WORKING DRAFT
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Tennessee
Payment Reform Initiative

Provider Meeting

October 9, 2013

PRELIMINARY WORKING DRAFT, SUBJECT TO CHANGE

Agenda for October 9th Provider Meeting

Activity	Time
▪ Introductory remarks	13:00 – 13:10
▪ How to build provider awareness	13:10 – 13:30
▪ Update on episode design decisions	13:30 – 14:20
▪ DRAFT: Review emerging episode definitions	13:20 – 14:40
▪ Timeline	14:40 – 14:50
▪ Discussion & next steps	14:50 – 15:00

Contents

High level timeline of episode roll-out

PRELIMINARY

Last Mo

Wave 1 Episodes

Design: 3 Episodes | Reporting/ refinement | Wave 1 First Performance Period | Wave 1 Second PP

1.25 years from design to start of Wave 1 Performance Period

2.5 years from design to Wave 1 payments issued[1]

Wave 2 Episodes

Design: ~5 Episodes | Reporting/ refinement | Wave 2 Performance Period

Continuous improvement, learning, and refinement

- **Current plan assumes gradual rollout**
- **First reports with payment calculations issued in Oct 2015**

1 There is a claims lag (3 mos.) between the end of a performance period and the issuance of payments.

Update on Payment Reform after significant input from providers

FOR DISCUSSION

1 Episodes

- Invested in resource-intensive TAG process to incorporate TN specific feedback
- 3 episodes selected for Wave 1: Perinatal, Asthma Acute Exacerbation, and Total Joint Replacement; one additional episode has completed design: COPD Acute Exacerbation
- Including multiple, somewhat overlapping design features (e.g., risk adjustment) to ensure real apples-to-apples performance measurement
- State guidelines on episode definitions shaped by TAG recommendations to be delivered to payers in Oct
- State to pursue a measured scale-up as opposed to all 15 AR episodes or all 50 BPCI episodes simultaneously

2 PCMH

- State has convened commercial payers to participate in PCMH when there had been prevailing ambivalence
- Payers have expressed desire to align on joint statement of intent to accelerate adoption of medical homes statewide. Opportunity for a provider or joint payer/provider statement exists.
- Current hypothesis is to test multi-payer collaboration model in 1-2 markets
- State exploring ways to accelerate or support PCMH investments

3 Imple-mentation

- Payers preparing for Wave 1 launch in accordance with previously discussed aspirational timelines
- Technical infrastructure in development in order to perform analytics and deliver provider reports on schedule
- State has driven alignment among payers to deliver a common report format with significant enhancements to report design that provides even more information to TN providers

4 SIM

- Tennessee has won a State Innovation Model “design” grant from CMS to initiate payment reform efforts and develop a State Healthcare Innovation Plan
- State preparing to submit a grant for State Innovation Model “testing” funds early next year
- CMS has emphasized need for multi-payer commitment and implementation readiness

FOR DISCUSSION: How else can the stakeholders involved build broader provider awareness?

FOR DISCUSSION

- What else can payers do?
  - Regional forums / town halls?
  - Utilize their provider network staff?
  - Emails, mailings, etc.?
  - Others?
- What else can providers (this group, TAGs, others) do?
  - Association news letters?
  - Conference calls with relevant associations?
  - Other?
- What else can other stakeholders do?

Contents

Cross-episode program design decisions

State hypothesis finalized

Emerging state hypothesis

Category	Decision to make
Participation	1 Payer participation
	2 Provider participation
Payment model mechanics	3 Prospective or retrospective model
	4a Risk-sharing agreement – types of incentives
	4b Risk-sharing agreement – amount of risk shared
	5 Approach to small case volume
	6 Role of quality metrics - clinical metrics
	7 Non-claims based quality metrics
	8 Provider stop-loss
	10 How to collect/pay-out
Performance management	11 Absolute vs. relative performance rewards
	12a Absolute performance rewards – Neutral zone between thresholds
	12b Absolute performance rewards – Gain sharing limit
	13 Risk adjustment approach

