

Arkansas Health Care Payment Improvement Initiative: 2nd Annual Statewide Tracking Report January 2016

Executive Summary

Participating Payers:



Prepared by:



A nonpartisan, independent, health policy center that serves as a catalyst to improve the health of Arkansans.

Overview

Statewide, multi-payer implementation of Arkansas's Health Care Payment Improvement Initiative (AHCPII) has positioned Arkansas as a national leader in value-based health care innovation. Since the first components were launched in the summer of 2012, AHCPII has supported and incentivized delivery of high-quality, efficient care for a large and increasing number of the state's citizens. As a key part of the state's total health system transformation effort, the AHCPII has fortified broad goals that include improving quality, expanding access, and avoiding unnecessary costs.

Arkansas was one of only six states awarded an initial State Innovation Model Testing grant by the Centers for Medicare and Medicaid Services, receiving \$42 million in federal funds to implement the AHCPII. AHCPII now has a strong foothold across the state through deployment of two primary strategies: Patient-centered medical homes (PCMH), designed to improve quality and contain costs by supporting the delivery of better-coordinated, team-based care,^a and a retrospective episodes of care model, designed to improve quality and reduce variation in treatment of acute conditions and delivery of specialty procedures.

A third component, originally introduced in 2012 by the Arkansas Department of Human Services (DHS) was a Health Home model—a client-based support strategy for individuals with needs exceeding the traditional medical home model. The health home strategy proposed to optimize coordination of services for those individuals, including the frail elderly, the severe and persistently mentally ill, and the developmentally disabled. These populations represent a large proportion of the state's overall Medicaid expenditure. As a Medicaid-only component of the AHCPII, the model has been met with challenges from both the provider community and other stakeholders and has not been implemented. The state is currently weighing alternative options to improve delivery of high-quality and efficient care to these special needs populations and through their deliberations may choose to pursue components of the Health Home model.

The AHCPII has the strength of multiple payer engagement with the participation of a majority of the state's health care payers including Arkansas Medicaid, Blue Cross and Blue Shield (AR BCBS), QualChoice (QC), Centene, and United Healthcare, along with Walmart, the State and Public School Employee benefits program, and other self-funded employers. Support for AHCPII includes a broader team of individuals at the Arkansas Department of Human Services, Hewlett-Packard, General Dynamics Health Solutions, Arkansas Foundation for Medical Care, Qualis Health, and the Advanced Health Information Network, among others.

As a result of continued progress and demonstrated success, additional payers have shown interest in joining the AHCPII. Importantly, leaders at the Center for Medicare & Medicaid Innovation (CMMI) have acknowledged the success of Arkansas's model and approached the state regarding expanding the program to include federal support for the approximately 71,000 Medicare beneficiaries in the state's PCMH program. As additional practices enroll, more of the state's 400,000 Medicare Part A and B beneficiaries could be served in a PCMH. CMMI has committed to assisting the state in exploring this opportunity—one that, if successful, would make Arkansas only the second state in the nation (behind Maryland) to receive a Federal Medicare waiver for a state-specific, value-based model.

AHCPII progress as well as quality and cost impacts are captured in the second annual AHCPII Statewide Tracking Report. The Arkansas Center for Health Improvement (ACHI) has worked with individual payers and providers to gather content for development of this report, designed to track progress and to help identify challenges and lessons learned.

Patient-Centered Medical Homes (PCMH)^b

This multi-payer, team-based primary care strategy has received legislative support and been adopted widely by providers across the state. Primary care clinics are given responsibility for total cost of care for their panel of patients and receive upside gain-sharing if they meet quality metrics and bring total costs under preset thresholds. Provider

^a To view a comprehensive video about AHCPII, visit <http://www.achi.net/pages/OurWork/Project.aspx?ID=81>.

