State Innovation Spotlight: Implementing Multi-Payer Bundled Payment Models

July 24, 2017

Speakers

Jeff Micklos
Executive Director
HCTTF
Washington, DC

Jeff has been the Executive Director of the Task Force since 2015. He previously served as General Counsel for the Federation of American Hospitals.

Joe Thompson, MD, MPH
President and CEO
Arkansas Center for Health Improvement

Dr. Thompson served as the Surgeon General for the State of Arkansas, and worked with private and public stakeholders to develop the “private option” to Medicaid expansion.

Andrew Baskin, MD
National Medical Director
Aetna

Dr. Baskin is responsible for initiatives at Aetna to measure and improve quality of care, and has developed products to improve affordability and quality of care, and promote payment reform.

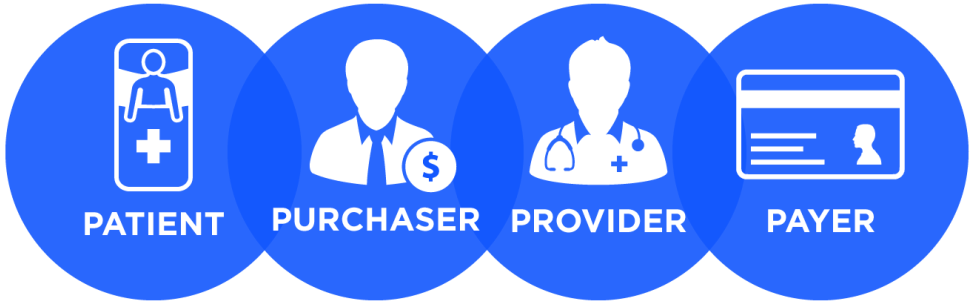
Agenda

- Introduction to the Health Care Transformation Task Force
- Scan of State Bundled Payment Models
- Case Study: Arkansas Payment Improvement Initiative
- Reactant: Commercial Payer Perspective
- Q&A

Who we are: Our mission to achieve results in value-based care

The Health Care Transformation Task Force is an industry consortium that brings together patients, payers, providers, and purchasers to align private and public sector efforts to clear the way for a sweeping transformation of the U.S. health care system. We are committed to rapid, measurable change, both for ourselves and our country.

We aspire to have 75% of our respective businesses operating under value-based payment arrangements by 2020.



Our Members: Patients, Payers, Providers and Purchasers committed to better value

The Task Force's guiding principles outline a financially and operationally viable and sustainable approach

- **Shift 75% of our respective businesses to be under value-based care contracts by 2020**
- Design programs that provide reasonable returns to deliver the triple aim of better health, better care and reduced total cost of care at or below GDP growth
- Equip market players with all tools necessary to compete in new market focused on people-centered primary care
- Encourage multi-payer participation and alignment to create common targets, metrics, and incentives
- Share cost savings with patients, payers, and providers to ensure adequate investment in new care models
- Foster transparency of quality and cost metrics in a manner that is accessible to, and easily understood by, consumers
- Support the needs of disadvantaged populations and help strengthen the safety net providers who serve them

TF Work Groups drive rapid-cycle product development

Improve the ACO Model

Develop aligned public-private action-steps and recommendations to improve the design and implementation of the ACO model

Develop Common Bundled Payment Framework

Create detailed principles and tools to align and evaluate episode definitions/pricing for public/private payer bundled payment programs.

New Model Development - Improving Care for High-cost Patients

Create, test and recommend a delivery/payment model that allows a wide range of provider organizations, including in rural areas with little to no current MA/ACO penetration, to engage in population health by starting with highest-cost patients (top 5%).

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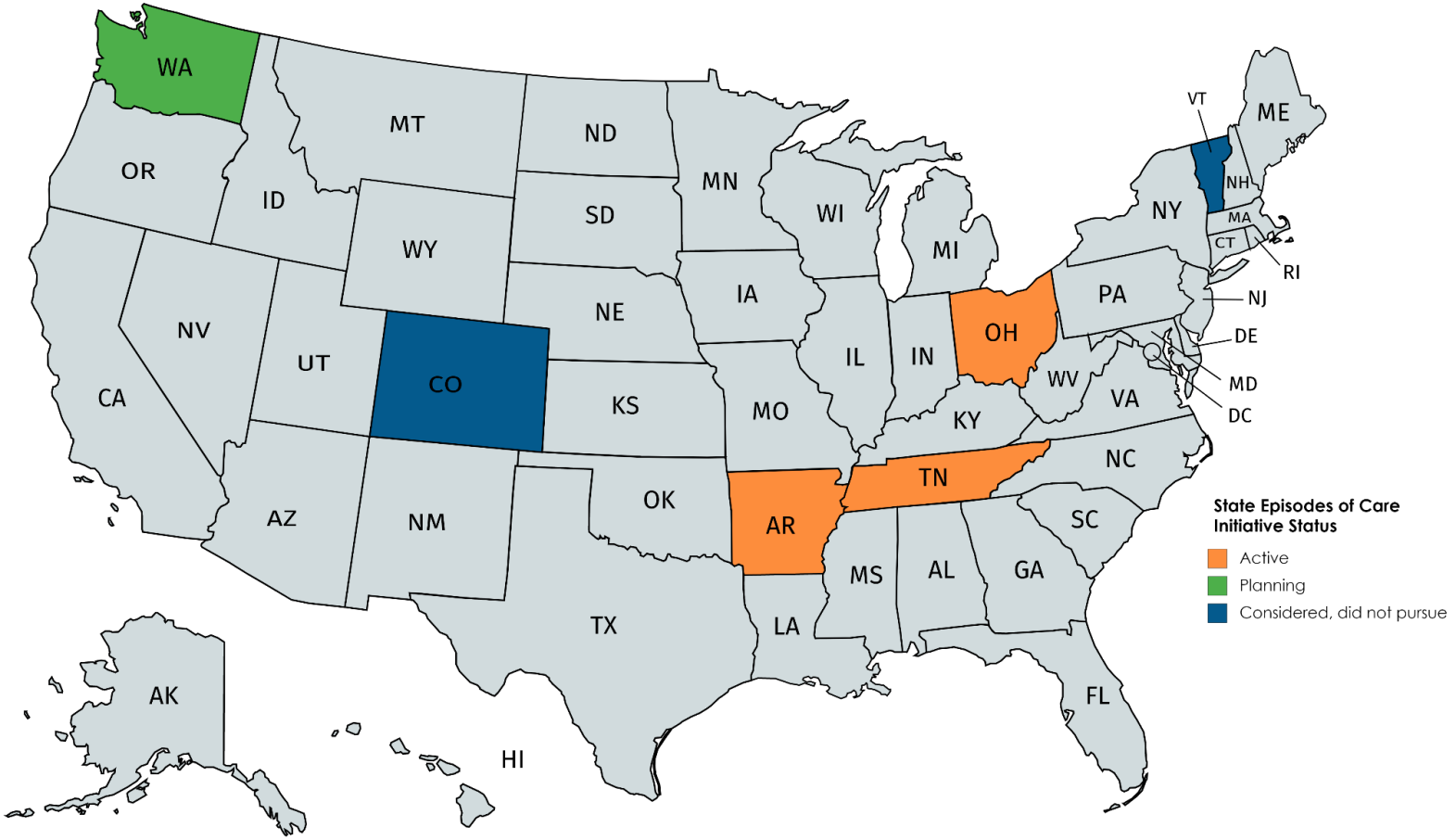
State Episodes of Care: Environmental Scan

- Seeking effective strategies to encourage alignment between public and private payers
- Reviewed of State Innovation Model participants
- Identified State authority to test value-based payment models

The state of state bundled payment programs



Hughes LS, Peltz A, Conway PH. State Innovation Model Initiative: a state-led approach to accelerating health care system transformation. *JAMA*. doi:10.1001/jama.2015.2017

Areas of alignment and difference across state bundled payment models

Alignment in methodology

- Benchmark methodology
- Episode initiators
- Risk thresholds
- Performance metrics (e.g., quality, utilization)

Differ by state design

- Requirements for participation
- Level of provider participation
- Payer participation (e.g., Medicaid/Medicaid managed care/MA/commercial)
- Results and lessons learned

State-by-state comparison overview available here : http://hcttf.org/bundled-payments/

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Arkansas Health Care Payment Improvement Initiative

