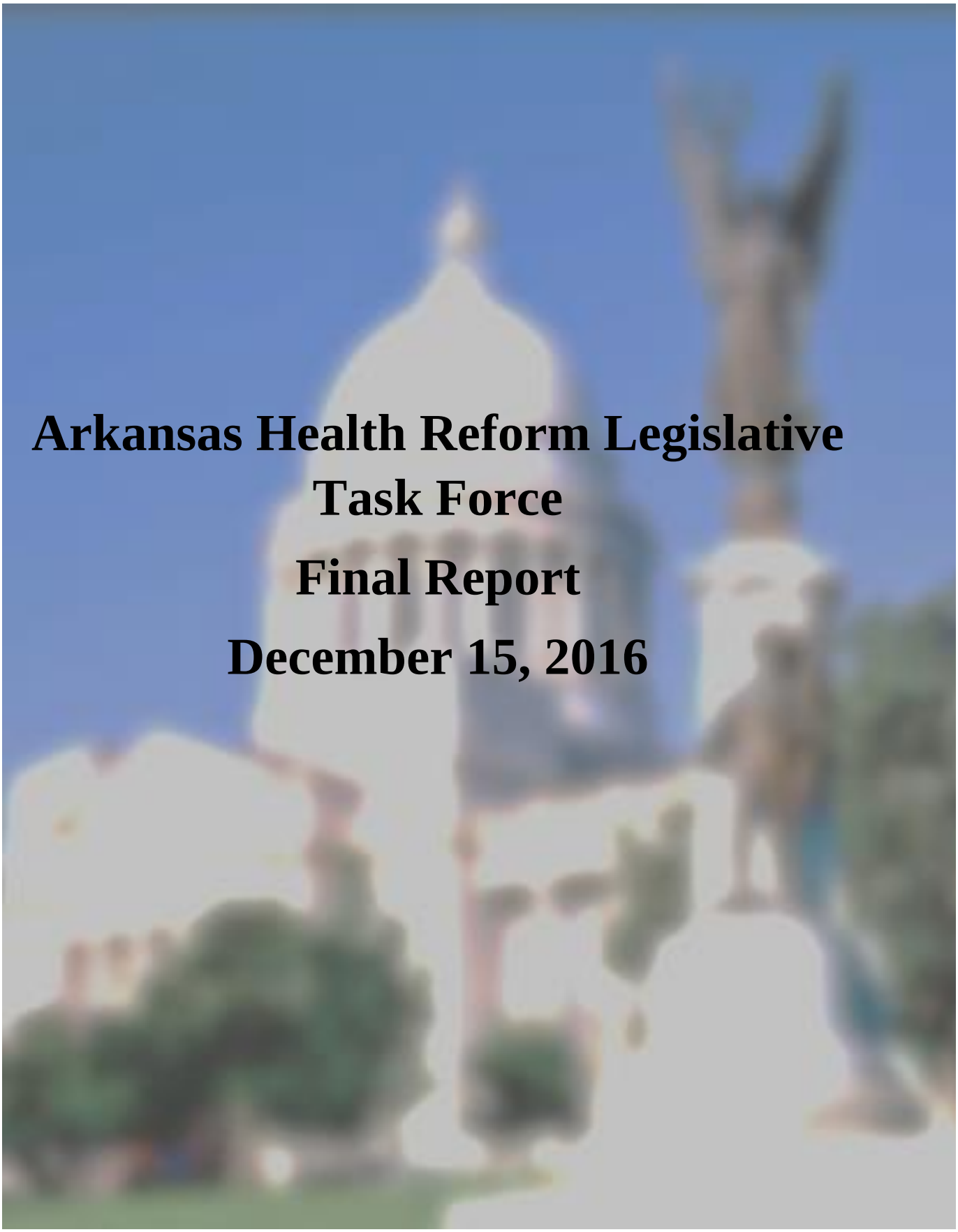

Arkansas Health Reform Legislative Task Force

Final Report

December 15, 2016

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The Task Force would like to specifically recognize and thank the many stakeholders who offered testimony and assistance over the past few months. We would also like to thank the Arkansas Department of Human Services for its steadfast commitment in helping us achieve our mission, and our consultant, The Stephen Group, for their outstanding research, analysis and expertise in addressing our many issues.

I. Background

Legislative Authorization and Intent

In the 2015 session the Arkansas Legislature passed a bill, known as the Arkansas Health Reform Act of 2015, that 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."

As the authorization of the Health Care Independence Program (HCIP) was set to expire on December 31, 2016, the Arkansas Health Reform Act of 2015 required 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 preliminary report was filed on December 15, 2015.

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.

Finally, the Task Force issued an RFP for the services of a Medicaid consultant to assist it in its research, analysis and in meeting its statutory objective. Through a competitive process, The Stephen Group, LLC. was selected to provide expert consulting services.

II. Task Force Findings

A. Key Findings: Private Option (PO)/HCIP

- Through September 2016, there were approximately 293,882 adults eligible since the passage of the Health Care Impendence Program (now Arkansas Works) (270,573 Private

Option (PO) and 23,309 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 M (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.

- An analysis of claims data among two of the three PO insurance carriers indicates a substantial increase in costs per claims by enrollees, driven largely by cost increases in the pharmacy benefit.
- PO has achieved state general fund savings through the use of shifting populations from traditional Medicaid (70% federal match) to PO/Arkansas Works (95% federal match). These populations include:
    - Medically needy
    - Aged blind disabled
    - SSI disability
    - Pregnant women
- Additionally, after the establishment of the PO, the state has achieved general fund savings through the discontinuation of the following programs:
    - ARHealthNetwork
    - Family Planning
    - Tuberculosis
    - Breast and Cervical

B. 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 are 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.
- In the past, 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.
- Among individuals receiving services for developmental disability, 96% of Waiver Spending is for Supportive Living
    - 20% of beneficiaries spend less than $20,000 – 80% less than $70,000
- The Stephen Group conducted a survey of the families of developmentally disabled individuals to determine the services they prefer. This survey found:
    - Supportive Living is the most highly valued service
    - Respite and Case Management were in respondents top 5 almost as often as Supportive Living, Supportive Employment is a distant fourth
- Wait list survey respondents seemed to value the full range of benefits – all services ranked in the top-5 for a substantial number of people
- 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.
- The Task Force found that the Rehabilitative Services for Persons with Mental Illness (RSPMI) Behavioral Health benefits program had significantly increased in costs for several years prior to 2014 without a corresponding decrease in high cost psychiatric inpatient and residential services. In 2014, DHS/DBHS attempted to introduce effort to bring accountability to these services. For a variety of competing interests, the necessary Rules and Benefits changes were not implemented at that time.
- The Stephen Group conducted a detailed claims and services code level analysis on utilization for 2014. Findings indicated a large number of beneficiaries (40,000+) using an unreasonably low amount of services for BH Rehabilitative level services, a small group of consumers using an abnormally high amount of services clustered among few providers, and an unusual pattern of RSMPI services being delivered in school settings.
- Simultaneous to the RSPMI claims/code analysis, the Office of the Medicaid Inspector General (OMIG) was engaged in a multi-state analysis of a certain Group Psychotherapy service billing code that indicated that Arkansas utilization of this service far surpassed that of neighboring states at a substantially higher rate. In reviewing the school based claims data with OMIG, there was a correlation with the use of this code regarding overutilization.

- OMIG reported their recommended changes to the Group Psychotherapy benefit (daily and annual unit caps and a rate reduction) to the Task Force, who supported OMIG moving forward through the necessary rules and rate changing processes. This will result in an expected savings of $15 million in FY 17.

