


Division of Health Care Finance & Administration

Health Care Innovation Initiative

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Tennessee Health Care Innovation Initiative

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 providers

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**

National movement toward value-based payment

Forty percent of commercial sector payments to doctors and hospitals now flow through value-oriented payment methods. -Catalyst for Payment Reform

PBGH PACIFIC BUSINESS GROUP ON HEALTH

"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."

BlueCross BlueShield

"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

"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

"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. "

HEALTH CARE TRANSFORMATION TASK FORCE

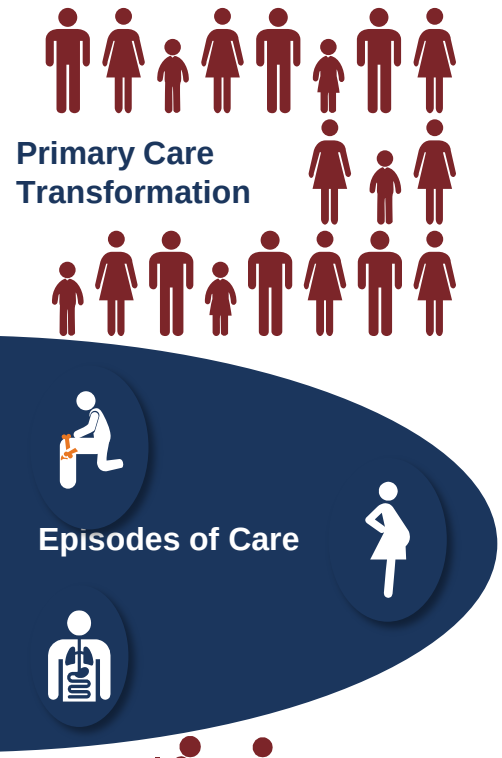
"Building a healthier world requires fresh thinking and innovation. It calls for everyone in health care to rally around the single goal of improving health and service while reducing costs – whether you give care, receive care, manage care, or pay for care."

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

"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."

TN

Tennessee's Three Strategies



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

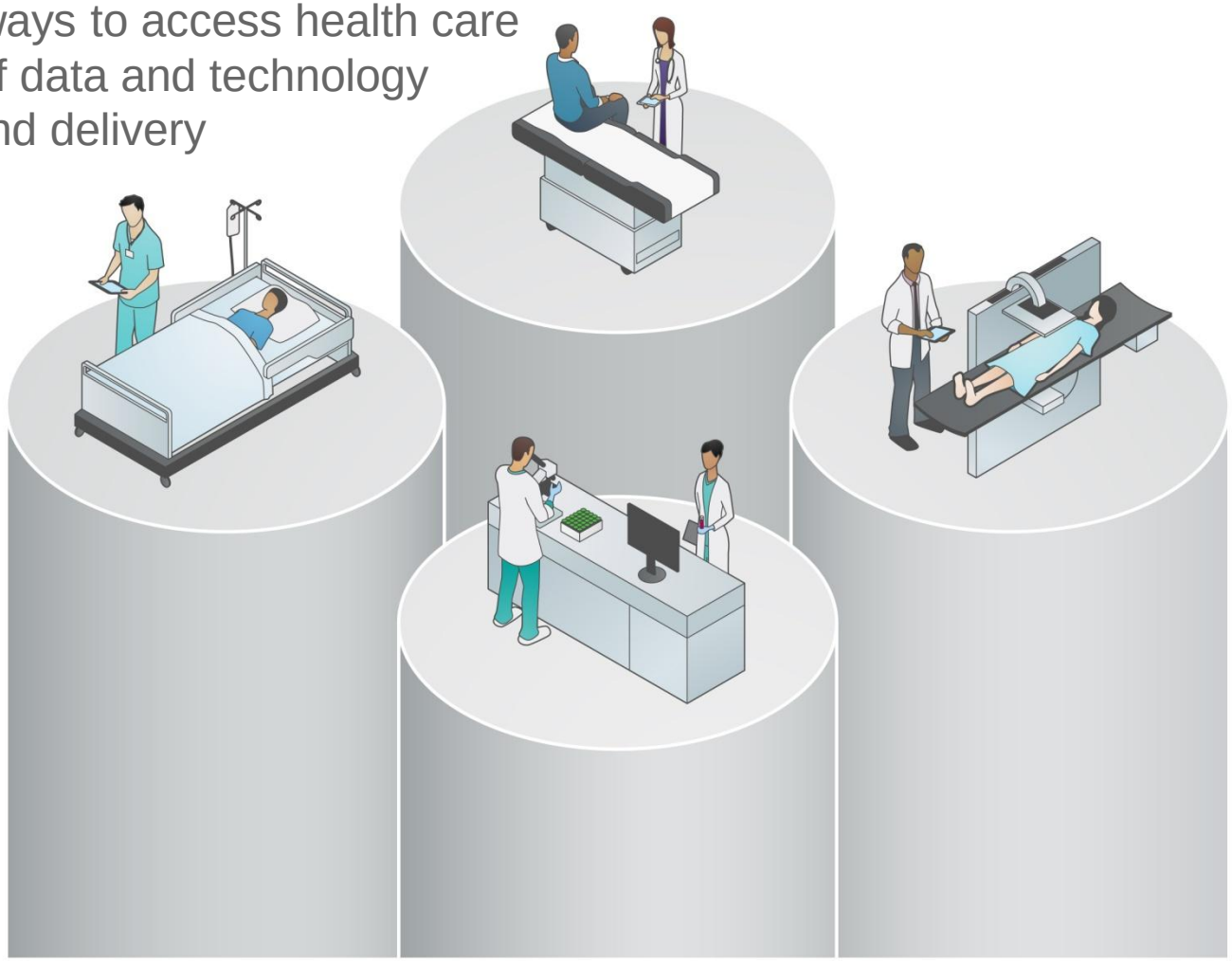
Stakeholder Process

Stakeholder group	Provider Stakeholder Group	Payer Coalition	Quality Improvement in Long-Term Services and Supports	Technical Advisory Groups	Employer Stakeholders
Stakeholders involved	Select providers meet regularly to advise on overall initiative implementation.	State health care purchasers (TennCare, Benefits Administration) and major commercial insurers meet regularly to advise on overall implementation.	18 community forums in 9 cities across the state for consumers, families, and providers; online survey process; meetings with key stakeholders. Ongoing stakeholder group.	Select clinicians meet to provide clinical advice on each strategy.	Periodic engagement with employers and employer associations.
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.

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

Primary Care Transformation Strategy

Most medical costs occur outside of the office of a primary care provider (PCP), but PCPs can guide many decisions that impact those broader costs, improving cost efficiency and care quality.

Patient Centered Medical Homes focus on prevention and management of chronic disease, seek to increase coordinated and integrated care across multidisciplinary provider teams, and improved wellness and preventive care.

Tennessee Health Link will support care coordination for TennCare members with the highest behavioral health needs.

Why participate in Primary Care Transformation?

Rewards for high performing providers

- Opportunity to earn **outcome payments** with a high **gain sharing rate or bonus amount**
- Continue to earn **full new clinical activity payments** to fund new activities
- Resources dedicated to **further, continuous improvement** through practice transformation vendor
- **Actionable reports** providing data on practice quality and efficiency compared to previous performance and peer organizations.
- Opportunity to **be a model leader and share learnings** with new practices
- Opportunity to **partner with State to further define design**

Primary Care Transformation: What we hope to achieve

PCMH and Health Link Practices commit to:

- Member-centered access
- Team-based care
- Population health management
- Care management support
- Care coordination and care transitions
- Performance measurement and quality improvement

Benefits to members, 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 member treatment compliance

Primary Care Transformation: Patient Centered Medical Home Overview

Members in this program	▪ Applies to all TennCare Members
Participating providers	▪ Primary care practices (i.e., family practice, general practice, pediatrics, internal medicine, geriatrics, FQHC) with one or more PCPs (including nurse practitioners) ▪ Approximately 30 practices beginning January 2017, additional practices added each year
Payment to providers	▪ **Practice transformation payment**: $1 per member per month (PMPM) to support initial investment for the first year of a practice's participation. ▪ **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. ▪ **Outcome payment**: Annual bonus payment available to high performing PCMHs based on quality and efficiency outcomes.
Other resources to providers	▪ **Navigant** will provide training and technical assistance for each site while also facilitating collaboration between providers. They will create custom curriculum and offer on-site training sessions. ▪ **Quarterly provider reports** will include cost and quality data aggregated at the practice level. Each health plan will send reports to participating providers. ▪ **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.

