V. Budget Narrative and Operational Expenditure Plan

I. SUMMARY

To implement the payment improvement program outlined in this plan, Medicaid projects a total investment of ~$178.4M, approximately $45M to be funded from State General Revenue (SGR), $73.4M from federal match, and $60M from requested SIM grant funds. This investment includes ~$30M between July 2011 and December 2012, less $4.5M of cash and in-kind contributions from private payers during this period; plus $174.5M investment less $21.7M of offsets and in-kind contributions from January 2013 to June 2016. This represents less than 1% of the overall Medicaid expenditures during this timeframe, with the potential to return >15-fold savings to the Medicaid program over the coming 10 years. Ongoing operating expenses beyond this timeframe are forecasted at $10-15M per year (estimated at $4-6M SGR), or ~0.3% of total program costs at steady state. For comparison, were Medicaid to outsource management to one or more managed care organizations (MCOs), the projected increase in administrative fees (over $1.4 billion) paid to the MCOs over 3 years would be more than 7 times the level of investment planned to support our payment improvement initiative, and more than 20-fold our projected steady state operating expenses to support the new payment models, without the same level of delivery system re-investment that we are committed to undertake as part of this effort.

BUDGET BY PERIOD

Period Prior to SIM Grant Award. Since July 2011, Medicaid has spent ~$22M ($8.4M SGR, and $11M federal match, and $2.6M private payer contributions) in addition to ~$2M of in-kind contributions from private payors to support design of episode, PCMH, and health home programs, and implementation of the first wave of episodes on a statewide basis. Medicaid projects ~$8M ($4M SGR) for continued episode implementation and planning for PCMH and health homes through the end of the calendar year.
Period Following SIM Grant Award. To stay on pace with our roll-out timelines, Medicaid will require an additional $174.5M investment over 42 months starting December 2012: $15.9M in the 6 month pre-testing period and $59.0M, $56.0M and $43.6M in testing years 1, 2 and 3, respectively. We are requesting a total of $60.0M in SIM funding during this 42-month period to support roll out: $15.3M (or 26%) for episodes, $8.9M (or 15%) for PCMH, $8.4M (or 14%) for health homes, and $27.4M (or 46%) for leadership and enabling infrastructure.

**Immediate Funding Requirements.** Given Arkansas’ existing activity and the urgency to maintain stakeholder support and momentum, we request that $10.0M of SIM funds be disbursed in January 2013 to be applied toward the $15.9 pre-testing budget and specifically devoted to launch and roll out supporting infrastructure for the next wave of episodes, for which CMS has already approved our State Plan Amendment. Were CMS to disburse this $10.0M in January 2013, our request for SIM funding during the following 3-year testing period would be $50.0M. Were CMS unable to disburse $10.0M for the 6-month pre-testing period, we would require a total of $60.0M for the testing period, but would need to delay implementation of episodes by 6 months with foregone savings to the Medicaid program.

### BUDGET BY COST CATEGORY

The 42-month budget includes $166.3M in costs for contractors/vendors, $6.3M for personnel, $1.7M for fringe costs, and $0.2M for other budget categories.
Approach-Specific vs. Foundational Investments. $51.5M of the $174.5M is specific to one of the 3 approaches being tested: episodes ($30.6M), PCMH ($10.1M), and health homes ($10.8M); $123.0M is to underwrite program leadership/strategy and infrastructure across all approaches.

Start-Up Costs vs. Operating Expenses vs. Benefit Expenses. SIM funding will be used exclusively to fund start-up costs, which total $137.0M. Operating costs comprise the remaining $37.5M. There could also be annual operating costs of as much as $10-15M annually after the performance period to fund continued activities such as client assessments and provider support. These costs would be partially offset by federal financial participation (FFP), and potential reduction of other programs that would be less necessary (e.g., pre-authorization).

SIM and Other Sources of Funding. Arkansas Governor Mike Beebe has appointed DHS as the state agency to receive and manage SIM funds. DHS will apply SIM funds to the subset of contractor costs intended to support implementation, totaling $60.0M: $27.4M for project leadership and management, $27.7M for clinical-economic analysis, and $4.9M for technical analysis. Net of $60.0M in SIM funds and $21.6M in in-kind contributions, the balance of $81.6M represents the total computable costs to be funded for the remainder of the budget. An
estimated $60.8M will be funded by FFP and $32.8M to be borne by general Medicaid funds.

II. 42-MONTH BUDGET BREAKDOWN BY OPERATING MODEL CATEGORY

For additional description of new roles, please see the insert in the Personnel section below.

1. **Overall strategy, coordination, and integration**: $13.5M is required to oversee the initiative, coordinate decision making, and guide implementation: contractor support ($12.4M) and DHS staff ($1.1M, ramping to 5 FTEs of senior leadership).

