Health Care
Innovation Initiative

Provider Stakeholder Group
September 9, 2015

Agenda

Update on Primary Care Transformation TAG process

PCMH and Health Home Case Studies

Fact base on primary care in Tennessee

Fact base on behavioral health care in Tennessee

Wave 4 Episodes of Care TAG members

TAG agendas

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	• **TAG recommendation on requirements for practices and Health Homes** • Briefing on patient privacy in Tennessee • Briefing on comprehensive risk assessment approach • Discussion of quality metrics • Discussion of patient engagement
Session 5	• Oct 29	• Oct 27	• **TAG recommendation on quality metrics** • **TAG recommendation on patient engagement** • Briefing on attribution methodology • Briefing on payment streams and incentives • Discussion of exclusions for financial risk adjustment • Discussion of practice and Health Home training and supports • Discussion of provider report design
Session 6	• Nov 17	• Nov 19	• **TAG recommendation 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**

Next session to include patient privacy briefing

Health Home and PCMH play complementary roles

	PCMH	Health Home
Integrated care plan	• **Develops care plan for patients' medical needs**, with consideration for interaction with behavioral health (e.g., medications)	• **Develops care plan for patients' behavioral health needs,** with consideration to the interaction with medical needs
Patient relationship	• **Educates patient on physical health** self-care and treatment adherence, with understanding of behavioral health conditions • **Conducts follow-ups with Health Home after medical healthcare encounters** • **Provides Health Home with medical information** (e.g., recent encounters)	• **Educates patient on behavioral health** including self-care and adherence to treatment plan, with understanding of medical health needs • **Primary point of contact for patient communication** • **Conducts follow ups with patient** on behavioral health care • **Provides PCMH with behavioral health information**
Transitions of care	• **Accountable for focus on admissions and discharge** for medically related treatment • **Follows up with Health Home** following BH discharge and discusses implications for medical care	• **Accountable for focus on admissions and discharges** related to behavioral health treatment • **Follows up with PCMH** following medical care event and discuss implications for behavioral health care
Engage medical care providers	• Provides **primary care** • Accountable for **referral decision support and scheduling** for medical care in inpatient, outpatient, and emergency settings	• **Supports scheduling** with guidance from PCMH and works with patient to reduce barriers to attendance (e.g., access to transportation) • **Follows up with PCMH** to understand implications from ambulatory or acute encounters (e.g., treatment adherence)
Engage behavioral health providers	• **Supports scheduling** with guidance from Health Home and works with patient where appropriate to reduce barriers to attendance • **Follows up with Health Home** to understand implications for physical health from behavioral health encounters (e.g., medication management)	• Provides **ambulatory behavioral health care** • Accountable for **referral decision support and scheduling** for behavioral health care in IP, OP, and ED settings
Engage supportive services	• Engages with supportive services **as required to support medical care** (e.g., home health) • May address broader range of patient needs	• Communicates with **residential and supportive services** partners to address patient needs • Arranges **new supports as needed** (e.g., child care)

- Can be two **separate entities, or a single entity playing two distinct sets of roles in an integrated way**
- Both are **accountable for overall patient needs**

Health Home care delivery improvement model

	Stage 1: Providers in transition	Stage 2: Emerging model	Stage 3: Steady-state transformation
Focus for care delivery improve-ments	• **Identify and manage patients** with behavioral health needs, including: – **Enhance access and continuity** (e.g., office hours, after-office access) – **Provide self-care support and community resources** to support self-care process – **Refer patients to high value** behavioral health specialists • **Plan and manage care** by developing care plan for individuals' behavioral health needs in consultation with PCP and with input from patient and their family – **Support medication adherence** • **Track and coordinate care** • **Measure and improve performance**	Additional priorities to include: • **Improve patient engagement** for individuals **not currently seeking care** – **Conduct outreach** to find and engage high-need BH patients – **Arrange higher-touch supports** to address the whole person (e.g., supportive housing, supportive employment) • **Joint decision-making** with PCPs and other specialists (e.g., medication reconciliation) • **Participate actively** in the development of the patient's **medical care plan**	Additional priorities to include: • **Enable multidisciplinary collaboration** across providers (e.g., Health Home, PCMH, specialists) through regular meetings – **Share up-to-date patient medical records** across providers with behavioral and physical health information – **Continue to improve care transitions** through partnerships and information sharing • **Co-location of behavioral and physical healthcare** where feasible • **Single entity PCMH and Health Home** where possible

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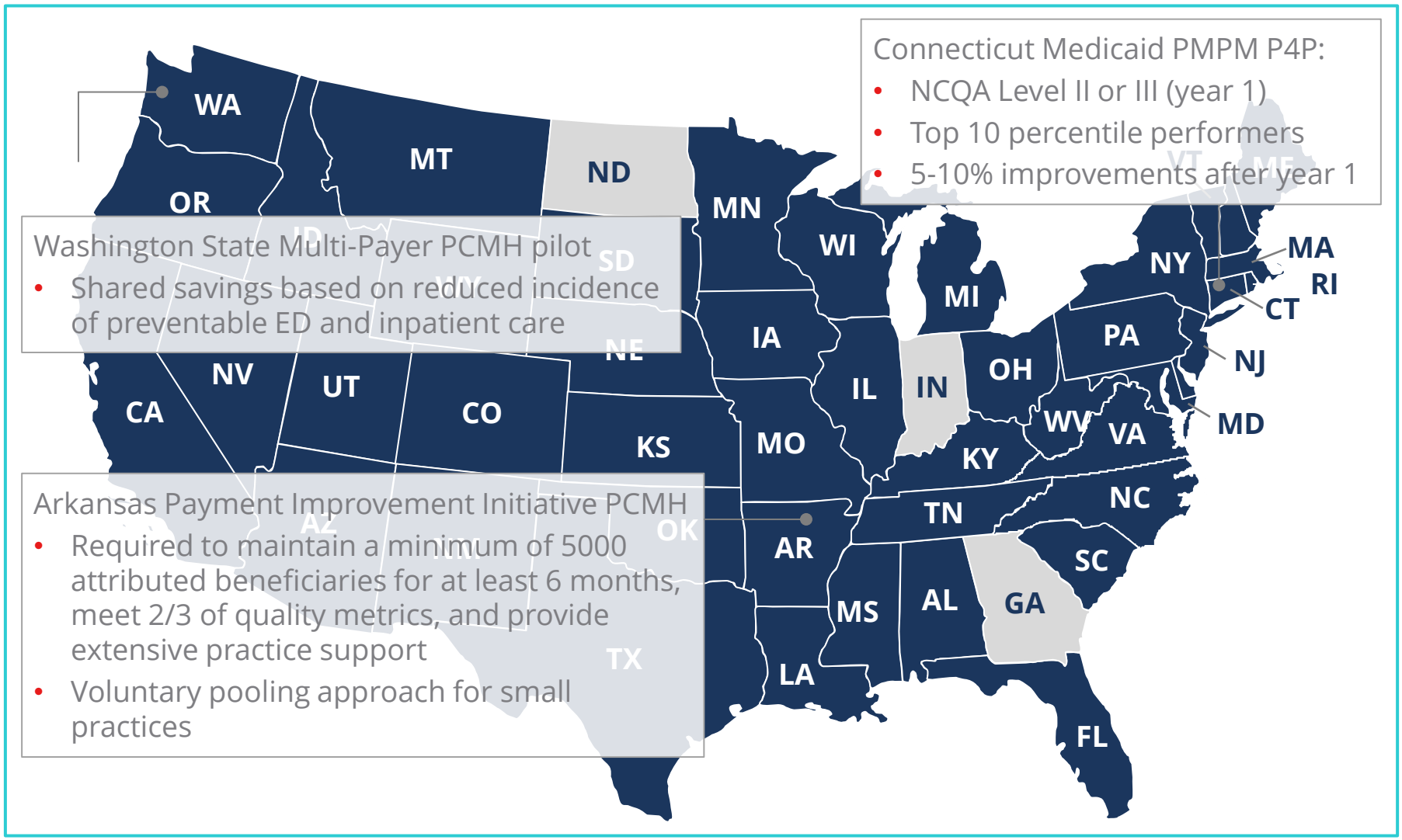
Wave 4 Episodes of Care TAG members

