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Department of Human Services Updates Medicaid Stakeholders on Payment Improvement Initiative

The Department of Human Services held another Stakeholders Meeting on Monday, August 8, to provide an update on the progress of the Arkansas Health Care Payment Improvement Initiative. (This is the same initiative that has previously referred to as "Medicaid Transformation" or "Bending the Cost Curve.")

Representatives from the Arkansas Center for Health Improvement went over the results of the online survey that was made available in May and June of this year. The summary included responses to the promising areas previously identified by Medicaid as well as additional areas for improvement identified by survey respondents. The summary presented the suggested improvements to the system as well as barriers to improvement identified by survey respondents. You may access the survey responses as well as the summary on the internet at https://ardhs.sharepointsite.net. (To get to the survey results from the main page, select "DMS Public" on the bar on the left side. Then select "Medicaid Transformation." Finally, click on "May 2011 Survey.")

As you may recall, at previous meetings, Medicaid has identified a number of diseases, conditions, and issues that were being considered as subjects for the payment improvement initiative. At Monday's meeting, DHS announced that ten topics are moving from "promising" to "priorities." In other words, these are the ten areas they are going to begin working on in the payment improvement initiative. Those areas, along with some of the factors that were mentioned relating to each area, are:

(1) Pregnancy—early detection of risk, interventions to prevent high-risk pregnancies, designating different delivery sites as appropriate for different risks of pregnancy, resource use of high-cost neonates, expected outcomes in terms of complication rates.
(2) Prevention—bundling expected services for specified population, for example women 40-55 who have low mammography rates.
(3) Mental health—children with a diagnosis of ADHD, accuracy of diagnosis, intensity of follow-up.
(4) Diabetes—Type 2, performance metrics, managing complex vs. newly diagnosed.
(5) Back pain—use of xrays for acute back pain, use of interventions in chronic back pain.
(6) Cardiovascular disease—readmission rates and follow-up testing intensity for congestive heart failure, performance metrics and intervention intensity for ischemic heart disease.
(7) Ambulatory upper respiratory tract infections—use of antibiotics and their effectiveness, ancillary xray testing and its usefulness.
(8) Developmental disabilities—coordinating health homes to integrate care plans for DD/MI dually diagnosed beneficiaries and integrating primary care plan with DD care plan to avoid duplication of services.

(9) Long-Term Care—services appropriate to activities of daily living, integrated management for Medicaid/Medicare dual eligibles.
(10) Systems support—appropriate reimbursement for ambulatory surgery, accountable expectations for medical homes, case management intervention for frequent ER users, radiology utilization.

These are the ten areas that will be addressed in the first year. Medicaid officials said the other topics that had been discussed at earlier meetings were being put off, not because they were unimportant, but because some other organization or initiative is working on the issue, the literature indicates there are no promising interventions, or the areas are not the best candidates for early episode monitoring.

Medicaid presented an example of how you might structure an episode-based system for the child ADHD population with different levels from a child who just needs assessment to a child who is in residential care. The "bundled" payment amount would increase at each level, with the most serious level perhaps reimbursed on a fee-for-service basis as now with an added managed care oversight function.

DHS announced that, in addition to Blue Cross Blue Shield, QualChoice and United and other smaller insurers have joined the payment improvement initiative. The representative from Blue Cross Blue Shield spoke and said that they are not planning to create a consolidated public/private payment system. What they are working toward is a health care environment where systems are consistent so that people moving back and forth from public to private and vice-versa will receive optimal care in the cross-over. He pointed out that in 2014, as a result of federal health care reform, many more people will be eligible for Medicaid and many more people will be receiving subsidies to purchase insurance on the health insurance exchange. For these people, there is likely to be significant movement back and forth from Medicaid to subsidized private insurance; consistency between the public and private systems will minimize the potential for disruption of health care delivery in the transition.

Thanks to a grant from Blue Cross Blue Shield, DHS has contracted with McKinsey & Co., an international management consulting firm, to help with this process. The representative from McKinsey said they will help Arkansas find local solutions, provide technical support, frame the options, and assist in analysis of data. Medicaid Director Gene Gessow said that in a state as small as Arkansas, it is possible to start with the administrative (claims) data and use that to spur questions and suggestions that patients and practitioners could answer, thereby "informing" the data by actual experience.

One of the ways Medicaid is going to work with patients and practitioners is by forming ten workgroups—one for each of the ten priority areas listed above. You can volunteer to participate in a workgroup by completing a form and returning it to DHS by August 29. The form is available at the same website referenced earlier in this summary. (Instead of clicking on "May 2011 Survey," click on "Health Care Payment Improvement Initiative Workgroups."). DHS Director John Selig stated that they want the groups to be small enough to be functional, but large enough to represent diverse viewpoints.

One provider group representative asked if the goal of this initiative is to identify inefficiencies and variations in care and lack of coordination and find solutions to those, or are we just assuming that the solution is bundling payments and episodes of care. The answer given was "both." Medicaid is clearly targeting the bundled payment/episode of care model. The task now is to develop the protocols and payment policies for those models in the ten areas listed above.