- DHS has implemented a comprehensive pharmacy reform that resulted in an anticipated $52.5 M annual savings.
- Two Committees of the Task Force were appointed to solicit testimony, conduct further research and develop findings and recommendations relative to Diagnostic Related Groups (DRG) and Human Development Centers (HDC). Their recommendations are listed below.

C. Key Findings Across Both 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.
- 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 is working to improve the eligibility system today, but has in the past experienced a significantly increased workload to verify eligibility and enroll expanded Medicaid applicants, with little increase in resources. DHS is still in the transition from the legacy Medicaid administration system to the new systems.
- There have been delays in the updating of Curam – the eligibility system software – and that has caused problems in the past with timely eligibility reviews.
- 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 flagged a substantial number of out of state addresses for participants of both PO and Traditional Medicaid (Traditional Medicaid 22,781, PO 20,110). 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.
- 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 the 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.

D. Task Force Votes

- The Task Force voted to pass the following resolutions and objectives at the December 22, 2015 meeting:
    - "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"
    - "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."
    - Support the Governor's efforts to negotiate waivers CMS consistent with the Arkansas Works framework
    - Conduct further hearings consistent with its statutory charge

- Make specific recommendations that will identify a minimum of $835 million in savings over 5 years

E. Arkansas Works

On June 28, 2016, Governor Hutchinson submitted the Arkansas Works waiver to the federal Secretary of Health and Human Services Sylvia Burwell. That waiver can be found here: https://www.medicaid.state.ar.us/Download/general/comment/ARWorksAppFinal.pdf. On December 8, 2016, the Arkansas Works waiver received final approval by the Secretary.

The Arkansas Works waiver, in its entirety, will make the following changes in Medicaid for those individuals newly eligible for Medicaid under the Affordable Care Act:

- Premium Assistance to those with employer sponsored health care – this change would require those with access to health insurance through their employer to take that coverage, with Medicaid providing coverage for premiums sharing, deductibles and co-payments
- Cost sharing for those not in poverty – this change would require all those between 100-138% of the federal poverty limit to pay 2% of their income in cost sharing payments; failure to pay premiums would result in the loss of enhanced benefits
- Elimination of retroactive eligibility – this change would cause eligibility to start upon application for Medicaid coverage, and end the practice of having Medicaid pay claims for up to 90 days prior to applying for Medicaid
- Work referrals – this change would give work referrals to the Department of Workforce Services to all individuals who apply for Medicaid and have an income less than 50% of the federal poverty limit and would have DHS offer work training opportunities to those of all incomes
- Wellness promotion – beneficiaries would be required to have a wellness visit with a primary care provider (PCP) within the first year or lose enhanced benefits
- Elimination of the Health Independence Accounts – this change would eliminate Health Independence Accounts under the Private Option, which were determined to be an inefficient way of promoting consumer choice and personal responsibility among beneficiaries

These change were put in place with the goal of enhancing accountability, personal responsibility and shifting the focus of the newly eligible, able-bodied population to focus on work participation.

F. Findings relative to Financial Impact and Cost Shift

Through the Private Option/Arkansas Works, the state has been able to shift state costs away from the traditional Medicaid program by moving populations to the newer programs, which offer a higher federal matching rate. This shifting occurred through both eliminating some

programs in the traditional Medicaid program that were then picked up in expansion or by moving some of those who were eligible for traditional Medicaid who were also eligible for expansion to the newer program.

Private Option Impact on Traditional Medicaid Spending

The following table shows the apparent impact of the PO on the general fund, through reductions in expenditures from traditional Medicaid, other impacts on expenditures, and new revenue from premium taxes and other economically sensitive taxes, based on data available from DHS.

Projected Aggregate Private Option Impact (SFY 2017-2021)							
(all figures millions $ unless otherwise indicated)							
		2017	2018	2019	2020	2021	2017-2021
Private option expenditures (all funds)		1,721	1,820	1,924	2,035	2,152	9,652
Impact on State Funds							
Impact on state expenditures	**State match on Private Option**	43	100	125	173	215	656
	State fund savings from optional Medicaid waiver programs discontinued after the establishment of the PO	(21)	(22)	(23)	(25)	(26)	(117)
	State fund savings from cost-shifting from traditional Medicaid to PO	(91)	(96)	(101)	(106)	(111)	(504)
	Administrative costs	3	3	3	3	3	14
	Reductions in state fund outlays for uncompensated care	(37)	(39)	(41)	(43)	(45)	(203)
	Total impact on expenditures	**(104)**	**(54)**	**(37)**	**3**	**37**	**(154)**
Impact on state revenues	**Increase in premium tax revenue**	22	23	25	26	27	123
	Increase in collections from economically-sensitive taxes (4%)	67	69	72	74	77	360
	Total impact on revenues	**89**	**92**	**97**	**100**	**105**	**483**
Net impact on state funds		**193**	**146**	**133**	**97**	**68**	**637**

Private Option Impact on Traditional Medicaid Enrollment

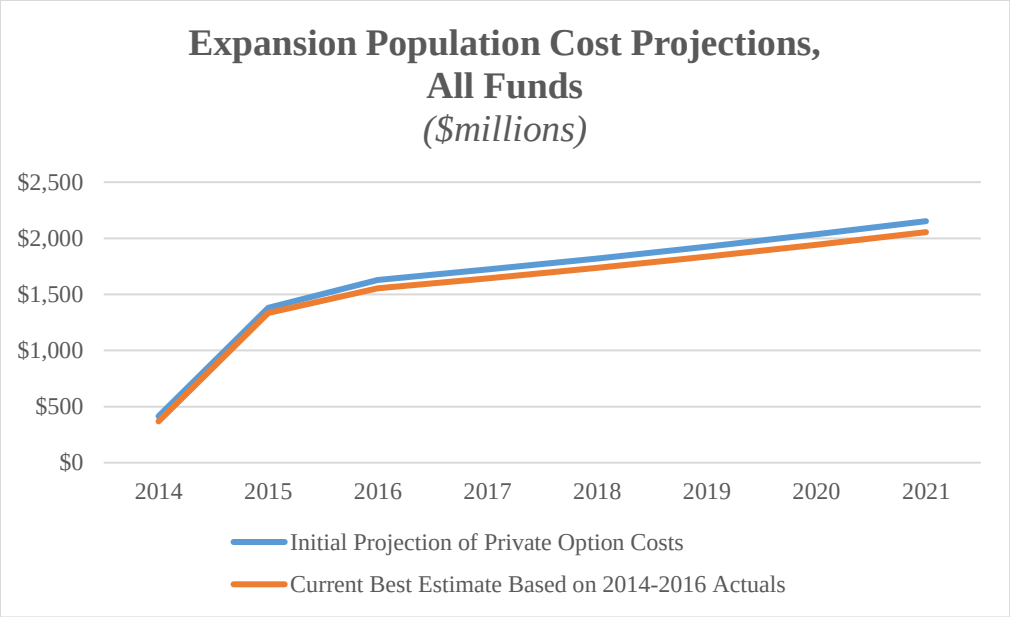
The following analysis shows the changes in enrollment in different Aid Categories after the establishment of the PO. The 'Other' aid category shown below, which includes ARHealthNetwork and the several waiver programs that were discontinued after the PO was established, disappears.