Joseph W. Thompson, MD, MPH

President and CEO, Arkansas Center for Health Improvement

Professor, UAMS Colleges of Medicine & Public Health

ACHI

Arkansas Center for Health Improvement

Health Care Transformation Task Force

State Innovation Spotlight: Implementing Multi-payer Bundled Payment Models

July 24th, 2017

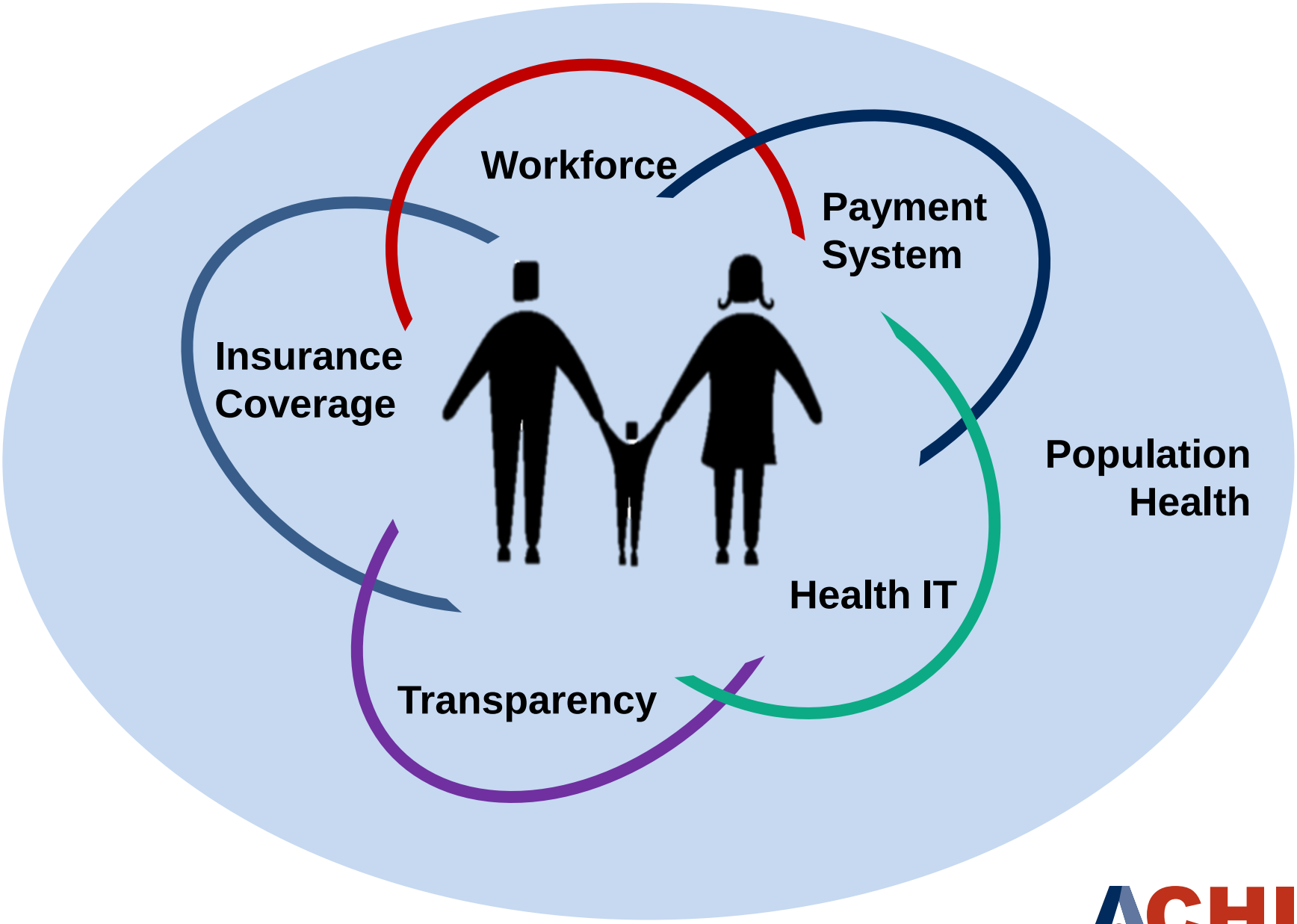
Arkansas Landscape (2009)

- Consistently ranked low on national health indicators
- >50% of Arkansas's adult population living with at least one chronic disease
- Many areas of Arkansas are medically underserved
- Insurance premiums doubled in 10 years resulting in growing numbers of uninsured
- One-fourth of working age Arkansans were uninsured
- Increasingly fragmented health care system hard for citizens to navigate
- Public and private expenditures exceeding revenues

Arkansas's Unique Payment Model Evolution Since 2011

- Initial concept included prospective global bundled payments
- Providers and other stakeholders pushed back against initial concept – lack of integration and infrastructure
- Extensive provider engagement and stakeholder input shaped current model
- Now includes a retrospective payment model and integration of patient-centered medical homes with episodes of care

Arkansas System Transformation Strategy



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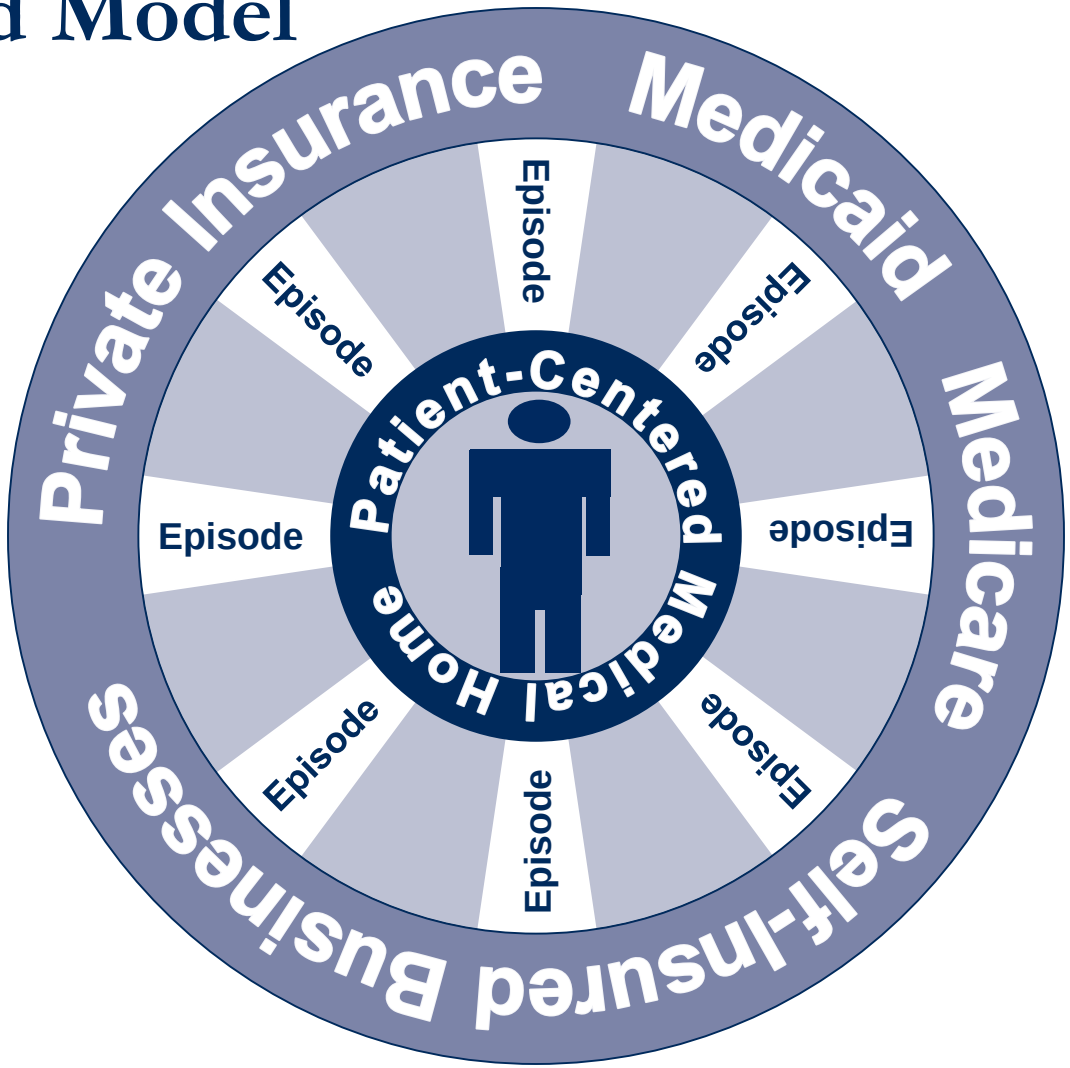
Arkansas Payment Improvement Initiative's Integrated Model



Coordinated Multi-payer Leadership

- **Consistent incentives** and standardized reporting rules and tools
- **Change in practice** patterns as program applies to many patients
- Enough scale to justify investments in **new infrastructure** and operational models
- **Motivate patients** to play larger role in their health and health care

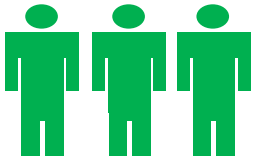
Arkansas Episode Strategy

- All care associated with treatment for a specific medical condition
- Time bound, defined start and end point
- Adhere to quality measures
- Lead principal accountable provider (PAP) assigned as ‘quarterback’
- **Mandatory** participation; Implemented *by* individual payers
- Intended to reduce the variation in cost and quality of care across providers for similar services
  - Improve quality and coordination for the patient, reduce inefficiency across health system, resulting in lowered cost of care
- **Upside and downside** gain/risk sharing model

How Episodes Work for Patients and Providers (1/2)

Patients and providers deliver care as today (performance period)

1



Patients seek care and select providers as they do today

2

Providers submit claims as they do today

3

Payers reimburse for all services as they do today

How Episodes Work for Patients and Providers (2/2)

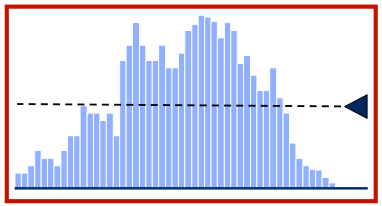
Calculate incentive payments based on outcomes after close of 12 month performance period

4

Review claims from performance period to identify a **'Principal Accountable Provider'** (PAP) for each episode

5

Payers calculate **average cost per episode** for each PAP[1]



Compare average costs to predetermined ''commendable' and 'acceptable' levels[2]

6

- **Based on results, providers will:**
- **Share savings:** avg. costs below commendable levels /quality targets met
- **Pay part of excess cost:** avg. costs above acceptable level
- **See no change in pay:** avg. costs between commendable and acceptable levels

