IV. Model Testing Proposal—Project Narrative

A. ARKANSAS HEALTH CARE INNOVATION PLAN TESTING STRATEGY

MODEL OVERVIEW

Model Purpose (Q1)

Arkansas 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 care delivery from fragmented and encounter-based care to coordinated, patient-centered and cost-effective care, organized around patients’ comprehensive health needs across providers and over time. Participating payers will enable the transformation by shifting payment from pure fee-for-service models that reward volume of care to models that support and reward effective care coordination and superior outcomes with respect to quality and cost effectiveness.

We have had substantive input and collaboration from CMS/CMMI since October 2011. Our initial efforts focused primarily on launching episodes of care. However, based on CMS/CMMI feedback, our health system transformation now includes two complementary strategies: population- and episode-based care delivery and payment.

- **Population-based care delivery, including medical homes and health homes:** Within 3–5 years, nearly every Arkansan will have access to a medical home that offers a local point of access to care and proactively looks after his or her health with a focus on preventive services and chronic disease management. Persons with developmental disabilities, long-term services and support needs, or more serious behavioral health needs will have access to health homes. Health homes complement medical homes by providing enhanced care coordination to improve how these populations navigate and experience the health care system.
- **Episode-based care delivery**: When a patient requires acute, procedural, or ongoing specialty care, one or more of the lead providers addressing the condition will be accountable for delivering high-quality, patient-centered, and cost-effective care across the entire clinical episode. The team will be evaluated and rewarded based on performance over the entire episode of care, with an expectation of coordinated management of services.

  We will enable these strategies through changes in payment, additional tools and direct provider support (including performance reports and access to expert practice transformation resources), and other enabling initiatives detailed in the *State Innovation Plan* (including workforce development, consumer engagement and personal responsibility, and health information technology adoption). The result will be improved health, quality, and cost.

**Scope of the Model (Q2)**

Arkansas intends to transform its health system through implementation of population- and episode-based care delivery and payment strategies. We have already made significant progress. Over the past year, participating payers have worked with more than 500 providers, patient representatives, and stakeholders to design and launch the first wave of episodes statewide. SIM grant support will enable Arkansas to build upon this initial wave of episodes, testing our population- and episode-based strategies with broader scale and scope across all major payers – Medicaid, private payers, and we hope Medicare. Our goal is to transition nearly all care in our state (more than 90% of spend covered by participating private payers, subject to exclusions and outliers) to these approaches over the next 3–5 years. See *Payment Model Approach* (p. 6) for detailed descriptions of the approaches.

The State (Medicaid), Arkansas BlueCross BlueShield, and QualChoice of Arkansas participated in the launch of the first wave of episodes and jointly developed the strategies and
plan described in this application. Together, these payers cover more than half the population and health care spending in Arkansas; with Medicare’s participation, the initiative would represent more than 90% of total healthcare expenditures for the insured population.

We have already reached an advanced state of planning and are beginning implementation. To maintain stakeholder momentum, we will request disbursement of SIM funds in early 2013 if awarded. Below is an overview of our plan to rapidly implement and scale population- and episode-based care delivery strategies (details in VII: Project Plan and Timeline).

A. Population-based care delivery and payment: Medical Homes (PCMH) roll-out

The Arkansas patient-centered medical home (PCMH) program will build on the CMS Comprehensive Primary Care Initiative (CPC) launching this fall. Over the next 2 years, we plan to expand the PCMH program to all of Medicaid’s primary care providers and the majority of those paid by Medicare and / or private insurers in 3 successive waves.

Wave 1 will comprise the practices already selected for CPC participation. This wave is set to receive care coordination fees in October 2012. Over time, we will fully integrate the CPC practices into the broader program. Wave 2 will begin voluntarily enrolling practices in early-2013 and will launch mid-2013. Payers expect about 30% of practices to enroll in this Wave. To qualify for shared savings, practices will need to meet a 5,000 person minimum panel size per payer and may do so independently or by entering virtual risk pools with other practices (described further in “Payment Models” pg. 6). Beginning in early-2014, Wave 3 will aim to enroll all or most remaining practices. As in Wave 2, minimum panel sizes (actual or virtual) will apply. At that point, provider eligibility for care coordination fees (including Medicaid ConnectCare) and shared savings will be contingent on program enrollment.
B. Population-based care delivery and payment: Health Homes roll-out

We plan to cover 100% of select complex populations with Medicaid health homes. Roll-out will occur in 3 population-based waves over the next 2 years. Wave 1 will include health homes for the adult developmental disabilities (DD) and long-term services and support (LTSS) populations. Performance reporting will begin in the second half of 2013. Payment changes will begin in Q1 2014 for DD and LTSS (the needs-based DD episode will launch at the same time). Health homes for DD children will follow 6–12 months after adults.

Waves 2 and 3 will cover high-needs behavioral health (BH) populations. Wave 2 will begin with a voluntary enrollment period for all interested and eligible providers. In Wave 3, all providers caring for this population will be required to become certified health homes.

C. Episode-based care delivery and payment: Retrospective risk sharing roll-out

We plan to apply retrospective episode-based payment (REBP; see Payment Model, p.6) to as many acute, procedural, or ongoing specialty care conditions as possible. Examples of addressable conditions include medical conditions such as acute ambulatory (e.g., upper respiratory infections [URI]), acute inpatient (e.g., CHF acute/post-acute, stroke, pneumonia), and acute procedural (e.g., coronary artery bypass graft [CABG]) episodes, among others and select behavioral health (BH) conditions with well-defined clinical guidelines (e.g., ADHD).

With the exception of complex conditions managed by specialists (e.g., cancer) and BH conditions like ADHD, we do not expect to implement episodes for chronic conditions. In most cases, chronic conditions will be addressed by Arkansas’ PCMH and health home initiatives.

At scale, participating payers aim to address as much as 50-70% of total spending through episodes, subject to exclusions and outliers (and if Medicaid expansion occurs as under the Patient Protection and Affordable Care Act, the percentage of spend addressable by REBP would
increase in 2014 as ~250,000 non aged, blind and disabled adults enter Medicaid).

The total spend base we are ultimately able to affect with episode-based payment will be influenced by several factors, including: the pace at which other organizations define episodes for payment; the efficacy and credibility of risk adjustment methodologies; and approaches to overcome small sample sizes for lower-volume providers. With the launch of Wave 1 episodes in July we have already made significant progress against these challenges.

To achieve our objective for penetration of episode-based payment, we expect to implement 75–100 episodes over the next 3-5 years, in three waves. **Wave 1**, comprising our initial 5 episodes, is already underway statewide and across payers. **Wave 2** will include 1-2 launches of 5-10 episodes each over the next 9-12 months. We aim to achieve full scale in **Wave 3**; starting in Q4 2013, we will roll-out ~5-10 episodes quarterly through mid-2016.

**D. Episode-based care delivery and payment: Assessment-based episode roll-out**

Over the next 3 years, we will also roll out assessment-based episodes in two population-based waves. These episodes, covering DD, LTSS and select BH services, will use individual assessments to identify a beneficiary’s “level of need” and associated care requirements. Payment for the episode will then be tied to the expected cost to administer the required services.

In **Wave 1** of the rollout, Medicaid will begin assessments for adults receiving DD or LTSS services, starting in November 2012 and continuing through 2013. In late 2013, Medicaid expects to begin episode-based payments, which will reach all adults in this population by the second half of 2014. Children will follow 6–12 months after adults. **Wave 2** will extend assessments to complex BH clients requiring the highest level of intensive, functional support.

**Payment Model (Q3)**
A. Population-based care delivery and payment: Medical Homes

Our PCMH payment model approach is designed to support and reward Arkansas’ primary care providers to transform our primary care delivery system. In addition, the State will provide transformation support to position practices for successful transitions to medical homes.

Payment

The payment model approach for PCMH consists of two components: care coordination fees and shared savings – each of which will begin upon enrollment. These are outlined below, followed by a number of technical details related to quality, reporting, provider participation, patient attribution, minimum panel sizes, and protections for financial sustainability.

