Tennessee
Payment Reform Initiative

Provider Stakeholder Group Meeting

August 14, 2013

PRELIMINARY WORKING DRAFT, SUBJECT TO CHANGE

Agenda for August 14th Provider Stakeholder Group meeting

Activity	Time
▪ Introductory remarks and overall progress update	13:00 – 13:15
▪ Episode TAG update and discussions	13:15 – 13:40
▪ PCMH scale-up update	13:40 – 13:50
▪ Provider report design workshop	13:50 – 14:40
▪ Closing discussion & next steps	14:40 – 15:00

Contents

Overview of the first phase

PRELIMINARY

April - June	June - August	August – September / October
Phase I	**Phase II**	**Phase III**
▪ General payment innovation model principles ▪ Episode priorities and road map; select initial three episodes ▪ Stakeholder engagement approach, including calendar and composition of key meetings ▪ Opportunities for collaboration – most important places to align / keep open ▪ Environmental scan of PCMH efforts	▪ Initial detailed design for three episodes, e.g. — Accountability — Statistical methods for transparency and risk adjustment ▪ Identification of areas for collaboration around PCMH ▪ Initial impact estimates ▪ Basic requirements for infrastructure ▪ Most critical design or infrastructure to align on (e.g. reporting) ▪ Regular meetings of Payment Reform Technical Advisory Groups	▪ Timing and approach to scale ▪ Proposed budget and source of funding ▪ Infrastructure / operating model ▪ Forecast impact goal ▪ Episode designs complete for three initial episodes

Long-term vision:

- **Additional episodes will be rolled out in batches every 3-6 months**
- **Within 3-5 years, episodes and population-based payment models account for the majority of health care spend**

Payment Reform Update

	Progress to date / current status	Next steps
Episodes	• Established Technical Advisory Groups (TAGs) with input from payers and providers for all episodes: perinatal, asthma acute exacerbation, total joint replacement (hip & knee) • Held 2 of 4 TAG meetings that discussed Tennessee specific design dimensions for each episode • Conducted preliminary analyses on TennCare's data (cost and volume for each episode) • Discussed additional analyses to bring to next TAG meeting to help guide episode design	• Pressure test and refine current episode analytics • Conduct TAG requested analyses (e.g., risk factor significance, etc.) • Continue episode design dimensions discussion with TAGs to bring recommendations to payers and providers • Discuss potential wave 2 episodes with payers and providers
Episodes Infrastructure	• **Analytics**: Discussed analytics development model/ options – payers reached agreement to conduct analytics development in-house and initiated planning/ resource allocation processes • **Reporting**: Evaluated reporting options and formats; achieved agreement regarding need for standardization across payers • **Portal**: Assessed possibility of centralization while still continuing to leverage existing payers' portals; initiated payer survey to assess existing portal utilization/ adoption	• **Analytics**: Develop analytics development timelines/ plan for 3 selected episodes and undertake coding/ implementation • **Reporting**: Finalize TN report template design and development options • **Portal**: Evaluate potential to ensure maximum provider adoption by best leveraging payers' existing portals and/ or developing a 'linked portal'
PCMH	• Developed and aligned on elements of a PCMH strategy • Conducted environmental scan of current payer initiatives in TN • Surveyed payers and providers about barriers to scale-up • Reviewed data on total cost of care variation across PCMHs • Discussed "game board" of scale-up options with payers and providers • Achieved initial alignment around pursuing a multi-payer scale-up strategy in selected geographies	• Analyze geographic areas and select areas for initial multi-payer PCMH launch • Decide on elements of PCMH design where payers would derive value by aligning on a common approach • Begin to align on key design elements as necessary

Payment Reform Update

	Progress to date / current status	Next steps
State Health Care Innovation Plan	• Currently developing initial draft • Held initial meetings held with stakeholders/ internal experts on: – Workforce (Public roundtable, 7/31) – Population health – Health information technology and health information exchange	• Continue to develop initial draft • Conduct meetings with DOH on workforce • Host upcoming Roundtables on health information technology, population health, and behavioral health • Develop financial analysis, including projected savings to the health care system over the project period • Develop budget for overall payment reform initiative • Draft initial SIM testing grant application
Stakeholder Engagement	• Formed core stakeholder groups, including Payer Coalition, Provider Stakeholder Group, Employer Stakeholder Group, Public Roundtables, and Technical Advisory Groups for each episode; met with regularly with each • Engaged THA Vision Task Force • Held regular meetings with payers and providers	• Continue to engage and seek input from stakeholder groups • Enhance Vision Task Force engagement • Meet individually with select providers • Continue one-on-one conversations with payers to understand individual payer perspectives and address concerns • Meet individually with large self-insured employers

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Highlights from TAG discussions to date: Perinatal

Progress to date / current status	Key findings/ highlights	Next steps
• Focus of TAGs has been less about identifying economic sources of value and more about **improving quality** • Requested that **no exclusions be applied**, but all potential risk factors should be analyzed for significance in TN • Suggested **P4P approach for C-section rate limit** and other quality metrics (e.g., vaccinations) • Would like visibility on **individual provider performance** instead of group (e.g., MFMs vs Vanderbilt overall)	• Less than **90% of quarterbacks** across the state are responsible for **over 60% of TennCare episodes** • On a non-risk adjusted basis, the **average cost of the 75th percentile** quarterback is nearly **1.5x the 25th percentile** quarterback • C-section rates per quarterback also show variation: **44% for the 75th percentile quarterback and 27% for the 25th percentile quarterback**	• Provide volume, cost, and significance for **potential risk factors** • Discuss **risk adjustment/exclusion** approach in TN • Discuss **quality metrics** to apply to TN and ways to capture additional non-claims based quality metrics (e.g., patient education)

Highlights from TAG discussions to date: Asthma acute exacerbation

Progress to date / current status	Key findings/ highlights	Next steps
• Importance of differentiating between pediatric vs adult cases in specialized facilities • Distribution and **fairness of costs** associated with inpatient versus outpatient cases • **Standardization of care** and how PCPs should be involved in an episode (e.g., increasing overall communication) • How **access to care for patient** affects the quality and quantity of care they receive	• While less than **10% of episodes involve inpatient admissions**, nearly 30% of costs are in inpatient episodes • Nearly **50% of episodes occur in 5 facilities** that each handle over 500 episodes per year • On a non-risk adjusted basis, the average cost of the **75th percentile quarterback is nearly 1.5x the 50th percentile quarterback** (assuming QB is facility) • **Significant variation in re-hospitalization rates**, ranging from less than 5% to greater than 20%	• Evaluate pediatric vs adult cost data and statistics. • Analyze **performance of pediatric specialist** institutions • Provide volume, cost, and significance for **potential risk factors** • Discuss **risk adjustment/exclusion** approach in TN

Highlights from TAG discussions to date: TJR

Progress to date / current status	Key findings/ highlights	Next steps
• TennCare data has **limited episode volume** so including spend from 2008-2012 • Debate about QB selection in TN (e.g., surgeon and/or facility), and about **facility choice as a source of value** • Debate about **episode inclusion period** and surgeon responsibility prior to trigger • Requested that **no exclusions be applied**, but all potential risk factors should be analyzed for significance in TN	• Mapping out facilities, no facility that has seen a TennCare episode in the last 5 years is **more than 40 miles away** from another facility that has seen a TennCare episode in the last 5 years • The plurality of orthopedic surgeons' first encounter with the patient in the **90 day pre-procedure window is between 40 and 50 days prior to the procedure** • On a non-risk adjusted basis, the average cost of the **75th percentile quarterback is nearly 1.5x the 25th percentile quarterback** (assuming QB is orthopedic surgeon) • There is **no statistical relationship between average inpatient cost and readmission rate** for a quarterback (assuming QB is orthopedic surgeon)	• Provide volume, cost, and significance for potential risk factors • Evaluate **cost and performance variability** across different time windows • Get granularity on what's included in **different cost categories** (e.g., inpatient, professional, etc.)

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Update on the path forward for PCMH

Direction from payer group

- The path forward on PCMH could involve **selection of ~2 markets** in which to a test **multi-payer, multi-book PCMH approach**
- In each market, **payers select the same providers** for implementation of a PCMH model
- The aim is to **achieve scale with a subset** of providers in selected markets
- The PCMH model allows room for innovation, but is consistent enough that **providers can easily participate with all payers** at the same time (e.g., even if payment streams or other elements differ by payer)

Questions for discussion

- Do **providers support** this approach?
- What **factors** would make this approach **more attractive** to providers?
- How can the participating payers best partner with providers? Does it make sense for **providers to be able to opt in to the PCMH model**, or could there be a selection process?
- What considerations should be taken into account in **selecting specific markets** for initial PCMH scale-up?

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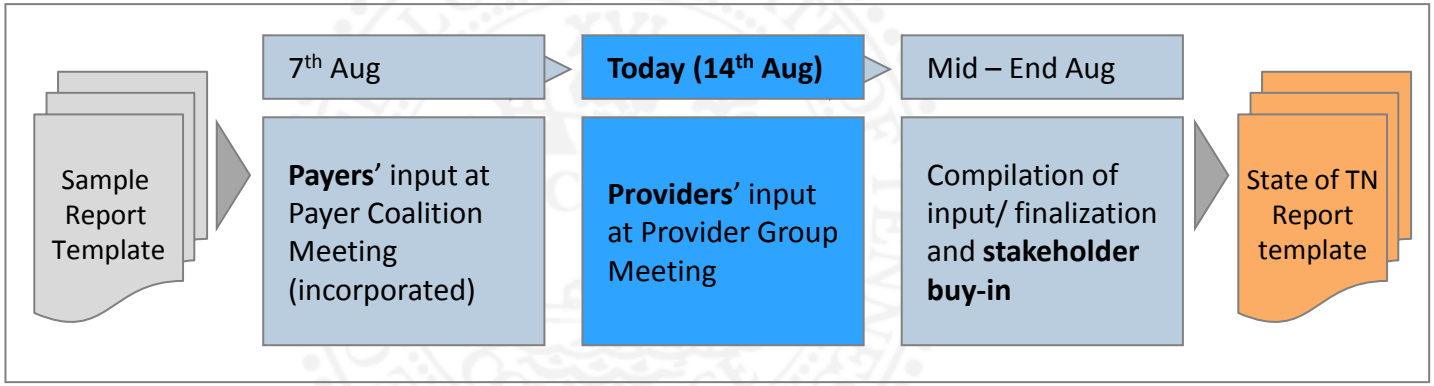
Provider report design: Overview and workshop objectives

What we are solving for?

How should the base/ sample report template be customized to **help providers gain better insight into their performance** (relative to others) and provide them with actionable information that they can leverage to **improve quality and reduce costs?**

How is the report design deliberation process structured?



A few aspects to keep in mind

- We are solving for **version 1 for phase 1** – the **report design is expected to be continually improved** based on stakeholder feedback
- These reports will go to the **episode quarterback – guidelines around downstream sharing** of these reports will be drafted keeping in perspective pertinent contractual/ statutory considerations around information sharing
- **Payers' feedback/ input** on the episode report design has been sought and specific elements have been incorporated in the base template (circulated during the meeting today)

Provider report design: A few key questions to be addressed

Key questions to help you structure your feedback

How will providers make use of the information (metrics) included in the sample report template?

Do providers have any recommendations to improve the **representation of current metrics**?

Are there any other **metrics that providers would like to see but are not included** in the sample report template?

