ARKANSAS HEALTH CARE PAYMENT IMPROVEMENT INITIATIVE

4th Annual Statewide Tracking Report

August 2019

Participating payers and partners:

Prepared by:

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This AHCPII Statewide Tracking Report is the fourth annual report on the progress of the state's system transformation effort. Information contained in this report represents aggregate results provided by individual payers for descriptive purposes.

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INTRODUCTION

With more than seven 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 healthcare 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 has improved the value of healthcare payments in the state through deployment of two primary strategies: 1) 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. 2) A retrospective episodes of care model, designed to improve quality and reduce variation in treatment of acute conditions and delivery of specialty procedures.

Highlights and Updates From AHCPII Contained in This Report

- A majority of the state's primary care providers in more than 200 practices are now participating in a PCMH program and/or the Comprehensive Primary Care Plus (CPC+) Initiative, serving upwards of three-quarters of a million patients.
- Seventy-five percent of PCMH quality metrics improved or maintained prior year levels for Medicaid, and nearly two-thirds of Arkansas Blue Cross and Blue Shield (AR BCBS) quality metrics for PCMH were met overall.
- The vast majority of PCMH providers have achieved sustained practice transformation activities designed to improve access, care management, and overall quality and efficiency.
- Data and reporting infrastructure improvements include a large number of providers using the State Health Alliance for Records Exchange (SHARE), and new "Medical Neighborhood" reporting.
- Targeted quality improvement and cost containment has been achieved within the episodes of care payment program.

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 to optimize coordination of services for higher-need 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 has now implemented the Provider-led Arkansas Shared Savings Entity (PASSE) Program to better serve these individuals.[b]

[a] What is the Health Care Payment Learning & Action Network? Retrieved from https://hcp-lan.org/
[b] PASSE - Provider-Led Arkansas Shared Savings Entity. Retrieved from https://humanservices.arkansas.gov/about-dhs/dms/passe

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

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 (CPC) Initiative. 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.

Arkansas was selected as one of 14 regions to participate in the Comprehensive Primary Care Plus (CPC+) initiative beginning in 2017, 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 to gather content for development of this report, designed to track progress and to help identify challenges and lessons learned.

CONTINUED MULTI-PAYER ALIGNMENT FOR ENHANCED PROVIDER REPORTING

Arkansas payers continue to work together to align on quality measurement and to support enhanced provider reporting tools

- Arkansas's efforts are unique in that the largest payers in the state, both public and private, have invested significant resources in an advanced support provider reports in an effort to improve care delivery throughout the state.
- 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
- For Medicaid, approximately 3.8 billion medical claims have been processed through the analytic engines for both the PCMH and episodes of care programs.
- Since 2012, for Arkansas Medicaid, 55,653 Principal Accountable Provider (PAP) reports have been produced through the October 2018 reporting period, with 6.6 million episodes triggered.
- 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.

ARKANSAS'S PATIENT-CENTERED MEDICAL HOME PROGRAM

Updates on 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 success in key areas. Launched in 2014 and now in its sixth 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. Provider enrollment in the program is voluntary and has increased each year.

The Medicaid PCMH results provided in this report are for beneficiaries who are managed by Arkansas Medicaid and do not include results for beneficiaries covered under a commercial qualified health plan (QHP). Results from private payer experiences are also included and additional private payer PCMH outcomes are anticipated to be available in future updates.

ARKANSAS MEDICAID PCMH UPDATES FOR 2019

Over the last five years, the Arkansas Medicaid PCMH program has been a popular initiative that has supported the transformation of primary care to a more patient-centered, population health model. Coupled with financial support from Medicare's CPC+ and participation by several private payers in the state, PCMH has supplied badly needed financial resources to rebuild and redesign primary care throughout the state. The Medicaid PCMH program has the active engagement of nearly 200 practice sites and more than 900 primary care physicians.

One of the key early features of the program was a strong financial incentive to manage total cost of care of a patient panel in the context of achieving targets on several quality of care metrics. Many practices have received large bonus checks for managing radiology use, emergency room utilization, hospital admissions, and other aspects of chronic disease management. Over time, the total cost of care methodology has proven difficult to sustain in a fair and reliable manner. Escalating pharmacy costs, changes to reimbursement for ambulatory surgery, continual coverage transitions within the Medicaid population, creation of the PASSE program, and implementation of a new DHS medical information system have led to time consuming difficulties in editing and sustaining a fair and consistent measurement of the total cost of care for an enrolled PCMH.

2019 Medicaid PCMH Features and Opportunities

- Practices must have 150 attributed beneficiaries to enroll.
- Shared Performance Entity minimum beneficiary threshold is 1,000 (down from previous minimum of 5,000).
- Core Metric: Minimal performance on a core metric; for 2019, infant wellness is the core metric.
- Performance-Based Incentive Payments based on select measures, including: inpatient admission rates, emergency department rates, and a focus metric (for 2019, adolescent wellness is focus metric).

As a result, after consultation with PCMH participants and DHS leadership, Medicaid will make significant changes to the PCMH incentive program for 2019. Enrolled PCMH sites will still be expected to meet specified activity requirements such as care plans for high-risk patients to qualify for per member per month practice support. Passing a basket of quality metrics to qualify for financial incentive bonuses will also remain a core feature of the program. Performance based incentive payments (PBIB) will now

[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.

focus on surrogate measures of total cost of care: risk-adjusted admission rates and emergency room utilization by a practice's patient panel. In addition, there will be a focus quality measure — wellness visit rates for adolescents for which high performing practices will receive incentive payments. Total incentive money available will be equal to if not greater than past payments to high performing participants. Moreover, practices can receive incentives for achievement on each of three measures and not just a single total cost of care calculation.

Highest performing practices will get the greatest rewards with a tiered bonus structure for practices in the upper 35 percent of achievement of each designated metric. By continuing to focus on targeted quality metrics and utilization, including rates of inpatient hospitalizations and ER use, providers are incentivized to improve quality and reduce unnecessary utilization.

This new format also reduces actuarial complexity of the program. In the past, PCMH required a practice or a pool of clinics to maintain a panel of at least 5,000 patients to assure statistical validity of total cost of care calculations. The change to the new incentive metrics will allow sites to qualify for these payments with only 1,000 patients on their panel. In addition, Medicaid has lowered the minimum panel size for a practice to participate in the program from 300 patients to 150.

The Medicaid PCMH program continues to evolve in partnership with commercial payers in the state. The support and engagement by the provider community has been a major strength of the effort. In the future, it is anticipated that a stronger health information exchange (HIE) capacity will facilitate reliable clinical from electronic medical records to produce even more robust and timely information to practice sites. PCMH has become a sustaining force for Arkansas primary care and better health experiences for the patients in our communities.

Arkansas PCMH Program Enrollment for Medicaid and Private Payers

MEDICAID PCMH ENROLLMENT

For Arkansas Medicaid, enrollment in the PCMH program has steadily increased since 2014, with more practices enrolled and more beneficiaries served each year. Table 1 displays the number of eligible practices, primary care providers (PCPs), and beneficiaries enrolled from 2014 through 2018.

Table 1: Arkansas Medicaid Patient PCMH Enrollment

Year	Practices			PCPs			Beneficiaries		
	Enrolled	Total	% Enrolled	Enrolled	Total	% Enrolled	Enrolled	Total	% Enrolled
2014	123	259	47%	659	1,074	61%	295K	386K	76%
2015	142	250	57%	780	1,074	73%	317K	386K	80%
2016	179	250	72%	878	1,010	87%	330K	414K	80%
2017	192	252	76%	928	1,068	87%	356K	420K	85%
2018	207	257	81%	943	1,101	86%	349K	405K	86%

ENROLLMENT FOR COMMERCIAL CARRIERS[d]

- AR BCBS: For 2018, 124,000 beneficiaries 169 practices, 519 PCPs
- QualChoice: For 2018, 43,000 beneficiaries, 114 practices
- Centene / Ambetter: 16,000 beneficiaries, 237 practices, 606 PCPs

ENROLLMENT FOR SELF-INSURED PAYERS:

Self-insured payers are also participating in the program, with an anticipated increase in 2017 and beyond. Self-insured participants include Walmart, the Arkansas State and Public Schools employees plans (AR Benefits), the federal employees plan, Baptist Health employees plan, Arkansas Blue Cross and Blue Shield employees plan, and HealthSCOPE, which represents several self-insured employers.

COMPREHENSIVE PRIMARY CARE PLUS PROGRAM ENROLLMENT AND INVESTMENT IN ARKANSAS

The CPC+ program is the largest national program of its kind designed to support primary care. Arkansas providers have received and continue to receive significant additional financial support as a result of the CPC+ program. Arkansas's own public and private payers are participating in CPC+ and continue to support practices under this program.

- For 2017 in CPC+, 181 practices, and 169,000 Medicare beneficiaries participated[e]
- For 2017-2018, $90 million in CPC+ payments were made to Arkansas providers, including care management fees, prospective performance based incentive payments, and comprehensive primary care payments[f]

[d] Commercial carrier information provided by individual carriers as of December 2018, with the exception of Centene Ambetter which was provided in May 2016.
[e] Medicare CPC+ Beneficiary enrollment totals and other information can be found at: https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus
[f] https://innovation.cms.gov/Files/reports/CPC+2017-Medicare-Payment-Summary.pdf , https://innovation.cms.gov/Files/reports/cpc+2018-medicare-payment-summary.pdf

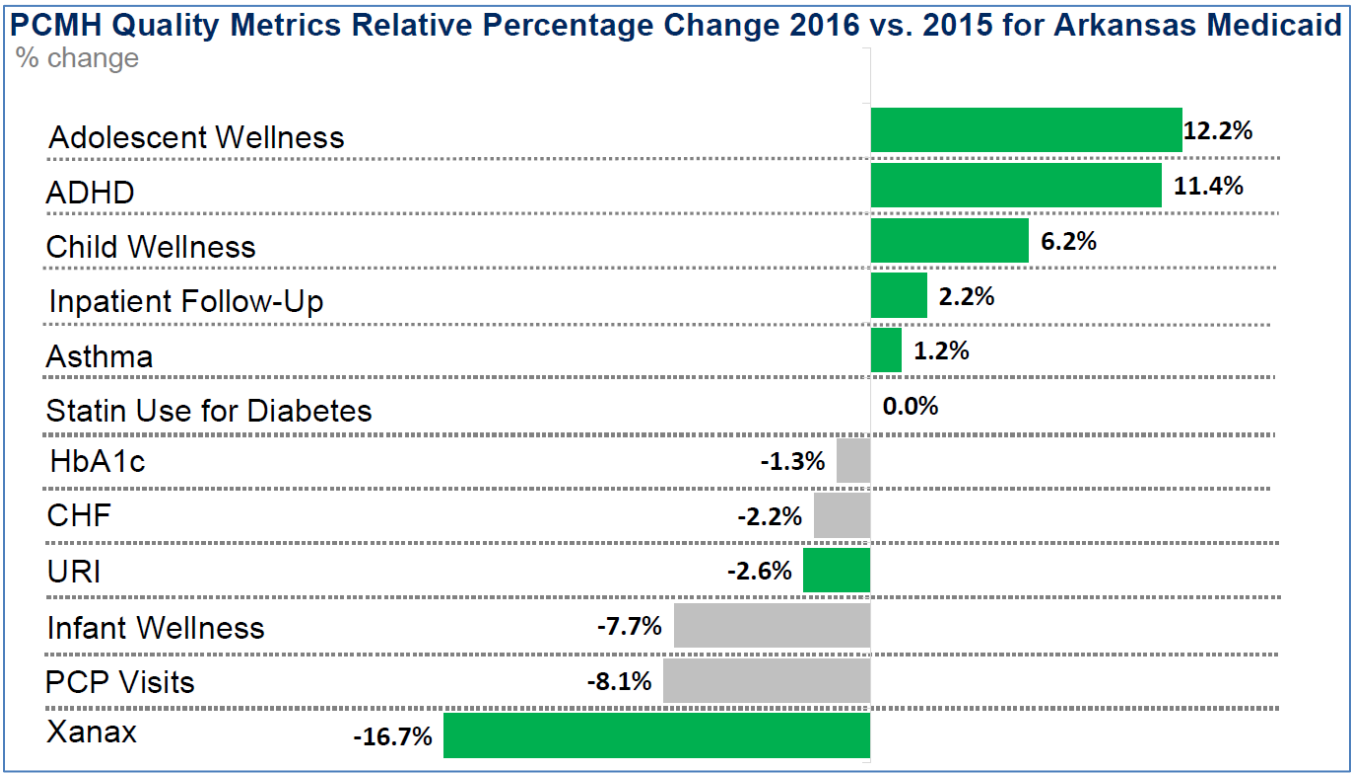
PCMH Quality Measure Outcomes

ARKANSAS MEDICAID

Arkansas's PCMH program includes quality measures that are generally aligned across public and private payers. Because of programmatic timelines and other factors, quality measure outcomes are currently available for Arkansas Medicaid and AR BCBS.

