Building a healthier future for all Arkansans

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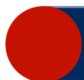
Arkansas Landscape

- With ~ 3M citizens, Arkansas is 32nd in population
- Urban center (Little Rock) but many rural areas
- >50% of adult population with $\geq$ one chronic disease
- Over 60% of physicians in practices of 5 or fewer
- Increasingly fragmented health care system resulting in difficulty for citizens to navigate in times of need
- Private insurance premiums doubled in past 10 years with growing numbers of uninsured
- Medicaid budget projecting unsustainable growth



Overall State Vision

Objective

- Improve the health of the population
- Enhance the patient experience of care
- Reduce or control the cost of care

Care delivery strategies

Population-based care delivery
- Medical Homes
- Health Homes

Episode-based care delivery
- Acute conditions, defined procedures

Enabling initiatives

- Payment innovation
- Health care workforce development
- Consumer engagement and personal responsibility
- Health information technology adoption
- Expanded coverage for health care services

Coordinated Multi-payer Leadership

Value of working together recognized by payers with close involvement from other stakeholders

Arkansas Medicaid

QualChoice HEALTH INSURANCE

- **Consistent incentives** and standardized reporting rules and tools
- **Change in practice** patterns as program applies to many patients
- Enough scale to justify investments in **new infrastructure** and operational models
- **Motivate patients** to play larger role in their health and health care

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Significant Input from Providers and Patients

500+

- **Providers, patients, family members**, and other stakeholders who helped shape the new model in public workgroups

20+
17

- **Public workgroup meetings** connected to 6–8 sites across the state through videoconference
- **Public town hall meetings** across the state

24

- **Months of research**, data analysis, expert interviews and infrastructure development to design and launch episode-based payments

Monthly

- **Updates with Arkansas provider associations** (AHA, AMS, Arkansas Waiver Association, Developmental Disabilities Provider Association)

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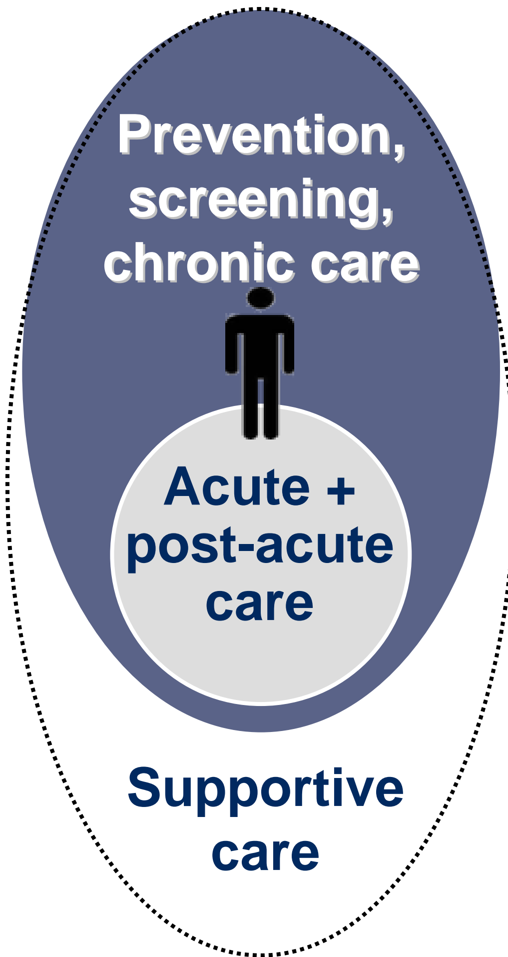
Overlapping Models in Arkansas Approach: Medical Homes, Health Homes, and Episodes



Patient populations (examples)	Care/payment models
Healthy, at-risk **Chronic**, e.g., •CHF •Diabetes	**Medical homes** • Care coordination • Overall health mgmt • Rewards quality, utilization, total cost
Acute medical • CHF • Pneumonia **Acute procedural** • Hip replacement	**Episodes** • Rewards high-quality, effective care delivery for a specific episode
Developmental disability **Long-term care** **Behavioral health (mental illness/ substance abuse)**	**Health homes + episodes** • Health home: care coordination