A few **topics for input/ feedback** and further deliberation

- **Existing reports from payers**: What related reports do providers receive from payers? How do they receive them? How useful is the data in these reports?
- **Reporting scope:** Should these reports only cover the PAP's or also address other providers with material impact on the episode?
- **Reporting level/ aggregation**: Should the reports be only specific to physicians or also be aggregated at a group level?
- **Reporting period**: How often should these reports be generated and distributed to make meaningful use of the information?
- **PAP identification/ assignment:** What are providers' perspectives on tracking of claims and PAP identification (billing/ tax ID vs. 'specific' provider)?
- **Report distribution and downstream sharing**: Who will be analyzing the information in the reports (for different types of providers)?
- **Facilities/ practice changes and rotations:** What are the avenues to consider when dealing with re-alignment/ changes in practices/ physicians/ facilities?

Provider report design: Summary of payer coalition feedback

Broad/ overall feedback	• **Report generation periodicity and reporting period** - needs to be determined as part of episode design considerations balanced with the need to offer providers actionable information in a timely manner • **Potential to divide TJR report into Hips and Knees** -- may be taken into consideration however episode volume may not make such a move feasible • **Include a brief report guide/ glossary** as part of the report to ensure consistent interpretation of report metrics
Page 0 (Provider Episode Summary)	• Include **net total gain/ risk share for all episodes** combined (more pertinent from long term perspective when number of episodes increase) • Evaluate potential to **include trends** i.e. performance comparison across periods to showcase progress by provider (Current + TTM) • Include **reporting period** (on every page)
Page 1 + 2 + 3 (Episode specific quality + cost summary and details)	• Provide **summary of exclusions** (detail by category/ type if possible) • Include **risk factor/ ratio** (showcasing severity of illness of patient base for a provider) • Consider **alternate design/ representation of quality metrics graphs** (especially considering potential for future episodes with over 6 metrics) • Explore **potential to combine summary metrics and detailed metrics** -- rationale of providing summary on one page and then repeating the same as details on the other • Evaluate various **graphical depiction of cost vs. quality** to build consistency • **De-wording** where possible (e.g. quality metrics summary section on page 1)
Report Annexure (Patient-wise episode details)	• Evaluate the possibility of **including references to primary and tertiary diagnosis** where applicable (in cases of co-morbidities) • Include **comparison of detailed cost to average cost** (use conditional formatting etc.) • Evaluate ways to **include Rx if PB carried out**

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Housekeeping questions and information

- Third round of **TAG meetings** (asthma acute exacerbation, perinatal and TJR) are scheduled in the following 2 weeks
- Next **Public Roundtable** meeting with focus on Health Information Technology will be held on August 26 (1-3pm; webinar available)

September 11 Payment Reform Provider Stakeholder Group meeting

PRELIMINARY

Agenda

- Introductory remarks
- PCMH Update
- Episodes: Analysis of TAGs findings and and additional design decisions
- Episode report design update
- Discussion and next steps

Preliminary topics for discussion on September 11

- Evaluating geographies, populations, or types of practices during the first stages of a PCMH program
- Discussing additional episode design decisions
- Aligning on TAGs design deliberations around clinical definition of episodes.
- Episode report design updates and discussions around distribution guidelines

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Information about the following analyses

PRELIMINARY

The analyses on the following pages is for informational purposes to facilitate discussion in the TAG meetings

- The analyses result from **applying the prototype episode design** to TennCare's data for all episodes:
  - Episodes **were triggered based on criteria specific** for each episode:
    - Perinatal: A live birth
    - Asthma: Visit to the hospital for acute exacerbation
    - TJR: A surgical procedure for Total Hip or Knee replacement
  - **Specific claims were included** during the episode duration
    - Perinatal: 40 weeks prior to delivery and 60 post delivery
    - Asthma: Facility visit through 30 days post-discharge
    - TJR: 30 days prior to admission and 90 days post discharge
  - The **quarterback was identified** using prototype methodology :
    - Perinatal: Delivering provider
    - Asthma: Facility
    - TJR: Orthopod that performed the surgery
  - **No exclusions** were removed
  - **No risk adjustments** were considered
- Additional QA must be run to ensure robustness of the prototype on TennCare's TJR data

Episode design dimensions for TAG discussion

Dimension	Description
1 Episode definition and scope of services	▪ What triggers an episode? ▪ What services / claims are included in calculating episode costs?
2 Episode exclusion criteria	▪ Are there episodes that should not be included in calculating episode costs? – Clinical exclusions – Business exclusions (e.g., not continuously enrolled)
3 Quarterback selection	▪ Who is the most appropriate quarterback (e.g., could be a facility or an individual provider)?
4 Episode adjustments	▪ How should a provider's cost be adjusted due to high-risk patients or other practice characteristics?
5 Quality metrics	▪ What quality metrics are most important to track? ▪ Should they be tracked or tied to episode-based payment?

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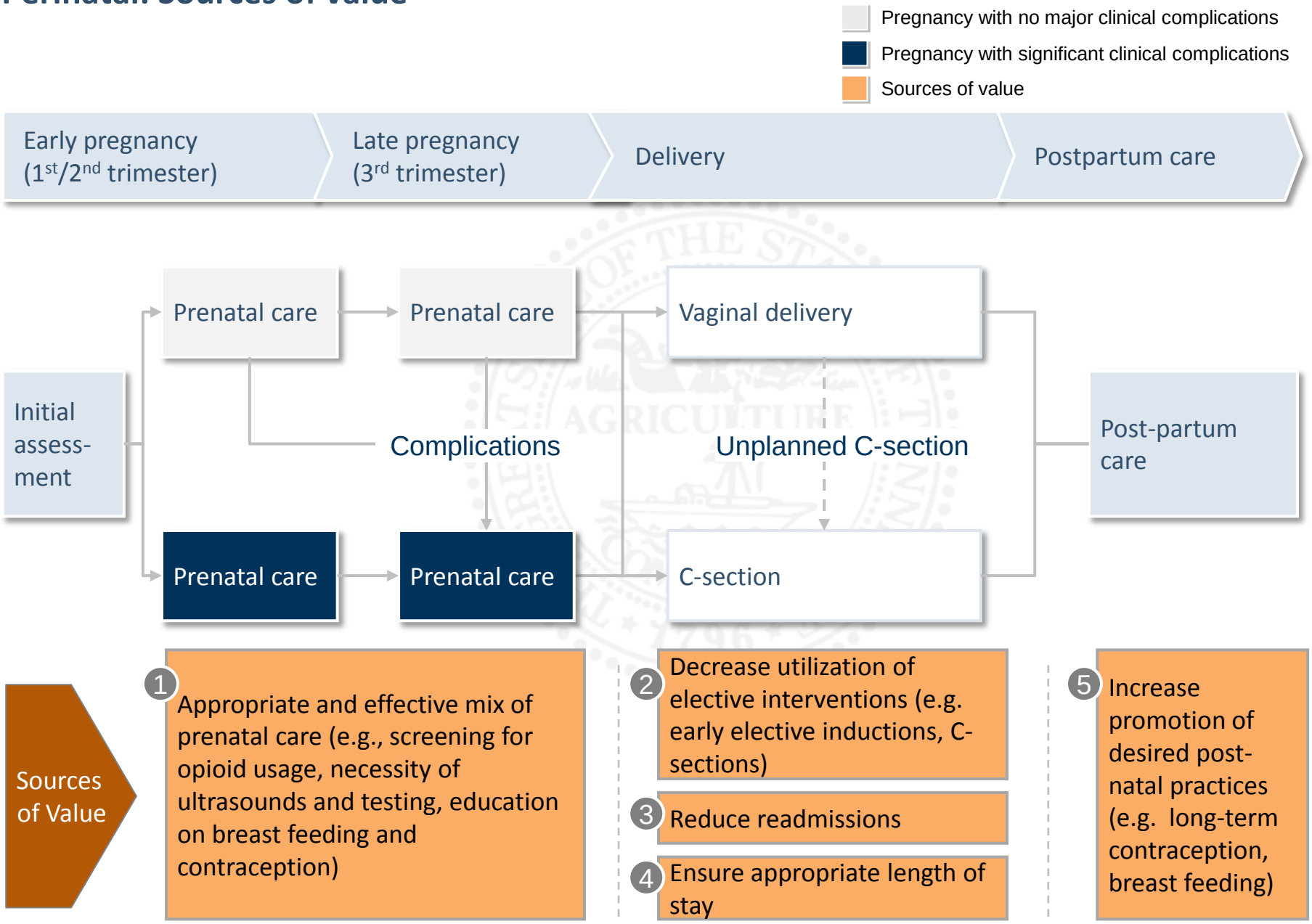
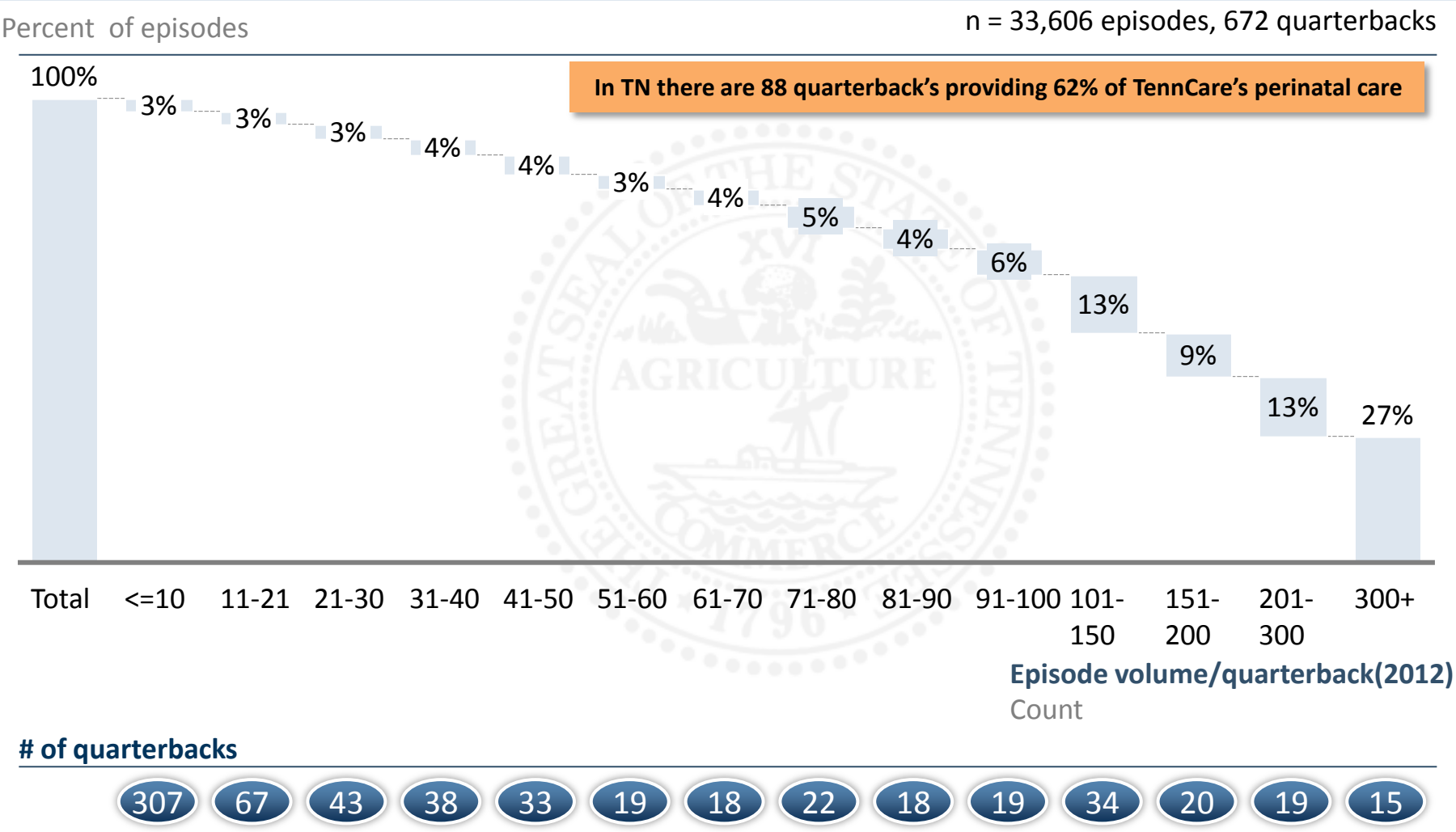
Perinatal: Sources of value



