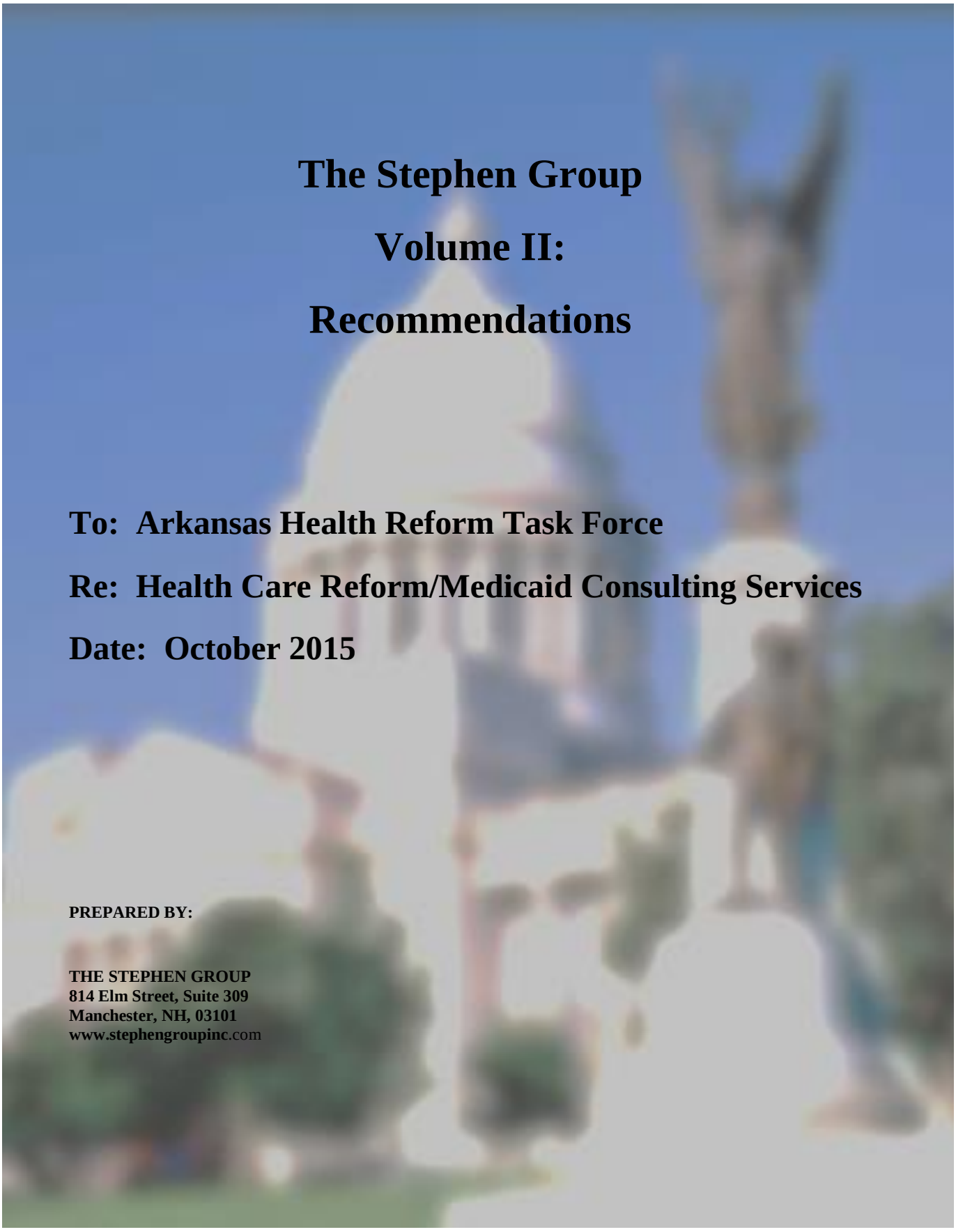

The Stephen Group

Volume II:

Recommendations

To: Arkansas Health Reform Task Force

Re: Health Care Reform/Medicaid Consulting Services

Date: October 2015

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EXECUTIVE SUMMARY

The Arkansas Health Reform Legislative Task Force engaged The Stephen Group (TSG) with the charge to assess Arkansas' Medicaid program, with a specific focus on the future of the newly eligible population under the Health Care Independence Program (HCIP), often called the Private Option. TSG's contracted responsibility calls for recommendations to improve the quality and efficiency of the traditional Medicaid program while offering a solution for the future of the Private Option, while maintaining coverage for the nearly 250,000 participants in the program.

While the following documents contain numerous opportunities to improve the quality of care, save taxpayer funds and make the delivery of Medicaid services more efficient, TSG has three fundamental recommendations that should drive the decision making for the Legislature.

1. **Bring personal responsibility, wellness and accountability to HCIP, with the goal of a greater commitment to work and opportunity in 2017.**
   The success of every public assistance program should be measured by how many people are able to move themselves off the aide and up the ladder of opportunity. This is particularly true for programs for able-bodied adults, like HCIP. We recommend shifting the focus of HCIP to be transitional, with a commitment to getting participants into work, having them take responsibly for their own health and bringing more accountability to individuals and carriers accountable for the results.

2. **Expand Patient Centered Medical Home or Bring Managed Care for all Medicaid beneficiaries. Expand care coordination to drive quality, increase options for aged, blind and disabled populations and reduce cost.**
   Nearly three-quarters of Medicaid expenditures are unmanaged. TSG identified that the long-term care, developmentally disabled and behavioral health populations within the program are losing opportunities for better care coordination, better placement in setting preferred by the beneficiaries and better assessment of need, all while costing taxpayers far more than is necessary.

   Arkansas policymakers should pick one of three options to manage care. One strategy would be to expand the use of current payment improvement initiatives (Primary Care Medical Home (PCMH) and Episodes of Care (EOC)) across all Medicaid populations. Another would be to expand all non-ABD populations into PCMH and EOC, and move the

ABD populations into full risk capitated managed care. A final strategy would be to cover the entire Medicaid program into full risk managed care. Each model has its own benefits and opportunities for consistent oversight. In any event, the state should look to improve the management of its Medicaid pharmacy program, and also move its dental program to be coordinated by an outside vendor in a similar manner. .

3. **Enhance eligibility and program integrity across the entire Medicaid enterprise.** Arkansans work diligently to fund the state's Medicaid program for the low income and the disabled. They should have the comfort of knowing that their tax dollars are being spent wisely and appropriately. Accordingly, they should have the most up to date, cutting edge tools in place to make sure that only those who are truly eligible receive Medicaid services.

   Additionally, the State has the obligation to make sure that everyone – beneficiaries, providers, carriers and vendors – are all operating within program guidelines and living up to their commitments. This means a strong front-end eligibility system that works in real time to make sure that no one – accidentally or intentionally – is getting access to service they don't deserve. It also means having a robust fraud detection system that consistently ensures that individuals and groups getting funds are held accountable for keeping standards high. This requires a robust program integrity function that uses surveillance, audits and the power of data to validate that programs are run in a compliant fashion and everyone is held accountable.

While the document that follows contains dozens of specific recommendations about improving the Medicaid program, every one of these suggestions is conditioned on these three big picture views. TSG strongly believes that once the Task Force, the Legislature and the Governor find consensus on these areas, the remaining recommendations will follow these decisions.

1. HCIP REFORM

In meeting with Task Force members and the Governor, one consistent message was the frustration that state leaders have with the lack of flexibility offered by the federal government in the management of those who became newly eligible under the Affordable Care Act. There is little question that Arkansas officials believe that Medicaid should be a state and federal partnership, but the opportunity for innovation is sometimes prevented because of federal rules and regulations. There is broad agreement that the program should operate with greater personal responsibility and commitment to wellness.

At the same time, based on the establishment of this Task Force, the scope of the request for proposals and the contract that led to these recommendations, and meeting with many members

of the Task Force, it is also clear that there is support for continuing care opportunities for the nearly 250,000 who are now enrolled in the Private Option.

Thus, TSG recommends shifting the Private Option to a model designed to focus on moving individuals upward on a ladder of opportunity. This is done by making work referrals and engagement mandatory, by offering employer support for businesses that hire HCIP participants into jobs with health insurance and by adding a dental and vision program for those who meet all the program requirements. In order to emphasize the need for this program to be temporary, we recommend changing the name of the program to the Transitional Health Insurance Program, or T-HIP.

In order to move up a career ladder, having good health is important. Our recommendation accomplishes this through creating health scorecards to provide transparency and quality awareness among providers, through having a Membership Agreement to hold enrollees accountable, through establishing a wellness scorecard for participants to track preventive care, through offering education to reduce health disparities, and through having a clinic diagnosis for the medically frail to implement care coordination.

Finally, personal responsibility is essential to any public assistance program. That's why T-HIP adds co-payments and premiums for those who don't live up to wellness and work search standards, includes mandatory HIPP so workers don't move from employer sponsored health care to taxpayer funded care, establishes an enhanced cost share for those with considerable assets, includes a lock out provision for those who don't follow program guidelines and don't pay premiums for the program, eliminates retroactive eligibility and establishes a consistent and effective eligibility and redetermination process.

While these are critical steps forward, we recommend that the state takes steps to set itself up for even greater progress in these areas starting in 2017. Once a new administration takes office, we propose the state prepare to take greater steps, such as using the work requirement and potential benefit limits consistent with the successful steps of the TANF program.

Private Option was an innovative strategy that made Arkansas a national model for its implementation. The recommendations included for T-HIP will assist the Task Force with recommendations to consider in moving that model forward.

2. BUILDING A 21ST CENTURY MEDICAID PROGRAM

While Arkansas' traditional Medicaid has taken some inventive steps in payment reform with the Patient Centered Medical Home (PCMH) and Episodes of Care (EOC) models for the non-disabled population, three-quarters of the program's expenditures are from a traditional 20th century Medicaid model of care. We recommend that Arkansas move from a lagging to a

leading Medicaid program by managing all Medicaid populations for better health, better enrollee satisfaction and a much less expensive system of care.

The question should not be whether or not to manage the care within Medicaid. The real question for state policymakers is this – who is better suited to properly manage and coordinate the care, the state or private entities, or should there be a hybrid model for different types of care? Each model has pluses and minuses.

Nationally in Medicaid, there is a growing trend toward full risk managed care. This means that the insurance carrier is responsible for care and is paid a per member per month (PMPM) fee for each individual enrolled in Medicaid, segmented by needs, such as developmentally disabled, pregnant mothers, etc. The carriers have considerable incentive to keep costs down, since they make money on healthy enrollees who seek appropriate care and lose money on enrollees with high medical costs or inappropriate care usage.

One model would involve putting the entirety of the traditional Medicaid program into full risk managed care. The Department of Human Services (DHS) would have the responsibility of enrolling and maintaining eligibility standards for Medicaid beneficiaries and closely managing the contracts of carriers to ensure that they were meeting program and quality standards. The rest of the work would be done by the carriers. This model brings about the greatest opportunity for reductions in Medicaid expenditures, especially with the additional general revenue captured from the premium tax paid by the carriers. These saving could be redeployed within DHS (such as towards the DD wait list), used elsewhere in the state budget, or simply returned to the taxpayers.

Another model would move the ABD population into full risk managed care and expand the PCMH and EOC model into the entirety of the non-disabled population. One advantage of a full risk model for ABD (also shared with the above recommendation) would be the shift away from costly institutional care to less expensive home and community based care, which seniors, in particular, have specifically indicated that they prefer as a setting. The PCMH model would have to expand from select Medicaid providers to all Medicaid providers. Beyond eligibility, DHS would still manage a process claims, while overseeing the contract of the ABD carriers.

The third possible model would be to expand the PCMH model across all Medicaid populations. This would ensure that every Medicaid enrollee would have a medical home and that there would be care coordination for all ABD beneficiaries. This would result in a high level of care coordination as it would shift the focus from providers to those receiving care. DHS would shift its current role only slightly and would still maintain tremendous involvement in engaging each individual client.

One enormous benefit to selecting any of the above three models is the cultural shift from paying claims to paying for performance. This brings the focus to quality and building a structure of

improving health care payments that would improve overall health across Arkansas. This is particularly true for the ABD population, which currently finds itself "siloed" and traveling across disparate systems of care. Putting the patient first, and not the specific program will improve outcomes across Medicaid.

TSG strongly recommends that DHS ensure that every person who seeks to receive care in the ABD system receive an independent clinical assessment, using a evidence-based state of the art test to determine the needs, plan of care and cost for each individual who qualifies for service. Getting this assessment done right is absolutely essential to making sure that these beneficiaries are placed in the right setting, at the right time, to get the services they need in an efficient and effective manner. If Arkansas chooses to provide ABD services through managed care, it is essential that DHS put in place strong contract provisions and a robust monitoring system to ensure that beneficiaries get high quality care that meets their needs in a timely and coordinated fashion and that the overall commitment to receiving care in the least restrictive setting possible becomes a reality.

No matter what model Arkansas chooses, one area of the Medicaid program that must be included in managing care is that of pharmacy. Without better pharmacy management, the state is losing money every day that could be better used elsewhere. If the state goes down the road of full risk managed care, those vendors should also pick up pharmacy in their contracts. In a PCMH model, the state should seek to efficiently pay for value and outcomes through a pharmacy benefit manager to oversee this benefit.

Implementing these recommendations will move Medicaid into the 21st century and offer tremendous benefit to the state, both to those receiving care and to the taxpayers, who are now paying for an expensive, archaic legacy program.

3. ENSURE PROGRAM INTEGRITY ACROSS MEDICAID

We recommend that Arkansas use Medicaid as an opportunity to show how an effective program integrity function can be a priority to building public trust and confidence that their contribution to help those in need is spent wisely.

An independent audit of the Medicaid program showed many individuals who are on the Medicaid or Private Option rolls could be living out of state. Some may be at risk for fraud or identity theft. In addition, there may be others who are listed on the rolls that are deceased or incarcerated, and others who might have excessive assets. Clearly, there is opportunity for important steps forward to verify addresses, identities and assets, but today DHS and OMIG lack the tools to advance to the leading edge.

That is why we recommend an Enterprise Benefit Integrity Hub, likely housed in the Department of Finance and Administration that could inspect in real time the eligibility of all individuals seeking state services. This would close the front door for individuals who do not qualify for services from getting them and ensure that important services are available for those that the program was intended to serve.

The State could look to other states in implementing such a program that can effectively authenticate identities and regularly identify changes in beneficiaries' status.

OMIG must purchase and implement its fraud detection system as soon as possible to begin to ramp up recovery opportunities and to ensure that vendors, providers and beneficiaries know that they will be caught if they violate program standards. At the same time, DHS should improve its audit and oversight capacities working collaboratively with OMIG so that small problems don't grow into larger ones and everyone knows there will be accountability.

DHS must improve its contract management and oversight responsibilities to ensure that the state is getting precisely what it is paying for and nothing less. At the same time, the state should tighten contract standards to reduce overhead and indirect costs.

The agency should also find a systems integrator to manage the eligibility system and other IT systems that share data across the Medicaid enterprise. The eligibility system is a critical link to ensuring an efficient enrollment process and the Medicaid IT system changes happening at the agency is a cumbersome processes, that is expensive, inefficient and unnecessarily creates demand for specialized knowledge.

4. ADDITIONAL CONSIDERATIONS

Throughout the attached recommendations, TSG has made numerous references to improving health care quality. While most policymakers are not involved in the direct provision of health care, they can take important steps toward using the leverage and opportunity of Medicaid as a driver for improving quality. Unfortunately, Arkansas scores poorly on many health rankings; however, improving services to those on Medicaid represent a great opportunity to lift those rankings and make the state healthier. TSG recommends that in changing Medicaid, whether staying with a traditional program or a Private Option, the state always consider the impact on the health of the population.

Task Force members asked TSG to consider the problem inherent with businesses with low-wage employees, dropping their health care in order to move those individuals to Medicaid or onto the Arkansas Health Connector with a heavily subsidized policy. For small business, the SHOP health insurance exchange should provide affordable policies to ensure that these workers stay on employer sponsored insurance. We recommend that Arkansas seek at Section 1332 waiver from the federal government to expand access to the SHOP exchange to larger businesses

that employ a substantial percentage of low-wage staff. Moreover, we recommend that the SHOP exchange also be able to waiver the Essential Health Benefits (EHB) provision of the Affordable Care Act to allow the sale of other types of policies, such as defined contribution plans like Health Savings Accounts.

TSG strongly recommends that the State of Arkansas and DHS consider partnering with a state university to develop a Center for Health Excellence. Similar to programs at Mississippi State and the University of Massachusetts, this would represent a tremendous opportunity to bridge the talent gap in health policy that is growing nationally. This would give the chance to provide infrastructure, data support, testing opportunities and development of experts that could make the state a leader nationally in health care.

5. CONCLUSION

Medicaid in Arkansas stands at a crossroads, with both near term and long-term challenges and opportunities. TSG feels that now is the time to act to bring stability to the program, both on the short-term decision regarding the Private Option and on the more far reaching decisions needed to bring the Medicaid program into the 21st century.

The solutions found in these recommendations have significant consequences for beneficiaries in the Medicaid program, the taxpayers who fund the program and the many providers and vendors who utilize Medicaid for their businesses. TSG recommends that the Task Force balance all of these interests as they make the critical decisions in the months and years to come.

Finally, each of the recommendations proposed to modernize Arkansas' Medicaid program have the potential for enormous savings for the program that will help to ensure the long-term viability of not only Medicaid itself, but also other critical government services that could be squeezed by the growth in the program. Over the short term, these could actually involve the state spending less on the entire enterprise. If this is the case, this presents the possibility to reinvest these funds in areas like the developmental disability wait list, provider rates, building infrastructure for community-based care or employer support for those transitioning off Medicaid. Alternately, these savings could be used to offer tax relief to Arkansan taxpayers. Ultimately, this will be the decision of the priorities of the Governor and Legislature in the coming years, should these recommendations be implemented thoughtfully.

BACKGROUND

Arkansas Medicaid must deal with two major fundamental challenges. There is a short-term issue regarding the population that became eligible under the Affordable Care Act and is currently covered through the Private Option. Additionally, there is a much larger looming

public policy crisis resulting from massive future growth in traditional Medicaid if the state does not reform this program.

The following recommendations will offer options for policy makers to achieve a number of key objectives that will provide improved services for needy Arkansas residents and certainty and affordability to taxpayers.

We will address the Private Option (short-term) and traditional Medicaid (long-term) components separately, but many of the key focus areas overlap and would work cohesively as an integrated solution that combine to meet strategic objectives of both aspects of the Medicaid program.

RECOMMENDATION ONE: HCIP REFORM

In meeting with the Task Force members jointly and separately, The Stephen Group (TSG) readily identified a number of shared objectives. These objectives became the foundation of a vision for the future for those who now receive services under the Private Option. They include:

- Providing health care access and services for low-income Arkansas residents
- Moving residents from assistance to independence – creating a ladder of opportunity and readiness for beneficiaries, the foundation of which is obtaining employment that leads out of government services
- A commitment to wellness that is built around the notion of residents taking personal responsibility for their health
- Improving the quality of care from providers through accountability to achieve measureable performance advances
- Working to ensure that the medically frail obtain health screening and prevention services
- Enhancing program integrity to reduce waste, fraud and abuse, delivering accountability for beneficiaries, providers, carriers, and taxpayers
- Reducing the impact of uncompensated care on health care costs
- Ensuring that all parties commit to providing the right care in the right setting, reducing the use of inappropriate care (e.g. unnecessary Emergency Room utilization or preventable readmissions)
- Providing incentives to encourage health care providers to achieve measureable performance outcomes and bring transparent health scorecards for carriers

The members of the Task Force passionately expressed their commitment to using Medicaid to make Arkansas healthier, and to offer tools to lift low-income residents out of poverty. Some members of the Task Force expressed to TSG that they are committed to working within the framework of what the federal government indicates that they will accept for changes within the Medicaid program (i.e. “In the Box”). Other members believe that states like Arkansas must be committed to running Medicaid in the way that makes the most sense for the state and are willing

to push the federal government to support innovative ways to delivering these services ("Out of the Box") once a new federal Administration takes office in 2017.

6. IN THE BOX SOLUTION

This solution maintains the eligibility levels for Medicaid as laid out under the Affordable Care Act and currently in place under the Private Option. It would also bring additional personal responsibility, accountability and focus on wellness and advancement for the expanded Medicaid population.

The Governor and DHS leadership have indicated that federal HHS officials, including Secretary Sylvia Burwell, have indicated that they will not approve provisions that would bring accountability and move able-bodied adults forward in their careers, such as a work requirement or benefit limits, similar to the Temporary Aid to Needy Families program. Accordingly, this recommendation is "in the box," meaning that it includes provisions that have been approved for other states, or that TSG believes are likely to receive approval from federal officials.

Create Transitional Health Insurance Program (T-HIP)

These changes would shift the focus of the program to creating opportunity and emphasizing participant health for those receiving benefits. This new program, TSG refers to as the **Transitional Health Insurance Program** (T-HIP) would measure its effectiveness through its ability to move beneficiaries up a career ladder towards independence.

T-HIP would differ from Private Option in many ways. Many of these differences focus on increasing personal responsibility and accountability through wellness, prevention, and appropriate use of health care services. Ultimately, T-HIP would incentivize participants to take ownership of their health and their decision to move up a career ladder.