1. Care coordination fees will be paid on a PMPM basis for attributed patients for the duration of the program to support ongoing operational expenses associated with care coordination and practice transformation tools, technology, and services. Providers will be expected to use these funds to meet ongoing program participation requirements. Accordingly, these fees will be tied to demonstrated practice transformation. Practice transformation will be measured based on metrics and milestones used in CPC and expanded to include nationally recognized quality metrics (e.g., by AHRQ) for pediatric care. Practices not demonstrating successful transformation initially will be required to develop and execute on a corrective action plan. Practices that consistently do not meet practice transformation requirements will not be eligible for continued receipt of care coordination fees (including Medicaid ConnectCare).

Arkansas Medicaid intends to maintain parity in care coordination fees among practices recently enrolled in CPC (Wave 1) and practices joining the Arkansas PCMH program in Waves 2 and 3. Arkansas Medicaid’s fee levels for CPC are $3 PMPM for children and $7 PMPM for adults. We propose that Medicare likewise preserve parity with CPC by paying an average of
$20 PMPM, tapering after two years. In order to preserve the independence of private payer decision making regarding payment levels, we would encourage CMS/CMMI to engage directly with private payers on their own plans. Arkansas Medicaid may make further adjustments to these proposed fee levels as necessary to provide support for reasonable costs for practice transformation and care coordination, including but not limited to an increase in fees for the first year of program participation and associated resource intensity. These costs will be further evaluated based on a public procurement process that Arkansas Medicaid will undertake to pre-qualify third-party vendors for transformation support, care coordination services, and technology to small provider practices unable to source these capabilities independently.

2. **Shared savings** payments will be paid for quality and efficient management of total cost of care. Again, our hope is to establish a shared savings model consistent with the one adopted by CPC. Since CMS/CMMI has not yet defined the shared savings model for CPC, we propose the following approach, which we are pleased to explore with the CPC team and modify as their own model is finalized. Our proposed shared savings approach will measure the value created by a provider (or virtual pool of providers), on a risk-adjusted basis, based on both (a) absolute performance and (b) performance improvement, and reward them based on the greater of the two amounts. This approach will create incentives for all providers to improve performance as well as to maintain strong performance.

2a. **Absolute Performance** will be measured based on calculation of the risk-adjusted total cost of care for patients attributed to a provider (or pool of providers), in comparison with thresholds for Acceptable and Commendable performance to be set by each participating payer, similar to the episode-of-care approach already approved by CMS for Arkansas’ Medicaid program, and also adopted by Arkansas BCBS and QualChoice. Similar to the episode-of care
approach, providers whose cost of care is below the Commendable threshold will be eligible to receive up to 50% of the difference between actual costs and the Commendable threshold. In contrast with the episode-of-care approach, providers whose costs exceed the Acceptable threshold will not be subject to downside risk, at least for the initial 3-year period of the program, recognizing that we are asking primary care providers to make a significant transition in their business models to manage total cost of care.

2b. Performance Improvement will be measured by comparing a practice’s risk-adjusted actual costs for a performance period to expected costs, calculated as the provider’s risk-adjusted historical baseline costs projected forward based on the Arkansas cost-of-care trend for that payer during the performance period. This approach is similar to that being used in several ACO demonstration projects previously introduced by CMS/CMMI. Our approach offers greater rewards to providers that start from a stronger baseline: those with baseline cost of care below Commendable will be eligible to earn 50% of savings achieved from performance improvement; those with Acceptable baseline performance will be eligible to earn 30% of savings achieved from performance improvement; and those whose baseline cost of care exceeds the Acceptable threshold will be eligible to receive 10% of savings achieved from performance improvement.

3. Quality and Reporting: Participating payers will track provider performance on quality and process measures consistent with those adopted as part of CPC, augmented to include quality metrics for pediatric populations (e.g., AHRQ metrics). Payments for care coordination and shared savings will be contingent on provider performance against a subset of these measures.

4. Participating providers: For Medicaid, a practice may become a medical home if identified as a primary care provider (PCP) through the state’s Primary Care Case Management (PCCM) program and reaches at least a minimum number of attributed Medicaid beneficiaries.
5. **Attribution**: The state intends to attribute to PCMHs all beneficiaries currently assigned under the state’s PCCM program. For beneficiaries not currently assigned, the state will either assign them to PCMHs through the same process used in the PCCM program or attribute them to the provider with whom they had the plurality of their Evaluation and Management (E&M) visits during the previous 2 years, depending on their beneficiary aid category. If a beneficiary did not have any E&M visits in that time period, the state will support these beneficiaries in engaging with a PCMH and over time will assign them to a PCMH based on their preferences.

6. **Minimum panel size**: Meaningfully differentiating provider performance from random statistical variation requires at least 5,000 patients per payer. Small providers therefore often lack the scale to participate in a shared savings model. The Arkansas PCMH program will address this challenge by facilitating voluntary affiliation of practices to achieve sufficient scale. The state will provide performance reports to help providers identify other practices with which they may form virtual pools.

7. **Stewardship of resources for the benefit of the PCMH program**: A number of rules will be applied to ensure appropriate stewardship of resources for the benefit of the PCMH program: (a) Medicaid and other participating payers will each establish a minimum savings rate (MSR), expressed as a percentage of total cost of care, that providers must exceed before they begin to share in savings; similar to other shared savings models introduced by Medicare and a number of private payers around the country, the MSR will ensure that payments reflect statistically-meaningful performance; (b) similar to the episode-of-care approach already approved by CMS for Medicaid and adopted by Arkansas BCBS and QualChoice, a gain sharing limit will be established which provides adequate opportunity for providers to earn significant upside to their base reimbursement while eliminating any incentive to achieve an extraordinarily
low cost of care; (c) provider’s cost of care for the performance period must be below the
Acceptable threshold to be eligible for shared savings; (d) in this upside-only model, portions of
losses and statistically non-significant gains may accrue over time and included in calculations of
future year shared savings, mitigating risk of year over year fluctuations to the PCMH program.

**Provider transformation support**

Successful transition to PCMH requires effective tools, capabilities, and personnel. Arkansas
will support PCMH providers in practice transformation by identifying and ensuring access to a
set of qualified vendors with expertise in facilitating and supporting successful practice
transformation, as well as care coordination services and technology for small practices unable to
efficiently source these capabilities themselves. With input from providers on required
capabilities, the state will identify and pre-qualify a set of vendors. Providers can then contract
directly with the vendors to source resources most relevant to their practice needs. This approach
accommodates the diverse needs of Arkansas primary care practices. Where there are not
vendors with the requisite capabilities, payers may also provide direct technical assistance.

**B. Population-based care delivery and payment: Health Homes**

For developmental disabilities (DD), long-term services and supports (LTSS) and behavioral
health (BH) populations, clients will have a health home managed by the client’s primary
provider of services over time, i.e., the “lead provider”. The health home assigns accountability
to the lead provider for the full client experience, including improving health outcomes,
streamlining the care planning process, and developing and executing an integrated plan
spanning medical care and DD, LTSS or BH services. The health home is a complement to, not a
substitute for the medical home: the medical home quarterbacks medical services while the
health home coordinates across medical and support services (e.g., waiver services).
**Payment**

Currently clients in institutional settings and on the ACS Waiver receive (explicitly or implicitly) a care coordination PMPM amount for case management that is not contingent on performance. In the future, health home payment will cover the full range of health home responsibilities and will include a PMPM fee. A portion of the PMPM will be at-risk based on acceptable performance on process and outcome metrics for care management and coordination. PMPM payments will be risk-adjusted based on the results of a universal assessment of a person’s level of DD, LTSS or BH needs and their medical complexity.

BH health homes will take responsibility for ensuring cost-effective and high-quality treatment in appropriate settings for all BH conditions not covered by episodes. Payments for these core BH services will be tied to performance using leading indicators and outcomes.

