Tennessee
Payment Reform Initiative

Employer Stakeholder Webinar

June 27, 2013

PRELIMINARY WORKING DRAFT, SUBJECT TO CHANGE

Agenda and questions for discussion

Agenda

- Vision for Tennessee Health Care Payment Reform Initiative
- Why we need payment reform
- Intro to payment reform in Tennessee
- Stakeholder involvement & timeline

We are soliciting input from employers

- To what extent have your organizations been discussing innovative payment reform strategies for your health care plans or the plans of the organizations you represent?
- What payment reform issues have you considered most important? What topics do you hope are discussed in the future?
- What are your largest concerns in participating in payment reform in Tennessee through your contracts with health insurance companies?
- How can the State best engage with employers?

Vision for Tennessee

- **At the direction of Governor Haslam**, Tennessee is **changing how the State pays for health care services**
- The goals of the initiative are to **reward high-quality care** and outcomes and **encourage clinical effectiveness**
- A coalition including TennCare, State Employee Benefits Administration, and major Tennessee insurance carriers is **working together** to **align incentives** in Tennessee
- **Tennessee employers can benefit from the initiative by asking their carrier to include their employees** in the new payment methods**.**
- The State of Tennessee has already been **awarded a grant** from the Federal Department of Health and Human Services to support payment reform. 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 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

SOURCE: State of Tennessee Newsroom and Media Center

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- **Why we need payment reform**
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Health care in the 21st Century brings a new set of demands on the system

20th Century system

- System that rewards **volume of services**
  - Fee for service model drives use of services rather than outcomes, quality, or use of evidence-based standards
- Focus on addressing acute events

21st Century system

- System that rewards **value** of services
  - Model pays for outcomes and quality
- Focus on preventing/ managing chronic illness escalation

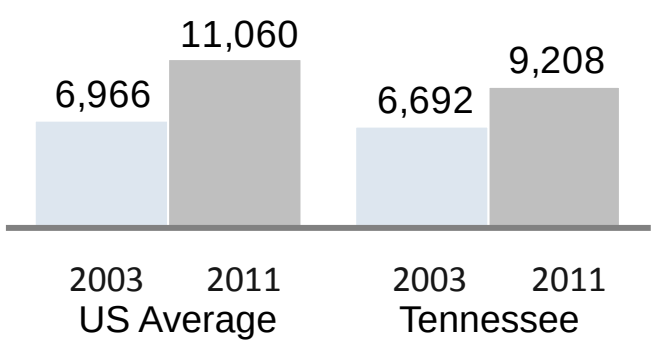
Costs escalating unsustainably at 2-3X general inflation

Payment reform can increase efficiency, drive down costs, and improve quality of health insurance benefits for employers in Tennessee

Key statistics that affect employers/employees

- Across the country, insurance premiums have risen far faster (62%) than median incomes for the under-65 population
  - Premiums in Tennessee increased 42% from 2003 to 2011
- Workers are paying more but getting less-protective benefits
  - Nationally, employee premium contributions have increased by 74%. In Tennessee, contributions increased by 55%
  - Average deductibles more than doubled between 2003 and 2011

Average annual employer premium contribution for family coverage, 2003 and 2011



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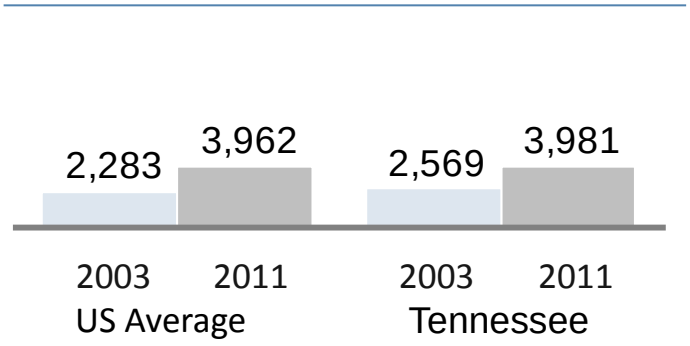


Why employer involvement?

