

Tennessee Health Care Innovation Quality Application RFP Background

In December 2014, Tennessee was awarded a \$65 million State Innovation Models (SIM) Round Two Model Testing Grant from the Centers for Medicare and Medicaid Services (CMS) to support the goals of the Tennessee Health Care Innovation Initiative: to make health care in Tennessee a value-based system focused on efficiency, quality of care, and the patient experience.

The Tennessee Health Care Innovation Initiative includes three strategies: Primary Care Transformation, Episodes of Care, and Long Term Services and Support (LTSS). Quality Applications will support the Episodes of Care and LTSS strategies to advance payment reform efforts for commercial and public payers.

Episodes of Care

Episode-based payment seeks to align incentives with successfully achieving a patient's desired outcome during an “episode of care”, a clinical situation with predictable start and end points. Episodes reward high-quality care, promote the use of clinical pathways and evidence-based guidelines, encourage coordination, and reduce ineffective and/or inappropriate care. Episode-based payment is applicable for most procedures, hospitalizations, acute outpatient care (e.g., broken bones), as well as some forms of treatment for cancer and behavioral health conditions (e.g., ADHD). Under the initiative, participating insurance companies will add additional episode every year with the goal of implementing 75 episodes by the end of 2019. We have currently finished four waves of episodes design.

All of TennCare insurers are participating in the Episode of Care programs including the three MCOs, United, Amerigroup, and Blue Cross Blue Shield of Tennessee, TennCare Select, and Cover Kids. In addition to TennCare program the State employee health plans, and private commercial insurers, and Medicare Advantage plans are participating as well.

Wave 1: In May 2014, the initiative launched three episodes of care: acute asthma exacerbation, perinatal, and total joint replacement. Over 500 providers are receiving quarterly reports from TennCare and commercial payers. Providers have been rewarded and penalized based on their performance for the 2015 calendar year for members of TennCare and CoverKids.

Wave 2: Insurers have sent out preview for wave 2 episode of care. Those episodes include acute COPD exacerbation, screening and surveillance colonoscopy, outpatient and non-acute inpatient cholecystectomy, acute percutaneous coronary intervention (PCI) and non-acute PCI. The performance period for wave 2 began in May 2015.

Wave 3: The preview period for wave 3 began in the spring of 2016. Insurers are sending quarterly preview reports for the next 6 episodes of care in Tennessee. These episodes include respiratory infection, pneumonia, inpatient urinary tract infection, outpatient urinary tract infection, esophagogastroduodenoscopy (EGD), and gastrointestinal hemorrhage.

Wave 4: Insurers are working on preparing the preview reports for wave 4. The episodes for this wave are Cardiac valve, CABG, ODD, CHF acute exacerbation, bariatric surgery and ADHD.

For more information on planned future episodes, see episode implementation timeline: <http://www.tn.gov/assets/entities/hcfa/attachments/FutureWavesEpisodes.pdf> .

For detailed descriptions of episodes that are in place, see: <http://tn.gov/hcfa/topic/episodes-of-care> .

For each type of episode of care, there is a type of provider group who is accountable for the cost and quality of the episode. Many quality measures are based on claims data that the insurance company already has access to. Quality applications will be used to collect data from the accountable provider billing entities for episode quality measures for which not all information is available through claims data. The quality applications will support all participating insurance companies.

The quality measure that are supported by quality applications are still in development and will be selected after the contract with the vendor is in place. The following list provides a set of examples of potential quality measures. Possible potential measures broken down by wave and episode include but are not limited to:

Wave 1:

Asthma:

- NQF 0047: Asthma: Pharmacologic Therapy for Persistent Asthma (concept was recommended during wave 1 annual review process)

Perinatal:

-NQF 0472 Appropriate Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision – Cesarean section

-NQF 0469 PC-01 Elective Delivery

-NQF 0471 PC-02 Cesarean Section (recommended in wave 1 annual review)

-NQF 0480 PC-05 Exclusive breast milk feeding

Total Joint Replacement:

-NQF 2653: Average change in functional status following total knee replacement surgery

-NQF 0218: Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis Within 24 Hours Prior to Surgery to 24 Hours After Surgery

Wave 2:

Percutaneous Coronary Intervention (PCI) – acute and Percutaneous Coronary Intervention (PCI) – non acute

