Building a healthier future for all Arkansans

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Existing Activities

- Pharmacy Management Programs
- Hospital Pay for Performance
  - Coordination of Care
  - Early Elective Deliveries
- Smoking Cessation
- Mental Health
  - Systems of Care, PsychTLC
- Telemedicine
- HIT
  - ePrescribing, ARRA Incentives, HIE

"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

Going to Scale

- Stakeholder Engagement

Background

- Goal: Transition to Episode Reimbursement
  - Promote Outcomes, Coordinated Care
- Topics For Initial Development Work
  - Models and Implementation Planning
- Criteria
  - Importance (Volume, Costs)
  - Practice Variation
  - Literature, Experience
  - Survey Data
  - Actionability

Problems with Status Quo

- Costs
- Silos
- Payment Rules
  - Resource Allocation
  - Service Delivery vs Outcome

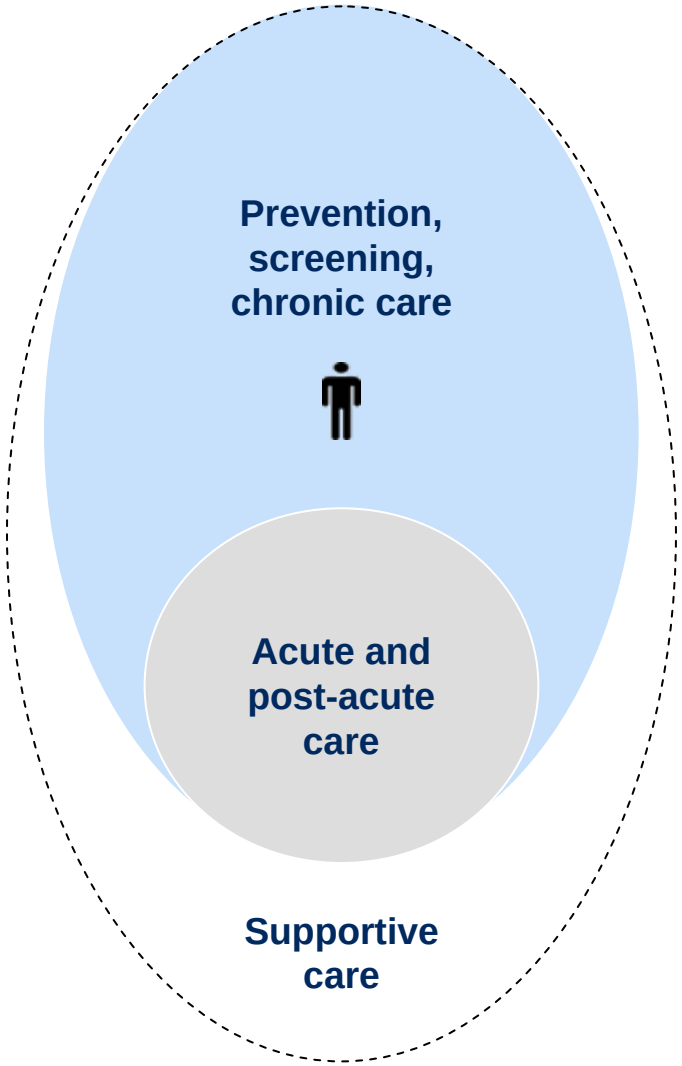
Payment Methods

- Targeting Efficiency vs Effectiveness
- Prospective vs Retrospective
- Target Costs vs Performance Based
- Defining Bundling, Gainsharing
- Implementation (System, Clinical Site)
- Fairness

Going to Scale

- Stakeholder Engagement
- Building Infrastructure

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

Episode-based payment provides a mechanism for supporting improvement in care for acute/post-acute and complex chronic conditions

Episode-based payment applies to persons with

- Acute medical conditions (e.g., AMI, URI)
- Acute procedures (e.g., hip replacements)
- Complex chronic conditions managed by specialists (e.g., cancer)

Elements of preliminary design

- Retrospective risk sharing model
  - Benchmark cost pre-determined and communicated to providers, based on identified clinical opportunities
  - 1-2 principal accountable providers to share gains/losses relative to benchmark cost, in pre-determined ratio
- Quality will play an important role
  - We will track and report high-priority quality metrics
  - Gain sharing payout may be contingent on quality
  - In some cases, we may make payment altogether contingent on universally agreed upon services (e.g., at least 1 ultrasound for pregnancy)
- Transition approach to be determined for each episode, based on degree of investment, change required
  - "Peg point" at which gain sharing begins may shift over time from provider baseline to standard benchmark
  - Level of risk may increase over time