Primary Care Transformation: Tennessee Health Link Overview

Members in this program	▪ Designed for TennCare members with the highest behavioral health needs (estimated 90,000 people)
Participating providers	▪ Providers able to treat members with the highest behavioral health needs (including Community Mental Health Centers, FQHCs, and others) ▪ 21 practices statewide, additional practices may be added each year ▪ Launched December 1, 2016
Payment to providers	▪ **Activity payment**: Transition rate of $200 as a monthly activity payment per member to support care and staffing for the first 7 months. Stabilization rate of $139 as a monthly activity payment per member begins 7/1/17 for additional 12 months. Recurring rate TBD will begin in 2018. ▪ **Outcome payment**: Annual bonus payment available to high performing Health Links based on quality and efficiency outcomes.
Other resources to providers	▪ **Navigant** will provide training and technical assistance for each site while also facilitating collaboration between providers. They will create custom curriculum and offer on-site training sessions. ▪ **Quarterly provider reports** will include cost and quality data aggregated at the practice level. Each MCO will send reports to participating providers. ▪ **Care Coordination Tool** will help Health Link 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.

Key differences between current Level 2 Case Management and new Tennessee Health Link reimbursement model

Broader set of activities[1]

These activities may be delivered to…

- The member
- Another provider, family member or someone else who is actively involved in the member's life.

… and be delivered

- In person
- or through an indirect contact

Members with at least 1 activity are eligible for a monthly payment

Expanded population

Maintain access for Level 2 Case Management patients

- Members actively receiving Level 2 Case Management will be enrolled with a Health Link

Include patients missed by the current system

- Members meeting the new Health Link criteria, which includes combination of severe BH conditions and utilization of acute services

Emphasis on recovery

Health Links should:

- Support increased self-sufficiency over time
- Help their patients towards recovery, which means that, on average, Health Link patients will require less support over time

Some members will be able to exit the Health Link as they meet their treatment goals

What does this mean for you?

The **flexibility to provide the right support** at the right time to the right person

1 Health Link activities: Comprehensive care management, Care coordination, Referral to social supports, Patient and family support, Transitional care, Health promotion

Health Link Identification Criteria

	Identification criteria
Category 1: Diagnostic criteria only	**A new or existing diagnosis or code of:** • Attempted suicide or self-injury • Bipolar disorder • Homicidal ideation • Schizophrenia
or	
Category 2: Diagnostic and utilization criteria	**One or more behavioral health-related (a) inpatient admissions or (b) crisis stabilization unit admissions (18 or over), ED admissions (under 18), or residential treatment facility admissions; WITH a diagnosis of:** • Abuse and psychological trauma • Adjustment reaction • Anxiety • Conduct disorder • Emotional disturbance of childhood and adolescence • Major depression • Other depression • Other mood disorders • Personality disorders • Psychosis • Psychosomatic disorders • PTSD • Somatoform disorders • Substance use • Other / unspecified
or	
Category 3: Functional need	**Up to 12/1/16: Receipt of 2 or more Level 2 Case Management (L2CM) services** **After 12/1/16: Provider documentation of functional need, to be attested to by the provider.[1]**

[1]Note: Functional need is defined as aligning with what the State of Tennessee has set out as the new Level 2 Case Management medical necessity criteria, effective March 1, 2016 for adults and April 1, 2016 for children. The look-back period for Category 1 and Category 3 identification criteria is April 1, 2016. The look-back period for Category 2 identification criteria is July 1, 2016.

Overview of support available to providers

Unchanged mechanism
Redesigned mechanism
New mechanism

		Objective	Support	Categories of support
Existing payments	Fee for Service Payment	• No change to existing reimbursement process	• Payments tied to discrete care services rendered	The following services remain paid through Fee for Service: • Evaluation & management services • Medication management • Therapy services • Psychiatric & psychosocial rehabilitation services • Level 1 Case Management
Health Link payments	Activity Payment	• Compensate for clinical activities performed by Health Link providers	• Monthly activity payment	• The 6 billable service areas consist of: ▫ Comprehensive care management ▫ Care coordination ▫ Referral to social supports ▫ Patient and family support ▫ Transitional care ▫ Health promotion
	Outcome Payment	• Encourage improvements in quality and efficiency	• Incentive payment based on outcome measures	• Performance measured against a combination of quality and efficiency metrics to determine the amount of the outcome payment
Support	Practice Transfor-mation Support	• Support initial investment in provider changes including infrastructure and personnel	• Support delivered by Navigant	• Includes in-person coaching, webinars, and learning collaboratives

Health Link Quality Metrics

1. **7- and 30-day psychiatric hospital / RTF readmission rate**
   - 7-day
   - 30-day
2. **Antidepressant medication management**
   - Acute phase treatment
   - Continuation phase treatment
3. **Follow-up after hospitalization for mental illness within 7 and 30 days**
   - 7-days
   - 30-days
4. **Initiation/engagement of alcohol and drug dependence treatment**
   - Initiation
   - Engagement
5. **Use of multiple concurrent antipsychotics in children/adolescents**
6. **BMI and weight composite metric**
   - Adult BMI screening
   - BMI percentile (children and adolescents only)
   - Counseling for nutrition (children and adolescents only)
7. **Comprehensive diabetes care (Composite 1)**
   - Diabetes eye exam
   - Diabetes BP < 140/90
   - Diabetes nephropathy
8. **Comprehensive diabetes care (Composite 2)**
   - Diabetes HbA1c testing
   - Diabetes HbA1c poor control (> 9%)
9. **EPSDT: Well-child visits ages 7-11 years**
10. **EPSDT: Adolescent well-care visits age 12-21**

Health Link Efficiency Metrics

1. All-cause hospital readmissions rate
2. Ambulatory care - ED visits
3. Inpatient admissions– Total inpatient
4. Mental health utilization- Inpatient
5. Rate of inpatient psychiatric admissions

How Will A Health Link Be Paid?

Health Link Outcome Payment

The outcome payment is meant to reward high quality providers in shared savings opportunities. This outcome payment is based on performance throughout a full calendar year.

Step 1:

Measure Quality

Statewide thresholds are set

Step 2:

Measure Efficiency Performance

Measure efficiency metrics against thresholds

Step 3:

Measure Efficiency Improvement

Measure improvement in efficiency metrics compared to your past performance

Step 4:

Calculate Payment

Eligible for up to 25% of shared savings

How Will A Health Link Be Paid?

Step 1: Measure Quality Performance (relative to statewide threshold)

Sample Health Link Provider

Quality Metric	Threshold	Denominator	Performance	Star
Quality Measure 1	≤ 10%	60	15%	☆
Quality Measure 2	≥ 45%	50	60%	★
Quality Measure 3	≥ 65%	65	60%	☆
Quality Measure 4	≥ 30%	80	52%	★
Quality Measure 5	≤ 1%	40	5%	☆
Quality Measure 6	≥ 30%	60	25%	☆
Quality Measure 7	≥ 50%	50	60%	★
Quality Measure 8	≥ 60%	65	35%	☆
Quality Measure 9	≥ 55%	80	58%	★
Quality Measure 10	≥ 40%	5	90%	☆ N/A

Quality stars: ★★★★☆ ☆☆☆☆☆

At least 4 stars earned? → Outcome payment eligible ✓ ✓

Each Quality Star is worth 5%. See Step 2.

A minimum denominator of 30 is required to be measured

How Will A Health Link Be Paid?

Step 2: Measure Efficiency Performance (relative to statewide threshold)

Efficiency metric	Threshold	Performance	Star
ED/ 1000 MM	≤ 70	60	★
Inpatient/ 1000 MM	≤ 15	10	★
Mental Health Inpatient /1000 MM	≤ 5	9	☆
All Cause Readmission /1000 MM	≤ 5	6	☆
Inpatient Psychiatric Admissions/ 1000 MM	≤ 25	30	☆

These thresholds are placeholders. They have been set by each MCO.

