RFI Response for the
State of Arkansas
Department of Human Services

Episode-Based Payment System

Date
July 20, 2012

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July 19, 2012

Ms. Dawn Zekis  
Issuing Officer  
Arkansas Department of Human Services  
Division of Medical Services  
PO Box 1437 – Slot S416  
Little Rock, AR 72203

Sent via email: Dawn.Zekis@Arkansas.gov

RE: Arkansas Department of Human Services, Division of Medical Services Request for Information for an Episode-Based Payment System to Support Payment Improvement Initiative

Dear Ms. Zekis:

On behalf of Optum1, I am pleased to offer the following response to the Arkansas Department of Human Services, Division of Medical Services’ Request for Information (RFI) for an Episode-Based Payment System. As our response indicates, we are most interested and engaged in this crucial component of overall health care reform and improvement. Optum, with our extensive base of resources and expertise, is well positioned to support Arkansas’ Health Care Payment Improvement Initiative.

Thank you for this opportunity to share ideas and collaborate as potential partners. If you have any questions about our response, please contact me at 303-520-1370 or willie.williams@optum.com.

Sincerely,

Willie Williams  
Client Sales Executive for Arkansas  
Optum

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1 The information set forth herein is offered in response to a Request for Information (RFI) for an anticipated Statement of Work and is offered by Optum Government Solutions, Inc. (“Optum”) for planning purposes only. This RFI is not an offer capable of acceptance and is subject to change or revision at any time without notice. The actual pricing for an agreed upon Statement of Work will be established through negotiation of a definitive written agreement between the parties.
# Table of Contents

1. Introduction ............................................................................................................................................. 1  
2. Understanding DMS’ Objectives and Approach ..................................................................................... 1  
3. Optum Capabilities and Value for DMS .................................................................................................. 2  
   3.1 Industry Leading Episode Definition Tools ............................................................................ 2  
   3.2 Leadership in Episode Bundle Definition ........................................................................... 3  
   3.3 Rich Experience in Provider Analytics ................................................................................. 4  
   3.4 Consulting and Actuarial Depth in Care Cost and Quality Analytics ..................................... 5  
   3.5 Hospital and Physician Contracting / Gain Sharing Arrangements ...................................... 5  
4. Optum’s Approach to Support the EBPS ............................................................................................... 5  
   4.1 Component A: Episode Design ............................................................................................. 6  
   4.1.1 Episode Definition ...................................................................................................... 6  
   4.1.2 Principal Accountable Provider Selection .................................................................. 6  
   4.1.3 Clinical and Business Exclusions .............................................................................. 7  
   4.1.4 Patient and Provider-Level Adjustments ................................................................... 7  
   4.1.5 Quality Metrics ........................................................................................................... 8  
   4.1.6 Maintenance and Algorithm Updates ........................................................................ 8  
   4.1.7 Threshold Setting ..................................................................................................... 10  
   4.2 Component B: Administration ............................................................................................. 10  
   4.2.1 Analytics Engine ...................................................................................................... 10  
   4.2.2 Report Generation and Distribution ......................................................................... 11  
   4.2.3 Data Exchange ........................................................................................................ 11  
   4.2.4 Payment Administration ........................................................................................... 11  
   4.2.5 Episode Deployments .............................................................................................. 11  
   4.3 Additional Program Activities .............................................................................................. 12  
   4.3.1 Support for Additional Bundles ................................................................................ 12  
   4.3.2 Deployment Planning ............................................................................................... 12  
   4.3.3 Program Management ............................................................................................. 13  
   4.4 Additional Issues for Consideration .................................................................................... 13  
   4.4.1 DMS Has Established a High Bar ............................................................................ 13  
   4.4.2 History of Payer-Based Care Standards ...................................................................... 13  
   4.4.3 Potential for a Conflict with a Center-of-Excellence Approach ................................ 14  
5. Conclusion ............................................................................................................................................ 14
List of Figures

Figure 3-1. Average Total Knee Replacement Costs for a Defined California Population ...................... 4

Figure 4-1. Bundled Administration Model Envisioned by DMS ................................................................. 9

Figure 4-2. Establish a “Bundle Intermediary” .......................................................................................... 10

