Building a healthier future for all Arkansans

Arkansas Payment Improvement Initiative (APII)

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"Let's Just Start Cutting and See What Happens."

Arkansas Healthcare Payment Improvement Initiative: A statewide, multi-payor effort

"Our goal is to align payment incentives to eliminate inefficiencies and improve coordination and effectiveness of care delivery."

– Gov. Mike Beebe

Episodes have the potential to …

Deliver coordinated, **evidence-based** care

Focus on **high-quality** outcomes

Improve **patient focus** and **experience**

Avoid **complications**, reduce **errors** and **redundancy**

Incentivize **cost-efficient** care

Our vision to improve care for Arkansas is a comprehensive, patient-centered delivery system…

Focus today

Objectives

For patients

- Improve the health of the population
- Enhance the patient experience of care
- Enable patients to take an active role in their care
- Encourage patient engagement/accountability

For providers

- Reward providers for high quality, efficient care
- Reduce or control the cost of care

How care is delivered

Population-based care

- Medical homes
- Health homes

Episode-based care

- Acute, procedures or defined conditions

Four aspects of broader program

- **Results-based payment and reporting**
- **Health care workforce development**
- **Health information technology (HIT) adoption**
- **Expanded access for health care services**

Payers recognize the value of working together to improve our system, with close involvement from other stakeholders…

Arkansas Medicaid

QualChoice HEALTH INSURANCE

Arkansas BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

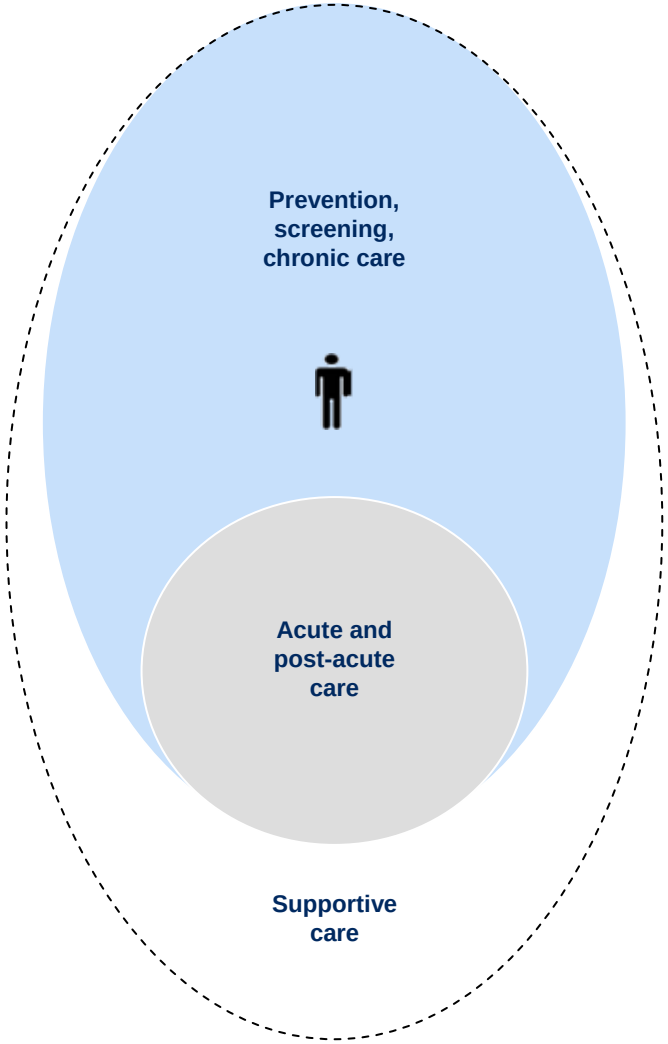
CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Coordinated multi-payer leadership…

- Creates **consistent incentives** and standardized reporting rules and tools
- Enables **change in practice** patterns as program applies to many patients
- Generates enough scale to justify investments in **new infrastructure** and operational models
- Helps **motivate patients** to play a larger role in their health and health care

1 Center for Medicare and Medicaid Services

The populations that we serve require care falling into three domains



Patient populations within scope (examples)	Care/payment models
• Healthy, at-risk • Chronic, e.g., – CHF – COPD – Diabetes	**Population-based**: medical homes responsible for care coordination, rewarded for quality, utilization, and savings against total cost of care
• Acute medical, e.g., – AMI – CHF – Pneumonia • Acute procedural, e.g., – CABG – Hip replacement	**Episode-based**: retrospective risk sharing with one or more providers, rewarded for quality and savings relative to benchmark cost per episode
• Developmental disabilities • Long-term care • Severe and persistent mental illness	**Combination of population- and episode-based models**: health homes responsible for care coordination; episode-based payment for supportive care services

The episode-based model is designed to reward coordinated, team-based high quality care for specific conditions or procedures

The goal

- **Coordinated, team based care** for all services related to a specific condition, procedure, or disability (e.g., pregnancy episode includes all care prenatal through delivery)

Accountability

- A provider 'quarterback', or **Principal Accountable Provider** (PAP) is designated as accountable for all pre-specified services across the episode (PAP is provider in best position to influence quality and cost of care)

Incentives

- **High-quality, cost efficient care** is rewarded beyond current reimbursement, based on the PAP's average cost and total quality of care across each episode

Qualifications for a Principal Accountable Provider (PAP) for episode-based models

Qualifications for a Principal Accountable Provider

- ☑ **Decision-making responsibility:** provider is principal (not exclusive) decision maker for most care during episode
  - Selects tests/ screenings
  - Determines treatment approach
  - Carries out procedures
  - Selects and/or procures medical device(s)

- ☑ **Influence over other providers**: provider is in best position to coordinate with, direct, or incent participating providers to improve performance
  - Makes referral decisions
  - Provides infrastructure
  - Organizes quality improvement efforts

- ☑ **Economic relevance**: provider bears a material portion of the episode cost or a significant case volume

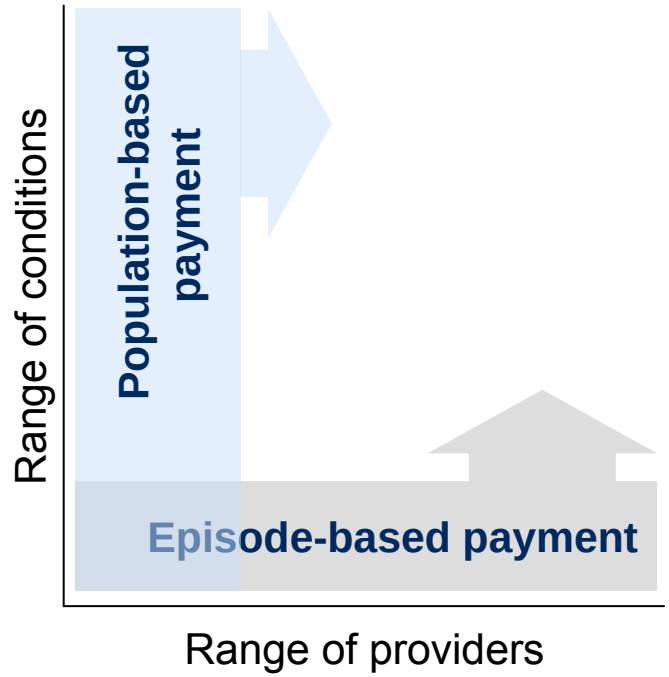
Given the scope of the change, transformation of the delivery system will be staged over the coming 3-5 years, along two dimensions

