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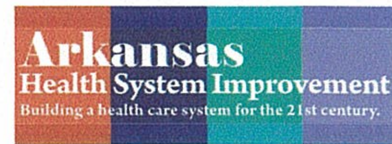


Arkansas Payment Improvement Initiative

Arkansas endeavors to create a 21st-century **patient-centered** health care system that embraces the "Triple Aim": (1) improving the **health** of the population; (2) enhancing the patient experience of **care**, including quality, access, and reliability; and (3) reducing, or at least controlling, the **cost** of health care.

At its core, the future system will be built around patient-centered care delivery models focusing on what the patient needs, rather than being designed around any particular delivery system structure. Our vision is built around two complementary strategies for clinical innovation in Arkansas (illustrated in Exhibit A and E of supporting materials):

- **Episode-based care delivery** rewards coordinated, team-based care for a patient, often spanning multiple encounters with the delivery system, such as hip replacement or pregnancy and delivery. It encourages clinicians to provide quality care across these multiple encounters, rather than in 'silos' of discrete services.
- **Medical homes or health homes**, which are responsible for proactively considering the needs of their patients or clients over time, independent of whether they are seeking care.

The new system will transform the state's payment model from one that rewards volume alone to one that **rewards outcomes**, particularly with respect to **quality and affordability**. Our approach is to ground payment design in principles that are patient-centered, clinically appropriate, practical, and data-based (Exhibit B). This multi-payor, system-wide strategy will move Arkansas to a new, sustainable model of financing.

Opportunities for improved quality and efficiency

The Payment Improvement Initiative has convened a number of clinical workgroups, which identified many opportunities to improve upon the current fee-for-service system. The Initiative seeks to address limitations of the current model, including:

- **No accountable provider for care coordination**: e.g., different segments of pregnancy/NICU care – the prenatal phase, delivery, and postnatal care for the mother – may be delivered by multiple, uncoordinated providers
- **Insufficient investment in patient education**: e.g., hospitals treating patients with congestive heart failure are not rewarded for high-quality transition education at discharge
- **Evidence-based medicine not rewarded**: e.g., nearly 50% of adults receiving care for simple upper respiratory infections in Arkansas receive antibiotics, even though evidence-based guidelines suggest prescribing very selectively, if at all (Exhibit C)

Note: Payment model described here differs from model for Developmental Disabilities episode, which is structured as described in March 6th meeting materials.

- **Significant administrative burdens:** e.g., Developmental Disabilities providers must maintain detailed activity logs for compensation, spending considerable resources on non-care activities.

EPISODE-BASED CARE DELIVERY

Overview of the episode performance payment model

The episode performance payment model creates incentives that reward providers who succeed in delivering high-quality, patient-centered, and cost-effective care for a clinical episode. Providers are initially paid separately for the care they deliver, filing claims as they do today. A Principal Accountable Provider (PAP) for each episode is expected to coordinate care and is held accountable for outcomes across the full episode.

At the end of each performance period (e.g., 3-6 months), payors will tally the average cost across episodes of care led by the PAP during the period. If the average episode cost is better than a 'commendable' level, the PAP will receive an additional payment from the payor as a gain share. If the average episode cost is higher than an 'acceptable' level, the PAP will share a portion of the excess costs (Exhibits F and G). These thresholds may be adjusted for several patient- and provider-level factors (Exhibit H).

For each episode, candidate PAPs have been identified based on their roles in leading the episodes of care (Exhibit I).

How does the model promote high-quality care?

Episodes will be designed to hold providers accountable for outcomes and reward those who are able to reduce complications, decrease error rates, and avoid care that is not evidence-based.

In addition, to reduce potential for underuse of care, we will define quality metrics which must be met to be eligible for gain share payments. To promote quality care, we expect to perform select reviews of metrics.

What will this mean for patients and providers?

The new payment model will encourage a number of changes that will benefit patients:

- Investment in diagnosis, patient education, treatment, and care coordination to reduce preventable complications and inefficient care
- Increasing provision of underused services
- Removing incentives for care that is medically unnecessary.

For providers, the new system will involve similar administrative procedures for submitting claims as in the current model. However, the new outcomes-based payment model will provide enhanced rewards for high-quality, team-based, coordinated care. Shared savings / risk through the episode performance payment will offer them

compensation that is aligned more closely with their achievement of high-quality, efficient care beyond a single encounter.

