

Arkansas Health Care Payment Improvement Initiative

3rd Annual Statewide Tracking Report May 2017

Participating Payers:



Prepared by:



A nonpartisan, independent health policy center that serves as a catalyst to improve the health of Arkansans

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Executive Summary

With over four years of progress, the statewide, multi-payer implementation of Arkansas's Health Care Payment Improvement Initiative (AHCPII) has positioned Arkansas as a national leader in value-based health care innovation. Since the first components were launched in the summer of 2012, AHCPII has supported and incentivized delivery of high-quality, efficient care for a large and increasing number of the state's citizens. As a key part of the state's total health system transformation effort, the AHCPII serves as a value-based payment framework that supports healthcare providers while achieving goals that include improving quality, expanding access, and avoiding unnecessary costs.

In January 2015, the U.S. Department of Health and Human Services (HHS) announced aggressive goals designed to shift the healthcare system away from a fee-for-service payment structure that has the potential to financially incentivize the volume of services delivered, rather than financially rewarding quality outcomes and efficiency. More specifically, HHS established a goal of having 50 percent of Medicare payments made through Alternative Payment Models (APMs), and 90 percent of Medicare fee-for-service payments tied to quality or value by 2018.¹ The AHCPII has positioned Arkansas providers to help achieve these goals. Furthermore, Arkansas's payer leaders have drawn on the state's experience to help inform national efforts by taking a lead role in groups such as the Health Care Payment and Learning Action Network^a.

AHCPII is now embedded across the state through deployment of two primary strategies: A multi-payer total cost of care (TCOC) patient-centered medical home (PCMH) program designed to improve quality and contain costs by supporting the delivery of better-coordinated, team-based care^b and a retrospective episodes of care model, designed to improve quality and reduce variation in treatment of acute conditions and delivery of specialty procedures. A third component, originally introduced in 2012 by the Arkansas Department of Human Services (DHS) is a health home model—a client-based support strategy for individuals with needs exceeding the traditional medical home model. The health home strategy proposes to optimize coordination of services for those individuals, including the frail elderly, the severe and persistently mentally ill, and the developmentally disabled. While this Medicaid-only component has been met with challenges from stakeholders, the state is currently weighing alternative options to improve delivery of high-quality and efficient care to these special needs populations and through their deliberations may choose to pursue major components of the health home model.

The AHCPII has the strength of multiple payer engagement with the participation of a majority of the state's health care payers including Arkansas Medicaid, Arkansas Blue Cross and Blue Shield (AR BCBS), QualChoice (QC), Centene / Ambetter, HealthSCOPE, and United Healthcare, along with Walmart, the State and Public School Employee Benefits program, and other self-funded employers.

Due in part to the state's multi-payer collaboration and coordination, Arkansas has been selected for multiple federally-supported programs designed to foster payment and delivery system innovation. In 2012, Arkansas was selected as one of seven regions to participate in CMS' Comprehensive Primary Care Initiative (CPC). In 2013, Arkansas was one of only six states awarded an initial State Innovation Model (SIM) Testing grant by the Centers for Medicare and Medicaid Services (CMS), receiving \$42 million in federal funds to implement the AHCPII. In 2015, Arkansas was one of only three CPC regions to achieve net savings as a state. Most recently the state was selected as one of 14 states to participate in the Comprehensive Primary Care Plus (CPC+) initiative, which extends Medicare participation in PCMH to approximately 182 primary care practices throughout the state.

Support for AHCPII includes a broader team of individuals at the Arkansas Department of Human Services, Hewlett-Packard, General Dynamics Health Solutions, Arkansas Foundation for Medical Care, and the Advanced Health Information Network, among others. The Arkansas Center for Health Improvement (ACHI) has worked with individual payers and providers to gather content for development of this report, designed to track progress and to help identify challenges and lessons learned.

^a <https://hcp-lan.org/>

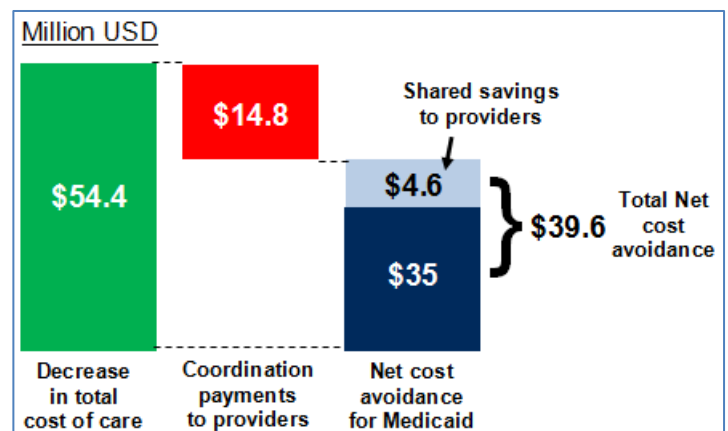
^b To view a comprehensive video about AHCPII, visit <http://www.achi.net/pages/OurWork/Project.aspx?ID=81>

Arkansas's Multi-Payer Total Cost of Care PCMH Program^c

While national and state level PCMH efforts have returned mixed results,² Arkansas's multi-payer total cost of care approach has experienced marked success. Unlike many other PCMH models, Arkansas's model places financial responsibility for the total experience of the attributed patients and their associated costs on PCMHs. With the exception of inpatient neonatal services for a newborn that the PCP has not yet seen, long-term services and support, and inpatient psychiatric for the severe and persistently mentally ill, the PCMH is responsible for all other clinical services delivered. Launched in 2014 and now entering its fourth year of voluntary and extensive provider participation, Arkansas's PCMH program has been recognized nationally as one of the most successful of its kind. This multi-payer, team-based primary care strategy has received legislative support and serves hundreds of thousands of citizens throughout the state. Participating clinics receive upside gain-sharing if they meet quality metrics and bring total costs under preset thresholds. Provider enrollment in the program is voluntary. The Medicaid PCMH results provided in this report are for beneficiaries that are managed by Arkansas Medicaid and do not include results for beneficiaries covered under a commercial qualified health plan (QHP). QHPs operating on the insurance marketplace and dual-specialized needs managed care plans are required to participate in the state PCMH program by either legislative or regulatory requirements. Results from private payer experiences are included for AR BCBS and the Arkansas State and Public School Employee (ASE / PSE) Plans. Additional private payer PCMH outcomes are anticipated to be available in future updates.

PCMH Program Highlights

- In 2015, for the second consecutive year, Medicaid realized direct cost-avoidance through trend reduction.
- Of the \$54.4 million decrease in total cost of care, \$14.8M went toward care coordination payments to providers. The remaining \$39.6M in net cost avoidance was shared between the state and those providers who met both quality and cost savings targets. Preliminary shared savings were issued in October 2016, with several clinics receiving over \$100,000. Final adjustments and payments to providers will be made in April 2017 after the full claims run-out period.



Cost Avoidance: Arkansas Medicaid 2015 Performance

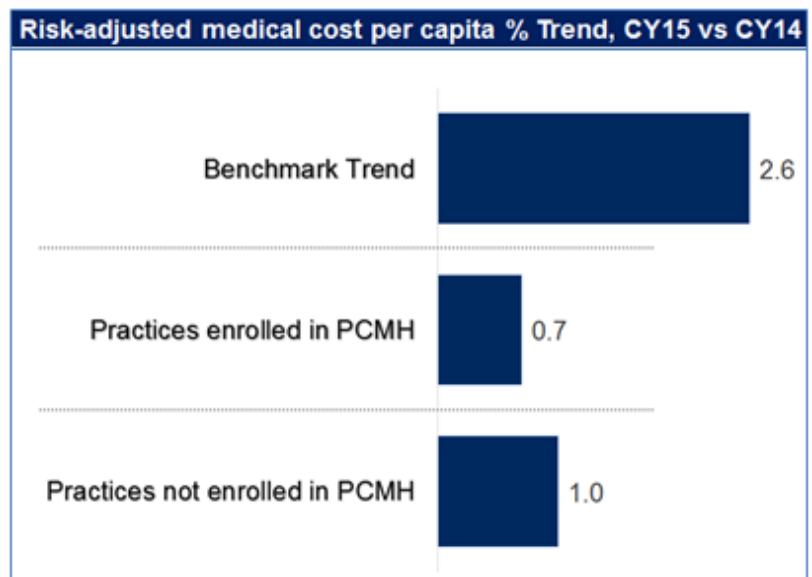
- Of the \$660.9 million predicted total cost of care, \$606.5M is the actual cost, and \$54.4M is the generated cost avoidance.

Of the \$54.4 million in generated cost avoidance:

- \$14.8M has been reinvested back into the provider community.
- \$4.6M is the shared savings incentive payment paid to 22 providers for CY '15 in Q1 '17.
- \$39.6M represents total net cost avoidance.

PCMH program cost trend comparison:

- PCMH practices in 2015 experienced cost 1.9% lower than the 2.6% benchmark trend.
- Non-PCMH practices experienced cost 1.6% lower than the benchmark trend.



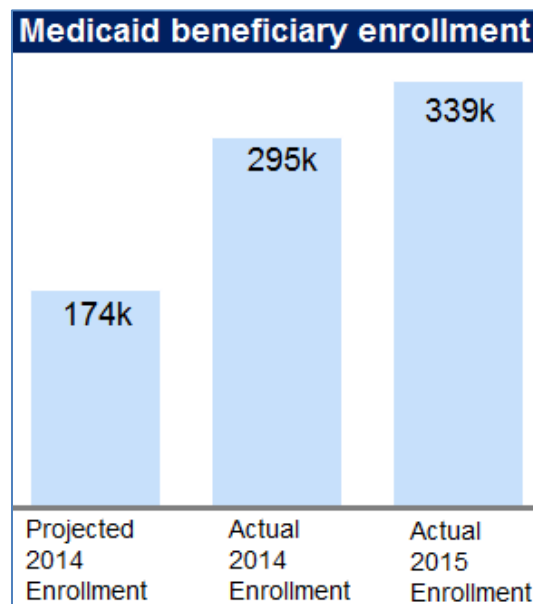
^c Medicaid PCMH data provided by Arkansas DHS, pulled from PCMH Q1 reporting as of April, 2017. Enrollment figures include practices that enrolled for 1/1/14, 7/1/14, 1/1/15, and 1/1/16 start dates. Commercial carrier data was provided by individual carriers.

Arkansas PCMH Program Enrollment for Medicaid and Private Payers

- In 2014, Arkansas Medicaid PCMH enrollment exceeded expectations. Building on 2014 momentum, for 2015 and 2016 Arkansas Medicaid and commercial carriers experienced increased enrollment by primary care providers (PCPs) and an increased number of beneficiaries served under the model.

Medicaid PCMH Enrollment

- From 2014 to 2016, PCP participation increased by 48.7%.
- In 2014, Medicaid enrollment included 295,000 (77%) eligible beneficiaries,^d 659 PCPs, and 123 practices.
- For 2015, Medicaid enrollment included 339,000 (82.5%) eligible beneficiaries, 769 PCPs, and 138 practices.
- For 2016, approximately 180 practices and 880 PCPs.^e
- For 2017, approximately 190 practices and 900 PCPs.^f



Enrollment for Commercial Carriers^g

- AR BCBS: For 2016, 250K beneficiaries (including fully and self-insured business), 158 practices, 678 PCPs
- QualChoice: 11K beneficiaries, 85 practices, 618 PCPs
- Centene / Ambetter: 16K beneficiaries, 237 practices, 606 PCPs
- United Healthcare: 2K beneficiaries, 59 practices, 295 PCPs

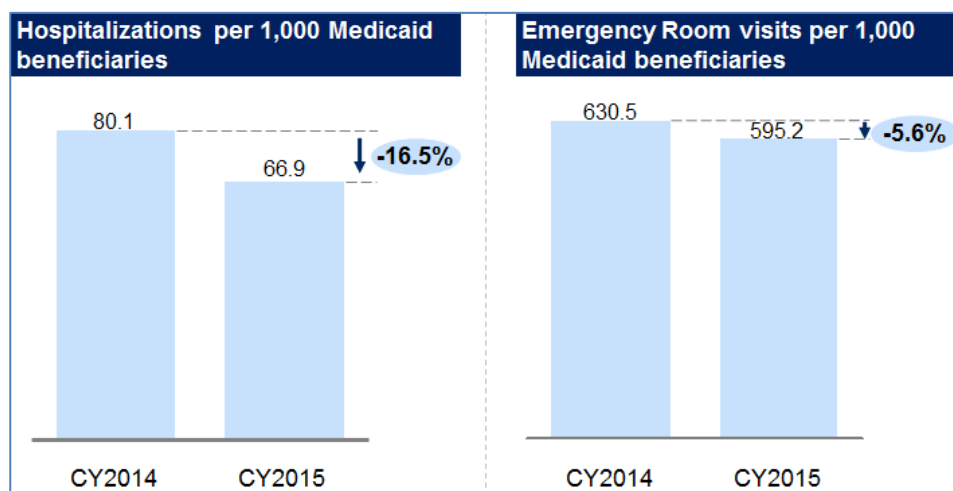
Enrollment for Self-Insured Payers:

Self-insured payers are also participating in the program, with an anticipated increase in 2017 and beyond. Two of the largest self-insured participants are Walmart and Arkansas State Employee and Public School Employee (ASEPSE) Plans, each with substantial numbers of employees served by a PCMH:

- Walmart: Approximately 20K beneficiaries
- Arkansas State Employees and Public School Employees: Approximately 30K beneficiaries
- Federal Employees Plan: Approximately 17K beneficiaries
- HealthSCOPE will attribute PCMH beneficiaries in 2017

Hospital Utilization Impact^h

- For the second consecutive year, Arkansas Medicaid experienced reduced rates of hospitalizations and emergency department visits, both of which are indicators of improved primary care quality and lower costs.
- Compared to 2014, 2015 hospitalization rates fell 16.5%, while emergency room visits decreased 5.6%.



^d Medicaid enrollment totals only include practices with at least 300 Medicaid beneficiaries, which is the minimum volume threshold for Medicaid program participation in 2014. Data provided by Arkansas Medicaid on September 30, 2016, and is from PCMH Q4 2014 and Q4 2015 reporting.

^e Provided by Arkansas DHS as of Q4 2016

^f Preliminary 2017 enrollment totals for Arkansas Medicaid provided by DHS in December 2016

^g Commercial carrier information provided by individual carriers as of May 2016

^h Medicaid Utilization data provided in October 2016, as of Q4 2016

Practice Improvements and Patient Experience

Arkansas's PCMH program requires practices to complete practice transformation activities and quality and utilization milestones, such as identifying the top 10 percent of high-priority patients, developing care plans, using electronic health records (EHR), and providing 24/7 live voice access to care, among other activities. Practices receive up-front care coordination payments to support these activities which are required by the three largest commercial carriers, three of the largest self-insured employers, and Medicare for CPC practices. While the vast majority of practices are in good standing and continue to achieve activity milestones, practices that fail to do so may be terminated from the program.

Clinics throughout the state have demonstrated progress towards PCMH activities and higher-quality, efficient care delivery. A series of PCMH case studies developed by the Arkansas Center for Health Improvement highlights PCMH success throughout the state.ⁱ Examples of anecdotal evidence and commentary from local providers regarding PCMH improvements include:

- **Improved care coordination:** Many PCMH practices have staff members who serve as care coordinators who work with high-priority beneficiaries to proactively assess needs.
- **Providing improved access:** PCMH clinics are required to provide 24/7 live voice access to care. This has enabled better doctor and patient communication, and it can potentially mitigate unnecessary emergency department utilization.
- **Enhanced team-based care:** PCMH practices have attested to improved team-oriented activities such as daily team huddles to better prepare staff for specific needs of patients scheduled for appointments on a given day.
- **Improved communication with hospitals, specialists, and integration with other providers:** PCMH providers have attested to an enhanced focus on communicating with other providers who may see their patients.

Patient Satisfaction and Experience of Care

One of the primary aims of the PCMH program is to improve patients' experience of care and their health outcomes. The Arkansas Division of Medical Services / Arkansas Medicaid contracted with the Arkansas Foundation for Medical Care to conduct a 2015 Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey.^j While the survey was not isolated only to PCMH practices, statewide results are indicative of overall improvements inclusive of PCMH impacts.

- Patient responses to the 2015 survey show improvements compared to survey results which were gathered prior to the 2014 implementation of the PCMH program.
- Adult consumers reported improvements in receiving good customer service (85% in 2015 vs. 63% in 2011) and in receiving coordinated care (82% in 2015 vs. 71% in 2011).
- For children, improvements were reported in doctors spending enough time with the patient (90% in 2015 vs. 85% in 2011) and in health promotion and education (67% in 2015 vs. 55% in 2011).

PCMH Quality Measure Outcomes

Arkansas Medicaid

Arkansas's PCMH program includes quality measures that are generally aligned across public and private payers. Because of programmatic timelines, quality measure outcomes are currently available for Arkansas Medicaid, AR BCBS, and Arkansas State and Public School Employee plans, or ARBenefits. Arkansas Medicaid quality measure outcomes include (see next page):

PCMH Quality metrics % change 2015 vs. 2014 for Arkansas Medicaid		
Diabetics on Statin Therapy		+7.5%
Breast Cancer Screening		+6.1%
Thyroid Screening		+1.1%
HbA1c test for Diabetics		+/-0%
Asthma Control	-1.1%	
ADHD Assessment	-2.8%	
Infant Wellness Visit	-4.3%	
Child Wellness Visit	-4.4%	
CHF Control	-6.1%	
Adolescent Wellness Visit	-10.9%	

ⁱ For detailed practice-level Arkansas PCMH case studies, please visit <http://www.achi.net/pages/OurWork/Project.aspx?ID=120>

^j For access to full Arkansas CAHPS reports and methodologies, please visit <http://humanservices.arkansas.gov/dms/Pages/agg-Patient-Satisfaction.aspx>

- In 2015 and 2016, the vast majority of practices met transformation milestones.^k
- In 2015, 40 percent of PCMH quality metric improved or maintained prior year levels including breast cancer screenings, thyroid medication management, diabetic statin therapy, and maintained hemoglobin A1c testing.
- In 2015, reductions in quality metrics for several indicators were observed warranting continued observation—ADHD assessments could have been reduced because of the associated episode driving more accurate diagnoses; child and adolescent well child visits warrant monitoring and may reflect access limitations in family practice clinics due to the concurrent expansion of adult coverage.

Private and Self-insured Payers

Quality measure outcomes for private and self-funded payers are currently available for AR BCBS and the Arkansas State and Public School Employee (ASE/PSE) Plan. Measures listed below include those tracked for 2015; additional quality measure outcomes for 2016^l are anticipated in future updates. The outcomes below represent the first performance year baseline outcomes for AR BCBS and ASE/PSE plans. ASE/PSE outcomes are included AR BCBS measure outcome totals.

