TSG Status Report # 3

To: Arkansas Health Reform Task Force

Re: Health Care Reform/Medicaid Consulting Services

Date: August 19 & 20, 2015

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2. UPDATE AND ACCOMPLISHMENTS

Interviews/Meetings

TSG continues to meet with numerous Arkansas legislators, stakeholders, physicians, dentists, health care administrators, Arkansas Department of Human Services staff, and community leaders. We also met with the Governor and his staff, and have attended two community health care forums in Pine Bluff and Forest City. We want to thank those who participated in organizing these important community forums.

Pertinent Research/Policy/Opinion Articles obtained and reviewed:

- Health and Human Services Integration Maturity Model: American Public Health Services Administrators (APHSA, 2013)
- Business Maturity Model: NWI/APHSA, 2014
- "Care Coordination in Managed Long Term Support and Services" (MLTSS): Public Policy Institute, AARP: 7/2015
- National Research Institute/National Association State Medicaid Health Policy Directors: FY 2013 State Profiles
- "Medicaid Expenditures for Long Term Support and Services (LTSS) in FY 2013": CMS/Mathematical, Traven Health Analytics, 6/30/15
- "The Medicaid Rehabilitative Services/"Rehab" Option": National State Technical Assistance Center
- "How Does Managed Care Affect Delivery of Medicaid Rehabilitation Option Services": Open Minds, Laura Morgan, 9/4/14
- Centers for Medicare and Medicaid Services (CMS). (2008). *Medicaid emergency room diversion grants: Grant summaries*. Retrieved April 12, 2012, from http://www.cms.gov/GrantsAlternaNonEmergServ/Downloads/ER_Diversion_Grants_State_summaries.pdf
- Delia, D., & Cantor, J. (2009). *Emergency department utilization and capacity*. Robert Wood Johnson Foundation. The Synthesis Project. Research Synthesis Report, No. 17. Retrieved June 1, 2012, from http://www.rwjf.org/pr/product.jsp?id=45929
- Hunt, K.A., Weber, E.J., Show stack, J.A., Colby, D.C., & Callahan, M.L. (2006). Characteristics of frequent user of emergency departments. *Annals of Emergency Medicine*, *48*(1), 1-8.
- Nicki, R., Bunya, F., & Xu, J. (2010). National hospital ambulatory medical care survey: 2007
- The Catalyst on the Pharma website GAO: Prescription Drugs Are Just 2% of Medicaid Spending Posted by Allyson Funk on August 5, 2015 at 4:05 PM. This comment on a recent GAO report covering Medicaid cost growth, brings perspective on the best way to

analyze FFS drugs costs. The piece points out the importance of net cost analysis, specifically, looking at costs net of rebates.

- Drug Channels: 8/11/15 Drug Channels is written by Adam J. Fein, Ph.D. Dr. Fein is President of Pembroke Consulting, Inc. and CEO of Drug Channels Institute. This article, from a pharmacy expert, gives context to The Stephen Group's 2014 paid drug claim analysis. With the advent of expensive hepatitis C treatments, programs experienced a double digit growth, however, that is expected to moderate over the next 10 years.
- Medicaid and CHIP Payment and Access Commission (MACPAC): Chapter 5: Use of Psychotropic Medications among Medicaid Beneficiaries, June 2015. This report chapter covers the use of psychotropic drugs in Medicaid populations. It will bring perspective to how the State currently manages patients on these powerful drugs. The state has put significant effort into managing children's access to these agents and this information allows for benchmarking.
- Webinar materials from Academy of Managed Care Pharmacy (AMCP) July 29, 2015 Presenters: Andrew Kolodny, MD Chief Medical Officer, Phoenix House Executive Director, Physicians for Responsible Opioid Prescribing (PROP) and Laurie Wesolowicz, Pharm.D. Director II of Pharmacy Services Clinical Blue Cross Blue Shield of Michigan. We attended this presentation and are offering a copy of the materials for review. The presentation focused on causes for the growth in the use of opioids and provides context for our analysis and recommendation on the use of this class of powerful drugs.
- Presentation from the Menges Group June 2015 by Joel Menges, CEO and Amira Mouna, Director of Pharmacy Services. Though based on 2011 data, the conclusion is that managed care Medicaid drug programs are overall less expensive for states to operate than FFS program when all costs and rebates are considered. This trend is stronger now and has not changed with time.

Hard copy materials available at The Stephen Group if needed.

Data Update

Refinement of the DHS data

We have now loaded 140 million Medical Claims and 15 million Pharmacy Claims from DHS and the three private carriers (BlueCross Blue Shield, Ambetter, and QualChoice). These claims files are tied to 10 million Recipient records and 30,000 Provider records.

In order to more easily work with the diagnostic and drug codes, files containing code dictionaries (ICD-9 and HIC3) were also loaded from national databases and integrated into the analysis tool.

As we worked with the data, generating overview reports on such things as number of claims and recipients, amounts paid, and drug costs, we've encountered a number of data issues. The following is a list of issues that the TSG team needed to straighten out. We have overcome each of these. We do believe it is critical to point out that there is a concern about the Agency's

capability in conducting this sort of analysis going further without additional well-experienced financial staff – rather than continuously relying on costly vendor analysis.

TSG is using data housed outside DHS because their data analysis tools only allow retrieval of files less than 500,000 records and TSG was not allowed to load our own, more flexible software. Fortunately, BLR created a suitable data server and it has been very valuable for the TSG team. Yet, off site data storage has its drawbacks, as TSG has had to re-specify and wait for each data issue with the extract. Examples of issues that have come up include:

- Data did not have the Category of Service (COS) the Agency uses to account for charges. This is crucial to ensure that numbers tie to the accounting records. On July 31, TSG finally received the COS file, but it included COS only for claims after 12/31/2014
- TSG was provided only part of the eligibility information—as a result many of the claims did not match to eligible beneficiaries
- The extract lacked adequate data in order to investigate several areas of the Private Option waiver. To fill the gap, the DHS CFO arranged for special extracts.

We are grateful to have the continued assistance of DHS and would like to give specific thanks to CFO Mark Story for his work in helping us sort through some of these issues for the Task Force.

Allocation of non-claims costs

As TSG reported in the first Monthly Update, Medicaid pays three quarters of a billion dollars outside the claims process. We investigated how these figures are arrived at, and how they could be associated with actual patient activity (claims). We discussed the cost settlements and other non-claims costs with the Agency CFO, the team than manages the payments, and Pinnacle, the auditors who review the reports. This led to a simple method by which TSG can reflect actual payments in its analysis.

Reviewed claims from the following perspectives:

Emergency Department

TSG reviewed emergency department (ED) costs from the perspective of what information they contain about the Private Option's impact on the use of the ED instead of primary care physicians (PCPs). TSG evaluated from the perspectives of:

- Frequent flyers: to what extent do we find people actually using the ED many times a month? How does this differ between the carrier (managed care) and Fee-For-Service (FFS) populations?
- Costs per life: how do Medicaid Fee-For-Service and carrier costs compare and what can we learn about the effectiveness of carrier's focus on managing ED use.

- ED use per 1000 lives: to what extent can we observe the carrier member use the ED differently than FFS beneficiaries?

Pregnancy

TSG considered the full medical costs of pregnant mothers from the perspective of how much it would cost traditional Medicaid to cover the mothers that were picked up by carrier (capitated) care.

Costs by diagnosis

TSG considered cost by diagnosis to better understand the true nature of what Medicaid is paying for. The historical reporting we found in the agency looks at payer type (e.g. hospital) or program (e.g. ARKids), or at specific disease groups (e.g. Episodes of Care). TSG used this analysis to characterize the whole of Medicaid. This analysis also allows TSG to compare FFS and carrier costs.

Costs by provider and provider type

Some of this analysis is available already, as in costs for "Hospital Services." TSG sought to compare carrier and FFS costs to assess whether capitated payment seems to be working to shift care from emergency rooms to physician office.

Full medical costs of waiver participants

TSG developed a method for comparing the full costs of beneficiaries managed under different waiver programs.

PMPM based on underlying carrier claims

TSG compared actual claims costs for the carriers to the premiums and cost sharing payments. This allows TSG to assess whether there is actual reduction in the cost of patient services, and whether carriers are being paid in accordance with the Medical Loss Ratio (MLR) as required by ACA.

Financial projection

TSG worked with the financial projection previously developed by the agency. TSG updated the approach and the assumptions to develop a projection for the years 2016 through 2021.

Retro costs

TSG identified the costs for interim and retroactive payments. This was for the purpose of considering the potential effect of moving from Arkansas' current method to one more like that of Indiana and New Hampshire where payments cover the point of eligibility forward and not the traditional 90 day prior to eligibility.

Confirmed analysis with Agency data analysts

TSG reviewed its methods and finding along the way with Agency IT and contract data analysis personnel. It also regularly validated them with the Agency CFO. Note: all have been very cooperative

Confirmed analysis with Carrier data analysts

TSG validated key analyses with carrier personnel.

Worked with UAMS CFO to develop a model for understanding Private Option impact on hospitals.

UAMS has been very helpful in understanding the impact. CFO Dan Riley worked with TSG to develop a method for understanding impact. This shows the impact from Medically Frail, Carrier coverage and change in recoveries for uncompensated costs

Worked with Arkansas Hospital Association to extend their analysis of Hospital Impact

During the same time as the TSG study, AHA conducted a survey of its members to document ACA impact. TSG requested that AHA confirm that the impact was experienced across the state, not just by a couple of large hospitals. They did that analysis and provided it to the TSG team—which is in our findings.

Arkansas Children's Hospital

Met with Arkansas Children's Hospital (ACH) CEO and CFO and reviewed cost-based payment methodology, discussed alternative methods of cost reimbursement and care coordination of high utilizers. During the meeting, TSG was informed by CEO Marcy Doderer that ACH's Board has decided to return to the state 3.5% of their Medicaid revenue for FY 15 – which amounts to approximately $9.6 MM.

Researched the issues of ACA impact, ED usage, healthcare growth rates, etc.

TSG reviewed the latest research nationally into these important aspects of the study.

Arkansas Hospital Association

TSG received data from the Arkansas Hospital Association on uncompensated care provided by hospitals in Arkansas and Medicare spending cuts enacted by federal legislation and regulation.

Arkansas Center for Health Innovation (ACHI)

TSG received a referral from ACHI to RAND for additional questions regarding RAND economic analysis of ACA impact in AR.

Payment Improvement

TSG met with DHS about TSG's analysis of the costs of the EOC program and received suggestions regarding refining the analysis.

DRG Review

TSG is making good progress in preparation to simulate a DRG-based reimbursement model for 2014 Medicaid inpatient claims. As with most of these claims data projects, the most difficult challenges are with the data themselves. We are looking to construct a representative sample of the 2014 Medicaid inpatient data and construct DRG Payment Rate scenarios and thus allow for what-if cost simulations. Moreover, we intend to compare costs of different hospitals by DRG (since DRG then becomes a "benchmark" for such metrics), and conduct other benchmarking exercises once we have DRG markers in place.

Eligibility Scrub

Both Lexis Nexis and Accuity have received the eligibility data files that TSG requested and are currently conducting the eligibility scrub. TSG expects to receive the preliminary results in early September.

Pharmacy

TSG drafted the data query and analysis plan. As expected, this was an iterative drill-down process throughout the month. Three areas of focus are pharmacy cost analysis, prescription limit program, and drugs with abuse potential analysis. We also plan to compare the Arkansas PDL to other state's PDL for breath and value.

The pharmacy data was loaded to BLR on 7/7/15. Our overall objective in analyzing this data is to:

- Analyze the pharmacy claims data and information provided to us to assess key attributes in the data and draw out and assess differences between the cost of comparable drugs between DHS and the Private Option Plans.
- Analyze the impact of the limit on number of prescriptions per person per month
- Analyze the use of drugs with abuse potential

3. PRELIMINARY OBSERVATIONS AND FINDINGS

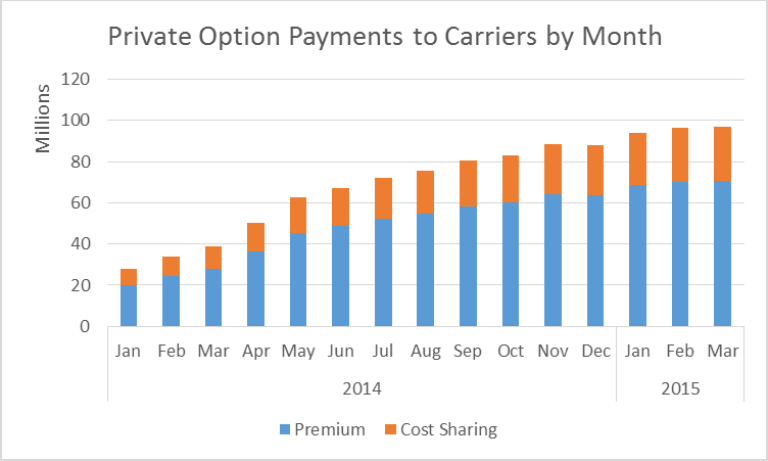
Note: TSG continues to conduct its on-the-ground analysis and has identified further preliminary observations that may or may not be part of its Final Report on October 1, 2015. We continue to offer observations and findings as an update to the Task Force which may be subject to change.

Examination of Financial Costs of Private Option

Carrier Premiums and Cost Sharing

Private Option beneficiaries cost Medicaid in three manners: premiums, cost adjustments and travel. Premiums are paid monthly for beneficiaries recorded as eligible in the MMIS system. While premium rates were set at the point Private Option was created, the actual payments are based on claims paid. During the year, payments to carriers have been increased based on claims experience. The Agency then pays an amount in addition to the regular premium, called "cost sharing". During calendar 2014 carriers received cost sharing payment totaling $212 million. Premiums and Cost Sharing payments are shown in Figure 1.

Figure 1—Payments to Private Option Carriers, through March 2015



DHS Premiums per Member per Month

DHS records a "claim" for each premium payment covering the monthly coverage of each beneficiary (member). Thus, TSG was able to count the payments (member months), count the unique beneficiary Medicaid IDs (members) and sum the premium payments.

Table 1 shows the combined premium cost per member per month. This cost includes cost sharing as well as the premiums.

Table 1—Premiums, Member Months and Members, through 2014

	Members at 12/31	Member Months	Premiums Paid	PMPM based on Premium
Carrier 1	141,458	1,172,978	535,963,758	$457
Carrier 2	39,430	337,403	196,095,108	$581
Carrier 3	20,233	68,914	32,404,755	$470
	201,121	1,579,295	764,463,621	$484

Thus, the average cost per member month to DHS is $484, based on premiums and cost sharing paid.

Carrier Claims per Member per Month

Carriers paid a total of $603 million in claims through the end of 2014. These covered the 1.6 million member months. Thus, carriers paid claims at a rate PMPM of $382. This ranged widely between carriers from $339 to $459, based on claims as submitted to the BLR for the TSG assessment.

Table 2—Carrier PMPM Based on Claims

	Member Months	Claims	PMPM based on Claims
Total	1,579,295	$603,283,865	$382.00

This claims-based PMPM compares to the average premium Medicaid pays, of $484[1]. The ACA includes several provisions that changed the way private health insurance is regulated in an effort to provide better value to consumers and increase transparency.

One such provision – the Medical Loss Ratio (or MLR) requirement – limits the portion of premium dollars health insurers may spend on administration, marketing, and profits. Under ACA, health insurers must publicly report the portion of premium dollars spent on health care and quality improvement and other activities in each state in which they operate. Insurers failing to meet the applicable MLR standard must pay rebates to consumers beginning in 2012.

[1] This paragraph and the following 2 are drawn liberally from Kaiser Family Foundation at: http://kff.org/health-reform/fact-sheet/explaining-health-care-reform-medical-loss-ratio-mlr/, viewed on August 12, 2015

The Medical Loss Ratio provision of the ACA requires most insurance companies to spend at least 80% of their premium income on health care claims and quality improvement, leaving the remaining 20% for administration, marketing, and profit. The MLR threshold is higher for large group plans, which must spend at least 85 percent of premium dollars on health care and quality improvement.

Of particular importance is the portion spent on Quality Improvement. To be included in this category, health improvement activities must lead to *measurable* improvements in patient outcomes or patient safety, prevent hospital readmissions, promote wellness, or enhance health information technology in a way that improves quality, transparency, or outcomes. Provider credentialing is also included as a health care improvement activity under the ACA.

Another important dimension of the MLR ratio analysis covers taxes, licensing and regulatory fees, which includes federal taxes and assessments, state and local taxes, and regulatory licenses and fees. Thus, it would appear that the Private Option carriers may include the Premium Tax (2.5%) they pay to Arkansas in their 20%.

The formula for Medical Loss Ratio is:

NUMERATOR: Medical Claims + Quality Improvement Expenditures
Divided by:
DENOMINATOR: Earned Premiums - Taxes, Licensing and Regulatory Fees[2]

Carriers will include in their federal reports many items outside the scope of the TSG research. However, as a simplification, Table 3 presents an approximation of MLR based simply on claims and premiums through the end of 2014. It appears that the current ratio of claims to premiums is 79%, thus lower than the amount allowed under ACA. Thus it would appear that the carriers will need to make a refund payment to its customer, being the State of Arkansas. Of course, 100% of that would accrue to CMS since the premiums are 100% matched. It is important to remember that MLR is a complicated calculation that takes into account factors such as carrier spending on quality improvement and taxes, items not included in the TSG analysis. For example, the Premium Tax (2.5%) factors into the calculation.