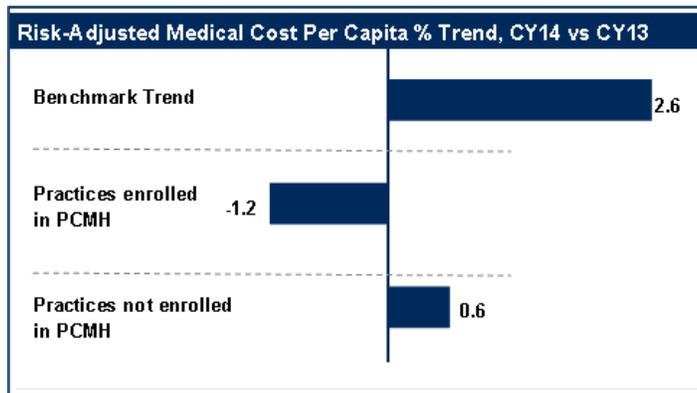
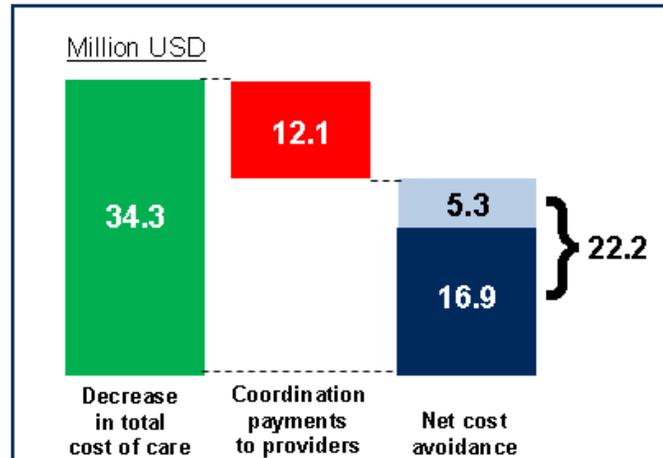
^b Medicaid PCMH data provided by Arkansas DHS, pulled from PCMH Q4 reporting as of December 10, 2014. Enrollment figures include practices that enrolled for 1/1/14, 7/1/14 and 1/1/15 start dates. Commercial carrier data provided by individual carriers.

enrollment in the program is voluntary. The Medicaid PCMH results depicted in this report are for beneficiaries that are managed by Arkansas Medicaid and do not include results for those beneficiaries who are covered under a commercial qualified health plan (QHP). Results from the QHP beneficiary PCMH experience are anticipated to be available for inclusion in the next annual Statewide Tracking Report.

PCMH Highlights

- Medicaid has more than 80 percent of its beneficiaries under this model.

- In 2014, Medicaid realized \$34.3 million in direct cost-avoidance through trend reduction. Of the \$34.3 million in savings, \$12.1 million went toward care coordination payments to providers. The remaining \$22.2 million in net cost avoidance was shared between the state and those providers who met both quality and cost savings requirements. Shared savings checks were issued in October 2015, with several clinics receiving over \$100,000.



- In 2014, enrolled practices experienced a cost decrease of 1.2 percent, beating both the 2.6 percent benchmark trend increase and the 0.6 percent cost growth of non-participating practices.

- In 2014, the vast majority of practices met transformation milestones and either improved or maintained prior-year levels for 78 percent of PCMH quality metrics. Quality metrics include: increased pediatric wellness visits, Hemoglobin A1c testing, breast cancer screenings, improved Attention Deficit Hyperactive Disorder (ADHD) management, and thyroid medication management.

PCMH Quality Metrics	Percent Change
Adolescent Wellness Visit	+14.6%
HbA1c Test for Diabetics	+5.9%
Breast Cancer Screening	+3.1%
ADHD Assessment	+2.9%
Child Wellness Visit	+1.5%
Thyroid Screening	+1.1%
Asthma Control	+/- 0%
Infant Wellness Visit	+/- 0%
CHF Control	-5.8%

- AR BCBS has recognized value and extended attribution of patients to all of its covered lives; AR BCBS has publicly stated intent to increase payment to primary care through markedly increased per-member per-month (PMPM) payments and hold/reduce fee-for-service (FFS) payments for services rendered over time.
- The federal Medicare program has approached the state to expand their participation to all Medicare beneficiaries (participation is currently limited to the original 69 clinics in the Comprehensive Primary Care Initiative). Arkansas would be only the second state for which Medicare has modified national payment strategies to support local payment transformation.
- Qualified health plans operating on the insurance exchange and dual-specialized needs managed care plans are required to participate in the state PCMH program by either legislative or regulatory requirements.
- Performance target requirements for a proportion of hypertensive and diabetic individuals under clinical control are proposed to explicitly link population health needs and clinical performance expectations.