PCMH Quality metrics: AR BCBS and Arkansas State and Public School Employee Plans 2015 outcomes			
Quality Measure	Measure Target	AR BCBS	ASE / PSE Plans
% of High Priority beneficiaries with updated care plans	At least 80%	54.3%	58.8%
% of High Priority beneficiaries seen at least 2 times in past 12 mos.	At least 75%	80.7%	83.0%
% of members w/ acute inpatient stay seen by provider within 10 days of discharge	At least 40%	41.8%	45.1%
% of ER visits deemed non-emergent by NYU ED algorithm	Less than or equal to 33%	22.1%	20.7%

- PCMH provider met the majority of quality metrics for AR BCBS and ASE/PSE Plans. Continued provider education and engagement will be aimed at improvement in the patient care plan measure.
- AR BCBS has recognized value and extended attribution of patients to all of its covered lives; AR BCBS has shifted payment to primary care to increase per-member-per-month (PMPM) payments.
- In 2017, the Medicare program will expand participation to approximately 182 total practices that have been selected for the Comprehensive Primary Care Plus (CPC+) program.
- New 2016 and 2017 performance target requirements explicitly link population health needs and clinical performance expectations.⁷

While provider participation in Arkansas's PCMH program is voluntary, private and self-insured payers have undertaken comprehensive efforts to attribute patients to primary care providers throughout the state to support broad diffusion of the PCMH program. AR BCBS and ASE/PSE plans have recognized the value and extended attribution of patients to all of their covered lives. Both payers have shifted payment to primary care to increased per-member per-month (PMPM) payments. These activities are part of the state's overall shift towards value-based alternative payment strategies and away from traditional FFS payments.

Retrospective Episodes of Care

This model to improve quality and efficiency and eliminate variation has achieved both quality enhancement and cost-saving goals. Arkansas's model has demonstrated success by incentivizing providers to manage all of the care within a designated timeframe for each type of episode. Other episodic programs that have recently adopted similar design characteristics have demonstrated positive outcomes.³ Since 2012 there have been 14 types of episodes launched within Arkansas's model, with new episode development focused primarily in the areas of surgical intervention and hospitalization management. While employers, consumers, and the state strive to optimize the value of their health care expenditures, Arkansas's episodes of care model puts the clinical leader in charge and aligns incentives to achieve the highest quality at the lowest cost.

^k Arkansas Medicaid PCMH measures and program details: <http://www.paymentinitiative.org/medicalHomes/Pages/Useful-Links.aspx>

^l AR BCBS 2016 PCMH program provider manual with detailed metrics:

http://www.arkansasbluecross.com/doclib/forms/providers/abcbs%20pcmh%20provider%20manual%202016%20v3_8.pdf

In an ongoing coordinated effort that includes close involvement with providers and other stakeholders, Arkansas Medicaid, AR BCBS, and QC all participate in the episodes model. Providers benefit from consistent incentives and reporting tools across payers. Together these payers cover a majority of Arkansas citizens, generating enough scale to promote change in practice patterns.

Current episodes outcomes include the most recently available payer data. Accurate episode reporting requires a mandatory claims run-out period and final adjudication which could take up to approximately one year. For this reason current episode results are typically based on the prior year's performance period.

Medicaid Quality Improvements and Cost Avoidance^m

- **Perinatal:** C-section rate reduced each year since 2012, from 39 percent in 2012 to 32 percent in 2015. Over the same period, average episode costs fell from \$3,508 in 2012 to \$3,413 in 2015.
- **URI:** 28 percent reduction in antibiotic prescriptions from 2012 relative to 2015; episode costs remained flat despite an increase in drug prices.
- **ADHD:** Average episode cost fell by 19 percent from 2013 to 2015.
- **Total Joint Replacement (TJR):** Average episode cost fell by 4 percent from 2014 to 2015.
- **Asthma:** Rate of physician follow-up increased by 15 percent from 2014 to 2016; the number of PAPs in the non-acceptable cost category dropped from 17 to 6 over the same period.
- **Chronic Obstructive Pulmonary Disease (COPD):** From 2014 to 2015, average episode cost fell 8 percent from \$1,355 to \$1,242; rate of follow-up physician visits increased by 87 percent.
- **Colonoscopy:** Average episode cost fell 9 percent from 2013 to 2015.
- **Tonsillectomy:** Use of surgical pathology lab tests fell by 47 percent from 2013 to 2015.

Arkansas Blue Cross and Blue Shield Episode Highlights

- **Tonsillectomy:** Average episode costs fell by 5 percent from 2014 to 2015.
- **Congestive Heart Failure:** Average length of stay fell by 17 percent, from 4.1 days in 2014 to 3.4 days in 2015; over the same period for the ASE/PSE population the length of stay fell by 40 percent from 5.5 days to 3.3 days.
- **Percutaneous Coronary Intervention (PCI):** Number of episodes fell by 19 percent, from 748 episodes in 2014 to 608 episodes in 2015.

Implementation of Episodes for Specialty, Surgical and Hospital Care

- Medicaid and AR BCBS are considering potential development of additional episodes including appendectomy, pediatric pneumonia, hysterectomy, and urinary tract infection (when an ER visit is involved).
- Experience from episode analysis is aiding in the creation of chronic disease profiles, which will be used by PCMHs in coordinating care for high risk patients as they pursue PMPM cost curve management.

System Infrastructure and Provider Reporting Development

The episode and PCMH models would not be possible without development of an advanced analytic infrastructure allowing participating payers to process large amounts of data. Since the inception of AHCPH, this analytic capability has been developed and refined. These efforts include a multi-payer online provider portal on a common platform, enabling secure distribution of quarterly reports to providers. These reports detail utilization and quality indicators to support better decision making and improved clinical outcomes. A large and increasing number of providers have accessed their reports:ⁿ

- For Medicaid, approximately 2 billion medical claims have been processed through the analytic engines for both episodes and PCMH. For episodes, those claims resulted in over 5.3 million episodes (before exclusions).
- As of April 2017 for Medicaid, for episodes, 41,120 reports were delivered to 2,584 distinct providers.

^m Data provided by Arkansas DHS/Medicaid in October 2016.

ⁿ Reporting totals provided by Arkansas DHS, October 2016

- Through October 2016 for Medicaid, for PCMHs, 3,271 individual-level PCMH reports and 2,139 are Shared Savings PCMH reports have been provided to practices.
- In an ongoing collaborative effort with Medicaid, aligned commercial payer provider reporting has been extensive.
- In 2017 Arkansas Medicaid launched Medical Neighborhood reporting for PCMH practices, whereby PCMHs receive performance data from hospitals and other providers in their regions. This data is designed to assist PCMHs in making efficient referrals and better understanding care patterns and is consistent with PCMH requirements in the Arkansas Works Act of 2016.

Sustaining Improvements and Continuing Evaluation

A large cadre of providers throughout the state are participating in the PCMH program which has demonstrated both quality improvements and system savings. Private payers have reported quality improvements and cost avoidance in episodes of care, and providers and patients are benefitting from practice support and improvements in quality of care. Infrastructure developments and reporting processes are in place to sustain our state's value-based payment models.

In 2017, the federal Medicare program will expand participation to approximately 182 total practices that have been selected for the Comprehensive Primary Care Plus (CPC+) Program. Prior to 2017, Medicare PCMH participation in Arkansas has been limited to the original 69 clinics in the Comprehensive Primary Care Initiative. The multi-payer PCMH team has aligned on new 2016 and 2017 performance target requirements explicitly link population health needs and clinical performance expectations.

While results are encouraging, early challenges have helped identify opportunities to improve the AHCPII. Efforts to track and evaluate AHCPII will continue in 2017 and beyond. The implementation of CPC+ represents the most recent phase in the states progression toward a value-based patient-centered delivery system. The episodes of care model will continue to be refined, while lessons learned from this component are already informing progress towards greater transparency, improved provider reporting, and more selective patient referrals. Due to the state's significant advancement toward value-based purchasing, Arkansas's provider community is more equipped to respond to similar efforts at the Federal level. Continued engagement and input from providers, patients, state leaders, and others is necessary to sustain progress of this successful initiative for the benefit of all Arkansans.

Introduction

In 2011, Arkansas, like other states, faced an increasingly fragmented health care system and escalating costs that threatened to exceed available revenue. With growing concern for the value of health care expenditures in both public and private sectors, the State of Arkansas, with its Surgeon General and through its Department of Human Services (DHS), convened its Medicaid program and the two largest commercial carriers—Arkansas Blue Cross and Blue Shield (AR BCBS) and QualChoice (QC)—to develop an initiative to transform the Arkansas health care payment system to a value-based purchasing model. From this convening, the collaborative effort known as the Arkansas Health Care Payment Improvement Initiative (AHCPII) was established. Arkansas Medicaid (Medicaid), AR BCBS, and QC have worked in concert with hundreds of physicians, hospital executives, patients, and advocates in designing, building, and implementing Arkansas’s new payment and delivery system. More recently, Centene/Ambetter (CAM), along with self-insured employers including Walmart, the State and Public School Employee Benefits Plan (ASE/PSE), and HealthSCOPE have joined and are participating in the initiative. The result is a bold statewide innovation tailored to the needs of Arkansas patients and providers that is gaining national recognition for its innovation and impact.

The AHCPII is designed to improve on the traditional fee-for-service (FFS) system by rewarding physicians, hospitals, and other providers that deliver high-quality care in an optimally efficient manner. Strategies to align financial incentives through structured provider payments across all payers result in consistent, large-scale support that enables providers to transform their practices and achieve desired outcomes. To view a comprehensive video about the AHCPII produced by the Arkansas Center for Health Improvement (ACHI), please visit <http://www.achi.net/pages/OurWork/Project.aspx?ID=81>.

The AHCPII incorporates two complementary strategies. First is the commitment to support a robust patient-centered medical home (PCMH) model. Through team-based preventive care and coordinated chronic disease management along with increased information and responsibility for the total experience of care, the PCMH is positioned to optimize appropriate patient utilization of services and guide referrals to the highest-value specialty providers. With design and implementation led by Medicaid, the expansion of the PCMH model throughout the state has exceeded enrollment expectations. In addition to Medicaid, Medicare, AR BCBS, QC, and Centene/Ambetter, HealthSCOPE joined the state’s PCMH efforts in 2017.

Improvements in Quality of Care

- For URI, a 27.7% reduction in use of unnecessary antibiotics from 2012 to 2015
- 7.5% increase in statin therapy for diabetic treatment
- 87.4% increase in physician follow-up for COPD patients
- Reduced inpatient length of stay for congestive heart failure patients
- 3% increase in breast cancer screenings

Complementing the PCMH model is the second major component—Arkansas’s retrospective episodes of care model for acute conditions that require care coordination and a more intensive use of resources. In an episode of care, a principal accountable provider (PAP) is identified to manage quality, minimize treatment variations, and control cost. Through identified opportunities to improve quality and reduce complications for the entire episode, established performance expectations enable the PAP to benefit from system efficiencies.

In addition to the episodes of care and PCMH models, a third component called health homes was introduced by Arkansas DHS in 2012. Through independent assessment, tiered provider payments, and accountability for quality targets, the health homes model was designed to provide additional support for some of the most vulnerable populations in the state. These include individuals with developmental disabilities, those who need long-term services and supports, and those with severe or persistent behavioral health needs including mental health and substance abuse disorders. These populations represent a major proportion of overall Medicaid expenditures in the state.

While implementation of the health homes model was delayed due to environmental challenges, the state is currently weighing alternative options to provide higher-quality and efficient care for these high-needs and higher-cost populations. Current alternative considerations include components of the originally developed health homes model as a viable option.

The state’s health care system has been impacted by the AHCPII in several ways. Enrollment in the state’s PCMH model is widespread, having over half of all eligible primary care providers enrolled, with the vast majority successfully completing practice transformation activities. Approximately 82 percent of eligible beneficiaries are now receiving care

under the state's program, far exceeding the initial year-one goal of 40 percent. In 2015, commercial carriers including AR BCBS, QC, and CAM have supported the model with an increasing number of beneficiaries now attributed to PCMH clinics.

The episodes of care model has generated meaningful impacts on quality and efficiency, and many providers have received enhanced payments for commendable performance or have been required to pay back a portion of the cost overage for not achieving acceptable performance. For example, AR BCBS results showed that quality of tonsillectomy procedures improved, and average costs for that episode fell by 5.2 percent in 2015.

Efforts to increase support for the AHCPII continue. Expansion of the PCMH model through commercial carriers operating as qualified health plans (QHPs) on the Health Insurance Marketplace was mandated through legislation implemented in 2015 and will continue through 2021. Self-insured interest continues to grow, with both public and private sector expansions anticipated. The most recent self-insured entity to join AHCPII is HealthSCOPE through participation in CPC+.

Cost and Utilization Avoidance

- \$54.4 million in cost avoidance from the PCMH program in the second program year (2015)
- Medicaid hospitalizations down 16.5% in 2015
- Medicaid ER visits reduced by 5.6% in 2015
- PCMH practices showed lower cost growth compared to the benchmark trend
- Medicaid tonsillectomy pathology lab use reduced by 47.5% from 2013 to 2015
- AR BCBS tonsillectomy episode costs were reduced by 5.2% from 2014 to 2015
- Medicaid heart failure episode average costs were reduced by 14.6% from 2014 to 2015

Prior to 2017, the largest challenge to full-scale implementation of the AHCPII had been the lack of expanded participation by Medicare which represents a significant portion of Arkansas's population and care usage in the state. In 2016 The Centers for Medicaid and Medicare Services (CMS) selected Arkansas as one of 14 states to participate in the Medicare-led CPC+ initiative, for which 182 practices throughout the state have been selected.^o Continued demonstration of successful progress will be used to solicit full federal participation. Continued success of the AHCPII relies on statewide participation, ongoing innovation, and research. Initial findings from the PCMH and episodes of care models have shown successes in the areas of improved practice patterns and more efficient treatment for patients.

Continued efforts to support practitioners with actionable information and to enable the more appropriate use of the highest quality providers will enhance system transformation. Through the avoidance of complications, re-hospitalizations, and unnecessary care, the goals of bending the cost curve will be supported. Updated information on the AHCPII progress can be found at www.paymentinitiative.org.

This AHCPII Statewide Tracking Report is the third annual report on the progress of the state's system transformation effort. Included as an appendix is a PCMH practice-level case study (Appendix A). Information contained in this report represents aggregate results provided by individual payers for descriptive purposes.

^o For more information on CPC+, please visit: <https://innovation.cms.gov/files/x/cpcplus-brief.pdf> or <https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus>

Arkansas's Patient-Centered Medical Home Program

Now heading into the fourth year of implementation, Arkansas's PCMH model is one of the largest of its kind in the U.S. The state's PCMH model is designed to support primary care providers with new tools and resources in an effort to deliver high-quality primary care that is patient-centered and team-based, with an emphasis on care coordination and proactive preventive care. Goals of the PCMH program are to help patients stay healthy, increase the quality of care they receive, and reduce costs. PCMH transformation has been underway in Arkansas since October 2012, with 69 practices initially selected to participate in the Comprehensive Primary Care (CPC) initiative—a multi-payer PCMH program sponsored by the Center for Medicare and Medicaid Innovation (CMMI).⁴ Building on successes and lessons learned from the CPC initiative, wave-two expansion of the state's Medicaid-led PCMH model began in January 2014. While the first wave of the state's program was predominately comprised of pediatric practices, subsequent enrollment periods and multi-payer participation have expanded the range of participation. With more providers delivering care under the PCMH model, Arkansas has made substantial progress towards the goal of having all of the state's citizens receiving comprehensive primary care under the PCMH model.

In this report, for the second program year, detailed information about system-wide cost and quality impacts of the PCMH model are available. After only one year of implementation, the state's model has demonstrated improvements in a range of quality indicators, while generating \$54.4 million in cost avoidance for the state, with shared savings distributed to eligible providers. At the same time, the Medicare-led CPC+ initiative is supporting many of the state's primary care providers in delivering high-quality and efficient care. While this report focuses on the state's own multi-payer PCMH model, recent CPC program outcomes are available and have been detailed in separate reports.⁵

PCMH Provider Spotlight: Harvey Pediatrics

"For many of our patients with complex or special needs, the program has better enabled us to organize and provide the care they need more efficiently and completely. Our vision is to have a one-stop shop to meet all of our patients' needs. The PCMH program aligns perfectly with that vision." Ashley Stone, Advanced Practice Nurse and Care Coordinator, Harvey Pediatrics in Bentonville, Arkansas

Practice Improvements Include:

- Automated care plans in the clinic's EHR
- 24/7 live voice access to care and improved patient communication

Participating PCMH practices receive up-front payments that enable them to more proactively meet patient needs and practice transformation milestones, which include providing extended office hours and 24/7 access to medical assistance. In addition to financial support for care coordination and practice transformation in the form of per-member, per-month (PMPM) payments, PCMHs can receive upside gain-sharing based on either performance improvements or high performance compared to statewide averages. Quality metrics must be met under both options.

Arkansas PCMH Enrollment Overview

- For 2017, **192 PCMHs are currently enrolled^p** in the state's Medicaid-led, multi-payer PCMH program.
- For 2017, approximately **919 primary care providers are participating**, representing approximately 90 percent of all eligible Medicaid providers.
- In 2016, approximately **330K Medicaid beneficiaries were covered**, representing approximately 80 percent of all eligible Medicaid beneficiaries.
- **In December 2016, 58 practices^q** completed the four-year Medicare-led CPC initiative.
- **182 practices^r** were selected for voluntary participation in the Comprehensive Primary Care Plus Initiative which begins in 2017.

^p Data provided by Arkansas DHS, as of January 2017. Includes practices that enrolled for 1/1/14, 7/1/14, 1/1/15, and 1/1/16, and 1/1/17 start dates.

^q Practices are enrolled individually in the CPC initiative and current enrollment numbers are tracked by the Centers for Medicaid and Medicare Services:

<http://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/Arkansas.html>

^r <https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus>

- Multi-payer participation in either the CPC initiative or the Arkansas PCMH program includes Medicaid, Medicare, AR BCBS, QC, United Healthcare, Centene/Ambetter (CAM), HealthSCOPE, Arkansas State and Public School Employee Benefits Plan (ASE/PSE), Federal Employee Plan, and Walmart.
- As of 2015, QHPs operating on the Health Insurance Marketplace are required to participate in PCMH as mandated through the state's Health Care Independence Act, known as the Private Option. This PCMH participation requirement for QHPs is now included as part of the Arkansas Works program.