[2] Medical Loss Ratio Requirements Under the Patient Protection and Affordable Care Act (ACA): Issues for Congress, Congressional Research Service 7-5700, www.crs.gov R42735

Table 3—Approximate MLR by Carrier

	Approximate MLR
Carrier 1	85%
Carrier 2	58%
Carrier 3	98%
Total	79%

Costs by Place of Service

According to carrier claims analyzed by TSG, 25% of claims paid on behalf of Private Option members were for inpatient hospitals, 19% for outpatient hospitals and 10% for emergency room services. That is, 54% of Private Option claims are paid to hospitals. Physician offices received 20% of claims paid. This raises a question about Private Option's effectiveness in moving patients from hospital and ER into the physician's office. Pharmacy costs are 16% of carrier claims.

Table 4—Carrier Claims by Place of Service, 2014

	Total	Percent of Carrier Claims
Inpatient Hospital	148,505,758	25%
Office	119,942,467	20%
Outpatient Hospital	114,976,853	19%
Pharmacy	98,173,400	16%
Emergency Room - Hospital	58,672,096	10%
Ambulatory Surgical Center	13,369,223	2%
Other	49,644,067	8%
Total	603,283,865	100%

Claims by Provider

The providers paid the most in claims vary widely by carrier. In addition, carriers use different provider codes and different names for providers, this requiring manual effort to combine amounts by provider. This is despite there being a national NPI or provider number system.

The largest providers by payment amount are listed in Table 5. These amounts are approximate since TSG cannot be certain that carriers have grouped providers' subsidiaries in a comparable manner. Note that according to agreement with carriers, details of payment by provider is

suppressed. Table 5 shows the wide dispersion of payments—that no one provider accounts for more than 4% of total claims paid.

Table 5—Top providers by total claim amount

	Total Claims Amount	Percent of Carrier Claims
UAMS	21,696,573	3.6%
Baptist Health Medical Center, Little Rock	19,567,107	3.2%
St Bernard's Medical Center	14,509,431	2.4%
St Vincent Infirmary Medical Center	13,187,430	2.2%
Jefferson Regional Center	9,696,803	1.6%
St Vincent Hospital Hot Springs	9,504,630	1.6%
White River Med Center	7,065,430	1.2%
Northwest Medical Center Willow Creek Women	8,608,182	1.4%
White County Medical Center	5,204,544	0.9%
National Park Medical Center	5,200,945	0.9%
Sparks Regional Medical Center	6,596,580	1.1%
St. Mary's Regional Medical Center	5,193,998	0.9%
Washington Regional Medical Center	9,464,877	1.6%
Pharmaceuticals	98,173,400	16.3%
Other	369,973,043	61.3%
Total	603,642,973	100.0%

Claims by Diagnosis

Reviewing DHS costs by diagnosis type reveals an important difference between the Carrier and FFS populations, on the significance of behavioral health, psychiatric and disabilities in the mix of FFS Medicaid. TSG analyzed the claims of each according to primary diagnosis. No individual diagnosis is significant to the TSG assessment. However, we observe that the most prevalent diagnoses are for physical conditions. This compares to DHS, for which a substantial portion of the largest diagnoses are for behavioral, psychological or disability conditions, though it is important to note that DHS covers the disabled and medically frail populations.

Table 5—Carrier claims by largest diagnoses

ICD-9	Description	Total
41401	Coronary atherosclerosis of native	9,117,395
78650	Chest pain, unspecified	7,637,595
389	Unspecified septicemia	5,806,359
7242	Lumbago	5,278,591

V5811	Encounter for antineoplastic chemot	5,102,586
4019	Abdominal pain, unspecified site	4,508,217
78900	Diabetes mellitus without mention o	4,326,602
25000	Headache	3,766,641
32723	Localized osteoarthrosis not specif	3,551,703
57410	Excessive or frequent menstruation	3,385,758
6262	Special screening for malignant neo	3,370,822
V7651	Major depressive disorder, recurren	3,338,145
65421	Obstructive sleep apnea (adult) (pe	3,262,556
78659	Lumbosacral spondylosis without mye	3,219,605
V5789	Chest pain, other	3,143,279
7213	Unspecified essential hypertension	3,083,427
7840	Other specified rehabilitation proc	2,986,069
2189	Degeneration of lumbar or lumbosacr	2,788,599
3051	Nonspecific (abnormal) findings on	2,665,403
486	Calculus of gallbladder with other	2,541,212
72252	Previous cesarean delivery, deliver	2,541,124
5990	Displacement of lumbar intervertebr	2,536,393
72210	Pneumonia, organism unspecified	2,500,637
311	Leiomyoma of uterus, unspecified	2,495,596
650	Malignant neoplasm of breast (femal	2,459,971
1749	Osteoarthrosis, unspecified whether	2,362,922
V700	Routine gynecological examination	2,345,017
3540	Normal delivery	2,334,827
V7231	Depressive disorder, not elsewhere	2,230,386
71946	Routine general medical examination	2,145,834
7295	Pain in joint, lower leg	2,103,077
71536	Urinary tract infection, site not s	2,100,584
6259	Carpal tunnel syndrome	2,068,805
7231	Essential hypertension, benign	2,060,375
30000	Bipolar I disorder, most recent epi	2,014,681
7245	Acute myocardial infarction, subend	2,004,990
Other Diagnoses		386,283,790
Pharmacy		98,173,400
Total		603,642,973

Members by County

Carriers have different presences by county. Figure 2 shows that BCBS dominates over half of Arkansas counties. This data does not reflect changes since 2014.

Figure 2—Carrier market share by county

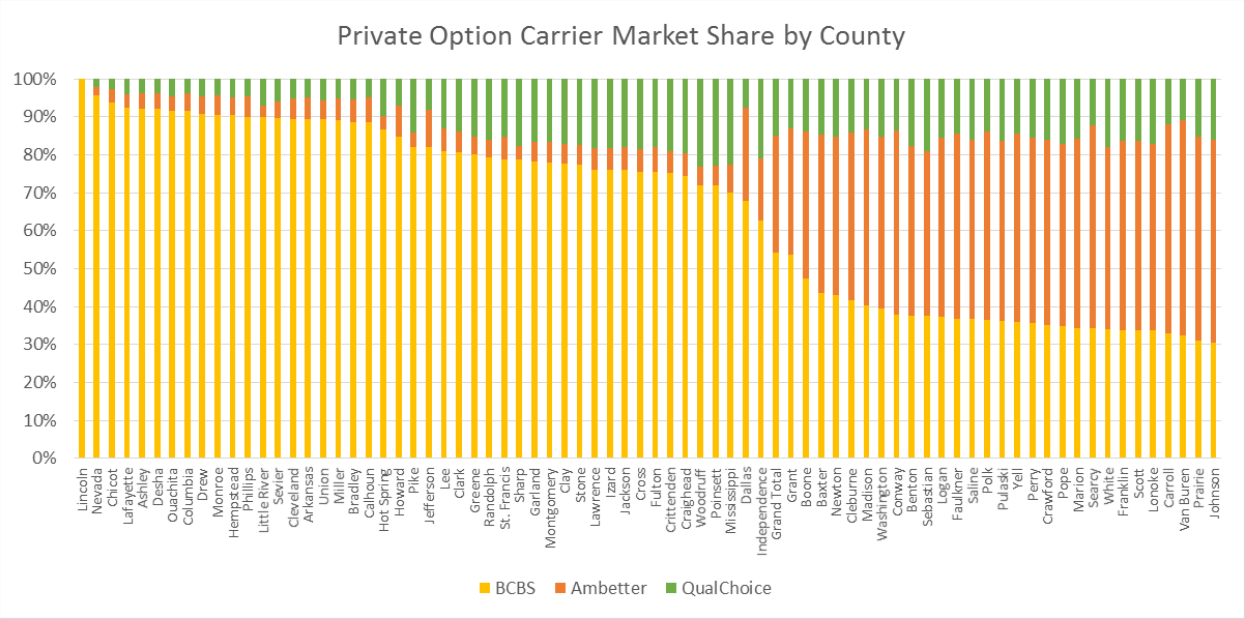


Figure 3 shows the extent of private option in each county, by number of members. Pulaski and the other large counties obviously have the largest membership. Figure 3 also shows male and female members: overall carrier membership is 51% female.

Figure 3—Carrier membership by county

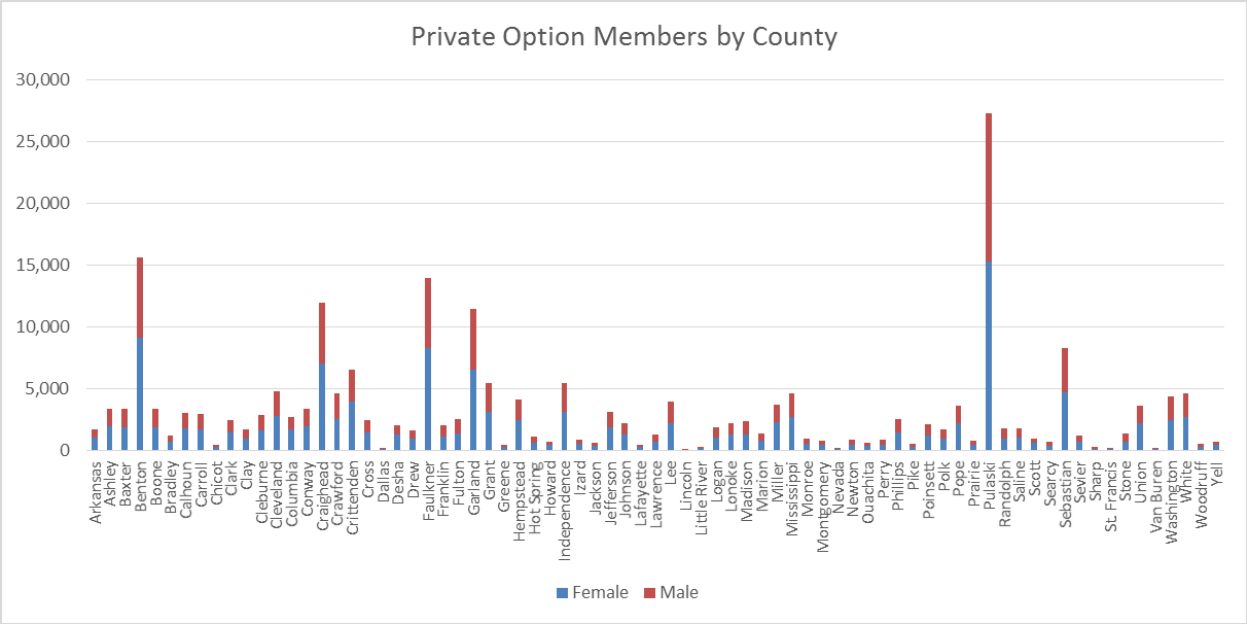


Figure 4 shows Private Option as a percent of population. TSG continues to investigate the situation in which several counties have penetration in excess of 50%. The comparison is made to census data, which might be collected on a different basis. In general, most counties are about 10%, with the overall average being 8%. Figure 5 shows the distribution of carrier membership penetration, with the average county having 10% penetration and the median county 8%.

Figure 4—Carrier membership as a percent of county population

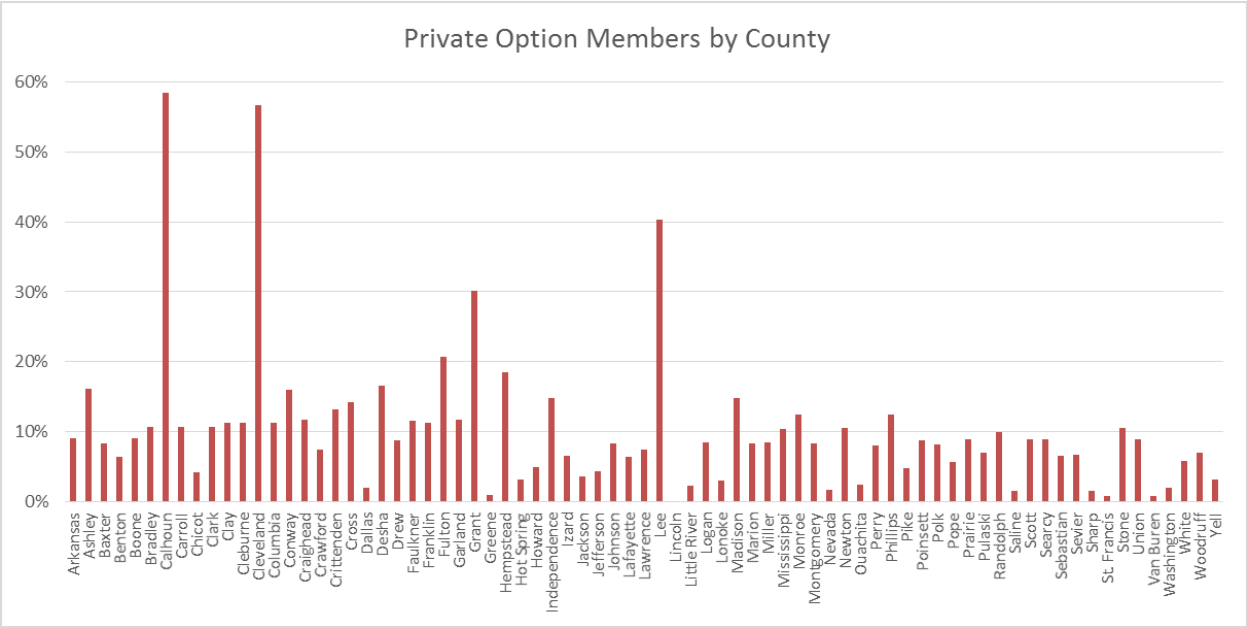


Table 7 shows the details of carrier presence in each county.

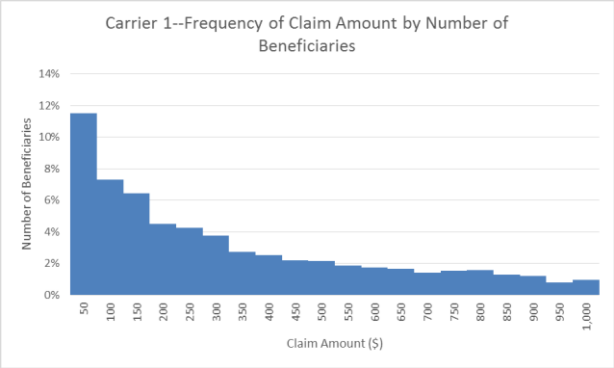
Table 6—Details of carrier membership by county