2. **Episodes**: $30.6M is required to roll out episodes: contractors to tailor algorithms to Arkansas ($29.0M), clinical provider council to validate episodes ($0.2M in personnel costs), and DHS staff ($1.4M, ramping to 7 FTEs of bus. ops. mgrs. and 1 FTE of a sr. clinical director).

3. **Patient Centered Medical Home**: $10.1M is required to roll out and manage the PCMH program statewide: contractor support for program leadership and strategy ($8.9M), DHS staff ($1.0M, ramping to 1 FTE of a sr. program director, 1 FTE of a bus. ops. mgrs. and 6 FTEs of program administrators) and a clinical provider council ($0.2M in personnel costs).

4. **Health Homes**: $10.8M is required to roll out and manage health homes for special needs populations: contractor support to directly engage providers ($8.7M) and DHS staff ($2.1M, ramping to 6 FTEs of business operations managers and 9 FTEs of program administrators).

5. **Enabling infrastructure**: $109.6M is required to develop the core infrastructure that will support all of the above components. This is detailed in several components, below.

5a. **Regulatory and contractual alignment**: $2.1M to ensure consistency with all applicable laws, regulations, and contracts, and to amend these as required: contractor support ($1.8M), and legal costs ($0.3M, ramping to 1 FTE each of legal staff and a program administrator).

5b. **Assessment administration**: $13.0M will be used to implement a patient needs assessment tool: support to administer assessments ($11.5M) and for leadership and clinical/technical
analytics ($1.3M), and DHS staff ($0.2M, ramping to 1 FTE of a bus. ops. mgr.).

5c. Provider portal and data entry: $13.1M to develop and manage the provider portal: software/equipment costs ($8.6M), contractor support ($4.3M), DHS staff ($0.2M, ramping to 1 FTE of a business operations manager).

5d. Payer and provider reporting: $10.1M to deliver actionable reports to providers to enable performance improvement: software and equipment hosting ($5.2M), vendor report development ($4.8M), DHS staff ($0.1M, ramping to 1 FTE of a business operations manager).

5e. Provider engagement and support: $18.5M to support provider engagement: direct education ($6.2M), indirect education (e.g. through provider associations) ($6.5M), contractor support ($4.2M), customer service analytics ($0.8M), DHS staff ($0.6M, ramping to 5 FTEs of program administrators) and $0.2M for travel.

5f. Patient engagement and support: $13.1M to support patients in improving their health and successfully navigating the system: education campaigns ($9.5M), contractor support ($3.3M), DHS staff ($0.3M, ramping to 1 FTE each of a bus. ops. mgr. and a program administrator).

5g. Continuous improvement and program evaluation: $8.3M to monitor and evaluate the program: analytics tool development ($3.9M), contracted evaluator services ($3.3M), program administration ($1.0M) and DHS staff ($0.1M, ramping to 1 FTE of business operations mgr.).

5h. Outcome-based payment analytic engine: $31.4M to calculate and administer provider performance and risk/rewards for episodes, PCMH, and health homes (e.g., grouping claims, attributing patients, applying risk adjustment, calculating performance, applying quality measure logic, etc.): $6.3M for contractor support, $13.3M for episode analytics engine ($5.4M for system integration, $7.9M for software license and maintenance); $5.6M for PCMH analytics ($2.6M for system integration, $3.0M for software license and maintenance); $5.6M for HH
analytics ($2.6M for system integration, $3.0M for software license and maintenance); $0.5M for program administration; DHS staff ($0.1M, ramping to 1 FTE of a business operations manager).

III. RESPONSE BY BUDGET NARRATIVE COMPONENT

<table>
<thead>
<tr>
<th>APII 42-month cumulative budget – personnel and fringe costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Job title</td>
</tr>
</tbody>
</table>
| DHS Senior Leadership   | • Directly responsible for the development, implementation and oversight of all APII strategic initiatives  
  • Coordinate programs, policies and implementation with multi-payer Executive Committees wherever possible | $65K          | 7  | $1.1M (+0.3M fringe) |  |  |  |
| Business Operations Manager | • Responsible for program goals, objectives and short & long-term planning  
  • Responsible for selection and oversight of all appropriate vendor contracts related to their role, e.g.  
  - Episode development – ensure timely completion of all required data requests, analytics and reporting  
  - PIMCH launch & mgmt. – develop and certify a list of approved vendors for provider PIMCH transformation tools and resources | $55K          | 20 | $2.6M (+0.6M fringe) |  |  |  |
| Program Administrator  | • Supervise staff, monitor and evaluate daily operations and service and assist in preparation of budgets  
  • Support coz ops mgts to oversee daily relationships with all vendors, e.g.  
  - HH launch & mgmt. – execute selection and registration of providers  
  - Communicate and syndicate program details with all appropriate stakeholders, e.g.  
  - PIMCH launch & mgnt. – coordinate and conduct regular meetings with provider engagement, customer service and escalation team | $45K          | 22 | $2.0M (+0.6M fringe) |  |  |  |
| Legal Staff            | • Responsible for ensuring regulatory compliance of all current and new APII programs  
  • Prepare policy and legal documents/presentation and advise DHS senior leadership on all issues related to legislation | $65K          | 1  | $0.5M |  |  |  |
| Total                  |  |  | 50 | $6.3M (+1.7M fringe) |  |  |  |

