



## Tennessee Health Care Innovations Initiative: TMA Position Statement and List of Concerns

### *October 2019 Position Statement*

*The TMA recognizes that being more efficient about the cost of health care delivery is a legitimate public health interest for Tennessee. The state Innovation Initiative's episodes of care program, now being implemented to address health care costs in the TennCare program, continues to have major flaws in design and implementation that concern our member physicians. TMA will continue to advocate for substantial revisions to the design and implementation of it in the TennCare and state employee benefit programs, and oppose any expansion of it into commercial health insurance products in the state unless such expansion is voluntary and not tied to participation in any other product or line of business.*

*Until revisions are made and tested, TMA believes that the state Innovation Initiative for episodes of care should remain paused:*

- *pending a truly independent evaluation of its costs;*
- *until a trustworthy data verification process can be implemented and sufficiently tested;*
- *until TMA is ensured that that provider participation in episodes of care models for any type of product, including commercial health insurance products, is voluntary and never tied to participation with any other network or line of business; and*
- *until TMA is assured that the program for the state employee benefits is gain-sharing only.*

### ***TMA's Efforts to Improve the Design and Implementation of Episodes of Care***

TMA has pursued all available avenues to try to improve the episodes of care initiative for all impacted physicians.

- Staff, Insurance Issues Committee, and other leadership meetings with state officials
- Staff and leadership testimony to oversight committees of the General Assembly
- Lobbying the General Assembly for legislative reforms
- Nomination of blue-chip physician specialists to the technical advisory committees
- Member advocacy during wave feedback sessions
- Innovations Initiative consultant to educate physicians and serve as a liaison to the state
- Educational programs for physicians and medical office staff
- Facilitation of medical practice administrator calls with the state and MCOs
- Hands-on instruction and counsel to gather practice perspectives to share with the state

### ***Improvements to the Episodes of Care Initiative to Date***

Advocacy by the house of medicine has resulted in some significant improvements to the TennCare episodes of care program since its inception.

- Keeping the risk-sharing portion limited to the TennCare program after the State announced plans to extend it into the commercial state employee health plan networks of major health plans. The SEHP networks will move forward with episodes of care, but with only gain-sharing opportunities.
- Obtaining a mechanism for TAG participants to be reimbursed their mileage to/from in-person meetings.
- Uniformity of report format
- Reports accessible on same platform as other MCO information
- Patient level information is available in an excel table that can be sorted by provider according to their own information needs
- Transparency of MCO risk adjustment methodologies
- Uniformity of cost and outlier exclusions
- Transparency of threshold levels; uniform acceptable threshold across MCOs
- Ability of quarterbacks to share data in provider reports with other providers
- Mechanism to appeal provider gainsharing or penalty classification within at least 30 days
- Identification of quality measures added to TAG responsibilities
- *New* – TAGs review episode designs before reports are issued.
- Delay in rollout of Wave 1 episodes of care performance period
- Procurement of outreach grant to fund a consultant to help physicians understand episodes of care and develop strategies to reduce costs
- Adjustments to provider reports (added patient date of birth and rendering provider NPI to the included and excluded episode lists)
- MCOs post provider “quarterback” episode reports onto secure portals for providers to access
- No mandatory participation in Initiative for commercial insurance in 2015, 2016, or 2017
- Only 10% of providers with highest cost episodes were subject to penalty for the 2015 performance period
- Improved recognition of the ability of MCOs to use Category II codes to track certain screenings
- 2016 law requiring the TennCare Bureau to report on all TAG recommendations and indicate whether they were acted on
- In 2017, TAG members now review the final design of the episode prior to the first preview reports are released
- The state sets a single threshold that determines which providers have risk sharing penalties, thus aligning the penalty threshold across all MCOs
- TennCare MCOs each program the detailed episode design specifications as does the state contractor (DXC); then each MCO’s results are compared with the consultant’s results. Discrepancies are researched, resolved or minimized with at least three rounds of comparisons. Design specifications are randomly audited by the Department of Commerce & Insurance to see if each MCO is following its own risk adjustment methodology
- There is an MCO reconsideration process if a physician feels there is a mistake in his provider report; if necessary, a physician can appeal to the Department of Commerce & Insurance
- *New* – For the perinatal episode, there is a reconsideration process for physicians penalized due to outlier hospital costs when a patient does not have a choice of facilities in which to deliver
- Reports show whether each quality measure was passed or failed at the patient level
- Reports include risk scores at the patient level

### **List of TMA's Ongoing Concerns about the Episodes of Care Initiative**

Despite TMA's advocacy efforts, significant concerns about the episodes of care initiative remain. Physician "buy-in" to the program has not been achieved. The program should not be expanded outside of TennCare until these issues are satisfactorily addressed and tested.

