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