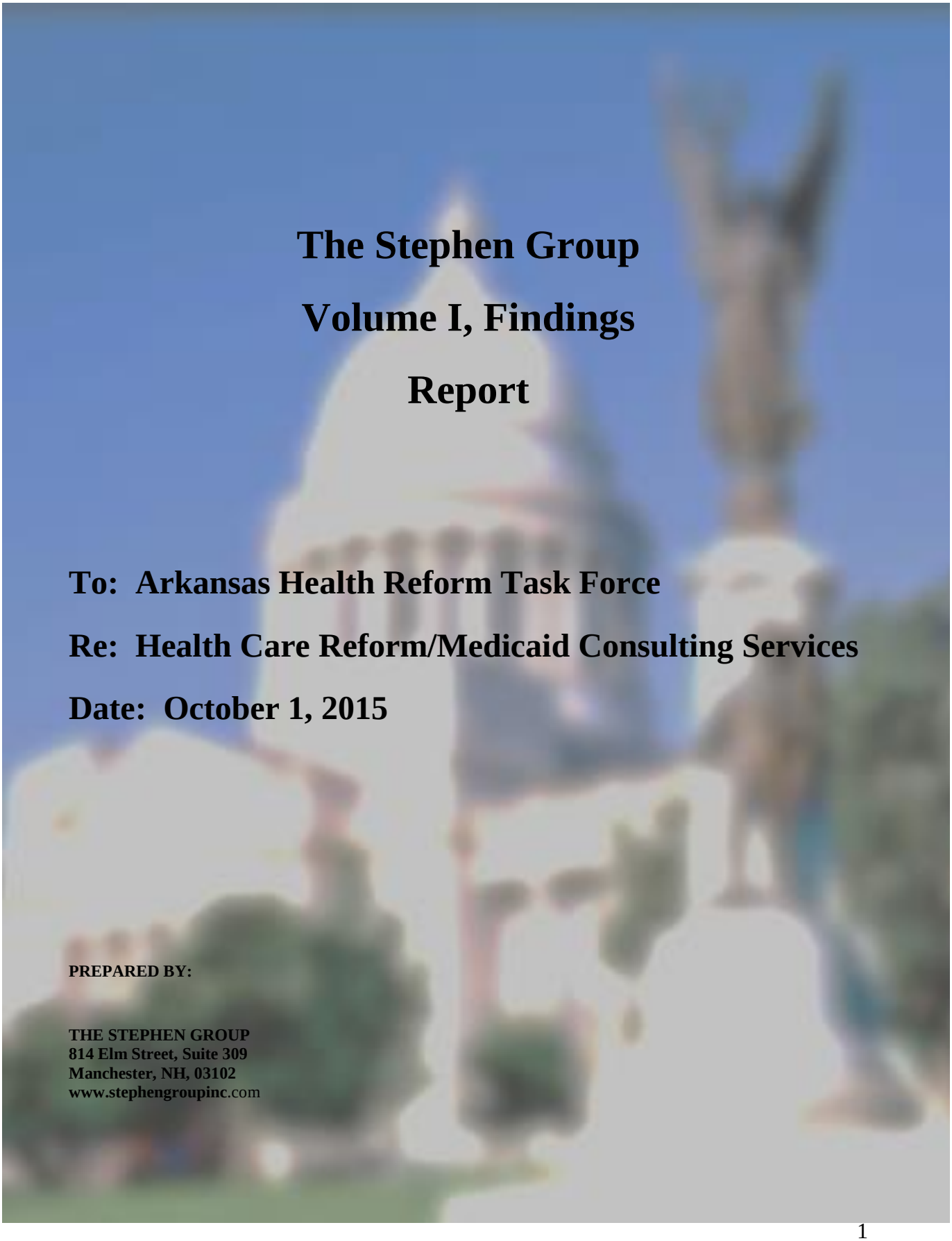


The Stephen Group

Volume I, Findings

Report

To: Arkansas Health Reform Task Force

Re: Health Care Reform/Medicaid Consulting Services

Date: October 1, 2015

PREPARED BY:

THE STEPHEN GROUP
814 Elm Street, Suite 309
Manchester, NH, 03102
www.stephengroupinc.com

TABLE OF CONTENTS

VOLUME I: FINDINGS

1. EXECUTIVE SUMMARY

Medicaid in Arkansas stands at a crossroads. In one direction, the State must decide whether to continue expanded Medicaid under the Affordable Care Act and, if so, decide how to provide these services. At the same time, the traditional Medicaid program is growing at an unsustainable pace, displacing other critical services, such as education, public safety, and criminal justice.

While these two factors might seem to be very different in nature, the reality is that they both lead to the same fundamental question: how does Arkansas best provide health care services to the needy in a manner that respects both those receiving care and the taxpayers?

To understand where the program is going, it is critical to recognize how Medicaid got to its current state, and how the program compares to other states in terms of quality, affordability, and efficiency of services. The best predictor of future performance follows the trajectory of the existing performance of the program.

The Stephen Group (TSG) was hired to assess the status of the traditional (pre-expansion) and expansion components of Arkansas Medicaid and make recommendations for improvement. The report that follows represents the assessment of these programs.

The Task Force was assembled largely to assist the Legislature in making a critical decision about the future of those newly eligible for Medicaid, who receive publicly-funded health insurance through the health insurance marketplace, a program often called the Private Option (PO). At the time of its implementation, Arkansas' solution to expanding Medicaid eligibility under the Affordable Care Act was a groundbreaking strategy that has been used as a model for other states.

1.1. Private Option

The goal of the PO was to bring more market-oriented principles to the delivery of care for a new population than are in place for the existing Medicaid program. By purchasing commercial insurance policies for these newly insured, the PO provides an opportunity to compare cost-effectiveness and quality against both the existing Medicaid program and those who purchase un-subsidized commercial policies through the exchange.

There can be no doubt about the impact of the PO on the health care and health insurance landscape of Arkansas. With nearly 250,000 Arkansans now covered through this plan, it has

fundamentally transformed the service delivery structure and uncompensated care, and added new health care providers across the state. Over $1 billion in new federal funds is now entering the Arkansas health care economy annually, and this is having a transformative effect on both the health care sector and the entire state.

For those now covered by PO plans, for providers and for policymakers, this represents a sea change in access to preventive care, in business models, and in decision-making about the future of the state health care environment going forward. Major policy shifts like this are, by their very nature, disruptive. Altering them in a rapid fashion could be equally disruptive.

With a little more than one year of relevant data, particularly since the initial few months involved a rapid buildup of new enrollees, broad conclusions regarding the overall success of the program remain elusive. Most notably, it is simply too soon to have reliable data to answer the critical question of whether or not the PO improves health outcomes for those who have enrolled.

However, there are a number of relevant findings about the PO and its participants that will inform policymakers. These include:

1. Individuals selecting health insurance through the marketplace via the PO are 80% of the total enrollment in the individual marketplace in Arkansas and approximately 65% of those enrolling through the PO are younger than 45 years old, compared to 45% of those enrolling in the Arkansas marketplace. Thus, the population enrolling through the PO is a younger group, and likely healthier and lower cost.
2. As a byproduct of using the provider networks of the private insurance companies instead of the traditional Medicaid program, insurance carriers paid 9,450 providers who had not filed claims through traditional Medicaid, thus expanding the pool of providers.
3. PO beneficiaries utilized Emergency Department services at a rate greater than traditional Medicaid, despite being a healthier population. This could be a byproduct of a lack of understanding of how to use services appropriately by individuals who are new to having coverage, or simply a reflection of ease, since PO beneficiaries do not have the same co-payments and deductibles that dis-incentivize commercial insurance policy holders from utilizing ED services.
4. Over the next five years, the federal share of the PO, in its current form, would result in roughly $9 billion in Medicaid federal match payments for Arkansas.
5. Hospitals report a substantial reduction in uncompensated care visits and costs since the beginning of the PO. Uninsured admissions dropped 48.7% between 2013 and 2014, uninsured Emergency Department visits dropped 38.8% and uninsured outpatient visits dropped 45.7%. It is important to recognize, however, that the beginning of 2014 also represented the start of health insurance policies (often subsidized) being available on the Arkansas Health Connector for purchase by individuals, as well as the individual mandate. Additionally, unemployment dropped from 6.7% in December 2013 to 5.7% in

December 2014, which likely indicates an increase in employer-sponsored insurance. Thus, the implementation of the PO is one factor among several that would lead to a reduction in uncompensated care.

