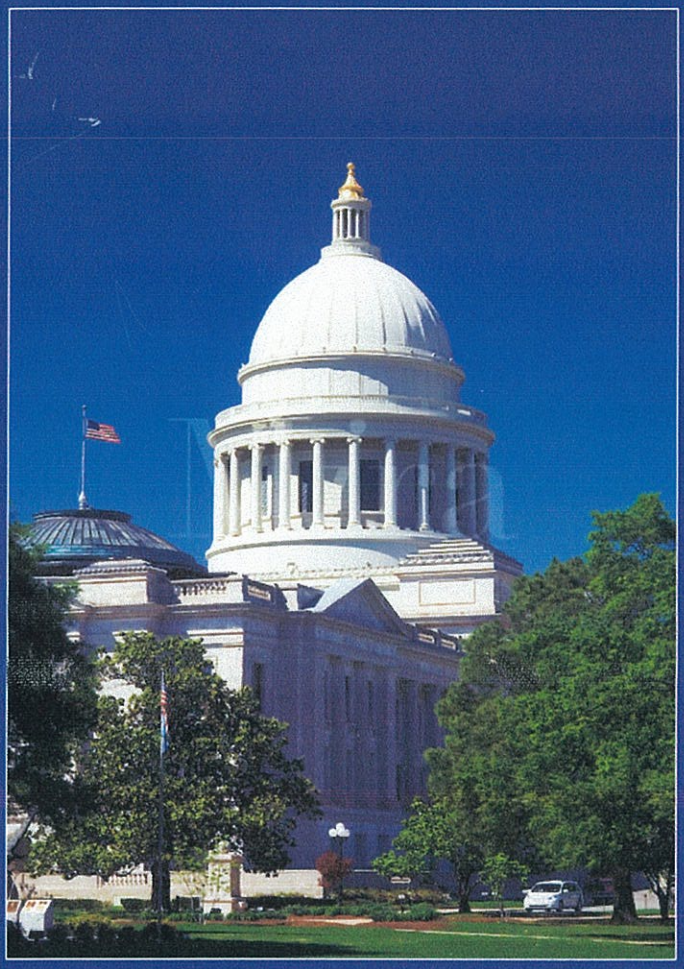


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Review of Arkansas's Medicaid and Public-Welfare System

Submitted to the General Assembly of the State of Arkansas

July 5, 2013

The Alexander Group, LLC
Providence, R.I.
Philadelphia, Pa.
Washington, D.C.

THE ALEXANDER GROUP LLC

Innovative Solutions for State Governments

Friday, July 5, 2013

Executive Subcommittee of the Legislative Council
The Legislature of the State of Arkansas
State Capitol, Room 315
Little Rock, Arkansas 72201

To the Subcommittee:

The Alexander Group (AG) is pleased to respectfully submit this review of Arkansas's Medicaid and public-welfare system.

The Bureau of Legislative Research of the General Assembly commissioned The Alexander Group to use its professional expertise and knowledge to assess Arkansas's public-welfare programs and to recommend preliminary short-term initiatives to help the General Assembly initiate cost savings. Now that our review is complete, we believe that our report will provide guidance and insight as Arkansas, like other states, grapples with the full implementation of the Affordable Care Act and the imperatives of Medicaid and welfare reform.

This study and report would never have materialized without the extensive help of the audit staff of the Division of Legislative Audit of the Arkansas legislature and the cooperation of several state agencies, especially the Departments of Human Services, Health, and Workforce Services. The prompt and professional assistance the AG staff received from the legislature and executive departments was indispensable to this project, acquainting our staff with Arkansas's welfare system, administration, and programs, as well as the state's current initiatives of reform. The fact that our work was conducted at the end of the state fiscal year--and both legislative and agency staff were overwhelmed with the issue of Medicaid expansion—makes their contribution to this study and report all that more impressive.

During the time allotted for this project, The Alexander Group delved into as many details, data, and issues as possible. Given the enormity and complexity of the public-welfare system, we sought to deliver for Arkansas the maximum return on investment: focusing our attention on the most prevalent and common elements to provide Arkansas a head start on cost savings and reform initiatives. A number of complex and time-consuming analyses had to be set aside as they would require a more thorough review. Nonetheless, our findings and

recommendations, especially those in Appendix A, can be fairly easily adopted. These recommendations will not only provide short-term savings but also will improve the administration, efficiencies, and outcomes of welfare programs. Appendix B provides two additional initiatives that are more involved but will also provide cost savings and improve quality. Beyond these specific recommendations, the report provides other recommendations for more necessary substantive and comprehensive reforms that will result in even better outcomes, alter the current cost trend, lower the welfare burden, provide serious relief to the Arkansas state budget, and vastly improve the lives of recipients.

During the time period of this review, AG was asked to perform other duties by the legislative leadership, including offering advice and analysis of the Public Option Medicaid expansion and various pieces of legislation affecting the public-welfare system.

While the Alexander Group is indeed grateful for the assistance received from the legislature and the executive departments, we accept full responsibility for the contents of this report, including any errors or omissions.

Thank you for giving us the opportunity to serve the State of Arkansas with this important review. If you have any questions or require further information, please contact me at: alexandergroupco@gmail.com.

Sincerely,

Gary D. Alexander
President and CEO

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1. BACKGROUND AND OVERVIEW

A team of professionals headed by Gary D. Alexander with experience leading two state welfare assistance agencies that resulted in better outcomes and significant savings, the Alexander Group (AG) has been engaged by the Bureau of Legislative Research of the Arkansas General Assembly to conduct a preliminary review of Arkansas's welfare programs, to offer preliminary short-term initiatives for consideration, and to provide an overview of program-integrity initiatives. This report provides a summary of the findings and recommendations, including an overview and a roadmap to help the General Assembly initiate cost savings and begin a discussion on welfare reform.

This report provides preliminary reviews and recommendations. The Alexander Group delved into as many details as possible. Of necessity, given the enormity and complexity of public-welfare programs, the Alexander Group focused its attention on the most prevalent and common elements to provide Arkansas a head start on cost savings and reform initiatives. A number of complex and time-consuming analyses had to be set aside as they would require a more thorough review, which the Alexander Group also recommends. In addition, the Alexander Group is including recommendations for additional reforms, including longer-range welfare reform that will significantly bend welfare-cost trajectories downward.

Scope of Work

Specifically, the contract detailed the following scope of work:

1. Preliminary review of the public-welfare programs administered by the State of Arkansas, including applicable rules, regulations, eligibility limits, and cost drivers. The emphasis of this review will be on Medicaid. It is anticipated that the results of this review will be employed to develop savings and efficiency options for legislative leaders to consider in their efforts to enhance the programs and overall taxpayer value.

2. Offer preliminary short-term initiatives to assist the legislature in addressing budget issues with an emphasis on those items that may be implemented with minimal federal approval. Main focus will be in the following areas:

- Medicaid
- TANF
- SNAP
- Child-Care assistance
- Operations and Administration

3. Overview of the current program-integrity practices.

In fulfillment of the terms of the contract and in order to deliver to Arkansas taxpayers the maximum return on investment (ROI), this report provides findings and recommendations in Appendix A that can be fairly easily adopted that will not only provide short-term savings but also will improve administration and outcomes of welfare programs. Appendix B provides two additional initiatives that are more involved but will also provide cost savings and improve quality. Beyond these specific recommendations, the report provides recommendations for more substantive reform that will result in even better outcomes, altering the current cost trend, ease the welfare burden, and provide serious relief to the Arkansas state budget.

Overview of the Medicaid-Welfare System

In general, Arkansas's system is no different than any other state. Welfare systems in America have been created sporadically on a piecemeal basis, as programs have been layered on top of each other by a combination of federal and state laws, regulations, and rules. *The Concise Encyclopedia on Economics* captures in a nutshell the state of affairs: "The U.S. welfare system would be an unlikely model for anyone designing a welfare system from scratch. The dozens of programs that make up the 'system' have different (sometimes competing) goals, inconsistent rules, and over-lapping groups of beneficiaries."[1]

The challenge is to redesign the system to fit the unique needs and people of Arkansas. Every state has its own strengths and weaknesses, and the degree to which each state minimizes systemic deficiencies also varies. Moreover, all states have opportunities to improve organizational structure, program design, and coordination. Overall the nation is grappling with systemic challenges, and states are generally seeking enhanced solutions to solve problems related to cost and quality. The recommendations in this report will assist Arkansas to realize significant improvements, become more efficient, and save money.

Like other states, there is no single entity in Arkansas responsible for the entire public-welfare system. Providing assistance for the various needs of food, shelter, cash assistance, child care, health care, energy, transportation, and special needs are divided among federal and state programs and spread across a multitude of agencies, including 144 active housing authorities.

By comparison, Arkansas shows a higher level of integration in state-run programs than other states, although the ideal arrangement would be to house all public-welfare services in one agency. The Department of Human Services (DHS) handles most state-run programs, with the notable exception of TANF in the Department of Workforce Services (DWS), child-support

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1. Introductory sentences on the topic of "welfare" by Thomas MaCurdy and Jeffrey M. Jones. Thomas MaCurdy is the Dean Witter senior fellow at the Hoover Institution and a professor of economics at Stanford University. He is a member of standing committees that advise the CBO, the U.S. Bureau of Labor Statistics, and the U.S. Census. Jeffrey M. Jones is a research fellow at the Hoover Institution. He was previously executive director of Promised Land Employment Service.

enforcement in the Department of Finance and Administration, and Women, Infants & Children (WIC) in the Department of Health. Within DHS, the Division of County Operations (DCO) plays a crucial role. This division provides case managers to help assist individuals to navigate the system and determine financial eligibility for most of the food programs, energy assistance, health care, and emergency-shelter grants. In addition, DCO determines financial eligibility for the Transitional Employment Assistance Program (TEA).

Administering the Medicaid program is the primary responsibility of the Division of Medical Services (DMS). It shares this responsibility with four other divisions within DHS and the University of Arkansas. DCO determines financial eligibility and manages enrollment for Medicaid programs and also operates Medicaid Eligibility Quality Control (MEQC) 1115 Waiver Pilot program, a research and demonstration project aimed at enhanced monitoring of the automatic renewal process. The Division for Medical Services (DMS) runs the standard Medicaid program, including Long Term Care. The Division of Aging and Adult Services (DAAS) oversees three federally-approved home- and community-based programs for Medicaid recipients as alternatives to institutional care operated by DMS estimated at nearly $120 million for SFY 2012. The Division Developmental Disabilities Services (DDDS) administers the Alternative Community Services Waiver at an estimated cost of $167 million for SFY 2012. The Division of Children & Family Services (DCFS) operates the Title IV-E Waiver that provides various services related to Foster Care. The University of Arkansas Medical Services Partner runs the program for autism at an estimated cost of $2.9 million for SFY 2013.

DCO provides financial eligibility for the Transitional Employment Assistance Program (TEA), but the Department of Workforce Services administers the program. Child-care services are administered solely by the Division of Child Care & Early Childhood Education (DCCECE).

With the exception of the Women Infant Children (WIC) program run by the Department of Health (DOH), DCO manages the food-assistance programs: Supplemental Nutrition Assistance Program (SNAP, formerly called the Food Stamp Program), Emergency Food Assistance, and the Commodity Distribution Program. Arkansas is responsible for administering the SNAP program and shares in the administrative costs. SNAP benefits are funded entirely by the Federal government.

DCO operates two energy programs—Home Energy Assistance Program (HEAP) and the Weatherization Assistance Program (WAP)—and manages the Community Services Block Grant Program and the Refugee Resettlement Program. Transportation assistance is provided by both the TEA program and the Medicaid program.

Housing is administered exclusively by the U.S. Department of Housing and Urban Development (HUD) through local housing authorities, and there is virtually no interaction

between state agencies and these authorities. HUD lists 144 active housing authorities in Arkansas with 14,672 low-rent units.[2]

Other divisions within DHS not mentioned include the Behavioral Health Services, Community Service and Nonprofit Support, Services for the Blind, and Youth Services.

Arkansas is required to interact with no less than seventeen federal agencies for the administration of welfare assistance programs. Some agencies are critically important to the function of programs and require the state to seek federal approvals for changes. Among the most important are the Centers for Medicare and Medicaid Services (CMS), the Food and Nutrition Service (FNS), Administration for Children and Families (ACF), and the Substance Abuse and Mental Health Services Administration (SAMHSA). Other agencies include Social Security Administration (SSA), Immigration and Customs Enforcement (ICE), Health Resources and Services Administration (HRSA), Administration on Aging (AoA), Veteran Affairs (VA), the Office of Inspector General (OIG), and the Department of Energy (DOE). Some federal agencies, such as the Department of Housing and Urban Development (HUD), have very little interaction with state agencies but play a critical role in administering welfare-assistance programs.

Arkansas has several units and processes that monitor and address program integrity and oversight processes, many of them federally required. The Alexander Group found many processes to be effective, but there are opportunities for improvement.

To successfully operate various welfare programs requires cooperation and coordination among the organizational structures, which can be achieved through both formal and informal arrangements. Several divisions have formalized coordination with signed agreements; in other cases, informal cooperation exists. We discovered significant efforts to this end, but there remains room for improvement and, as is often the case with large organizations, structure can limit effectiveness.

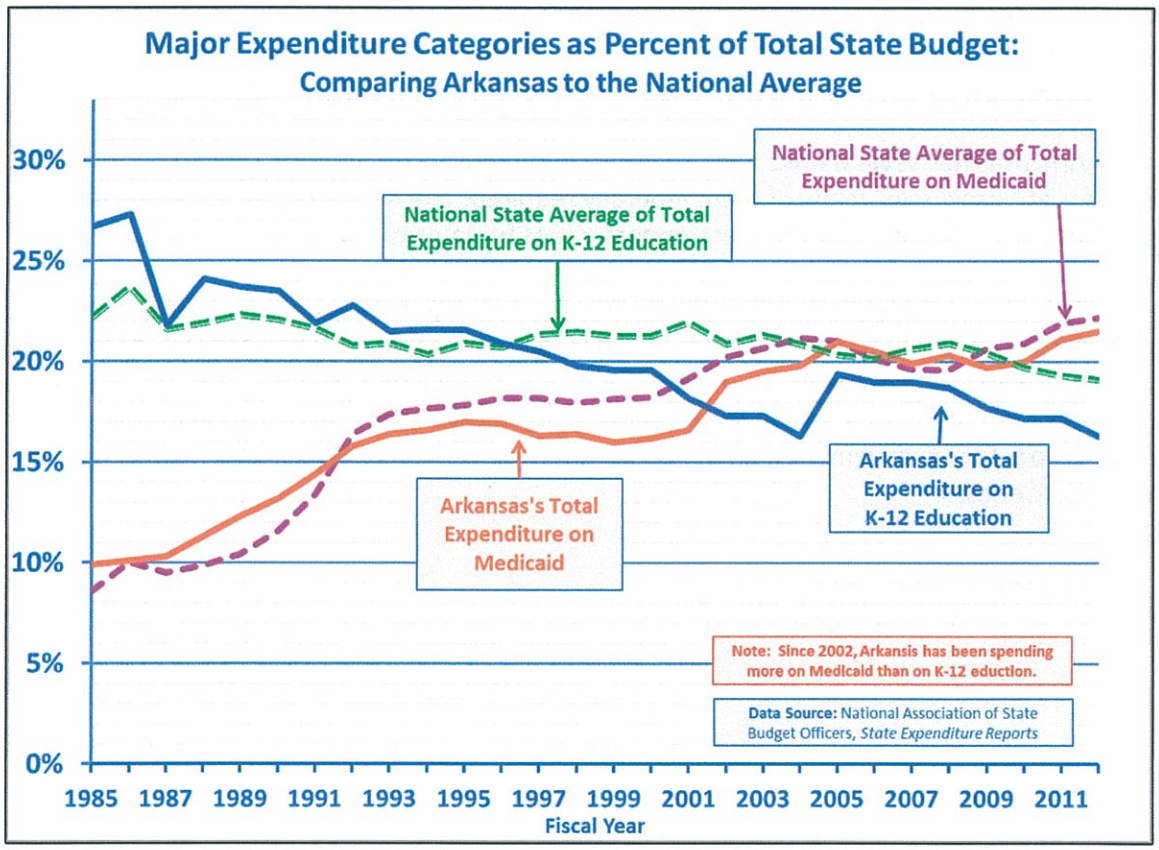
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2. U.S. Department of Housing and Urban Development (https://pic.hud.gov/pic/haprofiles/haprofilelist.asp, June 12, 2013). Data derived from programmatic reports compiled from HUD 52681-B forms made available in MS-Excel online: http://portal.hud.gov/hudportal/HUD?src=/program_offices/public_indian_housing/programs/hcv/psd.

2. THE BURDEN OF THE MEDICAID-WELFARE SYSTEM

The Costs of the System

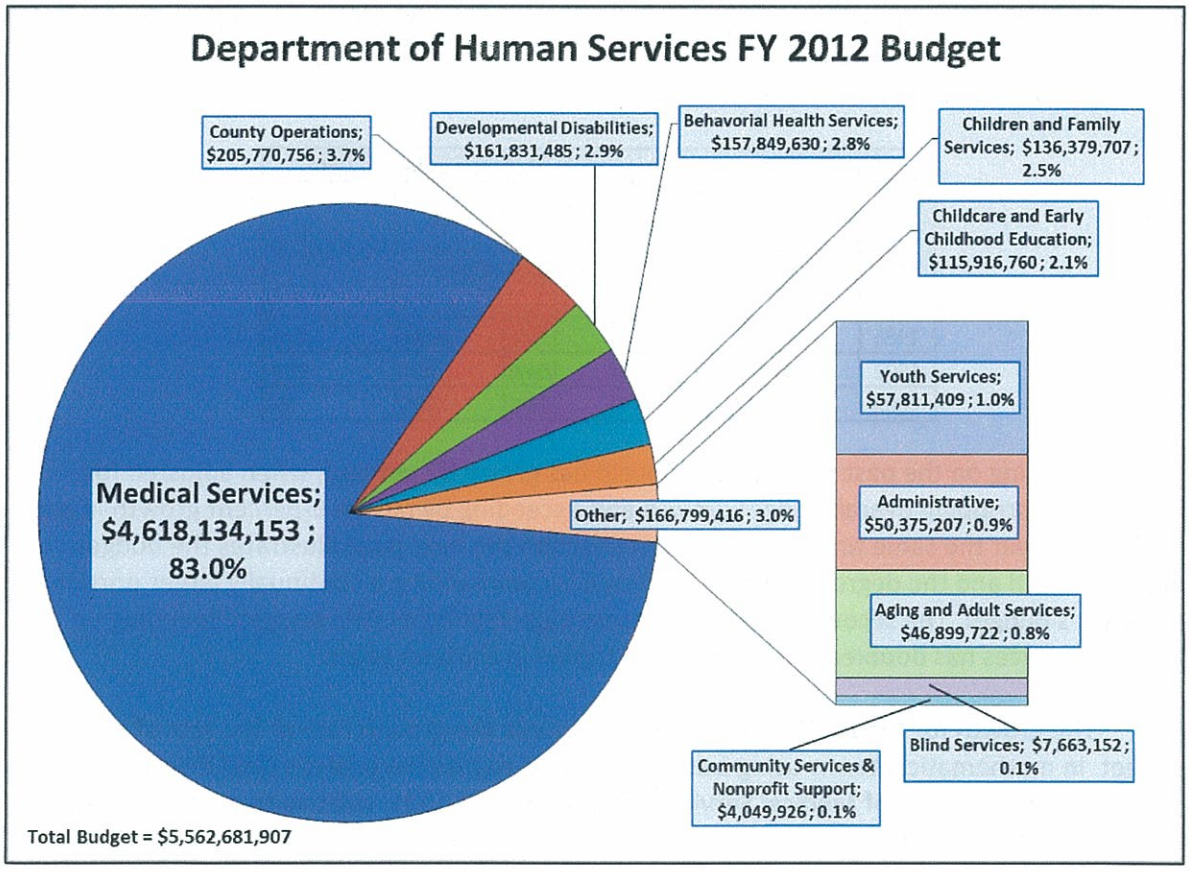
Welfare-assistance programs, Medicaid in particular, have become the most significant expenditure for Arkansas. Medicaid eclipsed basic education (kindergarten through twelfth grade) as the largest state expenditure in SFY 2002. This eclipsing occurred sooner for Arkansas than it did for the overall state average when Medicaid overtook basic education for the first time in 2004, even before the national average. Subsequently, the expenditures ran fairly close together until 2009 when Medicaid decisively took the lead position. See the graph below.



Medicaid expenditures have been undergoing a growth rate more than twice the rate of the rest of the budget since SFY 1985, chosen as the base year because it was the first year the National Association of State Budget Officers (NASBO) published its report on state expenditures. In state funds, Arkansas Medicaid grew from $99 million in SFY 1985 to an estimated $1.294 billion for SFY 2012, a 1,207 percent increase. For the rest of the state budget, state funds grew only 506 percent. In terms of federal funds, Medicaid grew from $270

million in SFY 1985 to an estimated $3.161 billion, 1,071-percent increase compared to 435 percent for the rest of the state budget. The first table below provides budget data that was reported to NASBO for Arkansas. Also relying in data reported to NASBO, the pie chart illustrates the size of Medical Services to the rest of the DHS budget. Spending on Medical Services is greater than all other DHS spending, comprising 83 percent.

Arkansas Budget Data as Reported to the National Association of State Budget Officers												
SFY Ending	Medicaid			Rest of Budget			Total Budget[1]			Medicaid		
	State Funds	Federal Funds	Total Funds	State Funds	Federal Funds	Total Funds	State Funds	Federal Funds	Total Funds	State Funds	Federal Funds	Total Funds
	Millions of Dollars									Percent to Total		
1985	99	270	370	2,140	586	2,726	2,239	856	3,096	4.4%	31.5%	12.0%
1992	225	692	917	3,935	928	4,863	4,160	1,620	5,780	5.4%	42.7%	15.9%
2002	626	1,663	2,289	7,934	1,798	9,732	8,560	3,461	12,021	7.3%	48.0%	19.0%
2012 (est.)	1,294	3,161	4,455	12,961	3,135	16,096	14,255	6,296	20,551	9.1%	50.2%	21.7%
From	Percentage Growth to SFY 2012 (estimated)											
1985	1207%	1071%	1104%	506%	435%	490%	537%	636%	564%			
1992	475%	357%	386%	229%	238%	231%	243%	289%	256%			
2002	107%	90%	95%	63%	74%	65%	67%	82%	71%			
Note: (1) Total Budget excluse of bond financing.												



Arkansas Budget Data as Reported to the NASBO						
SFY Ending	Public Assistance Programs					
	State Funds	Federal Funds	Total Funds	State Funds	Federal Funds	Total Funds
	Millions of Dollars			Percent to Total		
1985	10	29	39	0.4%	3.4%	1.3%
1992	81	135	216	1.9%	8.3%	3.7%
2002	114	169	283	1.3%	4.9%	2.4%
2012 (est.)	181	304	485	1.3%	4.8%	2.4%

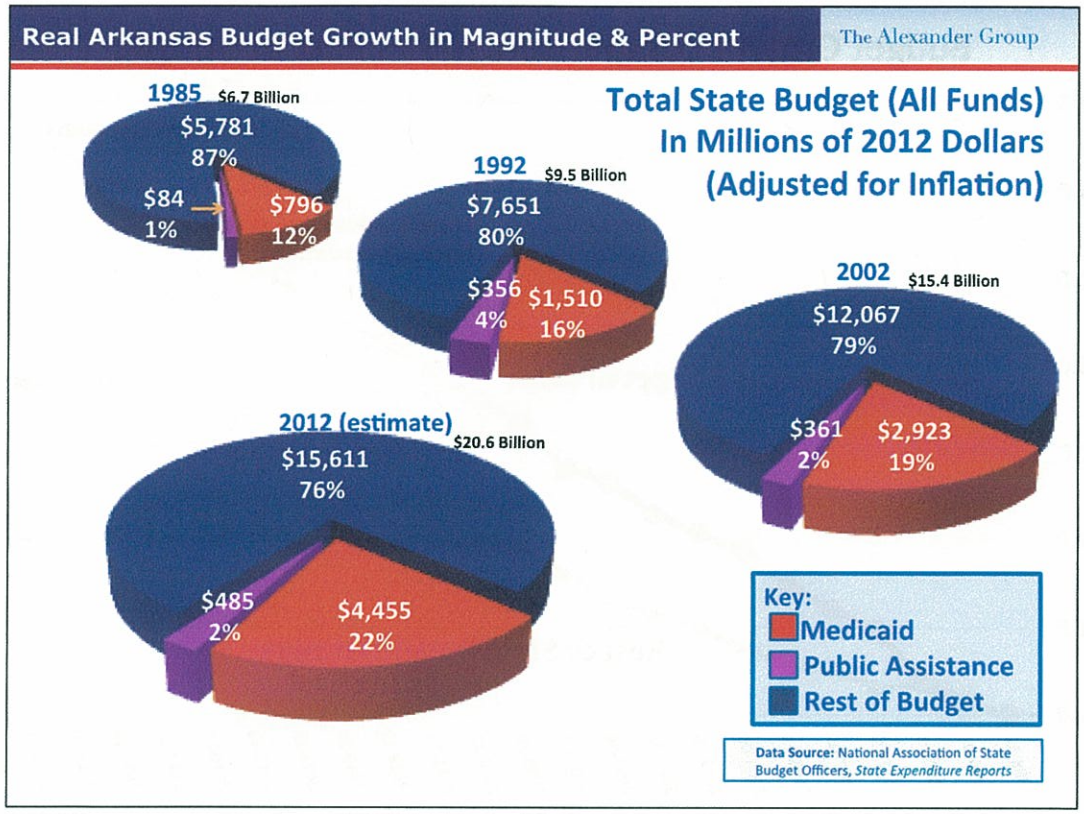
Public-assistance programs have also been growing faster than the rest of the budget, but not as fast as Medicaid. NASBO publishes data on public-assistance programs, sometimes referred to as cash assistance. While public assistance grew in nominal dollars, the table above reveals it has stabilized at around 2.4 percent of the overall state.