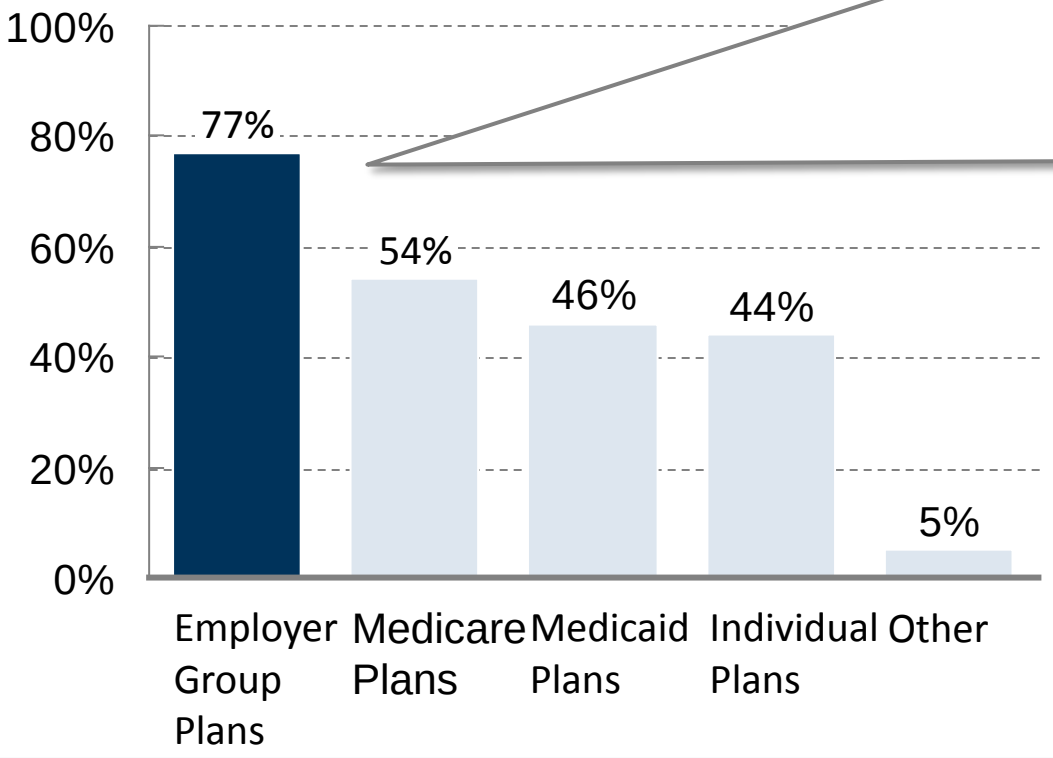
- Payment reform can reduce how much employers spend on health insurance benefits over time
- Payment reform can improve the quality of care practiced by physicians, and received by employees
- Payment reform can improve employees' experience of the health care system
- For self-insured employers, payment reform could have ASO contract implications

SOURCE: The Commonwealth Fund: Realizing health reform's potential Dec 2012

Health plans nationally rank employer group plans as the leading focus for payment model migration

Business lines – focus for future development

Question: *Over the next 12-18 months, which of the following business lines will your plan focus the development of value-based payment models?*



"The most popular target for implementation of value-based payment models is Employer Group business, at 77%... The focus is not surprising given the amount of business employer groups represent for most commercial and BlueCross BlueShield plans. Within those numbers, nearly 60% of health plans expect the new payment models to impact their high-deductible plans, which have grown in popularity with employer groups over the past several years."

- Availity Research, April 2013

SOURCE: Availity Health Plan Readiness to Operationalize Value-Based Payment Models April 2013

Why now for payment innovation?

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

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What actually is payment reform: The State's proposed payment innovation model includes "population" and "episode" based payment