Aid Category	Average Enrollment 2011-2013	Average Enrollment 2014-2016	% Change	Average Annual Cost of Aid Category (2016)
Low Income Children & Pregnant Women	306,580	347,165	13.2%	$3,130
SSI Disabled	115,955	108,344	-6.6%	$12,357
ARKids	76,426	58,281	-23.7%	$1,526
Other	61,503	754	-98.8%	$14,770
Medically Needy Aged	61,426	64,205	4.5%	$11,390
Medically Needy Families & TANF	27,644	41,997	51.9%	$2,991
Medically Needy Disabled	28,805	30,795	6.9%	$16,043
SSI Aged	6,644	5,700	-14.2%	$6,644
Adoption and Foster Care	7,091	8,550	20.6%	$9,929
Spenddown Disabled	1,596	205	-87.2%	$93,929
Spenddown Families & TANF	534	13	-97.7%	$76,550
Newly Eligible Adults	19	249,057		$5,811

Current Cost Projections

Currently, the cost of the Private Option has held slightly below the initial cost estimates when the program was first implemented. There was some concern about costs, driven largely by overruns on the Medically Frail population.

Maintaining the PO cost under the estimates is critical, since the Private Option was included in a federal waiver that requires a cap of federal participation, meaning state taxpayers would be responsible for costs above the cap.



Expansion Population Cost Projections, All Funds ($millions)								
	2014	2015	2016	2017	2018	2019	2020	2021
Initial Projection of Private Option Costs	$414	$1,379	$1,627	$1,721	$1,820	$1,924	$2,035	$2,152
Current Best Estimate Based on 2014-2016 Actuals	$368	$1,335	$1,553	$1,643	$1,737	$1,837	$1,943	$2,054

III. Task Force Recommendations

A. General Statement Regarding Recommendations

Over the duration of the Task Force, there has been substantial change in the nature of the Medicaid program. The Private Option was replaced by Arkansas Works, with many changes recommended by this body.

The Task Force commends the many individuals, groups and fellow legislators that offered their ideas, opinions and knowledge. The list of those who testified, submitted information and made personal contact to Task Force members was both expansive and comprehensive, and added a great deal to the work of this effort. In particular, the Task Force would like to offer our sincere thanks to the Department of Human Services for its assistance and responsiveness.

However, under the limitations of time and bandwidth, there was only so much time for this group to make good on the charge of the Legislature to advance change. With the termination of this group, we offer a number of substantive suggestions to continue to "[e]xplore and recommend options to modernize Medicaid programs serving the indigent, aged, and disabled."

Many of these recommendations tie directly to the responsibility the Task Force assumed to work to identify savings in the state's Medicaid program totaling, at a minimum, $835 million. Others relate to program improvements to advance the goals of the Medicaid program and improve beneficiary health status efficiently and effectively.

B. Arkansas Works: Continued Review

Clearly, there will be a number of opportunities to reshape the Medicaid program in 2017 and beyond. The changes taking place at the federal level will undoubtedly impact Arkansas in ways that are currently unknowable.

The incoming administration has clearly signaled two top priorities: repealing the Affordable Care Act and enhancing state flexibility through block grants. Both of these changes, if implemented would have a dramatic impact on the landscape of both traditional Medicaid and Arkansas Works.

Should the Medicaid program become a true block grant, many of the prior ideas raised during Task Force hearings and in prior reports could be implemented. This includes such items as:

- Work requirements for eligibility for able-bodied adults
- A Wellness Scorecard for incentivizing prevention
- Tailoring health benefits to meet individual needs
- Co-payments for inappropriate use of services (such as non-emergent ER visits)
- Cost sharing among the able-bodied adult population
- Tailoring eligibility standards to mitigate health disparities
- Payments to employers for insuring workers who might otherwise be Medicaid eligible
- Asset tests, and asset limits, for some Medicaid applicants
- Benefit limits for able-bodied adults

These are merely a small sample of potential changes that might become available to Arkansas Medicaid. Clearly, federal action will drive much of the program's future, so a great deal of vigilance by the Legislature will be necessary over the coming months to ensure that the state is prepared to move quickly to adapt and adjust to the new landscape.

C. Traditional Medicaid Program Reform

Traditional Medicaid in Arkansas's annual growth of 5% represents a pathway that requires reform, as it is the largest program in state government and on its current trajectory, threatens the future viability of other critical programs across the state. Instituting cost controls that limit Medicaid program growth are essential to the state's long-term solvency.

The Task Force has resolved to support the Governor's proposed $835 million savings initiative over five years to identify sufficient state general funds to support the state share of Arkansas

Works. Beyond this, the Task Force established a benchmark of $1 billion in savings over five years in order to take the necessary steps to limit program growth to ensure the long-term future of the Medicaid program.

These savings targets inform the basis for a number of the following recommendations in this report.

Through an analysis of program data, the Task Force identified the primary cost drivers among the high cost populations, many of which are not managed in any way. By isolating these areas, the Task Force has been able to work with providers and stakeholders, many of whom have submitted cost savings plans on their own.

Additionally, based upon findings and recommendations by this Task Force, DHS is moving forward with a number of reforms and program changes that will assist in identifying these savings, operating in a very proactive manner.

These changes, including major organizational changes at DHS, help to reduce the need for more dramatic changes by the Legislature, particularly in the areas with long-term populations, who critically need appropriate Medicaid services.

D. Recommended Behavioral Health Program Savings and Investments

The Task Force recommends and supports the Arkansas Department of Human Services moving forward transforming the Rehabilitative Services for Persons with Mental Illness (RSPMI) benefit into an evidence based/best practice Adult and Children/Adolescent Mental Health Rehabilitation Option benefit and that access to the revised benefit should be based on identified diagnoses and an independent assessment.

A report to the Task Force last year included recommendations for revision of the RSPMI Behavioral Health benefits program to an acuity based program eligibility model based on independent assessment, identified Adult and Child Behavioral Health services, evidenced based practices, and an increase in targeted services for adults, children and youth that are community based and designed to decrease reliance on expensive psychiatric inpatient for adults and residential services for children/youth, plus care coordination and an identified Behavioral Health home.

To a large extent, these recommendations mirrored the efforts of DHS/DBHS in 2014. Specific changes include:

- Redefine the SED and SMI category based on clinically-driven parameters (Counseling, Tiers II and III)
- Implement evidence based practices to a greater degree
- Implement independent assessment

- Reduce reliance on Inpatient Psychiatric Hospitalizations and Residential Treatment through Rules, process, approval changes and further development of Systems of Care and Wrap Around for SED children/youth
- Create a Therapeutic Residential services per diem benefit that addresses the 911 population
- Increase process efficiency and reduction of administrative burden upon providers
- Refine clinical eligibility for school based BH Outpatient services
- Reduce utilization of RSPMI Collateral and MHP/MHPP Intervention units (90887 HA, 90887 HA UB)
- Reduce utilization of Group Outpatient RSPMI benefit (90853)
- Ensure that multiple at school services rehabilitative level services and intensive level services in the school setting are necessary
- Assure that school- based programs are actually being operated during the summer while schools are closed or moved to another location without proper coding
- Care coordination and health homes for those served by DBHS is under consideration through either a managed fee for service or provider-led Accountable Care Organization model

As a result of the work of the Task Force, Medicaid Behavioral Health Services will improve in quality and outcomes, increase appropriate and effective use, and decrease costs. Savings of $15 million are expected in FY 2017 as a result of the OMIG led changes to the Group Psychotherapy benefit. Total savings of $215 million are projected for Behavioral Health Services from SFY 2018 to SFY 2022, inclusive of projected costs for Independent Assessment and Care Coordination investments.

E. Recommended Developmental Disability Program Savings and Investments

The Task Force recommends and supports the Arkansas Department of Human Services moving forward with a new waiver for a comprehensive revision of the Developmentally Disabled Services (DDS) Alternative Community Services waiver that is based on independent assessment, three levels of care, an institutional cost limit, tiered payments, and focuses on employment and community choices.

