DELIVERY SYSTEM TRANSFORMATION

Final Provider Stakeholder Group Meeting
March 12, 2020

Agenda

- State Innovation Model (SIM) grant overview

- Provider/stakeholder input

- Program Results
  - ❑ Long Term Services and Supports
  - ❑ Department of Health, population health model
  - ❑ Episodes of Care
  - ❑ Patient-Centered Medical Homes
  - ❑ Tennessee Health Link

- Awards and Accomplishments

State Innovation Model (SIM) Grant Goals

Tennessee aimed to increase high-quality, cost-effective primary care, episodic care, and long term services, and supports (LTSS) and to improve the overall health of Tennesseans.

- Enroll 37% of TennCare members in a PCMH practice by 2020

- Implement and maintain a Health Home model statewide by 2017

- Design and implement 48 Episodes of Care by 2020

- Include 75% of LTSS population in a value-based payment model by 2020

- Increase user of HIT/HIE

- Improve population health
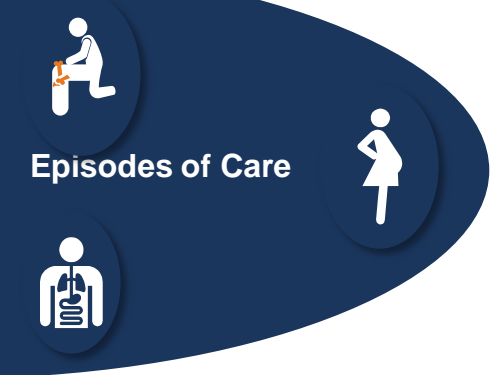
Delivery System Transformation Strategies

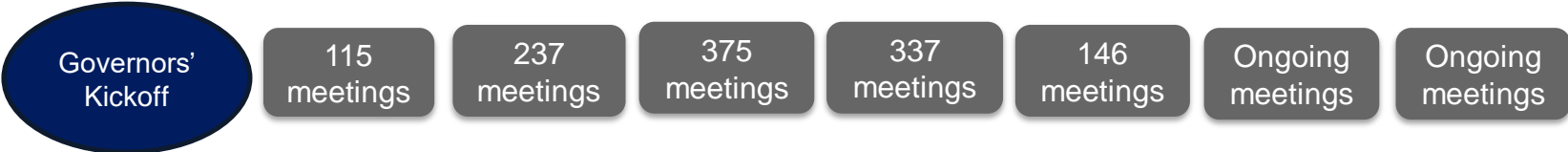|	Source of value	Strategy elements	Examples
Primary Care Transformation	• Maintaining a person's health overtime • Coordinating care by specialists • Avoiding episode events when appropriate	• Patient Centered Medical Homes • Tennessee Health Link for people with the highest behavioral health needs • 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
Episodes of Care	• Episodes of Care for acute and specialist-driven health care delivered during a specific time period to treat a physical or behavioral condition	• Retrospective Episodes of Care • 48 episodes designed	• Perinatal • Total joint replacement • Acute asthma exacerbation • Colonoscopy • ADHD
Long Term Services & Supports	• 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 NF services • Quality and acuity adjusted payments for HCBS • Workforce development	• New NF reimbursement methodology • Outcome-based payment for employment services • Workforce investments and incentives

Timeline: Tennessee Delivery System Transformation

2012　2013　2014　2015　2016　2017　2018　2019　2020

Vision Taskforce
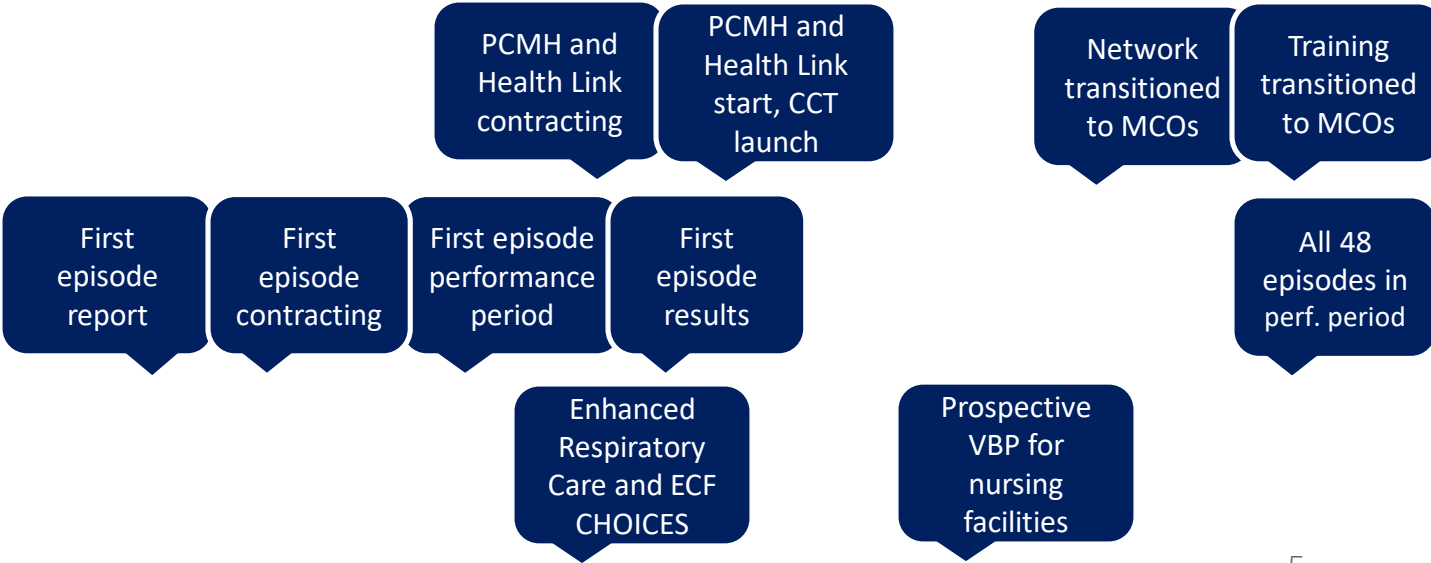
Tennessee Health Care Innovation Initiative

Over 1500 Stakeholder Meetings

| Governors' Kickoff | 115 meetings | 237 meetings | 375 meetings | 337 meetings | 146 meetings | Ongoing meetings | Ongoing meetings |

2 Grants

SIM Design　←→　SIM Testing

End of SIM: 1/31/20

Select Program Milestones

PCMH and Health Link contracting

PCMH and Health Link start, CCT launch

Network transitioned to MCOs

Training transitioned to MCOs

First episode report

First episode contracting

First episode performance period

First episode results

All 48 episodes in perf. period

Enhanced Respiratory Care and ECF CHOICES

Prospective VBP for nursing facilities

TN

5

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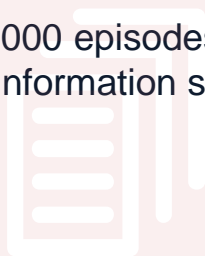- Awards and Accomplishments

Episodes of Care Stakeholder Engagement

Technical Advisory Groups

26 Technical Advisory Groups with over 360 providers

Provider Reports

Over 200,000 episodes reports with new information sent to providers

Episode Design

Made over 100 changes to episode design based on Stakeholder feedback:

- Pause new episode design
- Low volume exclusions
- Perinatal inpatient facility reconsideration

Stakeholders

More than 1500 stakeholder meetings

- 5 annual episodes design feedback sessions in 6 cities
- Hundreds of meetings per quarter between MCOs and providers

> **"I do feel 100% that I have been allowed to voice my opinions and to voice my concerns, to see the positives and the negatives. And I've always felt that you and your staff have always been very listening and approachable."**
>
> *An orthopedic provider*

> **"I felt like we actually had a significant input and changed a few ideas, again to avoid unintended consequences."**
>
> *A general surgeon*

Primary Care Transformation: Training & Learning Opportunities

Since January of 2017, PCMH and THL providers have been provided many training and learning opportunities:

27 Regional Conferences

174 Learning Collaboratives

27 Webinars

12 Videos

2 Curriculum & Compendium of Resources

Long-Term Services and Supports: Stakeholder Engagement and Support

Stakeholders have been engaged in each of the initiatives, from design through implementation and beyond. *Examples* include:

