

**BlueCross BlueShield of Tennessee:
Tennessee Healthcare Innovation Initiative (THCII) Frequently Asked Questions**

The Initiative

Q *What is the Tennessee Healthcare Innovation Initiative?*

A Led by the state of Tennessee, the Tennessee Healthcare 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?*

A Episode-based payments seek to 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 and/or inappropriate care. Episode-based payment is applicable for most procedures, hospitalizations, acute outpatient care (e.g., broken bones), as well as some forms of treatment for cancer and behavioral health conditions (e.g., ADHD).

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

A Technical Advisory Groups (TAGs) were formed for each episode of care. The TAG is responsible for 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 will be included in the Tennessee Health Care Innovation Initiative?*

A Approximately 60 episodes of care will be established. Each episode of care will include a preview period, a performance period – to give providers time to review their data – and a payment period.

For more information on the THCII episode of care, go to the State website at:

<https://www.tn.gov/tenncare/health-care-innovation/episodes-of-care/episodes-by-wave.html>.

Q *What is a Quarterback?*

A 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?*

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

Reporting

Q *What is the purpose of quarterly reports?*

A THCII episode of care reports are built by payers, using claims data submitted by physicians and facilities. The 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 to promote quality patient care.

Providers will receive information about what happens to their patients throughout each episode of care - information that has never been available to providers before.

You can see an example of the episode of care reports in the How to Read Your Report Guide on the Division of TennCare THCII Webpage at:

<https://www.tn.gov/content/dam/tn/tenncare/documents2/Howtoguide.pdf>

Q *Where are quarterly reports located?*

A Quarterly reports are available on Availity® for Principal Accountable Providers, or Quarterbacks. If you have not registered for Availity®:

- o Visit <https://www.availity.com/> and click the Register link at the top right hand corner of the page, which will guide you through registration.
- o Once in Availity®, scroll down to the “Applications” tab and use the next button until you find “THCII Reporting”.
- o Select BCBST from the “Payer Spaces” in the menu.
- o Click on “THCII Reporting” and select the organization from the reports you want to download. Then click submit.
- o You will be redirected to the THCII reporting portal where you can download THCII reports from each of the programs. The reports have been reorganized to help you quickly find the information you need.
- o For questions related to the provider reports, please call (423) 535-5717 and choose option 2.

Q What do the reports cover?

A Quarterbacks will be provided with the following information to assist in managing their performance and how they perform against their peers:

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 with comparison to 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 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?

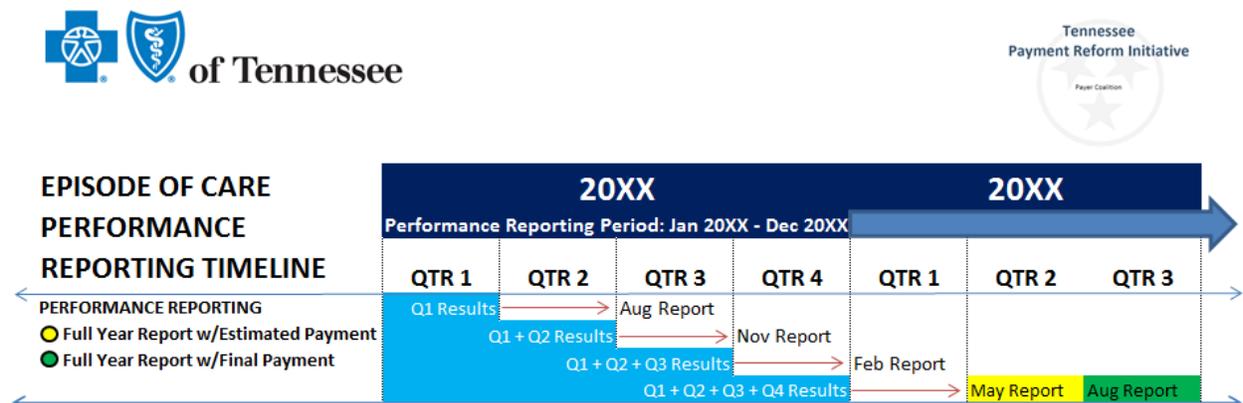
A Rendering physician and NPI information is included on the Excel file that is part of the quarterly reports.

