



STATE OF ARKANSAS  
MIKE BEEBE  
GOVERNOR

February 11, 2011

The Honorable Kathleen Sebelius  
Secretary of the U.S. Department of Health and Human Services  
330 Independence Avenue, S.W., Room 4257  
Washington, DC 20201

Dear Madam Secretary:

Arkansas is pleased to submit the enclosed proposal to develop a new payment system for its Medicaid program, one that will promote coordinated, evidence-based care while bending the cost curve. We believe that a public-private collaborative planning process will produce an effective new framework for organizing health services in preparation for implementation of the Affordable Care Act (ACA).

Blue Cross Blue Shield of Arkansas has expressed to me an interest in participating in the development of this new payment system, while, of course, reserving all decisions regarding its use of such a system, in whole or in part, until the particulars of the system are clear. I welcome their interest and will invite other insurers to participate, as well. Given the widespread challenges in sustaining local Medicaid programs, our statewide efforts could provide CMS with experience to guide nationwide efforts in health-care reform.

We have not had a chance to fully consider all the possible connections between Section 1332 of the ACA and our proposal. However, we would appreciate the opportunity to do so as part of the process described in our proposal. Our proposal represents an opportunity to create new approaches to achieve affordable, effective care in our communities. I look forward to productive conversations with you and your staff regarding our initiative.

Sincerely,

A handwritten signature in black ink, appearing to read "Mike Beebe".

Mike Beebe

MB:jb

## Transforming Arkansas Medicaid

The impact of the recession, including the reduction in state revenues and the increase in Medicaid enrollments, the continued rapid growth in health-care costs, mission-critical state public education and safety programs, and balanced-budget requirements are driving states toward dramatic cutbacks in their Medicaid programs. Many are making, or considering, substantial across-the-board rate cuts, elimination of vital services, and requesting federal waivers to cut back on eligibility.

Arkansas would like to try a different approach – a partnership between **Medicaid, Medicare, and private health insurers** that would fundamentally transform the fee-for-service system. The plan is bold. It is not based on small-scale pilot projects, because such projects cannot yield broad-based cost and quality improvements in the near future. It is, however, based on current data, research, and existing health-system-delivery capabilities.

**In conjunction with Medicare, Arkansas BlueCross and BlueShield, and private insurance plans, Arkansas Medicaid will design and then implement the nation's first statewide payment-reform initiative. The initiative will pay partnerships of local providers to act as health homes. To promote efficiency and long-term effectiveness, reimbursement will be for episodes of high-quality care.**

Arkansas provides a unique constellation of features that favor its role as a pioneer in reimbursement reform:

- A relatively small population, urban and rural;
- Currently stable Medicaid financing, but a real **sense of urgency** that bending the cost curve must start now and that a **multi-payer** approach is necessary;
- A strong not-for-profit private health insurer with aligned interest in quality enhancement and cost control which can bring significant information on the commercially insured population in Arkansas; and
- A governor who supports health-care reform **but firmly believes that cost containment is critical to its success** and that an electronic health-information exchange is necessary to control costs.

Arkansas has a unique window of opportunity. We are in a period when an ambitious, coherent, integrated cost-containment and quality-improvement strategy can work if it focuses on the following:

- The health-care-delivery system and its principal “rules” (price, units, and payers);
- The application of standards of effectiveness and efficiency to the health-care-delivery system;
- The three related, but in many important ways different, subsystems for illness, wellness, and long-term care;



- Engaging/assisting members with medical decisions and adherence to treatment plans;
- Quickly making “utilities”, such as care coordination and medical management, electronic clinical and personal health records, billing and other administrative support services, available to providers and beneficiaries on an as-needed basis.

Active participation in the proposal described below can provide CMS, in its dual capacity as the chief steward of, and senior partner in, Medicare and Medicaid, with critical lessons, both as to solutions and process that can be shared with other states as the nation continues to prepare for implementation of the Affordable Care Act and continues the progress toward full implementation of the HITECH Act.

