

Implementing Transformation at Scale

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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



“Let's Just Start Cutting and See What Happens.”



2011

Developing Vision

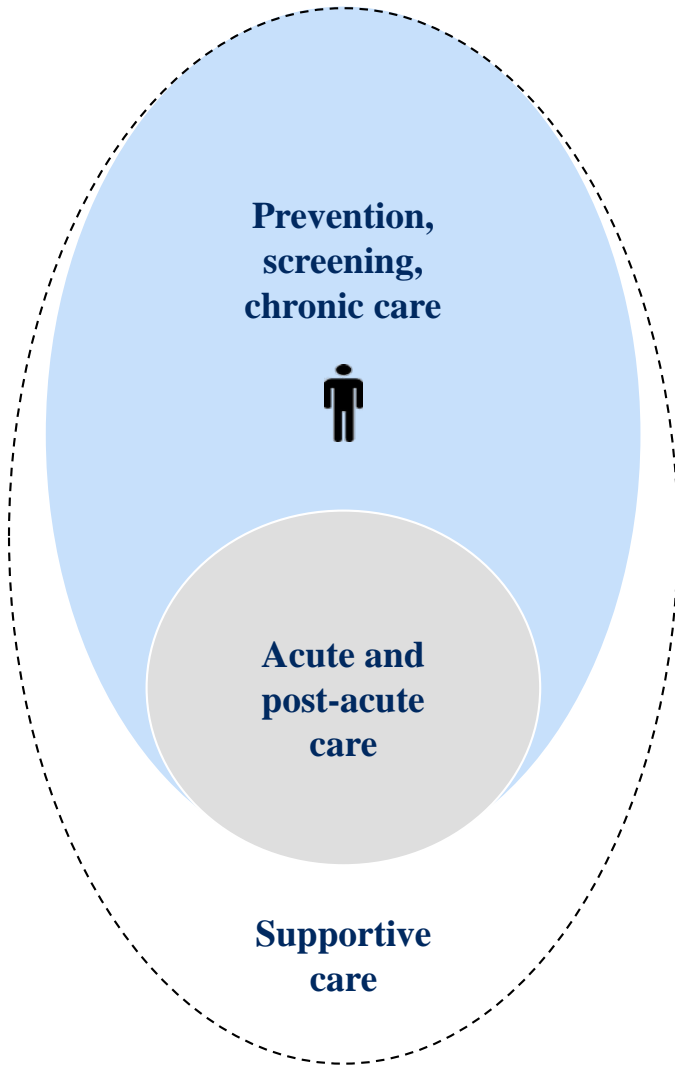
Medicaid and private insurers believe paying for patient results, rather than just individual patient services, is the best option to control costs and improve quality



- 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

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
- Acute medical, e.g.,
 - AMI
 - CHF
 - Pneumonia
- Acute procedural, e.g.,
 - CABG
 - Hip replacement
- Developmental disabilities
- Long-term care
- Severe and persistent mental illness

Population-based:
 medical homes responsible for care coordination, rewarded for quality, utilization, and savings against total cost of care

Episode-based:
 retrospective risk sharing with one or more providers, rewarded for quality and savings relative to benchmark cost per episode

Combination of population- and episode-based models:
 health homes responsible for care coordination; episode-based payment for supportive care services



