Division of
Health Care
Finance & Administration

Health Care
Innovation Initiative

Tennessee Charitable Care Network Conference
November 30, 2017

Tennessee Health Care Innovation Initiative

We are **deeply committed** to reforming the way that we pay for healthcare in Tennessee

Our goal is to **pay for outcomes and for quality care**, and to reward strongly performing providers

We plan to have value-based payment account for the **majority of healthcare spend** within the next three to five years

By **aligning on common approaches** we will see greater impact and ease the transition for providers

We appreciate that hospitals, medical providers, and payers have all demonstrated a **sincere willingness** to move toward payment reform

By working together, we can make significant progress toward **sustainable medical costs and improving care**

Tennessee's Three Strategies

	Source of value	Strategy elements	Examples
 **Primary Care Transformation**	• Maintaining a person's health over time • Coordinating care by specialists • Avoiding episode events when appropriate	• Patient Centered Medical Homes • Tennessee Health Link for people with the highest behavioral health needs • Care coordination tool with hospital and ED admission provider alerts	• Encouraging primary prevention for healthy consumers and coordinated care for the chronically ill • Coordinating primary and behavioral health care for those with the highest behavioral health needs
 **Episodes of Care**	• Achieving a specific member objective, including associated upstream and downstream cost and quality	• Retrospective Episodes of Care • 75 episodes designed by 2020	• Wave 1: Perinatal, joint replacement, asthma exacerbation • Wave 2: COPD, colonoscopy, cholecystectomy, PCI
 **Long Term Services & Supports**	• Provide long-term services and supports (LTSS) that are high quality in the areas that matter most to members	• Quality and acuity adjusted payments for LTSS services • Value-based purchasing for enhanced respiratory care • Workforce development	• Aligning payment with value and quality for nursing facilities (NFs) and home and community based care (HCBS) • Training for providers

National movement toward value-based payment

Forty percent of commercial sector payments to doctors and hospitals now flow through value-oriented payment methods. -Catalyst for Payment Reform

PBGH PACIFIC BUSINESS GROUP ON HEALTH

"Our current health care system is designed to pay for volume – the number of medical services delivered – not the value of those services. Value is far more important; it considers the results of the services provided in exchange for the costs incurred."

BlueCross BlueShield

"BCBSA and the 37 Blue Cross and Blue Shield companies look forward to partnering with government and other private sector payers on this important transition to a more effective, efficient and coordinated healthcare system that helps patients get healthy faster — and stay healthy longer."

Cigna

"Cigna has been at the forefront of the accountable care organization movement since 2008 and now has 150 Cigna Collaborative Care arrangements with large physician groups that span 29 states, reach more than 1.7 million commercial customers and encompass more than 69,000 doctors."

UnitedHealthcare

"UnitedHealthcare's total payments to physicians and hospitals that are tied to value-based arrangements have tripled in the last three years to over $46 billion. By the end of 2018, UnitedHealthcare expects that figure to reach $65 billion. "

Intermountain Healthcare

"The leading providers are taking an "all in" innovative approach as they do the hard work of developing new organizational competencies and nurturing cultural change from within. Their new high-value models will give them a clear advantage over institutions that fail to act strategically now."

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

TN

"HHS has set a goal of tying 30 percent of traditional, or fee-for-service, Medicare payments to quality or value through alternative payment models, such as Accountable Care Organizations (ACOs) or bundled payment arrangements by the end of 2016, and tying 50 percent of payments to these models by the end of 2018."

