GETTING MORE BANG FOR THE BUCK
CSG ANNUAL MEETING
Darin Gordon
Medicaid makes up a significant portion of total U.S. health spending. The chart shows the following sources of spending:

- **Private Health Insurance**: 35%
- **Medicare**: 22%
- **Other Public & Private**: 12%
- **Consumer Out of Pocket**: 14%

Total health spending is $2.5 trillion.

**NOTE**: Health spending total does not include administrative spending.

Medicaid is a major financing source for health care services

Medicaid as a share of spending by select services, 2013

<table>
<thead>
<tr>
<th>Service</th>
<th>Total National Spending (billions)</th>
<th>Medicaid as a Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Health Services and Supplies</td>
<td>$2,469</td>
<td>17%</td>
</tr>
<tr>
<td>Hospital Care</td>
<td>$937</td>
<td>17%</td>
</tr>
<tr>
<td>Professional Services</td>
<td>$778</td>
<td>8%</td>
</tr>
<tr>
<td>Nursing Home Care</td>
<td>$156</td>
<td>30%</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>$271</td>
<td>8%</td>
</tr>
</tbody>
</table>

• NOTE: Includes neither spending on CHIP nor administrative spending. Definition of nursing facility care was revised from previous years and no longer includes residential care facilities for mental retardation, mental health or substance abuse. The nursing facility category includes continuing care retirement communities.

TennCare - Medicaid in Tennessee

More than 1.4 million Tennesseans are enrolled in the program
That's more than 20% of the state's population

1,469,900

53%
TennCare pays for more than 50 percent of births in the state

2,534,700
Mental health & substance abuse counseling visits

2,347,500
Outpatient visits

544,900
Children dental check-ups

310,200
Receive Medicare assistance

2,250
Prosthetics

2,639,300
Prescriptions to treat diabetes, heart disease, and asthma

762,900
Inpatient days

455,000
Well-child visits

41,400
Treated for cancer

78
Transplants

50%
All members are enrolled in one of 3 health plans which consistently ranked in the top 50% nationwide.

Provides health insurance to approximately 50% of the state's children

Transplants

41,400

2,639,300

762,900

455,000

310,200

544,900

2,347,500

2,534,700

1,469,900

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4

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4
UT conducts an annual survey of TennCare members. Satisfaction has remained above 90% for the past 7 years.

94% of respondents said they initially sought care at a doctor’s office or clinic rather than a hospital.

“TennCare just has [a] really well-run system right now.” – Matt Salo, Executive Director of the National Association of Medicaid Directors (NAMD). From Governing Magazine Oct. 6, 2015
TennCare Successes - Fiscal

TennCare Financial Trends

According to a GAO report released in June 2014, TN was tied for the 4th lowest Medicaid spend per enrollee nationwide.

This graph shows projected medical trend for commercial insurance, Medicaid nationally, and TennCare. (Sources: Price WaterhouseCooper, CMS National Health Expenditure Data, and TennCare budget data)

Change in State Medicaid Spending as a Share of Own-Source Revenue, 2000 and 2013*

Percent point increase from 2000 to 2013 in Medicaid spending as part of state budget (state dollars).

TennCare Appropriations

For the past 10 years we’ve consistently remained approximately 20% of state appropriations.

* So as not to under-report TennCare Appropriations, 2009, 2010 & 2011 were increased to account for ARRA. The increases for these years were taken from the 2011 Governor’s Recommended Budget.


*Own-source revenue is derived from the U.S. Census Bureau’s “general revenue” minus federal funds to states
Access to Meaningful Data is Essential
Access to Meaningful Data is Essential

Enrollees
Total = 68.0 Million

Expenditures
Total = $420 Billion

Children 48%
Adults 27%
Elderly 9%
Disabled 15%

Disabled 42%
Elderly 21%
Adults 15%
Children 21%

SOURCE: Health expenditures: KFF calculations using 2013 NHE data from CMS, Office of the Actuary
### Breakdown of membership and spend by demographics