Commercial Payer PCMH Enrollment

Beginning in 2015, AR BCBS, QC, and CAM offered financial support to practices enrolled in the state's PCMH program. United Healthcare joined in 2016, and beginning in 2017 HealthSCOPE is participating in the CPC+ program. During the fall of 2015, AR BCBS and CAM held open enrollment for practices to sign up for PCMH program support. In addition to offering support to those PCMHs enrolled through Arkansas Medicaid, both AR BCBS and CAM have extended their support to include those practices that are certified as PCMHs by the National Committee for Quality Assurance (NCQA). For 2016, QC and United Healthcare offered support to those PCMHs enrolled via Arkansas Medicaid. Dual-specialized needs managed care plans are also required by regulation to participate in the state PCMH program. While PCMH beneficiary attribution is an ongoing process for payers, current estimates for the number of attributed beneficiaries for each payer are:

- AR BCBS: For 2016, 250K beneficiaries (including fully and self-insured business), 158 practices, 678 PCPs
- QualChoice: For 2016, 11K beneficiaries, 85 practices, 618 PCPs
- Centene / Ambetter: For 2016, 16K beneficiaries, 237 practices, 606 PCPs
- United Healthcare: For 2016, 2K beneficiaries, 59 practices, 295 PCPs

Enrollment for Self-Insured Payers:

Self-insured payers are also participating in the program, with an anticipated increase in 2017 and beyond. Two of the largest self-insured participants are Walmart and Arkansas State Employee and Public School Employee (ASEPSE) Plans, each with substantial numbers of employees served under a PCMH:

- Walmart: ~20,000 beneficiaries
- Arkansas State Employees and Public School Employees: ~30,000 beneficiaries
- Federal Employees Plan: 17K beneficiaries
- HealthSCOPE will attribute PCMH beneficiaries in 2017

Primary Care Provider Attribution

In an effort to improve overall population health management and support the PCMH model, AR BCBS conducted a primary care provider attribution initiative for all beneficiaries in their fully-insured plans. In a process that spanned most of 2015, AR BCBS identified which beneficiaries had not selected a primary care provider. Those beneficiaries were subsequently assigned a primary care provider in their geographic proximity. These newly-attributed beneficiaries were then notified by AR BCBS of their assigned primary care provider. Beneficiaries are free to select a different primary care provider at any time. This process will allow AR BCBS to accurately track progress of population health management and quality metric outcomes across their enrolled PCMH practices. For Arkansas Medicaid, a primary care physician's attributed beneficiaries are determined by the ConnectCare Primary Care Case Management (PCCM) program. Details regarding Arkansas Medicaid attribution are available in the PCMH provider manual.⁵

Practice Transformation and Patient Experience

Arkansas's program requires practices to complete transformation milestones, such as identifying the top 10 percent of high-priority patients, developing care plans, using electronic health records (EHR), and providing 24/7 live voice access to care. Practices receive up-front care coordination payments to support these required activities. While the vast majority of practices are in good standing and continue to achieve activity milestones, practices that fail to do so may be terminated from the

⁵ <http://www.paymentinitiative.org/referenceMaterials/Documents/2016%20PCMH%20manual.pdf>

program. Clinics throughout the state have demonstrated progress towards PCMH activities and higher-quality, efficient care delivery. Table 1 displays PCMH practice transformation milestone attestation as determined by Arkansas DHS as of October 2016:

Table 1: Practice Transformation Milestone Attestation	2014 Number (%)	2015 Number (%)	2016 Number (%)
PCMH 3-Month Activities			
Identify top 10% of high-priority beneficiaries	113 (100%)	133 (100.0%)	179 (100%)
Report Clinical Quality Measure data for 2015: Diabetes, A1c poor control; controlling high blood pressure; and weight assessment for children adolescents (BMI) <i>(2016 Activity)</i>	N/A	N/A	145 (96%)
PCMH 6-Month Activities			141 PCMH eligible for 6 month activities
Assess operations of practice and opportunities to improve	107 (94.7%)	124 (100.0%)	135 (96%)
Develop and record strategies to implement care coordination and practice transformation	107 (94.7%)	124 (100.0%)	135 (96%)
Identify and reduce medical neighborhood barriers to coordinated care at the practice level	107 (94.7%)	124 (100.0%)	135 (96%)
Make available 24/7 access to care	107 (94.7%)	123 (99.2%)	135 (96%)
Track same-day appointment requests	107 (94.7%)	124 (100.0%)	135 (96%)
PCMH 12-Month Activities			
Childhood/adult vaccination strategy <i>(2016 Activity)</i>	N/A	N/A	Activity due on 12/31/16
Establish processes that result in contact with beneficiaries who have not received preventive care	107 (100.0%)	123 (100%)	Activity due on 12/31/16
Complete a short survey related to beneficiaries' ability to receive timely care, appointments, and information from specialists, including behavioral health (BH) specialists	107 (100.0%)	123 (100%)	Activity due on 12/31/16
Invest in HIT or tools that support practice transformation	107 (100.0%)	123 (100%)	Activity due on 12/31/16
Join the Arkansas State Health Alliance for Records Exchange (SHARE) and access inpatient discharge and transfer information	107 (100.0%)	123 (100%)	Activity due on 12/31/16
Incorporate e-prescribing into practice workflows <i>(2016 Activity)</i>	N/A	N/A	Activity due on 12/31/16
Integrate EHR into practice workflow <i>(2016 Activity)</i>	N/A	N/A	Activity due on 12/31/16
Care Plans for High Priority Beneficiaries <i>(2016 Activity)</i>	N/A	N/A	Activity due on 12/31/16
PCMH 13-Month Activities (2016 Activity)			
Report Clinical Quality Measure data for 2015: Diabetes, A1c poor control; controlling high blood pressure; and weight assessment for children adolescents (BMI)	N/A	N/A	Activity due on 1/31/17
PCMH 18-Month Activities			
Incorporate e-prescribing into practice workflows	107 (100%)	119 (98%)	N/A
PCMH 24-Month Activities			
Use Electronic Health Records (EHRs) for care coordination	107 (100%)	113 (93%)	N/A
Extract clinical data from EHRs; at a minimum, data must include collection of A1c levels and collection of blood pressure readings	N/A	110 (90%)	N/A

Practice-level Improvements

In completing required practice transformation activities, clinics have demonstrated improvement processes. A series of PCMH case studies developed by the Arkansas Center for Health Improvement highlights practice-level PCMH success in the state[†]. Examples of anecdotal evidence from local providers regarding PCMH improvements include:

- **Improved care coordination:** Many PCMH practices have staff members who serve as care coordinators who work with high-priority beneficiaries to proactively assess care needs. Care coordinators perform a range of duties such as assisting with patient and family communication regarding care plans and using clinic EHRs to track care needs.
- **Providing improved access:** PCMH clinics are required to provide 24/7 live voice access to care. This has enabled better doctor and patient communication and can potentially mitigate unnecessary emergency department utilization during at times such as late at night or on weekends when the PCMH clinic may be closed.
- **Enhanced team-based care:** PCMH practices have attested to improved team-oriented activities such as daily team huddles to better prepare staff for specific needs of patients scheduled for appointments on a given day.
- **Improved communication with hospitals, specialists, and integration with other providers:** PCMH providers have attested to an enhanced focus on communicating with other providers who may see their patients. PCMH clinics have also integrated other providers into their primary care clinics, such as pharmacists for better medication management and behavioral health therapists to better serve patients in areas with limited access to these treatments.



Dr. Randy Walker's PCMH clinic in De Queen, AR has improved care coordination by using EHRs to track screenings and other needs.

Patient Satisfaction and Experience of Care

One of the primary aims of the PCMH program is to improve patients' satisfaction, experience of care, and health outcomes. The Arkansas Division of Medical Services / Arkansas Medicaid contracted with the Arkansas Foundation for Medical Care to conduct a 2015 Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey.^u While the survey was not isolated only to PCMH practices, statewide results are indicative of overall improvements inclusive of PCMH impacts.

Patient responses to the 2015 survey show improvements compared to survey results which were gathered prior to the 2014 implementation of the PCMH program. Table 2 below provides a summary of selected improved CAHPS measures.

Table 2: CAHPS Survey Highlights for Arkansas Medicaid

Medicaid Beneficiary Satisfaction: Select CAHPS Survey Results 2015 vs. 2011		
<i>Adult Survey questions</i>	2015	2011
Getting needed care	80.7%	70.9%
Customer Service	85.4%	63.0%
Coordination of care	82.3%	71.4%
<i>Child Survey questions</i>	2015	2011
Getting needed care	88.1%	84.2%
Seeing a specialist	85.4%	81.8%
Getting care quickly	95.2%	90.5%
Health promotion & education	67.0%	55.4%

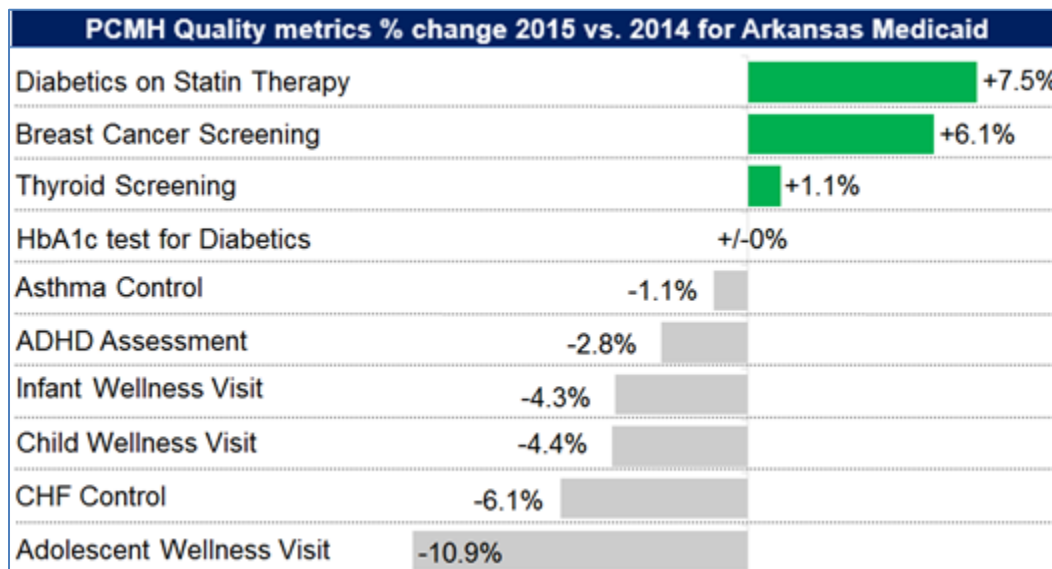
[†] For detailed practice-level Arkansas PCMH case studies please visit <http://www.achi.net/pages/OurWork/Project.aspx?ID=120>

^u CAHPS outcomes are displayed in this report. For access to reports and methodologies, please visit <http://humanservices.arkansas.gov/dms/Pages/agg-Patient-Satisfaction.aspx> or https://afmc.org/wp-content/uploads/2016/03/2015-AFMC-CAHPS-Exec-Summary_v1.4_062615.pdf

PCMH Quality Metric Outcomes for Medicaid

Figure 1 displays the percent change in PCMH quality metrics. For Medicaid, 40 percent of quality measures either improved or maintained prior-year levels,^v including breast cancer screenings, and thyroid medication management, diabetic statin therapy, and maintained hemoglobin A1c testing. After increasing from 2013 to 2014, there were slight reductions in child and adolescent wellness visits for 2015.

Figure 1: Arkansas Medicaid Quality Metrics



PCMH Quality Improvements for Private and Self-insured Payers

Table 3 displays quality measure outcomes for private and self-funded payers that are currently available for AR BCBS and the Arkansas State and Public School Employee Plan (ASE/PSE). Measures listed below include those tracked for 2015; additional quality measure outcomes for 2016^w are anticipated in future reports. Currently available outcomes include:

Table 3: Commercial and Self-funded Quality Metrics

PCMH Quality metrics: AR BCBS and Arkansas State and Public School Employee Plans 2015 outcomes			
Quality Measure	Measure Target	AR BCBS	ASE / PSE Only
% of High Priority beneficiaries with updated care plans	At least 80%	54.3%	58.8%
% of High Priority beneficiaries seen at least 2 times in past 12 mos.	At least 75%	80.7%	83.0%
% of members w/ acute inpatient stay seen by provider within 10 days of discharge	At least 40%	41.8%	45.1%
% of ER visits deemed non-emergent by NYU ED algorithm	Less than or equal to 33%	22.1%	20.7%

- PCMH provider met the majority of quality metrics for AR BCBS and ASE/PSE plans. Continued provider education and engagement will be aimed at improvement in the patient care plan measure.
- ASE/PSE Outcomes are included AR BCBS measure outcomes listed in Table 3 (above).

^v Information provided by Arkansas DHS in April 2016. Source: Q4'15 (CY2014 performance period) and Q1'17 (CY2015 performance period) reports. Detailed PCMH metric descriptions are available at www.paymentinitiative.org.

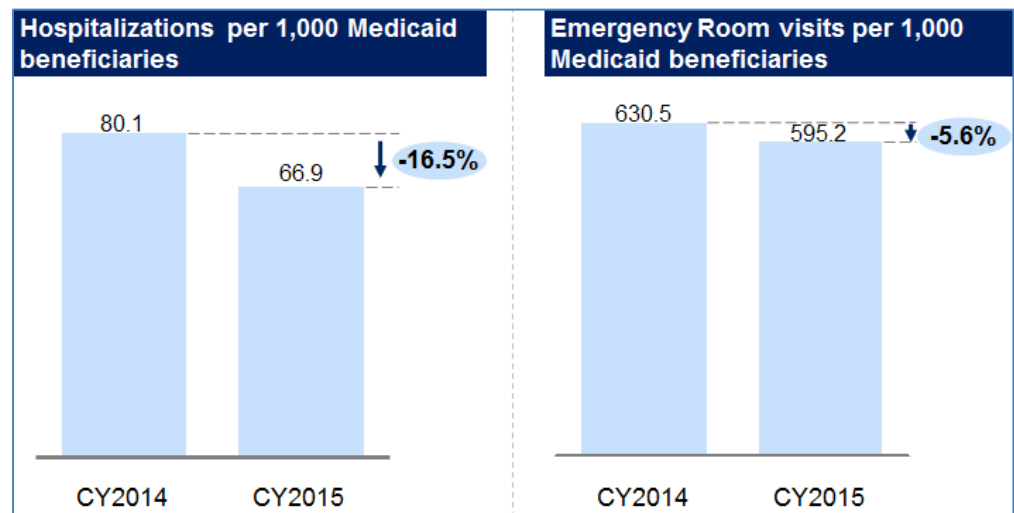
^w AR BCBS 2016 PCMH program provider manual with detailed metrics:

http://www.arkansasbluecross.com/doclib/forms/providers/abcbs%20pcmh%20provider%20manual%202016%20v3_8.pdf

Hospital and Emergency Department Utilization Impacts for Medicaid

For the second consecutive performance year, Medicaid beneficiaries enrolled in the PCMH program experienced reduced rates of hospitalizations and Emergency Room (ER) visits. These reductions are indicative of improved primary care quality and patient engagement, as well as lower costs.⁶ Figure 2 displays hospital and ER utilization among PCMH beneficiaries in 2014 and 2015. Hospitalizations per 1,000 beneficiaries were reduced by 16.5 percent in 2015, while ER visits were reduced by 5.6 percent over the same period.

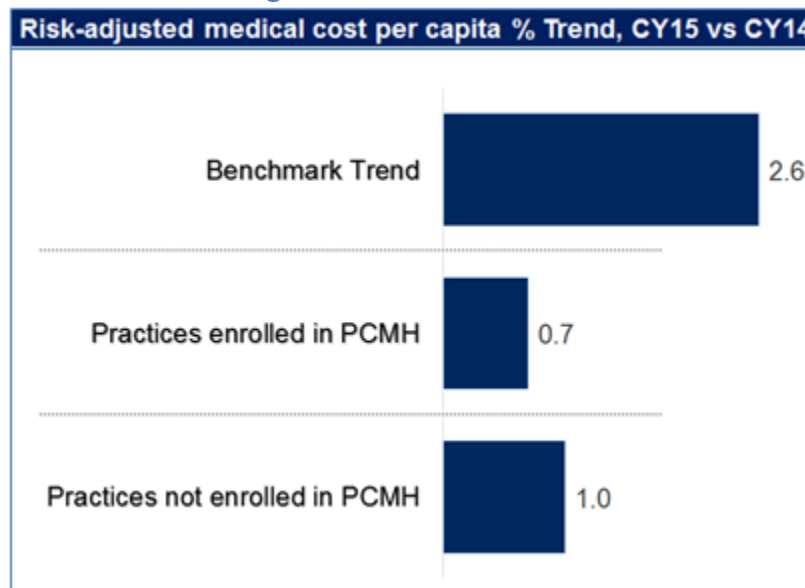
Figure 2: Hospital and Emergency Room Impacts



PCMH Financial Outcomes for Medicaid

Figure 3 displays PCMH cost growth comparisons across 2014 and 2015 for PCMH practices and practices not enrolled in the program. Participating practices experienced a 0.7 percent trend growth, while their peers who were not enrolled in the program experienced a 1.0 percent cost growth. Both groups achieved cost growth below the pre-set 2.6 percent benchmark trend, which is based on historical Arkansas cost growth.^x

Figure 3: PCMH Cost Trend



^x Source: Arkansas DHS; Q4'15 (CY2014 performance period) and Q1'17 (CY2015 performance period) reports. Details regarding baseline and benchmark cost calculations can be found within the Medicaid PCMH provider manual:

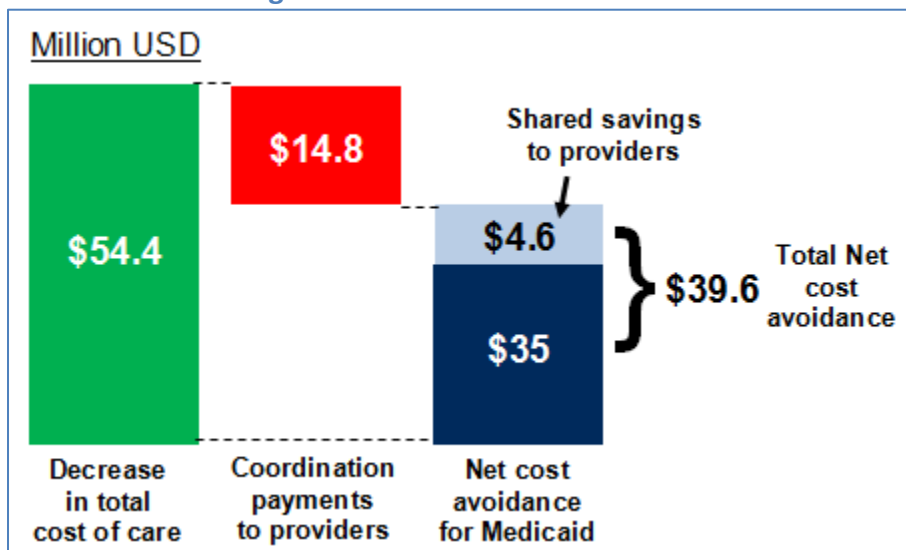
<http://www.paymentinitiative.org/referenceMaterials/Documents/2016%20PCMH%20manual.pdf>

PCMH Cost Avoidance for Arkansas Medicaid

For the second consecutive performance year, total cost of care for Medicaid beneficiaries enrolled in the PCMH program was lower than the projected total cost of care. The program generated gross savings of 34.3 million in 2014 and 54.4 million in 2015, for a total of 88.7 million.

Figure 4 displays PCMH cost avoidance for 2015. Of the \$54.4 million in savings, \$14.8 million was reinvested in system infrastructure via PMPM care coordination payments to providers, resulting in net savings of \$39.6 million, of which \$4.6 million has been distributed as shared savings among 22 provider groups.