PRIMARY CARE TRANSFORMATION

Primary Care Transformation: Patient Centered Medical Home Overview

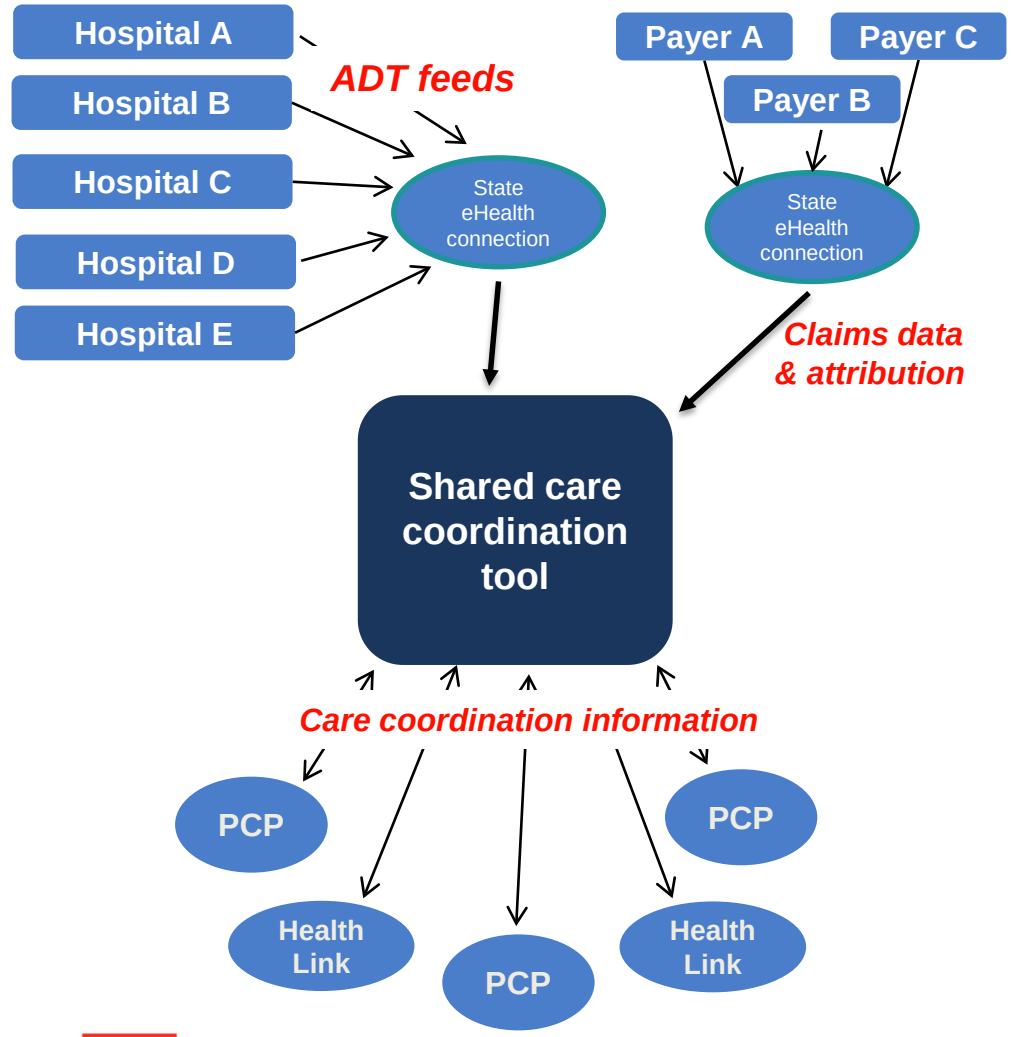
Members in this program	▪ Applies to all TennCare Members
Participating organizations	▪ Primary care organizations (i.e., family practice, general practice, pediatrics, internal medicine, geriatrics, FQHC) with one or more PCPs (including nurse practitioners) ▪ 29 organizations statewide, additional organizations added each year ▪ Launched January 1, 2017
Payment to organizations	▪ **Practice transformation payment**: $1 per member per month (PMPM) to support initial investment for the first year of an organization's participation. ▪ **Activity payment**: Risk-adjusted PMPM payment averaging $4 PMPM across all organizations to support organizations for the labor and time required to evolve their care delivery models. ▪ **Outcome payment**: Annual bonus payment available to high performing PCMHs based on quality and efficiency outcomes.
Other resources to organizations	▪ **Navigant** will provide training and technical assistance for each site while also facilitating collaboration among organizations. They will create custom curriculum and offer on-site training sessions. ▪ **Quarterly provider reports** will include cost and quality data aggregated at the organization level. Each health plan will send reports to participating organizations. ▪ **Care Coordination Tool** will help PCMH organizations provide better care coordination. The tool is designed to offer gap in care alerts, ER and inpatient admission hospital alerts, and prospective risk scores for an organization's attributed members.

Primary Care Transformation: Tennessee Health Link Overview

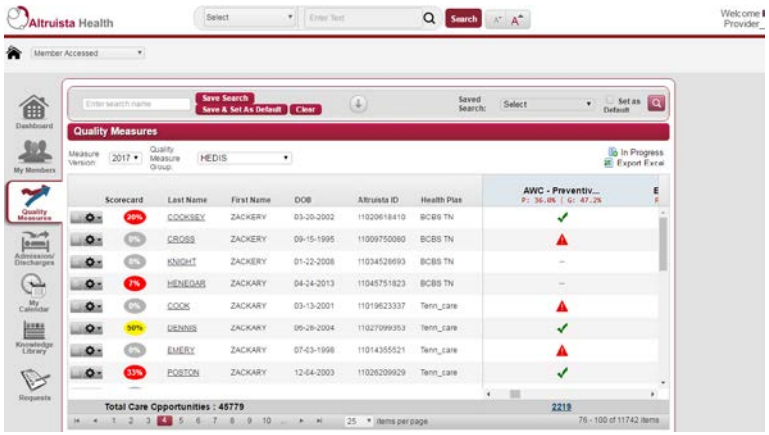
Members in this program	▪ Designed for TennCare members with the highest behavioral health needs (estimated 90,000 people)
Participating organizations	▪ Providers able to treat members with the highest behavioral health needs (including Community Mental Health Centers, FQHCs, and others) ▪ 21 organizations statewide, additional organizations may be added ▪ Launched December 1, 2016
Payment to organizations	▪ **Activity payment**: Transition rate of $200 as a monthly activity payment per member to support care and staffing through 11/30/17. Stabilization rate of $139 as a monthly activity payment per member begins 12/1/17 for additional 12 months. Recurring rate TBD. ▪ **Outcome payment**: Annual bonus payment available to high performing Health Links based on quality and efficiency outcomes.
Other resources to organizations	▪ **Navigant** will provide training and technical assistance for each site while also facilitating collaboration among organizations. They will create custom curriculum and offer on-site training sessions. ▪ **Quarterly provider reports** will include cost and quality data aggregated at the organization level. Each MCO will send reports to participating organizations. ▪ **Care Coordination Tool** will help Health Link organizations provide better care coordination. The tool is designed to offer gap in care alerts, ER and inpatient admission hospital alerts, and prospective risk scores for an organization's attributed members.

