



Bureau of Legislative Research

Arkansas Health Care Reform Task Force – Recommendations

October 7, 2015

Proprietary and Confidential

THE STEPHEN GROUP

Agenda

October 7 TSG Final Report Presentation August 19

- Summary of KEY HCIP Findings
- Summary of KEY Traditional Medicaid findings
- Financial Impact of HCIP
- TSG Recommendations
 - HCIP Reform
 - Governor's 7 Points
 - Traditional Medicaid
- Savings Estimates

Summary of Key HCIP Findings

- 250,000 newly eligible (225,000 PO and 25,000 Medically Frail FFS)
- Participants 80% of enrollment in marketplace
- PO participants are younger and thus healthier and lower cost – (65% under 45 years/compared to 45% marketplace)
- PO participants have access to substantially more providers than FFS
- PO participants utilize ED services at rate higher than regular Medicaid
- Health disparities – lack of understanding of system and appropriate utilization – Community concern
- No incentives for utilizing more appropriate care

Summary of Key HCIP Findings (cont.)

- \$9B in additional federal match payments over 5 years
- Uncompensated care dropped dramatically first year PO - PO played significant role
- **Note:** Subsidies above 138 % FPL also contributed to drop in uncompensated as well as reduction in unemployment rate – 6.7% 12/13 to 5.7% 12/14
- Rate of uninsured among non-elderly adults dropped from 27.5% to 15.6% 2013 to 2014
- Many in PO are not working – 40% have annual income of zero
- 54% have incomes below 50% FPL
- 15% between 100 and 138 FPL

Summary of Key HCIP Findings (cont.)

- Average claims to premiums is 79% - Below MLR in ACA
- Physician Licenses have not been impacted
- State Health Independence accounts not showing great success – 45,839 card issues and only 10,806 activated – only 2,500 individuals contributing monthly
- If Arkansas rejects Medicaid and returns to program status prior to 2014 the net impact to the state budget is approximately \$438 MM (2017 – 2021)(taking into account cost shifting, uncompensated care, premium tax and macro economic)
- State may have options available to limit some of the impact by not renewing optional programs or funding uncompensated care

Summary of Key Traditional Medicaid Findings

- Arkansas Medicaid program on an unsustainable path – using conservative growth estimate of 5% for next five years
- Between now and 2021, general revenue portion to fund traditional Medicaid would grow by \$500 Million
- Currently, the state has not implemented best practices that other states have used in Medicaid for large part of costs
 - Hospital payment initiatives based on value and risk
 - Care Management strategies based on full risk and particularly involving management of aged, blind and disabled and other high cost populations – ex: complex care for children
- $\frac{3}{4}$ of Traditional Medicaid expenditures on ABD population, including waiver and institutions and medical together

Summary of Key Traditional Medicaid Findings (cont.)

- Currently no independent assessment for ABD populations
- Overly high utilization of nursing home and other institutional settings
- State has not been successful in rebalancing long term care
- AARP survey showed 91% of Arkansas residents support home and community based options
- 2,900 now on DD Wait list and 91% of these individuals receiving some Medicaid services, totaling \$32 million
- Behavioral health system is highly siloed and fragmented
- Patient Centered Medical Home showing promise in improving outcomes, avoiding costs and leading to better access
- Episodes of Care is a national best practice example, ROI unclear

Health Care Payment Improvement Initiatives

Patient Centered Medical Homes

- Selected observations
 - \$19.7M in direct Medicaid cost avoidance compared to the benchmark trend
 - \$12.1M used to fund foundational investments in primary care
 - \$7.6M to be shared between the state and providers
 - 78% of quality measures improved or maintained for Medicaid enrolled practices, including reduced hospital stays and emergency room visits
 - 100% of enrolled beneficiaries with 24-7 phone access to their primary care practice doctors

Health Care Payment Improvement Initiatives

Episodes of Care

Financial Estimates for First Fourteen Episodes
(\$millions unless otherwise noted)

Development Costs	43.0
Annual Maintenance Costs	7.3
Annual Savings	8.7-20.3
ROI	3-32 years

