Building a healthier future for all Arkansans

Arkansas Payment Improvement Initiative (APIII)

Ray Montgomery, FACHE
President/CEO
White County Medical Center
Currently Uninsured:
~550,000

- Medicaid
- Medicare Disability*
- Medicaid—Extremely low-income parents*
- ARKids First A
- ARKids First B
- Medicaid for Pregnant Women
Medicaid Income Eligibility Limits as a Percent of Federal Poverty Level, July 2012

Arkansas:
Fed Min for Parents = 13% FPL
Jobless Parents = 13% FPL
Working Parents = 17% FPL

Working Parents

Arkansas Health System Transformation

Objective

Accountability for “The Triple Aim”
- Improving the health of the population
- Enhancing the patient experience of care
- Reducing or controlling the cost of care

Clinical innovation strategies

Population-based care delivery
- Care planning
- Enhanced access
- Team-based care
- Care coordination
- Performance transparency

Episode-based care delivery
- Clinical guidelines
- Shared decision making
- Team-based care
- Care coordination
- Performance transparency

Enabling initiatives

Outcomes-based payment and reporting
Health care workforce development
Health information technology adoption
Expanded coverage for health care services
Arkansas Health System Improvement Agency Organizational Structure

State Leadership

- Governor Mike Beebe

State Leadership Implementation & Coordination

- Governor’s Policy Staff & Dr. Joe Thompson
  - ACHI

Implementation

- Workforce Chancellor
  - Dan Rahn & Dr. Paul Halverson
- Payment & Quality Improvement
  - Mr. John Selig
- Health Information Technology
  - Mr. Ray Scott
- Insurance Exchange Commissioner
  - Jay Bradford

Workgroup Participation

- UAMS ADH & ACHI
  - Higher Ed (2- & 4 yr)
- Steering Group:
  - DHS, ADH, BCBS, QualChoice, United, ACHI
- AFMC UAMS DIS Medicaid
- AID (Exchange)
  - DHS (Mcd eligibility & expansion) EBD
Vision:

• **Goal** – 90% of payments for care to be under this system within 3 years

• Each episode cost approximately $3 million

• Incorporate Medicaid, Medicare, and Commercial Insurance into episodic-based care delivery payment model
What’s included in Payment Improvement?
Medical homes, health homes, and episodes

### Patient populations (examples)

<table>
<thead>
<tr>
<th>Type</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy, at-risk</td>
<td></td>
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<tr>
<td>Chronic, e.g.,</td>
<td>- CHF</td>
</tr>
<tr>
<td></td>
<td>- Diabetes</td>
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<tr>
<td>Acute medical, e.g.,</td>
<td>- CHF</td>
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<tr>
<td></td>
<td>- Pneumonia</td>
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<tr>
<td>Acute procedural, e.g.,</td>
<td>- Hip replacement</td>
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<tr>
<td></td>
<td>Developmental disabilities</td>
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<tr>
<td></td>
<td>Long-term care</td>
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<td></td>
<td>Behavioral health (mental illness/substance abuse)</td>
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</tbody>
</table>

### Care/payment models

<table>
<thead>
<tr>
<th>Type</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical homes</td>
<td>- Care coordination</td>
</tr>
<tr>
<td></td>
<td>- Overall health management</td>
</tr>
<tr>
<td></td>
<td>- Rewards for quality, utilization, total cost of care</td>
</tr>
<tr>
<td>Episodes</td>
<td>- Rewards for high quality, effective care delivery for a specific episode</td>
</tr>
<tr>
<td>Health homes + episodes</td>
<td>- Health Home: care coordination</td>
</tr>
</tbody>
</table>
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 year 2-4

http://innovations.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/index.html
Who is the PAP?

• Payors 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
### 2012: episode-based payment was launched or 5 episodes, statewide

<table>
<thead>
<tr>
<th>Condition</th>
<th>Most relevant payor types</th>
<th>Accountable provider</th>
<th>Key sources of value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnancy and delivery</td>
<td>• Medicaid*</td>
<td>Delivering physician</td>
<td>Eliminating unnecessary inductions, ces-sections, and extended length of stay in the hospital</td>
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<tr>
<td></td>
<td>• Commercial*</td>
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<td></td>
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<tr>
<td>ADHD</td>
<td>• Medicaid*</td>
<td>Treating physician or psychologist</td>
<td>Matching care to guidelines for pharmacotherapy &amp; counseling</td>
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<tr>
<td></td>
<td>• Commercial</td>
<td></td>
<td></td>
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<tr>
<td>Hip and knee replacement</td>
<td>• Medicare</td>
<td>Orthopedic surgeon</td>
<td>Workup, cost of implant, inpatient complications, readmission, physical therapy and rehabilitation</td>
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<tr>
<td></td>
<td>• Commercial*</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Medicaid*</td>
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<tr>
<td>Acute/post-acute heart failure</td>
<td>• Medicare</td>
<td>Hospital</td>
<td>Encouraging hospitals to extend reach beyond point of discharge, post-discharge coordination, reengagement of PCP</td>
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<tr>
<td></td>
<td>• Commercial*</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Medicaid*</td>
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<td>Upper respiratory infections</td>
<td>• Medicaid*</td>
<td>Diagnosing physician</td>
<td>Eliminating inappropriate use of antibiotics and radiology</td>
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<tr>
<td></td>
<td>• Commercial</td>
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* Implemented or in process; others to follow