Primary Care Transformation: Care Coordination Tool

A multi-payer shared care coordination tool will allow primary care providers to implement better care coordination in their offices.

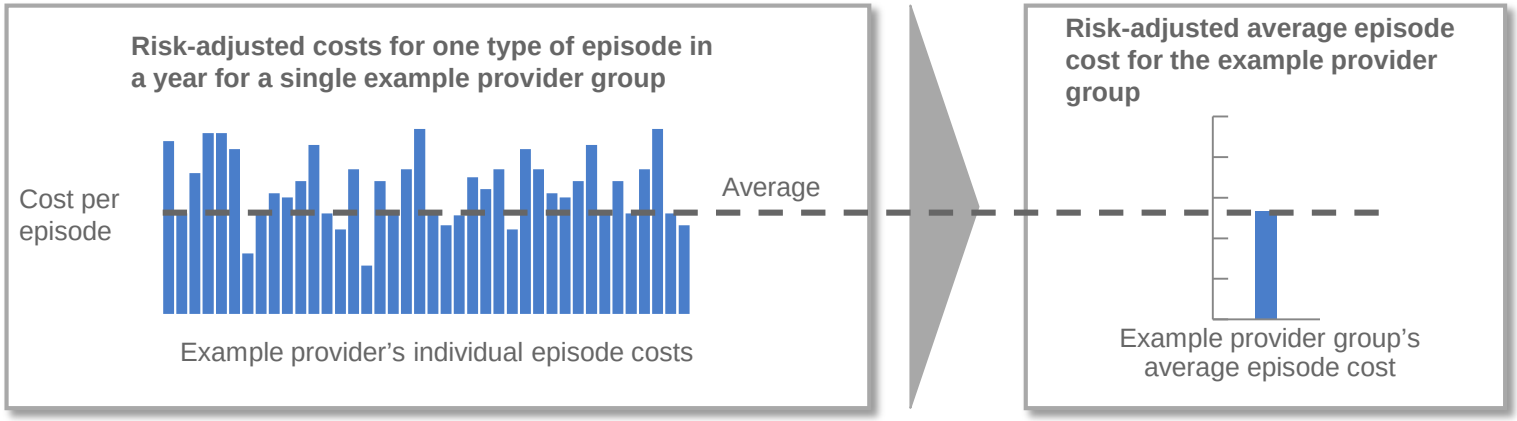


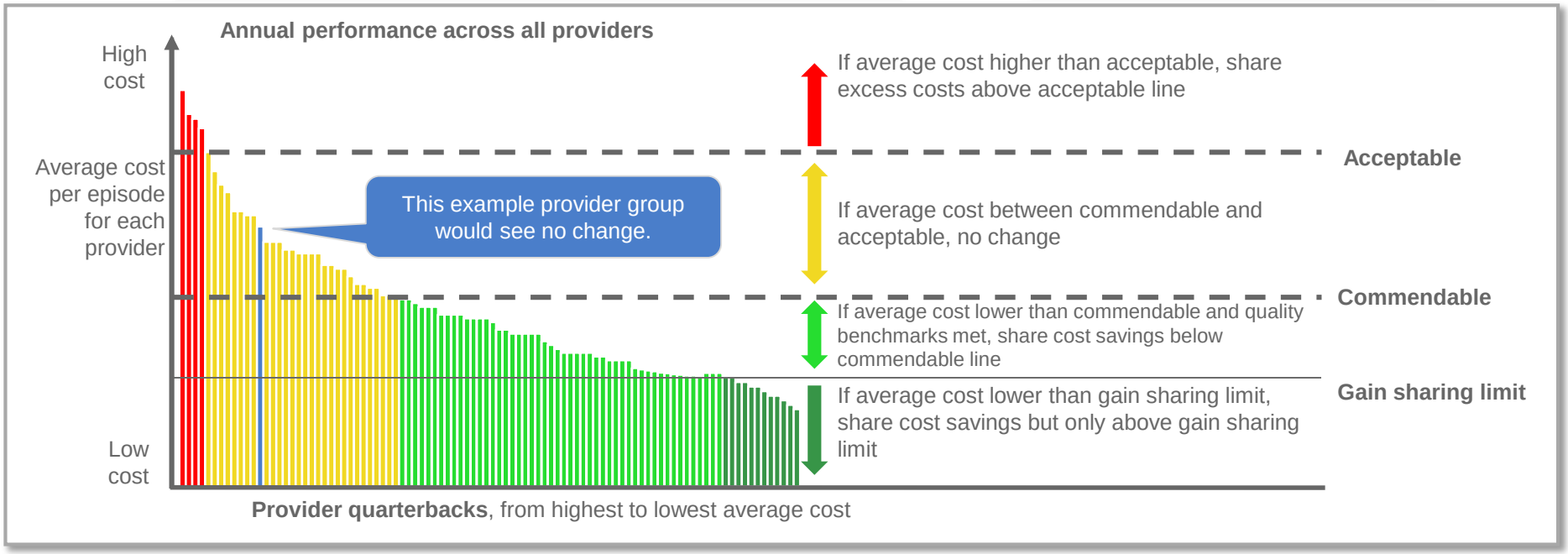
- Allows organizations to view their attributed member panel
- Alerts providers of their attributed members' hospital admissions, discharges, and transfers (ADT feeds) and tracks follow-up activities
- Identifies a provider's attributed members' risk scores
- Generates and displays gaps-in-care based on quality measures and tracks completion of activities