**TennCare**

<table>
<thead>
<tr>
<th>CY2014</th>
<th>Annualized members</th>
<th>Share of total</th>
<th>Initial baseline spend</th>
<th>Share of total</th>
<th>PMPM USD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Thousands</td>
<td>Percent</td>
<td>USD millions</td>
<td>Percent</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-17</td>
<td>349</td>
<td>27</td>
<td>909</td>
<td>14</td>
<td>217</td>
</tr>
<tr>
<td>18-64</td>
<td>176</td>
<td>14</td>
<td>1,375</td>
<td>22</td>
<td>651</td>
</tr>
<tr>
<td>65 and above</td>
<td>21</td>
<td>2</td>
<td>306</td>
<td>5</td>
<td>1,210</td>
</tr>
<tr>
<td>Total</td>
<td>546</td>
<td>42</td>
<td>2,590</td>
<td>41</td>
<td>395</td>
</tr>
<tr>
<td>Female</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-17</td>
<td>334</td>
<td>26</td>
<td>706</td>
<td>11</td>
<td>177</td>
</tr>
<tr>
<td>18-64</td>
<td>366</td>
<td>28</td>
<td>2,188</td>
<td>35</td>
<td>499</td>
</tr>
<tr>
<td>65 and above</td>
<td>48</td>
<td>4</td>
<td>793</td>
<td>13</td>
<td>1,364</td>
</tr>
<tr>
<td>Total</td>
<td>748</td>
<td>58</td>
<td>3,687</td>
<td>59</td>
<td>411</td>
</tr>
</tbody>
</table>

**Grand total:**

- **1,294K**
- **$6,277M**
- **$404**

---

**Note:** Applies only exclusion of ineligible members and foster care spend

**SOURCE:** TN 2011-2014 claims data
# Initial baseline spend by service category

## TennCare

### Concentration of spend by service

**CY2014, $M**

<table>
<thead>
<tr>
<th>Service Category</th>
<th>Initial baseline spend</th>
<th>Share of total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospital and ED (46%)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital inpatient care</td>
<td>1,086</td>
<td>17%</td>
</tr>
<tr>
<td>ED care</td>
<td>433</td>
<td>7%</td>
</tr>
<tr>
<td>Hospital outpatient care</td>
<td>1,351</td>
<td>22%</td>
</tr>
<tr>
<td><strong>Office and clinic (10%)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office and clinic care</td>
<td>632</td>
<td>10%</td>
</tr>
<tr>
<td><strong>Supportive and institutional care (25%)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Institutional care</td>
<td>1,189</td>
<td>19%</td>
</tr>
<tr>
<td>Home and community-based care</td>
<td>381</td>
<td>6%</td>
</tr>
<tr>
<td><strong>Pharmaceuticals (15%)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescription drugs</td>
<td>891</td>
<td>14%</td>
</tr>
<tr>
<td>Specialty pharma</td>
<td>39</td>
<td>1%</td>
</tr>
<tr>
<td><strong>Diagnostics (2%)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lab and pathology</td>
<td>87</td>
<td>1%</td>
</tr>
<tr>
<td>Radiology</td>
<td>53</td>
<td>1%</td>
</tr>
<tr>
<td><strong>Other (2%)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ancillary services</td>
<td>81</td>
<td>1%</td>
</tr>
<tr>
<td>DME and supplies</td>
<td>5</td>
<td>0%</td>
</tr>
<tr>
<td>PT/OT/ST</td>
<td>21</td>
<td>0%</td>
</tr>
<tr>
<td>Other locations</td>
<td>2</td>
<td>0%</td>
</tr>
<tr>
<td>Other types of care</td>
<td>26</td>
<td>0%</td>
</tr>
</tbody>
</table>

**Total spend=$6,277M**

**SOURCE:** TN 2011-2014 claims data
## Breakdown of adjusted spend by chronic condition

<table>
<thead>
<tr>
<th>2014, %</th>
<th>Share of members with condition</th>
<th>Adjusted spend associated with members with condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alzheimer’s disease</td>
<td>0%</td>
<td>1%</td>
</tr>
<tr>
<td>Arthritis</td>
<td>4%</td>
<td>16%</td>
</tr>
<tr>
<td>Asthma</td>
<td>9%</td>
<td>17%</td>
</tr>
<tr>
<td>Atrial Fibrillation</td>
<td>0%</td>
<td>2%</td>
</tr>
<tr>
<td>Cancer (breast, colorectal, lung, and prostate)</td>
<td>0%</td>
<td>4%</td>
</tr>
<tr>
<td>Chronic Kidney Disease</td>
<td>1%</td>
<td>12%</td>
</tr>
<tr>
<td>COPD</td>
<td>5%</td>
<td>18%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>4%</td>
<td>15%</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>1%</td>
<td>8%</td>
</tr>
<tr>
<td>Hyperlipidemia</td>
<td>6%</td>
<td>18%</td>
</tr>
<tr>
<td>Hypertension</td>
<td>9%</td>
<td>30%</td>
</tr>
<tr>
<td>Ischemic Heart Disease</td>
<td>1%</td>
<td>8%</td>
</tr>
<tr>
<td>Osteoporosis</td>
<td>0%</td>
<td>2%</td>
</tr>
<tr>
<td>Stroke</td>
<td>1%</td>
<td>5%</td>
</tr>
<tr>
<td>At least one condition</td>
<td>22%</td>
<td>55%</td>
</tr>
</tbody>
</table>

