Tennessee
Payment Reform Initiative

State Innovation Model Public Roundtable Meeting

June 26, 2013

PRELIMINARY WORKING DRAFT, SUBJECT TO CHANGE

Agenda for State Innovation Model Public Roundtable meeting

PRELIMINARY

Activity	Time	Owner
▪ Why we are here / Vision for Tennessee	10:00 - 10:20	Darin Gordon
▪ Stakeholder involvement	10:20 - 10:35	Darin Gordon
▪ Introduction to payment innovation	10:35 – 11:30	Brooks Daverman
▪ Questions & Discussion	11:20 - 12:00	Brooks Daverman

Objectives for today

- Why we are here / Vision for Tennessee
- Stakeholder involvement
- Introduction to payment innovation
- Next Steps, questions and discussion

Message from Governor Haslam

- We are **deeply committed** to reforming the way that we pay for healthcare in Tennessee
- Our goal is to **pay for outcomes and for quality care**, rather than for the amount of services provided
- As a centerpiece of payment reform, we will introduce payment based on **"episodes of care"; ** our aim is to design three episodes by September
- We plan to have episodes and population-based payment models account for the **majority of healthcare spend** within the next three to five years
- This effort will require **new relationships** and action between users, providers, and payers
- Hospitals, medical providers, and payers have all demonstrated a **sincere willingness** to move toward payment reform
- By working together, we can make significant progress toward **reducing medical costs and improving care**

"I believe Tennessee can also be a model for what true health care reform looks like."

"It's my hope that we can provide quality healthcare for more Tennesseans while transforming the relationship among health care users, providers and payers. If Tennessee can do that, we all win."

– Governor Haslam's address to a joint session of the state Legislature, March 2013

SIM is an expansive grant program that can fund State innovations in payment and care delivery over a 6-month to 3-year timeframe

Key facts on the initiative

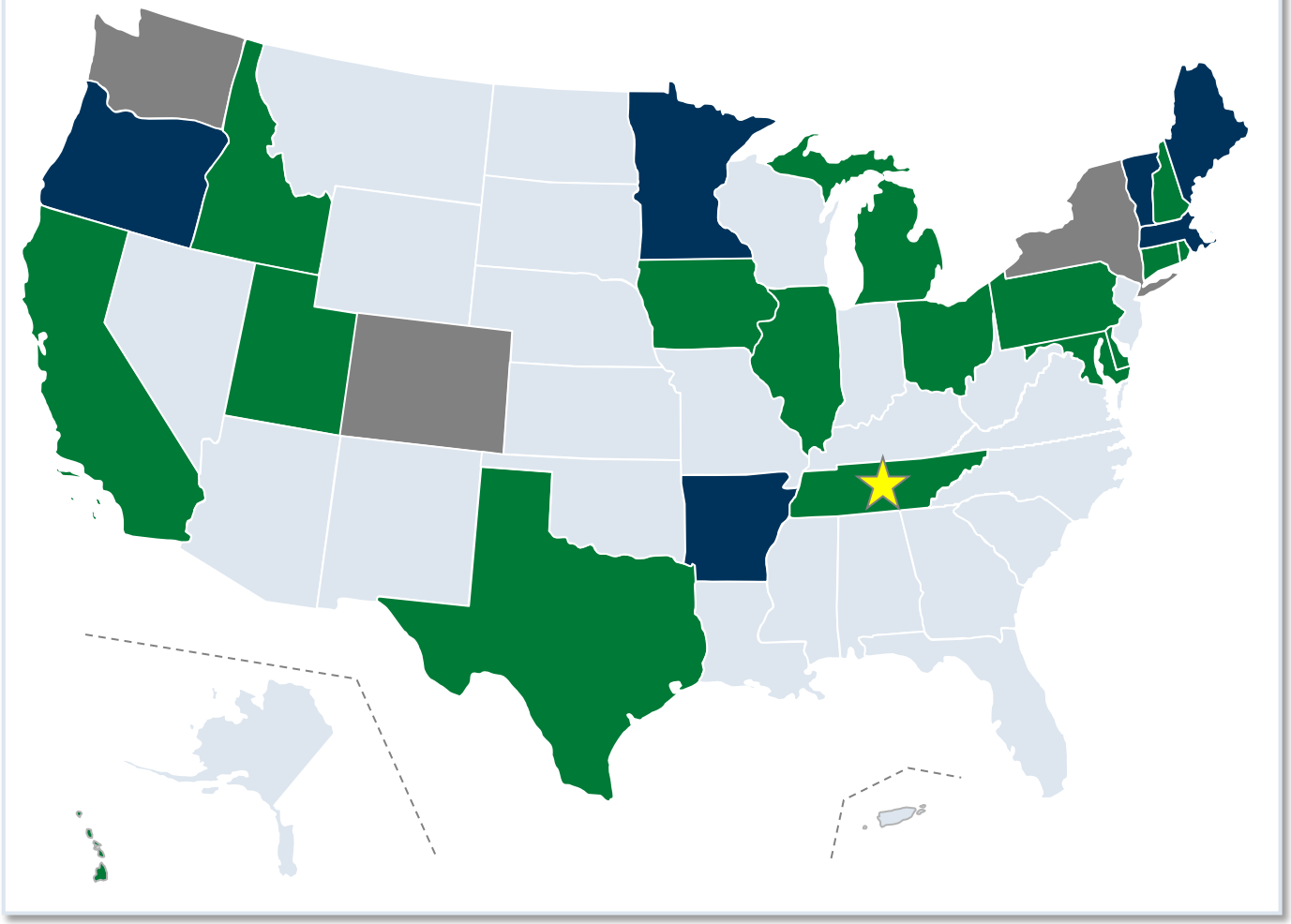
- Funding for states to **design** and **test comprehensive State Innovation Plans**
- Innovation plans must:
  - Be **Governor-led** and **multi-payer**
  - Improve **health**, improve **health care**, and **reduce costs**
  - Incorporate broad range of **stakeholder input**
- Significant funding pool, with first round of winners already announced:
  - Over 15 **"design" grants of $0-3M** each (TN was a winner)
  - 6 **"testing" grants of $~45M** each, and opportunity to request Medicare participation