Overall timeline

Preparation

1 **Episode model design**

Oct-Dec 2011

2 **Preparation for launch**

Jan-Jun 2012

3 **Implementation management**

Jul 2012 →

…

Begin work on additional episodes

Ongoing →

…

Goals for July

- Version 1.0
- Create Basic Episode Payment
  - Effectiveness > Efficiency?
  - Build Data Infrastructure
- Restructure Conventional Wisdom
- Restructure Conversations
- Engage Medicare, CMS
- Plan to Expand Clinical Content
- Plan to Refine Methodology

Going to Scale

- Stakeholder Engagement
- Building Infrastructure
- Stakeholder Input

Payment Improvement Initiative

- Town Hall Meetings
  - Central Location, Televideo Statewide
- Episode Based Payments
  - Efficient Providers Eligible for Gains Sharing
    - Must Demonstrate Effectiveness: ie Pass Quality Metrics
      - Good Performance vs Excellent Performance

An overview of the episode payment model

How does payment work?	▪ All providers submit claims as today ▪ A principal accountable provider (PAP) for each episode has main responsibility for ensuring episode is delivered at appropriate cost and quality ▪ PAP and payer share savings or excess costs
Who is the PAP?	▪ Payers designate the PAP based on three criteria: – Main decision maker for most care during episode – Ability to coordinate or direct other providers delivering care – Meaningful share of costs or volumes
How do we make this fair to all providers?	▪ Aim is to pay for as much care as possible using this system, but: – Some patient episodes will be excluded – Some adjustments will be made to costs ▪ Aim of making the payments fair
How does quality figure in the payment model?	▪ To meet the quality bar, providers will need to: – Meet specific thresholds for a set of performance metrics – Provide data on a further set of reporting metrics ▪ Payers will selectively audit data for accuracy

