TennCare Quarterly Report

October – December 2017

Submitted to the Members of the General Assembly

Status of TennCare Reforms and Improvements

Demonstration Amendment 32: Medication Therapy Management. As noted in TennCare's last quarterly report to the General Assembly, the Division of TennCare has submitted a demonstration amendment to the Centers for Medicare and Medicaid Services (CMS) to establish a two-year pilot project of medication therapy management (MTM) services. MTM is a clinical service provided by licensed pharmacists, the aim of which is to optimize drug therapy and improve therapeutic outcomes for patients. Amendment 32 would make MTM available to TennCare members enrolled in the State's health home program, and to members whose primary care providers are participants in the State's patient-centered medical home program. The pilot project would implement legislation passed by the 110th General Assembly.

During the October-December 2017 quarter, TennCare and CMS continued negotiations concerning the approval of Amendment 32, which the State expects to receive soon. Additional information about the State's proposal may be found on the TennCare website at https://www.tn.gov/content/dam/tn/tenncare/documents2/ComprehensiveNotice.pdf.

Demonstration Amendment 33: Supplemental Payment Pools for Tennessee Hospitals. During the October-December 2017 quarter, TennCare held a public notice and comment period regarding another demonstration amendment to be submitted to CMS. Amendment 33 concerns the supplemental payments that TennCare makes to Tennessee hospitals to help offset the costs these facilities incur in providing uncompensated care. With Amendment 33, the State is requesting that CMS revisit changes imposed on the supplemental payment structure during the most recent renewal of the TennCare Demonstration in 2016.

Amendment 33 will consist of three components:

- Restoration of approximately $90 million to the maximum amount TennCare is authorized to pay to hospitals each year for uncompensated care costs;

- Continuation of the Meharry Medical College Pool—currently scheduled to end on June 30, 2018—for the duration of the TennCare Demonstration; and
- Extending the implementation period of a new hospital payment structure currently scheduled to take effect on July 1, 2018.

TennCare's public notice and comment period concerning Amendment 33 commenced on December 1, 2017. By the conclusion of the October-December 2017 quarter, one set of comments had been received. The commenter expressed support for the State's proposal, while also urging the State to strengthen support for children's hospitals by adding funds to TennCare's Essential Access Hospital Pool.

TennCare's notice and comment period regarding Amendment 33 was scheduled to expire after January 2, 2018. Further details concerning Amendment 33 are available online at https://www.tn.gov/content/dam/tn/tenncare/documents2/ComprehensiveNotice33.pdf.

Tennessee Eligibility Determination System. Tennessee Eligibility Determination System (or "TEDS") is the name of the system that will be used by the State to process applications and identify persons who are eligible for TennCare and CoverKids. Development of the system continued during the October-December 2017 quarter, with particular emphasis on systems integration test scripts, which will be used to verify that TEDS performs according to expectations. TennCare staff reviewed the scripts during the quarter to ensure accuracy and to identify any gaps that must be addressed for the scripts to function properly. In addition, Deloitte Consulting, LLP—one of TennCare's business partners in the TEDS project—began systems integration testing and is expected to complete this task by the end of March 2018. Implementation of the TEDS system is planned for late 2018.

Payment Reform. Tennessee's Health Care Innovation Initiative is changing the way TennCare and commercial insurance pays for health care by rewarding providers for high-quality and efficient treatment of medical conditions. Payment reform aims to maintain a member's health over time by aligning providers' and patients' incentives, creating provider accountability and incentivizing care coordination. TennCare's payment reform initiative has strategies in three key domains: Episodes of Care, Long-Term Services and Supports, and Primary Care Transformation. Notable developments for Episodes of Care and Long-Term Services and Supports occurred during the October-December 2017 quarter.

Episodes of Care focuses on acute or specialist-driven health care delivered during a specified time period to treat physical or behavioral conditions such as an acute diabetes exacerbation or attention deficit and hyperactivity disorder (ADHD). Each episode has a principal accountable provider (sometimes referred to as the "quarterback") who is in the best position to influence the cost and quality of the episode. Episodes of care are implemented in groups or—in the terminology of the program—"waves."

Each episode is designed with significant input from stakeholders such as Tennessee providers, payers, administrators, and employers. For each episode, the program organizes Technical Advisory Groups (TAGs) composed of experts in the field to provide clinical feedback on each episode's design. Three TAG groups—Hospitalist Medicine, General Surgery, and Gynecological Surgery—convened between September and November 2017 to design the program's eighth wave of episodes. The ten episodes designed in Wave 8 are Acute Gastroenteritis, Acute Seizure, Appendectomy, Bronchiolitis, Colposcopy, Gastrointestinal Obstruction, Hernia Repair, Hysterectomy, Pediatric Pneumonia, and Syncope. The State incorporated over 220 recommendations made by the TAG members into the episode designs for Wave 8. For example, the original "Pediatric Lower Respiratory Infection" episode was split into two separate episodes—Pediatric Pneumonia and Bronchiolitis—following recommendations by the TAG. All TAG recommendations concerning these episodes are summarized in the Appendix to this report.

In 2018, 29 episodes of care will be in a performance period, with design having been completed for a total of 53 episodes. Estimates indicate that the Episodes of Care program saved Tennessee over $25 million in health care costs in Calendar Years 2015 (when three episodes were in a performance period) and 2016 (when eight episodes were in a performance period).

Long-term services and supports comprises quality- and acuity-based payment and delivery system reform for Nursing Facility (NF) services and Home and Community Based Services (HCBS). During this quarter, TennCare published a notice of rulemaking hearing outlining a proposed new reimbursement methodology for NFs. The new payment approach will take into consideration the acuity of residents served in facilities, as well as facilities' performance relative to specified quality measures. As part of TennCare's ongoing commitment to transparency, before publishing the draft rule, TennCare sought broad stakeholder input, hearing directly from residents receiving NF services and their family members, as well as from staff of NFs participating in TennCare's Quality Improvement in Long-Term Services and Supports (QuILTSS) initiative. Each of the Medicaid NFs in the State and their Resident/Family Councils were invited to complete surveys to provide feedback regarding quality-related components of the new rule. Facility representatives also had the opportunity to discuss their experience with the QuILTSS initiative and ways in which the program could be improved, not only to aid the initiative's goal of improving quality of care and quality of life for NF residents, but also to minimize administrative burden on facilities. The rulemaking hearing for the proposed reimbursement methodology will take place in 2018.

