Health Care
Innovation Initiative

Provider Stakeholder Group
October 7th, 2015

Agenda

Update on Primary Care Transformation

Update on Long Term Services and Supports (LTSS)

Technical Advisory Group Process

- Patient Centered Medical Homes and Health Homes TAGs have each met four times. Providers serving on the TAGs are engaged and discussions have been productive.
- Both of these groups will meet two more times and the final scheduled meetings are November 17th and 19th.

- Wave 4 episode of care TAGs have also begun.
  - Three of these TAGs have already begun meeting: (1) ADHD/ODD, (2) Bariatric Surgery, and (3) CABG and Cardiac Valve
  - Congestive heart failure (CHF) TAG will begin October 12th.

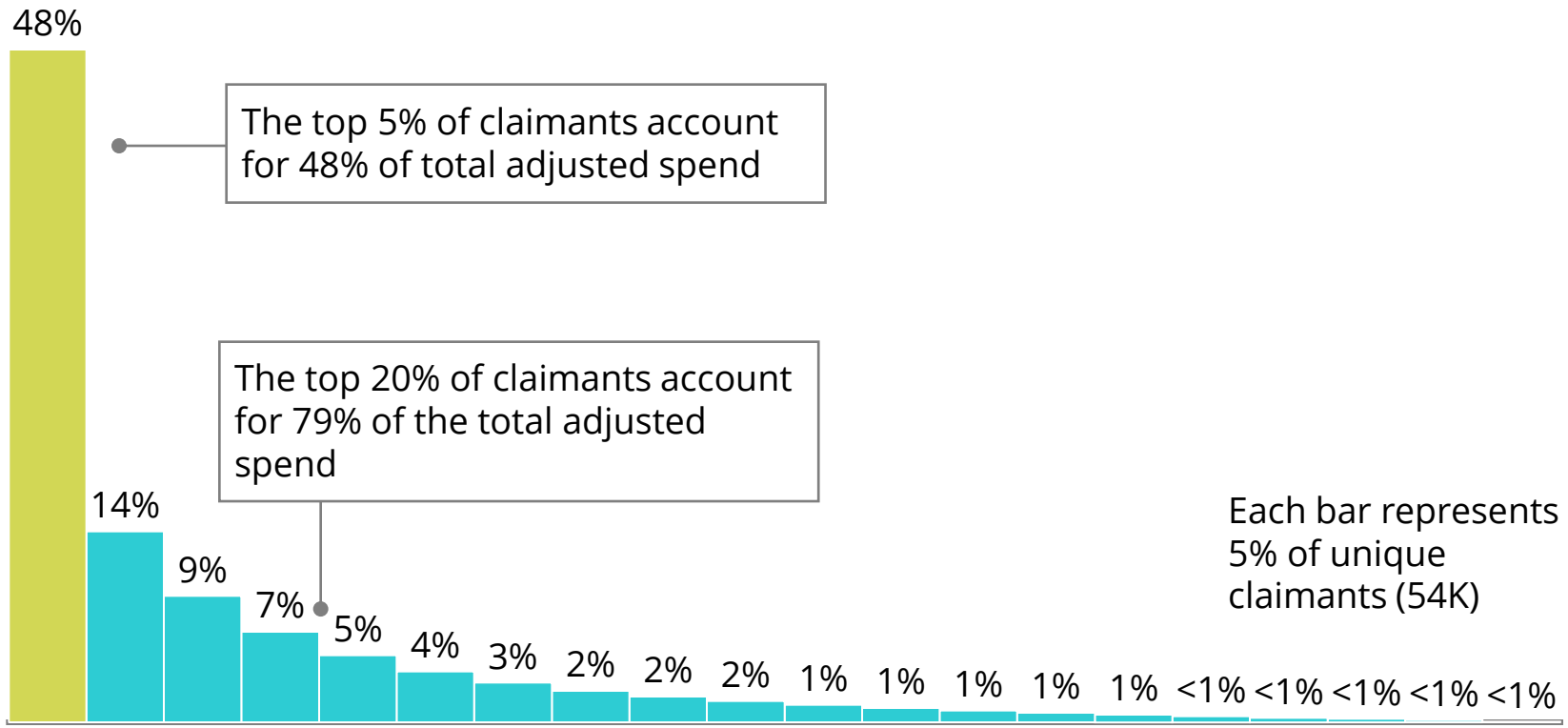
More detail from Tennessee Population Health Management diagnostic

1. Profile of **highest-spend patient population**
2. **Consistency of highest-spend patient population** year on year
3. **Utilization patterns** including avoidable ED and IP visits
4. **Diagnostic profile** of individuals with 3 or more co-morbidities
5. **Care access patterns** for individuals for behavioral healthcare

1 The highest cost 5% of TennCare members account for nearly half of total adjusted spend in 2014

Distribution of members with claims[1] by spend rank

Percent of adjusted spend, CY2014



1 Distribution of unique claimants shown, excluding members without claims.

Note: Does not include crossover and dental claims, supplemental payments, intellectual disability services, Medicare services, CoverKids, payments to DCS, DME, vision, transportation, nursing home, long-term care and home health, as well as members who are dual eligible or have third party liability. Top 5% members selected from claimants only (unique claimant basis).

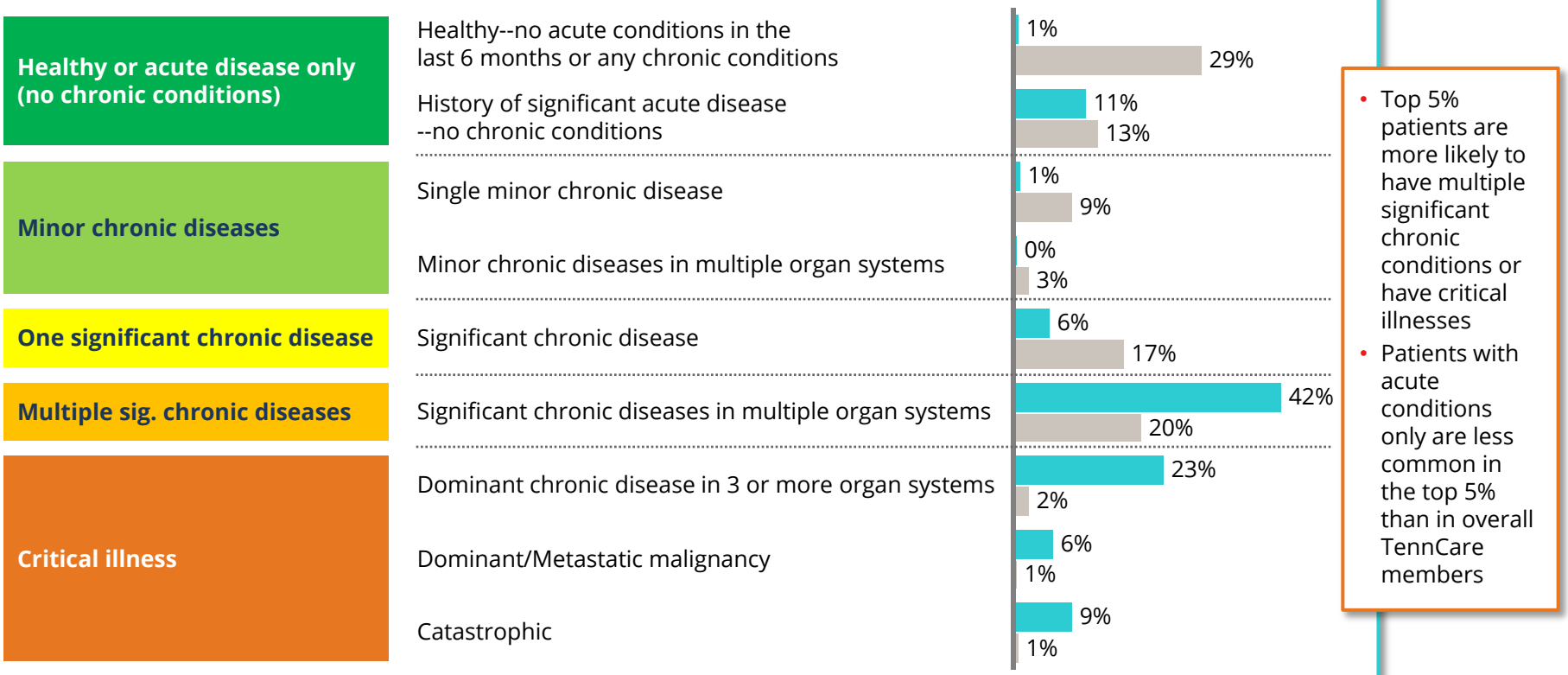
SOURCE: TN 2011-2014 claims data

1 Top 5% members have more severe chronic conditions and also more likely to have a catastrophic health event

ADJUSTED TOTAL

Percent of annualized members, CY2014
Top 5%=51K annualized members, 1.1M for total

Patient distribution by health risk status, CY2014[1]



- Top 5% patients are more likely to have multiple significant chronic conditions or have critical illnesses
- Patients with acute conditions only are less common in the top 5% than in overall TennCare members

1 Based on 3M-CRG health categories, using two-year claim history (CY2013-14). See appendix for definitions. Does not include members with unknown health status

Note: Does not include crossover and dental claims, supplemental payments, intellectual disability services, Medicare services, CoverKids, payments to DCS, DME, vision, transportation, nursing home, long-term care and home health, as well as members who are dual eligible or have third party liability. Top 5% members selected from claimants only (unique claimant basis).