### **Proposal**

Arkansas proposes that by May 1, 2011, Arkansas and CMS (Medicaid and Medicare) come to an agreement on the terms and conditions of a Section 1115 waiver under which:

- Arkansas Medicaid, Medicare, Arkansas BlueCross and BlueShield, and any other private insurers that elect to participate will develop a new price system for health care that will be employed by Medicaid and other third-party payers who **elect** to use it (in whole or in part). The new system would be based on the following:
  - ✓ Payments to medical-care partnerships for episodes of physical and behavioral care (acute, sub-acute, and chronic).
    - At least one partner would be a primary-care provider.
    - The primary-care providers, with any assistance requested from Arkansas Medicaid, would also assume the role of medical home.
    - No partnership would be required to treat any individual for an episode of care if it felt it lacked the capacity to do so.
    - Some individuals or practices and medical organizations could and likely would belong to more than one “partnership”, reflecting the multiple formal and informal practice patterns that currently exist in Arkansas and elsewhere.
    - **Note:** Arkansas has tentatively selected the “care partnerships” as the payee for the new pricing system. This reflects the fact that the Arkansas health-care system is characterized by a wide variety of formal and informal relationships, with practices and organizations of varying size and scope. The partnership would appear to be the most flexible form of business and professional organization available today that promotes the mutual respect and assistance required for successful health outcomes.
  - ✓ Payments to maternal and child-health partnerships for prenatal, birth and delivery, and post-natal care services, well-child care, and developmental services and to primary-care providers for adult preventive services.
  - ✓ Payments to long-term-care partnerships caring for individuals who need assistance with activities of daily living (ADLs).

- Long-term-care partnerships would be oriented to “recovery”, as that term is used today in the behavioral health area.
- The new price system would become effective for Medicaid statewide as follows:
  - 100% of the pricing for payments to maternal-and-child-health partnerships would be published by May 1, 2012, and become effective on July 1, 2012;
  - 25% of the pricing for payments to medical-care partnerships would be published by May 1, 2012, and become effective on July 1, 2012.
  - An additional 50% (for a total of 75%) of the pricing for payments to medical-care partnerships would be published by May 1, 2013, and become effective on July 1, 2013.
  - An additional 25% (for a total of 100%) of the pricing for payments to medical-care partnerships would be published by January 1, 2014, and become effective on that date.
  - 100% of the payments to long-term-care partnerships would be published by May 1, 2013, and become effective for new patients on July 1, 2013.
- The new price system is not intended to shift the medical risk associated with any Medicaid-covered population to any partnership or clinical entity. The medical risk includes the risk of illness in the population and the risk of failure inherent in the uncertainty associated with individual patient responses to any medical treatment.

Note: The term “price” is used in this paper – but the terms “reimbursement or payment” would be equally appropriate.

- Billing under the new system would utilize the same claim forms (paper and electronic) and the same information currently required to be submitted by medical-service providers (i.e. ICD-10CM, CPT, HCPC and HIPAA standards would apply).
- Nothing in the waiver would change the scope of practice or the conditions of any license of any Arkansas medical professional organization. However, it would lead to reorientation of clinical practice to achieve optimal efficiency.
- All prices would be continuously reviewed and adjusted to reflect improvements in the health-care-delivery system and advances in medical science and technology.
- The new system prices would be built on the following assumptions:



- All providers will be completely familiar with each patient’s medical record and history, including all diagnosis and treatment received from any provider, i.e. all providers will use the Health Information Exchange.
  - The patient is a fully informed and engaged participant in all decisions and treatment related to his or her care. The responsibility for engaging the patient is borne by Medicaid and the partnership.
  - All medical-service partnerships will use the most efficient and effective health-services-delivery systems/methods/protocols. Medicaid will provide the “utility services” (described on page 1) when requested.
  - All partnership providers, individually and collectively, will exercise excellent clinical judgment. Excellent clinical judgment is fully informed by the most current medical knowledge, including comparative effectiveness and evidenced-based practice guidelines and research. It is shaped by the treatment goals (medical and non-medical) of the individual patient. It is not a minimum standard of care.
  - Under the Affordable Care Act, no episode of care will be limited in scope solely because a patient is unable to afford all of the critical diagnostic and treatment elements of care.
- The new Medicaid price system would not become effective unless CMS accepts an Arkansas Operating Plan for the waiver by July 1, 2012. The Operating Plan would, among other things, do the following:
    - Establish that Arkansas Medicaid has made available the support services to providers and members necessary for the successful implementation of and transition to the new system. These support services may also be acquired collaboratively from a coordinated source for Medicare and private insurers that choose to adopt the payment methodologies supported by this initiative.
    - Identify how, under the new system, the Medicaid agency will handle its responsibilities for program integrity and the “on-going evaluation, on a sample basis, of the need for and the quality and timeliness of Medicaid services.” (42 CFR 456.22) Under an integrated approach such as this, it will be possible to create a collaborative public/private initiative to identify and address fraud and abuse in the system more effectively than each of the entities has been able to do independently.
    - Establish that sufficient care partnerships are enrolled in Arkansas Medicaid to provide access to care for covered services to the same extent that it is available to those enrolled in Medicare and/or with other insurers.

- Federal budget neutrality requirements would be satisfied if the average rate of increase in Arkansas Medicaid per-member, per-month costs between SFY 2010 and SFY 2015 did not exceed the average rate of increase in the Arkansas Medicare per-member, per-month costs during the same period. **The base year for determining state “maintenance of effort” would be SFY 2010.**

The State of Arkansas would provide assurances to private insurers who choose to align in whole, or in part, their pricing (or “reimbursement”) policy with that of Medicaid’s, that such alignment is consistent with state insurance requirements.

Medicare would, to the fullest extent possible (which would be determined solely by Medicare), align its pricing policy with that of Medicaid.

Medicare and Medicaid, Arkansas BlueCross and BlueShield, and any other private insurer that chooses to participate would agree to the following:

- Jointly staff the development of this new pricing system.
- Contribute to the multi-payer data set necessary for the successful design and implementation of the system
- Each reach to its own informed initial conclusion regarding whether or not to implement any of the pricing system, in whole or in part, by January 1, 2013.
- Develop the new system so that it supports and furthers the efforts of each party to be ready to comply with HHS requirements regarding the use of ICD-10 CM for claims for services provided on and after October 1, 2013.

In order to develop, transition to, and fully implement this new price system and to assure that providers can and will establish necessary care partnerships within the ambitious timetable set forth, it is necessary to build on an existing foundation of data and relationships. The foundation for such an effort exists in the following:

- Claims records of Arkansas Medicaid, Medicare, Arkansas BlueCross and BlueShield, and other private insurers and administrative service organizations;
- Recognizable formal and informal care patterns and partnerships which make up the existing Arkansas “system of care”;
- Extensive literature and “hands-on” knowledge of Arkansas (and other) practitioners about “better” if not “best” practices;
- An Arkansas Medicaid program that is positioned to be a partner in, as well as a payer in, the Arkansas health-care system;
- Underlying “value” that the development and implementation of this new system is not a “project” but a process that listens and learns and that will continue.

In summary, the timing is right and the strategic direction of the major public and private health-care payers are in alignment, which represents the potential for significant positive changes in the cost and quality of health care in Arkansas. Inclusion of the Medicare program in this public/private initiative creates increased potential to make real, broad-

based, positive changes to the financing of care in our State. By working on these initiatives together, minimizing the differences between systems of reimbursement, and jointly maximizing the efficiency and amount of supportive services made available, we believe the impact on providers, particularly the smaller entities such as rural primary-care practices, will be positive. We are excited about the opportunity this represents for Arkansas to become an example of how public and private health-care systems can together drive positive change that can become a model for consideration in other areas of the country.