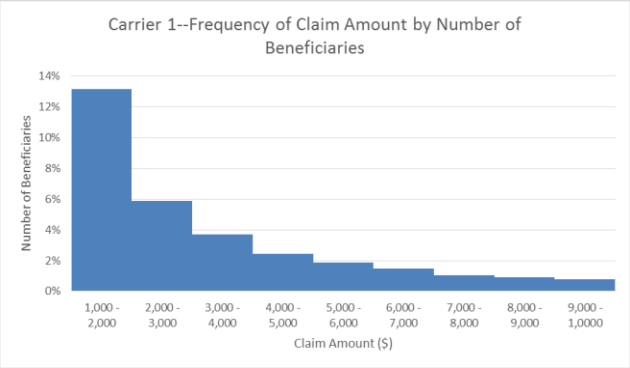
	Carrier Members						Market Share by County		
County	BCBS	Ambetter	QualChoice	Total Carrier	County Population	Percent	BCBS	Ambetter	QualChoice
Arkansas	1995	129	106	2230	18970	12%	89%	6%	5%
Ashley	3799	160	159	4118	21526	19%	92%	4%	4%
Baxter	2650	2545	899	6094	41055	15%	43%	42%	15%
Benton	10871	12860	5096	28827	232658	12%	38%	45%	18%
Boone	2847	2315	831	5993	37321	16%	48%	39%	14%
Bradley	1323	91	79	1493	11352	13%	89%	6%	5%
Calhoun	3358	254	182	3794	5317	71%	89%	7%	5%
Carroll	1897	3160	679	5736	27639	21%	33%	55%	12%
Chicot	538	19	16	573	11443	5%	94%	3%	3%
Clark	2697	184	461	3342	22811	15%	81%	6%	14%
Clay	1809	123	398	2330	15592	15%	78%	5%	17%
Cleburne	2241	2364	764	5369	25788	21%	42%	44%	14%
Cleveland	5497	335	311	6143	8639	71%	89%	5%	5%
Columbia	3123	157	131	3411	24386	14%	92%	5%	4%
Conway	2340	3000	837	6177	21250	29%	38%	49%	14%
Craighead	12717	1018	3373	17108	99920	17%	74%	6%	20%
Crawford	3047	4270	1390	8707	61943	14%	35%	49%	16%
Crittenden	6630	513	1667	8810	50088	18%	75%	6%	19%
Cross	2493	195	609	3297	17686	19%	76%	6%	18%
Dallas	144	52	16	212	7971	3%	68%	25%	8%
Desha	2385	106	100	2591	12566	21%	92%	4%	4%
Drew	1985	102	99	2186	18773	12%	91%	5%	5%
Faulkner	9657	12769	3760	26186	118692	22%	37%	49%	14%
Franklin	1276	1881	618	3775	18009	21%	34%	50%	16%
Fulton	2627	225	624	3476	12278	28%	76%	6%	18%
Garland	12593	860	2654	16107	96889	17%	78%	5%	16%
Grant	4706	2937	1133	8776	18013	49%	54%	33%	13%
Greene	433	26	82	541	43165	1%	80%	5%	15%
Hempstead	4716	244	251	5211	22380	23%	91%	5%	5%
Hot Spring	1339	57	150	1546	33417	5%	87%	4%	10%
Howard	786	76	66	928	13749	7%	85%	8%	7%
Independence	5110	1324	1715	8149	37020	22%	63%	16%	21%
Izard	961	75	229	1265	13505	9%	76%	6%	18%
Jackson	675	54	160	889	17619	5%	76%	6%	18%
Jefferson	3301	402	327	4030	74601	5%	82%	10%	8%
Johnson	1257	2207	659	4123	25866	16%	30%	54%	16%
Lafayette	496	20	21	537	7423	7%	92%	4%	4%
Lawrence	1266	96	302	1664	17028	10%	76%	6%	18%
Lee	4206	309	680	5195	10200	51%	81%	6%	13%
Lincoln	6			6	14133	0%	100%	0%	0%
Little River	294	10	23	327	12920	3%	90%	3%	7%
Logan	1275	1606	533	3414	21987	16%	37%	47%	16%
Lonoke	1337	1949	680	3966	70025	6%	34%	49%	17%
Madison	1813	2071	603	4487	15615	29%	40%	46%	13%
Marion	876	1277	402	2555	16599	15%	34%	50%	16%
Miller	4334	272	255	4861	43620	11%	89%	6%	5%
Mississippi	4455	455	1442	6352	45529	14%	70%	7%	23%
Monroe	1081	62	50	1193	7854	15%	91%	5%	4%
Montgomery	844	60	179	1083	9339	12%	78%	6%	17%
Nevada	175	4	4	183	8924	2%	96%	2%	2%
Newton	615	601	217	1433	8088	18%	43%	42%	15%
Ouachita	705	29	36	770	25389	3%	92%	4%	5%
Perry	533	733	232	1498	10310	15%	36%	49%	15%
Phillips	2714	166	135	3015	20789	15%	90%	6%	4%
Pike	607	29	104	740	11280	7%	82%	4%	14%
Poinsett	2180	164	690	3034	24270	13%	72%	5%	23%
Polk	1099	1488	420	3007	20460	15%	37%	49%	14%
Pope	2326	3226	1144	6696	62673	11%	35%	48%	17%
Prairie	428	744	211	1383	8462	16%	31%	54%	15%
Pulaski	18709	24668	8399	51776	388953	13%	36%	48%	16%
Randolph	1938	114	389	2441	17885	14%	79%	5%	16%
Saline	1188	1520	519	3227	111851	3%	37%	47%	16%
Scott	604	893	290	1787	11008	16%	34%	50%	16%
Searcy	464	727	164	1355	8026	17%	34%	54%	12%
Sebastian	5632	6466	2870	14968	127404	12%	38%	43%	19%
Sevier	1318	65	87	1470	17194	9%	90%	4%	6%
Sharp	296	14	66	376	17037	2%	79%	4%	18%
St. Francis	227	17	44	288	27859	1%	79%	6%	15%
Stone	1475	100	332	1907	12661	15%	77%	5%	17%
Union	4175	241	260	4676	40907	11%	89%	5%	6%
Van Buren	75	132	25	232	17074	1%	32%	57%	11%
Washington	3270	3742	1253	8265	211552	4%	40%	45%	15%
White	2871	4028	1511	8410	78622	11%	34%	48%	18%
Woodruff	453	30	146	629	7084	9%	72%	5%	23%
Yell	471	650	189	1310	21897	6%	36%	50%	14%
Grand Total	202654	115867	55538	374059			54%	31%	15%

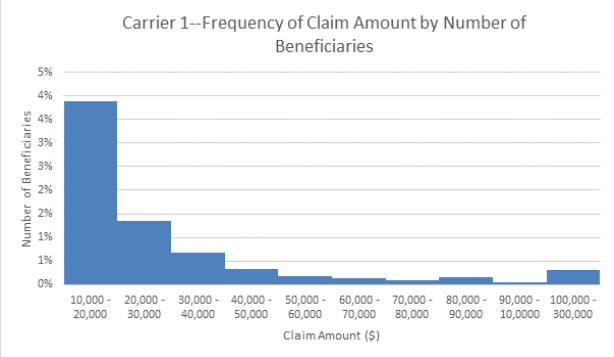
Claims by Size

Claims size is very long-tailed, meaning there are many claims for an amount less than $50. On the other hand, individual claims can also exceed $200,000. Figure 5 shows a three-part histogram of one of the carriers' claim size. Note that the second chart starts at 10,000, where the first leaves off. It shows that 12% of claims are less than $50 and 7% of claims are for amounts greater than $20,000. Each provider had outlier claims in the hundreds of thousands. TSG reviewed this for each of the carriers, and presents only one since the picture is quite similar across carriers.

Figure 5—Frequency distribution of claims by size of claim



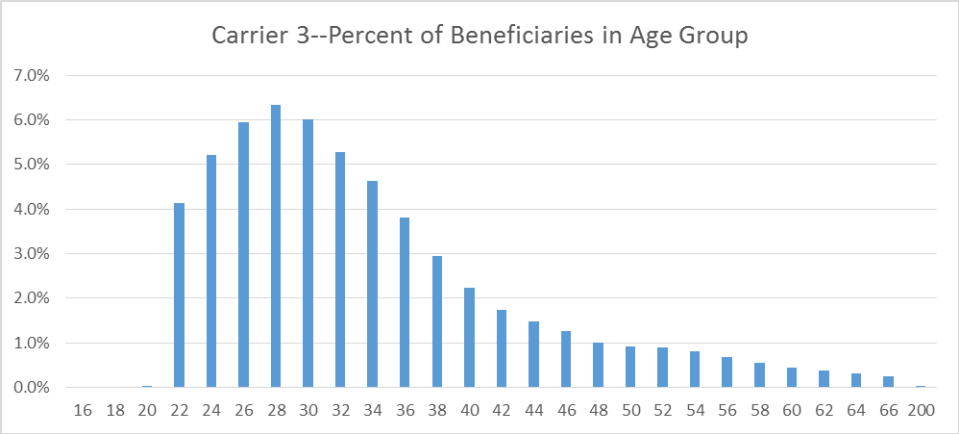




Claims by Age

Carriers demonstrated a similar pattern by age. Figure 6 shows the age distribution of Carrier 3. Note that only a few outliers outside the range 20-65 years old. While the expected tendency for twenty-year-olds to remain uninsured, 46.6% of beneficiaries are less than 40 years old. Only 4.3% of the carrier's beneficiaries are over 50 years old.

Figure 6—Age distribution—by percent of beneficiaries



The pattern is similar when looking at claims by age. Figure 7 also shows after a mode age of 30, claims amounts are higher by percent than number of beneficiaries.

Figure 7—Claims by Age

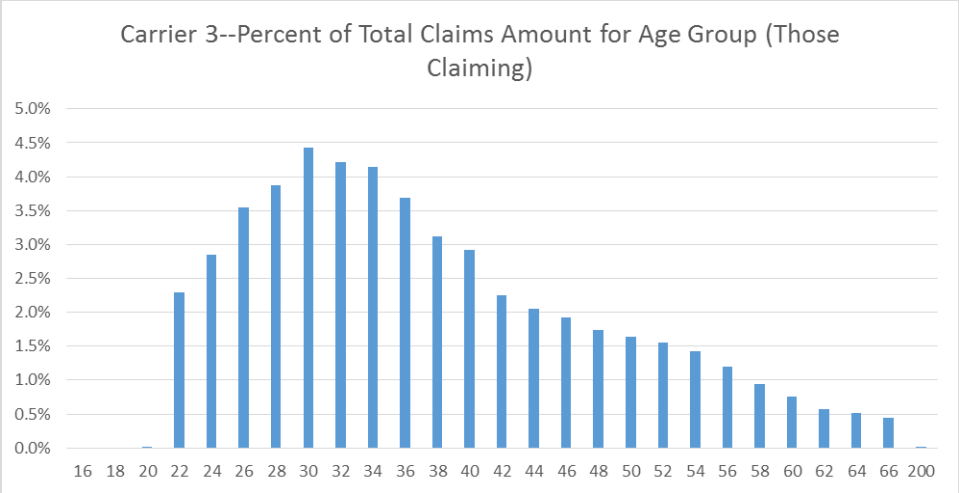


Figure 8 shows the distribution of claims volume by age. None of the carriers have Private Option members younger than 20 or older than 65. Claims are not evenly spread across the age groups, with members between the ages 30 and 60 claiming disproportionately more claims. Figure 8 shows claims volume / total claims.

Thus, 4% or Carrier 1's claims are for 26 year olds (Figure 7), and Figure 8 shows how many claims each age group was responsible for during 2014. As an example, 26 year olds who were responsible for claims activity generated on average 10 claims each during the period.

The largest group of claimants (both by average number of claims and percent of total claims) is the age group 52 to 58. Note that the average number of claims builds steadily through age 56, then holds flat—but the Private Option carriers cover fewer members over age 58.

Figure 8—Percent of total claims volume by age

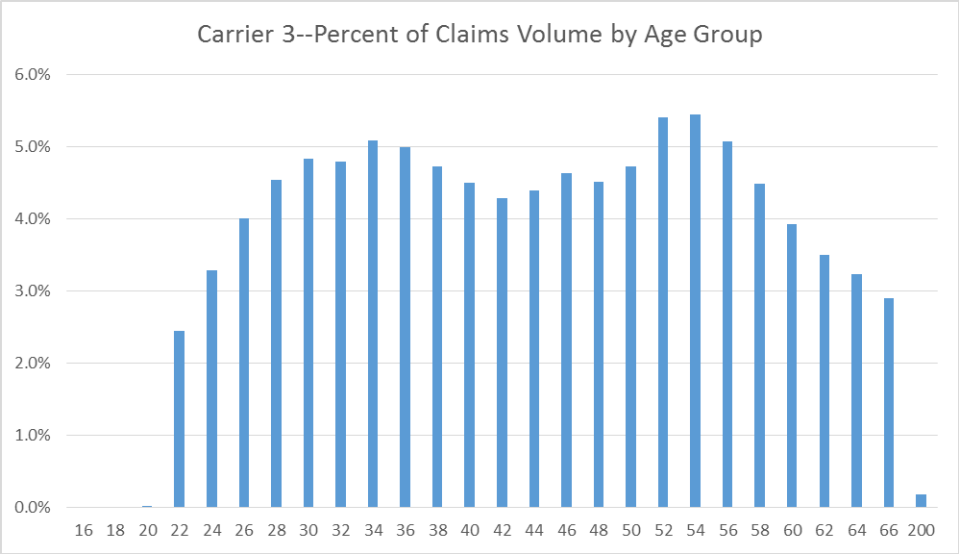


Figure 9—Average number of claims for age group

Figure 10 shows the average claim *amount* by age group. As expected, it increases sharply. The average claim for a 22 year old is 2,000, while the average claim for a

Figure 10—Average claim amount by age

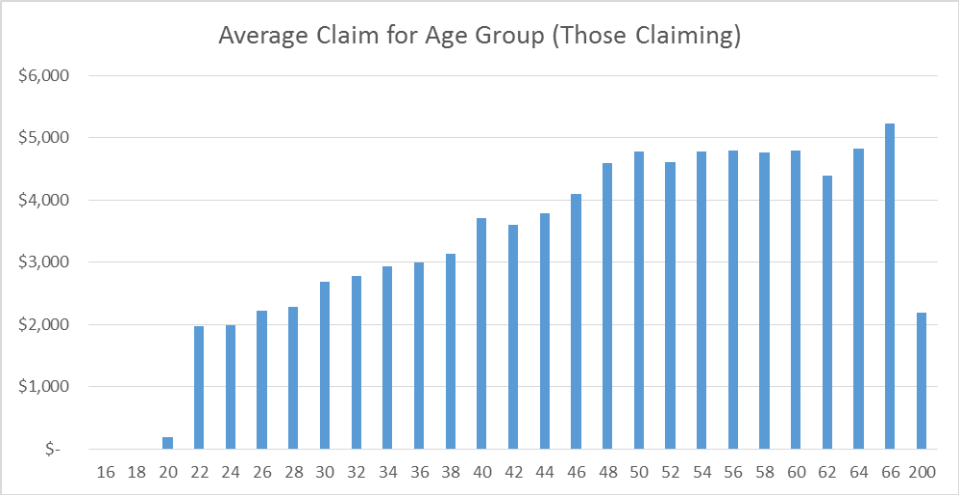


Figure 10 shows the average number of claims for age group. Note that while the average number of claims holds steady across the older ages, the average amount of those claims increase. The final bar in Figure 10 (200) simply captures everyone over 66.

Emergency Room Claims for Carriers

TSG has reviewed Emergency Department claims to establish the extent to which carriers have managed members away from the ED into primary care provider (PCP) offices. All analyses are conducted for carriers combined. TSG has looked at the data in 3 ways:

1. Frequent Flyers—number of visits per person to the ED in a month. We looked at this for all of 2014. We counted the number of 1st, 2nd, 3rd, etc. visits across all months. Note that since the member base is growing rapidly, this will understate the frequency of visits.
2. Total ER visits per member—this compares to the number reported in the literature of visits per 1,000 population. TSG assumes that the carrier members are the "population." This underestimates the "population" since in the general population some people are not covered by insurance.
3. Total ER costs PMPM—this compares to FFS costs. Since the populations are very different, this is a somewhat inappropriate (though inevitable) calculation.

Frequent Flyers

TSG observed the day of the month in which an ED claim was made, based on service end date. To conduct the analysis, TSG documented the ED claims by carrier member for each day in 2014. It found many instances of multiple claims for a single visit (as expected). More confounding, it found multiple "end of service dates" that spanned several days for each apparent ED visit. This could be the result of several visits back to back (unlikely) or billing irregularities.

TSG elected to consider the multiple consecutive "end of service" dates and "noise" and counted an ED visit as having ended when a member had been receiving claims, then stopped. This has the potential of underestimating the actual number of repeat visits, since some people (in the DHS experience) do actually visit many times. TSG observed one instance in which a person covered under DHS FFS appeared to have ED visits 30 days out of 31 in a month. This is clearly an aberration, and happens so infrequently, that the method TSG used to avoid spurious counting seemed reasonable.

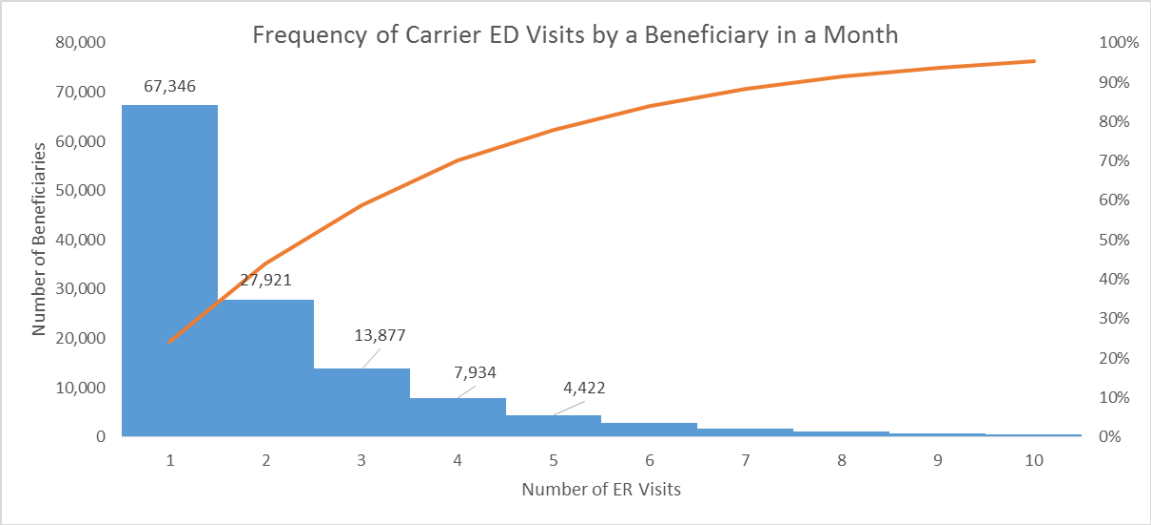
As Table 8 shows, TSG found 506,623 visits across the three carriers. We accounted for 417,616 instances in which members visited the ED. This is lower than the number of claims: we observed that ED visits generated many claims. We found 89,007 visits after the first visit by a member in a month (18% of ED visits). We found 52,042 visits after the second visit, representing 14,565 members. All data is through 12/31/2014 and includes all three carriers.

Figure 11 shows the results by number of visits in a month. The y-axis sums all the months. For example, if a member visited the ED 3 times a month for 9 months, the y-axis would reflect 27 visits. Figure 11 shows that 67,346 times a member made one and only one visit in the month (across all months), 27,921 made two visits, etc.