SOURCE: TN 2010-2014 claims data

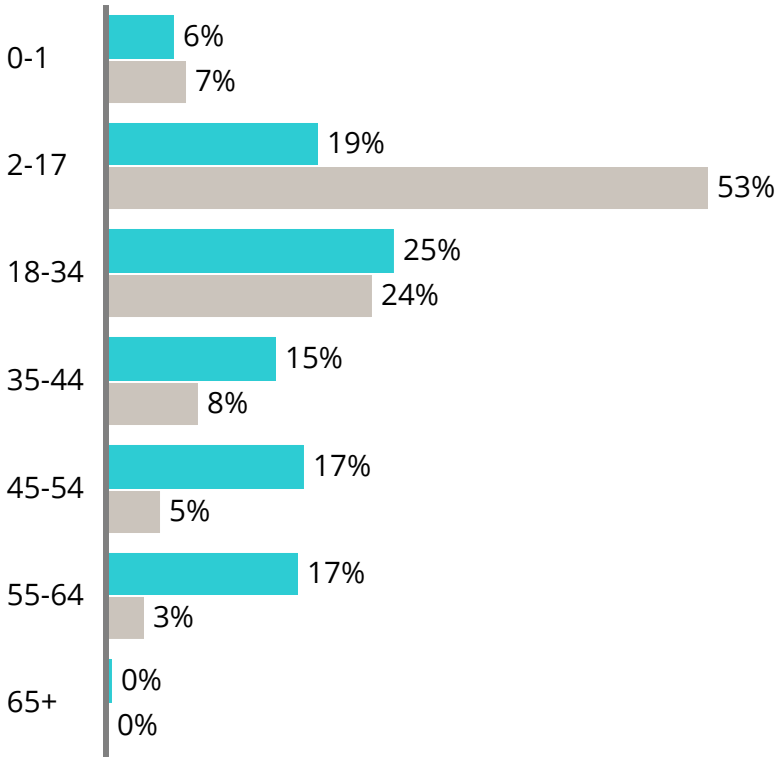
1 Top 5% are more likely to be 35 or older, have a BH condition in treatment, or receive LTSS services

ADJUSTED TOTAL

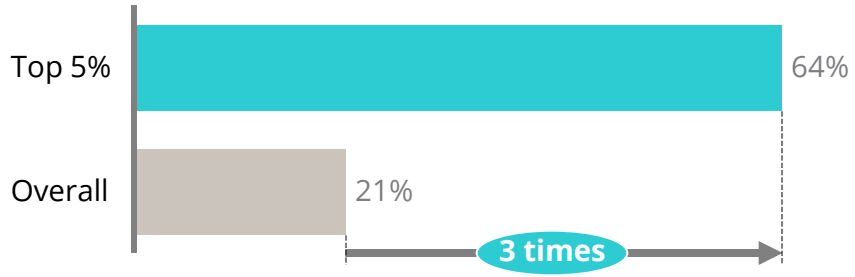
Percent of annualized members, CY2014
Top 5%=51K annualized members, 1.1M for total

Top 5%
All members

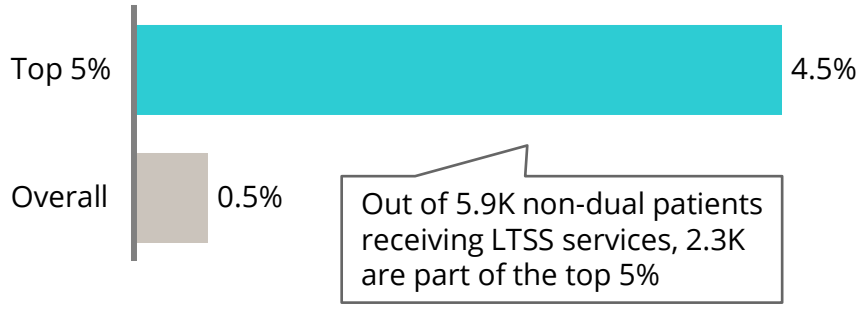
Age distribution



Share of members with a BH diagnosis and receiving treatment



Share of members receiving LTSS services[1]



1 Members who are part of the Choices program, ICF/IID, PACE, or any other waiver programs.
Note: Does not include crossover and dental claims, supplemental payments, intellectual disability services, Medicare services, CoverKids, payments to DCS, DME, vision, transportation, nursing home, long-term care and home health, as well as members who are dual eligible or have third party liability. Top 5% members selected from claimants only (unique claimant basis).

SOURCE: TN 2010-2014 claims data

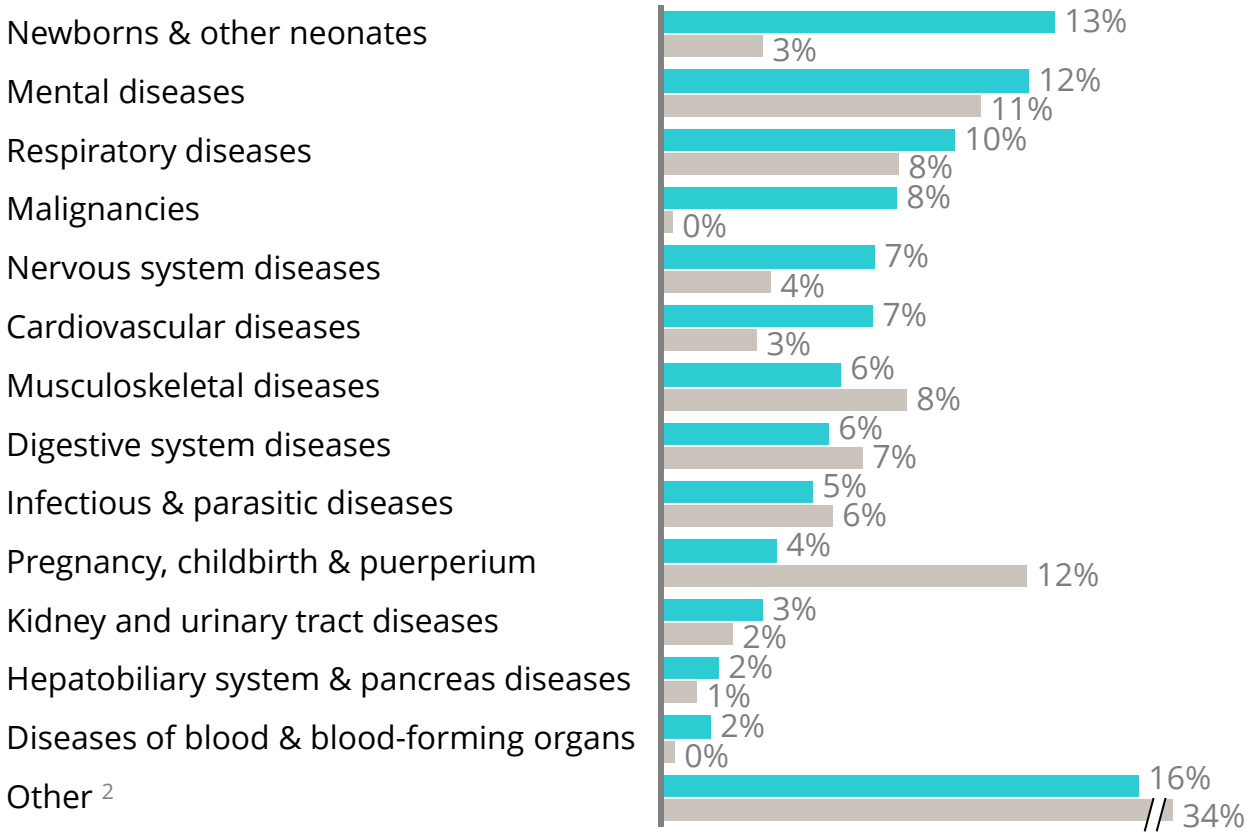
1 Diagnoses associated with most medical spend in the top 5 percentile are neonatal and mental diagnoses

ADJUSTED TOTAL

EXCLUDES PHARMACY SPEND

Medical spend by diagnosis for the top 5% claimants, CY 2014

Percent of medical spend[1]



- Medical service for diagnoses of neonatal conditions and mental diseases accounted for the largest share of medical spend for the top5%
- Neonatal conditions and malignancies are diagnoses for which there is a significant difference in share of spend for the top 5% and the remaining population

Note: Does not include crossover and dental claims, supplemental payments, intellectual disability services, Medicare services, CoverKids, payments to DCS, DME, vision, transportation, nursing home, long-term care and home health, as well as members who are dual eligible or have third party liability. Top 5% members selected from claimants only (unique claimant basis).

1 Analysis of medical spend only. Excludes pharmacy spend. 2 Includes Other Endocrine, Metabolic And Thyroid Disorders, Other Trauma, Diabetes Mellitus, Substance Abuse, Peripheral Vascular Disease And Other Non-Cardiac Vascular Diseases, Diseases And Disorders Of The Ear, Nose, Mouth And Throat, Chromosomal Anomalies, Mental Retardation And Other Developmental / Cognitive Diagnoses, Diseases And Disorders Of The Female Reproductive System, Diseases And Disorders Of The Skin, Subcutaneous Tissue, And Breast, Injuries, Poisoning And Toxic Effects Of Drugs, Connective Tissue Diseases, Diseases And Disorders Of The Eye, Burns, HIV Infection, Neoplasms Of Uncertain Behavior, Craniofacial Anomalies, Catastrophic Respiratory Conditions, Catastrophic Neurological Conditions, Diseases And Disorders Of The Male Reproductive System, Secondary Malignancy, etc,