Incentives for Providers to Use Electronic Health Records. The Electronic Health Records (EHR) Incentive Program is a partnership between federal and state governments that grew out of the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009. The purpose of the program is to provide financial incentives to Medicaid providers[1] to replace outdated, often paper-

[1] CMS allows two types of providers to participate in the Medicaid EHR Incentive Program: medical professionals (medical and osteopathic physicians, nurse practitioners, certified nurse midwives, dentists, and physician assistants who meet certain criteria) and hospitals (acute care hospitals, critical access hospitals, and children's hospitals).

based approaches to medical record-keeping with Certified Electronic Health Record Technology (as defined by CMS) that meets rigorous criteria and that can improve health care delivery and quality. The federal government provides 100 percent of the funding for the incentive payments and 90 percent of the funding for administrative costs. Tennessee's EHR program has issued payments for six program years to Medicaid providers meeting relevant eligibility requirements.

EHR payments made by TennCare during the October-December 2017 quarter as compared with payments made throughout the life of the program appear in the table below:

Payment Type	Number of Providers Paid During the Quarter	Quarterly Amount Paid (Oct-Dec 2017)	Cumulative Amount Paid to Date[2]
First-year payments	8	$170,000	$181,245,428
Second-year payments	15	$127,500	$57,517,400
Third-year payments	9	$643,050	$32,944,555
Fourth-year payments	3	$25,500	$5,408,844
Fifth-year payments	10	$82,167	$2,858,835
Sixth-year payments	3	$19,000	$843,500

Technical assistance activities, outreach efforts, and other EHR-related projects conducted by TennCare staff during the quarter included the following:

- Communicating with and assisting providers via emails, technical assistance calls, webinars, and onsite visits;
- Participation in the 69th Annual Scientific Assembly of the Tennessee Academy of Family Physicians in October 2017;
- Attendance in October and November 2017 at Tennessee Medical Association meetings in Chattanooga, Franklin, Jackson, Kingsport, Knoxville, and Memphis;
- Joining provider expos hosted by UnitedHealthcare in Knoxville and Nashville during October 2017;
- Participation throughout the quarter in several Southeast Regional Collaboration for HIT/HIE (SERCH) calls;
- Reconfiguration of TennCare's Provider Incentive Payment Program software to account for federally mandated changes related to "meaningful use" of EHR technology;
- Mailing of reminder notices to eligible professionals whose attestations were incomplete; and
- Newsletters and alerts distributed by TennCare's EHR ListServ.

Per CMS rules, provider enrollment ended on April 30, 2017, and Tennessee's EHR Incentive program continues through Program Year 2021 for providers who are currently enrolled. TennCare staff members continue to work with a variety of provider organizations to maintain the momentum of the

[2] Audits performed during the October-December 2017 quarter identified past payments to eligible hospitals to be recouped. The cumulative totals associated with first-year and second-year payments reflect these recoupments.

program. The focus of outreach efforts has shifted from new enrollments to providers who attested to EHR requirements only once or who have not attested in recent years.

Wilson v. Gordon. *Wilson v. Gordon* is a class action lawsuit filed against the Bureau of TennCare by the Tennessee Justice Center, the Southern Poverty Law Center, and the National Health Law Program. The suit, which is being heard by the U.S. District Court for the Middle District of Tennessee, alleges federal noncompliance in the Medicaid application and appeals process TennCare has been using since implementation of the Affordable Care Act.

Central to the *Wilson* suit is the issue of whether applications for TennCare coverage are being resolved in a proper and timely manner. In the fall of 2016, the State filed a Motion to Decertify the Class and Dismiss the Case. The basis of the motion was that processes used by TennCare and CMS for Medicaid applications and application appeals in Tennessee had evolved substantially. As a result of this evolution, the Motion contends, there are no remaining members in the Plaintiff class originally certified by the District Court, and any eligibility issues arising in 2016 are completely different from the issues that originally prompted the *Wilson* suit.

Oral argument and supplemental briefing on the State's Motion took place during the first half of Calendar Year 2017. On November 9, 2017, Plaintiffs and Defendants jointly requested that a pretrial conference scheduled for late November and a trial scheduled for December be postponed until the District Court rules on the Motion to Decertify the Class and Dismiss the Case. This request was granted on November 14, 2017. As of the conclusion of the October-December 2017 quarter, the District Court had not reached a decision on the State's Motion.

Public Forum on the TennCare Demonstration. In compliance with the federal regulation at 42 CFR § 431.420(c) and the Special Terms and Conditions of the TennCare Demonstration, the State hosted a public forum in Nashville on December 14, 2017. The purpose of the forum was to provide members of the public an opportunity to comment on the progress of the TennCare Demonstration project, which has delivered Medicaid services to eligible Tennesseans under a managed care model since 1994.

The December 14 open meeting was not the only avenue through which feedback could be offered. Notice of the forum, which appeared on the TennCare website, included an email address and a physical address at which comments would be accepted. TennCare is required to convene a forum on this subject each year for the foreseeable future.

In this year's forum, TennCare received one set of comments, concerning Employment and Community First CHOICES, the State's managed long-term services and supports program for individuals with intellectual and other types of developmental disabilities. Specifically, the comments acknowledge improvements that have been made to the program by the State, while also identifying areas of additional opportunity. These comments will be used to inform future program planning, and, as required by regulation, the State will furnish CMS a summary of the public forum and the comments received as a result of the forum process.

Essential Access Hospital (EAH) Payments. The Division of TennCare continued to make EAH payments during the October-December 2017 quarter. EAH payments are made from a pool of $100 million ($34,395,000 in State dollars) appropriated by the General Assembly and funded by the hospital assessment fee.

The methodology for distributing these funds, as outlined in Special Term and Condition 53.a. of the TennCare Demonstration Agreement with CMS, specifically considers each hospital's relative contribution to providing services to TennCare members, while also acknowledging differences in payer mix and hospitals' relative ability to make up TennCare losses. Data from the Hospital Joint Annual Report is used to determine hospitals' eligibility for these payments. Eligibility is determined each quarter based on each hospital's participation in TennCare. In order to receive a payment for the quarter, a hospital must be a contracted provider with TennCare Select and at least one other Managed Care Organization (MCO), and it must have contracted with TennCare Select for the entire quarter that the payment represents. Excluded from the Essential Access Hospital payments are Critical Access Hospitals, which receive cost-based reimbursement from the TennCare program and, therefore, are not included, and the four State mental health institutes.

The Essential Access Hospital payments made during the second quarter of State Fiscal Year 2018 (for dates of service during the first quarter) are shown in the table below.

