

ARKANSAS PAYMENT IMPROVEMENT INITIATIVE

Preparation for the second round of workgroups: a closer look at payment methods and quality

December 5, 2011

The Arkansas Health Care Payment Improvement Initiative is moving the state's entire health care system away from a fragmented fee-for-service approach to a more coordinated, incentive-based system that promotes the prevention and management of chronic conditions and the delivery of high-quality, efficient care. The Initiative is led by the Arkansas Department of Human Services and the largest private insurers in the state, with strong support from the federal Centers for Medicare and Medicaid Services (CMS).

We are deeply appreciative of the feedback and assistance we have received from a wide range of stakeholders, most notably in the first round of workgroup discussions in October and November. We received clear and constructive input on the opportunities to improve quality, patient experience, and cost effectiveness for each priority treatment area.

This initiative continues to be guided by the core principle of designing a 21st century health care payment system for Arkansas that is patient-centered, clinically appropriate, practical and data-driven. We continue to believe that **episode-based payment** best addresses these goals for most situations, particularly acute and post-acute care. We also continue to endorse development of medical homes and team-based care that apply a **population-based approach** to the prevention and management of chronic conditions through care coordination. We recognize that some important types of care, such as for people with developmental disabilities, may combine elements of both approaches to better provide **ongoing support that meets individual needs**.

In preparation for the next round of workgroup meetings, this paper outlines these complementary approaches and gives a closer examination of payment methods and quality measures.

EPISODE-BASED PAYMENT

An episode of care includes services associated with a desired clinical outcome, such as the delivery of a healthy baby, commonly spanning many treating providers. Payment for the episode should be based on quality and cost targets that reflect the total value of clinically appropriate care. This rewards high-quality care

and optimal outcomes for patients, promotes effective care, and encourages a reduction in ineffective care.

Early thinking on episode-based payment involved making a single “bundled” payment to one provider or team, and requiring that provider or team to distribute payments to other providers involved in the patient’s care during an episode. In this option, most individual providers would no longer receive payments directly from the payor, and so there would be no standard fee schedules or contracted rates for individual providers.

After listening to stakeholder feedback and studying the existing system, we propose that another option, **retrospective reconciliation**, is currently a more promising approach for episode-based payments in Arkansas. In this approach, a clinically appropriate target cost is determined for an episode. One or more providers is made principally accountable for the episode being delivered with desired outcomes within this cost target. Providers are initially paid separately for the care they deliver, filing claims as they do today. At the end of the episode, total costs and quality for the entire episode are compared with pre-determined targets. All savings or excess costs are divided between the payor and the principally accountable provider or providers. This model is illustrated in the box below.

Sample “retrospective reconciliation” payment

	 Accountable Provider Team A	 Accountable Provider Team B
Average cost per patient	\$14,500	\$16,500
Relevant measures of quality	Satisfactory	Satisfactory
Target price for the episode	\$15,500	\$15,500
Amount above or below target price	\$1,000 in savings shared between payor and accountable provider team	(\$1,000) in excess costs paid by payor and accountable provider team

In the retrospective reconciliation model, the payor initially distributes payments to each provider according to an established fee schedule. After the episode, the total cost of services is reconciled against a target price. Any savings or excess costs relative to the target price are divided among the payor and the accountable provider team.

This approach rewards collaboration and coordination without requiring providers to develop financial relationships with one another, or to have the capabilities to sub-contract with other providers.

Some providers may wish to move quickly to single prospective bundled payments. We will consider this option when it becomes administratively feasible.

POPULATION-BASED APPROACH

While episode-based payment is well suited to acute and post-acute care, payment for coordination of primary care and chronic care will require population-based management strategies to meet the full range of services required over an extended period of time, including management of patients with multiple chronic conditions as well as healthy individuals.

The ConnectCare program for Medicaid beneficiaries in Arkansas is an example of a population-based approach to supporting the prevention and management of chronic disease. Private sector models of patient-centered medical homes are also being designed and tested by several payors and provider organizations in Arkansas.

Another promising population-based approach is reflected in CMS' design of the Comprehensive Primary Care Initiative (CPCI). Under this model, payments to primary care physicians will be enhanced with care coordination fees to fund new infrastructure and processes for managing patients with one or more chronic conditions. Over time, providers participating in CPCI will be rewarded with a share of any savings achieved relative to a target cost for all services delivered to patients attributed to participating primary care providers within the market.

Alternative models for medical homes instead tie bonus payments to discrete measures of quality and utilization, such as the frequency of emergency room visits and inpatient admissions across all conditions.

While we have not yet arrived at a single approach to population-based payment, we believe that such an approach is necessary and is complementary to a episode-based payment for acute and post-acute care. Together with the Governor's Health Care Workforce Task Force, we will examine design options for medical homes, health homes and other population-based approaches. We look forward to seeking your feedback during this process in the weeks ahead.

PROVIDING ONGOING SUPPORT THAT MEETS INDIVIDUAL NEEDS

Some individuals, such as those living with developmental disabilities or restricted activities of daily living, require ongoing support.

To build further on our longstanding efforts in these areas, we believe these two approaches (episode-based and population-based) should be combined to best meet individual needs. Providing the most appropriate ongoing care requires a needs assessment and then an individualized plan of care that lays a foundation of supportive care, and episode-based payment matched to the assessed need is well suited to support these requirements. A population-based approach to the prevention and management of chronic conditions and/or acute episodes may be carried out on top of that foundation. We will seek your feedback on this in the coming weeks.

HOW WE ENSURE HIGH-QUALITY CARE FOR PATIENTS

The approaches described above inherently align financial incentives and reward high-quality care by enabling providers to be accountable for outcomes and costs.

For example, an episode for a hip replacement rewards providers for preventing complications that would lead to costly readmission to the hospital. It therefore rewards the surgeon, hospital and other treating providers for delivering the highest quality care and ensuring appropriate follow-up prior to and following discharge from the hospital. Meanwhile, population-based approaches such as CPCI offer an incentive for a primary care provider to closely manage patients suffering from hypertension, diabetes, or other chronic conditions, to ensure they get the appropriate care to avoid preventable admissions to the hospital.

While these payment models intrinsically support quality improvement, they may be further augmented with additional incentives attached to quality. In some cases, extra precaution will be necessary to ensure that the new payment models will not result in underuse of care. Options to deal with this include making payment contingent on the delivery of care that is widely agreed to be the clinical practice standard, and performing select “audits” of abnormally low utilization.

Beyond this, we will want to encourage evidence-based medicine and practices, and promote desirable patient outcomes that may not be directly related to the costs within an episode. Options to achieve this include requiring the reporting of select quality and process metrics, increasing the transparency of clinical decisions and outcomes, and perhaps linking quality to incremental payments or “bonuses.” The exact path will vary by episode.

MOVING AHEAD

In the next two weeks we will be discussing these topics with workgroups in more detail, and seeking input on some decisions specific to individual workgroup priority areas. As always we are eager to hear your ideas.

There remains much to do to meet Governor Beebe's challenge to begin implementation in the summer of 2012. In the early months of next year, we will finalize the remaining design decisions on initial targets, work through the wide range of implementation details, and devise a plan for supporting providers and other stakeholders through the transition to implementation. Each individual payor will determine and announce actual pricing within this structure.

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Thank you for your help so far. We look forward to seeing you in the next round of workgroups and continuing our joint effort to improve Arkansas' health care system for the benefit of patients and families.