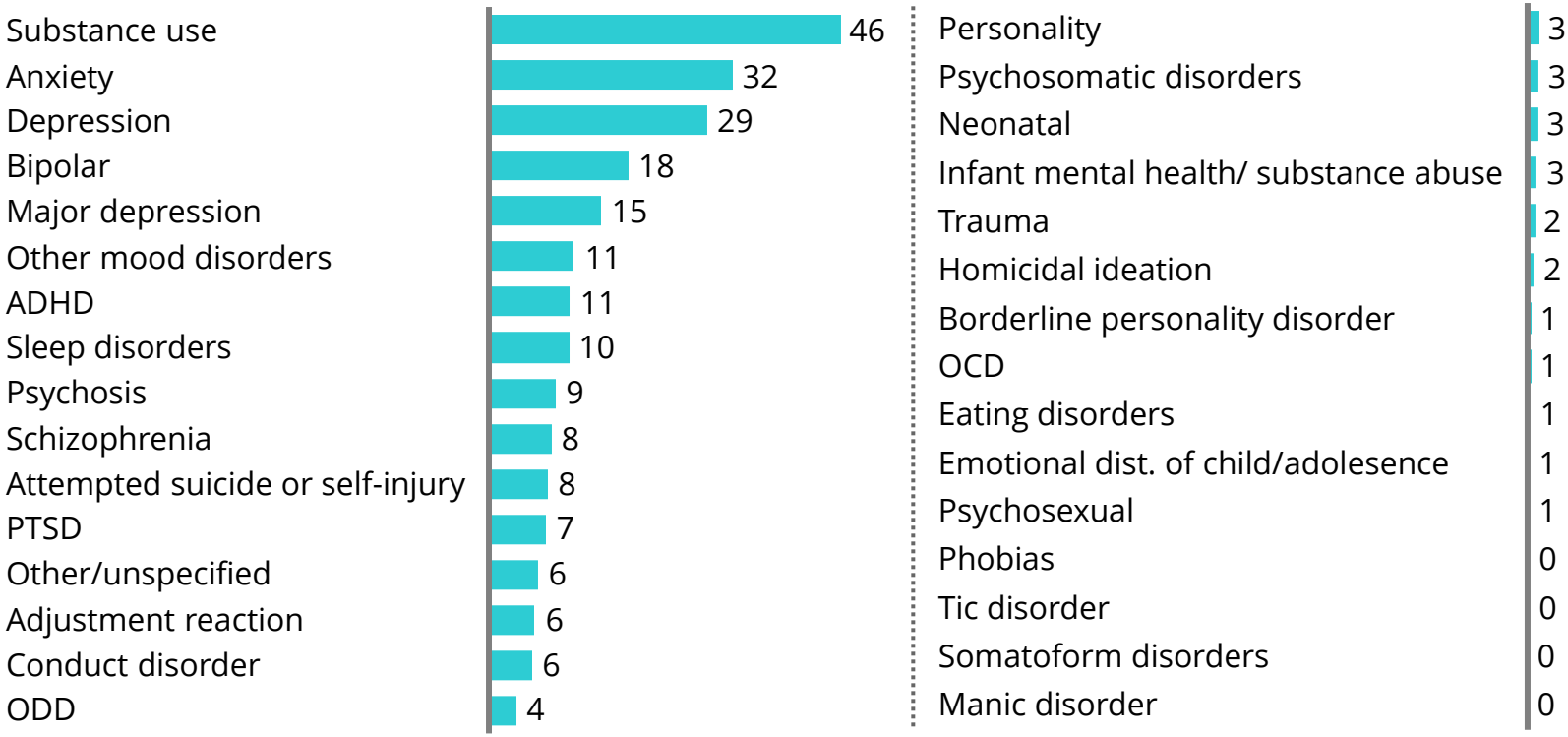
SOURCE: TN 2010-2014 claims data

1 Substance use, anxiety, and depression are the most common BH diagnoses

ADJUSTED TOTAL

Behavioral health diagnosis prevalence in top5% claimants, CY 2014

Percent of annualized top 5% members; a member can have multiple BH diagnoses



- Substance abuse, anxiety, and depression are the most common BH diagnoses in top 5%

Note: Does not include crossover and dental claims, supplemental payments, intellectual disability services, Medicare services, CoverKids, payments to DCS, DME, vision, transportation, nursing home, long-term care and home health, as well as members who are dual eligible or have third party liability. Top 5% members selected from claimants only (unique claimant basis).

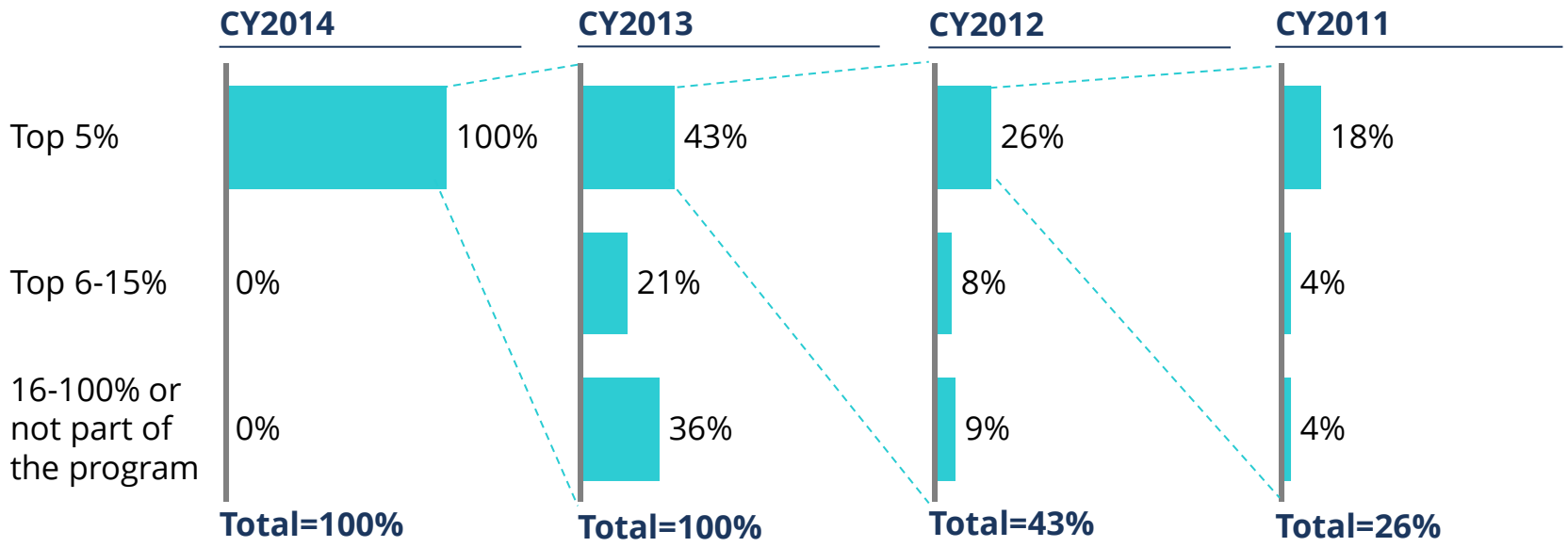
SOURCE: TN 2010-2014 claims data

2 Nearly half of top 5% members in 2014 were also part of top 5% in the previous year

ADJUSTED TOTAL

Top 5% members in CY2014=51K annualized members
Percent of top 5% total in 2014

Relative position of top 5% members in CY2014 in previous years, CY2011-2014



- 18% of the top 5% members in CY2014 have been in top 5% since 2011
- Within the 57% of members who were not in top 5% in 2013, 47% were in top 5% only in CY2014, with remaining 10% being part of top 5% again in other non-consecutive years[1]
- Two-thirds of members in top 5% in CY2014 were in top 15% in CY2013

Note: Does not include crossover and dental claims, supplemental payments, intellectual disability services, Medicare services, CoverKids, payments to DCS, DME, vision, transportation, nursing home, long-term care and home health, as well as members who are dual eligible or have third party liability. Top 5% members selected from claimants only (unique claimant basis).
1 Additional breakout of the 57% in Top 6%+ in CY2013

SOURCE: TN 2010-2014 claims data

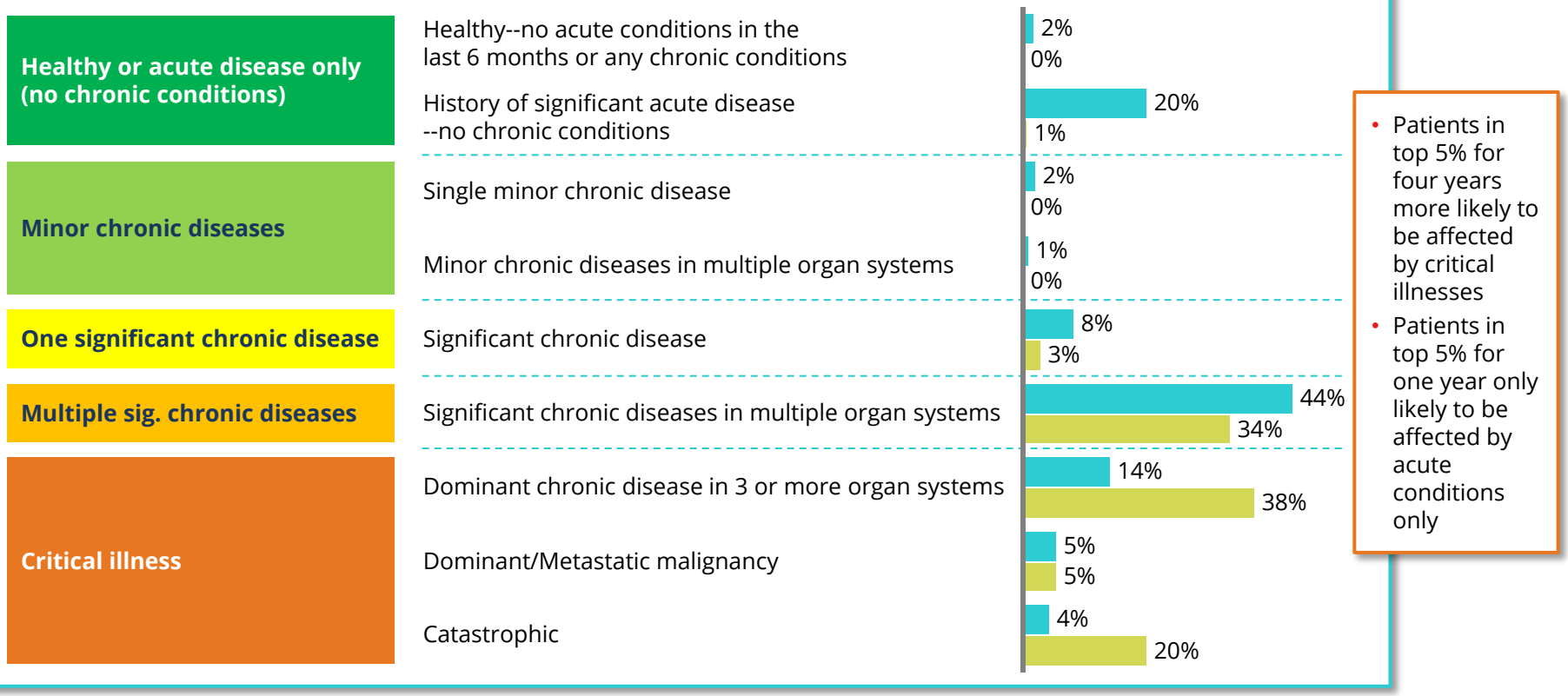
2 Patients in top 5% for 4 years have more severe chronic diseases and catastrophic health events

ADJUSTED TOTAL

Percent of annualized members, CY2014
100%=24K for in top 5% in CY14 only, 9K in top 5% in CY11-14

Top5% in 2014 in top 5% in 2014 only
Top 5% in 2014 in top 5% in 2011-2014

Patient distribution by health risk status, CY2014[1]



- Patients in top 5% for four years more likely to be affected by critical illnesses
- Patients in top 5% for one year only likely to be affected by acute conditions only

1 Based on 3M-CRG health categories, using two-year claim history (CY2013-14). See appendix for definitions. Does not include members with unknown health status

Note: Does not include crossover and dental claims, supplemental payments, intellectual disability services, Medicare services, CoverKids, payments to DCS, DME, vision, transportation, nursing home, long-term care and home health, as well as members who are dual eligible or have third party liability. Top 5% members selected from claimants only (unique claimant basis).