Category	Decision to make
Payment model timing and levels	14 Length of preparatory/"reporting-only" period
	15 Length of "performance" period
	16 Synchronization of performance periods
	17 Frequency of reports
	18 Timeliness of data
	19 Date range of historical data in each report
	20 Entity setting thresholds
Episode exclusions	21a High cost outliers
	21b Low cost outliers
	22 Claim completeness
	23 Business exclusions
	24 Clinical exclusions

Design decisions with clear state hypotheses (1/2)

Category		Decision to make	State hypothesis	Importance of TennCare alignment
Payment model mechanics	3	Prospective or retrospective model	Retrospective	High
	4a	Risk-sharing agreement – types of incentives	Both upside and downside	
	6	Role of quality metrics - clinical metrics	Select metrics tied to gain-sharing	
Performance management	11	Absolute vs. relative performance rewards	Absolute	
	12a	Absolute performance rewards – Neutral zone between thresholds	Exists	
	12b	Absolute performance rewards – Gain sharing limit	Exists	
Payment model timing and levels	20	Entity setting thresholds	Mixed (TennCare sets high, MCO low)	

FOR DISCUSSION

Design decisions with clear state hypotheses (1/2)

Category	Decision to make	State hypothesis	Importance of TennCare alignment
Payment model timing and levels	14 Length of 'reporting only' period	▪ 6 month reporting only period	▪ High
	15 Length of performance period	▪ Annual performance period	
	16 Syncing of performance periods	▪ Synced across payors	
	17 Frequency of reports	▪ At minimum, quarterly report generation	
	18 Timeliness of data	▪ 3 month claims run-out	
	19 Date range of historical data in each report	▪ 12 months (prior 4 quarters, ending just before claims run-out)	

FOR DISCUSSION

Emerging state hypotheses (1/2)

	Decision to make	State hypothesis	Working strawman -- TennCare alignment
Episode exclusions	21a High cost outliers	▪ All risk adjusted episodes that cost >3 standard deviations over the mean of each payer's book get excluded	▪ Important to align
	21b Low cost outliers	▪ Principle is to identify "incomplete" episodes ▪ Payers determine own methodology of identifying "incomplete" episodes	▪ Moderately important to align
	22 Claim completeness	▪ Exclude episodes where complete access to all relevant patient claims data during episode does not exist or is not acquirable	▪ Important to align
	24 Clinical exclusions	▪ Exclude when condition results in different patient pathway ▪ State is transparent on conditions but not codes	▪ Important to align

FOR DISCUSSION

Emerging state hypotheses (2/2)

Category	Decision to make	State hypothesis	Working strawman -- TennCare alignment
Payment model mechanics	5 Approach to small case volume	▪ No small case volume exclusion	▪ Important to align
	6 Role of quality metrics - clinical metrics	▪ Select metrics tied to gain-sharing	▪ Important to align
	7 Non-claims based quality metrics	▪ Not for Phase 1, but attempt to build capability in Phase 2	▪ Important to align
	8 Provider stop-loss	▪ State position is that this is important in concept ▪ Payers must individually decide	▪ Important to align on an existence of some stop loss provision ▪ State guidance to be determined
Performance management	13 Risk adjustment approach	▪ State is transparent in principles and approach ▪ State-led design process surfaces clinician input on important factors to consider for risk adjustment ▪ Payers individually administer risk adjustment	▪ Important to align on existence of risk adjustment ▪ Details at discretion of MCO

Contents

Asthma acute exacerbation care algorithm summary (1/3)

1 Triggers

- Facility visit (ER or inpatient)for acute exacerbation of asthma. Primary ICD-9 Diagnoses codes explicitly mentioning asthma or "wheezing" as potential trigger.
- *No ambulatory surgical centers, no PCP, other settings. Episode should occur at a hospital or extended care facility.

