Health Care Task Force Preliminary Report

LEGISLATIVE INTENT

Senate Bill 96 of the 2015 session, known as the Arkansas Health Reform Act of 2015, established the Arkansas Health Reform Legislative Task Force ("Task Force") to "(A) Recommend an alternative healthcare coverage model and legislative framework to ensure the continued availability of healthcare services for vulnerable populations covered by the Health Care Independence Program established by the Health Care Independence Act (HCIA) of 2013, §§ 20-77-2401 et seq., upon program termination; and (B) Explore and recommend options to modernize Medicaid programs serving the indigent, aged, and disabled."

Given that the authorization of the Health Care Independence Program (HCIP) expires on December 31, 2016, the Arkansas Health Reform Act of 2015 requires that "On or before December 31, 2015, the task force shall file with the Governor, the Speaker of the House of Representatives, and the President Pro Tempore of the Senate, a written report of the task force's activities, findings, and recommendations."

This report is in response to this statutory criterion.

Additionally, the Act states that "The task force may file with the Governor, the Speaker of the House of Representatives, and the President Pro Tempore of the Senate a final written report on or before December 30, 2016." The authorization for the Task Force expires on December 31, 2016.

BACKGROUND

HEALTH CARE INDEPENDENCE ACT

In spring of 2013, Arkansas took a then-unique approach to implementing the ACA option to expand health insurance for lower-income, able-bodied adults through the Medicaid program. Pursuant to HCIA, beneficiaries participate in a Qualified Health Plan (QHP) that they select. This is commonly referred to as the Private Option (PO). The State uses premium assistance to purchase QHPs offered in the individual market through the ACA exchange (The Arkansas Health Insurance Marketplace) for individuals eligible for expanded coverage under Title XIX of the Social Security Act who are either (1) childless adults between the ages of 19 and 65 with incomes below 138% of the federal poverty level (FPL -up to $16,242 per year for an individual in 2015) who are not enrolled in Medicare or (2) parents between the ages of 19 and 65 with incomes between 17 and 138% FPL who are not enrolled in Medicare (collectively "PO beneficiaries")[1].

[1] See description of the 1115 Wavier at: https://www.medicaid.state.ar.us/general/comment/demowaivers.aspx, viewed September 9, 2015

Objectives of the Health Care Independence Act of 2013 included[2]:

(1) Improve access to quality health care
(2) Attract insurance carriers and enhance competition in the Arkansas insurance marketplace
(3) Promote individually-owned health insurance
(4) Strengthen personal responsibility through cost-sharing
(5) Improve continuity of coverage
(6) Reduce the size of the state-administered Medicaid program
(7) Encourage appropriate care, including early intervention, prevention, and wellness
(8) Increase quality and delivery system efficiencies
(9) Facilitate Arkansas's continued payment innovation, delivery system reform, and market-driven improvements
(10) Discourage over-utilization
(11) Reduce waste, fraud, and abuse

HCIA was created with a goal of creating a "laboratory of comprehensive and innovative healthcare reform" with the objective to reduce the state and federal obligations to entitlement spending and minimize the disruptive challenges from federal legislation and regulations. HCIA was designed to bring a state, and not federal, solution to achieving health care access, improve health care quality, reduce traditional Medicaid enrollment, remove disincentives for work and social mobility, and require cost-containment.

The HCIA wording deliberately makes clear that it was not designed as a perpetual federal or state right or a guaranteed entitlement. The program is subject to cancellation upon appropriate notice and is not intended to be an entitlement program.[3]

HCIA creates a program of health insurance coverage for an expanded population through a QHP at the silver level as provided in the federal ACA. HCIA also includes Independence Accounts that were designed with similarities to Health Savings Accounts or Medical Savings Accounts, and were intended to promote independence and self-sufficiency.

[2] Wording adapted from the text of HOUSE BILL 1143 viewed on September 9, 2015, at http://www.achi.net/Content/Documents/ResourceRenderer.ashx?ID=122

[3] Wording taken from the bill, viewed at: http://www.achi.net/Content/Documents/ResourceRenderer.ashx?ID=122

HCIA Recognized as an Innovative Approach

HCIA has been recognized as a groundbreaking approach to expanding Medicaid coverage[4][5][6]. It required special approval, and in September 2013, the Centers for Medicare and Medicaid Services (CMS) approved a Section 1115 demonstration waiver to implement HCIA by using Medicaid funds as premium assistance to purchase coverage in Marketplace QHPs for newly eligible adults[7].

As of January 2014, Arkansas' demonstration:

- Expands Medicaid by purchasing Marketplace QHP coverage for all newly categorically eligible (under ACA) adults.
- Requires newly eligible adults to enroll in Marketplace QHPs to receive Medicaid services.
- Provides Medicaid services that are outside the QHP benefit package, such as Early Periodic Screening Diagnosis and Treatment for 19 and 20 year olds, free choice of family planning provider, and non-emergency medical transportation, through the state's traditional Medicaid delivery system.
- Allows for a path for medically frail individuals to receive traditional Medicaid benefits.

