

## **Transforming Arkansas Medicaid**

Medicaid programs in every state have the growing challenge of providing quality care with limited resources. In the face of immediate financial crises, many states are making or considering a variety of dramatic changes, including across the board rate cuts, elimination of vital services, shifting risk to large managed care companies and even requesting federal permission to eliminate many beneficiaries.

States are also testing new care and payment models, many based on the growing consensus that the predominant fee-for-service model of reimbursement creates tremendous inefficiencies. Unfortunately, most of these efforts are small scale and not expected to yield significant quality or cost impacts in the near future.

Arkansas Medicaid hopes to avoid the dramatic cuts or moves to capitated managed care being made in other states, but there is not time for small-scale demonstration projects to evaluate new approaches over several years. Rather, it is essential to take broad action now based on the best available evidence of what steps will truly transform Medicaid for the better.

Outlined below is an aggressive plan to transform the Arkansas Medicaid program from an inefficient fee-for-service system to one focused on providing quality care via “health homes”. The primary goal is to make more effective use of health care resources by:

- emphasizing wellness and prevention;
- paying for effective, coordinated episodes of care rather than for individual services;
- helping people live as independently as possible; and
- aligning financial incentives to achieve a transformed system.

By reducing inefficiencies, this new system will not only improve care but bring the added benefits of both reducing the growth of Medicaid expenditures and allowing improved reimbursement for appropriate care. This should also achieve the Beebe Administration’s goal of bending the Medicaid cost curve to reach sustainable levels of growth before assuming a portion of the cost for many new Medicaid eligibles.

To achieve this, the Arkansas Medicaid program intends to incentivize and support the development of local provider partnerships capable of serving as health homes for Medicaid enrollees. Providers in each partnership will coordinate their efforts to ensure high quality, cost-effective care. In return, the partnership will be reimbursed not for individual services, but for episodes of care. The reimbursement levels will support care that: (1) makes full use of the client’s electronic medical record and (2) uses the most cost-efficient and clinically effective treatment available based on current medical knowledge of best practices.

Acknowledging the varied support needs of differing groups in Medicaid, the new system will consist of three components:

- Diagnosis and treatment of disease – a medical model of care;
- Birth and well-child care and contraceptive management– a wellness model of care; and
- Care services in the most appropriate setting for individuals requiring assistance with activities of daily living – a caring model rather than a treatment-oriented medical model.

This plan is built around informed client participation with his or her primary care provider and other care team members. Both the client and team members will be supported, in turn, by Arkansas Medicaid which will offer, as needed, assistance in the areas of administration, care coordination and care management.

The transition to such a system will not be easy or occur overnight. It will require a federal Medicaid waiver, which should take approximately one year from development through approval. Medicaid will simultaneously work with providers and others over the next two years to (1) identify best practices for different diagnostic episodes, (2) create the reimbursement structure for those episodes, and (3) design and support the development of health home partnerships. Reimbursement will then begin to transition from fee-for-service to payments for episodes of care, building off of the bundled payment strategies now employed for prenatal and obstetric services.

As noted above, there is a growing consensus on the need to move away from fee-for-service reimbursement. To have optimal impact on the broader health system in Arkansas, Medicaid will need to bring Medicare to the table with the private sector to ensure that the new payment and care models are complementary and give consistent incentives to recipients and providers.

This approach builds on strengths in Arkansas' existing system and anticipates changes in health care across the country.

- Health homes where recipients, especially those with complex needs, can receive coordinated support and care is one of today's most promising concepts. Much work around the nation is being done to implement effective models, and the federal government has indicated its strong interest in supporting state models.
- Many, if not most, Arkansas providers already participate in local or regional networks, practices and partnerships. Some are formal in nature, others less formal but equally strong. This new system will build on those existing relationships and structures.
- Coordinated care across providers requires the ability to share accurate and timely health information. Current federal and state efforts to create electronic health

records and a statewide Health Information Exchange will allow for this information sharing.

- There is a growing body of evidence on the most effective approaches to preventing illness and treating various diagnoses. The new Medicaid reimbursement system will be designed to fairly compensate providers for using these best-practices. This should result in improved reimbursement levels for many cost-effective providers and services.
- Arkansas has made great strides in getting children and new mothers off to a good start and in assisting seniors and people with disabilities to live as independently as possible. To further these efforts, the new Arkansas Medicaid program will include health homes specially designed to support prevention and wellness and to ensure that people with long term care needs can be served in the most independent and cost-effective settings.

The transformation outlined above draws on the ongoing efforts around the country to stabilize and improve both Medicaid and broader health systems. While a strong concept, there are still many questions and much design work to be done in concert with providers, advocates, and other stakeholders.

In the meantime, the existing Medicaid program must continue to be managed very tightly.