Efficiency stars: ★★☆☆☆

Outcome savings percentage:

4 Quality stars at 5% 4*5% = 20%

2 Efficiency stars at 10% 2*10% = 20%

Outcome savings percentage: **40%**

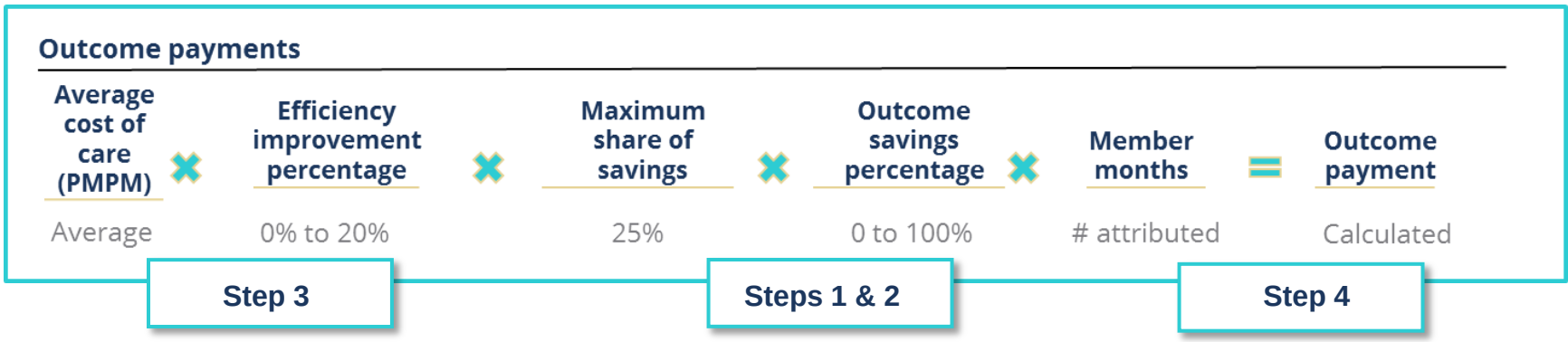
How Will A Health Link Be Paid?

Step 3: Measure Efficiency Performance (relative to self)

Efficiency Measure per 1,000 member months	Efficiency Improvement
All Cause Hospital Readmissions	+9.62%
ED visits	+2.69%
Inpatient Admissions	-7.14%
Mental Health Inpatient Utilization	+20.00%
Inpatient Psychiatric Admissions	+0.76%
Efficiency Improvement Percentage (Average) :	**5.18%**

How Will A Health Link Be Paid?

Step 4: Calculate payment



- **Average cost of care**: The average total cost of care for members in Health Links across all of TennCare.
- **Efficiency improvement percentage:** The average of percent improvement in each efficiency metric compared to the previous year for each Health Link.
- **Maximum share of savings:** The maximum percentage of estimated savings that can be shared with a Health Link. This value is set to one quarter for outcome payments based on total cost of care proxies. This value is the same share available to low-volume PCMH practices.
- **Outcome savings percentage**: The percentage earned from efficiency stars plus quality stars.
- **Member months in panels for quarterly reporting**: Number of attributed member months for members in the Health Link's panel for the performance period. As a reminder, the Health Link must be a member's attributed Health Link for nine or more months during the performance period for the member to be included in the Health Link's panel for outcome payment calculation.

How Will A Health Link Be Paid?

Step 4: Calculate payment

Outcome payments

Average cost of care (PMPM)		Efficiency improvement percentage		Maximum share of savings		Outcome savings percentage		Member months		Outcome payment
$835	✖	5.18%	✖	25%	✖	40%	✖	10,350	=	$44,766.86

*** Illustrative example, not based on real data ***

What Services Will A Health Link Provide?

There are 6 types of clinical activities that may be performed to receive an activity payment:

1) **Comprehensive care management:** Initiate, complete, update, and monitor the progress of a comprehensive person-centered care plan as needed
   - Example: creating care coordination and treatment plans

2) **Care coordination:** Participate in member's physical health treatment plan, support scheduling and reduce barriers to adherence for medical and behavioral health appointments, facilitate and participate in regular interdisciplinary care team meetings, follow up with PCP, proactive outreach with PCP, and follow up with other behavioral health providers or clinical staff
   - Example: proactive outreach and follow up with primary care and behavioral health providers

3) **Health promotion:** Educate the member and his/her family
   - Example: educating the member and his/her family on independent living skills

4) **Transitional care:** Provide additional high touch support in crisis situations, participate in development of discharge plan for each hospitalization, develop a systemic protocol to assure timely access to follow-up care post discharge, establish relationships, and communicate and provide education
   - Example: participating in the development of discharge plans

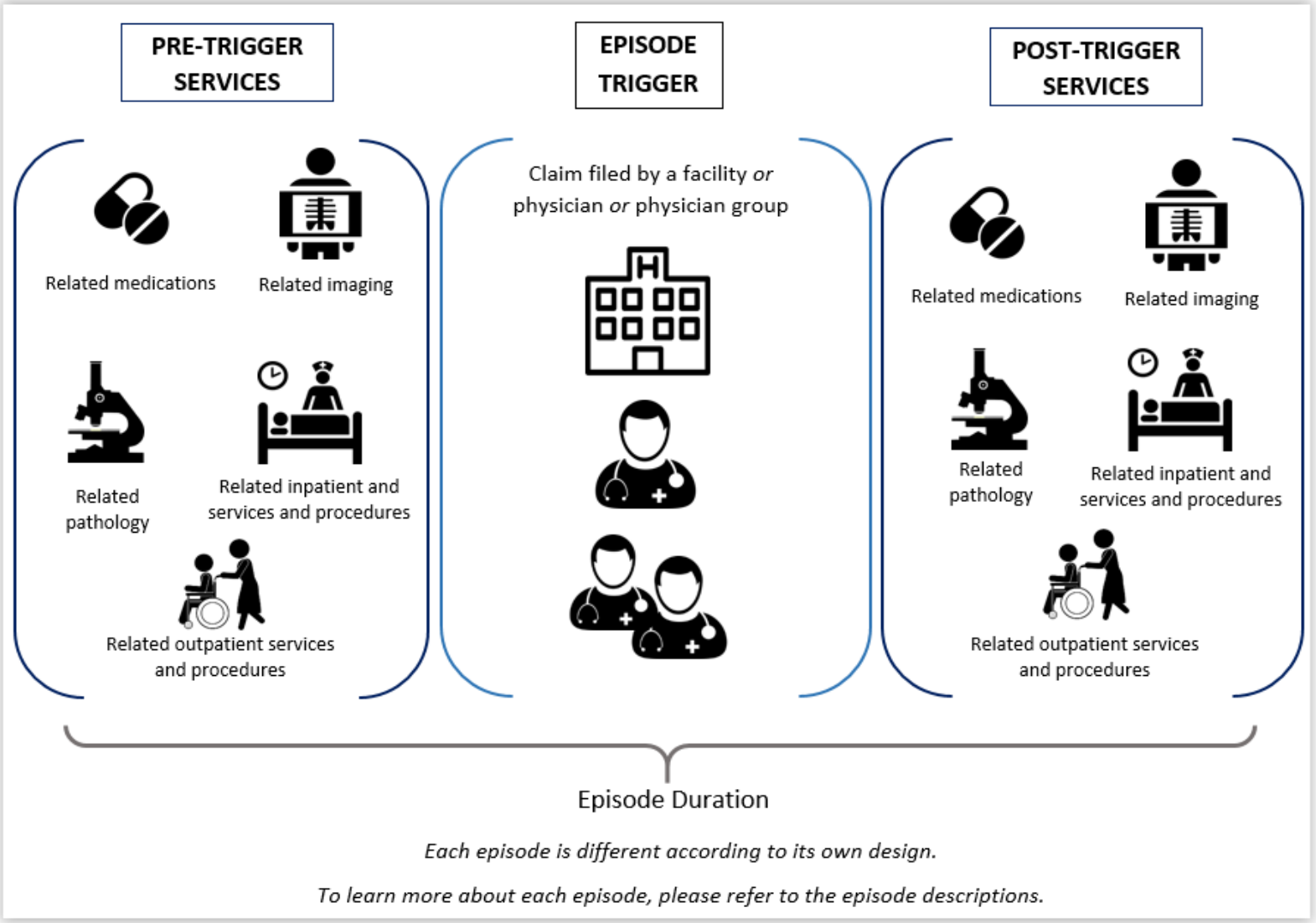
5) **Member and family support:** Provide high-touch in-person support, provider caregiver counseling or training, identify resources to assist individuals and family supporters, and check-ins with member
   - Example: supporting adherence to behavioral and physical health treatment

6) **Referral to social supports:** Identify and facilitate access to community supports, communicate member needs to community partners, and provide information and assistance in accessing services
   - Example: facilitating access to community supports including scheduling and follow through

