Building a healthier future for all Arkansans

Arkansas Payment Improvement Initiative (APII): Plans for the Medical Home

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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

Patient-centered medical homes are a core component of this shift to paying for results and part of a broader statewide effort

Enable and reward providers for

- Improving the **health** of the population
- Enhancing the **patient experience** of care
- Reducing or control the **cost of care**

How care is delivered

Medical homes + Health homes

Episode-based care delivery

Five aspects of broader program

- **Results-based payment and reporting**
- **Health care workforce development**
- **Health information technology adoption**
- **Consumer engagement and personal responsibility**
- **Expanded coverage for health care services**

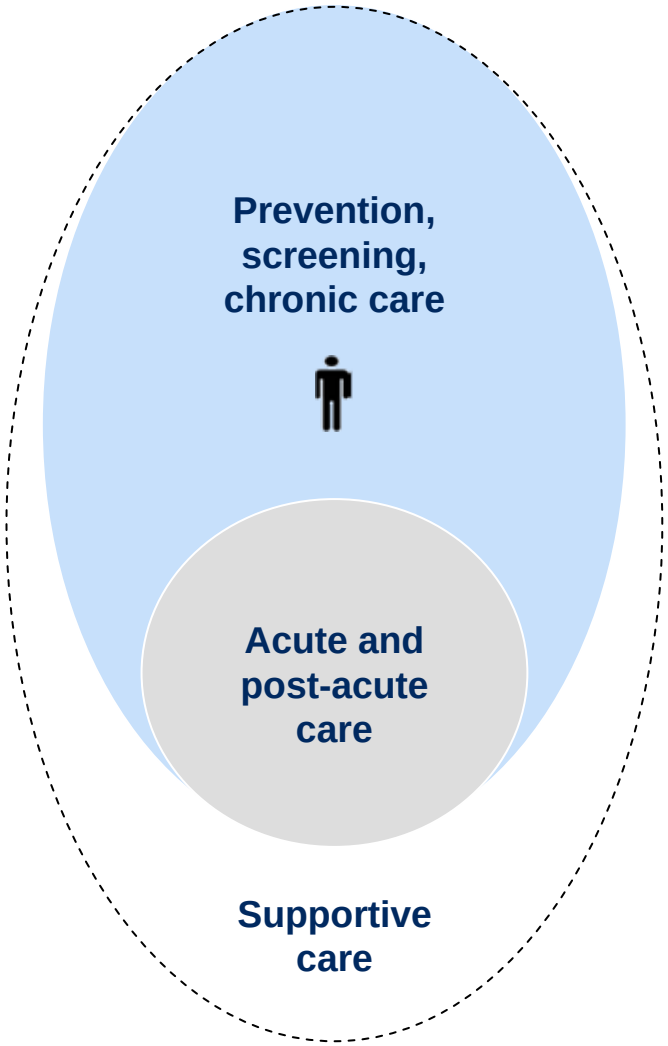
Payers recognize the value of working together to improve our system, with close involvement from other stakeholders…

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

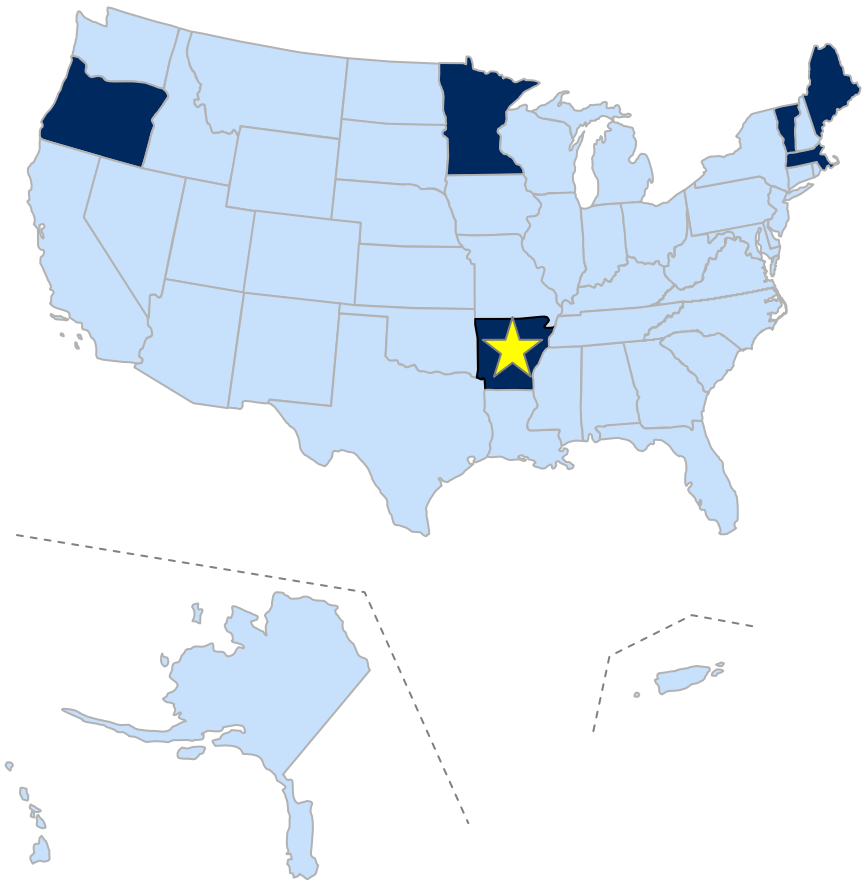
1 Center for Medicare and Medicaid Services

