Transforming Medicaid at Scale:

Looking Back and Ahead

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International Challenge

All Health Systems

- Have Service Demand and Limited Resources
  - Taxes vs. Premiums vs. Co-Pays vs. Access Limitations
- Need Greater Stewardship
  - Providers, Payers, Patients
- Should Explore New Incentives to Shape Delivery
  - Reward Outcomes, Effectiveness

Arkansas Journey

- Harnessing Big Data
  - Policy Reforms
  - P4P
- Medicaid Expansion
  - Private Option
- Multipayer Payment Reform
  - Episodes of Care
  - PCMH
- Provider Led Accountable Care

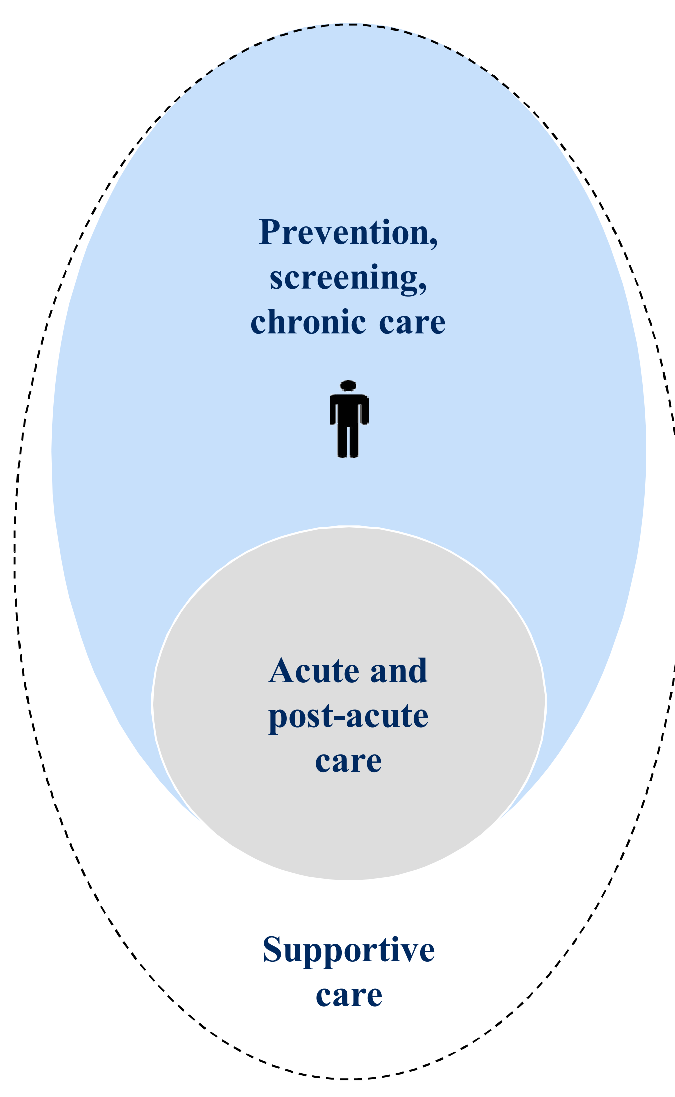
AR Medicaid – Payment Reform

- Journey Started 2011
- First CMMI Implementation Recipient
- Episodes of Care – July, 2012
- Voluntary PCMH – January 2014
  - 200+ Practices,
  - >950 PCPs,
  - 85%+ Eligible Medicaid Population

Engagement

Governor's Office – Vision, Recruit Payers
Dept Human Services – Host Meetings, Develop Framework
Legislature – Approve Regulations
Private Insurers – Develop Internal Programs
Professional Societies – Cautious Support, Engagement
Clinical Leaders – Acceptance of Need for Change
Contractors – Outreach Activities, Data Management