EPISODES OF CARE

Episodes of Care: Incentives





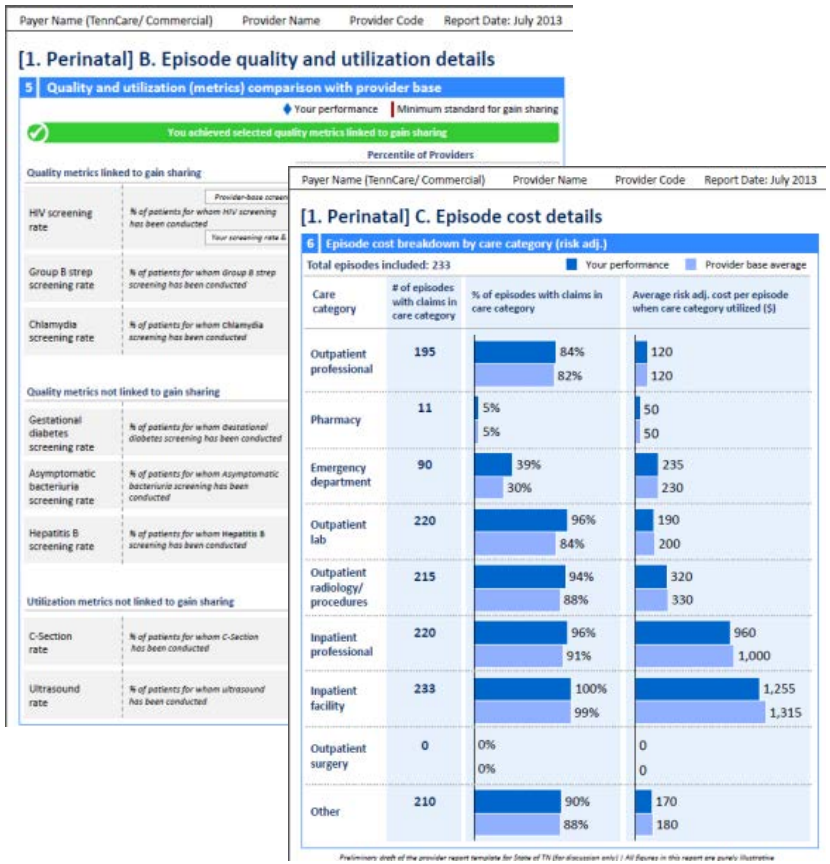
75 episodes of care will be designed and implemented over 5 years

Design year & wave		Episode
2013	1	Perinatal
		Asthma acute exacerbation
		Total joint replacement
2014	2	COPD acute exacerbation
		Colonoscopy
		Cholecystectomy
		PCI - acute
		PCI – non acute
2015	3	GI hemorrhage
		EGD
		Respiratory Infection
		Pneumonia
		UTI - outpatient
		UTI – inpatient
	4	ADHD
		CHF acute exacerbation
		ODD
		CABG
		Valve repair and replacement
		Bariatric surgery
2016	5	Breast biopsy
		Breast cancer, medical oncology
		Breast cancer, Mastectomy
		Otitis media
		Tonsillectomy
		Non-emergent depression
		Anxiety
2016	6	Skin and soft tissue infections
		Neonatal (Age 31 weeks or less)
		Neonatal (Age 32 to 36 weeks)
		Neonatal (Age 37 weeks or greater)
		HIV
		Pancreatitis
		Diabetes acute exacerbation
2017	7	Spinal fusion
		Spinal decompression (without spinal fusion)
		Femur / pelvic fracture
		Knee arthroscopy
		Ankle non-operative injuries
		Wrist non-operative injuries
		Shoulder non-operative injuries
		Knee non-operative injuries
		Back / Neck pain
	8	Acute Seizure
		Syncope
		Hyponatremia/dehydration
		Pediatric acute lower respiratory infection
		Colposcopy
		Hysterectomy
		GI obstruction
		Appendectomy
		Hernia procedures
2018	9	Conduct disorder
		Lung cancer (multiple)
		Colon cancer
		Female reproductive cancer
		Liver & pancreatic cancer
		Drug dependence
	10	Sickle cell
		Renal failure
		Other major bowel (multiple)
		Hepatitis C
		GERD acute exacerbation
		Kidney & urinary tract stones
		Hemophilia & other coag. dis.
		Rheumatoid arthritis
2019	11	Schizophrenia (multiple)
		Bipolar - chronic
		Bipolar – acute exacerbation
		PTSD
		Anal procedures
		CAD & angina
		Cardiac arrhythmia
		Depression – acute exacerbation
		Pacemaker / Defibrillator
		Dermatitis / Urticaria

Updated June 20, 2017

How are Providers Impacted?

