Health Care
Innovation Initiative

Provider Stakeholder Group
November 4th, 2015

Agenda

Update on Episodes of Care strategy

Primary Care Transformation updates

- Primary Care Transformation TAG process
- PCMH payment streams and supports
- Health Homes payment streams and supports
- Health Homes population definition
- Care Coordination Tool RFP

Update on Episodes of Care strategy

- Introducing HCFA's new Episodes Strategy Manger, Beth Wolf
- Update to Episodes of Care Timeline: Chronic Depression moves up to Wave 5 and PTSD moves back to Wave 9

Episodes by design year and wave, as of Nov 4 2015

Design year & wave		Episode
2013	1	Perinatal
		Asthma acute exacerbation
		Total joint replacement
2014	2	COPD acute exacerbation
		Colonoscopy
		Cholecystectomy
		PCI - acute
		PCI – non acute
2015	3	GI hemorrhage
		Upper GI endoscopy
		Respiratory Infection
		Pneumonia
		UTI - outpatient
		UTI – inpatient
	4	ADHD
		CHF acute exacerbation
		ODD
		CABG
		Valve repair and replacement
		Bariatric surgery
2016	5	Breast cancer (multiple)
		Tonsillectomy
		Otitis
		Anxiety
2016	5	Depression - chronic
		Breast biopsy
2016	6	Cellulitis & bacterial skin infec.
		Neonatal Parts I & II (multiple)
		HIV
		Hepatitis C
		Bronchiolitis & RSV pneumonia
2017	7	Medical non-infec. orthopedic
		Schizophrenia (multiple)
		Diabetes acute exacerbation
		Spinal fusion exc. cervical
		Lumbar laminectomy
		Hip/Pelvic fracture
		Knee arthroscopy
	8	Hemophilia & other coag. dis.
		Anal procedures
		Colon cancer
		CAD & angina
		Hernia procedures
		Cardiac arrhythmia
		Sickle cell
		Pacemaker / Defibrillator
2018	9	Depression – acute exacerbation
		Lung cancer (multiple)
		Female reproductive cancer
		Other major bowel (multiple)
		PTSD
	10	Fluid electrolyte imbalance
		Renal failure
		Liver & pancreatic cancer
		Pancreatitis
		GERD acute exacerbation
		Drug dependence
		GI obstruction
		Rheumatoid arthritis
2019	11	Bipolar - chronic
		Bipolar – acute exacerbation
		Conduct disorder
		Epileptic seizure
		Hypotension/Syncope
		Kidney & urinary tract stones
		Other respiratory infection
		Dermatitis/Urticaria

Status of Episodes of Care

Wave	Episode	Status
1	Perinatal Asthma acute exacerbation Total joint replacement	• First performance period: Jan 2015 – Dec 2015 • TJR supplemental report pilot in process
2	COPD acute exacerbation Colonoscopy Cholecystectomy PCI - acute PCI – non acute	• Contract amendments coming soon • First performance period January – December 2016
3	GI hemorrhage Upper GI endoscopy Respiratory Infection Pneumonia UTI - outpatient UTI – inpatient	• Preview reports to be sent May 2016 • First performance period January – December 2017
4	ADHD CHF acute exacerbation ODD CABG Valve repair and replacement Bariatric surgery	• Technical Advisory Groups (TAGs) in process • Preview reports to be sent May 2016 • First performance period January – December 2017

Agenda

Update on Episodes of Care strategy

Primary Care Transformation updates

- Primary Care Transformation TAG process
- PCMH payment streams and supports
- Health Homes payment streams and incentives
- Health Homes population definition
- Care Coordination Tool RFP