The Task Force found that DHS/DDS program expenditures were concentrated in the Human Development Centers, Alternative Community Services Waiver, and the Developmental Day Treatment Clinic (DDTCS) and Child Health Management Services (CHMS) programs that deliver Occupational, Physical, and Speech Therapy and Language (OT, PT, SL) state plan services.

Findings included a lack of independent assessment and authorization for OT, PT, and SL services, the volume of services was provider driven, and there were no annual benefit limits for

these services. The Task Force also found that the current waiver plans of care and cost were not based on need for services derived from an independent assessment, that the waiver had an upper payment limit of $176 a day ($64,064 annually) regardless of level of need for services, and that case management was not independent from the waiver services providers.

The Task Force recommends that DHS/DDS implement a three tier based waiver, similar to the current Tennessee Developmental Disabilities Home and Community Based Services waiver, as follows: 1) Essential Family Supports when a person chooses to live at home with their families (capped at $15,000 per year); 2) Essential Supports for Employment and Independent Living when a person chooses to live independently in the community and wishes to be employed (capped at $30,000 per year plus $6,000 for emergency situations); and, 3) Comprehensive Supports for Employment and Community Living when a person requires more complex services and supports to live in the community and be employed (capped between $45,000 and $60,000 per year). The Tennessee waiver uses an independent assessment to determine a person's tier of care.

The necessary Rules changes for the OT, PT, and SL state plan services (90 minutes per week each for these services) have been filed and reflective of the benefits of the DHS reorganization implemented by Director Gillespie related to integrated Medicaid policy development and shared services. Rule changes are scheduled to be voted on by the Arkansas Legislative Council on 12/16/16 for implementation on 7/1/2017. The Task Force recommends these Rule reforms.

The Task Force also recommends the implementation of an independent assessment for tier based DDS Home and Community Based Services waiver services and the implementation of Occupational, Physical, and Speech and Language therapy caps based on an Independent Developmental Screen that are expected to result in savings of $205 million between SFY 2018 and SFY 2022, including $8 million total costs for the independent assessment. Care coordination costs for the people served by DDS are in the process of being determined.

F. Recommended Care Management Model for BH and DD

The Task Force recommends and supports the Arkansas Department of Human Services developing and implementing a comprehensive approach that provides care management and coordination to all behavioral health and non-institutional intellectual and developmentally disabled populations eligible for Medicaid services. Care management includes the identification, stratification, and prioritization of high risk and complex individuals for the coordination of evidence based services, supports, and interventions that are provided in a cost effective and non-duplicated plan of care, and include provider payment accountability and risk for outcomes and quality.

The Task Force identified the critical importance of the implementation of comprehensive care coordination strategies for complex, high cost Aged, Blind, and Disabled beneficiaries served by Arkansas' Behavioral Health, Developmental Disabilities and Long Term Care services regardless of whether DHS evolves to a managed fee for service, managed care, or maintenance of the fee for service system in place.

The Task Force's assessment of the Arkansas Medicaid program as a whole found that comprehensive care coordination for the high cost BH and DDS populations was fragmented in relation to other medical services, resulting in a lack of integrated care for these individuals, and that there is a lack of alignment of financial incentives and risk among all providers serving the high cost populations. Importantly there are no incentives and risk for high quality outcomes and cost savings resulting from improved health status in the current services delivery model.

The Task Force has reviewed and discussed the care coordination aspects of the PCMH, "Diamond Care"/managed fee for services, managed care models and accountable care organizations, including projections of savings for SFY 2018 through SFY 2022.

Whatever the final model selected, the Task Force recommends that the model work to integrate and coordinate the care of each individual receiving Medicaid services, instead of continuing the siloed approach to care that results in uncoordinated care, increases cost and produces health outcomes that could be improved.

G. Recommended Long Term Care Program Savings and Investments

The Task Force supports the memorandum of understanding entered into by the Arkansas Department of Human Services and Arkansas Health Care Association on Mary 20, 2016 to achieve $250 Million in savings over a 5-year period through improved, high quality, person-centered, and cost-efficient Long Term Services and Support care delivery reform. The Task Force supports reforms to ensure supports and services in the community are cost effective, effectively serve transitions among care settings, and eliminate fragmentation and duplication in service coordination and delivery. Other reforms contained in the memorandum of agreement, including independent assessment, tiered levels of care, acuity-based and risk adjusted, and effective care management, coordination, and transition strategies, designed to enhance the most cost effective and quality enriched care are also supported.

Governor Hutchinson and the Arkansas Health Care Association entered into a memorandum of understanding (http://ee-governor-2015.ark.org/images/uploads/160520_MOU.pdf) to work closely to expand the use of community based care. This effort would result in expanded community choices and savings of $250 million over five years, while also ensuring a better continuum of care for those who qualify for long-term care services.

The Task Force fully supports these efforts and recommends they continue. The Legislature will need to monitor the progress of this MOU to ensure that this agreement yields the quality and cost savings included.

H. Recommended Pharmacy Program Savings

The Task Force recommends and supports the Arkansas Department of Human Services continuing implementation of the pharmacy quality and programmatic savings initiatives to achieve $262.5 Million is savings over a 5-year period through expansion of the preferred drug list (PDL), expansion of the CAP initiative, comprehensive management of antipsychotic medications by a Department psychiatrist for adults and children, limiting waste and clinically managing patients requiring hemophilia factor products, and reconfiguring reimbursement structure and rates for retail pharmacy providers. These initiatives are either fully underway or in the final stages of approval (CMS or State) prior to full implementation.

Prescription drug coverage is essential to an effective Medicaid program. However, Prescription spending is growing faster than other medical expenses, 12.9% in 2014 and 9% in 2015, an unsustainable rate. DHS pharmacy program costs over $400 million per year made up of over 5 million claims. The Task Force supports the ongoing efforts by DHS to implement the pharmacy quality and programmatic savings initiatives above.

The total annual estimated pharmacy savings are broken down as follows:

Total Annual Savings	**Savings $ millions**	**Effective Date**
PDL expansion	$10	Q4 2016
CAP expansion	$1	Q1 2017
Comprehensive antipsychotic management in adults (Abilify generic)	$20.5	Ongoing
Antipsychotic review (7,8,&9year olds)	included	Q1 2017
Manual Review Antidepressants (<4year olds)	included	Q1 2017
Manual review long acting antipsycotics	included	Q2 2016
Antipsychcotic review (10,11,&12year olds)	included	Q4 2017

Hemophilia factor waste and clinical management	$1	Q1 2017
Retail Pharmacy Reimbursement Reconfiguration	$20	Q2 2017
Total	$52.5	

I. Recommended Dental Managed Care Savings

The Task Force recommends that the Legislature closely monitor the implementation of managed care for dental services in Medicaid. Notably, ensuring network adequacy, vendor oversight and seeing that the Department meets its cost saving estimates.

The Dental Managed Care RFP was issued, responses received, and evaluated. An announcement of the anticipation to award contracts to two dental managed care organizations is expected imminently. The contracts will be submitted to the Legislature for review and contracts are anticipated to start in quarter one 2017. The dental managed care plans are expected to enroll members and begin services effective 1/1/18.

Currently, DHS offers dental providers a deferred compensation package that offers providers tax savings. As part of the RFP, DHS asked bidders to respond to how they would address deferred compensation. Dental providers have threatened to not participate in the dental MCO networks if deferred compensation is not addressed. DHS needs to monitor network adequacy as a result of this issue.

It is important for DHS to understand and plan for the fundamental shift in moving from fee for service oversight to managed care health plan oversight. DHS staff needs to be reorganized and retrained so that their focus shifts to health plan contract oversight and monitoring for dental managed care. If the dental MCO contracts are not monitored properly, savings from the move to managed care could be jeopardized.