Table 7—Multiple ED Visits

	Visits	Unique Beneficiaries	Multiple Visits/Beneficiary	
Total ER Visits	506,623	417,616	89,007	18%
More than 2	52,042	14,565		
	10%	3%		

Figure 11—Carrier Multiple ED Visits, by number of visits in the month



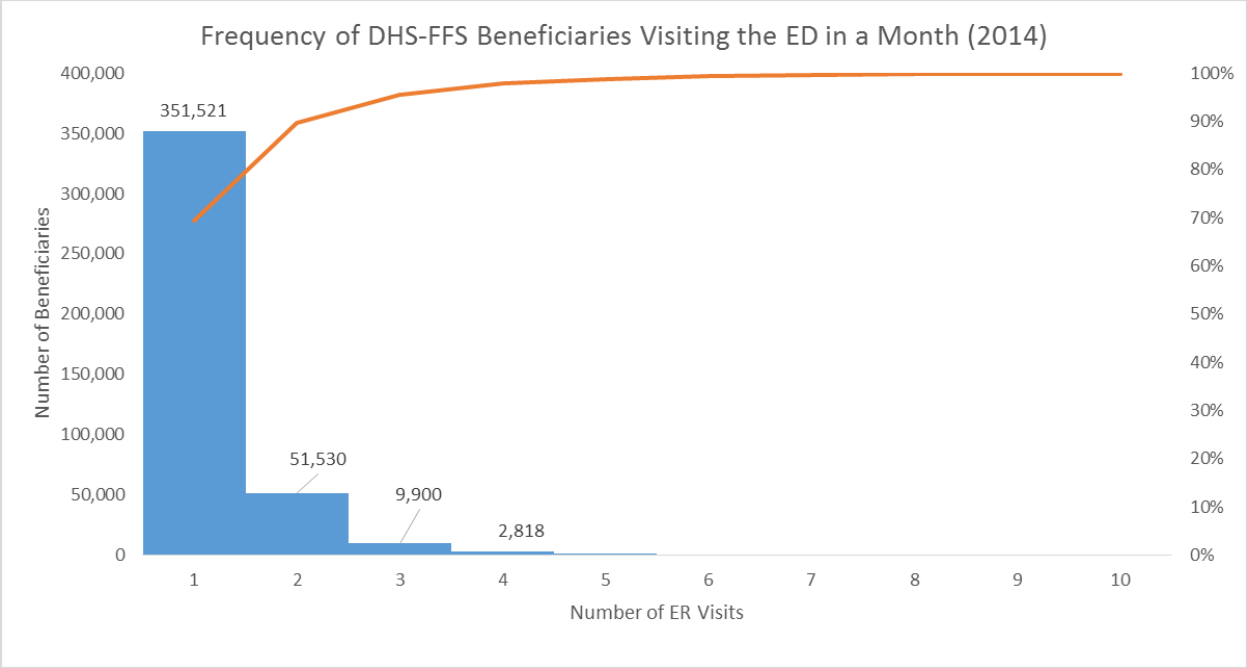
TSG concludes from this that the carriers are experiencing quite a few members visiting the ER many times a month. Over 26,000 times members visited the ED more than twice in a month. TSG will continue to investigate why that is. Initial observation is that the carriers have taken on members that are largely inexperienced with private health insurance—even with paid health insurance at all. Thus, they may not have PCPs, and not know how to find one. They may wait for a medical condition to become critical before seeking medical assistance—and need to go to the ED. They may simply not know where else to go to get help, owing to their inexperience with the system.

In addition, TSG heard from residents at the Forest City forum that timely access to PCP services had caused individuals to use the ER as primary care.

ER experience of DHS

To better evaluate Carrier ED experience TSG considered how that differs from DHS' FFS experience. Figure 12 shows the result of TSG's analysis.

Figure 12—DHS ED Medicaid Beneficiary experience



DHS built on the TSG research to validate the findings. Using a slightly different method, DHS confirmed the TSG finding: they found that between 13-16% of DHS traditional Medicaid ED visits paid were for a second, third or more visit in a month.

ER Visits per Member Month

TSG counted 506,623 ED visits in 1,579,295 member months. Member months are calculated as the count of premiums DHS paid to all three carriers. Thus, carriers are experiencing 320 ED visits per month per 1,000 members.

Further ED Investigation

ED is a complicated aspect of healthcare. TSG will continue to investigate ED from the following perspectives:

Frequent visits (as above)
ED visits per member (compared to ED visits per population)
ED costs per member
ED visits per physician

Private Option Forecast without Change

One of the areas in which TSG has been doing additional analysis is by attempting to capture the aggregate impact of the private option, particularly on issues relating to impact on the State budget due to traditional Medicaid program cost shifting, impact to the uninsured and uncompensated care, as well as implications from the premium tax and tax multiplier, as a result of the additional influx of federal funds. The following table and information are included as a preliminary iteration in this direction to show the Task Force the projected impact of the Private Option on the State general fund budget.

Projected Aggregate Private Option Impact (SFY 2017-2021)							
(all figures millions $ unless otherwise indicated)							
		2017	2018	2019	2020	2021	2017-2021
Private option expenditures		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	(22)	(23)	(25)	(26)	(27)	(123)
	State fund savings from cost-shifting from traditional Medicaid to PO	(39)	(41)	(43)	(45)	(47)	(214)
	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	**(52)**	**0**	**20**	**63**	**99**	**130**
Impact on state revenues	**Increase in premium tax revenue**	37	39	41	44	46	208
	Increase in collections from economically-sensitive taxes (4%)	67	69	72	74	77	360
	Total impact on revenues	**104**	**108**	**113**	**118**	**124**	**567**
Net impact on state funds		**156**	**108**	**93**	**56**	**25**	**438**

The private option expenditures row is the projected all-funds expenditures on the private option. The state match on private option row is the state matching funds required for the private option. The match rate ratchets upward from 5 to 10 percent between 2017 and 2020.

State general fund savings from optional Medicaid programs discontinued after the establishment of the private option are projected savings from the following Medicaid waiver programs that were in place prior to the establishment of the private option:

ARHealthNetwork
Family Planning
Tuberculosis
Breast and Cervical

These waiver programs were discontinued because their income eligibility ranges overlapped with the income eligibility range for the private option and the benefits offered under the waiver programs were available under the private option. With the shift from these waiver programs to the private option, AR is projected to recognize a positive impact to state funds since the expenditures under these waiver programs previously required 30% state matching funds whereas under the private option the maximum state matching rate is 10%.

State funding from cost-shifting from traditional Medicaid to the private option is the impact on state funds due to some individuals enrolling in the private option rather than in the following eligibility categories for traditional Medicaid:

Medically needy
Aged blind disabled
SSI disability
Pregnant women

These eligibility categories are projected to recognize lower growth than would have otherwise been the case due to individuals enrolling in the private option instead of enrolling in traditional Medicaid. The mechanism by which this occurs is different in each case.

The 'medically needy' category is often described as the 'spend down' category. In some cases, individuals might meet the income eligibility criteria for Medicaid, but have too many assets, in which cases, they can 'spend down' their assets and become eligible for Medicaid. Since the private option allows individuals to become eligible at higher income and asset levels, some individuals who might otherwise have 'spent down' their assets to become eligible for Medicaid through the 'medically needy' eligibility category no longer need to do so.

The 'aged blind and disabled' and 'SSI disability' categories are projected to see lower enrollment than otherwise would have been the case due a similar mechanism. The 'aged blind and disabled' and 'SSI disability' categories both require a disability determination. It is anticipated that some set of individuals who might otherwise have pursued a disability determination in order to get enrolled in Medicaid will not do so due to the simpler eligibility criteria for the private option and benefits coverage adequate for their needs in the private option.

The 'pregnant women' category is projected to see lower enrollment than would have otherwise been the case since some portion of the population of low-income of child-bearing age will be enrolled in private option plans prior to getting pregnant. Once pregnant, if already covered

under the private option, the women will remain enrolled in the private option plan, even though they would likely have historically become enrolled in traditional Medicaid.

In all of these cases, individuals who would otherwise have been enrolled in Medicaid become enrolled in the private option and their costs are covered at the higher federal matching rate, resulting in reduced state taxpayer outlays.

The increase in the premium tax revenue is due to additional health insurance policies being offered in the state through the private option carriers.

The increase in collections from economically-sensitive taxes is the additional state taxes collected from the addition of new federal funds to the state economy. A typical approach to modeling the economic impact of new programs or investments is to apply a multiplier to the size of the anticipated expenditure, to capture the fact that some proportion of the new funds will be expended through local economic activity, and then the providers of that local activity will expend the received funds on other local goods and services, etc. In the calculations above, no multiplier is applied, which should result in a conservative estimate. Marginal tax revenues due to the additional federal expenditures are calculated as the total private option spending, less the state match, times a percentage factor representing a blended tax rate. In the calculations above, 4% is used as the blended tax rate on economic activity, which compares favorably to the total forecast available general revenue for SFY 15 as a percentage of the SFY 15 forecast for all non-farm personal income ($5.15 billion /$112.6 billion=4.57%).

With those projections and assumptions, the total impact of the private option on state funds is projected to be positive for all years between 2017 and 2021, with an aggregate positive impact on state funds of $438 Million over those five years.

It is important to note that the assumptions above consider the fact that the current federal match will remain unchanged. Some congressional leaders have called the high federal rate "unsustainable.[3]" If the federal match rate were to drop, it would significantly reconfigure the state budgetary impact. Managing this risk, and developing a prospective risk tolerance for this possibility, should be a consideration for state legislatures in the nation.

In addition, some of the costs may be subject to change, as TSG is currently analyzing administrative contracts to determine a more accurate amount to attribute to the administrative cost of the Private Option. The amount included in the above table for total administrative costs was that provided to TSG by DHS. This is a preliminary report and it is being prepared before

[3] http://articles.chicagotribune.com/2013-04-22/news/chi-rep-paul-ryan-warns-governors-on-obama-health-care-plan-20130422_1_paul-ryan-reimbursement-federal-government

the Final Report. Thus, the analysis here in the forecast model is merely for discussion purposes and is subject to change.

Traditional Medicaid Forecast

While there has been considerable discussion about impact of the Private Option, the State of Arkansas should place as large, if not a larger, focus on the existing Medicaid program. Like many states, the traditional Medicaid program is eating up a greater and greater percentage of the state budget, and is trending to an even more concerning future, as Arkansas' demographics shift.

Traditional Medicaid has grown by a little more than 2% this past fiscal year in Arkansas. However, TSG has pointed out that a number of states have seen low growth in their Medicaid programs over the past couple of years. Despite the current growth in the traditional Medicaid program, the Centers for Medicare and Medicaid Services (CMS) is projecting for 2015 to 2024, Medicaid spending growth will increase 5.9% per year on average, "reflecting more gradual growth in enrollment as well as increased spending per beneficiary due to aging of the population." See https:/www.cms.gov/Research –Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/proj2014.pdf.

Thus, TSG has used a few spending growth scenarios ranging from 5% to 10% per year in combined caseload and utilization growth merely for modeling purposes and to give the Task Force members some idea as to the possibilities of general fund needed to sustain the traditional Medicaid program "as is." The following is the TSG preliminary forecast.

Medicaid Projected All Funds							
Growth Scenario	2015	2016	2017	2018	2019	2020	2021
5%	5,119,522,073	5,375,498,177	5,644,273,086	5,926,486,740	6,222,811,077	6,533,951,631	6,860,649,213
6%	5,119,522,073	5,426,693,398	5,752,295,002	6,097,432,702	6,463,278,664	6,851,075,384	7,262,139,907
7%	5,119,522,073	5,477,888,619	5,861,340,822	6,271,634,679	6,710,649,107	7,180,394,544	7,683,022,162
8%	5,119,522,073	5,529,083,839	5,971,410,546	6,449,123,390	6,965,053,261	7,522,257,522	8,124,038,124
9%	5,119,522,073	5,580,279,060	6,082,504,175	6,629,929,551	7,226,623,211	7,877,019,300	8,585,951,037
10%	5,119,522,073	5,631,474,281	6,194,621,709	6,814,083,880	7,495,492,268	8,245,041,494	9,069,545,644

Medicaid Projected General Revenue							
Growth Scenario	2015	2016	2017	2018	2019	2020	2021
5%	1,535,856,622	1,612,649,453	1,693,281,926	1,777,946,022	1,866,843,323	1,960,185,489	2,058,194,764
6%	1,535,856,622	1,628,008,019	1,725,688,500	1,829,229,811	1,938,983,599	2,055,322,615	2,178,641,972
7%	1,535,856,622	1,643,366,586	1,758,402,247	1,881,490,404	2,013,194,732	2,154,118,363	2,304,906,649
8%	1,535,856,622	1,658,725,152	1,791,423,164	1,934,737,017	2,089,515,978	2,256,677,257	2,437,211,437
9%	1,535,856,622	1,674,083,718	1,824,751,253	1,988,978,865	2,167,986,963	2,363,105,790	2,575,785,311
10%	1,535,856,622	1,689,442,284	1,858,386,513	2,044,225,164	2,248,647,680	2,473,512,448	2,720,863,693

Medicaid Projected General Revenue Increase over SFY15 level								
Growth Scenario	2015	2016	2017	2018	2019	2020	2021	Aggregate inceases over SFY15 level
5%	0	76,792,831	157,425,304	242,089,400	330,986,701	424,328,867	522,338,142	1,753,961,245
6%	0	92,151,397	189,831,878	293,373,189	403,126,977	519,465,993	642,785,350	2,140,734,785
7%	0	107,509,964	222,545,625	345,633,782	477,338,110	618,261,741	769,050,027	2,540,339,248
8%	0	122,868,530	255,566,542	398,880,395	553,659,356	720,820,635	901,354,815	2,953,150,273
9%	0	138,227,096	288,894,631	453,122,243	632,130,341	827,249,168	1,039,928,689	3,379,552,168
10%	0	153,585,662	322,529,891	508,368,542	712,791,058	937,655,826	1,185,007,071	3,819,938,050

Note that the amount of additional general funds needed to sustain the traditional Medicaid program beginning in calendar year 2016 to 2021, will be approximately $1.75 billion dollars of general funds, or greater if the higher range estimates for growth become a reality. Without change, this could put the state in the situation of looking to find $75 million to $100 million in new revenue each year simply to sustain the program, and that is by using low range estimates.

It is important to keep in mind that impact of growth in traditional Medicaid will vastly outstrip any state fiscal impact of the Private Option. In reviewing the future of the program, state leaders should put equal or greater focus on traditional Medicaid as on the expanded population.

The Private Option Population per FPL

Table 9 shows Private Option members per FPL. This data was presented to TSG by the Arkansas DHS.

Table 8—Private Option members per FPL

FPL	Med Frail	QHP	Total	%
0 - 50%	14,348	105,084	119,432	53.7
50.1 - 100%	5,314	56,474	61,788	27.8
100.1 – 115%	1,566	17,063	18,629	8.3
115.1 – 129%	1,267	14,076	15,343	7

129.1 – 138%	609	6,186	6,795	.03
Unknown	1	16	17	
Total	23,102	198,904	222,006	

In addition, DHS has indicated that in October of 2014 they had done a special data extract run to determine what percentage of the PO population was at 0% of FPL. The answer at the time was approximately 40%. DHS has indicated that they do not believe that this percentage has changed significantly.

Private Option Wellness Programs

TSG was asked by the Task Force at the July meeting to meet with Private Option carriers to determine the type of wellness related programs they offer to the Private Option beneficiaries. TSG was able to determine the following:

Ambetter has a wellness rewards program called MyHealthPays. In this program the individual Private Option beneficiary, as well as all beneficiaries in the federal subsidy program, can receive financial rewards for certain wellness related acts and demonstrated healthy behaviors. Specifically, pursuant to the program, cash rewards are put on cards that can be used to buy various health-related items. The amount of cash rewards are as follows:

- $50 for taking an initial health screen survey
- $50 for your first PCP visit
- $25 for an annual flu shot
- Attend a workout program and you are given 8 paid visits per month up to $20

Ambetter keeps records of the individual members that take advantage of the wellness program and the case rewards they give out. They indicate the program has been "very successful" and "beneficiaries like it." They "identify someone through the program to get them into care coordination early."

QualChoice offers smoking cessation programs, where people that are enrolled get a free PCP visit. They also get free access to smoking cessation strips and two treatments. They have access to a health coach and the outcomes have been very positive. They also put on wellness clinics with employers and conduct health fairs that concentrate on cholesterol and high blood pressure. They have partnerships, through subsidiary relationships, that can offer other wellness programs that they can build in on an individual basis.

Key Features of Alternative State Medicaid Expansions

TSG has reviewed key aspects of state Waivers for alternative features of Medicaid Expansion similar to Arkansas. TSG has conducted this analysis to give the Task Force members an idea as to some of the other state practices in terms of Waiver negotiation, especially related to the differences between benefit plan, cost sharing, premiums, and work engagement. The states that have looked at alternative benefit delivery systems, conditions for work engagement have done so in a manner that was typically not a major deviation from their existing programs. One area that other states have not significantly explored has been that of increased premiums or cost sharing, as the ACA does not apply the traditional restrictions to these venues.

As the Task Force prepares for its review of our Final Report and begins making decisions on any alternative to the current Private Option, TSG thought it would be beneficial to see a side by side comparison of the differences among these states. We also thought it was helpful to consider some of the recent Waiver proposals and approaches other states are taking in presenting their own plans to CMS. So, we have included some states that have publicly outlined their proposal but have not received CMS approval.

