Tennessee Health Care Innovation Initiative

“IT’s my hope that we can provide quality health care for more Tennesseans while transforming the relationship among health care users, providers and payers. If Tennessee can do that, we all win.”

– Governor Haslam’s address to a joint session of the state Legislature, March 2013

We are deeply committed to reforming the way that we pay for healthcare in Tennessee.

Our goal is to pay for outcomes and for quality care, and to reward strongly performing physicians.

We plan to have value-based payment account for the majority of healthcare spend within the next three to five years.

By aligning on common approaches we will see greater impact and ease the transition for providers.

We appreciate that hospitals, medical providers, and payers have all demonstrated a sincere willingness to move toward payment reform.

By working together, we can make significant progress toward sustainable medical costs and improving care.
Forty percent of commercial sector payments to doctors and hospitals now flow through value-oriented payment methods.

“Our current health care system is designed to pay for volume - the number of medical services delivered - not the value of those services. Value is far more important; it considers the results of the services provided in exchange for the costs incurred.”

“BCBSA and the 37 Blue Cross and Blue Shield companies look forward to partnering with government and other private sector payers on this important transition to a more effective, efficient and coordinated healthcare system that helps patients get healthy faster – and stay healthy longer.”

“Cigna has been at the forefront of the accountable care organization movement since 2008 and now has 150 Cigna Collaborative Care arrangements with large physician groups that span 29 states, reach more than 1.7 million commercial customers and encompass more than 69,000 doctors.”

“UnitedHealthcare’s total payments to physicians and hospitals that are tied to value-based arrangements have tripled in the last three years to over $46 billion. By the end of 2018, UnitedHealthcare expects that figure to reach $65 billion. “

“Building a healthier world requires fresh thinking and innovation. It calls for everyone in health care to rally around the single goal of improving health and service while reducing costs - whether you give care, receive care, manage care, or pay for care.”

“HHS has set a goal of tying 30 percent of traditional, or fee-for-service, Medicare payments to quality or value through alternative payment models, such as Accountable Care Organizations (ACOs) or bundled payment arrangements by the end of 2016, and tying 50 percent of payments to these models by the end of 2018.”

Tennessee’s Three Strategies

<table>
<thead>
<tr>
<th>Source of value</th>
<th>Strategy elements</th>
<th>Examples</th>
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</thead>
<tbody>
<tr>
<td>• Maintaining a person’s health over time</td>
<td>• Patient Centered Medical Homes</td>
<td>• Encouraging primary prevention for healthy consumers and coordinated care for the chronically ill</td>
</tr>
<tr>
<td>• Coordinating care by specialists</td>
<td>• Tennessee Health Link for people with significant behavioral health needs</td>
<td>• Coordinating primary and behavioral health care for those with significant BH needs</td>
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<tr>
<td>• Avoiding episode events when appropriate</td>
<td>• Care coordination tool with Hospital and ED admission provider alerts</td>
<td>• Wave 1: Perinatal, joint replacement, asthma exacerbation</td>
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<td></td>
<td>• Retrospective Episodes of Care</td>
<td>• Wave 2: COPD, colonoscopy, cholecystectomy, PCI</td>
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<tr>
<td></td>
<td>• 75 episodes designed by 2020</td>
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<tr>
<td>• Achieving a specific patient objective, including associated upstream and downstream cost and quality</td>
<td>• Quality and acuity adjusted payments for LTSS services</td>
<td>• Aligning payment with value and quality for nursing facilities (NFs) and home and community based care (HCBS)</td>
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<tr>
<td></td>
<td>• Value-based purchasing for enhanced respiratory care</td>
<td>• Training for providers</td>
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<td></td>
<td>• Workforce development</td>
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<tr>
<td>• Provide long-term services and supports (LTSS) that are high quality in the areas that matter most to recipients</td>
<td>• Long-term Services &amp; Supports</td>
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## Stakeholder Process

<table>
<thead>
<tr>
<th>Stakeholder group</th>
<th>Provider Stakeholder Group</th>
<th>Payer Coalition</th>
<th>Quality Improvement in Long Term Services and Supports</th>
<th>Technical Advisory Groups</th>
<th>Employer Stakeholders</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Select providers meet regularly to advise on overall initiative implementation.</td>
<td>State health care purchasers (TennCare, Benefits Administration) and major commercial insurers meet regularly to advise on overall implementation.</td>
<td>18 community forums in 9 cities across the state for consumers, families, and providers; online survey process; meetings with key stakeholders. Ongoing stakeholder group.</td>
<td>Select clinicians meet to provide clinical advice on each strategy.</td>
<td>Periodic engagement with employers and employer associations.</td>
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### Meeting Frequency
- Monthly
- 2 per month
- Ongoing
- 3-6 per group
- As needed

The initiative has met with over 250 stakeholder groups in over 900 meetings since February 2013.

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### What changes do we see for the health care system?