Nursing Facility QuILTSS (Quality Improvement in Long-Term Services and Supports)
- 18 community forums in 9 cities (> 1,200 participants)
- Online survey process to gather input from consumers, families and providers
- One-on-one meetings with key stakeholders
- NF QuILTSS Stakeholder Advisory Group convened to:
  - Design Quality Framework
  - Assist in procurement of standardized survey tool
  - Meet regularly to review data and discuss next steps
- Partnered with Tennessee Health Care Association to develop rules for new prospective quality- and acuity-based payment methodology

Enhanced Respiratory Care
- Site-based assessments of *each* facility
- In-person training on new payment methodology prior to launch
- Ongoing engagement and on-site support provided to facilities by Eventa, LLC
- Webinar trainings for launch of Quality Applications, significant measurement changes
- ERC program manual developed, updated
- Statewide in-person convening to share best practices
- ERC Joint Operating Committee meets quarterly to review data and discuss next steps

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Long Term Services and Supports

Value Based Payment

LTSS Outcomes and Successes:
NF QuILTSS Process Measures
(bridge to outcome-based measures now in place)

- Percentage of facilities conducting person centered care or culture change assessments increased **from 15% to 100%**

- Percentage of facilities undertaking specific quality improvement activities designed to support culture change and improve person-centered practices in their facilities increased **from 7% to 91%**

- Percentage of facilities providing choice in meal times *only* at 52% increased to percentage of facilities providing choice in 5 areas (meal time, menu at meal, sleep and wake times, bathing/shower option and time, and room furnishings/décor/appearance) at 82%
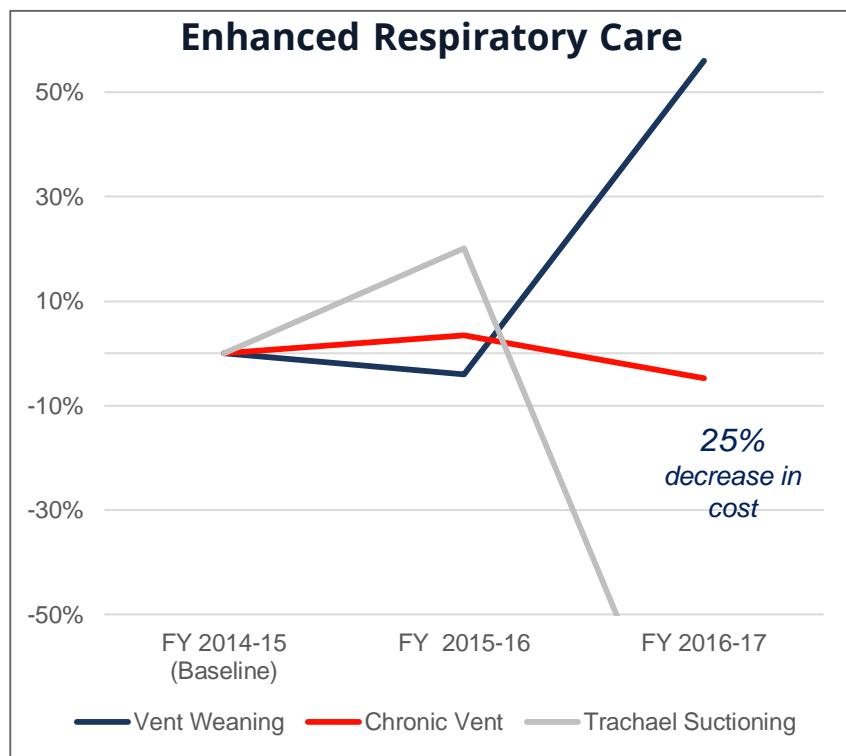
LTSS Outcomes and Successes:
NF QuILTSS Clinical Measures

Anti-psychotic drug use among long-stay residents in Tennessee 2011Q4 - 2018Q4
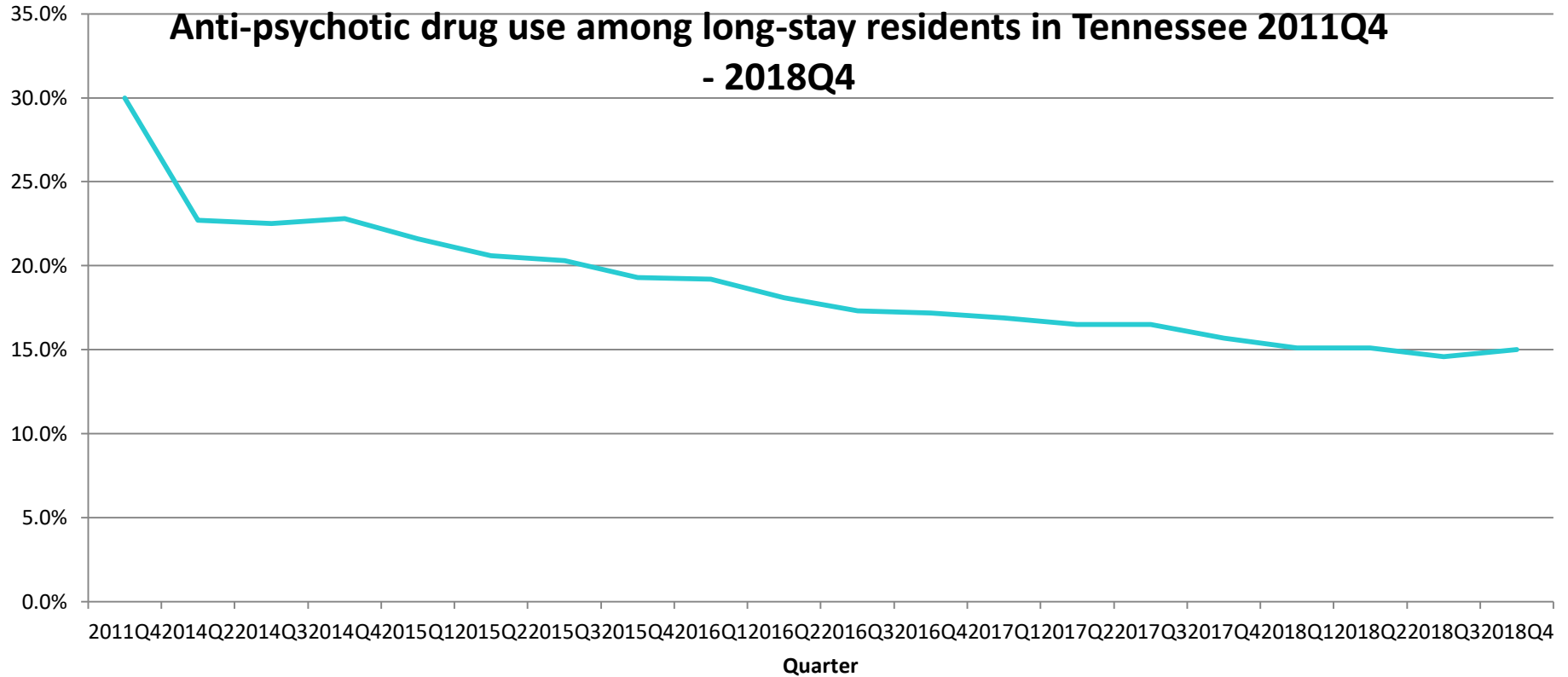
Tennessee's reduction in the use of antipsychotic medications (from 30% to 15%) among long-stay residents was the **2nd largest percentage point** and the **4th largest percent change** in the country from baseline (prior to the launch of QuILTSS) through April 2019.

Source: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Antipsychotic-Medication-Use-Data-Report.pdf

LTSS Outcomes and Successes: Enhanced Respiratory Care (ERC)

Enhanced Respiratory Care

Legend:
— Vent Weaning — Chronic Vent — Trachael Suctioning

25% decrease in cost

X-axis: FY 2014-15 (Baseline), FY 2015-16, FY 2016-17

In the first year of the ERC Initiative:
- A 55% increase in ventilator weaning utilization
- A 25% reduction in ERC expenditures
- 1 person weaned after 4 years of mechanical ventilation, 2 people after 3 years, 2 after 2 years

Shelina's Story

Shelina could not breathe without a ventilator after a massive stroke in 2014. With the support of TennCare's value-based approach to enhanced respiratory care and a dedicated care team, Shelina overcame her dependence on the device and now, has gotten married! Shelina's mother says "People need to see that people are still in love and committed…It gives hope to me, I've never seen anything like that."