The Matrix is attached as TSG Status Report # 3 Appendices.

Retroactive Coverage

In response to the question from TSG, DHS did not seek a waiver of retroactive eligibility under Section 1902(a) (34). Waivers of 1902(a) (34) enable the State to waive or modify the requirement to provide medical assistance for up to three months prior to the month of application. 90 days retroactive coverage is the standard under 1902(a) (34). As the TF will see in our Waiver analysis section, a few states have sought and were granted waivers from retroactive coverage. In those states, coverage begins on the day of eligibility and not 90 days earlier. For Arkansas, waiver of this provision could amount to approximately $10 million a year in total fund savings (TSG will have financial analysis on this issue in our Final Report).

Arkansas uses the he fee-for-service delivery system to provide retroactive coverage for the three months prior to the month in which an individual is determined eligible for Medicaid.

Long Term Care Comparison of Total Long Term Care Institutional Versus Community Based Care Costs for FY 2014

TSG has spent a great deal of time working through the Medicaid claims data, as well as meeting with the DHS CFO to expand on its prior status reports and identify the differences between costs of institutional care (Public and Private Nursing Homes) and community based care (Elder Choices Waiver, Alternatives for Adults with Physical Disabilities Waiver, Personal Care, Living Choices and Assisted Living Waiver). TSG will use this data to make recommendations in its Final Report.

For now, TSG thought it would be important to share with the Task Force its own Preliminary Analysis of the complete long term care costs, including costs related to nursing home and community long term care and costs associated with the additional medical care for each long term care beneficiary regardless of whether they are a nursing home resident or remain in the community receiving waiver services or services under a state plan amendment.

The following financial analysis underscores the need to provide quality of care in a community setting for as long as possible, prior to more costly institutional care.

TSG used original claims data to assess the total costs for patients in Long Term Care settings. There is a belief in some corners that institutional care avoids other medical costs, and is therefore less expensive for the beneficiary overall compared to Assisted Living or Home and Community-Based care. Table 10 and Figures 13-16 show instead that the cost of caring for beneficiaries in non-institutional settings is less than institutional settings—even after fully accounting for all forms of medical care. Figure 13 shows that Nursing Facility covers only 43% of population but represents close to 80% of all costs for those beneficiaries, including Medical

Figure 14 shows that fully loaded with medical costs, a Nursing facility is $157 per day. Thus, including all medical, the cost of Home and Community Care is much less. Elder Choices Waiver is approximately $35 dollars and Personal Care only $38. Note: some of the beneficiaries in Elder Choices are also getting personal care so this amount could be higher, but this will not substantially impact the large difference between institutional spend and community based care spend. Additionally, TSG has not yet accounted for the difference of costs after excluding the one public nursing facility in the state, but does not believe that would amount to a material change in the financial analysis.

Table 9—Analysis of Full Medical Costs for Beneficiaries of Long Term Care

	Total Costs					Average per Head				
	Nursing Facility	Elder Choices	Alternatives for Adults with Physical Disabilities (I0)	Personal Care	Living Choices/Assisted Living	Nursing Facility	Elder Choices	Alternatives for Adults with Physical Disabilities (I0)	Personal Care	Living Choices/Assisted Living
LTC Direct Costs (Decomp)	705,968,893	53,135,374	19,963,418	98,037,630	17,810,010	50,043	11,400	10,776	8,398	22,983
Related Waiver Costs (claims analysis)	11,233,432	3,397,422	9,691,083		3,397,422	796	729	5,231	0	4,384
Halo	90,222,255	3,541,848	21,945,159		3,541,848	6,395	760	11,846	5,574	4,571
Total	807,424,581	60,074,645	51,599,660	98,037,630	24,749,281	57,235	12,889	27,854	13,971	31,938
Number of Annual Equivallents	14,107	4,661	1,853	11,674	775					

2014 Costs	Amount					
H1 - Hospice	5,947,011	5,947,011				
59 - Private SNF Crossover	24,963,236	24,963,236				
H2 - Nursing Home Hospice	29,971,174	29,971,174				
63 - Public SNF	39,695,754	39,695,754				
58 - Private SNF	605,391,718	605,391,718				
97 - Elders Choices Waiver	53,130,713		53,130,713			
I0 - Independent Choices Treatment Elderly	19,961,565			19,961,565		
53 - Personal Care - Regular	98,025,956				98,025,956	
AL - Assisted Living Facility	17,809,236					17,809,236

Note: Source is 2014 DHS Medicaid Claims from DeComp independently analyzed by TSG with assistance from DHS

Figure 13—Breakdown of Full Costs Supporting Waiver Beneficiaries

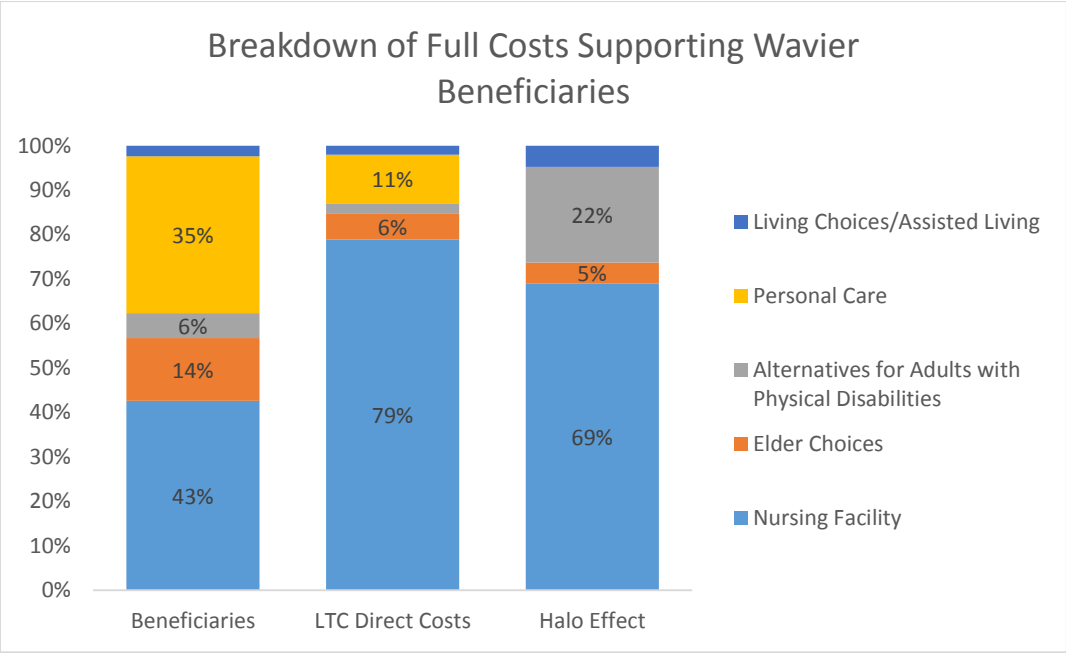


Figure 14—Per Day Costs of Long Term Care Including Halo Effect

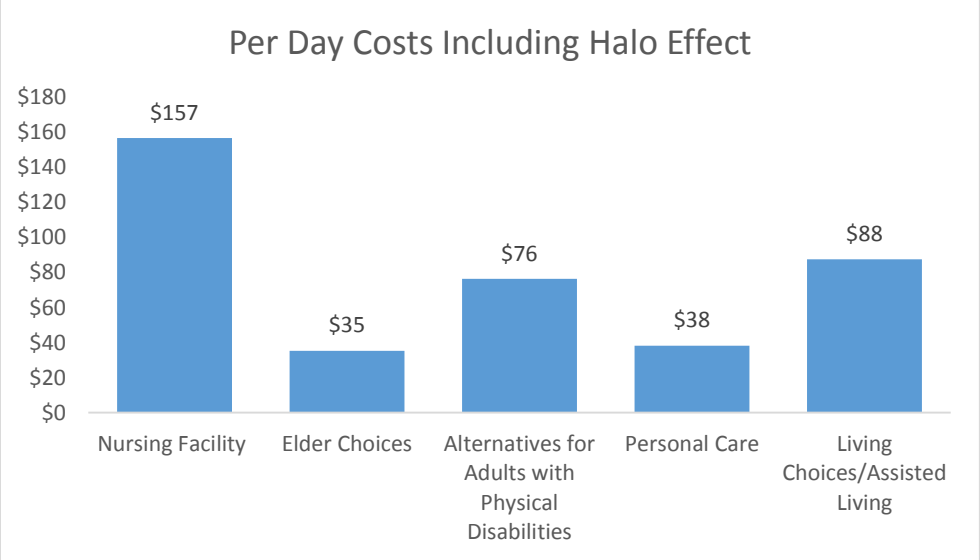


Figure 15—Breakdown of Full Long Term Care Costs, Including Medical

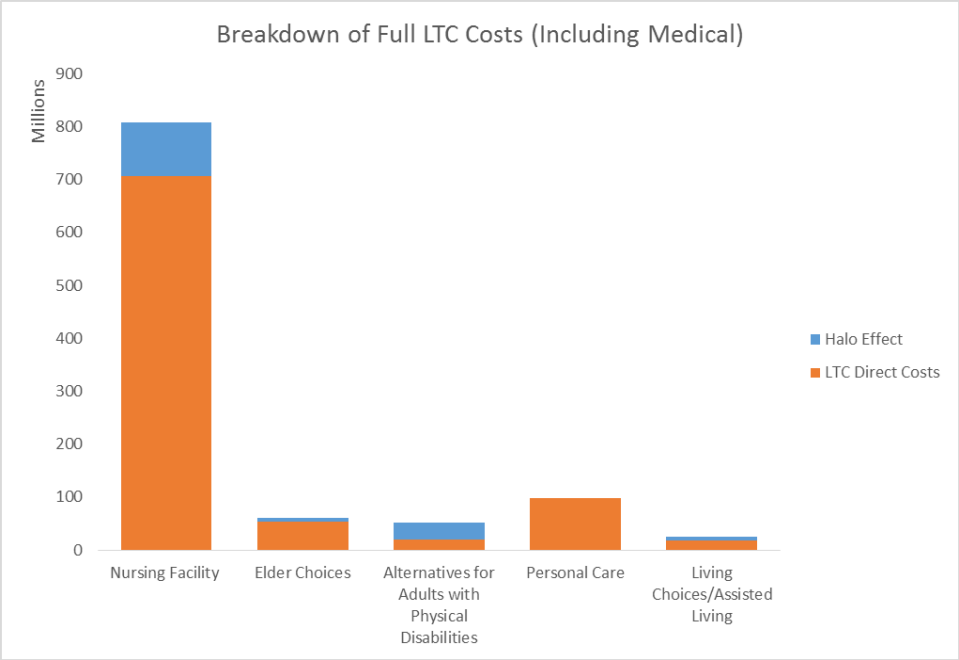
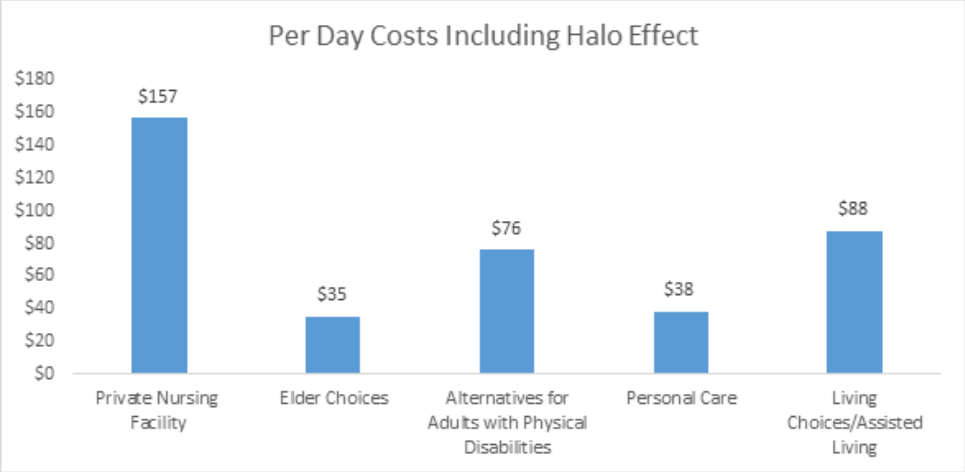


Figure 16—Long Term Care per Day Costs for Institution versus Community



Note: These costs include all Medical and other Waiver costs for the aged population served.
Note: Some Personal Care services may also be cross over with Elder Choices Waiver.

State Comparison of Total Medicaid and Total Long Term Care and Support Services Costs

State Costs Per State Resident (PSR): Total Medicaid and Total LTSS: FY 2013

Table 10—FY 2013 FMAP

	Total Medicaid Costs: PSR*	State Ranking*	Total LTSS Medicaid Costs: PSR**	State Ranking**	FY 2013 FMAP***
Arkansas	$1,408	19	$628	12	70.17%
Mississippi	1,583	13	504	19	73.43%
Louisiana	1,510	15	520	18	61.24%
Missouri	1,467	16	484	22	61.37%
Kansas	886	48	371	32	56.51%
Tennessee	1,337	20	368	33	66.13%
Oklahoma	1,247	27	344	39	64%
Texas	1,055	37	302	43	59.3%
US	$1,369	NA	$464	NA	NA

Source: Medicaid Expenditures for Long Term Services and Supports (LTSS) in FY 2013: Truven Health Analytics/Mathematica/CMS: 6/30/15: * Table AL; ** Table Y; *** ASPE FMAP 2013 Report

The Department of Health Recent Announcement

The Department of Health's (DOH) recent announcement to cease operations of its Home Health Services program was the result of an intense study that started two years ago. DOH engaged BKD CPA's and Advisors to conduct a study of the viability of the department's line of business for Personal Care, Home Health, Respite, Mother-Infant program, and case management with a focus on the cost of business and future projections.

The study found that between FY 2011 and FY 2015 there was a 28% decline in persons served from 18,700 to 13,200 while employees declined by 19% from approximately 2,900 to 2,400 for the same time period. Total labor costs of the DOH Home Health program had climbed to 84% of revenue with 37% benefits cost in 2015. AR private provider agencies cost of labor was 63% of revenue with 19% in benefits costs and the national industry average was 75% of revenue for labor costs with 15% benefits cost also in 2015.

BDK recommended that DOH "Divest the Home Care operations through either outright closure of the Home Care program or a potential sale of the Home Care Program" in their Final report to DOH on 4/6/15.

TSG was concerned about this announcement as being a potential barrier to further expansion of Home and Community Based Services options there by decreasing reliance on higher cost institutional care for the ABD population. The DOH Home Care program has also been impacted

by Medicare rate reductions of 10% between FY 2011-FY2014 and an additional 1% reduction a year from 2014 through 2017 as a result of the ACA (BDK).

In conversation with DOH we learned there was robust interest from in and out of state business entities in buying the DOH business enterprise outright as soon as the announcement to divest was made. DOH is currently studying the most effective method to market the Home Health enterprise and expects to take action in the next several months. Like other Home Care providers in the state, DOH has been subject to a lack of rate increases from the Arkansas Medicaid program since 2008 but feels there is significant interest in the business at current rates and opportunity to grow if rates are adjusted upward.

Arkansas Services System for People with Intellectual and Developmental Disabilities

The Division of Developmental Disabilities Services provides services for children and adults. Services include: Part C Early Intervention/Infant and Toddlers; Part B Early Childhood Services; Title V Children with Special Health Care Needs; Adaptive Equipment; DDS Waiver Services (HCBS); DDS Children's Services; Developmental Day Treatment Clinic Services (DDTCS); and five Human Development Centers (ICF/IDD).

DDS operates Intake and Referral Unit services for children 0-21 and adults. Currently DDS provides 2,000 assessments annually and serves approximately 4,200 persons on HCBS waiver, 920 individuals residing in state Human Development Centers, approximately 250 persons residing in private ICF/IDs, and approximately 50 children reside in four pediatric programs.

There are currently 107 private DDS case management providing organizations with many also providing DDS waiver services. Consumers and their families are provided an option for independent case management or provider based case management services. There are between 2,500 and 2,700 individuals on the HCBS waiting list. The waiting list is reviewed every three years. Current policy prioritizes available waiver services for persons wishing to transition from Human Development Centers, nursing facilities, and Arkansas State Hospital. Given the relatively low turnover of persons receiving waiver services or institutional care (110 to 140 per year) there are extensive wait times for persons currently living in the community regardless of the type of services they seek.

Arkansas System of Behavioral Health Care

Concerns about RSPMI (Rehabilitative Services for Persons with Mental Illness)

The Division certifies public (CMHCs) and private providers of the Medicaid Rehabilitative Services for Persons with Mental Illness Option services (RSPMI). There are currently 39 non-

CMHC RSPMI providers with a moratorium on further growth. One of the unintended consequences of the moratorium is that the RSPMI benefit is monopolized by currently licensed RSPMI providers resulting in no entity being contractually obligated to provide crisis diversion services from higher cost inpatient services when the level of care is clinically short of danger to self or others.

DBHS was originally included in the DHS plan to implement the mental health relevant version of the InterRAI universal assessment instrument. A decision was made by DHS to suspend this step of assuring standardized clinical assessment during 2015 without a time plan to restart implementation. DBHS reports there is no timeline to implement the InterRAI into the RSPMI system or for voluntary inpatient admissions.