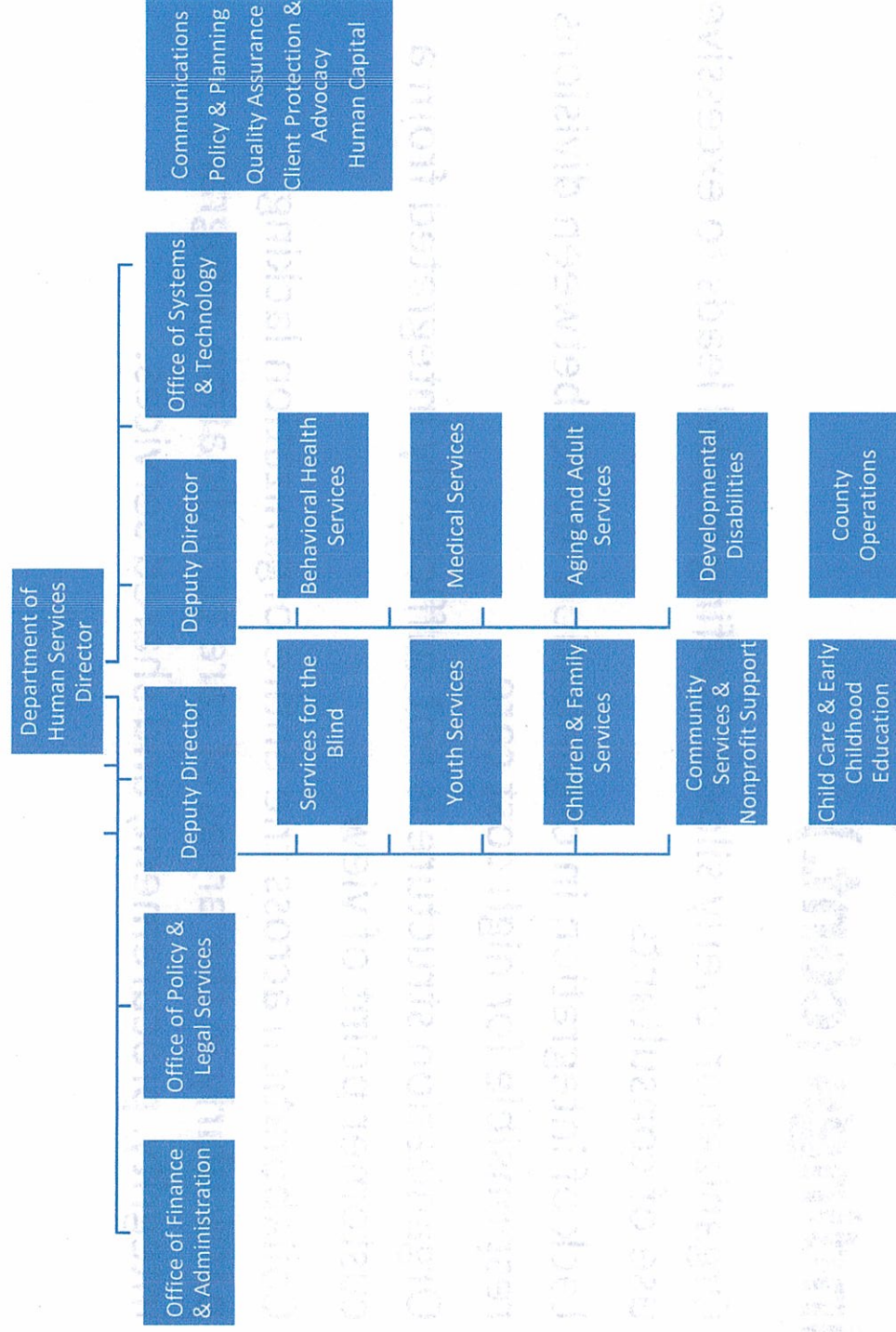
Summary of Key Traditional Medicaid Findings (cont.)

- State has atypically high cost for traditional Medicaid
- Four of Arkansas neighbors – Tenn, Miss, Texas and nearby Kansas – all utilize full risk managed care for aspects of population
- All four have significantly bent the cost curve and improved access and quality of care. (Source: in TSG findings and conversations TSG has had with state leaders in each state)
 - Texas saved over \$3.8 B since FY 10 according to independent Milliman study and estimated to save \$7.1 B through FY 2018
 - Kansas reduced spending from 7.5% to 5 % in first two years and used over \$60 Million in GF savings for DD Wait list amounting to over \$140 Million in total funds
 - Tennessee significantly reduced reliance on nursing home by changing levels of care

Summary of Key Traditional Medicaid Findings (cont.)

- Organization overly siloed. Staffing model leads to excessive use of consultants
- Lack of integration in organization model between divisions responsible for high cost care
- Organization structure is not sufficiently integrated from a customer point of view
- Collaboration across the entire organization lacking, particularly in the areas of care coordination, program integrity, procurement, and shared services.

Summary of Key Traditional Medicaid Findings (cont.)



Summary of Key Traditional Medicaid Findings (cont.)

- No centralized vendor management function or unit
- Very few people with availability to write RFPs – impacts planning and preparation as contract term expires and also impacts timing
- Procurement timeline lengthy
- Lack of sufficient number of resources with the skills to negotiate successfully with large, sophisticated vendors
- Strong examples of specific deliverables and consequences for missing deliverables

Summary of Key Traditional Medicaid Findings (cont.)

- Legislative review process can be lengthy and broadly construed by DHS to include any change in policy
- Legislative review requirements apply to any type of agency statement, policy, etc. that meets the definition of a "rule"
- Definition of a "rule" is very broad
- Additional committees involved in review
 - Any rule change related to episodes of care must be submitted to the Healthcare Quality and Payment Policy Advisory Committee for review at least 45 days before the Department begins the promulgation process
 - Any rule related to Medicaid (specifically, any rule "impacting state Medicaid costs") must be submitted to and reviewed by the House and Senate Committees on Public Health, Welfare, and Labor

Summary of Key Traditional Medicaid Findings (cont.)

