Health Care Payment Improvement Initiative

Building a healthier future for all Arkansans

Arkansas Payment Improvement Initiative (APII)

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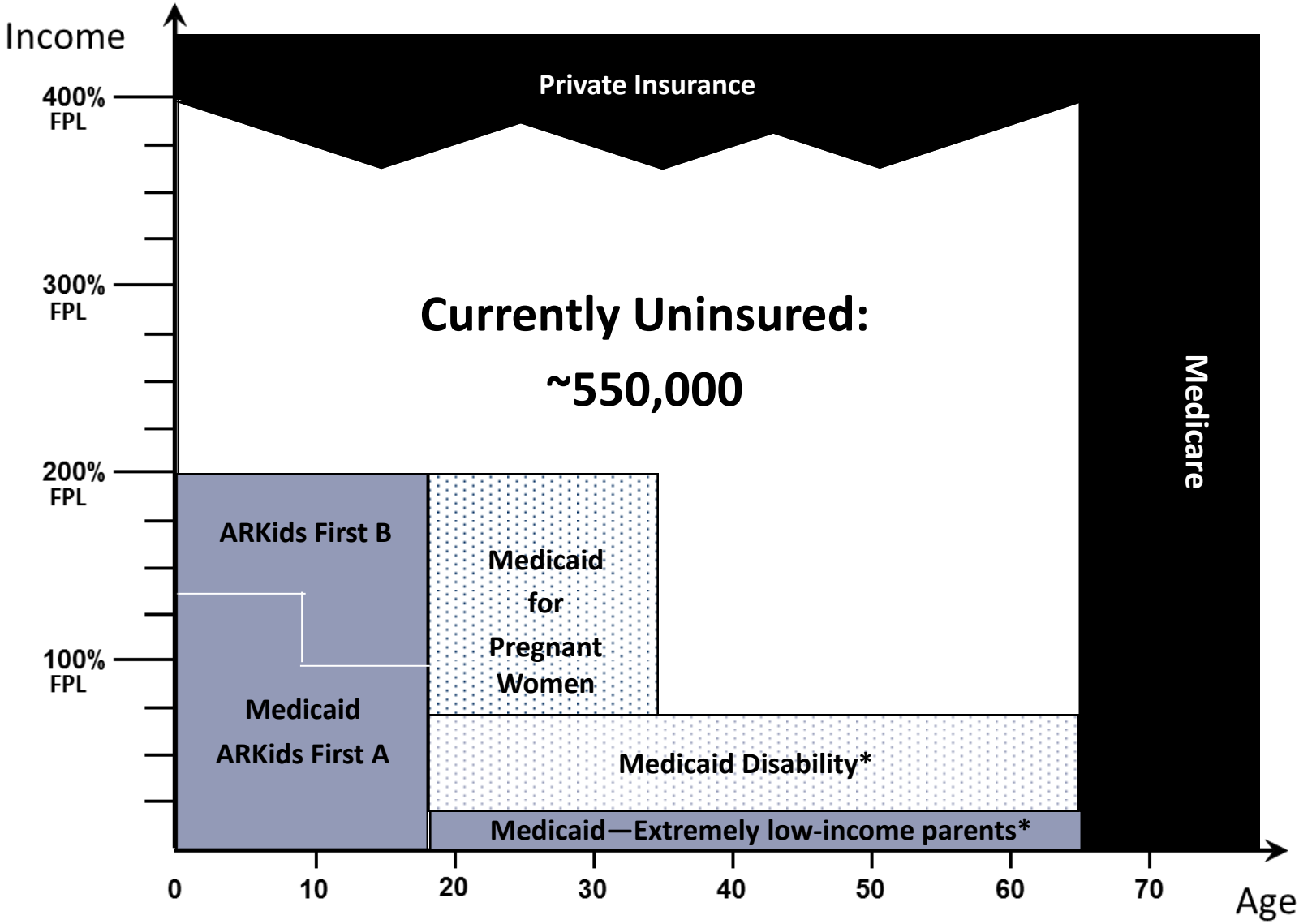
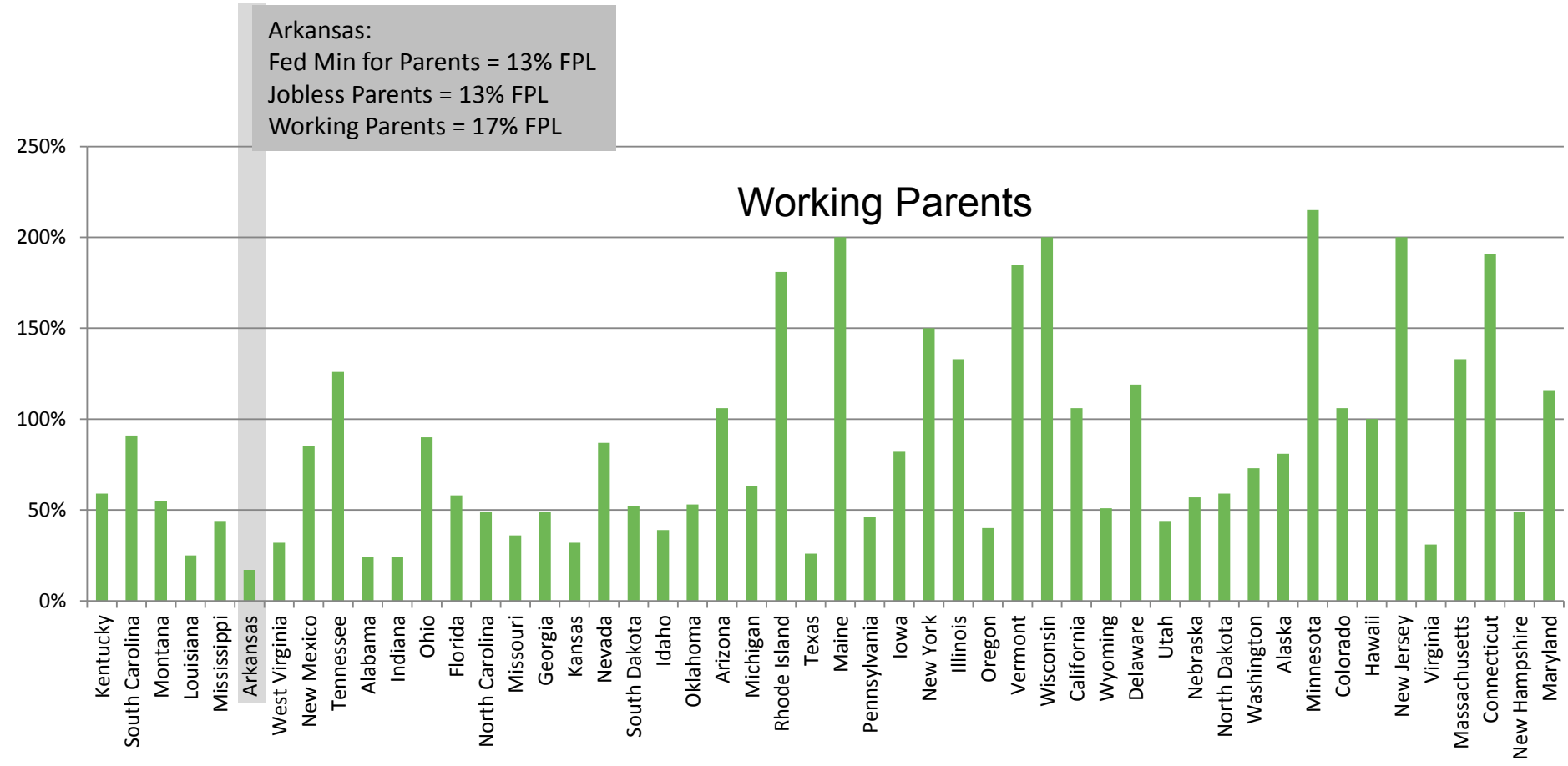
ACHI Arkansas Center for Health Improvement

