Tennessee
Health Care Innovation Initiative

Provider Stakeholder Group

March 25th, 2015

Agenda

Updates on the Tennessee Health Care Innovation Initiative

Next steps on Primary Care Transformation

Updates on the Tennessee Health Care Innovation Initiative

- *New training webinar*
  - Based on feedback from the Provider Stakeholder Group, the state has developed a new training webinar on the Tennessee Health Care Innovation Initiative. The webinar describes the initiative's three strategies, primary care transformation, episode of care and long-term services and supports. You can view the webinar on our website under the "Three strategies" section or access directly at: http://stateoftennessee.adobeconnect.com/p9dutc49lvm/.

- *Update on wave 3 Technical Advisory Groups*
  - Wave 3 episode of care TAGs started last week, and the state has held meetings with both the URI/Pneumonia TAG and the UTI TAG. The schedule for the remaining TAG meetings is below.

Technical Advisory Group	Meeting dates
Upper respiratory infection and Pneumonia	▪ Wednesday, April 8th (9AM-12PM CST) ▪ Wednesday, April 29th (9AM-12PM CST)
Outpatient urinary tract infection and Inpatient urinary tract infection	▪ Wednesday, April 15th (9AM-12PM CST) ▪ Tuesday, May 5th (1PM-4PM CST)
Esophagogastroduodenoscopy (EGD) and Gastrointestinal hemorrhage	▪ Tuesday, March 31st (9AM-12PM CST) ▪ Wednesday, April 22nd (9AM-12PM CST) ▪ Tuesday, May 5th (9AM-12PM CST)

Agenda

Updates on the Tennessee Health Care Innovation Initiative

Next steps on Primary Care Transformation

Primary Care Transformation- Key events timeline

- The Tennessee Health Care Innovation Initiative is procuring consultant services that include designing, implementing, and supporting two programs: (1) a Patient-Centered Medical Homes (PCMH) program for commercial and Medicaid insurance, and (2) Medicaid Health Homes for TennCare members with severe and persistent mental illness (SPMI).
- The State's goal is to have over 65% of primary care providers in the state enrolled in a PCMH model by 2020, engaging over 2.6M Tennesseans.
- Health Home providers will serve all of TennCare's SPMI population starting at program launch, approximately 55,000 Tennesseans.

Key events	Date
Contract term	May 15, 2015 – January 31, 2019
Multi-payer PCMH and SPMI Health Home TAG meetings	June 2015 – September 2015
Multi-payer PCMH launch (for 12 pilot practices)	April 2016
SPMI Health Homes launch statewide (2 Years Enhanced Prospective Payment Begins)	July 2016
PCMH for 12 practices, and 1 Grand Region Launches	April 2017
PCMH Launches Statewide	April 2018
Outcomes-based Payment Begins Health Homes	July 2018

Primary Care Transformation – PCMH Working Design Decisions

- **Patient population:** All members not eligible for the Health Home program.

- **Key quality metrics:** A key goal of the PCMH approach is to align the quality metrics that are used by each of the payers participating in the initiative. The strong preference of all stakeholders is to use quality metrics that are nationally recognized (such as National Quality Forum endorsed measures).

- **Attribution Model:** MCOs will continue to do attribution as they do today. Commercial payers may or may not adopt the same attribution approach and the Consultant will need to take different approaches to attribution into account in the program design.

- **Efficiency:** The initiative believes that when possible, rewards to providers should be significantly based on a cost and utilization measures such as total cost of care, avoidable emergency department use, and/or avoidable hospitalization.

- **Provider Requirements:** Stakeholders agree that the basis for requirements on primary care providers participating in the program should have NCQA PCMH recognition.

- **Reports to providers:** Reports to providers will highlight their achievement on quality and efficiency metrics, including total cost of care, and reward payments that providers have earned. The state imagines that these reports will be similar to the Episode of Care provider reports.

Primary Care Transformation – PCMH Working Design Decisions (continued)

- **Actionable information to providers:** Providers will receive ADT alerts when their attributed patients go to Tennessee hospitals and emergency departments from a shared provider facing population management software solution. In addition, this software will inform providers of their risk-stratified member panel, gaps in care reporting, and filled scripts reports.

- **Payment:** Different approaches to PCMH payment make sense for providers with different sized patient panels, different levels of PCMH readiness, and urban and rural providers. Therefore the initiative will not set a single payment approach but will create a menu of options for providers and payers to agree upon. The common goals and measures will also create alignment between providers' approaches to payment.