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

Arkansas is one of six states CMS awarded model-testing grant



- The **CMS State Innovation Models** (SIM) Initiative is providing funding to the State of Arkansas
  - **$42 million** to implement and test the initiatives over the next 42 months
  - **Funding covers** episode-based care delivery, patient-centered medical homes, and health homes
- The State sees this grant as an **indication of CMS' engagement** with the initiative and belief that it could be a model more broadly applied in the country

Medicaid and private insurers believe paying for patient results, rather than just individual patient services, is the best option to control costs and improve quality

- Transition to system that **financially rewards value** and **patient outcomes** and **encourages coordinated care**

- **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 clinical decisions** to manage use of expensive services (e.g. through prior authorizations) based on prescriptive clinical guidelines
- **Eliminate coverage of** expensive services, or eligibility

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

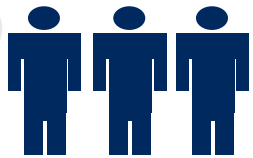
- Approaches under consideration for instances where multiple providers involved, e.g.,
  - Prenatal care and delivery carried out by different providers
  - Patient sees multiple providers for URI

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)

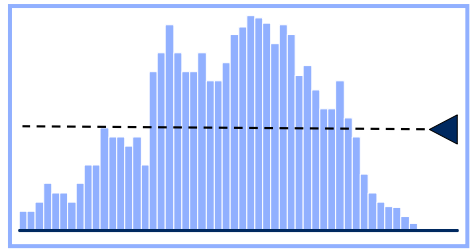
Calculate incentive payments based on outcomes after close of 12 month performance period

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]