The lack of an independent standardized clinical assessment instrument for adult and under 21 years of age individuals to access RSPMI services is a major concern given the growth in expenditures over the past several years with no discernable decrease in inpatient psychiatric services and child/adolescent residential services.

Prior authorization and utilization review services are provided under contract with DBHS/DMS by Value Options. Currently any RSPMI provider may "assess" an individual for Rehab Option services and forward the assessment and suggested plan of care for independent prior authorization approval.

Given the lack of a standardized assessment instrument Value Options relies on the clinical narrative of the RSPMI provider conducting the patient assessment who very likely would deliver and bill for the approved services. The program eligibility process for RSPMI services does not rely on a standardized clinical assessment instrument for any population it serves.

Value Options may approve the assessment and plan of care for 90 days at which time a treatment plan review takes place resulting in reauthorization, plan of care adjustments or denial. This service requires an annual psychiatric evaluation. Astonishingly, there are only daily limits on certain codes for Outpatient services, such as an RSPMI provider cannot bill more than 6 units of group therapy in a day. There is no evidence based mental health practice that includes 6 units of group therapy a day and appears subject to potential misuse or misalignment of evidence based clinical practice. There are no limits on outpatient units per authorization period which is a clear incentive for overutilization. Additionally, there are no limits on both inpatient psychiatric and residential services for the 21 years of age and under child/adolescent population and no discernable "hard wired" approach to comprehensive and coordinated post discharge plans of care.

The adult inpatient psychiatric benefit is limited by the benefit having a set number of annual inpatient days and is not subject to prior authorization, which is highly unusual for the most

expensive level of care regardless of the annual limit. Value Options reports they approve 95% of submitted RSPMI authorization requests. Of the 39 Outpatient RSPMI adult services 12 services require prior authorization. Of the 28 RSPMI services for less than 21 years of age, 15 require prior authorization. Services that do not require a prior authorization are limited to annual use. Value Options provides the following administrative only services on behalf of DBHS:

- Psychiatric Inpatient Services
- Certification of Need and determination of medical necessity for admission
- Continued stay and quality of care for inpatient psychiatric treatment by providers who are enrolled in the Arkansas Medicaid inpatient psychiatric program
- Care coordination in connection with admission diversion
- Discharge planning
- De-institutionalization for beneficiaries meeting predefined benchmark
  Outpatient utilization and quality control peer review activities include the following:
    - Prior authorization
    - On-site retrospective review activities including program policy
    - Medical necessity

Value Options also provides a limited care coordination service for up to 1,500 ("highest utilizers") beneficiaries a year with a goal of reducing readmissions to inpatient psychiatric beds and Psychiatric Residential Facilities. Children/adolescents make up a large percentage of this service group. The average follow-up period is 5 months and discharge is based on clinical criteria.

The "any willing provider" criteria for RSPMI services has resulted in increased utilization and cost for a benefit that is easy to access based on a lack of clinical eligibility criteria that indicates overall severity of condition and has unnecessarily fragmented care in a system that is structurally fragmented between a preferred provider model (CMHCs under contract with DBHS as single point of entry for civil commitments) and an any willing provider model that is now non-competitive, due to the moratorium, for other appropriately licensed mental health professionals, in some cases with higher level required credentials than current RSPMI providers.

The PCMH model was not designed to include the Serious Mental Illness (SMI) population. DBHS developed a mental health focused health home model in 2014 but planning was halted and has not been reconsidered within DHS/DMS. The DBHS model health home, with significant similarity to the successful Missouri model, is worth revisiting if no other comprehensive approach to care coordination other than the PCMH model is considered by DHS for the ABD populations.

In order to achieve an effective targeted population health home model the structural imbalances in the RSPMI delivery system will need to be addressed. DBHS is concerned about quality

services and a lack of incentive to avoid inpatient utilization or timely discharge with the current policy approach to RSPMI services and cost.

The current RSPMI benefit does not appear designed to provide a comprehensive strategy that includes a systemic focus on the highest acuity populations (other than civil commitment related crisis services contracted to the CMHCs) that incentivizes diversion from high cost inpatient services, nor does it include an Assertive Community Treatment benefit (ACT is an evidence based practice that is well researched. ACT provides a professional and peer based team that works with clients in the community/streets 24/7 that has been proven to increase community tenure while decreasing emergency room use and psychiatric inpatient utilization. SAMHSA considers ACT an evidence based practice (SMA08-4345) applicable for civil and forensic populations in the community).

Additionally, case management services for the SMI and populations were discontinued several years ago and replaced with "Intervention" services in the RSPMI program. Intervention services are billed in 15 minute increments and do not appear to be designed to provide assistance and support to the high acuity population in the community in a clinically defined manner that focus on avoiding decompensation, assisting clients with medication adherence, and avoiding costly inpatient care and readmission.

Universal Assessment for LTC, DD, and BH

DBHS reports there is no change in the current hold-up on implementing the MH InterRAI in the DBHS system.

Effective Care Coordination

One result of a "siloed" organizational structure within a state Health and Human Services agency is increased difficulty in planning, developing and implementing systems of care that provide effective and efficient care coordination for high cost, multiple chronic care and LTSS/BHS Aged, Blind, and Disabled populations across all services.

TSG interviews with DHS/DMS/DAAS leadership indicate the need for a comprehensive approach and plan for care coordination for high cost, multiple services population ("80% of spend goes for 20% of the Medicaid population"), all DAAS and DDS waiver recipients, and DBHS/RSPMI clients. While the PCMH model has elements of care coordination the model is essentially Primary Care focused and unconnected to the ABD and waiver(s) populations by design.

DHS has an outstanding opportunity to bring the knowledge gained through the successful launch of the PCMH model to scale across the ABD and waiver populations by committing to transform existing management, contracting and service delivery practices of medical and waiver services to a value based approach that provides care coordination across services delivery in all

settings resulting in a seamless service delivery pathway that integrates all care, services, and supports of medical and LTSS services across all eligible populations.

The Balancing Incentives Program grant model had some positive elements of care coordination at transitional points for exactly the right populations but was unconnected to the PCMH model and lacked a robust laser like care coordination resource across the BIP populations (DAAS, DDS, and DBHS). Best practice care coordination models focus on the whole person through integrated and comprehensive documented communication and care responsibilities across all providers enabled through payment models that incentivize integrated care for high need/high cost complex populations, and include outcomes, quality, and performance criteria that are measured and used to manage and fine tune the system.

The Agency of Healthcare Research and Quality describes the attributes of care coordination as follows:

- Care coordination involves *deliberately* organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care.
- Examples of specific care coordination activities include:
    - Establishing accountability and agreeing on responsibility.
    - Communicating/sharing knowledge.
    - Helping with transitions of care.
    - Assessing patient needs and goals.
    - Creating a proactive care plan.
    - Monitoring and follow up, including responding to changes in patients' needs.
    - Supporting patients' self-management goals.
    - Linking to community resources.
    - Working to align resources with patient and population needs.

The Public Policy Institute (PPI) of AARP conducted a study[4] of 18 states who have implemented Managed Long Term Services and Supports (MLTSS) delivery system models based on managed care methods and competitively bid Managed Care Organization (MCO) contracts. The study report was recently released (7/15), reviewed by CMS, and is the most recent research into the rapidly increasing number of states who are transforming their traditional uncoordinated fee for service HCBS LTSS waiver programs into comprehensive integrated medical, pharmacy, HCBS waivers, innovative prevention measures, and related state plan amendment services through at risk managed care models (MLTSS).

[4] http://www.aarp.org/ppi/

The PPI conducted in-depth case studies of the Illinois and Ohio contracts and delivery systems as well as an in-depth contract review of the MLTSS models in Arizona, California, Delaware, Florida, Hawaii, Kansas, Massachusetts, Minnesota, New Jersey, New Mexico, New York, Ohio, Rhode Island, Tennessee, Texas, Virginia, and Wisconsin.

The value of this study was that the PPI was able to identify emerging trends in how care coordination for the LTSS populations is being implemented while MLTSS is rapidly expanding across the country. For example, Iowa and Pennsylvania are currently in the process of transforming their LTSS systems and all medical services to a managed care model. Washington recently released a draft 1115 demonstration waiver that integrates all Medicaid services into one integrated care coordination focused managed care model similar to the comprehensiveness of the TennCare model but with the addition of Accountable Care Organizations, community based care delivery, attention to the social determinants of health, and innovative LTSS prevention strategies while targeting cost increases 2% below the national medical inflation rate throughout the five year demonstration.

It appears that after the past five years of innovative demonstration projects that many states have conducted with funds provided by CMS State Innovation Models (SIM) funding the concept of integrated care coordination models addressing the whole person are being integrated into many state's approaches to Managed Long Term Services and Supports (MLTSS) through comprehensive managed care contracting and payment models.

Given this relatively rapid change in state methods for contracting, delivering, and paying for Medicaid LTSS, the Public Policy Institute's findings on how integrated care coordination is being structured in state managed care contracts and developing in the field is valuable information for state policy makers and administrators to consider in future planning. The study found three trends on the methods LTSS MCOs were implementing care coordination at the community level of service delivery.

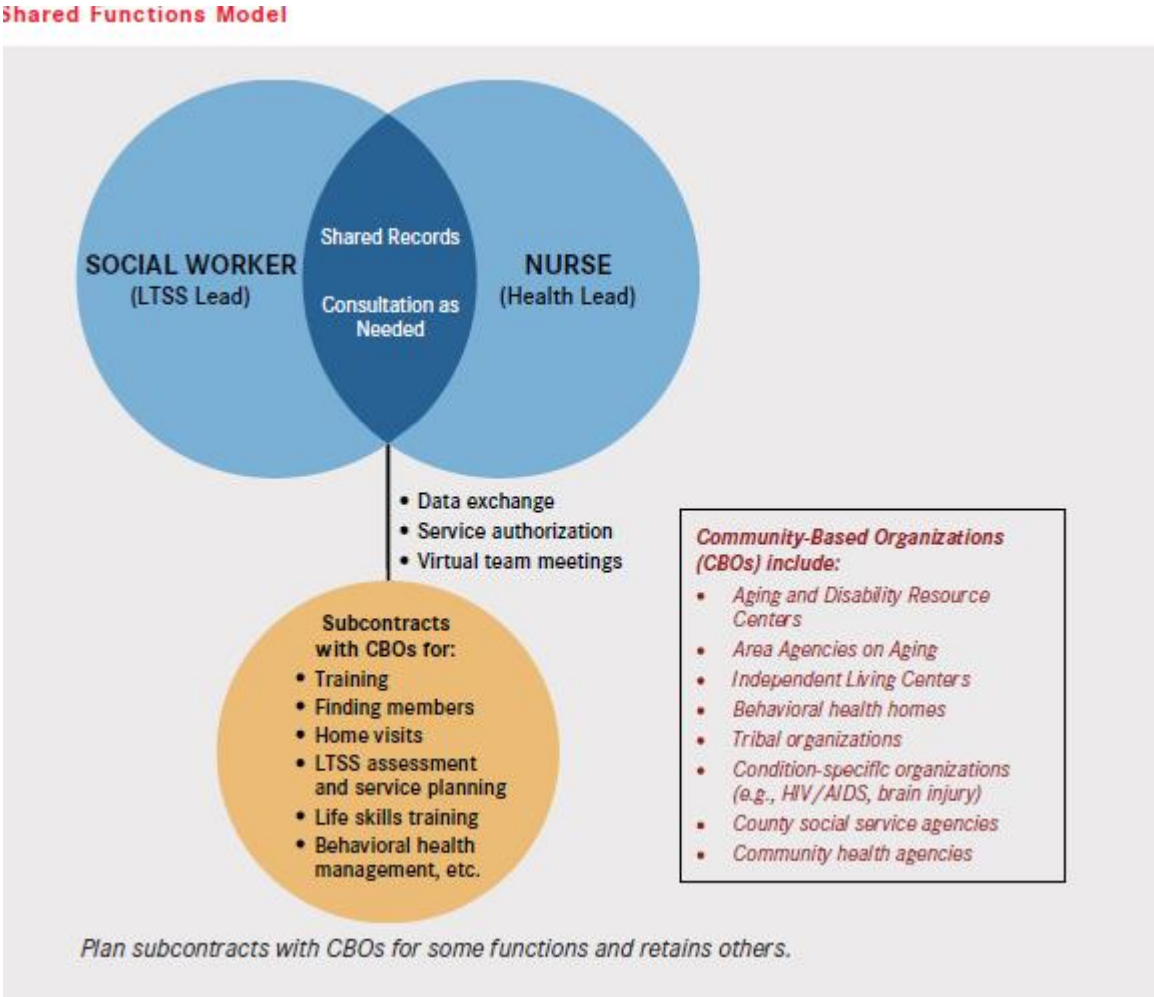
The first trend was "In House" model where the MCO provides care coordination with their own staff, primarily credentialed social workers and nurses. This model tends to connect with traditional waiver based case management. The second model is based on "Shared Functions" where health plans subcontract with existing community providers, such as case management, and retain other aspects of care coordination, such as medical services, and integrates with community partners through IT based shared data and case information. The third less used model involves a health plan that delegates all care coordination activities to a health system or provider already engaged with the client(s).

The Shared Functions model of MLTSS care coordination provides the opportunity for states to reconfigure their existing LTSS provider participants through an innovative business model that is based on operational and contractual partnerships.

In this model, the health plan structures comprehensive care coordination through a team approach. The health plan is operationally responsible for care coordination activities via a credentialed social worker and nurse working in tandem with the social worker responsible for community based (in some contracts nursing facilities as well) LTSS services and the credentialed nurse responsible for health related services. Shared records and plans of care/treatment plans are fundamental to the process of achieving quality outcomes and assuring safety in a coordinated framework backed up by documentation.

The plan contracts with community based organizations ("CBOs") for services such as training, finding and accessing members in need, home visits and traditional waiver services, LTSS assessment and plans of care, life skills and prevention training, and behavioral health management. Community based organizations include Aging and Disability Resource Centers (ADRCs), Area Agencies on Aging, Independent Living Centers, Behavioral Health homes, specialty services organizations, county social service agencies, and Community Health Agencies. CBOs depend on the structure of the traditional LTSS state and community system.

Figure 17—Shared Functions Model[5]



The study provided a clear analysis of how states are working with and directing managed care organizations to provide high quality care coordination that enhances or maintains health status while providing quality services and supports across all services received by an eligible individual through clearly identified care coordination practices. The model is based on the proposition that effectively coordinated care results in improved health outcomes and reduces costs.

[5] http://www.aarp.org/content/dam/aarp/ppi/2015/care-coordination-in-managed-long-term-services-and-supports-report.pdf viewed August 17, 2015

History of Payment Improvement in Long Term Care, Behavioral Health and Developmental Disabilities

At the July Task Force meeting, TSG was asked by the Task Force to review the prior history of some of the efforts to reform the long term care services and supports area in Arkansas Medicaid and report back. The following is a summation of what we have collected from DHS.

Behavioral Health

State staff and stakeholders began working together in 2012 to design a continuum of Medicaid services for adults and children with mental health needs as well as substance abuse issues. There were over 75 meetings and presentations during this effort with a wide range of stakeholders, including providers, consumers, and families. The results of those efforts were crafted into two state plan amendments (SPAs), 1915i and Health Homes, both of which needed to be submitted to CMS for approval as well as be promulgated through the regulatory processes associated with the Administrative Procedures Act.

The SPAs included the new requirement of an independent functional assessment that will establish several tiers of available services based on need. The introduction of the 1915i would include a continuum of needed home and community based behavioral health services such as:

- Substance abuse services for children and adults
- Wraparound support services for children and their families
- Recovery oriented services for adults
- Enhanced crisis stabilization and response services
- Peer Support and Family Support partners for adults and children

It was the DHS intention that the Behavioral Health Homes would provide intensive care coordination services for adults, children, and families identified to be high utilizers of behavioral health service. Additionally, Health Homes would serve as the single referral agencies for children's residential services.

Phase 2 of the promulgation would include policy amendments to dissolve the Rehabilitative Services for Persons with Mental Illness (RSPMI) program and change the requirements for admission to children's residential services to mandate referrals come only from Health Homes.

Per the Administrative Procedures Act rules, the proposed changes were put out for 30 days of public comment in the fall of 2014. A great many comments were received and reviewed. Division staff met with a small group of stakeholders in an effort to craft a proposal that would take into account some of the concerns raised during the public comment period. Those meetings continue.

Developmental Disabilities

Over the course of the past four years, the Division of Developmental Disabilities Services (DDS) has pursued the following payment improvement initiatives and reforms:

- Community First Choice Option
- Health Homes
- Episodes of Care that included an Assessment Based Payment methodology
- Waiver Renewal that includes an Assessment Based Payment methodology
- DDTCS/CHMS Moratorium on New Sites and Hybrid Service Model

In March of 2014, the Department submitted the Community First Choice Option (CFCO) State Plan Amendment to CMS. Stakeholder groups consisting parents/guardians of DDS consumers, Waiver providers and State staff met to discuss several cost control measures related to or running concurrent with CFCO. Those measures included development of DD Health Homes, Episodes, Assessment Based Payments and the possibility of being capable of serving eligible DDS consumers currently on the DDS Waiver waitlist, using the enhanced 6% federal match CFCO offered to all waiver consumers.

