

## 1. EXECUTIVE SUMMARY: VOLUME I

Medicaid in Arkansas stands at a crossroads. In one direction, the State must decide whether to continue expanded Medicaid under the Affordable Care Act and, if so, decide how to provide these services. At the same time, the traditional Medicaid program is growing at an unsustainable pace, displacing other critical services, such as education, public safety, and criminal justice.

While these two factors might seem to be very different in nature, the reality is that they both lead to the same fundamental question: how does Arkansas best provide health care services to the needy in a manner that respects both those receiving care and the taxpayers?

To understand where the program is going, it is critical to recognize how Medicaid got to its current state, and how the program compares to other states in terms of quality, affordability, and efficiency of services. The best predictor of future performance follows the trajectory of the existing performance of the program.

The Stephen Group (TSG) was hired to assess the status of the traditional (pre-expansion) and expansion components of Arkansas Medicaid and make recommendations for improvement. The report that follows represents the assessment of these programs.

The Task Force was assembled largely to assist the Legislature in making a critical decision about the future of those newly eligible for Medicaid, who receive publicly-funded health insurance through the health insurance marketplace, a program often called the Private Option (PO). At the time of its implementation, Arkansas' solution to expanding Medicaid eligibility under the Affordable Care Act was a groundbreaking strategy that has been used as a model for other states.

### 1.1. Private Option

The goal of the PO was to bring more market-oriented principles to the delivery of care for a new population than are in place for the existing Medicaid program. By purchasing commercial insurance policies for these newly insured, the PO provides an opportunity to compare cost-effectiveness and quality against both the existing Medicaid program and those who purchase un-subsidized commercial policies through the exchange.

There can be no doubt about the impact of the PO on the health care and health insurance landscape of Arkansas. With nearly 250,000 Arkansans now covered through this plan, it has fundamentally transformed the service delivery structure and uncompensated care, and added new health care providers across the state. Over \$1 billion in new federal funds is now entering

the Arkansas health care economy annually, and this is having a transformative effect on both the health care sector and the entire state.

For those now covered by PO plans, for providers and for policymakers, this represents a sea change in access to preventive care, in business models, and in decision-making about the future of the state health care environment going forward. Major policy shifts like this are, by their very nature, disruptive. Altering them in a rapid fashion could be equally disruptive.

With a little more than one year of relevant data, particularly since the initial few months involved a rapid buildup of new enrollees, broad conclusions regarding the overall success of the program remain elusive. Most notably, it is simply too soon to have reliable data to answer the critical question of whether or not the PO improves health outcomes for those who have enrolled.

However, there are a number of relevant findings about the PO and its participants that will inform policymakers. These include:

1. Individuals selecting health insurance through the marketplace via the PO are 80% of the total enrollment in the individual marketplace in Arkansas and approximately 65% of those enrolling through the PO are younger than 45 years old, compared to 45% of those enrolling in the Arkansas marketplace. Thus, the population enrolling through the PO is a younger group, and likely healthier and lower cost.
2. As a byproduct of using the provider networks of the private insurance companies instead of the traditional Medicaid program, insurance carriers paid 9,450 providers who had not filed claims through traditional Medicaid, thus expanding the pool of providers.
3. PO beneficiaries utilized Emergency Department services at a rate greater than traditional Medicaid, despite being a healthier population. This could be a byproduct of a lack of understanding of how to use services appropriately by individuals who are new to having coverage, or simply a reflection of ease, since PO beneficiaries do not have the same co-payments and deductibles that dis-incentivize commercial insurance policy holders from utilizing ED services.
4. Over the next five years, the federal share of the PO, in its current form, would result in roughly \$9 billion in Medicaid federal match payments for Arkansas.
5. Hospitals report a substantial reduction in uncompensated care visits and costs since the beginning of the PO. Uninsured admissions dropped 48.7% between 2013 and 2014, uninsured Emergency Department visits dropped 38.8% and uninsured outpatient visits dropped 45.7%. It is important to recognize, however, that the beginning of 2014 also represented the start of health insurance policies (often subsidized) being available on the Arkansas Health Connector for purchase by individuals, as well as the individual mandate. Additionally, unemployment dropped from 6.7% in December 2013 to 5.7% in December 2014, which likely indicates an increase in employer-sponsored insurance. Thus, the implementation of the PO is one factor among several that would lead to a reduction in uncompensated care.

