The TennCare Experience

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In 1994, Tennessee restructured its Medicaid program and became the first state in the nation to enroll its entire Medicaid population into managed care, as well as being the only state to offer Medicaid to all uninsured and uninsurable citizens – regardless of income.

This restructured and expanded Medicaid program was renamed “TennCare”.

At inception, the thought was the cost-savings from a managed care model would allow the state to cover an expanded population (individuals who would not qualify under traditional Medicaid eligibility standards) and additional benefits.

As a revolutionary model, this approach brought about some challenges which prompted the program to change and evolve to become the program it is today.
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%
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 now being produced.

Network requirements were expanded to include specialty standards.

Management of appeals shifted to TennCare.

TennCare Satisfaction Survey: 2003 – 83%
By 2006, TennCare reform was nearly complete and relief had been obtained from a particularly burdensome consent decree. After the release of a study by McKinsey & Company in 2004 showing that the growth of TennCare was projected to require every new state dollar in just a few short years, the state had to make some difficult decisions to keep the program operating. The most difficult decision was reducing enrollment, but children and mandatory Medicaid enrollees were protected from these reductions. Program reductions included imposing a limit on prescription drugs for most adults and eliminating adult dental coverage. These steps were challenging but necessary and allowed TennCare to return to firm financial footing.

- 7 plans – all HMOs
- Risk Model – ASOs (no risk)
  - However, TennCare was in the process of restructuring the program and request for proposals were made for at-risk plans in 1 of the 3 regions.
- Total Enrollment – 1.2 million

In 2006, TennCare became the first Medicaid agency in the country to require all MCOs be NCQA accredited. In addition, TennCare began requiring that all MCOs report annually on the full set of HEDIS measures.

EQRO role shifted to focus on Tennessee specific concerns and to assure annual on-site monitoring

Provider network monitoring was enhanced to include validation of MCO reported data and confirmation of time to appointment

Medical necessity rules were promulgated to assure evidence-based decision making

TennCare Satisfaction Survey: 2006 – 87%
By 2009, TennCare had secured contracts with two well-capitalized and experienced MCOs in each region. The plans were operating at full risk. These MCOs were selected through a competitive bid process. In addition, one health plan contracted to operate statewide to serve a select population of members and to function as a back-up health plan should another plan falter. Rates were determined by an outside actuary to ensure the rates were sufficient for the plans to provide necessary care and maintain stability. TennCare had also begun implementation planning for the new TennCare CHOICES in Long-Term Care program that would eventually bring LTC services for the elderly and adults with physical disabilities into managed care.

- 3 plans – all HMOs
- Risk Model – At-risk
- Total Enrollment – 1.2 million

By 2009, all MCOs were NCQA accredited and HEDIS scores were improving, particularly in the area of child health. Integration of behavioral health allowed for reporting of behavioral health HEDIS measures for the first time. Quality initiatives targeting emergency department over-utilization, comprehensive diabetes care and adolescent well care were underway.

EQRO tasked with producing annual summary of HEDIS results that includes statewide weighted averages as well as comparisons across MCOs and to national benchmarks. Reports published on TennCare website.

P4P program in place relative to selected HEDIS measures

TennCare Satisfaction Survey: 2009 – 92%
Today, TennCare has extended contracts with its MCOs in order to maintain stability throughout health reform planning. The CHOICES program was fully implemented in August of 2010, bringing LTC for the elderly and adults with physical disabilities into the managed care model and increasing HCBS options for members. Integration of physical health, behavioral health and LTC services promotes improved coordination of care for the “whole person.”

- 3 plans – all HMOs
- Risk Model – At-risk
- Total Enrollment – 1.2 million

TennCare 2012

2012 Overview

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: 2012 – 93%
Bending the Trend

U.S. Expenditure on Health Care Per Capita Vs. Comparable TennCare Per Member Cost

Projected Medical Inflation Trends

Pharmacy Spend

HH/PD Spend

Examples of tools to control trend...

