

**Arkansas Health System
Transformation**

State Innovation Plan

For submission to CMS and CMMI
September 21, 2012

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Introduction

The State Innovation Plan describes Arkansas’ comprehensive approach to achieve our “Triple Aim” of improving health, increasing quality and lowering the growth of health care costs. Our model integrates population-based and episode-based care delivery strategies to coordinate care across a team of providers, incentivize quality and cost-effectiveness, and improve outcomes. These strategies are supported by four core enabling initiatives: payment innovation, health care workforce development, consumer engagement and personal responsibility, and health information technology adoption.

We have organized our State Innovation Plan in the following sections:

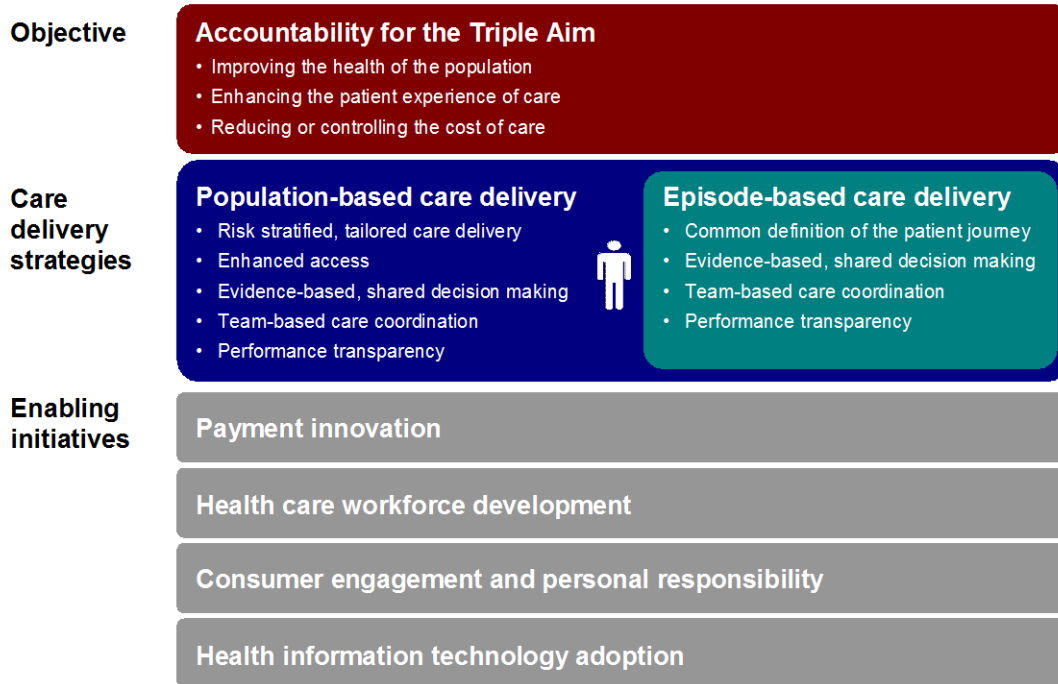
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A. Vision for Health System Transformation

Arkansas is creating a sustainable patient-centered health system that embraces our Triple Aim: (1) improving the health of the population; (2) enhancing the patient experience of care, including quality, access, and reliability; and (3) reducing, or at least controlling, the cost of health care. Our Triple Aim aligns with the aims set out by the Department of Health and Human Services in the National Quality Strategy: “better care, healthy people and communities, and affordable care.”

Achieving this Triple Aim will require transforming our care delivery system from fragmented and encounter-based care to coordinated, patient-centered and cost-effective care, organized around consumers’ comprehensive health needs across providers and over time. It also requires shifting away from pure fee-for-service payment mechanisms that lead to fragmented care with incentives to over-utilize services, to value-based payment mechanisms that reward effective care coordination and superior outcomes with respect to both quality and cost containment.

Exhibit A: Arkansas Health System Improvement



CARE DELIVERY STRATEGIES

Our goal is to fully develop this system within the next 3-5 years by adopting a model that integrates two complementary strategies for promoting clinical innovation on a multi-payer basis across the entire state: population-based care and episode-based care.

- **Population-based care delivery.** Within 3-5 years, most Arkansans will have access to a medical home that offers a local point of access to care and proactively looks after his or her health on a “24-7” basis. Special needs populations with developmental disabilities (DD), those requiring long-term services and support (LTSS), and those with serious behavioral health (BH) needs will also have access to health homes.
 - The **medical home** will support patients to connect with the full constellation of providers who together form their health services team, customized for their personal care needs and with a focus on prevention and management of chronic disease. For patients with chronic conditions, the medical home will assist with monitoring their progress and coordinating care among what will often be a multi-disciplinary provider team. The medical home will bear responsibility for coordinating care to address the complete health needs of a population.
 - The **health home** will be accountable for the full experience of individuals with special needs—the frail elderly, those with developmental disabilities, those with severe and persistent mental illness, and other high needs behavioral health clients. Accountability will include health outcomes, streamlining care planning, and ensuring each person has a single integrated plan across all types of care. To accomplish this, health home providers will work closely with consumers, their families, and other direct service providers, offering support and coaching in a community setting. The health home complements the medical home: the medical home will continue to retain responsibility for diagnosis, treatment, and referral, while the health home will help to ensure proper follow-up, treatment adherence, and communication between providers, individuals receiving services, and their families.
- **Episode-based care delivery.** Within 3-5 years, substantially all acute care and complex chronic conditions (50-70% of total health care spending) will be proactively managed by a principal accountable provider (PAP), who will embrace their role as the “quarterback” responsible for quality, access, and efficiency of all services delivered in response to a patient’s immediate needs. PAPs will be evaluated on their performance over entire episodes of care, with an expectation of coordinated, team-based management of services. Better data will help PAPs to understand and improve their performance over time, thus enhancing quality and outcomes and increasing cost-effectiveness of care.

ENABLING INITIATIVES

Effective implementation of integrated population- and episode-based care delivery strategies will require changes in incentives to providers, as well as the attitudes, behaviors and skills among our health care workforce. Providers and consumers will also need new tools and capabilities to enable clinical data sharing, care coordination, performance tracking and participation in decision making. The core initiatives to support these care delivery strategies are structured around these capabilities:

- **Payment innovation:** Across Medicaid, Medicare, and private payers, we will shift the state’s health care payment system from one that rewards volume alone to one that rewards target outcomes, particularly with respect to quality and affordability. This system-wide strategy will move Arkansas to a new, sustainable model of financing and is multi-payer in its leadership and support.
- **Health care workforce development:** Leaders in our provider community and educational institutions will bolster the attraction and retention of new talent to our health care workforce, and will support training programs to ensure that Arkansas’ health care workforce can meet the challenges of current and future demand for health care, including increasing the supply of primary care providers and supporting the adoption of team-based care. New patient care models are intended to increase the viability and attractiveness of primary care.
- **Consumer engagement and personal responsibility:** Through a combination of education, incentives, technology enablement, and regulation, we will ask consumers to take greater responsibility for their health and health care, including wellness, adherence to treatment plans, and navigation of the health care system. Our approach will be multi-faceted, involving consumer representatives, payers, providers, employers, schools, and other community leaders.
- **Health information technology adoption:** We will improve our health information technology (HIT) infrastructure to increase the adoption and effectiveness of electronic medical records (EMRs), computerized physician order entry, and electronic prescribing, as well as clinical data exchange among providers, care plan sharing, and the creation of an all-payer claims database to support research and performance understanding.

DISTINCTIVENESS OF OUR APPROACH

Many of the specific details of our approach mirror those being piloted in other geographic regions. However, our approach to health system transformation is distinctive in several ways:

- 1. Integration of population- and episode-based strategies.** Our population-based and episode-based care delivery approaches are closely linked. The medical and/or health home manage on-going health, and when a patient suffers an acute condition or has a specialized health care need, he or she may consult with the medical home to weigh treatment options and select a specialist provider to manage that episode of care. The episode team, managed by a PAP, provides the care to address that specific condition. The PAP may be the primary care provider for certain episodes (e.g., upper respiratory infections) or a specialist (e.g., orthopedic surgeon for hip replacement). After a defined episode has ended, the provider team managing the episode will transition care for the patient back to the medical home and ensure the home is effectively prepared to manage the patient's on-going care, in consultation with the individual and (where appropriate) his or her family. For individuals with special needs, the health home will work closely with the medical home, the individual, and his or her family to ensure appropriate follow-up care in both clinical and community settings.
- 2. Designed to suit a fragmented delivery system.** Within the past 60 days, we have implemented the first-ever statewide rollout of episode-based payment. To achieve this, we designed a model that is agnostic to delivery system structure, that encourages clinical integration among providers but does not prescribe new legal or financial relationships (e.g., we use retrospective episode-based payments rather than prospective bundles for medical episodes). This has been especially important because Arkansas has a large number of independent providers, with 60 percent of physicians in practices of 5 or fewer physicians. While this makes Arkansas unique among the handful of states currently poised to implement statewide payment reform, our delivery system fragmentation is in fact similar to most other states in the U.S. Therefore, success in Arkansas could provide an important model for states across the country with a low degree of provider consolidation and also for those with low-density, particularly rural populations.
- 3. Shaped through collaboration of Medicaid and private payers.** Our approach has been equally shaped by Arkansas' Medicaid program and private payers, and has been designed to extend to Medicare and Medicare/Medicaid Dual Eligible individuals, as well. The coordinated approach ensures that providers experience common expectations from payers and need not operate under conflicting systems nor shoulder the complexity of different business rules and reporting requirements for different patient populations. It also creates consistent incentives, standardized reporting tools, and unified clinical reports on quality and outcomes. Moreover, a multi-payer approach is necessary to achieve "critical mass," making incentives substantial enough to justify provider investments in infrastructure and changes in clinical decision-making and operational processes. The broad scale also helps motivate consumers to play a larger role in their health and health care.

- 4. Informed by extensive input from providers and other stakeholders.** Our approach has evolved significantly over the past 18 months – and continues to be refined – based on input from stakeholders, including consumers, providers, legislators, and community and professional organizations. The Health Care Workforce Initiative has involved almost 150 stakeholders, including state departments, provider systems and professional associations, payers, and universities and health educators among others. Meanwhile, our payment innovation efforts have involved over 1,000 stakeholders, spanning 21 public workgroups, nearly a dozen town halls across the state, monthly meetings with provider associations, customer service hotlines, and a multi-payer informational website (www.paymentinitiative.org). The Office of Health IT (OHIT) is collaborating with Medicare, Medicaid and the Insurance Department, among other stakeholders.
- 5. Enabled by an efficient operating model.** Without introducing any new bureaucracy, and retaining the independence of our private-sector partners, we have already been successful in establishing common payment mechanisms across Medicaid and private payers, consistent quality metrics, and a common design for provider performance reports, delivered to providers through a shared web-based portal also used for clinical data entry. This collaboration has reduced the potential for confusion among providers, and shortened the timeline for implementation of our episode-based performance reporting by more than 50%. Going forward, we estimate we may realize synergies of 30-50% in technology costs by adopting common solutions. We also share a common belief that providers will only be successful in adopting new care coordination technology and services if it may extend to their entire patient panel, regardless of the source of financial coverage.

CONTEXT FOR CURRENT STATUS

Care delivery transformation in Arkansas is already in process. We are building on existing assets and trends: existing data warehouses, growing use of HIT in community settings, a history of quality improvement initiatives, strong relationships between payers and provider communities, and increasing integration across providers. Moreover, there is strong alignment around the need for change. In the last year and a half, providers, payers, and other stakeholders have engaged to inform our framework and concepts supporting a move to population and episode-based care delivery.