SOURCE: TN 2010-2014 claims data

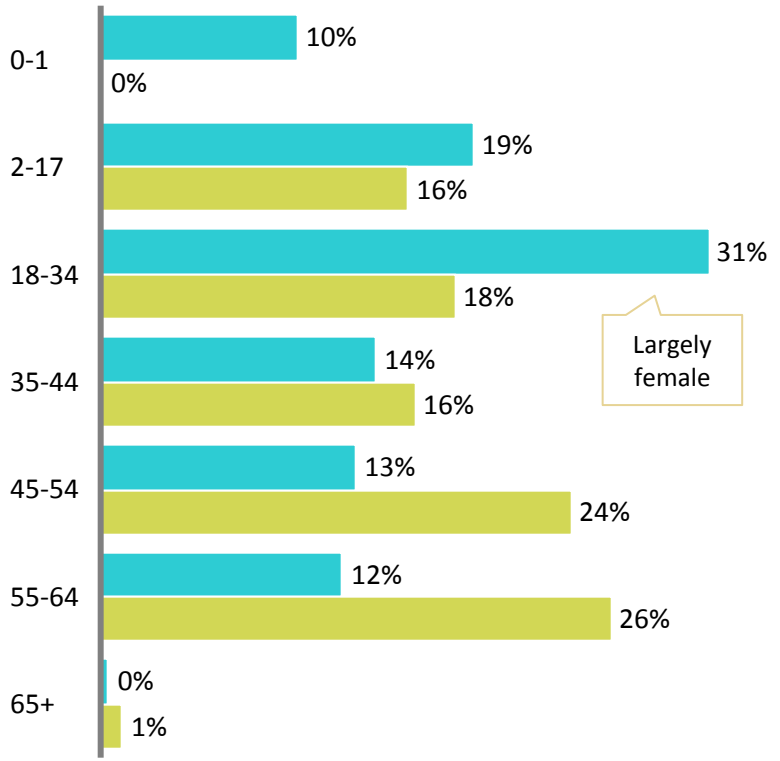
2 Patients in top 5% for 4 years are older, and four times more likely to receive LTSS services than those in top 5% in 2014 only

ADJUSTED TOTAL

Percent of annualized members, CY2014
100%=24K for in top 5% in CY14 only, 9K in top 5% in CY11-14

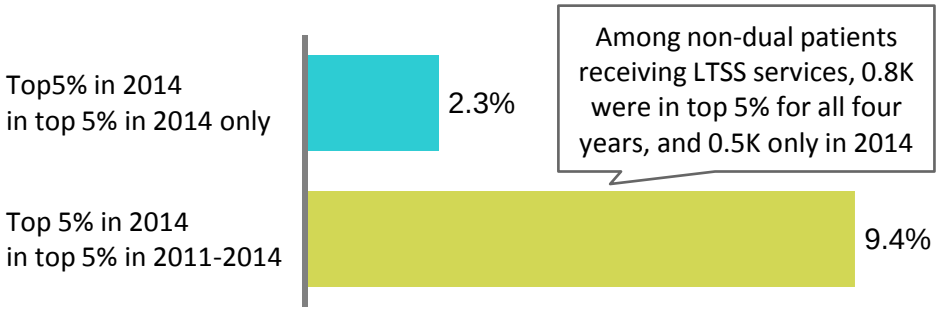
Top5% in 2014 in top 5% in 2014 only
Top 5% in 2014 in top 5% in 2011-2014

Age distribution



Share of members with a BH diagnosis and receiving treatment

Share of members receiving LTSS services[1]



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SOURCE: TN 2010-2014 claims data

3 Background on ambulatory care sensitive admissions and avoidable ER visits

	Ambulatory care sensitive IP admissions	Avoidable ER visits
Background	• Based on the list of diagnoses from Dartmouth Atlas of Health Care that identifies ambulatory care sensitive diagnoses that can be treated outside of a hospital, often used as an indicator the quality of primary care • Excludes discharges with surgical codes to ensure that the admission was for a medical condition	• Developed by the Medi-Cal Managed Care Division of the California Department of Health Care Services in 2007 during a statewide collaborative quality improvement initiative. • Selected diagnosis codes for avoidable ER visits in collaboration with ER experts from University of California and New York University
Sample diagnoses	• Chronic Obstructive Pulmonary Disease • Asthma • Bacterial Pneumonia • Congestive Heart Failure • Hypertension • Diabetes • Gastroenteritis • Kidney/Urinary Infection • Dehydration	• Acute Respiratory Infections • Otitis Media • Acute Pharyngitis • Headache • Urinary Tract Infections • Lumbago • Acute Bronchitis • Conjunctivitis • Chronic Sinusitis

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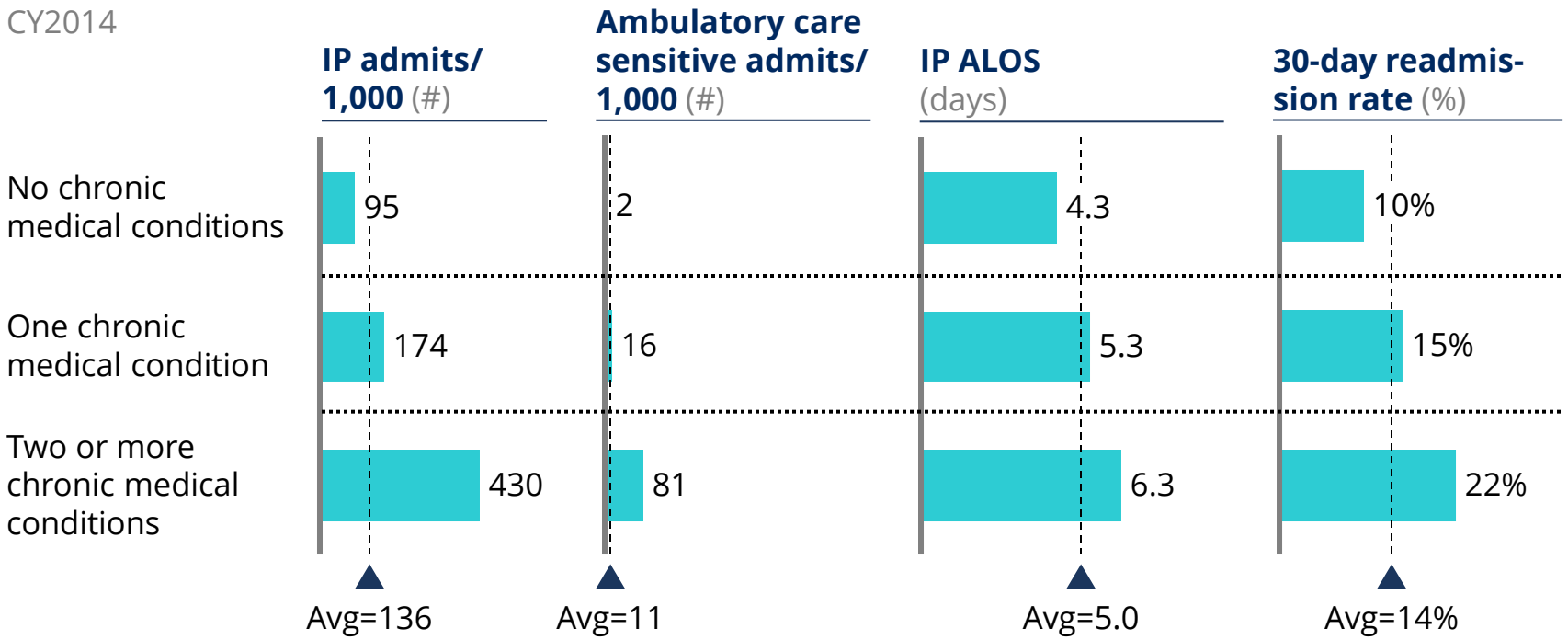
SOURCE: California Department of Health Care Services, Dartmouth Atlas of Health Care

3 IP utilization metrics by chronic condition status

ADJUSTED TOTAL

Key utilization metrics by chronic medical condition status[1]– Inpatient admissions

CY2014



- On average, one in 12 admissions are for ambulatory care sensitive conditions
- Close to 20% of the IP admissions for members with two or more chronic conditions are for ambulatory care sensitive conditions