The fundamental elements of change with T-HIP would include:

Enhance Eligibility Verification Process

An **Enhanced Eligibility Verification Process** would add greater screening of individuals' identities and addresses to efficiency eliminate payment to carriers for someone that could have moved out of state, and to prevent waste, fraud and abuse. Connecting through an Enterprise Benefit Integrity Hub, which TSG recommends be housed in the Department of Finance and Administration, applicants would not be enrolled until these essential components of eligibility are validated. Moreover, carriers would be required to notify DHS immediately if mail sent to the address of the beneficiary is returned. (Note: this is also included in the recommendations for traditional Medicaid, with greater detail.) DHS would then immediately send a notice to the individual at the address listed on the application and he or she would be enrolled once DHS has confirmed a valid address. The issue of location of an individual's address and place of

residence is important to ensuring that the individual is notified of the essential benefits and wellness program under T-HIP. Addresses could also be checked routinely under the Integrity Hub. It must be recognized that it is a requirement of the individual to notify DHS of any "change in circumstance," including a change in address to also ensure that taxpayers are not paying a monthly premium to carriers for someone who has moved out of state but failed to notify the state. TSG believes that this requirement alone will save the taxpayers millions of dollars.

Include Mandatory HIPP

Include Mandatory HIPP to reduce those who have the opportunity to keep employer sponsored insurance from entering T-HIP. The Health Insurance Premium Program (HIPP) uses Medicaid funds to offer wraparound treatment to pay for premiums, deductibles and co-payments for those who would otherwise be Medicaid eligible. This will require enhanced employment verification to ensure that DHS contacts employers to determine if enrollees have access to health insurance.

Enhance Cost Share

Add an **Enhanced Cost Share** for all program beneficiaries with substantial assets. Under eligibility rules included in ACA, only income is viewed to become eligible. That means any able-bodied individual with substantial assets, but who chooses not to work, can receive taxpayer-funded Medicaid benefits. This cost share would apply to those with a primary residence of over $200,000 and those with cash or cash-equivalent assets of $50,000 or more. In order to participate in T-HIP, these individuals would pay $100 per month, plus $4 per month for each $1,000 in assets above the amounts listed above. Assets would be identified using the same resource test currently in place for TANF and SNAP.

End the Health Care Independence Account

Acknowledge when things don't work and **End the Health Care Independence Account** model. Health saving accounts work in the commercial marketplace, where individuals' own dollars are at risk, but the program has been far less than successful in an environment with mandated Essential Health Benefits, which means that there is little risk to care and, thus, little risk for enrollees of Private Option. These resources would be far better deployed to expand work referral and engagement activities.

Introduce Mandated Work Referral

Include a **Mandated Work Referral** system where all beneficiaries who are not meeting TANF work requirement standards (20 hours per week as an individual, 35 joint hours per week for a couple) are required to participate in employment-related activities such as job training. Since T-HIP is available to mostly able-bodied adults who have no other pathway to Medicaid, there is little reason for individuals to not be seeking work. Arkansas could use an automated work

engagement system, such as the one used by the neighboring state of Mississippi – Mississippi Department of Employment working with nSPARC at Mississippi State University - so as to not add a new administrative burden. Failure to participate in this work referral program would trigger the maximum possible premiums and co-payments allowed federally (See Membership Agreement, below). The savings from the termination of the Health Care Independence Accounts could then be used to enhance work engagement opportunities at the Department of Workforce Services.

Establish Publicly Available Health Scorecards and Rating System

Arkansas Medicaid should promote **Quality and Transparency among Carriers** by requiring T-HIP carriers to provide publicly available health scorecards and rating system for program outcomes. These will be benchmarked against other carriers and national data to assess efforts to focus on wellness and prevention. This will cover statistics, such as what percentage of T-HIP beneficiaries visit their PCP within the first 90 days, and what percentage of those with chronic illness, such as diabetes, receive disease management.

Require Carriers to Reduce Health Disparities

Incorporate **Reduction in Health Disparities** into requirements for carriers. All carriers will be required to offer education about the appropriate and proper use of health care, such as Emergency Department care, use of primary care providers (PCPs) and treatment for chronic conditions. Insurance agents are often times the front line for carriers and are a key partner in signing-up newly eligible adults. Carriers will be required to provide all insurance agents with educational material, tools and training, and will also offer training to new enrollees about these matters.

Introduce Care Coordination for the Medically Frail

Ensure **Proper Care Coordination for the Medically Frail**. Federal rules require Medicaid expansion states to provide regular Medicaid benefits (fee for service), which are richer than what plans on the exchange offer, for those with special medical needs. Currently, Arkansas allows beneficiaries to self-report medical frailty. Under T-HIP, those who self-identify as medically frail will be required to visit their medical provider for a clinical determination to gain the Medically Frail status, similar to states like Iowa, Indiana, New Jersey and North Dakota. This will serve two purposes: ensuring that those who should not be classified as frail stay in the exchange-based plans and confirming that those who are frail get into a care coordination program quickly. Making sure that Medically Frail individuals have coordinated care is essential both to improving their health and reducing associated health care costs.

Offer Employer Support

Offer **Employer Support** for those businesses who offer employer sponsored insurance that hire individuals receiving T-HIP. This would consist of a one-time payment of $1,000 to the

employer, to help defray the cost of health insurance. This benefit would only be offered once per employee over his or her career and would make these candidates more attractive to employers, while saving both the state and federal government substantial funds by transitioning workers off Medicaid.

Require a Membership Agreement

Require T-HIP participants to sign a **Membership Agreement** for new enrollees as well as existing beneficiaries at their next redetermination. This agreement would require the beneficiary to visit his or her PCP within the first six months of signing, to comply with the follow-up instructions and to agree to the work engagement requirement. Failure to adhere to this agreement would result in the individual being required to pay the maximum premiums and co-payments allowed under federal law, as well as no longer being eligible for vision and dental benefits, which are a value-added benefit and not required under Private Option or the essential health benefits (EHBs) for individual marketplace plans today. This agreement will work to encourage individuals to commit to making work and their health a priority.

Create a Wellness Report Card

Create a **Wellness Report Card** for each enrollee that tracks critical health factors, like PCP visits, flu shots and other important health criteria. Carriers will send these report cards to beneficiaries annually, to ensure participants live up to their Membership Agreement.

Offer Vision and Dental Benefits

Currently, Private Option does not offer **Vision and Dental Benefits** to enrollees, though they are part of traditional (fee for service) Medicaid. We believe that vision and dental are important components of finding employment and moving up a career ladder, but these benefits should be tied to participants' engagement in general wellness activities. Thus, we recommend that T-HIP beneficiaries should be able to earn vision and dental services only after they have completed their initial visit to their PCP. Moreover, if a participant does not meet the wellness component of their annual report card and falls out of compliance of the Membership Agreement, he or she would not be eligible for vision and dental benefits until regaining compliance.

Initiate Member Lock-Out

Deliver accountability by initiating a **Member Lock-Out**, similar to the state of Indiana, for those individuals who fail to pay their premium or cost share for high assets (as recommended above) or who have failed to meet the terms of their membership agreement and are required to pay premium and cost share and fail to do so. If the member fails to pay, he or she will be given a 30 day notice to come into compliance before being removed from T-HIP and unable to regain eligibility for six months. It is important to note that if a participant meets wellness goals and does not have excessive assets, he or she will not have a premium or cost share payment and would not be subject to lock-out.

Institute Co-Payments

Institute **Co-Payments** to encourage appropriate use of services. Currently, Private Option beneficiaries are over-utilizing Emergency Department services. T-HIP creates a $20 co-payment for ED usage in non-emergencies, so that individuals are discouraged from using this service inappropriately. This will be managed by the carriers who already have a review process to determine if the ED usage was appropriate and who also have an appeal process. If the beneficiary fails to pay the co-pay to the carrier they will be subject to the lock-out provisions mentioned above. Additionally, for those individuals who are not meeting the wellness goals of their Membership Agreement, there would be a co-payment for prescription drugs: $1 for generic drugs and $5 for brand name drugs.

Eliminate 90-day Retroactive Eligibility

Personal responsibility begins when individuals seek assistance. Thus, T-HIP would **Eliminate the 90-day Retroactive Eligibility requirement.** Similar to Indiana's and New Hampshire's waivers, this means that the taxpayers are not liable for the health care costs that were incurred before a beneficiary sought health coverage through T-HIP.

Exit the Waiver with 30 Day Notice

The changes proposed in T-HIP would require a new 1115 waiver from the federal government. However, such a waiver should include two essential provisions: Allowing Arkansas to **Exit the Waiver with 30 day Notice.** This will allow the state to recalibrate if there are new opportunities for change in the Medicaid program. In addition, if the federal government chooses to alter the federal matching rate for the newly eligible population, the 30 day Notice provision would apply.

Strengthen and Streamline Redetermination Process

Establish a **Strengthened and Streamlined Redetermination Process** that is orderly, efficient, and increases accountability. This includes an automated system that regularly checks for changes in address and income using state databases and additional data sources from national vendors. These represent a "change in circumstance" that would then require a 30-day notice letter as required by the federal government. In essence, this turns the process into a real-time, data-driven function, operated in the background, as opposed to a batch process that can overwhelm DHS.

Require Transparent Carrier Health Wellness and Outcome Scorecards

T-HIP would require that the Insurance Department work with carriers to design a transparent health wellness and outcome scorecard that routinely offers data to policy makers and the public on important health care program indictors such as the percentage of individuals who have visited a primary care physician within 90 days, the percentage that have obtained flu shots,

reductions in hospital admissions for asthma, diabetes, and other preventable conditions, and other outcomes that further the health and wellness of the entire beneficiary population. This will further the interest enhancing the public health, as well as providing information to potential beneficiaries and policy makers on successful carrier intervention and care coordination strategies.

Create a Legislative Oversight Panel

Create a **Legislative Oversight** panel that has the responsibility of monitoring outcomes of the program and approving any substantial policy changes proposed by state agencies that could impact T-HIP. This would include any state plan amendments (SPAs), waivers, or changes in benefit structure or service delivery.

Taken together, these changes would strengthen the commitment to work, increase the focus on improving health, and ensure that personal responsibility is a cornerstone of the Arkansas health program serving the newly-eligible, able-bodied adult population. These would be significant program improvements from the existing Private Option, while also moving toward an emphasis on moving people into the workforce and increasing independence, as well as promoting overall health and wellness.

7. OUT OF THE BOX SOLUTION

A number of Task Force members expressed a belief that any welfare benefit for able-bodied adults must be conditioned on the idea that work, or actively seeking work, is an essential condition of receiving benefits. They expressed tremendous concern that 4 in 10 Private Option beneficiaries have a reported income of $0.

These same policymakers felt it would be appropriate to assist the working poor, but that providing a benefit to those who could work, but choose not to do so, undercuts the ability to encourage people to move up a career ladder, potentially locking individuals into a lifetime of dependence.

However, federal officials have made clear that they would not consider accepting a work requirement as part of a Medicaid expansion under ACA. Thus, this option is an "out of the box" solution, as it is highly unlikely to get approval of the current administration from federal HHS. Ultimately, TSG believes that is a strong solution that Arkansas could seek to implement with a new administration, starting in 2017. It must be recognized, however, that federal officials may not be willing to offer an enhanced match rate for this waiver program, so TSG has used the state's normal federal match in its financially modeling for this program – see below.

Create Work First

Thus, we propose that if Arkansas chooses to move forward on an alternative to the current Private Option, as outlined for T-HIP above, that the state also consider a replacement solution with a new administration in 2017. We are calling this replacement solution **WorkFirst,** and it would make clear that work, or meaningfully and actively participating in job search or job training, is the foundation of receiving benefits. It would also include a significant number of components of the "in the box" T-HIP program mentioned above to promote wellness and personal responsibility.

The key components of WorkFirst would be:

Similar Reforms to T-HIP Programming

The Enhanced Eligibility Verification Process, Enhanced Cost Share, Strengthened and Streamlined Redetermination Process, Quality and Transparency among Carriers, Reducing Health Disparities, Proper Care Coordination for the Medically Frail, Membership Agreement, Wellness Report Card, Vision and Dental Benefits, Member Lock-Out, Eliminate 90 day Retroactive Eligibility, Exit the Waiver with 30 day Notice, Transparent Carrier Outcome Scorecards, and Legislative Oversight features of T-HIP would also be included in WorkFirst.

Require a 20 Hour per Week Work Requirement

Require a 20 Hour per Week Work Requirement similar to the work requirement for single parents in the TANF program. Also, like TANF, the state would require a 35 hour combined work requirement for two-parent families. Unlike TANF, the only exemptions to this work requirement would be for those taking part in active job search or training and the clinically-determined Medically Frail, who would remain in the fee for service Medicaid program. This would require an enhanced automated online work portal, similar to nSPARC (Mississippi State University) mentioned above. Any enrollees not meeting the work requirement would be disenrolled from the program.

Cover Able-Bodied Adults up to 100% of FPL, Wraparound for those from 100-138% FPL

WorkFirst would **cover able-bodied adults up to 100% of the federal poverty level** (FPL). Above that income, individuals would receive their coverage through the Arkansas Health Connector. WorkFirst would offer a **Wraparound coverage for individuals between 100-138% FPL**. Similar to the current HIPP program, this would cover co-payments and deductibles for these beneficiaries. They would still be responsible for their monthly premium on the exchange ($20/month for those at 100% FPL). Enrollees above 100% FPL who do not pay monthly premiums will be disenrolled.

Include a Sliding Scale Premium

In order build personal responsibility into the program, WorkFirst would **include a Sliding Scale Premium** for those earning between 50-99% FPL. Between 50-74% the premium would be $5 per month and from 75-99% the premium would be $10 per month. This would make beneficiaries accustomed to paying a monthly premium as they transition into the exchange, where they will be expect to pay a monthly premium ($20/month at 100% FPL). Enrollees with a premium payment responsibility who do not pay monthly premiums will be disenrolled.

Consider Benefit Limits Similar to TANF

Similar to TANF, WorkFirst seeks to encourage able-bodied adults to advance in their career. To do this, it borrows a successful feature of Arkansas TANF, which has a **benefit limit of 2 Years to incentivize work**. The federal government requires a 5 year benefit limit and that could be another option to consider. This limit has been found to be an effective strategy in TANF to motivate people to take action. Also, like TANF, the legislature could allow exceptions for hardship to allow individuals to exceed the time limit.

WorkFirst would represent a new and innovative direction in health care policy, away from the notion of open-ended entitlements and toward moving welfare benefits for the able-bodied to transitional tools to encourage low-income individuals to get the services they need to advance in the workforce.

Table 1— Impact of Alternative for Expansion Population

Net impact on state funds from different decisions regarding the expansion population *($millions)*							
	2017	**2018**	**2019**	**2020**	**2021**	**2017-2021**	**Notes**
T-HIP	89	39	21	(19)	(53)	78	Keep the PO benefit structure as is, same eligibility criteria, same waiver authority
Rollback	(89)	(39)	(21)	19	53	(78)	Remove the PO altogether and do not replace it with anything
	(243)	(257)	(273)	(289)	(306)	(1,368)	Remove the current PO and replace it with a new PO with the same benefit structure, new eligibility criteria including mandatory work requirements, and pre-ACA 1115 waiver authority.
WorkFirst	58	48	37	(4)	(5)	135	Same as above except with ACA 1115 waiver authority and federal matching rates

8. ADDRESSING THE GOVERNOR'S 7 PRINCIPLES

Implement Mandatory Employer-Sponsored Premium Assistance

Making the Health Insurance Premium Payment (HIPP) program mandatory represents an important opportunity to reduce the cost of employees who would prefer Medicaid, but is operationally somewhat challenging.

HIPP uses Medicaid funds to pay for premiums, co-payments and deductibles, which represent out-of-pocket costs for employees, for those individual who would otherwise be eligible for Medicaid. If out-of-pocket costs are excessive for employees, they might try to forgo employer sponsored insurance (ESI) to find a less expensive plan on the exchange or through Medicaid. Alternately, if a low-income employee does not like the provider network offered through their ESI, they might attempt to forgo it for the exchange or Medicaid.

What makes this problematic is that employers do not know if an employee is Medicaid eligible, as they are likely not aware of that employee's household income. Additionally, if an employee declines ESI, unless the employee self-reports that they have found coverage via Medicaid, the employer is unlikely to know precisely why that employee abandoned ESI.

At the same time, when an individual applies for Medicaid, DHS does not know if that person has been offered ESI, unless that person self-reports that fact. Until there is the ability for DHS to determine in real-time if individuals who apply for Medicaid have the option of ESI, ensuring program integrity for mandatory HIPP will be labor intensive.

To make this effective, Medicaid will need to establish a Program Integrity function that contacts reported employers to determine if the employee has the opportunity to access ESI and get employers to comply with this request. TSG believes this would be a positive development, but would require additional resources for employer verification. It is included in the recommendation for T-HIP (above).

Implement premiums for incomes with more than 100% of FPL

TSG believes that premiums are better used as a disincentive for individuals who have not followed their wellness plans than for one particular segment of the population.

We do understand the value of starting to have individuals pay a premium, so that when they increase their income and move into the exchange, there is less of a shock to the system for paying a monthly fee. However, we feel the longer term benefits of lower claims and healthier beneficiaries outweigh this advantage.

Work training referrals required for unemployed or underemployed

This finding is included in our recommendation for the T-HIP program (above).

Eliminate non-emergency medical transportation coverage

TSG found a very effective brokerage model for non-emergency medical transportation (NEMT) with a capitated benefit structure that manages the program in a cost effective manner.

Table 2 shows the funding model:

Table 2—Funding model for the brokerage model for non-emergency transportation

Non-Emergency Transportation Standard V Enhanced Funding			
		NET	(PO expenditures)
FFY 2014	Jan - Mar 2014		$1,425,443
	Apr - June		$2,798,150
	July - Sept		$4,248,411
FFY 2015	Oct - Dec		$3,708,988
	Jan - Mar 2015		$3,551,206
	Apr - June		$3,237,314
	July - Sept		*$3,499,169*
FFY 2016	*Oct - Dec*		*$3,499,169*
	Italics = forecast (average of previous three quarters)		**Total Impact:**
	Total Spend - Inception thru 6/30/15		**$18,969,512**

After reviewing national studies and the Arkansas model, TSG found it to be a very cost effective benefit. A Florida State University study showed a return on investment (ROI) factor of 11:1 for NEMT.[1]

A study for the Transportation Research Board of the National Academies showed that if NEMT saved 1 hospitalization in 100 trips, the ROI would be 10:1.[2]

For these reasons, TSG recommends keeping NEMT in place. The system is running efficiently with the best model possible and the value of the services has been validated through national studies.

Limit access to the private market coverage for those not working

TSG believes the downside to this strategy outweighs the benefit. While we agree that plans through the exchange should be more appealing than Medicaid, we question whether a population of able-bodied adults who choose not to work despite relatively low unemployment would be incentivized to work by getting an exchange plan versus fee for service (FFS).

While exchange plans are slightly more expensive than FFS, they result in general fund revenue coming back through the insurance premium tax. For 70,000 individuals, this would represent a

[1] See further discussion at: http://s3-ap-southeast-2.amazonaws.com/resources.farm1.mycms.me/transportconnect-org-au/Resources/PDF/ROI_Florida.pdf
[2] For further discussion, see: http://onlinepubs.trb.org/onlinepubs/tcrp/tcrp_webdoc_29.pdf

substantial amount of state revenue, likely more than offsetting the savings generated by shifting enrollees from exchange plans to FFS.

Beyond this, exchange plans typically have superior wellness programs for beneficiaries and larger provider networks, making it more likely that individuals would have better health outcomes. This ultimately leads to long-term savings.

Finding cost savings in traditional Medicaid program

TSG agrees fully with the approach of taking needed steps of modernizing Medicaid to improve efficiency. We have listed numerous cost savings strategies in our recommendations and encourage the Legislature to move forward on them.

Strengthen program integrity of traditional and Private Option Medicaid

TSG has identified numerous opportunities to enhance program integrity. These are included in our recommendations. We believe that enhancing public integrity and ensuring accountability are critical steps moving forward.

9. HELPING EMPLOYERS PROVIDE COVERAGE FOR LOW INCOME WORKERS

A concern regarding the expansion of eligibility for Medicaid, along with the prospect of subsidies available through the insurance marketplace, is the possibility of employers discontinuing coverage for workers, in the hopes that they would receive subsidized care elsewhere. Knowing that their employees would have affordable alternatives outside of employer-sponsored-insurance (ESI), employers might offer health plans with premiums, co-payments and deductibles that would encourage low-income workers to decline ESI in favor of Medicaid or heavily-subsidized insurance on the health insurance marketplace.

Along these lines, ACA contemplated the Small Business Health Options Program (SHOP) exchange, which is designed to offer tax credits and subsidies for the purchase of group health insurance for small businesses. Under current federal law, access to the SHOP exchange is generally limited to those businesses that have 100 or fewer full time equivalent (FTE) employees, and who offer health insurance to workers who work 30 or more hours per week.

One way to ensure that more employers find ways to offer strong coverage to low-income workers, so that they remain on their ESI would be to expand the pool of employers eligible for the SHOP exchange.

Accordingly, we recommend that the State of Arkansas seek a waiver under Section 1332 of ACA from the Centers of Medicare and Medicaid Services (CMS) as a State Innovation Waiver to expand those businesses eligible for the SHOP exchange from companies with 100or fewer

employees all businesses that offer affordable health insurance to their workers and who also have a certain percentage of their full-time staff below a defined income level. We hasten to set fixed figures (e.g. 50% of full-time staff below $25,000 annual income, etc.), as those details would undoubtedly be part of a negotiation with federal counterparts.

