

**WORKING DRAFT**

Last Modified 9/11/2013 11:54 AM Central Standard Time

Printed 8/7/2013 8:21 AM Central Standard Time

# Tennessee Payment Reform Initiative

Provider Meeting

September 11, 2013

*PRELIMINARY WORKING DRAFT, SUBJECT TO CHANGE*

# Agenda for September 11<sup>th</sup> Provider Coalition meeting

Activity	Time
▪ Introductory remarks	13:00 – 13:10
▪ Potential path forward on PCMH	13:10 – 13:45
▪ Episode TAG updates	13:45 – 14:35
▪ Key operational decisions on Provider Report design	14:35 – 14:50
▪ Discussion and next steps	14:50 – 15:00

# Contents

- **Potential path forward on PCMH**
- Episode TAG updates
- Key operational decisions on Provider Report design
- Discussion and next steps
- Appendix

# Update on PCMH strategy

PRELIMINARY

## Current status

Payers are discussing the development of a multi-payer PCMH initiative. The purpose of multi-payer collaboration is to

- **Accelerate the transition of care delivery** to a system with improved coordination, access, and patient engagement
  - With transition support from multiple payers, providers will be better able to invest into PCMH
  - With access to payment streams from multiple payers, providers that participate will be more likely to succeed
- **Lower total investment costs** borne by payers (e.g., for provider training)
- **Create opportunities to learn more about what “works”** so that providers and payers can expand the program over time

## Elements under consideration

- **Joint statement of intent:** Payers are developing a “charter” that describes their shared vision for population-based models
- **Areas for alignment and differentiation:** Payers are defining areas where they should adopt a standard approach in order to streamline provider experience
- **Plans to build on existing programs:** Payers are discussing how to expand their current programs to a broader range of providers
- **Geographic rollout:** Payers will select two MSAs in which to test a multi-payer effort on PCMH
- **Plan for enrolling practices:** Payers are considering a common process for enrolling practices in selected MSAs

# Payers can assess the appropriate degree of standardization for each component of the PCMH care delivery and payment model

## “Standardize approach”

Standardize approach (i.e., identical design) only when:

- Alignment is critical to provider success or significantly eases implementation for providers (e.g., due to lower administrative burden)
- Meaningful economies of scale exist
- Standardization does not diminish potential sources of competitive advantage among payers
- Standardization is lawful
- Standardization promotes the best interest of patients

## “Align in principle”

Align in principle but allow for payer innovation consistent with those principles when:

- Payer alignment has benefits for the integrity of the program
- It benefits providers to understand where payers are moving in same direction
- Differences have modest impact on providers from an administrative standpoint
- Differences are necessary to account for legitimate differences among payers (e.g., varied customers, members, strategy, administrative systems)

## “Differ by design”

Differ by design when:

- Required by laws or regulations
- An element of the model is substantially tied to competitive advantage
- There exists meaningful opportunity for innovation or experimentation

# Considerations to inform selection of markets for PCMH focus

PRELIMINARY

	<b>Criteria by MSA<sup>1</sup></b>
<b>Economic opportunity</b>	<ul style="list-style-type: none"> <li>▪ Total spend</li> <li>▪ Variation in spend</li> </ul>
<b>Provider market structure</b>	<ul style="list-style-type: none"> <li>▪ Network adequacy</li> <li>▪ Provider fragmentation</li> <li>▪ PCP attribution</li> </ul>
<b>Payer coverage</b>	<ul style="list-style-type: none"> <li>▪ Presence of state-contracted payers</li> <li>▪ Market share of major payers</li> </ul>
<b>Demographic factors</b>	<ul style="list-style-type: none"> <li>▪ Age distribution</li> <li>▪ Risk stratification</li> </ul>
<b>Environmental success factors</b>	<ul style="list-style-type: none"> <li>▪ Presence of champions</li> <li>▪ HIE</li> <li>▪ Other considerations</li> </ul>

<sup>1</sup> Analysis will also include aggregate rural area not covered in MSAs

# Contents

- Potential path forward on PCMH
- **Episode TAG updates**
  - **Status of TAG meetings**
    - Asthma
    - Perinatal
    - Total Joint Replacement
- Key operational decisions on Provider Report design
- Discussion and next steps
- Appendix

# Status of TAG meetings

	TAGs		Notes
	Complete	Remaining	
<b>Asthma / COPD</b>	4	1	Finalization of TAG recommendation in progress
<b>Perinatal</b>	4	0	
<b>Total Joint Replacement</b>	4	1	Final meeting pending to align on TAG recommendation



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FURTHER QA NEEDED TO VERIFY DATA ROBUSTNESS OF ALL FACILITIES BELOW 25<sup>TH</sup> PERCENTILE AND ABOVE 75<sup>TH</sup> PERCENTILE

PRELIMINARY

# PRELIMINARY: Risk-Adjusted average episode cost per facility

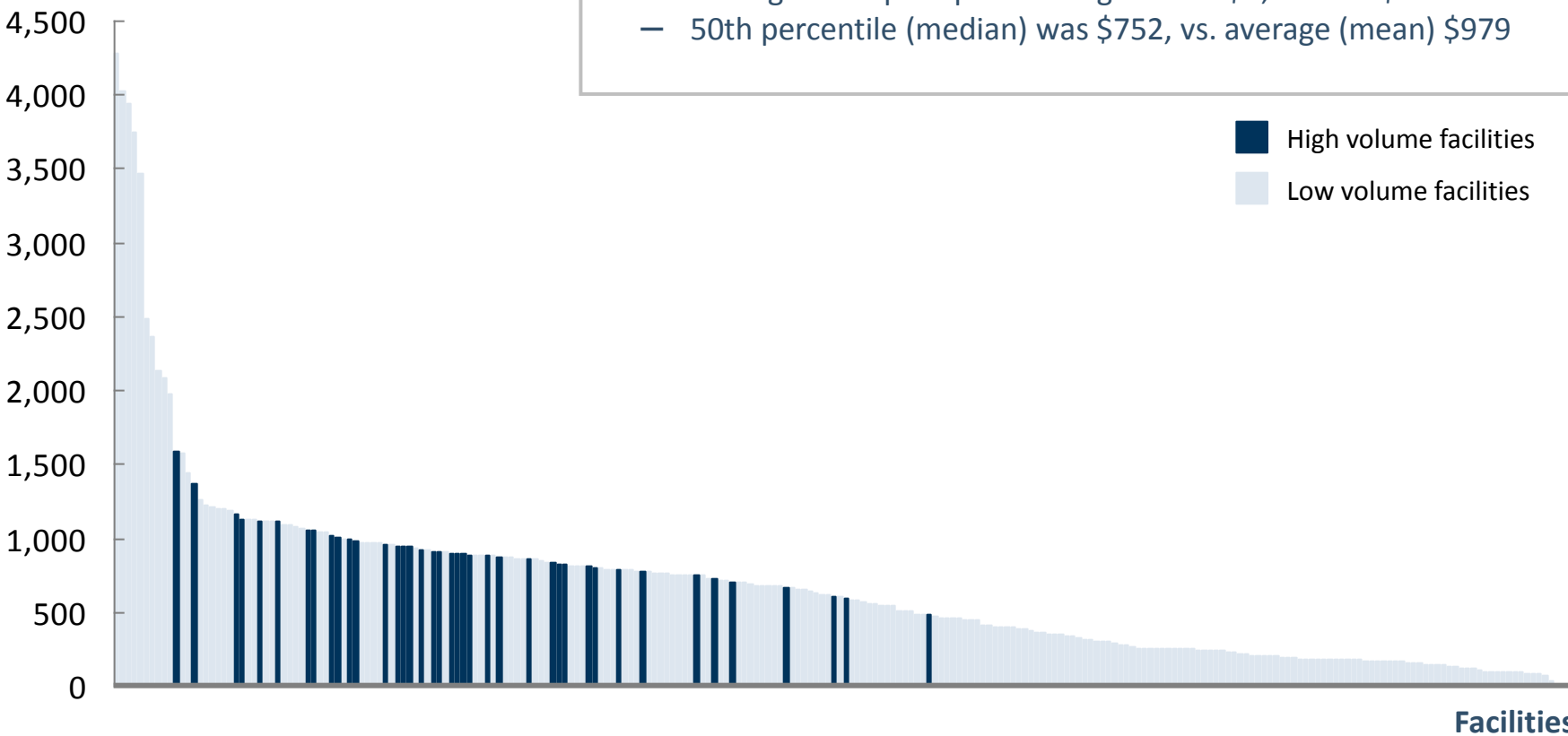
Average episode cost per facility: Asthma acute exacerbation

N=19,800 Providers=246

Risk-adjusted Average cost, trigger date 2012

Average cost/episode

\$



- Significant variation in average episode cost across facilities
  - Average costs per episode ranged from \$4,300 to ~\$0
  - 50th percentile (median) was \$752, vs. average (mean) \$979

1 2 facilities (2 episodes total) with Avg cost > \$5,000 were removed for further analysis. No other exclusions applied.

Source: TennCare, trigger dates during 2012

## Executive Summary: Major areas of focus in the Asthma Exacerbation TAG to date

### 1. Significant discussion around inclusions and exclusions

- What codes should actually be used a trigger for an asthma exacerbation?
- At what ages (if any) should patients be excluded?