LTSS Outcomes and Successes: Enhanced Respiratory Care (ERC)

- Ventilator wean rates have increased more than 100%--from a low of 28.28% to a high of 57.06%
- Admit to wean days have decreased 68.7%--from a high of 78.3 to a low of 24.5 days
- Decannulation rates have increased 88.7%--from a low of 22.96% to a high of 43.32%
- Average total quality points have increased 36.9%--from a low of 86.4 to a high of 118.3
- Average quality tier rates have improved 28.6%--from an average of 2.1 to 1.5

Tier Level Overtime
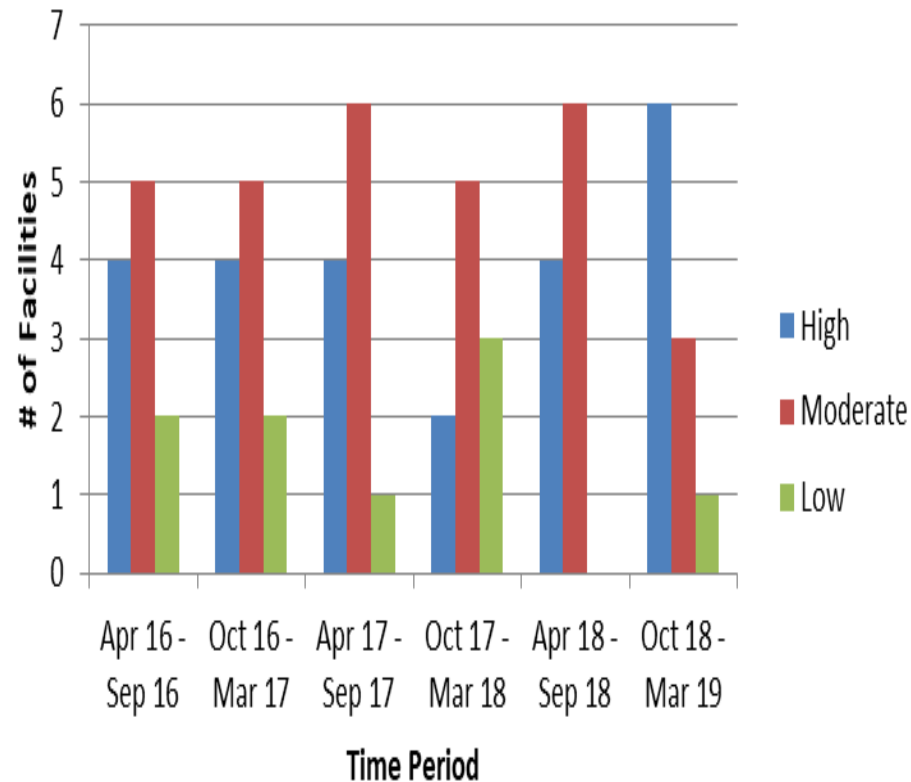
LTSS Outcomes and Successes:
Employment and Community First CHOICES

- The annualized cost of HCBS is less than half the average of previous programs for individuals with I/DD.

- As of December 2019, 27.4% of working age adults enrolled in the program are employed (50% higher than national average)
- Average wage > $9.00 per hour

- More than 325 companies have partnered to employ people in the program, representing more than 500 unique employment arrangements in local communities.

LTSS Outcomes and Successes: Employment and Community First CHOICES

Meet William

https://tinyurl.com/y4udhsl4

Meet Kezia

https://tinyurl.com/y3ozafkr

Department of Health Population Health Model

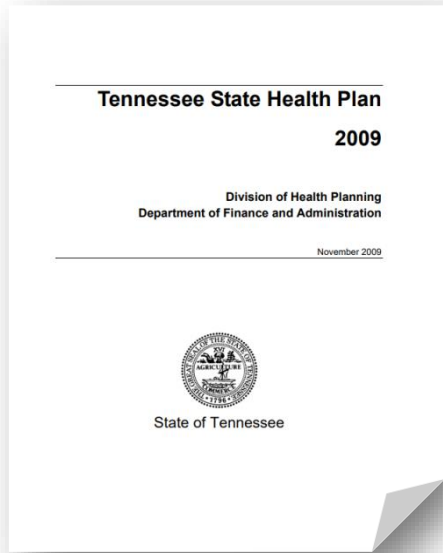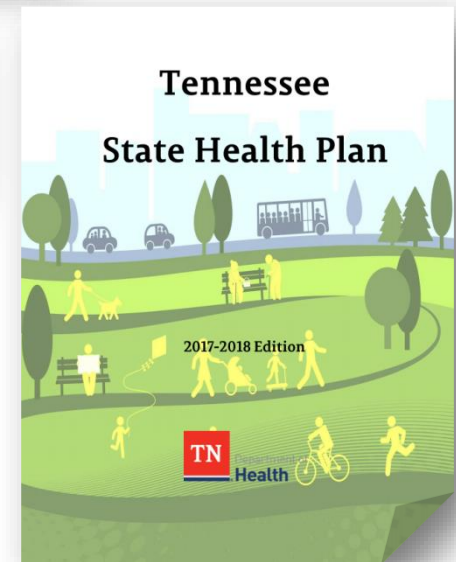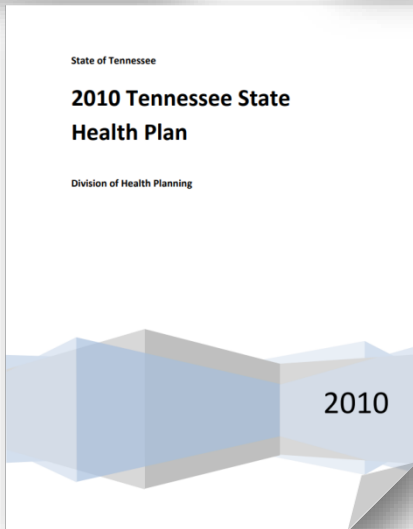**TN Department of Health**

Backdrop: The State Health Plan
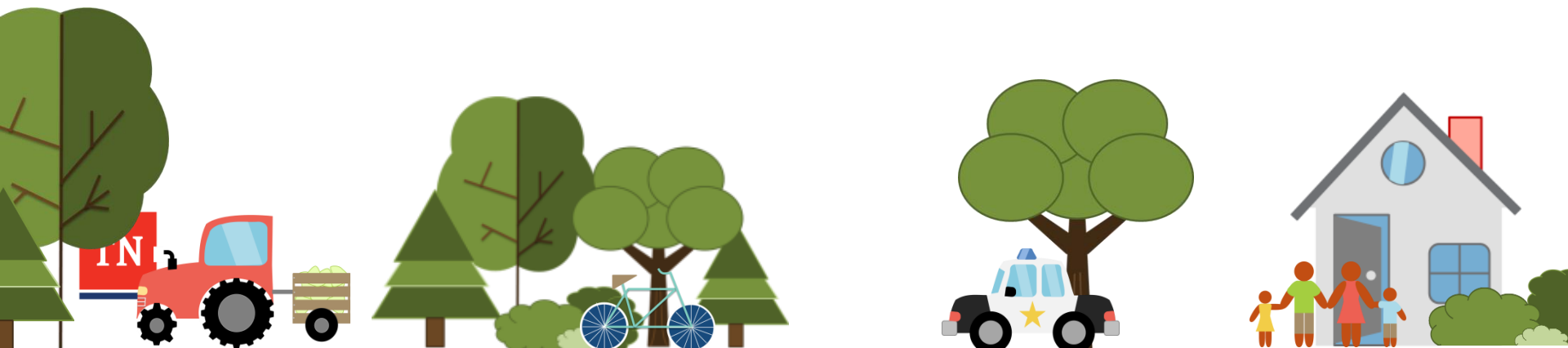
History of the State Health Plan

2008

2019

21

The State Health Plan Framework

1 **Vital Signs**: A set of Tennessee-specific measures to evaluate population health and progress