- **Episode of care "quarterbacks" are penalized for various costs that are out of the quarterbacks' control.** This is the most common feedback received about the episodes program. Often, physicians do not have a choice as to the facility where they operate, either due to a contractual relationship or geography, and therefore do not have control over the facility cost that is included in the episode. Likewise, facilities have no control over the follow-up care provided to patients who have procedures performed at their facilities, even though the cost of that follow up care is included in the facility-quarterback's episode. Philosophically, we are concerned that the episodes program will push reimbursement down to a point that is incompatible with high quality care and TMA first recommended that bifurcated "quarterbacking" be implemented in episodes containing both a hospital and physician component but this suggestion was rejected by the Bureau. TMA offered a second solution: that if a provider's penalty is based on a facility cost, the penalty is withdrawn.
  - **High**
- **Episode designs do not take into account regional fluctuations in cost.** Providers in very high cost regions such as Nashville are compared to providers in rural markets where costs are not as high. This is a concern of many providers. TMA would be interested in looking at the data on those quarterbacks who fell above the acceptable threshold to determine if this concern plays out. In other words, are those providers located in more high cost areas of the state, or are they spread across the various regions?
  - **High**
- **Each MCO has its own risk adjustment methodology as opposed to one standard.** We recommend standard and consistent methods for risk adjustment. While the MCOs use similar risk adjustment factors, such as age and certain comorbidities, the weights that they assign to each factor can be vastly different. The result is that, for a given episode of care, one quarterback provider may be considered a high cost provider for one MCO and a low-cost provider for another. That should not be the case. All three MCOs now cover TennCare lives in all three regions of the state. Therefore, their patient populations should not be so different as to warrant vastly different risk adjustment methodologies.
  - **High**
- **Currently, there is no formal data validation process for each episode prior to implementation.** There is a general concern in the provider community about the validity of the reports, i.e. whether the data and information in the reports are correct. There have been multiple instances where providers have identified codes included in an episode that are completely unrelated to that episode. This results in costs that are inappropriately attributed to the episode. If HCFA was required to conduct a data validation audit of each MCO's episode design prior to the preview reports being issued, those types of design flaws could be identified. This could be a simple step where the MCOs and providers partner to validate the claims information that populates the report. This would give confidence in the information and to the state's program. It is TMA's understanding that the MCOs have agreed to do this on a case by case basis.

- **High**
- **Provider reports should include more information at the patient encounter level, if requested by quarterback, to help with gap analysis.** Additionally, reports should include the cost of each line item in the provider claim level detail reports to help providers identify line items for appeals.
  - **High**
- **Patient Centered Medical Homes and Health Homes need to be physician led.** A physician needs to be in charge of patient care. TennCare patients often have multiple chronic conditions that should be managed by a physician, even if care is not delivered by a physician during every office visit. Any licensure or accreditation standards instituted by the State should require that the clinic be physician led.
  - **High**
- **Provider reports should show each risk adjustment factor attributed to each patient.** While the list of risk factors and weights are published and made available to quarterback providers, what is shown on provider reports is only the composite risk adjustment score for the patient. As a result, a quarterback provider cannot ascertain which individual risk factors were included in the composite score. It is almost impossible for quarterbacks to verify that the correct diagnoses were captured by the MCO's claims data.
  - **Medium**
- **TAGs should be consulted after annual feedback sessions.** Each summer, HCFA conducts feedback sessions for the episodes of care that are currently in performance periods. TAGs for those episodes should be convened as part of the wave feedback review process before HCFA responds to feedback session comments from the public. Currently, only the State, its consultant, and the MCOs review the feedback. This review does not have to be in person; it can be by electronic means.
  - **Medium**
- **True quality of care cannot be captured through claims data.** Many TAG participants and other physicians have expressed concern that the episode of care program is focused almost entirely on reducing costs and does not include enough accurate measures of quality and outcomes. These concerns are primarily directed at the nature of the episode designs which are based solely on claims data.
  - **Medium**
- **MCOs should share data in order for information in the reports to be complete.** The episodes design cannot adjust for patients within long episode windows, such as perinatal, who move between insurance carriers or are self-pay at some point. If MCOs shared data or were required to submit data to a claims database, the data for those patients that change MCOs in the middle of an episode window would not be lost.
  - **Medium**

- **The Initiative is not aligned with other mandated payment reform programs, such as MIPs.**  
Starting in 2017, physician practices that participate in Medicare will be required to submit data under the Merit-Based Incentive Program or participate in an alternative Advanced Payment Model, in addition to keeping track of the Initiative and any other quality-reporting program implemented by the various commercial health plans. If the quality reporting and episode designs for the Initiative could at least align with any federally-mandated programs, it could cut down on the overwhelming administrative burden almost all providers currently feel.
  - **Low**