- Traditional and PO conversion to MAGI – new ACA standard – coupled with effort to convert to new eligibility software system has led to significant obstacles and set backs
- Lack of real time system check of applicants identity, address, and assets – could lead to possibility of ineligible individuals receiving Medicaid services
- Lexis Nexis Scrub flagged significant number of different addresses that were not in eligibility system that were newer than ones supplied (Traditional Medicaid 155,300) (PO 108,877)
- Out of state addresses that were flagged as better were also significant in numbers (Traditional Medicaid 22,781) (PO 20,110)

Summary of Key Traditional Medicaid Findings (cont.)

Pharmacy

- Private option plans control underlying drug cost and dispensing fees better than DHS
- DHS has opportunities to better manage opioid use
- DHS pharmacy claim limits are not a best practice
- DHS PDL is unnecessarily narrow
- DHS contracts too many call centers

Summary of Key Traditional Medicaid Findings (cont.)

- DHS does not have a robust provider audit capacity
- OMIG statutory mission goes beyond fraud and committed to identifying abuse - vision is shared by current OMIG
- OMIG does not have the most innovative tools with sophisticated data analytics and pattern technology that other states have to combat fraud, waste and abuse
- OMIG working to correct this and in process of issuing RFP with assistance of DHS for data analytic tool capability
- State has a low per capita collection rate compared to other states

Summary of Key Traditional Medicaid Findings (cont.)

- Arkansas Health Status compared to other states low
- DHS places little emphasis on health care value
- Large claims processing and not outcome based model across board
- Not benchmarking outcomes for quality and improved health
- Improving Health Care Status is not only a Medicaid issue – a number of other departments, providers and community involved

Findings Re-cap

- Arkansas has a typically high cost of Medicaid compared to other states
- Tremendous opportunity to Improve:
 - Health outcomes
 - Care coordination
 - Vendor management
 - Public Integrity
 - Organization
 - Efficiency for Taxpayers

Traditional Medicaid

Growth Scenarios

Medicaid Projected All Funds (\$millions)									
Growth Scenario	2015	2016	2017	2018	2019	2020	2021		
5%	5,159	5,417	5,688	5,973	6,271	6,585	6,914		
6%	5,159	5,469	5,797	6,145	6,514	6,904	7,319		
7%	5,159	5,521	5,907	6,321	6,763	7,236	7,743		
8%	5,159	5,572	6,018	6,499	7,019	7,581	8,187		
9%	5,159	5,624	6,130	6,682	7,283	7,938	8,653		
10%	5,159	5,675	6,243	6,867	7,554	8,309	9,140		
Medicaid Projected General Revenue (\$millions)									
Growth Scenario	2015	2016	2017	2018	2019	2020	2021		
5%	1,548	1,625	1,706	1,792	1,881	1,975	2,074		
6%	1,548	1,641	1,739	1,843	1,954	2,071	2,196		
7%	1,548	1,656	1,772	1,896	2,029	2,171	2,323		
8%	1,548	1,672	1,805	1,950	2,106	2,274	2,456		
9%	1,548	1,687	1,839	2,004	2,185	2,382	2,596		
10%	1,548	1,703	1,873	2,060	2,266	2,493	2,742		

Need to Shift the Discussion to Healthcare Value, not Merely Cost

- Improving healthcare *value* involves reducing cost and *concurrently improving* health outcomes
- Outcomes include not only quality metrics, but also improvements in the health of the beneficiary
- Need outcomes data: neither traditional Medicaid nor the PO has created a regular, on-going method of collecting, evaluating, reporting and adjusting programs based on patient outcomes
- Improvement would require a greater shift toward collaboration and coordination—DHS must be positioned for this

Raise Arkansas' population health status to the
"best in the SEC"

Impact of the Private Option on State Funds

Projected Aggregate PO Impact (SFY 2017-2021)					
(\$millions)					
	2017	2018	2019	2020	2021
Federal match for PO	1,678	1,720	1,799	1,862	1,937
Impact on state funds from removing PO (without macroeconomic effect)	(89)	(39)	(21)	19	53
Impact on state funds from removing PO (without macroeconomic effect or restoration of state funded uncompensated care)	(52)	0	19	61	98
					125
					125

Impact of the Private Option

on Hospital Uncompensated Care

Impact on Hospital Uncompensated Care (\$millions)						
	2017	2018	2019	2020	2021	2017-2021
With PO	135	141	148	156	164	744
Without PO	329	345	362	380	400	1,816
Difference	194	204	214	225	236	1,072

Impact of Other ACA Changes on Arkansas Health Care Providers

Impacts of other ACA Changes on Arkansas Health Care Providers (\$millions)

	2017	2018	2019	2020	2021	2017 - 2021
Increase in other federal funds flowing into AR due to ACA (exchange subsidies)	846	939	995	1,032	1,097	4,911
Decrease in federal funds flowing into AR due to ACA (taxes and rate effects)	(1,386)	(1,730)	(2,055)	(2,279)	(2,539)	(9,989)
Net impact of other ACA changes	(539)	(791)	(1,060)	(1,246)	(1,442)	(5,078)

Economic Impact

of the Affordable Care Act

	2017	2018	2019	2020	2021	2017-2021
ACA net economic impact (\$millions)	578	606	637	669	702	3,191
Jobs impact (count)	6,510	6,836	7,177	7,536	7,913	NA