- Providers or facilities that are deemed a Quarterback are **compared to other providers in the state**.
- Quarterbacks receive **in-depth reports** each quarter.
- Quarterbacks are held accountable for:
  1) Cost
  2) Quality of care given
- At the end of each performance period, Quarterbacks either receive a **reward, a penalty or remain neutral** depending on where they fall in the risk-adjusted cost curve.
- Must **pass all quality metrics** to receive a reward.



Reporting period	Type of Report
Preview Period	Informational only
Performance Period	Financial Accountability

Results for First Three Episodes

- Perinatal, total joint replacement and acute asthma exacerbation episodes showed total costs were reduced while quality was maintained in CY 2015.

Perinatal: 3.4% decrease in cost

Acute asthma exacerbation: 8.8% decrease in cost

Total joint replacement: 6.7% decrease in cost

Doctors and hospitals reduced costs while maintaining quality of care

Wave 1 episodes reduced costs by $11.1 million
(assuming a 3 percent increase would have taken place in the absence of this initiative)

Episode Quality Measures - Perinatal

Quality Measures	CY 2015	CY 2016
Tied to Gain-Sharing		
1. HIV Screening (≥ 85%)	88.3%	87.7%
2. Group B Streptococcus Screening (≥ 85%)	85.9%	94.0%
3. C-Section Rate (≤ 41%)	31.6%	30.7%
Informational Only		
1. Gestational Diabetes Test	79.1%	83.8%
2. Asymptomatic Bacteriuria Screening Rate	79.8%	82.1%
3. Hepatitis B Screening Rate	83.6%	84.3%
4. Tdap Vaccination Rate	29.5%	79.0%

Green text = positive movement
Red text = negative movement
Black text = less than one percentage point movement

Episode Quality Measures – Acute Asthma Exacerbation

Quality Measures	CY 2015	CY 2016
Tied to Gain-Sharing		
1. Follow-up Visit with Physician (≥ 43%)	N/A	29.6%*
2. Patient on Appropriate Medication (≥ 82%)	N/A	60.3%*
Informational Only		
1. Repeat Acute Exacerbation within 30 days	6.9%	6.5%
2. Inpatient Episodes	4.1%	3.2%
3. Smoking Cessation Counseling	0.8%	2.1%
4. Patient Education	45.6%	20.3%
5. Chest X-ray	54.2%	62.8%

Green text = positive movement
Red text = negative movement
Black text = less than one percentage point movement
*There was a coding change to these quality metrics so there is no direct comparison.

Episode Quality Measures - Total Joint Replacement

Quality Measures	CY 2015	CY 2016
Informational Only		
1. Readmissions	3.4%	2.6%
2. Post-operative Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE)	2.1%	0.4%
3. Post-operative Wound Infection	6.7%	4.1%
4. Dislocations or Fractures	4.6%	3.7%
5. Average Length of Stay	3.71	4.08

Green text = positive movement
Red text = negative movement
Black text = less than one percentage point movement

Episode Quality Measures - Cholecystectomy

Quality Measures	CY 2015	CY 2016
Tied to Gain-Sharing		
1. Hospitalization in Post-Trigger Window (≤ 10%)	0.8%	1.0%
Informational Only		
1. Intraoperative cholangiography	20.0%	17.6%
2. ERCP	1.0%	0.5%
3. Average Length of Stay	1.17	1.55

Green text = positive movement
Red text = negative movement
Black text = less than one percentage point movement

Episode Quality Measures - Colonoscopy

Quality Measures	CY 2015	CY 2016
Informational Only		
1. Participation in QCDR (≥ 25%)	2.9%	9.0%
2. Perforation of colon	0.0%	0.0%
3. Post-polypectomy/biopsy bleed	0.1%	0.0%
4. Prior colonoscopy	1.7%	2.1%
5. Repeat colonoscopy	0.8%	0.3%

Green text = positive movement
Red text = negative movement
Black text = less than one percentage point movement

Episode Quality Measures- COPD

Quality Measures	CY 2015	CY 2016
Tied to Gain-Sharing		
1. Follow-up care within post-trigger window (≥ 60%)	45.1%	46.8%
Informational Only		
1. Repeat acute exacerbation within post-trigger	11.3%	12.3%
2. Inpatient setting of acute exacerbation	24.7%	22.1%
3. Smoking cessation counseling	23.5%	25.0%

Green text = positive movement
Red text = negative movement
Black text = less than one percentage point movement

Episode Quality Measures – Acute PCI

Quality Measures	CY 2015	CY 2016
Tied to Gain-Sharing		
1. Hospitalization in Post-Trigger Window (≤ 10%)	1.0%	0.7%
Informational Only		
1. Multiple-vessel PCI	16.0%	15.6%
2. Staged PCI	3.6%	2.9%

