Date: May 11, 2011

TO: Medicaid Stakeholders

FROM: John Selig, DHS Director

RE: Arkansas Payment Reform Strategy

I would like to provide this progress report on our efforts to safeguard the Medicaid program and the Arkansas healthcare system from a looming fiscal crisis.

Across the U.S., clinical inefficiencies and quality gaps result in avoidable care estimated to represent 5-30% of all healthcare expenditures. Rather than make the deep program cuts seen in other states, our goal is to align payment incentives to eliminate duplication of services and improve the coordination and effectiveness of care delivery. The strategy is to move from a fragmented, volume-driven fee-for-service system to one that pays teams of providers for episodes or bundles of care.

By improving the effectiveness of our system we will reduce system costs and demonstrate the fiscal stewardship of the Medicaid program expected by the public and the legislature.

Since Governor Beebe submitted our concept proposal to Secretary Sebelius in February, we have had ongoing discussions with the Secretary’s team, met with over 30 provider organizations, examined existing approaches considered and underway across the U.S., and explored current requirements and future flexibility afforded under the CMS Innovation Center.

In addition, we have invited private sector payers to participate in our developmental efforts. To date, BlueCross and BlueShield of Arkansas, the Employer Healthcare Coalition of Arkansas, and QualChoice of Arkansas have voiced commitment to participate in the development and refinement of our strategy.

In the Governor’s letter to the Secretary we described several aspects of our approach that upon discussions with the US DHHS, private sector payers, and providers, we believe should be modified.

We proposed three content areas under the definition of clinical “episodes” and payment “bundles”. These included 1) wellness or healthy care; 2) acute and chronic condition care; and 3) supportive care. We also suggested a sequence of development and implementation of healthy care followed by acute and chronic condition care, and finally supportive care. However, from discussion with provider groups, we believe there are conditions in each of the three areas that could be prioritized for examination, developed concurrently and deployed as soon as possible, followed by more difficult and/or complex conditions that may require more effort. Thus, we are now soliciting your support and engagement across all three areas to identify high impact clinical episodes for early implementation.

Second, we have proposed payment to local partnerships as a mechanism to foster greater coordinated, team care in a predominantly rural health care environment. As explained, this framework was chosen because of its ability to support accountable “teams” responsible for clinical services, effective use of resources, and patient outcomes responsive to local provider circumstances. While we initially felt that
work on the partnership or team concept could begin immediately, we now believe that it is better to first develop prioritized episodes and then design the provider relationships that will support accountable performance and fair payment for coordinated services.

Third, much support has been expressed for the Department of Human Services’ ConnectCare program, inclusive of its primary case-management model, quality improvement initiatives, patient support, and provider outreach programs. We plan on building on past successes and will carefully consider many of the suggestions submitted by partners and providers. In fact, strengthening ConnectCare is consistent with the goal of ensuring strong medical and health homes, and it will complement the broader fundamental restructuring of our payment system.

Finally, we have made available aggregate clinical data that describes historic Medicaid expenditures by diagnosis, provider type and clinical service. We believe that greater understanding of program data, in combination with the experience of other health care payers, will lead to a more accurate understanding of clinical need and more targeted approaches to identify and implement solutions to program management. We are working with the federal and private sector to achieve this goal of information availability. Over time, this enhanced data will allow us, in concert with Arkansas stakeholders, to model different concepts of episodes, profile service delivery, and examine practice variation.

Our discussions with many of you have identified several areas for improvement in the Arkansas health care system:

- **Handoffs in care between providers (Transitions in Care)** – Ineffective transfer of patients to the next health care professional or clinical setting (hospital to home, nursing home to hospital, ICU to general ward) can result in avoidable re-hospitalizations, trips to the emergency room, or setbacks in a patient’s recovery. One example is incomplete coordination of medications between sites of care which results in a patient receiving too many or too few drugs for their condition.

- **Inefficient care provided by individual providers** – Avoidable care within a facility that occurs because of poorly organized clinical information, untimely or absent communication between health professionals, and ineffective use of technology. These deficits can result in repetitive diagnostic testing, unnecessarily long lengths of stay, and overuse of expensive equipment.

