The Honorable Kathleen Sebelius
Secretary of the U.S. Department of Health and Human Services
330 Independence Avenue, S.W., Room 4257
Washington, DC 20201

Dear Madam Secretary:

Thank you for taking time from your busy schedule to visit with my team and me regarding Arkansas's Health Payment Improvement Initiative. I thought it was a very good discussion, driven by your interests in fully understanding our approach and the ways that we can best interact with your staff.

As promised, I have attached a breakdown of our cost estimates for the Initiative, including details about our request for funding from the CMS Innovation Center. You will see that the requested contribution from CMS is only a fraction of what we anticipate to be the total outlay from all sources. Moreover, it represents less than one percent of the total projected Medicaid spending for services in Arkansas over the three-year funding period. I hope that you agree that this would be an excellent bargain for transforming Arkansas's health-payment system and creating a model for other states.

I deeply appreciate your continued personal interest in this bold effort. I also commend the ongoing efforts of your CMS leadership team and extend an invitation for them to come to Arkansas in the near future for more in-depth discussions with key players in our endeavors. I will be in Washington, D.C., on November 17 and 18, and if your schedule permits, I would like to meet with you and your leadership team to continue the discussion of our Initiative. Please let us know if you need additional information.

Sincerely,

[Signature]

Mike Beebe

MB:jb
Enclosure
EXECUTIVE SUMMARY

The Arkansas Health Care Payment Improvement Initiative is moving the state’s entire health care financing system from fee-for-service to an episode-based bundled payment approach, creating financial incentives for delivery of high quality, coordinated care and active management of existing conditions. It is supported and led by Medicaid and the largest private insurers in the state, and we have commenced discussions about the participation of Medicare as a joint leader.

We believe this initiative is well suited to the mandate set down by Congress for the Center for Medicare and Medicaid Innovation (CMMI) to improve health care quality for Medicaid, Medicare, and SCHIP beneficiaries by involving as many payors as possible to align financial incentives for change. We believe this initiative complements anticipated provider-led projects, creates a model for supporting statewide implementation, and can provide significant value to CMS.

Given the scope of change required, we intend to stage the transition to episode-based payment in three waves of episode implementation, over the course of three years. For each wave we have itemized 15 deliverables across episode design, transition support, implementation and evaluation. We have detailed the activities required in each, and the cost and FTE implications. This has been informed by recent experience nationwide in payment reform and care model innovation.

The total estimated cost of this initiative is $90-150M to December 2014. We request that CMMI funds $50M over the period 2012-2014. This represents $30M (around two thirds of the total estimated cost) for the intensive transition support and implementation phases from January 2012 to June 2013; and a further $20M (around 30% of the total estimated cost, roughly reflecting the Medicare share of the effort for the period) for the following 18 months of rollout to additional episodes.

The remainder of this document includes details as follows:

- Background to this initiative and rationale for this request
- Proposed rollout schedule and deliverables in each wave
- Project funding requirements by wave
- Detailed resource requirements for Wave 1 (budget and FTE).
BACKGROUND

As Governor Mike Beebe outlined to Secretary Sebelius in his letters of February 11, 2011 and August 10, 2011, the Arkansas Health Care Payment Improvement Initiative is moving the state’s health care financing system from fee-for-service to an episode-based bundled payment approach, creating financial incentives for delivery of high quality, coordinated care and active management of existing conditions. The strategy is intended to move the entire Arkansas delivery system to a new and sustainable model of health care financing and stimulate needed system reform. The initiative is supported and led by Medicaid and the largest private insurers in the state, and we have commenced discussions about the active participation of Medicare as a joint leader.

Much progress has been made since this multi-payer, statewide initiative was begun nine months ago. Development of episodes to delineate conditions, care expectations, and provider payments is underway. Medicare data access has been secured and integration of Medicaid and private payor data is in progress. Through public comment, nine priority areas have been identified. Clinical evaluation to delineate types of treatment, episode definition, provider team components, and alternative payment approaches is ongoing. Arkansas’s proposal retains actuarial risk with public and private sector payors while transferring clinical management risk to teams of providers.

