II. Model Testing Proposal—Project Abstract

The State is creating a sustainable patient-centered health care system that embraces the Triple Aim of improving (1) population health, (2) patients’ experience of care, and (3) cost effectiveness of care. We will do so by transforming the vast majority of care and payment from a fragmented, fee-for-service model that rewards providers for volume, to a model that rewards and supports providers for delivering improved outcomes and high-quality, cost-effective care. We are rolling out two complementary strategies statewide across payers:

1. Population-based care delivery, including medical homes and health homes: By 2016 a majority of Arkansans will have access to a patient-centered medical home, which will provide comprehensive, team-based care, with a focus on chronic care management and preventive services. Persons with complex or special needs (e.g., developmental disabilities) will also have a health home, which will work with the medical home to coordinate across medical, community and social support services. Payments will include performance-based care coordination fees and, for medical homes, shared savings on total cost of care.

2. Episode-based care delivery: For acute, procedural or ongoing specialty care conditions, we will reward providers who deliver high-quality, cost-effective and team-based care across an entire episode. We have developed a retrospective episode payment approach that is applicable in our fragmented provider environment and does not require new contractual relationships between providers. For special needs populations, payment will be based on assessments reflecting a clients’ level of service needs.

In July 2012, Medicaid and the major private payers launched the first wave of 5 episodes statewide to over 1,000 providers. We will roll out all population- and episode-based approaches over the next 3 years in waves. By mid-2016, we expect to reach over 90% of participating payer spend, subject to patient exclusions and outliers, impacting over 3,000 providers and 2M patients. Net of delivery system re-investments (i.e., care coordination fees and incentive payments to providers) and CPC impact, we expect these approaches to save the system ~$1.1B over the 3-year Model Testing period ($8.9B through 2020) relative to baseline spend. For Medicaid, the 3-year savings is ~$540M; for Medicare, it is ~$265M; for commercial payers in total, it is ~$335M. Numbers do not include program startup and management costs.

We believe our model qualifies for Track 1 funding. Our health homes, medical homes, and assessment-based episodes are each consistent with models previously introduced by the Center for Medicare and Medicaid Innovation (CMMI) or approved for implementation in other states by the Centers for Medicare & Medicaid Services (CMS). Our retrospective episode approach has already received State Plan Amendment approval from CMS for Medicaid; we are requesting that Medicare also report performance to Arkansas providers on episode costs and quality, using the same measures, report designs, and data exchange channels already adopted by the participating payers.
We are requesting a $60M State Innovation Models (SIM) grant over 42 months to fund startup costs required to continue implementing our model, including technical analysis, infrastructure and contractors to accelerate development. Given our readiness for implementation and the urgency of maintaining stakeholder momentum, we ask that $10M of SIM funds be disbursed in January 2013; this is required to launch the next wave of episodes beginning in 2013. The overall budget for the 42 months is $174.5M, to be funded through the State ($32.8M), SIM and other sources, including private payers who are also contributing financial and in-kind support. This represents less than 1% of the overall Medicaid expenditures during this timeframe, with the potential to return more than 15-fold savings to the Medicaid program over 10 years.