States with PCMH activity since 2006



Hawaii has a full PCMH pilot underway and Alaska has medical home activity but no payments to medical homes
1 Definition includes Medicaid / CHIP participation and evidence of comment (e.g., workgroups, legislation)

SOURCE: Centers for Medicare & Medicaid Services, National Academy for State Health Policy

State PCMH case study: Pennsylvania Chronic Care Initiative

Background and approach	**First large-scale multi-payer medical home initiative** in US, Implemented in two phases
	• **Phase I (2008-2011)** covered 171 practices across 4 regions
	  • All rollouts occurred within 18 months
	  • First region was Southeast PA with 32 practices
	• **Phase II (2012 onward)** included 54 practices from original rollout
	  • Added Medicare to the payer mix through MAPCP
	  • MAPCP ended in December 2014

Target patients and scope	• Initial focus prioritized **adult diabetics and child asthmatics** • Program has grown to prioritize **additional chronic diseases**
Requirements for PCMH	• Must be **NCQA certified** within 18 months of enrollment • Phase II included **additional homegrown standards** • Must sign a participation agreement and **commit to a minimum three year participation**
Key message from primary stakeholders	• Process was **designed to be iterative**, with each region and phase learning from the previous one • Goals originally oriented on **process, not cost reduction;** progressed to emphasize cost, quality

PA saw major improvements on cost and quality measures between two studied models

Quality results

- **Southeast:** statistically significant improvement in 1 of 11 investigated quality measures: 11% increase nephropathy screening in diabetes
- **Northeast:** Statistically significant superior performance on 4 process measures of diabetes and breast CA screening

Utilization and cost of care

- Southeast: No significant change in utilization or costs of care despite average bonuses
- Northeast: Reduced costs driven by significantly lower all-cause hospitalizations and ED visits; higher rates of ambulatory visits

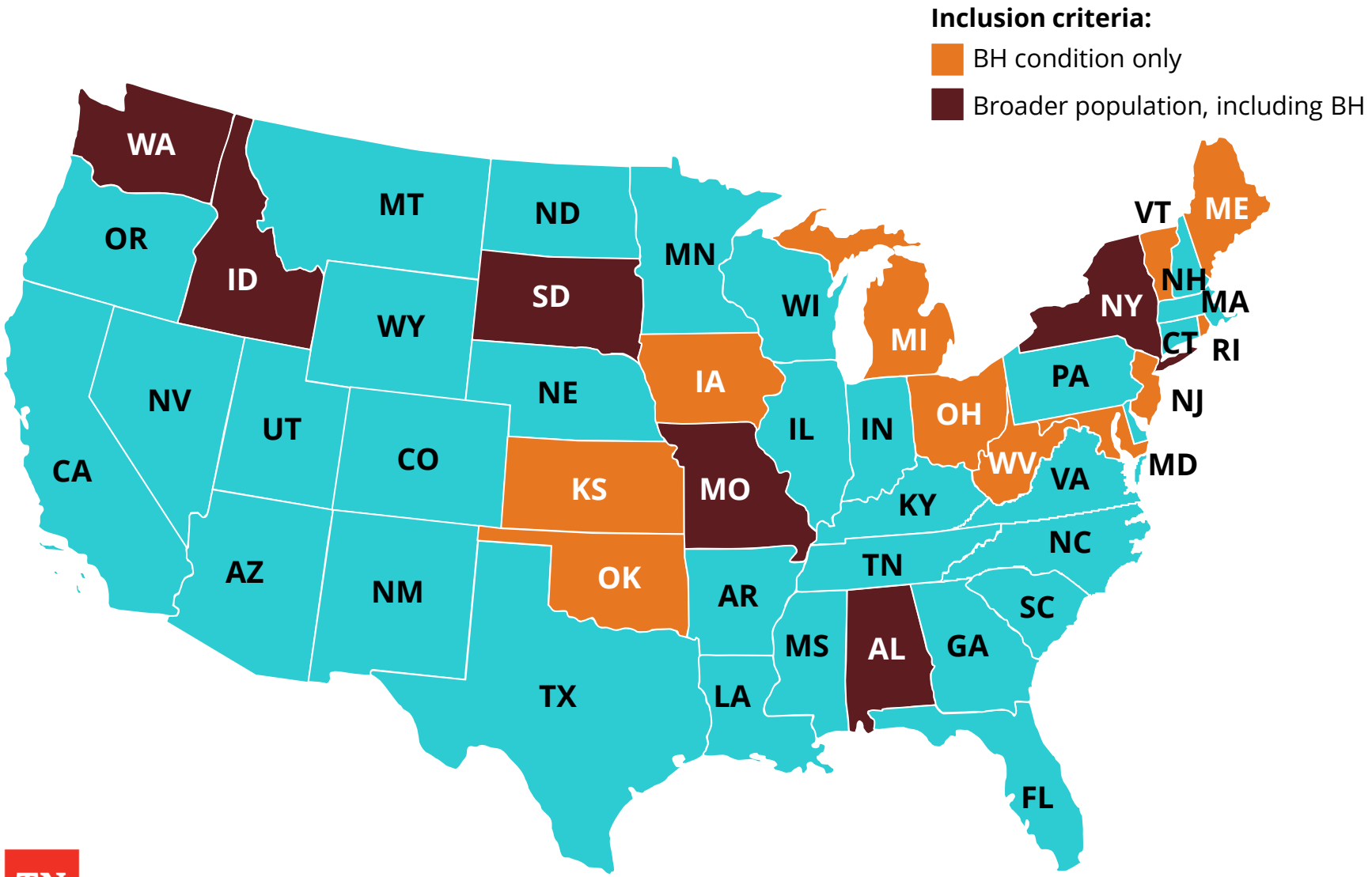
Potential rationale for results

- Impact of shared savings model in NE with emphasis on highest risk patients
- SE over-emphasized process (e.g., early NCQA eligibility) over performance
- All practices had EHR in NE; not in SE

1 Eligible chronic conditions include diabetes, asthma/COPD, cardiovascular disease, DD, overweight (BM >25), tobacco use

SOURCE: National Academy for State Health Policy; Pennsylvania Health Care Quality Alliance, Pennsylvania Academy of Family Physicians, The Journal of the American Medical Association (Freidberg et al., February 2014; 311(8):815-825), The Journal of the American Medical Association Internal Medicine (Freidberg et al., August 2015; 175(8):1362-8)

17 states have implemented a CMS-approved Medicaid Health Home for patients with behavioral health conditions



SOURCE: Centers for Medicare & Medicaid Services, Approved Medicaid Health Home State Plan Amendments, as of June 2015

Missouri's Health Home model

Target patients and scope	• Purposefully designed the Health Home to focus on a **broad range of patients** who have behavioral health and/or physical chronic conditions
	• Patients are eligible if they have:
	  ▫ A **serious mental illness**[1] (including children and adults receiving psychiatric rehabilitation services under the Medicaid Rehabilitation Option), or
	  ▫ A **mental health condition** or a **substance abuse disorder**, and a **chronic condition**[2]

Requirements for Health Home	• Encouraged Health Home development in **both primary care and behavioral health settings**, but analyzed a common set of health and cost outcomes • Health Home must have a **health team** comprising of a HH director, primary care consultant, nurse care manager, and admin support • **Flexibility in HH activities** (e.g., some HH provide primary care services, some only do care coordination), but enforced minimum requirements
Practice support	• In-kind assistance provided to enable practice transformation including **expert consultations, technical assistance, and training**

Missouri's program reduced net Medicaid spend by $38M in first year[3]