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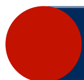
Arkansas Payment Improvement Initiative's Integrated Model

Private Insurance
Medicaid
Medicare
Self-Insured Businesses

Episode
Episode
Episode
Episode
Episode
Episode
Episode
Episode

Patient-Centered Medical Home



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Patient-Centered Medical Home: Arkansas Multi-payer Vision

Key attributes

- Providers with responsibility for entire experience of patient panel
- Evidence-informed care
- 24/7 access for all individuals
- Coordinated/integrated care across multidisciplinary provider teams
- Focus on management of chronic disease with avoided progression
- Referrals to high-value providers (e.g., specialists)
- Improved wellness and preventive care

Incentives

- Monthly fees support care coordination efforts and transformation to PCMH
- Shared savings model that rewards providers for controlling costs while maintaining or improving quality

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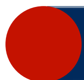
Medical Home: Comprehensive Primary Care Initiative

- **69 primary care practices**
  - Receiving FFS + enhanced payments
  - Improving patient experience: care coordination, access, communication
  - Practices responsible for ALL patients
  - Quality, cost, and transformation milestones will be evaluated
- **PMPM began October '12**
  - Medicare $8–40; risk-adjusted
  - Medicaid +$3 kids; +$7 adults
  - Private ~$5
- **Must meet targets**
  - Quality, performance, transformation
- **Shared savings model yrs 2–4**



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http://innovations.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/index.html

Medical Home: Rollout Timeline

PCMH coverage strategy over next several years

Wave 1

CPCI

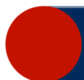
Wave 2

Open to all
(primary care early adopters enroll Fall 2013)

Wave 3

Expansion to remaining primary care (family practice, etc.)

Start of wave: October 2012 | Jan 2014 | Enroll throughout 2014



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Principal Accountable Providers – Episodes

Leads and coordinates services, ensuring quality of care across providers

PAP Selection	• Payers select PAP based on main responsibility for patient's care
Core Provider for Episode	• **Physician, practice, hospital** or **other provider** in the best position to influence overall quality, cost of care
Episode **"Quarterback"**	• **Leads and coordinates the team** of providers • Helps **drive improvement** across system
Performance Management	• Rewarded for **leading high-quality, cost-effective** care • **Receives performance reports and data** to support decision-making

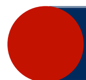
How episodes work for patients and providers (1/2)

Patients and providers deliver care as today (performance period)