In December 2014, CMS approved an amendment to Arkansas' demonstration, based on changes required by state legislation[8]. Previously, Arkansas' demonstration included cost-sharing at Medicaid state plan amounts at the point-of-service for beneficiaries from 100-138% FPL. As of January 2015, Arkansas' amended demonstration[9]:

[4] See for example the Kaiser Family Foundation report, from which this paragraph has been adapted. Viewed on September 9, 2015 at: http://kff.org/medicaid/fact-sheet/medicaid-expansion-in-arkansas/#footnote-143277

[5] See for example: http://khn.org/news/is-arkansas-private-option-medicaid-expansion-a-solution-for-other-red-states/

[6] See for example: http://www.arktimes.com/ArkansasBlog/archives/2015/08/26/arkansas-private-option-continues-to-get-rave-reviews

[7] Ark. Health Care Independence Program (Private Option), CMS Special Terms and Conditions (Sept. 27, 13), available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/Health-Care-Independence-Program-Private-Option/ar-private-option-app-ltr-09272013.pdf; *see also* Ark. Medicaid, Health Care Independence (a/k/a Private Options) § 1115 Waiver – FINAL (Aug. 2, 2013), available at https://www.medicaid.state.ar.us/general/comment/demowaivers.aspx.

[8] Ark. Act 257, § 17 (Feb. 18, 2014), available at http://www.arkleg.state.ar.us/assembly/2013/2014F/Pages/BillInformation.aspx?measureno=SB111; Ark. Health Care Independence Program (Private Option) CMS Special Terms and Conditions #11-W-00287/6 (Jan. 1, 2015), available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/ar-private-option-ca.pdf.

[9] See: http://kff.org/medicaid/fact-sheet/medicaid-expansion-in-arkansas/

- Establishes Health Independence Accounts to which non-medically frail beneficiaries from 50-138% FPL make monthly income-based contributions, ranging from $5 to $25 per month, to be used for co-payments and co-insurance. These contributions are not a condition of Medicaid eligibility. Since federal approval of the extension of the cost-sharing (and participation in the HIAs) into the population below 100% FPL was required, DHS made the administrative decision not to move forward with the plan.
- Imposes cost-sharing at the point-of-service at state plan amounts for beneficiaries above 100% FPL who do not make monthly account contributions.

Arkansas initially also sought waiver authority to limit non-emergency medical transportation (NEMT) to 8 trip legs per year for non-medically frail beneficiaries[10]. Instead, the state established a prior authorization process for NEMT for newly eligible adults (which does not require waiver authority).

Arkansas is among 29 states (including DC) implementing the Medicaid expansion to date[11], most of which are doing so through a state plan amendment, not waivers. To date, CMS has approved waivers in Arkansas, Iowa[12], Indiana[13], Michigan[14], New Hampshire[15] and Pennsylvania[16] to implement the ACA's Medicaid expansion.

The Arkansas Health Reform Act of 2015 (the "Act").

The Act, enacted by the 90th General Assembly, represented the Arkansas General Assembly's intentions to "seek out strategies to provide health care for low-income and other vulnerable populations in a manner that will promote accountability, personal responsibility, and transparency; remove disincentives for work and social mobility; encourage and reward healthy outcomes and responsible choices; and promote efficiencies that will deliver value to the taxpayers."

[10] See: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/Health-Care-Independence-Program-Private-Option/ar-private-option-pending-app-09172014.pdf

[11] See list at: http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/. Viewed September 9, 2015.

[12] For summary, see: http://kff.org/medicaid/fact-sheet/medicaid-expansion-in-iowa/

[13] For summary, see: http://kff.org/medicaid/fact-sheet/medicaid-expansion-in-indiana/

[14] For summary, see: http://kff.org/medicaid/fact-sheet/medicaid-expansion-in-michigan/

[15] For summary, see: http://kff.org/medicaid/fact-sheet/medicaid-expansion-in-new-hampshire/

[16] For summary, see: http://kff.org/medicaid/fact-sheet/medicaid-expansion-in-pennsylvania/

To achieve these goals, the Task Force contracted with The Stephen Group (TSG) through a competitive bid process to assist the Task Force in its work and offer recommendations that meet the above criteria. The TSG assessment report reviewed how efficiently the Arkansas Medicaid program, including the PO, is currently operating and how well-prepared the program is to meet the trends for the future (Volume I Findings Report). Additionally, the report considered how Arkansas Medicaid can change at the policy, financial, organizational, and operational levels in the future (Volume II Recommendations Report).

The Stephen Group, Volume I Findings report is located at:
http://www.arkleg.state.ar.us/assembly/2015/Meeting%20Attachments/836/I14099/TSG%20Volume%20I%20Findings%20Report%20amended%20to%20include%20all%20Appendix%20references.pdf

The Stephen Group, Volume II Recommendations report is located at:
http://www.arkleg.state.ar.us/assembly/2015/Meeting%20Attachments/836/I14099/TSG%20Volume%20II%20Recommendations.pdf

In addition to the TSG recommendations, a number of stakeholders, providers, Task Force members, and the Governor, provided additional recommendations which we have summarized below.

