Ready or Not... Tennessee Payment Reform is Here...

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OBJECTIVES

Explore key issues, challenges and concerns with the Tennessee Payment Reform Initiative

1. National Context
2. Tennessee Payment Reform Initiative Background
3. Scope & Key Design Elements
4. Impact on Physician Quarterbacks
5. Steps to Succeed
National Context

April 9, 2015
MARKET URGENCY DRIVING INTEGRATION PACE

01 What percentage of our net revenues will be tied to performance metrics?

02 When will our market tip?

03 Can we improve care & create a market advantage?

FFS

INCENTIVE BASED PAYMENT

PROVIDER NET REVENUE

TIME
UNSUSTAINABLE LEVELS OF HEALTH SPENDING

Paths of national health expenditures under different scenarios for payment reforms

Source: UnitedHealth Center for Health Reform and Modernization, 2012
“...HHS goal of shifting 30% traditional FFS Medicare payment through alternative payment models by the end of 2016... 50% by the end of 2018”

- HHS Press Office: January 26, 2015
ON AVERAGE, MEDICAID IS 26% OF STATE BUDGETS
Healthcare spending per person by state for 2009 (the latest data available)

SOURCE: National Association of State Budget Officers, Kaiser, WSJ
Tennessee Payment Reform Initiative
Background

April 9, 2015
VISION/GOALS FOR TENNESSEE HEALTHCARE

“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

- Within 3-5 years, the initiative aims to have value- and outcomes-based models account for the majority of health care spending
- Payment reform will reward high-quality care and outcomes and encourage clinical effectiveness
- A coalition including TennCare, State Employee Benefits Administration, healthcare providers, and major Tennessee insurance carriers is working to align incentives in Tennessee
- Tennessee has already been awarded a grant from the Federal Department of Health and Human Services to support payment reform.
WHY NOW?

- Proactive preparation more desirable than reactive alternatives (e.g., explicit rationing, rate cuts, more intensive “managed care”, greater regulation, etc.)
- Broad conceptual alignment among stakeholders on desirability to migrating from “volume to value”
- Availability of CMS Innovation Center funding
  - Tennessee received a State Innovation Model (SIM) planning grant of $65M
  - Opportunity to secure additional SIM grant for implementation & testing

SOURCE: State of Tennessee Newsroom and Media Center
HOW WAS THE PLAN DEVELOPED?

- State formed stakeholder committees to facilitate collaboration and incorporation of multiple perspectives in the overall reform initiative.
- Arkansas Health Care Payment Improvement Initiative design used as reference point.

Tennessee Payment Reform Initiative
Scope & Key Design Elements
April 9, 2015
THREE OVERARCHING STRATEGIES

<table>
<thead>
<tr>
<th>STRATEGY</th>
<th>SOURCE OF VALUE</th>
<th>STRATEGY ELEMENTS</th>
<th>EXAMPLES</th>
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<tbody>
<tr>
<td>1. Primary Care Transformation</td>
<td>- Maintaining a person’s health over time, coordinating care by specialists, and avoiding episode events when appropriate</td>
<td>- Patient centered medical homes</td>
<td>- Encouraging primary prevention for healthy consumers and coordinated care for chronically ill</td>
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<td></td>
<td>- Achieving a specific patient objective including associated upstream and downstream cost and quality</td>
<td>- Health homes for people with serious and persistent mental illness</td>
<td>- Coordinating primary and behavioral health for people with SPMI</td>
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<td>- Provide long-term services and supports (LTSS) that are high quality in the areas that matter most to recipients</td>
<td>- Care coordination tool with Hospital and ED admission provider alerts</td>
<td>- Wave 1: perinatal, joint replacement, asthma exacerbation</td>
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<tr>
<td>2. Episodes of Care</td>
<td></td>
<td>- Retrospective Episodes of Care</td>
<td>- Wave 2: COPD, colonoscopy, cholecystectomy, PCI</td>
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<tr>
<td>3. Long Term Services and Supports</td>
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<td>- Quality and acuity adjusted payments for LTSS services</td>
<td>- 75 episodes by 2019</td>
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<td>- Value-based purchasing for enhanced respiratory care</td>
<td>- Aligning payment with value and quality for nursing facilities (NFs) and home and community based care (HCBS)</td>
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<td>- Workforce development</td>
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## WHO’S INVOLVED IN THE TN INITIATIVE?

