Tennessee
Payment Reform Initiative

Provider Stakeholder Group Meeting

May 22, 2013

PRELIMINARY WORKING DRAFT, SUBJECT TO CHANGE

Objectives for today

- **Why we are here / the case for change**
- Vision for Tennessee & how we can work together toward it
- Proposed payment reform models
- Perspective from providers
- Approach and strategy for success
- Discussion & Next Steps

We believe payment innovation is a critical need for this type of transformation, but why now?

- Broad conceptual alignment among stakeholders on desirability to migrate from paying for activity to paying for “value”
- Better to shape than to be forced to accept what evolves
- Growing body of experience and advances in technical sophistication (e.g., risk adjustment) increasing feasibility
- $10B in Innovation Center investment capital
- Alternatives are even less desirable for all stakeholders (e.g., explicit rationing, rate cuts, more intensive “managed care”, greater regulation, etc.)

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**, and to reward strongly performing physicians
- As a centerpiece of payment reform, the State 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 collaboration between users, providers, and payers
- We appreciate that hospitals, reform medical providers, and payers have all demonstrated a **sincere willingness** to move toward payment
- By working together, we can make significant progress toward **reducing medical costs and improving care**

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Vision for Tennessee

- **At the request of Governor Haslam,** Tennessee is embarking on an initiative to **change how the State pays for healthcare services**
- The goals of the initiative are **to reward high-quality care and outcomes** and **encourage clinical effectiveness**
- At the Governor's request, we are assembling a **coalition of providers** to help carry forward this vision. This coalition will **input into the state led process and the payer coalition assembled by the state** and ensure provider interests are being met
- The State of Tennessee has already been **awarded a grant** from the Federal Department of Health and Human Services to **design a model to test Tennessee's vision**. We will also finalize a State Innovation Plan by the end of the summer

"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

SOURCE: State of Tennessee Newsroom and Media Center

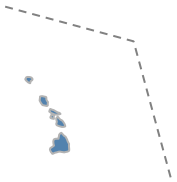
A number of states have adopted major payment reform legislation affecting Medicaid

Select examples

Oregon Coordinated Care Organizations
- All Medicaid plus Duals by 2015
- Capitation+transformation fees
- PCMH to coordinate care
- Community-based governance

Massachusetts Health Care Cost Commission
- Target trend of Gross State Product minus 0.5%
- Provider unit price transparency
- Penalties to providers who don't save money

New York Medicaid Waiver
- Global spending cap
- Waiver to reinvest federal share of savings in:
  - PCMH, HIE, Telemedicine
  - Grants for new care models
  - Safety net hospitals
  - Supportive housing



Alabama and North Carolina
- Statewide Medicaid PCMH network
- Care coordination fees
- Community-based infrastructure

Hawaii – medical homes development
- Care provided through PCMHs for those with chronic conditions
- QUEST Expanded Medicaid offers medical, dental, and BH services through managed care

Arkansas – goal of transitioning 100% spend
- All payers, all spend by 2015
- Episodes, PCMH, health homes
- Multi-payer HIE, reporting, care coordination

SOURCE: McKinsey Center for U.S. Health System reform; Medicaid.gov; press articles

We have a vision for transforming healthcare in Tennessee through payment reform

Today

- Managed Care Organizations use fee for service payment arrangements
- Payers and providers have launched some pilot programs on Patient-Centered Medical Homes, ACOs, and episodes
- Limited multi-payer collaboration

Future

- Competition and innovation are strong among payers and providers
- Most healthcare spending flows through new outcomes-based payment models
- Providers have opportunity to “win” / given transparency
- Healthcare costs decline while quality improves

