ALTERNATIVE PAYMENT MODELS

NEW HAMPSHIRE DSRIP LEARNING COLLABORATIVE – NOVEMBER 1, 2017

DEDICATED TO GOVERNMENT HEALTH PROGRAMS
AGENDA

• Introductions

• State Alternative Payment Model (APM) Roadmap Presentation

• State Expert Presentations

• Break

• National Expert Presentation

• Panel Q&A Session

• Closing/Next Steps
LEARNING GOALS

• Learn about the New Hampshire (NH) APM Roadmap, including a basic introduction to the Learning & Action Network APM framework.

• Explore the Roadmap’s relevance to the NH DSRIP project, how APMs are currently used within the State, and the expectation of the transition to APMs as part of the integration progression.

• Learn about building APMs across payers and collaborators; including MCOs, public and private payers, IDNs, and their partners.
LEARNING OBJECTIVES

- Use the NH APM Roadmap as the basis for understanding APM readiness (i.e., what does ready look like, who is ready/am I ready, what can I do to get ready, what is the path forward, how do I bring along non-traditional partners).

- Recognize synergies and resource overlaps that might support participation in an APM (i.e., what internal and/or external resources can I use to get started, who are my potential partners, how can I leverage existing innovations/projects).

- Apply information from the LC to identify opportunities for aligning operational components of APMs with other practice efforts (i.e., how do I get this done with economy/efficiency, how do I create the best outcomes for my patients).
STATE APM ROADMAP PRESENTATION
JEFFREY MEYERS, JD, COMMISSIONER, NEW HAMPSHIRE DHHS

• Commissioner Meyers has recently helped oversee major initiatives such as the implementation of the bipartisan New Hampshire Health Protection Program and the development and negotiation of a federal waiver that will strengthen the capacity of the State's behavioral health system and will promote further integration of mental health and substance use disorder services with medical care across the State.

• Prior to becoming Commissioner of the Department of Health and Human Services, Commissioner Meyers was the Director of Intergovernmental Affairs, working within the Department, across the executive branch, and with legislators, federal officials and stakeholder groups to help develop and implement Department programs, strategies and services.

• Commissioner Meyers previously worked as Director of Government Relations for Granite Healthcare Network, Chief Legal Counsel to Governor John H. Lynch, Legal Counsel for the New Hampshire State Senate, and Assistant Attorney General in the Office of the New Hampshire Attorney General. He received his undergraduate degree from George Washington University and his law degree from Georgetown University Law Center.
Medicaid Alternate Payment Model Strategy

IDN Learning Collaborative
November 1, 2017
Jeffrey Meyers, Commissioner, DHHS
Strategy Summary: Goals

Ensure that by the end of the demonstration, we have moved towards a more sustainable health-outcome driven model of care in the Medicaid program, focusing on behavioral health and high need populations.

Improve upon alternative payment models with our high value providers and high need beneficiaries and develop new and innovative models to support our mental health and substance use disorder infrastructure.

Work together with the stakeholders that form the building blocks of our health care delivery system.
“This initiative will provide a short term federal investment, such that by the end of the demonstration the behavioral health infrastructure will be supported through the state's managed care delivery system using alternative payment methodologies, without the need for demonstration authority.” January 5, 2016 Letter of Approval from Andy Slavitt, Acting Administrator, CMS for NH’s DSRIP waiver.

“The Medicaid service delivery plan should address what approaches service delivery providers will use to reimburse providers to encourage practices consistent with IDN objectives and metrics, including how the state will plan and implement a goal of 50 percent of Medicaid provider payments to providers using Alternative Payment Methodologies.” STC 33
Build on what works.

Focus on our high need populations.

Leverage existing efforts across all payers moving towards population based payments.

Meet the outcome goals and metrics of the DSRIP program as they exist now and as developed based on successes over the waiver term.
The Roadmap

• A collaborative plan.

• Incorporate stakeholder engagement in considering APM options.

• Envisions a plan that allows the successes and failures of the DSRIP process to inform APM choices, taking into consideration readiness, IDN outcomes, operational feasibility, economic sustainability.

• Improves upon and develop APMs that support the state’s behavioral health infrastructure and help achieve the IDN metrics/measures.
The Roadmap Summary, cont.

• Leverages strategies used across all payers and to develop new innovative strategies that meet IDN metrics/measures.

• Relies on a population health framework for APMs.

• Plans for APMs that encourage providers to care for high need beneficiaries by achieving metrics and measures that ensure good care through sustainable payment models in the best interest of our beneficiaries and Medicaid program.

• Establishes a goal of moving at least 50% of Medicaid payments to APMs by 2020 and relying on stakeholder engagement to inform the process.

• IDN experience will help shape which APMs are implemented, and the related financial and operational components of the selected APMs.
APM Planning Process

- The state shall meet with managed care plans to review current APM models that support the state’s population health goals.
- The state shall seek input from stakeholders to develop payment methods that can help support the state’s behavioral health infrastructure needs consistent with the IDN metrics and supporting the DSRIP goals of:
  - improved behavioral health integration,
  - care coordination transitions and
  - prevention, treatment and recovery.
- APM strategies shall be flexible in order to reflect the multi-year goals of the reform plan.
IDNs and APMs

The state will reflect the impact of IDNs, IDN projects and IDN outcome measures in provider contracts and rate setting approaches by:

- Recognizing and supporting IDN investments through the state’s MCO and Medicaid service delivery contracts as a core component of long term sustainability
- Improving the ability of providers and plans to coordinate care and efficiently deliver high quality services to Medicaid beneficiaries with diagnosed or emerging behavioral health issues through comprehensive payment reform.
- Strengthening provider networks and care coordination.
The state shall develop methods to reimburse providers to encourage practices consistent with IDN objectives and metrics.

The state shall incorporate APM goals and efforts of MCOs that meet overall goals of the DSRIP waiver.