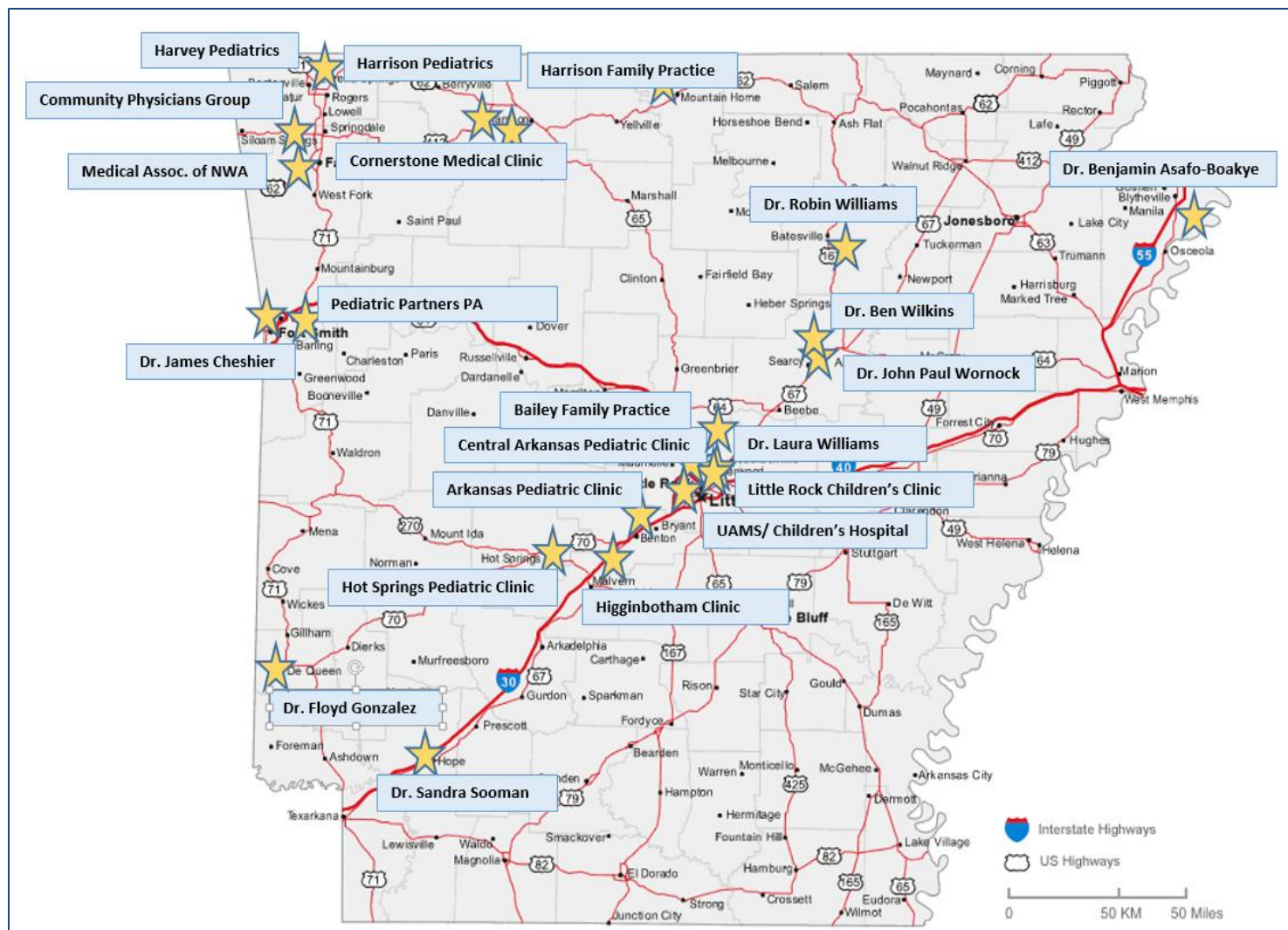
Figure 4: Medicaid Cost Avoidance



PCMH Shared Savings for Medicaid 2015 Performance

For providers in the PCMH program, once quality, transformation activity, and financial outcomes are assessed, qualifying practices received a portion of net savings as Shared Savings. Due to the time needed for necessary claims adjudication and reconciliation, Arkansas Medicaid finalizes shared savings payments approximately one year after the end of the preceding year performance period. For 2015 performance, 22 provider groups throughout the state received shared savings payments ranging from approximately \$35,000 to \$1,544,000. Figure 5 displays the location of these 22 providers.

Figure 5: Locations of PCMHs Receiving Share Savings Preliminary Payments for 2015 Performance



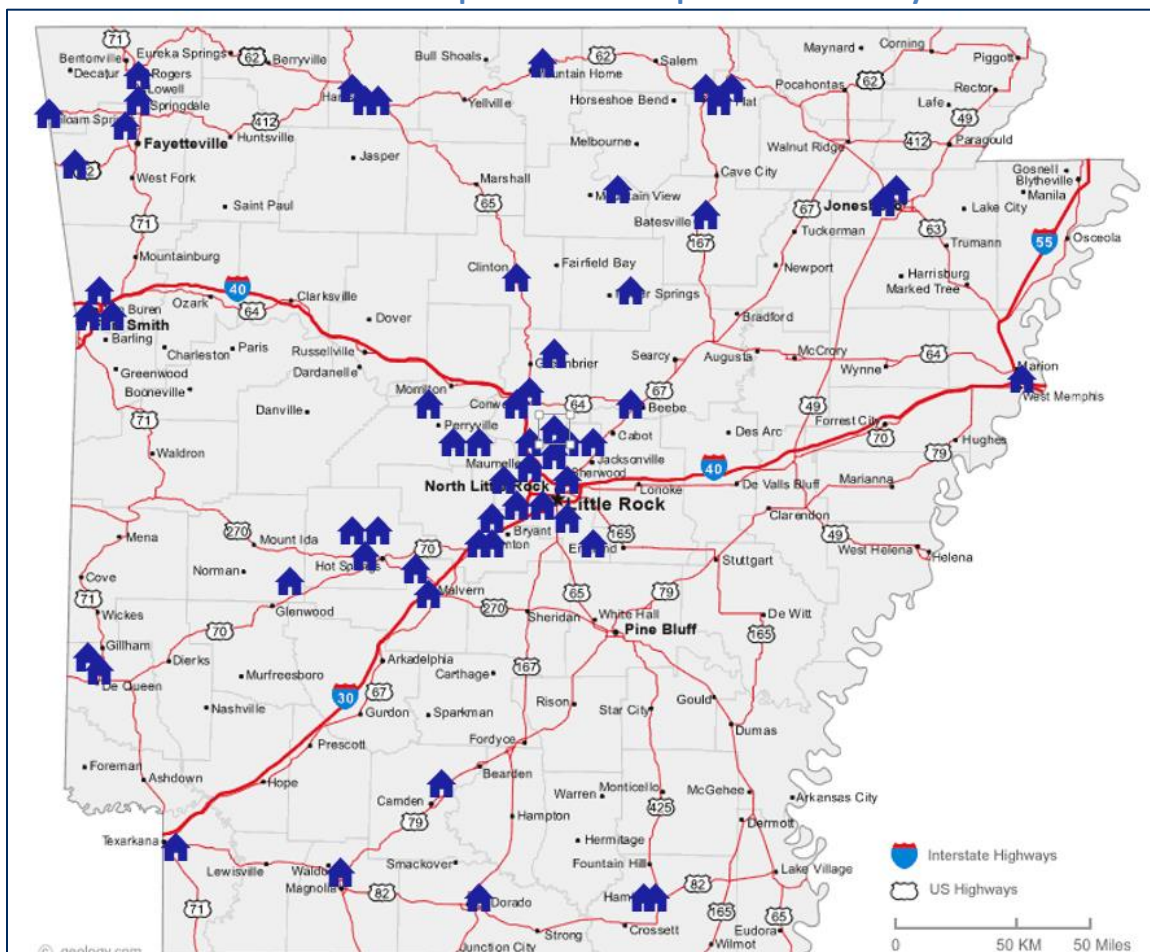
Comprehensive Primary Care Initiative (CPC)

Arkansas was one of only seven regions selected for the original Comprehensive Primary Care Initiative (CPC), for which 69 original practices were chosen in a competitive process. Launched in October 2012, this four year Medicare-led initiative shares the same goals as Arkansas's State PCMH program. Arkansas has been a leading region in CPC, and most recently was one of 4 regions in CPC to generate shared savings.^y Mathematica has been chosen to conduct an independent evaluation of the CPC program and detailed CPC outcomes can be found in their latest evaluation report.^z The success of CPC and Arkansas's PCMH program have prepared the state's providers to participate in the CPC+ program which begins in 2017.^z

CPC Outcomes for Arkansas

- 58 practices remained in the program as of December 2016 (see Figure 6 below), including 230 PCPs serving 337,660 beneficiaries.^{aa,bb}
- For Medicare, for 2015 performance Arkansas CPC practices experienced gross savings of 4.3 percent, or 420.6 million, and achieved net savings of 2.4%, or \$11.5 million (\$18.86 per beneficiary per month).
- Arkansas practices reduced hospital admissions by 15.7 percent; improving more than any other CPC region.^{cc}
- For 2014, Arkansas achieved savings but did not recoup more than the cost of care coordination payments.
- For AR BCBS, 54 practices met quality requirements to be eligible to receive any shared savings earned by the region for 2015 performance, with an average payment of \$43,700.
- For 2015 Medicare performance, 56 CPC practices (97 percent) in Arkansas were eligible to receive shared savings, with an average payment of \$13,376 per practice.

Figure 6: Locations of Clinics that Participated in the Comprehensive Primary Care Initiative in 2016



^y <https://blog.cms.gov/2016/10/17/medicares-investment-in-primary-care-shows-progress/>

^z CPC+ Website: <https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus>

^{aa} <https://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/Arkansas.html>

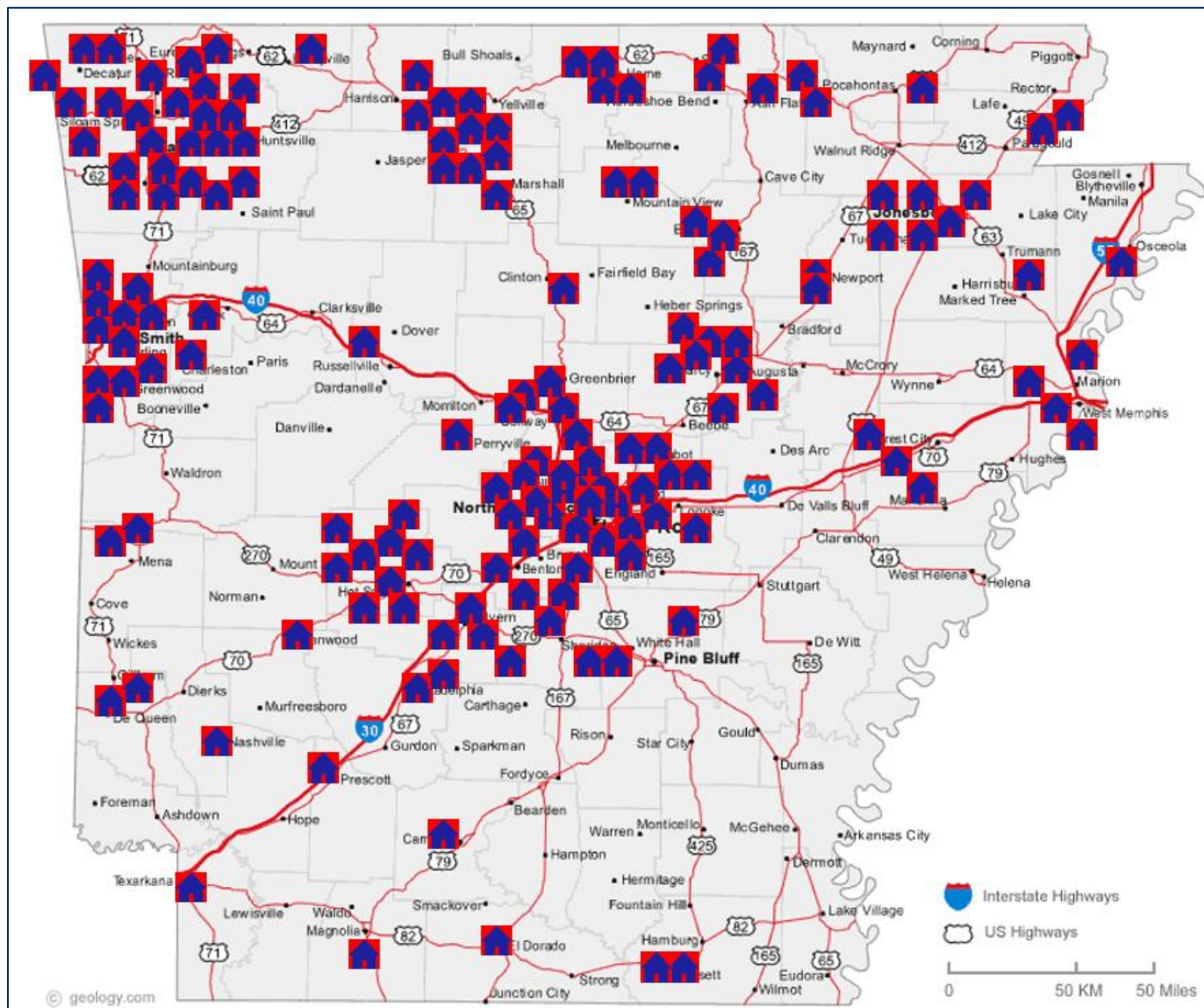
^{bb} <https://innovation.cms.gov/Files/x/cpci-ssqaldatasummary2015.pdf>

^{cc} CMS Q14 Regional Feedback Report (CPC At-a-Glance & table 5), provided by Rachel Wallis and TMF health Quality Institute December 2016

Comprehensive Primary Care Plus Initiative (CPC+)

Building on the foundation of CPC, Arkansas was selected as one of 14 regions to participate in CPC+. This five-year model begins in 2017 and includes participation from Medicare, Arkansas Medicaid, AR BCBS, QC, Centene/Ambetter (Arkansas Health and Wellness Solutions), HealthSCOPE, and Arkansas Superior Select. Locations of the 182 practices throughout the state that voluntarily applied and were selected for participation in CPC+ are displayed in Figure 7 below.

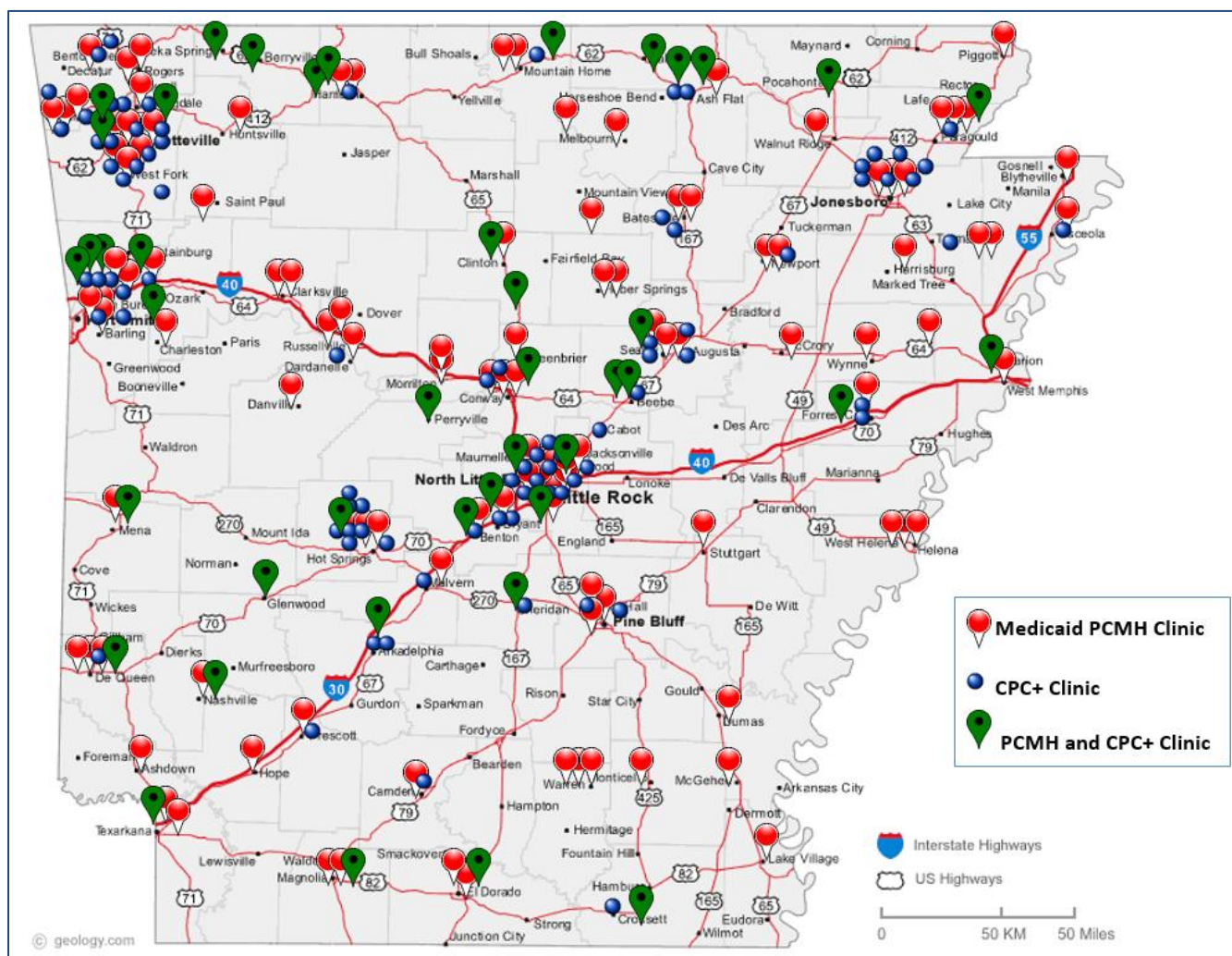
Figure 7: Locations of Clinics Participating in the Comprehensive Primary Care Plus Initiative



Overall Practice Participation in PCMH and CPC+

Participation in the states PCMH program and CPC+ is now occurring throughout the state. Locations of practices throughout the state. For Arkansas Medicaid, 192 practices are participating in the PCMH program. 182 practices are participating in the CPC+ program, and approximately 55 practices have all of their primary care providers enrolled in both PCMH and CPC+. Practices that are currently participating in PCMH and/or CPC+ are displayed in Figure 8 below.

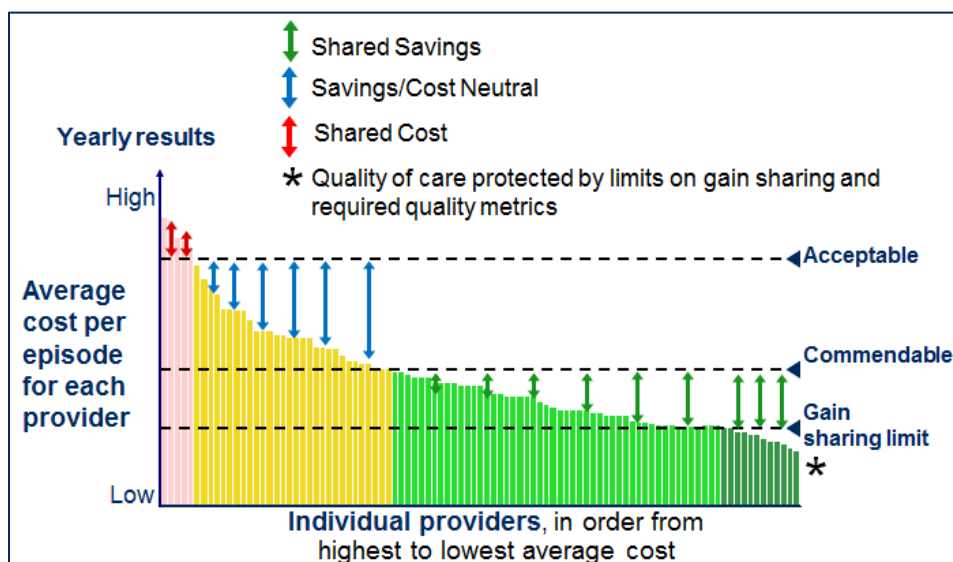
Figure 8: Locations of Clinics Participating in PCMH, CPC+, or both programs



Episodes of Care

An episode of care is the collection of care provided to treat a particular condition for a given length of time. The episode model, illustrated in Figure 9 below, assigns a PAP for each type of episode. The “patient journey” was developed and reviewed by patients, providers, and payers to determine quality events that should happen and potentially avoidable complications that should not happen. All providers submit claims and are paid at the time service is provided.