The initiative is directly supported and led by key leaders across the state government and payor community. It is the single biggest priority for the State Director of Human Services and Medicaid Director. The State Surgeon-General and Medicaid Medical Director are also providing considerable policy and clinical leadership. From the private payor community, the leadership of Arkansas BlueCross BlueShield, United Healthcare and QualChoice are personally engaged in the effort.

BASIS FOR THIS REQUEST

The three-part aim of better health, better health care, and reduced expenditures through continuous improvement for Medicare, Medicaid, and Children’s Health Insurance Program beneficiaries will be achieved through aligned financial incentives to support transformational change. “Bundled” payment approaches, which combine payment for physician, hospital, and other provider services into a single payment for a predetermined episode of care, have been advocated as a way to align provider incentives with three-part aim outcomes. These are at the heart of the Arkansas Payment Improvement Initiative.
Under Section 1115A of the Social Security Act, the Center for Medicare and Medicaid Innovation (CMMI) is authorized to test innovative payment and service delivery models that have the potential to reduce program expenditures while maintaining or improving the quality of care for beneficiaries.

We believe the Arkansas proposal is well suited to the mandate set down by Congress that the Innovation Center improve health care quality for Medicaid, Medicare, and SCHIP beneficiaries by involving as many payors as possible to align financial incentives for change, and we believe this initiative can provide significant value to CMS.

The effort complements several others that CMS is supporting. It represents a multi-payor model to compare with the anticipated provider-led demonstration projects running concurrently in other parts of the US. It creates a model for supporting statewide implementation and provider transition that may be replicated in other states following success of provider-led demonstration projects. Also, it would leverage existing episode grouper technologies in Wave 1, as well as broader grouper technologies that may emerge in the coming 2-3 years based on CMMI demonstration projects as well as any standards that CMS may choose to adopt in the coming 2-3 years.

Opportunities exist for state Medicaid programs to partner with CMS on behalf of Medicare beneficiaries and/or private sector insurers to develop incentives that can transform the delivery system.

Finally, states are uniquely positioned to bring together private insurers with Medicare and Medicaid to develop, test, and deploy bundled payment strategies.

**PROPOSED ROLLOUT SCHEDULE**

Given the scope of change required on the part of both payors and providers, we intend to stage the transition from fee-for-service to episode-based payment in three waves of episode implementation, over the course of three years.

As illustrated below, implementation of the first wave is planned for the second half of 2012, targeting an initial set of episodes. Successive waves 2 and 3 would be expanded in scope, as both payors and providers in the state gain experience with episodes.

The focus of our efforts will be on developing an episode-based payment model design and transition support for the delivery system. We are not aiming to design our own grouper technology and intend to leverage grouper technology which already exists or which will exist during successive waves of roll-out.
Below is an outline of the anticipated scope of each of the three Waves, including the estimated share of total Arkansas healthcare spending to be impacted, and the anticipated number of providers and patients that may be involved.

**Wave 1**

The first wave of implementation is targeted for the second half of 2012, to include an initial set of episodes of care (e.g., congestive heart failure, hip replacement, developmental disabilities, etc.). We intend in this wave to address up to 10% of annual spending across Medicaid, Medicare, and Commercial insurance. Depending on the episodes chosen for implementation, the first wave would likely involve nearly all of the 100 hospitals in Arkansas, as well as at least 1,000 practicing physicians and over 1,000 ancillary providers and allied health professionals. The new episode-based payment model could reach as many as 700,000 Arkansans per year in the first wave, which would put it among the largest payment reform implementations in the U.S. since the introduction of DRGs.

