Tennessee
Payment Reform Initiative

Provider Stakeholder Group Meeting

July 17, 2013

PRELIMINARY WORKING DRAFT, SUBJECT TO CHANGE

Agenda for July 17th Provider Stakeholder Group meeting

Activity	Time
▪ Introductory remarks	13:00 – 13:05
▪ Debrief of barriers to reform activity	13:05 – 13:15
▪ PCMH scale-up options	13:15 – 13:40
▪ Episode design decisions	13:40 – 14:00
▪ Episode TAG updates	14:00 – 14:10
▪ Deep dive on asthma acute exacerbation episode	14:10 – 14:40
▪ Review of potential provider report	14:40 - 14:50
▪ Discussion & next steps	14:50 - 15:00

Contents

- **Debrief of barriers to reform**
- PCMH scale-up options
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Executive Summary: Reviewing the payment reform barriers to scale-up exercise

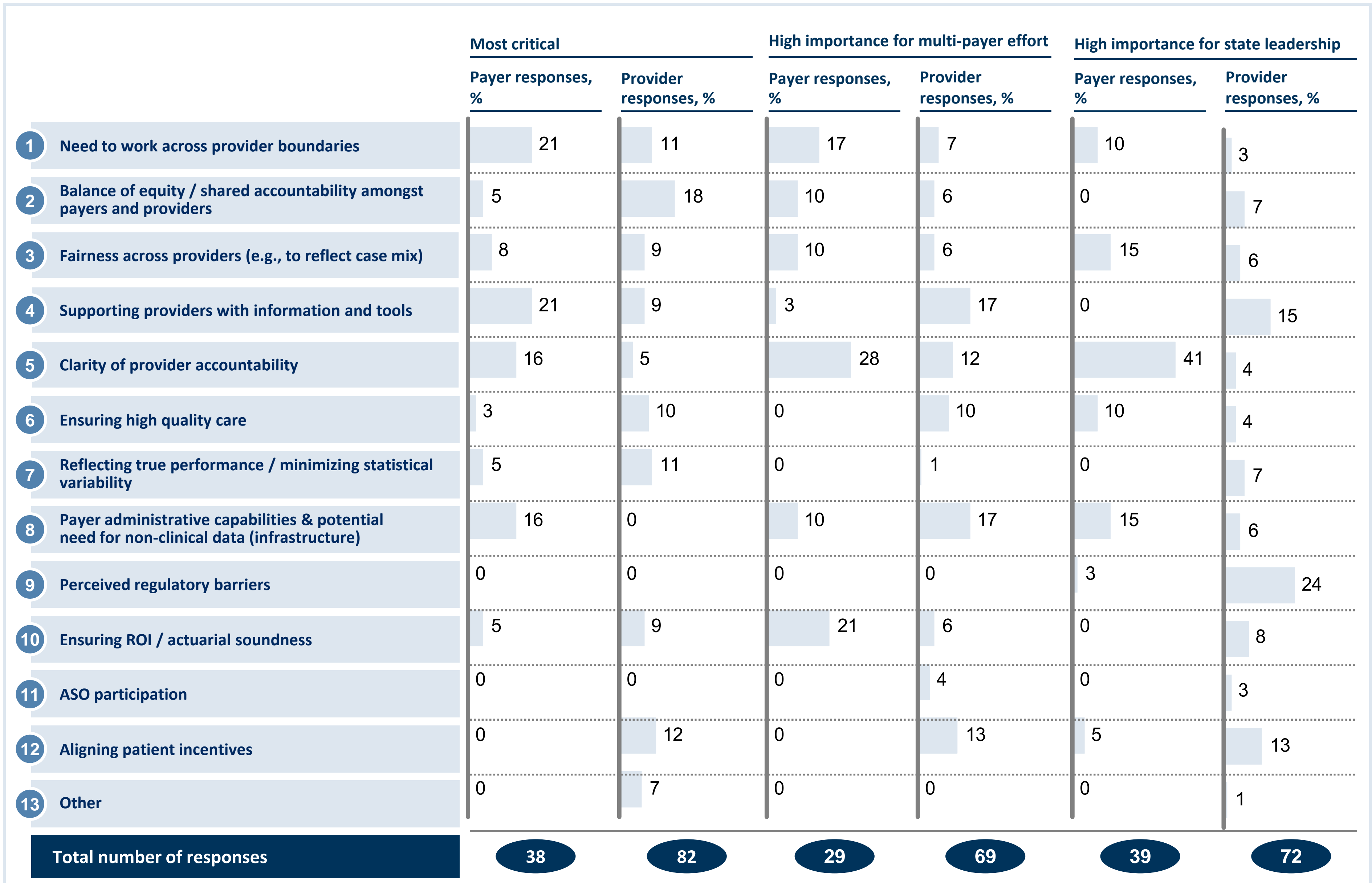
PRELIMINARY

1. A few barriers emerged as priorities across the questions being posed, and across stakeholders
   - Both payers and providers prioritized **"supporting providers with information and tools"** and **"payer administrative capabilities (infrastructure)"**
2. Beyond these areas, payers and providers focused their attention somewhat differently
   - Payers felt that **"clarity of provider accountability"** is important across all three questions, but providers did not prioritize this barrier
   - Providers felt that **"aligning patient incentives"** is important across all three questions, but payers did not prioritize this barrier
3. Payers and providers see different roles for state leadership, and much value likely derived from State playing a convening function
   - Providers feel one of the most important area for state leadership is **"supporting providers with information and tools"** – payers agree the issue is critical but see no / minimal role for the state
   - Payers seem to want state leadership on **provider accountability and fairness** issues, as well as on **administrative capabilities** needed to implement payment reform

NOTE: Payers assessed barriers in context of scaling up PCMH. Providers assessed barriers in context of scaling up episodes & PCMH.

Comparison of payer and provider responses

PRELIMINARY



	Most critical: Payer responses, %	Most critical: Provider responses, %	High importance for multi-payer effort: Payer responses, %	High importance for multi-payer effort: Provider responses, %	High importance for state leadership: Payer responses, %	High importance for state leadership: Provider responses, %
1 Need to work across provider boundaries	21	11	17	7	10	3
2 Balance of equity / shared accountability amongst payers and providers	5	18	10	6	0	7
3 Fairness across providers (e.g., to reflect case mix)	8	9	10	6	15	6
4 Supporting providers with information and tools	21	9	3	17	0	15
5 Clarity of provider accountability	16	5	28	12	41	4
6 Ensuring high quality care	3	10	0	10	10	4
7 Reflecting true performance / minimizing statistical variability	5	11	0	1	0	7
8 Payer administrative capabilities & potential need for non-clinical data (infrastructure)	16	0	10	17	15	6
9 Perceived regulatory barriers	0	0	0	0	3	24
10 Ensuring ROI / actuarial soundness	5	9	21	6	0	8
11 ASO participation	0	0	0	4	0	3
12 Aligning patient incentives	0	12	0	13	5	13
13 Other	0	7	0	0	0	1
Total number of responses	38	82	29	69	39	72

NOTE: Payers assessed barriers in context of scaling up PCMH. Providers assessed barriers in context of scaling up episodes & PCMH.