2 **Vital Sign Actions**: A curated set of evidence-based intervention strategies to improve population health

TN

Tennessee's Vital Signs

Youth Obesity
39%
of public school students with an "overweight" or "obese" BMI

Physical Activity
69%
of adults who reported doing physical activity during the past 30 days

Youth Nicotine Use
12%
of high school students who currently use electronic cigrettes

Drug Overdose
23,657
Annual non-fatal drug overdoses

Infant Mortality
7.4
Infant deaths per 1,000 live births

Teen Births
26.6
Births per 1,000 teenage women

Community Water Fluoridation
89%
of residents served by fluoridated water systems

Frequent Mental Distress
14%
of adults reporting mental health as 'not good' for ≥14 days during the past 30

3rd Grade Reading Level
37%
of 3rd graders reading at grade level

Preventable Hospitalizations
1,531
Preventable hospitalizations per 100,000 adults

Per Capita Personal Income
$47,179
Annual income per person

Access to Parks and Greenways
71%
of population with adequate access to locations for physical activity

*Color Indicates 3 Year Trend: green is moving in a positive direction, orange is stagnant, red is moving in a negative direction

www.tn.gov/vitalsigns

Vital Sign Actions

- Curated, evidence informed strategies to improve population health

- Offers actions to address priorities identified through the CHA process

- Includes
  - Programming Options
  - Funding Opportunities
  - Community Education and Awareness Strategies
  - Policy Recommendations for various settings such as clinical, community, or school-based

County Health Councils

- Established in the 1990's

- Representative of multiple sectors within a community

- Exist in all 95 TN counties

- Top resource for improving population health at the local level

CHA

TDH's County Health Assessment

Health Equity

Engaging low-income, minority, and under-served populations

1 Identify & Invite Stakeholders to the Table

2 Review Secondary Data using Common Terms

3 Seek & Listen to Input from Community Members

4 Establish Shared Priorities

5 Develop a Collaborative Action Plan

TN
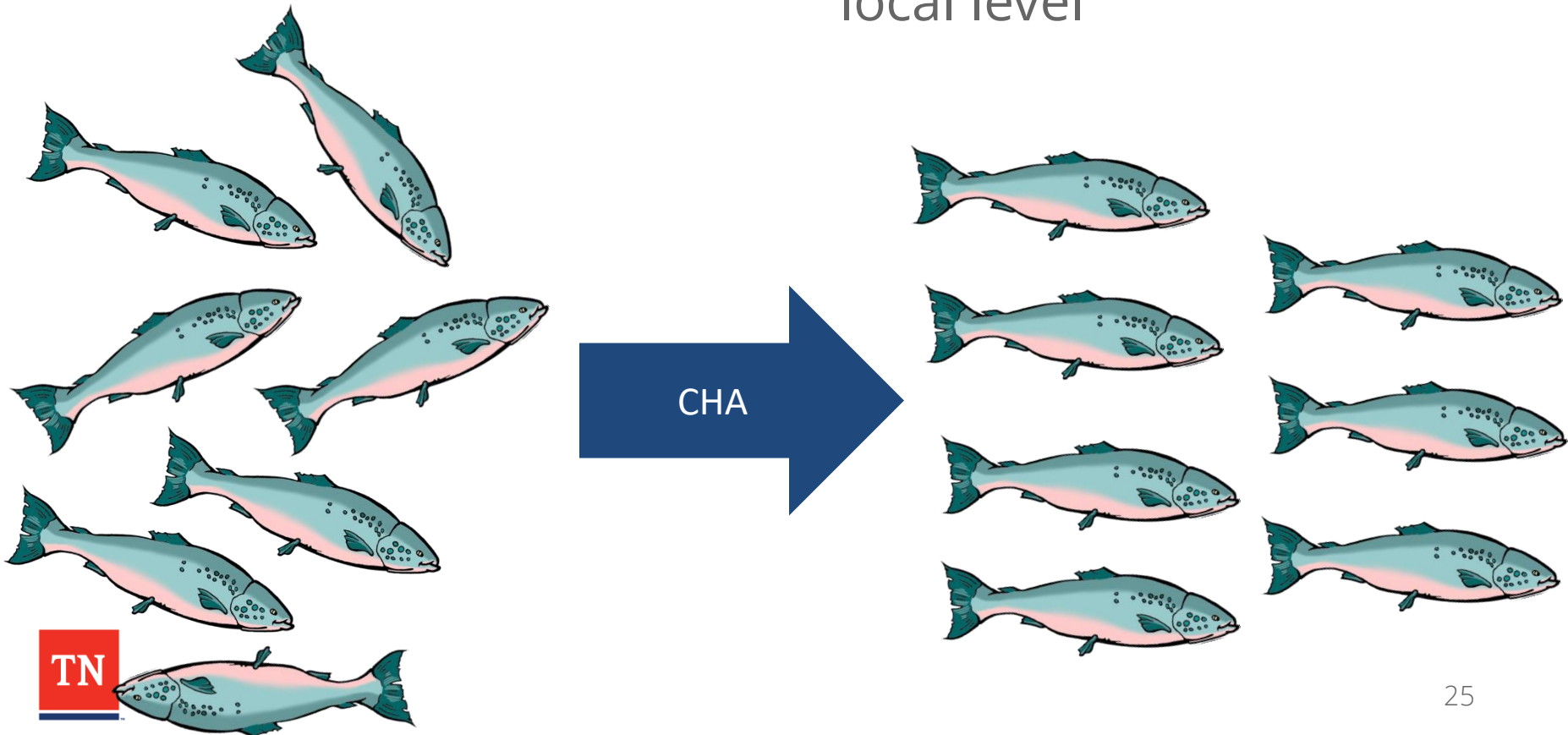
County Health Assessment Pilot Counties (2019)
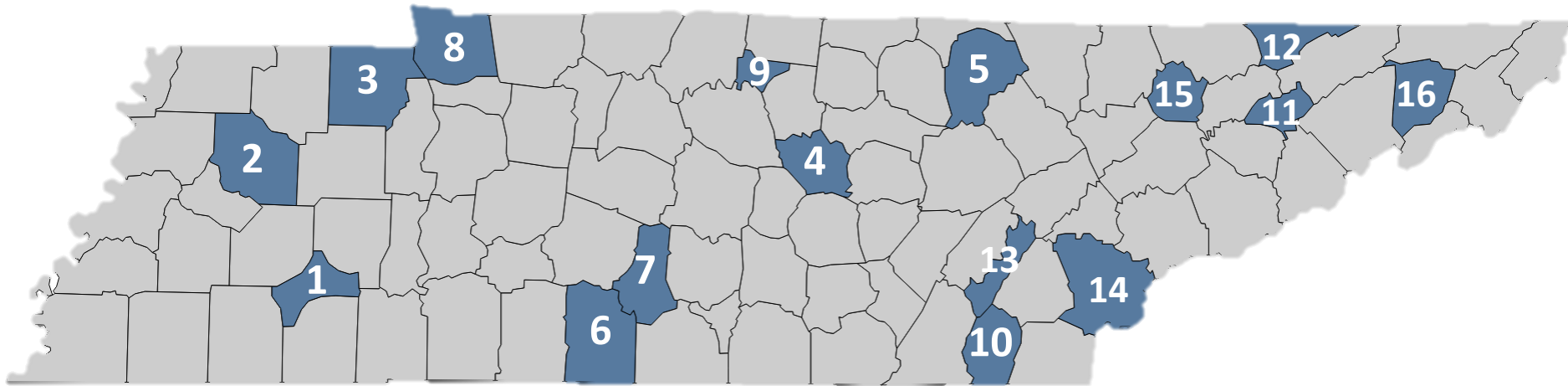
West TN

East TN

1. Chester, WTR
10. Bradley, SER
2. Gibson, WTR
11. Hamblen, ETR
3. Henry, WTR
12. Hancock, NER

13. Meigs, SER

Middle TN

4. DeKalb, UCR

5. Fentress, UCR

6. Giles, SCR

7. Marshall, SCR

8. Stewart, MCR

2019 CHA Priorities

Youth Nicotine Use

Adverse Childhood Experiences (ACEs)