TN

EPISODES OF CARE

Episodes of Care: Definition



Episodes of Care: Process

Unchanged Billing Process

1

Members seek care and select providers as they do today

2

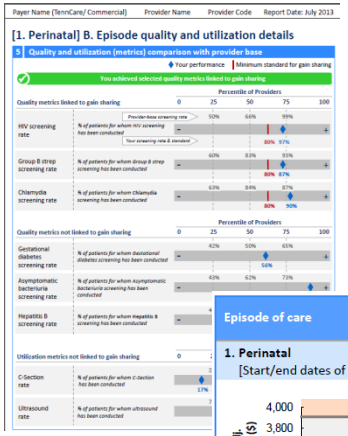
Providers submit claims as they do today

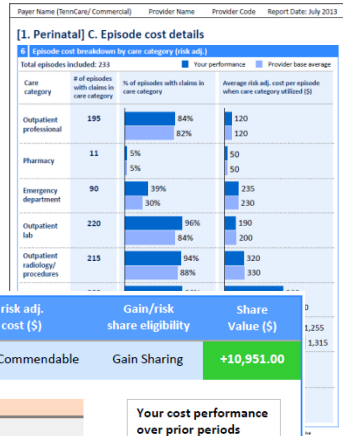
3

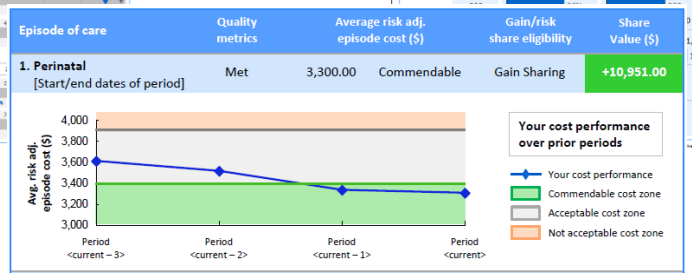
Payers reimburse for all services as they do today

New Information

'Quarterbacks' are provided detailed information for each episode which includes **actionable data**