1 BH conditions not considered in determining the number of chronic conditions

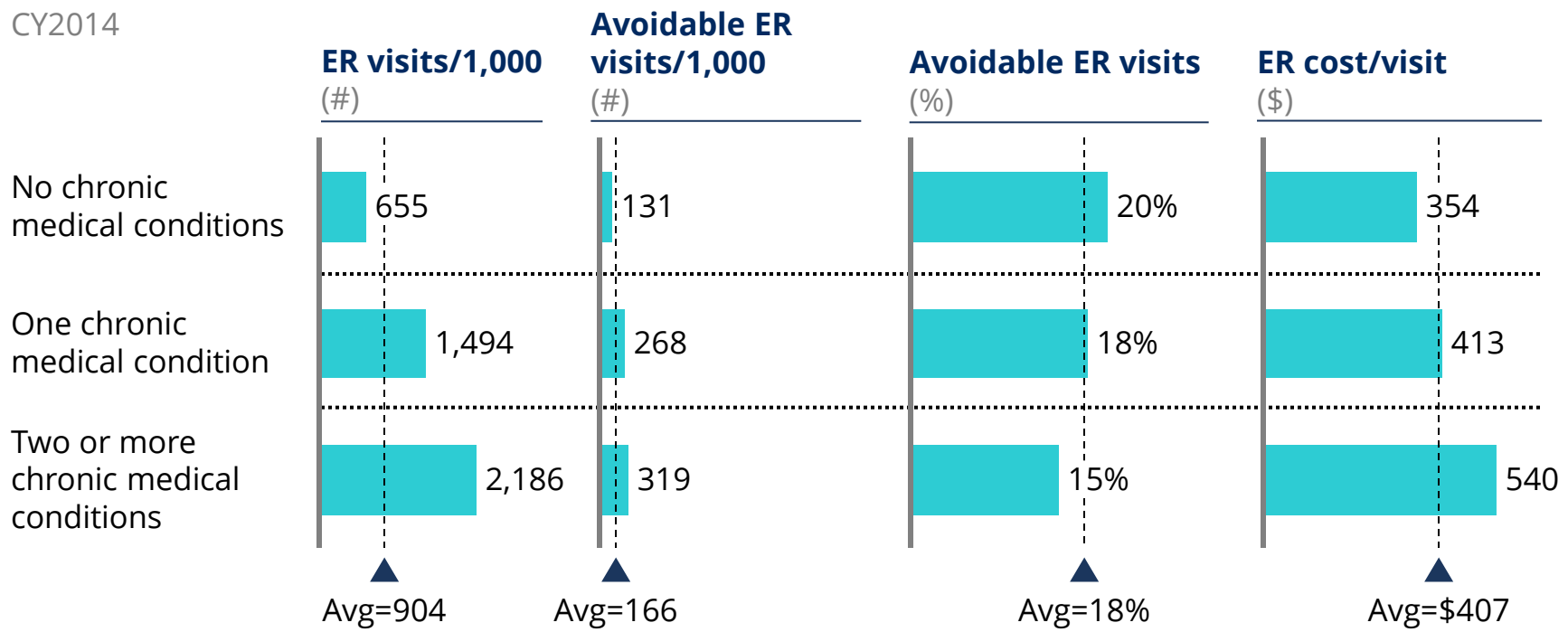
Note: Using the list of major chronic conditions defined by CMS, i.e., Alzheimer's disease Arthritis, Asthma, Atrial Fibrillation, Cancer (breast, colorectal, lung, and prostate), Chronic Kidney Disease, COPD, Diabetes, Heart Failure, Hyperlipidemia, Hypertension, Ischemic Heart Disease, Osteoporosis, Stroke. Note from the original list from CMS, depression, autism, and schizophrenia was removed since a deeper analysis on BH spend is conducted. Does not include crossover and dental claims, supplemental payments, intellectual disability services, Medicare services, CoverKids, payments to DCS, DME, vision, transportation, nursing home, long-term care and home health, as well as members who are dual eligible or have third party liability.

SOURCE: TN 2011-2014 claims data

3 ER utilization metrics by chronic condition status

ADJUSTED TOTAL

Key utilization metrics by chronic medical condition status[1]– ER admissions by type



On average, one in 5 ER visits were for potentially avoidable conditions

1 BH conditions not considered in determining the number of chronic conditions

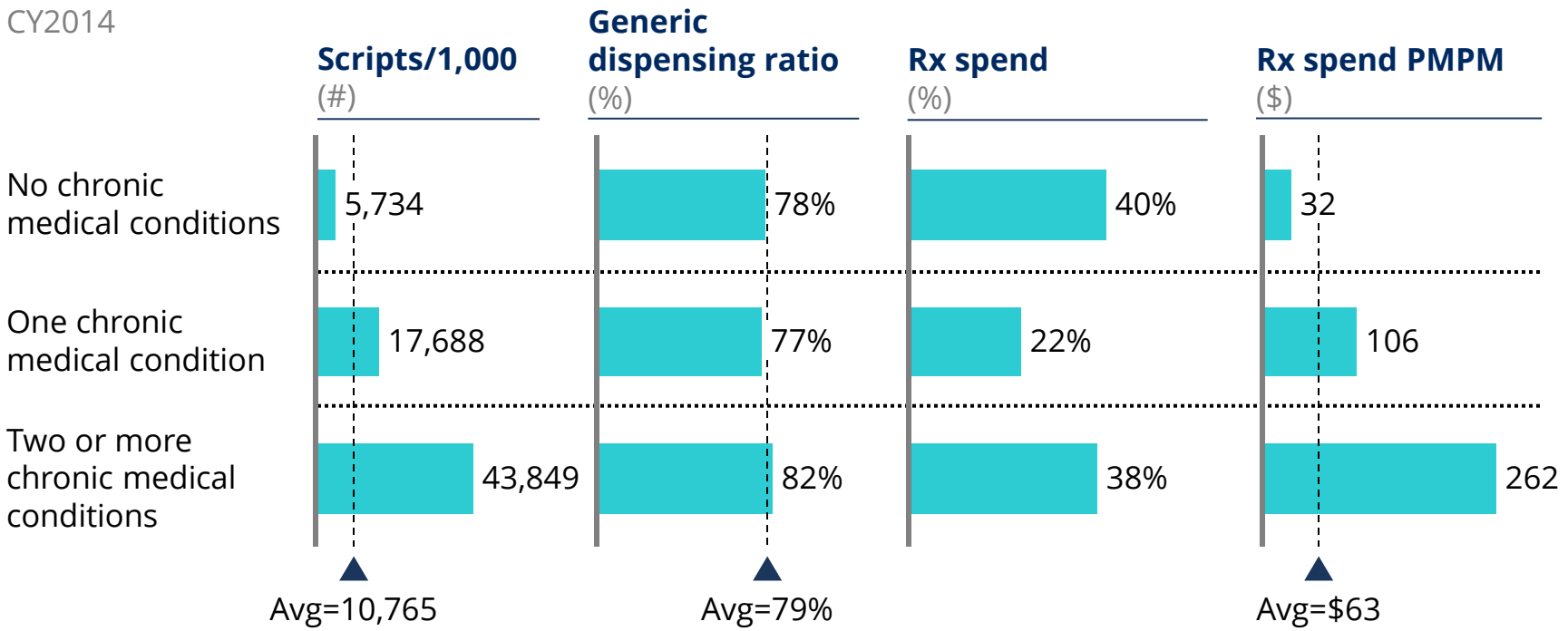
Note: Using the list of major chronic conditions defined by CMS, i.e., Alzheimer's disease Arthritis, Asthma, Atrial Fibrillation, Cancer (breast, colorectal, lung, and prostate), Chronic Kidney Disease, COPD, Diabetes, Heart Failure, Hyperlipidemia, Hypertension, Ischemic Heart Disease, Osteoporosis, Stroke. Note from the original list from CMS, depression, autism, and schizophrenia was removed since a deeper analysis on BH spend is conducted. Does not include crossover and dental claims, supplemental payments, intellectual disability services, Medicare services, CoverKids, payments to DCS, DME, vision, transportation, nursing home, long-term care and home health, as well as members who are dual eligible or have third party liability.

SOURCE: TN 2011-2014 claims data

3 Prescription utilization metrics by chronic condition status

Key utilization metrics by chronic medical condition status[1] – Pharmacy costs

CY2014



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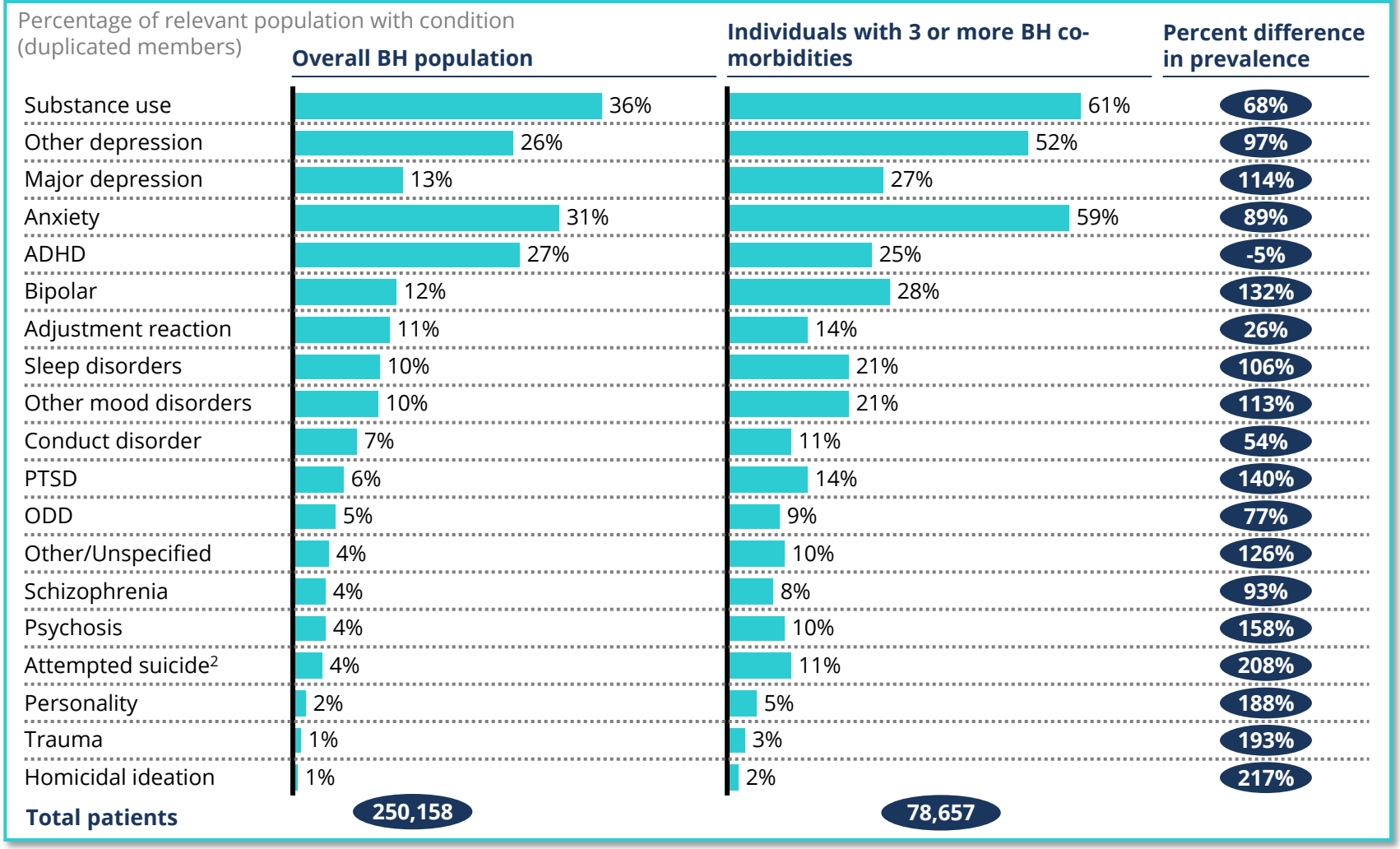
SOURCE: TN 2011-2014 claims data