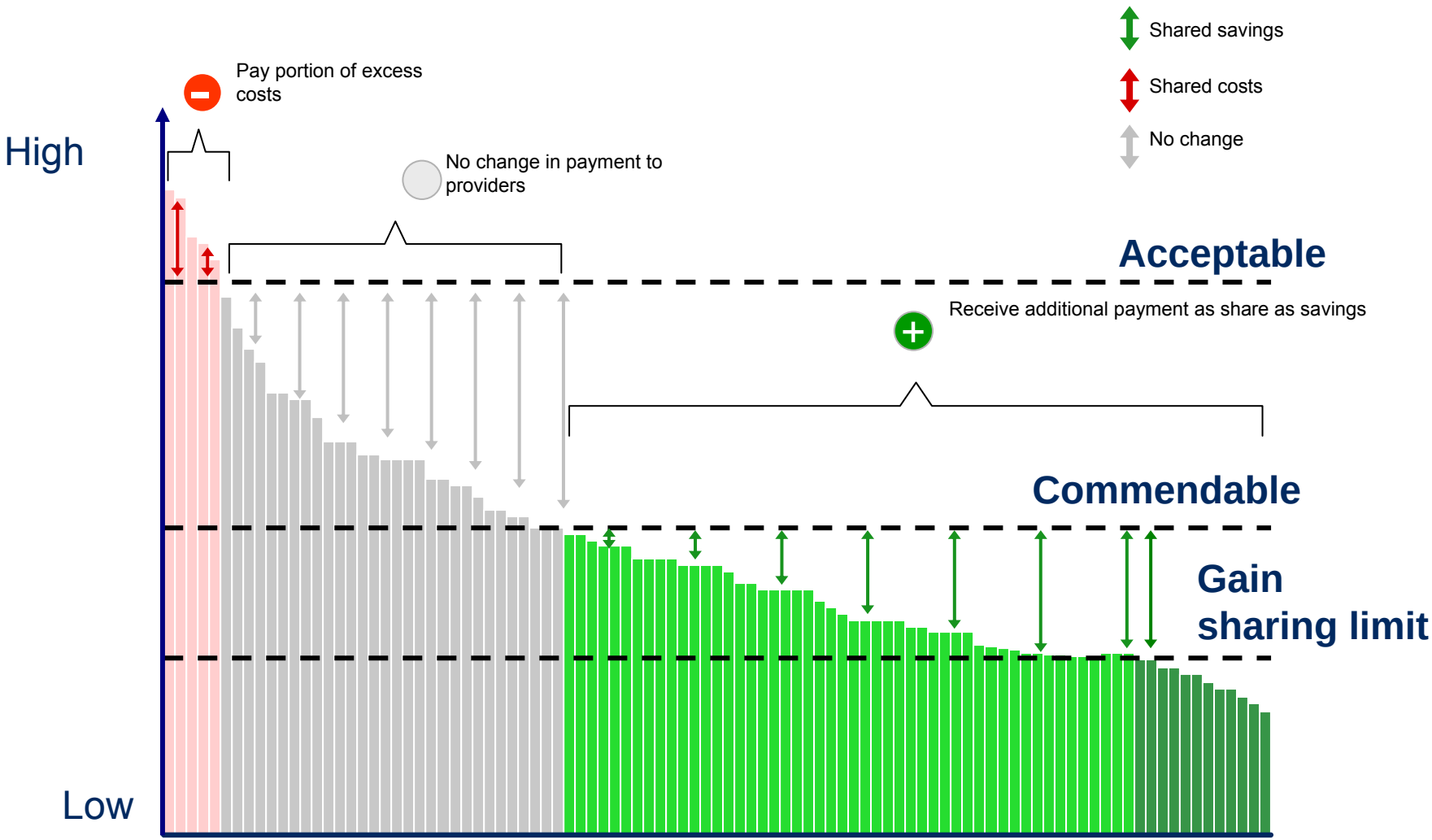


6 **Based on results, providers will:**

- **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