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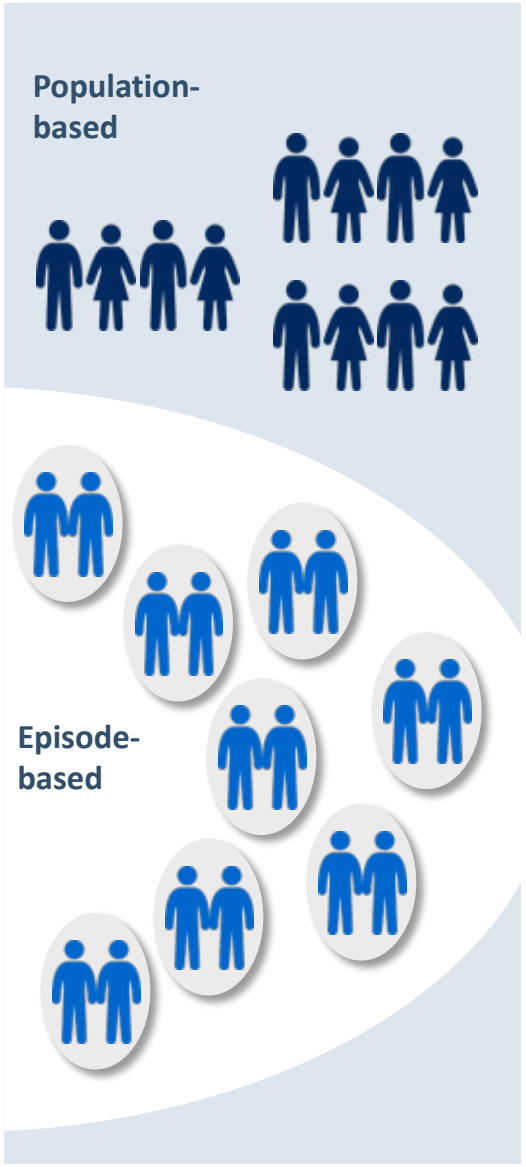


Basis of payment	TN Payment Reform Approach	Examples
▪ Maintaining patient's health over time, coordinating care by specialists, and avoiding episode events when appropriate.	▪ Patient centered medical homes (PCMH)	▪ Encouraging primary prevention for healthy consumers and care for chronically ill, e.g., ▪ Obesity support for otherwise healthy person ▪ Management of congestive heart failure
▪ Achieving a specific patient objective at including all associated upstream and downstream care and cost	▪ Retrospective Episode Based Payment (REBP)	▪ 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

How retrospective episodes 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

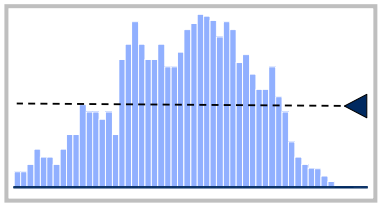
Calculate incentive payments based on outcomes after performance period (e.g. 12 months)

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]

