

Transforming the Arkansas Health Care System to a Sustainable Model

Environmental assessment:

- 45 states with significant budget deficits
 - Most cutting benefits, slashing provider payments, restricting enrollment
- Health care costs continue to rise – public and private – faster than revenues available
- Fee-for-service leads to fragmented, volume-based treatment; capitation shifts insurance risks to providers; managed care extracts resources from care delivery
- Need for a new payment system that rewards high-quality, patient-centered, efficient care

What we are not proposing:

- No reduction in benefits
- No cuts in provider payments
- No restriction in eligibility
- No outsourced managed care
- No major budget reduction
- No expectations of providers to join a single “accountable care organization”
- Not Medicaid only
- Not a secret plan

A new direction:

- Emphasizing wellness and prevention
- Paying for effective, coordinated episodes of care rather than for individual services
- Building off of existing practices, referral networks, and partnerships
- Building off of existing claims forms (paper and electronic) and using existing data to model results
- Helping people live as independently as possible
- Aligning financial incentives to achieve a transformed system of care

A new framework:

Three payment components for care:

- Diagnosis and treatment of disease—a medical model of care for episodes of physical and behavioral care (acute, sub-acute, and chronic)
- Birth, well-child, contraceptive, and preventive services—a wellness model of care
- Care services in the most appropriate setting for individuals requiring assistance with activities of daily living—a supportive model of care

The new concept:

- Providers will be responsible and familiar with each patient's history and have information available through the information exchange to optimize treatment efficiency and outcome
- Patients will be informed and engaged in all decisions related to their care
- Medical-service partnerships will use the most efficient and effective delivery systems, methods, and evidence-based protocols
- Provider partnerships will exercise excellent clinical judgment
- The episode(s) of care will not be restricted if a patient is unable to afford critical diagnostic and treatment elements

A new strategy:

- Identify best practices and recognizable formal and informal care patterns and partnerships which make up the existing Arkansas “system of care” to determine appropriate “episodes”
- Use claims records of Arkansas Medicaid, Medicare, Arkansas BlueCross and BlueShield and other private insurers to create a new reimbursement structure for these “episodes”
- Design the development of health-home partnerships and financial reimbursement strategy
- Transition from fee-for-service to a new reimbursement strategy supporting high-quality, patient-centered efficient care

Why Arkansas?

- Relatively small population, urban and rural
- Currently stable Medicaid program that has not turned to managed care but that faces a real fiscal threat
- Strong provider community committed to the state and working to resolve challenges
- Strong not-for-profit private health insurer with aligned interests in quality enhancement and cost control
- Stable executive branch with Governor who is committed to cost-containment prior to coverage expansion

Request of Secretary Sebelius:

- Support to implement the nation's first statewide payment reform initiative
- Political support for required Medicaid waiver for development of new payment strategy
- Inclusion of all Medicare recipients in partnership with Medicaid and private payers
- Contribution of fiscal and intellectual support for development and implementation

State of Arkansas proposed timeline:

- By May 1, 2011, Arkansas and the Centers for Medicaid and Medicare Services (CMS) agree to pursue a Section 1115 Waiver for plan development
- Partnership and pricing requirements would be published between May 2012 and July 2013
- Phased implementation from July 2012 through January 2014 (wellness, medical-care, long-term care in sequence)

Timeline for the process:

- Request of Sebelius (3/1)
- Briefing of General Assembly leadership (3/7)
- Provider briefing (3/7)
- Invitation to other insurance companies (3/7)
- Medicaid stakeholder meeting (3/10)
- Establishment of all-payer database (April)
- Establishment of working groups and transparent process for development (April)
- Adoption of rules/regulations for implementation