J. Patient-Centered Medical Home (PCMH)

The Task Force recommends that DHS should expand the Patient-Centered Medical (PCMH) Home Program to include more enrollees and services, and should share

information on provider Episode-of-Care (EOC) performance with primary care practices participating in the PCMH program.

The Task Force identified several ways that the patient-centered medical home (PCMH) program could be adjusted to increase potential cost savings.

- Increasing the number of beneficiaries covered by PCMH by lowering the required number of beneficiaries served by a practice to include more primary care providers (PCPs).
- Increasing the effectiveness of PCMH by providing PCPs with information about the cost-effectiveness of Principal Accountable Providers associated with Episodes of Care.
- Increasing the services managed by PCMH by including low-level behavioral health services in the primary care office.

DHS is already implementing certain program changes to increase the cost and clinical effectiveness of the PCMH program, including the following:

- Lowering the required number of beneficiaries served by a practice, which will make more PCPs eligible and align with the federal Comprehensive Primary Care Plus (CPC+) initiative.
- Doing additional outreach to bring more PCPs into the program.
- Authorizing billing for behavioral health services on the same day and in the same location as primary care services.

While the agency anticipates that these initiatives will result in additional cost savings, the specific level of savings anticipated has not been identified.

K. Five Year Net Savings Plan for Traditional Medicaid along with program savings and investment recommendations

The Task Force recommends and supports that the Arkansas Department of Human Services develop and implement a Five-Year Medicaid Program Savings Plan that is in excess of the $835 million in net savings to trend proposed by Governor Asa Hutchinson starting no later than July 1, 2017. Savings must be achieved through an increase in care management and coordination resulting in improved outcomes, quality, appropriate utilization based on need, reduction of duplication and unnecessary services, and the introduction of value based purchasing strategies and some degree of provider risk. The Department of Human Services will provide a Comprehensive Medicaid Budget Savings Dashboard Report tracking savings to trend to the Bureau of Legislative Research every quarter commencing September 1, 2017 and thereafter for five years.

This analysis, by The Stephen Group, considers three primary models for reducing spending in Arkansas' traditional Medicaid program below:

1) The "Current Model" – a set of benefit modifications and program adjustments that have been identified over the last 2 years with the Task Force.
2) A Provider-led "Collaborative Care Organization" model that has been put forth by the DHS for the behavioral health and developmental disability enrollee populations.
3) A capitated managed care model for the behavioral health and developmental disability enrollee populations that is being analyzed for comparison

In the following sections, the savings assumptions for the different models and the anticipated savings are described. For all of the models, the baseline is a 5% annual cost increase starting with SFY 2015 actual expenditures.

Baseline and Savings Models

The following table shows the baseline spending projection, along with the spending projections with the implementation of the different cost savings models. The baseline and cost savings model projections are shown with and without Arkansas Works expenditures.

All Figures in $Millions; Years are SFY								
Model/ Program	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2017 – 2021**	**2018 – 2022**
Baseline, Traditional Only	$5,379	$5,648	$5,930	$6,227	$6,538	$6,865	$29,722	$31,208
"Current Model", Traditional Only	$5,302	$5,495	$5,757	$6,026	$6,322	$6,649	$28,902	$30,249
Provider-Led CCO for BH and DD, Traditional Only	$5,302	$5,495	$5,757	$6,026	$6,227	$6,549	$28,806	$30,053
Capitated Managed Care for BH and DD, Traditional Only	$5,302	$5,495	$5,757	$5,951	$6,202	$6,523	$28,707	$29,928
Arkansas Works	$1,721	$1,820	$1,924	$2,035	$2,152	$2,276	$9,652	$10,207
Baseline, Traditional and AW	$7,100	$7,468	$7,855	$8,262	$8,690	$9,141	$39,374	$41,415
"Current Model", Traditional and AW	$7,023	$7,315	$7,681	$8,061	$8,474	$8,925	$38,554	$40,456
Provider-Led CCO for BH and DD, Traditional and AW	$7,023	$7,315	$7,681	$8,061	$8,379	$8,824	$38,458	$40,260
Capitated Managed Care for BH and DD, Traditional and AW	$7,023	$7,315	$7,681	$7,986	$8,354	$8,798	$38,359	$40,135

Current Model

The following table describes the cost saving strategy for each program under the "Current Model", and the assumptions regarding the timing of the cost savings and any administrative costs that will need to be borne by the agency to affect such changes.

	Savings Strategy	**Savings Timing**	**Admin Considerations and Costs**
DD	$18M per year in therapy caps; $14M/yr. from screenings for children[1]; $17M/yr. from independent assessment and tiers for waiver services	therapy caps and screenings for children begin July 1, 2017 (savings over 5 years); independent assessment and tiers start July 1, 2019	$2M per year for independent assessments starting July 1, 2019
BH	Updated outpatient policy, reduction in inpatient from independent assessment	Begins July 1, 2017; savings over 5 years	$108M investment over 5 years for independent assessment and care coordination
Dental	$5M per year in savings from capitated managed care	Begins Jan 1, 2018	
Elder	Industry MOU to save $250M over 5 years	Begins July 1, 2016; savings evenly spread across 5 years; assume $50M/yr. savings continues into SFY2022	None
Low-cost	No program changes		
Pharmacy	$250M in savings	Begins July 1, 2016; savings evenly spread across 5 years	

The following table shows the anticipated savings from the programmatic changes already being implemented.

[1] Note: The DDTCS and CHMS providers have a lower savings estimate of $5 Million per year due to the screening changes

Savings by year and program	SFY17	SFY18	SFY19	SFY20	SFY21	SFY22	SFY17-21	SFY18-22
DD Savings - Therapy Caps	$0	$18	$18	$18	$18	$18	$72	$90
DD Savings - Screenings for Children	$0	$14	$14	$14	$14	$14	$56	$70
DD Savings - Independent Assessment and Tiers/Waiver Changes	$0	$0	$0	$17	$17	$17	$34	$51
DD Cost - Independent Assessment	($0)	($0)	($2)	($2)	($2)	($2)	($6)	($8)
Net DD Savings	$0	$32	$30	$47	$47	$47	$156	$203
BH Savings - Updated Outpatient Benefits Policy	$12	$16	$33	$33	$33	$33	$127	$148
BH Savings - Inpatient	$0	$15	$25	$35	$50	$50	$125	$175
BH Cost - Independent Assessment	($0)	($1)	($2)	($2)	($2)	($2)	($7)	($9)
BH Cost - Care Coordination	($0)	($15)	($21)	($21)	($21)	($21)	($78)	($99)
Net BH Savings	$12	$15	$35	$45	$60	$60	$167	$215
Dental Savings - Capitated Managed Care	$0	$3	$5	$5	$5	$5	$18	$23
Dental Premium Tax	$0	$3	$3	$4	$4	$4	$14	$18
Net Dental All-Funds Impact	$0	$6	$8	$9	$9	$9	$32	$41
Elder Savings	$15	$50	$50	$50	$50	$50	$215	$250
Low-Cost Populations	$0	$0	$0	$0	$0	$0	$0	$0
Pharmacy	$50	$50	$50	$50	$50	$50	$250	$250
Net Fiscal Impact	**$77**	**$153**	**$173**	**$201**	**$216**	**$216**	**$820**	**$959**

If the current programmatic cost saving opportunities that have already been identified are implemented, AR stands to save about $959 million between SFY2018 and SFY2022.

Provider-Led CCO Model

DHS has put forward the concept of provider-led coordinated care organizations for the BH and DD programs. The following table describes the cost saving assumptions for the CCO-based approach proposed by DHS.