SOURCE: CMMI State Innovation Models announcement

State innovation model work across the country

SIM Testing | SIM Pre-Testing | SIM Design

State Innovation Model (SIM) funding, 2013



- Six states have already been awarded over $250 million to implement their State HealthCare Innovation Plans
- Nearly 20 others will be competing with Tennessee for a second wave of funding to implement their plans

SOURCE: CMMI State Innovation Model: http://innovation.cms.gov/initiatives/state-innovations/

Requirements for State Innovation Plan

Content objectives

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Focus of today's presentation

Components of State Innovation Plan	
A	State goals
B	Description of state health care environment
C	Report on process deliberations
D	Health system design and performance objectives
E	Proposed payment and delivery system models
F	Health information technology
G	Workforce development
H	Financial analysis
I	Evaluation plans
J	Roadmap for health system transformation

SOURCE: Notice of Award, Attachment B, Section 9

Objectives for today

- Why we are here / Vision for Tennessee
- **Stakeholder involvement**
- Introduction to payment innovation
- Next Steps, questions and discussion

The state will engage a broad array of stakeholders in payment reform and development of the State Innovation Plan

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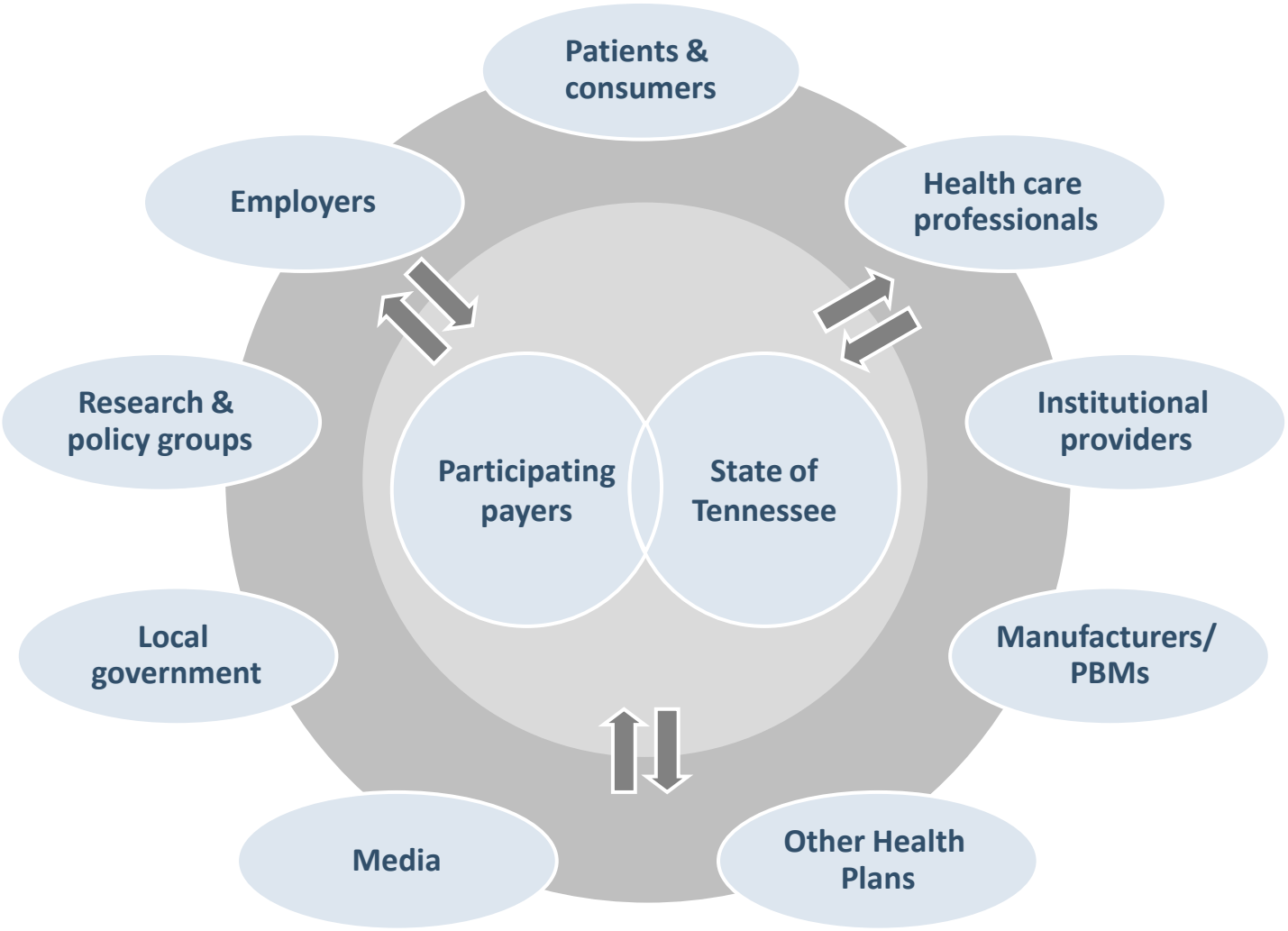