Minority Health

Obesity

Mental Health

Cardiovascular Health

Teen Births

3rd Grade Reading Level

Lack of Child Care

Substance Misuse

Community Violence

Access to Affordable Healthcare
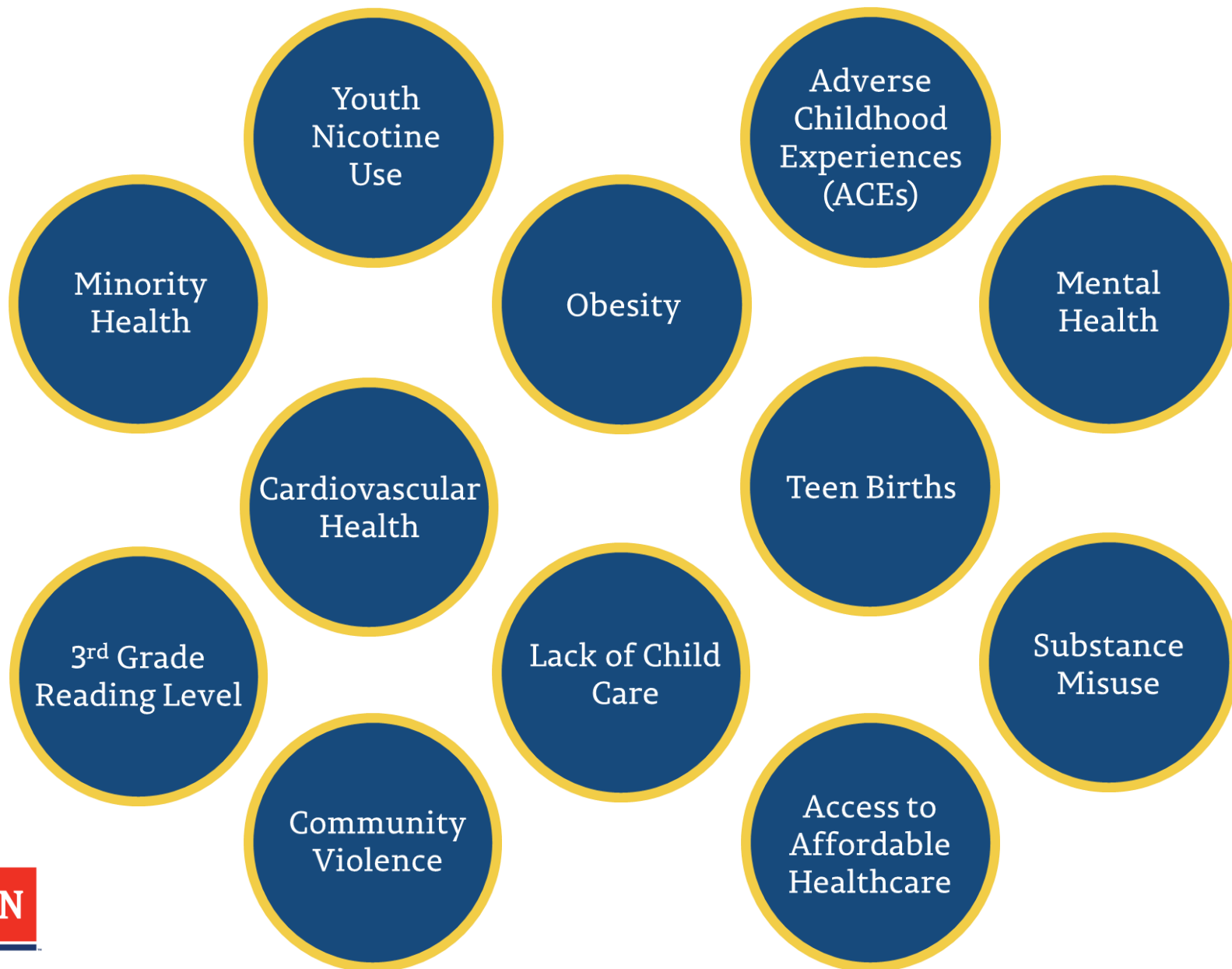
2020 CHA Counties

Mid-Cumberland Region

- Cheatham
- Humphreys
- Montgomery
- Wilson

Upper-Cumberland Region

- Clay
- Jackson
- Smith
- Van Buren

Northeast Region

- None
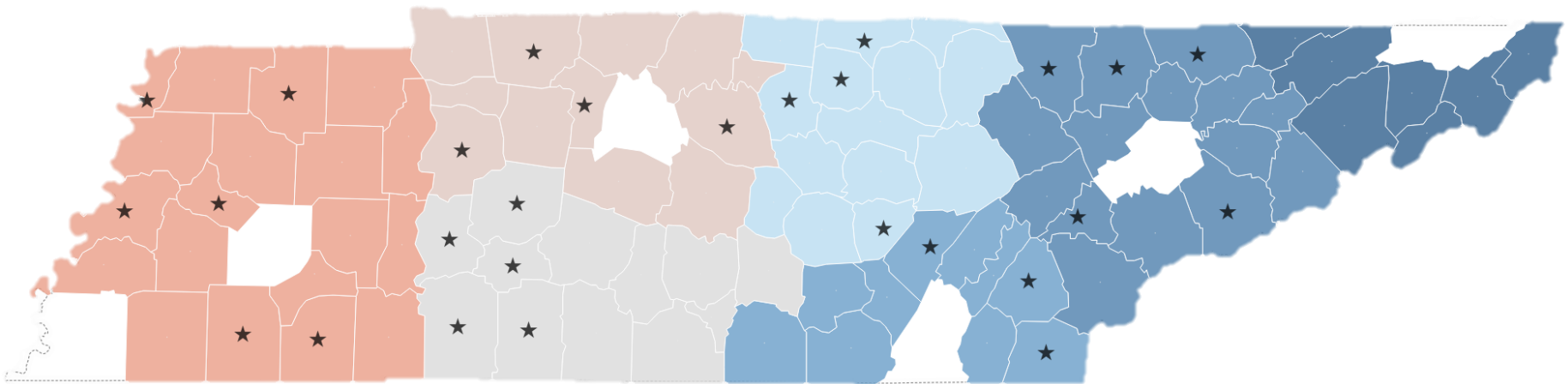
West TN Region

- Crockett
- Hardeman
- Lake
- Lauderdale
- McNairy
- Weakley

South Central Region

- Hickman
- Lawrence
- Lewis
- Perry
- Wayne

Southeast Region

- Bledsoe
- McMinn
- Polk

East TN Region

- Campbell
- Claiborne
- Loudon
- Scott
- Sevier

TN

The Long-Term Vision

1. Utilize CHA and VSAs to inform TDH's strategic planning process and engage community experts from our rural regions

2. Build a robust, user-friendly Vital Signs website to house information and resources easily accessed by county and topic

3. Grow an ecosystem of resources for each Vital Sign to serve as road maps for counties

4. Empower County Health Councils to establish a sustainable process where counties can engage in conversations and cross-sector collaborations that address upstream public health challenges

Episodes of Care

48 TennCare Episodes of Care

As of January 1, 2020, all 48 of the state's episodes of care are in a performance period. This means that all 9 waves have accountable providers that are receiving quarterly cost and quality performance reports with financial accountability.

