Tennessee
Payment Reform Initiative

Provider stakeholder group meeting

June 19, 2013

PRELIMINARY WORKING DRAFT, SUBJECT TO CHANGE

Agenda for Provider Stakeholder Group meeting

Activity	Time
▪ Introductory Remarks	13:00 – 13:15
▪ Overcoming barriers to reform activity	13:15 – 13:40
▪ Episode selection	13:40 – 14:00
▪ Episode TAG selection	14:00 - 14:20
▪ Approaches to obstacles – episode design decisions	14:20 - 14:30
▪ PCMH approach and relevant case studies	14:30 - 14:50
▪ Discussion & Next steps	14:50 - 15:00

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 healthcare spend

Major topics for upcoming Provider Stakeholder Group meetings

PRELIMINARY

SUBJECT TO CHANGE

Agenda (7/17)

- Discuss overall episode design decision elements
- Discuss elements of PCMH model design
- Update group on TAG progress
- State's infrastructure assessments and working hypothesis on infrastructure needs for phase 1
- Discuss the State Innovation Plan
- Next steps for Provider Stakeholder Group

Agenda (8/14)

- Discuss key findings of episode TAGs
- Developing hypotheses on episode design decisions
- PCMH strawman and areas of alignment
- Infrastructure update
- Discuss/get input on the State Innovation Plan application
- Implementation timeline details

Agenda (9/11)

- Episode data refinement progress – estimated financial impact for state and providers
- TAG progress and additional episode design decisions
- Discussion of episode reports
- PCMH Refinement and launch expectations
- Infrastructure progress and timeline
- State Innovation Plan application

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Potential barriers to Episodes and PCMH innovation at scale

PRELIMINARY

1. Need to work across provider boundaries
2. Balance of equity / shared accountability amongst payers and providers
3. Fairness across providers (e.g., to reflect case mix)
4. Supporting providers with information and tools
5. Clarity of provider accountability
6. Ensuring high quality care
7. Reflecting true performance / minimizing statistical variability
8. Payer administrative capabilities & potential need for non-clinical data (infrastructure)
9. Perceived regulatory barriers
10. Ensuring ROI / actuarial soundness
11. ASO participation
12. Aligning patient incentives
13. Other?

- **Which are most important for Tennessee?**
- **Where can multi-payer alignment help to overcome?**
- **Where is State leadership most helpful?**

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Episodes design timeline and metrics for episode selection

PRELIMINARY

Strawman for episode design timeline

- Month of June: Episode selection complete
- By end of June: Selection of TAG members complete
- July & August: TAG meetings and other stakeholder meetings to input on episode design
- August: Publicize designs and hold public roundtables asking for comment
- End of August & early September: Collect and respond to any public feedback
- Early September: Risk-adjust the episodes
- Mid September: Finalize episode design

Metrics for selection	Key considerations
1 Total spend	▪ Concentration of spend across care categories & episodic areas
2 Potential for improvement	▪ Evidence indicating sources of value in relation to improved cost efficiency, quality, and patient experience
3 Implementation complexity	▪ Degree of change required — Clinical processes — Clinical infrastructure (HIT, care coordination) — Patient behavior — Provider economics — Administrative processes ▪ Scope of implementation — Number of providers impacted — Number of patients impacted
4 Diversity of episode portfolio	▪ Range of episode types (e.g., wellness, early chronic, complex chronic, acute, long-term care) ▪ Range of payers impacted (Commercial, Medicaid, Medicare)

1 Approximate spend by care category – national view

ILLUSTRATIVE

TN data Discussed on following page

Care categories	Examples	Percent of total spend: Medicaid	Commercial	Medicare
Prevention	Health screenings, colonoscopy	~5	~5	~3-5
Chronic care (medical)	Diabetes, chronic CHF, CAD	~10-15	~15-25	~20-30
Acute outpatient medical	Ambulatory URI, sprained ankle	~5-10	~5-10	~5-10
Acute inpatient medical	CHF, pneumonia, AMI, stroke	~5-10	~20-25	~20-30
Acute procedural	Hip/knee, CABG, PCI, pregnancy	~15-20	~25-35	~20-25
Cancer	Breast cancer	<5	~10	~10
Behavioral health	ADHD, depression	~15-20	~5	~5
Supportive care	Develop. disability, Long-term care	~15 ~15-20	n/a	n/a

Episodes

Medical homes and health homes

Note: Percentages represent national estimates

SOURCE: Team analysis

1 Initial analysis of Total TennCare spend by care category

PRELIMINARY

DATA IS PRELIMINARY – DIRECTIONAL ONLY – LIKELY UNDERSTATED

Care category	Total Medicaid spend $ M 2012	Share of total	Total # of covered lives[2] Thousands 2012	Share of total	Per Patient Avg $ 2012
Supportive care Long term care	~1,000	25%	~40	4%	~27,000
Outpatient	~1,000	24%	~1,000	88%	~1,000
Inpatient	~900	21%	~100	9%	~9,000
Chronic care	~600	13%	~400	40%	~2,000
Behavioral health	400	10%	~200	19%	~3,000
Cancer	~200	3%	~40	3%	~4,000
Prevention	~100	2%	~500	48%	~200
Total	**4,350**				**3,777**

1 Categories created based on ACA definitions (Prevention), CCS categories (Chronic conditions, Cancer, Behavioral health) or McKinsey definitions (Acute). Total number of covered lives (these are the number of people in TennCare that have an acute outpatient claim – more than total number of TennCare members because people are appearing in more than one bucket. (average per patient)

2 Numbers below represent the incidence of patients with at least one claim in each care category. Total TennCare lives is 1,152

3 FFS Data (primarily DD) was not included

SOURCE: TN State Medicaid Data

1 Initial spend and provider count for episodes under consideration

PRELIMINARY

DATA IS PRELIMINARY – DIRECTIONAL ONLY – LIKELY UNDERSTATED

Episodes considered	Total TennCare spend[1] $ Millions	Total number of providers that trigger claims
Perinatal[2]	150-200	1,500-2,000
ADHD[3]	25-75	1,500-2,000
Asthma Exacerbation	10-50	<100
COPD Exacerbation	10-50	100-150
Congestive Heart Failure	5-15	<100
TJR (Hip & Knee)	< 10	50-75
Tonsillectomy	< 10	100-150
PCI	< 10	50-75
Cholecystectomy	< 10	100-150
CABG	< 10	10-20
ODD	TBD	TBD
ADHD/ODD Comorbidity	TBD	TBD
Colonoscopy	TBD	TBD
Ambulatory URI	TBD	TBD

1 Episode spend estimated using APR-DRGs plus an estimate of spending pre and post episode trigger. No patients were excluded
2 Perinatal spend does not include protracted Neonatal care
3 Primary Dx of ADHD and ODD within a larger set of childhood behavioral disorders. For comorbidity both primary and secondary Dx are considered.

SOURCE: TN Medicaid data, team analysis

2 Potential for improvement: Sources of value

PRELIMINARY

Episode addressable

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

3 Implementation complexity: Degree of change required (criteria)

PRELIMINARY

	Low change	High change	Examples
Clinical processes	Necessary changes are straightforward and/or concentrated with single decision-making provider	Requires collaboration of multiple providers who today operate without any common processes	Example High: ED physician, surgeon, & rehab/pcp coordination (CHF, Asthma acute exacerbation, COPD)
Clinical infrastructure	Limited need for new infrastructure, or potential for providers to share existing infrastructure	Likely to require adoption of care coordinators, HIT, other infrastructure by large number of providers	Example High: clinician coordination (above); portal based quality metric entry (colonoscopy, tonsillectomy)
Patient behavior	Decision making exercised largely by treating providers	Changes in daily lifestyle or routine over extended period, including diet, exercise, drug compliance	Example High: family involvement in therapy (ODD), rehab / medication compliance (TJR / URI)
Provider economics	Eliminating inefficiencies poses no adverse impact on providers whose cooperation is required	Eliminating inefficiencies dependent on taking capacity offline for high-fixed-cost providers	Example High: unneeded psychotherapy (ADHD), C-sections (perinatal), general anasthesia (colonoscopy)
Administrative processes	Proven models for administration of episode-based payment and performance reporting	No existing examples of administration of episode-based payment and performance reporting	Example High: high degree of PCP / specialist / hospital / diagnostic coordination (cholecystectomy)

Episode candidates for first phase launch

PRELIMINARY

State's working hypothesis

Represents episodes that score highly on previously discussed selection criteria, as well as episodes launched in Arkansas

Categories	Episodes Considered
Prevention	Colonoscopy
Acute outpatient medical	Ambulatory URI
Behavioral Health	ADHD
	ODD
	ADHD/ODD Comorbidity
Acute inpatient medical	CHF Exacerbation
	Asthma Exacerbation
	COPD Exacerbation
Acute procedural	Cholecystectomy
	PCI
	CABG
	TJR (Hip & Knee)
	Tonsillectomy
	Perinatal

Reflections / reactions?