We intend for Wave 1 to represent a significant portion of the overall work required to roll out this initiative. In particular, Wave 1 efforts will focus on identifying a workable episode payment model across a range of episode “archetypes” (e.g., acute vs. complex chronic episodes). In addition, Wave 1 will be instrumental in priming the healthcare delivery system across a range of
providers and patient types for a broader transition to an episode-based payment model. We are mindfully designing the first wave of episodes to be representative across acuity and provider type, such that we can apply lessons learned to subsequent waves.

**Wave 2**

The second wave of implementation is targeted for the second half of 2013. We intend to address up to 25% of annual spending in this wave, across Medicaid, Medicare, and Commercial insurance. Wave 2 would reach 2,000-3,000 physicians and over 1,000 ancillary providers and allied health professionals, and could reach more than half of the entire state population.

**Wave 3**

The third wave of implementation is targeted for the second half of 2014, to address the majority of the more than ~$9-10B in total statewide healthcare spending. This wave would expand episode-based payment to all hospitals and ~5,000 physicians in the state, and affecting the entire state population.

**DELIVERABLES IN EACH WAVE**

Our workplan is based on a specified set of deliverables for the phases within each Wave. The deliverables that are required in each phase are as follows:

**Phase A (Episode Payment Model Design) deliverables**

1. Analysis of size and type of opportunities and “sources of value” for improved quality, cost, and patient experience
2. Definition of each episode (start/end, inclusions and exclusions)
3. Payment model design and pricing mechanisms, including upside and downside risk corridors, outlier provisions
4. Facilitation of stakeholder workgroups and other interactions including education and outreach
5. Preliminary forecast of impact on health system and providers
Phase B (Transition Support) deliverables

6. Pricing decisions and technical analysis, including setting specific pricing levels based on clinical risk, geographic adjustment factors, and provider type
7. IT/operational changes to support claims payment
8. Development of patient, provider, payor reporting
9. Development of management services organization, HIT, or other capabilities to support provider transition
10. Provider and patient training, education and outreach to prepare for implementation

Phase C (Implementation and Evaluation) deliverables

11. Evaluation of impact on quality, cost, experience
12. First-year incremental operational costs for payor IT/claims
13. First-year incremental costs for reporting
14. First-year operational costs for management services organization and other provider support
15. Continued provider and patient training/education

PROJECT FUNDING REQUIREMENTS BY WAVE

Estimated project funding requirements by wave are shown in Table 1, with further explanation outlined following, including a description of how we propose this funding would be divided between CMMI and other funding sources.

Table 1: Summary of Project Funding Requirements ($ million)

<table>
<thead>
<tr>
<th>$ millions</th>
<th>I. Episode design</th>
<th>II. Transition support</th>
<th>III. Implementation and evaluation</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wave 1</td>
<td>5</td>
<td>10-15</td>
<td>10-15</td>
<td>25-35</td>
</tr>
<tr>
<td>Wave 2</td>
<td>5-10</td>
<td>10-15</td>
<td>10-20</td>
<td>25-45</td>
</tr>
<tr>
<td>Wave 3</td>
<td>10-15</td>
<td>20-30</td>
<td>10-25</td>
<td>40-70</td>
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<tr>
<td>--------</td>
<td>-------</td>
<td>-------</td>
<td>-------</td>
<td>-------</td>
</tr>
<tr>
<td>Total</td>
<td>20-30</td>
<td>40-60</td>
<td>30-60</td>
<td>90-150</td>
</tr>
</tbody>
</table>

Medicaid will fund the episode design phase for Wave 1, which stretches through December 2011, with the State share funded by contributions from BCBS.

In the period from January 2012 through 2013, shaded in gray in Table 1 above, funding is needed for the significant effort required across Wave 1 transition support, implementation and evaluation; and Wave 2 episode design and transition support. For these phases of activity, Arkansas requests that CMMI fund $30M, or about two thirds of the estimated project costs from January 2012 through June 2013. We expect that the balance of project costs during this period will be funded by the state, private payors and through grants from private foundations.

