Tennessee's TennCare: A Statewide System of Integrated Care

Keith Gaither
Director of Managed Care Operations, TennCare, Tennessee

Tricia Lea, PhD, MBA
Vice President, Behavioral Health, Tennessee Health Plan
UnitedHealthcare Community and State

Charles Freed, Jr, MD, MHA, CPE, FAPA
CMO of Behavioral Health Services, Tennessee Health Plan
UnitedHealthcare Community and State
This Webinar Will Be Recorded and Distributed to All Participants. It will also be made available at our website:

GoodCareCollaborative.org
Good Care Collaborative Steering Committee:

- Camden Coalition of Healthcare Providers
- Trenton Health Team
- Greater Newark Healthcare Coalition
- AARP NJ
- NJ Health Care Quality Institute
- PICO NJ
- New Jersey Policy Perspective
We are proud to announce the following organizations have pledged their support for the Good Care Collaborative:

- UnitedHealthcare
- Senator Joseph Vitale
- AARP NJ
- Greater Newark Healthcare Coalition
- Trenton Health Team
- Camden Churches Organized for People
- Volunteers of America – Delaware Valley
- Hospital Alliance of NJ
- New Jersey Health Care Quality Institute
- Greater Trenton Behavioral HealthCare
- Reliance Medical Group
- Bridgeway Rehabilitation Services
- PICO NJ
- St. Luke’s Catholic Medical Services
About the Good Care Collaborative:

The Good Care Collaborative is a coalition of providers and advocates from across the healthcare spectrum in New Jersey. We are committed to discussing sensible Medicaid reform and defining a collaborative vision of good care.

Our goal is to improve the quality of Medicaid services while decreasing costs of the system. In an effort to do so, we will focus on a comprehensive legislative agenda that includes short-, mid- and long-range Medicaid reforms.
Bureau of TennCare
Tennessee’s State Medicaid Agency

Keith Gaither, Director,
Managed Care Operations

July 15, 2014
TennCare Background

- TennCare: Medicaid managed care program began on January 1, 1994
- TennCare operates under a 1115 waiver from CMS
- Covers 1.2 million lives with an annual budget of approximately $9 billion
- Since 2007, all MCOs are fully integrated with medical and behavioral health; 2010 with Long-Term Services and Supports (LTSS)
Behavioral Health Benefit

- The Behavioral Health (BH) benefit was a carve out managed by a BHO until 2007 when it was phased into the integrated TennCare contract.
- Behavioral Health state oversight was managed by Dept of Mental Health until 2008 when the oversight was transitioned to Bureau of TennCare.
Preparing for Integrated MCOs

- Reviewed Policies and Procedures to ensure their processes were integrated
- Conducted on-site to ensure IT supported integrated UM
- We had several meetings with the outpatient providers with and without the MCOs to discuss billing, code definition, etc.
- Reviewed the MCOs provider communications and gave advice.
Go Live

- Members get services, providers get paid
- Daily calls to make sure phone lines answered and issues are identified and fixed
- Encourage providers to inform us of issues
- We did not have many issues related to behavioral health at go live
- Few outpatient services required authorization at the outset
Behavioral Health Reimbursements & Utilization

• We have not observed a redirection of funding
• Utilization of services drives funding
• Generally, they contracted at rates the providers were getting paid by the BHO
• There was some difficulty converting grants to fee for service rate due to lack of utilization data from the provider
Worries about Transition

No oversight from TennCare

- TennCare continues to monitor the same reports and data (including additional reports) as before 2008.
- TennCare received an award from the Community Mental Health Center (CMHC) trade organization in 2009 for the smooth transition of the BH program.

TennCare would be hand’s off

- Started visiting providers in early 2009
- Every year, visits to both mental health and substance abuse providers
Worries about Transition

*Members would not receive services*

- The MCO network providers were basically the same as in the former BHO network
- No complaints from the community about delay of services. The system continued to work as it had before.