Additionally, we recommend that Arkansas include in the request for the SHOP exchange to be allowed to modify the essential health benefits (EHB) requirements to allow for the purchase of defined contribution plans (such as health savings accounts) on the exchanges. This will allow for greater diversity of coverage that might better suit the needs of some companies in Arkansas.

A component of Section 1332 waivers is that they cannot add to the federal deficit. In other words, these waivers cannot cost the federal government more than the government might make back in savings or additional revenue in the aggregate. This will require the collection of data that demonstrates that the benefit of tax credits and subsidies on the SHOP exchange will ultimately not cost the federal government more than the costs of potential employees participating in Medicaid or the state health exchange.

RECOMMENDATION TWO: BUILDING A 21ST CENTURY MEDICAID PROGRAM

TSG offers a series of recommendations below to make Arkansas a national leader for modernizing Medicaid. Taken together, these suggest a significant change of focus for Medicaid at the strategic level. TSG found that, today, traditional Medicaid presents substantial funding challenges to the state general fund and economy. Without a change in the current direction, the legislature will soon need to find substantial additional resources to balance the general fund, or make major programmatic cuts to programs elsewhere in Arkansas government.

To prevent this, TSG recommends an overall change in direction for the Medicaid program. Our recommendations start the state on a path *from* high-cost and low value *to* becoming a leader in the region for improving health outcomes, by building a Medicaid program that provides the greatest healthcare value. TSG recommends that the following.

10. EXPANSION OF EXISTING PAYMENT IMPROVEMENT INITIATIVE WITH EMPHASIS ON VALUE-BASED PURCHASING AND ALIGNMENT OF INCENTIVES

While major strides have been made in Arkansas to improve the way health services are reimbursed through the Health Care Payment Improvement Initiatives, these improvements have

not touched the majority of the spending under the state Medicaid program, nor do they go far enough in those areas to which they do apply.

One high-level strategic direction identified by TSG would be a significant expansion of the existing payment improvement initiatives into all areas of the state Medicaid program with an emphasis on value-based purchasing (requiring vendor contracts to include risk based on clearly defined outcomes), along with meaningful re-structuring of all programs to align incentives toward quality and efficiency.

If the Legislature decides to guide the Arkansas Medicaid program in this direction, TSG has identified a number of additional specific recommendations within several program areas, as noted below.

10.1. Enhancement of Existing Payment Improvement Initiatives

The components of the Arkansas Health Care Payment Improvement Initiatives (HCPII) that have been implemented, including the Patient Centered Medical Home (PCMH) and Episodes of Care (EOC) initiatives, are consistent with this recommendation, in that they create provider incentives for higher quality, and more efficient care. It should also be noted that they have received national attention for their innovation and sophistication. Nonetheless, it is clear that certain adjustments and enhancements should be made to both the PCMH and EOC initiatives.

As currently scoped, the EOCs include some primary care episodes, the goals of which would be better addressed through the PCMH initiative. Also, and most importantly, the current structure and scope of the EOC and PCMH initiatives largely does not address the high-cost populations, particularly the elderly, developmentally disabled, and individuals with severe and persistent mental illness.

Patient-Centered Medical Home

The following characteristics of the Arkansas PCMH model are particularly well-suited to reinforcing the delivery of high-quality, efficient care:

- Measurement of practice improvement measures
- Measurement of process measures
- Shared savings for groups of providers seeing large numbers of Medicaid beneficiaries

The following changes should be made to the PCMH initiative:

Expand PCMH into all Medicaid PCPs and low-cost populations.

Allow FQHCs to be medical homes.

Add upside cost-sharing for situations where average costs go above target thresholds.

Episodes of Care

As noted above, the EOC initiative has received national attention for its innovation and sophistication. However, the EOC initiative has not proven to be a good fit for primary care, and it has been expensive to develop and deploy. TSG recommends making the following changes to the EOC initiative:

Rescind EOCs for primary care and incorporate the corresponding measures/goals into the PCMH initiative.

Develop and deploy additional EOCs for specialty care, particularly procedures.

Continue to monitor all active EOCs very closely to ensure that they are providing value

10.2. Expansion of Payment Improvement Initiatives into High-Cost Areas

While the original scope of the HCPII included the development of health homes for some set of high-cost populations (elderly, developmentally disabled, and those with severe and persistent mental illness), that initiative was never developed. The health home programs for each of those three high-cost groups would look somewhat different with some of the particular characteristics recommended as follows:

- Elderly and physically disabled – Health homes for the elderly and physically disabled should be organizations with an expertise in providing care to elderly and physically disabled populations, such as nursing homes or home health agencies. The health home providers should be incentivized to place individuals in the least restrictive setting, such as their home or assisted living, and to move individuals from institutional residence (often nursing homes) into the community. The health home providers could have staff in hospitals and rehab facilities to manage transitions from acute care settings into long-term settings, including finding capacity and ensuring quality in the community.

- Developmentally disabled – Health homes for the developmentally disabled should be structured in similar ways to health homes for the elderly and physically disabled. As in the case of health homes for the elderly and physically disabled, health homes for the developmentally disabled should manage the services for a particular subset of the DD population and be incentivized to place individuals in the community and to move individuals from institutional settings into the community, while emphasizing consumer choice.

- Severe and persistent mental illness – Health homes for individuals with severe and persistent mental illness (SPMI) will be focused more on managing the overall cost of care,

and less on moving individuals from institutional settings into the community. Health homes for individuals with SPMI should be incentivized to achieve certain quality outcomes while keeping the overall cost of care within certain thresholds. The incentive structure for health homes for individuals with SPMI would also drive toward more appropriate medication usage, fewer psychiatric hospitalizations, and more appropriate use of rehabilitation services for persistent and mental illness (RSPMI).

In addition to the expansion of the HCPII to its originally planned scope, there is an opportunity to identify other populations that might benefit from more intensive care management within the pool of Medicaid enrollees generally considered to be low-cost (pregnant women and kids).

In particular, many of the highest cost Medicaid patients in any given year are babies born prematurely or with congenital conditions. These newborns have very high costs immediately after birth, but then also often have ongoing health issues throughout their childhood that would benefit from expertise and continuity of care.

TSG recommends expanding the payment improvement initiatives as follows:

Establish a health home initiative for high-cost enrollees

This would include the elderly, developmentally disabled, and those with severe and persistent mental illness.

Include up-side and down-side risk in health homes for high-cost populations

Under this recommendation the health home will share in savings, and bear a shared portion of costs if its enrollees, on average, are above certain target thresholds.

Establish an intensive care management program for neonatal patients

This would include long-term care management and two-sided risk-sharing for certain categories of newborns, including those born before a certain proportion of term, and those born with significant health issues.

10.3. Critical Consideration – Contract Management

Implementation of the recommendations identified above will require the development and management of numerous sophisticated contracts. Success in the implementation of these recommendations will require significant improvements in the agency's ability to manage contracts which we will address later on in these recommendations.

11. ALTERNATIVELY ADOPT A CARE MANAGEMENT STRATEGY INVOLVING MANAGED CARE

Full Risk Managed Care for All Populations and Services

A recommendation to transform the Arkansas Medicaid program into a full-risk managed care model includes all eligibility groups and all services in all settings. Based on the experience of many other states noted in other sections of this report and the direct state government experience of several of our Team members, we believe that the comprehensive full-risk integrated Medicaid program care coordination model has the highest probability of improving the health status of Medicaid beneficiaries over time, rebalancing the Long Term Care system, and achieving initial cost savings and offering the greatest cost avoidance over time.

TSG makes the following recommendations we believe are necessary ingredients[3] for Arkansas to achieve maximum benefit from a comprehensive integrated Medicaid managed care financing and delivery system for all beneficiaries for all services:

[3] In addition to MCO Readiness Review requirements and CMS requirements for Medicaid managed care plans

All eligible beneficiaries carved-in for all services in all settings.

Use of capitated rate cells based on acuity and risk to be developed in conjunction with the state's contracted actuarial firm in a full-risk model.

Consider including state institutions in the benefits design; discuss feasibility with actuarial firm, stakeholders, and CMS during the planning stage.

Require 85% Medical Loss Ratio.

The state should set all rates for the first three years and reconsider thereafter.

Negotiate administrative rate to a limit of 10%.

Cover the whole state through one RFP, with multiple vendors and adequate choice.

Provide beneficiary choice of several plans while assuring actuarial soundness of the total enterprise.

Medical necessity determined by the MCO(s) with state override process built in real time.

Assure MCOs have measurable community health worker outreach and health education/literacy services that promote access and self-responsibility.

Assure MCOs have Wellness Programs and beneficiary incentives that promote preventive healthy behaviors and self-responsibility.

The state should allow MCOs to develop provider payment models that pay 95% to 97% of the required rate and hold back 3% to 5% for provider incentives and gain-share for specified data-based outcomes.

If the 3% to 5% set aside remains unspent at the end of each year the balance reverts to the state unless otherwise negotiated for a specified purpose such as uncompensated care.

- Allow any willing provider to join MCO panels providing they meet credentialing requirements.
- Permit MCOs to pay non-network providers 90% of the required rates for providers who choose not to join their network after three documented MCO attempts to contact the provider and a ten day written notice.
- Allow Arkansas current PCMH model for low risk/need beneficiaries and children.
- Allow optional specialty health homes for people with intellectual and developmental disabilities and adults with serious mental illness.

- Require integrated intensive care coordination by licensed RNs or MSWs for high acuity/high cost beneficiaries identified by data and predictive modeling analytics[4] by the MCO(s).
- All program eligibility assessments for Long Term Care, services for people with Developmental Disabilities, and Behavioral Health services to be administered by the MCOs.
- Incentivize home and community based services for all populations through risk model
- Require Transition services for all populations from all institutional settings
- Aged and Physically Disabled Population
    - Reform the benefit structure and replace the fragmented Form 703/InterRai assessment process by changing the levels of care to a higher level of acuity for nursing facility level care and adding a preventive level of care designed to keep people from deteriorating to a NF level of care based on the TennCare Choices acuity based assessment instrument, levels of service and payment structure.
    - Expand Assisted Living as a beneficiary choice.
    - Adapt the Targeted Case Management benefit to high risk/high cost beneficiaries identified by the MCOs and APS.
- Revise benefits for Intellectual and Developmental Disabilities
    - Revise the benefits structure to allow for a "supports type" waiver with limited benefits based on assessment and choice and appropriate cost share.
    - Adapt the case management benefit to high risk/high cost beneficiaries identified by the MCO.
    - Require MCOs to work with residential services providers on an innovative model for care coordination of medical and pharmacy benefits for beneficiaries in their care.
    - Consider replacing the IDD version of the InterRai with the SIS Adult version (Supports Intensity Scale[5]) used in Virginia, Tennessee, Louisiana, California, Kentucky and Pennsylvania. Takes into account 57 life activities and 28 behavioral/medical areas and was preferred by many in the Arkansas DD community.

[4] Washington Health Services Encounter Risk Criteria: Based on assessment and encounter data: client lives alone; high risk behaviors; medication management risk; self-report of "poor health"; analysis of past 15 months of health claims determines future medical cost/risk of hospitalization; high frequency mental health, substance abuse, diabetes, cardiovascular disease; minimum risk score in top 20% expected medical cost for SSI related population. D. Mancuso, Ph. D. Super Utilizer Summit: 2/11/2013. Robert Wood Johnson Foundation

[5] "SIS": Supports Intensity Scale. American Association of Intellectual and Developmental Disabilities

  - Require the use of the SIS – Children's version assessment instrument for all children's day habilitation services (DDTS and CHMS); require annual reassessment of eligibility for day habilitation services.
  - Incentivize shared living as a home and community based choice.
  - Incentivize supported employment with an annual benchmark of getting more people engaged in meaningful employment.

- Revise benefits for Behavioral Health

  - Implement the LOCUS[6] Adult assessment instrument for program eligibility for Mental Health Rehabilitation Option services.
  - Implement the CANS[7] assessment instrument for child and adolescent Rehabilitation Option services.
  - Replace the RSPMI benefit with an Adult and Child/Adolescent Rehabilitation Services option benefit based on recognized Evidence Based Practice or known Best Practice.
  - Limit outpatient benefits to time and condition limited crisis services and time limited community stabilization services for adults.
  - Contractual requirement for MCOs, DBHS, Child Welfare, hospitals, the Courts and public safety, and consumers to develop community based diversion strategies from unnecessary psychiatric hospitalizations, child/adolescent residential placements, and low barrier crime jail admissions.

11.1. Alternative to All Populations in Full Risk Managed Care

The Aged, Blind, and Disabled Medicaid population represents 74% of all expenditures, a total of $4.023 billion in 2014, and includes all Medicaid paid institutional levels of care and home and community based services. A second approach for Arkansas to consider is a full-risk managed care model for all services for the ABD populations (Medical, pharmacy, ancillary, institutional, and home and community based services) and a "carve out" of the TANF and CHIP populations.

This approach has the value of continuing the PCMH model and continued development of the Episodes of Care model in the legacy fee-for-service payment system. This approach would provide continuity of the PCMH model in Arkansas as we recommend it be included in the full-risk managed care model above (with the exception of the specialty health home recommendation for people with developmental and intellectual disabilities and the serious

[6] "LOCUS": Level of Care Utilization System. American Association of Community Psychiatrists
[7] "CANS": Child and Adolescent Needs and Strategies Assessment. Public Doman. John Praed Foundation holds copyright.

mentally ill adult population). Currently, the ABD population is "carved out" of PCMH and Episodes of Care, so in this approach, the care management for the current population that get these initiatives would continue to get these services.

Coordinate PCMH and Episodes of Care between FFS and capitated models

If the ABD only model is chosen we would strongly recommend that the PCMH and Episodes of Care model development be closely coordinated between the FFS payment and delivery model and the capitated payment and delivery model.

11.2. Provider Risk Bearing in Medicaid Managed Care

One of the significant market innovations in response to state value-based managed care purchasing strategies has been the establishment of community health systems bearing risk and providing health plan coverage for Medicaid adults and children.

During our Assessment of the Arkansas health system market we heard from several of the Arkansas hospital providers that they may be interested in forming a managed care collaborative to be a potential bidder should the state decide to implement an at-risk managed care Medicaid services strategy. We see this as a potentially very positive health market development for the state of Arkansas. There are several successful examples of provider-based, risk-bearing Medicaid health plan models that have proven to provide quality services, safety-net level of care coordination, cost containment, and a local commitment. Partners Health Care/Neighborhood Health Plan was founded by Brigham and Women's and Mass General Hospital (both affiliated with the Harvard Medical School) and has successfully provided health plan coverage for Medicaid adults and children for the past 25 years. The University of Illinois Hospital and Health System (UI Health Plus) and the Cook County Health and Hospital System (County Care Health Plan) are now offering full benefit health plans for Medicaid beneficiaries in response to the state's innovative value based purchasing strategy. The University of Pittsburg Medical Center also offers the UPMC Health Plan to full-benefit Medicaid recipients.

Several of these health and hospital based systems are ranked in the top 15 health systems in the country.[8] It is obvious that the more competition there is for a state RFP for full or partial Medicaid benefits, the better the state's contracting position will be. We believe that as long as a provider-based organization is willing to meet all the requirements of a full-risk capitated model they should be given every opportunity to move in this direction on a level playing field based on a competitive RFP bid process.

[8] "Best Hospitals": US News and World Report. 2015-2016

12. DENTAL PROGRAM SHOULD BE BASED ON VALUE PURCHASING OR MANAGED CARE

Medicaid's dental program should also move in the direction of value based purchasing or managed care. If the state decides to move in the direction of full risk managed care, either the MCOs chosen or a separate MCO – similar to the model in Texas, Florida and Louisiana – should provide dental care management and claims management. In the alternative, a third party administrator could properly manage the care, improve oral health outcomes, develop robust provider networks, and adopt and integrate clinically focused care solutions under a value based purchasing model.

Evidence suggests that the managed care approach has had some proven success and the third-party-administrator program approach may also prove beneficial so long as the vendors bear risk and responsibility to mitigate costs and have a financial incentive to administer quality-based utilization management.

12.1. Dental Managed Care Experience

The State of Texas is a good example of the success that can be seen in adopting full risk, capitated, dental managed care. After several years of explosive cost growth in the Medicaid dental program, the 2011 Legislature directed the Health and Human Services Commission (HHSC) to transition Medicaid dental benefits from the traditional fee-for-service (FFS) model to the dental managed care model to better manage costs and increase access and quality of care.

Implement Dental Managed Care

Overall, dental managed care has reduced Medicaid dental costs in Texas by nearly 30% compared to projected spending under the traditional FFS model. State spending on Medicaid dental services decreased by nearly $260 million during the first full two years of dental managed care implementation. Since 2012, the use of managed care for Medicaid dental services has successfully improved access to timely, preventive care for children in Texas while driving down dental costs. See The Texas Association of Health Plans September 2015 release of Dental Managed Care Successful Approach.

12.2. Dental Home with Value Based contracting to Third Party Administrator

Implement Value Based Third Party Administer for Dental

The other approach to improving oral health outcomes in the dental program in Arkansas, and the approach supported by the Arkansas State Dental Association, would involve the type of value-based contracting to a third party vendor that would administer claims and address care management issues but not accept full-risk in a capitated management care model. This would

involve continuation of fee-for-service provider reimbursement with care management to encourage high risk patients to fully complete treatment plans and help all patients overcome obstacles which create "no shows" in dental offices. Like managed care:

- High risk patients here could also be risk stratified and assigned to a dental home
- Mobile units could be used to treat rural areas where there is a dental shortage, going to schools, community health fairs etc.
- Benefit plan designs may be customized as desired including use of no show codes for tracking of non-compliance and/or the addition of risk codes to identify those patients with the greatest need for on-going case management
- There would be established a medical and dental home for each patient
- The vendor could also provide afterhours emergency help line with the intention of circumventing ER visits.

Also, the third party administrator would be charged with providing coordination of hospital care and with periodic review of non-utilization to support outreach and preventative care initiatives.

The major difference between the two models is that the full-risk capitated managed care model limits the risk to the state. If Arkansas chooses to move in the value-based contracting/third-party-administrator area, TSG recommends that there be risk assigned to the contract for not meeting quality benchmarks in terms of increased access and prevention services, and also gain-share for increasing same.

12.3. Dental Fraud, Waste and Abuse

DHS internal data analysts retrospectively identified and referred only 3 dental cases in 2014 to OMIG for suspected fraud, waste and abuse. OMIG also performs retrospective reviews of dental claims along with all other types of medical claims. Additionally, DHS has Dental Peer Review consultants that prospectively identify questionable practices as part of prior authorization. But, very little in terms of recoveries and improper billing patters has been found. National estimates for fraud average 3% to 5% in claims activity per year. Thus, a focused dental fraud, waste and abuse solution with advanced analytics would provide additional value and savings.

Utilization Review Example: The State of Texas saved over $3 Billion (nearly 30%) in Savings by bringing in a Dental Managed Care program that significantly improved the program oversight. The majority of funds saved over the last few years were due to better oversight of orthodontic services and more cost-effective preventive dentistry.

12.4. State and MCO Readiness

Should the state chooses to move in the path of full risk managed care, there will need to be both state readiness and MCO readiness review to ensure that there are no interruption of essential medical and waiver services for beneficiaries. In Appendix 1 we have provided the Task Force with a list of State and MCO Readiness Review factors that DHS should consider and which CMS more than likely will require.

13. DEVELOP A SYSTEM-WIDE ARKANSAS HEALTH IMPROVEMENT DASHBOARD

Recently, Arkansas was in the news as the most obese state in the country.[9] In 2014, the state was ranked 49th in the country in overall health, 50th in child immunizations, 50th in stroke deaths, and 44th in preventable hospitalizations.[10]

These poor health standards ultimately result in negative child development and educational opportunities, negative business development opportunities, and premature death. While Arkansas moves to transform its Medicaid program from a fragmented, disease-focused program, fee for service model, to an integrated, value-based health care system, the state should look to develop a statewide health improvement dashboard with quality indicators that show the movement of critical health outcomes.

States that have been able to reform their entire Medicaid program into the type of delivery system TSG is recommending have seen impressive results in reducing unnecessary hospitalizations and ED use, increased choice of home and community based services, and decreased use of high cost institutional care, resulting in more predictable costs that bend the curve downward from the prior history of fee-for-service payment.

Arkansas can shine a light on the investment it makes in the Medicaid program based on a population health status improvement campaign by creating an **Arkansas Health Improvement Dashboard**[11] that measures the progress and outcomes of a reformed Medicaid program based on an integrated full risk care management – managed care contracting and delivery system model or an enhancement of the payment improvement initiative through patient centered medical homes.

[9] Forbes: 9/21/15
[10] America's Health Ranking, 2014
[11] National Committee for Quality Assurance/HEDIS measures for CMS Managed Care Health Plans: currently not required by Arkansas Medicaid program.

14. ENHANCING HOME AND COMMUNITY BASED CARE

14.1. Reforming the Front Door: Assessments and Level of Care

The independent assessment process for Medicaid long term care services for elders and the physically disabled, people with intellectual and developmental disabilities, and adults with serious mental illness and children and adolescents with serious emotional disorders and related conditions is the **critical factor** in determining a person's needs, strengths, preferences, plan of care, and cost. Without an independent administration of a well thought out program of eligibility assessment instruments, states cannot be assured that eligible individuals are getting the right services, in the setting of their preference, at the right amount, for the right amount of time, and at the right cost.