	Savings Strategy	Savings Timing	Admin Considerations and Costs
Current strategy	All savings from current strategy as above	As above	As above
DD Provider-led CCO model	Care coordination for DD halo services	5% savings off of halo spend starting year 4	Savings net of admin costs (admin under APCCO/RCCO payment)
BH Provider-led CCO model	Care coordination for BH halo services	5% savings off of halo spend starting year 4	Savings net of admin costs (admin under APCCO/RCCO payment)

The following table describes the projected cost savings from the provider-led CCO model. The starting point for these cost savings are the cost savings from the programmatic changes already identified and described in the previous tables. There remains an opportunity for additional savings within the DD and BH programs through greater care coordination, specifically with respect to the medical and pharmacy benefits (the "halo" spend for the BH and DD populations).

Savings by year and program	SFY17	SFY18	SFY19	SFY20	SFY21	SFY22	SFY17-21	SFY18-22
All cost savings from current model	$77	$153	$173	$201	$216	$216	$820	$959
DD Provider-Led CCO Model Savings	$0	$0	$0	$0	$12	$13	$12	$25
DD Provider-Led CCO Model Premium Tax	$0	$0	$0	$0	$26	$27	$26	$52
Net additional DD all funds impact	$0	$0	$0	$0	$38	$40	$38	$77
BH Provider-Led CCO Model Savings	$0	$0	$0	$0	$28	$29	$28	$57
BH Provider-Led CCO Model Premium Tax	$0	$0	$0	$0	$30	$31	$30	$61
Net additional BH all funds impact	$0	$0	$0	$0	$58	$61	$58	$118
Net Fiscal Impact	**$77**	**$153**	**$173**	**$201**	**$311**	**$316**	**$915**	**$1,154**

If the DD and BH provider-led CCO models, and the current programmatic cost saving opportunities that have already been identified are implemented, AR stands to save about $1,154 million between SFY2018 and SFY2022. Note that this assumes $61 Million in premium tax revenue, which DHS is currently reviewing the issue to determine if future legislation is required should the state move in this direction.

Capitated Full Risk Managed Care Model

Recognizing that most states are moving toward greater use of capitated managed care in their Medicaid programs, TSG has developed the following projections of capitated full risk Medicaid managed care for the BH and DD populations. The following table describes the cost saving assumptions for the capitated managed care approach.

	Savings Strategy	**Savings Timing**	**Admin Considerations and Costs**
Current strategy	All savings from current strategy as above	As above	As above
DD Capitated Managed Care	Care coordination for DD halo services	8.07% savings off of halo spend starting year 3	Savings net of admin costs (admin under MCO payment)
BH Capitated Managed Care	Care coordination for BH halo services	8.07% savings off of halo spend starting year 3	Savings net of admin costs (admin under MCO payment)

The following table describes the projected cost savings from the capitated managed care model. As above, the starting point for these cost savings are the cost savings from the programmatic changes already identified and described in the previous tables.

Savings by year and program	SFY17	SFY18	SFY19	SFY20	SFY21	SFY22	SFY17-21	SFY18-22
All cost savings from current model	$77	$153	$173	$201	$216	$216	$820	$959
DD Capitated Managed Care Savings	$0	$0	$0	$19	$20	$21	$39	$59
DD Capitated Managed Care Premium Tax	$0	$0	$0	$24	$26	$27	$50	$77
Net DD additional all funds impact	$0	$0	$0	$43	$45	$48	$88	$136
BH Capitated Managed Care Savings	$0	$0	$0	$3	$45	$47	$48	$96
BH Capitated Managed Care Premium Tax	$0	$0	$0	$28	$30	$31	$58	$89
Net additional BH all funds impact	$0	$0	$0	$32	$75	$78	$107	$185
Net Fiscal Impact	**$77**	**$153**	**$173**	**$276**	**$336**	**$342**	**$1,015**	**$1,280**

If the DD and BH capitated managed care models, and the current programmatic cost saving opportunities that have already been identified are implemented, AR stands to save about $1,280 million between SFY2018 and SFY2022.

IV. Other Recommendations

A. Eligibility and Enrollment Framework Project

The Task Force recommends that the Arkansas Legislature continue to monitor progress and receive timely updates to ensure the successful award and implementation of the Arkansas Medicaid Integrated Eligibility - Benefits Management System (IE-BM).

DHS has hired a consultant, Gartner, to assess the systems and make recommendations to enhancing the EEF project. It will be incumbent upon the Legislature to monitor this closely, as the DHS has worked to reduce the backlog successfully, but must also ensure that the Department moves forward effectively on resolving the system issues. DHS currently is prepared to issue an RFP on this project, and should check in with the Legislature throughout the process.

B. DD Wait List

The Task Force recommends that DHS develop a plan to provide services to those on the Developmental Disability Waiting List, either through a benefit structure that is capped with tiered levels of payment for some services, or through the Governor's plan to use Tobacco Settlement Funds to provide services for those currently waiting for waiver services on the Developmental Disabilities Waiting List.

Currently there are over 2,900 individuals on the Arkansas Alternative Community Services Waiver Waiting List. During hearings we received testimony and showing that all of these individuals are receiving Medicaid covered health services and some are also receiving state plan services. However, most are waiting to be approved for home and community based waiver services that they are unable to access today, such as the supportive living benefit. These Medicaid home and community based services are effective and designed to keep individuals from a more expensive and more restrictive setting.

Task Force heard testimony from DHS about the Governor's desire to use Tobacco Settlement funds to provide services for those currently waiting for waiver services. The total amount of Tobacco Settlement dollars available is approximately $8.5 Million. The federal matching funds bring that total to approximately $28 Million dollars. These funds could be used to cover approximately 499 individuals with developmental disabilities with home and community based waiver services in the next fiscal year.

The Task Force supports the Governor's plan to use Tobacco Settlement dollars to provide waiver services for those currently on the developmentally disabled waiting list and encourages DHS to identify cost effective ways of serving even more individuals with developmental disabilities who are eligible for the full array of home and community based waiver services in the future.

C. Organizational recommendations to support DHS Transformation

The Task Force recommends that DHS continue its ongoing efforts to enhance care integration and focusing the organization of the department around bringing services to individuals, as opposed to keeping individuals in distinct systems of care that lead to fragmented services. Additionally, DHS should continue to expand its efforts to leverage greater efficiency of economy of scale through a shared service model that promotes excellence across the Department. The Arkansas Legislature should monitor these efforts to ensure they maximize both quality improvements and cost reductions.

An earlier review of DHS organization found that the structure did not support moving the entire Medicaid program into an integrated services care coordination model. Instead, it prioritized single issue policy making and forced individuals to travel through different systems of care. This led to poor customer service, lack of accountability and coordination and inefficient service delivery.

The Stephen Group's "Recommendations Report" last year recommended that the reorganization of DHS into a value based enterprise be based on elevating the Medicaid program to the DHS Director's Office, including the integration of Behavioral Health, Developmental Disabilities, and Long Term Care under the Medicaid Director, to support integrated policy and budget development, integrated care coordination, and integrated care management. Coordination with Medical Services and Pharmacy would focus on quality, population health, and cost while moving away from a "compliance only" mentality across DHS.

Additionally, TSG recommended that DHS integrate all IT functions under an Information and Data Analytics framework, create an Office of General Council, Office of Communications, and Office of (General) Operations. TSG also recommended that the DHS of the future would require new skills, including IT, data analytics, project management, and contracts management, at comparable market salaries.

In June, 2016 DHS Director Cindy Gillespie announced a business oriented reorganization. Cutting through the silos of separate DHS Division practices for procurement, contracting, human resources management, Information and Technology Director Gillespie implemented the creation of the Offices of Finance, Procurement, Human Resources, Information Technology, Legislative and Intergovernmental Affairs, and General Counsel. The new centralized functional offices will serve the DHS enterprise on a platform of shared services, integrated policy and management practices, reduced duplication and increased efficiency resulting in a net reduction of 25 FTE positions and net savings of $597,583. Simultaneously, Director Gillespie announced the cessation of two vendor contracts resulting in savings of $23 million annually.