- **Effective rollout** (as of June 2013)
  - 28 CMHCs enrolled as Health Home
  - Over 18,000 total patients enrolled
- **Clinical outcomes[4]**
  - Proportion of diabetics with LDL and A1c increased by 114% and 190% respectively
  - Proportion of HTN patients with BP under control increased 129%
  - No material improvement proportion of asthma patients receiving corticosteroid, and proportion of members reporting tobacco use slightly increased
- **Decreased utilization**
  - 13% reduction in hospital admissions and 8% reduction in ER usage

1 SPMI defined as schizophrenia, bipolar, major depressive, delusional, panic disorder, psychotic disorder NOS, generalized anxiety disorder, agoraphobia, social phobia, obsessive-compulsive, borderline personality, PTSD, reactive attachment disorder of infancy or early childhood
2 Eligible chronic conditions include diabetes, asthma/COPD, cardiovascular disease, DD, overweight (BM >25), tobacco use
3 Total cost savings to Medicaid includes cost savings for duals; unclear how much spend shifted to Medicare
4 Clinical outcomes compare Jun 13 to Feb 12 for HH population; utilization outcomes compare pre-HH and post-HH 1-year periods

SOURCE: MO SMHC Healthcare Home State Plan Amendment, Nov 2013 Progress Report, MO Dept. of Mental Health

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Iowa's Health Home model

Target patients and scope	• Patients are eligible if they meet any of the following criteria:
	  ▫ Diagnosed with **SMI**[1] or **SED**
	  ▫ Referred based on **functional assessment** conducted by the Health Home

Requirements for Health Home	• **Flexibility in Health Home entities**, including BH centers, health centers, and case management entities • HHs must show **evidence of integration with primary care** within the first 6 months (e.g., contract or written agreement with a PCP must be approved by the state) • Health Homes were required to maintain minimum staffing ratios for their **care coordination teams**, which included nurse care manager, care coordinator, peer support (for adult), and family support (for children) • Some Health Homes were designated **specifically for children** (less prevalent in rural communities)
Scale-up approach	• **3-phase roll out** of the program over a two year period based on county • **Managed by statewide MCO** that also has an at risk Medicaid BH carve out contract

Early studies indicate Iowa's HH program reduces healthcare utilization

- **Effective rollout** (as of Jan 2015)
  - 40 providers enrolled as Health Home
  - Over 21,000 total patients enrolled
- **Decreased utilization**[2]
  - 18% reduction in mental health admissions and 16% reduction in ER usage
- **Reduction in claims**
  - 12% reduction in medical claims and 16% of mental health claims

1 SMI defined as Psychotic Disorders, Schizophrenia, Schizoaffective, Major Depression, Bipolar, Delusional Disorder, Obsessive-Compulsive

2 Claims and utilization results refer to pre-HH and post-HH comparison for ~3,500 members sampled; information shared with the community as an early indication report

SOURCE: Iowa State Plan Amendment, Magellan of Iowa Report to Community Jan 2015

Ohio's Health Home model

Target patients and scope	• Patients are eligible if they have a **serious and persistent mental illness**[1] or **SED** • SMI patients who are **currently being served** at a community behavioral health center (CBHC) will be **auto-enrolled**, with an **opt-out option** • **Patients can also be referred** to CBHC Health Home for assessment of need by other healthcare providers (ED, specialists)
Requirements for Health Home	• **CBHCs** can be Health Home providers in Ohio • All Health Home must have an **embedded primary care clinician**, who doesn't necessarily have to provide direct care to beneficiaries (care coordination only) • **Medical screening / treatment must be provided** onsite or through a written agreement with a PCP • Health Home must be able to **receive electronic utilization data upon registration**, and demonstrate usage of **EHR within 12 months**

Ohio's Health Home showed mixed clinical outcomes and increased cost

- **Clinical outcomes mixed**
  - 7 of 17 measures[2] were below national 2013 HEDIS Medicaid 10th percentile
  - Some measures (3 of 17) met or exceeded HEDIS 75th percentile
- **Increased healthcare cost**[3]
  - Total cost per patient increased by $516 PMPM, driven by Health Home case rate and increased pharmacy cost
- **Behavioral health redesign**
  - Proposed plan will focus HCBS resources toward subset of SPMI patients with highest needs
  - Health Home services will be disaggregated, defined, and reimbursed with intent to give providers more flexibility

1 SPMI defined in Ohio Administrative Code as DSM-IV-TR diagnoses excluding DD, substance use, dementia, diagnosis associated with unknown physical condition, amnesic, or delirium sleep. Also requires some "treatment history" requirements (e.g., utilization over the past year, continuous treatment for 12 months, functional assessment score)

2 Measures below 10th percentile included cholesterol management for patients with CV conditions, HbA1c levels, postpartum care, counseling for nutrition, counseling for physical activity, adolescent well-care visits, and appropriate treatment for children with upper respiratory infections

3 Cost increase calculated by comparing costs for patients enrolled in a Health Home (8,335 patients) in FY2013 vs. baseline 1-year period of Jul 2011 to Jun 2012; found to be statistically significant at the 95% confidence interval or greater

SOURCE: OH State Plan Amendment, Health Home Performance Measures Comprehensive Evaluation Report (Apr 2015), Ohio Health and Human Services Cabinet Behavioral Health Redesign-1915i project plan

TN

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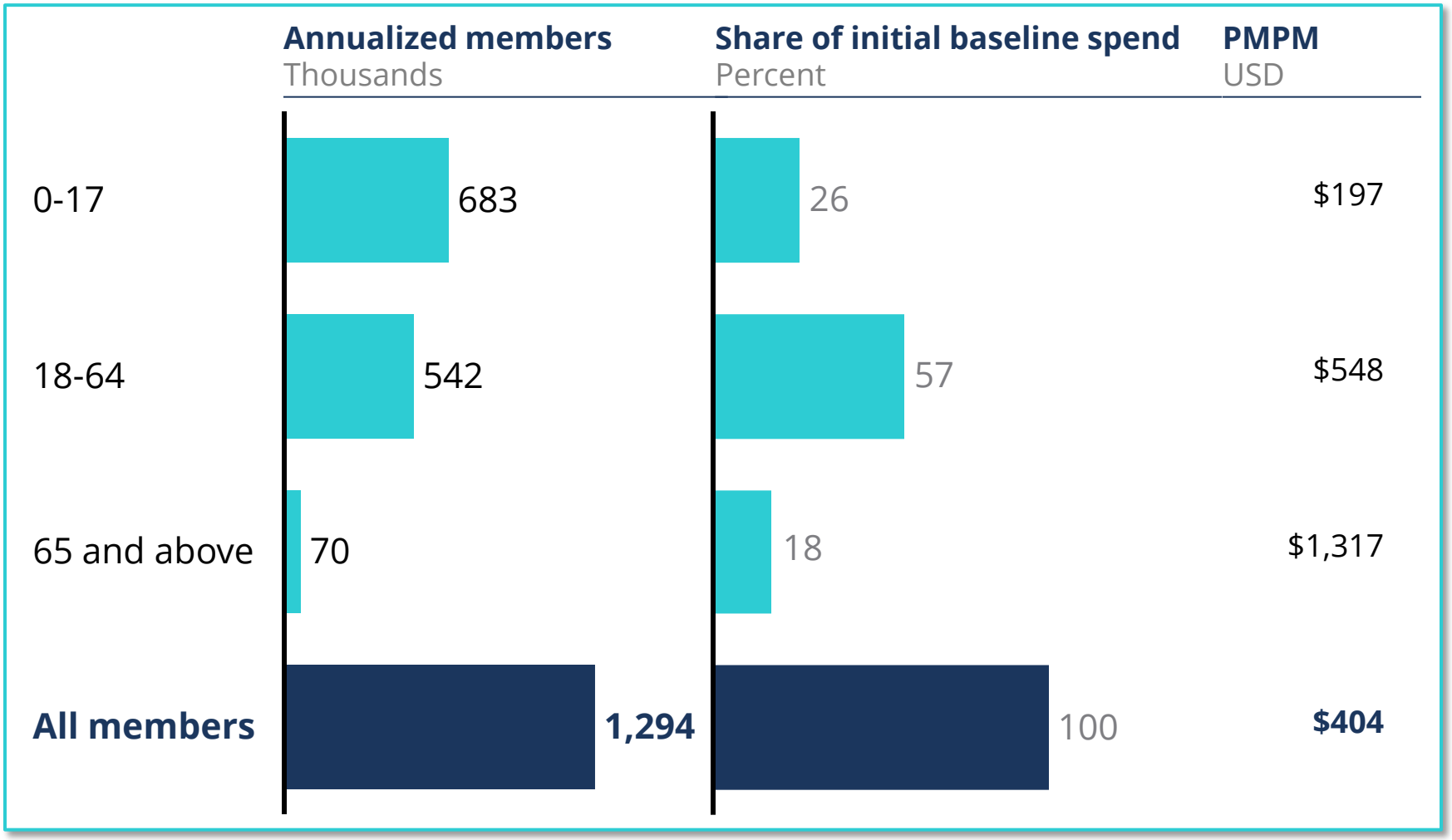
Wave 4 Episodes of Care TAG members

