TENNCARE: TESTED STRATEGIES AND NEW CHALLENGES
October 21, 2015

### TennCare 1994

#### 1994 Overview

At TennCare’s inception, there were 12 different community service areas (CSAs) and a dozen health plans - only two were statewide. TennCare did not restrict the number of health plans; nor did it require a procurement process for plan selection. Prior to TennCare, Tennessee Medicaid was entirely fee-for-service.

- 12 Plans total – 8 HMOs; 4 PPOs
- Risk Model – All plans were “at-risk”
- Total Enrollment – 1.1 million

#### 1994 Service Areas

#### TennCare Satisfaction Survey: 1994 – 61%

#### Services

<table>
<thead>
<tr>
<th>Carved In</th>
<th>Carved Out</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical</td>
<td>Long-Term Care</td>
</tr>
<tr>
<td>Dental</td>
<td>Specialized Mental Health Services</td>
</tr>
<tr>
<td>Pharmacy</td>
<td></td>
</tr>
<tr>
<td>Routine Mental Health Services</td>
<td></td>
</tr>
</tbody>
</table>

#### Quality Monitoring

TennCare outlined basic quality management requirements in the contracts with the health plans and contracted with an External Quality Review Organization (EQRO) to review and report on MCO quality. Out of necessity, the EQRO’s primary focus was on getting health plans to a point where they had appropriate policies in place.

- Quality of encounter data – **poor**
- Network monitoring focused on Geoaccess mapping of MCO reported primary care providers
- Appeals were handled by MCOs
- TennCare Satisfaction Survey: 1994 – 61%
10/5/15

TennCare 2003

2003 Overview

By 2003, TennCare required all health plans to be HMOs and serve all areas within each Grand Region in which they participate, resulting in three Service Areas (West, Middle and East). At this time, health plans had begun to experience problems, and some were at risk of becoming insolvent which caused the state to bring them into an Administrative Service Organization (ASO) arrangement. Contributing factors included the impact of lawsuits/consent decrees and a lack of experience and capital on the part of some MCOs.

- 9 plans – all HMOs
- Risk Model – All plans were brought into an ASO arrangement (no risk)
- Total Enrollment – 1.35 million

2003 Service Areas

TennCare 2015

2015 Overview

TennCare transitioned to three statewide MCOs and had already limited the MCO network to 3 plans. LTSS for the elderly and adults with physical disabilities has been fully integrated into the managed care model. Integration of physical health, behavioral health and LTSS services promotes improved coordination of care for the "whole person." Further integration of LTSS services for individuals with intellectual & developmental disabilities into managed care has been designed and is scheduled to be implemented in 2016. Payment & delivery system redesign is on track to impact 80% of Tennesseans by 2020.

- 3 statewide plans – all HMOs
- Risk Model – At-risk
- Total Enrollment – 1.4 million

2015 Service Areas

Quality Monitoring

By now the EQRO was able to focus on adherence to policies. Encounter data quality had improved. By the late 90’s, TennCare had commissioned several studies on quality including delivery of preventative services, prenatal care and ER utilization. In addition, an annual Women’s Health report was being produced.

- Network requirements were expanded to include specialty standards
- Management of appeals shifted to TennCare
- TennCare Satisfaction Survey: 2003 – 83%

Services

Carved In

- Physical
- Behavioral Health
- Long-Term Care (for E/D)

Carved Out

- Dental
- Pharmacy
- Long-Term Care (for ID)*

Quality Monitoring

Today, TennCare rates above the national Medicaid average in many quality measures and continues to demonstrate improvement. With the integration of LTC into the managed care model, efforts to monitor quality of care in the elderly and disabled population are a new focus of attention.

We continue to enhance quality standards – recently added contractual requirement for all plans to utilize hybrid methodology in HEDIS reporting in cases where either hybrid or administrative is acceptable to NCQA

TennCare Satisfaction Survey: 2015 – 95%
Overview of TennCare Experience

<table>
<thead>
<tr>
<th>Then</th>
<th>Now</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rapidly Escalating Costs</td>
<td>Stable Cost Trends</td>
</tr>
<tr>
<td>Volatile Health Plans</td>
<td>Experienced, Well-Capitalized Health Plans</td>
</tr>
<tr>
<td>Few Quality Measures / Data Limitations</td>
<td>NCQA Accreditation &amp; Full Set of HEDIS Measures &amp; CAHPS/Improved Data Capabilities</td>
</tr>
<tr>
<td>Fragmented Long-Term Services and Supports System</td>
<td>Integrated Long-Term Services and Supports</td>
</tr>
</tbody>
</table>

TennCare’s Success to Date

Tennessee’s strives to: Simplify Complexity, Enhance Data Use, and Redesign Incentives

Financial Trends

According to a GAO report released in June 2014, TN was tied for the 4th lowest Medicaid spend per enrollee nationwide.

