

State Employee Health Plan and Fully Insured Episodes of Care BlueCross BlueShield of Tennessee – Blue Network S Frequently Asked Questions

The Initiative

1. *What is the Tennessee Healthcare Innovation Initiative?*

Led by the state of Tennessee, the Tennessee Healthcare Innovation Initiative (THCII) was created to lower costs and improve health care for Tennesseans.

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 reducing ineffective or inappropriate treatments by rewarding doctors and hospitals for high quality, efficient treatment of medical conditions.

2. *What is the Blue Network S State Employee Health Plan and Fully Insured Episodes of Care program and how is it different from the THCII Episodes of Care program?*

Effective Jan. 1, 2017, BlueCross BlueShield of Tennessee will launch the THCII Episodes of Care program for our State Employee Health Plan (SEHP) and Fully Insured members who use Blue Network SSM with a few key differences:

- The Commercial program is a shared savings program only, which means the Principal Accountable Provider (PAP), also known as the Quarterback, faces no risk
- The Quarterback must have 40 or more episodes to be eligible for shared savings.
- Only a subset of episode types from the THCII Episodes of Care program will be selected and implemented.

3. *When does the performance period begin for SEHP and Fully Insured?*

SEHP – Jan. 1, 2017

The performance period for SEHP will begin Jan. 1, 2017. Preview reports related to performance have been available for review since May 2014.

Fully Insured – Jan. 1, 2018

The performance period for Fully Insured will begin Jan. 1, 2018. Calendar year 2017 is a reporting only period, where preview reports will be provided for informational purposes only.

4. *What are episode-based payments?*

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 payments are 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).

5. *How are clinical pathways and guidelines established for each episode of care?*

Technical Advisory Groups (TAGs) are composed of expert clinicians in Tennessee with relevant specialties who volunteer their time to make recommendations on the clinical design of episodes by the HealthCare Financing Administration (HCFA) and McKinsey & Company.

6. *How many episodes of care will be included in this initiative?*

Only a subset of episode types from the THCI Episodes of Care program will be selected and implemented. Each episode of care will include a preview period, a performance period to give providers time to review their data, and a payment period.

7. *What episodes of care are in a performance period?*

- Perinatal
- Total Joint Replacement (Hip and Knee)
- Screening and Surveillance Colonoscopy
- Outpatient and Non-Acute Inpatient Cholecystectomy
- Acute Percutaneous Coronary Intervention (PCI)
- Non-acute Percutaneous Coronary Intervention (PCI)

8. *What episodes are in a preview period?*

For 2018

- Upper GI Endoscopy (EGD)
- Bariatric Surgery
- CABG
- Valve Repair and Replacement

For 2019

- Hysterectomy
- Knee Arthroscopy

9. *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.

10. *How do Quarterbacks impact incentive payments?*

Quarterbacks that help members achieve high-quality, cost-effective health care outcomes for episodes of care will be financially rewarded.

11. *What is the requirement to be eligible for shared savings?*

Quarterbacks must have 40 or more episodes to be eligible for shared savings.

Reporting

1. *What is the purpose of quarterly reports?*

THCI episodes 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 episodes 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.

2. *Where are quarterly reports located?*

Principal Accountable Providers or quarterbacks can find quarterly reports online by logging in to our secure Availity® provider portal at [Availity.com](https://www.availity.com). If you haven't signed up for Availity®, please do so today. Simply go to [Availity.com](https://www.availity.com), where you can find complete enrollment information.

3. *What if I have questions about my reports?*

For questions about the provider reports, please call (423) 535-5717 and choose option 2.

4. What do the reports cover?

The reports show providers their average costs and how they compare to the commendable and acceptable levels.

5. Are the rendering physician and national provider identifier (NPI) details shown on the reports?

Yes, the rendering physician and NPI information is included on the excel file that is part of the quarterly reports.

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

Yes, members' dates of birth are provided on the excel file that is part of the quarterly reports.

7. What is the performance reporting timeline for episodes of care?

The reporting timeline is as follows*:



* Each episode of care reporting timeline includes a preview period, a 12 month performance period, and a pay-out period.