### 2. Significant discussion around quality metrics

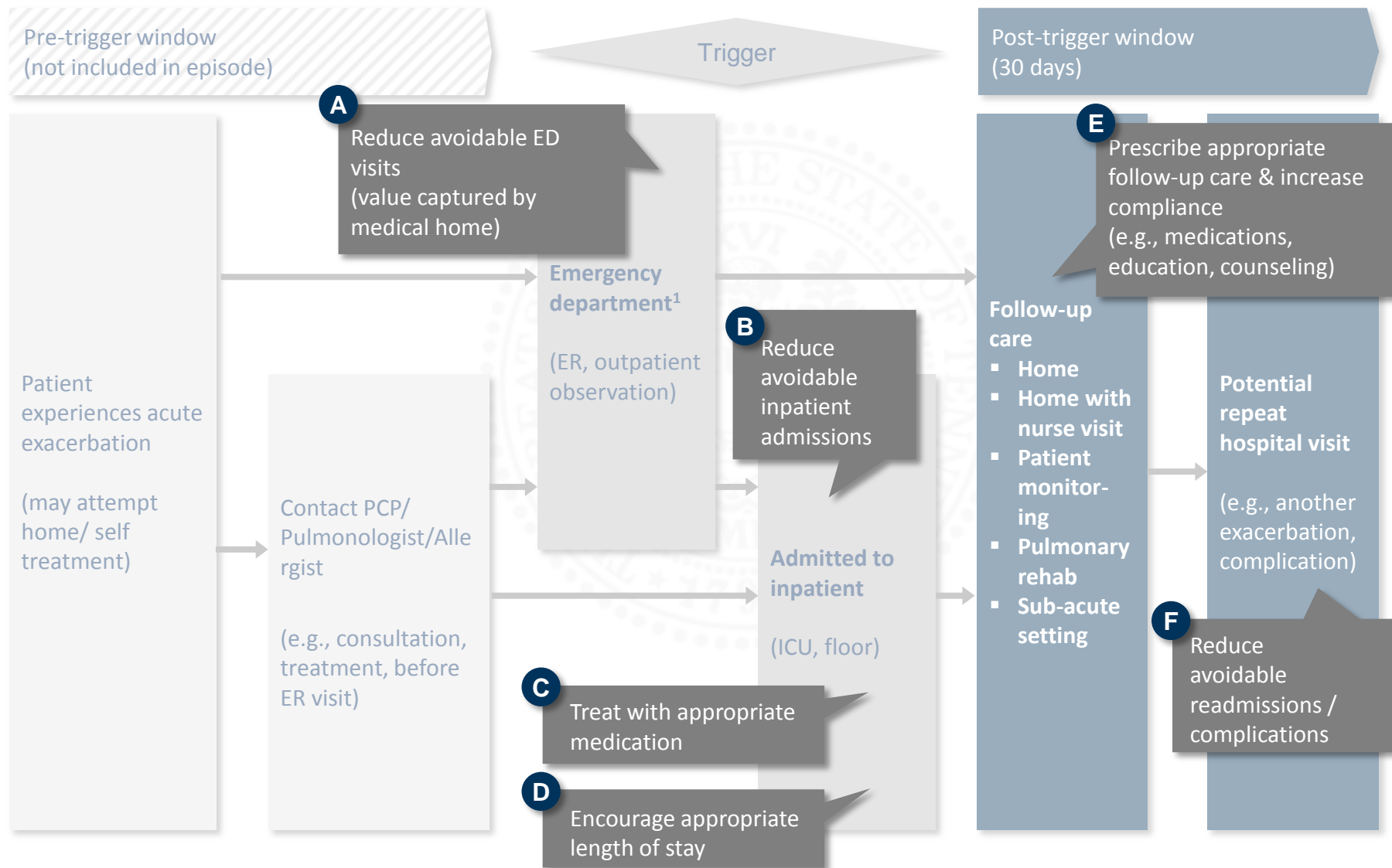
- TAG recommended to keep all Arkansas quality metrics, with one small adjustment
- TAG recommended the addition of five additional metrics to track

### 3. Some discussion around quarterback preference in transfer episodes: when a patient is transferred from one facility to another, who should be the quarterback?

# Asthma acute exacerbation

## Proposed sources of value

■ Sources of value



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<sup>1</sup> May include urgent care facility

# 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	DRG code	Avg claim count per year
33.00	BORDETELLA PERTUSSIS	203	335
33.10	BORDETELLA PARAPERTUSSIS	203	44,591
33.80	WHOOPING COUGH NEC	203	135
33.90	WHOOPING COUGH NOS	203	0
464.10	AC TRACHEITIS NO OBSTRUC	203	473
464.11	AC TRACHEITIS W OBSTRUCT	203	10
466.00	ACUTE BRONCHITIS	203	0
466.11	ACU BRONCHOLITIS D/T RSV	203	12,920
466.19	ACU BRNCHLTS D/T OTH ORG	203	27,493
490.00	BRONCHITIS NOS	203	0
491.00	SIMPLE CHR BRONCHITIS	203	0
493.00	EXTRINSIC ASTHMA NOS	203	22,109
493.01	EXT ASTHMA W STATUS ASTH	203	2,171
493.02	EXT ASTHMA W(ACUTE) EXAC	203	4,535
493.10	INTRINSIC ASTHMA NOS	203	2,346
493.11	INT ASTHMA W STATUS ASTH	203	155
493.12	INT ASTHMA W (AC) EXAC	203	683
493.20	CHRON OBST ASTHMA, NOS	203	5,387
493.21	CHRON OBST ASTHMA STAT ASTH	203	516
493.22	CHRON OBST ASTHMA (ACUTE) EXAC	203	2,548
493.81	EXERCSE IND BRONCHOSPASM	203	465
493.82	COUGH VARIANT ASTHMA	203	1016
493.90	ASTHMA NOS	203	74,930

ICD-9 Dx	ICD-9 Dx Description	DRG code	Avg claim count per year
493.91	ASTHMA W STATUS ASTHMAT	203	5,749
493.92	ASTHMA NOS W (AC) EXAC	203	28,574
519.11	ACUTE BRONCHOSPASM	203	4,687
519.19	TRACHEA & BRONCH DIS NEC	203	1,746
327.22	HIGH ALTITUDE BREATHING	204	5
518.82	OTHER PULMONARY INSUFF	204	2,273
786.00	RESPIRATORY ABNORM NOS	204	1,494
786.01	HYPERVENTILATION	204	724
786.02	ORTHOPNEA	204	208
786.03	APNEA	204	3,127
786.04	CHEYNE-STOKES RESPIRATN	204	21
786.05	SHORTNESS OF BREATH	204	57,813
786.06	TACHYPNEA	204	1,129
786.07	WHEEZING	204	28,978
786.09	RESPIRATORY ABNORM NEC	204	43,358
786.10	STRIDOR	204	0
786.20	COUGH	204	0
786.30	HEMOPTYSIS	204	951
786.40	ABNORMAL SPUTUM	204	0
786.52	PAINFUL RESPIRATION	204	17,908
786.60	CHEST SWELLING/MASS/LUMP	204	0
786.70	ABNORMAL CHEST SOUNDS	204	0
786.80	HICCOUGH	204	0
786.90	RESP SYS/CHEST SYMP NEC	204	4,912
793.10	NONSP ABN FD-LUNG FIELD	204	0

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## Episode definition and scope of services:

### Count and spend associated with potential triggers

19,488 episodes triggered in 2012

Trigger	Count of episodes Count	Total paid cost \$ K	Avg paid cost \$
Asthma, unspecified type, with (acute) exacerbation	10,846	13,465	1,241
Asthma, unspecified type, unspecified	4,927	4,525	918
Acute bronchospasm	1,173	995	849
Asthma, unspecified type, with status asthmaticus	1,018	3,313	3,255
Chronic obstructive asthma; with (acute) exacerbation	598	2,733	4,569
Wheezing	212	226	1,067
Extrinsic asthma with (acute) exacerbation	179	354	1,978
Extrinsic asthma, unspecified	167	171	1,025
Chronic obstructive asthma; unspecified	128	306	2,393
Cough variant asthma	110	72	651
Extrinsic asthma with status asthmaticus	56	254	4,529
Chronic obstructive asthma; with status asthmaticus	23	75	3,265
Exercise induced bronchospasm	21	11	503
Intrinsic asthma, unspecified	19	16	846
Intrinsic asthma with (acute) exacerbation	6	24	3,991
Intrinsic asthma with status asthmaticus	5	29	5,787

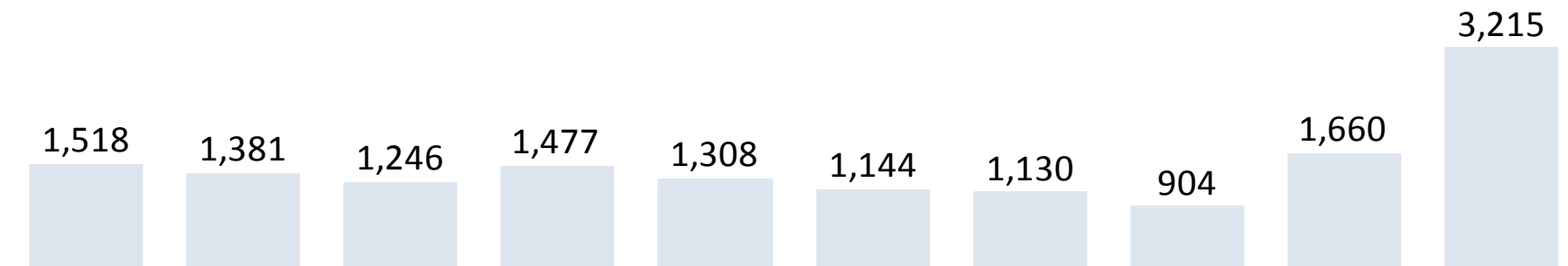
# PRELIMINARY: Distribution of episodes by patient age groups

PRELIMINARY

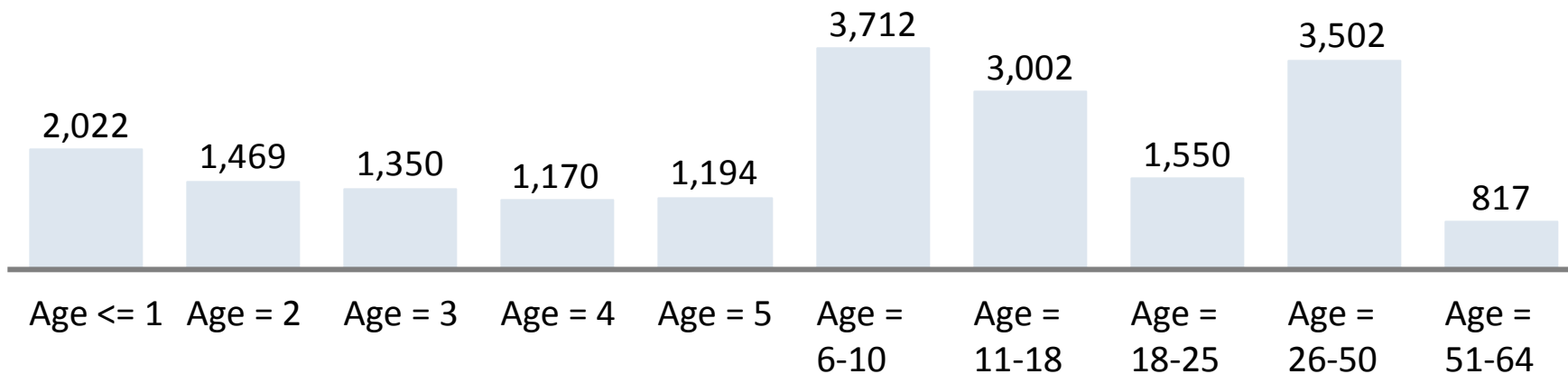
## Age distribution: asthma acute exacerbation

n = 19,780 episodes, 246 facilities

Avg cost/episode  
\$



## # of episodes



Age groups

1 No exclusions. Age 65+ data not shown (20 episodes)

Source: TennCare, trigger dates during 2012

# The TAG advises that several quality metrics be added to those used by Arkansas

## *Quality Metrics*

### Arkansas quality metrics agreed upon by TAG

- 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 (excludes patients < 5 years old)
- Percent of patients with repeat acute exacerbation during episode window as measured by a re-encounter with the facility within 30 days or discharge

### New quality metrics added by Tennessee TAG

#### To be encouraged

- 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 (when appropriate)
- The addition of a controller if the patient has had two “episodes” in a 3 month time period.