The independent assessment process for program eligibility for Medicaid paid LTSS services was directly addressed by the Final Federal Rule for HCBS.[12] Pursuant to that rule, a person's assessment process must be conducted by an "independent" qualified professional. The rule further requires a face-to-face interview, informed consent, assistance for the person as needed, including relevant health history, an assessment of physical, cognitive, and behavioral health needs and strengths, personal preferences, housing options, and information about unpaid and natural supports caregivers.[13] The rule requires states to have a conflict of interest statement that defines "independent" to exclude individuals that have a financial interest[14] in any entity that is paid to provide care to the individual, is related by blood or marriage, or is empowered to make financial decisions on behalf of the individual.[15]

The importance of an independent assessment cannot be underscored given the current Arkansas assessment for Nursing Facility level of care being conducted by qualified Nursing Facility employees on a different form (Form 703) than that used for Home and Community Based Services (the InterRai), and the medical necessity decision for Nursing Facility level of care being made in the Office of Long Term Care and the medical necessity decision for waiver services being made at DAAS.

DHS, DAAS, and DDS have invested a significant amount of resources, time, and effort on the implementation of the InterRai for each of their covered populations. Regardless of the significant problems with Project Management and IT vendor operations and payment issues with this project, progress has been made, not as much as all involved would like, but nevertheless the investment has been made and DAAS and DDS are using the InterRai for initial

[12] Federal Register. CMS-2249-F and CMS 2296-F. 1/16/14
[13] Ibid. Section 441.720
[14] Section 411.354 defines financial interest as direct or indirect ownership or compensation
[15] Ibid. Section 441.730

assessments for new cases seeking services and required reassessments for individuals currently receiving DAAS and DDS home and community based waiver services or assisted living. DAAS reports they are ready to "go live" on the date CMS approves the AR Choices waiver renewal application. At this time, 1/1/2016 is the expected approval date.

DAAS reports they will be able to do a work around IT issues through CIM, a contracted vendor. DDS is not quite as far along the three phases on the InterRai implementation process (Assessment, Plan of Care, Assignment of Cost based on level of care needs).

DDS is using the InterRai for all assessments for new people seeking HCBS services as well as using the instrument for all reassessments of existing cases, which amounts to 4,200+ reassessments over a three year period. DDS expects that complete implementation of the InterRai for all three phases of the project should be completed by mid-2016.

Should the Arkansas Health Reform Task Force and State Legislature decide to maintain or adapt the current fee-for-service PCMH and Episodes of Care model and maintain HCBS waivers in a fee-for-service payment model, we recommend that DHS, DAAS, and DDS continue the implementation and use of the InterRai assessment model through completion.

Our recommendation includes the use of the InterRai for all DAAS levels of care (nursing facility and HCBS/Assisted Living), that the assessments be administered according to the CMS rule regarding independent assessment (with the possible predetermined exception of rural areas due to timeliness and access factors), and that DHS resolve the internal organizational fragmentation between the Office of Long Term Care and DAAS regarding the medical necessity decision.

Given that there has been little if any IT work on the use of the InterRai behavioral health instrument in the DBHS system we recommend that DHS and DBHS consider the use of the LOCUS assessment instrument for adults with Serious Mental Illness and the CANS assessment instrument for children with serious emotional disturbance and related conditions. This recommendation mirrors the assessment recommendation for DBHS should the Task Force decide to implement at risk care coordination managed care for all Medicaid services or the ABD population only.

In a managed care contract model, all costs for implementation and administration of Managed Long Term Services and Supports assessment processes should be the responsibility of the managed care organization.

14.2. Rebalancing Long-Term Services and Supports for the Elderly and Physically Disabled

Move towards community based care priority and away from institutional bias for long term services and support

Medicaid pays for long-terms services and supports (LTSS) for the elderly and physically disabled who demonstrate a functional need for such services and whose income is below 300% of the social security income level, or about 222% of the federal poverty level. Generally, in Medicaid, institutional care is the entitlement service for LTSS. For the elderly and physically disabled, institutional care takes the form of nursing facilities, either private or state-run.

State Medicaid programs generally include a number of community-based services as well, some of which are delivered through 'waiver' programs that allow individuals requiring the nursing facility level-of-care to receive services in the community. As was mentioned during our Assessment, over the last several decades, there has been a significant movement to try to provide services to individuals in the community rather than in institutions. Community-based services can often be provided at a lower cost than institutional services, although in some cases, for individuals with particularly high levels of need, community-based care might be more expensive.

Nationally, the proportion of Medicaid funding going to support the elderly and physically disabled in the community is about 50%. In Arkansas, the amount of funding going to support the elderly and physically disabled in the community is only about 35%.

"Rebalancing", in this context, generally refers to shifting the public investment away from institutional care, toward community-based care. If the Arkansas Medicaid program were to shift its expenditures on LTSS such that expenditures on community-based represented 50% of the overall expenditures on LTSS, then, assuming similar per-capita expenditures as historically for each setting, the Arkansas Medicaid program could recognize almost $200 million in annual, all-funds savings by 2021.

Table 3—Impact with and without rebalancing

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

The estimates for '2021 without rebalancing' assume a 3% annual census growth in both nursing facilities and community-based care, and a 2% annual per capita cost growth in both settings as well. The estimates for '2021 with rebalancing' assume a 7% annual decline in nursing facility census and a 9% annual increase in census for community-based care, both beginning in 2018. Starting the new trend in 2018 assumes about a 2 year ramp-up for the policy and programmatic components necessary to effectuate such a transition.

With these assumptions, the 5-year cost savings due to rebalancing would be just over $500 million all funds, as shown below.

Table 4—5 year cost savings due to rebalancing

Arkansas LTSS Expenditures *($millions)*						
	2017	2018	2019	2020	2021	2017-2021
All LTSS without rebalancing	1,318	1,385	1,455	1,529	1,606	5,975
All LTSS with rebalancing	1,318	1,330	1,350	1,377	1,414	5,471
Savings (all funds)	0	55	105	151	192	504

Note: If Arkansas moves to a capitated Full Risk Managed Care model, rebalancing would be accomplished by the Managed Care Organization per contract incentives and normal operations. Thus, these savings would be built into any MCO savings estimates we offer.

14.3. Remove Barriers to Enhancing Choice of Community Based Care

In Arkansas Medicaid today, there are a number of barriers to entry into either the Elder Choices Home and Community Based Waiver or the Living Choices Assisted Living Waiver that should be removed to move the state more in line with other states that have successfully rebalanced long term care.

Improve the Reimbursement Approval Process for Providers

For example, the reimbursement approval process puts the financial risk upon the provider and, therefore, does not incentivize community based care. If you are determined to meet the levels of care for nursing home eligibility and meet the financial threshold for Medicaid, you have the choice to for a slot in the above community waivers. However, the Medicaid program and financial eligibility approval can take a number of weeks. If you are seeking eligibility for one of the Waivers, and you are deemed eligible, payment is not retroactive to the date of application like it is with nursing facilities. Thus, providers may care for an individual looking for community based services during a period of time where they will not be reimbursed by the state, even where the individual is eligible for community waiver services.

Reimburse residential care facilities for transportation

Rationalize rules guiding residential care facilities

In addition, residential care facilities operating in the Living Choices Waiver have to, in addition to the application with Medicaid, also have a care plan approved by a physician so there is a further need for a timely physician appointment before a person is eligible and a facility can be compensated. This can take time as well. Residential care facilities are also not reimbursed for transportation, whereas nursing facilities are.

TSG found that some regulations are unnecessary like the rule that a cook in a residential care facility that receives Medicaid be a Certified Nurse Assistant, whereas there is no such requirement in a nursing facility. There is no question that residential care facilities and community services must meet the highest quality and we understand there have been issues in the past leading to a moratorium in 2005 on new residential care facilities, but some of the rules have no direct relationship to quality and can be a detriment to a senior remaining in a home and community based setting for as long as possible.

Home and community based providers, assisted living facilities and residential care facilities play a critical role in the care continuum, and offer quality care for as long as a senior or mentally ill adult can remain in the community. The state should do all that it can to remove barriers that serve to prevent the incentive of these providers to develop the capacity and services needed to meet the growing future demands of many vulnerable elders in Arkansas.

14.4. Make Community-First Choice Option Part of 1115 Waiver Negotiations without Agreeing to an Entitlement

Under the traditional Medicaid LTSS benefit, institutional care is generally the entitlement, with community-based services provided through waivers that are capped in terms of overall enrollment, with waiting lists maintained once caps are reached. The Community-First Choice Option was created by the Affordable Care Act and establishes a new Medicaid LTSS entitlement for community-based services. The CFCO is implemented as a state plan amendment and is optional at the discretion of the state. In addition to establishing the CFCO as an entitlement, the enabling legislation also established an incremental boost to the federal matching rate of 6% for CFCO services. DHS has estimated that the fiscal impact of implementing the CFCO would be a net positive to state funds compared to the current set of programs, cost trends, and federal matching rates.

TSG's recommendations are aligned with the purpose and intent of CFCO and the state should make home and community based alternatives to institutional care a priority, However, the state should approach CMS regarding the CFCO enhanced match and program purpose as part of its future re-design and a more global Section 1115 waiver plan that will achieve the same purposes without creating an entitlement. In this regard, the state could offer to meet de-institutional benchmarks in exchange for some form of enhanced funding.

15. PHARMACY PROGRAM EFFICIENCIES

The most impactful approach the State can take to reign in pharmacy cost risk is to outsource the management of the FFS Medicaid program to managed care, even outside of the scope of managed care for the entire Medicaid program. Ideally, the pharmacy benefit management should be outsourced together with the medical benefit risk. This will result in known program cost to the State and a reduction in State overhead costs.

The State would need to have air tight contracts with managed care vendors and implement a process to continuously oversee vendor performance. A transition like this will take time and planning. In the meantime the State continues to operate the FFS Medicaid program for approximately 500,000 beneficiaries. The State could take steps toward some short term savings opportunities while transitioning to a fully outsourced managed care program.

Re-contract the Retail Pharmacy Network

The State should re-contract the pharmacy network seeking better ingredient cost discounts for brand drugs and lower dispensing fees for all brand and generic prescriptions. To manage the inevitable pushback from retail pharmacies, consider having two network pricing tiers, one for underserved and rural areas with little or no retail pharmacy competition, and a different discount

structure for areas with an oversupply of retail pharmacies. This is not unlike the CMS fee schedule for hospitals in rural and underserved areas.

Table 5—Sensitivity Estimate annual savings: brand drugs

BRAND DRUGS	Total Amount Paid	Total Claims	Average Amount Paid/Claim
Brand Cost Per Claim (PO carriers)	$41,051,153	199,586	$205.68
Brand Cost Per Claim (DHS)	$144,862,822	480,320	$301.60
Difference between PO carriers and DHS average amount paid per claim for brand drugs *Note: Average day supply is lower for DHS*			$95.91
For every one percentage point reduction in the brand discount rate, DHS can realize the following estimated annual savings *Note: Prescription drug cost is made up of ingredient cost minus the network rate plus dispensing fee and sales tax. We are using amount paid per claim which is total drug cost minus member cost share. To estimate savings we removed the dispensing fee of $2,593,979 from the amount paid totals. Sales tax is negligible. The savings estimate is understated because member cost share was not removed from the equation.*			$1.4M
For each $1 reduction in brand claim dispensing fees, DHS could realize an estimated annual savings of the following. *Note: The dispensing fee value range between PO carriers and DHS is $1.00 to $5.40.*			$480,000

Table 6—Sensitivity Estimate annual savings: generic drugs

GENERIC DRUGS	Total Amount Paid	Total Claims	Average Amount Paid/Claim
Generic Cost Per Claim (PO carriers)	$34,625,332	1,929,740	$17.94
Generic Cost Per Claim (DHS)	$152,259,715	4,776,911	$31.87
Difference between PO carriers and DHS average amount paid per claim for generic drugs *Note: average day supply for generic drugs is lower for DHS*			$13.93
For every one percentage point reduction in the average generic discount rate, DHS can realize the following estimated annual savings *Note: Prescription drug cost is made up of ingredient cost minus the network rate plus dispensing fee and sales tax. We are using amount paid per claim which is total drug cost minus member cost share. To estimate savings we removed the dispensing fee of* $23,151,886 *from the amount paid totals. Sales tax is negligible. The savings estimate is understated because member cost share was not removed from the equation.*			$1.3M (not recommended)
For each $1 reduction in generic claim dispensing fees, DHS could realize an estimated annual savings of the following. *Note: The dispensing fee value range between PO carriers and DHS is $1.00 to $4.85.*			$4.7M

Increase use of pharmacy lock-in, add prescriber lock-in, and allow DHS clinical personnel access to The Arkansas Prescription Drug Monitoring Program.

Opioid misuse is a national epidemic. After reviewing the 2014 paid claims data and focusing on opioid users, there appears to be an opportunity to further manage obvious misusers. This is not

necessarily a cost saving recommendation as it will not affect many beneficiaries or claims nor are the claims themselves very expensive. This is a more of a quality and clinical program recommendation.

The DHS also has a lock-in program for identified substance abusers. Candidates for lock-in are identified by the retrospective DUR vendor, HID. With appropriate notification, a beneficiary can be limited to only having Medicaid covered prescriptions filled at a single pharmacy. There are currently 70 beneficiaries subject to the dispensing pharmacy lock-in program.

Our analysis revealed over 550 DHS beneficiaries who had opioid prescriptions written by 4 or more prescribers and had those prescriptions filled at 4 or more pharmacies. One could imagine explanations for 2-3 prescribers or pharmacies, but 4 or more of both is beyond explanation. The best practice in lock-in also has the beneficiary locked into just one prescriber in addition to just one dispensing pharmacy. Processes would need to be carefully implemented to not cause undue burden on providers as this is implemented, but as it will likely only affect a small number of beneficiaries, it is worth considering.

The Arkansas Prescription Drug Monitoring Program is a database of opiate prescription fills accessed by prescribers and dispensing pharmacies to assist in appropriate clinical management of patients requiring opiate therapy. The State Medicaid program is broadly responsible for quality and the health of the Medicaid population and pays the bills, so certainly should have ready access to this database to optimize performance of duties. Apparently, they do not currently have access. We recommend granting access to the statewide database for clinicians in the DHS. Access to this information would dramatically improve the ability to identify pharmacy and prescriber lock-in candidates.

Eliminate pharmacy claim limits for maintenance medications

Remove the claim limit for approved maintenance medications used in approved chronic conditions. Maintain the limit for all other drugs. Drugs on the list would not count against the claim limit. Non- maintenance drugs can still be subject to the limit or a modified limit. Valuable pharmacist consultation time would then be spent on solving medication problems and assisting beneficiaries to follow their treatment plan, not managing the available slots in the monthly prescription limit. Prescribers would be relieved from calling the voice response unit (VRU) every six months to request an extension of benefits.

Prescription medicine is generally a low cost intervention, especially with chronic use generic prescriptions. If the limits on prescriptions were modified, other important pharmacy concepts could flourish, such as medication synchronization, medication management services, and other appointment-based pharmacy services to monitor biometrics and lab results, provide needed immunizations, and increase medication adherence.

Expand the PDL, (relax the evidence-based PDL requirements)

In supplemental rebates, two factors drive rebates, size and control. The State has its own supplemental rebate agreements for the approximately 500k FFS beneficiaries. The best rebates go to entities with 3mm or more Medicaid beneficiaries. Control of the preferred drugs on the PDL through edits and prior authorization is the other factor which influences rebate yield. The State seems to be doing fine with control. To improve leverage from size, consider joining one of the multi-state supplemental rebate pools

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 net price.

The PDL strategy of 'evidence first, cost second' is great when there is evidence and a class review. Consider modifying the rule to allow for expanded PDL classes and the incremental supplemental rebates that come along with the expansion. With the current approach some costly drug classes and the coming wave of biosimilars, the first of which launched in the US in September 2015, will not be eligible for supplemental rebates.

Consolidate the Outsourced Pharmacy Call Centers

The UAMS College of Pharmacy's EBRx, and Magellan, operate outsourced call centers serving providers and beneficiaries in the FFS Medicaid pharmacy program. At a minimum, this represents duplicative administration and contracting and could be evaluated for consolidation through a competitive bid process. Depending on if and how the PDL is expanded either Magellan or UAMS may become more logical as the single outsourced call center.

Total Pharmacy Program Estimated Annual Savings

Table 7 summarizes savings opportunities that State could take advantage of in the short term. Our estimates range from $0 for doing nothing in an area, to the annual savings available if the State moved to the average performance for each of the metrics. We do not recommend improving the discounts on generic drugs at this time. There is upside available if the State were to perform better than average in any of the recommended areas, however, to be both realistic and conservative in the estimates, we refrained from extreme savings estimates.

Table 7—Range of annual savings from pharmacy recommendations

Savings Opportunity	Range of Annual Savings
Brand and Generic Drugs	
Estimated annual savings if DHS reduced the effective brand discount rate. (Range 0 to 2 percentage points)	$0.0 to $2.8M
Estimated annual savings if DHS decreased the brand dispensing fee. (Range of reduction is 0-$3)	$0.0 to $1.4M
Estimated annual savings if DHS decreased the generic dispensing fee. (Range of reduction is 0-$3)	$0.0 to $14.1M
Pharmacy Retail Network Re-contracting Subtotal	Up to $18.3M
PDL Expansion	**Range of Annual Savings**
For every 1% increase in Federal rebate return DHS could see additional rebates of $3.25 million annually (Range 0 – 4 percentage points)	$0.0 to $13 M
For every 1 percentage point increase in the number of claims covered by the PDL , DHS could see an additional $375K in supplemental rebates (Range 0-26 percentage points)	$0.0 to $9.75 M
PDL Subtotal	Up to $22.75 M
Grand Total Annual Pharmacy Savings Estimates	**Up to $41.05 M**

16. CONTRACT CHANGES TO EMBRACE ENHANCED PCMH OR MANAGED CARE

If Arkansas moves in the direction of a MCO or a PCMH model across all Medicaid, there will be a number of key changes to the existing relationships with key service suppliers. TSG considered a number of sources of changes to existing contract expenditures. These changes include discontinuing a particular contract when the work comes to a natural conclusion, renegotiating or re-procuring a contract to obtain a more favorable price, reducing the indirect costs associated with intra-agency contracts, and moving the work to an MCO. TSG assumed a full implementation of an MCO model by mid fiscal year 2018. All numbers in this section represent the approximate State share of each contract – not the total contract cost.

Renegotiate IT Contracts Following the Principles in the TSG Recommendations

The summary of all the possible contract changes, and corresponding spending level changes is shown in Table 8 below. The amounts shown in the Table represent the full implementation of the change. In many cases, the full benefit of the changes may not occur until FY18 or FY19.

Table 8—Changes in Annual Contract State Spend Levels

	FY16 Contract Spend	Change in a PCMH model	Change in an MCO model
FY16 Spend on the top 25 contracts	**$62,691,762**		
Savings from discontinuing contracts (already planned by DHS)		$18,929,554	$18,929,554
Savings from renegotiating contracts		$7,046,064	$ 4,100,000
Savings from reducing overhead costs		$1,796,970	$ 1,176,461[16]
Costs shifted to an MCO			$16,191,357
Total Changes		**$27,772,588**	**$40,397,373**

Discontinue Contracts

Discontinue Certain IT Contracts Already Planned by DHS

There are certain evolutionary changes to the contract spend levels and vendor relationships that will likely occur independent of any legislative decisions. These changes are planned by DHS and will impact a number of contracts. The details of these changes have been reviewed with the Task Force and with DHS.

17. ORGANIZATIONAL CHANGES TO EMBRACE PCMH OR MANAGED CARE

17.1. DHS Organization Changes

Modify Organization Structure to add Additional Emphasis on Collaboration and Vendor Oversight

Arkansas Medicaid is a $5 Billion annual enterprise. As such, TSG recommends that DHS modify the current organization structure to add additional emphasis on collaboration and vendor oversight to better manage the providers and services to stakeholders.

In addition, Arkansas will have to supplement the skills in the areas needed to support enhanced PCMH or managed care. Redesigning an organization is a costly exercise that introduces turmoil. Redesigning an organization can send a "wake-up call" to employees that something is

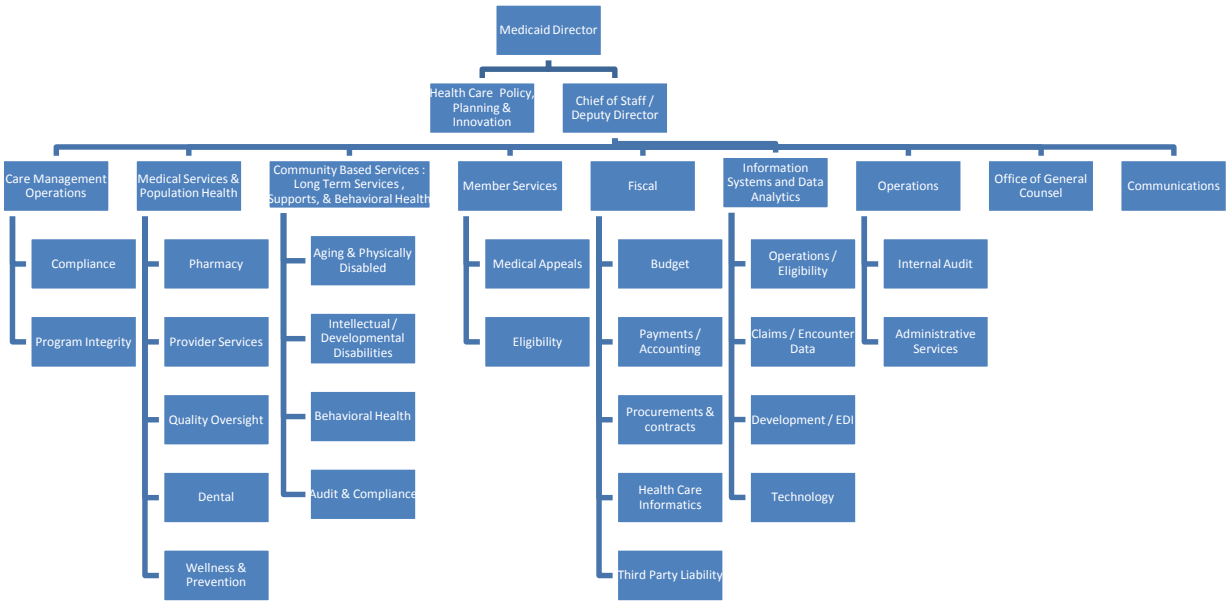
[16] In the case of MCO, some intra-agency contracts go away. The savings from reducing overhead costs is less than the PCMH model because the entire contract moves to the MCO.

different. However, by itself it is insufficient to solve most problems. Beyond redesigning the agency organization, TSG recommends that Arkansas move the agency to a cabinet level position and to change the focus of the organization away from a compliance mentality to one of ownership for the quality and cost of health care throughout the state.