Select examples of potential episode details in the Appendix

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TAG Timeline

PRELIMINARY

Dates	TAG Selection deadlines
June 12	▪ Payers requested to recommend 1-2 providers for each TAG ▪ Payer's medical director TAG representatives requested to provide availability for July & Aug
June 19	▪ State will ask provider associations for TAG nominees
June 24 - 28	▪ State prioritizes nominees for each TAG ▪ State & nominating payer or provider organization outreach to nominees
July 1	▪ TAG member participation confirmed

Clinical input from Tennessee providers for episode development

Input required from local clinicians to develop episodes:

- Clinical rationale behind episode design
- Episode logic in light of Tennessee-specific practice patterns and population characteristics
- Operational considerations for launching the episode

- **Technical Advisory Group (TAG) membership:**
  - Each episode will have a TAG of 5-7 Tennessee clinicians, plus medical representatives from each participating payer
  - TAG members will be identified based on input from TennCare, Benefits Administration, Payer Coalition, and Provider Stakeholder group
- **Format for engaging clinicians:**
  - Initial introductory conference call: introduction to episode concept
  - 2-4 meetings (1-2 hours each) to review design proposals and data, and discuss specific design elements and clinical topics
  - Pre-readings to be reviewed prior to meetings/calls

Note that TAGs are one source of input only; we anticipate significant engagement of other groups/organizations during the episode design process

Selecting TAG members to nominate

Overall TAG member selection metrics:

- Diversity in representation
  - From all three regions
  - Rural and urban setting
  - Private practice and hospital affiliations
- Professional and personal reputation
  - Thought leader for particular episode
  - Representative of practicing physicians in TN
  - Collaborative team player
  - Enthusiastic about improving care delivery
- Availability to attend 2-4 meetings in July and August

TAG member specialties:

Asthma/COPD:

- Pulmonologist
- Emergency medicine physician
- Pediatrician

Perinatal:

- Obstetrician/ gynecologist
- Family practice physician

TJR:

- Orthopedic surgeons

EXAMPLE: The following is the list of individuals within Arkansas / APII who actively advised and / or consulted on the Asthma episode

Department of Human Services

- Dr. William Golden, Medical Director for Medicaid

Arkansas Blue Cross Blue Shield

- Matt Flora, Statistical Development & Reporting Supervisor
- Dr. Clement Fox, Medical Director

Clinical advisors (outside TAG members)

- Dr. Paula Anderson (Critical Care Medicine, Internal Medicine, Pulmonologist – University Hospital Arkansas)
- Dr. Larry Simmons (Pediatric and Pediatric Pulmonology – Arkansas Children's Hospital
- Dr. Keith Criner (Pulmonologist – NEA Baptist Clinic)
- Dr. Gary Templeton (Anesthesiologist (pain control), Internist, Critical Care Specialist, Pulmonologist – Fayetteville Diagnostic Clinic)
- Dr. Matt Jaegar (Emergency Medicine – Arkansas Children's Hospital)

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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	Need to work across provider boundaries	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	Fairness across providers (e.g., to reflect case mix)	Cost outliers, risk adjustment approach
4	Supporting providers with information and tools	Preparatory/reporting only period length, provider stop-loss
5	Clarity of provider 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	ASO participation	Participation
12	Aligning patient incentives	Stakeholder engagement, patient incentives, state wide consistency of definitions and communications
13	Lack of standard episode definitions	

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

PRELIMINARY

Focus of today's discussion

Program-level design decisions

- Participation
- Accountability
- Payment model mechanics
- Performance management
- Payment model timing
- Payment model thresholds
- Episode exclusions

Often require additional decisions on adaption/ exception rulings at episode-level

Episode-level design decisions

- Core episode definition
- Episode cost adjustment
- Quality metric selection

Often require decisions on approach to be made at program level

Complete list of program-level design decisions

PRELIMINARY

Focus of today's discussion

Category	Decision to make
Participation	1 Payer participation
	2 Provider participation
Accountability	3 Providers at risk – Number
	4 Providers at risk – Type of provider(s)
	5 Providers at risk – Exclusions
Payment model mechanics	6 Prospective or retrospective model
	7a Risk-sharing agreement – types of incentives
	7b Risk-sharing agreement – amount of risk shared
	8 Small case volume principles
	9a Role of quality metrics – clinical metrics
	9b Role of quality metrics – utilization metrics
	10 Provider stop-loss
Performance management	11 Absolute vs. relative performance rewards
	12a Absolute performance rewards & existence of neutral zone
	12b Absolute performance rewards – Gain sharing limit
	13 Risk adjustment principles
Payment model timing	14 Length of preparatory/ "reporting-only" period
	15 Length of "performance" period
	16 Synchronization of performance periods
Episode exclusions	17 Cost outliers
	18 Claim completeness
	19 Business exclusions
	20 Non-claims based quality metrics
	21 Quality metric sampling

Coordination vs independence for the episode design decisions across TN Payers. **How will the level of payer coordination for each design decision's affect providers**?