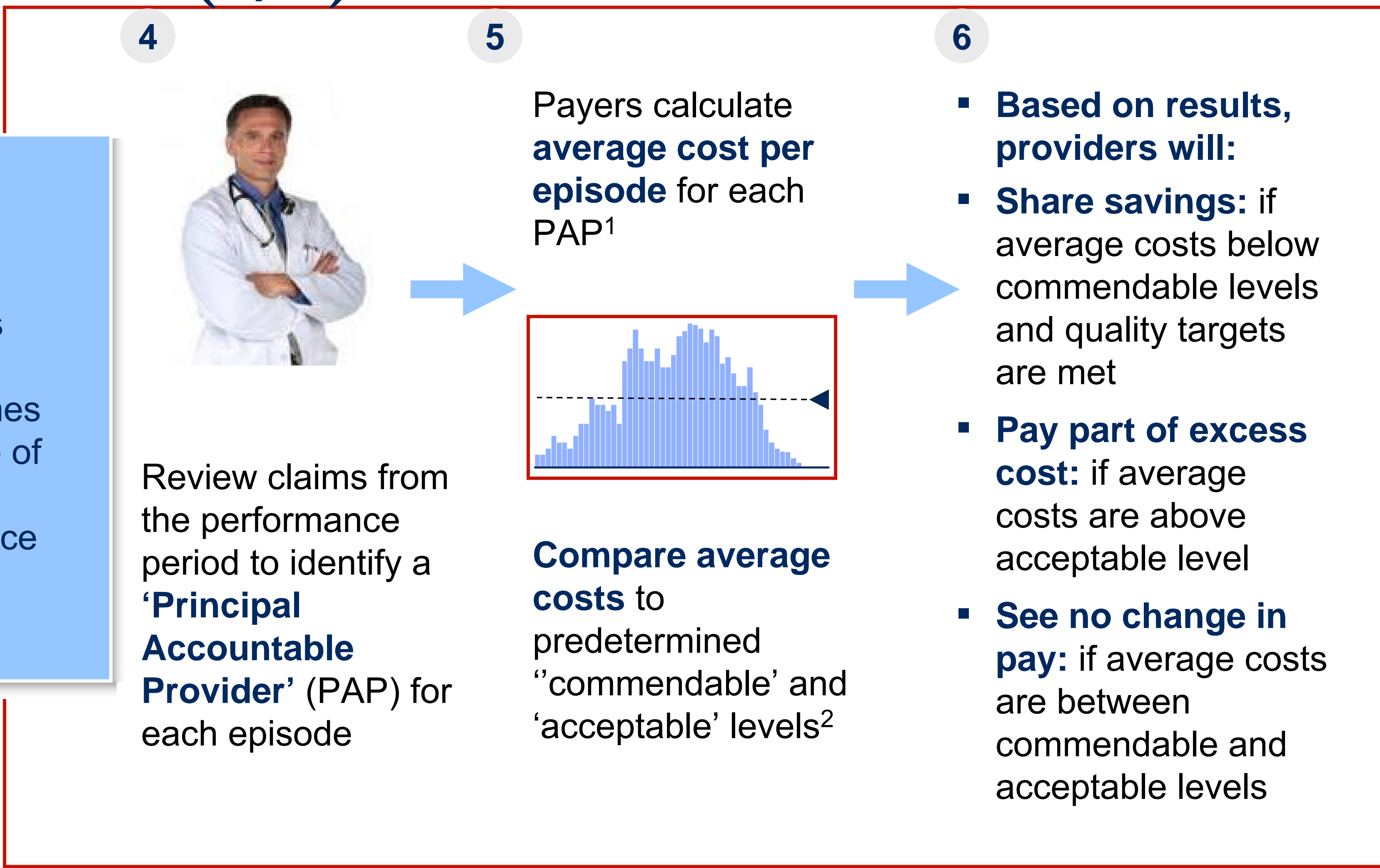
1. **Patients** seek care and select providers as they do today

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)



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

Wave 1 Episodes

Episode	Description	Principal Accountable Provider
Total Hip/ Knee replacement	• Surgical procedure plus related claims 30 days prior to 90 days after	Orthopedic surgeon
Perinatal (non-NICU)	• Pregnancy-related claims for mother 40 wks before to 60 days after delivery	Delivering provider
Ambulatory URI	• 21-day window beginning with initial consultation	First provider to diagnose patient in-person
Congestive Heart Failure Admission	• Hospital admission and care within 30 days of discharge	Admitting hospital
ADHD	• 12-month episode including all ADHD services plus pharmacy costs	Physician or licensed mental health provider