In addition, we have been collaborating with the Center for Medicare and Medicaid Innovation (CMMI) since October 2011 as we have developed our approach. In particular, input from CMMI has been crucial in helping us evolve our approach from focusing on episode-based care delivery to a including a strong focus on population-based care delivery as well.

Elements of our enabling initiatives are currently underway. For payment innovation, in July of this year, we launched 5 episodes on a statewide, multi-payer basis that will

impact over 1,000 providers in Arkansas. In addition, we have obtained the state, federal regulatory, and legislative approvals to launch our first wave of episode-based payments. In other initiatives, the Health Care Workforce Strategic Plan was completed in April 2012 and new training programs for physician assistants and advanced nurse practitioners are under development. Furthermore, significant progress has been made deploying health information technology: broad-band access is being enhanced statewide through the 2nd largest US Commerce Department Broadband Technology Operations Project grant, over half of primary care providers have achieved level-one meaningful use, and Arkansas was the first state to receive approval to move to Phase II of health information exchange.

Technical elements required for payment innovation have been deployed: Medicaid developed and deployed state-wide their analytics engine to calculate per-episode costs and generate provider reports; Medicaid and Arkansas BlueCross BlueShield worked closely to implement the multi-payer provider portal, where providers enter quality data and can access their reports, and Medicaid has completed an RFI process to better understand the capabilities of existing episode-based payment software solutions, leading to common understanding between Medicaid and private payers regarding the options for creating a scalable, multi-payer analytic solution.

B. Target Populations and Challenges

STATE DEMOGRAPHICS

Arkansas has a population of 2.9 million, with a predominantly rural population distribution. With approximately 240,000 Arkansans aged 65 or older, Arkansas ranks 9th among states for the highest portion of elderly population, and this population is growing rapidly.^{1,2} Population growth has been 29% among ethnic minorities, relative to 3.5% for whites.³

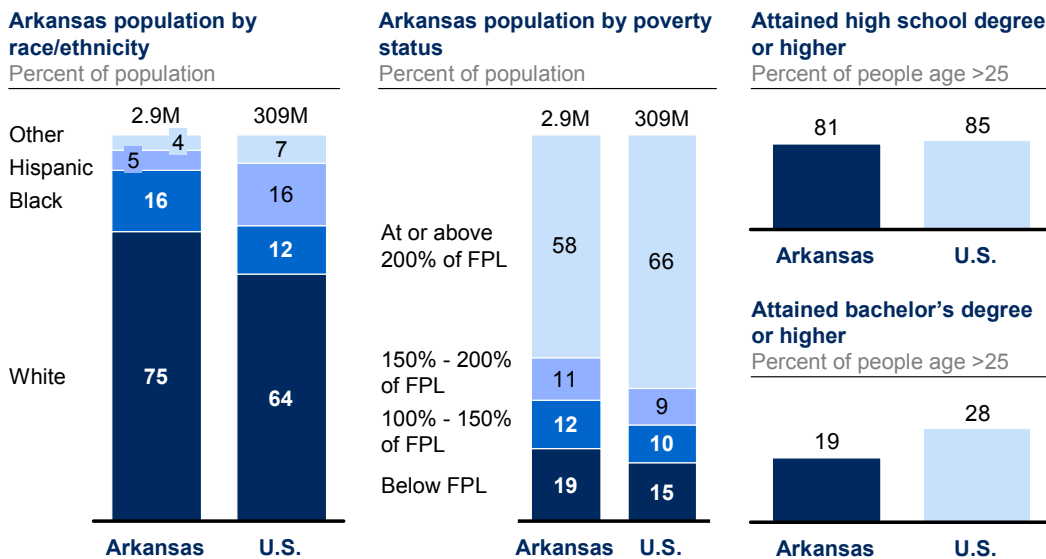
1 Werner, Carrie A. "The Older Population: 2010." Press & Media: Press Kits: 2010 Census Briefs. U.S. Census Bureau, Nov. 2011. Web. 25 Jan. 2012. <http://www.census.gov/prod/cen2010/briefs/c2010br-09.pdf>

2 "Table 4: Change in Total population and population 65 and older by state: 2000 to 2030." U.S. Population Projections: State Interim Population Projections by Age and Sex: 2004-2030. U.S. Census Bureau: Population Division, 21 Apr. 2005. Web. 25 Jan. 2012. <http://www.census.gov/population/www/projections/projectionsagesex.html>

3 Humes, Karen R., Nicholas A. Jones, and Roberto R. Ramirez. "Overview of Race and Hispanic Origin: 2010." Press & Media: Press Kits: 2010 Census Briefs. U.S. Census Bureau, Mar. 2011. Web. 25 Jan. 2012. <<http://www.census.gov/prod/cen2010/briefs/c2010br-02.pdf>

In socio-economic indicators, Arkansas ranks near the bottom. The state's median household income ranks 48th in the nation, per capita income ranks 46th among states and the child poverty rate is the 5th highest.⁴ The state has lower high school graduation rates (81%) than the U.S. average (85%) and college graduation rates are significantly below the national average (19% vs 28% obtain bachelors degree by age 25).⁵ In addition, the violent crime rate is the 12th highest in the country.⁶

Exhibit B1: Arkansas state demographics



SOURCE: 2010 American Community Survey

POPULATION HEALTH

Health coverage

Approximately 540,000 Arkansans (19% of the state population) are uninsured. 46% of the population has commercial insurance, with 1.2 million receiving coverage through employers and 114,000 covered through individual policies. Medicare covers 492,000⁷

⁴ "CENSUS DATA: Climb in Number of Poor Arkansans Slowing, But Levels Still High After Recession." Newsroom. Arkansas Advocates for Children and Families, 22 Sept. 2010. Web. 25 Jan. 2012. <http://www.aradvocates.org/census-data-climb-in-number-of-poor-arkansans-slowing-but-levels-still-high-after-recession/>

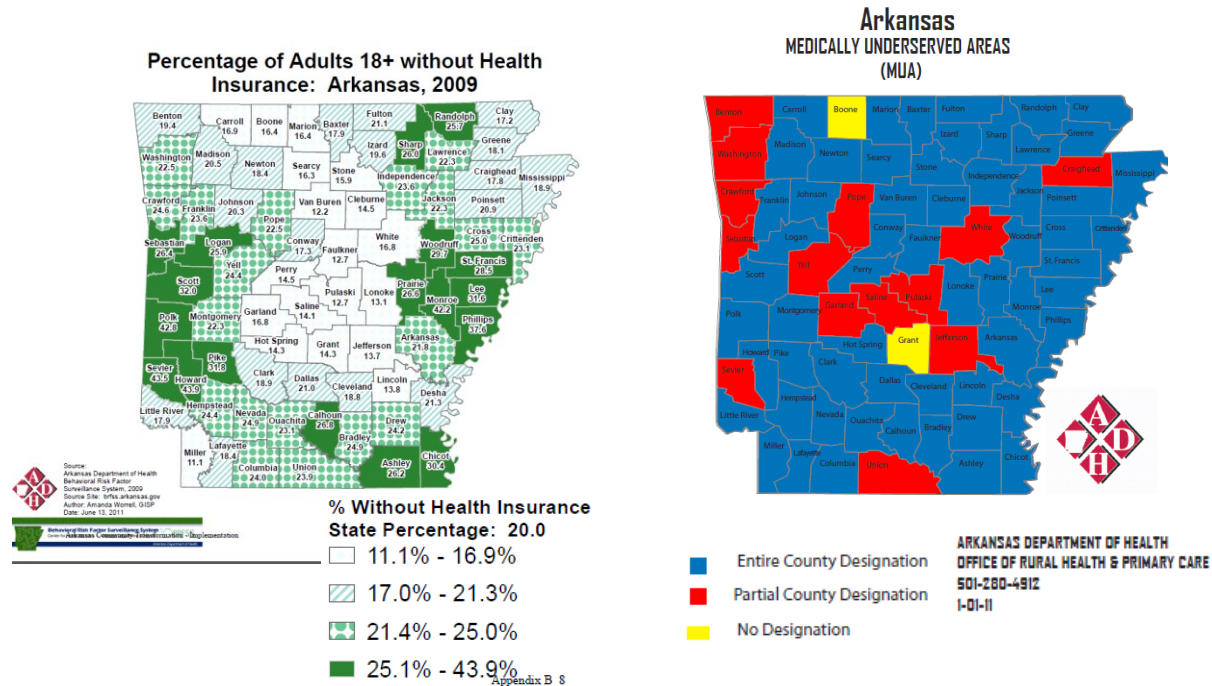
⁵ American Community Survey 2010

⁶ U.S. Census Bureau. 2012 Statistical Abstract of the United States (2007 data). <http://www.census.gov/compendia/statab/2012/ranks/rank21.html>

⁷ Administrative enrollment count for Medicaid of about 675,000 per month

include areas in central and western Arkansas with medically underserved communities and regions with high uninsured populations (Exhibit B3).^{11,12}

Exhibit B3: Communities with limited healthcare access



Source: Arkansas Department of Health - Behavioral Risk Factor Surveillance System, 2009 Source Site: brfss.arkansas.gov Author: Amanda Worrell, GISP Date: June 13, 2011 (for uninsured map); Arkansas Department of Health – Office of Rural Health and Primary Care 1-01-11 (for Medically Underserved Areas map)

Special Needs Populations

Arkansas also has sizeable special needs populations who receive support services primarily through Medicaid. In 2010, approximately 7,000 adults and 17,500 children with developmental disabilities received developmental disabilities services through Medicaid. In the same time period, approximately 110,000 Arkansans received behavioral health services through Medicaid, and 20,500 received long term services and supports (through nursing homes and home and community based services).

TARGET POPULATIONS

Our State Innovation Plan applies to privately insured Arkansans, as well as those covered by Medicaid and Medicare, including Medicare/Medicaid Dual Eligible

¹¹ Arkansas Department of Health - Behavioral Risk Factor Surveillance System, 2009 Source Site: brfss.arkansas.gov Author: Amanda Worrell, GISP Date: June 13, 2011

¹² Arkansas Department of Health – Office of Rural Health and Primary Care 1-01-11

individuals and CHIP. Payers already actively participating in the State Innovation Plan represent more than half of both the total Arkansas population and total health care spending. Were Medicare to commit fully to the Plan, we would improve care for a large majority of the state’s citizens and exceed 90% of total health care expenditures for the insured population.

CLINICAL CHALLENGES

The new care delivery and payment models described in our State Innovation Plan extend to all Arkansans covered by participating payers. However, additional, specialized clinical capabilities and payment mechanisms are included, targeted at persons with chronic medical needs, acute conditions, behavioral illness, developmental disabilities, or functional impairment requiring long-term services and supports.