Breakdown of membership and spend by age

CY2014

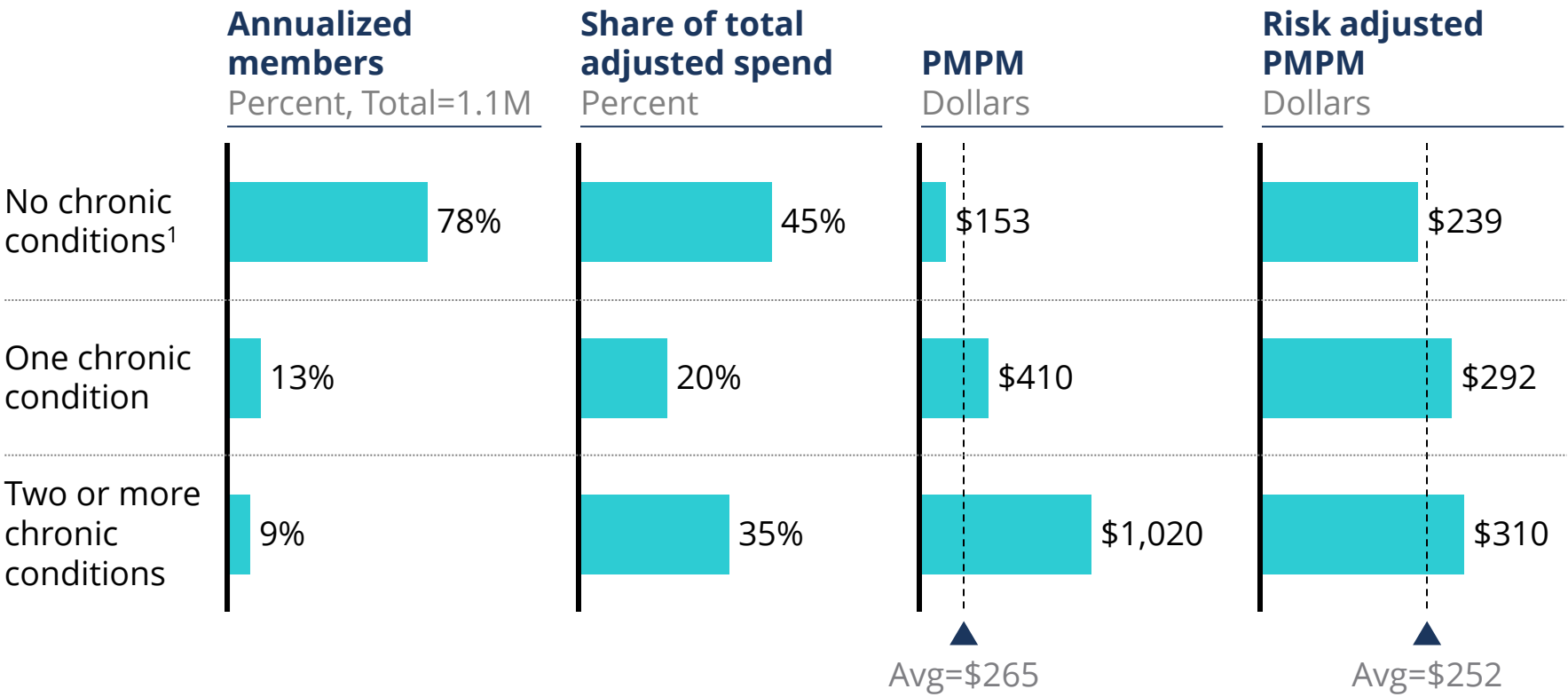


Note: Does not include crossover and dental claims, supplemental payments, intellectual disability services, Medicare services, CoverKids, and payments to DCS.

SOURCE: TN 2011-2014 claims data, TN HCFA budget FY15

Patients with common chronic conditions account for 22% of total adjusted members and 55% of adjusted spend

Distribution of members and spend by chronic disease segments[2]



1 Spend for individuals with no identified chronic conditions driven by individuals 0-1 years old, pregnant women, and individuals with an acute disease or behavioral health condition

2 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

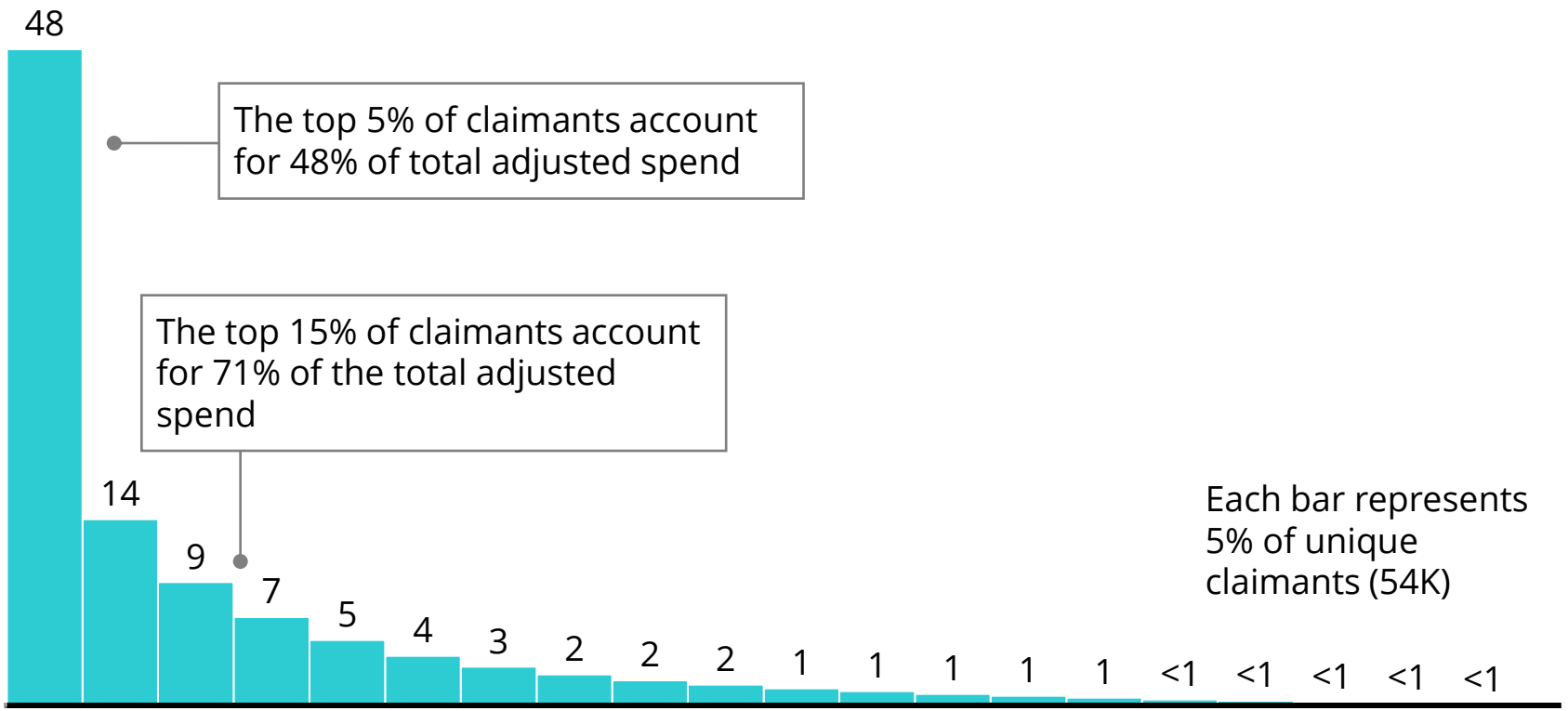
Note: Does not include crossover and dental claims, supplemental payments, intellectual disability services, Medicare services, CoverKids, payments to DCS, DME, vision, transportation, nursing home, long-term care and home health, as well as members who are dual eligible or have third party liability.

