Strategic Planning and Innovation Group: 
Tennessee Health Care Payment Reform Initiative 

August 2013
Agenda

• Strategic Planning and Innovation Group

• Payment Reform Initiative

• Episode-based payment model

• Patient Centered Medical Home (PCMH)

• For employers to consider
Strategic Planning and Innovation Group

1. Payment Reform
   ✓ Governor-led
   ✓ State Innovation Model design grant
   ✓ Changing the way that TennCare MCOs and coalition partners pay for health care
   ✓ Pay for value instead of volume

2. Cover Tennessee
   ✓ Adjust CoverTN, AccessTN, CoverKids, and CoverRx for the 2014 policy context

3. Insurance Exchange
   ✓ Monitor the federal insurance exchange, assist TN stakeholders
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We face major health care challenges in Tennessee

- The health status of Tennesseans leaves much room for improvement. The state is ranked at or near the bottom of all states on several national health indicators, such as heart disease and diabetes.
- The health care system is hard for patients to navigate, and it does not reward providers who work as a team to coordinate care for patients.
- Health care spending is growing unsustainably. For the last 10 years, insurance premiums have been rising faster than median incomes.
A 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, medical providers, and payers have all demonstrated a **sincere willingness** to move toward payment reform
- By working together, we can make significant progress toward **reducing medical costs and improving care**

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

“It’s my hope that we can provide quality health care 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
Designing “Episode-based” Payment Model

### Basis of payment
- Maintaining patient’s health over time, coordinating care by specialists, and avoiding episode events when appropriate.
- Achieving a specific patient objective at including all associated upstream and downstream care and cost

### TN Payment Reform Approach
- Patient centered medical homes (PCMH)
- Retrospective Episode Based Payment (REBP)

### Examples
- Encouraging primary prevention for healthy consumers and care for chronically ill, e.g., obesity support for otherwise healthy person
- Management of congestive heart failure
- Acute procedures (e.g., hip or knee replacement)
- Perinatal
- Acute outpatient care (e.g., asthma exacerbation)
- Most inpatient stays including post-acute care, readmissions
- Some behavior health
- Some cancers
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What are retrospective episode-based payments?

- **Evidence based**: For each episode of care, the Initiative is convening a Technical Advisory Group of clinicians from Tennessee to advise on all aspects of episode design.

- **Holistic**: Episode-based payments reimburse providers for treatment of conditions or major procedures from start to finish, and include clinically related services provided by various providers over that period of time.

- **Targeted**: Episode-based payments are available to the type of provider or facility most able to impact the cost and quality of the episode and its outcome. This provider or facility is the “quarterback” coordinating the team of care providers.

- **Outcomes-oriented**: Episode-based payments do not dictate clinical decisions. Providers will be rewarded for any way that they achieve the desired outcomes with quality, efficient care.

- **Informative**: Providers will receive information about what happens to their patients throughout the episode—information that has never been available to providers before.
Initial episodes selected for the first wave

**Episode selection driven by diversity considerations** including
- Impacted population
- Therapeutic area
- Spend (State and commercial)
- Quarterback (PAP)

**Asthma Exacerbation**
- Significant proportion of cost incurred at the hospital
- Captures pediatric patients
- Demands emergency response

**Total Joint Replacement (Hip & Knee)**
- Largely covered by commercial segment (vs. TennCare)
- Older patient population
- Primarily elective cases

**Perinatal**
- High case volume across commercial and TennCare
- Touches a large number of providers across the state
How retrospective episodes will work for patients and providers

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.

**Patients and providers deliver care as today (performance period)**

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

5. **Payers** calculate **average cost per episode** for each Quarterback.

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.

- Review claims from the performance period to identify episodes that have occurred and the ‘Quarterback’ involved.
- Compare average costs to predetermined “commendable” and ‘acceptable’ levels.
Review claims from the performance period to identify episodes that have occurred and the ‘Quarterback’ involved.

<table>
<thead>
<tr>
<th>Quarterback role</th>
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<tr>
<td>Review claims from the performance period to identify episodes that have occurred and the ‘Quarterback’ involved.</td>
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### What it means...

- **Physician, practice, hospital, or other provider** in the best position to influence overall quality, cost of care for episode

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### ‘Quarterback’ selection:

- Advisory committees will suggest rule designs for which providers is designated as the “Quarterback” based on the provider with the main responsibility for the patient’s care.

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- Leads and coordinates the team of care providers
- Helps drive improvement across system (e.g., through care coordination, early intervention, patient education, etc.)