- Efficiency
- Effectiveness
- Complexity

State hypotheses on initial design decisions

State's working hypothesis on importance of coordination across payers

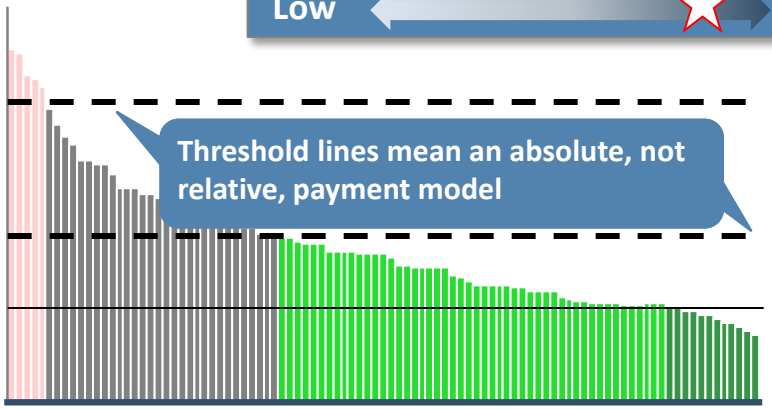
6 Type of model: **Retrospective**

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

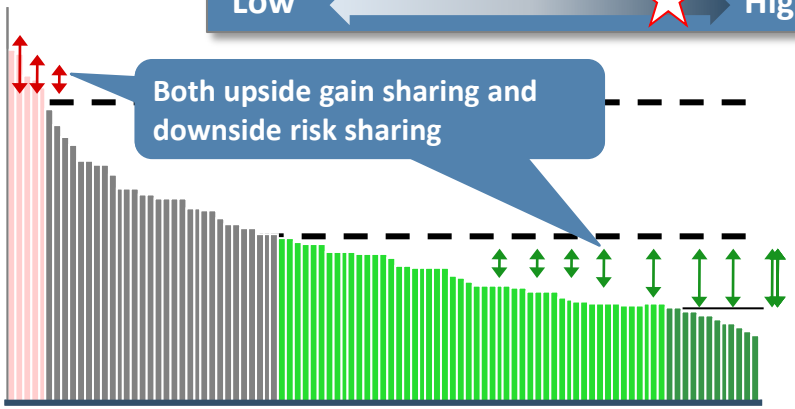
11 Type of payments: **Absolute**

Low ★ High



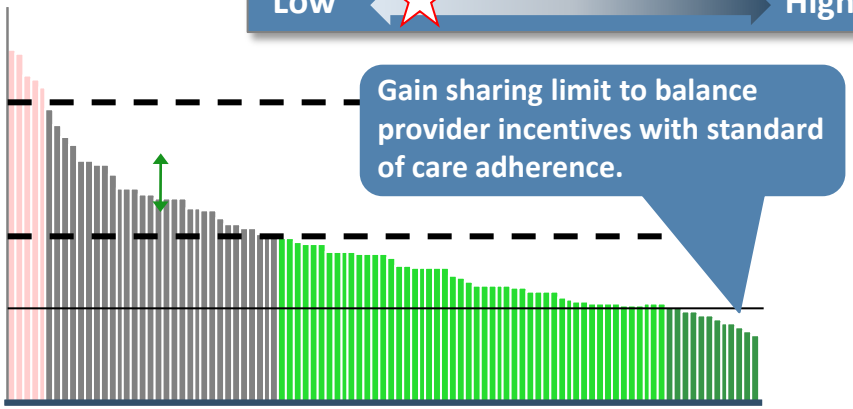
7a Type of incentives: **Upside & Downside**

Low ★ High



12b Gain sharing limit: **Yes**

Low ★ High



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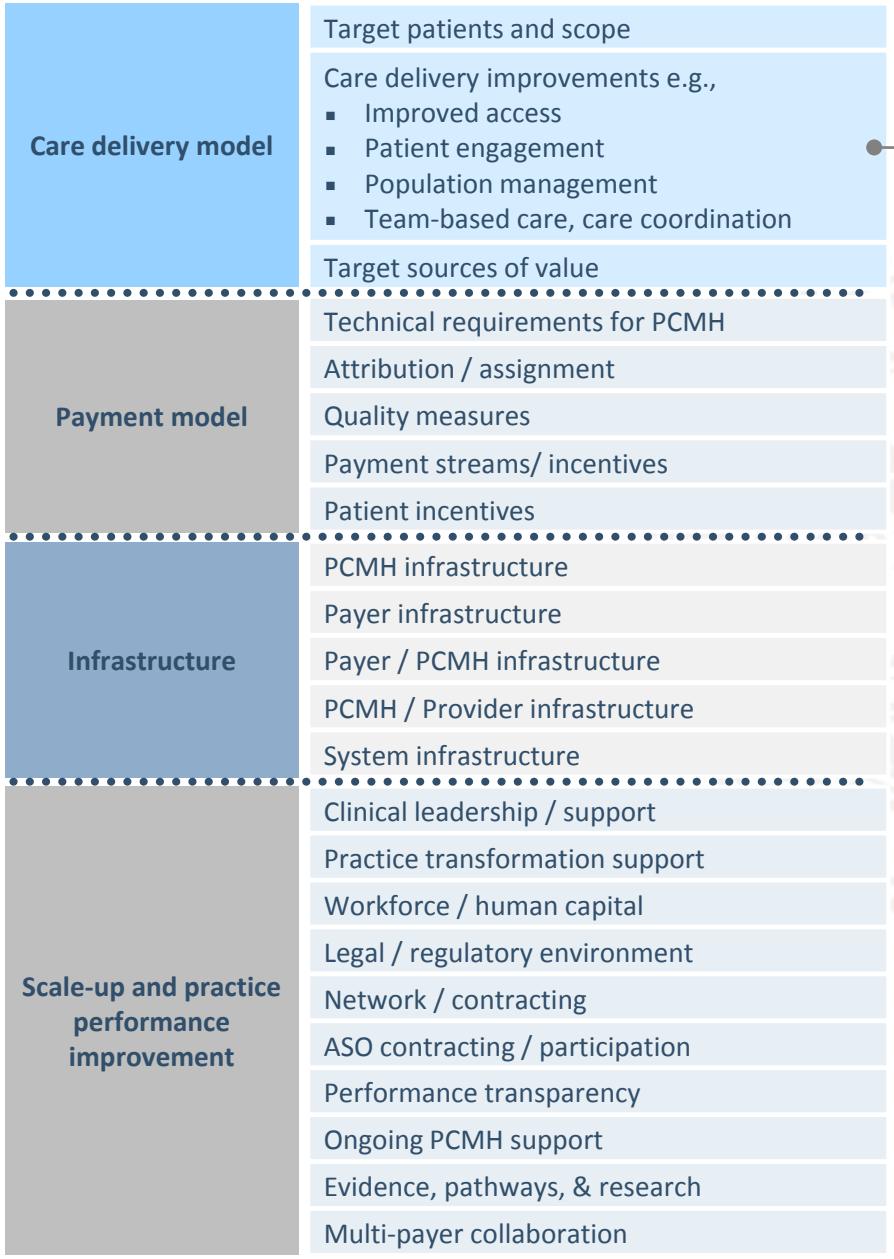
Elements of a PCMH Strategy

PRELIMINARY

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 to increase participation 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

Case study: Community Care of North Carolina (CCNC)



Situation:

- Smaller physician groups struggle to fund transition to PCMH
- Community Care of NC (CCNC) model started in 1998 to coordinate care among large and small physician practices
- Now a collaboration between the state and 14 nonprofit, regional **community-care networks** that coordinate care for 750,000 Medicaid and SCHIP individuals

Key innovations:

- CCNC hires **local care managers**; each network elects a physician to serve as a clinical director
  - Director is responsible for working with a statewide board of directors to organize **disease and care management initiatives** throughout the networks
- **Case management nurses** support high-risk patient care needs and implement disease management programs[2]
- CCNC allows patients **access to acute and preventive services** and after-hours coverage
- Participating networks receive $3PMPM care coordination fee

Impact:

- Total annual savings to the Medicaid and SCHIP programs are calculated to be $400mn for the aged, blind, and disabled populations
- Savings are calculated to be $135mn for "TANF-linked" population
- Improved quality: 16% lower ER visit rate; diabetes quality measures improved by 15%

- **CCNC is a Medicaid-led program that has generated significant cost savings through disease management, care coordination, and enhanced access to care**

Case study: Greater Rochester Independent Practice Association (GRIPA)

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
Payment model	Technical requirements for PCMH
	Attribution / assignment
	Quality measures
	Payment streams/ incentives
	Patient incentives
Infrastructure	PCMH infrastructure
	Payer infrastructure
	Payer / PCMH infrastructure
	PCMH / Provider infrastructure
	System infrastructure
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

Situation:

- Association of 800 PCPs and specialists in small, independent practices serving the Rochester, NY area.
- Doctors work in advisory groups to develop and implement standardized evidence-based clinical protocols
- Care managers make 8,000 phone calls and home visits to high-risk patients annually

Key innovations:

- **Web-based portal** operates alongside existing paper and electronic records
  - Physicians and patients have **secure access to EMRs**
  - Providers have tools to analyze data for individuals and populations
- **Point-of-care prompts** alert doctors in real time of gaps in care based on evidence-based medicine
- **e-prescribing** enables GRIPA pharmacists to recommend less costly medication when appropriate
- Incentive payments are linked to care quality and use of evidence-based protocol

Impact:

- 10% increase in well-controlled blood sugar among diabetics
  - Estimated $120,000-180,000 savings per patient over three years, 770 extra total life years, 1,230 sight years, and 925 years without kidney disease
- 1% annual increase in pharmacy costs vs. 9% area average
- 70% of patients believe GRIPA improved their health

- **In the GRIPA model, infrastructure links small independent providers to improve use of evidence-based care**
- **GRIPA suggests that programs can be successful with simple but effective infrastructure**

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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?
- What are your largest concerns / what do you think are the largest barriers to reform in Tennessee?
- What are your reflections on the episodes the state desires to pursue? Are there unique aspects of the selected episodes in Tennessee to be mindful of?
- Do any episode design elements discussed today give you pause?
- Where do you think payer coordination is more / least important?
- What are your thoughts on the timing goals for payment reform?
- How if at all can the State better engage with providers outside of this forum?

