Arkansas Healthcare Payment Improvement Initiative

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Arkansas Blue Cross and Blue Shield

Agenda for today

- Overview of the Payment Improvement Initiative
- Operational details on how the initiative works

Goals, history and structure of initiative
- Description of model (episode-based payment)
- How episode-based payments work
- New roles for patients and providers
- How incentive payments are calculated
- Comments, questions and answers

Tools for providers and next steps to take
- Comments, questions and answers
Today, we face major healthcare challenges in Arkansas

- The health status of Arkansans is poor, the state is ranked at or near the bottom of all states on national health indicators, such as heart disease and diabetes
- The healthcare system is hard for patients to navigate, and it does not reward providers who work as a team to coordinate care for patients
- Healthcare spending is growing unsustainably:
  - Insurance premiums doubled for employers and families in past 10 years (adding to uninsured population)
  - Large projected budget shortfalls for Medicaid

Our vision to improve care for Arkansas is a comprehensive, patient-centered delivery system ...

**Objectives**

- **For patients**
  - Improve the health of the population
  - Enhance the patient experience of care
  - Enable patients to take an active role in their care
- **For provider**
  - Reward providers for high-quality, efficient care
  - Reduce or control the cost of care

**How care is delivered**

- Population-based care
  - Medical homes
  - Health homes
- **Episode-based care**
  - Acute, procedures or defined conditions

**Four aspects of broader program**

- Results-based payment and reporting
- Health care workforce development
- Health information technology (HIT) adoption
- Expanded access for health care services
Payers recognize the value of working together to improve our system, with close involvement from 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 healthcare

Medicaid and private insurers believe paying for results, not just individual services, is the best option to improve quality and control costs

- Transition to payment system that rewards value and patient health outcomes by aligning financial incentives
- 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 copayments (private payers), or higher taxes (Medicaid)
- Intensify payer intervention in decisions though managed care or elimination of expensive services (e.g. through prior authorizations) based on restrictive guidelines
- Eliminate coverage of expensive services or eligibility
Ensuring high-quality care for every Arkansan is at the heart of this initiative, and is a requirement to receive performance incentives.

### Two types of quality metrics for providers

<table>
<thead>
<tr>
<th>Quality metric(s)</th>
<th>Description</th>
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</table>
| **1** Quality metric(s) “to pass” are linked to payment | - Core measures indicating basic standard of care was met  
- **Quality requirements** set for these metrics, a provider must meet required level to be eligible for incentive payments  
- In select instances, quality metrics must be entered in portal (heart failure, ADHD) |
| **2** Quality metric(s) “to track” are not linked to payment | - Key to understand overall quality of care and quality improvement opportunities  
- Shared with providers but not linked to payment |

*There are five or fewer per episode

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We have worked closely with providers and patients across Arkansas to shape an approach and set of initiatives to achieve this goal.

<table>
<thead>
<tr>
<th>500+</th>
<th>Providers, patients, family members and other stakeholders who helped shape the new model in public workgroups</th>
</tr>
</thead>
<tbody>
<tr>
<td>21</td>
<td><strong>Public workgroup meetings</strong> connected to 6-8 sites across the state through videoconference</td>
</tr>
<tr>
<td>16</td>
<td><strong>Months of research</strong>, data analysis, expert interviews and infrastructure development to design and launch episode-based payments</td>
</tr>
<tr>
<td>Monthly</td>
<td><strong>Updates with many Arkansas provider associations</strong> (e.g., AHA, AMS, Arkansas Waiver Association, Developmental Disabilities Provider Association)</td>
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</table>
The episode-based model is designed to reward coordinated, team-based, high-quality care for specific conditions or procedures

**The goal**
- 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)

**Accountability**
- 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)

**Incentives**
- High-quality, cost-efficient care is rewarded beyond current reimbursement, based on the PAP’s average cost and total quality of care across each episode

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The model rewards a Principal Accountable Provider (PAP) for leading and coordinating services and ensuring quality of care across providers