Enrollment for Arkansas Medicaid (as of October 2015):

- **136 practices** are participating out of 263 eligible (52%). For 2016, Medicaid will continue recruitment of new practice participants as will both AR BCBS and Ambetter.
- **780 primary care providers** are participating (69% of eligible Medicaid providers)
- **331,000 eligible Medicaid beneficiaries** are covered under the state PCMH program (82%)

Enrollment for Commercial Carriers: (PCMH beneficiary attribution is still underway for the commercial carriers. These are estimates for the number of attributed beneficiaries for each payer)

- **AR BCBS: 157,000** attributed beneficiaries
- **QC: 4,300** attributed beneficiaries^c
- **Centene / Ambetter: 44,000** eligible beneficiaries (final attribution numbers pending)
- **United Healthcare:** United is offering a QHP and will attribute members in 2016

Enrollment for Self-Insured Payers:

Self-insured payers are also participating in the program, with an anticipated increase in 2016 and beyond. Two of the largest self-insured participants are Walmart and Arkansas State Employee and Public School Employee (ASEPSE) Plans, each with substantial numbers of employees served under a PCMH:

- **Walmart: ~21,000 beneficiaries**
- **Arkansas State Employees and Public School Employees: ~30,000 beneficiaries**

Retrospective Episodes of Care

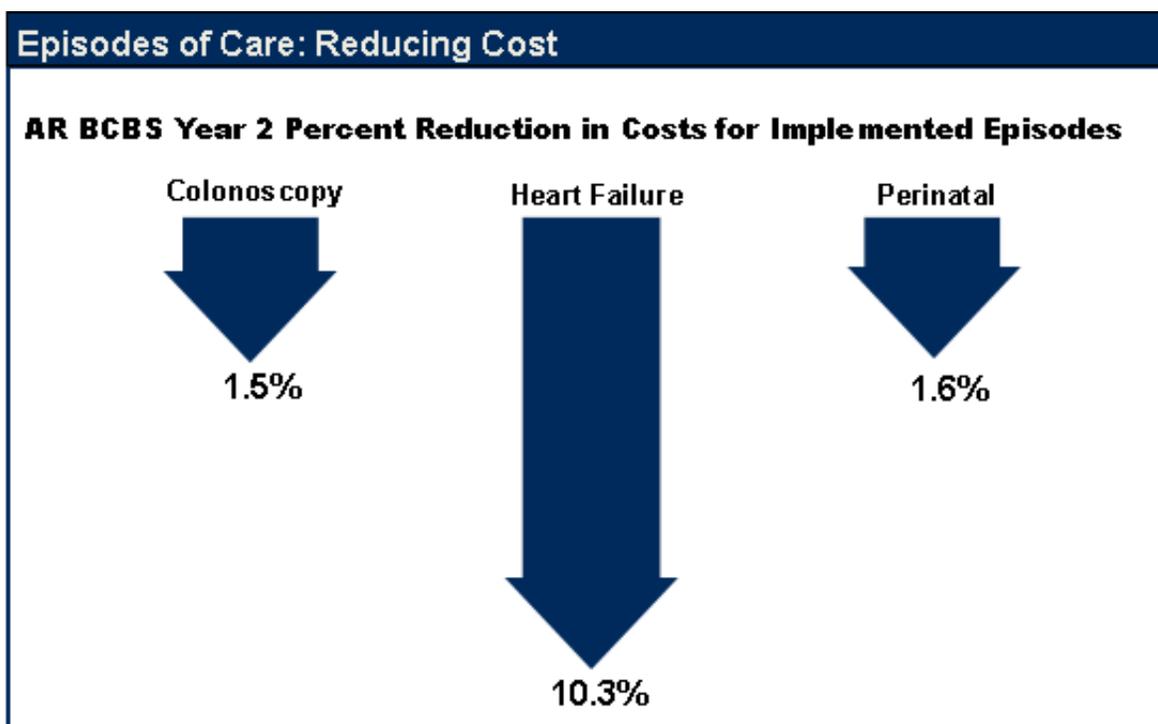
This model to improve quality and efficiency and eliminate variation has achieved both quality enhancement and cost-saving goals. Since 2013 there have been 14 types of episodes launched with new episode development focused primarily in the areas of surgical intervention and hospitalization management. While employers, consumers, and the state strive to optimize the value of their health care expenditures, Arkansas's episodes of care model puts the clinical leader in charge and aligns incentives to achieve the highest quality at the lowest cost.

In an ongoing coordinated effort that includes close involvement with providers and other stakeholders, Arkansas Medicaid, AR BCBS, and QC all participate in the episodes model. Providers benefit from consistent incentives and reporting tools across payers. Together these payers cover a majority of Arkansas citizens, generating enough scale to promote change in practice patterns.

^c Data provided by QualChoice in October 2015.