Other updates and housekeeping items

- First public roundtable meeting will be next week (Wednesday, 6/26)
- First employer stakeholder group meeting will be next week (Thursday, 6/27)
- Reminder to submit TAG nominees. *(Email Brooks Daverman by end of week, Friday 6/21)*.

July 15th Provider Stakeholder Group meeting plan and interim next steps

PRELIMINARY

Agenda

- Update group on progress made by payer coalition, and payer participation
- Discuss overall episode design
- Discuss elements of PCMH model design
- Update group on TAG progress
- State's infrastructure assessments and working hypothesis on infrastructure needs for phase 1
- Discuss the State Innovation Plan
- Next steps for Provider Stakeholder Group

Questions for discussion on July 15th

- What support do you need to participate effectively in payment reform?
- What elements of payment reform infrastructure are most important to achieve?
- What are the most important PCMH elements for payers to align on?

Tennessee
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APPENDIX

June 19, 2013

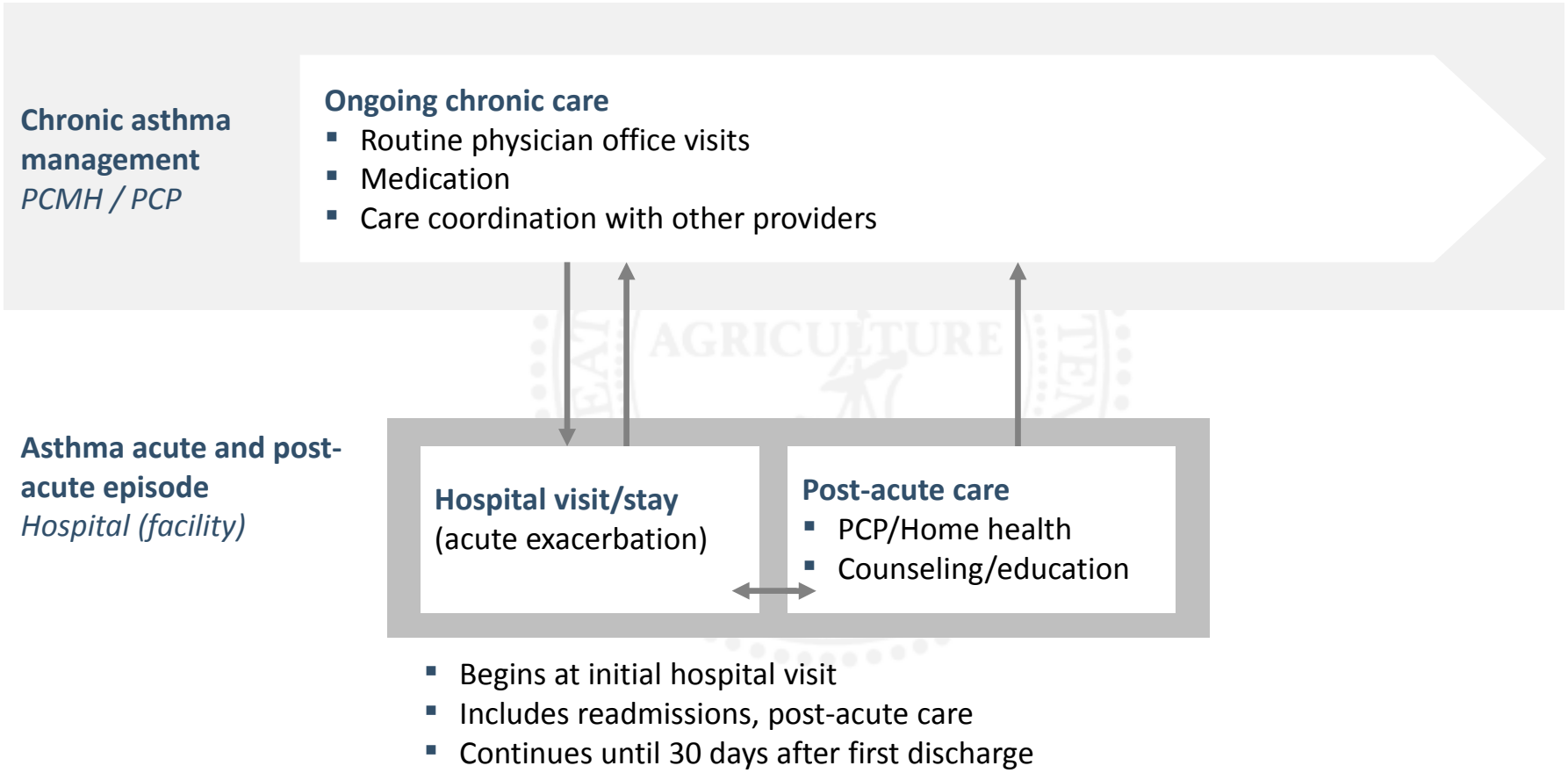
PRELIMINARY WORKING DRAFT, SUBJECT TO CHANGE

Contents

Asthma acute exacerbation: Overview of patient care and example of interaction between PCMH and episode model

PRELIMINARY

Focus of episode design

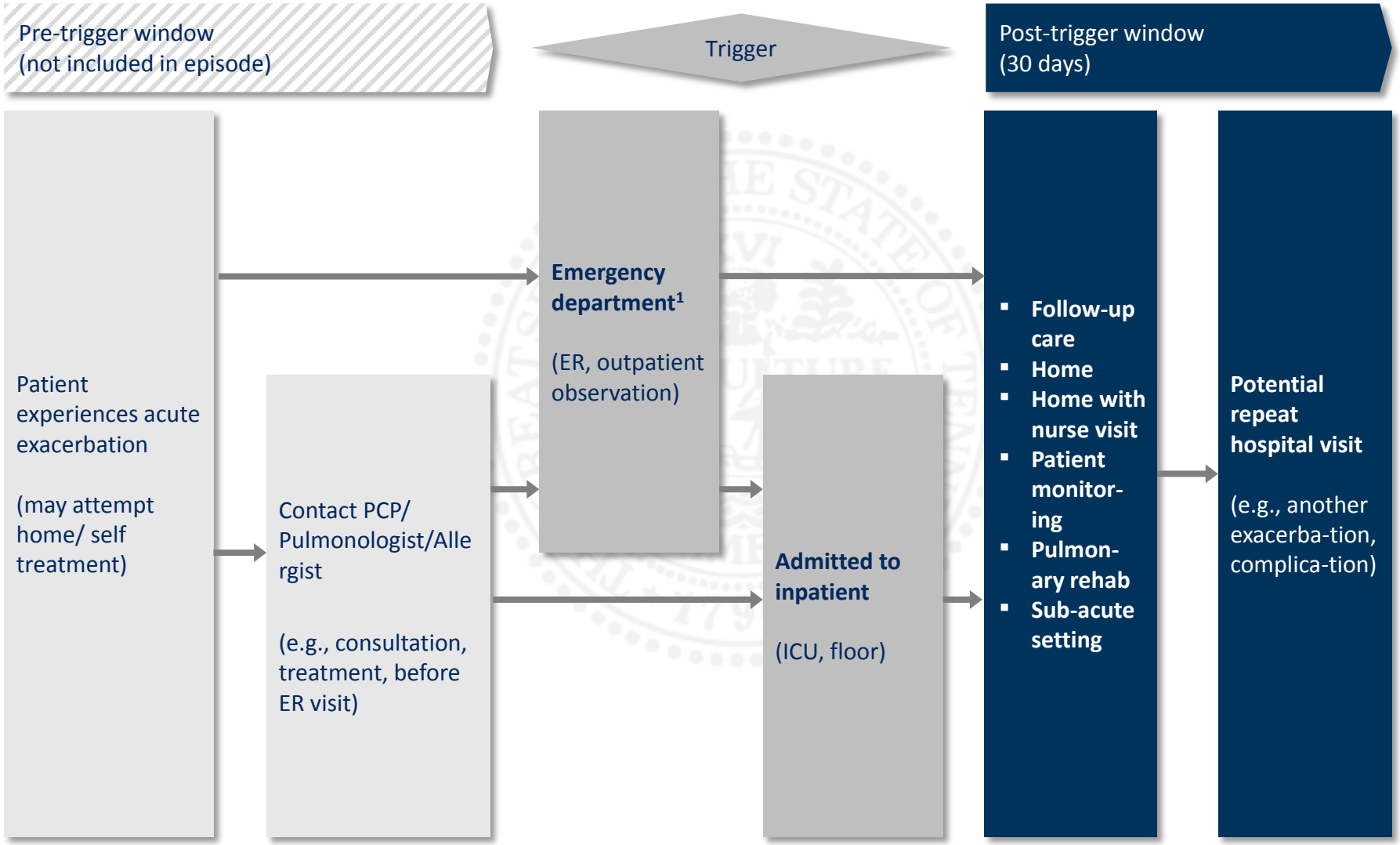


SOURCE: AR clinical workgroups

Example: Asthma acute exacerbation (1/4)