TAG agendas – Where we are today

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** (sources of value, care delivery improvement, and Health Home activities) • Briefing on interaction model of PCMH and Health Homes • Discussion of requirements for practices and Health Homes
Session 4	• Oct 1	• Sept 29	• **Discussion of requirements for practices and Health Homes** • Briefing on patient privacy in Tennessee • Discussion of quality metrics • Discussion of patient engagement
Session 5	• Oct 29	• Oct 27	• **TAG recommendation on requirements for practices and Health Homes** • **TAG recommendation on patient engagement** • Briefing on payment streams and incentives • Discussion of quality metrics • Discussion of practice training and supports • Discussion of provider report design
Session 6	• Nov 19	• Nov 17	• Briefing on attribution methodology • Briefing on comprehensive risk assessment approach • Briefing on exclusions for financial risk adjustment • **TAG recommendation of practice and Health Home training and supports** • **TAG recommendation of provider report design** • **Review of recommendations discussed throughout the series**

Agenda

Update on Episodes of Care strategy

Primary Care Transformation updates

- Primary Care Transformation TAG process
- PCMH payment streams and supports
- Health Homes payment streams and supports
- Health Homes population definition
- Care Coordination Tool RFP

Overview of payment model for PCMH

	Objective	Payment	Requirements for initial period payment	Additional requirements
1 Practice transfor-mation	• Support initial investment in practice changes including infrastructure and personnel	**a** In-kind coaching and support **b** Direct, non-risk adjusted payment	• Eligibility requirements	• In-kind coaching and support sunsets after 2 years
2 New clinical activities	• Compensate for new clinical activities not currently, directly reimbursed for on the condition of quality and cost improvement	• Risk-adjusted PMPM payment with restrictions on use	• Eligibility requirements • Activity verification	• Achieving quality and cost outcomes required to receive payments beyond first year
3 Outcomes-based payment	• Encourage improvements in total-cost-of care and clinical outcomes	**a** **High-volume PCMH practices** (or pools of smaller practices): Shared savings based on total cost of care	• Improvement in Total Cost of Care, post technical adjustment • Quality measures • Minimum panel size	• Same as initial period • Opportunity for large practices to gain further incentives
		b **Low-volume PCMH practices:** Bonus payment based on TCOC proxies (e.g., ED utilization, quality)	• Quality and cost outcomes	• Same as initial period

Potential training and practice transformation services

Pre-transformation assessment	• An initial, rapid, standardized assessment to develop a tailored curriculum for each site to establish baseline level of readiness for transformation • Focus of assessment to be strengths and gaps in workforce, infrastructure, and workflows as they relate to capabilities and transformation milestones, prioritizing areas for improvement

Practice transformation support curriculum	• Develop and execute a standard curriculum that can be tailored for each primary care practice site based on the needs identified in the pre-transformation assessment
	• Should cover 1st and 2nd years of transformation including frequency and structure of learning activities
	• Curriculum may include content structured through the following:
	  ▫ Learning collaboratives
	  ▫ Large format in-person trainings
	  ▫ Live webinars
	  ▫ Recorded trainings
	  ▫ On-site coaching

Semi-annual assessment	• Conduct assessments of progress toward each practice transformation milestone every 6 months; document progress

Agenda

Update on Episodes of Care strategy

Primary Care Transformation updates

- Primary Care Transformation TAG process
- PCMH payment streams and supports
- Health Homes payment streams and supports
- Health Homes population definition
- Care Coordination Tool RFP

Briefing on payment model for Health Home

	Objective	Payment	Requirements for initial period payment[1]	Additional requirements
1 Practice transfor-mation	• Support initial investment in practice changes including infrastructure and personnel	a In-kind coaching and support b Time-limited, non-risk adjusted payment	• Eligibility requirements	• Personnel and activity requirements in later period • Payments sunset after limited time
2 New clinical activities	• Compensate for new clinical activities not currently, directly reimbursed for on the condition of quality and cost improvement	• PMPM payment with restrictions on use	• Eligibility requirements • Personnel requirements • Activity verification (e.g., care plans, follow-up post discharge)	• Achieving quality and cost outcomes required to receive payments beyond first year • Activity requirements increase over time
3 Outcome based payment	• Encourage improvements in clinical and efficiency outcomes	• Incentive payment based on outcomes proxies	• Eligibility requirements • Quality and efficiency outcomes	• Quality and efficiency requirements increase over time

