



i. Model Test Project Narrative

Tennessee is an excellent choice for a State Innovation Model (SIM) testing grant because the state can deliver comprehensive statewide payment reform. Tennessee is poised for success:

Leadership of Governor Haslam: Governor Haslam launched Tennessee’s Health Care Innovation Initiative with a speech to a joint session of Tennessee’s legislature. The Governor meets with stakeholders and is a tireless supporter of getting to value-based health care.

Stakeholder Support: All influential groups in the state are supportive of Tennessee’s approach and have submitted letters of support for this grant (70 letters total).

Demonstrated Success: Tennessee is already moving forward on each of its strategies, including implementing the first wave of three episodes of care to over 500 providers statewide with the four major commercial payers, all three TennCare (Medicaid) Managed Care Organizations (MCOs), and CoverKids, TN’s Children’s Health Insurance Program (CHIP).

Complete Leveraging of Tennessee’s Purchasing Power: Tennessee’s Benefits Administration, TennCare, and CoverKids participate as partners in the initiative and all require participation in payment and delivery system reform in their contracts. In TennCare’s latest procurement, the state received binding commitments for participation in the SIM health care initiative from each MCO’s commercial lines of business and Medicare Advantage plans, in addition to Medicaid.

A Comprehensive Approach: Tennessee’s strategies address population health and health care; primary care, acute care, and Long Term Services and Supports (LTSS); health care professionals and facilities; physical and behavioral health; providers of all sizes; children and adults; disabled and non-disabled—all statewide.

Part 1: Health Care Delivery System Transformation in Tennessee

Over the next five years, the initiative plans to reach over 80% of the state's population with value-based payment and delivery models. The initiative includes payers who cover 3.86 million Tennesseans; with the additional participation of Medicare fee-for-service, 83% of Tennessee's population will be covered by a participating plan.

Governor Haslam is negotiating with the Federal Government to increase health insurance coverage in the state. The Governor has been clear that the expansion of government-sponsored health coverage is contingent upon significant reform of Tennessee's health care payment and delivery system.

Payer Participation: Tennessee's approach to leveraging the health care purchasing power of the state can be a model for other states. Tennessee is fully leveraging state purchasing power through the joint efforts of TennCare, CoverKids, and Benefits Administration, and working with a coalition of commercial insurance carriers. TennCare contractually requires its three MCOs—Amerigroup/Wellpoint, BlueCross BlueShield of Tennessee (BCBST), and UnitedHealthcare—to participate in payment and delivery system reform for the 1.3 million TennCare members. In addition, in the most recent request for proposals process, Tennessee solicited and received binding commitments from MCOs to have their commercial insurance and Medicare Advantage lines of business fully participate in the initiative. CoverKids includes payment and delivery system reform in its contract with BCBST covering 68,000 members.

Tennessee's Division of Benefits Administration, the largest self-insured employer plan in Tennessee, requires its two ASOs—BCBST and Cigna—to participate in payment and delivery system reform for its 277,000 members including employees, dependents, and retirees of the state, higher education, local education agencies, and local government. Benefits

Administration already has an impressive track record of pursuing value based design, receiving the 2012 Employer Excellence in Value-Based Purchasing Award at the National Business Coalition on Health's annual conference. The Executive Director of Benefits Administration is an ambassador to other large employers in the state, and has discussed the initiative one-on-one with employers as well as presented in conferences organized by Tennessee's employer health care purchaser coalitions. The initiative has also held multiple meetings with other interested commercial insurers to lay the groundwork for future participation: Aetna and Community Health Alliance, a new market entrant and Tennessee's CO-OP plan.

Provider Participation: Tennessee providers are engaged in health care delivery system transformation through the initiative's extensive stakeholder process and outreach efforts. The initiative has participated in over 220 stakeholder meetings with Tennessee providers (see Stakeholder Engagement on page 19). Already, more than 500 unique providers have received episode of care reports, and the initiative plans to add cost and quality reports for primary care providers (PCPs), Health Homes, and LTSS providers.

Tennessee's strategies for payment and delivery system reform are designed to work together to give Tennessee providers across the care continuum the ability to coordinate care in a virtually integrated delivery model. Tennessee providers will receive information in the form of reports and Health Information Technology (HIT) that tells them about their patient's experience with other health care providers. When Tennessee providers coordinate their patient's care across providers and settings, they will be rewarded for doing so. Starting in 2015, every member of the TennCare program will have a provider group that is uniquely responsible for the member's primary care. Those PCPs will be accountable for the total cost and quality of their patients' health care. Similarly, specialists will be accountable for the cost and quality of acute episodes of

care and LTSS providers will be accountable for the cost and quality of care for individuals receiving their services. Population health measures will be integrated into the delivery system as quality measures for primary care and LTSS.

Part 2: Three Strategies for Payment and Delivery System Reform

The initiative will pursue three statewide payment and delivery system reform strategies that make up a comprehensive whole. The state anticipates that these strategies will improve quality of care, improve the patient experience of care, and lead to an estimated system-wide cost avoidance of \$2.23 billion after delivery system reinvestments during the four-year grant period compared with baseline projections. Four-year projections include cost avoidance of \$742 million to Medicaid and CHIP after reinvestments (see the Financial Analysis). In the years following the grant period, estimated cost avoidance is an annualized \$2 billion versus baseline.