Composition of stakeholder committees

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Stakeholder group	A **State Innovation Model Public Roundtables**	B **Provider Stakeholder Group**	C **Payment Reform Payer Coalition**	D **Employer Stakeholder Group**	E **Payment Reform Technical Advisory Groups**
Stakeholders involved	Open to the public in person or by conference call: ▪ June 26, 10am-noon ▪ July 31, 1-3pm ▪ August 26, 1-3pm ▪ September 25, 1-3pm	Select providers meet regularly to advise on overall initiative implementation	State healthcare purchasers (TennCare, Benefits Administration) and major insurers meet regularly to advise on overall initiative implementation	Introductory webinar will be held on Thursday June 27 at 11am CT, and will repeat on July 18 at 11 am CT, followed by additional opportunities to engage	Select Clinicians meet to advise on each episode of care
Meeting rhythm	4 by October	Monthly	2 per month	3 by October	2-3 per episode

The State will convene stakeholders, incorporate input, and lead by example

Example of how the state is leading in payment reform

- Tennessee will lead by reforming health care payments for the 1.2 million TennCare enrollees and 300,000 members of the state employee Benefits Administration coverage.
- We are inviting the major insurance companies that do business with the State to increase the impact of payment reform by including their commercial lines of business.
- All stakeholders are invited to participate in the initiative through multiple avenues for input.
- In addition, the state will review other areas of health care innovations in this series of public Roundtable meetings. Topics to be addressed include:
- Financing and delivery of public health services and community prevention strategies;
- Early childhood and adolescent health prevention strategies
- Community stabilization development initiatives
- Behavioral health services
- LTSS
- Substance abuse services
- Children's dental health services
- Healthcare workforce
- Health information technology, EHR systems, HIE technologies

Contents

- Why we are here / Vision for Tennessee
- Stakeholder involvement
- **Introduction to payment innovation**
- Next Steps, questions and discussion

Tennessee's vision for a 21st century healthcare system includes payment reforms that will improve incentives to empower physicians

Today

- Fee-for-service arrangements, in which health care providers are financially rewarded for doing more, and more expensive interventions
- Fragmented health care system with limited multi-payer or provider collaboration
- Some payers and providers have launched some pilot programs on Patient-Centered Medical Homes, ACOs, and episodes

Future

- Most healthcare spending flows through outcomes-based payment models
- Providers have more information to see the whole picture of the care their patients receive
- Value-based incentives are aligned across payers, so providers can concentrate on giving patients the best value

Why now for payment innovation?

- Stakeholders agree on the desirability to migrate from paying for activity to paying for "value"
- A growing body of experience and advances in technical sophistication has increased the feasibility of new payment models
- If we do not adopt positive reforms now, rising costs will force negative reforms in the future (e.g., explicit rationing, rate cuts, more intensive "managed care", greater regulation, etc.)
- $10B in Innovation Center investment capital

Tennessee's Payment Reform Plan: The State's proposed plan includes "population" and "episode" based payment reforms

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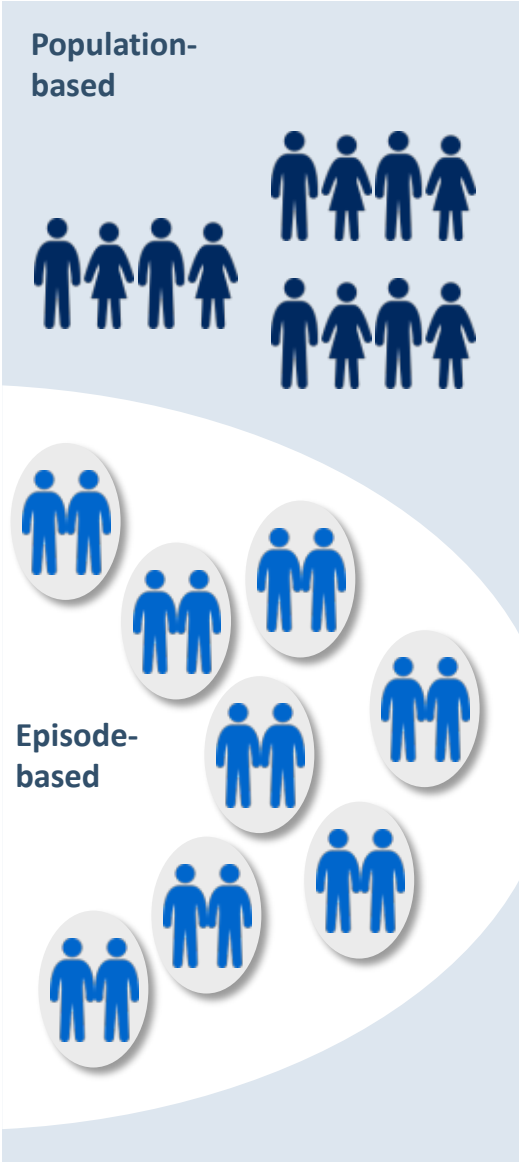


Basis of payment	TN Payment Reform Approach	Examples
▪ Maintaining patient's health over time, coordinating care by specialists, and avoiding episode events when appropriate.	▪ Patient centered medical homes (PCMH)	▪ Encouraging primary prevention for healthy consumers and care for chronically ill, e.g., ▪ Obesity support for otherwise healthy person ▪ Management of congestive heart failure
▪ Achieving a specific patient objective at including all associated upstream and downstream care and cost	▪ Retrospective Episode Based Payment (REBP)	▪ Acute procedures (e.g., hip or knee replacement) ▪ Perinatal ▪ Acute outpatient care (e.g., asthma exacerbation) ▪ Most inpatient stays including post-acute care, readmissions ▪ Some behavior health ▪ Some cancers

Sources of value that can be realized

Primarily via:	*PCMH*	*Episodes*		*PCMH and episodes*
	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

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

What are episode-based payments and who is the responsible provider?

- Episode-based payments reimburse providers on the basis of costs for selected conditions or major procedures, and include clinically related services provided by various providers over a period of time.
- Episodes cover a specified period that could range from a few days to a year, during which patients may receive care from multiple providers.
- A physician chosen to be the episode “quarterback” leads and coordinates the team of care providers
- The “quarterback” helps drive improvement across system (e.g., through care coordination, early intervention, patient education, etc.)