Figure 4-3. Deployed Episode Bundles Site Locations ............................................................................. 11

Figure 4-4. Approach to Working with Delivery Systems to Implement Bundled Payment .................... 12
1 Introduction

Optum is pleased to offer our response to the Arkansas Department of Human Services (DHS), Division of Medical Services (DMS) Request for Information (RFI) for an Episode-Based Payment System (EBPS). Optum has been at the forefront of episode-based payment reform, and we are pleased to see the State of Arkansas undertake such a significant initiative toward this objective. We have a substantial experience base in tools and techniques to support episode-of-care analysis, definition, management and administration. We look forward to bringing these strengths to assist DMS in this endeavor.

2 Understanding DMS’ Objectives and Approach

We understand that DMS’ overall objective is to reform the statewide payment system to fundamentally improve the cost and quality drivers of the Arkansas health ecosystem. To date, specific DMS actions in support of this objective include:

- Focusing on bundling payment to selected providers to improve accountability
- Structuring the program to make the initiative extensible to 75 percent of the medical expenditure in the state
- Establishing an operating framework that can be adopted by most (or all) payers in the state
- Establishing an implementation horizon of three to four years to achieve control over that level of medical expenditure.

Entry tactics in bundling will focus on selected episodes, including:

- Pregnancy
- Ambulatory Upper Respiratory Infections
- Hip/knee Replacements
- Congestive Heart Failure
- Attention Deficit Hyperactivity Disorder.

DMS seeks a partner to assist in framing the launch and delivery of this program, including bundle definition, identification of participating partners, and deployment of a flexible, scalable system.

We understand DMS’ approach to this initiative to be:

- **Establish standard bundle definitions** – Use existing care standards and analytical tools to establish a standard reference of care for each episode of care.
- **Identify key participating providers** – Find specific Participating Accountable Providers (PAPs) to participate in this program.
- **Continue payment in the traditional fee for service model** – Minimize disruption to the provider ecosystem by continuing the current practices in provider billing and payment.
- **Establish performance incentives** – Set and communicate performance incentives for PAPs who deliver care consistent with established care standards for each bundle.
- **Compare claims retrospectively against the standard bundle definitions** – Periodically compare claims experience for each PAP against the standard care bundles, adjusted for appropriate considerations in risk and geography.
• **Pay out incentive payments** – Pay PAPs incremental payments beyond the previously-paid claims, based on comparing clinical performance against standards.

DMS’ intent is to drive the majority of care delivery in the health ecosystem toward a quality standard-driven performance model that rationalizes cost and quality by increasing accountability.

Optum’s vision for improvement in health system performance is based on our intent to move providers from a focus on volume to a focus on value. We believe that this Arkansas initiative is well aligned with our vision and strategic intent.

### 3 Optum Capabilities and Value for DMS

*We understand that DMS strives to improve health outcomes for patients while managing clinical and administrative costs — without sacrificing the quality of care or disrupting provider relationships.*

Optum has an industry leadership position in the tools and techniques needed to support the EBPS initiative, including:

- Industry leading episode definition tools
- Leadership in episode bundle definition
- Rich experience in provider analytics
- Consulting and actuarial depth in care cost and quality analytics
- Hospital and provider contracting/gain sharing agreements.

The following sections explain how Optum will assist DMS with solutions designed to roll out and administer the EBPS.

#### 3.1 Industry Leading Episode Definition Tools

Optum’s Symmetry® and Impact® products have set industry standards in care analytics, provider analytics and predictive modeling. Our analytics evaluate the health status, cost, and quality trends of over 170 million Americans (over half of the US population). They are currently employed by 14 state agencies and 37 commercial organizations managing the care of Medicaid populations. These tools are based on sophisticated analytical groupers that assess administrative and clinical datasets. The key groupers include:

- **Episode Treatment Groups® (ETG)** – The ETG grouper stratifies claims by patient by medical condition to establish the range of costs to treat patients for a given medical condition. The ETG model characterizes all costs of care in a population in terms of approximately 1,400 such disease states or conditions. Claims for the same patient with multiple conditions are extracted and accumulated separately. The end result is a condition-driven analytic base that can be further subdivided by provider, by provider group, by geography or by other cohort analytic.