Composition of stakeholder committees

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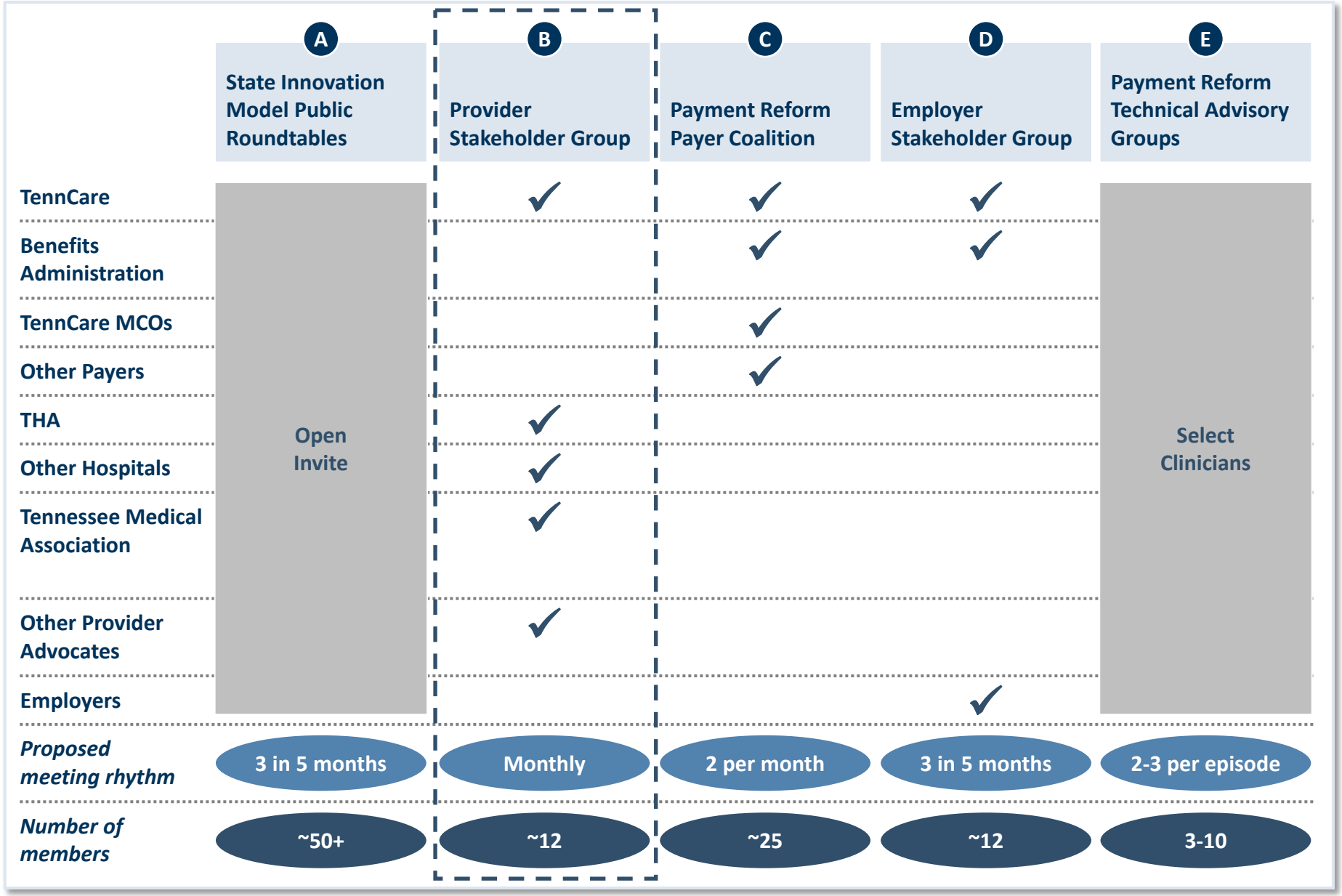

The State's role in designing the payment improvement program

How the State will work with Providers

- Gather input and facts; define common challenges
- Bring "straw-man" proposals to the table for discussion with this Provider Stakeholder Group
- Consult Provider Stakeholder Group as well as the coalition of payers in the decision-making process
- Facilitate collaboration among payers and providers where there are common benefits
- For each set of design decisions, acknowledge which answers would promote fairness and maximize simplicity for providers
- Lead by example; align state contracts with payment reform principles and models
- Use payment reform models to apply for State Innovation Model testing funds

The Provider Stakeholder Group will have a strong role in developing that common strategy

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	Proposed model
Membership	▪ The coalition will consist of the providers and provider associations assembled today
Proposed responsi-bilities	▪ The coalition is responsible for: — Direct involvement in State Innovation Plan design and implementation — Leadership in supplying the "provider perspective" with regards to proposed payment reform hypotheses, and active contribution toward ensuring that the payment reform design and implementation process properly balances the need for fairness, simplicity, and scalability — Providing feedback on the implementation roadmap to ensure coordinated effort that achieves greatest simplicity for providers