For the following period from July 2013 to December 2014, shaded in black in Table 1 above, we expect that the early results from Wave 1 will allow sufficient proof of concept for participating payors to fund the project costs. Given the direct benefits to Medicare as one of the participating payors, we would ask CMMI to fund an additional $20M for this period, just less than one third of the estimated project costs of this period.

Note that the funds we are requesting from CMMI are not intended to be used as match for other federal funds.

A breakdown of our current estimate of the expected use of these funds, by deliverable and across all waves, is shown in Table 2 below. Our estimates are based on a detailed deliverable-by-deliverable assessment for Wave 1 (described in the following section) that is then used as a model for the following waves. During 2012 we would review the resource requirements for Waves 2 and 3 in the light of actual outcomes in Wave 1, and adjust accordingly. For this reason, actual allocations could vary from the split shown in Table 2.
## Table 2: Expected use of CMMI funding requested

<table>
<thead>
<tr>
<th>Phase</th>
<th>Deliverable</th>
<th>Expected use of funds requested from CMMI $m</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>2011 (funded by current participants)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2011</td>
</tr>
<tr>
<td>A)</td>
<td>1. Episode design</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. Analysis of opportunities for quality, cost, experience*</td>
<td>0.00</td>
</tr>
<tr>
<td></td>
<td>2. Definition of each episode (start/stop, inclusions and exclusions)*</td>
<td>0.00</td>
</tr>
<tr>
<td></td>
<td>3. Payment model inc. risk corridors, outlier provisions</td>
<td>0.00</td>
</tr>
<tr>
<td></td>
<td>4. Facilitation of stakeholder workgroups, other interactions</td>
<td>0.00</td>
</tr>
<tr>
<td></td>
<td>5. Preliminary forecast of improvement</td>
<td>0.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td>0.00</td>
</tr>
<tr>
<td>B)</td>
<td>2. Transition support</td>
<td></td>
</tr>
<tr>
<td></td>
<td>6. Pricing decisions and technical analysis (e.g., geographic/adjustment)</td>
<td>16.67</td>
</tr>
<tr>
<td></td>
<td>7. Operational changes to support claims payment</td>
<td>3.87</td>
</tr>
<tr>
<td></td>
<td>8. Development of patient, provider, payer reporting</td>
<td>4.13</td>
</tr>
<tr>
<td></td>
<td>9. Development of MCO, HIT, or other transition capabilities</td>
<td>3.93</td>
</tr>
<tr>
<td></td>
<td>10. Provider and patient training/education for implementation</td>
<td>1.47</td>
</tr>
<tr>
<td>C)</td>
<td>3. Implementation and evaluation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>11. Evaluation of impact on quality, cost, experience</td>
<td>8.33</td>
</tr>
<tr>
<td></td>
<td>12. First-year incremental operational costs for payor IT/claims</td>
<td>1.43</td>
</tr>
<tr>
<td></td>
<td>13. First-year incremental costs for reporting</td>
<td>2.17</td>
</tr>
<tr>
<td></td>
<td>14. First-year operational costs for MCO, other provider support</td>
<td>2.23</td>
</tr>
<tr>
<td></td>
<td>15. Continued provider and patient training/education</td>
<td>1.23</td>
</tr>
<tr>
<td></td>
<td>16. Continued provider and patient training/education</td>
<td>1.27</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>0.00</td>
</tr>
</tbody>
</table>

Note: Initial expectation of use of requested CMMI funds; actual allocations could vary

* Includes clinical expertise and support
DETAILED RESOURCE REQUIREMENTS FOR WAVE 1

What follows is a description of the activities and costs for each deliverable in Wave 1, as well as the peak full-time equivalent employees (FTEs) required from the State of Arkansas\(^1\) for each of the three phases.