**Provider transformation support**

As in the medical home approach, the State will assist provider transformation with programs to enable efficient data management and sharing across providers. This will occur both by identifying and prequalifying appropriate vendors and by building Medicaid capabilities to enable data collection and reporting. The state will also support provider learning and continuous improvement (e.g. via training programs and learning collaboratives for best-practice sharing).

**C. Episode-based care delivery and payment: Retrospective risk sharing**

The episode-based care delivery and payment model rewards providers who deliver high-quality, patient-centered, and cost-effective care for a clinical episode. Providers will be incented to make earlier investments in diagnosis, patient education and treatment; to effectively coordinate care minimizing preventable complications, duplications and inefficient use of services; and to refer patients to the highest-value providers. We believe that an episode-based
approach for acute medical / procedural and select complex chronic conditions managed by specialists is complementary to a population-based care delivery strategy.

**Payment**

Participating payers have defined and implemented a comprehensive “retrospective episode-based payment” model, or REBP, for medical episodes and behavioral health conditions. This innovation will allow us to roll out episodes statewide, including among fragmented providers.

For each episode, patients seek care as they do today, and providers continue to file associated claims and receive payments on a fee-for-service basis as they do today. At the end of a predetermined “performance period,” payers review claims and attribute one or more providers as the principal accountable provider (PAP) for each qualifying episode. The PAP is responsible for the overall quality and cost effectiveness of care included in the episode. Payers then calculate each PAP’s average costs and quality across all of the episodes delivered during that performance period and compares them against performance thresholds independently preset by each payer. If a PAP achieves an average episode cost below a “commendable” threshold and meets quality requirements, savings beneath the commendable threshold are divided between the PAP(s) and the payer or plan sponsor. If a PAP’s performance reflects an average cost exceeding an “acceptable” threshold, the PAP is responsible for a share of costs in excess of the threshold.

![Illustrative provider average costs for general URI episodes](chart.png)

"Year 3 average cost / episode

Dollars ($)"

- Pay portion of excess costs
- No change in payment to providers
- Receive additional payment as share as savings
- “Acceptable”
- “Commendable”
- Gain share limit

PAPs
This approach encourages PAPs to consider and manage care across the episode, but does not require providers to develop new contractual relationships with one another, enabling a broader and faster statewide rollout. This payment structure emerged after substantial feedback from stakeholders and public workgroups and takes into account Arkansas’s relatively fragmented delivery system. Based on provider input, the approach also implements several adjustments for fairness and accuracy, including patient exclusions, patient risk adjustment, provider adjustments, regional adjustments, and stop-loss provisions. In addition, savings and excess cost calculations are made based on average cost of care, not just the cost of a particular episode. This allows for biological variation across patients and for physicians to apply clinical judgment, using evidence informed care.

Our approach reinforces quality in several ways relative to the fee-for-service system. By design, it holds providers accountable for quality outcomes and rewards those who are able to reduce complications, error rates, and care that is not evidence-informed. In addition, to avoid any unforeseen incentives for underuse of care, we define two types of quality measures for each episode: quality metrics linked to payment (“performance metrics”) and quality metrics for reporting only (“reporting metrics”). To be eligible for gain sharing, a provider must meet a quality threshold on all performance metrics, as well as fully report data for reporting metrics. Moreover, gain sharing payments will not be made beyond a “gain sharing limit” to be set by each payer. We expect to perform select “audits” of abnormally low utilization or of poor performance on other measures. Our response to Question 13 (p. 30) provides additional detail.

**Provider transformation support**

Providers will receive detailed reports of their performance on cost, quality, and utilization metrics. The reports will show a provider how his or her performance compares with others in
the state, and will allow providers to identify which utilization categories drive performance on cost effectiveness. In addition, we will enlist providers and provider associations across the state to help drive practice pattern changes across episodes. This might include, for example, sharing best practices, guidelines, and success cases for how to improve cost and quality for an episode.

D. Episode-based care delivery and payment: Assessment-based episode

The primary goals of the episode approach for DD and LTSS are to: (1) ensure that care provision is efficient and based on client needs (aligning resources provided with a client’s level of need and expanding plan customization options for clients); and (2) minimize time and resources not focused on delivering client care (e.g., limiting administrative requirements to report low-value data that goes unused).

To achieve these goals, episode payment for DD and LTSS episodes will be based on individual assessments carried out by independent assessors using a consistent assessment tool. The assessment will identify a “level of need” for each client to be matched to a prospectively-determined dollar amount for service provision. The assessment ensures that a fair, fact-based, comprehensive view of a client’s need is the foundation for service allocation.

In the current delivery system, nearly all clients have a clear lead DD or LTSS provider. In line with this, payers will remit the prospectively bundled payment to the single lead provider selected by the client (with advice from his/her family). This lead provider will be responsible for ensuring that services across clients are delivered within a total budget and according to each client’s plan of care. This will avoid perpetuating any misaligned incentives.

Value Propositions and Performance/Improvement Objectives (Q4)

Value proposition
For patients: Payers will explicitly be rewarding providers to improve the patient experience, i.e., to be efficient, to better coordinate care and care transitions, and to invest more time directly engaging patients in their health, health care, and prevention. This will enable and encourage patients to take an active role in their health and health care. Finally, we expect long-term reductions in health care costs to directly benefit Arkansans by lowering private insurance premiums and public program expenditures.

For providers: Payers will explicitly reward providers who consistently give excellent care to their patients, i.e., high-quality, efficient care, without intervening in care decisions to do so. For example, there is no reason for payers to require pre-authorization of a diagnostic test if the prescribing physician is held financially accountable for the value that test offers. Payers will also provide detailed data to help providers understand their performance and opportunities to improve how they serve patients. Finally, as described above, payers will provide support for practice transformation to medical home and health home providers.

Improvement objectives: As detailed in the State Innovation Plan, our improvement objectives span time horizons and target each element of the Triple Aim, described below:

- **Improve the health of the population:** We aim to significantly improve health outcomes for Arkansans. While changes to health outcomes will occur over the longer term, we will monitor our trajectory by assessing progress indicators and intermediate outcomes, such as decreased disease progression (e.g., diabetes, CHF), greater control of hypertension, reduced readmission rates and ambulatory sensitive hospitalizations (e.g., pneumonia, asthma), and fewer late-stage cancer diagnoses.

- **Enhance the patient experience of care, including quality, access and reliability:** We aim to significantly improve health care quality as we implement new care delivery approaches.
We will monitor our progress and seek to consistently improve and sustain results, actively tracking measures such as AHRQ indicators, the new CMS-CHIPRA pediatric quality indicators and CMS adult quality measures. Examples of specific metrics include reducing early deliveries (before 39 weeks) to less than 10% state-wide, achieving 50% completion rate of comprehensive diabetes metrics (including hemoglobin A1C, lipid measurement, and eye exams), and measuring and improving documentation of blood pressure control.

- **Control the cost of health care**: Net of delivery system re-investments,\(^1\) we expect our model to save the system $1.1B\(^2\) over the 3-year grant period, including $540M to Medicaid and $265M to Medicare, and $8.9B through 2020 relative to baseline spending.

**Evidence Basis for Testing the Model (Q5)**

Nationally, payers, providers and integrated systems have achieved results with similar delivery models, e.g., episodes (e.g., CMS ACE demonstration, IHA bundled episode of care pilot, Geisinger ProvenCare program, Prometheus/HCI3) and primary care transformation. And many are pursuing strategies similar to our DD, LTSS and BH approaches, e.g., at least eight states have begun development of “assessment-based models” with individual or level-based budget allocations, and more than 10 states have established health home models (including for DD, LTSS and BH populations). However it is not clear that any health care market in the U.S. has rapidly or comprehensively scaled a delivery system transformation successfully.

Additionally, while many programs have demonstrated improvements in the quality and efficiency of care, none provide a template for rapidly transforming an entire state’s delivery system. With PCMH, for example, significant improvements in care coordination are typically limited to integrated systems or large multispecialty practices; cases of clinical practice change at

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1 Savings after payout of care coordination fees and incentive payments/ savings shared with providers
2 Excludes impact attributable to CPC
scale are generally achieved at modest pace, e.g., Vermont BluePrint for Health, Community Care of North Carolina. Most assessment-based episodes and health home models are still in pilot or development phases that have not yet demonstrated results.