According to a Pew report issued in April 2015, TN had the 3rd lowest change in Medicaid Spending as a share of own-source revenue, 2000 and 2013.

HEDIS quality results showed:

- Out of 33 HEDIS measures tracked since 2007, 28 have shown improvement over time (85%). These measures include access and availability, prevention and screening, and effectiveness of care.
- 47 measures have shown improvement from 2014-2015

Member Satisfaction

- UT conducts an annual survey of TennCare members.
- Satisfaction has remained above 90% for the past 7 years.
Lessons Learned: High-level

1. Don’t bite off more than you can chew. TN went from 100% FFS to 100% Managed Care in less than 6 months and expanded coverage to new populations all at once.

2. Build a robust data infrastructure. Commit to data-driven decision making and sharing actionable data with providers.

3. Leverage MCO expertise when appropriate. When you have experienced plans, there is a lot they can bring to the table with creative solutions to complex problems.

4. Manageable system design. Transitioning to fewer MCOs allowed us to develop high functioning relationships with each payer and achieve appropriate plan oversight (we were able to interact with the plans more frequently and effectively).

5. Never stop innovating and looking for best practices. Eg. payment and delivery system reforms, incorporating more social/non-traditional supports.
Lessons Learned: Effective Contracting

1. The MCO procurement process and implementation must be well thought out. TN’s RFP required detailed operational plans for high-priority issues and oral interviews.

2. Contracts must be detailed, with each requirement carefully defined, and with appropriate reporting and monitoring processes to ensure compliance. TennCare distributes 7,000 deliverables annually to Business Owners. We have a centralized, automated compliance tool to monitor each aspect of the contract.

3. New skill sets are required of staff as you shift from FFS to managed care – more of a regulator function.

4. Contracts should be routinely reviewed and amended – continuous improvement.

5. There must be different types and levels of incentives and sanctions which are used when necessary to ensure compliance. Not every situation calls for Liquidated Damages.

Lessons Learned: Cost Containment

1. Savings estimates need to be realistic. Managed care assumptions should vary by region/location. There may be significantly different utilization patterns, levels of reimbursement and existing managed care penetration.

2. Aligning financial incentives is key. Opportunities for cost shifting should be identified and minimized – e.g. integration of nursing facility benefit.

3. MCOs need multiple tools to manage benefits and cost.

4. Data analytics unit and tailored dashboards have been invaluable to state-level monitoring efforts.

5. Not all problems can be solved by the MCOs themselves. Be willing to consider state-level action when necessary (e.g. payment and delivery system reform).
Lessons Learned: Quality

1. Access to reliable encounter data as quickly as possible is extremely important.

2. Quality requirements should be clear to health plans – e.g. accreditation requirements and timelines, performance measure reporting requirements.

3. Independent, external review goes a long way to quelling stakeholder concerns (e.g. EQRO, accrediting body like NCQA).

4. MCO required reporting of standardized, evidenced-based performance measures allows for tracking trends over time and for comparison to national norms (e.g. HEDIS). State-level surveys can also help track issues of interest over time.

5. Pay for Performance incentives tied to specific performance measures can be used effectively to target attention to your highest priorities.

6. Network monitoring is key and should include network standards for various provider types, tracking compliance with standards based on network information self-reported by MCOs, and an audit process to validate MCO self-reported information.

7. Tracking and analysis of enrollee appeals is an important quality monitoring tool.

VALUE-BASED PAYMENT STRATEGIES
National movement toward value-based payment

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

“Looking forward, we project that 20% to 25% of our medical costs will run through some form of value-based network contract in 2014 and are committed to increasing that participation percentage to 45% by 2017.”

“Thirty-seven Blue Plans have more than 350 value-based programs in market or in development, with more than 215,000 participating providers providing care to nearly 24 million members.”

“Cigna has been at the forefront of the accountable care organization movement since 2008 and now has 114 Cigna Collaborative Care arrangements with large physician groups that span 28 states, reach more than 1.2 million commercial customers and encompass more than 45,000 doctors.”

“...increase value-based payments to doctors and hospitals by 20% this year to north of $43 billion...ended the year at about $36 billion of spend in value-based arrangements and we’re looking to drive that north of $43 billion in 2015”

“We hope to have 75 percent of primary care physicians in our networks participating in this population health model by 2016.”

“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.”