Population-based models

- Begin with initial wave of medical homes and health homes
- Expand to other providers as they become ready to undertake new processes and capabilities
  - E.g., HIT, care coordinators

Episode-based payment

- Begin with a handful of episodes, rolled out to all providers statewide
- Expand to other episodes as local providers adopt common definitions for clinical pathways and desired outcomes



Potential principal accountable providers across episodes

	Principal accountable provider(s)
Hip/knee replacements	▪ Orthopedic surgeon ▪ Hospital
Perinatal (non NICU)	▪ Primary physician (e.g., OB/GYN, family practice physician) ▪ (Hospital?)
Ambulatory URI	▪ Provider for the in-person URI consultation(s)
Acute/post-acute CHF	▪ Hospital ▪ (Outpatient provider will be incented by medical home model to prevent readmissions)
ADHD	▪ Could be the PCP, mental health professional, and/or the RSPMI provider organization, depending on the pathway of care
Developmental disabilities	▪ Primary DD provider

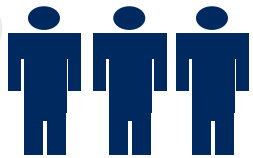
- Approaches under consideration for instances where multiple providers involved, e.g.,
  - Prenatal care and delivery carried out by different providers
  - Patient sees multiple providers for URI

1 Multiple approaches under consideration for instances when prenatal care and delivery carried out by different providers

How episodes work for patients and providers (1/2)

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

How episodes work for patients and providers (2/2)

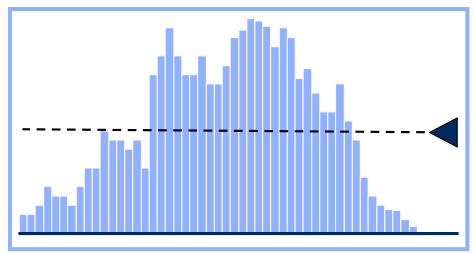
Calculate incentive payments based on outcomes after close of 12 month performance period

4

Review claims from the performance period to identify a **'Principal Accountable Provider'** (PAP) for each episode

5 Payers calculate **average cost per episode** for each PAP[1]

Compare average costs to predetermined ''commendable' and 'acceptable' levels[2]

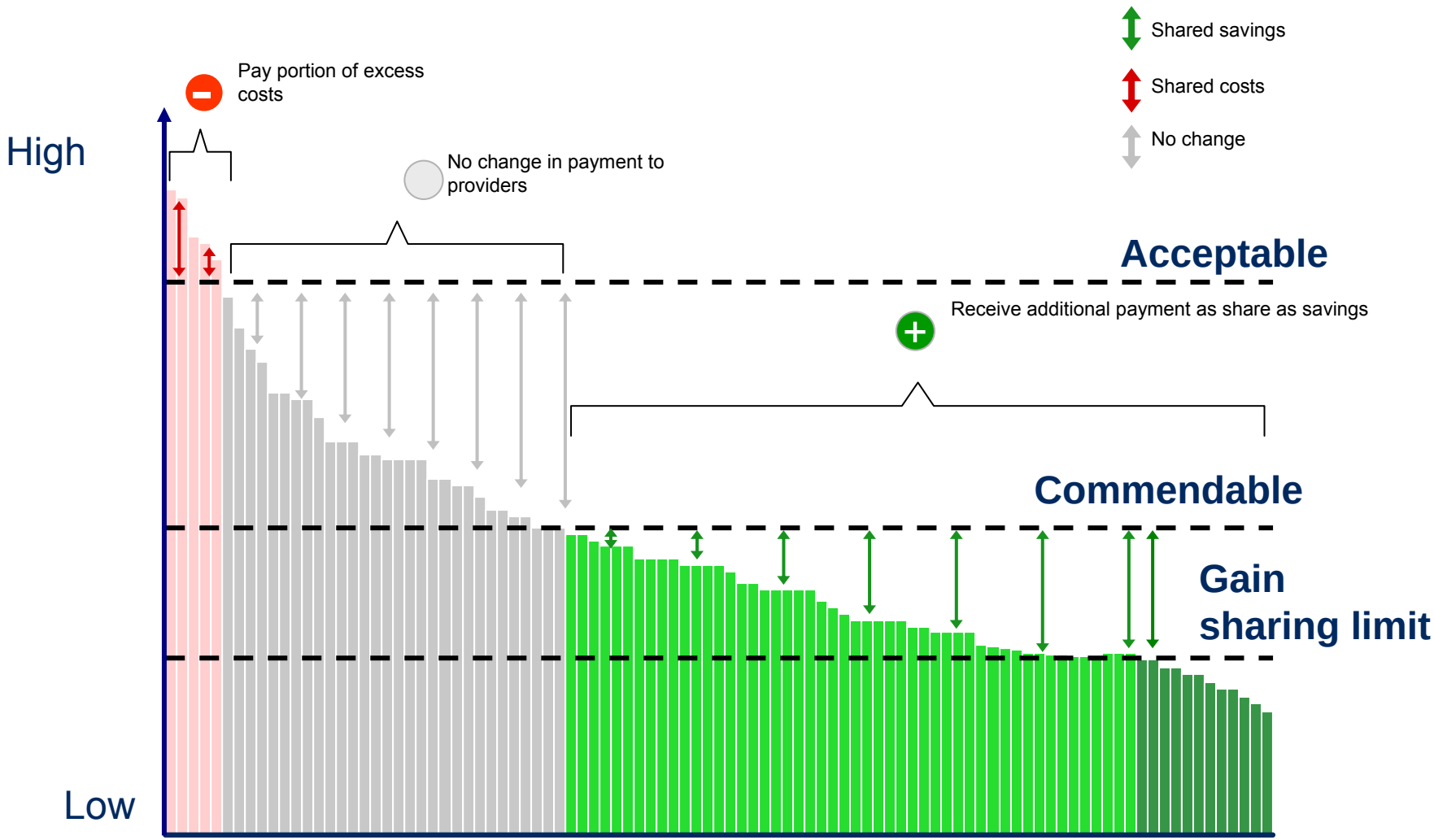


6 **Based on results, providers will:**

- **Share savings:** if average costs below commendable levels and quality targets are met
- **Pay part of excess cost:** if average costs are above acceptable level
- **See no change in pay:** if average costs are between commendable and acceptable levels