Exhibit B4: Target spend by clinical risk

	Examples	Percent of total spend		
		Commercial	Medicaid	Medicare
Prevention	Routine health screenings	~5	~5	~3-5
Chronic care (medical)	Diabetes, chronic CHF, CAD	~15-25	~10-15	~20-30
Acute outpatient medical	Ambulatory URI, sprained ankle	~5-10	~5-10	~5-10
Acute inpatient medical	CHF, pneumonia, AMI, stroke	~20-25	~5-10	~20-30
Acute procedural	Hip/knee, CABG, PCI, pregnancy	~25-35	~15-20	~20-25
Cancer	Breast cancer	~10	<5	~10
Behavioral health	ADHD, depression, SED, SMI	~5	~15-20	~5
Supportive care	Develop. disability, Long-term care	n/a	~15 ~15-20	n/a

Retrospective episodes

Assessment-based episodes

Medical homes and health homes

Many segments of our population have unique challenges, which we aim to address through our proposed care delivery model:

- **Chronic and post-acute illness:** difficulty navigating a fragmented system, patient non-adherence with prescribed treatment

- **Acute illness or condition:** lack of access to performance and quality information with the referral network, lack of shared decision making
- **Behavioral health:** Inconsistent diagnosis, patient non-adherence with prescribed treatment; limited availability of community-based services; complicated co-morbid medical conditions
- **Disabled (requiring supportive care):** limitations to family support; limited availability of community-based services; poor communication between the individual, his or her family and provider regarding preferences; poor coordination of care with multiple disciplines of providers involved; inconsistencies between needs, services, and resource allocation.

C. Health System Performance

Our aspiration is to achieve significant and measurable improvements against each of the elements of our Triple Aim. Following, we provide details on Arkansas’ “current state” performance and goals for improving health, improving patient experience, and controlling the rate of growth in health care costs.

AIM #1: IMPROVING THE HEALTH OF THE POPULATION

Across all states, Arkansas currently ranks near the bottom on a range of health indicators. In cardiovascular, premature, and cancer mortality, 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.¹³ Rising rates of obesity and Type 2 diabetes contribute to the state’s disease burden as well.¹⁴ Recently, the Arkansas Cardiovascular Health Examination Survey (ARCHES) – an in-person assessment of risks including clinical examination – revealed that hypertension, obesity and diabetes are about 50% higher than self-reported (based on the Behavioral Risk Factor Surveillance System).¹⁵ Only 75% of people with high blood pressure and 62% with diabetes are aware of their conditions. Combining the impact of lack of awareness and lack of treatment even for those who are aware, only 30% of people with high blood pressure and 28% of diabetes have their conditions controlled.¹⁶

¹³ America’s Health Rankings 2011. United Health Foundation

¹⁴ America’s Health Rankings 2011. United Health Foundation

¹⁵ Zohoori, Namvar, L. Pulley, C. Jones, J. Senner, H. Shoob and R. Merritt. Conducting a state-wide health examination survey: The Arkansas Cardiovascular Health Examination Survey (ARCHES). Preventing Chronic Disease. 2011;8(3)

¹⁶ Arkansas Cardiovascular Health Examination Survey. Unpublished data on file. Arkansas Department of Health

These outcomes are influenced in part by the socio-economic factors, education levels, and access challenges discussed above. Low income impacts access to health insurance, care affordability, and use of prevention and earlier intervention options, with delayed care often increasing complications. Education levels also impact health literacy and overall health. Arkansas' geography also contributes to these health outcomes, with provider access more of an issue in rural communities.

Target for Improvement

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, congestive heart failure), greater control of hypertension, reduced re-hospitalization rates and ambulatory sensitive hospitalizations (e.g., pneumonia, asthma), and fewer late-stage cancer diagnoses. We also recognize that the level of change possible in Arkansas' health outcomes will be shaped by the state's poverty and other socioeconomic challenges, even once the care delivery system transformation is well underway. However, even these socioeconomic characteristics may be positively influenced long-term through enhanced health, increased productivity, and avoided disability, and we are designing our interventions to specifically address and support challenges faced by our communities.

AIM #2: ENHANCING THE PATIENT EXPERIENCE OF CARE, INCLUDING QUALITY, ACCESS, AND RELIABILITY

While Arkansas quality ratings have significantly improved over the last decade, based on the 2011 Agency for Healthcare Research and Quality (AHRQ) ratings, the overall quality of care in Arkansas is weak compared with other states and average in the region. (Overall ratings reflect a composite of scores for below/at/above average performance on specific indicators.) 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 was rated weak in care quality disparities based on socio-economic status, though it performed stronger than average in quality disparities based on race. Significant discrepancies in care were also noted by payer type, with low quality ratings for Medicare recipients. While all other payer types (Medicaid, commercial, uninsured) received borderline average/weak performance ratings for hospital care, performance for Medicare was rated weak/very weak. In particular, communication with patients, experience at visits, and ability to make appointments were noted as low performing metrics for Medicare recipients.¹⁷ Access to care is a broader issue in the state as well,

¹⁷ AHRQ Arkansas State Snapshot 2011.
http://statesnapshots.ahrq.gov/snaps11/download/AR_2011_Snapshots.pdf

with 500,000 Arkansans (over 17% of the population) living in primary care health professional shortage areas.¹⁸⁻¹⁹ Exacerbating the provider shortage, 540,000 Arkansans are uninsured (19% of the population), further limiting access due to lack of coverage and affordability.²⁰

Target for Improvement

We aim to significantly improve health care quality as our new delivery model is implemented. We will monitor our progress and seek to consistently improve and sustain our results, sharing results in an annual stateside report. We will actively track measures such as AHRQ indicators, the new CMS-CHIPRA pediatric quality indicators and CMS adult quality measures, continuing and expanding on Arkansas Medicaid's track record of collecting performance data and publishing reports on CAHPS and HEDIS measures. We will also integrate emerging national metrics on health care value as they become recognized. Examples of specific goals include reducing premature deliveries (before 39 weeks) to less than 10% state-wide, achieving 50% adherence rate of comprehensive diabetes metrics (encompassing provision of haemoglobin A1C, lipid measurement, and eye exams), and measuring and improving documentation of blood pressure control in PCMHs.

AIM #3: CONTROLLING THE COST OF HEALTH CARE

In recent years, health care expenditures in Arkansas have been growing approximately 6% per year for Medicaid and Medicare and 5.5% per year for commercial insurers.²¹ From 2000-2010, health insurance premium costs in Arkansas grew over 85%, and the share paid by individuals with employer sponsored insurance grew from 28% to 34%.²² Rapidly rising health care costs are both a driver and result of a high disease burden. As costs increase, consumers avoid or postpone care due to affordability. However, this often results in later presentation with more severe, complex conditions that are more expensive to treat, driving costs even higher. This cycle is exacerbated by a fragmented delivery system which impedes care coordination and the efficient use of health care resources, and fee-for-service payments which incentivize volume of care – and even

¹⁸ Arkansas Healthcare Workforce Strategic Plan: A Roadmap to Change. April 20, 2012

¹⁹ "Rural Health and Primary Care: Downloads." Office of Rural Health & Primary Care: Programs & Services: Hometown Health. Arkansas Department of Health, 1 Sept. 2011. Web. 25 Jan. 2012.
<http://www.healthy.arkansas.gov/programsServices/hometownHealth/ORHPC/Pages/default.aspx>

²⁰ Kaiser Family Foundation 2009-2010 data.

<http://www.statehealthfacts.org/profileind.jsp?cmprgn=1&cat=3&rqn=5&ind=125&sub=39>

²¹ CMS National Health Expenditure Accounts

²² AHRQ, Medical Expenditure Panel Survey (2000-2010 Table of private-sector data by firm size and state (Table II.D.1) and II.D.2) www.meps.ahrq.gov/mepsweb/data_stats/quick_tables_search.jsp?component=2&subcomponent=2.

rewards ineffective or duplicative care – and fail to reward outcomes and cost-effectiveness.

Target for Improvement

If we are successful in bringing about the changes outlined in this Plan, we expect to save the system \$1.1B over the 3-year Model Testing period (\$8.9B through 2020) relative to baseline spending, net of delivery system re-investments (i.e., care coordination fees and incentive payments / savings shared with providers)²³. These targets are based on a scenario in which there is a 3-10% reduction in costs due to eliminating inefficiencies (over 4 years) and a 1-2% reduction in the medical inflation trend (over 4-7 years), and that approximately 40% of savings are re-invested in delivery system (e.g., through gain sharing to providers), with the balance passed on to customers in the form of lower-than-anticipated premiums for individuals and employers with private insurance and lower-than-anticipated public program expenditures.

D. Health Care Delivery System Model

The Arkansas health care delivery system includes:

- Approximately 1,900 primary care physicians and 3,500 specialist physicians, among other health care professionals^{24,25}
- Over 75 acute care hospitals, including one major academic medical center, one children’s hospital, and 29 critical access hospitals²⁶
- Approximately 300 developmental disabilities providers across institutional and home- and community-based settings
- 229 nursing homes, 77 assisted living facilities, 8 area agencies on aging, 26 adult day care facilities, and supports to a further 8,000 clients on LTSS waivers.

That Arkansas is a poor state compounds the many challenges attached to our delivery system, outlined below, some of which are common to other parts of the U.S., and others that are more extreme in Arkansas.

²³ Excludes impact of CPC

²⁴ Arkansas Medicaid data

²⁵ Arkansas Healthcare Workforce Strategic Plan, table 1

²⁶ American Hospital Directory; AHA Guide, 2010

- **Limited capacity and geographic access.** 36 counties in Arkansas are designated as health professional shortage areas (HPSAs) for primary care. Furthermore, 69 counties are mental health services HPSAs and 20 counties are dental HPSAs^{27,28}. 22 counties have no hospital and 36 counties have just one hospital, covering for 45% of the population of Arkansas²⁹.
- **Lack of clinical integration.** With few exceptions, primary care providers, specialists, and hospitals are largely independent and do not effectively communicate or coordinate care. With no incentives to work together, care has devolved into silos.
- **Emerging use of EMR but without functional HIE.** Based on 2010 data, 25% of physician practices in Arkansas had adopted basic EMR capabilities, in line with the national average³⁰. Currently, over 50% of primary care providers have committed to EMR adoption. The HIE infrastructure to effectively link health information is currently in development.
- **Inconsistent incorporation of evidence-based medicine.** Established clinical guidelines broadly acknowledged to improve quality of care and health outcomes are too infrequently integrated into standard practice. For example, in the status quo, nearly 50% of adults receiving care for simple upper respiratory infections in Arkansas receive antibiotics, though nearly all these infections are viral and unaffected by antibiotic treatment.
- **Lack of consumer accountability for care.** For example, medication adherence issues are a significant issue in the treatment of chronic conditions nationwide, with almost 50% of medications for these conditions not taken as prescribed.³¹⁻³²

POPULATION-BASED CARE DELIVERY

Population-based care delivery requires a shift away from the traditional model in which providers focus on discrete patient visits, providing care for the condition presented by a

²⁷ "Shortage Designation: Health Professional Shortage Areas & Medically Underserved Areas/Populations." Health Resources and Services Administration. U.S. Department of Health and Human Services, 16 Nov. 2011. Web. 16 Nov. 2011. <http://bhpr.hrsa.gov/shortage/index.html>

²⁸ HPSAs defined as areas with ratio of population to practitioner of less than 2000:1 for primary care, 3000:1 for dental and 10000:1 for mental health

²⁹ American Hospital Directory; AHA Guide, 2010

³⁰ CDC/ National Center for Health Statistics report, "Electronic Medical Record/Electronic Health Record Systems of Office based Physicians: United States, 2009 and Preliminary 2010 State Estimates"

³¹ Peterson AM, Takiya L, Finley R. Meta-analysis of trials of interventions to improve medication adherence. *Am J Health Syst Pharm.* 2003;60:657-65. [PMID: 12701547]

³² Viswanathan, Meera et al. Interventions to Improve Adherence to Self-administered Medications for Chronic Diseases in the United States A Systematic Review" *Annals of internal medicine.* Sept 11 2012

given patient at a given moment, then moving on to the next case. Rather, with population-based care delivery, providers need to take an integrated perspective of the health of their entire patient panel. This entails understanding the characteristics and disease state of the patient population and assembling practice resources, structuring teams and setting priorities based on the needs of this population.