Q Will providers be able to see members' dates of birth on quarterly reports?

A 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?

A 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.

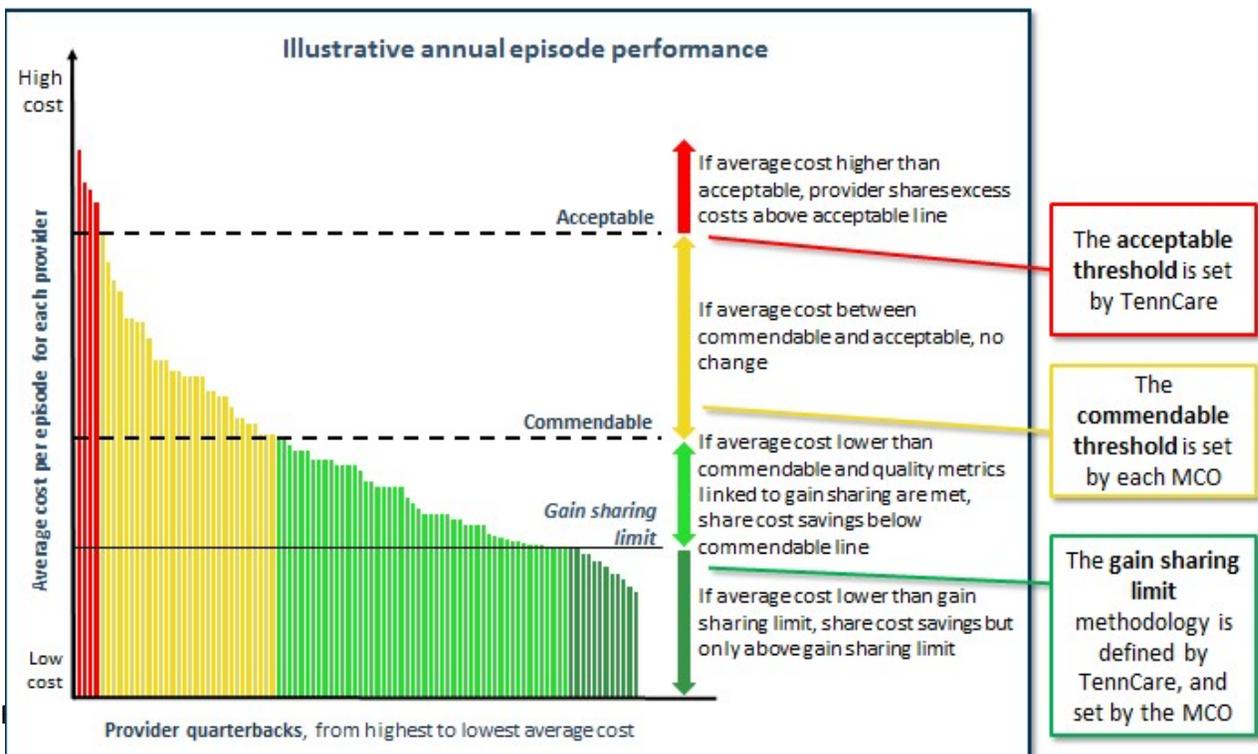
Q What are the report titles?

A THCI report titles have changed to:

- o **Preview without Thresholds**
 - Informational report without cost or quality thresholds.
- o **Preview with Thresholds**
 - Informational report with cost and quality thresholds
- o **Interim Performance**
 - Interim performance report for contracted lines of business BlueCare, and TennCareSelect/CoverKids in a performance period.
- o **Final Performance**
 - Final performance report for contracted lines of business BlueCare and TennCareSelect/CoverKids.

Q What are thresholds?

A Two cost threshold are established for each THCI episode of care: a maximum allowable cost above which providers will share payment of excess costs, and a low allowable cost below which providers may earn gain sharing rewards.