2012

Implementation

Engagement

Governor's Office – Vision, Recruit Payers

Dept Human Services – Host Meetings, Develop Framework

Legislature – Approve Regulations

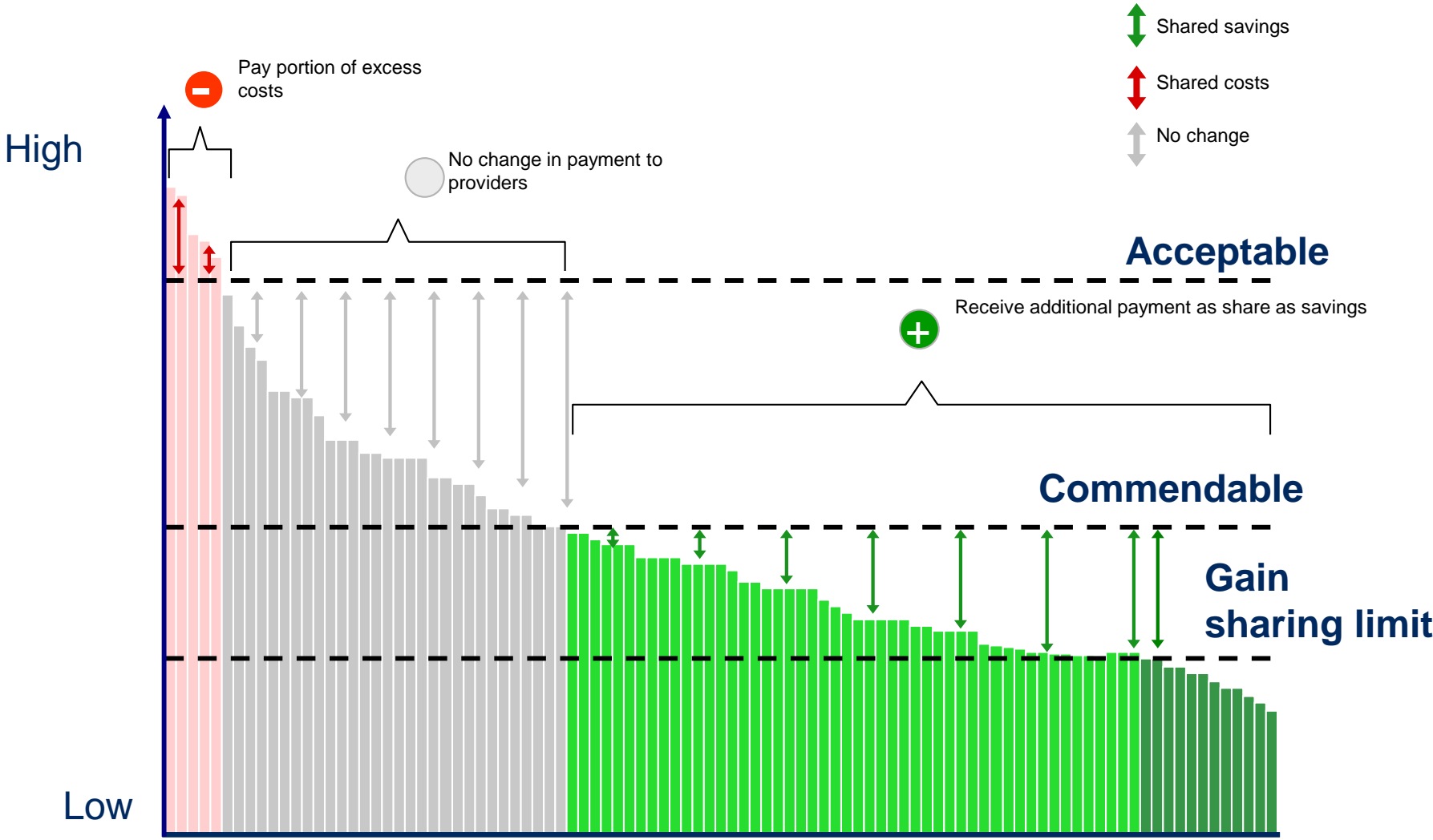
Private Insurers – Develop Internal Programs

Professional Societies – Cautious Support, Engagement

Clinical Leaders – Acceptance of Need for Change

Contractors – Outreach Activities, Data Management

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













Individual providers, in order from highest to lowest average cost



For Medicaid, work has occurred on 24 Episodes, with 13 having gone live

In Development
 Live
 Seeking clinical input
 Pending legislative review

1 MAY 2014

	Episode	Portal Live Date	Reporting Period Start Date	Multipayer Participation ¹
1-3	Upper Respiratory Infection	NA ²	July 2012	
4	Attention Deficit Hyperactivity Disorder (ADHD)	Oct 1, 2012	July 2012	
5	Perinatal	Oct 1, 2012	July 2012	 QualChoice
6	Congestive Heart Failure	Dec 1, 2013	October 2012	
7	Total Joint Replacement (Hip & Knee)	Dec 1, 2013	October 2012	 QualChoice
8	Colonoscopy	May 29, 2014 ³	July 2013	 QualChoice
9	Cholecystectomy (Gallbladder Removal)	NA ²	July 2013	 QualChoice
10	Tonsillectomy	May 29, 2014 ³	July 2013	
11	Oppositional Defiance Disorder (ODD)	Apr. 3, 2014	October 2013	
12	Coronary Artery Bypass Grafting (CABG)	Apr. 3, 2014	January 2014	
13	Asthma	NA ²	April 2014	
14	Percutaneous Coronary Intervention (PCI)	TBD	...	 QualChoice
15	Chronic Obstructive Pulmonary Disease (COPD)	NA ²	...	
16-23	Neonatal	TBD	...	
24	ADHD/ODD Comorbidity	TBD	...	
...	Future Episodes to Be Determined		...	

