ARKANSAS HEALTH CARE PAYMENT IMPROVEMENT INITIATIVE OVERVIEW FAQS

■ What is the main goal of the payment improvement initiative?
  The main goal is to move the Arkansas health system from a payment model that rewards volume to one that rewards high-quality, efficient outcomes for patients by aligning financial incentives for how care is delivered.

  We aim to promote and reward prevention and early intervention, coordinated team-based care, and clinical innovation that results in more efficient delivery of high-quality care.

■ Why is this happening now?
  There are major health care challenges facing Arkansas. Health outcomes for people in Arkansas are poor, with the state ranked at or near bottom of all states on national health indicators. The fragmented health care system is hard for patients to navigate, and system does not promote team-based care.

  In addition, health care spending is growing at an unsustainable rate. Insurance premiums doubled for Arkansas employers and families in past 10 years, adding to the uninsured population, and large (and growing) budget shortfalls are projected for Medicaid over the next few years.

■ Why are the private insurers participating in this initiative?
  The private insurers face many of the same challenges that Medicaid does. They view the transition to a payment system that rewards outcomes as the best option for improving quality and controlling costs.

  If they do not move to a payment system that aligns incentives, they face a number of unattractive options: reduce payment levels for providers across-the-board; pass growing costs on to consumers through higher premiums, deductibles, or co-pays; intensify their intervention in clinical decisions (e.g. through prior authorizations); or eliminate coverage of expensive services.

■ Does this involve bundled payments?
  No, the initiative does not involve bundled payments. Providers will continue to bill separately for services delivered and will receive reimbursement for services delivered as they do today.

  At the conclusion of each performance period, the average cost of the episode for a Principal Accountable Provider (PAP, defined below) will be calculated and evaluated against cost thresholds (detailed below) to determine whether there will be risk or gain sharing payments for the PAP. The cost thresholds are set independently by each provider.
Is this related to national health reform?
This initiative is not linked to the national Affordable Care Act. It is not dependent upon or related to events in Washington, DC. Starting in July 2012, Arkansas launched the first wave of episodes as the beginning of a long term process of health care payment improvement.

Will there be an appeals process?
Yes, each payer is developing that process. Until it is completed, please contact the relevant payer for more information.

Can patients get access to information about who are poor performers and who has highest readmission rate?
Initially, information will be limited to providers. However, the initiative will create a great deal of data that may be shared publicly in an aggregated way in the future.

How will you prevent people from gaming the system (e.g., by changing coding practices)?
Each payer will implement a detailed audit function. This audit function will use current procedures and also additional triggers created by the episode model to ensure proper coding and appropriate provision of service.

Where else has this model been used?
There are a number of payers and providers that have used payment improvement models. Examples include: Geisinger’s ProvenCare model, Horizon Blue Cross Blue Shield of New Jersey, the PROMETHEUS payment model, and Medicare’s Acute Care Episode (ACE) demonstration project.

What evidence exists that this model has been successful in the past?
Results from a number of pilots as well as academic literature suggest significant potential savings. A paper by David Cutler in the New England Journal of Medicine, for instance, estimated that episode-based payment could result in savings of 7-15% on Medicare’s top 17 episodes by spending.

What are other models that were rejected?
There are a number of ways payers have attempted to deal with rising costs, which Arkansas payers are attempting to avoid: reduce payment levels for providers across-the board; pass growing costs on to consumers through higher premiums, deductibles, or copays; intensify their intervention in clinical decisions (e.g. through prior authorizations); or eliminate coverage of expensive services. Among options for outcome-based payment models, we initially explored a prospective bundled payment model, but received feedback from providers that this was not appropriate for the Arkansas context, since it would pose a significant administrative burden to develop new financial and contracting relationships.
■ Why aren't we moving completely away from fee-for-service (FFS)?

The episode payment model is a change from the fee-for-service model. Although providers are initially reimbursed under the current fee-for-service claims system, the episode payments align incentives for the PAP to take a look at the overall episode and coordinate care.

The benefit of building the new payment model on top of the existing system is that it minimizes administrative disruption for providers. Providers continue to have the same administrative and financial relationships with the payers as before, but the payments are structured to better align incentives to promote high-quality and efficient care.

■ Will this model penalize doctors who take on particularly sick patients?

When the provider’s performance is evaluated, a number of steps may be taken to ensure that the measurement is fair. Adjustments are made for patient risk/severity, and outlier cases are excluded. Provider level adjustments may include stop-loss provisions, potential adjustments for providers in areas with poor physician access, cost-based facilities, differences in regional pricing, and exclusions for providers with low case-volume. This protects providers whose patients are more vulnerable.

■ Is this fair to doctors? How can they be held accountable for things that are outside their control (e.g., if another doctor runs up a large bill or if a patient doesn’t take prescriptions)?

The PAP, determined as the provider most likely to coordinate care for that episode, will be responsible for including and encouraging other providers in each episode to undertake effective care. It is the role of the PAP to encourage practice behaviors that are most appropriate for their patients.

■ Doesn’t this add to the administrative burden for providers?

The additional administrative requirements are limited, and in some cases the episode model will reduce administrative burden. A benefit of the initiative is the coordination of requirements and portal across the payers. The high-volume episodes (Ambulatory URI, Pregnancy) do not require providers to submit any additional information. In some cases, the episode model allows payers to get rid of prior authorization processes, which can ultimately reduce administrative burden (e.g., ADHD).

■ Will this cut physicians’ rates?

The aim of the payment initiative is to change the structure of payment, not the level of payment. While some physicians may earn less money if they provide care inefficiently, many physicians are performing commendably and will be rewarded with greater payment under the new system.

■ Why doesn’t the initiative simply target physicians with truly poor performance, instead of changing the payment model for everyone?
The goal of the payment initiative is not only to discourage inefficient and low-quality care, but also to reward providers for their high-quality, efficient care. Our aim is to fundamentally align incentives and set up a system that will promote and reward clinical innovation.

- Does the payment improvement initiative represent a consolidation of private and commercial payers?
  No. This initiative represents a cooperative effort to create a methodology to allow providers to succeed by maintaining the same practice methods across payers. We maintained independent approaches to setting thresholds but are collaborating on provider engagement, report design and other key elements that help make the initiative scalable for providers.

- Will I be penalized for extreme high-cost patients within an episode?
  Adjustments are made for patient risk/ severity, and outlier cases. Average episode cost for a PAP excludes extreme high-cost outliers. There are further details in the episode fact sheets provided on the payment initiative website: www.paymentinitiative.org.

- Will this initiative address larger costs such as long-term care and mental health?
  Yes. Additional episodes are being developed that encompass a broad range of care, including developmental disabilities, long-term care, and mental health. Long term care and mental health are also being targeting through population-based care delivery via development of a statewide patient-centered medical home program. More details can be found in the episode specific FAQs.

- How does the initiative insure that patients will continue to receive high quality care when it incentivizes lower costs?
  Patients will continue to seek care as they do today, with the same access to providers. The only difference is the new incentives providers have to deliver high quality care. Increased quality is a primary purpose of this initiative. In designing the episodes of care, we set required targets for quality measures to reward desired health outcomes such as decreased re-hospitalization and reductions in unnecessary antibiotic usage. In addition to a gain-sharing limit threshold to ensure providers offer a baseline of care, there are indicators in the quality metrics of each episode that expose shortcuts that may undercut quality.

- How much is the state expected to gain in total savings through this initiative?
  The goal is to achieve sustainable improvements in cost and quality across the state, for patients, providers and the health care system overall. We will actively track the results of the initiative and report to stakeholders on the gains being achieved.