

**Health
Care
Payment
Improvement
Initiative**

Building a healthier future for all Arkansans

Patient Centered Medical Home Town Hall

April 16th, 2013

Welcome



**Andy
Allison**

Director
Arkansas Medicaid



**Bill Golden,
MD**

Medical Director
Arkansas Department
of Human Services /
Medicaid



**Steve
Spaulding**

Vice President
Enterprise Networks,
Arkansas BlueCross
BlueShield



**Joe
Thompson,
MD, MPH**

**Surgeon General;
Director**
Arkansas Center for
Health Improvement



**Randal
Hundley,
MD**

Medical Director
Arkansas Health
Group/ Baptist Health

Contents

- **Discuss Patient centered medical homes (PCMH)
– an opportunity for more effective healthcare**
- Highlight current Arkansas PCMH experience
- Review Arkansas Payment Improvement Initiative (APII) and role of PCMH
- Discuss Medicaid's PCMH design
- Review next steps

Nationally, Patient Centered Medical Homes aim to reinvigorate primary care and achieve the triple aim

Current state



**Jim
(citizen)**

- Does not have a single provider who the system has assigned to be accountable for his care
- Has difficulty navigating a complex system



**Dr. Smith
(PCP)**

- Receives lower income than specialist peers
- Has difficulty finding a younger physician to work in practice
- Considering using EMR, but not using it currently
- Gets little information from hospitals and ER's about his patients

Future state through PCMH

Triple Aim:

Improve the health of the population



Enhance the patient experience of care



Reduce or control the cost of care



Reinvigorate primary care:

Increase in PCP's revenue and take-home pay



Improved practice processes and workflows



These aims are fully aligned with APII goals



Reward high-quality care and outcomes



Encourage clinical effectiveness



Promote early intervention and coordination to reduce complications and associated costs



Encourage referral to higher-value downstream providers

Who is pursuing PCMH?

“Currently, more than **90 health plans, dozens of employers, 42 state Medicaid programs, numerous federal agencies, hundreds of safety net clinics, and thousands of small and large clinical practices** nationwide have adopted this innovative model”

- Patient-Centered Primary Care Collaborative (PCPCC)

What is PCMH?

A team-based care delivery model led by a primary care provider who comprehensively manages a patient's health needs with an emphasis on health care value

What is PCMH?

- Care is coordinated and integrated across multi-disciplinary provider teams

A **team-based care delivery model** led by a primary care provider who comprehensively manages a patient's health needs with an emphasis on health care value

What is PCMH?

A team-based care delivery model **led by a primary care provider** who comprehensively manages a patient's health needs with an emphasis on health care value

- Patients are linked to primary care providers who lead the multi-disciplinary care teams
- While only 3-5% of health care dollars are spent on primary care services, a PCMH PCP influences nearly all of health care expenditure

What is PCMH?

A team-based care delivery model led by a primary care provider who **comprehensively manages a patient's health needs** with an emphasis on health care value

- Improved access to primary care services
- An emphasis on prevention
- Proactive management of chronic disease

What is PCMH?

Emphasis on

- quality of care
- stewardship of resources
- paying for results instead of volume of services

A team-based care delivery model led by a primary care provider who comprehensively manages a patient's health needs with an emphasis on **health care value**

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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

Patient-centered medical homes are part of a broader statewide effort

Enable and reward providers for

- Improving the **health** of the population
- Enhancing the **patient experience** of care
- Reducing or control the **cost of care**