<table>
<thead>
<tr>
<th>PAP role</th>
<th>What it means ...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Core provider</td>
<td>Physician, practice, hospital or other provider in the best position to influence overall quality, cost of care for episode</td>
</tr>
<tr>
<td>for episode</td>
<td></td>
</tr>
<tr>
<td>Episode “Quarterback”</td>
<td>Leads and coordinates the team of care providers</td>
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<td></td>
<td>Helps drive improvement across system (e.g., through care coordination, early intervention, patient education, etc.)</td>
</tr>
<tr>
<td>Performance</td>
<td>Rewarded for leading high-quality, cost-effective care</td>
</tr>
<tr>
<td>management</td>
<td>Receives performance reports and data to support decision-making</td>
</tr>
</tbody>
</table>

PAP selection:
- Payers review claims to see which providers patients chose for episode related care
- Payers select PAP based main responsibility for the patient’s care

**NOTE:** Episode and health home model for adult DD population in development. Model will utilize lead provider and health home to drive coordination.
How episodes work for patients and providers (1/2)

1. **Patients and providers deliver care as today (performance period)**
   - **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

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

4. **Calculate incentive payments based on outcomes after close of 12-month performance period**
   - 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**
   - Compare average costs to predetermined “commendable” and “acceptable” levels

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

\*Appropriate cost and quality metrics based on latest and best clinical evidence, nationally recognized clinical guidelines and local considerations
Five initial episodes launched in July 2012 (1/2)

<table>
<thead>
<tr>
<th>Details</th>
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</thead>
<tbody>
<tr>
<td><strong>Total Hip/ Knee replacement</strong></td>
</tr>
<tr>
<td>▪ Care from 30 days before to 90 days after the surgical procedure</td>
</tr>
<tr>
<td><strong>Perinatal (non-NICU)</strong></td>
</tr>
<tr>
<td>▪ Prenatal care, delivery and postnatal care for the mother</td>
</tr>
<tr>
<td>▪ 40 weeks before to 60 days after delivery</td>
</tr>
<tr>
<td>▪ Excludes neonatal care</td>
</tr>
<tr>
<td><strong>Ambulatory URI</strong></td>
</tr>
<tr>
<td>▪ Includes colds, sore throats, sinusitis</td>
</tr>
<tr>
<td>▪ Care from initial consultation to 21 days after</td>
</tr>
<tr>
<td>▪ Excludes inpatient hospitalizations and surgical procedures</td>
</tr>
<tr>
<td><strong>Acute-, post-acute heart failure</strong></td>
</tr>
<tr>
<td>▪ Care from hospital admission for heart failure to 30 days after</td>
</tr>
<tr>
<td>▪ Discharge</td>
</tr>
<tr>
<td><strong>ADHD</strong></td>
</tr>
<tr>
<td>▪ Care over 12-month period, including all ADHD services and</td>
</tr>
<tr>
<td>▪ Pharmacy costs (with exception of initial assessment of patient)</td>
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</tbody>
</table>

NOTE: Episode and health home model for adult DD population in development.
Neonatal intensive care unit.

Five initial episodes launched in July 2012 (1/2)

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<th>Principal Accountable Provider (PAP)</th>
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<tr>
<td><strong>Total Hip/ Knee replacement</strong></td>
</tr>
<tr>
<td>▪ Orthopedic surgeon</td>
</tr>
<tr>
<td><strong>Perinatal (non-NICU)</strong></td>
</tr>
<tr>
<td>▪ Delivering provider</td>
</tr>
<tr>
<td><strong>Ambulatory URI</strong></td>
</tr>
<tr>
<td>▪ First provider to diagnose patient in-person</td>
</tr>
<tr>
<td><strong>Acute-, post-acute heart failure</strong></td>
</tr>
<tr>
<td>▪ Admitting hospital</td>
</tr>
<tr>
<td><strong>ADHD</strong></td>
</tr>
<tr>
<td>▪ Depends care pathway</td>
</tr>
<tr>
<td>▪ Physician</td>
</tr>
<tr>
<td>▪ Licensed clinical psychologist, and/or</td>
</tr>
<tr>
<td>▪ RSPMI provider</td>
</tr>
</tbody>
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NOTE: Episode and health home model for adult DD population in development.
Neonatal intensive care unit.
Guiding principles that payers use to determine cost levels (e.g., ‘commendable’ and ‘acceptable’ thresholds) and incentive payments

1. **Reward high-quality, efficient** delivery of clinical care
2. **Promote fairness** by considering patient access, provider economics and changes required for improvement
3. **Acknowledge that poor performance is a reality** and should not be rewarded
4. **Protect quality and access** by setting a gain-sharing limit at a reasonable, achievable level
5. **Sustain thresholds for reasonable period** to allow for adjustment and learning