The state shall consider APMs for integrated care practices, acute and chronic bundled rates, global capitation for entire populations or special needs populations, and incentive pool methodologies that take into consideration IDN objectives/measures.
For more information on the approved Roadmap, see DSRIP Alternative Payment Models Roadmap for Year 2 and Year 3 (CY 2018)

Thank you

APM Stakeholder Group: First meeting in November

Stakeholder support: UNH policy partners

We have a team prepared to incorporate your concerns, ideas, lessons learned and strategic thinking to help move our Medicaid program to a population health based system, incorporating the goals and metrics of the IDN process to better support our behavioral health and high need care infrastructure going forward.
JO PORTER, MPH

• Ms. Porter serves as the Director for the Institute for Health Policy and Practice (IHPP). She joined the Institute in December 2007 as a project director, and served as the Deputy Director for several years, before becoming the Director in 2015. Ms. Porter also co-chairs the All-Payer Claims Database Council and serves on the Governor’s Commission for Medicaid Care Management. She is part of Academy Health’s State-University Partnership Learning Network, and is a steering committee member for that group.

• Ms. Porter brings many years of health care-related project management and program development experience to IHPP. She has private sector experience, including program management with Health Dialog, Inc., a care management firm. She also previously served as the Associate Director of the New Hampshire Health Information Center at UNH, and was the NH BRFSS state coordinator for the NH Department of Health and Human Services. Her research interests are in health data collection and dissemination, and using data to effectively improve health care quality.

• Ms. Porter earned her undergraduate degree, Summa Cum Laude, from UNH with a major in Microbiology and a minor in Health Management and Policy. She earned her Masters of Public Health with honors from Boston University, with dual concentrations in epidemiology/biostatistics and social/behavioral health.
STATE EXPERT PRESENTATIONS
JEANNE RYER, MSC, EDD

- Dr. Ryer is Director of the NH Citizens Health Initiative (NHCHI), a multi-stakeholder statewide effort to create a system of care that promotes health, assures quality and makes care affordable, effective, and accessible to all New Hampshire residents. NHCHI is a project under the NH Institute for Health Policy and Practice.

- From 2003 until 2011, Dr. Ryer was Program Director at the Endowment for Health, New Hampshire’s statewide health foundation, where she managed a portfolio of grants, projects, and policy initiatives addressing economic and geographic barriers to health. Her work focused on state and federal health system reforms, safety net health services, and community transportation. She led efforts to develop and implement a Mission Related Investment strategy to create the Safety Net Loan Fund, a working capital loan fund for safety net primary care, mental health, and oral health clinics.

- Before joining the Endowment, Dr. Ryer served as Senior Program Officer for the New Hampshire Charitable Foundation, lead staff for the Lakes Region Charitable Foundation, and principal of a consulting firm specializing in community health and human services planning and primary health care access. Earlier in her career Dr. Ryer worked in direct service, patient education, and program administration in community health programs.
Alternative Payment Models in NH: A Brief History of Initiative-Led Efforts

Jeanne Ryer, MSc, EdD
NH Citizens Health Initiative

- 4 Core Projects that span healthcare initiatives across New Hampshire
  - PTN: 839 Clinicians, 168 PTN Practices total
  - BHI: 225 Participants, 14 PI Practices
  - PIP: 14 PIP Practices, 3 Funded Projects
  - RHC: 3 RHC Practices
- 3 Advisory Boards/ 1 Workgroup
- 26 Reporting ACLN Practices
- Supporting 5+ State and National Funders
Year 3: *Using Data to Drive ACTION*

Opening Session: Wednesday, November 8, 2017 from 8:30-12:00 @ UNH Law

*Understanding the Current State: Moving Beyond Screening to Tracking Remission and Reduction of Depression*

Guest Speaker: Anna D. Ratzliff, MD, PhD, University of Washington AIMS Center and CMS Transforming Clinical Practice Initiative National Faculty

*CME/CNE Available*

[Registration]
Current Projects

Northern NE Practice Transformation Network
- Partnership with Maine Quality Counts, Vermont Program for Quality in Health Care
- NH partner: North Country Health Consortium
- Primary Care, Behavioral Health and Specialty Clinicians
- Practice facilitation
- Clinical and claims data
- Preparing for Value-Based payment, MIPS, QPP

- Payers, providers and other stakeholders
- Clinical and claims data driven
- Payment models for Depression, SUD, Anxiety
- SBIRT payment discussions

New Projects:
- Northern NE Project ECHO with MQC & VPQHC
- UNH CHHS HRSA Workforce Grant
And More....

**NH Rural Health Clinic Technical Assistance Network**
- With JSI/Community Health Institute
- Three participating qualified rural health clinics
- Focusing on Diabetes management, previous focus on hypertension control

**IDN Partners**
- Site Self-Assessments
- Practice and project facilitation
- With IHPP Health Law & Policy: 42 CFR Part 2 Technical Assistance

**NH Pediatric Improvement Partnership**
- Developmental Screening
- Oral Health
- Adolescent Well Care
- ADHD and more
Finding a Path:
Initiative Adventures in APMs
Initiative APM Timeline

- **2006-2008** Pay for Performance Project
- **2008-2011** Commercial Medical Home Pilot
- **2010-2011** ACO Pilot
- **2012-Present** ACO Project (now Accountable Care Learning Network)
- **2015-Present** Behavioral Health Integration Learning Collaborative
- **2015-Present** Northern NE Practice Transformation Network
Pay for Performance (P4P)

- Identified P4P measures for commercial payers and Medicare
- Commercial payers agreed on 4 common metrics
NH Commercial Medical Home Pilot

- **Structure**
  - 4 commercial Payers, 9 primary care sites
  - Claims and clinical data measures
  - Individual contracting for PMPM for PCMH tiered by NCQA level (range was $4-$6 PMPM)
  - All sites reached NCQA Level 3 by end of Year 1

