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TRANSFORMATION & TRIBULATIONS
The Barriers to Arkansas' Healthcare Reform and Possible Ways to Overcome Them

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Introduction

Despite making some modifications to Governor Beebe's healthcare reform initiative, state officials are finding it difficult to win provider support. This should come as no surprise. Conceived in a theoretical vacuum and cloaked in secrecy, the ambitious initiative was on life-support when introduced. Even with the modifications, practical problems abound.

What follows is an analysis of the key concepts in the proposal. Also included are ideas physicians may want to use in future discussions with the Governor's team to help move reform efforts in a direction that physicians can support. In next month's *Journal* we will examine the actual cost drivers in the healthcare system and how much of the growth is attributable to physician services.

"Secret Plan"

Governor Beebe presented the proposal in a February 11, 2011, letter to Health and Human Services (HHS) Secretary Kathleen Sebelius.[1] The initiative was first entitled "Arkansas Health System Reform and Medicaid Transformation," or simply "Transformation." More recently the state started calling it the "Arkansas Health Payment Improvement Initiative."

Governor Mike Beebe

The Governor's letter sought HHS approval to reform the state's Medicaid program through "a partnership between Medicaid, Medicare, and private health insurers that would fundamentally transform the fee-for-service system." Providers and the rest of the public did not even learn about the proposal until a month later, pretty much the kiss of death in and of itself. The Governor insisted it was not a "secret plan," but to providers it sure seemed that way.

The state must have CMS approval, through a "waiver" process, to implement the Medicaid portion of the initiative. HHS has encouraged the state to move forward with more detailed ideas.

Gene Gessow

Joe Thompson

John Selig

From all indications, the proposal was developed by Gene Gessow, Arkansas' Medicaid director, with help from Joe Thompson, M.D., the state's surgeon general and director of the Arkansas Center for Health Improvement, and John Selig, director of the Arkansas Department of Human Services, which includes Medicaid. Arkansas Blue Cross and Blue Shield is also at the table through Steve Spaulding, vice president of enterprise networks for Arkansas Blue Cross and Blue Shield.

To their credit, state officials have responded to some of the provider concerns. They have backed away from an attempt to reform the system all at once and, for the first year, will target ten specific "priority areas" where they believe the greatest impact can be felt first:

•Pregnancy
•Prevention
•Mental health (ADHD)
•Diabetes
•Back pain

•Cardiovascular disease
•Ambulatory upper respiratory tract infections
•Developmental disabilities
•Long-term care

Officials still intend to start the transition July 1, 2012, but they will not attempt to move the entire system as fast as previously planned. They have not out-right abandoned any major piece of the proposal, but seem to be rethinking how to proceed on key parts, like provider partnerships. They are actively soliciting more provider input. Having started at the finish line, they must now back up and determine what the road to reform looks like.

Good Intentions

Few would seriously question Governor Beebe's intentions as anything but sincere. He has persuasively made the case that the current rate of Medicaid growth is unsustainable. Some 750,000 Arkansans depend on Medicaid, about a fourth of the state's population.[2] Medicaid spending has been growing at a rate of 7%, higher than the state budget, inflation, and the growth in national income.[3] The state is facing a $60-80 million deficit in Medicaid in fiscal year 2012-13 and some $200 million in $2013-14. The architects of the plan seem to be trying their best to satisfy the charge from the Governor to bend the cost curve. However, despite the good intentions and recent modifications, the initiative is still plagued by provider anxiety, lack of necessary infrastructure, and real questions about whether the proposal is aimed at the primary cost drivers.

Key Elements

Key features of this public-private cooperation include the following:

•"Partnerships" of providers
•Bundled payments for episodes of care
•Health homes
•All-payer claims database/Transparency
•Health information technology
•Wellness and prevention (including maternal and child health)

The Governor frequently says that he is not wedded to any particular plan and welcomes other ideas for bending the cost curve. However, the Administration has been steadfast in its position that two aspects of the healthcare system must change: fee-for-service and provider fragmentation. Almost all the ideas in the state's initiative are aimed at these two areas.

Partnerships

The one aspect of the Arkansas plan that perhaps has not been attempted anywhere else is the "partnership" concept. When first released, the proposal called for Medicaid to incentivize and support the development of local provider "partnerships." Partnerships would serve as "health homes" (discussed below) and be accountable for coordinating care and providing high quality, cost efficient outcomes. In return they would be reimbursed not on a fee-for-service basis for individual services, but a bundled payment for episodes of care.

