Health Care
Innovation Initiative

Health Care Payment Learning and Action Network Summit
October 26, 2015

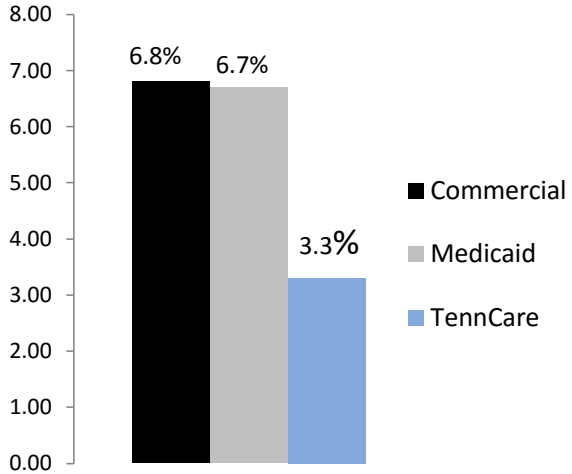
TennCare's Success to Date

Tennessee's strives to: Simplify Complexity, Enhance Data Use, and Redesign Incentives

Financial Trends

According to a GAO report released in June 2014, **TN was tied for the 4th lowest Medicaid spend per enrollee nationwide**.

According to a Pew report issued in April 2015, **TN had the 3rd lowest change in Medicaid Spending as a share of own-source revenue**, 2000 and 2013.



This graph shows projected medical trend for commercial insurance, Medicaid nationally, and actual TennCare. (Sources: Price WaterhouseCooper, CMS National Health Expenditure Data, and TennCare budget data)

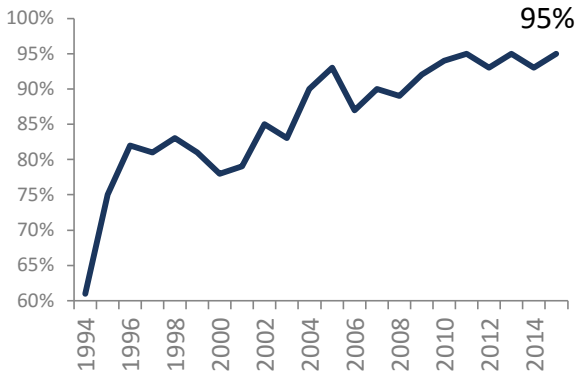
HEDIS quality results showed:

Out of 33 HEDIS measures tracked since 2007**, 28 have shown improvement over time (85%).** These measures include access and availability, prevention and screening, and effectiveness of care.

47 measures have shown improvement from 2014-2015

Member Satisfaction

- UT conducts an annual survey of TennCare members.
- Satisfaction has remained above 90% for the past 7 years.



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 **reducing 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

aetna	"Looking forward, we project that 20% to 25% of our medical costs will run through some form of value-based network contract in 2014 and are committed to increasing that participation percentage to 45% by 2017"
BlueCross BlueShield	"Thirty-seven Blue Plans have more than 350 value-based programs in market or in development, with more than 215,000 participating providers providing care to nearly 24 million members."
Cigna	"Cigna has been at the forefront of the accountable care organization movement since 2008 and now has 114 Cigna Collaborative Care arrangements with large physician groups that span 28 states, reach more than 1.2 million commercial customers and encompass more than 48,000 doctors."
UnitedHealthcare	"...increase value-based payments to doctors and hospitals by 20% this year to north of $43 billion...ended the year at about $36 billion of spend in value-based arrangements and we're looking to drive that north of $43 billion in 2015"
WELLPOINT	"We hope to have 75 percent of primary care physicians in our networks participating in this population health model by 2016."
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."

