

## BACKGROUND INFORMATION

### **The Tennessee Health Care Innovation Initiative**

Through Governor Haslam's leadership, the State of Tennessee launched the Tennessee Health Care Innovation Initiative to transition its health care payment system to better reward patient-centered, high-value health care outcomes for all Tennesseans. The initiative is led by the state Division of Health Care Finance and Administration (the division of state government that includes TennCare and CoverKids), and includes a broad group of stakeholders, including the Benefits Administration for state employees, the largest private insurers in Tennessee, and leading Tennessee health care providers. Tennessee is pursuing three complementary strategies in payment and delivery system reform:

- **Primary Care Transformation:** Tennessee will implement a multi-payer Patient Centered Medical Home model to reduce avoidable hospitalizations, increase coordinated care, and improve quality of care. The state will also implement Health Homes for TennCare members with severe and persistent mental illness. The State will also fund a Care Coordination Tool to support the work of these practices by providing an off the shelf solution with customization that will process Admission Discharge and Transfer (ADT) alerts, identify gaps in care, and allow for care coordination.
- **Episodes of Care:** Tennessee will implement 75 multi-payer episodes of care over the next five years to reward high-quality and efficient acute health care. Tennessee insurers have already implemented eight episodes of care. Providers in Tennessee are receiving over 1,200 unique cost and quality performance reports. The activities under the episodes of care strategy are not part of this scope of work.
- **Quality- and Acuity-Based Payment for Long Term Services and Supports (LTSS):** TennCare's payments will be adjusted for quality and acuity for LTSS services in nursing facilities and home and community based care, including for individuals with intellectual and developmental disabilities and people receiving respiratory care. The activities under the LTSS strategy are not part of this scope of work.

Tennessee is leveraging state purchasing power through the joint efforts of TennCare, CoverKids (Tennessee's Children's Health Insurance Program), and Benefits Administration, and working with a coalition of commercial insurance carriers. TennCare contractually requires its three managed care organizations (MCOs)—Amerigroup/Wellpoint, BlueCross BlueShield of Tennessee (BCBST), and UnitedHealthcare—to participate in payment and delivery system reform, including the TennCare*Select* administrative services only (ASO) network for children in state custody.

The State of Tennessee has been awarded a State Innovation Model (SIM) Testing Grant from the Centers for Medicare and Medicaid Innovation (CMMI) to support the three initiative strategies.

### **Practice Transformation Training Scale Up**

The Practice Transformation Training contractor responsible for this Scope of Work will contribute exclusively to the success of the State's Primary Care Transformation strategy. The State has several goals for Primary Care Transformation, including:

- Reduce non-emergency ED use
- Reduce preventable hospitalizations
- Reduce readmissions
- Increase adherence to preventative care
- Increase pharmacy adherence
- Reduce duplication

- Improve health and patient experience

All participating Patient Centered Medical Home (PCMH) and Health Home providers in the State will be eligible for 2 years of practice transformation support from the Practice Transformation Training contractor. While certain training opportunities that will be offered by the Practice Transformation Training contractor will be required for practices, not all aspects of the training are required. Therefore, some practices that have already made investments in transformation may choose not to participate in all aspects of the training. However, HCFA assumes that the majority of Tennessee PCMH practices and Health Homes will enroll for practice transformation support organized through this RFP over the next 4 years. Scale up plans for both PCMH and Health Homes are below:

<b>Scale up plan and timeline for PCMH and Health Homes</b>	<b>Dates</b>
Complete Statewide Health Home Provider Readiness Assessment	4/1/2016
Health Homes Program launches statewide (approximately 30 practices, comprising approximately 200 sites, impacting approximately 90,000 TennCare members, requiring 2 years of vendor support)	10/1/2016
Wave 1 PCMH begins (approximately 25 practices, comprising approximately 50 sites, impacting approximately 139,000 TennCare members, requiring 2 years of vendor support)	1/1/2017
Wave 2 PCMH begins (approximately 63 additional practices, comprising approximately 125 sites, impacting approximately 266,000 TennCare members, requiring 2 years of vendor support)	1/1/2018
Wave 3 PCMH begins (approximately 50 additional practices, comprising approximately 100 sites, impacting approximately 277,000 TennCare members; Contractor will provide 1 year of training while simultaneously coaching MCOs to take over training in second year)	1/1/2019

The Practice Transformation Training contract period will cover PCMH Wave 1, Wave 2, and 13 months of Wave 3 vendor support for practice transformation training and technical assistance (Wave 3 support is contingent on extension of SIM grant funding period). The Contractor will be responsible for training the state’s MCOs to take over training and technical assistance in the final year of the contract period. MCOs will be encouraged to attend periodic onsite coaching and large format in-person training sessions. When MCOs attend onsite coaching, they will have the opportunity to present performance and other data for PCMHs and Health Homes.