#### To be discouraged

- The routine usage of higher cost Xopenex over Albuterol
- Any use of albuterol syrup



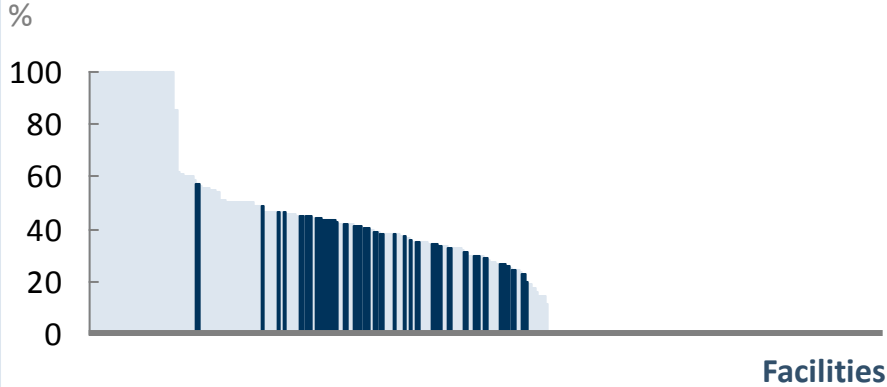
# Variability in TennCare's Asthma quality metric data

N=19,810 episodes ; Providers=246

High volume  
Low volume

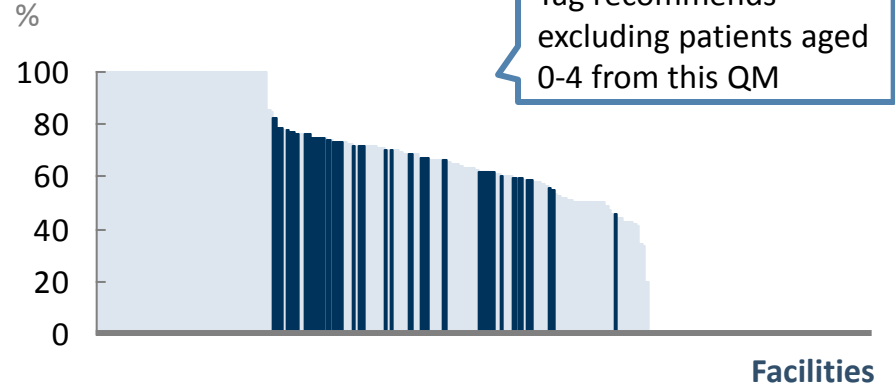
## Average follow-up visit rate per facility

### Follow-up visit rate



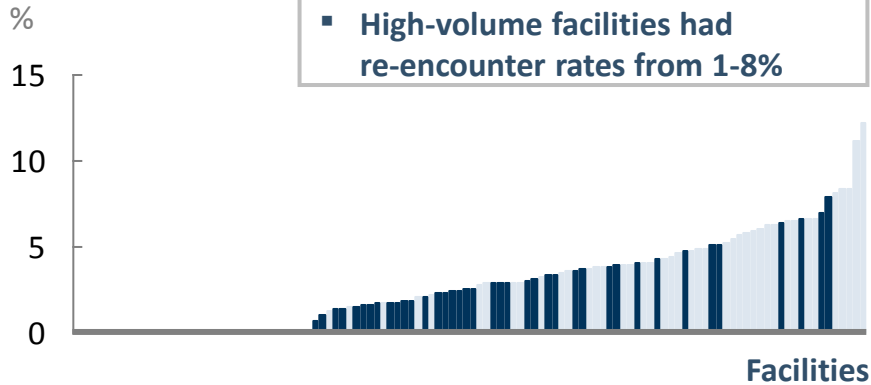
## Average appropriate medication rate per facility

### Appropriate medication rate



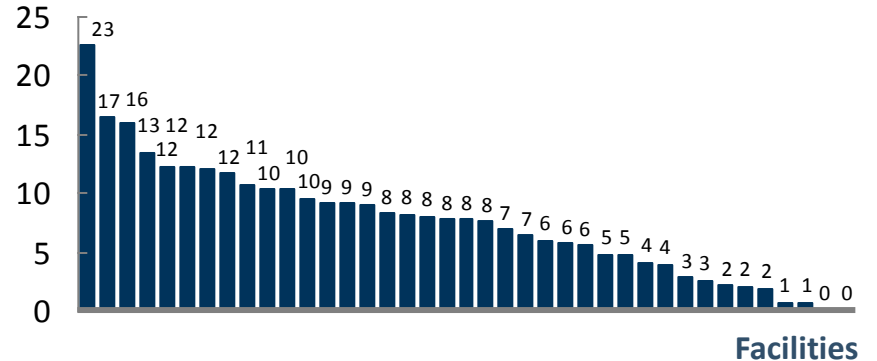
## Average re-encounter rate per facility<sup>3</sup>

### Re-encounter rate



## Variation in high-volume facility admission rates

### Facility inpatient admission rate



1 No exclusions applied.

2 High-volume facilities had >=100 episodes in 2012

3 9 facilities (15 episodes) with >25% re-encounter rate were removed, 121 facilities (134 episodes) with 0% re-encounter rate were removed

Source: TennCare, trigger dates during 2012

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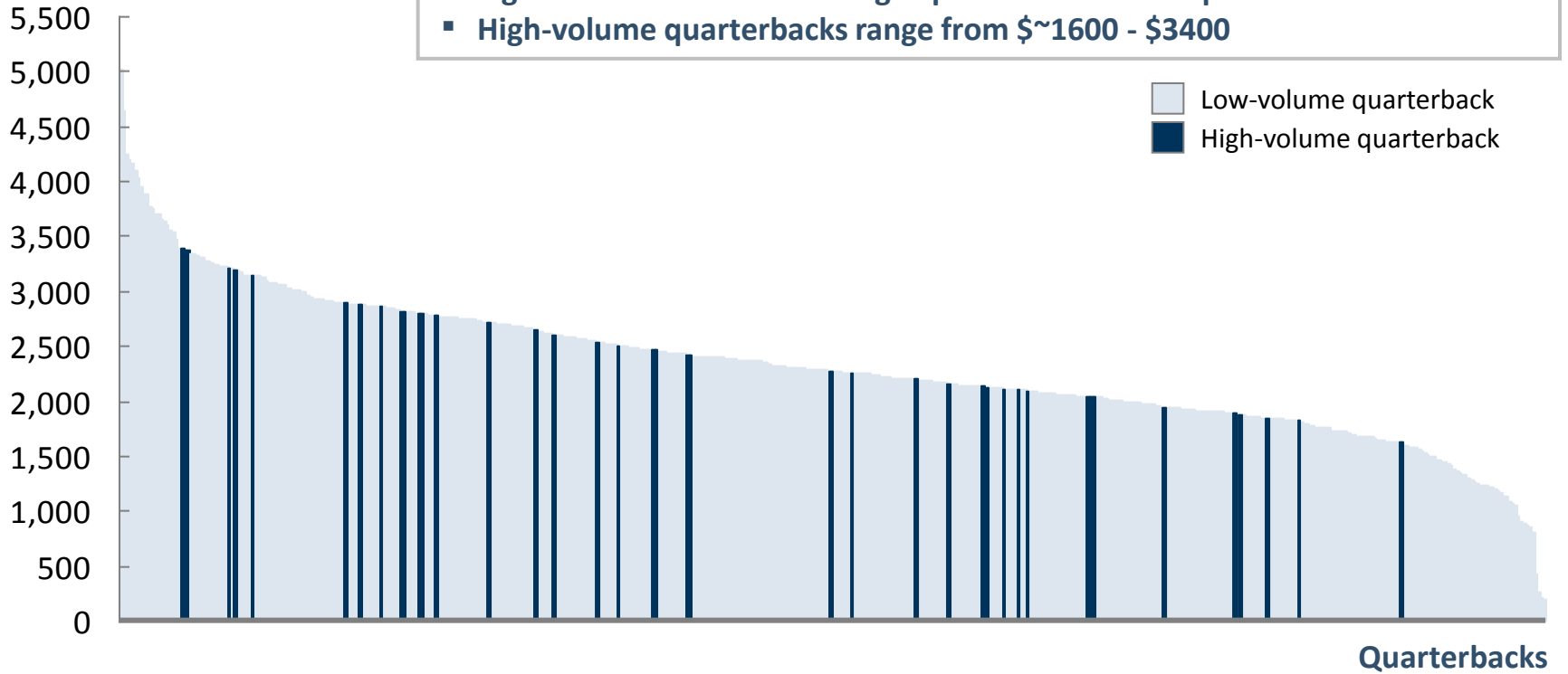
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# PRELIMINARY: Average episode cost per quarterback

Risk-adjusted quarterback average cost distribution: Perinatal

n = 33,606 episodes, 488 quarterbacks

Adj. average cost/episode  
\$



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Printed 8/7/2013 8:21 AM Central Standard Time

1 Unknown providers (3914 episodes) were removed. 5 providers (6 episodes total) with Avg cost > \$17000 were removed)

Source: TennCare, trigger dates during 2012

## Executive Summary: Major areas of focus in the Perinatal TAG to date

### 1. Significant discussion around quarterback choice

- Should the pre-natal care provider be evaluated separately from the delivering provider?
- If a payer chooses to make the delivering provider the quarterback, what rules should payers consider to account for cases in which pre-natal care may have been performed by a different quarterback?