TSG Recommendations: Transformational Reform

1. HCIP: Bring personal responsibility, wellness and accountability and focus on Transition and promoting “ladder of opportunity” – meaningful work engagement
2. Traditional Medicaid: Chose one of two overarching directions, either:
 - Expand *care management* through Patient Centered Medical Homes, Episodes of Care, and health home model with risk/reward and accountability for outcomes **for all populations, including elderly, and those with developmental disabilities and severe and persistent mental illness**
 - Use the private sector to bring *managed care* to all Medicaid beneficiaries, or, at the minimum high cost beneficiaries
3. Enhance eligibility and program integrity across the entire Medicaid enterprise

TSG Recommendation: HCIP Reform

- Key Principles:
 - Providing health care access and services for low-income Arkansas residents
 - Moving residents from assistance to independence – creating a ladder of opportunity and readiness for beneficiaries, the foundation of which is obtaining employment that leads out of government services
 - A commitment to wellness that is built around the notion of residents taking personal responsibility for their health based on increased health literacy and education
 - Improving the quality of care from providers through accountability to achieve measurable performance advances
 - Working to ensure that the medically frail obtain health screening and prevention services

TSG Recommendations: HCIP Reform (cont.)

- Key principles (cont.)
 - Enhancing program integrity to reduce waste, fraud and abuse, delivering accountability for beneficiaries, providers, carriers, and taxpayers
 - Reducing the impact of uncompensated care on health care costs
 - Ensuring that all parties commit to providing the right care in the right setting, reducing the use of inappropriate care (e.g. unnecessary Emergency Room utilization or preventable readmissions)
 - Providing incentives to encourage health care providers to achieve measureable performance outcomes and bring transparent health scorecards for carriers

“In The Box” - T-HIP

- Create program emphasizing wellness, work readiness and personal responsibility
- Enhanced eligibility verification process
- Mandatory Health Insurance Premium Program – employee wrap around benefit
- Enhanced Cost Share for Beneficiaries with Substantial Assets
- End Health Care Independence Accounts
- Mandate Work Referral and Engagement
- Promote quality and transparency among carriers with publicly available health scorecards and ratings
- Reduce health disparities – through education and training
- Medically frail proper care coordination and evaluation

“In The Box” - T-HIP (cont.)

- Employer support for those who transition into ESI
- Membership agreement required to promote accountability among beneficiaries
- Create a wellness report card for enrollees managed by carriers
- Offer vision and dental benefits for those meeting all program goals
- Co-payment to incentivize appropriate utilization of care

“In The Box” - T-HIP (cont.)

- Create member lock out for those who do not comply with wellness and then do not pay premiums as a result of non-compliance with wellness
- Eliminate 90 day retroactivity requirement
- Allow exit from Waiver with 30 day notice to give state ability to adjust to federal changes
- Strengthen and streamline eligibility process
- Create legislative oversight – monitor outcomes and approve significant policy changes

“Out of Box” - WorkFirst

- Similarities
 - Enhance Eligibility process
 - Create program emphasizing wellness, work readiness and personal responsibility
 - Membership agreement
 - Lock out and retroactivity waived
 - Quality scorecards for carriers
 - Enhanced cost share
 - Health Disparities – education
 - Streamlined re-determination
 - Care coordination and evaluation for Medically Frail
 - Vision and dental
 - Exit waiver within 30 days
 - Legislative oversight

“Out of Box” - WorkFirst (cont.)

- Differences
 - Like TANF – 20 hour per week work requirement (35 hour combined for 2 parent families)
 - Exception from work requirement only for active job search or training or for clinically determined medically frail
 - Automated work portal like other states use – (Mississippi)
 - Wrap around services for 100 to 138% FPL – buy policy on exchange and wrap around for everything but premium (2% of income/\$20.00 single at 100% FPL)
 - Sliding scale premium between 50% - 74% (\$5/month) 75% to 99% (\$10/month)
 - Like TANF, state could choose a lifetime benefit limit with hardship exemptions

Governor's 7 Points

- Mandatory HIPP – included in T-HIP (need enhanced program integrity function)
- Premiums above 100% FPL – Following wellness plan as way of avoiding premiums (or all income levels)
- Training referrals for unemployed – T-HIP
- Non-emergency Transportation – Not in T-HIP – return on investment warrants continuation
- Limit access to private market for non-workers – Not included in T-HIP - premium tax impact and larger marketplace pool
- Cost savings in traditional Medicaid – included in recommendations
- Strengthen program integrity – included in recommendations

Small Business Health Options Program (SHOP) Marketplace

- Part of ACA, provides marketplace for small businesses and non-profits (currently 50 FTE max, growing to 100 FTE in 2016)
- Employer must offer coverage to all full-time employees
- For employer eligibility in Arkansas, at least 75% of employees offered coverage must accept
- Employer can tailor type of care offered to employees (coverages, benefits)
- Tax credits available for employers of 25 or smaller with average salary (across all employees) less than \$50,000 annually
- To qualify for credits, employer must pay at least 50% of employee premiums
- Tax credits are worth up to 50% of employer health insurance costs (35% for non-profits), up to \$1,000 annually
- All SHOP plans must include Essential Health Benefits (EHB) package

Small Business Health Options Program (SHOP) Marketplace (cont.)

