

BlueCare Tennessee Tennessee Health Care Innovation Initiative – Episodes of Care Frequently Asked Questions

The Initiative

Q: What is the Tennessee Health Care Innovation Initiative?

Led by the state of Tennessee, the Tennessee Health Care Innovation Initiative (THCII) aims to lower costs and improve health care for Tennesseans by bringing together state leaders, hospitals, clinicians and insurers.

THCII aims to shift the health care system from **volume-based** to **value-based**. The program is designed to protect our members' physical and fiscal health by rewarding doctors and hospitals for high-quality, efficient treatment of medical conditions, and by reducing ineffective or inappropriate treatments.

Q: What are episode-based payments?

Episode-based payments align incentives with successfully achieving a patient's desired outcome during an "episode of care," a clinical situation with predictable start and end points. Episodes reward high-quality care, promote the use of clinical pathways and evidence-based guidelines, encourage coordination, and reduce ineffective or inappropriate care. Episode-based payment is applicable for most procedures, hospitalizations and acute outpatient care (e.g., broken bones), as well as some forms of treatment for cancer and behavioral health conditions, like attention-deficit/hyperactivity disorder (ADHD).

Q: How were clinical pathways and guidelines established for each episode of care?

Technical Advisory Groups (TAGs) were formed for each episode of care. The TAG is responsible for giving clinical advice on the design of the retrospective episodes of care. Each TAG includes clinical experts from all regions of the state.

Q: How many episodes of care are included in the Tennessee Health Care Innovation Initiative?

Currently, there are 48 episodes of care in performance. You can view the list of episodes here: tn.gov/content/dam/tn/tennicare/documents2/48EpisodesByWave.pdf.

Q: What lines of business are included in this program?

The Episodes of Care program includes BlueCare only. TennCareSelect phased out of the program in 2019, and CoverKids phased out in 2020.

Q: What is a Quarterback?

For each episode of care, there's a Principal Accountable Provider or "quarterback" – typically, the contracted provider – whose care has the most impact on the overall cost and quality of a patient's treatment. The quarterback coordinates care and chooses the patient's treatment path.

Q: How do Quarterbacks impact incentive payments?

Quarterbacks that help members achieve high-quality, cost-effective health care outcomes during episodes of care are financially rewarded. Those who perform outside the benchmarks pay a portion of the excess costs associated with care back to the state.

Reporting

Q: What is the purpose of quarterly reports?

Payers build THCII Episodes of Care reports using claims data submitted by physicians and facilities. This claims data is compiled into a quarterly report that provides a performance summary, as well as quality and cost details related to the episode of care. The reports identify areas of improvement in care coordination, costs and practice changes that promote quality patient care.

In the reports, providers receive information about what happens to their patients throughout each episode of care – information that's never been available before. You can see an example report in the **How to Read Your Report Guide** on the Division of TennCare THCII webpage: tn.gov/content/dam/tn/tenncare/documents2/Howtoguide.pdf.

Q: Where are quarterly reports located?

Quarterly reports are available on Availity® for Principal Accountable Providers, or Quarterbacks. If you haven't registered for Availity, please follow these steps to set up your account:

- Visit Availity.com and click the **Register** link at the top right-hand corner of the page, which will guide you through registration.
- Once in Availity, click the **Payer Spaces** link, and select the **BCBST icon**.
- Next, scroll to the **THCII Reporting** tile and click to open it. Then, select the organization for the reports you want to download and click **Submit**.
- You'll be redirected to the THCII reporting portal, where you can download THCII reports for each of the programs. The reports have been reorganized to help you quickly find the information you need.

If you have questions about your reports or where to find them, please call (423) 535-5717 and choose option 2.

Q: What do the reports cover?

Reports contain information to help quarterbacks manage their performance and see how they perform against their peers. Types of information in the reports include:

Performance summary

- Total number of episodes (included and excluded)
- Quality thresholds achieved
- Average non-risk-adjusted and risk-adjusted cost of care
- Cost comparison to other providers, and gain- and risk-sharing thresholds
- Gain-sharing and risk-sharing eligibility and calculated amounts

Quality detail

- Scores for each quality metric and comparisons to the gain-share standard or provider base average

Cost detail

- Breakdown of episode cost by care category
- Benchmarks against provider base average

Episode detail

- Cost detail by care category for each individual episode a provider treats
- Reason for any episode exclusions

In the reports, providers can also look at their average costs and see how they compare to the commendable and acceptable levels.

Q: Will providers be able to see the rendering physician and national provider identifier (NPI) on the reports?