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Requirements for payment reform to drive cost-reducing innovations

	**Re-set expectations and align payment**	Create clear roles for Component Providers, Healers, and Partners; pay through a mix of enhanced fee-for-service, episode-based , and population-based payments
	**Significant**	Maximize the proportion of revenue that is subject to outcomes-based payment
	**At Scale**	Work with providers to move toward a critical mass transitioning to outcomes-based reimbursement
	**Stable**	Clarify long-term vision and make a long-term commitment to providers
	**Striving but practical**	Design the new approach so that it is effective in current regulatory, legal, and industry structures
	**Sustainable**	Ensure that providers that adapt thrive financially
	**Supportive**	Champion innovation with information, insights, and infrastructure
	**Synch with consumers**	Align payment with benefits, network design, and consumer engagement

The State's proposed payment innovation model includes "population" and "episode" based payment

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	Basis of payment	Examples	Most applicable
Population-based	▪ Total health, quality of healthcare, and total cost of a population of patients over time	▪ Patient centered medical homes (PCMH) ▪ Accountable Care Organizations (ACO) ▪ Capitation ▪ Global payments	▪ Encouraging primary prevention for healthy consumers and care for chronically ill, e.g., ▪ Obesity support for otherwise healthy 35-year old male ▪ Management of congestive heart failure
Episode-based	▪ Achieving a specific patient objective at including all associated upstream and downstream care and cost	▪ Retrospective Episode Based Payment (REBP) ▪ Bundled payment	▪ Acute procedures (e.g., CABG, hip replacement) ▪ Most inpatient stays including post-acute care, readmissions ▪ Acute outpatient care (e.g., broken arm, URI) ▪ Some behavior health ▪ Some cancers

Sources of value that can be realized

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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 ▪ 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 episode-based payments and who is the responsible provider?

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Definition	▪ Episode-based payments reward one or more providers for total performance, for a specific event, procedure or condition.
Specifics	▪ Episodes cover a specified period that could range from a few days to a year, during which patients may receive care from multiple providers.
Episode 'quarterback'	▪ Leads and coordinates the team of care providers ▪ Helps drive improvement across system (e.g., through care coordination, early intervention, patient education, etc.)

Source: New England Journal of Medicine, 2011

Example patient journey: Hip/knee replacement

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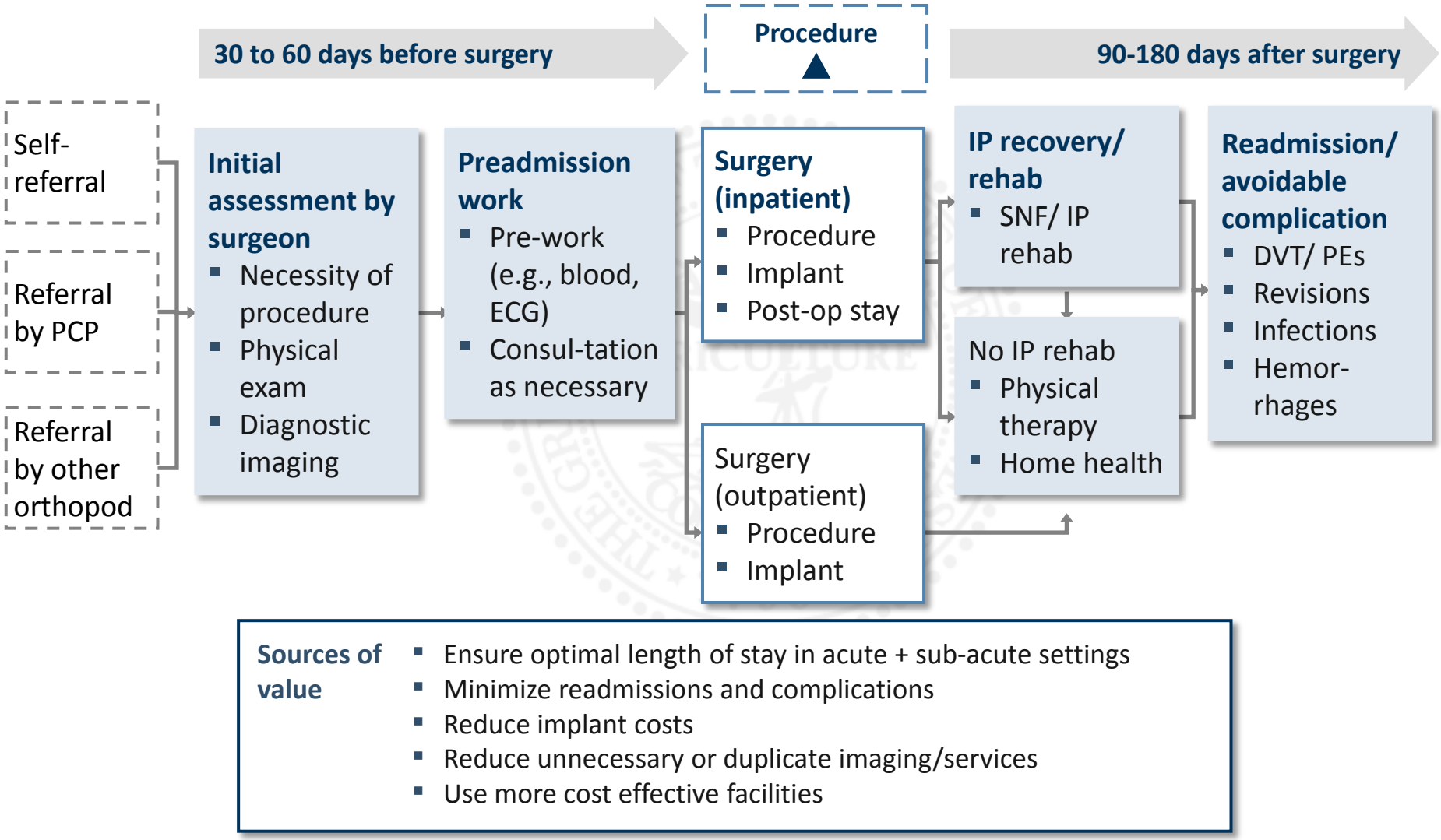