How proposed retrospective episodes would work for patients & providers

Patients and providers deliver care as today (performance period)

1

Patients seek care and select providers as they do today

2

Providers submit claims as they do today

3

Payers reimburse for all services as they do today

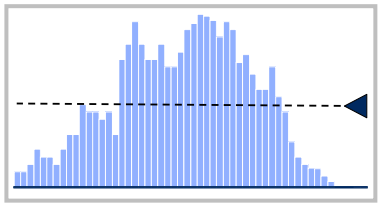
Calculate incentive payments based on outcomes after performance period (e.g. 12 months)

4

Review claims from the performance period to identify a **'quarterback'** for each episode

5

Payers calculate **average cost per episode** for each Quarterback[1]



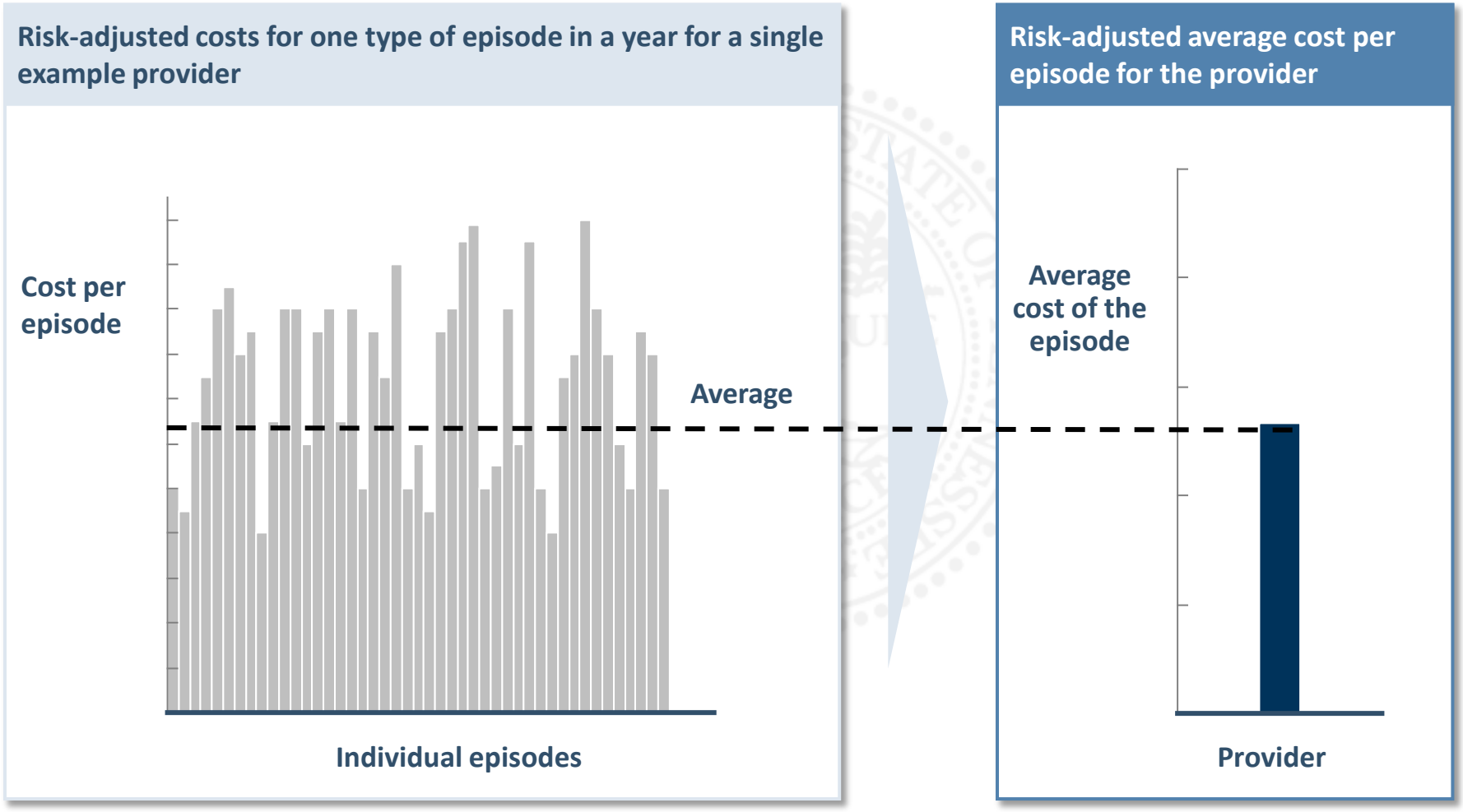
Compare average costs to predetermined ''commendable' and 'acceptable' levels[2]