1 Outliers removed and adjusted for risk and hospital per diems
2 Appropriate cost and quality metrics based on latest and best clinical evidence, nationally recognized clinical guidelines and local considerations

Significant Input from Providers and Patients

500+

- **Providers, patients, family members**, and other stakeholders who helped shape the new model in public workgroups

20+
17

- **Public workgroup meetings** connected to 6–8 sites across the state through videoconference
- **Public town hall meetings** across the state

24

- **Months of research**, data analysis, expert interviews and infrastructure development to design and launch episode-based payments

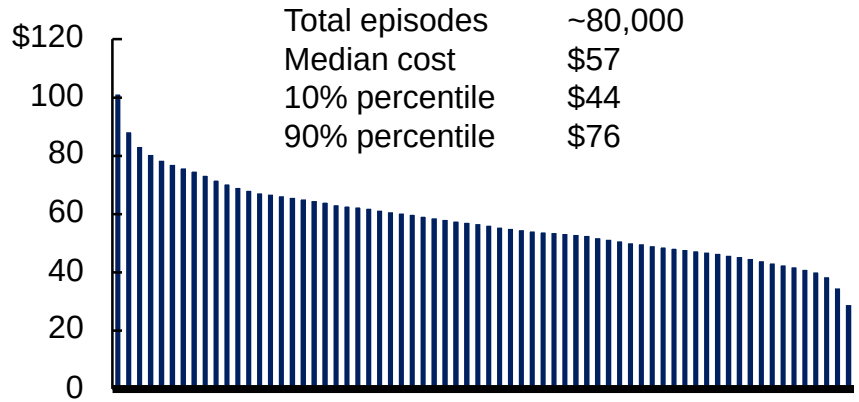
Monthly

- **Updates with Arkansas provider associations** (AHA, AMS, Arkansas Waiver Association, Developmental Disabilities Provider Association)

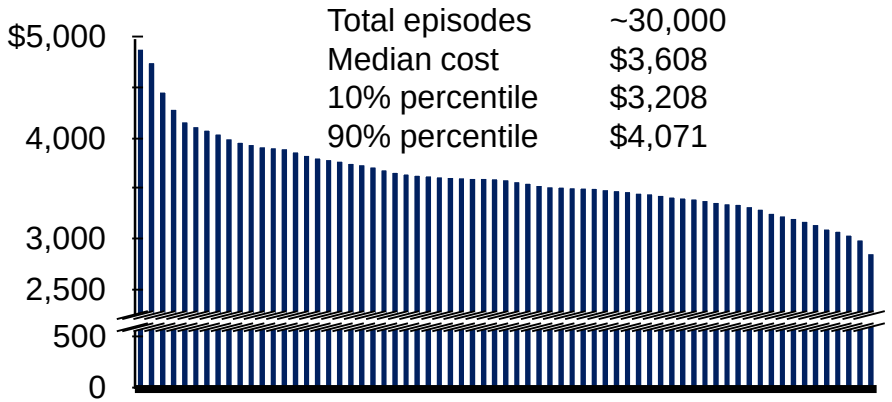
Case for Change

Total average cost per episode post-risk adjustment by Principal Accountable Provider, 2008-2010

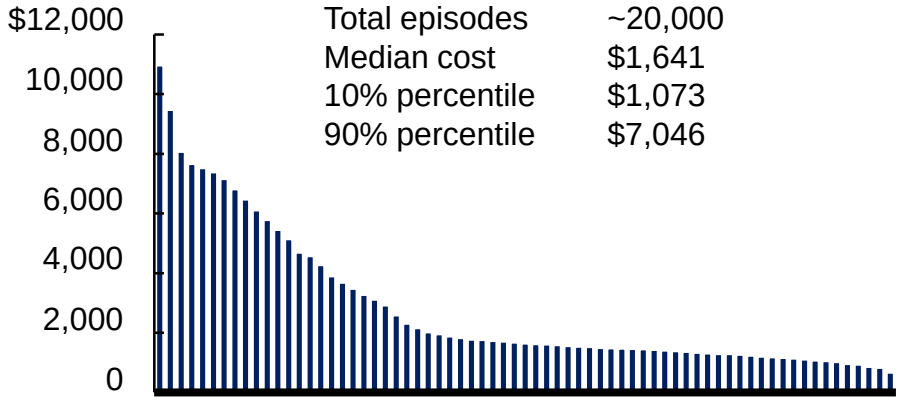
Simple upper respiratory infection[1]



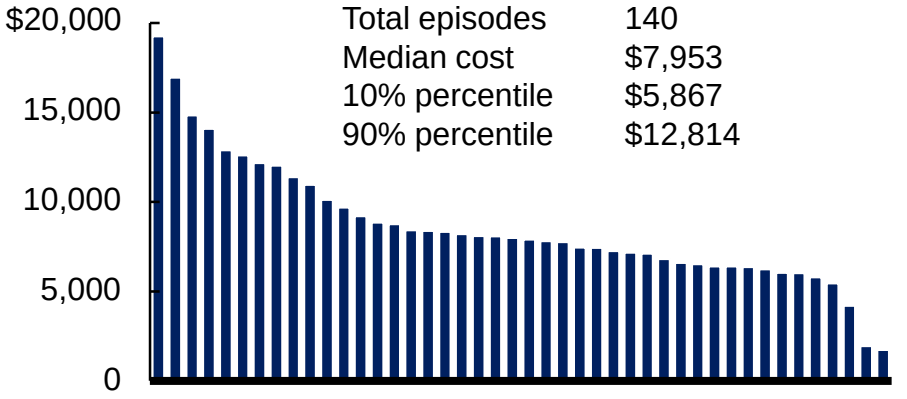
Pregnancy[2]



ADHD[3]



Total hip replacement



1 Episode costs for children less than 10 risk-adjusted by a historically-derived multiplier.
2 Individual episode costs risk-adjusted for clinical drivers of severity based upon historically-derived multipliers.
3 Eligible defined as ADHD without comorbidities between ages 6 and 17.

SOURCE: Arkansas Medicaid claims data; Team analysis

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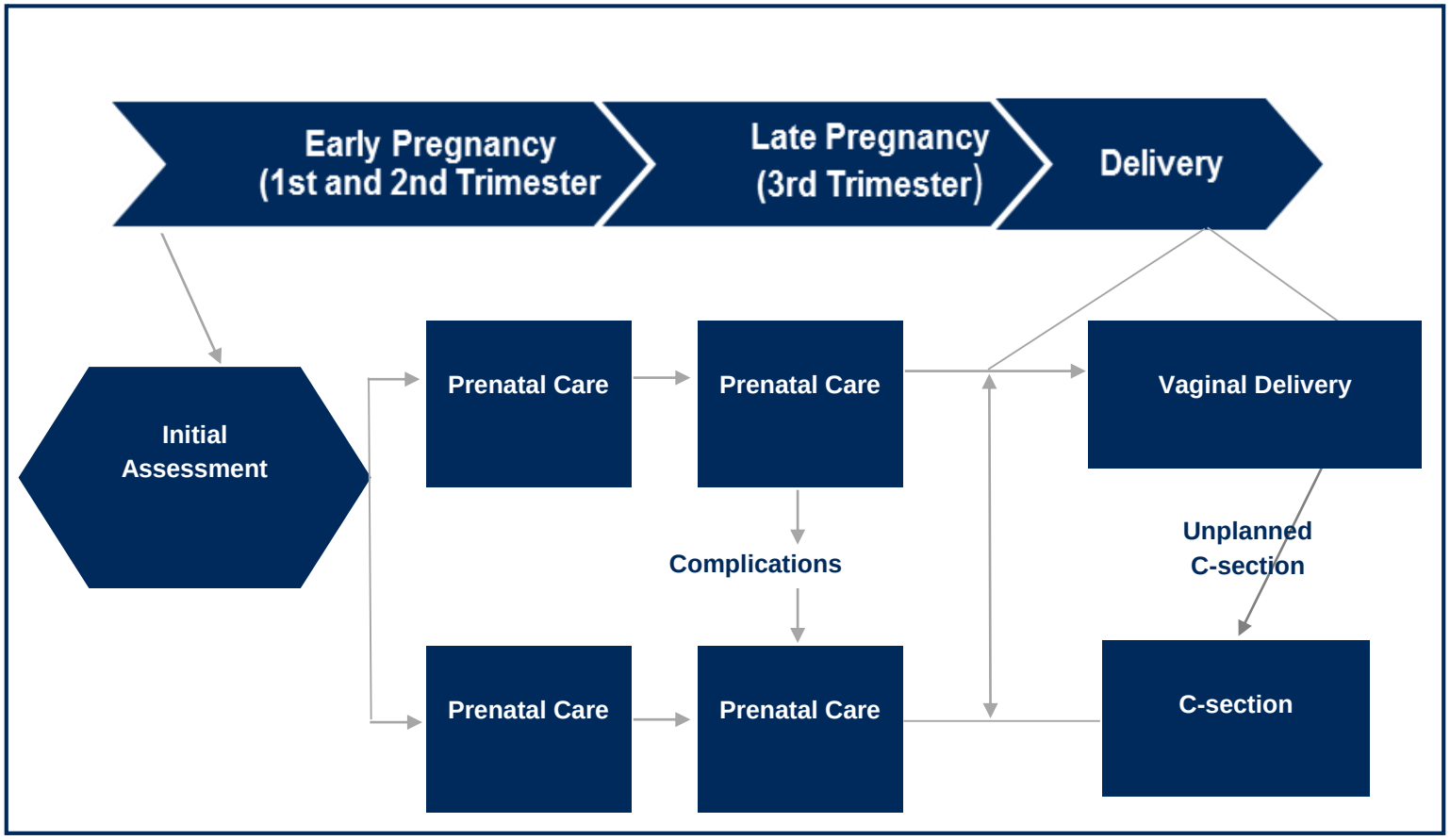
Clinical Input Guides Patient Journey: Perinatal Episode Example

