Division of
Health Care
Finance & Administration

Health Care
Innovation Initiative

Provider Stakeholder Group
August 12, 2015

Agenda

- **Update on Primary Care Transformation TAG process**
- Feedback on Episode of Care Annual Review session

Primary Care Transformation TAG process

- Patient Centered Medical Home (PCMH) and Health Home Technical Advisory Group (TAG) members convened for a joint opening session on July 30th.
- TAG meetings will continue approximately every 3 weeks through mid-November.
- TAG members will be advising on:
  - Best clinical practices and sources of value
  - Quality metrics and gaps in care alert
  - Requirements for practices and Health Homes
  - Exclusions for financial risk adjustment
  - Opportunities to address patient engagement
  - Training and supports
  - Provider report design

TAG agendas

TOPIC SCHEDULE SUBJECT TO CHANGE

Bold: TAG recommendations

	PCMH date	HH date	Agenda
Session 1	Thurs Jul 30 (combined session)		• Briefing on overall goals for primary and behavioral health care transformation • Briefing on PCMH and Health Home vision and objectives • PCMH and Health Home design frameworks & approach for multi-payer participation • Role of TAG and process for designing standard model • Briefing on care coordination tool
Session 2	Aug 20	Aug 18	• Fact base on Tennessee primary care: outputs of environmental scan • Discussion of best clinical practices and evidence: Patient journey (sources of value, care delivery improvements, and activities) • Case examples of successful models at scale • Briefing on NCQA requirements and recognition revisions
Session 3	Sept 10	Sept 8	• Fact base on Tennessee primary care: outputs of diagnostic • **TAG recommendation on best clinical practices and evidence** (sources of value, care delivery improvement, and Health Home activities) • Discussion of requirements for practices and Health Homes • Discussion of quality metrics and gaps in care alerts
Session 4	Oct 1	Sept 29	• **TAG recommendation on quality metrics and gaps in care alert** • **TAG recommendation on requirements for practices and Health Homes** • Briefing on payment streams and incentives • Briefing on comprehensive risk assessment approach • Briefing on interaction model of PCMH and Health Homes • Discussion of exclusions for financial risk adjustment • Discussion of patient engagement
Session 5	Oct 29	Oct 27	• **TAG recommendation on exclusions for financial risk adjustment** • **TAG recommendation on patient engagement** • Briefing on attribution methodology • Discussion of practice and Health Home training and supports • Discussion of provider report design
Session 6	Nov 19	Nov 17	• **TAG recommendation of practice and Health Home training and supports** • **TAG recommendation of provider report design** • **Review of recommendations discussed throughout the series**

Highlights from first TAG

- **Primary Care Transformation** fits into broader state agenda and is complementary to Episodes and LTSS priorities
- Objective is to **enhance integration and coordination across the continuum of care** including behavioral health, physical health, and supportive services
- **Care coordination tool** to provide infrastructure to support program across payers and providers
- **Role of the TAG** is to include input on key recommendation areas including sources of value, provider requirements, quality metrics, financial risk adjustment, training, and other areas
- **Open questions** on patient engagement and privacy approaches

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 patients
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 and including those with long-term services and supports needs
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	• **Potential 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	• **Potential 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

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

Agenda

Update on Primary Care Transformation TAG process

Feedback on Episode of Care Annual Review session

Feedback on Episode of Care Annual Review session

- On June 18th episode feedback session, the state convened over 100 stakeholders from across the state to weigh in on what is working well with the wave 1 episode designs and where providers would suggest changes for next year. During the session, the state received recommendations on how to improve the design of the wave 1 episodes of care, as well as programmatic feedback.
- The state and the Payer Coalition reviewed the recommendations and plan to move forward with implementing several of the changes for the 2016 performance period. All of the suggested recommendations and planned changes for 2016 are outlined in the attached memo.

Division of Health Care Finance & Administration

MEMO

Date: August 2015

Subject: Update on the Tennessee Health Care Innovation Initiative

Stakeholder input from Tennessee providers, payers, patients, and employers has continued to shape the design of the Tennessee's Health Care Innovation Initiative strategies. The Initiative has held over 500 meetings with stakeholders to date and continues to regularly seek stakeholder input. In the episodes of care strategy, the design of each episode is informed by a Technical Advisory Group composed of expert Tennessee clinicians representing a diversity of relevant specialties, provider types, and urban and rural practices. Providers have been receiving reports on the first three episodes for one year, thus it is a good time to review the episode design with stakeholders from across the state—aspects of each episodes design that are working and changes that may be appropriate.

On June 18, 2015, the state met with over 100 stakeholders from across Tennessee to discuss potential changes to the wave 1 episodes of care—perinatal, total joint replacement, and asthma acute exacerbation episode. The meeting was teleconferenced to five cities in Tennessee, so that providers across the state could participate. The state, as well as our payer partners have reviewed this feedback, and plan to incorporate many of these changes into the design of these episodes of care beginning in 2016. Highlighted below are the recommendations received by the state during the June 18th meeting, as well as a description of the state's next steps in addressing each recommendation.