6

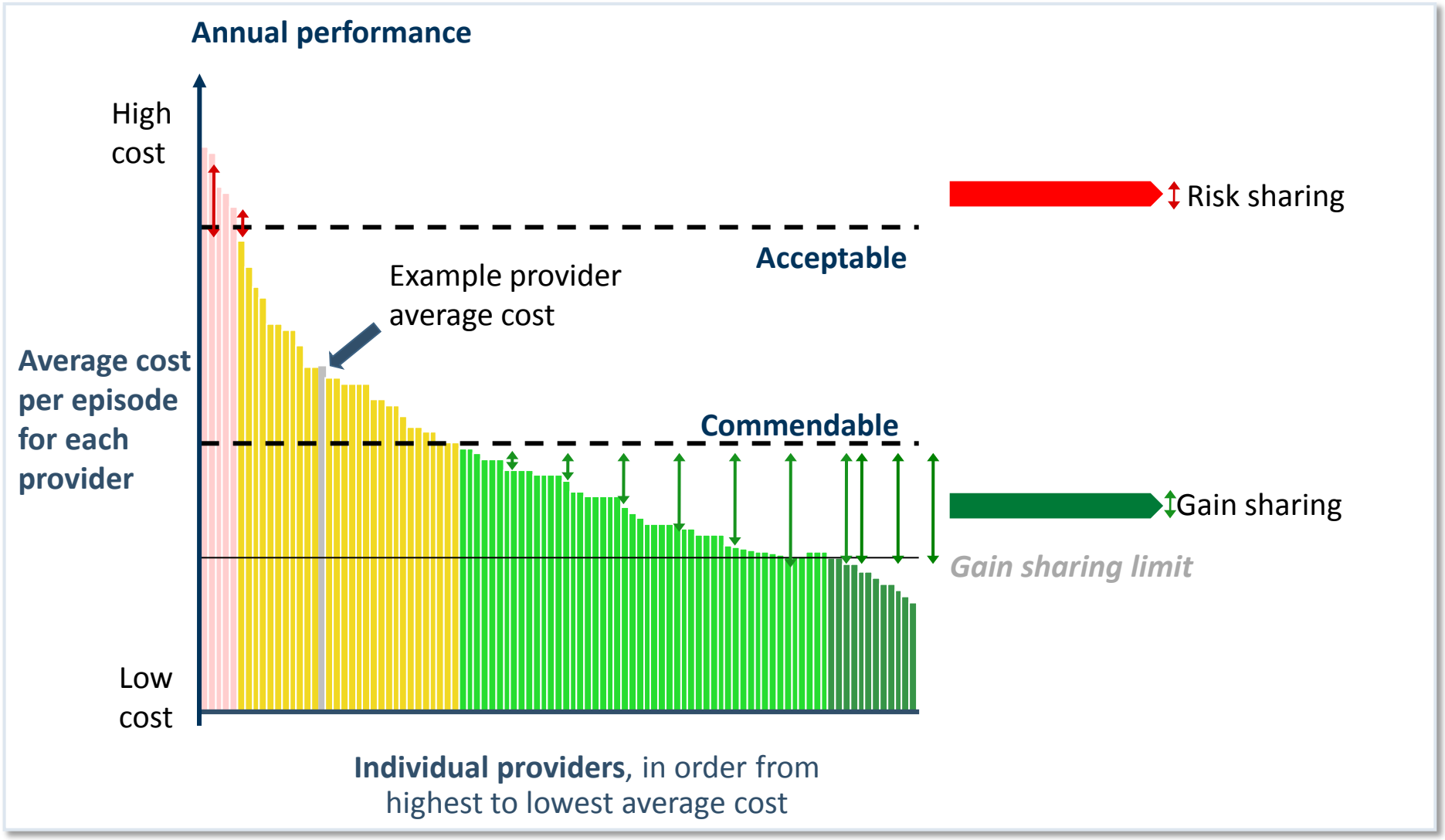
Providers will:

- **Share savings:** if avg. costs below commendable levels and quality targets met
- **Pay part of excess cost:** if avg costs are above acceptable level
- **See no change in pay:** if average costs are between commendable and acceptable levels

For providers, risk adjusted average cost of the total patient population they serve is what matters – NOT the cost of each episode



Example: in implementing retrospective-based payment, savings and cost sharing with providers derives from evaluating provider performance against acceptable and commendable "thresholds"



By design, episode-based payment rewards high quality care

Encourages accurate and specific diagnosis

Rewards clinically appropriate treatment and treatment intensity

Encourages clinically appropriate use of medications

Motivates appropriate use of medical professionals across the treatment spectrum

Episodic payment **rewards providers for effective management** while holding them accountable for downstream outcomes and costs

In some cases, the model may be further augmented with additional quality objectives

Objectives	Examples of options
Encourage evidence-based medicine and practices	▪ Require reporting of select quality + process metrics (e.g. frequency of antibiotics usage for URI episode) ▪ Increase transparency of quality metrics (i.e. to other providers)
Ensure model will not result in underuse of care	▪ Payment contingent on delivery of services universally agreed as critical / necessary ▪ Select “audits” to understand abnormally low utilization