While health homes and bundled payments for episodes of care are in various stages of development across the country, the "partnership" concept had nearly everyone scratching their heads. Providers did not understand what type of legal arrangement the state was suggesting; they predicted an administrative nightmare in trying to manage multiple entities; and they did not want to be forced into partnerships with anyone.

In a May 11, 2011 letter to stakeholders, DHS Director Selig backed away from the partnership idea, at least for the time being, saying the department will focus first on defining episodes of care, and then on the provider relationships that will support accountable care.[4] At a June 14, 2011, meeting before a legislative committee, Selig and others acknowledged that the partnership concept was the weakest part of the initiative, but officials seemed to have no Plan B to achieve integration.

The Governor and his team seem to be stymied in part by their insistence on statewide reform through one integration model as opposed to several smaller pilot projects testing different models. Partnerships might work with a few larger physician clinics that have close ties to one particular hospital. But other models will be necessary as well. After all, if the state will accept only one model, then (1) all those providers without sufficient integration and infrastructure to participate will be unable to make even the small improvements in value they could offer if given the opportunity to participate at their own level, and (2) those providers who could accept greater accountability than permitted by the state's model will be unable to deliver all the improvements in value they could offer. The state may find that it is possible to achieve savings more quickly by taking incremental steps than by trying to implement a complete episode-of-care payment system all at once.[5]

Bundled Payments for Episodes of Care

A bundled payment is a fixed prepayment to a group of providers for all care related to a specific treatment or condition. A popular approach among policymakers is using a bundled payment for an "episode-of-care." As envisioned in the Arkansas plan, the bundled payment would cover the services of multiple providers in multiple settings. For instance, a single payment could be made for a surgical procedure, including presurgical services, hospital and physician fees for the surgery (including lab, radiology, and pharmacy), and follow-up care with monitoring and

rehabilitation. The same principle would apply with other conditions, such as heart attack, pneumonia, diabetes, or hip replacement.

Note that bundled payments do not move completely away from the volume-based approach of fee-for-service. They eliminate incentives to order unnecessary tests within an episode, but they create new incentives to generate more episodes by conducting diagnostic testing that finds more treatable conditions eligible for the bundled payments.[6] Also, there is concern that, with a fixed payment, providers might cut back on necessary care, not just unnecessary care ("stinting").[7] Theoretically, quality measurements will counterbalance the temptation, but they are notoriously difficult to implement.

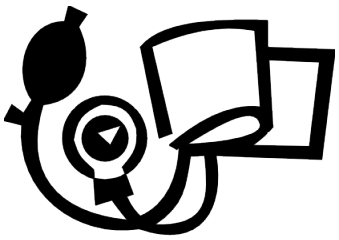
Medicaid officials originally planned to make a single bundled payment to a partnership, and the providers in that partnership would have to decide among themselves how to divide it up. Providers immediately dubbed this forced "cannibalism," pitting primary care physicians, specialists, hospitals, pharmacists, and post-acute providers against one another. Because it has not figured out how to get providers to integrate, the state seems unable to figure out how to pay bundled payments.

In light of staunch provider opposition, it is unlikely that true bundled payments are going to be feasible at this time outside of integrated settings like UAMS and Arkansas Children's Hospital, where the physicians are employed by the hospital. Some physician-hospital organizations (PHOs) may be open to some bundled physician and hospital payments, and independent practice associations (IPAs) may be amenable to bundling different types of physician payments. If payers piloted a few of these for different procedures or diagnoses and met with success, then smaller, independent providers might be incentivized to integrate in some form or fashion to participate.

State officials also could pilot other types of payment models as transitional steps.[8] For instance, "case rates" or "global fees" may be more acceptable to providers. Under this model, a single payment is made to a physician for all the care he or she provides to a patient for a condition or diagnosis or episode of care. However, unlike "bundled" payments, services provided by other providers are not included, which is likely to make it more acceptable.

Health Homes

Whether or not physicians form "partnerships," they will be expected to become "medical homes" or "health homes" to address problems created by fragmented care delivery. Very generally, "medical homes" focus on primary care practices or similar teams of providers led by a primary care physician, while "health homes" carry a broader meaning, including linkages and integration with specialists, hospitals, post-acute care facilities, long-term care, developmental disabilities providers, behavioral healthcare, and other community-based services and support.