**SOURCE:** Arkansas Payment Improvement Initiative
How episodes work for patients and providers (1/2)

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

Patients and providers deliver care as today (performance period)

Still a fee for service model
How episodes work for patients and providers (2/2)

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

5 Payers calculate average cost per episode for each Principal Accountable Provider (PAP).

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.

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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.
How do we make this fair to all providers?

• Aim is to include as much care as possible under this system, but:
  – Some patient episodes will be excluded
  – Some *adjustments* will be made to costs (e.g., stop-loss)
  – This will always be with the aim of ensuring quality care for patients and making the payments fair to providers
How does quality figure in the payment model?

• To meet the quality bar for receiving gain share, providers will need to:
  – Meet specific thresholds for a set of metrics
  – Provide data on a set of metrics
• Claims-based quality metrics will also be tracked and reported
• Payors will selectively audit data for accuracy
Each payor then selects thresholds to promote high quality and cost effective care.
…and we expect that provider cost effectiveness will improve

**Year 2 results**

**High**

Average cost per episode for each provider

**Low**

**Individual providers**, in order from highest to lowest average cost

- **Year 2 results**
- **Year 1 results**

- Acceptable
- Commendable
- Gain sharing limit
Providers with average costs between commendable and acceptable receive neither risk-share nor gain-share.

Year 2 results

Average cost per episode for each provider

Individual providers, in order from highest to lowest average cost
Providers with average costs above the acceptable limit will have to share in these costs.

**Year 2 results**

- **High**
- **Low**

**Average cost per episode for each provider**

**Individual providers**, in order from highest to lowest average cost.

- ▼ Shared costs
- ▲ Shared savings

- Acceptable
- Commendable
- Gain sharing limit
Providers meeting quality standards that have 
average costs below the gain sharing limit will share 
savings up to a limit to protect quality of care.

Year 2 results

Individual providers, in order from 
highest to lowest average cost

↑ Shared costs  ↓ Shared savings

Acceptable

Commendable

Gain sharing limit

Average cost per episode for each provider

High

Low
At the end of the period, the payor performs a risk-adjustment to account for patient-specific factors …

Year 2 results

**Gain sharing limit**

**Commendable**

**Acceptable**

Number of episodes

Low  **Cost per episode for an individual Principal Accountable Provider (unadjusted)**  High

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<table>
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- Risk adjusted
- Unadjusted
… and outliers are removed
A Principal Accountable Provider’s performance is assessed based on his or her adjusted cost averaged across all non-outlier episodes.

Year 2 results

- Gain sharing limit
- Commendable
- Acceptable

Cost per episode for an individual Principal Accountable Provider (unadjusted)

- Low
- Average adjusted episode cost
- High

Outliers removed
PAPs will be provided new tools to help measure and improve utilization.

Reports provide performance information for PAP’s episode(s):

- Overview of **quality** across a PAP’s episodes
- Overview of **cost effectiveness** (how a PAP is doing relative to cost thresholds and relative to other providers)
- Overview of **utilization** and drivers of a PAP’s average episode cost

NOTE: Episode and health home model for adult DD population in development. Tools and reports still to be defined.
Spending Breakdown for CHF 30-day Episodes with and without a Readmission

N=4,992 CHF episodes

Avg Total Episode Cost = $23,511

Readmits

% Total Costs

Index 27%
Readmits 45%
PAC 17%
OPD 2%
Physician 6%
Other 4%

Index $6,305
Readmits $10,569
PAC $3,975
OPD $379
Physician $1,453
Other $832

Avg Total Episode Cost = $9,440

No readmits

% Total Costs

Index 63%
Readmits 0%
PAC 27%
OPD 3%
Physician 4%
Other 4%

Index $5,936
Readmits $0
PAC $2,510
OPD $288
Physician $337
Other $368

Source: Medicare FFS claims data, 2010
Building an Arkansas Health System for the 21st Century

Thank You!