- **Rapid spread of PCMH in NH subsequently**

- **Anthem/Wellpoint adoption in EPC/PC model**
Mixed results for pilot*

- No significant difference in cost/utilization EXCEPT higher specialty care utilization
- Higher Medical Home Index Scores ==
  - Lower ED visit rates
  - Lower ED ambulatory care sensitive visits
  - Lower readmissions
  - Higher hospital admissions
  - Better performance on several diabetes quality measures
- Follow-up Medicare Medical Home Demonstration project participation not possible for NH
- CPC and CPC+ were not adopted in NH

*Flieger 2014
ACO Pilot

Structure
- 4 commercial payers, 5 health systems
- Clinician Committee guided clinical and claims measures
- Developed upside only and upside/downside risk models
- Stalled at payer adoption
Accountable Care Project

Daughter of ACO Pilot
Now the Accountable Care Learning Network

Structure

- Multi-stakeholder group
- Clinical and claims measures and reporting
- “Shared Data = Shared Learning”
- Data drives projects
- SAS Visual Analytics claims reports
NNE Practice Transformation Network

- Funded by CMS CMMI Transforming Clinical Practice Initiative
- More than 1000 NH Clinicians in 183 Practices have participated
- Uses Quality Improvement/Change Management principles to get practices ready for MIPS, QPP, and APMs
  - On-site practice facilitation
  - Clinical and claims data
  - MIPS reporting
  - Clinical leadership development
  - Education
- 95% of NH practices submitted clinical measure for 2017
Behavioral Health Integration Learning Collaborative

- Providers, public and private payers, other stakeholders participate in PRACTICE and PAYMENT transformation
- Focus on integration of behavioral health into primary care, but includes primary care integration into behavioral health
- Combines didactic content, change strategies, application, clinical and claims data
- Exploration of sustainable payment challenges and development of payment model templates
- First two years included practice facilitation for implementation projects
- 60+ organizations, all major payers, 14 practices in implementation activities
Behavioral Health Learning Collaborative

Current State: Substance Use + SBIRT* Payment

Major Carrier #1: 44 NH SBIRT billings/year

Major Carrier #2: 75 NH SBIRT billings/year

*Screening, Brief Intervention, Referral to Treatment

Source: Center for Excellence, JSI/Community Health Institute, [http://www.sbirtnh.org/](http://www.sbirtnh.org/)

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**NH Health Protection Program Substance Use Disorder Service Benefit (only for NH HPP beneficiaries NOT traditional Medicaid)**

<table>
<thead>
<tr>
<th>Description</th>
<th>Code</th>
<th>Charge</th>
</tr>
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<tbody>
<tr>
<td>Screening</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Screening by Behavioral Health practitioners</td>
<td>H0049</td>
<td>$65.01</td>
</tr>
<tr>
<td>S•BI•RT 15-30 minutes</td>
<td>99408</td>
<td>$37.33</td>
</tr>
<tr>
<td>S•BI•RT &gt;30 minutes</td>
<td>99409</td>
<td>$71.64</td>
</tr>
<tr>
<td>Individual Counseling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30 minutes</td>
<td>U1</td>
<td>$65.01</td>
</tr>
<tr>
<td>45 minutes</td>
<td>U2</td>
<td>$86.18</td>
</tr>
<tr>
<td>60 minutes</td>
<td>U3</td>
<td>$112.96</td>
</tr>
<tr>
<td>Family Counseling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Without patient present</td>
<td>H0047-HS</td>
<td>$104.58</td>
</tr>
<tr>
<td>With patient present</td>
<td>H0047-HR</td>
<td>$107.79</td>
</tr>
<tr>
<td>Group Counseling</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>H0005</td>
<td>$26.59</td>
</tr>
</tbody>
</table>

**Additional Notes:**
- Code G0442 is an annual benefit so at least 11 months must pass between services.
- Both screening and counseling services have time elements of 15 minutes, so documentation should include duration of visit as well as screening or counseling notes.
- Counseling for alcohol misuse must be based on the Five As (Assess, Advise, Agree, Assist, and Arrange), so be sure your documentation reflects this.
- The alcohol screening and counseling services are payable with another visit on the same day (e.g., office visit for other problems), except for the initial Preventive Physical Exam (“Welcome to Medicare” physical).
- Medicare allows payment for both G0442 and G0443 on the same date (except in rural health clinics and FQHCs), but will not pay for more than one G0443 service on the same date.
- These services are not subject to deductible or co-insurance.
# Behavioral Health Learning Collaborative

## Table 2. Depression/ Anxiety and Co-Morbid Chronic Illness

<table>
<thead>
<tr>
<th>Condition</th>
<th>PM/PM</th>
<th>Cost</th>
<th>%</th>
<th>PM/PM</th>
<th>Cost</th>
<th>%</th>
<th>PM/PM</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Chronic or BH Condition</td>
<td>$202</td>
<td>$241</td>
<td>169</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression w/ Co-Morbidity**</td>
<td>41,632</td>
<td>$492</td>
<td>6,211</td>
<td>$631</td>
<td>5,157</td>
<td>$491</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression w/ Co-Morbidity**</td>
<td>25,729</td>
<td>$1,001</td>
<td>30%</td>
<td>2,411</td>
<td>$839</td>
<td>40%</td>
<td>25,735</td>
<td>$1,286</td>
</tr>
<tr>
<td>Mood Disorder Depressed - All</td>
<td>67,361</td>
<td>$887</td>
<td>10,422</td>
<td>$686</td>
<td>30,952</td>
<td>$1,199</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety w/ Co-Morbidity**</td>
<td>32,470</td>
<td>$391</td>
<td>3,959</td>
<td>$502</td>
<td>2,357</td>
<td>$478</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety w/ Co-Morbidity**</td>
<td>16,564</td>
<td>$818</td>
<td>34%</td>
<td>1,988</td>
<td>$694</td>
<td>43%</td>
<td>12,402</td>
<td>$1,641</td>
</tr>
<tr>
<td>Mood Disorder Anxiety - All</td>
<td>40,064</td>
<td>$536</td>
<td>5,947</td>
<td>$686</td>
<td>14,759</td>
<td>$961</td>
<td></td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Condition</th>
<th>PM/PM</th>
<th>Cost</th>
<th>%</th>
<th>PM/PM</th>
<th>Cost</th>
<th>%</th>
<th>PM/PM</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Members with Depression/Axiety</td>
<td>116,425</td>
<td>$16,39</td>
<td>45,711</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total members with Depression/Axiety, Commercial, Medicaid, Medicare: 176,595</td>
<td></td>
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<td></td>
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<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