Note that the proposed model for Developmental Disabilities (DD) is different because of certain characteristics of the supportive care provided for DD clients; this model is described in the March 6th workgroup materials, available online at http://humanservices.arkansas.gov/director/Pages/Developmental-Disabilities-Workgroup.aspx.

MEDICAL AND HEALTH HOMES

The aim of medical and health homes is to meet the full range of needs across a population, promoting higher quality of care, improved patient experience, and more efficient health care, while rewarding providers who achieve strong performance. Accountable providers will be responsible for proactively considering the needs of their patients or clients, independent of whether they are seeking care.

For some populations, a primary care physician practice will be most effective in adopting this role, whereas for certain special needs population, the accountable provider could be another provider working in collaboration with primary care providers—for example, a developmental disability or behavioral health provider may be better equipped to coordinate care for certain populations. These homes will serve not as gatekeepers for medical care, but rather as a hub from which the patient may connect with the full constellation of providers who together form the patient's health services team.

SCOPE AND PACE OF ADOPTION

Given the scope of the transformation, participating payors will promote adoption of both episode-based care and medical and health homes across Arkansas over the coming three to five years. For episode-based care, the roll-out will begin with the launch of six Wave I episodes: Attention Deficit Hyperactivity Disorder, Ambulatory Upper Respiratory Infections, Congestive Heart Failure, Developmental Disabilities, Hip/Knee Replacements, and Pregnancy.

There will be an initial preparatory period of 3-6 months for providers to begin implementing practice changes. In this period, payment will continue under the current fee-for-service system. Starting in Oct. 2012 or Jan. 2013, the first 'performance period' will begin; episodes initiated in this period will be covered under the new payment model (Exhibit J). Over time, the roll-out will expand to a second wave of episodes.

For medical and health homes, transformation will occur initially with a limited set of providers, but will span broad patient populations including healthy, at-risk, and those with one or more chronic conditions. This model will expand to other providers as they become ready to undertake new processes and capabilities (e.g., health information technology, care coordinators).

DRAFT

Arkansas Payment Improvement Initiative

Supporting materials

April 19, 2012

PRELIMINARY WORKING DRAFT, SUBJECT TO CHANGE

EXHIBIT A

Arkansas Health System Improvement

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

Care delivery strategies

Medical and health homes
- Risk stratified, tailored care delivery
- Enhanced access
- Evidence-based, shared decision making
- Team-based care coordination
- Performance transparency

Episode-based care delivery
- Common definition of the patient journey
- Evidence-based, shared decision making
- Team-based 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

EXHIBIT B

Principles of payment design for Arkansas

Principle	Description
Patient-centered	Focus on improving quality, patient experience and cost efficiency
Clinically appropriate	Evidenced-based design with close input from Arkansas patients, family members, and providers
Practical	Consider scope and complexity of implementation
Data-based	Make design decisions based on facts and data