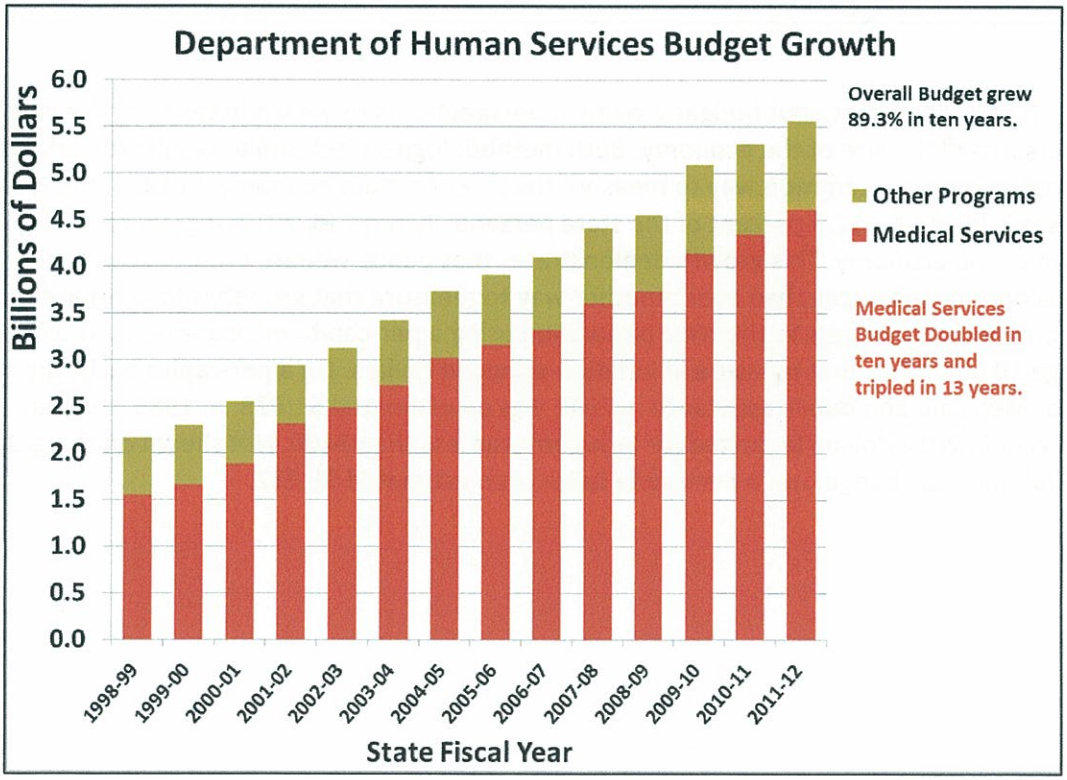
A more sophisticated way to analyze budget data is to remove the impact of inflation to compare constant dollars, and then compare that result to the population growth. The table below demonstrates that growth for the Medicaid and cash programs. Even after adjusting for inflation, the Arkansas budget has more than doubled since 1985 while the state population grew only 27 percent. A major contributor to the growth, both in terms of magnitude and percentage change, has been Medicaid. Over that same period, public-assistance growth exceeded that of Medicaid, but public assistance is only about 11 percent of the size of Medicaid today, thus public assistance is a less-significant cost driver.

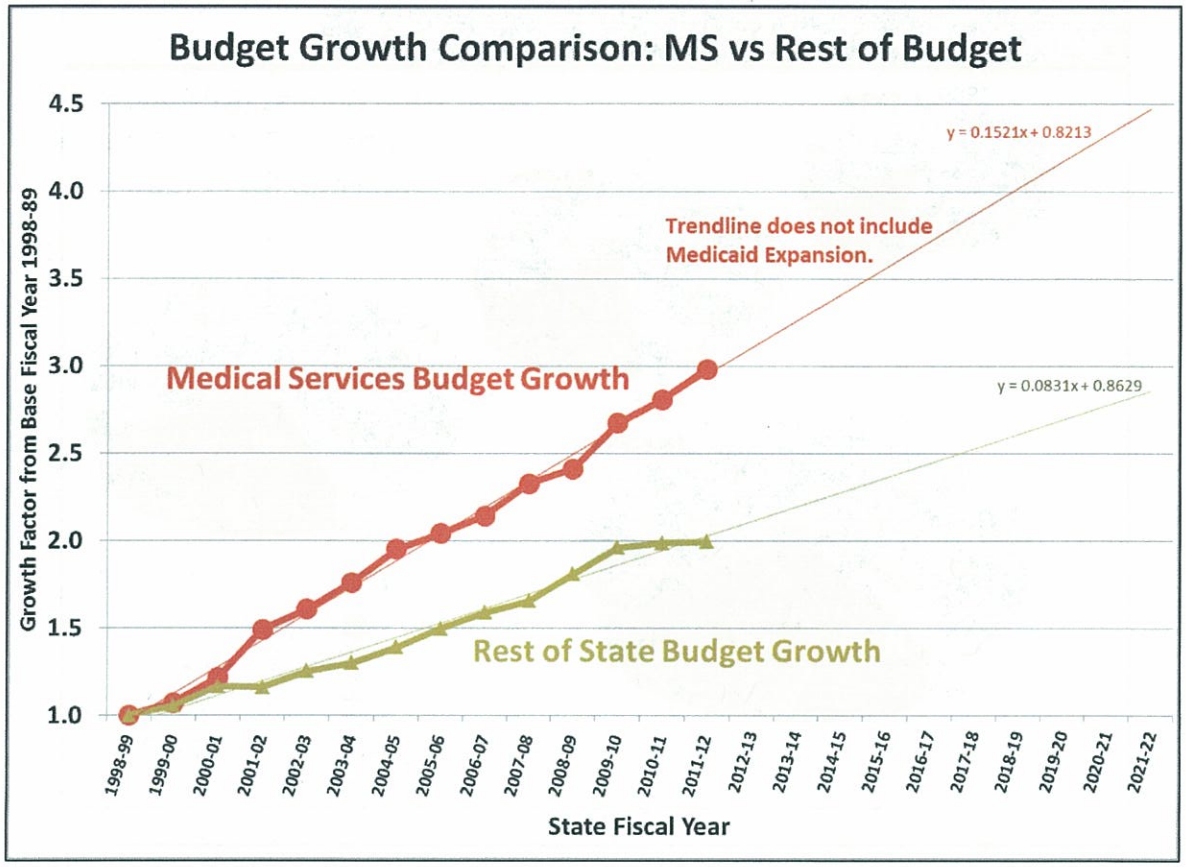
Comparing Growth Rates to SFY 2012 Using NASBO Data					
Base Year	Medicaid	Public Assistance	Rest of Budget	Total	Population
	Percentage Change in Inflation-Adjusted Budget Dollars				
1985	460%	478%	170%	209%	27%
1992	195%	36%	104%	116%	23%
2002	52%	34%	29%	34%	9%

Focusing on the past ten years, Medicaid has grown 52 percent, when adjusted for inflation, outstripping overall budget growth and exceeding by far the 9-percent growth in state population over the same time span. The first chart on the next page illustrates the budget overall growth and the degree to which Medicaid is commanding a continually larger portion of Arkansas's budget. The second chart on the same page highlights DHS budget. Spending on Medical Services has doubled in ten years and tripled in thirteen years.

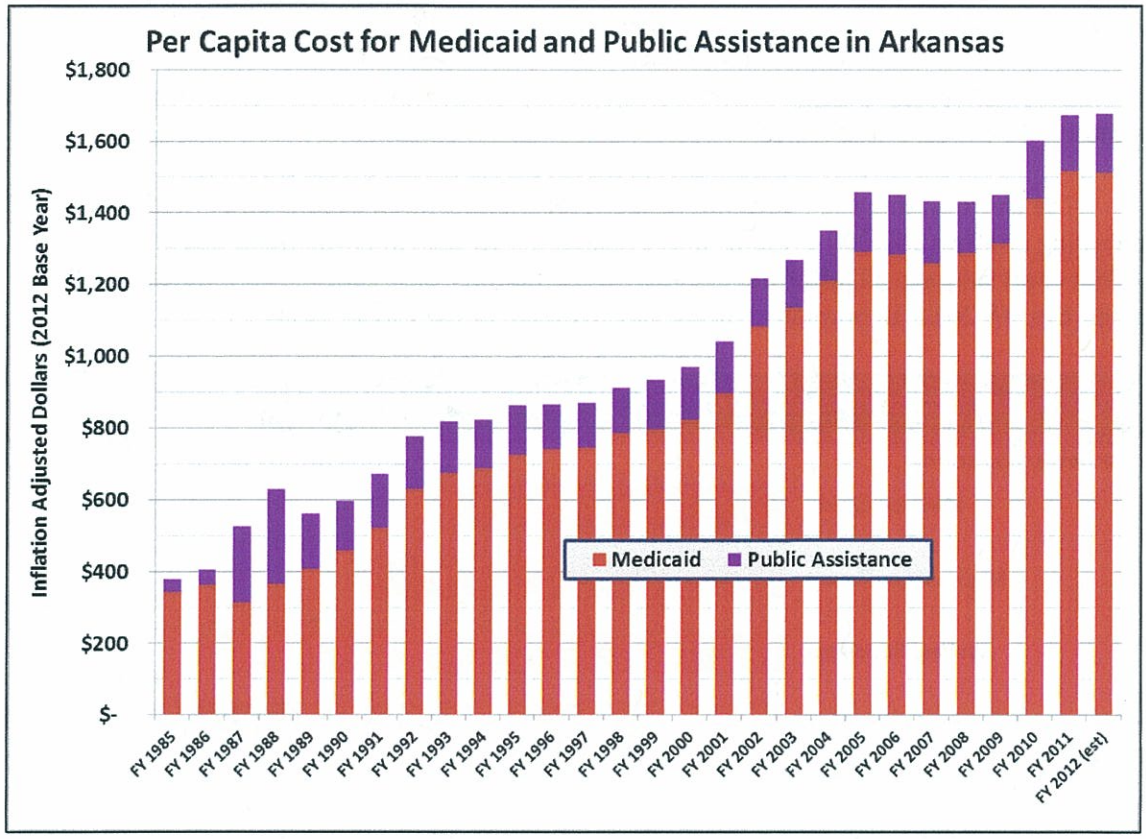
The growth for Medical Services is nearly double the growth rate of the rest of the state budget. In mathematical terms using a standard linear-regression analysis (and displayed on page 9) the growth rate of Medical Services has a slope of 0.1521, relative to a slope of 0.0831 for the rest of the budget.


Real Arkansas Budget Growth in Magnitude & Percent
The Alexander Group
Total State Budget (All Funds)
In Millions of 2012 Dollars
(Adjusted for Inflation)
1985 $6.7 Billion
$5,781
87%
$84
1%
$796
12%
1992 $9.5 Billion
$7,651
80%
$356
4%
$1,510
16%
2002 $15.4 Billion
$12,067
79%
$361
2%
$2,923
19%
2012 (estimate) $20.6 Billion
$15,611
76%
$485
2%
$4,455
22%
Key:
Medicaid
Public Assistance
Rest of Budget
Data Source: National Association of State Budget Officers, State Expenditure Reports


Department of Human Services Budget Growth
Billions of Dollars
6.0
5.5
5.0
4.5
4.0
3.5
3.0
2.5
2.0
1.5
1.0
0.5
0.0
1998-99
1999-00
2000-01
2001-02
2002-03
2003-04
2004-05
2005-06
2006-07
2007-08
2008-09
2009-10
2010-11
2011-12
State Fiscal Year
Overall Budget grew 89.3% in ten years.
Other Programs
Medical Services
Medical Services Budget Doubled in ten years and tripled in 13 years.



A common way to put budget growth in perspective is to view it in terms of the cost per-person and the size of the economy. Both methodologies yield similar results for Arkansas. Personal income is a common way to measure the size of a state economy. In 1985, the total Arkansas budget was 12.3 percent of the state personal income. By 2012, it grew to absorb 20.5 percent of the economy. This growth demonstrates that public-welfare programs are utilizing more economic resources than ever. Another way to measure that growth is to compare the inflation-adjusted budgets to the total population using a per-capita measurement. The chart on page 10 quantifies that measure in inflation-adjusted dollars. On a per-capita basis, the total cost for Medicaid and public assistance in 2012 was an estimated $1,678. In 1985, the per-capita cost in 2012 dollars (adjusted for inflation) was less than $400. Not shown on the graph, the total Arkansas budget, on a per-capita basis, is an estimated $6,982.



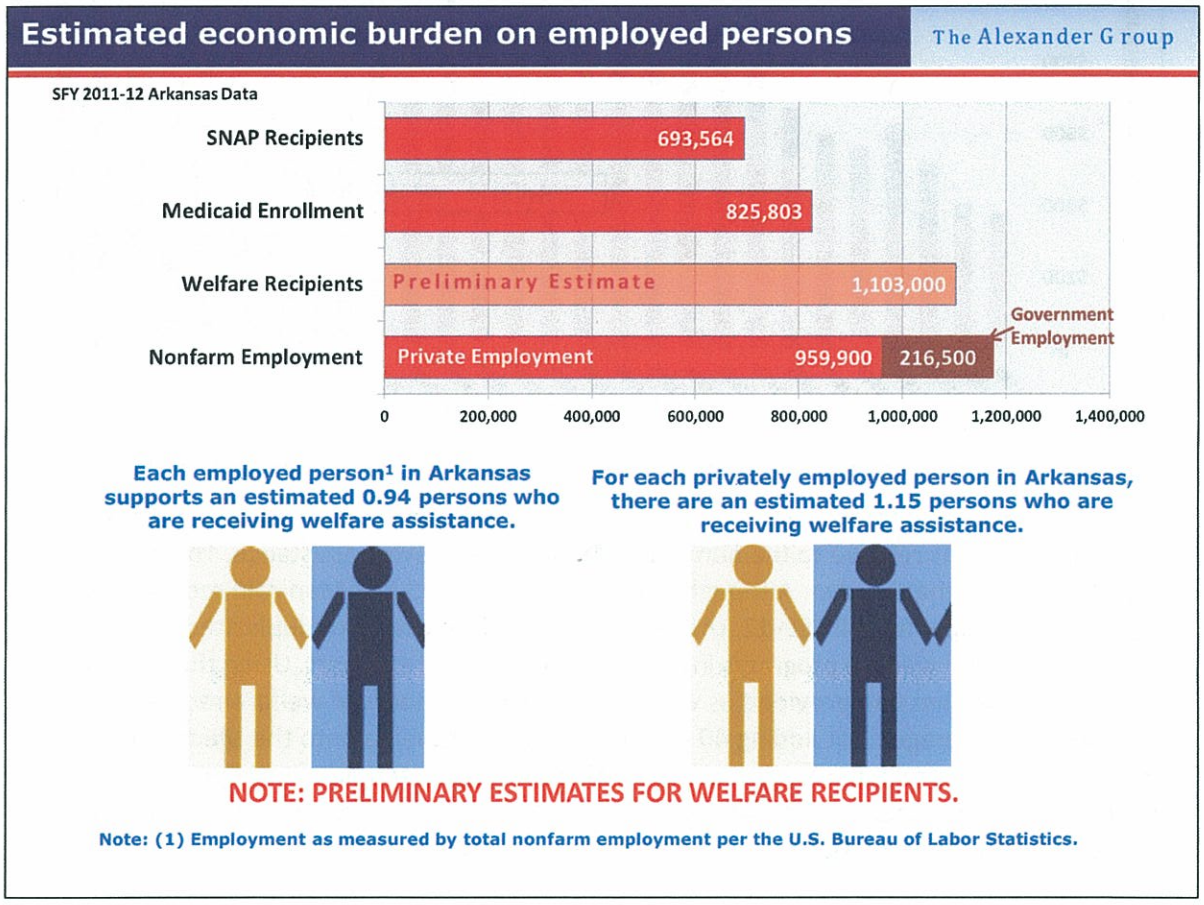
A final way to demonstrate the burden of public welfare is to compare the number of employed Arkansans relative to the number of Arkansans receiving assistance. The chart on page 11 estimates that burden. Although DHS data indicate 825,803 Medicaid recipients and 693,564 SNAP recipients in 2011–12, DHS was unable to produce an unduplicated number of recipients across all welfare programs in a timely manner for this report. Using the pattern of eight other states that had provided us with unduplicated numbers of welfare recipients,[3] we determined, on average, that adding 40 percent of SNAP recipients onto the Medicaid enrollment yields a preliminary approximation of the unduplicated number of welfare recipients. Applying that same formula to Arkansas computes an unduplicated number of welfare recipients of 1,103,000.

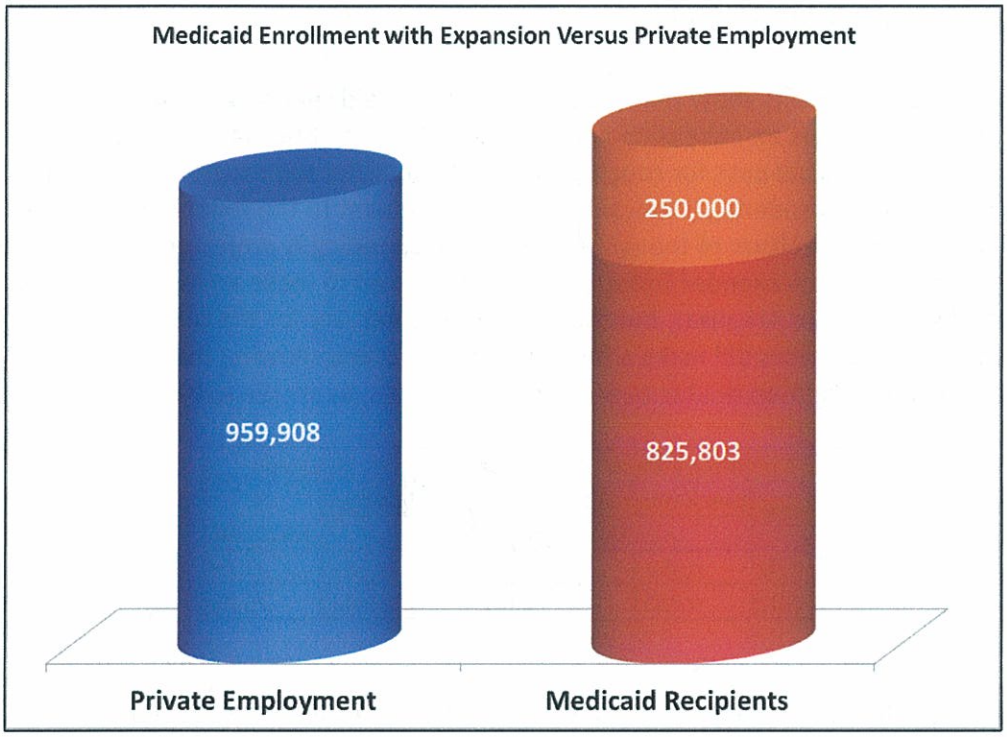
The chart displays two employment measures: total employment and privately employed persons. According to the U.S. Bureau of Labor Statistics, total employment in Arkansas was 1,176,400 in 2011-12. This gives us the following ratio: each employed Arkansan supports 0.94 recipients on welfare. Most states that we have looked at enjoy a significantly higher number of employed individuals relative to those receiving welfare benefits; our preliminary national estimate suggests between 1.8 and 2.0 workers, depending on the total-

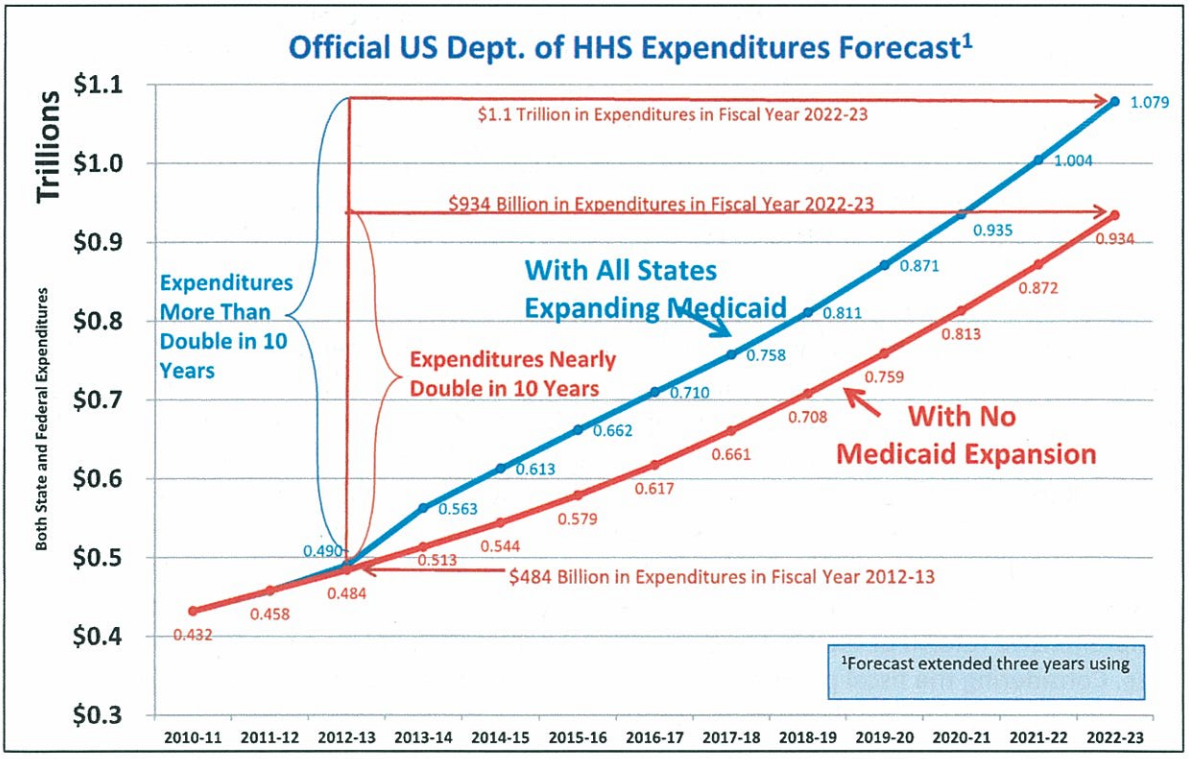
3. The states are Florida, Georgia, Maine, Michigan, Minnesota, New Hampshire, Pennsylvania, and Utah.

employment measured used, supporting every welfare recipient. This means the burden is significantly heavier in Arkansas. The private-employment metric further illustrates a disproportionately high welfare burden in Arkansas. For each privately employed Arkansan, we estimate 1.15 persons receiving some form of welfare assistance.

The chart on this page does not account for the projected expansion of Medicaid. DHS is estimating another 250,000 persons, or a 30-percent increase in enrollment. But according to the first chart on page 12, after the expansion, the number of Arkansans on Medicaid will exceed the SFY 2011-12 number of Arkansans working in the private sector.