How Tennessee Selected Its Strategies

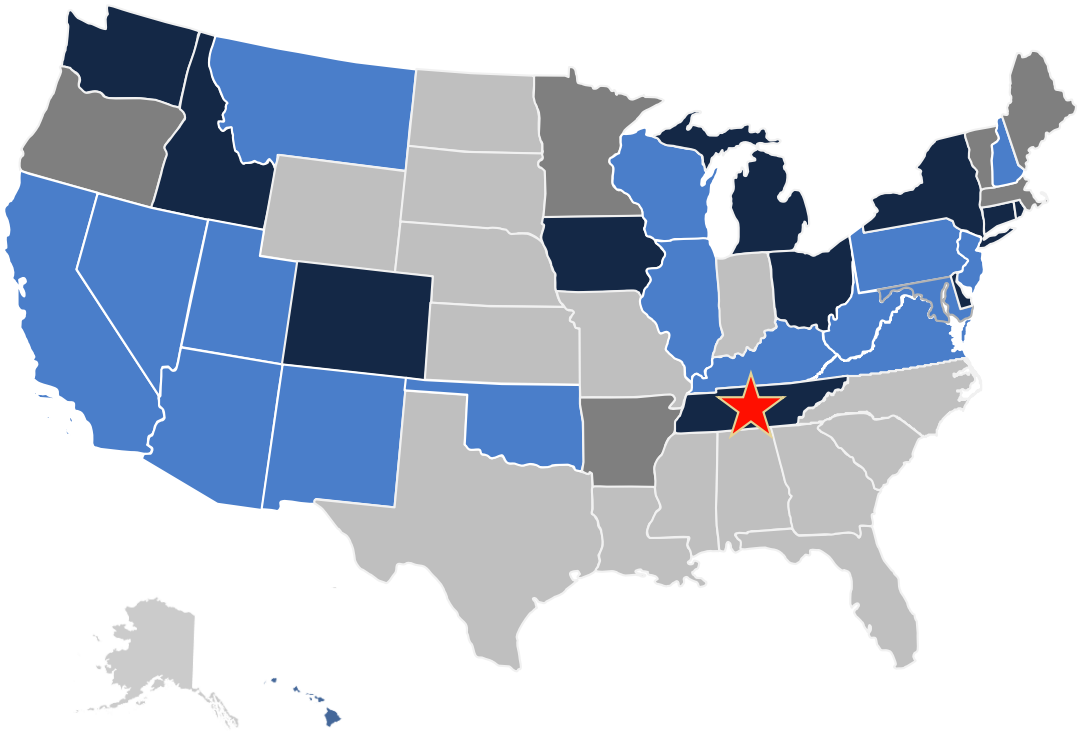
- Strategies must **compliment each other** to comprehensively address the areas of health care
- Strategies must work for all **types of providers**: Urban and rural, individual practitioners and integrated systems, specialists and primary care practitioners
- Strategies must allow for **rapid statewide adoption** so that the majority of health care spending in Tennessee will be paid using value based approaches within five years—including commercial, Medicaid, and Medicare

Tennessee's Three Strategies

	Source of value	Strategy elements	Examples
 **Primary Care Transformation**	• Maintaining a person's health overtime • Coordinating care by specialists • Avoiding episode events when appropriate	• Patient Centered Medical Homes • Health homes for people with serious and persistent mental illness • 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 for people with SPMI
 **Episodes of Care**	• Achieving a specific patient objective, including associated upstream and downstream cost and quality	• Retrospective Episodes of Care	• Wave 1: Perinatal, joint replacement, asthma exacerbation • Wave 2: COPD, colonoscopy, cholecystectomy, PCI • 75 episodes by 2019
 **Long Term Services and Supports**	• Provide long-term services and supports (LTSS) that are high quality in the areas that matter most to recipients	• 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

State Innovation Model Grant

State Innovation Model (SIM) grant recipients



SIM Testing Round One grant (6 states)
SIM Testing Round Two grant (11 states)
SIM Round Two Design grant (17 states plus DC)

- In December 2014, Tennessee was awarded a $65 million State Innovation Model Testing grant.
- Tennessee plans to engage over 65% of primary care providers in multi-payer PCMH by 2020, impacting almost 3 million beneficiaries.
- The initiative will implement 75 episodes of care within five years and is already engaging all hospitals in the state with asthma exacerbation episode.
- Health Homes will include all 200 Community Mental Health Centers and additional behavioral health providers, supporting 55,000 TennCare members.
- LTSS Reform will affect 40,000 members receiving TennCare LTSS and an additional 7,000 members with Intellectual Disabilities currently on a wait list.

SOURCE: CMMI State Innovation Model: http://innovation.cms.gov/initiatives/state-innovations/

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.	Regional Community Forums hosted twice in each of the 9 regions across the state for consumers, family members, and providers.	Select clinicians meet to provide clinical advice on each strategy	Periodic engagement with employers and employer associations.
Meeting frequency	Monthly	2 per month	2 per region	3-6 per group	As needed

The initiative has met with over 250 stakeholder groups in more than 500 meetings since February 2013.