-Participation in ACC registry (all measures that follow are from ACC)

-NQF 0535-6 30-day all-cause risk-standardized mortality rate following Percutaneous Coronary Intervention (PCI) for patients with (and without) ST segment elevation myocardial infarction or cardiogenic shock

-NQF 2377 Defect free care for AMI

-NQF 2452 PCI: post-procedural optimal medical therapy
Appropriate reason for elective PCI

Cholecystectomy

-NQF 0753 American College of Surgeons – Centers for Disease Control and Prevention (ACS-CDC) Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure

Colonoscopy (screening):

- NQF 0658 Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients
- Adenoma detection rate
- Incidence of perforation
- Repeat colonoscopy due to inadequate bowel preparation
- Age-appropriate colonoscopy screening

Wave 3:

Pneumonia:

- NQF 1717 National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure
- NQF 0096 CAP: empiric antibiotic selection
- NQF 0500 Severe sepsis and septic shock management bundle

EGD (all are GIQuIC measures):

- H pylori status
- Immediate adverse events
- Appropriate specimen acquisition in Barrett's esophagus
- Appropriate management of new diagnoses of bleeding esophageal varices
- Appropriate endoscopic therapy for stigmata of peptic ulcer disease bleeding
- Appropriate anticoagulation management
- Appropriate antibiotic prophylaxis

Respiratory infection:

- Strep test/culture result (can inform appropriateness of antibiotic use)

UTI (outpatient):

- Percentage of uncomplicated UTIs managed without a face-to-face encounter

Wave 4:

-CABG and valve (all from the STS registry):

- NQF 0696 STS CABG composite score
- NQF 0130 Risk-adjusted deep sternal wound infection rate
- Risk-adjusted operative mortality (there are a number of these, would need to decide how/if to aggregate versus keep individual)

Bariatric:

- Clinical risk factors (e.g., history of prior procedure, diabetes control, specific BMI): Composite
- Measures for Profiling Hospitals on Bariatric Surgery Performance (see JAMA Surg.

2014;149(1):10-16)

ADHD:

- Improvement in symptoms from DSM-IV symptom list
- Disease-specific quality of life (currently only specified for adults)

Wave 5:

Breast cancer:

- Cancer stage
- Tumor pathology
- History of prior breast cancer
- NQF 0220 Adjuvant hormonal therapy
- NQF 0559 Combination chemotherapy is considered or administered within 4 months (120 days) of diagnosis for women under 70 with AJCC T1cN0M0, or Stage IB - III hormone receptor negative breast cancer.
- NQF 1858 Trastuzumab administered to patients with AJCC stage I (T1c) – III and human epidermal growth factor receptor 2 (HER2) positive breast cancer who receive adjuvant chemotherapy
- NQF 0219 Post breast conservation surgery irradiation

Long Term Services and Supports reforms

Tennessee is implementing quality- and acuity-based payment and delivery system reform for LTSS, including Nursing Facility services and Home and Community Based Services (HCBS) for seniors and adults with physical, intellectual and developmental disabilities (I/DD). The initiative's approach will combine a quality measure framework focused on the member experience that is applied across care settings, with modifications as appropriate.

Quality- and Acuity-Based Payment for Nursing Facilities and Home and Community Based Services: Under the Quality Improvement in Long-Term Services and Supports (QuILTSS) initiative, Nursing Facility payment is based in part on residents' assessed levels of need and adjusted based on quality metrics. HCBS payments is adjusted to incorporate the same quality metrics when they apply across service delivery settings, along with modified and additional quality metrics specific to HCBS. These changes reward providers that improve the member's experience of care and promote a person-centered care delivery model. For individuals with I/DD, Tennessee apply quality and acuity-based payments to address inequities in the system, encourage appropriate high-quality and efficient care, and increase the number of people who can be served.

Value-Based Purchasing Initiative for Enhanced Respiratory Care (ERC): TennCare revised its reimbursement structure for ERC services in a Nursing Facility, using a point system to adjust rates based on the facility's performance on key performance indicators. This will be combined with strengthened standards of care, and educational programs to promote quality and best practices.