SOURCE: Arkansas Payment Improvement Initiative

Example patient journey: Asthma acute exacerbation

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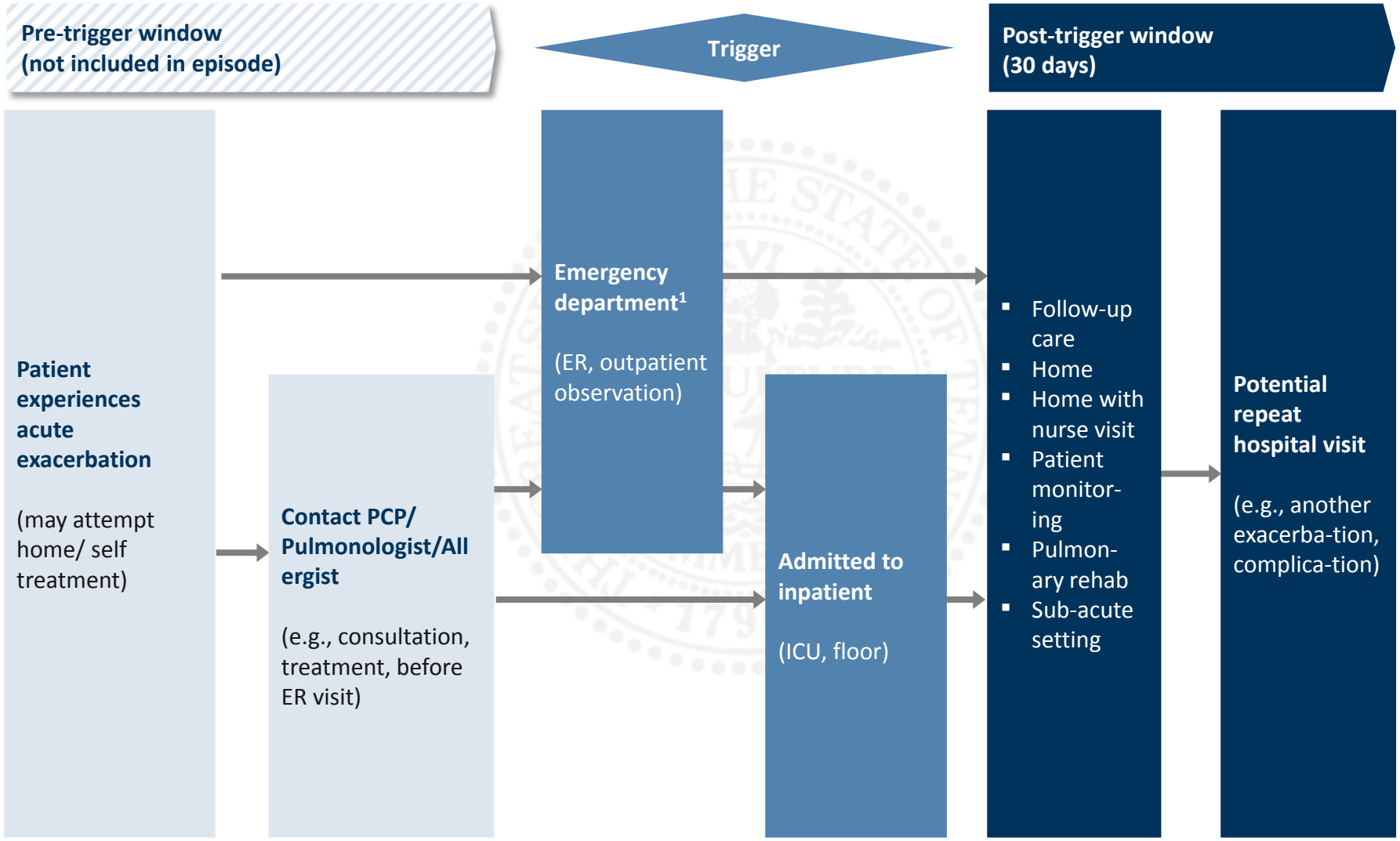