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Sources of value realized through payment reform

PRELIMINARY

	Primary prevention and early detection	Choice of tests, treatment, and setting of care	Efficient and effective delivery of each clinical encounter	Care coordination and treatment adherence
Root causes of inefficiency, poor clinical outcomes and patient experiences	▪ Behavioral health risks (e.g., smoking, poor diet, sedentary lifestyle, etc.) ▪ Delayed detection contributing to increased severity and preventable complications	▪ Overuse or misuse of diagnostics ▪ Use of medically unnecessary care ▪ Use of higher-cost setting of care where not indicated	▪ Medical errors ▪ Clinicians practicing below top of license ▪ High fixed costs due to excess capacity ▪ High fixed costs due to sub-scale ▪ Use of branded drugs instead of generic equivalents ▪ Use of medical devices ill-matched to patient needs	▪ Poor treatment compliance ▪ Missed follow-up care leading to preventable complications ▪ Ineffective transitions of care ▪ Misaligned treatment guidance among providers

Payment reform must incorporate both population-based and episode-based models to comprehensively address sources of value

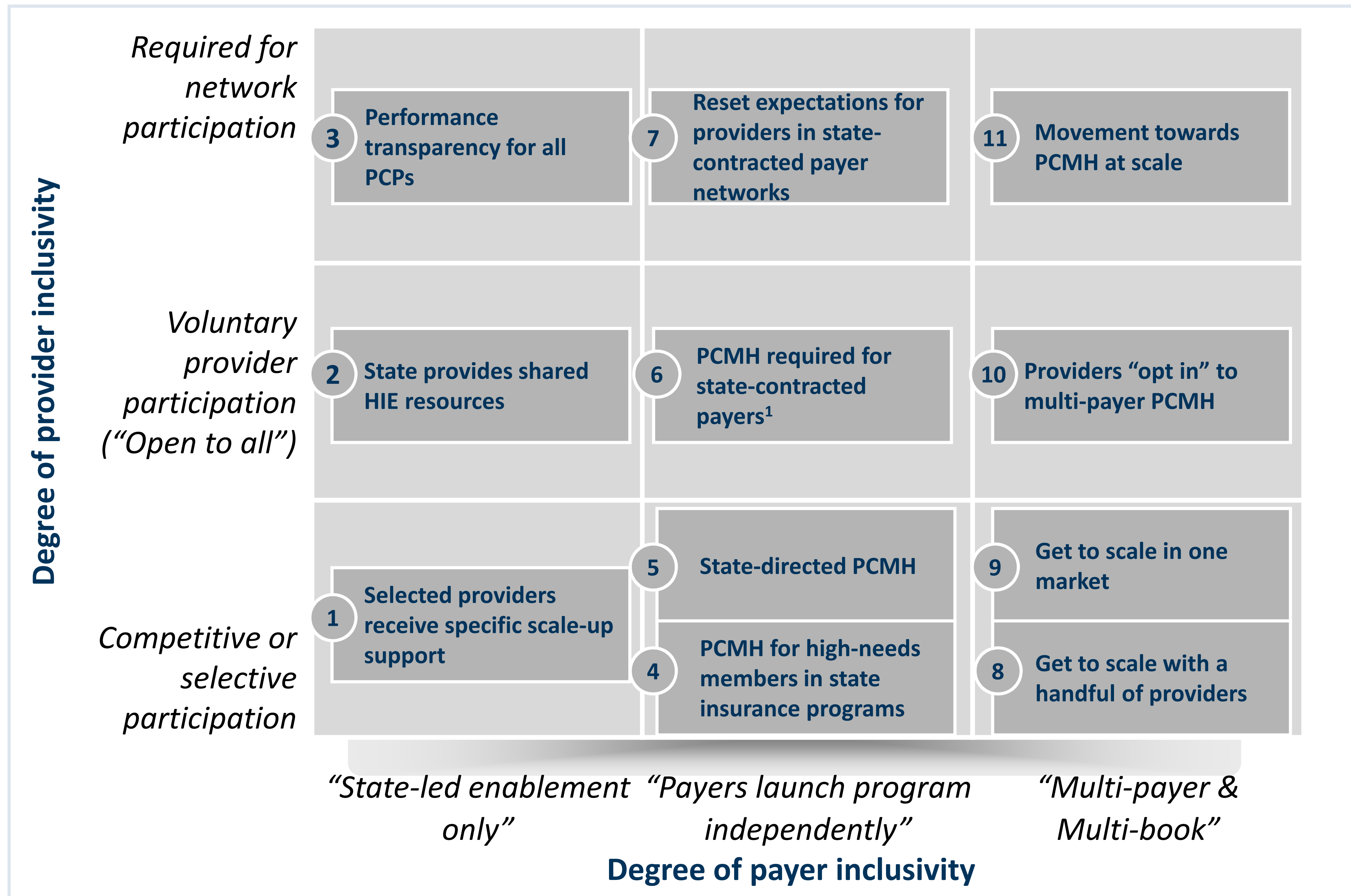
What are the possible inclusion strategies for the next 18-36 months?

Degree of provider inclusivity			
Required for network participation			
Voluntary provider participation ("Open to all")			
Competitive or selective participation			
	"State-led enablement only"	*"Payers launch program independently"*	*"Multi-payer & Multi-book"*

Degree of payer inclusivity

What could the state develop for PCMH over 18-36 months?

ILLUSTRATIVE OPTIONS



1 Can also be competitive or selective provider participation

What models or enablement could the State aspire to build for PCMH over the next 18-36 months? (1/3)

ILLUSTRATIVE OPTIONS

Potential approach:	Description:	Factors for success:
1 Selected providers receive specific scale-up support	▪ State fosters success among PMCH practices by **funding and facilitating learning collaboratives** for selected PCMH providers ▪ State identifies vendor to facilitate learning collaboratives through competitive RFP ▪ State holds competitive process to select providers for scale-up support	▪ State-developed resources would be accepted and utilized by payers ▪ PMCH providers will be willing to share lessons learned with others Competitive process for scale-up support will motivate practices to advance PCMH efforts
2 State provides shared HIE resources	▪ **Providers can utilize HIE resources provided by the state:** – Through vendor, State supports admission / discharge / transfer database that providers can participate in and access voluntarily – Providers pull ADT data into care coordination software – State creates standards for interoperability of IT platforms; providers will comply in order to access data from other entities	▪ State-developed resources would be accepted and utilized by payers ▪ Infrastructure developed by the state would facilitate care coordination and empower PCPs to transform their practices into PCMHs across the state
3 Performance transparency for all PCPs	▪ **State provides reporting on total cost of care** for all PCPs for their patients ▪ Vendor selected by the State calculates total cost of care for each PCP in TN ▪ Vendor generates PDF reports monthly and posts reports to a secure provider portal ▪ Providers can log in to view data on risk-adjusted cost of care for their own patients, compared to state averages	▪ State-developed resources would be accepted and utilized by payers ▪ Transparency would encourage greater provider participation and magnify near-term value generated by PCMH pilots

What models or enablement could the State aspire to build for PCMH over the next 18-36 months? (2/3)

ILLUSTRATIVE OPTIONS

Potential approach:	Description:	Factors for success:
4 **PCMH for high-needs members in state insurance programs**	▪ State-contracted payers implement **PCMH in largest behavioral health providers** in the state (or other provider type) ▪ BH providers must submit application to receive PCMH transformation support ▪ Due to potentially small panel size, would need to consider pooling and PMPM support	▪ Incentives/payments from Medicaid-only model are enough to encourage provider participation and change provider behavior ▪ Medicaid will eventually be able to expand model to additional provider types to achieve payment reform at scale
5 **State-directed PCMH**	▪ **The state creates, designs, and administers PCMH program for members of state-contracted payers,** dictating program requirements for payers ▪ The state selects PCMH providers, prioritizing those with highest payer volume ▪ Providers may or may not receive PMPM payments or shared savings	▪ Incentives from Medicaid-only model are sufficient to encourage provider ▪ State-contracted payers will be willing to accept PCMH efforts designed centrally by the state ▪ State-contracted payers will be willing to financially support incentive payments for a program they did not design
6 **PCMH required for state-contracted payers**	▪ **The state requires each state-contracted payer to enroll X% of book into PCMH** in the next procurement ▪ Each payer can determine whether to select providers or let providers opt in ▪ Each payer can determine whether to act in certain markets, or across the state	▪ Incentives from Medicaid-only model are sufficient to encourage provider participation and change provider behavior
7 **Reset expectations for providers in state-contracted payer networks**	▪ The state requires that all providers must migrate to some form of **accountability for total cost of care** to participate in network ▪ Providers can choose PCMH, ACO, or capitation arrangement, but must include X% of revenue in TCOC model within three years	▪ Incentives from Medicaid-only model are sufficient to change provider behavior ▪ "Mandatory" provider participation is more effective than offering incentives ▪ Even small provider practices can make transition to PCMH

