# Tennessee Payment Reform Initiative

Through Governor Haslam's leadership, the State of Tennessee has launched a state-wide initiative to transition its healthcare payment system to better reward patient-centered, high-quality, high-value health care outcomes for all Tennesseans.

The Initiative is led by the state Division of Healthcare Finance and Administration (the division of state government that includes TennCare) but includes a broad coalition of stakeholders, including the Benefits Administration for state employees and the largest private insurers in Tennessee, with close involvement from many leading healthcare providers. The State anticipates finalizing its strategy by the fall of 2013 and beginning phased implementation in early 2014.

Tennessee's Payment Reform Initiative is a top priority for Governor Haslam. During a joint session of the state Legislature in March 2013, the Governor declared that Tennessee would become a "model for what true health care reform looks like." The Governor is directly involved with the progress of the Payment Reform Initiative and has met with provider and payer stakeholders from across the state.

This paper provides background on the Initiative, the work completed as of early August, 2013, and the planned path forward. The paper's content has been strongly influenced by substantial input from the stakeholders engaged in the Initiative so far.

**The end-state vision, objectives, and timing**

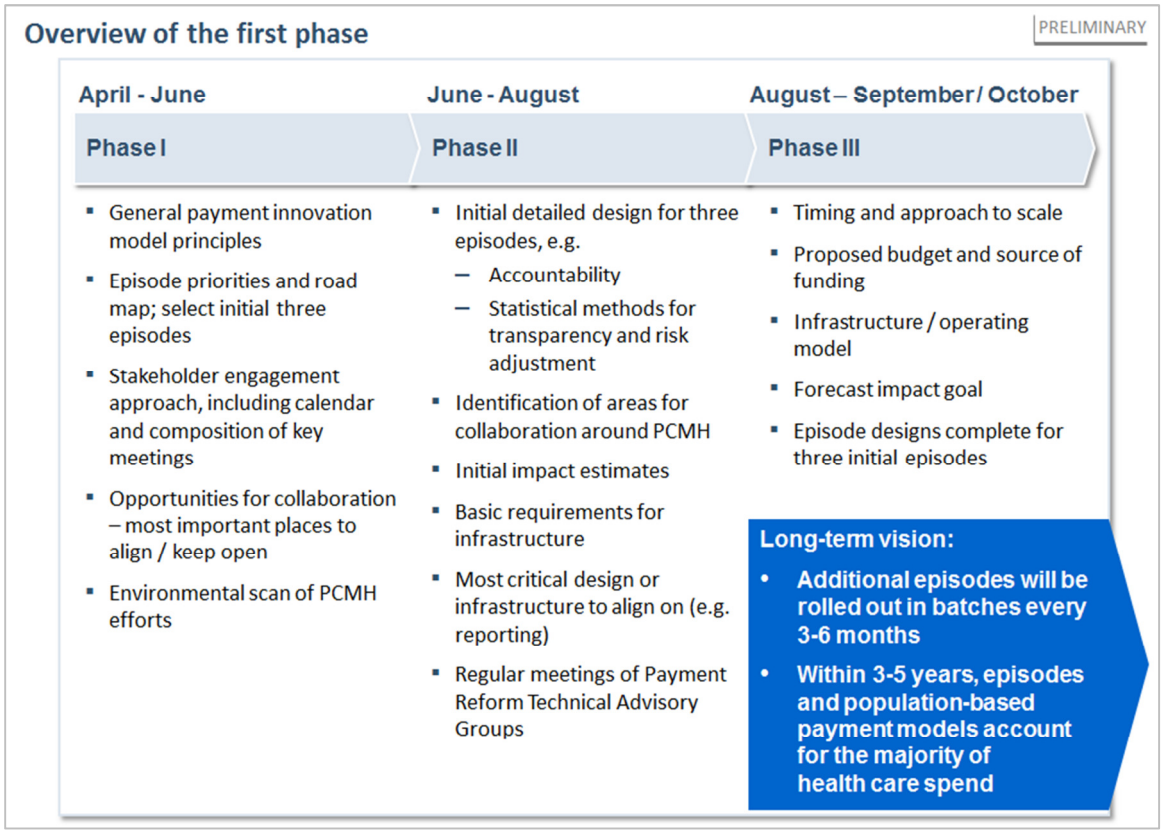
Over the next three to five years, the Initiative plans to migrate a majority of healthcare spending across Tennessee's public and private sector into outcomes-based payment and service delivery models. The goal is to work with all stakeholders to make this transition together.

