A) Description of Payer

Payer Name	Arkansas Medicaid
Corporate Address	Donaghey Plaza, P.O. Box 1437
Corporate City	Little Rock
Corporate State	AR
Corporate Zip	72203
Point of Contact(POC) First Name	Sheena
Point of Contact(POC) Last Name	Olson
POC Title	Assistant Director for Medical Services
POC Address	Donaghey Plaza, P.O. Box 1437
POC City	Little Rock
POC State	AR
POC Zip	72203
POC Phone	(501) 683-5287
POC E-Mail	sheena.olson@arkansas.gov
POC Fax	(501) 682-1197

B) Proposed Market

B1 Please define the geographic service area for this proposal by selecting your state and adding MSA/county/zip code descriptors to the list below. A complete list of MSAs may be found at http://www.census.gov/geo/www/maps/msa_maps2009/us_wall_1209.html Additionally, the U.S. Census Bureau has made available a map of the United States displaying all metropolitan and micropolitan statistical areas. You may find this map to be a helpful resource. This map can be found on the left hand side of the following website: http://www.census.gov/geo/www/maps/msa_maps2009/us_wall_1209.html

Type	State	County/Code	MSA/Code	Zip Code	Last Modified
Entire State	AR				Mon Jan 16 17:57:45 GMT 2012

B2 Within this service area, how many primary care practices and primary care practitioners (e.g. physicians, nurses practitioners, etc) are in your network?

Statewide, Arkansas Medicaid has approximately 1560 primary care practitioners (not including physician assistants and advanced practice nurses) within the network. These providers are spread throughout a network of approximately 880 practices. These numbers include pediatricians and pediatric practices. Approximately, 220 of the above referenced practitioners have identified themselves as having the primary specialty of pediatrics.

B3 Please provide the number of members under each line of business, in the geographic service area you proposed in question B1. For each line of business, will you have the operational capability and legal authority by the Summer of 2012 to pay a non-visit-based payment that is not tied to fee-for-service billing (e.g., a monthly care management fee)? For lines of business which are not included in your proposal, please select "N/A" in the drop down menu.

Question	Number	
Commercial insurance plan	0.0	N/A
Medicare Advantage Plan	0.0	N/A
Medicaid managed care	0.0	N/A
Medicaid fee-for-service	330000.0	Yes
CHIP	70000.0	Yes
State or federal high-risk pool	0.0	N/A
TPA/ASO	0.0	N/A
Direct purchaser/business	0.0	N/A

B4 (Optional) If applicable, please describe your reasoning for not wanting to collaborate with the Innovation Center in existing line(s) of business not included in your answer to question B3.

Not Applicable.

C) Primary Care Support

C1 Please explain why you want to be part of the Comprehensive Primary Care Initiative. For states applying for their Medicaid fee-for-service beneficiaries, please describe how participating in this initiative would impact existing primary care services.

Participation in the CPCI will allow Arkansas to partner with CMS to build much-needed primary care infrastructure that supports ongoing health transformation initiatives in the state. The CPCI will catalyze existing state initiatives focusing on outcomes-based payment and reporting; health care workforce development; and health information technology adoption by providing a continued strong coalition of support for change. We appreciate that partnership with other payers is required to shape change, and the CPCI provides us an opportunity to align with private and public payers incentives for primary care practices to better coordinate care for their patients, thereby offering an enhanced opportunity for success.

The Arkansas Payment Improvement Initiative (APII) will shift the state's payment system from one that rewards volume to one that rewards desired outcomes, particularly with respect to quality and affordability. The APII reflects two complementary care delivery strategies: (1) Population-based care delivery through medical homes, health homes, and other care delivery models that bear responsibility for the complete needs of a population; and (2) Episode-based care delivery with coordinated, team-based management of services provided to a patient frequently spanning multiple encounters with the delivery system, such as hip replacement or pregnancy and delivery.

The APII has a multi-payer approach and is supported and led by Arkansas Medicaid and private insurers in the state. The state anticipates that payment structures will include complementary approaches for wellness and chronic care, acute/post-acute care, and supportive care. These approaches are designed to reflect differences in patient needs by type of care, and in the performance risks to be borne by providers. The payment models in these approaches span care coordination fees, bonus payments for quality / utilization, and shared savings / risk, and will dovetail nicely with CPCI incentive strategies.

Our CPCI participation will also support the current work of the Arkansas Health Workforce Initiative in meeting the challenges of current and future demand for health care, and the expectations of patients and families. More specifically, the CPCI will assist in the implementation of and transition to Patient-Centered Medical Homes (PCMH), team-based care, and care coordination; enhanced and increased use of HIT; and the adoption of new reimbursement methods.

As an integral part of the statewide health system efforts, the Office of Health Information Technology (OHIT) is planning and implementing the statewide HIE, the State Health Alliance for Records Exchange (SHARE), and coordinating with all state HIT programs. With access to complete medical information, practices can provide high-quality care and coordinated treatment. Our partnership with CMS on the CPCI will enable primary care practices to build technology-based care coordination capacity and share resources across care sites.

The convergence of statewide efforts to prepare the workforce, improve the payment system, and implement and promote the use of health information exchanges (HIE) ensures activities are neither

duplicative nor incongruous. Incorporating the CPCI into these efforts will more quickly propel the state forward.

C2a Current support: Please describe any non-fee-for-service support you currently provide to primary care practices in the proposed market, such as (but not limited to) care management fees, quality related bonuses, or direct support such as embedded care managers.