1 May include urgent care facility

SOURCE: Arkansas Payment Improvement Initiative

Episode-based payment mechanics can be retrospective or prospective

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State's working hypothesis

	Description	Considerations
Retrospective	▪ Providers receive payment after services delivered ▪ All providers involved in continue to be paid through current mechanisms ▪ "Quarterback" receives rewards or penalties based on overall cost of episode	▪ Built on today's claims/billing systems ▪ Funds disbursed after care delivered
Prospective	▪ "Quarterback" receives payment at beginning of episode ▪ "Quarterback" divides single payment among all providers involved ▪ "Quarterback" assumes risk for costs above single payment; accrues gains from delivering care at a cost below payment	▪ Administratively burdensome due to need for "Quarterback" to distribute reimbursement among providers ▪ Earlier disbursement of funds

How retrospective episodes would work for patients and 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

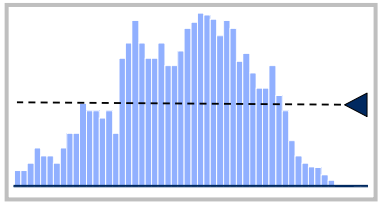
Calculate incentive payments based on outcomes after performance period (e.g. 12 months)

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]

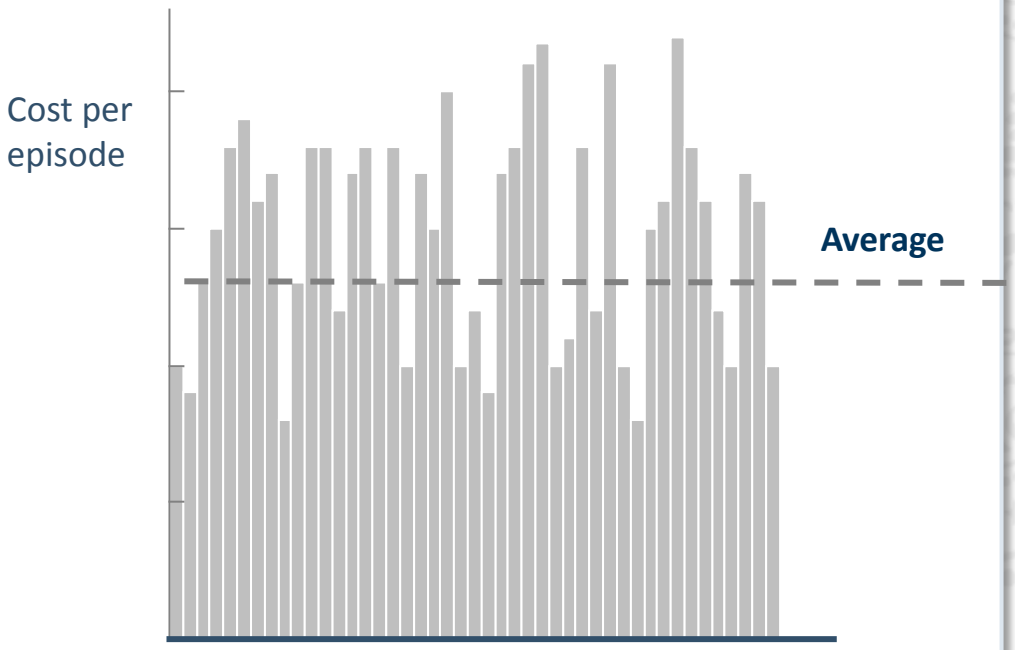
6

Providers will:

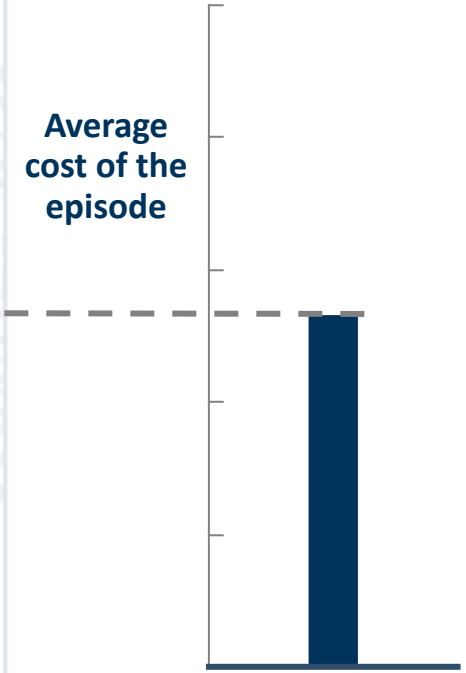
- **Share savings:** if avg. costs below commendable levels and quality targets met
- **Pay part of excess cost:** if avg costs are above acceptable level
- **See no change in pay:** if average costs are between commendable and acceptable levels

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

Risk-adjusted costs for one type of episode in a year for a single example provider