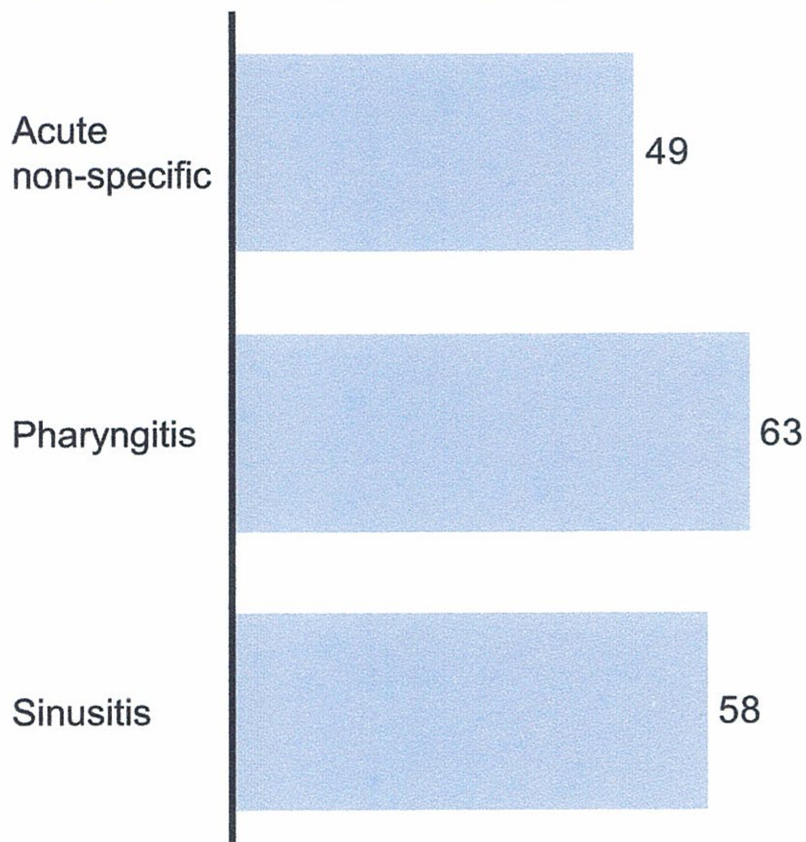
EXHIBIT C

What challenges are we trying to address? URI example

MEDICAID DATA

Antibiotic prescription rates for adults are high…

% of episodes resulting in filled antibiotic[1]



…yet evidence-based guidelines suggest prescribing very selectively, if at all

- "Antibiotics should not be used to treat **nonspecific upper respiratory tract infections** in adults, since antibiotics do not improve illness resolution"
- "For **acute pharyngitis,** antibiotic use should be limited to patients who are most likely to have group a β-hemolytic streptococcus"
- "For **acute sinusitis,** narrow-spectrum antibiotics should be given only to patients with persistent purulent nasal discharge and facial pain or tenderness who have not improved after 7 days or those with severe symptoms."

CDC guidance[2]

1 ICD-9 034.0 not included in analysis. All patients with tonsil-related procedures and outpatient observations in hospitals excluded

2 From CDC, summarized in Gill et. al., "Use of Antibiotics for Adult Upper Respiratory Infections in Outpatient Settings: A National Ambulatory Network Study" (2006) (internal citations removed)

