TennCare Patient Centered Medical Home: Provider Operating Manual 2017

Version 4.0
Released May 2018

TABLE OF CONTENTS

All information included herein is subject to further updates and refinement from TennCare.

1 GENERAL INFORMATION

1.1 Objective of Patient Centered Medical Homes (PCMH) in Tennessee

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.

Tennessee has built on the existing PCMH efforts by providers and payers in the State to create a robust PCMH program that features alignment across payers on critical elements. A PCMH Technical Advisory Group (TAG) of Tennessee clinicians was convened in 2015 to develop recommendations in several areas of program design including, quality measures, sources of value, and provider activity requirements.

1.2 Roadmap for PCMH in Tennessee

Following much stakeholder input and design work, TennCare's three Managed Care Organizations (MCOs) launched a statewide aligned PCMH program starting with 29 organizations on January 1, 2017.

The PCMH program is being rolled out in Tennessee following a staged implementation schedule in which additional organizations will be added each year.

The second wave of eligible PCMH providers has been selected and notified. Contracting with PCMH providers will be completed by the Managed Care Organizations (MCOs). MCOs will work with the selected PCMHs to modify provider contract language to incorporate the incentive structure of PCMH, including the activity payments and the outcome payment.

It is expected that by 2020, approximately 250 organizations representing ~65% of TennCare members will have joined the PCMH program.

1.3 Sources of Value

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

Successfully executed, the PCMH program will deliver 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 ▪ Improved care coordination with behavioral health providers	▪ Support for performance improvement ▪ Direct financial support for care coordination ▪ Specialized training for practice transformation ▪ Access to outcome payments ▪ Input from other members of care delivery team ▪ Access to better information with which to make decisions ▪ Improved work flows and processes that positively impact productivity and efficiency	▪ Higher quality care ▪ Reduced total cost of care – Reduced utilization of secondary care through better management of chronic conditions – Reduced utilization of unnecessary procedures and visits (e.g., unnecessary emergency room visits) – More cost conscious referrals ▪ System shift towards greater coordination and information sharing

2 HOW DOES AN ORGANIZATION BECOME A PCMH?

2.1 Application

The application to become a PCMH is voluntary. Organizations must submit a complete and accurate application to become a PCMH. One application should be submitted per Tax ID. The Division of TennCare will identify those practices able to meet the program requirements. Organizations will be selected to reflect the state's diverse primary care provider landscape (e.g., panel size, grand region, degree of prior experience with PCMH, etc.). The TennCare MCOs will then choose to contract for PCMH from a list of accepted PCMH providers.

The application process will be open each summer for organizations interested in participating beginning in January of the following year. Questions about the application process should be directed to the Division of TennCare.

2.2 Eligibility

TennCare PCMHs will be defined and measured at the Tax ID level. All primary care providers serving Medicaid members under that Tax ID will be included in the PCMH. One PCMH may have multiple physical locations or sites.

All rules, processes, and requirements detailed herein apply only to the TennCare PCMH program. To be eligible for the program:

1) The entity must be a participating TennCare practice with one or more PCPs (including nurse practitioners) with any of the specialty types designated by TennCare as primary care practitioners including family medicine, internal medicine, and pediatrics;

2) The organization must have at least 500 attributed TennCare beneficiaries contracted under one managed care organization (MCO) at the time of enrollment. The organization may have fewer beneficiaries with other MCOs, however, there must be at least 500 with one MCO;

3) The organization attests to commit to the goals of value-based payment including, but not limited to:
   - Increased care coordination
   - Proactive management of the patient panel
   - Focus on improving quality and outcomes performance identified in quarterly reports
   - Integrated care across multidisciplinary provider teams;

4) The organization must designate a PCMH Director to serve as point of contact for the State, MCOs, and other parties;

5) The organization must commit to the following PCMH activities:

- Participate in 2 years of practice transformation and support through State's provider training vendor (described in Section 9)
- Maintain Level 2 or 3 PCMH recognition from the National Committee for Quality Assurance (NCQA) **OR** NCQA's 2017 PCMH recognition
- Sign up and use State's Care Coordination Tool; and
- Share best practices with other participating PCMH organizations and support other organizations in their practice transformation by participating in learning collaboratives on an ongoing basis

A participating organization remains enrolled in the PCMH program until any of the following occur:

1) The organization withdraws;
2) The organization or provider becomes ineligible, is suspended or terminated from the TennCare program or the PCMH program; or
3) Division of TennCare terminates the PCMH program.

To withdraw from PCMH, the participating organization must email intent to withdraw to payment.reform@tn.gov and to their contracted MCO(s).

2.3 Provider contracting

If selected during the application process, an organization must update its contract(s) with the relevant health plan(s). MCO contracting must be completed prior to the start of the performance period on the first of January each year. Organizations will not be required to contract with health plans with which they do not have an existing contract. However, when an organization agrees to participate in the TennCare PCMH program that organization is agreeing to participate with all of the MCOs with which they currently have contracts.

If an organization has less than 500 members attributed to a given MCO, that MCO will determine if it will extend a PCMH contract to the organization.

An organization may not participate in two overlapping value-based payment programs with the same health plan simultaneously. The State and health plan will work together to determine if an organization's existing value based payment arrangement with an MCO is duplicative of the TennCare PCMH program. Organizations may need to terminate existing value based payment arrangements in order to participate in the TennCare PCMH to avoid duplication.

3 WHICH MEMBERS ARE IN A PCMH?

3.1 Member Inclusion

The intent of the PCMH program is to be as broad and inclusive as possible. As a result, all TennCare members enrolled with the MCO are eligible for the PCMH program, including adults and children. CoverKids members are not included at this time.

The program explicitly includes individuals that are dually eligible in Medicare and Medicaid if their D-SNP health plans are with the same MCO. Members may be enrolled in both a PCMH and a Tennessee Health Link (THL) organization simultaneously. THL is a program designed to coordinate health care services for TennCare members with the highest behavioral health needs.

All TennCare eligible members attributed to a PCMH are included in the calculation for the monthly activity per member per month payment. Some members are excluded in the calculation for performance evaluation and therefore excluded from the outcome payment calculation.

Members **are excluded** from the PCMH program performance evaluation under any of the following scenarios (i.e., these members are not counted in quality and efficiency metrics):

- **Member is dual-eligible but is not enrolled in an aligned D-SNP.** Members could be excluded from performance evaluation if they are dual eligibles not enrolled in an aligned D-SNP health plan (at the MCO's discretion). Being "aligned" means that the member is enrolled in a Medicare Advantage D-SNP plan with the same MCO participating in the TennCare Medicaid program. Examples of not being enrolled in an aligned D-SNP health plan include cases where the member is dual-eligible but enrolled in a Medicare Advantage health plan that is not a D-SNP, a D-SNP health plan with another insurer, or Medicare fee-for-service.
- **Member has or obtains third-party liability (TPL) coverage.** Members with confirmed TPL coverage or with a claim within the previous quarter indicating TPL coverage could be excluded from the PCMH program performance evaluation.
- **Member has a long-term nursing home stay:** Members with an active nursing home stay that covers 90 or more consecutive days are not included in the PCMH program evaluation. Members must be discharged to home from a previous nursing home stay to regain PCMH program performance evaluation eligibility.
- **Member with long-term residential treatment facility stay:** Members with one or more residential treatment facility (RTF) claims that cover more than 90

consecutive days that are ongoing as of the eligibility update start date are not included in the PCMH program evaluation. Members must be discharged to home from a previous RTF stay to regain PCMH program performance evaluation eligibility.

- **Member has less than 9 months of attribution to that PCMH:** Only those members with at least 9 months of cumulative attribution to the PCMH are counted towards performance outcomes. These 9 months do not have to be consecutive. This policy is in place to ensure that the provider has had adequate time with the member to affect their quality and efficiency outcomes.

Once excluded, a member may become eligible again for the PCMH program if his or her exclusion status changes.

3.2 Member Attribution

Attribution uses the existing member to PCP assignment conducted by the MCOs today. Members are attributed for each month to the PCMH associated with the member's active PCP. If the member's PCP is not part of an organization that participates in the PCMH program, the member will not be attributed to any PCMH for the month. If a provider wishes to remove a member from their attributed panel, this program will follow the same guidelines/existing rules that each MCO already has in place for member change requests submitted by primary care providers.