Medicaid Enrollment with Expansion Versus Private Employment
959,908
250,000
825,803
Private Employment
Medicaid Recipients


Official US Dept. of HHS Expenditures Forecast[1]
Trillions
Both State and Federal Expenditures
$1.1
$1.0
$0.9
$0.8
$0.7
$0.6
$0.5
$0.4
$0.3
$1.1 Trillion in Expenditures in Fiscal Year 2022-23
$934 Billion in Expenditures in Fiscal Year 2022-23
$484 Billion in Expenditures in Fiscal Year 2012-13
Expenditures More Than Double in 10 Years
Expenditures Nearly Double in 10 Years
With All States Expanding Medicaid
With No Medicaid Expansion
0.432
0.458
0.484
0.490
0.513
0.544
0.563
0.579
0.613
0.617
0.662
0.661
0.710
0.708
0.758
0.759
0.811
0.813
0.871
0.872
0.935
0.934
1.004
1.079
[1]Forecast extended three years using
2010-11
2011-12
2012-13
2013-14
2014-15
2015-16
2016-17
2017-18
2018-19
2019-20
2020-21
2021-22
2022-23

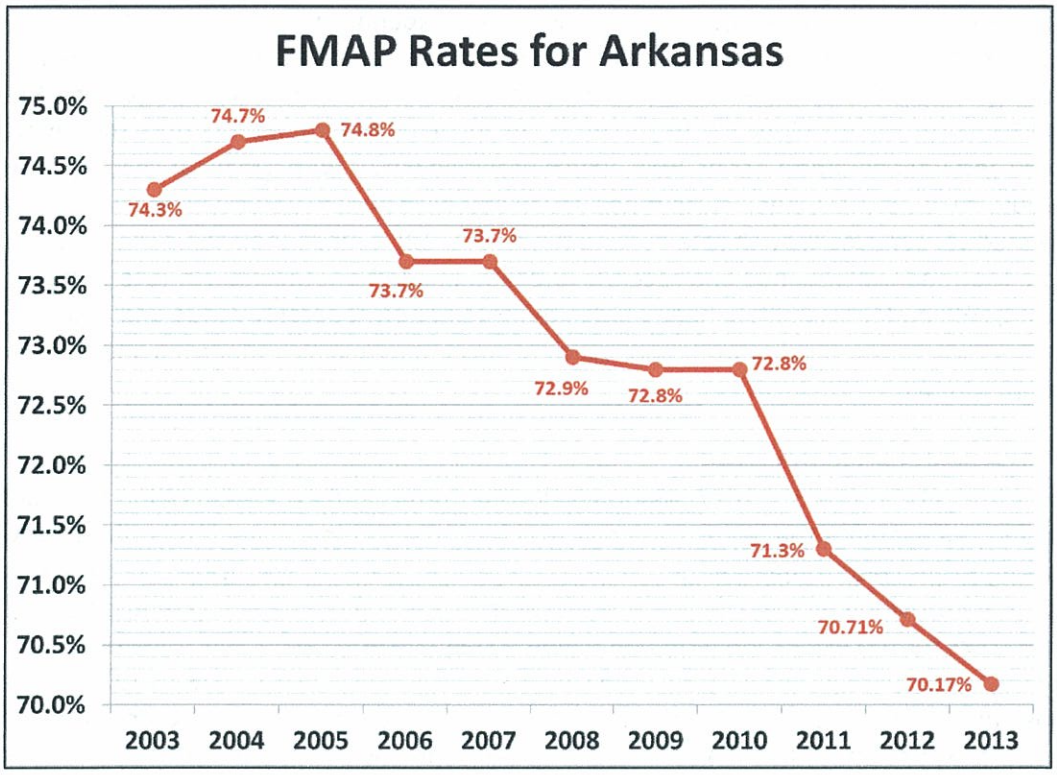
Medicaid Spending Projections

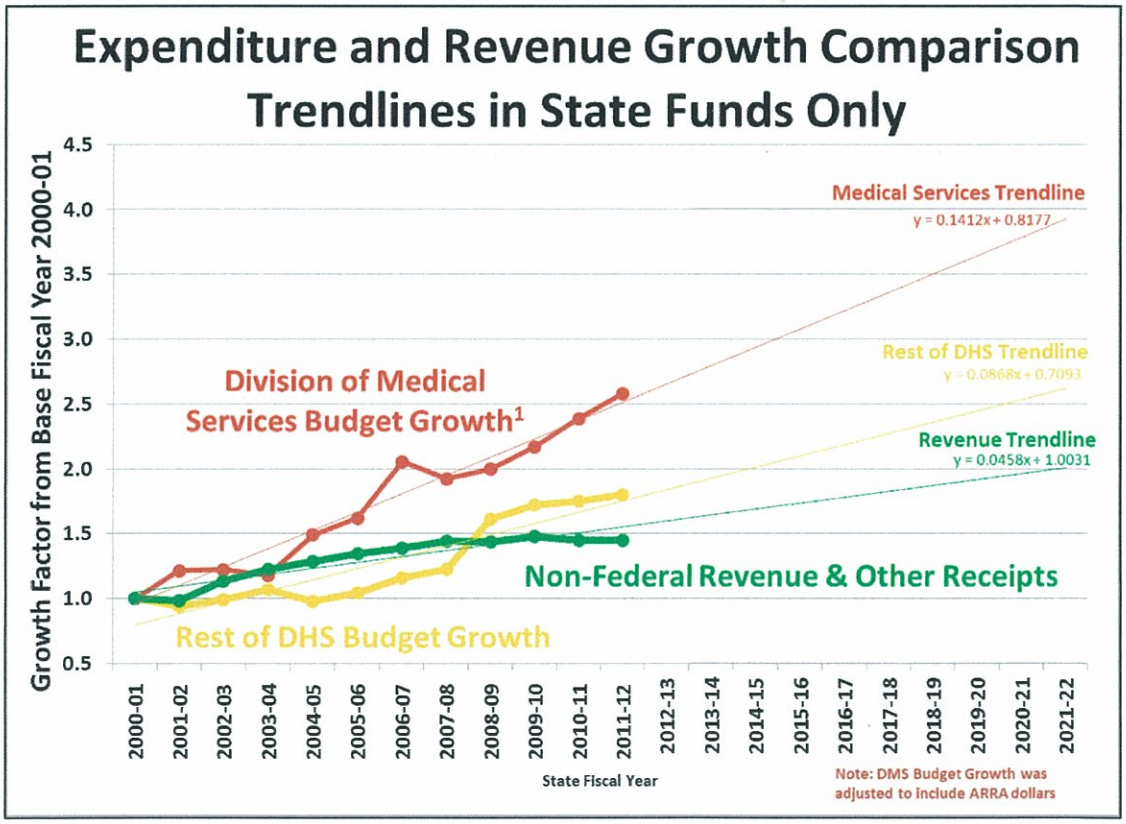
Reputable forecasts show that the growth in Medicaid spending will likely accelerate. Already, Medicaid covers an increasing amount of health care at both the beginning and end of life. In Arkansas, Medicaid pays for roughly two-thirds of births and roughly 70 percent of nursing-home care. Considering Medicaid expansion pursuant to the federal Affordable Care Act and without major reform of the system, Medicaid spending is projected to increase even more dramatically. The Alexander Group was not contracted to make an independent forecast of Medicaid spending for Arkansas, but the Office of the Actuary for the U.S. Department of Health and Human Services did make a forecast for the nation, showing that Medicaid expenditures will more than double over the next ten years, as shown in he table below:

Simple Forecast of Arkansas Budget in Ten Years				
SFY	Medicaid	Rest of Budget	Total Budget	% Medicaid
	Millions of Dollars			
2012	4,455	16,096	20,551	21.7%
2022	9,810	26,622	36,432	26.9%

A simple forecast using budget trends and HHS Medicaid forecasts predicts that Arkansas will need another $15.9 billion in revenue in ten years to meet budget demands even without the Medicaid expansion. Over the past ten years, the Arkansas budget, excluding Medicaid, grew 65 percent. If this growth rate continues, then the total state budget will reach $36.4 billion in SFY 2022, of which 26.9 percent will be Medicaid. Considering economic and fiscal factors, this growth will not likely be realized. Instead, it is very reasonable to expect that the rest of the budget will not be able to grow at the same pace, thus giving Medicaid a far larger share of the total budget than the predicted 26.9 percent. That means continued reduction or forced cuts in other state programs and services. Based on these forecasts, it is reasonable to conclude that Medicaid will continue crowding out other state priorities.

Sometimes an increase in federal funds can help offset the budgetary demand for public welfare, but recent history shows otherwise. Growth rates in DHS spending have far outpaced growth in revenue. Arkansas has been facing declining Federal Medical Assistance Percentage (FMAP), i.e., the share of the Medicaid program paid for by the federal government, illustrated in the first chart on page 14. Furthermore, Federal Funds Information for the States, a joint project of the National Governor's Association and the National Conference of State Legislatures, predicts that the FMAP for Arkansas will continue to decline. While available analyses show Arkansas will gain federal funds with Medicaid expansion, the complexity of the ACA and the uncertainty of forecasting suggest that gain will be short-lived. Without a comprehensive reform of the Medicaid program, it will continue to be a financial burden on the state. Considering the fiscal problems of the federal government, anything is possible, including less federal support for Medicaid in the future.

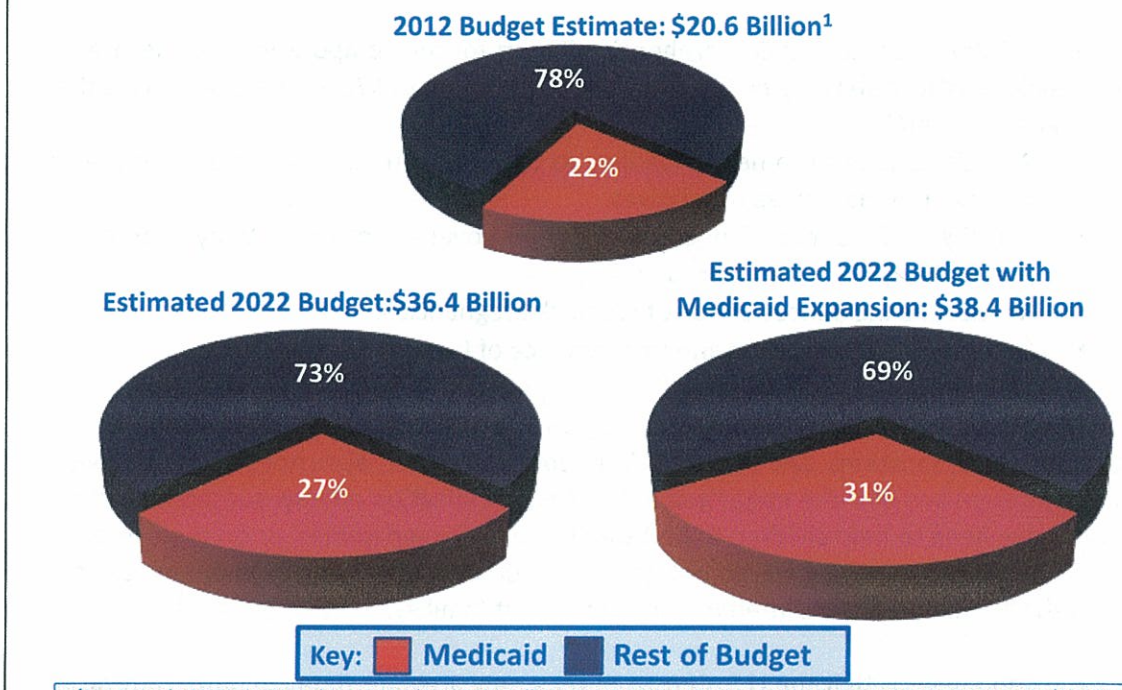

FMAP Rates for Arkansas
75.0%
74.5%
74.0%
73.5%
73.0%
72.5%
72.0%
71.5%
71.0%
70.5%
70.0%
74.3%
74.7%
74.8%
73.7%
73.7%
72.9%
72.8%
72.8%
71.3%
70.71%
70.17%
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013


Expenditure and Revenue Growth Comparison
Trendlines in State Funds Only
Growth Factor from Base Fiscal Year 2000-01
4.5
4.0
3.5
3.0
2.5
2.0
1.5
1.0
0.5
Medical Services Trendline
y = 0.1412x + 0.8177
Rest of DHS Trendline
y = 0.0868x + 0.7093
Revenue Trendline
y = 0.0458x + 1.0031
Division of Medical
Services Budget Growth[1]
Non-Federal Revenue & Other Receipts
Rest of DHS Budget Growth
2000-01
2001-02
2002-03
2003-04
2004-05
2005-06
2006-07
2007-08
2008-09
2009-10
2010-11
2011-12
2012-13
2013-14
2014-15
2015-16
2016-17
2017-18
2018-19
2019-20
2020-21
2021-22
State Fiscal Year
Note: DMS Budget Growth was
adjusted to include ARRA dollars

Our budget-trend analysis shows that Medicaid expenditures in state funds are growing three times faster than state revenue. The second chart on page 14 compares three growth rates using ten-year data as the base: Medical Services, the rest of the DHS budget, and Non-Federal Revenue and Receipts. For the analysis, we included federal money from the American Recovery and Rehabilitation Act of 2009, which provided states with funds for Medical Services that would have normally been state funds. Using standard linear-regression analysis, the slope for the medical-services growth rate in state funds (0.1412) is more than triple the growth rate for state (non-federal) revenue and receipts (0.0458). In addition, the growth-rate slope for the remaining DHS budget is 0.0868, nearly twice the rate of non-federal revenue and receipts. This trend underscores the need to find more efficient ways to administer Medicaid and the other welfare programs.

The final chart in this chapter, on page 16, offers a preliminary projection of the Arkansas budget through SFY 2022. Assuming current trends and expansion of the Medicaid population, we estimate the SFY 2022 budget will be $38.4 billion in total funds with Medicaid comprising 31 percent of that amount. For this projection, we used Medicaid cost expansion forecast data provided by DHS. Because this forecast made the unrealistic assumption that program costs for the expansion population would stagnate after 2017, we adjusted the forecast by adding Arkansas's historic Medicaid growth factor for years 2018 to 2022. For a baseline comparison, the chart also shows how the 2022 budget will look under current trends without the expansion. Unless Arkansas experiences unprecedented economic growth over the next ten years, we believe revenue will not be able to sustain these cost trends.

Total State Budget (All Funds): Assumes Current Trends



[1]Data Source for 2012 is the National Association of State Budget Officers, *State Expenditure Reports.* Actual budget exceeded NASBO estimate by $0.6 Billion.

3. SOCIOECONOMIC COSTS AND DISINCENTIVES

In the 2009–2011 Annual Comprehensive Report for the Temporary Assistance for Needy Families (TANF) published by the Arkansas Department of Workforce Services list the following goals for TANF:

- Provide assistance to needy families so that children may be cared for in their own homes or in the homes of relatives.
- End the dependence of needy parents on government benefits by promoting job preparation, work, and marriage.
- Reduce the incidences of out-of-wedlock pregnancies.
- Encourage the formation and maintenance of two-parent families.

The report itself provides numerous programs, including job placements, retention rates, hourly rates, sanctions, and deferrals. The report, however, does not provide a single metric to measure any of these major goals. There is no indication on how successful welfare programs have been to help children to be cared for in their own homes, or on the overall reduction on dependence on government, the reduction in out-of-wedlock pregnancies and births, or the formation and maintenance of two-parent families.

The good news is that the U.S. Census Bureau now provides detailed data from various surveys, including the American Community Survey (ACS), enabling researchers to answer specific questions about societal changes. The bad news is that our analysis of the Census data indicates that *none* of the admirable goals of TANF are being met. In fact, the social indicators reveal that the overall well-being of the target population has significantly declined.

Arkansas Families with Children under 18 Headed by Married or Unmarried Partner Couples			
	1959	**2011**	
	Married	**Married**	**Married or Unmarried Partner**
In Poverty	89.5%	19.0%	31.6%
Not in Poverty	97.5%	39.7%	43.4%

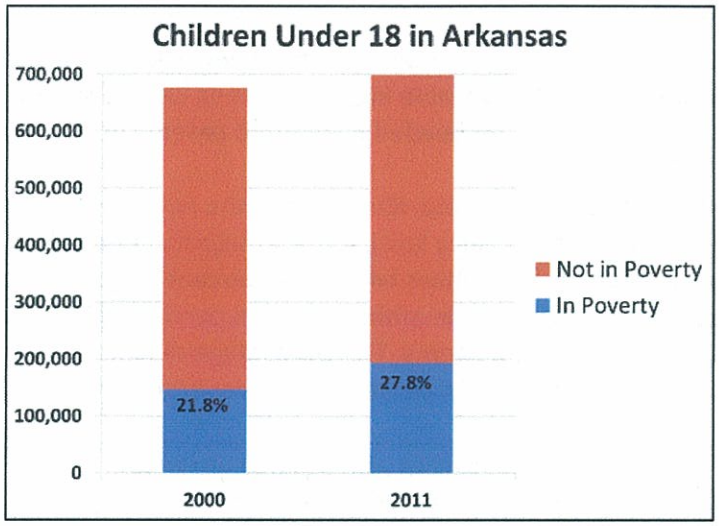
Starting with the TANF goals of promoting marriage and two-parent households, there are far fewer two-parent households in Arkansas today than ever. As the table above illustrates, among family households, defined by the Census Bureau as households with children under 18, that were living in poverty in 1959, 89.5 percent were headed by married couples. As a matter of comparison, among families living above the poverty line in 1959, 97.5 percent were headed by married parents. In 2011, however, only 19 percent of families in poverty were headed by

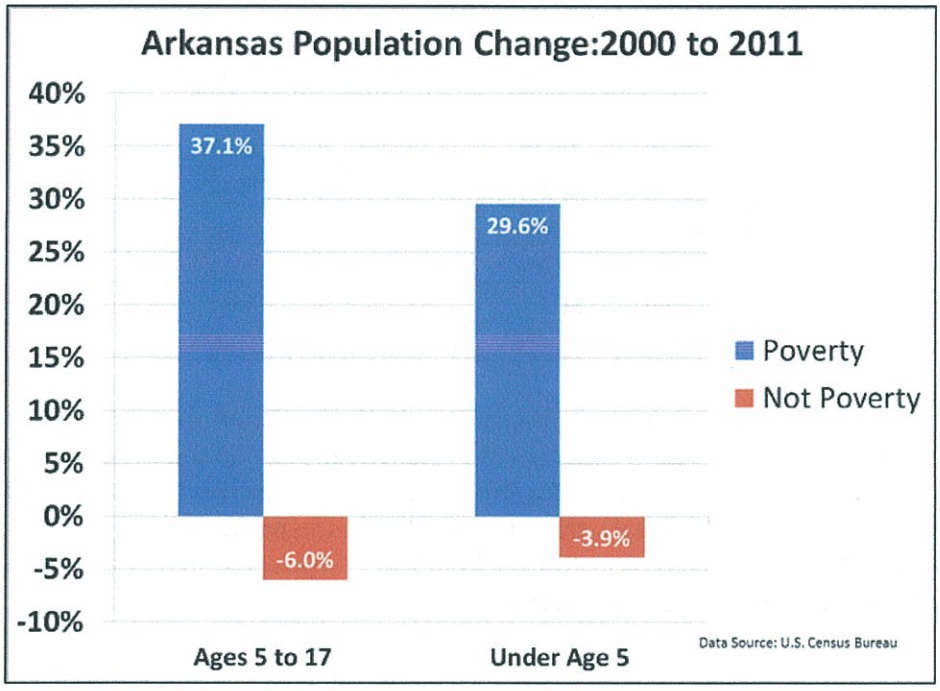
married couples. Of families living above the poverty line in 2011, 39.7 percent were headed by married couples, more than double the percentage rate. If we expand the definition to include an unmarried partner, something unavailable in the 1959 long Census survey, only 31.6 percent of families with dependent children are headed by married parents or an unmarried couple.

A further query using 2011 ACS data, illustrated in the figure below, shows that at incomes above 500 percent of the poverty level, a slight majority are headed by married couples, compared to 19 percent for families between 0 percent and 100 percent. Also apparent from the data, after some simple arithmetic, 12.6 percent of households with children in poverty are headed by unmarried partners. This percentage diminishes as income rises to be just 1.1 percent for households above 500 percent of the poverty level.

Arkansas Families with Children under 18 by Parental-Marital Status in 2011			
Income to Poverty Range	**Married**	**Married or Unmarried Partner**	**No Partner**
0% to 100%	19.0%	31.6%	68.3%
101% to 133%	29.2%	35.7%	64.0%
134% to 200%	33.3%	38.8%	61.2%
201% to 300%	38.9%	42.7%	57.1%
301% to 400%	44.5%	46.5%	53.3%
401% to 500%	47.2%	48.5%	51.4%
501% and over	50.6%	51.7%	49.0%
All Incomes	34.9%	40.6%	59.4%

The number of children in poverty is growing. As the first chart on page 19 indicates, 21.8 percent of children under 18 in Arkansas in the calendar year 2000 were classified as in poverty by the U.S. Census Bureau. By 2011, the percentage had grown to 27.8 percent. As the second chart on the next page reveals, the entire growth in the population of Arkansas children over that eleven-year period has come entirely from those in poverty. In fact, there was a negative population growth for children not in poverty.





One reason for this trend is the difference in birthrates for women in poverty and women not in poverty. Our analysis of ACS data shows that the higher the household income, the lower the birthrate. For family households in poverty with mothers between the ages 15 and 50, 7.3 percent gave birth to a child within twelve months of the 2011 American Community Survey. This compares to only 2.3 percent of households at more than 500 percent of the poverty level. See the table on page 20.

Percentage of Arkansas Women Between Ages 15 and 50 who Gave Birth within the Past 12 Months of the 2011 American Community Survey of the U.S. Census Bureau			
Income to Poverty Range	**Married Couple Household**	**Other Household Type**	**All Household Types**
0% to 100%	11.1%	6.3%	7.3%
101% to 133%	10.0%	2.8%	5.4%
134% to 200%	6.2%	4.0%	4.9%
201% to 300%	5.4%	2.4%	3.6%
301% to 400%	5.4%	1.0%	2.9%
401% to 500%	2.2%	0.0%	1.1%
501% and over	2.0%	2.9%	2.3%
All Incomes	6.6%	4.1%	5.0%

The decline of two-parent households, the increase of out-of-wedlock birthrates, and the rise in child poverty raise more questions than this report can adequately address. Nonetheless, the Census data do give us serious pause as to the effectiveness of welfare programs on either of these two TANF goals. The data show 68.3 percent of families at 100 percent or below the poverty threshold fall short of the goal of being two-parent households compared to 49 percent for wealthier families at more than 500 percent of the poverty threshold. If TEA is effective, why the large disparity?

The Census data do suggest that TANF and TEA are far from ending the "dependence of needy parents on government benefits by promoting job preparation, work, and marriage." Indeed, the County Office Operations Report of 2013 indicates that TANF caseload is actually declining (now a modest 12,953 recipients) while other welfare caseloads have increased. That SNAP now has caseload of 500,587 and Medical Services has a caseload of 684,384 underscores that the welfare system is doing less to promote independence than dependency on other types of services beyond cash assistance.

Arkansas Families with Children under 18 Receiving Medicaid or Food Stamps in 2011 (ACS U.S. Census Data)			
	Receives Food Stamps	**Does Not Receive Food Stamps**	**Total**
Receives Medicaid	26.7%	16.1%	42.8%
Does Not Receive Medicaid	14.0%	43.2%	57.2%
Total	40.7%	59.3%	100.0%

Receives Either Medicaid or Food Stamps	56.8%

According to 2011 ACS data, 56.8 percent of families with children in Arkansas receive either Medicaid or food stamps, showed on the table on page 20. With more than half of all families with children on Medicaid or receiving food stamps, it is difficult to argue that the goal of reducing dependence on government is being achieved.

Regarding the TANF goal of caring of the child in his or her home or in the home of a relative: the prevalent interpretation is that this means the children are safe to live in the homes of their parents or relatives as opposed to having to place them in foster care or in some form of institutional care; the goal should not be confused with providing care when parents work or train. Child care outside the home does not deter from this goal. The federal emphasis has been promoting this interpretation with the simultaneous goal of encouraging high-quality child-care settings.

In terms of providing child-care services, however, the state is not promoting the idea of providing child care in the home or with a relative. Standard forms for the federal Child Care and Development Fund clearly indicate that state programs must allow for the option of in-home care, defined as care within the home of the child. Forms submitted to the federal government by the Arkansas Division of Child Care and Early Childhood Education indicate that in-home services would be provided as long as the in-home care was licensed or registered. However, this statement is misleading because the Arkansas child-care program does not allow this option. In FFY 2012, Arkansas received $49.6 million in federal funds for the child-care program, which was matched with $4 million in state funds.

To summarize, socioeconomic data provide little evidence that any of the four goals identified by DWS and established by PRWORA are being achieved. The data instead suggest reforms of the current system are needed, including the establishment of a dashboard metric system to help legislators and top executives monitor the effectiveness of the welfare system.