Primary ICD-9 Dx trigger codes:

493.00,493.01, 493.02, 493.10, 493.11, 493.12, 493.81, 493.82, 493.20, 493.21, 493.22, 493.90, 493.91, 493.92, 519.11

ICD-9 Dx trigger code if Asthma trigger code occurred in previous year:

786.07

2 Episode time window

- Overall: Episode begins with the acute exacerbation and ends 30 days after discharge from the last facility during the trigger window
- Pre-trigger window: None
- Trigger window: Begins on the first day of the final facility during the first asthma acute exacerbation encounter of an episode and ends day of discharge from that admission
- Post-trigger window: Begins on discharge from the final hospital in the initial trigger window and continues to the later of the 30 days or the last day of discharge from any readmission that starts within that 30 day post-trigger period

3 Claims included

- Pre-trigger window: None.
- Trigger window: All claims included (starting from the final transfer facility during the trigger window).
  - Trigger must be preceded by 30-day period clean of any claim or combination thereof that would trigger an asthma acute exacerbation episode
- Post-trigger window: Claims for related services only (with a Primary Dx code related to asthma)
  - Readmissions: All costs relating to readmissions for any cause except BPCI exclusions
- Medications (see list): **Trigger window**: All medications included. **Post –trigger window**- Relevant medications included

Proposed approach for cost inclusions/exclusions:

1. Aim to include relevant claims/medications only
2. Include costs for claims/drugs that are always contraindicated
3. Adjust costs for expensive claims/drugs that you want to either incentivize and/or for which you want to allow clinical guidance to determine appropriateness

Asthma acute exacerbation care algorithm summary (2/3)

4 Exclusions

Episodes meeting one or more of the following criteria will be excluded:

Clinical exclusions:

A. Age < 2 and > 64

B. Complications: Patients with intubation, patients with supplemental oxygen, patients with current or previous tracheostomy within the last year

C. Comorbidities: Cystic fibrosis, Pulmonary hypertension, Chronic airway obstruction (search period for comorbidities will be 1 year prior to the episode start)

D. Other: Patient left against medical advice, Death in hospital

Claim completeness exclusions:

A. Dual - eligibles, non-continuous enrollment, TPL

B. Episodes with incomplete data, mis-coding, or incomplete claims submitted

Other exclusions:

A. Episodes where the trigger admission occurred in an ASC, PCP office, or any other care setting than Facility (ER or inpatient)

B. High-cost outliers: > 3Std from post-risk adjusted average episode cost

Proposed approach for clinical exclusions:

1. Factors that could result in a significantly different care delivery pathway from a clinical perspective
2. Factors with a low prevalence or significance that would make accurate risk adjustment difficult

5 Quarterback

- For each episode, the quarterback is the facility of the trigger claim. In the case of a transfer, the quarterback is the final facility

6 Adjustments

- See list: For the purposes of determining a quarterback's performance, the total reimbursement attributable to the quarterback is adjusted to reflect risk and/or severity factors captured in recent claims data in order to be fair to providers with high-risk patients, to avoid any incentive for adverse selection of patients and to encourage high-quality, efficient care. Episode reimbursement attributable to a quarterback for calculating average adjusted episode reimbursement may be adjusted based on these selected risk factors. Over time, a payer may add or subtract risk factors in line with new research and/or empirical evidence.

Proposed approach for adjustments:

1. Our intention was to include as many episodes as possible and risk adjust when appropriate and fair

Asthma acute exacerbation care algorithm summary (3/3)

7 Quality measures

Quality measures "to pass"

- Percent of episodes where patient visits a physician or mid-level provider in the outpatient setting within 30 days of initial discharge
- 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 (Exclude patients < 5 years old)

Quality measures "to track"

- Percent of patients with repeat acute exacerbation during episode window as measured by a re-encounter with the facility within 30 days of discharge
- Average inpatient admission rate
- Percent of cases where education on proper use of medication, trigger avoidance or asthma action plan was discussed
- Percent of cases where smoking cessation counseling for patient and/or family was offered
- The addition of a controller if the patient has had two asthma related encounters in a 3 month time period
- Rate of CXR utilization (aim for as little as possible)

Potential Phase 2 metrics (see list)

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Episode definition and scope of services:

Diagnostic trigger ICD-9 codes within Asthma DRG groups

Clear and likely trigger (obvious)

Unlikely trigger (much more severe or possible exclusion)

Possible trigger (likely asthma exacerbation, but not 100% clear)