PRELIMINARY: Variation in episode volume per quarterback

PRELIMINARY

Variation in volume per quarterback: perinatal



1 No exclusions applied (except unknown providers (3914 episodes) were removed)

Source: TennCare, trigger dates during 2012

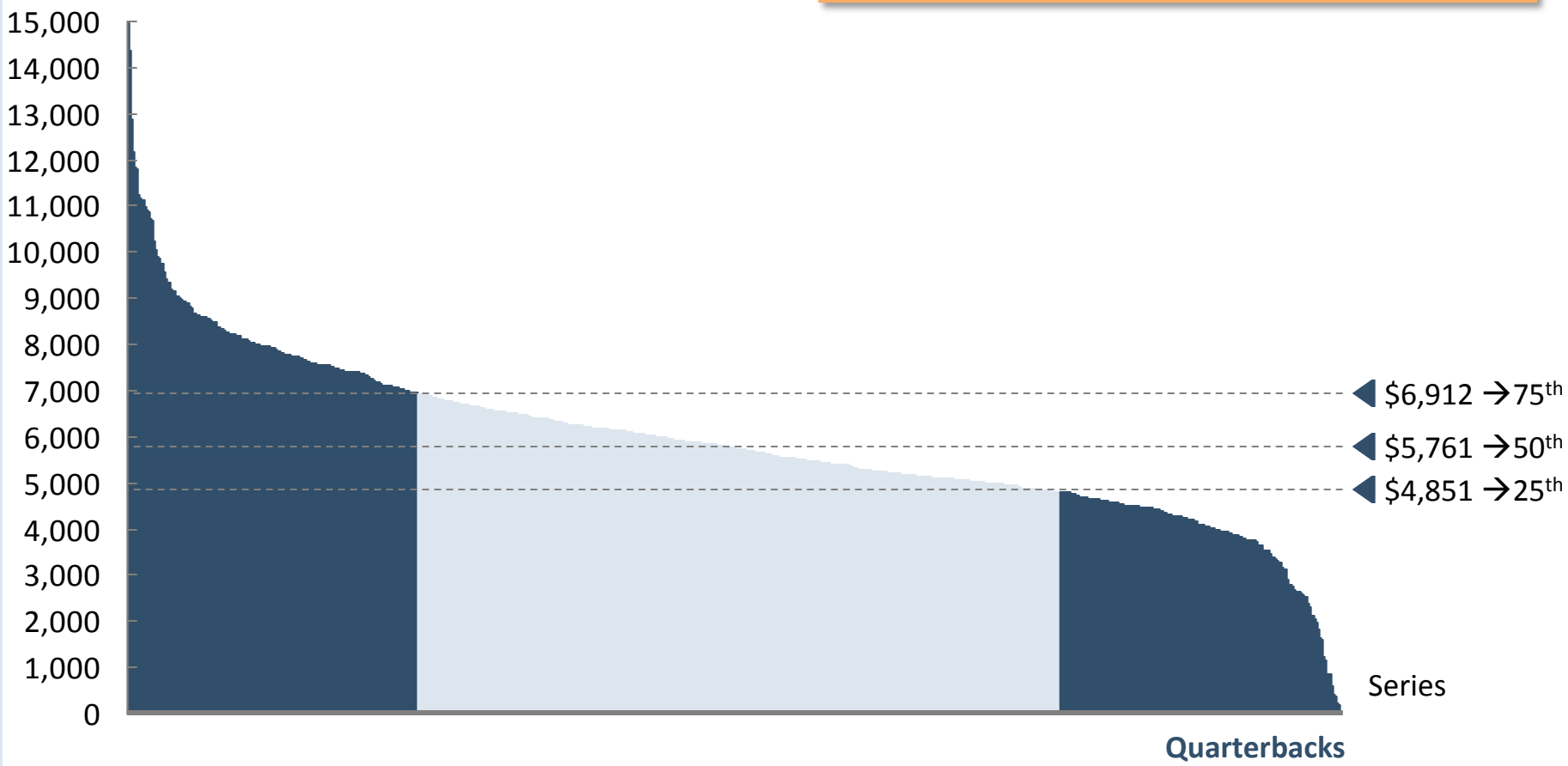
PRELIMINARY: Average episode cost per quarterback

NON-RISK ADJUSTED COST DATA | PRELIMINARY

Further QA to ensure data robustness

Quarterback average cost distribution: perinatal

Significant variation in average episode cost across quarterback exists in TN



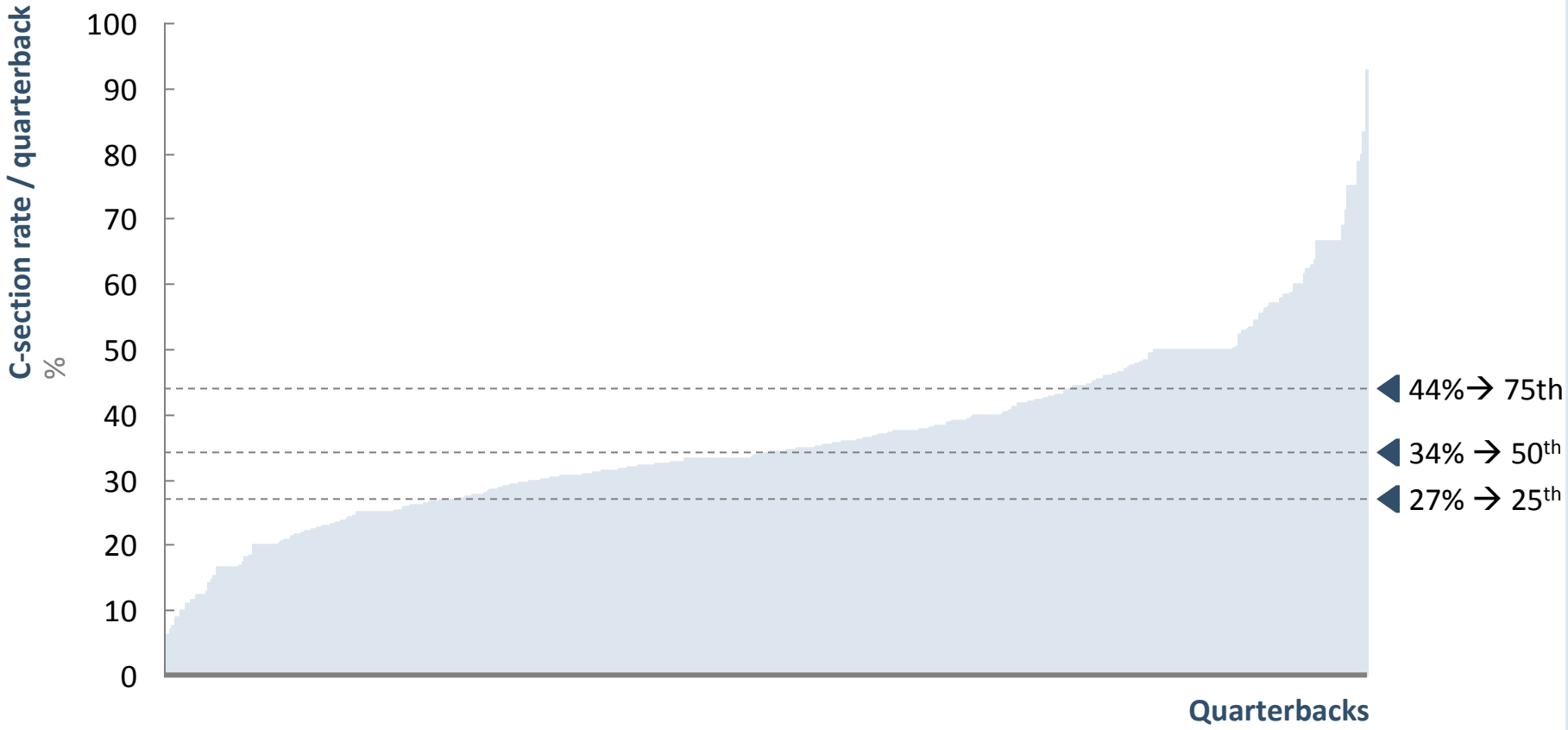
1 4 providers (6 episodes total) with Avg cost > $15000 were removed for further analysis; unknown providers (3914 episodes) were removed

Source: TennCare, trigger dates during 2012

PRELIMINARY: Average C-section rate per quarterback

PRELIMINARY

Quarterback C-section rate distribution: Perinatal



1 Excludes unknown providers (3914 episodes), 61 quarterback s(87 episodes total) with 100% C-section rate and 145 quarterbacks (562 episodes total) with 0% C-section rate

Source: TennCare, trigger dates during 2012

Episode exclusions and adjustments – Perinatal (1/2)

Perinatal TAG has currently put all potential risk factors on the table to understand significance in TN

Exclusions (pregnancy related conditions)

- Amniotic fluid embolism
- Obstetric blood clot embolism
- Placenta previa
- Severe preeclampsia
- Multiple gestation ≥3
- Late effect complications of pregnancy/childbirth
- Puerperal sepsis
- Suspected damage to fetus from viral disease in mother

Exclusions (severe/chronic diseases)

- Cancer
- Cystic fibrosis
- Cardiovascular disorders
- DVT/pulmonary embolism
- Other phlebitis and thrombosis
- End-stage renal disease
- Sickle cell
  Type I diabetes

Risk factors

Cardiomyopathy
Other major puerperal infection
Fetal Damage from Other Disease
Prolonged First Stage
Breast Abscess In Preg
Twin Pregnancy
Puerperal Endometritis
Major puerperal infection; unspecified
Prolong Rupt Membran Nos
Eclampsia
Fetal Damage D/T Drug
Cervix Incompet In Preg
Hyperemesis gravidarum w/metabolic disturbance
Toxemia W Old Hyperten
Disrupt Cesarean Wound
Fail Induction Labor Nos
Venous comp/Pyrexia of unkn origin in puerperium
Mild/Nos Pre-Eclampsia
Oth Compl Ob Surg Wound
Diabetes Mellit In Preg
Malposition unspecified
Indicat Care Lab/Del Nec
Oth Compl Anesth In Del
Cardiovas Dis Nec In Pg

SOURCE: Arkansas Payment Improvement Initiative

Episode exclusions and adjustments – Perinatal (2/2)

Perinatal TAG has currently put all potential risk factors on the table to understand significance in TN

Risk factors	Risk factors
Infection In Preg Nos	Hemorr In Early Preg Nos
Renal Dis In Preg Nos	Trans Hypertension Preg
Delay Postpartum Hemorr	Supervision of unspecified high-risk pregnancy
Uterine Inertia Nec/Nos	Fetal Abnormality Nec
Puerperal Compl Nec/Nos	Breech Presentation
Early Onset Of Delivery	Infectiv Dis In Preg Nec
Secondar Uterine Inertia	Threatened Abortion
Fetopelvic Disproportion	Pregnancy Compl Nec
Previous C-Section Nos	Antepartum Hemorr Nos
Mental Disorders In Preg	Abn Ftl Hrt Rate
Hypertens Compl Preg Nos	Dec Fetal Mvmt Affctg Mthr
Fetal Distress	Pregnancy, Post Term
Failed Trial Labor Nos	Anemia In Pregnancy
Pregnancy Compl Nos	
Oligohydramnios	
Bone Disorder In Preg	
Threaten Premature Labor	
Other Viral Dis In Preg	
Mild Hyperemesis Gravi	
Fetal Chromosomal Abn	
Vomiting Pregnancy Nos	
Oth Current Cond Of Preg	
Oth Placental Conditions	
Infect Amniotic Cavity	