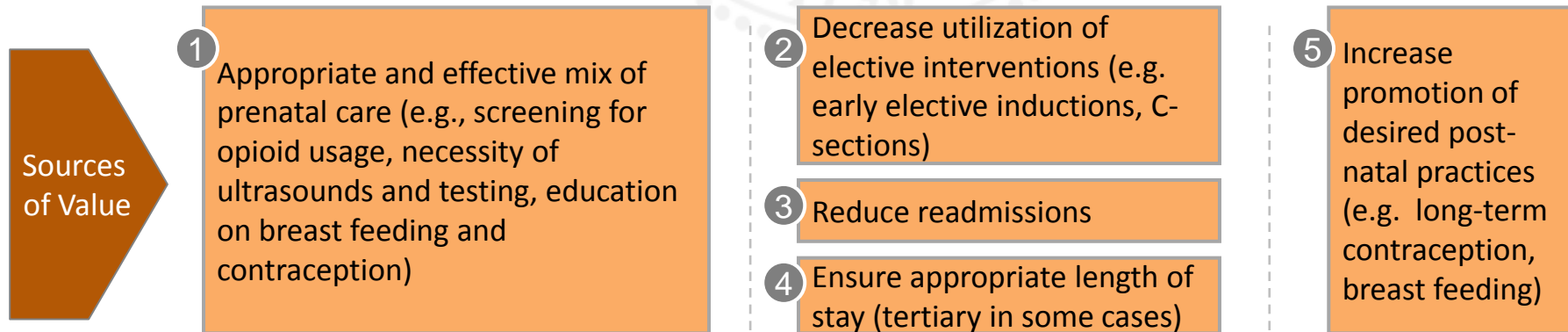
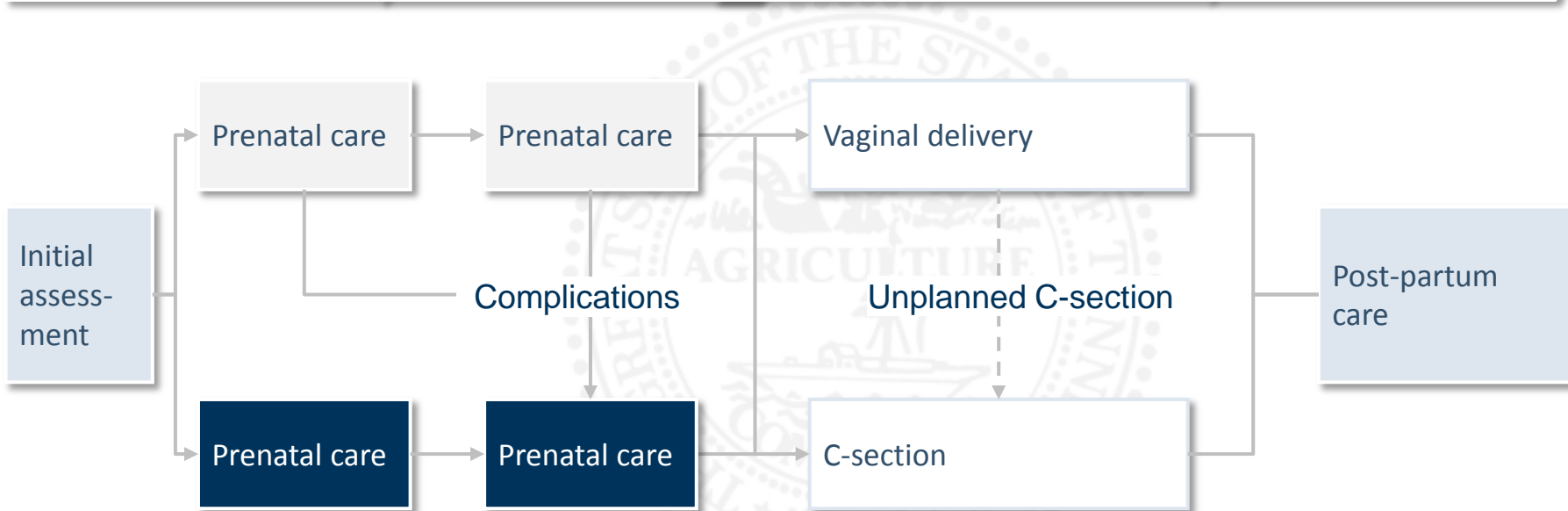
### 2. Significant discussion around improving quality of care

- TAG recommended to keep all Arkansas quality metrics, but questioned the need for chlamydia screening
- TAG wants to add additional quality metrics to measure rate of Tdap vaccinations

### 3. TAG is focused on inclusion, and risk adjusting instead of excluding as much as possible

# Perinatal: Sources of value

- Pregnancy with no major clinical complications
- Pregnancy with significant clinical complications
- Sources of value



### 3. Quarterback selection – Perinatal:

#### Assessment of provider types used to determine most appropriate episode ‘quarterback’

● Low ● High

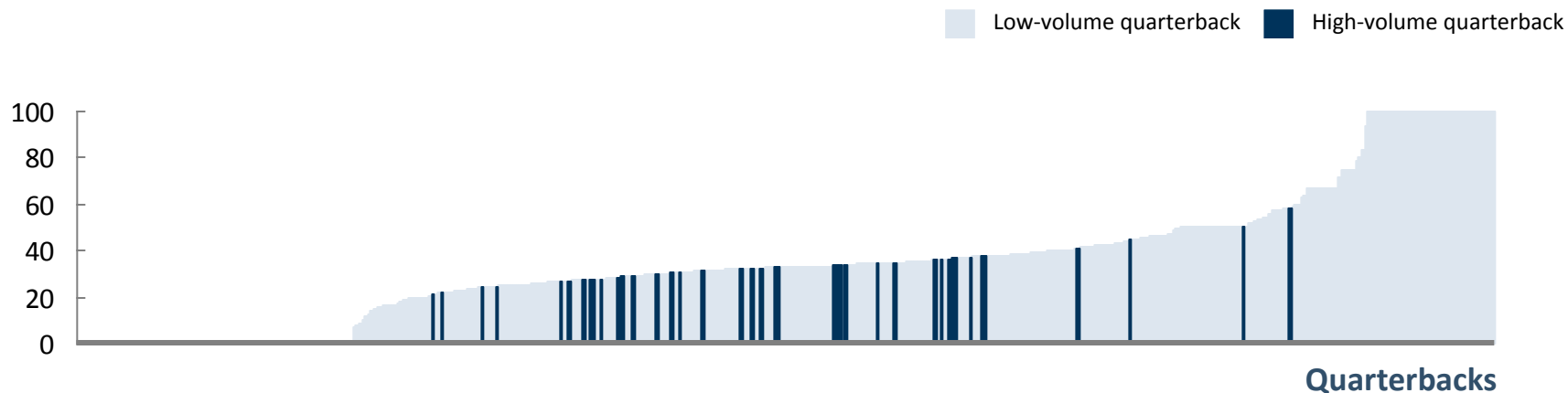
Providers involved in episode	Criteria for “Quarterback” selection <sup>1</sup>				Rationale
	Significant decision making responsibilities	Most influence over other providers	Bears material portion of episode cost	Influence over outcomes	
Delivering provider or provider group (e.g., OB-Gyn, Nurse midwife, Family Practice Physician)					<div style="border: 1px solid black; padding: 5px; display: inline-block; margin-bottom: 10px;">Proposed ‘Quarterback’ for TN</div> <ul style="list-style-type: none"> <li>Most influence over delivery method and setting when prior arrangements have not been made</li> <li>Provides prenatal care to the mother (unless separate prenatal care provider)</li> <li>Lead provider in inpatient setting; discharges mother</li> </ul> <hr/> <ul style="list-style-type: none"> <li>Accounts for significant portion of delivery, postpartum, and neonatal costs</li> </ul> <hr/> <ul style="list-style-type: none"> <li>Decides what prenatal services to provide (and sometimes what delivery method to use)</li> </ul>
Delivering facility					
Prenatal care provider (if not delivering provider)					

<sup>1</sup> Based on objective assessment of ‘Quarterback’ criteria; individual participating payers will need to make own assessment of which providers to designate as “Quarterback”

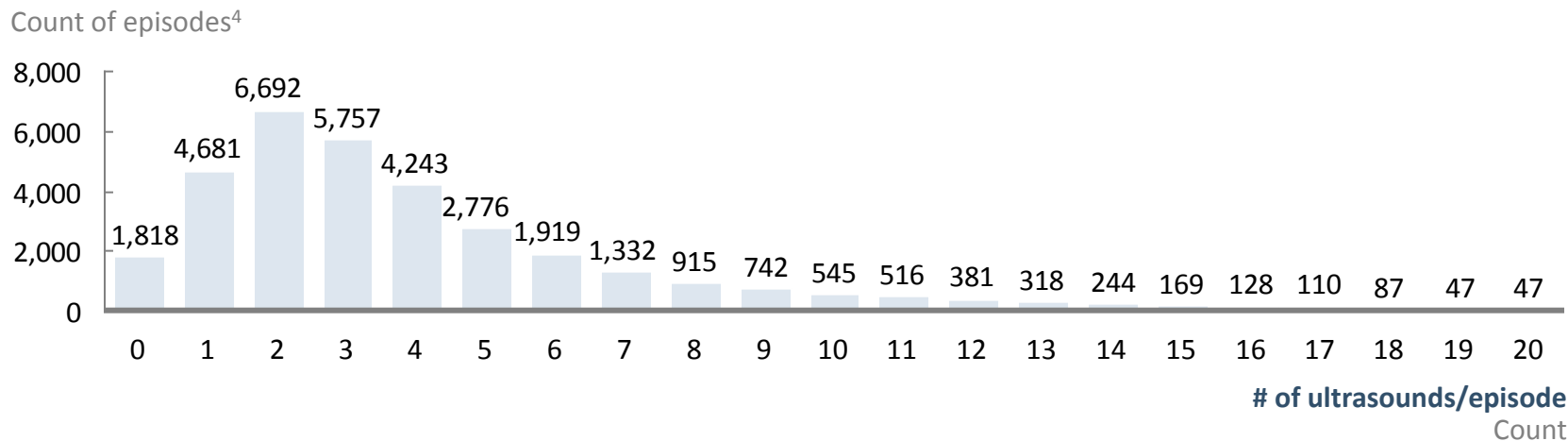
# Procedural sources of variation exist as well