*Claims would not be paid*

- This was an issue for both the providers, CMHCs and the MCOs.
- Providers had to conform to standard billing practices.
- Some instances where MCO had to increase provider outreach, education and waive timely filling
Behavioral and Physical Health Integration

Managed Care Organizations
- All systems and staff are integrated
- Care managers and utilization staff work together

Providers, including Community Mental Health Centers
- Work in progress
- Some BH providers consult at primary care; encouraging screening at primary care
- Three CMHCs just started offering primary care at a few locations
- State Innovation Model (SIM) Grant application for Health Homes
MCO & TennCare Collaboration

- Longevity with the MCOs has allowed for stronger partnerships between MCO and state staff
- For example, MCOs and TennCare are set to launch a pilot on August 1 for in-home services for children and youth
- This is a product of a 2 year-long workgroup with all 3 MCOs and TennCare
Introducing Integrated Medicaid Care in TN: The Payer’s Perspective

Charles Freed, Jr, MD, MHA, CPE, FAPA
CMO of Behavioral Health Services
Tennessee Health Plan

Tricia Lea, PhD, MBA
Executive Director, Behavioral Health
Tennessee Health Plan

July 15, 2014
UnitedHealthcare

- Part of UnitedHealth Group, whose mission is “Helping people live healthier lives and helping make the health system work better for everyone”
- UnitedHealthcare Community Plan provides innovative solutions to state Medicaid programs in 23 states, serving over 4 Million people
- Began delivering integrated healthcare in Tennessee in 2007, and has expanded integrated care in four other states
- One of three MCOs in TN
  - April 2007, began integrated services in Middle TN region only
  - November 2008, expanded to West TN region
  - January 2009, expanded to East TN region
  - 2010, integrated Long Term Services and Supports with medical and behavioral health care
- Now serving almost 600,000 members across the state
Community Concerns

- Behavioral Health providers will not have a voice in the development of the new delivery model
- Replacing the historical BH carve-out model will result in BH services becoming de-prioritized by the Health Plan, resulting in contraction of BH services, quality oversight, access and funding
- Reduced funding of BH services will compromise the ability of providers to serve their mission and even remain financially viable
- Consumers will suffer and not get the services they need in a comprehensive and timely manner, or potentially not at all.
Fallacy of Community Concerns

- UHCCP has much hanging on collaboration and partnering with providers (e.g.-without partnering service access will suffer resulting in higher costs of care, lower member/provider satisfaction, inability to effect innovative system infrastructural and service delivery changes)- so providers MUST have a voice in our development and be true partners in the process.

- While BH costs are a small percentage of overall direct benefit expense for the Health Plan, BH conditions in the medical sphere are so pervasive that medical costs are significantly higher. UHCCP realized that supporting and funding BH services results in reduction of the HP direct benefit expenses. Our success significantly impacts their success, so BH is not de-prioritized. Our financial performance is not separated like it is in the carve-out model.

- Funding of BH services has changed in distribution but not in overall expenditures- money saved by managing higher cost services goes to develop and support lower cost services to meet the populations’ needs)

- UHCCP realized that paying for services requested early on appears on the surface to cost more, but saves money in the long run (i.e.- restricting funding and access up front results in higher costs downstream). Members need the right service at the right time and at the right place.
Addressing Community Concerns - Key Interventions

• Ongoing, repetitive reassurance of providers was the first critical step.
  • Reassurance came in the form of creation of the Behavioral Health Advisory Committees in each Region. Membership comprised of consumers, advocates, and providers. Recommendations are funneled to the UHCCP Board of Directors for action.
  • Ongoing relationships with professional and consumer organizations were developed early on with emphasis on collaboration in system development activities. Providers and members are our partners in this developmental phase.
  • Transparency and honest dialogue, combined with behavior consistent with our commitments and mission over time lead to increasing degrees of trust and collaboration.
• Members, advocates and providers began to see and understand that BH services were not being thrown under the bus. Funding of BH services did not dry up as imagined. Access was not restricted as imagined.
• Infrastructural system changes relied on innovation and small scale piloting to ensure system changes would actually deliver as planned, be methodical, thoughtful and road tested before larger scale implementation (i.e.- no big overnight changes upsetting the system)
• Providers began to understand their critical role in effecting system change, and came to understand that UHCCP has a vital interest is seeing them be successful (or we lose them). This led to greater partnership between UHCCP and providers.
Examples of Interventions