Current Health Insurance Distribution



Medicaid Income Eligibility Limits as a Percent of Federal Poverty Level, July 2012



Source: Kaiser Family Foundation's statehealthfacts.org. Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2012, with data updates. Available at: http://www.kff.org/medicaid/upload/7993-02.pdf.

ACHI
Arkansas Center for Health Improvement

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

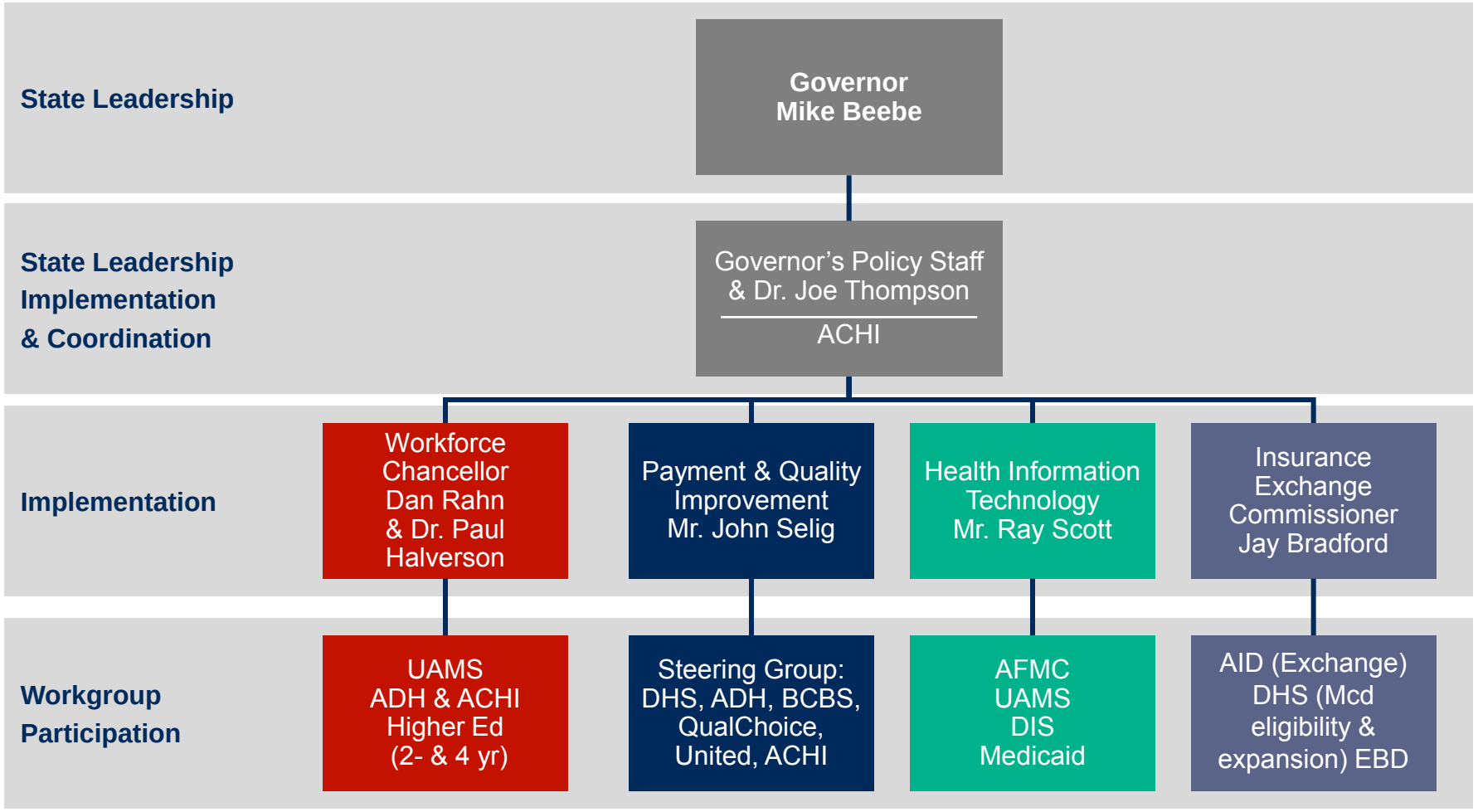
Outcomes-based payment and reporting

Health care workforce development

Health information technology adoption

Expanded coverage for health care services

Arkansas Health System Improvement Agency Organizational Structure



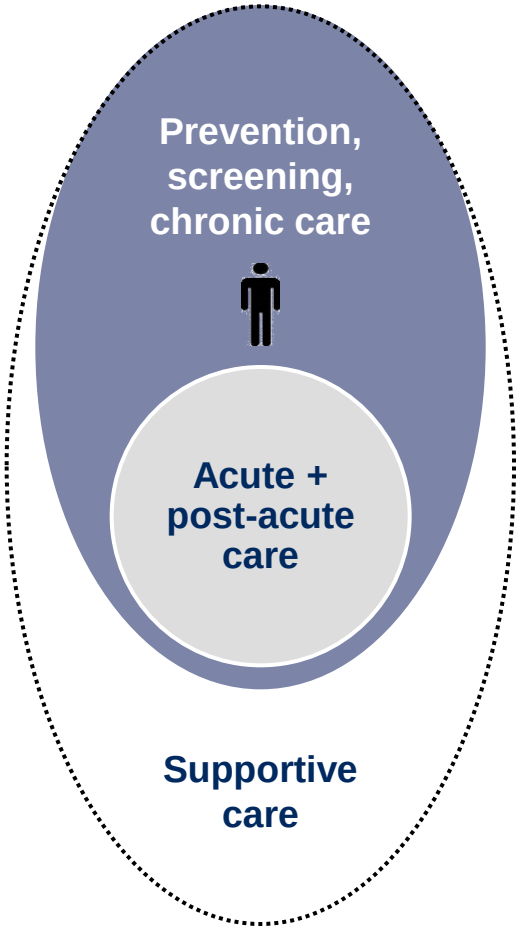
Vision:

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

- Each episode cost approximately $3 million

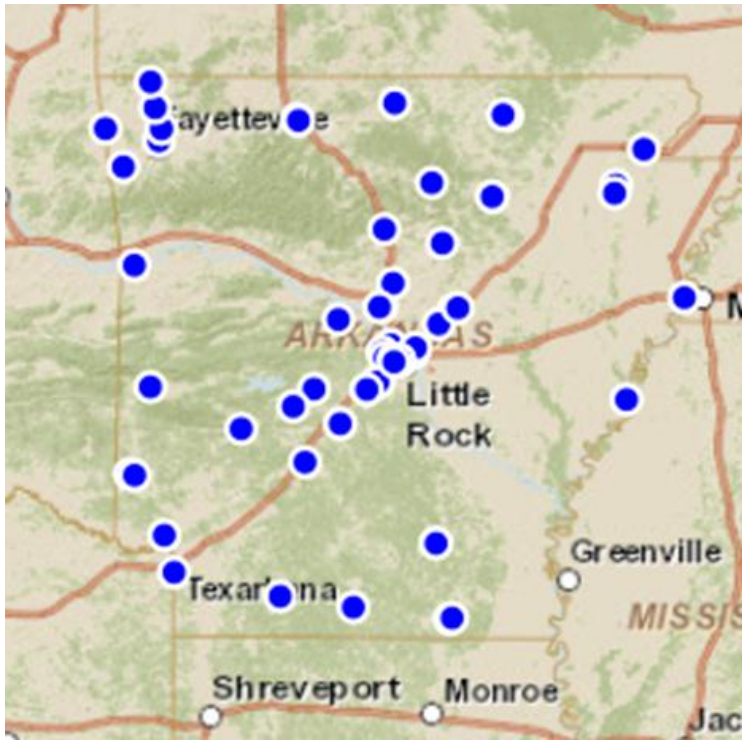
- Incorporate Medicaid, Medicare, and Commercial Insurance into episodic-based care delivery payment model

What's included in Payment Improvement? Medical homes, health homes, and episodes



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

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

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

* Implemented or in process; others to follow
SOURCE: Arkansas Payment Improvement Initiative

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

Still a fee for service model

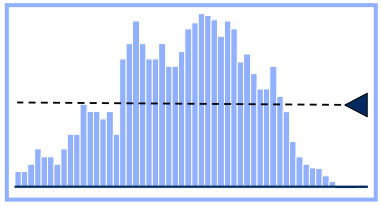
How episodes work for patients and providers (2/2)

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

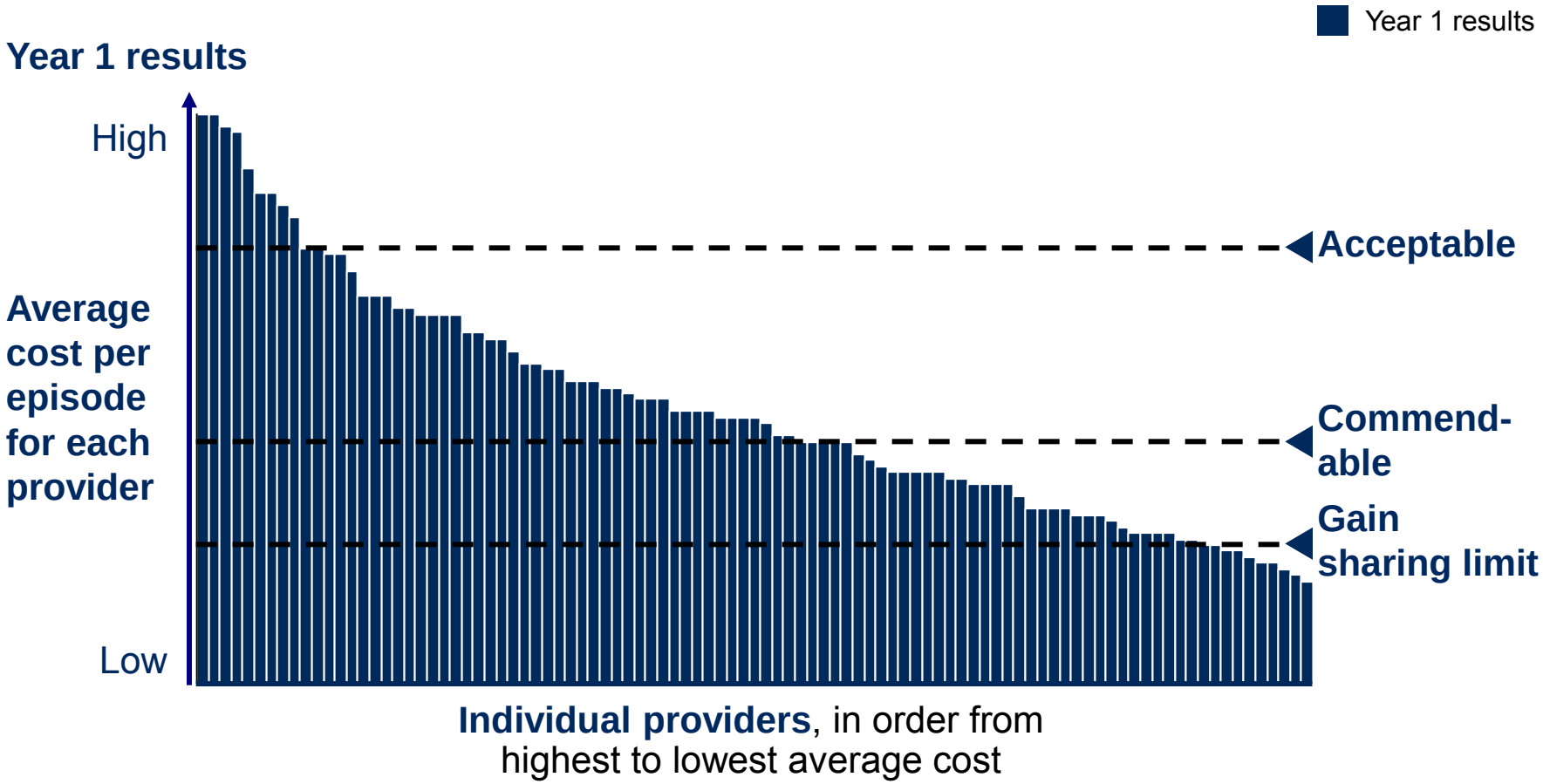
How do we make this fair to all providers?