Organization

TSG recommends the newly restructured agency may look something like the diagram shown below in Figure 1 below. A larger copy is provided in Appendix 2.

Figure 1—Proposed Arkansas Department of Health Care Financing



This organization was inspired by the work across multiple states that have significant experience with Managed Care. As reference, the organization chart for the Tennessee Medicaid agency is shown in Appendix 3.

The key components of this proposed organization are as follows.

Chief of Staff/Deputy Director

It is common in state agency organizations to have a Deputy Director who focuses on the internal operations of the department. This allows the Medicaid Director to focus on strategic planning and external stakeholder needs while allowing the Deputy Director to manage the daily operations.

Health Care Policy, Planning and Innovation

This position should be a direct report to the Agency leader. This will be instrumental in making the change in the agency's culture from a compliance mentality to a cost and quality ownership focus. The Legislature and Governor will play a large role in setting the tone and direction and

this function will take that direction and help the agency implement it. The agency will need to work with federal stakeholders, providers, and citizens to implement the new path. Policy and Planning will be key in making this happened. This person needs to see themselves as the key problem solver on a journey to cost effectiveness, scope of coverage, and efficacy of medical services to the citizens of Arkansas.

Care Management Operations

The majority of Medicaid spend and the largest vendor contracts will be consolidated into this oversight function. This area will manage the MCO or Value Based Purchasing vendor's compliance with the terms of the contract and be responsible for program integrity of these operations. DHS must be proactive and act to minimize fraud, waste and abuse that potentially cost taxpayers millions of dollars and effectively collaborate with OMIG in making appropriate referrals for further investigation. There is also opportunity for improvement by collaborating across divisions to tackle this challenge. Patterns of abuse in developmental disabilities might provide an insight into something that Behavioral Health should look at. Trends with the aging population might apply to the overall Medicaid population. An integrated approach to developing the analytical tools should lower the cost of building the tools and should also yield higher benefits from a more comprehensive view of the information.

Medical Services & Population Health

TSG recommends that DHS add greater emphasis on collaboration across areas of the medical services and the populations they serve. This includes pharmacy, provider services, quality oversight, dental, and wellness and prevention. This collaboration is easiest to achieve when a single unit leader is accountable for the results of the coordination of services.

Community Based Services; Long Term Services, Supports & Behavioral Health

This organization unit will support the integration of services in the communities, and coordinate the support for the aging and physically disabled population, the intellectual/developmental disabilities population, and the people with the behavioral health needs. This will be supported by an audit and compliance function.

Member Services

This organization unit will handle the medical appeals and the eligibility and enrollment processes.

Fiscal

This financial unit will coordinate all aspects of planning and managing the fiscal authority given to the agency. They will have a budget function, a group responsible for payments and accounting, a group focused on the procurement and contracting with vendors, a Health Care Informatics function, and a Third Party Liability function.

Information Services and Data Analytics

Information Services will continue as a separate organizational unit with its subcomponents typically organized around the various software applications and technology components they support. These will be Operations/Eligibility, Claims/Encounter data, overall development for smaller application areas, and technology. This technology unit typically handles everything from PCs to email to any cross-application shared services. There should also be a data analytic component that serves to analyze claims data and provide decision makers at DHS with important program analytics.

Operations

The Operations unit will house the Internal Audit function as well as Administrative Services.

Office of General Counsel

The Legal group is typically a direct report to the agency leader and handles legal matters across all portions of the agency's mission.

Communications

The Communications group will handle internal communications as well as communications with all agency stakeholders.

17.2. Staff Capabilities

Implement a New Staffing Model Placing New Importance on Paying for Performance, In-house Data Analytics, Collaboration, Vendor Procurement and Vendor Management

There are many new skills the agency will need to manage the future work. They will need much greater emphasis on performance management, collaboration across programs and populations, vendor procurement, and vendor management. The financial and data analytics capabilities need to be enhanced. Arkansas needs to solve the personnel hiring constraints where the rely only on vendor personnel for key analytics skill sets because of limits on the number of hours allowed for temporary personnel or unrealistic caps on state salaries for these critical skills.

TSG interviewed many other states to discuss the transition from an environment similar to Arkansas to a Managed Care model. The Kansas experience may be relevant where Kansas said "We were not like Tennessee where we had a large staff. We had to repurpose our staff so they are more contract managers than program managers." Kansas went on to say "The big change was culture. We had to train our agency that we were not a fee for service operation anymore

but overseeing managed care entities." [17] The same holds true if the contract management functions are overseeing complex value based purchasing arrangements.

RECOMMENDATION THREE: ENHANCE PROGRAM INTEGRITY ACROSS MEDICAID

18. CREATE AN ENTERPRISE BENEFIT INTEGRITY HUB

As can be seen by the results of the eligibility data scrub, there may exist potential eligibility issues involving the possibility of individuals moving out of state and not notifying the state that they have moved and their names remain on the Medicaid or Private Option rolls.

In such a case, the state is still paying a premium to private carriers until the time of the redetermination process, and, if the state moves to any form of capitated payment for its traditional Medicaid program, there will be an even more pressing need to identify individuals that have moved out of state in real time so that any payment to carriers can be stopped.

In addition, there exists the potential that individuals could have listed questionable addresses at the time of eligibility (note: TSG makes no representation that the results of the eligibility data scrub are conclusive of any fraudulent activity, and stresses that the results need to be further reviewed and investigated by the state before any conclusions of fraud can be made).

In order to guard against any potential identity or residency risk, the state should look to install a strong eligibility screen system on the front end of eligibility that is geared towards identity management that will authenticate identity and residency in real time. This front end system, which we are calling the Enterprise Benefit Integrity Hub, would offer sufficient tools to deter fraud and require individuals to provide factual, up-to-date information to validate their identity, address and income up front during the eligibility process and can also be used as a real time continuous check on residency status. Thankfully, technology currently exists to make this a reality.

Under such a Hub, initially, a prospective enrollee would enter the Access Arkansas, Healthcare.gov, Insureark.org or via referral from a district office visit to seek eligibility. There,

[17] Interview with Mike Randol, Mary Stewart, Paul Endacott with KanCare officials. Quotes from Mike Randol.

he or she would enter information such as name, Social Security Number, address, income and other information to identify what services for which he or she might be eligible.

At this point, the applicant would be transferred to the Enterprise Benefit Integrity Hub, connected to data vendors and operated through a security-protected hub, that would verify identity by offering a series of challenge questions, using real information drawn from commercially available data, such as past addresses, currently registered automobiles or names of relatives. At the same time, the system would verify the applicant's offered residence against a database of current addresses.

If either the identity or residence check failed to verify the applicant's offered information, he or she would be referred to the local district office, where a case worker would be flagged to verify these data elements independently.

Assuming the applicant cleared the identity and address verification, they would move to the normal eligibility screen, where the application would be formalized and there would be no delay. The individual would be deemed eligible while DHS verifies the income, using both federal and state databases to check for household income sources. Additionally, DHS could use a national data vendor to check individuals' assets – see recommendation on asset verification system. Those whose income or assets are found later to not meet program qualifications would be referred for immediate removal from Medicaid and could then be flagged for benefit recovery for possible recoupment.

Decreasing the time to discover fraud or abuse issues also dramatically improves the real savings. Florida has developed integrated eligibility systems that actively verify identity of the applicant before further automated application processing can be done. Florida's system includes applicant challenge and response identity verification, as is now becoming common for financial institutions. This means applicants must be able to answer questions that are based on their personal history in public records before being able to go any further with the application process. Florida claims dramatic savings have resulted.

The Federal Portal, which Arkansas makes use of, has a much improved identity integrity check than early in the process when negative news reports were common, and the identity check is now dynamic and further identity processing depends on the status of the initial review. However, Florida's system takes the level of identity integrity to another level, the management of the system is within the state, and they are not dependent on federal processing.

Identify Additional Verifications Required for Specific Programs

Ultimately, there might be additional verifications necessary for specific programming, such as a check to determine if a potential enrollee has employer sponsored insurance, to determine if he or she should be referred to the HIPP program, but this would be outside the Hub or automated check at this time.

The state should consider housing the Enterprise Eligibility Hub at the Department of Finance Administration

Such an Enterprise Eligibility Hub should be housed outside DHS but integrated within the DHS eligibility system framework. The reason for this is the expanded use that such a system could have for all departments in Arkansas that offer benefits or services for Arkansas, such as the revenue department, workforce department issuing unemployment benefits, and the motor vehicle and safety departments issuing licenses and certificates.

Expand Data Sources Available for Automated Eligibility Verification

Moreover, expanded data sources are important if Arkansas wants high identity integrity. Every independent source of data increases identification range and decreases risk. For example, Delaware is now using more than 15 external databases to validate their eligibility information. Somewhat less commonly used databases which are, however, used by some states include:

- State Schools - CO;
- Social Security Death Index – many states;
- SOLQi SSN Verification Service – many states;
- WorkNumber/TALX (larger employers) – IN, MS, TX;
- PARIS – many states, used different ways on different timelines;
- New Hire – many states;
- State Lottery - IN;
- Child Support - IN;
- Various State level aid programs - CO;
- Department of Motor Vehicles - TX;
- SNAP/TANF – many states, including AR to some degree;
- State Retirement System - MS;
- Systematic Alien Verification for Entitlements/SAVE - TX;
- Department of Health/State Vital Statistics – many states.

Some or all of these data sources could be housed within the Hub and be used to authenticate identity and eligibility for services.

Other Benefits

Returned Mail Savings: One example of an apparently mundane but actually powerful side benefit from both consolidating citizen information across programs and increasing the quality of the residence/address information can be dramatically lowering returned mail costs; a savings that could be in the millions even for a smaller state, such as Arkansas.

These economies of scale resulting from comprehensive integration, can extend beyond the eligibility function we are focused on here. Again, consolidating these everyday functions can seem trivial, but the savings mount up and can not only offset development costs early on but

will create dramatic long term cost avoidance as these basic capabilities are updated for all state departments as needed in the future.

Suggested Funding for Such an Enterprise Benefit Integrity Hub

CMS will likely support cost sharing programs for this kind of state data integration hub. However, the opportunity to get highly leveraged federal financial support for this kind of project may not exist indefinitely. Currently OMIG has an approved Planning Advanced Planning Document (PAPD) with CMS through the end of September of 2016 for and Enterprise Fraud Detection Program (see below). The approval allows for 90% federal funding for infrastructure development. In the PAPD approval letter, CMS has notified the state that it is possible to amend the funding request up to the September deadline (see Appendix 4). It is possible, therefore, that the scope of that document may be broadened by CMS to include the Enterprise Benefit Integrity Hub.

19. Other Sources of Income Should Be Used For Eligibility Verification

Arkansas should look to amend Act 1265 to enable other sources of income information to be used for the initial Medicaid application. The Act requires federal sources to be used, but some state sources, primarily the Unemployment Insurance database, which is updated quarterly by Workforce Services, are more current and just as accurate sources of income information.

The savings could be significant because using the state information sources could significantly increase the number of applications that could be processed automatically without manual DHS worker review. Right now front end applications that can be handled without manual review are fewer than 20%. That manual review is a huge cost driver; just increasing the number that could be processed automatically from that 20% to 30% could yield significant cost avoidance.

20. Automated Income Checks Should be Done Routinely

TSG recommends that Arkansas work with federal authority to use quarterly Unemployment Insurance Income Information and New Hire information as a basis to selectively review income eligibility for those whose income circumstances have changed. CMS will not allow across-the-board income reviews more than annually, but they would likely allow reviews where there is specific information about specific beneficiaries reasonably indicating that their eligibility status has changed. The relevant regulation, citing from 435.916, reads (emphasis ours):

> *Renewal on basis of information available to agency. The agency must make a redetermination of eligibility without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more*

current information available to the agency, ***including but not limited to information accessed through any data bases accessed by the agency…***

Use Quarterly Unemployment Insurance Income Information and New Hire Information as a Basis to Selectively Review Income Eligibility

Some states, such as Texas, routinely apply automated income checks throughout the year for adult beneficiaries (children are protected by continuous eligibility regulation) pre-MAGI rule implementation. Now states must ensure that they follow the different and more explicit continuous eligibility rules for adult beneficiaries.

TSG's preliminary research using the Unemployment Insurance database Income information for the last two years indicates that as many as 2,000 beneficiaries in the Private Option program may increase their income levels in any given quarter to where their eligibility is in question. The current rate of terminations of eligibility as the backlog of annual renewals is processed also suggests that earlier reviews might be worth the administrative effort.

If a quarterly review identified 1,000 clients who no longer qualified for the program, and thus removed from the roles those no longer qualified an average of six months sooner than the annual renewal would have done, the savings, at $450 per month per Private Option client, could be between $8-12 million a year. A refined review may show much less savings once all factors are taken into account, including the offsetting administrative costs of more reviews every year. But even much reduced, the potential savings makes researching this option further an easy recommendation.

The normal disenrollment processes would, of course, be used. And any client who no longer qualifies for Private Option should be directed to the Premium Tax credit program, as is current DHS practice, for which they would likely qualify. They would just be moving along the reasonable path of graduated state support in a more timely way than if the state waited until their annual review.

21. REVISIT FEDERAL DECISION TO DISALLOW SNAP INFORMATION TO IDENTIFY INCOME CHANGES

Use SNAP information to identify Income Changes for Medicaid Eligibility

For similar reasons, TSG recommends that the state revisit the Federal decision to disallow SNAP information to identify Income changes for Medicaid eligibility. A carefully structured proposal that emphasizes that the state only wants to review beneficiaries for whom they have specific information indicating a significant and material increase in income might be interpreted by CMS as falling with their guidelines quoted above requiring the State to act on any such specific information.

Compatibility Formula Review

This is the formula to establish a range around the target number for income qualification for a particular client given their family size. This is partly intended to reduce churn, on and off eligibility, for clients whose income is near the border thresholds. CMS indicated that this formula is not a federal standard applied the same across all states, rather that CMS must approve the formula but states have a role in defining what they would choose to use in their state.

Right now everyone who has worked with the detail of the formula being used in Arkansas knows that it is unnecessarily complicated and it is inconsistent in that beneficiaries with different family sizes have different ranges of acceptable leeway applied for their eligibility renewals. A proposal to CMS that accomplishes the same function but is simpler to implement and more consistently applied may be worthwhile. CMS told TSG they would consider such a proposal.

22. ASSET VERIFICATION

As referenced in our Assessment, DHS/DAAS has already begun planning for the implementation of electronic asset verification system (AVS) for long term care financial eligibility, which is a requirement of CMS. The implementation of AVS will go a long way in ensuring proper financial asset disclosure and reducing the potential for fraud in the long term care program.

TSG further recommends that DHS should also consider the use of this innovative data mining program for other beneficiaries in the areas of DHS programs where financial asset checks are required.

23. OMIG SHOULD CONTINUE FOCUS ON BUILDING ENTERPRISE FRAUD PROGRAM

As was mentioned in our assessment, there needs to be additional innovative data analytic capabilities brought to OMIG so that it can effectively serve its mission. In fact, in March of 2014, Act 259 of the Arkansas Legislative Fiscal Session was signed into law requiring the OMIG to establish an Enterprise Fraud Program. The purpose of the program was to utilize state of the art technology to detect and prevent fraud, waste, abuse, and improper payments within the Arkansas Medicaid Program. The Arkansas Legislature and OMIG both share this correct and necessary vision.

As an initial step of procurement, OMIG and the Office of State Procurement drafted a Request for Information (RFI) to assist the Enterprise Fraud Program in understanding the capabilities

and support services of fraud detection technology in the current marketplace. DHS also submitted a Planning Advance Planning Document (PAPD) to inform the CMS of planned activities and to request approval of an RFP for the implementation of an Enterprise Medicaid Fraud and Detection (EMFAD) solution for Arkansas.

The PAPD was recently approved by CMS on September 1, 2015 allowing DHS to obtain 90% federal funding for the development of the system. It is expected that this new system will provide enhanced automated capabilities for detecting and preventing fraud, abuse, noncompliance, and improper Medicaid payments. The new system should include:

- Improved automated detection and alerting.
- Continuing monitoring of Medicaid program transactions.
- Improved prospective identification of possible fraud and abuse activities.
- Improved detection of non-transactional fraud such as eligibility issues and identity theft, use of state-of-the-art analytical techniques, and feedback and self-learning capability.

OMIG and DHS have moved in the right direction here. The PAPD approval for federal funding for this program is set to expire one year from September, on September 30, 2016. There were no actual funds approved with the PAPD for the OMIG Enterprise Program and funding will be based on amounts outlined in the final contract(s) when submitted to CMS with an Implementation Advance Planning Document Update (IAPD) document that includes the budget tables, deliverables, and requested Federal Financial Participation (FFP) breakouts. This will be after the RFP is issued and a successful vendor(s) has been chosen.

TSG believes that the importance of this particular resource for OMIG should be emphasized, since it will undoubtedly strengthen and enhance its own fraud, waste and abuse detection and prevention capabilities. It will also serve as an important piece of the integrity link to the programmatic reforms recommended herein.

Thus, we recommend the following:

OMIG and DHS continue to move aggressively down the path of the Enterprise Fraud Program RFP and ensure that RFP is issued and a vendor is selected with a budget so that the state can take advantage of the federal funding;

Along with the establishment of the enterprise program there should be a renewed focus for coordination of program integrity functions between OMIG and DHS

DHS should also consider amending the PAPD to include a request for funding and approval of the Enterprise Benefit Integrity Hub, recommended by TSG to be housed at the Department of Finance and Administration.

It should be looked at by CMS as one integrated public integrity program that will serve to reduce Medicaid fraud across the board.

24. ELIGIBILITY ENHANCEMENT FRAMEWORK PROJECT RECOMMENDATIONS

24.1. Hire a Strong Systems Integrator to Ensure Enterprise Integration

One of the most important design consideration for large complex systems is integration of common functionality. There are numerous issues that arise when diverse and complicated systems need to interact. Integration of shared functions is fundamental.

The lack of understanding about how systems interact undermines the capacity of the state to know if its eligibility process is successful or not. This is where the most glaring deficit in Arkansas's program governance becomes apparent – the lack of a true Systems Integrator role guiding the process. That lack of a strong systems integrator, often the lack of even a weak systems integrator, has caused many problems. We know this has been reported by others, and it is likely that this opinion will be confirmed yet again by other assessments still underway.

Restructure IT Development Governance

One of our leading recommendation around eligibility systems is to restructure the development governance so that all future systems design and development are managed by a fully empowered Systems Integration contractor who is operating within a clearly articulated vision of the state's long term goals.

Require System Integrators to Staff with Experienced Project Managers

The State should also require the system integrator to staff the key personnel on the project with experienced project managers. The contract should give the state the right to approve or reject the vendor's proposed key personnel. The State should not hesitate to be demanding in this aspect of managing any vendor. Staffing the right team from the beginning can minimize the headaches down the road.

24.2. Project Management

Use Fixed Prices Contracts for Systems Development and Services

The management of the EEF Project should change dramatically when the new procurement processes are completed and a systems integrator is in place. Ideally, the new contract will be for a firm fixed price implementation of traditional Medicaid functions. The systems integrator should assume responsibility for the project management of the scope, schedule, deliverables, and price. The contract should have strong incentives, in the form of liquidated damages, for schedule delays at every major milestone. The new contract should put the responsibility for federal certification of the system in the hands of the systems integrator as part of an overall

warranty process. Any deficiencies identified by the federal authorities should be corrected by the systems integrator without additional compensation.

By transferring the risk of schedule and budget overruns to the systems integrator, the State eliminates the need to have a separate PMO vendor watching the systems integrator. The contract creates the right incentives and incremental milestones with tangible deliverables eliminate the likelihood the vendor can falsely report status for long. CMS will still want an independent verification contractor, so some degree of oversight by a second vendor will still be in place.

24.3. Program Efficiencies

Standardize Eligibility and Enrollment Processes to Reduce Cost of System Development

The State should carefully consider the economies of scale across the various eligibility and enrollment processes and find ways to standardize them where possible. The State should minimize customizations to the software products, for internal processing reasons as a way to reduce the cost and complexity of future phases of the EEF project.