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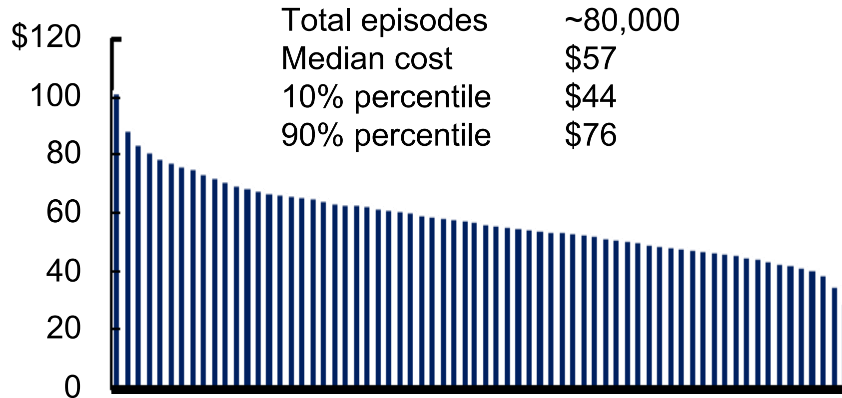
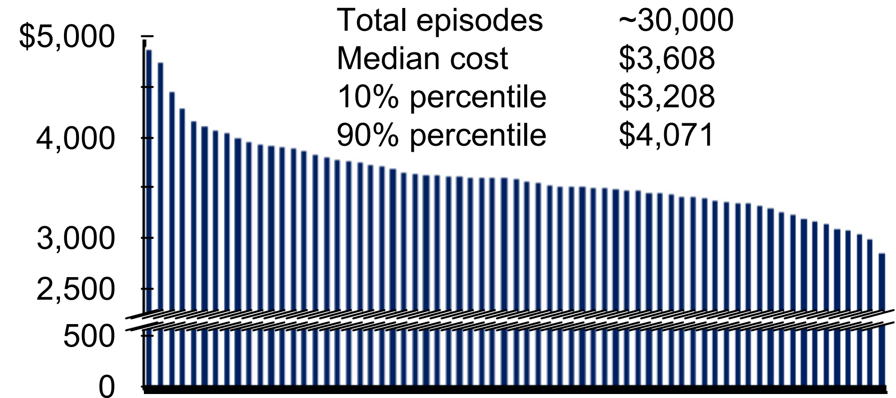
Case for Change

Total average cost per episode post-risk adjustment by Principal Accountable Provider, 2008-2010

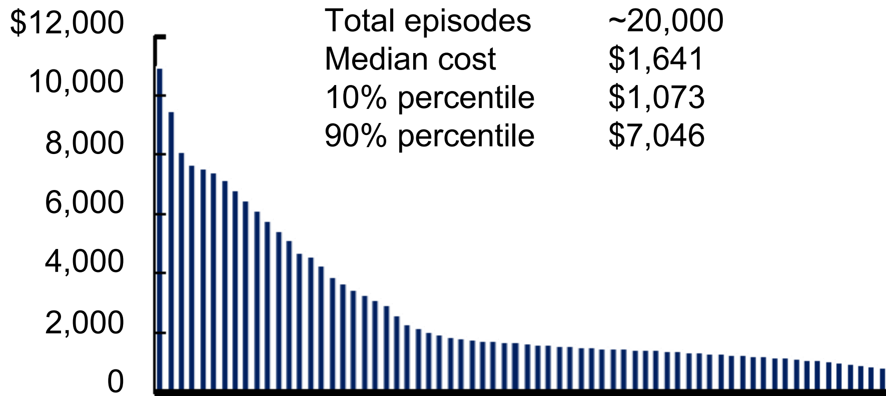
Simple upper respiratory infection[1]



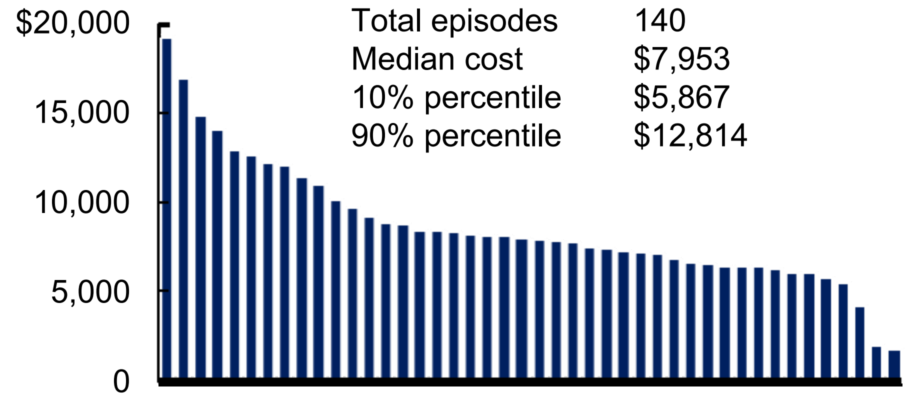
Pregnancy[2]