- Seek Federal Waiver to Encourage Larger Employers to Keep Full-Time Employees and Not Push Individuals onto Medicaid or Arkansas Health Connector
- Seek federal 1332 waiver to extend access to SHOP marketplace and tax credits to employers of all sizes who are determined to hire many employees who might be eligible for Medicaid or heavily subsidized policies on the individual marketplace
- Goal would be to get or keep as many people in full-time employment with employer sponsored insurance
- State would have to negotiate with CMS to ensure proposal did not increase federal deficit
- Negotiations would need to set criteria for employer eligibility, and would include average salary, percentage of full-time employment, etc
- State should also seek waiver of essential health benefits to allow more employer choice, for plans like defined contribution models

Building a 21st Century Medicaid Program

- Cultural shift from paying claims to paying for performance (outcomes)
- Independent clinical assessment, using an evidence-based state of the art test to determine the needs, plan of care and cost for each individual who qualifies for service
- Strong contract provisions and a robust monitoring system to ensure that beneficiaries get high quality care that meets their needs in a timely and coordinated fashion
- Overall commitment to paying for care in the least restrictive setting
- Efficiently pay for value and outcomes through a pharmacy benefit manager to oversee this benefit
- System wide dashboard with outcomes

Three Alternative Approaches:

	Care Management	Hybrid	Managed Care
ABD Populations	Extend traditional Medicaid's EOC and PCMH into the high-cost populations	Private insurance carriers develop new care management programs for high-cost populations	Use private insurance carriers to develop new care management programs for both populations
Non-ABD	Expand traditional Medicaid's tools of care management and incentives alignment (EOC and PCMH) to include all providers and beneficiaries		

Expand PCMH into all Medicaid PCPs and high cost areas

- Develop and deploy additional EOCs for specialty care, particularly procedures
- Continue to monitor all active EOCs very closely to ensure that they are providing value
- Expand payment improvement initiatives into high cost areas
- Health home programs for each of those three high-cost groups
- Elderly and physically disabled incentivized to place individuals in least restrictive setting
- Payment methodology about value, risk and reward
- Allow FQHCs to be medical homes.
- Add upside cost-sharing for situations where average costs go above target thresholds
- Rescind EOCs for primary care and incorporate the corresponding measures/goals into the PCMH initiative

Alternative Approach: Comprehensive Integrated Full Risk Managed Care

- All beneficiaries carved in for all services
 - Focus entire contracting approach on population health status improvement and home and community based services as the first option for all Long Term Services and Supports
 - Identify “Arkansas Health Improvement Scorecard” as a function of the RFP and MCO contract(s)
 - Identify populations covered by high intensity care coordination
 - Capitated rate payment to MCOs: “Actuarially Sound”
 - State sets the provider rates by group and category of service
 - Require 85% MLR; state sets the profit margin plus incentive payments for contracted outcomes
 - Administrative rate capped at 10% and administrative services identified in the contract

Alternative Approach: Comprehensive Integrated Full Risk Managed Care (cont.)

- Cover the whole state based on one RFP
- Provide choice of several MCOs, including community based
- Require any willing provider with allowance for MCO reach out
- Include all waivers services
- Include reform of LTC and RSPMI benefits based on stakeholder and best practices input
- Include PCMH and Episodes of Care in benefits and payment design, including gainshare based on savings
- Program Integrity requirements clearly identified

Alternative Approach: Comprehensive Integrated Full Risk Managed Care for Aged, Blind and Disabled Only

- ABD population, including all medical, pharmacy, ancillary services LTC and DD waivers and RSPMI in comprehensive integrated at risk managed care as above (covers 74% of Medicaid expenditures).
- Other categorically eligible populations, such as TANF and ARKIDS A and B continue in current PCMH and Episodes of care model under fee for service, current DHS requirements and future developments (covers approx. 26% of Medicaid expenditures).
- Clear delineation of hospital, PCP, and specialist requirements between the two models by contract and provider agreement(s).

Move Dental Program to Care Management Approaches

- Move to value based purchasing – third party administrator with risk and reward for good outcomes
- Managed care - Texas, LA. and Florida
- Improve access
- Focus on prevention
- Enhanced public integrity

Focus on Community Based Care as Priority

- Independent Assessment to identify appropriate level of care for ABD population
- Assessment Tools across program
- Enhancing community based care
- Remove barriers to enhancing choice in community
 - Improve reimbursement approval process for providers
 - Reimburse residential care for transportation
 - Rationalize rules for guiding residential care facilities
- Community First Choice Option part of 1115 negotiations rather than entitlement

Rebalancing Long-Term Services and Supports for the Elderly and Individuals with Physical Disabilities

	Nursing Facilities				Community-based Care				Total cost \$millions
	Census	Cost per capita	Total cost, SNF \$millions	% of all LTSS	Census	Cost per capita	Total Cost, community \$millions	% of all LTSS	
Estimated 2015	11,958	64,295	757	65%	14,847	27,453	408	35%	1,165
2021 without rebalancing	14,278	73,131	1,044	65%	17,995	31,226	562	35%	1,606
2021 with rebalancing	9,695	73,131	709	50%	22,568	31,226	705	50%	1,414

