antigen tests for COVID-19.

Response: The Episodes of Care program does not set specific costs. Instead, providers are accountable for total cost of care, which includes diagnostic testing. It is a source of value for the episodes program to hold providers accountable for the higher costs of more expensive diagnostic testing. This level of accountability is consistent with all aspects of the program.

Episode-Specific Feedback

Attention Deficit and Hyperactivity Disorder (ADHD)

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

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

Comment: Do not use symptoms related to ADHD as an episode trigger for ADHD.

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

Comment: Exclude members who turn six years old during the measurement year from the Utilization of Therapy for 4-to-5 year-olds quality metric.

Response: The TAG recommendation for this quality metric is to capture members who are four or five years old at the start of the quality metric window. Additionally, it is not technically feasible for episode logic to exclude those members who turn six years old during the episode window (or within the calendar year).

Comment: Providers are disadvantaged when a member fills a more expensive form of a preferred medication in order to reduce their copay costs.

Response: In 2018, the state announced a pharmacy cost adjustment for all episode types. If a pharmacy claim contains a medication that is a preferred brand or preferred generic medication as identified on the TennCare Preferred Drug List (PDL), the included spend of that medication for episodes will be set at $10 in the episodes reports – regardless of the member's copay for that medication. This adjustment is made at the national drug code (NDC) level. The copay a member pays for a prescription is not included in episode cost; all prescriptions on the TennCare PDL are set to $10 for the purposes of episodes reporting.

Comment: Remove the Long-acting Stimulants for Members Aged 6 to 11 informational quality metric.

Response: The Long-acting Stimulants for Members Aged 6 to 11 informational quality metric will be removed as part of our ongoing efforts to evaluate episode quality metrics for value and relevance to the program. This routine maintenance of episode quality metrics is part of the state's efforts to continuously improve the program.

Comment: Remove the Long-acting Stimulants for Members Aged 12 to 20 informational quality metric.

Response: The Long-acting Stimulants for Members Aged 12 to 20 informational quality metric will be removed as part of our ongoing efforts to evaluate episode quality metrics for value and relevance to the program. This routine maintenance of episode quality metrics is part of the state's efforts to continuously improve the program.

Comment: Combine the existing informational quality metrics for Utilization of Medication for Members Aged 6 to 11 and Utilization of Medication for Members Aged 12 to 20.

Response: The informational quality metrics for Utilization of Medication for Members Aged 6 to 11 and Utilization of Medication for Members Aged 12 to 20 will be combined into a new metric for Utilization of Medication for Members Aged 6 to 20 as part of our ongoing efforts to evaluate episode quality metrics for value and relevance to the program. This routine maintenance of episode quality metrics is part of the state's efforts to continuously improve the program.

Comment: Combine the existing informational quality metrics for Utilization of Therapy for Members Aged 6 to 11 and Utilization of Therapy for Members Aged 12 to 20.

Response: The informational quality metrics for Utilization of Therapy for Members Aged 6 to 11 and Utilization of Therapy for Members Aged 12 to 20 will be combined into a new metric for Utilization of Therapy for Members Aged 6 to 20 as part of our ongoing efforts to evaluate episode quality metrics for value and relevance to the program. This routine maintenance of episode quality metrics is part of the state's efforts to continuously improve the program.

Comment: Referrals to ABA therapy are challenging because ABA facilities request a diagnosis of autism before accepting the referral.

Response: ABA therapy is not an appropriate treatment for patients with ADHD. Therefore, ABA therapy visits do not count towards the ADHD episodes' minimum care requirement quality metric.

Perinatal

Comment: Add a new quality metric to capture uncomplicated, routine follow-up visits postpartum.

Response: The state will add new informational quality metrics for Routine Postpartum Care. These metrics will capture one visit and two visits for routine postpartum care. These quality metrics will have an additional 24 days beyond the existing post-trigger window for capturing quality only (no cost), for a total of 84 days.[1]

Comment: Remove the informational quality metric Screening for Asymptomatic Bacteriuria.