ADHD[3]



Total hip replacement



1 Episode costs for children less than 10 risk-adjusted by a historically-derived multiplier.
2 Individual episode costs risk-adjusted for clinical drivers of severity based upon historically-derived multipliers.
3 Eligible defined as ADHD without comorbidities between ages 6 and 17.

SOURCE: Arkansas Medicaid claims data; Team analysis

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How the Episode Payment Model Works

- **Historic distribution of provider average costs for an episode are assessed**

Year 1 results

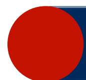
■ Year 1 results

High

Average cost per episode for each provider

Low

Individual providers, in order from highest to lowest average cost



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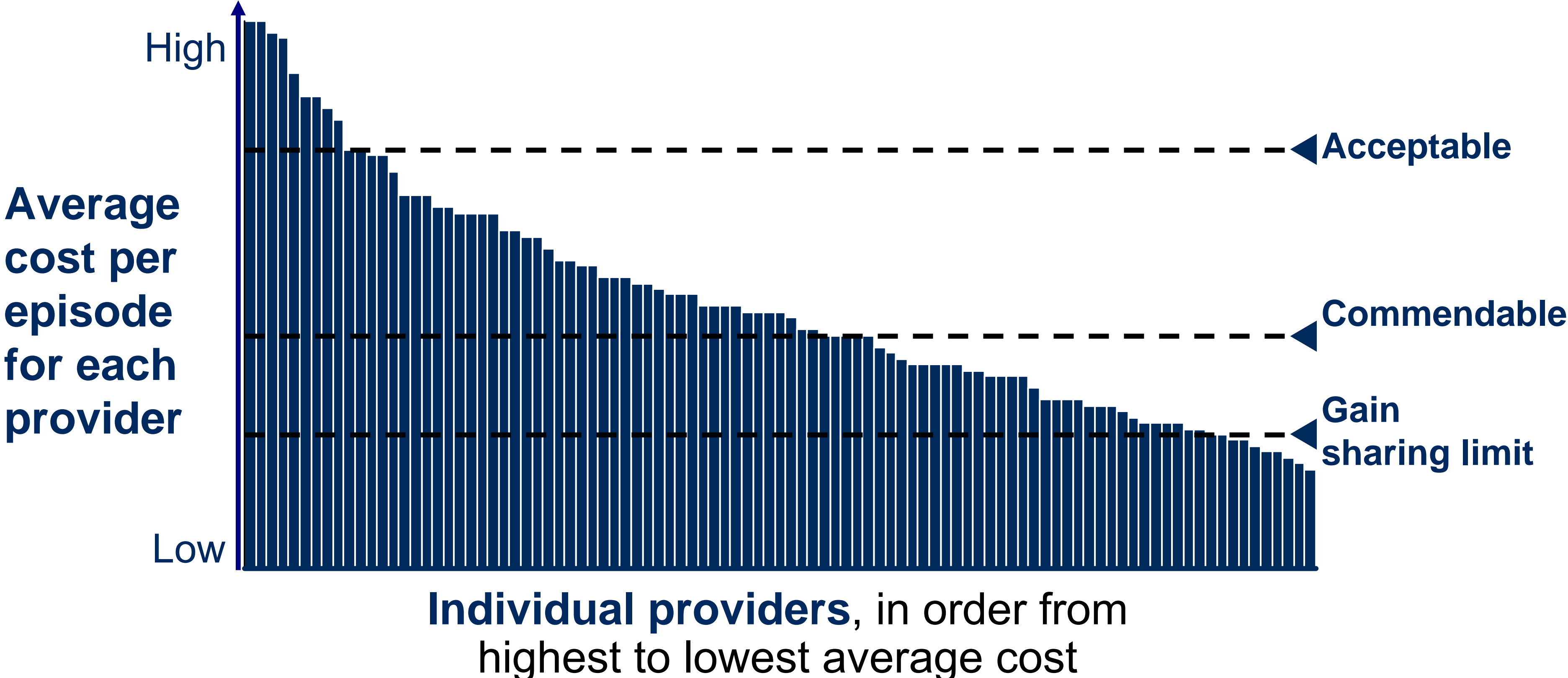
How the Episode Payment Model Works