Medicaid has achieved quality improvements and cost avoidance^d

- **Perinatal:** C-section rate reduced from 39 percent to 34 percent, with an estimated 2-4 percent direct savings to date.
- **URI:** 17 percent reduction in antibiotic prescriptions; episode costs remained flat despite a 10 percent increase in drug prices.
- **ADHD:** Average episode cost fell by 22 percent, with 400 providers contacted by Medicaid regarding appropriate stimulant prescribing.
- **Total Joint Replacement:** Number of episodes down from 141 to 101; 30-day all-cause readmission rate reduced from 3.9 percent to 0 percent; estimated 5-10 percent direct savings to date.
- The most recent gain and risk sharing calculations from finalized episodes resulted in 648 providers receiving gain-share payments totaling \$642,200 and 605 providers deemed eligible for risk sharing totaling \$710,034.



AR BCBS reported that this year they will pay out nearly \$1.3 million in shared savings with approximately \$250K being recovered in the form of risk-sharing payments.

Following Arkansas's lead, Medicare has now implemented its own version of mandatory episodes for hip and knee replacement in 50 market areas nationally —inclusive of Hot Springs and Memphis^e.

^d Data provided by Arkansas DHS/Medicaid. Information was presented by Arkansas Medicaid Director Dawn Stehle to the Arkansas Legislative Health Care Task Force on July 16th, 2015.

^e <https://innovation.cms.gov/initiatives/cjr>

Implementation of Episodes for Specialty, Surgical and Hospital Care

- Additional episodes of care were launched by AR BCBS in January 2015, including Percutaneous Coronary Intervention (PCI), Coronary Artery Bypass Grafting (CABG), Asthma, and Chronic Obstructive Pulmonary Disease (COPD).
- Medicaid and AR BCBS are considering potential development of additional episodes including appendectomy, pediatric pneumonia, hysterectomy, and urinary tract infection (when an ER visit is involved). AR BCBS is also reviewing tympanostomy (ear tube procedure) for possible episode development.
- Experience from episode analysis is aiding in the creation of chronic disease profiles, which can be used by PCMHs in coordinating care for high risk patients as they pursue per member, per year cost curve management.

System Infrastructure Development

The episode and PCMH models would not be possible without development of an advanced analytic infrastructure allowing participating payers to process large amounts of data. This analytic capability has been developed including a multi-payer portal on a common platform, enabling production of quarterly reports to providers. These new tools detail utilization and quality indicators to support better decision making and improved clinical outcomes. A large and increasing number of providers have accessed their reports:

- Approximately 500 million medical claims have been processed through the analytic engines for both episodes and PCMH. For episodes, those claims resulted in over 3.78 million episodes.
- As of October 2015, for episodes 31,781 reports were delivered to 2,252 distinct principal accountable providers (PAP).^f
- Through September 2015, for PCMHs 1,918 reports have been provided to practices.

Conclusion

Today, the state's Medicaid growth rate is relatively flat, the PCMH program has demonstrated quality improvements and system savings, private payers have reported quality improvements and cost avoidance in episodes of care, and providers and patients are benefitting from practice support and improvements in quality of care. While results are encouraging, early challenges have helped identify opportunities to improve the AHCPII. Continued engagement and input from providers, patients, state leaders, and others is necessary to sustain progress of this initiative.

Acknowledgements

The staff at ACHI appreciate the opportunity to work with individuals leading the implementation of the Arkansas Health Care Payment Improvement Initiative. The production of this report would not have been possible without the efforts of:

The Arkansas Department of Human Services, Division of Medical Services staff including Lee Clark, Sharon Donovan, William Golden, MD, Kiral Gunter, Brandi Hinkle, Lech Matuszewski, Maggie Newton, Sheila Nix, Anne Santifer, Dawn Stehle, Shelley Tounzen, David Walker, Michelle Young-Hobbs and other members of the Arkansas Medicaid team.

General Dynamics Health Solutions staff including Jane Gokun, Marlo Harris, Nena Sanchez, and E.J. Shoptaw.

Arkansas Blue Cross and Blue Shield Staff including Alicia Berkemeyer, Matt Flora, David Greenwood, Randal Hundley, MD, Steve Spaulding, and Sarah Wang among others.

QualChoice staff including Mark Johnson, Lubna Maruf, MD, and Stephen Sorsby, MD.

ACHI staff including Michael Motley, Debra Pate, Leah Ramirez, and Joseph W. Thompson, MD, MPH.

This report was made possible in part by grant funding from Walmart.

^f Reporting totals provided by Arkansas DHS, October 2015