TASK FORCE ACTIVITIES SUMMARIZED

May 28, 2015

- The Stephen Group (TSG) was hired on May 15, 2015 and attended this first Task Force meeting at which TSG presented its project planning efforts. TSG also discussed Medicaid eligibility verification and the redetermination process.
- Dr. Lanhee Chen, of Stanford University's Hoover Institution, provided an overview of how Section 1332 waivers might work, what states can and can't do with a Section 1332 waiver, and the process to get a waiver, as well as a brief overview of state options from other states.
- Medicaid Director Dawn Stehle presented an overview and comparison of costs for the medically frail in the private option program and enrollees in traditional Medicaid.
- Billy Tarpley of the Arkansas State Dental Association presented an overview of the current Medicaid dental program and recommended changes, including a dedicated dental Medicaid claims system to manage the program and outsourcing of administration to a dental-specific entity.

June 11, 2015

- TSG presented their first monthly status report to the Task Force, which included the need for improved contract & vendor management from eligibility to program operations; the high focus on institutional care in both long-term care (LTC) and developmental disability (DD) systems of care, resulting in very high costs; opportunities to adopt best practices from other states to control costs; and opportunities to consolidate existing Medicaid waivers.
- TSG presented data on LTC, hospitals and mental health costs for 2014; detailed data on Medicaid beneficiary per member per month (PMPM) costs from 2007 to 2014; top Medicaid areas of growth 2007-2014; projection of state revenue share of Private Option from 2014 to 2020; and Medicaid enrollment history from 2006 and projected to 2030.
- TSG presented comparisons of Arkansas Medicaid costs to other neighboring states.
- TSG presented information on Arkansas' nine current CMS waivers.
- TSG participated in a presentation and discussion on the Medicaid pharmacy program.
- Express Scripts and CVS Health presented a discussion of pharmacy benefit managers.

July 15, 2015

- TSG presented on its interviews with various state agencies and other organizations and presented an update on the process of cleansing the data from private carriers and DHS on beneficiary claims.
- TSG discussed the Health Care Independence Program and its relation to traditional fee-for-service Medicaid, the Private Option, the medically frail, and pregnant women.
- TSG presented on its survey to physicians and other health care providers on their perceptions of the Payment Improvement Initiative/Episodes of Care.
- TSG discussed the human development centers and the health independence account program.
- TSG participated in the presentation and discussion of the Medicaid pharmacy program including the prescription process at Magellan, the role of pharmacists and economic impact on pharmacies by the lack of reimbursements from generic drugs, and a synopsis and recommendations for improvement of the evidence-based prescription drug program.
- TSG presented an analysis of Arkansas pharmacy practices and recommendations for improvement, identifying that Arkansas ranks highly nationwide for prescription opiate use.
- TSG presented an overview of DHS contracting and key contracts and made recommendations.
- Express Scripts presented a discussion of pharmacy benefit managers, noting the positive impact on the quality and cost of prescription drugs. They presented their best practice management tools and provided clarification on how Arkansas legislation impacted Express Scripts' contract so as to not allow them to do business with Arkansas Medicaid.

- CVS Health presented an overview of their pharmacy practices and the structure and goals for their managed care program in Arkansas, particularly for complex populations, high utilizers, and high risk members. In addition, CVS Health has published findings on the impact of improved adherence counseling for the mentally ill.
- TSG presented information on the status of DHS implementation of InterRAI assessment tools for LTC, DD, and mental health and data on the scope and costs of Medicaid-paid case management.

July 16, 2015

- TSG provided an analysis of the Health Care Payment Improvement Initiative and emphasized the need for Arkansas to focus on high utilizers.
- TSG discussed Patient-Centered Medical Homes, the Episodes of Care Payment Model, and a complementary DRG payment model as ways to realize future savings. TSG also highlighted the need for comprehensive care coordination.
- TSG presented an overview and update on the Medicaid Eligibility and Enrollment Framework Project, highlighting opportunities for improvement and the establishment of a project management office.
- Dawn Stehle and Dr. Bill Golden, Arkansas Medicaid Medical Director, discussed the Payment Improvement Initiative in relation to the Episodes of Care and Patient-Centered Medical Homes programs as possible reasons for decreasing Medicaid costs and improved primary care quality.