How care is delivered

Medical homes +
Health homes



Episode-based
care delivery

Five aspects
of broader
program

Results-based payment and reporting

Health care workforce development

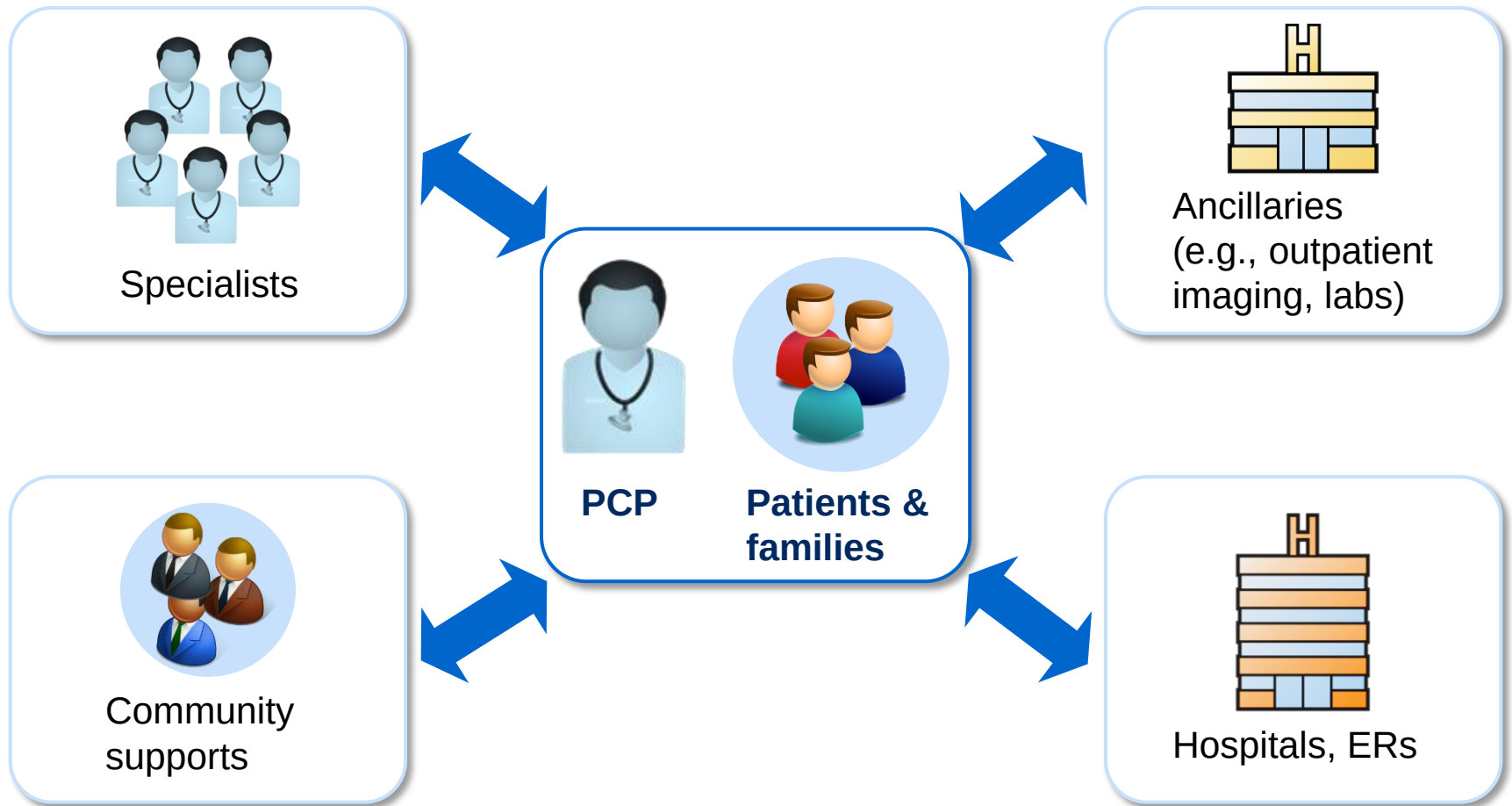
Health information technology adoption (e.g. SHARE)

Consumer engagement and personal responsibility

Expanded coverage for health care services

Why primary care and PCMH?

Most medical costs occur outside of the office of a primary care physician (PCP) , but PCPs can guide many decisions that impact those broader costs, improving cost efficiency and care quality



Several developments in Medicaid primary care payment aim to more appropriately compensate PCPs for playing this essential role

Medicaid rate bump – increase in primary care rates paid by Medicaid starting in April

Outside of PCMH

Coverage expansion – decrease in uncompensated care with increase in coverage on exchanges

Shared savings – significant upside only opportunity to share in savings from effectively patient panels' total cost of care

Inside of PCMH

Support payments for PCMH – per member per month (PMPM) payments to support investment in care coordination and practice transformation activities