Status	Wave	Episode
In Performance	1	Perinatal
		Asthma acute exacerbation
		Total joint replacement
	2	COPD acute exacerbation
		Colonoscopy
		Cholecystectomy
		PCI – acute
		PCI – non acute
	3	GI hemorrhage
		EGD
		Respiratory infection
		Pneumonia
		UTI – outpatient
		UTI – inpatient
	4	ADHD
		CHF acute exacerbation
		ODD
		CABG
		Valve repair and replacement
		Bariatric surgery

Status	Wave	Episode
In Performance	5	Breast biopsy
		Otitis media
		Tonsillectomy
	6	Skin and soft tissue infections
		HIV
		Pancreatitis
		Diabetes acute exacerbation
	7	Spinal fusion
		Spinal decompression
		Femur / pelvic fracture
		Knee arthroscopy
		Ankle non-operative injuries
		Wrist non-operative injuries
		Shoulder non-operative injuries
		Knee non-operative injuries
		Back / neck pain

Status	Wave	Episode
In Performance	8	Acute Seizure
		Syncope
		Acute gastroenteritis
		Bronchiolitis
		Pediatric pneumonia
		Colposcopy
		Hysterectomy
		Gastrointestinal obstruction
		Appendectomy
		Hernia repair
	9	Acute kidney and ureter stones
		Cystourethroscopy

Episodes of Care Results

CY 2015

Estimated Savings*:
$10.8 million

- Providers and hospitals reduced costs while maintaining quality of care
- Gain sharing payments to providers exceeded risk sharing payments by **$280,000**

Episodes included: perinatal, total joint replacement (TJR), acute asthma exacerbation (asthma)

CY 2016

Estimated Savings*:
$14.5 million

- Quality metrics **improved** for perinatal, total joint replacement, and COPD, and were mostly maintained for the remaining episodes
- Gain sharing payments to providers exceeded risk sharing payments by **$395,000**

Episodes included: perinatal, TJR, asthma, colonoscopy, acute PCI, non-acute PCI, cholecystectomy, COPD

CY 2017

Estimated Savings*:
$28.6 million

- Quality metrics **improved** or maintained for most episodes
- Gain sharing payments to providers exceeded risk sharing payments by **$206,900**

Episodes included: perinatal, TJR, asthma, colonoscopy, acute PCI, non-acute PCI, cholecystectomy (CHOLE), COPD, GI hemorrhage (GIH), EGD, respiratory infection (RI), pneumonia, UTI outpatient (UTI-O), UTI inpatient (UTI-I), CHF, ODD, CABG, valve, bariatric

CY 2018

Estimated Savings*:
$38.3 million

- Quality metrics **improved** or maintained for most episodes
- Gain sharing payments to providers exceeded risk sharing payments by **$686,000**

Episodes included: perinatal, TJR, asthma, colonoscopy, acute PCI, non-acute PCI, CHOLE, COPD, GIH, EGD, RI, pneumonia, UTI-O, UTI-I, CHF, ODD, CABG, valve, bariatric, ADHD, breast biopsy, otitis media, tonsillectomy, SSTI, HIV, pancreatitis, and acute diabetes exacerbation

*Estimated savings are calculated as the difference between actual cost and project cost. The project cost includes a 3 percent medical inflation rate.

Episodes of Care Results

Oppositional Defiant Disorder:
Episodes in which children receive unnecessary medication decreased from 23% to 4% (2015 – 2018)

CABG:
Follow-up care within the post-trigger window increased from 71% to 79% (2016 – 2018)

Perinatal:
Group B Streptococcus screening increased from 88% to 95% (2014 – 2018)

Asthma:
Patient on appropriate medication increased from 60% to 70% (2016 – 2018)*
***Metric changed in 2016**

Asthma:
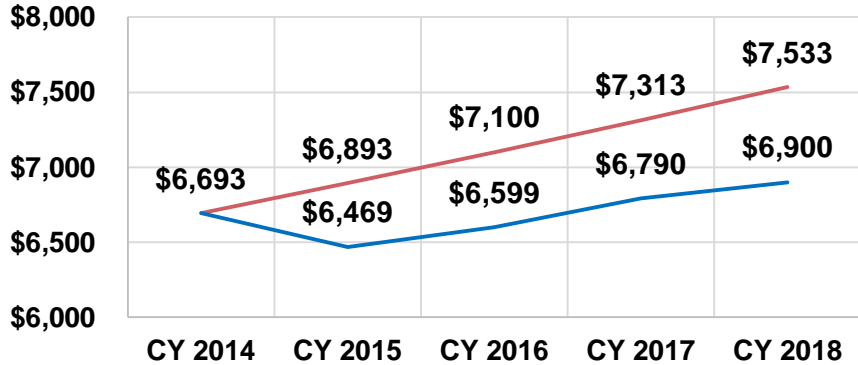**Avoidable hospital admissions decreased from 6% to 3% (2014 – 2018)**

Bariatric Surgery:
Follow-up care within the post-trigger window increased from 36% to 43% (2016 to 2018)
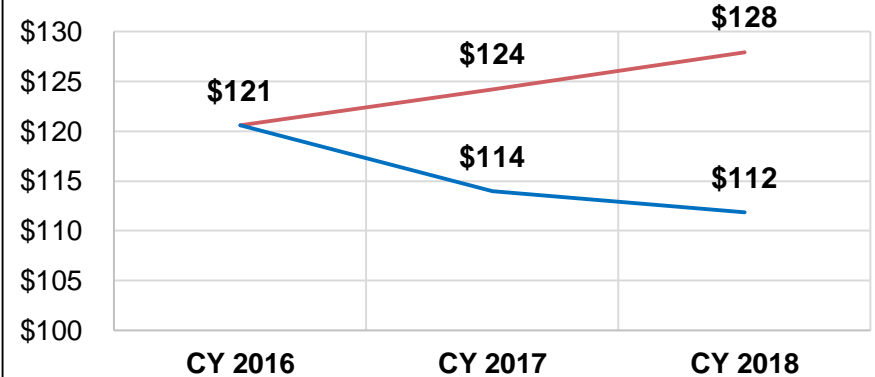
TN

Episodes Impact on Healthcare Spend

Perinatal
Analysis of Risk-Adjusted Cost Trend, CY 2014 - CY 2018

Projected: $6,693 (CY 2014), $6,893 (CY 2015), $7,100 (CY 2016), $7,313 (CY 2017), $7,533 (CY 2018)

Actual: $6,693 (CY 2014), $6,469 (CY 2015), $6,599 (CY 2016), $6,790 (CY 2017), $6,900 (CY 2018)

Respiratory Infection
Analysis of Risk-Adjusted Cost Trend, CY 2016 - CY 2018

Projected: $121 (CY 2016), $124 (CY 2017), $128 (CY 2018)

Actual: $121 (CY 2016), $114 (CY 2017), $112 (CY 2018)

Asthma Acute Exacerbation
Analysis of Risk-Adjusted Cost Trend, CY 2014 - CY 2018

Projected: $1,178 (CY 2014), $1,213 (CY 2015), $1,249 (CY 2016), $1,287 (CY 2017), $1,326 (CY 2018)

Actual: $1,178 (CY 2014), $1,074 (CY 2015), $1,067 (CY 2016), $942 (CY 2017), $951 (CY 2018)
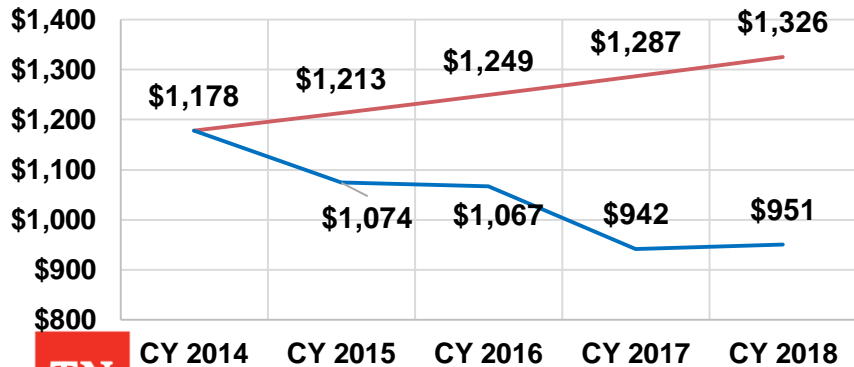
Oppositional Defiant Disorder
Analysis of Risk-Adjusted Cost Trend, CY 2016 - CY 2018

Projected: $1,324 (CY 2016), $1,364 (CY 2017), $1,405 (CY 2018)