- **Ineffective diagnostic decisions** – Patients can undergo excessive diagnostic testing avoidable by a careful history, physical, and review of past medical records. Other patients receive unnecessary therapy for conditions that were either misdiagnosed or incorrectly attributed to their presentation. Examples include prescription of multiple drugs for poorly documented mental health disorders or brain scans for patients with simple headaches.

- **Ineffective clinical decision making** – Failure to use clinical guidelines can result in treatment plans that miss diagnoses, overuse resources, and fail to create optimal clinical outcomes. Examples include advanced antibiotics for routine community acquired infections, ordering an MRI of joints for vague musculoskeletal problems, or premature referral to a specialist instead of a brief assessment in primary care.
• **Missed health promotion opportunities** – Examples of such opportunities include immunizations, smoking cessation counseling, cancer screening, or diagnostic testing to avoid new complications from previous heart disease or lung conditions.

• **Better patient support and engagement** – We need to build into our system mechanisms to educate and engage patients and their families regarding appropriate care seeking behavior, regimen adherence, and personal health maintenance. An improved system would answer patient questions and reinforce important clinical advice.

• **Reducing health care acquired conditions**—Examples include wrong-side surgery, pressure ulcers, falls resulting in injuries, hospital acquired infections, dosing errors, etc.

Based upon your input and our analysis of the data we are beginning to identify conditions in each of the three content areas which appear promising for early program implementation. **On Thursday, May 26th at 1pm we will convene a stakeholder meeting to cover progress to date, discuss potential priority conditions with you, and outline a more detailed work plan for the future.** In addition, building on the seven areas for potential improvements outlined above, we are establishing an electronic mechanism to solicit your input on additional possibilities for early program implementation. We will be asking your respective organizations or individual members to submit suggestions by July 1, including information on:

- **Patient population affected**
- **Area of system (health, acute/chronic condition / support services)**
- **Primary provider type responsible (if one)**
- **Providers involved / affected**
- **Description of inefficiency and/or quality gap**
- **Impact assessment: number of patients / risk of bad outcome / cumulative cost estimates**
- **Suggested improvement / path for change**
- **Estimated impact of improvement -- # of individuals affected / savings to system**

We will establish a public review process for open participation and periodic updates. We anticipate publishing an initial list of potential priority areas for consideration in each of the three areas by June 15th. Following stakeholder suggestions through June, this list will be refined, and membership for workgroups will be determined to examine data, review strategies to date, and develop options for consideration. We anticipate establishing open workgroups with your participation in July.

We recognize the transition and uncertainty in the healthcare system and are committed to safeguarding the future of our Arkansas healthcare system with you. Our proposal to reduce duplication, increase coordination, and achieve higher quality of care for our beneficiaries holds opportunity but is a work in progress. Other alternatives promise to contain costs at the expense of providers and/or beneficiary services, and failure to act is not an option.

Thank you for your continued engagement on this critical effort.
Medicaid Stakeholders Meeting
Thursday, May 26th

Blue Flame Room located at
400 E. Capitol in Little Rock
Office of Child Support Enforcement (OCSE)

Blue Flame Room Guidelines

Since the Blue Flame Room is located in the same building as the Customer Service Office for the Office of Child Support Enforcement, we must maintain the following guidelines.

- **Food and drink** - Food and drink are only allowed in the exhibit area surrounding the auditorium. **No food or drink will be permitted inside the auditorium.**

- **Messages** - OCSE cannot be responsible for delivering messages.

- **Parking** – The parking lot in front of their building is for customers only. Attendees can park in the Best parking lot at the SW corner of 6th & Cumberland; there is also a Moses-Tucker “For Sale” sign in the parking lot (two blocks from the office); those who park there will need to put a sign in their windows with “OCSE” written on it. Please note: there is a Best Parking lot across the street from the bus station at Cumberland and Capitol – **this is not associated with OCSE, and you will be ticketed for parking there.**

Public parking decks and street parking are available. There is a parking lot belonging to Trapnall Hall that is across the street from our building on Capitol Street. This is NOT public parking; your car may get towed.

- **Secure building** - Restrict all activity to the Blue Flame Room Area. The adjacent lobby and its facilities are for our customers requesting service. **Please note:** This is a secure building. Should attendees choose to visit the break room at the north end of the building, they will need to sign in with the guard and wear a visitor’s badge.

- **Smoking** – Smoking within 25 feet of entrances to state government buildings is prohibited.