Imbedded Disincentives

A well-known feature of public-welfare programs is that they trap recipients in welfare dependency. In other words, the system has imbedded economic incentives that undermine the goals achieving independence, the stated purposes of TANF. States, however, can work to minimize these disincentives to the degree that they have the latitude to do so. Additionally, federal law provides opportunities to seek waivers, and states are free to design waiver requests to help facilitate the goal of reducing these disincentives. Indeed, when setting up Medicaid in 1965, Congress explicitly intended the program, in part, "to help . . . families and individuals attain or retain capacity for independence or self-care." (42 U.S.C. § 1396)

The TANF program was designed to reduce dependency as much as possible. TANF relies on a combination of training and time limits, and Arkansas's program has some very strong strengths. TANF, however, is just one program and is relatively small in terms of enrollment and expenditures compared to other programs. For example, the federal Earned Income Tax Credit

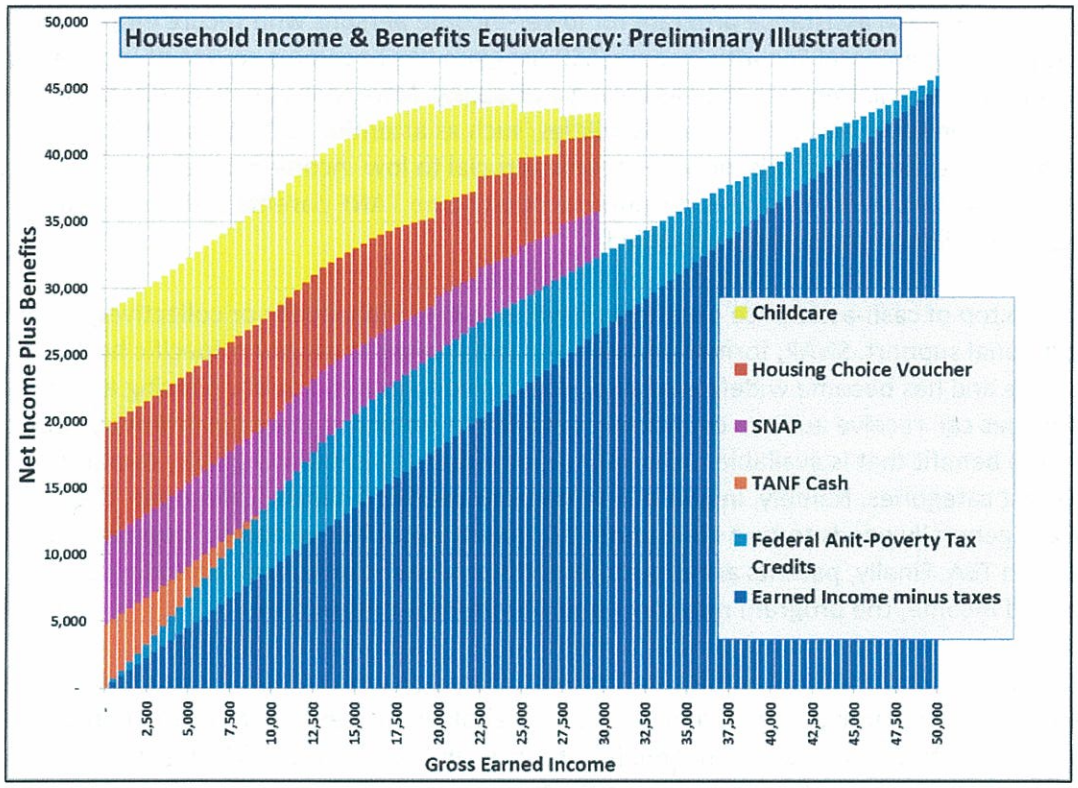
is a much larger cash assistance program for lower-income persons who secure employment. The federal Supplemental Security Income (SSI) program has become a source of income for families that have children classified as having a disability. Note that not all SSI disabilities are severe. Children with relatively minor disabilities, such as attention-deficit disorders, qualify for monthly income, and often this income becomes crucial to low-income households, so much so that studies and news reports have documented that some TANF parents actively pursue having their children diagnosed as disabled.[4]

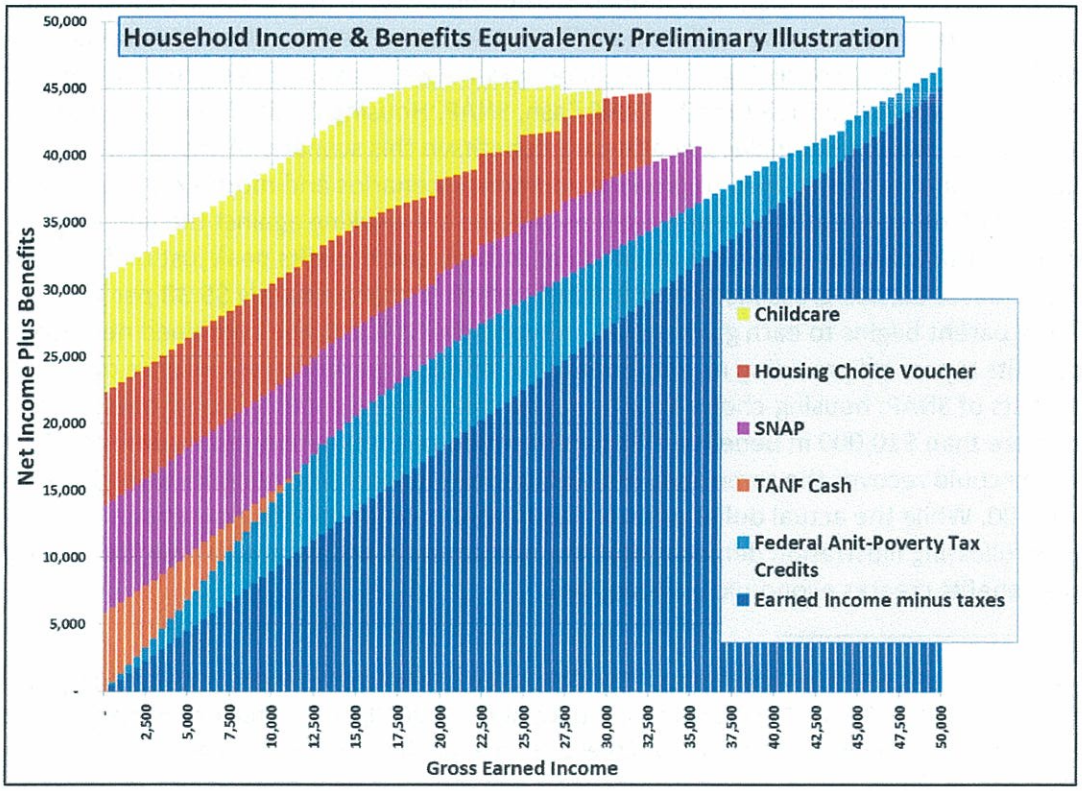
On top of cash-assistance programs, families, either individually or collectively, qualify for additional support. SNAP, formerly known as food stamps, is based on specific household definitions and has become widely available. Housing vouchers and public housing are benefits that families can receive and are completely outside the control of state government. Medicaid is a health benefit that is available only to those individuals that meet eligibility requirements for distinct categories. Namely, in addition to meeting specific financial categories, the applicant generally needs to be a child under 18, elderly, disabled, widowed, pregnant, or enrolled in TEA. Finally, parents are eligible for child-care assistance, and depending on household income, the program may pay up to 100 percent of the cost.

It is the culmination of these benefits in combination with earned income that creates the economic disincentives. For example, as a household increases its gross earned income, ideally the combination of its net income (after taxes) and benefits should increase. Using a preliminary economic model, illustrated on the first chart on the next page, we ran a scenario for a household of three consisting of a single parent with two children, which represents a typical TEA household receiving welfare benefits in Arkansas. The formulas used are based on federal rules and tables consisting of the Federal Anti-Poverty Tax Credits (Earned Income Tax Credit and Additional Child Tax Credit). TANF Cash, SNAP, Housing Choice Vouchers, and Child-care Assistance. We did not include health-care benefits in this scenario. Although this preliminary model can be refined to produce additional scenarios and more exact numbers, it is illustrative and demonstrates how economic incentives are working against the family. According to this scenario, family's combined net income and benefits peak just under $44,000 when it achieves earned gross income of $19,500, which is approximately $9.38 per hour. When the parent begins to earn gross income beyond the $19,500, the combined net income and benefits tapers off providing no additional gain. At about earned gross income of $29,500, the benefits of SNAP, housing-choice vouchers, and child-care assistance would cease, causing a loss of more than $10,000 in benefits. This parent would need to earn gross income of $44,000 before she could recover the same level of combined net income and benefits when it earned just $19,500. While the actual dollar amounts and experience of specific households would vary, the following illustration demonstrates the fundamental problem with how the totality of welfare benefits creates economic disincentives.

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4. See, for example, the three-part series, "The Other Side of Welfare" by Patricia Wen, "A Legacy of Unintended Side Effects," *The Boston Globe*, December 12, 2010; "A Coveted Benefit: A Failure to Follow Up," December 13, 2010; and "A Cruel Dilemma for Those on the Cusp of Adult Life," December 14, 2010.


Household Income & Benefits Equivalency: Preliminary Illustration
Net Income Plus Benefits
50,000
45,000
40,000
35,000
30,000
25,000
20,000
15,000
10,000
5,000
-
2,500
5,000
7,500
10,000
12,500
15,000
17,500
20,000
22,500
25,000
27,500
30,000
32,500
35,000
37,500
40,000
42,500
45,000
47,500
50,000
Gross Earned Income
Childcare
Housing Choice Voucher
SNAP
TANF Cash
Federal Anit-Poverty Tax Credits
Earned Income minus taxes


Household Income & Benefits Equivalency: Preliminary Illustration
Net Income Plus Benefits
50,000
45,000
40,000
35,000
30,000
25,000
20,000
15,000
10,000
5,000
-
2,500
5,000
7,500
10,000
12,500
15,000
17,500
20,000
22,500
25,000
27,500
30,000
32,500
35,000
37,500
40,000
42,500
45,000
47,500
50,000
Gross Earned Income
Childcare
Housing Choice Voucher
SNAP
TANF Cash
Federal Anit-Poverty Tax Credits
Earned Income minus taxes

Further analysis demonstrates how the disincentives undermine the TANF goals of promoting marriage and the formation and maintenance of two-parent families. If we add into the economic model the second parent, in most cases the father, we get a revised scenario in the second chart on page 23. As before, the combination of net income and benefits peak at around $19,500, but there is a very important difference. If both parents work and earn gross income around minimum wage or a little bit more, their total household gross income will likely fall within the cliff area of the chart, meaning that they are sacrificing a significant amount of benefits. This economic model provides evidence that the welfare system discourages two-parent family formation. Combined with the socioeconomic data reviewed earlier, this model suggests that the disparities between households in poverty and those not in poverty are partly unintended consequences of the welfare system itself.

Realigning the economic incentives embedded in the welfare system will require major reforms of the welfare system requiring flexibility and approval from the federal government. Such approval may take the form of global waivers from multiple federal agencies or congressional authority. It is outside the scope of this review to offer the Alexander Group's comprehensive approach of realigning the economic incentives and developing a federal strategy. The next two chapters detail reforms that Arkansas might consider.

4. MAJOR POLICY-REFORM RECOMMENDATIONS

Medicaid Global Waiver

Because of the complexity and burden of overlapping federal and state laws, rules, and regulations, the task of transforming the welfare system into an efficient operation focused on independence is more difficult than changing private-sector entities. Unlike successful businesses that quickly learn from mistakes, adapt to new realities, and have to be accountable or else they can fail, governments can continue for years operating a system under outdated and misguided assumptions. Even in the face of clear program failure, our top-down, hierarchical system never calls for reexamination or repeal of programs, only for the adding of new levels of programming onto an already bloated and disorganized system.

True reform must be based on a reexamination of the very assumptions of the War on Poverty that was announced by President Lyndon Johnson nearly fifty years ago. Rather than relying upon the so-called experts who believe there is no social or economic problem government cannot fix, true reform calls for a government that respects the natural family as the fundamental social unit, ensures results through performance accountability, and promotes innovation through competition and creativity. Reinvented government is citizen-centered, focuses on family responsibility, demands efficiency, utilizes results-oriented performance measures, and maximizes market-based solutions where feasible. Government must be modernized both in personnel and technology, lean, performance driven, and accountable to the taxpayers.

To help Arkansas adapt to a rapidly changing world, it is our recommendation that Arkansas pursue a global and comprehensive redesign utilizing one waiver of its entire Medicaid program. Currently, the state operates a myriad of Medicaid waivers and state plan amendments that do not comport across all programs. These thousands of rules, service definitions, and conflicting regulations yield operational chaos, cost escalation, lack of transparency, and a preoccupation with formal compliance with Uncle Sam, not better health outcomes for recipients. Consequently, a global redesign would not only make Medicaid more efficient, transparent, and accountable but also more accessible to legislators and even taxpayers. Moreover, this option would improve performance for employees and contractors, outcomes for recipients, and realize significant cost savings well beyond the thirty-two initiatives identified in the Appendices.

A comprehensive redesign of the state Medicaid system through a single waiver is not an ivory-tower dream of policy experts. In 2009, the State of Rhode Island secured such a waiver from the Centers for Medicare and Medicaid Services (CMS) that exempted the state from the overkill of federal micromanagement in exchange for a five-year spending cap. That

culture-changing, landmark initiative transformed a sluggish state bureaucracy into a performance-driven system that not only increased access and choice but also improved care quality and outcomes—while saving taxpayers approximately $100 million. And Rhode Island brought in total Medicaid spending at billions of dollars below the spending cap.

Other states have achieved similar success in bending the Medicaid-spending curve. In Indiana, former Gov. Mitch Daniels created the Healthy Indiana Plan (HIP), an alternative health-care plan for a group of Medicaid recipients that paired catastrophic insurance with a Personal Wellness and Responsibility (or POWER) health-savings account for households with incomes up to 200 percent of the federal poverty level.

Given the pending expansion of the Medicaid system demanded by the Affordable Care Act, there is no better time for a state like Arkansas to pursue a global reform of the broken system than now. The top-down, one-size-fits-all bureaucratic model that the federal government has imposed upon the states through both Medicaid and the ACA is unsustainable. Yet Arkansas can show leadership for the nation by taking control on her own resources and possibly even repurposing savings for more promising uses—like infrastructure improvements, vocational training, or tax relief to revitalize industry—that can enhance economic and job prospects for all.

Comprehensive Welfare Reform

Comprehensive welfare reform goes beyond the global waiver for Medicaid to include all components of the welfare system to address family and individual needs as it relates to food, housing, child care, health care, transportation, and special needs. The redesign is overarching and comprehensive. It keeps those portions of the current welfare system that are working, but it will also completely restructure other components, merging multiple programs into a cohesive system. It will not make change for the sake of change, but it will target those areas where performance outcomes need improvement and where cohesiveness is lacking with other programs.

In the final redesign, each recipient's situation should be assessed relative to needs, including consideration of income and resources of his or her family, and would be given an individual plan—specific to the person's situation—focused on completely moving the recipient off the welfare system. The redesigned system will adhere to the following principles:

1. **Welfare cliffs are eliminated.**
    - It actively encourages progress toward attaining self-sufficiency.
    - It encourages work
2. **The system is person and household centered**
    - It is customized to the specific situation
    - It is needs-based

3. **The system is equitable**
    - Persons above the eligibility line are always better off than those below it even after benefits are dispensed.
4. **Natural supports, including familial relationships, are encouraged**
5. **It promotes personal responsibility and decision-making.**
6. **Time sensitive**
    - The system recognizes how need changes with time and adequately accounts for those changes.
    - The system establishes time-sensitive milestones that recipients must meet on their way to self-sufficiency.

While the global waiver will dramatically improve the Medicaid program, the comprehensive reform is needed to dramatically improve the public-welfare system. However, preparing a comprehensive welfare reform is more complex than preparing a global waiver, as it must include a strategy to secure approvals from the federal government, and no state has yet accomplished this task. Nonetheless, comprehensive reform offers the only real promise of transforming the entire welfare system. Arkansas might consider becoming the state to lead the way.

5. BUDGETARY CONSIDERATIONS

A review of budget documents relating to public-welfare programs shows both strengths and weaknesses. The program narratives, including the statutory history and scope of the programs, are well done and better than other states we have reviewed. There are two large weaknesses. First, the budget documentation lacks performance measures. Second, it lacks initiatives to improve outcomes and efficiency of operations.

Budgetary and Programmatic Performance Measures

Arkansas organizes its budget on a program basis whereby budgets are formulated and appropriations that are made on the basis of expected results of services to be carried out by programs. Most states, however, are moving to integrate performance-based measures more fully into their budgeting processes. NASBO defines performance budgeting as follows:

> Performance budgets are constructed by program but focus on program goals and objectives; measured by short-term outputs, projected longer-term outcomes, and cost/benefits analysis. Appropriations are not only linked with programs, but also with expected results specified by these performance criteria.

Moreover, NASBO reports that:

- 40 states collect program-level performance measures,
- 39 states require performance measures as part of each agency budget request,
- 31 states have budget agencies that coordinate performance measures,
- 29 states formally review or audit performance measures on regular basis,
- 25 states utilize performance budgeting as a budgeting procedure.[5]

Arkansas could benefit by initiating steps to integrate performance measures into its budget process, especially in the area of human services.

Performance measures are beneficial at more than one level. Foremost, they require policymakers and top executives to establish specific goals and provide an objective way to determine whether programs are meeting those goals. Second, they enable program managers to establish benchmarks for outcomes and efficiencies. These in turn can be monitored by auditors and reported back to legislators, helping to facilitate monitoring of program success.

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5. National Association of State Budget Officers, *Budget Processes of the States*, Summer 2008.

Public-welfare programs pose peculiar challenges for performance measures, as the system was not established in a manner conducive for measuring policy goals and performance. The various programs that make up the welfare system were created in intervals and on a piecemeal basis with the primary goals of determining eligibility and dispensing benefits. The basic reality is the welfare system was established prior to the development of modern computer technology and interrelational databases. Early statistics were limited to tabulations and general descriptions, negating the ability for policymakers to determine outcomes and impact in a very meaningful way.

Today, however, information technology enables both operational proficiencies and policy analysis suitable for legislators and top executives. This development provides policymakers with an unprecedented opportunity. By establishing proper metrics and management techniques pursuant to well-defined business goals, outcomes can be improved for both recipients while better controlling costs and program integrity. In general, states have been moving toward developing their systems so that outcomes can be more intelligently managed and directed.

Establishing meaningful performance measures that are consistently captured and tracked is not an easy task. To do it right requires the input of multiple stakeholders at various stages. First, it is important to have legislative leaders and top executives committed to performance measuring. Without support at the highest levels, the effort will fall short of its potential. Second, it is important to review and perhaps redefine program goals to reflect important principles and realities. Examples of these overarching principles include person-centered care for a person at the right setting at the right time, promoting progression toward independence and fostering personal responsibility. Third, state systems must be set up in a manner conducive to capture and track the necessary data, requiring cooperation from operational staff and technological capabilities. Fourth, the measures must be integrated into the operational system so it becomes part of the culture. Dashboards are extremely helpful in this regard because they provide constant reminders, helping guide day-to-day decisions of online staff. Fifth, the results need to be included in program audits and reported back to the legislature. Finally, periodic reviews are needed to improve performance measures, revise program goals, and make programmatic adjustments.

In order to tap into the potential, it is not necessary to have a single database, but the databases need to be set up intelligently to allow queries across systems. To that end, it is crucial that the systems establish a recipient identification number. Without such a standard, it becomes difficult to determine even the simplest information, such as the number of benefits a specific recipient might be receiving, tracking the recipient over time to follow progress, or to effectively query program results on a macro scale. Arkansas has a data warehouse, and conversations with key staff indicate that Arkansas has the ability to query across systems.

We had requested from DHS an unduplicated count of all welfare recipients. Based on conversations with DHS staff, it seemed possible to link up the various databases through fields identifying individuals. DHS, however, had not delivered the answer by the time of this report's

publication. We are not certain whether DHS does indeed have the capability but was unable to generate the data in a timely manner or if it simply does not have the technical capabilities. Whatever the case, there is room for improvement in DHS being able to generate basic policy level data. It should be common practice to be able to generate these data on a regular and timely basis.

In addition, we strongly recommend that the state review all of its contract terms. There are currently in excess of $40 million in DHS contracts with contract terms requiring them to provide active feedback, ensure quality of services, and to collect and report data. However, many data request were unable to be fulfilled for analysis in this report.

We strongly recommend that Arkansas develop performance measures for budgeting, programmatic, and management purposes. More research needs to be done to verify capabilities, but Arkansas appears to have many of the pieces that would enable it to initiate a performance-based system.

Cost-Savings Budget-Process Initiatives

While budget documentation does mention some cost containment efforts, we recommend that cost saving initiatives receive a far more prominent role in the documentation. It is within the narrative section of the budget documentation where these saving initiatives are mentioned. For example, page 419 of volume 9 of Budget Summary Information for the 2013–15 Biennial Budget states that the DMS Medicaid "Pharmacy Program continues to implement additional edits on medications which serve to assure appropriate utilization and patient safety, and prevent waste and abuse with the end result being cost containment." On the same page, it states: "Third Party Liability (TPL) collections and cost avoidance have doubled from 2007-2009 ($28 mil. to $56 mil.)". On page 421, the same volume states, "The Division of Medical Services is on the cutting edge of discovering efficiencies to improve access to programs while containing program costs." Throughout the document, there are various other places where specific processes or programs are mentioned that promote efficiency and cost savings.

According to this documentation, the Arkansas legislature has entrusted DHS to be responsible for seeking efficiencies. As stated on page 129 of the same volume: "The Director has the authority to transfer or assign duties or programs whether existing or new to offices, sections or units as deemed necessary for efficient and necessary operation of the department." We believe that this flexibility is a good thing. However, when we inquired whether the director had ever used this power for the benefit of DHS, we were provided with no incidences where it was ever used.

We recommend raising the level of cost savings by having the legislature require the executive agencies to propose specific cost-savings initiatives with each budget submission. These initiatives need to include brief information on the initiative and estimates of cost savings. It is helpful if these initiatives are organized within the documentation where there is a

summary by department and then more detailed information under each division or office. In addition, the agencies ought to be required to make periodic reports on the progress of initiatives being undertaken and be held accountable.

The legislature may also want to consider a semiannual caseload, utilization, and expenditure estimating conference to ensure not only that the DHS is meeting its targets but also that cost overruns and supplemental budget requests are kept to a minimum.

There are several distinct advantages to this recommendation. First, the requirement makes savings a specific focus, enhancing the need for the executive branch to put forth proposals. Second, it gives legislators the opportunity to review savings initiatives and also to offer their own proposals. Legislators need to see all the initiatives being undertaken in one place. We know from experience that raising savings initiatives to this level will secure greater efficiencies and deliver value to the state.

6. PROGRAM REVIEWS

The TANF System

Temporary Assistance for Needy Families (TANF) is a federally sponsored program created by Congress in 1996 with the enactment of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA). It replaced Aid to Families with Dependent Children (AFDC). To implement TANF in the state, Arkansas created the Transitional Assistance (TEA) program in 1997.

The 1996 welfare-reform law (P.L. 104-193) entitled states to a basic TANF block grant equal to peak expenditures for pre-TANF programs during FFY 1992 to 1995, when welfare rolls were at their all-time high. Each state's individual grant in the original TANF law is based on the federal share of expenditures in the pre-1996 Aid to Families with Dependent Children (AFDC), Emergency Assistance, and Job Opportunities and Basic Skills (JOBS) training programs.

To supplement its TANF block grant each fiscal year, a state must spend a specified amount of its own funds for benefits and services that assist eligible families in ways that are consistent with one of the four purposes of TANF program. The money that a state is required to spend out of its own funds is called Maintenance of Effort (MOE). The amount of annual state expenditures on TANF-related programs must equal at least 80 percent of its spending on AFDC and related programs in 1994. This percentage is reduced to 75 percent if the state meets the federally mandated Work Participation Rates (WPR) for two categories of recipients: "all families" and "two-parent families."

States may use TANF funds for any benefit or activity related to one of four statutory purposes:

- to provide assistance to needy families so that the children may be cared for in their homes or in the homes of relatives;
- to end dependency of needy parents on government benefits by promoting job preparation, work, and marriage;
- to prevent and reduce the incidence of out-of-wedlock pregnancies and establish annual numerical goals for preventing and reducing the incidence of these pregnancies;
- to encourage the formation and maintenance of two-parent families

MOE expenditures must be for an allowable purpose, must be made to or on behalf of an "eligible family," must meet the "new spending test," and not be otherwise excludable. Allowable purposes for which state expenditures may count as MOE are cash assistance, child-care assistance, educational activities that promote self-sufficiency, job training, or work. These

can be anything reasonably intended to fulfill a TANF purpose, and up to 15 percent on related administrative costs.

Arkansas TANF Overview

Funding of Arkansas's TANF program breaks down as follows:

- Arkansas's Basic TANF Block Grant is $56.7 million annually. Arkansas's portion represents 0.3 percent of $16.4 billion allocated to the fifty states and the District of Columbia.
- 80 percent of Arkansas's required MOE is $22.2 million dollars or 75 percent is 20.8 million provided the state meets federally mandated work participation rates.
- Arkansas was one of seventeen states that received TANF Supplemental Grants every year. However, Arkansas lost $6.2 million when this facet of TANF funding was omitted from the February 22, 2012, TANF extension signed by President Obama.