- **Procedure Episode Groups® (PEG)** – The PEG grouper further slices the ETG data for the subset of time-boxed conditions that are related to key medical procedures. PEGs currently cover approximately 140 conditions, and include all major procedures including major joint replacement, coronary artery bypass grafts, and most general surgery episodes. The PEGs can be further subdivided by provider, geography, or other cohort.

- **Episode Risk Groups® (ERG)** – The ERG grouper characterizes each care episode based on patient risk. The ERGs can be used to adjust and predict the risk of patient
populations under any provider or provider set, so that clinical performance can be compared even when populations are not clinically equivalent at the outset. The ERG tool set is a key element in risk adjustment of payment incentives for providers.

- **Evidence Based Medicine (EBM) Tools** – The EBM groupers (EBM Connect®) are used to identify compliance with industry standards for clinical management. EBM Connect performs compliance analysis based on treatment, care and patient adherence guidelines written by national standards organizations and an independent expert panel of board-certified physicians, pharmacologists, coding specialists and medical analysts. Rigorous use of national standard measures and input of a panel of experts enhances credibility when EBM Connect is used to assess disease management or provider quality. All measures are reviewed periodically, and are fully transparent to share with patients and provider groups.

- **Pharmacy Risk Groups® (PRGs)** – The PRG grouper uses prescription data and proprietary classification systems to measure health risk. PRGs provide risk measures for every individual in a covered population, and assist in identifying patients with highest risk through the creation of markers indicating person-specific disease severity and comorbidities. PRGs allow for assessment of risk sooner versus later given the immediacy of receiving point of sale drug claims.

In aggregate, these tools are used to identify the costs for treatment of conditions, the relative risk of a patient or sets of patients in a cohort, the relative performance of providers treating these patients, the compliance with nationally accepted standards and the variances in care that occur within geographic or other parametric categories.

### 3.2 Leadership in Episode Bundle Definition

Optum has been at the forefront of efforts on the part of providers and payers to define models for episode-based care and episode-based payment. Much of this work was a natural development from the increasing sophistication of our analytical tools and our ongoing work in clinical areas such as the following.

- **Chronic disease management** – Optum manages ongoing programs to improve the cost/quality performance of patient cohorts with key chronic diseases, such as diabetes mellitus and congestive heart failure.

- **Utilization management** – Optum assists clients in identification of clinical conditions that are candidates for structured authorization rules to mitigate the risk of inappropriate utilization.

- **Management of specific high-risk clinical settings** – Optum deploys clinical staff to improve the outcomes and cost performance of patients in acute care, long-term care, patients at risk for long-term care, and other settings.

- **Management of high-cost conditions** – Optum mediates the implementation of center-of-excellence structures for high-cost interventions, such as organ transplants.

Because of our involvement in these types of activities, payers and providers have asked us to assist in the planning and implementation of the transition to bundled payment. The vast majority of these initiatives are still in the planning stages. In spite of the extensive national discourse related to bundled payment, the actual implementation progress on payment bundles (in terms of implemented changes to payment models) has been light.

Optum has been involved with two key initiatives over the last several years that have made significant progress, as described below.
Integrated HealthCare Association (IHA), California

IHA sponsored an initiative to pilot bundled payment for total knee surgery in 2010. Optum assisted with the selection of the initial pilot episode, the episode definition, and the patient inclusion criteria. Early in the episode definition process, Optum used PEG to frame the episode costs, as shown in Figure 3-1.

![Figure 3-1. Average Total Knee Replacement Costs for a Defined California Population](image)

Optum staff worked with IHA to define the standard entry point for the episode, the standard episode interventions, the standard reimbursement cost, and the metrics for patient inclusion in the episode.

The Cleveland Clinic, Ohio

Optum is working with the Cleveland Clinic as an “alpha” client to develop our software to support structured bundled payments from providers. The Clinic is in the process of implementing episode definitions in pilot for total knee replacement, total hip replacement, and coronary artery bypass grafts. The Clinic has another set of episodes in development with Optum. The software in development at the Clinic will be jointly marketed commercially by Optum and the Clinic.