Procurement

Specify Detail Requirements in Procurement Documents

It is essential to specify the requirements correctly in the upcoming procurement documents. The vendors will price their proposals based on what the State documents in the RFP. The vendors will strive to do what the State asks, particularly if there are strong financial incentives to do so. The adage "be careful what you ask for" applies in this situation.

TSG recommends the State be even more aware of what requirements might be omitted from the RFP as these will be even more problematic. Extra review and attention to the preparation of the RFP will payback several fold. TSG recommends the State ask the systems integrator to help manage scope, minimize software customizations, and own the performance and usability of the final result of the EEF project.

ADDITIONAL CONSIDERATIONS

In addition to the program and organizational reforms listed above, there are other operational changes that should be made to the Arkansas Medicaid program that will help to align incentives more appropriately. TSG makes the following recommendations:

25. ESTABLISH A STUDY GROUP TO WORK WITH DHS AND HOSPITAL REPRESENTATIVES TO REVIEW THE IMPACT OF MOVING TO DIAGNOSIS-RELATED GROUP (DRG) SYSTEM OF REIMBURSING HOSPITALS

The Task Force should establish a study group to review reimbursing hospitals by DRGs. In doing so, the study group should evaluate the best and noteworthy practices, experiences and applicable lessons from other states where meaningful and referenceable insight may be gleaned. An example of such a reference site would be the Texas Medicaid Program and their journey to adoption of APR-DRG. Their painstaking and collaborative work with Children's Hospital Association of Texas (CHAT) yielded excellent teamwork and achievement from all stakeholders.

- Consider appropriate measures to ensure fair treatment of impacted providers and a pragmatic transition to a new reimbursement methodology, while providing the economic outcome for the Medicaid program and setting clear targets and goals for implementation
- Strive for a simpler financial model
- Conduct a comprehensive DRG simulation using the most current APR-DRG model on all 2014 claims plus any available 2015 claims

Include Arkansas Children's Hospital (since APR-DRG could provider better, usable simulation results than Medicare MS-DRG). In addition, include Outpatient Cases (Outpatient Surgeries & Procedures, Imaging, etc.) for potential applicable opportunities beyond inpatient services.

Note that the following states (including 4 SEC states) are using APR-DRG for their Medicaid payment methodology: Arizona, California, Colorado, Connecticut, Florida, Illinois, Massachusetts, Mississippi, Montana, Nebraska, North Dakota, Ohio, Pennsylvania, Rhode Island, South Carolina, Texas, Virginia, Washington DC.

Moreover:

- Consider thorough examination of Supplemental Payments including all sources and uses of funds
- Evaluate results collaboratively with All Stakeholders, including the Task Force, DHS and key and representative hospitals
- Examine the potential impact, positive or negative, of a DRG payment model on the Medicaid program, as well as key and representative hospitals, keeping in mind the following:
    - The budgetary impact a DRG payment will have on the State
    - How a DRG payment model integrates with each institution's efforts to improve value and efficiency in the delivery of quality care (e.g. Arkansas Children's Hospital's Strategic Plan, etc.)

  - The necessary measures to ensure fair treatment of impacted providers and a pragmatic transition to a new reimbursement methodology, while providing the economic outcome for the Medicaid program

- Conduct impact and disruption analyses to determine the potential effect of a DRG/APR-DRG based payment model on Medicaid hospitals and their patients to determine

The study group should be tasked with presenting to the Task Force clearly defined proposals for new payment model options with impact analysis within clear defined timelines.

26. OPPORTUNITIES FOR IMPROVEMENT IN VENDOR MANAGEMENT

Streamline the Procurement Timeline

TSG recommends the Arkansas legislature streamline their procurement timeline by consolidating reviews and conducting more activities in parallel where possible. The longer the procurement timeline, the more risk is introduced that an agency's requirements will be vague or undefined in the Request for Proposal or that business events will drive a project in a new direction. Vendors have the opportunity to make a large amount of money through change orders.

The State's goal should be to reduce the need for change orders, where possible. The current Arkansas procurement timeline is at least a year with the potential for some types of procurement to take between one and two years. While reviews are useful, it is important to balance the need for "one more review" with the risk of elongating the procurement timeline.

State Term Contracts

Institute a Program of State Term Contracts

Many states have a process where every few years, they conduct a competitive bid process to receive billing rate quotes from management consulting firms, information technology firms, and other niche providers for any work any State agency wishes to do over the next few years. They select a number of vendors to be on their "acceptable" list to provide the scope of services covered under the original procurement. The vendors are locked into the billing rates they quoted.

Any agency can issue a Request for Quote to these "pre-approved" vendors and receive a rapid response from the vendors on whether they have the people available to do the work and how many hours they estimate it will take. They are constrained by the billing rates they previously agreed to. For example, Florida has 10 vendors on their management consulting services master list. Each vendor has agreed to a billing rate for one of five categories of personnel. In this case,

the rates are valid from 2014 through 2017. [18] Similarly, Florida has a state term contract for a broad range of IT services which are divided into four project areas. This practice allows an agency to avoid a formal bid process, vendors are pre-qualified, and hourly rates are classified, capped, and easily accessible to users before the buy process starts. [19] This practice would also allow Arkansas to have another procurement option, other than sole source extensions, to quickly onboard PMO skills, IV&V skills, data analytics skills or technology development contractors.

Contract Best Practices

Develop a Consistent Approach to Tough Performance Metrics for Contracts

Arkansas has made significant improvements in their procurement practices including the mandatory use of performance indicators in supplier contracts. TSG recommends further refinements can be made in drafting the content and language around the performance indicators and the remedies for vendor failures to meet the performance indicators.

TSG observed a wide variance in the specificity of the language around the performance indicators. Some contracts include performance indicators that read more like a statement of work or a statement of the scope of a project. Other contracts had highly quantitative indicators with a great deal of financial backing to motivate the vendor to perform admirably. There is an opportunity for better vendor performance by standardizing performance indicators to a quantitative outcome.

There is an art to packaging agency needs into bundles of services for competitive procurement. Ideally, an agency aims to bundle their request for services into something that a reasonable number of vendors commonly do. This enables the maximum number of vendors to respond to a request for proposal (RFP).

If a vendor has the skills to do only 75% of the scope of an RFP, the vendor must either find another company to subcontract with for the other services or decline to bid. Often times the short turnaround time of an RFP response precludes a vendor from finding a qualified subcontractor. Another downside of overly broad RFP scope is that the agency may pay more than necessary for portions of the work. For example, bundling of administrative tasks with a larger management consulting contract may mean the agency awards the work to an out-of-state vendor and pays travel costs on the administrative work. There is similar risk if the scope of the RFP is too narrow. That situation leads to the agency filling the role of integrator having to piece together the work of several vendors to deliver an integrated product or service.

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[18]http://www.dms.myflorida.com/business_operations/state_purchasing/vendor_information/state_contracts_and_agreements/state_term_contracts/management_consulting_services/pricing
[19]http://www.dms.myflorida.com/business_operations/state_purchasing/vendor_information/state_contracts_and_agreements/state_term_contracts/information_technology_it_consulting_services

In the case of the 25 contracts that TSG reviewed, there are a few instances that stood out in this "bundling of services" dilemma. The EEF project is an example where DHS has to manage several independent vendors to deliver one system. The RedMane and eSystems work is highly dependent on the IBM Cúram product. DHS separately hired Cognosante to provide additional information about how each of these vendors is doing. While Cognosante has highly skilled people who know how to run projects, they are not legally or financially responsible for the work of the other vendors. They essentially provide a "news reporter" function to alert others to key issues. This structure is very different from having an overall "systems integrator" who is legally and financially responsible for successful coordination of all the moving pieces and delivery of the final product.

Similarly, DHS uses Cognosante to perform the services necessary to obtain federal compliance for the MMIS AME project. In other states, the vendor who developed the system is required to obtain federal compliance as part of the warranty provisions and maintenance work associated with the original development of the system. In any scenario, the work must be done. The difference is who pays for any problems that are uncovered. The separate contract with Cognosante potentially leaves the State vulnerable for eating the cost to fix problems.

Performance Indicators

Develop a System of Managing Contracts through Performance Indicators

In TSG's opinion, the weakest portion of the existing contracts is the way the performance indicators are written. With a few notable exceptions, most of the performance indicators read more like a Statement of Work than a quantitative quality standard for how the work is to be performed. We understand the importance of keeping the contract scope broad enough that the agency can direct the vendor to do the work required and to accommodate changes without triggering a protest from another vendor or triggering a need for an additional procurement. However, there should be a better way to provide this agency control over the work without abandoning the specificity around performance indicators.

State Personnel

Improve the Staffing Model and Recruiting Processes to Attract More Highest-Quality New Hires

Every state is challenged with hiring and retaining personnel with deep experience in large project management and with the technology skills to perform much of the needed work. States often find that new graduates are not interested in older technologies and that consulting firms offer significantly higher salaries.

Some states have found they can attract more talent if they aim for people who are tired of the travel schedule consulting firms require. States agencies may offer a more attractive work-life

balance and a greater sense of giving back to their community to the personnel in their thirties and forties.

Many states completed cost/benefit analysis on using contractors versus hiring employees years ago when the average state agency employee stayed their entire career and accrued the maximum retirement and health care benefits. Under this calculation, states often found that paying the contractor billing rate was a good tradeoff. However, the retention of state agencies in most states has decreased dramatically as the younger generations move from job to job much more readily. TSG is not aware of the calculations Arkansas may have done and the corresponding implications for salaries or stipends for particular skills. It may be appropriate to reconsider this analysis in light of the amount DHS spends on certain high value skill sets.

Vendor Management

DHS is required to manage very large sums of money under the existing contracts. With the potential for expanded PCMH or managed care, the size of the individual contracts may grow even larger. The current manual processes for reconciling invoices to contract deliverables will be difficult to administer on a much larger and more complex scale. TSG recommends the legislature consider this administrative burden and not wind up inadvertently creating a barrier to detailed deliverable payments.

New Legislation

Share Vendor Performance Data Between Agencies

TSG understands the new procurement legislation calls for quarterly status reports on vendor performance. Allowing agencies to share data about which vendors consistently perform well will assist the state in the future. It is not yet clear how this performance data will be factored into future procurements.

In an ideal world, a track record of successful delivery to any State agency could give a vendor "bonus" points in the evaluation criteria of the next procurement. Conversely, a vendor who consistently under-delivers would be held accountable for their deficiencies in future procurements with the State. There must be a mechanism to ensure the status reports are fair and consistent and that this scoring would not open the agencies up for more vendor protests.

TSG also understands that the new legislation made some revisions to the standards for professional services and for technical service contracts. It is not clear that these revisions went far enough to require best practice procurement of technical services for both Design and Development projects as well as on-going technical operations projects.

Renegotiate contracts

There are many contracts that will be affected by the course of action enacted by the Legislature. There are actions that the agency may be able to start as soon as the direction of health care reform is clear. The actions should include the following areas of focus.

PMO, Technical, and Analytical Skills

Eliminate the 1,000 Hour Cap for Contract Personnel

The State uses a number of vendors to provide personnel with project management, technical, or analytical skills. These contracts often continue for long periods of time and the agency pays a large sum of money for the people. In some cases, these skills are needed so quickly that the agency relies on sole source contracts to onboard personnel quickly.

Currently, Arkansas has a category of contract personnel that agencies can use for temporary skills; however, there is a cap of 1,000 hours for this type of person. If the State could eliminate this 1,000 hour cap, the agencies could hire the contractors directly. This eliminates the middle man and the mark-up on the resource costs that vendors typically charge. It also minimizes the State's benefits costs as these types of "employees" do not accrue full State benefits. This will not work for all skill categories but it may work for some positions.

Rebid Work Where Circumstances Have Changed

There are several examples of existing contracts where the circumstances have changed since the contract was awarded. It is in the best interest of the State to go through a new procurement process to reduce the scope or size of the contract to meet the current and future needs. In some cases, it may be possible to convince a vendor to lower the price on an existing contract by threatening to rebid the work. In the future, the state should incorporate mechanisms into the contract language to allow for downward adjustments to price in the event the vendor's workload is dramatically decreased.

Indirect Costs

Regularly Reconsider the Acceptable Percentage of Indirect Costs Charged For Contracts

There is an opportunity to reconsider the acceptable percentage of indirect costs charged for contracts that bill actual direct and indirect costs. DHS identified 23 contracts that bill direct and indirect costs. These contracts include those of smaller size than were considered in the previous analysis of the largest 25 contracts. Their total dollar value is $58.2 million of direct costs and $11.5 million of indirect costs. Of these contracts, the ratio of indirect costs as a percentage of the direct costs are as follows: six charged 0% indirect costs, five charge between 5% and 10% indirect costs, six charged between 11% and 30% indirect costs, and six charged between 31% and 53% indirect costs.

While renegotiating contracts without going through a new competitive procurement may be difficult, there may still be opportunities for the legislature to consider suggesting that interagency agreements have a cap on indirect costs and for procurement experts to consider a reasonableness check on indirect costs for future procurements. If DHS were able to cap the indirect costs at the current average of all these contracts, they would save $10.2 million a year.

Reduce Indirect Costs on Intra-Agency Contracts

Independent of other legislative changes, Arkansas should consider capping the amount of indirect, or "overhead" charges, that one agency can bill another agency. For the top 25 contracts, this amount is projected to be approximately $1.796 million a year upon full implementation. These savings come from contracts where the overhead rate varies from 20% to 32%. The savings could come from standardizing the overhead rates charged by contractors. There are additional smaller contracts that would benefit from this change as well.

TSG recommends the Arkansas legislature streamline their procurement timeline by consolidating reviews and conducting more activities in parallel where possible. The longer the procurement timeline, the more risk is introduced that an agency's requirements will be vague or undefined in the Request for Proposal or that business events will drive a project in a new direction. Vendors have the opportunity to make a large amount of money through change orders.

The State's goal should be to reduce the need for change orders, where possible. The current Arkansas procurement timeline is at least a year with the potential for some types of procurement to take between one and two years. While reviews are useful, it is important to balance the need for "one more review" with the risk of elongating the procurement timeline.

27. REVIEW THE NEED FOR HEALTHCARE FACILITY LIABILITY PROTECTION

Create a New Policy under which an Administrative Finding of Deficiency could not be used as a Basis for Civil Action or Liability

During our Assessment, we learned that results of nursing home surveys conducted by DHS staff have also been used in the past by those suing nursing homes for negligent care. DHS is the state survey agency for CMS and conducts both routine and special inspections of nursing homes and other health care facilities to determine ongoing compliance with regulatory requirements which is a condition of licensure and certification.

If DHS determines that a health care facility does not meet regulatory requirements, no matter the level of severity, DHS notifies the facility of the Deficiency in a formal process and the

health care facility then has to show a corrective action. The facility has to file the corrective action in order to continue to operate and get paid.

A **Plan of Correction**, for purposes of **licensure** and **certification**, however, is not an admission of wrongdoing on the part of the facility for purposes of a private lawsuit and should not be regarded as such. DHS also does not intend for its inspection reports to be used in the advertisements for legal services or as a basis for solicitation of any type. These are regulatory actions that are done to ensure compliance with several regulatory rules, many of which have may have no relation to any allegation of negligence or malpractice.

States, such as Pennsylvania, have recognized this as an issue and have provided notice that any finding of deficiency should not be used as a basis for civil action or liability. TSG believes that the Task Force should consider this type of reasonable liability protection for nursing homes and other health care facilities in the future to reduce the cost of liability insurance, which impacts the cost of health care and rates.

Investigate Options for Addressing Growing Concern over Liability Insurance for Healthcare Facilities

On a related note, while interviewing skilled nursing facility and assisted living facility owners, we heard complaints about the substantial cost and impact of liability insurance on both the nursing facilities and assisting living facilities. Nursing facilities pay on average approximately $1200 per bed per year for liability insurance and assisted living facilities pay a little less. Some nursing facilities have decided to self-insure because of the high insurance cost. Medicaid does reimburse for the cost of insurance in the skilled nursing facilities, but a facility could be one law suit away from closing its doors. We have also heard that attorneys have filed frivolous suits in order to obtain a quick and easy settlement. TSG was not able to weigh both sides of this issue, as it was not part of the scope of our review. However, we do think it would be wise for the Task Force to hear further evidence about this growing concern and take whatever action it deems necessary. Limiting frivolous action here could result in substantial savings to the state and to the facilities.

28. ESTABLISH A COMMISSION ON THE FUTURE OF THE HUMAN DEVELOPMENT CENTERS

Arkansas should establish a commission on the future of the human development centers and look to include consumers and families in decisions related to deinstitutionalization. Arkansas continues to operate five Human Development Centers (Intermediate Care Facilities for Individuals with Intellectual Disability) for approximately 925 individuals at an annual cost of $159 million while providing the Alternative Community Services Waiver for approximately

4,200 individuals at a cost of $197 million. Additionally, there are approximately 2,900 individuals on the Waiting List for HCBS services.

In 2015, Disability Rights of Arkansas recommended that the Booneville facility be phased out over a 12 to 18 month period of time due to the "unsafe" buildings (despite significant capital investment in the facility over recent years), and excessive use of restraint. Given the overall age of the five HDCs, future capital investment costs in the near future may appear to be a significant budget challenge for the state in the future.

28.1. A National Movement for Home and Community Based Services

Between 1960 and 2015, 219 of 354 large state-operated ICF/IDs have closed. While the reasons are many and often complex, the basic driver of change has been the fact that people with intellectual and developmental disabilities have the choice of living in the community as it is their right under federal law. Federal litigation and cost have also been important factors as well as newer alternative living choices, such as shared living, more flexible state Medicaid integrated home and community based living services, and supports and intensive care coordination.

TSG believes that the time is now for the state of Arkansas to establish a Commission on the Future of the Arkansas Human Development Centers to consider the future of not only each HDC but each individual currently residing in these facilities and what makes the best sense for their quality of life in the near and long term.

It is imperative that the families of the current residents of the HDCs and those receiving home and community based services have a place "at the table", along with advocates, providers, DHS/DDS, the Arkansas Building Authority, Executive and Legislative Branch representatives, and home and community based services and medical expertise. The Commission should be charged with producing a "Comprehensive Plan for the Future of Arkansas' Human Development Centers" and any related legislation and budget changes that would be required to assure success. We have offered possible action strategies to help guide this Commission should the Task Force agree with this recommendation as part of Appendix 5.

29. TELEMEDICINE

Telemedicine is the use of electronic communications to provide medical services remotely. State laws and medical boards generally place some restrictions on the use of telemedicine to provide medical services, often by requiring one or more of the following:

- An existing patient-physician relationship must be in place;
- A patient-physician relationship must be established through a face-to-face encounter;

- The patient must be at a clinical location;
- A health care provider must be present with the patient at the remote location; and/or
- Certain communication media must be used, such as high-definition video.

Telemedicine has the potential to increase access to medical care in general, and to specialty care in particular, by allowing highly-specialized physicians based at hospitals such as UAMS to provide remote consultations to primary care physicians all over the state.

Through the course of many independent studies, telemedicine has been found to be a safe mechanism for delivering medical services.

State law in Arkansas currently requires that the patient and physician have an existing patient-physician relationship, although the Arkansas Medical Board is given some flexibility in interpreting that requirement. Many states are moving toward a regulatory framework that would allow for the patient-physician relationship to be established via a telemedicine encounter, as long as the telemedicine encounter is a "face-to-face" encounter using video and not just telephone communication. The Arkansas Medical Board appears to be moving in this direction.

TSG recommends continuing to move in this direction while closely monitoring both the quality and the utilization of telemedicine services to ensure that patient safety is preserved, while not causing excessive spending in Medicaid.

30. COLLABORATIONS WITH ARKANSAS COLLEGES AND UNIVERSITIES TO RECRUIT FUTURE HEALTH CARE LEADERS WITHIN ARKANSAS

Develop Collaborations with Arkansas Colleges and Universities to Recruit Future Arkansas Health Care Leaders

DHS Should Develop Collaborations with Arkansas Colleges and Universities to Recruit Future Health Care Leaders within Arkansas. Today, DHS uses a number of outside expert consultants to assist it with various aspects of its Medicaid program, many whose principle place of business is outside Arkansas. In large part, this is because DHS either lacks the internal resources or has had difficulty finding the level of interest or talent within the state. Many of these consulting projects include data analysis, project management, claims analysis, reviewing and implementing Medicaid health care policy, utilization reviews, and other similar functions. There is nothing wrong with using outside resources for special needs. However, DHS depends too heavily on these consultants for regular analyses at high hourly rates. This means the knowledge and money leaves the state. It also means that DHS is not developing the requisite internal skills.

Healthcare is one of the largest employment sectors in the country. DHS does have a very beneficial working relationship with UAMS but, outside of this relationship, does not currently

have a programmatic or staff augmentation consulting relationship with any of the colleges or universities in Arkansas to foster development of future in-state talent.

TSG is aware of programs that other state health and human services departments have established within their states that allow these colleges and universities to offer talented resources for the state at lower costs and also keep this talent in state. It is a win-win for the colleges, the individuals involved, the state department and the taxpayers. Thus, TSG recommends that the Legislature look to drive a new form of collaborative resource effort where the state university or college system develops a collaborative relationship with DHS to cultivate talented resources through internships, externships and other business opportunities.

We recommend that these colleges and universities of Arkansas be incentivized to establish centers for population health improvement and that DHS work towards forging a more well defined and supportive environment for future employment opportunities and economic development for Arkansas college and university students or employees. This relationship can even go beyond the healthcare sector.