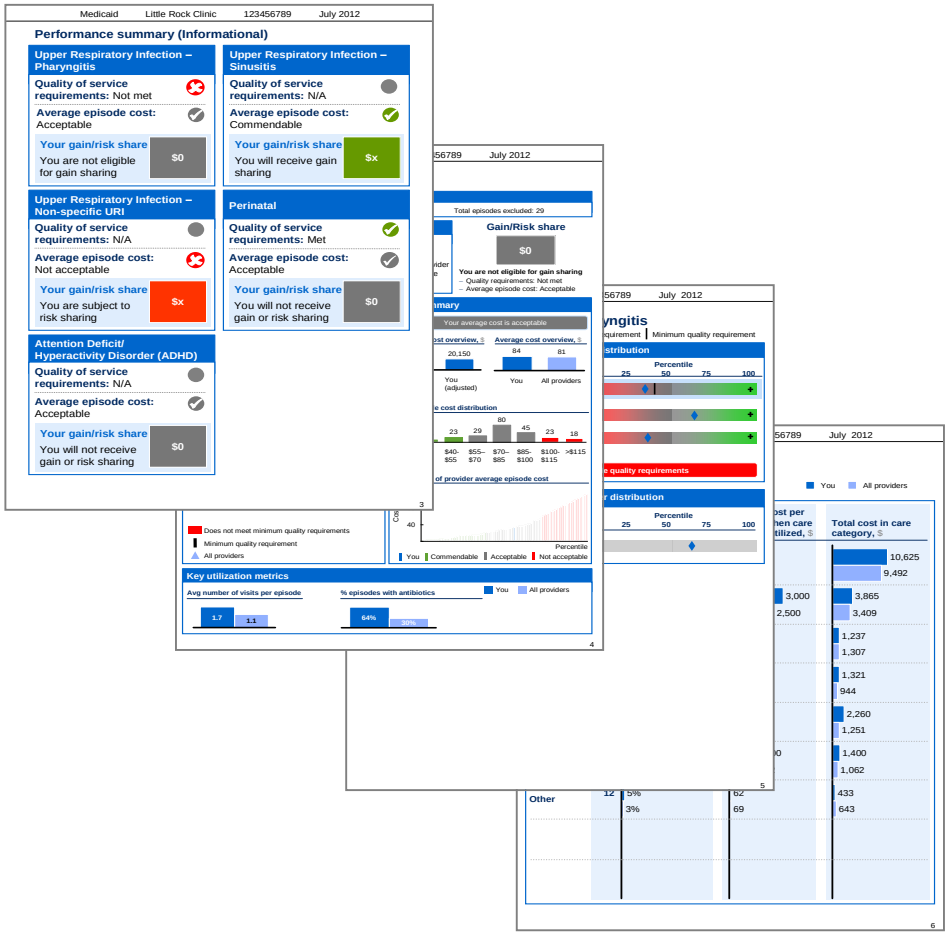


PAPs are Provided with New Tools to Measure and Improve Care

Reports provide performance information for PAP's episode(s):

- Overview of **quality** across a PAP's episodes
- Overview of **cost effectiveness** (how a PAP is doing relative to cost thresholds and relative to other providers)
- Overview of **utilization** and drivers of a PAP's average episode cost

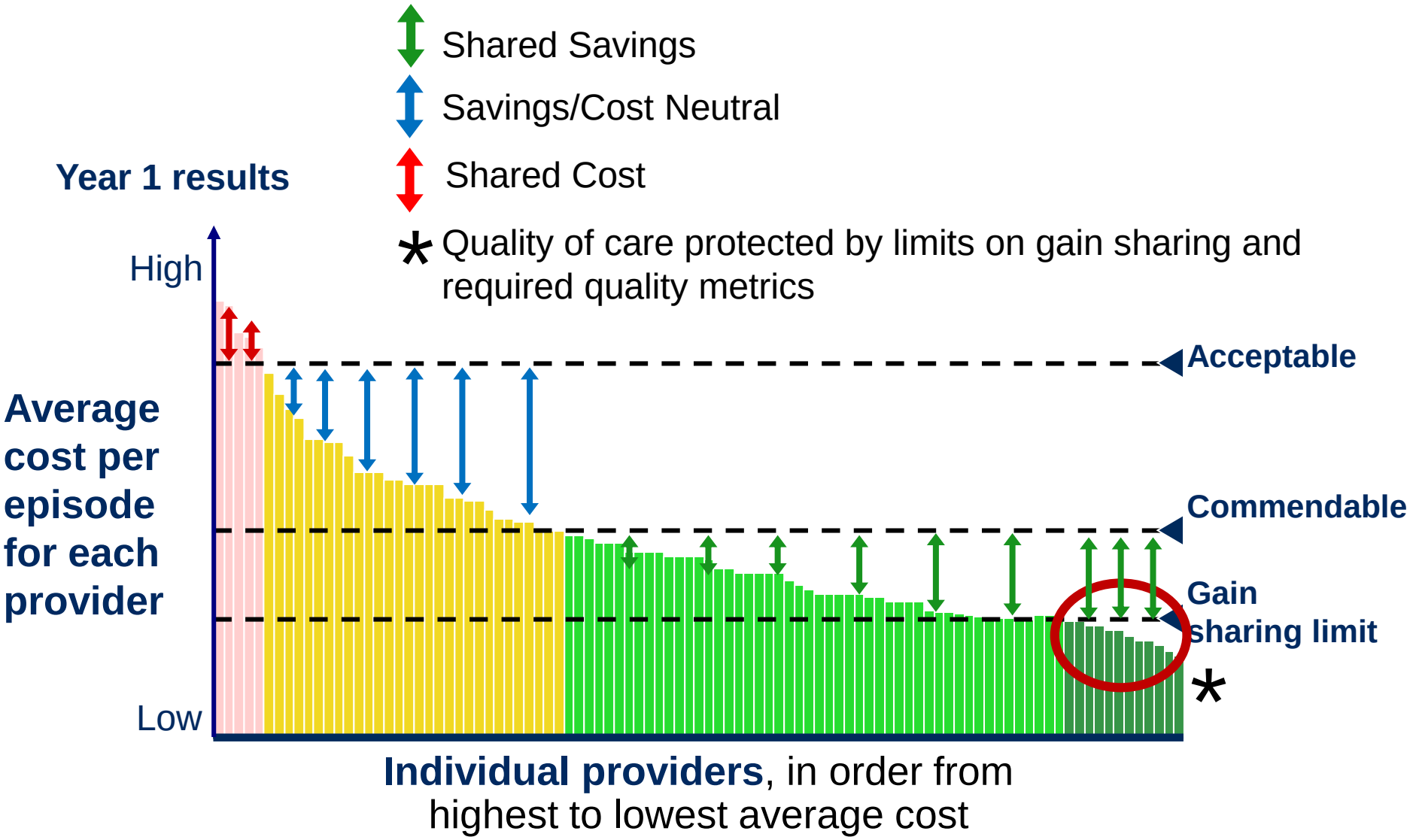
Example of provider reports



Wave 1 Episodes

		Principal Accountable Provider
Total Hip/ Knee replacement	• Surgical procedure plus related claims 30 days prior to 90 days after	Orthopedic surgeon
Perinatal (non-NICU)	• Pregnancy-related claims for mother 40 wks before to 60 days after delivery	Delivering provider
Ambulatory URI	• 21-day window beginning with initial consultation	First provider to diagnose patient in-person
Congestive Heart Failure Admission	• Hospital admission and care within 30 days of discharge	Admitting hospital
ADHD	• 12-month episode including all ADHD services plus pharmacy costs	Physician or licensed mental health provider

How the Episode Payment Model Works



Current Arkansas Multi-payer Episode Participation

Episodes	Multi-Payer Participation
Upper Respiratory Infection	Medicaid
Attention Deficit Hyperactivity Disorder	Medicaid
Perinatal	Medicaid, BCBS, QualChoice
Congestive Heart Failure	Medicaid, BCBS
Total Joint Replacement (Hip & Knee)	Medicaid, BCBS, QualChoice
Colonoscopy	Medicaid, BCBS, QualChoice
Cholecystectomy (Gallbladder Removal)	Medicaid, BCBS, QualChoice
Tonsillectomy	Medicaid, BCBS
Oppositional Defiance Disorder	Medicaid
Coronary Artery Bypass Grafting	Medicaid, BCBS
Asthma	Medicaid, BCBS
Percutaneous Coronary Intervention	Medicaid, BCBS, QualChoice
Chronic Obstructive Pulmonary Disease	Medicaid, BCBS
Neonatal	Medicaid
ADHD/ODD Comorbidity	Medicaid