Contracting approach

Contract	TennCare	State Employee Health Plan
# of members	~ 1.3 million	~ 270,000
Value based payment required for members?	✓	✓ by January 1, 2017
Participating Insurers	BCBS, United, and Amerigroup	Cigna and BCBS
Language on broader commercial implementation	RFP Question: "What are your plans to adopt episode based payment models population based payment models in other books of business and/or other geographies, and at what pace?"	**2017**: 50% of fully insured members & 10% self insured ASO members **2019**: 60% of fully insured members & 15% self insured ASO members
Link to contract or RFP	http://www.tn.gov/tenncare/forms/MCOStatewideContract.pdf	http://tn.gov/generalserv/cpo/sourcing_sub/NewestFiles/31786-00125%20Amd%204.pdf

PRIMARY CARE TRANSFORMATION

Objectives of PCMH and Health Homes is to improve patient outcomes through increased coordination

	PCMH: Holistic approach to care coordination for all patients	**Health Home**: Coordinated approach for highest-needs behavioral health members
Access	▪ Ensure access to the **full spectrum of needed care for all patients**[1], including those with long-term services and supports needs	▪ Ensure access to a **range of behavioral-health related supports** aligned with level of need
Joint decision making	▪ Promote joint decision making across the **continuum of care providers**	▪ Foster joint decision making across **behavioral and other health providers**
Mindsets	▪ Instill awareness of **quality, cost, and patient access** across range of providers	▪ Instill awareness of **interaction of behavioral and physical health needs** including quality and cost impact
Sources of value	▪ **Expected sources of value** to include – Appropriateness of care setting[2] – Appropriateness of treatment[3] – Improved patient treatment compliance – Referrals to high-value providers – Reduced readmissions	▪ **Expected sources of value** to include – Appropriateness of behavioral health care setting / forms of delivery – Choice of behavioral healthcare providers – Referrals to high-value providers – Medication management

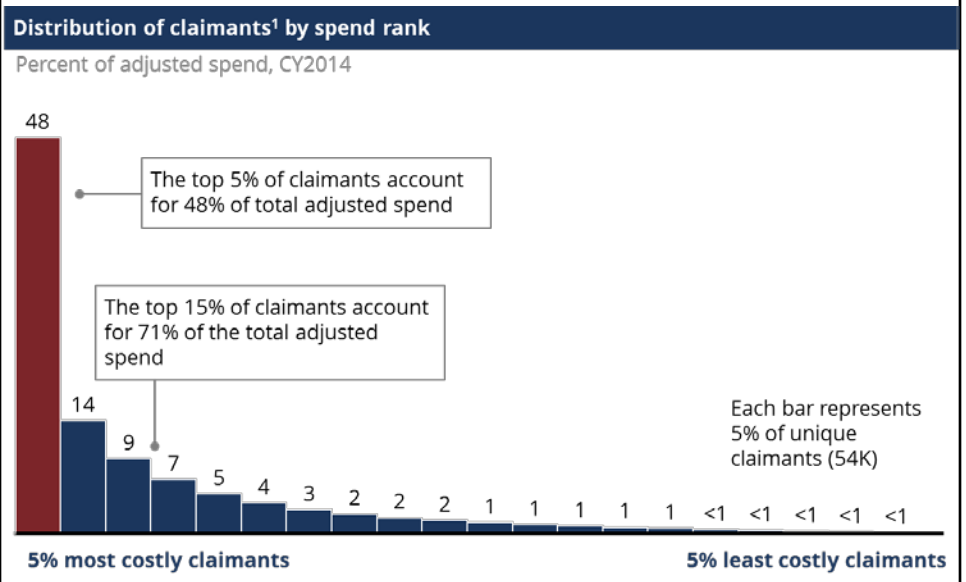
Primary care transformation aims to enhance coordination and integration across behavioral and physical health

1 E.g., Extended office hours, open scheduling
2 E.g., Reduction in unnecessary ED visits and inpatient admissions; shift to lower cost facilities
3 E.g., Improved medical management, appropriate length of stay, effective resource utilization