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

2012

Implementation

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

Shared savings
Shared costs
No change

Pay portion of excess costs

No change in payment to providers

Receive additional payment as share as savings

High

Low

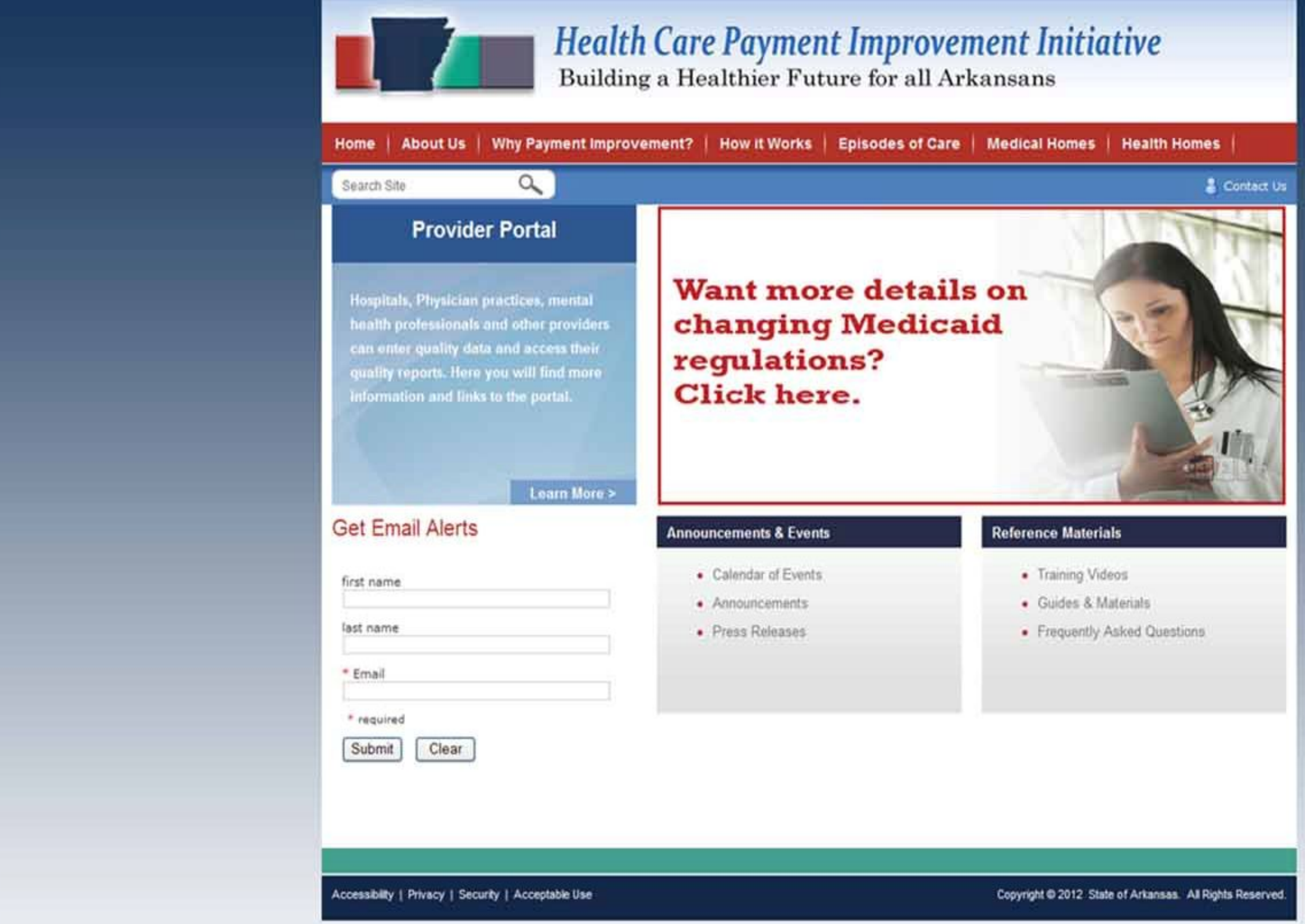
Acceptable

Commendable

Gain sharing limit

Individual providers, in order from highest to lowest average cost

Provider Portal



2014

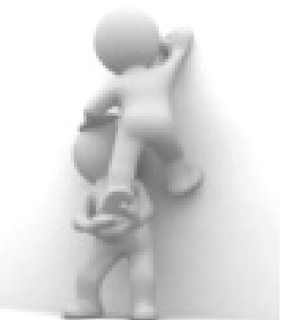
PCMH

Providers can then receive support to invest in improvements, as well as incentives to improve quality and cost of care

Practice support

Invest in primary care to improve quality and cost of care for all beneficiaries through:

- Care coordination
- Practice transformation



Shared savings

Reward high quality care and cost efficiency by:

- Focusing on improving quality of care
- Incentivizing practices to effectively manage growth in costs