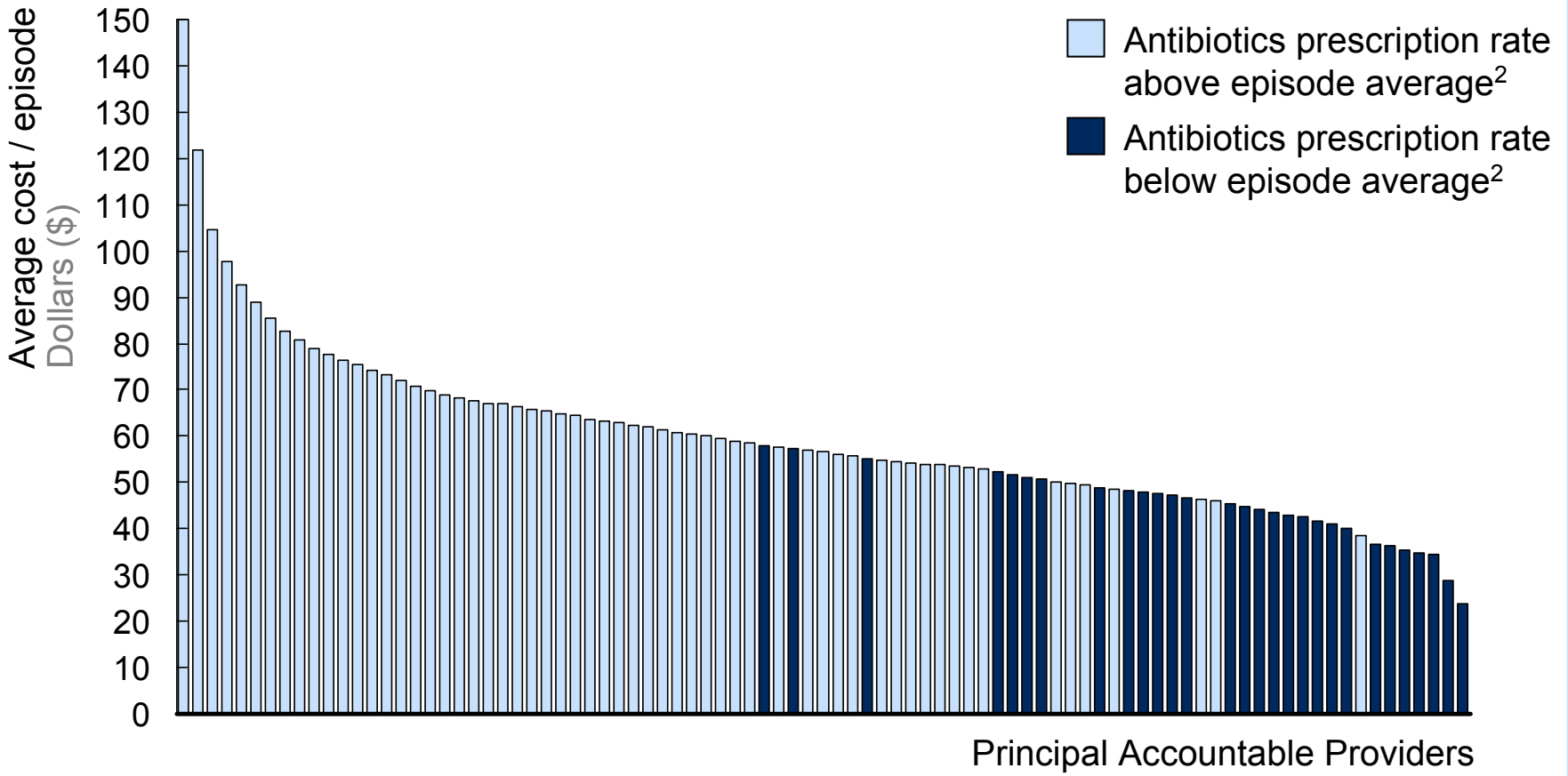
Key Points

- Measurement Should Achieve Its Purpose
- Efficiency is Multidimensional
- Inappropriate Care Cannot Be Efficient
- Measurement Selection Should Have Criteria
- Measures Should Have Leverage
- Measures Should Promote Shared Accountability
- Measures Should be Harmonized Across Sites
- Measures Should be Understandable
- Measures Should Promote Learning
- Benchmark

Distribution of provider average costs for General URIs in SFY2010

Provider average costs for General URI episodes

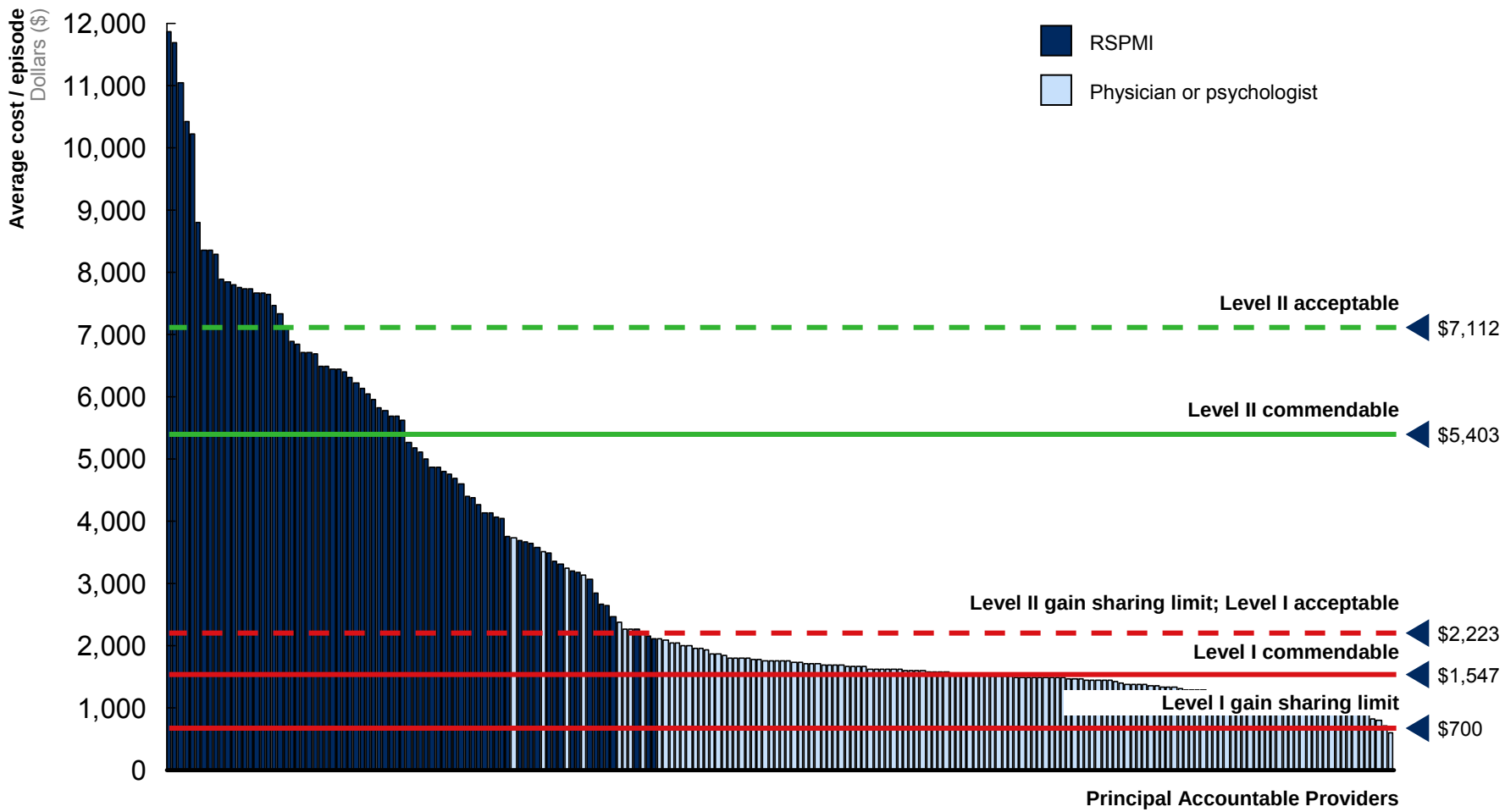
Adjusted average episode cost per principal accountable provider[1]