- 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

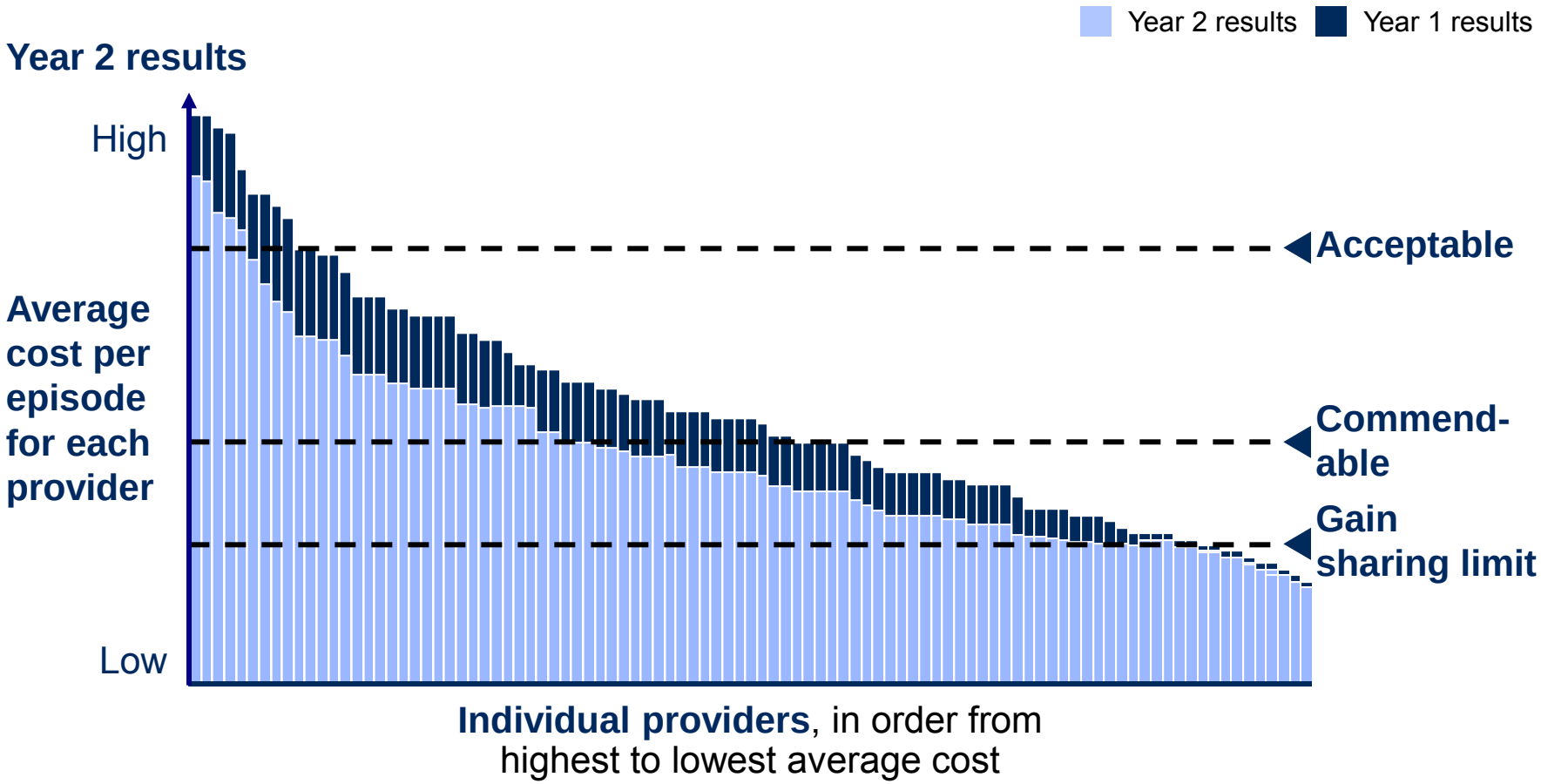
How does quality figure in the payment model?

- 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

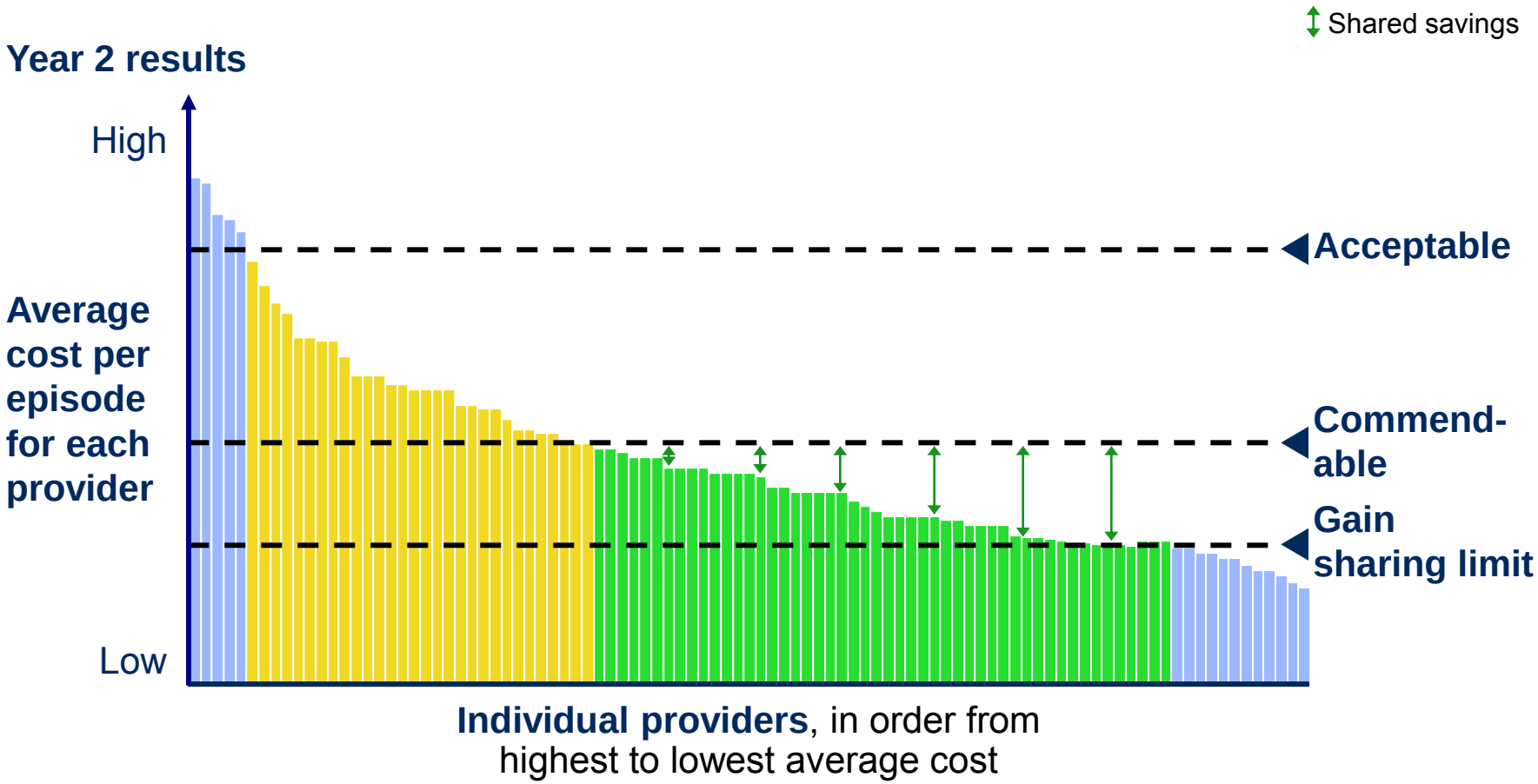
Each payor then selects thresholds to promote high quality and cost effective care