Green text = positive movement
Red text = negative movement
Black text = less than one percentage point movement

Episode Quality Measures – Non-acute PCI

Quality Measures	CY 2015	CY 2016
Tied to Gain-Sharing		
1. Hospitalization in Post-Trigger Window (≤ 10%)	0.0%	1.5%
Informational Only		
1. Multiple-vessel PCI	14.1%	16.2%
2. Staged PCI	3.3%	3.1%

Green text = positive movement
Red text = negative movement
Black text = less than one percentage point movement

Episodes-Associated Savings, Risk-adjusted

Episode	Difference (Actual – Forecasted Average Episode Cost, Risk-adjusted, CY 2016)		Number of Valid Episodes	Total Estimated Savings
	Actual	Percent		
Perinatal	-$493	-7.0%	22,149	$10,919,176
Acute Asthma Exacerbation	-$182	-14.6%	12,939	$2,358,883
Total Joint Replacement	-$977	-7.6%	460	$449,610
Cholecystectomy	+$38	+0.8%	2,110	-$79,720

Episodes-Associated Savings, Risk-adjusted

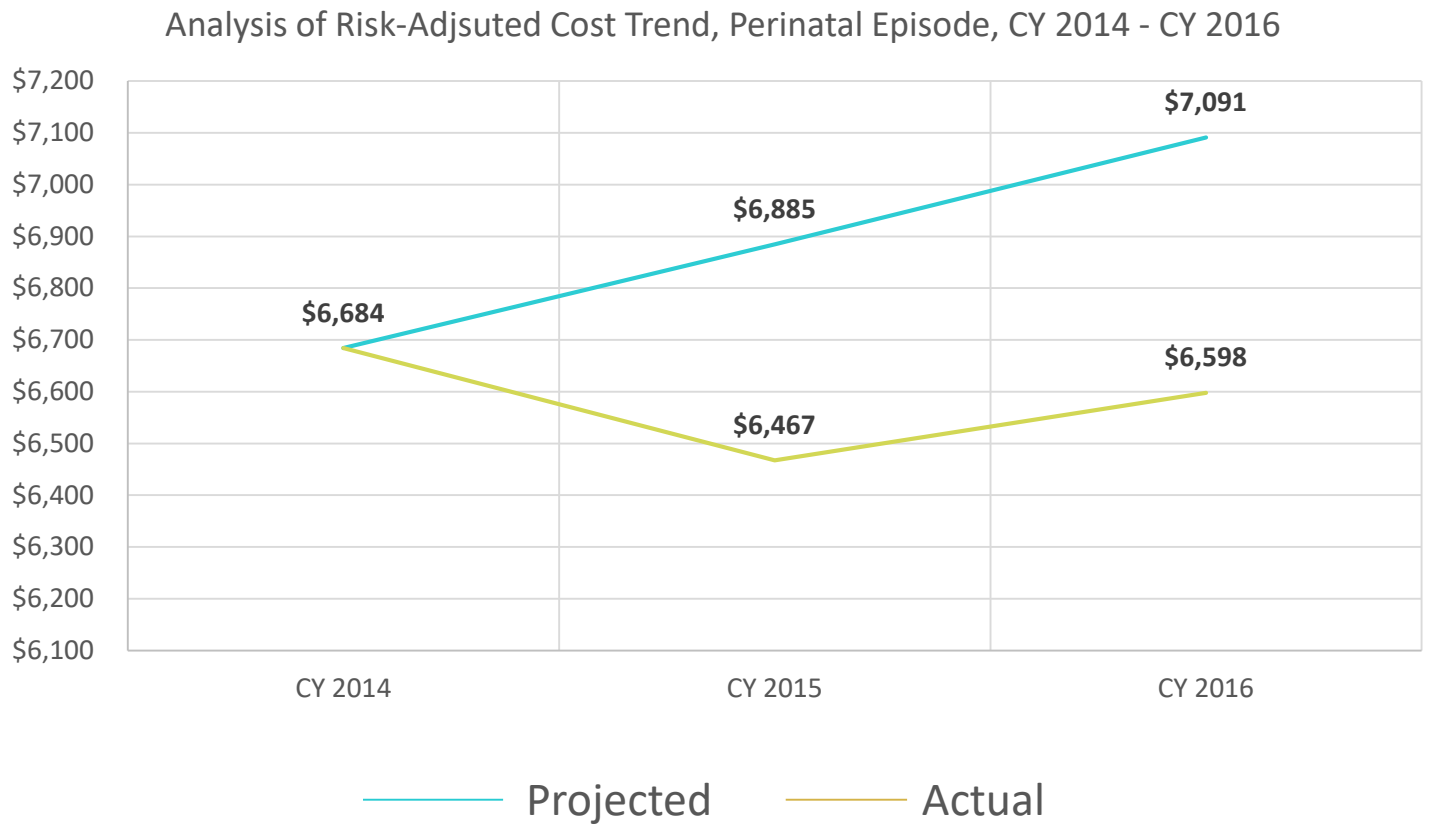
Episode	Difference (Actual – Forecasted Average Episode Cost, Risk-adjusted, CY 2016)		Number of Valid Episodes	Total Estimated Savings
	Actual	Percent		
Colonoscopy	-$30	-2.7%	2,929	$86,564
COPD	-$137	-5.7%	4,116	$561,376
Acute PCI	-$92	-1.0%	416	$38,279
Non-acute PCI	+$1,107	+16.0%	128	-$141,689