6. The Arkansas rate of uninsured among non-elderly adults dropped from 27.5% to 15.6% from 2013 to 2014. The PO was clearly a substantial factor in this drop, though, as mentioned above, there were additional factors that may have contributed to this reduction.
7. Many PO enrollees are not working at all or not working substantially. 40% of beneficiaries have an annual income of $0. 54% had incomes below 50% of the federal poverty level (FPL). Only a little over 15% were between 100-138% FPL.
8. The PO has added nearly 250,000 covered lives to the Arkansas health insurance marketplace, creating a larger actuarial pool. It does not appear, based on existing data, that adding Medicaid enrollees to the marketplace is creating an upward impact on premiums in the Arkansas exchange.
9. It appears that the current ratio of claims to premiums is 79%, thus lower than the amount allowed under the Affordable Care Act (ACA). Thus based on TSG's claims analysis, the average PMPM for the first year is lower than what was anticipated during the initial waiver agreement.
10. Physician licensure rates appear largely not to be impacted by the PO, though it is too soon to draw any long-term conclusions.
11. The State Health Independence Accounts appear largely to have missed their mark. Only 10,806 cards have been activated of the 45,839 issued. Only roughly 2,500 individuals contribute to these accounts monthly.

The PO allowed the state to shift or discontinue several areas that had been covered by traditional Medicaid. This allowed the state to receive a higher match rate for these services.

Thus, if the state chooses to end Medicaid expansion and return to the Medicaid program is it was constituted prior to the PO, there would be a substantial cost to the state general revenue to restore these programs. TSG estimates that the total state fund impact of restoring these programs could be as high as $438 million above the general revenue portion of the PO between 2017-2021, with the most immediate impact coming sooner and diminishing over time, as the state matching percentage increases for this population, up to 10% in existing federal law in 2021.

With the conclusion of both the waiver and legal authority for the PO ending on December 31, 2016, policy leaders currently face a critical deadline about how to move forward with this program.

1.2. Traditional Medicaid

TSG's review shows a traditional Medicaid program that is poorly positioned to meet the state's needs going forward. Future growth in the non-expansion program, even at a level below the growth projection of the federal government, shows an unsustainable, and unaffordable, path forward. To continue down the current path would result in substantial tax increases, reductions to other important State programs, cuts to Medicaid services or all three of the above.

Today's traditional Medicaid program will spend $5.2 billion in state fiscal year 2015. Using conservative projections, that number will grow to $6.91 billion in fiscal year 2021, with the general revenue portion growing from $1.55 billion to $2.07 billion over the same timeframe. That means that, if Medicaid is allowed to grow at its projected rate, in 2021, taxpayers will need to be contributing more than half a billion dollars more than current levels in general revenue to support the traditional Medicaid program. Given the shifting demographics that both Arkansas and the nation are undergoing, the actual fiscal impact could potentially be much greater.

It is true that the state's growth in traditional Medicaid has moderated in recent years. However, this is due in part to national Medicaid trends and the state's ability to move groups of people from the fee for service (FFS) Medicaid to the PO since 2014. We expect that the state will revert back to more traditional trends, consistent with future national Medicaid spending projections.

There are several areas where the Arkansas Medicaid program has not yet taken approaches that are considered best practices across the country, including in the areas of hospital payment and care management. For example, most states have created incentives through reimbursement for providers to manage resources and length-of-stay for Medicaid patients. If left unmanaged, this may also drive up costs across the entire system. Moreover, there are proven tools that are not being used to develop system-wide care management and encourage providers to help in that goal. Patients with chronic conditions do not use just one provider, so care coordination is required. Tools such as alliances and Electronic Health Records would help expand the impact.

Additionally, Arkansas is one of a small number of states that have not implemented some component of its Medicaid program into full-risk managed care for the delivery of medical services. Other states have found that a full-risk model has been beneficial in lowering Medicaid costs, while often seeing quality improvement.

Nearly three-quarters of expenditures under traditional Medicaid are made for those beneficiaries in the elderly, mental health and developmentally disabled populations. However, the state's efforts for cost management, such as patient-centered medical home (PCMH) and Episodes of Care (EOC), are only targeting the final one-quarter of Medicaid expenditures. While these

initiatives have shown some ability to deliver savings, they cannot significantly reduce the fiscal growth trends in Medicaid, since they don't deal with the bulk of the program costs.

Presently, Arkansas does not consistently use an independent assessment for determining the right level and place of care for the elder, disabled and behavioral health populations within Medicaid. This means that many individuals might get services at higher cost in more restrictive settings, which may not be the best outcome for both the recipients and taxpayers, who must pay the bill.

Partly as a result of the lack of a consistently applied assessment, as well as a lack of appropriate incentives, Arkansas has not made significant strides in rebalancing care for its ABD population. Across the nation, states have identified both great program savings as well as improvements in satisfaction from those receiving care by moving these high-cost Medicaid beneficiaries from expensive institutional settings, like nursing homes, to supported care in homes and communities across Arkansas through care coordination and aligning payment incentives.

This finding is despite the fact that Arkansas citizens in general and seniors in particular have expressed tremendous support for expanded home and community based care. A random survey conducted on behalf of AARP of Arkansas found that 91% of residents supported moving more funds from nursing homes into home and community based settings for long-term care. These results are consistent with findings from other states.

Similar to the care for the aged, the developmentally disabled system still maintains a high reliance on expensive institutional care. At a time when states across the country are moving away from institutions and toward independence, Arkansas maintains a significant commitment to providing care at this level.

One major focus within the long term supports and services population is the developmentally disabled wait list for waiver services. There are approximately 2900 individuals with developmental disabilities that are currently waiting for community waiver services. Although, it is important to note that 91% are receiving some Medicaid services, totaling $32 million annually.

DHS has offered a number of steps to connect behavioral health to overall health. Moving forward on these is critical to improving the mental health system, as the existing billing structure and service delivery model is highly "siloed" and fails to connect the physical health or other factors, such as substance abuse treatment, into a coordinated care model. This leads to expensive and disconnected care that results in missed opportunities for quality improvement.

The PCMH model, while still relatively new, is a care coordination model for driving payment reform at the provider level. It has shown the ability to improve measured health outcomes, led to better access for Medicaid beneficiaries who might otherwise use inappropriate care and, thus,

has allowed Medicaid to avoid costs. By offering a medical home with 24/7 access to a provider, PCMH offers better opportunity to provide timely care at a more appropriate level.

The Episodes of Care model, also early in its inception, is another provider-based payment reform that shows some promise. By changing provider incentives to focus on quality and utilization reductions, it shows potential for savings in an FFS environment. However, with a high cost of developing and deploying episodes, it means that the return on investment can often take many years before the program becomes a net positive payment model.

While PCMH and Episodes of Care have shown value in modernizing Medicaid payment systems, many other states, including neighbors Tennessee and Texas, as well as nearby Kansas, have engaged in comprehensive Medicaid modernization efforts that have pushed these states to the forefront nationally. There are numerous opportunities from those and other states to implement best practice models that have been validated elsewhere.

TSG conducted field research to assess the issue of health disparity in Arkansas. We received considerable anecdotal evidence of the significant concerns that many in the community had little to no knowledge of much of the health care system, and thus utilize inappropriate care venues (such as the Emergency Department). Some who have enrolled in the PO indicate that they do not understand how to navigate the health care system. Presently, data show Arkansas to have very low rankings nationally on numerous health indicators. Poor awareness of healthy lifestyle choices and of using wellness and preventive services undoubtedly contribute to these standings.

Like many states working to implement the eligibility standards verification of the ACA, Arkansas' experience has included many frustrating obstacles and setbacks. The conversion to Modified Adjusted Gross Income (MAGI) and the simultaneous effort to convert to a new software system, Curam, have been enormous challenges. Regardless of how the eligibility and redetermination process got to the point it is in today, the reality is that it is not meeting program integrity standards.

Most notably, the eligibility determination process is still missing an efficient automated process that verifies that eligibility standards are being materially met without draining staff time. The current system still demands considerable involvement and continued rechecking, often at the expense of those who need services or the taxpayers. The recent redetermination issues certainly have garnered great attention, but the issues internally speak to a system that has troubling deeper issues.

Of equal concern is the lack of a real-time system to check applicants' identities and addresses, or to quickly verify income or assets. A Lexis-Nexis review of DHS data shows that some beneficiaries who are currently receiving services or payments may have a primary address out

of state. This means that Arkansas may be paying carriers a PMPM payment for individuals who are no longer eligible.