- Silos are starting to come down
- Growth in new ways to access health care
- Increased use of data and technology
- New payment and delivery models
Primary Care Transformation: What we hope to achieve

PCMH and Health Link Practices commit to:
• Patient-centered access
• Team-based care
• Population health management
• Care management support
• Care coordination and care transitions
• Performance measurement and quality improvement

Benefits to patients, providers, and the health care system:
• Improved quality of care for Medicaid members throughout Tennessee
• Deep collaboration between providers and health plans
• Support and learning opportunities for primary care and behavioral health providers
• Appropriateness of care setting and forms of delivery
• Joint decision making across the continuum of care providers
• Reduced readmissions through effective follow-up and transition management
• Improved patient treatment compliance
Primary Care Transformation:
Patient Centered Medical Home Overview

<table>
<thead>
<tr>
<th>Members in this program</th>
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</thead>
<tbody>
<tr>
<td>Applies to all TennCare Members</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Participating providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Providers (i.e., family practice, general practice, pediatrics, internal medicine, geriatrics, FQHC) with one or more PCPs (including nurse practitioners)</td>
</tr>
<tr>
<td>20 – 30 practices beginning January 2017, additional practices added each year</td>
</tr>
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<table>
<thead>
<tr>
<th>Payment to providers</th>
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<tbody>
<tr>
<td>Practice transformation payment: $1 per member per month (PMPM) to support initial investment for the first year of a practice's participation.</td>
</tr>
<tr>
<td>Activity payment: Risk-adjusted PMPM payment averaging $4 PMPM across all practices to support practices for the labor and time required to evolve their care delivery models.</td>
</tr>
<tr>
<td>Outcome payment: Annual bonus payment available to high performing PCMHs based on quality and efficiency outcomes.</td>
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<th>Other resources to providers</th>
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<td>Training Vendor will provide training and technical assistance for each site while also facilitating collaboration between providers. The trainer will create custom curriculum and offer on-site training sessions.</td>
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<td>Quarterly provider reports will include cost and quality data aggregated at the practice level. Each MCO will send reports to participating providers.</td>
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<td>Care Coordination Tool will help PCMH practices to provide better care coordination. The tool is designed to offer gap in care alerts, ER and inpatient admission hospital alerts, and prospective risk scores for a provider’s attributed members.</td>
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Primary Care Transformation:
Tennessee Health Link Overview

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<tr>
<td>Designed for TennCare members with significant behavioral health care needs (estimated 100,000 people)</td>
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<tr>
<td>Providers able to treat members with significant behavioral health needs (including Community Mental Health Centers, FQHCs, and others)</td>
</tr>
<tr>
<td>20 practices beginning statewide December 2016, additional practices added each year</td>
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<tr>
<td>Activity payment: $200 monthly activity payment to support care and staffing for the first 7 months. Stabilization rate of $139 monthly activity payment begins 7/1/17 for additional 12 months, lower recurring rate will begin in 2018.</td>
</tr>
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<td>Outcome payment: Annual bonus payment available to high performing Health Links based on quality and efficiency outcomes.</td>
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Primary Care Transformation: Care Coordination Tool

A multi-payer shared care coordination tool will allow primary care providers to implement better care coordination in their offices.

- Identifies a provider’s attributed patients’ risk scores
- Generates and displays gaps-in-care and creates prioritized workflows for the care team
- Maintains, executes and tracks activities against patient-specific care plans
- Alerts providers of any of their attributed patients’ hospital admissions, discharges, and transfers (ADT feeds)

Primary Care Transformation: Overall Timeline

Tennessee’s timeline for PCMH and Tennessee Health Link rollout:

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<thead>
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<th>2016</th>
<th>2017</th>
<th>2018</th>
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<tr>
<td>June - October: Pilot of Care Coordination Tool</td>
<td>Jan: Launch PCMH for 20–30 Wave 1 practices</td>
<td>Jan: Expand PCMH to Wave 2 practices</td>
</tr>
<tr>
<td>November 2016: Provider training and technical assistance vendor contract begins</td>
<td>Provider training and technical assistance</td>
<td>Provider training and technical assistance</td>
</tr>
<tr>
<td>December: Launch Tennessee Health Link statewide for TennCare members with significant Behavioral Health needs</td>
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Tennessee’s goal is to enroll 65% of TennCare members in a PCMH practice by 2020
Primary Care Transformation:
Medicare Comprehensive Primary Care Plus (CPC+)

- Medicare fee-for-service members

- Providers must have at least 150 Medicare fee-for-service members.
- Providers may apply as Track 1 or Track 2 (Track 2 practices must use certified health IT.)
- Applications are due September 15, 2016

- Care Management Fee: Participating practices will receive an average of $15 to $28 per month for their Medicare fee-for-service patients.
- Performance-based incentive payment: CPC+ will prospectively pay and retrospectively reconcile a performance-based incentive based on quality and utilization measures.
- Payment under the Medicare Physician Fee Schedule: Track 1 continues to bill and receive payment from Medicare FFS as usual. Track 2 practices also continue to bill as usual, but the FFS payment will be reduced to account for CMS shifting a portion of Medicare FFS payments into Comprehensive Primary Care Payments (CPCP), which will be paid in a lump sum on a quarterly basis absent a claim. The CPCP amounts will be larger than the FFS payment amounts they are intended to replace.