Figures 1a and 1b display the change in percentage for PCMH quality metrics. Green bars represent performance improvement over prior year levels. For Medicaid, the majority of quality measures either improved or maintained prior-year levels,[g] including adolescent and child wellness, ADHD management, asthma management, statin therapy for patients with diabetes, antibiotic use for upper respiratory infection (URI), and chronic Xanax use. After increasing from 2013 to 2014, there were slight reductions in child and adolescent wellness visits for 2015. The URI measure and chronic Xanax use measure are inverse metrics, therefore lower rates indicate better performance.

Figure 1a: Arkansas Medicaid PCMH Quality Metrics for 2016 Performance[h]

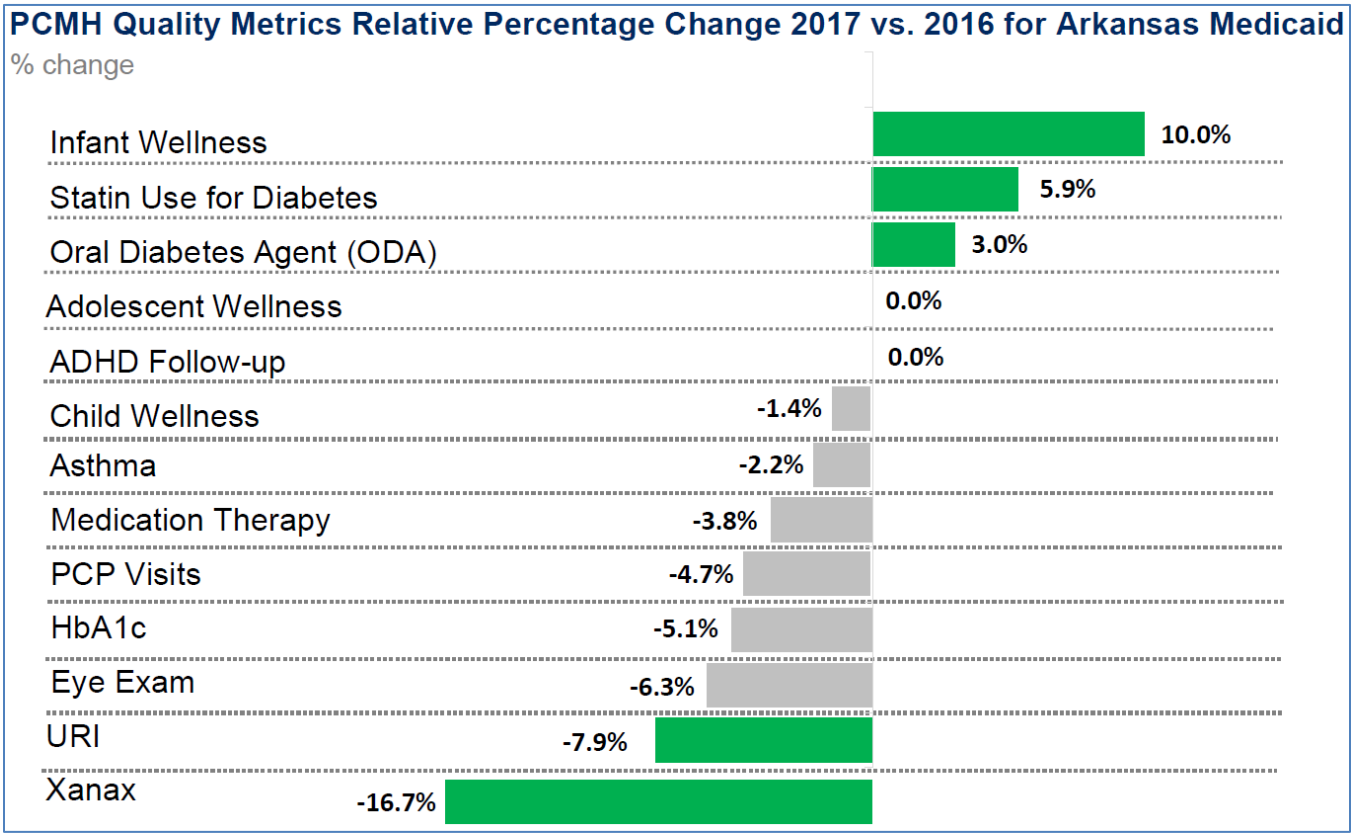


- From 2015 through 2018, the vast majority of practices have met transformation milestones.[i]
- In 2016 and 2017, the majority of PCMH quality metrics improved or maintained prior year levels, including adolescent and child wellness, ADHD management, asthma management, statin therapy for patients with diabetes, antibiotic use for URI, and chronic Xanax use.

[g] Information provided by Arkansas DHS in December 2018. Source: Q1 2017 (CY2015 performance period) and Q3 2018 (CY2016 performance period) reports. Detailed PCMH metric descriptions are available at www.paymentinitiative.org.
[h] Source: Q3 2017 (CY2015 performance period) and Q3 2018 (CY2016 performance period) reports. Detailed metric descriptions are available at www.paymentinitiative.org
[i] Arkansas Medicaid PCMH measures and program details: https://www.paymentinitiative.org/Websites/paymentinitiative/images/2016-2017%20PCMH%20Manual.pdf

- In 2016 and 2017, reductions in quality metrics for some indicators were observed, warranting continued observation.
- In 2016, infant wellness visits and PCP visits experienced relative decreases of 7.7 percent, and 8.1 percent, respectively.
- In 2017, HbA1c Screenings and eye exams experienced relative decreases of 5.1 percent, and 6.3 percent, respectively.

Figure 1b: Arkansas Medicaid PCMH Quality Metrics for 2017 Performance[i]



[i] Source: Q4 2017 (CY2016 performance period) and Q4 2018 (CY2017 performance period) reports. Detailed metric descriptions are available at www.paymentinitiative.org

PCMH QUALITY MEASURE OUTCOMES FOR PRIVATE PAYERS

Quality measure outcomes for private and self-funded payers are currently available for AR BCBS. Measures listed below include those tracked for 2016; additional quality measure outcomes[k] are anticipated in future updates.

Table 2: AR BCBS PCMH Quality Measure Outcomes

AR BCBS PCMH Quality Measure	2016 Measure Target	AR BCBS 2016 Aggregate Performance	Percentage of AR BCBS PCMHs Meeting Target
Percentage of patients who turned 15 months old during the performance period and who received at least four wellness visits in their first 15 months	At least 70%	94%	89%
Percentage of patients 3-6 years old who had one or more well-child visits during the measurement year	At least 67%	72%	38%
Percentage of patients 12-21 years old who had one or more well-care visits during measurement year	At least 45%	43%	22%
Percentage of patients 6-12 years old with an Ambulatory prescription dispensed for ADHD medication prescribed by their PCMH, and a follow-up visit within 30 days by any practitioner with prescribing authority	At least 36%	34%	42%
Percentage of patients prescribed appropriate asthma medications	At least 85%	74%	38%
Percentage of CHF patients age 18 years and older on beta blockers.	At least 49%	82%	91%
Percentage of children who received appropriate treatment for Upper Respiratory Infection (URI)	No More Than 65%	22%	65%
Percentage of patients 18-75 years of age with diabetes who complete annual HbA1C	At least 78%	90%	90%
Percentage of patients with diabetes and CAD who are currently taking a statin.	At least 70%	62%	29%
Percentage of High Priority beneficiaries seen at least two times in past 12 months	At least 76%	83%	77%
Percentage of members with acute inpatient stay seen by provider within 10 days of discharge	At least 40%	44%	51%

- For AR BCBS for 2016, PCMH aggregate performance met targets for a majority of measures.
- 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.
- Performance target requirements explicitly link population health needs and clinical performance expectations.[7]

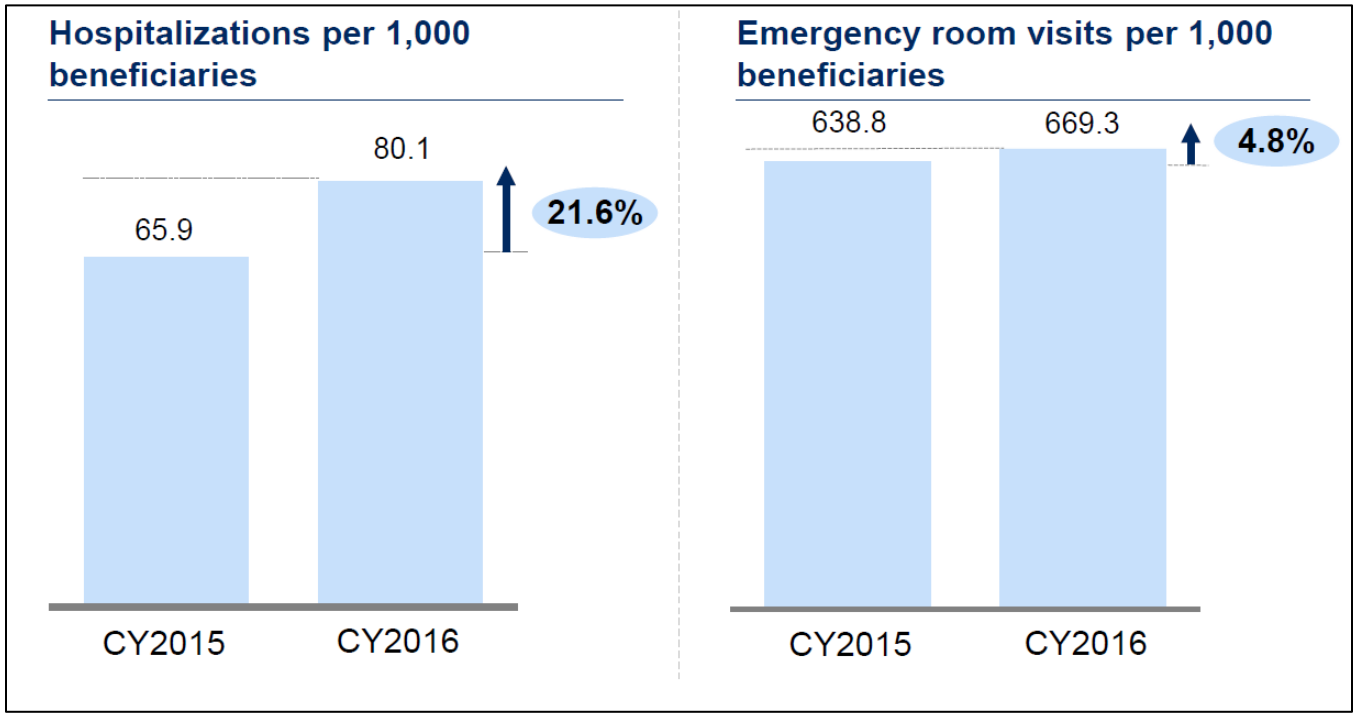
[k] AR BCBS 2016 PCMH program provider manual with detailed metrics: http://www.arkansasbluecross.com/doclib/forms/providers/abcbs%20pcmh%20provider%20manual%202016%20v3_8.pdf

Hospital and Emergency Department Utilization Impacts for Medicaid [l]

- Although the rates of inpatient admissions and emergency department visits both decreased from 2014 to 2015, rates for both measures increased in 2016, and stabilized in 2017.[m]
- Arkansas Medicaid's increased rates of hospitalizations and emergency department visits are contributing factors to the increase in 2016 total cost of care.
- Compared to 2015, 2016 hospitalization rates increased by 21.6 percent, while emergency room visits increased by 4.8 percent.
- Compared to 2016, hospitalizations in 2017 increased by only 0.4 percent, while emergency room visits decreased by 0.2 percent.

Figures 2a and 2b display hospital and ER utilization among PCMH beneficiaries from 2015 through 2017.