Essential Access Hospital Payments for the Quarter

Hospital Name	County	EAH Second Quarter FY 2018
Vanderbilt University Hospital	Davidson County	$3,652,292
Regional One Health	Shelby County	$3,216,140
Erlanger Medical Center	Hamilton County	$2,258,399
University of Tennessee Memorial Hospital	Knox County	$1,666,652
Johnson City Medical Center (with Woodridge)	Washington County	$1,151,981
Parkridge Medical Center (with Parkridge Valley)	Hamilton County	$864,997
LeBonheur Children's Medical Center	Shelby County	$770,710
Metro Nashville General Hospital	Davidson County	$554,536
Jackson – Madison County General Hospital	Madison County	$525,180
East Tennessee Children's Hospital	Knox County	$479,290
TriStar Skyline Medical Center (with Madison Campus)	Davidson County	$473,961
Saint Jude Children's Research Hospital	Shelby County	$409,472
Methodist Healthcare – Memphis Hospitals	Shelby County	$408,893
TriStar Centennial Medical Center	Davidson County	$367,639
Parkridge East Hospital	Hamilton County	$357,795
Methodist Healthcare – South	Shelby County	$345,033
Delta Medical Center	Shelby County	$306,238
Parkwest Medical Center (with Peninsula)	Knox County	$286,797

Hospital Name	County	EAH Second Quarter FY 2018
Baptist Memorial Hospital for Women	Shelby County	$266,102
Saint Thomas Midtown Hospital	Davidson County	$257,058
Methodist Healthcare – North	Shelby County	$251,979
Saint Francis Hospital	Shelby County	$231,026
University Medical Center (with McFarland)	Wilson County	$226,838
Saint Thomas Rutherford Hospital	Rutherford County	$210,289
Baptist Memorial Hospital – Memphis	Shelby County	$197,002
Fort Sanders Regional Medical Center	Knox County	$193,449
Wellmont – Holston Valley Medical Center	Sullivan County	$186,927
Erlanger North Hospital	Hamilton County	$185,902
Pathways of Tennessee	Madison County	$185,668
Ridgeview Psychiatric Hospital and Center	Anderson County	$180,838
Maury Regional Hospital	Maury County	$168,830
TriStar StoneCrest Medical Center	Rutherford County	$158,600
Methodist Le Bonheur Germantown Hospital	Shelby County	$157,629
TriStar Horizon Medical Center	Dickson County	$151,915
Tennova Healthcare	Knox County	$149,111
Wellmont – Bristol Regional Medical Center	Sullivan County	$140,210
TriStar Summit Medical Center	Davidson County	$138,487
Cookeville Regional Medical Center	Putnam County	$136,499
Rolling Hills Hospital	Williamson County	$133,494
Blount Memorial Hospital	Blount County	$130,221
Gateway Medical Center	Montgomery County	$125,027
TriStar Southern Hills Medical Center	Davidson County	$122,543
Dyersburg Regional Medical Center	Dyer County	$112,776
Lincoln Medical Center	Lincoln County	$110,047
Morristown – Hamblen Healthcare System	Hamblen County	$106,829
Skyridge Medical Center	Bradley County	$105,970
LeConte Medical Center	Sevier County	$96,650
Sumner Regional Medical Center	Sumner County	$95,962
Methodist Medical Center of Oak Ridge	Anderson County	$87,506
Takoma Regional Hospital	Greene County	$84,687
TriStar Hendersonville Medical Center	Sumner County	$82,775
Tennova Healthcare – Newport Medical Center	Cocke County	$78,212
Saint Francis Hospital – Bartlett	Shelby County	$75,410
Jellico Community Hospital	Campbell County	$70,720
Tennova Healthcare – Harton Regional Medical Center	Coffee County	$69,339
Indian Path Medical Center	Sullivan County	$68,505
Starr Regional Medical Center – Athens	McMinn County	$67,485
Tennova Healthcare – LaFollette Medical Center	Campbell County	$63,631
NorthCrest Medical Center	Robertson County	$61,899
Parkridge West Hospital	Marion County	$60,869
Henry County Medical Center	Henry County	$58,304

Hospital Name	County	EAH Second Quarter FY 2018
Southern Tennessee Regional Health System – Winchester	Franklin County	$53,465
Regional Hospital of Jackson	Madison County	$52,727
Wellmont Hawkins County Memorial Hospital	Hawkins County	$52,520
Roane Medical Center	Roane County	$46,046
Sycamore Shoals Hospital	Carter County	$45,530
Saint Thomas River Park Hospital	Warren County	$43,101
Southern Tennessee Regional Health System – Lawrenceburg	Lawrence County	$41,834
Heritage Medical Center	Bedford County	$40,545
Skyridge Medical Center – Westside	Bradley County	$39,467
Hardin Medical Center	Hardin County	$38,710
Bolivar General Hospital	Hardeman County	$37,424
Baptist Memorial Hospital – Union City	Obion County	$36,063
Erlanger Health System – East Campus	Hamilton County	$35,990
McKenzie Regional Hospital	Carroll County	$35,895
Lakeway Regional Hospital	Hamblen County	$35,793
Hillside Hospital	Giles County	$34,780
Starr Regional Medical Center – Etowah	McMinn County	$34,149
Livingston Regional Hospital	Overton County	$34,074
TrustPoint Hospital	Rutherford County	$30,931
United Regional Medical Center	Coffee County	$28,494
Tennova Healthcare – Jefferson Memorial Hospital	Jefferson County	$28,380
Volunteer Community Hospital	Weakley County	$28,026
Claiborne County Hospital	Claiborne County	$27,770
Saint Thomas DeKalb Hospital	DeKalb County	$23,856
Saint Thomas Stones River Hospital	Cannon County	$23,237
Henderson County Community Hospital	Henderson County	$23,155
Jamestown Regional Medical Center	Fentress County	$21,823
Milan General Hospital	Gibson County	$21,013
Wayne Medical Center	Wayne County	$17,854
Decatur County General Hospital	Decatur County	$13,709
Kindred Hospital – Chattanooga	Hamilton County	$12,854
Southern Tennessee Regional Health System – Sewanee	Franklin County	$11,391
Houston County Community Hospital	Houston County	$10,169
TOTAL		**$25,000,000**

Number of Recipients on TennCare and Costs to the State

During the month of December 2017, there were 1,452,145 Medicaid eligibles and 13,932 Demonstration eligibles enrolled in TennCare, for a total of 1,466,077 persons.

Estimates of TennCare spending for the second quarter of State Fiscal Year 2018 are summarized in the table below.

