Medicaid and Health System Transformation in Arkansas

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Summary

Federal programs, such as Medicaid, are essential in helping our most vulnerable citizens receive essential health care. Dramatic changes in our nation's health care system—rising costs, expanding need for government assistance, and increasing numbers of low-income uninsured—have put tremendous strains on not only the federal–state partnership through Medicaid, but also on Medicare and private insurance programs. The systems, as they are currently designed, are not sustainable. Thus, it is essential that the federal government work as a partner with the states to transform the health care system of our nation.

Arkansas has begun a major transformation of its health care system, implementing episode-based bundled payments in lieu of fee-for-service standards, in an effort to align payment incentives with improved health care quality, better outcomes, and lower or contained costs. This transformation is made possible by Centers for Medicaid and Medicare Services' (CMS) approval of Arkansas's state Medicaid plan. Further, Arkansas's General Assembly recently passed a state law to create a "private option" that will enable expansion of private health care coverage to low-income (under 139 percent of the federal poverty level) through Medicaid-supported premium assistance.

State-plan amendments and Medicaid program waivers are essential tools available to the federal government and to states that can be used to accomplish broad health care system transformation. Only through innovative transformations such as those being deployed in Arkansas will our system once again become viable and be able to provide efficient, accountable, and responsive delivery of health care to our citizens.

Importance of Medicaid in our Nation's Changing Health Care System

Since their inception in 1965, Medicaid and Medicare have provided critical support for individuals to receive life-saving health care and manage life-altering diseases. For nearly five decades Medicaid—as a partnership between the federal and state governments—has been the primary and often the only source of health care coverage for the poorest, sickest, and most disabled Americans. Many of these citizens are those most in need of coverage, having multiple and complex health conditions but lacking the financial resources to secure private-market health insurance. The comprehensive scope of services and limited cost-sharing design was intended to address the complex health needs of low-income populations, including the chronically ill and individuals with severe physical and mental disabilities.

Over these five decades, the U.S. health care system has changed dramatically. Along with increased diagnostic and therapeutic options, we have an expanded ability to extend life, resulting in increased costs of care. Life expectancy has increased by nearly 10 years since the 1960s. At the same time, health care costs now represent 17 percent of the gross domestic product and place the nation and our economic competitiveness at risk. Private health insurance costs, Medicare costs, and Medicaid costs have consistently outpaced economic growth by every indicator. In Arkansas, private premiums for family coverage have nearly doubled from ~$6000 to ~$12,000 in the past decade. Similar inflationary increases have been felt in Medicaid programs across the country, exacerbated by the economic downturn that has increased the number of individuals relying on the program for basic health care services.

Thus, the Medicaid program is one major component of a health care system entering a necessary transition—one that achieves accessible, high-quality care at a cost that is sustainable. This challenge is in no way limited to Medicaid. Private insurance, Medicare, and self-insured employers are each faced with similar challenges. However, the shared financial obligation

between the federal government and states is unique to Medicaid and too frequently places tension on the partnership relationship that must be productive to be successful. This tension should result in reinforcing support for change, not evisceration of the federal government's responsibility to achieve that change.

Health System Transformation in Arkansas

Arkansas Payment Improvement Initiative

Arkansas has tackled the challenge of system reform and demonstrated the ability to have Medicaid lead a creative new strategy for health care system transformation by utilizing tools that are available today. Starting three years ago, the Arkansas Payment Improvement Initiative, led by Medicaid, began to establish a multi-payer effort to realign payment incentives to improve quality, achieve better outcomes, and contain costs. This initiative created a transition from a fee-for-service system to an incented episode-based model with both upside and downside risk on providers, with incentives paid through the Medicaid program. Accomplishing this required both state legislative and federal Centers for Medicaid and Medicare Services (CMS) approval. Using the state-plan amendment process, Arkansas gained federal approval within two months of submitting its plan. In large part, this approval was due to the demonstrated benefit and safeguards for the patient, the alignment of payment incentives for outcomes, and the potential to improve the system of care. As we extend this initiative by implementing new bundled episodes of care for various health conditions, we anticipate generating shared savings—savings for providers and savings to the state and federal governments.

Private Option in Arkansas

Most recently, the Arkansas General Assembly authorized the use of Medicaid funding through the Patient Protection and Affordable Care Act (PPACA) to provide premium assistance

to individuals under 139 percent of FPL for the purchase of private insurance qualified health plans (QHPs) via the new marketplace, or the Arkansas Health Connector.

Nationwide, Medicaid has historically used three mechanisms to finance and deliver health care for eligible individuals—direct provider payments (primary method used by Arkansas), competitive contracts directly with Medicaid managed care companies, or premium assistance through employers (limited to select cases where employer coverage was more cost effective). Arkansas's new approach is essentially premium assistance through the newly established marketplaces, achieving equivalent access for Medicaid beneficiaries and the privately insured while also incorporating private-sector cost-containment mechanisms. The explicit intent of the Republican leadership in our state legislature is to transform Medicaid and the Arkansas health care system into a more efficient, accountable, and responsive delivery system. Secretary Sebelius and CMS are working closely together to achieve successful implementation through necessary state plan amendments and/or waivers under her authority.

Role of Waivers in Transforming Health Care

As of 2012, Arkansas Medicaid was operating nine waiver programs designed by the state and approved by the federal government to provide Arkansans with better access, higher quality, and more cost-effective care. Among these is the ARHealthNetworks program, which is a low-cost, limited, health-care benefit program aimed at providing financial access to working-age adults and designed specifically for small businesses and self-employed individuals without medical coverage.

Arkansas is not alone among states in either seeking or obtaining flexibility through waivers to innovate and provide better value through Medicaid. Nearly every state in the union operates a waiver program. Currently 381 active waivers provide states with flexibility, enable the provision of services through managed care delivery systems, test new financing and delivery

models, or modify administrative processes and improve program integrity. While still recognizing the need for accountability for significant federal expenditures via waivers, CMS is working to streamline the waiver application process and to provide greater flexibility in light of the creativity of states and the rapidly changing marketplace. In addition, the new Center for Medicaid & Medicare Innovation has established more than 40 models for system transformation available to providers, communities, and states. These innovations are beginning to gain traction under the current partnership model where the risk of innovation is shared by the federal and state governments.

A call for block grants or "capped" exposure by the federal government to states is frequently cloaked in the justification of needed state flexibility but stems from a desire to limit federal fiscal exposure to the Medicaid program, with the possibility of curbing the very innovation that needs to be encouraged.

Conclusion

Accelerated change is needed in the Medicaid program but more importantly in the health care system itself. Medicaid, as a substantial purchaser of health care services that shares risks with states, is in a position to lead.

Tools exist now to achieve federal support of states when the approach to changing Medicaid includes recognition of the needs of low-income and disabled beneficiaries; the changes are part of a long-term state strategy to improve quality outcomes and costs; and the proposed changes offer an advance to the system. Now is not the time to weaken the federal-state partnership within Medicaid. It is the time to align federal and state commitments to achieve a high-quality health care system for all, inclusive of those who are most vulnerable.