Perinatal episode of care:

- Appropriately account for the increased cost of delivering multiple gestations: Multiple gestation patients may have higher costs than single gestation patients, and patients with three or more gestations represent a different patient pathway compared to other perinatal episodes. To account for these cost differences, the state will recommend to each payer that multiple gestations be included as a risk adjustment factor to be assessed during the development of the perinatal risk adjustment model. Additionally, the perinatal episode definition will be updated to exclude all pregnancies with three or more gestations. As there may be differences in risk and care delivered across the different types of multi-fetal gestations, the state will recommend to each payer that multiple gestation placenta status be included as a risk adjustment factor to be assessed during the perinatal risk adjustment model.
- Revise the C-section quality metric rate to reflect the JCAHO/NQF C-section metric: The current episode quality measures are claims based. The state is working on incorporating more clinical measures, like the JCAHO/NQF metric suggested, into the episode of care model, and will consider including this metric in future years after the portal infrastructure to support provider-submitted clinical data is developed.
- Remove IUDs and contraceptive implants from episode spend: Removing IUDs and contraceptive implants from included episode spend will eliminate the disincentive providers currently have to reduce their use within 60 days of discharge from delivery. The perinatal episode definition will be updated to remove all intrauterine devices and implantable contraceptives from episode spend.
- Include only related emergency department visits in the pre-trigger window: The perinatal

episode creates accountability for the total cost of care for patients who are pregnant, but the episode definition may include ED spend that is not directly related to the pregnancy, such as care that predates the diagnosis of pregnancy. The perinatal episode definition will be updated to require a confirming pregnancy-related diagnosis code for all emergency department visits to ensure that they are related to the episode. This means that ED visits prior to the start of pregnancy will not be included in the episode spend.

- Only identify the quarterback if they have provided at least 50% of care during the pregnancy: The delivering physician administers the care that accounts for the largest share of cost in an episode. Every episode also has a clear mechanism for identifying the physician who performed the delivery. Often, though not always, the delivering physician is affiliated with the group or hospital that provided prenatal care to the patient. For these reasons, the state, together with input from a technical advisory group of obstetricians, identified the delivering physician as the most appropriate quarterback. Therefore, the provider who performs the delivery of the baby will remain as the quarterback.
- Update the TDaP vaccination rate to included revenue codes 0636 and 0771, as well as exclude members who are eligible for Tennessee's Vaccines for Children (VFC) program: TDaP vaccination is an important component of perinatal care. If revenue codes 0636 and 0771 are included, then the measure will correctly identify additional patients who receive the vaccine. Furthermore, removing from the denominator the patients eligible for Tennessee's VFC program will reduce the likelihood of a "false negative" due to the absence of a TDaP claim in the claims data. The perinatal episode definition will be updated to include revenue codes 0636 and 0771 within the list of codes for the TDaP vaccination metric, and will also be updated to exclude members less than 21 years of age, from being included in the metric.
- Exclude emergency department providers as quarterbacks: Although emergency room physicians are unlikely to have provided longitudinal perinatal care to a patient who is pregnant, the delivering physician is still responsible for what is typically the largest share of spend within the perinatal episode. Furthermore, maintaining a consistent approach to assigning the quarterback will help promote shared accountability within the health system. Therefore, a provider who performs the delivery of the baby, regardless of specialty, will remain the quarterback.
- Establish a minimum criterion for length of antenatal care in order to be assigned as a quarterback: Limiting accountability based on the duration of antenatal care is inconsistent with the state's objective of promoting shared accountability for patients across the health system and of improving the health of mothers and babies in Tennessee. Therefore, the delivering provider will remain as the quarterback regardless of length of antenatal care.
- Develop risk weights for prior pregnancy complications that affect the management of subsequent pregnancies: A history of pregnancy complications may bring about more costly care in subsequent pregnancies. The state will include diagnosis codes that account for a history of complications during pregnancy in the list of recommended risk factors for each payer to test.
- Exclude MFMs as potential quarterbacks for the episode: MFMs provide care to some of Tennessee's most vulnerable and high-risk mothers. Although MFM physicians are more likely to deliver the babies of high-risk patients and are more likely to have patients who require cesarean delivery, the risk adjustment process accounts for these increased costs based on differences in patient population. Furthermore, the delivering physician is responsible for what is typically the largest share of spend within the perinatal episode. The state also notes that the current episode design promotes appropriate early engagement of

an MFM in the expectant management of high-risk patients given their ability to improve outcomes for the mother. Therefore, the state proposes that the provider who performs the delivery of the baby, regardless of specialty, remains the quarterback. Any future changes that incorporate more of the newborn costs in the episode could further reflect the value that the MFM provides in the perinatal episode.

