Amerigroup
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Provider update

FAQ: Episodes of Care — quick reference

Q: Why is TennCare using a retrospective episode-based payments (EBP) model?
A: The goal of EBP is to pay for high-quality, cost-effective care. This moves our system from paying for volume to paying for value. Because it is retrospective, current payment agreements will not be affected. All TennCare payers are participating in this model. Participation is not optional for providers.

Q: What are the episodes that are included in this model, and who is responsible for the costs?
A: There are a total of 48 specific episodes currently developed. These episodes have been thoughtfully discussed, defined and designed by a technical advisory group (TAG) that includes peer provider experts. Examples of these episodes are the Perinatal, Asthma, Urinary Tract Infection (UTI) — Inpatient and Urinary Tract Infection (UTI) — Outpatient. You can find the full list of episodes here:
https://www.tn.gov/tenncare/health-care-innovation/episodes-of-care.html.

The provider with the greatest opportunity to influence the cost and quality of a specific episode will be deemed the principal accountable provider or Quarterback. The Quarterback may be an individual or a facility, depending on the episode. Quarterbacks will be notified of their accountability for an Episode of Care (EOC) and receive quarterly reports.

Q: What are the episode reports?
A: The key to success for a Quarterback is effectively utilizing the EOC reports, which provide cost summary and details for quality indicators. Reports are prepared quarterly from each managed care organization (MCO). For new episodes, preview reports will begin in the year before financial accountability. Performance reports have financial accountability and always begin on January 1. Final reports are generated in August of the following performance year. For example, the 2015 final performance report would be available in August 2017. A final performance year report that includes the entire calendar year period will be used to determine any gain/risk share payments. Reports are available through Availity.

Q: What are gain sharing and risk sharing?
A: With expert input from TAGs, the state will identify included costs and quality for each EOC. A risk-adjusted average cost will compare Quarterbacks to all other Quarterbacks for that episode across the state. Based on that comparison, an acceptable threshold will be established by the state. Amerigroup Community Care and the other MCOs will then set their own commendable threshold. Quarterbacks whose costs are below the commendable threshold **and** who meet quality metrics will receive a share of the savings. Quarterbacks who are above the acceptable threshold will share in the excess costs by risk sharing.

Q: When will gain sharing and risk sharing payments occur?
A: Either Amerigroup or the Quarterback, as applicable, will pay to the other party the gain or risk payments after Amerigroup provides the final performance report in August of the following calendar year.

Q: How can Quarterbacks best identify ways to improve their performance?
A: Quarterbacks are highly encouraged to review interim performance and preview reports on a quarterly basis to provide the best opportunity to review cost and quality patterns, which affect gain sharing and risk sharing, as well as identify the overall patient journey for each episode.

Q: What if I identify errors on an interim performance report?
A: If a provider identifies areas of missed opportunity regarding risk capture/quality metrics or has questions regarding appropriate application of detailed business requirements (DBR), the Quarterback can notify Amerigroup of any discrepancies or concerns identified. This should be done within 30 days of the report notification either by sending an email to the Amerigroup EOC provider communication mailbox at agpepisode.reporting@amerigroup.com or contacting your EOC provider representative (contact details listed below). Amerigroup will then work with you to investigate the reported concerns and determine the best course of action to address the issue.

Q: Is there a reconsideration process?
A: In the event that a Quarterback has concerns regarding the provider's risk share and/or metric accuracy of the final performance report, the Quarterback will submit a formal reconsideration request as detailed below.

Within 30 business days following the date of the final performance report notification, providers have the right to submit a written request for reconsideration to Amerigroup. Amerigroup will review and respond within 30 business days of receipt of the reconsideration.

Steps for submitting a written reconsideration request:

- Send reconsideration requests in writing to Amerigroup via:
  - Mail: Provider Relations — Episodes of Care
    Amerigroup Community Care
    22 Century Blvd., Suite 220
    Nashville, TN 37214
  - Email: agpepisode.reporting@amerigroup.com
- Provide a detailed rationale to support the reconsideration request and include:
  - Identification of each performance result (payment and metrics) for reconsideration.
  - Identification of the contested result calculated.
  - A detailed explanation of why the provider believes the determination is incorrect.
  - Any other relevant information to support the provider's reconsideration request.

If the Quarterback does not object to a final reconsideration in writing within 30 days following the receipt of the Amerigroup reconciliation report, the Quarterback will be deemed to have accepted the reconciliation determination.

If a provider is dissatisfied with the result of the reconsideration process, or if Amerigroup fails to respond to the reconsideration request within 30 days from the received date of the payment dispute, the provider may submit a request to the Commissioner of the Department of Commerce and Insurance for an independent review of the disputed claims as set forth in *T.C.A. 56-32-126*. The independent review process is available to providers to resolve EOC disputes. It is understood that in the event providers file a request with the Commissioner for independent review, the dispute shall be governed by *T.C.A. 56-32-126(b)*.

The field form to *Request Independent Review of Disputed TennCare Episode of Care Cycle Provider Gain/Risk Share Total*, instructions for completing the form, sample copies of request forms and frequently asked questions can be found on the state website at https://www.tn.gov/commerce > Our Divisions > TennCare Oversight > MCO Dispute Resolution > Independent Review Process.

The provider may also file a state complaint with the TennCare Oversight Division at the TennCare Department of Commerce and Insurance before they submit a request for an independent review. A state complaint can be filed by following instructions at https://www.tn.gov/commerce/tenncare-oversight/mco-dispute-resolution/provider-complaint-process.html. This process is also available for disputing annual EOC reports.

Q: What if I have more questions?
A: You can contact your Amerigroup EOC provider representative if you have more questions. Please see contact information below:

- Deborah Bien, clinical program development manager for EOC, 615-316-2400, ext. 106-126-0123, Deborah.Bien@amerigroup.com
- Shannon Marcum, provider clinical liaison, 615-316-2400, ext. 106-126-0064, Shannon.Marcum@amerigroup.com
- Email: agpepisode.reporting@amerigroup.com

You can also find additional detailed information regarding EOC at https://www.tn.gov/tenncare/health-care-innovation/episodes-of-care.html.