Primary Care Transformation

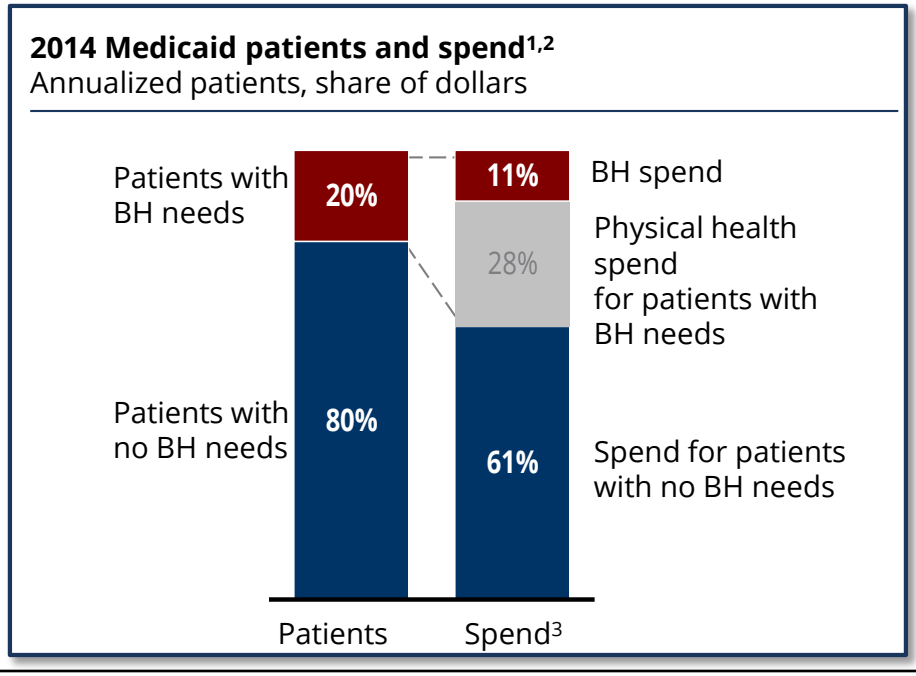
Patient Centered Medical Homes (PCMH)
for all Tennesseans

- Prevention and chronic disease management
- Avoiding episode events when appropriate
- The highest cost 5% of TennCare members account for nearly half of total adjusted spend
- Members in the highest cost 5% were also in that category the previous year 43% of the time.



Health Homes
for TennCare members with Severe Mental Illness

- Behavioral and physical health services integration
- Individuals with behavioral health needs make up only 20% of the TennCare population, but 39% of the total spend



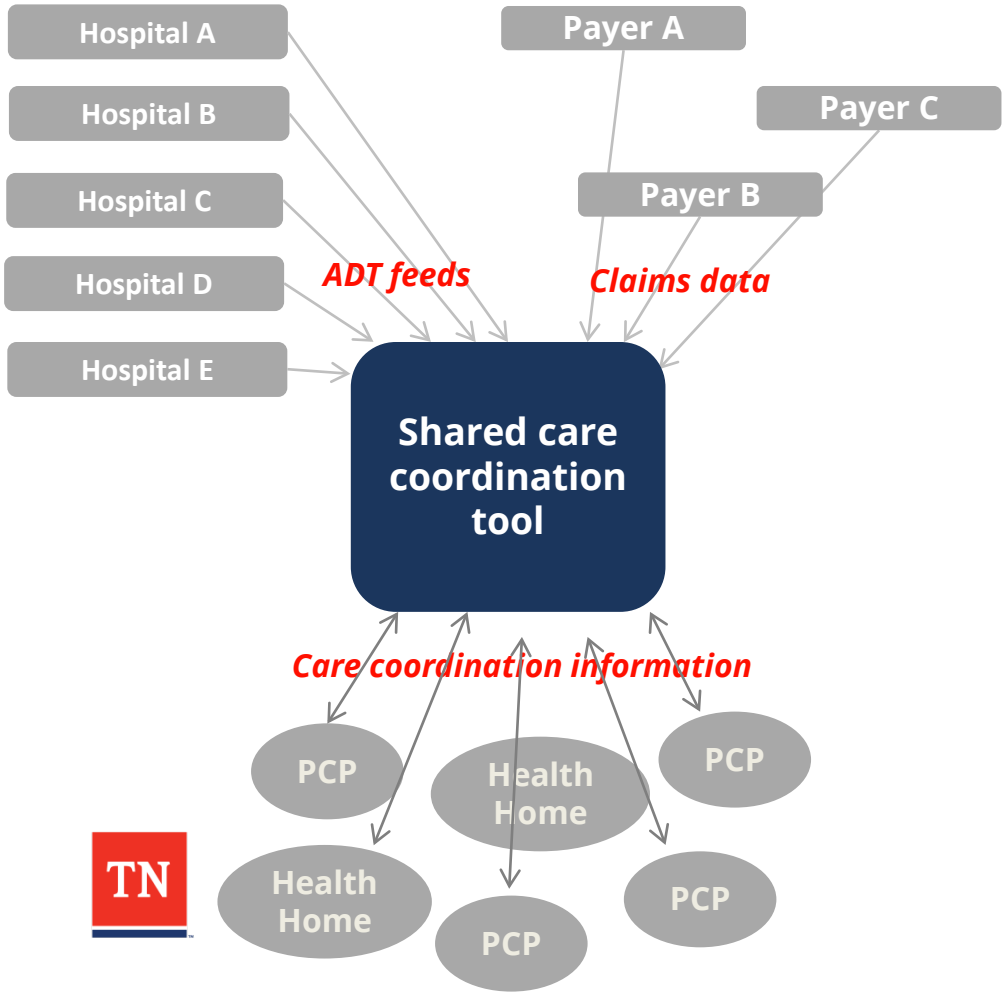
1 Annualized members (not unique members) shown here with no exclusions made on population or spend. Only 86% of Annualized members were claimants

