Arkansas Health System Improvement

**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**

Medical and health homes
- 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**

Outcomes-based payment and reporting
Health care workforce development
Health information technology adoption
Expanded coverage for health care services
## Principles of payment design for Arkansas

<table>
<thead>
<tr>
<th>Principle</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient-centered</td>
<td>Focus on improving quality, patient experience and cost efficiency</td>
</tr>
<tr>
<td>Clinically appropriate</td>
<td>Evidenced-based design with close input from Arkansas patients, family members, and providers</td>
</tr>
<tr>
<td>Practical</td>
<td>Consider scope and complexity of implementation</td>
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<tr>
<td>Data-based</td>
<td>Make design decisions based on facts and data</td>
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</table>
What challenges are we trying to address? URI example

Antibiotic prescription rates for adults are high... % of episodes resulting in filled antibiotic\(^1\)

<table>
<thead>
<tr>
<th>Condition</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute non-specific</td>
<td>49</td>
</tr>
<tr>
<td>Pharyngitis</td>
<td>63</td>
</tr>
<tr>
<td>Sinusitis</td>
<td>58</td>
</tr>
</tbody>
</table>

...yet evidence-based guidelines suggest prescribing very selectively, if at all

- “Antibiotics should not be used to treat nonspecific upper respiratory tract infections in adults, since antibiotics do not improve illness resolution”
- “For acute pharyngitis, antibiotic use should be limited to patients who are most likely to have group a β-hemolytic streptococcus”
- “For acute sinusitis, narrow-spectrum antibiotics should be given only to patients with persistent purulent nasal discharge and facial pain or tenderness who have not improved after 7 days or those with severe symptoms.”

**EXHIBIT C**

**SOURCE:** Medicaid claims SFY2010; CDC

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1 ICD-9 034.0 not included in analysis. All patients with tonsil-related procedures and outpatient observations in hospitals excluded.
Example current practice: ADHD episode cost distribution

Episodes ending in SFY 2009 – SFY 2010 (i.e two years of data), Medicaid only

NOTE: Includes episodes with primary care physicians or RSPMIs as Principal Accountable Providers
SOURCE: Arkansas Department of Human Services (DHS), Division of Medical Services
The populations that we serve require care falling into three domains:

<table>
<thead>
<tr>
<th>Prevention, screening, chronic care</th>
<th>Patient populations (examples)</th>
<th>Care/payment models</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute and post-acute care</td>
<td>• Healthy, at-risk</td>
<td>Population-based: medical homes responsible for care coordination, rewarded for quality, utilization, and total care cost</td>
</tr>
<tr>
<td>Supportive care</td>
<td>• Chronic, e.g.,</td>
<td></td>
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<tr>
<td></td>
<td>– CHF</td>
<td></td>
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<tr>
<td></td>
<td>– Diabetes</td>
<td></td>
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<tr>
<td></td>
<td>• Acute medical, e.g.,</td>
<td>Episode-based: gain and risk sharing with one or more providers, rewarded for quality and savings relative to cost thresholds</td>
</tr>
<tr>
<td></td>
<td>– CHF</td>
<td></td>
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<tr>
<td></td>
<td>– Pneumonia</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Acute procedural, e.g.,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>– Hip replacement</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Developmental disabilities</td>
<td>Combination of population- and episode-based models: health homes responsible for care coordination; episode-based payment for care provision</td>
</tr>
<tr>
<td></td>
<td>• Long-term care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Behavioral health</td>
<td></td>
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<tr>
<td></td>
<td>(mental illness / substance abuse)</td>
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</tbody>
</table>
Episode payment model: illustrative example

Principal Accountable Provider(s) A
Sub-par cost performance

Acceptable cost threshold¹

Commendable cost threshold¹

Gain sharing limit¹

$17,500

Principal Accountable Provider(s) B
Commendable cost performance

Average episode cost is $500 above acceptable threshold
Excess cost is divided between payor and PAP