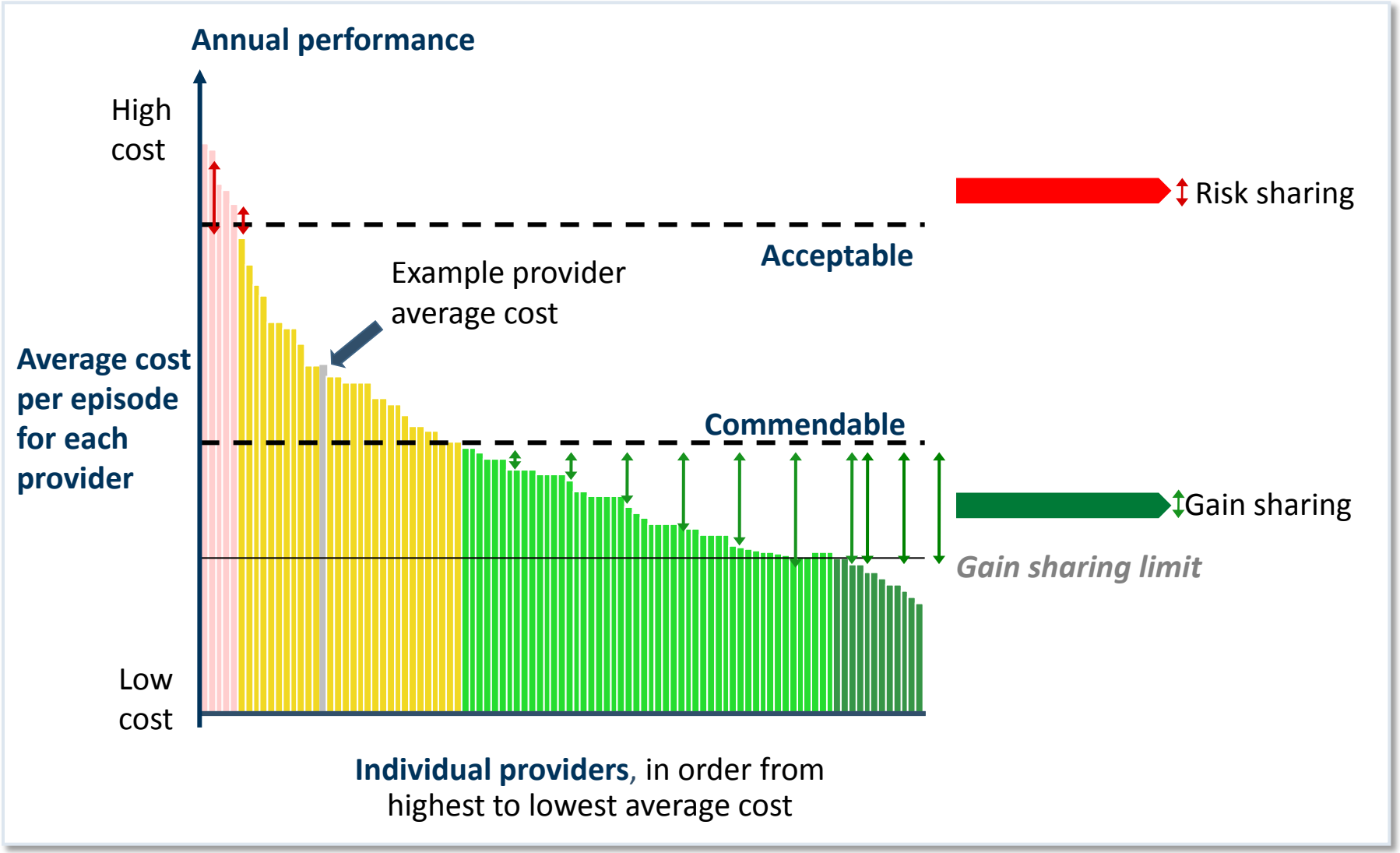


Risk-adjusted average cost per episode for the provider



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

ILLUSTRATIVE EXAMPLE



By design, episode-based payment rewards high quality care

Episode-based payment rewards providers for **effective management** and therefore:

- 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 inherently rewards quality care by holding providers accountable for downstream outcomes and costs

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

Objectives	Examples of options
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