2 Most inclusive definition of patients with BH needs used here of members who are diagnosed and receiving care, diagnosed but not receiving care, and receiving care but undiagnosed. Behavioral health spend defined as all spend with a BH primary diagnosis or BH-specific procedure, revenue, or HIC3 pharmacy code.

3 Excludes claims billed through the Department of Children's Services

Primary Care Transformation: Strategy

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

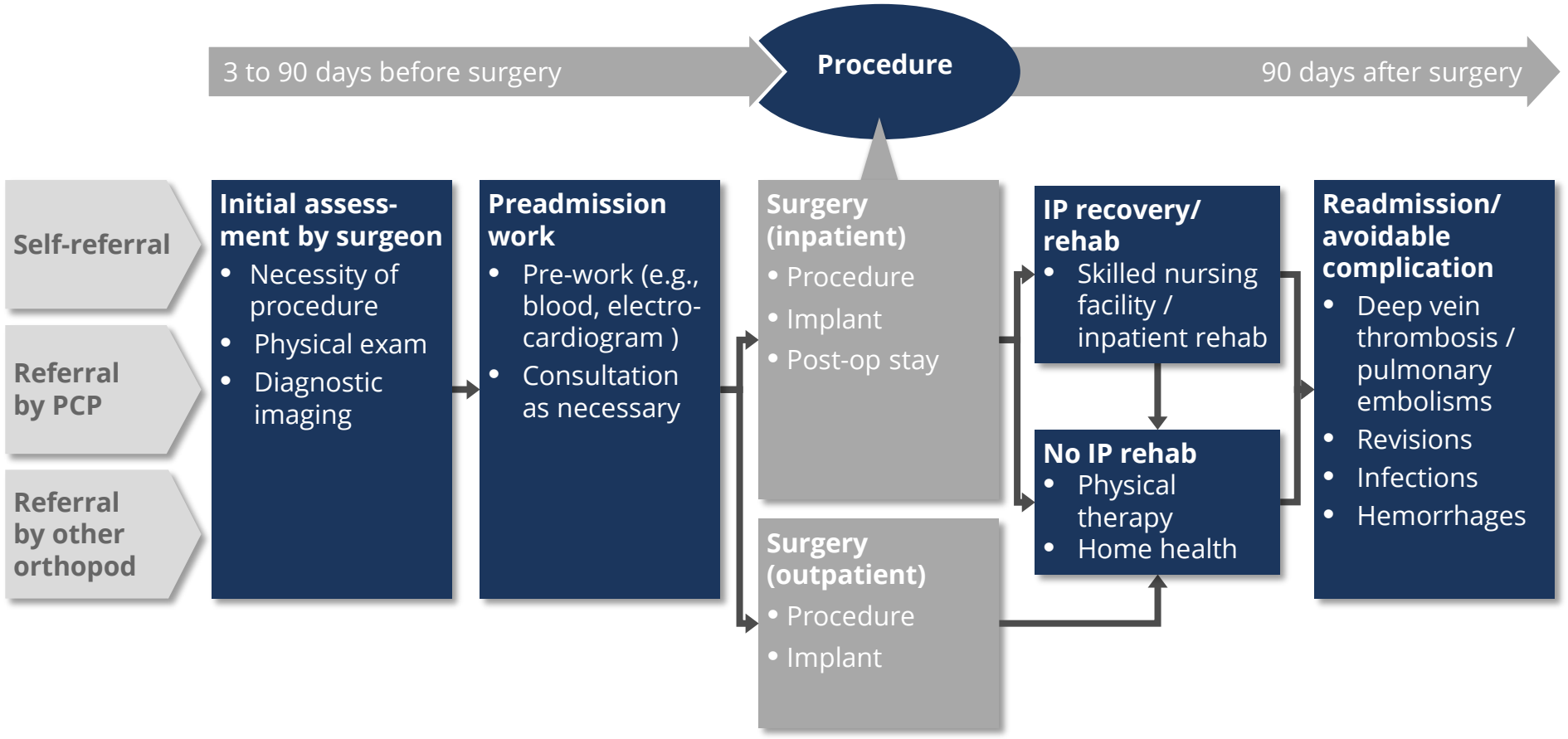


- Alerts providers of any of their attributed patients' hospital admissions, discharges, and transfers (ADT feeds)
- Identifies patients risk scores
- Generates and displays gaps-in-care and creates prioritized workflows for the care team
- Maintains, executes and tracks activities against patient-specific care plans
- Displays prescription fills, with alerts on polypharma and gaps in medication adherence