4 WHAT SERVICES WILL A PCMH PROVIDE?

The PCMH organizations will provide team-based care, patient-centered access, care coordination, and improved quality of care to their members. To ensure that these principles are being achieved, each PCMH will be required to maintain or achieve NCQA recognition (refer to Section 5.2 for further detail).

The following are functions each PCMH will do to ensure patients receive enhanced patient-centered care:

1. **Team-based care and practice organization:** The PCMH provides continuity of care, communicates roles and responsibilities of the medical home to patients/families/caregivers and organizes and trains staff to work to the top of their license and ability to provide effective team-based care.
2. **Knowing and managing your patients:** The PCMH captures and analyzes information about the patients and community it serves and uses the information to deliver evidence-based care that supports population needs and provision of culturally and linguistically appropriate services.
3. **Patient-centered access and continuity:** Patients/families/caregivers have 24/7 access to clinical advice and appropriate care facilitated by their designated clinician/care team and supported by access to their medical record. The PCMH considers the needs and preferences of the patient population when establishing and updating standards for access.
4. **Care management and support:** The PCMH identifies patient needs at the individual and population levels to effectively plan, manage and coordinate patient care in partnership with patients/families/caregivers. Emphasis is placed on supporting patients at highest risk.
5. **Care coordination and transitions:** The PCMH tracks tests, referrals and care transitions to ensure comprehensive care coordination and communication with specialists and other providers in the medical neighborhood.
6. **Performance measurement and quality improvement:** The PCMH collects, reports and uses performance data to identify opportunities for quality improvement, sets goals and acts to improve clinical quality, efficiency, patient experience and engages the staff and patients/families/caregivers in the quality improvement activities.

5 HOW WILL A PCMH BE PAID?

5.1 Fee-for-service

The current fee-for-service delivery model will remain unchanged under the PCMH program.

5.2 Practice Support Payments

Practice support payments are per-member-per month (PMPM) payments made to the PCMH to support the delivery of care under the PCMH model.

There are 2 components to practice support payments:

1. Practice transformation payments; and
2. Activity payments

Both types of practice support payments are calculated retrospectively. The payments are calculated and made on a monthly basis.

The **practice transformation payment** is set at $1 PMPM and is provided for the first year of program participation only. This value is not risk adjusted.

The **activity payment** is a risk adjusted PMPM amount and will continue throughout the duration of the program. Each PCMH will receive their PMPM payment amount from the MCO based on the risk of their membership panel. The payments will primarily support the PCMH for the labor and time required to improve and support their care delivery models. PCMHs may hire new staff (e.g., care coordinators) or change responsibilities for existing staff to support the required care delivery changes.

- **Determination of risk-adjusted activity payment amounts**

Activity payment amounts are risk-adjusted to account for differences in the degree of care coordination required for members with serious or chronic health conditions. Refer to Section 7 for further detail of the risk adjustment methodology.

While the payment amount per risk band is left to MCO discretion, the average payout across all of an MCO's PCMHs must average at least $4 PMPM. No PMPM will be less than $1.

At the beginning of each performance period, a practice risk score will be calculated that will define the PCMH's risk for the year. The MCO will determine the PMPM amount based on that risk. The PCMH risk score will be updated annually before the

start of the next performance period to account for changes in the PCMH risk over time.

- **Requirements for Activity Payment**

1) Initial eligibility: requirements for payments will be contingent on enrollment in the PCMH program as defined in Section 2.2.
2) Activity requirements: Practices must perform all activities in order to continue receiving payments. The organization must commit to the following PCMH activities:
   - Maintain Level 2 or 3 PCMH recognition from the National Committee for Quality Assurance (NCQA) **OR** NCQA's 2017 PCMH accreditation (Refer to NCQA Requirement- Detail below);
   - Sign up and use State's Care Coordination Tool (Refer to Section 11 for further detail on the CCT); and
   - Share best practices with other participating PCMH organizations and support other organizations in their organization transformation by participating in learning collaboratives on an ongoing basis

NCQA Requirement - Detail:

Organizations with NCQA Level 2 or 3 recognition automatically meet the minimum requirements for TennCare's PCMH until their accreditation expires. When that accreditation expires, these organizations must transition to NCQA's 2017 standards to maintain eligibility for the TennCare's PCMH program.

Organizations should obtain NCQA 2017 accreditation for all sites within one year of the opportunity being presented or within one year of their current accreditation's expiration. TennCare will fund all of the fees associated with the NCQA 2017 PCMH process and provide organizations with guidance on achieving recognition. If an extension is necessary, an organization must submit a request for extension to TennCare no later than two months before the one year deadline. The extension request will require a justified explanation from the practice and Navigant coach for the delayed recognition.

NCQA's 2017 standards are available here:
http://www.ncqa.org/Portals/0/Programs/Recognition/PCMH/2017%20PCMH%20Concepts%20Overview.pdf?ver=2017-03-08-220342-4902017

- **Adjustment based on PCMH quality and efficiency metric performance**

During the first two years of the PCMH program, activity payments are not placed at risk, and are simply equal to the PMPM payment amount associated with the member's risk band.

Starting in performance period CY2019, a portion of the activity payment amount is placed at risk based on the PCMH's performance. After the end of each performance period (starting at the end of CY2018), the activity payment amount is adjusted based on the PCMH's performance on the quality and efficiency stars as defined in Section 7 – How Will Quality and Efficiency Be Measured?.

- **Addition of organization transformation payment amounts**

The organization transformation payment amount ($1 PMPM) paid in the first year of participation is added to the adjusted activity payment amount to determine the total organization support payment PMPM for the member.

On the whole, organization support payment amounts are summed across members attributed to a PCMH to obtain the total organization support payment amount for the PCMH organization for each month.

5.3 Outcome Payments

Outcome payments are designed to reward the high performing PCMHs for providing high-quality care while effectively managing overall spending. There are 2 kinds of outcome payments:

- **Outcome payments based on total cost of care (TCOC):** For high volume panel PCMH organizations with 5,000 or more members, savings on TCOC generated through the PCMH program will be shared based on each PCMH organization's actual risk-adjusted TCOC relative to its benchmark TCOC; and
- **Outcome payments based on efficiency metric improvement:** For low volume panel practices with fewer than 5,000 members, PCMH organizations may earn outcome payments for annual improvement on efficiency metrics compared to the performance on the same metrics in the previous year.

PCMH organizations are eligible for either type of outcome payment **only** if the following 2 conditions are met:

1. The PCMH earns a minimum number of quality stars: 2 (out of possible 5) for pediatric and adult PCMHs, 4 (out of possible 10) for family PCMHs; and

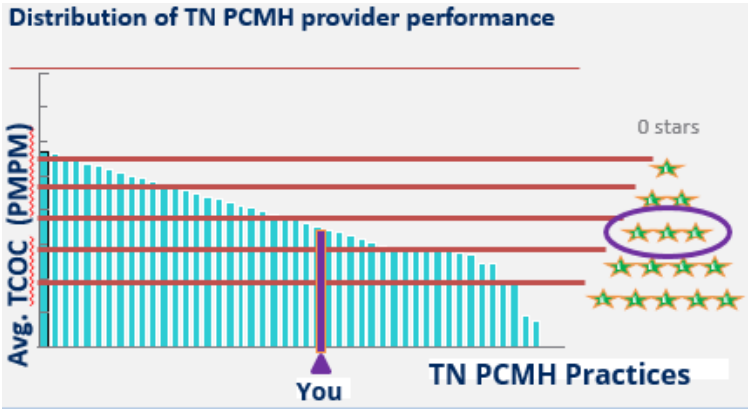
2. The PCMH shows improved efficiency (i.e. better results on efficiency metrics during the performance year over the previous year, or lower total cost of care compared to the benchmark)

5.3.1 Outcome Savings Percentage

PCMH organizations may earn between 0 to 100% of the outcome savings percentage based on quality and efficiency stars earned. The outcome savings percentage is calculated differently based on the panel size of the PCMH's panel, i.e., for PCMHs with 5,000 or more unique attributed members in a single MCO's panel and PCMHs with fewer than 5,000 unique members.