This recommendation could include the creation of a university or college Center for Health Excellence in that could bring the following benefits:

- Improve the quality of consulting work by creating an internal source for high-level talent easily available to DHS and other agencies. The Center would improve continuity of resources, ensuring that certain research faculty are available year after year. It would develop methods and data analysis tools that could be reused project after project, without paying again and again. Further, it would help transfer skills to DHS and other agencies.

- Build young healthcare leadership talent in Arkansas for Arkansas. Use the university systems to build capability within Arkansas strong healthcare management capabilities, an industry that already accounts for 17% of GDP. Today universities build this talent "outside the system" of healthcare delivery. Healthcare and business management schools will benefit from access to "real data" doing real research on the most pressing healthcare management issues. Through this brand new effort, Arkansas will build more capable future healthcare leaders, and integrate them into the Arkansas industry so they remain after graduation.

- Strengthen the Arkansas economy. The Center will help in two ways. First, it will pay local students and faculty to perform policy-level research avoiding some part of the need to hire outside consultants. In SFY2015, DHS alone paid over $270 million for IT and consulting services. The recommendation is to instead leverage faculty researchers and students to conduct research projects. This would keep some large portion of those consulting expenditures in the state's economy.

- Reduce the cost of state government. Through the proposed Center for Excellence Health, Arkansas will reduce the cost of advancing the population's health. First, it will obtain services at lower cost. Today, DHS and other health-related agencies turn to private

contractors. They (quite necessarily) add overhead and the cost of travel to their budgets. In addition, while many of the resources have little more experience than a college upperclassman or graduate student, resources bill at high rates—usually well over $100 per hour. In contrast, the proposed Center could provide services at a lower rate. In many cases, students are obliged to work for the university as part of tuition assistance they are already receiving; the Center could make more effective use of time students already have to work. The second way it reduces the cost of state government is to build a more dependable source of new talent for DHS and other health-related agencies to draw from. Through the work of the Center, students would leave school already integrated into DHS: they would know people, know the issues and know the data. The best students would be more inclined to remain in the state and work with DHS after graduation. Now able to attract better talent, DHS would lean less on outside resources to conduct valuable strategic projects.

To provide these resources a small leadership group will draw from resources at Arkansas higher educational institutions. The Center will build relationships with various educational resources, who will build data tools and staff projects. The Center should develop on-going methods for building a collaborate team such as workshops, training and relationship building. It will also manage projects staffed by academic resources.

30.1. Relationship to DHS:

Key to Center success is that it sits outside DHS. At the same time, it must grow close to DHS and other state agencies with roles that relate to healthcare. It is probably not an over-characterization to say that, DHS views people who work for groups outside the Agency as outsiders and tends not to collaborate with them. The Center will start as an "outsider" group, no matter what anyone says to the contrary. The Center will have to work to embed itself in DHS, to create within DHS a new culture of collaboration with outsiders. This will take time and deliberate effort on the part of both the Center and DHS.

30.2. Success Models

Mississippi has done this already. When it needs systems or data projects conducted, Mississippi's Medicaid agency hires nSPARC, a center created at Mississippi State University.[20] This allows simpler procurement, keeps the knowledge in state and reduces cost. University of Mississippi's NSPARC program offers a useful reference model for Arkansas.[21]

> "NSPARC has a mission to expand the reach of the university to policymakers, industry, and the public. We use smart data, analytical techniques, and high technology to make a

[20] For more information, see: http://nsparc.msstate.edu/
[21] Taken from: http://nsparc.msstate.edu/

difference, such as explaining education outcomes, helping Mississippi attract new businesses, and connecting job seekers to employment opportunities. NSPARC bases its innovative solutions on academic research from an ever-growing number of fields and always keeps an eye on the big picture.

"NSPARC scientists and technicians produce peer-reviewed journal articles, technical reports, and web applications, including web sites, interactive technology such as kiosks, and mobile phone applications. Explore examples of our works below. Contact us to learn more about research and solutions or to find out what we can do for you.

"NSPARC offers flexible research and development services to meet the specific needs of its partners. The center follows Mississippi State's Responsible Conduct of Research plan, which requires researchers to conduct excellent research responsibly and ethically to gain public trust, and NSPARC provides state-of-the-art protection for the privacy and confidentiality of sensitive data…Signature Research Areas include:

- Computer Science & Cyber-Security
- Demography & Geospatial Science
- Early Childhood
- Economic Development, Labor Market Analysis, & Business Outreach
- Education & Workforce
- Energy Policy
- Management Information Systems
- Policy Analysis & Management
- Race & Class Relations
- Research Methods & Statistics"

Appendix 6 provides the enabling legislation for an analogous operation the State of Mississippi created. Mississippi built on an existing system currently housed, developed and maintained by the National Strategic Planning and Analysis Research Center (nSPARC) at Mississippi State University.

Another example for Arkansas is Commonwealth Medicine which operates within University of Massachusetts. Commonwealth Medicine is dedicated to improving health care for people in need, while also controlling costs and maximizing revenue for our clients. Public- and private-sector organizations throughout New England turn to Commonwealth Medicine for "evidence-based recommendations and innovative solutions produce tangible results: better health

outcomes, lower health care costs and more access to health care".[22] Arkansas can draw on these and other examples of university-based Centers.

TSG proposes that like Commonwealth Medicine, the Center would build a link between public universities and key state initiatives, such as improving health care delivery, controlling the cost of care, and maximizing revenue. The public university partnership model offers benefits for the university and the state alike. The following is from the Commonwealth Medicine web site, it paints a picture of that organization's mission and objectives, and illustrates key aspects of the TSG recommendation:[23]

> "At Commonwealth Medicine, our original partnership with the Massachusetts Medicaid program produced greater revenue for the state. This led to an increasingly expansive role within Massachusetts as we developed more initiatives for controlling costs and improving quality for our public agency partners. As a result, our reach now extends throughout the United States and into numerous foreign nations. And our clients include both public- and private-sector organizations.
>
> Today, Commonwealth Medicine consultants help academic colleagues across the nation explore opportunities to establish similar public university partnership models in their states. We help public universities develop the foundation that will enable them to achieve the following:
>
> - Build a public university partnership model — with credibility on both sides — between the university and the state Medicaid agency
> - Identify champions within both organizations at the highest levels of leadership
> - Obtain legislative support for public-to-public contracting — a model with the capacity to enhance state revenues
> - Assemble teams with core expertise in the areas that will be part of the partnership
>
> We believe that partnerships between public universities and state agencies provide a model that has the potential to enhance the quality of care for special populations, improve health care outcomes, and at the same time alleviate some of the financial pressures on the public health care system."

[22] For more information, see: http://commed.umassmed.edu/
[23] For full quote and more information, see: http://commed.umassmed.edu/services/consulting/partnership-between-public-universities-and-state-agencies

30.3. Building on the Concept of SB 827 2015

Recently, the Arkansas legislature passed SB 827 which has the goal of implementing a collaborative relationship between the University of Arkansas' System Division of Agriculture Cooperative Extension Service and the Department of Human Services. In this Bill, the resulting Healthy Arkansas Educational Program would create opportunities for Medicaid beneficiaries to receive training and education in areas which may include[24]:

(A) Nutrition, food safety and food preservation;

(B) Family and consumer economics;

(C) Marriage, parenting and family life; and

(D) Health, wellness and prevention.

This is consistent with the approach recommended here.

31. Clear the Backlog in Long Term Care Financial Eligibility Determinations

Continue to Work with the Health Care Association to Clear the Backlog in Long Term Care Financial Eligibility Determinations

DHS Should Continue to Work with the Health Care Association to Clear the Backlog in Long Term Care Financial Eligibility Determinations. During our Assessment, TSG was informed by both DHS and the Health Care Association that there were a few hundred backlog nursing facility eligibility determinations that have been pending for a substantial amount of time, and in some cases over one year. This presents a financial hardship for the nursing homes in the state. We are aware that the Director of DAAS has made it a commitment to develop a plan to address the backlog and is working collaboratively with the Health Care Association. We recommend that the Task Force receive updates of such work and the DHS plan to reduce the backlog in the short term and then a plan for a long term solution so that there is no unusual delay in the process for nursing home eligibility.

32. Develop an Action Strategy to Address the Mentally Ill and Jail Diversion

The issue of the mentally ill in jails, especially for low barrier crimes, cuts across the Department of Human Services, police and sheriffs, prosecutors and courts and results in poor outcomes and

[24] TSG reviewed the text of Senator Irvin's bill at: ftp://www.arkleg.state.ar.us/AMEND/2015/Public/SB827-S1.pdf

wasted dollars. Local communities search for answers, stop gap measures, and attempts to find solutions with success in some cases and frustration in others due to the fragmentation and lack of coordination of the various public "players" involved at different points in the trajectory of a person with mental illness being arrested and quickly ending up in jail, often for extended periods of time for low level non-victim alleged crimes.

We recommend that the Department of Human Services/Division of Behavioral Health Services/ Office of Alcohol and Drug Abuse Prevention form a time limited **Task Force on Jail Diversion for Adults with Serious Mental Illness.** The members of the Task Force should at the minimum include representative of the Attorney General's Office, Arkansas Municipal League, Association of Arkansas Counties, the Arkansas Police Chiefs and Sheriff Associations, County Judges Association of Arkansas, Arkansas Prosecuting Attorneys Association, the UAMS Department of Psychiatry, the Arkansas Hospital Association, the Mental Health Council of Arkansas, the Alliance for Health Improvement, and representation from the substance abuse provider community.

The purpose of the Task Force would be to develop a Blueprint for Action and a way to provide sustainable support for local communities to address the issue of diverting adults with serious mental illness charged with low barrier crimes from jail and getting them into treatment in a timely way that addresses recovery and increased ability for self-responsibility. Specific elements of the proposed Blueprint for Action should include ways to identify and improve community based communication and coordination among local police and numerous stakeholders and community leaders during screening, assessment, and even pre-booking diversion. Critical Intervention Training for law enforcement, and accountability and support are also important factors.

BUILDING A SUSTAINABLE FINANCIAL FUTURE FOR ARKANSAS MEDICAID

32.1. Scenarios

Baseline scenario – Current scale of HCPII, no capitated managed care

This scenario includes the current scale of the HCPII (PCMH and EOCs), providing a level of care management and incentive alignment for a part of the low-cost population (pregnant women and kids), but no meaningful care management or alignment of incentives for the high cost population.

Scenario 1 – Managed Fee-for-service, all providers, all populations

This scenario includes enhancing the existing payment improvement initiatives of PCMH and EOC in a number of ways, and expanding it into all populations.

Scenario 2 – Managed fee-for-service for low-cost populations (pregnant women and children) and capitated managed care for ABD populations

This scenario includes enhancement of the existing payment improvement initiative in a number of ways, and deployment of capitated managed care into the high-cost populations (elderly, DD, SPMI).

Scenario 3 – Capitated managed care for all populations

This scenario includes the deployment of capitated managed care into all populations.

32.2. Modeling Assumptions

The main cost-savings assumptions that will be used in this analysis are based on recent analysis from Louisiana of both a shared-savings model that is similar to the Arkansas PCMH initiative, and a capitated managed care model. The state found that the shared savings model saved about 6.8% compared to the traditional fee-for-service model, and that capitated managed care saved about 12.7% compared to the traditional fee-for-service model. Estimates of both shared savings, PCMH, and related programs; and capitated managed care models from other states have cost-saving estimates that are consistent with those found in Louisiana. The Louisiana estimates will be used here because the estimates of cost-saving for shared savings and capitated managed care are from the same state, developed using the same methodology, and because the Medicaid population in Louisiana is very similar to that in Arkansas.

It is further assumed that the existing deployment off the HCPII is already capturing some of the potential savings from a shared-savings or PCMH model, so for estimating the marginal impact of an expansion of the HCPII, it is assumed that about half of the potential savings from that model (about 3.4%) remain to be captured. Similarly, it is assumed for the capitated managed care modeling that some of the potential savings from capitated managed care are already being captured through the existing deployment of the HCPII, leaving about 9.3% in additional savings to be captured.

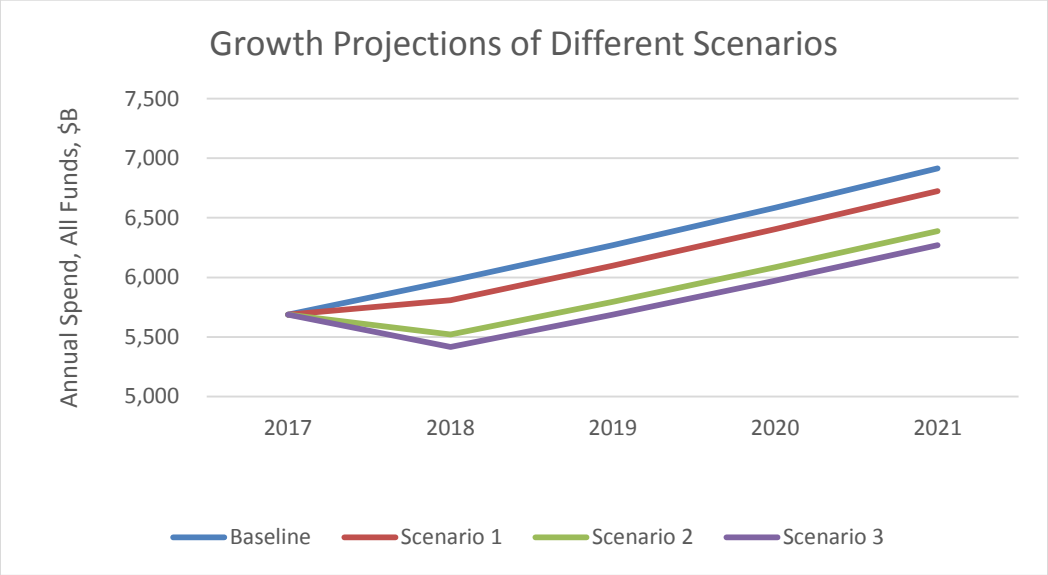
Finally, the baseline model assumes a 5% across-the-board growth rate and all of the models assume about a 2 year ramp-up period beginning immediately, with cost-savings beginning to accrue in SFY2018.

Table 9—Projected Medicaid Expenditures under Managed Care Models

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

The cost savings in these projections due to the roll-out of managed fee-for-service and/or capitated managed care assume an 18 month development period beginning January 2016, with the new programs fully-deployed as of July 2017 (i.e., the beginning of SFY 2018).

Figure 2—Growth projections of different scenarios



Baseline – Current program framework; partial managed FFS, no capitated managed care

Scenario 1 – All managed FFS

Scenario 2 – Managed FFS for low-cost populations, capitated managed care for high-cost populations

Scenario 3 – Capitated managed care for all populations

Note: These projections assume no program effect in SFY2017, with the cost savings from different program structures beginning in 2018.

32.3. Additional Potential Savings

In addition to the savings that could arise from alternate program structures, TSG identified a number of additional savings opportunities.

LTSS Rebalancing for Elderly and Individuals with Physical Disabilities

As noted above, there is a significant opportunity to reduce overall LTSS outlays for the elderly and individuals with physical disabilities by rebalancing LTSS expenditures for these populations toward national proportions.

Table 10— Potential LTSS Expenditures for Elderly and Individuals with Physical Disabilities

Potential LTSS Expenditures for Elderly and Individuals with Physical Disabilities ($millions, all funds)						
	2017	2018	2019	2020	2021	2017-2021
Savings	0	55	105	151	192	504

If PCMH enhancement or capitated managed care is deployed for high-cost populations, whether as part of an across-the-board shift to some form of value purchasing or capitated managed care, or as part of a blended program, rebalancing toward community-based care is often one of the key mechanisms by which you will see organizations put downward pressure on costs. Therefore, the savings for rebalancing noted above should not be considered additive, where the state uses either approach to begin to rebalance long term care costs for the high-cost populations.

Pharmacy Savings

In addition to capitated managed care or PCMH decreasing costs by managing care more effectively and thus lowering utilization, there are additional pharmacy savings that could be possible, specifically relating to pricing more aggressively in the pharmacy retail network and maximizing returns through the preferred drug list. The projections below are based on the potential savings identified in the previous section on pharmacy savings of $41.05 million for 2014 with a 5% annual cost growth factor applied.

Table 11—Potential pharmacy savings

Potential Pharmacy Savings ($millions, all funds)					
	2017	2018	2019	2020	2021
Savings	47.5	49.9	52.4	55.0	57.8

Similar to the case of rebalancing, the potential pharmacy savings noted above should not be considered strictly additive with the projections of savings under capitated managed care since the particular cost-saving strategies that are represented by these savings are among those that could be used by a managed care organization.

Contract Savings

The largest administrative contracts held by the agency were reviewed to identify possible areas for savings. There are a number of areas in which existing contracts may be able to be renegotiated to result in lower outlays, which, in some cases, may be lower still if the state decides to pursue managed care as a service delivery strategy. Table 12 provides potential savings estimates for each of three scenarios previously discussed.

Table 12— Potential Contract Savings under Different Program Scenarios

Potential Contract Savings under Different Program Scenarios *($millions, all funds)*					
	2017	2018	2019	2020	2021
Scenario 1 - All managed FFS	10	25	27	19	19
Scenario 2 - managed FFS for low-cost populations, capitated managed care for high-cost populations	13	25	32	30	30
Scenario 3 - capitated managed care for all populations	14	25	33	33	33

Program Integrity – Recoveries

While the state Office of Medicaid Inspector General and Medicaid Fraud Control Unit have been making recoveries of inappropriately expended Medicaid funds, there is significant opportunity for greater recoveries, but specific possible savings targets cannot be identified.

Program Integrity – Eligibility

Similarly, the preliminary analysis by Lexis-Nexis of the eligibility files for traditional Medicaid and the Private Option identified a number of possible cases of individuals who should not be enrolled in Arkansas Medicaid. Once investigated, some portion of these cases, once

32.4. Reinvestment Opportunities

It is important to note that the purpose of re-structuring the delivery system for Medicaid should not be just to save money; it should be to improve value. In addition to improving quality while lowering cost through the different program restructuring options discussed above, there are a number of areas where some of the cost-savings could be re-invested in the state Medicaid program in order to strengthen it even more.

DD Waiting List

There are about 2,900 individuals on the waiting list for the community-based waiver for developmentally disabled individuals. Moving all of these individuals onto the waiver would cost about $147.5 million annually. Many of the individuals currently on the waiting list are receiving services (e.g., individuals on the waiting list received approximately $32 million in SFY2015), so the total incremental cost to the state Medicaid program to shift these individuals into the community-based waiver program could be somewhat lower than $147.5 million, but the non-waiver costs would not necessarily all go away since not all of the non-waiver services are covered under the waiver.

Rate Enhancements

Under an optimized state Medicaid program that emphasizes health, efficiency, and quality, those service providers that are well-positioned to further these goals should be reimbursed at levels that encourage adequate market participation. In particular, primary care and

Primary Care

The Affordable Care Act included a boost in Medicaid primary care payments up to the Medicare level. The Congressional Budget Office estimated that the total cost of the boost would be about $11.4 billion nationally for the two years that the increase was in effect (2013 and 2014). While each state has a different Medicaid-to-Medicare fee index, Arkansas' is above the national average, indicating that a pro rata allocation of the federal cost of the boost should provide an estimate of the cost of re-instating the primary care boost that is somewhat higher than the actual cost would be. The annualized pro rata share of reinstating the primary care payment boost is about $59 million per year, all funds.

LTSS – Community-based Services

One of the challenges in trying to rebalance a state's Medicaid LTSS system toward community-based care is the historically low level of reimbursements for community-based care. In 2014, the total spend on community-based services for both the elderly and individuals with physical disabilities, and individuals with developmental disabilities was about $884 million. Providing a 10% increase in rates for all community-based services would cost about $88 million per year.

Additional Investigators

The program integrity studies undertaken through this project, including the verifications of eligibility and assets, have identified thousands of potentially problematic enrollees. The agency does not currently have the resources to investigate all of these cases of potential fraud. Cost-savings from programmatic changes could be re-invested back into the agency's program integrity efforts.

Additional Employer Supports

Employers fund a significant amount of health insurance, representing an important component of the overall health financing structure. While existing mechanisms through the Small Business Health Options Program (SHOP) allow some employers to receive subsidies for purchasing health insurance for their employees, additional supports for more and larger employers could keep more employer "at the table" and financing a portion of health insurance costs for their employees.

WAIVER APPROACHES

Like many states' Medicaid programs, Arkansas is awash in federal waivers. Each of these waivers has substantial reporting requirements, fixed numbers of slots and a burdensome paperwork process to make even minor changes. Below are federal waivers currently operating in Arkansas Medicaid:

- Arkansas Health Care Independence Program: 1115
- Arkansas Elder Choices: 1915 (c)
- Arkansas Tax Equity & Fiscal Responsibility: 1115
- Alternative Community Services: 1915 (c)
- Alternatives for People with Physical Disabilities: 1915 (c)
- Non-Emergency Transportation: 1915 (b4)
- AR Autism: 1915 (c)
- ARKidsB: 1115
- AR Living Choices Assisted Living: 1915 (c)

While each of these waivers adds functionality and benefit to the Medicaid program, taken as a whole, they represent a challenging mixture of requirements that confounds streamlined reporting and management.

Thus, TSG recommends seeking a streamlined 1115 waiver that encompasses many of these waivers into one. We believe the two best options would be to combine all aged, blind and disabled (ABD) waivers – all of the Section 1915 waivers – into one larger waiver, or a Global Choice Medicaid Waiver, similar to that currently operating in the state of Rhode Island, that would consist of all of the above waivers.