<table>
<thead>
<tr>
<th>PROVIDERS</th>
<th>PAYORS</th>
<th>PATIENTS</th>
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</thead>
<tbody>
<tr>
<td>All TennCare providers</td>
<td>TennCare / MCOs</td>
<td>TennCare enrollees</td>
</tr>
<tr>
<td>Providers treating State employees</td>
<td>Blue Cross, Cigna</td>
<td>State employees</td>
</tr>
<tr>
<td>Other providers (optional)</td>
<td>Other commercial payors (optional)</td>
<td>Other (optional)</td>
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<table>
<thead>
<tr>
<th>Medicaid, commercial, and Medicare membership</th>
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<tr>
<td>Number of members, Thousands (Percent of total Medicaid and commercial membership)</td>
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<thead>
<tr>
<th>BCBS</th>
<th>United</th>
<th>Amerigroup/Wellpoint</th>
<th>Cigna</th>
<th>Aetna</th>
<th>Other Payers</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 TennCare</td>
<td>460 (9%)</td>
<td>565 (11%)</td>
<td>198 (4%)</td>
<td></td>
<td></td>
<td>1,223 (22%)</td>
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<tr>
<td>2 State Employee Plan¹</td>
<td>150 (3%)</td>
<td></td>
<td></td>
<td>126 (2%)</td>
<td></td>
<td>276 (5%)</td>
</tr>
<tr>
<td>3 Commercial Self Insured (other)</td>
<td>510 (10%)</td>
<td>230 (4%)</td>
<td>104 (2%)</td>
<td>554 (10%)</td>
<td></td>
<td>1,793 (33%)</td>
</tr>
<tr>
<td>4 Commercial Fully Insured</td>
<td>511 (10%)</td>
<td>142 (3%)</td>
<td>82 (2%)</td>
<td>46 (1%)</td>
<td>39 (1%)</td>
<td>939 (18%)</td>
</tr>
<tr>
<td>5 Medicare Advantage</td>
<td>34 (1%)</td>
<td>70 (1%)</td>
<td>3 (0%)</td>
<td>75 (1%)</td>
<td>1 (0%)</td>
<td>127 (2%)</td>
</tr>
<tr>
<td>6 Medicare FFS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>817 (15%)</td>
<td>817 (15%)</td>
</tr>
<tr>
<td>Total</td>
<td>1,665 (31%)</td>
<td>1,007 (19%)</td>
<td>387 (7%)</td>
<td>801 (15%)</td>
<td>176 (3%)</td>
<td>5,359 (100%)</td>
</tr>
</tbody>
</table>

~1.5M members
~27% of all covered lives in TN

Sources:
- Tennessee Benefits Administration Group Health split per Benefits Administration staff, April 2013
- Source: 2012 Health Leaders / InterStudy; State Group Insurance Program 2011 Annual Report
EPISODES OF CARE

- Most developed of 3 strategies and “in-play” already today
- Retrospective episode-based payments beginning with:
  1. Total Joint Replacement (hips & knees)
  2. Asthma Acute Exacerbation/COPD Acute Exacerbation
  3. Perinatal Care

- Focus on **acute healthcare events** such as a surgical procedure or an inpatient hospitalization.
- Encompass care delivered by multiple providers in relation to a specific health care event.
- Providers receive quarterly reports on the cost and quality of care that their patients receive.
- State will roll out new waves of episodes every 6 months, with the goal of designing 75 episodes by the end of 2019.