- **High volume panel PCMHs: PCMHs with 5,000 or more unique attributed members in a single MCO's panel**

Each PCMH is awarded TCOC efficiency stars based on its risk-adjusted TCOC. Risk-adjusted TCOC thresholds for the number of TCOC efficiency stars to be awarded will be provided in a separate document. A sample of a practice earning 3 TCOC efficiency stars is below.



Then, quality stars and TCOC efficiency stars are combined to calculate the outcomes savings percentage. Each TCOC efficiency star earned by the PCMH organization contributes 10% to the outcome savings percentage. Each quality star earned by the PCMH organization contributes 10% to the outcome savings percentage for adult and pediatric PCMH organizations and 5% for family PCMH organizations.

For example, the following pediatric PCMH organization would have an outcome savings percentage of 70%:

- **Low volume panel PCMHs: PCMHs with fewer than 5,000 unique attributed members in the panel**

Outcome savings percentage for these PCMH organizations is also based on the number of quality stars and the efficiency stars. The difference is that low volume panel PCMHs earn their efficiency stars based on efficiency metrics rather than based on TCOC. Refer to Section 12 Table 8 for detail on the efficiency metrics. Each efficiency star earned by the PCMH organization contributes 10% to the outcome savings percentage. Each quality star earned by the PCMH organization contributes 10% to the outcome savings percentage for adult only and pediatric only PCMH organizations and 5% for family PCMH organizations.

For example, the following family PCMH organization would have an outcome savings percentage of 60%.

5.3.2 Efficiency Improvement Percentage

The efficiency improvement percentage is used only for low volume panel PCMHs. This percentage will reward PCMH organizations which have improved relative to their previous year's performance. The efficiency improvement percentage is the average of improvement in each efficiency metric compared to previous year's performance for the PCMH. Efficiency improvement for a given metric is calculated as the following:

$$\begin{pmatrix} Efficiency \\ Improvement \\ Percentage \end{pmatrix} = \frac{\begin{pmatrix} Efficiency\ metric\ 1 \\ Performance\ at\ baseline \end{pmatrix} - \begin{pmatrix} Efficiency\ Metric\ 1 \\ Performance\ since\ 1/1/17 \end{pmatrix}}{\begin{pmatrix} Efficiency\ metric\ 1 \\ Performance\ at\ baseline \end{pmatrix}}$$

After calculating the efficiency improvement percentage for each metric, the average of the five is taken.

TABLE- Illustrative Example of Efficiency Improvement Percentage

Note: Values rounded to nearest hundredth decimal place

Efficiency Measure per 1,000 member months	Performance at baseline	Performance since 1/1/17	Efficiency Improvement
All cause hospital readmissions	0.52	0.47	9.62%
ED visits	78.10	76.00	2.69%
Inpatient admissions	2.80	3.00	-7.14%
Mental health inpatient utilization	0.15	0.12	20.00%
Avoidable ED visits (Ambulatory sensitive)	13.10	13.00	0.76%
EFFICIENCY IMPROVEMENT PERCENTAGE (AVERAGE)			**5.18%**

If the average efficiency improvement percentage results in a negative number, it will be set to 0 and if the average calculation exceeds 20% it will be capped at that value. In addition, each individual measure's efficiency improvement is capped at

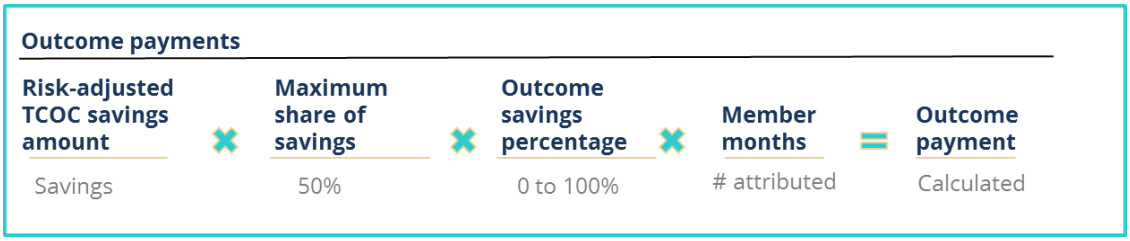
positive and negative 20.00%. In other words, if your organization sees a decrease in efficiency of 31.25%, it will only show a decrease of 20.00%.

5.3.3 Outcome Payments Based on Total Cost of Care

High volume PCMHs generate outcome payments based on Total Cost of Care (TCOC).

Outcome payments based on TCOC are determined by comparing a PCMH organization's risk adjusted TCOC to their benchmark TCOC to determine whether the PCMH organization achieved lower costs relative to the expected benchmark.

The outcome payment based on total cost of care amount for a PCMH organization can be summarized as:



Each of the four components to determining shared savings based on TCOC are described below:

- **Risk-adjusted TCOC savings amount:** Risk-adjusted TCOC savings are calculated by taking the difference between the actual adjusted TCOC and the benchmark adjusted TCOC for each PCMH in a given performance year. If the PCMH organization's actual costs are higher than their benchmark, then the TCOC savings amount is set to zero, and no outcome payment is earned for that year.
- **Maximum share of savings:** The maximum percentage of estimated savings that can be shared with a PCMH. This value is set to 50% for outcome payments based on total cost of care.
- **Outcome savings percentage:** The percentage earned from TCOC Stars plus Quality stars. Refer to Section 5.3.1 for further detail.
- **Member months**: Risk-adjusted TCOC savings amounts are on a per member basis. In order to convert this per member rate into total shared savings for the PCMH organization, the savings are multiplied by the total number of attributed member months. Only member months for members in each PCMH's annual performance panel as defined in Section 3.1 are included in this calculation.

5.3.4 Outcome payments based on efficiency measures

Eligibility for outcome payments

PCMH organizations with less than 5,000 members with a given MCO, also called low volume PCMHs in this document, will have their efficiency performance translated into implied savings based on utilization. These low volume PCMHs are measured based on 5 efficiency measures rather than total cost of care. These core efficiency measures are described in Section7.2 and in the Quality and Efficiency Metrics Appendix Tables 7 and 8.

PCMHs must meet the minimum quality star requirement in the performance report at the end of year to qualify for outcome payments. The minimum quality star requirement is 2 stars for adult only and pediatric only PCMH organizations, and 4 stars for family PCMH organizations. For PCMHs with the number of stars meeting the minimum requirement, the outcome payment amount is calculated as the following:

- **Average cost of care:** The average total cost of care for members in primary care organizations across all of TennCare. This value is set at $234.
- **Efficiency improvement percentage**: The average of percent improvement in each efficiency metric compared to the previous year for each PCMH, as defined in Section 7.2.
- **Maximum share of savings:** The maximum percentage of estimated savings that can be shared with a PCMH. This value is set to one quarter for outcome payments based on total cost of care proxies.
- **Outcome savings percentage**: The percentage earned from efficiency stars plus quality stars. As defined in Section 5.3.1.
- **Member months**: Outcome payments are generated based on the number of members attributed to your PCMH over time. Only member months for members in each PCMH's annual performance panel as defined in Section 3.1 are included in this calculation.

6 PCMH REMEDIATION PROCESS

The remediation process is initiated when a PCMH organization fails to meet deadlines and/or performance targets on required program activities. A PCMH may trigger probation, remediation and/or removal under any of the following circumstances:

- Not meeting program requirements (e.g. NCQA recognition requirements)
- Poor performance defined as:
  - A family PCMH earning 2 or fewer quality stars at the end of a performance period (12 months); or
  - A pediatric or adult PCMH earning 1 or fewer quality stars at the end of a performance period (12 months); or
  - PCMH earning 1 or fewer efficiency stars at the end of a performance period (12 months)
- Failure to respond and meet with MCO and/or TennCare

The remediation process includes three phases outlined below.