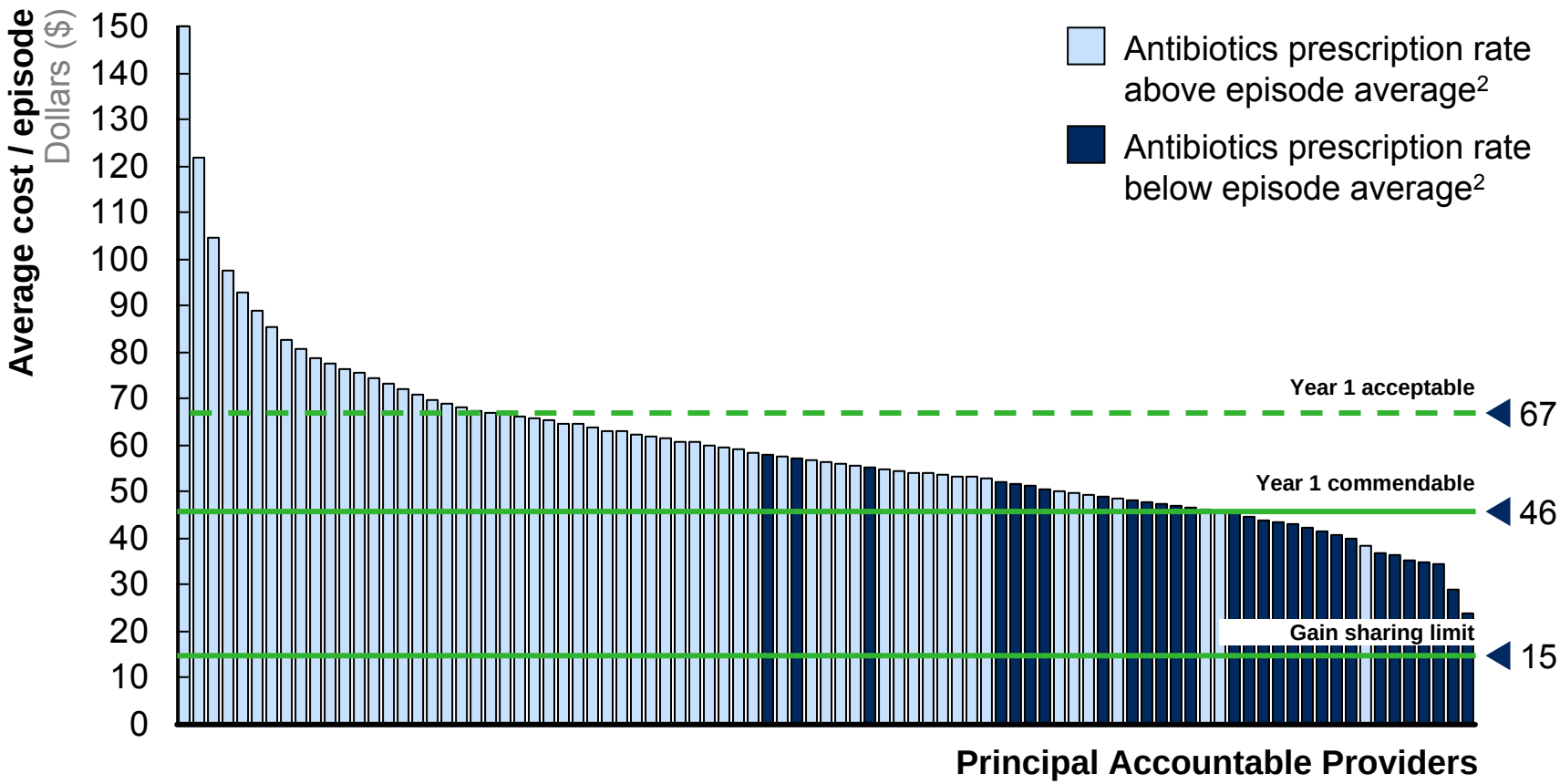
PAPs that meet quality standards and have average costs below the commendable threshold will share in savings up to a limit