Today, most healthcare payment from payers to providers in Tennessee is "fee for service", meaning that a healthcare provider is paid to perform a specific activity or task. Fee-for-service payment fails to reward providers who strive for more integrated, coordinated care or who provide excellent primary or secondary prevention.

The Initiative purposefully does not have specific cost reduction or quality improvement targets. Rather, it is based on the belief that a transition to outcomes-based payment will improve the

quality of healthcare delivered in Tennessee, reduce wasteful spending, reduce excessive increases in healthcare costs, and encourage greater value-adding innovation over time. These changes will help improve the economic climate in Tennessee and the well-being of Tennesseans.

The initial phase of the Initiative, from May 2013 to October 2013, is intended to design the approach to making the transition to outcomes-based reimbursement, including the design of the payment models themselves, determination of the pace and sequence of implementation, and delineation of the resources required. The exhibit below describes some specific milestones.




**Why Now?**

The State believes that now is the right time to pursue this Initiative for the following reasons:

- There is broad alignment among stakeholders – both payers and providers – that transitioning from paying for activity to paying for outcomes is important and necessary.
- Paying for outcomes is a national trend with significant momentum. It is better for Tennesseans to shape the future in Tennessee than be forced to accept what may evolve in other parts of the country.

- There is a growing body of experience with outcomes-based payment and advances in technical sophistication (e.g., risk adjustment) increasing feasibility.
- Federal grant dollars are available to support transition costs through the State Innovation Model program[1]. Tennessee has already won a "design grant" and is in competition with other states to receive as much as $60 mm in additional funding per state to support the program over the next 3 years.
- Alternatives to address Tennessee's rising healthcare costs are less desirable for all stakeholders (e.g., benefit limitations, provider rate cuts, greater regulation, etc.).
- Many states across the US are now pursuing similar payment reform initiatives, which provide experiences Tennessee can benefit from, but also raises the importance of Tennessee moving quickly and remaining competitive.

**Two core components: episode-based payment and medical homes**

Following a thorough review of outcomes-based payment strategies and with the input of stakeholders, Tennessee is pursuing two complementary payment strategies: First, a retrospective episode-based payment strategy to reward providers for providing high-quality and efficient care for acute medical and behavioral treatments and conditions. Second, a Patient-Centered Medical Home (PCMH) strategy to reward health care providers who care for their patients on an ongoing basis, promote prevention, treat chronic conditions, and coordinate care over time.

**Episode-based payment** seeks to align incentives with successfully achieving a patient's desired outcome during an "episode of care", in a clinical situation with predictable start and end points. This approach seeks to reward high-quality care, promote the use of clinical pathways and evidence-based guidelines, encourage coordination, and reduce ineffective and/or inappropriate care. Episode-based payment is applicable for most procedures, hospitalizations, acute outpatient care (e.g., broken bones), as well as some forms of treatment for cancer and behavioral health conditions (e.g., ADHD).

[1] The State Innovation Model initiative was created by the Center for Medicare and Medicaid Innovation (CMMI). It makes funding available to support states in designing and testing comprehensive State Innovation Plans, which must be Governor-led and multi-payer; improve health, improve health care, and reduce costs; and incorporate broad range of stakeholder input. Tennessee was selected for 1 of 19 "Design" or "Pre-Testing" grants of up to $3 mm each to develop a plan. 6 additional states received "Testing" grants between $30 to $45 mm each. A second opportunity to receive Testing grants is expected to be announced in the first quarter of 2014 and Tennessee plans to submit an application for consideration.