Probation

- MCO(s) and TennCare will be in monthly contact with a PCMH with clear communication regarding performance and program requirements at least six months before a warning would be issued. This period spans six months from the date TennCare issues a pre-warning notification to a PCMH. TennCare will provide a copy of the pre-warning notification to MCO(s).
- MCO(s) notifies TennCare of PCMH's failure to correct performance and/or program requirement issues. Documentation of prior discussions and reports will be provided to TennCare.
- TennCare issues warning document outlining performance and/or program requirement issues, to PCMH within 3 calendar days of MCO(s) notification. TennCare will provide copy of the warning document to MCO(s).
- MCO(s) work with the PCMH and those providing coaching to write a corrective action plan. The corrective action plan must be submitted to MCOs, TennCare and coach(s) within 30 calendar days of receiving TennCare's warning.
- A PCMH will remain in probation for the duration of the period outlined in the corrective action plan, when their performance will be reevaluated based on their corrective action plan and performance improvement. If performance has not improved, then the PCMH would be moved into remediation.

Remediation

- If correction action plan is not followed within specified timeline, TennCare will notify the PCMH that they are in remediation within 3 calendar days through a remediation document.
- The MCOs will review the corrective action plan and work with coaches to determine if the PCMH is making improvements in performance and/or program requirements issues with further analysis.
- MCOs will stop activity payments if corrective action plan is not followed.
- MCOs may move a PCMH from remediation to probation under a revised corrective action plan at their discretion.

Removal from PCMH

- TennCare and MCOs work together within 10 calendar days to determine if a PCMH who has not fulfilled all corrective actions should be removed from the program.
- TennCare will notify MCOs within 3 calendar days of decision to remove a PCMH organization.
- MCOs will terminate all PCMH payment streams after receiving removal letter from TennCare.
- MCOs and TennCare reserve the right to remove a PCMH from the program in less than 10 calendar days in extreme circumstances.

7 HOW WILL QUALITY AND EFFICIENCY BE MEASURED?

7.1 Quality Measures

Quality metrics are tracked to ensure that PCMHs are meeting specified quality performance levels and to provide them with information they can use to improve the quality of care they provide.

There are 3 types of PCMH organizations for purposes of determining performance: pediatric, adult, and family practices. For the purpose of organization type setting, members aged 21 or younger are considered to be children, and all other members are considered to be adults. PCMH organization type is determined based on the percentage of adults and children on an organization's panel as well as the number of adults and children on the organization's panel.

Practice type is defined in 2 steps.

1. Determine the percentage of adults and children in an organization's panel.
    a. If the organization's attribution from that MCO is 70% or more children, the organization may be a pediatric practice
    b. If the organization's attribution from that MCO is 70% or greater adults, the practice may be an adult practice.
    c. If the organization's attribution from that MCO has a mixture of adults and children that does not meet one of the above criteria, it is a family organization.
2. If a member panel has more than 500 children members and also more than 500 adult members attributed, it is a family organization. This step overrides the first step of determining percentages.

The organization type of each PCMH is determined at the beginning of each year, and an organization's type remains constant for the duration of the performance period.

Various quality performance metrics are used across the 3 types of organizations. Adult and pediatric organizations will be evaluated on 5 quality metrics, while family organizations will be evaluated on 10 quality metrics, as shown in Table 3.

Core quality metrics that will be used to determine outcome payment levels are shown in Table 3. Some measures are grouped into composites. Each composite is worth one quality star. All sub-measures within a composite must meet or exceed the threshold in order for a practice to earn that star. Additional reporting only metrics will also be provided on reports. There is a more detailed table with sources and descriptions in Section 12 – Quality Appendix – Tables 7 and 8.

TABLE 3– Quality Metrics by PCMH Organization Type

Pediatric Practice Quality Metrics

1. **EPSDT screening rate (composite for older kids)**
   - Well-child visits ages 7-11 years
   - Adolescent well-care visits age 12-21
2. **Asthma medication management**
3. **Immunization composite metric**
   - Childhood immunizations
   - Immunizations for adolescents
4. **EPSDT screening rate (composite for younger kids)**
   - Well-child visits first 15 months
   - Well-child visits at 18, 24, & 30 months
   - Well-child visits ages 3-6 years
5. **Weight assessment and nutritional counseling**
   - BMI percentile
   - Counseling for nutrition

Adult Practice Quality Metrics

1. **Adult BMI screening**
2. **Antidepressant medication management**
3. **EPSDT: Adolescent well-care visits age 12-21**
4. **Comprehensive diabetes care (composite 1)**
   - Diabetes care: eye exam
   - Diabetes care: BP < 140/90
   - Diabetes care: nephropathy
5. **Comprehensive diabetes care (composite 2)**
   - Diabetes HbA1c testing
   - Diabetes HbA1c poor control (>9%)

Family Practice Quality Metrics

1. **Adult BMI screening**
2. **Antidepressant medication management**
3. **Comprehensive diabetes care (composite 1)**
   - Diabetes eye exam
   - Diabetes BP < 140/90
   - Diabetes nephropathy
4. **Comprehensive diabetes care (composite 2)**
   - Diabetes HbA1c testing
   - Diabetes HbA1c poor control (> 9%)
5. **Asthma medication management**
6. **Immunization composite metric**
   - Childhood immunizations
   - Immunizations for adolescents
7. **EPSDT screening rate (Composite for youngest kids)**
   - Well-child visits first 15 months
   - Well-child visits at 18, 24, & 30 months
8. **EPSDT: Well-child visits ages 3-6 years**
9. **EPSDT Screening (Composite for older kids)**
   - Well-child visits ages 7-11 years
   - Adolescent well-care visits age 12-21
10. **Weight assessment and nutritional counseling**
    - BMI percentile
    - Counseling for nutrition

7.2 Efficiency Measures

Efficiency metrics are tracked to ensure that low- volume PCMHs are meeting specified efficiency performance levels and to provide them with information they can use to improve the quality of care they provide. Core efficiency metrics that will be used to determine outcome payment levels are shown in Table 4. Additional reporting only metrics will also be provided on reports.

Core efficiency metrics that will be used to determine outcome payment levels are shown in the table below. There is a more detailed table with sources and descriptions in Section 12 – Quality Appendix- Table 7.

TABLE 4 – PCMH Efficiency Metrics

PCMH Efficiency Metrics
per 1,000 member months

1	All-cause hospital readmissions rate
2	Ambulatory care - ED visits
3	Inpatient admissions– Total inpatient
4	Mental health utilization- Inpatient
5	Avoidable ED visits

7.3 Total Cost of Care Calculation

Total cost of care (TCOC) refers to average total spending of the members in a PCMH's panel, adjusted for the member months during which the member was eligible for TennCare. At the end of each quarter, the TCOC is generated for the PCMH report, based on each PCMH's member panel for performance. The following calculations are displayed in each PCMH report:

- Non-risk-adjusted TCOC
- Risk-adjusted TCOC
- Non-risk-adjusted TCOC for behavioral health

TCOC amounts are used to calculate outcome payments for practices with 5,000 or more members. In order to support the calculation of outcome payments based on total cost of care, a baseline and benchmark TCOC is calculated for each PCMH, in addition to the actual TCOC. Baseline and benchmark TCOCs are calculated on risk-adjusted basis only.

For PCMH organizations with less than 5,000 members, TCOC amounts will be displayed for informational purposes only. Each of these TCOC calculations is discussed in greater detail in the sections that follow.

- **Definition of Total Cost of Care**

The total cost of care is meant to capture the total cost of an average member in a PCMH's organization. Using this, the MCOs can calculate the savings a practice has generated and share in those savings with organizations.

For purposes of the PCMH program, there are 4 categories of spending excluded from TCOC calculation:

- Dental
- Transportation
- NICU and nursery
- Any spending during the first month of life

In addition to traditional claims-based payments, there are 3 types of spending incorporated into the TCOC calculation:

- PCMH activity payments are considered a cost associated with delivering care. As a result, the activity payments from the prior quarter are added to TCOC at the member level;
- Tennessee Health Link support payments are also considered a cost associated with delivering care. Tennessee Health Link payments from the previous quarter are added to TCOC at the member level; and
- Gain-sharing payment made to the PCMH as a Principle Accountable Provider (i.e. Quarterback) of episode-based payment models.

- **Actual Total Cost of Care**

Actual total cost of care for a PCMH is calculated as a per-member-per-month metric, on a separate basis for each MCO with which the PCMH contracts.