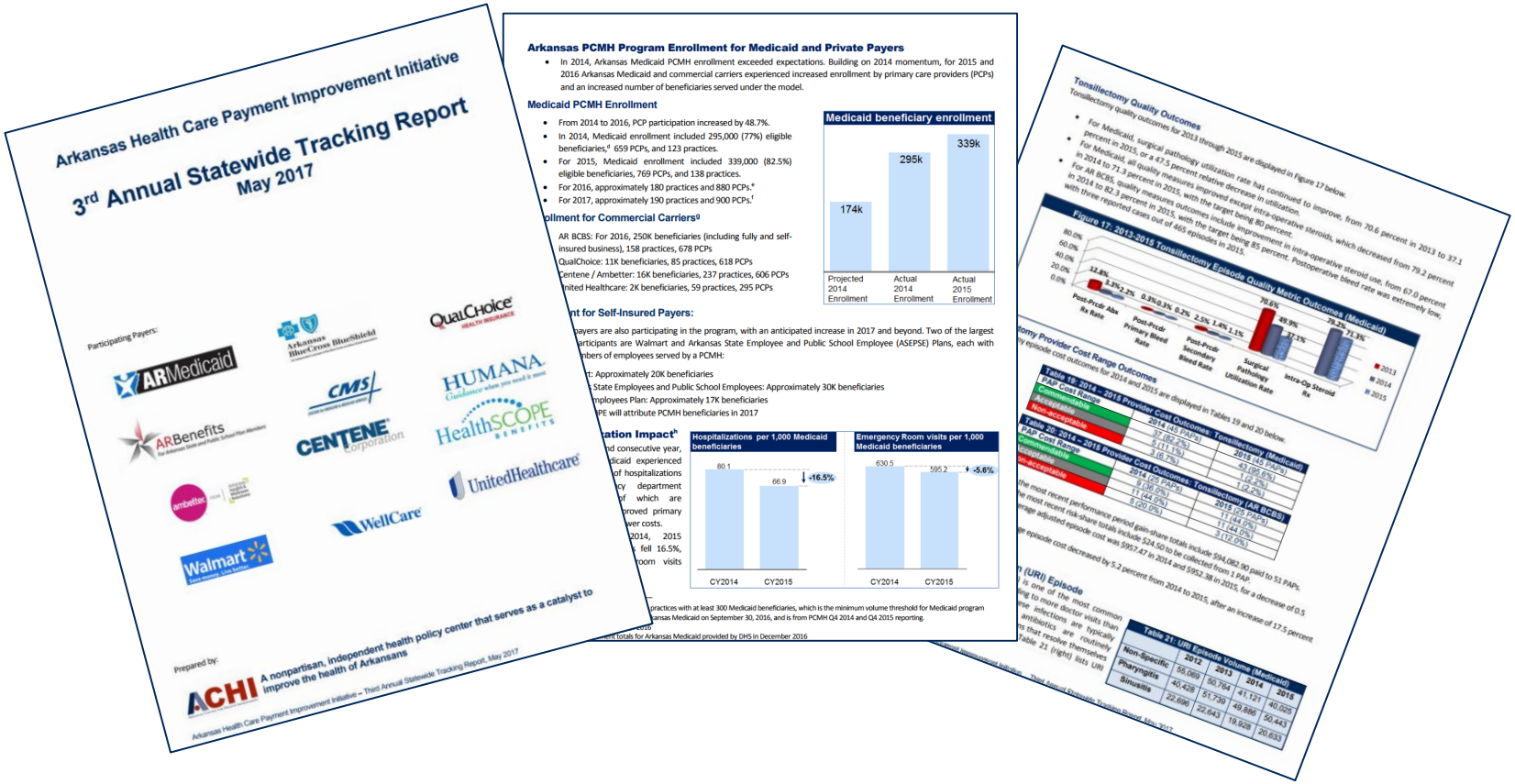
Multi-payer Episode Volume 2012 - 2015

Episode	2012	2013	2014	2015
Perinatal	8,716	9,167	16,095	9,920
TJR	964	870	1,104	954
URI	118,193	125,146	110,935	111,101
CHF	273	274	299	273
Colonoscopy	NA	10,547	9,854	9,676
Tonsillectomy	NA	3,363	3,505	3,874
Cholecystectomy	NA	2,448	2,176	1,878
ADHD	NA	3,048	3,630	4,426
CABG	NA	32	206	172
Asthma	NA	NA	4,248	4,280
COPD	NA	NA	1,286	981
ODD	NA	NA	2,981	3,183
PCI	NA	NA	748	608

ACHI Statewide Tracking Report

- **Annual report tracks multi-payer progress**

http://www.achi.net/pages/OurWork/Project.aspx?ID=112



Arkansas Episodes of Care Highlights

- **URI:** 28% drop in unnecessary antibiotic prescribing for non-specific URI from 2012-2015
- **Perinatal:** Sustained improvements in perinatal screening rates; reduced C-Section rates; 3-4% overall cost reduction compared to neighbor states
- **Tonsillectomy:** Path lab use down 48% for Medicaid; costs reduced by 5% for ARBCBS
- **Congestive Heart Failure:** Medicaid CHF costs reduced by 14% from 2014-2015
- **For 2015 Medicaid performance: $519k in gain-share payments and $257k in risk-share**

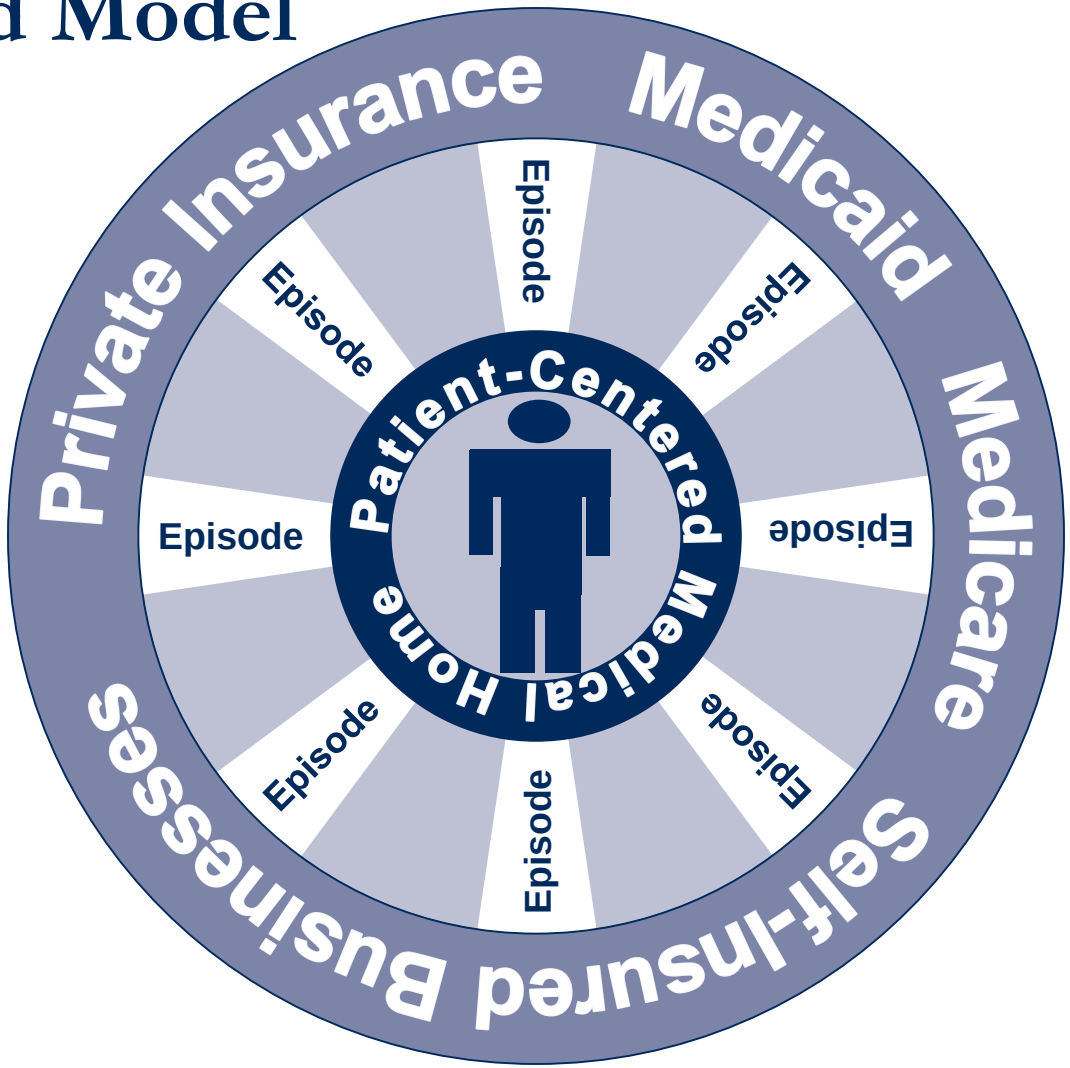
Implementation Challenge Example: ADHD Episode

- **Episode duration:** Year-long episode algorithm; technical updates can be more challenging
- **Multiple provider types:** Primary care physician vs RSPMI provider business model
- **Potential for coding subjectivity:** State saw substantial decrease in ADHD billing; simultaneous increase in billing for Oppositional Defiant Disorder
- **Provider Outreach:** Required one-on-one outreach to 400+ providers to discuss continued stimulant prescribing (inappropriate for ODD)