Arkansas Medicaid can do a better job managing its pharmacy benefit. This statement can be validated by the substantial difference in the price of prescription drugs that the traditional Medicaid program pays, versus the much lower price paid by PO carriers. At the same time, there are three different call centers that manage prior authorization for drugs on the preferred drug list (PDL). This represents an area for streamlining and tighter controls that will improve affordability and program efficiency.

Our analysis of the program integrity function at the Office of Medicaid Inspector General (OMIG) demonstrates a staff that is committed to eliminating waste, fraud and abuse, but does not have the tools in place to do so effectively. The State has a very low rate of collections on a per capita basis and does not have full use of data analytic capabilities focused primarily on identifying patterns of fraud, waste and abuse. The newly appointed head of OMIG indicated that this is a top priority. In addition, there are limited resources at the Department of Human Services (DHS) directed towards provider audit functions.

The State of Arkansas has an atypically high per capita cost for its Medicaid program. This represents a tremendous opportunity for change that could result in tremendous program efficiencies that could save state taxpayers considerably, provide opportunities to resolve outstanding issues (such as the developmental disability wait list) and put Medicaid on track financially for years to come.

While TSG certainly recognizes that the Task Force is committed to resolving the immediate issue of those newly eligible for Medicaid, it must also place high priority on finding solutions to contain the growing costs of the traditional Arkansas Medicaid program, which is just as deserving of considerable and immediate attention by policymakers.

1.3. Observation Concerning Healthcare Value

TSG found that DHS places too little emphasis on healthcare *value*. Instead, most of the focus has been on reducing cost—which is also critically important. Healthcare value is the relationship between costs and outcomes. In neither traditional Medicaid nor the PO has the State created a regular, on-going method of collecting, evaluating and adjusting programs based on patient outcomes. Outcomes include not only quality metrics, but also improvements in the health of the patient. The combination of traditional Medicaid and the PO constitutes a substantial portion of healthcare payment in Arkansas. However, the programs are mostly focused on medical intervention, and too little on overall health. DHS invests little of its

research and management effort developing programs and policies to improve the overall health of Arkansans – neither those directly served by its programs nor the general population.

During one of the Task Force meetings, Dr. Daniel W. Rahn, the Chancellor of the University of Arkansas Medicaid School (UAMS), made reference to the fact that he would love to see Arkansas' health status raised to the "best in the SEC" (reference to the powerhouse Southeast Conference in NCAA football and basketball). TSG applauds that vision and believes that, together, policy makers, stakeholders, department heads, health and human service entities, for profit and not for profit businesses, community leaders, and Arkansas families and individuals should all share Dr. Rahn's vision. Working together, each could contribute to raising the healthcare value in Arkansas. However, as the department charged with overseeing medical services delivered to a substantial segment of the Arkansas population, DHS must be a one of the leaders in the future in making "best in the SEC" a reality for all Arkansans.

2. INTRODUCTION

The Bureau of Legislative Research retained TSG through a competitive bid process to conduct an investigation that will provide to members of the Arkansas Health Reform Legislative Task Force (Task Force) detailed and accurate information concerning the current state of health care programs in the State of Arkansas, as well as recommendations for alternatives to the current programs and options for modernizing traditional Medicaid programs. This is the final report of that project, conducted from May through September, 2015.

2.1. Project Support

All of the individuals with whom TSG has come into contact during its assessment have warmly embraced the project—providing strong support to TSG. DHS staff, in particular, treated this project a top priority and made every resource available. Senior leadership, program staff, and IT personnel, including contactors, were generous in their support for our efforts. TSG would also like to recognize and thank other state departments, policy makers, providers, stakeholders, community leaders, and individuals in communities we visited that represent the best of Arkansas.

The project was a far-reaching investigation based on broad original information and data collection:

- Extract of 140 million lines of DHS claims data
- Claims, membership and provider files from each of the three PO carriers, a total of 2.6 gigabytes comprising all the claims paid from program inception through May 2015
- Interviews and work sessions with hundreds of key members of the community.

Building on these knowledge sources, TSG conducted a series of unique data analyses. These are described in this Findings Volume 1 report and include:

- Pharmacy claims
- Eligibility files
- Eligibility compared to external resources
- Provider costs compared to Medicare DRG rates
- Demographic profile of PO beneficiaries, providers and claims
- Emergency Department utilization
- Cost of care for pregnant mothers
- Costs of PO claims by: diagnosis, provider, category of service
- The PO's impact on healthcare access
- DHS contracts and contract management
- DHS organization structure
- Three community forums to gather input statewide
- A survey of providers' thoughts on Agency health improvement efforts

TSG would like to thank the MANY contributors who offered their generous support in many ways throughout the project. A few of these examples are acknowledged in Appendix 1.

2.2. About The Stephen Group

TSG is a business and government consultant. TSG combines strategic government and private sector intelligence with deep government and regulatory experience that offers state agencies tactical and practical information that addresses their most critical challenges, transforms their agencies and helps achieve extraordinary results. State agencies measure those results as significant improvements in efficiencies, quality of service, increased cost savings, and (ultimately) benefit to the taxpayer. For more information on the TSG assessment project team and background see Appendix 2.

3. BACKGROUND

Healthcare is in a crucial period of change in Arkansas and across the country. Change in the American healthcare system has been a constant for decades, and was accelerated by the passage of the Affordable Care Act and the Arkansas' Health Independence Act (HCIA) in 2013 creating a new program, the Health Care Independence Program, commonly referred to as the Private Option (PO).

The Arkansas Health Reform Act of 2015 (the "Act"), enacted by the 90th General Assembly, represented the Arkansas General Assembly's intentions to "seek out strategies to provide health care for low-income and other vulnerable populations in a manner that will promote accountability,

personal responsibility, and transparency; remove disincentives for work and social mobility; encourage and reward healthy outcomes and responsible choices; and promote efficiencies that will deliver value to the taxpayers". In order to accomplish these goals, the Act created the Arkansas Health Reform Legislative Task Force and set forth two purposes of the Task Force, as follows:

- To recommend an alternative healthcare coverage model and legislative framework to ensure the continued availability of healthcare services for vulnerable populations covered by the Health Care Independence Program established by the Health Care Independence Act of 2013, §§ 20-77-2401, *et seq*., upon program termination; and
- To explore and recommend options to modernize Medicaid programs serving the indigent, aged, and disabled.

Subsequently, TSG was hired through a competitive bid process to address the components contained in RFP BLR-150002 and assist the Task Force in its work and offer recommendations that meet the above criteria. This TSG assessment report considers how well-prepared Arkansas Medicaid is to meet the trends for the future (Volume I Findings Report) and how Arkansas Medicaid can be steered at the policy level toward better preparedness (Volume II Recommendations Report) to meet the goals of the Act.

SECTION 1: FINDINGS SPECIFIC TO THE PRIVATE OPTION

4. HEALTH CARE INDEPENDENCE ACT

In spring of 2013, Arkansas took a then-unique approach to implementing the federal Affordable Care Act to expand health insurance for certain populations.

Pursuant to HCIA, PO beneficiaries participate in a Qualified Health Plan (QHP) that they select. The State uses premium assistance to purchase QHPs offered in the individual market through the ACA Marketplace for individuals eligible for expanded coverage under Title XIX of the Social Security Act who are either (1) childless adults between the ages of 19 and 65 with incomes below 138% of the federal poverty level (FPL) (up to $16,242 per year for an individual in 2015) who are not enrolled in Medicare or (2) parents between the ages of 19 and 65 with

incomes between 17 and 138% FPL who are not enrolled in Medicare (collectively "PO beneficiaries")[1].

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

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

In addition, HCIA sought to enable:

- Continuing alignment of payment incentives
- Health care delivery system improvements
- Enhanced rural health care access
- Initiatives to reduce waste, fraud and abuse
- Policies and plan structures to encourage the proper utilization of the healthcare system
- Policies to advance disease prevention and health promotion

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

[1] See description of the 1115 Wavier at: https://www.medicaid.state.ar.us/general/comment/demowaivers.aspx, viewed September 9, 2015
[2] Wording adapted from the text of HOUSE BILL 1143 viewed on September 9, 2015, at http://www.achi.net/Content/Documents/ResourceRenderer.ashx?ID=122

The HCIA wording is clear: it is not a perpetual federal or state right or a guaranteed entitlement. The program is subject to cancellation upon appropriate notice and is not an entitlement program[3].