Response: The state will remove the informational quality metric Screening for Asymptomatic Bacteriuria as part of our ongoing efforts to evaluate episode quality metrics for value and relevance to the program. As the state proactively identifies quality metrics that have high performance rates for multiple years and/or are no longer as relevant to the program, those metrics may be replaced. This routine maintenance of episode quality metrics is part of the state's efforts to continuously improve the program.

[1] Entry updated January 2023.

Comment: Remove the informational quality metric for Genetic Testing.

Response: The state will remove the informational quality metric for Genetic Testing. Prenatal genetic testing has undergone significant changes since this metric was first designed and implemented, and this quality metric is no longer a significant source of value for the program. This is part of the state's efforts to continuously improve the program.

Comment: Move the informational quality metric Primary C-section up to gain-sharing.

Response: The state will promote the informational quality metric Primary C-section rate to gain-sharing.

Comment: Move the gain-sharing quality metric C-section to informational.

Response: The state will shift the gain-sharing quality metric C-section rate to informational.

Comment: Remove code Z36 (encounter for antenatal screening of the mother) from the gain-sharing Screening for Group B streptococcus quality metric.

Response: The state will remove code Z36 (encounter for antenatal screening of the mother) from the gain-sharing Screening for Group B streptococcus quality metric.

Comment: Remove code J153 (pneumonia due to Group B strep) from the gain-sharing Screening for Group B streptococcus quality metric.

Response: The state will remove code J153 (pneumonia due to Group B strep) from the gain-sharing Screening for Group B streptococcus quality metric.

Comment: Add a new informational quality metric that captures mental health screening for the mother.

Response: The state will add a new informational quality metric that captures code 96160 with TH modifier (mental health screen).

Respiratory Infection

Comment: Performing lab tests in the office are more expensive than sending tests (for example, strep, flu, and RSV) to an outside laboratory.

Response: It is a source of value for the episodes program to hold providers accountable for the higher costs of more expensive diagnostic testing. Providers can often lower episode costs by utilizing an in-network laboratory because the MCOs have the ability to negotiate more favorable rates with higher volume outside laboratories.

Summary of Program Changes Taking Effect in 2023

Providers will first see these changes reflected in their interim performance reports released in August 2023 that cover the first quarter of the 2023 performance period (January through March 2023).

Episode Type(s) Impacted	Change to Episode Design
All Episodes	Removal of invalidated codes and the addition of new or revised codes related to configuration file maintenance.
ADHD	The Long-acting Stimulants for Members Aged 6 to 11 informational quality metric will be removed.
ADHD	The Long-acting Stimulants for Members Aged 12 to 20 informational quality metric will be removed.
ADHD	The informational quality metrics for Utilization of Medication for Members Aged 6 to 11 and Utilization of Medication for Members Aged 12 to 20 will be combined into a new metric for Utilization of Medication for Members Aged 6 to 20.
ADHD	The informational quality metrics for Utilization of Therapy for Members Aged 6 to 11 and Utilization of Therapy for Members Aged 12 to 20 will be combined into a new metric for Utilization of Therapy for Members Aged 6 to 20.
Perinatal	The state will add two new informational quality metrics for routine postpartum care. These metrics will capture one visit and two visits for routine postpartum care, with an additional 24 days beyond the existing post-trigger window for capturing quality only (no cost), for a total of 84 days.
Perinatal	The state will remove the informational quality metric Screening for Asymptomatic Bacteriuria.
Perinatal	The state will remove the informational quality metric for Genetic Testing.
Perinatal	The state will promote the informational quality metric Primary C-section rate to gain-sharing.
Perinatal	The state will shift the gain-sharing quality metric C-section rate to informational.
Perinatal	The state will remove code Z36 (encounter for antenatal screening of the mother) from the gain-sharing Screening for Group B streptococcus quality metric.
Perinatal	The state will remove code J153 (pneumonia due to Group B strep) from the gain-sharing Screening for Group B streptococcus quality metric.
Perinatal	The state will add a new informational quality metric that captures code 96160 with TH modifier (mental health screen).

(Updated January 2023)