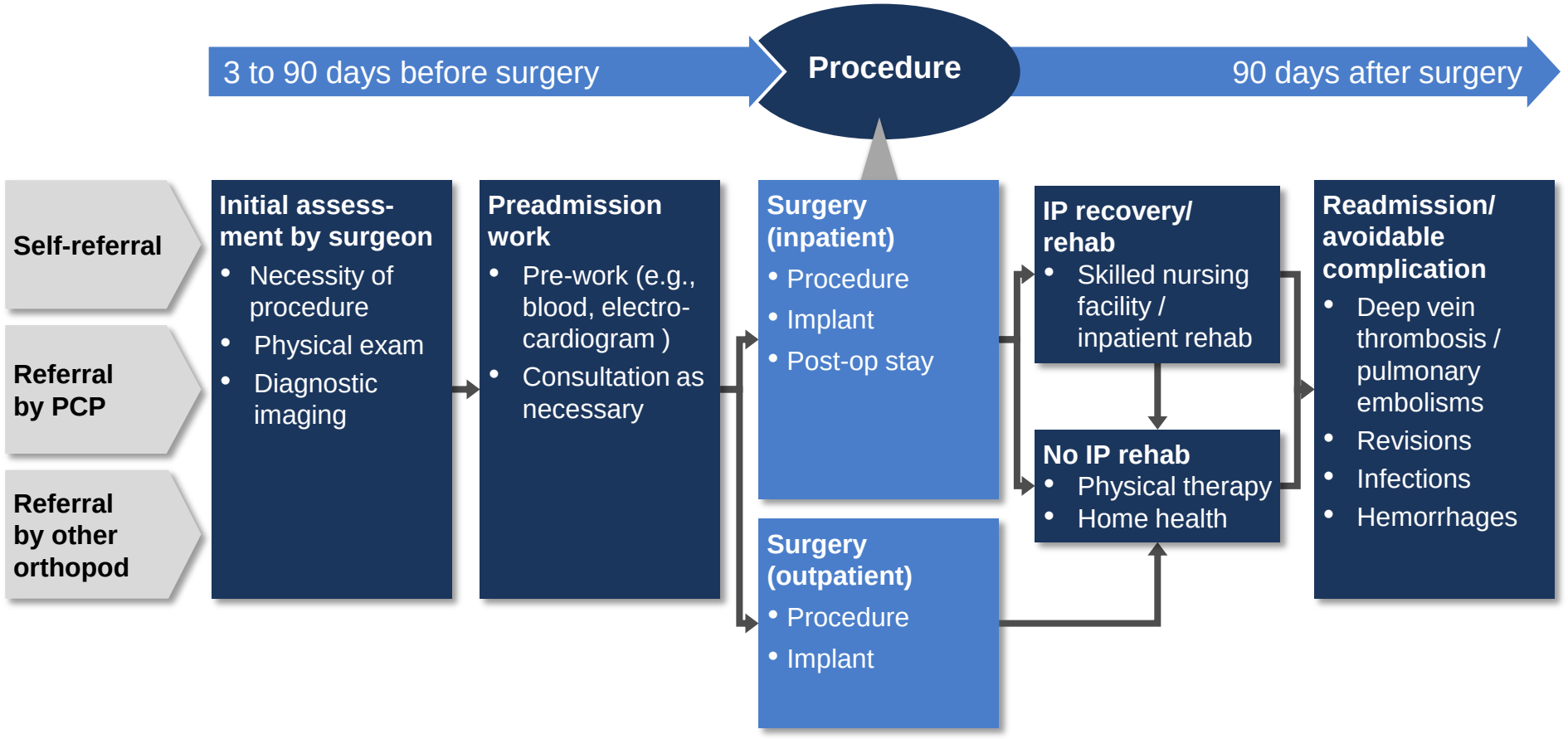






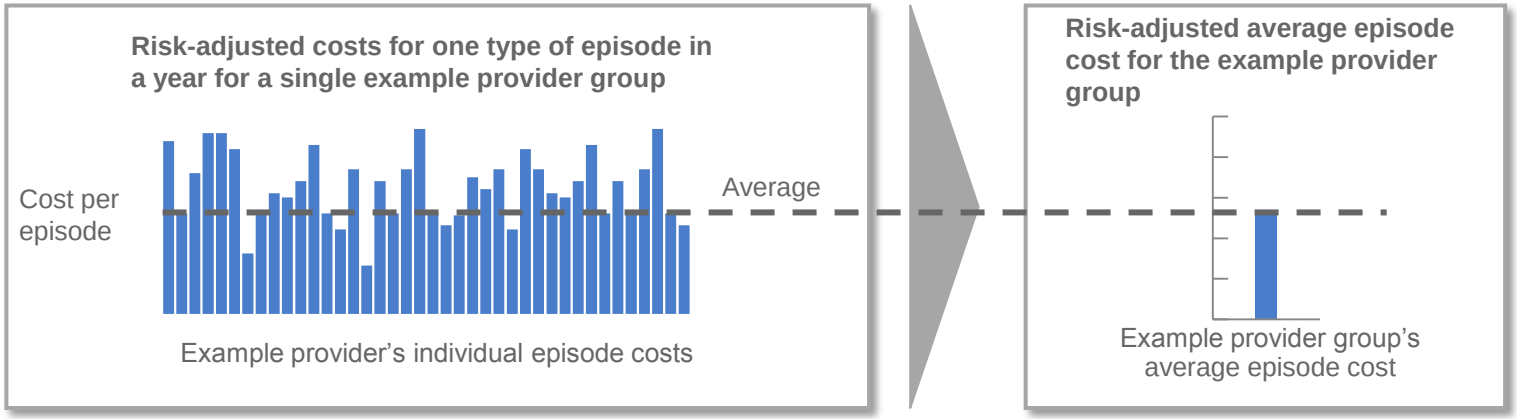
Episodes of Care

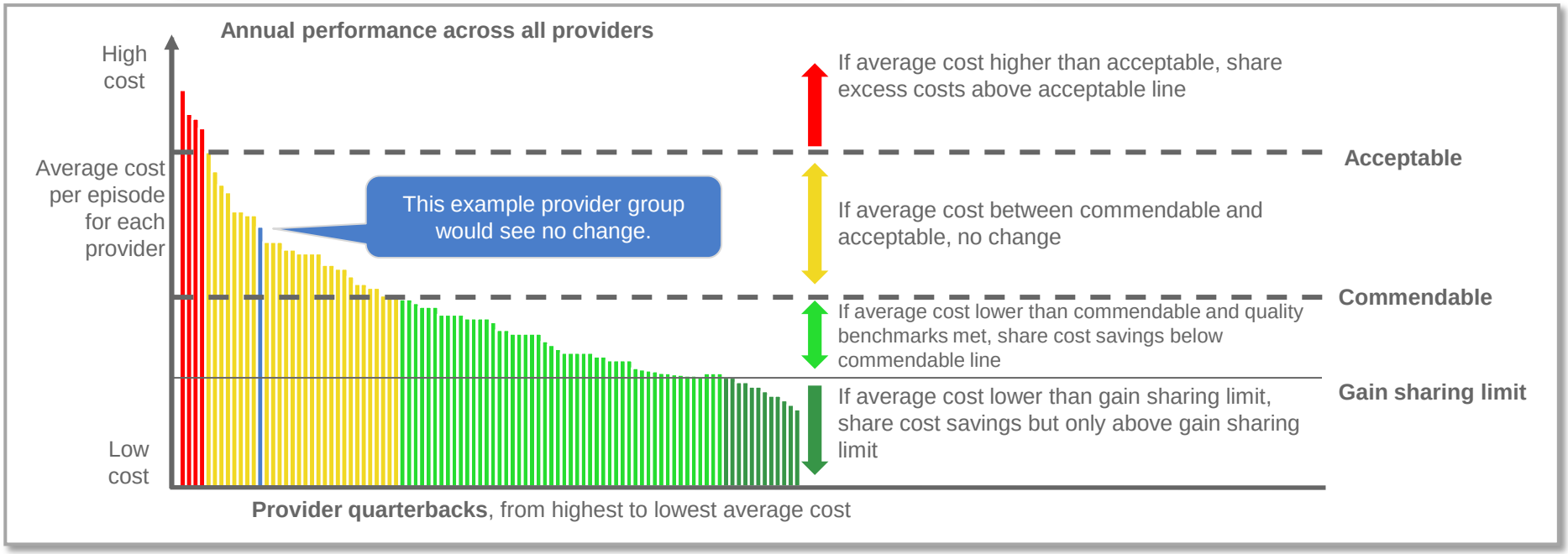
Example member journey for hip & knee replacement



Episodes include services from multiple providers

Episodes of Care: Incentives





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

ASTHMA EXACERBATION

- **Linked to gain-sharing:**
  - Follow-up visit rate (43%)
  - Percent of members on an appropriate medication (82%)
- **Informational only:**
  - Repeat asthma exacerbation rate
  - Inpatient admission rate
  - Percent of episodes with chest x-ray
  - Rate of member self-management education
  - Percent of episodes with smoking cessation counseling offered

PERINATAL

- **Linked to gain-sharing:**
  - HIV screening rate (85%)
  - Group B streptococcus screening rate (85%)
  - Overall C-section rate (41%)
- **Informational only:**
  - Gestational diabetes screening rate
  - Asymptomatic bacteriuria screening rate
  - Hepatitis B screening rate
  - Tdap vaccination rate

SCREENING AND SURVEILLANCE COLONOSCOPY

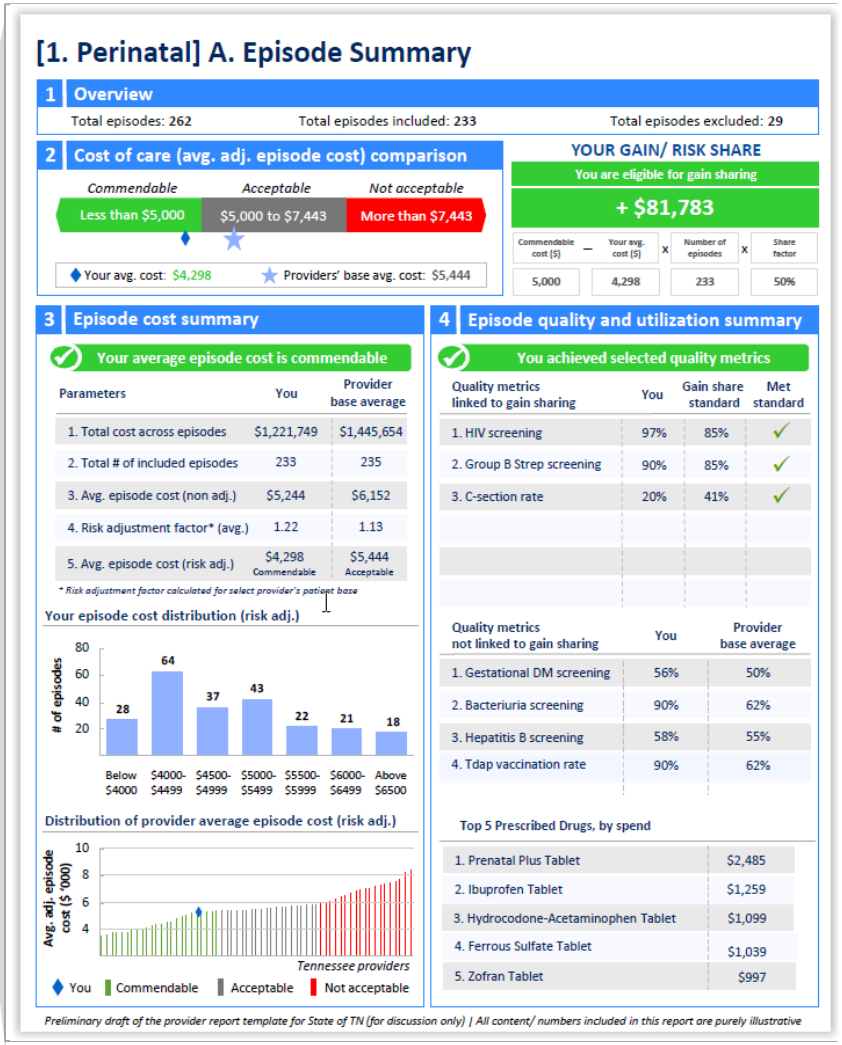
- **Linked to gain-sharing:**
  - None
- **Informational only:**
  - Participating in a Qualified Clinical Data Registry (e.g., GIQuIC) *[May be linked to gain-sharing starting in 2017]*
  - Perforation of colon rate
  - Post-polypectomy/biopsy bleed rate
  - Prior colonoscopy rate
  - Repeat colonoscopy rate

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: 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 treats
  - Reason for any episode exclusions
  - Top 5 prescribed drugs by spend



[1. Perinatal] A. Episode Summary

1 Overview

Total episodes: 262 | Total episodes included: 233 | Total episodes excluded: 29

2 Cost of care (avg. adj. episode cost) comparison

Commendable	Acceptable	Not acceptable
Less than $5,000	$5,000 to $7,443	More than $7,443

Your avg. cost: $4,298 | Providers' base avg. cost: $5,444

YOUR GAIN/ RISK SHARE

You are eligible for gain sharing

+ $81,783

Commendable cost ($)	–	Your avg. cost ($)	x	Number of episodes	x	Share factor
5,000		4,298		233		50%

3 Episode cost summary

Your average episode cost is commendable

Parameters	You	Provider base average
1. Total cost across episodes	$1,221,749	$1,445,654
2. Total # of included episodes	233	235
3. Avg. episode cost (non adj.)	$5,244	$6,152
4. Risk adjustment factor* (avg.)	1.22	1.13
5. Avg. episode cost (risk adj.)	$4,298 Commendable	$5,444 Acceptable

* Risk adjustment factor calculated for select provider's patient base

Your episode cost distribution (risk adj.)

Distribution of provider average episode cost (risk adj.)