What models or enablement could the State aspire to build for PCMH over the next 18-36 months? (3/3)

ILLUSTRATIVE OPTIONS

Potential approach:	Description:	Factors for success:
8 **Get to scale with a handful of providers**	▪ **Payers select 1-5 providers in each metro market** and one rural area, with goal of transitioning to payment based on total cost of care for large majority of their patients ▪ Providers can select PCMH, ACO, or capitation ▪ Payers can negotiate with individual providers to customize TCOC program	▪ Anticipated shared savings are sufficient to – Attract high-performing provider partners without guaranteed PMPMs – Encourage lower-performing practices to build capabilities/ work toward participation
9 **Get to scale in one market**	▪ **Payers select a single metro market** with goal of transitioning to total cost accountability for majority of patients in that market ▪ Providers can select PCMH, ACO, or capitation ▪ Payers can negotiate with individual providers to customize PCMH program	▪ Same as above ▪ There are benefits to scaling up in a single geography; e.g., State can support adjustments to local HIE
10 **Providers “opt in” to multi-payer PCMH**	▪ Payers create consistent, not necessarily standardized, requirements to qualify as PCMH; **all providers meeting requirements are eligible for incentive payments** ▪ Because of open participation and varied provider capabilities, model may require PMPM support for care coordination/transformation	▪ Model is financially viable without support of Medicare ▪ Payers are able to achieve consensus on design/guidelines for new model ▪ Could bring providers on board in a way that balances scale-up with initial set of provider capabilities
11 **Movement towards PCMH at scale**	▪ Coalition of payers requires that all providers migrate to some form of **accountability for total cost of care** to participate in networks ▪ Providers can choose PCMH, ACO, or capitation arrangement, but must include X% of revenue in TCOC model within three years	▪ Even small provider practices can make transition to PCMH ▪ Model is financially viable without support of Medicare ▪ Payers are able to achieve consensus on design/guidelines for new model

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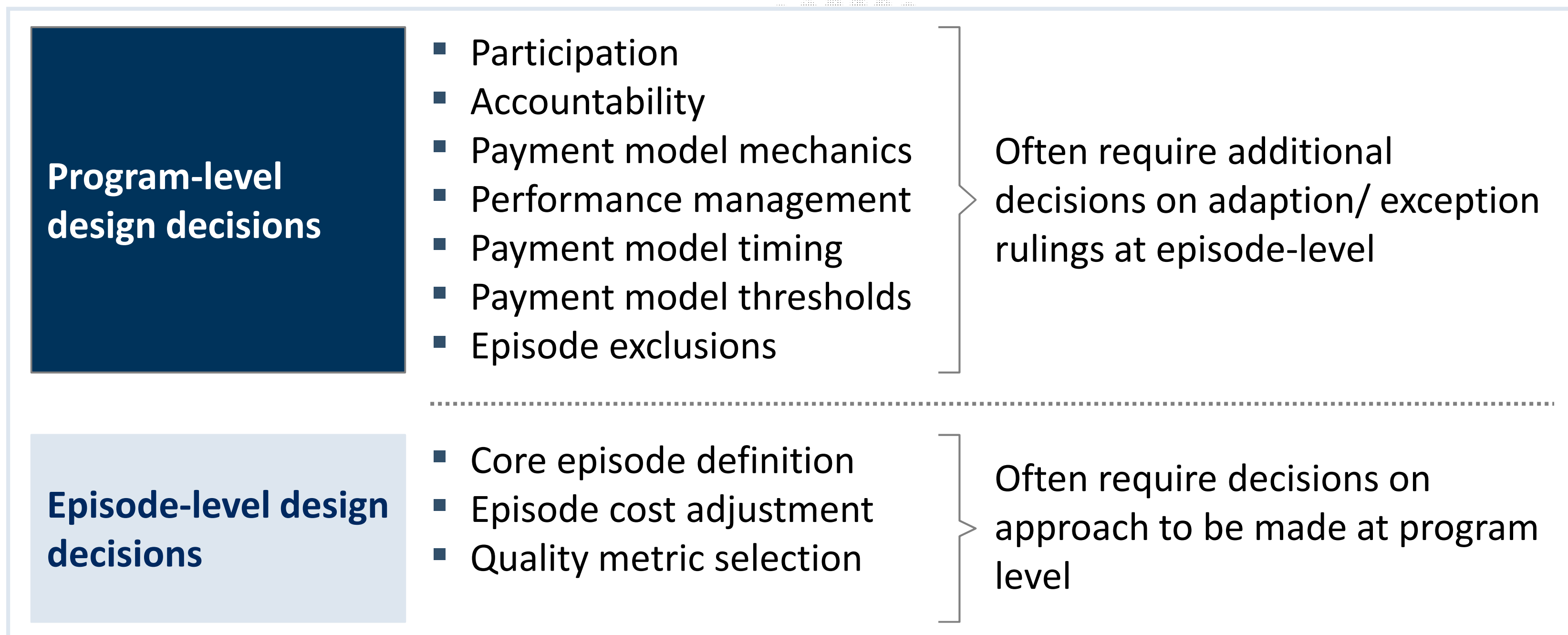
Episode design decisions are required at both the program and episode-specific levels

PRELIMINARY



Barriers to building the episode model at scale drive several design decisions as well as broader implementation requirements

PRELIMINARY

#	Barriers	Potential Elements of Solution
1	Lack of provider integration	Prospective vs. retrospective
2	Balance of equity / shared accountability amongst payers and providers	Upside/downside, absolute/relative performance measures, degree of gain/risk sharing
3	Standardization across providers (e.g., patient needs / risks)	Cost outliers, risk adjustment approach
4	Provider support to improve performance	Preparatory/reporting only period length, provider stop-loss
5	Provider participation and accountability	Participation, exclusions, providers at risk
6	Ensuring high quality care	Role of quality & utilization metrics, gain sharing limit
7	Reflecting true performance / minimizing statistical variability	Small case volume solutions, length of "performance" period
8	Payer administrative capabilities & potential need for non-clinical data	Infrastructure development, other payer support for model needs
9	Perceived regulatory barriers	Engagement with legislature, CMS, Governor and others
10	Ensuring ROI / actuarial soundness	Provider inclusion, opt-in / opt-out decisions
11	Aligning patient incentives	Stakeholder engagement, patient incentives, state wide consistency of definitions and communications
12	Lack of standard episode definitions	

Inventory of program level and episode-specific design choices to make

■ Program level decision
■ Episode-specific decision

Category	#	Decision to make
Participation	1	Provider participation
	2	Payer participation
Account-ability	3	Providers at risk – Number
	4	Providers at risk – Type of provider(s)
	5	Providers at risk – Unique providers
Payment model mechanics	6	Prospective or retrospective model
	7a	Risk-sharing agreement – types of incentives
	7b	Risk-sharing agreement – amount of risk shared
	8	Approach to small case volume
	9a	Role of clinical metrics
	9b	Role of utilization metrics
	10	Provider stop-loss
	11	Absolute vs. relative performance rewards
Performance management	12a	Absolute performance rewards – Grey zone
	12b	Absolute performance rewards – Gain sharing limit
	13	Relative performance rewards – TBD
	14	Length of preparatory/“reporting-only” period
	15	Length of “performance” period
Payment model timing	16	Synchronization of performance periods
Payment model thresholds	20	Cost outliers
	21	Claim completeness
Episode exclusions	22	Business exclusions
	23	Clinical exclusions