Figure 9: How the Episode Payment Model Works



However, after each performance period, each provider’s average costs are compared to pre-determined cost thresholds that have been established for each episode using historical Arkansas data. Each payer sets their own cost thresholds independently. The thresholds establish commendable, acceptable and unacceptable cost levels.

PAPs are given quarterly reports that outline their team’s performance across the entire episode, including quality metrics, utilization variation, and aggregate costs.

Upon completion of a retrospective performance period (usually one year), each PAP may be eligible for gain-sharing if their team’s performance has achieved commendable status. If the team’s performance is not acceptable and exceeds the acceptable threshold, the PAP may be required to refund a portion of their payments. Figure 9 above displays the episode payment framework and the cost thresholds for gain/ risk share payments.

To date, Medicaid has introduced fourteen different episodes of care. The following episodes have completed at least one full performance period and have been reported by payers for this report: Upper respiratory infections (URI), total joint replacements (TJR) - hip and knee, congestive heart failure (CHF), attention deficit hyperactivity disorder (ADHD), perinatal, colonoscopy, tonsillectomy, cholecystectomy, coronary artery bypass grafting (CABG), asthma, chronic obstructive pulmonary disease (COPD), and oppositional defiant disorder (ODD). AR BCBS has also implemented an episode for percutaneous coronary intervention (PCI). For these episodes, payers agreed upon the following strategies for aligning financial incentives to improve care:

- **Upper Respiratory Infections (URI):** The episode trigger is the first diagnosis of a URI; the PAP is the initial diagnosing clinician; the time period is 21 days; quality metrics include appropriate testing prior to antibiotic use; costs include all associated diagnostic and therapeutic costs.
- **Perinatal:** The episode trigger is delivery of a live infant; the PAP is the delivering provider; the time period is the prenatal period and 60 days postpartum; quality metrics include prenatal screenings and appropriate utilization of diagnostic tests; costs include all pregnancy related costs.

- **Total Joint Replacements (TJR) – Hip and Knee:** The episode trigger is the total joint replacement; the PAP is the orthopedic surgeon; the time period is 30 days preoperative to 90 days postoperative; quality metrics include the use of deep-vein thrombosis prophylaxis and complication rates; costs include all orthopedic related costs during the episode.
- **Congestive Heart Failure (CHF):** The trigger is a hospitalization for CHF; the PAP is the admitting hospital; the time period is the admission day plus 30 days; quality metrics include appropriate cardiac medication management and follow up to avoid readmission; costs include all facility services, inpatient professional services, emergency department visits, observation, and post-acute care; any CHF-related outpatient labs and diagnostics, outpatient costs, and medications are also included.
- **Attention Deficit Hyperactivity Disorder (ADHD):** The trigger is diagnosis of ADHD; the PAP is the provider (primary care or mental health provider) with the majority of visits; the time period is 12 months; complexity and quality assessments are through provider attestation; costs include all ADHD-related charges.
- **Colonoscopy:** The trigger is an outpatient colonoscopy procedure and primary or secondary diagnosis indicating conditions that require a colonoscopy; the PAP is the primary provider providing the colonoscopy; an episode begins with the initial consult with the performing provider (within 30 days prior to procedure) and ends 30 days after the procedure; includes all related costs 30 days prior to 30 days after the procedure except ER visits on the day of the procedure; Quality metrics include cecal intubation rate and withdrawal time, perforation rate, and post polypectomy/biopsy bleed rate.
- **Tonsillectomy:** Episode is triggered by an outpatient tonsillectomy, adenoidectomy, or adeno-tonsillectomy procedure, and a primary or secondary diagnosis indicating conditions that require tonsillectomy/adenoidectomy; the PAP is the provider performing the procedure; episode begins with the initial consult with the performing provider (within 90 days prior to procedure) and ends 30 days after the procedure; costs include all related services within the episode duration. Quality metrics include the percent of episodes with administration of intra-operative steroids (must meet a minimum of 85 percent of episodes), post-operative primary bleed rate, secondary bleed rate, and avoidance of post-operative antibiotics prescriptions.
- **Cholecystectomy:** The episode is triggered by open or laparoscopic cholecystectomy procedure and a primary or secondary diagnosis indicating related conditions; the PAP is the surgeon; episode begins with the cholecystectomy procedure and ends 90 days post-procedure and includes all related costs; Quality metrics include pre-operation CT scan rate (must be below 44 percent), rate of major complications, rate of procedures converted from laparoscopic to open surgery, and number of procedures initiated via open surgery.
- **Coronary Artery Bypass Graft (CABG):** The trigger is a CABG procedure; PAP is the physician performing the CABG; episode duration is the timeframe from the date of surgery through 30 days post discharge from the facility stay during which the procedure occurred; costs include all procedure services and all related services within 30 days of discharge; quality metrics require PAPs to meet 2/3 of adverse outcome metrics inclusive of stroke, deep sternal wound, and renal failure.
- **Asthma:** The trigger is an emergency department, observation room, or inpatient visit for treatment of an acute exacerbation of asthma; the PAP is the inpatient or outpatient facility where the triggering event is treated; episode duration is the timeframe from the triggering event until 30 days after discharge or until the end of a readmission where the patient had entered the hospital within the 30 day post-discharge period; costs include all claims for trigger hospitalization and any asthma-related inpatient, outpatient, professional and pharmacy claims within the 30-day window; quality metrics include rate of episodes with patient follow-up during 30day window (must be at least 38%), rate of episodes where the patient receives appropriate asthma controller medication during the episode or within 30 days prior to the episode (minimum is 59 percent), rate of episodes with a repeat acute exacerbation during the 30-day post-trigger window.
- **Chronic Obstructive Pulmonary Disease (COPD):** The trigger is a COPD acute exacerbation in an emergency department or inpatient facility; the PAP is the facility; episode duration is 30 days after hospital discharge or

until the end of readmission period if applicable; costs include inpatient and outpatient facility services, professional services, related medications, treatment for post-procedure complications, and readmissions or repeat visits to the emergency department; quality metrics include rate of episodes where patient visits outpatient physician within 30 days post initial discharge (minimum threshold is 36 percent), rate of repeat acute exacerbation within 30 days post initial hospital discharge.

- **Oppositional Defiant Disorder (ODD):** The trigger is three medical claims with a diagnosis of ODD; the PAP is the provider responsible for the greatest number of ODD claims within an episode and may be primary care physicians, psychiatrists, clinical psychologists, and rehabilitative services for persons with mental illness (RSPMI) providers ; episode duration is a 90-day period beginning at the time of the first trigger claim; costs include All claims with a primary diagnosis of ODD; quality metrics include rate of episodes with completion of either Continuing Care or Quality Assessment certification (minimum threshold of 90 percent), rate of new episodes for beneficiaries in which behavioral health medications were received (must be less than 20 percent), percentage of repeat for which the beneficiary received medications (must be equal to 0 percent), percentage of episodes resulting in remission (minimum threshold of 40 percent).
- **Percutaneous Coronary Intervention (PCI):** The trigger is a pre-procedure angiogram or PCI procedure; the PAP is the cardiologist or radiologist performing the procedure; episode duration is 30 days after PCI procedure or date of angiogram if within 30 days prior to the procedure; costs include inpatient, outpatient, professional services, and medications; quality metrics include having greater than or equal to 95 percent of episodes not flagged for adverse outcomes, and the proportion of patients with any adverse outcomes. Adverse outcomes include myocardial infarction, stroke, stent thrombosis, AV fistula, pulmonary embolism, and wound infection.

Summary of Episode Results

Payers selected the episodes for implementation that met their covered population needs and corporate interests; thus, not every episode was implemented by each payer. While design consistency was achieved across all episodes by the payers, performance thresholds for gain and risk sharing are established independently for each payer. Outcomes for performance years spanning approximately 2014 through 2015 are reported below for Medicaid and AR BCBS.^{dd} AR BCBS serves as the third-party administrator for the ASE/PSE plans. While ASE/PSE episode results are displayed separately for some measures, ASE/PSE totals are included in all overall AR BCBS outcomes. Due to QualChoice episode reporting and payment bundling software undergoing upgrades, QualChoice episode outcomes for 2015 were not available for this report but are anticipated to be included in future reports. The most recently available QualChoice episode outcomes are available in the 2016 Statewide Tracking Report.^{ee}

Perinatal Episode

The perinatal episode aims to ensure a healthy pregnancy and follow-up care for the mother and baby, requiring months of care, possibly involving many different providers ranging from obstetricians, family practice physicians, and nurse midwives, to hospitals, emergency departments, obstetric specialists, and others. The perinatal episode includes all pregnancy-related care provided during the course of the pregnancy. This includes all of the prenatal care, care related to labor and delivery, and postpartum maternal care—roughly 40 weeks before delivery and 60 days postpartum. It encompasses the full range of services provided during this time period. Table 4 (right) lists the perinatal episode yearly volume for 2012-2015.

	2012	2013	2014	2015
Medicaid	5,845	5,946	12,596	7,230
AR BCBS^{ff}	2,871	2,536	2,858	2,690
ASE/PSE^{gg}	NA	653	680	662
QC	NA	685	641	NA

Quality metrics for the perinatal episode are aimed at increasing pregnancy screenings as a form of preventive care to reduce high-risk pregnancies. Perinatal care has three quality metrics that PAPs must pass in order to participate in

^{dd} Due to QualChoice episode reporting and payment bundling software undergoing upgrades, QualChoice episode outcomes for 2015 were not available for this report but are anticipated to be included in future reports.

^{ee} The 2016 Statewide Tracking Report for AHCPII is available at: <http://www.achi.net/Content/Documents/ResourceRenderer.ashx?ID=338>

^{ff} AR BCBS totals include ASE/PSE episode totals.

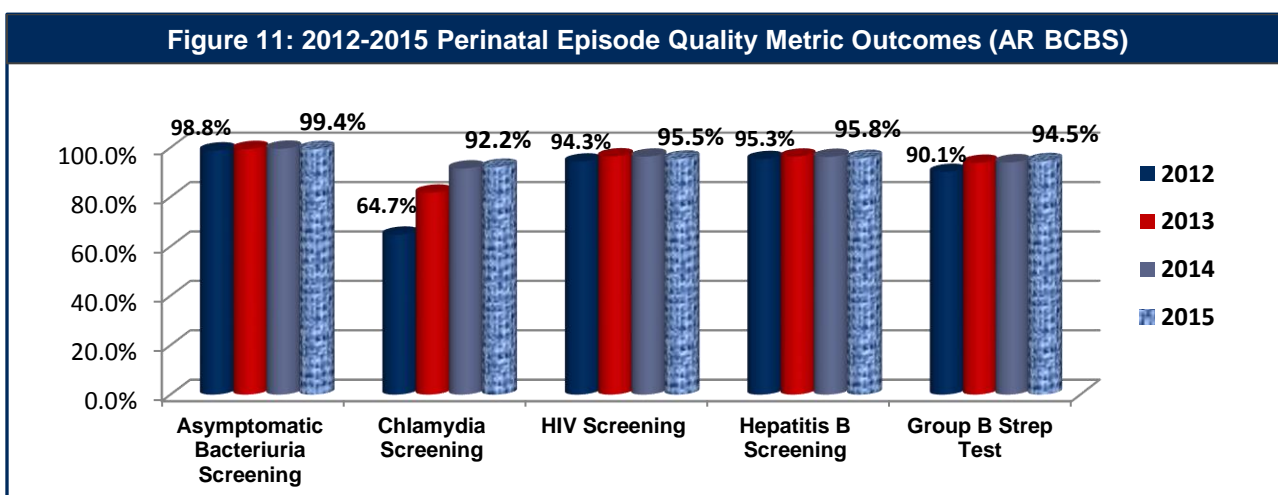
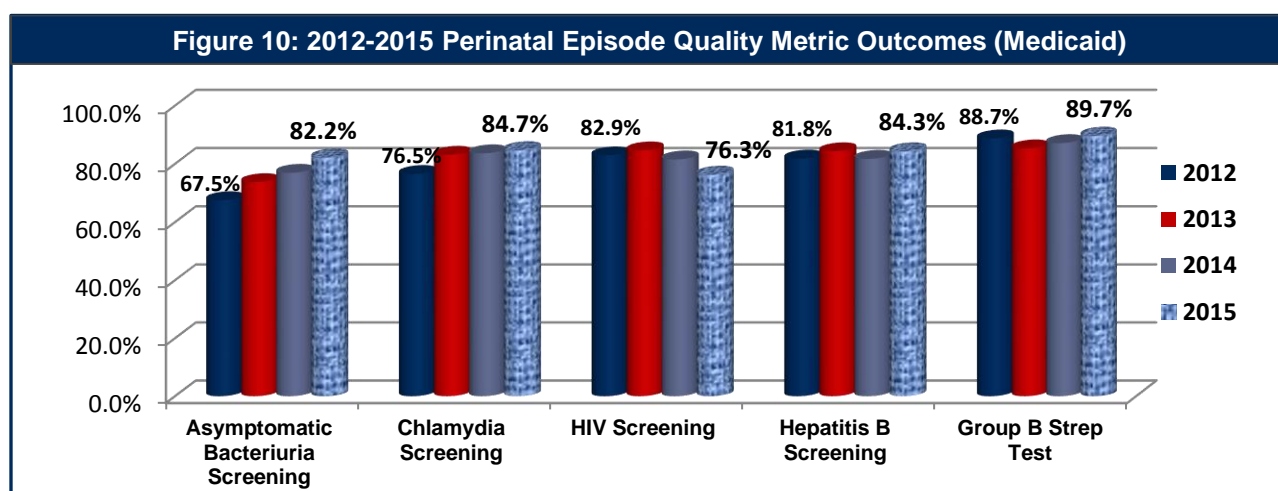
^{gg} While displayed as a separate payer category, all ASE/PSE outcomes are also included in AR BCBS totals.

shared savings. Providers must provide the following quality metrics to pregnant patients: HIV, group B streptococcus (GBS), and chlamydia screenings. Each screening must meet the minimum threshold of 80 percent to pass. There are five additional quality metrics that PAPs are tracked on in the perinatal episode for quality of care and care improvement opportunities. Four of these metrics are the following screenings: ultrasound, gestational diabetes, asymptomatic bacteriuria, and hepatitis B specific antigen. The fifth metric is Cesarean section (C-section) rate. Medicaid, AR BCBS, and QC are participating in the episode. Key findings include the following:

Perinatal Quality Outcomes

Perinatal quality metric outcomes from 2012 through 2015 are displayed in Figures 10 and 11 below.

- Screening rates generally remained at prior year levels or continued to improve for AR BCBS and Medicaid. The Chlamydia screening rate showed the most improvement for AR BCBS, while Medicaid showed the most improvement in asymptomatic bacteriuria screening.
- Medicaid's C-section rate has steadily improved each year since the episode was launched, from 38.5 percent in 2012 to 31.8 percent in 2015. The average length of stay for C-sections remained at 2.6 days for 2014 and 2015.^{hh}
- C-Section rate for AR BCBS improved from 38.7 percent in 2014 to 35.9 percent in 2015.
- AR BCBS average perinatal episode cost increased by 1.3 percent from 2014 to 2015 after falling 1.6 percent from 2013 to 2014.



^{hh} Medicaid's baseline period was 3/1/12 through 9/30/12, while the performance period for 2013 was 3/1/13 through 9/20/13, and the 2014 performance year was 10/1/13 through 9/30/14, and 10/1/14 to 9/30/15 for 2015.

Perinatal Provider Cost Range Outcomes

Perinatal cost outcomes for 2014 and 2015 are displayed in Tables 5 and 6 below.

Table 5: 2014 – 2015 Provider Cost Outcomes: Perinatal (Medicaid)		
PAP Cost Range	2014 (139 PAPs)	2015 (129 PAPs)
Commendable	45.3%	20.9%
Acceptable	47.5%	73.6%
Non-acceptable	7.19%	5.43%

Table 6: 2014 – 2015 Provider Cost Outcomes: Perinatal (AR BCBS)*		
PAP Cost Range	2014 (147 PAPs)	2015 (147 PAPs)
Commendable	82 (59.9%)	49 (33.3%)
Acceptable	56 (38.1%)	61 (41.5%)
Non-acceptable	9 (6.1%)	37 (25.2%)

*AR BCBS provider cost outcomes in this report do not include principle accountable providers who were eligible in only one performance year.

- For Medicaid, the most recent performance period gain-share totals include \$73,650.47 paid to 14 PAPs.
- For Medicaid, the most recent risk-share totals include \$14,281.62 to be collected from 7 PAPs.
- For Medicaid, average adjusted episode cost was \$3,402.72 in 2014 and \$3,412.75 in 2015, for an increase of 0.29 percent.
- For AR BCBS, average perinatal episode cost increased by 1.3 percent from 2014 to 2015, after a decrease of 1.6 percent from 2013 to 2014.

Total Joint Replacement (TJR)—Hip and Knee Episode

Previously, multiple providers have been involved at each stage of total hip and knee replacements without optimal care coordination. This led to duplication of efforts, increased costs, and the potential for decreased quality of care. The hip and knee total joint replacement (TJR) episode includes all services related to elective hip and knee replacement procedures, from the initial consultation to post surgery follow-up care.⁸ Hip and knee replacements resulting from joint degeneration and osteoarthritis are among the top five elective procedures performed. Each operation involves pre-surgery diagnostics and testing, hospitalization, the procedure itself, and post-surgery rehabilitation.⁹ TJR includes all care related to the procedure in the period 30 days prior to the surgery to 90 days after.⁸ This episode has four quality metrics to track in place for quality of care and improvement opportunities: 30-day all-cause readmission rate;ⁱⁱ frequency of use of prophylaxis against postoperative Deep Venous Thrombosis (DVT) / Pulmonary Embolism (PE); frequency of postoperative DVT/PE; and 30-day wound infection rate. Medicaid, AR BCBS, and QC are participating in the TJR episode. Table 7 (above) lists the TJR episode volume, 2012-2015.

Table 7: Total Joint Replacement Episode Volume				
	2012	2013	2014	2015
Medicaid	141	100	120	132
AR BCBS	823	659	862	822
ASE/PSE	NA	223	317	287
QC	NA	111	122	NA

Key findings include the following:

TJR Quality Outcomes

Quality metric outcomes for 2012 through 2015 are displayed in Figures 12 and 13 (next page).

- For AR BCBS, the trend decreased slightly each year for average length of stay for inpatient admissions for TJR, from 2.6 days in 2013 to 2.3 days in 2015.
- For Medicaid, the post-operation complication rate improved from 14.2 percent in 2014 to 12.1 percent in 2015.
- AR BCBS was responsible for the majority of TJR episodes, with 822 episodes in 2015, compared to 132 for Medicaid. 287 of AR BCBS episodes were attributed to ASE/PSE members.

ⁱⁱ The 30-day all-cause readmission rate is for patient readmissions only related to the TJR procedure. Occurrences between 30-90 days post-surgery count toward the episode.