Strategy 1: Primary Care Transformation: Primary Care Transformation will assist primary care providers in achieving all elements of the Triple Aim. Practices will promote better care through care coordination and proactive closing of gaps in care (e.g., following up to ensure that a diabetic patient receives recommended A1C screenings, foot and eye exams). Practices will promote better population health by shifting the focus of care towards prevention, health maintenance, and proactive management of chronic conditions. Patient Centered Medical Homes (PCMHs) will reward providers for addressing the social and behavioral determinants of health such as discussing environmental asthma triggers with parents, connecting tobacco users to the Tennessee Tobacco Quitline, and connecting patients to community social services. Finally, population-based payment models will reduce the cost of care through total cost of care accountability with reporting and financial incentives.

Adult Patient-Centered Medical Homes:

Tennessee will build on the existing PCMH efforts by providers and payers in Tennessee to create a robust PCMH program that features alignment across payers on critical elements. There are already 560 PCPs in Tennessee recognized by the National Committee for Quality Assurance (NCQA) as a PCMH, and all of the major insurance companies in Tennessee have implemented a medical home program. However, the impact of the medical home programs in Tennessee is muted by the differences between them. Providers complain that it is impossible to participate in a PCMH program with more than one payer because of separate systems and divergent incentives. At the same time, many providers that could participate in PCMH programs based on all of their members find that their patient panel with any one payer is too small.

The initiative will lead a multi-payer PCMH approach for a greater impact. The major payers in Tennessee have agreed to adopt a multi-payer population-based approach and have signed a “Joint Statement of Intent for Population-Based Models,” committing to have 80% of members across books of business cared for through a population-based model within five years. The state will lead by example by requiring the three TennCare MCOs to participate in a statewide joint PCMH program and will incorporate commercial payers starting with 12 practices in Knoxville and Memphis and building up to a statewide aligned commercial and

Tennessee is Ready to Implement Primary Care Transformation

- A partnership is in place for NCQA to lend its expertise to stakeholder discussions of quality and outcomes-based measures for Tennessee’s primary care transformation strategy. Tennessee and NCQA have a history of partnering as Tennessee was the first state to require all Medicaid MCOs to be NCQA accredited.
- A partnership is in place for the Tennessee Chapter of the American Academy of Pediatricians (TNAAP) to train pediatricians in quality improvement.
- Stakeholders are universally supportive of PCMH and Health Homes.
- Legislation passed this year allows community mental health centers (CMHCs) to hire primary care physicians.

Medicaid PCMH program. If Tennessee is awarded a SIM grant, then the initiative will convene a Technical Advisory Group (TAG) of Tennessee clinical experts to advise on the clinical details of the multi-payer PCMH program. Design elements of the multi-payer program will include:

- Goals: Tennessee stakeholders agree on the goals for Tennessee's PCMH program.
- Measures: Tennessee, in partnership with NCQA, will work with the TAG to set common quality, cost, process, and utilization measures.
- Attribution: Tennessee's PCMH approach will feature prospective attribution of every member of a participating payer to a single PCP.
- Reporting: The initiative will support the creation of a common reporting template that payers will use to show the quality and cost of their patients' health care experience.
- Real time information: The state will make a significant investment in health information exchange to support primary care transformation (see HIT on page 16).
- Training and Coaching: The initiative will use SIM funds to support a common training partner for all participating providers.
- Payment: Different approaches to PCMH payment make sense for providers with different sized patient panels, different levels of PCMH readiness, and urban and rural providers. Therefore the initiative will not set a single payment approach but will create a menu of options for providers and payers to agree upon. The common goals and measures will also create alignment between providers' approaches to payment.

Pediatric Patient-Centered Medical Homes: Tennessee will partner with TNAAP to implement a portfolio of quality improvement projects working with Tennessee pediatricians to meet the distinct health care needs of infants, children and adolescents. Since 2008, TNAAP has collaborated with the Bureau of TennCare in a multi-year medical home implementation project

to promote Pediatric PCMH implementation across the state. TNAAP has evaluated barriers to implementation for pediatricians, dissected practical workflows, job descriptions, and practice processes, participated in PCMH pilots to better understand the features of successful pilots, educated practices on strategies for PCMH development, and provided technical assistance to practices working to implement PCMH.

Health Homes: If Tennessee is awarded a SIM testing grant, the state will work with providers to achieve integrated and value-based behavioral and primary care services for people with Severe and Persistent Mental Illness (SPMI). The state will leverage the enhanced federal match for Health Homes to offer prospective payments for care coordination and case management for these providers for two years, coupled with SIM-supported training and capacity building, and quarterly cost and quality reporting. These two years will provide a bridge at the end of which providers will be ready to receive value-based payments tied to process and outcome measures of quality and utilization on both behavioral health and primary care.