August 19, 2015

- Governor Asa Hutchinson addressed the Task Force and provided the Task Force with his seven elements of a potential plan, as it considers its statutory obligation. The Governor stated that his principles for reform would be as follows:

    1. Must implement mandatory employer-sponsored premium assistance.
    2. Implement premiums for incomes with more than 100% of FPL.
    3. Work training referrals required for unemployed or underemployed.
    4. Eliminate non-emergency medical transportation coverage
    5. Limit access to the private market coverage
    6. Cost savings
    7. Strengthen program integrity
- TSG provided a financial forecast for the Private Option and Traditional Medicaid, with data on the high cost populations. TSG also provided an analysis of the RSPMI program.
- TSG presented an overview of other states' Medicaid payment reform models and waivers for the expanded Medicaid and high cost populations, as well as a comparison of Arkansas Medicaid spending with other states.

- TSG presented detailed data on nursing home, Developmental Disability (DD), and mental health costs and associated ("halo effect") medical costs and neighboring state comparison costs for high cost Medicaid utilizers.
- TSG presented information on other states' Medicaid modernization efforts, best practices and general principles for controlling state Medicaid costs regardless of payment models.
- American Health Care Association and representatives from AARP and Central Arkansas Area Agency on Aging (AAA) provided information on cost of services, care coordination and financial data for skilled nursing facilities, assisted living facilities, managed care services, and home and community-based services. They agreed to provide information regarding suggestions for cost savings from value based purchasing, care coordination, and liability and litigation cost reductions to TSG. AARP and AAA strongly support increasing in-home services and community-based care over nursing home care whenever possible.

August 20, 2015

- Dr. Daniel Rahn, UAMS, commented that UAMS' focus is on population health and that healthcare plans are moving toward preventive health care to identify and reduce health care risks. UAMS will provide recommendations for legislative actions and state policies to improve health, access to health care, and reduce costs.
- TSG presented an update and comparison of state models for care coordination and care coordination models and trends in Medicaid managed care programs.
- Nine managed Care companies presented their healthcare programs for discussion and agreed to provide additional information to the Task Force.
- TSG provided follow-up on retroactive terminations, the Payment Improvement Initiative Episodes of Care Cost-Benefit Analysis, and the healthcare provider survey.

September 16, 2015

- TSG provided an overview and led discussions on the costs of Arkansas Medicaid Long Term Care (LTC), the cost of care for DD services, cost data for people on wait lists and cost considerations for removing people from wait lists, and the Community First Choice Option (CFCO) as implemented in six other states and CFCO policy considerations.
- Various agencies, provider groups, and DHS presented updates on mental health issues and special-needs populations.
- DHS led a discussion of the Community First Choice Option plan, emphasizing the need for individualized care plans to ensure necessary services.
- The Developmental Disability Provider Association presented updates on developmental disability issues and special populations, along with suggestions for improving services,

cutting costs and necessary policy decisions that would need to be made, and stated that waiver services are already well-managed in Arkansas.

- Child Health Management Services presented an overview of their programs and services, which were noted by the Task Force members to be an excellent example of total care coordination.
- Parents of human development center residents presented their stories of the critical role played by centers in the lives of their developmentally disabled children.
- The Task Force took testimony from organizations and individuals in support of the Community First Choice Option.

October 7, 2015

- TSG presented its Final Assessment and Recommendations reports for Arkansas Medicaid. Findings highlight Arkansas' high cost of Medicaid as compared to other states, with opportunities to improve health outcomes, care coordination, vendor management, public integrity, organization, and efficiency.
- TSG recommendations for transformation include bringing personal responsibility for wellness, accountability, and meaningful work engagement into HCIP; expanding care management for all populations or use the private sector to bring managed care coordination to all, or at least high cost, beneficiaries; and enhancing eligibility and program integrity across the entire Medicaid program.
- TSG offered two plans for improving traditional Medicaid and three plans for reforming the Medicaid Private Option, noting that any replacement of the Arkansas Private Option must meet certain requirements.
- In response to Task Force questions, TSG explained possible contract savings and recommendations for improving the mental health program, as well as addressing other topics raised.

October 20, 2015

- TSG presented follow-up research on various questions raised at the last Task Force meeting, including unemployment demographics, nursing home issues, Federally Qualified Health Centers, human development centers, use of different Diagnosis Related Grouper (DRG) methodologies, outreach regarding Health Independence Accounts, uncompensated care, real-time eligibility online system, and prescription rates in Medicaid and the Private Option, with removal of limits on maintenance medications.
- Responses to TSG report were presented to the Task Force by DHS, Office of Medicaid Inspector General, Department of Workforce Services, and the Arkansas Health Insurance Market Board.

- Additional responses and concerns were presented on behalf of Arkansas insurance agents on the Private Option; and on behalf of inpatient psychiatric hospitals and by the Assisted Living Association on needed Medicaid reforms.

November 10, 2015

- TSG responded to questions posed by the Task Force in response to the report, including the DRG issue, historical nursing home census issue, the Private Option, The Tennessee Primary Prevention Initiative, and lock-out provisions for non-payment of premiums.
- TSG presented an overview of the recent expansion waiver approved for Montana.
- TSG is researching people in the private option who are already subject to work requirements for TANF, SNAP and unemployment benefits, as well as other states' processes for determining medical frailty.
- DHS reported that they have begun using the new eligibility determination process.
- Representatives of Private Option insurance carriers responded to TSG report, agreeing with key aspects that place the focus on Patient Centered Medical Homes (PCMH), ensure patient information is available to providers, integrate primary and behavioral health care and encourage preventive care, encourage Primary Care Physician (PCP) use over Emergency Room (ER) use, and improve eligibility issues.