Ultimately, we recommend a Global Waiver that would maximize flexibility, dramatically simplify reporting requirements, create a streamline process for adjustment of waiver slots for community-based improvements and bring accountability to DHS for the overall success of the Medicaid program. Rhode Island's waiver has shown to be a model of success for lowering costs, improving services in the ABD population and giving that state's Medicaid program unrivaled flexibility to make program changes. Tennessee's waiver has given them the opportunity to establish levels of care for services, so that Medicaid patients get the right care, at the right time, in the right setting.

Moreover, such a waiver could allow the state to negotiate the opportunity for additional funding opportunities not currently available under the traditional Medicaid program. Other states have been able to obtain additional funding opportunities not available to some states by incorporating a vision in an 1115 waiver that is consistent with state and federal health policy and furthers the goals of the waiver, and is fiscally responsible. This is an opportunity that the Task Force should ensure DHS takes advantage of.

Any such waiver should have, similar to Rhode Island, the opportunity to back out with limited notice (such as 30 days), if the landscape for the program changes nationally. For example, if a new administration were to allow for the opportunity for more of a block grant model for Medicaid, Arkansas would not want to be locked into a 5 year waiver. Rhode Island has a similar provision, and Arkansas should insist on one as well.

A Global 1115 Waiver would require the state to ensure that it maintains budget neutrality. This means that the program cannot spend more after the waiver than it would have before. This is unlikely a problem, since the program would be built, by design, to reduce costs by providing care in settings that are less costly, yet still remain where individuals have indicated they prefer to get care.

Constructing an appropriate 1115 waiver will take considerable discussion both from the Legislature, to ensure that policy goals are met, and the Executive Branch, who would have to negotiate the waiver with the federal government. However, the payoff for the citizens of Arkansas is certainly worth the effort, as such a waiver could transform service delivery across the state for the better.

APPENDICES FOR VOLUME II RECOMENDATIONS

APPENDIX 1. STATE AND MCO READINESS FOR THE STATE AGENCY TRANSFORMATION

Medicaid managed care strategy is a serious consideration for decision makers. In many ways, a managed care model requires umbrella type state health and human services agencies to centralize shared budgeting, policy, rules and regulations, eligibility, consumer protections, service delivery systems through integration of benefits, and program integrity that matches up with the contractual requirements of the managed care organizations for which the state becomes responsible.

DHS Readiness

Develop an accountable Leadership and Management Chain of Command with the necessary skills to effectively administer a Medicaid managed care system.

Develop and implement a comprehensive set of Guiding Principles and a governance and organizational structure represented in a Master Enterprise Project Management Plan and Timeline.

Identify the key Arkansas Medicaid Enterprise and contract functions that will be critical for successful implementation of an integrated managed care model. Identify the current functions and contracts that should be retained and/or adapted and those that are no longer required.

Identify new functions that need to be developed and an implementation plan and timeline.

Identify and implement the best approach to build cooperative relationships among Child Welfare, K-12 Education/Special Education, Corrections, and Juvenile Justice for DHS in a managed care environment.

Focus on care coordination and continuity of care within a comprehensive managed care Arkansas model.

Identify DHS IT assets and contracts that need to change to be successful in a managed care environment. Learn MCO IT linkage processes and requirements from other states.

Consider a DHS an organizational and functional readiness assessment and implementation plan prior to issuing a RFP

Identify necessary changes in organizational culture, functions and process as a result of a change from FFS to Managed Care environment. Develop culture change action plan.

Develop a process to assess the skills and capacity of the existing staff
Identify staff that may disagree with the shift and have performance issues as a result

Identify, plan and implement a comprehensive Stakeholder Engagement process that is timely, responsive, and transparent from the beginning of the enterprise.

Plan and implement a comprehensive Communications Plan from the initial decision to issue an RFP for managed care, through the RFP process to award, announcement of go live, readiness review and start date for beneficiaries, staff, Governor/Legislature, and general public.

In addition, should the state chooses to move in the path of full risk managed care, there will need to be an MCO Readiness Review process to ensure no interruption of essential medical and waiver services for beneficiaries. Below we have provided the Task Force with a list of MCO Readiness Review factors that DHS should ensure and which CMS more than likely will require.

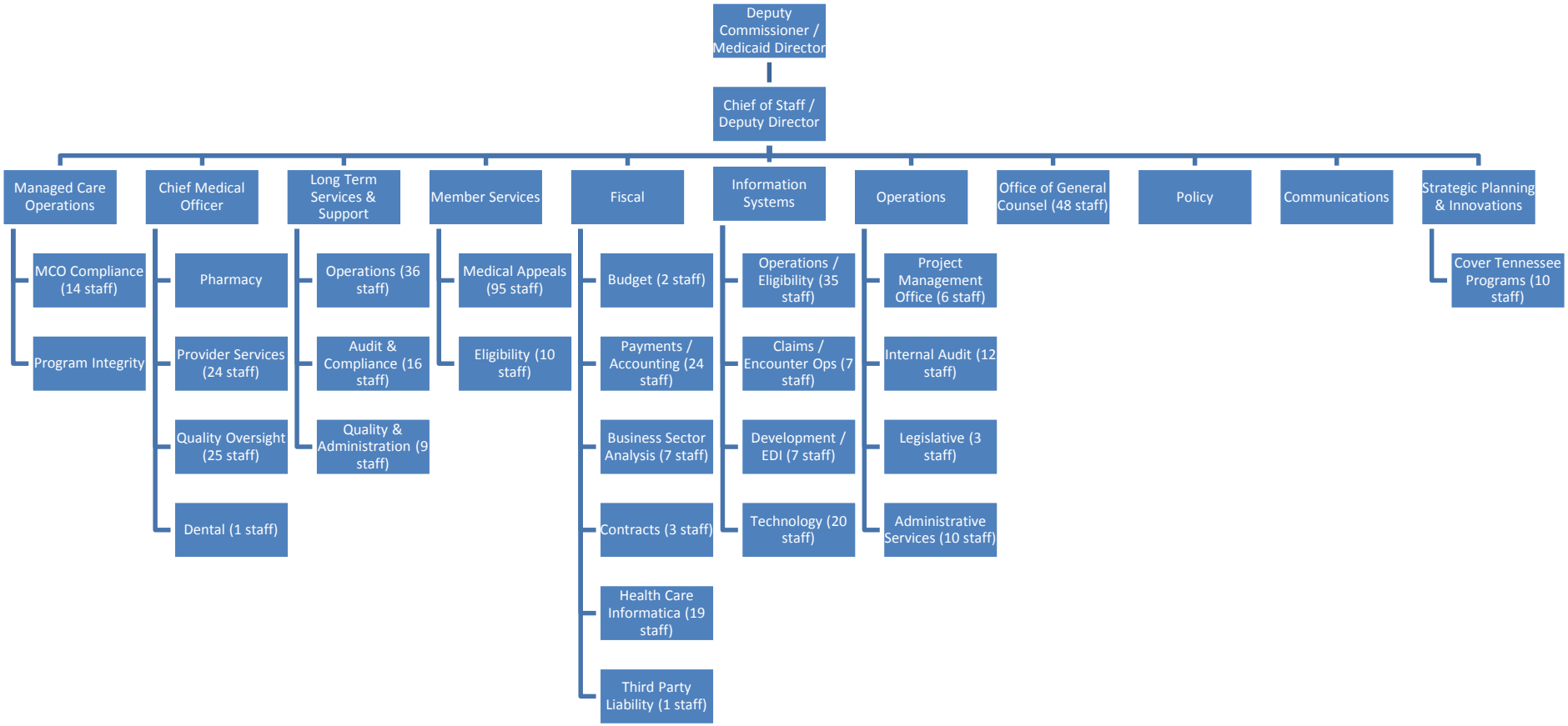
Managed Care Organization Readiness Review

- All State readiness review tools must address key areas that directly impact a ben's ability to receive services including, but not limited to: assessment processes, plans of care, care coordination, provider network, staffing, and systems to ensure that the organization has the capacity to handle the increase in enrollment of the complex and heterogeneous Medicare (If DSP requirement is included)-Medicaid enrollee population.
- Readiness criteria must focus on whether a MCO has the appropriate beneficiary protections in place, including but not limited to, whether the MCO has policies that adhere to the Americans with Disabilities Act, uses person-centered language, and network complies with all CMS Rules, including 11/14 HCBS Rule.
- Contract Elements that require a Readiness Review Process and Timeline between date of contract award and planned "Go Live" date:
    - Call Center/Benefits Education
    - Assurance of access
    - Assessment processes: MLTSS and Behavioral Health
    - Cultural knowledge and sensitivity
    - Care coordination
    - Confidentiality
    - Enrollment
    - Enrollee and provider communications
    - Enrollee protections
    - Financial reporting
    - Financial soundness
    - Organizational structure and staffing
    - Performance and quality improvement
    - Program Integrity
    - Provider credentialing
    - Provider network
    - Qualifications of first-tier, downstream, and related Entities
    - **IT Systems Connectivity (e.g.,** claims enrollment, payment, etc.)

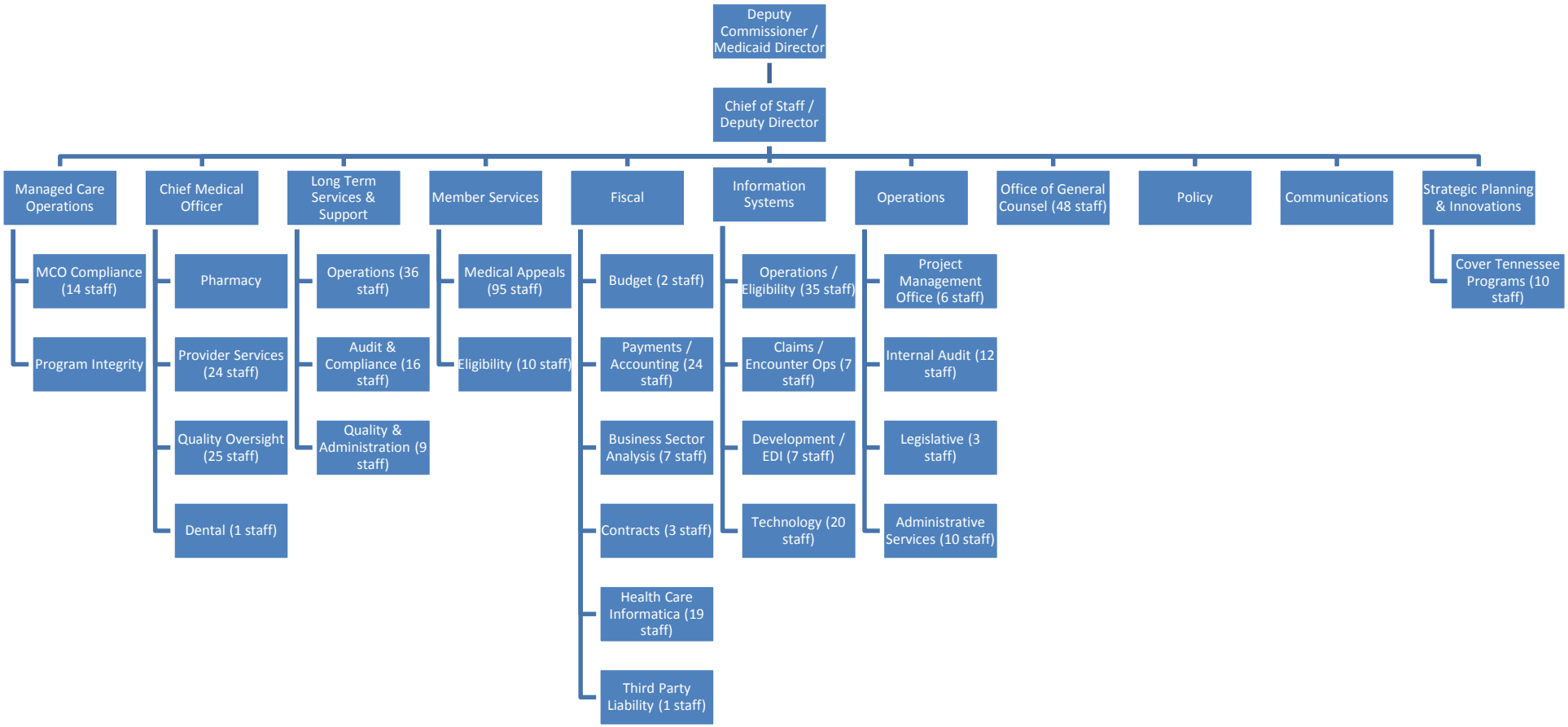
- Utilization management
- Appeals, grievances
- Audit
- Assurance MCO reinforces beneficiary rights and empowerment, supports independent living, and promotes recovery-oriented models of behavioral health services.

Note: MCO readiness reviews usually includes a desk review, site visits, and a separate network validation review.

APPENDIX 2. PROPOSED DHS ORGANIZATION CHART (LARGER COPY)



APPENDIX 3. TENNESSEE ORGANIZATION CHART



APPENDIX 4. CMS PAPD

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Dallas Regional Office
1301 Young Street, Suite 833
Dallas, Texas 75202

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CONSORTIUM FOR MEDICAID
& CHILDREN'S HEALTH OPERATIONS

DIVISION OF MEDICAID & CHILDREN'S HEALTH - REGION VI

September 1, 2015 AR-15-08 - PAPD - Medicaid Enterprise Fraud Program

Dawn Stehle
State Medicaid Director
Division of Medical Services
P.O. Box 1437
Little Rock, Arkansas 72203-1437

Dear Ms. Stehle:

This letter is in response to the State's June 17, 2015 request for approval of a Request for Proposal (RFP) for the procurement and implementation of an Enterprise Medicaid Fraud and Abuse Detection (EMFAD) solution for Arkansas Medicaid.

The proposed Planning Advanced Planning Document (PAPD) is requesting approval of the Request for Proposal (RFP) for an Enterprise Fraud Program. The Arkansas Office of Medicaid Inspector General (OMIG) plans to use this new system to enhance the States' automated capabilities to detect, prevent and report fraud, waste, abuse and improper payment activity within the Arkansas Medicaid program.

Following the review of the PAPD, CMS approves this request in accordance with 45 Code of Federal Regulations (CFR) 95.611.

There are no actual funds approved with this PAPD. The actual funds approved will be based on amounts outlined in the final contract(s) when submitted to CMS with an Implementation Advance Planning Document Update (IAPD) that includes the budget tables, deliverables, and requested Federal Financial Participation (FFP) breakouts. Until such review occurs, no approval for FFP will be granted. FFP is limited to Medicaid Title XIX programs only. Federal funds are not to be included in the monies being matched with federal funds. Upon receipt of an agreeable contract between the Vendor(s) and the State, please submit the Contract to CMS for prior approval as outlined in 45 CFR 95.611.

The length of this approval is for twelve (12) months from the approval date and will expire on September 30, 2016. If the scope, timeframe of work, or expenditures change or exceed the amounts approved in this PAPD, please submit a PAPDU to CMS for prior approval as outlined in 45 CFR 95.611.

If you have any questions, please feel free to contact Tobias Griffin at 214-767-4425 or via e-mail at Tobias.Griffin@cms.hhs.gov.

Sincerely,

Bill Brooks
Associate Regional Administrator
Division of Medicaid and Children's Health

cc: Tim Taylor / DHS
Victor Sterling / DHS
Roger Patton / DHS

APPENDIX 5. ACTION STRATEGIES FOR FUTURE OF HUMAN DEVELOPMENT CENTERS

TSG recommends that the Commission include a number of action strategies as fundamental to the work necessary for Commission members to work together to achieve the optimal solution for Arkansas.

- Commission membership has to be comprehensively representative of all consumers, families, advocates, providers, and interested parties.
- The Commission should consider independent expert facilitation of all meetings under direction of the Chair/Co-Chairs.
- The Commission should consider an updated analysis of the capital costs and infrastructure over the next 25 years should all HDCs remain open into the future.
- The Commission should consider a detailed HDC closure plan for individual or all facilities with a time line, individual consumer services plans assured, and an Enterprise Financial Plan that takes into account the future role of current state employees in an expanded home and community based services system; costs of facility closure, continued maintenance, and possible sale; and costs required to expand the home and community based services system.
- The Commission should assure an independent expert review and assessment of the current processes and tools (medical and developmental assessments) used in the HDCs for individual person centered care plan development for individuals who choose and/or should be considered for community placement based on acuity. Independent and individual assessment in the facility and community is fundamental in determining what a person needs, what their strengths are, what their individual services plan would be, and controlling costs. Arkansas should take advantage of advances in the assessment process and focus on medical necessity that several other states have based their systemic improvements on such as North Carolina and Louisiana.
- Each HDC should have an up to date discharge plan in place for each resident regardless of their length of time in HDC residency. TSG recommends and could facilitate the development of a Comprehensive Community First Option Implementation Plan based on the development of a facility Master Client Index for Community Placement (MCIFCP) from all HDCs and a corresponding Transformative Community Services Business Development Strategy based on each HDC clustering all resident data, based on quality assessments, into diagnostic categories (Autism; Cerebral Palsy, Dual Diagnosis, Epilepsy, Hearing Deficit; Pervasive Developmental Disability; Severe or Profound Intellectual Disability, Unable to Walk, Vision Difficulty; Behavioral Challenges) and Primary Service Needs (Significant Health Needs, Extensive Personal Care, Significant Behavior Issues, Protection and Safety, Low Structured Setting, Specialized Service Setting, Needs Related to Aging, and Criminal Justice Involvement). From this data the Commission would have the information it needs to determine which HDCs could be closed and in what sequence based on facility size, overall level of acuity, numbers of individuals who can safely return to community living, and those individuals who will continue to require an HDC level of care, perhaps in specialized community based ICF/ID. Based on individual client data preferences and profiles community discharge planning could begin supported by a

comprehensive active business development strategy for the growth of needed but unavailable community based residential and services capacity along a project managed timeline.

- Comprehensive stakeholder involvement through development and implementation of the Community First Transformation Plan, and maintenance/adaptations of the system thereafter.
- The Commission would require a Comprehensive Communications Plan that is updated in real time.
- A review of best practices/"lessons learned" from other states that have completed closures; Identification of resources needed by DHS/DAAS to support closure and identification of any federal funding that can support this effort.
- Assess current community based waivers and related "case management" strategies with a goal to create innovative opportunities to integrate "care coordination" and more specialized services that increase the community's ability to serve higher levels of acuity. Would need to be coordinated with any Medicaid modernization strategies in real time.
- Identification of the current community residential capacity and strategies to build provider capacity in the community that supports successful residential opportunities for current HDC residents, including opportunities for public-private partnerships, that will provide residential models for high risk behavioral health and specialized service(s) needs.
- An assessment of the DAAS system of client crisis management and "Protection from Harm," including incident and abuse/neglect reporting methods, responses, oversight, sanctions, licensing/contract compliance requirements and relationship with law enforcement, if any, and CMS reporting requirements.
- Commission coordination with any active DAAS litigation.
- Strategies for the level of oversight that is needed for residents transitioning to the community to ensure their safety, maintain compliance with DOJ settlement agreement, and alleviate family concerns.
- Identification of the best outcome metrics to use in monitoring safety.
- Identification of the best strategy to close any HDCs and how to manage the logistics of the closure from a facility-perspective including legislative direction/mandates/changes.
- Identification of an Employee Transition plan that connects HDC facility employees who will lose their jobs with community capacity growth, other career options, and re-training.
- Identification of any needed modifications to the existing appeals process that are needed to ensure fair hearings for all residents who want to appeal.

APPENDIX 6. MISSISSIPPI STATE LONGITUDINAL DATA SYSTEM

CHAPTER 154

State Longitudinal Data System [Effective July 1, 2013]

Sec.
37-154-1. State Longitudinal Data System (SLDS); establishment [Effective July 1, 2013]. 37-154-3. Governance [Effective July 1, 2013].

§ 37-154-1. State Longitudinal Data System (SLDS); establishment [Effective July 1, 2013].

(1) To improve quality of life, education and employment opportunities for all citizens, the appropriate agencies of the State of Mississippi listed in subsection (2) of this section shall develop and maintain a State Longitudinal Data System (SLDS). The system will allow stakeholders and policymakers access data on state residents from birth to the workforce to drive accountability and investment decisions. The system will include data from multiple state agencies and entities. The system will provide decision makers a tool to develop policies to support objectives, including, but not limited to:

(a) Enabling Mississippians to secure and retain employment and receive better pay after completing training or postsecondary degrees;

(b) Enabling Mississippi to meet the education and job skill demands of business and industry;

(c) Developing an early warning system, which allows the state to intervene early, improving the graduation rates in high school and college;

(d) Identifying teachers, teaching methods and programs that lead to positive student outcomes; and

(e) Encouraging the sharing of electronic data across educational and other entities.

(2) Individual state agencies and state entities will send data from their internal system to the Statewide Longitudinal Data System. These initial agencies and entities shall provide data to the SLDS under the provisions developed by the SLDS Governing Board established in Section 37-154-3:

(a) Mississippi Department of Education (MDE);
(b) State Board for Community and Junior Colleges (SBCJC);
(c) Board of Trustees of State Institutions of Higher Learning (IHL);
(d) State Workforce Investment Board (SWIB);
(e) Mississippi Department of Employment Security (MDES);
(f) Mississippi Department of Human Services (MDHS); and
(g) State Early Childhood Advisory Council (SECAC).

Any agencies or entities added to SLDS shall provide a representative to the SLDS Governing Board and be governed in the same manner as the initial agencies and entities.