Category	#	Decision to make
Core Episode definition	1	PAP selection
	2	Triggers
	3a	Episode timeframe – Type/length of pre-procedure/ event window
	3b	Episode timeframe – Type/length of post-procedure/ event window
	4a	Claims in- or excluded: pre-procedure/event window
	4b	Claims in- or excluded: during procedure/event
	4c	Claims in- or excluded: post procedure/e vent (incl. readmission policy)
Episode cost adjustment	5	Risk adjustment approach
	6	Risk adjustors
	7a	Unit cost normalization - Inpatient
	7b	Unit cost normalization - Other
	8	Adjustments for provider access
	9	Approach to cost-based providers
Quality metric selection	10	Approach to non-claims-based quality metrics
	11	Quality metric sampling
	12	Quality metrics linked to payment
	13	Quality metrics for reporting only
	14	Utilization metrics

State hypotheses on initial design decisions

State's working hypothesis on importance of coordination across payers

6 Type of model: **Retrospective**

Low — High

- Providers receive payment or penalty after services delivered
- Providers continue to be paid through current mechanisms
- "Quarterback" receives rewards or penalties based on average cost of episode

11 Type of payments: **Absolute**

Low — High

Threshold lines mean an absolute, not relative, payment model

7a Type of incentives: **Upside & Downside**

Low — High

Both upside gain sharing and downside risk sharing

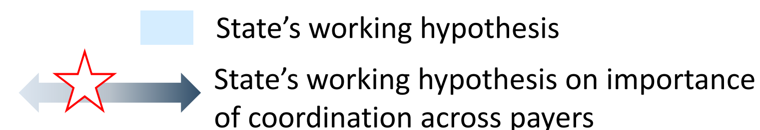
12b Gain sharing limit: **Yes**

Low — High

Gain sharing limit to balance provider incentives with standard of care adherence.

9a Approach to quality metrics

PRELIMINARY



Options	Description	Rationale	Considerations
1 Report on provider performance	▪ Report on provider performance for certain clinical metrics but do not tie to reward or penalty payment	▪ Increases providers' awareness of their own performance in relation to other providers	▪ May not have as big an impact as providers may not change behavior without penalty
2 Gate for cost-based reward eligibility	▪ Do not pay providers for cost-based rewards unless they meet minimum thresholds on certain clinical metrics	▪ Ensures providers do not sacrifice quality of care to achieve cost savings	▪ Only establishes minimum, does not incentivize high standards beyond
3 Pay for performance	▪ Reward providers for achieving certain clinical metrics, pay for performance	▪ Directly rewards/penalizes for performance	▪ Inconsistent with overarching EBP model/ principles ▪ Difficult to quantify the monetary value of quality

Methodology for choosing quality metrics

Establish quality base	▪ Start with national guidelines
Refine	▪ Discuss and refine aggregated metrics with technical advisory group and external experts ▪ Enhance recommended practices from literature on up-to-date practices
Analyze variability	▪ Evaluate episode data and quantify variability for the state ▪ Discuss common practice variations and identify potential pitfalls with technical advisory group and external experts
Define	▪ Select clinical and utilization metrics

TJR (Hip & knee replacements): Quality metrics overview

TO BE REFINED WITH TAGs

Arkansas example

	Quality metric	Objective	Use	Source
Rate of readmissions	▪ 30-day all cause readmission rate	▪ Decrease	▪ Reporting only	▪ Claims
Utilization rate of preventative measures	▪ Frequency of use of prophylaxis against post-op Deep Venous Thrombosis (DVT) / Pulmonary Embolism (PE) (pharmacologic or mechanical compression)	▪ Increase	▪ Reporting only	▪ Claims
Rate of post op complications	▪ Frequency of post-op DV/PE ▪ 30-day wound infection rate	▪ Decrease	▪ Reporting only	▪ Claims

SOURCE: Arkansas Payment Improvement Initiative

Perinatal: Quality metrics overview

TO BE REFINED WITH TAGs

Arkansas example

	Quality metric	Objective	Use	Source
Rate of preventative screening	HIV screening – must meet minimum threshold of 80% of episodes	Increase	Linked to gain sharing	Claims or Self-report
	Chlamydia screening – must meet minimum threshold of 80% of episodes	Increase	Linked to gain sharing	Claims or Self-report
	Group B strep screening – must meet minimum threshold of 80% of episodes	Increase	Linked to gain sharing	Claims or Self-report
Rate of preventative screening	Ultrasound screening	Increase	Reporting only	Claims
	Screening for Gestational diabetes	Increase	Reporting only	Claims or Self-report
	Screening for Asymptomatic Bacteriuria	Increase	Reporting only	Claims or Self-report
	Hepatitis B specific antigen screening	Increase	Reporting only	Claims or Self-report
Rate of elective procedures	C-Section Rate	Decrease	Reporting only	Claims

SOURCE: Arkansas Payment Improvement Initiative

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TAG update on membership and logistics

PRELIMINARY

TAG Update

- **Initial invitations were sent out July 1st** to a subset of TAG nominees
  - Selected to maximize variability in providers (e.g., region, practice, specialty, etc.)
- **3 identical one-hour webinars** were held last week to provide members with an overview of episodes and an opportunity to ask general questions
- **First TAG** meetings are scheduled for this week
- TAG members will be able to **attend TAGs in person or by video or teleconference**

Responses and general meeting schedule

Perinatal

- 10 acceptances
- TAG #1 week of July 15th
- TAG #2 week of July 29th
- TAG #3 TBD
- TAG #4 TBD

Asthma acute exacerbation

- 13 acceptances
- TAG #1 week of July 15th
- TAG #2 week of July 29th
- TAG #3 week of August 19th
- TAG #4 week of Sept 2nd

TJR

- 9 acceptances
- TAG #1 week of July 22nd
- TAG #2 week of August 5th
- TAG #3 week of August 26th
- TAG #4 week of Sept 9th

Acceptances and meetings will be refined based on TAG member availability

Potential topics for discussion at each TAG workgroup

SUBJECT TO CHANGE | PRELIMINARY

	TAG Workgroup 1	TAG Workgroup 2 - 3	TAG Workgroup 4
Workgroup objectives	Introduction to retrospective episode model	Provider and patient inclusion/exclusion criteria	Remaining questions on trigger, exclusion, and inclusion codes
	Developing the clinical episode (e.g., patient journey, trigger, window, etc.)	Inclusion & exclusion implications on spend, case volume, etc. using episode specific data	Outstanding episode window items and adjustments
	Sources of value (deviations from evidence based medicine guidelines, other practice pattern variation)	Episode refinement: ▪ Performance period (pre/post trigger) ▪ Risk factors ▪ Quality metrics (e.g., medication, screening tests, procedures, follow-up appointments, etc.)	Align on quality metrics
		Quarterback considerations	

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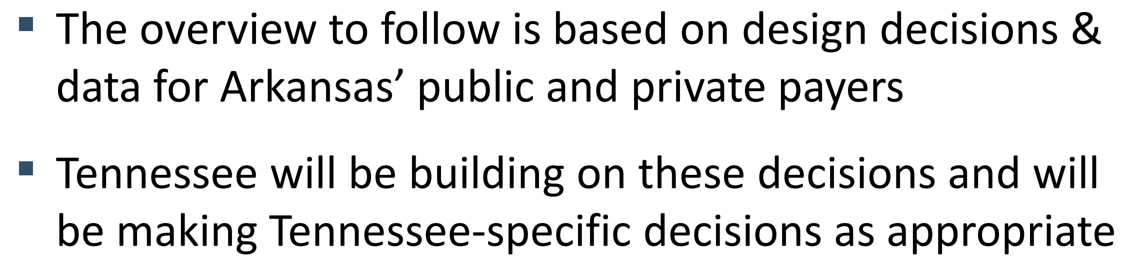
Context for this overview