SOURCE: TN 2011-2014 claims data

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

Distribution of claimants[1] by spend rank

Percent of adjusted spend, CY2014



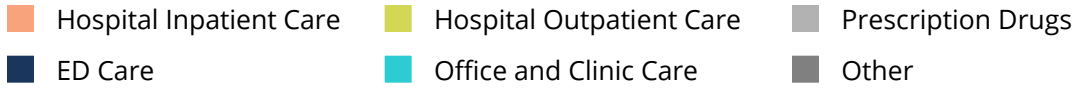
1 Distribution of unique claimants shown, excluding members without claims.

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.

SOURCE: TN 2011-2014 claims data

The top 5% most expensive claimants account for 75% of hospital inpatient care

ADJUSTED TOTAL



Distribution of adjusted spend, CY2014

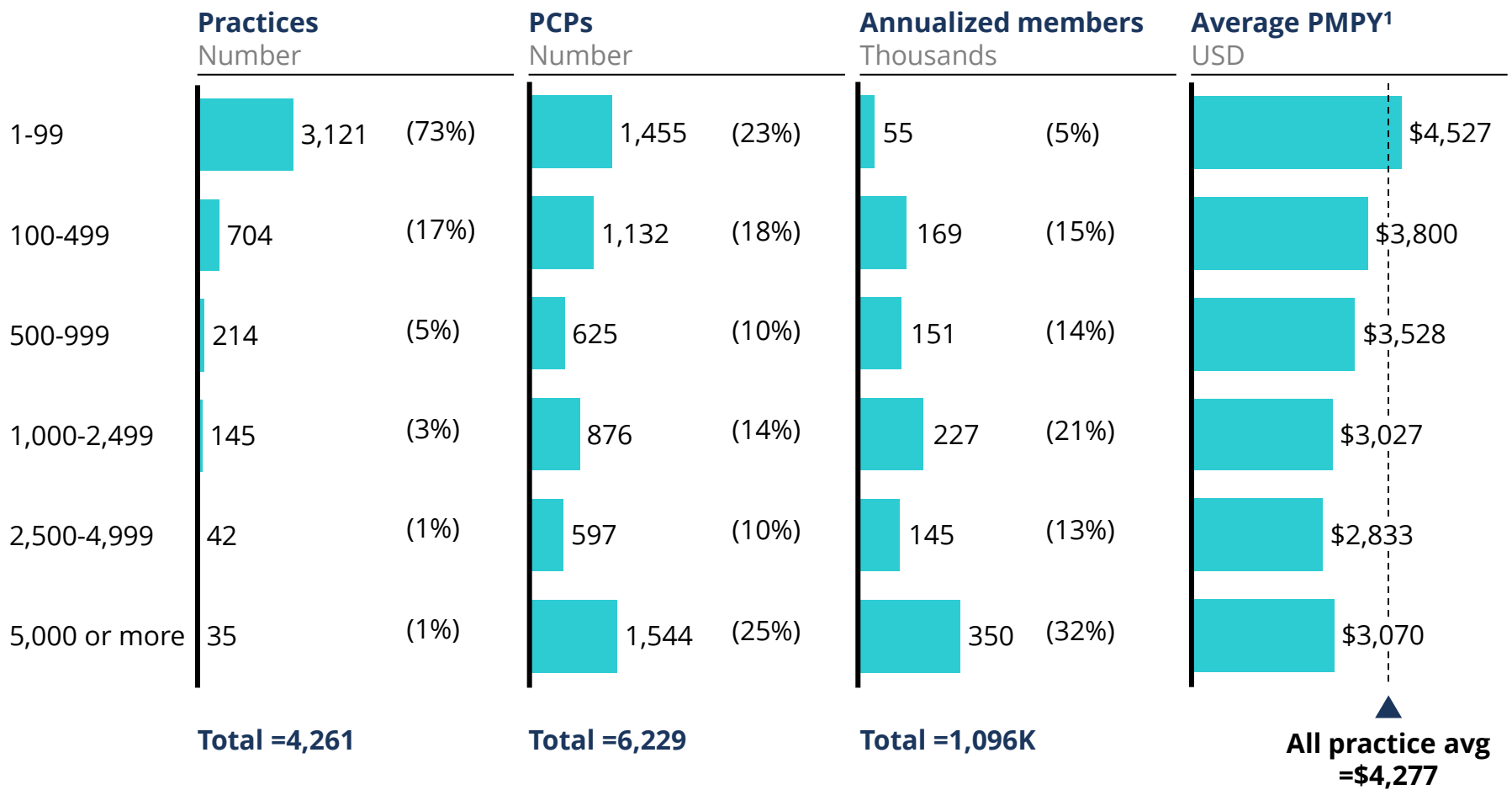
Unique claimants by spend[1]	% of adj. spend	Breakdown of adjusted spend	PMPM Dollars	Risk-adj PMPM Dollars
Top 1%	25%	55.5 / 3.1 / 8.4 / 5.4 / 22.1 / 5.5	7,819	2,471
2-5%	23%	33.5 / 8.9 / 13.2 / 8.9 / 26.7 / 8.8	1,726	764
6-15%	23%	24.9 / 12.3 / 14.1 / 13.8 / 22.8 / 12.1	662	456
16-25%	11%	9.1 / 17.5 / 13.6 / 21.6 / 25.5 / 12.7	328	380
26-100%	18%	2.5 / 22.9 / 6.5 / 37.5 / 21.3 / 9.3	70	190
All members	100%	28.8 / 11.7 / 11.1 / 15.6 / 23.6 / 9.3	265	252

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.
SOURCE: TN 2011-2014 claims data

One third of members are attributed to practices with panel larger than 5K across TennCare

ADJUSTED TOTAL

Practice distribution by total TennCare panel size, CY2014



1 Calculated as average of mean PMPY for each practice. Each practice with same weight, without adjustment for panel size variance.

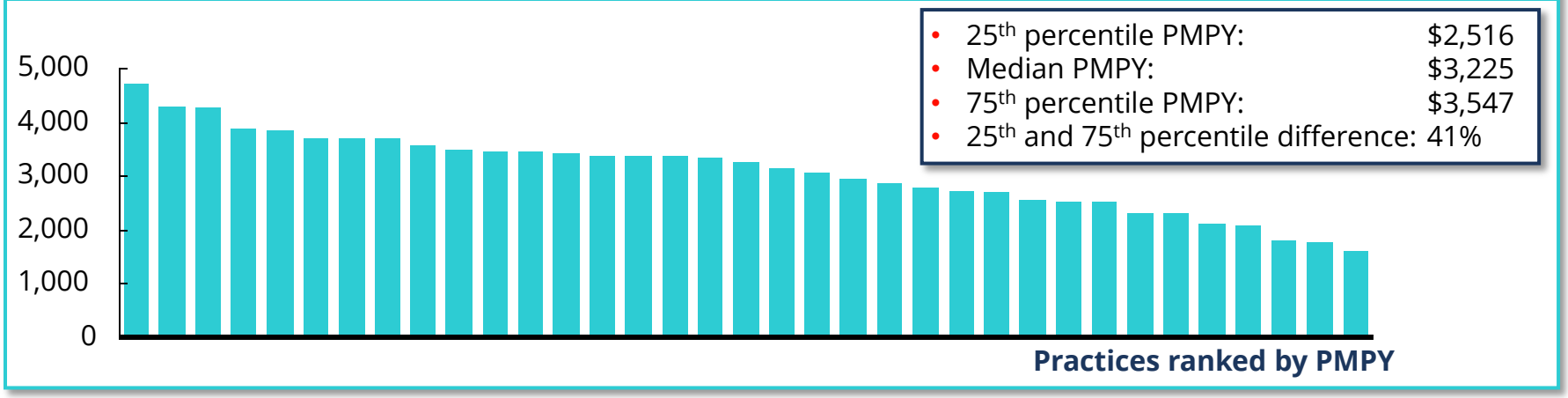
Note: Does not include crossover and dental claims, supplemental payments, intellectual disability services, Medicare services, CoverKids, payments to DCS, DME, vision, transportation, nursing home, long-term care and home health, as well as members who are dual eligible or have third party liability. Attribution is conducted through a two-step process. Members are assigned to individual physicians based on PCP assignment data provided by the payers. Physicians are then assigned to the practices (billing providers) on the basis of claims history (volume and preponderance of E&M claims).