Lessons Learned

Challenges

- Too much data and not enough data
- Too many measures and not the right ones
- Not enough resources (financial and human capital) to get data, understand data, act on data
- Bandwidth
- Risk tolerance, depth of financial resources and transitional funding
- Pool size

Gaps

- Take-up of patient experience surveys and data
- Meaningful measurement of patient engagement
- SDOH measurement
- Shared measurement and accountability

Recommendations

- ALIGN, ALIGN, ALIGN!
- Level the field for all players
- Include SDOH drivers and services
- Parsimony of measurement
- Engage public, patients in APM design
- Fund measurement of patient experience
- Share your data. Don't be afraid!
- Public quality reporting
ROLAND LAMY, JR, MBA

• Mr. Lamy is currently a Principal with Helms & Company, LLC Healthcare Consulting and Management; however, he has held a variety of leadership positions in the healthcare industry including sales management, underwriting, employee benefit and rate development, hospital and physician negotiations and contracting, and government programs.

• At Helms & Company, Mr. Lamy provides clients with expertise in health care provider strategic retreats and initiatives, provider contract negotiations, hospital labor benchmarking and operational assessments, physician practice management, physician practice evaluations, payer strategies on new technology and new clinical programs, and evaluation of commercial insurance options for employers and government agencies.

• Mr. Lamy is the Executive Director of the NH Community Behavioral Health Association, the association for the state’s ten designated community mental health centers. During New Hampshire’s transition to the Medicaid Care Management program, Mr. Lamy worked to create and establish a new payment model with the Managed Care Organizations, transforming the payment system toward a new model designed to create predictability of costs and revenue and incentivize quality and efficiency.
A Perspective on APM Readiness: The NH Community Behavioral Health Association

Prepared by:
Roland Lamy
Executive Director
NH Community Behavioral Health Association

**Agenda**

1. Introduction – NHCBHA
2. CMHC payment model – “cliff notes”
3. Preparedness for payment reform
4. Challenges and opportunities
5. Where should you start in APM design?
NH Community Behavioral Health Association

1. **NHCBHA – Who are we?**

- All 10 Community Mental Health Centers
- Formed in 2001
- Administrative and Government relations components
- Project management, data analytics and business development
Where we are

Northern Human Services
1. Berlin
2. Conway
3. Wolfeboro
4. Colebrook
5. Groveton
6. Littleton
7. Woodsville
8. Lincoln
9. Lancaster

West Central Behavioral Health
1. Lebanon
2. Claremont
3. Newport

Genesis Behavioral Health
1. Laconia
2. Plymouth

Riverbend Community Mental Health Center
1. Concord
2. Franklin
3. Penacook
4. Boscawen

Monadnock Family Services
1. Keene
2. Winchester
3. Jaffrey
4. Peterborough
5. Walpole
6. Antrim

Community Council of Nashua, NH
1. Nashua

Mental Health Center of Greater Manchester
1. Manchester

Seacoast Mental Health Center
1. Portsmouth
2. Exeter

Community Partners
1. Dover
2. Rochester

Center for Life Management
1. Derry
What Counts as an Alternative Payment Model?

New Hampshire Approach – Likely Categories 3 and 4

Figure 1. APM Framework (At-A-Glance)

Category 1
Fee for Service – No Link to Quality & Value

Category 2
Fee for Service – Link to Quality & Value

Category 3
APMs Built on Fee-for-Service Architecture

Category 4
Population-Based Payment

- A: Foundational Payments for Infrastructure & Operations
- B: Pay for Reporting
- C: Rewards for Performance
- D: Rewards and Penalties for Performance

- A: APMs with Upside Gainsharing
- B: APMs with Upside Gainsharing/Downside Risk

- A: Condition-Specific Population-Based Payment
- B: Comprehensive Population-Based Payment

Deb Fournier, September 2017 NHHA Annual Meeting
### Discussion Point 2: What Counts As a Value-Based Payment? (cont.)

#### New York Approach

<table>
<thead>
<tr>
<th>Options</th>
<th>Level 0 VBP</th>
<th>Level 1 VBP</th>
<th>Level 2 VBP</th>
<th>Level 3 VBP</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Care for General Population</strong></td>
<td>FFS with bonus and/or withhold based on quality scores</td>
<td>FFS with upside only shared savings when quality scores are sufficient</td>
<td>FFS with risk sharing (upside available when outcome scores are sufficient; downside is reduced or eliminated when quality scores are high)</td>
<td>Global capitation (with quality-based component)</td>
</tr>
<tr>
<td><strong>Integrated Primary Care</strong></td>
<td>FFS (plus PMPM subsidy) with bonus and/or withhold based on quality scores</td>
<td>FFS (plus PMPM subsidy) with upside only shared savings based on total cost of care (savings available when quality scores are sufficient)</td>
<td>FFS (plus PMPM subsidy) with risk sharing based on total cost of care (upside available when outcome scores are sufficient; downside is reduced or eliminated when quality scores are high)</td>
<td>PMPM capitated payment for primary care services (with quality-based component)</td>
</tr>
<tr>
<td><strong>Bundles</strong></td>
<td>FFS with bonus and/or withhold based on quality scores</td>
<td>FFS with upside-only shared savings based on bundle of care (savings available when quality scores are sufficient)</td>
<td>FFS with risk sharing based on bundle of care (upside available when outcome scores are sufficient; downside is reduced or eliminated when quality scores are high)</td>
<td>Prospective bundled payment (with quality-based component)</td>
</tr>
<tr>
<td><strong>Total Care for Subpopulation</strong></td>
<td>FFS with bonus and/or withhold based on quality scores</td>
<td>FFS with upside-only shared savings based on subpopulation capitation (savings available when quality scores are sufficient)</td>
<td>FFS with risk sharing based on subpopulation capitation (upside available when outcome scores are sufficient; downside is reduced or eliminated when quality scores are high)</td>
<td>PMPM capitated payment for Total Care for Subpopulation (with quality-based component)</td>
</tr>
</tbody>
</table>