Workforce Development: Through its extensive stakeholder input processes, Tennessee has identified that one of the most critical aspects of LTSS value pertains to the level of training and

competency of professionals delivering direct supports—whether in a Nursing Facility or in the community. Therefore the initiative invested in the development of a comprehensive training program for individuals paid to deliver LTSS. Since staff training will be an important quality measure and will also impact a provider's success across other measures, agencies employing better trained and qualified staff will be appropriately compensated for the higher quality of care experienced by individuals they serve.

The purpose of this RFP is to procure services for the collection of clinical focused quality data that is non-claims related. Quality Applications will monitor and aggregate data regarding Episodes of Care and LTSS in support of performance measures. The performance measures factor into the provider incentive payment calculations. Each Quality Application will apply one or more analytic methods as defined by the State. The Quality Applications Contractor will collect and parse both standard and custom data types, including CCD-A, CCD, clinical registries, QRDA, HL7, X.12, provider self-reporting, and survey data (reference Attachments B-I).

The Contractor will support providers, otherwise known as billing entities, in quarterly submissions of clinical quality measures that include patient personal health information (PHI) related to a health condition or procedure. Quality Applications data will feed into Contractor produced reports and sent to payers. These reports will link patient, provider and payer. The Quality Applications service includes a web portal, data access, and data management needs of the Quality Applications user community. The user community includes State staff, payer staff, and provider staff. State workers will receive training from the Contractor in order to effectively triage questions received from clinical providers. Payers will use the quality metric values to compute quality incentive payments for the participating providers.

All users of the Quality Applications service will enter the service by logging into the State provider portal using State provisioned credentials. The credentials will link the entity/provider to the applications. The billing entities will enroll with specific quality metric(s) most applicable to their patient group. Every quarter the billing entity will submit data for the given cycle. A batch process notification will be sent to providers via email when the deadline to submit data is approaching. The data will be collected using web forms, data file upload, direct message file attachments, and registry vendors. Once data is submitted, batch process generation occurs and creates a Quality Applications report, computing metric values for each provider and sending the report to the payer.

The State will perform identity proofing to verify the identity and organization affiliation of each entity/provider requesting access to the Quality Applications service. The State provider portal will pass a SAML token asserting the identity of the user to the Quality Applications service when the user elects to navigate from the provider portal to the Quality Applications service web portal. The Quality Applications service will accept this token as authentication into the system, enforce role based authorizations, and enforce data access rights on the asserted identify received from the State provider portal. The State will alert the Quality Applications Contractor when each account is provisioned with the appropriate account role. This will enable the Contractor to create role based access to system functionality within the service. Each account created will also be associated with TIN(s) to support privacy controls and data ownership rights for data and file

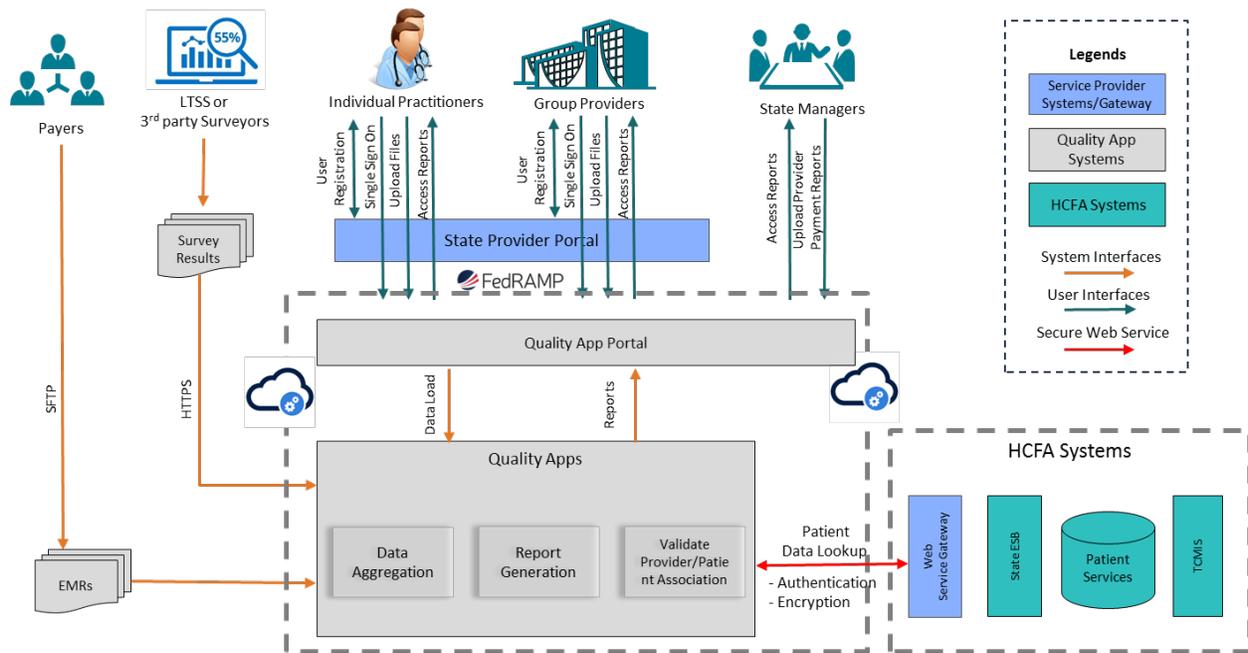
administration. For support and data privacy controls, the State will advise the Contractor in regards to payer identified accounts.