Integrated and value-based payment and delivery of care will improve clinical outcomes, quality of care, and patient experience for Tennesseans with SPMI, who have a great need for improved coordinated care. At a national level, adults with SPMI die, on average, 25 years earlier than the general population.¹ In Tennessee, TennCare members with SPMI have higher rates of chronic disease and over twice as many Emergency Department (ED) visits as other TennCare members. Tennessee has taken significant steps to make integrated behavioral and primary care possible. TennCare integrated the administration of physical and behavioral health (including substance use disorders) within each MCO in 2007. As a result, providers have taken

¹ Parks J et al., *Mortality and Morbidity in People with Serious Mental Illness*, National Association of State Mental Health Program Directors, October 2006.

a number of approaches to integrate physical and behavioral care. CMHCs and Federally Qualified Health Centers (FQHCs) such as Cherokee Health, Mental Health Cooperative, and Centerstone are examples of providers who have already integrated care for people with SPMI in Tennessee.

Strategy 2: Retrospective Episodes of Care: Building on the successful implementation of the first wave of episodes, Tennessee will continue to address value-based payment and delivery system reform through the development and implementation of episodes of care. If the state receives SIM funding, the initiative will add additional episodes every six months with a goal of implementing 75 episodes within five years. Episodes align actionable information and rewards for acute care providers to successfully achieve a patient’s desired outcome during an “episode of care,” a clinical situation with predictable start and end points.

Payers participating in the initiative are sending Principal Accountable Providers (also called “quarterbacks”) actionable information about the episodes of care for which they are accountable. In May, over 500 quarterbacks started to receive quarterly reports showing underlying costs and quality indicators for their episodes, including relevant services their patients receive from other health care providers. Quarterbacks are able to assess their performance relative to other quarterbacks in the state. The initiative gathered feedback from provider and payer stakeholders to ensure that the report design was clear and actionable.

<p><u>Tennessee is Ready to Implement Episodes of Care</u></p> <ul style="list-style-type: none">▪ Reports on three episodes (representing 10% of medical spend) were released to over 500 providers across Tennessee in May 2014.▪ Tennessee is currently designing five new episodes.▪ Tennessee has a contract with McKinsey & Company to design 75 episodes in five years.
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With SIM support the Tennessee Hospital Association (THA) will undertake a project to provide additional analysis on episode performance to hospitals for internal use and to inform conversations between hospitals and other providers involved in an episode. THA already partners with the Tennessee Department of Health (DOH) to collect hospital discharge data for public health uses. THA will analyze this data and use a web-based tool to display hospitals' risk adjusted average charges, average cost, and length of stay and specific utilization of physicians practicing at the hospital benchmarked against a peer group of all other physicians practicing in that hospital and across the state.

Quarterbacks will be financially rewarded for high quality and efficient care across the episode. Providers will share in the savings achieved when their patients receive high-quality, efficient care, or in the excess costs if their patients' care is considerably above average cost. Each payer will analyze the episodes occurring during a quarterback's one year performance period and calculate average costs for each quarterback, as well as performance on quality metrics (including the relevant services their patients received from other providers).

Episodes address the fragmentation of care, reward high-quality care, promote the use of clinical pathways and evidence-based guidelines, encourage coordination, and reduce ineffective and/or inappropriate care. Patients will experience better coordinated care across providers and improved quality of care. The episodes strategy has the benefit of being relevant and workable for all current Tennessee providers in a short timeframe. Unlike prospective payments such as bundled payments, episodes can be implemented for small and large providers, independent providers and integrated Accountable Care Organizations (ACOs), urban and rural, without any changes to providers' infrastructure or business relationships.

For every episode, the initiative will convene a TAG of Tennessee clinicians with expertise in the relevant area to advise on design elements such as:

- The principal accountable provider who is in the best position to influence the quality and cost of the overall outcome of the episode.
- The types of health care services that are related to the treatment of one acute health care event and should be included in the episode.
- Quality measures that should be included in the episode to ensure that care meets evidence-based standards and to protect against underuse of care.
- The sources of value associated with each episode of care.

Strategy 3: Long Term Services and Supports Reform: Tennessee will implement quality- and acuity-based payment and delivery system reform for LTSS, including Nursing Facility (NF) services and Home and Community Based Services (HCBS) for seniors and adults with physical, intellectual and developmental disabilities (I/DD). The initiative’s approach will combine a quality measure framework focused on the member experience that is consistent across care settings, quality- and acuity-based payments, and workforce development.

Tennessee has a record of successfully implementing innovations in LTSS, especially the

Tennessee is Ready to Implement LTSS Reform

- Demonstrated success of the Choices Act passed unanimously by the legislature and rebalanced the use of HCBS from 17 percent to 40 percent.
- QuILTSS stakeholder process to gather input on NF and HCBS quality measures and payment approach completed in November 2013.
- Tennessee is already a leader in approach and payment for ERC.
- White paper on I/DD LTSS care released June 2014 for public comment.

landmark CHOICES program,² but Tennessee's LTSS payment and delivery system faces challenges due in part to its cost-based reimbursement system. Quality performance is not uniformly recognized or rewarded under the current system. Tennessee facilities are 48th in the nation in the Center for Medicare and Medicaid Services (CMS) Five-Star Quality Rating System, and only half of Tennessee facilities participate in Advancing Excellence in America's Nursing Homes Campaign. HCBS' do not have uniform applicable quality measures. Average per capita waiver expenditures for persons with I/DD are double the national average, while there are almost as many people waiting to receive HCBS (approximately 7,000) as are currently enrolled in these programs.