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**Revised Roadmap specifies new criteria for Level 1 and Level 2 Arrangements:**

- To count as Level 1, MCOs must allocate at minimum 40% of potential savings to high-scoring providers.
- To count as Level 2, MCOs must allocate at least 20% of losses (3-5% of the target budget) to low-scoring providers.
CMHC Payment Model – “cliff notes”

- Capitated payment based on 4 clinical eligibility categories:
  - Severely Persistently Mentally ill – SPMI
  - Severely Mentally ill – SMI
  - Severely Emotionally Disturbed – SED
  - Low Utilizer – LU

- Prospective monthly payment
- Quality incentive program for performance against agreed upon metrics
2 CMHC Payment Model – “cliff notes”

- Rates negotiated annually as a function of the “State Rate Book”.
- Maintenance of Effort (MOE) key component for payer and provider – essentially measures performance to a “baseline”.
- Shadow billing necessary to measure performance.
Preparedness – Are you ready for an APM?

- Do you have credible historical data to understand your payment history?
- Is patient attribution clear and common agreement among payer and provider on patient definition?
- Is there a large enough population where an APM makes sense?
- Are the services in your APM well defined and codified?
Preparedness – Are you ready for an APM?

- Does the model include common agreement from payer and provider with respect to quality metrics or quality outcomes?
- As a provider have you defined what you expect as “success” for an APM?
- Can you collect credible data to validate the APM, and is the data electronically available?
- If multiple provider partners are in the same APM, can you establish clinical consistency?
4 Challenges and Opportunities

- Aligning MCO/Payer business functions with provider business functions, try to avoid manual effort whenever possible.
- Creating business functionality that supports the APM; patient definitions, services covered, reimbursement for services outside the APM, etc.
- MCO/Payer consistency in talent – creating a broad understanding of the APM, shifting the culture.
Challenges and Opportunities

- Defining quality and improving patient outcomes, start with items that are small and meaningful and expand over time with supported data from a common source.

- Back office functions; APMs can sometimes challenge traditional back office functions, simple issues like revenue cycle management, posting cash to patient accounts, coordination of benefits can be turned inside out by APMs.
4 Challenges and Opportunities

- Sustainability of the APM can be tricky; APMs for public sector business are NOT solely a provider-payer negotiation. State and Federal policies, revenue streams and budgeting play a key role.

- Documenting the intent of the APM and relationship among the parties – no contract language is perfect but you must continuously improve on documentation supporting the APM.
Where should you start?

- Define the patient base you are serving very specifically, are they a certain Dx, eligibility category, how many, what data exists on that defined population, etc.
- Determine the services you seek to include in an APM.
- Define the outcome you are trying to achieve.
- Create a value proposition for the payer partner.
- Determine what basic business functions are required to support the model.
APM a Matter of Readiness

Are you ready to be a learner-leader?

E.D. Shanshala II, MSHSA, MSEd

CEO Ammonoosuc Community Health Services, Inc.,
Founding Board Director North Country ACO
Founding Board Director NH Rural ACO
Founding Board Director North Country CCO, LLC

Ed.Shanshala@ACHS-Inc.Org
E.D. SHANSHALA II, MSHSA, MSEd

- Mr. Shanshala is the CEO of Ammonoosuc Community Health Services, Inc. (ACHS) a Federally Qualified Health Center in the rural White Mountains of northern New Hampshire. In addition to his role as CEO he is a past president and board director of Bi-State Primary Care Association, board director and president of the North Country Health Consortium, board trustee of Littleton Regional Healthcare, a founding board director of North Country Rural Accountable Care Organization, NH Rural Accountable Care Organization, and the North Country Community Care Organization.

- Through his leadership as the ACHS CEO, ACHS has demonstrated innovation with being one of the first Patient Centered Medical Homes in NH, being a participant in a medical / legal partnership with George Washington University, a patient safety organization pilot project with ECRI / HRSA, a dental and oral health workforce development site with the University of New England / HRSA, and a HRSA patient safety clinical pharmacy (PSPC) collaborator.

- Mr. Shanshala has undergraduate degrees in chemistry and biotechnology from RIT, a MSEd from the U of R, and an MSHSA from RIT.
Leadership

“Never doubt that a small, group of thoughtful, committed citizens can change the world. Indeed, it is the only thing that ever has.”

– Margaret Mead
Questions to Run on..

1. What are characteristics of deemed to be “ready” to participate in any APM?
2. What steps have you taken to align operations or projects for practices?
3. Which types seem to be the most productive in the NH healthcare environment?
4. Are APMs for everybody?
5. What factors prevent widespread adoption of APMs, especially in the NH market?
6. What are key issues to be addressed when negotiating value-based contracts?
7. What have been the best options for engaging MCOs in value-based purchasing?
8. What you can do next?
9. How can the various partners in attendance today begin to engage in the process?
10. What are the opportunities for those partners with Medicare APM?
Questions to Run on..

1. What are characteristics of deemed to be “ready” to participate in any APM?
   - Purpose, People, Process, Performance
Questions to Run on...

2. What steps have you taken to align operations or projects for practices?

- NH Citizens Health Initiative Patient Centered Medical Home Pilot Project 2009
- North Country Accountable Care Organization 2012-2015
- New Hampshire Rural Accountable Care Organization 2016-2018
- North Country Community Care Organization, LLC 2016
3. Which types seem to be the most productive in the NH healthcare environment?

Questions to Run on..

