VI. Project Plan for Performance Reporting, Continuous Improvement, and Evaluation Support

PERFORMANCE REPORTING, MONITORING AND EVALUATION

As described in the State Innovation Plan, monitoring progress in implementing our model and achieving our scale-up goals and outcomes targets will occur at three levels:

1. Overall assessment of progress against targets
2. System surveillance for unintended consequences and methods for course correction
3. Detailed operational monitoring

Initially, we will place greater emphasis on meeting operational targets for scale-up (e.g., launching the next wave of episodes) and early indicators of progress in meeting targets (e.g., frequency of screenings and tests). Over time, the focus will shift more toward outcomes targets.

Data Collection: Approaches to Tracking and Reporting Performance

Overall Assessment of Progress against Targets

We have several approaches to system-wide assessment. First, each payer will perform detailed analyses on administrative claims data to assess performance on cost, quality and utilization targets. We have already invested significant time into reporting capabilities – this includes algorithms to assess risk-adjusted costs for episodes as well as numerous quality and utilization metrics (see exhibit). Second, we are supplementing claims data through a web-based multi-payer provider portal, which currently collects quality data for episode-based payments. These include, for example, use of...
ACEs and ARBs as well as left ejection fraction value for CHF patients, and use of prophylaxis to prevent DVT/PEs for hip and knee replacement patients. The portal will expand to provide a richer set of episode functionality as well as to support PCMH and health homes. Approximately 90% of Arkansas providers who have currently launched episodes have registered for this portal. We are also working closely with Arkansas’s Health Information Exchange (SHARE) to enable providers to submit data directly through their EMR systems.

At a provider level, we have developed detailed performance reports with information on each provider’s episode performance (cost, quality, utilization), and are augmenting those for PCMH and health homes. Reports are consistent across payers, and are being continually refined by a multi-payer report feedback committee.

**Programmatic tracking and public reporting:** Annual assessments of healthcare quality, provider participation, and impact on healthcare costs in the deployment of PCMH, Health Homes, and Episodes will be conducted by each payer. We will integrate these into a single statewide report to inform consumer, provider, employer, and public officials on progress and challenges in deployment. This will also provide our foundation for continuous improvement.

**System Surveillance for Unintended Consequences and Methods for Course Correction**

Across care delivery approaches, we are identifying a range of potential unintended consequences that might result from our new care delivery and payment approaches. These include, for example, changes in access to care in various counties across the state as certain providers shift behaviors as a result of new payment models. These might also include ways in which the system may be “gamed,” including when this leads to over- or under-delivery of care.

To track this, Medicaid intends to use “smart” logic (e.g., identifying unusual swings in coding practices) and analyses of administrative claims data to trigger potential audits within
Program Integrity. Each payer will also track changes in provider access across the state.

**Detailed operational monitoring**

We are also tracking performance on a number of operational metrics, including accuracy of our reporting and payment algorithms, ease of use for our multi-payer provider portal, and responsiveness to provider questions and feedback. To track performance, we have instituted a multi-payer customer service escalation team that handles incoming questions or feedback from providers and triages them for response or escalation. Already, this process has identified a number of areas for improvement for Wave 1 episodes. We will also be monitoring feedback through provider forums, meetings, and input from provider associations.

### CONTINUOUS IMPROVEMENT AND LEARNING

Continuous improvement is a core component of our approach. We have described our approaches to stakeholders as “version 1.0” to recognize the ongoing refinement we expect. In striving to improve the overall impact and effectiveness of our model, we aim for continuous improvement around 5 dimensions: (1) **technical and clinical design** (e.g., episode definitions, risk adjustments); (2) **structure of the payment model** (e.g., are the incentives fair and meaningful); (3) **supports for providers**; (4) **operational performance**; and (5) **patient engagement and education**.

**Data Collection: Identifying Opportunities for Continuous Improvement**

The identification of improvement opportunities is integrated into our core operating model. Our performance reporting infrastructure serves as our basis to systematically, and regularly evaluate overall and component specific performance against goals and target outcomes (tracking and public reporting described above). Formal management and multi-payer performance reviews allows us to test and refine our approach. In addition to our own analytic
assessments, we have two primary mechanisms to synthesize inbound stakeholder feedback. First, most waves start with a “preparatory period” allowing us to test provider feedback and make adjustments before going live with a performance period. Second, our customer service teams use a standard case management tool (across payers) that allows us to rapidly identify and respond to specific issues, questions and themes. Our multi-payer customer service escalation teams and provider engagement teams each meet weekly to discuss issues, takeaways and opportunities to improve. In addition, we proactively seek input from a diverse set of stakeholders, including regular meetings with core provider; public workgroups that include providers, patient advocates, patients and other caregivers; and collaborations with a subset of dedicated provider leaders who give expert and constituent-based feedback on an ongoing basis. Over time we anticipate supporting providers directly in the identification and dissemination of best-practices (e.g., through organized learning collaboratives). Finally, we will regularly review detailed performance and outcomes data to identify incremental sources of value, ongoing variation in care and unintended consequences.

**Approach to Making Continuous Improvements**

For each improvement dimension, we have formal and informal processes for making continuous improvements. Payer organizations will systematically review and refine the strategies, in particular, as we transition our organizations to the new payment models. We will focus on reforming and improving the execution of new payment methods, and will re-visit our approaches every few years to update thresholds, definitions, quality metrics, and improvement targets. In addition, clinical and technical design issues or opportunities will be escalated to single and/or multi-payer expert teams to evaluate the relevance/impact of the potential change; conduct related analytic assessments; and make a decision on implementation, approach and
timing. Our communications and customer service teams are represented on these committees to ensure rapid dissemination to stakeholders. Similarly, a multi-payer provider report committee has already met twice to refine the “version 1.0” reports that went to providers in July 2012 based on incoming and solicited feedback. On dimension 4 (operational performance), we maintain multi-payer committees on program strategy, customer service, provider engagement and provider reporting each tasked with maintaining an effective operating model. For example, our customer service escalation team has already redesigned its internal process across teams when root cause analysis revealed insufficient processes delayed provider feedback on a request to understand his report. Finally, our infrastructure rollout includes a modular and flexible analytic engine the enables rapid adjustment of model logic and parameters based on feedback.

**COLLABORATION WITH CMS EVALUATORS**

We anticipate working closely with the Innovation Center’s own evaluation contractor in an agreed on format and timeframe that allows data, results and best practice codification to be shared. Our vision is that Medicare participates fully in our delivery system, payment and reporting models. We envision full integration of the CMMI technical and evaluation teams with the Arkansas teams and local evaluators. Our quarterly performance reports will include specific quality and cost performance information (addressing all 5 impact dimensions listed in the FOA, page 55). These report summaries will reveal progress to date against impact forecasts. We expect to translate these into the CMS-required format. In addition, we believe our detailed reports will suffice for rapid-cycle evaluation. We envision sharing ongoing performance reports with CMS/CMMI and welcome feedback and suggestions. We also welcome the chance to share and discuss experiences with other states undergoing similar transformations.