ICD-9 Dx	ICD-9 Dx Description	Avg claim count per year
33.00	BORDETELLA PERTUSSIS	335
33.10	BORDETELLA PARAPERTUSSIS	44,591
33.80	WHOOPING COUGH NEC	135
33.90	WHOOPING COUGH NOS	0
464.10	AC TRACHEITIS NO OBSTRUC	473
464.11	AC TRACHEITIS W OBSTRUCT	10
466.00	ACUTE BRONCHITIS	0
466.11	ACU BRONCHOLITIS D/T RSV	12,920
466.19	ACU BRNCHLTS D/T OTH ORG	27,493
490.00	BRONCHITIS NOS	0
491.00	SIMPLE CHR BRONCHITIS	0
493.00	EXTRINSIC ASTHMA NOS	22,109
493.01	EXT ASTHMA W STATUS ASTH	2,171
493.02	EXT ASTHMA W(ACUTE) EXAC	4,535
493.10	INTRINSIC ASTHMA NOS	2,346
493.11	INT ASTHMA W STATUS ASTH	155
493.12	INT ASTHMA W (AC) EXAC	683
493.20	CHRON OBST ASTHMA, NOS	5,387
493.21	CHRON OBST ASTHMA STAT ASTH	516
493.22	CHRON OBST ASTHMA (ACUTE) EXAC	2,548
493.81	EXERCSE IND BRONCHOSPASM	465
493.82	COUGH VARIANT ASTHMA	1016
493.90	ASTHMA NOS	74,930

ICD-9 Dx	ICD-9 Dx Description	Avg claim count per year
493.91	ASTHMA W STATUS ASTHMAT	5,749
493.92	ASTHMA NOS W (AC) EXAC	28,574
519.11	ACUTE BRONCHOSPASM	4,687
519.19	TRACHEA & BRONCH DIS NEC	1,746
327.22	HIGH ALTITUDE BREATHING	5
518.82	OTHER PULMONARY INSUFF	2,273
786.00	RESPIRATORY ABNORM NOS	1,494
786.01	HYPERVENTILATION	724
786.02	ORTHOPNEA	208
786.03	APNEA	3,127
786.04	CHEYNE-STOKES RESPIRATN	21
786.05	SHORTNESS OF BREATH	57,813
786.06	TACHYPNEA	1,129
786.07	WHEEZING	28,978
786.09	RESPIRATORY ABNORM NEC	43,358
786.10	STRIDOR	0
786.20	COUGH	0
786.30	HEMOPTYSIS	951
786.40	ABNORMAL SPUTUM	0
786.52	PAINFUL RESPIRATION	17,908
786.60	CHEST SWELLING/MASS/LUMP	0
786.70	ABNORMAL CHEST SOUNDS	0
786.80	HICCOUGH	0
786.90	RESP SYS/CHEST SYMP NEC	4,912
793.10	NONSP ABN FD-LUNG FIELD	0

Source: TennCare, Primary Dx only, claims from 2008-2012 included

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Asthma acute exacerbation episode definition

TENNESSEE DRAFT

Phase 2 quality metrics

Potential phase 2 refinements (potential evidence based treatments to encourage)

1) Specialist involvement (pulmonologist or allergist) for "high flyers"
2) Time of steroid administration during ED visit
3) The addition of a controller if the patient has had two asthma related encounters in a 3 month time period
4) Assurance of the availability of a rescue medication by evidence of a filled prescription in the previous 30 days or by the end of the episode period
5) A short course of oral steroids which could/should potentially include Decadron in the ED
6) Assurance of prescription compliance and the ability to fill the prescriptions
7) The evaluation and treatment of allergic disease if appropriate. May be difficulty to determine the "appropriateness"
8) Asthma severity assessment in hospital or at follow-up
9) Based on new evidence for persistent asthma, potentially the use of combo therapy over double dose ICS