Figure 12: 2012-2015 TJR Quality Metric Outcomes (Medicaid)

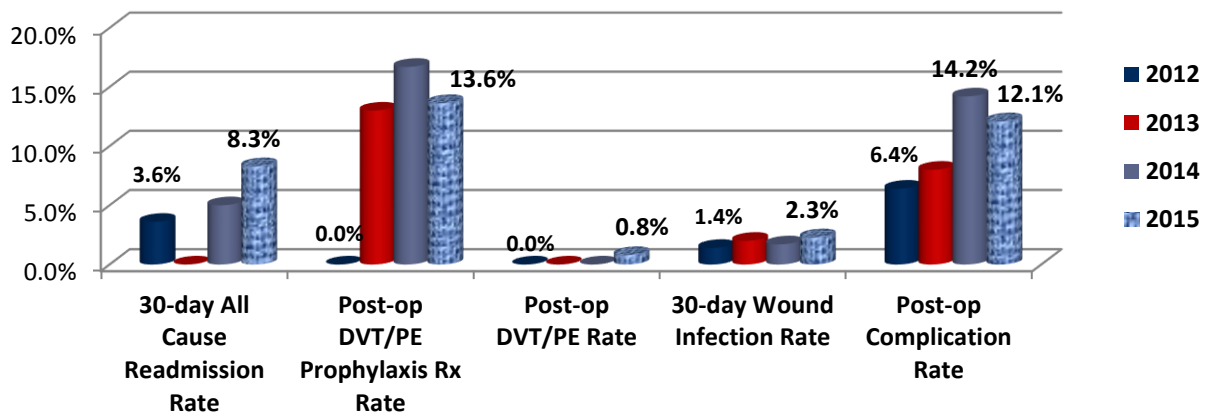
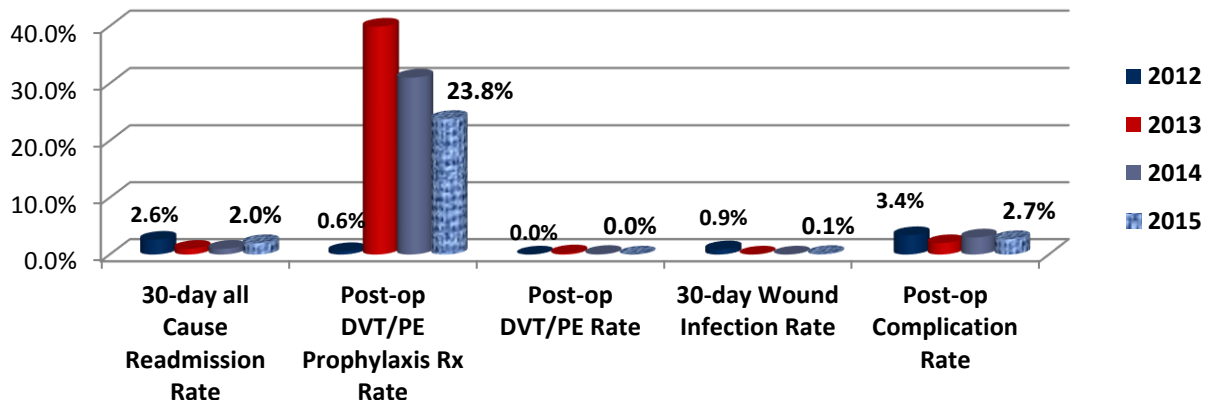


Figure 13: 2012-2015 TJR Episode Quality Metric Outcomes (AR BCBS)



TJR Provider Cost Range Outcomes

TJR cost outcomes for 2014 and 2015 are displayed in Tables 8 and 9 below.

Table 8: 2014 – 2015 Provider Cost Outcomes: TJR (Medicaid)

PAP Cost Range	2014 (5 PAPs)	2015 (9 PAPs)
Commendable	1 (20.0%)	2 (22.2%)
Acceptable	4 (80.0%)	7 (77.8%)
Non-acceptable	0	0

Table 9: 2014 – 2015 Provider Cost Outcomes: TJR (AR BCBS)

PAP Cost Range	2014 (35 PAPs)	2015 (35 PAPs)
Commendable	20 (57.1%)	21 (60.0%)
Acceptable	11 (31.4%)	8 (22.9%)
Non-acceptable	4 (11.4%)	6 (17.1%)

- For Medicaid, the most recent performance period gain-share totals include \$4,264.15 paid to 12 PAPs.
- For Medicaid, no PAPS experienced risk-share payments.
- For Medicaid, average adjusted episode cost was \$9,248.44 in 2014 and \$8,864.08 in 2015, for a decrease of 4.2 percent.
- For AR BCBS, average TJR Episode cost increased by 2.8 percent from 2014 to 2015, after an increase of 0.8 percent from 2013 to 2014.

Congestive Heart Failure (CHF) Episode

In Arkansas, 24 percent of hospitalized Medicare patients with congestive heart failure (CHF) will be re-admitted within 30 days annually.¹⁰ Active management of CHF through adherence to proper diet, weight management, and medication can reduce symptoms and improve quality of life for CHF patients. CHF affects a significant number of Arkansans, and represents an opportunity to improve quality, patient experience, and efficiency. CHF can be acute, sub-acute, or chronic. This episode focuses on acute CHF exacerbations that result in hospitalization and post-acute follow-up care. The focus is on improved care coordination and effectiveness between the hospital and post-discharge providers. Patient education and post-discharge follow up are key factors to prevent readmission. Increased use of evidence-based therapies could save the lives of up to 700 Arkansans each year.¹⁰ Table 10 (right) lists the CHF episode volume for 2012-2015.

Table 10: CHF Episode Volume

	2012	2013	2014	2015
Medicaid	225	204	232	207
AR BCBS	48	70	67	66
ASE/PSE	NA	16	16	25

Quality metrics for the CHF episode include the prescribing rate of an angiotensin-converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy at hospital discharge to patients with left ventricular systolic dysfunction (LVSD); frequency of outpatient follow up within seven and 14 days after discharge; proportion of patients matching hyper dynamic, normal to severe dysfunction (for qualitative assessments of the left ventricular ejection fraction [LVEF]); average quantitative ejection fraction value; 30-day all-cause readmission rate; 30-day heart failure readmission rate; and 30-day outpatient observation care rate (a utilization metric).¹¹ Medicaid and AR BCBS are participating in the CHF episode. Key findings include:

- For Medicaid average length of stay improved from 4.8 days in 2014 to 4.2 days in 2015.
- For Medicaid, rate of follow-up outpatient visits decreased from 48.3 percent in 2014 to 40.6 percent in 2015.
- For AR BCBS, average length of stay improved from 4.1 days in 2014 to 3.4 days in 2015.
- For AR BCBS, CHF episode costs increased by 15 percent from 2014 to 2015, after decreasing by 10.3 percent from 2013 to 2014.

CHF Quality Outcomes

CHF Quality metric outcomes for 2013 through 2015 are displayed in Figures 14 and 15 below.

Figure 14: 2013-2015 CHF Episode Quality Metric Outcomes (Medicaid)

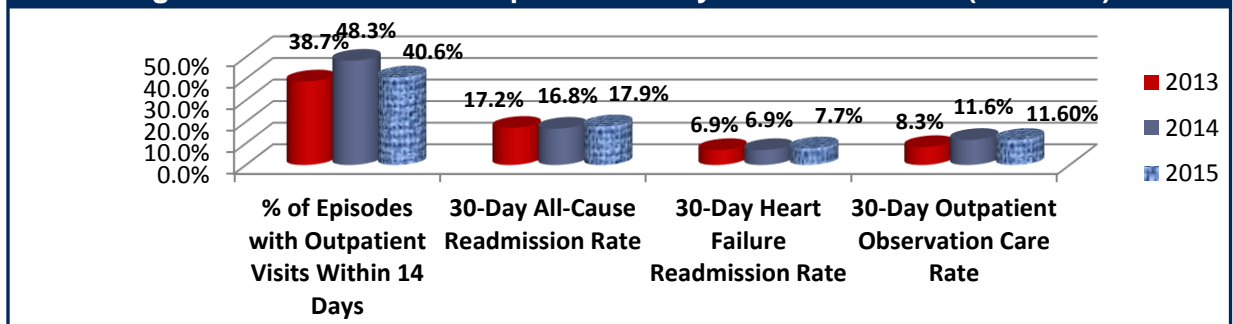
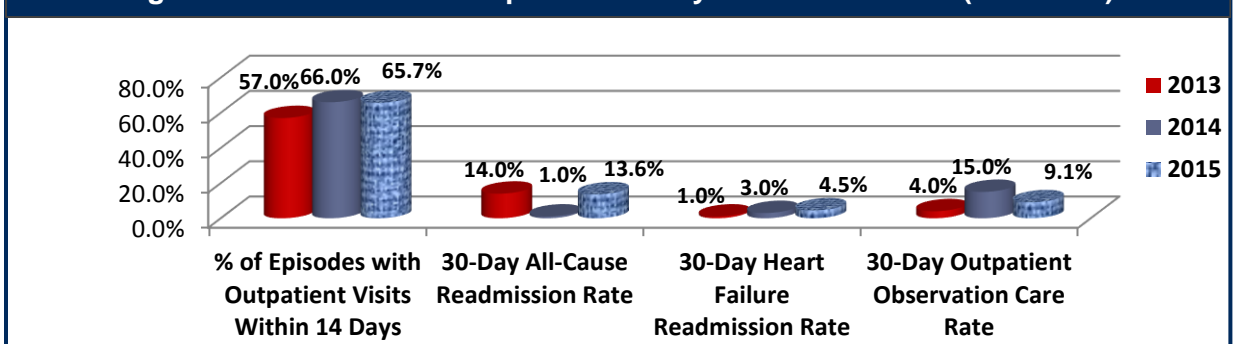


Figure 15: 2013-2015 CHF Episode Quality Metric Outcomes (AR BCBS)



CHF Provider Cost Range Outcomes

CHF cost outcomes for 2014 and 2015 are displayed in Table 11 below.

Table 11: 2014 – 2015 Provider Cost Outcomes: CHF (Medicaid)		
PAP Cost Range	2014 (16 PAPs)	2015 (15 PAPs)
Commendable	6 (37.5%)	7 (46.7%)
Acceptable	6 (37.5%)	7 (46.7%)
Non-acceptable	4 (25.0%)	1 (6.7%)

- AR BCBS had one PAP for CHF during 2014 and 2015. The PAP moved from the commendable category in 2014 to the unacceptable category in 2015.
- For Medicaid, no PAPS achieved gain-share payments for the most recent performance period due to not meeting quality metrics.
- For Medicaid, one PAP experienced risk-share payments totaling \$1,935.95.
- For Medicaid, average adjusted episode cost was \$5,240.29 in 2014 and \$4,476.74 in 2015, for a decrease of 14.26 percent.
- For AR BCBS, average episode cost increased by 15.0 percent from 2014 to 2015, after a decrease of 10.3 percent from 2013 to 2014.

Cholecystectomy Episode

Cholecystectomy is the surgical removal of the gall bladder, most commonly to alleviate gallstones. The most common procedure used is called laparoscopic cholecystectomy. The cholecystectomy episode includes all related services during cholecystectomy procedure and 90 days after procedure. This includes inpatient and outpatient facility services, professional services, related medications, complications and post procedure admissions. The cholecystectomy episode is triggered by services provided by the responsible surgical team, and the PAP is the primary surgeon performing the procedure. This episode includes patients between the ages of one year and 65 years.

In order to participate in Medicaid gain-sharing, providers are required to pass a quality metric related to the percentage of episodes with CT scan 30 days prior to cholecystectomy. An acceptable threshold would be less than the state average of 44 percent of cases. Metrics intended for reporting only include the rate of major complications occurring in the episode, either during the procedure or in the post-procedure window, such as common bile duct injury, abdominal blood vessel injury, bowel injury, the number of laparoscopic cholecystectomies converted to open surgeries and the number of cholecystectomies initiated via open surgery. Medicaid and AR BCBS participate in the cholecystectomy episode. Table 12 (right) lists the cholecystectomy episode volume for 2013-2015.

Table 12: Cholecystectomy Episode Volume			
	2013	2014	2015
Medicaid	523	520	600
AR BCBS	1,606	1,368	1,278
ASE/PSE	422	329	303
QC	319	288	NA

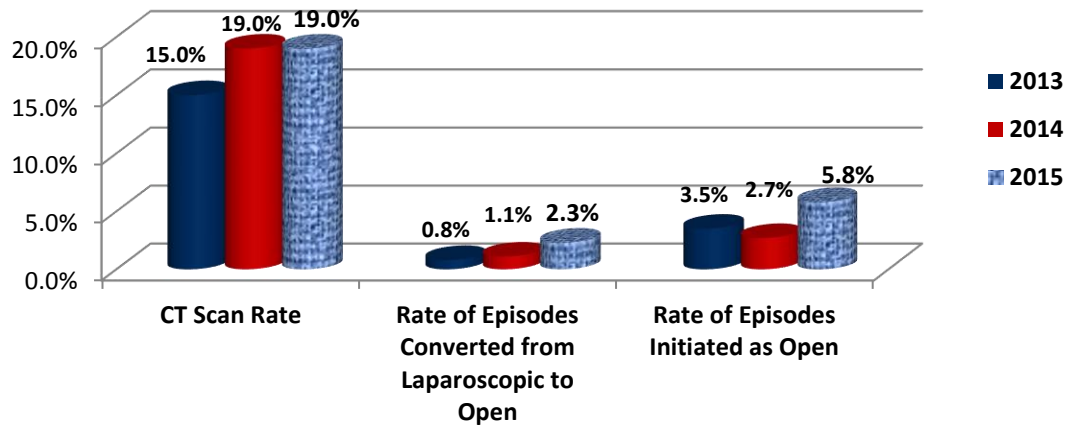
Cholecystectomy Quality Outcomes

Cholecystectomy quality outcomes for 2013 through 2015 are displayed in Figure 16 (next page).

- For Medicaid, all metrics remained at 0 percent from 2014 to 2015, with the exception of CT scan rate and abdominal blood vessel injury rate. The CT scan rate increased to 24.3 percent for 2015, up from 16.6 percent in 2013 and 23.9 percent in 2014.^{jj} Abdominal blood vessel injury rate increased from 0 percent to 0.2 percent.
- For AR BCBS the rate of episode converted from laparoscopic to open increased from 1.3 percent in 2014 to 2.3 percent in 2015. The rate of episodes initiated as open increased from 2.7 percent in 2014 to 5.8 percent in 2015.

^{jj} For the Cholecystectomy episode, additional CT scan codes were added to the episode algorithm in 2014 in order to more accurately assess provider practice and service delivery.

Figure 16: 2013-2015 Cholecystectomy Quality Metric Outcomes (AR BCBS)



Cholecystectomy Provider Cost Range Outcomes

Cholecystectomy cost outcomes for 2014 and 2015 are displayed in Tables 13 and 14 below.

Table 13: 2014 – 2015 Provider Cost Outcomes: Cholecystectomy (Medicaid)		
PAP Cost Range	2014 (39 PAPs)	2015 (40 PAPs)
Commendable	20 (51.3%)	19 (47.5%)
Acceptable	13 (33.3%)	11 (27.5%)
Non-acceptable	6 (15.4%)	10 (25.0)

Table 14: 2014 – 2015 Provider Cost Outcomes: Cholecystectomy (AR BCBS)		
PAP Cost Range	2014 (80 PAPs)	2015 (80 PAPs)
Commendable	19 (23.8%)	58 (72.5%)
Acceptable	52 (65.0%)	11 (13.8%)
Non-acceptable	9 (11.25%)	11 (13.8%)

- For Medicaid, the most recent performance period gain-share totals include \$15,589.09 paid to 119 PAPs.
- For Medicaid , the most recent risk-share totals include \$22,457.90 to be collected from 10 PAPs.
- For Medicaid, Average adjusted episode cost was \$1,738.76 in 2014 and \$1,804.39 in 2015, for an increase of 3.8 percent.
- For AR BCBS, average episode cost increased by 2.0 percent from 2014 to 2015, after an increase of 4.1 percent from 2013 to 2014.

Colonoscopy Episode

Colonoscopy is the endoscopic examination of the large bowel and the distal part of the small bowel. It is used for visual diagnosis or biopsy/lesion removal purposes. Colorectal cancer is the third most commonly diagnosed cancer and the third leading cause of cancer death in both men and women in the US, with an overall incidence rate per 100,000 of 57.2 for men and 42.5 for women.¹² The colonoscopy is the only therapeutic technique used for removal of a potentially precancerous growth during the screening procedure. The episode applies to patients between the ages of 18 and 64 and includes all related services within seven days prior to the procedure, the day of the procedure and within 30 days after the procedure. Two quality metrics cited by the American Society of Gastrointestinal Endoscopy are included in this episode. Table 15 (right) lists the colonoscopy episode volume for 2013-2015.

Table 15: Colonoscopy Episode Volume			
	2013	2014	2015
Medicaid	1,283	1,424	1,624
AR BCBS	9,264	8,430	8,052
ASE/PSE	3,515	3,085	2,702

To participate in gain-sharing payments at least 80 percent of a provider's valid colonoscopy episodes must meet the following quality metrics: 1) documentation of endoscopy procedures reaching cecum, and 2) an endoscope withdrawal time greater than six minutes. Reaching the cecum is critical to a complete examination. Episode advisors have selected the following quality metrics to track for future evaluation: 1) perforation rate and 2) post-polypectomy/biopsy bleed rate. AR BCBS and Medicaid participate in the colonoscopy episode.

Colonoscopy Quality Outcomes

- For Medicaid, the perforation rate and post polypectomy/biopsy bleed rate remained at 0 percent in 2015. Cecal intubation rate worsened slightly from 68.7 percent in 2014 to 64.6 percent in 2015. Withdrawal time of at least 6 minutes was achieved in 60.2 percent of episodes in 2014 and 55.8 percent of episodes in 2015.
- For AR BCBS, cecal intubation rate improved from 82.9 percent in 2014 to 85.7 percent in 2015. The target for cecal intubation rate is at least 75 percent. The withdrawal time of at least 6 minutes rate improved from 73.3 percent in 2014 and 79.7 percent of episodes in 2015, with the target being at least 80 percent.

Colonoscopy Provider Cost Range Outcomes

Colonoscopy cost outcomes for 2014 and 2015 are displayed in Tables 16 and 17 below.

Table 16: 2014 – 2015 Provider Cost Outcomes: Colonoscopy (Medicaid)		
PAP Cost Range	2014 (73 PAPs)	2015 (77 PAPs)
Commendable	32 (43.8%)	30 (39.0%)
Acceptable	25 (24.3%)	28 (36.4%)
Non-acceptable	16 (21.9%)	19 (24.7%)

Table 17: 2014 – 2015 Provider Cost Outcomes: Colonoscopy (AR BCBS)		
PAP Cost Range	2014 (149 PAPs)	2015 (149 PAPs)
Commendable	86 (57.7%)	64 (43.0%)
Acceptable	63 (42.3%)	80 (53.7%)
Non-acceptable	0	5 (3.4%)

- For Medicaid, the most recent performance period gain-share totals include \$11,750.70 paid to 13 PAPs.
- For Medicaid, the most recent risk-share totals include \$10,736.92 to be collected from 19 PAPs.
- For Medicaid, average adjusted episode cost was \$821.17 in 2014 and \$808.71 in 2015, for a decrease of 1.5 percent.
- For AR BCBS, average episode cost increased by 0.8 percent from 2014 to 2015, after a decrease of 1.5 percent from 2013 to 2014.

Tonsillectomy Episode

Tonsillectomy is one of the most common surgical procedures in Arkansas in children under the age of 15.¹³ It is performed to alleviate such conditions as recurrent tonsillitis and sleep breathing disorder. A tonsillectomy episode is an outpatient tonsillectomy, adenoidectomy, or adeno-tonsillectomy procedure on a patient between the ages of three and 21. It includes related procedure services during and within 90 days prior to and 30 days post-procedure. Examples of related services include initial consult, inpatient and outpatient facility services, professional services, and related medications, or any post-procedure complications that result in additional care. Table 18 (right) lists the tonsillectomy episode volume for 2013-2015.