3.3 Rich Experience in Provider Analytics

Optum has extensive experience in evaluating the performance of providers at the individual practitioner and group levels, as well as between facilities. Our Impact Intelligence® data analytics tool set is specifically designed to capture and report on differential performance of defined practitioner and facility-centric analytics for cost and quality. Impact Intelligence is a specific implementation of the Symmetry tools to assess and manage overall provider performance. Based on output from these tools, Optum has assisted payers and provider organizations to assess and improve the performance of their provider communities.
3.4 Consulting and Actuarial Depth in Care Cost and Quality Analytics

Optum has over 400 actuaries and cost analytics consultants who work to assist our clients. All of the following steps in the bundle definition require analytics, actuarial analysis, or both where this actuarial expertise will be essential.

- Identification of episodes of care that are targets for bundling
- Identification of the intervention components of the target episode
- Identification and quantification of the variances in the components, or variances by geography
- Selection of components of the standard episode model
- Identification of the criteria for inclusion and exclusion of patients
- Pricing the standard episode
- Modeling and quantification of performance incentives.

3.5 Hospital and Physician Contracting / Gain Sharing Arrangements

Optum has experience in development of contracts to support episode-based payment. Considerations include division of care services, accountability for outcomes, and revenue among providers within the bundled episode.

Optum has participated in each of these steps with various clients. We look forward to bringing our tools and experience to assist DMS in the successful EBPS implementation.

4 Optum’s Approach to Support the EBPS

This section describes our approach to support the Arkansas EBPS initiative, as well as our capabilities to meet DMS’ needs. We mapped our capabilities to the structure outlined in the RFI. We also document some considerations that were outside of the capabilities requested in the RFI. That discussion begins in section 4.3 below.

Two Approaches to Bundled Payment

In our view, there are two fundamentally different approaches to managing episode bundles. These two approaches are often described as “retrospective” (or “virtual”) versus “prospective” (or “structured”). Optum has tools and products to support both approaches. Given DMS’ intent to capture 75 percent of medical expenditure under episode-based payment, we expect that both formats will be used, and that much of the work will be specifically developed for Arkansas.

Bundle Characteristics May Vary by Payer

We also believe that the issues related to bundle definition (and particularly exclusion factors) are likely to vary substantially by payer within Arkansas. It is certainly true that the Medicaid eligibility issues drive exclusion factors (and, perhaps, changes in provider incentives) unique to Medicaid. Similarly, in the commercial marketplace, the nature of benefit design from commercial insurers may drive inclusion/exclusion criteria specific to the commercial market that do not apply to Medicaid.
A Scan of the Competition
In our view, there are very few competitors to Optum that have a footing in this market. The Prometheus tool set acquired some market presence in the “retrospective” bundle management space, even before being acquired by MedAssets. We are not certain about the breadth of Prometheus implementations. There are a handful of tool vendors that market claim groupers, but we are not aware of their successes in either episode definition or bundled payment implementation.

Rough Order of Magnitude Project Scale
This is an extensive project. We believe that Optum is the only partner that has a footing in both the retrospective (virtual) and prospective (structured) episode bundle markets, and adequate resources to staff an initiative this size. It is likely that the effort to define a new episode bundle can be managed down to three to four work months per bundle over time, although initial definitions will likely be larger efforts. Deployment effort is driven by the number of payers and the number or PAPs, among other factors. We anticipate the deployment effort will be a multiple of the episode definition effort. If we add a reasonable budget for communications management and program management over a four-year horizon, we could expect this project effort in total to easily exceed 200 work years. Greater specificity will require significantly more detail in the implementation approach and the structure of the program and subordinate projects.

The remainder of this section details how Optum will work with DMS on each of the specified tasks in the RFI.

4.1 Component A: Episode Design
Optum will be able to fully assist DMS in episode design as we discuss below.

4.1.1 Episode Definition
Relying on our industry-standard tools (as described in Section 3) and deep experience in episode analytics, Optum will:

- Identify components in the episodes of interest
- Identify the target interventions in the preferred standard episode structure
- Identify the standard cost targets for the standard episodes
- Identify the performance incentives (or levels of performance incentives) for compliance with the standards
- Develop a strategy for deploying the episodes across Arkansas.

