

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, moving to managed care
- AR faces major Medicaid shortfalls beginning in July 2012
- Rather than making deep cuts, AR wants to use health care dollars more wisely by reducing unnecessary costs
 - (e.g. duplicate tests, poor coordination, unnecessary procedures)
- Fee-for-service leads to fragmented, volume-based treatment. Marginal changes won't work.
- Long term stability requires significant payment reform
- Need for a new payment system that rewards high-quality, patient-centered, efficient care

What we are not proposing:

- Reduction in benefits
- Cuts in provider rates
- Restriction in eligibility
- Outsourced managed care
- Major budget reduction
- Expectations of providers to join a single “accountable care organization”
- Full-risk capitated payments

What we are proposing:

- Working with Medicare and private payors to move from fee-for-service to a system where:
 - consumers have health homes and
 - partnerships of providers are paid for episodes of care

A new direction:

- Emphasizing wellness and prevention
- Helping people live as independently as possible
- Paying for effective, coordinated episodes of care rather than for individual services
- Building off of existing practices, referral networks, and partnerships
- 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

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

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