However, when pursued together, we believe our population- and episode-based approaches have significant potential for achieving our objectives for the following reasons:

(1) These complementary strategies address the spectrum of unjustifiable variation in the quality and cost of health care in Arkansas. Population-based strategies (e.g., PCMH) provide the “umbrella” for total quality and cost accountability. Episodes are “nested within” population-strategies to target episode-level variation and inefficiencies. For example, nearly 50% of Arkansans presenting with general upper respiratory infection (URI) are prescribed an antibiotic even though antibiotics are indicated in less than 5% of cases. This type of analyses, together with provider discussions and reviews of available literature, highlight many targeted opportunities to improve health care delivery in Arkansas. Analysis of special populations (DD, LTSS and BH) revealed significant variation in the level of care provided across clients with a similar demonstrated level of need. Key drivers of variation include lack of a comprehensive and standardized client needs assessment and use of fragmented, duplicative care planning processes.

(2) Outcomes-based care delivery and payment models can change provider practice patterns in Arkansas. The evidence is already here. Since launching our initial Wave of episodes in July, we have observed providers taking new actions to better manage patient care and care coordination as a result of the enhanced accountability, incentives and reporting. For example, we have seen, providers proactively approach hospitals at which they practice to collaborate on ways to reduce length of stay and enhance outcomes. More broadly, our discussions with over 500 providers and patient representatives have helped us better appreciate
how fee-for-service (FFS) payments undermine attempts at better end-to-end management of care. As we roll-out new models, participating payers are committed to continue providing requisite incentives and provider support (e.g., tools and resources) to enable success. Where providers cannot easily access resources, we will consider direct support.

**Theory of Action (Q6)**

Three fundamental principles underlie both population- and episode-based strategies:

1. **Rewarding outcomes, not volume, will lead to changes in practice patterns.**

Expanding provider accountability beyond direct services rendered encourages team-based care and, coupled with meaningful financial incentives (direct support and/or risk-sharing), motivates providers to invest both time and money in practice pattern changes. Finally, incentives contingent upon quality improve outcomes. For example, in our model, a joint replacement episode comprises all related services 30 days prior through 180 days after the procedure. This incents the lead surgeon to proactively manage transitions, minimize duplicate or unnecessary care, refer patients to efficient providers and optimize post-acute services.

2. **Continually involving providers in delivery system innovation improves outcomes for patients and providers.** The new payment model represents a new and permanent partnership with clinicians in Arkansas. These payment reforms take outcomes, performance and quality directly into account, and are an extension of clinical judgment of physician leaders.

3. **For payment model transformation to be successful, payers must complement financial incentives with data, tools, and other support for providers.** As we broaden provider accountability beyond services rendered, providers must also have access to the full range of care received by a patient panel or within episode regardless of who rendered care. For the first time, we are providing this data to providers in Arkansas. For example, an orthopedic
surgeon now knows when his/her patient is readmitted and whether the team of post-acute providers is cost effective. Similarly, primary care physicians will know when their patients have gaps in care as well as how well other providers on the team—including specialists—are delivering care. In addition, providers must be able to access and support the resources and capabilities needed to deliver team-based care. In our PCMH approach, practices will have access to vendors, pre-qualified by the state to support practice transformation, and to organized learning collaboratives where innovative providers across the state share best-practices.

**Related Federal & State Initiatives (Q7)**

The delivery system and payment approaches being implemented in Arkansas are founded upon and/or tightly linked to existing CMS/CMMI models, e.g., medical homes, health homes and episode-based care. We aim to have Medicare join as a participating payer, adopting the Arkansas approach and rollout schedule. We recognize that Medicare will continue to operate autonomously and may need to make specialized or independent design decisions.

**A. Population-based care delivery and payment: Medical Homes**

The state’s public and private payers are jointly participating in the federally sponsored multi-payer demonstration project, the Comprehensive Primary Care Initiative (CPC). Arkansas has designed its broader scale-up strategy for medical homes to be consistent with the design and structure of CPC. While PCMH provider payments within SIM would be underwritten and managed separately from CPC. Medicaid and participating private payers will manage the broader program in a consistent way and over time will fully integrate CPC.

**B. Population-based care delivery and payment: Health Homes (for Medicaid)**

The Arkansas health home model is fully aligned with CMS on its mandate to provide enhanced care coordination to beneficiaries with complex needs and multiple co-morbid
conditions. Led by a client’s special needs provider, health homes will function as coordinators of a client’s comprehensive care plan rather than as direct providers of enhanced primary care or medical services as with CMS. Arkansas Medicaid continues working closely with CMS to fully align its health homes models, beneficiary eligibility criteria, and definitions of chronic conditions with federal guidelines as established by 2703 of the Affordable Care Act.

C. Episode-based care delivery and payment: Retrospective risk sharing

Comprising select acute- and post-acute services (e.g., 30–180 days post-discharge) with retrospective risk sharing payments, the Arkansas model aligns closely with the CMMI Bundled Payments for Care Initiative (BPCI), Model 2. While the distribution of payments differs slightly, the clinical and financial rationale, episode logic, and structures are consistent. For example, a provider in Arkansas preparing a BPCI application worked hand-in-hand with the AHCPII team in designing Wave 1 of our retrospective-risk sharing episodes to define clinically and structurally consistent episodes for the same conditions using the BPCI Model 2. Going forward, Medicare could continue to align on episode rationale, logic and sequencing.

D. Episode-based care delivery and payment: Assessment-based episodes

Our approach to assessment-based episodes in Arkansas aligns with related federal funding programs for the applicable populations (i.e., DD, LTSS, BH), including Community First Choice Option, Balancing Incentives Payment Program, and Money Follows the Person.

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<th>PAYMENT MODEL DETAILS</th>
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<td>Sustainability Plans (Q8)</td>
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Our model test is part of an evolving delivery system transformation in Arkansas. Maintaining our momentum and stakeholder alignment is key to establishing and sustaining these models. Over the past 1½ years, Medicaid has invested to build a sustainable foundation
for change, including deep engagement with providers and stakeholders on the value proposition
supporting the move to population- and episode-based care delivery. Over the next 3 years, we
will rapidly expand our model; we are committed to funding this. Participating private payers
have provided significant in-kind and financial support to date which we expect to continue.

(1) **Build a payment innovation team and continue investment in program management:**
Our team has designed and begun to onboard a payment innovation organization within
Medicaid. The team will provide core PMO functions, e.g., strategy and leadership, project
management, and continuous improvement. Seventeen of the FTEs needed to support full scale
payment reform are already in the Medicaid budget. As upfront vendor support ramps down,
Medicaid plans to increase internal capacity through ongoing commitment of state resources,
internal capability building and/or realignment, normal attrition, and consolidation of functions.
We expect this team, coupled with continued vendor-based program maintenance (e.g., software,
analytics) will sustainably operate, manage and improve the program over time.

(2) **Complete a substantial portion of the rollout and launch over the next 3 years:**
Across PCMH, health homes and episodes, Medicaid has committed to an aggressive scale-up
plan over the next 3 years, including rollout of PCMH, health homes, and episodes to cover the
vast majority of spend in Arkansas. Our approach includes the use of third party expertise and
support to accomplish this. After 3 years, emphasis of our resources will shift toward overall
program maintenance and incremental expansion rather than increases in scope or complexity,
with ongoing operations and maintenance conducted by our payment innovation team.

(3) **Establish a sustainable operating model:** Medicaid is transforming our internal
capabilities and infrastructure in parallel with the Arkansas delivery system. Like many states,
we are resource constrained. We have invested substantially upfront to develop an operating
model and supporting infrastructure that will support rapid scale-up within our existing resource limitations and capabilities. We believe we are developing an efficient and truly innovative approach to scale-up and sustainability including: (a) Streamlined, standardized processes for episode development, local customization, approval and launch, (b) Modular infrastructure for reporting and analytics that is able to bolt onto existing claims databases, is customizable by payer, and adaptable across payment models, and (c) Partnerships for rapid episode definition and support for provider transformation and care coordination.