4. Are APMs for everybody?
Questions to Run on..

5. What factors prevent widespread adoption of APMs, especially in the NH market?

– Mindset between a zero sum winners/losers paradigm and win-win optimize synergy paradigm
– Engagement of New Hampshire Residents from the demand side of healthcare economics.
– Too many tails wagging too many dogs. Lack of consensus amongst all payers regarding design, testing, and implementation of the best minimalistic APM so providers have one set of rules of engagement.
Questions to Run on..

6. What are key issues to be addressed when negotiating value-based contracts?
Questions to Run on..

7. What have been the best options for engaging MCOs in value-based purchasing?
Questions to Run on..

8. What you can do next?
9. How can the various partners in attendance today begin to engage in the process?
10. What are the opportunities for those partners with Medicare APM?
Requests and Offers

“In times of change, learners inherit the Earth, while the learned find themselves beautifully equipped to deal with a world that no longer exists.”
– Eric Hoffer

Request: “Become the learner-leader to create a new reality”
Offer: “Don’t stay ‘stuck’, contact me; we will get ‘unstuck’”

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BREAK
NATIONAL EXPERT PRESENTATION
Mr. Motley is Assistant Director of Health Policy at the Arkansas Center for Health Improvement, a non-partisan health policy organization that serves as a catalyst to improve the health of Arkansans.

Mr. Motley has led numerous projects and has been involved in designing, implementing and evaluating components of Arkansas’s Health Care Payment Improvement Initiative in support of private and public payers in the state. He also works with the State and Public School Employee plans to conduct policy and analysis projects aimed at improving quality of care and controlling plan costs.

His current work is focused on designing and implementing an enhanced payment model for population based health care in Arkansas, inclusive of coordinating stakeholder engagement activities across public and private entities. Through these efforts he has actively educated and recruited additional payers, primarily self-insured employers, into the patient-centered medical home models in Arkansas. Additionally, he serves as project leader in collaboration with the Arkansas Department of Human Services and the Center for Medicaid and Medicare Innovation to conduct an evaluation of the state’s payment improvement efforts.

Mr. Motley holds a Master of Public Health degree from the University of Georgia, College of Public Health.
Arkansas Health Care Payment Improvement Initiative

Michael Motley, MPH
Assistant Director, Health Policy

New Hampshire DSRIP Learning Collaborative

November 1, 2017
Arkansas Landscape

- Consistently ranked at bottom 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 have 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
Arkansas Health Care Payment Improvement Initiative (AHCPPII)

- Reward high quality care and outcomes
- Ensure clinical effectiveness
- Promote early intervention and coordination to reduce complications and associated costs
- Encourage referral to higher-value downstream providers
Arkansas System Transformation Strategy

- Workforce
- Payment System
- Insurance Coverage
- Population Health
- Health IT
- Transparency
National Framework for Alternative Payment Models (APM)

**Category 1**
Fee for Service – No Link to Quality & Value

**Category 2**
Fee for Service – Link to Quality & Value
- A Foundational Payments for Infrastructure & Operations
- B Pay for Reporting
- C Rewards for Performance
- D Rewards and Penalties for Performance

**Category 3**
APMs Built on Fee-for-Service Architecture
- A APMs with Upside Gainsharing
- B APMs with Upside Gainsharing/Downside Risk

**Category 4**
Population-Based Payment
- A Condition-Specific Population-Based Payment
- B Comprehensive Population-Based Payment
National Goal for Alternative Payment Models (APM)

2016
30%
At least 30% of U.S. health care payments are linked to quality and value through APMs

2018
50%
At least 50% of U.S. health care payments are so linked
What is a Patient Centered Medical Home (PCMH)?

• Not a physical building, and extends beyond the walls of a practice

• Arkansas Medicaid characterizes it as:

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

• Concept introduced in 1967 by American Academy of Pediatrics with a focus on children and youth with special needs
Arkansas Payment Improvement Initiative’s Integrated Model
Why primary care and PCMH?

- Puts primary care providers back in charge
- Allows for better patient management
- Provides opportunity for higher earnings
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 Patient-Centered Medical Home

Key Attributes

• Evidence-informed preventive care; focus on improved wellness, chronic disease management
• 24/7 access for all individuals / networked EMRs
• Responsibility for entire patient panel; Coordinated integrated care across multidisciplinary provider teams
• Referrals to high-value providers (e.g. specialists)

Financial Incentives

• Monthly fees support care coordination and transformation
• **Upside-only** shared savings model rewards providers for controlling costs while maintaining or improving quality
## PCMH Framework for Transformation

<table>
<thead>
<tr>
<th>Activity</th>
<th>3 MO</th>
<th>6 MO</th>
<th>12 MO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify top 10% high-priority patients</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assess operations of practice and opportunities to improve</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Develop implementation strategy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identify and address medical neighborhood barriers to coordinated care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provide 24/7 access to care (live voice)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Document approach to expanding access to same-day appts</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Establish process for preventive care contact</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complete patient ability survey</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Document investment in health care tech/tools</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Join SHARE or a Regional information exchange</td>
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<td></td>
</tr>
<tr>
<td>Incorporate e-prescribing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Integrate EHR</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ability to extract data from EHR</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Completion of activity and timing of reporting
# Quality metrics tracked for shared savings