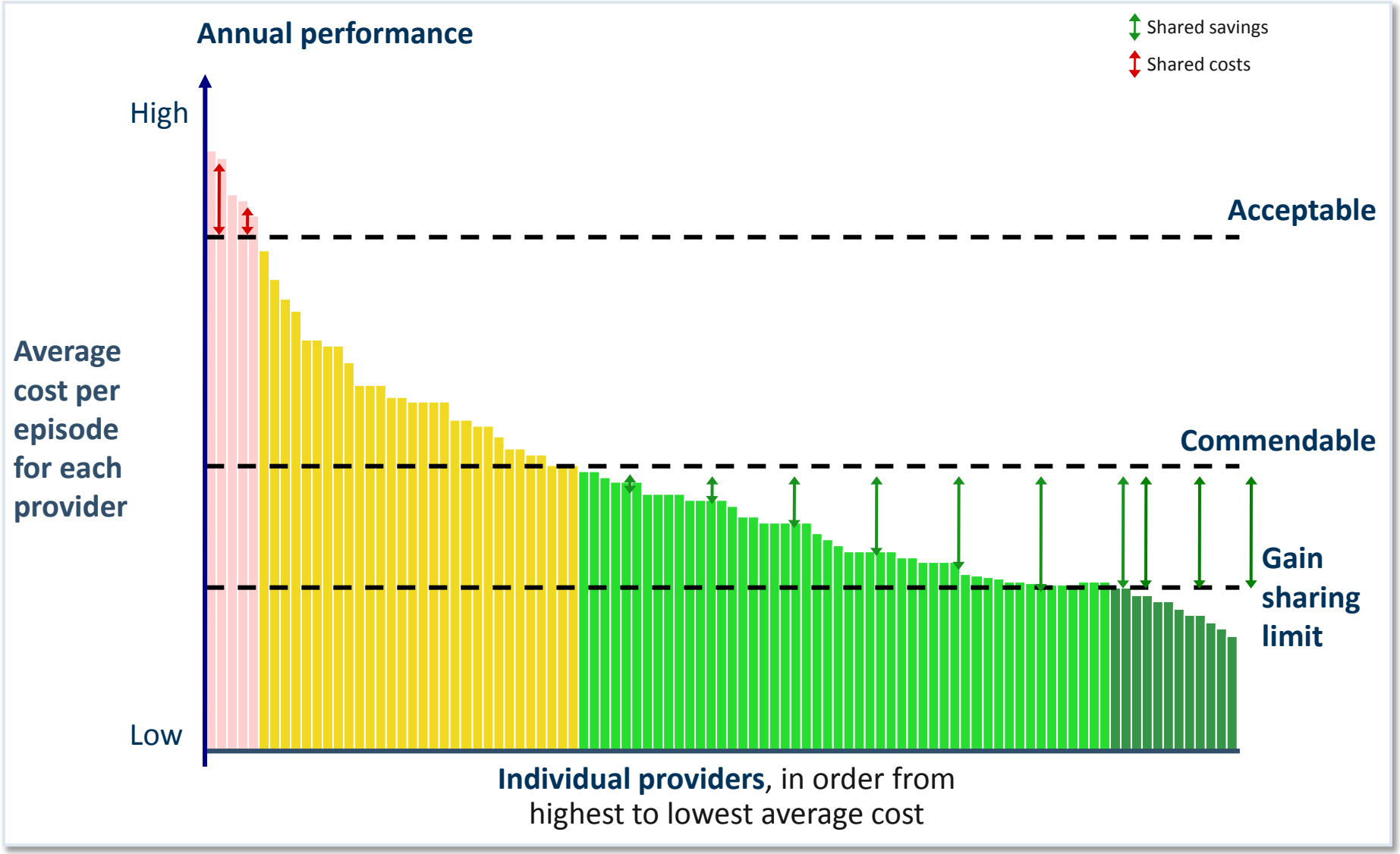
6

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

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

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 **rewards providers for effective management** while holding them accountable for downstream outcomes and costs

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

Objectives	Examples of options
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)
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

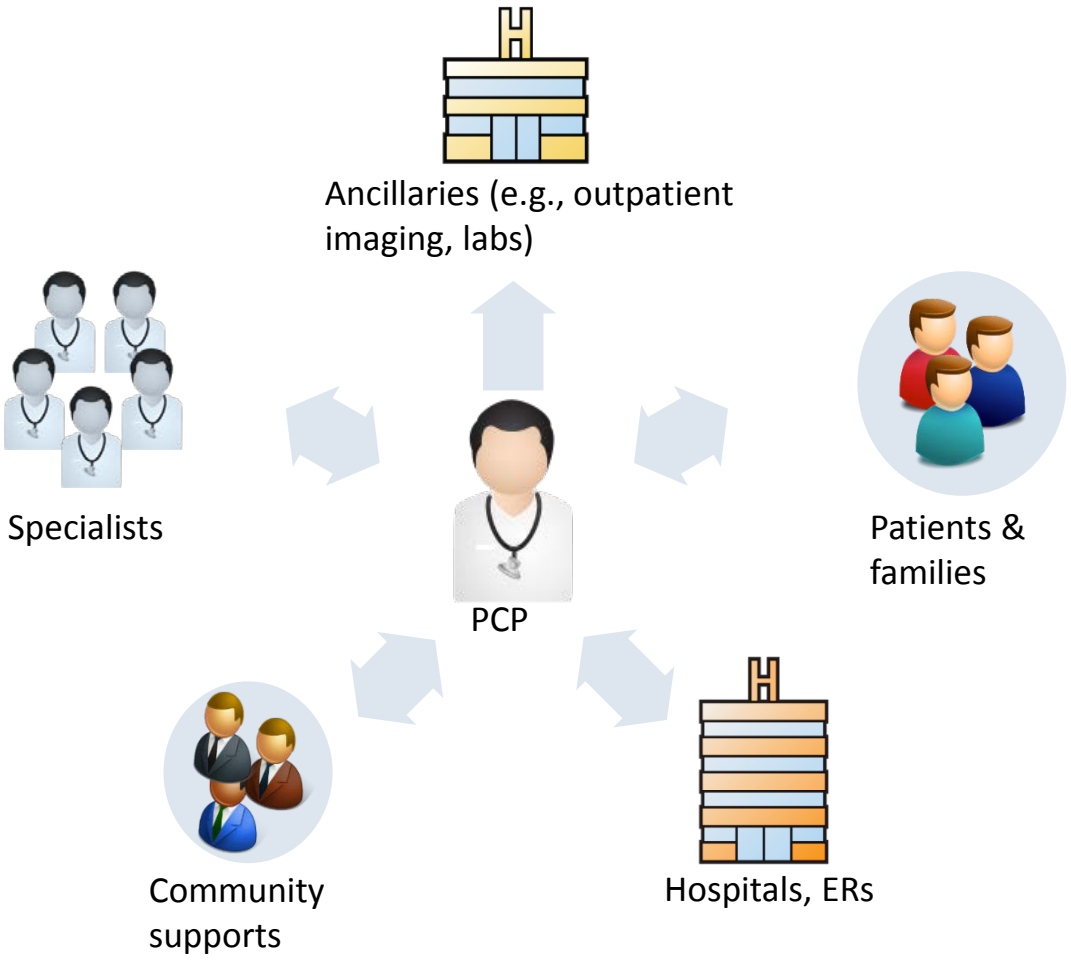
1 Avoid directly linking performance on specific measures to payment as episodic payment already takes this into account