6. The Arkansas rate of uninsured among non-elderly adults dropped from 27.5% to 15.6% from 2013 to 2014. The PO was clearly a substantial factor in this drop, though, as mentioned above, there were additional factors that may have contributed to this reduction.
7. Many PO enrollees are not working at all or not working substantially. 40% of beneficiaries have an annual income of \$0. 54% had incomes below 50% of the federal poverty level (FPL). Only a little over 15% were between 100-138% FPL.
8. The PO has added nearly 250,000 covered lives to the Arkansas health insurance marketplace, creating a larger actuarial pool. It does not appear, based on existing data, that adding Medicaid enrollees to the marketplace is creating an upward impact on premiums in the Arkansas exchange.
9. It appears that the current ratio of claims to premiums is 79%, thus lower than the amount allowed under the Affordable Care Act (ACA). Thus based on TSG's claims analysis, the average PMPM for the first year is lower than what was anticipated during the initial waiver agreement.
10. Physician licensure rates appear largely not to be impacted by the PO, though it is too soon to draw any long-term conclusions.
11. The State Health Independence Accounts appear largely to have missed their mark. Only 10,806 cards have been activated of the 45,839 issued. Only roughly 2,500 individuals contribute to these accounts monthly.

The PO allowed the state to shift or discontinue several areas that had been covered by traditional Medicaid. This allowed the state to receive a higher match rate for these services.

Thus, if the state chooses to end Medicaid expansion and return to the Medicaid program as it was constituted prior to the PO, there would be a substantial cost to the state general revenue to restore these programs. TSG estimates that the total state fund impact of restoring these programs could be as high as \$438 million above the general revenue portion of the PO between 2017-2021, with the most immediate impact coming sooner and diminishing over time, as the state matching percentage increases for this population, up to 10% in existing federal law in 2021.

With the conclusion of both the waiver and legal authority for the PO ending on December 31, 2016, policy leaders currently face a critical deadline about how to move forward with this program.

## **1.2. Traditional Medicaid**

TSG's review shows a traditional Medicaid program that is poorly positioned to meet the state's needs going forward. Future growth in the non-expansion program, even at a level below the growth projection of the federal government, shows an unsustainable, and unaffordable, path

forward. To continue down the current path would result in substantial tax increases, reductions to other important State programs, cuts to Medicaid services or all three of the above.

Today's traditional Medicaid program will spend \$5.2 billion in state fiscal year 2015. Using conservative projections, that number will grow to \$6.91 billion in fiscal year 2021, with the general revenue portion growing from \$1.55 billion to \$2.07 billion over the same timeframe. That means that, if Medicaid is allowed to grow at its projected rate, in 2021, taxpayers will need to be contributing more than half a billion dollars more than current levels in general revenue to support the traditional Medicaid program. Given the shifting demographics that both Arkansas and the nation are undergoing, the actual fiscal impact could potentially be much greater.

It is true that the state's growth in traditional Medicaid has moderated in recent years. However, this is due in part to national Medicaid trends and the state's ability to move groups of people from the fee for service (FFS) Medicaid to the PO since 2014. We expect that the state will revert back to more traditional trends, consistent with future national Medicaid spending projections.