<table>
<thead>
<tr>
<th>Metric</th>
<th>2016 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pediatric patients who receive age-appropriate wellness visits</strong></td>
<td></td>
</tr>
<tr>
<td>• 0-15 months (at least 4 wellness visits)</td>
<td>&gt;70%</td>
</tr>
<tr>
<td>• 3 - 6 years (1 or more well-child visits)</td>
<td>&gt;67%</td>
</tr>
<tr>
<td>• 12-21 years (1 or more well-care visits)</td>
<td>&gt;50%</td>
</tr>
<tr>
<td><strong>Diabetes patients</strong> who:</td>
<td></td>
</tr>
<tr>
<td>• receive annual HbA1C testing</td>
<td>&gt;78%</td>
</tr>
<tr>
<td>• are on statin medication</td>
<td>&gt;45%</td>
</tr>
<tr>
<td>• with HbA1C level greater than 9%, missing result, or test not done</td>
<td>&lt;35%</td>
</tr>
<tr>
<td><strong>Patients prescribed appropriate asthma medications</strong></td>
<td>&gt;85%</td>
</tr>
<tr>
<td><strong>CHF patients on beta blockers</strong></td>
<td>&gt;49%</td>
</tr>
<tr>
<td><strong>High priority patients seen by PCP at least twice/12 mo</strong></td>
<td>&gt;76%</td>
</tr>
<tr>
<td><strong>Patients with acute inpatient hospital stays seen by PCP within 10 days of discharge</strong></td>
<td>&gt;40%</td>
</tr>
<tr>
<td><strong>Patients prescribed ADHD meds by PCP who receive follow-up care</strong></td>
<td>&gt;36%</td>
</tr>
<tr>
<td><strong>Patients with diagnosis of non-specified URI w/ antibiotic treatment</strong></td>
<td>&lt;65%</td>
</tr>
<tr>
<td><strong>Patients with hypertension whose blood pressure is controlled</strong></td>
<td>&gt;55%</td>
</tr>
<tr>
<td><strong>Patients 3-17 yrs old who had outpatient visit with documented BMI</strong></td>
<td>&gt;45%</td>
</tr>
<tr>
<td><strong>Patients &gt;18 yrs old prescribed chronic Alprazolam (Xanax)</strong></td>
<td>&lt;12%</td>
</tr>
</tbody>
</table>
With PCMH, existing fee-for-service reimbursement remains the same...

Patients and providers deliver care as today

- Patients seek care and select providers as they do today
- Providers submit claims as they do today
- Payers reimburse for all services as they do today
... But PCPs can also receive shared savings payments

For a shared savings entity (PCMH or group of voluntarily affiliated PCMHs)

Providers must perform on quality metrics
- Must meet ¾ of targets for quality metrics
- And providers must remain in good standing for practice support payments

Payers calculate average yearly cost per member for each shared savings entity

Average costs are compared to
- Pre-set “medium” and “high” cost levels
- Benchmark costs, based on historical costs projected forward

Results
PCMH can earn shared savings payment in one of two ways (receive greater of the two):
- Beating its own benchmark cost
- Beating a system-wide medium cost threshold

If the PCMH is not eligible for either payment, then the provider sees no change in reimbursement.
Significant Input from Providers and Patients

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

- **20+** Public workgroup meetings connected to 6–8 sites across the state through videoconference
  - **17** 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)
PCMHs receive quarterly reports to help measure and improve patient care

Reports provide performance information for PCMHs panel:

- Overview of **quality** across a PCMH attributed patients
- Overview of **cost effectiveness** (how a PCMH is doing relative to cost thresholds and relative to other providers)
- Overview of **utilization** and drivers of a PCMH average cost
Medical Home: Rollout Timeline

Multi-payer PCMH Coverage Strategy

Wave 1
Comprehensive Primary Care Initiative (CPC)
69 Practices

Start of wave:
October 2012

Wave 2
123 Practices

January 2014

Wave 3
135 Practices

January 2015

Wave 4
178 practices

January 2016

Wave 5
192 Practices with 182 enrolled in new CPC+ Initiative

January 2017
Patient-Centered Medical Home Enrollment Highlights

- Approximately 900 primary care providers enrolled
- 340K Medicaid beneficiaries (83%) now served in value-based payment strategy
- 313K Commercial Carrier beneficiaries enrolled
- 67K Self-Insured Employer beneficiaries enrolled
Medicaid: Reductions in Hospitalizations and ER Visits Indicate Improved Quality and Cost

Hospitalizations per 1,000 Beneficiaries

<table>
<thead>
<tr>
<th>CY2014</th>
<th>CY2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>80.1</td>
<td>66.9</td>
</tr>
</tbody>
</table>

-16.5%

Emergency Room Visits per 1,000 Beneficiaries

<table>
<thead>
<tr>
<th>CY2014</th>
<th>CY2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>630.5</td>
<td>595.2</td>
</tr>
</tbody>
</table>

-5.6%

Source: AR DHS Q415 reports
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
For Medicaid, 22 Provider Groups received Shared Savings

- Amounts from $35k to $1.54 million
Comprehensive Primary Care Plus

• Arkansas one of 14 markets selected for this CMS initiative; 182 practices participating

• Builds on original CPC Initiative; supports HHS goals of majority of care tied to value by 2018

• 5 year model; participation from Medicare, Medicaid, ARBCBS, QualChoice, Centene, HealthSCOPE, AR Superior Select

• Two tracks for providers, each with enhanced care management payments and quality / performance-based incentives

• MACRA implications: CPC+ providers not subject to potential negative Medicare payment adjustments that begin in 2019
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*
Enrollment Requirements for AR Medicaid

✓ The entity must be one of the following:
  - An individual PCP (Provider type 01 or 03)
  - A physician group of PCPs w/ a common group ID
  - A Rural Health Clinic (Provider type 29)
  - An Area Health Education Center (Provider type 69)

✓ Practice must have at least 300 Medicaid beneficiaries at time of enrollment and have PCPs enrolled in Primary Care Case Management program via Medicaid

Enrollment for 2018 began in September 2017
PCMH: Clinic-level Case Studies

• ACHI produced a series of case studies on clinics throughout AR
• Focus on clinic PCMH approach and impacts
• Go to: [www.achi.net](http://www.achi.net)
Arkansas Payment Improvement Initiative’s Integrated Model
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 provider assigned as ‘quarterback’
- 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
Case for Change

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

**Simple upper respiratory infection**

<table>
<thead>
<tr>
<th>Total episodes</th>
<th>~80,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median cost</td>
<td>$57</td>
</tr>
<tr>
<td>10% percentile</td>
<td>$44</td>
</tr>
<tr>
<td>90% percentile</td>
<td>$76</td>
</tr>
</tbody>
</table>