• Subacute Hospital Stays- Several members with SPMIs, some of whom had ‘lived’ on subacute units for years on end, required more supportive services in order to be discharged to the community. Collaboration between TennCare, UHCCP and TAMHO (the largest provider organization in the state) developed Supported Housing, Enhanced (serving the more medically compromised member) and Supported Community Living resources enabling members to return to the community in large numbers.

• Case Management service costs have continued to grow without attendant improvement in member outcome being demonstrated. A collaboration between TennCare, the MCOs, provider organizations (TVC, TAMHO), the Dept. of Mental Health and SA Services (TDMHSAS) was created to make improvements to existing Case Management services. The new model relies on the evidence-based System of Care model philosophy and practice and is entering piloting phase.

• A collaboration between TennCare, UHCCP and a large provider in Middle TN have implemented the Child and Adolescent Stabilization and Treatment program. This is an intensive in home service for C&A and their families that does ‘whatever is necessary’ to meet the treatment needs of C&A and avoid costly and often ineffective RTC placements.
Integration within the Health Plan

- The HP Senior Leadership team includes our Behavioral Health Executive Director and Vice President of Clinical Operations
- BH and Medical utilize the same clinical documentation platform. This allows all clinical staff to access assessments, care plans, authorized services and contact notes to enhance care coordination
- BH and Medical also utilize one claims platform that supports enrollment, eligibility, claim validation, adjudication, and payment, and provides the source data for our encounter submissions, for behavioral health and physical health services
- We have one call center that allows members and providers to use our toll-free Customer Service Line, with trained staff capable of handling routine, urgent and emergent issues in both the physical and behavioral health domains
- Partnering BH and Medical Care Management staff together for cross-training and support leading to optimal management of members with comorbidities.
Integration within the Health Plan

• Multidisciplinary clinical rounds and case conferences in each Region involving clinical staff with expertise in physical, behavioral and long term care services to create a member-centric approach to care

• We administer a comprehensive Health Risk Assessments on all members, with incorporation of screenings for depression and substance abuse, along with typical physical health screening tools.

• We conduct Integrated training opportunities where staff learn about medical and behavioral health conditions and treatments, including how behavioral health conditions may mask medical disorders and vice versa

• We created policies and processes around coordinated care management that utilizes a member-centric, multidisciplinary team approach to care, but allows for a single clinician responsible for coordinating the full range of the member’s care
Population Health

- Whole-person oriented approach based upon the risk stratification of the population compared to disease management, which is aimed at helping members prevent the worsening of a single chronic condition
- Touches members across the entire care continuum, promoting healthy behaviors and self-management as well as providing care coordination and intense care management for members with chronic and complex conditions
- Members are stratified from ‘wellness’ levels of care up to ‘complex’, and interventions are targeted to help close members’ gaps in care
- Members with behavioral health conditions and/or receiving long term services and supports are not treated separately for stratification or reporting
Population Health--integration

• Through our Population Health clinical model, we are building integrated health care networks, increasing the use of telepsychiatry, and introducing and managing our Population Registry
• Population Registry enables providers to have critical information on the members they serve—regarding medical and behavioral health services and issues
• It reports member risk level, quality based gaps in care, and identifies members who were discharged from the ER or from an inpatient stay the prior day
• It allows bi-directional transfer of data, so physicians can update/report actions taken on the member’s gaps in care
Funding Mechanisms- The Tail that Wags the Dog

- One of the biggest challenges we have faced has been infusing the routine practice of integration in a large system that has relied on primarily FFS funding (= volume, not quality, drivers). Mechanisms to effect change relied on provider and member education (e.g. – around HEDIS metrics, benefits of coordinating care), development and distribution of supporting tools (e.g.- PCP Toolkit), quality-monitoring and feedback to providers. Given the longstanding fragmentation/siloing of services (even within the BH sphere itself) it has been a long, slow process.