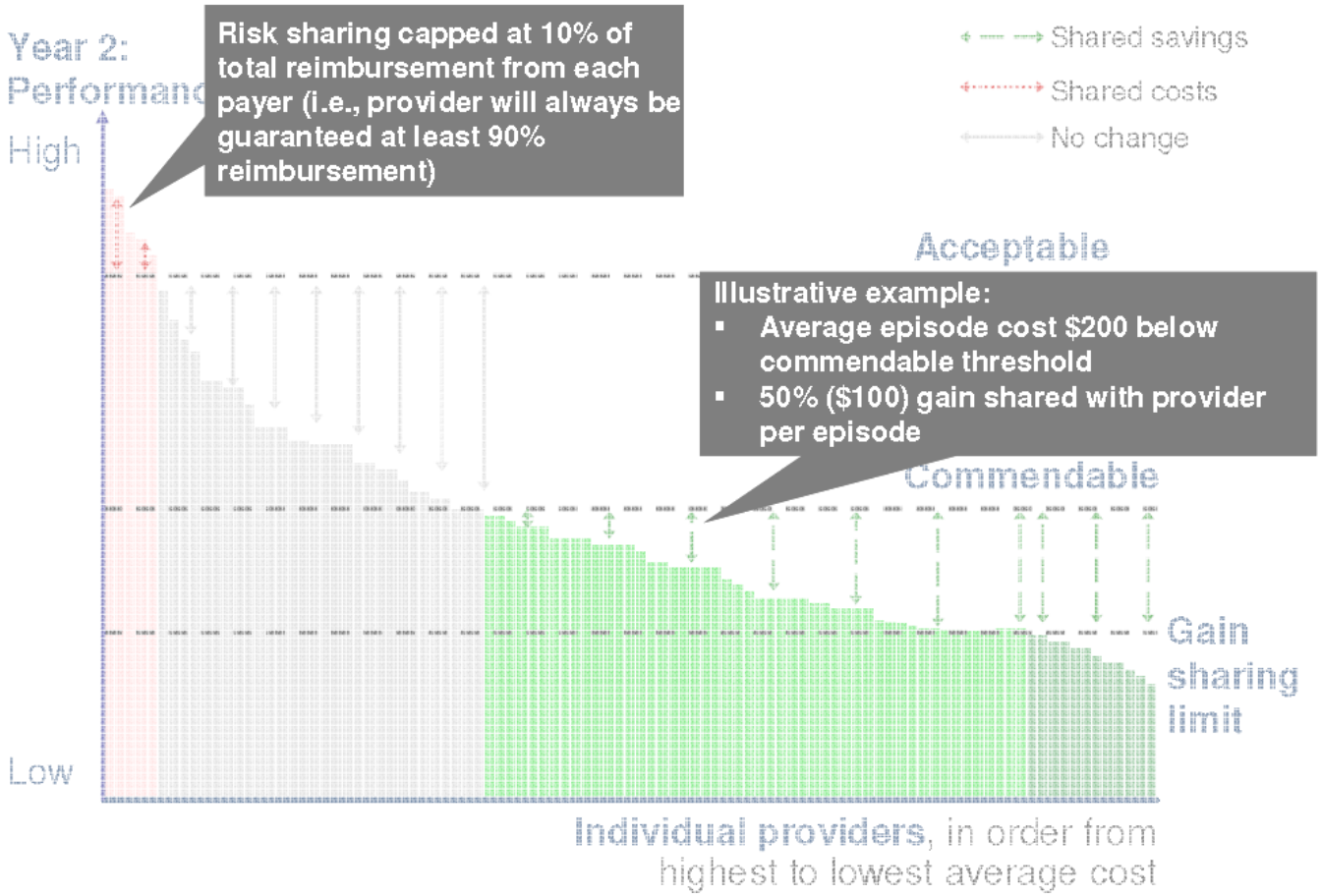
1 Outliers removed and adjusted for risk and hospital per diems
2 Appropriate cost and quality metrics based on latest and best clinical evidence, nationally recognized clinical guidelines and local considerations

PAPs that meet quality standards and have average costs below the commendable threshold will share in savings up to a limit