Each payer assesses historic provider average costs for an episode

- **Year 1: Preparatory period**
- **Year 1: Distribution of provider costs**
... then selects thresholds to promote high-quality, guideline-based and cost-effective care

Individual providers, in order from highest to lowest average cost

Selected thresholds applied to provider performance in the following year ... even though we expect that cost effectiveness will have improved

Individual providers, in order from highest to lowest average cost
PAPs that meet quality standards and have average costs below the commendable threshold will share in savings up to a limit.
PAPs will be provided new tools to help measure and improve patient care

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

Example of provider reports

PAP performance reports have summary results and detailed analysis of episode costs, quality and utilization

Details on the reports

- First time PAPs receive detailed analysis on costs and quality for their patients increasing performance transparency
- Guide to Reading Your Reports available online and at this event
  - Valuable to both PAPs and non-PAPs to understand the reports
- Reports issued quarterly starting July 2012
  - July 2012 report is informational only
  - Gain/risk sharing results reflect claims data from Jan – Dec 2011
- Reports will be available online via the provider portal
The provider portal is a multi-payer tool that allows providers to enter quality metrics for certain episodes and access their PAP reports.

**Details on the provider portal**
- Accessible to all PAPs
- Login with existing username/ password
- New users follow enrollment process detailed online
- Key components of the portal are to provide a way for providers to
  - Enter additional quality metrics for select episodes (Hip, Knee, CHF and ADHD with potential for other episodes in the future)
  - Access current and past performance reports for all payers where designated the PAP

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**AHCPPII: Quarterly and Annual Reports**

![Table and chart showing provider portal login and payment initiative website with AHCPII quarterly and annual reports.](image)
AHCP II: Review

- First-year settlements, Wave 1 episodes
  - Gain Share: $400,000 (81 PAPs)
  - Loss Share: $169,000 (36 PAPs)
- Second-year settlements, Wave 1 and 2a episodes
  - Gain Share: $1,484,000 (248 PAPs)
  - Loss Share: $79,000 (34 PAPs)
- Program “wins”
  - Seeing improved compliance in clinical quality, especially in perinatal screening measures
  - Now tracking quality information that we could not before
    - DVT/PE management in TKR/THR
    - ACE/ARB prescription in heart failure
  - Increased transparency
    - Orthopedic surgeons are more selective in hospitals they choose to do replacements
    - Facilities are now encouraged to be more competitive in negotiated costs
    - Providers are more engaged with Arkansas Blue Cross and Blue Shield and are collaborating to help shape the program

Medical Homes

Transformative Compensation for Transformative Thinking

- FFS Thinking – The drive to work
  “I wonder what kind of services I will need to provide to patients who decide to come in and see me today?”
- PCMH Thinking – The drive to work
  “I am confident that I have built a model and a plan to make sure that my patients who are in greatest need of care get the care they need today!”
Medical Homes

Primary Care Compensation

- Fee for service reimbursement is an ineffective way to pay primary care physicians if your goal is to have them manage populations
- It is not uncommon for PCP compensation to be in the range of 10% to 15% less than other providers relative to Medicare payment levels
- Non-activity based payment allows a PCMH practice the resources to manage a population effectively
  - Removes in large measure the pressure to see a large number of patients each day and perform a large number of billable services

The Importance of Accurate Diagnostic and Treatment Data

- Stars and Risk Adjustment Opportunities
  - Star ratings are an indication of how well a plan manages chronic conditions, customer service, wellness programs, member complaints, access to care, and quality improvement
  - Risk adjustment refers to an assessment of the general health status of the members in a specific health plan as compared to the health of the overall members in all health plans for a specific population (Medicare Advantage or exchange qualified health plans for example)
- Health plan performance on these measures will determine the revenue a plan receives. Good performance increases premium revenue which will result in more money for provider incentives.
The future of successful provider business models will rely more on how to create a stream of revenue that is not directly tied to resource consumption

- FFS Margins will necessarily be compressed
- Waste and inefficiency will no longer be rewarded
- Keep a close watch on MACRA and other initiatives that are implemented by public programs, and in the exchanges

- The most successful business models will be those that are able to access the new “pool of value” that will be created by value based compensation systems

Thank You

- Questions?