Legislative and stakeholder opposition for both CFCO and episodes generally resulted in the CFCO SPA being withdrawn earlier this year. According to DDS, they have since moved forward with an Assessment Based Payment methodology for the current 1915(c) Waiver. Because the DD Health Home design was based on moving case management services from the Waiver into CFCO, moving forward with the DD Health Home became impractical when the CFCO SPA was pulled back because that service category remains in the waiver for the time being.

DDS indicated that it is currently working on several initiatives to control and minimize the current program growth rate of the DDS Waiver and ensure individuals with developmental disabilities receive quality care tailored to their specific needs. They continue efforts on the Assessment Based Payment methodology and hope to implement a payment system based on resource utilization groups (RUGs) or tiers. A Waiver amendment including RUGs would be required.

DDS has included stakeholders throughout the development of the Assessment Based Payment effort. The independent assessment tool selected for this purpose was the InterRAI. Two stakeholder groups were assembled made up of Waiver providers, clinicians, and State Staff. One group analyzed assessment tools for children while the other analyzed assessment tools for adults. Over time, the goal is to roll out needs based assessments for resource allocation to all DD clients.

Nursing Facility Payment Improvement

Beginning in 2012, the initial proposed model by DHS was a case-mix system. This system would:

- Determine the acuity level of each individual applying for placement in a nursing facility by utilizing a universal assessment instrument that relied on the InterRAI algorithm developed by the InterRAI consortium
- Determine an individualized reimbursement rate from the acuity level
- Apply the rate in "real time"

Rates would be set on a per-individual basis, and adjusted as individuals left placement or as their acuity changed. This model was eventually abandoned when it became obvious that the IT infrastructure would not support such a computationally-intensive program.

The DHS then proposed an acuity-based model. Under this model:

- All clients would be assessed (through the Minimum Data Set (MDS)
- All clients would be classified as either "low care" or "high care" where "low care" clients represent individuals who, although they meet the institutional level of care, have the lowest level of support requirements and can likely be effectively served in the community
- Nursing facilities that have a larger share of "low-care" client bed-days than a threshold level would have their payment (full per diem rate) adjusted downward
- The level of the adjustment would be tiered based on how far below the threshold the facility was with respect to its high-care percentage
- In order to most accurately reflect the wide range of client and facility situations, a robust set of client- and facility-level exceptions would be a core part of the model

Under the acuity-based model, facilities that reduced or eliminated the percentage of low-care population (when exceptions did not exist to allow low care individuals) would avoid penalties. Under both models, facilities would be rewarded for meeting specified quality metrics. It was agreed that at least some of the metrics would be assessed through a tool offered by the American Health Care Association called Trend Tracker.

Concurrent with the DHS acuity-based proposal, the Arkansas Health Care Association (AHCA), the trade group for most nursing facilities in Arkansas, offered a counter proposal. AHCA proposed:

- Elimination of the use of provisional rates after a transfer in ownership of facilities (provisional rates would be maintained for physically new facilities)
- Lowering the cap on facility liability insurance (which is reimbursed by the State)
- A moratorium on population based beds

- A change in the cap on direct care per diems from 105% of the 90th percentile to 100% of the 90th percentile

In October of 2014, the acuity-based model was presented to all nursing facility owners. However, while the DHS believed that it was necessary to continue to pursue the acuity-based model for various reasons (cost control; rebalancing between institutional and Home- and Community-Based Services or HSBS), DHS agreed to accept the first two proposed cost savings measures offered by the AHCA, as well as the use of the Trend Tracker instrument for measuring quality metrics.

DHS and AHCA continued to have regular meetings around the acuity based model but there was no agreement reached. According to AHCA, the DHS plan would have substantially impacted a number of providers, especially in rural areas of the state. AHCA was willing to entertain a discussion of using certain episodes of care, but that has not materialized as well. Based on the opposition and with the general legislative session looming, DHS decided to indefinitely suspend development of the acuity-based model.

Managed Care Organizations

At the August 20 Health Reform Task Force meeting, the Task Force has invited Managed Care Organizations that offer capitated, full risk, Medicaid Managed Care services to Medicaid populations in other states to present their thoughts on Medicaid reform in Arkansas. Towards that end, the Task Force asked TSG to prepare a number of questions to present to the Managed Care Organizations (MCO) prior to the testimony. These questions were prepared by TSG and sent to each of the MCOs by BLR and they were required to address these questions in writing prior to the testimony. TSG has been presented with responses from the following MCOs who will offer testimony to the Task Force at the August 20th meeting:

- Aetna
- AmeriHealth Caritas
- Amerigroup Real Solutions in Health Care (Anthem)
- Arkansas Health and Wellness Solutions (Centene)
- Blue Cross and Blue Shield of Arkansas
- Magellan Complete Care
- Meridian Health Plan
- Molina Health Care
- United Health Care Community and State
- WellCare

The responses have been summarized by TSG for the Task Force and contained in TSG Status Report # 3 Appendices. The full responses for each company will be provided to each Task Force member by BLR prior to the hearing on August 20th.

Retroactive Coverage

In response to the question from TSG, DHS did not seek a waiver of retroactive eligibility under Section 1902(a) (34). Waivers of 1902(a) (34) enable the State to waive or modify the requirement to provide medical assistance for up to three months prior to the month of application. 90 days retroactive coverage is the standard under 1902(a) (34). As the TF will see in our Waiver analysis section, a few states have sought and were granted waivers from retroactive coverage. In those states, coverage begins on the day of eligibility and not 90 days earlier. For Arkansas, waiver of this provision could amount to approximately $10 million a year in total fund savings (TSG will have financial analysis on this issue in our Final Report).

Arkansas uses the fee-for-service delivery system to provide retroactive coverage for the three months prior to the month in which an individual is determined eligible for Medicaid.

Section 1115 Demonstration Waivers

From CMS Website:

Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and CHIP programs. The purpose of these demonstrations, which give states additional flexibility to design and improve their programs, is to demonstrate and evaluate policy approaches such as:

- Expanding eligibility to individuals who are not otherwise Medicaid or CHIP eligible;
- Providing services not typically covered by Medicaid; or
- Using innovative service delivery systems that improve care, increase efficiency, and reduce costs.

There are general criteria CMS uses to determine whether Medicaid/CHIP program objectives are met. These criteria include whether the demonstration will:

- Increase and strengthen overall coverage of low-income individuals in the state;
- Increase access to, stabilize, and strengthen providers and provider networks available to serve Medicaid and low-income populations in the state;
- Improve health outcomes for Medicaid and other low-income populations in the state; or
- Increase the efficiency and quality of care for Medicaid and other low-income populations through initiatives to transform service delivery networks.

Demonstrations must also be "budget neutral" to the Federal government, which means that during the course of the project Federal Medicaid expenditures will not be more than Federal spending without the waiver.

Generally, section 1115 demonstrations are approved for an initial five-year period and can be extended for an additional three years. States commonly request and receive additional 3-year extension approvals. Certain demonstrations that have had at least one full extension cycle without substantial program changes will be eligible for CMS' "fast track" review process for demonstration extensions.

Public Comments

The Affordable Care Act requires opportunity for public comment and greater transparency of the section 1115 demonstration projects. A final rule, effective on April 27, 2012, establishes a process for ensuring public input into the development and approval of new section 1115 demonstrations as well as extensions of existing demonstrations.

This final rule sets standards for making information about Medicaid and CHIP demonstration applications and approved demonstration projects publicly available at the State and Federal levels. The rule ensures that the public will have an opportunity to provide comments on a demonstration while it is under review at CMS. At the same time, the final rule ensures that the development and review of demonstration applications will proceed in a timely and responsive manner.

There will be a 30-day Federal comment period for the general public and stakeholders to submit comments. CMS will not act on the demonstration request until 15 days, at a minimum, after the conclusion of the public comment period. CMS will continue to accept comments beyond the 30-day period; however, CMS cannot guarantee that comments received after the 30-day comment period will be considered due to the need for timely Federal review of a State's request. Therefore, CMS strongly encourages comments to be submitted within the 30-day Federal comment period.

Once a State's 30-day public comment period has ended, the State will submit an application to CMS. Within 15 days of receipt of the application, CMS will determine whether the application is complete. CMS will send the State written notice informing the State of receipt of the complete application, the date on which the Secretary received the application, and the start date of the 30-day Federal public notice period. If CMS determines that the application is not complete, CMS will notify the State of any missing elements in the application.

Observations about the Rhode Island 1115 Waiver

- Covers all Title XIX Medicaid eligible individuals
- State manages one 1115 Waiver with administrative efficiencies

- Focus of original waiver on deinstitutionalization
- 5 year global budget
- Aged, blind and disabled Medicaid population obtain right service at right time in right setting
- Spending cap creates culture of efficiency driving program savings and large Medicaid cost avoidance
- Nursing home admissions reduced due to managed care strategies and changes in levels of care
- Focus on prevention

See TSG Status Report # 3 Appendices for description of the Rhode Island Global Waiver Flexibility. Approved by CMS January 16, 2009

Observations about the TennCare II 1115 Waiver

- Covers all Title XIX Medicaid eligible individuals, except those only covered for Medicare premiums
- All Medicaid eligibles, with exception of those eligible for TennCare Select, are enrolled in managed care including PBM, DBM, NFs, and ICFs
- TennCare Select covers children with SSI, in state custody, residing in NFs/ICFs; option to select TennCare managed care
- TennCare CHOICES is a service provision within managed care contracts that serves people in NFs, those with NF level of care needs treated in the community, those at risk of NF eligibility, and those at Interim Risk. All levels of care require SSI determination accept those in a NF (entitlement service)
- 12 MCOs covered the state in 1994; 6 MCOs covered the state in 2004; 3 MCOs cover the state in 2015
- Total FY 2016 budget: $10.5 billion
- In 2008, Tennessee passed the LTC Community Choices Act designed to transform LTC integrated with managed care.
- In 2008, 87% of LTC was provided in NFs; 13% was provided HCBS
- In 2014, 60.7% of LTC was provided in NFs; 39.3% provided HCBS with the trend continuing to HCBS at 4-5% per year

Observations about the "Medi-Cal 2020" 1115 Waiver

- Managed care reforms include: mandatory enrollment of dual eligibles; expansion of General Managed Care and County Based Risk Sharing Managed Care with rural adjustments; shared savings with MCOs with required provider pay for performance/quality improvements; adds behavioral health; adds Seniors and Persons with Disabilities (NFs included); requires two plan choice.

- DSRIP (Delivery System Reform Incentive Program) transformation based on past DSRIP experience aligned with state strategies on national quality (NQS) and prevention (NPS).
- Total 5 Year Budget: $269.4 Billion Without Waiver; $253 Billion With waiver

(Sourced from state waiver documents on CMS website)

Contract Observations

The MMIS work is covered under 5 contracts – the Hewlett Packard existing MMIS contract, the HP contract to develop the new system, the Optum contract, the Magellan contract, and the Cognosante Program Management Office contract. Once the new components of the MMIS go into production, many of the costs will decrease as the State is no longer paying for the simultaneous "build the new" while "running the old" components.

There are a number of contracts which bill direct and indirect costs. The range of indirect costs, as a percentage of direct costs, ranges from 0% to 53%. Arkansas could limit the amount of indirect costs companies can bill under these arrangements. In particular, Arkansas could limit the amount one state agency can charge another state agency for these overhead costs. If all the contracts could be managed to 20% indirect costs, the State could save $10 million a year.

The money DHS pays for the third party liability (TPL) and recovery process demonstrates a very favorable rate-of-return for the state in that the TPL vendor collects significantly more than the contract costs.

TSG probed into the two Cognosante contracts for Program Management Office services to understand the skills provided under these contracts, the working relationship with the other vendors on the MMIS and the EEF projects, and the lack of skills available within the State to perform these roles.

The DataPath contract supports the private option Health Independence Accounts (HIA). The timeframe and approach to HIAs is a direct result of the Arkansas legislation for this program. There were initial fees paid to this vendor to develop the system, stand up a web site, create educational collateral, and stand up a call center. HIA recipients were sent a MasterCard that they activate via a portal, www.myindycard.org, or by calling the call center.

DataPath administers the financial transactions and pays the providers. The original procurement estimated there would be 95,000 participants. In reality, the last report showed 45,000 people had been issued cards of which only 10,000 cards are activated. As a result, the cost of each card increased dramatically due to underutilization. The program is now costing the State approximately $820 per activated card. The agency is required to comply with the current legislation and does not feel it is able to discontinue or modify this program on its own.

The Pine Bluff Psychological Associates contract provides independent assessments for the persons on the waiver list. TSG brainstormed with DHS personnel where there may be an economic reasons to modify the process for conducting these assessments.

The Health Services Advisory Group contract provides on-site and off-site personnel to conduct Medicaid Data Mining.

Agency Collaboration

TSG reviewed the existing organization chart and compared it to other states. We reviewed the size of the existing organization and the challenges of finding and retaining staff in certain positions.

TSG observed the current focus on the organization is on compliance. While compliance is always important, there is a higher standard DHS will need to evolve to meet the challenges of the future. DHS needs to own the improvement of the system of care for its beneficiaries.

TSG also observed a strong need for additional collaboration and coordination across the parts of the existing organization. In particular, this collaboration is most needed in the following areas:

- Care Coordination to reduce costs and improve the efficacy of services
- Program Integrity to improve the detection of fraud, waste, and abuse
- Procurement to shift more responsibility and risk to vendors and not rely on State personnel to integrate services and products.
- Shared Services

Payment Improvement

TSG Physician Survey Results Update

On June 25, TSG released a survey to physicians and hospitals in Arkansas to gauge their impressions of the miscellaneous Arkansas payment improvement initiatives, particularly the episodes of care (EOCs) and patient centered medical home (PCMH). In the July interim report, we noted that as of July 9, 250 responses had been received. As of August 13, a total of 438 responses have been received. TSG intends to close the survey at the end of August to allow adequate time for analysis prior to the September interim report and final project report.

A preliminary analysis of the new responses did not identify any major changes in the overall pattern of responses. The proportion of respondents who are physicians remains similar at about 2/3 and the range of responses follows a similar pattern as in the analysis of the first 250 responses with a mix of opinions about the EOC and PCMH initiatives. The final analysis of the survey data will include a break-out of responses by provider type and physician specialty and more content analysis of the open-ended questions.

Episodes-of-care Update

In the July report, TSG reported on our analysis of the estimated costs and potential savings associated with the EOC initiative. Subsequent to the July interim report and the corresponding TSG update presentation at the July Task Force meeting, TSG has met with DHS to discuss the assumptions and methods used to develop those estimates and has refined the estimates based on additional detail provided by DHS.

With the addition of a new estimate for the potential cost savings attributable to the perinatal EOC, the new estimate of the total annual potential cost savings due to the first 14 EOCs is in the range $8.7M-$20.3M. (The previously reported analysis of potential savings estimated that the annual potential savings for the first 14 EOCs deployed was in the range of $6.9M-$28.2M.)

On the cost side, some costs were removed from the estimation that did not support development of the original 14 EOCs, leaving a total cost for the first 14 episodes of $49M or about $3.5M per episode.

Table 11—Revised per Episode Cost Benefit Estimate

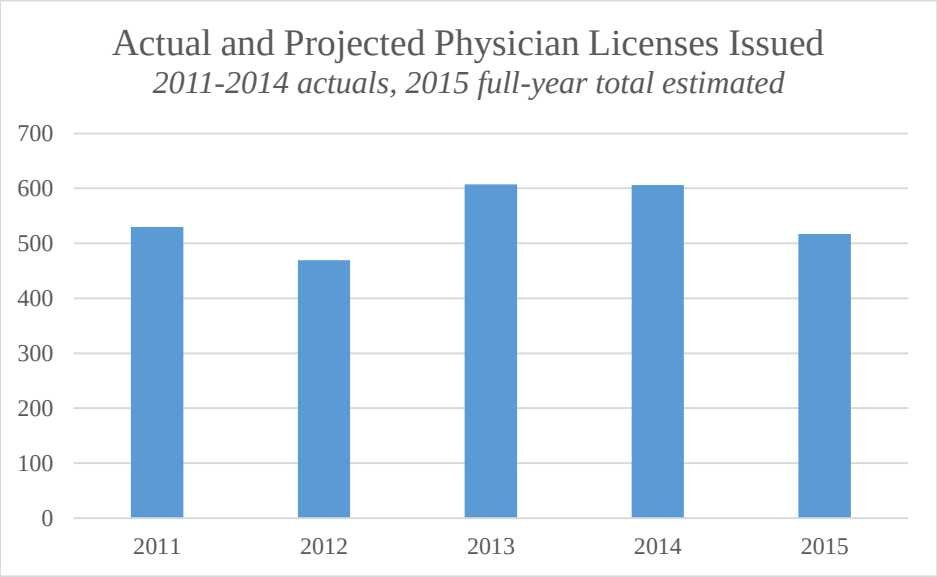
Revised Per-Episode Cost-Benefit Estimates		
Expense Category	Amount	Payoff (years)
Cost	$3,500,376	
Conservative savings	$620,286/yr	5.64
Aggressive savings	$1,451,643/yr	2.41

Health Workforce

The July interim report to the Task Force reviewed past studies that have done on health workforce in Arkansas, with a focus on physician workforce. As noted in that report, the past reports are not timely enough to provide insight into the question of whether the private option has created a more favorable environment for health workforce in Arkansas. Therefore, data on physician license applications received and licenses issued was requested and received from the Arkansas Medical Board.