**Replicability (Q9)**

As outlined in the *State Innovation Plan*, our transformation approach has significance beyond Arkansas. Like many states, ours is fragmented; with 60% of physicians in practices of 5 or fewer physicians it is characterized by a large number of independent providers with a large rural population. In addition, our model is replicable in both MCO and non-MCO settings, i.e., independent of the underlying insurance model. Successful implementation could represent an important model both for other Delta region states, and for states across the country with distributed patients or providers.

**A. Population-based approach:** Two features of our PCMH program make it broadly replicable and rapidly scalable in other markets. First is allowing practices to pool volume for incentive payments. Typically physician accountability for total cost of care is difficult in fragmented markets, because most practices do not have the scale necessary to participate in a statistically meaningful way. Through voluntary affiliation with other practices, our PCMH program enables practices to achieve the scale needed to participate in shared savings on total cost of care. Second is enabling at-scale practice transformation. Many small practices do not have requisite resources or capabilities to perform new care coordination services effectively.
The state will pre-qualify a small set of vendors with established expertise in facilitating successful practice transformation and providing tools and resources to do so. Providers can then contract directly with vendors as needed to access services, tools and resources most relevant to their practice and population needs. We believe this approach will be attractive for many other states with fragmented provider communities.

**B. Episode-based approach:** In Arkansas, few providers are able and willing to perform administrative functions customized for new payment models (e.g., prospective bundles). As a result, we developed a retrospective episode-based payment model (see *Payment Model*, p.6), built on the existing fee-for-service payment system without requiring independent providers to develop new contractual relationships with one another. This has allowed Arkansas to rapidly roll out episodes statewide across providers; we believe this model is applicable in any market.

### Target Population (Q10)

Our proposed model will target the entire delivery system in Arkansas, across the continuum of care and over all populations. Like many states, Arkansas is largely rural - about 40% of Arkansans live in rural areas. With a disproportionate share of physicians and acute facilities operating in urban areas, many communities are underserved. For example, in 2009, 8 counties had more than 5,000-15,000 people per primary care physician. Improving outcomes for Arkansans must therefore include a comprehensive transformation. Our medical home and retrospective episode models therefore target all insured Arkansans; our health home and assessment-based episodes target specific special needs populations.

**A. Population-based approach: Medical Homes:** PCMH will focus on the entire primary care community in Arkansas and therefore all patients in Arkansas. In the first several years, it will focus on primary care providers in the following specialties: pediatrics, family medicine,
internal medicine, geriatrics, and general medicine. Over time, the program will expand to include additional specialties (i.e., where practices commit to providing PCMH-type care). Full participation of all PCPs is critical; if necessary, payers may establish incentives to motivate practices that do not enroll in the early phases.

B. Population-based approach: Health Homes: The health home component of the program will span all providers serving clients with developmental disabilities or requiring long-term services and supports. The model for behavioral health will focus only on providers serving the highest needs clients (as defined by a combination of condition-specific and utilization criteria). The model will launch gradually over the next 2–3 years. In the first phase, the model will include all adults with DD or adults receiving LTSS only followed 6–12 months later by children with DD and select behavioral health clients.

C. Episode-based approach: Retrospective Risk Sharing: We intend to roll out episodes in statewide waves based on clinical condition rather than geography or patient population. These waves will launch batches of episodes prioritized using a combination of factors, including public domain episode definitions, expanding coverage to a comprehensive set of spend for specific provider types, and episodes where there is a large amount of meaningful variation in spend. We will target higher spend areas first. Similarly, we will prioritize rollout of episodes for the behavioral health population. It is a priority that we fully involve the mental health provider community in the move toward value (building on the ADHD episode launched in July).

D. Episode-based approach: Assessment-based: We intend to cover the vast majority of DD and LTSS expenditures through assessment-based episodes. These will include all clients of all ages, regardless of setting of care. To achieve this goal, the state is launching assessments and reporting at the end of 2012, which will rollout gradually throughout 2013 and 2014, beginning
Potential for success: We have high expectations for success of our models.

We have already accomplished significant, ground-breaking milestones. In July 2012, we launched 5 episodes on a statewide, multi-payer basis that impact over 1,000 providers in Arkansas. We succeeded in rapidly developing the infrastructure to support the launch, providing performance reports to all designated Principal Accountable Providers, and launched a multi-payer portal to provide reports to providers and to collect supplemental quality metrics for select episodes. In addition, we obtained the state and federal regulatory and legislative approvals required to launch our retrospective episode-based payment models.

Local stakeholders, clinicians, and patient representatives provided substantial input into the design of our models. We have engaged more than 500 stakeholders statewide through multi-payer workgroups, with more than 20 workgroup meetings since summer 2011. Input from these workgroups has substantially defined the direction of our initiative. For example, we had initially started with a prospective bundled-payment model for episodes; our change to a more broadly applicable and scalable retrospective model was the result of stakeholder feedback.

We designed our approach to address many of the challenges we face in implementing health system transformation. For example, our fragmented health system presents challenges to scaling care coordination and to implementing typical shared savings models as commonly conceived. As described, we developed innovative approaches for both population- and episode-based models to address the challenges of provider scale.

We see early evidence that our efforts are changing provider dialogue and behaviors. For our Wave 1 episodes already launched, we have spent significant time with individual

Arkansas State Innovation Model
providers and have observed providers taking new actions to better manage patient care as a result (see also

*Evidence Basis for Testing the Model*, p. 16) of the enhanced data and future incentives. In addition, we are seeing early evidence that providers are changing their business models in preparation for enhanced collaboration and risk-sharing capabilities through both formal and informal changes in provider practice alignment.

**Risk factors:** Several external factors may influence our ability to reach desired scale at the timelines we have set forth. We are working proactively to identify, address and / or mitigate any potential risks with a focus on the following:

**Continuing stakeholder support:** While many providers and other stakeholders have been deeply involved and supportive to date, the success of our initiative will depend on continued engagement from and collaboration with Arkansas’s clinical leaders and providers. Provider support is likely to hinge critically on payers’ ability to follow through with investments, supporting tools, and meaningful performance incentives as described in the grant application.

**Medicare and continued multi-payer participation:** The new delivery models require substantial behavioral and practice transformations by providers, as well as sufficient volume for statistical reliability. Medicare and multi-payer participation enable this by (a) providing incremental PMPM funding to providers to support new business model and care coordination requirements and (b) ensuring “critical patient mass” both to cover most of a relevant provider’s reimbursement through the new model and to meet minimum case volume thresholds. Without Medicare alignment, we expect transformation to be more challenging for providers with the potential for insufficient funding and patient volume to fully motivate practice transformation.

**Challenges for episodes:** The pace of our rollout is dependent on external organizations
defining episodes for payment, the efficacy and credibility of risk adjustment methodologies, and overcoming relatively small sample sizes of lower volume episodes or lower volume PAPs. Rollout for assessment-based episodes will depend on the ability to maintain pace of independent assessments, particularly for children and select behavioral health clients.

**Challenges for medical homes**: Transformation of primary care in Arkansas requires overcoming challenges associated with a fragmented primary care system with varied technological sophistication, relatively small sizes of primary care patient panels, and a broad array of baseline practice patterns, workflows, and cultures.

**Challenges for health homes**: Health home lead providers will increasingly be required to coordinate seamlessly with each patient’s medical home as PCPs transition to HIE and data exchange; however, this will challenge seamless integration of non-medical providers who, to date, have not been a part of recent EMR/HIE supplements and development efforts.

**Unintended consequences**: The state has already expanded its program integrity focus to enable early identification of changes in coding practices, other unfavorable shifts in care practices that take advantage of episode logic, as well as unexpected shifts in cost or quality. Medicaid has added a new high-level program integrity officer dedicated to review, improve, and potentially redesign program integrity efforts to support performance- and risk-based models.