Actual: $1,324 (CY 2016), $1,187 (CY 2017), $1,042 (CY 2018)
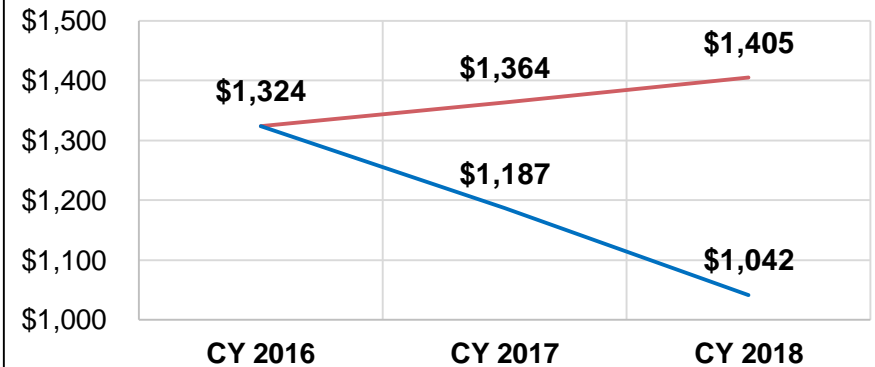
—— Projected   —— Actual

Projected costs are based on a 3% annual growth rate

Patient-Centered Medical Homes

Patient Centered Medical Home: 2020 Wave 1, 2, 3 & 4 Organizations

	Wave 1	Wave 2	Wave 3	Wave 4	Total
Number of PCMH organizations	28	36	17	2	83
Total number of members	249,146	215,837	82,211	25,525	572,719
Number of sites	172	234	57	25	488

Patient Centered Medical Home Results

$12.6 million in quality outcome payments since program launch
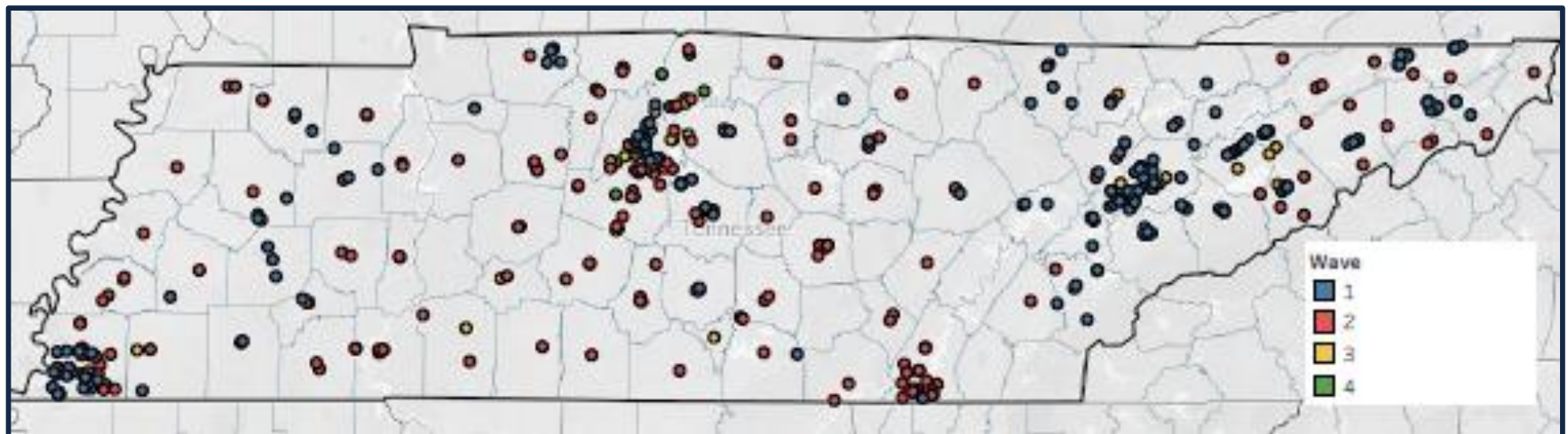
Outcome payments awarded to high performing PCMH providers for performance in 2017 and 2018.

$78M invested in primary care services

This investment, made over the first three years of the program in the form of activity payments, is paid to PCMH providers to provide care coordination for patients

375 sites achieving NCQA PCMH Recognition

As of March 2020, approximately 77% of the 488 PCMH sites have achieved NCQA PCMH Recognition.

"The activity payments have enabled us to hire more care coordinators"

- Participating PCMH Provider

"We are better able to treat the whole person"

- Participating PCMH Provider

Patient Centered Medical Home Results: Improvements in quality of care in primary health from 2016-2018

4,103

additional people with diabetes had their high blood pressure controlled

1,784

additional people with diabetes benefited from eye examinations to test for complications of diabetes

19,523

additional adults had their BMI measured and documented

38,352

additional children and teens had their BMI measured and documented

38,226

additional children and teens obtained nutritional counseling

6,936

additional children ages 7-11 years had a visit with a primary care physician

"By becoming a [PCMH], our practice is more patient centered. We have been more able to streamline our case management and coordination of care. We have improved our efficiency by offering same day appointments and patient care hours outside our normal business day, including Saturday clinics."

- PCMH Administrator

Tennessee Health Link

Tennessee Health Link

	Total
Number of THL Orgs	20
Number of sites	205
Total number of active members	74,485
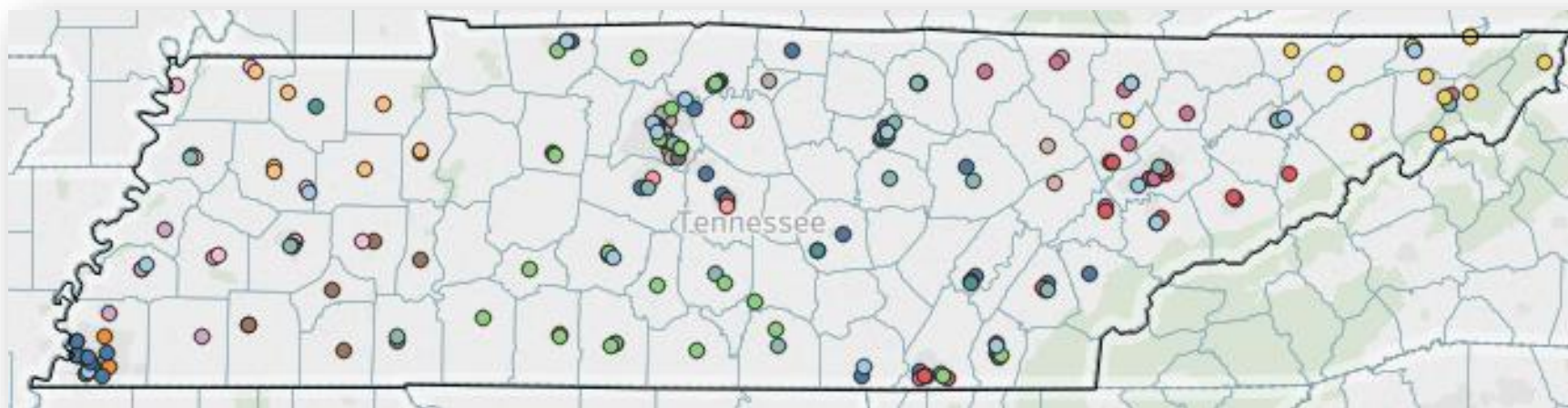
Tennessee Health Link Results

-3% decrease in **inpatient hospital admissions** for active Health Link members in the 2 years following program launch

6% increase in **primary care provider visits** within 7 days following an inpatient hospital admission, for active Health Link members*

-6% decrease in **emergency department visits** for active Health Link members in the 2 years following program launch
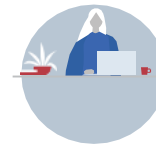
6% increase in **behavioral health provider visits** for outpatient treatment

Tennessee Health Link Results and Improvements

$17.8 million in outcome payments since program launch

Outcomes payment awarded to high performing Health Link providers. 14 providers were awarded $6.8M in 2018 for 2017 performance and 17 providers were awarded $11M in 2019 for 2018 performance

