Moving to a Value-based Health Care Payment System in Arkansas

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NASHP Conference 2015
Dallas, Texas
Arkansas System Transformation Strategy

Payment System
Workforce
Health Information Technology
Population Health
Insurance Coverage
Significant Input from Providers and Patients

- Providers, patients, family members, and other stakeholders who helped shape the new model in public workgroups
- Public workgroup meetings connected to 6–8 sites across the state through videoconference
- Public town hall meetings across the state
- Months of research, data analysis, expert interviews and infrastructure development to design and launch episode-based payments
- Updates with Arkansas provider associations (AHA, AMS, Arkansas Waiver Association, Developmental Disabilities Provider Association)
Arkansas Payment Improvement Initiative’s Integrated Model
Coordinated Multi-payer Leadership

- **Consistent incentives** and standardized reporting rules and tools
- **Change in practice** patterns as program applies to many patients
- Enough scale to justify investments in **new infrastructure** and operational models
- **Motivate patients** to play larger role in their health and health care
Arkansas Episode Strategy

• All care associated with treatment for a specific condition
• Time bound – defined start and end point
• Achieve quality targets
• Lead provider assigned as ‘quarterback’
• Implemented by individual payers
• Improve quality and coordination for the patient, reduce inefficiency across health system, resulting in lowered cost of care

• **Upside and downside** gain/risk sharing model
Reports provide performance information for PAP’s episode(s):

- Overview of **quality** across 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 average episode cost
How the Episode Payment Model Works

- **Shared Savings**
- **Savings/Cost Neutral**
- **Shared Cost**

🌟 Quality of care protected by limits on gain sharing and required quality metrics

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**Year 1 results**

**Average cost per episode for each provider**

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

Individual providers, in order from highest to lowest average cost
<table>
<thead>
<tr>
<th>Episodes</th>
<th>Multi-Payer Participation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upper Respiratory Infection</td>
<td>Medicaid</td>
</tr>
<tr>
<td>Attention Deficit Hyperactivity Disorder</td>
<td>Medicaid</td>
</tr>
<tr>
<td>Perinatal</td>
<td>Medicaid QualChoice</td>
</tr>
<tr>
<td>Congestive Heart Failure</td>
<td>Medicaid</td>
</tr>
<tr>
<td>Total Joint Replacement (Hip &amp; Knee)</td>
<td>Medicaid QualChoice</td>
</tr>
<tr>
<td>Colonoscopy</td>
<td>Medicaid QualChoice</td>
</tr>
<tr>
<td>Cholecystectomy (Gallbladder Removal)</td>
<td>Medicaid QualChoice</td>
</tr>
<tr>
<td>Tonsillectomy</td>
<td>Medicaid</td>
</tr>
<tr>
<td>Oppositional Defiance Disorder</td>
<td>Medicaid</td>
</tr>
<tr>
<td>Coronary Artery Bypass Grafting</td>
<td>Medicaid</td>
</tr>
<tr>
<td>Asthma</td>
<td>Medicaid</td>
</tr>
<tr>
<td>Percutaneous Coronary Intervention</td>
<td>Medicaid QualChoice</td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disease</td>
<td>Medicaid</td>
</tr>
<tr>
<td>Neonatal</td>
<td>Medicaid</td>
</tr>
<tr>
<td>ADHD/ODD Comorbidity</td>
<td>Medicaid</td>
</tr>
<tr>
<td>Patient-Centered Medical Home</td>
<td>Medicaid QualChoice</td>
</tr>
</tbody>
</table>
Episodes of Care First-Year Highlights

• 17% drop in unnecessary antibiotic prescribing for non-specific URI

• Across the board improvements in perinatal screening rates

• AR BCBS hip/knee replacement costs reduced by 1.4% (7% below projected costs)

• 73% of Medicaid and 60% of ARBCBS Principal Accountable Providers improved costs or remained in a commendable/acceptable cost range