Pharmacy
- Point of Sale Edits
- Preferred Drug List/Drug Rebates/Generics
- Prescription Limits

Medical
- Prior authorization
- Medical Home
- Network Consolidation
- Disease Management
- Case Management

Fraud and Abuse
- Narcotic Controls
- Pharmacy Lock-In
- Outlier Monitoring

*Source: OMB 2012; Kaiser 2013  **Source: PricewaterhouseCoopers
**Background**

- In 2006, TennCare became the first state in the country to require NCQA accreditation across its Medicaid managed care network.

- NCQA is an independent, nonprofit organization that assesses and scores managed care organization performance in the areas of quality improvement, utilization management, provider credentialing and member rights and responsibilities.

- TennCare MCOs are also required to report the full set of HEDIS measures. HEDIS is a set of standardized performance measures that makes it possible to track and compare MCO performance over time.

**Data - HEDIS**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Amerigroup - East</th>
<th>Amerigroup - West</th>
<th>BlueCare - East</th>
<th>BlueCare - West</th>
<th>TennCare Select - East</th>
<th>TennCare Select - West</th>
<th>UnitedHealthcare - East</th>
<th>UnitedHealthcare - West</th>
<th>HEDIS 2011 National Medicaid 50th Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diuretics</td>
<td>88.08%</td>
<td>91.77%</td>
<td>91.22%</td>
<td>92.63%</td>
<td>91.83%</td>
<td>89.75%</td>
<td>89.39%</td>
<td>85.8%</td>
<td></td>
</tr>
<tr>
<td>Anticonvulsants</td>
<td>74.17%</td>
<td>77.70%</td>
<td>72.46%</td>
<td>74.64%</td>
<td>77.22%</td>
<td>73.72%</td>
<td>72.47%</td>
<td>68.6%</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>86.57%</td>
<td>89.97%</td>
<td>89.37%</td>
<td>87.60%</td>
<td>90.26%</td>
<td>87.93%</td>
<td>88.18%</td>
<td>84.2%</td>
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**Medical Assistance With Smoking and Tobacco Use Cessation (MSC)**

- Advising Smokers and Tobacco Users to Quit: 78.55%, 79.34%, 76.67%, 64.04%, 74.80%, 75.79%, 80.67%, 74.82%
- Discussing Cessation Medications: 43.15%, 40.93%, 39.96%, 35.71%, 41.86%, 39.07%, 37.21%, 42.71%
- Discussing Cessation Strategies: 33.73%, 41.44%, 41.11%, 46.41%, 30.60%, 33.82%, 31.08%, 38.14%

*For ASN age stratification changed for 2012 HEDIS; hence, there are no national data.

**Member Satisfaction Rates**

- UT surveys random sampling of TennCare households for annual satisfaction report.

- **All Time High – 95%**

**The 2012 HEDIS results showed:**

- Improvement in 88% of measures tracked since 2006.
- Improvement in 31 of 41 measures introduced more recently.

- TennCare’s health plans continue to be ranked among the top 100 Medicaid health plans in the country, with our highest ranking plan moving from 37th in 2011 to 30th.
Overview of TennCare Experience

**Then**
- Rapidly Escalating Costs
- Volatile Health Plans
- Few Quality Measures
- Limited Long-Term Care Options
- Fragmented Health Care Delivery System

**Now**
- Significantly Reduced Cost Trends
- Stable, Well-Capitalized and Experienced Health Plans
- NCQA Accreditation & Full Set of HEDIS Measures & CAHPS
- More Home and Community Based Options for More People
- Integrated Health Care Delivery System
Lesson Learned

On Effective Contracting and Implementation

1. The MCO procurement process and implementation must be well thought out.
   - Local Familiarity and Ability to Apply Content Expertise: The RFP required proposers to respond with detailed operational plans to high-priority issues.
   - Oral Interviews: Making sure proposers know what they are bidding on.
   - Staggered Implementation: Bringing up the regions in some sequence helped both with the procurement (provides a chance to refine the RFPs, etc.) and with the implementation (allowing a measured, focused approach).
   - Thorough readiness review processes are critical.