The vast majority of this work is customized. Optum does have entry bundle definitions for some bundles. However, we expect that the strategic objective to attain management of 75 percent of medical expenditure will require detailing the boundaries of (at least) dozens of new episode bundle definitions. Our view is that the majority this work will be ground-breaking, and hence will be built specifically for Arkansas DMS.

4.1.2 Principal Accountable Provider Selection
We will use our provider analytics tools to identify the providers that have historically had the strongest performance against the standard episodes. Selection of the entry PAPs, however, will likely be based on factors more broad that historical performance. Other factors that drive the selection may include:
• Provider performance in more than a single episode type
• Provider group performance in more than a single episode type
• The willingness/interest in any specific provider group acting in a leadership role in the initiative
• The willingness of any specific provider group in assisting in the effort to manage the evolution of the episode definition over time
• The geographic coverage of providers
• The market dynamics at play in each geography that may impact economic incentives of individual participants.

4.1.3 Clinical and Business Exclusions

Optum will work with DMS to identify the criteria for inclusion and exclusion of patients from each episode. Exclusion factors will likely include some level of comorbidity. However, for providers managing larger populations, it will often be advantageous to expand the boundaries of acceptance of comorbidity in exchange for a slightly higher reimbursement level.

Common and expensive episodes (such as coronary artery bypass grafts) or episodes for patients that are unavoidably comorbid (such as renal transplants) may well be reasonable candidates for bundling, as long as the average reimbursement level is higher than the median cost level. Given the objective of advancing the initiative to cover 75 percent of medical expenditure, it will be reasonable to look for opportunities to limit the clinical exclusion criteria and maintain cost management incentives for as broad a population as possible. For some procedural episodes, the exclusion criteria may be indirectly related to comorbidity. An example of an indirect criterion might be the American Society of Anesthesiology (ASA) score before surgery. Alternatively, ASA scores (or comorbidities) could be used as payment classification/modulation factors (as opposed to exclusion factors).

The Medicaid population has a particularly difficult actuarial issue with respect to continuity of active eligibility. The eligibility churn in and out of Medicaid coverage is far higher than that of commercial insurance enrollment change. In that context, DMS has some unique business issues that insurers in the commercial population do not necessarily have to address. Given the eligibility churn, it may be reasonable to establish some multi-factor adjustment model such as:

• Patients who are not continually covered are excluded from the general performance risk pool
• Patient episodes that were substantially complete before disenrollment may drive some form of individually-assessed benefit.

The latter consideration will preserve provider interest in care episodes that tend to be long (or chronic) even though the fully enrolled patient population may dwindle through the performance year.

Though many considerations are feasible, it is worthwhile to remember that simplicity in design translates into ease of administration.

4.1.4 Patient and Provider-Level Adjustments

We will work with DMS to structure patient and provider-level adjustments. For larger patient populations, the simplest model will generally be to exclude as few patients as possible and to adjust the risk score of the population based on severity. This has the advantage of being easy to administer, but loses some luster in terms of understandability to the provider population.
The risk adjustment mechanisms that Optum uses for actuarial analysis do withstand detailed scrutiny, but such scrutiny is not for the faint of heart. Nevertheless, given the strategic intent to manage 75 percent of the population under EBPS, a broad-based, risk-adjusted payment schema may be mandatory.

There is no easy answer to the populations in rural areas that do not concentrate episodes in adequate quantity to justify analytical comparison of populations. This issue can be partially offset by explicitly focusing on transporting patients to Centers of Excellence (COE) that have adequate populations (this making the rural populations even lower). However, the residual population could conceivably be less severe and hence more amenable to performance incentives.

Raw cost outliers may be used to adjust some patients, and they tend to be easy to administer. However, the specific level of cost outliers can be difficult to establish. Outliers were used with some success in DRG administration, but the cost denominator (an inpatient admission) was a somewhat large basis for an outlier factor. A cost outlier that is set too low may drive overutilization, and a cost outlier set too high can be a disincentive to work with the program. The specifics of outliers must be considered unique to each episode cost model.