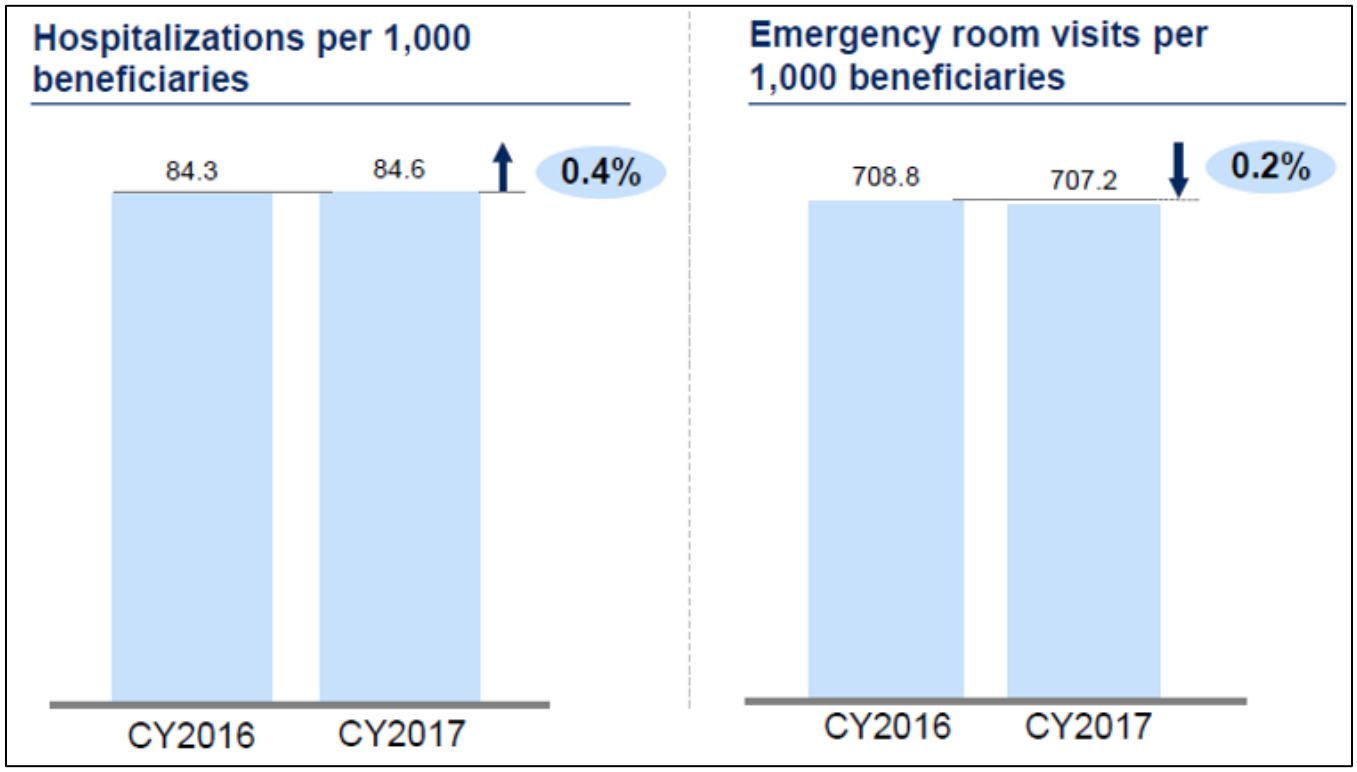
Figure 2a: Arkansas Medicaid Hospital and Emergency Room Impacts from 2015 to 2016



[l] Medicaid Utilization data provided in December 2018, as of Q3 '18 (CY2016 performance period) reporting, and in June, 2019 for CY2017 performance period .

[m] 3rd Annual Statewide Tracking Report for Arkansas Healthcare Payment Improvement initiative can be found at: https://achi.net/library/ahcpii-tracking-report/

Figure 2b: Arkansas Medicaid Hospital and Emergency Room Impacts from 2016 to 2017



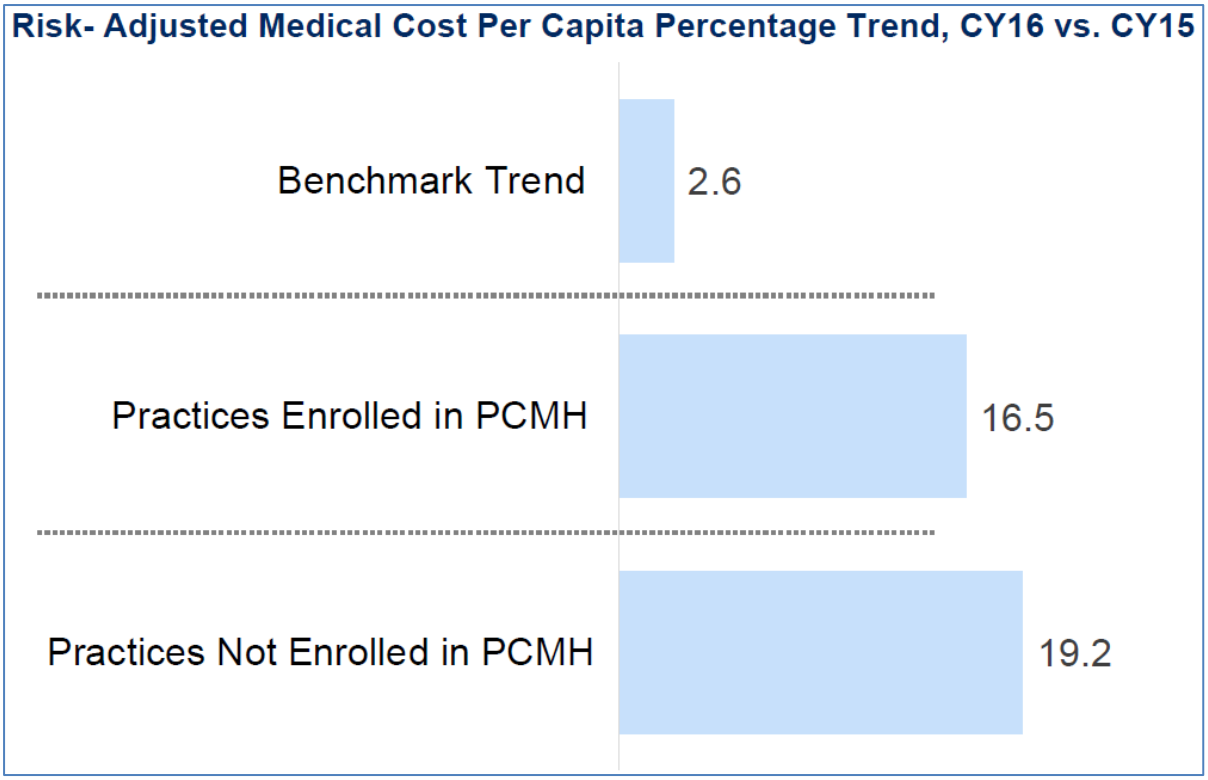
PCMH Program Cost Trend Comparison for Arkansas Medicaid

Figures 3a and 3b display PCMH cost growth comparisons across 2015 and 2016 for PCMH practices and practices not enrolled in the program. After experiencing reduced cost growth for 2014 and 2015,[n] 2016 performance experienced increased cost growth.

One contributing factor to the increased cost trend growth for 2016 is that in that year Arkansas Medicaid reviewed and updated PCMH beneficiary attribution. This process resulted in a remaining PCMH-attributed population that, on average, incurred higher per-capita costs than prior PCMH-attributed populations.[o]

However, for both 2017 and 2016, practices enrolled in the PCMH program had lower cost growth than practices not enrolled in the program. For 2016 performance, participating practices experienced a 16.5 percent trend growth, while their peers who were not enrolled in the program experienced a 19.2 percent cost growth. Both groups achieved cost growth above the pre-set 2.6 percent benchmark trend, which is based on historical Arkansas cost growth.[p]

Figure 3a: Arkansas Medicaid PCMH Cost Trend, 2015 to 2016



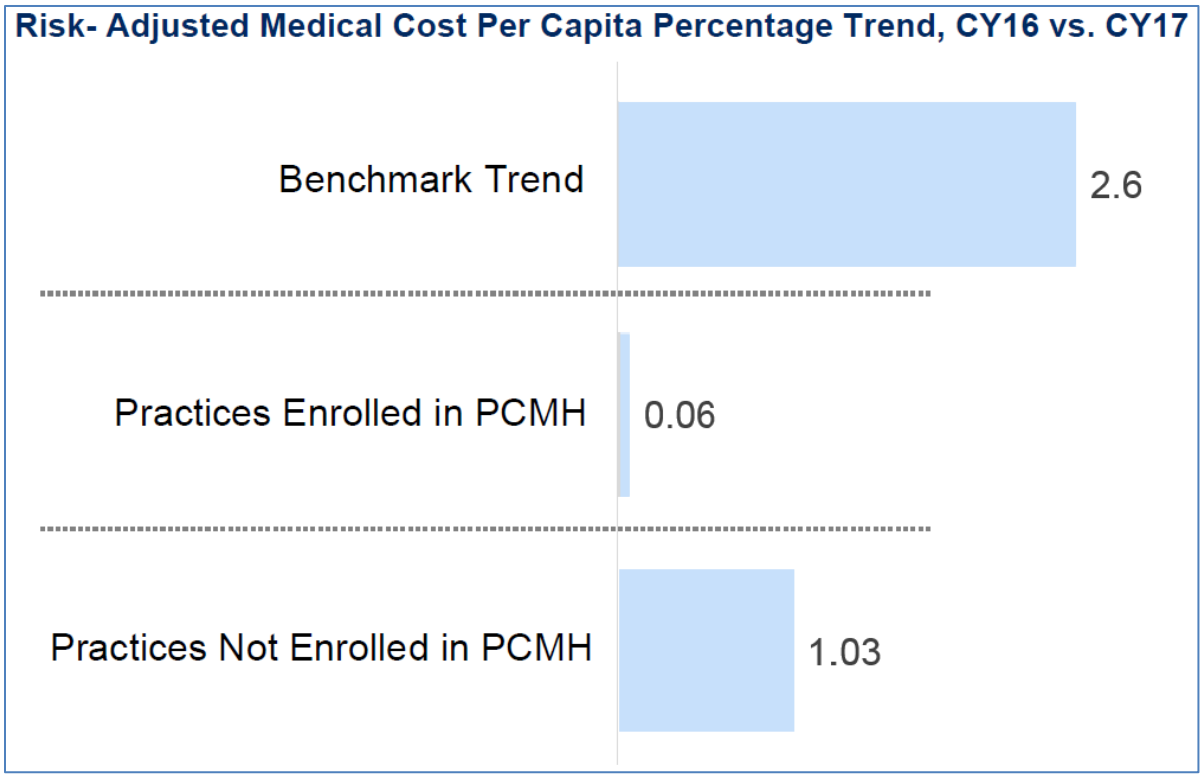
[n] 3rd Annual Statewide Tracking Report for Arkansas Healthcare Payment Improvement initiative can be found at: https://achi.net/library/ahcpii-tracking-report/

[o] Golden, W. (2019, April 1). Personal communication

[p] Source: Medicaid PCMH cost trend information provided by Arkansas Medicaid in December, 2018, and June 2019. Figures are based on at least 365 days of claims run out on Medicaid data.benchmark cost calculations can be found within the Medicaid PCMH provider manual: https://www.paymentinitiative.org/Websites/paymentinitiative/images/2016-2017%20PCMH%20Manual.pdf

For 2017 performance, participating practices experienced only a 0.06 percent trend growth, while their peers who were not enrolled in the program experienced a 1.03 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.

Figure 3b: Arkansas Medicaid PCMH Cost Trend, 2016 to 2017

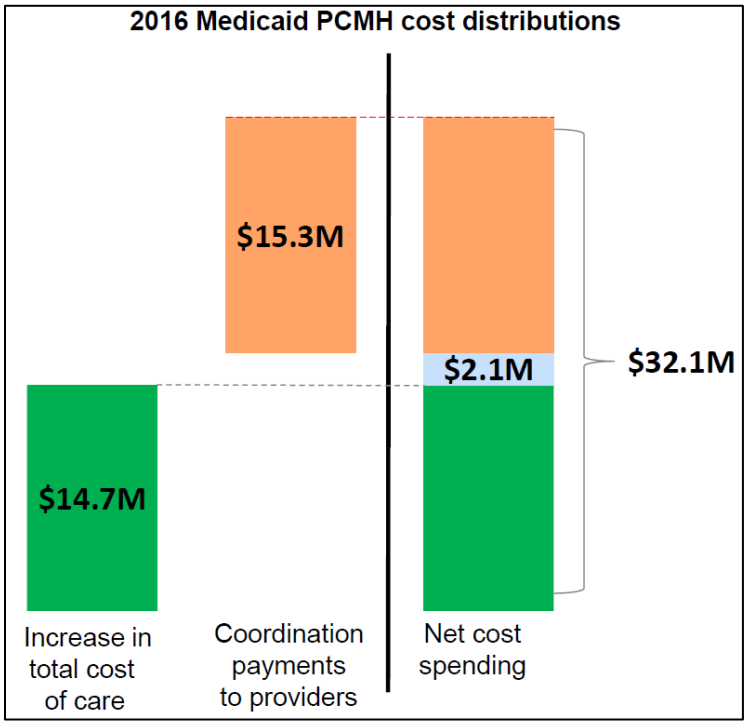


PCMH TOTAL COST OF CARE: ARKANSAS MEDICAID PERFORMANCE

While in 2014 and 2015, Medicaid realized direct cost-avoidance through trend reduction[q], in 2016 the program experienced cost increase due in part to increases in hospitalizations and emergency room visits. While the program generated gross savings of $34.3 million in 2014 and $54.4 million in 2015, for a total of savings of $88.7 million, the program experienced increased costs of $14.7 million in 2016. Figure 4 shows the Medicaid PCMH program cost for 2016.