May 2015
All episodes live in 2014 had an average cost between 2% and 39% under the projections for 2014.
Arkansas Payment Improvement Initiative’s Integrated Model
Arkansas Patient-Centered Medical Homes (PCMH)

Key attributes

• Providers responsible for entire experience and cost of patient panel
• Evidence-informed preventive care and improved wellness
• 24/7 access for all individuals / networked EMRs
• Coordinated/integrated care across multidisciplinary provider teams
• Focus on management of chronic disease with avoided progression
• Referrals to high-value providers (e.g., specialists)

Incentives

• Monthly fees support care coordination efforts and transformation
• **Upside-only** shared savings model that rewards providers for controlling total patient costs while maintaining or improving quality
With PCMH, existing fee-for-service reimbursement remains the same...

Patients and providers deliver care as today

Patients seek care and select providers as they do today

Providers submit claims as they do today

Payers reimburse for all services as they do today
... But PCPs can also receive shared savings payments

For a shared savings entity (PCMH or group of voluntarily affiliated PCMHs)

Payers calculate average yearly cost per member for each shared savings entity.

Providers must perform on quality metrics
- Must meet \( \frac{3}{4} \) of targets for quality metrics
And providers must
- Remain in good standing for practice support payments

Average costs are compared to
- Pre-set “medium” and “high” cost levels
- Benchmark costs, based on historical costs projected forward

Results
PCMH can earn shared savings payment in one of two ways (receive greater of the two):
- Beating its own benchmark cost
- Beating a system-wide medium cost threshold

If the PCMH is not eligible for either payment, then the provider sees no change in reimbursement.
Launch of PCMH and Multi-payer Progress to Date

<table>
<thead>
<tr>
<th>Medicaid</th>
<th>Exceeded 2014 enrollment target of 40% with 79% of eligible beneficiaries enrolled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial</td>
<td>~250K commercially covered individuals in qualified health plans</td>
</tr>
<tr>
<td></td>
<td>ARBCBS extending to all books of business</td>
</tr>
<tr>
<td>Physician Impact</td>
<td>761(68%) Medicaid eligible PCPs in 135 practices (51%) enrolled</td>
</tr>
<tr>
<td></td>
<td>20% of PCMHs pooled for shared savings</td>
</tr>
</tbody>
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Medical Home: Rollout Timeline

**PCMH Coverage Strategy**

- **Wave 1**: Comprehensive Primary Care Initiative (CPC) - 69 Practices
  - Start of wave: October 2012

- **Wave 2**: ~123 Practices
  - Start of wave: January 2014

- **Wave 3**: ~135 Practices
  - Start of wave: January 2015

- **Expansion to all Practices**: On-going
Medicaid: Majority of 2014 PCMH Quality Measures Showed Improvement Over 2013

**PMCH Quality Metrics**

<table>
<thead>
<tr>
<th>Metric</th>
<th>% change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wellness, adolescent</td>
<td>+8.8%</td>
</tr>
<tr>
<td>HBA1C</td>
<td>+5.0%</td>
</tr>
<tr>
<td>ADHD</td>
<td>+4.5%</td>
</tr>
<tr>
<td>Breast cancer</td>
<td>+1.8%</td>
</tr>
<tr>
<td>Thyroid</td>
<td>+0.8%</td>
</tr>
<tr>
<td>Asthma</td>
<td>+0.1%</td>
</tr>
<tr>
<td>Wellness, infant</td>
<td>+0.1%</td>
</tr>
<tr>
<td>Wellness, child</td>
<td>-4.9%</td>
</tr>
<tr>
<td>CHF</td>
<td>-5.1%</td>
</tr>
</tbody>
</table>
Medicaid: Reductions in Hospitalizations and ER Visits Indicate Improved Quality and Cost

<table>
<thead>
<tr>
<th></th>
<th>CY2013</th>
<th>CY2014</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitalizations</td>
<td>83.8</td>
<td>78.9</td>
<td>-5.9%</td>
</tr>
<tr>
<td>Emergency Room Visits</td>
<td>635.5</td>
<td>617.1</td>
<td>-2.9%</td>
</tr>
</tbody>
</table>