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

4.1. HCIA Recognized as an Innovative Approach

HCIA has been recognized as an innovative approach to expanding healthcare coverage[4][5][6]. It required special approval, and in September 2013, the Centers for Medicare and Medicaid Services (CMS) approved a Section 1115 demonstration waiver to implement HCIA by using Medicaid funds as premium assistance to purchase coverage in Marketplace QHPs for newly eligible adults.[7] As of January 2014, Arkansas' demonstration:

- Expands Medicaid by purchasing Marketplace QHP coverage for all newly eligible adults.
- Requires newly eligible adults to enroll in Marketplace QHPs to receive Medicaid services.
- Provides services that are outside the QHP benefit package, such as Early Periodic Screening Diagnosis and Treatment for 19 and 20 year olds, free choice of family planning provider, and non-emergency medical transportation, through the state's Medicaid fee-for-service delivery system.

[3] Wording taken from the bill, viewed at: http://www.achi.net/Content/Documents/ResourceRenderer.ashx?ID=122
[4] See for example the Kaiser Family Foundation report, from which this paragraph has been adapted. Viewed on September 9, 2015 at: http://kff.org/medicaid/fact-sheet/medicaid-expansion-in-arkansas/#footnote-143277-
[5] See for example: http://khn.org/news/is-arkansas-private-option-medicaid-expansion-a-solution-for-other-red-states/
[6] See for example: http://www.arktimes.com/ArkansasBlog/archives/2015/08/26/arkansas-private-option-continues-to-get-rave-reviews
[7] Ark. Health Care Independence Program (Private Option), CMS Special Terms and Conditions (Sept. 27, 13), available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/Health-Care-Independence-Program-Private-Option/ar-private-option-app-ltr-09272013.pdf; *see also* Ark. Medicaid, Health Care Independence (a/k/a Private Options) § 1115 Waiver – FINAL (Aug. 2, 2013), available at https://www.medicaid.state.ar.us/general/comment/demowaivers.aspx.

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

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

- Imposes cost-sharing at the point-of-service at state plan amounts for beneficiaries above 100% FPL who do not make monthly account contributions.

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

Arkansas is among the 29 states (including DC) implementing the Medicaid expansion to date[11], most of which are doing so through a state plan amendment. To date, CMS has approved waivers in Arkansas, Iowa[12], Indiana[13], Michigan[14], New Hampshire[15] and Pennsylvania[16] to

[8] Ark. Act 257, § 17 (Feb. 18, 2014), available at http://www.arkleg.state.ar.us/assembly/2013/2014F/Pages/BillInformation.aspx?measureno=SB111; Ark. Health Care Independence Program (Private Option) CMS Special Terms and Conditions #11-W-00287/6 (Jan. 1, 2015), available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/ar-private-option-ca.pdf.
[9] See: http://kff.org/medicaid/fact-sheet/medicaid-expansion-in-arkansas/
[10] See: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/Health-Care-Independence-Program-Private-Option/ar-private-option-pending-app-09172014.pdf
[11] See list at: http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/ Viewed September 9, 2015
[12] For summary, see: http://kff.org/medicaid/fact-sheet/medicaid-expansion-in-iowa/
[13] For summary, see: http://kff.org/medicaid/fact-sheet/medicaid-expansion-in-indiana/
[14] For summary, see: http://kff.org/medicaid/fact-sheet/medicaid-expansion-in-michigan/
[15] For summary, see: http://kff.org/medicaid/fact-sheet/medicaid-expansion-in-new-hampshire/
[16] For summary, see: http://kff.org/medicaid/fact-sheet/medicaid-expansion-in-pennsylvania/

implement the ACA's Medicaid expansion. In addition, Tennessee[17] and Utah[18] have proposals for Medicaid expansion.

4.2. Medically Frail

The medically frail are treated differently in the Arkansas HCIP than the non-frail population and carriers are not responsible for their care. Currently approximately 10% or about 25,000 individuals on HCIP are classified as Medically Frail.

During the eligibility process, the individual signing up for HCIP is asked a number of questions to determine if they are medically frail. This is a self-test attestation. CMS defines medical frailty as involving individuals who have one of the following conditions:

- Disabling mental disorders
- Chronic substance abuse disorders
- Serious and complex medical conditions
- Physical, intellectual, or developmental disability that impairs one or more activities of daily living
- Disability determination by Social Security criteria or state plan criteria

The Centers of Medicare and Medicaid Services (CMS) does not determine how to define such categories as disabling mental disorders, chronic substance abuse disorders, and serious and complex medical conditions, and leaves it up to the states to determine the definition of these criteria. CMS has provided guidelines for medical frailty, but has not directed states on the specific methods used to determine if an individual meets criteria for medical frailty or not.

In a recent study by the University of Massachusetts Medical School, Disability Evaluation Services, the researchers found that there are substantial differences in how the 11 states reviewed assess medical frailty. Four primary methods of assessment were derived: self-report, data review, administrative and clinical. Note that several states use more than one method to determine medical frailty.[19]

Arkansas is one of nine expansion states that have chosen the self-report method where potential beneficiaries answer a series of questions related to medical condition on a standard

---

[17] Information about the proposal can be viewed at: http://kff.org/medicaid/fact-sheet/proposed-medicaid-expansion-in-tennessee/

[18] Information about the proposal can be viewed at: http://kff.org/medicaid/fact-sheet/proposed-medicaid-expansion-in-utah/

[19] State Differences in the Application of Medical Frailty under the Affordable Care Act, University of Massachusetts Medical School, Disability Evaluation Services, 2015, available at: http://commed.umassmed.edu/sites/default/files/cwm/files/UMASS_Poster_AH_StateDiffAppMedFrailtyACA_DES_Final%20(7).pdf

questionnaire that is provided during the eligibility process, and self-attest to their current medical condition. See Appendix 3 (Medically Frail Questionnaire). If it is determined after this self-attestation process that the individual is medically frail, they are given the choice to receive Medicaid benefits in the fee for service program, or the more limited benefit package offered by carriers. The individual's benefits, however, are paid for by the state in the Medicaid fee for service program no matter what the choice is.

The study by UMass Medical School found that there are three states that use the data review method for determining frailty, five states that use the administrative review process and five states that base their determinations on a clinical review. See Appendix 4 (UMASS chart).

4.3. Key Provisions of HCIA Enabling Legislation

An important aspect of HCIA for the purpose of the TSG assessment is the requirement that effective December 31, 2016 the program's legislative authority will expire.

Another key aspect of the HCIA is that its continuation is predicated on the following federal expanded match:

- One hundred percent (100%) in 2014-2016
- Ninety-five percent (95%) in 2017;
- Ninety-four percent (94%) in 2018;
- Ninety-three percent (93%) in 2019; and
- Ninety percent (90%) in 2020 or any year after 2020

The HCIA set up a requirement that DHS project, track, and report state obligations for uncompensated care to identify potential incremental future decreases. This includes the Hospital Assessment Fee as well as:

- Program enrollment
- Patient experience
- Economic impact including enrollment distribution
- Carrier competition
- Avoided uncompensated care

The HCIP requires that participating carriers maintain a Medical Loss Ratio (MLR) of at least eighty percent (80%) for an individual and small group market policy and at least eighty-five percent (85%) for a large group market policy. The Act required the State Insurance Department to assure that at least two (2) qualified health plans be offered in each county in the state.

HCIA also required that carriers' programs provide for:

- Assignment of primary care clinician
- Support for patient-centered medical home
- Access of clinical performance data for providers

HCIA specifically required that the program include an enrollment mechanism that includes an automatic verification system to guard against waste, fraud, and abuse in the program.

The Legislature created the Health Care Independence Program Trust Fund to capture savings from the HCIP. The Fund may be used by the DHS to pay for future obligations under the Program. It consists of moneys saved and accrued under the Act, including[20]:

- Increases in premium tax collections
- Reductions in uncompensated care
- Other spending reductions resulting from the Act

The Program requires private insurance companies to create, present to DHS for approval, implement, and market a new kind of insurance policy.