PRELIMINARY

Average C-section rate per quarterback – Quarterback C-section rate distribution: Perinatal n = 33,606 episodes, 488 quarterbacks<sup>1</sup>



Distribution of ultrasounds – Variation in ultrasounds per episode: Perinatal n = 33,467 episodes<sup>2</sup>, 488 quarterbacks<sup>3</sup>



1 Excludes unknown providers (3914 episodes)  
 2 Excludes 139 episodes with over 20 ultrasounds an episode  
 3 No other exclusions applied (except unknown providers (3914 episodes) were removed)  
 4 Ultrasounds claims were counted if they were performed on different days

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## Quality metrics – Perinatal:

Quality metric	Objective
▪ HIV screening – must meet minimum threshold	▪ Increase
▪ Tdap vaccination – must meet minimum threshold	▪ Increase
▪ Group B strep screening – must meet minimum threshold	▪ Increase
▪ Screening for Gestational diabetes	▪ Increase
▪ Screening for Asymptomatic Bacteriuria	▪ Increase
▪ Hepatitis B specific antigen screening	▪ Increase
▪ C-Section Rate	▪ Decrease



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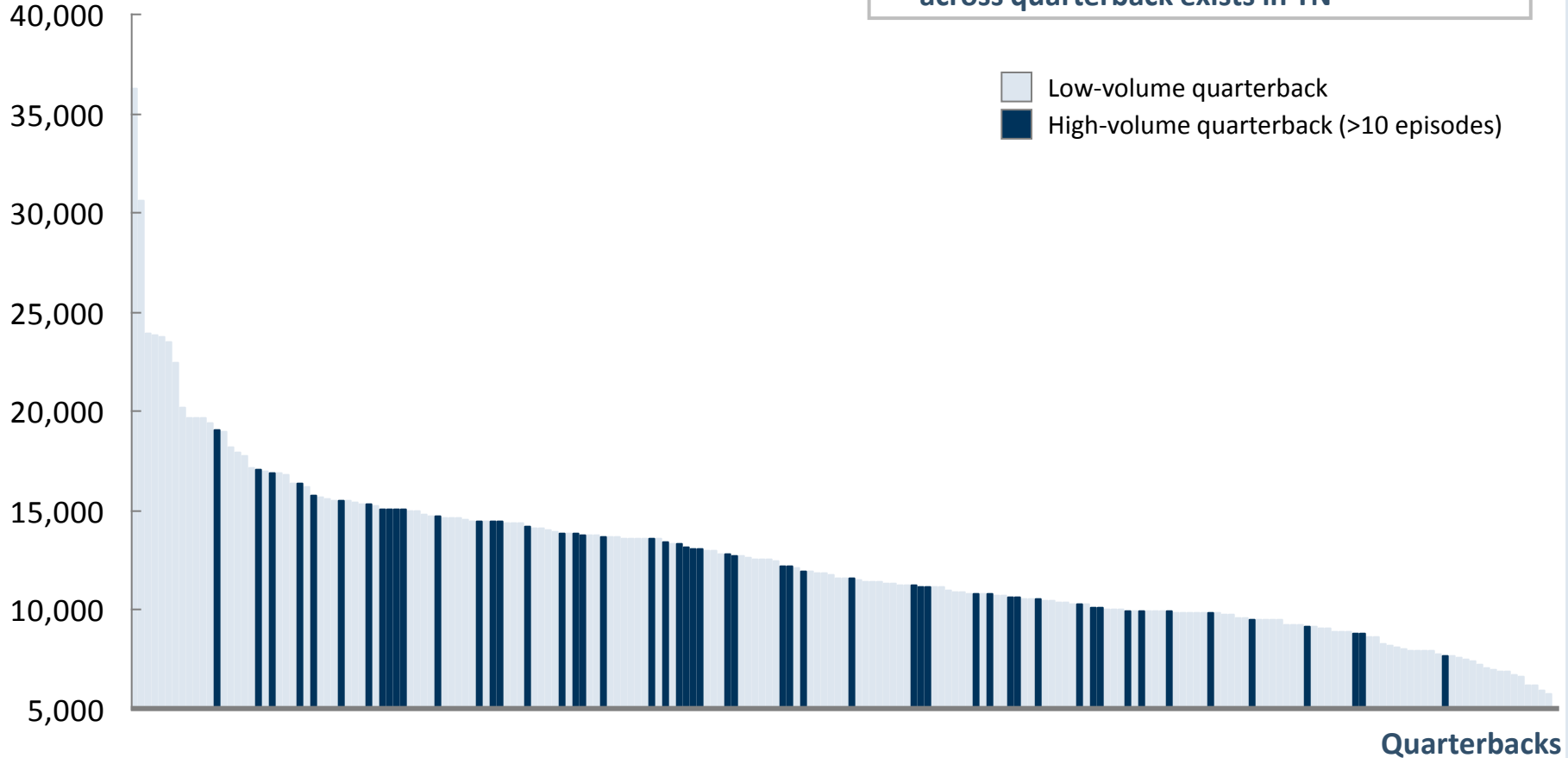
# PRELIMINARY: Average episode cost per quarterback

Original paid cost, non risk-adjusted data (\$)

Quarterback average cost distribution: TJR

n =2,309 episodes, 207 quarterbacks

Adj. average cost/episode  
\$



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1 Unknown providers (496 episodes) were removed

Source: TennCare, trigger dates during 2008- 2012

## Executive Summary: Major areas of focus in the TJR TAG to date

### 1. Inpatient facility costs raise a conversation around accountability in a total joint replacement episode, as well as quarterback considerations

- Over 60% of the costs are inpatient facility costs at the time of the procedure; average episode cost per physician outside of this inpatient facility costs ranges from \$3250 to \$6950<sup>1</sup>
- In almost every market, there are multiple hospitals with varying inpatient facility costs  
Approximately two thirds of large volume TennCare providers perform procedures at more than one facility
- Approximately 20% of orthopedic surgeons in Tennessee are employed by hospitals, and that number is growing. In cases where surgeons are not employed by the facility, surgeons or their practices decide where to perform procedures
- Switching facilities or shifting volume amongst existing facilities raises operational considerations

### 2. Certain aspects of a pre-procedure window require more discussion

- Interactions with other physicians in the pre-trigger window
- Referral choice in the pre-procedure window

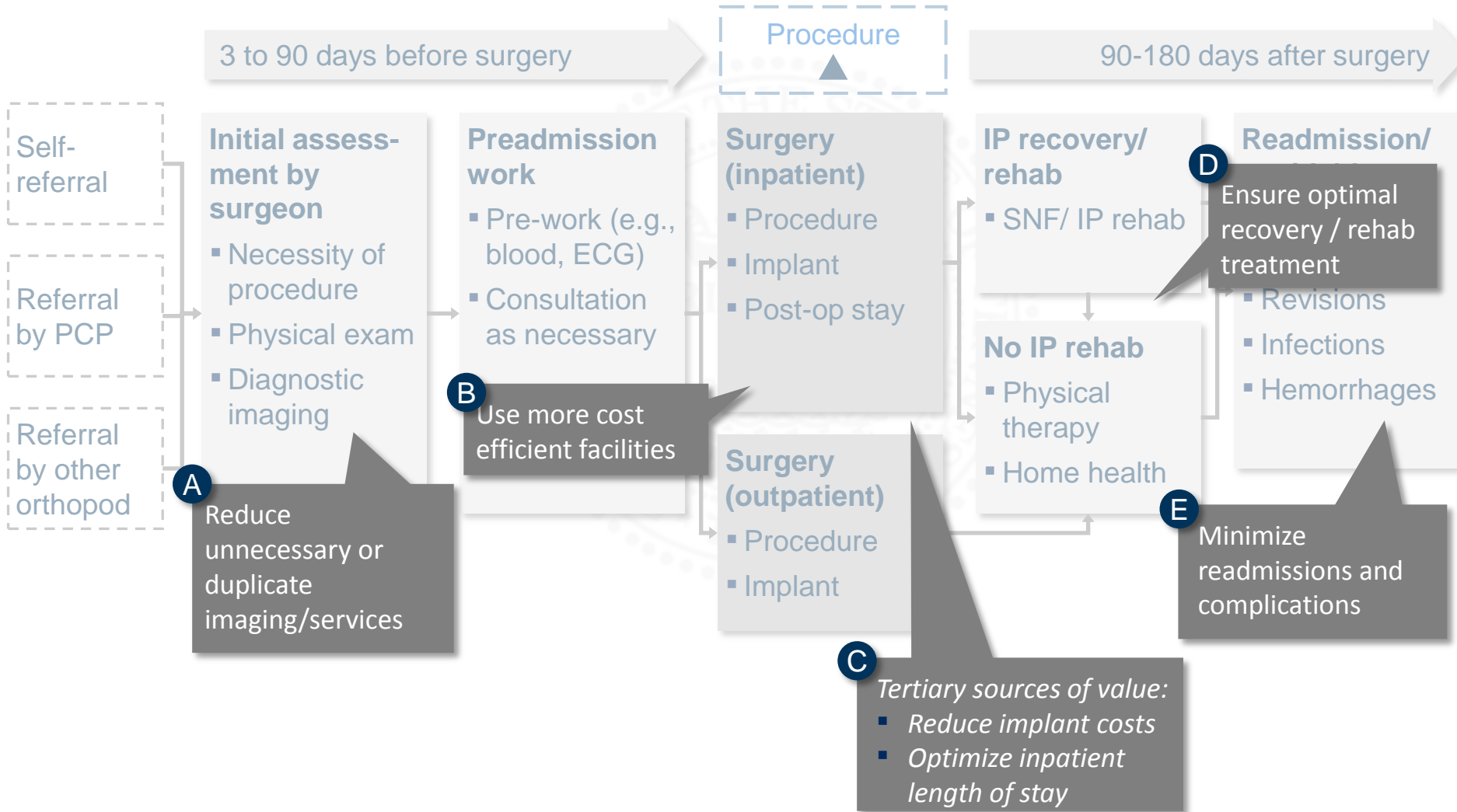
### 3. Several source of value exist under the DRG that require more discussion

- Orthopedic surgeons have direct control over several source of value, but are concerned that they don't benefit from any value realized. These include:
  - the cost of the implant
  - the length of stay in the hospital
- The TAG members have asked that we explore how these potential sources of value could be realized within the payment reform initiative