Quality- and Acuity-Based Payment for NFs and HCBS: Under the Quality Improvement in Long-Term Services and Supports (QuILTSS) initiative, NF payment will be based in part on residents' assessed levels of need and adjusted based on quality metrics. HCBS payments will be adjusted to incorporate the same quality metrics when they apply across service delivery settings, along with modified and additional quality metrics specific to HCBS (see Quality Measure Alignment on page 22). These changes will reward providers that improve the member's experience of care and promote a person-centered care delivery model.

For individuals with I/DD, Tennessee will apply quality and acuity-based payments to address inequities in the system, encourage appropriate high-quality and efficient care, and increase the number of people who can be served. In addition to paying for integrated, competitive employment outcomes, the initiative will use the Supports Intensity Scale (SIS) tool to measure support needs in the areas of home living, community living, lifelong learning,

² The CHOICES program, authorized by legislation passed in 2008, aligned TennCare's LTSS payments with the goals of allowing beneficiaries to remain in their home as long as possible, and ensuring that the array of HCBS provided to members living in the community is appropriate and sufficient.

employment, health and safety, social activities, and protection and advocacy. Tennessee will partner with experts to test a new version of a supplement to the SIS intended to help fully account for specialized support needs of certain individuals. The data will be used to establish a methodology for payment of certain services (primarily residential) and in the proposed new Managed LTSS program, to set an annual services and supports budget for individuals with more comprehensive levels of need. The individual can direct that the budget be managed by a fiscal employer agent, an agency that coordinates physical and behavioral health services in addition to HCBS, or a person-centered planning process led by an MCO that coordinates physical and behavioral health and LTSS.

Value-Based Purchasing Initiative for Enhanced Respiratory Care (ERC): TennCare will revise its reimbursement structure for ERC services in a NF, using a point system to adjust rates based on the facility's performance on key performance indicators (e.g., rates of liberation, decannulation, infection, unplanned hospitalization and death; and the use of advanced technology to improve quality of care and quality of life). This will be combined with strengthened standards of care, and educational programs to promote quality and best practices.

Workforce Development: Through its extensive stakeholder input processes, Tennessee has identified that one of the most critical aspects of LTSS value pertains to the level of training and competency of professionals delivering direct supports—whether in a NF or in the community. Therefore the initiative will invest in the development of a comprehensive training program for individuals paid to deliver LTSS. Since staff training will be an important quality measure and will also impact a provider's success across other measures, agencies employing better trained and qualified staff will be appropriately compensated for the higher quality of care experienced by individuals they serve.

Part 3. A Plan for Improving Population Health

The DOH will lead the development of a statewide plan for improving population health. The DOH currently has the legislatively mandated responsibility to maintain and update a State Health Plan that is approved and adopted by the Governor annually. With SIM support, the Plan will be enhanced through the development of specific and measurable goals, an increased focus on population health improvements and addressing disparities, and specific commitments from stakeholders to actions that support the goals using

the following steps of a year-long process:

(1) In early 2015 state officials will hold a two-day conclave with Centers for Disease Control (CDC) for federal and state officials to discuss ideas, strategies and initiatives to inform the rest of the process. (2) A regional process to identify goals and

Tennessee is Ready to Implement a Population Health Plan

- Tennessee already produces a legislatively required annual State Health Plan.
- The State Health Plan is considered in all Certificate of Need applications.

measurable objectives will be led by at least one university academic public health program from each of the three grand regions of Tennessee. The DOH will share population health and county level Community Health Assessments data with the universities to inform their approaches to draft regional goals and objectives and gather public input on population health priority topics (obesity, diabetes, tobacco, child health, and perinatal health). (3) Each sample regional plan will be presented at a statewide meeting to assure relevance, adoption and elaboration for statewide use. (4) The overall plan will be presented at a statewide conference of key associations and stakeholders, each of which would be requested to gather their members' input and solidify commitment to the Plan. The conference will engage other public and private entities including the Governor's Foundation for Health and Wellness, major health care systems, insurance

carriers and advocacy groups. (5) The final draft plan including statements of commitments will be presented to the Governor.

Part 4. Leveraging Regulatory Authority

Tennessee is committed to taking advantage of regulatory levers to improve the performance and efficiency of the health care system and to improve the health of Tennesseans.

Primary Care Transformation: Tennessee's efforts to increase the integration of physical and behavioral health care providers, especially for people with serious mental illness through the Health Homes program, would not be possible without legislation passed in 2014 that allows CMHCs to hire primary care physicians.³

Aligning State Issuer Regulations to Reinforce Payment Reform: Tennessee has made the necessary legal changes to facilitate payment reform. Recently-enacted changes to its health maintenance organization (HMO) licensure statute expressly allow for risk-sharing arrangements between HMOs (including TennCare MCOs) and physician-hospital organizations, other providers or provider groups, or provider networks.⁴ This new statutory authority now permits the types of payment reforms proposed in this grant.

Tennessee's LTSS reforms build on the success of the Choices Act of 2008⁵ by continuing to promote the expansion of HCBS with the goal of allowing Tennesseans to remain in their homes as long as possible. Recently-enacted legislation⁶ allows the state to embed a quality performance component in nursing facility reimbursement methodologies.

³ Pub. Ch. 695 (Acts 2014) codified at TCA § 63-6-204(e).

⁴ Pub. Ch. 409 (Acts 2013) codified at TCA § 56-32-104(a)(3)(E) and 56-2-201(1).