4.4. Special Provisions of the CMS 1115 Waiver that Enabled HCIA

Participants must contribute to the premium. The new adult population with incomes above 100% of the federal poverty level (FPL) and below 138% are required to make contributions of $10-$25 per month to their Health Independence Account, depending on income and processed through a card similar to an EBT card. Individuals at this income level who fail to make contributions must pay the carrier's (QHP's) copayments or coinsurance at the point of service in order to receive services. If the individual restarts making contribution payments, the card will be reactivated to cover QHP-level copayments or coinsurance at the point of service. While the authorization to require certain populations to make HIA contributions was expanded to include those with incomes between 50% and 100% FPL, the agency chose not to implement that expansion. The purpose of HIAs is to help participants:

- Gain knowledge about appropriate access points for health care services and their associated costs
- Gain experience making monthly contributions to cover costs associated with health care expenditures
- Gain experience paying cost-sharing at point of service
- Take personal responsibility for their health care

[20] See full act for more information. Available at: http://www.arkleg.state.ar.us/assembly/2013/2013R/Acts/Act1498.pdf

- Accrue funds that can be used to offset the costs of premiums and cost-sharing in the Marketplace when their incomes rise above 138% FPL[21]

The Program is crafted to allow continuity of coverage even though participant incomes may vary during the year. By using premium assistance to purchase premium-based coverage through QHPs offered in the Marketplace, HCIA allows participants to continue their premium-based coverage even if income improves to a level that would otherwise disqualify them. This promotes continuity of coverage and expands provider access, while avoiding avoidable administrative work related to removing and adding participants. It also accelerates multi-payer cost-containment and quality improvement efforts[22].

The 1115 Waiver spells out specific metrics by which the program would be evaluated[23]:

Access

- Access consistent with traditional fee-for-service Medicaid
- Access to preventive care services consistent with traditional fee-for-service
- Lower non-emergent use of emergency room services
- Fewer gaps in insurance coverage than Medicaid beneficiaries in non-Premium Assistance expansions nationally
- Continuous access to the same health plans and/or providers at higher rates than under a traditional Medicaid expansion

Churning

- Reduction in churning for PO Beneficiaries should lead to reduced administrative costs
- Cost for covering PO beneficiaries should be comparable to what the costs would have been for covering the same expansion group in Arkansas Medicaid fee-for-service
- Uncompensated care costs should go down
- PO should drive down overall premium costs in the Marketplace

Quality

- PO enrollees will have lower rates of potentially preventable admissions
- PO carriers will produce improved quality

The initial projection was that approximately 225,000 individuals would be eligible for the Demonstration. Currently, the State estimates that approximately 250,000 individuals will be newly eligible for or newly enrolled in Medicaid in Arkansas in 2015. It is projected that 90% of newly eligible Medicaid beneficiaries will also be eligible for the Demonstration, with the remaining 10% of the newly eligibles self-identifying as medically frail or enrolling in standard

[21] Adapted by TSG from: https://www.medicaid.state.ar.us/Download/general/comment/HCIWPresentation2015.pdf
[22] https://www.medicaid.state.ar.us/Download/general/comment/FinalHCIWApp.pdf
[23] A table in the 1115 Waiver description includes details as well as metrics and data sources, at: https://www.medicaid.state.ar.us/Download/general/comment/FinalHCIWApp.pdf

Medicaid coverage under the State Plan. Though there has recently been talk of capping enrollment in the PO, the initial waiver indicated that the plan was that "there are no caps on enrollment in the Demonstration."

Coverage does not include certain high-risk (high-cost) populations including:

- Dual Eligibles
- Individuals who are medically frail/have exceptional medical needs.
- Incarcerated individuals

The waiver allows that "issuers will receive per member per month payments during the benefit year" and these payments will be subject to reconciliation at the conclusion of the benefit year based on actual Cost-Sharing Reduction (CSR) advance payments made by PO members (akin to co-pay). "If an issuer's actuary determines during the benefit year that the estimated advance CSR payments are significantly different than the CSR payments the issuer will be entitled to at the time of annual reconciliation, the issuer may ask HHS or Arkansas Medicaid to adjust the advance payments."

QHP carriers are required to participate in the Arkansas Health Care Payment Improvement Initiative (AHCPII)[24]—an innovative, multi-payer initiative to improve quality and reduce costs statewide. Because the HCIP adds approximately 250,000 individuals to carriers' enrollment rosters, HCIA expands the number of patients for whom participating providers are held accountable for the cost and quality of care.

The HCIP is also designed to improve access to care for PO beneficiaries by expanding the number of in-network providers. Because Medicaid reimbursement rates have historically been lower than Medicare or commercial rates, many providers in Arkansas accept only limited numbers of Medicaid patients and expansion of the Medicaid network to absorb an expansion population would not succeed without meaningful increases in provider reimbursement.

By expanding the number of individuals enrolled in the QHP plans, the State expects the HCIP to encourage carrier and provider entry, expanded service areas, and competitive pricing in the Marketplace, thereby enabling QHP carriers to better leverage economies of scale to drive pricing down even further.

4.5. HCIP QHP Carriers

Three QHPs are authorized to take on members through the HCIP.

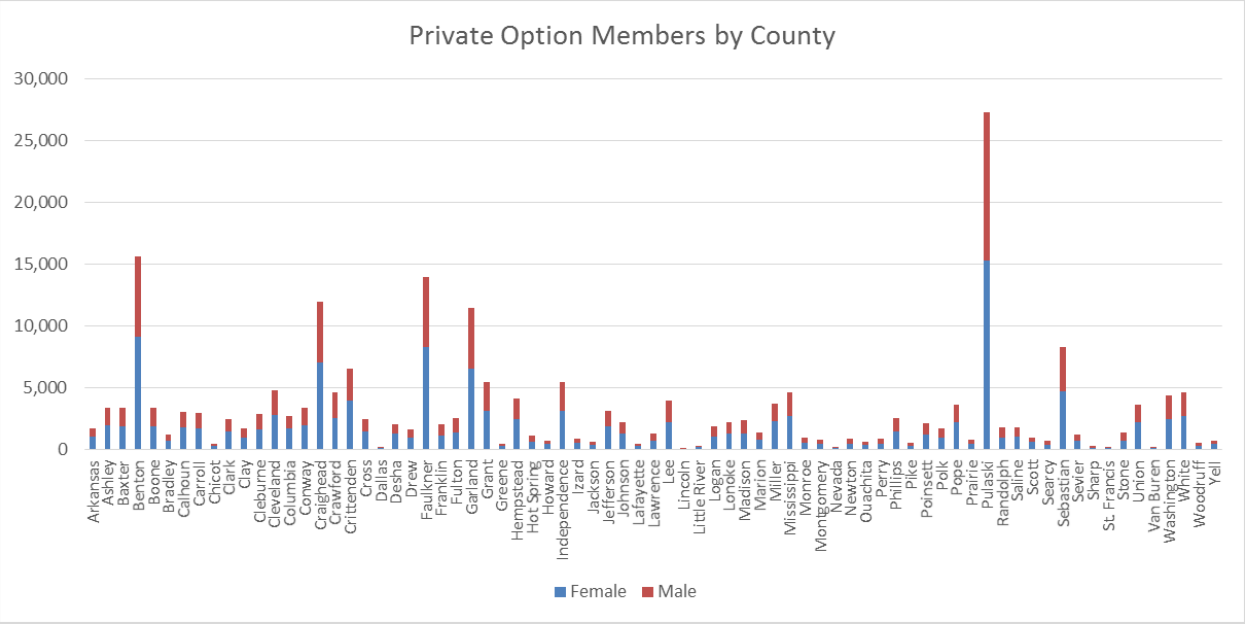
[24] See http://www.achi.net/pages/OurWork/Project.aspx?ID=47

- Ambetter of Arkansas – Celtic Insurance Company (selling in Arkansas as Ambetter)
- Blue Cross Blue Shield of Arkansas
- QualChoice -- QualChoice Holdings, Inc., is the parent company of QCA Health Plan, Inc., and QualChoice Life and Health Insurance Company, Inc., (collectively 'QualChoice'). QualChoice is headquartered in Little Rock with a sales and service office in Springdale, Arkansas

4.6. HCIP by County

Figure 1 shows the distribution of PO in each county, by number of members. Pulaski and the other large counties obviously have the largest membership. Figure 1 also shows male and female members: overall carrier membership is 58% female.