- **Scale up:** The program will begin with 12 practices in East and West Tennessee by July 2016. The program will then expand to cover one grand region (East, West, or Middle Tennessee) by July 2017. By July 2018, the program will go state-wide and by 2020, our goal is to have over 65% of primary care providers in the state enrolled in a PCMH model. The Consultants advice on engaging with providers with a relatively small number of patients will be important to reaching the states goal.

Primary Care Transformation – Health Home Working Design Decisions

- **Patient population:** All TennCare members who have claims with diagnoses of schizophrenia, bipolar, personality disorder, and major depression (an estimated 55,000 members).

- **Key quality metrics:** TennCare will use all recommended CMS Health Home Core Quality measures including, adult BMI, ambulatory care sensitive condition admission, care transition-transition record submitted to the healthcare professional, follow-up after hospitalization for mental illness, all cause readmission, screening for clinical depression and follow-up plan, initiation and engagement of alcohol and other drug dependence treatment, controlling high blood pressure. In addition, the state will likely adopt quality and outcome measures recommended by the Health Home TAG. Likely outcome measures include avoidable Emergency Department utilization and avoidable in-patient admission and readmission rates.

- **Efficiency:** The initiative believes that after the first two years of the Health Home program, rewards to providers should be significantly based on a cost and utilization measure such as total cost of care, avoidable emergency department use, and/or avoidable hospitalization.

- **Attribution Model:** There is some question as to how the MCO's existing attribution system can be adapted for an SPMI member who may have a primary care provider and a behavioral health provider, both of whom would benefit from being attributed providers.

- **Accreditation:** TennCare's expectation is that Health Homes will be working towards receiving NCQA Level One PCMH accreditation, NCQA patient-centered specialty practice recognition, Joint Commission PCMH accreditation, Joint Commission Behavioral Health Home certification, or CARF Behavioral Health Home as part of the provider's requirements for participating in the program.

Primary Care Transformation – Health Home Working Design Decisions (continued)

- **Reports to providers:** Reports to providers will highlight their achievement on quality and efficiency metrics, including total cost of care, and reward payments that providers have earned. These reports will be similar to Episode of Care provider reports.

- **Actionable information to providers:** Providers will receive ADT feeds, their risk-stratified member panel, gaps in care reporting, and filled scripts reports.

- **Payment:** Providers will receive a PMPM tied to process measures with the possibility of a quality bonus for the first two years of Health Homes. The PMPM will be distributed for every Health Home member that receives one of the six designated Health Home services over the course of a quarter (the provider's active patient panel). These payments will not duplicate services already financed through the TennCare program. The rate will be developed based on anticipated service volumes, member acuity, provider's ability to handle different levels of member complexity, and expected Health Home staffing needs to support the Health Home enrolled populations. After two years the Health Homes program will shift to outcome-based payments.

- **Scale up:** Because Health Homes are a state plan service and because Tennessee plans to launch state-wide, Health Homes must offer an adequate state-wide network of providers when the program launches.

Primary Care Transformation – TAG detailed timeline

- We are moving forward with two TAGs; one for multi-payer PCMH design and another to design TennCare Health Homes for members with severe and persistent mental illness.
- We anticipate accepting no more than 20 TAG nominees for each group.

Events	Date
Announce PCMH and Health Home TAGs, call for nominees opens	April 15, 2015
Provider nominations due to the state	April 30, 2015
Primary Transformation Contractor starts	May 15, 2015
Notify final TAG members of acceptance	May 21, 2015
1st PCMH and Health Home TAG meeting (joint kickoff meeting)	June 18th, 1-3pm
2nd PCMH and Health Home TAG meeting	July 7th & July 9th, 1-3pm
3rd PCMH and Health Home TAG meeting	July 28th & July 30th 1-3pm
4th PCMH and Health Home TAG meeting	August 18th & August 20th, 1-3pm
5th PCMH and Health Home TAG meeting (joint final meeting)	September 10th, 1-3pm

- If there is a need for a 6th TAG meeting, we will hold separate PCMH and Health Home TAGs for the 5th meeting (September 8th &10th) and we will have a final joint meeting of the TAGs on October 1st, 1-3pm.

Primary Care Transformation – Possible TAG topics to cover with providers

- Feedback on the design of provider reports
- Feedback on comprehensive risk assessment/comprehensive health assessment content
- Feedback on provider actionable information (e.g. ADT feeds, pharmacy claims, risk scores, gaps in care, etc.)
- Quality metrics and process gates
- Possible outcome measures
- Feedback on requirements and expectations of a PCMH /Health Home
- Feedback on provider supports (e.g. what kind of training do you want?)
- How to best develop partnerships between primary care and behavioral health providers