Arkansas Medicaid administers an 1115 (a) demonstration waiver known as the Health Insurance Flexibility and Accountability (HIFA) initiative which emphasizes broad statewide coverage approaches that target populations with incomes at or below 200 percent of the Federal poverty level (FPL) and coordinate public title XIX and title XXI and private coverage. An additional purpose of the waiver is to coordinate and manage the State's Medicaid and CHIP beneficiaries through a Primary Care Case Management (PCCM) model. Arkansas's PCCM, ConnectCare, assigns beneficiaries to a single primary care physician who is responsible for the referral or management, or both, of a beneficiary's health care. This waiver allows the Medicaid program to make a per member per month payment to primary care physicians for those services. During state fiscal year 2011, over $14 million dollars were expended in case management fees to participating primary care physicians for the care of approximately 407,250 individuals.

C2a1 Non-visit-based payments to practices (e.g. care management fees paid to practices)

3.00

C2a2 In-kind support to practices (practice-wide resources available to all individuals served by the practice, provided at the point of care, and not segmented by payer; e.g. embedded care manager)

0.63

C2b (Optional) Please describe one specific instance in which your additional support for primary care transformation led to improvements in quality, outcome, and/or costs in primary care.

Arkansas Medicaid has focused on improving preventive care for its beneficiaries both those in ConnectCare and those outside of that program. The large majority of all children covered by Arkansas Medicaid and CHIP are also included in the ConnectCare program. With the goal of improving rates of well-child exams and preventive services to children, Arkansas Medicaid has initiated several outreach and education efforts directed to both the provider and beneficiary. These activities also included practice training regarding appropriate management of panels, proactive approaches to providing preventive services and use of the Arkansas Medicaid Information Interchange in which a provider can see claims history for certain preventive services for members of his or her panel. Additionally, Arkansas Medicaid supported a $1.5 million dollar pay for performance initiative in which physicians were compensated for measurable improvement in well-child exam ratios. The pay for performance initiative was not sustained due to budget constraints. However, these intensified efforts significantly increased Arkansas's HEDIS performance measure for the well-child metrics over the past 5 years.

C3a Proposed Support: Please describe the method by which you propose to build on the support method described in question C2, using the operational capacity and legal authority described in question B3. Please answer this question with a narrative (8000 characters max), a spreadsheet detailing the elements of your quantitative "support build up", and a summary of the dollar value of the support build up using the summary boxes below. For states applying for their Medicaid fee-for-service beneficiaries, please indicate how you would augment existing PCCM payments or any other payments to primary care practices.

The transformation model proposed by Arkansas Medicaid is based on observations from regional and national efforts to enhance primary care. Our study has led us to design our model around 6 elements of care that have been required for success elsewhere. The 6 elements are:

1. **Available patient data**: Ensuring that providers have ready access to patients' clinical diagnoses as well as information regarding functional status and family or other support structures, to support effective management across the population. Robust health information exchange will lead to integration across electronic health records (EHRs) and creation of specific patient registries.

2. **Disease severity:** Understanding patients' level of need, health risks and severity to enable risk stratified care.

3. **Patient specific care planning:** Developing integrated, pro-active care plans that vary according to risk and need with patient needs and preferences helping guide the shared decision-making process.

4. **Evidence informed practice:** Developing protocols for team members and employing practice patterns for the system that are informed by evidence based medicine.

5. **Team-based care delivery:** Caring for patients in an effective and coordinated manner through multi-disciplinary teams that extend beyond the walls of the physician's office, which may include primary care providers, care coordinators, support services providers, pharmacists, social workers, and others.

6. **Accountable care**: Giving providers practice-specific metrics with public transparency, enabling them to a) understand the cost, quality, health outcomes of care for their patients and b) drive continuous performance improvement and innovation.

To better align provider incentives to support the 6 elements, we are considering enhancements to PCCM payments, including the four complementary payment streams outlined below. These approaches are designed to provide a mix of up-front support for primary care providers to build the capabilities required to further enhance quality of care and back-end payments to ensure delivery of high-quality, cost-efficient care. Payments will be applicable to all providers participating in Arkansas Medicaid's current PCCM Program and to the Medicaid beneficiaries that are currently enrolled with a PCCM.

Selectively enhanced/expanded FFS payments: We expect that we will enhance specific fee-for-service payments for care that is usually high-value and potentially under-delivered today. An example of this type of care is telehealth. Arkansas Medicaid has pioneered development, implementation and payment for telehealth and teleconsultation for high-risk OB-GYN as well as cardiology and is now aggressively pursuing a program for psychiatric services for rural primary care.

Care coordination fees: We anticipate enhancing current PCCM payments with flat, or non-risk adjusted, per beneficiary per month (PBPM) care coordination fees. Care coordination fees will be tied to practice transformation milestones (e.g., enhanced access) and high value care delivery improvements (e.g., care plans for high risk beneficiaries) that are aligned with the five functions that form the framework for comprehensive primary care. These care coordination fees will be paid to practices or to regional consortiums.

Quality related bonus payments: We intend to tie bonus payments to quality where there is sufficient scale. This will reward those providers who are effectively integrating the infrastructure developed via care coordination fees and embracing the functions of comprehensive primary care. The metrics selected for these bonus payments will aim to both measure the improvement and effectiveness of primary care practice patterns.

Shared savings related to cost of care: Initially, we may elect to reward providers based on performance across utilization metrics – a proxy for total cost of care – such as inpatient admissions, ER visits, generic dispensing rate. In select instances, we will move to reward providers with a share of savings against benchmark levels of risk-adjusted total cost of care, where providers have sufficient patient volume to make such payments statistically reliable. Over time this model may evolve into a sharing model with both upside and downside elements, in which providers can more fully benefit and assume responsibility for the value they create in the system.

To enable bonus payments and shared savings, in a highly fragmented Arkansas delivery system, we are developing a model that would rely on evaluating performance (e.g., total cost of care) for a group of providers within a geographic market. This pooled experience could come in the form of a community based consortium that shares savings and care coordination resources. Our goal to provide options for practices in a highly fragmented system is bolstered by the multi-payor approach (described in other sections) and aligned with the CPCI's aim to strengthen free-standing primary care capacity.