The aim of population-based care delivery is to meet the full range of needs across a population, promoting higher quality of care, and improved consumer experience. It will be built around accountable providers who are responsible for proactively considering the needs of their patients. For all Arkansans, primary care physician practices will adopt this role through patient centered medical homes (PCMHs). In addition to medical homes, for certain special needs populations, individuals will also have health homes that will work in collaboration with medical homes—for example, a person’s lead DD provider would act as the health home and be responsible for coordinating across all types of care for that individual and for supporting him or her on care transitions, adherence to the care plan, and access to community and social supports.

We are focusing on five core characteristics of successful population-based care.

- 1. Enhanced access.** Consumers will have the ability to choose a provider and have access to appropriate routine/urgent care and clinical advice/information at all times, whether in-person, by phone, or electronically (e.g., email or website). Tele-health technologies may also enable expanded access to providers, especially for those in rural areas and for mental health services with limited access.
- 2. Risk stratified, tailored care delivery.** Providers will have readily available information on patients’ health risks, clinical diagnoses and severity, as well as information regarding functional status and family or other support structures, ensuring the type and intensity of care is tailored to each individual and to similar populations. Practice-based patient registries can equip providers to effectively manage the needs of their specific populations.
- 3. Evidence-informed, shared decision making.** Providers will consult with patients about treatment options, making decisions on clinical care that reflect both (a) an in-depth, up-to-date understanding of evidenced-based care reflecting clinical outcomes and cost-effectiveness, and (b) patient needs and preferences. In parallel, providers will innovate with new approaches to more effectively deliver care.
- 4. Team-based care coordination.** Multi-disciplinary teams, including primary care providers, care coordinators, and support services providers, will collaborate to improve care planning, diagnosis, treatment, patient coaching to ensure treatment adherence, and management through transitions of care. Teams will extend their reach beyond the walls of the hospital or physician’s office to include pharmacists, social workers, and others.

- 5. Enhanced practice metrics.** Providers will better understand the cost, quality and health outcomes of care for their patients – both for care they provide themselves, as well as for care given by other providers.

Medical Homes

Historically, we have expected our primary care providers to focus entirely on the discrete patient needs immediately in front of them. In the future, we aspire that our primary care providers will take accountability for a population of patients, 24/7, across five dimensions of primary care delivery:

- ❖ Evidence-informed preventative services
- ❖ Diagnosis and management of acute and chronic conditions
- ❖ Use of high-performing referral providers
- ❖ Coordination of care across the health care system
- ❖ Proactive engagement of high-risk patients.

While access to screening, prevention, diagnosis, and treatment have varied across socio-demographic and geographic boundaries within Arkansas, all parts of our primary care delivery system stand to improve in effectiveness of referrals, care coordination, and consumer engagement. Our primary care transformation intends to bring about greater consistency in the former, and improved capabilities and performance among all primary care providers with respect to the latter three dimensions of primary care.

The Arkansas PCMH program represents a fundamentally innovative approach to organize for access to the scale necessary to achieve transformation. Our approach includes changing the payment mechanism to underwrite the costs of primary care practice transformation and reward providers for effective population health management, and facilitating the design, implementation, and operation of a broad set of enabling capabilities that enable providers accept outcomes-based payment and efficiently transition to population-based care.

In particular, our PCMH approach addresses the challenge of achieving the scale needed for team-based care in a highly fragmented provider environment. It will provide access to vendors pre-qualified by the state to support individual practice transformation, enable small practices to voluntarily affiliate to reach the scale required for risk-based incentive structures to be effective, and create learning collaboratives where innovative providers across the state can learn from each other about the transformation experience

Health Homes

Developmental Disabilities (DD), Long-Term Services and Supports (LTSS) and Behavioral Health (BH), which includes mental health and substance abuse, cover some of the most vulnerable populations in the state, and many people with needs in these areas require significant amounts of support over many years from Medicaid. The Medicaid system has an explicit responsibility to provide high-quality and cost-effective care for these individuals.

The three areas of DD, LTSS and BH also represent a major proportion of Medicaid expenditures in Arkansas. Over \$2B is spent directly on these areas each year. In addition, the DD, LTSS and BH populations receive approximately \$0.5B of other Medicaid services, and many receive Medicare-funded services also. Commercial payers have a small percentage of their total medical costs in LTSS and BH (typically 5% or less), although as for Medicaid there are opportunities to improve quality and decrease costs elsewhere in the system by improving care and coordination for these members.

For developmental disabilities, long-term services and supports and behavioral health populations, health homes will be centered around a lead provider, the client's main caregiver over time. The health home aims to ensure provider accountability for the full client experience including health outcomes, streamlining the care planning process, and ensuring that there is a single integrated plan for each client across DD, LTSS or BH, and medical care. The health home complements the medical home and does not replace it. The health home will coordinate all health care and support services needed by a client over time, while the medical home is responsible for quarterbacking the required medical services.

The health home functions (which match CMS' definition) include:

- ❖ Comprehensive care management
- ❖ Care coordination; health promotion
- ❖ Comprehensive transitional care
- ❖ Assistance (as advocate and educator) for individuals and their families
- ❖ Referral to community and social supports
- ❖ Appropriate use of health information technology.

While DD, LTSS and BH health homes will all incorporate these functions, the specific health home activities, provider responsibilities, and performance-based payments will reflect the unique needs of each population.

EPISODE-BASED CARE DELIVERY

The aim of episode-based care is to deliver high-quality, patient-centered, and cost-effective care for a clinical episode and to reward providers that succeed in doing so. Providers will no longer view care for patients in “silos” of discrete encounters in separate settings, but will be incented and supported to: (1) make earlier investments in diagnosis, patient education, treatment, and care coordination to reduce preventable complications and inefficient care; (2) increase provision of underused services and reduce use of medically unnecessary or duplicative services; and (3) refer patients to higher-value providers.

We believe that an episode-based approach is complementary to population-based care delivery. While PCMHs and health homes manage overall health and wellness, episode-based approaches provide a focused, coordinated approach to services and payment for specific, defined conditions that may arise. This approach applies to many acute medical episodes (e.g., acute myocardial infarction), acute procedures (e.g., hip replacement, coronary artery bypass graft), and select complex chronic conditions managed by specialists (e.g., cancer). It also applies to care for populations with supportive care needs (e.g., developmental disabilities and long-term services and supports).

We see four characteristics of high-quality and efficient delivery of episode-based care:

- 1. Common definition of the patient journey.** Providers share a common understanding of patient needs and organize processes around those needs, rather than requiring patients to adapt to existing delivery system structures.
- 2. Evidence-informed, shared decision-making.** Providers and patients will jointly make decisions among treatment alternatives, based on: (a) an in-depth, up-to-date understanding of evidenced-based care; and (b) patient needs and preferences. In parallel, providers will constantly innovate with new approaches to more effectively deliver care.
- 3. Team-based care coordination.** One or more principal accountable provider(s) will ensure that the team of providers for an episode (e.g., surgeon, hospital, rehab center, and home health nurse) works together to improve the quality and efficiency of care for consumers.
- 4. Enhanced practice metrics.** As with population-based care delivery, providers participating in episodes of care will understand the cost, quality and health outcomes for their patients across the entire episode – both for care they provide themselves, as well as for care given by other providers.

E. Payment Innovation

The Arkansas Payment Improvement Initiative will shift the state’s payment system from one that primarily rewards service volume to one that rewards desired outcomes, particularly with respect to quality and affordability. This system-wide strategy will move Arkansas to a new, sustainable model of financing and is multi-payer in its leadership and support.

This initiative continues to be guided by the core principle of designing a health care payment system for Arkansas that is patient-centered, clinically appropriate, practical and data-driven. The payment mechanisms take different forms for the different care delivery approaches.

POPULATION-BASED PAYMENT: MEDICAL HOMES

Our PCMH payment approach is designed to support and reward Arkansas’ primary care providers to transform our primary care delivery system. The payers in Arkansas will support primary care transformation through a two-part payment structure:

- 1. Care coordination fees** will be paid on a PMPM basis for attributed patients, for the duration of the program to cover the ongoing operational expenses associated with tools, technology, and services to support business model transformation and care coordination. Providers will be expected to use these funds to meet the ongoing participation requirements for the program and these fees will be linked to demonstrated practice transformation. Practice transformation will be measured based on the outcomes used in the Comprehensive Primary Care initiative and expanded to include nationally recognized metrics (e.g., by AHRQ) for pediatric care. In most cases, fee levels will be higher in year 1 of program participation, in light of the greater resource intensity of business model transformation at the beginning of the program.
- 2. Shared savings** for effective and efficient management of total cost of care. 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. The shared savings model requires quality achievement for eligibility and sets two performance thresholds: “commendable,” and “acceptable.” Providers whose average total cost of care is “commendable” may share in savings based on their absolute performance, measured as the difference between their actual costs and the commendable threshold level. All providers have the opportunity for rewards for performance improvement, by sharing in savings from controlling the rate of growth in costs compared with the statewide average trend in total cost of care. Providers starting from a stronger baseline performance will be eligible to receive a

greater proportion of savings. The shared savings model includes a number of rules to ensure appropriate stewardship of resources for the PCMH program.

Staged Rollout

The Arkansas PCMH program will build on the CPC initiative sponsored by CMS that is launching this fall, with three successive waves of provider adoption over the course of the coming 2 years.

- **Wave 1** will be limited to the practices selected for the CPC initiative. The CPC initiative is scheduled to initiate care coordination fees in October 2012, and to begin transition to include shared savings in 2013. Provider payments under this initiative are being underwritten and managed separately from the state's SIM application. However, Medicaid and private payers participating in the broader PCMH program outlined here will manage the CPC initiative in tandem with the broader PCMH program, and over time will work to integrate CPC initiative-participating providers into the Arkansas PCMH 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 and may do so independently or by entering virtual risk pools with other practices **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 upon enrollment in the program.

POPULATION-BASED PAYMENT: HEALTH HOMES

Currently individuals in institutional settings and on the ACS Waiver receive (explicitly or implied) a care coordination per-member per-month (PMPM) amount for case management which 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 process and outcome metrics and only paid when these metrics show that an acceptable level of care management and coordination has been delivered. PMPM payments will be risk adjusted based on the results of a universal assessment of a person's level of DD, LTSS or BH need and their medical complexity. In addition, episode-based payments will be made for care for the particular condition, as described below.

In addition, episode-based payments will be made for the core DD and LTSS services, and for some BH services, as described below. BH health homes will be expected to take

responsibility for ensuring cost-effective and high-quality treatment in appropriate settings for all BH conditions that are not paid for via guideline-based episodes. Payments for these core BH services will be tied to performance using leading indicators and outcomes.

Staged Rollout

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 for adult DD health homes will launch with the assessment-based adult DD episode in Q1 2014 and payment changes for LTSS are also expected in Q1 2014. Health homes for DD children will follow 6–12 months later.

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.