- o **Acceptable threshold:** TennCare sets acceptable threshold so that the providers with the highest risk-adjusted average annual cost for all TennCare would see a penalty.
- o **Commendable threshold:** Each MCO sets its own commendable thresholds. For wave 1 episodes, the commendable threshold is set so that reward and penalty dollar amounts are projected to be equal, based on historical data. Information on the commendable threshold is available from each MCO.
- o **Gain sharing limit threshold:** The gain sharing limit is a cost threshold below the commendable threshold. It is meant to represent the cost below which appropriate services have likely not been rendered to the patient.
- o **Quality metrics linked to gain-sharing thresholds:** Some quality metrics will be linked to gain sharing, while others will be reported for information only. To be eligible for gain sharing, providers must meet predetermined thresholds for gain sharing-linked quality metrics.

Q *How often do thresholds change?*

A All thresholds are set before the performance year and do not change. Actual experience may be different from previous years, so actual results will vary from the projections. The best outcome would be that results would be lower than the state's projections, which would lead to savings for the payers and rewards for providers.

Q *Will threshold always be set so rewards and penalties are equal?*

A Although thresholds for Wave 1 were set so that rewards and penalties were equal, this may not always be the case. Faced with a choice between lowering rates across the board versus lowering thresholds, for example, thresholds would result in concentrating payments to high value providers.

Q *Who can answer questions on THCI episode of care reports?*

A Call the Provider Service phone line at 1-800-924-7141 or contact your local Network Manager. If you do not know your Network Manager you can go to the BlueCare Tennessee website at: <https://www.bcbst.com/providers/mycontact/?nav=calltoaction> and enter your provider name or NPI number.

Products

Q *What BlueCross products does THCI impact?*

A THCI is currently focused on TennCare; however, BlueCross provides separate THCI reports for our commercially-insured member population. Please note that there are no financial incentives or penalties tied to the commercial reports; they are only informational. Financial reward and penalty payments will only apply to BlueCare and TennCareSelect and CoverKids episodes of care. Beginning performance period 2019, TennCareSelect will no longer be included in the program.

Contract ID

Q ***What is a Contract ID?***

A A 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 together who share the same core agreement?***

A The Contract ID is created to send amendments or new contracts to only one individual who has signature authority on behalf of the groups or facilities. Also, the Contract ID affords the ability to identify all physicians associated with groups based on the network. It assists in targeting the right providers and ensures none are missed.

Q ***How are Contract IDs assigned?***

A **Physician**

- For an individual contracted provider, the Contract ID reflects the individual contracted practitioner NPI.
- For a single group contract, the individual physicians under the group are each assigned a Group Provider number. The Group Provider number will be used as the Contract ID number.
- For a multiple group contract, individual physicians under each group are each assigned a provider number and then linked together with an assigned Group Provider number for each group. The Group Provider number will be linked together under one assigned Contract ID number.

Facility

- For a single facility contract, a Contract ID is assigned.
- For a multiple facility contract, one Contract ID is assigned.

Contract Entity Identifier

Q ***How does the Contract ID and Tax ID combination impact the state's Tennessee Health Care Innovation Initiative (THCII) episode of care program reporting?***

A Multiple groups or facilities under the same Contract ID and Tax ID combination will see their results on a single report. Although each physician or facility will be able to view their own episodes in the reports, there will be some information that will not be available by individual physician or facility, such as stop loss, comparison to thresholds, and quality scores.

Q ***How does the Contract ID and Tax ID combination impact the state's Tennessee Health Care Innovation Initiative (THCII) episode of care gain and risk share payments?***

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

Risk Share Gain or Financial Reduction

Q ***How will the risk share gains and/or financial reductions be administered to providers?***

A Risk share gains will be sent through contract payment preferences. If you are signed up to receive your claims payments by electronic funds transfer, then your risk gain sharing will be sent to you through electronic funds transfer. If you receive your claims payments by check, then you will receive a check.

Financial reductions will need to be sent into BlueCare Tennessee at:
1 Cameron Hill Cr., Ste. 0049
Chattanooga, TN 37402

If payment is not submitted within 60 days of the posting of your THCII remit on BlueAccess, it will be deducted from future claims payments.