Draft thresholds for General URIs

Provider average costs for General URI episodes

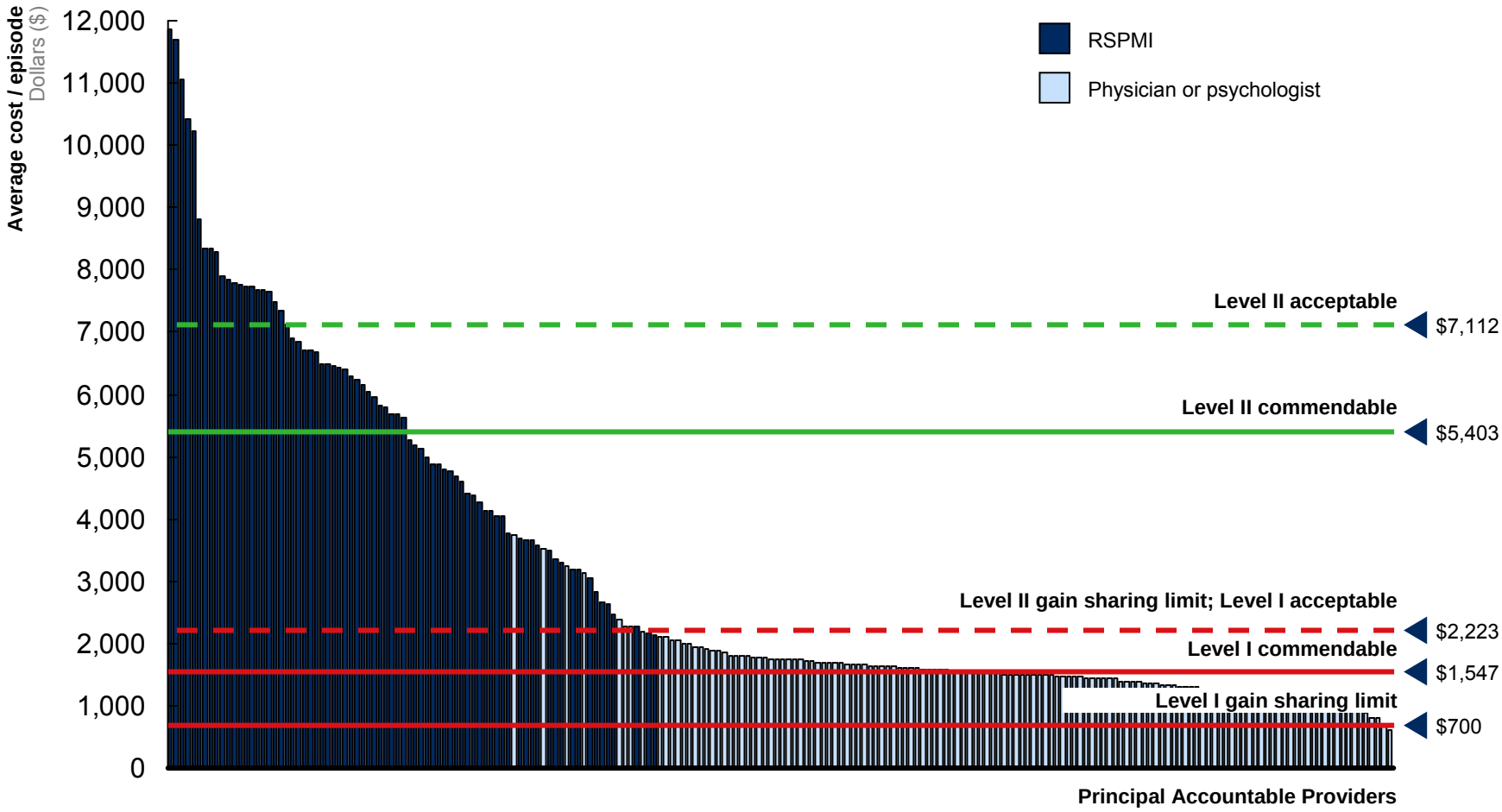
Adjusted average episode cost per principal accountable provider[1]