There are several areas where the Arkansas Medicaid program has not yet taken approaches that are considered best practices across the country, including in the areas of hospital payment and care management. For example, most states have created incentives through reimbursement for providers to manage resources and length-of-stay for Medicaid patients. If left unmanaged, this may also drive up costs across the entire system. Moreover, there are proven tools that are not being used to develop system-wide care management and encourage providers to help in that goal. Patients with chronic conditions do not use just one provider, so care coordination is required. Tools such as alliances and Electronic Health Records would help expand the impact.

Additionally, Arkansas is one of a small number of states that have not implemented some component of its Medicaid program into full-risk managed care for the delivery of medical services. Other states have found that a full-risk model has been beneficial in lowering Medicaid costs, while often seeing quality improvement.

Nearly three-quarters of expenditures under traditional Medicaid are made for those beneficiaries in the elderly, mental health and developmentally disabled populations. However, the state's efforts for cost management, such as patient-centered medical home (PCMH) and Episodes of Care (EOC), are only targeting the final one-quarter of Medicaid expenditures. While these initiatives have shown some ability to deliver savings, they cannot significantly reduce the fiscal growth trends in Medicaid, since they don't deal with the bulk of the program costs.

Presently, Arkansas does not consistently use an independent assessment for determining the right level and place of care for the elder, disabled and behavioral health populations within Medicaid. This means that many individuals might get services at higher cost in more restrictive

settings, which may not be the best outcome for both the recipients and taxpayers, who must pay the bill.

Partly as a result of the lack of a consistently applied assessment, as well as a lack of appropriate incentives, Arkansas has not made significant strides in rebalancing care for its ABD population. Across the nation, states have identified both great program savings as well as improvements in satisfaction from those receiving care by moving these high-cost Medicaid beneficiaries from expensive institutional settings, like nursing homes, to supported care in homes and communities across Arkansas through care coordination and aligning payment incentives.

This finding is despite the fact that Arkansas citizens in general and seniors in particular have expressed tremendous support for expanded home and community based care. A random survey conducted on behalf of AARP of Arkansas found that 91% of residents supported moving more funds from nursing homes into home and community based settings for long-term care. These results are consistent with findings from other states.

Similar to the care for the aged, the developmentally disabled system still maintains a high reliance on expensive institutional care. At a time when states across the country are moving away from institutions and toward independence, Arkansas maintains a significant commitment to providing care at this level.

One major focus within the long term supports and services population is the developmentally disabled wait list for waiver services. There are approximately 2900 individuals with developmental disabilities that are currently waiting for community waiver services. Although, it is important to note that 91% are receiving some Medicaid services, totaling \$32 million annually.

DHS has offered a number of steps to connect behavioral health to overall health. Moving forward on these is critical to improving the mental health system, as the existing billing structure and service delivery model is highly “siloeed” and fails to connect the physical health or other factors, such as substance abuse treatment, into a coordinated care model. This leads to expensive and disconnected care that results in missed opportunities for quality improvement.

The PCMH model, while still relatively new, is a care coordination model for driving payment reform at the provider level. It has shown the ability to improve measured health outcomes, led to better access for Medicaid beneficiaries who might otherwise use inappropriate care and, thus, has allowed Medicaid to avoid costs. By offering a medical home with 24/7 access to a provider, PCMH offers better opportunity to provide timely care at a more appropriate level.

The Episodes of Care model, also early in its inception, is another provider-based payment reform that shows some promise. By changing provider incentives to focus on quality and utilization reductions, it shows potential for savings in an FFS environment. However, with a

high cost of developing and deploying episodes, it means that the return on investment can often take many years before the program becomes a net positive payment model.

While PCMH and Episodes of Care have shown value in modernizing Medicaid payment systems, many other states, including neighbors Tennessee and Texas, as well as nearby Kansas, have engaged in comprehensive Medicaid modernization efforts that have pushed these states to the forefront nationally. There are numerous opportunities from those and other states to implement best practice models that have been validated elsewhere.