Non-risk-adjusted TCOC is defined as the sum of spend included in TCOC divided by the sum of the number of enrollment months with the MCO, for all the members in the PCMH's panel. In other words, across all members of the PCMH's panel within an MCO:

$$Non\ risk\ adjusted\ TCOC = \frac{\sum Included\ Spend}{\sum Member\ months\ with\ MCO}$$

Risk-adjusted TCOC reflects the risk score of the members in the PCMH's panel, and includes a maximum spend cap to remove the impact of outliers. Risk-adjusted TCOC for a PCMH organization is calculated by summing the included spend for all members in the PCMH's outcome payments panel, capped at a set amount per member (to be provided with State thresholds), and dividing by the sum of each member's risk score multiplied by the number of months each member was enrolled with the MCO during the year. In other words, across all members of the PCMH's panel within an MCO:

$$Risk\ adjusted\ TCOC = \frac{\sum Capped\ spend}{\sum(Member\ months\ with\ MCO * Adjusted\ risk\ score)}$$

Non-risk-adjusted TCOC for behavioral health is defined analogously with the non-risk-adjusted TCOC above, but taking into account only the BH spend. For non-risk-adjusted TCOC for behavioral health, spend included is spend that meets the BH spend definition as well as the TCOC definition.

- **Baseline Total Cost of Care**

The baseline TCOC for each PCMH is the 3-year average of risk-adjusted TCOC for the given PCMH, and is used to estimate the historical per member cost of care for a PCMH organization as it enters the PCMH program. Three years are used to account for potential year-to-year variation.

The baseline TCOC for a PCMH is defined as the risk-adjusted TCOC values of year 1, year 2, and year 3, defined as CY2013, CY2014, and CY2015. CY2013 and CY2014 values are adjusted for inflation. If the PCMH does not have CY2013 and/or CY2014 values for TCOC available, then those values are replaced by CY2015 values. If the CY2015 value for TCOC is not available because membership was less than 5,000 members that year, then the PCMH does not qualify for TCOC-based shared savings.

- **Benchmark Total Cost of Care**

The benchmark TCOC is the figure against which a PCMH's actual TCOC will be assessed when determining performance for outcome payments. The benchmark is calculated as baseline TCOC adjusted using a common adjustment rate of 1.0% as

compound annual growth rate to match the performance period. For example, the benchmark for the 2017 performance period is calculated as the 2013 to 2015 baseline, adjusted by the common adjustment rate for two years, as illustrated in Table 5. This reflects the expected cost for the PCMH.

TABLE 5 – Example of benchmark TCOC calculation

CY13-15 TCOC baseline	Benchmark rate	Growth for 1 year	2017 Benchmark TCOC
$200	1%	$200 X (1.01)	$204.02

7.4 Earning Stars

In each quarterly report, PCMH organizations earn stars based on their performance across the core quality and efficiency metrics. There are 5 quality stars and 5 efficiency stars for a total of 10 stars for adult only and pediatric only PCMH organization s, and 10 quality stars and 5 efficiency stars for a total of 15 stars for family PCMH organizations.

- Each quality metric or quality composite that meets or outperforms the state threshold translates into 1 quality star.
- Each efficiency metric that meets or outperforms the threshold translates into 1 efficiency star.

Adult and pediatric core quality and efficiency metrics are defined in Sections7.1 and 7.2 and further detailed in Section 12 – Quality Appendix- Tables 7 and8. State thresholds for each core metric are provided in a separate document.

Some of these measures are composites with multiple sub-measures. In order to earn a star for a given measure, the PCMH must pass all of the sub-measures.

PCMH organizations can only earn credit for quality and efficiency metrics with 30 or more observations in the metric's denominator. For example, a PCMH organization will only be measured on the quality measure asthma medication management if it has seen at least 30 patients eligible for the metric.

PCMHs must meet the minimum quality star requirement in the performance report at the end of year to qualify for outcome payments. The minimum quality star requirement is 2 stars for adult only and pediatric only PCMH organizations, and 4 stars for family PCMH organizations.

8 RISK ADJUSTMENT

Risk adjustment is an essential analytic element of the PCMH program. Risk adjustment will be used in the TennCare PCMH program in 2 ways:

- Risk adjustment of the activity payments PMPM; and
- Risk adjustment of total cost of care

The TennCare PCMH program utilizes the Combined Chronic Illness and Pharmacy Payment System (CDPS+Rx) version 6.1 for risk adjustment.

CDPS is a diagnosis-based risk assessment and classification system that supports health status-based capitated payments for Medicaid and Medicare populations. The CDPS model was first developed in 2000 by the University of California, San Diego (UCSD), and has since been expanded to include diagnostic and pharmacy risk assessment models. To date, approximately 15 states use CDPS to determine risk adjusted capitated payments for their Medicaid programs. The CDPS model has the option to run in either prospective or concurrent mode.

8.1 Risk adjustment for practice support payments

The CDPS prospective model is used to calculate risk score for activity payments. The prospective model was chosen because these risk scores are being calculated at the beginning of the year and will be used for the rest of the year. Based on the risk score generated for each member, the PCMH organization's average risk score is assigned to a risk band, which determines the level of the activities PMPM payment for each member in the practice. This risk adjusted activity payment amount will be recalculated each year to account for any change in the members' risk in that practice.

8.2 Risk adjustment for Total Cost of Care

The CDPS concurrent model is used to calculate risk score for total cost of care. The concurrent model was chosen because it is calibrated to reflect realized risk during a historical period. For this purpose, CDPS will be run at the end of each quarter, taking into account a claims run-out period of 90 days.

9 REPORTING

PCMH providers will be sent quarterly reports, detailing their efficiency and quality stars, total cost of care and potential payments for the relevant performance period. Each MCO will send providers reports quarterly. These quarterly reports aim to provide PCMHs an interim view of the member panels that they will be held accountable for during the performance period. The first performance period for PCMH is January 1 - December 31, 2018.

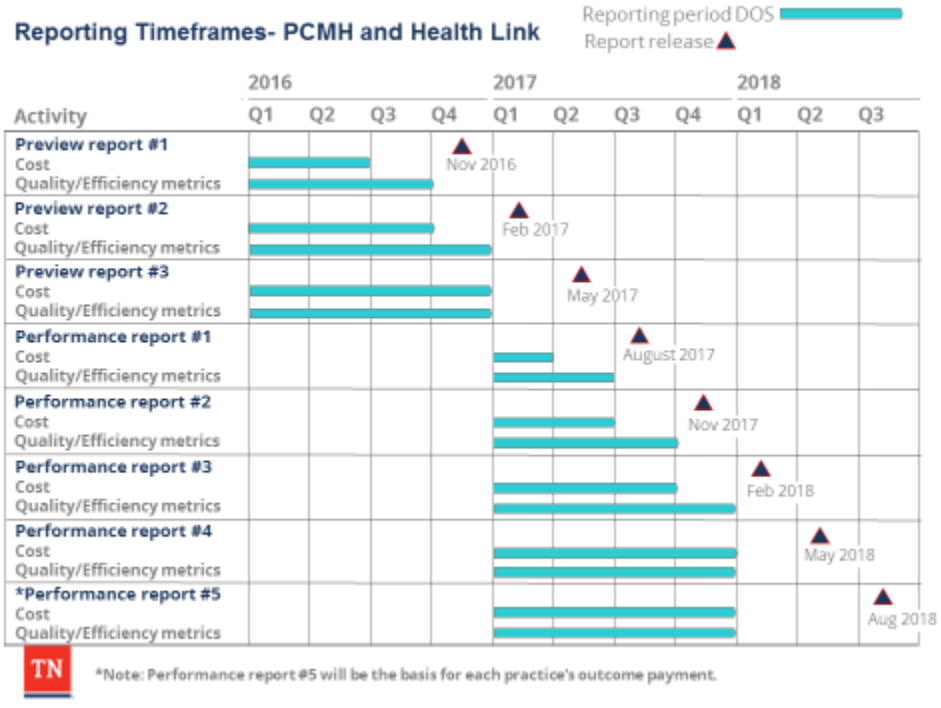
There are 2 types of quarterly provider reports:

- Preview reports; and
- Performance reports.