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

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

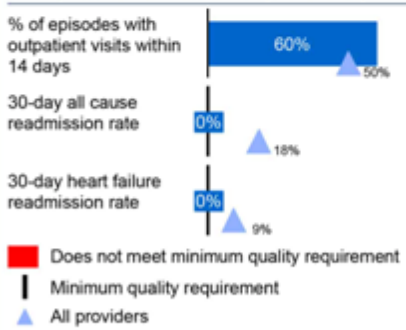
Quality summary

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.

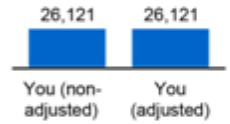
Quality metrics - not linked to gain sharing



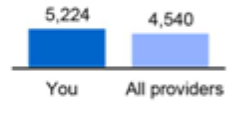
Cost summary

Your average cost is acceptable

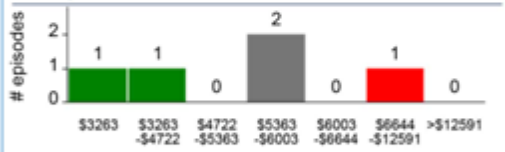
Your total cost overview, $



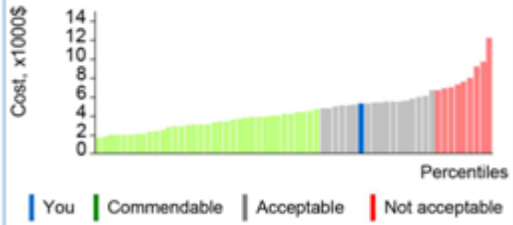
Average cost overview, $