Spending Category	Second Quarter FY 2018*
MCO services**	$1,493,503,300
Dental services	$41,110,200
Pharmacy services	$289,651,400
Medicare "clawback"***	$56,535,900

**These figures are cash basis as of December 31 and are unaudited.*

***This figure includes Integrated Managed Care MCO expenditures.*

****The Medicare Part D clawback is money that states are required to pay to the federal government to help offset costs the federal government incurs by covering the prescription benefit for enrollees who have both Medicare and Medicaid.*

Viability of Managed Care Contractors (MCCs) in the TennCare Program

Claims payment analysis. TennCare's prompt pay requirements may be summarized as shown below.

Entity	Standard	Authority
MCOs (services other than CHOICES and ECF CHOICES)	90% of clean claims for payment for services delivered to TennCare enrollees are processed and, if appropriate, paid within 30 calendar days of the receipt of such claims. 99.5% of all provider claims are processed, and, if appropriate, paid within 60 calendar days of receipt.	TennCare contract and in accordance with T.C.A. § 56-32-126(b)
MCOs (CHOICES and ECF CHOICES services)	90% of clean electronically submitted Nursing Facility and applicable Home and Community Based Services claims[3] are processed and paid within 14 calendar days of receipt. 99.5% of clean electronically submitted Nursing Facility and applicable Home and Community Based Services claims[4] are processed and paid within 21 calendar days of receipt.	TennCare contract

[3] Excludes Personal Emergency Response Systems (PERS), assistive technology, minor home modifications, and pest control claims. Claims for delivery of these services are handled like general MCO claims.

[4] Ibid.

Entity	Standard	Authority
Dental Benefits Manager (DBM)	90% of clean claims for payment for services delivered to TennCare enrollees are processed, and, if appropriate, paid within 30 calendar days of the receipt of such claims. 99.5% of all provider claims are processed, and, if appropriate, paid within 60 calendar days of receipt.	TennCare contract and in accordance with T.C.A. § 56-32-126(b)
Pharmacy Benefits Manager (PBM)	100% of all clean claims submitted by pharmacy providers are paid within 10 calendar days of receipt.	TennCare contract

The MCOs, the DBM, and the PBM are required to submit monthly claims data files of all TennCare claims processed to the Tennessee Department of Commerce and Insurance (TDCI) for verification of statutory and contractual prompt pay compliance. The plans are required to separate their claims data by claims processor (e.g., MCO, vision benefits manager, etc.). Furthermore, the MCOs are required to identify separately non-emergency transportation (NEMT) claims in the data files. Finally, the MCOs are required to submit separate claims data files representing a subset of electronically submitted Nursing Facility and applicable Home and Community Based Services claims for CHOICES and ECF CHOICES enrollees. TDCI then performs an analysis and reports the results of the prompt pay analyses by NEMT and CHOICES and ECF CHOICES claim types, by claims processor, and by total claims processed for the month.

If an MCO does not comply with the prompt pay requirements based on the total claims processed in a month, TDCI has the statutory authority to levy an administrative penalty of $10,000 for each month of non-compliance after the first instance of non-compliance was reported to the plan. The Division of TennCare may also assess liquidated damages pursuant to the terms of the TennCare Contract. If the DBM and PBM do not meet their contractual prompt pay requirements, only TennCare may assess applicable liquidated damages against these entities.

Net worth and company action level requirements. According to Tennessee's "Health Maintenance Organization Act of 1986" statute (T.C.A. § 56-32-101 *et seq.*), the minimum net worth requirement for each TennCare MCO is calculated based on premium revenue reported on the National Association of Insurance Commissioners (NAIC) Annual Financial Statement for the most recent calendar year, as well as any TennCare payments made to the MCO that are not reported as premium revenue.

During the October-December 2017 quarter, the MCOs submitted their NAIC Third Quarter 2017 Financial Statements. As of September 30, 2017, TennCare MCOs reported net worth as indicated in the table below.[5]

[5] The "Net Worth Requirement" and "Reported Net Worth" figures in the table are based on the MCOs' company-wide operations, not merely their TennCare operations.

MCO	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$33,420,759	$195,394,728	$161,973,969
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$57,158,856	$445,991,794	$388,832,938
Volunteer State Health Plan (BlueCare & TennCare Select)	$46,879,872	$458,687,006	$411,807,134

During the October-December 2017 quarter, the MCOs were also required to comply with Tennessee's "Risk-Based Capital for Health Organizations" statute (T.C.A. § 56-46-201 *et seq.*). Risk-based capital (RBC) involves a method of calculating the minimum amount of capital necessary for a health entity to support its overall business operations depending on its size and risk profile. A health entity with a higher amount of risk is required to hold a higher amount of capital. The RBC statute gives TDCI the authority and mandate to use preventive and corrective measures that vary depending on the amount of capital deficiency indicated by the RBC calculations. A "Company Action Level" deficiency (defined at T.C.A. § 56-46-203(a)) would require the submission of a plan to correct the entity's capital deficiency.

The following table compares the MCOs' net worth to the Company Action Level requirements as of September 30, 2017:

MCO	Company Action Level	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$122,877,816	$195,394,728	$72,516,912
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$205,480,268	$445,991,794	$240,511,526
Volunteer State Health Plan (BlueCare & TennCare Select)	$148,059,416	$458,687,006	$310,627,590

All TennCare MCOs met their minimum net worth requirements and Company Action Level requirements as of September 30, 2017.

Success of Fraud Detection and Prevention

The mission of the Tennessee Office of Inspector General (OIG) is to identify, investigate, prosecute, and arrest persons who commit fraud or abuse against the TennCare program and to recoup money owed to the State of Tennessee. The OIG receives case information from a variety of sources, including local law enforcement, the Division of TennCare, Health Related Boards, the Department of Human Services (DHS), other State agencies, health care providers, MCCs, and the general public via the OIG website, fax, written correspondence, and phone calls to the OIG hotline. Cases adjudicated during a particular fiscal year may have no relationship to dates of arrest during the same year. Selected statistics for the second quarter of Fiscal Year 2018 are as follows:

Fraud and Abuse Complaints	Second Quarter FY 2018
Fraud Allegations	1,030
Abuse Allegations*	599
Arrest/Conviction/Judicial Diversion Totals	**Second Quarter FY 2018**
Arrests	30
Convictions	16
Judicial Diversions	5

***** *Abuse cases may be referred to the appropriate Managed Care Contractor (MCC), the Division of TennCare, or DHS for further review/action.*

Criminal Court Fines and Costs Imposed	Second Quarter FY 2018
Court Costs & Taxes	$4,334
Fines	$4,100
Drug Funds/Forfeitures	$208
Criminal Restitution Ordered	$106,071
Criminal Restitution Received[6]	$37,600
Civil Restitution/Civil Court Judgments	**Second Quarter FY 2018**
Civil Restitution Ordered[7]	$5,861
Civil Restitution Received[8]	$4,770

Recommendations for Review	Second Quarter FY 2018
Recommended TennCare Terminations[9]	81
Potential Savings[10]	$296,168

[6] Restitution may have been ordered in a fiscal year other than the one in which payment was actually received.