In addition to these payment streams, we will promote different operating models for care coordination that providers may adopt to best match the local needs of our various markets. Examples may include:

Provider-based care coordination: Where a practice or clinical site has sufficient scale, they may employ their own care coordinators with enabling infrastructure.

Community-based care coordination: In cases where a practice or clinical site lacks the scale to support their own care coordinators and infrastructure, participating payors will work with local providers to establish community-based care coordinators.

Payors will also actively collaborate to define additional care coordination and care delivery support mechanisms such as clinical decision support tools to enable the use of evidenced based medicine and point of care information to facilitate clinical decision making.

C3a1 Non-visit-based payments to practices (e.g. care management fees paid to practices)

4.00

C3a2 In-Kind Support (practice-wide resources available to all individuals served by the practice, provided at the point of care, and not segmented by payer; e.g. embedded care manager)

0.00

C4 How does your support build-up align with each of the enhanced primary care functions upon which this initiative is based? (Risk-based management; Access and continuity; Planned care for chronic conditions and preventive care; Patient and family engagement; Coordination of care across the medical neighborhood)

The payment streams, care coordination efforts and performance management plans (e.g., tracking and monitoring practice transformation) come together to both incent and enable primary care providers to develop the enhanced primary care functions.

Risk-based management: Bonus payments and shared savings align providers with severity-appropriate care management as both create the incentive to increase the level of intensity of care on the most complex patients. Complex beneficiaries, often those beneficiaries with mental illness, developmental disabilities and/or multiple chronic conditions, account for a significant portion of total utilization of inpatient and ER services. Primary care practices that focus additional efforts on the highest risk patients are most likely to see improvement in metrics and total cost of care. Similarly, an appropriately lighter touch approach for less complex beneficiaries is incented through the use of quality metrics that promote preventative care, for example.

In addition to incentives our goal is to enable risk-stratified care management through infrastructure / support mechanisms. First, we aim to provide reporting that uses claims-based data as a starting point for the primary care team to segment their patient panel. We expect that stratification of patients must in large part be conducted using clinical data and clinical judgment (e.g., rankings) and accordingly we would not expect to manage practices to a pre-specified list of "complex beneficiaries." Second, although the care coordination operating model may vary as described above, we aim to provide clear guidance on high-value roles and responsibilities of these care coordinators. We will recommend that the majority of the care coordinator's time be spent with the most complex patients and that specific protocols be in place to optimize care. For example, we may suggest that the care coordinator ensure an immediate appointment (e.g., within one week) for all high-risk beneficiaries discharged from an inpatient admission and that this visit include medication reconciliation.

Access and continuity: Arkansas Medicaid expects to apply the primary care payment increase to primary care services delivered by a range of provider types and care delivery mechanisms (in line with the selectively expanded FFS payments). Payments for telehealth, which enhances access to distant

providers, are an example of an innovative care delivery mechanism that increases access to care and may be funded through expanded FFS payments. Similarly, Arkansas Medicaid is moving towards team-based primary care to increase access within an office. The goal is to pay for services from the full range of primary care providers, including nurse practitioners and physician assistants, to better meet the needs of Medicaid beneficiaries.

In May of 2011, Arkansas Medicaid contracted for a survey to assess access to care, focusing on how well physicians enrolled in the PCCM program were adhering to after-hours access requirements. The results were distributed to all Medicaid PCPs with the intention of alerting Arkansas physicians to the importance of 24/7 patient live access to a provider. Arkansas Medicaid will continue to support access through such efforts and is currently working with commercial payors to jointly promote and support greater 24/7 access to clinical services. These efforts may include new methods to provide after-hours availability, such as group after-hours services that are nurse-centered and use commercially available algorithm based triage services.

Planned care for chronic conditions and preventative care: The intent of selectively enhanced/expanded FFS payments is to identify and incent high-value services such as planned care for chronic conditions. For example, chronic disease group visits and periodic, comprehensive assessments of patients' complex and co-morbid disease states are potentially high-value services which could be further utilized by primary are practitioners. Bonus payments and shared savings also provide incentives to ensure pro-active care for both complex beneficiaries with multiple diseases and less complex patients requiring preventative care. These are supported by the associated quality reports and practice transformation tools / criteria.

Similar to the guidance for risk stratified care management, we intend to provide a tool or set of tools for care planning. The goal of these care planning tools is to create consistency in the type and level of plan for patients (at similar levels of complexity). Care plans will include a range of medical, social, and behavioral elements that can be utilized by both the patient and the care team. Aligned with care planning, the primary care team (e.g. care coordinator) may act as a "navigator" to ensure complex patients effectively manage the health care system and meet goals of the care plan.

Patient and family engagement: The care coordination fees, bonus payments, shared savings, and transformation milestones all promote patient and family engagement as improved patient awareness, understanding and ownership of their health / healthcare will lead to improvements in experience, quality and cost. As the program evolves, Arkansas Medicaid envisions an increase in the sophistication of patient and family engagement; however several ongoing efforts, many of which have been in place for several years, immediately support this function of comprehensive primary care. These efforts include a statewide website accessible to providers with a variety of patient engagement tools, ranging from disease specific education materials to broad prevention related awareness documents. In addition, in-office patient awareness / education materials are available and currently utilized across Arkansas. Arkansas Medicaid also envisions shared decision-making as a critical component of patient and family engagement. A recent quality improvement effort that led to a new informed consent program for atypical antipsychotics for children (<18 year) is an example of the movement towards shared decision-making.