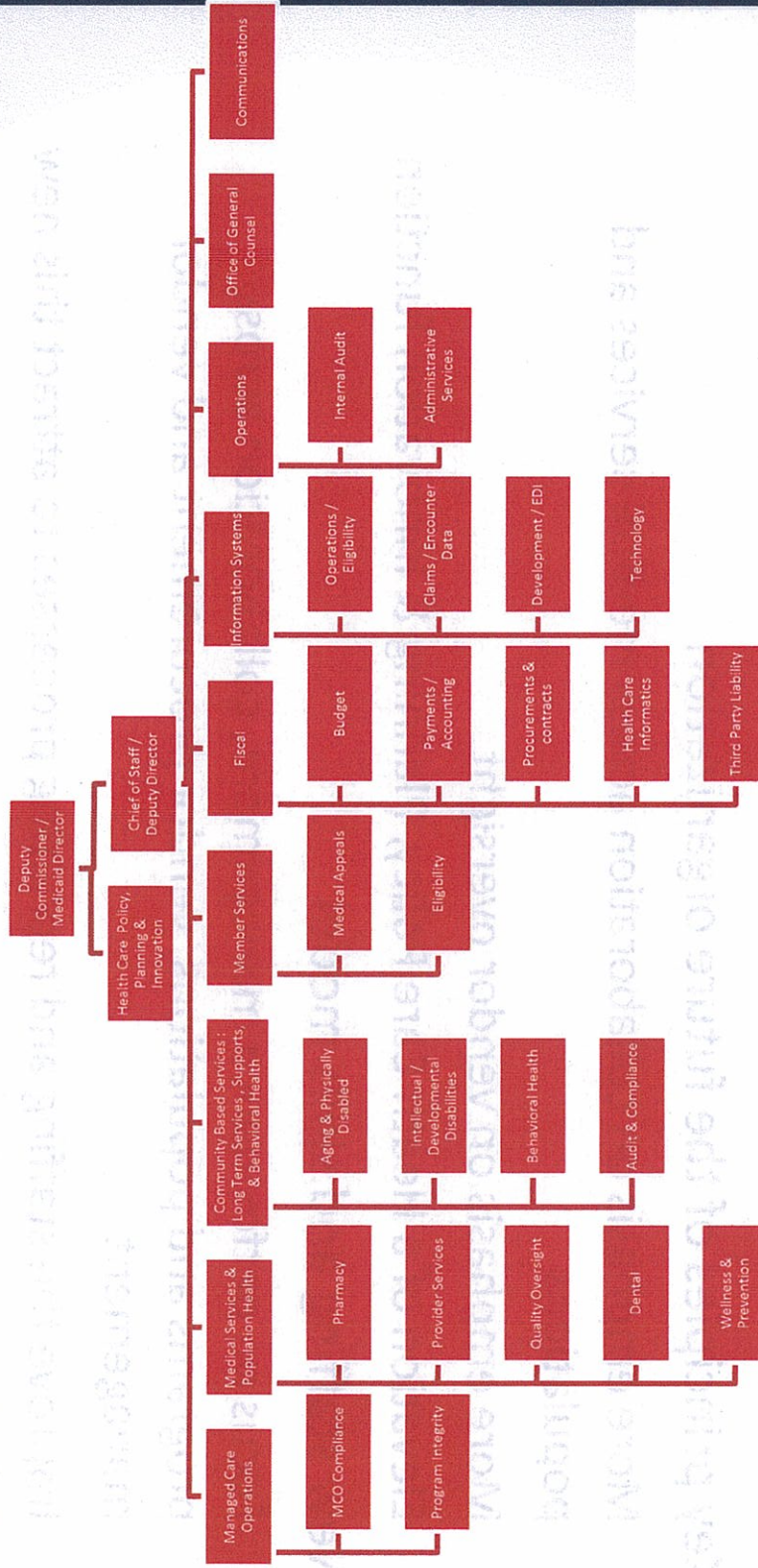
Enhance Program Integrity

- Enhance program Integrity
- Enterprise Benefit Integrity Hub – at DFA
 - Address
 - Additional benefits – return mail
- Expand data base search for income to other available data bases to identify income
- Routine Automated income checks
- Automated Asset Verification
- Support OMIG building enterprise fraud program

Organization

- Key principles of the future organization
 - More emphasis on collaboration across medical services and populations
 - More emphasis on vendor oversight
 - Elevation of a Health Care Policy, Planning & Innovation function
- New staffing and skills model
 - Focus on performance management, collaboration across programs and populations, vendor procurement and vendor management
 - Improve the staffing and recruiting processes to attract this new talent
- Eliminate the 1,000 hour cap for contract personnel

Arkansas Department of Health Care Financing



Recommended Contract Changes

- FY16 Spend on top 25 contracts equals \$62 mil
- DHS anticipates reducing spend on these contracts by \$19 mil as the work they cover is completed
- TSG recommends renegotiating several contracts for potential savings
- TSG recommends reducing overheads on intra-agency and on cost-plus contracts for possible savings on \$1.7 mil
- TSG estimates shifting \$16 mil of cost from the existing contracts to an MCO should the State choose that model