Other Model Comparisons with AR Model

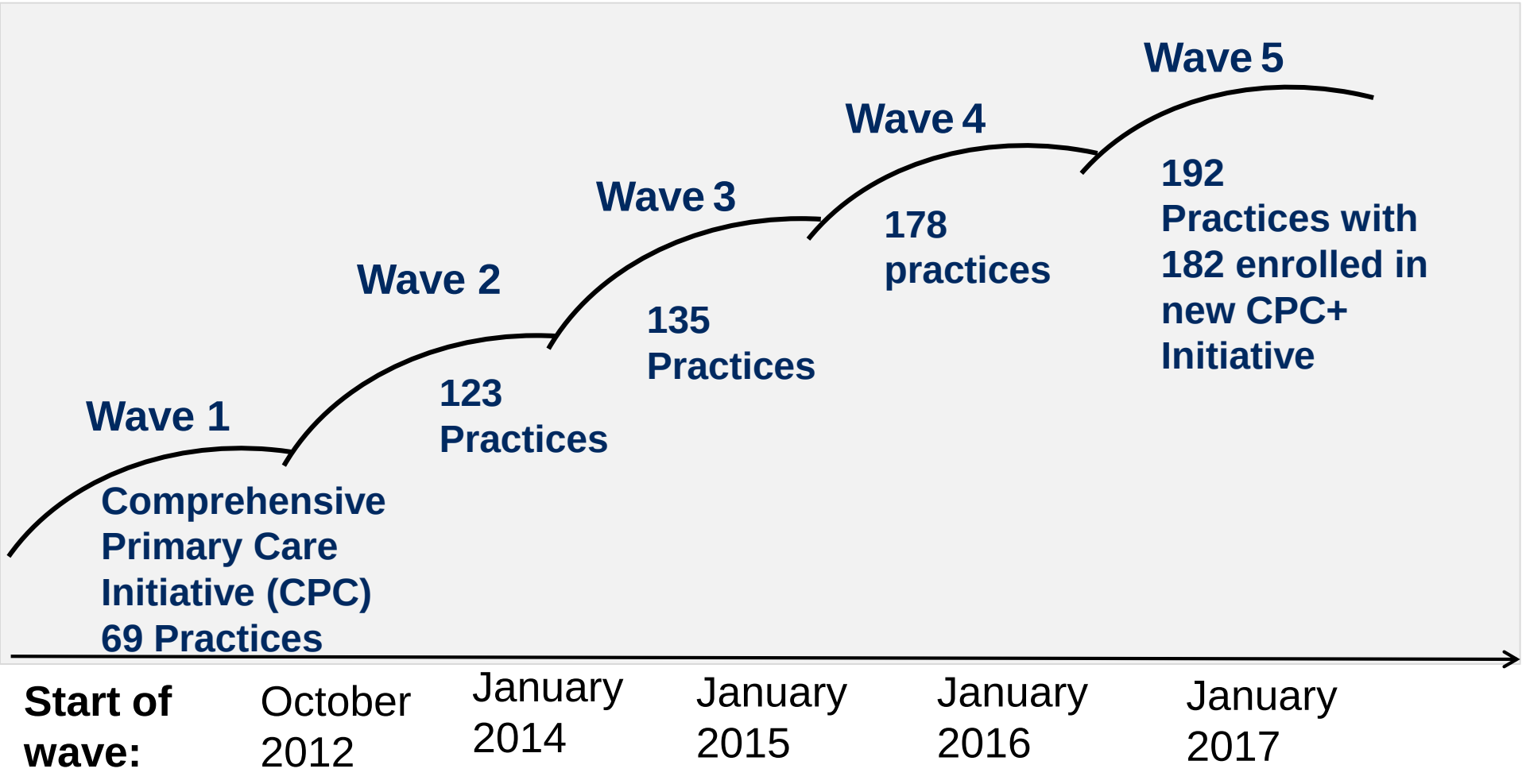
- **AR model** is mandatory and assigns episode type-specific principal accountable provider;
  - Based on who has most ability to influence treatment decisions, cost and quality
- **Bundled Payment for Care Improvement (BPCI) Model** is voluntary and allows for variation in provider and participant types
  - Majority of participants are hospitals or skilled nursing facilities; option to assign individual physician champion or specialty coordinator for management responsibility

Arkansas Payment Improvement Initiative's Integrated Model

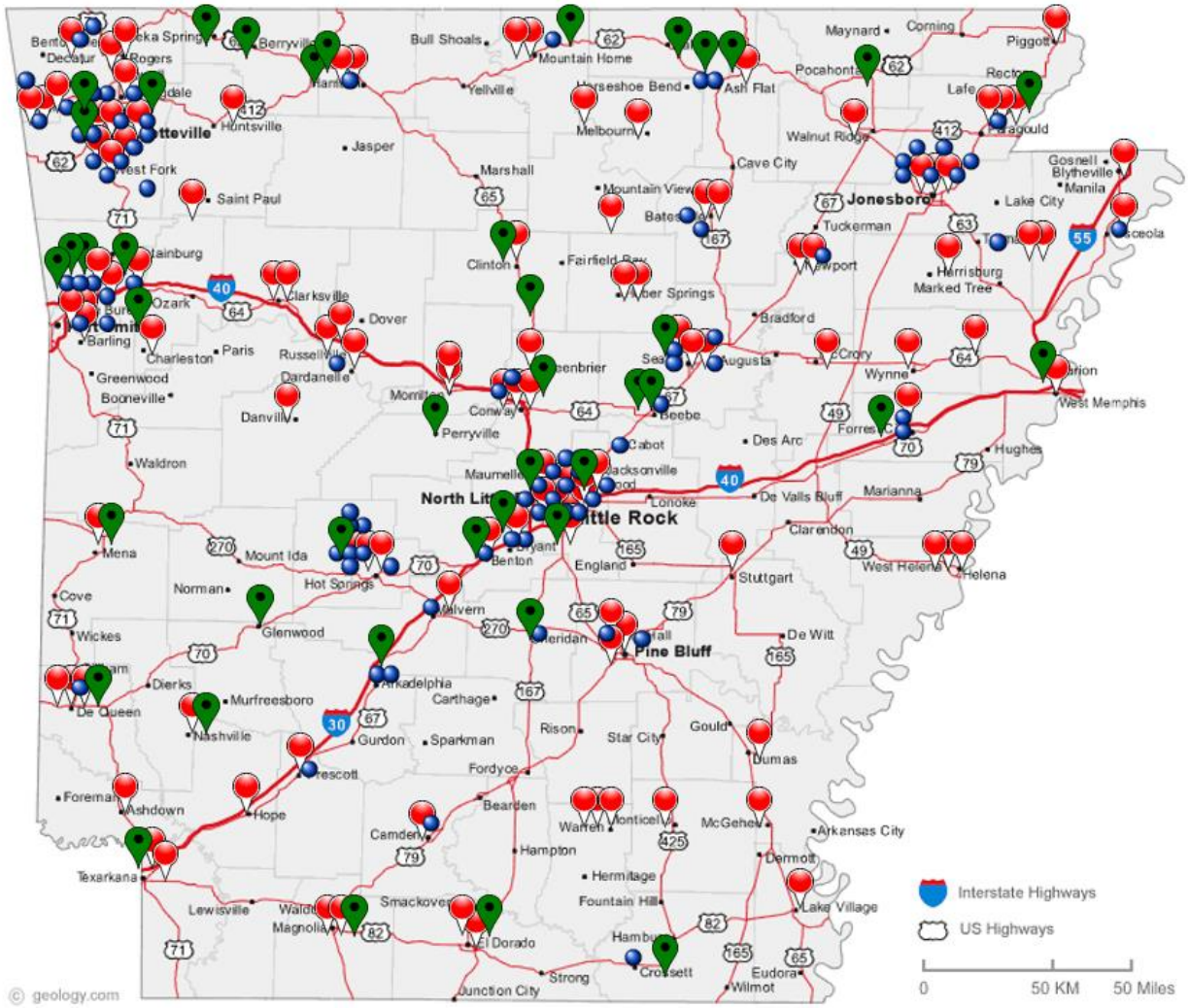


Medical Home: Rollout Timeline

Multi-payer PCMH Coverage Strategy



2017 Participation in PCMH and CPC+



Medicaid PCMH Clinic (192)

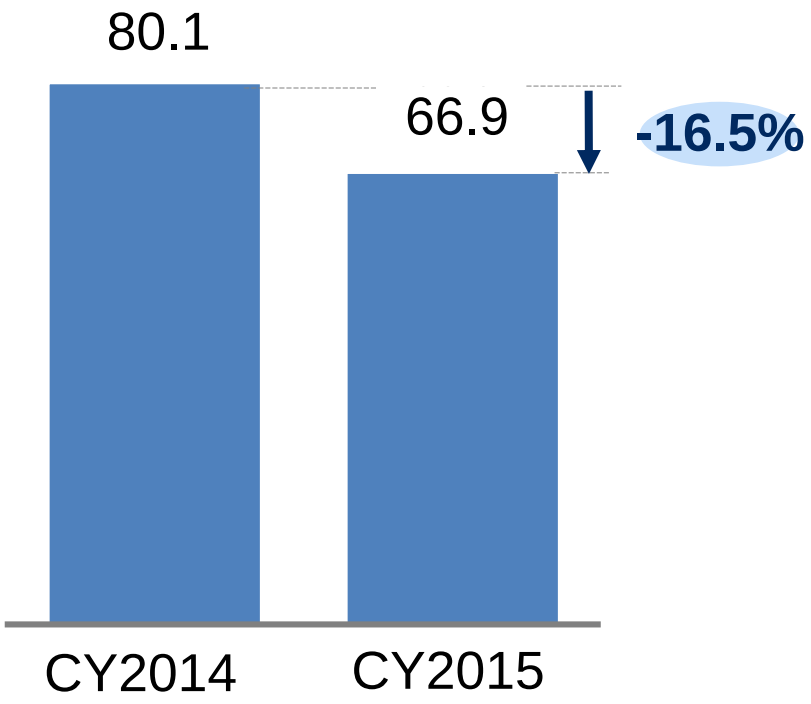
CPC+ Clinic (127)

PCMH and CPC+ Clinic (55 w/ 100% of PCPs in CPC+)