Average episode cost is $1000 below acceptable threshold
The PAP shares this gain with the payor, so long as quality measures are satisfactory

Amount of gain or risk sharing

$17,000

$12,000

$3,500

¹ May be risk-adjusted. For simplicity of illustration, all patients in this example are of the same level of severity
Note: in the coming months, each participating payor will independently determine cost thresholds and level of upside/downside sharing for each episode
Gain and risk sharing: a Principal Accountable Provider will fall into one of four categories, depending on the provider’s average cost per episode

Average cost per episode, for each Principal Accountable Provider

- **Sub-par performance**: Providers whose costs exceed the acceptable threshold will be held responsible for a share of costs above this threshold – shown by the arrow above.

- **Acceptable performance**: The provider neither gains nor loses because costs are neither above the acceptable threshold nor below the commendable threshold.

- **Commendable performance**: Savings below the commendable threshold – shown by the arrow above – are shared between provider and payor, until the gain sharing limit is reached.

- **Beyond commendable performance**: The provider will receive a share of savings up to a gain sharing limit, but not beyond.

Note: in the coming months, each participating payor will determine the level of upside and downside sharing for each episode. Model described here does not apply to Developmental Disabilities episode, which is structured as described in March 6th meeting materials.
The episode performance payment may be adjusted for a number of patient- and provider-level factors

### Patient-level adjustments
- Patient risk/severity adjustments
- Outlier exclusions on a cost basis

### Provider-level adjustments
- Stop-loss provisions
- Adjustments for providers in areas with poor physician access
- Adjustments for cost-based facilities
- Adjustments for differences in regional pricing
- Adjustments or exclusions for providers with low case-volume

Note: Model described here does not apply to Developmental Disabilities episode, which is structured as described in March 6th meeting materials.
Candidate principal accountable providers across episodes

Candidate principal accountable provider(s)\(^1\)

- **Hip/knee replacements**
  - Orthopedic surgeon
  - Hospital

- **Perinatal (non NICU)**
  - Delivering provider
  - If separate providers perform prenatal care and delivery, both providers are PAPs (shared accountability)
  - Provider for the first in-person URI consultation

- **Ambulatory URI**
  - Hospital

- **Acute/post-acute CHF**
  - Could be the PCP, mental health professional, and/or the RSPMI provider organization, depending on the pathway of care

- **ADHD**
  - Primary DD provider\(^2\)

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1 Based on objective assessment of PAP criteria; participating payors will make own assessment of which providers to designate as PAP
2 For DD, Lead Provider will be chosen and is responsible for coordination across integrated care plan & reporting / performance on quality metrics
**July 1st launch: current thinking**

<table>
<thead>
<tr>
<th>Key milestones</th>
<th>Description</th>
<th>Timing</th>
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<tbody>
<tr>
<td>Program announcement and education</td>
<td>Payment design and documentation published</td>
<td>May/ June</td>
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<td></td>
<td>Educational workgroups and townhalls to answer questions</td>
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<tr>
<td>Program launch</td>
<td>All analytic/ reporting engines up and running</td>
<td>July 1st</td>
</tr>
<tr>
<td>Reporting period (3-6 months)</td>
<td>Principal Accountable Providers (PAP) begin data exchange and later receive baseline historical performance reports</td>
<td>July 1st</td>
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<tr>
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<td>Analytic/ reporting engines track “virtual” performance for each PAP</td>
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<td>Performance does not yet impact payment</td>
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<tr>
<td>Feedback period</td>
<td>Workgroups provide feedback on version 1.0</td>
<td>July 1st – Sep 1st</td>
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<td>Payors refine version 1.0 design</td>
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<tr>
<td>Performance period begins</td>
<td>New episodes begin to count towards a PAP’s share of risk or gain sharing</td>
<td>Q4 2012 or Q1 2013</td>
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NOTE: Developmental disabilities are on a separate timeline, as described in the workgroup on March 6.