Principles of patient-centered medical home design for Arkansas

Patient-centered

Focus on improving quality, patient experience and cost efficiency

Empowering

Provide support to enable clinical leadership

Balanced

Provide autonomy as well as guidance

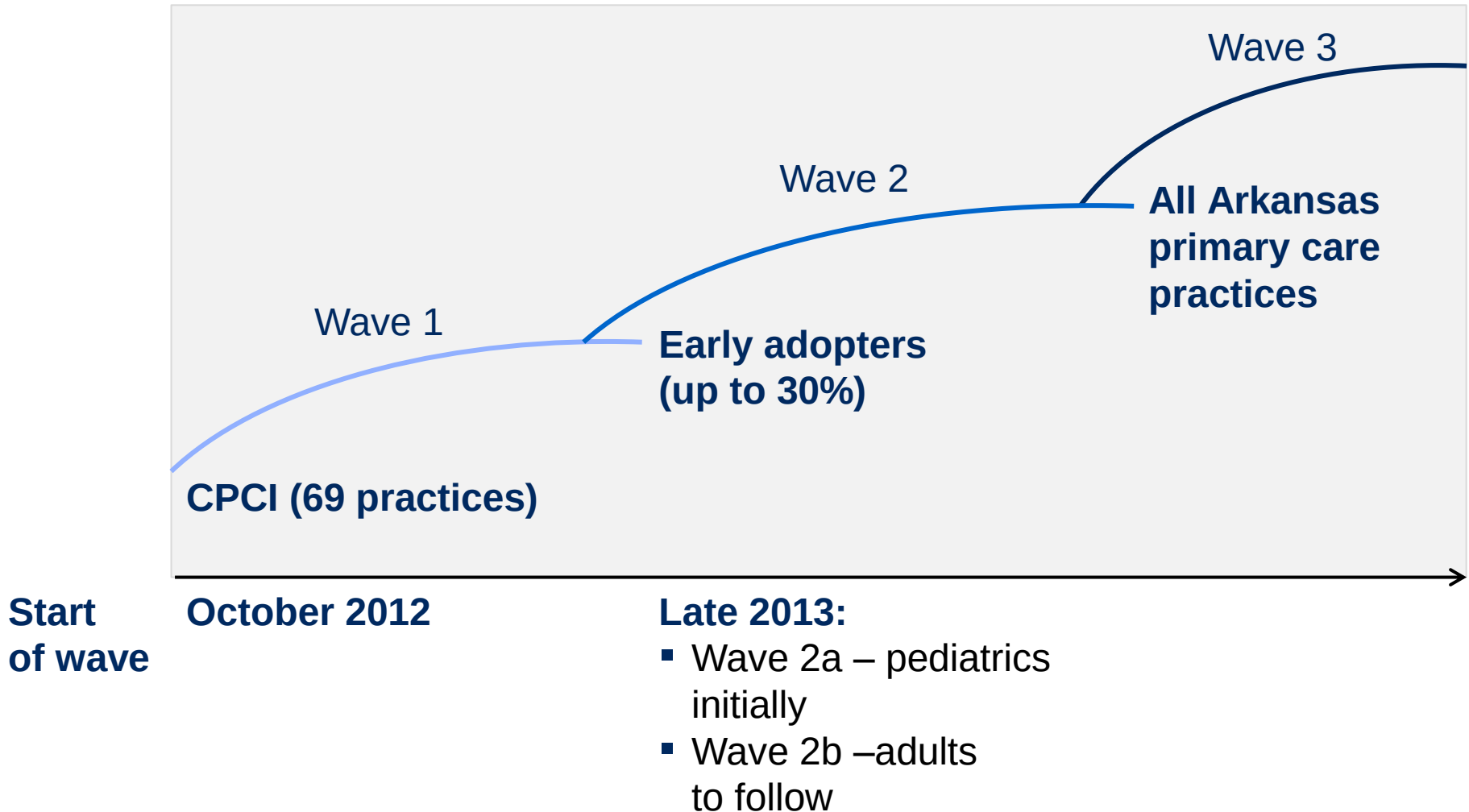
Practical

Minimize requirements and administrative burden

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Anticipated PCMH rollout



Design of PCMH Wave 2 and beyond is shaped by ongoing feedback from Arkansas providers and stakeholders (we look forward to your input)

Examples of what we've heard to date

- PCMH is a journey, requiring upfront payment support to enable transformation
- PCMH design must address practices' different starting points – “one size doesn't fit all”
- Many practices require detailed, practice-specific guidance on how to implement PCMH
- Detailed, standardized guidance may lead to “box-checking” mindset and divert attention away from triple aim
- Minimize unwarranted administrative burden
- Identifying high-risk patients requires more than claims-based information

Arkansas PCMH strategy centers on three core elements:



Support for providers

- Monthly payments to support care coordination and practice transformation
- Pre-qualified vendors that providers can contract with for
 - Care coordination support
 - Practice transformation support
- Guidelines, metrics, and data will guide practices through transformation



Incentives

- Shared savings
- Payments tied to meeting quality metrics
- No downside risk



Clinical leadership

- Physician “champions” role model change
- Practice leaders (clinical and office) support and enable improvement

Practices will receive monthly payments to support care coordination and practice transformation