Diverse mix of episodes chosen for Wave 1 implementation

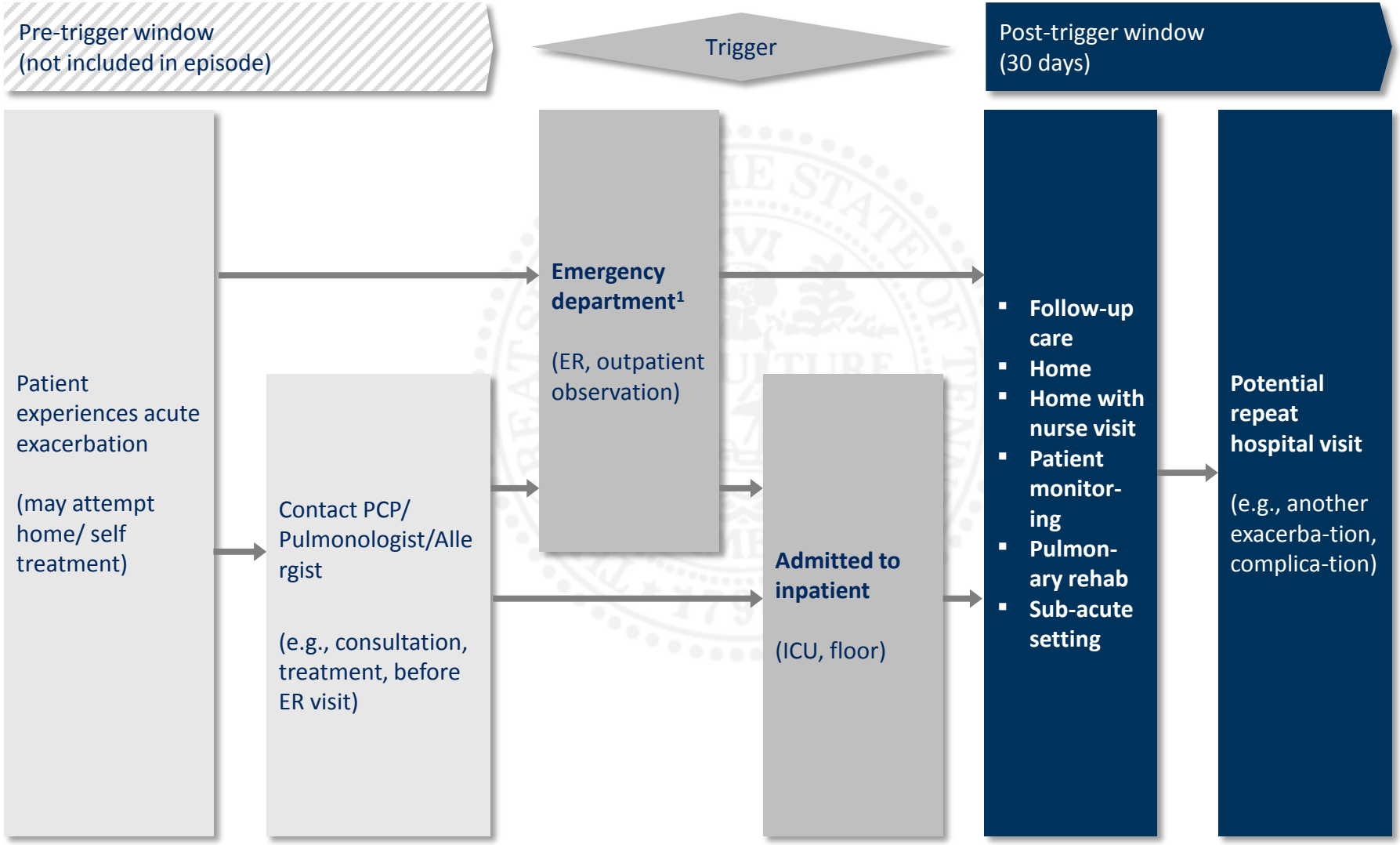
Example elements on next two pages

	Potential Accountable provider	Potential Sources of Value
Hip and knee replacement	Orthopedic surgeon	▪ Ensure optimal length of stay in acute + sub-acute settings ▪ Minimize readmissions and complications ▪ Reduce implant costs ▪ Reduce unnecessary or duplicate imaging/ services
Pregnancy and delivery	Delivering physician	▪ More effective prenatal care (low and high-risk pregnancies) ▪ Eliminating unnecessary inductions, c-sections, and extended length of stay
Asthma Acute Exacerbation	Hospital	▪ Treat with appropriate medication ▪ Reduce avoidable inpatient admissions ▪ Encourage appropriate length of stay ▪ Encourage hospitals to extend reach beyond point of discharge — Prescribe appropriate follow-up care & increased compliance — Reduce avoidable readmissions / complications