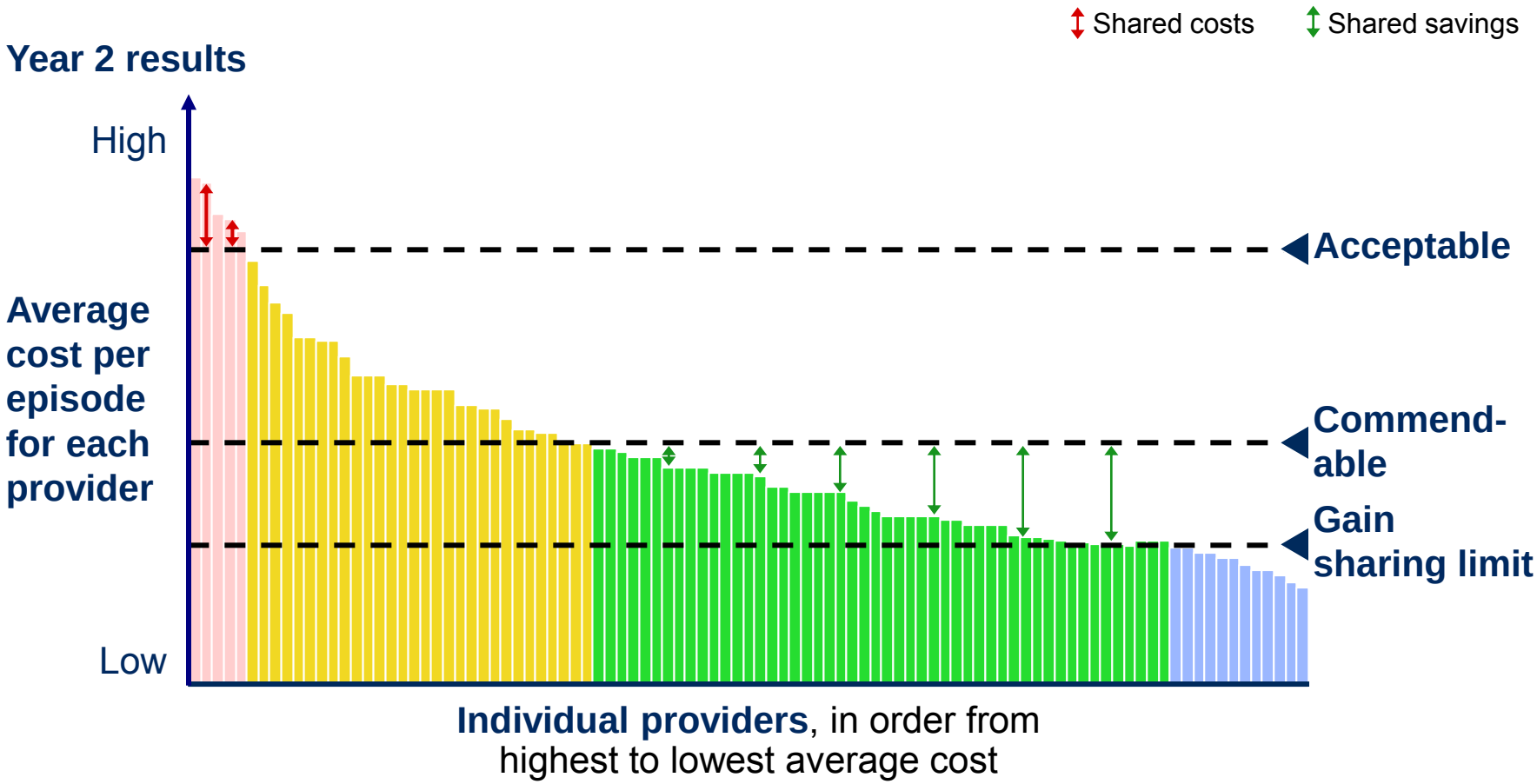
…and we expect that provider cost effectiveness will improve



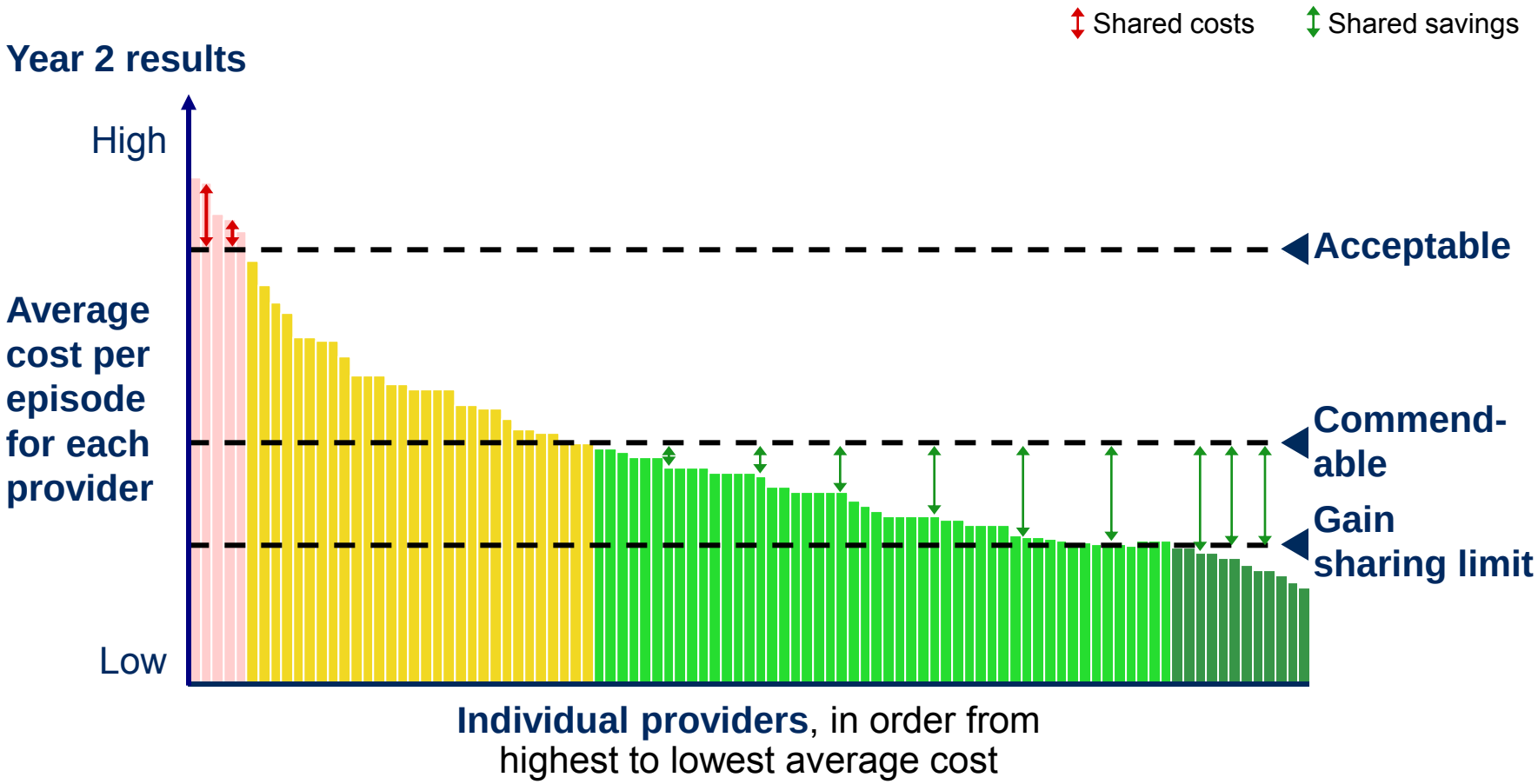
Providers with average costs between commendable and acceptable receive neither risk-share nor gain-share