4 Episode quality and utilization summary

You achieved selected quality metrics

Quality metrics linked to gain sharing	You	Gain share standard	Met standard
1. HIV screening	97%	85%	✓
2. Group B Strep screening	90%	85%	✓
3. C-section rate	20%	41%	✓

Quality metrics not linked to gain sharing	You	Provider base average
1. Gestational DM screening	56%	50%
2. Bacteriuria screening	90%	62%
3. Hepatitis B screening	58%	55%
4. Tdap vaccination rate	90%	62%

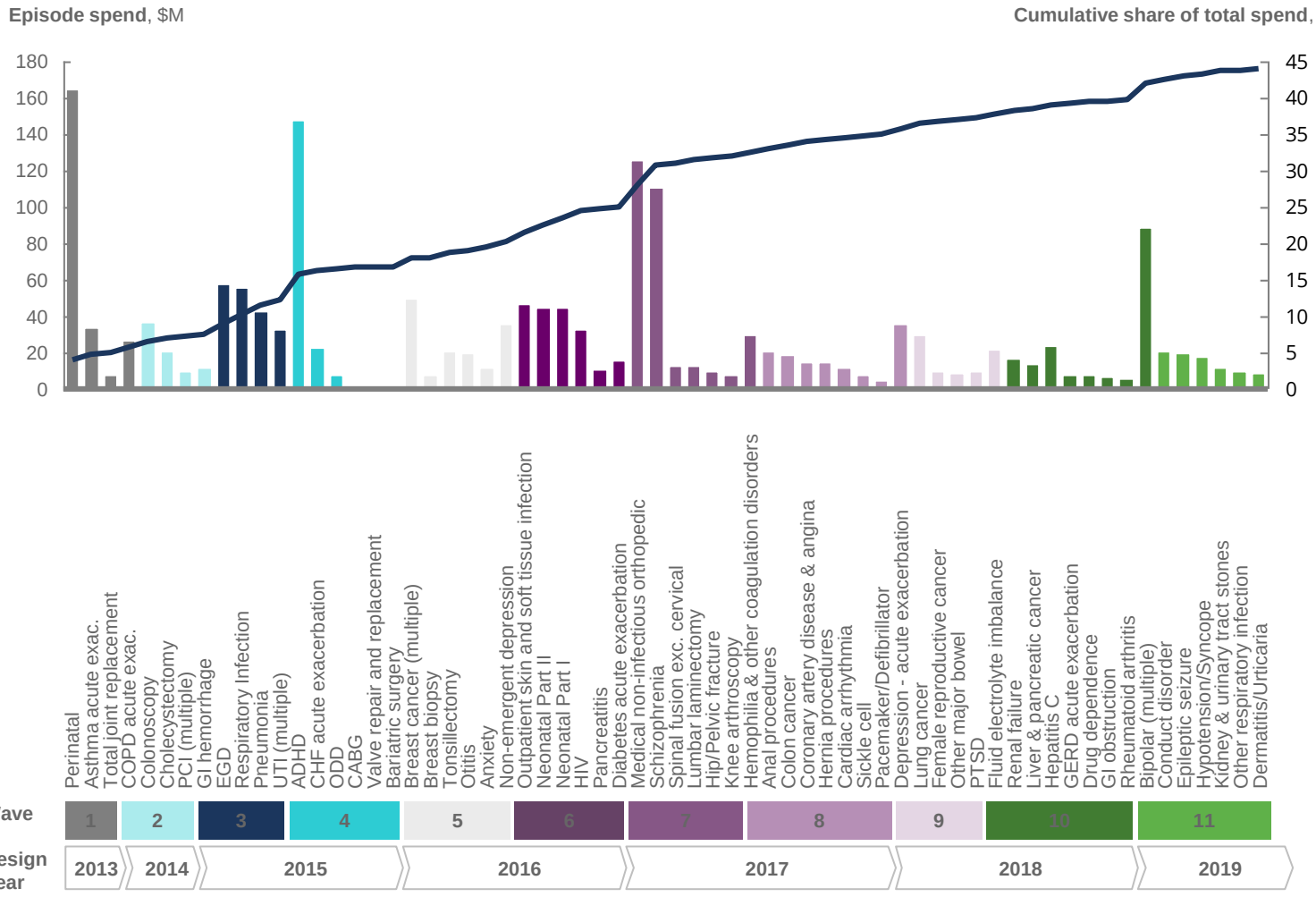
Top 5 Prescribed Drugs, by spend

1. Prenatal Plus Tablet	$2,485
2. Ibuprofen Tablet	$1,259
3. Hydrocodone-Acetaminophen Tablet	$1,099
4. Ferrous Sulfate Tablet	$1,039
5. Zofran Tablet	$997

Preliminary draft of the provider report template for State of TN (for discussion only) | All content/ numbers included in this report are purely illustrative

Episodes of Care: 75 in 5 years

Episodes of care: 75 in 5 years



Overview

- 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 member health, improve quality of member 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

Long-term Services and Supports Overview

Value-Based Purchasing Initiatives for NFs and HCBS

- 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

Value-Based Purchasing Initiatives for I/DD

- 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

Workforce Development

- 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

TN

Value-Based Purchasing Initiatives for NFs and HCBS

Phase 1 (Bridge)
Quarterly adjustments to per diem rates largely focused on QI *activities* (i.e., process measures)

Phase 2 (Full Model)
Prospective per diem based on quality *performance* compared against benchmarks

Improvements in person-centered care delivery model is evaluated through a point system and rewarded as a *retroactive rate adjustment*:

Satisfaction 35 points

Member (15)
Family (10)
Staff (10)

Culture Change/Quality of Life
30 Points

Respectful treatment (10)
Member choice (10)
Member/family input (5)
Meaningful activities (5)

Staffing/Staff Competency
25 Points

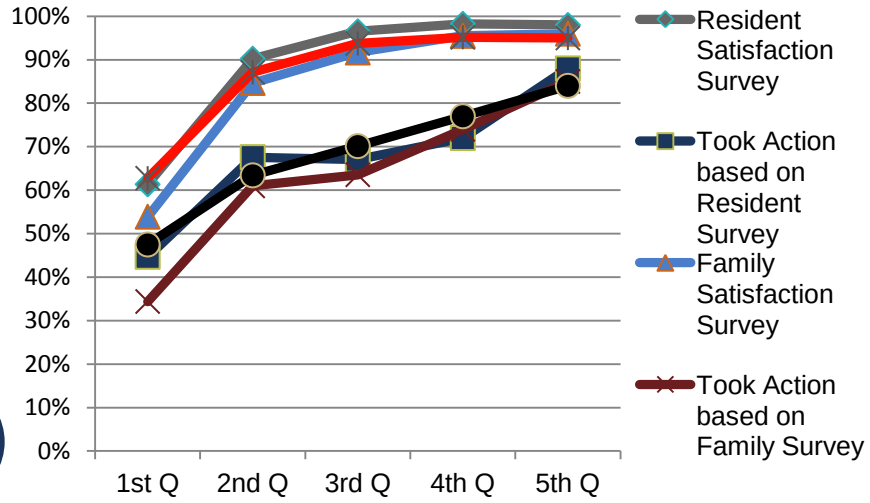
RN hours per day (5)
CNA hours per day (5)
Staff Retention (5)
Consistent Staff Assignment (5)
Staff Training (5)

Clinical Performance
10 Points

Antipsychotic Medication (5)
Urinary Tract Infection (5)

Bonus Points: QI initiatives

Significant improvement in conducting satisfaction surveys and taking actions to improve satisfaction



Enhanced Respiratory Care (ERC) reimbursement based on performance on clinical and technology measures that support liberation and maximize independence & quality of life such as: Ventilator wean rate, Average length of stay to wean, Infection rate, Unplanned hospitalizations, Non-invasive open ventilation, Alarm paging or beeping system, Cough assist, Non-invasive ventilation (volume)

Value-Based Purchasing Initiatives for I/DD[1]

Behavioral Health Crisis Prevention, Intervention and Stabilization Services	**Section 1915(c) waivers**	**Employment and Community First CHOICES MLTSS Program**
• To be implemented this year • Delivered under managed care program, in collaboration with I/DD agency • Focus on crisis prevention, in-home stabilization, sustained community living, • Performance measures[2] will be tracked and utilized to establish a VBP component (incentive or shared savings) for the reimbursement structure	• Utilize Supports Intensity Scale to develop acuity-adjusted rates for residential and day services (key cost drivers) • Adjust based on quality performance utilizing Quality Framework for HCBS	• Implementation in 2016 • Promotes integrated employment and community living as the first and preferred outcome • Employment benefits[3] create a pathway to employment, even for people with severe disabilities ▪ Outcome-based reimbursement for certain employment services ▪ Reimbursement approach for other services will take into account provider's performance on key outcomes[4]

1 I/DD = Intellectual and Developmental Disabilities
2 e.g., decrease in PRN use of anti-psychotics, crisis events, inpatient psychiatric admissions and inpatient days
3 designed in consultation with experts from the Office of Disability Employment Policy
4 including # or % of persons employed in integrated settings, # of hours of employment, wage, etc. (after a reasonable period for data collection and benchmarking)

LTSS Workforce Development

Currently developing a comprehensive **competency based** workforce development program and credentialing registry[1] .