Physicians in Arkansas are familiar with one of the earliest medical home models -- Arkansas Medicaid's ConnectCare PCP program, housed at the Health Department and promoted to physicians through the Arkansas Foundation for Medical Care (AFMC). Physicians receive about $36 per year for each beneficiary assigned to them. The current models are much more involved. A good description of today's health homes comes from the Kaiser Family Foundation:

- Provides person-centered care
- Facilitates access to the full array of primary and acute physical healthcare, behavioral healthcare, and long-term community-based services and supports
- Enhances coordination and integration of care, especially for persons with multiple chronic illnesses
- Improves quality and clinical outcomes
- Improves the patient care experience
- Reduces costs through more efficient care[9]

Most models involve extensive care coordination and wellness efforts.

AFMC has proposed an enhanced version of the ConnectCare program. In response to urging from the Arkansas Medical Society, Medicaid also has a planning grant through the Patient Protection and Affordable Care Act,[10] for health homes for individuals with chronic conditions. On the private side, Arkansas Blue Cross and Blue Shield is sponsoring seven clinics in a medical homes pilot.[11] Overall, Arkansas, like most states, is in the infancy of medical/health homes.

The big question is how physicians will be paid to deliver all these prevention, education, and care coordination services. Commentators agree that payment to physicians should recognize this added value, but the long-term solution to paying for these services has not been resolved. Presumably this will be worked out under the Medicaid planning grant and pilots by private insurers.

A more immediate problem is who is going to pay the upfront costs of "building" the medical home. The estimated cost of setting up a medical home ranges from $60 to $1,800 per person per year, while gross savings have been estimated at $250 per person per year, according to the National Conference of State Legislators.[12] Short of consolidating practices or selling out to

hospitals, options[13] may include physicians sharing resources, perhaps in the nature of an independent practice association. Payers may be able to offer assistance with health information technology, data collection and reporting, staff training, team-based care, and other aspects of health homes. If payers do not pay for the cost of these patient-centered services, many physicians will not have the means on their own to establish the sophisticated models that are needed to achieve savings.

All-Payer Claims Database

Almost everything in health care reform depends on data – more specifically, comparable data. Governor Beebe and his team want to be able to compare Medicaid, Medicare, private insurers and employer plans to provide a system-wide view of quality, cost, and access, particularly which providers are high quality/low cost and vice versa. The problem is that data between payers is often not comparable, and even if it is, it is not shared.[14]

Arkansas officials, like those in many states, see the establishment of an "all-payer claims database" or APCD as the solution. APCDs are a statewide repository of health insurance claims information from all healthcare payers. They typically include data on patient demographics, diagnoses, procedures, care locations, payers, providers, provider charges, and actual payments.[15]

In Arkansas, it appears that officials are most interested in using an APCDB to reduce variations in healthcare. In recent presentations, state officials and Blue Cross and Blue Shield have relied heavily on charts purporting to show wide variations in care patterns and in payments to providers for the same services. This is the type of work for which the Dartmouth Atlas of Health Care is particularly known.[16] However, providers are not convinced that payers have investigated all the bases for the variations, and the presentation got a cool reception at a recent legislative hearing. This is probably a worthwhile use of the APCDB, but it will take a while before payers have sufficiently refined their methods to secure provider trust.

One use of the APCDB that has received little if any attention could be important to physicians and other providers, and that is administrative simplification. [17] Providers have long endured fragmented and inconsistent payer policies. As much as fourteen percent of physician revenue is used just to deal with insurer claims processing requirements.[18] Governor Beebe has already made considerable progress in getting Medicaid, Medicare, and private payers to all start talking to one another about an all-payer claims database. It is possible, if enough forethought goes into it, that the database could be used to create efficiencies simply by reducing administrative burdens for providers.

Transparency

Traditionally, payers have shared very little claims data with providers. Under Gene Gessow, Medicaid is attempting to do this now, but the process is slow and cumbersome, requiring each

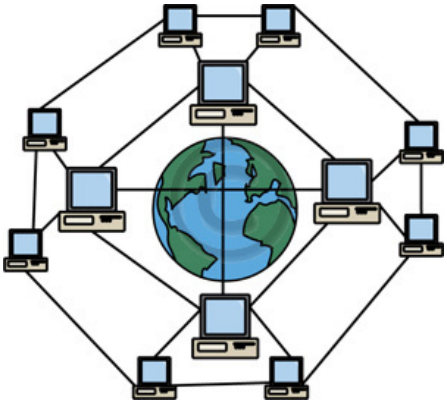
request for de-identified beneficiary data to be reviewed by the Medicaid Security Advisory Committee. The Security Advisory Committee is cooperative, and DHS has made genuine efforts to provide requested data, but this is not a workable approach long-term. It may be necessary to have some sort of disclosure to beneficiaries on the front end, informing them that their protected heath information may be used to improve care in this way and providing them a way to opt-out if they object, along the lines of what CMS proposed for accountable care organizations. But even that approach can be administratively complicated. Eventually, regulators or legislators must come up with a solution that enables providers to access beneficiary databases quickly and easily.