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 physicians

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 reducing medical costs and improving care
Tennessee’s SIM Stakeholder Process

<table>
<thead>
<tr>
<th>Stakeholder group</th>
<th>General Public</th>
<th>Providers</th>
<th>Payers</th>
<th>Long-Term Services and Supports</th>
<th>Employers</th>
<th>Public Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stakeholders involved</td>
<td>Open to the public in person or by conference call. Topics include payment reform and other health policy issues facing the state of Tennessee.</td>
<td>Providers and provider associations meet regularly to advise on overall initiative implementation.</td>
<td>State health care purchasers (TennCare, Benefits Administration) and major commercial insurers meet regularly to advise on overall implementation.</td>
<td>Regional Community Forums hosted twice in each of the 9 regions across the state for consumers, family members, and providers.</td>
<td>Periodic engagement with employers and employer associations.</td>
<td>Partnered with Tennessee Department of Health and Public Health Schools to develop the plan to improve population health.</td>
</tr>
<tr>
<td>Meeting frequency</td>
<td>As needed</td>
<td>Monthly</td>
<td>2 per month</td>
<td>2 per region</td>
<td>As needed</td>
<td>As needed</td>
</tr>
</tbody>
</table>

The Initiative has met with over 250 stakeholder groups in more than 500 meetings since February 2013.

Tennessee’s Three Strategies

<table>
<thead>
<tr>
<th>Source of value</th>
<th>Strategy elements</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maintaining a person’s health overtime</td>
<td>Patient Centered Medical Homes</td>
<td>Encouraging primary prevention for healthy consumers and coordinated care for the chronically ill</td>
</tr>
<tr>
<td>Coordinating care by specialists</td>
<td>Health homes for people with serious and persistent mental illness</td>
<td>Coordinating primary and behavioral health for people with SPMI</td>
</tr>
<tr>
<td>Avoiding episode events when appropriate</td>
<td>Care coordination tool with Hospital and ED admission provider alerts</td>
<td>Wave 1: Perinatal, joint replacement, asthma exacerbation</td>
</tr>
<tr>
<td>Achieving a specific patient objective, including associated upstream and downstream cost and quality</td>
<td>Retrospective Episodes of Care</td>
<td>Wave 2: COPD, colonoscopy, cholecystectomy, PCI</td>
</tr>
<tr>
<td>Provide long-term services and supports (LTSS) that are high quality in the areas that matter most to recipients</td>
<td>Quality and acuity adjusted payments for LTSS services</td>
<td>75 episodes by 2019</td>
</tr>
<tr>
<td></td>
<td>Value-based purchasing for enhanced respiratory care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Workforce development</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Aligning payment with value and quality for nursing facilities (NFs) and home and community based care (HCBS)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Training for providers</td>
<td></td>
</tr>
</tbody>
</table>
EPISODES OF CARE

Episodes of Care: Incentives

Risk-adjusted costs for one type of episode in a year for a single example provider

Example provider’s individual episode costs

Risk-adjusted average episode cost for the example provider

Example provider’s average episode cost

Cost per episode

Average

High cost

Low cost

Annual performance across all providers

Provider quarterbacks, from highest to lowest average cost

High cost

Low cost

Acceptable

Commendable

Gain sharing limit

If average cost higher than acceptable, share excess costs above acceptable line

If average cost between commendable and acceptable, no change

If average cost lower than commendable and quality benchmarks met, share cost savings below commendable line

If average cost lower than gain sharing limit, share cost savings but only above gain sharing limit

This example provider would see no change.
Episodes of Care: Reporting

Quarterbacks will receive quarterly report from payers:

- Performance summary
  - Total number of episodes (included and excluded)
  - Quality thresholds achieved
  - Average non-risk adjusted and risk adjusted cost of care
  - Cost comparison to other providers and gain and risk sharing thresholds
  - Gain sharing and risk sharing eligibility and calculated amounts
  - Key utilization statistics
- Quality detail: Scores for each quality metric with comparison to gain share standard or provider base average
- Cost detail:
  - Breakdown of episode cost by care category
  - Benchmarks against provider base average
- Episode detail:
  - Cost detail by care category for each individual episode a provider treats
  - Reason for any episode exclusions