In addition, Director Gillespie implemented the reorganization of the Arkansas Medicaid program based on the creation of the position of Deputy Director for Health and Medical Services encompassing the Divisions of Behavioral Health, Medical services, Aging and Adult Services, Developmental Disabilities, and County Operations resulting in an anticipated dramatic improvement of the integration of Medicaid policy, care coordination strategies, budget control and financial planning, and implementation strategies.

The attributes of this reorganization should achieve improved quality, improved care coordination across all high needs populations, and cost savings over the next several years.

DHS has added a national level expert to the Director's Office as Senior Advisor for Medicaid and HealthCare Reform to lead the necessary changes to the Medicaid program's benefits design, purchasing, and population health improvement strategies. All Children and Family services provided by DHS have been reorganized in the Director's Office under the Deputy Director for Children and Families position.

Additionally, Director Gillespie has created a DHS interdisciplinary leadership team to serve as the Department's Policy Review Committee. Much progress in the transformation of DHS into a more integrated, quality and customer oriented and accountable organization has been made over the past year.

The Task Force applauds these efforts and encourages DHS to continue moving forward to reorganize the Department around the needs of the beneficiaries, not the agency. This will lead to less fragmented services, higher quality and cost savings. The Legislature should continue to monitor these efforts closely to ensure that they achieve success and DHS has the tools it needs to continue.

D. Increase State Vaccination Rates

The Task Force recommends that Public Health reevaluate vaccination reimbursement to all providers, including separating the ingredient reimbursement from the professional administration fee for adult vaccinations, and reevaluate the professional administration fee for the free vaccines distributed in the vaccines for children (VFC) program.

The public and individual health benefits of high vaccination rates are well understood. Unfortunately, according to federal data, Arkansas's young children rank behind all but two states, Kentucky and West Virginia. One impediment to provider participation and promotion of vaccinations is the low reimbursement rates. The Task Force believes that the entire vaccine program should be reevaluated to promote more vaccinations.

E. Monthly Prescription Limits

The Task Force recommends the removal of the monthly prescription limit for approved maintenance medications used in approved chronic conditions and maintenance of a monthly prescription limit for all other drugs.

Prescription medications are among the most cost effective medical interventions; this is most true for chronically ill patients requiring maintenance medications to treat their conditions. Currently there are various limits on access to needed prescriptions based on age and site of care. These limitations in pharmacy can cause unintended medical costs which actually outstrip the pharmacy savings from limiting prescription access. The Task Force recommends that prescribers should be alleviated from having to request an extension every six months of benefits for chronically ill beneficiaries requiring maintenance medications.

F. Combating the Opioid Crisis

The Task Force makes the following recommendations to help combat the opioid epidemic in Arkansas. #1) Allow DHS clinical staff to access the State Prescription Drug Management Program (PDMP). #2) Recommend that DHS pharmacy group continue to tighten opioid dispensing limits, measure limited quantities in morphine milligram equivalents, and tightly manage early opioid prescription refill requests. #3) Expand the frequency and number of drug take-back locations. #4) Encourage prescribers to consult the PDMP prior to prescribing drugs of potential abuse.

Opioid overuse, misuse and abuse remain significant threats to public health in the US and in Arkansas. There are positive efforts taking place, which are beginning to show signs of positive impact, but there is a long way to go. Arkansas Medicaid is controlling access to opioids in a logical and progressive manner and seems poised to continue to add new and sophisticated drug utilization management tools as they emerge. As e-prescribing continues to flourish (now approximately 85% of all prescriptions), it is expected that controlled substances will also be primarily e-prescribed. The Task Force recommends a multi-faceted approach to managing this critical reality.

G. State Data Integration/research and decision making

The Task Force recommends that the Arkansas Legislature consider the feasibility of establishing a statewide, comprehensive data sharing system at a public university to coordinate the multiple systems to ensure efficiency and effectiveness of human service programs.

The State of Arkansas has a vested interest in developing a data system to assist the Governor, General Assembly, and other policymakers to make data-driven decisions that result in more efficient usage of taxpayer funds and better matching of state needs with state priorities. To accomplish this goal, the Task Force recommends that the state explore the feasibility of establishing such a data system in cooperation with a research-based public university with a proven track record of analytical research and data system development and implementation.

H. Eligibility Integrity

The Task Force supports the use of both state and publicly available databases to promote public integrity in the Medicaid eligibility process, through an electronic identity, asset and income verification solution pre-and post-eligibility.

There are considerable data available to the State, both currently in agency databases and among private data vendors, which could be used to enhance eligibility screening to ensure that only those who truly meet the criteria to enroll in state benefit programs actually receive them. The Task Force recommends that DHS review national best practices and to use these tools to ensure program integrity of public assistance programs.

I. Certified Agents Role

The Task Force recommends that DHS work with National Association of Insurance and Financial Advisors (NAIFA) and clarify the authority of Exchange Certified Producer (certified agents who are compensated from Insurance plan premiums) to represent and speak on behalf of applicants, when given the proper signed authority and consent by applicants, with DHS on any matter involving enrollment and eligibility for the Private Option or the proposed alternative to replace it.

It is understood that such Exchange Certified Agents will provide assistance governed by the State and Federal guideline as they have abided by for years. The Certified Agents should be included in the development of the DHS guidelines that will govern their role in the enrollment process for all the new plans.

J. Independent Medicaid Provider Rate Review

The Task Force recommends a yearly Medicaid provider rate review conducted by an independent actuarial or professional consulting firm, with experience in Medicaid rate methodology that compares Arkansas' Medicaid provider rates to those of other state Medicaid programs, and Medicare and commercial insurance as well, and to provide an annual report of its findings to DHS and the legislature for review and consideration.

K. Medicaid Fairness Act

The Task Force supports amending certain provisions of the Medicaid Fairness Act to allow prior authorizations to be based on recognized standards of evidence-based practice or professionally recognized standards for health care. Moreover, the Task Force supports legislation making it clear that DHS is not required to promulgate rules to incorporate recognized standards of evidence-based practice or professionally recognized standards of care that practitioners use in determining medical necessity or rendering medical decisions, diagnoses, or treatment.

L. Health Disparities and Access

The Task Force supports cost effective policies that serve to reduce health disparities, increase access to health care and allow for appropriate use of health care services for those eligible for Medicaid

The Center for Disease Control and Prevention's "national data on health disparities indicates that heart disease, cancer, stroke, diabetes, and unintentional injuries are the leading causes of death among African Americans, resulting in shorter comparative life spans." Further, the CDC reported that Arkansas ranked among the least healthy states in the country based on indicators

such as incidence of diabetes, cardiovascular deaths, infectious disease, and deaths by stroke, and obesity. Child health measures for child immunization, infant mortality, and preventable hospitalizations also ranked Arkansas among the least healthy states in the country.

The Task Force recommends that the reduction of health disparities in Arkansas be included in the Medicaid services spectrum of services and current and future delivery systems through beneficiary education at the community level on appropriate use of the health care system including Emergency Department care, access and use of primary care, and treatment of chronic medical conditions. Further, DHS should track Arkansas' Medicaid population health status improvement through a "State Health Scorecard" approach as tracked by the CDC.