SOURCE: Arkansas Payment Improvement Initiative

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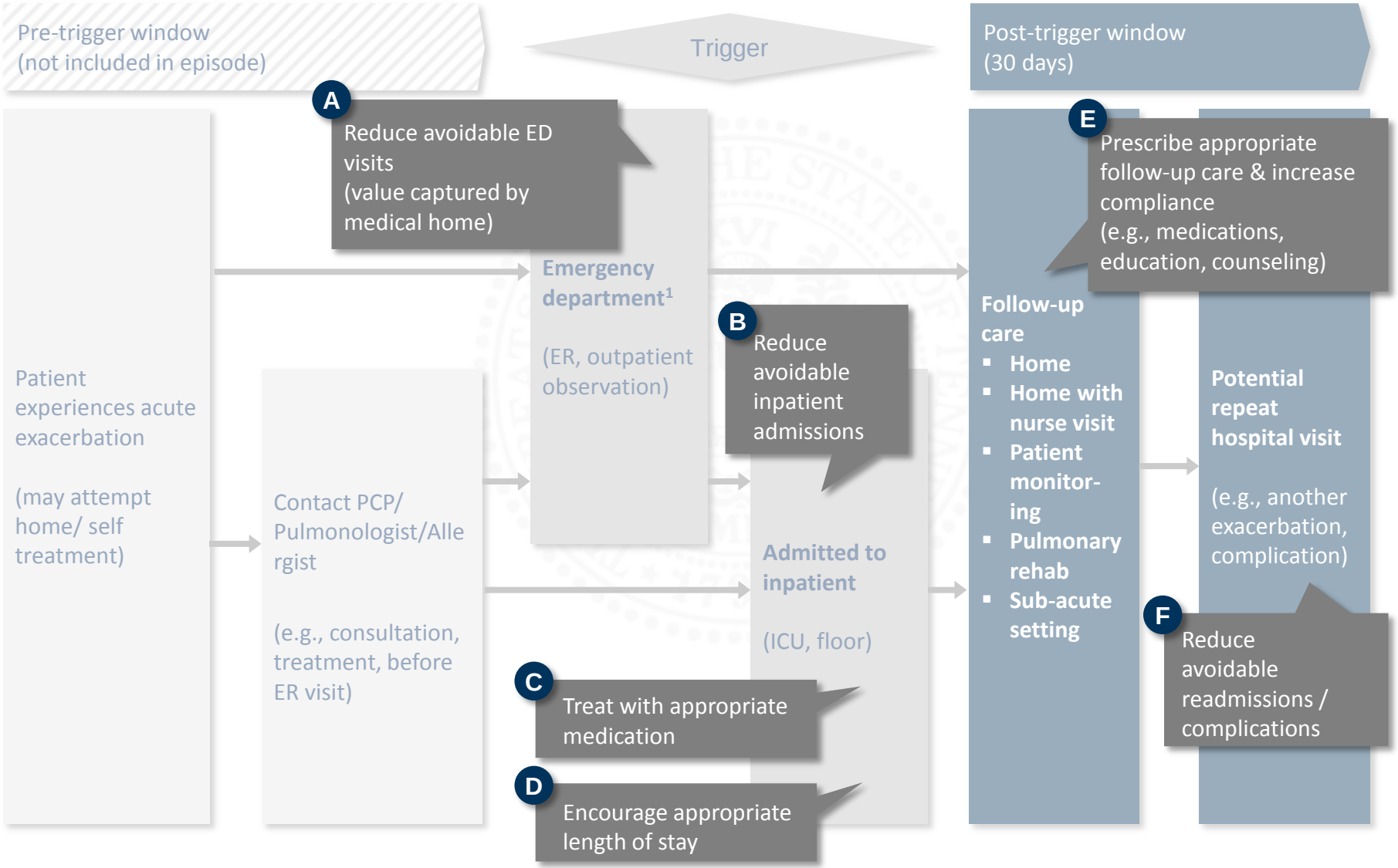
Asthma acute exacerbation

Proposed sources of value

TENNESSEE DRAFT

Sources of value



1 May include urgent care facility

SOURCE: Arkansas Payment Improvement Initiative

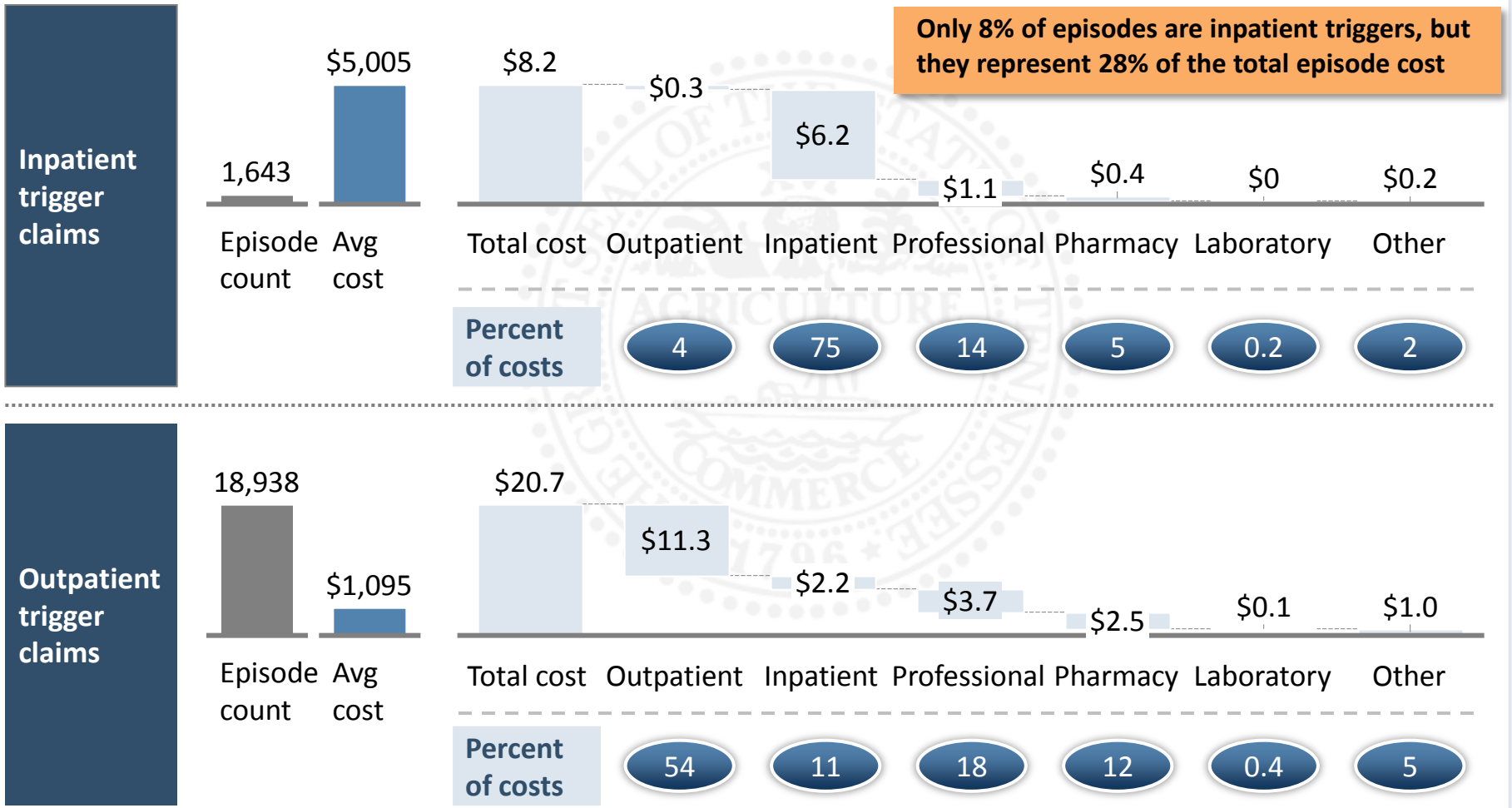
PRELIMINARY: Overview of TennCare cost and breakdown by trigger claim type

PRELIMINARY

NON-RISK ADJUSTED COST DATA

Inpatient vs outpatient episode cost breakdown: asthma acute exacerbation

$M (trigger date in SFY2012)



1 No exclusions applied

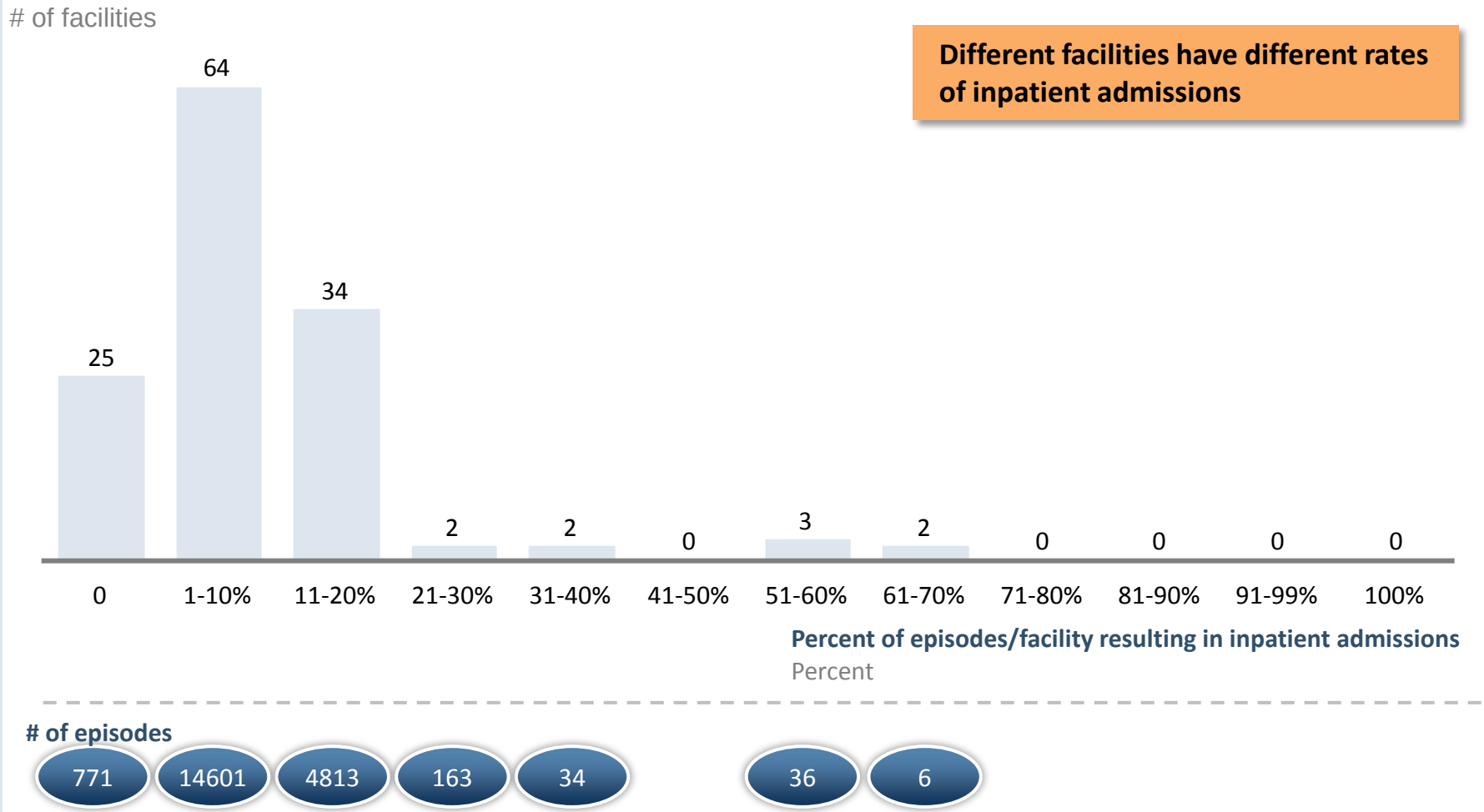
Source: TennCare, trigger dates during 2012

