Building a healthier future for all Arkansans

Arkansas Health Care Payment Improvement Initiative (AHCPII)
State Innovation Model (SIM) Update
April 18, 2014
We face major health care challenges in Arkansas

- **Fragmented provider system**
  - Many independent providers
  - >60% physicians in practices of 5 or fewer

- **Mix of rural and urban populations**
  - About 40% of Arkansans in rural areas
  - Health care system not integrated

- **Low rankings on national health indicators**
  - Ranked at or near the bottom of all states on national health indicators, such as heart disease and diabetes

- **Navigation challenges in the health care system**
  - Hard for patients to navigate
  - Does not reward providers who work as a team to coordinate care for patients
Payers recognize the value of working together to improve our system, with close involvement from providers and other stakeholders

Coordinated multi-payer leadership...

- Creates **consistent incentives** and standardized reporting rules and tools

- Enables **change in practice** patterns as program applies to many patients

- Generates enough scale to justify investments in **new infrastructure** and operational models

- Helps **motivate patients** to play a larger role in their health and health care
We have worked closely with providers and patients across Arkansas to shape an approach and set of initiatives to achieve this goal.

- **1,000+** Providers, patients, family members, and other stakeholders who helped shape the new model in public workgroup meetings.

- **29** Public workgroup meetings connected to 6-8 sites across the state through videoconference.

- **26** Months of research, data analysis, expert interviews and infrastructure development to design and launch episode-based payments.

- **Monthly** Updates with many Arkansas provider associations (e.g., AHA, AMS, Arkansas Waiver Association, Developmental Disabilities Provider Association).
Arkansas aims to create a sustainable patient-centered health system

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
Population-based care delivery
- 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
Payment improvement initiative
- Health care workforce development
- Consumer engagement and personal responsibility
- Health information technology adoption
- Expanded coverage for health care services
The episode-based model is designed to reward coordinated, team-based, high quality care for specific conditions or procedures.

<table>
<thead>
<tr>
<th>The goal</th>
<th>Coordinated, team-based care for all services related to a specific condition, procedure, or disability (e.g., pregnancy episode includes all care prenatal through delivery)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accountability</td>
<td>A provider ‘quarterback’, or Principal Accountable Provider (PAP) is designated as accountable for all pre-specified services across the episode (PAP is provider in best position to influence quality and cost of care)</td>
</tr>
<tr>
<td>Incentives</td>
<td>High-quality, cost-efficient care is rewarded beyond current reimbursement, based on the PAP’s average cost and total quality of care</td>
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</tbody>
</table>
For Medicaid, work has occurred on 24 Episodes, with 12 having gone live

<table>
<thead>
<tr>
<th>Episode</th>
<th>Portal Live Date</th>
<th>Reporting Period Start Date</th>
<th>Multipayer Participation</th>
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<tbody>
<tr>
<td>1-3</td>
<td>NA²</td>
<td>July 2012</td>
<td>QualChoice</td>
</tr>
<tr>
<td>4</td>
<td>Oct 1, 2012</td>
<td>July 2012</td>
<td>QualChoice</td>
</tr>
<tr>
<td>5</td>
<td>Oct 1, 2012</td>
<td>July 2012</td>
<td>QualChoice</td>
</tr>
<tr>
<td>6</td>
<td>Dec 1, 2013</td>
<td>October 2012</td>
<td>QualChoice</td>
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<tr>
<td>7</td>
<td>Dec 1, 2013</td>
<td>October 2012</td>
<td>QualChoice</td>
</tr>
<tr>
<td>8</td>
<td>May 29, 2014³</td>
<td>July 2013</td>
<td>QualChoice</td>
</tr>
<tr>
<td>9</td>
<td>NA²</td>
<td>July 2013</td>
<td>QualChoice</td>
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<tr>
<td>10</td>
<td>May 29, 2014³</td>
<td>July 2013</td>
<td>QualChoice</td>
</tr>
<tr>
<td>11</td>
<td>Apr. 3, 2014</td>
<td>October 2013</td>
<td>QualChoice</td>
</tr>
<tr>
<td>12</td>
<td>Apr. 3, 2014</td>
<td>January 2014</td>
<td>QualChoice</td>
</tr>
<tr>
<td>13</td>
<td>Oct 1, 2014</td>
<td>...</td>
<td>QualChoice</td>
</tr>
<tr>
<td>14</td>
<td>NA²</td>
<td>...</td>
<td>...</td>
</tr>
<tr>
<td>15</td>
<td>NA²</td>
<td>...</td>
<td>...</td>
</tr>
<tr>
<td>16-23</td>
<td>Jan 1, 2015⁴</td>
<td>...</td>
<td>...</td>
</tr>
<tr>
<td>24</td>
<td>TBD</td>
<td>...</td>
<td>...</td>
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<tr>
<td>...</td>
<td>Undecided</td>
<td>...</td>
<td>...</td>
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</table>