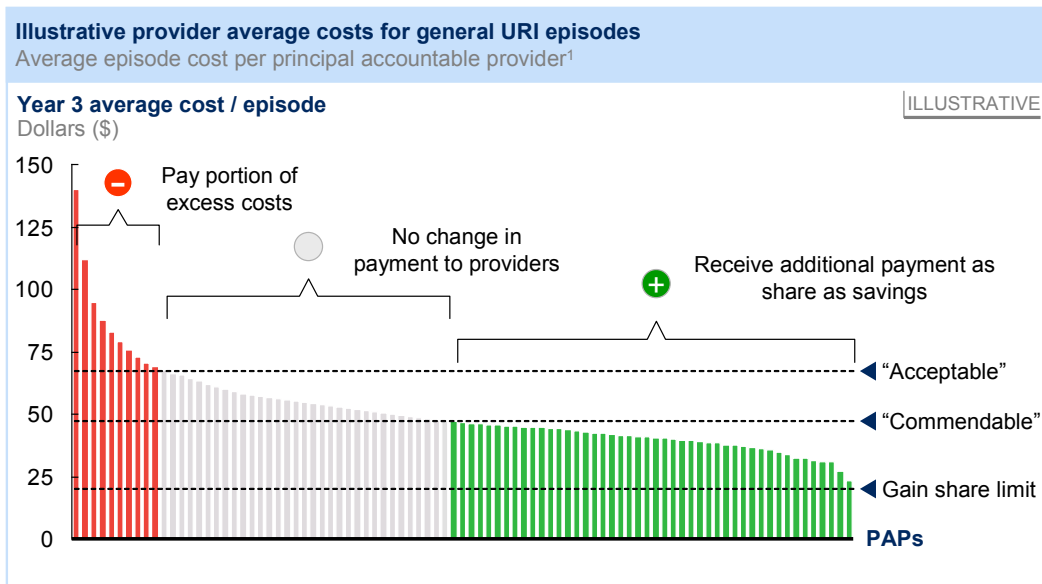
EPISODE-BASED PAYMENT: RETROSPECTIVE RISK SHARING

For medical episodes, participating payers have defined and implemented comprehensive “retrospective episode-based payment,” or REBP. This mechanism is also being developed for selected behavioral health conditions. This is a critical innovation that will allow us to roll out episodes across the state for both fragmented and more integrated providers. In early explorations of our system transformation initiative, prospective bundled payments were considered (i.e., one provider would receive a single payment for an entire episode of care and would be responsible for disbursing payment among other rendering providers). In some markets this approach holds great promise, but in Arkansas few providers are able and willing to perform the needed administrative functions.

In our approach, each payer designates one or more providers as the Principal Accountable Provider (PAP). 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 time period and compares them against performance thresholds independently preset by each payer. As illustrated in Exhibit E, 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. Conversely, 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. PAPs not meeting quality targets are not eligible for shared savings.

Exhibit E: Over time, if providers improve performance more will share in savings (URI example)



¹ Each vertical bar represents the average cost for a group of 10 providers, sorted from highest to lowest average cost

Importantly, the payment mechanism includes a number of adjustments to make it as fair and accurate as possible, 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. While these adjustments add complexity they have been crucial to build support in the provider community.

REBP encourages PAPs to consider and manage care across the episode without requiring independent providers to develop new fiduciary relationships with one another, thereby accelerating the pace and enabling the breadth of roll out across the state. This decision was the result of substantial feedback from stakeholders and public workgroups, and reflects the needs of the relatively fragmented nature of Arkansas’ delivery system in place today.

Our approach reinforces quality in several ways relative to the fee-for-service system. By design, it holds providers accountable for outcomes and rewards those who are able to reduce complications, error rates, and care that is not evidence-informed. But we also

want to ensure we do not create any unforeseen incentives for the underuse of care. We incorporated two types of quality measures for each episode: quality metrics linked to payment (“performance metrics”) and quality metrics for reporting only (“reporting metrics”). In order 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.

Staged Rollout

We hope to apply episode-based payment to as many acute, post-acute, and treatable conditions as possible. At this stage, we do not intend to implement episode-based payment for chronic medical conditions (other than complex conditions managed by specialists such as cancer), as these will be addressed through Arkansas’ Patient Centered Medical Homes (PCMH) initiative. Applicable medical conditions include acute outpatient medical (e.g., URI, orthopedic fractures), acute inpatient medical (e.g., stroke, AMI, pneumonia), and acute procedural (e.g., PCI, CABG) episodes, among others. Guideline-based episode payments will also be defined for select behavioral health conditions.

Over the next several years, participating payers in Arkansas intend to cover the majority of spend across Medicaid, private insurers, and Medicare under episode-based payments. For the participating payers it may be possible to apply episode-based payment to as much as 50-70% of spending in total. This reflects that some conditions will not be covered with episodes and there will be some patient exclusions.

The total spend base we are ultimately able to affect with episode-based payment will be governed by several factors including the pace at which claims-based strategies to define episodes for payment become available, the efficacy and credibility of risk adjustment methodologies, and overcoming relatively small sample sizes of lower volume episodes or lower volume PAPs.

To achieve our objective for penetration of episode-based payment, we expect to implement 75-100 episodes over the next three years, over the course of 3 waves:

- **Wave 1 – all payers launch initial episodes:** Across payers, we have already launched episode-based payments across 5 episodes, including perinatal care, ambulatory upper respiratory infections (URIs), ADHD, CHF, and hip and knee replacements. In addition, we propose for Medicare to launch these episodes on a voluntary basis in 2013.
- **Wave 2 – transition to scalable infrastructure model while maintaining momentum:** Over the next 9-12 months, participating payers intend to implement a

modular, scalable infrastructure platform for launching and administering episodes. During this period, we will have 1-2 launches of 5-10 episodes. Episode rollout will occur at a significantly more rapid pace than Wave 1. The launch and administration of these episodes (including the process of loading the episode definitions into the analytic engine) will use the Wave 1 infrastructure platform.

- **Wave 3 – accelerate scale up:** From Q4 2013 through mid 2016, we intend to rapidly achieve scale through quarterly launches of ~5-10 sub-waves of episodes. We expect the scalable infrastructure model will be in place and able to support the rapid launch and administration of these episodes

EPISODE-BASED PAYMENT: ASSESSMENT-BASED PAYMENT

Payment for DD and LTSS episodes will be based on individual assessments of support and healthcare needs with subsequently tiered episode funding targets based upon need. The goal is initially to cover all adults in institutional or waiver settings; over time this will be rolled out with appropriate adjustments to children and to those currently receiving other services outside these settings. The assessment is needed to ensure that a fair, fact-based, comprehensive view of an individual's need is the foundation for service allocation. Assessments will be carried out by independent assessors using a consistent tool. The assessment will result in the determination of a "level of need" for each person; this level of need will in turn be matched to a dollar amount to be paid for service provision.

Given the delivery system structure for these populations, in which almost all individuals with DD or LTSS have a clear lead provider, these episodes would use assessment-based bundles paid to a single lead provider selected by the individual with advice from his or her family. The lead provider selected will be responsible for ensuring that services across all the individuals for whom they are leads are delivered within the total budget and according to each individual's plan of care. These will avoid perpetuating any misaligned incentives (for example, by reducing payments after an initial limit to reflect periods when individuals who are part of health homes are inpatients in other facilities).

Staged Rollout

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.

For the adult DD service episodes, significant progress has been achieved. The effort has identified and contracted with an appropriate assessment tool (InterRAI ID); run an RFP and contracted with a supplier to conduct assessments across the state (Pine Bluff Psychological Associates) which will start in November 2012 in the field; contracted with

a supporting IT tool for the assessments (CH Mack); and agreed all key principles of the approach with the individual, family and provider communities and through workgroups.

We expect the basic payment structure will be similar for school-aged children. There will be some adaptation required because the needs of children with DD may evolve over time more rapidly than those of adults. Consequently we will need to determine an appropriately flexible assessment method, assessment frequency and episode duration. In addition, links to school-based care for both the DD episode and the health home may be needed, and we will need to consider how to encourage family participation. For children less than 6 years of age, additional modifications may be required.

There has also been significant progress on LTSS episodes. The InteRAI Home Care assessment tool has been selected to implement the needs-based assessment underpinning eligibility and episodes, and state agencies are working closely with InteRAI experts to adapt the tool to Arkansas. Assessor training and IT development are underway. In nursing homes, the Minimum Data Set (MDS) is currently in place as required by CMS. The InterRAI tool is being developed with an aim to integrate with current eligibility determinations. Initial segmentation (Resource Utilization Groups or RUG) is in progress and the data refinement / pricing approach in development.

There are significant timing advantages for implementing LTSS service episodes, as the InteRAI assessment tool is already well-established for LTSS and has been nationally tested. Since detailed time surveys have been carried out in other states, it will be significantly quicker to link levels of need to the service delivery intensities required for any individual.

F. Health Care Workforce Development

Addressing the health care workforce is critical to transforming the care delivery system. Not only is there a general provider shortage, particularly in primary care, mental health and dentistry, but physicians are geographically dispersed due to a largely rural population – 60 percent of physicians are in practices of 5 or fewer physicians, creating challenges for care coordination and sufficient scale to transform.

At Governor Beebe's request, leaders in health education, public health, and health policy convened the Health Care Workforce Initiative. The initiative team delivered a strategic plan in April 2012 that outlined a number of concepts that have since been folded into this State Innovation Plan: support the implementation of and transition to team-based care; enhance and increase the use of health information technology (HIT); increase the supply of and improve the equitable distribution of primary care providers; and adopt new financing, payment, and reimbursement policies and mechanisms.

Looking forward, efforts to improve the capacity and effectiveness of our health care workforce will concentrate on four priorities to support the rollout of the population- and episode-based care delivery strategies previously described.

- 1. Increasing the supply of providers** through initiatives that could include increased funding for primary care residency slots, new programs for non-physician providers, and funding/loan forgiveness incentives for providers who practice in underserved areas
- 2. Increasing availability of care** through optimizing the use of non-physician providers, employing mobile health units, and providing tele-health alternatives for rural communities
- 3. Defining requirements for care coordinators**, including the number and geographic distribution, skills and training curricula
- 4. Expanding from individual to team-based care**, through optimizing practice at top of skill level within license, enabling strategies will allow broader access to basic and preventative care.

G. Consumer Engagement and Personal Responsibility

We aspire to help all Arkansans assume personal responsibility for their health and health care. Arkansas' strategies to improve health care delivery will only succeed if there is full alignment and partnership with the very consumers whom the delivery system exists to serve.

We will help Arkansans assume greater personal responsibility by encouraging more direct, more effective engagement between consumers, providers, and third-parties working to address a host of interrelated issues such as lifestyle choices, health literacy, preventive health, provider selection, treatment selection, and treatment adherence. Greater engagement will require leadership and action by a wide range of stakeholders including families, providers, payers, employers, religious institutions, school systems, and the Department of Health, among others.

Specific initiatives to increase consumer engagement and foster greater personal responsibility fall into four main approaches: incent, educate, enable, and intervene.

INCENT

We have a shared goal to fully align payment mechanisms to both physicians and consumers through a combination of network design and benefits. Both private payers and Medicaid are exploring options for value-based insurance designs, where individuals' contributions to their insurance costs are changed to encourage the use of high-value care (e.g., lower co-pays or deductibles for the use of preventative services and medications effective in controlling a given condition) and discourage the use of low-value care (e.g., higher co-pays). Beyond benefit design, across the U.S. there is a growing interest in applying behavior science to health. Examples include the use of public commitments, team- and community-based initiatives and small rewards for reaching health goals or engaging in desired behaviors. These are potential consumer engagement tools for employers, schools, payers, providers, and other stakeholders to apply.