- TennCare’s mission is to move from a Disease Mgmt model to a Population Health model with payment reform (outcomes tied to payment). This will result in financing driving behavior, lead to greater access, more timely treatment of illnesses (= reduced long term costs of care) and greater quality of care. Management of utilization increasingly becomes the responsibility of the provider system and not that of UHCCP; quality target payments incent providers to offer optimal and timely services for the member.

- For providers to be successful, they need data and the tools/applications to effective receive and manage according to the data. UHCCP shifts focus from UM Mgmt to ensuring providers have access to actionable data in a timely manner.
Takeaways

• Fears and concerns of the community around introducing Integrated Care, while understandable, were not realized. Satisfaction with changes is high.
• Developing trust in the community is a requisite for system change. Trust comes from partnering, consistency, honesty and transparency.
• UHCCP does not operate in a vacuum. Without our providers being strong and focused, we would not be successful.
• Pay now or pay (much more) later. Taking care of the member up front significantly reduces downstream costs.
• Funding has not been reduced in the process; it has been redirected from higher cost services to lower cost services, creating a more robust continuum of services which act to prevent the need for higher cost services.
• The attitude and approach of the Contractor has a significant impact of everything we do. TennCare, while keeping us accountable, does not micromanage us (i.e.- it is not a ‘gotcha’ relationship). The relationship is one of true collaboration and support, enabling us to more effectively achieve our mutual objectives; reduced costs, improved quality of care, improved population health, improved stakeholder satisfaction.
Questions?

• UHCCP thanks you for your participation today!
Save the Date: Next GCC Site Visit

September 30, 10 am – 12 pm

Join GCC at Greater Trenton Behavioral HealthCare for an in-depth look at Housing First, an approach to ending homelessness that centers on providing people experiencing homelessness with housing as quickly as possible – and then providing services as needed.

This innovative supportive housing model has been shown to lower healthcare costs and rates of chronic homelessness.
Additional Slides of Interest which convey our current focus on Population Health and Payment Reform
Integration outside the Health Plan- Population Health Phase

• In the Population Health phase of integrated care, we are now identifying provider collaboration initiatives, from embedding PCPs in CMHCs, to development of Health Homes and everything in between.
  • Because financial incentives are being utilized in this phase, the degree and consistency of integration will be greatly accelerated. Volume of services as a driver of provider revenue will be supplanted by increasing access to services (by expanding hours of operation, utilizing telemedicine, etc.), improving quality of care (do it right the first time), with providers sharing in cost savings
  • Providers require timely and accurate/complete data on ADTs, clinical care gaps, lab and pharmacy utilization data as well as the tools to receive and manage this data within provider sites. UHCCP offers resources and services to support our providers in managing Population needs (Predictive Analytic information, PCP Registries, Cloud-based clinical platforms, UHCCP staff embedded in provider sites, etc.).
Initial Focus for Behavioral Health

• Team of clinicians available to receive warm transfer calls from Call Center to handle providers seeking behavioral health authorizations or members needing assistance in crisis
• No prior authorization for typical outpatient services
• Focus on management of high cost and restrictive services such as Inpatient and Residential
• Detailed focus on several initiatives:
  • Moving members who had been in the state-run mental health facilities for a long time to the community with appropriate supports
  • Diversion of children and adolescents from residential treatment center admissions to community based services
  • Development of Enhanced Supported Housing to address members with significant co-occurring and co-morbid conditions and allow them to remain in the community
  • Peer Support through our Peer Link program
Care/Disease Management

• One primary case manager to manage all health care needs (medical, behavioral, long term care) of the member
• Identification of high risk members based on significant disease states or higher risk scores on health risk assessments
• Interventions targeted at disease state to help members prevent the worsening of single chronic condition
Payer-Based Population Health