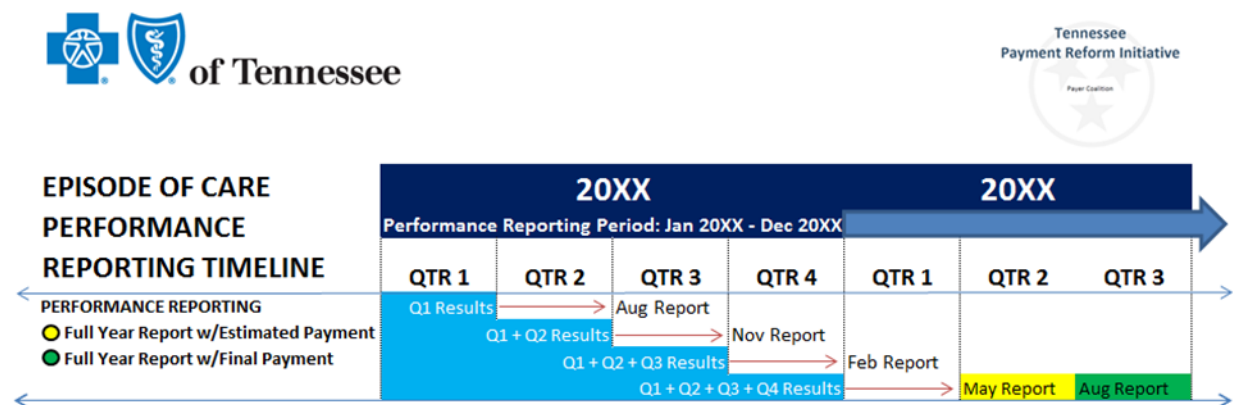
Yes. Rendering physician and NPI information is included on the Excel file that is part of the quarterly reports.

Q: Will providers be able to see members’ dates of birth on their quarterly reports?

Yes. Members’ dates of birth are provided on the Excel file that is part of the quarterly reports.

Q: What is the reporting timeline for episodes of care?

The reporting timeline is as follows*:

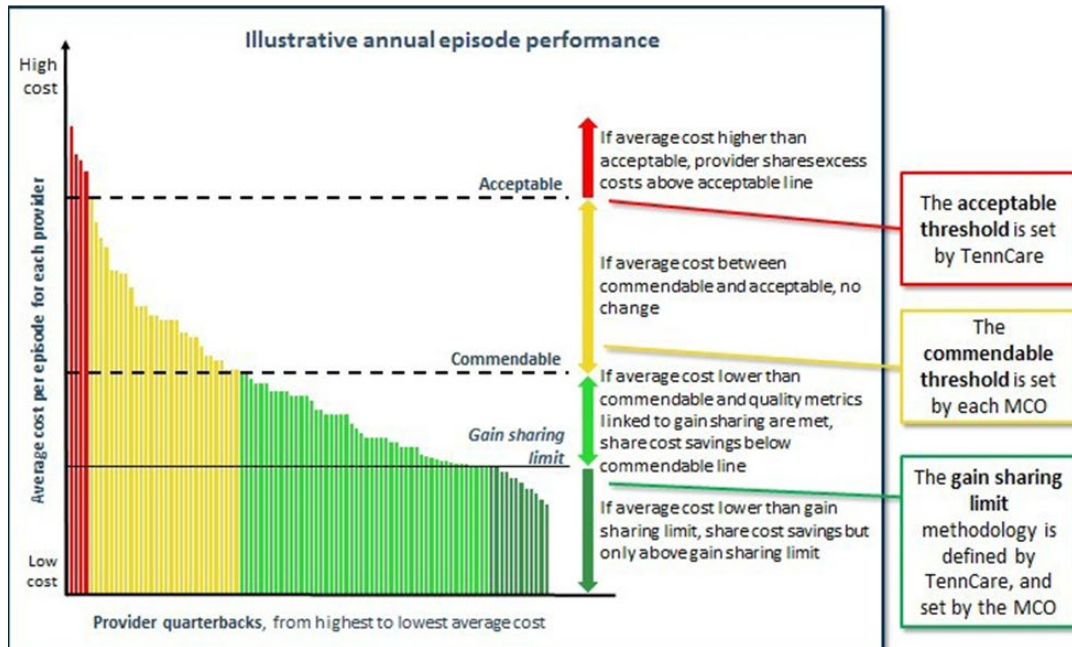


*Please note that each episode of care reporting timeline includes a full year for the preview, performance, and reward/pay-out periods. Each episode of care reporting timeline includes a preview period, a 12-month performance period and a pay-out period.