### 4.1.5 Quality Metrics

The RFI discussed the key question of whether quality metrics should be used for payment purposes or only for reporting purposes. The general rule is that metrics that are accurate and under the control of the provider will tend to be used for payment. Metrics that are less accurate and less within provider control should either be ignored, or only used for reporting purposes. Some Healthcare Effectiveness Data and Information Set (HEDIS) scores, for example, are better measures of patient compliance than of provider performance (e.g., annual eye exams). Similarly, client satisfaction scores, although useful, may not correlate well with outcomes, unless the scores are risk adjusted by severity of condition.

Objective clinical measures are common for procedural episodes (e.g., functional status six months post discharge for total knee replacement). In chronic disease, objective measures of metrics that are jointly managed by the clinician and the patient (e.g., daily weights for CHF patients, peak flow for asthmatic patients) can be meaningful measures of clinical performance and of the clinician’s ability to engage the chronic patient, but such measures do not aggregate well for population-based reporting.

For the initial episode types that DMS specified, our belief is that it will be straightforward to establish quality metrics for three of the conditions: pregnancy, joint replacement and congestive heart failure. It will be somewhat more challenging to aggregate consensus quality metrics for ADHD and Ambulatory URI because of the broad clinical presentation of each, and the subjective nature of severity in both instances.

### 4.1.6 Maintenance and Algorithm Updates

This issue is a key driver of bundling strategy. To the extent that DMS wants to use standard episodes (retrospectively) to reduce practice variation in the network, the criticality of evolving the standard bundle definition is lower. DMS could essentially wait for national standards organizations to update their standards of care and incorporate them as they develop. However, the approach to maintenance will vary from the above process if DMS wants to maintain the bundle definition to be consistent with current emergent standards, and even to allow variation (such as allowing different standards from different provider groups).

Further, if the objective is to achieve coverage for 75 percent of medical expenditure in four years, it is probable that there will not be an adequate quantity of standard episode definitions to...
encapsulate that volume of clinical activity. This target essentially obligates DMS to take a leadership role in definition of incremental episode definitions, and also to manage the evolution of the quality of those bundles.

Optum is able to assist with development of either retrospective or prospective episode definitions. Our expectation is that it will be strategically more effective to allow individual provider organizations to differentiate on their own processes (less so on quality metrics) to engender inter-provider competition on cost and quality. This approach has the advantage of “outsourcing” episode bundle definition to the provider organizations, and has the additional advantage of spurring innovation and competition.

In cases where there is no emergent standard for an episode of care, this provider-centric model may be the only viable solution. Optum could certainly assist in identification of median costs and ranges of approach from locale to locale, but enforcing a common state-wide standard episode may not be effective in such cases.

This discussion also surfaces the alternative models for payment bundle administration. The model described in the RFI could be represented by Figure 4-1.

*Figure 4-1. Bundled Administration Model Envisioned by DMS*

This model has the advantage of allowing each payer to manage its own provider community, but incurs the disadvantage of requiring each payer to implement its own bundle management software and management processes. Further, the probability of the rules being identical for each payer are small, hence the incentives for performance against standards may be diluted somewhat at each practitioner organization, since each would experience multiple performance standards.

In contrast, DMS could elect to sponsor a solution as represented in Figure 4-2.
In this model, a single bundle administrator would manage the bundle administration and essentially forward a payment request to each payer. This model is more reasonably used in cases where a fixed-price-per-bundle model is implemented, versus a more traditional pay-as-you-go followed by an incentive payment. This model may also make sense for the large number of conditions where there is no national standard, and Arkansas may have multiple regional performance approaches that are similarly effective.

Optum is able to assist with either model.

**4.1.7 Threshold Setting**

Most of the issues related to patient inclusion/exclusion, provider inclusion/exclusion and cost inclusion/exclusion were discussed above. The key issue is that if the payment is by episode, the thresholds are by episode. As the episode count rises into the hundreds (which is likely if the objective is to reach 75 percent of medical expenditure), the degree of complexity in the threshold definitions increases. As mentioned previously, simplicity is useful. As Albert Einstein said, “Everything should be made as simple as possible, but no simpler…”

**4.2 Component B: Administration**

Optum has broad capabilities to support DMS in the administration of the EBPS, as we discuss in this section.