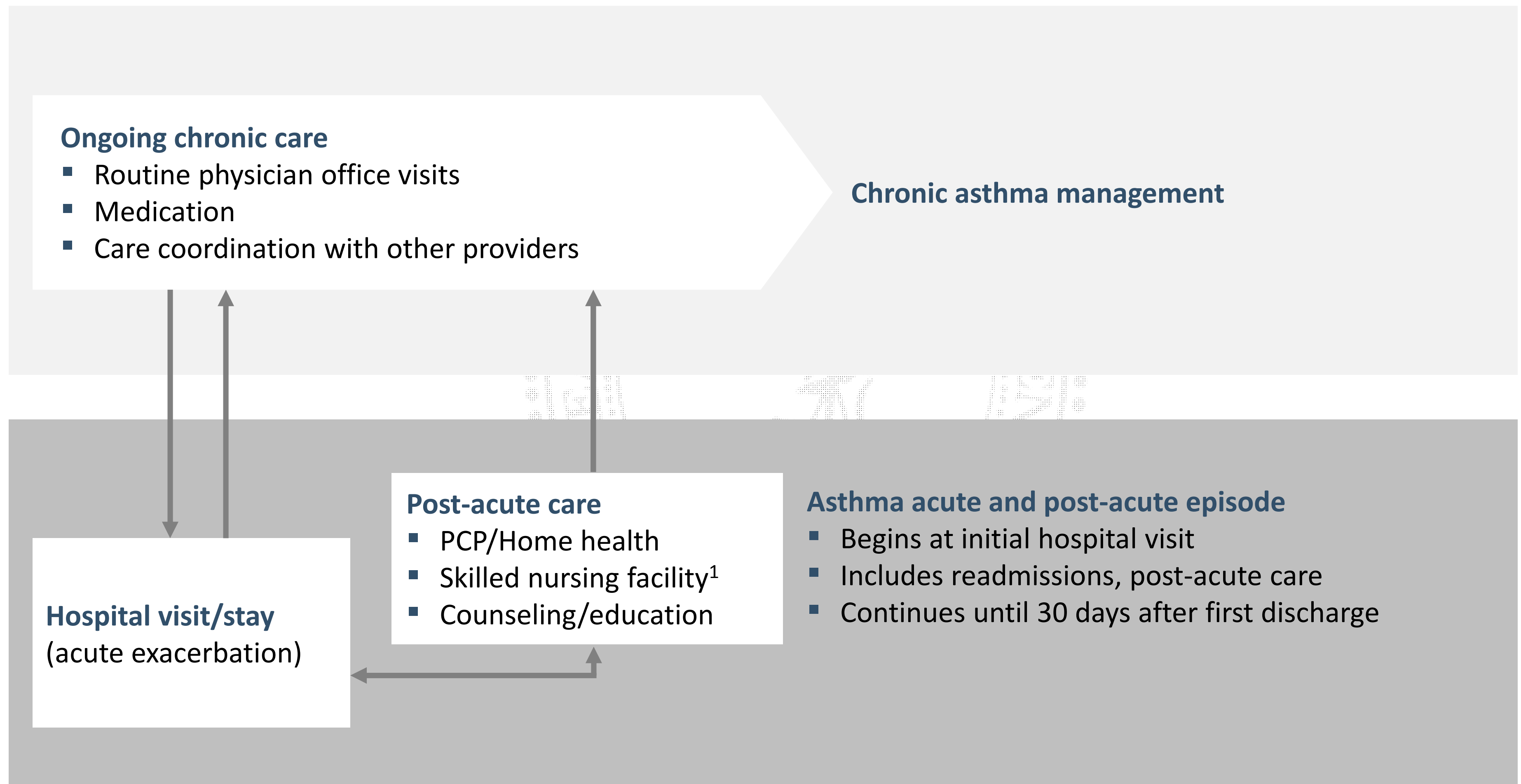


- The overview to follow is based on design decisions & data for Arkansas' public and private payers
- Tennessee will be building on these decisions and will be making Tennessee-specific decisions as appropriate