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

Going to Scale

- Stakeholder Engagement
- Building Infrastructure
- Stakeholder Input
- Launch

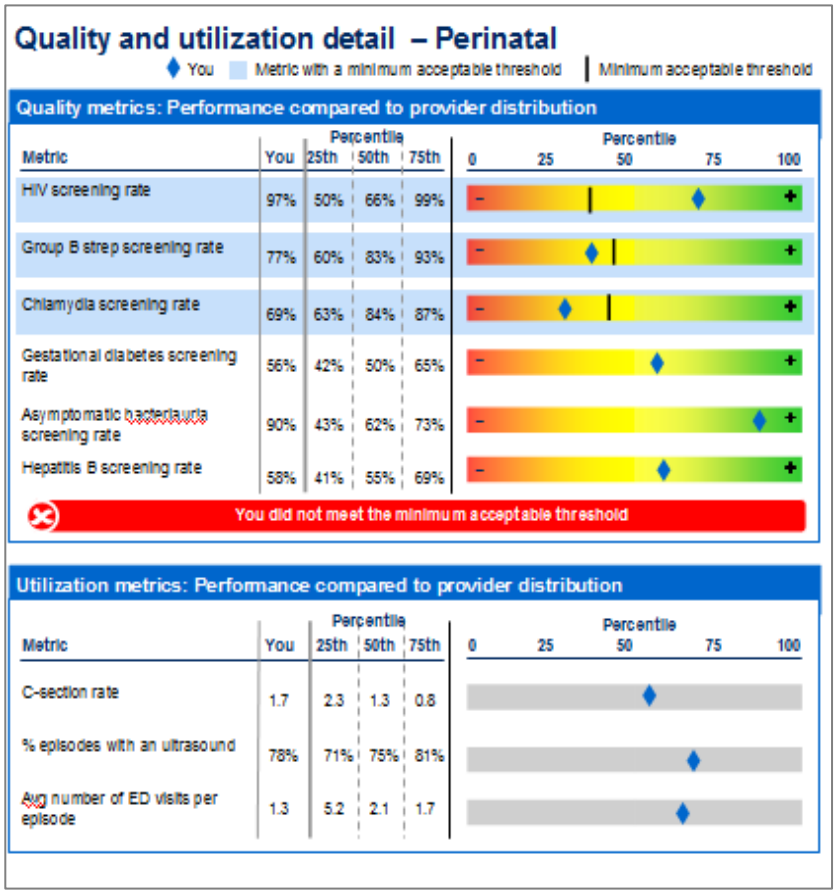
Launch Activities

- Report Cards – Mail and Portal
- Town Halls – Webinars
- Outreach Team Training
- Consultations
- Revisions