Your episode cost distribution



Distribution of provider average episode cost

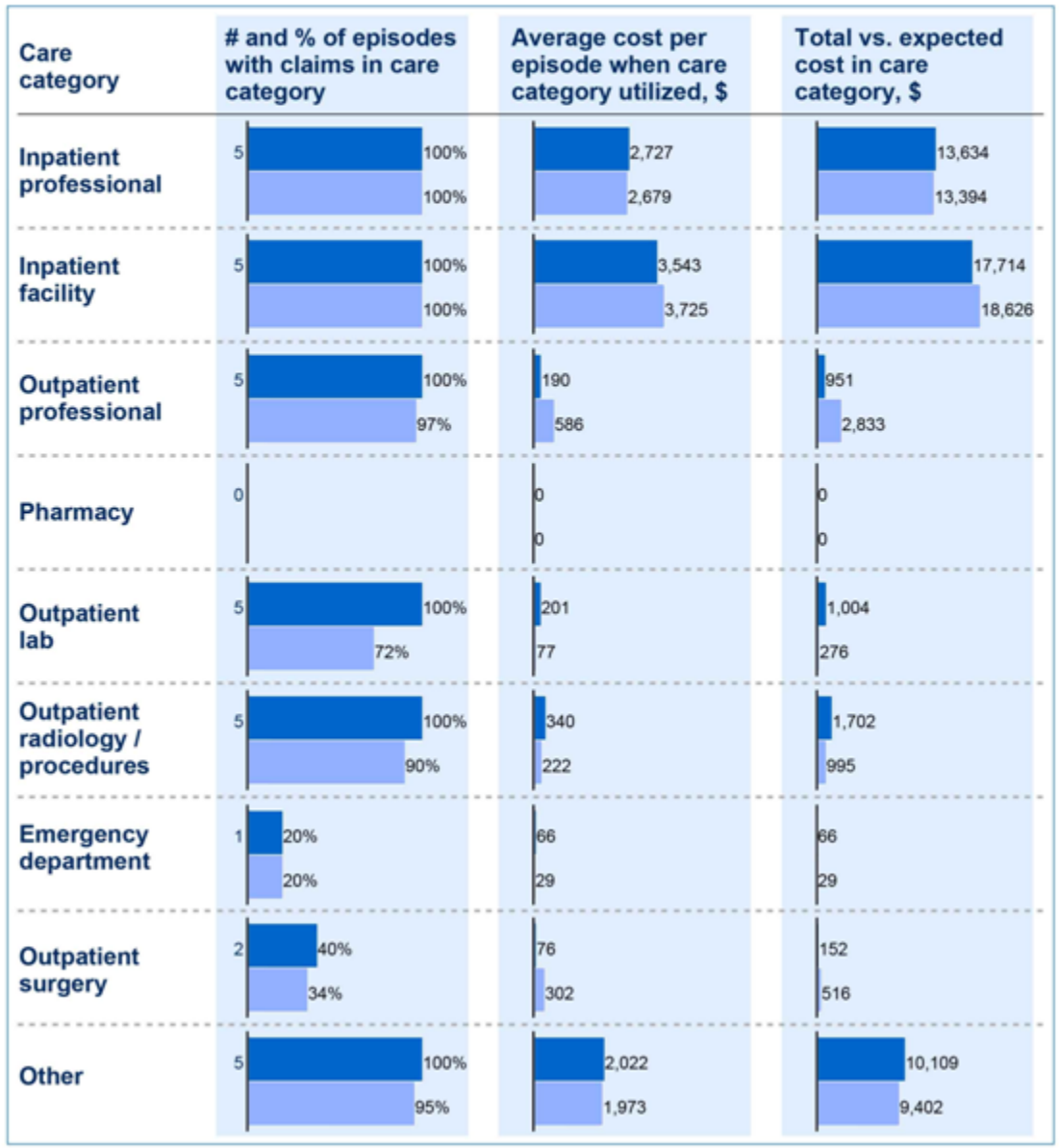


Key utilization metrics

30-day outpatient observation care rate

Cost detail - Total Joint Replacement

Total episodes included = 5



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

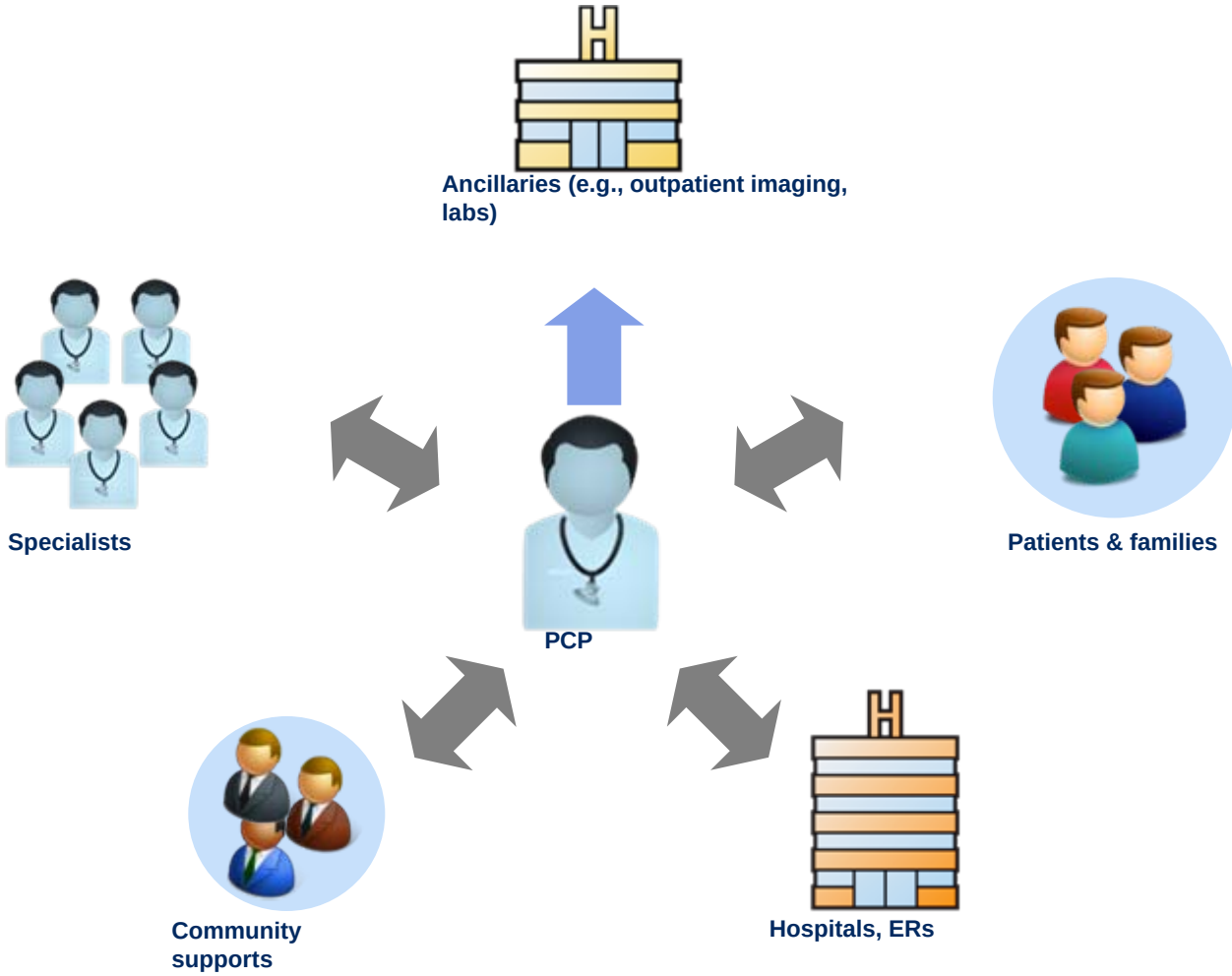
- Manage quality and cost of services provided within the PCP practice
- Provide primary care clinical services
- Focus on diagnosis and treatment
- Focus on the issue presented at a given visit