Example: Asthma acute exacerbation episode
Overview of patient care

PRELIMINARY

Focus of current episode design

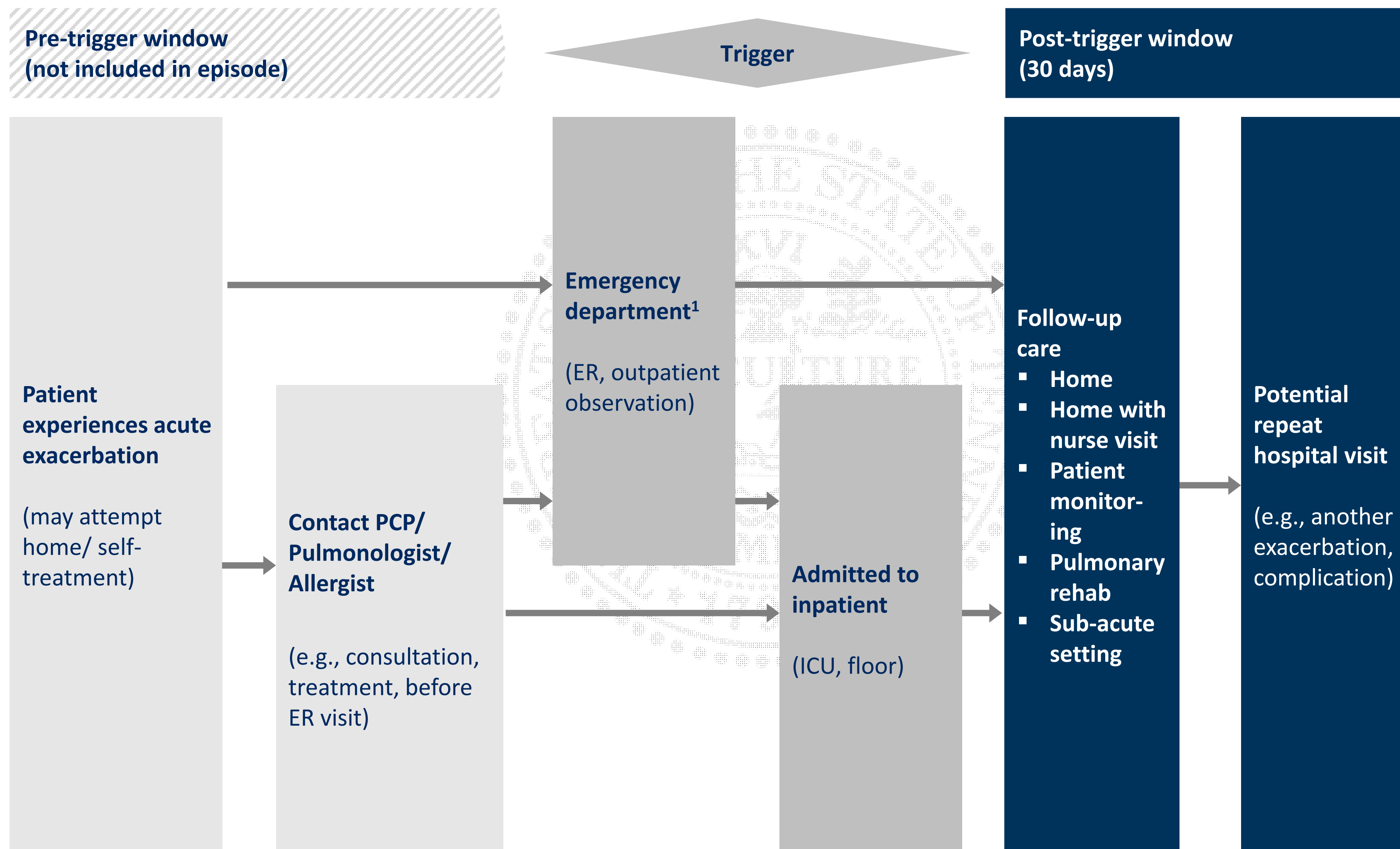


1 Very rarely applicable for this episode

SOURCE: Arkansas Payment Improvement Initiative

Arkansas example

Example: Asthma acute exacerbation
Patient Journey



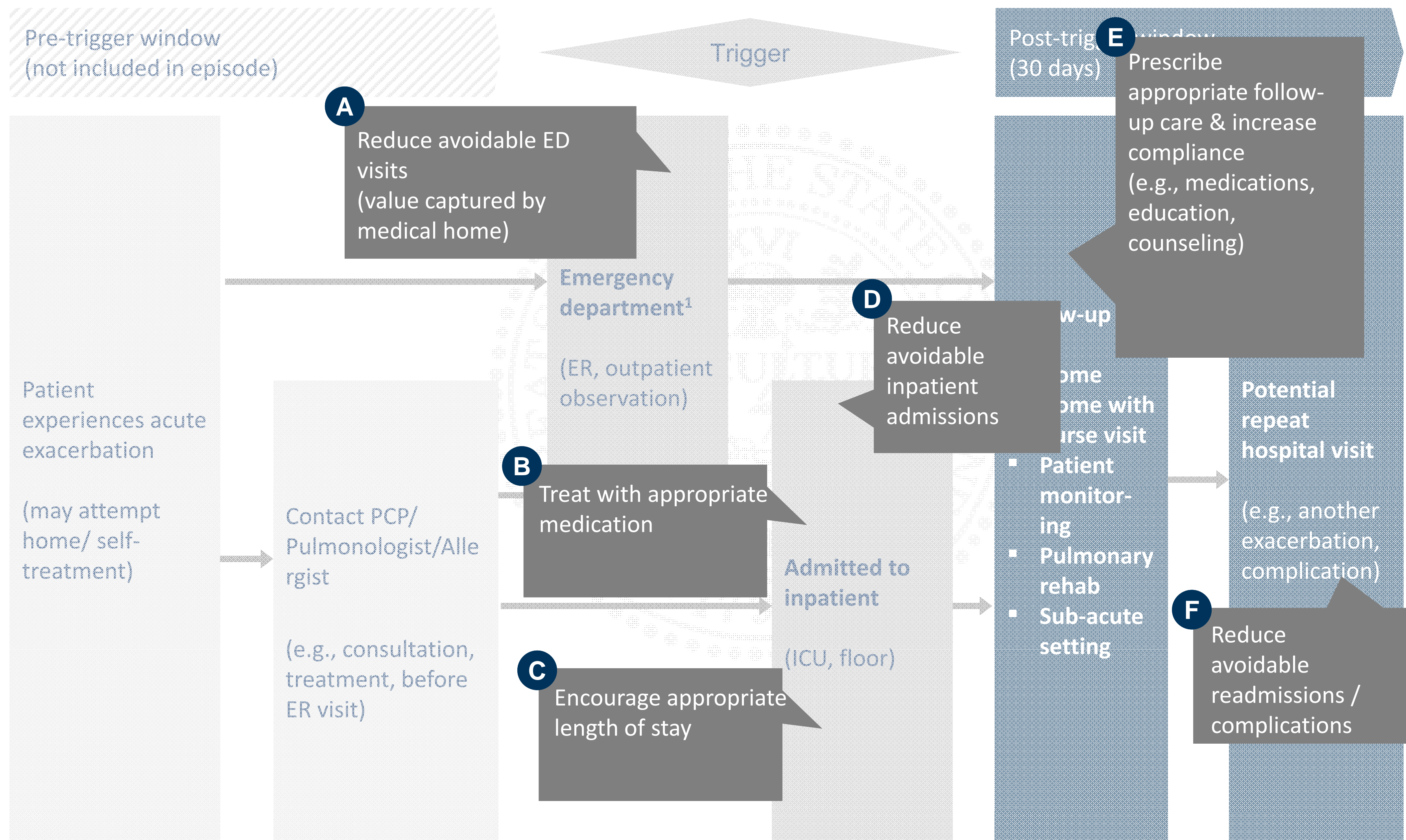
1 May include urgent care facility

SOURCE: Arkansas Payment Improvement Initiative

Example: Asthma acute exacerbation

Sources of value

Arkansas example



1 May include urgent care facility

SOURCE: Arkansas Payment Improvement Initiative

Asthma acute exacerbation episode design dimensions to review today

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?

1 Episode definition and scope of services: what's included in the episode

Arkansas example

- **Episode trigger: Visit to hospital (ER, inpatient) for acute exacerbation** which includes:
  - Primary diagnosis condition related to asthma with select codes requiring confirming asthma diagnosis from claims data within 365 days prior
  - Trigger must be preceded by 30-day all-cause clean period
  - Includes both ER and inpatient cases (risk adjustments apply)
- **Services included:** All related facility services, inpatient professional services, emergency department visits, observation, labs and diagnostics, outpatient costs (e.g., counseling), medications as well as select costs for relevant post-acute care
  - Costs associated with readmissions as outlined by Bundled Payment for Care Improvement (BPCI) exclusions list from CMS
- **Episode time frame:**
  - **Pre-trigger:** No pre-trigger window
  - **Post-trigger:** Episode begins on day of facility visit through 30 days after first discharge, including any relevant repeat hospital visit or readmission during post-trigger window

SOURCE: Arkansas Payment Improvement Initiative

Arkansas example

PRELIMINARY

1 Episode definition and scope of services: Diagnosis trigger codes for asthma acute exacerbation episode may require confirming evidence

Requires one of the codes under 'Trigger codes' in any diagnosis field of claim type M, D, S, J within 365 days prior to qualify as a trigger

Trigger codes

ICD-9 Dx	Description
493.92	▪ Asthma, unspecified type, with (acute) exacerbation
493.90	▪ Asthma, unspecified type, unspecified
493.22	▪ Chronic obstructive asthma; with (acute) exacerbation
493.91	▪ Asthma, unspecified type, with status asthmaticus
519.11	▪ Acute bronchospasm
493.00	▪ Extrinsic asthma, unspecified
493.02	▪ Extrinsic asthma with (acute) exacerbation
493.20	▪ Chronic obstructive asthma; unspecified
493.01	▪ Extrinsic asthma with status asthmaticus
493.10	▪ Intrinsic asthma, unspecified
493.11	▪ Intrinsic asthma with status asthmaticus
493.12	▪ Intrinsic asthma with (acute) exacerbation
493.21	▪ Chronic obstructive asthma; with status asthmaticus
493.81	▪ Exercise induced bronchospasm
493.82	▪ Cough variant asthma
493.80	▪ Other forms of asthma

Potential Trigger (requires asthma-specific trigger code 365 days prior to become a trigger)

ICD-9 Dx	Description
786.09	▪ Dyspnea and respiratory abnormalities; other
786.05	▪ Shortness of breath
786.07	▪ Wheezing
786.90	▪ Other symptoms involving resp. system and chest
786.00	▪ Respiratory abnormality, unspecified

Rationale

Coding, especially in the ER, can be imprecise therefore, for some codes that are not specifically for asthma to be included as triggers in the episode requires historical evidence of asthma in a patient's past[1]

SOURCE: Arkansas Payment Improvement Initiative (Arkansas Medicaid claims, 2011)