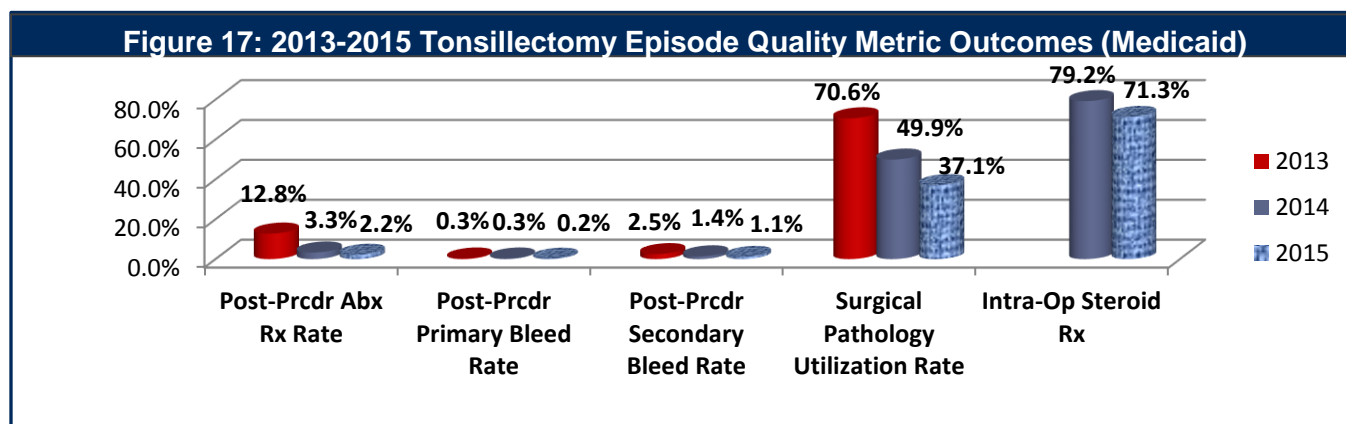
Table 18: Tonsillectomy Episode Volume			
	2013	2014	2015
Medicaid	2,693	3,096	3,409
AR BCBS	670	409	465
ASE/PSE	152	85	99

To participate in episode gain-sharing, providers are required to pass a quality metric to administer intra-operative steroids in a minimum of 85 percent of their tonsillectomy episodes. The report-only quality metrics are postoperative primary bleed rate, secondary bleed rate, and avoidance of post-operative antibiotic prescriptions. The American Academy of Otolaryngology recommends against the use of antibiotics post-procedure.¹⁴ Medicaid and AR BCBS participate in the tonsillectomy episode.

Tonsillectomy Quality Outcomes

Tonsillectomy quality outcomes for 2013 through 2015 are displayed in Figure 17 below.

- For Medicaid, surgical pathology utilization rate has continued to improve, from 70.6 percent in 2013 to 37.1 percent in 2015, or a 47.5 percent relative decrease in utilization.
- For Medicaid, all quality measures improved except intra-operative steroids, which decreased from 79.2 percent in 2014 to 71.3 percent in 2015, with the target being 80 percent.
- For AR BCBS, quality measures outcomes include improvement in intra-operative steroid use, from 67.0 percent in 2014 to 82.3 percent in 2015, with the target being 85 percent. Postoperative bleed rate was extremely low, with three reported cases out of 465 episodes in 2015.



Tonsillectomy Provider Cost Range Outcomes

Tonsillectomy episode cost outcomes for 2014 and 2015 are displayed in Tables 19 and 20 below.

Table 19: 2014 – 2015 Provider Cost Outcomes: Tonsillectomy (Medicaid)		
PAP Cost Range	2014 (45 PAPs)	2015 (45 PAPs)
Commendable	37 (82.2%)	43 (95.6%)
Acceptable	5 (11.1%)	1 (2.2%)
Non-acceptable	3 (6.7%)	1 (2.2%)

Table 20: 2014 – 2015 Provider Cost Outcomes: Tonsillectomy (AR BCBS)		
PAP Cost Range	2014 (25 PAPs)	2015 (25 PAPs)
Commendable	9 (36.0%)	11 (44.0%)
Acceptable	11 (44.0%)	11 (44.0%)
Non-acceptable	5 (20.0%)	3 (12.0%)

- For Medicaid, the most recent performance period gain-share totals include \$94,082.90 paid to 51 PAPs.
- For Medicaid, the most recent risk-share totals include \$24.50 to be collected from 1 PAP.
- For Medicaid, average adjusted episode cost was \$957.47 in 2014 and \$952.38 in 2015, for a decrease of 0.5 percent.
- For AR BCBS, average episode cost decreased by 5.2 percent from 2014 to 2015, after an increase of 17.5 percent from 2013 to 2014.

Upper Respiratory Infection (URI) Episode

Upper Respiratory Infection (URIs) is one of the most common illnesses suffered by Arkansans, leading to more doctor visits than any other ailment each year.¹⁵ These infections are typically unaffected by antibiotics, though antibiotics are routinely prescribed. Most URIs are viral infections that resolve themselves without antibiotic use within 10 days. Table 21 (right) lists URI episode volume for 2012-2015.

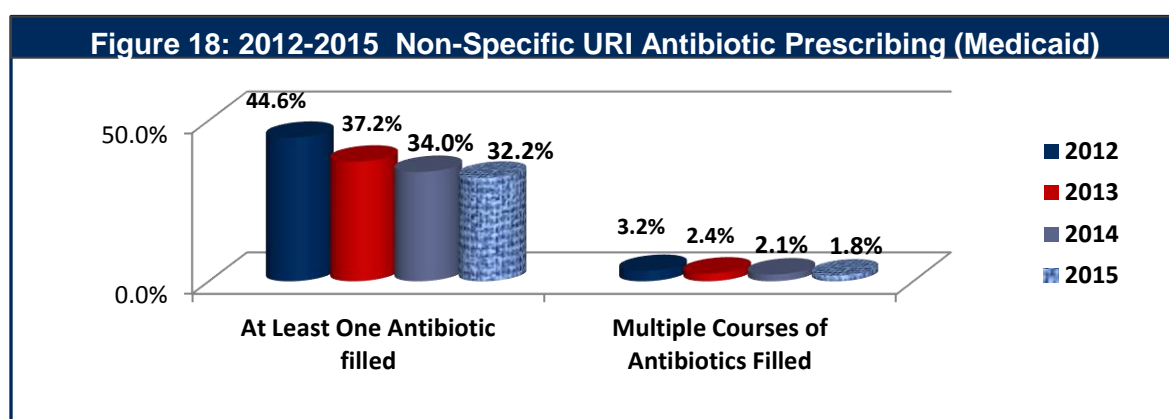
Table 21: URI Episode Volume (Medicaid)				
	2012	2013	2014	2015
Non-Specific	55,069	50,764	41,121	40,025
Pharyngitis	40,428	51,739	49,886	50,443
Sinusitis	22,696	22,643	19,928	20,633

This episode encourages efficient treatment and consultation with the physician, including follow-up appointments as well as urging physicians to better manage prescribing antibiotics. The URI episode includes three different types of URI—non-specific URI, sinusitis, and pharyngitis. Currently, Medicaid is the only payer participating in the URI episode.

URI Quality Outcomes

URI quality outcomes for 2012 through 2015 are displayed in Figure 18 below.

- All three of the URI (pharyngitis, sinusitis, and non-specified URI) episode metrics for antibiotic prescribing rates improved each year from the 2012 baseline to 2015 performance period.^{kk,ll}
- **Non-specific URI:** As displayed in the figure below, the antibiotic prescribing rate decreased from 44.6 percent of patients receiving antibiotic prescriptions in the baseline year to 32.2 percent in 2015, for a relative reduction of 27.8 percent. This decrease is an improvement toward the CDC recommendation that antibiotics should not be used to treat non-specific URIs, since antibiotics do not improve URI.¹⁶
- **Sinusitis URI:** The antibiotic prescribing rate has improved from 90.1 percent in the baseline year to 88.9 percent in the 2015 performance period.
- **Pharyngitis URI:** The antibiotic prescribing rate has improved from 72.8 percent in the baseline year to 68.9 percent in the 2015 performance year.



URI Provider Cost Range Outcomes

URI cost outcomes for 2014 and 2015 are displayed in Tables 22, 23, and 24 below.

Table 22: 2014 – 2015 Provider Cost Outcomes: URI Non-specific (Medicaid)		
PAP Cost Range	2014 (537 PAPs)	2015 (540 PAPs)
Commendable	108 (20.1%)	105 (19.4%)
Acceptable	331 (61.6%)	302 (55.9%)
Non-acceptable	98 (18.3)	133 (24.6%)

Table 23: 2014 – 2015 Provider Cost Outcomes: URI Pharyngitis (Medicaid)		
PAP Cost Range	2014 (601 PAPs)	2015 (601 PAPs)
Commendable	148 (24.6%)	124 (20.6%)
Acceptable	317 (52.8%)	317 (52.8%)
Non-acceptable	136 (22.6%)	160 (26.6%)

Table 24: 2014 – 2015 Provider Cost Outcomes: URI Sinusitis (Medicaid)		
PAP Cost Range	2014 (401 PAPs)	2015 (421 PAPs)
Commendable	221 (55.1%)	202 (48.0%)
Acceptable	120 (29.9%)	153 (36.3%)
Non-acceptable	60 (15.0%)	66 (15.7%)

^{kk} Medicaid's baseline period was 10/1/11 through 9/30/12, while the performance period (initial period for payment) was 10/1/12 through 9/30/13, 10/1/13 through 9/30/14. And 10/1/13 through 9/30/15.

^{ll} Having consistent start and end dates for baseline and performance effectively removes seasonality associated with URI rates.

- For Medicaid, the most recent performance period gain-share totals for all URI episodes include \$16,385.29 paid to 105 PAPs for Non-specific URI, \$6,108.94 paid to 49 PAPs for Pharyngitis, and \$42,261.61 paid to 202 PAPs for Sinusitis.
- For Medicaid, the most recent risk-share totals for all URI episodes include \$24,176.19 to be collected from 133 PAPs for Non-specific URI, \$78,256.41 to be collected from 160 PAPs for Pharyngitis, and \$8,179.75 to be collected from 66 PAPs for Sinusitis.
- For Medicaid, average adjusted episode cost for Non-specific URI was \$53.91 in 2014 and \$55.27 in 2015, for an increase of 2.5 percent. Average episode costs for Pharyngitis were \$72.63 in 2014 and \$74.26 in 2015, for an increase of 2.2 percent. Average episode costs for Sinusitis were \$67.89 in 2014 and \$69.80 in 2015, for an increase of 2.8 percent.

Attention Deficit Hyperactivity Disorder (ADHD) Episode

The American Psychiatric Association states in the *Diagnostic and Statistical Manual of Mental Disorders* that 5 percent of children have ADHD.¹⁷ The primary care clinician should initiate an evaluation for ADHD for any child four through 18 years of age who presents with academic or behavioral problems and symptoms of inattention, hyperactivity, or impulsivity.¹⁸ In 2011, Arkansas ranked 2nd nationally in parent-reported diagnoses of ADHD at 14.6 percent of children in the state.¹⁹ The episode includes all ADHD-related care provided during the 12-month duration of the episode, excluding initial assessment. This includes the full range of services provided (e.g., physician visits, psychosocial therapy) as well as all medication used to treat ADHD. If a patient continues treatment after the end of the initial 12-month episode, a new episode is triggered.

The ADHD episode consists of level 1 and level 2 patients. Level 1 patients who do not respond adequately to medication and other primary treatments will begin a level 2 episode once their provider certifies the severity and rationale for level 2 designation. ADHD is only being implemented by Medicaid at this time. Table 25 (right) lists the ADHD episode volume for 2013-2015.

Table 25: ADHD Episode Volume (Medicaid)

	2013	2014	2015
Level 1	3,046	3,529	4,329
Level 2	2	101	97

ADHD Level 1 Quality Outcomes

ADHD level 1 episode quality outcomes for 2013 through 2015 are displayed in Figures 19 (below) and 20 (next page).

- For ADHD level 1 episodes, the average number of behavioral therapy visits per episode has continued to improve, from 3.3 visits per episode in 2013 to 1.2 visits per episode in 2014, to 0.5 percent in 2015. The rate of episodes with non-guideline concordant care with no rationale improved from 4.5 percent in 2014 to 2.7 percent in 2015.

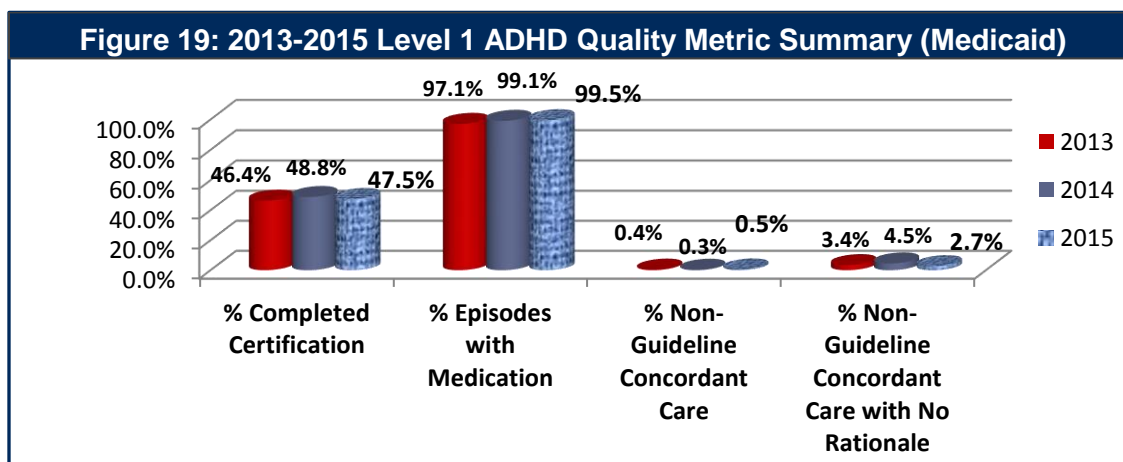
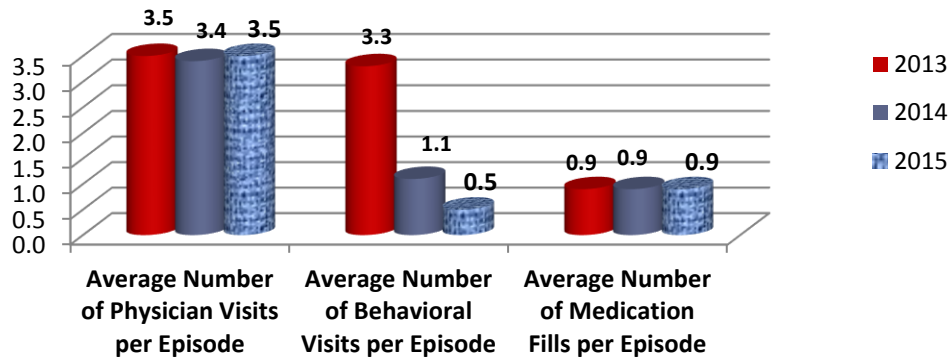


Figure 20: 2013-2015 Level 1 ADHD Utilization Summary (Medicaid)



ADHD Level 2 Quality Outcomes

ADHD level 2 episode outcomes for 2013 through 2015 are displayed in Figures 21 and 22 below.

- The rate of episodes with completed certification improved from 50 percent in 2013 to 60.8 percent in 2015. The average number of physician visits increased from 2.9 to 3.5 per episode from 2014 to 2015. The average number of behavioral visits per episode also increased from 3.7 to 5.2 from 2014 to 2015.

Figure 21: 2013-2015 Level 2 ADHD Quality Metric Summary (Medicaid)

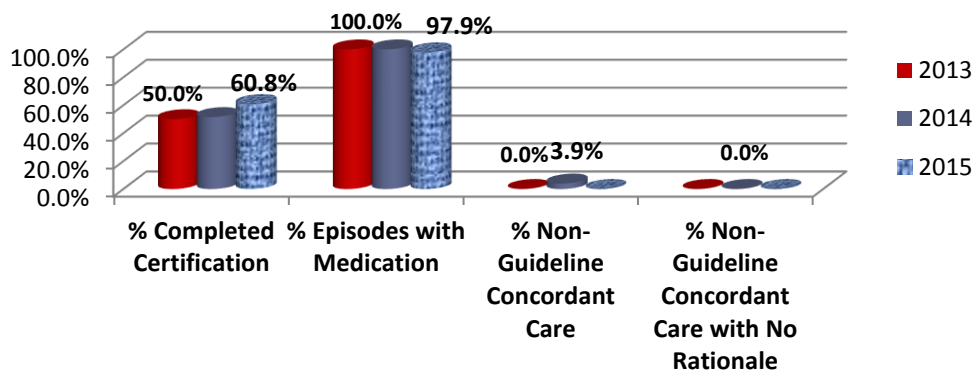
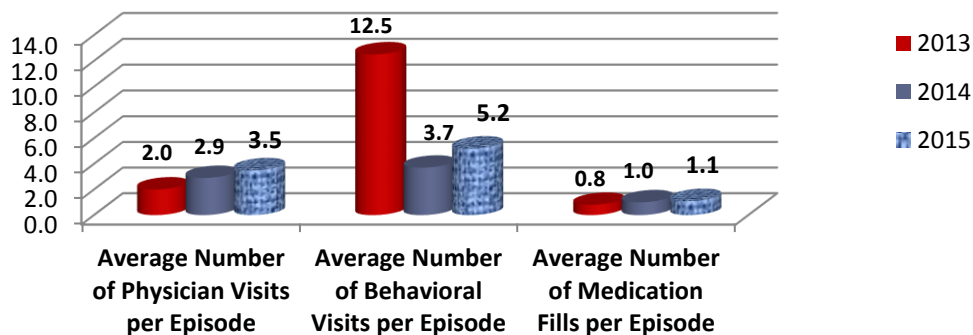


Figure 22: 2013-2015 Level 2 ADHD Utilization Summary (Medicaid)



ADHD Provider Cost Range Outcomes

ADHD level 1 cost outcomes for 2014 and 2015 are displayed in Table 26 below.

Table 26: 2014 – 2015 Provider Cost Outcomes: ADHD Level 1 (Medicaid)		
PAP Cost Range	2014 (170 PAPs)	2015 (182 PAPs)
Commendable	119 (70.0%)	129 (70.9%)
Acceptable	41 (24.1%)	47 (25.8%)
Non-acceptable	10 (5.9%)	6 (3.3%)

- For ADHD level 2, there were 6 PAPs in 2014 and 4 PAPs in 2015. All PAP average episode costs were in the commendable range for both years.
- For Medicaid, the most recent performance period gain-share totals include \$77,343.24 paid to 19 PAPs for ADHD level 1, and \$41,591.05 paid to 3 PAPs for level 2 ADHD.
- For Medicaid, the most recent risk-share totals include \$10,841.08 to be collected from 5 PAPs, and for level 2 ADHD no PAPs experience risk-sharing.
- For Medicaid, average adjusted episode cost for level 1 ADHD was \$1,529.58 in 2014 and \$1,463.42 in 2015, for a decrease of 4.3 percent. Average episode cost for level 2 ADHD was \$2,089.06 in 2014 and \$2,064.02 in 2015, for a decrease of 1.2 percent.