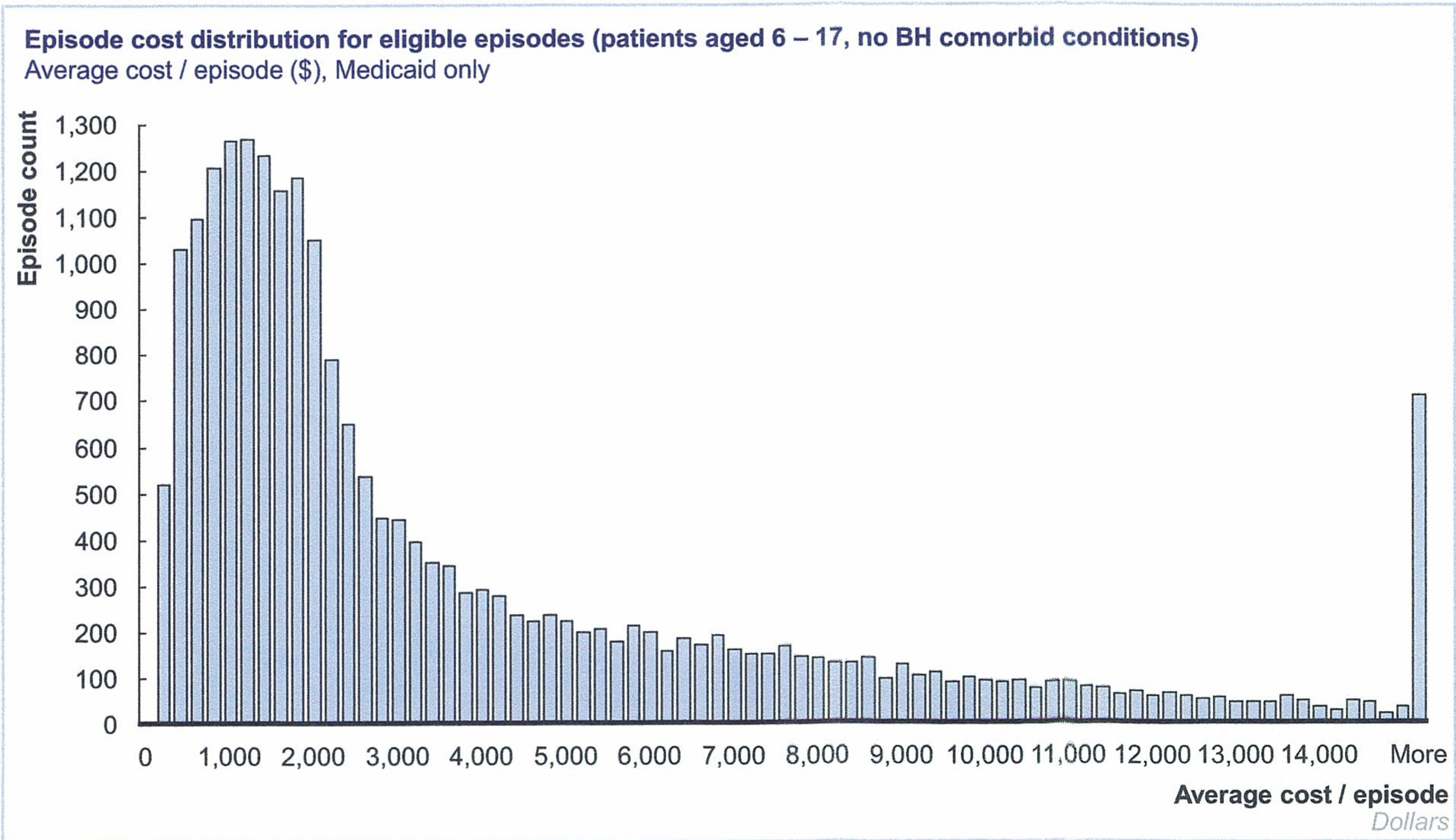
SOURCE: Medicaid claims SFY2010; CDC

EXHIBIT D

Example current practice: ADHD episode cost distribution

MEDICAID DATA

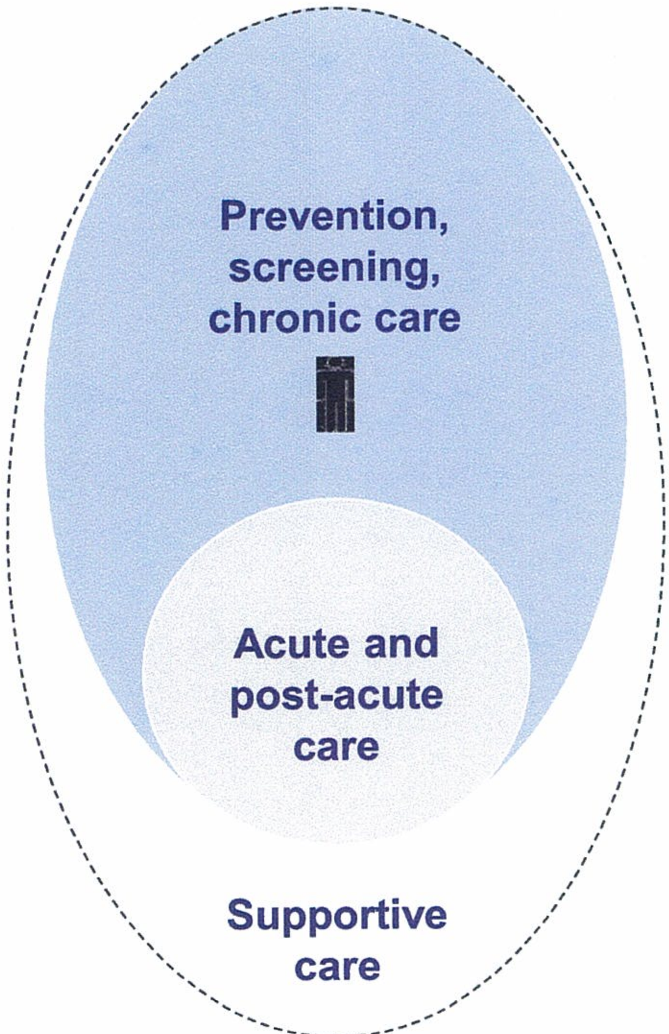
Episodes ending in SFY 2009 – SFY 2010 (i.e two years of data), Medicaid only



NOTE: Includes episodes with primary care physicians or RSPMIs as Principal Accountable Providers
SOURCE: Arkansas Department of Human Services (DHS), Division of Medical Services