1 Not mutually exclusive categories

Note: Excludes dual eligibles and TPL; excludes dental, vision, transportation, DME, home health, nursing home and HCBS services; spend and PMPM may change depending on the final spend exclusion

SOURCE: TN 2011-2014 claims data
Over half of Medicaid beneficiaries receive care through Managed Care Organizations (MCOs) – and growing. States are also increasingly covering long term care in managed care, primarily through managed long-term services and supports (MLTSS) programs.
New Populations and Services in Managed Care

**New Populations**

- Traditionally served mothers and children—a relatively young and healthy group
- States increasingly enrolling higher-needs and higher-cost beneficiaries
  - Beneficiaries with serious mental illness
  - Beneficiaries with substance abuse disorders
  - Intellectually & Developmentally disabled beneficiaries
  - Dual eligible beneficiaries

**New Services**

- States “carving in” new benefits, such as:
  - Behavioral health services
  - Pharmacy
  - Long-term nursing home stays
  - Hospice care
  - Personal care services
  - Home health services
There are 19 ACOs participating in the Pioneer ACO Model in 11 states.

State Innovation Model Design & Testing States

- SIM Testing States (17) (round 1 & 2)
- SIM Design States (17)

Pioneer ACO State

Comprehensive Primary Care Initiative States

Note: Arkansas, Colorado, New Jersey, and Oregon all have statewide pilots. New York’s pilot is focused in the Capital District-Hudson Valley Region, Ohio and Kentucky’s pilot is focused in the Cincinnati-Dayton Region, and Oklahoma’s is focused in the Greater Tulsa Region.
## New Payment Models and Delivery Structures

<table>
<thead>
<tr>
<th>Select examples</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Payor-led</strong> integrated network</td>
<td>- Payor-led affiliation or acquisition of health system which seeks full clinical and operational integration to reduce cost, improve member experience, and manage referral volume</td>
</tr>
<tr>
<td><strong>Provider-led</strong> integrated network</td>
<td>- Provider system builds a health-plan, leveraging brand name to drive volume to provider system</td>
</tr>
<tr>
<td>ACO</td>
<td>- An organization of health care providers accountable for quality, cost, and overall care; share cost savings if performance metrics are met</td>
</tr>
<tr>
<td>Episodes of care</td>
<td>- Covers all aspects of preadmission, inpatient, and follow-up care, including postoperative complications within a set time period for procedures, e.g., hip replacement</td>
</tr>
<tr>
<td>Patient centered medical home</td>
<td>- Team of physicians and extenders, coordinated by a PCP coordinate provide high levels of coordinated care; typically tied to P4P contract</td>
</tr>
<tr>
<td>Pay for value</td>
<td>- Payment bonus tied to efficiency metrics (e.g., reduction in ER visits, imaging)</td>
</tr>
<tr>
<td>“Basic P4P”</td>
<td>- Payment upside based on performance metrics linked to value creation (e.g. BCSMA Alternative Quality Contract / AQC)</td>
</tr>
</tbody>
</table>
## New Payment Models and Delivery Structures

<table>
<thead>
<tr>
<th>Source of value</th>
<th>Strategy elements</th>
<th>Examples</th>
</tr>
</thead>
</table>
| • Maintaining a person’s health overtime
  • Coordinating care by specialists
  • Avoiding episode events when appropriate | • Patient Centered Medical Homes
  • Health homes for people with serious and persistent mental illness
  • Care coordination tool with Hospital and ED admission provider alerts | • Encouraging primary prevention for healthy consumers and coordinated care for the chronically ill
  • Coordinating primary and behavioral health for people with SPMI |
| • Achieving a specific patient objective, including associated upstream and downstream cost and quality | • Retrospective Episodes of Care | • Wave 1: Perinatal, joint replacement, asthma exacerbation
  • Wave 2: COPD, colonoscopy, cholecystectomy, PCI
  • 75 episodes by 2019 |
| • Provide long-term services and supports (LTSS) that are high quality in the areas that matter most to recipients | • Quality and acuity adjusted payments for LTSS services
  • Value-based purchasing for enhanced respiratory care
  • Workforce development | • Aligning payment with value and quality for nursing facilities (NFs) and home and community based care (HCBS)
  • Training for providers |
Primary Care Transformation