1 Initial payment to be defined for a specified range of time, e.g., first year of practice operations

Content of training curriculum for a typical Health Home

	Traditional behavioral health providers
Health Home leaders	• **Business support** (e.g., how to financially succeed as a Tennessee Health Home) • **Workflow management** (e.g., designing new clinical workflows to enable person-centered care) • **Patient access** (e.g., flexible scheduling, expanded hours) • **Workforce management** (e.g., recruiting clinical care coordinators, Health Home organization / reporting structure)
Clinical directors (RNs)	• **Management training** (e.g., how to manage and engage case managers) • **Clinical workflows** (e.g., detailed process for when a member is admitted into inpatient psychiatric treatment)
Case managers	• **Patient education** (e.g., developing and communicating a plan for getting patients comfortable using TennCare transportation) • **Family and community engagement** (e.g., developing a plan for a family member to take patient to appointments, over time) • **Clinical workflows** (e.g., detailed process for when a member is admitted into inpatient psychiatric treatment
Direct clinical service providers	• **Clinical workflows** (e.g., knowing when and how to engage care coordinator)

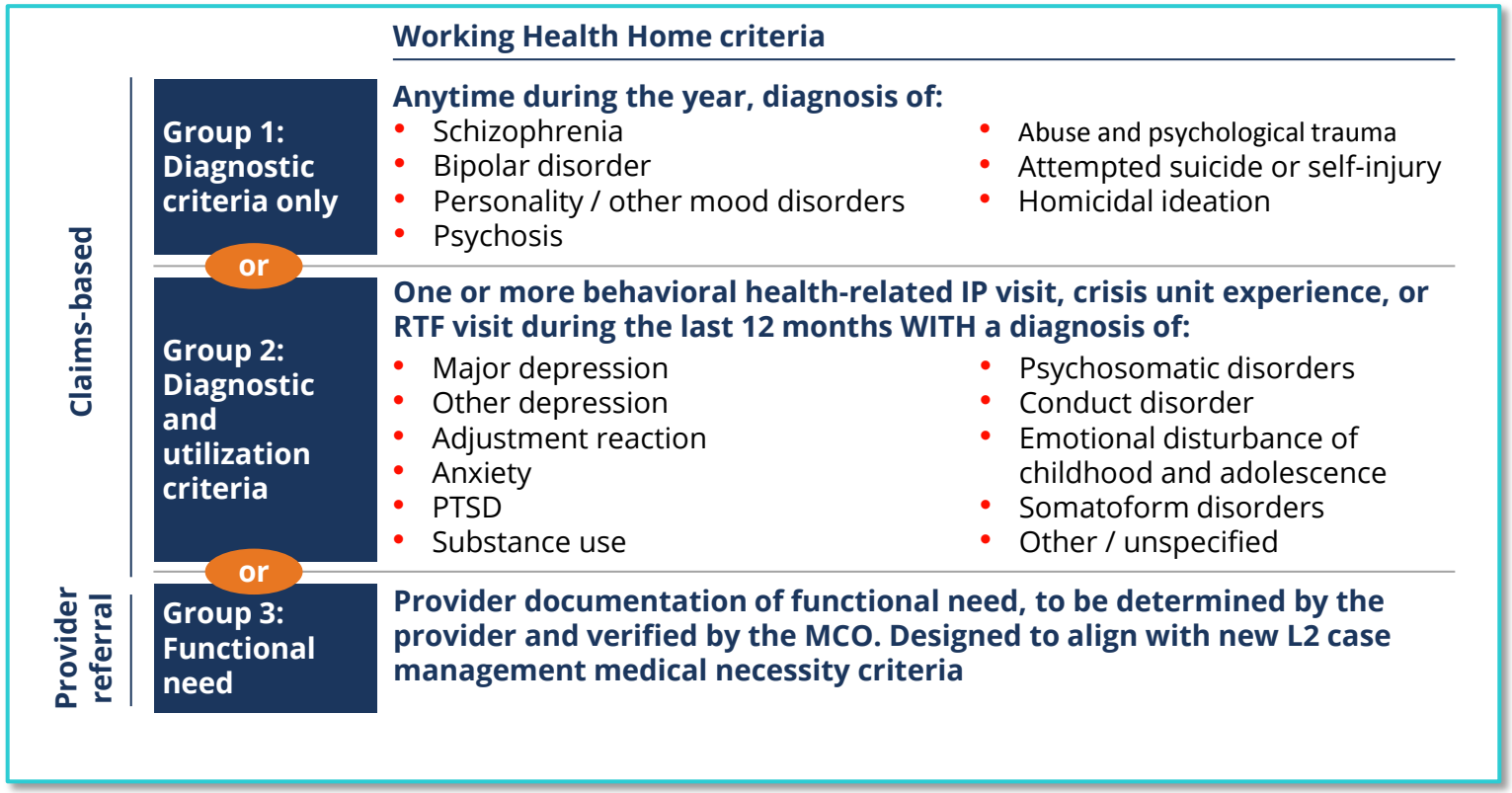
Agenda

Update on Episodes of Care strategy

Primary Care Transformation updates

- Primary Care Transformation TAG process
- PCMH payment streams and supports
- Health Homes payment streams and supports
- Health Homes population definition
- Care Coordination Tool RFP

Briefing on Health Home member identification criteria



Commonalities between Health Home activities and Level 2 case management

	Potential activity requirements for Health Home providers	Core part of L2 CM[1]
Integrated care plan	• Create and update care plan in collaboration with the patient, which addresses barriers to treatment adherence and crisis management • Support the patient's behavioral health provider in the development and update of BH treatment plan • Ensure BH input into the development of the medical treatment plan	✓
Patient relationship	• Check ins with patient to support treatment adherence • Provide high-touch in-person support to ensure treatment and medication adherence (e.g., medication drop-off, transportation to appointments) • Provide additional high touch support in crisis situations when other resources are unavailable, or as an alternative to ED / crisis services • Educate the patient and his/her family on independent living skills with attainable and increasingly aspirational goals	✓ ✓