[q] 3rd Annual Statewide Tracking Report for Arkansas Healthcare Payment Improvement initiative can be found at: https://achi.net/library/ahcpii-tracking-report/

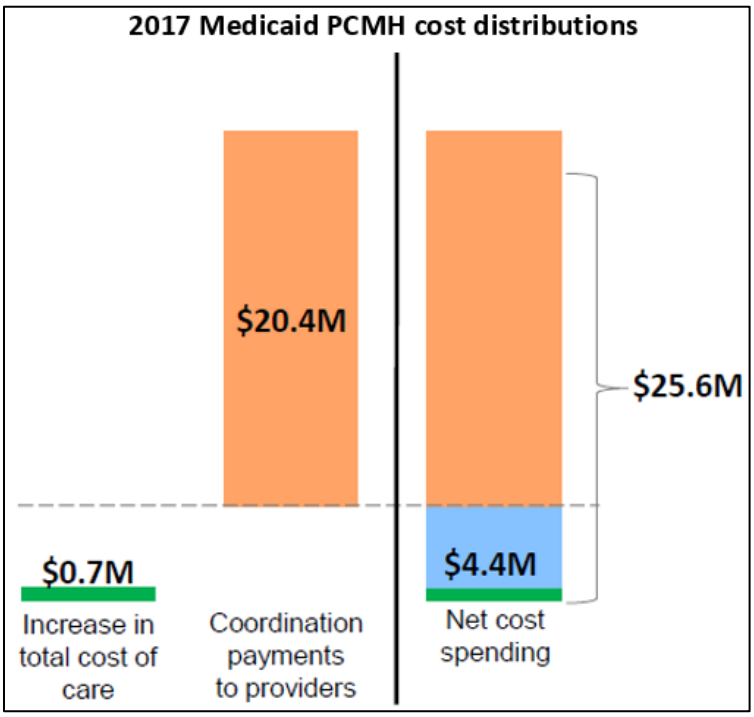
Figure 4a: Medicaid PCMH Program 2016 Cost[r]



- For 2016, the predicted total cost of care was $665.8 million, but the actual cost was $680.5 million — for an increase in total cost of care of $14.7 million.
- For 2016, $15.3 million has been reinvested back into the provider community.
- $2.1 million is the shared savings incentive payment paid to providers for CY2016 in Q3 2018.
- For 2016, $32.1 million represents the total net cost.

[r] Information provided by Arkansas DHS in December 2018.

Figure 4b: Medicaid PCMH Program Preliminary 2017 Cost[s]



- For 2017, the predicted total cost of care was $715.8 million, but the actual cost was $716.5 million — for an increase in total cost of care of $0.7 million.
- For 2017, $20.4 million has been reinvested back into the provider community.
- $4.4 million is the shared savings incentive payment paid to providers for CY2017 in Q1 2019.
- For 2017, $25.6 million represents the total net cost.

[s] Information provided by Arkansas DHS in June 2019.

PCMH Practice Improvements and Patient Experience

Arkansas's PCMH program requires practices to complete practice transformation activities, as well as quality and utilization milestones, such as identifying the top 10 percent of high-priority patients, developing care plans, and using electronic health records (EHR), 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 made progress towards PCMH activities and high-quality, efficient care delivery:

- **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 enables better patient communication, and may potentially mitigate unnecessary emergency department use.
- **Enhanced team-based care:** PCMH practices have attested to improved team-oriented activities such as daily team huddles to better prepare staff for the 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.

Primary Care Provider Attribution

In an effort to improve overall population health management and support the PCMH model, AR BCBS has updated primary care provider attribution initiative for all beneficiaries in their fully insured plans. In this process, AR BCBS identifies which beneficiaries have not selected a primary care provider. These beneficiaries are subsequently assigned a primary care provider in their geographic proximity. These newly attributed beneficiaries are 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 allows AR BCBS to track accurately the 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.[t]

[t] https://www.paymentinitiative.org/Websites/paymentinitiative/images/2016-2017%20PCMH%20Manual.pdf

Table 3: PCMH Practice Transformation Milestone Attestation as Determined by Arkansas Medicaid as of December 2018:

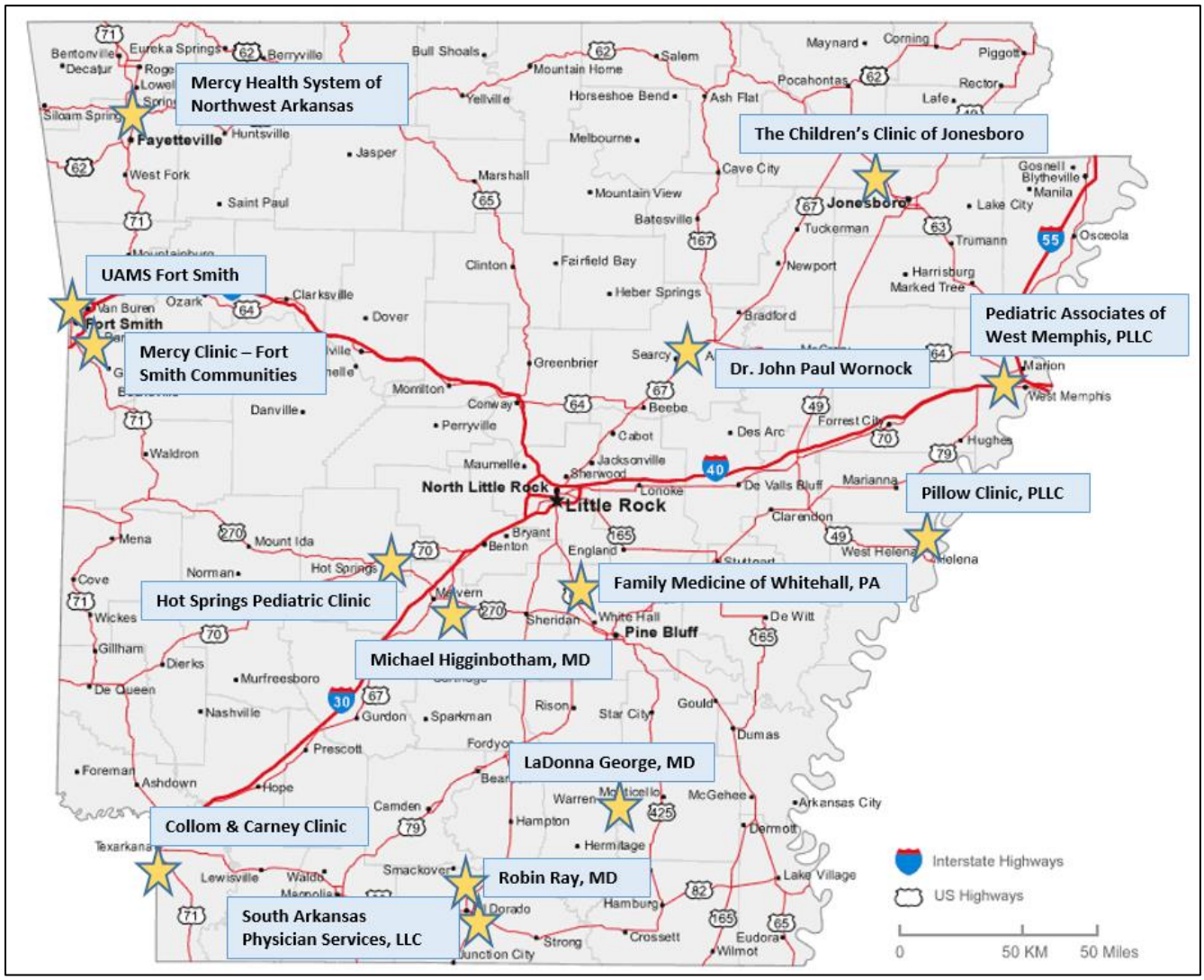
PCMH Practice Transformation Milestone Attestation Validation	2014 Number (Percentage)	2015 Number (Percentage)	2016 Number (Percentage)	2017 Number (Percentage)	2018 Number (Percentage)
PCMH 3-Month Activities				**185 PCMHs eligible for 3-month activities**	**205 PCMHs eligible for 3-month activities**
Identify top 10% of high-priority beneficiaries	113 (100%)	133 (100.0%)	179 (100%) included CPC practices	185 (100%)	205 (100%)
Report Clinical Quality Measure data for 2015: Diabetes, A1c poor control; controlling high blood pressure; and weight assessment for children adolescents (BMI) *(2016 Activity*)	N/A	N/A	145 (96%)	N/A	N/A
PCMH 6-Month Activities			**141 PCMH eligible for 6-month activities**	**185 PCMHs eligible for 6-month activities**	**198 PCMHs eligible for 6-month activities**
Assess operations of practice and opportunities to improve	107 (94.7%)	124 (100.0%)	135 (96%)	N/A	N/A
Develop and record strategies to implement care coordination and practice transformation	107 (94.7%)	124 (100.0%)	135 (96%)	N/A	N/A
Identify and reduce medical neighborhood barriers to coordinated care at the practice level	107 (94.7%)	124 (100.0%)	135 (96%)	N/A	N/A
Make available 24/7 access to care	107 (94.7%)	123 (99.2%)	135 (96%)	185 (100%)	198 (100%)
Track same-day appointment requests	107 (94.7%)	124 (100.0%)	135 (96%)	185 (100%)	198 (100%)
Capacity to receive direct e-messaging from the patients (2017 activity)	N/A	N/A	N/A	185 (100%)	198 (100%)
Enrollment in the Arkansas Prescription Drug Monitoring Program (PDMP) (2017 activity)	N/A	N/A	N/A	185 (100%)	198 (100%)

PCMH Practice Transformation Milestone Attestation Validation	2014 Number (Percentage)	2015 Number (Percentage)	2016 Number (Percentage)	2017 Number (Percentage)	2018 Number (Percentage)
PCMH 12-Month Activities			**134 PCMHs eligible for 12-month activities**	**181 PCMHs eligible for 12-month activities**	**197 PCMHs eligible for 12-month activities**
Childhood/adult vaccination strategy (2016 Activity)	N/A	N/A	133 (99%)	181 (100%)	Was due 12/31/18
Establish processes that result in contact with beneficiaries who have not received preventive care	107 (100.0%)	123 (100%)	133 (99%)	N/A	N/A
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%)	133 (99%)	N/A	N/A
Invest in healthcare technology or tools that support practice transformation	107 (100.0%)	123 (100%)	133 (99%)	N/A	N/A
Join the State Health Alliance for Records Exchange (SHARE) and access inpatient discharge and transfer information	107 (100.0%)	123 (100%)	133 (99%)	181 (100%)	Was due 12/31/18
Incorporate e-prescribing into practice workflows (2016 Activity)	N/A	N/A	133 (99%)	181 (100%)	Was due 12/31/18
Integrate EHR into practice workflow (2016 Activity)	N/A	N/A	133 (99%)	N/A	N/A
Care Plans for High Priority Beneficiaries (2016 Activity)	N/A	N/A	102 (90%)	181 (100%)	Was due 12/31/18
Patient literacy assessment tool (2017 activity)	N/A	N/A	N/A	181 (100%)	Was due 12/31/18
Ability to receive patient feedback (2017 activity)	N/A	N/A	N/A	181 (100%)	Was due 12/31/18
Care instructions for high-priority beneficiaries (2017 activity)	N/A	N/A	N/A	181 (100%)	Was due 12/31/18
Medication management (2017 activity)	N/A	N/A	N/A	181 (100%)	Was due 12/31/18
10-day follow-up after an acute hospital stay (2017 activity)	N/A	N/A	N/A	181 (100%)	Was due 12/31/18
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	133 (97%)	N/A	Was due 12/31/18
PCMH 18-Month Activities					
Incorporate e-prescribing into practice workflows	107 (100%)	119 (98%)	N/A	N/A	N/A
PCMH 24-Month Activities					
Use Electronic Health Records (EHRs) for care coordination	107 (100%)	113 (93%)	N/A	N/A	N/A
Extract clinical data from EHRs. At a minimum the data must include collection of A1c levels, collection of blood pressure readings.	N/A	110 (90%)	N/A	N/A	N/A

PCMH Shared Savings for Medicaid 2016 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 after the end of the preceding year performance period. For 2016 performance, 14 provider groups throughout the state received shared savings payments that totaled more than $2 million. Figure 5 displays the location of these 14 providers.