EXHIBIT E

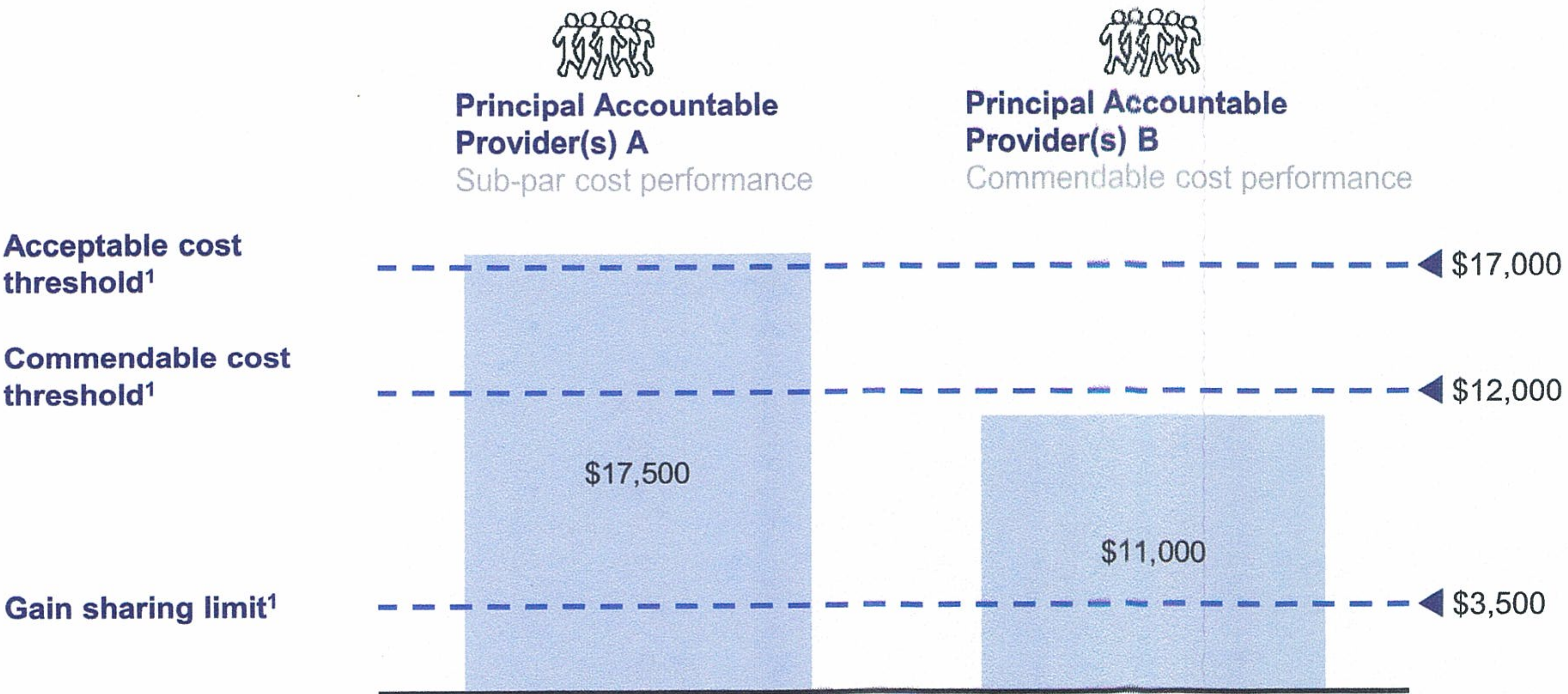
The populations that we serve require care falling into three domains



Patient populations (examples)	Care/payment models
• Healthy, at-risk • Chronic, e.g., – CHF – Diabetes	**Population-based**: medical homes responsible for care coordination, rewarded for quality, utilization, and total care cost
• Acute medical, e.g., – CHF – Pneumonia • Acute procedural, e.g., – Hip replacement	**Episode-based**: gain and risk sharing with one or more providers, rewarded for quality and savings relative to cost thresholds
• Developmental disabilities • Long-term care • Behavioral health (mental illness / substance abuse)	**Combination of population- and episode-based models**: health homes responsible for care coordination; episode-based payment for care provision

EXHIBIT F

Episode payment model: illustrative example



Amount of gain or risk sharing

Principal Accountable Provider(s) A:

- Average episode cost is $500 above acceptable threshold
- Excess cost is divided between payor and PAP

Principal Accountable Provider(s) B:

- Average episode cost is $1000 below acceptable threshold
- The PAP shares this gain with the payor, so long as quality measures are satisfactory

