International Challenge

All Health Systems

• Have Service Demand and Limited Resources
  – Taxes vs. Premiums vs. Co-Pays vs. Access Limitations

• Need Greater Stewardship
  – Providers, Payers, Patients

• Should Explore New Incentives to Shape Delivery
  – Reward Outcomes, Effectiveness
Goals

2016
In 2016, at least 30% of U.S. health care payments are linked to quality and value through Alternative Payment Models (APMs).

30%

2018
In 2018, at least 50% of U.S. health care payments are so linked.

50%

These payment reforms are expected to demonstrate better outcomes and lower costs for patients.
Working Version of APM Framework Model

Category 1: FFS with No link to Quality and Value
- Traditional FFS
- DRGs Not linked To Quality

Category 2: FFS for Service Linked to Quality and Value
- Category 2a: Infrastructure and operations
- Category 2b: Pay for reporting
- Category 2c: Pay for performance
- Bonus payments based on quality and/or efficiency
- DRGs with reward/penalty for reporting
- FFS with reward/penalty linked to quality

Category 3: APMs Built on FFS Architecture
- Category 3a: APMs with upside risk
- Bundled (e.g., episode-based) payment with downside risk
- ACOs with upside risk
- PCMHs with upside risk
- COEs with upside risk

Category 4: Population Based Payment
- Category 4a: Limited capitation
- Capitation for specialty and condition-specific care (e.g., via an ACO, PCMH, or COE)
- Partial capitation (e.g., via an ACO, PCMH, or COE)
- Global budget for hospitals linked to quality
- Global budget based on population served linked to quality

- Category 4b: Full capitation
- Percent of premium capitation linked to quality (e.g., via an ACO, PCMH, or COE)
- Full Capitation (e.g., via an ACO, PCMH, or COE)

3N
Episode based payments, bundled payments, ACOs, and COEs NOT linked to quality

4N
Capitated payments NOT linked to quality

For Limited Release (LAN CMS Participants and GC Members Only)
What is “MACRA”? 

The **Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)** is a bipartisan legislation signed into law on April 16, 2015.

**What does MACRA do?**

- **Repeals** the Sustainable Growth Rate (SGR) Formula
- **Changes the way that Medicare pays physicians** and establishes a new framework to reward clinicians for **value** over **volume**
- **Streamlines** the new Merit-Based Incentive Payments System (MIPS) **Provides incentives** for participation in **certain** alternative payment models (APMs)
How much can MIPS adjust payments?

The potential adjustment % will increase each year from 2019 to 2022:

- 2019: 4%
- 2020: 5%
- 2021: 7%
- 2022: 9%

Final payment to provider
MACRA moves us closer to meeting these goals...

The law also incentivizes participation in APMs, whether via the special incentive payment for Qualifying APM Participants (QPs), or favorable weighting in MIPS categories for APM participants who are not QPs.

MIPS helps to link fee-for-service payments to quality and value.

New HHS Goals:
- 2016:
  - 30% of payments linked to quality and value
  - 85% of payments linked to MIPS

- 2018:
  - 50% of payments linked to quality and value
  - 95% of payments linked to MIPS

- All Medicare fee-for-service (FFS) payments (Categories 1-4)
- Medicare FFS payments linked to quality and value (Categories 2-4)
- Medicare payments linked to quality and value via APMs (Categories 3-4)
- Incentive payments for participation in eligible APMs
Arkansas is one of six states CMS awarded model-testing grant

The CMS State Innovation Models (SIM) Initiative is providing funding to the State of Arkansas

- $42 million to implement and test the initiatives over the next 42 months
- Funding covers episode-based care delivery, patient-centered medical homes, and health homes

The State sees this grant as an indication of CMS’ engagement with the initiative and belief that it could be a model more broadly applied in the country
Medicaid and private insurers believe paying for patient results, rather than just individual patient services, is the best option to control costs and improve quality.

- Transition to system that financially rewards value and patient outcomes and encourages coordinated care.

- Reduce payment levels for all providers regardless of their quality of care or efficiency in managing costs.

- Pass growing costs on to consumers through higher premiums, deductibles and co-pays (private payers), or higher taxes (Medicaid).

- Intensify payer intervention in clinical decisions to manage use of expensive services (e.g. through prior authorizations) based on prescriptive clinical guidelines.