2. Contracts with MCOs must be detailed, with each requirement carefully defined, and with appropriate reporting and monitoring processes to ensure compliance.

3. Marketing guidelines should be structured so as to prevent potential problems.

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

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

6. There must be different types and levels of incentives and sanctions which are used when necessary to ensure compliance. Automated systems for tracking deliverables is recommended.

7. Remember – this is a partnership. Be willing to take a look at issues when circumstances arise that could not have been foreseen.
1. Access to reliable encounter data as quickly as possible is extremely important. Hard data is needed to dispel misinformation and anecdotes.

2. Quality requirements should be spelled out for health plans – e.g. accreditation requirements and timelines, performance measure reporting requirements. Accreditation takes time so clear milestones should be established to assess progress toward the goal. Consider P4P arrangement to reward plans for accreditation level received.

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

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).

5. Consider developing a state level survey that will allow you to track issues of interest to the state over time. This would be in addition to MCO level surveys like CAHPS.

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

7. Network monitoring should include three components:
   • Establishment of network standards for various provider types (e.g. geographic, appointment time)
   • Tracking compliance with standards based on network information self-reported by MCOs
   • An audit process to validate MCO self-reported information

8. Tracking and analysis of enrollee appeals can be an important quality monitoring tool
On Cost Containment

1. Savings estimates need to be realistic.
   a) Health care is local. Managed care assumptions should vary by region/location. Within the same State there may be significantly different utilization patterns, levels of reimbursement and existing managed care penetration.
   b) Also, the first year of operation for a new health plan is typically focused on continuity of care for enrollees and building/strengthening network. Meaningful change to how the delivery system functions begins to materialize in year two and beyond.

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. Careful consideration must be given to the division of responsibilities between the Medicaid agency vs. the MCO.

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

5. Not all problems can be solved by the managed care organizations themselves. Be willing to consider state-level action (e.g. benefit and eligibility changes) when necessary.

6. Constant vigilance is needed to defend against special interest groups intent on undermining managed care cost containment efforts – e.g. initiatives that would undermine PDL, pressure for inclusion of particular providers in managed care networks and/or any willing provider requirements, efforts to limit MCO utilization management options.......
# What is on the Horizon?
New Payment Models and Delivery Structures

<table>
<thead>
<tr>
<th>Select examples</th>
<th>Description</th>
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<tbody>
<tr>
<td>“Payor-led” integrated network</td>
<td>Payor-led affiliation or acquisition of health system which seeks full clinical and operational integration to reduce cost, improve member experience, and manage referral volume</td>
</tr>
<tr>
<td>“Provider-led” integrated network</td>
<td>Provider system builds a health-plan, leveraging brand name to drive volume to provider system</td>
</tr>
<tr>
<td>ACO</td>
<td>An organization of health care providers accountable for quality, cost, and overall care; share cost savings if performance metrics are met</td>
</tr>
<tr>
<td>Episodes of care</td>
<td>Covers all aspects of preadmission, inpatient, and follow-up care, including postoperative complications within a set time period for procedures, e.g., hip replacement</td>
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<tr>
<td>Patient centered medical home</td>
<td>Team of physicians and extenders, coordinated by a PCP coordinate provide high levels of coordinated care; typically tied to P4P contract</td>
</tr>
<tr>
<td>Pay for value</td>
<td>Payment bonus tied to efficiency metrics (e.g., reduction in ER visits, imaging)</td>
</tr>
<tr>
<td>“Basic P4P”</td>
<td>Payment upside based on performance metrics linked to value creation (e.g. BCSMA Alternative Quality Contract / AQC)</td>
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