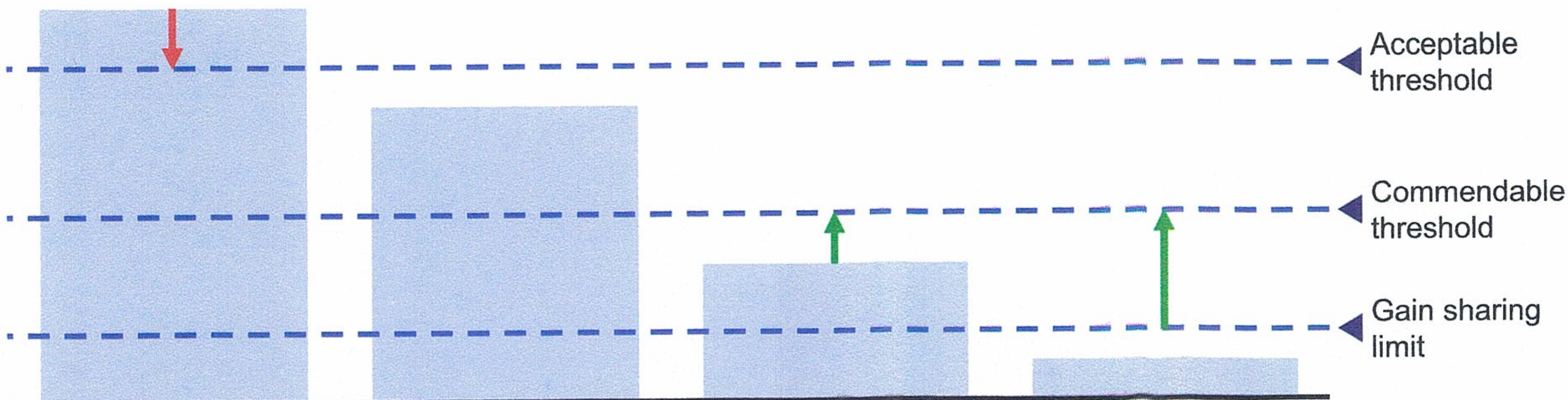
1 May be risk-adjusted. For simplicity of illustration, all patients in this example are of the same level of severity

Note: in the coming months, each participating payor will independently determine cost thresholds and level of upside/downside sharing for each episode

EXHIBIT G

Gain and risk sharing: a Principal Accountable Provider will fall into one of four categories, depending on the provider's average cost per episode

Average cost per episode, for each Principal Accountable Provider



Sub-par performance	Acceptable performance	Commendable performance	Beyond commendable performance
Providers whose costs exceed the acceptable threshold will be held **responsible for a share of costs above this threshold** – shown by the arrow above	The provider **neither gains nor loses** because costs are neither above the acceptable threshold nor below the commendable threshold	**Savings** below the commendable threshold – shown by the arrow above– **are shared** between provider and payor, until the gain sharing limit is reached	The provider will receive a share of **savings up to a gain sharing limit, but not beyond**

Note: in the coming months, each participating payor will determine the level of upside and downside sharing for each episode. Model described here does not apply to Developmental Disabilities episode, which is structured as described in March 6th meeting materials.

EXHIBIT H

The episode performance payment may be adjusted for a number of patient- and provider-level factors

	Description
A Patient-level adjustments	▪ Patient risk/severity adjustments ▪ Outlier exclusions on a cost basis
B Provider-level adjustments	▪ Stop-loss provisions ▪ Adjustments for providers in areas with poor physician access ▪ Adjustments for cost-based facilities ▪ Adjustments for differences in regional pricing ▪ Adjustments or exclusions for providers with low case-volume

Note: Model described here does not apply to Developmental Disabilities episode, which is structured as described in March 6th meeting materials.

EXHIBIT I

Candidate principal accountable providers across episodes

	Candidate principal accountable provider(s)[1]
Hip/knee replacements	▪ Orthopedic surgeon ▪ Hospital
Perinatal (non NICU)	▪ Delivering provider ▪ If separate providers perform prenatal care and delivery, both providers are PAPs (shared accountability)
Ambulatory URI	▪ Provider for the first in-person URI consultation
Acute/post-acute CHF	▪ Hospital
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[2]

1 Based on objective assessment of PAP criteria; participating payors will make own assessment of which providers to designate as PAP
2 For DD, Lead Provider will be chosen and is responsible for coordination across integrated care plan & reporting / performance on quality metrics

EXHIBIT J

July 1st launch: current thinking

Key milestones	Description	Timing
▪ **Program announcement and education**	▪ Payment design and documentation published ▪ Educational workgroups and townhalls to answer questions	May/ June
▪ **Program launch**	▪ All analytic/ reporting engines up and running	July 1st
▪ **Reporting period (3-6 months)**	▪ Principal Accountable Providers (PAP) begin data exchange and later receive baseline historical performance reports ▪ Analytic/ reporting engines track "virtual" performance for each PAP ▪ Performance does not yet impact payment	July 1st
▪ **Feedback period**	▪ Workgroups provide feedback on version 1.0 ▪ Payors refine version 1.0 design	July 1st – Sep 1st
▪ **Performance period begins**	▪ New episodes begin to count towards a PAP's share of risk or gain sharing	Q4 2012 or Q1 2013