TSG conducted field research to assess the issue of health disparity in Arkansas. We received considerable anecdotal evidence of the significant concerns that many in the community had little to no knowledge of much of the health care system, and thus utilize inappropriate care venues (such as the Emergency Department). Some who have enrolled in the PO indicate that they do not understand how to navigate the health care system. Presently, data show Arkansas to have very low rankings nationally on numerous health indicators. Poor awareness of healthy lifestyle choices and of using wellness and preventive services undoubtedly contribute to these standings.

Like many states working to implement the eligibility standards verification of the ACA, Arkansas' experience has included many frustrating obstacles and setbacks. The conversion to Modified Adjusted Gross Income (MAGI) and the simultaneous effort to convert to a new software system, Curam, have been enormous challenges. Regardless of how the eligibility and redetermination process got to the point it is in today, the reality is that it is not meeting program integrity standards.

Most notably, the eligibility determination process is still missing an efficient automated process that verifies that eligibility standards are being materially met without draining staff time. The current system still demands considerable involvement and continued rechecking, often at the expense of those who need services or the taxpayers. The recent redetermination issues certainly have garnered great attention, but the issues internally speak to a system that has troubling deeper issues.

Of equal concern is the lack of a real-time system to check applicants' identities and addresses, or to quickly verify income or assets. A Lexis-Nexis review of DHS data shows that some beneficiaries who are currently receiving services or payments may have a primary address out of state. This means that Arkansas may be paying carriers a PMPM payment for individuals who are no longer eligible.

Arkansas Medicaid can do a better job managing its pharmacy benefit. This statement can be validated by the substantial difference in the price of prescription drugs that the traditional Medicaid program pays, versus the much lower price paid by PO carriers. At the same time, there are three different call centers that manage prior authorization for drugs on the preferred

drug list (PDL). This represents an area for streamlining and tighter controls that will improve affordability and program efficiency.

Our analysis of the program integrity function at the Office of Medicaid Inspector General (OMIG) demonstrates a staff that is committed to eliminating waste, fraud and abuse, but does not have the tools in place to do so effectively. The State has a very low rate of collections on a per capita basis and does not have full use of data analytic capabilities focused primarily on identifying patterns of fraud, waste and abuse. The newly appointed head of OMIG indicated that this is a top priority. In addition, there are limited resources at the Department of Human Services (DHS) directed towards provider audit functions.

The State of Arkansas has an atypically high per capita cost for its Medicaid program. This represents a tremendous opportunity for change that could result in tremendous program efficiencies that could save state taxpayers considerably, provide opportunities to resolve outstanding issues (such as the developmental disability wait list) and put Medicaid on track financially for years to come.

While TSG certainly recognizes that the Task Force is committed to resolving the immediate issue of those newly eligible for Medicaid, it must also place high priority on finding solutions to contain the growing costs of the traditional Arkansas Medicaid program, which is just as deserving of considerable and immediate attention by policymakers.

### **1.3. Observation Concerning Healthcare Value**

TSG found that DHS places too little emphasis on healthcare *value*. Instead, most of the focus has been on reducing cost—which is also critically important. Healthcare value is the relationship between costs and outcomes. In neither traditional Medicaid nor the PO has the State created a regular, on-going method of collecting, evaluating and adjusting programs based on patient outcomes. Outcomes include not only quality metrics, but also improvements in the health of the patient. The combination of traditional Medicaid and the PO constitutes a substantial portion of healthcare payment in Arkansas. However, the programs are mostly focused on medical intervention, and too little on overall health. DHS invests little of its research and management effort developing programs and policies to improve the overall health of Arkansans – neither those directly served by its programs nor the general population.

During one of the Task Force meetings, Dr. Daniel W. Rahn, the Chancellor of the University of Arkansas Medicaid School (UAMS), made reference to the fact that he would love to see Arkansas' health status raised to the “best in the SEC” (reference to the powerhouse Southeast Conference in NCAA football and basketball). TSG applauds that vision and believes that, together, policy makers, stakeholders, department heads, health and human service entities, for profit and not for profit businesses, community leaders, and Arkansas families and individuals should all share Dr. Rahn's vision. Working together, each could contribute to raising the

healthcare value in Arkansas. However, as the department charged with overseeing medical services delivered to a substantial segment of the Arkansas population, DHS must be a one of the leaders in the future in making “best in the SEC” a reality for all Arkansans.