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

Patient Journey



1 May include urgent care facility

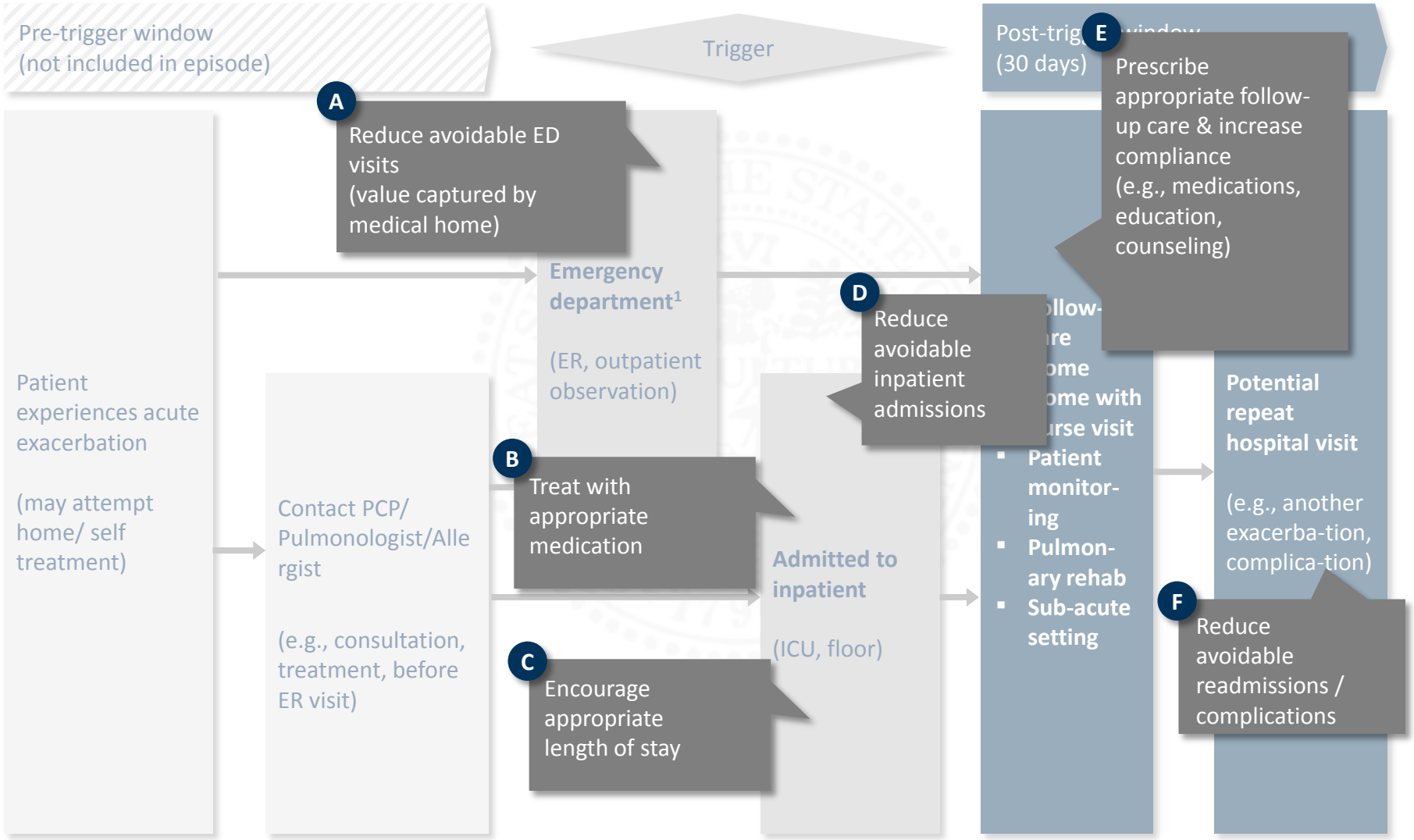
SOURCE: Arkansas Payment Improvement Initiative

Example: Asthma acute exacerbation (2/4)

Sources of value

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

Sources of value



1 May include urgent care facility

SOURCE: Arkansas Payment Improvement Initiative

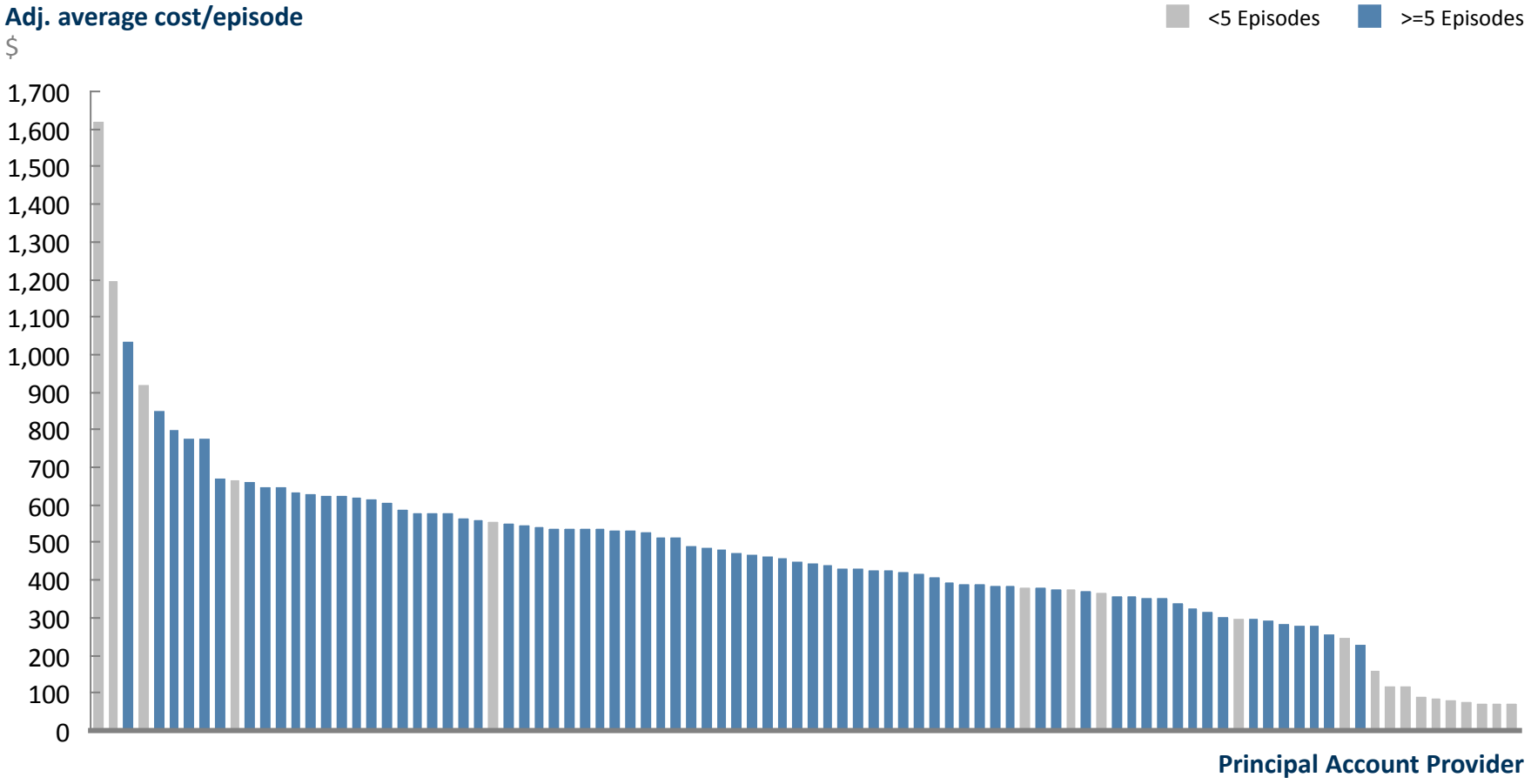
Example: Asthma acute exacerbation (3/4)