In passing Arkansas Act 1705 of 2005, Arkansas made a number of courageous reforms to its welfare system by recognizing the Department of Workforce Services (DWS) as the administering agency for the program. Different from other state structures, the Division of County Operations within the Department of Human Services is a formal partner with DWS in the operation of TANF, called Transitional Employment Assistance (TEA) Program. This Act further established the Work Pays Program as an incentive to encourage working TEA participants to remain employed after closure of the TEA case while increasing their hours of work and/or hourly wages. Typically, the human-services agency is designated as the administrative entity for TANF programs and enters into agreements with its respective state employment agency.

Beginning January 1, 2006, DWS assumed overall program responsibility for TANF operations and case management; the Division of County Operations held responsibility for eligibility determinations and client payments.

In interviewing administrators from both agencies, this major restructuring has led to well-defined roles and responsibilities for managers and workers alike and seemingly simplified avenues of service delivery for needy families seeking assistance. In addition to interviews, the Alexander Group carried out a general review of relevant policies and processes, along with an examination of most recent state and national data reports. Together, this information provided a number of useful perspectives on the effectiveness of policies, expenditures, and outcomes in Arkansas compared to other states. It must be emphasized that these reviews were necessarily preliminary as are the ideas and recommendations being made to the Arkansas legislature.

Arkansas TANF Findings

- For a family of three, Arkansas provides a maximum payment level of $204 per month. This is the third lowest payment level in the country.
- TEA Program families have a 24-month lifetime limit on cash assistance. Work Pays families may receive up to 24 months of additional payments provided they meet eligibility requirements. This work-incentive program may be limited to 3,000 families.
- As of April 2013, TEA caseload is approximately 5,897 cases, with approximately 12,952 recipients. This represents an 8-percent decline compared to April 2012.
- As of April 2013, the County reported approximately 1,014 Work Pays active cases. This represents a 10-percent decrease over April 2012.
- The most recent ACF Report on TANF Participation Status for Arkansas (March 2011) reflects that actual participation of Work Eligible families in countable work activities is approximately 19.7 percent. The same report reflects that approximately 66.2 percent have zero countable hours of participation. Nationally, 23.6 percent are meeting the federal participation-rate standards and 52.3 percent are in zero hours of participation.
- The state has met the required work-participation rate level at 26 percent. Arkansas, as with virtually all other states, achieves its federal work-participation rates for both categories of All Families and Two-Parent Families in part due to the Caseload Reduction Credit formula, which reduces the actual rate in accordance with MOE-spending calculations.

TANF Fiscal and Program Risks and Recommendations

The Department of Workforce Services budget analysis of July 2012 clearly articulates that Arkansas faces significant fiscal constraints resulting from the loss of substantial TANF dollars on the federal level combined with the fact that the state has relied heavily on its previously robust level of carryover funds which, together, have been used to support major initiatives defined in the state program. These funds are running low and cannot be viewed as ongoing resources to support the current comprehensive service model.

Arkansas already has a tremendous emphasis on providing support for working parents and attempting to end dependence on welfare under the current system. However, with the loss of TANF dollars on the federal level and the greatly diminished level of carry forward funds, there are some straightforward reductions that should be made with the following considerations in mind.

The first recommendation is an obvious one, which is to avoid TANF penalties at all costs. This will require prioritizing only countable work activities. According to the federal HHS Office of Family Assistance, TANF penalties remain a threat in the future for all states. Arkansas is not slated for a penalty at this time but could incur a penalty as funding levels and programs contract in the future.

Failing the TANF work-participation rate is only one of at least fourteen different penalties that can be imposed if a state fails to comply with various requirements. If imposed, these penalties are costly, and can result in a compounding loss of funds to a state. While there may be corrective measures available to a state, the process is onerous and creates a tremendous level of uncertainty while the federal review and determination is made.

The second recommendation is to target existing programs funded with TANF and MOE dollars with up to a 10-percent cut in 2014 and 2015. Where practical, establish performance based contracts/payments with high performance indicators of activities and outcomes, which readily contribute to helping the state meet its work-participation rates: 50 percent for All Families and 90 percent for Two-Parent Families.

Third, Arkansas should reexamine current policies on Extended Support Services (ESS) and reduce funding of certain categories of support that are least impactful on the economic well-being of families. Because of the rural nature of the state, transportation assistance is essential to facilitating the parent's participation in work and training activities. However, there may be opportunities to reduce the amount of dollars committed to this and other Extended Support Services (ESS) in a number of categories, which—by comparison to most other states—are extensive and costly to the Arkansas TANF program. That is, twelve months of post-cash case-management services, emergency payments and relocation expenses up to $2,000, vehicle down-payments up to $2,500, and if funding is not available, cut back on the twenty-four month payments for Work Pays households, to name a few.

Fourth, even though the federal government does not mandate this, the state should begin tracking the number of TANF recipients that are working a minimum of thirty hours a week or more. Although forty hours remains the standard for a full-time job, the thirty-hour number will allow administrator and taxpayers to actually track real welfare-to-work achievement. A measure that focuses more on actual employment than a myriad of services would help to restore the original focus of the 1996 TANF legislation.

Appendix A also lists an initiative (#23) to expand and redesigned employment in the state. Subsidized employment placements do increase job placements. Employers will participate in well-run, simplified systems of recruitment, placement, and reimbursement.

Arkansas should consider building a new model of collaboration to operate subsidized jobs for the TANF caseload. Employers already report salary and wages earned by TEA and Work Pays families through DWS and are required to report corporate earnings through tax revenue functions of the Department of Finance and Administration. Melding together these reporting systems for TANF-subsidized workers facilitates greater transparency and accuracy.

This model of operating TANF subsidies also facilitates program integrity in all levels of the system, including linking employer reporting by matching TANF placements with DWS salary and wage reports with information at the Department of Administration and Finance. A similar design was implemented in the State of Rhode Island through TANF ARRA funding in

2010 and 2011. Employers, while initially skeptical, did in fact create some jobs that otherwise did not exist, saw benefits to their bottom line, and were eager to participate in similar programs again. For-profit firms were more likely to retain workers after the subsidy ended and were more willing to participate in programs with only a partial subsidy. Nonprofits were more motivated by assisting participants and may be more willing to take on workers with less education and work experience to help them gain experience. Even though this represents a new form of spending for the state, it is reasonable to assume that more jobs will be created for TANF recipients that would improve the work-participation rate for TANF program and, more importantly, will lead to long-term job retention beyond the period of the subsidy.

Arkansas will face new funding challenges and vulnerabilities in 2014 and 2015, which influence the types of recommendations being offered. Recommendations are based upon a preliminary review of the Arkansas TANF Program, a review that included state- and federal-level contracts and review of a broad range of state and national data reports. A closer scrutiny is unquestionably required in order to help the state make sound decisions to continue to assist families to achieve economic independence. Arkansas has begun work to improve computer systems and had designed a number of impressive methods for streamlining essential services. Building upon the 2006 restructured administration and service-delivery system, the state is uniquely poised for even greater effectiveness if it embarks upon a global redesign.

Child-Care Program

According to the 2013 Arkansas Child Care Development Fund State Plan (CCDF), the Department of Human Services is the designated lead agency to administer the CCDF program. The lead agency estimates that the FY 2013 Federal CCDF allocation will be $49,551,087. This includes discretionary, mandatory, and matching funds. The total amount of state CCDF maintenance-of-effort funds is approximately $1,886,541; the state matching funds are expected to be $4,038,094. Federal regulation states that no more than 5 percent of the aggregated CCDF funds, including the required matching funds, can be expended on administration costs once all funds have been liquidated. State maintenance-of-effort funds are not subject to this limitation.

A review of the FFY 2011 Data provided by HHS Administration for Children and Families, reported by Arkansas Child-Care Program through its 801 report showed:

- On average, 5,600 families per month were served.
- On average, 9,000 children per month were served,
- 100 percent of those served were paid through certificate program
- 88 percent received center-based child care
- 12 percent were cared for in regulated family-home settings
- 99 percent of children were in licensed/regulated settings
- 1 percent were in sites that were legally operating without regulation
- Arkansas has 348 home-based providers and 926 center-based providers

The age breakdown of children served showed the following:

- 9 percent—Newborn - < 1 year
- 15 percent—1 year to < 2 years
- 17 percent—2 years to < 3 years
- 16 percent—3 years to < 4 years
- 14 percent—4 years to < 5 years
- 10 percent—5 years to < 6 years
- 19 percent—6 years to < 13 years

Reasons for needing care:

- 65 percent due to employment
- 17 percent due to training/education
- 4 percent due to both employment and training/education
- 14 percent due to protective services

Compared to the previous year, the average number of families served per month was lower in 2011 (5,600 families and 9,000 children) than reported in 2010 (8,600 families and 14,100 children). Also, there were fewer child-care providers reported in 2011 (1,274) than reported in 2010 (1,471 total providers). The state reflects that 87 percent of children are placed in licensed center-based care. Nationally, 80 percent rely on center-based care.

The state has opted to "exclude" child-support income in determining eligibility for recipients. If counted, such income would determine that some eligible families might be required to make a copayment when they are not required to make a copayment now. Furthermore, some otherwise eligible families might even fail the income test. In effect, over-income applicants would be denied child-care assistance and thus reduce number of families accepted into the child-care program. However, changing the policy to include child-support income when considering eligibility in the child-care program would very likely improve overall program integrity. This requirement builds in better eligibility controls and would give greater recognition that both parents are responsible for supporting their children. Other states have adopted this policy with a fair degree of improvement in program integrity resulting from such a change.

DHS is in the process of revising its copayment schedule for child-care services after North Carolina's program. This new model will require copayments from everyone with incomes above the federal poverty level, but copayments will be based on a percentage of family income.

There is significant opportunity to improve program integrity with the child-care program. DHS relies on an electronic-billing system for attendance, consistent with how other states administer the program but also known for being error prone. DHS is considering moving to a paperless system. There is no mention, however, of exactly what the new system will entail. Indiana utilizes technology whereby parents and guardians must swipe a card whenever

a child is dropped off or picked up, which is connected to the payment system. The Indiana system provides a safeguard that the children are actually receiving the service, which reduces the potential for fraud and abuse. Indeed, Indiana's entire benefit-information system is so good that FNS is looking at it as a potential model for the food-stamps system.

A system similar to Indiana's will require startup costs and a well-staffed administrative office for card replacements, point-of-service (POS) failures, etc. POS devices, however, are relatively inexpensive. We recommend that Arkansas conduct a cost-benefit analysis and consider a system similar to Indiana's.

Food Stamps

In SFY 2012, Arkansas received $31,213,427 from the federal government for the administration of the administration of the Supplemental Nutritional Assistance Program, or SNAP, formerly called the food stamp program. While SNAP benefits are paid 100 percent by federal USDA, administrative costs are primarily based upon a 50/50 matching requirement. However, the total figure provided by FNS includes two other programs that are federally funded at 100 percent: the Food Stamp Employment and Training Program and the SNAP Nutrition Education Program.

Congress reauthorizes SNAP approximately every five years as part of "the farm bill." During the reauthorization process, Congress can address a number of issues, including the amount of funding SNAP will receive for the next five years. The current farm bill expired on September 30, 2012, but was extended until the end of September 2013 in the American Taxpayer Relief Act, which Congress passed on January 1, 2013. On January 22, 2013, Congress again took up debate on the farm bill and as is widely known, there has been focused debate in Congress as to the funding and provisions of the farm bill. The House farm bill failed passage on June 20, 2013, due to unresolved issues related to a significant number of proposed amendments. The recent defeat of the bill means that for now, these amendments will not become law. Last year, the farm bill was extended through September 2013, and it will again face expiration on October 1, 2013, if nothing else is done. For states, SNAP will continue unchanged until a new farm bill is passed and enacted into law.

According to DHS County Office Operational Report for the month of April 2013:

• Total number of cases receiving SNAP	223,272
• Total number of recipients	500,597
• Total amount of dollars issued in benefits for month	$60,601,508
• Total number of applications received in April	35,904
• Total number approved applications	24,044
• Total number denied applications	10,057
• Total number of cases referred for fraud review	923
• Total number of cases resulted in closure	382

- Total number of cases found with errors 529
- Total amount of dollars saved in April $511,773

A review of National SNAP data reports in FFY 2011:

- Total number of fraud Investigations completed 9,758
- Total amount of fraud dollars determined $5,958,809
- In 2011, the caseload increased +6.60%
- Administrative cost/case per month in 2011 $24.97
- State administrative cost was lower in 2011 than 2010 –5.92%
- FY 2011, average monthly SNAP benefits were approximately $285.67 per household

Arkansas has done comparatively well at responding to potential fraud, waste, and/or abuse relative to SNAP. For example, the state ranks ninth highest in the number of investigations completed. The state ranks sixth highest in total fraud dollars determined by post-certification Investigations. Also, 80.58 percent of Arkansas Fair Hearings are upheld.

Perspectives vary on the SNAP program due to its continuing growth in both participation levels and the increasing attendant costs to the federal government. Supporters argue that it is the most effective anti-poverty investment ever made in this country and that feeding low-income families children, unemployed and marginally employed adults, people with disabilities, homeless, and the elderly are entirely worthy of receiving this crucial benefit. Critics have concerns about the runaway costs and the high potential for fraud and abuse.

Assuring responsible administration of this admittedly costly program to America's taxpayers is imperative, which is why USDA and Congress have established strident measures to avoid, detect, and act aggressively to mitigate fraud, waste, and abuse in this program.

If funding cuts being proposed in Congress are passed, it is possible that the farm bill of 2013 could see reductions of $20.5 billion and a cut of at least 2 million recipients from the program. Additionally, a number of the more stringent rules from the past may find their way back into the regulations which will, in effect, contract the size of the caseload over time.

According to USDA, program integrity efforts of FNS and its state partners are yielding results trending in the right direction. Two areas showing excellent measures relate to certification errors, occurring when an eligibility worker authorizes benefits in the wrong amount, and trafficking, which occurs when SNAP benefits are traded for cash.

The magnitude of federal USDA dollars coming into the state is significant. However, the breadth of rules and regulations that govern the use of these dollars is understandably very complex, multi-layered, and, in many situations, highly error prone if states are not properly administering program services. In SNAP, states are measured annually on a number of benchmarks and may qualify for either bonuses or penalties, depending on their performance in the following areas:

- Best Payment Accuracy based on Payment Error Rate
- Most Improved Payment Accuracy, based on decreased percentage in Payment Error Rate
- Best Negative Error Rate
- Most Improved Negative Error Rate
- Best Program Access Index
- Most Improved Program Access Index
- Best Application Processing Timelines Rate

Arkansas was not among the states earning either a bonus or a penalty in its performance measures for 2011. However on June 28, 2012, FNS noted that even though Arkansas—along one other state (Missouri)—was not assessed a financial penalty only because the error rate was below 6 percent. They went on to state that these two states were considered in liability status for the 2011 year. States in liability status for two consecutive years can set in motion a penalty if this performance measure remains close to or above the 6-percent error trigger. Considering this exposure, it is recommended that the state improve on payment accuracy standards and, at the same time, monitor the timeliness of processing applications and recertifications.

Arkansas's administrative costs of SNAP leave room for improvement. According to information provided by DHS, the total administrative cost for SNAP in SFY 2012 was $65,996,054. Of the amount, $31,213,427 was state funds. According to FNS statistical tables for 2011, twenty-seven states had lower administrative costs per-case per month. Arkansas's total monthly cost to administer the program was $24.97 per household that received SNAP benefits. Nearly half that amount is paid for using state funds.

We recommend an in-depth analysis of all administrative expenditures, staffing levels, and functions to clarify that whatever expenditures assigns to state administrative dollars are essential and contribute to the mandates of SNAP-benefit issuances. This is an opportunity to bring down the average administrative cost, saving the taxpayer money.

Finally, Arkansas could petition FNS for enhanced administrative dollars in exchange for increased program-integrity efforts. This would yield significant savings for both the federal and state governments and reward the state for taking initiative to enhance its fraud initiatives.

Medicaid

Arkansas receives the majority of Medicaid funding from the federal government. State support includes general revenues, license fees, drug rebates, and the Medicaid Trust Fund. The federal share however has fallen from 77 percent in 2004 to 70 percent in FY 2012. The most recent federal estimates project that the Federal Medical Assistance Percentage (FMAP) will fall below 70 percent through FY2015.[6]

In comparison to Medicaid growth, state revenue growth is projected to increase between 2–4 percent per year according to the Department of Finance and Administration. As a result, Arkansas Medicaid spending by itself will account for almost 30 cents of each additional tax dollar and 40 percent of all funds. Continuing Medicaid spending at the current level is crowding out all other legislative priorities. Without a planned restructuring of current Medicaid costs there will be increasing pressure to implement arbitrary across the board cuts in all programs. In order to prevent these disruptive measures the Alexander Group would need to look at the overall spending patterns and program controls for all Medicaid areas.

Hospitals, long-term care for the elderly, and services for individuals with developmental disabilities account for more than 60 percent of all Arkansas Medicaid claims. Recommendations will place a high priority on these three categories of service. All three categories continue to rely on cost-based reimbursements. Only five other states use this methodology to reimburse inpatient hospital services. This report will address more effective payments that promote the efficient delivery of care.

Changes in Arkansas Medicaid policy and utilization patterns have resulted in several new cost drivers that require payment reform and/or program-integrity initiatives. These include non-emergency transportation, hospice services, and durable medical equipment. For these categories we are proposing savings initiatives that will assist DHS in lowering year-to-year per-person increases to below 4 percent.

Of the thirty-two initiatives listed in Appendices A and B, nineteen are specific to Medicaid. Additionally, nine others impact multiple programs, including Medicaid. Also, this report's recommendation for a global waiver is also specific to Medicaid, and the recommendation for comprehensive welfare reform obviously would include Medicaid.

Program Integrity, Monitoring, and Oversight

Several offices have responsibility for program integrity, monitoring, and oversight. The Office of Quality Assurance (OQA) within DHS consists of three sections: Audit, Quality

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6. "Federal Funds Information for the States," a project of the National Governors Association and the National Conference of State Legislatures.

Assurance Analysts, and Fraud Investigations, which include the Internal Affairs Unit. In addition, the following program-integrity subdivisions exist: Quality Assurance, Certification, and Licensure (DMS), Long-Term Care Medicaid Waiver Quality Assurance, Program Planning & Development (DMS), Child Welfare Quality Assurance (DCFS), special investigations (DCO), and Medicaid Eligibility Quality Control (MEQC) 1115 Waiver Pilot (DCO).

The DHS operates a Program-Integrity Unit (PIU) to comply with CMS Medicaid integrity program. The responsibilities, according to CMS, are to hire contractors to review Medicaid provider activities and audit claims, identify overpayments, and educate providers and others on Medicaid program integrity issues, and to provide effective support and assistance to states in their efforts to combat Medicaid provider fraud, waste, and abuse. Federal regulations require that a state's Medicaid agency have a method to verify whether services reimbursed by Medicaid were actually furnished to beneficiaries.

The PIU has a few restrictions that inhibit its effectiveness. There are instances of program-integrity reports not being issued. Independence and effectiveness is in question due to the reporting structure to program and provider management rather than the DMS or DHS director. Management prevented the issuance of several reports prepared by the PIU regarding home- and community-based service providers that included improper payments. Results of the PIU's provider field reviews are not extrapolated to the sample population to determine provider overpayments subject to recoupment.

The Medicaid Fairness Act inhibits the PIU recoupments until it can establish a "pattern of waste, fraud, and abuse." The act may prevent the state from recovering overpayments to providers, but it does not prevent the federal government from recovering the federal share of overpayments from the state. The state is placed at a disadvantage because it must return federal funds, although it may have no way to recover the funds from a provider. The Medicaid Fairness Act of 2005 is intended to ensure that DHS and its outside contractors treat providers fairly and follow due process. Specifically, DHS cannot use a technical deficiency as grounds for recoupment unless identifying the deficiency as an overpayment is mandated by a specific federal statute or regulation or the state is required to repay the funds to CMS. Therefore, the PIU can recoup overpayments based only on cases it has reviewed.

Recipient eligibility determinations are open to review by DCO supervisors and DHS departments. The Medicaid Eligibility Quality Control (MEQC) unit, the PERM unit, the fraud unit, as well as the PUI are utilized for the reviews. Many of these departments are federally mandated and developed to safeguard against fraud, waste, and abuse and to establish the policies that govern Medicaid. Through a CMS waiver, the MEQC unit only reviews long-term care Medicaid cases for eligibility. DMS also contracts with a fiscal agent that performs provider background searches utilizing LexisNexis and the Office of Inspector General (OIG) website to ensure that sanctions or negative actions are not associated with a provider. Additionally, through a corrective action plan, all cases with paid claims totaling more than $50,000 per year would be reviewed by the DCO Quality Assurance unit to ensure recipient eligibility.

The Medicaid services manual provides criteria for ensuring applicants meet eligibility requirements, but Medicaid associated with cash programs are referred to the cash manuals. The cash manuals are considered reference manuals rather than eligibility manuals for Medicaid creating a gap in maintaining the integrity of the program. Medicaid beneficiaries are to inform DCO of any changes immediately regarding their household composition, income, resources, or other criteria that may affect eligibility. DCO county offices often lack sufficient adequate trained staff, resulting in heavy caseloads and error in Medicaid recipient eligibility.

Enrollment criteria for each provider type are based on federal and state laws and regulations outlined in the Medicaid provider manuals. Providers are to notify the Medicaid provider enrollment unit of any change to its application or contract, including conviction of crime. The DHS participant exclusion rule provides the parameters in which a participant will be excluded from participation in DHS programs to protect public funds. Specific HCBS providers are required to maintain documentation supporting services rendered, but controls are lacking.

The DHS has established organizational units and business processes to address program integrity, monitoring, and oversight. Many of the processes have been effective; however, there are many opportunities for improvement. In the most recent session of the General Assembly, the legislature created an independent Medicaid Office of Inspector General that will significantly improve accountability and oversight. Even with that, continued improvement in program integrity, monitoring, and oversight would help meet federal and state requirements, earn the trust of the taxpayers, safeguard against fraud, waste, and abuse, and protect public funds.

7. Cost-Saving Initiatives Summary

In fulfillment of the terms of the contract and to deliver to Arkansas taxpayers the maximum return on investment (ROI), the Alexander Group has identified thirty-two initiatives that will improve administration and outcomes of welfare programs. Thirty of these initiatives, outlined in Appendix A, can be adopted fairly easily and will provide short-term savings and cost avoidance.

Savings from Short-Term Initiatives		
	Low Estimate	High Estimate
State Funds	($65,192,000)	($98,166,000)
Federal Funds	($143,948,000)	($218,554,000)
Total Funds	($209,140,000)	($316,720,000)

As the table indicates, these initiatives will increase program performance and save Arkansas between $65,192,000 and $98,166,000 in state funds. More than half of these initiatives are exclusive to Medicaid, but the others impact TANF, child care, and SNAP.

In addition to the short-term initiatives, the Alexander Group is recommending two major initiatives. The first is the Private Market Health-Care Transition initiative (#31), detailed in Appendix B. This initiative will provide greater savings of $300 million to $400 million, of which $15 million to $20 million would be in state funds. The Private Market Health-Care Transition initiative redesigns and simplifies benefit packages with the flexibility to offer basic benefit packages that align with the core needs of recipients with additional options through a cost-sharing component will meet the needs in a sustainable manner. The flexibility to enroll Medicaid recipients in free-market health-care plans enables Arkansas to promote personal responsibility and independence. This reform will need federal approval.

The second major initiative (#32) calls for the creation of a transparent health-care program/plan for state and public-school employees. It connects the payer to providers and deploys payments for appropriate level of care. This initiative will save an estimated $36,185,000 to $48,956,000, of which $31,843,000 to $43,081,000 is estimated to be state funds. The table below summarizes the savings from these two initiatives.

Savings from Two Major Initiatives		
	Low Estimate	High Estimate
State Funds	($46,843,000)	($63,081,000)
Federal Funds	($289,342,000)	($385,875,000)
Total Funds	($336,185,000)	($448,956,000)

The combined savings from all thirty-two initiatives are estimated to be between $545 million to $766 million in total funds, or $112 million to $161 million in state funds.

Savings for All Initiatives		
	Low Estimate	High Estimate
State Funds	($112,035,000)	($161,247,000)
Federal Funds	($433,290,000)	($604,429,000)
Total Funds	($545,325,000)	($765,676,000)

The table below lists each initiative along with the estimated savings for the State of Arkansas and the federal government.