Illustrative examples of risk and gain sharing

ILLUSTRATIVE EXAMPLE

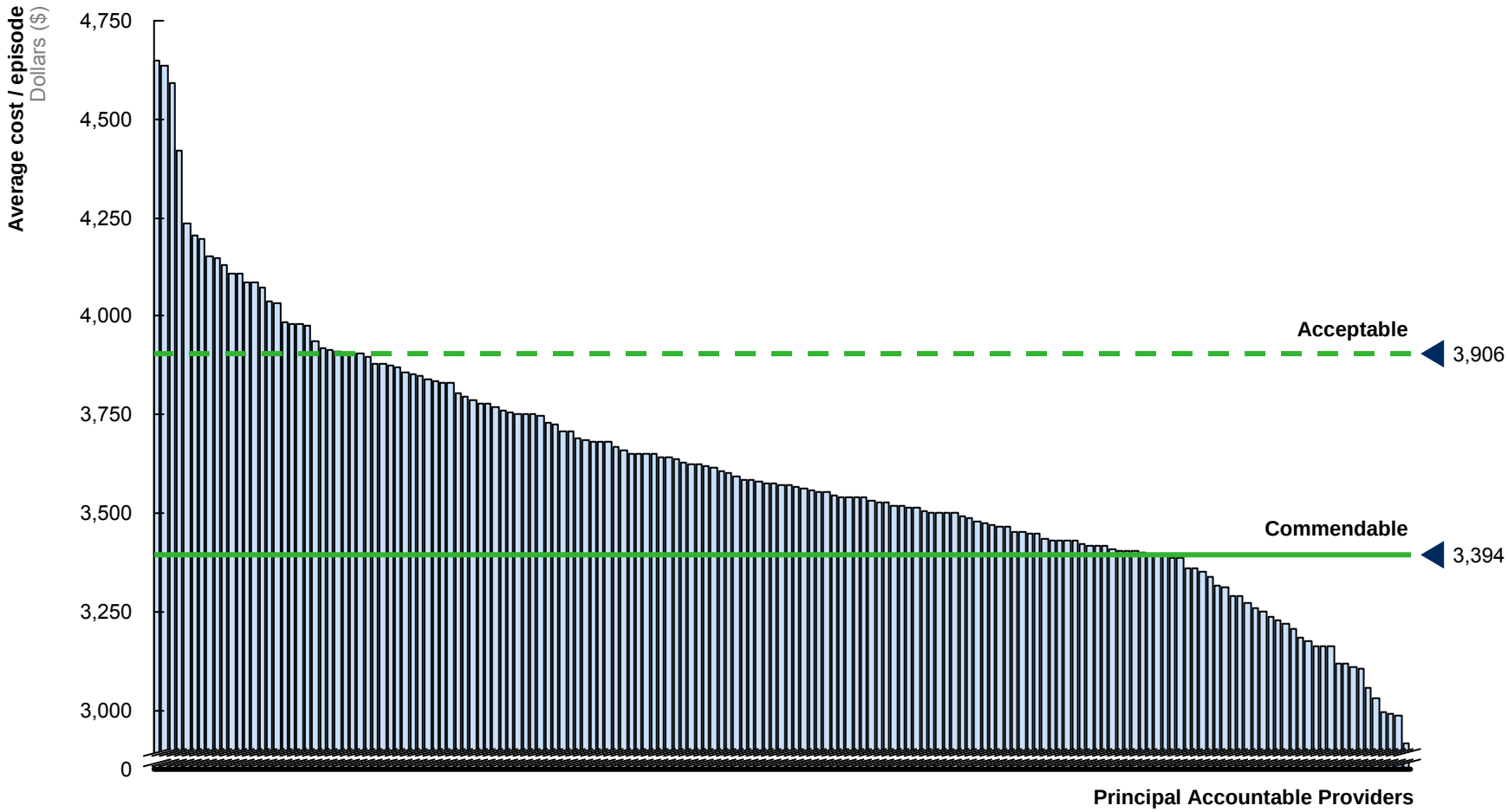


Ensuring high quality care for every Arkansan is at the heart of this initiative, and is a requirement to receive performance incentives

Two types of quality metrics for providers	Description
1 **Quality metric(s) "to pass"** are linked to payment	➢ **Core measures** indicating basic standard of care was met ➢ **Quality requirements** set for these metrics, a provider must meet required level to be eligible for incentive payments ➢ In select instances, quality metrics must be entered in portal (heart failure, ADHD)
2 **Quality metric(s) "to track"** are not linked to payment	➢ Key to understand overall quality of care and quality **improvement opportunities** ➢ Shared with providers but **not linked to payment**

Draft perinatal thresholds

Perinatal provider cost distribution
Risk-adjusted average episode cost per provider

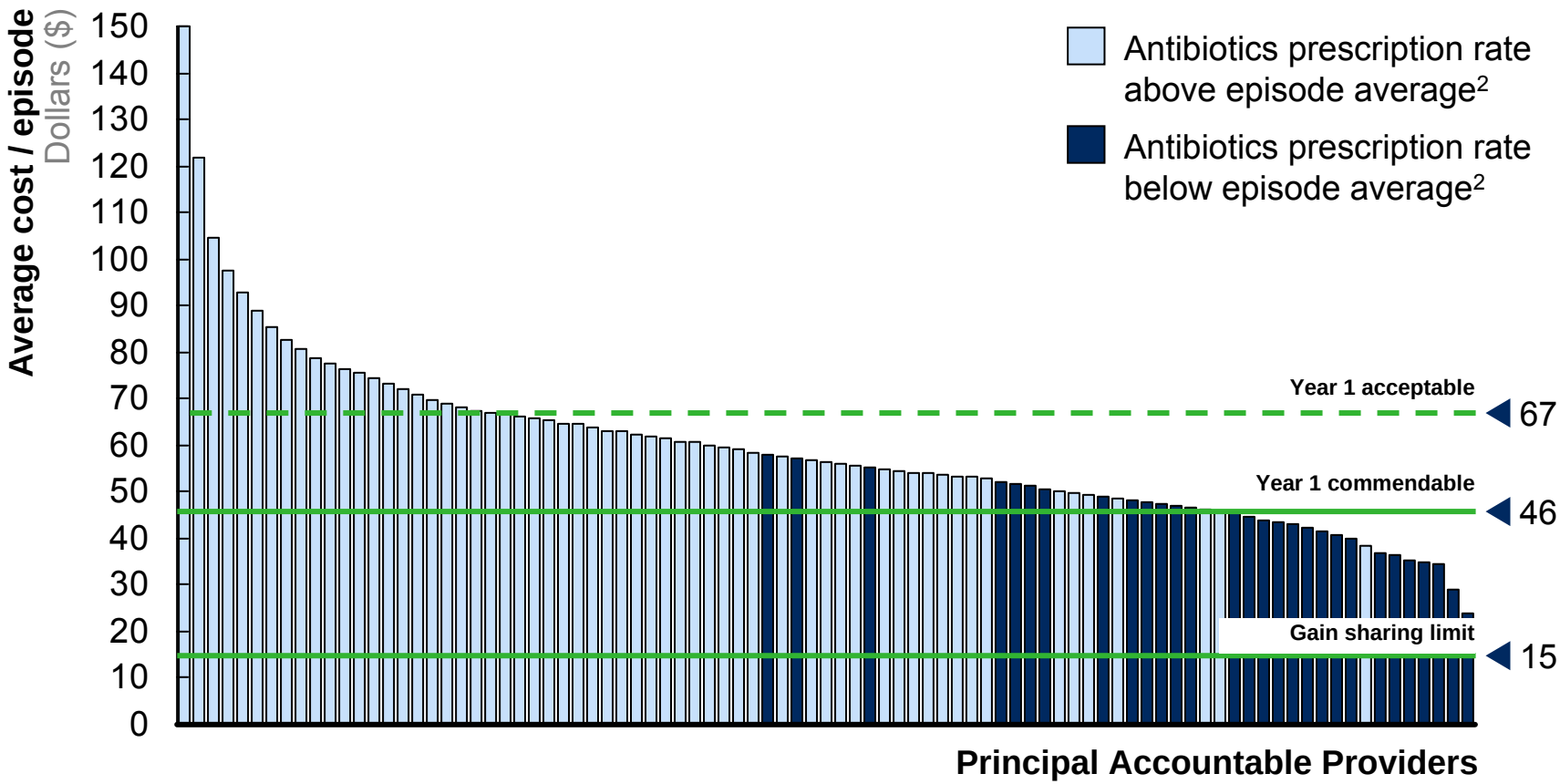


SOURCE: Episodes with live births May 1, 2009 – April 30, 2010; data includes Arkansas Medicaid claims paid SFY09 - SFY10