Initially, at program launch, PCMH providers will receive three preview reports on their performance until the first claims run-out is complete, after which they will start to receive quarterly performance reports. These preview reports will give PCMHs a sense of how they were performing before the program launched. MCOs will also send providers a final annual report seven to eight months after the end of Q4 which will calculate the annual outcome payment. Only data from January 1, 2018 to December 31, 2018 will be included in performance evaluation.

Each quarterly performance report will provide a summary of the PCMH's total cost of care performance from the beginning of the performance period to the end of each quarter, and will incorporate 90 days of claims run-out after the end of each quarter. Each performance report will also include the most recent data available for performance on quality and efficiency metrics. The final performance report will calculate the outcome payment. This final report will incorporate 180 days of claims run out after the end of the year. The following table represents the timeframes of data that will be included in each report.

TABLE 6 – Data timeframes for each quarterly report



The reports for high volume panel organizations will be different from the reports sent to low volume panel organizations because of the difference in their outcome payment calculation.

9.1 High volume panel size

High volume panel size refers to PCMHs with 5,000 or more unique attributed members in a single MCOs panel. Outcome savings percentage used to calculate outcome payments for these organizations is based on the number of quality stars and the TCOC efficiency stars.

All MCOs will use the same template to generate reports. The report will contain the following sections (A-E):

A. Quality Stars: This section summarizes the quality stars earned by the provider as of the end of the given quarter. Adult and pediatric PCMH organizations will view the 5 applicable adult/pediatric quality metrics, with each quality star contributing 10% to the outcome saving percentage. Family PCMH organizations will see all 10 applicable quality metrics, with each quality star contributing 5% to the outcome savings percentage.

B. Efficiency Stars: Total Cost of Care: This section outlines the provider's risk-adjusted average per member per month Total Cost of Care for the quarter. It will provide a mapping of how many efficiency stars this average total cost of care is rewarded, based on pre-determined thresholds. The potential number of efficiency stars a provider can receive is 0 through 5, with each star contributing 10% to the outcome savings percentage. This section also offers provider TCOC information by care category. The provider TCOC figures are compared to a provider average, and are provided on a non-risk adjusted basis for both total cost of care and behavioral health specific cost of case.

C. Total Cost of Care Savings Amount: The total cost of care savings amount shows how much your PCMH organization saved per member per month this year. This section shows the TCOC values for your PCMH organization necessary to determine your savings.

D. Potential for Annual Outcome Payments: This section provides information on potential (or actual, if it is the annual report) outcome payments. It lists the amount of the potential payment, and details of the calculation of that amount.

Appendix: This section contains more detail on the quality metrics performance. It includes an indication of whether the provider has met the minimum number of members for each metric and, if not, how many members are included. The section also includes a short description of each quality metric and a visual depiction of the provider performance on each metric as compared to other providers and as compared to the metric threshold for earning a star.

9.2 Low volume panel size

Low volume panel size refers to PCMHs with fewer than 5,000 unique attributed members in the panel. Outcome savings percentage used to calculate outcome payments for these practices is based on the number of quality stars and efficiency stars.

The report will contain the following sections (A-F):

A. Quality Stars: This section summarizes the quality stars earned by the provider as of the end of the given quarter. Adult and pediatric PCMH organizations will view the 5 applicable adult/pediatric quality metrics, with each quality star contributing 10% to the outcome saving percentage. Family PCMH organizations will see all 10 applicable quality metrics, with each quality star contributing 5% to the outcome savings percentage.

B. Efficiency Stars: This section summarizes the efficiency stars earned by the provider as of the end of the given quarter. Each star earned will contribute 10% to the outcomes savings percentage.

C. Efficiency Improvement Percentage: This section includes the calculation of the efficiency improvement score, an input to the outcome payment calculation. The provider's current performance (year to date) on the five efficiency metrics is compared to a performance from the prior year to determine the PCMH improvement. The improvement percentages for each metric are averaged together to generate the total efficiency score. If the average efficiency improvement percentage results in a negative number, it will be set to 0 and if the calculation exceeds 20% it will be capped at that value.

D. Potential for Annual Outcome Payments: This section provides information on potential (or actual, if it is the annual report) outcome payments. It lists the amount of the potential payment, and details of the calculation of that amount. The outcome payment is calculated as detailed in Section 5.3.4.

E. Total Cost of Care (for reporting only): This section offers provider total cost of care information by care category. The provider TCOC figures are provided on a non-risk adjusted basis for both total cost of care and behavioral health specific cost of case. This section also shows providers how they compare to other Medicaid primary care organizations throughout the state.

Appendix: This section contains more detail on the quality metrics. It includes an indication of whether the provider has met the minimum number of members for each metric and, if not, how many members are included. The section also includes a short description of each quality metric and a visual depiction of the provider performance on each metric as compared to other providers and as compared to the metric threshold for earning a star.

10 PROVIDER TRAINING

TennCare has contracted with Navigant to deliver provider training and technical assistance services to Health Link and PCMH providers across the State. Navigant will help providers make the needed investments in practice transformation across all of their sites. This in-kind training investment is intended as a co-investment with PCMH organizations and not as full coverage for the time, infrastructure, and other investments that practices will need to make.

10.1 Scope of provider training

Navigant will conduct an initial assessment of each PCMH practice that identifies current capabilities. The results of this assessment will allow the trainer to create a custom curricula for each organization to help in meeting transformation milestones. The custom plan will be refined periodically through semi-annual assessments.

The PCMH curriculum will focus on building health care provider capabilities for effective patient population health management to reduce the rate of growth in total cost of care while improving health, quality of care, and patient experience.

This curriculum will include content in the following areas:

a. Delivering integrated physical and behavioral health services;
b. Team-based care and care coordination;
c. Organization workflow redesign and management;
d. Risk stratified and tailored care delivery;
e. Enhanced patient access (e.g., flexible scheduling, expanded hours);
f. Evidence-informed and shared decision making;
g. Developing an integrated care plan;
h. Patient and family engagement (e.g., motivational interviewing);
i. Making meaningful use of Health Information Technology (HIT)/ Health Information Exchange (HIE);
j. Making meaningful use of the care coordination tool (e.g., ADT feeds);
k. Making meaningful use of provider reports;
l. Business support; and
m. Clinical workflow management

Providers will be encouraged to access this curriculum in various ways including:

- **On-site coaching**: on-site coaching for practice staff, e.g., one-on-one coaching sessions with small groups of organization staff including physicians, office managers, care coordinators and/or PCMH Directors.
- **Large format in-person trainings**: large-format regional conferences, trainings, or symposia three times per year in each of the Grand Regions
- **Live webinars**: live, hosted webinars with live Q&A on a quarterly basis
- **Recorded trainings**: recorded video trainings available to providers online on a self-serve basis

- **Compendium of resources**: a library of documents and resources available online

Navigant will also establish and facilitate peer-to peer **learning collaboratives** among organizations to allow PCMH providers to learn from one another's experience. To enable learning and adoption at the organization level, Navigant will create mechanisms for providers to share best practices, to collaborate on common problems, and to adopt and refine evidence-informed protocols.

MCOs may choose to supplement this in-kind training with new or existing programs geared toward PCMH training. Navigant will coordinate support with MCOs to minimize duplication and maximize efficiency for the MCO, vendor, and providers alike. For example, MCOs will be encouraged to join on-site coaching sessions where they will be able to share their performance data and advice directly with PCMH organizations.

10.2 Timeline of provider training

Navigant will begin scheduling initial assessments for both Health Link and PCMH providers in January of each year. Onsite coaching sessions will begin once the initial assessments are complete.

10.3 Duration of provider training

Navigant will develop individualized curricula for both PCMH and Tennessee Health Link that cover the first two years of an organization's transformation.

Payments to Navigant on behalf of a participating organization will continue for 2 years. Over time (i.e., once federal funding is no longer available to support the training and technical assistance vendor), the MCOs will take over the Navigant's training role.

11 CARE COORDINATION TOOL

A shared, multi-payer Care Coordination Tool (CCT) will allow PCMH organizations to better coordinate care for their attributed members. The tool is designed to offer useful, up-to-date information to PCMH organizations.