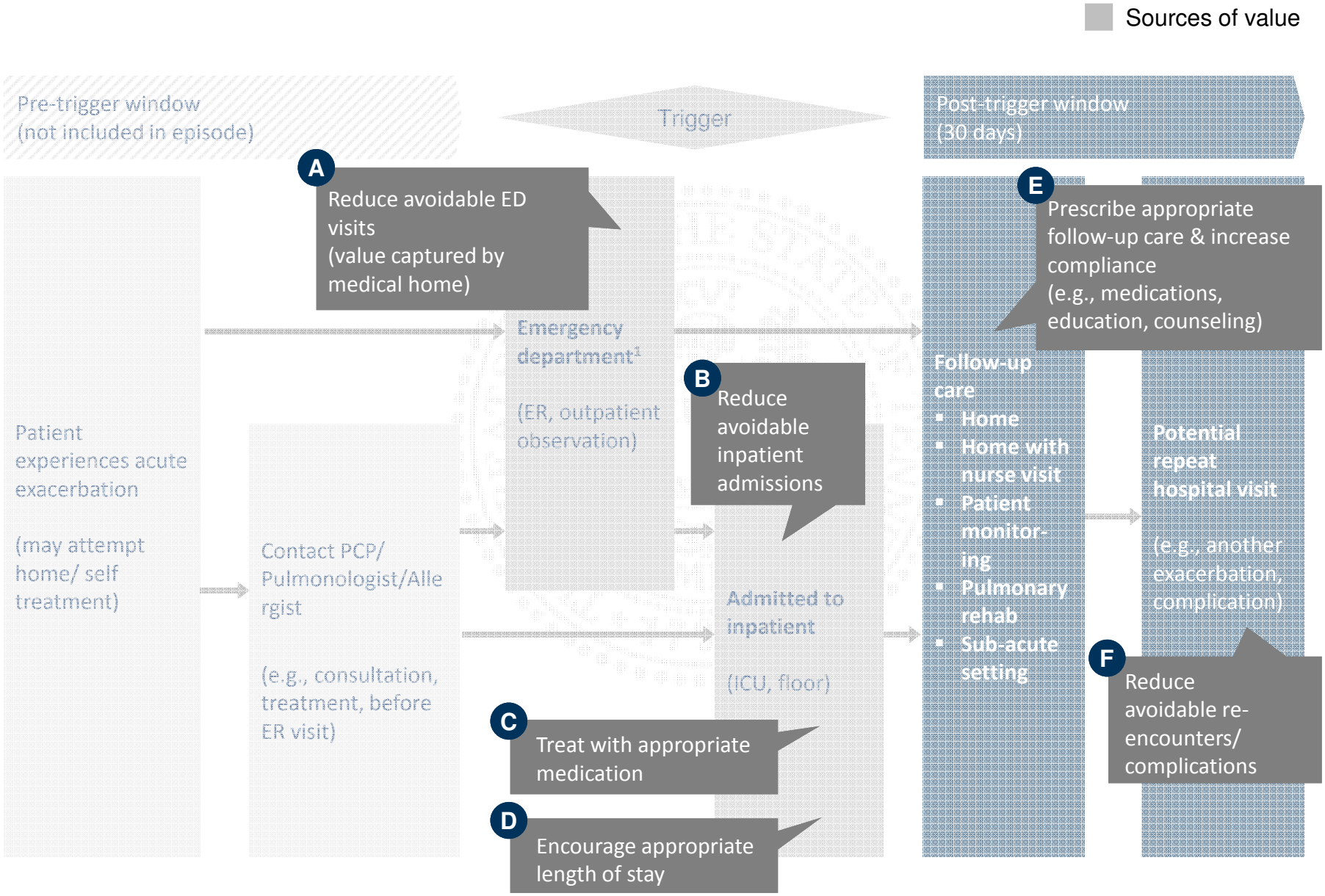
Potential phase 2 refinements (potential non-evidence based treatments to discourage)

1) The use of antibiotics with uncomplicated Asthma
2) The routine usage of higher cost Xopenex over Albuterol
3) Any use of albuterol syrup
4) The use of theophylline in the pediatric age group

1 From the SHM: Pediatric Hospital Medicine Choosing Wisely Endorsement (Payer data since care is bundled may not capture this): Don't order chest radiographs in children with uncomplicated asthma or bronchiolitis: National guidelines articulate a reliance on physical examination and patient history for diagnosis of asthma and bronchiolitis in the pediatric population. Multiple studies have established limited clinical utility of chest radiographs for patients with asthma or bronchiolitis. Omission of the use of chest radiography will reduce costs, but not compromise diagnostic accuracy and care.