- **Thresholds are selected to promote high-quality and cost-effective care**



How the Episode Payment Model Works

- **Thresholds remain the same the next year with expectation that cost effectiveness will improve**

Year 2 results

Year 2 results
Year 1 results

High

Low

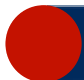
Average cost per episode for each provider

Acceptable

Commendable

Gain sharing limit

Individual providers, in order from highest to lowest average cost



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How the Episode Payment Model Works

Shared Savings

Year 2 results

High

Average cost per episode for each provider

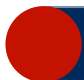
Acceptable

Commendable

Gain sharing limit

Low

Individual providers, in order from highest to lowest average cost



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How the Episode Payment Model Works

Savings/Cost Neutral

Year 2 results

High

Average cost per episode for each provider

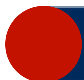
Low

Acceptable

Commendable

Gain sharing limit

Individual providers, in order from highest to lowest average cost



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How the Episode Payment Model Works

Shared Costs

Year 1 results

High

Acceptable

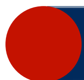
Average cost per episode for each provider

Commendable

Gain sharing limit

Low

Individual providers, in order from highest to lowest average cost



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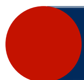
How the Episode Payment Model Works

- **Quality of care protected by limits on gain sharing and required quality metrics**

Year 1 results



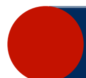
2013 Episodes: Wave 2 Launch

Wave 2a (Summer 2013)

- Tonsillectomy
- Cholecystectomy
- Colonoscopy
- Oppositional Defiant Disorder (ODD)

Wave 2b to follow (2014)

- PCI & CABG
- COPD exacerbation/Asthma exacerbation
- Neonatal Care
- ODD / ADHD