Example of detailed data provided in reports

<table>
<thead>
<tr>
<th>Episode</th>
<th>Patient</th>
<th>Name</th>
<th>Race</th>
<th>Age</th>
<th>Gender</th>
<th>Episode start date</th>
<th>Episode end date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1A123456</td>
<td>Robert</td>
<td>Black</td>
<td>35</td>
<td>Male</td>
<td>01/01/12</td>
<td>01/31/12</td>
<td></td>
</tr>
<tr>
<td>2A123456</td>
<td>Julia</td>
<td>White</td>
<td>45</td>
<td>Female</td>
<td>02/01/12</td>
<td>02/28/12</td>
<td></td>
</tr>
<tr>
<td>3A123456</td>
<td>Swia</td>
<td>Hispanic</td>
<td>55</td>
<td>Male</td>
<td>03/01/12</td>
<td>03/31/12</td>
<td></td>
</tr>
<tr>
<td>4A123456</td>
<td>Middleton</td>
<td>Caucasian</td>
<td>65</td>
<td>Female</td>
<td>04/01/12</td>
<td>04/30/12</td>
<td></td>
</tr>
<tr>
<td>5A123456</td>
<td>Catherine</td>
<td>Black</td>
<td>75</td>
<td>Male</td>
<td>05/01/12</td>
<td>05/31/12</td>
<td></td>
</tr>
</tbody>
</table>

Total episodes included: 233
Note: Tennessee may want to assess benefits of securing additional TennCare and state commercial data with which to design and localize certain episodes (multiple) indicators define episodes in which more than one episode may be designed.

Source: TennCare and state commercial plans claims data, episode diagnostic models, team analysis.

**Episodes of Care: 75 in 5 years**

- TennCare
- State Commercial Plans

Episode spend, $:
- $6,125,011,076.65
- $5,219,718,641.88

Cumulative share of total spend, %

Design progress to date

Episodes implemented:
- 8 episodes implemented
- 13 episodes to be implemented May 2016

Design Year:
- 2013
- 2014
- 2015
- 2016
- 2017
- 2018
- 2019

Primary Care Transformation
Primary Care Transformation

Patient Centered Medical Homes (PCMH) for all Tennesseans
- Prevention and chronic disease management
- Avoiding episode events when appropriate
- The highest cost 5% of TennCare members account for nearly half of total adjusted spend
- Members in the highest cost 5% were also in that category the previous year 43% of the time.

Health Homes for TennCare members with Severe Mental Illness
- Behavioral and physical health services integration
- Individuals with behavioral health needs make up only 20% of the TennCare population, but 30% of the total spend

2014 Medicaid patients and spend\(^1,2\)
Annualized patients, share of dollars

- Patients with BH needs: 20% (28% BH spend, 28% spend for patients with BH needs)
- Patients with no BH needs: 80% (61% spend for patients with no BH needs)

\(^1\) Annualized members (not unique members) shown here with no exclusions made on population or spend. Only 69% of Annualized members were claimants
\(^2\) Most inclusive definition of patients with BH needs used here of members who are diagnosed and receiving care, diagnosed but not receiving care, and receiving care but undiagnosed. Behavioral health spend defined as all spend with a BH primary diagnosis or BH-specific procedures, revenue, or HCPCS pharmacy code.

Primary Care Transformation

Care Coordination Tool
- Multi-payer tool that allows primary care providers to implement better care coordination in their offices.

Patient Centered Medical Homes
- Focus on prevention and management of chronic disease, seek to increase coordinated and integrated care across multidisciplinary provider teams, and improved wellness and preventive care.
- Primary care providers are responsible for proactively managing their attributed patient’s health care.
- Rewards for reduced avoidable ED visits and hospitalizations, more coordinated care, and improved quality of care.
- Training and technical assistance supports to providers.
Long-term Services and Supports

Quality- and acuity-based payment
- Nursing facility (NF) and Home and community based care payments will be based in part on patient need and quality outcomes including member experience.

Value-Based Purchasing Initiative for Enhanced Respiratory Care
- Point system to adjust rates based on the facility’s performance on key performance indicators.
- Strengthened standards of care, and educational programs.

Workforce Development
- Comprehensive training program for individuals paid to deliver LTSS.
- Agencies employing better trained and qualified staff will be rewarded.
Leveraging Managed Care in Pursuit of New Reforms

- Managed Care gave us critical Payer-level transformation:
  - Member engagement
  - Wellness programs/ population health programs
  - Management of the provider network
  - Implementation of value-based contracting with providers
  - Integration of physical health, behavioral health and LTSS (lays the foundation total cost of care accountability and incentivizes provider level integration)
  - Managed Care allowed us to incentivize payment reform objectives through state contracts and leverage payer relationship to bring in multiple lines of business (e.g. Medicare Advantage)

- Payment and delivery system reform encourages Practice-level transformation and allows us to further leverage Payer capacity:
  - Many providers have not invested in process transformation, personnel, or the IT systems needed to become a practice that maximizes the desired outcomes of prevention and whole patient wellness over time.
  - Most providers have also lacked actionable information on their patients’ interactions with the fragmented health care system outside of their office.
  - We are leveraging the capacity and resources of our plans to incentivize significant practice transformation.