¹ Participation includes development and rollout of episode

² Episode does not use portal metrics

³ Estimate only


⁴ Estimate. Portal expected to go live at the beginning of the performance period, 3 months after the episode is implemented. Earliest possible date is Apr 2015

Provider Portal

The screenshot shows the homepage of the Health Care Payment Improvement Initiative. At the top, there is a logo for the state of Arkansas and the text "Health Care Payment Improvement Initiative Building a Healthier Future for all Arkansans". Below this is a navigation menu with links: Home, About Us, Why Payment Improvement?, How it Works, Episodes of Care, Medical Homes, and Health Homes. A search bar and a "Contact Us" link are also present. The main content area is divided into several sections: a "Provider Portal" section with a description and a "Learn More" button; a "Get Email Alerts" section with a form for first name, last name, and email; an "Announcements & Events" section with a list of links; and a "Reference Materials" section with a list of links. A large banner on the right side of the main content area features a photo of a doctor and the text "Want more details on changing Medicaid regulations? Click here." The footer contains links for Accessibility, Privacy, Security, and Acceptable Use, along with a copyright notice for 2012.

Health Care Payment Improvement Initiative
Building a Healthier Future for all Arkansans

Home | About Us | Why Payment Improvement? | How it Works | Episodes of Care | Medical Homes | Health Homes

Search Site  [Contact Us](#)

Provider Portal

Hospitals, Physician practices, mental health professionals and other providers can enter quality data and access their quality reports. Here you will find more information and links to the portal.

[Learn More >](#)

Get Email Alerts

first name

last name

* Email

* required

Announcements & Events

- Calendar of Events
- Announcements
- Press Releases

Reference Materials

- Training Videos
- Guides & Materials
- Frequently Asked Questions

Want more details on changing Medicaid regulations? Click here.

Accessibility | Privacy | Security | Acceptable Use

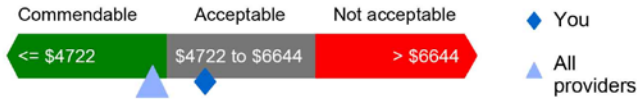
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Summary - Congestive Heart Failure

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

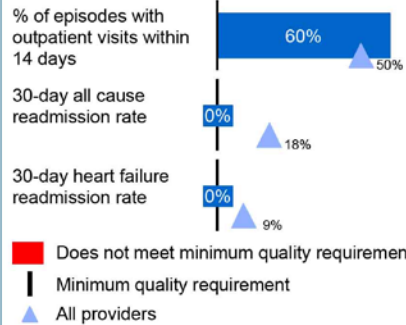
Quality summary

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.

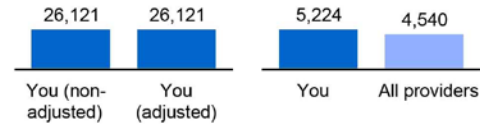
Quality metrics - not linked to gain sharing



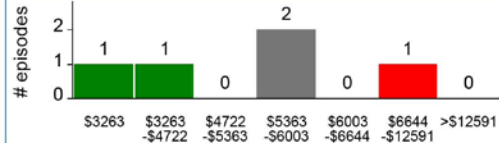
Cost summary

Your average cost is acceptable

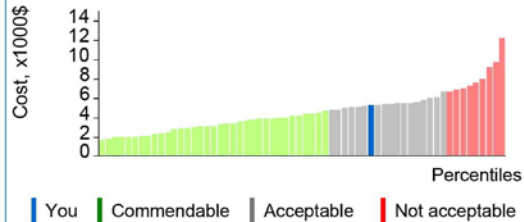
Your total cost overview, \$ Average cost overview, \$