Average cost curve

ARKANSAS EXAMPLE

Asthma provider cost distribution

Adjusted average cost per provider[1]



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

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

Example: Asthma acute exacerbation (4/4)

Working hypothesis on design parameters

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

	Design element	Details
Design details	**PAP**	▪ For Medicaid, the PAP would be the facility for initial hospital visit (e.g., ER). Other payers independently determine the PAP by considering the following factors: ▪ Decision making responsibilities ▪ Influence over other providers ▪ Portion of episode cost
	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
	Duration	▪ 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
Quality metrics	**Tied to gain sharing**	▪ Corticosteroid and/or inhaled corticosteroid usage determined by filled prescription rate for medication within +/- 30 days of trigger start date ▪ Percent of episodes where patient visits outpatient physician within 30 days post initial discharge
	Reporting only	▪ Rate of repeat acute exacerbation within 30 days post initial discharge
Sources of value		▪ Reduce avoidable ED visits (value captured by medical home) ▪ Treat with appropriate medication ▪ Encourage appropriate length of stay ▪ Reduce avoidable inpatient admissions ▪ Prescribe appropriate follow-up care & increase compliance (e.g., medications, education, counseling) ▪ Reduce avoidable readmissions / complications

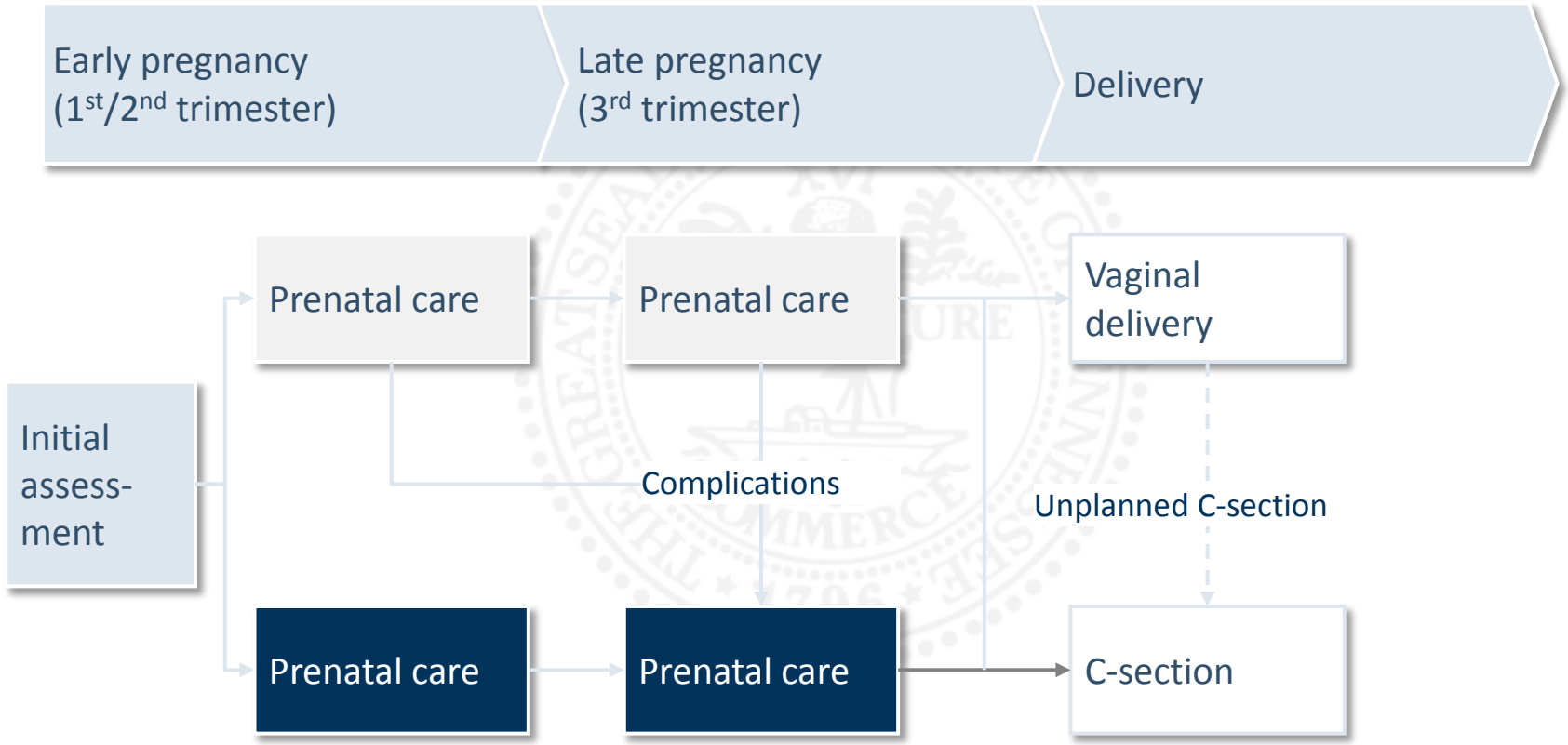
SOURCE: Arkansas Payment Improvement Initiative

Contents

Example: Perinatal (1/4)

Patient Journey

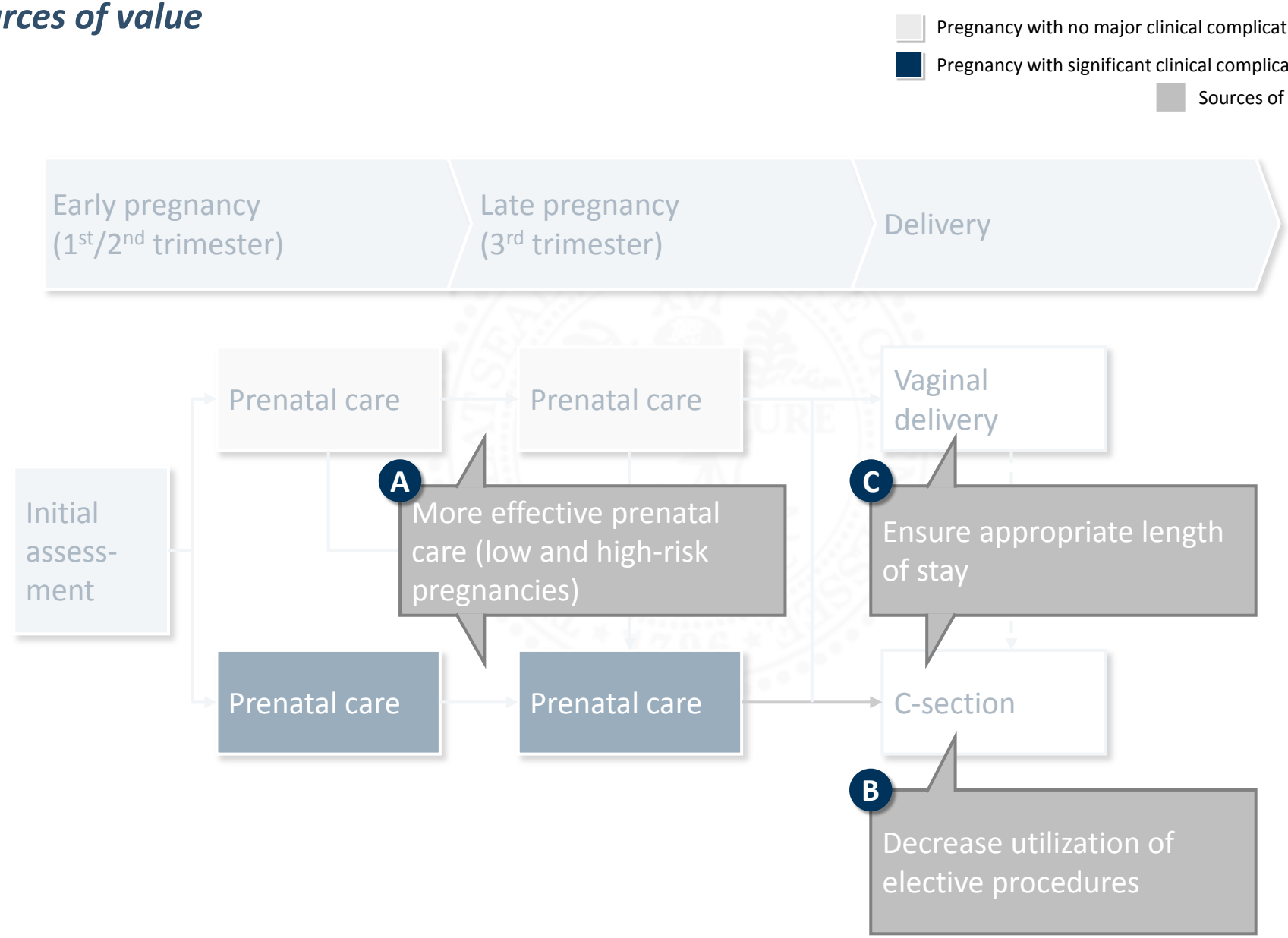
TO BE MODIFIED/VERIFIED BY TAG'S | ARKANSAS EXAMPLE