Episodes-Associated Savings, Risk-adjusted

Episode	Difference (Actual – Forecasted Average Episode Cost, Risk-adjusted, CY 2016)		Number of Valid Episodes	Total Estimated Savings
	Actual	Percent		
Total	-	-	45,247	$14,192,479

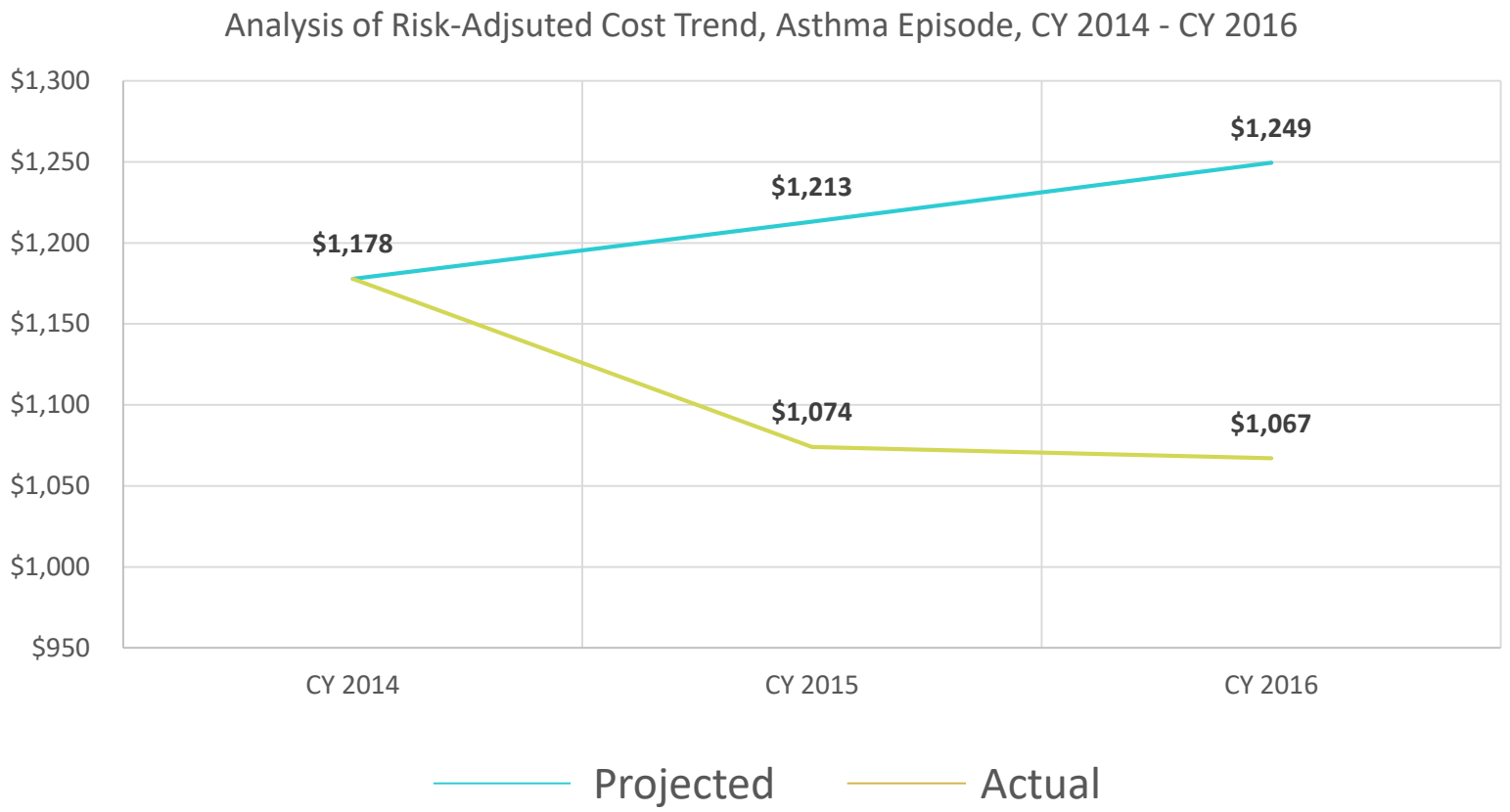
Due to episodes' risk adjusted cost being lower than projected medical trend of a 3.0% annual increase, 2016 estimated savings is approximately $14 million.