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

Why primary care and PCMH?

Most medical costs occur outside of the office of a primary care physician (PCP) , but PCPs can guide many decisions that impact those broader costs, improving cost efficiency and care quality



Goals of episode-based and PCMH components of the Payment Initiative are aligned

- ✓ Reward high-quality care and outcomes
- ✓ Encourage clinical effectiveness
- ✓ Promote early intervention and coordination to reduce complications and associated costs
- ✓ Encourage referral to higher-value downstream providers

Several developments in primary care payment aim to more appropriately compensate PCPs for playing this essential role

Medicaid rate bump – increase in primary care rates paid by Medicaid starting in April

Outside of PCMH

Coverage expansion – decrease in uncompensated care with increase in coverage on exchanges

Gain-sharing – significant upside only opportunity to share in savings from effectively patient panels' total cost of care

Part of PCMH

Support payments for PCMH – per member per month (PMPM) payments to support investment in care coordination and practice transformation activities

Arkansas PCMH strategy centers on three core elements:

Incentives

- Gain-sharing
- Payments tied to meeting quality metrics
- No downside risk

Support for providers

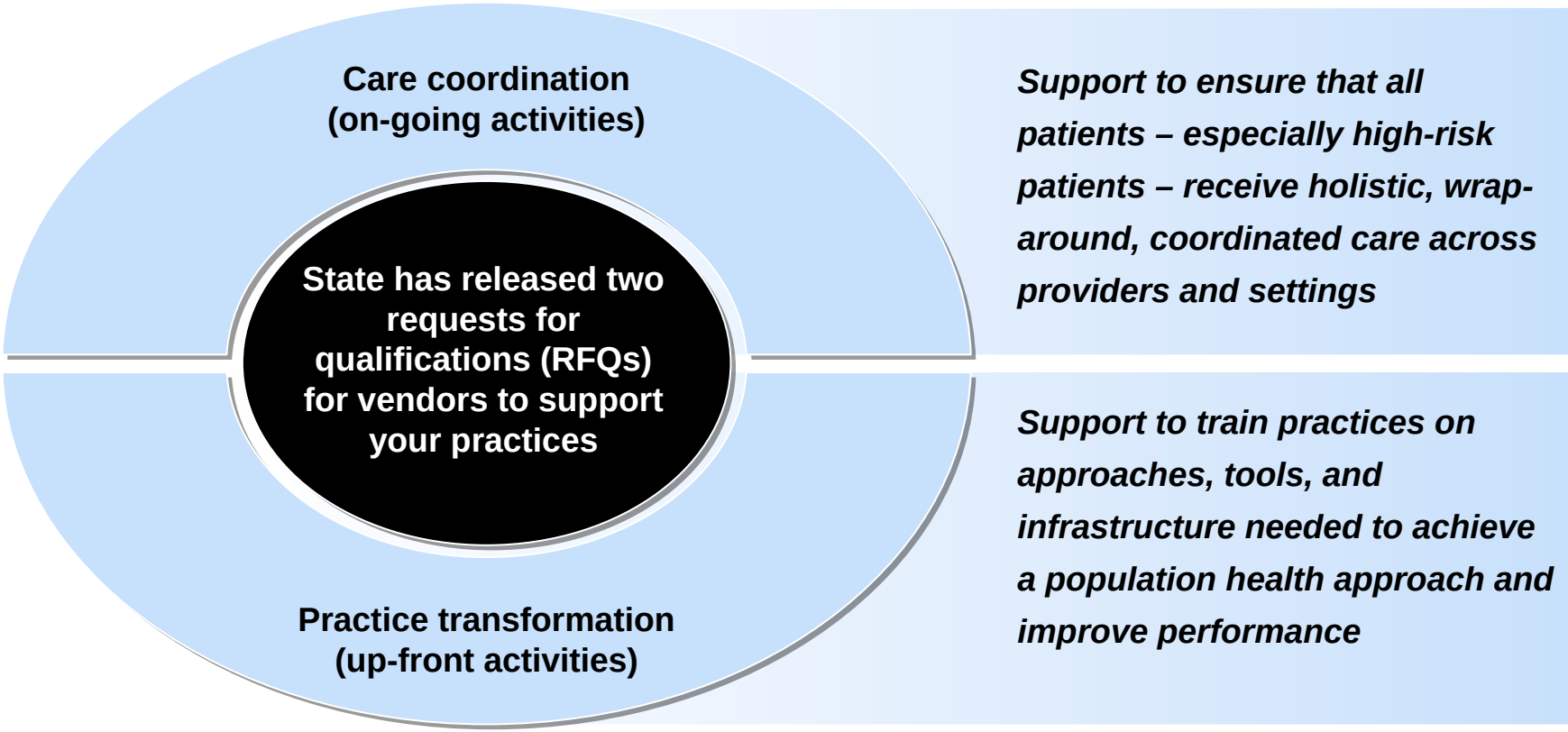
- Monthly payments to support care coordination and practice transformation
- Pre-qualified vendors that providers can contract with for
  - Care coordination support
  - Practice transformation support
- Performance reports and information

Clinical leadership

- Physician “champions” role model change
- Practice leaders (clinical and office) support and enable improvement

SUPPORT FOR PCMH ACTIVITIES

Practices will have the option to contract with pre-qualified vendors to support for care coordination and practice transformation activities



- Use of pre-qualified vendors is optional
- **Vendor model developed based on provider input that:**
  - **An easy process to identify vendors is important**
  - **Support is needed**
  - **Providers need flexibility to tailor support to their own practices**

Practices will receive monthly payments to support these activities

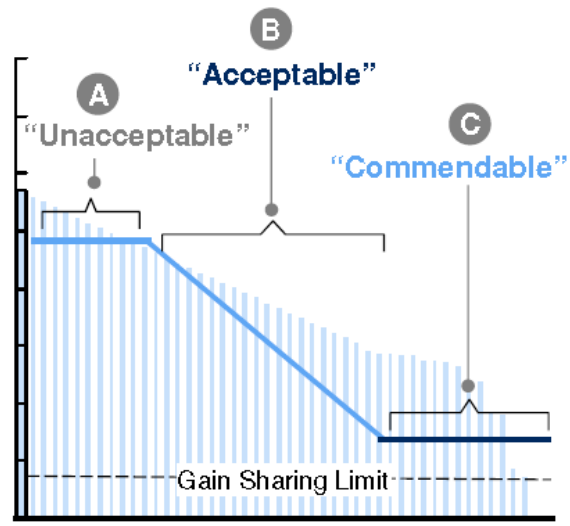
	Care coordination and general practice investment	Practice transformation
Payment amount	▪ Average of $4 per member per month (PMPM) ▪ Actual amount paid to be adjusted based on risk and complexity of patient panel	▪ $1 per member per month (PMPM) ▪ Flat amount per patient – not risk adjusted
Purpose and uses	▪ Fund on-going care coordination activities ▪ Fund PCP and staff time invested in new care model ▪ PCPs choose how to use funds (e.g., pre-qualified vendor, other external support, internal practice investment)	▪ Fund costs to transition practice model to PCMH ▪ PCPs only receive $1 PMPM payment if they contract with a pre-qualified vendor

A PCP with 2000 attributed patients could receive up to $120,000 a year in support

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)

- **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