These estimates are informed by our observations of multiple commercial payors’ implementations of payment and care model innovation. For example, we are aware of one single-state payor covering comparable medical spend of around $10B which is forecasting a spend of approximately $150M over four years to cover design, transition support, implementation and evaluation for payment innovation.

Table 3 below summarizes the estimated costs.

Phase A: Episode Payment Model Design

Note that the currently participating payors (Medicaid and commercial) expect to wholly fund this Episode Design phase for Wave 1.

*Deliverable 1. Analysis of opportunities and “sources of value” for improved quality, cost, and patient experience*

- Activities: Assess each episode category and patient journey to understand sources of sub-optimal quality and patient experience as well as sources of cost inefficiencies. This includes analysis of Arkansas-specific data (claims + other quality and outcomes metrics), reviews of clinical literature and national evidence-based guidelines, existing industry models, interviews with Arkansas clinicians, and close involvement of clinical experts. For example, we will identify opportunities to reduce unnecessarily high hospital readmission rates for Congestive Heart Failure, as well as underlying clinical reasons for what drives the high rate of readmissions.

- Total cost: ~$1.70M in the second half of 2011

- Type of costs (expected): Human capital (State of Arkansas, private insurer and external): $1.50M; Data, research, software, databases, IT: $0.20M

\(^1\) Includes staff from Arkansas Center for Health Improvement, Arkansas Medicaid or other Department of Human Services personnel
### Table 3: Summary of Costs and FTE Requirements by Deliverable for Wave 1

<table>
<thead>
<tr>
<th>Phase</th>
<th>Deliverable</th>
<th>Costs, $m</th>
<th>Timing of cost</th>
<th>Type of cost (expected)</th>
<th>State FTE State of Arkansas* FTE at peak</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Total cost</td>
<td>2H 2011 and earlier</td>
<td>1H 2012</td>
<td>2H 2012</td>
</tr>
<tr>
<td>A) Episode design</td>
<td>Analysis of opportunities for quality, cost, experience</td>
<td>5.00</td>
<td>5.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Definition of each episode (start/end, inclusions and exclusions)</td>
<td>1.70</td>
<td>1.70</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Payment model inc. risk corridors, outlier provisions</td>
<td>0.65</td>
<td>0.65</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Facilitation of stakeholder workgroups, other interactions</td>
<td>0.90</td>
<td>0.90</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preliminary forecast of improvement</td>
<td>0.85</td>
<td>0.85</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B) Transition support</td>
<td>Pricing decisions and technical analysis (e.g., geographic/adjustment)</td>
<td>12.50</td>
<td>12.50</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>IT/operational changes to support claims payment</td>
<td>2.90</td>
<td>2.90</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Development of patient, provider, payer reporting</td>
<td>3.10</td>
<td>3.10</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Development of MSG, HIT, or other transition capabilities</td>
<td>2.45</td>
<td>2.45</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Provider and patient training/education for implementation</td>
<td>2.95</td>
<td>2.95</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C) Implementation and evaluation</td>
<td>Evaluation of impact on quality, cost, experience</td>
<td>12.50</td>
<td>12.50</td>
<td>6.25</td>
<td>6.25</td>
</tr>
<tr>
<td></td>
<td>First-year incremental operational costs for payer IT/claims</td>
<td>2.16</td>
<td>1.63</td>
<td>1.63</td>
<td></td>
</tr>
<tr>
<td></td>
<td>First-year incremental costs for reporting</td>
<td>3.25</td>
<td>1.69</td>
<td>1.69</td>
<td></td>
</tr>
<tr>
<td></td>
<td>First-year operational costs for MSG, other provider support</td>
<td>2.55</td>
<td>0.93</td>
<td>0.93</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Continued provider and patient training/education</td>
<td>1.85</td>
<td>0.90</td>
<td>0.95</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>30.00</td>
<td>5.00</td>
<td>12.50</td>
<td>6.25</td>
</tr>
</tbody>
</table>

*Includes staff from Arkansas Center for Health Improvement, Arkansas Medicaid or other Department of Human Services personnel
1 Includes clinical expertise and support
Deliverable 2. Definition of each episode (start/end, inclusions and exclusions)

- Activities: Determine the definition of each episode (start/end, services included or excluded), patient inclusion criteria and adjustments (age/sex, diagnoses, procedures, geographic locations), and provider inclusion criteria (specialty, capabilities, scale/volume).

