Tennessee Health Care Innovation Initiative

Tennessee Healthcare Financial Management Association
Spring Institute
May 19, 2015

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 episodes and population-based payment models account for the majority of healthcare spend within the next three to five years.

This effort will require new relationships and collaboration between users, providers, and payers.

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.

“I believe Tennessee can also be a model for what true health care reform looks like.”

“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
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

“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.”

“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”

“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 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.”

"...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”

“We hope to have 75 percent of primary care physicians in our networks participating in this population health model by 2016.”
Tennessee’s Three Strategies

### Source of value
- Maintaining a person’s health overtime
- Coordinating care by specialists
- Avoiding episode events when appropriate
- Achieving a specific patient objective, including associated upstream and downstream cost and quality
- Provide long-term services and supports (LTSS) that are high quality in the areas that matter most to recipients

### Strategy elements
- Patient Centered Medical Homes
- Health homes for people with serious and persistent mental illness
- Care coordination tool with Hospital and ED admission provider alerts
- Retrospective Episodes of Care
- Quality and acuity adjusted payments for LTSS services
- Value-based purchasing for enhanced respiratory care
- Workforce development

### Examples
- Encouraging primary prevention for healthy consumers and coordinated care for the chronically ill
- Coordinating primary and behavioral health for people with SPMI
- Wave 1: Perinatal, joint replacement, asthma exacerbation
- Wave 2: COPD, colonoscopy, cholecystectomy, PCI
- 75 episodes by 2019
- Aligning payment with value and quality for nursing facilities (NFs) and home and community based care (HCBS)
- Training for providers
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 multipayer 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.

# 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>Stakeholders involved</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>Regional Community Forums hosted twice in each of the 9 regions across the state for consumers, family members, and providers.</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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<tr>
<td>Meeting frequency</td>
<td>Monthly</td>
<td>2 per month</td>
<td>2 per region</td>
<td>3-6 per group</td>
<td>As needed</td>
</tr>
</tbody>
</table>

The Initiative has met with over 250 stakeholder groups in more than 425 meetings since February 2013.
PRIMARY CARE TRANSFORMATION
Most medical costs occur outside of the office of a primary care physician (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. Health Homes will further incorporate behavioral care for TennCare members with severe and persistent mental illness.

- Primary care providers are responsible for proactively managing their attributed patient’s health care.
- Rewards for reduced avoidable ED visits and hospitalizations, more coordinated care, and improved quality of care.
- Training and technical assistance supports to providers.
- Regular reports to providers on the quality and efficiency of the care their attributed patients receive.
- Primary care providers are alerted when their attributed patients are admitted, discharged, or transferred to the hospital or emergency department.
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
Major payers in Tennessee have committed to have 80% of members across all books of business cared for through a population-based model within five years.

Tennessee’s timeline for PCMH and Health Home rollout:

<table>
<thead>
<tr>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q3 – Q4: PCMH and Health Home Technical Advisory Groups meet to advise on design elements of the program</td>
<td>Q2: Launch multi-payer PCMH pilot for a minimum of 12 practices</td>
<td>Q2: Expand multi-payer PCMH to pilot practices plus one grand region</td>
<td>Q2: Expand multi-payer PCMH statewide</td>
</tr>
<tr>
<td></td>
<td>Q2: Launch Health Homes statewide</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Q2: Practice transformation training begins</td>
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</table>
EPISODES OF CARE
Episodes of Care: Definition

Example patient journey for hip & knee replacement

3 to 90 days before surgery

Self-referral
- Initial assessment by surgeon
  - Necessity of procedure
  - Physical exam
  - Diagnostic imaging

Referral by PCP
- Preadmission work
  - Pre-work (e.g., blood, electrocardiogram)
  - Consultation as necessary

Referral by other orthopod

Procedure

Surgery (inpatient)
- Surgery
- 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

Surgery (outpatient)
- Surgery
- Implant

Episodes include services from multiple providers
Episodes of Care: 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

Unchanged Billing Process

New Information

‘Quarterbacks’ are provided detailed information for each episode which includes actionable data
Episodes of Care: Incentives

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

- **Cost per episode**
- **Example provider’s individual episode costs**
- **Average**

**Risk-adjusted average episode cost for the example provider**

- **Example provider’s average episode cost**

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**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**

- **Commendable**

**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 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>ASTHMA EXACERBATION</th>
<th>PERINATAL</th>
<th>SCREENING AND SURVEILLANCE COLONOSCOPY</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Linked to gain-sharing:</strong></td>
<td><strong>Linked to gain-sharing:</strong></td>
<td><strong>Linked to gain-sharing:</strong></td>
</tr>
<tr>
<td>- Follow-up visit rate (42%)</td>
<td>- HIV screening rate (85%)</td>
<td>- Participating in a Qualified Clinical Data Registry (e.g., GIQuIC)</td>
</tr>
<tr>
<td>- Percent of patients on an appropriate medication (82%)</td>
<td>- Group B streptococcus screening rate (85%)</td>
<td><strong>Informational only:</strong></td>
</tr>
<tr>
<td><strong>Informational only:</strong></td>
<td>- Overall C-section rate (41%)</td>
<td>- Perforation of colon rate</td>
</tr>
<tr>
<td>- Repeat asthma exacerbation rate</td>
<td><strong>Informational only:</strong></td>
<td>- Post-polypectomy/biopsy bleed rate</td>
</tr>
<tr>
<td>- Inpatient admission rate</td>
<td>- Gestational diabetes screening rate</td>
<td>- Prior colonoscopy rate</td>
</tr>
<tr>
<td>- Percent of episodes with chest x-ray</td>
<td>- Asymptomatic bacteriuria screening rate</td>
<td>- Repeat colonoscopy rate</td>
</tr>
<tr>
<td>- Rate of patient self-management education</td>
<td>- Hepatitis B screening rate</td>
<td>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</td>
</tr>
<tr>
<td>- Percent of episodes with smoking cessation counseling offered</td>
<td>- Tdap vaccination rate</td>
<td></td>
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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

### 1. Asthma 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

**YOUR GAIN / RISK SHARE**

<table>
<thead>
<tr>
<th>Cost comparison</th>
<th>Your gain ($1,091.80)</th>
<th>Providers’ base avg. cost ($1,242.20)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average</td>
<td>Less than $1,000</td>
<td>$1,000 to $1,750</td>
</tr>
<tr>
<td></td>
<td>Acceptable</td>
<td>Not acceptable</td>
</tr>
</tbody>
</table>

#### 3. Episode cost summary

- **Your average episode cost is commendable**

#### 4. Episode quality and utilization summary

- **You achieved selected quality metrics**
- **Quality metrics linked to gain sharing**
  - You: 1,242.20
  - Provider base average: 1,242.20

- **Quality metrics not linked to gain sharing**
  - You: 1,242.20
  - Provider base average: 1,242.20

### 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 episodes in 5 years

Note: (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