Q: What are thresholds?

Two cost thresholds have been established for each THCII episode of care: a maximum allowable cost and a low allowable cost. If providers exceed the maximum allowable cost, they’ll share responsibility for a portion of the excess costs. If the cost of care is below the low allowable cost, providers may earn gain-sharing rewards.

For more information, please review the chart and definitions below:



Acceptable threshold: TennCare sets an acceptable threshold so that providers with the highest risk-adjusted average annual cost have a risk-share payment.

Commendable threshold: Each managed care organization (MCO) sets its commendable thresholds. For wave 1 episodes, the commendable threshold is set so that gain- and risk-share dollar amounts are projected to be equal, based on historical data. Each MCO can provide more information about its commendable thresholds.

Gain-sharing limit threshold: The gain-sharing limit is a cost threshold below the commendable threshold. If costs for an episode of care fall below the gain-sharing limit threshold, the patient has likely not received appropriate care.

Quality metrics linked to gain-sharing thresholds: Some quality metrics are linked to gain-sharing, while others are reported for information only. Providers must meet predetermined thresholds for gain-sharing-linked quality metrics to be eligible for gain-sharing payments.

Q: How often do thresholds change?

All thresholds are set before the performance year and don't change. Because providers' experiences may differ from year to year, actual results will vary from the projections. The best outcome occurs when actual results are lower than the state's projections, which leads to provider gain-sharing payments and payer savings.

Q: Who can answer questions about THCI episode of care reports?

If you have questions, please call the Provider Service line at 1-800-924-7141 or your local Provider Network Manager. If you don't know who your Network Manager is, visit provider.bcbst.com/contact-us/my-contact and enter your provider name or NPI number.

Program Exclusions

Q: What episodes are Informational Only, and when will these episode reports be released?

Beginning with the 2021 performance period, five episode types will shift to informational-only reporting. These episodes won't be subject to risk- or gain-share provisions:

1. Coronary Artery Bypass Graft (CABG)
2. Femur/Pelvic Fracture
3. Human Immunodeficiency Virus (HIV) Infection
4. Non-acute Percutaneous Coronary Intervention (PCI)
5. Valve Repair and Replacement

The first informational-only reports will be released in August 2021, which will reflect first quarter 2021 performance.

Q: Are Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) excluded from Episodes of Care? How will their episodes be reported?

Yes. All known FQHCs and RHCs are included on a list maintained by TennCare's fiscal team that contains the corresponding Tax ID and facility National Provider Identifier (NPI).

Products

Q: What BlueCross products does THCII impact?

Even though THCII is currently focused on TennCare, we provide separate THCII reports for our commercially insured member population. There are only financial incentives (gain-share payments) tied to these Commercial reports.

Both gain- and risk-share payments apply to BlueCare. Beginning with the 2019 performance period, TennCare*Select* is no longer included in the THCII program, and CoverKids phased out after the 2020 performance period.

Contract ID

Q: What is a Contract ID?

The contract ID is an internal BlueCross reference code that connects providers who participate under the same core agreements for specific networks.

Q: Why do we use a contract ID to link multiple contracted provider groups or facilities who share the same core agreement?

The contract ID was created so that we can send amendments or new contracts to only the individual who has signature authority on behalf of the groups or facilities. The contract ID also allows us to identify all physicians associated with groups based on the network. It helps us target the right providers and make sure none are missed.

Q: How are Contract IDs assigned?

Physician

- The contract ID for an individual contracted provider is the practitioner's NPI.
- In cases of a single group contract, the individual providers under the group are assigned a group provider number. The group provider number is used as the contract ID.
- In cases of a multiple group contract, individual providers under each group are assigned a provider number and then linked with an assigned group provider number for each group. The group provider numbers will then be linked under one assigned contract ID.

Facility

- A contract ID is assigned to each single-facility contract.
- One contract ID is also assigned for each multiple-facility contract.

Contract Entity Identifier

Q: How does the contract ID and tax ID combination impact the state's THCII Episode of Care program reporting?

Results for multiple groups or facilities under the same contract ID and tax ID combination are shared on one report. Each physician or facility will be able to view their own episodes in the reports, but some information will not be available to each individual physician or facility, such as stop loss, quality scores and threshold comparisons.

Q: How does the contract ID and tax ID combination impact the state's THCII Episode of Care gain- and risk-share payments?