- Total cost: ~$0.65M in the second half of 2011

- Type of costs (expected): Human capital (State of Arkansas, private insurer and external): $0.65M; Data, research, software, databases, IT: --

Deliverable 3. Payment model design and pricing mechanisms, including upside and downside risk corridors, outlier provisions

- Activities: Determine payment model specifics and mechanics, including type of payment (prospective vs. retrospective), level of upside and downside risk (as well as risk and max/min corridors), and outlier/stop loss thresholds.

- Total cost: ~$0.90M in the second half of 2011

- Type of costs (expected): Human capital (State of Arkansas, private insurer and external): $0.90M; Data, research, software, databases, IT: --

Deliverable 4. Facilitation of stakeholder workgroups and other interactions

- Activities: Conduct regular workgroups involving range of stakeholders (patients and families, relevant Arkansas clinicians, hospital and institutional provider representatives, etc.). Workgroups will focus on multiple types of feedback: (1) patient and clinical input on draft patient flows and experience, identified inefficiencies and their root causes, and improvement potential; (2) feedback and discussion on payment model design; (3) feedback on practical implementation challenges to overcome (e.g., clinical infrastructure, patient behaviors). Workgroups will also be open to the public and accessible across the state via videoconference technology. In addition, initiate outreach to minority community, patient groups, and employers as appropriate.

- Total cost: ~$0.90M in the second half of 2011

- Type of costs (expected): Human capital (State of Arkansas, private insurer and external): $0.80M; Data, research, software, databases, IT: $0.10M

Deliverable 5. Preliminary forecast of impact on health system and providers
Activities: Estimate the impact on health system costs (by payor) and the economic impact for providers, as well as timing of impact. In addition, identify major sources of expected improvement in quality and patient outcomes.

- Total cost: ~$0.85M in the second half of 2011
- Type of costs (expected): Human capital (State of Arkansas, private insurer and external): $0.85M; Data, research, software, databases, IT: --

In summary, we anticipate Wave 1 Episode Design (Phase I) will cost $5M in total and will require 10 State of Arkansas FTEs at peak.

**Phase II: Transition Support**

*Deliverable 6. Pricing decisions and technical analysis, including setting specific pricing levels based on clinical risk, geographic adjustment factors, and provider type*

- Activities: Finalize specific pricing decisions for each episode, including adjustments for case severity and clinical risk as well as geographic, demographic and socioeconomic adjustment factors.
- Total cost: ~$2.90 M in the first half of 2012
- Type of costs (expected): Human capital (State of Arkansas, private insurer and external): $2.40M; Data, research, software, databases, IT: $0.50M

*Deliverable 7. IT/operational changes to support claims payment*

- Activities: Determine and implement specific IT, informatics and operational requirements to support the new episode payment model. This includes making adjustments to claims processing, billing and payment systems, customer service support, and other operational elements. In addition, this would include new informatics requirements (e.g., grouper technology, methods to estimate severity-adjusted episode pricing for a given provider) necessary to support payment.
- Total cost: ~$3.10M in the first half of 2012
- Type of costs (expected): Human capital (State of Arkansas, private insurer and external): $2.60M; Data, research, software, databases, IT: $0.50M
Deliverable 8. Development of patient, provider, payor reporting