Figure 5: Locations of PCMHs Receiving Share Savings Preliminary Payments for 2016 Performance



Comprehensive Primary Care Initiative (CPC)

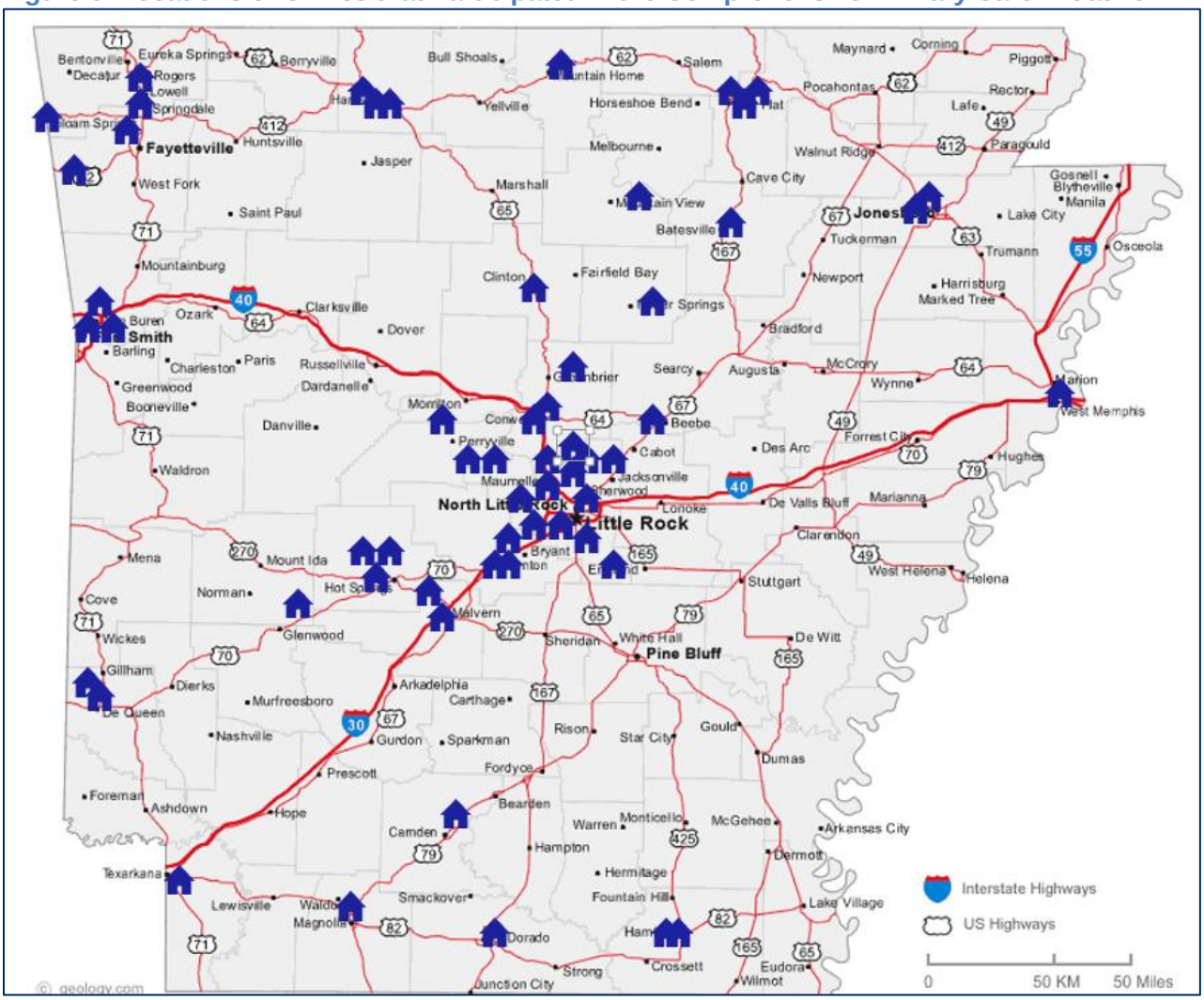
Arkansas was one of only seven regions selected for the original Comprehensive Primary Care Initiative (CPC), for which 69 original practices were chosen in a competitive process. Launched in October 2012, this four-year Medicare-led initiative shares the same goals as Arkansas's State PCMH program. Arkansas has been a leading region in CPC. In 2015, it was one of four regions in CPC to generate shared savings, and in 2016 was one of only two regions to generate shared savings. 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.[3] The success of CPC and Arkansas's PCMH program prepared the state's providers to participate in the CPC+ program, which began in 2017.[u]

CPC OUTCOMES FOR ARKANSAS

- As of December 2016, 57 practices remained in the program, (see Figure 6), including 233 PCPs serving 308,756 beneficiaries.[v]
- For Medicare, for 2015 performance, Arkansas CPC practices experienced a gross savings of 4.3 percent, and achieved net savings of 2.4 percent, or $11.5 million ($18.86 per beneficiary per month).[w]
- For Medicare, for 2016 performance, Arkansas CPC practices experienced a gross savings of 4.6 percent, and a net savings of 2.7 percent, or $12.5 million ($20.95 per beneficiary per month).[x]
- In 2015, Arkansas practices reduced hospital admissions by 15.7 percent; improving more than any other CPC region.[y]
- For 2016 Medicare performance, Arkansas was one of only two (out of seven) regions to achieve net savings, with 54 practices eligible to receive shared savings.

[u] CPC+ Website: https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus
[v] Evaluation of the Comprehensive Primary Care Initiative: Fourth Annual Report, Mathematica, May 2018. https://www.mathematica-mpr.com/our-publications-and-findings/publications/evaluation-of-the-comprehensive-primary-care-initiative-fourth-annual-report
[w] CMS CPC 2015 Shared Savings and Quality Results https://innovation.cms.gov/files/x/cpci-ssqualdatasummary2015.pdf
[x] CMS CPC 2016 Shared Savings and Quality Results: https://innovation.cms.gov/files/x/cpci-2016sharedsavings-qualitydata.pdf
[y] CMS Q14 Regional Feedback Report (CPC At-a-Glance & table 5), provided by Rachel Wallis and TMF health Quality Institute December 2016

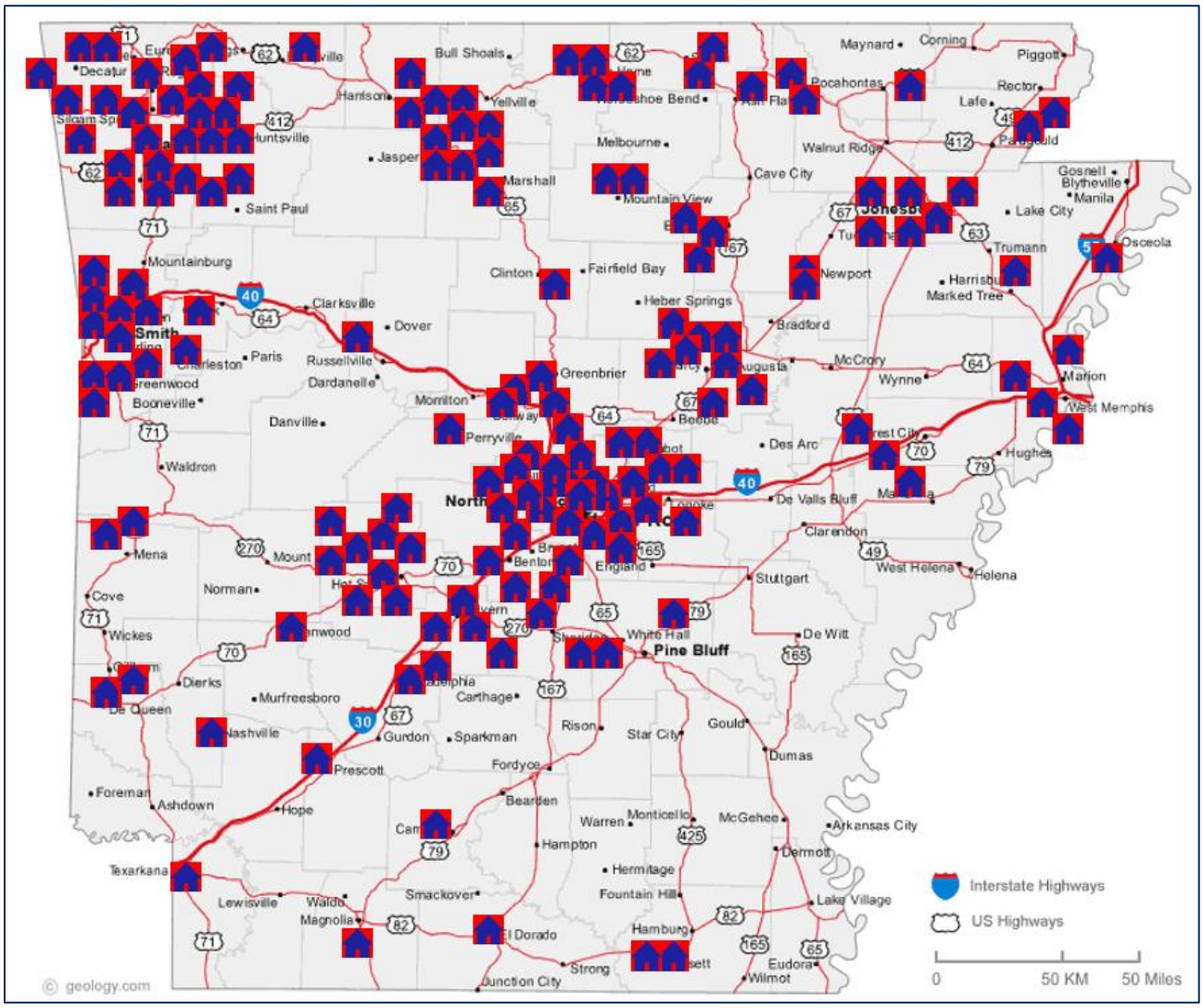
Figure 6: Locations of Clinics that Participated in the Comprehensive Primary Care Initiative in 2016



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 began in 2017[z] and includes participation from Medicare, Arkansas Medicaid, AR BCBS, Centene/Ambetter (Arkansas Health and Wellness Solutions), and HealthSCOPE. Locations of the original 182 practices throughout the state that voluntarily applied and were selected for participation in CPC+ are displayed in Figure 7.