November 24, 2015

- TSG presented follow-ups on questions raised at the November 10th Task Force meeting. Topics included pharmacy savings and quality improvements, vaccination findings and recommendations, premium collection and lock-out provisions in other states, updates on the DRG work group, marketplace plan update, nursing home census data, review of care management models contracting issues, and assumptions and estimates for savings from potential models, including a PCMH model proposed by the following Task Force members: Representative Michelle Gray, Representative Justin Boyd, Representative Joe Farrer, and Representative Deborah Ferguson, as well as non-voting member Senator Missy Irvin.

December 15, 2015

- Representative Michelle Gray, Representative Justin Boyd, Representative Joe Farrer, Representative Deborah Ferguson, and Senator Missy Irvin presented their proposed recommendation plan to the Task Force called DiamondCare. The full DiamondCare proposal is located at http://www.arkleg.state.ar.us/assembly/2015/2015R/Pages/MeetingDetailsPopupPage.aspx?meetingId=26775&CalType=ME&List=Meetings&btnok=nook. Some of the key principles outlined in DiamondCare and provided to the Task Force are as follows:

- Medicaid Fee for Service payment model for all traditional Medicaid populations, except the Dental program, which would be covered under a capitated full risk managed care model.
- PCMH model for all Developmental Disabilities and Behavioral Health populations, with independent assessments
- Administrative Services Organization (ASO) model for Developmental Disabilities and Behavioral Health populations
- PCMH model with care coordinated between Medical Director, Nursing Facility, and Community Based Services for Long Term care elder programs, including utilizing existing infrastructure of rural nursing facilities to provide care coordination and home and community based services
- Work to transition beneficiaries to home care following rehab stays
- Promotes wellness and telemedicine for specialists
- Recommends a range of changes on of lowering/adding volume to certain procedures/policies PCMH and Pharmacy

December 16, 2015

Governor Asa Hutchinson addressed the Task Force and expressed support for continuing the coverage for the expanded population on two conditions:

1) That savings are identified within the Medicaid budget to pay for the state's share of the costs; and
2) That the rules are changed so that the Arkansas values of personal responsibility, work, and program integrity are reinforced.

Governor Hutchinson identified the goal of saving $835 million in all funds over 5 years from the traditional Medicaid program, which averages to $167 million per year in all funds ($50 million per year general revenue) in order to get the "Best service for the customer at the best price for the taxpayer."

Governor Hutchinson went on to explain that a number of different provider groups have come forward with proposals for saving money, some of which appear to be very realistic, others of which require some additional analysis to validate. Realistic savings opportunities may be identified that do not require capitated managed care, but capitated managed care may be the only way to capture the necessary levels of savings for certain populations.

Governor Hutchinson also laid out his goals for a reformed PO, to be called Arkansas Works, as follows:

1. **Encourage employer based insurance** rather than a permanent reliance on government insurance, by implementing implement mandatory employer-sponsored premium assistance. This requires Medicaid-eligible individuals with access to cost-effective ESI to enroll in employer coverage with Medicaid (a) covering the employee's premium and cost sharing that might exceed Medicaid levels; and (a) providing any benefits not covered by ESI but offered by Medicaid.

   The state should also look for additional incentives for employer based insurance coverage and should consider Sec. 1332 waiver to more effectively use the SHOP exchange to provide cost effective insurance for a larger number of employers.

2. **Incentivize work**

   The state should require work training referral requirements along with the continued discussion with that administration on the need for work requirements (this would only apply to those who are able bodied)

   Also, the state should offer enhanced coverage options or other incentives for those who are in compliance and who meet the goals of a Healthy, Active Arkansas.

3. **Personal responsibility including Healthy, Active Arkansas emphasis and incentives**

   Premium payments should be required for those with incomes above 100% of FPL (similar to the marketplace of 2%)

   Additionally, there should be other waivers requested for options to include some contribution for those above 50% of FPL with premiums waived for those who accomplish objectives of a Healthy, Active Arkansas, e.g. wellness exam.

4. **Program Integrity**

   Arkansas needs to start the debate on restrictions on coverage or increased cost sharing for those with substantial assets. For example, a primary residence of over $200,000 or those with cash or cash equivalent assets of $50,000 or more; but this restriction is currently not allowed under federal law.

   There should be a cap on the length of coverage for those not participating in work opportunities and *who are able bodied*. (Similar to TANF)

   Eliminate the 90 day retroactive eligibility

There should be an option to exit the waiver with 30 day notice and wind down plan; if the match rate is changed

A copy of the Governor's remarks can be downloaded at http://www.arkleg.state.ar.us/assembly/2015/2015R/Pages/MeetingDetailsPopupPage.aspx?meetingId=26598&CalType=ME&List=Meetings&btnok=nook.