A. Personnel Cost (6.3M): SIM funding will not be used for any personnel costs. The number of positions dedicated to AHCPII will be increased to 50 FTEs required by year 3 to manage and sustain the program. To the extent possible, these resources will be comprised of a mix of State positions, repurposing of existing DHS positions, positions that become available through natural attrition and personnel sourced from vendors.

B. Fringe Benefits (1.7M). The SIM grant will not be used to fund any fringe benefit costs. Similar to personnel funding outlined above, in-kind contributions will account all of the fringe benefit costs (1.7M).

Calculation of fringe benefits was 30% of salaries for full-time DHS positions only.
will be funded by Medicaid revenues ($32.6M) and FFP ($60.1M) at variable match rates.

**Contractor costs, 42-month cumulative (12/12-6/16), Medicaid only**

<table>
<thead>
<tr>
<th>Match assumptions</th>
<th>Implementation vendors</th>
<th>Technology vendors</th>
<th>Ops vendors</th>
<th>Total</th>
<th>Contractor/ Vendor costs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Project leadership &amp; mgmt.</td>
<td>Clinical-economic analysis</td>
<td>Technical analysis</td>
<td>System integration &amp; eqpt. hosting</td>
<td>Software vendors</td>
</tr>
<tr>
<td>1 Leadership / strategy</td>
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<td>4.5</td>
<td>3.0</td>
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<td>-</td>
</tr>
<tr>
<td>2 Episode launch and management</td>
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<td>3 MMH launch and management</td>
<td>3.0</td>
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<td>2.1</td>
<td>-</td>
<td>-</td>
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<tr>
<td>4 MH launch and management</td>
<td>3.4</td>
<td>3.0</td>
<td>2.0</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>5 Enabling infrastructure</td>
<td>$0.5</td>
<td>$0.5</td>
<td>$0.8</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>6 Assess. admin</td>
<td>$0.5</td>
<td>$0.5</td>
<td>$0.3</td>
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<td>-</td>
</tr>
<tr>
<td>7 Provider portal</td>
<td>$1.7</td>
<td>$1.5</td>
<td>$1.0</td>
<td>$2.0</td>
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<tr>
<td>8 Reporting</td>
<td>$1.9</td>
<td>$1.7</td>
<td>$1.2</td>
<td>$1.0</td>
<td>$4.2</td>
</tr>
<tr>
<td>9 Provider eng.</td>
<td>$1.7</td>
<td>$1.5</td>
<td>$1.0</td>
<td>$0.8</td>
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<tr>
<td>10 Patient eng.</td>
<td>$1.3</td>
<td>$1.2</td>
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<tr>
<td>11 Cont. improve.</td>
<td>$1.3</td>
<td>$1.2</td>
<td>$0.8</td>
<td>$2.3</td>
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<tr>
<td>12 Analytic engine</td>
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<tr>
<td>Total budget</td>
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<td>$17.5</td>
<td>$27.1</td>
<td>$29.2</td>
</tr>
</tbody>
</table>

**Project leadership and management ($28.3M) – $27.4M for strategy definition, program mgmt., and joint leadership (with DHS staff) of each component of the operating model will come from SIM funds. The remainder will come from repurposing current contracts ($0.9M).**

**Clinical-economic analysis ($28.5M) – $27.7M to perform detailed analysis required to localize clinical episode definitions will come from SIM funds. The remainder will come from repurposing current contracts ($0.8M).**

**Technical analysis ($17.5M) – $4.9M to perform technical analytics to establish thresholds and maintain episode algorithm definitions will come from SIM funds. The remainder will come from repurposing current contracts ($0.6M) and Medicaid general revenues ($6.0M) to be matched by FFP funds ($6.0M) at an assumed rate of 50/50. This analysis includes testing the impact of scenarios for performance improvement on providers and payers. Maintenance includes assessing impact of algorithm modifications and adjusting underlying algorithms.**
Software vendors ($29.2M) – SIM funding will not be applied to this component, which includes software on a license and subscription basis. Key software components provided include episode, PCMH and health home analytics engines ($13.8M), provider portal ($6.6M), and reporting ($4.2M) software. Remaining components (e.g., customer service tools and continuous improvement analytics) will cost $4.6M.