- Eliminate coverage of expensive services, or eligibility.
Engagement

Governor’s Office – Vision, Recruit Payers
Dept Human Services – Host Meetings, Develop Framework
Legislature – Approve Regulations
Private Insurers – Develop Internal Programs
Professional Societies – Cautious Support, Engagement
Clinical Leaders – Acceptance of Need for Change
Contractors – Outreach Activities, Data Management
The populations that we serve require care falling into three domains

**Prevention, screening, chronic care**
- Healthy, at-risk
- Chronic, e.g.,
  - CHF
  - COPD
  - Diabetes

**Acute and post-acute care**
- Acute medical, e.g.,
  - AMI
  - CHF
  - Pneumonia
- Acute procedural, e.g.,
  - CABG
  - Hip replacement

**Supportive care**
- Developmental disabilities
- Long-term care
- Severe and persistent mental illness

**Patient populations within scope (examples)**

**Care/payment models**

**Population-based:** medical homes responsible for care coordination, rewarded for quality, utilization, and savings against total cost of care.

**Episode-based:** retrospective risk sharing with one or more providers, rewarded for quality and savings relative to benchmark cost per episode.

**Combination of population-and episode-based models:** health homes responsible for care coordination; episode-based payment for supportive care services.
Provider Portal

Health Care Payment Improvement Initiative
Building a Healthier Future for all Arkansans

Provider Portal

Hospitals, Physician practices, mental health professionals and other providers can enter quality data and access their quality reports. Here you will find more information and links to the portal.

Get Email Alerts

Announcements & Events
- Calendar of Events
- Announcements
- Press Releases

Reference Materials
- Training Videos
- Guides & Materials
- Frequently Asked Questions

Want more details on changing Medicaid regulations? Click here.
EOCs Progress to Date

- Engine has processed 454.9 Million Claims
- 3.7 Million Episodes (before exclusions)
- 28,331 Reports
  - 13,834 EOC level payment or performance reports
  - 2,890 EOC level reconciliation reports
- 2,213 distinct PAPs
- PAPs received a collective gain share of $793,337
- Risk Share applied to PAPs for -$1,010,676
Outcomes/Lessons

• Learning System
  – Stretch the Providers Who ----
  – Provide Program Feedback ---
  – That Modifies Requirements/Analytics ---
  – Which Support Practice Transformation ---
  – And Starts New Cycle of Dialogue
2014

PCMH
Providers can then receive support to invest in improvements, as well as incentives to improve quality and cost of care.

### Practice support
Invest in primary care to improve quality and cost of care for all beneficiaries through:
- Care coordination
- Practice transformation

### Shared savings
Reward high quality care and cost efficiency by:
- Focusing on improving quality of care
- Incentivizing practices to effectively manage growth in costs
<table>
<thead>
<tr>
<th>Activity</th>
<th>Commit to PCMH Month 0-3</th>
<th>Start your journey Month 6</th>
<th>Evolve your processes Month 12</th>
<th>Continue to innovate Month 16-18 Month 24</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Identify office lead(s) for both care coordination and practice</td>
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<tr>
<td>transformation⁰</td>
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<tr>
<td>2 Assess operations of practice and opportunities to improve (internal</td>
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<tr>
<td>to PCMH</td>
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<tr>
<td>3 Develop strategy to implement care coordination and practice</td>
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<tr>
<td>transformation improvements</td>
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<tr>
<td>4 Identify top 10% of high-priority patients (including BH clients)²</td>
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<tr>
<td>5 Identify and address medical neighborhood barriers to coordinated care</td>
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<tr>
<td>(including BH professionals and facilities)</td>
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<tr>
<td>6 Provide 24/7 access to care</td>
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<td>7 Document approach to expanding access to same-day appointments</td>
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<tr>
<td>8 Complete a short survey related to patients' ability to receive</td>
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<tr>
<td>timely care, appointments, and information from specialists</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>(including BH specialists)</td>
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<tr>
<td>9 Document approach to contacting patients who have not received</td>
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<tr>
<td>preventive care</td>
<td></td>
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<tr>
<td>10 Document investment in healthcare technology or tools that support</td>
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<tr>
<td>practice transformation</td>
<td></td>
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<tr>
<td>11 Join SHARE to get inpatient discharge information from hospitals</td>
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<tr>
<td>12 Incorporate e-prescribing into practice workflows³</td>
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<tr>
<td>13 Integrate EHR into practice workflows</td>
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</tbody>
</table>

1 - At enrollment; 2 - Three months after the start of each performance period; 3 - At 18 months
Data 2014

• Total Costs PMPM
  – State: 314.84
  – Non PCMH 332.87
  – PCMH 303.97
  – PCMH Shared 292.29
  – PCMH nonShared 322.58
Data 2014

• Readmissions
  – State: 7.3%
  – Non PCMH: 7.6%
  – PCMH: 7.0%
  – PCMH Shared: 6.8%
  – PCMH nonShared: 7.3%
Data Points 2014