EDUCATE

Providers have the potential to play a critical role in educating consumers regarding the range of health and health care decisions they face. However, providers need support to be more effective in doing so (along with the rewards outlined in our payment innovation strategy). In PCMHs and health homes, lead providers will need to work closely with their patients and families or caregivers to ensure understanding of their conditions, treatment plans, and how to navigate the health care system. The use of team-based care within medical homes will allow care coordinators to play this educator role along with physicians. In the coming months, Medicaid and other participating payers will screen the third-party vendor landscape for tools, technologies, and services that may be made available to providers to support their efforts in consumer engagement.

ENABLE

Consumers also need tools to be able to effectively manage their own health. Many technology enablers can support this goal, including the availability of personal electronic health records (EHRs), online tools to track and manage treatment plans, and information about provider availability and performance. Tele-health can also play an important role, especially given the uneven distribution of the health care workforce across a rural state, and limited online access among some of our populations with the most pressing needs. These could range from text reminders to take medications to video-consultations with specialists. Moreover, providers and members of care-coordination teams can use coaching, different structures for care (e.g., group visits for social support) and other tools to address the individual socioeconomic and behavioral determinants of health that impact a given person's ability to effectively manage his or her health.

INTERVENE

In some cases, individuals may be unresponsive to the efforts of medical homes to engage in proactive management of their care. On a selective basis, medical homes should have the opportunity to bring these challenges to the attention of their sponsoring payer, so that an alternative model for engagement and care coordination may be deployed. For example, Arkansas Medicaid is considering the development of a separate, intensive coordination unit to work with these consumers, similar to the Camden Coalition of Healthcare Providers which targets health care “superusers” in Camden, New Jersey. Such a unit may be linked to the new payment mechanisms, for example, by allowing medical homes to initiate exceptions from their performance reporting (and rewards calculations) for a select number of patients whom they have “referred out” for specialized care coordination.

Many of these approaches will be implemented directly as part of the integrated population- and episode-based delivery model. Through PCMHs, care coordinators will have an explicit role to invest time in consumer education as part of care management. EMR and technology investments made by both payers and providers as part of payment innovation will provide tools for consumers to have the information to play a central role in managing their health care. In addition, other initiatives will involve coordinated efforts with public and private stakeholders across the state.

H. Health Information Technology Adoption

Improved health information technology infrastructure will support consumer access to personal health information and will give providers and payers the integrated data systems they need to effectively coordinate delivery of high-quality, efficient care. Current infrastructure development includes: adoption of electronic medical record and computerized physician order entry systems, a unified claims database, a state-wide health information exchange, and electronic claims submission tools. While several initiatives are underway to develop these capabilities, as outlined below, additional resources are required.

1. **APCD+:** All-Payer Claims Database Plus is an effort undertaken by the Arkansas Center for Health Improvement to integrate claims data across Medicare, Medicaid, and private payers. This capability will support design of new payment mechanisms, profile provider patient panels, create patient registries, measure quality, and better position the state to meet any payer data collection requirements for the Health Benefits Exchange. Entities submitting data will serve as members of an advisory committee that will guide use of the data.

2. **SHARE:** The Office of Health Information Technology is developing statewide policy, governance, technical infrastructure, and business practices to support The State Health Alliance for Records Exchange, which will allow secure electronic exchange of medical information among participating providers.
3. **AHIN:** Advanced Health Information Network, underwritten by Arkansas BlueCross BlueShield, provides desktop online access to patient eligibility information and electronic claims submission currently reaching 98 percent of providers in Arkansas, paving the way for statewide adoption of other HIT solutions such as SHARE to support new payment mechanisms.
4. **BTOP:** The Broadband Technology Opportunities Program is a grant-funded project designed to increase broadband capacities and equipment at 474 health care, higher education, public safety, and research entities in Arkansas. Aligning partners from across Arkansas, this project aims to improve broadband resources in all 75 Arkansas counties.

Staged Rollout

Medicaid has developed a detailed roadmap for payment innovation technology, inclusive of episode-based payment, PCMH and health homes. The scale-up approach for all of these areas has been to use existing systems and capabilities wherever possible.

For episodes, Medicaid plans to launch an analytics engine RFP in the coming months to implement a robust solution that will enable rapidly scaling episodes. This approach will also leverage (with local customization) existing episode definitions where possible to increase scalability.

For Health Homes, DHS has selected CH Mack as a core vendor. CH Mack will enable long-term scalability, and will provide a variety of capabilities, including assessment workflow and analytics.

Medicaid will also continue to build on existing solutions. For instance, AHIN currently provides provider portal functionality for episode reporting, which Medicaid intends to significantly expand over the next 6-9 months.

The Arkansas Office of Health Information Technology (OHIT) leads the Arkansas HIE effort, which is expected to play a critical role at the forefront of payment improvement. The HIE will reduce provider administrative burden by seamlessly integrating with their EMR systems, enhancing population and episode-based care delivery.

I. Governance Structure, Operating Model, and Stakeholder Input

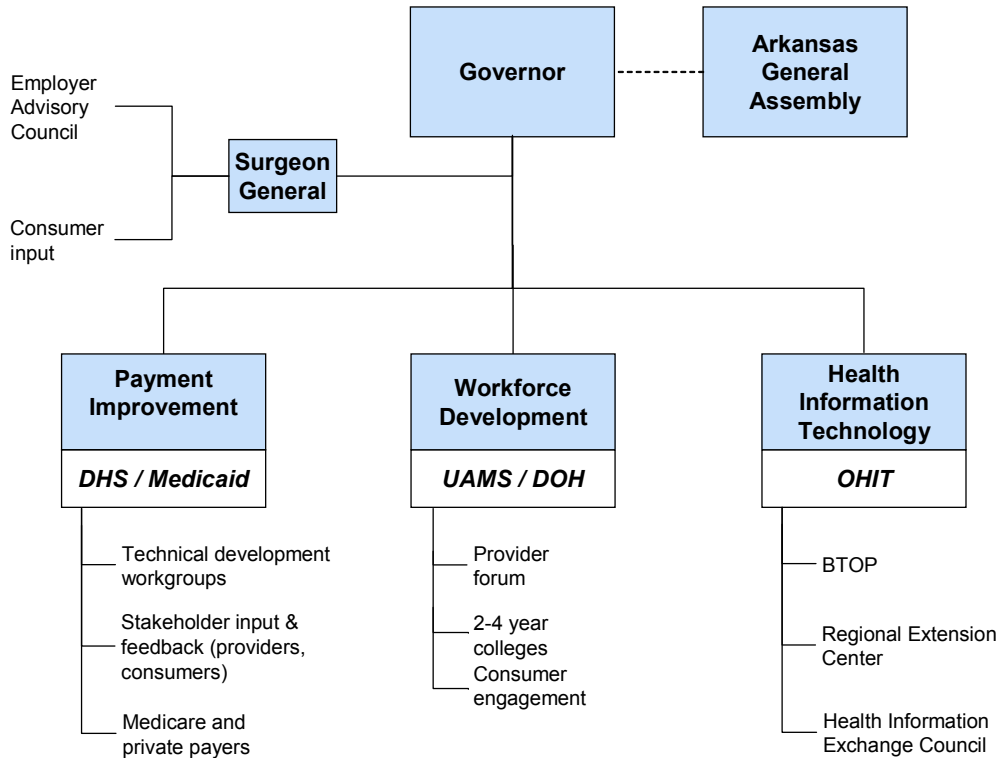
Our approach toward governance will reflect the following principles, which have been applied successfully over the past 12 months, leading to alignment of payers and other stakeholders around the key elements of the State Innovation Plan and successful state-wide implementation of the first wave of episodes.

- 1. Consistent Business Rules.** Payers will continue to adopt and maintain common payment mechanisms, including similar or identical business rules for provider participation requirements, the structure of incentives, and the type of enabling capabilities that will be made available. Whenever possible, payers will adopt common quality metrics and criteria for clinical exclusions, largely shaped based on commonly accepted practices with significant input from local providers.
- 2. Continuous Stakeholder Input.** Providers and consumers will continue to have opportunity for input into design and implementation decisions, both during concept development as well as in the period immediately prior to any legislative or regulatory changes necessary for the Medicaid program, in particular.
- 3. Efficient Operating Model.** In deploying new infrastructure, we will seek to optimize efficiency for both payers as well as providers, developing shared or common solutions whenever possible.
- 4. Independent Decision Making.** Payers will ultimately retain independence in formal policy decisions. Most importantly, payers will preserve complete independence in establishing cost threshold and PMPM levels, performance thresholds, and risk corridors independent of one another, in accordance with all laws and regulations.

GOVERNANCE STRUCTURE

These initiatives are being organized through a state-led process including multi-payer, multi-stakeholder collaboration and advice (Exhibit I1).

Exhibit I1: Governance Structure for Arkansas Health System Transformation



The initiative is sponsored by Governor Beebe, and three of the core initiatives – payment improvement, workforce development, and health information technology – have implementation sponsors within the state structure. Each of these initiatives draws heavily on advice and collaboration with a wide range of stakeholders. For example within the payment initiative, a multi-payer group including the Department of Human Services / Medicaid, the Surgeon General, Arkansas BlueCross BlueShield, and QualChoice of Arkansas meets frequently to coordinate efforts, align on design concepts and ensure consistent approaches to payment design that will enable the initiative to be broadly scaled across the state. However, this group does not have formal decision rights.

The consumer engagement and personal responsibility strategy will be driven by efforts across a wide range of stakeholders, including consumer groups, providers, payers, and employers, with involvement by the state Department of Education and Department of Health on specific initiatives as well.

Employers and consumers will also be engaged in all of the initiatives. We are developing a Employer Advisory Council to be coordinated through the Surgeon General’s office that will provide a two-way forum for input and involvement across the broader health system transformation strategy. Broader consumer input and feedback will be facilitated through the Surgeon General as well.

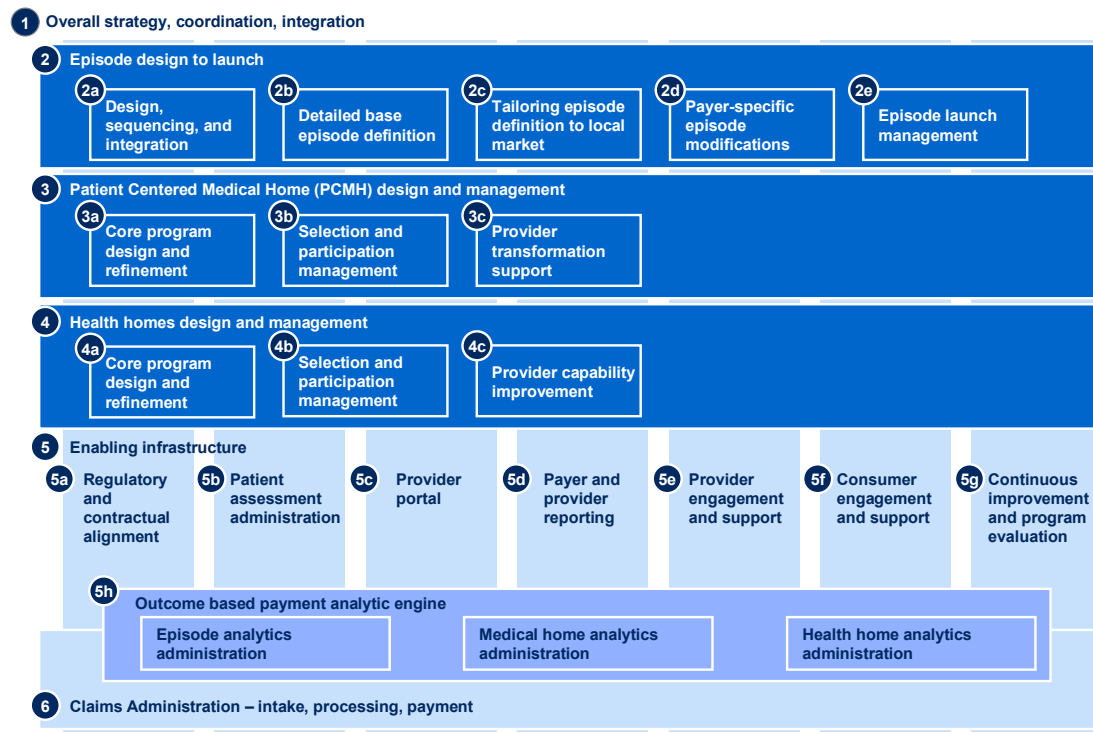
PAYMENT INNOVATION OPERATING MODEL

The operating model includes the activities required to coordinate and strategically manage the overall initiative, as well as the operational needs of the State and other participating payers to implement the integrated population and episode-based care strategies.