NOTE: Developmental disabilities are on a separate timeline, as described in the workgroup on March 6

ADHD: promoting use of evidence-based guidelines and encouraging consistent interaction with parents and patients

How ADHD is treated today

- Non-medication interventions account for over 50% of total costs for ADHD patients[1] and are in many cases used when evidence-based clinical guidelines recommend alternative approaches including careful medication management
- The choice of interventions is closely related to setting of care and not necessarily to needs

Our vision for improved delivery of ADHD care

- Providers will use assessments in line with AAP/AACAP[2] guidelines to determine the appropriate combination of medication, parent/teacher behavior support, and psychosocial therapy for the child's condition
- The providers most involved in a child's care will educate the patient and the patient's family on appropriate support and coordinate care to ensure consistent monitoring

Why the episode model encourages improvements in ADHD care delivery

- Providers delivering ADHD care will share financial responsibility for the costs of non-medication interventions; cost thresholds will be set in line with certifications identifying the guideline-prescribed level of care for each patient's condition
- Providers who effectively educate families on how to support their children and who consistently coordinate care to monitor the children's conditions will be rewarded, as they share in the savings from reduced need for inpatient stays or residential treatment

ADHD will provide a model for the design of other clinical episodes

- **Episodes for other behavioral and mental health conditions**
- **Episodes in which coordinating care with families plays a key role in effective management**

1 Based on ADHD patients age 6-17 with no major comorbidities
2 American Academy of Pediatrics / American Academy of Child and Adolescent Psychiatry

Ambulatory Upper Respiratory Infections: encouraging appropriate use of antibiotics and choice of care setting

How Ambulatory URIs are treated today

- Nearly 50% of adults receiving care for simple upper respiratory infections in AR receive antibiotics, even though nearly all of these infections are viral and unaffected by antibiotic treatment
- Follow-up care often occurs in-person when a telephone call would suffice, as providers are only compensated for in-person follow-up
- Approximately 10% of patients who seek care for a cold or sore throat visit the Emergency Department

Our vision for improved Ambulatory URI care

- Clinicians invest time in patient education about the typical course of upper respiratory infections
- Antibiotics are prescribed only in cases in which the infection is likely bacterial and the patient could benefit from antibiotic therapy
- Patients are able to receive follow-up consultation over the phone or by email, instead of having to return to a physician clinic
- Emergency Departments (EDs) refer patients to PCPs when the clinic is a more appropriate setting

Why the episode model encourages improvements in Ambulatory URI care delivery

- Clinicians share financial responsibility for the costs of antibiotic prescriptions, encouraging more judicious use
- Providers are rewarded for offering follow-up care in lower-cost, more convenient care settings (e.g., by phone, email, or PCP if needed), as they share in the costs of additional in-person follow-up
- EDs are incentivized to refer URIs to more appropriate settings, as they share accountability for costs incurred

Ambulatory URI will provide a model for the design of other clinical episodes

- **Episodes with many patients who are not treated in the appropriate setting of care:** e.g., otitis media, ankle sprains
- **Episodes in which the primary care provider is principally accountable:** e.g., diabetes, hypertension

Congestive Heart Failure: extending the hospital's accountability beyond the point of discharge

How CHF acute/post-acute care is treated today

- Care is fragmented among many providers – hospitals, cardiologists, primary care providers, hospitalists, SNFs/rehab facilities, and others – and no single provider is accountable
- Quality patient education at discharge is not rewarded, and care after discharge is rarely coordinated with hospital care
- Across all payors, ~20% of CHF admissions have at least one all-cause readmission within 30 days

Our vision for improved delivery of CHF care

- Providers will work together as a team to deliver care for a CHF episode, and the hospital will be accountable for coordinating
- Hospitals will invest in patient education, improving the quality and accessibility of discharge instructions
- The hospital will be accountable for managing the transition to chronic care management, improving coordination of care

Why the episode model encourages improvements in CHF care delivery

- Innovations that reduce the rate of complications (e.g., due to medical errors, infections, etc.) will be rewarded, as providers will receive a share of the resulting cost savings
- The hospital will share financial responsibility for readmissions, encouraging investment in patient education, transition management, and other services that improve post-discharge outcomes