Patient Centered Medical Homes (PCMH) for all TennCare members

- Prevention and chronic disease management
- Avoiding episode events when appropriate
- The highest cost 5% of TennCare members account for nearly half of total adjusted spend (physical and behavioral health only)
- Members in the highest cost 5% were also in that category the previous year 43% of the time.

Health Homes for TennCare members with Severe Mental Illness

- Behavioral and physical health services integration
- Individuals with behavioral health needs make up only 20% of the TennCare population, but 39% of the total spend.

Distribution of claimants\(^1\) by spend rank

<table>
<thead>
<tr>
<th>Percent of adjusted spend, CY2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>48</td>
</tr>
<tr>
<td>The top 5% of claimants account for 48% of total adjusted spend</td>
</tr>
<tr>
<td>14</td>
</tr>
<tr>
<td>The top 15% of claimants account for 71% of the total adjusted spend</td>
</tr>
<tr>
<td>9</td>
</tr>
<tr>
<td>7</td>
</tr>
<tr>
<td>5</td>
</tr>
<tr>
<td>4</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>&lt;1</td>
</tr>
<tr>
<td>&lt;1</td>
</tr>
<tr>
<td>&lt;1</td>
</tr>
<tr>
<td>&lt;1</td>
</tr>
<tr>
<td>5% most costly claimants</td>
</tr>
<tr>
<td>5% least costly claimants</td>
</tr>
</tbody>
</table>

2014 Medicaid patients and spend\(^1,2\)

Annualized patients, share of dollars

- Patients with BH needs
  - 20%
  - 80%
- Patients with no BH needs
  - 39%
  - 61%

1 Distribution of unique claimants shown, excluding members without claims.
   Note: Does not include crossover and dental claims, supplemental payments, intellectual disability services, Medicare services, CoverKids, payments to DCS, DME, vision, transportation, nursing home, long-term care and home health, as well as members who are dual eligible or have third party liability. Top 5% members selected from claimants only (unique claimant basis).

2 Most inclusive definition of patients with BH needs used here of members who are diagnosed and receiving care, diagnosed but not receiving care, and receiving care but undiagnosed. Behavioral health spend defined as all spend with a BH primary diagnosis or BH-specific procedure, revenue, or HIC3 pharmacy code.

3 Excludes claims billed through the Department of Children’s Services

SOURCE: TN 2011-2014 claims data
Retrospective Episodes of Care

Unchanged Billing Process

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

New Information

‘Quarterbacks’ are provided detailed information for each episode which includes actionable data
Episodes of Care: Incentives

Risk-adjusted costs for one type of episode in a year for a single example provider

Example provider's individual episode costs

Cost per episode

Average

Example provider's average episode cost

Risk-adjusted average episode cost for the example provider

Annual performance across all providers

Provider quarterbacks, from highest to lowest average cost

High cost

Average cost per episode for each provider

Low cost

If average cost higher than acceptable, share excess costs above acceptable line

Acceptable

If average cost between commendable and acceptable, no change

Commendable

If average cost lower than commendable and quality benchmarks met, share cost savings below commendable line

Gain sharing limit

If average cost lower than gain sharing limit, share cost savings but only above gain sharing limit

This example provider would see no change.
Quarterbacks will receive quarterly report from payers:

- **Performance summary**
  - Total number of episodes (included and excluded)
  - Quality thresholds achieved
  - Average non-risk adjusted and risk adjusted cost of care
  - Cost comparison to other providers and gain and risk sharing thresholds
  - Gain sharing and risk sharing eligibility and calculated amounts
  - Key utilization statistics

- **Quality detail**: Scores for each quality metric with comparison to gain share standard or provider base average

- **Cost detail**: Breakdown of episode cost by care category
  - Benchmarks against provider base average