PRELIMINARY: Distribution of inpatient trigger claims

PRELIMINARY

Inpatient rate distribution: asthma acute exacerbation

n = 20,424 episodes, 132 facilities



1 Excludes 142 facilities with fewer than 2 episodes

Source: TennCare, trigger dates during 2012

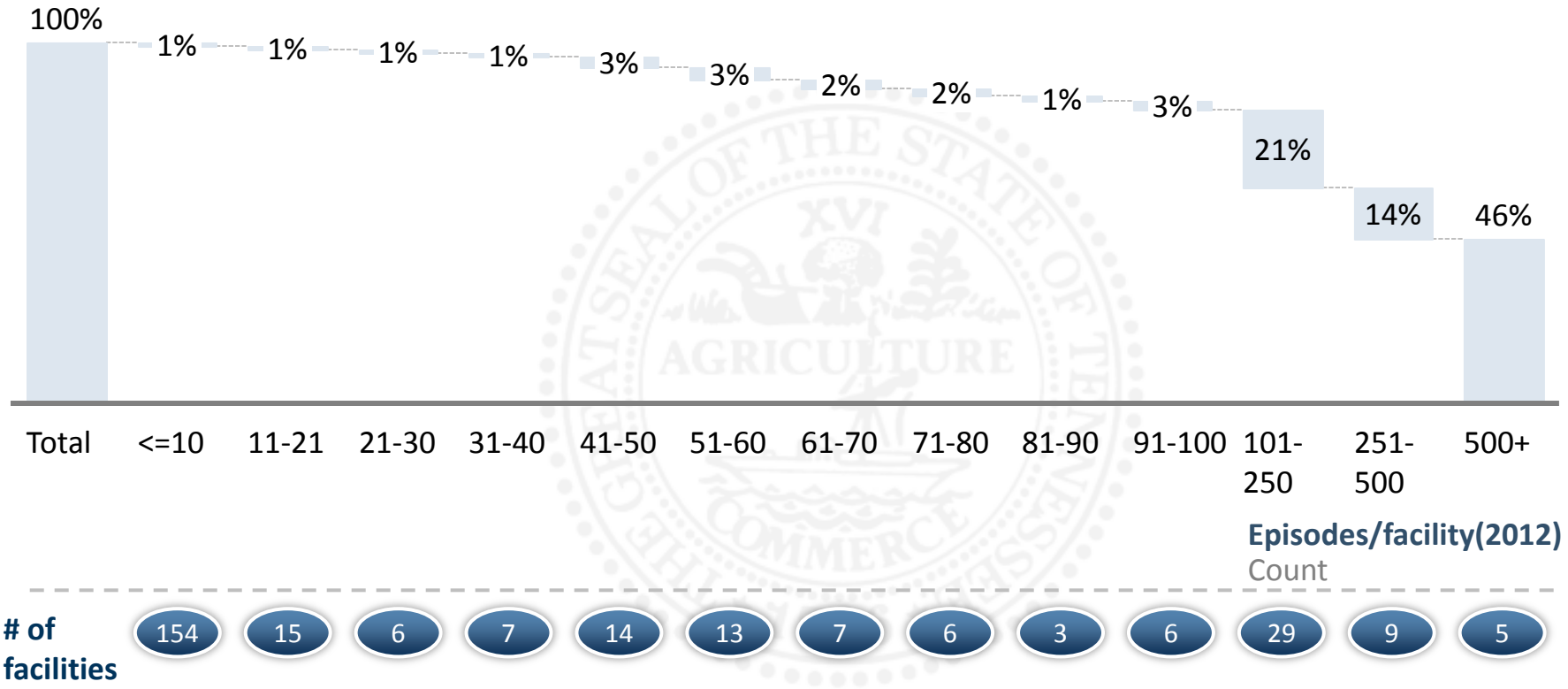
PRELIMINARY: Variation in episode volume per facility

PRELIMINARY

Variation in volume per facility: asthma acute exacerbation

Percent of episodes

n = 20,582 episodes, 274 facilities



- 46% of episodes served by facilities potentially accountable for at least 500 episodes per year (5 facilities)
- 81% of episodes served by facilities potentially accountable for at least 100 episodes per year (43 facilities)
- 78 facilities potentially accountable for 91% of episodes
- 196 facilities (of 274 total) potentially accountable for fewer than 50 episodes per year

1 No exclusions applied

Source: TennCare, trigger dates during 2012

PRELIMINARY: Average episode cost per facility

NON-RISK ADJUSTED COST DATA | PRELIMINARY

Further QA to ensure data robustness

Average episode cost per facility: Asthma acute exacerbation

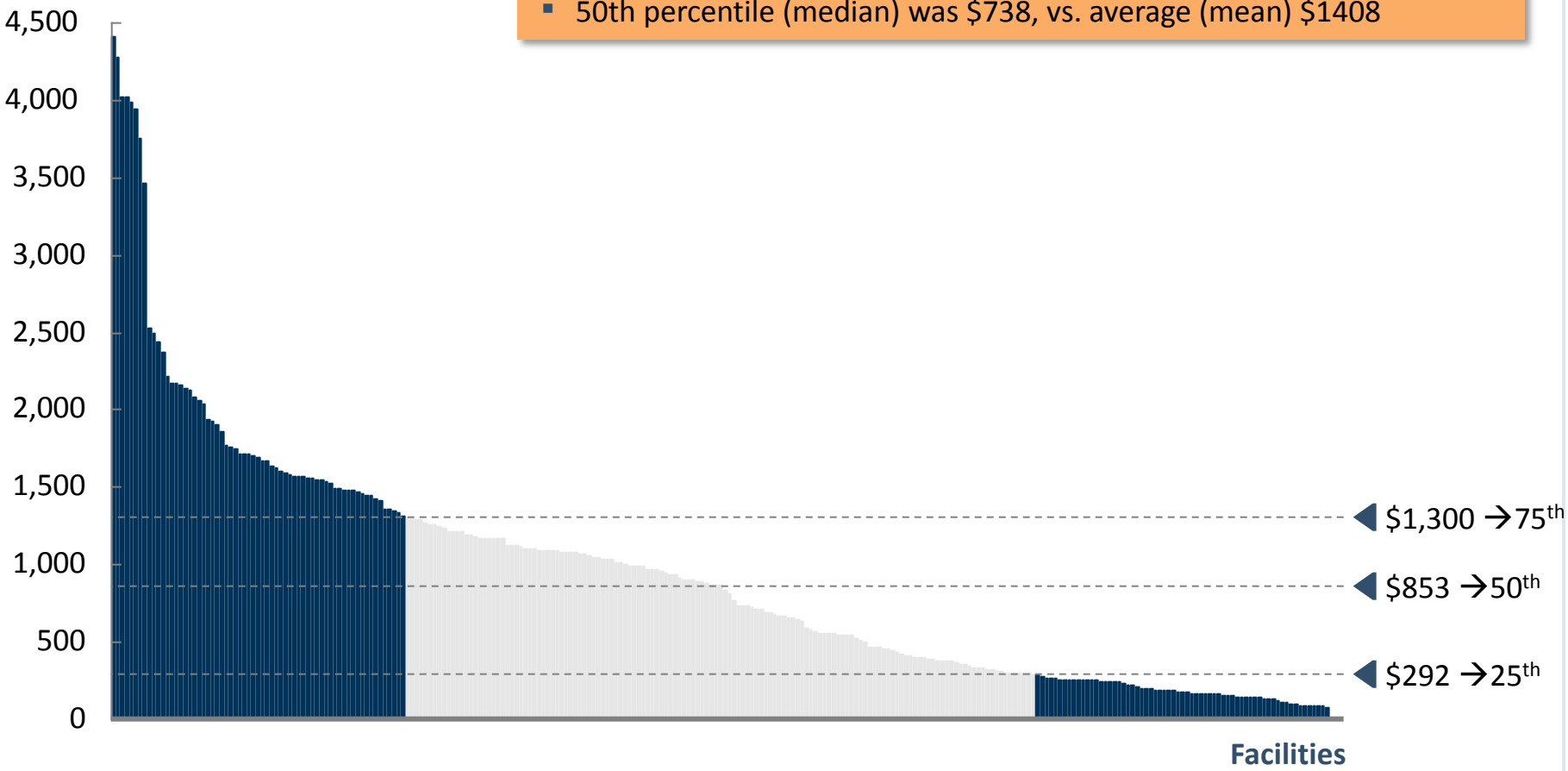
Average cost, trigger date SFY2012

Non-Adj. average cost/episode

$

Significant variation in average episode cost across facilities

- Average costs per episode ranged from $4,500 to less than $300
- 50th percentile (median) was $738, vs. average (mean) $1408



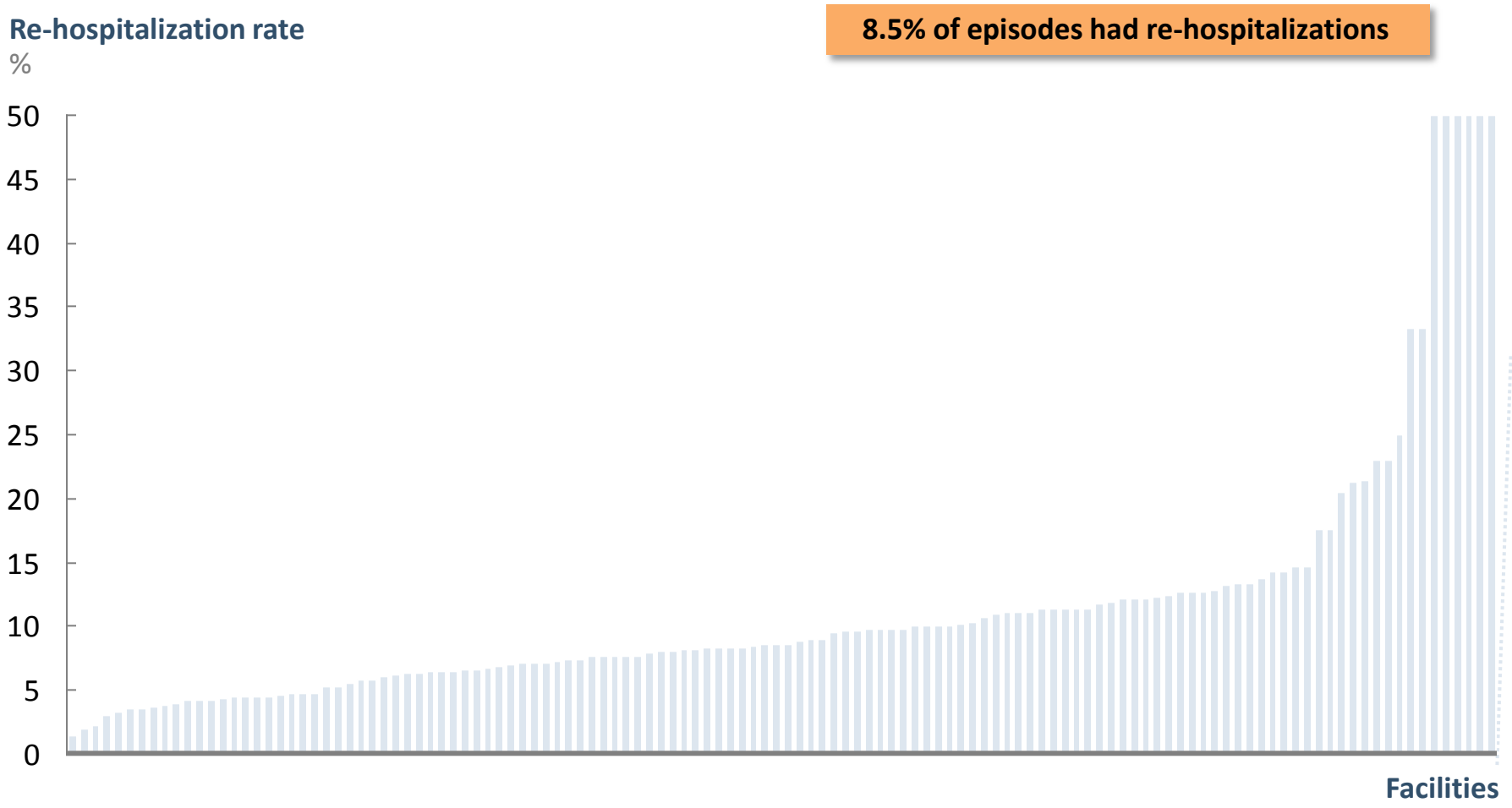
1 2 facilities (2 episodes total) with Avg cost > $5000 were removed for further analysis. No other exclusions applied.