Coordination of care across the medical neighborhood: Care coordination fees will directly support the enhanced coordination of care and will be tied to practice transformation milestones (e.g., enhanced access) and high value care delivery improvements (e.g., care plans for complex beneficiaries). Furthermore, as providers are guided by bonus payments and shared savings they will be incented to develop and coordinate care across their medical neighborhood. Efficient use of consultants and medical resources will help decrease avoidable utilization (e.g., ER visits, inpatient admissions, diagnostics) while strong relationships will ensure coordination and communication between providers.

Additionally Arkansas Medicaid will enable coordination across providers by promoting efforts such as the State Health Alliance for Records Exchange (SHARE). The Office of Health Information Technology is developing statewide policy, governance, technical infrastructure, and business practices to support SHARE, which will allow secure electronic exchange of medical information among participating providers. SHARE also will allow Arkansans to readily access information to manage their personal health.

C5 How will your proposed support strategy be fully integrated at the practice level and delivered at the point of care so as to support practice transformation?

Practice-level integration of the support strategy is best explained by the patient experience. In the patient-centered health care system, a patient will be served by a medical home, which will offer the patient a local point of access to care and proactively look after the patient's health. The patient will visit this local provider for preventive services, receive education on wellness, and have access to the provider with extended hours of operation and electronic communication. For patients with chronic conditions, the medical home will assist with monitoring the condition and coordinating care among the patient's provider team. This home will serve not as a gatekeeper for medical care, but rather as a hub from which the patient may connect with the full constellation of providers who together form the patient's health services team.

Using electronic health records, the primary care team will identify patients in need of preventive screenings. Patients will have the option to choose among several appointment times. The practice will set aside allotted time periods—entire days, if necessary—for scheduling preventive screenings, and the time periods will include hours outside regular business hours.

If a patient develops an acute condition, the medical home will assist the patient with a referral to a provider or provider team who will manage care for the condition, with the team evaluated on its performance over the entire episode of care. Improved performance transparency will help the patient to be informed about the choice of providers, and the patient will be able to consult with the medical home in navigating the choice.

After the acute care episode, the provider team managing the acute condition will transition care for the patient back to the medical home and ensure that the home is effectively prepared to manage the patient's post-acute care. The patient will also able to play an active role in managing his or her own care, with full access to a personal health record and enhanced communication with his or her provider teams.

The patient journey described above is enabled by Arkansas Medicaid's integrated plan to transform primary care in Arkansas. Components of the integrated plan are discussed throughout the sections in this document and include the following:

Six elements of care: We will be supporting 6 key elements observed in successful initiatives elsewhere: available patient data, disease severity, patient-specific care planning, evidence informed practice, team-based care delivery, and accountable care.

Enhanced payment: Arkansas Medicaid is considering four streams of payment to align incentives across health care stakeholders and to ensure execution on the 6 elements of care. Payment streams include a) selectively enhanced/expanded FFS payments to incent the use of high-value services such as telehealth, b) care coordination fees to enable primary care practices to build infrastructure required to improve care, c) quality-related bonus payments which incent improved quality, and d) shared savings which enables providers to share in the value they create for the system.

Quality: Providers must meet and maintain quality standards to participate and maintain status as a participant in good standing. Similarly, practices must make progress against practice transformation criteria to remain in the program or must create a corrective action plan and demonstrate significant progress against that plan at short intervals.

Workforce and IT Initiative: Complementary statewide initiatives are underway to provide the required workforce support and healthcare IT tools and information exchange.

C6 How do you intend to work with providers to enhance primary care services?

Our aim is to collaborate with providers in a coordinated, multi-payor manner to enable providers to build on the strength of the community – whether that means primary care providers, ancillary providers, community resources, or families and support services – to improve the quality of care. Our approach considers three different levels of engagement: practice-specific, community-specific, and Arkansas-wide. The three levels enable a practice-tailored approach where possible while ensuring a scalable, consistent effort across a community or the state, to reduce the administrative and coordination burden among providers and between payors and providers.

Practice-level engagement: Where a practice has sufficient scale, they may employ their own health care team (e.g., including a care coordinator) and enabling infrastructure. This care team will tailor its work to the local practice environment. In these practices, we will conduct site visits / outreach and academic detailing to understand the successes and challenges of practice transformation, and accordingly we will act as a conduit of effective approaches across practices. Similarly, we will provide practice-specific reporting including quality, utilization and cost data as well as care management tools that enable a starting point for risk stratified care management.

Community-level engagement: In cases where providers lack the scale to support their own care team (e.g., care coordinator) and infrastructure, we will work to establish community-based care coordinators

with infrastructure that may be licensed by participating providers or underwritten directly by participating payors. This community-based care coordination model with its concept of shared resources is an example of our approach to community-level engagement.

In the community-based model, the shared infrastructure may comprise a multi-disciplinary team that is part of a community consortium that can provide guidance and support to practices and their patients that may otherwise not have access to nurses, pharmacists and nutritionists, for example. We expect to support a robust network of telecommunications, including seminars, collaborative sessions and conferences. Arkansas Medicaid currently has and is using teleconference capabilities. We envision that periodic use of these media will serve as an enabler to bring together primary care providers and staff within and across communities. The goal is to a) enhance the relationships between local but geographically distant providers, b) provide a forum for acknowledging achievements, c) facilitate sharing of best practices and group problem solving of challenges, d) increase peer or social obligation to improve care.

Arkansas-wide primary care level engagement: At a state-wide level, improved health information technology infrastructure will give providers and payors the integrated data systems they need to effectively coordinate delivery of high-quality, efficient care. Arkansas Medicaid is part of an effort along with Medicare and private payors to develop an "All-Payor Claims Database Plus," supporting the design of provider patient panels, patient registries, quality measures, and positioning the state to meet any payor data collection requirements for the Health Benefits Exchange. Similarly, Arkansas Medicaid is in the process of redesigning and re-procuring enterprise-wide Medicaid Management Information Systems (MMIS) to provide the functionality required for this new era in health care (e.g., patient registries, quality measurement).