⁵ Pub. Ch. 1190 (Acts 2008). See *also* Administrative Rules Chap. 1200-13-01.

⁶ Pub. Ch. 859 (Acts 2014) codified at TCA § 71-5-2801 *et seq.*

Aligning Certificate of Need (CON) Criteria with Payment Reform: Tennessee is required by law to have a state health plan updated annually and approved by the Governor which covers the topics of population health, access to health care, economic efficiency, health care quality, and health care workforce.⁷ Pursuant to the State Health Plan, Tennessee regulates the establishment and modification of health care institutions, facilities and services through CON. Certificate of Need applications are reviewed by an independent appointed board based on whether the proposed project is consistent with the State Health Plan, as required by the Tennessee Health Services and Planning Act.⁸ Therefore, changes to the State Health Plan as a result of the SIM design grant will align CON criteria with payment and delivery system reform.

Regulatory Approach to Improve Health Care Workforce: Tennessee law promotes an effective, efficient, and appropriate mix of professionals in its health care workforce, with an emphasis on integrative primary care. Tennessee's graduate medical education funding is allocated directly to medical schools, with half of the funding based on primary care residencies. Tennessee's advance practice registered nurses are able to diagnose, treat, and refer patients and prescribe drugs, including controlled substances, under a supervising physician.⁹ As a result, Tennessee has a higher concentration of nurse practitioners (NP) than the national average (91 NPs per 100,000 compared to 58 nationally).¹⁰

Integrating Value-Based Principles Across Payers: Tennessee's approach to leveraging the state's purchasing power to integrate value-based principles across payers is a model for other states to follow. Tennessee currently has an all payer claims database (APCD)

⁷ TCA § 68-11-1625(b).

⁸ TCA § 68-11-1608 (a)(5).

⁹ Pearson, Linda. The Pearson Report 2010. The American Journal for Nurse Practitioners.

¹⁰ Kaiser State Health Facts; calculations based on *The 2012 Pearson Report*, The American Journal for Nurse Practitioners, NP Communications LLC.

law¹¹ that allows the state to conduct system-wide analysis of health care utilization and associated trends across payers.

Part 5. Health Information Technology

Tennessee is working with stakeholders to build the framework for a state HIE. Tennessee's approach is to begin with a statewide shared solution for the most impactful health information exchange: real-time and daily batch Admitting/Discharge/Transfer (ADT) data collected from hospitals and EDs and sent to a care coordination interface for PCPs. Over time additional functions and connectivity will be added to this shared solution to get to full HIE functionality.

Commercial payers and Medicaid MCOs will participate and fund the multi-payer, multi-plan, shared solution. Medicaid MCOs are required by their contract with the state to have a provider that is uniquely responsible for each member's primary care and to send ADT information to those PCPs. The MCOs are committed to collaborating and leveraging the state's Medicaid Management Information System (MMIS) capabilities to create and maintain electronic data interfaces with all of Tennessee's hospitals. Commercial payers see the value of being able to

participate in this shared approach. Providers will benefit from having a single system to use for information on members of their commercial, Medicaid, and CHIP insurance plans.

Tennessee Ready to Implement HIE

- Payers are currently agreeing on scope and meeting with shared solution vendors.
- In 2015, TennCare MCOs are required to ensure that all primary care services are delivered and coordinated by a single attributed PCP and to provide ADT alerts to those PCPs.
- UnitedHealthcare is already collecting ADT feeds from 66 facilities and sharing alerts to 121 practice sites.
- Two public regional HIE systems located in Memphis and Knoxville have 26 hospitals connected and 9 more being on-boarded in 2014.

¹¹ TCA § 56-2-125. See also Administrative Rules § 0780-01-79.

In addition to using the system for ADT information, payers have agreed to send their claims data to the shared solution to generate gaps in care analyses, patient risk scores, and patient prioritization functionality. The shared care coordination solution will be more useful to providers than simple ADT alerts, because it will direct care coordinators to their highest priority patients. The business rules for gaps in care, patient risk score, and patient prioritization will correspond to the quality measures and payment approaches of the multi-payer PCMH and the Health Homes programs. Although the shared care coordination solution will be especially helpful to PCMH and Health Homes practices, all primary care practices will be able to benefit from the new information that is available to them.

SIM funding will support a provider-facing portal that includes single sign-on capability and role-based access for providers to connect all SIM-related provider interfaces. When a provider logs in, the provider will be able to access the shared care coordination solution, link to episode and PCMH reports, and enter non-claims based quality information for episodes and LTSS. Quality measures for our current episodes are all claims-based; however, with the development of this portal, providers will be able to report additional quality measures they feel are critical to future episodes of care.

Tennessee's approach to funding the shared care coordination solution primarily with recurring funding sources ensures sustainability after the grant period. The SIM testing grant will fund the development of a provider-facing portal, and the rest of the solution will be paid for using sources of funding that will continue after the grant period. The centralized state HIE will be integrated with the current state MMIS system for the maintenance and operation of the solution for the Medicaid population with state funds providing the required match. Commercial

payers would contribute a fair share amount based on the volume of their members benefiting from the solution.