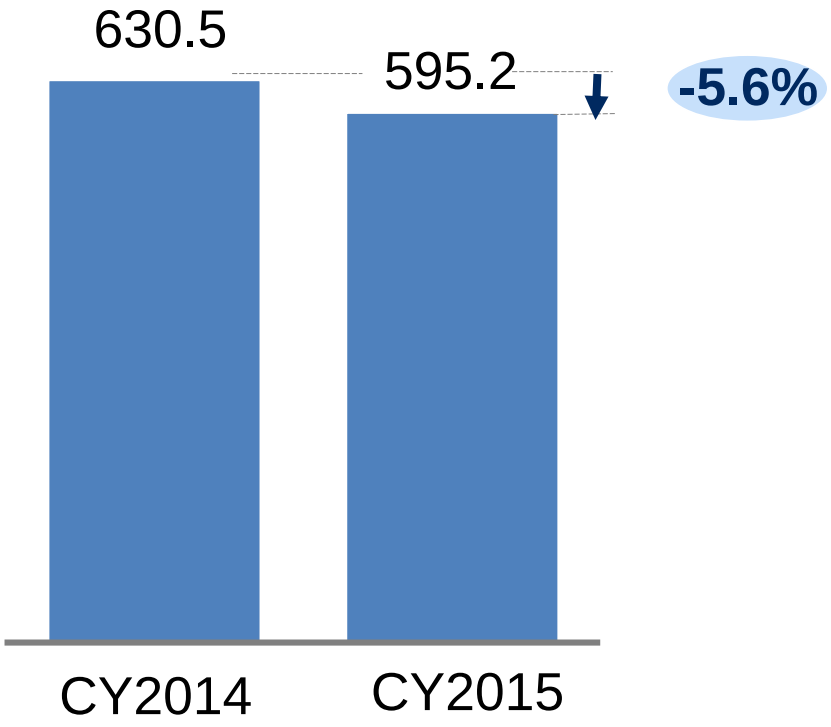
182 CPC+ Clinics overall

Medicaid: Reductions in Hospitalizations and ER Visits Indicate Improved Quality and Cost

Hospitalizations per 1,000 Beneficiaries

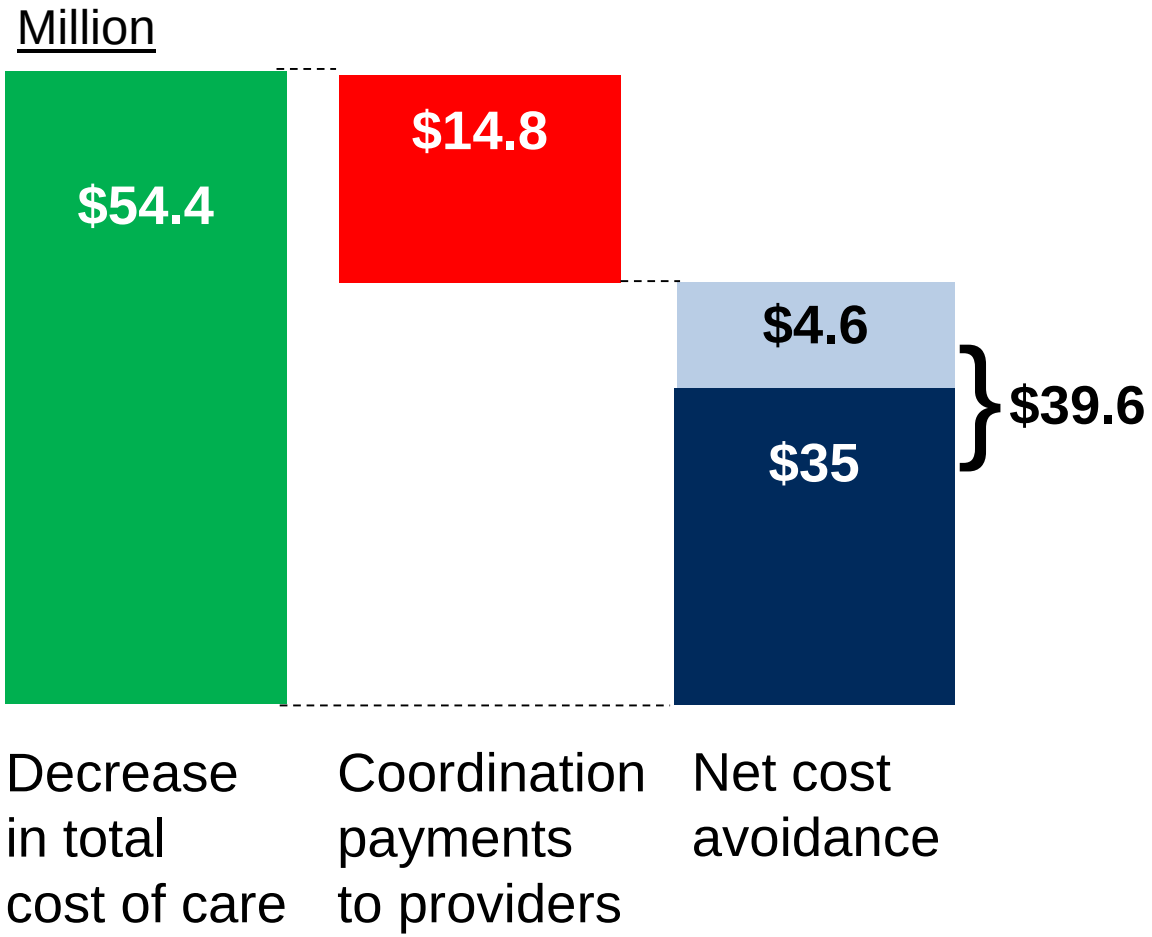


Emergency Room Visits per 1,000 Beneficiaries



Source: AR DHS Q415 reports

2015 PCMH Medicaid Cost Avoidance



- Of the $660.9M predicted total cost of care, $606.5M is the actual cost, $54.4M is the generated cost avoidance

Of the $54.4M in cost avoidance:

- $14.8M has been reinvested back into the provider community
- $39.6M represents total net cost avoidance
- $4.6M shared savings payments to providers for CY2015

MAY 2017 Final Reconciliation

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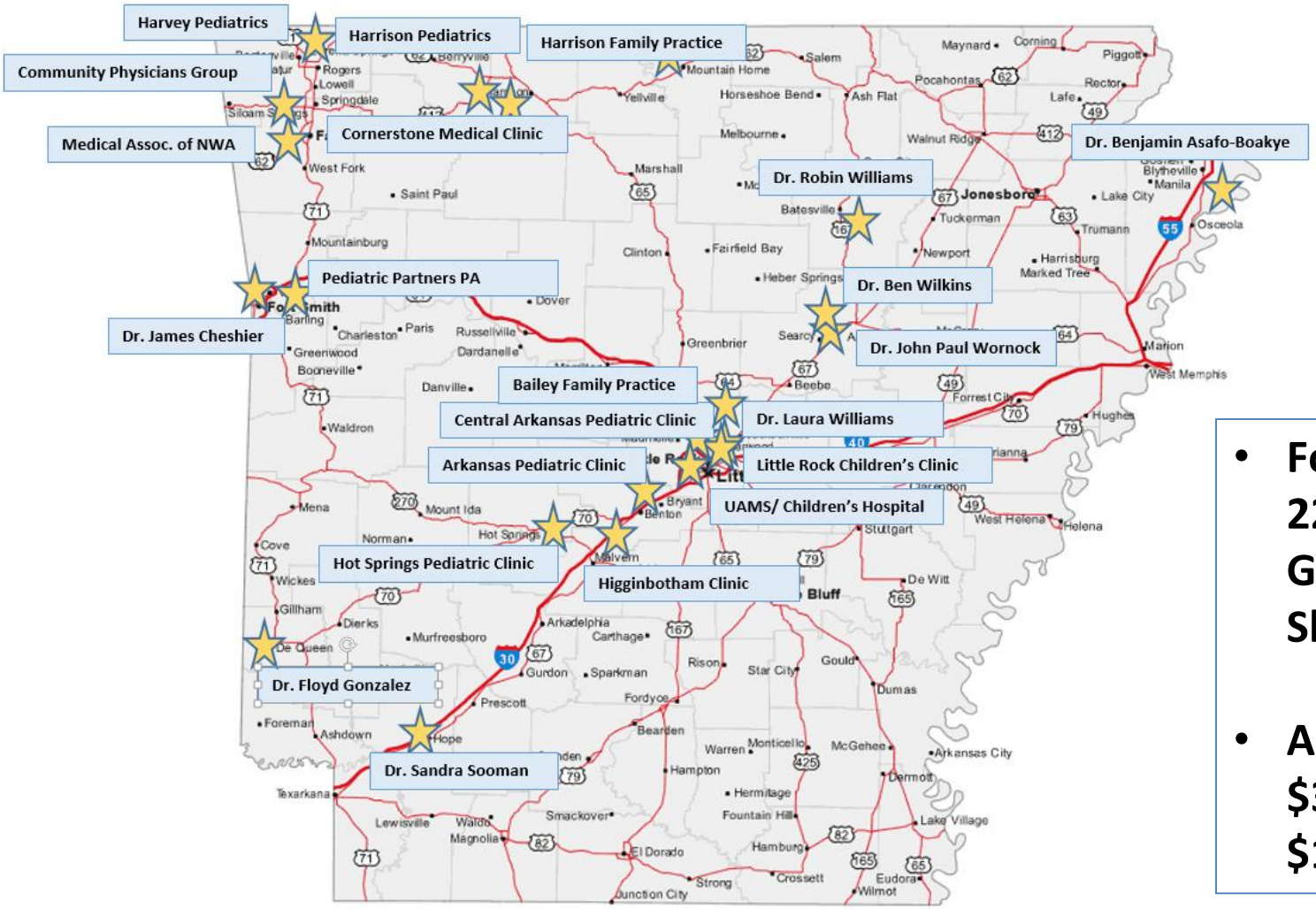
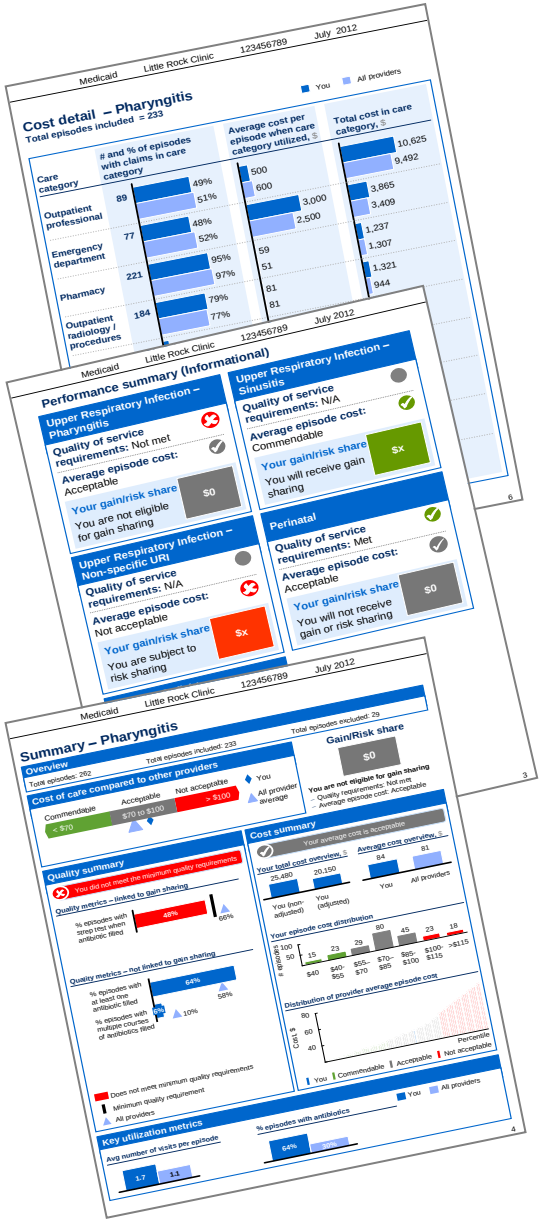
PCMHs Receiving Shared Savings in 2017



