Arkansas SIM Initiative

Award
$42 million

Period of performance
October 1, 2013 – September 30, 2016

Pre-SIM Landscape

Arkansas Center for Health Improvement
Non-profit established in 1998 to conduct evidence-based policy analysis.

Health Information Exchange
State Health Alliance for Records Exchange developed in 2010 using federal funds.

Arkansas Health Care Payment Improvement Initiative
Established in 2011 and proposed a multipayer model that included EOCs.

CMS's Comprehensive Primary Care Initiative
State participation began in 2012 with the development of multipayer PCMHs.

Health Care Independence Act of 2013
Expanded Medicaid to childless adults with household incomes <138 percent FPL using a "private option."

Plans for Delivery System Reform
The State engaged stakeholders starting in 2012 to design and plan Medicaid Section 2703 health homes.

Strategies

Symbols represent strategies that build on efforts that pre-date SIM.

Establish EOCs
Arkansas established a multipayer, retrospective episode of care model with financial and quality metrics incorporating risk and gain sharing.

Expand PCMHs
Arkansas established a PCMH model for Medicaid, later adopted by commercial payers, that complements the CPC initiative by making PBPM payments available for a broader range of providers, including pediatricians, and offering an opportunity for shared savings.

Pursue health homes
Arkansas pursued Medicaid health homes or older adults and people with DD, SMI, and LTSS needs, but did not implement them due to provider resistance and shifting legislative focus.

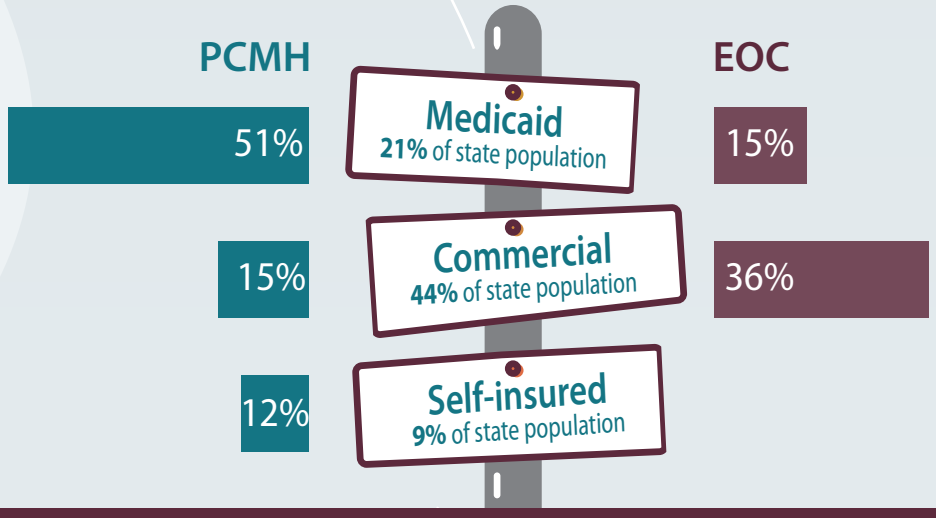
Enhance health IT and data infrastructure
The state leveraged the BCBS provider portal to deliver performance reports, developed a Medicaid claims tool for EOC and PCMH metrics, and required PCMHs to receive ED and inpatient utilization information from hospitals.

Emphasize LTSS reforms
LTSS providers signed memoranda of understanding with the state to commit to savings by enhancing care coordination, emphasizing HCBS, and using independent assessments to establish level of care.