SOURCE: Arkansas Payment Improvement Initiative

Example: Perinatal (2/4)
Sources of value

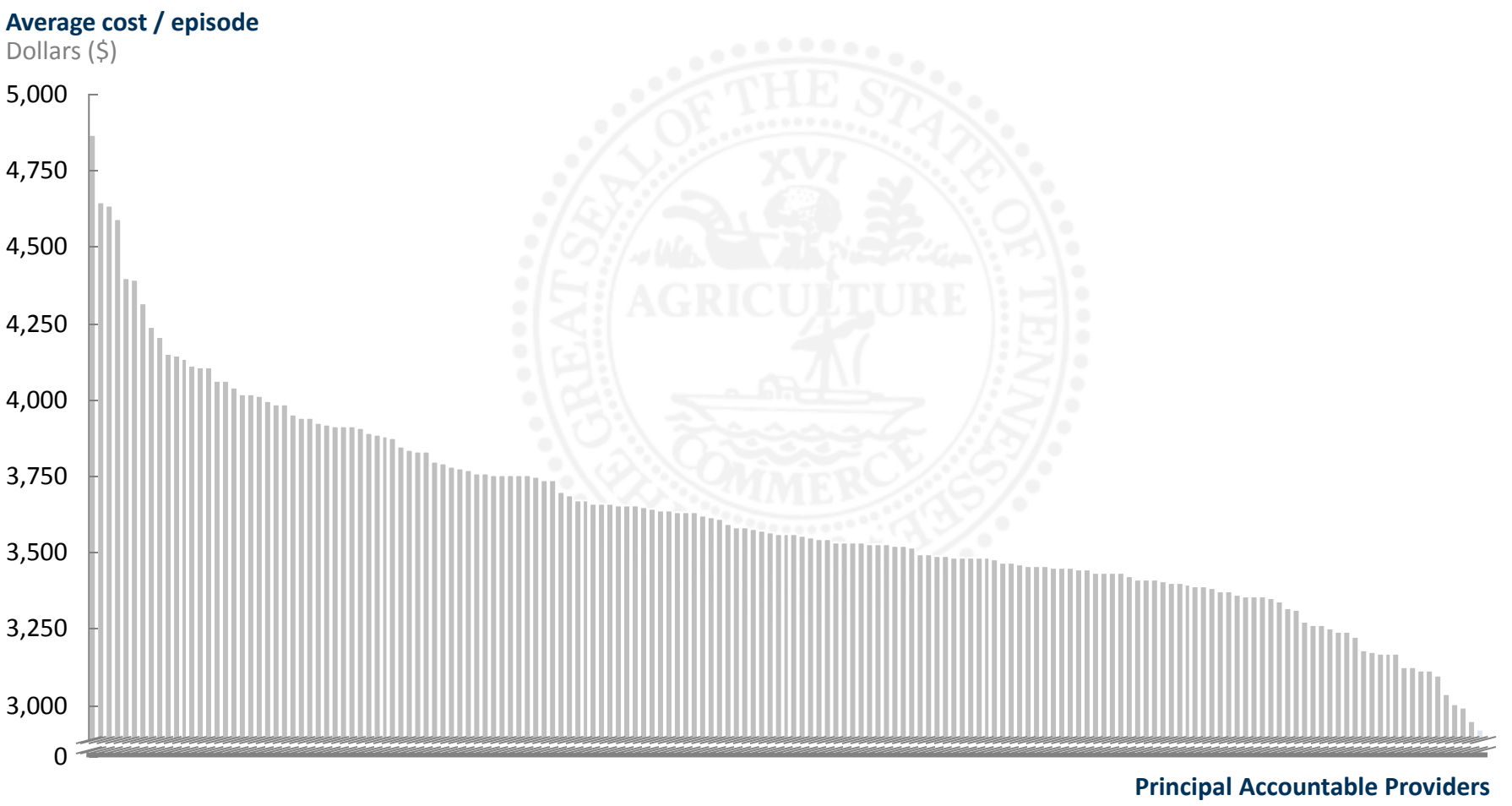
TO BE MODIFIED/VERIFIED BY TAG'S | ARKANSAS EXAMPLE



SOURCE: Arkansas Payment Improvement Initiative

Example: Perinatal (3/4)
Average cost curve

Perinatal provider cost distribution
Risk-adjusted average episode cost per provider



SOURCE: Episodes with live births May 1, 2009 – April 30, 2010; data includes Arkansas Medicaid claims paid SFY09 - SFY10

Example: Perinatal (4/4)

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

Working hypothesis on design parameters

	Design element	Details
Design details	**PAP**	▪ Provider or provider group that performs the delivery
	Trigger	▪ A live birth on a facility claim
	Duration	▪ 40 weeks before to 60 days after delivery
	To pass	1. HIV screening – must meet minimum threshold of 80% of episodes 2. Chlamydia screening – must meet minimum threshold of 80% of episodes
Quality metrics	**To track**	1. Ultrasound screening 2. Screening for Gestational diabetes 3. Screening for Asymptomatic Bacteriuria 4. Hepatitis B specific antigen screening 5. C-Section Rate
Sources of value		▪ More effective prenatal care ▪ Decrease C-section rate ▪ Ensure appropriate length of stay