**Pregnancy**

<table>
<thead>
<tr>
<th>Total episodes</th>
<th>~30,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median cost</td>
<td>$3,608</td>
</tr>
<tr>
<td>10% percentile</td>
<td>$3,208</td>
</tr>
<tr>
<td>90% percentile</td>
<td>$4,071</td>
</tr>
</tbody>
</table>

**ADHD**

<table>
<thead>
<tr>
<th>Total episodes</th>
<th>~20,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median cost</td>
<td>$1,641</td>
</tr>
<tr>
<td>10% percentile</td>
<td>$1,073</td>
</tr>
<tr>
<td>90% percentile</td>
<td>$7,046</td>
</tr>
</tbody>
</table>

**Total hip replacement**

<table>
<thead>
<tr>
<th>Total episodes</th>
<th>140</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median cost</td>
<td>$7,953</td>
</tr>
<tr>
<td>10% percentile</td>
<td>$5,867</td>
</tr>
<tr>
<td>90% percentile</td>
<td>$12,814</td>
</tr>
</tbody>
</table>

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
PAPs will be provided new tools to help measure and improve patient 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**

NOTE: Episode and health home model for adult DD population in development. Tools and reports still to be defined.
How episodes work for patients and providers (1/2)

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

Patients and providers deliver care as today (performance period)
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

How episodes work for patients and providers (2/2)

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

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

Payers calculate average cost per episode for each PAP

Compare average costs to predetermined ‘commendable’ and ‘acceptable’ levels

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

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
## Wave 1 Episodes

<table>
<thead>
<tr>
<th>Wave 1 Episode</th>
<th>Description</th>
<th>Principal Accountable Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Hip/ Knee replacement</strong></td>
<td>• Surgical procedure plus related claims 30 days prior to 90 days after</td>
<td>Orthopedic surgeon</td>
</tr>
<tr>
<td><strong>Perinatal (non-NICU)</strong></td>
<td>• Pregnancy-related claims for mother 40 wks before to 60 days after delivery</td>
<td>Delivering provider</td>
</tr>
<tr>
<td><strong>Ambulatory URI</strong></td>
<td>• 21-day window beginning with initial consultation</td>
<td>First provider to diagnose patient in-person</td>
</tr>
<tr>
<td><strong>Congestive Heart Failure Admission</strong></td>
<td>• Hospital admission and care within 30 days of discharge</td>
<td>Admitting hospital</td>
</tr>
<tr>
<td><strong>ADHD</strong></td>
<td>• 12-month episode including all ADHD services plus pharmacy costs</td>
<td>Physician or licensed mental health provider</td>
</tr>
</tbody>
</table>
Arkansas Medicaid Cost Thresholds for Perinatal Episode

Risk-adjusted average episode cost per provider (Medicaid)

Average cost/episode Dollars ($)

Acceptable 3,906
Commendable 3,394
Gain sharing Limit 2,000

SOURCE: Episodes with live births May 1, 2009 – April 30, 2010; data includes Arkansas Medicaid claims paid SFY09 - SFY10
How the Episode Payment Model Works

Shared Savings
Savings/Cost Neutral
Shared Cost

* Quality of care protected by limits on gain sharing and required quality metrics

Year 1 results

High
Average cost per episode for each provider
Low

Individual providers, in order from highest to lowest average cost
<table>
<thead>
<tr>
<th>Episodes</th>
<th>Multi-Payer Participation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upper Respiratory Infection</td>
<td>Medicaid</td>
</tr>
<tr>
<td>Attention Deficit Hyperactivity Disorder</td>
<td>Medicaid</td>
</tr>
<tr>
<td>Perinatal</td>
<td>Medicaid</td>
</tr>
<tr>
<td>Congestive Heart Failure</td>
<td>Medicaid</td>
</tr>
<tr>
<td>Total Joint Replacement (Hip &amp; Knee)</td>
<td>Medicaid</td>
</tr>
<tr>
<td>Colonoscopy</td>
<td>Medicaid</td>
</tr>
<tr>
<td>Cholecystectomy (Gallbladder Removal)</td>
<td>Medicaid</td>
</tr>
<tr>
<td>Tonsillectomy</td>
<td>Medicaid</td>
</tr>
<tr>
<td>Oppositional Defiance Disorder</td>
<td>Medicaid</td>
</tr>
<tr>
<td>Coronary Artery Bypass Grafting</td>
<td>Medicaid</td>
</tr>
<tr>
<td>Asthma</td>
<td>Medicaid</td>
</tr>
<tr>
<td>Percutaneous Coronary Intervention</td>
<td>Medicaid</td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disease</td>
<td>Medicaid</td>
</tr>
<tr>
<td>Neonatal</td>
<td>Medicaid</td>
</tr>
<tr>
<td>ADHD/ODD Comorbidity</td>
<td>Medicaid</td>
</tr>
</tbody>
</table>
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)
Provider Reporting: Transparency of Information

- Billions of claims processed; reports display quality, cost and utilization
- Facilitates integration of primary care and specialty support via episodes
- Medical Neighborhood reports: New for 2017, PCPs receive information on specialist referral sources
- **Overall value**: Reporting transparency provides more effective tools than have been available for providers
ACHI Statewide Tracking Report

• Annual report tracks multi-payer progress

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

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

Patient Centered Medical Homes

The goal of PCMH is to achieve the Triple Aim

- Improve the health of the population
- Enhance the patient experience of care
- Reduce or control the cost of care

Today, visits to primary care doctors often focus on acute illnesses with much less attention on preventive care. PCMH can change that. PCMH will actively promote prevention services, such as screenings, to empower patients with the education they need to stay healthy.

For more information, please watch this quick video.

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PANEL Q&A SESSION
CLOSING/NEXT STEPS

• Survey @ https://www.surveymonkey.com/r/LQSGS3X

• Meeting Materials @ https://cpasnh.mslc.com/lc-all-partner-statewide-meeting

• Additional Information About APMs @ https://cpasnh.mslc.com/public-resource-link, NH APM Resource Guide

• 2018 Learning Collaborative Curriculum and Schedule (February, May, August, November)