Encourage evidence-based medicine and practices[1]	▪ 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) ▪ Consider linking to incremental payments or "bonuses"

1 Avoid directly linking performance on specific measures to payment as episodic payment already incents this

We see a robust PCMH program as a natural complement to an episode-based payments program

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

A PCMH must meet certain requirements in order to deliver value

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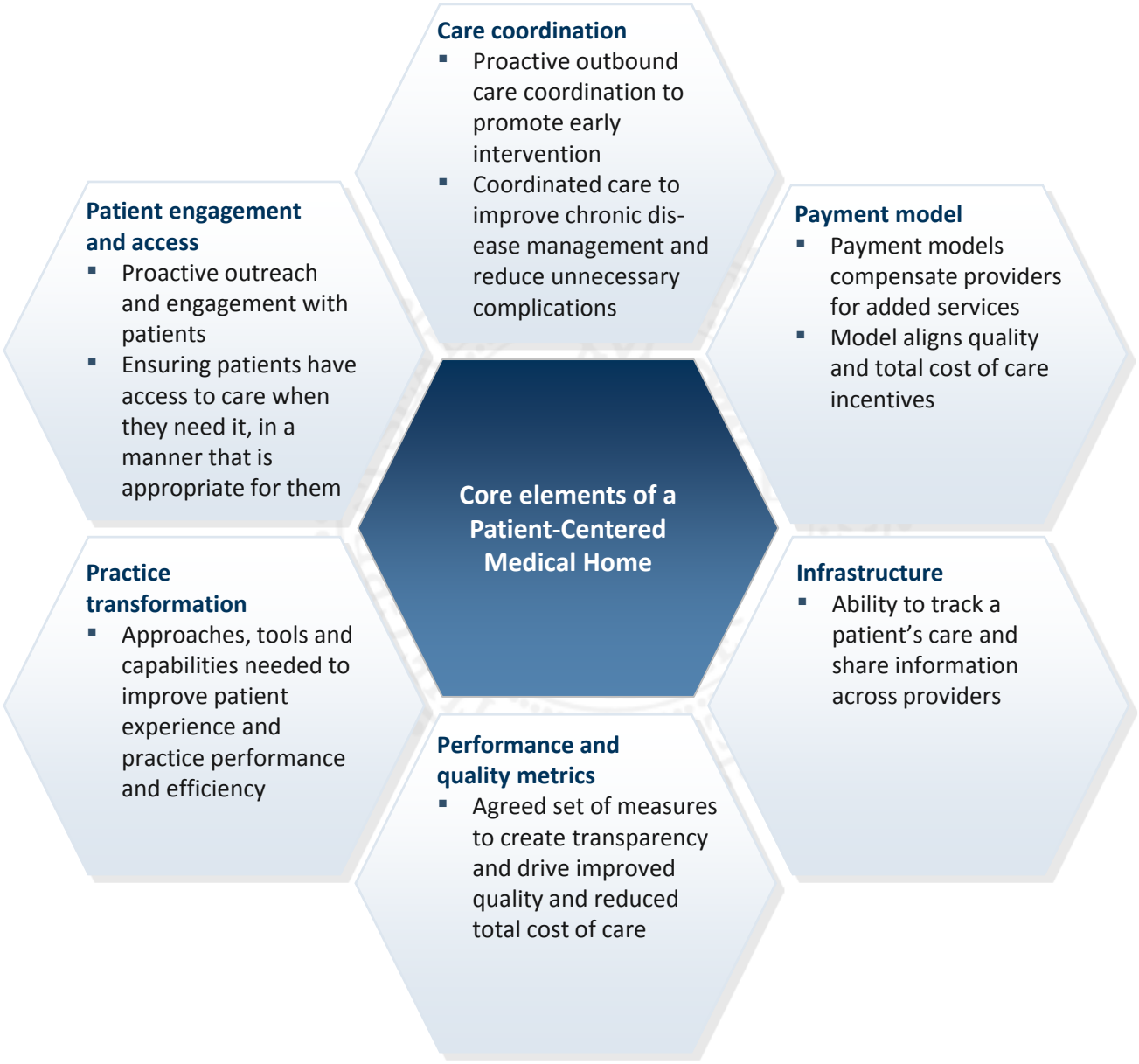