Sources of value: Asthma acute exacerbation

TENNESSEE DRAFT



1 May include urgent care facility

Contents

Perinatal care algorithm summary (1/3)

1 Triggers

- Live birth diagnosis code or delivery procedure code in any claim type and any care setting

2 Episode time window

- Overall: Episode begins 40 weeks prior to day of admission for delivery and ends 60 days after discharge
- Pre-trigger window: Begins 40 weeks prior to day of admission for delivery to day before admission for delivery
- Trigger window: Begins day of admission for delivery and ends day of discharge
- Post-trigger window: begins day after discharge and ends 60 days after day of discharge

3 Claims included

- Pre-trigger window: All care associated with a pregnancy-related ICD-9 diagnosis code is included (unless explicitly excluded). Including all ED claims.
- Trigger window: All claims included
- Post-trigger window: All care associated with a pregnancy-related ICD-9 diagnosis code is included (unless explicitly excluded). Including all ED claims during 0-30 and relevant ED claims 31-60.
- Medications: All claims for mother are included (unless explicitly excluded e.g., biologics, MS medications, Hep B and Hep C medications)
- All care related to neonatal care is not included.

Proposed approach for cost inclusions/exclusions:

1. Aim to include relevant claims/medications only
2. Include costs for claims/medications that are always contraindicated
3. Adjust costs for select ,very expensive, claims/medications that reflect treatment for very different conditions (e.g., specialty medications/conditions)

Perinatal care algorithm summary (2/3)

4 Exclusions

Episodes meeting one or more of the following criteria will be excluded:

Clinical exclusions:

A. Comorbidities: Cancer

B. Other: Patient left against medical advice, Death in hospital

Claim completeness exclusions:

A. Dual - eligibles, non-continuous enrollment, TPL

B. Episodes with incomplete data, mis-coding, or incomplete claims submitted

Other exclusions:

A. High-cost outliers: > 3Std from post-risk adjusted average episode cost

Proposed approach for clinical exclusions:

- Factors that could result in a significantly different care delivery pathway from a clinical perspective
- Factors with a low prevalence or significance that would make accurate risk adjustment difficult

5 Quarterback

- For each episode, the quarterback is the provider or provider group (by Tax ID) that performs the delivery

Perinatal care algorithm summary (3/3)

6 Adjustments

- For the purposes of determining a quarterback's performance, the total reimbursement attributable to the quarterback will be adjusted to reflect risk and/or severity factors captured in recent claims data in order to be fair to providers with high-risk patients, to avoid any incentive for adverse selection of patients and to encourage high-quality, efficient care. Episode reimbursement attributable to a quarterback for calculating average adjusted episode reimbursement may be adjusted based on these selected risk factors. Over time, a payer may add or subtract risk factors in line with new research and/or empirical evidence.

Clinical conditions or factors to NOT be risk adjusted:

Complications to NOT risk adjust for:
- **Ob Blood-Clot embolism**
- **Antepar Deep Vein Thromb**
- **Thrombophlebiitis in Preg**
- **DVT-Postpar**
- **Oth Injury Pelvic Organs**
- **Oth Obstetric Surg compl**

Proposed approach to adjustments:
- Our intention is to include as many episodes as possible and risk adjust when appropriate and fair