Figure 18 shows the levels of physician licenses issued.

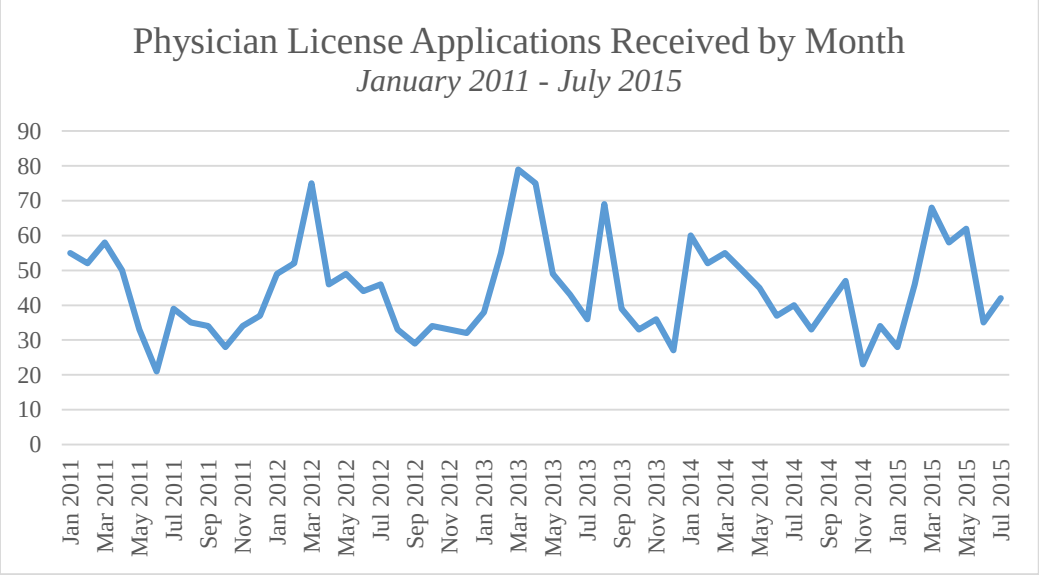
Figure 18—Actual and Projected Physician Licenses Issued



Although the annual nature of this data results in a very small data sample, there is very little in this data to suggest a significant change in the number of licenses issued after the establishment of the private option. However, since license issuance could be constrained by the administrative capacity of the agency, license applications are also examined.

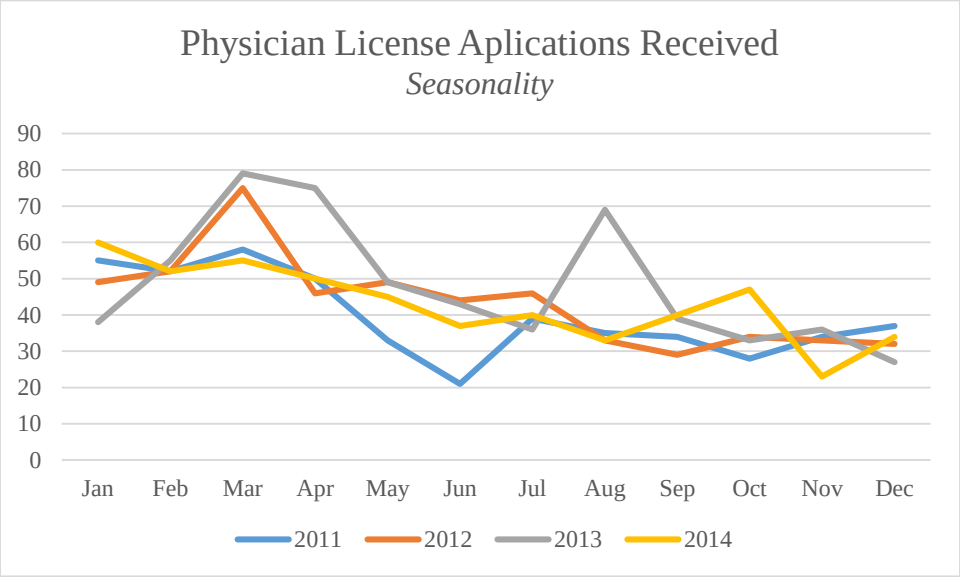
The following figure shows the number of license applications received by month, between January 2011 and July 2015.

Figure 19—Physician License Applications Received by Month



Although this data is more granular than the annual data, there still is no obvious change in the level or trend of the data around the time of the beginning of the private option in early 2014. This graph does suggest that the data exhibits seasonality – a repeating pattern that aligns with a time period, in this case the year. Graphing the multiple years on top of each other rather than in series shows that there are common trends across the years, but also reinforces the observation that there does not seem to be a discernible change in the pattern after the implementation of the PO.

Figure 20—Physician License Applications Received Seasonally



If there were any significant impact on physician license applications after the implementation of the PO, we would expect the line representing 2014 license applications to be noticeably different from the other year lines.

Taken as a set, the data representing physician license applications and approvals do not appear to show any noticeable change after the implementation of the PO.

Eligibility and Enrollment

Notification for Renewal:

There have been various stresses and problems experienced as DHS is now working to clear the backlog of annual renewal eligibility reviews of nearly 300,000 Arkansas beneficiaries. One consequence has been to highlight the rules and regulations concerning notification times for the beneficiaries to respond to income verification requests because a higher than expected percent of beneficiaries have not responded to the income verification request within the nominal 10 day period. Some of the relevant federal rules and guidelines have had enough ambiguity to stimulate a review.

Arkansas DHS state officials, as well as TSG, have asked CMS for clarification of the federal regulation regarding time required to be given to beneficiaries when they need to revalidate their income qualifications.

Whatever the regulation review comes up with, it is already clear by reviewing the processes other states are using and initial exchange with CMS officials that Arkansas almost certainly has the option to extend the verification notice time periods.

Longer Response Time:

Given that Arkansas is now resolving a backlog built up over a year, and considering that the state must support many of these renewal cases with individual case worker and call center support, and considering that a significant portion of the new Medicaid clients are new to these processes and procedures there seems to be a reasonable argument for significantly extending the renewal response time – at least until the backlog is resolved.

Slower Pace of Renewal Backlog Recovery:

A second alternative would be to slow the pace of renewals so that there would be more adequate DHS resources to deal with individual case issues as they arise. This however would likely be a less successful standalone solution than simply providing more response time to the beneficiaries as proposed above. A combination of these two adjustments would probably completely alleviate the current problems for legitimate beneficiaries and the DHS overload.

We have already informally confirmed with CMS that changes along these lines should not jeopardize the federal waiver under which this renewal delay is operating, although that should be explicitly confirmed if the state chooses to make a change to their process.

Decreased Income:

Even though it might require federal agreement, it would also be reasonable to not disqualify beneficiaries whose reported income has gone down. In those cases the evidence at hand indicates that the beneficiary would still likely qualify for Medicaid. The policy change should include a review process to bring the income being used for services determination into line with current reality, but without the intermediate step of disqualifying the beneficiary for all services because the beneficiary didn't document their decreased income.

Most likely, any service level adjustment should not be made until the new, lower income is verified, but it is questionable to disqualify someone because their income has decreased without notification to DHS. Over time, this policy change would probably save administrative effort and money for those who will almost surely continue to remain eligible.

Reasonable Compatibility

The federal program created their "reasonable compatibility" rule (the approximately 10% difference rule) to simplify things for states and to prevent much wasted time over hair-splittingly small differences in income numbers. But we may now be seeing unintended consequences that Arkansas should work with federal program to alleviate.

Income Verification

When an Arkansas applicant for Medicaid services first applies for assistance their reported income is initially verified against federal IRS income data. This sounds like a good idea, but for most applicants the federal data is more out of date and inaccurate than Arkansas sources, especially the unemployment insurance database. In addition, the federal data is obviously highly sensitive and must be accessed and used within the strictures of strong privacy controls, which can be burdensome.

Unnecessary Cost

Using the more out of date federal databases likely increases the amount of manual case processing effort, time, and expense to review an applicant's eligibility because a higher percentage of applicants must then have their income assessed by manual methods. As much as 20% or more of applications that currently require manual review could have their income evaluated automatically, "no-touch," with this change.

Inconsistent Standards

Currently, the review of income for renewal of eligibility already does primarily use in-state sources of information, again primarily the unemployment insurance database. It is only the initial review that uses the federal data. If nothing else, there is an argument for the state to use a consistent standard for both the initial income eligibility review and the renewal reviews to follow.

There was likely a reason to use the federal data when these new systems were being implemented a couple of years ago. But our review does not support that decision at this time. In fact, we believe it is costing the state money for no real benefit.

TSG informally reviewed this issue with CMS authorities and it appears they would have no objection and might even actively support Arkansas making this change. On the state side this might require a rule change through standard process.

Ex Parte Based Eligibility

SNAP eligibility can be used to meet Medicaid eligibility requirements. Although SNAP eligibility and renewal processes are different, the differences in aggregate result in an eligibility

scrub that is generally more stringent than current Medicaid requirements, so using SNAP information does not degrade the quality of eligibility review, since both require similar documentation.

Incarcerated Beneficiaries

There has been no comparison made between incarceration data and beneficiaries who are managed in the new, IBM/Curam, eligibility database. Any beneficiaries who were incarcerated and were not being discovered by cross comparison with incarceration information continued to qualify for Medicaid benefits. Obviously, for traditional Medicaid fee for service this is not a significant problem. For Private Option beneficiaries this is a problem because payment continued to be made to the carrier even though the beneficiary cannot legally receive benefits while incarcerated.

Note that beneficiaries managed in the legacy, Answer, system have been being cross-check against incarceration rolls and removed from the benefit programs as appropriate on a monthly basis using a manual comparison process.

More than 200 client matches are made between the legacy/Answer database and the incarceration data every month.

Paying premiums to Private Option carriers for beneficiaries who are incarcerated can cost the state and federal government if not properly recouped.

In July DHS reported they were note yet managing incarceration reviews in the new IBM/Curam eligibility system. DHS has now implemented a short term work around plan where DCO will provide an incarcerated list monthly to be compared to the beneficiary list in the new system. Incarcerated beneficiary cases will then be closed as is currently being done in the legacy system. So starting now, the new eligibility system and the legacy eligibility system will both manually cross-check beneficiary roles with lists of newly incarcerated on a monthly basis. The longer term plan, of course, is for that cross-check of beneficiaries and incarcerated to be automated.

Deceased Beneficiaries

Data management of benefit cessation for deceased seems to be improving relative to practice when this issue was raised by the Medicaid Inspector General last year. Our more comprehensive database comparison to validate the status of this issue is ongoing.

A few known-to-be-deceased beneficiaries remain on DHS roles at any given time because the department has not yet received official verification of death from the Department of Health and the DoH, in turn, can be held up by delays in the information being provided to them. But, with current procedure, the correct date of death should be entered and adjustments with carriers made correspondingly.

In terms of carrier notification and retroactive recoupment, the larger related issue of carrier notification and retroactive recoupment for deceased beneficiaries is still being investigated.

LTSS Eligibility

Applications for Long Term Services and Support (LTSS) through DHS/AAS require meeting asset requirements, including the basic requirement of having less than $2,000 cash or convertible assets, excepting the exclusion of one car. This asset assessment is partially by attestation of or for the applicant (form DCO-727) and partly by documentation review by the AAS case worker.

For example, a case worker will review 3 recent months of provided bank statements. The applicant is asked to report on any money or property that has been transferred in the last five years. If the applicant does report such transfer of assets they are asked to provide documentation about that transfer. But at this time no external service is being used for asset verification so much of the information is essentially self-attested only.

LTSS applications also require a review of any third party insurance resource. There is a form (EMS-662) where an applicant is asked to identify other parties, such as BC/BS or AARP, who might have some support liability

It is clear that asset verification needs to be brought up to current standards. AAS is currently preparing an RFP to contract for Asset verification services. TSG will review the RFP work against current best practices for our final report.

Work Engagement

TSG is currently reviewing the number of expanded Medicaid population beneficiaries who are able bodied adults who are unemployed and might reasonably be required to participate in an appropriate employment and training program. Any regulatory or legal constraints that would have to be addressed are also being reviewed.

Renewal Status

The governor issued a moratorium on additional renewal processing so that various issues of concern could be addressed. Consequently this information is dated by over a week, but new information may be available by the scheduled hearings on August 19 and 20.

Table 12—Eligibility Renewals, Current Report

INDIVIDUAL RENEWALS INITIATED	332,269
INDIVIDUALS RENEWED	64,434
ARKids A	5,911
ARKids B	131

Former Foster Care	72
Healthcare Independence Program < 100%	46,555
Healthcare Independence Program 100 - 138%	8,933
Newborn	15
Parent or Caretaker Relative	2,817
COVERAGE ENDED BASED UPON RENEWAL	48,598
ARKids A	3,677
ARKids B	4
Healthcare Independence Program < 100%	35,185
Healthcare Independence Program 100 - 138%	9,227
Parent or Caretaker Relative	505
COVERAGE END REASON	
FAILED TO PROVIDE VERIFICATION	46,981
NO LONGER ELIGIBILE	1,617
INITIATED AWAITING CLIENT RESPONSE	219,237

Pharmacy costs

Monthly Prescription Limits

One approach used in the State FFS drug plan to manage costs is limiting the number of prescriptions per beneficiary per month. There are various limits based on age and site of care. Our analysis reveals beneficiaries who have exceeded the limit. We are drilling into the disease states and medicines used by beneficiaries at or just below the limit to see if it we can determine that the limit is preventing them from getting needed medications for chronic conditions.

PDL Limitations

There is a state rule in place which limits the PDL classes to only those classes in which there is an evidence based review of efficacy and safety. This rule currently limits adding PDL classes, and the supplemental rebates associated with the preferred drugs in those classes, if the only difference among drugs in the class is price. We expect to present a deep comparison of Arkansas to other states in the breadth of the PDL and the supplemental rebates performance in various other states.

Opioid Use

The US represents 4.5% of the globe's population, yet consumes 90% of all oral opioids in the world. Opioids are subject to abuse and misuse. There is an astonishingly high percentage of beneficiaries getting at least one prescription per year and a large subset of those, are getting opioids chronically, we defined that as longer than 90 days. Almost a thousand beneficiaries visited 4 or more doctors or 4 or more pharmacies. Our hypothesis that the lock-in program

could help deter abuse is likely correct. We are digging further to be sure, including seeing what the overlap is between doctor shoppers and pharmacy shoppers and a review of diagnoses.

Private Carrier Pharmacy Cost Management

Paid pharmacy claims for all of 2014 were collected and analyzed. Great effort was taken to make the comparison as comparable as possible removing outliers that could skew the averages. Though the full impact of rebates is still unclear, especially in the Private Option carriers, our findings mirror others that the managed care plans can manage pharmacy costs better than the State. Managed care plans are better at managing the underlying drug cost and dispensing fee. Even with the substantial drug cost reduction available from OBRA and supplemental rebates for the state (somewhat offset by state overhead), the managed care plans appear to function more efficiently.

4. ISSUES/CONCERNS

Minority Health Disparities

During the past month, TSG has attended community meetings in Pine Bluff and Forrest City as the guest of local legislators to hear from community members, physicians, hospital and FQHC/Community Health Centers administrators, and pastors. We have appreciated these opportunities and the richness of the experience of meeting people who are trying to improve the health status of their communities.

We have heard a consistent voice that the Private Option has had a positive effect on their communities with many people and families having health coverage for the first time in their lives. We have also heard that the communities see a great need for culturally relevant health education after an individual obtains coverage. Many individuals have used local Emergency Department as their sole source of primary care services for years and have little experience in accessing primary care let alone specialty care now that they have health insurance.

Often primary care is not available when needed even when an individual seeks to access a doctor so they revert to the local Emergency Room. If Arkansas is to improve individual and population health status there needs to be greater emphasis placed on helping newly insured individuals learn how to "navigate" the health care system while addressing access disparity over time based on a sustainable Plan.

Proven programs like the Arkansas based Community Connector model can be brought to scale at very low cost, perhaps as a value added support service in managed systems models as a required state contracting practice, to assist people to access needed care, become independent in navigating the health care system, stay in their homes, and save money. The key is a community based approach ("Medicaid Savings Resulted When Community Health Workers Matched Those with Needs to Home and Community Services": Health Affairs, 30, No. 7 (2011): 1366-1374)

Carriers claims experience

TSG observed that the MLR for the carriers is very different. TSG has only an opaque window into the ultimate MLR carriers will report. However, our initial observation is that the carriers are not benefiting from the scale offered by the full one million lives Medicaid manages. Instead, carriers have different contracts with different rate, and different processes that produce different results. Yet, DHS has no regular on-going window into carrier costs.

Healthcare System Improvements in Private Option

Very preliminary evidence suggests that many Private Option beneficiaries visit the ED more than once a month. The carriers expected this finding, and believe that the newly eligible

members they took on have little experience with the system, and still behave as those without coverage: they do have a PCP, and do not know how to find one.

TSG will continue to investigate the issue of ED usage.