Division of TennCare

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Primary Care Transformation:

Patient Centered Medical Homes for the TennCare population

Partnering to improve care in Tennessee

TennCare has created an aligned Patient Centered Medical Home (PCMH) program across the State's Managed Care Organizations (MCOs) to improve the quality of care among primary care providers in Tennessee. PCMH programs put primary care providers in the center of their patients' medical networks. From this central position, providers can ensure that their patients are receiving high quality and efficient health care.

What is a PCMH?

PCMH is a comprehensive care delivery model designed to improve the quality of primary care services for TennCare members, the capabilities of and practice standards of primary care providers, and the overall value of health care delivered to the TennCare population.

The PCMH program delivers a number of benefits to members, providers, and the system as a whole. A few of the most important benefits are outlined in Table 1.

TABLE 1 – Sources of Value

Members	Practices	System
▪ Better access to primary care providers ▪ Tailored care for those most in need ▪ Care coordination services leading to improved quality and outcomes ▪ Greater emphasis on primary and preventative care	▪ Support for performance improvement ▪ Direct financial support for care coordination ▪ Specialized training for practice transformation ▪ Access to outcome payments	▪ Higher quality care ▪ Reduced total cost of care – Reduced utilization of secondary care through better management of chronic conditions – Reduced utilization of

▪ Improved care coordination with behavioral health providers	▪ Input from other members of care delivery team ▪ Access to better information with which to make decisions ▪ Improved workflows and processes that positively impact productivity and efficiency	unnecessary procedures and visits (e.g., unnecessary emergency room visits) – More cost-conscious referrals ▪ System shift towards greater coordination and information sharing

PCMH providers commit to various evidenced based transformational standards and activities, including:

- **Patient-centered access** (e.g., providing same-day appointments for routine and urgent care)
- **Team-based care** (e.g., holding scheduled patient care team meetings or a structured communication process focused on individual patient care)
- **Population health management** (e.g., using data for population management to address chronic and acute care services)
- **Care management support** (e.g., identifying high-risk patients for care management and care plans with self-care support recommendations for each of them)
- **Care coordination and care transitions** (e.g., referral tracking and follow up and coordinating care transitions)
- **Performance measurement and quality improvement** (e.g., measuring and tracking performance on quality and efficiency measures)

In TennCare's PCMH program, providers are compensated for supporting the initial start-up requirements of becoming a PCMH and for performing the required new activities. In addition, providers are eligible for bonus payments for improvements in the quality and efficiency of the care they provide.

How can Tennessee providers participate?

An organization must be selected by an MCO to participate as a TennCare PCMH with that MCO. Please contact your MCO representative for more information. To participate in the Tennessee PCMH programs, providers must meet the following minimum criteria:

- **Commitment:** Stated commitment to the program by attesting that the practice will meet all PCMH requirements, share learnings, and support future PCMH providers.
- **Practice type:** Must be an eligible primary care TennCare practice type (i.e., family practice, general practice, pediatrics, internal medicine, geriatrics, FQHC) with one or more PCPs, including nurse practitioners.
- **Tools:** Commitment to use the State's web-based Care Coordination Tool.
- **Personnel:** Designation of a PCMH Director (no licensure requirement, though ongoing physical presence is required) and employment of care coordinators to work with high risk members and their treatment network.
- **Training:** All practices will have access to training and support through the MCOs. Practices will also have the opportunity to participate in collaborative conferences and webinars throughout the year.

As providers begin operating as PCMHs, they will be expected to perform all required PCMH activities for their members. To meet activity requirements, practices may either:

✓ Maintain PCMH Recognition from the National Committee for Quality Assurance (NCQA) for all practice sites

OR

✓ Begin working towards meeting NCQA PCMH Recognition for all practice sites not currently recognized.

How are providers supported?

PCMH participating providers in Tennessee receive support in addition to fee-for-service payments to support the practices new PCMH activities:

- **Training:** Organizations receive practice transformation training and support from the MCOs.
- **Transformation Payment:** Providers receive a per-member per-month payment for the first year to support PCMH transformation efforts.
- **Activity payment:** Providers receive a risk-adjusted per-member per-month payment to support PCMH activities for their panels of assigned members.
- **Outcomes payment:** Providers may earn outcomes-based payments to reward practices that succeed in increasing efficiency and quality.
    - **Large panel providers:** Organizations with greater than 5,000 members with a single TennCare MCO will be evaluated for quality improvement and shared savings on total cost of care.
    - **Small panel providers:** Organizations with 500 to 5,000 members with a single TennCare MCO will be evaluated for quality improvement and efficiency performance metrics that serve as a proxy for shared savings on total cost of care.

Increased information sharing for PCMH providers

PCMH providers have access to actionable, real-time patient information through the State's Care Coordination Tool. This web-based tool enables providers to view when an attributed member has had an admission, discharge, or transfer from a hospital, such as a visit to the emergency room, to improve care coordination. The tool also identifies and tracks the closure of gaps in care linked to quality measures. Additionally, it allows providers to view their member panels and members' risk scores, which facilitates provider outreach to members with higher likelihoods of adverse health events.

PCMH providers also receive detailed quality and efficiency reports from TennCare health plans on a quarterly basis to track their performance. Core quality metrics will be measured to ensure that PCMHs are meeting specified quality performance levels and to provide information that practices can use to improve the quality of care they provide.

Frequently Asked Questions (FAQs)

Is the PCMH program mandatory for primary care providers in Tennessee?

No. Providers' participation in PCMH is voluntary.

How does the NCQA requirement work?

Organizations that have achieved NCQA PCMH Recognition for all practice sites automatically meet the minimum requirements for Tennessee's PCMH when they maintain their recognition status. Organizations must renew their NCQA PCMH Recognition through NCQA's Annual Reporting process for all practice sites to maintain eligibility for the Tennessee PCMH program. It's important to note that NCQA PCMH Recognition is evaluated at the site level. Multi-site organizations must maintain PCMH recognition status for each of its primary care sites.

Organizations without NCQA PCMH Recognition are expected to pursue recognition for all sites to maintain eligibility for the Tennessee PCMH program.

NCQA's PCMH Standards and Guidelines and Annual Reporting publications are available for download here: http://store.ncqa.org/index.php/recognition/patient-centered-medical-home-pcmh.html

Are the program requirements different for pediatric and adult populations?

No. The eligibility and activity requirements are the same for both pediatric and adult populations, though specific quality measures are different for pediatric and adult populations.

Can practices with lower volume pool together to access the 5,000-member requirement for Total Cost of Care savings?

Pooling is not available for the PCMH program.

Where should I look for more details about the PCMH program?

Additional details about the program can be found in the PCMH Provider Operating Manual on our website under the Key Documents section.