IT systems integration and equipment vendors ($27.1M) – SIM funding will not be applied to this category, which includes the hardware required for necessary software products. Example hardware includes servers and required data storage. Examples system integration components include episode-specific development ($10.5M) and episode, PCMH and health home analytics engine ($10.6M) integration. Remaining components will cost $6.0M.

Operations and program administration ($35.7M) – SIM funding will not be applied to this category, which includes the execution of assessments ($11.5M), direct and indirect provider engagement ($12.7M), patient engagement ($9.5M) and other costs ($2.0M)

D. Equipment cost ($0). Medicaid will not directly purchase any meaningful amount of equipment for Arkansas Health Care Payment Improvement Initiative (AHCPII).

E. Travel, training, hotel costs ($220K). Medicaid staff will travel extensively throughout Arkansas to engage providers, including direct engagement, town halls and episode design workgroups. Additionally, $22K has been budgeted for representatives to travel to regular SIM workshops and conferences. SIM funding will not be applied to any part of this component.

Arkansas program travel ($198K) = 900 trips (25 / month) * $220 (400 miles * $0.55 / mile)

SIM program travel ($22K) = 12 trips (4 / year) * 3 representatives * $600 (travel + lodging)

F. Supplies and miscellaneous ($0). The cost for these materials will be managed by contractors as described above. SIM funding will not be applied to this component.
G. System and/or data collection cost ($0). All IT and assessment costs ($56.3M over 42 months) are captured in the contractor exhibit above. Additionally, $11.5M included in operations contracts goes to health home assessments.

H. State evaluator costs ($0). The $8.3M required for continual program evaluation is captured in the contractor budget components of the continuous improvement category outlined above. We will apply $3.3M of SIM funds to contractor support required for this purpose.

I. Other ($0). There are no other costs included in the Medicaid AHCPII budget.

J. Indirect / overhead charges ($0). No indirect costs to be requested for funding.

K. Other grants, revenue-in-kind services ($21.7M). Of the $174.5M total AHCPII budget, Medicaid expects $21.7M to be paid for through additional funding sources:

Repurposing Medicaid funds – We expect that $10.4M in current Medicaid funding will be repurposed to support AHCPII. This will consist of $0.8M in provider engagement vendor spend, and $8.0M in previously allocated Medicaid staff, $1.6M in data analytics vendor spend.

Contributions from other payers – Arkansas BCBS and QualChoice have each contributed significantly to AHCPII to date, both monetarily and in terms of dedicated leadership time. Continued participation by these payers ($6.3M in-kind for the provider portal in year 1) and potentially Medicare, would require significant contributions from each (e.g., in technology solutions). Additionally, we estimate that cost synergies from the shared use of technology vendors will provide some meaningful savings from economies of scale ($5.0M) as multiple payers continue to work more closely together.

Additional grants – Medicaid has not secured any other grants that will be applied to this budget and has made sure to exclude any costs part of the CPC initiative, or other CMS/CMMI grants.

L. Expected or needed funding from other federal sources ($0). Medicaid plans to use a total
of $60.1M in FFP to match its share of the budget, following established matching rules. However, matching will not be applied to any funds provided through the SIM grant.

**M. Attestation that Innovation Center funding will not supplant any other funding sources.**

We attest that Innovation Center funding will not supplant any other funding sources.

**N. Budget to collect data and perform continuous quality improvement.** Driving continuous improvement requires both cultural and organizational strategies as well as infrastructure required to measure performance, gather feedback, and make changes rapidly at acceptable costs. We appreciate that AHCP II is bold and in some respects new. As such it is especially important to be able to learn and refine over time. We estimate that $8.3M will be required to fund continuous improvement (see section II. 5g. for a cost breakdown). The contractor portion of these expenses is included within the funds requested to be funded by SIM grant. The personnel expenses are to be borne by the Medicaid program.

### IV. VENDORS

Medicaid will work with a number of vendors to support the AHCP II over the term of this grant. Each will be selected based on its unique capabilities to meet specific AHCP II needs and deliverables. Medicaid already has working relationships with the following vendors who are likely to be among those used: Advanced Healthcare Information Network (AHIN, underwritten by Arkansas BCBS), Arkansas Center for Health Improvement (ACHI), Arkansas Foundation for Medical Care (AFMC), Arkansas Office of Health Information Technology (OHIT), CH Mack, Health Services Advisory Group, Hewlett Packard, McKinsey & Company, ValueOptions and Q Source. When grant awards are dispersed, Medicaid will pursue contracts with vendors through the solicitation of bids, interagency agreements and other formal mechanisms.