**Provider practice sustainability**: Providers must rapidly evolve their business models to avoid economic risks where the costs of new capabilities outweigh the incentives. Practitioners may also perceive greater risks for malpractice when shifting to evidence-informed care that potentially conflicts with traditional patient expectations for services.

**Health care workforce**: While the state’s formal health care workforce effort will support system transformation, developing enough resources with adequate skills quickly enough to
implement these changes over the next 3 years will be a challenge.

**Clinical Improvement Targets (Q12)**

**Current Clinical Quality and Beneficiary Experience**

Over the past decade, Arkansas’s Agency for Healthcare Research and Quality (AHRQ) ratings across 145 clinical quality and experience metrics have significantly improved, achieving an average performance in the region; however, the rank for overall quality of care in Arkansas is still weak compared to other states. Arkansas is rated strong for nursing home care, but weak to very weak across almost all other settings, types of care and clinical conditions. Additionally, Arkansas rated weak in care quality disparities based on socio-economic status, though it performed stronger than average in quality disparities based on race.³

**Improvement Targets**

Maintaining and improving quality and patient experience is a core part of both our population- and episode-based strategies. Our vision is that all patients receive high-quality cost-effective care. We will achieve this in several ways.

**Use of performance metrics**

Each care delivery and payment approach will include evidence-informed clinical quality and/or beneficiary experience metrics, linked to payment and/or reporting.⁴ At a minimum, quality performance is reported to providers quarterly; we believe performance transparency will enhance awareness and lead to improved performance. For select measures, incentive payments (e.g., shared savings) are contingent upon meeting minimum requirements for the measure—a unique feature of our gain sharing model. We are tracking additional metrics as well.

**Incentives for high-quality episodic care**

³ AHRQ Arkansas State Snapshot 2011
⁴ Metrics typically aligned with those already in use by national organizations, e.g., CMS, Agency for Healthcare Research and Quality, and the National Quality Forum
The episode model is inherently structured to incent high-quality care by incorporating all of the care associated with a specific condition in the calculation of total cost. For example, by including readmissions in the design of the congestive heart failure (CHF) episode, the payment model encourages management of patient transitions to avoid subsequent inpatient stays.

**Episode-related clinical quality and patient experience metrics**

Each episode also includes a set of clinical quality and patient experience metrics. Some of these measures are directly linked to PAP payment, while others are provided for reporting purposes to offer added transparency into care patterns. For instance, for total hip and knee replacement episodes, PAPs receive reports highlighting their performance on a set of measures including post-op symptomatic deep venous thrombosis/pulmonary embolism during inpatient stays and 30-day infection rate resulting in hospitalization. In the perinatal episode, PAPs are accountable for performing prenatal screenings (e.g., must demonstrate a minimum 80% rate for prenatal HIV screening). And, in the URI episode for pharyngitis, PAPs are accountable for their rate of strep testing when prescribing antibiotics.

The episode model also incorporates features to address the potential for low utilization or other quality issues. In the ADHD episode, for example, PAPs must certify they have provided guideline-concordant care. The State's program integrity efforts have been expanded to identify changes in utilization or prescribing as a result of the episode model.

**Metrics for population-based medical and health home approaches**

Metrics will range from patient experience (e.g., CAHPS survey metrics), care coordination (e.g., AHRQ prevention quality indicators), and preventive health for at-risk populations. Aggregate performance measures will be reported to providers and used to determine provider eligibility for incentive payments (shared savings and/or PMPM care coordination fees).
Health Status and Target Outcomes (Q13)

For a number of reasons, Arkansas currently ranks at or near the bottom of all states on a range of overall and specific health indicators. Arkansans have limited awareness of their health. For example, only 75% of Arkansans with high blood pressure and 62% with diabetes are aware of it and only 30% of Arkansans with high blood pressure and 28% of diabetics have their conditions controlled due to limited awareness or understanding of the treatment. We aim to reduce these rates through population-based models which support and reward providers who actively engage patients in education, adherence and prevention.

Similarly, statistics show we can improve population health through early intervention. In cardiovascular, premature and cancer deaths, we rank 46th, 46th, and 43rd, respectively. These outcomes correspond to poor rankings in determinants of health: 46th in smoking, 43rd in early prenatal care, and 43rd in preventable hospitalizations. Rising rates of obesity and diabetes contribute to the state’s disease burden as well. For example, 65% of the adults with developmentally disabilities have at least one secondary condition (e.g., high blood pressure, high cholesterol, diabetes). The same study has show that the prevalence of obesity in the DD population is higher than average (86% of all adults with DD are also obese). With a focus on care coordination, coaching, and preventive measures, our medical and health home models will be accountable for improving these outcomes and will help patients and providers manage conditions before they cause acute issues or health deterioration.

Episodes seek to improve outcomes for specific clinical episodes. With over 75-100 episodes to roll out, these are too numerous to detail on a condition by condition basis but are reflected

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6 America’s Health Rankings 2011. United Health Foundation
7 America’s Health Rankings 2011. United Health Foundation
8 A Report on the Health of People with Developmental Disabilities in Arkansas, UAMS
below through a representative example (URI). The acute ambulatory upper respiratory infections (URIs) episode includes all URI-related care in a 21-day window beginning with a patient's first visit with diagnosis of URI. In Arkansas today, approximately half of all patients presenting with non-specific URI receive antibiotics although national guidelines suggest these URIs are typically viral, and antibiotics are rarely indicated. The episode cost thresholds explicitly adjust for the expectations set by the national guidelines for antibiotic usage, ensuring the URI episode aligns financial incentives with more clinically effective and cost-efficient care.

Medicare Payment Models & Medicaid Waiver Authorities (Q14)

We believe our proposal will qualify for Track 1 funding. CMS has already approved Arkansas’s State Plan Amendment (SPA) for our episode model, and we intend that future episodes align to this model. As described in this section and elsewhere, the delivery and payment models being implemented in Arkansas are aligned or linked to existing CMS/CMMI models. In addition, we request Medicare join as a participating payer, recognizing Medicare may need to make its own design decisions.

A. Population-based Care: Medical Homes

Arkansas’s PCMH payment approach aligns with both existing Medicare demonstration models and Medicaid waiver authority. Our payment structure that includes care coordination support and shared savings is consistent with the payment model in the Comprehensive Primary
Care Initiative (CPC). Since the Center for Medicare and Medicaid Services through CPC has not fully defined its shared savings approach, our approach employs two reference points in doing so. Within the shared savings model, the absolute performance component aligns with the payment structure for our episodes, which has already received federal and state approval (see below). The performance improvement component of the shared savings model, including the elements to ensure appropriate stewardship of funds, is similar to that used by several ACO demonstration projects led by CMS/CMMI.

The PCMH payment structure – modeled on CPC – is consistent with the guidance provided in the State Medicaid Director’s Letter (SMDL) on Policy Considerations for Integrated Care Models from July 2012. Our specific payment approaches of care coordination support on a PMPM basis and shared savings, align with the models described in attachment 4 of the SMDL. Based on guidance from that letter, the State expects to build from our existing 1115(a) demonstration waiver for PCCM to implement our PCMH program.

B. Population-based Care: Health Homes

The state’s health homes will fully align with CMS guidance and will follow the seven core components outlined in the state plan amendment template. While health homes in Arkansas will be tailored to address specific needs of target populations, they will maintain a consistent approach to care coordination, performance measurement and payment (where appropriate). Based on review of models in over 10 states with recently drafted state plan amendments for health home services, we expect that each of our health homes will be compliant.

C. Episode-based Care: Retrospective Risk Sharing

Arkansas has received state and federal approval for its retrospective episode model. CMS reviewed and approved the State Plan Amendment this year, and the Arkansas General Assembly
gave favorable review to a new "Episode-based payment" section for the Arkansas Provider Manual. We believe broader rollout is consistent with the CMS approved approach.