Name	State Funds		Federal Funds		Total	
	Low	High	Low	High	Low	High
Contract Consolidation	($4,500,000)	($6,000,000)	($10,500,000)	($14,000,000)	($15,000,000)	($20,000,000)
Hospital Readmissions	NA	NA	NA	NA	NA	NA
High Cost Case Review	($711,000)	($1,185,000)	($1,659,000)	($2,765,000)	($2,370,000)	($3,950,000)
Optimizing third party Liability (TPL)	($1,500,000)	($2,100,000)	($3,500,000)	($4,900,000)	($5,000,000)	($7,000,000)
Self Reported Services	($600,000)	($900,000)	($1,400,000)	($2,100,000)	($2,000,000)	($3,000,000)
Hospice Cost Reduction	($300,000)	($600,000)	($700,000)	($1,400,000)	($1,000,000)	($2,000,000)
Restructure Programs for Persons with DD	($1,500,000)	($2,700,000)	($3,500,000)	($6,300,000)	($5,000,000)	($9,000,000)
Home & Community Based Services Promotion	($12,000,000)	($15,000,000)	($28,000,000)	($35,000,000)	($40,000,000)	($50,000,000)
Home & Community Based Services DAAS	($1,500,000)	($2,100,000)	($3,500,000)	($4,900,000)	($5,000,000)	($7,000,000)
Inpatient Acute Care Rate Restructuring	($1,800,000)	($3,000,000)	($4,200,000)	($7,000,000)	($6,000,000)	($10,000,000)
Emergency Department Visits	($390,000)	($540,000)	($910,000)	($1,260,000)	($1,300,000)	($1,800,000)
Pre-Payment Medicaid Claim Verification	($1,212,000)	($1,638,000)	($2,828,000)	($3,822,000)	($4,040,000)	($5,460,000)
Annual & Semi-Annual Case Reviews	($15,000,000)	($24,000,000)	($35,000,000)	($56,000,000)	($50,000,000)	($80,000,000)
OMV Access for Front End Detection Unit	($540,000)	($720,000)	($1,260,000)	($1,680,000)	($1,800,000)	($2,400,000)
Non-Citizen Beneficiaries	($255,000)	($345,000)	($595,000)	($805,000)	($850,000)	($1,150,000)
Selective Contracting - Durable Medical Equipment	($600,000)	($810,000)	($1,400,000)	($1,890,000)	($2,000,000)	($2,700,000)
Data Exchange	($4,500,000)	($7,500,000)	($10,500,000)	($17,500,000)	($15,000,000)	($25,000,000)
Edits/Audits/Alerts	($5,400,000)	($9,000,000)	($12,600,000)	($21,000,000)	($18,000,000)	($30,000,000)
Out-of-State Benefit Usage	($54,000)	($108,000)	($126,000)	($252,000)	($180,000)	($360,000)
Deceased Persons Eligibility Data Match	($375,000)	($600,000)	($875,000)	($1,400,000)	($1,250,000)	($2,000,000)
Modify Medicare Buy-In Auto-Accrete Process	($600,000)	($1,275,000)	($1,400,000)	($2,975,000)	($2,000,000)	($4,250,000)
SSI Suspensions	($255,000)	($345,000)	($595,000)	($805,000)	($850,000)	($1,150,000)
Expand/Redesign Subsidized Employment	NA	NA	NA	NA	NA	NA
Revamp TANF Budget Priorities	NA	NA	NA	NA	NA	NA
Expanded Recovery—Estate Liens	($1,500,000)	($2,100,000)	($3,500,000)	($4,900,000)	($5,000,000)	($7,000,000)
Children's Health Account Enhancements	($900,000)	($1,500,000)	($2,100,000)	($3,500,000)	($3,000,000)	($5,000,000)
Enhanced Preferred Drug List – MH Medications	($900,000)	($2,100,000)	($2,100,000)	($4,900,000)	($3,000,000)	($7,000,000)
Childcare Program Integrity	NA	NA	NA	NA	NA	NA
Behavioral Health System Payment Reform	($4,800,000)	($7,500,000)	($11,200,000)	($17,500,000)	($16,000,000)	($25,000,000)
Medicaid for Prisoners	($3,500,000)	($4,500,000)	$0	$0	($3,500,000)	($4,500,000)
TOTAL SHORT TERM INITIATIVES	**($65,192,000)**	**($98,166,000)**	**($143,948,000)**	**($218,554,000)**	**($209,140,000)**	**($316,720,000)**
Private Market Health Care Transition	($15,000,000)	($20,000,000)	($285,000,000)	($380,000,000)	($300,000,000)	($400,000,000)
Self-Insured Employee Health Plan	($31,843,000)	($43,081,000)	($4,342,000)	($5,875,000)	($36,185,000)	($48,956,000)
TOTAL MAJOR INITIATIVES	**($46,843,000)**	**($63,081,000)**	**($289,342,000)**	**($385,875,000)**	**($336,185,000)**	**($448,956,000)**
TOTAL ALL INITIATIVES	**($112,035,000)**	**($161,247,000)**	**($433,290,000)**	**($604,429,000)**	**($545,325,000)**	**($765,676,000)**

Additional Recommendations

Throughout this report, we have made recommendations in addition to the initiatives in Appendices A and B. The following is a summary of these recommendations.

1. We strongly recommend that Arkansas adopt a system of detailed metrics that will serve programmatic needs and policy-level analysis. Several of these metrics can become performance-based measurements to be used in concert with performance-based budgeting. As part of the system, DHS and DWS will provide monthly data to the General Assembly that shall include, but not be limited to, actual caseloads and expenditures by category for the following programs: Medicaid, TANF, SSI program, child care, and SNAP.
2. The Arkansas General Assembly should consider adopting legislation to require executive agencies to include all cost-saving initiatives as part of their budget proposals. This will greatly enhance the ability of the General Assembly to monitor and control costs. In addition, the General Assembly should establish a biannual (twice a year) caseload, utilization, and expenditure-estimating conference between the department and the legislature to hold agency heads accountable and ensure that supplemental requests are kept to a minimum.
3. There is room to find greater efficiencies in the SNAP Program. Further analysis is needed to determine specific ways to improve the administration of the SNAP program. Because state funds are used to fund nearly fifty percent of the administrative costs, Arkansas would benefit financially from the cost savings.
4. The child-care assistance program also presents a good opportunity for improvement. We recommend further research and cost-benefit analysis of instituting as system similar to Indiana's system.
5. Arkansas should engage a qualified professional consulting firm with specific expertise in designing and managing global waivers to develop a redesign proposal on Medicaid and other public-welfare programs. This would streamline its waivers and state-plan amendments and ensure that all programs share the same goals, objectives, and regulatory structure (to be submitted to the federal government). A global redesign and waiver will dramatically improve efficiencies and outcomes, reduce the welfare burden on the state and save significantly more money than the initiatives detailed in Appendices A and B. This comprehensive redesign proposal would include a strategy to gain approvals from the federal government.
6. Arkansas should consider engaging a qualified professional consulting firm with specific expertise in designing and managing an enterprise-wide program-integrity plan to develop such an initiative for Arkansas that would work in tandem with, and provide oversight over, the global redesign (waiver). This initiative would include all public-welfare programs and address the negative economic incentives imbedded in the welfare system.

Appendix A: BASIC INITIATIVES

Each initiative includes an informed range for the annual estimated savings that may be phased in over the next two years and is consistent with federal and state law. Proposals may include application for federal waiver where it is reasonable to expect approval. Proposals include the impacts on providers, consumers, and state agencies. The assumptions and savings methodology are supported by data from Arkansas and/or other state agencies. The final annual savings are estimated in a range, typically a variance of 15 percent that allows for both the overlap among programs and the complexity of federal and state program rules. Where applicable, the assumed FMAP rate assumed is 70 percent, rounded from the current FMAP rate of 70.17 percent. Arkansas's FMAP has been falling over the last ten years and the Federal Funds Information for the States predicts it will continue to fall for Arkansas.

1. Contract Consolidation

Estimated Range of Annual Spending/(Savings)			
State Funds	($4,500,000)	to	($6,000,000)
Federal Funds	($10,500,000)	to	($14,000,000)
Total Funds	($15,000,000)	to	($20,000,000)

Description

The Department of Human Services (DHS) and the Department of Health (DOH) will support sixty-nine contracts in 2013 valued at $181,108,771. DHS supports forty-two of the contracts for $93,248,892; DOH supports twenty-seven contracts for $87,859,879. There are contracts that provide similar services, such as beneficiary assessments, or the same services in different geographical areas. In addition, there are contracts that provide similar services already performed by other state employees or divisions.

Proposal

Consolidating similar contracts can reduce costs by ten percent. A review of each of the contracts and the contract provisions will be required. Short and long term strategies will need to be established due to varying contract cycles.

- Review each of the contracts delivering similar services.
- Review contract deliverables to ensure they are meeting the needs of the programs.
- Determine the ability to modify the contract provisions.
- Consolidate contracts that can be completed without a contract renewal.
- Establish a contract schedule for consolidations that require renewal or a new RFP.

Interagency Impact: DHS and DOH will need to cooperate in the initiative.
Provider/Community Impact: Contractors will likely resist consolidation and funding reductions.
Federal Change Impact: None.
Timetable: Process can begin January 2014.

2. Hospital Readmissions

Estimated Range of Annual Spending/(Savings)	
State Funds	NA
Federal Funds	NA
Total Funds	NA

Description

Inpatient readmissions at medical facilities are very costly to the entire medical provider network, insurance providers and government entities providing health-care benefits. The Division of Medical Services (DMS) and its contracted vendors—the Arkansas Foundation for Medical Care (AFMC), the Health Services Advisory Group (HSAG), and Hewlett Packard (HP)—were unable to provide current information nor historical data on the number on hospital readmissions and the associated costs in a timely manner. AFMC, HSAG, and HP have existing contracts totaling more than $40 million annually to perform data mining and program evaluation services. While it may be understandable that current data might be unavailable, DMS should at least be able to generate historical data.

The Patient Protection and Affordable Care Act (ACA) included a provision aimed at lowering hospital inpatient readmissions. Medicare has begun assessing penalties against hospitals with excessive rates compared to baselines data. The most recent report (March 2013) includes 45 Arkansas hospitals, many receiving the maximum penalty based on episodes such as cardiovascular disease. The United Health Foundation 2011 Americas Health Rankings places Arkansas 46th in the treatment of heart disease and 43rd in preventable hospitalizations.

These same health rankings indicate that Medicaid and other impoverished patients are more likely to end up returning within 30 days of hospital discharge. The Governor is relying on his Payment Improvement Initiative to lower hospital readmissions for these individuals by rewarding high performing physicians through a retrospective review. For these reasons it is recommended that Arkansas establish a monthly tracking and evaluation process for hospital readmissions.

Proposal

DMS needs to develop standard benchmarking metrics and review current contracts for data mining and program evaluation services to ensure that state and federal funds are expended in manner that provides data in a timely manner. This information is vital to legislators and other leaders in decision-making capacities. As a result of this, we were unable to estimate cost savings.

DMS should develop policies to require contractors and others charged with program monitoring to review inpatient hospital discharges from the same facility within a thirty-day window to determine if these admissions are related. Changes to the reimbursement policy would be implemented to prevent or discourage abuses. This would align the Medical Assistance policy with health-care industry standards, including Medicare. System changes would be required to prevent claims from being processed when readmissions occur within 30 days.

In addition, DMS needs to develop standard benchmarking metrics and review its contracts for data-mining and program evaluation services.

Interagency Impact: None

Provider/Community Impact: Reimbursement policy would change for readmissions within 30 days of an initial admission

Federal Change Impact: None

Timetable: July 2014

3. High-Cost Case Review

Estimated Range of Annual Spending/(Savings)			
State Funds	($711,000)	to	($1,185,000)
Federal Funds	($1,659,000)	to	($2,765,000)
Total Funds	($2,370,000)	to	($3,950,000)

Description

Based upon Department of Human Services data, the Medicaid program paid $79,040,035 in SFY 2011-12 on behalf of just 100 individuals for services with an average annual cost of $790,400. Twenty of the top 100 cases cost well in excess of $1 million. While DHS is able to identify top beneficiaries, there is currently no process in place to determine if services rendered are effective in the current delivery system. DMS and their contracted vendors are not currently producing benchmarks in a timely manner in order to identify areas in which quality-of-care to beneficiaries could be improved or where costs could be decreased as a resulted of decreased emergency room visitation, hospital admission, and re-admissions.

Proposal

This initiative proposes to intensively manage high cost cases through an inter-divisional DHS workgroup primarily focused on inpatient utilization. Savings will be generated through decreased emergency-room utilization, hospital admissions and re-admissions, and an increase in on-going care management. If the High-Cost Case Review team finds that an individual has utilized Medicaid services at a frequency or amount that is not medically necessary, in accordance with utilization guidelines, DHS may restrict that individual from obtaining Medicaid services from other than designated providers except emergency medical services. However, DHS will ensure the recipient has reasonable access to Medicaid services of adequate quality. An intradepartmental team will develop and implement strategies to identify "upstream" and "downstream" approaches designed to target and case-manage high cost individuals prioritizing the high and immediate return on investment (ROI). Cost savings assume trimming costs by 3 percent to 5 percent.

The Team should develop the following approach:

- Identify top 100 recipients by claims data for FY 2012 and 2013.
- Develop process and goals for High-Cost Case Review team.
- Create work plan, define outcome measures, reporting and monitoring goals, identify data and analytical needs, and maximize care management.
- Review current literature and other state programs (Washington State Model) and "Hot Spotting" by the Camden Coalition of Health Care Providers.
- Incorporate a predictive modeling program to identify current and future cases.
- Identify and integrate budget initiatives to support and provide synergy.
- Identify acute inpatient individuals who should be in a lesser restrictive setting.
- Develop gain-sharing strategy for any care-management entity.

Interagency Impact: All DHS divisions will participate with varying operational costs.

Provider/Community Impact: Decrease in hospital utilization with an increase in care coordination in a medical home. Individual and family caregivers will be actively involved in treatment decisions.

Federal Change Impact: None

Timetable: Begin process in September 1, 2013.

4. Optimizing Third Party Liability (TPL)

Estimated Range of Annual Spending/(Savings)			
State Funds	($1,500,000)	to	($2,100,000)
Federal Funds	($3,500,000)	to	($4,900,000)
Total Funds	($5,000,000)	to	($7,000,000)

Description

State Medicaid agencies operate as the payer of last resort. States identify potential third-party payment and use either a cost-avoidance strategy or pay-and-chase. For most third parties, states bill directly to obtain recoveries. Since states cannot bill Medicare directly they can either recover money immediately or wait a specified amount of time to seek recoupment. In Arkansas, when Medicare balances are then submitted for deductibles and coinsurance, payments often exceed Medicaid fee limits. Arkansas Medicaid recovered $33 million from providers in FY 2010 and $27.9 million in FY 2012.

When an adult is identified as having other private insurance coverage the member's commercial insurance or employer-sponsored insurance (ESI) becomes primary and Medicaid fee-for-service is secondary. The TPL division relies primarily on self-reporting by enrollees to provide information on private health insurance. The Division of Medical Services has identified lack of enforcement and penalties as a barrier to provider compliance (Office of Inspector General, Jan. 2013). Arkansas Medicaid cost avoidance efforts were $27 million in FY 2010 and $30.2 million in FY 2012.

Proposal

1. The Division of Medical Services (DMS) should adopt a Medicaid reimbursement schedule for Medicare coinsurance and deductibles for inpatient and outpatient hospital services that do not exceed the lesser of allowable Medicare or Medicaid payments for those respective services.
2. Legislation should be adopted to require all Medicaid providers to share data on ESI on a timely basis.

The savings estimate assumes these two provisions will increase current recovery and cost avoidance efforts by approximately ten percent.

Interagency Impact: System changes will be necessary. Legislation required.
Provider/Community Impact: Providers would need to adjust to a refined claims system.
Federal Change Impact: None.
Timetable: January 1, 2014

5. Self-Reported Services

Estimated Range of Annual Spending/(Savings)			
State Funds	($600,000)	to	($900,000)
Federal Funds	($1,400,000)	to	($2,100,000)
Total Funds	($2,000,000)	to	($3,000,000)

Description

The Department Human Services (DHS) provides a multitude of services for various populations where the service is provided in the community, such as child-care and home- and community-based services. Many of the services to which the department has fiscal responsibility are rendered through a self-reported model. For instance, many home- and community-based services (HCBS) are rendered through an attendant visit to a home following a care plan, and child-care services are based upon attendance plans established with recipients. The attendants and child-care providers self-report the visits and attendance respectively the department, and payments are issued based upon the reports in conjunction with the established plans. Payments for providers are made to a financial intermediary in advance of service delivery for which there is currently no reconciliation.

Self-reporting processes are merit-based, error prone, and subject to fraud, waste, and abuse. One of the first tasks in an audit is to identify the controls an organization has in place to ensure the integrity of operational processes. The lack of controls related to self-reported service tracking is an obvious fiscal risk. Where controls are lacking, it is difficult to estimate the associated costs because information is lacking. The methodology used to estimate the costs are derived from organizations that addressed the same issue. Los Angeles County conducted a study and concluded with an expected return on investment of $6.8 million by identifying child-care payments paid for non-existent or overstated care. The excess expenditures due to self-reported services for Arkansas are conservatively estimated at $2 to $3 million.

Proposal

- Revise policy, regulations, and contracts as appropriate to permit payment processes based upon services rendered.
- Identify the prioritization sequence for specific self-reported program changes.
- Establish baseline metrics and a monitoring process to measure outcomes.
- Begin a check-in and checkout process for self-reported services.
- Establish audits and controls to reconcile provider payments with services rendered and define long-term business processes to reduce operational impacts.

Interagency Impact: Self-reported services will be paid to staff for services rendered.
Provider/Community Impact: Providers will collect specific service encounters.
Federal Change Impact: None
Timetable: A manual process can begin January 2014, automation July 2014.

6. Hospice Cost Reduction

Estimated Range of Annual Spending/(Savings)			
State Funds	($300,000)	to	($600,000)
Federal Funds	($700,000)	to	($1,400,000)
Total Funds	($1,000,000)	to	($2,000,000)

Description

Payment for hospice services by Arkansas Medicaid has been a major growth area. Hospice care increased from $13.1 million in 2005 to $30.4 million in SFY 2012. Payments include in-home care as well as room and board in a nursing facility. Nursing-home reimbursement is paid to the hospice at 95 percent of the daily rate ($150). The hospice then remits that amount to the nursing facility. In-home hospice includes professional services for nurses and respite. Prior authorization is not required. DHS does not report nursing-home bed days for hospice understating the trend in total facility days.

Proposal

- Develop a prior authorization program for inpatient hospice services, including a clinical review for appropriateness.
- Consolidate hospice-nursing expenditures in the nursing-home line item.
- In addition, DHS should develop procedures to prevent payments to other community providers for services included in hospice election.

Savings is based on a 5-percent reduction in utilization due to prior authorization of service.

Interagency Impact: State plan amendment required.
Provider/Community Impact: Nursing home providers will likely provide resistance.
Federal Change Impact: None.
Timetable: Initiatives can be implemented beginning July 1, 2014.

7. Restructure Programs for Persons with Developmental Disabilities

Estimated Range of Annual Spending/(Savings)			
State Funds	($1,500,000)	to	($2,700,000)
Federal Funds	($3,500,000)	to	($6,300,000)
Total Funds	($5,000,000)	to	($9,000,000)

Description

Service for persons with developmental disabilities (DD) is the third largest Medicaid category after hospitals and nursing homes. More than $600 million in behavioral and medical services are spent annually for community waiver services (Alternative Community Services—ACS), smaller private and large state-run residential settings (Intermediate Care Facilities—ICF/DD) and clinic-based rehabilitative services. In FY 2012, the ACS waiver served 4,055 individuals and 1,360 were in one of thirty-six ICF/DDs (excluding children).

Arkansas bases payment to the ICF/DD facilities on allowable costs and pays fee for service for other support and medical needs. There is little coordination and oversight of total per-person funding levels. Arkansas wants to change the system so that someone is responsible for the patient's overall health. The state is currently pursuing a long-term care balancing-incentive program that will coordinate care for individuals in a health home. However, it is not clear how this initiative will either bend the cost curve for high-end residential placements or insure that persons are assessing the most appropriate and cost-effective care.

Shared living is an option available for adults who cannot live alone and require a considerable amount of help with daily-living activities, such as eating, dressing, and personal hygiene. Shared living provides an alternative to institutional care for those that meet clinical, financial, and other program criteria. Shared living is an individual-directed service designed to maximize recipient control and choice over services provided.

Proposal

This initiative will help relocate or divert approximately 10 percent of ICF/DD residents into community placements by changing current policy to use shared-living arrangements (SLAs) when 24-hour residential placement is required. SLAs (when clinically appropriate) are less than half the cost of private group homes.

How it Works: Shared living provides a home-like setting for individuals who cannot live alone but who want to continue to live in the community as long as possible. There are two components to understanding shared living: (1) the shared living agency and (2) the caregiver and the host home. The shared living agency helps individuals who need care to find an appropriate host home/caregiver. This may be someone the individual already knows, like a relative, neighbor, or friend. The agency will "match" the individual with a caregiver and will make sure the caregiver receives all needed training and support.

The Caregiver/Host Home: Typically, the caregiver lives in his or her own home and agrees to have recipient live with him or her. In some situations, the caregiver may agree to move into the recipient's home. The caregiver receives a stipend based on level of care.

With the use of a community/home based system of care, the division will be able to significantly reduce the number of high-end residential placements and provide a more-appropriate and less-restrictive level of care.

Facility	Current Population	Annual Residential Cost	Estimated Per Person SLA Savings	Residents Using SLAs	Annual Savings Target
Human Development Centers[1]	1,010	$126,500	$63,250	100	$6,325,000
Private ICF/ID	350	$72,800	$36,400	35	$1,274,000
Total				135	$7,599,000

Note: (1) Human Development Centers are state run facilities. Initial savings would be less as fixed costs adjust to the census decrease.

Interagency Impact: DHS policy, regulatory, and contractual changes.
Provider/Community Impact: Developmental-disability advocates will support if part of assessment process.
Federal Change Impact: State plan amendment.
Timetable: Phase in over 30 months beginning January 2014.

8. Home & Community Based Services Promotion

Estimated Range of Annual Spending/(Savings)			
State Funds	($12,000,000)	to	($15,000,000)
Federal Funds	($28,000,000)	to	($35,000,000)
Total Funds	($40,000,000)	to	($50,000,000)

Description

Arkansas expended an average of $29,713 per person for long-term care services and an average of $9,798 per person for home- and community-based services (HCBS) in FY 2009–10. There were 24,015 recipients at a total cost of $713,554,610 receiving long-term care services and 26,369 recipients at a total cost of $258,355,951 in HCBS during the same period. Long-term service requirements are different for each individual, and the ability to relocate individuals into community setting is dependent upon meeting the individual specific needs.

Relocating a greater proportion of the nursing facility population into HCBS will reduce costs substantially. Moving 10 percent (approximately 2,400) of the long-term care population into HCBS will result in cost reductions of $47,796,375.

Proposal

- Define the conditions in which residents of nursing facilities have permitted relocation into community settings.
- Assess the barriers of the current nursing facility population that prevent relocation to community settings.
- Utilize individual assessments to create tailored development plans to move individuals into community settings.
- Establish baseline metrics and a monitoring process to measure outcomes.
- Validate vehicle ownership prior to authorizing vehicle purchase allowances.
- Rebalancing funding (see below)

Arkansas, like many other states, has seen continuing decreases in nursing-facility bed days (4 percent reduction since FY 2005). Because institutional spending is segregated from community spending in the budget, any such savings from the reduction in nursing-home days were available for the General Fund and were not directly realized or utilized by elderly or disabled persons in less restrictive settings. The state should combine nursing-home expenditures and community spending into one line item in the Medicaid budget. As such, any nursing facility savings from rebalanced appropriations can be utilized and will be available for HCBS for elders or adults with disabilities. Legislation should be developed requiring a consensus estimate of nursing home bed days and per diems. Tracking this progress along with the proper assessment of applicants will ensure that savings achieved in per-person community costs will not be offset by nursing-home placements

In addition, the provider capacity will be enhanced in order to provide additional choices by:

- Developing shared-living alternatives.
- Developing a medication-management program.
- Increasing HCBS rates that are tied to performance by using the rebalanced appropriations.

Interagency Impact: Agencies that provide long-term care community supports and services will experience an increase in service needs.

Provider/Community Impact: Agencies that provide long-term care institutional supports and services will experience a decrease in service needs.

Federal Change Impact: Waiver amendment or state plan amendment.

Timetable: Process can begin January 2014

9. Home & Community Based Services DAAS

Estimated Range of Annual Spending/(Savings)			
State Funds	($1,500,000)	to	($2,100,000)
Federal Funds	($3,500,000)	to	($4,900,000)
Total Funds	($5,000,000)	to	($7,000,000)

Description

The DHS Division of Aging and Adult Services (DAAS) administers Home & Community Based Services (HCBS) Medicaid Programs including nursing-home alternatives provided by the Alternatives for Adults with Physical Disabilities (AAPD), self-directed IndependentChoices Program, and the Living Choices Assisted Living Program. IN FY 2012, these programs cost Arkansas Medicaid more than $80 million. In Arkansas, registered nurses and physicians are authorized to determine the level of care required and assess the amount of services a recipient needs.

While most Arkansas Medicaid claims are processed through the fiscal agent responsible for the MMIS, a third-party financial intermediary receives payment for services prior to delivery for these HCBS providers. In FY 2012 this vendor was paid $1.8 million. It is not clear what additional value this service is providing. In addition, based on a 2012 Division of Legislative Audit (DLA) review, it appears prospective payments and refunds are not routinely reconciled.