Care coordination and general practice investment

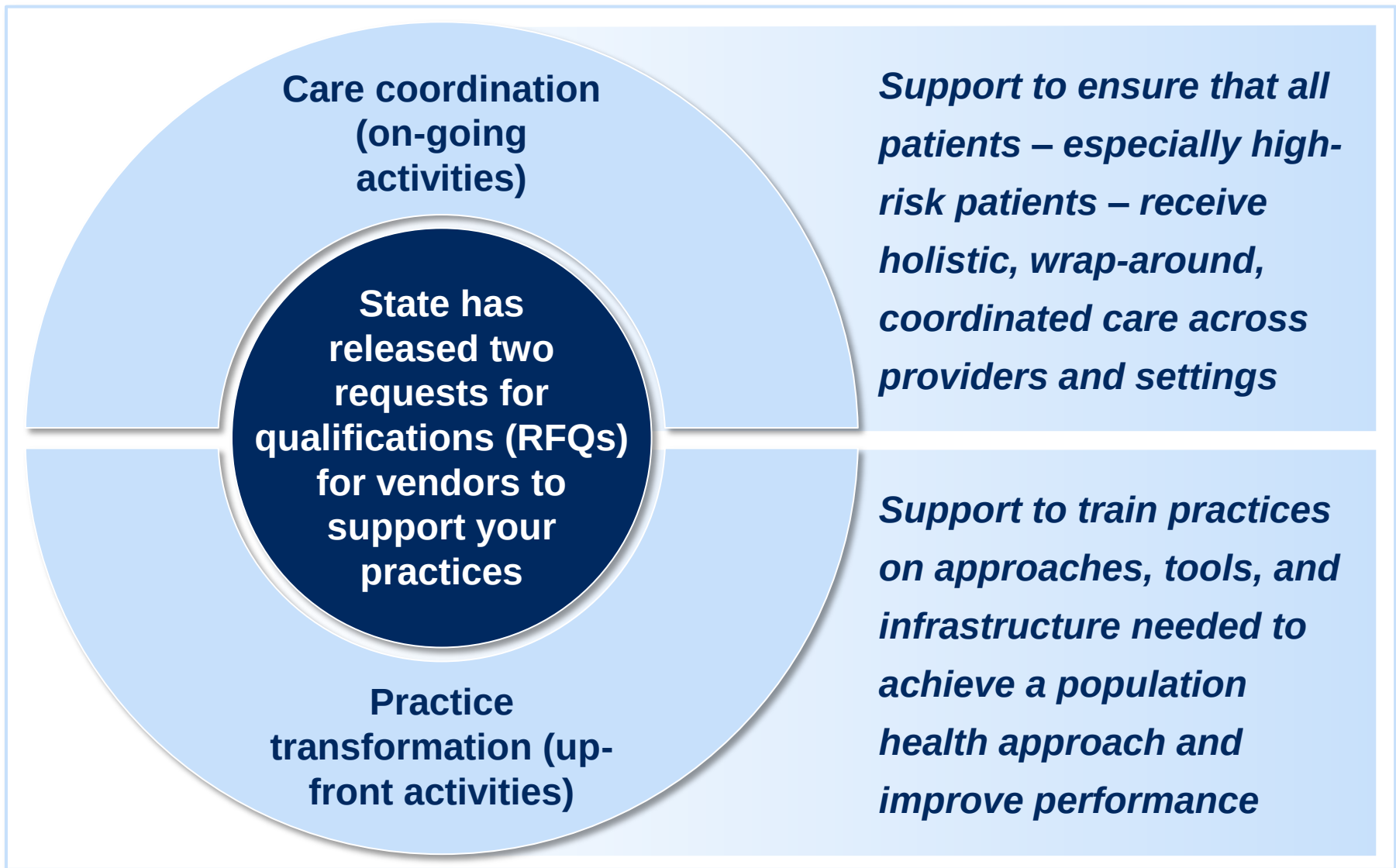
- Average of \$4 per member per month¹ (PMPM)
- Risk-adjusted
- Intended to be ongoing for successful practices