Draft thresholds for General URIs

Provider average costs for General URI episodes

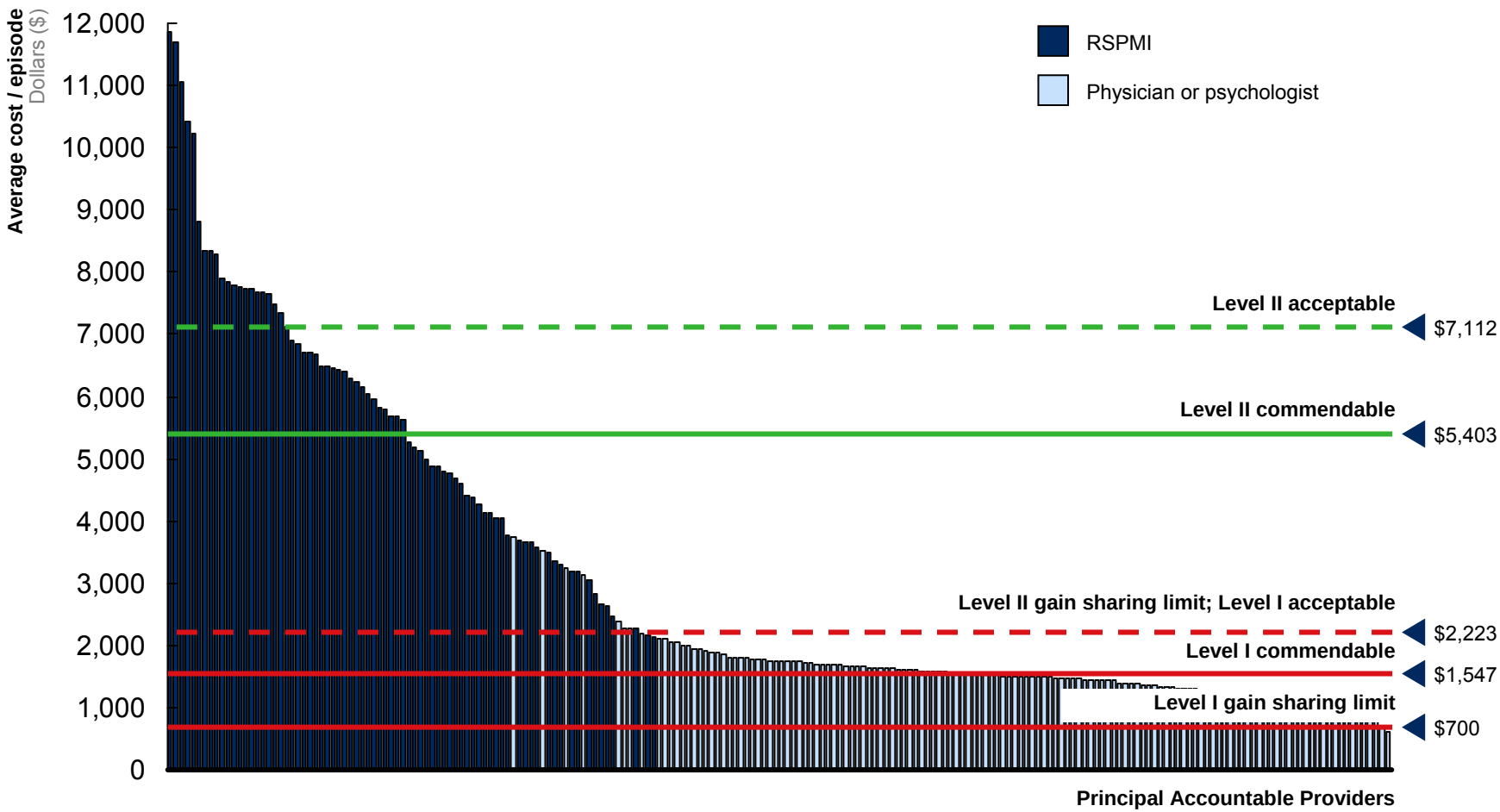
Adjusted average episode cost per principal accountable provider[1]



1 Each vertical bar represents the average cost and prescription rate for a group of 10 providers, sorted from highest to lowest average cost
2 Episode average antibiotic rate = 41.9%
SOURCE: Arkansas Medicaid claims paid, SFY10

Draft ADHD thresholds

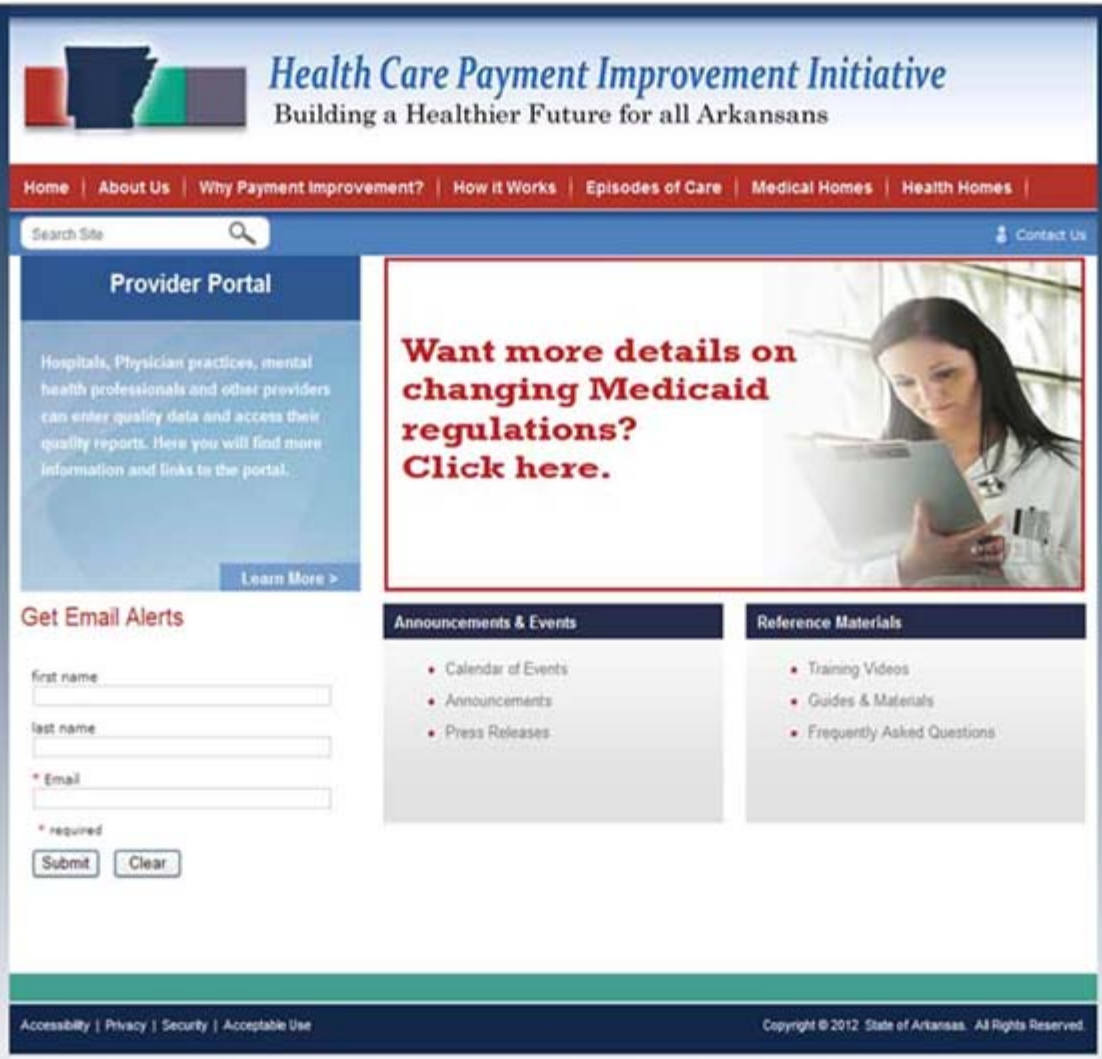
ADHD provider cost distribution
Average episode cost per provider[1]