This is an example of the type of effort that we will undertake to engage providers across the state in a scalable, replicable manner. Overtime, we will consider an update to utilization management programs that will build off of the new payment streams and aligned incentives. The goal is to reduce the administrative burden across primary care practices while maintaining care quality.

C7 Describe your methodology for associating your members served by participating practices. CMS beneficiary alignment methodology is described in Section IIF of the solicitation. You have the option of using the same attribution methodology as CMS.

As previously described, our PCCM requires that beneficiaries are assigned to a primary care physician. We will continue to use this methodology.

C8a Describe any current shared savings program or other accountable payment arrangements with primary care practices (including pay-for-performance or bonus payments).

As previously described, Arkansas Medicaid supported a $1.5 million dollar pay for performance initiative in which physicians were compensated for measurable improvement in well-child exam ratios. The pay for performance initiative was not sustained due to budget constraints. However, the intensified effort to incentivize performance of a comprehensive well child exam not only imporved Arkansas's performance in the bonus year, but significantly increased Arkansas's HEDIS performance measure for the well-child metrics over the past 5 years.

C8b (Not applicable to states) Please describe your proposed shared savings arrangement if selected to be part of the Comprehensive Primary Care Initiative.

D) Data Sharing

D1 Please indicate your current strategy for sharing data with primary care practices in the proposed market, including the level of data shared (individual or aggregate) as well as the frequency of reporting.

Currently Arkansas Medicaid contracts with various Quality Improvement Organizations to provide quarterly profiles related to provider practices as compared with their peers such as generic prescribing and to assist providers in Medicaid related matters in order to improve the quality and effectiveness of the medical care received by Arkansas Medicaid beneficiaries. Additionally, providers may access the provider portal to view characteristics of their assigned Medicaid panel such as demographic information as well as last ER visit or certain preventive visits or procedures (i.e. well-child visits, women's health screenings).

Our QIO contracts assist and promote the Primary Care Case Management system by providing Primary Care Physicians enrolled in the Medicaid program with an effective means of communication concerning program requirements and operations, new initiatives, caseload management, the effective use of the provider portal, and any other DMS priorities or concerns. In addition, our QIOs provide technical assistance in matters concerning Medicaid providers including: Medicaid policy, implementation of best practices, and assistance or guidance with billing or enrollment and ePrescribing.

Finally, Arkansas Medicaid contracts to facilitate the assignment of beneficiaries to a primary care physician through a call center and website.

D2 Please describe your plan for enhanced data feedback to practices in the proposed market, including cost data, utilization data, and real-time hospital and ER data.

The data feedback plan is grounded in the multi-payor concept. We will provide practices with data showing a "pooled experience," *i.e.*, a common denominator and common numerator indicating performance on quality measures across all payers. Payor-participants are committed to working together in an operational phase of the Initiative to provide practices with a common report on quality measures that is representative of a practice's entire patient panel. Once again, payor methodology for scoring particular measures and then adjusting payments accordingly is individualized, although we are open to Medicare suggestions for common scoring in the operational phase. The intent of providing a "pooled experience" to practices is to reduce statistical issues associated with basing quality measures on small populations and to minimize administrative burdens. In fact, Arkansas Medicaid has experience with multi-payer data sharing/aggregation through the Regional Quality Initiative (RQI) in which Medicaid and commercial payors pooled HEDIS data for diabetes and preventive services.

In addition, Arkansas Medicaid will provide comprehensive, accessible, dynamic and real-time feedback to practices as described below.

Comprehensive: Our goal is to provide a comprehensive set of data enabling providers to understand the cost, quality and health outcomes of care for their patients. While some data will have implications for payment and participation in the program, additional data will be provided for information purposes only (e.g., to catalyze performance improvement efforts).

Quality data. Providers will receive a range of quality metrics including preventative maintenance, at-risk population process metrics, and outcome metrics (examples provided in E2a).

Utilization data. Utilization will include data that provides insight into the effectiveness of primary care practice patterns (e.g., ER visits, inpatient admissions) and the efficiency of downstream care (e.g., specialist referral information).

Cost data. Total cost data as well as cost breakdown by category may be provided for those providers with sufficient volume to make such information statistically reliable.

Real-time hospital and ER data to support clinical management and decision-making.

Accessible: Arkansas Medicaid recognizes that there is a wide diversity in practice technical capabilities. Accordingly, our approach provides multiple report delivery mechanisms and levels of interactivity that will evolve over time. For example:

Multi-payor web portal. The web portal will provide advanced search features that will allow providers to see a range of data cuts – from summary views to detailed "drill downs" based on specified criteria (e.g., condition, utilization metric).

XML (Extensible Markup Language)-based interface. Application Program Interfaces (APIs) may be provided to allow for dynamic machine-to-machine communication, and similar functionality to the web portal.

Actionable: We envision that all reports will be user-friendly and provide performance data for the practice and a comparison group – the type of data that can catalyze performance improvement efforts. The web-portal and XML-based delivery mechanisms provide another level of granularity, allowing providers to "drill down" to further understand the root causes for high or low performance.

Real-time: We recognize the tremendous benefit in providing real-time data to physicians (e.g., alerting the PCMH when a patient is hospitalized). We are working with providers to provide real-time information, and developing the systems to drive communication and usage of the information. For example, we are beginning to work with acute care providers to integrate our multi-payor portal into their patient intake and discharge process. Similarly, we are developing an event-based notification engine that will allow practices to subscribe to specific events for their patients.

D3 Please describe any involvement with local multi-purchaser databases or Health Information Exchanges.