Since our reporting is by the contract ID and tax ID combination and providers' episodes are aggregated based on this combination, we pay out and recoup gain- and risk-share payments according to the contract ID and tax ID combination as a whole. We won't split out payments to the entity but will allow the contracted entity/provider(s) to distribute the payments as they see fit.

Risk-Share, Gain or Financial Reduction

Q: How are gain- and risk-share payments distributed?

Gain-share payments are sent through contract payment preferences. If you're signed up to get your claims payments by electronic funds transfer, you'll also get your gain-share payment through electronic funds transfer. If you receive your claims payments by check, then you'll get a check.

If you owe a risk-share payment, please send the payment to:

**BlueCare Tennessee
1 Cameron Hill Cr., Ste. 0049
Chattanooga, TN 37402**

If we don't receive your risk-share payment within 60 days of posting your THCII remittance advice on Availity, the payment will be deducted from future claims payments.

THCII Provider Dispute Resolution Procedure

Q: What is the process for appealing information in the THCII episode of care reports?

You can learn more about the THCII Provider Dispute Resolution process in the [BlueCare Tennessee Provider Administration Manual](#).

Please review your THCII interim and performance reports each quarter and contact your Provider Network Manager (PNM) if you have questions about your reported claims data and quality measures. Your PNM will alert the resolution team, which includes representatives from medical informatics, PNMs, data specialists, clinical staff and the program owner. This team will work closely with members of your office staff to resolve any issues.

If we can't reach a resolution, you can file a formal inquiry/reconsideration. When you file your inquiry/reconsideration, you'll need to show that at least one of the State's Detailed Business Requirements (DBRs) wasn't followed. You can view the DBRs at: tn.gov/tenncare/health-care-innovation/episodes-of-care/technical-documents.html.

THCII inquiries/reconsiderations follow the BlueCare Tennessee Provider Dispute Resolution procedures, with some differences specific to this initiative. Please follow the instructions below to submit an inquiry/reconsideration for your interim performance report if you've already contacted your PNM and wish to further pursue your concern:

Step 1 – Inquiry/Reconsideration:

- a. An inquiry/reconsideration must include evidence and supporting documentation that the BlueCare Tennessee episode of care presented in the report didn't follow State of Tennessee DBRs. You can find episode of care information and requirements at: tn.gov/tenncare/health-care-innovation/episodes-of-care.html.
- b. Complete the [THCII Value-Based Payment Reconsideration form](#) on the BlueCare Tennessee website, and send the completed form to the THCII Reconsideration mailbox. Please include the DBRs with your submission. We'll review the reconsideration and respond in a timely manner.

Step 2 – Appeal:

If the dispute isn't resolved during the inquiry/reconsideration review, please complete the [Value-Based Payment Provider Appeal form](#) on the BlueCare Tennessee website. Send the completed form to the THCII Appeals mailbox. Please include the information submitted with the inquiry/reconsideration and any additional details. This appeal will go to the Appeals committee, which includes management and medical director review, for a decision. Appeals committee meetings are held at least quarterly on the first Wednesday of the month.

Binding Arbitration

Binding arbitration isn't a required step in the process, but it's an option after the appeal has gone through committee. You can learn more about the binding arbitration process in the [BlueCare Tennessee Provider Administration Manual](#).

Tennessee Department of Commerce and Insurance (TDCI) Formal Appeals Process

- a. TDCI's existing process for providers appealing an MCO's payment applies to episode value-based payments. This process should be used if we're unable to address complaints about the final gain- or risk-share amount presented in the Final Performance Report released in August. One element of TDCI's Formal Appeals Process requires providers to make one attempt for reconsideration with the MCO before using this appeals process.

- b. Providers may file a request for an independent review to dispute their episode value-based payment with the Commissioner of Commerce and Insurance according to the TennCare Provider Independent Review of Disputed Claims process. It's understood that, in the event providers file such a request with the Commissioner of Commerce and Insurance for Independent Review, the dispute will be governed by T.C.A. 56-32-126.
- c. The [Request to Commissioner of Commerce for Independent Review of Disputed TennCare Claim form](#) is located on the State's website. You can also find additional information about the Independent Review process developed by the State of Tennessee Department of Commerce and Insurance at tn.gov/commerce/tenncare-oversight/mco-dispute-resolution.html or by calling the State of Tennessee at (615) 741-2677.

Q: Where can I find more information about THCII?

For additional information on THCII, please visit the State of Tennessee's online resource at tn.gov/tenncare/health-care-innovation/episodes-of-care.html or visit the BlueCare Tennessee THCII resource page at bluecare.bcbst.com/providers/quality-care/thcii.