4 Prevalence of conditions in patients with 3 or more BH co-morbidities

BH condition prevalence in overall behavioral health population vs. patients who have 3 or more BH co-morbidities[1]



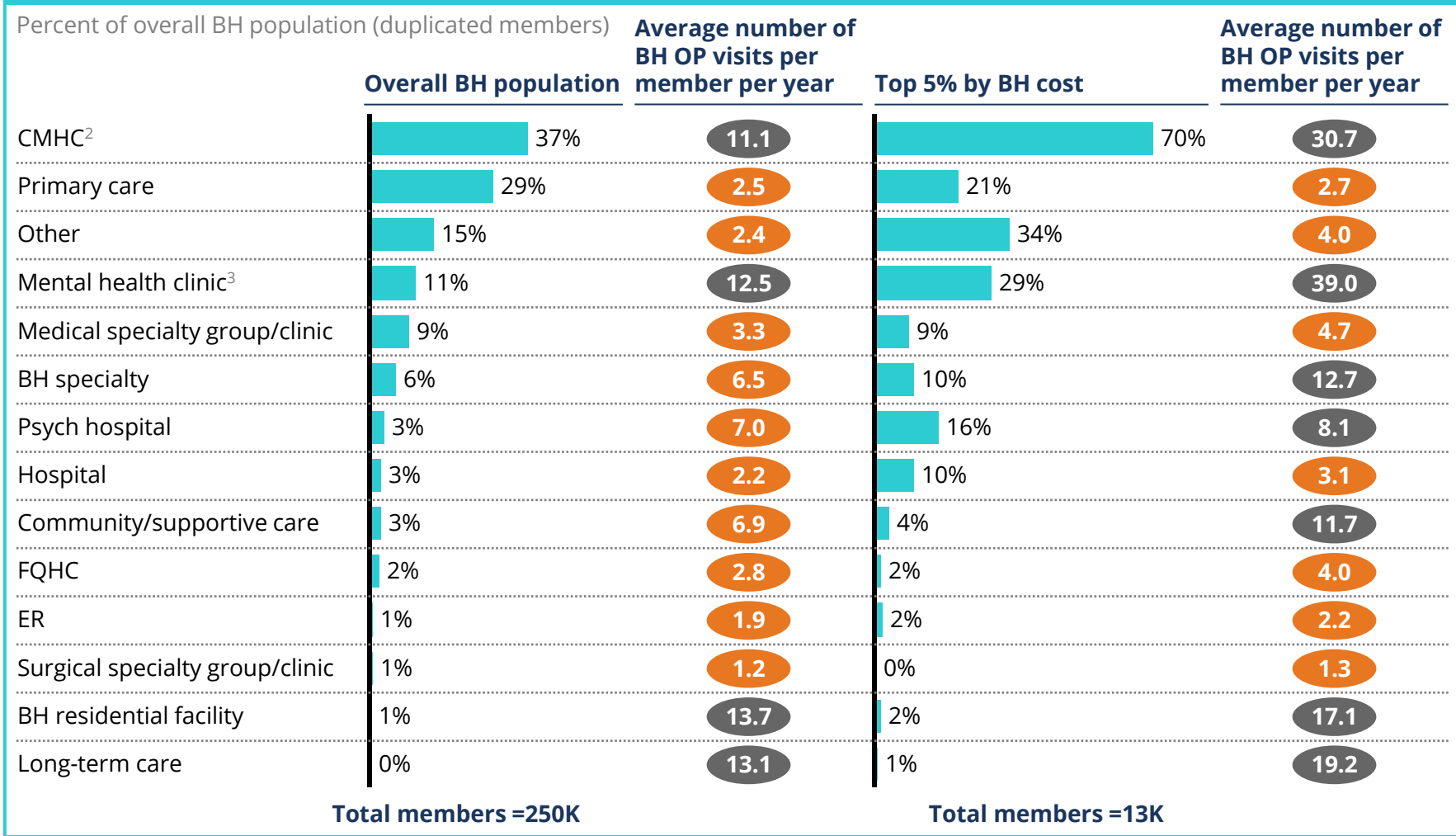
1 Only the top 18 conditions, out of 32 possible BH conditions shown here which have over 5% prevalence in either population. Looks at all diagnosis fields; members are duplicated across conditions
2 Also includes attempted self-injury

SOURCE: CY14 TennCare claims data

5 High cost members receive significantly more BH outpatient services at CMHCs and mental health clinics

XX 7+ visits

Percentage of members by their visits with each provider type for an outpatient BH treatment[1]



1 Claims billed in an office, clinic, or hospital outpatient service location
2 Estimate may be slightly low
3 Mental health providers without the full continuum of services

SOURCE: CY14 TennCare claims data

Agenda

Update on Primary Care Transformation

Update on Long Term Services and Supports (LTSS)

The LTSS payment reform strategy includes 3 elements:

- Acuity- and quality-based payments for LTSS (Nursing Facilities and HCBS)
- Value-based purchasing for Enhanced Respiratory Care (ERC) services in a Nursing Facility
- Workforce development

Extensive Stakeholder Engagement

- 18 community forums in 9 cities and an on-line survey
- Gathered member and family input on quality from member's perspective (the member's experience of care)
- More than 1200 participants, 1750 responses objectively evaluated and analyzed using acceptable statistical methods
- Survey of federal & state landscape
- Literature review
- Key informant interviews with other states
- Technical Assistance Report by Lipscomb University's School of TransformAging available at: http://www.lipscomb.edu/transformaging/tareport
- Facilitation of ongoing stakeholder processes to develop and implement Quality Framework and payment approach

Quality Improvement in Long Term Services and Supports (QuILTSS) Quality Framework

- **Threshold Measures**
  - Minimum standards to participate in QuILTSS
- **Quality Measures**
  - **Satisfaction** **35 points**
    - Member (15 points)
    - Family (10 points)
    - Staff (10 points)
  - **Culture Change/Quality of Life** **30 Points**
    - Respectful treatment, member choice, member/family input, meaningful activities
  - **Staffing/Staff Competency** **25 Points**
    - Staffing ratios, retention, consistent assignment, initial and ongoing staff training
  - **Clinical Performance** **10 Points**
    - Health related measures, prevention and early detection, ongoing functional assessment
  - **Bonus Points** for significant quality improvement initiatives

Acuity- and Quality-based payment for NFs and HCBS

- Implemented first with NFs
- Acuity determined by RUG scores from MDS
- Quality based on NF performance on specified quality measures
  - Phase 1 (bridge) quarterly adjustments to per diem rates—largely focused on quality improvement *activities* (i.e., process measures)
  - Phase 2 (full model) component of prospective per diem based on quality *performance* compared against benchmarks
- Utilizing interim web-based submission tool and process
- 5 quarterly submissions completed; NFs receive a summary score sheet with explanation of point awards
- Reconsideration committee of external stakeholders
- MCOs have distributed over $18 million in payments for quality-based rate adjustments for the first 4 submissions