Practice transformation

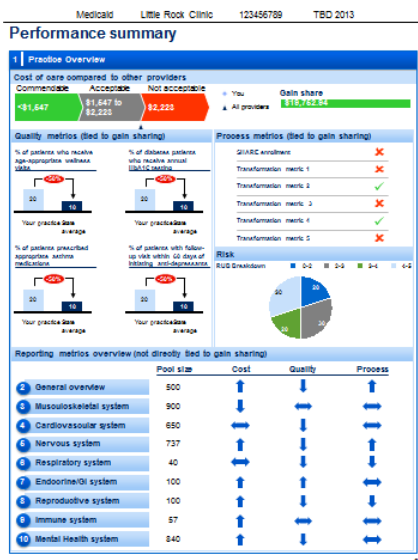
- \$1 per member per month (PMPM)
- Fixed amount per patient to support practices choosing pre-qualified transformation vendor
- Intended to catalyze transformation

A PCP with 2000 attributed patients could receive up to \$120,000 a year in support

Practices will have the option to contract with pre-qualified vendors to support care coordination and practice transformation activities



Practices will receive guidelines, metrics, and data



- **Guidelines / metrics** (e.g. % of patients with inpatient stay who were seen by a physician within 7 days of discharge) are **designed to guide practices forward without being overly prescriptive**
- **Monthly payments will be tied to these metrics and guidelines**

- **Quality, cost, and utilization data** help practices locate and address opportunities to improve as well as track progress over time



Example guidelines and metrics to enable launch of PCMH

Commit to PCMH and understand your starting point

At enrollment

- Conduct self-assessment
- Develop strategy to implement care coordination and practice transformation improvements



Start your journey

After 6 months

- Identify high-priority patients with data provided by payers and your own clinical judgment
- Identify and address barriers to care coordination in the medical neighborhood
- Expand access to care



Evolve your processes & continue to innovate

One year and beyond

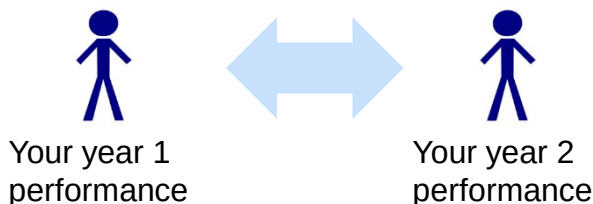
- Invest in tools and technology that support practice transformation (e.g. SHARE)
- Percentage of high-priority patients that have been seen by PCP at least twice in the past 12 months
- Percentage of patients who had an inpatient stay who were seen by a physician within 7 days of discharge

Simple, open-ended forms will help guide practices' through transformation and keep the program aware of their progress

Rewards for excellence: PCMH model has two ways for PCPs to receive upside-only shared savings

1

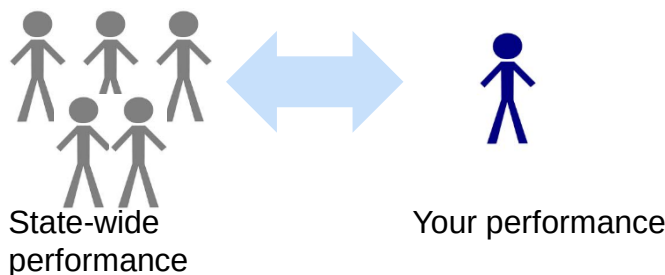
Receive shared savings based on your own performance improvement



or...

2

Receive shared savings based on being a high performer in the state



For both options:

- Quality metrics must be met for shared savings
- Costs to calculate shared savings are risk-adjusted and exclude high-cost outliers
- Practices may pool patients to meet minimum patient panel size of 5000

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Upcoming town halls

April 18

4 – 6 p.m.

Mountain Home

Arkansas State University-Mountain Home – McMullin Hall

April 22

4 – 6 p.m.

Fort Smith

Golden Living Building – Rogers Taylor Conference Room

April 25

4 – 6 p.m.

El Dorado

South Arkansas Community College – Library Auditorium

May 7

4 – 6 p.m.

Hot Springs

National Park Community College – Auditorium

May 9

4 – 6 p.m.

Bentonville

Northwest Arkansas Community College – Wal-Mart Auditorium

May 15

4 – 6 p.m.

Paragould

Arkansas Methodist Medical Center – Auditorium

For more information talk with provider support representatives...

Online

- **More information on the Payment Improvement Initiative** can be found at www.paymentinitiative.org
 - Further detail on PCMH
 - Printable flyers for bulletin boards, staff offices, etc.
 - Contact information for each payer's support staff
-

Phone and email

- **Medicaid:** 1-866-322-4696 (in-state) or 1-501-301-8311 (local and out-of state) or ARKPII@hp.com
- **Blue Cross Blue Shield:** Providers 1-800-827- 4814, direct to EBI 1-888-800-3283, APIICustomerSupport@arkbluecross.com
- **QualChoice:** 1-501-228-7111, providerrelations@qualchoice.com