Quality of care improvements across physical and behavioral health

Quality has improved across 9 out of 18 measures, particularly those for physical health
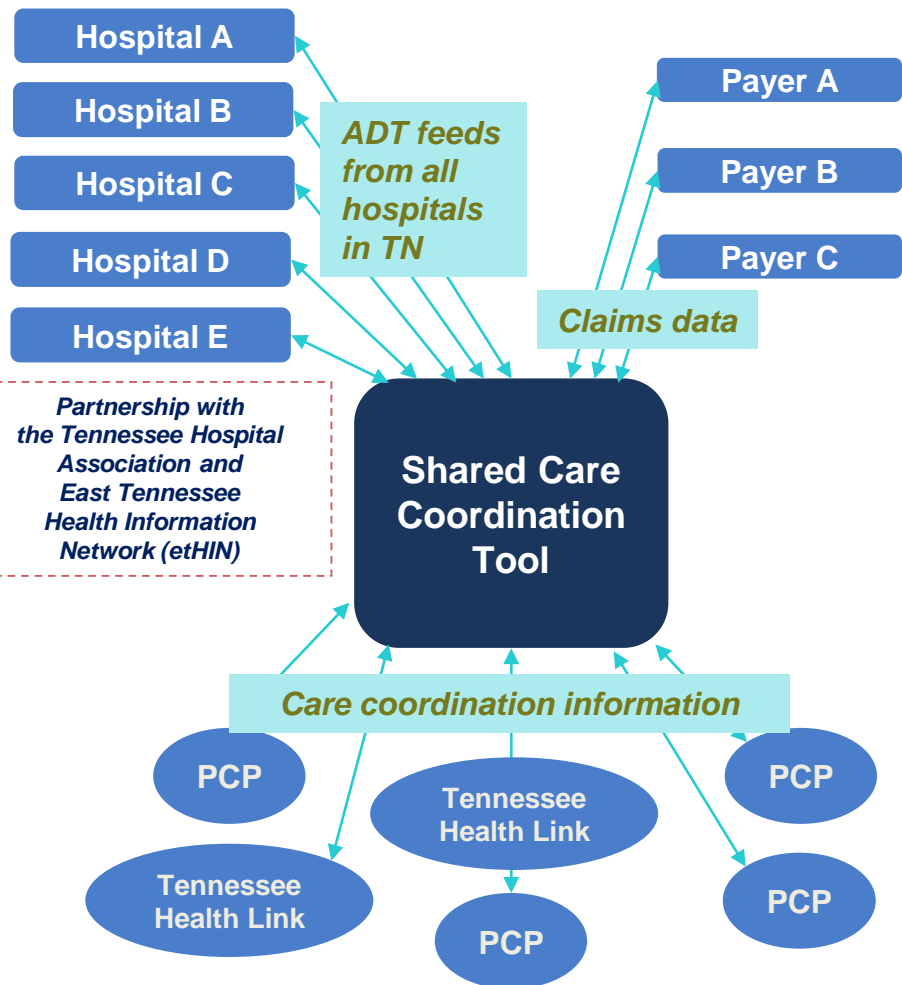
131% increase in controlling high blood pressure for people with diabetes

44% increase in BMI and weight assessment for children and adolescents

Care Coordination Tool for Primary Care Transformation

Innovative application that allows primary care and behavioral health providers to identify, track, and resolve gaps in care, effectively implementing better care coordination

Hospital A
Hospital B
Hospital C
Hospital D
Hospital E

ADT feeds from all hospitals in TN

Payer A
Payer B
Payer C

Claims data

Partnership with the Tennessee Hospital Association and East Tennessee Health Information Network (etHIN)

Shared Care Coordination Tool

Care coordination information

PCP
Tennessee Health Link
PCP
Tennessee Health Link
PCP
PCP

"The information that is really helpful in the CCT for our agency is the ADT data. We've been able to really monitor the ADT feeds and recently noticed we had a consumer that went 18 times for a hospitalization or ED visit over 90 days. That was eye opening for us."

Andrea Westerfield, Mental Health Cooperative

"We had a patient we'd been treating since 1993 for schizophrenia. When we started receiving admission, discharge and transfer feeds from the hospitals, we discovered that she would come to our office and then immediately head to the ER for treatment of her physical health conditions. This was a real opportunity for us to improve care."

Pam Womack, MSSW CEO, Mental Health Cooperative

Agenda

- State Innovation Model (SIM) grant overview

- Provider/stakeholder input

- Program Results
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  - ❑ Patient-Centered Medical Homes
  - ❑ Tennessee Health Link

- Awards and Accomplishments

Accomplishments under SIM Grant

Press Release, 10/31/19: TennCare's Delivery System Transformation Shows Savings and Improved Outcomes

Quality of care was improved or maintained across the majority of episodes, while achieving an estimated savings of $38.3M to the state in 2018

In treating 550,000 TennCare members, PCMH providers delivered a **68 percent improvement** in controlling high blood pressure for diabetics, **40 percent increase** in nutritional counseling for children and adolescents, and a **20 percent increase** in childhood immunizations.

100% of Medicaid nursing facilities receiving prospective value based payments

TennCare's LTSS value-based enhanced respiratory care program is **achieving ventilator liberation rates of 55%, while reducing cost by 25%.** This work is done by 10 independently owned Skilled Nursing Facilities achieving ventilator weaning rates comparable to (and in some cases higher than) the Mayo Clinic.

The Episodes of Care program was approved as an Advanced Alternative Payment Model by CMS through 2025. This gives **Tennessee providers more flexibility** to join the APM track of Medicare's Quality Payment Program (QPP) and earn potential bonuses from Medicare.

Humana.

362 PCMH sites (67 organizations) have NCQA recognition

Humana implemented three episodes nationally based on TennCare's episodes design

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

27 Regional Conferences and **174** Learning Collaboratives

Tennessee Health Link, which serves 70,000 TennCare members, has **reduced inpatient hospital admissions by 11 percent** through one-on-one interaction with these members from 2013-2018.

National Association of Medicaid Directors (NAMD) awarded TennCare for delivery system transformation efforts.
The value-based payment programs created and implemented in these areas under the State Innovation Model (SIM) grant **are all sustainable** after the conclusion of the SIM grant.

TennCare, in partnership with the Tennessee Hospital Association, is now sending alerts in real time to primary care providers in PCMH and Tennessee Health Link when their patients go to the hospital or emergency room.

TN Department of **Health**

The State Population Health Improvement Plan (PHIP) was signed into official state health policy and the Department of Health finalized a list of 12 Vital Sign's metrics meant to measure the pulse of Tennessee's population and evaluate policies and programs in the PHIP.

NAMD
National Association of Medicaid Directors

Transforming the Health Care Delivery System

Tennessee Health Link

Serves 70,000 TennCare members with significant behavioral health needs:
- ✓ Reduced inpatient hospital admissions by 11 percent.
- ✓ Primary care follow-up visits after acute hospital events have increased by 7 percent.
- ✓ Physical health quality measures improved.

Tennessee Health Link providers received almost **$12 million in reward payments** from TennCare in 2019.

Episodes of Care

Now covers **48 episodes** and has shown improvements in quality:
- ✓ Reduction in acute exacerbations of asthma treated in the inpatient setting from six percent in 2014 to three percent in 2018.
- ✓ Reduction in the number of children with non-comorbid oppositional defiant disorder (ODD) receiving inappropriate medications from 23 percent in 2015 to 4 percent in 2018 in the ODD episode.
- ✓ TennCare has reduced its budget by $43.6 million (recurring) in recognition of episodes savings through FY20.

Reward to providers have exceeded risk sharing payments every year of the episodes program.

Patient-Centered Medical Homes

Supports providers who deliver primary care to **more than 550,000 TennCare members.** In the last two years:
- ✓ 38,226 additional children and teens received nutritional counseling.
- ✓ 4,103 additional patients with diabetes were able to control their blood pressure.
- ✓ Key childhood immunizations increased by 20 percent.

Additional $40M invested into PCMH primary care providers to support increased care coordination and primary care services.
- ✓ PCMH providers received **$11 million in reward payments.**
- ✓ Initial investment into primary care were offset by more cost-effective utilization of services.

TN

Continued Partnership with You

- This is our final provider stakeholder group meeting in this series, but this is not the end of our partnership!

- Here are ways that we plan to continue to communicate with you:
    - Email us at payment.reform@tn.gov
    - Delivery System Transformation newsletter
        - Sign up here: https://stateoftennessee.formstack.com/forms/episodes_newsletter_subscribe)
    - Delivery System Transformation conferences
    - Episodes of Care Annual Feedback Sessions
    - Website updates: https://www.tn.gov/tenncare/health-care-innovation.html

Thank You

Questions?

Contact E-mail: <u>payment.reform@tn.gov</u>

Website: <u>https://www.tn.gov/tenncare/health-care-innovation/episodes-of-care.html</u>