SOURCE: TN 2011-2014 claims data

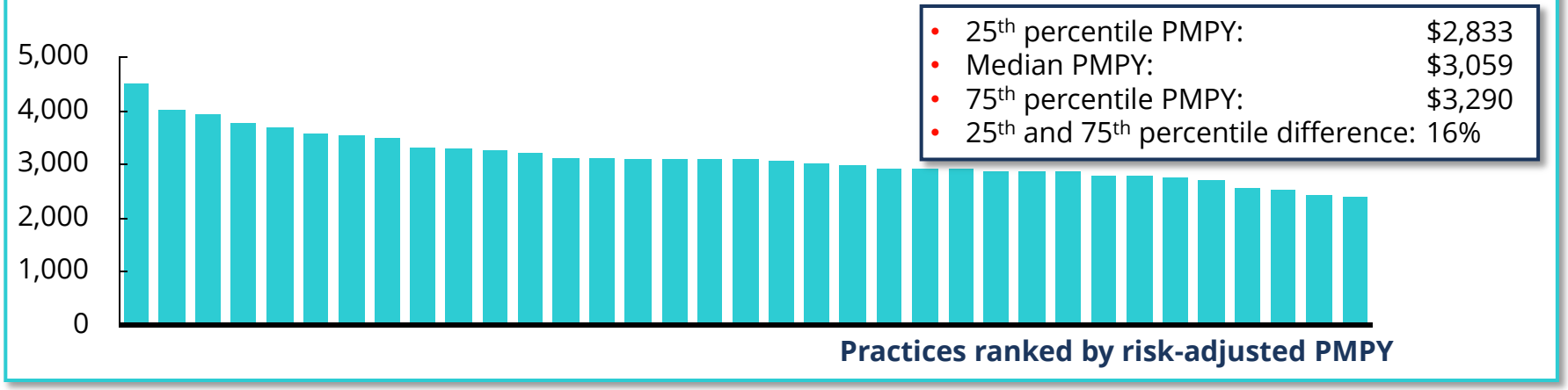
Practices in the 75th percentile cost 16% more PMPY than those in the 25th percentile, even adjusting for risk (Panel > 5k)

ADJUSTED TOTAL

Average PMPY by practice, CY2014, USD, 35 practices with 5,000 or more members attributed



Average risk-adjusted PMPY by practice, CY2014, USD, 35 practices with 5,000 or more members attributed



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. Attribution is conducted through a two-step process. Members are assigned to individual physicians based on PCP assignment data provided by the payers. Physicians are then assigned to the practices (billing providers) on the basis of claims history (volume and preponderance of E&M claims).

SOURCE: TN 2011-2014 claims data

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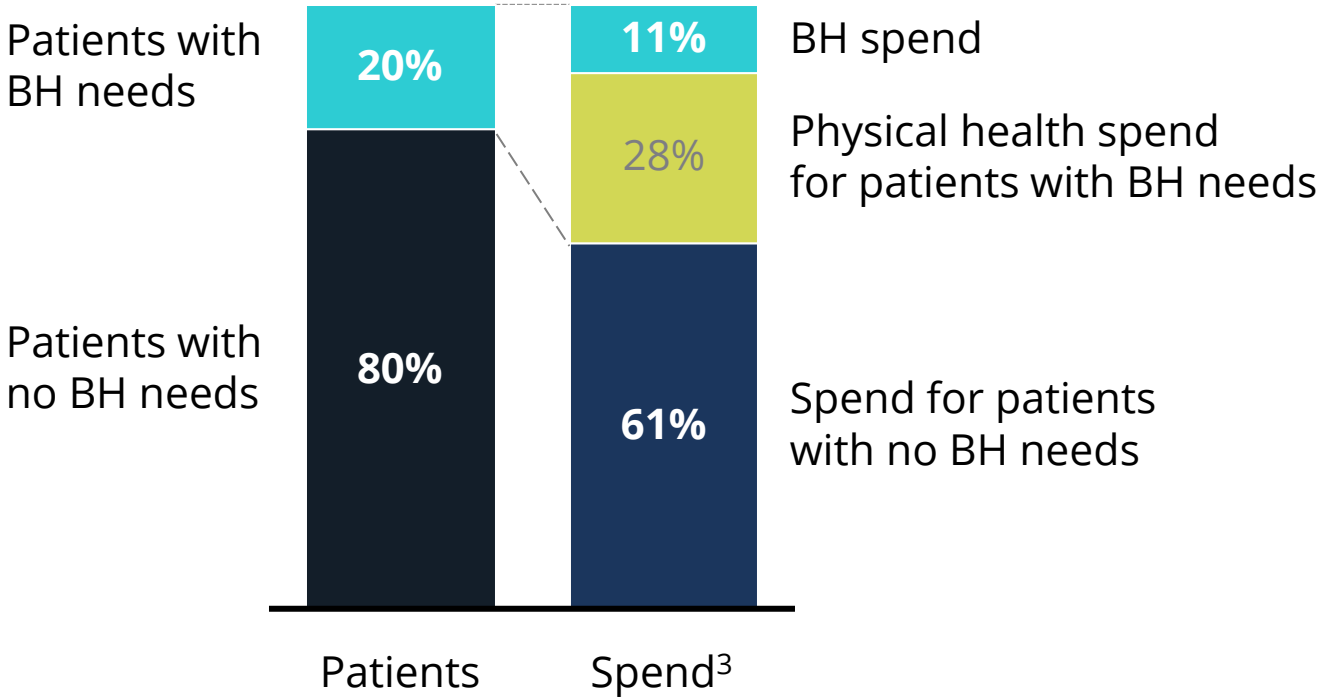
Individuals with behavioral health needs make up only 20% of the TennCare population, but 39% of the total spend

2014 Medicaid patients and spend[1,2]

Annualized patients, share of dollars



1 Annualized members (not unique members) shown here with no exclusions made on population or spend. Only 86% of Annualized members were claimants