Technical Background

The State of Tennessee requires that any and all systems involved in the processing of Affordable Care Act (ACA) and Health Insurance Portability and Accountability Act of 1996 (HIPAA) related information follow the guidance of Centers for Medicare & Medicaid Services (CMS) and all other applicable state and federal laws and regulations as required by data types and classifications for security and privacy. This includes but is not limited to all phases of system development, implementation, and operation and focuses on the minimization of risk to sensitive data whether in transit or at rest and further, applies to all personnel whether State worker or Contractor.

To meet the accelerated project schedule, the Quality Application is envisioned to be Federal Risk and Authorization Management Program (FedRAMP) compliant SaaS. FedRAMP is a government-wide program that provides a standardized approach to security and privacy control assessment, authorization, and continuous monitoring for cloud products and services.

The following diagram represents a conceptual Quality Application Solution Architecture and its data sources.



Below are descriptions of various solution components, the connection points and user groups:

HCFA Systems

HCFA has a number of existing systems including infrastructure, enterprise and agency applications and ongoing projects that can be leveraged to implement the Quality Application. The relevant systems are:

- TCMIS - This is the Medicaid Management Information System (MMIS) and it is operated by HP. The system supports the TennCare's MCO business model.
- State hosted patient services- State hosted patient data look up services provided by HCFA for patient matching to payer identity, retrieve provider information, primary care physician etc.
- State Enterprise Service Bus (ESB) - HCFA owns middleware infrastructure being used by a number of systems to exchange information via push/pull query and file transfer.
- Web Service Gateway – HCFA leverages a web service gateway to expose external facing service end points and handle authentication, authorization and encryption etc.

State Provider Portal

The State will manage identity proofing and the provisioning of credentials for access to the Quality Applications service through the State provider portal. The Quality Applications service shall accept a standard SAML token from the State provider portal as sufficient authentication for user access.

Quality Applications Service Web Portal

The Quality Applications service web portal provides user interfaces of Quality Applications. The portal provides a graduated access privilege control of portal resources based on account roles. Users will use the portal to upload and manage self-reporting data files as feeds to the Quality Application(s) as well as to view/download reports available to them based on their user roles. The portal shall also provide provision for web form based data entry.

The Quality Applications service web portal also allows State managers to retrieve and upload internally generated reports, e.g. payment reports.

Quality Applications

Quality Applications will aggregate, transform and store data from various sources as required. This includes but not limited to:

- Self-reporting data files uploaded from the Quality Application Portal
- Survey questionnaires from LTSS vendors or third party survey providers
- Electronic health records (EHR) from providers
- Electronic health records (EHR) from MCOs

Quality Applications will connect with HCFA systems to query/pull provider data from the State managed web services in order to link quality data entered into the quality applications with payer organizations.

Quality Applications shall provide the data analytic capabilities to generated reports within the State mandated template and format, either scheduled or on demand and then make them available on the Quality Application portal. Reports in the State mandated machine readable format are also required. These machine readable reports will be distributed by the system to payer organizations through secure channels as prescribed by the State.