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

■ You ■ All providers

Care category	# and % of episodes with claims in care category	Average cost per episode when care category utilized, \$	Total vs. expected cost in care category, \$
Inpatient professional			
Inpatient facility			
Outpatient professional			
Pharmacy			
Outpatient lab			
Outpatient radiology / procedures			
Emergency department			
Outpatient surgery			
Other			

EOCs Progress to Date

- Engine has processed 454.9 Million Claims
- 3.7 Million Episodes (before exclusions)
- 28,331 Reports
 - 13,834 EOC level payment or performance reports
 - 2,890 EOC level reconciliation reports
- 2,213 distinct PAPs
- PAPs received a collective gain share of \$793,337
- Risk Share applied to PAPs for -\$1,010,676



2014

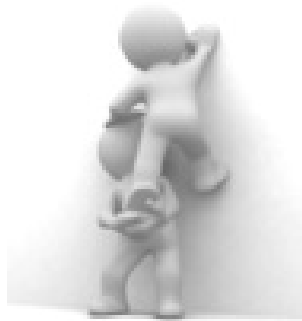
PCMH

2/3 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	Start your journey	Evolve your processes	Continue to innovate	
	Month 0-3	Month 6	Month 12	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

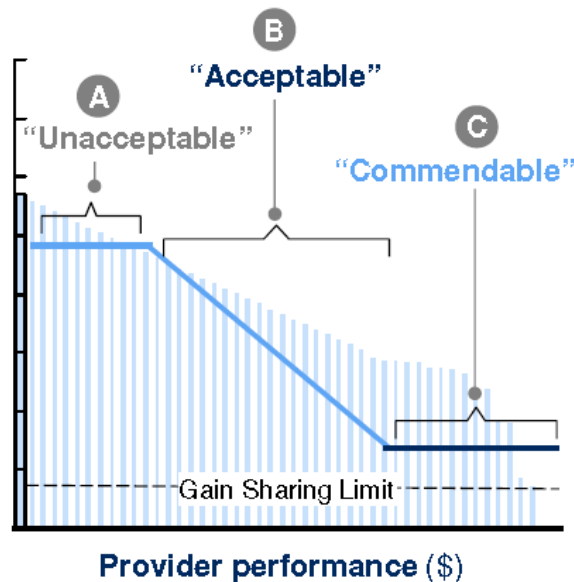
Shared savings entity performance on Quality metrics (based on 4/1/13-3/31/14 data from Q3 2014 report)

Metric	2014 target	1000 10000	1000 10001	1000 10002	1000 10003	1000 10004	1000 10005	1000 10006	1000 10007	1000 10008	1000 10009	1000 10010	1000 10011	1000 10012	1000 10013	1000 10014	1243 13069	1414 74002	1454 28002	1523 63002	1556 63002	1852 50002
ADHD	25%	48	27	35	41	23	40	29	20	18	N/A	33	38	20	20	N/A	N/A	34	17	30	43	33
TSH	80%	N/A	98	92	94	N/A	92	87	N/A	94	85	96	93	N/A	94	91	93	N/A	N/A	N/A	N/A	91
Breast cancer	50%	N/A	43	40	N/A	N/A	26	27	N/A	19	32	23	36	N/A	30	47	44	N/A	N/A	N/A	N/A	N/A
CHF	40%	N/A	56	N/A	N/A	N/A	56	37	N/A	N/A	44	N/A	N/A	N/A	N/A	55	47	N/A	N/A	N/A	N/A	N/A
Asthma	70%	97	86	91	92	94	89	67	94	87	85	92	88	93	95	86	82	95	98	83	86	96
HbA1c	75%	N/A	76	N/A	N/A	N/A	78	54	N/A	84	78	N/A	71	N/A	75	68	77	N/A	N/A	N/A	N/A	N/A
Adolescent wellness	40%	37	54	43	51	57	44	29	42	39	29	34	38	38	46	28	37	50	42	48	49	38
Child wellness	67%	63	73	59	72	74	61	47	64	68	58	57	62	67	63	58	65	69	63	72	63	67
Infant wellness	67%	82	71	60	84	79	68	54	78	62	71	58	82	74	68	62	57	79	74	63	80	87
Total		3/5	8/9	4/7	6/6	4/5	7/9	2/9	3/5	4/8	5/8	3/7	4/8	3/5	5/8	3/8	4/8	5/5	3/5	4/5	4/5	5/6

PCMH strategy: proposed AR shared savings model (upside only)

Distribution of provider performance

Average total cost of care



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?