The state will be responsible for implementing the ADT feeds for the shared care coordination solution as it will be based on the state's MMIS infrastructure. Commercial payers will be able to enter into contracts with the care coordination interface vendor in order to participate. As more commercial payers join, and as additional HIE functionality and provider connections come on line, the initiative will explore the development of a public/private partnership governance structure.

Tennessee will use SIM grant funds for HIT for providers who are pivotal to the initiative's payment and delivery system approach, but are not currently eligible for meaningful use programs. Behavioral health providers participating in the Health Homes program will be eligible for upgrades to their current Electronic Health Record (EHR) systems, closing the gap in the meaningful use program for these providers.

As of April 2014, 41% of office-based providers overall and 55% of PCPs had adopted at least a "basic" EHR system.¹² Tennessee hospitals overall have a 53% adoption rate of EHRs and 49% of rural hospitals have EHRs. As of May 2014, over 13,500 Medicare and Medicaid EHR Incentive Program payments amounting to \$202 million for health professionals and \$342 million for Tennessee's hospitals have been distributed.¹³

¹² U.S. Department of Health and Human Services, Office of the National Coordinator for Health IT, Health IT Dashboard, <http://dashboard.healthit.gov/quickstats/widget/state-summaries/TN.pdf>

¹³ CMS Electronic health Record Incentive Programs. EHR incentive program payments to eligible providers. <http://dashboard.healthit.gov/meaningfuluse/>

Part 6. Stakeholder Engagement

The initiative will continue the extensive stakeholder consultation process that has proven successful during and since the SIM design grant period. The initiative has met with over 250 stakeholder groups in more than 220 meetings since February 2013, including stakeholder meetings led by Governor Haslam. This application includes 70 letters of support from health care providers, commercial payers, state hospital and medical associations, LTSS providers, consumer advocacy groups, and employers. We engage stakeholders in the following ways:

Public Roundtables: The initiative holds Public Roundtables open to all interested parties, organized by topic with a significant portion of the agenda devoted to soliciting stakeholder questions and feedback. Roundtables include a webinar link and conference line, for participants across the state. At a minimum the initiative will hold eight Roundtable meetings during the grant period. The four Public Roundtables held by the state to date had enthusiastic participation from health care consumers, state and local government agencies, health care advocates, community- and faith-based organizations, providers, payers, self-insured employers, and academic and research institutions including academic medical centers.

Provider Stakeholder Group: The state will continue to convene monthly Provider Stakeholder Group meetings, which include representation from major provider associations across Tennessee and the major payers in the state, including Capella Health, the Children's Hospital Alliance of Tennessee, East Tennessee State University Quillen College of Medicine, Hospital Alliance of Tennessee, Methodist Le Bonheur Healthcare, Tennessee Academy of Family Physicians, Tennessee Academy of Physician Assistants, Tennessee Association of Mental Health Organizations, the Tennessee chapter of the American Academy of Pediatrics, Tennessee Department of Health, Tennessee Department of Mental Health and Substance Abuse

Services, Tennessee Hospital Association, Tennessee Medical Association (TMA), Tennessee Nurses Association, Tennessee Orthopedic Society, Tennessee Primary Care Association, and the University of Tennessee Health Science Center School of Medicine. BCBST, UnitedHealthcare, Amerigroup/Wellpoint, and Cigna also participate in these meetings. Monthly provider meetings have been ongoing since May 2013.

Payer Coalition: The state will continue to convene bi-weekly meetings of the Payer Coalition, which includes representation from each of the major payers in the state- Amerigroup/Wellpoint, BCBST, Cigna, and UnitedHealthcare. Both commercial and Medicaid plans are represented. Payer meetings have been ongoing since May 2013.

Long-Term Services and Supports Stakeholder Process: The state recently completed an in-depth stakeholder process around QuILTSS, including 18 Community Forums; two in each of the nine regions across the state (one for TennCare members, their family and community members, and one for providers), and dialogue with key stakeholder groups to develop a quality framework for NF reimbursement, with work ongoing for HCBS. TennCare also hosted similar regional community meetings with consumers, family members, and providers around HCBS for individuals with I/DD, and gathered feedback through an online survey and one-on-one meetings.

Technical Advisory Groups (TAGs): The state will continue to convene TAGs to deliver recommendations around all episodes of care, and will convene TAGs to get clinical input on PCMHs and Health Homes. TAGs will have representation across provider type, the state's three regions, rural and urban locations, and type of practice. The state will solicit nominations for TAG members from providers, payers, and other stakeholders. Each TAG will meet 3 times to complete their recommendations. TAGs around episodes of care will provide

input on design elements including the patient journey and pathways of care, appropriate quality metrics, and measures to ensure fairness to and protections for providers. Primary Care Transformation TAGs will provide feedback on quality metrics, provider report design, and the criteria for selecting practices included in the multi-payer PCMH pilot. The state hosted 3 TAGs for each of the first wave episodes in 2013, consisting of 12-16 providers each.

Employer engagement: The state will continue to reach out to employers in the state around payment and delivery system reform. The state held two webinars for employers, and is working with regional and state Chambers of Commerce, the HealthCare21 Business Coalition, the Memphis Business Group on Health, and the Common Table Health Alliance to engage employers. These groups serve as a channel for employer input and feedback. Representatives from the initiative have also met individually with employers to provide updates and solicit input. The state is also a member of the Catalyst for Payment Reform, which provides opportunities to engage with national employers and health care purchasers.