[7] This total reflects dollars identified for recoupment by the OIG in such non-criminal contexts as civil cases, administrative hearings, and voluntary reimbursements to TennCare.

[8] Restitution may have been agreed to in a fiscal year other than the one in which payment was actually received.

[9] Recommendations that enrollees' TennCare coverage should be terminated are sent to the Division of TennCare for review and determination of appropriate action. These recommendations are based on information received and reviewed by the OIG. TennCare determines whether these referrals meet the criteria for termination. Reviews of these recommendations must factor in some limitations, such as the inability to disenroll individuals in certain federally protected categories.

[10] Potential savings are determined by multiplying the number of enrollees whose coverage would be terminated, assuming all of the State's criteria for termination are met, by the average annual cost per enrollee for MCO, pharmacy, and dental services (currently estimated by TennCare to be $3,656.39).

Statewide Communication

In an effort to stay connected with local law enforcement and achieve the OIG's mission, Special Agents continue to meet in person with sheriffs and police chiefs throughout the state. These meetings further collaborative relationships and aid the mutual goal of stopping TennCare fraud and prescription drug diversion.

Appendix

TAG Recommendations for Wave 8 Episodes of Care

Acute Gastroenteritis episode design summary

Identifying episode triggers

An Acute Gastroenteritis episode is triggered by an inpatient or emergency department (ED) claim that has a defined diagnosis code for acute gastroenteritis or related diagnoses or combination of diagnoses of signs and symptoms of acute gastroenteritis (e.g., abdominal pain, vomiting).

Attributing episodes to quarterbacks

The quarterback is the facility that diagnoses the acute gastroenteritis or related diagnoses; the contracting entity ID or Tax ID number of the facility on the professional claim will be used to identify the quarterback.

Identifying services to include in episode spend

The Acute Gastroenteritis episode begins on the day when the patient was diagnosed with acute gastroenteritis or related diagnoses (trigger window) and ends 30 days following discharge from the facility where the acute gastroenteritis was diagnosed (post-trigger window). Services included in the episode spend during the day when the acute gastroenteritis was diagnosed or for the duration of admission (trigger window) are all professional and facility medical services. Services included in the episode spend on the day when the patient is discharged and up to 30 days following discharge from the facility where the acute gastroenteritis was diagnosed (post-trigger window) include relevant care, evaluation, and management with relevant diagnoses, relevant complications, relevant imaging and testing, relevant procedures, and relevant medications.

Excluding episodes

There are three types of exclusions. Business exclusions: available information is not comparable or is incomplete (e.g., third party liability, non-continuous eligibility, left against medical advice). Clinical exclusions: patient's care pathway is different for clinical reasons, such as age (≤6 months or >64 years), episodes with active cancer management, genetic immune disorders, inflammatory bowel disease (IBD), short bowel syndrome. High-cost outlier exclusions: episode's risk-adjusted spend is three standard deviations above the mean.

Determining quality metrics performance

The quality metrics tied to gain sharing are: percentage of valid episodes for patients aged older than 17 with abdominal or pelvic computed tomography (CT) imaging or magnetic resonance imaging (MRI) during the episode window; percentage of valid episodes for patients aged 17 or less than 17 with abdominal or pelvic CT or MRI imaging during the episode window; percentage of valid episodes without documented bacterial infection and with antibiotic prescriptions during the episode window.

Quality metrics not tied to gain sharing are: percentage of valid episodes for patients aged older than 17 in which stool culture was performed during the episode window; percentage of valid episodes with a related admission during the post-trigger window; percentage of valid episodes with a related ED visit during the post-trigger window; percentage of valid episodes with complications during the post-trigger window; difference in average morphine equivalent dose (MED)/day between opioid prescriptions during the post-trigger window and 1 to 30 days before the trigger; average MED/day for opioid prescriptions for 1 to 30 days before the trigger; average MED/day for opioid prescriptions during the post-trigger window.

Acute Seizure episode design summary

Identifying episode triggers
An Acute Seizure episode is triggered by an inpatient or emergency department (ED) claim where either the primary diagnosis code is one of the defined trigger codes for epilepsy or convulsions, or the primary diagnosis is of an etiology or complication of seizure (e.g., head injury, neurocognitive disturbances, endocrine or metabolic disorders, substance abuse) contingent on a secondary diagnosis of epilepsy or convulsions.

Attributing episodes to quarterbacks
The quarterback is the facility that diagnoses the acute seizure; the contracting entity ID or Tax ID number of the facility on the professional claim will be used to identify the quarterback.

Identifying services to include in episode spend
The Acute Seizure episode begins on the day when the acute seizure was diagnosed (trigger window) and ends 30 days following discharge from the facility where the acute seizure was diagnosed (post-trigger window). Services included in the episode spend during the day when the acute seizure was diagnosed or for the duration of admission (trigger window) are all professional and facility medical services. Services included in the episode spend on the day when the patient is discharged and up to 30 days following discharge from the facility where acute seizure was diagnosed (post-trigger window) are relevant care, evaluation and management with relevant diagnoses, relevant complications, relevant imaging and testing, relevant procedures, and relevant medications.

Excluding episodes
There are three types of exclusions. Business exclusions: available information is not comparable or is incomplete (e.g., third party liability, non-continuous eligibility, left against medical advice). Clinical exclusions: patient's care pathway is different for clinical reasons, such as age (<1 year or >64 years), patients with active cancer treatment, patients who receive a craniotomy. High-cost outlier exclusions: episode's risk-adjusted spend is three standard deviations above the mean.

Determining quality metrics performance
The quality metrics tied to gain sharing are: percentage of valid episodes with focal epilepsy in which brain MRI imaging was conducted during the episode window; percentage of valid episodes with a newly diagnosed seizure in which electroencephalography (EEG) monitoring of 1 hour or more was conducted during the episode window.