Source: TennCare, trigger dates during 2012

PRELIMINARY: Average re-hospitalization rate per facility

PRELIMINARY

Facility re-hospitalization rate distribution: Asthma acute exacerbation



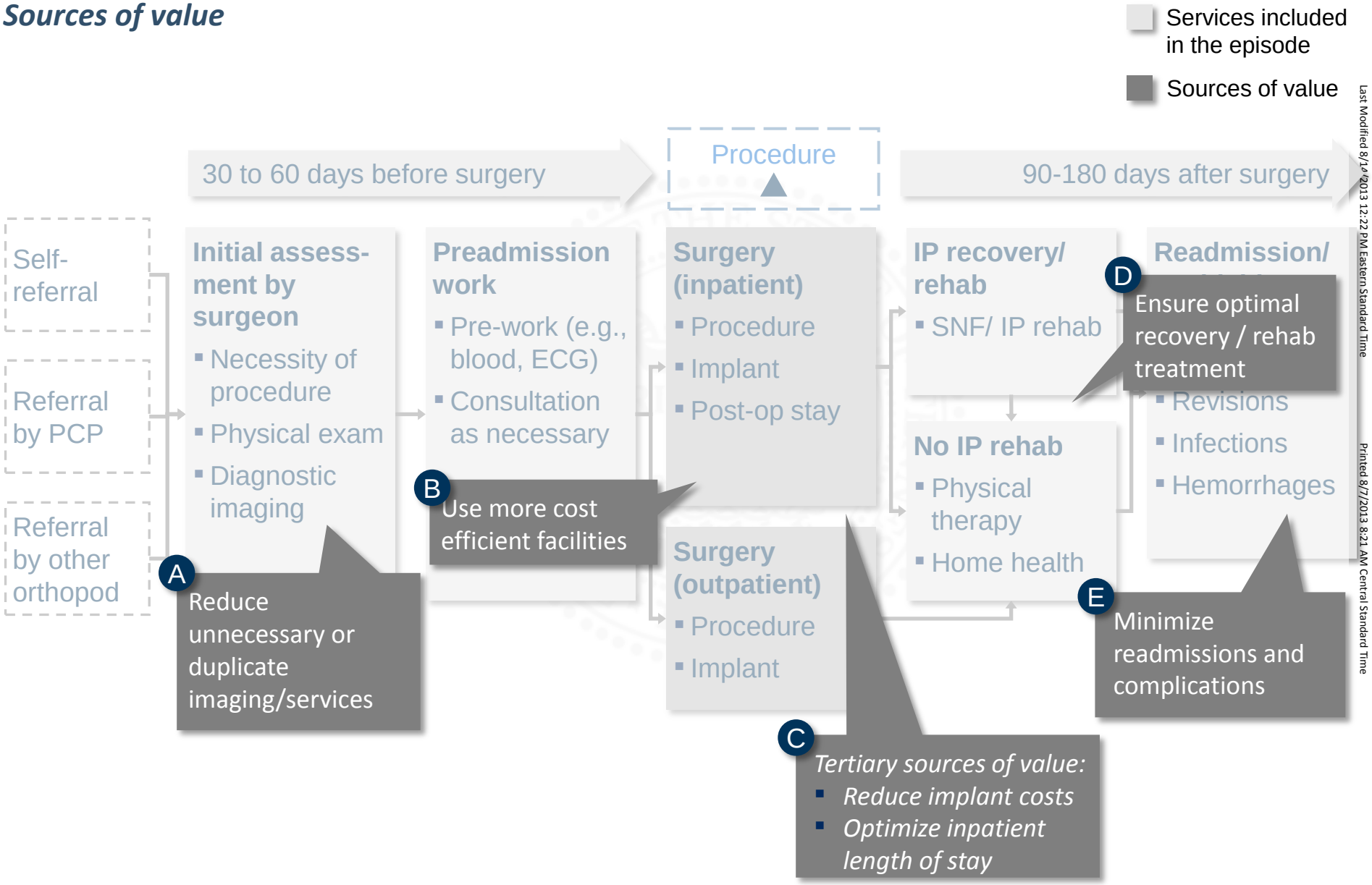
1 Excludes 139 facilities with 0% readmissions and 11 facilities with 100% readmissions (resulting in less than 2% of episodes being excluded) No other exclusions applied.

Source: TennCare, trigger dates during 2012

Contents

Episode definition and scope of services – TJR (Hip & knee replacements) :

Sources of value

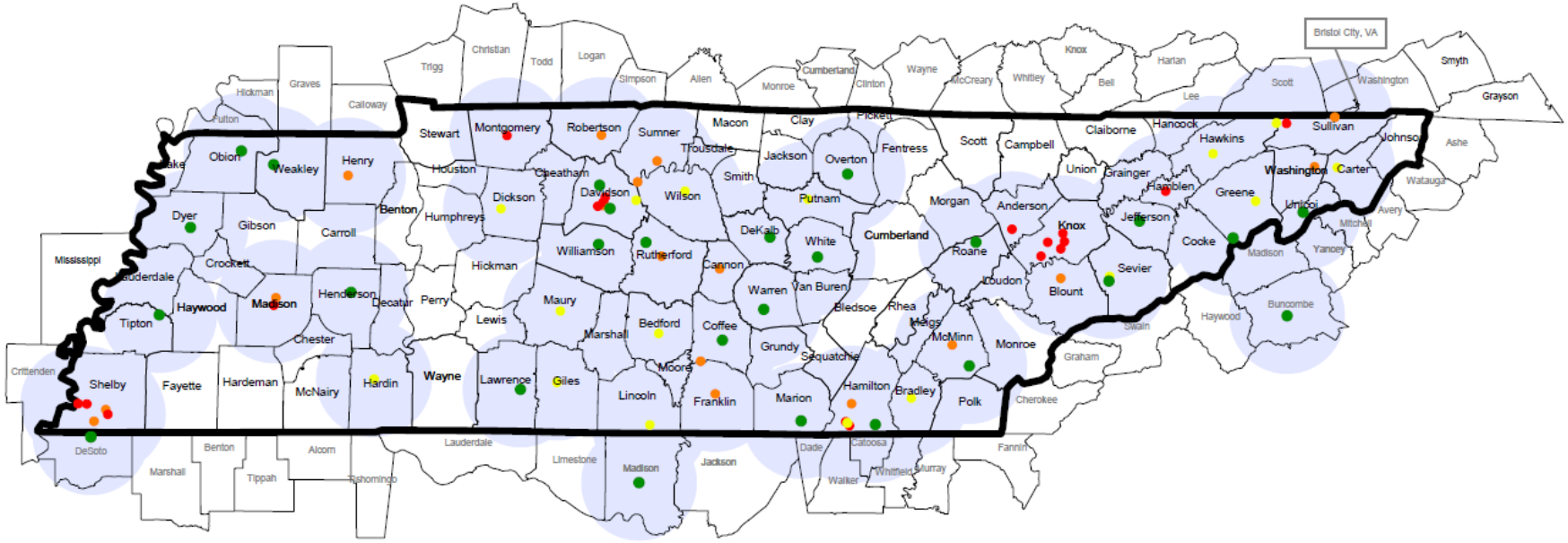


SOURCE: Arkansas Payment Improvement Initiative

Facility locations in Tennessee

- >=50 episodes
- 20-49 episodes
- 10-19 episodes
- < 10 episodes

Area represented by a 20 mile radius around existing facilities



All facilities are within a 20 mile radius of at least one other facility

Source: TennCare, trigger dates during 2008-2012, 3 facilities out of state (3 episodes), 3 episodes with unknown facilities

NON-RISK ADJUSTED COST DATA

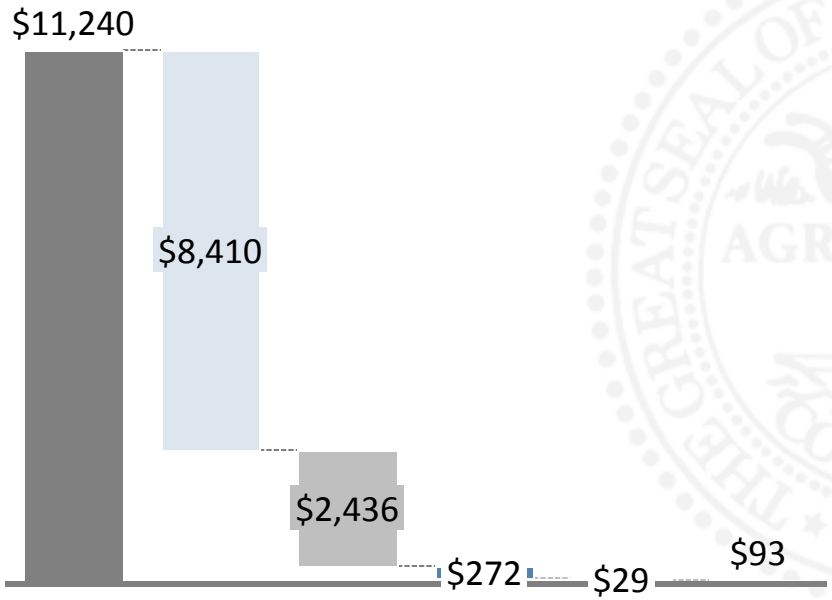
PRELIMINARY

PRELIMINARY: Overview of TennCare cost and breakdown by claim type for Hip and Knee replacements