Source: ARS tables from CY10,11,12,13,Q215 reports
PCMH Cost Avoidance Distributions¹

<table>
<thead>
<tr>
<th>Decrease in total cost of care</th>
<th>Coordination payments to providers</th>
<th>Net cost avoidance</th>
</tr>
</thead>
<tbody>
<tr>
<td>19.7 Million USD</td>
<td>12.1 Million USD</td>
<td>7.6 Million USD</td>
</tr>
</tbody>
</table>

Of the $19.7M in generated cost avoidance
- $12.1M has been reinvested back into the provider community
- $7.6M is projected to be shared between the state and providers

¹ These preliminary figures were calculated using a more conservative method than using the forecasted base year medium threshold of $1972
Medicaid: Bending the Cost Curve

Risk-Adjusted Medical Cost Per Capita
% Trend, CY14 vs. CY13

Benchmark trend

Practices enrolled in PCMH

Practices not enrolled in PCMH

PCMH practices in 2014 had cost growth 1.1 percentage points lower than the 2.6% benchmark trend while their unenrolled peers were 0.6 percentage points higher than trend.

Source: ARS tables from CY10,11,12,13,Q2’15 reports
Medicaid: PCMH Shared Savings

- $5.3 Million paid out to providers for 2014 outcomes
- Among 37 eligible practices, 19 received shared savings
- Amounts range from $9,000 to $923,000
- For 2015, all of the approximately 135 enrolled practices will have the opportunity to achieve shared savings
Expanded Participation Requirements for AHCP II

• Health Care Independence Act of 2013
• Dual-Eligible Special Needs Plans (DSNP) via DHS MOU

Health insurance carriers offering health care coverage for program eligible individuals shall participate in Arkansas Payment Improvement Initiatives including:
• Assignment of primary care clinician;
• Support for patient-centered medical home; and
• Access of clinical performance data for providers.
Health Homes

Developmentally Disabled
Medically Frail
Serious and Persistent Mental Illness

PATIENT-CENTERED MEDICAL HOME

Independent Assessment

Health Home
Video: Arkansas Health Care Payment Improvement Initiative

Arkansas’s innovative initiative to improve health system quality and control rising costs is documented in this video. Featured are overviews of each initiative component, including patient-centered medical homes, health homes and episodes of care, along with commentary from key stakeholders and project leaders.

ACHI was envisioned as an organization dedicated to change—change that leads to improved health for all Arkansans. While we have made positive strides in changing Arkansas’s health environment, our work is far from finished. Ongoing activities as well as historical successes are described in Our Work.

As our nation and state undergo dramatic and rapid shifts,ACHI is committed to adapting to these changing opportunities and challenges and works to keep you up to date on the latest news and events that impact the health of Arkansans. Please visit our News & Events page for the most recent information that affects our policy work.

ACHI’s activities are centered in three Areas of Focus that influence the health of Arkansans—population health policy, access to quality care, and health care financing—with supporting infrastructure of health data and research.

Links to our numerous policy issue briefs, reports, and research briefs, along with tools for those working to combat childhood obesity can be found in the Resource Library.

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Latest News
Third in Series of Health Affairs Blogs on Arkansas Health Care Payment Improvement Initiative
First year results for episodes of care component adds context to the discussion.

Private Option Delivering on Promise
Arkansas getting the health care services they need and at the same time creating new jobs and increased availability of medical services.

External RSS Feeds
- Hidden Costs For 'Fully Covered Care Can Slam Patients' Wallets' - 10/9/2014, via Kaiser Health News
- Patent Of sales gams wiped out by race expenses - 10/9/2014, via Modern Healthcare
- White House dismisses prostitution allegations as old news - 10/9/2014, via TheHill.com
- Rutgers Initiative to Examine Health Impacts of Post-Sandu Decision