Workgroup III: Ambulatory URI

The third session of the Arkansas Healthcare Payment Improvement Initiative Ambulatory URI Workgroup convened on February 27, 2012 to discuss payment innovation in Arkansas, with an emphasis on episode-based payment for Ambulatory URIs.

Approximately 50 Arkansas healthcare professionals and patients were in attendance, representing perspectives of patients, providers (internists, family medicine physicians, pediatricians, pharmacists, nurses), advocacy groups, hospital administrators, nonprofit administrators, and government administrators.

Workgroup materials and an overview of the payment model can be accessed online at <http://humanservices.arkansas.gov/director/Pages/Ambulatory-Upper-Respiratory-Infections.aspx>. Key components of the discussion are summarized below.

KEY COMPONENTS OF WORKGROUP III DISCUSSION

■ The third workgroup session focused on reviewing:
  – Upcoming milestones for the Payment Initiative
  – Version 1.0 design elements specific to the Ambulatory URI episode
  – Historical data for Ambulatory URI episodes based on version 1.0 design
  – Episode design elements common across episodes

■ The workgroup reviewed the goals and basic structure of episode-based care delivery
  – The goal of the model is to encourage effective, high-quality care and outcomes
  – The approach is built around an “episode performance payment” model, which identifies one or more providers as a Principal Accountable Provider (PAP); average costs and quality for the entire episode are aggregated and compared with the pre-determined threshold, with savings or excess costs shared between the PAP and payor/plan sponsor
  – The episode-based care delivery model is intended to provide a similar approach across payors

■ Workgroup members provided input on version 1.0 design for the Ambulatory URI episode
  – Several questions were raised related to episode definition
The group raised two questions about beginning the episode with an in-person visit. First, could the episode design inadvertently increase the number of in-person consults, even though many could be appropriately diagnosed by phone? Second, does the episode trigger fully adjust for the onset of symptoms (i.e., the episode begins with the first visit, regardless of when symptoms began)?

- Workgroup leaders acknowledged both of these as important questions. They noted that because the episode design builds from claims, it increases the complexity in incorporating non claims-based elements such as remote consultations and onset of symptoms. Population-based programs such as the medical home will address some of these elements.

The group also asked two questions about differences in treatment patterns. First, are there differences in treatment patterns based on patient age (e.g., higher antibiotic usage for younger children)? Second, are there differences in treatment patterns based on provider type? Additional analysis will be conducted to follow-up on these questions.

- Participants also discussed patient exclusions from the episode

Participants identified some conditions (e.g., Asthma) that may not be present at the onset of the episode, but may nonetheless merit exclusion from version 1.0 of the episode design. Workgroup members sought clarification about whether this may require changes in coding practices.

- Workgroup leaders noted that the episode design is not intended to require changes in coding practice; rather, it will identify relevant patient exclusions based on current coding practices.

Participants also noted that certain conditions may arise during the episode that affect the normal treatment pathway for a URI (e.g., Otitis Media), and asked whether these should be excluded from the episode design.

Workgroup members also inquired about how many patients would be excluded from the episode design based on the current exclusions, and requested further analysis to quantify the impact.

- The workgroup discussed relevant structural differences in the setting of care for URI episodes (e.g., regulatory requirements and higher costs for the Emergency Department). Participants asked whether these differences may require a modified approach for each setting of care.

- Participants also reviewed the quality measures for the episode and noted that sometimes, clinical experience and observation may not always require diagnostic testing (e.g., for Strep throat) to confirm.
Workgroup leaders noted that nonetheless, the gap between antibiotic prescription rates and incidence of bacterial infection is quite significant.

- The workgroup reviewed historical data based on the version 1.0 design for the Ambulatory URI episode
  - Some participants noted that although data presented showed significant variation in the costs of URI episodes, the amount of variation may be reduced when patient exclusions are applied. They asked for additional analysis about the impact of the exclusions on cost variations
  - Workgroup leaders noted that even if there is less variation when patient exclusions are applied, there will likely remain significant opportunity to improve quality through the episode design because some clinical sites will still exhibit significant variation

- The workgroup discussed payment mechanics for the episode
  - The group discussed factors that may affect payment mechanics over time. Participants requested clarification about how the pricing approach will vary with changes over time (e.g., changes in pharmacy coverage, inflation)