D. Episode-based Care: Assessment-based

Assessment-based episodes will operate under separate state and federal waiver authority from the recently approved SPA for retrospective episode-based payments. Payment will operate under one of two existing regulatory authorities: (1) for populations where services are delivered in a community setting, episode-based payments will operate under existing 1915c waivers or through the Community First Choice Option (CFCO) state plan authority, or (2) for facility-based payments (nursing homes, ICF), changes in Arkansas will be based on CMS current Medicare methodology (i.e., based on the MDS [InterRAI] assessment data); however, specific payment levels will be determined using a broad data set spanning all levels of care.

REQUEST FOR CMS/CMMI SUPPORT:

While our ability to move forward is not immediately contingent on Medicare participation, we believe alignment of Medicare is critical to achieving critical mass for our providers. As such, we are requesting that Medicare: (1) at minimum begin reporting performance to Arkansas providers on episode-based costs and quality, using the same measures, report designs, data exchange channels, and potentially the same analytic and reporting platform already implemented for retrospective episodes by the participating payers; (2) provide a technical support team to work with the Arkansas multi-payer effort to define how Medicare can best participate in the new payment models; and (3) join with the other payers in rolling out PCMH broadly to the entire state, building on the principles of CPC. In addition, we ask that Medicare consider adopting the same payment models as other participating payers in Arkansas, recognizing Medicare may need to make its own design decisions.
For further consideration, providers within our community have asked for support in determining whether they may share with one another rewards received from our new payment approaches, while remaining in compliance with Stark and other applicable federal and state laws and regulations. In response to their request, we will in the coming weeks seek an OIG opinion on this matter to determine whether gains may be shared without further waivers. Depending on the opinion received from OIG, we may then wish to explore with CMS/CMMI the potential for waivers to be granted to Arkansas similar to those applied to the Medicare Shared Savings Program. In the interim, we ask that this application for funding be evaluated for approval without contingency on review for such waivers.

**Alternative Plans for Implementation (Q15)**

Because we have either aligned our approaches with existing CMS/CMMI models and demonstrations, or have already received required regulatory approval, we anticipate full implementation of our proposals. In the event we do not receive approval to modify our existing 1115(a) demonstration waiver for PCMH payment, and/or we do not receive approval for a State Plan Amendment for health homes, we plan to proceed with the non-payment “core elements” of our both models regardless of approval status. We believe there is an opportunity to drive change through our core non-payment levers such as: performance measurement and reporting, enhanced care coordination and transformation support through learning collaboratives, best practice sharing, and continuous improvement.

Over time, CMS may determine that aligning fully with the Arkansas retrospective risk sharing payment model will optimize impact for Medicare beneficiaries and cost-savings to the public. At such time, we will work with CMS to determine any regulatory modifications.

**PROJECT PROCESSES AND OPERATIONAL PLANNING (Q17)**
A. Data Collection and Reporting

As a system, we intend to collect data and report performance at three levels. First, we will track overall performance against targets. This will include analyses of administrative claims data and collection of supplemental quality metrics through a web-based provider portal. Second, we will have system surveillance for unintended consequences. This will include analyses of administrative claims data using “smart” logic to trigger potential audits. Each payer will also track changes in provider access across the state. Third, we will monitor operational details and areas for improvement. This includes our multi-payer customer service escalation team that is tracking and triaging sources of provider concern and feedback.

At a provider level, we have developed detailed performance reports with information on each provider’s episode performance (cost, quality, utilization), and are augmenting those for PCMH and health homes. These reports draw from both claims and provider-entered data. Underlying system- and provider-level data collection and reporting, each payer has an “analytics engine” that calculates quality metric and cost performance for each of the models being launched.

B. Provider Payment Systems

In most cases, payment to providers will be based on the existing fee-for-service claims process, with additional PMPMs and retrospective adjudication of gain/risk sharing payments. Payments will be calculated using an initiative-wide analytics engine developed for each payer, based on established algorithms and required administrative and clinical data. The analytics engine is integrated with payer payment systems, which execute the payments and/or withholds (for risk sharing). In most cases, the performance period lasts 12 months, and payments are issued in full once calculated. Risk sharing totals are pro-rated and withheld in equal amounts.
over a 12 month period. In some models (e.g., assessment-based episodes), we will use prospective payments. The same analytic engine will calculate and inform disbursement of payment; payer payment systems will be adjusted accordingly.

**C. Model Enrollment and Assignment Processes**

The process for model enrollment and assignment varies for each model. Episodes are retrospectively assigned to a Principal Accountable Provider (PAP) based on pre-determined claims logic for each episode (e.g., PAP for a pregnancy episode is the delivering provider). PCMH and health homes will require modifying the provider enrollment process to identify eligible providers (e.g., meeting select requirements). Patient attribution will be based on retrospective claims analysis (e.g., plurality of office visits) or patient assignment in a PCMH.

**D. Contracting and Administrative Processes**

There are three major components to this, the importance of which varies by payer.

1. **Regulatory Alignment.** Pursuant to regulatory requirements in Arkansas, DMS will continue to follow a standard promulgation process, including early stakeholder engagement, notice of promulgation, 30-day comment period, public hearing, committee briefings and final presentation to the rules and regulations committee. In July 2012, the State gave favorable review for the REBP model and the specific payment changes in Medicaid’s first three episodes. Because the July approval adopted a new episode-based payments section in the Arkansas Provider Manual, future episodes will only require approval for specific payment adjustments.

2. **Federal Regulatory Process.** In August 2012, CMS approved a State Plan Amendment enabling the payment adjustments in the model. This upfront approval paves the way for future episode launches and associated payment changes (See Question 14 for details on other models).

3. **Contractual Alignment.** Private payers must ensure all payment changes align with
their provider contracts. In some cases, modifications and renegotiation are required.

**E. Continuous Improvement Analysis & Performance Optimization Process**

We aim for continuous improvement on five dimensions: (1) technical and clinical design; (2) structure of payment; (3) supports for providers; (4) operational performance; and (5) patient engagement. We have several approaches to achieving this. First, our payment models include a “preparatory period” wherein providers can provide feedback and test the initial launch before actual payment begins. Second, we have established analytically sound performance baselines by episode and PAP to measure changes over time and perform root-cause analyses. Third, we have multiple mechanisms for stakeholders to share input and suggestions (e.g., provider workgroups, report feedback committee). Finally, our infrastructure rollout includes a modular and flexible analytic engine the enables rapid adjustment of payment model logic.

**F. Other Processes to Complete Delivery System Reform**

We have implemented several other processes to enable successful launch and scale up. First, we have developed a multi-payer customer service escalation process – this involves a multi-payer team that intakes, triages, and responds to provider and stakeholder feedback. Substantive points of feedback are escalated to leads across payers. Second, we have developed a report feedback committee that reviews suggestions from providers and stakeholders on provider performance reports. Third, we have outlined an engagement plan that builds on our approach to date of periodically updating stakeholders and obtaining input on model design.

**G. Project Management and Governance Structure**

The participating payers have chosen to coordinate as broad a set of design parameters as possible, within full legal and regulatory requirements, in order to ensure consistency of models for providers. Together with the Arkansas Surgeon General, and Arkansas Center for Health
Improvement (ACHI), payers work closely in regular working sessions on design and implementation but govern their own efforts. Each model (e.g., PCMH, health homes, episodes) has a set of payer leads responsible for managing progress, design, and implementation.

**H. Model Staffing Resources and Roles**

Medicaid has dedicated a number of resources to this initiative, and has secured funding to staff an additional 17 FTEs to manage it. The private payers have also dedicated resources to implementation. Medicaid staff will manage the program on an ongoing basis. Over the next 3 years, we will continue to leverage vendors as “startup” resources to support statewide rollout.

**B. TRANSFORMATION EXPECTED**

Transforming the way care is delivered in Arkansas over the next 3-5 years will require a comprehensive effort across providers to fundamentally change the way they deliver care.