Legislative engagement: The state will continue to brief members of the state Legislature on the initiative. This year the state reached all members of Tennessee's legislature through a combination of testimony at five legislative committee and budget hearings, and 19 individual meetings with legislators.

Additional stakeholder meetings: The initiative engages regularly in many other forms of dialogue with individuals and institutions to understand their perspectives and gather input. Representatives of the initiative will continue to meet with stakeholders. In addition, the Tennessee Medical Association will hire a Payment and Delivery System Ombudsman, partially funded by the SIM grant, which will be dedicated to educating doctors and other providers about payment and delivery system reform.

Part 7. Quality Measure Alignment

The initiative and Tennessee stakeholders are committed to statewide quality measure alignment across payers in order to increase the impact on health care quality and outcomes, improve reporting timeliness and accuracy, and reduce the administrative burden on providers. The initiative will align quality measures in each of its strategies. In each strategy, Tennessee stakeholder input is solicited on the selection of quality measures. All Tennessee stakeholders have demonstrated a preference for existing and nationally endorsed measures. In each strategy, the state will use SIM grant funds to support the development of multi-payer technological solutions that simplify the reporting of quality measures for providers.

Primary Care Transformation: The state will gather general Tennessee stakeholder input and will convene TAG meetings to solicit expert clinical advice on the multi-payer quality measures for its primary care transformation approaches. These measures will be used not only in reports to providers participating in the PCMH and Health Homes programs, but also to PCPs not participating in these programs. NCQA will partner with Tennessee to lend their expertise on primary care quality measurement. NCQA staff will participate in the TAG meetings as well.

Tennessee stakeholders agree that the PCMH program should focus on outcomes where possible; examples of outcomes measures are: avoidable ED visits, avoidable hospitalizations, and total cost of care. Potential process measures include the percent of patients actively engaged by the provider. Quality measures that the TAG will consider could include: rates of controlled high blood pressure and diabetes and screening rates for clinical depression and follow-up plan. The shared care coordination solution discussed in detail in Part 5 on page 16 will allow providers to indicate that gaps in care related to quality measures have been closed even when that information is unavailable in claims data.

Episodes of Care: All payers participating in the initiative have agreed to track providers’ performance on aligned quality metrics and are reporting to providers on Wave 1 episodes using the exact recommendations of the TAGs. The TAGs decided on seven asthma-specific quality metrics, seven quality metrics for perinatal, and five quality metrics for total joint replacement (hip and knee) (see Exhibit 1). TAGs will be convened for future episodes of care and expert clinicians participating in the TAGs will recommend quality measures specific to each episode.

Exhibit 1: Wave 1 Episode-specific Quality Metrics		
Asthma Exacerbation	Total Joint Replacement	Perinatal
<ul style="list-style-type: none"> ➤ Follow-up visit rate (linked to gain sharing) ➤ Percent of patients on an appropriate medication (linked to gain sharing) ➤ Repeat asthma exacerbation rate ➤ Inpatient admission rate ➤ Percent of episodes with chest x-ray ➤ Rate of patient self-management education ➤ Percent of episodes with smoking cessation counseling offered 	<ul style="list-style-type: none"> ➤ 30 day readmission rate (linked to gain sharing) ➤ Frequency of post-op DVT/PE (30 days post-surgery) ➤ Frequency of post-op wound infection (90 days post-surgery) ➤ Frequency of dislocations or fractures (90 days post-surgery) ➤ Average length of stay 	<ul style="list-style-type: none"> ➤ HIV screening rate (linked to gain sharing) ➤ Group B streptococcus screening rate (linked to gain sharing) ➤ Overall C-section rate (linked to gain sharing) ➤ Gestational diabetes screening rate ➤ Asymptomatic bacteriuria screening rate ➤ Hepatitis B screening rate ➤ Tdap vaccination rate

With SIM funding, Tennessee will review episodes with stakeholders after the first performance period is complete and make adjustments to the quality measures based on that

feedback. Individual performance on the quality measures is reported to providers through quarterly reports. All payers are using the same quality metrics and thresholds.

LTSS value-based purchasing initiatives: QuILTSS – TennCare’s value-based purchasing initiative to promote quality improvement in Nursing Facilities and Home and Community-Based Services – is focused in part on providers’ performance on specified quality measures. An extensive stakeholder process allowed the state to collect input from over 1,200 participants, including providers and consumers, on indicators of quality in LTSS services. Based on this input, the state developed quality measures for NFs. A modified set of quality domains and quality performance measures are also being developed for HCBS, including measures that are applicable across service delivery settings as well as additional measures that are specific to HCBS.

Part 8. Monitoring and Evaluation Plan

The Tennessee Health Care Innovation Initiative will contract with an independent evaluation contractor to evaluate the impact of the initiative on quality of care, population health, and health care costs for all Tennesseans. There are two purposes for Tennessee's evaluation plan. The first is to conduct an ongoing evaluation for continuous improvement of the program, to amplify what is working and to modify what is not working. The initiative will create a dashboard so that lead decision-makers involved in the initiative can track the initiative's progress. The second purpose is to publicize the results of Tennessee's approach so that others can learn from Tennessee's activities. Especially if the strategies show positive impact, Tennessee will benefit if its strategies are adopted and become more prevalent across the country. However, the initiative is equally committed to publicizing any unsuccessful results so that others can learn from those as well.