Example pages of provider report – quality, utilization and cost detail

DRAFT

Quality and utilization detail



Quality and utilization detail – Perinatal

You | Metric with a minimum acceptable threshold | Minimum acceptable threshold

Quality metrics: Performance compared to provider distribution

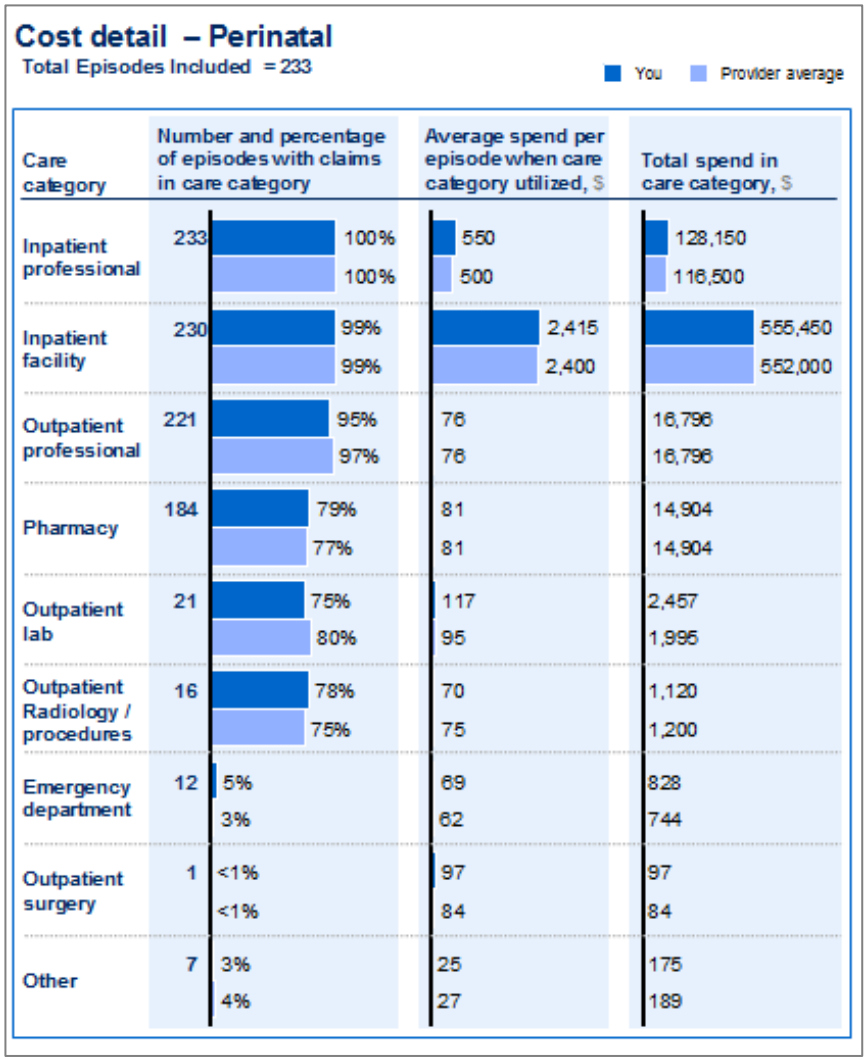
Metric	You	Percentile 25th	50th	75th	Percentile 0 25 50 75 100
HIV screening rate	97%	50%	66%	99%	
Group B strep screening rate	77%	60%	83%	93%	
Chlamydia screening rate	69%	63%	84%	87%	
Gestational diabetes screening rate	56%	42%	50%	65%	
Asymptomatic bacteriuria screening rate	90%	43%	62%	73%	
Hepatitis B screening rate	58%	41%	55%	69%	

You did not meet the minimum acceptable threshold

Utilization metrics: Performance compared to provider distribution

Metric	You	Percentile 25th	50th	75th	Percentile 0 25 50 75 100
C-section rate	1.7	2.3	1.3	0.8	
% episodes with an ultrasound	78%	71%	75%	81%	
Avg number of ED visits per episode	1.3	5.2	2.1	1.7	

Cost detail



Cost detail – Perinatal

Total Episodes Included = 233

You | Provider average

Care category	Number and percentage of episodes with claims in care category		Average spend per episode when care category utilized, $		Total spend in care category, $	
Inpatient professional	233	100%	550		128,150	
		100%	500		116,500	
Inpatient facility	230	99%	2,415		555,450	
		99%	2,400		552,000	
Outpatient professional	221	95%	76		16,796	
		97%	76		16,796	
Pharmacy	184	79%	81		14,904	
		77%	81		14,904	
Outpatient lab	21	75%	117		2,457	
		80%	95		1,995	
Outpatient Radiology / procedures	16	78%	70		1,120	
		75%	75		1,200	
Emergency department	12	5%	69		828	
		3%	62		744	
Outpatient surgery	1	<1%	97		97	
		<1%	84		84	
Other	7	3%	25		175	
		4%	27		189	

Going to Scale

- Stakeholder Engagement
- Building Infrastructure
- Stakeholder Input
- Launch
- Outreach, Expansion

2013

- Episode Support, Maintenance
  - New and Repurposed Staff
- New Episodes
  - Expert Panels, New Methods
  - PCI, CABG, Colonoscopies, Opp Defiant Disorder, NICU
- Medical Home
- Long term Care and Support for Disabled
- CMMI Implementation Grant