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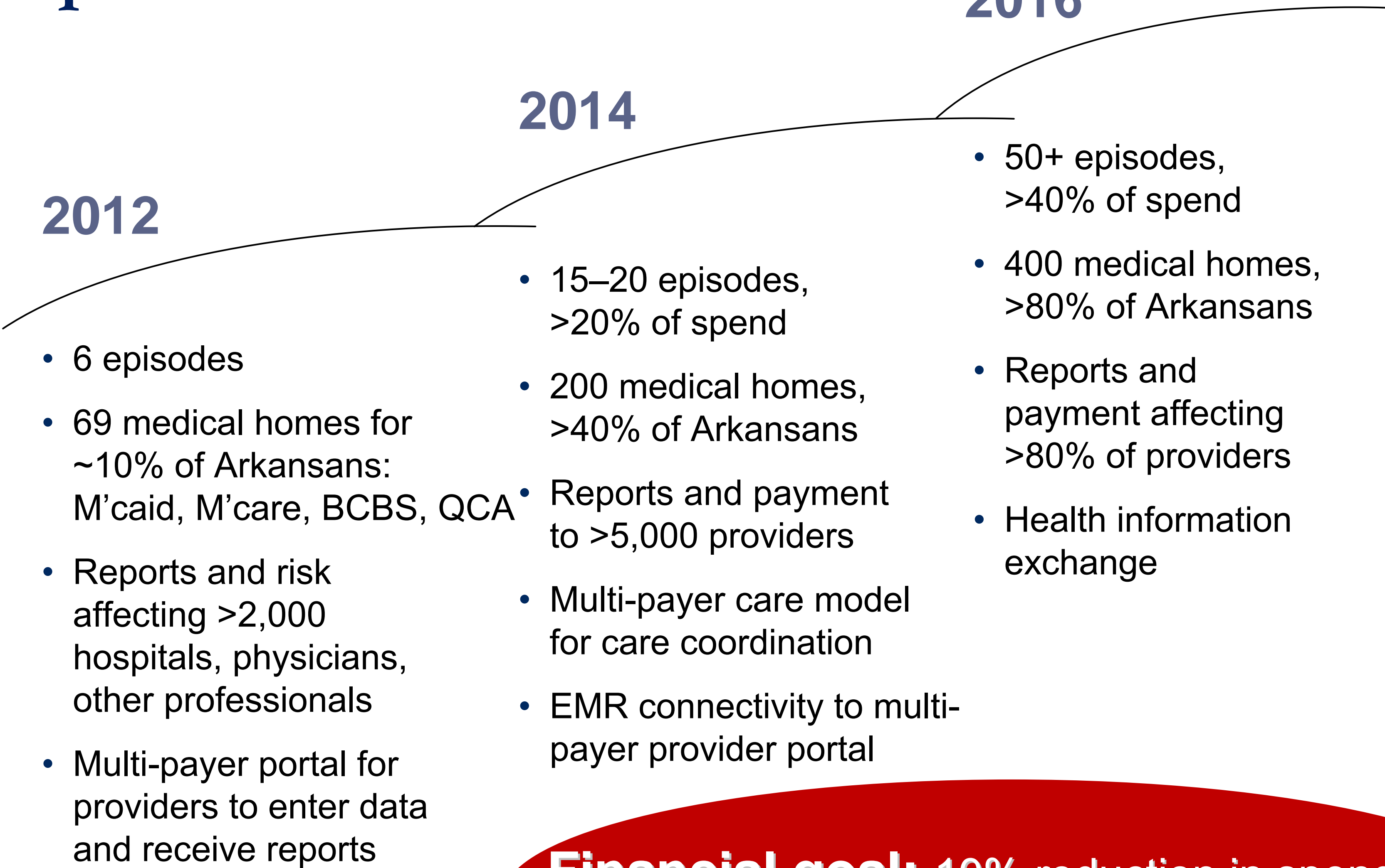
Scope and Pace of Rollout



Financial goal: 10% reduction in spend by 2017, followed by sustained reduction in trend*

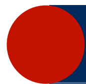
*Reflects goal publicly communicated by Arkansas Medicaid; similar success case for BCBS

Arkansas Act 1498: The Health Care Independence Act of 2013

- Expansion of Medicaid under PPACA using premium assistance—buying through the insurance exchange
- APII Participation requirements on carriers

  Section d) *Health insurance carriers offering health care coverage for program eligible individuals shall participate in Arkansas Payment Improvement Initiatives including but not limited to:*
  (1) Assignment of primary care clinician;
  (2) Support for patient-centered medical home; and
  (3) Access of clinical performance data for providers.

  - Effectively results in carrier mandate for APII



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What's Evolved, What's Stayed the Same

Stayed the same

- Multi-payer approach
- Aim to cover majority (>80%) of health care spending
- Transfer clinical management and efficiency risk to providers, but retain actuarial risk with payers

Evolved

- From prospective bundles to retrospective payment
- Integration of Patient Centered Medical Home model with episodes
- Voluntary participation to mandatory

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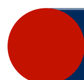
Lessons Learned Along the Way

1. Fundamental recognition that the healthcare system is not working and must change
2. Opportunity for the state to convene and lead
3. Multi-payer necessity: public/private, Medicaid/Medicare, fully and self-insured
4. Alignment of incentives for quality/outcomes critical
5. Opportunity to "lead or follow" across payers
6. Tension between fairness, simplicity, and scalability
7. Opportunity to lift up unanticipated champions
8. Focus on real transformation not a demonstration



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