The **Office of Health Information Technology** (OHIT) is planning and implementing the statewide HIE, the State Health Alliance for Records Exchange (SHARE), and coordinating with all state HIT programs. OHIT is developing statewide policy, governance, technical infrastructure, and business practices to support SHARE, which will allow secure electronic exchange of medical information among participating providers. With access to complete medical information providers can give high-quality care and coordinated treatment. SHARE will also allow Arkansans to readily access information to manage their personal health. OHIT has recently developed a financial feasibility and sustainability report and selected a vendor to build the SHARE infrastructure.

E) Implementation Milestones and Quality Improvement Measures

E1 Please list specific quality metrics that you are currently using in pay-for-performance programs or in other payment programs for primary care practices in any market.

Not Applicable.

E2a Please describe any alignment you have created with other payers in your region or state around quality measures.

The CPCI payer-participants have envisioned an alignment of quality metrics from the start of the application process. The Arkansas Center for Health Improvement (ACHI) assisted in creating a collaborative environment between the payers, and the payer-participants were able to achieve commonality among quality metrics to determine whether practices have improved processes and outcomes. The quality metrics are designed ultimately to gauge whether a practice is providing coordinated, comprehensive, patient-centered care.

The payer-participants have also designed quality metrics that dovetail with acute episode quality metrics expected to be put forth by the Arkansas Payment Improvement Initiative (APII), with which ACHI has been intimately involved as well. In fact, system-wide alignment of incentives will be achieved given that the process metrics chosen are also the focus of the APII, which work toward preventing acute episodes resulting from chronic disease. Additionally, we have designed the quality metrics and transformation milestones to better accommodate and effect more seamless transitions of care for patients who experience acute episodes.

Following a series of weekly meetings during the application process, the payer-participants reached a consensus on quality metrics in the following areas: process metrics for preventive maintenance and at-risk populations; outcome metrics; and patient/caregiver experience metrics. The metrics stated below are first-year metrics, and the payer-participants expect to add metrics during each year of the CPCI. We believe a stepped approach to quality metrics is important both to achieve provider buy-in at the outset and to obviate provider inertia through the CPCI.

Preventive maintenance process metrics are pneumonia vaccinations for older adults, breast cancer screenings, and colorectal screenings. At-risk population process metrics are measurement of hemoglobin A1c for diabetics, use of ACE inhibitors versus ARBs for patients with coronary artery disease, and beta blocker therapy for patients with heart failure. Outcome metrics are the number of inpatient stays per 1,000 patients and the number of emergency department visits per 1,000 patients. Common metrics associated with the patient/caregiver experience, which will be acquired via patient surveys, are: the ability to get timely appointments, care, and information; patient rating of the primary care provider; and provision of health promotion and education. Generic prescription use will be one common metric used to assess cost containment.

Importantly, the payer-participants stopped short of assigning point values to each metric. We believe that the development of the methodologies for assigning point values to certain metrics is better suited for an operational phase in which Medicare officials can have input. While we feel we have made significant headway in our collaborative efforts to reach common metrics, we are not bound to the metrics developed and are willing—as we have discussed elsewhere in the application—to work with Medicare to make our common metrics consistent with those chosen by Medicare.

The common metrics presented here provide a healthy platform for building a patient-centered medical home. Second, the metrics are designed to provoke practice change without being overly burdensome, so as to make CPCI participation attractive at the outset. Finally, the metrics are tailored to complement ongoing payment improvement initiatives in the state in order to achieve system-wide transformation.

E2b Please describe your willingness to align quality measures with CMS, particularly around practice transformation milestones.

To achieve wholesale change within the chosen practices in the Arkansas market, the payer-participants fully appreciate the need to align transformation milestones—in addition to quality metrics—with Medicare. Indeed, we have already achieved consensus among the CPCI payer-participants in the Arkansas market on a menu of transformation milestones detailed below and are willing to align those with any proposed by Medicare. We are further willing to align quality metrics and scoring mechanisms for emphasizing the importance of certain metrics to the extent that metrics proposed by Medicare are not limited to those that can be measured within the Medicare population.

Importantly, the payer-participants have achieved consensus on merely a menu of transformation milestones for two reasons. To the extent there are particular milestones that Medicare desires to incentivize first or operational scoring mechanisms that Medicare views as emphasizing certain milestones, the payer-participants wanted to remain flexible. Second, we sense that Arkansas's rural practices will need flexibility among milestones—as opposed to concretely set milestones—because of a perceived or real lack of infrastructure. Although the payer-participants believe that some flexibility for practices' choosing among milestones is needed, we will demand that practices reach a set number of milestones over each year of the CPCI to demonstrate progress and as a requirement for receiving shared savings.

We have derived the menu of milestones from the National Committee for Quality Assurance's 2011 Patient-Centered Medical Home standards. The six "must-pass" elements that we have adopted are: **(1)** providing team-based care with access and advice during and after hours and patient/family information about medical home; **(2)** acquiring and using data for care of the practice's population; **(3)** using evidence-based guidelines for preventive, acute and chronic care management for chronic, frequent and behavior-based conditions, including medication management; **(4)** supporting patient and family in self-care with information, tools and community resources; **(5)** track and coordinate tests, referrals and transitions of care; and **(6)** using performance and patient experience data for continuous quality improvement.

We believe that these milestones represent the necessary building blocks for creating patient-centered care in Arkansas. Moreover, they align with CMS Meaningful Use requirements. The payer-participants have also proposed that element **(1)** regarding team-based care include incentivizing practices to

document inclusion of mid-level practitioners, technicians and other support personnel into the team. This particular goal is a focus of Arkansas's workforce strategic plan and is necessary to build capacity in rural environments, where Arkansas experiences workforce shortages because of difficulty recruiting practitioners to those areas.

The milestones harmonize well with the Arkansas Payment Improvement Initiative because they emphasize coordination of care transitions and require documentation and tracking of care received outside of the medical home. Additionally, the milestones highlight the value of electronic exchange of patient information across care sites and engagement of patients in their own care. The attainment of these milestones is crucial as our state transitions to a 21st-century, patient-centered health care system that accepts accountability for the "Triple Aim."

