THE CAMDEN GROUP

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Implementing Episodes of Care in Arkansas

Bundled Payment Summit
Washington DC
June 14, 2014

The Arkansas Landscape

- 3 million people
  - Poor health status
    - Obesity
    - Smoking
  - Low educational status
  - High incidence of poverty
- 3 major insurers cover roughly 2/3 of the population
  - Medicare
  - Medicaid
  - Arkansas Blue Cross Blue Shield
- Access to care
  - Predominantly rural geography
  - No integrated care systems

Arkansas Payment Reform Status

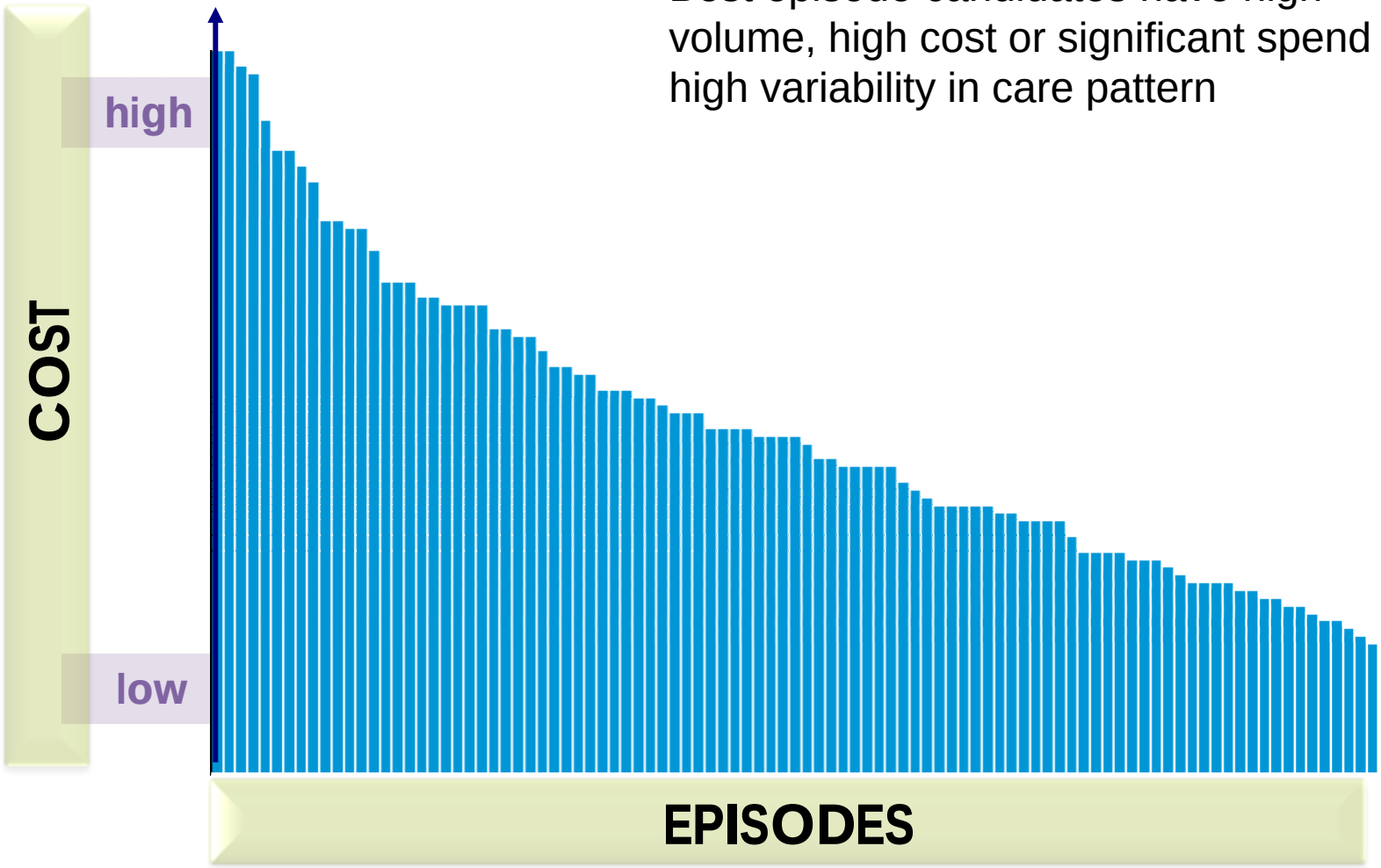
- Currently the largest multi-payer statewide bundled payment initiative in the country
- SIM Grant award for payment transformation
- Selected as a Comprehensive Primary Care Initiative (CPCI) pilot site by CMS
  - 66 practices participating
- Walmart (and other self funded employer) participation in both CPCI and episodes of care
- Medicaid and Arkansas Blue Cross Blue Shield both pursuing Patient Centered Medical Home programs
  - ABCBS-Pilot with multiple clinics
  - Medicaid-Statewide launch 2014