The Stephen Group presented updates on the following topics:

- Participation other public programs by participants in the Health Care Independence Program
- Nursing homes residence by state income
- Possible multiple billing for behavioral health services
- Diagnosis related groups (hospital payment)
- Pharmacy savings

TASK FORCE FINDINGS

Key Findings: Private Option/HCIP

- At the time of this report, there are approximately 250,000 newly eligible adults (225,000 PO and 25,000 Medically Frail, who currently utilize traditional fee-for-service Medicaid)
- 80% of all individuals selecting insurance through the marketplace in Arkansas are enrolled via the PO.
- PO participants are younger and thus healthier and lower cost. 65% of those enrolled through the Private Option are younger than 45 years old, compared to 45% of those enrolled through the Arkansas marketplace.
- PO participants have access to substantially more providers than through traditional Medicaid due to access to the private insurance company provider networks.
- PO beneficiaries utilized Emergency Department services at a rate greater than traditional Medicaid beneficiaries, despite being a healthier population.
- Health disparities and use of Emergency Departments appear to be due, in part, to a lack of understanding of how to use the health care system by individuals who are new to having coverage, or because there are no incentives for utilizing more appropriate care.
- Over the next five years, the federal share of the PO, in its current form, would result in roughly $9 billion in Medicaid federal match payments for Arkansas.
- Hospitals report a substantial reduction in uncompensated care visits and costs since the beginning of the Private Option. Uninsured admissions dropped 48.7% between 2013 and 2014, uninsured Emergency Department visits dropped 38.8%, and uninsured outpatient visits dropped 45.7%. This drop could also be partly attributed to the

availability of insurance policies with subsidies for incomes above 138% Federal Poverty Level (FPL) on the Arkansas Health Connector, or a drop in unemployment which likely indicates an increase in employer insurance.

- The Arkansas rate of uninsured among non-elderly adults dropped from 27.5% to 15.6% from 2013 to 2014. The PO was clearly a substantial factor in this drop.
- Many PO enrollees are not working at all or not working substantially. Forty percent of beneficiaries have an annual income of $0. Over 54% had incomes below 50% of the FPL. Only a little over 15% were between 100-138% FPL.
- Average ratio of claims to premiums among the three QHP carriers is 79%, lower than the 80% (85% for large group carriers) allowed under the Affordable Care Act.
- Physician licensure rates appear largely not to be impacted by the PO.
- The Health Independence Accounts appear largely to have missed their mark. Only 10,806 cards have been activated of the 45,839 issued, with only roughly 2,500 individuals contributing to these accounts monthly.
- If Arkansas rejects Medicaid and returns to program status prior to 2014, the negative impact to the state budget is approximately $438 MM (2017 – 2021), taking into account cost shifting, uncompensated care, premium tax and macro-economic effects).
- The state may have options available to limit some of the impact by not renewing optional programs or funding uncompensated care.

Key Findings: Traditional Medicaid

- Arkansas Medicaid program is on an unsustainable path, using conservative growth estimate of 5% for next five years.
- Between now and 2021, the general revenue portion to fund traditional Medicaid is projected to grow by $500 Million.
- Currently, the state has not implemented best practices that other states have used in Medicaid for a large part of costs, such as:
    - Hospital payment initiatives based on value and risk
    - Care Management strategies based on full or substantial risk and particularly involving management of aged, blind and disabled and other high cost populations – example: complex care for children
- 74% of traditional Medicaid claims are for the aged, blind, disabled (ABD) population. These claims fall heavily under the institutional care categories of service (hospitals and nursing homes) for services to the high risk, high cost elderly, disabled and behavioral health populations, and include additional medical costs (‘halo’ effect).
- Almost 20% of Medicaid expenditures are paid outside of the stringent controls of the Medicaid Management Information System (claims payment processing system).