EEF Project Recommendations

- Hire a strong systems integrator to manage the scope, cost, schedule, and risks of this project
- Restructure IT governance
- Require vendor to staff with experienced project managers
- Use Fixed Price Contract for system development and services
- Manage the development of the requirements for the next EEF procurements to be as complete and accurate as possible

Recommended Vendor Management Approaches

- Streamline the procurement timeline
- Institute a program of state term contracts
- Develop a consistent approach to tough performance indicators for contracts
- Manage the contracts through the performance indicators
- Effectively use the performance data across state agency contracts
- Centralized procurement with skilled negotiation resources
- Rebid work where circumstances have changed
- Reconsider appropriate percentage of indirect costs charged on cost plus contracts
- Reduce indirect costs on intra-agency contracts

Pharmacy Recommendations

- Outsource to Managed Care or Develop more value and risk based contracting with current PBM
 - Until this can be done consider:
 - Renegotiate the retail pharmacy network
 - Increase the use of pharmacy lock-in
 - Add prescriber lock-in
 - Allow DHS clinicians access to State Prescription Monitoring Program
 - Eliminate pharmacy claim limits for maintenance medications
 - Expand the PDL
 - Consolidate outsourced call centers

DHS Pharmacy Program Savings Potential

- Retail pharmacy network re-contracting
 - Up to \$18.3 M
- PDL expansion
 - Up to \$22.75 M
- Savings estimates are for average performance in each initiative
- Consolidating call centers and decreasing opioid use should be considered but are less impactful on pharmacy costs

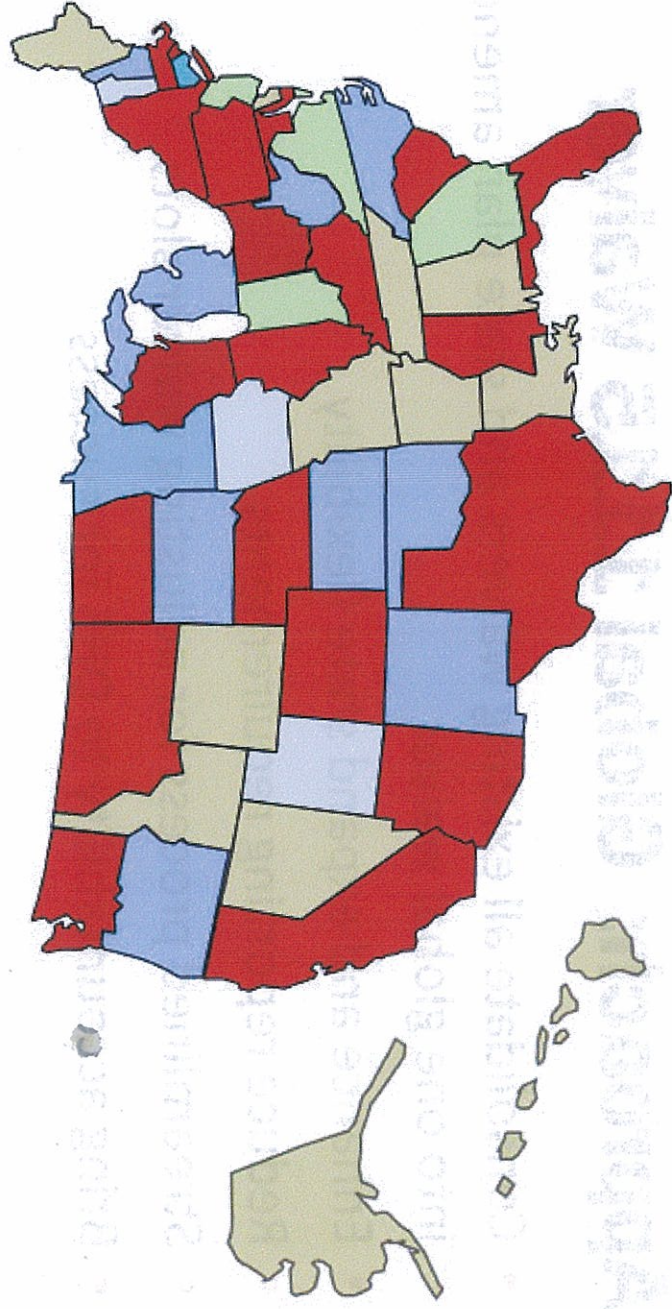
Additional Considerations (cont.)

- Improvement in vendor management
- Health Care Facility Liability protection
- Commission on future of HDC
- Continue focus on telemedicine to expand access
- Collaboration with Arkansas universities and colleges – center for health excellence
- Clear backlog in long term care eligibility determinations
- Develop strategy to address mentally ill and jail diversion strategy

Study Group to Consider Move to DRG Hospital Payment Methodology

What Are Other State Medicaid Programs Doing?

