Arkansas SIM Initiative

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.

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.

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.

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.

Strategies Symbols

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Strategies for Health Improvement

Stakeholders are directed to their respective states. Source: State Health Innovation Cooperative Agreement.

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PCMH

Medicaid 21% of state population
Commercial 44% of state population
Self-insured 9% of state population

EOC

Commercial 36%
Medicaid 15%
Self-insured 12%
## Impact on Medicaid Population

### Goals

<table>
<thead>
<tr>
<th>Better Care Coordination</th>
<th>Increased Quality of Care</th>
<th>Appropriate Utilization of Services</th>
<th>Lower Total Spending</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PCMH</strong></td>
<td><strong>URI EOC</strong></td>
<td><strong>Perinatal EOC</strong></td>
<td></td>
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<tr>
<td>Yes</td>
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</tbody>
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#### Physician visits
Consumers and providers reported improved access to same day appointments.

#### Asthma control
- Medication use
  - ADHD medication and follow-up
  - HbA1c testing

#### Appropriate antibiotic use
- Strep test for pharyngitis

#### Inpatient admissions
- ED visits

#### Inpatient PBPM spending
- Total PBPM spending
- Other services PBPM spending

#### ED visits during pregnancy
- Inpatient visits during pregnancy
- Readmissions

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.