Savings are based on both a 5-percent reduction in AAPD, IndependentChoices, and the Living Choices Assisted Living waiver programs.

Proposal

- Eliminate the financial agent contract and allow the MMIS vendor to make direct payment to HCBS providers. If necessary, these payments should be directed through the Area Agency on Aging or other organizations that act as the case managers and responsible for coordination and monitoring care. These agencies are often reached when emergency situations arise for delivery of care.
- Require DHS/provider-organization case managers responsible for monitoring the activity and coordinate care to maintain more detailed documentation, including status of critical medical changes, to allow for better payment reconciliation and delivery of care.
- Eliminate the assessment by DHS nurses for eligibility and require a physician review and approval for the AAPD, IndependentChoices, and the Living Choices Assisted Living Program. Current waiver requirements maintain that a beneficiary must meet nursing-home level of care and currently allow for DHS registered nurses to make the determination. All other state programs that require nursing-home level-of-care determination are required to be reviewed and approved by physician. This proposed step would align Medicaid programs and medical necessity, resulting in better outcomes and placement for recipients.

Interagency Impact: Coordinate with DHS Contracts Office.
Provider/Community Impact: Stakeholders should be informed of changes in review process.
Federal Change Impact: None
Timetable: Software changes can be accomplished by October 1, 2013.

10. Inpatient Acute-Care Rate Restructuring

Estimated Range of Annual Spending/(Savings)			
State Funds	($1,800,000)	to	($3,000,000)
Federal Funds	($4,200,000)	to	($7,000,000)
Total Funds	($6,000,000)	to	($10,000,000)

Description

In SFY 2012, Arkansas Medicaid reimbursement to community hospitals exceeded $ 1 billion, including all payments. Of this amount, more than $420 million represents fee-for-service claims to hospitals for inpatient services on a cost basis with year-end reconciliation. Only a handful of states continue to use this approach. Most other states have moved to either a modified Diagnosis-Related Group (DRG) or a flat per diem. The DRG creates a rate-of-payment based on the "average" cost to deliver care (bundled services) to a patient with a particular disease. Community hospitals report losses each year and assert that, overall, Medicaid funding is too low. However, payment for at least certain categories of services is too high when judged against the Medicare benchmark. Moving to a case-base reimbursement will support a balanced and more rational utilization of services.

Proposal

Moving to a modified DRG system can be accomplished under three distinct scenarios.

1. Budget Neutral—existing resources are re-arrayed across all hospitals with some winners and some losers.
2. Hold Harmless—same as budget neutral except that losers are insulated form loss.
3. Net Savings—DHS would benchmark its payment to a set relationship against Medicare without regard to hospital-level impact.

If option 3 is adopted, we would recommend a 2-percent benchmark discount used as the basis for instituting DRG specific relative weights. Pregnancy, delivery, and neonatal-intensive care (NICUs) comprise one of several clinical areas prioritized for possible inclusion in the 2012 Arkansas Payment Improvement Initiative. These new prospective payments would have the added benefit of rewarding high-performing NICU providers and more fully utilize criteria such as birth weight and clinical severity.

Interagency Impact: System changes will be needed. Contract to develop DRG.
Provider/Community Impact: Consumer and legal advocates will likely oppose.
Federal Change Impact: CMS Approval, State Plan Approval, and Public Notice.
Timetable: July 2014 –July 2016.

11. Emergency Department Visits

Estimated Range of Annual Spending/(Savings)			
State Funds	($390,000)	to	($540,000)
Federal Funds	($910,000)	to	($1,260,000)
Total Funds	($1,300,000)	to	($1,800,000)

Description

In SFY 2009, Medicaid beneficiaries incurred approximately 70,000 emergency department (ED) visits that did not result in a hospital admission. Over the past several years, a greater proportion of ED visits are coded for higher rate reimbursement. Within FFS from 2002–2009, lower-end codes declined from 32 percent to 11 percent, and higher-end codes increased from 6 percent to 22 percent. There has been a 33 percent increase in the level of utilization per-1,000 enrollees. It is unlikely the increase is associated with a proportional increase of true emergencies; "up-coding" to higher levels of severity is one cause.

The Rand Corporation reported in 2013 that many primary-care practices do not offer after-hours or weekend care, and many surveyed patients perceive that they cannot easily contact their health-care provider. The findings suggest that assessments conducted in the ED can be needlessly costly relative to the resulting benefits. Incentivizing care received in alternative ambulatory settings and dis-incentivizing higher-cost care in emergency-room settings can reduce the costs and maintain adequate care. Arkansas expended $21,687,367 for emergency room services in 2010.

Proposal

Estimates assume 8.4 percent of ED claims would be adjusted and 5 percent shifted to alternative care.

- Review ED visits for two fiscal years to determine the incidents of "up-coding."
- Review coding of ED visits by the facility/physician to identify discrepancies.
- Define the conditions in which individuals seek medical treatment in the ED.
- Assess the barriers to obtaining medical treatment in alternative settings.
- Create incentives to seek alternative care and disincentives to seek ED care.
- Establish baseline metrics and a monitoring process to measure outcomes.
- Revise policy, regulations, and contracts as appropriate to permit enforcement of incentive-based changes to service settings

Interagency Impact: Policy, regulatory, and contractual changes
Provider/Community Impact: Emergency rooms will experience a decrease in service needs with an increase in alternative service settings.
Federal Change Impact: None
Timetable: Process can begin in January 2014.

12. Pre-Payment Medicaid Claim Verification

Estimated Range of Annual Spending/(Savings)			
State Funds	($1,212,000)	to	($1,638,000)
Federal Funds	($2,828,000)	to	($3,822,000)
Total Funds	($4,040,000)	to	($5,460,000)

Description

The cost of health-care fraud poses a significant threat to private health-care payers and undermines the integrity of publicly funded health. The National Health Care Anti-Fraud Association (NHCAA) estimates conservatively that 3 percent of all health-care spending—or $68 billion per year—is lost to health-care fraud. For many years, health-care payers have used a retrospective "pay and chase" methodology in their attempts to combat fraud and improper payments. This is inconsistent with real health-care fraud patterns, which are dynamic and quickly adapt to new recovery and fraud, waste, and abuse efforts. DHS needs will benefit by switching from a retrospective to a prospective method for preventing fraud before paying bad claims. Prevention of improper payments up front will reduce program expenditures and minimize operational costs for post-payment recovery activities. A pre-payment and post-payment validation system will reduce waste, fraud, and abuse.

Proposal

This initiative will move from the pay-and-chase model to more upfront prevention of incorrect payments model. The initiative will provide a program where DHS will be able to edit more claims BEFORE paying them. The program will automatically review Medicaid claims for potential waste, fraud, and abuse before payment of the claims (fee-for-service), as well as conduct a post review on claims after they have been paid. The review will be based on waste, fraud, and abuse trends as well as data analytics (up-coding, overbilling for services provided, excessive billing for unnecessary or over-utilized services, and inconsistency due to definitions of medical necessity), current law/regulations, and best practices. Bad claims will be flagged and either the claim will be investigated or sent back to the provider as a bad claim by the vendor or staff. The savings numbers assume 33 percent of all fraud, waste, and abuse will be captured upfront.

Interagency Impact: System changes will be needed
Provider/Community Impact: Some providers may oppose as this could delay payments if "bad claims" are submitted but are actually valid
Federal Change Impact: None
Timetable: January 2014

13. Annual & Semi-Annual Case Reviews

Estimated Range of Annual Spending/(Savings)			
State Funds	($15,000,000)	to	($24,000,000)
Federal Funds	($35,000,000)	to	($56,000,000)
Total Funds	($50,000,000)	to	($80,000,000)

Description

Shrinking budgets, increasing caseloads, and staffing constraints create operational burdens. Maintaining annual, semi-annual, or monthly case reviews often become the victim of the increasing workload. Maintaining cases that are overdue for reviews creates unnecessary excess consumption of state-budget resources.

Typically, 20 to 25 percent of overdue reviews result in the discontinuance of a case resulting in an annual excess expenditure of $50 to $80 million. Cost-savings estimates are based upon the current Medicaid population and the current average annual cost of $5,914. Establishing a logical progressive methodology to completing the reviews can substantially reduce costs and free scarce budget resources to invest in permanent innovative solutions that significantly improve operational efficiencies.

Proposal

- Extract a baseline from the ANSWER system comprised of a complete list of all annual and semi-annual cases reviews that a have a due date that is not current.
- Analyze the data and identify opportunities to make mass updates to groups of cases.
- Filter the list by category, due date, and operational location responsible for processing.
- Prioritize the lists based upon greatest impact and distribute for processing.
- Execute the extracts used to establish the baseline on a regular frequency to measure outcomes and continue to re-prioritize the remaining workload.
- Define long-term business processes to reduce operational impacts.

Interagency Impact: None
Provider/Community Impact: Case review process should be communicated to advocacy groups.
Federal Change Impact: None
Timetable: Process can begin July 2013.

14. OMV Access for Front End Detection Unit

Estimated Range of Annual Spending/(Savings)			
State Funds	($540,000)	to	($720,000)
Federal Funds	($1,260,000)	to	($1,680,000)
Total Funds	($1,800,000)	to	($2,400,000)

Description
DHS eligibility technicians validate information reported on the applications in determining eligibility for welfare programs. Information maintained by the Office of Motor Vehicles (OMV) is not available to eligibility staff in an electronic format, and DHS staff must visit the OMV in person for verifications. The inefficient process increases costs due to non-value added labor, overtime, and travel costs.

Arkansas issues 77 percent of the supportive services associated with the Transitional Employment Assistance and the Work Pays programs related to transportation amounting to $1,522,497. States have identified individuals requesting vehicle purchase allowances currently own a vehicle in 25 percent of requests.

Proposal
The department would request query access from the OMV to verify demographic information and vehicle ownership on clients applying for DHS programs. DHS eligibility technicians would immediately validate information reported on the applications without visiting the OMV. Savings would come from improved eligibility monitoring of programs to reduce fraud and abuse as well as staff hours, overtime, and mileage savings. Our analysis shows a cost savings of $1,848,372 from a 10-percent increase in cases found to be ineligible with overtime and mileage savings. Our analysis shows a cost savings of $2.1 million by decreasing eligibility by 10 percent and vehicle purchase allowance by 5 percent considering that 5 percent would be re-allocated to other supportive services.

- Institute a control process when vehicle purchase requests are received.
- Obtain access to OMV to verify demographic information and vehicle ownership.
- Develop a business process with the motor-vehicle department to verify vehicle ownership and demographic information.
- Establish baseline metrics and a monitoring process to measure outcomes.
- Validate vehicle ownership and demographics prior to authorizing eligibility.
- Define long-term verification processes.

Interagency Impact: Need cooperation from OMV to establish access agreements.
Provider/Community Impact: Delays could occur in finalizing vehicle purchases.
Federal Change Impact: None
Timetable: Process can begin July 2013.

15. Non-Citizen Beneficiaries

Estimated Range of Annual Spending/(Savings)			
State Funds	($255,000)	to	($345,000)
Federal Funds	($595,000)	to	($805,000)
Total Funds	($850,000)	to	($1,150,000)

Description
Following the conversion efforts associated with full implementation of PRWORA, many states still possess individuals under the five-year ban on federal matching funds who are receiving assistance in violation of federal law. There may be also be individuals on the state's cash assistance program, who had passed the five-year ban on federal matching funds that remain on the Medicaid program in a category associated with state-only funding.

States incur substantial costs providing services to non-citizens. Qualified aliens who entered the United States before August 22, 1996, are generally eligible for Medicaid under specific eligibility criteria. Except for emergency treatment, lawfully admitted qualified aliens who entered the United States on or after August 22, 1996, are barred for five years from participation in Medicaid. Certain groups of qualified aliens are exempt from this five-year ban. Conditions exist where adequate documentation is not provided to establish eligibility for Medicaid, which leads to substantial costs to the state.

Proposal
The current initiative proposes a software change to identify and document qualification for coverage with federal funds. The initiative will also include a retroactive adjustment to July 1, 2012, to recover the over-expenditure of state funds on their behalf. A narrowly defined software change to the eligibility system is required.

- Extract a baseline comprised of a complete list of noncitizens.
- Analyze the data and update individual demographic information.
- Update the system to capture date of entry into the United States and the five-year bar date.
- Add system edits and audits to prevent inappropriate benefit receipt.
- Identify potentially ineligible individuals and filter the list by operational location responsible for processing then distribute for investigation and update.
- Execute the extracts used to establish the baseline on a regular frequency to measure outcomes and continue to re-prioritize the remaining workload.
- Define long-term business processes to reduce operational impacts.

Interagency Impact: None
Provider/Community Impact: An increase in uncompensated care may result.
Federal Change Impact: None
Timetable: Software changes can be accomplished by February 1, 2014.

16. Selective Contracting–Durable Medical Equipment

Estimated Range of Annual Spending/(Savings)			
State Funds	($600,000)	to	($810,000)
Federal Funds	($1,400,000)	to	($1,890,000)
Total Funds	($2,000,000)	to	($2,700,000)

Description

The Medicaid program currently reimburses the majority of Durable Medical Equipment (DME)[7] vendors based on 95 percent of the allowable Medicare reimbursement fee schedule or with a Medicaid rate for items not covered by Medicare. For other items, such as wheelchairs, Medicaid reimburses at rates higher than Medicare. In FY 2012, Arkansas spent $46,888,327 on DME.

Proposal

The DHS could realize a minimum 5-percent savings in SFY 2014 by selective contracting through a limited number of providers to supply DME products and who will bid a price that is lower than the Medicare/Medicaid fee-for-service (FFS). Outpatient facilities, physicians, and other medical providers will use contracted providers or supply DME items at the contracted amount. Selective contracting with a competitive bid process for medically necessary DME services will eliminate unnecessary options. The recipient can be provided the opportunity to purchase the non-medically necessary options. The targeted savings are derived through reductions in the estimated amount that would have been expended under current FFS reimbursement. Savings can also be realized by reviewing items where Medicaid pays more than Medicare and then limiting those payments to the Medicare rates.

In addition, policies and procedures should be developed to require vendors to provide and make available for review delivery confirmation of DME products.

Interagency Impact: None
Provider/Community Impact: DME providers may provide resistance.
Federal Change Impact: CMS approval required.
Timetable: A request for proposals may take six months. Alternatively, lower the reimbursement percentage and eliminate manual retail pricing (percent above cost only).

7. Also known as Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS).

17. Data Exchanges

Estimated Range of Annual Spending/(Savings)			
State Funds	($4,500,000)	to	($7,500,000)
Federal Funds	($10,500,000)	to	($17,500,000)
Total Funds	($15,000,000)	to	($25,000,000)

Description

Data exchanges provide information from third-party sources, information used to ensure program eligibility. Data-exchange sources provide millions of hits each year through the ANSWER system, and the same budget and operational constraints exist as identified previously. Untimely case actions based upon the exchange information unduly strains state-budget resources.

Typically, 15 to 20 percent of overdue data exchange results in the discontinuance of a case resulting in excess annual expenditures of $15 million to $25 million. Cost-savings estimates are based upon the current Medicaid-recipient population and the current average costs. Establishing a logical-progressive methodology to take timely case actions based upon exchange data can substantially reduce costs. Business processes to improve the timeliness of case actions can be funded through the cost savings derived from addressing the operational processes with the initial volume of overdue data exchanges.

Proposal

- Extract a baseline comprised of a complete list of all welfare recipients with data exchanges information that has not been disposed.
- Analyze the data and identify opportunities to make mass updates to groups of cases.
- Filter the list by category, due date, and operational location responsible for processing.
- Prioritize the lists based upon greatest impact and distribute for processing.
- Execute the extracts used to establish the baseline on a regular frequency to measure outcomes and continue to re-prioritize the remaining workload.
- Define long-term business processes to reduce operational impacts.

Interagency Impact: None
Provider/Community Impact: The data-exchange review process should be communicated to advocacy groups.
Federal Change Impact: None
Timetable: Process can begin July 2013.

18. Edits/Audits/Alerts

Estimated Range of Annual Spending/(Savings)			
State Funds	($5,400,000)	to	($9,000,000)
Federal Funds	($12,600,000)	to	($21,000,000)
Total Funds	($18,000,000)	to	($30,000,000)

Description

System edits, audits, or alerts provide information from within the system that indicates there may be a change to program eligibility of recipients. Millions of edits, audits, or alerts are generated each year and are difficult to manage operationally. Edits, audits, or alerts are established in relation to specific eligibility criteria and failure to take action on a case creates excess expenditures when cases should be modified or closed. In addition, independent auditing groups have found several errors related to documentation of program changes, including insufficient approval to remove edit, audit, and alerts. Fifteen to 20 percent of overdue edits, audits or alerts are typically discontinued which results in gratuitous annual expenditures of $18 million to $30 million. Cost-savings estimates are based upon the current Medicaid-recipient population and the current average costs. Establishing a logical-progressive alert handling methodology supporting desired business processes can substantially reduce costs and can be funded through the cost savings derived from addressing the initial volume of overdue alerts.

Proposal

- Extract a baseline comprised of a complete list of all cases that edits, audits, or alerts have been generated regarding eligibility factors and the eligibility review is not complete.
- Analyze the data and identify opportunities to make mass updates to groups of cases.
- Filter the list by category, due date, and operational location responsible for processing.
- Prioritize the lists based upon greatest impact and distribute for processing.
- Execute the extracts used to establish the baseline on a regular frequency to measure outcomes and continue to re-prioritize the remaining workload.
- Define long-term business processes to reduce operational impacts.
- Independent group can provide third-party review. The new Arkansas Office of Inspector General could fulfill this function.

Interagency Impact: None
Provider/Community Impact: The alert review process should be communicated to advocacy groups.
Federal Change Impact: None
Timetable: Process can begin July 2013.

19. Out-of-State Benefit Usage

Estimated Range of Annual Spending/(Savings)			
State Funds	($54,000)	to	($108,000)
Federal Funds	($126,000)	to	($252,000)
Total Funds	($180,000)	to	($360,000)

Description

Out-of-State benefit usage is common with contiguous states. Individuals may be utilizing benefits appropriately, however sustained use in contiguous states potentially represents welfare recipients of one state also receiving benefits in another and should be terminated. Additionally, out-of-state usage may indicate border jumping where there is a concerted effort to receive benefits in multiple states. This condition is most prevalent where multiple state borders converge. For instance, an applicant in Texarkana, Arkansas, indicates they are homeless and the county office issues expedited SNAP. The same person subsequently goes to Texarkana, Texas, with the same claim and again receives another expedited SNAP. He may then travel thirty minutes south to Louisiana to receive benefits, and then 30 minutes northwest to Oklahoma to obtain SNAP benefits again. PARIS matches are time delayed; it takes months to identify the situation, allowing substantial ineligible expenditures to occur.

Proposal

Identifying fraudulent cases of out-of-state benefit usage improves the integrity of any program using the EBT system to dispense benefits. Utilizing the EBT contractor (FIS), generate reports of out-of-state usage will identify the population using benefits outside the Arkansas borders. A list of cases with EBT transactions made exclusively out of state for three-month periods will provide the likelihood of out-of-state residency. Additionally, establishing data-matching agreements with contiguous states can identify these individuals well in advance of a PARIS match. Savings will be disbursed across multiple programs. Therefore, savings estimates are based upon standard match rates.

- Extract a complete list of all individuals who have utilized the FIS-EBT system from an out-of-state location.
- Analyze the data and identify patterns of usage to define ongoing extract parameters and continue the extracts on a monthly basis.
- Filter the list by the operational location responsible for maintaining to case and distribute for processing.
- Request verification of residency from the beneficiary and discontinue those that fail to respond for failing to respond. Ensure compliance with FNS residency closure rules for that respond.
- Contact contiguous states to establish data-matching agreements.
- Define long-term business processes to reduce operational impacts.

Interagency Impact: None
Provider/Community Impact: None.
Federal Change Impact: None
Timetable: Manual process can begin July 2013; contiguous states January 2015.

20. Deceased Person Eligibility Data Match

Estimated Range of Annual Spending/(Savings)			
State Funds	($375,000)	to	($600,000)
Federal Funds	($875,000)	to	($1,400,000)
Total Funds	($1,250,000)	to	($2,000,000)

Description

Deceased-person data matched from Social Security and state sources provide information about current recipients that are deceased. The Social Security information has historically been more than 98-percent accurate. Thousands of individuals are reported as deceased by third-party sources each year. Providers can provide recoupment of some costs, but there are limitations.

Failure to act upon the information results in excess annual expenditures of approximately $2 million. Cost-savings estimates are based upon the current Medicaid-recipient population and current average costs. Establishing an efficient methodology to discontinue deceased individuals will markedly reduce the costs to maintain the population. Enhanced business processes to remove deceased individuals can be funded through the cost savings obtained by removing the initial deceased population.

Proposal

- Extract a baseline comprised of a complete list of all individuals that have been reported as deceased and appropriate action has not been taken.
- Review the integrity of the source data and the disposition logic to determine gaps in the ANSWER system automated actions.
- Analyze the data and identify opportunities to make mass updates to groups of cases.
- Filter the list by category, due date, and operational location responsible for processing.
- Prioritize the lists based upon greatest impact and distribute for processing.
- Execute the extracts used to establish the baseline on a regular frequency to measure outcomes and continue to re-prioritize the remaining workload.
- Define long-term business processes to reduce operational impacts.
- Procedures need to be developed to review claims relative to deceased persons to determine whether payments were made to providers and for the recoupment of those funds.

Interagency Impact: None
Provider/Community Impact: None
Federal Change Impact: None
Timetable: Process can begin July 2013.

21. Modify Medicare Buy-In Auto-Accrete Process

Estimated Range of Annual Spending/(Savings)			
State Funds	($600,000)	to	($1,275,000)
Federal Funds	($1,400,000)	to	($2,975,000)
Total Funds	($2,000,000)	to	($4,250,000)

Description

The Medicare program provides supplemental physician coverage through Part B. The premiums for eligible low-income households are paid by their respective state through a buy-in program. The state buy-in of Medicare Part B premiums is done through an auto-accrete process. States that have chosen to participate in the process receive files from the Social Security Administration (SSA) with the beneficiaries who have become eligible for Medicare Part B.

Through the auto-accrete process, Arkansas enrolled 4700 participants into Medicare Part B during FFY 2011. The Centers for Medicare and Medicaid Services (CMS) has provided that "any Medicare Fee-For-Service claim with a date of service on or after January 1, 2010, must be received by your Medicare contractor no later than one calendar year (12 months)—or Medicare will deny the claim." The change in the maximum period for the submission of Medicare claims created a situation in which premiums are being paid and coverage is being provided for periods in which claims for prior services cannot be recouped. The files received with the auto-accrete process many times contain dates of coverage that are in excess of the period in which prior service claims can be recouped.

The excess cost associated with the Arkansas Medicare Part A premium payments amounts to approximately $2 million annually and $4.25 million per year in Part B premiums. A change in the Medicare Part A process can be accomplished locally, however the auto-accrete process should be modified by SSA, but could be done locally.

Proposal

- Identify cases in which the date of eligibility defined in the Social Security eligible file is greater than 12 months from the current date.
- Restrict the retroactive Medicare Part A premium payment to 12 months.
- Obtain SSA approval to modify the Medicare Part B premium calculation.
- Restrict the retroactive Medicare Part B premium payment to 12 months.
- Modify the auto-accrete process to restrict retroactive premium payments to one year.

Interagency Impact: None
Provider/Community Impact: None
Federal Change Impact: SSA will need to agree to update the auto-accrete process.
Timetable: Process can begin January 2014 for Part A and July 2014 for Part B.

22. SSI Suspensions

Estimated Range of Annual Spending/(Savings)			
State Funds	($255,000)	to	($345,000)
Federal Funds	($595,000)	to	($805,000)
Total Funds	($850,000)	to	($1,150,000)

Description
Social Security provides information regarding Supplemental Security Income (SSI) cases through the SDX exchange that is used to manage SSI recipients. Untimely, case actions based upon the SDX exchange generally results in the discontinuance of 30 to 35 percent of the SSI individual changes reported. The excess expenditures total $1 million to $1.25 million.

Cost-savings estimates are based upon the current SSI-recipient population and the current Medicare average costs. Enhancing the processing methodology to take timely case actions based upon the SSI-exchange data will reduce costs and long-term business process changes can be funded through initial cost savings.

Proposal

- Identify cases and establish a baseline of individuals that the Social Security SDX file has identified as having a change in SSI eligibility but appropriate action has not been taken.
- Analyze the data and identify opportunities to make mass updates to groups of cases.
- Filter the list by due date and operational location responsible for processing.
- Prioritize the lists based upon greatest impact and distribute for processing.
- Execute the extracts used to establish the baseline on a regular frequency to measure outcomes and continue to re-prioritize the remaining workload.
- Define long-term business processes to reduce operational impacts and refine the auto-SSI process.