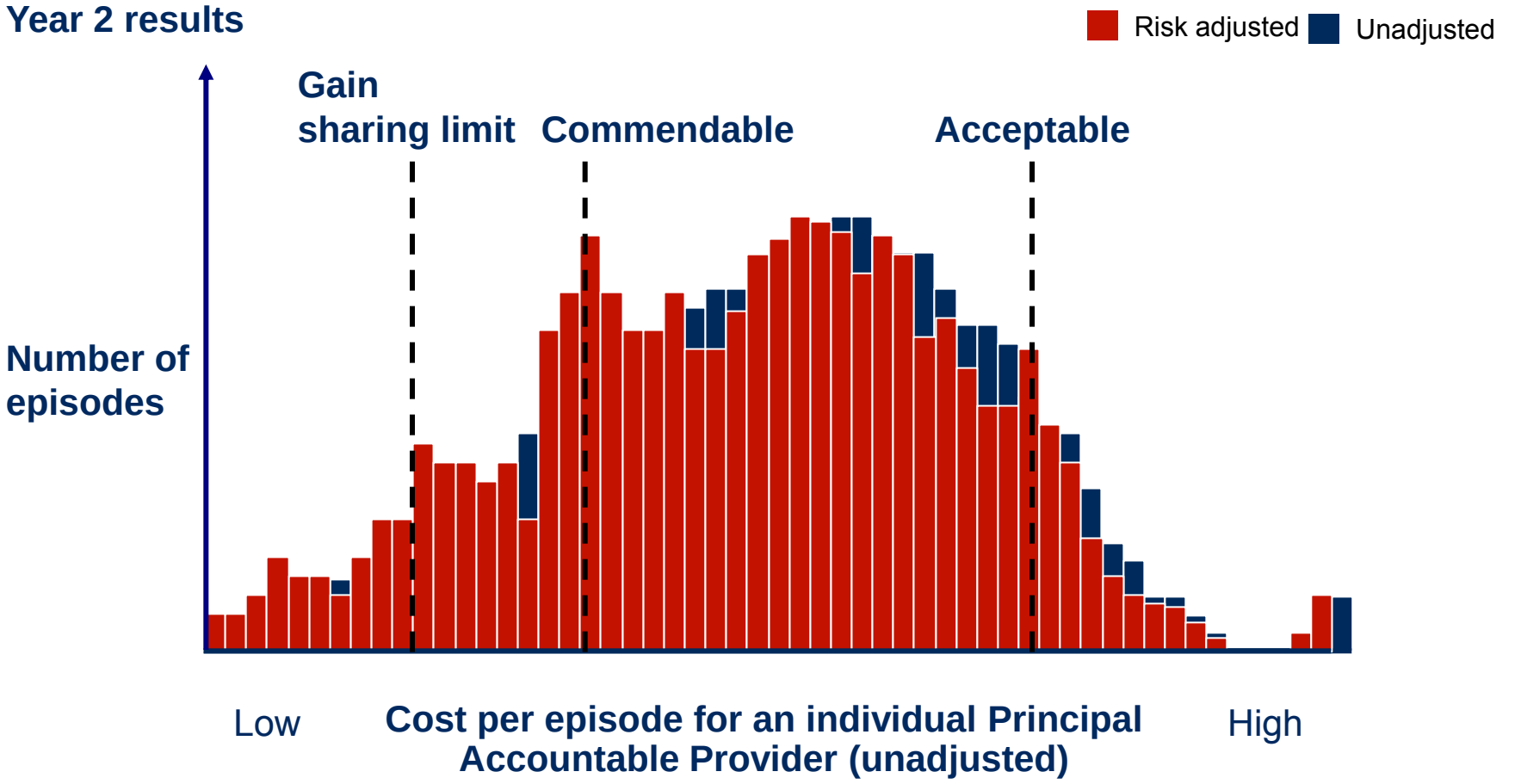
Providers with average costs above the acceptable limit will have to share in these costs