E3 Please describe how you would propose to monitor that practices participating in the initiative are achieving the goals of practice transformation.

Arkansas Medicaid will include a self-reporting tool based on the elements listed below. The objective is to encourage improvement and provide milestones for practices to improve performance. For those providers who do not experience sufficient progress, self-reporting may provide an opportunity to develop a "corrective action plan."

Additionally, Arkansas Medicaid may conduct site visits to both understand the level of practice transformation and act as a conduit for best practice sharing and coaching for improvement. Site visits will be scheduled on a regular basis but practices may be randomly selected to minimize the burden on practices. Site visits may also be triggered by outlier performance on metrics or through self-reported need for closer partnership and coaching.

Arkansas Medicaid will utilize a menu of milestones / activities to monitor progress towards practice transformation. This menu includes a list of critical transformation activities as well as NCQA elements referenced below. Selected, non-overlapping activities will be scored and a minimum performance established.

Menu of critical transformation activities: expanded office hours beyond normal work hours at least two days per week (or weekend hours), 24/7 access to a live voice/electronic covering clinician, documentation of phone calls, regular review/maintenance of patient problem list, complete documentation of patient immunization status, documentation/maintenance of medical allergies, adoption of e-prescribing, documentation of lab and radiology testing, documentation of missed appointments, documentation of refills, documentation of referrals to specialists, regular patient survey of access/ communication/staff support, identified referral sources for social work consults, diabetic teaching, mental health services, school related issues, collaborative agreements to assure weekend and evening call for patient-related problem solving, identified resources for translation assistance, practice-wide training in team-based care, including an office policy manual on expectations for the entire team (inclusive of MD), successful qualification for an EHR incentive payment (or its equivalent depending on eligibility), submission of a written office protocol that demonstrates the systematic use of electronic medical records to assess and improve the effectiveness of preventive evaluation and chronic care management of the practice's patient population for 5 specific conditions, documented status of at least 50% of referrals/transitions involving the patient panel, including specialist consults, hospitalizations, ED visits and community agency referrals, maintain/revise an active, accurate medication list on each visit.

PCMH 1: Must have at least two of the elements.

The practice has a written process and defined standards, and demonstrates that it monitors performance against the standards for:

1. **Providing same-day appointments.**

2. **Providing timely clinical advice by telephone during office hours.**

3. **Providing timely clinical advice by secure electronic messages during office hours.**

4. **Documenting clinical advice in the medical record.**

PCMH 2: Must have at least two of the elements.

The practice uses patient information, clinical data and evidence-based guidelines to generate lists of patients and to proactively remind patients/families and clinicians of services needed for:

1. **At least three different preventive care services.**

2. **At least three different chronic care services.**

3. **Patients not recently seen by the practice.**

4. **Specific medications.**

Other NCQA elements include PCMH 3: Care Planning (e.g., pre-visit preparations, written plan of care); PCMH 4: Support patients/families in self-management (e.g.,provides self-management tools); PCMH 5: Referral coordination (e.g., tracking status of referrals); PCMH 6: Ongoing quality improvement processes (e.g., surveys to evaluate patient/family experiences).

E4 Please describe how you plan to evaluate the impact of your investment in supporting primary care transformation.

Arkansas Medicaid expects to evaluate the impact of our investment in supporting primary care transformation by tracking both quantitative and qualitative measures through the lens of the Triple Aim.

Improving the health of the population: To assess our impact on improving the health of the population, we will establish clear baseline performance and targets against the set of outcomes-based metrics that have been agreed upon across payors (as described in E2a). We will look to see progress toward these metrics across all participating providers.

Enhancing the patient experience of care, including quality, access, and reliability: We expect to measure activity-based metrics, such as use of HIT tools, in addition to potentially seeking direct patient feedback through surveys such as the Agency for Healthcare Research and Quality's (AHRQ) Consumer Assessment of Healthcare Providers and Systems (CAHPS). Ratings and qualitative feedback from surveys will provide insight into the level and impact of increased care coordination and effectiveness of patient-focused tools such as SHARE.

Reducing, or at least controlling, the cost of health care. Core to practice transformation is reducing or controlling the cost of health care. Measuring progress against this goal will require behavior change / improvement in practice patterns within a practice, with the ultimate goal of reducing the absolute cost of care. Practice behavior change can be assessed by developing a grading scale (e.g., does not meet, meets, exceeds) and measuring improvement against the elements described in question E3. Secondly, we will track practices' ability to impact and make progress toward targets tied to controlling or reducing total cost of care.

In addition, we intend to understand the impact of our initiatives on creating a sustainable market for free-standing primary care practices. Our intent is to utilize a mix of qualitative and quantitative measures, focused across three areas: 1) feedback from the provider community, 2) monitoring market dynamics and structural changes and 3) understanding of changes in utilization management as we shift toward outcomes-based payment.

To accomplish this, we will actively solicit feedback from provider groups to understand the impact of the tools and new payment programs. In the long run, we may also attempt to gather input from our Medical Schools with the ultimate goal of seeing increased enrollment in primary-care focused programs as an indicator of increasing excitement around the patient-centered approach. Understanding the impact on PCP income changes in practice revenues over time may also provide insight into the economic health of the market.

F) Involvement in Multi-payer/Multi-stakeholder Efforts

F1 Please describe any past or current involvement with multi-payer or multi-stakeholder collaborations in the proposed market. Please indicate the various functions of any collaboratives in which you are currently supporting (e.g. data exchange, technical assistance, learning and diffusion, etc.).