Quality metrics not tied to gain sharing are: percentage of valid episodes with newly diagnosed seizure where brain MRI imaging was conducted during the episode window; percentage of valid episodes for patients 17 years or younger where brain MRI imaging was conducted during the episode window; percentage of valid episodes for patients older than 17 years where head CT was conducted during the episode window; percentage of valid episodes with a newly diagnosed seizure in which the patient received safety counseling during the episode window; percentage of valid episodes with a related ED visit during the post-trigger window; percentage of valid episodes with a related admission during the post-trigger window; percentage of valid episodes with a related follow-up visit during the post-trigger window.

Appendectomy episode design summary

Identifying episode triggers
An Appendectomy episode is triggered by a professional claim that has one of the defined procedure codes for appendectomy and a corresponding inpatient or outpatient facility claim with a relevant diagnosis.

Attributing episodes to quarterbacks
The quarterback is the physician or physician group that performed the appendectomy; the contracting entity ID or Tax ID number of the physician (or group) on the professional claim will be used to identify the quarterback.

Identifying services to include in episode spend
The Appendectomy episode begins on the day when the appendectomy procedure is performed (trigger window) and ends 30 days following discharge from the facility where the appendectomy was performed (post-trigger window). During the trigger window, all professional and facility medical services on the day when the appendectomy procedure is performed or for the duration of admission are included in spend. For the post-trigger window, specific care and evaluation and management services for relevant diagnoses including complications, relevant imaging and testing, relevant procedures, and relevant medications during the 30 days following discharge from the facility where the appendectomy was performed are included in episode spend.

Excluding episodes
There are three types of exclusions. Business exclusions: available information is not comparable or is incomplete (e.g., third party liability, non-continuous eligibility, left against

medical advice). Clinical exclusions: patient's care pathway is different for clinical reasons, such as age (<2 years or >64 years), open appendectomy for ruptured appendix, laparoscopic appendectomies with a 22 modifier and diagnosis of acute appendicitis with generalized peritonitis, end-stage renal disease (ERSD). High-cost outlier exclusions: episode's risk-adjusted spend is three standard deviations above the mean.

Determining quality metrics performance

Quality metrics tied to gain sharing are: percentage of valid episodes for members <18 years that have abdominopelvic CT scans as the only imaging modality in the trigger window; difference in average MED/day between opioid prescriptions for 7 to 30 days after discharge and 1 to 60 days before the trigger.

Quality metrics not tied to gain sharing are: percentage of valid episodes that are negative appendectomies; percentage of valid episodes with complications during the post-trigger window; percentage of valid episodes with a related admission during the post-trigger window; percentage of valid episodes with a related ED visit during the post-trigger window; average MED/day for opioid prescriptions for 1 to 60 days before the trigger; average MED/day for opioid prescriptions for 7 to 30 days after discharge; percentage of valid episodes with opioid and benzodiazepine prescriptions during the episode window.

<u>Bronchiolitis episode design summary</u>

Identifying episode triggers

A Bronchiolitis episode is triggered by an inpatient or emergency department (ED) claim where either the primary diagnoses is one of the defined codes for bronchiolitis, or the primary diagnosis is one of the signs and symptoms (e.g, cough) contingent on a secondary diagnosis of bronchiolitis.

Attributing episodes to quarterbacks

The quarterback is the facility that diagnoses the bronchiolitis; the contracting entity ID or Tax ID number of the facility on the professional claim will be used to identify the quarterback.

Identifying services to include in episode spend

The Bronchiolitis episode begins on the day when the patient is diagnosed with bronchiolitis (trigger window) and ends 7 days after discharge from the facility where the bronchiolitis was diagnosed (post-trigger window). Services included in the episode spend during the day when the bronchiolitis was diagnosed or for the duration of admission (trigger window) are all professional and facility medical services. Services included in the episode spend on the day when the patient is discharged and up to 7 days following discharge from the facility where the bronchiolitis was diagnosed (post-trigger window) are relevant care, evaluation, and management with relevant diagnoses, relevant

complications, relevant imaging and testing, relevant procedures, and relevant medications.

Excluding episodes

There are three types of exclusions. Business exclusions: available information is not comparable or is incomplete (e.g., third party liability, non-continuous eligibility, left against medical advice). Clinical exclusions: patient's care pathway is different for clinical reasons, such as age (<7 months or >17 years), active cancer management, acute respiratory distress syndrome, bronchiectasis, bronchiolitis obliterans, chronic obstructive pulmonary disease (COPD), congenital heart disease, cystic fibrosis, empyema, end stage renal disease (ERSD), excluded infections, extracorporeal membrane oxygenation (ECMO), history of < 34 weeks gestational age, idiopathic hemosiderosis, immotile cilia syndrome, immunodeficiency, interstitial pulmonary diseases, neuromuscular disease, pulmonary hemorrhage, pulmonary vascular disease, severe sepsis, or septic shock.

Determining quality metrics performance

The quality metrics tied to gain sharing are: related admission during the post-trigger window; utilization of bronchodilators; utilization of steroids.

Quality metrics not tied to gain sharing are: utilization of antibiotics; admission during the trigger window; utilization of chest physical therapy (PT); utilization of blood or sputum cultures; utilization of respiratory viral testing; utilization of chest x-ray.

<u>Colposcopy episode design summary</u>

Identifying episode triggers

A Colposcopy episode is triggered by a professional claim that has one of the defined procedure codes for colposcopy performed in an outpatient or office setting.

Attributing episodes to quarterbacks

The quarterback is the physician or physician group that performed the colposcopy; the contracting entity ID or Tax ID number of the physician (or group) on the professional claim will be used to identify the quarterback.

Identifying services to include in episode spend

The Colposcopy episode begins the day when the colposcopy procedure was performed (trigger window) and ends 90 days following the colposcopy (post-trigger window). Specific professional and facility medical services and medications relevant to the triggering colposcopy including imaging and testing, concurrent procedures (e.g., loop electrosurgical excision procedure or "LEEP") are included in episode spend from the day when the colposcopy procedure is performed (trigger window). Specific care and evaluation and management services for relevant diagnoses and management of low-grade lesions including complications, imaging and testing, additional procedures (e.g., conizations), and

medications are included in episode spend during the 90 days following the colposcopy (post-trigger window).

Excluding episodes

There are three types of exclusions. Business exclusions: available information is not comparable or is incomplete (e.g., third party liability, non-continuous eligibility, left against medical advice). Clinical exclusions: patient's care pathway is different for clinical reasons, such as age (<0 years and >12 years), cervical cancer, hysterectomy, pregnancy. High-cost outlier exclusions: episode's risk-adjusted spend is three standard deviations above the mean.