The State of Tennessee is contracted with Altruista Health for development of the Care Coordination Tool, based on Altruista's Guiding Care platform. Guiding Care is a cloud based tool accessible online. Practices will not have to install any special programs.

Information in the tool will be populated by claims data from the State; MCOs; and Admission, Discharge, and Transfer data received from participating hospitals.

Using the CCT is a provider activity requirement for PCMH; however, we expect PCMH organizations will each use the tool differently after assessing its capabilities and integrating its usage into their current work flows.

11.1 Care Coordination Tool Functionalities

The CCT has several functionalities including:

- Displays providers' attributed member panels;
- Calculates members' risk scores and stratifies providers' panels for more focused outreach;
- Generates, displays, and records closure of gaps-in-care; and
- Displays hospital and ED admission, discharges, and transfers (ADTs).

The tool enables providers to see real-time information about members in need of follow-ups, which will allow providers to manually close gaps in care. At this time, those manual gaps in care closures will not contribute to the quality performance reported from the MCOs each quarter unless a corresponding claim is received to verify the gap has been closed.

11.2 CCT User Expectations

Although daily use of the CCT is not strictly required, it is expected that PCMH organizations will designate staff, ideally care coordinators, to use the tool daily. Any staff using the CCT is expected to abide by patient privacy and confidentiality laws and regulations.

11.3 TennCare Provider Registration Portal (PDMS)

In order for the provider information to display accurately in the CCT, each PCMH must ensure that their registration is up to date in the PDMS.

All individual providers must be **entered and added** into the individual registration portal (PDMS) to be affiliated within the organization's registration. Once an individual provider is registered, they should appear in the Care Coordination Tool for that organization. Each PCMH organization will be responsible for updating its list of providers in the PDMS; the Care Coordination Tool will reflect any changes made in the PDMS within one week.

To register and add individual providers to the PDMS, both of the following steps must be completed:

1. Registration for ALL Individual Providers:
    a. Navigate to: **https://pdms.tenncare.tn.gov/ProviderPersonRegistration/Process/Register.aspx** and complete all entries.
    b. Complete the CAQH profile for the individual provider at: **https://proview.caqh.org/Login.** Note: Please make sure to authorize TennCare access to the information to enable TennCare to receive the file information from CAQH.

2. Adding the Individual Providers to the Entity/Group:
    a. Navigate to **https://pdms.tenncare.tn.gov/Account/Login.aspx** and log in.
    b. Select **Add Affiliations**
    c. Select **Individual Providers**
    d. Select the **green plus sign**
    e. Add the individual provider information (name, individual NPI, and start date).

11.4 How to Access the CCT

Altruista will be responsible for setting up all users with logins and passwords. If you want access to the Care Coordination Tool and haven't received a user name and password yet, contact your practice's point of contact for the Care Coordination Tool. If you do not know who that is, email **hcfa.spigcct@tn.gov**.

Each user will be required to sign security forms to ensure that health information is protected.

Once login credentials have been created and sent to new users via email from Altruista, the Care Coordination Tool landing page can be accessed at: https://tn.guidingcare.com/.

If you have **any issues** with **or questions** regarding the Care Coordination Tool, contact the Altruista Help Desk at 855-596-2491 or support@altruistahealth.com.

11.5 CCT Training Sessions and Materials

Altruista will also deliver online trainings and develop easy to understand self-guided user materials so that providers are comfortable with all functionalities available in the CCT. It is recommended that new users review training materials prior to using the tool. To join an upcoming training session, email **hcfa.spigcct@tn.gov**. Training sessions will be held a few times per year; specific details about the training session dates will be provided via email.

Self-guided training materials can be found on the State's website: https://www.tn.gov/hcfa/article/care-coordination-tool. Updates to the training materials online will be made on an ongoing basis.

11.6 Data in the Care Coordination Tool

Member attribution data in the CCT is derived directly from the Managed Care Organizations and is updated once per week. The primary source of data within the Care Coordination Tool is paid claims which determine patient diagnoses, pharmacy information, risk scores, and gaps in care for members. Please note that information regarding substance use or treatment is not available within the CCT due to federal regulations.

In the future, more member data will be available within the Care Coordination Tool. The State is currently collaborating with the Department of Health in order to determine the feasibility of including immunization data from the Tennessee Immunization Information System (TennIIS) in the CCT. Furthermore, both primary care and behavioral health providers will be able to see when their patients have filled prescriptions in more real-time.

12 QUALITY APPENDIX

TennCare has selected a group of core quality metrics for the PCMH program. TennCare recognizes that this is not the complete set of measures required for a member to be considered compliant across all HEDIS measures. TennCare encourages PCMHs to continue to work closely with the MCOs to identify and close those care opportunities.

The descriptions for HEDIS measures below are based on HEDIS 2016 specifications. Practices will always be measured on the most recent HEDIS specifications available.

TABLE 7 – Core quality metrics

Category	Core metric	Source	Description	Threshold
Quality metrics for adult practices	**Adult BMI assessment**	HEDIS (ABA)	% of patients, ages 18-74 years, with an OP visit whose BMI was documented during the measurement year or the year prior	≥60%
	Antidepressant medication management (adults only)	HEDIS (AMM)	% of 18 and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant regime;	
	– Acute phase	HEDIS (AMM)	% who remained on antidepressant medication for at least 84 days (12 weeks)	≥55%
	– Continuation phase	HEDIS (AMM)	% who remained on antidepressant medication for at least 180 days (6 months)	≥40%
	Comprehensive diabetes care composite number 1		% of patients 18 to 75 years of age with type 1 or type 2 diabetes;	

Category	Core metric	Source	Description	Threshold
	– Comprehensive Diabetes Care: Eye exam (retinal) performed	HEDIS (CDC)	% who had an eye exam (retinal) performed	≥40%
	– Comprehensive Diabetes Care: BP control (<140/90 mm Hg)	HEDIS (CDC)	% whose most recent blood pressure reading is less than 140/90 mm Hg (controlled)	≥50%
	– Comprehensive diabetes care: Medical attention for nephropathy	HEDIS (CDC)	% who received medical attention for nephropathy	≥85%
	Comprehensive diabetes care composite number 2		% of patients 18 to 75 years of age with type 1 or type 2 diabetes who	
	– Comprehensive diabetes care: Hemoglobin A1c (HbA1c) testing	HEDIS (CDC)	% with HbA1c test performed in the measurement year	≥85%
	– Comprehensive diabetes care: HbA1c poor control (>9.0%)	HEDIS (CDC)	% with most recent HbA1c level during the measurement year greater than 9.0%	≤50%
	EPSDT: Adolescent well-care visits age 12-21	HEDIS (AWC)	Percentage of enrolled patients 12-21 years of age who had at least one comprehensive well-care visit with a PCP	≥45%

Category	Core metric	Source	Description	Threshold
			or OB/GYN during the measurement year	
Quality metrics for pediatric practices	**EPSDT (composite for older kids)**			
	– EPSDT: Well-child visits ages 7-11 years	TennCare	Percentage of patients 7-11 years of age who had one or more well-child visits with a PCP during the measurement year	≥55%
	– EPSDT: Adolescent well-care visits age 12-21	HEDIS (AWC)	Percentage of enrolled patients 12-21 years of age who had at least one comprehensive well-care visit with a PCP or OB/GYN during the measurement year	≥45%
	EPSDT (composite for younger kids)			
	– EPSDT: Well-child visits first 15 months – 6 or more visits	HEDIS (W15)	Percentage of patients who turned 15 months of age during the measurement year and who had 6+ well-child visits with a PCP during their first 15 months of life	≥45%
	– EPSDT: Well-child visits at 18, 24, & 30 months	TennCare	The percentage of members who turned 35 months old during the measurement timeframe who had at least one well-child	≥34%

Category	Core metric	Source	Description	Threshold
			visit within each of the following intervals: • 2 weeks before 18 month up to 2 weeks before 24 months • 2 weeks before 24 month up to 2 weeks before 30 months • 2 weeks before 30 month up to 35 months • Total: at least one visit during each of the three intervals above	
	– EPSDT: Well-child visits ages 3-6 years	HEDIS (W34)	Percentage of patients 3-6 years of age who had one or more well-child visits with a PCP during the measurement year	≥65%
	Asthma medication management	HEDIS (MMA)	The % of members during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. The rate included in this measure is the % of members in this	≥30%