- Key health value improvement programs (Patient-Centered Medical Homes, Episodes of Care) do not address the 74% of Medicaid costs incurred by the ABD population, but focus on the 26% of the Medicaid population who are not ABD.
- There is overly high use of nursing homes and other institutional settings.
    - Two-thirds of care costs for Arkansas' elders is paid to nursing homes. The average cost for caring for an elder in a private nursing home is approximately $67,000 per year, more than twice the $27,000 cost of caring for an elder in the home and community based programs, including the Elder Choice Waiver.
    - Institutional care accounts for one third of total developmental disability claims, of which 80% is for adult care and 20% is for pediatric care. The average cost for adult institutional care is $135,000 per person per year, compared with $69,000 in the Alternative Choices Waiver program. Pediatric institutional care averages $162,809, compared to $45,937 for community-based care under a waiver program.
- Arkansas hospitals are generally reimbursed at a maximum per diem amount, with a few paid on a cost basis, reconciled annually; both models include several different supplemental payments.
- The state has not been successful in rebalancing long term care. There is a lack of active and effective transitional services between hospitalization, nursing facility rehabilitative treatment paid for by Medicare, and community options. Combined with the lack of a single assessment process for LTC services, this results in a fragmented approach to care coordination and choice of least restrictive environment.
- The lack of an independent standardized clinical assessment for treatment planning and efficiency strategies for individuals who access mental health services is a major driver of the growth in mental health care expenditures.
- There is a lack of a comprehensive public mental health strategy designed to support recovery within a community-based care environment and divert individuals from unnecessary inpatient psychiatric hospitalizations, residential placements, and avoidable jail admissions. The mental health system lacks evidence-based practices and incentives for comprehensive care coordination.
- There are over 2,900 people who are now on the Developmental Disabilities Wait list, of which 2,640 already incur a total of almost $32 million in Medicaid costs.
- The mental health system is highly siloed and fragmented. Case management services are available in the DAAS and DDS home and community based services programs, but are not included in the mental health structure within DBHS. There is currently no IT capacity to track beneficiaries across program codes. However, the creation of the DMS Data Warehouse should provide DHS the ability to track beneficiaries across all treatment types.
- Arkansas implemented the PCMH model with 295,000 Medicaid beneficiaries in 2013, excluding the Aged, Blind and Disabled population and all waivers and with limited risk. The model is based on care coordination and attention to transitions of care, primary care

provider (PCP) practice transformation, and improved access based on 24/7 beneficiary telephone access. The full implementation timeline is three to five years; the model has so far seen some positive results in cost avoidance, primary care investments, and shared savings between the state and providers.

- Episodes of Care is a national best practice example, although the return on investment for the program is unclear.
- Arkansas has an atypically high cost for traditional Medicaid.
- Four of Arkansas' neighbors – Tennessee, Mississippi, Texas and nearby Kansas – all utilize full risk managed care for aspects of their populations and according to reports reviewed:
    - Texas saved over $3.8 B since FY 10 according to an independent Milliman study and is estimated to save $7.1 B through FY 2018.
    - Kansas reduced spending growth from 7.5% to 5% in the first two years and then used over $60 million in GF savings for their DD wait list, amounting to over $140 Million in total funds.
    - Tennessee significantly reduced reliance on nursing homes by changing levels of care while achieving budget neutrality for LTC.

Key Findings Across Programs

- Arkansas Health Status is low compared to other states.
- Not enough emphasis is placed on health care value, meaning the return on investment of Medicaid dollars.
- There is an across-the-board focus on large claims processing and not on an outcome based model.
- There is no benchmarking of outcomes for quality and improved health.
- Medicaid is only one piece of the total health status outcome, but an important one.
- Health care professionals and community members believe that the PO has had a positive impact on health disparities, with many people having access to health coverage for the first time. However, they recognize the need for education and community-based assistance on the process of navigating the health care system to help people learn how to access the right services at the right time, thereby addressing access disparity, increasing self-responsibility, and avoiding unnecessary costs such as unnecessary ER use.
- Neither DHS nor OMIG have invested in state of the art technology and vendors dedicated to payment integrity by using enhanced predictive capabilities, although OMIG has issued an RFP for data analytic tool capabilities filling an important future gap.
- There are a large number of vendor contracts at DHS that have some role in the issue of payment integrity – HMS for third party liability (TPL) recoveries were $23.4 million in 2014), HP for MMIS, Curam for eligibility, Value Options for behavioral health review, Optum for analytics – but there is no clear owner of payment integrity at DHS. Current

data analytic capabilities have been focused in the past on verifying fraud, rather than identifying waste and abuse.

- There is limited oversight at DHS into billing in the long term care and support services (LTSS) area.
- Audits at the facility and provider level and of providers and associated care plans are limited.
- Traditional and PO conversion to MAGI, the new ACA financial eligibility standard, coupled with the effort to convert to a new eligibility software system has led to significant obstacles and setbacks in eligibility verification. DHS experienced a significantly increased workload to verify eligibility and enroll expanded Medicaid applicants, with little increase in resources. In addition, the Curam software, designed to provide automated validation of requirements, failed to meet expectations and resulted in a higher volume of applicants that had to be managed manually. DHS is still in the transition from the legacy Medicaid administration system to the new systems.
- Delays in the updating of Curam left the state unable to process required annual eligibility reviews, resulting in people no longer qualified for the program continuing to receive services.
- The current Curam software to manage the basic enrollment and re-enrollment process does not manage all basic Medicaid requirements, including removing incarcerated beneficiaries from receiving services, and must be supported with manual DHS processes.
- A data scrub by Lexis Nexis found a substantial number of newer addresses than the ones supplied by DHS for roughly 48% of the participants of both PO and Traditional Medicaid, and a significant number of out-of-state addresses were flagged (Traditional Medicaid 22,781, PO 20,110) and have been reviewed by DHS. Note: The out of state addresses could be for individuals that resided out of state but moved into Arkansas prior to PO or Medicaid eligibility so further investigation by DHS is warranted.
- Managed care plans control underlying drug costs and dispensing fees better than DHS. In 2014, DHS paid average claims of $301 for brand name drugs and $32 for generic drugs, compared to PO carriers paying a combined average of $190 for comparable brand name drug claims and $15.66 for generic drugs.
- Private Option carriers had roughly twice the claims for opioids as a percent of all drugs, as compared to DHS, and a higher percent of drug utilizers with at least one opioid claim. The numbers are less pronounced when considering that the average age of Private Option beneficiaries is 42 years old, compared to 24 years old for traditional Medicaid. The top conditions reported for high utilizing beneficiaries do not support long term use of opioids. Clinical personnel at DHS do not have access to State Prescription Drug Monitoring Program database.
- The expenditures of the 1.6% of DHS beneficiaries who approached or hit the per person per month claim limit made up 40% of total drug claims. However, much of this