Tennessee and its evaluator will work with Center for Medicare and Medicaid Innovation (CMMI) and CMMI's evaluation contractor to support the most effective analysis methods. Most of Tennessee's strategies must occur statewide and therefore will not allow for an in-state control group. In those cases the evaluation contractor will use an out-of state control group. However, the multi-payer PCMH will begin with a subset of PCMH providers and so it will be possible to have an in-state matched case control group. Episodes of care will be implemented in waves set six months apart allowing for a nuanced time trend analysis.

Evaluating the Impact on Population Health: Tennessee will enhance its State Health Plan as described in the Plan to Improve Population Health on page 13. The plan will include a focus on measuring the impact of its strategies and will gather stakeholder input in 2015 on the best measures to use. At a minimum the initiative will analyze its impact on the following

measures of population health identified in the State Health Plan: child immunization status, self-reported health status, tobacco use, youth and adult obesity, and proportion of diabetics with 2 or more A1C tests in the past year. All measures will be monitored and reported across the state's entire population.

The initiative will also evaluate the specific impact of its health care payment and delivery system reform strategies on the people who receive care. The long term care strategy involves directly collecting information on members' self-reported wellbeing, and stakeholders have discussed collecting patient wellness in the quality measures for future episodes of care and in primary care transformation. The evaluation contractor will also contact recipients of care for more information on the impact of the strategies on patient wellness.

Evaluating the Transformation of the Delivery System: Each of Tennessee's strategies involves provider-level reporting and accountability for quality measures. These same data will be used to evaluate the impact of the strategies on the transformation of the health care system, including:

- Quantifying the number of providers participating in integrated networks and/or episodes of care (virtually integrated networks) and monitoring over time.
- Evaluating the degree of care coordination for PCPs, Health Home providers, and Principal Accountable Providers over time to see if they are practicing differently.
- Analyzing episodes of care for changes on quality indicators, utilization, or referral patterns.
- Evaluating improvements in LTSS quality measures across NFs and for HCBS.
- Quantifying the percent of payments to providers, by payer, which are linked to value as compared to fee-for-service.

- Evaluating the degree to which providers leverage HIT to improve patient care, such as utilizing the shared care coordination solution to close gaps in care.

Although much of the quantitative evaluation will be based on multi-payer claims data and Tennessee's APCD, each of the strategies involves the creation of a new method for provider reporting on quality measures: closed gaps in care for primary care transformation, non-claims-based quality measures for episodes, and quality and patient experience measures in LTSS. These provider-reported measures will be used for evaluation as well. The evaluator will also conduct interviews and focus groups with providers, payers, and patients to gather qualitative information on each strategy. At the same time that the state evaluator evaluates the initiative at the strategy level, Tennessee will also monitor high-level quality measures such as Consumer Assessment of Healthcare Providers and Systems (CAHPS) scores and hospital readmissions rates for system-wide impacts (see Quality Measure Alignment on page 22).

Evaluating the Impact on the Cost of Care: The evaluator will analyze the overall impact of the initiative on the cost of health care and the specific impact of each strategy on health care spending and utilization using Medicaid, CHIP, and commercial claims data. For PCMH and Health Homes, the initiative will compare participating providers with case matched non-participating providers on their patients' total cost of care and utilization measures such as avoidable ED use, avoidable hospitalization, and readmissions. For each episode of care the initiative has identified sources of value that the initiative is attempting to address. For example, rate of C-sections in perinatal, use of inpatient versus outpatient rehabilitation in total joint replacement, and readmissions for asthma. The initiative will use time trend analysis to find changes in these sources of value that occur with the implementation of episodes. For LTSS the initiative will monitor changes in per member cost.

Part 9. Alignment with State and Federal Innovation

The initiative aligns with goals established in the National Quality Strategy developed by the U.S. Department of Health and Human Services (HHS): “better care, healthy people and communities, and affordable care” and the National Prevention Strategy which outlines priorities including tobacco free living, preventing drug abuse and excessive alcohol use, healthy eating, active living, and emotional wellbeing.

The initiative will leverage the design of CMS approaches where applicable, including Bundled Payments for Care Improvement (BPCI) design for episodes and Comprehensive Primary Care (CPCI) for PCMH. Numerous partners of the initiative have received Health Care Innovation Awards from CMS and many health care facilities in Tennessee have received CMS funding for Innovation Model testing including BPCI, Advance Payment ACOs, and Advanced Primary Care Practice Demonstrations. Our multi-payer efforts will also complement the public and private population-based models currently underway, including existing PCMH programs and ACOs. The Robert Wood Johnson Foundation funded an Aligning Forces for Quality (AF4Q) initiative in Memphis through Common Table Health Alliance (one of our partners), a regional health and health care improvement collaborative. Our proposal will coordinate and build upon existing state initiatives and federal funding will not be used for duplicative activities or to supplant current federal or state funding.

The Bureau of TennCare is partnering with the Million Hearts Initiative to prevent one million heart attacks and strokes over five years by empowering people to make healthy choices such as preventing tobacco use. TennCare supports Million Hearts especially for members with serious mental illness who are disproportionately impacted by preventable chronic health conditions such as heart disease and hypertension.