Better for Workforce

- Opportunity to both learn and earn by acquiring **shorter term credentials** with clear labor market value
- Credentials are portable **across service settings**
- Earn college credit toward certificate and/or degree program—**education path** for direct support professionals
- Build competencies to access more advanced jobs and higher wages—**career path** for direct support professionals

Better for Members & Providers

- Promotes delivery of high quality person-centered services
- Registry for matching by individuals, families, providers based on needs/interests of person needing support
- Agencies employing better trained and qualified staff will be **appropriately compensated** for the higher quality of care experienced by individuals they serve

[1] for deployment through secondary, vo-tech, trade schools, community colleges, and 4-year institutions, offering portable, stackable credentials and college credit toward certificate and/or degree program

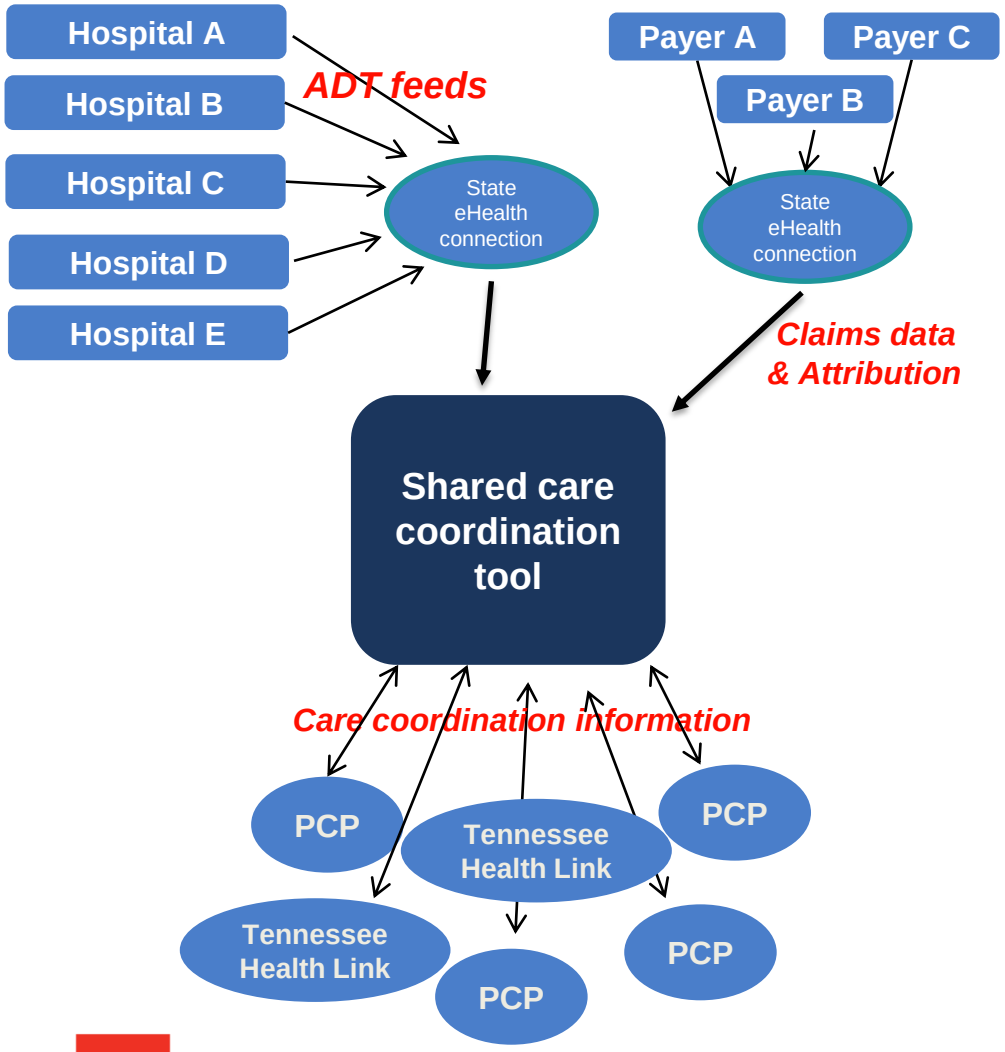
Supporting Initiative: TennCare - Patient-Centered Dental Home (PCDH)

- In April 2014, TennCare's dental benefit manager, DentaQuest, implemented the Patient-Centered Dental Home Program in Tennessee for TennCare members under age 21.
- The PCDH program emphasizes prevention, increased member utilization, quality, and cost effectiveness.
- Member assignment to a PCDH demonstrates that TennCare children have access to a participating primary care dentist .
- Beginning in March 2016, DentaQuest began financially rewarding providers based on improved quality of care and increased TennCare member participation.
- In Spring 2017, rewards will be based solely on achieving or exceeding all quality measures found in Provider Performance Reports (PPRs).

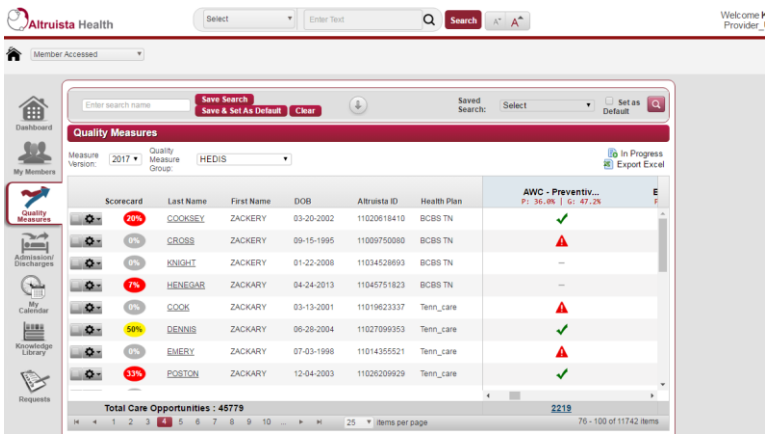
CARE COORDINATION TOOL

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.



- Allows practices to view their attributed member panel
- Identifies a provider's attributed member's risk scores
- Generates and displays gaps-in-care based on quality measures and tracks completion of activities
- Alerts providers of any of their attributed members' hospital admissions, discharges, and transfers (ADT feeds) and tracks follow-up activities



INNOVATION INITIATIVES ACCOMPLISHMENTS & NEXT STEPS

Innovation Initiatives

- Primary Care Transformation
  - Tennessee Health Link
  - Patient Centered Medical Homes
  - Practice Transformation Training
- Episodes of Care
- Care Coordination Tool

Primary Care Transformation: Overall Timeline

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

2016	2017	2018
• December: Launched Tennessee Health Link statewide for TennCare members with the highest behavioral health needs	• January: Launch PCMH for approximately 30 Wave 1 practices • January: Navigant begins provider training and technical assistance • January: Care Coordination Tool is available to PCMH and Health Link providers	• January: Expand PCMH to Wave 2 practices • Provider training and technical assistance ongoing • Care Coordination Tool is available to all primary care providers

Tennessee's goal is to enroll 65% of TennCare members in a PCMH practice by 2020

Tennessee Health Link

- Launched Tennessee Health Link on December 1, 2016
- 21 Health Link providers statewide
- With the assistance of the Technical Advisory Group and the MCOs, the following were designed:
  - Identification criteria for members
  - Practice eligibility requirements
  - Activity requirements
  - Quality metrics
  - Patient engagement recommendations
  - Sources of value
  - Curriculum of training and technical supports
  - Key practice transformation services to be provided
  - Provider reports

Tennessee Health Link Organizations

- **21 provider groups are participating in Health Link**

Alliance Healthcare Services
Camelot Care Centers
CareMore Medical Group of Tennessee
Carey Counseling Center
Case Management
Centerstone
Cherokee Health Systems
Frontier Health
Generations Health Association
Health Connect America
Helen Ross McNabb Center
LifeCare Family Services
Mental Health Cooperative
Omni Community Health
Pathways of Tennessee
Peninsula
Professional Care Services of West TN
Quinco Community Mental Health Center
Ridgeview Behavioral Health Services
Unity Management Services
Volunteer Behavioral Health Care System

PCMH

- 1st phase going live on January 1, 2017 with approximately 30 providers
- HCFA has worked with all 3 MCOs to design an aligned PCMH model for providers
- Reporting, quality measures and the way outcome payments are calculated will be aligned for Medicaid payers
- Providers will have access to their members' total cost of care and comparison to other PCMHs across the state
- PCMH providers will have support to achieve the National Committee for Quality Assurance (NCQA) recognition

Practice Transformation Training

- Navigant is the training vendor for PCMH and Health Link
- This contract began on November 1, 2016
- This training is supported by the State Innovation Model (SIM) grant
- Navigant will provide training and technical assistance for practice transformation:
  - On-site agency evaluations begin in January using an assessment tool
  - Provider outreach and education
  - Develop master curricula for PCMH and Health Link
  - Customized curricula for practices based on assessments
  - On-site coaching
  - Large format in-person trainings
  - Live webinars
  - Recorded webinars
  - Compendium of resources

TN

Episodes of Care

- Tennessee has designed and implemented 20 episodes to date (Waves 1 – 4)
- Tennessee is in the implementation phase of Wave 5 and 6 episodes, with preview reports for both waves going out May 2017.
- Tennessee will begin the Technical Advisory Group (TAG) process for Wave 7 episodes in early Spring 2017.