Reach

as of September 2016

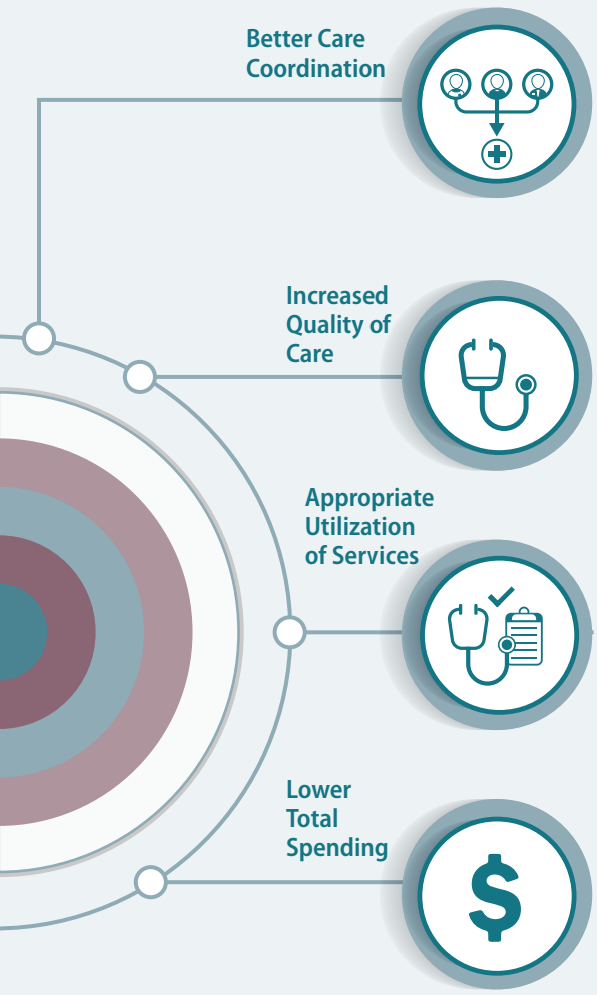
Arkansas' PCMH model reached 51% of the state's total Medicaid population, while 15% received care paid under the EOC model.



BCBS = Blue Cross and Blue Shield; DD = developmental disabilities; ED = emergency department; EOC = episode of care; HCBS = home- and community-based services; LTSS = long-term services and supports; PCMH = patient-centered medical home; PBPM = per beneficiary per month; SMI = serious mental illness

Impact on Medicaid Population

✓ = Performed better than the CG
✗ = Performed worse than the CG
● = No statistically significant change



Goals	PCMH	URI EOC	Perinatal EOC
Better Care Coordination	✓ Physician visits Consumers and providers reported improved access to same day appointments.	▲	▲
Increased Quality of Care	✓ Asthma control medication use ● ADHD medication and follow-up ● HbA1c testing	✓ Appropriate antibiotic use ✓ Strep test for pharyngitis	✓ HIV, chlamydia, strep B screening ● C-section rate
Appropriate Utilization of Services	✓ Inpatient admissions ● ED visits	✓ Antibiotic dispensing ✓ URI-related physician visits ✗ ED visits	✓ ED visits during pregnancy ✗ Inpatient visits during pregnancy ✗ Readmissions
Lower Total Spending	✓ Inpatient PBPM spending ✓ Total PBPM spending ● Other services PBPM spending	▲	▲

▲ Care coordination measures were not considered relevant to the objectives of these EOCs. Expenditures could not be analyzed relative to the CG.

Limitations

PCMH findings should be interpreted with caution because 1) they compare early adopter PCMH practices to late adopter practices, and there may be unobserved systematic differences between the two; and 2) we only observe the first year of PCMH implementation.

Both of the comparison states for the perinatal EOC had Strong Start funding and Arkansas did not, which may result in underestimation of findings.

Not all Medicaid-covered births (and associated perinatal care) are eligible for payment under the perinatal EOC, so results should not be generalized to the entire Medicaid population.

Lessons Learned

- ☑ The state found success investing in a physician outreach specialist early in the payment design process, to help them gain provider perspectives on key EOC and PCMH implementation challenges.
- ☑ Acute or procedure-based EOCs (such as URI and total joint replacement) with defined start and end dates were easier to implement than EOCs for conditions requiring ongoing care (such as ADHD or asthma).
- ☑ To mitigate the high cost of connecting to the state HIE, the state allowed providers to obtain information about patient hospitalizations and ED visits from local information sharing networks.

ADHD = attention-deficit/hyperactivity disorder; CG = comparison group; ED = emergency department; EOC = episode of care; HIE = health information exchange; PCMH = patient-centered medical home; PBPM = per beneficiary per month; URI = upper respiratory infection