M. Task Force Sub-Committee Recommendations

DRG Sub-Committee Recommendation

The Task Force supports DHS, to the extent possible, and after collaboration with the Arkansas Hospital Association, converting hospital reimbursement systems under the traditional Medicaid programs to a diagnosis-related groups (DRG) methodology that will allow DHS to more accurately classify specific patient populations and account for severity of patient illness and mortality risk. The Task Force also supports DHS promulgating rules to achieve this purpose that shall address how supplemental payments would be considered, whether transition funding should be provided and whether certain providers should be carved out.

DRG payments are a common way of health care payors to hold providers accountable for health care costs. Additionally, this payment method helps to deliver great cost certainty to payors. Many insurers utilize DRG payment structures, so this change should not be out of the norm for providers.

HDC Sub-Committee Recommendations

DHS should create a long-term plan for the legislature that considers the following over the next five years:

- ***Forecasted demand for HDC services at state and regional level, assuming changes in resident acuity if applicable;***
- ***Forecasted cost for operation of the HDC system (aggregated and per diem cost information);***
- ***Analysis of how DHS can most effectively and efficiently meet forecasted need through existing HDCs or changes to the system (size, location); and,***
- ***Cost estimate to meet forecasted demand (including estimated infrastructure needs). As part of the long-range planning, conduct an appraisal of any lands or properties***

not in use that could be sold that are not essential to current services that would create revenue for capital improvement projects.

This recommendation contemplates a different planning process than the annual strategic planning process used at each center and is not intended to supplant that process. HDC strategic plans outline current and future initiatives and center goals and are very client outcome-focused. They are developed by a multi-disciplinary group of local stakeholders. The center-level plans serve a different purpose and do not analyze long-term system needs.

Based on this planning process, the legislature should ensure availability of adequate funding for repair and maintenance of existing facilities and new construction, as needed.

Conduct an evaluation of the current capacity and quality of the home and community based care system for serving those with developmental disabilities.

The Task Force and this Committee has heard testimony concerning the future focus of the DHS to enhance capacity and opportunities for individuals with disabilities to live in homes and communities as part of the continuum of care. DHS should conduct a thorough evaluation of community provider current capacity and needs, and make recommendations to ensure adequate provider capacity, infrastructure, quality and support.

Publish data about licensing and maltreatment across programs

Making data about licensing violations and abuse/neglect/exploitation of consumers across DDS programs available online increases transparency about the quality of service delivery in those settings. It may inform decisions of consumers, their families, and legal guardians about whether to transfer to another program or aid in provider selection.

Centralize DHS investigations and licensing functions

Centralization of DHS investigations and licensing functions would allow DHS to gain additional efficiencies and organizational benefits, as well as enhance the rigor of investigations across programs by cross-pollinating some of the best practices and tools.

Continue to evaluate the capacity of licensing function

DHS should continue to monitor the ratio of licensing/oversight FTE resources to consumers served in its programs to ensure that the agency is providing an appropriate level of resources. While not a concern at present, if enrollment in community-based programs grows, it will be important for the agency to ensure that oversight resources keep pace with that growth.

DDS should review its current process of informing families/guardians of community waiver placement options to determine if additional methods are available to increase awareness of alternative placement options.

The current system informs families/guardians alternative placement options prior to admission, during the admission process, and at a minimum, annually thereafter. Each facility also conducts a provider fair at least annually, in which community providers come to the facility campuses to visit with parents/guardians.

DDS should adapt its post-placement monitoring tool as needed to incorporate best practices from other states.

The monitoring tool should prompt the worker to assess the person's safety and capture data in that area, as well as considered whether quality of life and person-centered care is being delivered. DDS should establish a survey to measure parental/guardian/resident satisfaction with the transitions process. In reviewing the tool**,** DDS should also consider formalizing in a written policy or protocol its operating procedures and guidelines for post-placement monitoring for persons who transfer from an HDC to a community setting

The DHS Office of the Chief Financial Officer, in conjunction with DDS, should conduct further analysis to understand cost variations across HDCs and identify efficiencies that can be replicated at other facilities. Examples to investigate include:

- ***Heath Care – This category comprises a large share of the total daily rate. It includes direct care staff. While most of the facilities are comparable here and maintain similar staffing ratios, Booneville's total cost per bed day is lower than the other HDCs and this should be explored.***
- ***Room and Board – Warren's costs here are higher than its three other peers of a similar size. There may be practices it can replicate from its peers to bring down these costs.***
- ***Maintenance and Operations – Conway has the lowest cost per bed day, which is likely due to efficiencies gained due to its larger relative size, but Jonesboro's cost is low relative to its peers of a similar size and its experience may be instructive.***

Savings and efficiencies identified by DHS/DDS, as well as other DHS cost containment strategies such as use of bulk contracting and purchasing and identifying more efficient approaches to contracting for professional services (such as dental services) should be monitored and tracked by DHS.

DHS Should establish a new supervisor development program

Quality supervision is important in the provision of services at HDCs and is critical to staff retention. Literature across disciplines suggests that a supervisor can be a key reason a worker leaves or stays at a job. The Department provides mandatory four days of policy and procedures training and a mandatory three-day leadership training for new supervisors. There is also a mandatory supervisory update training that occurs after a person has been a supervisor for five years. The department does offer a menu of professional and personal growth training opportunities through its internal staff development section and its inter-agency training program, but most of these items are not mandatory. There is currently no mandatory, ongoing training program to strengthen the managerial and leadership skills of its supervisory workforce outside of those mentioned above. Exit interviews with workers suggest there are concerns with the quality of supervision in certain areas of the state and that some new supervisors may struggle with the role of manager. An on-going mandatory training and development program for supervisors throughout the course their career would not only improve the quality of supervision and strengthen supervisory skills, but would also provide supervisors with guidance on how to develop their staff. Such a program could include supportive features (such as mentoring) to provide personal and professional support to supervisors. It is expected that this program would aid in the retention of both supervisors and workers.

DHS should explore the feasibility and cost of establishing a career ladder for supervision/management

Absence of an extended career ladder/low pay is a factor contributing to supervisor turnover, especially in areas with direct competitors (i.e., a new healthcare facility). Direct care staff members advance from the entry-level position of Residential Care Assistant to the next level (Residential Care Technician) in a career ladder format but must apply, interview, and be selected for positions beyond that. There is currently no other career ladder mechanism outside the traditional interview/selection process that allows a direct services staff person to promote, though they are eligible for annual bonuses based on performance. Providing for an extended career ladder for staff could address a reason direct services personnel leave HDC employment.

DHS should ensure adequacy of entry-level worker salaries

Each HDC operates in a local labor market and competes with other regional employers for staff. DHS staff has analyzed the salaries of other major employers in the markets where the HDCs are located and found DDS salaries to be less competitive in some areas (though benefits tend to be more robust at DDS compared to its competitors). In parts of state where economic opportunities result in the expansion of industry, HDCs may have an especially difficult time attracting and retaining staff. The state's Office of Personnel Management establishes the pay plan for the state.

DDS has received permission previously to offer the mid-point of the salary range (instead of the bottom of the range as is typically offered) for certain positions in certain areas of the state and is currently in the process of implementing that salary adjustment. This recommendation is for a more generalized increase of salaries across the direct care staff positions to enable DDS to attract the best applicants for HDCs statewide and prevent loss of qualified staff to other employers.

DHS should ensure adequate funding for the demolition of vacant buildings on HDC campuses that produce potential risk to residents.

Demolition of such buildings has been prioritized by current DDS leadership and the process is underway to remove the buildings in question. Going forward, the legislature should ensure that adequate funding exists to ensure the timely demolition or repair of these buildings to mitigate any adverse resident impact. DDS should include such needs in its long-range plan to the legislature.

Note: A copy of the complete HDC Committee Report (filed with the Task Force October 2016) can be obtained by contacting the Arkansas Bureau of Legislative Research