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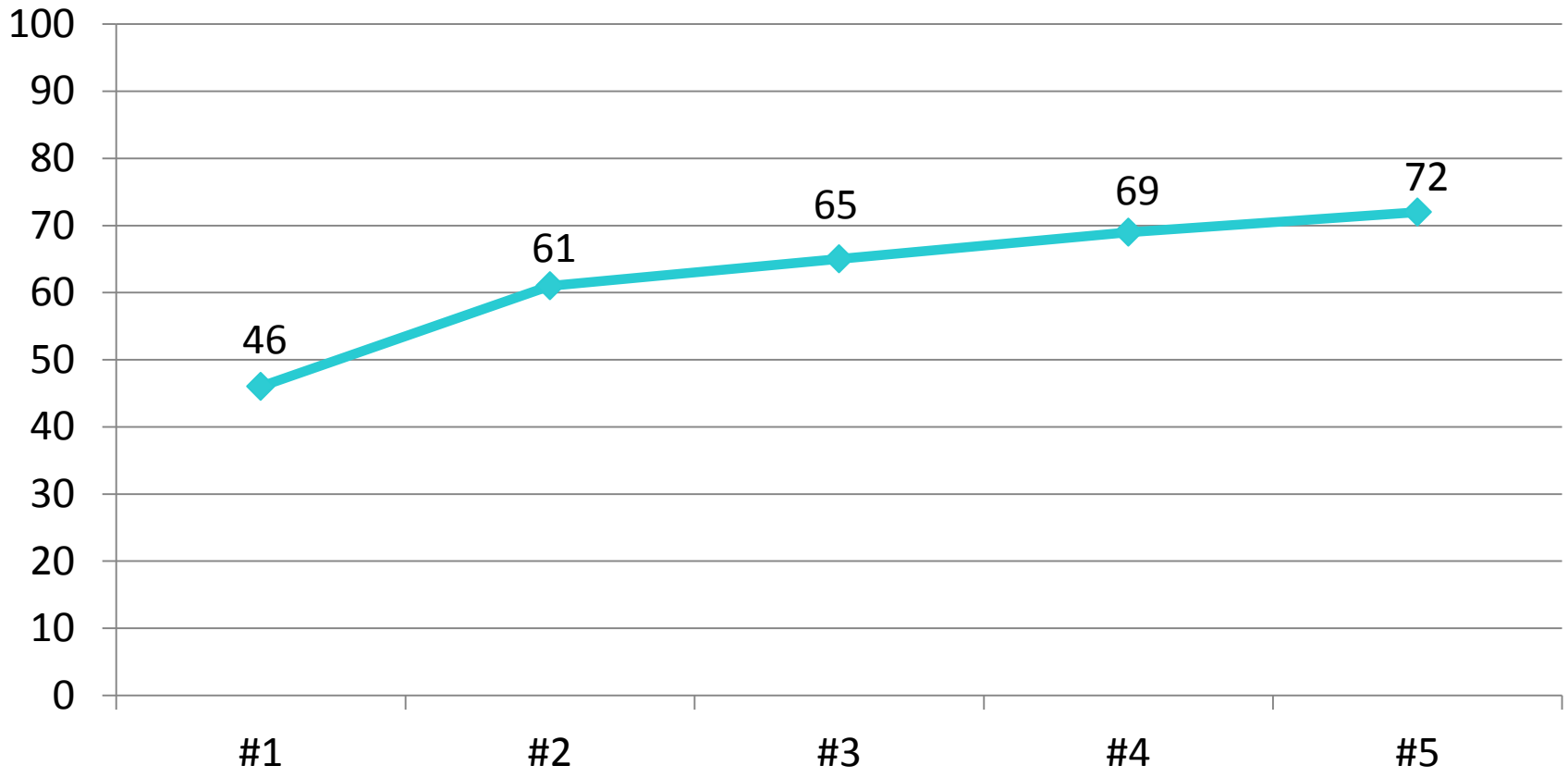
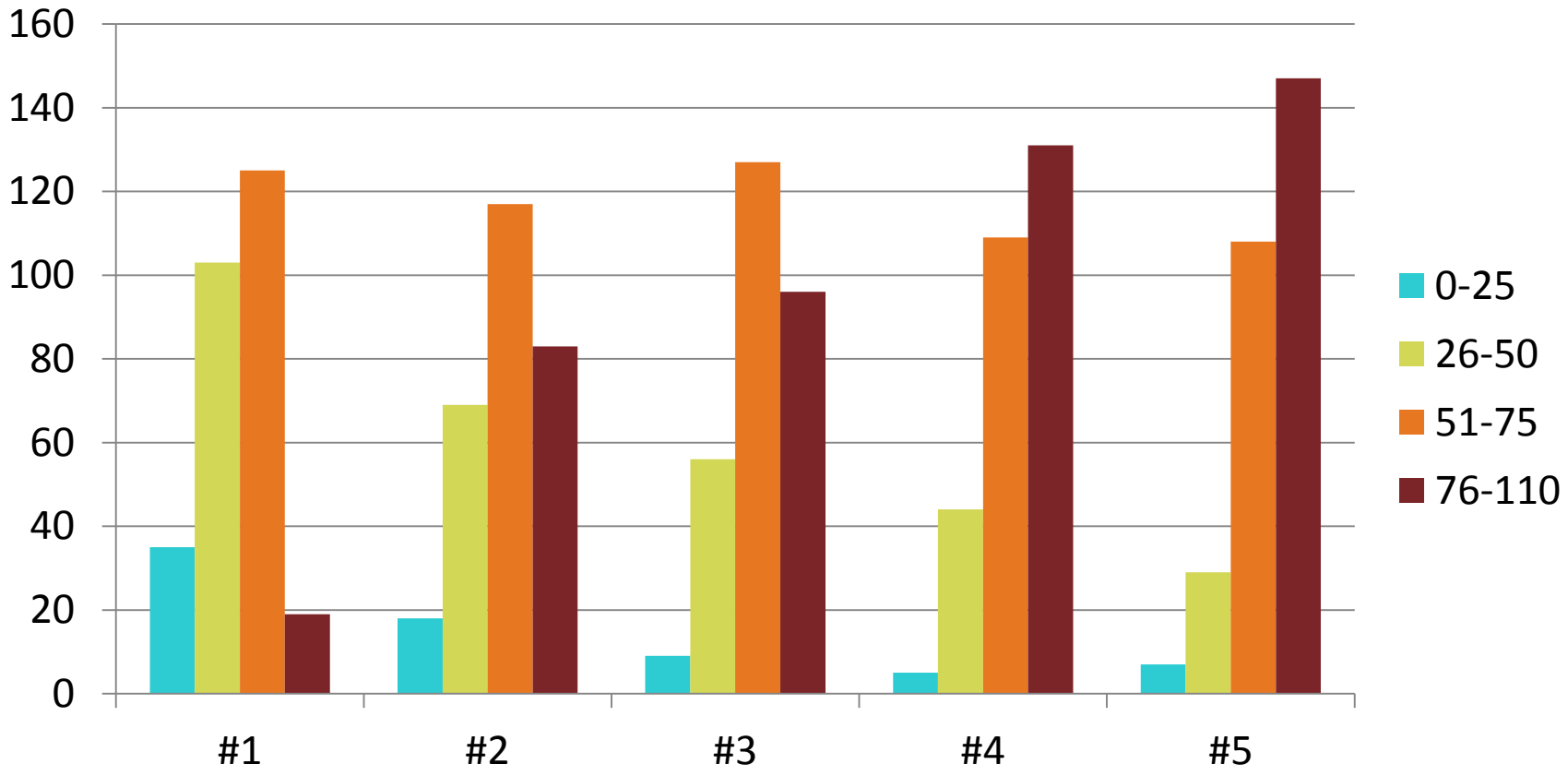
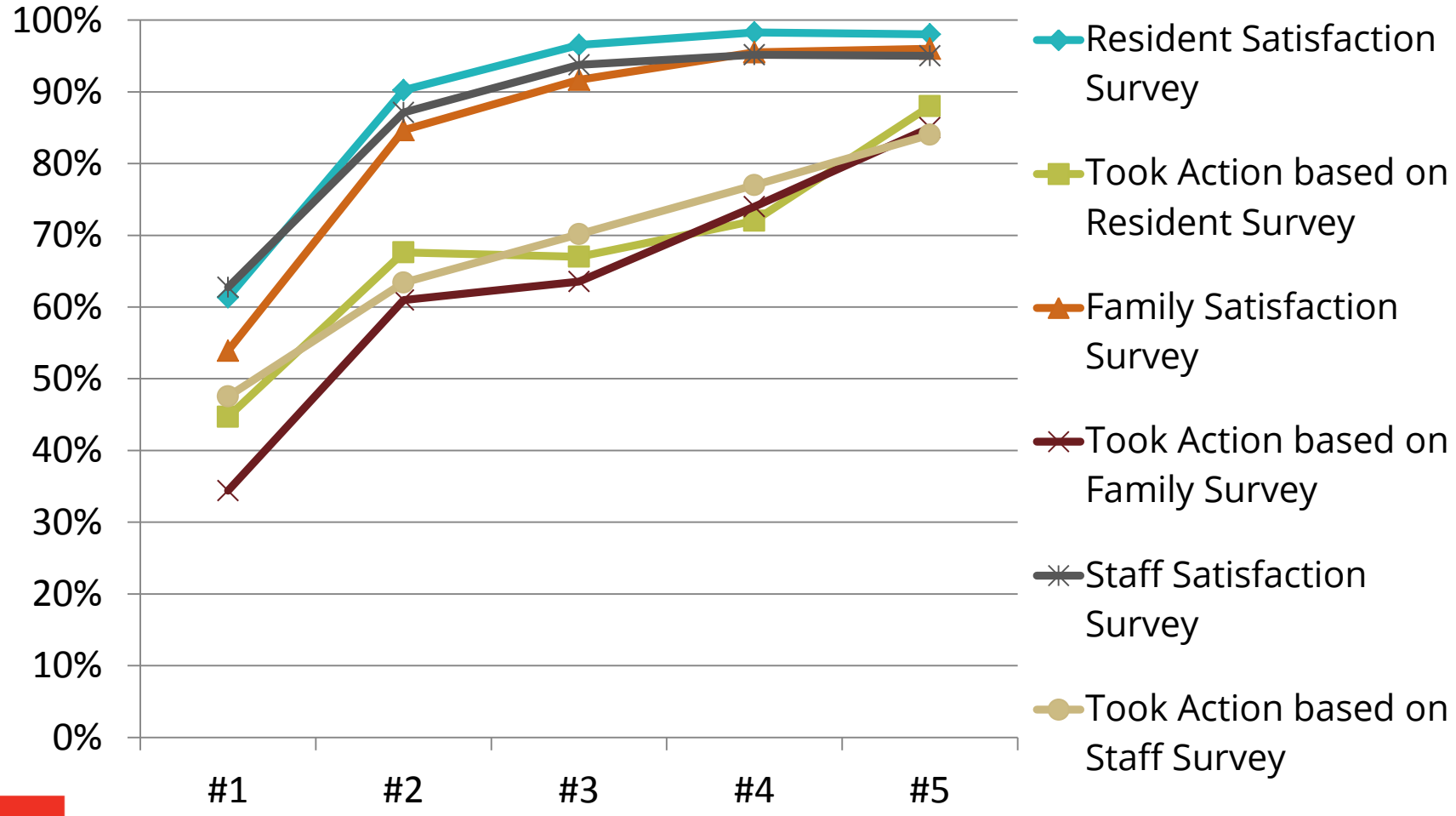
Total quality scores continue to improve
(average total scores for all submitting NFs)



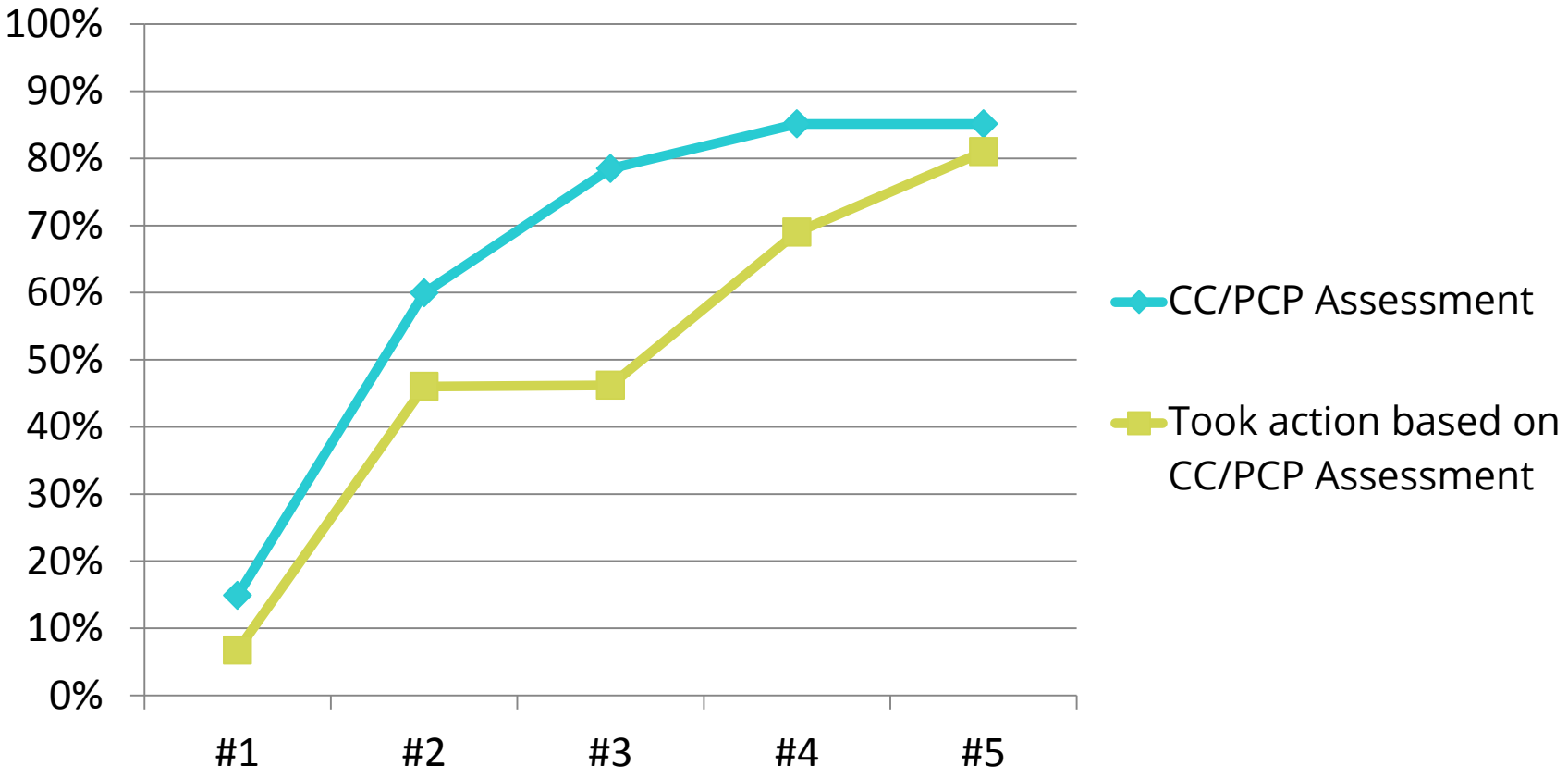
Number of NFs with higher quality scores continues to increase; number of NFs with lower quality scores declining