8. What are the report titles?

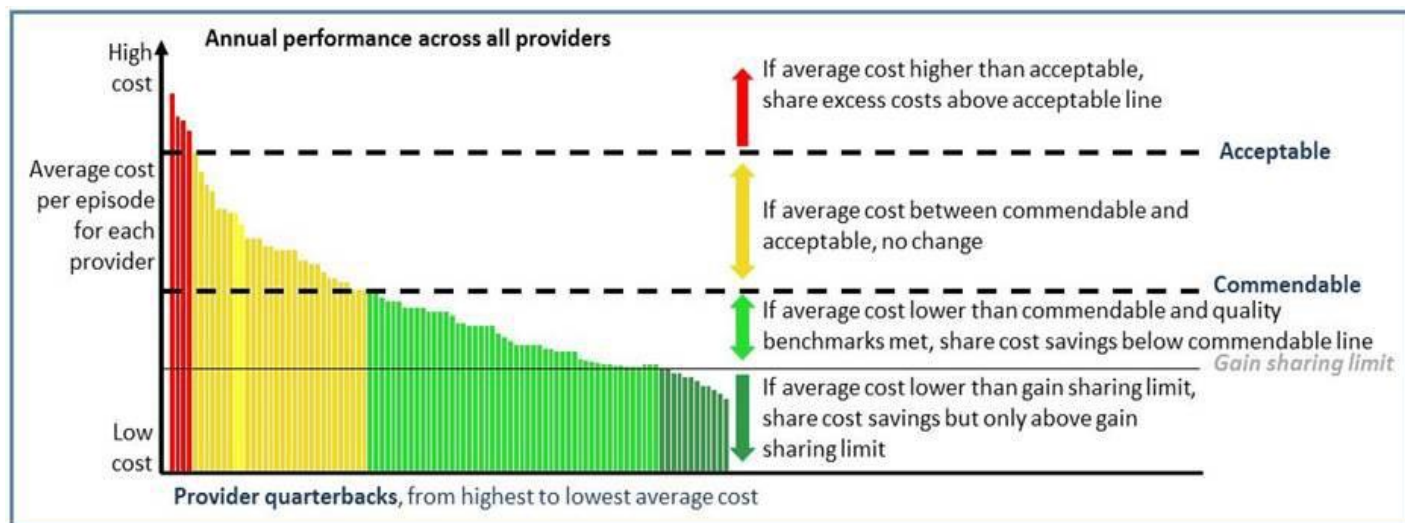
THCII report titles have changed to:

- **Preview without Thresholds** – Informational report without cost or quality thresholds.
- **Preview with Thresholds** – Informational report with cost and quality thresholds.
- **Interim Performance** – Interim performance report for contracted lines of business BlueNetwork S (SEHP and Fully Insured Only).
- **Final Performance** – Final performance report for contracted lines of business Blue Network S (SEHP and Fully Insured Only).

9. What are thresholds?

Two cost thresholds are established for each THCII episode of care:

1. a maximum allowable cost (informational only), and
2. a low allowable cost below which providers may earn gain sharing rewards.



- **Acceptable threshold:** The acceptable threshold is determined using the same methodology used for the THCI episodes of care program. This is set so that 10 percent of providers are above this threshold.
- **Commendable threshold:** The commendable threshold is set at a net zero level. If a provider is below this threshold, the provider earns a shared savings payment.
- **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.
- **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.

10. How often do thresholds change?

All thresholds are set before the performance year and do not change during the performance period. 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.

11. Who can answer questions on SEHP and Fully Insured Episodes of Care reports?

Call the Provider Service phone line at 1-800-924-7141 or contact your local Network Manager. If you do not know who your Network Manager is, visit <http://www.bcbst.com/providers/mycontact/> to locate your BlueCross contact.

12. How are reports aggregated?

SEHP and Fully Insured Reports are aggregated using a combination of the provider's contract ID and tax ID based on how a provider is contracted (i.e., individual, group, facility, health system, IPA, etc.).

13. What BlueCross products are impacted?

This only applies to Blue Network S providers – applicable **ONLY** to SEHP and Fully Insured members.

Contract ID

1. What is a Contract ID?

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

2. How are Contract IDs assigned?

Physician Contract IDs

- For an individually-contracted provider, the Contract ID reflects the individually-contracted practitioner provider number for the report.
- For a single group contract, the individual physicians under the group are each assigned a Group Provider number. The Group Provider number is 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 is linked under one assigned Contract ID number.

Facility Contract IDs

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

3. Why do we use both the Contract ID and Tax ID in combination to link multiple-contracted provider groups or facilities who share the same core agreement and Tax ID?

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. That, along with the Tax ID, assists in targeting the right providers and ensures none are missed.

4. *How does the Contract ID and Tax ID combination impact the Blue Network S SEHP and Fully Insured Episodes of Care program reporting?*

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.

5. *How does the Contract ID and Tax ID combination impact Blue Network S SEHP and Fully Insured Episodes of Care shared savings payments?*

Since our reporting is by Contract ID and Tax ID combination and the provider's episodes are aggregated based on this combination, we will pay out shared savings 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.

Shared Savings Payment

1. *How will the shared savings payment be administered to providers?*

Shared savings will be sent according to a provider's contract payment preferences. If you are signed up to receive your claims payments by electronic funds transfer (EFT), then your shared savings will be sent via EFT. If you receive your claims payments by check, then you will receive a check.