Exhibit I2 describes the six principal components of an at-scale operating model:

- Overall strategy, coordination and integration for the initiative (#1)
- Definition and management for each of medical episodes, PCMH, and health homes (#2-4)
- Enabling infrastructure required across the initiative and for each of the payers to successfully and sustainably implement each of these components (#5)
- Claims administration platform unique to each payer (#6).

Exhibit I2: Proposed Operating Model



1. **Overall strategy, coordination and integration:** This includes defining the goals and roll out timelines for the various initiatives, facilitating decision making and alignment across the payers where necessary, coordinating with related initiatives across the state, and engaging stakeholders.

2. **Episode definition and management:** This includes design, sequencing, and integration, base episode definition, tailoring episode definition to local markets, payer-specific episode modifications, and episode launch management.

3 and 4. **PCMH and health home definition and management:** For both PCMHs and health homes, this includes core program design and refinement, provider selection and participation management, and provider capability improvement.

5. **Enabling infrastructure:** This includes several sub-components that cut across payment and delivery approaches.

- a. **Regulatory and contractual alignment:** Includes contract negotiations, compliance with regulatory requirements, legislative approvals, and / or other requirements. These elements tend to be highly unique for each payer, including state approvals and CMS State Plan Amendment approvals required for changes to Medicaid payments, and private payer alignment with specific provider contract conditions.
- b. **Patient assessment administration:** Includes assessment tool selection and development, identification of relevant populations, selection of an appropriate assessor entity and development of a process to collect the assessment data over time. CH Mack has been selected to develop a supporting IT tool for the administration of the InterRAI assessments (for DD and LTSS). DHS is working to develop a streamlined process for administration and data collection across all relevant populations.
- c. **Provider portal:** Includes web-based, HIPAA-compliant mechanisms for providers to view performance information and for providers and payers to share clinical patient data. The Advanced Health Information Network (AHIN), owned and managed by Arkansas BCBS, built and currently maintains a multi-payer provider portal for physician and hospital providers. This allows registered providers to submit additional quality data for each patient episode with which they were involved and give access PAs access to current and past performance reports. Enhancements being considered include search capabilities, dynamic report creation and “drill downs”, and enhanced connectivity to provider EMRs.
- d. **Payer and provider reporting:** Includes all aspects of provider performance measurement and reporting across payment mechanisms. To date, payers have designed, developed and launched detailed reports for each Wave 1 episode. PAs can see their historical performance on cost and quality, a “virtual ledger” of total gains/losses, a drill down into the key drivers of performance, and patient/claim level detail to understand performance by episode. Payers used claims data only for these initial reports, but will use quality metrics entered in the provider portal over time. In October, 2012 Medicaid will issue the first reports that show results that will be tied to payment. In the future, we also aim to increase dynamic

functionality on the portal so that providers can review reports in a more interactive and potentially real-time way. Payers are actively accepting feedback to improve design for clarity, accuracy and completeness.

- e. **Provider engagement and support:** Includes all strategies and interactions to support providers in improving the care they deliver. We know from experience in Arkansas and elsewhere that changing incentives alone is insufficient to drive improvements in care delivery. Success will require provider leadership and adoption of new business models supported by the modified payment system. Our provider engagement approach includes recruitment, assessment, collaboration, and education.
- f. **Consumer engagement and support:** Includes all strategies and interactions to support consumers in improving and maintaining their health and successfully navigating the care delivery system. This includes information, tools, support, and consumer level incentives. Core payment mechanisms also directly encourage and, in some cases require, enhanced consumer engagement across the care continuum including greater education and awareness, care coordination, care adherence tools, and encouragement of patient self-monitoring. We plan to significantly expand and accelerate additional approaches that payers can take to engage consumers, potentially including awareness campaigns, creation (or modification) of incentives (e.g., co-pays, rewards, etc.), and tools and information to effectively navigate the health care system.
- g. **Continuous improvement and program evaluation:** Includes all strategies, processes, incentives, etc. to encourage refinement and improvement over time. First, the episode-based payment approach explicitly includes 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 analysis. Third, we have multiple mechanisms for stakeholders to share input and suggestions. Going forward, we plan to augment our approach by deploying even more modular/flexible reporting and analytic engine technologies to ensure refinements to program design can be made quickly at acceptable cost. Annual assessments of healthcare quality, provider participation, and impact on healthcare costs in the deployment of PCMH, Health Homes, and Episodes will be conducted by each payer. These will be integrated into a single statewide report to inform consumer, provider, employer, and public officials on progress and challenges in deployment.
- h. **Outcome-based payment analytic engine:** Includes all calculation/ administration of provider performance and risk/rewards for REBP, PCMH, and Health Homes (e.g., grouping claims, attributing patients, applying risk adjustment, calculating performance, calculating average performance, applying quality measure logic,

etc.). The analytic engine interacts with each payer's core claims systems and links to report generation and other related components.

6. Claims administration (intake, processing, payment): Includes core IT system and related human organizations to run on the existing fee-for-service payment system that the payment improvement initiative will build upon. Each payer will continue to use its existing core claims platform.

STAKEHOLDER INPUT

We know that changing incentives alone is insufficient to drive improvements in care delivery. This is especially true in Arkansas given the relatively high prevalence of smaller practices. Our provider engagement approach for payment transformation and care delivery includes assessment, collaboration, and education.

Stakeholder Input to Date

- **Assessment:** We have (1) conducted 16 months of research, data analysis, expert interviews and infrastructure development to design and launch episode-based payments and (2) met with or took input from over 500 stakeholders including consumers, providers, provider office staff, legislators and organizations who helped shape the new model.
- **Collaboration:** (1) Held 21 public workgroup meetings sessions across episodes and the initiative approach broadly. We connected these sessions through videoconference to 6-8 sites across the state to allow broader participation, and posted records of these meetings online for ongoing public access and reference. (2) Continue regular monthly meetings with many Arkansas provider associations including the Arkansas Hospital Association, Arkansas Medical Society, Arkansas Waiver Association, and the Developmental Disabilities Provider Association among others to take in regular feedback, ideas and align on next steps for the initiative. (3) 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 (ABHPAC).
- **Education:** (1) Launched a multi-payer initiative website that includes information about all episodes, the design of the incentive payment model, shares regular status updates, and has contact information for provider support staff. (2) Trained dedicated staff for customer service support at all of the payers, who are now answering provider questions and directing them to resources on a regular basis. (3) Organized and are holding Town Hall meetings across the state, featuring members of the payment initiative executive committee describing the initiative, the payment model, and taking questions from providers. To date, over 700 providers have participated. (4) Created and distributed FAQs, episode fact sheets, instructions on portal use and a guide to reading reports to aid providers in transitioning to and learning about the initiative. As part of the initial wave of episode-based payment,

we have distributed actual performance reports to all designated Principal Accountable Provider which detail providers' relative cost and quality performance and utilization levels.

Approach to Stakeholder Input Going Forward

Going forward we plan to expand our provider engagement approaches (e.g., webinars, reporting, town halls, etc.) while looking for additional approaches to augment historical approach (e.g., improved best practice sharing, learning collaboratives, more one-on-one training, etc.). We will institutionalize our model for stakeholder input, to be organized around three stages, as outlined below.

- **Stage 1 Technical Input:** Payers will contract directly with a small number of leading health care professionals from around the state, including clinicians and administrators, to provide detailed input into development of technical details of implementation for new processes and infrastructure. Consumers and employers will also be included in this process, when appropriate. In most cases, this contracted technical input will comprise multiple working sessions spanning several weeks, focused on a specific scope of design/implementation, e.g., definition of clinical exclusions, or development of curriculum for practice transformation.
- **Stage 2 Broad Syndication:** In the weeks prior to finalizing new technical designs, and in the weeks surrounding implementation of changes, participating payers will use a number of communication channels to promote awareness of new model and invite feedback. To date, these have included public forums, webinars, communications on the DHS website, and interviews on local television and radio. To augment these channels, going forward, DHS will contract with each of 8-10 local provider associations to create a structured channel for communication with association members on a monthly basis.
- **Stage 3 Continuous Improvement:** On an ongoing basis following implementation of changes in payment, (a) participating payers will maintain customer service channels to address questions from providers and consumers, triage and escalate as needed, and catalogue for changes to the technical design, operational processes, or communications. In addition, (b) providers will be encouraged to initiate their own forums for clinical innovation. In the case of PCMH, these will include learning collaboratives underwritten by participating payers, led by professional facilitators; for most episodes of care, specialty societies or other provider organizations will be encouraged to structure their own forums to exchange best practices, which payers will support with analysis of performance data to inform opportunity identification.

J. Policy, Legislative, Regulatory Changes

The comprehensive health system transformation envisioned and underway in Arkansas is driven by a collaborative effort across public and private sector health system leaders that is directly sponsored by Governor Beebe. The State is using its full breadth of regulatory and legal authority to support this strategy, including

- Use of current regulatory authority (e.g. to implement changes to Medicaid payments)
- Pursuing adaptations to regulatory authority as needed (e.g. received CMS approval of State Plan Amendment, and the State Legislature adopted the episode-based payment section in the ‘All Provider Manual’)
- Pursuing changes to state laws as needed (e.g., implementation of recommendations from Health Care Workforce Strategy support team-based distributed care)
- Collaborating with federal partners (e.g., work with CMMI innovation programs, SPA and waivers as needed, Medicare participation in payment initiatives).

In July, Medicaid sought and received favourable review from the State of Arkansas’ General Assembly for the episode-based payment mechanism and for the specific payment changes in Medicaid’s first 3 episodes. Pursuant to regulatory requirements in Arkansas, DMS followed and 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. Because the July approval adopted a new section in the Arkansas Provider Manual for episode-based payments, future episodes will only require approval for the specific payment adjustment (versus for the overall payment mechanism).

In August, CMS approved a State Plan Amendment (SPA) enabling the payment adjustments in the model. This established approval and modification of the SPA paves the way for future episode launches and associated payment changes. While we believe that our PCMH and health home payment approaches to be tested are aligned with existing CMS demonstration models and guidance, additional waivers may be required to implement specific designs.

Beyond payment, additional regulatory approvals may be required for elements of the other core initiatives as well, e.g., legislative approval to create the financial incentive programs recommended to build the health care workforce, regulatory and/or legislative approvals should HIT capabilities be required to participate in future payment initiative programs.

Initiatives relating to the health transformation strategy reach beyond the Department of Human Services and will involve multiple state actors, from the Departments of Human Services and Insurance, to state universities and public school systems and community programs.