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- Rewarded for leading high-quality, cost-effective care
- Receives performance reports and data to support decision-making

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- With the advice of the advisory committees, payers will apply rules for designating a ‘quarterback’
For providers, risk adjusted average cost of the total patient population they serve is what matters – NOT the cost of each episode.
Each payer assesses historic provider average costs for an episode...
... then selects thresholds to promote high quality, guideline-based and cost effective care.
Providers with average costs below the commendable threshold share in the savings*

Individual providers, in order from highest to lowest average cost

* Shared savings may be contingent on meeting certain quality criteria
Providers with average costs between commendable and acceptable do not receive risk-share or gain-share.

Individual providers, in order from highest to lowest average cost.
Providers with average costs above the acceptable limit will have to share in these costs.
By design, episode-based payment rewards high quality care

<table>
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<th>Benefits</th>
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<tr>
<td>Encourages accurate and specific diagnosis</td>
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<tr>
<td>Rewards clinically appropriate treatment and treatment intensity</td>
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<tr>
<td>Encourages clinically appropriate use of medications</td>
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<tr>
<td>Motivates appropriate use of medical professionals across the treatment spectrum</td>
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The holistic approach **rewards providers for effective management** while holding them accountable for downstream outcomes and costs.
For some types of episodes, there may be additional quality objectives not captured in the episode

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<tr>
<th>Two types of quality measures</th>
<th>Examples of options</th>
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</table>
| Quality measures available from claims data | - Threshold quality measures must be met in order for a provider to be eligible for rewards.  
- If quality measures are available in the claims data then including these in the algorithm is relatively easy. |
| Quality measures that must be collected through a new portal | - New data collection requires new infrastructure from payers.  
- Added burden on providers to have to enter information into a separate system.  
- By definition, these measures are not a basis of payment today.  
- Over time, electronic health records may help here. |
Providers will receive several reports from payers:

- **Summary**
  - Overview: Total number of episodes (included and excluded)
  - Average cost of care compared to other providers
  - Quality summary
  - Cost summary
  - Key utilization statistics

- **Performance summary**
  - Data for all episodes the provider is considered the ‘Quarterback’
  - Includes gain sharing and risk sharing eligibility

- **Quality detail**: Detail benchmarks for quality metrics across all providers

- **Cost detail**:
  - Breakdown of episode cost by care category
  - Benchmarks against commendable providers

- **Episode detail**: Cost detail by care category for each individual episode a provider treats

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**Sample provider report**

**Summary – Perinatal**

<table>
<thead>
<tr>
<th>Overview</th>
<th>Total episodes: 282</th>
<th>Total episodes included: 233</th>
<th>Total episodes excluded: 49</th>
</tr>
</thead>
</table>

**Cost of care compared to other providers**

- Gain/Risk share: $0

**Quality summary**

- Linked to gain sharing

**Cost summary**

- Your average cost is acceptable

**Key utilization metrics**

- Avg. number of ED visits per episode
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Why primary care and PCMH?

Most medical costs occur outside of the office of a primary care physician (PCP), but PCPs can guide many decisions that impact those broader costs, improving cost efficiency and care quality.

- The State is currently surveying the landscape to understand the scope of current PCMH efforts and barriers to scale.
- In the coming months, Tennessee will be defining a strategy for the scale-up of PCMH programs.
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For employers to consider
# Stakeholder Involvement

<table>
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<tr>
<th>Stakeholder group</th>
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<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
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</thead>
<tbody>
<tr>
<td><strong>State Innovation Model Public Roundtables</strong></td>
<td><strong>Provider Stakeholder Group</strong></td>
<td><strong>Payment Reform Payer Coalition</strong></td>
<td><strong>Employer Stakeholder Group</strong></td>
<td><strong>Payment Reform Technical Advisory Groups</strong></td>
<td></td>
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</tbody>
</table>
| Stakeholders involved | Open to the public in person or by conference call:  
  - June 26, 10am-noon  
  - July 31, 1-3pm  
  - August 26, 1-3pm  
  - September 25, 1-3pm | Select providers meet regularly to advise on overall initiative implementation | State healthcare purchasers (TennCare, Benefits Administration) and major insurers meet regularly to advise on overall initiative implementation | Periodic engagement with employers and employer associations | Select clinicians meet to advise on each episode of care |
| Meeting rhythm | 4 by October | Monthly | 2 per month | 3 by October | 2-3 per episode |
For employers to consider

• Changes to employers ASO contracts may be required

• No significant employer infrastructure required

• Employees should have better health care experience, but will not have to deal with a new “system”

• Compatible with other reforms: consumer-directed health plans, high performance networks, etc.

• What is (or is not) attractive about this approach to you?