Example: Asthma acute exacerbation

TO BE MODIFIED/VERIFIED BY TAG'S | ARKANSAS EXAMPLE

Patient Journey



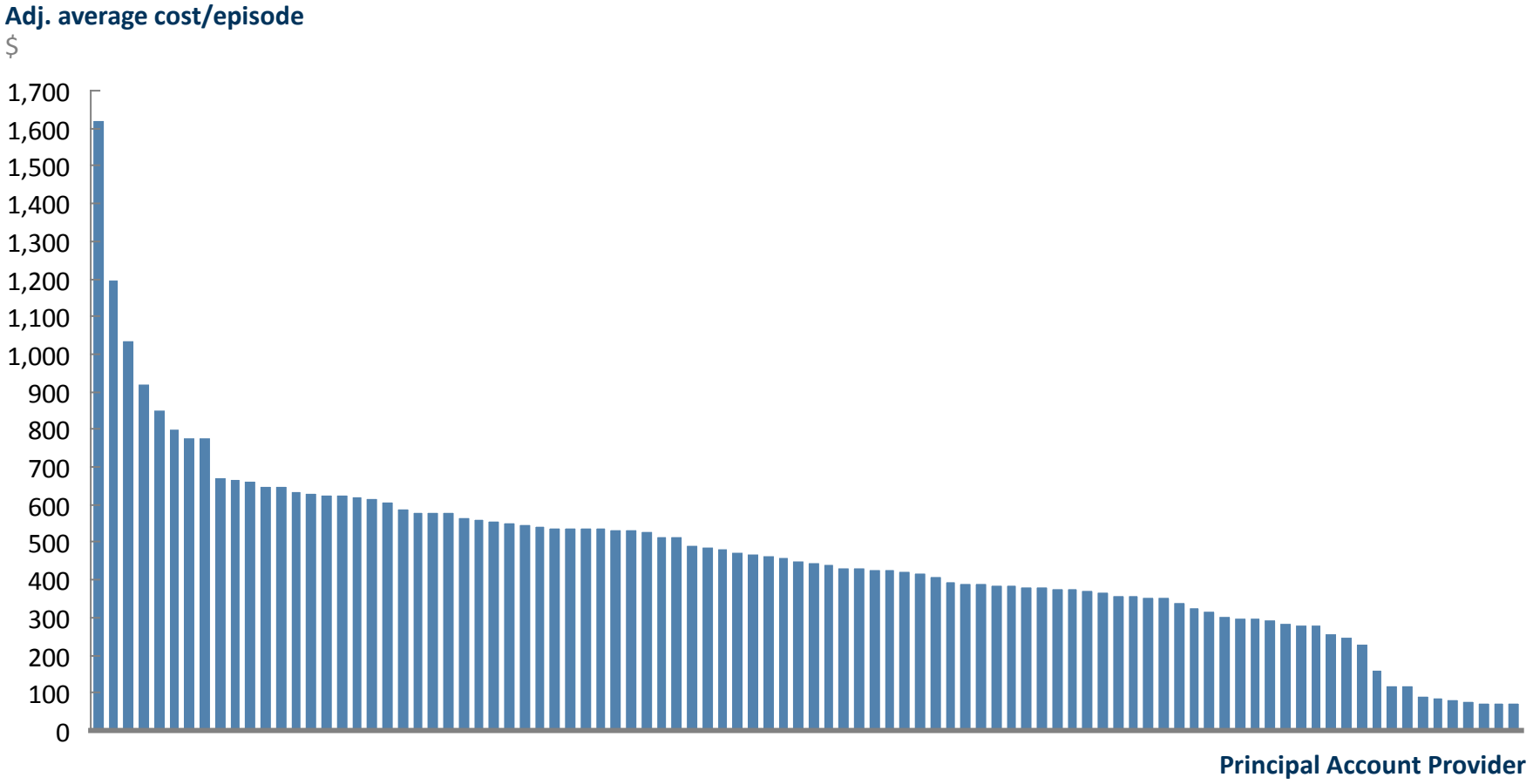
1 May include urgent care facility

SOURCE: Arkansas Payment Improvement Initiative

Example: Asthma acute exacerbation
Cost Variation Across Providers

ARKANSAS EXAMPLE

Asthma provider cost distribution
Adjusted average cost per provider[1]



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

SOURCE: Arkansas Payment Improvement Initiative

What is a Patient-Centered Medical Home (PCMH)?

Vision

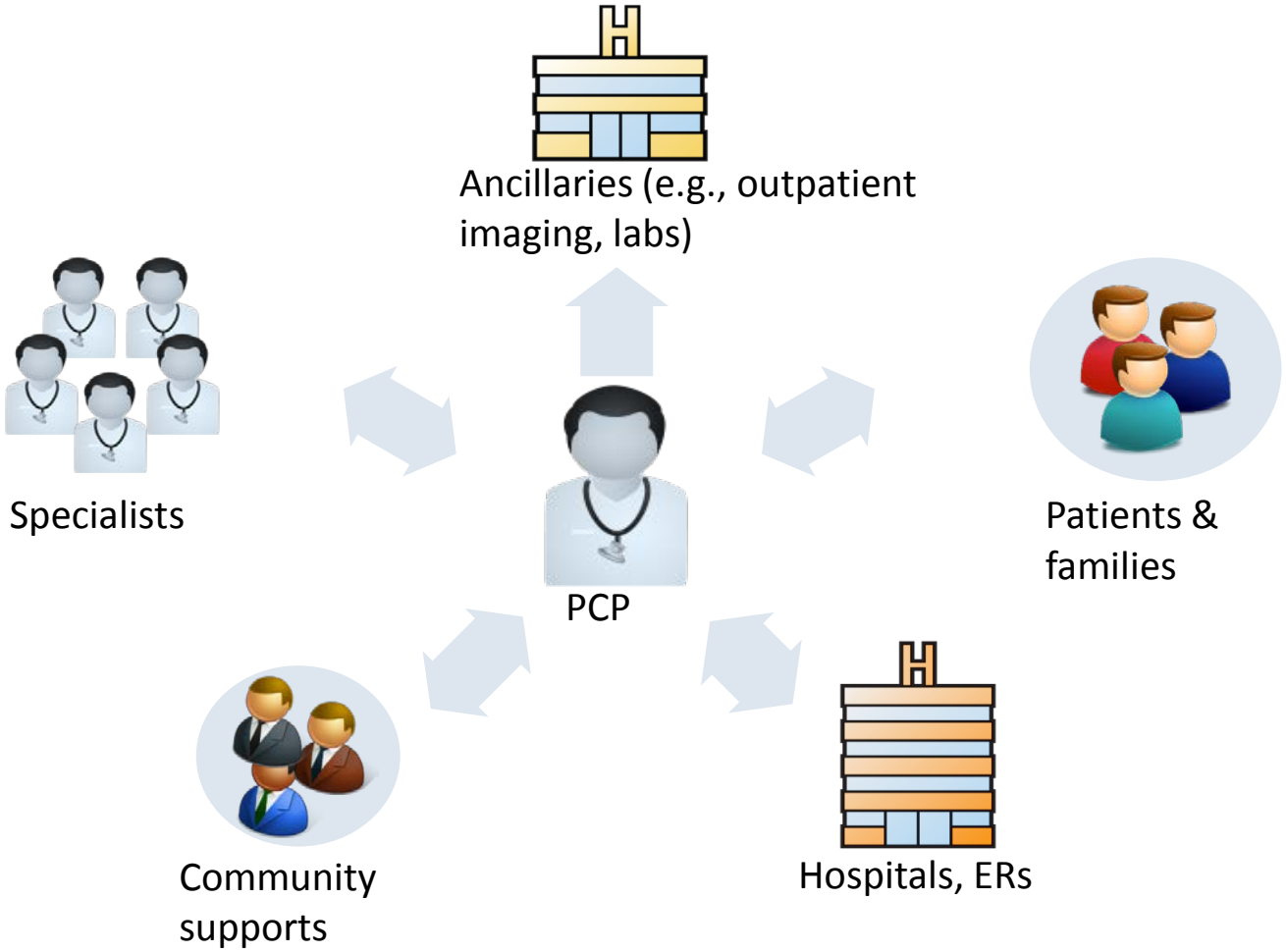
A team-based care delivery model led by a primary care provider that comprehensively manages a patient's health needs

Elements

- Providers are responsible for managing health across their patient panel
- Coordinated and integrated care across multidisciplinary provider teams
- Focus on prevention and management of chronic disease
- Expanded access
- Referrals to high-value providers (e.g., specialists)
- Improved wellness and preventative care
- Use of evidence-informed care

Why primary care and PCMH?