Determining quality metrics performance

The quality metrics tied to gain sharing are: percentage of valid episodes with a LEEP or conization where the patient had a diagnosis of low-grade dysplasia (CIN1 or lower, or no dysplasia coded); percentage of valid episodes in patients <26 years of age with a LEEP or conization during the episode.

Quality metrics not tied to gain sharing are: percentage of valid episodes with a cervical cancer screening within 90 days prior to the triggering colposcopy; percentage of valid episodes with a diagnostic colposcopy in the post-trigger window; percentage of valid episodes with a LEEP or conization during the episode window; percentage of valid episodes with a LEEP or conization during the trigger window; difference in average MED/day between opioid prescriptions during the episode window and for 1 to 60 days before the trigger window; average MED/day for opioid prescriptions for 1 to 60 days before the trigger; average MED/day for opioid prescriptions during the episode window; percentage of valid episodes with opioid and benzodiazepine prescriptions during the episode window.

<u>Gastrointestinal (GI) Obstruction episode design summary</u>

Identifying episode triggers

A GI Obstruction episode is triggered by an inpatient or emergency department (ED) claim where either the primary diagnosis is one of the defined GI obstruction trigger codes, or the primary diagnosis is one of the defined symptoms or potential etiologies contingent on a secondary diagnosis from the defined GI obstruction trigger codes.

Attributing episodes to quarterbacks

The quarterback is the facility that diagnoses the GI obstruction; the contracting entity ID or Tax ID number of the facility on the professional claim will be used to identify the quarterback.

Identifying services to include in episode spend

The GI Obstruction episode begins on the day when the GI obstruction was diagnosed (trigger window) and ends 30 days following discharge from the facility where the GI obstruction was treated (post-trigger window). Services to include in the episode spend during the day when the GI obstruction was diagnosed or for the duration of admission (trigger window) are all professional and facility medical services. Services to include in the episode spend on the day when the patient is discharged and up to 30 days following discharge from the facility where GI obstruction was treated (post-trigger window) are relevant care, evaluation, and management with relevant diagnoses, relevant complications, relevant imaging and testing, relevant procedures, and relevant medications.

Excluding episodes

There are three types of exclusions. Business exclusions: available information is not comparable or is incomplete (e.g., third party liability, non-continuous eligibility, left against medical advice). Clinical exclusions: patient's care pathway is different for clinical reasons, such as age (<1 year or >64 years), end-stage renal disease (ERSD). High-cost outlier exclusions: episode's risk-adjusted spend is three standard deviations above the mean.

Determining quality metrics performance

Quality metrics tied to gain sharing are: percentage of valid episodes with related follow-up care during the post-trigger window; difference in average MED/day between opioid prescriptions for 7 to 30 days after discharge and 1 to 60 days before the trigger.

Quality metrics not tied to gain sharing are: percentage of valid episodes with surgical treatment during the trigger window; percentage of valid episodes with an inflammatory bowel disorder that have two or more abdominopelvic CT scans during the trigger window; percentage of valid episodes with an inflammatory bowel disorder that have abdominopelvic MRI scans as the only imaging modality during the trigger window; percentage of valid episodes with complications during the post-trigger window; percentage of valid episodes with a related admission during the post-trigger window; percentage of valid episodes with a related ED visit during the post-trigger window; average MED/day for opioid prescriptions for 1 to 60 days before the trigger; average MED/day for opioid prescriptions for 7 to 30 days after discharge; percentage of valid episodes with opioid and benzodiazepine prescriptions during the episode window.

<u>Hernia Repair episode design summary</u>

Identifying episode triggers

A Hernia Repair episode is triggered by a professional claim that has one of the defined procedure codes for abdominal wall or groin (inguinal and femoral) hernia repair and a corresponding inpatient or outpatient facility claim with a relevant diagnosis.

Attributing episodes to quarterbacks

The quarterback is the physician or physician group that performed the hernia repair; the contracting entity ID or Tax ID number of the physician (or group) on the professional claim will be used to identify the quarterback.

Identifying services to include in episode spend

The Hernia Repair episode begins 30 days prior to the hernia repair (pre-trigger window) and ends 30 days following discharge from the facility where the hernia repair was performed (post-trigger window). During the pre-trigger window (30 days prior to the hernia repair), specific care and evaluation and management services for relevant diagnoses, imaging and testing, procedures, and medications are included in episode spend. All professional and facility medical services on the day when the hernia repair procedure is performed or for the duration of admission (trigger window) are included in spend. During the 30 days following discharge (post-trigger window), specific care and evaluation and management services for relevant diagnoses including complications, relevant imaging and testing, relevant procedures, and relevant medications are included in episode spend.

Excluding episodes

There are three types of exclusions. Business exclusions: available information is not comparable or is incomplete (e.g., third party liability, non-continuous eligibility, left against medical advice). Clinical exclusions: patient's care pathway is different for clinical reasons, such as age (<6 months or >64 years), gangrenous hernia, bowel vascular insufficiency, bowel resection, end-stage renal disease (ERSD). High-cost outlier exclusions: episode's risk-adjusted spend is three standard deviations above the mean.

Determining quality metrics performance

The quality metric tied to gain sharing is: difference in average MED/day between opioid prescriptions for 7 to 30 days after discharge and 1 to 60 days before the trigger.

Quality metrics not tied to gain sharing are: percentage of valid episodes with an open incisional or ventral hernia repair that involve mesh implantation during the trigger window; percentage of valid episodes with complications during the post-trigger window; percentage of valid episodes with a related admission during the post-trigger window; percentage of valid episodes with a related ED visit for pain during the post-trigger window; percentage of valid episodes with a related ED visit for a reason other than pain during the post-trigger window; percentage of valid episodes with related follow-up care during the post-trigger window; average MED/day for opioid prescriptions for 1 to 60 days before the trigger; average MED/day for opioid prescriptions for 7 to 30 days after discharge; percentage of valid episodes with opioid and benzodiazepine prescriptions during the trigger or post-trigger windows.

Hysterectomy episode design summary

Identifying episode triggers

A Hysterectomy episode is triggered by a professional claim that has one of the defined procedure codes for hysterectomy and a corresponding inpatient or outpatient facility claim with a relevant diagnosis.

Attributing episodes to quarterbacks

The quarterback is the physician or physician group that performed the hysterectomy; the contracting entity ID or Tax ID number of the physician (or group) on the professional claim will be used to identify the quarterback.