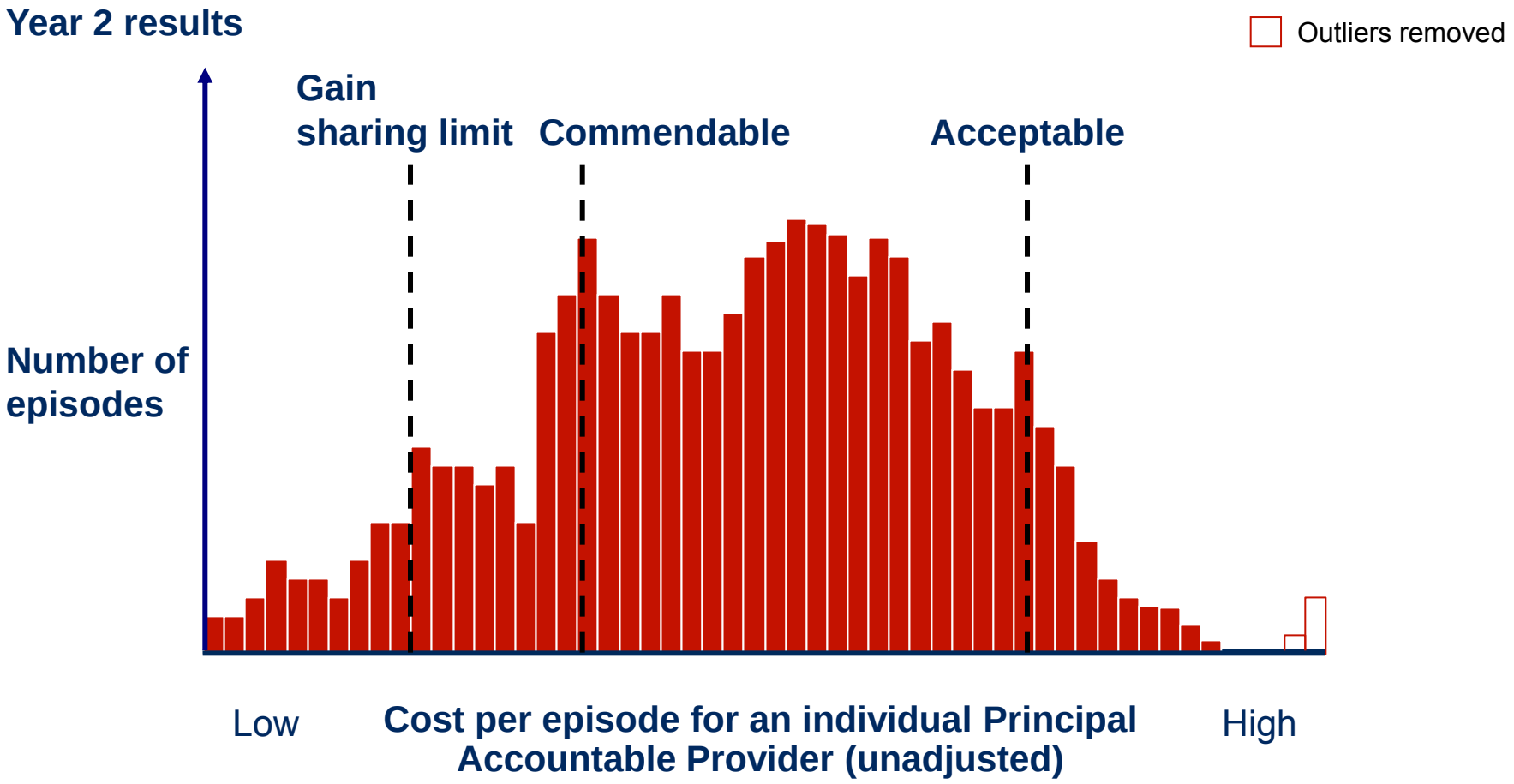
Providers meeting quality standards that have average costs below the gain sharing limit will share savings up to a limit to protect quality of care



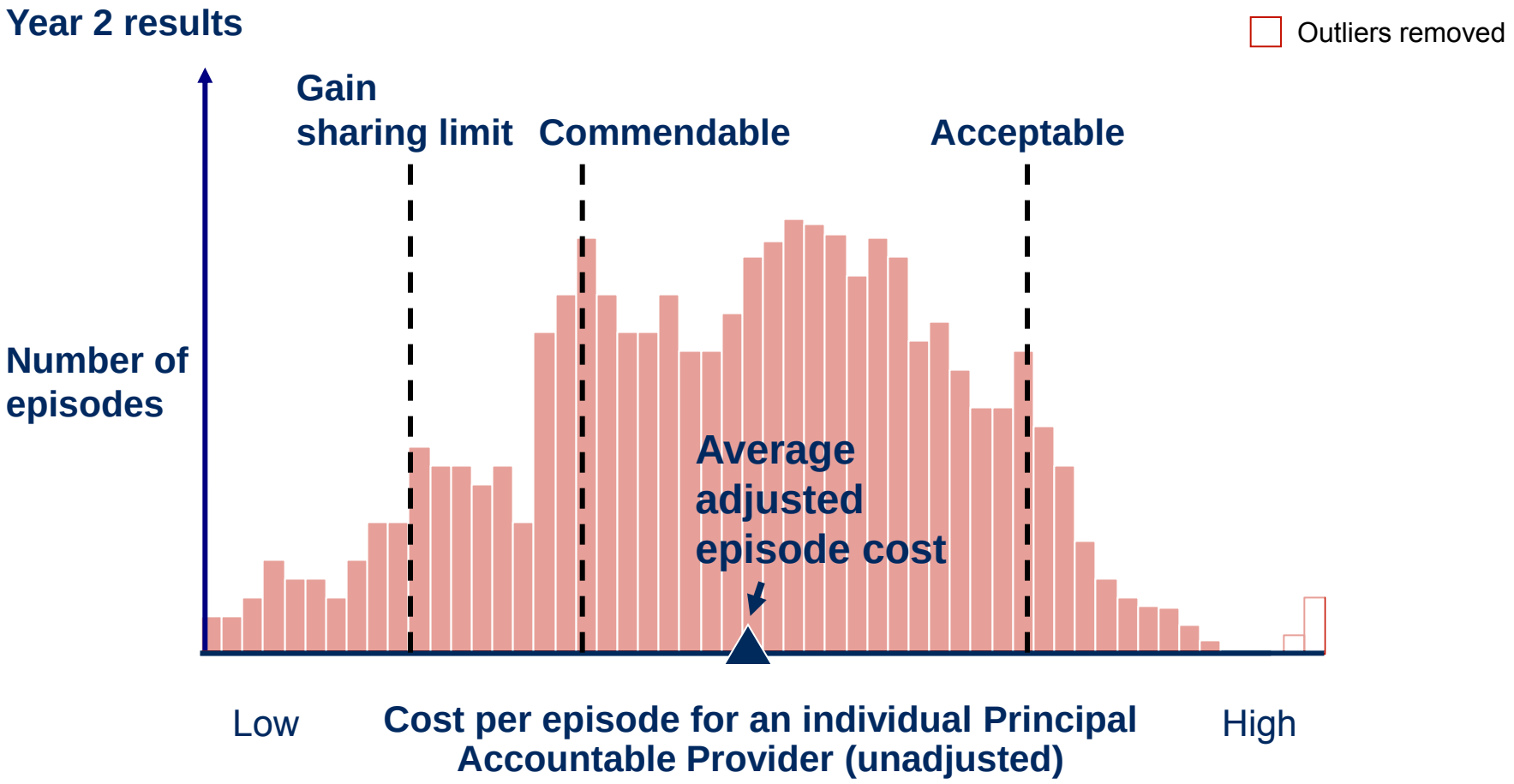
At the end of the period, the payor performs a risk-adjustment to account for patient-specific factors …