- **For Medicaid, 22 Provider Groups received Shared Savings**
- **Amounts from $35k to $1.54 million**

Provider Reporting Opportunity: Transparency of Information

- Billions of claims processed for reports; display quality, cost and utilization
- Facilitates integration of primary care and specialty support via episodes
- Episode PAP engagement w/ PCP prospectively for elective opportunities, and re-engagement for all opportunities
- New for 2017, PCPs now receiving information on specialist referral sources
- **Overall value**: Reporting transparency provides more effective tools than have been available



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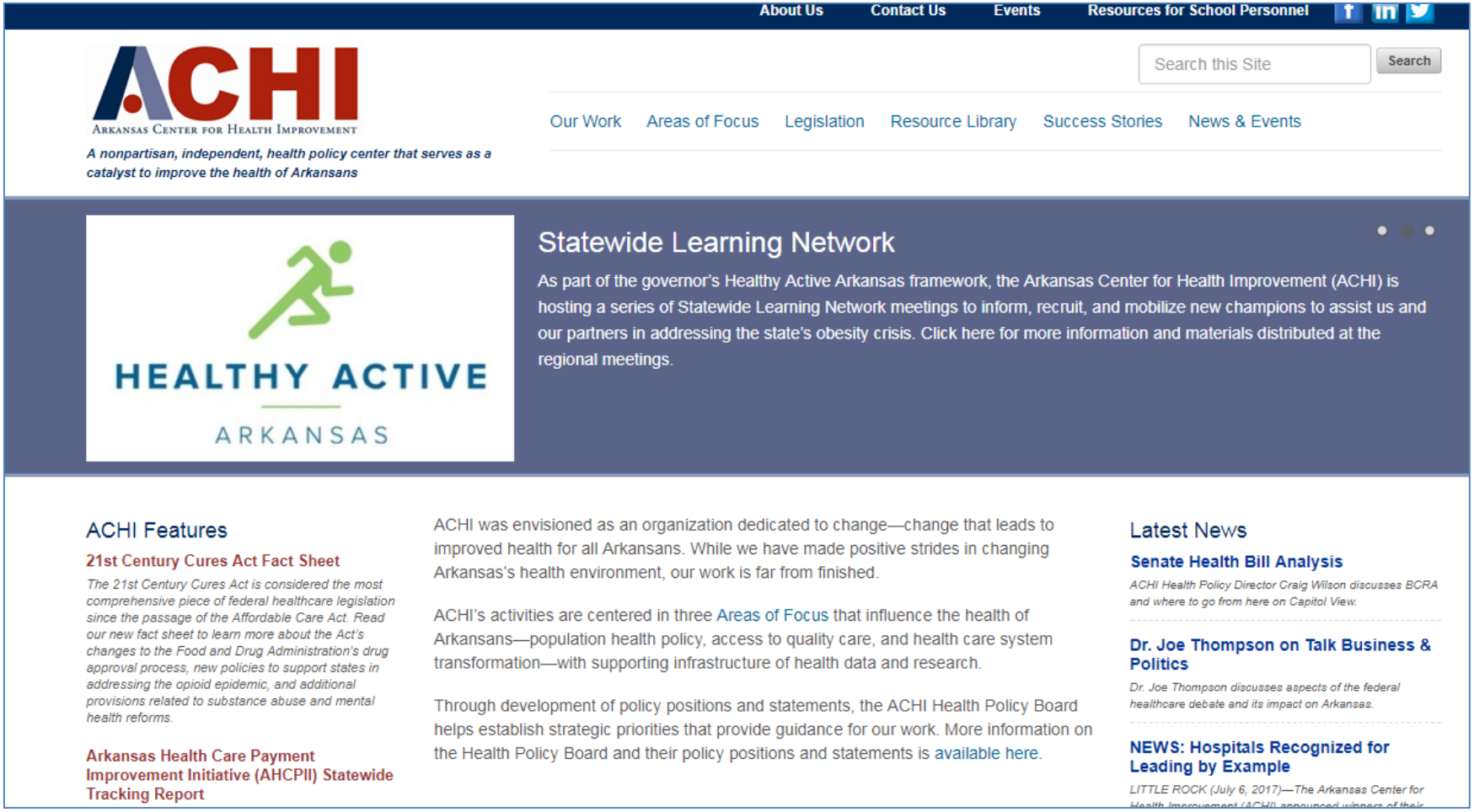
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As part of the governor's Healthy Active Arkansas framework, the Arkansas Center for Health Improvement (ACHI) is hosting a series of Statewide Learning Network meetings to inform, recruit, and mobilize new champions to assist us and our partners in addressing the state's obesity crisis. Click here for more information and materials distributed at the regional meetings.
ACHI Features
21st Century Cures Act Fact Sheet
The 21st Century Cures Act is considered the most comprehensive piece of federal healthcare legislation since the passage of the Affordable Care Act. Read our new fact sheet to learn more about the Act's changes to the Food and Drug Administration's drug approval process, new policies to support states in addressing the opioid epidemic, and additional provisions related to substance abuse and mental health reforms.
Arkansas Health Care Payment Improvement Initiative (AHCPII) Statewide Tracking Report
ACHI was envisioned as an organization dedicated to change—change that leads to improved health for all Arkansans. While we have made positive strides in changing Arkansas's health environment, our work is far from finished.
ACHI's activities are centered in three Areas of Focus that influence the health of Arkansans—population health policy, access to quality care, and health care system transformation—with supporting infrastructure of health data and research.
Through development of policy positions and statements, the ACHI Health Policy Board helps establish strategic priorities that provide guidance for our work. More information on the Health Policy Board and their policy positions and statements is available here.
Latest News
Senate Health Bill Analysis
ACHI Health Policy Director Craig Wilson discusses BCRA and where to go from here on Capitol View.
Dr. Joe Thompson on Talk Business & Politics
Dr. Joe Thompson discusses aspects of the federal healthcare debate and its impact on Arkansas.
NEWS: Hospitals Recognized for Leading by Example
LITTLE ROCK (July 6, 2017)—The Arkansas Center for

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Payer Perspective

Andrew Baskin, MD
National Medical Director

aetna℠

Ohio Episode-Based Payment Charter for Payers

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Questions?

Use the question box on the Zoom screen

To access our materials and the recording of this webinar, please visit: http://hcttf.org/bundled-payments/

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Upcoming Webinars

September

Social Services Integration: Effective Financing Strategies

- An in-depth discussion of financing mechanisms used by health care organizations to fund the integration of social services into medical care.

October

The Path to Transformation: Moving an Organization from Volume to Value

- Introduction of the Dimensions of Transformation Matrix, an overview of analysis/findings from interviews with strategic leaders, and member case studies.

November

The Essential Elements of Effective Accountable Care

- An overview of best practices and key learnings from interviews with ACO that were successful earning shared savings and high quality marks in the Medicare ACO programs.

To sign up for invitations to our webinar series, please visit: http://hcttf.org/sign-up