Identifying services to include in episode spend

The Hysterectomy episode begins 30 days prior to the hysterectomy (pre-trigger window) and ends 30 days following discharge from the facility where the hysterectomy was performed (post-trigger window). During the pre-trigger window (30 days prior to the hysterectomy), specific care and evaluation and management services for relevant diagnoses, imaging and testing, relevant procedures, and relevant medications are included in episode spend. All professional and facility medical services on the day when the hysterectomy procedure is performed or for the duration of admission (trigger window) are included in spend. During the 30 days following (post-trigger window), specific care and evaluation and management services for relevant diagnoses including complications, relevant imaging and testing, relevant procedures, and relevant medications are included in episode spend.

Excluding episodes

There are three types of exclusions. Business exclusions: available information is not comparable or is incomplete (e.g., third party liability, non-continuous eligibility, left against medical advice). Clinical exclusions: patient's care pathway is different for clinical reasons, such as active gynecologic cancer. High-cost outlier exclusions: episode's risk-adjusted spend is three standard deviations above the mean.

Determining quality metrics performance

The quality metrics tied to gain sharing are: percentage of valid episodes with alternative treatments up to 180 days prior to hysterectomy; percentage of valid episodes with related follow-up care within 42 days after discharge.

Quality metrics not tied to gain sharing are: percentage of valid episodes with an abdominal hysterectomy during the trigger window; average length of stay during triggering procedure for inpatient-triggered valid episodes; percentage of valid episodes with a complication during the trigger or post-trigger window; percentage of valid episodes with a related ED visit during the post-trigger window; difference in average MED/day between opioid prescriptions for 31 to 60 days after discharge and 1 to 60 days before the

trigger; average MED/day for opioid prescriptions for 1 to 60 days before the trigger; average MED/day for opioid prescriptions for 31 to 60 days after discharge; percentage of valid episodes with opioid and benzodiazepine prescriptions during the trigger or post-trigger windows.

Syncope episode design summary

Identifying episode triggers
A Syncope episode is triggered by a professional claim in an emergency department (ED) or outpatient setting where either the primary diagnosis code is one of the defined syncope trigger codes, or the primary diagnosis code is one of the symptoms or potential etiologies of syncope (e.g., dehydration) with a secondary diagnosis code from the defined syncope trigger codes.

Attributing episodes to quarterbacks
The quarterback is the physician or physician group that performed the syncope work-up; the contracting entity ID or Tax ID number of the physician (or group) on the professional claim will be used to identify the quarterback.

Identifying services to include in episode spend
The Syncope episode begins the day when the patient is diagnosed with a syncope event (trigger window) and ends 30 days following the initial diagnosis of syncope/related diagnoses (post-trigger window). On the day when the patient is diagnosed or for the duration of the observation stay (trigger window), the services included in the episode spend are care with relevant diagnosis, evaluation and management services for relevant diagnoses, relevant imaging and testing, relevant procedures, and relevant medications. During the post-trigger window or 30 days following the initial diagnosis of syncope/related diagnoses, the services included in episode spend are care with relevant diagnosis, evaluation and management services for relevant diagnoses, relevant imaging and testing, relevant procedures, and relevant medications.

Excluding episodes
There are three types of exclusions. Business exclusions: available information is not comparable or is incomplete (e.g., third party liability, non-continuous eligibility, left against medical advice). Clinical exclusions: patient's care pathway is different for clinical reasons, such as age (<1 years and >64 years), episodes with sepsis, active cancer, end-stage renal disease (ERSD). High-cost outlier exclusions: episode's risk-adjusted spend is three standard deviations above the mean.

Determining quality metrics performance
The quality metric tied to gain sharing is: percentage of valid episodes for patients older than 17 with carotid ultrasound during the episode window.

Quality metrics not tied to gain sharing are: percentage of valid episodes with electrocardiogram (EKG) during the trigger window; percentage of valid episodes for patients older than 17 with a head and neck CT or brain MRI during the episode window; percentage of valid episodes with echocardiogram during the episode window; percentage of valid episodes with related follow-up care during the post-trigger window; percentage of valid and invalid episodes with hospitalizations during the trigger window; percentage of valid episodes with a related admission during the post-trigger window; percentage of valid episodes with a related ED visit during the post-trigger window.

Pediatric Pneumonia episode design summary

Identifying episode triggers
A Pediatric Pneumonia episode is triggered by an inpatient or emergency department (ED) claim where either the primary diagnosis is one of the defined codes for pneumonia, or the primary diagnosis is one of the signs and symptoms (e.g., cough, wheezing, fever, hypoxemia) contingent on a secondary diagnosis of pneumonia.

Attributing episodes to quarterbacks
The quarterback is the facility that diagnoses the pediatric pneumonia; the contracting entity ID or Tax ID number of the facility on the professional claim will be used to identify the quarterback.

Identifying services to include in episode spend
The Pediatric Pneumonia episode begins on the day when the patient is diagnosed with pediatric pneumonia (trigger window) and ends 7 days after discharge from the facility where the pediatric pneumonia was diagnosed (post-trigger window). Services included in the episode spend during the day when the pediatric pneumonia was diagnosed or for the duration of admission (trigger window) are all professional and facility medical services. Services included in the episode spend on the day when the patient is discharged and up to 7 days following discharge from the facility where the pediatric pneumonia was diagnosed (post-trigger window) are relevant care, evaluation and management with relevant diagnoses, relevant complications, relevant imaging and testing, relevant procedures, and relevant medications.

Excluding episodes
There are three types of exclusions. Business exclusions: available information is not comparable or is incomplete (e.g., third party liability, non-continuous eligibility, left against medical advice). Clinical exclusions: patient's care pathway is different for clinical reasons, such as age (<7 months or >17 years), acute respiratory distress syndrome, bronchiectasis, bronchiolitis obliterans, congenital heart disease, chronic obstructive pulmonary disease (COPD), cystic fibrosis, empyema, end-stage renal disease (ERSD), excluded infections, extracorporeal membrane oxygenation (ECMO), history of < 34 weeks gestational age, idiopathic hemosiderosis, immotile cilia syndrome, immunodeficiency, interstitial

pulmonary diseases, neuromuscular disease, pulmonary hemorrhage, pulmonary vascular disease, severe sepsis or septic shock. High-cost outlier exclusions: episode's risk-adjusted spend is three standard deviations above the mean.

Determining quality metrics performance

The quality metrics tied to gain sharing are: related admission during the post-trigger window; utilization of macrolides in patients under 6 years old; utilization of narrow spectrum antibiotics during episode window.

Quality metrics not tied to gain sharing are: admission during the trigger window; utilization of chest physical therapy (PT); utilization of blood or sputum cultures; utilization of respiratory viral testing; utilization of more than one chest x-ray.