Significant improvement in conducting satisfaction surveys and taking actions to improve satisfaction

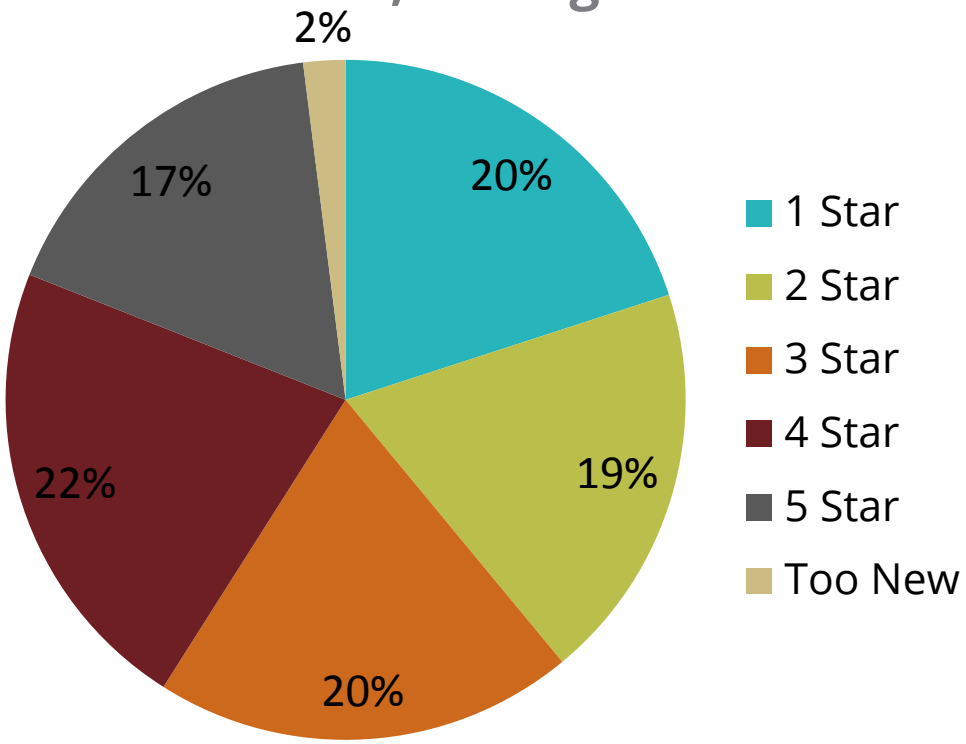


Facilities engaging in Culture Change/Person Centered Planning assessment and improvement

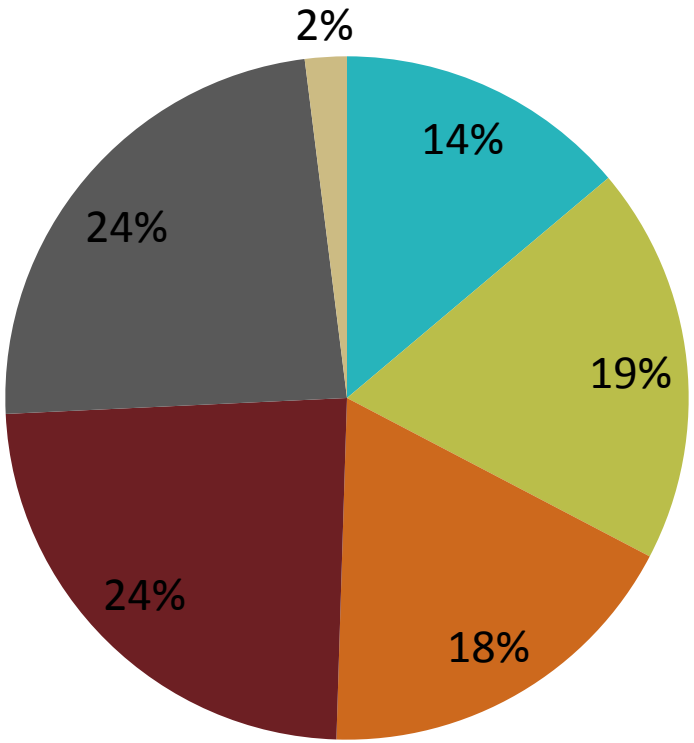


TN 5 Star rating is improving

October 2013, average=2.9



February 2015, average=3.2



Acuity- and Quality-based payment for NFs and HCBS

- Next Step for NFs:
  - Working with stakeholders to finalize measures and approach for implementation of full VBP model in 2016
  - Bridge data collection and payment processes will continue pending implementation of full model

Acuity- and Quality-based payment for NFs and HCBS

- Next Step for CHOICES HCBS:
  - Stakeholder processes continue and will be expanded
  - Focus on personal assistance and residential services
  - Utilize the QuILTSS framework, with adjustments as appropriate
  - Person-Centered Plan is key to driving the member experience
    - Goals and preferences
    - Employment and community integration
  - Leverage technology
    - Point-of-service satisfaction survey in EVV 10/1

Acuity- and Quality-based payment for NFs and HCBS

- Next Steps for HCBS for Individuals with I/DD:
  - New Behavioral Health Crisis Prevention, Intervention and Stabilization services to be implemented this year
    - Delivered under managed care program, in collaboration with I/DD agency
    - Focus on crisis prevention and in-home stabilization, sustained community living, reduced inpatient utilization
    - Performance measures (e.g., decrease in PRN use of anti-psychotics, decrease in crisis events, increase in in-place stabilization when crises occur, and decrease in inpatient psychiatric admissions and inpatient days) will be tracked and utilized to establish a VBP component (incentive or shared savings) for the reimbursement structure

Acuity- and Quality-based payment for NFs and HCBS

- Next Steps for HCBS for Individuals with I/DD:
  - Section 1915(c) waivers
    - Developing acuity-based reimbursement approach for residential and day services, using the Supports Intensity Scale
    - Plan to develop a “QuILTSS-like” quality component of reimbursement as well

Acuity- and Quality-based payment for NFs and HCBS

- Next Steps for HCBS for Individuals with I/DD:
  - Employment and Community First (ECF) CHOICES
    - MLTSS program to be implemented in 2016
    - Promotes integrated employment and community living as the first and preferred outcome for individuals with I/DD
    - Employment benefits designed in consultation with experts from the federal Office of Disability Employment Policy create a pathway to employment, even for people with severe disabilities, with outcome or value-based reimbursement approaches
      - Outcome-based reimbursement for certain employment services
      - Reimbursement approach for other services will take into account provider's performance on key outcomes, including number of persons employed in integrated settings and # of hours of employment (after a reasonable period for data collection and benchmarking)

TN

Value-Based Purchasing for Enhanced Respiratory Care (ERC)

- Enhanced per diem rates for nursing facility services for individuals requiring Chronic Ventilator Care, Frequent Tracheal Suctioning and Ventilator Weaning
- VBP initiative developed in response to significant increases in service utilization but without expected quality and outcomes
- Will implement a revised reimbursement approach for these services as an add-on to the new NF acuity-based per diem based on NF performance on clinical and technology measures
- Combine with strengthened standards of care and education to promote quality and best practices

Value-Based Purchasing for Enhanced Respiratory Care (ERC)

- Key Performance Indicators include:
  - Quality Measures
    - Ventilator wean rate
    - Average length of stay to wean
    - Infection rate
    - Unplanned hospitalizations
    - Decannulation rate
    - Unanticipated deaths
    - Denial rate

Value-Based Purchasing for Enhanced Respiratory Care (ERC)

- Key Performance Indicators include:
  - Technology Measures
    - Incentive spirometer or any PEP therapy
    - High frequency chest wall oscillation or IPV
    - Non-invasive open ventilation
    - Heated wire circuits
    - Alarm paging or beeping system
    - High flow molecular humidifcation
    - Cough assist
    - Non-invasive ventilation (volume)

Value-Based Purchasing for Enhanced Respiratory Care (ERC)

- Initial data collection tool/process implemented
- 4 months of quality data in hand across funding sources (not just Medicaid)
- Additional months of data being held by NFs
- Working with a vendor to develop new submission process for the collected data and feedback to NFs and MCOs
- At least 6 months of analyzed data will allow setting of specific benchmarks and development of payment approach
- Must be implemented along with new NF reimbursement methodology (as add-on to facility per diem)

Workforce Development

- Stakeholder input highlighted critical importance of training and competency of professionals delivering HCBS and NF services
- Develop a comprehensive workforce training program and credentialing registry for individuals paid to deliver LTSS for deployment through secondary, vo-tech, trade schools, community colleges, and 4-year institutions, offering college credit, stackable credentials
- Staff training will be an important quality measure and will also impact a provider's success across other measures
- Agencies employing better trained and qualified staff will be compensated for the higher quality of care experienced by individuals they serve