Figure 1—Carrier membership by county[25]



[25] TSG analysis of members according to the carriers extracts provided for the TSG assessment

Table 1—Details of HCIP participation by county[26]

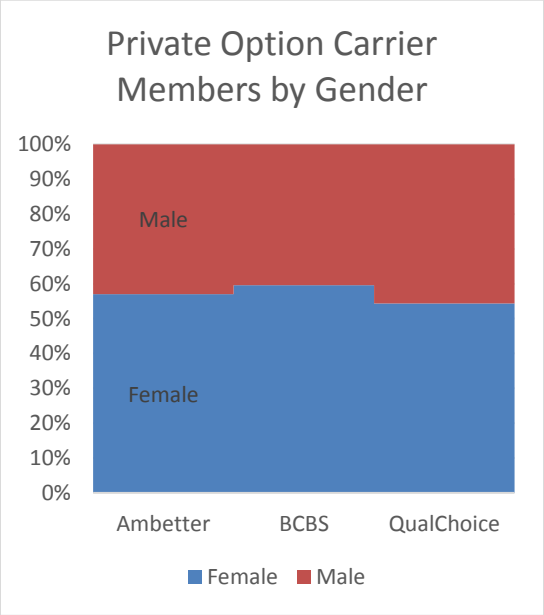
	Carrier Members						Market Share by County		
County	BCBS	Ambetter	QualChoice	Total Carrier	County Population	Percent	BCBS	Ambetter	QualChoice
Arkansas	1995	129	106	2230	18970	12%	89%	6%	5%
Ashley	3799	160	159	4118	21526	19%	92%	4%	4%
Baxter	2650	2545	899	6094	41055	15%	43%	42%	15%
Benton	10871	12860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

[26] TSG analysis of membership data provided by the three Private Option carriers

4.7. HCIP by Gender

PO/HCIP members include more women than men. Females account for 51% of the total Arkansas population, but 58% of HCIP members. This 58% holds true for each of the PO carriers, Figure 2. It holds true across all age groups.

Figure 2—PO beneficiaries by gender



4.8. HCIP by Income

HCIP is an income-based program, designed to help those with incomes up to 138% of the federal poverty level (FPL). According to Agency eligibility records, the PO and Medically Frail population members at a point in time in October of 2014 had the following income levels as a percent of Federal Poverty Levels (Table 2):

Table 2—PO members by percent federal poverty level[27]

FPL	Med Frail	PO	Total	%
0 - 50%	14,348	105,084	119,432	54%
50.1 - 100%	5,314	56,474	61,788	28%
100.1 – 115%	1,566	17,063	18,629	8%
115.1 – 129%	1,267	14,076	15,343	7%
129.1 – 138%	609	6,186	6,795	3%

This report showed that that 40% of the PO population was at 0% or had no income at all. DHS informed TSG that they have no indication that the above income percentages have changed significantly.

Evaluating HCIP by income levels is problematic because it requires knowledge of family size as well as dependable income information. TSG was informed that the income data held by the county offices was self-reported by the applicants and not a reliable source of data for verification or analysis.

4.9. Number of Participants in HCIP

The number of new PO members each month has leveled off over the period since the program was launched in January 2013. In the first month, the Agency automatically registered about 60,000 new members. In total, as of March 2015 (cutoff for the data TSG used from the carriers), the PO program included 233,000 members, as shown in Figures 3 & 4. These show that in the months since then the number of new members has dropped steadily. These two figures lead TSG to conclude that barring some change in the program or its promotion (or possibly the economy), PO membership has plateaued.

[27] TGSG analysis of Agency data

Figure 3—Membership of Premium-based PO Programs[28]

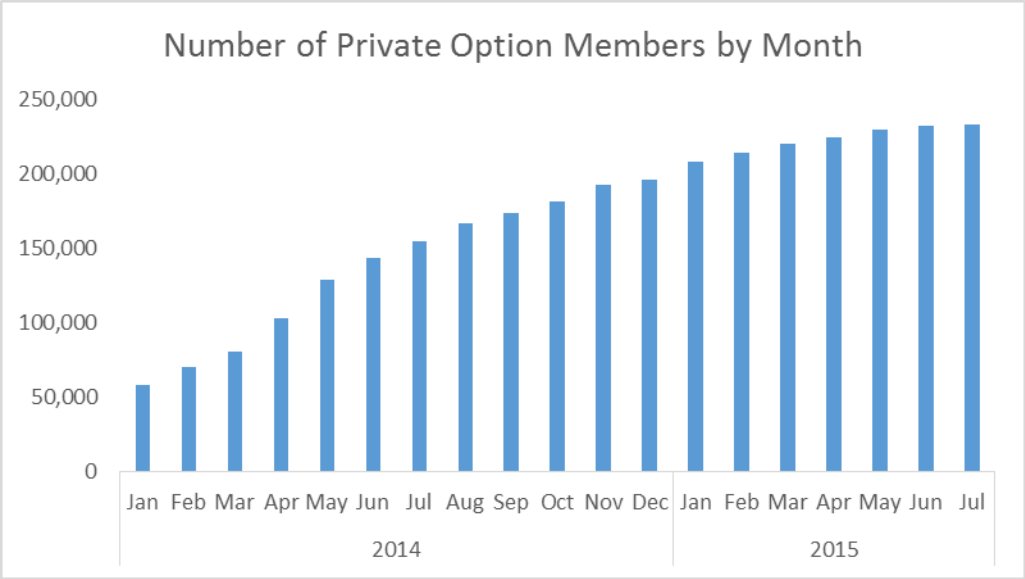
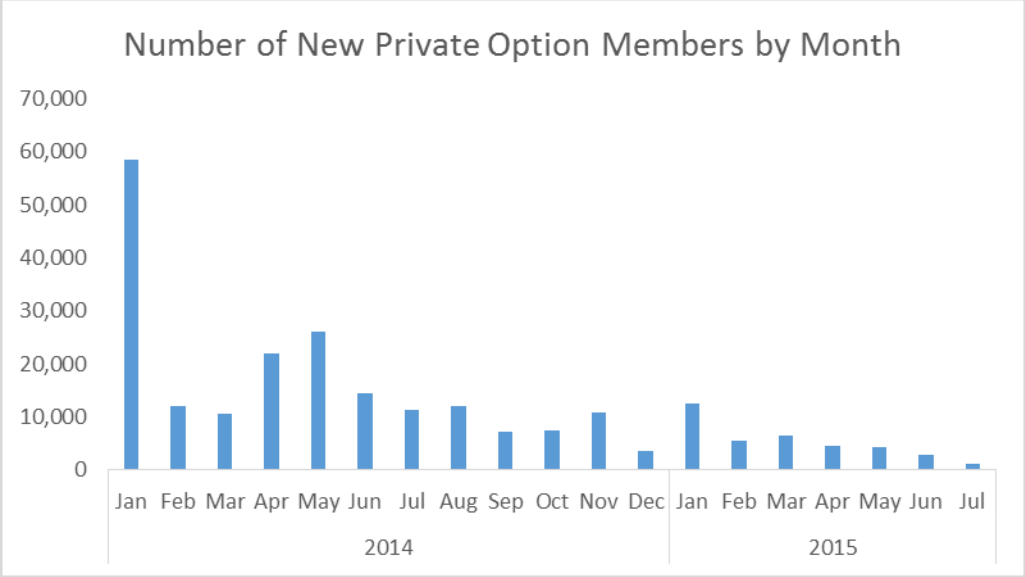


Figure 4—New PO Members by Month since Inception[29]



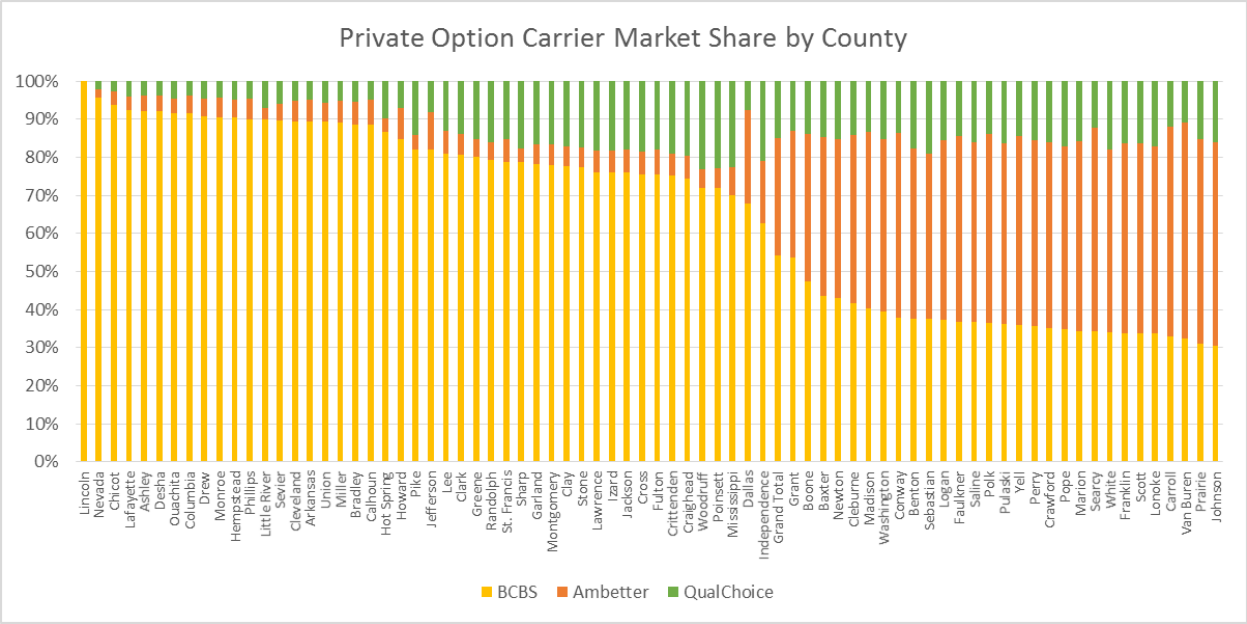
[28] TSG analysis of membership files provided by the three Private Options carriers for the TSG study. Cutoff date: June, 2015