Arkansas example

2 Exclusion criteria

- Select co-morbid conditions (e.g., cystic fibrosis, alpha1-antitrypsin deficiency, bronchiectasis, lung cancers)
- Patients who are intubated or have home oxygen use during episode
- ICU admissions greater than 72 hours
- Death in hospital during episode
- Patient status of "left against medical advice" during episode
- Asthma: Age less than 5
- Dual coverage of primary medical services
- Third party liabilities
- Inconsistent enrollment (i.e. not continuously enrolled) during the episode

SOURCE: Arkansas Payment Improvement Initiative

3 Quarterback selection

Arkansas example

Low ○ High ●

Providers involved in episode	Criteria for 'Quarterback' selection[1]: Significant decision making responsibilities	Most influence over other providers	Bears material portion of episode cost	Rationale
ER Physician for trigger visit	◑	◑	◔	▪ Delivers and prescribes appropriate medication / therapy ▪ Decides if patient is admitted (i.e. inpatient admission)
ER / Inpatient Facility	◑	◕	◕	▪ Responsible for majority of costs ▪ Most control over major sources of value (e.g., readmissions, inpatient admission) ▪ Can coordinate follow-up care with PCP/pulmonologist/allergist
Primary care physician/ pulmonologist	◔	◔	○	▪ Can influence whether patient is administered into ER during non-life threatening visit ▪ Oversees long-term follow-up, chronic care

Selected 'Quarterback' for AR Medicaid: ER / Inpatient Facility

1 Based on objective assessment of 'Quarterback' criteria; individual participating payers will need to make own assessment of which providers to designate as 'Quarterback'

SOURCE: Arkansas Payment Improvement Initiative

Arkansas example

4 Episode adjustments

Patients may have **co-morbidities or other conditions that are beyond a Quarterback's control** which may contribute to an increased episode cost (e.g., more complex treatments). These episode costs are risk-adjusted and then included in a Quarterback's average episode cost calculation

- **Episode cost is adjusted based on historical costs:**
  - Patient co-morbidities which may be risk factors that influence episode cost (e.g., obesity, pneumonia, diabetes)
  - Other risk factors (e.g., age)
  - High cost or low cost outliers, applied after other cost adjustments
- Only providers with at least 5 episodes per year will be eligible for gain sharing/risk sharing

Example list of clinically and economically significant risk factors

- Dysphagia
- Pneumonia
- Chronic respiratory failure
- Respiratory acidosis
- Diabetes - Type II
- Obesity
- Age >= 45
- 25 <= Age <= 34
- 35 <= Age <= 44

SOURCE: Arkansas Payment Improvement Initiative

5 Quality metrics

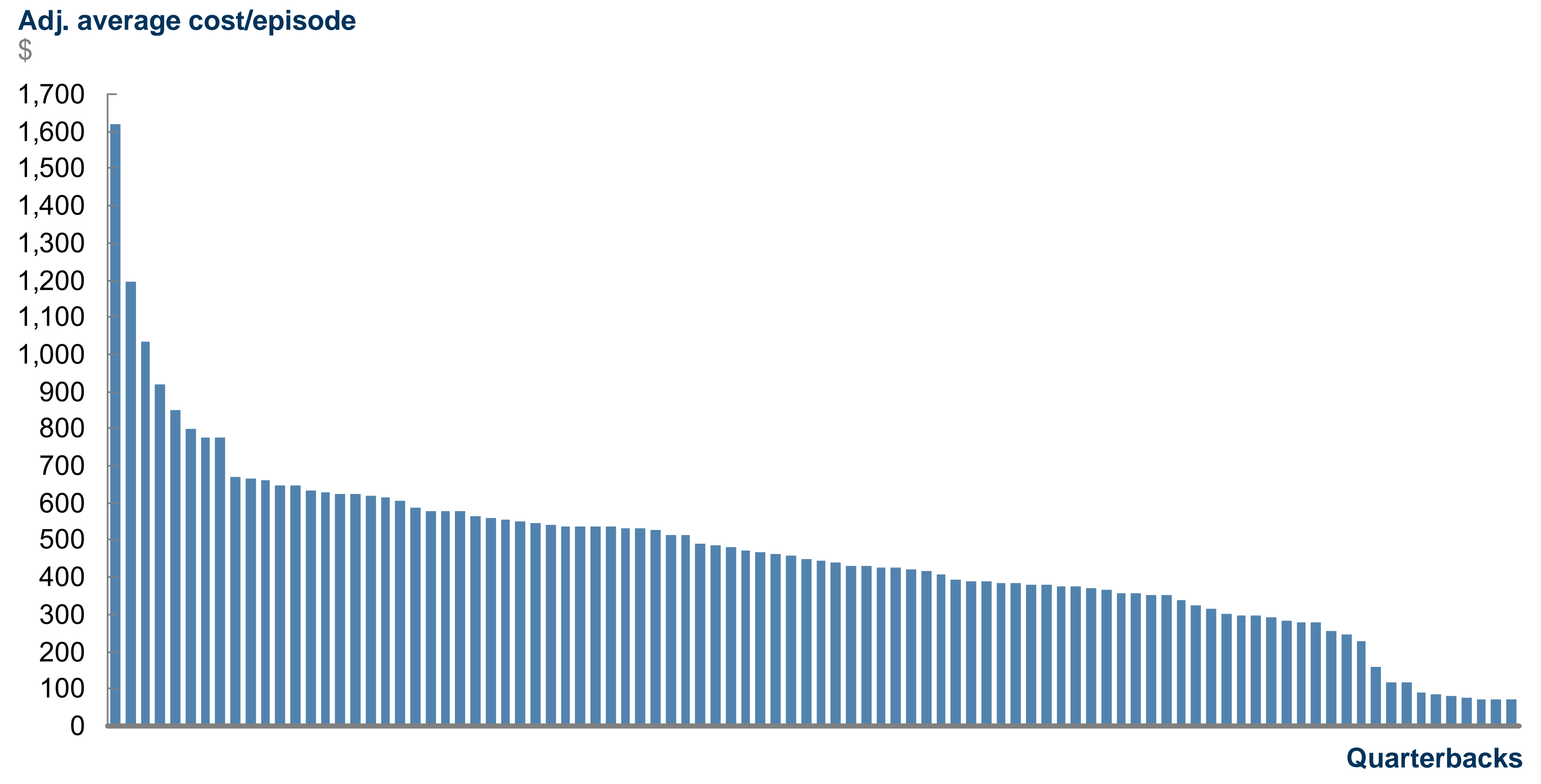
Arkansas example

	Quality metric	Objective	Use	Source
Rate of follow-up visit with physician	▪ Percent of episodes where patient visits a physician in the outpatient setting within 30 days of initial discharge	▪ Increase	▪ Linked to gain sharing	▪ Claims
Rate of patient on appropriate medication	▪ Percent of patients on appropriate medication determined by a filled prescription for oral corticosteroid and/or inhaled corticosteroids during episode window or (within 30 days prior to trigger)	▪ Increase	▪ Linked to gain sharing	▪ Claims
Repeat acute exacerbation within 30 days	▪ Percent of patients with repeat acute exacerbation during episode window	▪ Decrease	▪ Reporting only	▪ Claims