- Wave 1 includes 3 episodes above
- In May 2014, providers received initial episode reports for Wave 1 from Amerigroup, BCBST, and UnitedHealthcare. 1,700+ reports were sent to 500+ unique providers.
- **Performance period for Wave 1 episodes began January 2015.**
- Initiative working with Tennessee clinicians & stakeholders to design Wave 2: acute and non-acute PCI, cholecystectomy, colonoscopy, and COPD.

SOURCE: State of Tennessee Newsroom and Media Center
HOW EPISODES WILL WORK

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.

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.

Providers deliver care as today.
Payers pay providers as they do today.

SOURCE: State of Tennessee Newsroom and Media Center
RISK ADJUSTED COST MATTERS MOST

SOURCE: State of Tennessee Newsroom and Media Center
EPISODE OF CARE – NOTABLE DESIGN DECISIONS

- All thresholds are absolute (no shared savings based on provider improvement)
- State sets the “acceptable” threshold
- Only the quarterback pays excess cost or shares savings
- Each MCO sets their own commendable and gain-sharing thresholds as well as gain sharing percentage
- The model includes additional quality objectives
  - Evidence-based medicine and practices
  - Guard against under-use of care
- Variety of means to fairly address atypical or complex patients (e.g., risk adjustment, clinical & non-clinical exclusions, cost exclusions, adjustment of thresholds, etc.)
NEXT WAVES OF EPISODES – 75 OVER 5 YEARS

SOURCE: State of Tennessee Newsroom and Media Center
**PRIMARY CARE TRANSFORMATION**

**PATIENT-CENTERED MEDICAL HOMES (PCMHs)**

PCMHs are a logical next step in progressing from volume to value. The PCMH envisions a team-based care delivery model led by Primary Care Provider (PCP) that comprehensively manages patient’s health needs.

- 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

**SOURCE:** State of Tennessee Newsroom and Media Center
UPDATE ON PCMH STRATEGY & ROLLOUT

GOALS

- Accelerate “transition of care delivery”, improving coordination, access, and patient engagement
- Lower total investment costs borne by payers (e.g., for provider training)
- Create learning opportunities so that providers/payers can improve & expand program over time

ELEMENTS STILL UNDER DEVELOPMENT

- Design Timeframe
- Joint Statement of Intent
- Plans to Build on Existing Programs
- Geographic Rollout
- Practice Enrollment Plan
- Reimbursement Model(s)
PCMH ELEMENTS/OPTIONS & DIALOGUE TO-DATE

- **Timeframe**
  - RFP for Detailed Design & Implementation – Closed Late-March 2015
  - Selection of Design & Implementation Firm – April 9, 2015
  - Draft Models – August 2015
  - Models Finalized – Late 2015
  - Pilot Sites Go-Live – Early 2016
  - Scale-Up to Single “Grand Region” *(West, Middle, East) – 2017
  - Roll-Out to 65% of Corresponding Providers - 2019

- **Reimbursement Options** – Some combination of the following:
  - FFS
  - Fixed PMPM care management fee
  - Variable performance based-component

- **Provider Participation Options**
  - Required for network participation
  - Voluntary provider participation (open to all)
  - Competitive or selective participation

- **Degree Of Payer Inclusion**
  - State-led enablement only
  - State payers (TennCare, state employees) launch program independently
  - Multi-payer, multi-book payer launch
## LONG-TERM SERVICES & SUPPORT (LTSS)