# 1. Episode definition and scope of services – TJR (Hip & knee replacements) :

## Sources of value

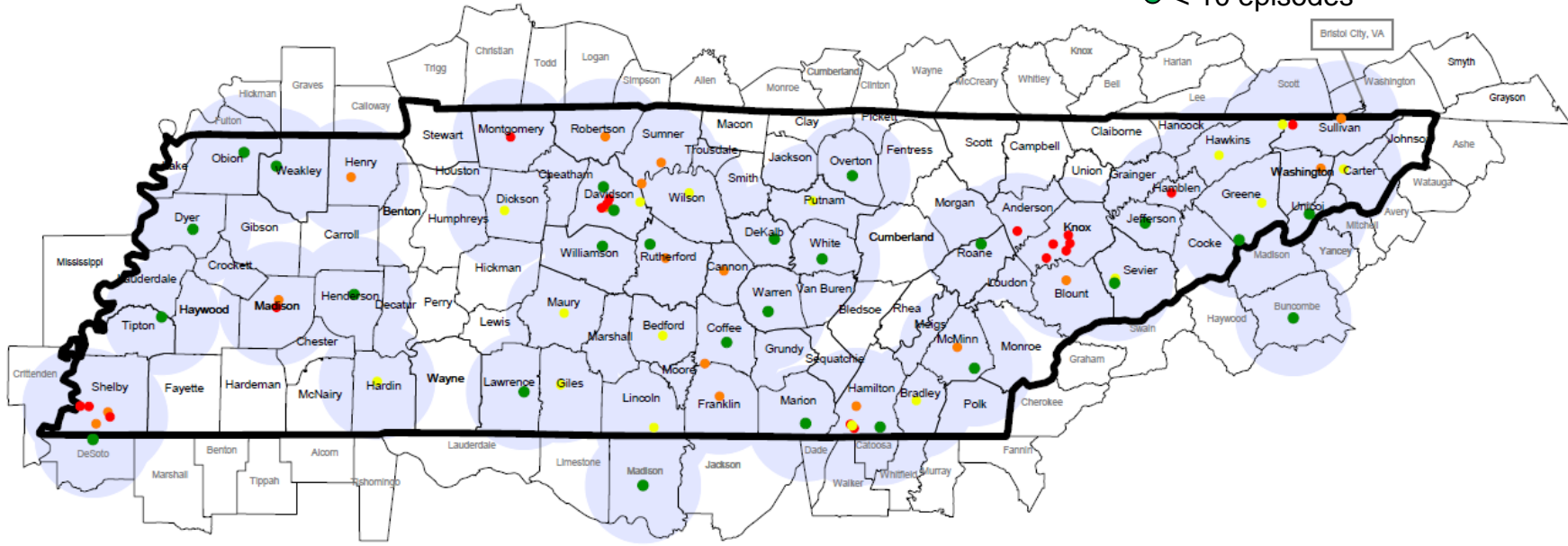
- Services included in the episode
- Sources of value



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# Facility locations in Tennessee

- >=50 episodes
  - 20-49 episodes
  - 10-19 episodes
  - < 10 episodes
- Area represented by a 20 mil radius around existing facilities



All facilities are within a 20 mile radius of at least one other facility

MSA	% of episode volume	Cumulative episode volume
Nashville	25.2%	25.2%
Knoxville	23.6%	48.7%
Memphis	14.4%	63.1%
Chattanooga	7.5%	70.6%
Jackson	5.3%	75.9%
Johnson City	5.9%	81.8%
Other	18.2%	100.0%

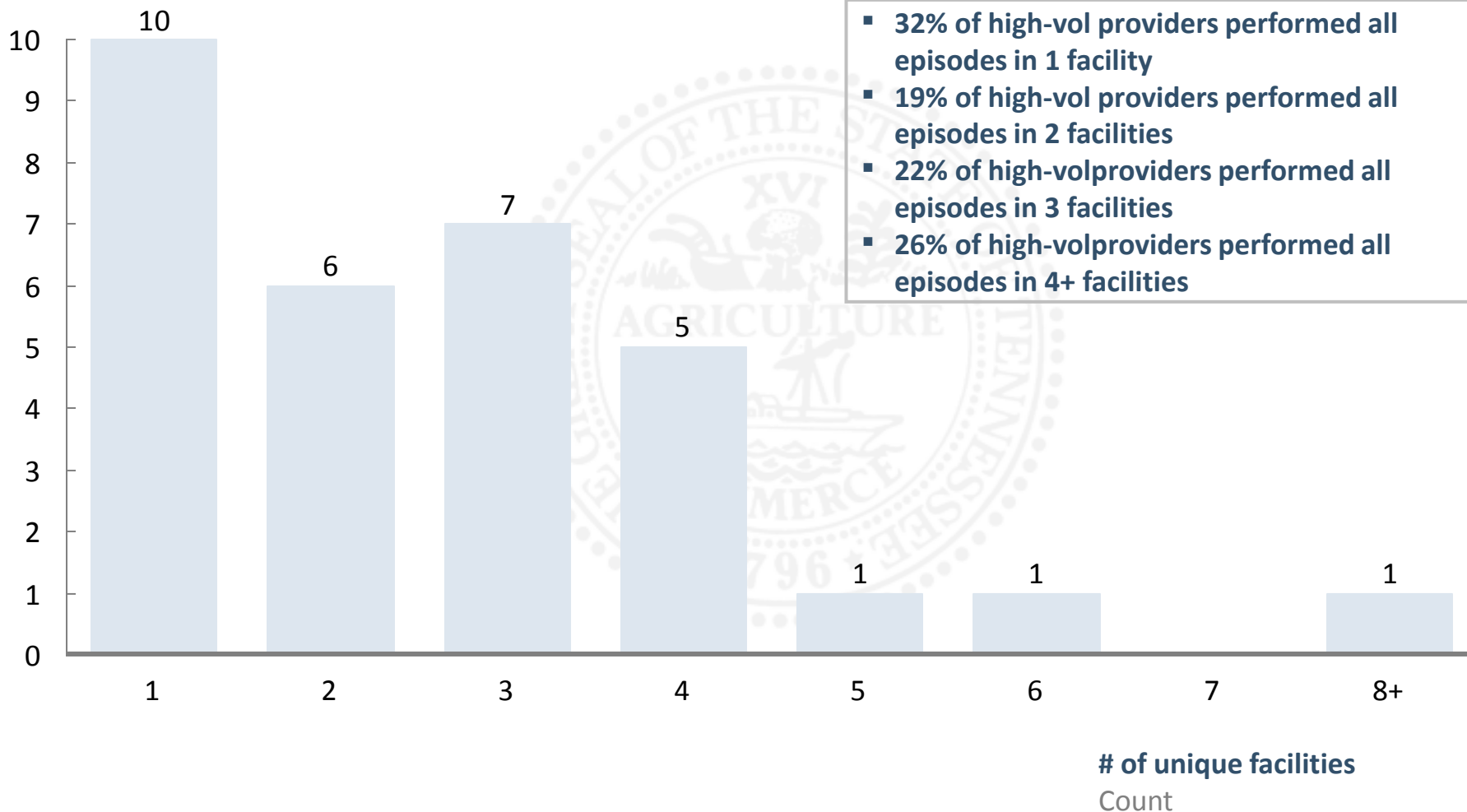
# PRELIMINARY: # of facilities each provider has episodes in

PRELIMINARY

Facilities utilized per provider: TJR, hip or knee

n =1,242 episodes, 31 providers (by Billing ID)

Count of providers



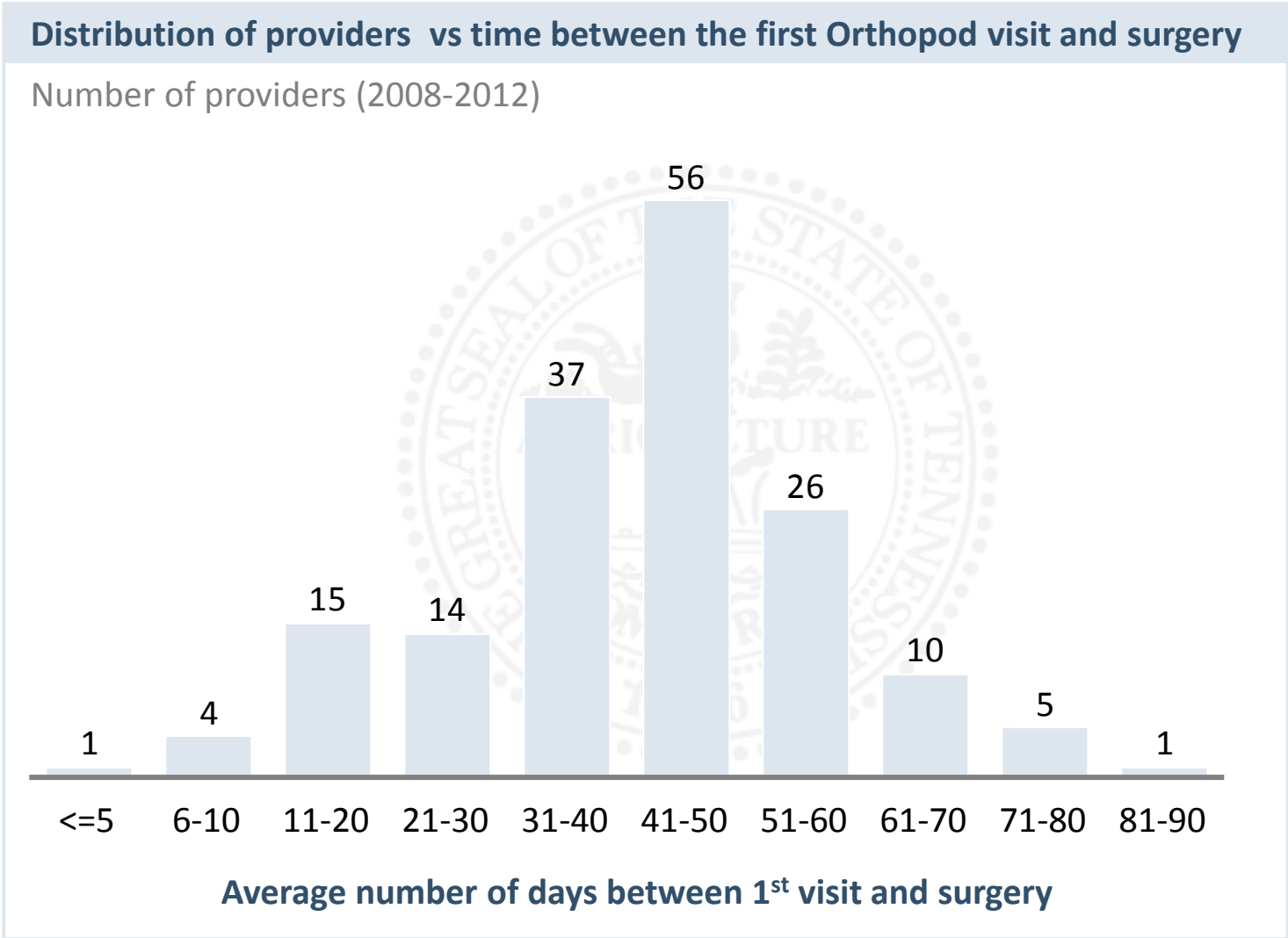
- 32% of high-vol providers performed all episodes in 1 facility
- 19% of high-vol providers performed all episodes in 2 facilities
- 22% of high-vol providers performed all episodes in 3 facilities
- 26% of high-vol providers performed all episodes in 4+ facilities