SOURCE: Arkansas Payment Improvement Initiative

Summary data: Average episode cost per quarterback

Arkansas example



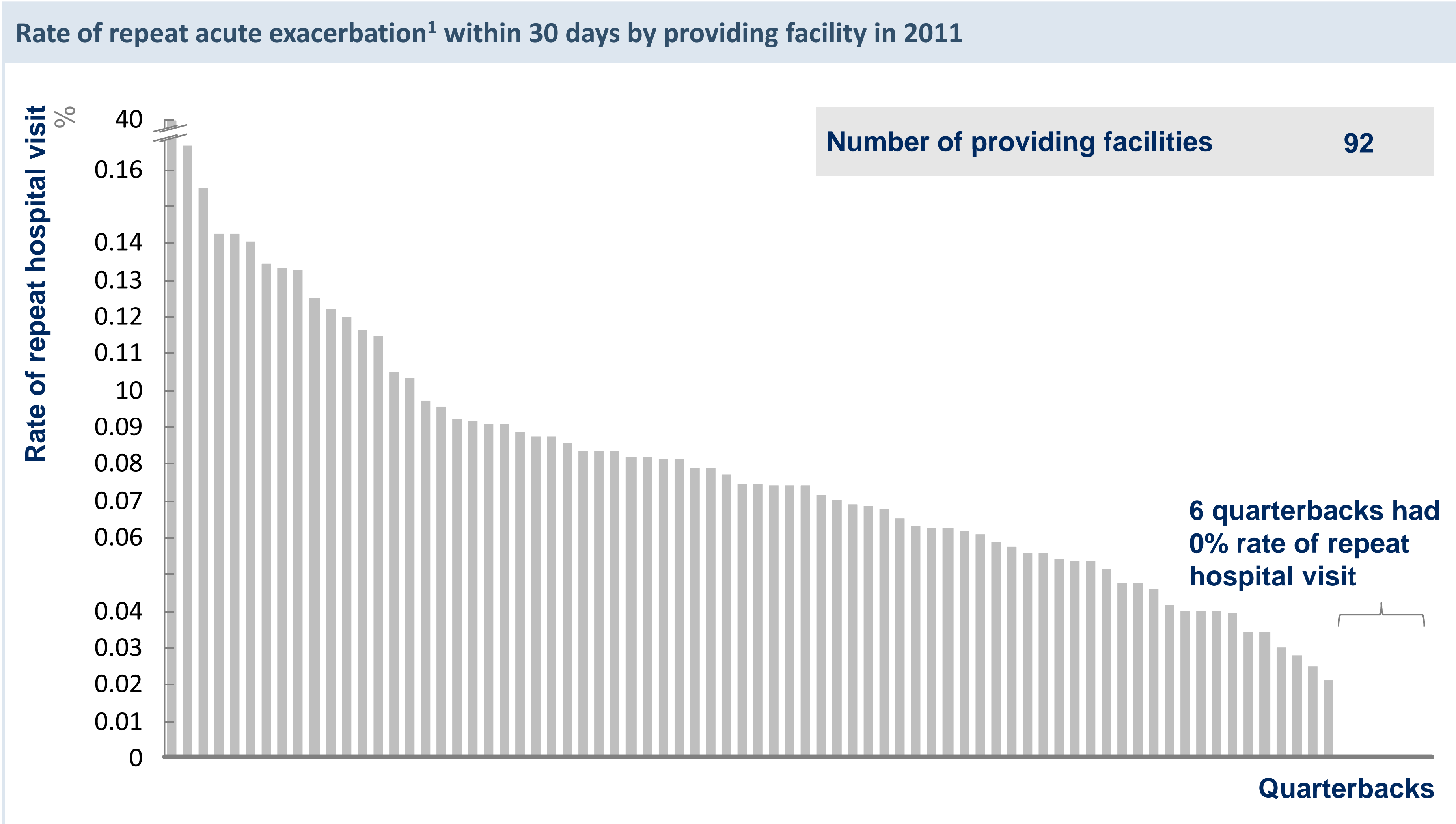
1 Each vertical bar represents the adjusted average cost an individual quarterback, sorted from highest to lowest average cost; 94 total quarterback's

SOURCE: Arkansas Medicaid claims paid, July 2011 – June 2012

Summary data: Rate of repeat acute exacerbation variation across providing facilities

AR MEDICAID
AS OF 2/20/13

Arkansas example



1 A visit is considered a repeat acute exacerbation if a diagnosis trigger code matches the primary diagnostic field during a hospital visit

SOURCE: Arkansas Medicaid claims during 2011

Arkansas example

Summary data: Quality metrics

	Quality metric	2012 Average[1]	Low/High[1]
Rate of follow-up visit with physician	▪ Percent of episodes where patient visits a physician in the outpatient setting within 30 days of initial discharge	▪ 38%	▪ 7% - 83%
Rate of patient on appropriate medication	▪ Percent of patients on appropriate medication determined by a filled prescription for oral corticosteroid and/or inhaled corticosteroids during episode window or (within 30 days prior to trigger	▪ 68%	▪ 39% - 100%
Repeat acute exacerbation within 30 days	▪ Percent of patients with repeat acute exacerbation during episode window	▪ 8%	▪ 0% - 30%

1 For Quarterbacks with 5 or more episodes

SOURCE: Arkansas Payment Improvement Initiative

Contents

- Debrief of barriers to reform
- PCMH scale-up options
- Episode design decisions
- Episode TAG updates
- Deep-dive: Asthma acute exacerbation episode
- **Review of potential provider report**
- Discussion and next steps

Sample of potential provider report

ILLUSTRATIVE EXAMPLE

Medicaid Little Rock Clinic 123456789 July 2013

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Health Care Payment Improvement Initiative

Building a healthier future for all Arkansans

Arkansas Health Care Payment Improvement Initiative Provider Report

Medicaid
Report date: July 2013

Performance Period Report

DISCLAIMER: The information contained in these reports is intended solely for use in the administration of the Medicaid program. The data in the reports is neither intended nor suitable for other uses, including the selection of a health care provider. The figures in this report are preliminary and are subject to revision. For more information, please visit www.paymentinitiative.org

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Medicaid Little Rock Clinic 123456789 July 2013

Summary – Congestive Heart Failure

1 Overview

Total episodes: 15 Total episodes included: 14 Total episodes excluded: 1

2 Cost of care compared to other providers

Commendable: < $4,722
Acceptable: $4,722 to $6,644
Not acceptable: > $6,644
You
All providers

Gain/Risk share

$0

You are not eligible for gain sharing
– Selected quality metrics: Not met
– Average episode cost: Acceptable

3 Quality summary

You did not achieve selected quality metrics

Linked to gain sharing

ACE-I / ARB Rx rate: 100%, 50%, 0%; You, Avg

OP visit within 14 days: 100%, 50%, 0%; You, Avg

30-day all cause readmit: 100%, 50%, 0%; You, Avg

30-day HF readmit: 100%, 50%, 0%; You, Avg

4 Cost summary

Your average cost is acceptable

Your total cost overview, $

You (non-adjusted)	You (adjusted)
85000	84000

Average cost overview, $

You	All providers
6000	5500

Your episode cost distribution

# episodes	<$3263	$3263-$4722	$4722–$5363	$5363–$6003	$6003-$6644	$6644-$12591	>$12591
	1	1	2	6	2	1	1

Distribution of provider average episode cost

Cost, $: 21000, 14000, 7000
Percentile
You | Commendable | Acceptable | Not acceptable

5 Key utilization metrics

30-day outpatient observation care rate

You: 17%
All providers: 30%

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Housekeeping questions and information

- First **TAG meetings** (asthma acute exacerbation and perinatal) are kicking off this week
- Repeat of first **Employer Stakeholder Group** webinar will be tomorrow (7/18, 11am to noon)
- Next **Public Roundtable** meeting will be held at the end of the month (7/31, 1-3pm; webinar available)

August 14th Payment Reform Provider Stakeholder Group meeting

PRELIMINARY

Agenda

- Introductory remarks
- Episodes: Progress of TAGs
- Episodes: Deep-dive on asthma episode
- Infrastructure: Feedback on episode report design and distribution
- PCMH: Review of fact base and environmental scan
- Discussion and next steps

Questions for discussion on August 14th

- What reactions do you have to activity of TAGS to date?
- What feedback do you have on proposed report design?
- What are your reactions to the options for PCMH scale-up?
- What challenges to PCMH scale-up do you anticipate given your preferred options for payer and provider participation?