7 Quality measures

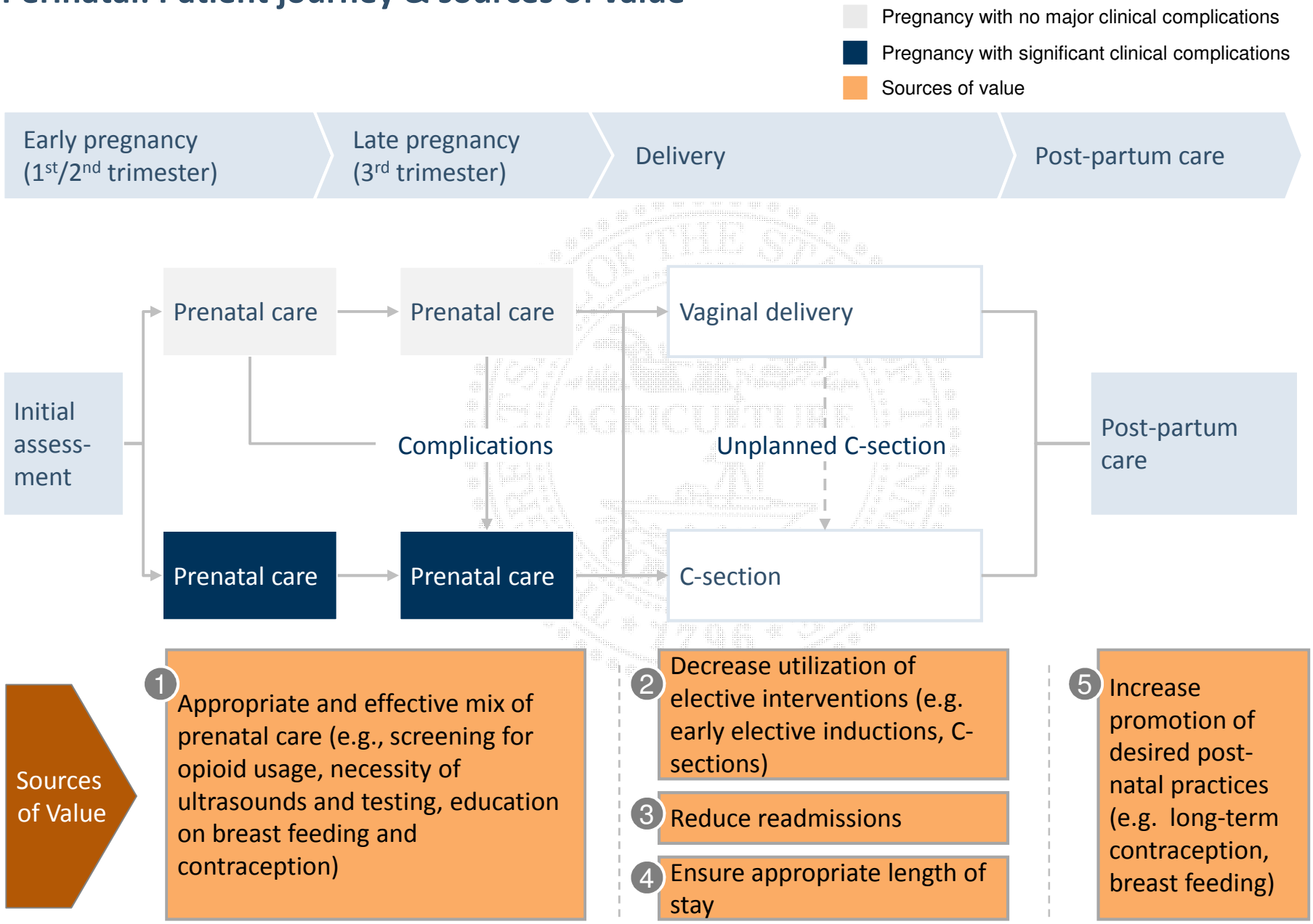
Quality measures "to pass":
- HIV screening
- Group B streptococcus screening (GBS)
- C-Section Rate

Quality measures "to track":
- Screening for Gestational Diabetes
- Screening for Asymptomatic Bacteriuria
- Hepatitis B specific antigen screening
- Tdap vaccination

Potential Phase 2 metrics
- Rate of NICU admissions (explore feasibility to track; e.g., birth certificate data to link mother/baby)
- Rate of early-elective delivery and/or inductions
- Rate of contraceptive prescription (and/or discussion). Tracked through pharmacy data, procedural codes, and revenue codes.
- Others: Rate of births before 37 weeks, primary vs repeat C-section rate, 17p administration for women with a history of pre-term birth, rate of breast feeding education, rate of steroid administration at less than 34 weeks, drug screening rate, etc