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

Vision	Elements
A team-based care delivery model led by a primary care provider that comprehensively manages a 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

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

Collaboration will be required to scale these initiatives and overcome common challenges

Common set of challenges to implementing payment reform at scale

Engaging providers in change

Many providers are willing to change, however there may not be a consistent set of glide paths for them to adapt

Ensuring sufficient scale

In isolation, most private payers may not have critical scale in all regions to introduce change

Changing patient behaviors

Inconsistency in plan designs, programs and patient education may make it difficult for changes to stick

Developing infrastructure

Could be expensive for single entity to develop all of the required infrastructure (e.g., information exchange, provider portals)

Landscape of Tennessee lives

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Medicaid, commercial, and Medicare membership

Number of members, Thousands (Percent of total Medicaid and commercial membership)

	A BCBS	B United	C Amerigroup/ Wellpoint	D Cigna	E Aetna	Other Payers	Total
1 TennCare	460 (9%)	565 (11%)	198 (4%)				1,223 (22%)
2 State Employee Plan[1]	150 (3%)[1]			126(2%)[1]			276 (5%)
3 Commercial Self Insured (other)	510 (10%)	230 (4%)	104 (2%)	554(10%)	136 (3%)	259 (5%)	1,793 (33%)
4 Commercial Fully Insured	511 (10%)	142 (3%)	82 (2%)	46 (1%)	39 (1%)	118 (2%)	939 (18%)
5 Medicare Advantage	34 (1%)	70 (1%)	3 (0%)	75 (1%)	1 (0%)	127 (2%)	310 (6%)
6 Medicare FFS						817 (15%)	817 (15%)
Total	1,665 (31%)	1,007(19%)	387 (7%)	801 (15%)	176 (3%)	1,322 (25%)	5,359 (100%)

1 Tennessee Benefits Administration Group Health split per Benefits Administration staff, April 2013

SOURCE: 2012 Health Leaders / InterStudy; State Group Insurance Program 2011 Annual Report

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The state will engage a broad array of stakeholders in payment reform and development of the State Innovation Plan