Arkansas Medicaid is currently collaborating with public and private payers, providers, patients and other stakeholders in a statewide initiative to transform the healthcare payment system. The Arkansas Payment Improvement Initiative (APII) aims to move away from fee-for-service to an episode-based, bundled payment approach. The APII's goal is to design payments that will incentivize care coordination, improve efficiency, eliminate low-value services, and dramatically improve the patient experience.

The collaborative transformation of the payment system has begun with design of a handful of acute medical and procedural episodes—*e.g.*, coronary heart failure, upper respiratory infection, ADHD—with a statewide rollout scheduled for mid-2012. The APII expects to implement more than 30 episodes by 2015. Workgroups inclusive of all stakeholders are charged with designing episodes that encourage shared decision-making and stewardship of care delivery.

Arkansas Medicaid has taken a leading role in the payment improvement initiative by providing financial support and key staff. The Director of the the Department of Human Services, the Medicaid Director and the Medicaid Medical Director all serve on the APII steering committee and have served as workgroup facilitators and have spoken to stakeholder groups and legislative committees regarding the initiative.

We are confident that the APII will harmonize well with the CPCI. While the APII will incentivize care coordination and quality outcomes *within* acute episodes, the CPCI will incentivize population-based, longitudinal coordination of preventive services and chronic disease management at a primary care level, which will reduce the number and extent of acute episodes.

We have also collaborated with public and private payers and other stakeholders in the development of the State Health Alliance for Records Exchange (SHARE), through which consumers and providers will have real-time access to health information in a secured environment. Our organization has participated since 2009 in the Governor's Health Information Technology (HIT) Executive Committee and HIT Taskforce. Via that process, the Committee and Taskforce developed an overall vision for health information exchange (HIE) in the state and, ultimately, Arkansas's Strategic and Operational Plans. The Governor has since appointed an HIT Coordinator and established an Office of Health Information Technology (Office of HIT) to coordinate HIT activities and develop and expand HIE capacity among Arkansas providers.

In addition to the APII, payers have further collaborated to standardize quality reporting using HEDIS® measures. This collaboration and data sharing was first experienced as part of the Regional Quality Initiative (RQI) in which Medicaid and other commercial payers pooled HEDIS data for diabetes and

preventive services. For the CPCI, we have focused on providing clear, concise summaries and detailed reports to providers, noting trends and opportunities so that practices can improve patient care and prevent catastrophic illness.

The Arkansas payers involved in the CPCI efforts have shown unprecedented cooperation in a coordinated effort to streamline quality metrics, data sharing, and infrastructure milestones in order to make CPCI participation more attractive to providers. Without such multi-payer collaboration, large-scale practice transformation to a medical home model would be virtually impossible, especially for small, rural practices.

F2 Please describe your vision for how multi-payer collaboration will transform primary care in the proposed market.

The CPCI payer-participants' vision is to maximize population-based care in order to meet the full range of needs across a diverse population, not only promoting higher quality of care, patient experience, and more efficient health care but also rewarding providers who achieve strong performance in population health. We believe there are six core characteristics of successful population-based care: **(1) Data-driven population management**, such that providers have at their fingertips patients' disease characteristics and severity, enabling the type and intensity of care to be tailored to each individual and to similar groups of patients; **(2) Enhanced access**, such that patients have the right 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; **(3) Evidenced-based care delivery**, such that providers make decisions on clinical care based on an in-depth, up-to-date understanding of evidenced- based care while constantly innovating new approaches to more effectively deliver care; **(4) Team-based communication**, such that multi-disciplinary teams that extend beyond the walls of the primary care provider's office to improve the preparation and delivery of care for complex patients; **(5) Coordination of care around a patient**, such that a nurse, social worker, or point of care technology, ensures care across all providers is offered to a patient in a timely and synchronized fashion; and **(6) Performance transparency**, such that providers understand cost, quality and outcomes of care for their patients–both for care they directly provide, as well as for care given by other providers.

While these characteristics of population-based care will emerge through different formats across Arkansas—Patient-Centered Medical Homes (PCMH), Accountable Care Organizations, and Health Homes—the common quality metrics and transformation milestones outlined in this application will focus solely on building infrastructure for the PCMH. We will provide in-kind tools such as patient registries and one of several care coordination methods--embedded care coordinators in provider offices (e.g., primary care providers), community-based shared coordination resources, and/or technology based care coordination—depending on the method of care coordination that best matches local needs. Our expectation is that providers will realize the value of these tools and, with technical assistance from our organization, build sufficient infrastructure during the CPCI process to provide these tools independently.

We aim to implement incentives that are aligned among the payer-participants as well as Medicare, so that providers do not operate under conflicting incentives or shoulder the complexity of different business rules and reporting requirements for the different patient populations for whom they care. Our multi-payer approach, which is also exhibited in the Arkansas Payment Improvement Initiative for acute

episodes, is also essential in that it creates sufficient “critical mass” to make incentives substantial enough to support changes in provider infrastructure, clinical decision-making, and operational processes, ultimately leading to improved health, enhanced patient experience, and lower costs.

G) Participation in Other Initiatives

G1 Please describe your participation in any other primary care models you are currently testing, or if you are participating in any other local, state, or national initiatives (e.g. medical home or primary care programs, transitional care programs, accountable care organizations, local community health teams, HIT meaningful use programs, chronic disease self-management).

Arkansas Medicaid is not currently testing any other exclusively primary care models. However, Arkansas Medicaid is actively supporting practices in their efforts to reach Meaningful Use requirements through the HIT Incentive Payment Program.

As well documented in this proposal, Arkansas Medicaid is involved in payment reform through the APII which will include the population based approaches described in this proposal. Additionally, Arkansas Medicaid is in the planning stage of its Health Home for Chronic Conditions program. We expect that the CPCI and Medical Home/Neighborhood proposal will work with the Health Home model but serve two separate and distinct purposes.