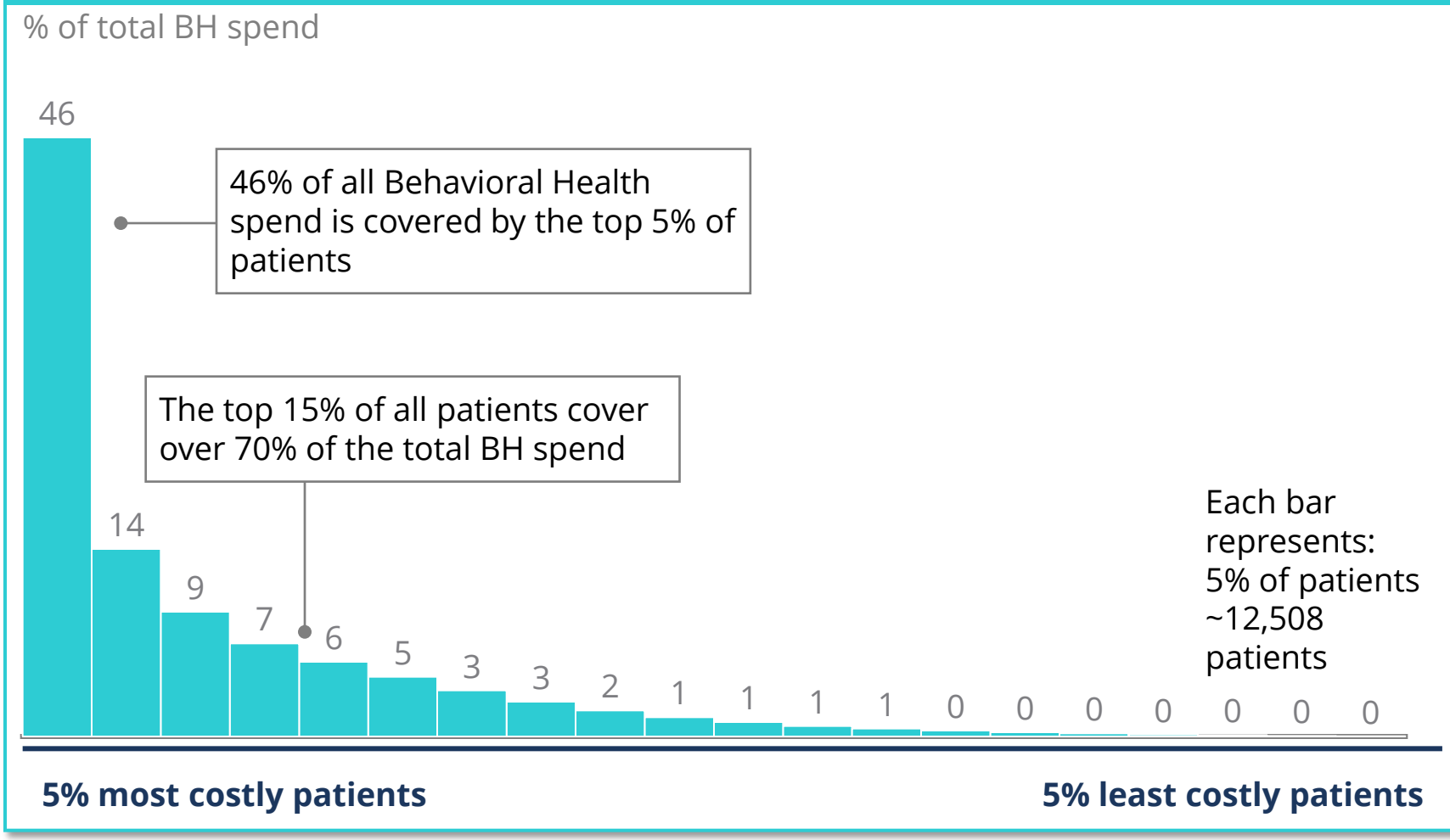
2 Most inclusive definition of patients with BH needs used here of members who are diagnosed and receiving care, diagnosed but not receiving care, and receiving care but undiagnosed. Behavioral health spend defined as all spend with a BH primary diagnosis or BH-specific procedure, revenue, or HIC3 pharmacy code.

3 Excludes claims billed through the Department of Children's Services

SOURCE: CY14 TennCare claims data

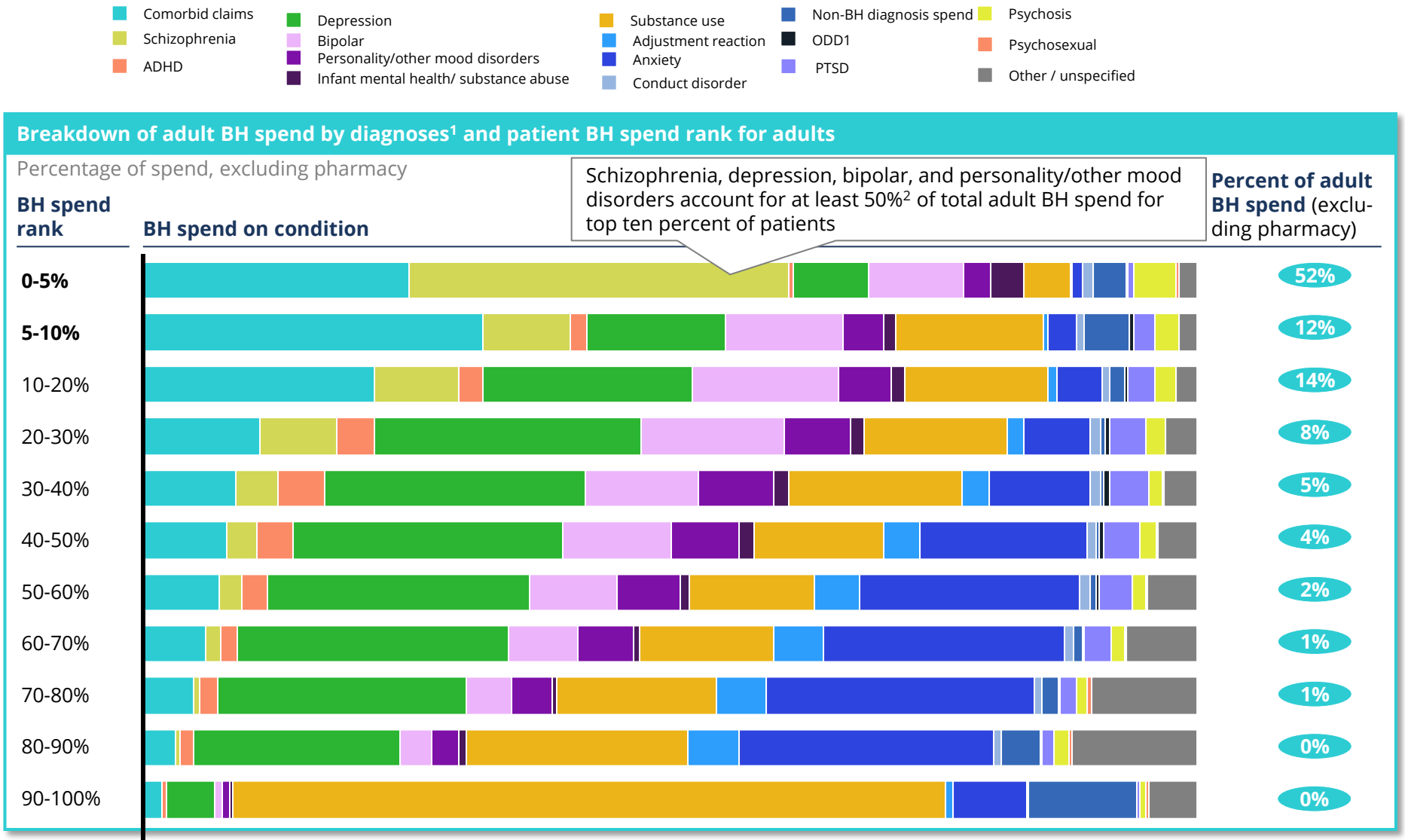
The top 5% of patients with BH needs by behavioral health cost account for nearly 50% of all behavioral health spend

Distribution of patients with BH needs by Behavioral Health spend rank



SOURCE: CY14 TennCare claims data

Schizophrenia, depression, and bipolar make up a significant portion of BH spend of the highest cost adults