TENNESSEE DRAFT

Perinatal: Patient journey & sources of value



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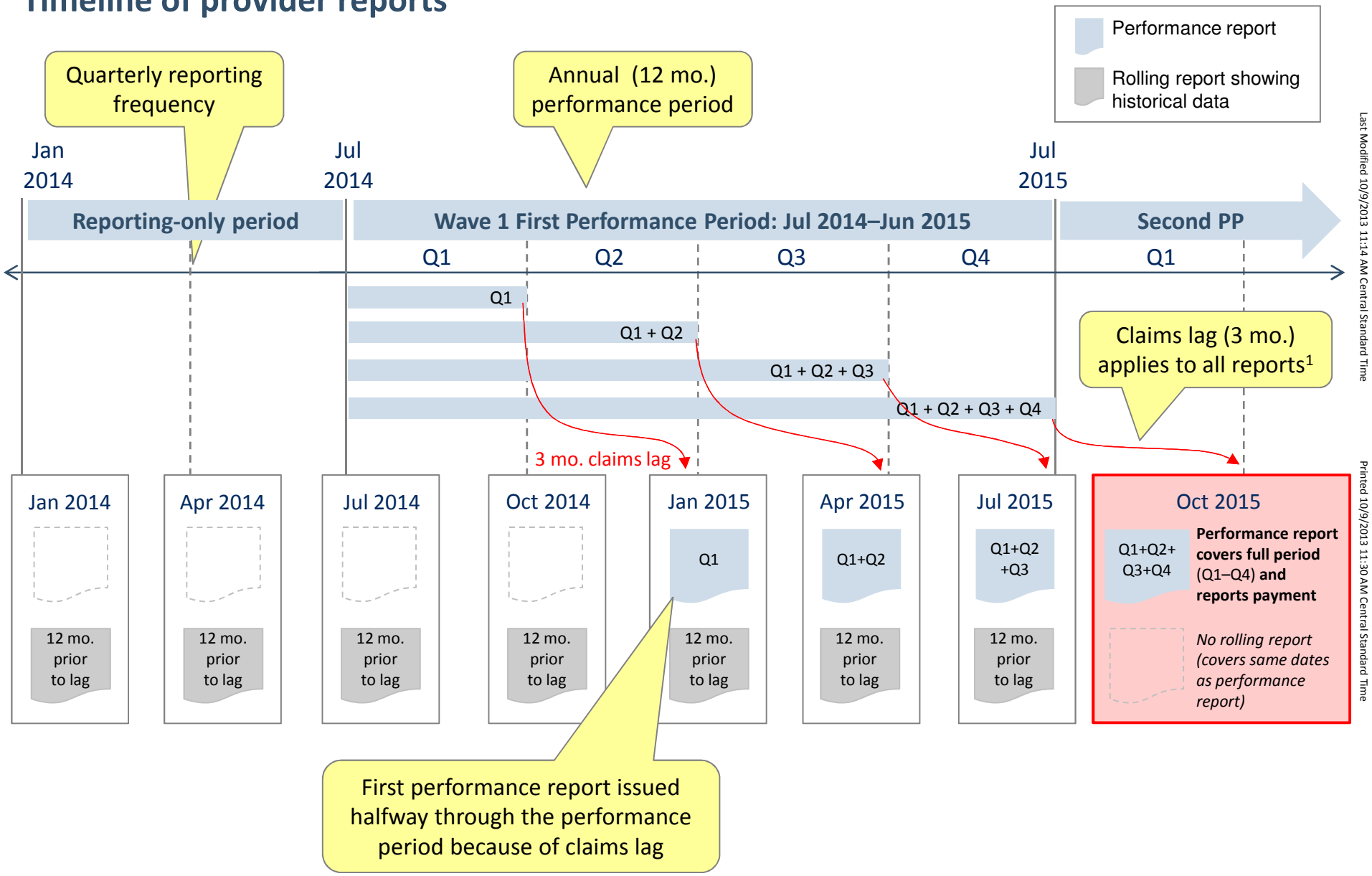
IN DEVELOPMENT | FOR DISCUSSION

Timeline of provider reports



1 Payments are reported after a complete performance period ends, plus any time in claims lag. For an annual performance period and 3 mo. claims lag, payments would be calculated 15 mo. after the start of the first performance period and every year thereafter.