- Include newborn care costs in OB/GYN episodes: Expanding the accountability of OB/GYN physicians to the cost of newborn care could further the goal of improving value for all beneficiaries and promoting shared accountability across the health system. A mechanism for linking neonatal and perinatal episodes could provide valuable accountability of providers for perinatal care, reduce costs, and improve quality. The state plans to convene a neonatal episode TAG in the fall of 2016 and will at that time consider whether some of the neonatal costs can be included in the perinatal episode as well.
- Remove group B strep/HIV metrics, update metric codes, or lower thresholds to account for patient variation: Multiple factors may influence a provider's performance on perinatal screening measures, including a history of GBS or a patient declining an HIV exam. Patients who have an active GBS infection (e.g., as diagnosed by urine culture) or a history of colonization are not currently included in the numerator of the GBS quality measure. Therefore, the state proposes updating the metric definition to include specific diagnosis codes that specify a history of or active group B streptococcus into the list of acceptable codes to satisfy the quality metric. The state recognizes that some patients may decline an HIV test, despite its being indicated in the prenatal period. For this reason, the threshold for the quality measure is set below 100% and is based on the historical experience of Tennessee providers. The state does not propose any adjustments to the HIV quality measure threshold. The state does, however, propose expanding the set of codes in the numerator of the HIV quality metric to incorporate a broader set of potential assays for HIV.
- Concern that the episode's accounting of transportation cost would discourage utilization of appropriate post-natal visits for the mother: The state agrees that structural barriers such as transportation can potentially limit access to care, both in the prenatal and postnatal periods. The state will remove transportation from the calculation of episode cost.

Asthma Acute Exacerbation episode of care:

- Risk adjust for higher cost pediatric patients or only compare pediatric facilities to each other: Risk adjustment is the mechanism the episode-based payment program uses to account for patient variation. All the payers currently use age as a risk adjustment factor for this episode, and there is not a need for a difference according to the designation of the facility.
- Update the corticosteroid quality measure to include Decadron from hospital claims in the list of codes for the quality metric and broaden the window for scripts to 90 days from 30 days to allow for 90 day refills: As Decadron is a relevant drug to be included in the medication quality metric, the asthma acute exacerbation episode definition will be updated to include Decadron from hospital claims within the list of acceptable codes for the medication quality metric.

  After further review, the intent of the corticoid steroid quality metric can be better captured by focusing on the patient population that requires systemic corticosteroids for asthma acute exacerbations. Therefore, all inhaled corticosteroids will be removed from the numerator, leaving only oral and injectable systemic corticosteroids within 30 days of the end of the trigger window as contributing to acceptable performance.
- Remove code 493.00 from the list of trigger codes: Code 493.00 (Extrinsic asthma

unspecified) should not normally placed in the primary position. In the few cases where the code is used in the primary diagnosis field, the treatment pathway is similar it to an asthma acute exacerbation. Thus, removing the claim entirely would likely remove cases that are appropriate for the episode. To ensure that the episodes included do indeed clinically represent an asthma acute exacerbation, the state will change the episode logic so that episodes with 493.00 are only triggered in the event that a confirming asthma acute exacerbation-related diagnosis code appears within one year prior to the episode. This approach is the same as the TAG-recommended trigger logic used for wheezing.

Total Joint Replacement episode of care:

- Shorten the pre-trigger window to 10 days from 45 days: Episode window lengths accurately reflect the span of relevant care delivered. Accountability in the pre-trigger window for the total joint replacement episode is limited to office visits, imaging, testing, and laboratory spend billed by the quarterback. Therefore, the state will maintain the current pre-trigger window length.

Additionally, during the June 18th meeting, stakeholders recommended program level changes for consideration by the state. Based on that feedback, the state plans to implement the following changes for the 2016 performance period:

Enhancements to episode of care reporting: On several occasions, the state has made changes to episode of care reports in response to requests from stakeholders. Based on feedback from stakeholders, the episode of care reports will be further improved with three new features:

- Quality metrics results for each included episode of care
- Total risk adjusted cost for each included episode of care
- Prescription drug summary of quarterback's most frequently prescribed drugs

Minimum volume threshold: During the June 18th feedback session, it was suggested that providers with a low volume of episodes should not be held financially accountable under the episode of care model. The state believes that all providers should be held accountable under the episode of care model, regardless of the number of episodes they perform. However, beginning in the 2016 performance period, providers with risk sharing payment of less than $100 dollars will not be penalized. All providers will continue to receive reports, but only those providers with a final risk sharing payment in excess of $100 will be required to make a shared risk payment back to the MCO. Providers with a shared savings reward of any amount will continue to receive the reward payment.

Aligning readmission logic with future waves of episodes: Currently, all wave one episodes of care include readmissions based on an exclusionary logic. Going forward, readmissions will be based on an inclusionary logic meaning that only specifically related admissions are included. This change aligns closely with a related care logic already included in the pre-trigger window for the perinatal and total joint replacement episodes, and will be easier for the state to update and maintain over time.