## 2. EXECUTIVE SUMMARY: VOLUME II

The Arkansas Health Reform Legislative Task Force engaged The Stephen Group (TSG) with the charge to assess Arkansas’ Medicaid program, with a specific focus on the future of the newly eligible population under the Health Care Independence Program (HCIP), often called the Private Option. TSG’s contracted responsibility calls for recommendations to improve the quality and efficiency of the traditional Medicaid program while offering a solution for the future of the Private Option, while maintaining coverage for the nearly 250,000 participants in the program.

While the following documents contain numerous opportunities to improve the quality of care, save taxpayer funds and make the delivery of Medicaid services more efficient, TSG has three fundamental recommendations that should drive the decision making for the Legislature.

12. Bring personal responsibility, wellness and accountability to HCIP, with the goal of a greater commitment to work and opportunity in 2017.

The success of every public assistance program should be measured by how many people are able to move themselves off the aide and up the ladder of opportunity. This is particularly true for programs for able-bodied adults, like HCIP. We recommend shifting the focus of HCIP to be transitional, with a commitment to getting participants into work, having them take responsibly for their own health and bringing more accountability to individuals and carriers accountable for the results.

13. Expand Patient Centered Medical Home or Bring Managed Care for all Medicaid beneficiaries. Expand care coordination to drive quality, increase options for aged, blind and disabled populations and reduce cost.

Nearly three-quarters of Medicaid expenditures are unmanaged. TSG identified that the long-term care, developmentally disabled and behavioral health populations within the program are losing opportunities for better care coordination, better placement in setting preferred by the beneficiaries and better assessment of need, all while costing taxpayers far more than is necessary.

Arkansas policymakers should pick one of three options to manage care. One strategy would be to expand the use of current payment improvement initiatives (Primary Care Medical Home (PCMH) and Episodes of Care (EOC)) across all Medicaid populations. Another would be to expand all non-ABD populations into PCMH and EOC, and move the



ABD populations into full risk capitated managed care. A final strategy would be to cover the entire Medicaid program into full risk managed care. Each model has its own benefits and opportunities for consistent oversight. In any event, the state should look to improve the management of its Medicaid pharmacy program, and also move its dental program to be coordinated by an outside vendor in a similar manner. .

14. Enhance eligibility and program integrity across the entire Medicaid enterprise.

Arkansans work diligently to fund the state's Medicaid program for the low income and the disabled. They should have the comfort of knowing that their tax dollars are being spent wisely and appropriately. Accordingly, they should have the most up to date, cutting edge tools in place to make sure that only those who are truly eligible receive Medicaid services.

Additionally, the State has the obligation to make sure that everyone – beneficiaries, providers, carriers and vendors – are all operating within program guidelines and living up to their commitments. This means a strong front-end eligibility system that works in real time to make sure that no one – accidentally or intentionally – is getting access to service they don't deserve. It also means having a robust fraud detection system that consistently ensures that individuals and groups getting funds are held accountable for keeping standards high. This requires a robust program integrity function that uses surveillance, audits and the power of data to validate that programs are run in a compliant fashion and everyone is held accountable.

While the document that follows contains dozens of specific recommendations about improving the Medicaid program, every one of these suggestions is conditioned on these three big picture views. TSG strongly believes that once the Task Force, the Legislature and the Governor find consensus on these areas, the remaining recommendations will follow these decisions.