- Medicare selected Tennessee as one of fourteen regions for CPC+.
- CPC+ is a Medicare program with the same goals as TennCare’s PCMH program. However, CPC+ does not impact TennCare in any way.
- For more information, visit [http://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Plus](http://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Plus) or email CPCplus@cms.hhs.gov.
Episodes of Care: Definition

Example patient journey for hip & knee replacement

3 to 90 days before surgery

Surgery (outpatient)
- Procedure
- Implant

Surgery (inpatient)
- Procedure
- Implant
- Post-op stay

IP recovery/ rehab
- Skilled nursing facility / inpatient rehab

No IP rehab
- Physical therapy
- Home health

Readmission/ avoidable complication
- Deep vein thrombosis / pulmonary embolisms
- Revisions
- Infections
- Hemorrhages

Episodes include services from multiple providers

Episodes of Care: Process

Unchanged Billing Process

Patients seek care and select providers as they do today

Providers submit claims as they do today

Payers reimburse for all services as they do today

New Information

'Quarterbacks' are provided detailed information for each episode which includes actionable data
Episodes of Care: Reporting

Quarterbacks will receive quarterly report from payers:

- **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
  - Key utilization statistics

- **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 episode a provider treats
  - Reason for any episode exclusions
  - Top 5 prescribed drugs by spend

Episodes of Care: Incentives

Risk-adjusted costs for one type of episode in a year for a single example provider group

Example provider’s individual episode costs

Example provider group’s average episode cost

Annual performance across all providers

- High cost
- Average cost per episode for each provider
- Low cost

Provider quarterbacks: from highest to lowest average cost

If average cost higher than acceptable, share excess costs above acceptable line

Acceptable

If average cost between commendable and acceptable, no change

Commandable

If average cost lower than commendable and quality benchmarks met, share cost savings below commendable line

Gain sharing limit

If average cost lower than gain sharing limit, share cost savings but only above gain sharing limit

This example provider group would see no change.
Episodes of Care: Quality metrics

- Some quality metrics will be linked to gain sharing, while others will be reported for information only
  - Quality metrics linked to gain sharing incentivize cost improvements without compromising on quality
  - Quality metrics for information only emphasize and highlight some known challenges to the State
- Each provider report will include provider performance on key quality metrics specific to that episode

Example of quality metrics from episodes in prior waves

<table>
<thead>
<tr>
<th>Episode of Care</th>
<th>Linked to gain-sharing</th>
<th>Informational only</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Asthma Exacerbation</strong></td>
<td>Follow-up visit rate (43%)</td>
<td>Repeat asthma exacerbation rate</td>
</tr>
<tr>
<td></td>
<td>Percent of patients on an appropriate medication (82%)</td>
<td>Inpatient admission rate</td>
</tr>
<tr>
<td><strong>Pernatal</strong></td>
<td>HIV screening rate (85%)</td>
<td>Asymptomatic bacteriuria screening rate</td>
</tr>
<tr>
<td></td>
<td>Group B streptococcus screening rate (85%)</td>
<td>Hepatitis B screening rate</td>
</tr>
<tr>
<td><strong>Screening and Surveillance Colonoscopy</strong></td>
<td>Overall C-section rate (41%)</td>
<td>Post-polypectomy/biopsy bleed rate</td>
</tr>
<tr>
<td></td>
<td>Repeat colonoscopy rate</td>
<td>Perforation of colon rate</td>
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The quality metric ‘Participating in a Qualified Clinical Data Registry’ is a first attempt at using quality metrics based on other information sources than medical claims.

Episodes of Care: 75 in 5 years

- A review and planning process identified 75 episodes to develop over the coming 5 years
- Episodes were chosen and sequenced based on opportunities to improve patient health, improve quality of patient experiences, and to deliver care more efficiently
- Recently finished the design of the wave 5 episodes

Source: TennCare and State Commercial Plans claims data, episode diagnostic model
Long-term Services and Supports Overview

- Nursing facility (NF) and Home and community based services (HCBS) payments will be based in part on member need and quality outcomes
- Goal to reward providers that improve the member’s experience of care and promote a person-centered care delivery model
- Revised reimbursement structure for Enhanced Respiratory Care (ERC) services in a nursing facility
- ERC point system to adjust rates based on the facility’s performance on key performance indicators and use of technology
- Behavioral Health Crisis Prevention, Intervention and Stabilization Services will incorporate performance measures into reimbursement structure
- Section 1915(c) waivers: Utilize Supports Intensity Scale to develop acuity-adjusted rates for residential and day services
- Employment and Community First CHOICES MLTSS Program

- Invest in the development of a comprehensive competency-based workforce development program and credentialing registry for individuals paid to deliver LTSS
- Agencies employing better trained and qualified staff will be appropriately compensated for the higher quality of care experienced by individuals they serve
Thank You

• Questions? Email payment.reform@tn.gov