The Practice Transformation Training contract period will cover all Health Home providers at program launch statewide October 1, 2016, for 2 years of practice transformation training and technical assistance from the Contractor.

**Shared Care Coordination Tool**

Tennessee is working with Altruista Health to develop a web-based Care Coordination Tool. The tool will alert participating PCMH and Health Home providers when one of their attributed patients has had an admission, discharge, or transfer from a hospital using real-time or daily batch Admitting/Discharge/Transfer (ADT) data collected from hospitals and Emergency Departments across the state. The tool will also alert providers of potential gaps in care and needed services their patients may not have received. Additionally, the tool will show patient risk scores, which will allow care coordinators to reach out to patients with a higher likelihood of adverse health events. The Care Coordination Tool will be piloted with select PCMH and Health Home providers June-August 2016. The tool will become available to PCMH and Health Home providers more broadly starting in the fall of 2016.

### **Patient-Centered Medical Home in Tennessee**

Tennessee is building 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. The State's current thinking around the design elements for multi-payer PCMH includes:

- **Patient inclusion:** All TennCare members.
- **Attribution Model:** In early 2016, TennCare MCOs began only paying a patient's attributed PCP for primary care services and will provide ADT alerts to those attributed PCPs. All MCOs are required to ensure that all primary care services are delivered and coordinated by a single attributed provider. TennCare believes that this tight attribution approach will be of great advantage to the PCMH program. The Care Coordination Tool will track patient attribution.
- **Provider Requirements:** The basis for requirements on primary care providers participating in the program are NCQA's PCMH recognition program.
- **Reports to providers:** Quarterly reports to providers will highlight their achievement on quality and efficiency metrics, including total cost of care, and reward payments that providers have earned.
- **Actionable information to providers:** Providers will receive ADT alerts through the Care Coordination Tool when their attributed patients go to Tennessee hospitals and emergency departments from a shared provider facing population management software solution. In addition this software will inform providers of their risk-stratified member panel and gaps in care reporting.

### **Health Homes for TennCare members with acute behavioral health needs**

The State will work with providers to achieve integrated and value-based behavioral and primary care services for TennCare members with acute behavioral health needs. The State will leverage the enhanced federal match for Medicaid Health Homes. As defined by CMS, a Health Home provides six specific services beyond the clinical services offered by a typical primary care provider including comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support services, and referral to community and support services.

The State's current thinking around design elements for Health Homes includes:

- **Patient population:** High-needs behavioral health members, defined based on three categories;
  - a) **Diagnostic criteria:** A select list of behavioral health diagnoses occur anytime during the year, including schizophrenia and bipolar disorder.
  - b) **Diagnostic and utilization criteria:** Inpatient admission, crisis stabilization, or residential treatment with a broad set of behavioral health diagnoses including major depression, anxiety, emotional disturbance of childhood, PTSD, personality disorder, and substance use.
  - c) **Functional need:** Provider documentation of functional need which must be approved by the MCO.

- **Assignment Model:** Health Home members will be assigned based using a hierarchy that includes 2 or more behavioral health outpatient services from a single provider (excluding Level 2 Case Management), followed by Level 2 Case Management, followed by the attributed primary care practitioner, followed by MCO discretion.
- **Accreditation:** Health Homes will not be required to receive external accreditation, but will instead need to demonstrate a set of activities to be verified by the MCOs.
- **Reports to providers:** Quarterly reports to providers will highlight their achievement on quality and efficiency metrics, and reward payments that providers have earned.
- **Actionable information to providers:** Providers will receive ADT alerts through the Care Coordination Tool when their attributed patients go to Tennessee hospitals and emergency departments from a shared provider facing population management software solution. In addition this software will inform providers of their risk-stratified member panel and gaps in care reporting.
- **Statewide Launch:** There will be approximately 30 Health Home providers, many of which will have multiple sites (approximately 200 sites), that will all start at the same time on October 1, 2016.

### **MCO involvement**

Each TennCare Managed Care Organization will be encouraged to attend in-person provider coaching sessions, where they will be able to review MCO-specific data and priorities with practices. Additionally, each MCO will be invited to attend all Contractor led trainings, such as conferences and webinars, to support the transition of recurring contract activities to the MCOs at the end of this contract.