The State of Arkansas implements a new payment initiative designed to incentivize individual providers to improve efficiency without compromising quality.

By Jenny Jones

Health-care expenditures in the United States increased tenfold between 1980 and 2010 and continue to rise.¹ As a result, states across the nation are seeking solutions for controlling health-care costs without compromising care. While many states are turning to managed care companies and accountable care organizations, Arkansas has embarked on a different approach that offers financial incentives to individual health-care providers to deliver more efficient care.

The Health Care Payment Improvement Initiative is a collaboration between Medicaid, the Arkansas Department of Human Services, and two of the state’s largest private insurers — Arkansas Blue Cross and Blue Shield and Arkansas QualChoice. Introduced by Gov. Mike Beebe in 2011 and launched in late 2012, the initiative is designed to reduce health-care costs while ensuring patients receive premium care, says Dawn Zekis, director of health-care innovation for the Arkansas Department of Human Services. “When it comes to Arkansas, we knew the things we didn’t want to do in terms of having to reduce rates, cut benefits, or do things that would cause us to get between the patient and the provider,” she says. “We saw the payment improvement initiative as the best path forward for us to be able to increase efficiency, bend the cost curve, and increase the overall quality in the system.”

The initiative creates an incentive for health-care providers to manage costs and quality. Those providers who do not exceed a predetermined cost threshold as established by each payer and who meet quality metrics as developed in coordination with stakeholders — including providers, patients, advocates, policy makers, and caregivers — will receive a share of the savings (an incentive), but those who go over the threshold and/or fail to meet the quality metrics must cover a portion of the excess costs (a penalty). The approach is expected to have a significant impact on how care is managed. One likely result will be increased data sharing as referring physicians seek consultation from radiologists and other specialists to ensure they order appropriate tests at appropriate times. James E. McDonald, MD, vice chairman in the Department of Radiology, and director of the Division of Nuclear Medicine at the University of Arkansas, thinks this consultative approach will highlight and enhance the value of radiology. “The opportunity for radiology is significant in this system, because we can distinguish ourselves by the quality of service and particularly by the quality of advice we provide,” McDonald says. “My vision is that, with this structure, the physician caring for the patient will come to rely on the radiologist to help determine the most cost-effective and appropriate imaging plan for each patient.”

Key Takeaways:

- The Arkansas Department of Human Services and two of the state’s largest private insurers have partnered to form the Health Care Payment Improvement Initiative in an effort to reduce health-care costs.
- The Health Care Payment Improvement Initiative offers financial incentives as a way to encourage physicians to provide more efficient care without compromising quality.
- As referring physicians work to provide more efficient care, they will likely seek increased consultation from radiologists to ensure they request appropriate imaging for patients.
Multi-Pronged Approach

The payment improvement initiative has two main components. The first focuses on conditions known as episodes of care that should be treated within a given length of time. The payers — Medicaid and the private insurers — have established five common episodes as a starting point: upper respiratory infection, perinatal care, attention deficit/hyperactivity disorder, congestive heart failure, and total hip and knee replacement. For each episode, the payers will designate a caregiver — often the diagnosing physician — to serve as the principal accountable provider (PAP), who will be responsible for managing the cost and quality for that episode. In the case of an upper respiratory infection, for instance, the PAP will most likely be the primary care physician but could also be a surgeon or even an entire hospital, depending on the episode, Zekis says. “For example, if we’re working on a tonsillectomy episode, in that case the provider performing the procedure would be the PAP,” she explains.

PAPs and all other health-care providers, including radiologists, will submit claims and receive payments, just as they have always done. The difference is that at the end of a predetermined performance period, typically a year, the payers will reconcile each PAP’s claims to determine eligibility for a financial incentive or penalty. In addition to examining costs, the payers will compare the care that was provided to established quality metrics to ensure the PAP didn’t skimp on services. If the PAP does not meet those quality metrics, even if costs were within the commendable range, he or she will be ineligible for the cost-savings incentive, explains David Wroten, executive vice president for the Arkansas Medical Society. “Between the quality measures and the setting of the cost thresholds, they’ve done a pretty good job of removing any incentive to under treat or ration care,” he says.

The other chief component of the initiative focuses on population-based health care through patient-centered medical homes and health homes. Under this concept, providers will have incentives to address a patient’s overall health needs, with emphasis on preventative care and chronic conditions. In addition to financial incentives, providers will receive per-member, per-month payments to cover the costs of such things as coordinating care and providing consultations. This represents a significant change from the traditional fee-for-service model, which does not compensate providers for many of the services they provide outside of office visits, Wroten says. “Under the fee-for-service model you only get paid for the services you actually deliver for which there’s a CPT code,” he says. “The fee-for-service model does not compensate physicians for the things that we need physicians to do in order to keep patients healthier, which in turn holds down health-care costs.”

An Opportunity to Stand Out

In the past, most referring physicians had no idea how much imaging, lab tests, medications, and other care components cost. But this new initiative requires them to be more aware of such costs and more discriminant about the care they dispense. For instance, when patients presented with common upper respiratory infections under the old payment model, providers often issued prescriptions for antibiotics, even though the medications do not treat viruses. Now, physicians have an incentive to explain why antibiotics won’t work. “Way too many antibiotics were being written for just normal, run-of-the-mill acute respiratory infections, and a lot of that is because of patient demand,” Wroten says. “Every parent that takes a sick kid to the doctor or emergency room wants an antibiotic, and the physicians have to start saying, ‘No, that’s not necessary.’”

Physicians will also be prompted to give greater consideration to the tests they order and the specialists with whom they work. As a result, radiologists may find themselves in a more competitive position for referring physicians’ business. “For the first time, the referring physician can be financially rewarded by identifying the high-quality imaging provider and will be motivated to look to that provider for advice about the most cost-effective way to answer the clinical question,” McDonald says. “I see this as a tremendous opportunity for radiologists to distinguish themselves as true partners for referring physicians.”
Case Study: Bending the Cost Curve

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One way McDonald envisions helping referring physicians manage costs is by incorporating ACR Select (www.acrselect.org) into the university’s Epic electronic medical record (EMR), the first phase of which is scheduled to go live in August. Referring physicians could then access the system to retrieve information about different radiology tests, which would help them determine the best tests for specific conditions. From there, they could click on a link to view the imaging schedule and arrange appointments for their patients directly, McDonald says. “Now primary care physicians, motivated to make sure they order the right test, will have the evidence at their fingertips to make the right choice,” McDonald says. “With everybody going to an EMR and with ACR Select available as a plug-in solution, I think we will have the tools we can use to educate our referring physicians to do a better job for the patient, in addition to lowering costs and reducing radiation exposure.”