• Imaging per 100
  – State: 20.37
  – Non PCMH 26.97
  – PCMH: 16.39
  – PCMH Shared 13.52
  – PCMH non Shared 20.97
<table>
<thead>
<tr>
<th>Metro Area</th>
<th>Enrolled Count</th>
<th>Enrolled Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural</td>
<td>97</td>
<td>54.2%</td>
</tr>
<tr>
<td>Urban</td>
<td>82</td>
<td>45.8%</td>
</tr>
</tbody>
</table>

### Counties Not Enrolled

<table>
<thead>
<tr>
<th>Metro Area</th>
<th>Counties Not Enrolled</th>
<th>Counties Not Enrolled Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural</td>
<td>14</td>
<td>82.4%</td>
</tr>
<tr>
<td>Urban</td>
<td>3</td>
<td>17.6%</td>
</tr>
</tbody>
</table>
PCMH enrollment status for Q4 2015 (as of 12/1)\textsuperscript{1,2,4}

- ~142 PCMHs enrolled out of 250\textsuperscript{3} (57%)
- ~780 PCPs enrolled out of 1,074\textsuperscript{3} (73%)
- ~309K benes enrolled out of 386K\textsuperscript{3} (80%)
  - ~286K enrolled only in PCMH
  - ~23K enrolled in CPC and PCMH

\textsuperscript{1} Data pulled from PCMH Q4 reporting as of December 1, 2014; includes practices that enrolled for 1/1/15 start date in PCMH
\textsuperscript{2} Data pulled from PCMH Q4 reporting as of December 1, 2014 for PCPs enrolled in 2014, and from MMIS for PCPs new to 2015
\textsuperscript{3} Based on practices eligible for PCMH with at least 300 beneficiaries from Q3 2014 Reporting Period
\textsuperscript{4} Q1 2015 attribution algorithm has not been run at the time of creation of this report; these attribution numbers are based on Q3 & Q4 figures
Outcomes/Lessons

- Learning System
  - Stretch the Providers Who ----
  - Provide Program Feedback ---
  - That Modifies Requirements/Analytics ---
  - Which Support Practice Transformation ---
  - And Starts New Cycle of Dialogue
2016
Next steps
PCMH 2016

• EHR Data
  – BMI, Control of Blood Pressure and Diabetes
  – ONC MU Protocol
  – Submission of 2015 Data in March
    • Practice Activity Requirement
    • All Payer Data
  – Submission of 2016 Data in 2017
    • Quality Metric to Qualify for Shared Savings
HbA1c Poor Control

Proposed Target for 2016: 35%

*Inverse rate based on adequate control rate
Controlling High Blood Pressure (CBP)

Controlling High Blood Pressure

Proposed Target for 2016: 55%

- Medicare (MSSP) ACO 50th Percentile 2014 Benchmark
- Physician Quality Reporting System 2013 Mean Performance
- FQHC National Average
- HEDIS 50th Percentile 2014 Benchmark Commercial HHS Region 6
- Million Hearts HRSA UDS AR Performance Rate (2013)
- FQHC AR Average
- HEDIS 50th Percentile 2014 Benchmark Medicaid National
- Million Hearts Medicaid Regional Performance Rate (2013)
Other Quality Metrics

• Chronic Xanax
  – Short Half Life, Habituating, Reinforces Anxiety
  – 4 or More Prescribing Events a Year
  – Must be < 12% of Adult Patients

• Nonspecific URI
  – Episode of Care = 20% Reduction in Antibiotic Use
  – Must be < 65% of URI events
  – State Average Currently 35%
Distribution of Xanax

XANAX: Percent of Xanax Beneficiaries in Q1 2015 Performance Period for 2015 Enrolled PCMHs

<table>
<thead>
<tr>
<th>Quantile</th>
<th>Observed</th>
<th>Estimated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Min</td>
<td>0 %</td>
<td>0 %</td>
</tr>
<tr>
<td>50%</td>
<td>4.6%</td>
<td>5.9%</td>
</tr>
<tr>
<td>75%</td>
<td>8.2%</td>
<td>9.5%</td>
</tr>
<tr>
<td>Max</td>
<td>25.3%</td>
<td></td>
</tr>
<tr>
<td>PCMH Avg</td>
<td>6.4%</td>
<td></td>
</tr>
</tbody>
</table>

1 Q1 2015 represents performance period of April 1, 2014 – March 31, 2015
TARGETS FOR 2016

Distribution Upper Respiratory Infection (URI)\(^1\)

URI: Percent of URI Beneficiaries in Q1 2015 Performance Period for 2015 Enrolled PCMHs

<table>
<thead>
<tr>
<th>Quantile</th>
<th>Observed</th>
<th>Estimated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Min</td>
<td>7.6%</td>
<td></td>
</tr>
<tr>
<td>50%</td>
<td>42.0%</td>
<td>44.7%</td>
</tr>
<tr>
<td>75%</td>
<td>59.5%</td>
<td>58.3%</td>
</tr>
<tr>
<td>Max</td>
<td>95.5%</td>
<td></td>
</tr>
<tr>
<td>PCMH Avg</td>
<td>36.7%</td>
<td></td>
</tr>
</tbody>
</table>

Curve Normal (Mu=44.682 Sigma=20.183)

Target= 65

1 Q1 2015 represents performance period of April 1, 2014 – March 31, 2015
Which targets should be modified for the 2016 performance period?