UHC Population Health Team:

 +/- 100 Physicians, Nurses, Case Managers, Coaches, Social Workers

570,000 Total Members: Ratio 5,700:1

26,537 L2 & 1a Members: Ratio 265:1

*excludes members in a nursing facility.
Network Delegation Model:
16,857 Members: Total Cost of Care $438,600,000

WEST
ACC Locations: 35
Super Utilizers: 1,065, $86.2M (Annual)
Level 2 Non-Super Utilizers: 3,343, $38.1M (Annual)

MIDDLE
ACC Locations: 30
Super Utilizers: 1,346, $102.3M (Annual)
Level 2 Non-Super Utilizers: 5,219, $70.0M (Annual)

EAST
ACC Locations: 74
Super Utilizers: 1,157, $83.6M (Annual)
Level 2 Non-Super Utilizers: 4,727, $58.4M (Annual)

5,000 PCPs to 16,857 Highest Risk Members: 1:3 Ratio
+/-100 Field-based Case Managers, Coaches, Care Coordinators & Social Workers 168:1 Ratio

*excludes members in a nursing facility.
Feet on the Street Models

CHOICES
Care Coordinators

TennCare
Navigators
TCM’s

Neighborhood
Connections
Service Coordinators

Nurse
Practitioner
Home visit Program

Behavioral
Health Field
Coordinators

Readmission
Reduction

ACC
PCMH
Embedded CM’s

DSNP Care
Navigators

PDN Field staff
Virtual Teams in the 3 largest urban areas
• Memphis, Nashville, and Knoxville
• High population areas of high risk members - “Hot Spots”

Purpose- To bring together our health plan and shared service partners to coordinate the care management of high risk TennCare, CHOICES, and SNP members- to reduce unnecessary Inpatient /ER utilization (affordability), and to close evidence based care gaps (quality- HEDIS, STARS-)

High Risk Members
• Superutilizers- high spend (>35000/yr.)
• Population Health- Level 2- complex care management
• Other definitions by CM teams- High readmission risk scores etc., ORR (Marcia Davis)
Community Care Teams

Internal
- Transitional Case Manager and Navigator working in that city
- Inpatient Team - Discharge planner for region
- Neighborhood Connections
- PCMH - Clinical Management Consultant
- CHOICES – Care Coordinators
- Behavioral Case Managers
- Maternity – Navigators and Social Workers

External
- PCMH - Head Nurse Coordinator for Provider Practice,
  Embedded Case Managers
- Hospitals (high volume) - manager of CM/DP, ER
  (social worker diversion programs)
- Other possible - SNF, AIR, HH, DME
Accountable Care Goals

- Improve Access to Care
- Reduce Non Emergent Emergency Room Visits
- Reduce Inappropriate Admissions/Readmissions
- Improve Care of High Risk Patients
Patient Centered Medical Homes

• Deployed more than 123 practice sites covering over 100K members across all three Grand Regions
• Use of Population Registry allows providers to have real time data on members’ ER use, admissions and discharges from hospitals, and gaps in care
• Identifying PCMHs that are interested in co-location of Behavioral Health service providers and those that could benefit from Telepsychiatry services.
Health Homes

• There are more than 7K Tennessee members that are considered Level 2 members and super utilizers with SPMI. These members account for 1.3% of total members, but 12% of total cost.
• There are also 844 Level 2 or super-utilizing members with SPMI who are associated with a health home, representing almost 1% of all ACC members and 8% of all ACC costs.

• Develop Health Home for members with serious mental illness and high utilization of services
• Located at largest CMHC
• Assigned Care Coordinator
• PCPs co-located at CMHC sites
• High level of coordination between BH and Medical providers
• Monitoring gaps in care
Current Initiatives

• Expansion of Peer Support Services, including Family Support Services
• Development of a Living Room Model program
• CAST Program (Community Assessment Stabilization Team)
• Children’s Case Management Redesign
• Mental Health First Aid training
• Increased use of Ambulatory Detox services