[29] TSG analysis of membership files provided by the three Private Options carriers for the TSG study. Cutoff date: June, 2015

4.10.Members by County

HCIP required that carriers provide (in total) programs available to residents of every county. They have. However, carriers have different presences by county. Figure 5 shows that as of December 2014, BCBS dominates over half of Arkansas' counties.

Figure 5—Carrier market share by county[30]



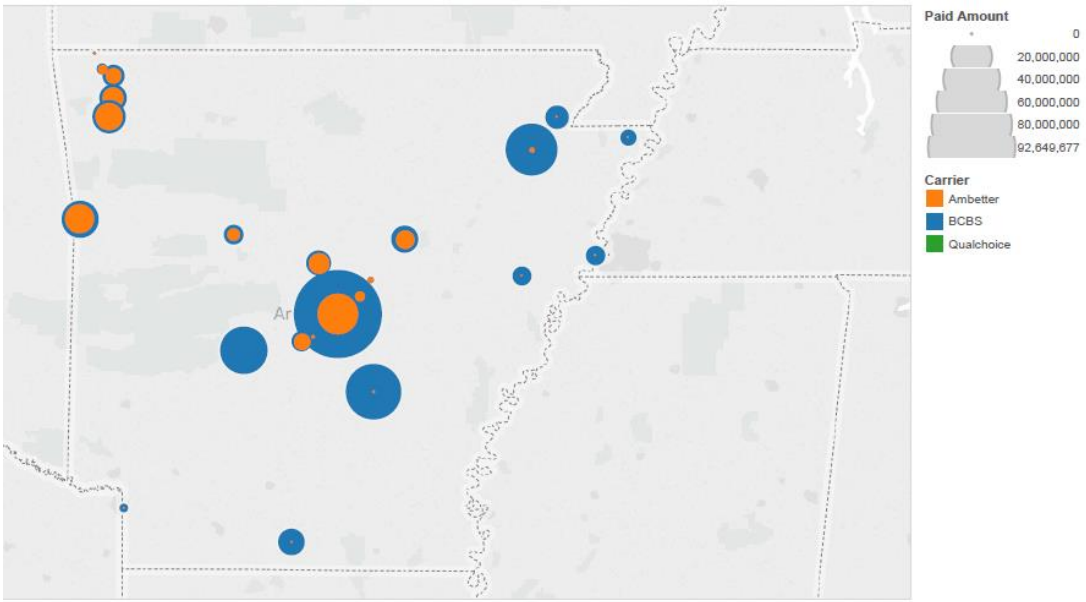
This can also be seen by looking at the heat map in Figure 6. It shows that BCBS vendor claims are concentrated in the center and eastern half of the state, while Ambetter is concentrated in the center and northwest.

The size of the ball represents the claims total by city. QualChoice represented a small claims amount through December 2014, so the scale is such that it does not show on the map. TSG observe that providers are quite concentrated, that large portions of the state have such small provider representation the provider ball size is too small to include on the chart. This does not say that providers are not available, only that claims are concentrated geographically.

[30] TSG analysis of member files from the carriers extracts provided for the TSG assessment

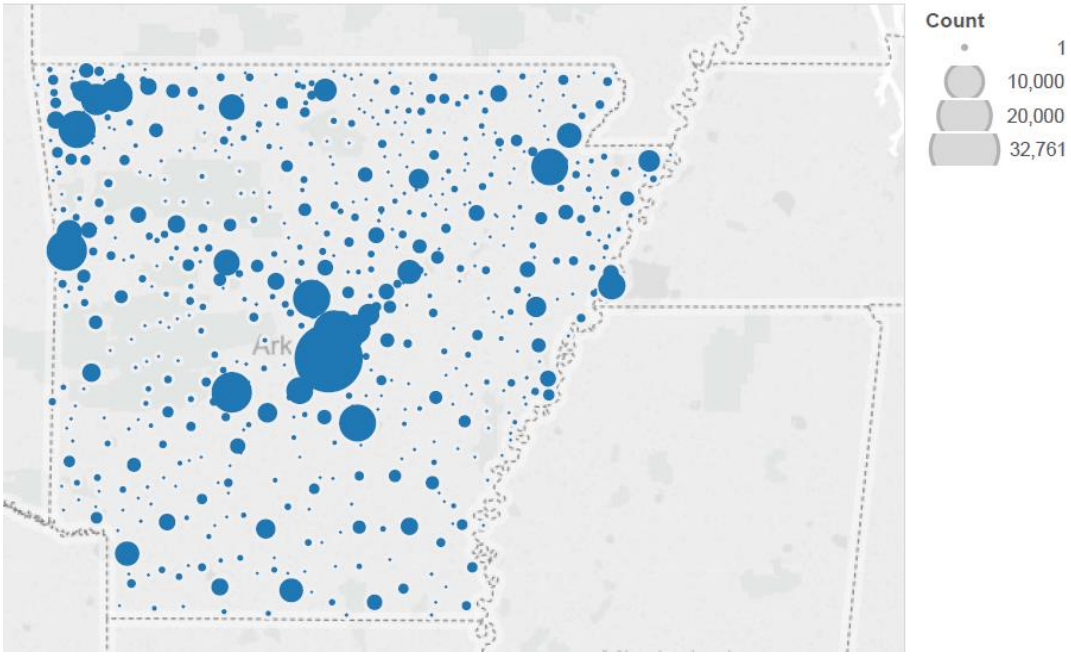
TSG reviewed Arkansas population density shown in Figure 7 to confirm that vendor claims concentrate in roughly the same as the carrier members' distribution. Figure 7 is a heat map that shows the distribution of the general population in the figure above.

Figure 6—PO provider claims amount by provider city, heat map[31]



[31] TSG analysis of provider and claims data files provided by Private Option carriers

Figure 7—PO beneficiaries' home address of beneficiaries, by zip code[32]

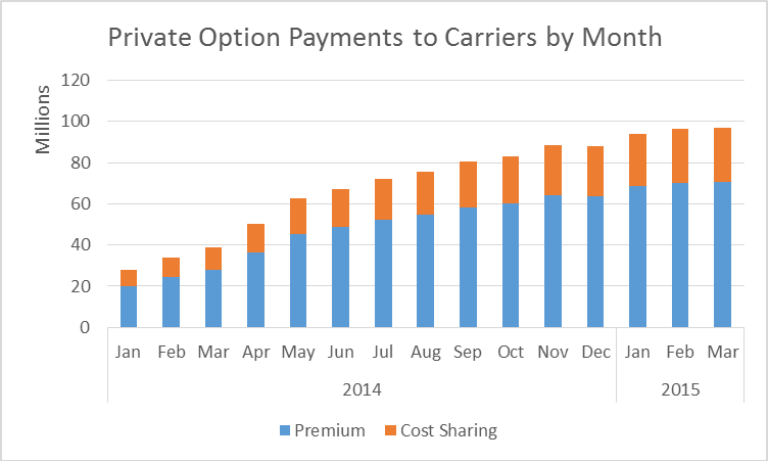


4.11.Carrier Premiums and Cost Sharing

PO beneficiaries cost Medicaid in three manners: premiums, cost adjustments and travel. Premiums are paid monthly for beneficiaries recorded as eligible in the MMIS system. During the year, payments to carriers have been increased based on claims experience. Premiums and Cost Sharing payments are shown in Figure 8. Cost Sharing includes the payments made by DHS directly to carriers.