<table>
<thead>
<tr>
<th>Metric</th>
<th>2015 target (%)</th>
<th>AR Medicaid avg ('11) (%)</th>
<th>Nat'l Medicaid avg ('11) (%)</th>
<th>4/1/14-3/31/15 PCMH avg (%)</th>
<th>Q3 PCMH performance relative to target</th>
<th>Proposed 2016 target (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADHD</td>
<td>50</td>
<td>N/A</td>
<td>N/A</td>
<td>35</td>
<td>1/33 above</td>
<td>40</td>
</tr>
<tr>
<td>Asthma</td>
<td>85</td>
<td>87</td>
<td>89</td>
<td>88</td>
<td>39/60 above</td>
<td>85</td>
</tr>
<tr>
<td>CHF</td>
<td>50</td>
<td>N/A</td>
<td>N/A</td>
<td>48</td>
<td>5/12 above</td>
<td>50</td>
</tr>
<tr>
<td>Diabetics on statin</td>
<td>45</td>
<td>N/A</td>
<td>N/A</td>
<td>39</td>
<td>7/37 above</td>
<td>45</td>
</tr>
<tr>
<td>HbA1c</td>
<td>75</td>
<td>68</td>
<td>82</td>
<td>73</td>
<td>25/37 above</td>
<td>80</td>
</tr>
<tr>
<td>Adolescent wellness</td>
<td>40</td>
<td>38</td>
<td>46</td>
<td>47</td>
<td>82/139 above</td>
<td>45</td>
</tr>
<tr>
<td>Child wellness</td>
<td>67</td>
<td>62</td>
<td>72</td>
<td>65</td>
<td>57/134 above</td>
<td>70</td>
</tr>
<tr>
<td>Infant wellness</td>
<td>67</td>
<td>72</td>
<td>87</td>
<td>71</td>
<td>47/83 above</td>
<td>70</td>
</tr>
<tr>
<td>Inpatient follow-up¹</td>
<td>40</td>
<td>N/A</td>
<td>N/A</td>
<td>36</td>
<td>56/139 above</td>
<td>40</td>
</tr>
<tr>
<td>PCP visits¹</td>
<td>75</td>
<td>N/A</td>
<td>N/A</td>
<td>78</td>
<td>88/125 above</td>
<td>80</td>
</tr>
<tr>
<td>HbA1C Poor control*</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>35²</td>
</tr>
<tr>
<td>CBP</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>55²</td>
</tr>
<tr>
<td>URI*</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>37</td>
<td>94/115 above³</td>
<td>65²</td>
</tr>
<tr>
<td>Xanax*</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>6</td>
<td>97/111 above³</td>
<td>12²</td>
</tr>
<tr>
<td>BMI</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>45</td>
</tr>
</tbody>
</table>

1 To be incorporated as a quality metric and will be tied to shared saving payments in the 2016 program year (currently as practice support metric in the 2015 program year)
2 Provided the final list of metrics on July 2, 2015 to be used for 2016 program year, which included new metrics
3 Analyzed based on the proposed 2016 target.

*Lower score indicates better quality
Hysterectomy

• 20 PAPs With at Least 20 Cases:
  – 2 Performed Vaginal Hysterectomy > 70% of Cases
  – 7 Never Performed Vaginal Hysterectomy
  – 4 Performed Supracervical Surgery > 15% of Cases
  – 7 Converted from Lap to Open > 25% of Cases
Quality Improvement

• Monitoring of Warfarin
  – Documentation of INR at Least Quarterly
Coverage Reform

• Benefit Limits: A1C, INR, Mammogram, etc
• Co-Location of Behavioral Health
FQHCs

• Cost Based Reimbursement
• Separate Incentives?
  – Imaging, ER Use, Bed Days
  – Quality Metrics
Episodes: What’s Next

• Practice Variation
  – Medicaid and Per Diem Reimbursement
    • Economic Ceiling
  – Practice Style Snapshots
    • Value to Provider
    • Value to PCMH
  – Method of Transparency?
    • Region, System, Location, Provider
More information on the Payment Improvement Initiative can be found at www.paymentinitiative.org

- Further detail on the initiative, PAP and portal
- Printable flyers for bulletin boards, staff offices, etc.
- Specific details on all episodes
- Contact information for each payer’s support staff
- All previous workgroup materials