2011

Developing Vision
Medicaid and private insurers believe paying for patient results, rather than just individual patient services, is the best option to control costs and improve quality.

- Transition to system that **financially rewards value** and patient outcomes and encourages coordinated care.

- **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 co-pays (private payers), or higher taxes (Medicaid).

- **Intensify payer intervention in clinical decisions** to manage use of expensive services (e.g. through prior authorizations) based on prescriptive clinical guidelines.

- **Eliminate coverage of** expensive services, or eligibility.
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 health care
Arkansas is one of six states CMS awarded model-testing grant

- The **CMS State Innovation Models (SIM) Initiative** is providing funding to the State of Arkansas
  - **$42 million** to implement and test the initiatives over the next 42 months
  - **Funding covers** episode-based care delivery, patient-centered medical homes, and health homes

- The State sees this grant as an **indication of CMS’ engagement** with the initiative and belief that it could be a model more broadly applied in the country
How episodes work for patients and providers (2/2)

4. Calculate incentive payments based on outcomes after close of 12 month performance period.

5. Payers calculate average cost per episode for each PAP.

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

Review claims from the performance period to identify a ‘Principal Accountable Provider’ (PAP) for each episode.

Compare average costs to predetermined ‘commendable’ and ‘acceptable’ levels.

---

1. Outliers removed and adjusted for risk and hospital per diems
2. Appropriate cost and quality metrics based on latest and best clinical evidence, nationally recognized clinical guidelines and local considerations
PAPs that meet quality standards and have average costs below the commendable threshold will share in savings up to a limit

- **High**: Pay portion of excess costs
- **Acceptable**: No change in payment to providers
- **Commendable**: Gain sharing limit
- **Low**: Pay portion of excess costs

**Shared savings**

**Shared costs**

**No change**

**Individual providers**, in order from highest to lowest average cost
2012

Implementation
## Desired Impact of Model Test Component

- **Provider Engagement**
  - Town Hall Meetings, Webinars, Advisory Groups, Association Meetings, Local Provider Representatives

- **Payer Participation**
  - Regular Steering Committee Meetings, Regular Operations Staff Meetings

- **Beneficiaries**
  - Maintain Current Providers, Monitor Improved Access, Visit With Advocates,

- **Stakeholders**
  - Monthly Meetings With AHA/AMA, Town Halls, Legislative Hearings
"I'll Pause for a Moment So You Can Let This Information Sink In."
Provider Portal

Health Care Payment Improvement Initiative
Building a Healthier Future for all Arkansans

Want more details on changing Medicaid regulations? Click here.

Get Email Alerts

first name
last name
* Email
* required
Submit Clear

Announcements & Events
- Calendar of Events
- Announcements
- Press Releases

Reference Materials
- Training Videos
- Guides & Materials
- Frequently Asked Questions
Summary - Congestive Heart Failure

Overview
Total episodes: 16
Total episodes included: 5
Total episodes excluded: 11

Average cost of care compared to other providers

Gain/Risk share
$0
You will not receive gain or risk sharing
- Quality requirements: N/A
- Average episode cost: Acceptable

Quality summary

Quality metrics - linked to gain sharing
There are no quality metrics linked to gain sharing generated from historical claims data. Selected quality data submitted on the Provider Portal on or after February 1, 2013 will generate additional quality metrics for future reports.

Quality metrics - not linked to gain sharing

Quality metrics

Key utilization metrics

30-day outpatient observation care rate

Cost summary

Your total cost overview, $
26,121 26,121
Your average cost is acceptable

Average cost overview, $
5,224 4,540
You (non-adjusted) You (adjusted) You All providers

Your episode cost distribution

Distribution of provider average episode cost

Percentiles

You Commendable Acceptable Not acceptable

0 2 1 1 1 2 0 0 0 1 0
$3263 $3263 $4722 $4722 $5363 $5363 $6644 $6644 $12591 $12591
### Cost detail - Total Joint Replacement

**Total episodes included = 5**

<table>
<thead>
<tr>
<th>Care category</th>
<th># and % of episodes with claims in care category</th>
<th>Average cost per episode when care category utilized, $</th>
<th>Total vs. expected cost in care category, $</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient professional</td>
<td>5 (100%)</td>
<td>2,727 (2,679)</td>
<td>13,634 (13,394)</td>
</tr>
<tr>
<td>Inpatient facility</td>
<td>5 (100%)</td>
<td>3,543 (3,725)</td>
<td>17,714 (18,626)</td>
</tr>
<tr>
<td>Outpatient professional</td>
<td>5 (100%)</td>
<td>190 (586)</td>
<td>951 (2,833)</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Outpatient lab</td>
<td>5 (100%)</td>
<td>201 (77)</td>
<td>1,004 (276)</td>
</tr>
<tr>
<td>Outpatient radiology / procedures</td>
<td>5 (100%)</td>
<td>340 (222)</td>
<td>1,702 (995)</td>
</tr>
<tr>
<td>Emergency department</td>
<td>1 (20%)</td>
<td>66 (29)</td>
<td>66 (29)</td>
</tr>
<tr>
<td>Outpatient surgery</td>
<td>2 (40%)</td>
<td>76 (302)</td>
<td>152 (516)</td>
</tr>
<tr>
<td>Other</td>
<td>5 (100%)</td>
<td>2,022 (1,973)</td>
<td>10,109 (9,402)</td>
</tr>
</tbody>
</table>
Since the initial release of the EOC program in 2012:

- 14 quarterly EOC runs have been completed
- 6 payment runs have been completed, including generation of gain/risk share payments
- The Episode Engine has identified approximately 2,000 Principal Accountable Providers (PAPs)
- The Episode Engine has processed over 456.4 million Medicaid claims and generated over 3.3 million episodes
- The Reporting Engine has generated over 26,000 Principal Accountable Provider (PAP) Reports
Trending: Quality metric results

**URI-Nonspecific: Episodes with an antibiotic claim**
GDIT implemented an interactive dashboard that provides graphical visualizations for the following components:

- **Program Summary** – Provides an overall summary of providers, episodes, and costs involved in the EOC program over time
- **Episode Summary** – Provides a summary of the providers, episodes, and costs involved in the EOC program for a specific episode over time
- **PAP Detail** – Provides details of the specific providers, including demographic information, reported episodes, and costs over time
- **Episode Detail** – Provides episode-specific measure details over time
- **Engagement Summary** – Provides metrics on the providers who viewed their PAP reports
- The EOC Dashboard is accessible through the secure Episode-Based Payment System (EBPS) Application and is refreshed quarterly with additional EOC data and daily with additional engagement data.
Goals

2016
In 2016, at least 30% of U.S. health care payments are linked to quality and value through Alternative Payment Models (APMs).

30%

2018
In 2018, at least 50% of U.S. health care payments are so linked.

50%

These payment reforms are expected to demonstrate better outcomes and lower costs for patients.
Outcomes/Lessons

• Learning System
  – Stretch the Providers Who ----
  – Provide Program Feedback ---
  – That Modifies Requirements/Analytics ---
  – Which Support Practice Transformation ---
  – And Starts New Cycle of Dialogue