DRAFT

Arkansas Health System Improvement
Building a health care system for the 21st century.

Arkansas Payment Improvement Initiative

Arkansas endeavors to create a 21st-century **patient-centered** health care system that embraces the "Triple Aim": (1) improving the **health** of the population; (2) enhancing the patient experience of **care**, including quality, access, and reliability; and (3) reducing, or at least controlling, the **cost** of health care.

At its core, the future system will be built around patient-centered care delivery models focusing on what the patient needs, rather than being designed around any particular delivery system structure. Our vision is built around two complementary strategies for clinical innovation in Arkansas (illustrated in Exhibit A and E of supporting materials):

- **Episode-based care delivery** rewards coordinated, team-based care for a patient, often spanning multiple encounters with the delivery system, such as hip replacement or pregnancy and delivery. It encourages clinicians to provide quality care across these multiple encounters, rather than in 'silos' of discrete services.
- **Medical homes or health homes**, which are responsible for proactively considering the needs of their patients or clients over time, independent of whether they are seeking care.

The new system will transform the state's payment model from one that rewards volume alone to one that **rewards outcomes**, particularly with respect to **quality and affordability**. Our approach is to ground payment design in principles that are patient-centered, clinically appropriate, practical, and data-based (Exhibit B). This multi-payor, system-wide strategy will move Arkansas to a new, sustainable model of financing.

Opportunities for improved quality and efficiency

The Payment Improvement Initiative has convened a number of clinical workgroups, which identified many opportunities to improve upon the current fee-for-service system. The Initiative seeks to address limitations of the current model, including:

- **No accountable provider for care coordination**: e.g., different segments of pregnancy/NICU care – the prenatal phase, delivery, and postnatal care for the mother – may be delivered by multiple, uncoordinated providers
- **Insufficient investment in patient education**: e.g., hospitals treating patients with congestive heart failure are not rewarded for high-quality transition education at discharge
- **Evidence-based medicine not rewarded**: e.g., nearly 50% of adults receiving care for simple upper respiratory infections in Arkansas receive antibiotics, even though evidence-based guidelines suggest prescribing very selectively, if at all (Exhibit C)

Note: Payment model described here differs from model for Developmental Disabilities episode, which is structured as described in March 6th meeting materials.

- **Significant administrative burdens:** e.g., Developmental Disabilities providers must maintain detailed activity logs for compensation, spending considerable resources on non-care activities.

EPISODE-BASED CARE DELIVERY

Overview of the episode performance payment model

The episode performance payment model creates incentives that reward providers who succeed in delivering high-quality, patient-centered, and cost-effective care for a clinical episode. Providers are initially paid separately for the care they deliver, filing claims as they do today. A Principal Accountable Provider (PAP) for each episode is expected to coordinate care and is held accountable for outcomes across the full episode.

At the end of each performance period (e.g., 3-6 months), payors will tally the average cost across episodes of care led by the PAP during the period. If the average episode cost is better than a 'commendable' level, the PAP will receive an additional payment from the payor as a gain share. If the average episode cost is higher than an 'acceptable' level, the PAP will share a portion of the excess costs (Exhibits F and G). These thresholds may be adjusted for several patient- and provider-level factors (Exhibit H).

For each episode, candidate PAPs have been identified based on their roles in leading the episodes of care (Exhibit I).

How does the model promote high-quality care?

Episodes will be designed to hold providers accountable for outcomes and reward those who are able to reduce complications, decrease error rates, and avoid care that is not evidence-based.

In addition, to reduce potential for underuse of care, we will define quality metrics which must be met to be eligible for gain share payments. To promote quality care, we expect to perform select reviews of metrics.

What will this mean for patients and providers?

The new payment model will encourage a number of changes that will benefit patients:

- Investment in diagnosis, patient education, treatment, and care coordination to reduce preventable complications and inefficient care
- Increasing provision of underused services
- Removing incentives for care that is medically unnecessary.

For providers, the new system will involve similar administrative procedures for submitting claims as in the current model. However, the new outcomes-based payment model will provide enhanced rewards for high-quality, team-based, coordinated care. Shared savings / risk through the episode performance payment will offer them

compensation that is aligned more closely with their achievement of high-quality, efficient care beyond a single encounter.

Note that the proposed model for Developmental Disabilities (DD) is different because of certain characteristics of the supportive care provided for DD clients; this model is described in the March 6th workgroup materials, available online at http://humanservices.arkansas.gov/director/Pages/Developmental-Disabilities-Workgroup.aspx.

MEDICAL AND HEALTH HOMES

The aim of medical and health homes is to meet the full range of needs across a population, promoting higher quality of care, improved patient experience, and more efficient health care, while rewarding providers who achieve strong performance. Accountable providers will be responsible for proactively considering the needs of their patients or clients, independent of whether they are seeking care.

For some populations, a primary care physician practice will be most effective in adopting this role, whereas for certain special needs population, the accountable provider could be another provider working in collaboration with primary care providers—for example, a developmental disability or behavioral health provider may be better equipped to coordinate care for certain populations. These homes will serve not as gatekeepers for medical care, but rather as a hub from which the patient may connect with the full constellation of providers who together form the patient's health services team.

SCOPE AND PACE OF ADOPTION

Given the scope of the transformation, participating payors will promote adoption of both episode-based care and medical and health homes across Arkansas over the coming three to five years. For episode-based care, the roll-out will begin with the launch of six Wave I episodes: Attention Deficit Hyperactivity Disorder, Ambulatory Upper Respiratory Infections, Congestive Heart Failure, Developmental Disabilities, Hip/Knee Replacements, and Pregnancy.

There will be an initial preparatory period of 3-6 months for providers to begin implementing practice changes. In this period, payment will continue under the current fee-for-service system. Starting in Oct. 2012 or Jan. 2013, the first 'performance period' will begin; episodes initiated in this period will be covered under the new payment model (Exhibit J). Over time, the roll-out will expand to a second wave of episodes.

For medical and health homes, transformation will occur initially with a limited set of providers, but will span broad patient populations including healthy, at-risk, and those with one or more chronic conditions. This model will expand to other providers as they become ready to undertake new processes and capabilities (e.g., health information technology, care coordinators).