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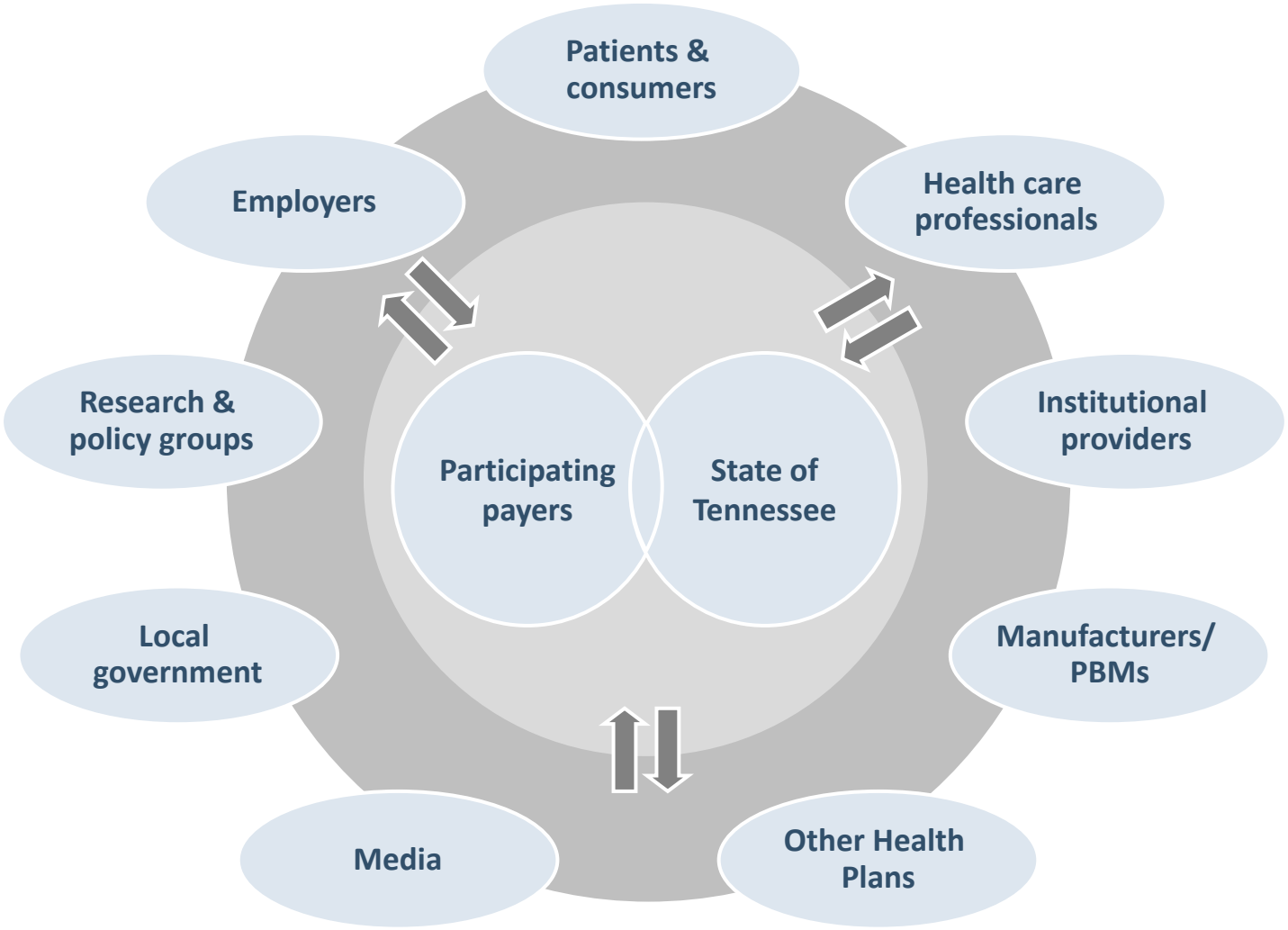

Composition of stakeholder committees

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Stakeholder group	A State Innovation Model Public Roundtables	B Provider Stakeholder Group	C Payment Reform Payer Coalition	D Employer Stakeholder Group	E Payment Reform Technical Advisory Groups
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 health care purchasers (TennCare, Benefits Administration) and major insurers meet regularly to advise on overall initiative implementation	Introductory webinar will be held on Thursday June 27 at 11am CT, and will repeat on July 18 at 11 am CT, followed by additional opportunities to engage	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

How employers can be involved

- Share this information with others in your organizations
  - This presentation will be repeated on July 18 at 11am
- Attend future presentations to stay informed on progress of the Tennessee Health Care Payment Reform Initiative
- Attend Public Roundtable meetings
- Discuss the Tennessee Health Care Payment Reform Initiative with your insurance carrier or ASO contractor

Overview of the first phase

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April - June	June - 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	▪ 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 health care spend**