Interagency Impact: Eligibility for alternative health-care programs will need to be explored.
Provider/Community Impact: None
Federal Change Impact: SSA may need to approve changes to the auto-SSI process.
Timetable: Process can begin July 2013.

23. Expand/Redesign Subsidized Employment

Estimated Range of Annual Spending/(Savings)	
State Funds	NA
Federal Funds	NA
Total Funds	NA

Description

Subsidized employment placements increase job placements for low-income workers. Employers will participate in well-run, simplified systems of recruitment, placement, and reimbursement. Rhode Island implemented this design using TANF-ARRA funding in 2010 and 2011. Employers, while initially skeptical, did in fact create a number of jobs that otherwise did not exist, saw benefits to their bottom line, and were eager to participate in similar programs again. For-profit firms were more likely to retain workers after the subsidy ended and were more willing to participate in programs with only a partial subsidy. Nonprofits were more motivated by assisting participants and may be more willing to take on workers with less education and work experience to help them gain experience.

Proposal

Build a new model of collaboration to operate subsidize jobs for TANF families. Employers already report salary and wages earned by TEA and Work Pays families through DWS and are required to report corporate earnings through the Department of Taxation. Melding together these reporting systems for TANF subsidized workers promotes greater accuracy for these individuals in a way that otherwise. This model of operating TANF subsidies facilitates program integrity in all levels of the system, including employer reporting by matching TANF placements with DWS Salary and Wage Reports and Department of Tax Revenues related to these specific employees. Even though this represents a new form of spending for the state, it is reasonable to assume that more jobs will be created for TANF families that would logically improve the work participation rate for the TANF program. As importantly, such opportunities for working families will lead to long term job retention beyond the period of the subsidy.

Interagency Impact: DWS and DHS will need to revise current ESS policies as appropriate. New collaborations will need to be established with Department of Taxation, if subsidized employment model is developed. Higher Education may be affected if Career Pathways funding is reduced.

Provider/Community Impact: State has strong community advocacy network. Anything that modifies the existing provisions downward may meet with opposition.

Federal Change Impact: TANF State Plan is up for renewal effective October 1, 2013, but it can be submitted as late as December 31, 2013. The plan must be made available for public review at least 60 days prior to submission. Alternatively, TANF State Plans may be amended even after submission. Because HHS does not approve plans but rather "accepts" them as complete, there is no risk of disapproval.

Timetable: Begin process immediately. See "Federal Change Impact" above.

24. Revamp TANF Budget Priorities

Estimated Range of Annual Spending/(Savings)	
State Funds	NA
Federal Funds	NA
Total Funds	NA

Description

According to federal HHS Office of Family Assistance (OFA), TANF penalties remain a threat in the future for all states. Arkansas is not slated for a penalty at this time but could incur a penalty as funding levels and programs contract in the future. Failing TANF Work Participation Rates (WPR) is only one of at least fourteen different penalties that can be imposed if a state fails to comply with various requirements. If imposed, TANF penalties are costly and can result in a compounding loss of funds to a state. While there may be corrective measures available to a state, the process is onerous and creates a tremendous level of uncertainty while the federal review and determination is made.

Proposal

Revamp TANF budget priorities to improve outcomes, especially with WPR. Focus on existing programs funded with TANF and maintenance-of-effort dollars that are expected to receive cuts up to 10 percent in 2014 and 2015. Where practical, establish performance-based contracts/payments with high performance indicators of activities and outcomes, which will readily contribute to helping the state meet its work-participation rate of 50 percent for all families and 90 percent for two-parent families.

Reexamine current policies on Extended Support Services (ESS) and reduce funding of certain categories of support that are least impactful on the economic well-being of families. Because of the rural nature of the state, transportation assistance is essential to facilitating parental participation in work and training activities. However, there may be opportunities to reduce the amount of dollars committed to transportation and other ESS in categories that—by comparison to most other states—are extensive and costly to the Arkansas TANF program. That is, savings opportunities may emerge by reviewing policies related to twelve months of post-cash case-management services, emergency payments and relocation expenses up to $2,000, and vehicle down-payments up to $2,500. If funding is no longer available, the state may choose to cut back on the 24-month payments for Work Pays households by six or twelve months.

Interagency Impact: DHS and DWS will need to revise their respective regulation if any of these proposals are accepted. The rule-making process requires states to give public notice.

Provider/Community Impact: Some providers may receive additional funding, and the community at large benefits by increased employment. As with any initiative perceived to reduce support for families, the state needs to be ready to respond to criticism.

Federal Change Impact: Federal TANF allows states broad flexibility in operating programs as long as state follows appropriate policy and rule-making process. Otherwise, such program changes will not require federal approvals

Timetable: Begin immediately.

25. Expanded Recovery—Estate Liens

Estimated Range of Annual Spending/(Savings)			
State Funds	($1,500,000)	to	($2,100,000)
Federal Funds	($3,500,000)	to	($4,900,000)
Total Funds	($5,000,000)	to	($7,000,000)

Description

The Medicaid Estate Recovery Program is a federal-state program designed to recover Medicaid-funded medical costs from the estates of Medicaid recipients, including nursing-home residents whose costs of care were covered by Medicaid. A claim may not be filed where the recipient is under the age of 55 or where there is a surviving spouse, minor child, or blind/disabled child. The current law allows Arkansas Medicaid to file a claim in probate court, file liens on property of the probate estate, and recover up to the amount of Medicaid expenditures paid on behalf of a recipient. In addition, certain transfer of assets prior to or after becoming eligible, are prohibited.

Although Medicaid reimbursement to private nursing homes exceeds $600 million, current estate-recovery efforts are minimal. Arkansas has ranked in the bottom third of states, collecting just 0.4 percent (states range from 0 percent to 10.4 percent) of nursing home spending or an annual amount of approximately $2.5 million. This is due partly to the minimum scope of policy options for estate recovery and a minimal commitment to provide adequate administrative resources, such as integrated information systems and/or trained staff.

Proposal

- Impose a lien on property of a Medicaid recipient during his or her lifetime (TEFRA—Tax Equity Fiscal Responsibility Act) and act upon that lien upon transfer or death. This practice has been adopted by thirty-six states.
- Expand the definition of estates to permit the recovery of expenditures paid on behalf of the recipients to include jointly owned property prior to the death of the recipient.
- Add one attorney and one paralegal position to work and identify existing probate cases and the additional inventory of estates created by this initiative. The savings (net of additional administrative costs) assume these proposals will increase collections to approximately 1 percent of nursing home spending or $6 million. If the TEFRA lien option were not adopted, the estimate would be reduced to $5 million.

Interagency Impact: Requires legislative change and policy change.
Provider/Community Impact: Arkansas Bar Association, elder-law attorneys and state legislators who are practicing attorneys will oppose this legislation.
Federal Change Impact: State plan amendment.
Timetable: January 2014—January 2015.

26. Children's Health Account Enhancements

Estimated Range of Annual Spending/(Savings)			
State Funds	($900,000)	to	($1,500,000)
Federal Funds	($2,100,000)	to	($3,500,000)
Total Funds	($3,000,000)	to	($5,000,000)

Description

Over the five-year period, FY2007—FY2011, Arkansas spent an average $200 million for outpatient mental-health services and private-duty nurses for children under age 18. The actual savings will be based on total claims for expenditures specified in legislation for children with third-party insurance, subject to a $7,500 cap.

Proposal

Arkansas should consider creating a children's health account to provide a mechanism for the Department of Human Services to recoup from insurance companies, a portion of the expense of Medicaid-funded services for children with special health-care needs who have some form of comprehensive third-party liability (TPL). An assessment should be made on every insurance company doing business in Arkansas that provides coverage(s) to be determined annually based on several factors:

1. The total premiums written during the previous calendar year by each company assessed.
2. The total Medicaid spending for the services listed in new legislation (certain home-based and outpatient mental-health services and private-duty nursing).
3. The total annual Medicaid spending for the services listed above will not exceed $7,500 per child, per year.

Based on experience in other states, it is anticipated that a minimum of 2 percent of total claims would qualify (includes discount for inpatient psychiatric services and children with no TPL).

Interagency Impact: System changes may be necessary. Statute is required.
Provider/Community Impact: Insurers would oppose this, as it would result in substantial increases in the amount that they would be required to pay in Assessments.
Federal Change Impact: None
Timetable: January 2014.

27. Enhanced Preferred Drug List – MH Medications

Estimated Range of Annual Spending/(Savings)			
State Funds	($900,000)	to	($2,100,000)
Federal Funds	($2,100,000)	to	($4,900,000)
Total Funds	($3,000,000)	to	($7,000,000)

Description

For SFY 2009, Arkansas mental-health medication expenditures were $102 million. Included in that category were $60 million for antipsychotic drugs that represented approximately 18 percent of total pharmacy spending. Currently, these drug classes are exempt from the Medicaid preferred-drug list (PDL). States have designed PDLs as a method of encouraging specific drugs for classes of treatment. As of 2012, forty-eight states use some type of PDL; forty-three of those include antipsychotics and forty-five include anti-depressants. Both preferred and non-preferred mental-health drugs would be available to Medicaid recipients. However, non-preferred drugs would require additional authorizations.

Proposal

Include antipsychotics in the Arkansas Medicaid Pharmacy Program PDL. Savings assume that DHS obtains 5 percent of drug costs in supplemental rebates for these new therapeutic classes and experiences a 3-percent reduction in drug ingredient costs due to a shift in market share to less expensive medications.

Interagency Impact: University of Arkansas
Provider/Community Impact: Coordination with the pharmaceutical industry is needed. Mental-health community will likely oppose.
Federal Change Impact: None
Timetable: July 1, 2014.

28. Child-Care Program Integrity

Estimated Range of Annual Spending/(Savings)	
State Funds	NA
Federal Funds	NA
Total Funds	NA

Description
Within the CCDF Plan, the state has opted to exclude child-support payments from monthly income eligibility determination. Excluding child-support payments received by single-parent applicants and recipients results in a greater number of families being found income eligible, even though their true income is higher than the program's limit. This policy should be reconsidered, as it may no longer be practical at a time when the state is facing funding challenges. Additionally, if the state includes actual dollar amounts being received by such applicants, there is a secondary benefit. In practice, acknowledging child support as countable income gives focus and validity to child support as an obligation of both parents. Such a policy may also have a chilling effect on the applicants presenting themselves as single-parent household when, in fact, they may be living with the other biological parent.

It is not possible to estimate how many families fall into this condition. However, counting child-support income may help contain the overall number of cases that are eligible, and it also honors the principle that both parents are responsible for the children. Other states have adopted this policy with a fair degree of improvement in program integrity resulting from such a change.

Proposal
Change the policy to include child support when considering family eligibility in the child-care program. This change would very likely improve overall program integrity.

Interagency Impact: None
Provider/Community Impact: None
Federal Change Impact: None
Timetable: January 1, 2014

29. Behavioral Health System Payment Reform

Estimated Range of Annual Spending/(Savings)			
State Funds	($4,800,000)	to	($7,500,000)
Federal Funds	($11,200,000)	to	($17,500,000)
Total Funds	($16,000,000)	to	($25,000,000)

Description

The mental-health component of Medicaid cost the state $460.3 million in FY 2012, approximately 10 percent of the total. Two-thirds of the spending is for rehabilitative outpatient services for persons with mental illness. These services are fragmented across numerous providers that bill the state for many procedures with little coordination. Many of these clients are also served through the Division of Developmental Disabilities (DDS) separately administered by Developmental Day Clinic Treatment Services (DDTCS) and the Child Health Management Service (CHMS). All these programs are high-growth areas that often duplicate therapies and program goals. Services for DDTCS totaled $153.2 million. In FY 2012, DDS reported that 4 percent of preschool Medicaid recipients used both CHMS administered by the Division of Medical Services and DDTCS. In FY 2012, Medicaid paid clinics more than $200 million based on the number of encounters for specialized therapy services for children less than 5 years of age.

Arkansas Medicaid is transitioning to an episode-based delivery system for all acute medical care but has not yet outlined a comprehensive overhaul of all mental-health payments. Under this proposal, a single accountable agency will be responsible for the full continuum of behavioral-health services. Savings are based on a 5-percent reduction in both mental-health outpatient services and DDTCS currently billing Medicaid more than $400 million.

Proposal

- Make one accountable organization responsible for the enhanced coordination of behavioral health care to ensure that services provided are medically necessary and in appropriate settings.
- Roll out will begin with preschool children.
- Fee-for-service payments will be converted to bundled or per-person amounts for all habilitation services. During the transition phase, all DDTCS, CHMS, and mental-health outpatient services will be limited to six hours per day.
- The accountable agency will utilize one universal developmental assessment for habilitation services.
- With the implementation of this program, there is also an expectation of cost savings across inpatient hospital settings, residential care, and emergency rooms (not included in savings estimate).
- Recommend a further discussion regarding occupational therapy, physical therapy, and speech therapy, which will not be included in initial conversion.

Interagency Impact: Requires ongoing discussion between DDS and Division of Behavioral Health Services.
Provider/Community Impact: Stakeholders should be involved in development of assessment.
Federal Change Impact: State Plan
Timetable: Software changes can be accomplished by January 1, 2014.

30. Medicaid for Prisoners

Estimated Range of Annual Spending/(Savings)			
State Funds	($3,500,000)	to	($4,500,000)
Federal Funds	$0	to	$0
Total Funds	($3,500,000)	to	($4,500,000)

Description
The U.S. Department of Health and Human Services informed regional Medicaid directors in 1997 that otherwise Medicaid-eligible inmates, who leave state or local facilities for at least 24 hours to receive treatment in local hospitals or nursing facilities, could participate in the federal Medicaid match. States, such as Arkansas, that are expanding Medicaid under the Affordable Care Act will see correctional inmates immediately become newly eligible for Medicaid. The newly eligible Medicaid population would be funded through a 100-percent federal match through 2017 and incrementally moving to a 90-percent match over the next three years.

North Carolina started the reimbursement process in 2011. In May, the state reported that federal payments came to $10 million in the first year, a 4-percent chunk out of the state's $259 million prison health-care bill. Of the 1,449 inmates admitted to North Carolina hospitals in the fiscal year that ends July 1, almost half were eligible for Medicaid.

Proposal
The Pew Center on the States reported in June 2010 the Arkansas prison population was 15,171 and cost $349 million, representing 8 percent of the general fund with and expected growth of 43 percent over the next ten years. Comparatively, the North Carolina prison population was 40,379 in 2010, based upon the Department of Corrections statistics. The Arkansas cost savings are estimated at $3.5 to $4.5 million based upon North Carolina's experience.

- Identify inmates receiving health-care services outside of the correctional facility.
- Establish an application process to receive Medicaid applications for the prisoners
- Complete the eligibility determination for a retroactive or non-continuous eligibility period to cover the health-care services.
- Create reports capturing prisoner authorizations and expenditures.
- Create a process to pass the state Medicaid costs onto the Department of Corrections.
- Define long-term business process improvements to mitigate operational impacts.

Interagency Impact: Agreements will need to be established with state and local correctional organizations.
Provider/Community Impact: Providers would receive Medicaid reimbursement rates.
Federal Change Impact: None
Timetable: The process can begin January 2014.

Appendix B: ADDITIONAL RECOMMENDATIONS

31. Private Market Health-Care Transition

Estimated Range of Annual Spending/(Savings)			
State Funds	($15,000,000)	to	($20,000,000)
Federal Funds	($285,000,000)	to	($380,000,000)
Total Funds	($300,000,000)	to	($400,000,000)

Description
Health-insurance costs are escalating at a state and federal level that are not sustainable. The Affordable Care Act is expected to increase the adult Arkansas Medicaid-population by 219,233 people. The additional long-term cost of the current and new Medicaid population baseline is not sustainable. The existing Medicaid system, which is intended to serve as a safety net for our most vulnerable citizens, places an extreme and increasing burden on Arkansas taxpayers. Without changing the Medicaid paradigm of health-care coverage, health-care costs would follow the same trajectory, just at a lower level and merely delay the inevitable, unsustainable result. Delivering a benefit without addressing the barriers will not succeed.

Proposal
It is important to redesign and simplify benefit packages with the flexibility to offer basic benefit packages that align with the core needs of consumers with additional options through a cost-sharing component will meet the needs in a sustainable manner. The flexibility to enroll consumers in free market health-care plans enables Arkansas to serve more individuals and promote personal responsibility and independence.

The Society of Actuaries' March 2013 report, "The Cost of the Future Newly Insured under the Affordable Care Act (ACA)," estimates a monthly cost for health-care coverage of $419 in 2014. The current monthly cost for the private-sector Arkansas Blue Cross Blue Shield PPO III with a $1000 deductible is $152.42. The total cost reduction is estimated at $433,857,007 in the first year with the state portion at $21,629,850. The proposal includes funding a $1,000 deductible through a health-savings account (HSA). A benefit-cost analysis provides a net present value of $339 million in state funds over a ten-year period considering $100 million to build the system. The plan provides a benefit-cost ratio of 2.33, an ROI of 133 percent, and a payback period of 5.68 years.

- Streamline basic benefit packages for Medicaid recipients.
- Develop a self-screening process to identify high- or low-health risk individuals.
- Establish private market health-care packages that include preventative and primary care, hospitalizations, and optional coverage to address other needs.
- Create a health-savings account to cover co-pays and deductibles.

Interagency Impact: Policy, regulatory, and contractual changes will be necessary.
Provider/Community Impact: Providers and insurers would compete for business.
Federal Change Impact: CMS approval would be required.
Timetable: The process can begin July 2014.

32. State Employee Health Plan

Estimated Range of Annual Spending/(Savings)			
State Funds	($31,843,000)	to	($43,081,000)
Federal Funds	($4,342,000)	to	($5,875,000)
Total Funds	($36,185,000)	to	($48,956,000)

Description

The State Employee Health Benefit Plan is traditional health plan offered through Blue Cross/Blue Shield of Arkansas. To increase its purchasing power, the state plan is also available to public-school teachers and employees. The plan offers three benefit levels including Gold, Silver and Bronze, with the greatest employee contribution coming out of the "gold" level. Total expenditures for the plan were approximately $573 million for calendar year 2012. Claim expenses by employees have been growing an average rate of about 6 percent per year.

The cost of managed care is increasing because of the relationship between the hospitals and Preferred Provider Organizations (PPO). Current billing practices between hospitals and managed-care organizations (MCO) are complex, hidden, and unaccountable. Within the system, a multi-billion dollar industry has been created called where hospitals employ outside contractors to help maximize billing. The ultimate cost is passed on the organizations that pay for the claims: individuals, companies, municipalities, and state agencies.

AG's modeling shows significant savings in moving to a plan whereby organizations purchase health-care services, based on transparency, clearly understood terms and conditions, and where a clear relationship between cost and price exists.

There is a false perception that hospitals are either not making a profit or breaking even. The data available from the Centers for Medicare and Medicaid Services (CMS) presents a different picture. The table below provides a sample of average net profits for Arkansas hospitals.

Average Net Profit from 2007 to 2011		
Facility	**Location**	**Net Profit**
Arkansas Children's Hospital	Little Rock, AR	$33,564,420
Babtist Medical Center	Little Rock, AR	$16,430,648
St. Bernards Medical Center	Jonesboro, AR	$9,259,227
Piney Ridge Center	Fayetteville, AR	$2,566,309
White County Medical Center North	Searcy, AR	$12,962,605
Washington Regional Hospital	Fayetteville, AR	$10,230,256

Proposal

- Create a transparent, health-care plan for state and public school employees.
- Connect payer to provider(s) using an administrator that will pay for appropriate level of care without inconveniencing employees or asking for increased premiums. The state can modify its plan language to purchase certain medical products at a reasonable margin (bottom-up) rather than a percentage-off billed charges (top-down).

- Move away from billed charges that are based on closed negotiations to a transparent and rational model.
- Analyze pharmacy data. Nationally, pharmacy claims in 2011 were $263 billion and represent a significant cost to all plan sponsors. A pharmacy cost and utilization audit will provide information both to the prescriber and the patient at the point of decision. A competitive process could then be created, which drives cost down for patients and plan sponsors.

AG's payer-to-provider modeling in other localities has found average savings of $240,000 for every 100 employees. To err on the conservative side, we reduced the potential savings by 50 percent and applied the standard 15-percent variance. We based the estimate on 95,880 employees and retirees currently on the state-employee health-care plan. State contributions account for 37 percent of all contribution to the system. Because federal funds partially pay for personnel expenses, the total savings in state contributions will split between federal and state funds. We were unable to obtain data on the exact split but estimate that 12 percent of the savings will be for the federal government with the remaining 88 percent for the State of Arkansas.

In addition to the state benefiting, school districts and employees will also benefit because their health-care contribution will be reduced at estimated $18,409,000 for the districts and $43,721,000 for employees.

Interagency Impact: None
Provider/Community Impact: Hospitals will likely provide resistance.
Federal Change Impact: None
Timetable: Initiatives can be implemented beginning July 1, 2015.

LIST OF ACRYONYMS

AAPD	Alternatives for Adults with Physical Disabilities
ACA	Patient Protection and Affordable Care Act, commonly known as ObamaCare
ACF	U.S. Administration on Children and Families
ACS	American Community Survey of the U.S. Census Bureau
ACS	Alternative Community Services
AFDC	Aid to Families with Dependent Children program, the precursor to TANF
AFMC	Arkansas Foundation for Medical Care
ANSWER	Arkansas Networked System for Welfare Eligibility and Reporting
AoA	U.S. Administration on Aging
ARRA	American Recovery and Reinvestment Act of 2009
BLS	U.S. Bureau of Labor Statistics
CCDF	Child Care Development Fund
CHMS	Child Health Management Services
CMS	U.S. Center on Medicare and Medicaid Services
DAAS	Division of Aging and Adult Services, Arkansas Department of Human Services
DBHS	Division of Behavioral Health Services, Arkansas Department of Human Services
DCCECE	Division of Child Care & Early Childhood Education, Arkansas Department of Human Services
DCFS	Division of Children & Family Services, Arkansas Department of Human Services
DCO	Division of County Operations, Arkansas Department of Human Services
DCSNS	Division of Community Service and Nonprofit Support, Arkansas Department of Human Services
DD	Developmental Disabilities, also ID.
DDDS	Division Developmental Disabilities Services, Arkansas Department of Human Services
DDTCS	Developmental Day Clinic Treatment Services
DFA	Arkansas Department of Finance and Administration
DHS	Arkansas Department of Human Services
DHS	U.S. Department of Homeland Security
DLA	Arkansas Division of Legislative Audit
DME	Durable Medical Equipment
DMS	Division of Medical Services, Arkansas Department of Human Services
DOA	U.S Department of Agriculture
DOE	U.S. Department of Energy
DOH	Arkansas Department of Health

DOJ	U.S. Department of Justice
DOT	U.S. Department of Transportation
DRG	Diagnosis-Related Group
EBT	Electronic Benefit Transfer
ED	Emergency Department or Emergency Room at a hospital
ESI	Employer-Sponsored Insurance
ESS	Extended Support Services
FBI	U.S. Federal Bureau of Investigation
FFS	Fee for Service
FMAP	Federal Medical Assistance Percentage
FNS	U.S. Food and Nutrition Services
HCBS	Home and Community Based Services
HEAP	Home Energy Assistance Program
HHS	U.S. Department of Health and Human Services
HP	Hewlett Packard
HRSA	U.S. Health Resources and Services Administration
HSAG	Health Services Advisory Group
HUD	U.S. Department of Housing and Urban Development
ICE	U.S. Immigration and Customs Enforcement
ICF	Intermediate Care Facilities
JOBS	The federal Job Opportunities and Basic Skills training program
MCO	Managed Care Organizations
MEQC	Medicaid Eligibility Quality Control
MMIS	Medicaid Management Information Systems
MOE	Maintenance of Effort
NASBO	National Association of State Budget Officers
NHCAA	National Health Care Anti-Fraud Association
OFA	U.S. Office of Family Assistance
OIG	U.S. Office of Inspector General
OMV	Office of Motor Vehicles, Arkansas Department of Finance and Administration
OQA	The Office of Quality Assurance, Arkansas Department of Human Services
OSEP	U.S. Office of Special Education Programs
PARIS	Public Assistance Reporting Information System
PDL	Preferred Drug List
PERM	Payment Error Rate Measurement
PIU	Program Integrity Unit. Arkansas Department of Human Services
POS	Point of Service
PPO	Preferred Provider Organizations

PRWORA	Personal Responsibility and Work Opportunity Reconciliation Act of 1996.
RN	Registered Nurse
SAMHSA	U.S. Substance Abuse and Mental Health Services Administration
SNAP	Supplemental Nutrition Assistance Program, more commonly known as Food Stamps.
SSA	U.S. Social Security Administration
SSI	The federal Supplemental Security Income program
TANF	Temporary Assistance for Needy Families, federal program created by the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996.
TEA	Transitional Employment Assistance Program
TEFRA	Tax Equity Fiscal Responsibility Act
TPL	Third Party Liability
VA	U.S. Veteran Affairs Administration
WAP	Weatherization Assistance Program
WIC	Women Infant Children program
WPR	Work Participation Rate



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