- APR-DRGs (Using or Moving Toward Use)
- MS-DRGs (Using or Moving Toward Use)
- CMS-DRGs
- AP or Tricare DRGs
- Per Stay/Per Diem/Cost Reimbursement/Other



Recommended Waiver Implementation

Approach: Global 1115 Waiver

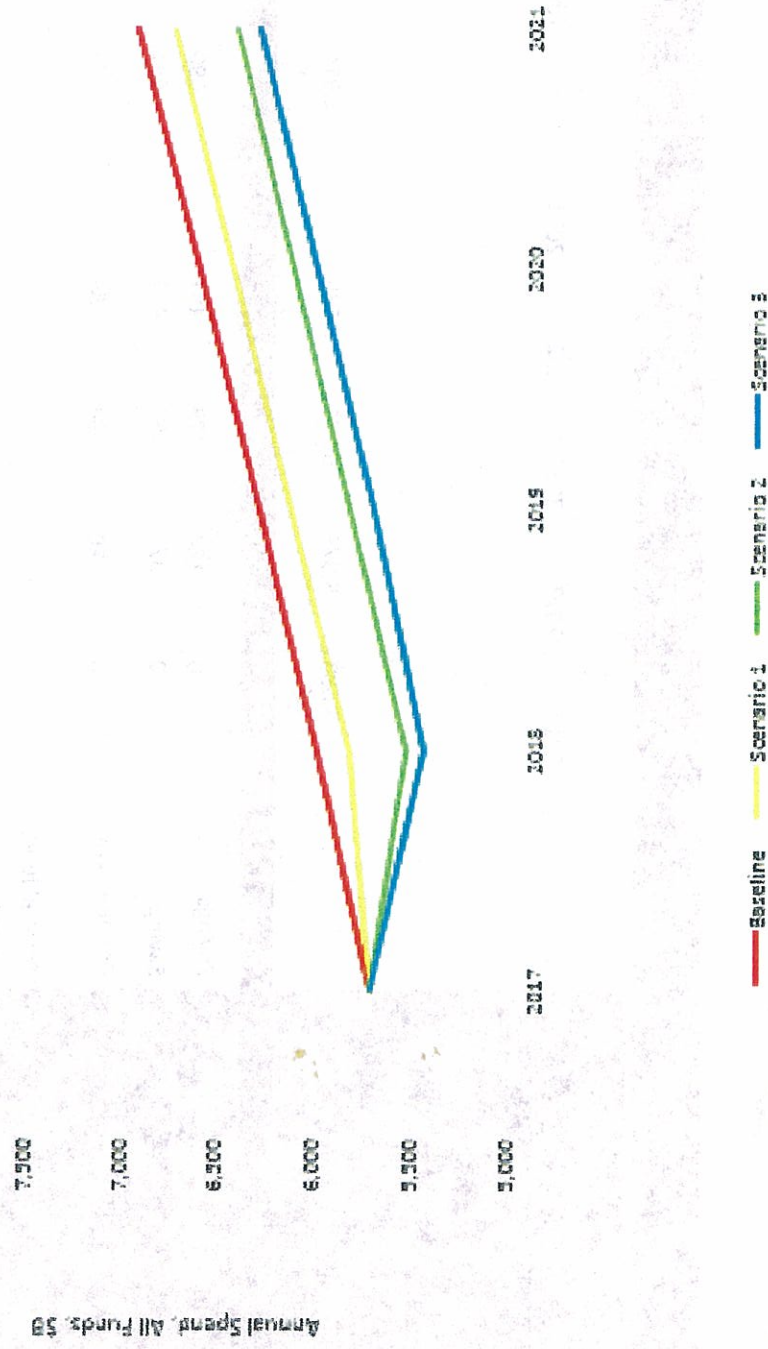
- Consolidate all existing waivers and state plan amendments into one global waiver
- Enhance and expand state flexibility
- Reduce reporting requirements
- Streamlined process for adjusting waiver slots
- Bring accountability to DHS for success

Savings Estimates

Projected Medicaid Expenditures and Savings with Different Program Structures (\$millions)							
SFY	2017	2018	2019	2020	2021	Total (2017-2021)	
Baseline all-funds spending - current program framework; partial managed FFS, no capitated managed care	5,688	5,973	6,271	6,585	6,914	31,431	
All -funds savings against baseline							
Scenario 1 - All managed FFS	Savings	0	164	173	181	190	708
	Savings	0	373	391	411	431	1,606
	Premium tax	0	80	84	89	93	347
Scenario 2 - managed FFS for low-cost populations, capitated managed care for high-cost populations	Total all fund impact	0	453	476	500	525	1,953
	Savings	0	448	470	493	518	1,929
	Premium tax	0	109	115	121	127	471
Scenario 3 - capitated managed care for all populations	Total all fund impact	0	557	585	614	645	2,400

Savings off Baseline

Growth Projections of Different Scenarios



Possible Re-Investments

- DD Wait List
- Rate enhancements
- Primary care
- LTSS community based services
- Additional investigators OMIG
- Additional employer support

Population Health! Best in the SEC!



- Reframe the debate to how to improve healthcare value: reduce cost AND increase outcomes
- Expand care management to all populations, especially the high-cost ABD
- Move away from high-cost institutional care, embracing HCBC
- Choose between three options for care management: all inside DHS, all outside through insurance, or a hybrid
- Build in better integrity at the front door
- Build more of a culture of coordination collaboration between all players
- Align personal accountability through work