… and outliers are removed



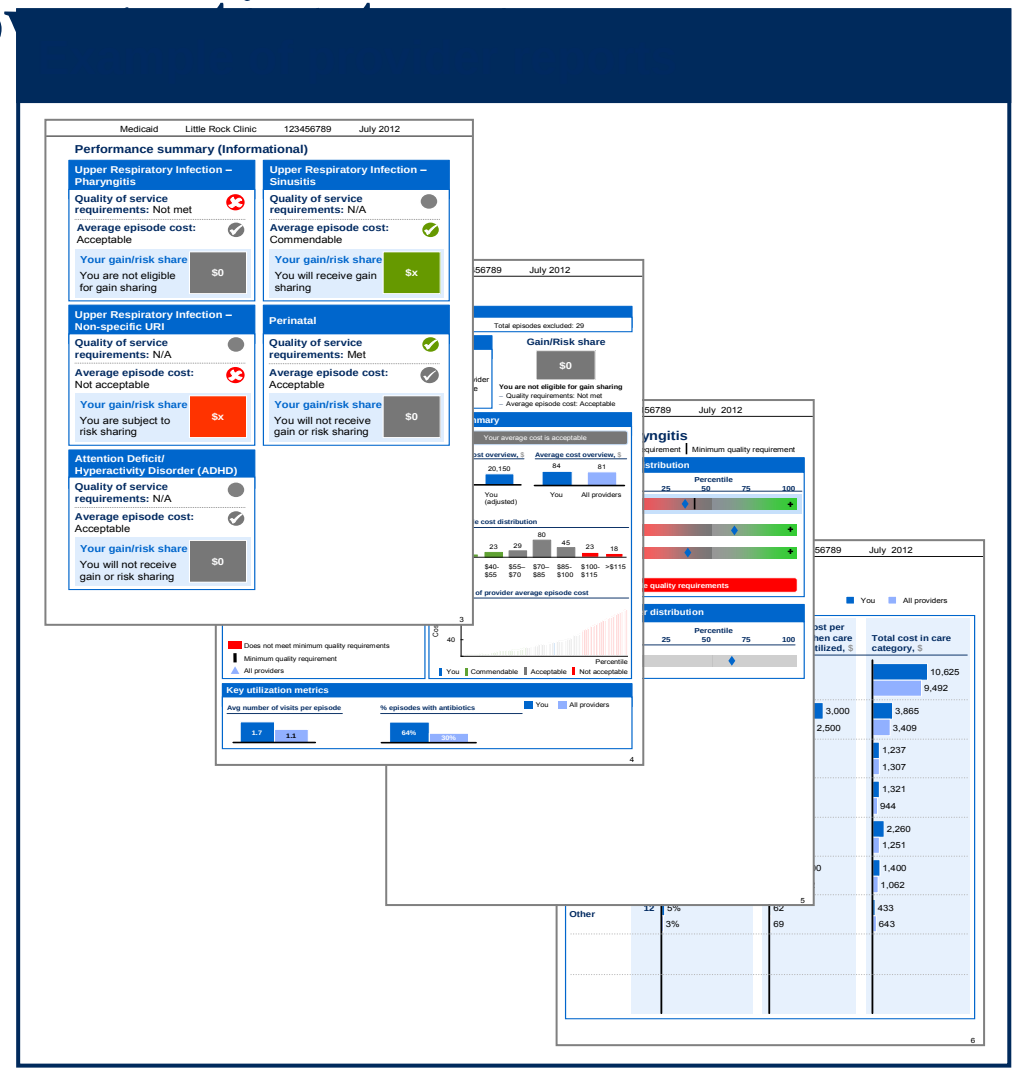
A Principal Accountable Provider's performance is assessed based on his or her adjusted cost averaged across all non-outlier episodes



PAPs will be provided new tools to help measure and impro

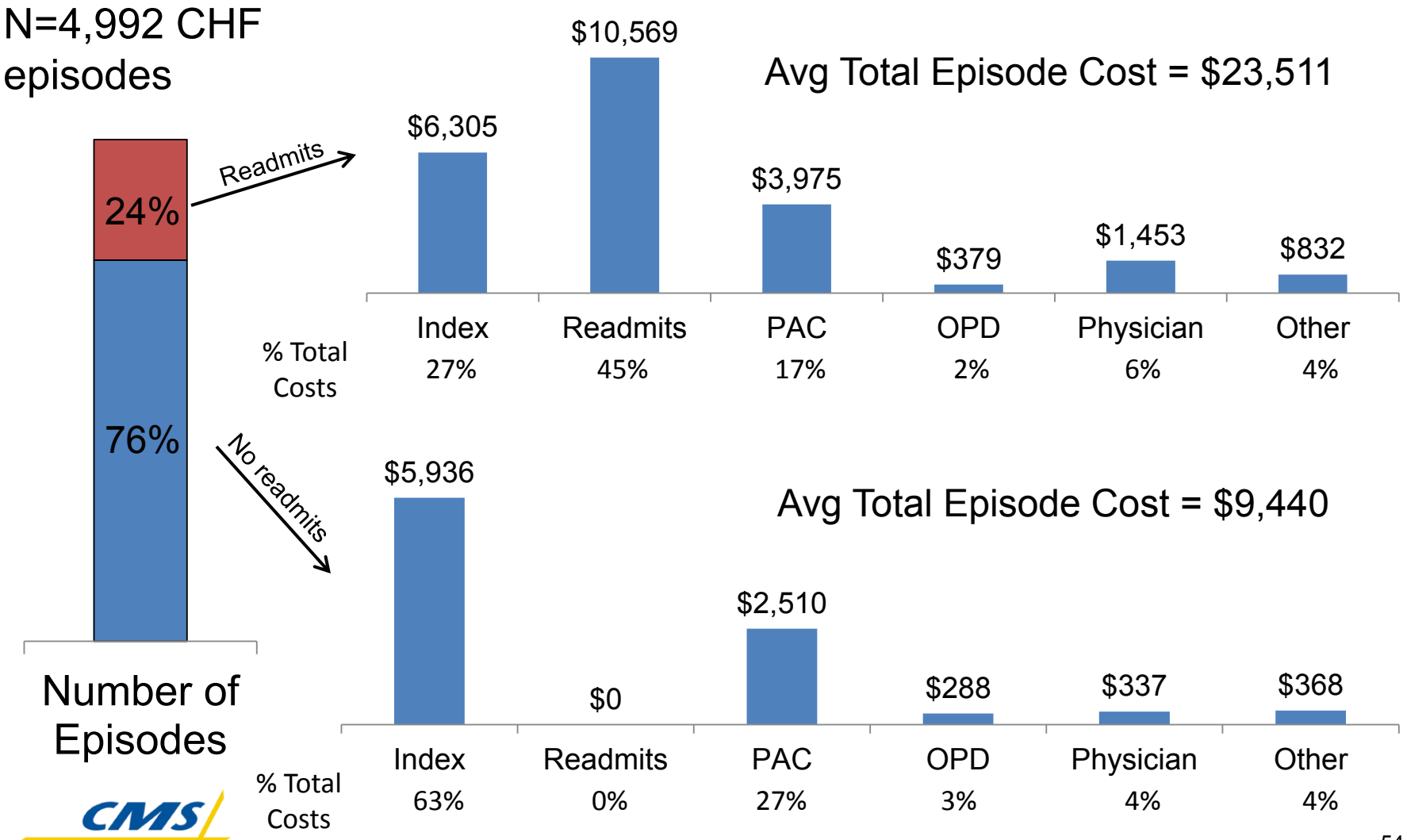
Reports provide performance information for PAP's episode(s):

- 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



Source: Medicare FFS claims data, 2010

Building an Arkansas Health System for the 21st Century

Thank You!

White County Medical Center My Hospital

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