CHF will provide a model for the design of other clinical episodes

- **Episodes with a high rate of preventable hospital readmissions:** e.g., acute myocardial infarction (heart attacks), pneumonia
- **Episodes with follow-up chronic care management:** e.g., autoimmune disorders, chronic kidney disease
- **Episodes in which the hospital is the principal accountable provider:** e.g., trauma

Developmental Disabilities: minimizing resources not focused on delivering care and improving coordination of DD and medical care

How DD services are provided today

- Level of services provided varies significantly but is not tied to a consistently deployed assessment of the client's level of need
- Providers must maintain detailed activity logs for compensation, spending considerable resources on non-care activities
- DD clients incur greater medical costs than the population at large, often due to a lack of coordination between DD services and medical care

Our vision for improved delivery of DD services

- A consistent assessment will be used to determine each client's level of need, and providers will be compensated based on the level of services required to effectively match the client's need
- Information that providers are required to record and submit will be limited to that which is needed to ensure quality of care
- DD clients will be served by a health home which considers the client's full set of needs across the entire continuum of care, including DD, medical and behavior health, and coordinates among participating providers.

Why the new payment model encourages improvements in DD service delivery

- Instead of receiving fee-for-service payments tied to detailed activity logs, providers will receive a bundled episode payment set in line with the level of services suggested by an assessment administered annually
- Health homes will be rewarded for coordinating care for DD clients

The Developmental Disabilities episode will provide a model for the design of other episodes

- **Episodes in which significant resources are devoted to non-care services**
- **Episodes in which level of care is not effectively aligned today with level of patient/client need**

Hip/Knee replacement: reducing readmissions and rewarding efficient hospitals

How hip/knee replacements are performed today

- The operating surgeon is responsible for a patient while he or she is in the OR, but has limited accountability for care before and after the procedure
- There is wide variation in readmission rate by surgeon, ranging from under 5% to above 30%
- Surgeons and hospitals are not rewarded for innovations that allow for more efficient delivery of hip/knee replacements

Our vision for improved hip/knee replacements

- The surgeon who performs the procedure will coordinate care leading up to and following the procedure
- Surgeons and hospitals will partner to reduce the rate of post-op infections and to drive clinical innovations for more efficient care delivery
- Hip/knee replacements will be provided by the highest-quality, most efficient hospitals in a region

Why the episode model encourages improvements in hip/knee replacement care

- The orthopedic surgeon will be held accountable for a portion of the cost of readmissions, rewarding surgeons who succeed in coordinating pre- and post-operation care, patient education, and post-discharge management
- Hospitals will share financial responsibility for the overall episode costs, encouraging them to invest in finding operational efficiencies and reducing readmissions
- Surgeons also receive a share of episode savings, encouraging them to partner with hospitals to improve care quality and directing additional case volume to the most efficient hospitals

The hip/knee replacement episode will provide a model for the design of other clinical episodes

- **Episodes in which surgeons have a choice of hospitals for acute procedures**
- **Episodes in which there are multiple principal accountable providers**

Pregnancy: rewarding evidence-based prenatal care and promoting more appropriate use of C-sections

How pregnancies are cared for today

- Different segments of care – the prenatal phase, delivery, postnatal care for the mother, and neonatal care for the child – may be delivered by multiple, uncoordinated providers
- There is material variation among providers in the rate of elective C-sections, which drive higher costs and may expose patients to greater risk during delivery: 34% of all Medicaid pregnancies involve C-sections, and about one-third of providers have rates in excess of 45% in the Medicaid population

Our vision for improved delivery of perinatal care

- One physician will be accountable for the whole episode from prenatal care through delivery and will coordinate care among all providers involved
- Evidence-based prenatal care will be provided to maximize the likelihood of a successful delivery and health baby
- Patients will undergo delivery by C-section only when risk factors suggest that it is medically beneficial

Why the episode model encourages improvements in perinatal care delivery

- The physician overseeing prenatal care and delivery is accountable for the full episode of care; those who excel at delivering high-quality prenatal care share in the financial savings from improved outcomes in delivery and postnatal care
- The episode holds providers accountable for a portion of the additional costs and risks incurred for elective C-sections, while recognizing that such procedures are appropriate for patients with certain risk factors

The Pregnancy/NICU episode will provide a model for the design of other clinical episodes

- **Episodes with a significant period of monitoring and preventive care prior to an acute procedure**