TennCare spent a total of ~$24.8M for 2,255 episodes between 2008-2012

Cost breakdown for eligible THR Episodes

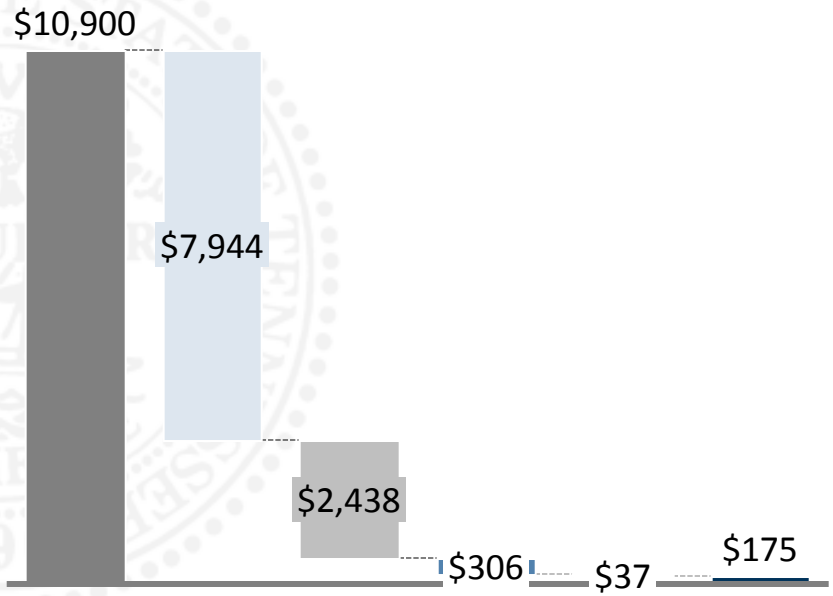
Average cost (2008-2012)
N = 774 Hip Replacements



	Total	In-patient	Profes-sional	Out-patient	Labora-tory	Other
% total cost		74.8	21.7	2.4	0.3	0.8

Cost breakdown for eligible TKR Episodes

Average cost (2008-2012)
N = 1,481 Knee Replacements



	Total	In-patient	Profes-sional	Out-patient	Labora-tory	Other
% total cost		72.9	22.4	2.8	0.3	1.6

1 No exclusions applied (except unknown providers (no professional claim) (544 episodes, $5,648,374) were removed)

Source: TennCare, trigger dates during 2008-2012

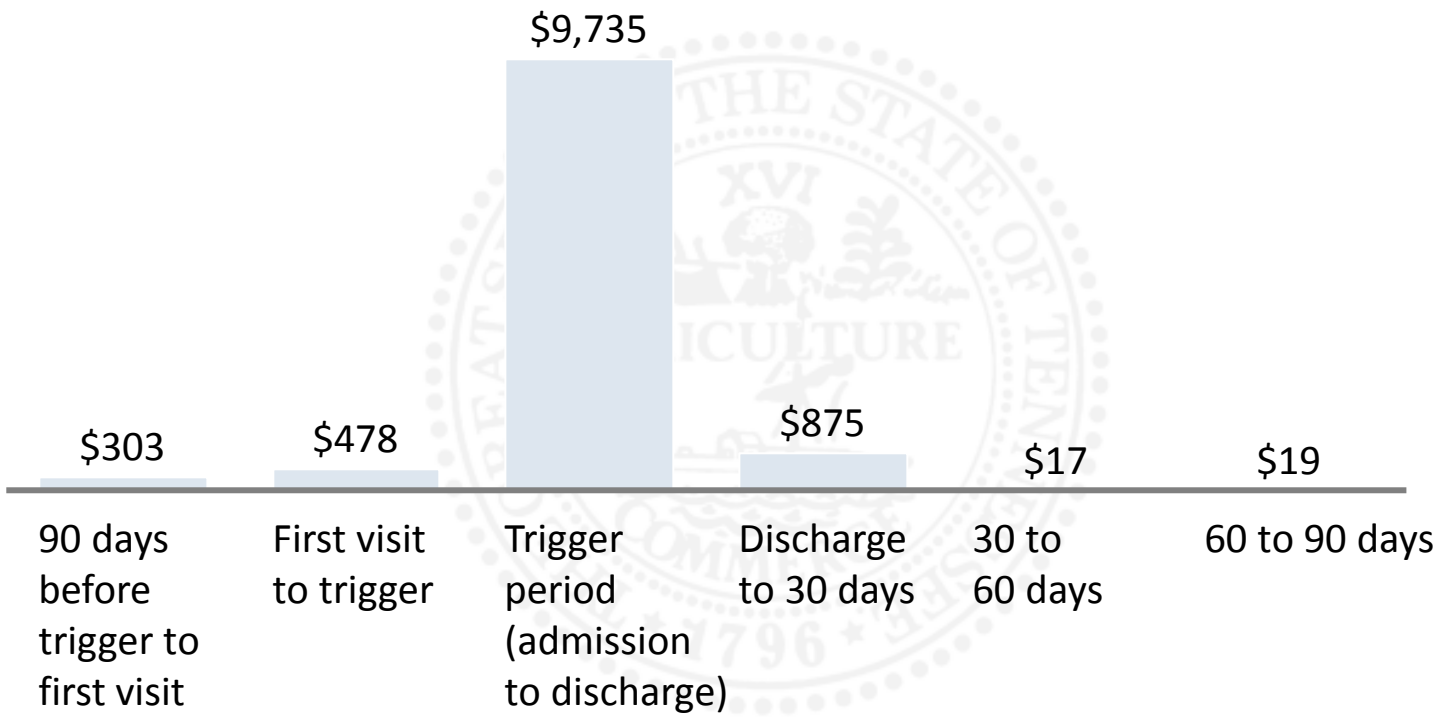
NON-RISK ADJUSTED COST DATA

PRELIMINARY: Overview of TennCare costs pre-Orthopod vs post-Orthopod

PRELIMINARY

Average episode cost breakdown by time period: TJR

$ (2008-2012)



Percent of costs

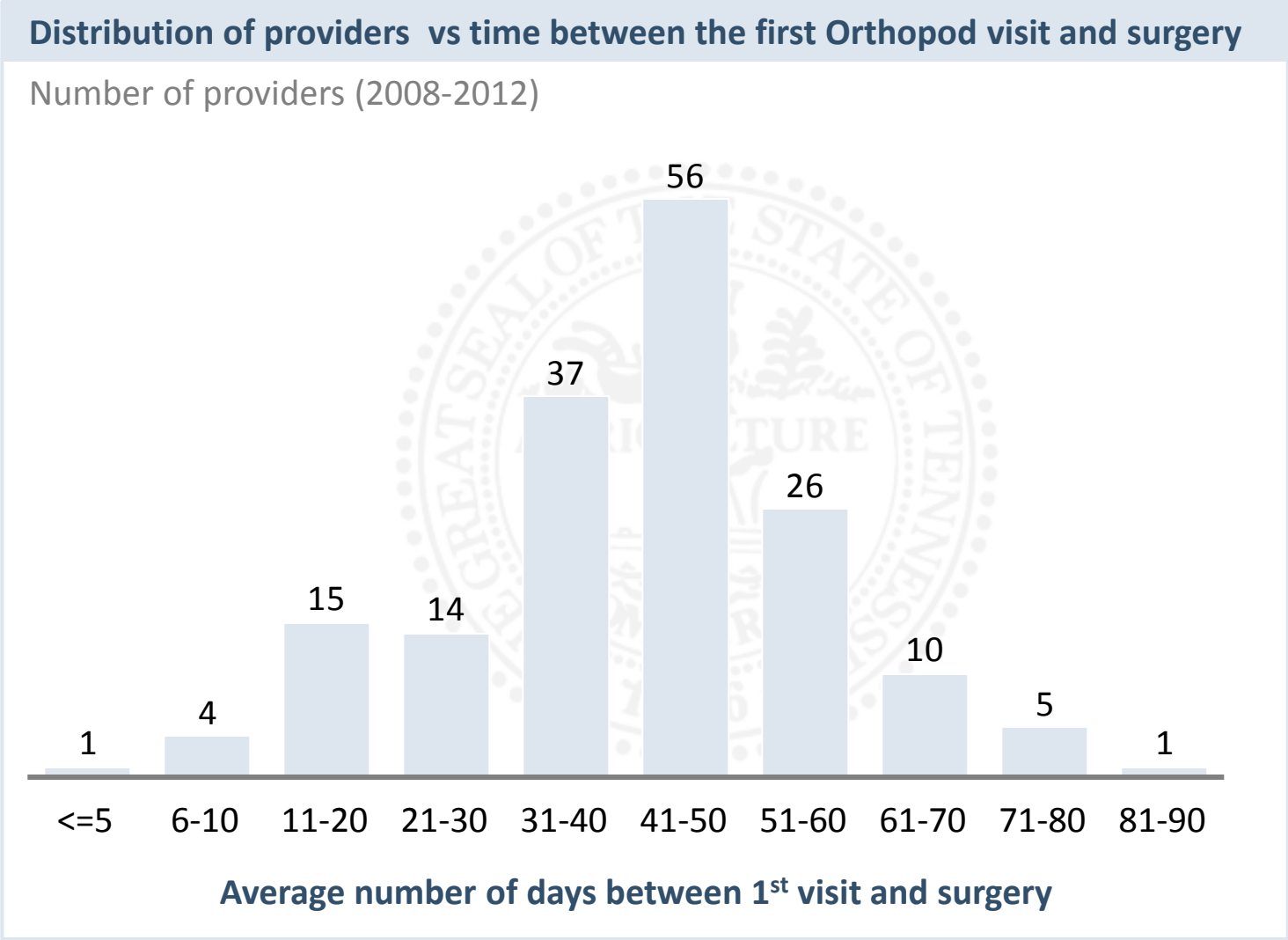
2.6	4.2	85.2	7.7	0.2	0.2

1 1 Trigger includes all cost from admission to discharge
2 No exclusions applied (except unknown providers (no professional claim) (544 episodes, $5,648,374) were removed)

Source: TennCare, trigger dates during 2008-2012

PRELIMINARY: Distribution of providers vs time between the first Orthopod visit and surgery

PRELIMINARY



1 Unknown providers (no professional claim) (544 episodes, $5,648,374) were removed
2 36 providers without a recorded visit in the performance period (43episodes, $358,826)