### **3. HCIP REFORM**

In meeting with Task Force members and the Governor, one consistent message was the frustration that state leaders have with the lack of flexibility offered by the federal government in the management of those who became newly eligible under the Affordable Care Act. There is little question that Arkansas officials believe that Medicaid should be a state and federal partnership, but the opportunity for innovation is sometimes prevented because of federal rules and regulations. There is broad agreement that the program should operate with greater personal responsibility and commitment to wellness.

At the same time, based on the establishment of this Task Force, the scope of the request for proposals and the contract that led to these recommendations, and meeting with many members

of the Task Force, it is also clear that there is support for continuing care opportunities for the nearly 250,000 who are now enrolled in the Private Option.

Thus, TSG recommends shifting the Private Option to a model designed to focus on moving individuals upward on a ladder of opportunity. This is done by making work referrals and engagement mandatory, by offering employer support for businesses that hire HCIP participants into jobs with health insurance and by adding a dental and vision program for those who meet all the program requirements. In order to emphasize the need for this program to be temporary, we recommend changing the name of the program to the Transitional Health Insurance Program, or T-HIP.

In order to move up a career ladder, having good health is important. Our recommendation accomplishes this through creating health scorecards to provide transparency and quality awareness among providers, through having a Membership Agreement to hold enrollees accountable, through establishing a wellness scorecard for participants to track preventive care, through offering education to reduce health disparities, and through having a clinic diagnosis for the medically frail to implement care coordination.

Finally, personal responsibility is essential to any public assistance program. That's why T-HIP adds co-payments and premiums for those who don't live up to wellness and work search standards, includes mandatory HIPP so workers don't move from employer sponsored health care to taxpayer funded care, establishes an enhanced cost share for those with considerable assets, includes a lock out provision for those who don't follow program guidelines and don't pay premiums for the program, eliminates retroactive eligibility and establishes a consistent and effective eligibility and redetermination process.

While these are critical steps forward, we recommend that the state takes steps to set itself up for even greater progress in these areas starting in 2017. Once a new administration takes office, we propose the state prepare to take greater steps, such as using the work requirement and potential benefit limits consistent with the successful steps of the TANF program.

Private Option was an innovative strategy that made Arkansas a national model for its implementation. The recommendations included for T-HIP will assist the Task Force with recommendations to consider in moving that model forward.

#### **4. BUILDING A 21ST CENTURY MEDICAID PROGRAM**

While Arkansas' traditional Medicaid has taken some inventive steps in payment reform with the Patient Centered Medical Home (PCMH) and Episodes of Care (EOC) models for the non-disabled population, three-quarters of the program's expenditures are from a traditional 20<sup>th</sup> century Medicaid model of care. We recommend that Arkansas move from a lagging to a

leading Medicaid program by managing all Medicaid populations for better health, better enrollee satisfaction and a much less expensive system of care.

The question should not be whether or not to manage the care within Medicaid. The real question for state policymakers is this – who is better suited to properly manage and coordinate the care, the state or private entities, or should there be a hybrid model for different types of care? Each model has pluses and minuses.

Nationally in Medicaid, there is a growing trend toward full risk managed care. This means that the insurance carrier is responsible for care and is paid a per member per month (PMPM) fee for each individual enrolled in Medicaid, segmented by needs, such as developmentally disabled, pregnant mothers, etc. The carriers have considerable incentive to keep costs down, since they make money on healthy enrollees who seek appropriate care and lose money on enrollees with high medical costs or inappropriate care usage.

One model would involve putting the entirety of the traditional Medicaid program into full risk managed care. The Department of Human Services (DHS) would have the responsibility of enrolling and maintaining eligibility standards for Medicaid beneficiaries and closely managing the contracts of carriers to ensure that they were meeting program and quality standards. The rest of the work would be done by the carriers. This model brings about the greatest opportunity for reductions in Medicaid expenditures, especially with the additional general revenue captured from the premium tax paid by the carriers. These savings could be redeployed within DHS (such as towards the DD wait list), used elsewhere in the state budget, or simply returned to the taxpayers.