K. Timeline and Milestones

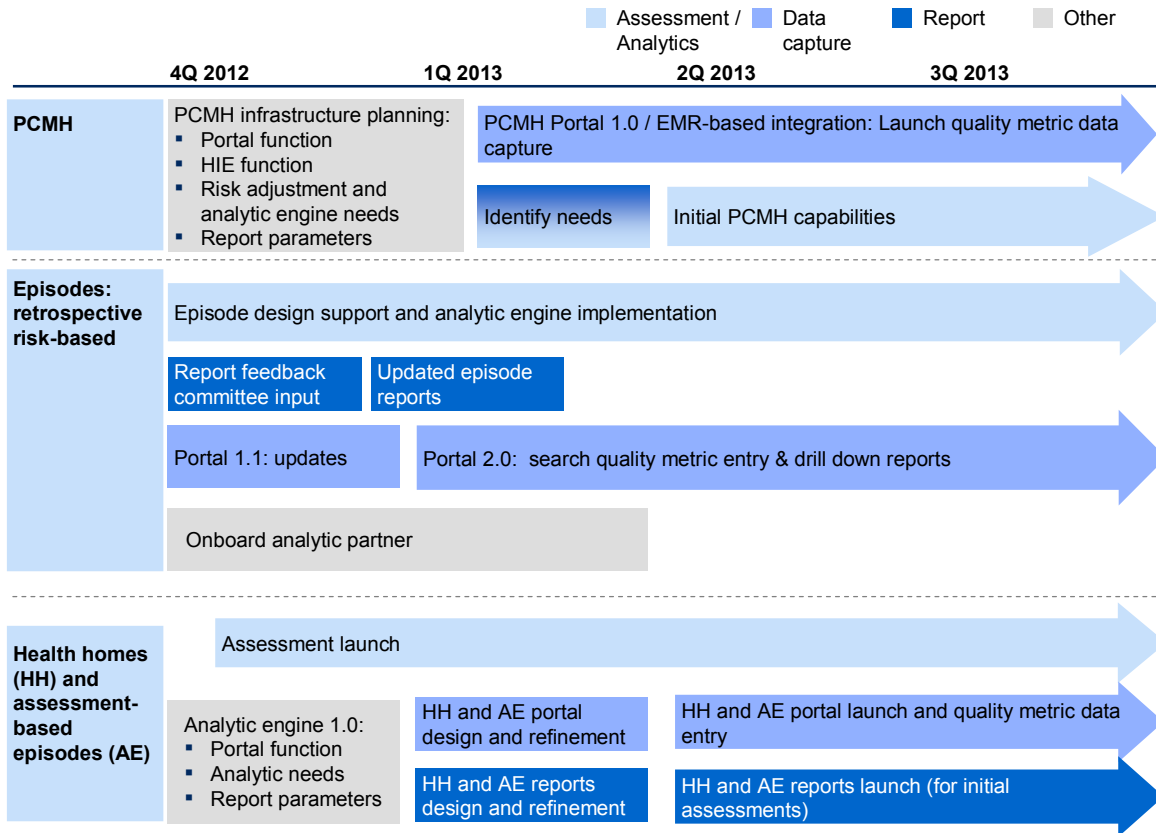
We aim to broadly roll out both population and episode based delivery systems over the next 3-5 years. Exhibit K1 describes the stages and key milestones for developing the PCMH, health home, and episode-based care delivery and the associated payment innovations. Exhibit K2 details the steps over the next 12 months to build the HIT infrastructure that will support implementation of these components of our model. In addition, activities by multiple stakeholders to shape a health care workforce that can effectively provide care in this new model and improve consumer engagement will happen in parallel, particularly as PCMHs and health homes are established.

Exhibit K1. Scale up timing and sequence for Arkansas State Innovation Model

Approach	Timing	Wave (description)
Population-based models	PCMH	2Q 2012 — 3Q 2012 1 66 CPC enrolled practices, 228 providers, 50k+ Arkansans
		3Q 2013 — 3Q 2014 2 Target voluntary enrollment of 30% practices (including “virtual practices,” ¹)
		3Q 2014 — 3Q 2015 3 Target enrollment of remaining primary care practices
	Health Homes	1H 2013 — 1H 2014 1 All LTSS and adult DD providers (children follow 6-12 months)
		2H 2013 — 2H 2014 2 Voluntary enrollment for eligible BH providers
		2H 2014 — 2H 2014 3 Enrollment of remaining eligible BH providers
Episode-based models	Episodes: Retrospective risk-based	3Q 2012 — 4Q 2012 1 Multi-payer launch of first 5 episodes (ADHD, URI, CHF, Joint replacement, Perinatal)
		4Q 2012 — 4Q 2013 2 Transition to scale while maintaining momentum: 1-2 sub-waves of 5-10 episodes
		4Q 2013 — 2Q 2016 3 Accelerate scale up: quarterly launch of 5-10 episodes
	Episodes: Assessment based	2H 2013 — 2H 2014 1 All adult DD and LTSS services (DD kids phase-in 6-12 months behind adult)
		1H 2014 — 2H 2015 2 Behavioral health institutional level of care services

¹ Virtual aggregation of patient panels to meet minimum scale of 5,000 persons
² CPC practice participation as of September 10, 2012

Exhibit K2: Healthcare IT to support delivery models 12-month timeline



L. Evaluation and Monitoring

Monitoring the development and implementation of the innovation plan and success in achieving our scale-up goals and outcomes targets will occur at three levels:

- **Overall assessment** of progress against targets
- **System surveillance** for unintended consequences and methods for course correction
- **Detailed operational monitoring.**

Overall assessment against targets

The overall assessment of progress will occur at a consolidated level across the comprehensive health care transformation plan. Over the next few years, this will focus both on meeting operational targets for scale-up (e.g., launching the next wave of episodes) and early indicators of progress in meeting outcomes targets for improving health, quality and cost effectiveness. Over time, the focus will shift more toward these outcomes targets. This assessment will require central oversight and responsibility, with the ability to aggregate inputs and disseminate findings across all the stakeholder groups

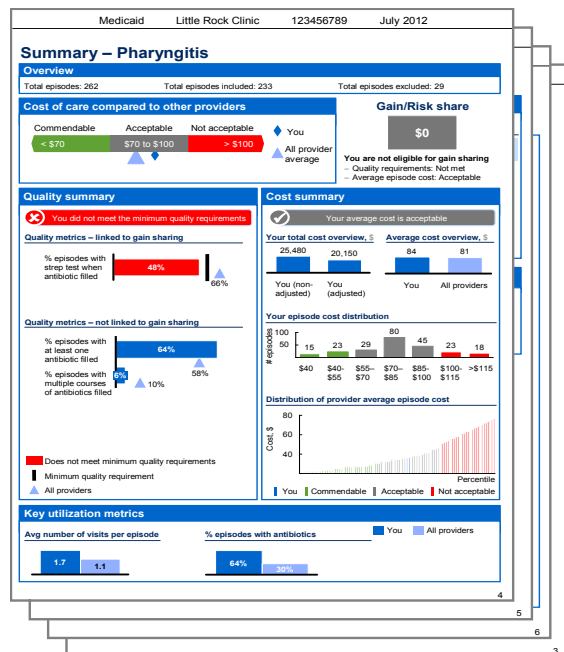
involved. It will leverage existing outcome reporting mechanisms and data collection methods being developed as part of the overall strategy.

We have two principal approaches to this assessment currently in place including 1) provider performance reports, and 2) quality and outcomes metrics tracking.

1) Provider performance reports

We have invested significant time over the past 9 months to develop robust, detailed provider performance reports on quality, cost, and utilization. Our initial reports have been focused on episodes (see Exhibit L) and have been made available to all principal accountable providers for the initial waves of episodes; we will roll these out in parallel with the launch of additional episodes, and we will adapt these reports for medical homes and health homes as well. These reports are and will be consistent across the payers. The algorithms we have developed for the various components of our model (for example, detailed episode definitions) give us and providers a complete picture of care that we otherwise would not have (for example, the overall cost and quality variation across the state and all principal accountable providers for an end-to-end knee replacement episode); they are also risk adjusted (whether for individual episodes or on total cost of care for PCMH). These algorithms lay the foundation for developing system-wide performance dashboards on the progress and impact of our model – across quality, cost and utilization.

Exhibit L: Example Provider Report



2) Quality and outcomes metrics tracking

We have and will continue to invest substantially in tracking a host of quality and outcomes metrics. Medicaid, for example, tracks many of the nationally recognized population health and outcomes measures that we are looking to improve. Many of these are based on administrative claims data. In some instances, Medicaid will conduct targeted chart reviews to assess quality metrics not available through claims data (for example, to estimate the rate of early elective inductions in the state before 39 weeks). Arkansas Blue Cross Blue Shield has also invested substantially in tracking and reporting a large panel of quality metrics for a range of physician specialties.

Going forward, we are investing resources in filling gaps for quality and other metrics where we currently do not have access. In particular, in our Wave 1 launch of episodes, we also launched a multi-payer, HIPAA-compliant, provider portal for providers to input required quality metrics not available through claims data. These include, for example,

use of ACEs and ARBs as well as Left Ejection Fraction Value for CHF patients, and use of prophylaxis to prevent DVT/PEs for hip and knee replacement patients. We anticipate development of a more “real time” clinical information accessibility as EMRs and the use of SHARE become standards of practice.

Taken together, we will have a robust set of data and performance metrics to provide clear performance dashboards and reports to our program leads to track progress against our range of target quality, utilization, and cost metrics.

System surveillance

Across the components of our model, we are identifying a range of potential unintended consequences that might result from our new care delivery and payment mechanisms. These include, for example, changes in access to care in various counties across the state as certain providers shift behaviors as a result of new payment approaches. These might also include ways in which the system may be “gamed”, including when this leads to over- or under-delivery of care. For Medicaid, we have begun and are continuing to outline logic and criteria that will help us flag and track instances of these unintended consequences. For example, Medicaid has identified for the ADHD episode a set of metrics that will be monitored to identify and address any such impacts. In addition, Medicaid program integrity is involved in areas where we recognize a potential for providers to game the system.

Detailed operational monitoring

Finally, detailed operational monitoring for each initiative is required to monitor progress. This will include efforts by individual payers and provider practices to measure their status in implementing the initiatives as well as the impact on their patient populations, operations, and finances. Many of the data tools and resources used to measure progress against overall targets (e.g., provider reports) can also be applied at this more granular level and used to inform on-the-ground modifications to practices. Specific lessons learned from operational monitoring will also be crucial to aggregate and share more broadly across Arkansas’ payers and provider communities, to help understand broader trends, explain drivers of successes, and understand root causes of challenges.

M. CONCLUSION

The State of Arkansas is actively managing a major healthcare system transformation required by the current fragmented status of our healthcare system negatively impacting quality, the current unsustainable costs of our healthcare system outpacing both public

and private sector abilities to maintain support, and the marginal value to our citizens of the fee-for-service system currently in place. The state recognizes the need to support and develop our healthcare workforce, to optimize health information technology solutions, to engage in consumers in new ways for their own health interests, and importantly, to change the mechanism of payments to align expected healthcare outcomes with payment incentives. The state has the public and private sector support from within the state to effect these changes. With Medicare's participation in the CPC initiative, the Department of Health and Human Services (HHS) has also contributed. Through this proposal the State is engaging HHS for additional support, and over time as success is demonstrated, more complete participation to optimize success in this transformation effort.