Source: TennCare, trigger dates during 2008-2012

NON-RISK ADJUSTED COST DATA

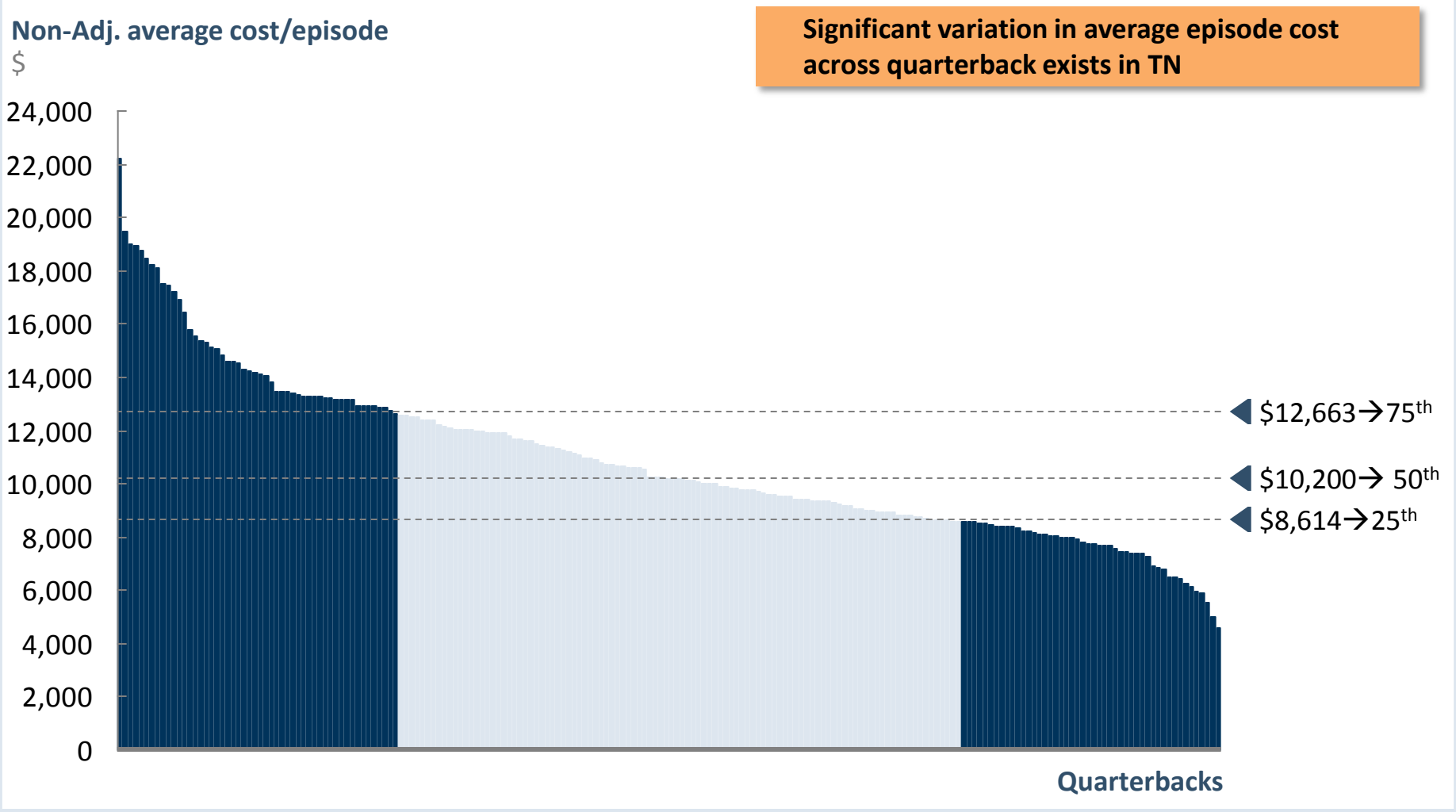
PRELIMINARY: Average episode cost per quarterback (by Tax ID)

PRELIMINARY

Further analysis required to ensure data accuracy

Quarterback average cost distribution: TJR

n = 2,254 episodes,204 quarterbacks by Tax ID



1 1 provider (1 episodes total) with Avg cost > $30000 were removed for further analysis; unknown providers (544 episodes) were removed

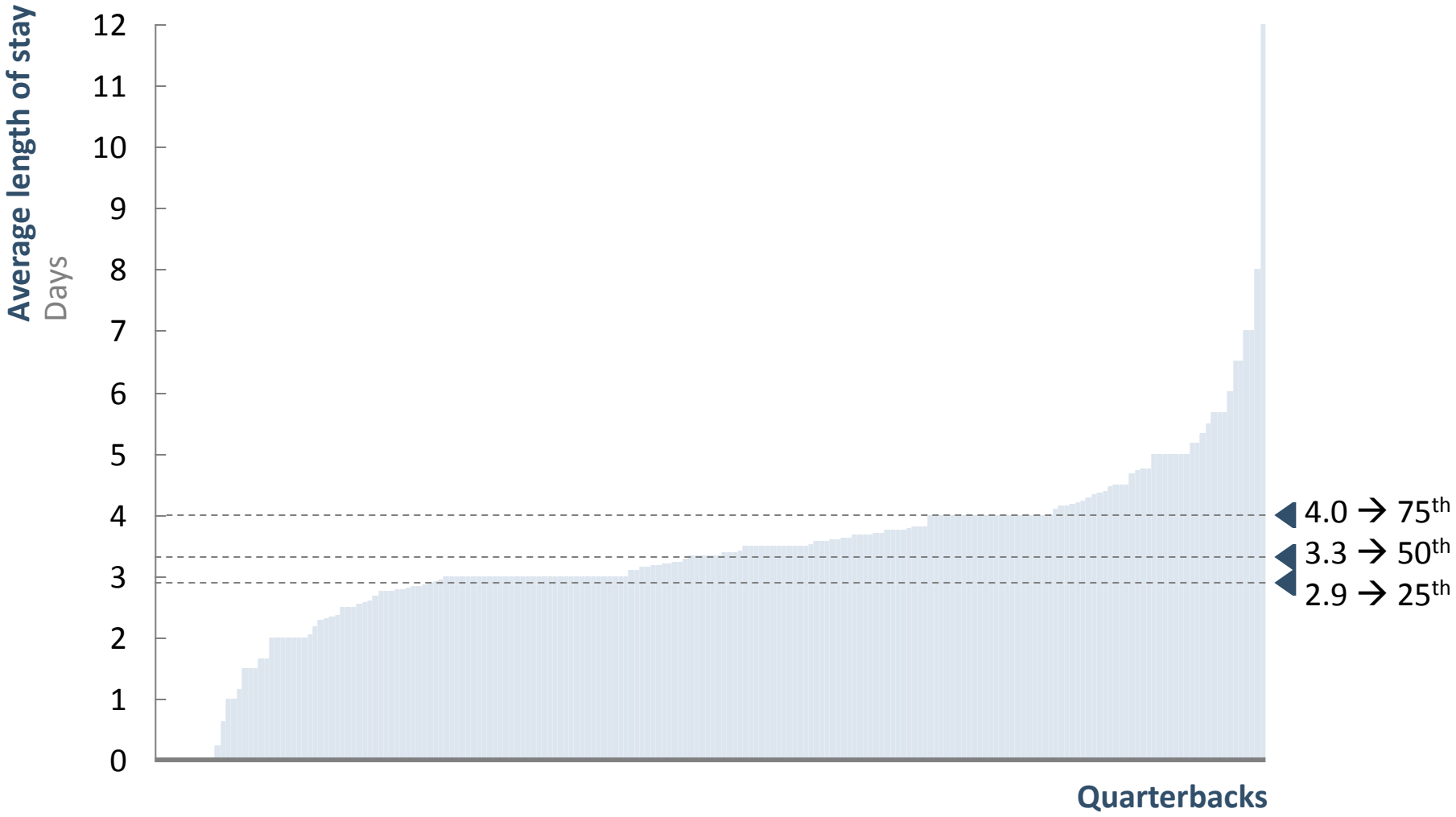
Source: TennCare, trigger dates during 2008-2012

PRELIMINARY: Average length of stay per quarterback

PRELIMINARY

Quarterback length of stay distribution: TJR

n = 2,254 episodes,204 quarterbacks by Tax ID



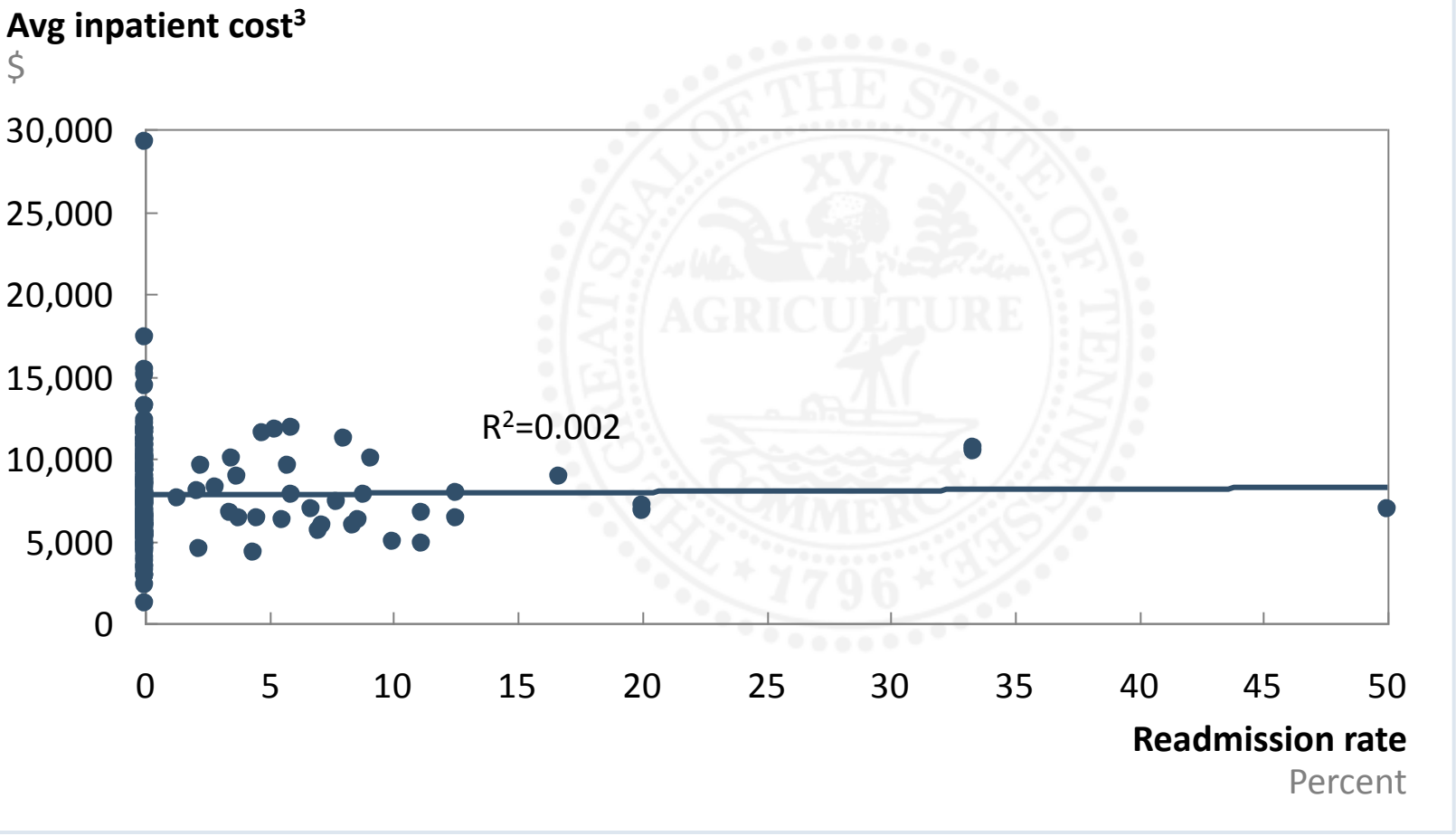
1 Excludes unknown providers (544 episodes), 1 quarterback 1 episodes total) with104 days was removed

Source: TennCare, trigger dates during 2008-2012

NON-RISK ADJUSTED COST DATA

PRELIMINARY: Inpatient cost correlation with readmissions and LOS

PRELIMINARY



1 Unknown providers (no professional claim) (544 episodes, $5,648,374) were removed
2 1 outlier with 100% readmission removed
3 Avg Inpatient cost was calculated only for the Trigger period
Source: TennCare, trigger dates during 2008-2012

Potential patient exclusions/risk factors – TJR (Hip & knee replacements) :

Age criteria

- < 18 years of age

Comorbid conditions

- Select Autoimmune Diseases
- HIV
- End-Stage Renal Disease
- Select organ transplants (liver, kidney, heart and lung)
- Pregnancy
- Sickle cell disease
- Fractures dislocations
- Open wounds
- Trauma
- Obesity (in a stratified approach)
- Cancer

Other

- Death in hospital
- Discharged against medical advice
- Dual eligibility
- Lack of continuous eligibility
- Third-Party Liability

TAG has requested that no exclusions be applied and would like to see what the significance is of each potential risk factor/comorbidity on TN data

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