Enabling payment innovation capabilities

Areas of focus

Payer infrastructure	▪ Analytic engine to administer episode based payment or calculate total cost of care ▪ Performance report generation ▪ PCMH infrastructure (e.g., practice enrollment, monitoring) ▪ Integration of payment model into billing/accounting systems ▪ Provider support (e.g., call centers, website, outbound education, etc.)
System infrastructure	▪ Patient registry (including multi-payer portal, if needed) ▪ Provider performance transparent to other providers ▪ Cross-provider information exchange
Clinical support	▪ Evidence-based medicine (e.g., clinical pathways) ▪ Workforce training and licensing ▪ Changes to medical school curriculum
Practice transformation	▪ Methodology/approach to organize smaller practices ▪ Governance and leadership to manage practice transformation ▪ Clinical leadership/governance
Medical home infrastructure	▪ Care planning tools (e.g., risk stratification, care plans, clinical protocols) ▪ Practice workflows and processes (e.g., case conferences, expanded hours) ▪ Personnel (e.g., care coordinators, medical home point person)
Other stakeholder initiatives	▪ Employer wellness efforts ▪ School prevention programs ▪ Public health programs and policies (e.g., awareness campaigns, support systems)
Patient engagement	▪ Patient education/information ▪ Tools for health management ▪ Transparent provider performance data

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Soliciting perspectives on the discussion so far

- What are key attributes you have noted of successful reform models?
- What lessons have been learned from previous payment reform efforts? How can we ensure success?
- What principles are most important to uphold? (e.g., promote fairness, maximize simplicity, ensure high quality, etc.)
- What is the best way to proactively engage this group and your colleagues?
- Are there additional provider groups that should be included?
- What support do you need to efficiently implement payment reform?

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Select overview of key upcoming decisions

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April – May / June	May – July / 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 for episodes and PCMH	▪ 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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June 19th Provider Stakeholder Group meeting plan and interim next steps

Agenda

- Update group on progress made by payer coalition, and payer participation
- Update group on episode selection
- Update group on status of TAG selection
- Solicit input on key PCMH model elements and barriers to implementation
- Next steps for Provider Stakeholder Group

Questions for discussion on June19th

- What support do you need to participate effectively in payment reform?
- What principles are the most important to uphold?
- What parts of the episodes and PCMH models do you want to discuss more deeply?

Interim next steps

- How providers and associations can engage on the payment reform effort:
  - Share prior work
  - Make introductions to their thought leaders on these topics