**4.2.1 Analytics Engine**

The same tools that we use to establish the bundles can be configured to run in batch as processing engines to support payment. The configuration of each batch will be specific to each episode definition, including the specifics for the inclusion/exclusion criteria and the threshold criteria for payment. Although the number of batches over time could be large (in the hundreds), we expect that the performance incentive payment process will be an infrequent event, and could be as rare as an annual run. The output of the batch will be an individual payment amount for each PAP and a remittance advice supporting the performance payment by episode type for that provider.
4.2.2 Report Generation and Distribution
In our view, the analytics engine will be a batch process against the data warehouse. We will work with DMS to define the data footprint of the data warehouse to include:

- The data sets for inclusion, and the periodicity of the data updates as appropriate
- The sources for data, including administrative data from the DHS MMIS system, clinical data from (likely) the AR SHARE HIE, geographic and public health data from various public sources
- Standard reporting for internal and external reporting purposes
- Methods to generate and maintain provider and patient indices, such that data accrued from separate sources (e.g., the MMIS and the HIE) are merged into accurate longitudinal data sets
- Dashboard reporting for in-year progress reports on program success. Dashboards will be customized for each user type (executive, operating officer, clinical leadership, fiscal analyst) and will be maintained and continually supported over the life of the program.

4.2.3 Data Exchange
As part of the data warehouse technical design mentioned above, we will identify technical data collection methods (data types, sources, periodicity, etc.) in support of the episode analytics and administration.

4.2.4 Payment Administration
As an output of the batch analytics process identified above, we will identify payment amounts to the participating providers and provide remittance advice documentation to detail the payment amounts to participating providers.

4.2.5 Episode Deployments
We identified the specifics of our pilot deployments above. We have deployed episode bundles in pilot at the sites listed in Figure 4-3.

Figure 4-3. Deployed Episode Bundles Site Locations

<table>
<thead>
<tr>
<th>Location</th>
<th>Episode name</th>
<th># of providers</th>
<th>Pilot</th>
<th>In Production?</th>
<th>Included Payment?</th>
</tr>
</thead>
<tbody>
<tr>
<td>IHA - California</td>
<td>Total Knee</td>
<td>6 hospitals</td>
<td>Yes</td>
<td>Contracts in Development</td>
<td>Contracts in Development</td>
</tr>
<tr>
<td>IHA - California</td>
<td>Total Hip</td>
<td>6 hospitals</td>
<td>Yes</td>
<td>Contracts in Development</td>
<td>Contracts in Development</td>
</tr>
<tr>
<td>Cleveland Clinic</td>
<td>Total Knee</td>
<td>Main Campus</td>
<td>Scheduled</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cleveland Clinic</td>
<td>Total Hip</td>
<td>Main Campus</td>
<td>Scheduled</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cleveland Clinic</td>
<td>CABG</td>
<td>Main Campus</td>
<td>Scheduled</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
4.3 Additional Program Activities
This section describes additional activities are able to perform in support of the EBPS initiative.

4.3.1 Support for Additional Bundles
The RFI identified the initial set of episode types targeted for deployment. Clearly, if the intent of DMS is to achieve 75 percent of medical expenditure under EBPS, many more episode types will need to be detailed. We have structured a methodology to help payers and providers achieve this end. An example of the process we use with delivery systems to identify bundle and provider candidates is shown in Figure 4-4.

Figure 4-4. Approach to Working with Delivery Systems to Implement Bundled Payment

In our view, the process to engage key delivery systems in the effort to define episodes is as critical as the effort to engage the full array of payers.

Further, in most instances it will be important to outline the relationship with primary care providers. For some episodes, we will likely have primary care practitioners (or primary care groups) acting as PAPs. In others, primary care clinicians will be the lead referring entities. In this context, engaging primary care practitioners as active participants in growing the volume of episodes referred to PAPs will be a key to success.