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 Jan 2015.
Patient Centered Medical Homes will support patients to connect with the full constellation of providers who form their health services team...

<table>
<thead>
<tr>
<th>What is PCMH?</th>
<th>Key Attributes</th>
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<tbody>
<tr>
<td><strong>A team based care delivery model led by a primary care provider that holistically manages a patient’s health needs</strong></td>
<td>24/7 access for all individuals</td>
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<td></td>
<td>Evidence-informed care</td>
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<td>Providers with responsibility for a practice’s entire population</td>
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<td>Coordinated and integrated care across multidisciplinary provider teams</td>
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<td>Focus on prevention and management of chronic disease</td>
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<td>Referrals to high-value providers (e.g., specialists)</td>
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<td>Improved wellness and preventative care</td>
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**Incentives**

- Monthly fees to support care coordination efforts and ramp-up of PCMH model
- Shared savings model that rewards providers for controlling costs while maintaining or improving quality
Medical Home: Rollout Timeline

PCMH coverage strategy over next several years

Wave 1: CPCI
Wave 2: Open to all (primary care early adopters enroll 10/1/13-12/15/13)
Wave 3: Expansion to remaining primary care (family practice, etc.)

Start of wave:
- October 2012
- Jan 2014
- Enroll throughout 2014
Wave 1: Comprehensive Primary Care Initiative (CPCI)

69 primary care practices
- FFS + enhanced payments
- Improving patient experience
- Practices responsible for ALL patients
- Quality, cost, and transformation milestones 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 yrs 2–4
Wave 2: Patient Centered Medical Home (PCMH) Enrollment

- 637 primary care physicians
- Covering nearly 243,000 Medicaid beneficiaries (including 40,000 covered in Wave 1: CPC)
- Together PCMH and CPC cover about 72% of all eligible Medicaid beneficiaries
## Episodes and PCMH Progress to Date

| Episodes | Completed first performance period reconciliation for URI  
|  | 4 additional reconciliations will occur for ADHD, Perinatal, CHF, and TJR in April  |
| Providers | Issued quarterly reports to over 2,500 Principle Accountable Providers (PAPs) since July 2012  
| Impact | Seeing gradual increases in quality and decreases in costs (unnecessary use of antibiotics to treat URIs, use of strep tests to diagnose pharyngitis, and increase in perinatal screenings)  
| | Changing specialist and facility referral patterns  |
| PCMH | Practice transformation vendor engaging with practices  
| | Intent to award issued for care coordination vendor  
| | Enrollment underway for next wave of expansion  
| | Pursuing shadow reporting with Medicare for enrolled practices  |
| Payments | In January, practices received a total of $2.75 million in enhanced per-member per-month (PMPM) payments  |
| Reports | In February, practices received their first quarterly PCMH reports showing quality and cost data for all covered clients  
| | In April, they selected their top 10% high-risk patients  |
For more information regarding ACHPII . . .

**Online**
- More information on the Payment Improvement Initiative can be found at [www.paymentinitiative.org](http://www.paymentinitiative.org)
  - Further detail on the initiative, PAP and portal
  - Printable flyers for bulletin boards, staff offices, etc.
  - Specific details on all episodes
  - Contact information for each payer’s support staff
  - All previous workgroup materials

**Phone/email**
- **Medicaid**: 1-866-322-4696 (in-state) or 1-501-301-8311 (local and out-of-state) or ARKPII@hp.com
- **Blue Cross Blue Shield**: Providers 1-800-827-4814, direct to EBI 1-888-800-3283, APIICustomerSupport@arkbluecross.com
- **QualChoice**: 1-501-228-7111, providerrelations@qualchoice.com

**Today’s Presentation**
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