EPISODES OF CARE

Episodes of Care: Definition

Example patient journey for hip & knee replacement



Episodes include services from multiple providers

Episodes of Care: Process

Unchanged Billing Process

1

Patients seek care and select providers as they do today

2

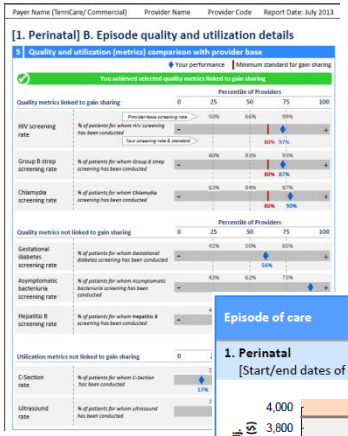
Providers submit claims as they do today

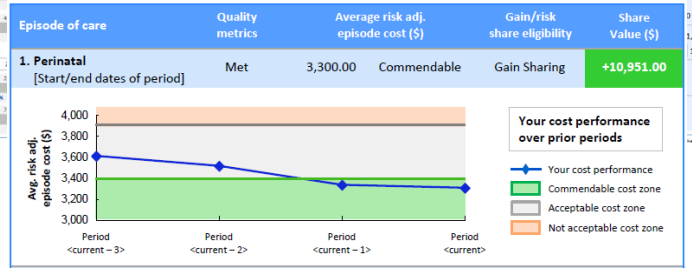
3

Payers reimburse for all services as they do today

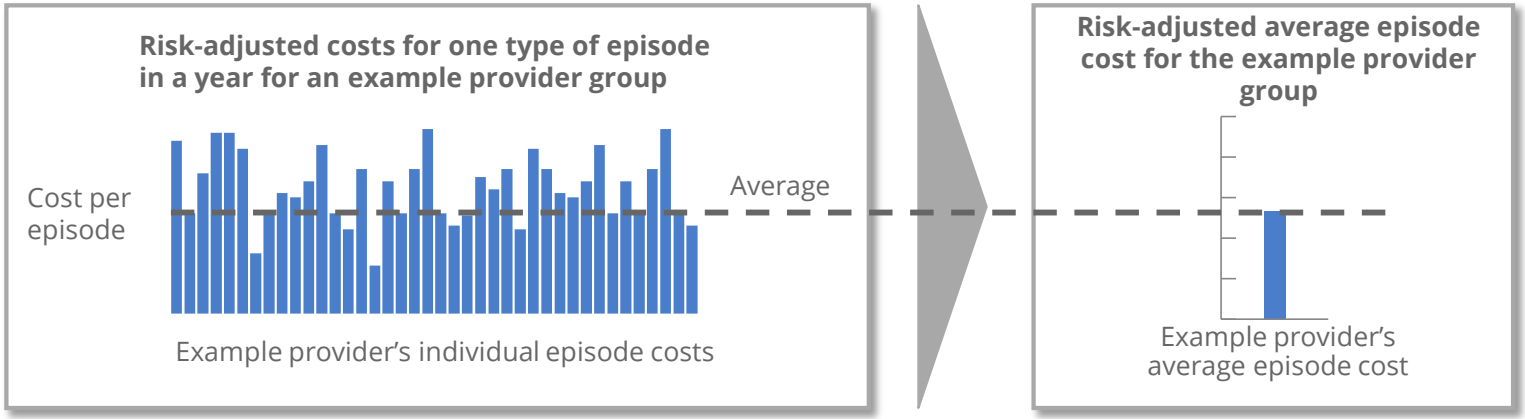
New Information

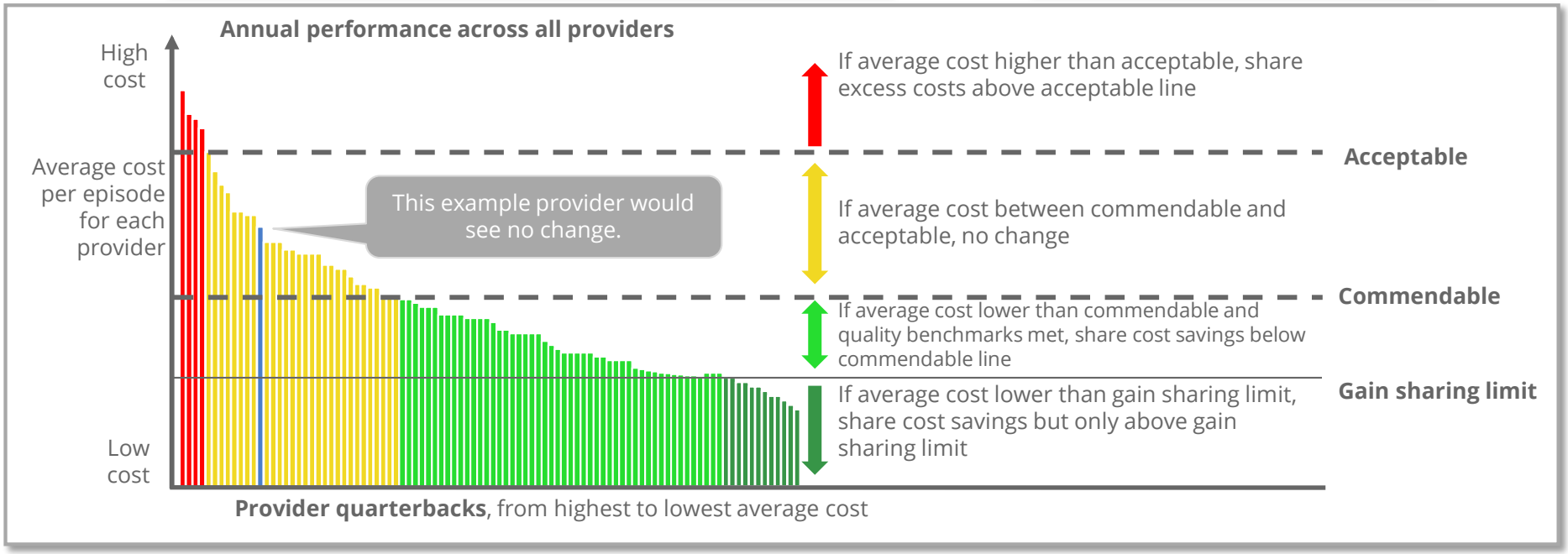
'Quarterbacks' are provided detailed information for each episode which includes **actionable data**





Episodes of Care: 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 (42%)
  - Percent of patients on an appropriate medication (82%)
- **Informational only:**
  - Repeat asthma exacerbation rate
  - Inpatient admission rate
  - Percent of episodes with chest x-ray
  - Rate of patient 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:**
  - Participating in a Qualified Clinical Data Registry (e.g., GIQuIC)
- **Informational only:**
  - 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

Payer Name (TennCare/ Commercial) | Provider Name | Provider Code | Report Date: July 2013

[1. Asthma] A. Episode Summary [Period: Start/end dates of period]

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 $1,000	$1,000 to $1,750	$1,750

Your avg. cost: $911.80 | Providers' base avg. cost: $1,242.20

YOUR GAIN/ RISK SHARE

You are eligible for gain sharing

+$10,391.80

Commendable cost ($)	–	Your avg. cost ($)	x	Number of episodes	x	Share factor
1,000		910.80		233		50%

3 Episode cost summary

Your average episode cost is commendable

Parameters	You	Provider base average
1. Total cost across episodes	$235,796.00	$317,301.09
2. Total # of included episodes	233	235
3. Avg. episode cost (non adj.)	$1,012.00	$1,350.22
4. Risk adjustment factor* (avg.)	0.90	0.92
5. Avg. episode cost (risk adj.)	$910.80 Commendable	$1,242.20 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