Most medical costs occur outside of the primary care physician's office, but PCPs can guide many decisions that impact those broader costs



Elements that could be incorporated in a PCMH program

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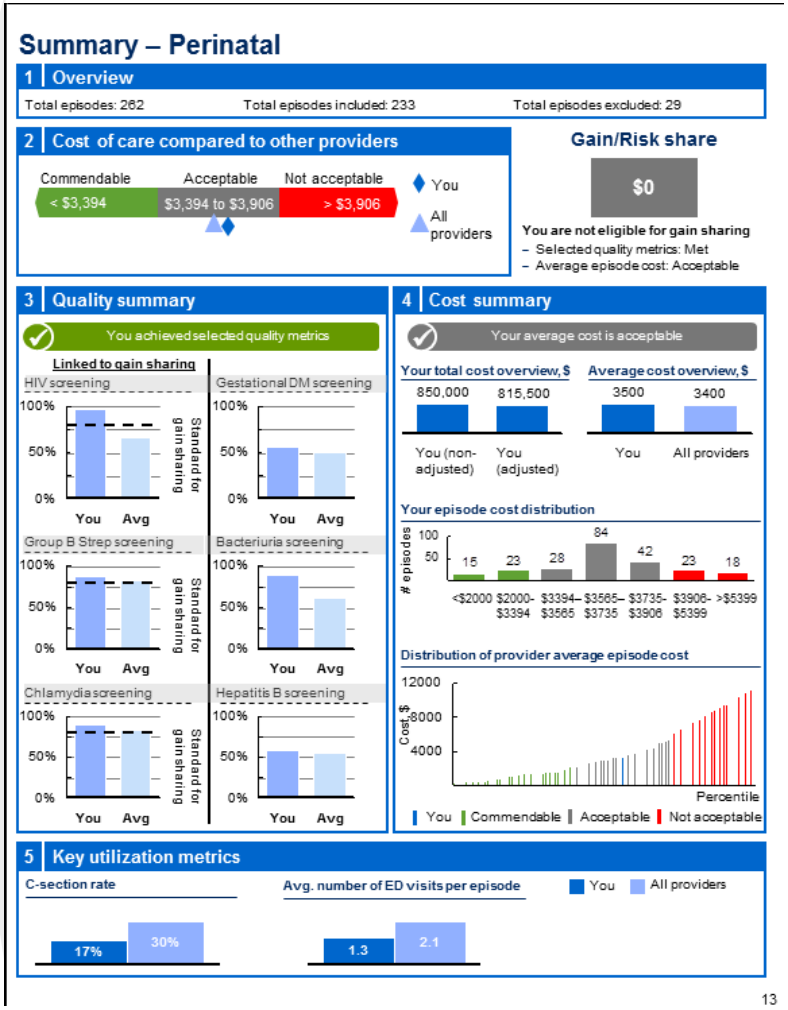
Care delivery model	Target patients and scope Care delivery improvements e.g., ▪ Improved access ▪ Patient engagement ▪ Population management ▪ Team-based care, care coordination Target sources of value	Vision for a PCMH's role in the healthcare eco system, including who they should target, how care should be delivered (including differences from today), and which sources of value to prioritize over time.
Payment model	Technical requirements for PCMH Attribution / assignment Quality measures Payment streams/ incentives Patient incentives	Holistic approach to use payment (from payers) to encourage the creation of PCMHs, ensure adequate resources to fund transformation from today's model, and reward PCMH's for improving in outcomes and total cost of care over time
Infrastructure	PCMH infrastructure Payer infrastructure Payer / PCMH infrastructure PCMH / Provider infrastructure System infrastructure	Technology, data, systems, and people required to enable creation of PCMH, administer new payment models, and support PCMHs in making desired changes in care delivery
Scale-up and practice performance improvement	Clinical leadership / support Practice transformation support Workforce / human capital Legal / regulatory environment Network / contracting ASO contracting / participation Performance transparency Ongoing PCMH support Evidence, pathways, & research Multi-payer collaboration	Support, resources, or activities to enable practices to adopt the PCMH delivery model, sustain transformation and maximize impact

Successful payment reform depends on transparency for providers

Potential information to include in reports

- **Performance summary**
  - Episode performance and gain / risk sharing amount
  - Quality requirements
- **Report summary**
  - Cost summary and benchmarks
  - Quality of service summary
  - Utilization summary
- **Quality of service:** Detail benchmarks for quality metrics across all quarterbacks
- **Care categories**
  - Breakdown of episode cost by care category
  - Benchmarks against commendable providers
- **Episode detail:** Cost detail by care category for each individual episode a provider treats
- **Glossary:** Definition and calculation of terminology/metrics used in the report

Illustrative Example



Proposed overview of the first phase of payment reform

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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 healthcare spend**

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Three additional public roundtable meetings have been scheduled

PRELIMINARY

- Wednesday, July 31, 2013
- Monday, August 26, 2013
- Wednesday, September 25, 2013

- Meeting topics will be released at least two weeks prior to scheduled meetings
- Please check for updates here: http://www.tn.gov/HCFA/strategic.shtml
- To sign up for our mailing list, email payment.reform@TN.gov

Soliciting perspectives on the discussion so far

- What items discussed so far have you considered most important? What topics do you hope are discussed in the near future?
- How can the State best gather stakeholder input into the State Innovation Plan? How can the State better engage with stakeholders outside of this forum?
- What are your largest concerns / what do you think are the largest barriers to reform in Tennessee?