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1 Only showing providers with >=20 episodes

# PRELIMINARY: Distribution of providers vs time between the first Orthopedic surgeon visit and surgery PRELIMINARY



1 Unknown providers (no professional claim) (544 episodes, \$5,648,374) were removed  
 2 36 providers without a recorded visit in the performance period (43 episodes, \$358,826)

Source: TennCare, trigger dates during 2008-2012

# Variability in TennCare's TJR data

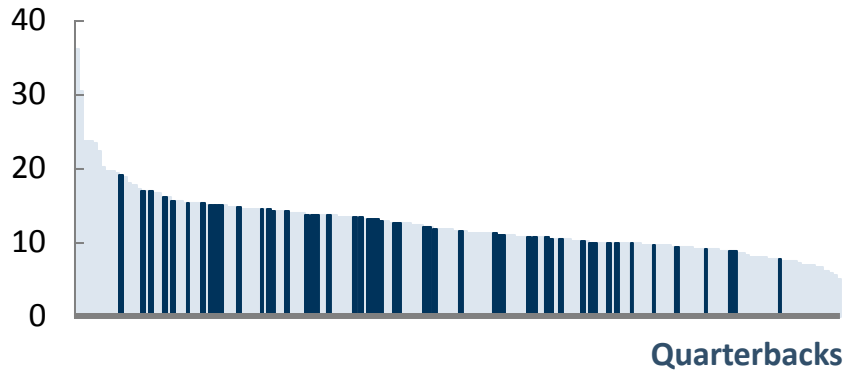
n =2,309 episodes, 207 quarterbacks

Low-volume quarterback  
High-volume quarterback

PRELIMINARY

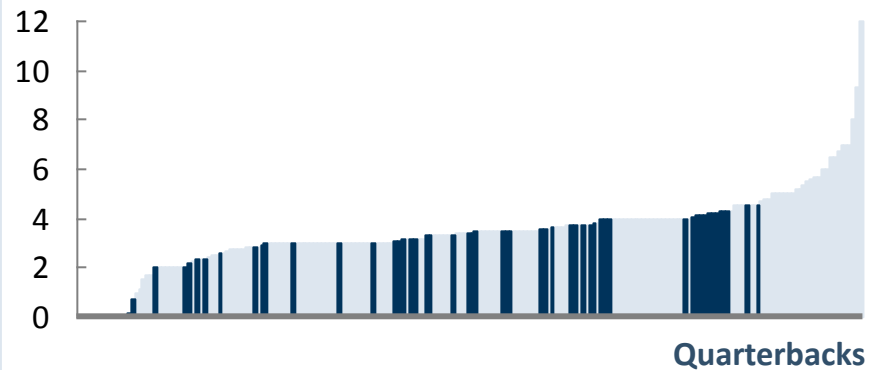
## Quarterback average cost distribution

Average cost/episode (\$K)



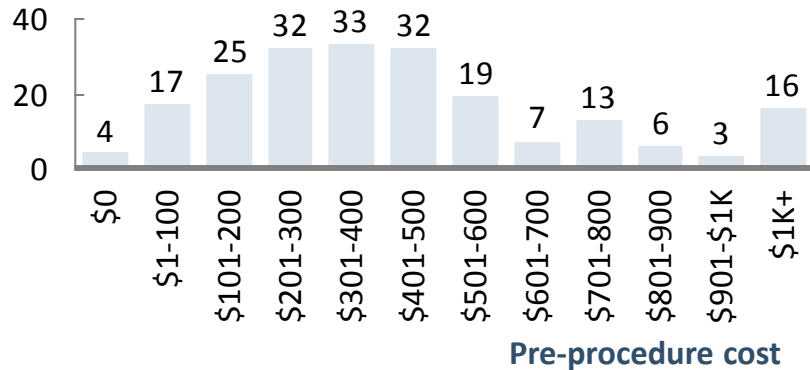
## Quarterback length of stay distribution

Average length of stay quarterback (# Days)



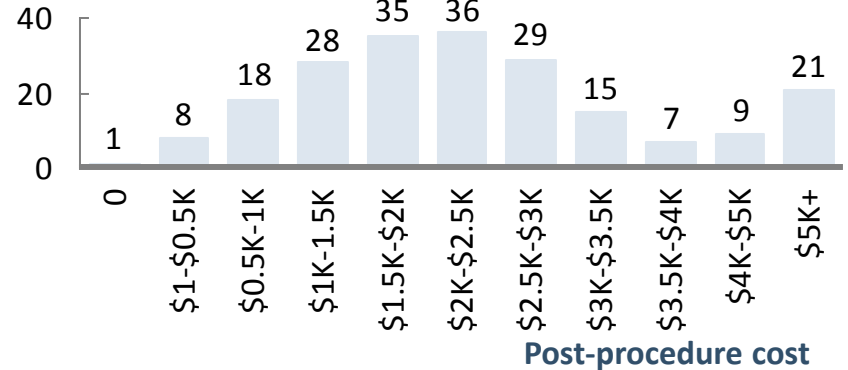
## Variation in pre-procedure cost per episode

Count of providers



## Variation in post-procedure cost per episode

Count of providers

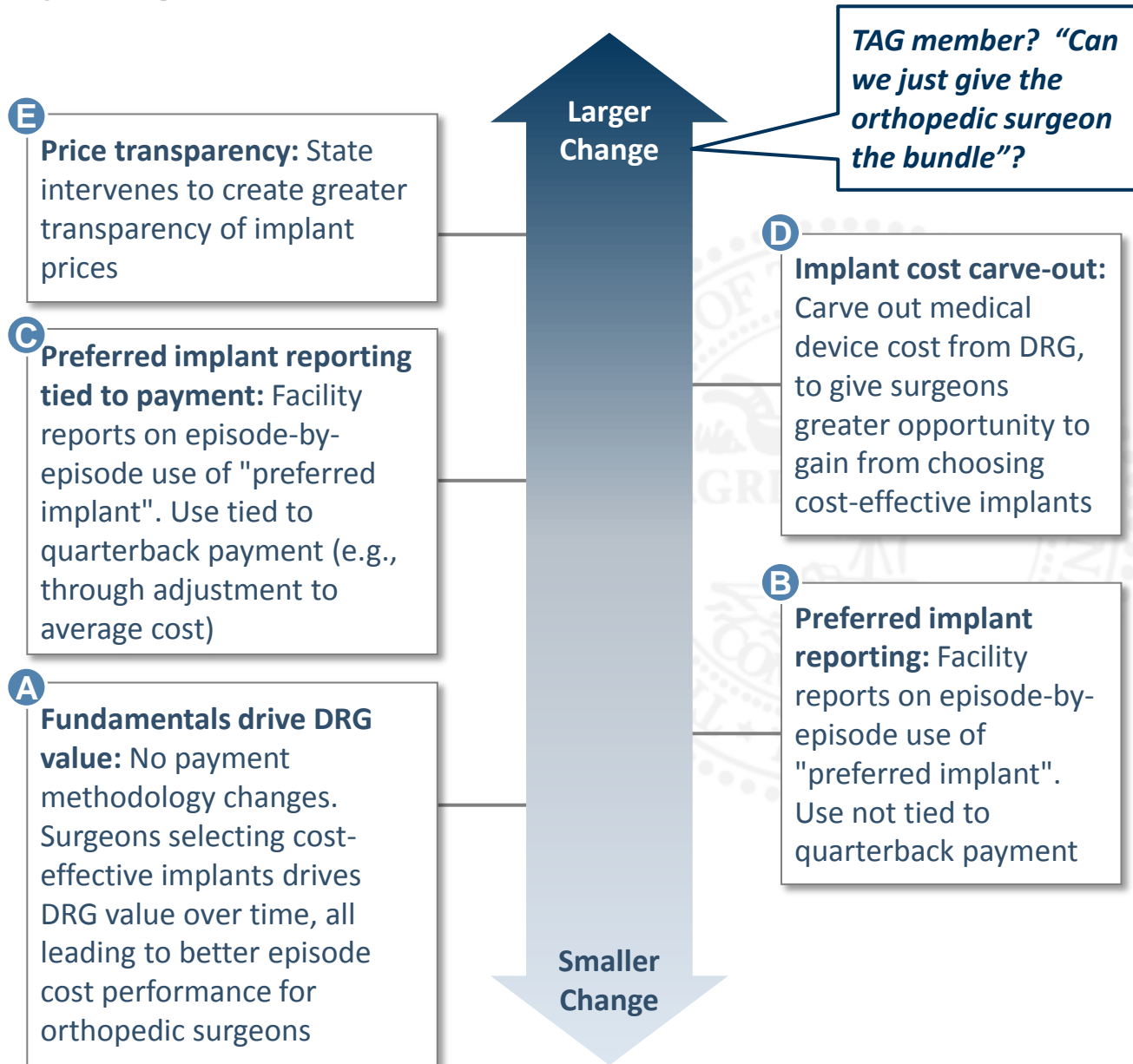


11 Unknown providers (496 episodes) were removed

Source: TennCare, trigger dates during 2012



# Capturing value under the DRG – for discussion



- ### Considerations
- A** Requires minimal change. Episode construct as described will reduce DRG price over time
  - B** Requires hospital reporting. Increase transparency on implant but no tie to payment
  - C** Requires hospital reporting. Increased transparency on implant tied to payment
  - D** Could require large amount of administrative changes. Directly tie implant choice to physician
  - E** Could require state / legal / legislative action