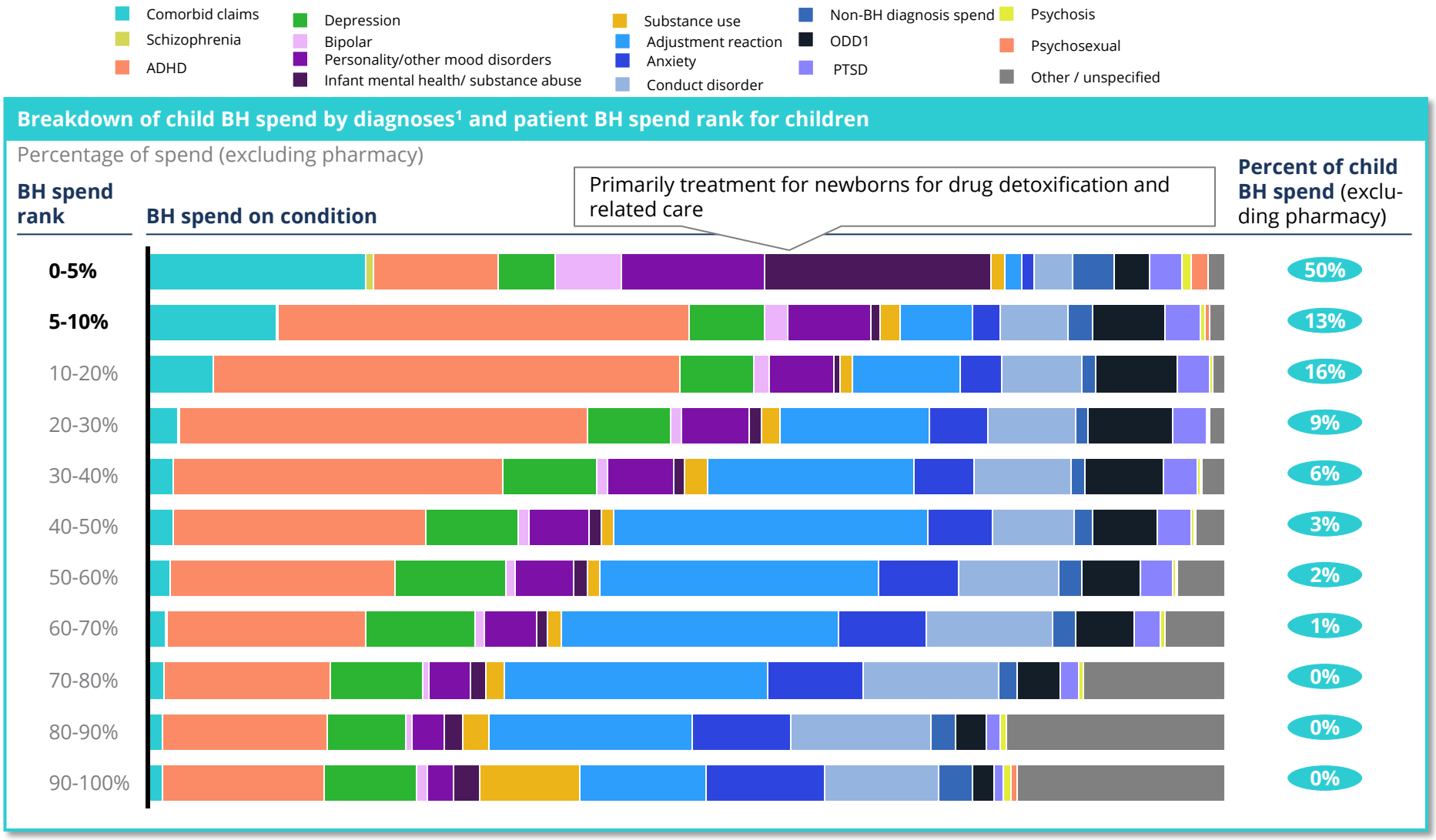


1 Claims identified as behavioral health spend are classified into diagnoses based on the first BH diagnosis to appear on them. Claims with 3 or more BH diagnoses are classified as co-morbid claims

2 Does not take into account the co-morbid claims that could be due to these conditions

SOURCE: CY14 TennCare claims data; pharmacy claims excluded

High-cost children have different prevalent diagnoses than high-cost adults, such as ADHD and infant mental health / substance use



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SOURCE: CY14 TennCare claims data; pharmacy claims excluded

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Attention Deficit Hyperactivity Disorder (ADHD) & Opposition Defiance Disorder (ODD)

	TAG 1	TAG 2	TAG 3
Attention Deficit Hyperactivity Disorder (ADHD) & Opposition Defiance Disorder (ODD)	September 16th 9AM-12PM (CT) Wednesday	October 7th 9AM-12PM (CT) Wednesday	October 28th 9AM-12PM (CT) Wednesday

Name	Affiliation
Valerie Arnold, MD	CNS Healthcare
Alison Asaro, MD	Mid-Cumberland Regional Health Office
Kathy A. Benedetto, SPE	Frontier Health
Howard Burley, MD	Department of Mental Health & Substance Abuse Services
Debbie Christiansen, MD	East Tennessee Children's Hospital
Daniel H. Donovan, MD	Associates in Neurology
Vanya Hamrin, DNP	Vanderbilt University Medical Center
Todd Hickman, LCSW	Health Connect America
James E. Keffer, MD	Old Harding Pediatrics
C. Allen Musil, MD	Frontier Health
David Patzer, MD	Mental Health Cooperative
Todd Peters, MD	Vanderbilt University Medical Center
Karen Rhea, MD	Centerstone
David Wood, MD	Department of Pediatrics/ETSU College of Medicine
Charles R. Freed, MD	UnitedHealthcare
Deborah Gatlin, MD	BlueCare of Tennessee
Jeanne James, MD	BlueCare of Tennessee
Mark Mahler, MD	Amerigroup
Renee McLaughlin, MD	Cigna
Julie Riedel, APN	Amerigroup

Bariatric Surgery

	TAG 1	TAG 2
Bariatric Surgery	September 30th 9AM-12PM (CT) Wednesday	October 21st 9AM-12PM (CT) Wednesday

Name	Affiliation
Stephen G. Boyce, MD	New Life Center for Bariatric Surgery
Ronald Clements, MD	Vanderbilt University Medical Center
Mark A. Colquitt, MD	Foothills Weight Loss
Kimberly A. Howerton, MD	Patient Centered Physician's Care, P.C.
Jennifer Jayaram, RN	Vanderbilt Center for Surgical Weight Loss
George B. Lynch, MD	Center for Surgical and Medical Weight Loss
Gregory Mancini, MD	University Surgeons Associates
Linda Pennington, MS	Dietitian Associates, Inc.
Pamela Rhea Davis, RN	TriStar Centennial Medical Center
Christopher Sanborn, MD	Erlanger Health System
Joel Bradley, MD	UnitedHealthcare
Jeanne James, MD	BlueCare of Tennessee
Mark Mahler, MD	Amerigroup
Renee McLaughlin, MD	Cigna
Julie Riedel, APN	Amerigroup

Coronary Artery Bypass Graft (CABG) & Valve Repair and Replacement

	TAG 1	TAG 2	TAG 3
Coronary Artery Bypass Graft (CABG) & Valve Repair and Replacement	September 23rd 9AM-12PM (CT) Wednesday	October 14th 9AM-12PM (CT) Wednesday	November 4th 9AM-12PM (CT) Wednesday

Name	Affiliation
Robert Headrick, MD	Alliance of Cardio-Thoracic and Vascular Surgeons
Clay Kaiser, MD	Vanderbilt University Medical Center
Joseph Palazzo, MD	Mountain States Medical Group
Mike Petracek, MD	Vanderbilt University Medical Center
Gwin Robbins, MD	Cardiovascular Center
Nathan Schatzman, MD	American Anesthesiology, Inc.
Megan Shifrin, DNP	Vanderbilt University Medical Center
Robert Lewis Wilson, Jr., MD	Cookeville Regional Medical Center
John J. Young, Md	Life Point Health
Joel Bradley, MD	UnitedHealthcare
Cy Huffman, MD	BlueCross BlueShield of Tennessee
Mark Mahler, MD	Amerigroup
Renee McLaughlin, MD	Cigna
Julie Riedel, APN	Amerigroup

Acute Exacerbation of Congestive Heart Failure (CHF)

	TAG 1	TAG 2
Acute Exacerbation of Congestive Heart Failure (CHF)	October 12th 1PM-4PM (CT) Monday	November 3rd 9AM-12PM (CT) Tuesday

Name	Affiliation
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