<table>
<thead>
<tr>
<th>QUALITY &amp; ACUITY-BASED PAYMENT FOR NFs &amp; HCBCs</th>
<th>VALUE-BASED PURCHASING INITIATIVE FOR ENHANCED RESPIRATORY CARE (ERC)</th>
<th>WORKFORCE DEVELOPMENT</th>
</tr>
</thead>
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<tr>
<td>Nursing facility (NF) and home and community based care (HCBC) payments will be based in part on patient need and quality outcomes</td>
<td>Revised reimbursement structure for ERC services in a nursing facility</td>
<td>Invest in the development of a comprehensive training program for individuals paid to deliver LTSS</td>
</tr>
<tr>
<td>Goal is to reward providers that improve the member’s experience of care and promote a person-centered care delivery model</td>
<td>Point system to adjust rates based on the facility’s performance on key performance indicators (e.g., rates of liberation, decannulation, infection, unplanned hospitalization and death)</td>
<td>Agencies employing better trained and qualified staff will be appropriately compensated for the higher quality of care experienced by individuals they serve</td>
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<td>Strengthened standards of care, and educational programs to promote quality and best practices</td>
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Impact of Initiative on Physician Quarterbacks

April 9, 2015
‘QUARTERBACKS’ AND THEIR RESPONSIBILITIES

- Selection of episode “quarterback” based on historical claims/billings
- ‘Quarterback’ leads and coordinates team of care providers to help drive improvement across system, for example through:
  - Care coordination
  - Early intervention
  - Patient education
  - Etc.
- “Quarterback” receives rewards or penalties based on overall, risk-adjusted cost of episode
PRACTICAL IMPLICATIONS FOR PHYSICIANS

REIMBURSEMENT WILL BE IMPACTED

- Approximately 48% of the covered lives in TN will be shifting to value-based reimbursement, with increasing speed with the rollout of both State and Federal initiatives
- In TN Payment Reform Initiative, ‘quarterbacks’ will receive rewards or penalties based on overall, risk-adjusted cost of episode
- Administrative burden for providers still unclear since payers may still have differing
  - Risk adjustment methodology
  - Commendable and gainsharing thresholds
  - Low-cost outliers

SHIFT IN FOCUS & INVESTMENT WILL BE REQUIRED

Providers will need to invest into development of ‘quarterbacking’ infrastructure and competencies, for example:

- Monitoring and sharing data/results
- Regular meetings with other providers included in episode(s)
- Staying current on relevant emerging episodes
- Etc.
Steps to Succeed
April 9, 2015
1. DISCOVER
Assess where you stand and how your practice will be impacted by the Tennessee Payment Reform Initiative

2. DEVELOP
Create a plan to build-out any needed “quarterbacking” infrastructure and competencies

3. DEPLOY
Execute against your plan, with an eye towards continuous improvement and the introduction of additional episodes of care
DISCOVER – WHERE DO YOU STAND?

1. READ-UP

2. GEAR-UP

3. PARTNER-UP

MARKET CONDITIONS
Educate yourself on everything you can related to the TN Payment Reform Initiative

CAPABILITY ASSESSMENT
- Revenue Transformation
- Clinical Enterprise Maturity
- Enterprise Intelligence

PARTNERSHIP ASSESSMENT
Establish criteria, benchmark and track performance of your partners

OPTIMIZE
RISK CAPABILITY ASSESSMENT

Enterprise Intelligence
- Define the populations
- Understand utilization trends and related costs
- Create more elegant and sophisticated forecasts
- Stress test historic and evolving assumptions
- Build ways to monitor expectations and results

Revenue Transformation
- Understand reimbursement across multiple revenue models (e.g. FFS, value)
- Proactively identify & address process improvement opportunities
- Monitor & rapidly address revenue leakage
- Utilize forward looking data elements to make go-forward decisions
- Quickly adapt and actively manage new revenue models

Clinical Enterprise Maturity
- Organize, build and operate an integrated clinical enterprise
- Build multi-disciplinary teams that cross historic boundaries
- Improve outcomes and manage costs within the populations they serve
- Thoughtfully accept outcomes-based risk and compensation
Questions & Discussion

April 9, 2015
QUESTIONS/DISCUSSION

Thank you for your time and attention.

For further information/questions, please contact:

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