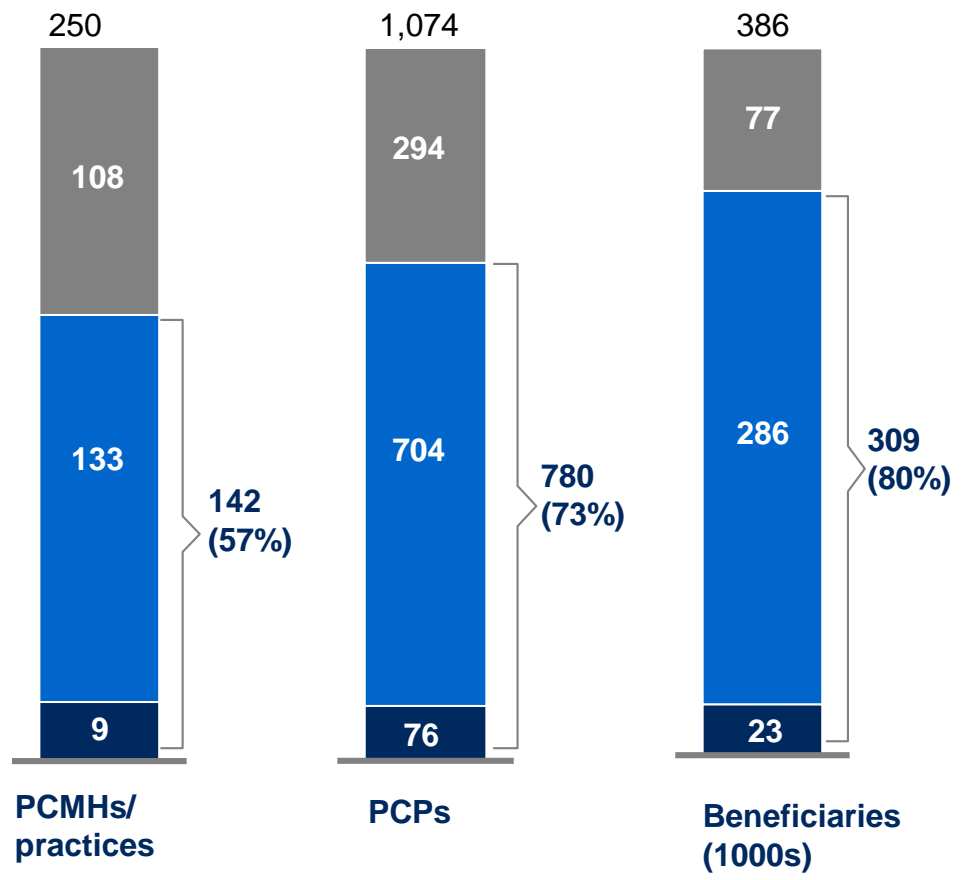
Notes

- 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)

PCMH enrollment status for Q4 2015 (as of 12/1)^{1,2,4}

■ Unenrolled ■ CPC + PCMH
 ■ PCMH only

PCMH/CPC enrollment
 Q4 2014¹



- ~142 PCMHs enrolled out of 250³ (57%)
- ~780 PCPs enrolled out of 1,074³ (73%)
- ~309K benes enrolled out of 386K³ (80%)
 - ~286K enrolled only in PCMH
 - ~23K enrolled in CPC and PCMH

1 Data pulled from PCMH Q4 reporting as of December 1, 2014; includes practices that enrolled for 1/1/15 start date in PCMH
 2 Data pulled from PCMH Q4 reporting as of December 1, 2014 for PCPs enrolled in 2014, and from MMIS for PCPs new to 2015
 3 Based on practices eligible for PCMH with at least 300 beneficiaries from Q3 2014 Reporting Period
 4 Q1 2015 attribution algorithm has not been run at the time of creation of this report; these attribution numbers are based on Q3 & Q4 figures

Outcomes/Lessons

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

For more information ...

Online

- **More information on the Payment Improvement Initiative can be found at www.paymentinitiative.org**
 - Further detail on the initiative
 - Specific details on all episodes
 - Information on PCMH
-

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