Transitions of care	• Receive ADT notifications for the patient • Participate in development of discharge plan for each hospitalization, beginning at admission	
Engage medical care providers	• Supports scheduling and reduce barriers to adherence for medical appointments, including in-person accompaniment to some appointments • Follow up with PCP to understand significant changes in medical status, and translate into care plan • Proactive outreach with PCP regarding specific gaps in care	✓
Engage BH providers	• Supports scheduling and reduce barriers to adherence for medical appointments, including in-person accompaniment to some appointments • Follow up with provider to understand BH needs, and translate into care plan	✓
Engage supportive services	• Facilitates access to community supports, including scheduling and follow through • Communicate patient needs to community partners	✓
Population health management	• Track and report on clinical quality outcomes as required • Continuously identify highest risk patients and align with organization to focus resources and interventions	

1 Other Health Home activities may be performed by some case managers, but not universally

Different emphasis in Health Home care model and L2 case management

Opportunities for Health Home model

Improved service delivery model

Increased emphasis on:

- **Coordination with medical providers** and addressing gaps in care / treatment adherence for **physical health conditions**
- Interaction with **behavioral health providers**
- **Collateral contacts** with family, community, and other providers
- Focus on **patient recovery**, including independent living skill development
- Opportunity to create **interdisciplinary care team** to deliver services

Payment structure

- **Reduced emphasis on required face-to-face encounters**
- **Flexibility to adjust service intensity** to serve patients in different ways as patient needs fluctuate over time
- Financial incentives for **high performing providers**
- **Payment for L2 case management services would be included in Health Home payment structure (i.e., PMPM)**

TN

Agenda

Update on Episodes of Care strategy

Primary Care Transformation updates

- Primary Care Transformation TAG process
- PCMH payment streams and supports
- Health Homes payment streams and supports
- Health Homes population definition
- Care Coordination Tool RFP

Schedule: Request For Proposal for Care Coordination Tool

EVENT	DATE (all dates are state business days)
RFP Issued	September 28, 2015
Response Deadline	November 4, 2015
Contractor Signature Deadline	December 7, 2015
Contract Start Date	January 4, 2016

Care Coordination Tool RFP can be found here:
https://www.tn.gov/assets/entities/generalservices/cpo/attachments/RFP_31865-00410.pdf