SOURCE: Arkansas Payment Improvement Initiative

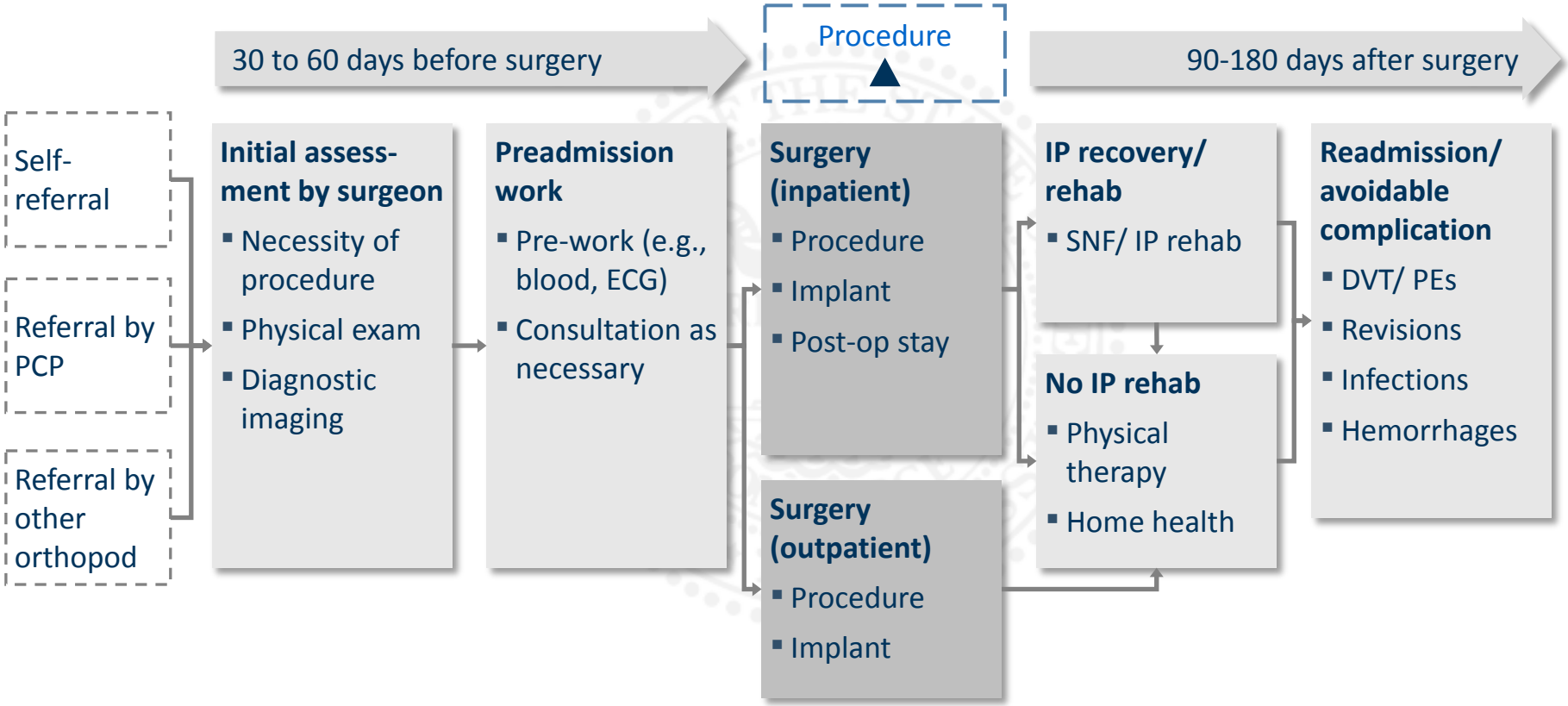
Contents

Example: Hip/knee replacement (1/3)

Patient Journey

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

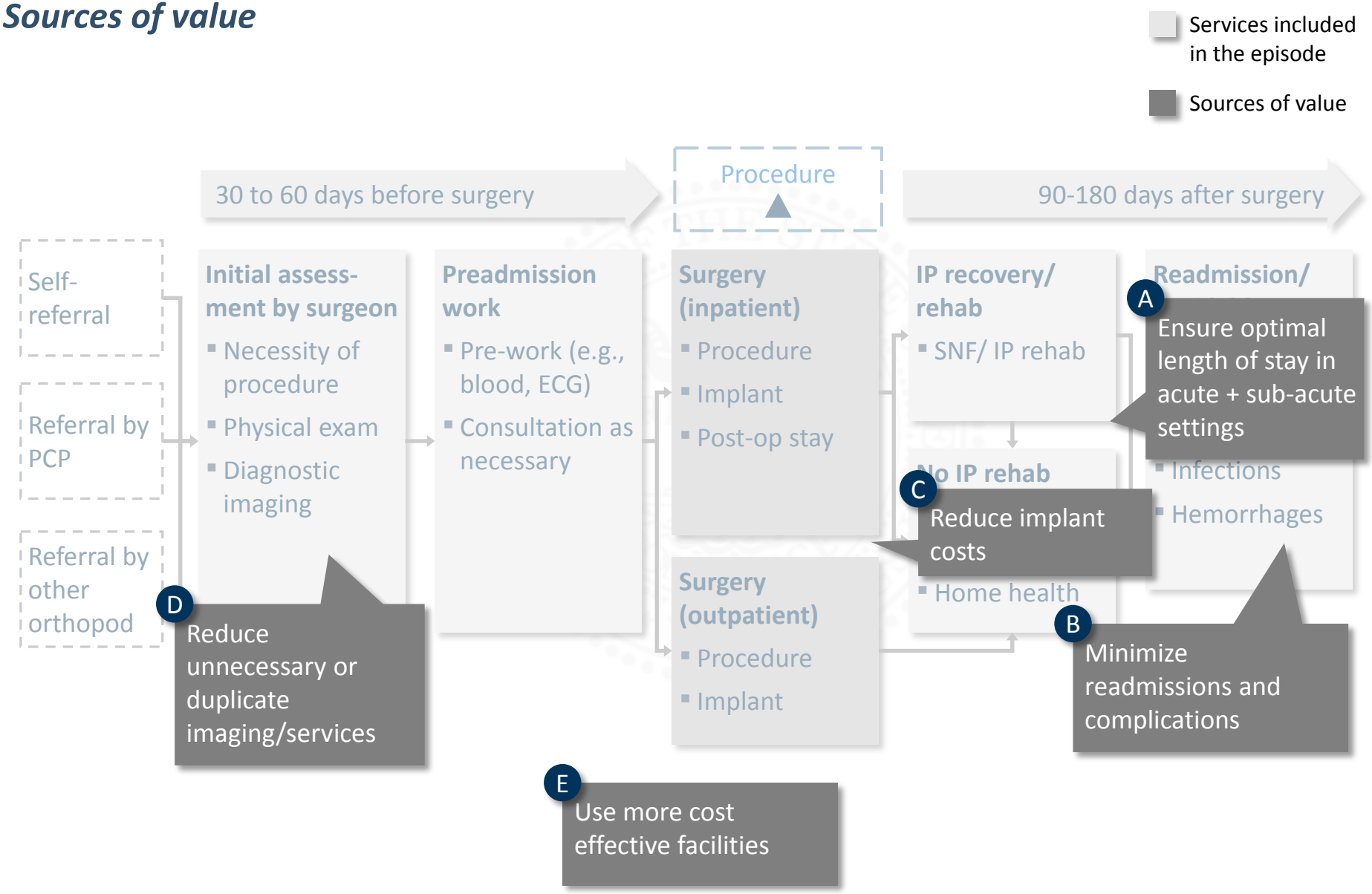
Services included in the episode



SOURCE: Arkansas Payment Improvement Initiative

Example: Hip/knee replacement (2/3)
Sources of value

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



SOURCE: Arkansas Payment Improvement Initiative

Example: Hip/knee replacement (3/3)

Working hypothesis on design parameters

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

	Design element	Details
Design details	**PAP**	▪ Orthopedic surgeon performing the TJR procedure
	Trigger	▪ A surgical procedure for total hip replacement or total knee replacement
	Duration	▪ Episode begins 30 days prior to date of admission for the inpatient hospitalization for the TJR surgery and end 60 days after the date of discharge
Quality metrics	**To track**	1. 30-day all cause readmission rate 2. 2Frequency of use of prophylaxis against post-op Deep Venous Thrombosis (DVT) / Pulmonary Embolism (PE) (pharmacologic or mechanical compression) 3. Frequency of post-op DV/PE 4. 30-day wound infection rate
Sources of value		▪ Reducing readmission ▪ Reducing utilization of a very expensive brand of hip implant

SOURCE: Arkansas Payment Improvement Initiative

Tennessee
Payment Reform Initiative

Provider stakeholder group meeting

PAYER RESULTS FOR BARRIERS ACTIVITY

June 19, 2013

PRELIMINARY WORKING DRAFT, SUBJECT TO CHANGE

Payer responses to potential barriers to innovation at scale

PRELIMINARY