Coronary Artery Bypass Grafting Episode

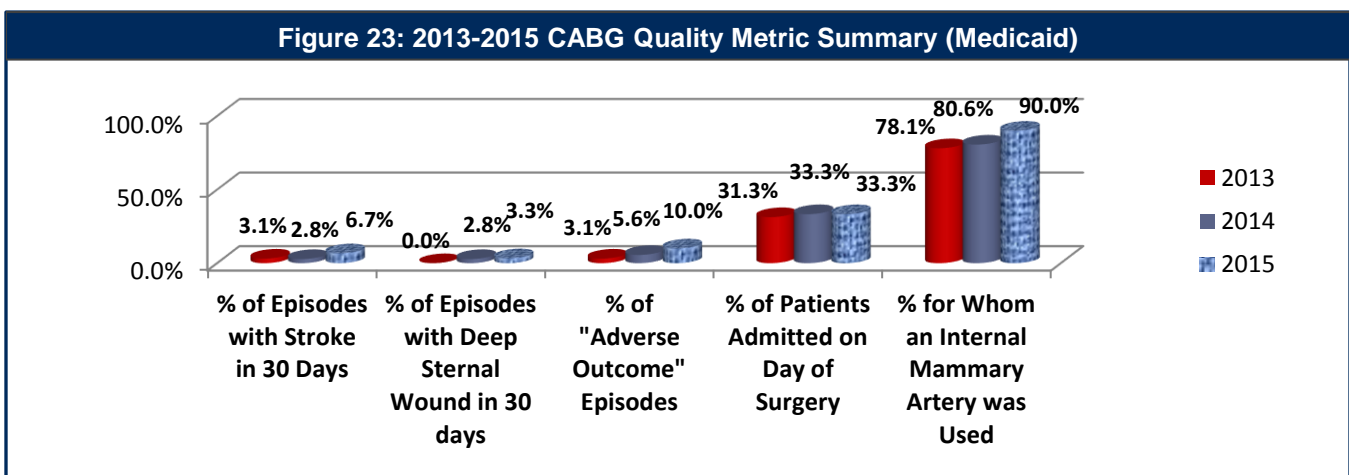
Coronary artery bypass graft (CABG) is the re-routing of blood vessels in the heart around blockages using arteries or veins from other parts of the body. It is an open-chest surgery and is performed when less invasive methods are not sufficient to restore blood flow through the blocked vessels. CABG episodes begin on the first day of the procedure and end 30-days after discharge from the facility in which the procedure occurred, or at the end of a readmission where the patient entered the hospital within the 30 day post-discharge period. All inpatient, outpatient, professional, and pharmacy services related to the CABG, delivered within the episode timeframe are included in the episode. AR BCBS and Medicaid participate in the CABG episode. Table 27 (right) lists the CABG episode volume for 2013-2015.

Table 27: CABG Episode Volume			
	2013	2014	2015
Medicaid	32	36	30
AR BCBS	NA	170	142
ASE/PSE	NA	42	43

CABG Quality Outcomes

CABG quality metric outcomes for 2013-2015 are displayed in Figure 23 (below).

- For Medicaid CABG episodes, inpatient length of stay increased from 1.6 days to 2.8 days on average.
- For Medicaid, the proportion of CABG episodes with an adverse outcome, including stroke and/or deep sternal wound within 30 days, was increased from 5.6 percent in 2014 to 10 percent in 2015.
- For AR BCBS CABG episodes, inpatient length of stay decreased from 1.6 days to 1.4 days on average.
- For AR BCBS CABG episodes, the rate of patients admitted to the facility on the day of the procedure increased from 39.4 percent in 2014 to 44.4 percent in 2015.



CABG Provider Cost Range Outcomes

CABG cost outcomes for 2014 and 2015 are displayed in Table 28.

Table 28: 2014 – 2015 Provider Cost Outcomes: CABG (AR BCBS)		
PAP Cost Range	2014 (8 PAPs)	2015 (8 PAPs)
Commendable	2 (25.0%)	3 (37.5%)
Acceptable	6 (75.0%)	3 (37.5%)
Non-acceptable	0	2 (25.0%)

- For Medicaid CABG episodes there was one PAP in 2014 and 2015, for which average episode costs were in the acceptable range each year.
- For Medicaid, average adjusted episode cost was \$9,839.91 in 2014 and \$9,916.39 in 2015, for an increase of 0.8 percent.
- For AR BCBS, average CABG episode cost increased by 2.8 percent from 2014 to 2015.

Chronic Obstructive Pulmonary Disease (COPD) Episode

COPD is the name for a group of diseases that restrict air flow and cause trouble breathing. COPD includes emphysema and chronic bronchitis. Chronic lower respiratory disease, including COPD, is the third leading cause of death in the United States. COPD typically affects individuals age 45 and older. About 7.9 percent of Arkansas residents surveyed in 2011 reported having been told by a health care professional that they have COPD.²⁰ Quality metrics include percentage of episodes where patient visits outpatient physician within 30 days post initial discharge (minimum threshold is 36 percent) and the rate of repeat acute exacerbation within 30 days post initial hospital discharge. Medicaid and AR BCBS participate in the COPD episode. Table 29 (right) lists the COPD episode volume for 2014-2015.

Table 29: COPD Episode Volume		
	2014	2015
Medicaid	990	924
AR BCBS	296	334
ASE/PSE	58	57

COPD Quality Outcomes

- For Medicaid, the rate of follow up with a physician increased from 31.8 percent in 2014 to 59.6 percent in 2015, for a relative increase of 87.4 percent.
- For Medicaid, the rate of acute exacerbation within 30 days slightly worsened from 16.9 percent in 2014 to 20.7 percent in 2015.
- For AR BCBS, the rate of follow up with a physician within 30 days decreased from 62.2 percent in 2014 to 60.2 percent in 2015.

COPD Provider Cost Range Outcomes

COPD cost outcomes for 2014 and 2015 are displayed in Tables 30 and 31.

Table 30: 2014 – 2015 Provider Cost Outcomes: COPD (Medicaid)		
PAP Cost Range	2014 (56 PAPs)	2015 (61 PAPs)
Commendable	29 (51.8%)	42 (68.9%)
Acceptable	17 (30.4%)	13 (21.3%)
Non-acceptable	10 (17.9%)	6 (9.8%)

Table 31: 2014 – 2015 Provider Cost Outcomes: COPD (AR BCBS)		
PAP Cost Range	2014 (19 PAPs)	2015 (19 PAPs)
Commendable	5 (26.3%)	4 (21.1%)
Acceptable	13 (68.4%)	10 (52.6%)
Non-acceptable	1 (5.3%)	5 (26.3%)

- For Medicaid, the most recent performance period gain-share totals include \$131,322.29 paid to 37 PAPs.
- For Medicaid, the most recent risk-share totals include \$20,328.31 to be collected from 6 PAPs.
- For Medicaid, average adjusted episode cost was \$1,355.29 in 2014 and \$1,241.81 in 2015, for a decrease of 8.4 percent.
- For AR BCBS, average COPD episode cost increased by 7.7 percent from 2014 to 2015.

Asthma Episode

Asthma is a chronic lung condition which causes inflamed, narrow airways. Often diagnosed in childhood, asthma is characterized by difficulty breathing, wheezing, chest tightness, and shortness of breath. Asthma is part of a group of diseases (called chronic lower respiratory diseases) that caused the third highest number of deaths in Arkansas in 2010.²¹ In 2014 the prevalence of asthma among adults in Arkansas was 8.8 percent, compared to 7.4 percent nationally. Nationally in 2014 the prevalence of asthma among children was 8.6 percent.²² AR BCBS and Medicaid participate in the asthma episode. Table 32 (right) lists the asthma episode volume for 2014-2016.

Table 32: Asthma Episode Volume

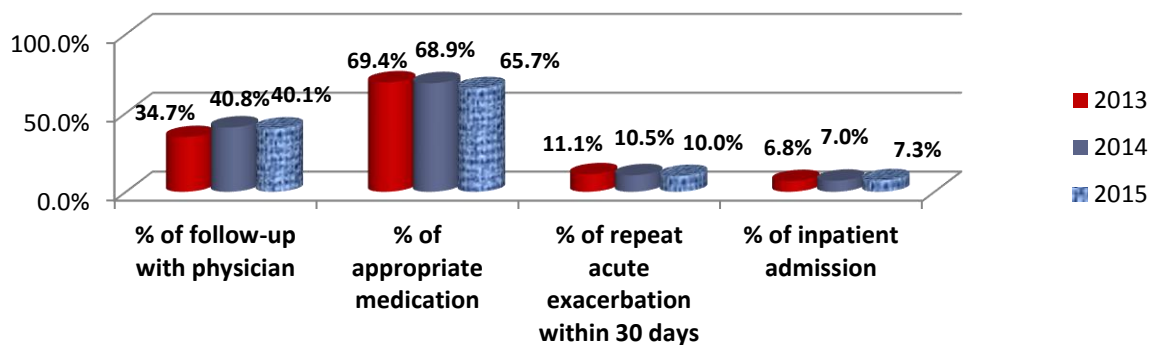
	2014	2015	2016
Medicaid	2,981	3,183	2,868
AR BCBS	1,267	1,097	NA
ASE/PSE	396	318	NA

Asthma Quality Outcomes

Asthma quality metric outcomes for 2013 through 2015 are displayed in Figure 24 below.

- For Medicaid, the rate of episodes with appropriate medication decreased from 68.9 percent to 65.7 percent from 2014 to 2015.
- For Medicaid, the average length of stay remained nearly unchanged, at 0.11 percent in 2014 and 0.12 percent in 2015.
- For AR BCBS, the rate of acute exacerbation within 30 days after initial discharge was reduced from 100 percent of episodes in 2014 to 33.5 percent in 2016.
- For AR BCBS, the rate of PAPS passing the quality metric for payment was 48.5 percent in 2015, up from 47 percent in 2014.^{mm}

Figure 24: 2013-2015 Asthma Quality Metric Summary (Medicaid)



Asthma Provider Cost Range Outcomes

Asthma episode cost outcomes for 2014 and 2015 are displayed in Tables 33 and 34 below.

Table 33: 2014 – 2015 Provider Cost Outcomes: Asthma (Medicaid)		
PAP Cost Range	2014 (72 PAPs)	2015 (72 PAPs)
Commendable	36 (50.0%)	33 (47.1%)
Acceptable	27 (37.5%)	31 (44.3%)
Non-acceptable	9 (12.5%)	6 (8.6%)

Table 34: 2014 – 2015 Provider Cost Outcomes: Asthma (AR BCBS)		
PAP Cost Range	2014 (40 PAPs)	2015 (40 PAPs)
Commendable	1 (2.5%)	2 (5.0%)
Acceptable	30 (75.0%)	24 (60.0%)
Non-acceptable	9 (22.5%)	14 (35.0%)

^{mm} AR BCBS defines passing metric for payment as PAPS with both a corticosteroid prescription rate AND follow-up visit rate of 50% or greater.

- For Medicaid, the most recent performance period gain-share totals include \$4,588.98 paid to 9 PAPs.
- For Medicaid, the most recent risk-share totals include \$25,186.23 to be collected from 6 PAPs.
- For Medicaid, average adjusted episode cost was \$482.57 in 2014 and \$489.81 in 2015, for an increase of 1.5 percent.
- For AR BCBS, average episode cost for asthma increased by 13 percent from 2014 to 2015.

Oppositional Defiant Disorder (ODD)

ODD typically affects children beginning before age 12. While most children are defiant or oppositional occasionally, children with ODD are more likely to act oppositional or defiant around parents, a regular care provider, friends or teachers to the point of interfering in regular day to day functions. Treatment may include cognitive behavioral therapy and medication may be helpful in some cases.²³ Arkansas Medicaid participates in the ODD episode. Quality metrics include rate of episodes with completion of either Continuing Care or Quality Assessment certification (minimum threshold of 90 percent), rate of new episodes for beneficiaries in which behavioral health medications were received (must be less than 20 percent), percentage of repeat for which the beneficiary received medications (must be equal to 0 percent), percentage of episodes resulting in remission (minimum threshold of 40 percent). Medicaid is currently the only payer participating in the ODD episode. Table 35 (right) lists the ODD episode volume for 2014-2015.

Table 35: ODD Episode Volume

	2014	2015
Medicaid	2,981	3,183

ODD Quality Outcomes

ODD episode quality outcomes for 2014 and 2015 are displayed in Table 36 below.

- For Medicaid, several ODD quality measures showed improvements from 2014 to 2015 including the rate of episodes with remission which was increased from 28.2 percent to 50.6 percent, and the rate of repeat episodes with medication, which was reduced from 29.2 percent to 19.5 percent.

Table 36: 2014 – 2015 ODD Quality Metric Summary (Medicaid)

% Episodes with remission (base on episodes with 180 day run out)	28.2%	50.6%
% Episodes with >7 family visits	2.5%	2.8%
% Episodes with >9 family visits	99.6%	99.6%
% New episodes with medication	30.8%	38.1%
% Non-guideline concordant	N/A	9.1%
% Repeat episodes with medication	29.2%	19.5%
% With completed certification	0.02%	1.7%
Average number of behavioral visits per episode	20.7	20.1
Average number of family therapy visits per episode	1.7	1.8

ODD Provider Cost Range Outcomes

ODD cost outcomes for 2014 and 2015 are displayed in Table 37 below.

Table 37: 2014 – 2015 Provider Cost Outcomes: ODD (Medicaid)

PAP Cost Range	2014 (123 PAPs)	2015 (66 PAPs)
Commendable	28 (22.8%)	22 (33.3%)
Acceptable	61 (49.6%)	34 (51.5%)
Non-acceptable	34 (27.6%)	10 (15.2%)

- For Medicaid, no PAPs achieved gain-sharing for the most recent performance period.
- For Medicaid, the most recent risk-share totals include \$40,431.12 to be collected from 9 PAPs.
- For Medicaid, average adjusted episode cost was \$2,363.73 in 2014 and \$2,265.93 in 2015, for a decrease of 4.1 percent.

Percutaneous Coronary Intervention (PCI)

Percutaneous coronary intervention (PCI), also known as coronary angioplasty, is a nonsurgical procedure that improves blood flow to your heart. Doctors use PCI to open coronary arteries that are narrowed or blocked by the buildup of atherosclerotic plaque. PCI may be used to relieve symptoms of coronary heart disease or to reduce heart damage during or after a heart attack²⁴. Quality metrics include having greater than or equal to 95 percent of episodes not flagged for adverse outcomes, and the proportion of patients with any adverse outcomes. Adverse outcomes include myocardial infarction, stroke, stent thrombosis, AV fistula, pulmonary embolism, and wound infection. AR BCBS participates in the PCI episode. Table 38 (right) lists the PCI episode volume for 2014-2015.

Table 38: PCI Episode Volume		
	2014	2015
AR BCBS	748	608
ASE/PSE	210	159

PCI Quality Outcomes

- Currently AR BCBS is the only payer participating in the PCI episode.
- For 2015, the rate of PAPs passing the metric of having greater than or equal to 95 percent of episodes not flagged for adverse outcomes was 98 percent.
- The proportion of patients with any adverse outcomes was 2.5 percent in 2014 and 3.9 percent in 2015.

PCI Provider Cost Range Outcomes

PCI episode cost outcomes for 2014 and 2015 are displayed in Table 39 below.

Table 39: 2014 – 2015 Provider Cost Outcomes: PCI (AR BCBS)		
PAP Cost Range	2014 (39 PAPs)	2015 (39 PAPs)
Commendable	21 (53.8%)	25 (64.1%)
Acceptable	7 (17.9%)	12 (30.8%)
Non-acceptable	5 (12.8%)	2 (5.1%)

- For AR BCBS, average episode cost for PCI increased by 8.6 percent from 2014 to 2015.

Additional Episodes

Additional episodes deployed or under development are increasing the proportion of surgical, specialty, or intensive care under value-based purchasing strategies. Medicaid and AR BCBS are exploring development of additional episodes including appendectomy, pediatric pneumonia, hysterectomy, and urinary tract infection (when an ER visit is involved). Medicaid has agreed not to develop any more episodes, such as URI, where a primary care provider will serve as the principal accountable provider. This is because the state's PCMH model is designed to support higher-quality and efficient care for the bulk of care delivered by primary care providers. Experience from episode analysis is aiding in the creation of chronic disease profiles which can be used by PCMHs in coordinating care for high risk patients as they pursue per member, per year cost curve management.

The consistent definition of the episode, identification of the PAP, and articulation of quality expectations across payers will continue to reinforce and support the desired reduction in variability in utilization, outcomes, and costs. Quarterly reports for each PAP will continue to inform and identify areas of threat to quality and practice variation. Table 40 on the next page displays episodes that are either deployed or in development across participating payers.

Table 40: Episodes Deployed, In Development, or Under Review for Potential Development

Episode	Payer Participation	Performance Period Start Date
Upper Respiratory Infection (URI)	Medicaid	July 2012
Attention Deficit Hyperactivity Disorder (ADHD)	Medicaid	July 2012
Perinatal	Medicaid, AR BCBS, QC	July 2012: Medicaid January 2013: AR BCBS January 2014: QC
Congestive Heart Failure (CHF)	Medicaid, AR BCBS	October 2012: Medicaid January 2013: AR BCBS
Total Joint Replacement (TJR)	Medicaid, AR BCBS, QC	October 2012: Medicaid January 2013: AR BCBS January 2014: QC
Cholecystectomy (Gall Bladder Removal)	Medicaid, AR BCBS, QC	July 2013: Medicaid January 2014: AR BCBS, QC
Colonoscopy	Medicaid, AR BCBS,	July 2013: Medicaid January 2014: AR BCBS
Tonsillectomy	Medicaid, AR BCBS	July 2013: Medicaid January 2014: AR BCBS
Oppositional Defiant Disorder (ODD)	Medicaid	October 2013
Coronary Artery Bypass Grafting (CABG)	Medicaid, AR BCBS	January 2014: Medicaid January 2015: AR BCBS
Asthma	Medicaid, AR BCBS	April 2014: Medicaid January 2015: AR BCBS
Chronic Obstructive Pulmonary Disease (COPD)	Medicaid, AR BCBS	October 2014: Medicaid January 2015: AR BCBS
Percutaneous Coronary Intervention (PCI)	Medicaid, AR BCBS, QC	July 2015: Medicaid January 2015: AR BCBS
ADHD/ODD Comorbidity	Medicaid	TBD
Neonatal	Medicaid	TBD
Appendectomy	Medicaid	TBD
Urinary Tract Infection	Medicaid	TBD
Hysterectomy	Medicaid, AR BCBS	TBD
Pneumonia	Medicaid (Pediatric), AR BCBS (Adult)	TBD
Non-cervical Spinal Fusion	AR BCBS, QC	TBD

Conclusion

Now in its fifth year of implementation, the AHCPII has demonstrated statewide improvements in quality and cost containment, while positioning Arkansas as a national leader in shifting a majority of care to value-based models. Multi-payer participation has been more fully realized and in turn has increased provider incentives and bolstered participation. The total transformation of Arkansas's health system will be strengthened if every payer in the state, including Medicare, joins in and continues to operate under the AHCPII. As more providers join the PCMH program, and more care is delivered under value-based strategies, patients, providers, and payers all stand to benefit. Updated information on the AHCPII progress can be found at www.paymentinitiative.org. Subsequent annual statewide tracking reports will capture future system impacts, including more detailed information on PCMHs, episodes of care, and other applicable value-based models.

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