Category	Core metric	Source	Description	Threshold
			age group who remained on an asthma controller medication for at least 75% of their treatment – Total rate	
	Immunization composite metric (children and adolescents only)			
	– Childhood immunizations – Combination 3	HEDIS (CIS)	% children 2 years of age who had 4 DTaP), 3 polio, 1 MMR, 3 HiB, 3 HepB, 1 VZV, and 4 PCV by their second birthday	≥45%
	– Immunizations for adolescents – Total rate	HEDIS (IMA)	The % of adolescents 13 years of age who had one dose of meningococcal vaccine and one Tdap by their 13th birthday	≥65%
	Weight assessment and nutritional counseling for children/adolescents	HEDIS (WCC)	Weight assessment and counseling for children/adolescents ages 3-17, defined as:	
	– BMI percentile	HEDIS (WCC)	BMI percentile: % of members who had an outpatient visit with a PCP or OB/GYN and whose body mass index (BMI) was documented during	≥30%

Category	Core metric	Source	Description	Threshold
			the measurement year or the year prior to the measurement year.	
	– Counseling for nutrition	HEDIS (WCC)	Counseling for nutrition: % of member who had an outpatient visit with a PCP or OB/GYN who had evidence of counseling for nutrition during the measurement year	≥30%
Quality metrics for family practices	**EPSDT (composite for older kids)**			
	– EPSDT: Well-child visits ages 7-11 years	TennCare	Percentage of patients 7-11 years of age who had one or more well-child visits with a PCP during the measurement year	≥55%
	– EPSDT: Adolescent well-care visits age 12-21	HEDIS (AWC)	Percentage of enrolled patients 12-21 years of age who had at least one comprehensive well-care visit with a PCP or OB/GYN during the measurement year	≥45%
	EPSDT (Composite for younger kids)			
	– EPSDT: Well-child visits first 15 months – 6 or more visits	HEDIS (W15)	Percentage of patients who turned 15 months of age during the measurement year	≥45%

Category	Core metric	Source	Description	Threshold
			and who had 6+ well-child visits with a PCP during their first 15 months of life	
	– EPSDT: Well-child visits at 18, 24, & 30 months	TennCare	Percentage of patients who turned 30 months of age during the measurement year and who had one or more well-child visits with a PCP by 18, 24, and 30 months of age	≥34%
	EPSDT: Well-child visits ages 3-6 years	HEDIS (W34)	Percentage of patients 3-6 years of age who had one or more well-child visits with a PCP during the measurement year	≥65%
	Immunization composite metric (children and adolescents only)			
	– Childhood immunizations – Combination 3	HEDIS (CIS)	% children 2 years of age who had 4 DTaP), 3 polio, 1 MMR, 3 HiB, 3 HepB, 1 VZV, and 4 PCV by their second birthday	≥45%
	– Immunizations for adolescents – Total rate	HEDIS (IMA)	The % of adolescents 13 years of age who had one dose of meningococcal vaccine and one	≥65%

Category	Core metric	Source	Description	Threshold
			Tdap by their 13th birthday	
	Asthma medication management	HEDIS (MMA)	The % of members during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. The rate included in this measure is the % of members in this age group who remained on an asthma controller medication for at least 75% of their treatment – Total rate	≥30%
	Adult BMI assessment	HEDIS (ABA)	% of patients, ages 18-74 years, with an OP visit whose BMI was documented during the measurement year or the year prior	≥60%
	Weight assessment and counseling for nutrition for children/adolescents	HEDIS (WCC)	Weight assessment and counseling for children/adolescents ages 3-17, defined as:	
	– BMI percentile	HEDIS (WCC)	BMI percentile: % of members who had an outpatient visit with a PCP or	≥30%

Category	Core metric	Source	Description	Threshold
			OB/GYN and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year.	
	– Counseling for nutrition	HEDIS (WCC)	Counseling for nutrition: % of members who had an outpatient visit with a PCP or OB/GYN who had evidence of counseling for nutrition during the measurement year	≥30%
	Antidepressant medication management (adults only) [1]	HEDIS (AMM)	% of 18 and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant regime; report	
	– Acute phase	HEDIS (AMM)	% who remained on antidepressant medication for at least 84 days (12 weeks)	≥55%
	– Continuation phase	HEDIS (AMM)	% who remained on antidepressant medication for at least 180 days (6 mo.)	≥40%
	Comprehensive diabetes care composite number 1		% of patients 18 to 75 years of age with type 1 or type 2 diabetes who	

Category	Core metric	Source	Description	Threshold
	Comprehensive Diabetes Care: Eye exam (retinal) performed	HEDIS (CDC)	% who had an eye exam (retinal) performed	≥40%
	Comprehensive Diabetes Care: BP control (<140/90 mm Hg)	HEDIS (CDC)	% whose most recent blood pressure reading is less than 140/90 mm Hg (controlled)	≥50%
	Comprehensive diabetes care: Medical attention for nephropathy	HEDIS (CDC)	% who received medical attention for nephropathy	≥85%
	Comprehensive diabetes care composite number 2		% of patients 18 to 75 years of age with type 1 or type 2 diabetes who	
	Comprehensive diabetes care: Hemoglobin A1c (HbA1c) testing	HEDIS (CDC)	% with HbA1c test performed in the measurement year	≥85%
	Comprehensive diabetes care: HbA1c poor control (>9.0%)	HEDIS (CDC)	% with most recent HbA1c level during the measurement year greater than 9.0%	≤50%

[1] Designates a unique HEDIS reporting timeframe that is not based on information with a date of service during a standard calendar year.

TABLE 8 – Core efficiency metrics
Each MCO will set thresholds for core efficiency metrics. The State has provided each MCO guidance on setting these thresholds. This guidance can be found on the State's PCMH website.

Category	Core metric	Source	Description
Efficiency metrics	**All-cause hospital readmissions rate per 1,000 member months**	HEDIS (PCR)	For patients 18 years of age and older, number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days (non-risk adjusted) per 1,000 member months
	Avoidable ED visits per 1,000 member months	TennCare, adapted from IOM/ Michigan	Number of ED visits for ambulatory care sensitive conditions (ACSC), per 1,000 member months, based on ACSCs as defined by the Institute of Medicine
	Ambulatory care - ED visits per 1,000 member months	HEDIS (AMB)	Number of ED visits per 1,000 member months
	Inpatient admissions per 1,000 member months – Total inpatient	HEDIS (IPU)	Number of acute inpatient admissions per 1,000 member months
	Mental health utilization per 1,000 member months - Inpatient	HEDIS (MPT)	Inpatient mental health services during the measurement year per 1,000 member months

TABLE 9- Total cost of care categories

Each PCMH organization will receive a breakdown of their TCOC by category in each quarterly report. Only high volume PCMHs will generate outcome payments based on these values.

Category	Description
Inpatient facility	All services provided during an inpatient facility stay including room and board, recovery room, operating room and other services.
Emergency department or observation	All services delivered in an Emergency Department or Observation Room setting including facility and professional services.
Outpatient facility	All services delivered by a facility during an outpatient surgical encounter, including operating and recovery room and other services.
Inpatient professional	Services delivered by a professional provider during an inpatient hospital stay, including patient visits and consultations, surgery and diagnostic tests.
Outpatient laboratory	All laboratory services in an inpatient, outpatient or professional setting.
Outpatient radiology	All radiology services such as MRI, X-Ray, CT and PET scan performed in an inpatient, outpatient or professional setting.
Outpatient professional	Uncategorized professional claims such as evaluation and management, health screenings and specialists visits.
Pharmacy	Any pharmacy claims billed under the pharmacy or medical benefit with a valid National Drug Code.
Other	PCMH support payments, DME, transportation, Home health and any remaining uncategorized claims.

For purposes of the PCMH program, there are four categories of spending excluded from the TCOC calculation:

- Dental
- Transportation
- NICU and nursery
- Any spending during the first month of life
- Mobile Crisis Capitation payments