Another model would move the ABD population into full risk managed care and expand the PCMH and EOC model into the entirety of the non-disabled population. One advantage of a full risk model for ABD (also shared with the above recommendation) would be the shift away from costly institutional care to less expensive home and community based care, which seniors, in particular, have specifically indicated that they prefer as a setting. The PCMH model would have to expand from select Medicaid providers to all Medicaid providers. Beyond eligibility, DHS would still manage a process claims, while overseeing the contract of the ABD carriers.

The third possible model would be to expand the PCMH model across all Medicaid populations. This would ensure that every Medicaid enrollee would have a medical home and that there would be care coordination for all ABD beneficiaries. This would result in a high level of care coordination as it would shift the focus from providers to those receiving care. DHS would shift its current role only slightly and would still maintain tremendous involvement in engaging each individual client.

One enormous benefit to selecting any of the above three models is the cultural shift from paying claims to paying for performance. This brings the focus to quality and building a structure of improving health care payments that would improve overall health across Arkansas. This is

particularly true for the ABD population, which currently finds itself “siloed” and traveling across disparate systems of care. Putting the patient first, and not the specific program will improve outcomes across Medicaid.

TSG strongly recommends that DHS ensure that every person who seeks to receive care in the ABD system receive an independent clinical assessment, using a evidence-based state of the art test to determine the needs, plan of care and cost for each individual who qualifies for service. Getting this assessment done right is absolutely essential to making sure that these beneficiaries are placed in the right setting, at the right time, to get the services they need in an efficient and effective manner. If Arkansas chooses to provide ABD services through managed care, it is essential that DHS put in place strong contract provisions and a robust monitoring system to ensure that beneficiaries get high quality care that meets their needs in a timely and coordinated fashion and that the overall commitment to receiving care in the least restrictive setting possible becomes a reality.

No matter what model Arkansas chooses, one area of the Medicaid program that must be included in managing care is that of pharmacy. Without better pharmacy management, the state is losing money every day that could be better used elsewhere. If the state goes down the road of full risk managed care, those vendors should also pick up pharmacy in their contracts. In a PCMH model, the state should seek to efficiently pay for value and outcomes through a pharmacy benefit manager to oversee this benefit.

Implementing these recommendations will move Medicaid into the 21<sup>st</sup> century and offer tremendous benefit to the state, both to those receiving care and to the taxpayers, who are now paying for an expensive, archaic legacy program.

## **5. ENSURE PROGRAM INTEGRITY ACROSS MEDICAID**

We recommend that Arkansas use Medicaid as an opportunity to show how an effective program integrity function can be a priority to building public trust and confidence that their contribution to help those in need is spent wisely.

An independent audit of the Medicaid program showed many individuals who are on the Medicaid or Private Option rolls could be living out of state. Some may be at risk for fraud or identity theft. In addition, there may be others who are listed on the rolls that are deceased or incarcerated, and others who might have excessive assets. Clearly, there is opportunity for important steps forward to verify addresses, identities and assets, but today DHS and OMIG lack the tools to advance to the leading edge.

That is why we recommend an Enterprise Benefit Integrity Hub, likely housed in the Department of Finance and Administration that could inspect in real time the eligibility of all individuals

seeking state services. This would close the front door for individuals who do not qualify for services from getting them and ensure that important services are available for those that the program was intended to serve.

The State could look to other states in implementing such a program that can effectively authenticate identities and regularly identify changes in beneficiaries' status.

OMIG must purchase and implement its fraud detection system as soon as possible to begin to ramp up recovery opportunities and to ensure that vendors, providers and beneficiaries know that they will be caught if they violate program standards. At the same time, DHS should improve its audit and oversight capacities working collaboratively with OMIG so that small problems don't grow into larger ones and everyone knows there will be accountability.

DHS must improve its contract management and oversight responsibilities to ensure that the state is getting precisely what it is paying for and nothing less. At the same time, the state should tighten contract standards to reduce overhead and indirect costs.