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

---

**[1. Asthma] A. Episode Summary**

<table>
<thead>
<tr>
<th>Parameters</th>
<th>You</th>
<th>Provider base average</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Total cost across episodes</td>
<td>$235,796.00</td>
<td>$317,301.09</td>
</tr>
<tr>
<td>2. Total # of included episodes</td>
<td>233</td>
<td>235</td>
</tr>
<tr>
<td>3. Avg. episode cost (non adj.)</td>
<td>$1,012.00</td>
<td>$1,350.22</td>
</tr>
<tr>
<td>4. Risk adjustment factor* (avg.)</td>
<td>0.90</td>
<td>0.92</td>
</tr>
<tr>
<td>5. Avg. episode cost (risk adj.)</td>
<td>$910.80</td>
<td>$1,242.20</td>
</tr>
</tbody>
</table>

* Risk adjustment factor calculated for select provider's patient base

---

**Episode quality and utilization summary**

<table>
<thead>
<tr>
<th>Quality metrics not linked to gain sharing</th>
<th>You</th>
<th>Provider base average</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Repeat acute exacerbation within 30 days</td>
<td>5%</td>
<td>8%</td>
</tr>
</tbody>
</table>

---

**Distribution of provider average episode cost risk (adj.)**

- **Avg. episode cost ($)**
  - Below $500: 28
  - $500 - $833: 64
  - $833 - $1,012: 37
  - $1,012 - $1,167: 43
  - $1,167 - $1,242: 22
  - $1,242 - $1,350: 21
  - Above $1,350: 18

---

**Distribution of provider average episode cost (adj.)**

- **Avg. episode cost ($)**
  - Below $500: 0
  - $500 - $833: 0
  - $833 - $1,012: 0
  - $1,012 - $1,167: 0
  - $1,167 - $1,242: 0
  - $1,242 - $1,350: 0
  - Above $1,350: 0

---

**YOUR GAIN/ RISK SHARE**

- **Number of episodes**: 233
- **Share factor**: 50%
- **Gain**: $10,391.80
- **Cost comparison to other providers and gain and risk sharing thresholds**

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Preliminary draft of the provider report template for State of TN (for discussion only) | All content/numbers included in this report are purely illustrative.
## Episodes of Care: Reporting

### Cost breakdown by care category (non-risk adj.)

<table>
<thead>
<tr>
<th>Episod ID</th>
<th>Patient name</th>
<th>Episode start &amp; end date</th>
<th>Non-adjusted cost</th>
<th>Outpatient Professional Cost # claims</th>
<th>Pharmacy Cost # claims</th>
<th>Emergency Department Cost # claims</th>
<th>Outpatient Lab Cost # claims</th>
<th>Outpatient Radiology Cost # claims</th>
<th>Inpatient Professional Cost # claims</th>
<th>Inpatient Facility Cost # claims</th>
<th>Outpatient Surgery Cost # claims</th>
<th>Other Cost # claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>AVG_B</td>
<td>Provider Base Average</td>
<td></td>
<td>$1,350</td>
<td>$162</td>
<td>$135</td>
<td>$405</td>
<td>$14</td>
<td>$135</td>
<td>$54</td>
<td>$392</td>
<td>$0</td>
<td>$54</td>
</tr>
<tr>
<td>AVG_Y</td>
<td>Your Average</td>
<td></td>
<td>$1,012</td>
<td>$121</td>
<td>$101</td>
<td>$304</td>
<td>$10</td>
<td>$101</td>
<td>$40</td>
<td>$293</td>
<td>$0</td>
<td>$40</td>
</tr>
<tr>
<td>82192</td>
<td>Camilla Rosemary</td>
<td>12/02/12</td>
<td>$1,367</td>
<td>$164</td>
<td>$137</td>
<td>$415</td>
<td>$13</td>
<td>$138</td>
<td>$50</td>
<td>$396</td>
<td>$0</td>
<td>$55</td>
</tr>
<tr>
<td>82192</td>
<td>Lawrenc e Croft</td>
<td>01/03/12</td>
<td>$1,054</td>
<td>$126</td>
<td>$145</td>
<td>$276</td>
<td>$11</td>
<td>$105</td>
<td>$42</td>
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Episodes of Care: 75 in 5 years

TennCare

State Commercial Plans

Note: Tennessee may want to assess benefits of securing additional Tennessee Commercial Data with which to design and localize certain episodes (multiple) indication identifies episodes in which more than one episode may be designed.

Source: TennCare and State Commercial Plans claims data, episode diagnostic model, team analysis.