1 Each vertical bar represents the average cost and prescription rate for a group of 3 providers, sorted from highest to lowest average cost

SOURCE: Episodes ending in SFY10, data includes Arkansas Medicaid claims paid SFY09 - SFY10

Provider Portal

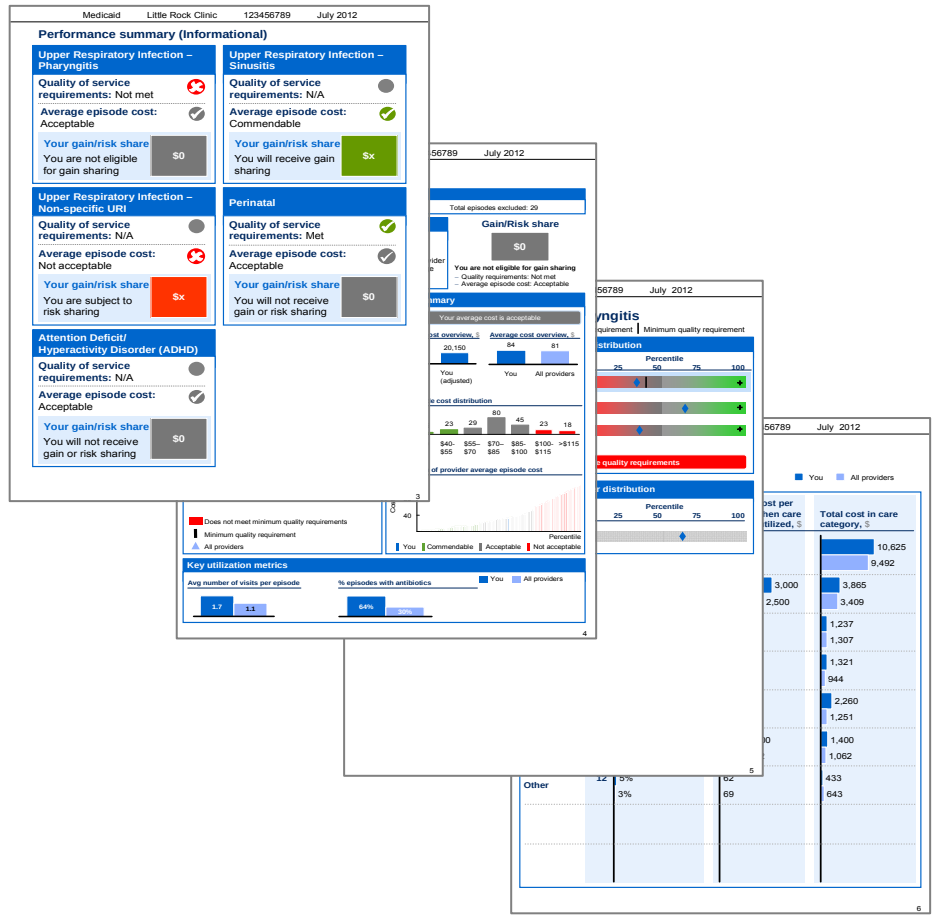


PAPs will be provided tools to help measure and improve patient care

Reports provide performance information for PAP's episode(s):

- Overview of **quality** across a PAP's episodes
- Overview of **cost effectiveness** (how a PAP is doing relative to cost thresholds and relative to other providers)
- Overview of **utilization** and drivers of a PAP's average episode cost

Example of provider reports



NOTE: Episode and health home model for adult DD population in development. Tools and reports still to be defined.

Summary - Congestive Heart Failure

Overview

Total episodes: 16 | Total episodes included: 5 | Total episodes excluded: 11

Average cost of care compared to other providers

Gain/Risk share

You will not receive gain or risk sharing
- Quality requirements: N/A
- Average episode cost: Acceptable

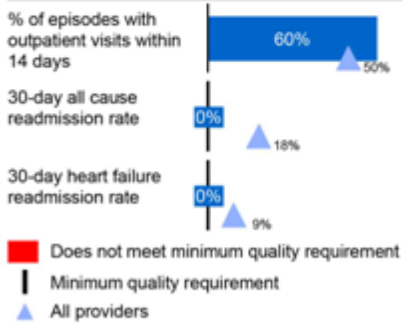
Quality summary

No quality metrics linked to gain sharing at this time

Quality metrics - linked to gain sharing

There are no quality metrics linked to gain sharing generated from historical claims data. Selected quality data submitted on the Provider Portal on or after February 1, 2013 will generate additional quality metrics for future reports.

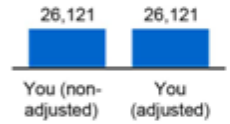
Quality metrics - not linked to gain sharing



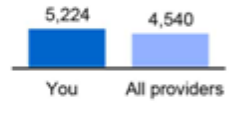
Cost summary

Your average cost is acceptable

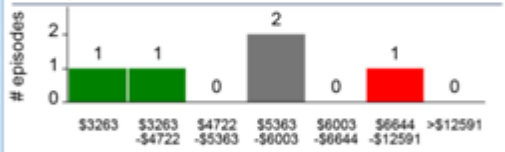
Your total cost overview, $



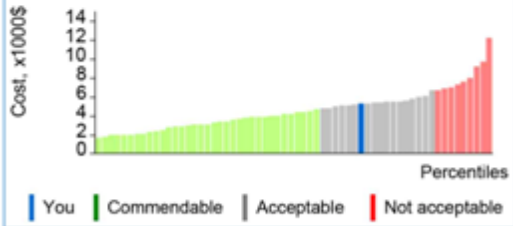
Average cost overview, $



Your episode cost distribution



Distribution of provider average episode cost



Key utilization metrics

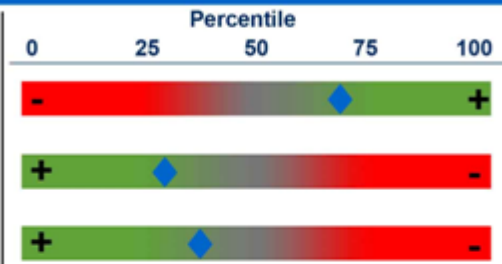
30-day outpatient observation care rate

Quality and utilization detail - Congestive Heart Failure

◆ You Metric with a minimum quality requirement | Minimum quality requirement

Quality metrics: Performance compared to provider distribution

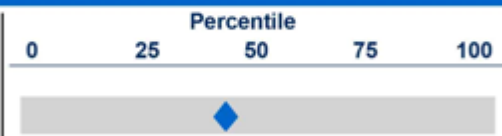
Metric	You	Percentile 25th	50th	75th
% of episodes with outpatient visits within 14 days	60%	22%	50%	100%
30-day all cause readmission rate	0%	0%	0%	25%
30-day heart failure readmission rate	0%	0%	0%	7%