The agency should also find a systems integrator to manage the eligibility system and other IT systems that share data across the Medicaid enterprise. The eligibility system is a critical link to ensuring an efficient enrollment process and the Medicaid IT system changes happening at the agency is a cumbersome processes, that is expensive, inefficient and unnecessarily creates demand for specialized knowledge.

## **6. ADDITIONAL CONSIDERATIONS**

Throughout the attached recommendations, TSG has made numerous references to improving health care quality. While most policymakers are not involved in the direct provision of health care, they can take important steps toward using the leverage and opportunity of Medicaid as a driver for improving quality. Unfortunately, Arkansas scores poorly on many health rankings; however, improving services to those on Medicaid represent a great opportunity to lift those rankings and make the state healthier. TSG recommends that in changing Medicaid, whether staying with a traditional program or a Private Option, the state always consider the impact on the health of the population.

Task Force members asked TSG to consider the problem inherent with businesses with low-wage employees, dropping their health care in order to move those individuals to Medicaid or onto the Arkansas Health Connector with a heavily subsidized policy. For small business, the SHOP health insurance exchange should provide affordable policies to ensure that these workers stay on employer sponsored insurance. We recommend that Arkansas seek at Section 1332 waiver from the federal government to expand access to the SHOP exchange to larger businesses that employ a substantial percentage of low-wage staff. Moreover, we recommend that the SHOP exchange also be able to waiver the Essential Health Benefits (EHB) provision of the

Affordable Care Act to allow the sale of other types of policies, such as defined contribution plans like Health Savings Accounts.

TSG strongly recommends that the State of Arkansas and DHS consider partnering with a state university to develop a Center for Health Excellence. Similar to programs at Mississippi State and the University of Massachusetts, this would represent a tremendous opportunity to bridge the talent gap in health policy that is growing nationally. This would give the chance to provide infrastructure, data support, testing opportunities and development of experts that could make the state a leader nationally in health care.

## 7. CONCLUSION

Medicaid in Arkansas stands at a crossroads, with both near term and long-term challenges and opportunities. TSG feels that now is the time to act to bring stability to the program, both on the short-term decision regarding the Private Option and on the more far reaching decisions needed to bring the Medicaid program into the 21<sup>st</sup> century.

The solutions found in these recommendations have significant consequences for beneficiaries in the Medicaid program, the taxpayers who fund the program and the many providers and vendors who utilize Medicaid for their businesses. TSG recommends that the Task Force balance all of these interests as they make the critical decisions in the months and years to come.

Finally, each of the recommendations proposed to modernize Arkansas' Medicaid program have the potential for enormous savings for the program that will help to ensure the long-term viability of not only Medicaid itself, but also other critical government services that could be squeezed by the growth in the program. Over the short term, these could actually involve the state spending less on the entire enterprise. If this is the case, this presents the possibility to reinvest these funds in areas like the developmental disability wait list, provider rates, building infrastructure for community-based care or employer support for those transitioning off Medicaid. Alternately, these savings could be used to offer tax relief to Arkansan taxpayers. Ultimately, this will be the decision of the priorities of the Governor and Legislature in the coming years, should these recommendations be implemented thoughtfully.

### Background

Arkansas Medicaid must deal with two major fundamental challenges. There is a short-term issue regarding the population that became eligible under the Affordable Care Act and is currently covered through the Private Option. Additionally, there is a much larger looming public policy crisis resulting from massive future growth in traditional Medicaid if the state does not reform this program.

The following recommendations will offer options for policy makers to achieve a number of key objectives that will provide improved services for needy Arkansas residents and certainty and affordability to taxpayers.

We will address the Private Option (short-term) and traditional Medicaid (long-term) components separately, but many of the key focus areas overlap and would work cohesively as an integrated solution that combine to meet strategic objectives of both aspects of the Medicaid program.