- Activities: Design and implement informatics support to enable accurate assessment of episode impact. For example, this would include development of specific metrics and reports to track impact (breadth of providers and patients involved, impact on cost trends across payors, impact on quality and utilization metrics).
- Total cost: ~$2.45M in the first half of 2012
- Type of costs (expected): Human capital (State of Arkansas, private insurer and external): $1.65M; Data, research, software, databases, IT: $0.80M

Deliverable 9. Development of management services organization, HIT, or other capabilities to support provider transition

- Activities: Determine specific types of provider transition support required, taking into account the range of provider capabilities in Arkansas across rural and urban geographies. Develop and implement a plan for providing transition support, including potential management services organization, HIT support, and other capabilities (e.g., disease registries).
- Total cost: ~$2.95M in the second half of 2011
- Type of costs (expected): Human capital (State of Arkansas, private insurer and external): $1.75M; Data, research, software, databases, IT: $1.20M

Deliverable 10. Provider and patient training and education to prepare for implementation

- Activities: Educate and communicate changes to patients and providers (including hospitals, physicians, community clinics, rehabilitation facilities, etc.). Develop sufficient and timely communications to providers to explain payment model changes (including descriptive examples, FAQs, etc.). Initiate education patient campaign where necessary.
- Total cost: ~$1.10M in the first half of 2012
- Type of costs (expected): Human capital (State of Arkansas, private insurer and external): $1.10M; Data, research, software, databases, IT: --

In summary, we anticipate Wave 1 Transition Support details (Phase II) will cost $10-15M in total and will require 20 State of Arkansas FTEs at peak.
Phase III: Implementation and evaluation

Deliverable 11. Evaluation of impact on quality, cost, experience

- Activities: Assess ongoing impact for episodes that have launched based on quantitative analysis of quality and cost from multiple sources, as well as qualitative interviews with patients, providers, and other stakeholders. In addition, identify ongoing refinements to the episode model and implications / adjustments for additional waves.
- Total cost: \(~ \$2.15M\) between July 2012 and June 2013
- Type of costs (expected): Human capital (State of Arkansas, private insurer and external): \$1.90M; Data, research, software, databases, IT: \$0.25M

Deliverable 12. First-year incremental operational costs for payor IT/claims

- Activities: Includes the costs of staff and IT / data / informatics requirements necessary to support and implement the new payment model for episodes that have launched.
- Total cost: \(~ \$3.25M\) between July 2012 and June 2013
- Type of costs (expected): Human capital (State of Arkansas, private insurer and external): \$1.75M; Data, research, software, databases, IT: \$1.50M

Deliverable 13. First-year incremental costs for reporting

- Activities: Includes the costs of staff and IT / data / informatics requirements necessary to support ongoing development of metrics and reports that will be used for ongoing evaluation of overall impact.
- Total cost: \(~ \$3.35M\) between July 2012 and June 2013
- Type of costs (expected): Human capital (State of Arkansas, private insurer and external): \$1.85M; Data, research, software, databases, IT: \$1.50M

Deliverable 14. First-year operational costs for management services organization, other provider support
Activities: Includes the costs of staff and IT/data/informatics requirements necessary for any management services organization, HIT, and other types of provider support.

Total cost: ~$1.85M between July 2012 and June 2013

Type of costs (expected): Human capital (State of Arkansas, private insurer and external): $0.85M; Data, research, software, databases, IT: $1.00M

**Deliverable 15. Continued provider and patient training/education**

Activities: Includes ongoing education and training for providers to assist in the transition to the new episode payment model. This includes FAQs and potentially hands-on seminars/workshops for providers. For specific episodes, this could also include assistance to providers on high impact patient education as necessary.

Total cost: ~$1.90M between July 2012 and June 2013

Type of costs (expected): Human capital (State of Arkansas, private insurer and external): $1.70M; Data, research, software, databases, IT: $0.20M

In summary, we anticipate Wave 1 Implementation and Evaluation (Phase III) will cost $10-15M in total and will require 20 State of Arkansas FTEs at peak.