Three examples of episodes of care are listed below:

- A total hip replacement including diagnostics (e.g. imaging and laboratory tests), professional and facility fees, medical device(s), physical therapy and other forms of post-acute care, pharmaceuticals, and treatment of any complications and/or related readmissions.
- A hospitalization for severe asthma exacerbation including professional and facility fees, post-acute care, care management through the transition to ongoing outpatient care, pharmaceuticals, and treatment of any complications and/or related readmissions.
- A pregnancy including prenatal care, delivery, postpartum care, and treatment of any complications or related readmissions of the mother.

In today's system, as many as a dozen different providers may be involved in each of these episodes of care. But today, since each provider is paid "piecemeal", no provider is rewarded financially for helping ensure that the desired outcome is delivered with the highest quality at lowest cost across the entire continuum of the episode.

During the current phase of work, the Initiative is using input from a wide array of stakeholders to design an episode-based payment model that will succeed in Tennessee. While many design elements remain a work in progress, the Initiative expects the Tennessee model to include the following characteristics:

- Principal Accountable Provider, or "quarterback": In most cases, a single provider, either clinician or institution, will be designated as the Principal Accountable Provider (or "PAP") for each episode of care. The PAP is in effect the "quarterback" for the care delivered in that episode. Tennessee's strategy is to better align payment with each quarterback's performance, both quality and cost, for the episodes of care that they help deliver.

  PAPs will be designated only when they have significant influence over clinical decisions and the care delivered during the episode of care. That said, PAPs do not need to have direct managerial, legal, or financial control over other providers that may participate in the episode.

  The type of provider designated as a PAP will vary by episode. Examples include physicians or physician groups, hospitals, or mental health professionals. For example, a hospital that admits an asthma patient could be designated the PAP for that episode of care, whereas a surgeon who performs a hip replacement could be designated as the PAP for that procedure.

- Balanced financial accountability: Tennessee's strategy is to set quality and cost expectations for each episode based on the input of a cross-functional technical advisory group of experts, and provide financial rewards to PAPs who deliver excellent performance. To the extent that there are PAPs who deliver consistently poor performance, they will be expected to bear some level of financial risk for that performance. Said differently, the Initiative expects payers to continue to assume 100% of "actuarial risk", but intends to start sharing accountability for care delivery performance with the providers best able to influence it.

  The Initiative intends to calibrate the incentive levels, both upside and risk, to where they are meaningful but manageable, especially in the initial years of the Initiative.

  Finally, the Tennessee model will be designed to give all PAPs the potential to financially benefit (compared with today) if they already deliver strong performance or make required improvements.

- Retrospective administration: Rather than paying PAPs a lump sum "bundled payment" for each episode of care at its onset, the Tennessee model will calculate performance after services have been performed, reconciling any gains or losses periodically (e.g., quarterly, yearly). In other words, all providers involved in an episode of care will be paid as they are today, under the terms of their existing contracts, for services rendered. Periodically, performance for each PAP will be measured for each episode where they are designated the PAP. Measuring performance would include calculating all costs incurred during the episode along with assessing quality of care provided. The PAPs' performance, on average, will be compared with pre-existing thresholds. Based on their performance, payers will then "reconcile" total payment with each PAP. The detailed mechanics of this reconciliation process and the timing of cash flows are currently being defined.

- Fairness: State leaders are keenly aware that it is critical to ensure fairness for all providers in this model. For example, when appropriate the costs of an episode will be risk-adjusted so that providers who deliver effective and efficient care to more complex patients are appropriately rewarded. Some episodes with patients whose co-morbidities, age or other characteristics demand a different care pathway altogether would be excluded from the model. The State is also considering whether and how to apply protection for outliers (very high- or low-cost episodes after risk-adjustment). Finally, other transitional support and/or protections are also being considered.

- Performance measurement and transparency: The Initiative will provide PAPs with significant data and information related to episodes of care for which they are accountable, to enable greater understanding of the drivers of performance. With actionable information, PAPs should have transparency into underlying costs and quality indicators for their episodes, and should be able to assess their performance relative to all other PAPs for that episode type.

The first wave of episodes in Tennessee will include perinatal care, total joint replacements, and acute asthma exacerbations. The timing of execution and scale up of episode based payment is under development.