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

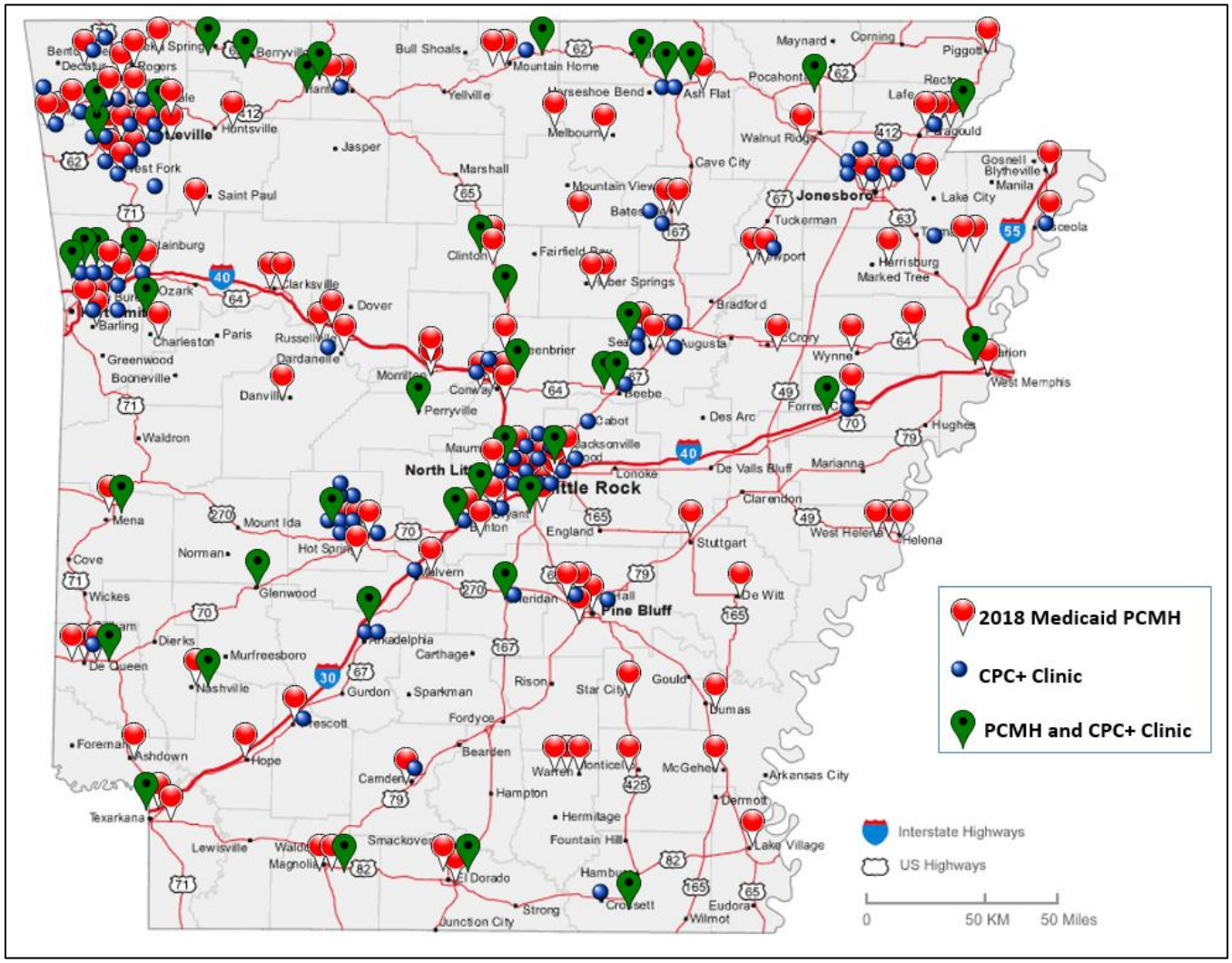


[z] A Comprehensive Primary Care fact Sheet is available at: https://achi.net/wp-content/uploads/2018/10/CPC-Fact-Sheet.pdf

Overall Practice Participation in PCMH and CPC+ in 2018

Participation in Arkansas's PCMH program and CPC+ is now occurring throughout the state. For Arkansas Medicaid, 207 practices were participating in the PCMH program as of 2018. For the CPC+ program, 182 practices are participating, and approximately 50 practices have their primary care providers enrolled in both PCMH and CPC+. Pediatric practices are not eligible for CPC+ due to Medicare patient volume minimum requirements. Practices currently participating in PCMH and/or CPC+ are shown on the map in Figure 8.

Figure 8: Locations of Clinics Participating in PCMH, CPC+, or Both Programs



SUSTAINING PCMH IMPROVEMENTS AND CONTINUING EVALUATION

A large number 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 expanded 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 aligned on new 2016 and 2017 performance target requirements to explicitly link population health needs and clinical performance expectations.

Early challenges helped identify opportunities to improve the AHCPII. Efforts to track and evaluate AHCPII will continue in 2019 and beyond. The implementation of CPC+ represents the most recent phase in the state's progression toward a value-based patient-centered delivery system. Lessons learned from the episodes of care components are informing progress toward 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.

STATE HEALTH ALLIANCE FOR RECORDS EXCHANGE (SHARE) UPDATE

The Office of Health Information Technology (OHIT), a Division of the Arkansas Department of Health, enables Arkansas's Health Information Exchange (HIE), SHARE, to transform the methods used to transmit health information across the state. By using various technical mechanisms for health information exchange, OHIT is able to provide vendor-neutral options for health information exchange to hospitals, provider practices, behavioral health PASSEs, payers, eligible professionals (EPs), behavioral health providers (BH) and long-term post-acute care (LTPAC) facilities.

OHIT continues to develop various strategies for onboarding, training, and implementing SHARE operationally and uses these processes to tie the technical capabilities of health care organizations to the daily workflow of the facility staff throughout the course of their daily operations. The workflow assessment in turn is followed by workflow redesign, which incorporated the new utility (SHARE) into the daily workflow processes. OHIT identifies target hospitals connected to SHARE and accesses these hospital referral networks (Clinically Integrated Networks and Accountable Care Organizations) to replicate similar results and increase transmissions for transitions of care documentation throughout the state. The following section of this report provides an update on SHARE and the many connections in Arkansas and nationwide.

Current Number of Facilities Participating in SHARE

Time Frame	Type	Number
As of 12/01/18	Arkansas Hospitals Live	71
As of 12/01/18	Oklahoma Hospitals Live	84
As of 12/01/18	Missouri Hospitals Live	14
As of 12/01/18	HIE to HIE	22
As of 12/01/18	Behavioral Health PASSE	4
As of 12/01/18	Practices Live	1,214
As of 12/01/18	Behavioral Health Facilities Live	165
As of 12/01/18	LTPAC Facilities Live	45
As of 12/01/18	Ancillary Healthcare Organizations Live	54

Comprehensive Primary Care Plus (CPC+): In all, 171 CPC+ clinics are connected to SHARE. Assisting with HIE Integration with EMR system, Virtual Health Record and Secure Messaging access, as well as supporting sending immunizations to the Immunizations Registry and connecting to the Public Reporting Registries.

Daily Reports/Event Notifications: SHARE alerts clinics when their patients are admitted or discharged from the ED and report inpatient discharge encounters over the last 24 hours. From January to November 2018 there were 683,776 daily reports and event notifications.

30-Day Readmission Notifications to 55 Hospitals in Arkansas: SHARE sends 30-day readmission notifications in real-time across the state to assist hospitals in combatting readmissions. The 30-day readmission notification project allows hospitals to receive a secure message notification when a patient that was discharged from their facility, was subsequently readmitted into any SHARE participating hospital within a 30-day timeframe.

- November 2018: 30-Day Readmit Received — 92,898; 30-Day Readmit Sent — 90,630

Behavioral Health PASSEs Participating in SHARE:

- Arkansas Total Care Inc.: admit, discharge, or transfer (ADT) notification feed, daily reports, virtual health record, and secure messaging
- Empower Healthcare Solutions, LLC: daily reports, virtual health record, and secure messaging
- Summit Community Care: daily reports, virtual health record, and secure messaging
- ForeverCare Inc.: ADT feed, daily reports, virtual health record, and secure messaging

Medicaid PCMH Program, Required Activity G: Join SHARE or participate in a network that delivers hospital discharge information to practice within 48 hours.

- Indicate the ability to access inpatient discharge information via SHARE. Indicate the ability to access patient transfer information via SHARE.
- If the practice has not joined SHARE, indicate if the practice participates in a network that delivers hospital discharge information to the practices within 48 hours of discharge.

Current Number of PCMH Practices Participating in SHARE

Time Frame	Type	Number
December 2018	PCMH Practices LIVE	176
December 2018	Satellite PCMH Practices LIVE	193
December 2018	PCMH Practices & Satellite Practices (recruiting-not connected)	25

Immunization Registry and Public Health Reporting:

- Linked with SHARE and supporting bi-directional Immunizations and connected to Immunization Registry as pass-through for hospitals and clinics.
- Linked with SHARE and connected to Public Health Reporting Registries: Syndromic Surveillance, Cancer Registry, and Electronic Lab Reporting Registry as a pass-through for hospitals and clinics.

Connected to Patient Centered Data Home (PCDH): PCDH is an initiative of the Strategic Health Information Exchange Collaborative (SHIEC) and SHARE is currently connected to 22 HIE's to date nationwide. It is based on triggering episode alerts, which notify providers that a care event has occurred outside of the patient's "home" HIE, and confirms the availability and the specific location of the clinical data. This enables providers to initiate additional data exchanges to access real-time information across state and regional lines and the care continuum.

Connected to eHealth Exchange: eHealth Exchange is a group of federal agencies and non-federal organizations that came together under a common mission and purpose to improve patient care, streamline disability benefit claims, and improve public health reporting through secure, trusted, and interoperable health information exchange (HIE). The eHealth Exchange connectivity spans across all 50 states and is now the largest health-data-sharing network, or HIE, in the U.S. SHARE will soon be connected to the VA Health System.

Virtual Health Record (VHR) and Secure Messaging (SM): The VHR displays information as a traditional clinical chart, with tabs to separate patient information into groups for easy chart review. The VHR retrieves and shows all available data for a selected patient gathered from all participants within SHARE to enable a single, consolidated view of a patient's health history. SM allows healthcare organizations to share clinical information — such as clinical care summaries, referrals, transitions-of-care documents, immunization records, and lab results — through a secure, encrypted email exchange with other providers.

Continuity of Care Documents (CCDs) utilizing xds.b/xca protocol: The need for a standardized way to exchange comprehensive clinical documents between providers — beyond individual results and reports — is clear. SHARE is deploying the use of Continuity of Care Documents (CCDs) to meet this need. The usage is being bolstered by Meaningful Use Stage 3.

Assist with MIPS/MACRA: SHARE can help Increase provider ACI category score. Practices can integrate with SHARE and send data to the state's immunization registry, which can help them earn the full 10 percent performance measure. SHARE can help increase Improvement Activities scores for practices that send care summaries, or continuity of care documents (CCDs), into the SHARE. Providers' cost category scores may be improved through receipt of patients' clinical results, which may be used to educate patients on hospital utilization to support reductions in unnecessary utilization and costs.

HIE-to-HIE Connections: SHARE is connected to Missouri HIE (Missouri Health Connection) and Oklahoma HIE (Myhealth Access Network), exchanging data across state lines on patients' home of record. SHARE is deploying connections to more states in the coming year.

ARKANSAS BLUE CROSS BLUE SHIELD VALUE-BASED COMPENSATION INITIATIVE AND EPISODES OF CARE PROGRAM PHASE-OUT

The Value-Based Compensation Initiative (VBCI) is AR BCBS's new provider payment model intended to improve the quality, affordability and sustainability of health care by moving from volume-based to value-based compensation. In 2018, AR BCBS held several stakeholder meetings to gain feedback on VCBI, which is a new initiative designed to shift further away from traditional fee-for-service payments towards value-based payments.

There has been widespread agreement that the current fee-for-service based system does not provide a long-term, sustainable path. Through a series of ongoing program development meetings, AR BCBS has received feedback that there is agreement on the mission – improving efficiency and funding for providers to deliver proactive, patient-centric, performance-based, coordinated care. However, AR BCBS has communicated to stakeholders that there is currently less agreement on the method for achieving the goal.

Therefore, in a second phase beginning this year, AR BCBS will be extending its development process of the program, focusing on its Collaborative Health Initiative partnerships (which are similar to Accountable Care Organizations). The opportunity in working through these relationships is to be able to find a performance model for defining and rewarding value-focused care, quality and efficiency that can serve as a platform for expansion to a broader population of providers in the future.

In conjunction with ongoing efforts to implement the VBCI, AR BCBS has phased out its episodes of care program, effective Dec. 31, 2018. The episodes of care program is summarized in the following section of this report. AR BCBS plans to build upon the progress and experience of the episodes program with the broader scope of the VBCI. In the years since it was first implemented, the AR BCBS Episodes of Care Program has been successful in creating transparency associated with variation in treatment and cost. This transparency has enabled improvements in care and compression of cost variation within these episodes, and these improvements have been important to the continued transition of the healthcare system toward a more consumer-centric system, focused on sustainability and the delivery of greater value for purchasers[aa]

Other AR BCBS value-based programs [CPC+, PCMH, & Collaborative Health Initiatives] will remain operational.