No quality metrics linked to gain sharing at this time

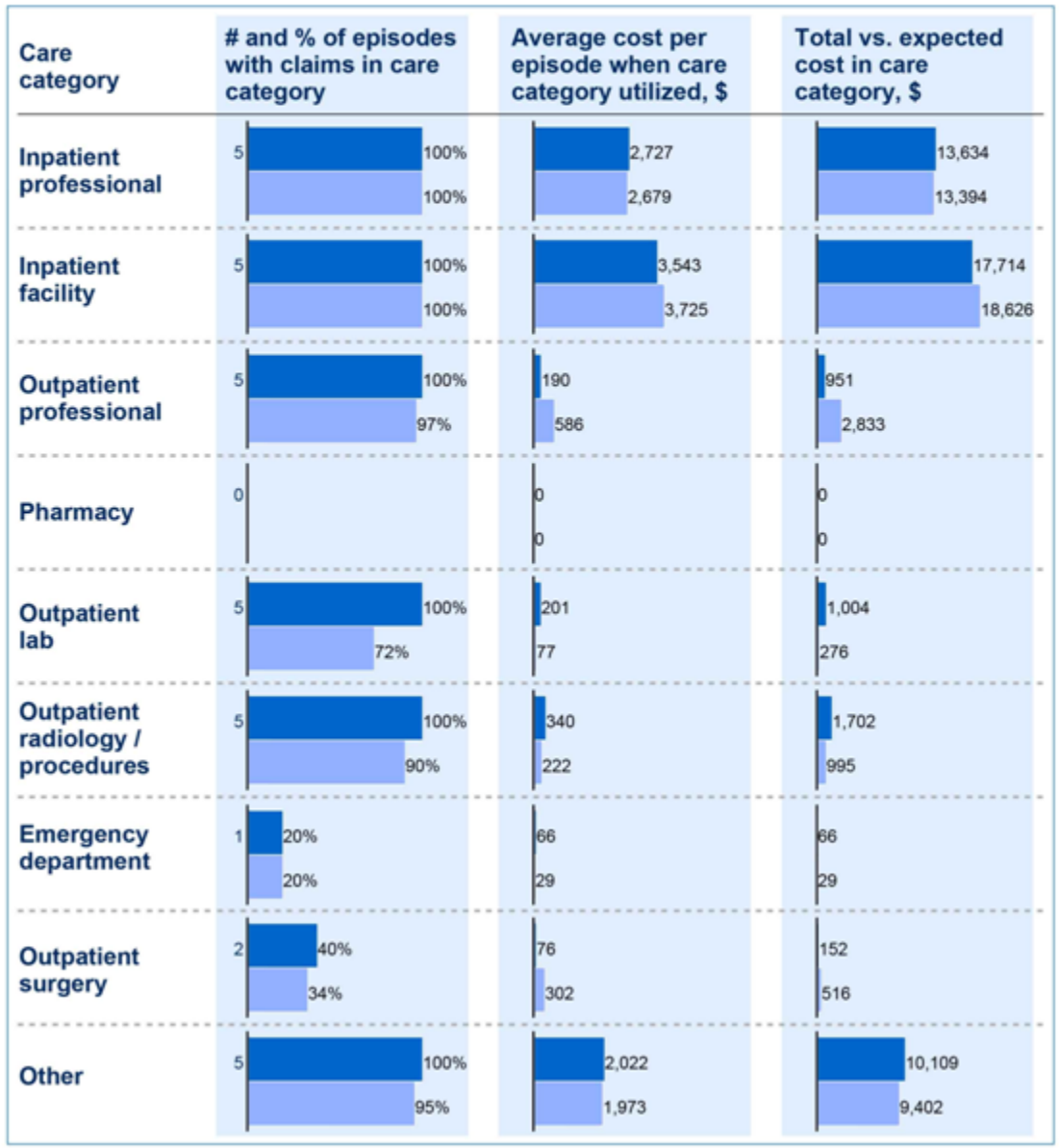
Utilization metrics: Performance compared to provider distribution

Metric	You	Percentile 25th	50th	75th
30-day outpatient observation care rate	0%	0%	0%	0%



Cost detail - Total Joint Replacement

Total episodes included = 5



Population-based models provide the "umbrella" for ensuring that the full range of needs are met for a population

Elements of preliminary design

Medical homes for most populations

- **Attribution** of members to accountable primary care provider, to avoid restrictions on member access
- **Care coordination** for high-risk patients with one or more chronic conditions
- **Rewards for costs and quality of care** for direct, indirect decisions (e.g., referrals)

Health homes for those receiving supportive care

- Similar approach as above; however,
- Responsibility for health promotion and **care coordination vested with providers of supportive care**, recognizing their greater influence in daily routines

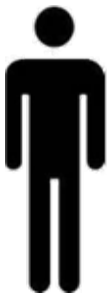
Each payor independently defines incentives, to include a combination of:

- Care coordination fees
- Shared savings against total cost of care targets
- For smaller providers, bonus payments based on quality and utilization

DD: Payment Initiative aims to address three opportunities

PRELIMINARY

Initial phase: Adult DD clients[1] 7,020



DD service episode

$ 300 M
DD expenditures for adults[1]

1 Ensure DD care provision is efficient and based on client needs

- Align resources provided with level of need
- Expand plan customization options for clients

2 Minimize resources / time not focused on delivering client care

Care coordination (within health home)

$ 35 M
Halo expenditures for adults[1] (e.g., medical, behavioral)

3 Increased care coordination

- Integrate care across DD, medical & behavioral health
- Reduce unnecessary medical and behavioral health spend
- Promote wellness activities

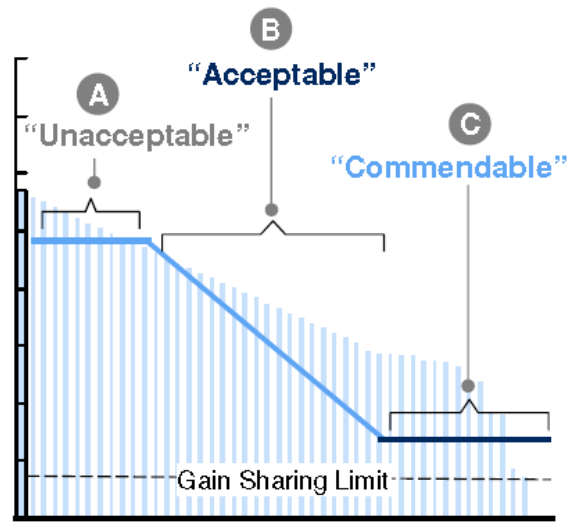
1 Includes DD clients ages 18+, not currently enrolled in public school, excludes 22 clients receiving therapy only
2 Includes all medical and behavioral spend, in-patient, out-patient and pharmacy spend

SOURCE: Medicaid claims data for claims incurred in SFY 2010

PCMH strategy: proposed AR shared savings model (upside only)

Distribution of provider performance

Average total cost of care



Provider performance ($)

Description of potential shared savings approach

A "Unacceptable" baseline performers

- Share in 10% of savings based on provider performance improvement relative to benchmark trend, if move to acceptable zone

B "Acceptable" baseline performers

- Share in 30% of savings based provider performance improvement relative to benchmark trend

C "Commendable" baseline providers

- Share in 50% of savings based on greater of (1) performance vs "commendable" level or (2) performance improvement

What do you think about balance of rewarding performance improvement and absolute performance?