**Patient Centered Medical Homes** (PCMHs) are intended to help patients maintain or improve their health over time. At their best, PCMHs encourage primary prevention for healthy or at-risk patients, coordinate care for the chronically ill (e.g., support in the management of congestive heart failure), and help patients make value-conscious treatment and provider choices. A PCMH's performance is best measured by how its panel of patients' health status, quality of life, and total healthcare costs change over time.

Payers can support the creation and success of PCMHs by aligning payment/incentives with the PCMH's goals, supporting aspects of business model transformation required, and providing enabling data and/or infrastructure.

Multiple payers in the State have medical home pilots initiatives underway, but none are yet implemented at scale. The development of Tennessee's approach to supporting the implementation and scale-up of these initiatives is in progress. The Initiative is seeking significant stakeholder input and advice as this develops.

**Stakeholder engagement**

The Governor has asked Healthcare Finance Administration (HCFA) and Benefits Administration to lead the Initiative from the State, and create a highly transparent process that includes a wide array of stakeholders. As such, the following are underway:

- The State has held two public roundtable meetings (in Nashville, with links to other locations in the State) and the dates for the next two roundtables in August and September

have been set. The State and has launched a website to share key documents and updates: http://www.tn.gov/HCFA/strategic.shtml.

- The State convenes monthly meetings of the Provider Stakeholder Group, which includes representation from major physician and hospital associations in the State. At the request of the members of this group, the major insurance carriers in the State also participate in the meeting. The initial Provider Stakeholder Group meeting was held on May 22, 2013.
- Payers, including Amerigroup Wellpoint, the Benefits Administration, Blue Cross Blue Shield of Tennessee, Cigna, HCFA, and UnitedHealthcare, have met every second week since May 15, 2013.
- In late June 2013, the Initiative started an intensive process of engaging clinicians across the State in designing Tennessee's first wave of episodes. The composition of three Technical Advisory Groups (TAGs), composed of 12-16 providers, was finalized in early July with broad representation across provider type, the State's three regions, rural vs. urban locations, and type of practice. The State solicited nominations from providers, payers, and other stakeholders and TAGs will meet into September to complete the design of the first wave of episodes.
- The State has held two webinars for employers, and is working with regional and state Chambers of Commerce, HealthCare21Business Coalition, the Memphis Business Group on Health, and Healthy Memphis Common Table to engage employers. In addition, the State is a member of the Catalyst for Payment Reform, which provides opportunities to engage with national employers and health care purchasers.
- The State and other participating stakeholders have encouraged and participated in many other forms of dialogue with individuals and institutions (for example, with the Tennessee Hospital Association Vision Task Force) to understand their perspectives and gather their input.

Across these interactions, the State is acting as the lead convener. It hopes to drive progress by assuming the following responsibilities:

- Gather input and facts; define common challenges
- Bring "straw-man" proposals to the table for discussion
- Consult the Provider Stakeholder Group as well as the payers in the decision-making process

- Facilitate collaboration, discussion, and debate among payers and providers regarding issues of common interest
- Lead by example; align State contracts – both Tenncare and State Employee Benefits – with payment reform principles and models
- Use payment reform models to apply for State Innovation Model testing funds.

**Enabling investments**

The State is evaluating possible investments that could provide critical infrastructure or other enabling capabilities to the Payment Reform Initiative, with input from a broad range of stakeholders. Current priorities for evaluation are investments that:

- Enable data/performance transparency, including the creation and distribution of reporting tools that help providers understand their performance and identify opportunities for improvement
- Advance the healthcare workforce. The State is gathering background information on State licensure, training, scope of practice statutes, graduate medical education, and incentives to draw practitioners to rural areas, and is in the process of assessing strategies to improve the effectiveness, efficiency, and mix of the health care workforce in the State.

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The Tennessee Payment Reform Initiative has begun the process of designing a series of innovations that promises to transform patient-centered care in Tennessee and create an outcomes-based health system for the State. With a concerted effort of the State's healthcare leaders, Tennessee can make a definitive turn that promises far-reaching impacts for the health and quality of life for all Tennesseans, and for the affordability of top-quality care in our State.