Savings From Perinatal Episode



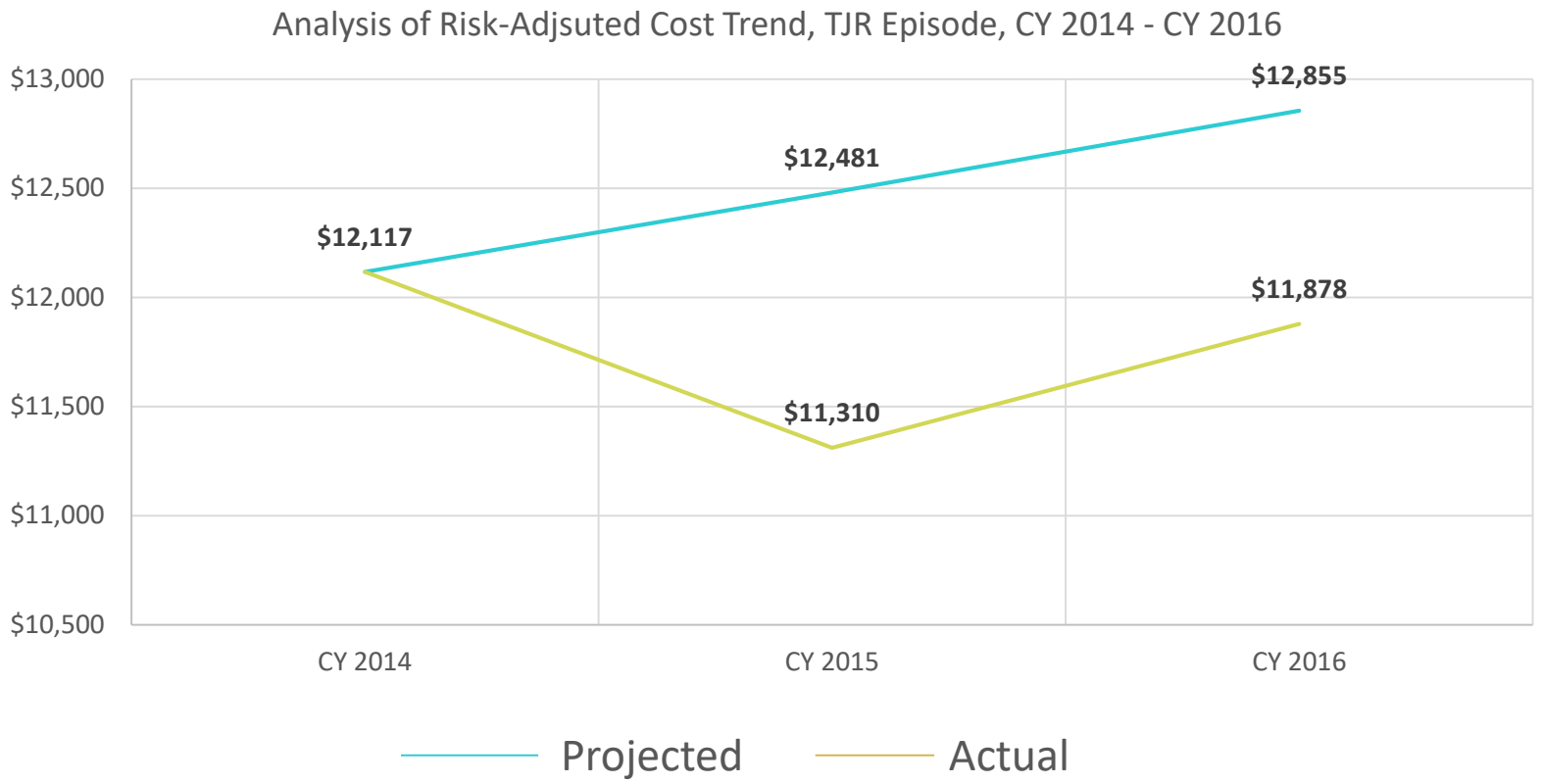
- Estimated adjusted episode cost for CY 2016, based on 3% annual increase = $157,058,559
- Estimated adjusted episode cost for CY 2016, based on MCO reports with 6 months claims run-out = $146,139,383
- **Estimated Savings = $10,919,176**

Savings From Asthma Episode



- Estimated adjusted episode cost for CY 2016, based on 3% annual increase = $16,167,094
- Estimated adjusted episode cost for CY 2016, based on MCO reports with 6 months claims run-out = $13,808,211
- **Estimated Savings = $2,358,883**

Savings From Total Joint Replacement Episode



- Estimated adjusted episode cost for CY 2016, based on 3% annual increase = $5,913,436
- Estimated adjusted episode cost for CY 2016, based on MCO reports with 6 months claims run-out = $5,463,827
- **Estimated Savings = $449,610**

Estimate of Penalties and Rewards, CY 2016, With One-Time Penalty Adjustment

Total, excluding TennCare Select/CoverKids			
	Rewards	**Penalties**	**Balance**
Perinatal	$777,731	$359,946	$417,785
Asthma	$13,318	$50,558	($37,240)
TJR	$5,556	$29,513	($23,958)
CHOLE	$22,735	$25,997	($3,262)
COLO	$18,884	$22,299	($3,416)
COPD	$55,833	$7,285	$48,547
PCIA	$27,989	$37,720	($9,732)
PCIN	$15,171	$9,072	$6,098
Total	**$937,216**	**$542,392**	**$394,824**

Thank You

- Questions? Email payment.reform@tn.gov
- More information: http://www.tn.gov/hcfa/section/strategic-planning-and-innovation-group