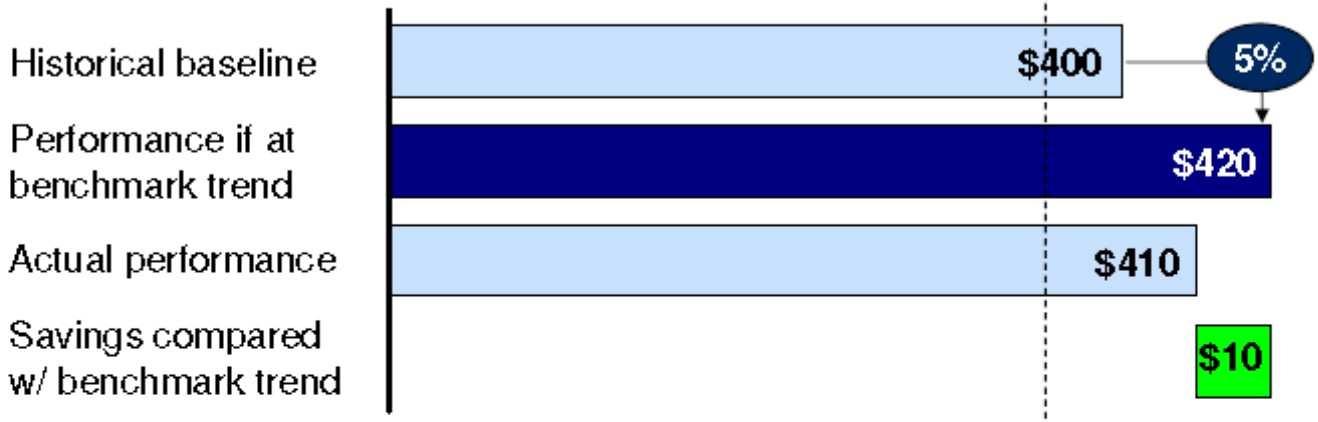
Notes

- Based on risk adjusted total cost of care
- All providers must meet quality requirements to participate in shared savings
- Baseline performance level resets each year of performance improvement (e.g., if move from acceptable to commendable, participate in commendable levels beginning in year 2)

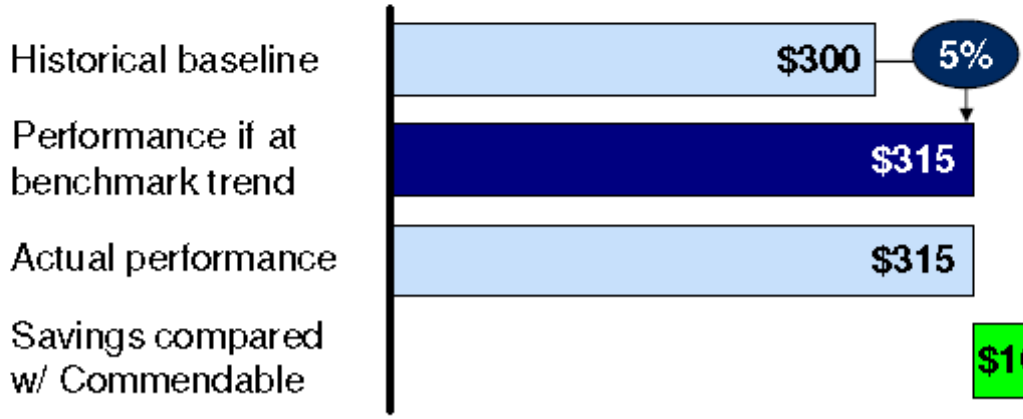
PCMH shared savings calculation

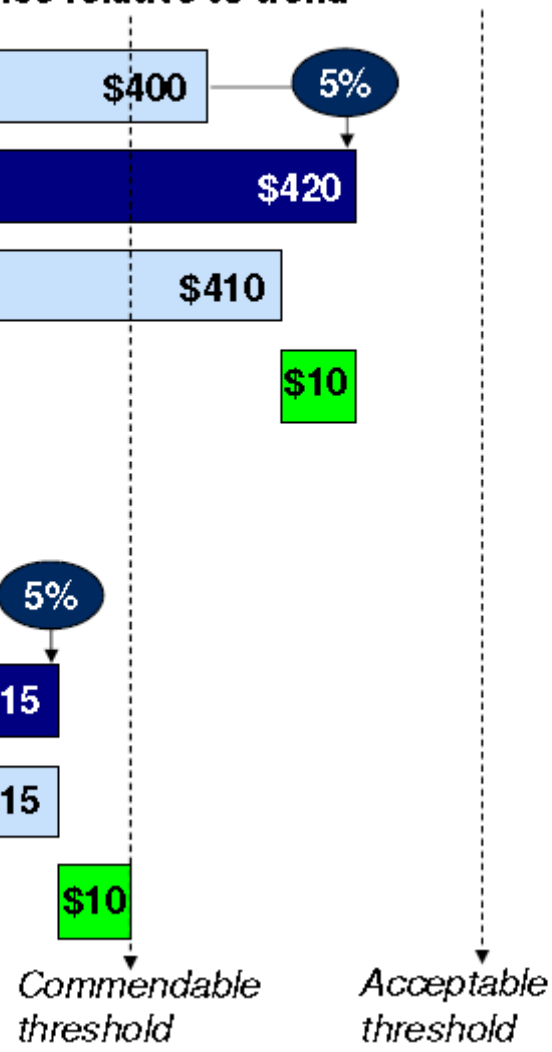
ALL NUMBERS FICTITIOUS FOR ILLUSTRATION

Provider A: Acceptable performer improving performance relative to trend



Provider B: Commendable performer





*All calculated on a risk-adjusted basis

PCMH changes the role, responsibilities and opportunities for primary care providers

Reflects a fundamental shift in payer expectations for primary care and a new financial relationship with PCPs

What the system incents today for PCPs

- Manage quality and cost of services provided within the PCP practice
- Provide primary care clinical services
- Focus on diagnosis and treatment
- Focus on the issue presented at a given visit

What the system will incent going forward with PCMH

- Manage patient total cost of care (<10% of which occurs in PCP practice)
- Act as the hub to integrate care for a patient's overall health and medical needs across a multi-disciplinary team
- Focus on full spectrum of primary care – prevention, diagnosis, treatment, care coordination, referrals to high value specialists, patient engagement
- Focus on population health, including overall patient panel assessment and management

- **More information on the Payment Improvement Initiative can be found at www.paymentinitiative.org**
  - Further detail on the initiative, PAP and portal
  - Printable flyers for bulletin boards, staff offices, etc.
  - Specific details on all episodes
  - Contact information for each payer's support staff
  - All previous workgroup materials