Moreover, the whole attitude toward sharing data with providers and their associations must change. To improve care for particular patients, especially those accessing care in multiple settings, providers need direct access to real-time claims data on identified patients, without payers having to approve such requests on a case-by-case basis.

Providers also must have a way to see the big picture if they are to improve care delivery. That means they and their representatives need streamlined access to beneficiary databanks for benchmarking utilization and costs. Providers have to have baseline data of particular patient populations in order to evaluate and improve care, and it must be continuously updated. This means *meaningful* data, not data dumps that are sometimes posted to the web.

Health Information Technology

Healthcare reform cannot be fully accomplished without health information technology or "HIT." HIT refers to both the hardware and software that is used for the entry, storage, retrieval, sharing, and use of healthcare information.[19] A big part of HIT is simply getting providers to convert from paper to digital format, but an even bigger challenge is making sure that all this technology is "interoperable," i.e., that all these systems "talk to each other."



Although adoption of HIT is progressing, Arkansas, like all states, has far to go. So far, about 60% of doctors and 33% of hospitals in Arkansas currently use electronic health records, and about 18% of office-based physicians use electronic prescribing.[20] Moreover, many EHRs have limited capabilities. To speed up the pace of HIT adoption nationwide, Congress passed and President Obama signed the Health Information Technology for Economic and Clinical Health Act (HITECH),[21] part of the American Recovery and Reinvestment Act of 2009 (ARRA). HITECH is the guiding framework for expansion of HIT in the United States, including specific incentives under Medicare and Medicaid to accelerate adoption of electronic health record (EHR) systems among providers.

HITECH funding for providers comes to about $27 billion, but the incentives are only available for some hospitals and physicians (plus some physician extenders for Medicaid). Home health, behavioral health clinics, developmental disability providers, long-term care, rehabilitation hospitals, psychiatric hospitals, and other providers were cut out during negotiations.[22] It will be impossible to fully implement Arkansas' Transformation if all these other providers are not connected with physicians electronically.

The Arkansas reform documents promise that Medicaid will offer support – what they call "utilities" – to providers and beneficiaries in the form of care coordination, medical management, electronic clinical records, personal health records, billing and other administrative support services. So far, however, Medicaid officials have been unable to provide clear answers to how this would work. In response to a recent request by some providers for HIT assistance, Medicaid came back with a polite response but no support.

Wellness and Prevention

Although wellness and preventions efforts are a part of the Arkansas proposal, not enough specifics have been included to assess them. Wellness and prevention are part of every serious healthcare reform effort in the country. There seems to be general agreement among providers in Arkansas that this is a good idea, especially if personal responsibility by patients is incorporated into the plan. Medicaid officials have waffled a little on this part, indicating that their hands are tied by federal limits on co-pays, but this could be included in the planned request for CMS to grant Arkansas a waiver from various other federal requirements. In addition, Medicaid could seek a waiver to require sliding-scale premium-sharing based on level of income for programs in which a beneficiary qualifies for Medicaid but has family support. In various settings, providers have been vocal in urging Medicaid to impose more personal responsibility on beneficiaries and stop exploitation of certain services, but have been unable to gain Medicaid's ear. Educating patients and helping them become active participants in managing their own care is a particularly helpful role payers could play, addressing a major concern for providers.

Conclusion

While the decision to focus on priority areas rather than the entire system at once is a positive step in the Governor's reform effort, fundamental problems remains. Options for overcoming them include:

•Implement smaller pilots projects instead of statewide reform, at least for now.

•Craft a plan that is not wholly dependent on provider integration since most care in Arkansas is not provided in integrated settings.

•Persuade independent providers to integrate in incremental steps.

•Consider payment models other than bundled payments for episodes of care, since that model is not well developed for most conditions.

•Provide health information technology and other supports that will enable physicians to serve as true patient-centered health homes.

•Educate patients and impose greater personal responsibility.

•Proceed with the all-payer claims database, but broaden its purpose to include administrative simplification.

•Provide direct, real-time claims data to providers and streamlined access to beneficiary databanks for benchmarking.

•Make investment in health information technology the top priority. Almost everything that Arkansas wants to accomplish under this reform effort depends on widespread use of HIT. Until Arkansas officials figure out a way to make this a reality, it is doubtful much of anything in the initiative will be accomplished.

Next month: Does the state's reform effort address the real cost drivers in healthcare?

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