population requires consistent access to maintenance drug therapy for chronic health conditions and interruptions in drug treatments could lead to preventable complications resulting in additional health care costs.

- DHS' preferred drug list covers 38% of all claims paid in the FFS program, compared to an average of 64% in comparable states and a best practice figure of 80%. Eighty five percent of claims at DHS are for generic drugs, accounting for 30% of total drug spend, slightly higher than the 22% average of other states reviewed.
- DHS contracts with more than one call center for its Medicaid pharmacy benefit.

Organization and Staff

- Divisions within DHS are siloed, with a lack of an integrated leadership and policy making platform.
- Staffing model leads to excessive use of consultants.
- DHS staff has few people with the necessary capacity to determine what the state needs for services, write RFPs, plan for the evolution of needs over the life of a contract, and maximize the results of money spent.
- There is no centralized vendor management function or unit.
    - DHS lacks the resources with Vendor Management skills to negotiate successfully with large vendors, maintain oversight of contracts, enforce terms and resolve issues quickly.
    - Procurement practices for the largest contracts include many standard favorable contract terms and conditions, and contracts are managed one year at a time to encourage vendors to re-earn the business annually.
    - DHS does have some strong examples of specific deliverables and consequences for missing deliverables.
    - A review of the top 25 contracts showed that increases were due to authorized scope extensions or changes in volume based on unit pricing.
    - Financial tracking of vendor invoices against contract budgets, funding sources, dates and amounts paid is done manually.
- Lack of coordination between DHS Divisions negatively impacts developing and implementing a system of care that provides efficient care coordination across programs for high need/high-cost populations. PCMH model includes some care coordination, but excludes the ABD and waiver populations. The Balancing Incentives Program has elements of care coordination for these populations, but is unconnected to the PCMH model and lacks resources. There is an opportunity to bring the knowledge and successes of these programs to scale across all populations.
- The organization structure is not sufficiently integrated from a customer point of view. The functional design of DHS organization allows divisions to build deep skills and focus on particular services; however clients with multiple needs have to interface with different employees to meet their needs, large providers have to navigate different parts

of DHS to understand all policy requirements, and suppliers may have multiple contracts to provide different services.

- There is lack of collaboration across the entire organization, particularly in the areas of care coordination, program integrity, procurement and shared services.
- The legislative review process can be lengthy and is broadly construed by DHS to include any change in policy. Additional committees are involved in review process.
    - Legislative review requirements apply to any type of agency statement, policy, etc. that meets the definition of a "rule." The definition of a "rule" is very broad.
    - 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.

RECOMMENDATIONS

At the Task Force meeting on December 16, 2015, the Governor requested a motion to support his interest in opening negotiations with CMS on the Arkansas Works proposal and committing to achieve his target of $835 million in savings to the traditional Medicaid program over 5 years.

Subsequent to the Governor's remarks, the Task Force voted unanimously in favor of the following motion:

"We move to support the Governor's efforts to negotiate waivers from the Centers for Medicaid Services (CMS) consistent with the Arkansas Works framework and we further agree that a minimum of $835 million over 5 years need to be saved from the Medicaid budget and we support further efforts to identify those savings"

The Task Force then also unanimously voted in favor of a subsequent motion as follows:

"We move to task The Stephen Group to assist the task force to find at least $835 million in savings without managed care, with the exception of dental."

Additional conversation between Mr. Stephen and the Task Force clarified that the intent of the subsequent motion was to identify savings without capitated, full-risk managed care, except for dental.

Thus, given that the authorization of the Task Force expires on December 31, 2016, and the Task Force may issue a final report at the time, the Task Force recommends, in addition to the above two motions that were approved on December 16, 2015, that it:

- Support the Governor's efforts to negotiate waivers CMS consistent with the Arkansas Works framework;
- Conduct further hearings consistent with its statutory charge; and,
- Make specific recommendations that will identify a minimum of $835 million in savings over 5 years