4.3.2 Deployment Planning
Under any scenario, this is a large deployment program with a diverse contingent of stakeholders with varying objectives. The effort to plan for involvement of stakeholders will be large and will include the:

- Provider community
- Key metropolitan delivery systems
- Medical academic community
- Community stakeholders, including senior groups
- Participating commercial health plans.
In our view, a significant part of the success of a program of this scale will depend on active alignment and communication with these stakeholders. Development of a credible deployment plan, followed by development of a credible communications plan, will be key steps in this process. We have deployment planning resources that are able to address this requirement.

4.3.3 Program Management

Once the deployment plan and communication plan are developed, a team must be assembled to coordinate deployment of the program across the various stakeholders. Optum has substantial experience in managing large state-wide programs and could supply personnel to support this activity as well.

4.4 Additional Issues for Consideration

Optum has identified several additional issues that we offer for consideration by DMS. The context of this section is specifically related to the use of payer-based care standards to achieve management of 75 percent of medical expenditure.

4.4.1 DMS Has Established a High Bar

DMS’ strategic intent to achieve bundled management of 75 percent of medical expenditure within four years is indeed a significant challenge. In our view, several implications immediately surface:

- **Involvement of primary care** – It is likely that achieving the management objectives will heavily involve primary care practitioners, even if they are not PAPs. Explicit consideration for the approach to involve primary care practitioners (via a patient-centered medical home initiative or otherwise) early in the program would both ease and expedite the success of the program.

- **Consideration for synergistic accountable care models might be useful** – Most accountable care frameworks include a model for attribution of membership to primary care, and some include a per member per month payment structure for (at least) primary care services. This model may be useful in many geographic areas in Arkansas. Further, if we consider primary care as a “general” episode bundle, it may alter the task for definition of other chronic disease bundles (certainly CHF, CAD and diabetes mellitus) to separate the milder chronic disease instances into primary care and the more severe instances toward the appropriate medical subspecialists.

This consideration might not only move more patients into a simpler more holistic care framework, but also allows the planning effort to balance the quantity of effort among the workforce available to support the population. The general model that focuses on primary care (with some care cost at risk) and leverages complexity to medical specialists has had some success in the western U.S, particularly in California.

4.4.2 History of Payer-Based Care Standards

Payers have historically used centrally established care standards as a tool to manage their provider communities. Implementation of episode-based care standards is an advance in that framework, but it does not fundamentally alter the frame of reference for practitioners unless all payers act exactly the same way. Experience suggests that it is a challenge to move all payers to act in concert. Arkansas may have unique success in this regard, but history suggests the effort could be daunting. One of the positive points in establishing a bundling intermediary (as shown earlier in Figure 4-2) is that any provider that elects to bundle could act the same way for
all payers (assuming that they will contract for fixed-fee bundles). Critically, both approaches could be used at the same time, and each may have their place.

4.4.3 Potential for a Conflict with a Center-of-Excellence Approach

It is occasionally true that national standards for episodes of care are at odds with standards of practice within COEs in the state. In cases where local COEs have demonstrably superior outcomes, it is worthwhile to consider the local COE as the standard of care in the geography. Further, where there are multiple regional centers, each with superior outcomes, it might not be useful or practical to move multiple COEs toward a common episode standard. The separate COEs could still bundle services, but might not be best served by incentives to migrate either or both toward a national standard.

For episode types where Arkansas has multiple high-quality COEs with different episode standards, it might be more useful to incentivize primary care to increase COE utilization than to incentivize COEs to move to a common standard.

5 Conclusion

Optum applauds and supports the Arkansas Health Care Payment Improvement Initiative. Episode-based payments are a vital strategy within the framework of comprehensive health care payment reform and overall Arkansas health improvement. This activity is consistent with our strategic intent to move clients from payment frameworks based on volume to those based on value. Optum is enthusiastic about leveraging our market experience, knowledge and sharing lessons and successes learned from working with other state leaders. We believe Optum has the most applicable experience in this area, and has the resources to drive this initiative to a successful conclusion.

We look forward to exploring a comprehensive approach to health care improvement that considers all stakeholders within the community and aligns with the other key Arkansas initiatives such as the Governor’s Health Care Workforce Task Force, Arkansas HIE, and the CMS Primary Care Initiative.