[aa] https://www.healthadvantage-hmo.com/docs/librariesprovider6/publications/providers-news-december-2018.pdf?sfvrsn=159869fd_2

EPISODES OF CARE

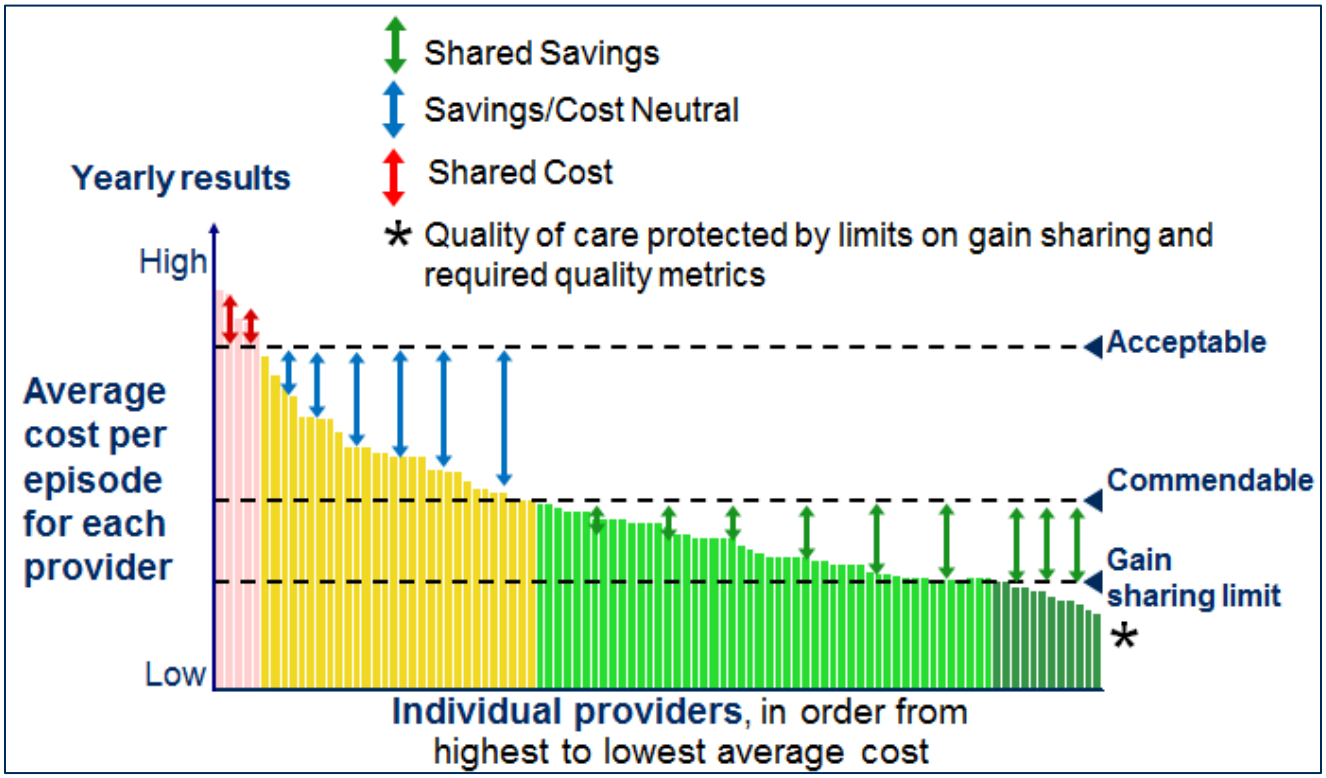
Updated episodes of care results for Arkansas Medicaid were not available for inclusion in this report. Prior year updates for the Arkansas Medicaid episodes of care program are available in the 2017 Statewide Tracking Report available at www.achi.net.

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 Principal Accountable Provider (PAP) for each type of episode, which is usually the physician delivering the most care within an 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.

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

Figure 9: How the Arkansas Episode Payment Model Works



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 displays the episode payment framework and the cost thresholds for gain/risk share payments.

To date, Medicaid has introduced 14 different episodes of care, while AR BCBS implemented 12 types of episodes. These episodes include 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 also implemented an episode for percutaneous coronary intervention (PCI).

Episodes of Care Summary Descriptions

For the episodes of care model, 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, and the PAP is the initial diagnosing clinician. The time period is 21 days. Quality metrics include appropriate testing prior to antibiotic use, and costs include all associated diagnostic and therapeutic costs.
- **Perinatal:** The episode trigger is delivery of a live infant, and 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, and costs include all pregnancy related costs.
- **Total Joint Replacements (TJR) — Hip and Knee:** The episode trigger is the total joint replacement, and 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, and costs include all orthopedic related costs during the episode.
- **Congestive Heart Failure (CHF):** The trigger is a hospitalization for CHF, and 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, and 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, and the PAP is the provider (primary care or mental health provider) with the majority of visits. The window is 12 months. Complexity and quality assessments are through provider attestation, and 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, and an episode begins with the initial consult with the performing provider (within 30 days prior to procedure) and ends 30 days after the procedure. All related costs are included 30 days prior to and 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:** The episode is triggered by an outpatient tonsillectomy, adenoidectomy, or adeno-tonsillectomy procedure, and primary or secondary diagnosis indicating conditions that require tonsillectomy/adenoidectomy. The PAP is the provider performing the procedure, and the

episode begins with the initial consult with the provider (within 90 days prior to procedure) and ends 30 days after the procedure. Costs include all related services within the episode, and quality metrics include the percentage of episodes with administration of 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 an open or laparoscopic cholecystectomy procedure and a primary or secondary diagnosis indicating related conditions. The PAP is the surgeon, and an 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, and number of procedures initiated via open surgery.
- **Coronary Artery Bypass Graft (CABG):** The trigger is a CABG procedure, and the PAP is the physician performing the CABG. Episode duration is the timeframe beginning with the date of surgery and lasting 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 two-thirds of adverse outcome metrics, inclusive of stroke, deep sternal wound, and renal failure.
- **Asthma:** The episode trigger is an emergency department, observation room, or inpatient visit for treatment of an acute exacerbation of asthma, and 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 30-day window (must be at least 38 percent), 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), and 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, and 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) and 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, and the PAP is the provider responsible for the greatest number of ODD claims within an episode and may include 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, and 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 episodes for which the beneficiary received medications (must be equal to 0 percent), and 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, and the PAP is the cardiologist or radiologist performing the procedure. Episode duration is 30 days after the PCI procedure or the date of angiogram if within the 30 days prior to the procedure. Costs include inpatient services, outpatient services, 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.

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.[4] 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 healthcare 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.

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.

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 through 2016 are reported below for AR BCBS.[bb]

Updated episodes of care results for Arkansas Medicaid were not available for inclusion in this report. Prior year updates for the Arkansas Medicaid episodes of care program are available in the 2017 Statewide Tracking Report available at www.achi.net.

[bb] 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.

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 lists the perinatal episode yearly volume for 2012–2016.

Table 4: Perinatal Episode Yearly Volume

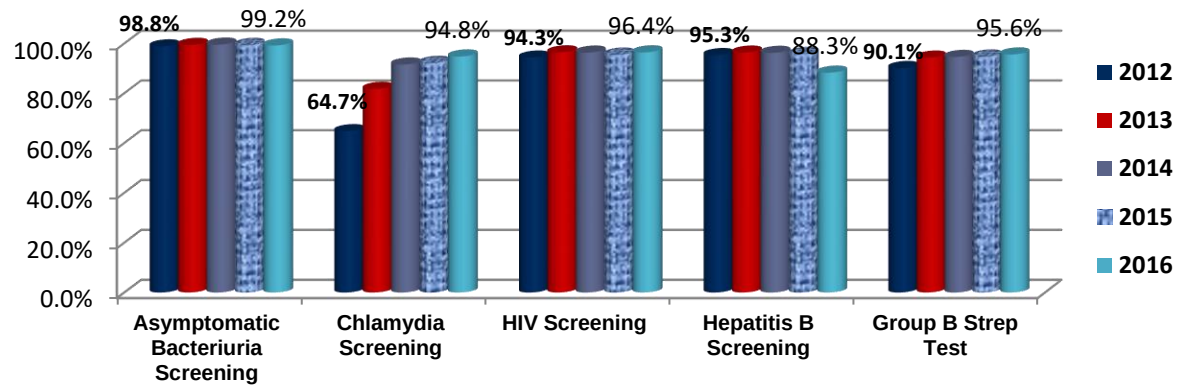
	2012	2013	2014	2015	2016
Medicaid	5,845	5,946	12,596	7,230	NA[cc]
AR BCBS	2,871	2,362	2,719	2,568	2,229

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 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 Qualchoice participated in the episode. Key findings include the following.

PERINATAL QUALITY OUTCOMES

Perinatal quality metric outcomes from 2012 through 2016 are displayed in Figure 10. Percentages are reported and displayed numerically for the earliest and most recently available reporting years.

Figure 10: 2012-2016 Perinatal Episode Quality Metric Outcomes (AR BCBS)



[cc] Medicaid Episode outcomes were not available for this report.

PERINATAL PROVIDER COST RANGE OUTCOMES

Perinatal cost outcomes for 2014 through 2016 are displayed in Table 5.

Table 5: 2014 – 2016 Provider Cost Outcomes: Perinatal (AR BCBS)*			
PAP Cost Range	**2014** (164 PAPs)	**2015** (163 PAPs)	**2016** (155 PAPs)
Commendable	56.1%	33.7%	52.3%
Acceptable	38.4%	41.1%	27.1%
Unacceptable	5.5%	25.2%	20.7%

For AR BCBS, average perinatal episode cost increased by 2.1 percent from 2015 to 2016, after increasing 1.3 percent from 2014 to 2015 and decreasing 1.6 percent from 2013 to 2014.

AR BCBS paid $457,705 in gain share payments in 2016 for perinatal episodes to 81 PAPs, while assessing risk-share payments of $12,730 across 32 PAPs.

TOTAL JOINT REPLACEMENT (TJR) 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.[5]

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.[6] TJR includes all care related to the procedure in the period 30 days prior to the surgery to 90 days after.[Error! Bookmark not defined.] This episode has four quality metrics to track in place for quality of care and improvement opportunities: 30-day all-cause readmission rate;[dd] 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. Table 6 lists the TJR episode volume, 2012-2016. Key findings include the following.

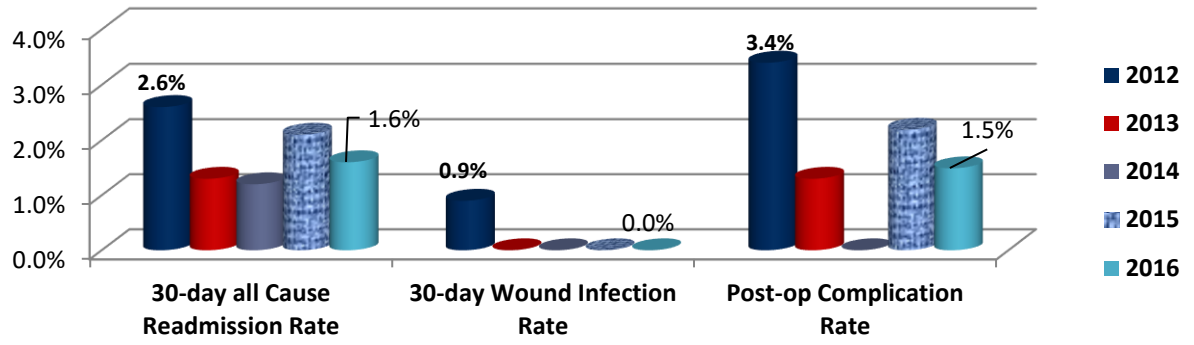
Table 6: Total Joint Replacement Episode Volume					
	2012	**2013**	**2014**	**2015**	**2016**
Medicaid	141	100	120	132	NA
AR BCBS	823	528	725	678	757

[dd] 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.

TJR QUALITY OUTCOMES

Quality metric outcomes for 2012 through 2016 are displayed in Figure 11.

Figure 11: 2012–2016 TJR Episode Quality Metric Outcomes (AR BCBS)



TJR PROVIDER COST RANGE OUTCOMES

TJR cost outcomes for 2014 through 2016 are displayed in Table 7 below.

Table 7: 2014–2016 Provider Cost Outcomes: TJR (AR BCBS)

PAP Cost Range	**2014** (45 PAPs)	**2015** (51 PAPs)	**2016** (54 PAPs)
Commendable	51.1%	54.9%	72.2%
Acceptable	35.6%	25.5%	11.1%
Unacceptable	13.3%	19.6%	16.7%

For AR BCBS, the average TJR episode cost decreased by 5.1 percent from 2015 to 2016, after increasing by 2.8 percent from 2014 to 2015 and increasing 0.8 percent from 2013 to 2014.

AR BCBS paid $596,207 in gain-share payments in 2016 for TJR episodes to 39 PAPs, while assessing risk-share payments of $7,041 across nine PAPs.

CONGESTIVE HEART FAILURE (CHF) EPISODE

In Arkansas, 24 percent of hospitalized Medicare patients with congestive heart failure (CHF) are historically re-admitted within 30 days annually.[7] 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. Table 8 lists the CHF episode volume for 2012–2016.