Comparison of Episode Cost

Episode	Reduction in Average Episode Cost 2014 to 2015 (Risk Adjusted)		Number of Valid Episodes	Total Reduction in Episode Cost
	Actual	Percent		
Perinatal	$224	3.4%	21,058	$4,719,519
Acute Asthma Exacerbation	$104	8.8%	12,616	$1,308,279
Total Joint Replacement	$807	6.7%	329	$265,605
Total			34,003	$6,293,403

HHS Office of the Actuary projected a 5.5% national medical cost trend for 2015. Conservatively, if medical trend would otherwise have been 3%, then savings would have been $11.1 million.

Payments to Providers

Episode	Rewards	Penalties	Balance
Perinatal	$527,466	($244,953)	$282,512
Acute Asthma Exacerbation	$112,671	($103,410)	$9,261
Total Joint Replacement	$24,928	($22,664)	$2,264
Total	**$665,065**	**($371,028)**	**$294,037**

Reward payments are only made to providers who passed all quality measures tied to gain-sharing.

Quality Measures for Episode Quarterbacks with 2015 Rewards Perinatal Episode

Quality Measures	CY 2014	CY 2015
Tied to Gain-Sharing		
1. HIV Screening (> 85%)	90.1%	91.7%
2. Group B Streptococcus Screening (> 85%)	88.2%	92.1%
3. C-Section Rate (<41%)	31.4%	29.2%
Informational Only		
1. Gestational Diabetes Test	82.1%	83.7%
2. Asymptomatic Bacteriuria Screening Rate	79.5%	79.7%
3. Hepatitis B Screening Rate	86.0%	87.0%
4. Tdap Vaccination Rate	31.5%	33.8%

Episodes of Care: Status Report

Episodes in Performance Period	Episodes in Preview Period Performance Period begins January 1, 2017	Episodes in Design Preview Period begins Summer 2017
• Perinatal • Acute Asthma Exacerbation • Total Joint Replacement • Colonoscopy • Cholecystectomy • COPD • Acute PCI • Non-acute PCI	• Upper GI Endoscopy (EGD) • GI Hemorrhage • Outpatient UTI • Inpatient UTI • Respiratory Infection • Pneumonia • ADHD* • ODD • CHF Acute Exacerbation • CABG • Valve Replacement & Repair • Bariatric Surgery	• Anxiety • Tonsillectomy • Non-Emergent Depression • Mastectomy • Breast Biopsy • Breast Cancer Medical Oncology • Otitis Media • HIV • Skin and Soft Tissue Infection • Neonatal (37+ weeks) • Neonatal (32-36 weeks) • Neonatal (31- weeks) • Pancreatitis • Diabetes Acute Exacerbation
Wave 1 & 2	Wave 3 & 4	Wave 5 & 6

*ADHD will have an additional preview period. Performance will begin CY 2018

Summary of TAG recommendations – ADHD episode (11.15.2016)

Area	Episode design summary
1 Identifying episode triggers	▪ An ADHD episode is triggered by a professional claim that has: — A **primary diagnosis of ADHD** (ICD-9 diagnosis code 314 – Hyperkinetic syndrome of childhood), or — A **secondary diagnosis of ADHD and a primary diagnosis of a symptom of ADHD**[1] ▪ This professional visit must also have a procedure code that is for assessment, therapy, case management, or physician services
2 Attributing episodes to quarterbacks	▪ The quarterback is the **provider or group with the plurality of ADHD-related visits** during the episode ▪ The contracting entity ID with the plurality of ADHD visits will be used to identify the quarterback
3 Identifying services to include in episode spend	▪ The length of the ADHD episode is **180 days**. During this time period the following services are included in episode spend: — All inpatient, outpatient, professional, and long-term care claims with a **primary diagnosis of ADHD** — All inpatient, outpatient, professional, and long-term care claims with a **secondary diagnosis of ADHD and a primary diagnosis of a symptom of ADHD** — Pharmacy claims with **eligible therapeutic codes**
4 Risk adjusting and excluding episodes	▪ Episodes affected by **factors that make them inherently more costly than others are risk adjusted.** The list of factors recommended for testing will be provided in the DBR ▪ Episodes which are **not comparable** or affected by factors that make them inherently more costly but that **cannot be risk adjusted for are excluded**. There are three types of exclusions: — Business exclusions: Available information is not comparable or is incomplete[2] — Clinical exclusions: Patient's care pathway is different for clinical reasons: ▫ These include age (<4 or >20), attempted suicide, autism, bipolar, BPD, conduct disorder, delirium, dementia, dissociative disorders, homicidal ideation, intellectual disabilities, manic disorders, psychoses, PTSD, schizophrenia, specific psychosomatic disorders (e.g. factitious disorder), substance abuse, **homelessness, disruptive dysregulation mood disorder (DDMD), children in custody (DCS)** and **Level 1 case management**[3] — High cost outlier exclusions: Episode's risk adjusted spend is three standard deviations above the mean
5 Determining quality metrics performance	▪ Quality metrics **tied to gain sharing** are: — Percentage of valid episodes that meet the minimum care requirement. The minimum care requirement is set at 5 visits/claims with a related diagnosis code during the episode window. These may be a combination of physician visits, therapy visits, level I case management visits, or pharmacy claims for treatment of ADHD — **Rate of long-acting medication use by age group (4 and 5, 6 to 11, 12 to 20)** — **Average number of therapy visits per valid episode for the 4 and 5 age group** ▪ Quality metrics **not tied to gain sharing** are: — Average number of physician visits per valid episode — **Average number of therapy visits per valid episode by age group (6 to 11, and 12 to 20)** — Average number of level I case management visits per valid episode — Percentage of valid episodes with medication by age group (4 and 5, 6 to 11, and 12 to 20) — Percentage of valid episodes for which the patient has a physician, therapy, or level I case management visit within 30 days of the triggering visit

1 Symptoms of ADHD are identified by ICD-9 diagnosis codes 312.30 – Impulse control disorder and 312.9 - Unspecified disturbance of conduct)

2 Episodes with inconsistent enrollment, third-party liability, or dual eligibility; episodes where triggering procedure occurs in a Federally Qualified Health Center or Rural Health Clinic; episodes that cannot be associated with a quarterback ID; episodes with zero triggering professional spend; episodes where total non-risk-adjusted spend is within the bottom 2.5% of all episodes; and episodes where patients expired in the hospital or left against medical advice

3 Level 1 case management will be revisited before the 2018 performance period.

Care Coordination Tool

- Altruista is our contracted vendor
- This contract began April 1, 2016
- Altruista provided an “off-the shelf” shared care coordination tool that will help PCMH and Health Link providers be more successful in the state’s new payment models.

CCT Pilot Purpose & Feedback

- Facilitate assessment of CCT capabilities and functions,
- Use end-user experience to confirm that tool is meeting user expectations
- Identify and fix bugs
- Participants:

Practice	Practice Type
Centerstone/Unity	THL & Family
Prime Care	Family
Plateau Pediatrics	Pediatric
ETSU Family Medicine	Family
Mental Health Cooperative	THL
Jackson Clinic	Family
Chota Community Health Services	Family
Cherokee Health Systems	THL & Family

Strengths Identified by Practices

- “User friendly, easy to go about, just very easy to use”- MHC
- Practices liked the ability to identify gaps in care and track there closure
  - Ability to focus on one quality measure at a time
- The feature that practices seemed to be looking forward to the most was ADTs
- “ADTs will be very helpful and useful” –Chota
- Practices were glad it will work with a variety of work flows, and individual practices foresee using features in different ways
- Practices appreciated the inclusion of enhancements based on their feedback
- Videos were very helpful for training

Thank You

- Questions? Email payment.reform@tn.gov
- More information: http://www.tn.gov/hcfa/section/strategic-planning-and-innovation-group