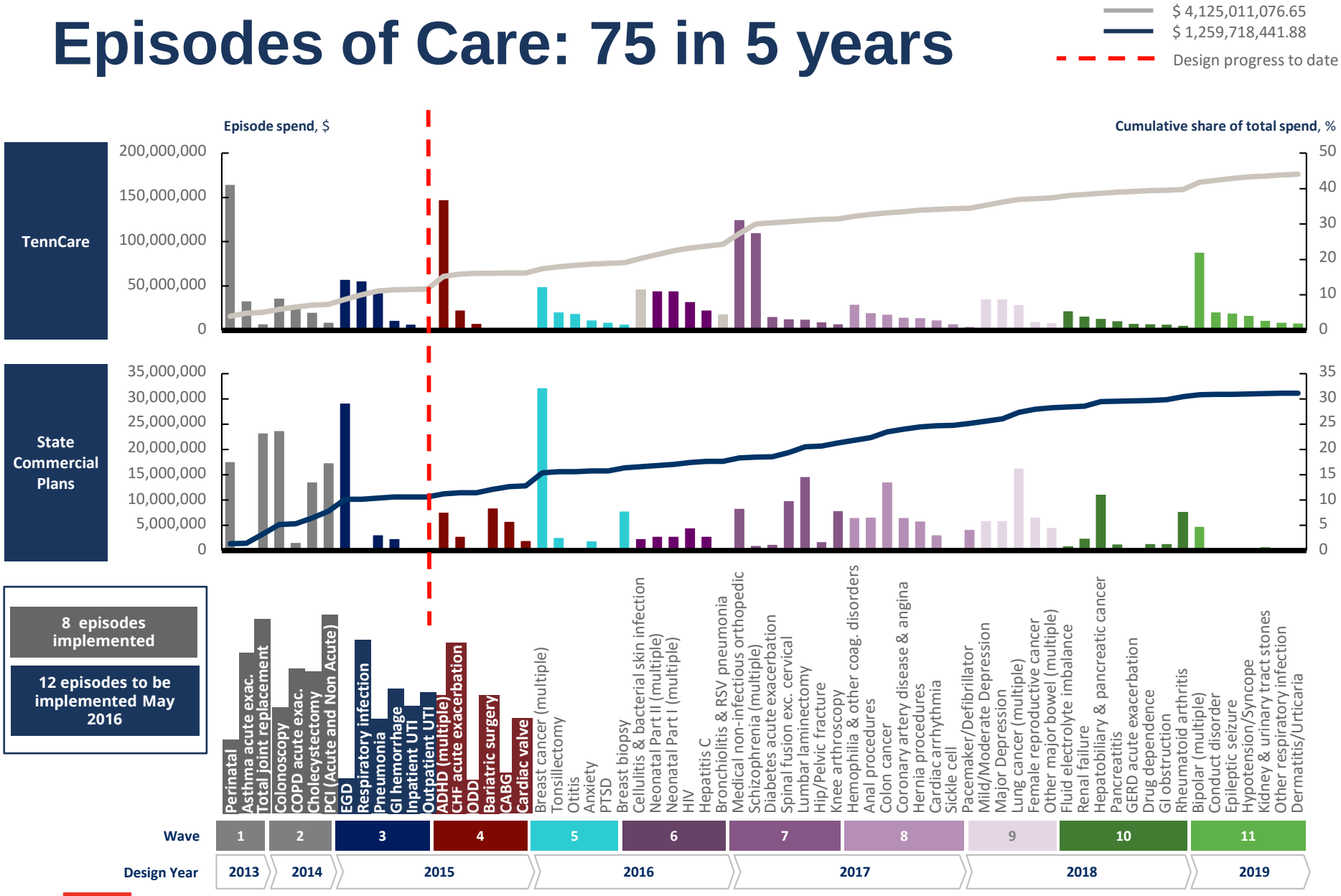
You achieved selected quality metrics

Quality metrics linked to gain sharing	You	Gain share standard	Met standard
1. Follow-up visit w/ physician	61%	55%	✓
2. Patient on appropriate medication	77%	70%	✓

Quality metrics not linked to gain sharing	You	Provider base average
1. Repeat acute exacerbation within 30 days	5%	8%

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



Note: Tennessee may want to assess benefits of securing additional Tennessee Commercial Data with which to design and localize certain episodes (multiple) indication identifies episodes in which more than one episode may be designed

Source: TennCare and State Commercial Plans claims data, episode diagnostic model, team analysis

LONG-TERM SERVICES AND SUPPORTS

Long-term Services and Supports

Quality- and acuity-based payment for NFs and HCBC

- Nursing facility (NF) and Home and community based care payments will be based in part on patient need and quality outcomes
- Goal to reward providers that improve the member's experience of care and promote a person-centered care delivery model

Value-Based Purchasing Initiative for Enhanced Respiratory Care (ERC)

- Revised reimbursement structure for ERC services in a nursing facility
- Point system to adjust rates based on the facility's performance on key performance indicators (e.g., rates of liberation, decannulation, infection, unplanned hospitalization and death)
- Strengthened standards of care, and educational programs to promote quality and best practices.

Workforce Development

- Invest in the development of a comprehensive training program 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