Table 8: CHF Episode Volume					
	2012	2013	2014	2015	2016
Medicaid	225	204	232	207	NA
AR BCBS	48	17	19	9	14

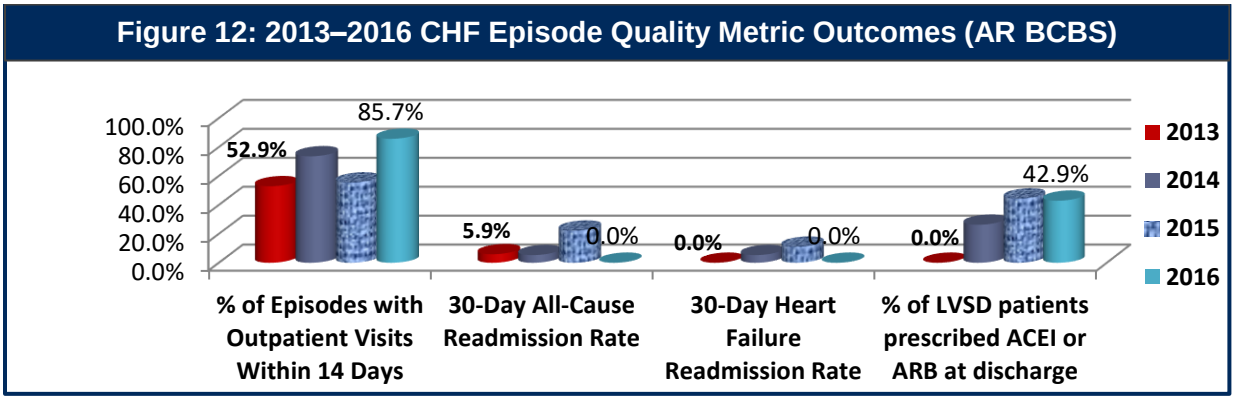
Quality metrics for the CHF episode include the prescribing rate of an angiotensin-converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy at hospital discharge to patients with left ventricular systolic dysfunction (LVSD); frequency of outpatient follow up within seven and 14 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)[8]. Key findings include:

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 2016 are displayed in Figure 12.

Figure 12: 2013–2016 CHF Episode Quality Metric Outcomes (AR BCBS)



CHF PROVIDER COST RANGE OUTCOMES

AR BCBS had one PAP for CHF during 2015 and 2016. The PAP moved from the unacceptable category in 2015 to the acceptable category in 2016.

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 1–65.

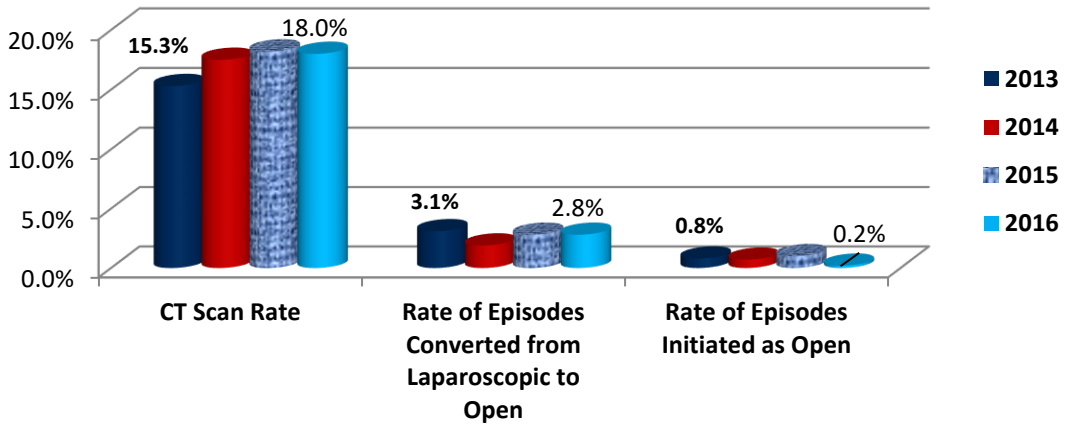
Table 9: Cholecystectomy Episode Volume				
	2013	2014	2015	2016
Medicaid	523	520	600	NA
AR BCBS	1,479	1,239	1,151	1,151

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 9 lists the cholecystectomy episode volume for 2013 through 2016.

CHOLECYSTECTOMY QUALITY OUTCOMES

Cholecystectomy quality outcomes for 2013 through 2016 are displayed in Figure 13.

Figure 13: 2013–2016 Cholecystectomy Quality Metric Outcomes (AR BCBS)



CHOLECYSTECTOMY PROVIDER COST RANGE OUTCOMES

Cholecystectomy cost outcomes for 2014 through 2016 are displayed in Table 10.

Table 10: 2014–2016 Provider Cost Outcomes: Cholecystectomy (AR BCBS)

PAP Cost Range	**2014** (98 PAPs)	**2015** (103 PAPs)	**2016** (100 PAPs)
Commendable	23.5%	70.9%	85.0%
Acceptable	63.3%	13.6%	6.0%
Unacceptable	13.3%	15.5%	9.0%

For AR BCBS, average episode cost increased by 10.5 percent from 2015 to 2016, after an increase of 2.0 percent from 2014 to 2015 and an increase of 4.1 percent from 2013 to 2014.

AR BCBS paid $167,836 in gain-share payments in 2016 for cholecystectomy episodes to 85 PAPs, while assessing risk-share payments of $20,733 across nine PAPs.

TONSILLECTOMY EPISODE

Tonsillectomy is one of the most common surgical procedures in Arkansas in children under the age of 15.[9] 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 3 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 11 lists the tonsillectomy episode volume for 2013 through 2016.

Table 11: Tonsillectomy Episode Volume

	2013	2014	2015	2016
Medicaid	2,693	3,096	3,409	NA
AR BCBS	638	341	392	639

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 post-operative 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.[10] Medicaid and AR BCBS participate in the tonsillectomy episode.

TONSILLECTOMY QUALITY OUTCOMES

For AR BCBS, quality measure outcomes include a slight reduction in intra-operative steroid use, from 83.7 percent in 2015 to 72.1 percent in 2016.

TONSILLECTOMY PROVIDER COST RANGE OUTCOMES

Tonsillectomy episode cost outcomes for 2015 and 2016 are displayed in Table 12.

Table 12: 2014–2016 Provider Cost Outcomes: Tonsillectomy (AR BCBS)

PAP Cost Range	**2014** (36 PAPs)	**2015** (33 PAPs)	**2016** (50 PAPs)
Commendable	38.9%	45.5%	32.0%
Acceptable	44.4%	42.4%	44.0%
Unacceptable	16.7%	12.1%	24.0%

For AR BCBS, the average episode cost decreased by 5.2 percent from 2015 to 2016, after a decrease of 5.2 percent from 2014 to 2015 and an increase of 17.5 percent from 2013 to 2014.

AR BCBS paid $23,478 in gain-share payments in 2016 for tonsillectomy episodes to 16 PAPs, while assessing risk-share payments of $7,326 across 12 PAPs.

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 at 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,

Table 13: CABG Episode Volume

	2013	2014	2015	2016
Medicaid	32	36	30	NA
AR BCBS	NA	135	88	157

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 13 lists the CABG episode volume for 2013 through 2016.

CABG QUALITY OUTCOMES

For AR BCBS CABG episodes, pre-operative inpatient length of stay increased slightly from 2.6 days in 2015 to 2.8 days in 2016.

For AR BCBS CABG episodes, the rate of patients admitted to the facility on the day of the procedure decreased from 47.7 percent in 2015 to 40.1 percent in 2016.

CABG PROVIDER COST RANGE OUTCOMES

CABG cost outcomes for 2015 and 2016 are displayed in Table 14.

Table 14: 2014–2015 Provider Cost Outcomes: CABG (AR BCBS)			
PAP Cost Range	**2014** (14 PAPs)	**2015** (9 PAPs)	**2016** (19 PAPs)
Commendable	35.7%	33.3%	52.6%
Acceptable	64.3%	44.4%	36.8%
Unacceptable	0.0%	22.2%	10.5%

For AR BCBS, the average CABG episode cost increased by 3.6 percent from 2015 to 2016, after an increase of 2.8 percent from 2014 to 2015.

AR BCBS paid $136,299 in gain-share payments in 2016 for CABG episodes to 10 PAPs, while assessing no risk-share payments for the 2016 performance period for CABG episodes.

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 healthcare professional that they have COPD.[11] Quality metrics include percentage of episodes where the patient visits an 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 15 lists the COPD episode volume for 2014 through 2016.

Table 15: COPD Episode Volume			
	2014	**2015**	**2016**
Medicaid	990	924	NA
AR BCBS	223	250	218

COPD QUALITY OUTCOMES

For AR BCBS, the rate of follow-up with a physician within 30 days decreased from 65.6 percent in 2015 to 64.7 percent in 2016.

COPD PROVIDER COST RANGE OUTCOMES

COPD cost outcomes for 2014 through 2016 are displayed in Table 16.

Table 16: 2014–2016 Provider Cost Outcomes: COPD (AR BCBS)			
PAP Cost Range	**2014** (23 PAPs)	**2015** (27 PAPs)	**2016** (26 PAPs)
Commendable	26.1%	22.2%	73.1%
Acceptable	69.6%	59.3%	19.2%
Unacceptable	4.4%	18.5%	7.7%

AR BCBS paid $6,691 in gain-share payments in 2016 for COPD episodes to five PAPs, while assessing risk-share payments of $20,821 for two PAPs.

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 attack.[12] 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 17 lists the PCI episode volume for 2014 through 2015.

Table 17: PCI Episode Volume			
	2014	**2015**	**2016**
AR BCBS	619	474	512

PCI QUALITY OUTCOMES

For 2016, the rate of PAPs passing the metric of having greater than or equal to 95 percent of episodes not flagged for adverse outcomes was 92.9 percent.

The proportion of patients with any adverse outcomes was 2.4 percent in 2014, 3.6 percent in 2015, and 4.9 percent in 2016.

PCI PROVIDER COST RANGE OUTCOMES

PCI episode cost outcomes for 2014 through 2016 are displayed in Table 18.

Table 18: 2014–2016 Provider Cost Outcomes: PCI (AR BCBS)			
PAP Cost Range	**2014** (58 PAPs)	**2015** (52 PAPs)	**2016** (56 PAPs)
Commendable	69.0%	67.3%	58.9%
Acceptable	19.0%	28.9%	25.0%
Unacceptable	12.1%	3.9%	16.1%

For AR BCBS, average episode cost for PCI increased by 7.8 percent from 2015 to 2016, after an increase of 8.6 percent from 2014 to 2015.

AR BCBS paid $263,853 in gain-share payments in 2016 for PCI episodes to 33 PAPs, while assessing risk-share payments of $56,749 across nine PAPs.

ADDITIONAL EPISODES

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 has aided in the development of Arkansas Medicaid's Medical Neighborhood reporting, which can be used by PCMHs in coordinating care for high-risk patients as they pursue per member, per year management strategies to contain costs.

Table 19 on the following page displays episodes that historically have been either deployed or developed across participating payers.

Table 19: 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 (inactive as of 2018)
Perinatal	Medicaid, AR BCBS (ended 12/31/2018)	July 2012: Medicaid January 2013: AR BCBS January 2014: QC
Congestive Heart Failure (CHF)	Medicaid, AR BCBS (ended 12/31/2018)	October 2012: Medicaid January 2013: AR BCBS
Total Joint Replacement (TJR)	Medicaid, AR BCBS (ended 12/31/2018)	October 2012: Medicaid January 2013: AR BCBS January 2014: QC
Cholecystectomy (Gall Bladder Removal)	Medicaid, AR BCBS (ended 12/31/2018)	July 2013: Medicaid January 2014: AR BCBS
Colonoscopy	Medicaid, AR BCBS (ended 12/31/2015)	July 2013: Medicaid
Tonsillectomy	Medicaid, AR BCBS (ended 12/31/2018)	July 2013: Medicaid January 2014: AR BCBS
Oppositional Defiant Disorder (ODD)	Medicaid	October 2013 (inactive as of 2018)
Coronary Artery Bypass Grafting (CABG)	Medicaid, AR BCBS (ended 12/31/2018)	January 2014: Medicaid January 2015: AR BCBS
Asthma	Medicaid	April 2014: Medicaid
Chronic Obstructive Pulmonary Disease (COPD)	Medicaid, AR BCBS (ended 12/31/2018)	October 2014: Medicaid January 2015: AR BCBS
Percutaneous Coronary Intervention (PCI)	Medicaid, AR BCBS (ended 12/31/2018)	July 2015: Medicaid January 2015: AR BCBS
Appendectomy	Medicaid	April 2018 (informational episode)
Urinary Tract Infection	Medicaid	April 2018 (informational episode)
Hysterectomy	Medicaid	April 2018 (informational episode)
Uncomplicated Pediatric Pneumonia	Medicaid	April 2018 (informational episode)

CONCLUSION

Now in its seventh 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. 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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