- **Physician practices:** Individual physicians and the teams in their practices will transition to more population-based, patient-centered care for their patients. Whether they are the PAP for an episode or a PCMH, they will work closely with other providers across the medical neighborhood to help their patients navigate the health system in a more effective and cost-efficient way. This will likely involve increased communication with hospitals and specialists to monitor their patients’ care and engagement with hospitals and specialists on important clinical decisions. Practices will have access to more health system data on the quality and cost of other providers; this will allow them to make more informed referral decisions to specialists and hospitals. PCMH practices will also expand access to patients through nontraditional office hours and greater after-hours access. This will enable providers to engage more comprehensively with patients to improve quality and better manage costs.

- **Hospitals:** Hospitals will transform to increase their focus on comprehensive patient care
across the medical neighborhood. For some acute episodes of care, hospitals may be the PAP and have accountability for efficient and effective care for the entire duration of the episode. More broadly, hospitals will communicate more closely with physicians and other providers in the outpatient setting to improve inpatient care (e.g., by reducing duplicate testing) and improve patient handoffs to allow seamless transition and continuation of the plan of care.

- **Other providers:** Pharmacists, social workers, and other providers will become more active members of care teams, whether for episodes or for care provided in the PCMH and health home population-based settings. This will involve enhanced communication with physician practices and hospitals to develop and manage an integrated plan of care.

The state expects this type of transformation to occur for the major health care entities within its control as well (e.g., the University Hospital system, the health department). For example, the Arkansas Department of Health (ADH) today provides significant early prenatal services to pregnant women. In the future, the state will expect ADH and the OB/GYN or family physician who provides the remainder of prenatal care to work more closely together to ensure completeness in prenatal screening and to identify early signs of potential complications.

There is broad evidence that providers will commit to making this transformation. For example, a number of providers have already adopted practice changes consistent with the principles of the medical home. In fact, more than 100 practices applied for the CPC, indicating a broad interest in transitioning to more comprehensive population health models of care delivery. As noted in Section C, providers have engaged actively in the design and rollout of the initial wave of episodes. This model of co-creation provides evidence of support for moving toward the type of care envisioned by the state as part of its overall health care transformation.

**C. PAYERS’ AND STAKEHOLDERS’ ROLES**
Payment improvement continues to be a multi-payer, multi-stakeholder effort in Arkansas. To date, the state has worked closely with payer, provider and public stakeholders to design and implement new delivery and payment approaches. Since early 2011, the following collaborations have occurred and we expect to continue a highly collaborative effort going forward: (1) DHS, Medicaid, Arkansas BlueCross BlueShield (ABCBS) and QualChoice of Arkansas leadership, and the Arkansas Surgeon General/ACHI, have met weekly or bi-weekly to design and launch the initiative, (2) Payer leaders have held monthly discussions with key provider associations and more than 20 public workgroups have engaged 500+ patients and providers to shape the initiative, and (3) 10 Townhalls reached over 700 providers with launch of Wave 1 episodes.

### ROLES FOR STAKEHOLDERS

**Payers**

Arkansas’ approach continues to be unique in the level of commitment demonstrated by the participating payers to transform the state’s health care system on a multi-payer basis. Participation of multiple payers is essential to long-term success of the initiative, particularly in the ability to support providers in their transformation (e.g., covering adequate spend to motivate practice change for providers, cost-effectively supporting care delivery transformation, and preventing proliferation of new administrative and/or reporting requirements for providers).

To date, Medicaid has worked in an unprecedented way, hand-in-hand with ABCBS and QualChoice on the design and implementation of payment improvement and delivery system initiatives in Arkansas. So far, in simultaneously launching episode-based payments, ABCBS and QualChoice have contributed more than $4.5M in direct and indirect resources to the project across four categories: (1) **active program governance** through weekly executive meetings with

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9 For example, Arkansas Medical Society, Arkansas Hospital Association, Arkansas Waiver Association and DD Provider Associations
participating payers, (2) **direct financial support** for program research, design and management, (3) **in-kind contributed staff** time, including clinical, technical and operations experts, and (4) **infrastructure** platform development and implementation.

These core payers remain committed to program scale-up and understand they will need to make similar levels of investments going forward (see *Letters of Support*). In addition, they are committed to supporting providers structurally and financially in transforming their business models over the next 3–5 years. We envision Medicare also participating as a core payer.

**Patients**

Our future system is designed to provide enhanced cost and quality transparency and care coordination for patients. These tools are intended to simplify the patient experience, to educate beneficiaries about evidence-informed care and ultimately to empower them as partners in their health and care management. In the future, we expect patients to engage fully in their health.

**Providers**

As detailed in Section IV.B, Arkansas provider associations have and will continue to play a critical role in partnering with program leadership around major implementation decisions. We will maintain this meeting cadence and will continue to seek partnership of core provider associations for implementation, provider transformation and continuous improvement.

### D. MODEL’S LINKAGE TO ARKANSAS HEALTH CARE INNOVATION PLAN

**LINKED INITIATIVES**

The delivery and payment approaches outlined in this grant are part of a broader health system improvement initiative to transform health care delivery in Arkansas (see *State Innovation Plan*). Other core initiatives include health care workforce development and health information technology (HIT) adoption. The Arkansas Health Workforce Initiative developed a
strategic plan\textsuperscript{10} to address Arkansas’s healthcare workforce challenges. This plan ties closely to the delivery and payment models we will be testing, with specific recommendations to support a transition to team-based care, improve the use of HIT, and adopt new payment mechanisms.

The Arkansas Office of Health Information Technology (OHIT) is developing statewide policy, governance, technical infrastructure, and business practices to support the State Health Alliance for Records Exchange (SHARE), which will allow secure electronic exchange of medical information among participating providers. OHIT is expected to play a critical role at the forefront of payment improvement. SHARE will reduce provider administrative burden by seamlessly integrating with their EMR systems. While relevant for episode-based payment, it is critical to the success of PCMH.

The models being tested also align with broader health initiatives in the state. Arkansas’s Healthy People 2020 framework for action, linked to the National Prevention Strategy, specifically identifies the Health System Improvement Initiative as supporting the overarching goals #3–5 of its chronic disease framework for action: to improve access to screening and health care services for all chronic diseases in rural and underserved areas (#3); educate and inform the public on health issues related to community partnerships, prevention, screening, treatment, outreach, and control of chronic diseases (#4); and develop and implement a legislative agenda to support the policy and fiscal needs of chronic disease activities (#5). Furthermore, the triple aim of the delivery model transformation (described in the State Innovation Plan) is aligned with the aims of the National Quality Strategy, and the coordinated care approach fundamental to these models is designed to improve quality and patient experience.

INTEGRATION WITH THE ARKANSAS STATE INNOVATION MODEL

Stakeholders from developmental disabilities, behavioral health and long-term services and supports are fully integrated in the state's proposed payment models. Both the population-based and episode of care approaches have been designed to encourage accountability across the entire continuum of care for improved health outcomes and increased client engagement. This spans medical, behavioral, support and preventive service providers regardless of setting. Each approach has been tailored to and addresses the full spend for these high-needs populations, and is integrated in the broader medical home and episode based payment approaches.

E. MULTI-STAKEHOLDER COMMITMENT

Stakeholders have been at the center of design and implementation of both the population health and episode approaches. Through regular working sessions, public workgroups, focus groups and/or interviews, providers, clients, families/guardians and other advocates from across Arkansas have invested significant time to co-develop the approaches. Provider organizations and associations have committed significant time and energy to shaping major design decisions (see Letters of Support). For example, program leadership meets monthly with the Arkansas Hospital and Arkansas Medical Associations. The Medicaid team works closely with various stakeholder groups across DD, LTSS and behavioral health to develop population specific approaches. Participating groups include the Development Disabilities Provider Association, Arkansas Waiver Association, and the Mental Health Council. In addition, we have met and will continue to meet regularly with the Community Mental Health Centers, Substance Abuse Providers, and the consumer group Arkansas Behavioral Health Planning and Advisory Council to ensure continuous improvement of the approaches. The state will maintain strong stakeholder engagement to gather feedback on model effectiveness over time.