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# Provider report: Key operational aspects to consider

Current working hypothesis  
Still requiring payer finalization

FOR DISCUSSION

Operational aspect	Questions to answer	Arkansas model	Considerations
<b>1</b> Length of performance period	What should be the length of the performance period? How would this be related to reporting frequency?	Annual performance period	<ul style="list-style-type: none"> <li>Shorter performance period allows for more frequent payments</li> <li>Longer performance period includes more data for low volume episodes/providers</li> </ul>
<b>2</b> Frequency of reports	How often should providers receive reports?	Quarterly report generation	<ul style="list-style-type: none"> <li>Interim reports<sup>1</sup> allow providers to track performance btwn payments</li> <li>Overly frequent reports may cause numbing effect or be overlooked</li> </ul>
<b>3</b> Timeliness of data	How recent a time period should payors report on? How quickly can payors generate reports from claims data?	3 month claims run-out	<ul style="list-style-type: none"> <li>A run-out period allows for claims data to come in, payments to be calculated, and reports generated</li> <li>Providers more likely to remember recent data</li> </ul>
<b>4</b> Date range of historical data in each report	How much historical data should be shown (e.g., data even prior to the current performance period)?	12 mo. (prior 4 quarters, ending just before claims run-out)	<ul style="list-style-type: none"> <li>Historical data may put into context performance data from a shorter period</li> <li>Historical data increases the size and complexity of each report</li> </ul>
<b>5</b> Syncing across payors	Should start and end dates of periods align across payors?	Synced across payors	<ul style="list-style-type: none"> <li>Standardized dates create consistency for payors</li> <li>Payors may have preexisting dates</li> </ul>

1 If the reporting frequency is less than the length of the performance period, providers would receive interim reports. Interim reports would show performance in between reports that calculate payments.

# Contents

- Potential path forward on PCMH
- Episode TAG updates
- Key operational decisions on Provider Report design
- **Discussion and next steps**
- Appendix

# October 9<sup>th</sup> Provider meeting

## Preliminary agenda

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- Discuss PCMH charter & market  
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- Discuss final episode designs & areas where payers choose to align  
.....
- Discuss episode level design decisions  
.....
- Review latest timeline  
.....
- Discussion and next steps

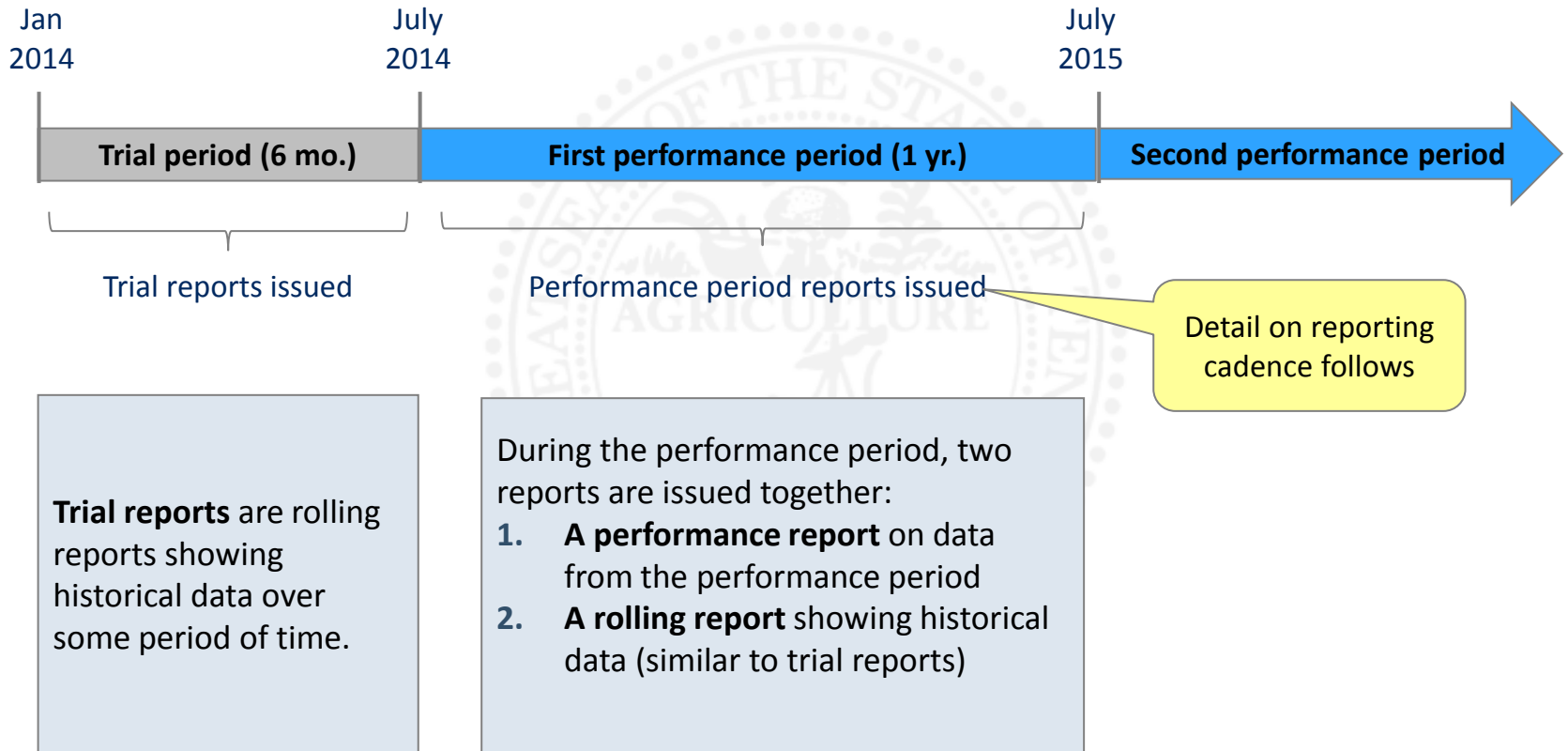
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# Trial period and performance period using Arkansas reporting model

A period of trial reporting acclimates providers to upcoming performance reports

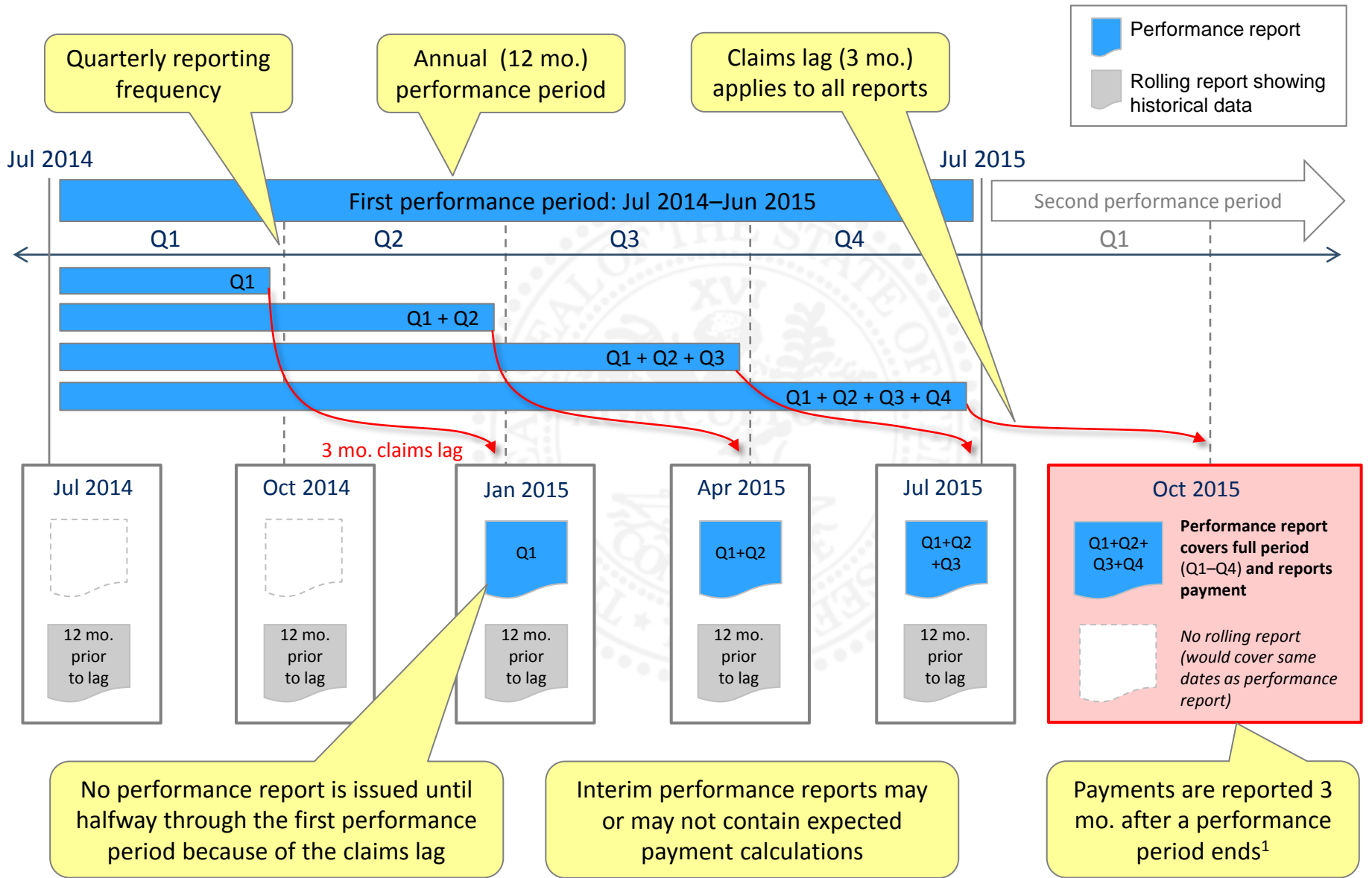
FOR DISCUSSION



# Provider report timeline using Arkansas reporting model

IN DEVELOPMENT

FOR DISCUSSION



Last Modified 9/11/2013 11:54 AM Central Standard Time

Printed 8/7/2013 8:21 AM Central Standard Time

<sup>1</sup> 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.