Activities tracked for practice support payments provide a framework for transformation

● Completion of activity and timing of reporting

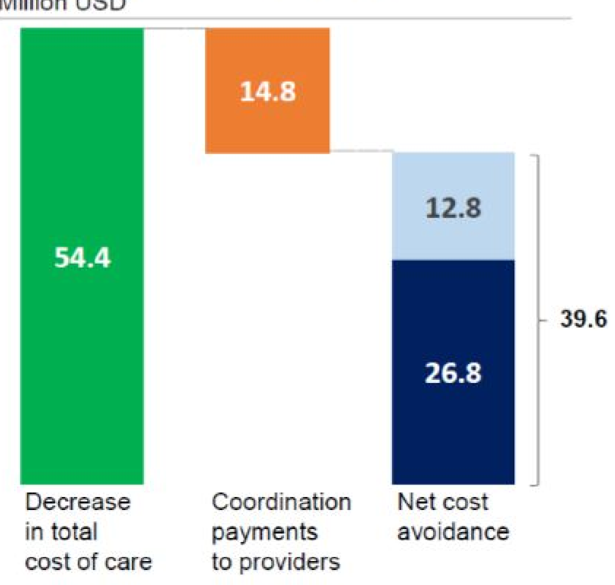
	Activity	Commit to PCMH Month 0-3	Start your journey Month 6	Evolve your proce-sses Month 12	Continue to innovate Month 16-18	 Month 24
1	Identify office lead(s) for both care coordination and practice transformation[1]	●				
2	Assess operations of practice and opportunities to improve (internal to PCMH)		●			●
3	Develop strategy to implement care coordination and practice transformation improvements		●			●
4	Identify top 10% of high-priority patients (including BH clients)[2]	●			●	
5	Identify and address medical neighborhood barriers to coordinated care (including BH professionals and facilities)		●			
6	Provide 24/7 access to care		●			
7	Document approach to expanding access to same-day appointments		●			
8	Complete a short survey related to patients' ability to receive timely care, appointments, and information from specialists (including BH specialists)			●		
9	Document approach to contacting patients who have not received preventive care			●		
10	Document investment in healthcare technology or tools that support practice transformation			●		
11	Join SHARE to get inpatient discharge information from hospitals			●		
12	Incorporate e-prescribing into practice workflows[3]				●	
13	Integrate EHR into practice workflows					●

1 - At enrollment; 2 - Three months after the start of each performance period; 3 - At 18 months

PCMH Results

Cost Reduction

1 **Reduce or control the cost of care for 2015**



- *Of the $660.9M predicted total cost of care[2], $606.5M is the actual cost[3], $54.4M is the generated cost avoidance*

Of the $54.4M in generated cost avoidance

- *$14.8M has been reinvested back into the provider community*
- *$12.8M is the shared savings incentive paid to providers for CY2015 in Q3'16, Q1'17 and Q3'17*
- *$39.6M represents total net cost avoidance*

1 2015 figures are based on 365 days of claims run out on Medicaid data.
2 2015 projected total cost of care per member per year ($2082.8), multiplied by the number of six month attributed beneficiaries.
3 2015 actual total cost of care per member per year ($1911.2), multiplied by the number of six month attributed beneficiaries.

PCMH 2018

- EHR Data
  - BMI, Control of Blood Pressure and Diabetes
  - EHR Data Often **Not** Practice Level
  - Inconsistent Data Generation Across Platforms
  - Implications for CPC+, MACRA, MIPS
- Clinical Data Enterprise
  - Greater Payer Engagement, Financing
- Co-location of Behavioral Health

Lessons

- Big Data
  - Analytics Essential – BUT a Demanding Garden
  - Real Time vs Claims Data
  - System Data vs Patient Journey
  - Missing Data, Clunky Metrics

Stewardship

- Learning System
  - Stretch the Providers Who ----
  - Provide Program Feedback ---
  - That Modifies Requirements/Analytics ---
  - Which Support Practice Transformation ---
  - And Starts New Cycle of Dialogue
- National Payers/Self Insureds Awkward Partners

Implications

- Future Metrics = Stewardship
  - Accountability for Patient Journey
  - Total Cost of Care, Outcome, Patient Satisfaction
  - Role of the Medical Neighborhood
- Reward Early Adopters

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