THCII Provider Dispute Resolution Procedure

Q ***What is the process for appealing the THCII episode of care reports?***

A THCII Provider Dispute Resolution process is in the THCII Provider Guide that can be found on the BlueCare Tennessee website at:

<http://bluecare.bcbst.com/Providers/Provider-Education-and-Resources/THCII.html> or in the BlueCare Tennessee Provider Administration Manual:
<http://bluecare.bcbst.com/Providers/Provider-Administration-Manual.html>

It is important that Tennessee Health Care Innovation Initiative (THCII) participants review interim and performance reports quarterly. Any questions about reported claims data and quality measures should be directed to the appropriate Provider Relations Consultants (PRC). The PRC will engage a resolution team (members including, but not limited to medical informatics, network manager, data specialists, clinical staff and program owner.) The resolution team will work closely with the appropriate members of the provider's office staff to reconcile issues.

If a resolution cannot be agreed upon by both parties, a formal Inquiry/Reconsideration can be filed. Due to primary source verification requirements, BlueCare Tennessee must receive sufficient evidence data business rules developed by the State of Tennessee were not followed. THCII Inquiry/Reconsideration will follow the BlueCare Tennessee Provider Dispute Resolution procedure with some variation due to the nature of this initiative. For interim performance reports, once you have engaged your PRC and make the decision to pursue further, please follow the instructions listed below:

Step 1 Inquiry/Reconsideration:

- a. An Inquiry/reconsideration must include sufficient evidence and supporting documentation that BlueCare Tennessee episode of care presented in the report did not follow the State of

Tennessee Detailed Business Requirements. The episode of care information and requirements are found at: <http://www.tn.gov/hcfa/topic/episodes-of-care>.

- b. Complete the THCI Value-Based Payment Reconsideration form located on the BlueCare Tennessee Website at: <http://bluecare.bcbst.com/Providers/Provider-Education-and-Resources/THCI.html>. Include the detailed Business Requirements and submit to the THCI Reconsideration mailbox. The reconsideration will be reviewed and an answer returned in a timely manner.

Step 2 Appeal:

If the provider dispute is not resolved during the Inquiry/Reconsideration review, the provider need only to complete the Value-Based Payment Provider Appeal form found in the THCI Provider Guide on the BlueCare Tennessee website at: <http://bluecare.bcbst.com/Providers/Provider-Education-and-Resources/THCI.html>. Complete the form and send to the THCI appeals mailbox including all that the information submitted with the Inquiry/Reconsideration and any additional information. This appeal will go to the Appeals committee, which includes management and medical director review, for a decision. The Appeals committee meetings are held a minimum of quarterly, regularly the first Wednesday of each month.

Binding Arbitration

Binding arbitration is not a required step in the process but is an option after the appeal has gone through committee. The binding arbitration process can be found in the BlueCare Tennessee Provider Administration Manual at: http://www.bcbst.com/providers/manuals/BCT_PAM.pdf.

TDCI Formal Appeals Process

- a. TDCI's existing process for providers appealing MCO's payment will apply to episode value-based payments. This process should be utilized if BlueCare Tennessee is unable to address a provider's complaint pertaining to 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 (1) attempt for reconsideration with MCO prior to utilizing this appeals process
- b. Providers may file a request in order to dispute their episode value-based **payment** with the Commissioner of Commerce and Insurance for an independent review pursuant to the TennCare Provider Independent Review of Disputed Claims process, which shall be available to Providers to resolve final performance period gain or risk share reported by BlueCare Tennessee, as provided in T.C.A. 56-32-126. It is understood that in the event Providers file such a request with the Commissioner of Commerce and Insurance for Independent Review, such dispute shall 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 at <http://www.tn.gov/assets/entities/commerce/attachments/TCD-IR-RequestForm-July2015.pdf>. Additional information regarding the Independent Review process developed by the State of Tennessee Department of Commerce and Insurance are also online at

<http://www.tn.gov/assets/entities/commerce/attachments/ProviderIRInfoPacket062615.pdf>
or by calling the State of Tennessee at (615) 741-2677.

Q *Where can I find more information on THCI?*

A For additional information on THCI, please visit the State of Tennessee's online resource at <http://www.tn.gov/hcfa/topic/episodes-of-care> or visit the BlueCare THCI resource page at bluecare.bcbst.com/Providers/Provider-Education-and-Resources/THCI.html