Starting the Discussion

- ✓ Transition to payment system that rewards value and patient health outcomes by aligning financial incentives
- ✗ Reduce payment levels for all providers regardless of their quality of care or efficiency in managing costs
- ✗ Pass growing costs on to consumers through higher premiums, deductibles and co-pays (private payers), or higher taxes (Medicaid)
- ✗ Intensify payer intervention in decisions though managed care or elimination of expensive services (e.g. through prior authorizations) based on restrictive guidelines
- ✗ Eliminate coverage of expensive services or eligibility

Cost Variation by Provider

Best episode candidates have high volume, high cost or significant spend and high variability in care pattern



Cost Variation

Cost for an uncomplicated hip/knee replacement
(general acute care hospital – highest-volume provider)

in **Little Rock**	$**18,911**
in **Jonesboro**	$**22,014**
in **NW Arkansas**	$**21,864**
in **Ft. Smith**	$**24,114**
in **Russellville**	$**22,695**
in **El Dorado**	$**28,247**

Majority of the variation is due to inpatient facility contracts

A New Level of Transparency

"Transparency is like a disinfectant for business. It will purify things and help start the healing, but… It's going to sting like hell."

Multi-Payer Episode Participation Chart

In Development | Live | Seeking clinical input | Pending legislative review

			Episode	Legislative Review	Reporting Period Start Date	Multipayer Participation[1]
Wave 1	Wave 1a	1	Upper Respiratory Infection	Spring 2012	July 2012	
		2	Attention Deficit Hyperactivity Disorder (ADHD)	Spring 2012	July 2012	
		3	Perinatal	Spring 2012	July 2012	QualChoice
	Wave 1b	4	Congestive Heart Failure	November 2012	October 2012	
		5	Total Joint Replacement (Hip & Knee)	November 2012	October 2012	QualChoice
Wave 2	Wave 2a	6	Colonoscopy	May 2013	July 2013	QualChoice
		7	Cholecystectomy (Gallbladder Removal)	May 2013	July 2013	QualChoice
		8	Tonsillectomy	May 2013	July 2013	
		9	Oppositional Defiance Disorder (ODD)	July 2013	October 2013	
	Wave 2b	10	Coronary Artery Bypass Grafting (CABG)	July 2013	January 2014	
		11	Percutaneous Coronary Intervention (PCI)	July 2013	Q2 CY 2014	QualChoice
		12	Asthma	July 2013	Q2 CY 2014	
		13	Chronic Obstructive Pulmonary Disease (COPD)	July 2013	Q2 CY 2014	
		14	ADHD/ODD Comorbidity	Q2 CY 2014	2H CY 2014	
		15	Neonatal	Q2 CY 2014	2H CY 2014	

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

Calculate incentive payments based on outcomes after performance period, typically 12 months long (retrospective reimbursement)

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

   Compare average costs to predetermined ''commendable' and 'acceptable' levels

6. Based on results, providers will

Share savings:

If average costs below commendable levels and quality targets are met

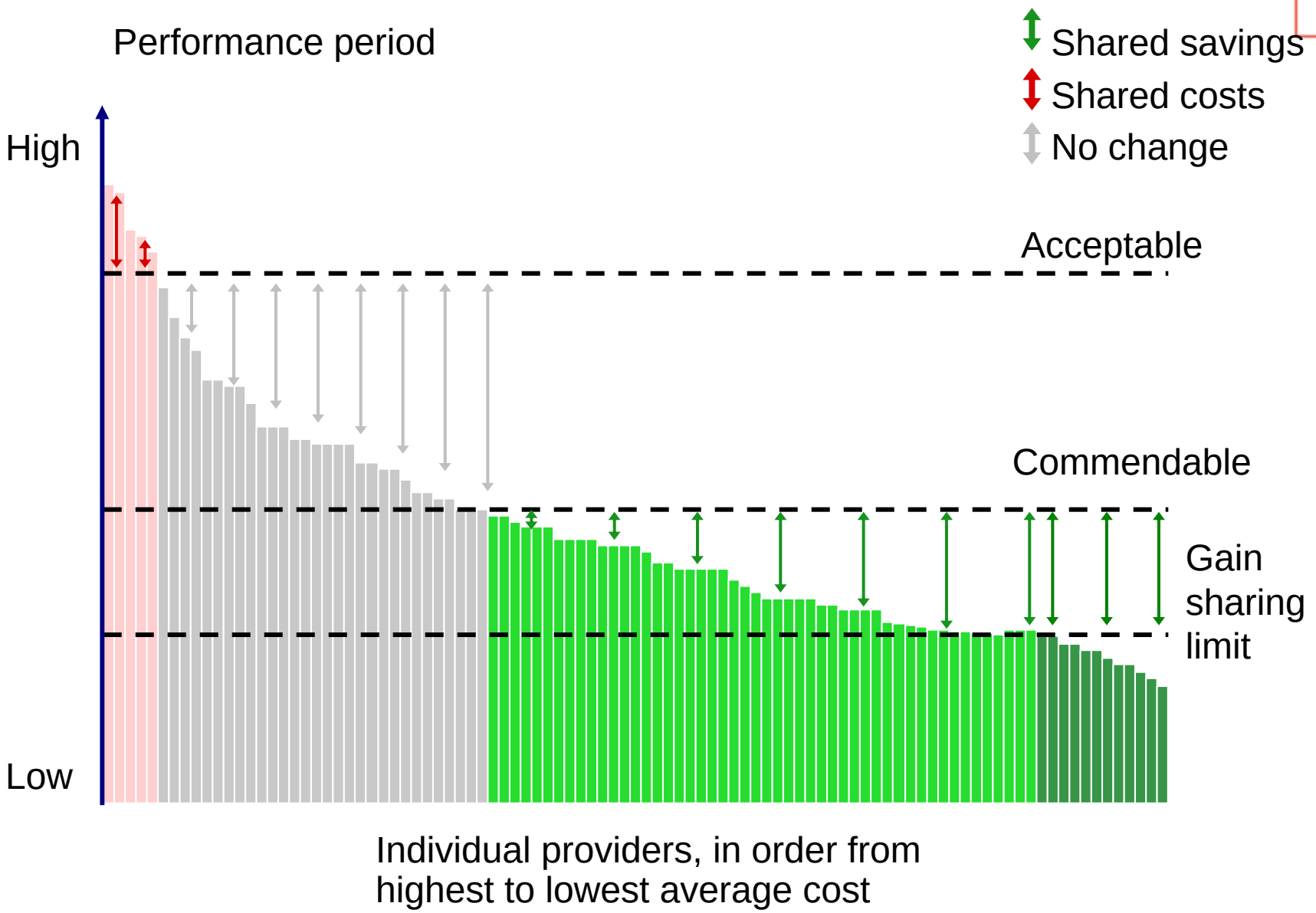
Pay part of excess cost:

if average costs are above acceptable level

See no change in pay:

if average costs are between commendable and acceptable levels.

Example Gain/Risk Sharing Graphic



Implementation Scalability

- Consider the specialties and number of providers involved in the episodes as part of launch strategy
  - Do you want to launch a primary care episode first?
  - Focus on smaller specialties
- Initial program launch and provider education is EXTREMELY labor intensive
  - One on one, face to face meetings
  - Broad town hall meetings, attendance at specialty society meetings, hospital association, medical society etc
  - Some require individual meetings without partners present
  - Most effective team is a physician accompanied by someone knowledgeable about the details of the data/methodology
  - Every provider in a loss sharing position should have an in person meeting to explain the practice pattern variation identified in the reports

Implementation Scalability

- What staff will answer provider questions (customer service unit)
  - How many? What background? Analysts? Customer Service?
  - Repurpose existing staff or new hire?
  - What kind of analytical platform?
  - Each provider has a different set of circumstances and requires an individualized evaluation/report drilldown
    - Difficult to automate
  - Response times for turnaround of information
- Call volume
  - Expect a call from every provider in a loss sharing position
  - Motivated high performers that want to continue performance improvement
  - Mid range docs looking to achieve gain sharing

Preliminary Results

- With properly aligned incentives, behavior change is almost immediate
  - Increased compliance with ACOG Guidelines for Perinatal
  - Decreased antibiotic use in URI episodes
  - Significant cost savings for ADHD/ODD episodes
  - Providers practicing at different hospitals
  - Decreased use of inpatient rehab
  - Different conversations between payers and hospitals regarding reimbursement
    - Can no longer afford to be the most expensive in the market
- Better communication and collaboration between the hospitals, payers and physicians
- Better care being rendered to Arkansans

Why It Worked

- Provider participation is mandatory
  - Medicaid legislated participation
  - Arkansas Blue Cross Blue Shield business decision to require participation or leave network completely
  - Not a single provider left the networks because of the initiative
- Initial statewide launch-not a pilot
- Payers participating represent significant enough market share for any practice that providers can’t afford to walk away from the initiative financially
- Physician champions emerged and encouraged their peers
- Transparency

Questions?

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