[32] For this chart, TSG has excluded beneficiaries with addresses outside Arkansas

Figure 8—Payments to PO Carriers, through March 2015[33]



4.12.PO Premiums and Claims PMPM

DHS Premiums per Member per Month

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

Table 3 shows the combined premium cost per member per month. This cost includes cost sharing as well as the premiums.[34]

Table 3—Premiums, Member Months and Members, through 2014[35]

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

[33] TSG analysis of Agency DeComp accounting data
[34] TSG committed to the carriers that it would not disclose proprietary claims information. This data comes directly from DHS, not from the carriers
[35] TSG analysis of DeComp accounting report. Members is a snapshot taken of the number of claims being paid to each carrier. Accumulated Member Months is the sum of snapshots of membership for each of the 12 months in 2014

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

Carrier Claims per Member per Month

Carriers paid a total of $603 million in claims through the end of 2014. These covered the 1.6 million member months. Thus, carriers paid claims at a rate PMPM of $382. Table 4 shows that this ranged widely between carriers from $339 to $459, based on claims as submitted to the BLR for the TSG assessment.

Table 4—Carrier PMPM Based on Claims[36]

	Member Months	Claims	PMPM based on Claims
Carrier 1	#	$	$389.64
Carrier 2	#	$	$339.66
Carrier 3	#	$	$459.22
Total	1,579,295	$603,283,865	$382.00

This claims-based PMPM compares to the average premium Medicaid pays of $484[37]. The ACA includes several provisions that changed the way private health insurance is regulated in an effort to provide better value to consumers and increase transparency.

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

The Medical Loss Ratio provision of the ACA requires most insurance companies to spend at least 80% of their premium income on health care claims and quality improvement, leaving the remaining 20% for administration, marketing, and profit[38]. The MLR threshold is higher for large group plans, which must spend at least 85% of premium dollars on health care and quality improvement.

[36] TSG analysis of member months from DeComp (see footnote above), Claims from carrier claims extracts obtained for the TSG assessment
[37] This paragraph and the following 2 are drawn liberally from Kaiser Family Foundation at: http://kff.org/health-reform/fact-sheet/explaining-health-care-reform-medical-loss-ratio-mlr/, viewed on August 12, 2015
[38] 85% for large company programs

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

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

The formula for Medical Loss Ratio is:

NUMERATOR: Medical Claims + Quality Improvement Expenditures
Divided by:
DENOMINATOR: Earned Premiums - Taxes, Licensing and Regulatory Fees[39]

Carriers will include in their federal reports many items outside the scope of the TSG research. However, as a simplification, Table 5 presents an approximation of MLR based simply on claims and premiums through the end of 2014.

It appears that the current ratio of claims to premiums is 79%, thus lower than the amount allowed under ACA. Thus it would appear that some carriers might need to make a refund payment to its customer, the State of Arkansas. Of course, 100% of that would accrue to CMS since the premiums are 100% matched. It is important to remember that MLR is a complicated calculation that takes into account factors such as carrier spending on quality improvement and taxes, items not included in the TSG analysis. For example, the Premium Tax (2.5%) factors into the calculation.

Table 5—Approximate Medical Loss Ratio by Carrier Claims[40]

	Member Months	Claims	Premiums	Approximate MLR
Carrier 1	1,172,978	$457,033,455	$535,963,758	85%
Carrier 2	337,403	$114,603,552	$196,095,108	58%
Carrier 3	68,914	$31,646,859	$32,404,755	98%
Total	1,579,295	$603,283,865	$764,463,621	79%

[39] Medical Loss Ratio Requirements Under the Patient Protection and Affordable Care Act (ACA): Issues for Congress, Congressional Research Service 7-5700, www.crs.gov R42735
[40] TSG analysis: Member Months and Premiums from the Agency DeComp, Claims from the carriers claims extracts provided for the TSG assessment

4.13.Claims by Place of Service

According to carrier claims analyzed by TSG, 25% of claims paid on behalf of PO members were for inpatient hospitals, 19% for outpatient hospitals and 10% for emergency room services (Table 6). That is, 54% of PO claims are paid to hospitals. Physician offices received 20% of claims paid. This raises a question about the PO's effectiveness in moving patients from hospital and ER into the physician's office.[41] Pharmacy costs are 16% of carrier claims.

Table 6—Carrier Claims by Place of Service, 2014[42]

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

Claims by Provider

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

The largest providers by payment amount are listed in Table 7. These amounts are approximate since TSG cannot be certain that carriers have grouped providers' subsidiaries in a comparable manner. Note that according to agreement with carriers, details of payment by provider is confidential. Table 7 shows the wide dispersion of payments—that no one provider accounts for more than 4% of total claims paid.

[41] To pursue this question, TSG considers in this report the use of ED and the elapsed time before newly eligible Private Option beneficiaries visit a PCP
[42] TSG analysis of claims according to the carriers extracts provided for the TSG assessment

Table 7—Top providers by amount claimed[43]

	Amount	Percent of Carrier Claims
UAMS-UNIV AR MED HOSPITAL	21,696,573	3.6%
BAPTIST HEALTH MED CTR LITTLE ROCK	19,567,107	3.2%
ST BERNARDS MEDICAL CENTER	14,509,431	2.4%
ST VINCENT INFIRMARY MEDICAL CENTER	13,187,430	2.2%
JEFFERSON REGI CENTER	9,696,803	1.6%
ST VINCENT HOSPITAL HOT SPRINGS	9,504,630	1.6%
WHITE RIVER MED CENTER	7,065,430	1.2%
NORTHWEST MED CTR WILLOW CREEK WOMEN	8,608,182	1.4%
WHITE COUNTY MEDICAL CENTER	5,204,544	0.9%
NATIONAL PARK MEDICAL CENTER	5,200,945	0.9%
SPARKS REG MEDICAL CNTR	6,596,580	1.1%
St. Mary's Regional Medical Center Inc.	5,193,998	0.9%
Washington Regional Medical Center	9,464,877	1.6%
Pharmaceuticals	98,173,400	16.3%
Other	369,613,934	61.3%
Total	603,283,865	100.0%

4.14. Claims by Diagnosis

Reviewing DHS costs by diagnosis type reveals an important difference between the PO and FFS populations (Table 8). TSG found that behavioral health, psychiatric and disabilities comprise the largest share of traditional Medicaid. TSG analyzed the claims of each claim according to primary diagnosis. No individual diagnosis is significant to the TSG assessment. However, we observe that the most prevalent diagnoses are for physical conditions. This compares to traditional Medicaid, for which a substantial portion of the most frequent diagnoses are depression, Alzheimer's, Parkinson's, bipolar disorder, autism or similar behavioral conditions. It is important to note that DHS covers the disabled and medically frail populations.

[43] TSG analysis of claims according to the carriers extracts provided for the TSG assessment

Table 8—Carrier claims by largest diagnoses[44]

ICD-9	Description	Total
41401	Coronary atherosclerosis of native	9,117,395
78650	Chest pain, unspecified	7,637,595
389	Unspecified septicemia	5,806,359
7242	Lumbago	5,278,591
V5811	Encounter for antineoplastic chemot	5,102,586
4019	Abdominal pain, unspecified site	4,508,217
78900	Diabetes mellitus without mention o	4,326,602
25000	Headache	3,766,641
32723	Localized osteoarthrosis not specif	3,551,703
57410	Excessive or frequent menstruation	3,385,758
6262	Special screening for malignant neo	3,370,822
V7651	Major depressive disorder, recurren	3,338,145
65421	Obstructive sleep apnea (adult) (pe	3,262,556
78659	Lumbosacral spondylosis without mye	3,219,605
V5789	Chest pain, other	3,143,279
7213	Unspecified essential hypertension	3,083,427
7840	Other specified rehabilitation proc	2,986,069
2189	Degeneration of lumbar or lumbosacr	2,788,599
3051	Nonspecific (abnormal) findings on	2,665,403
486	Calculus of gallbladder with other	2,541,212
72252	Previous cesarean delivery, deliver	2,541,124
5990	Displacement of lumbar intervertebr	2,536,393
72210	Pneumonia, organism unspecified	2,500,637
311	Leiomyoma of uterus, unspecified	2,495,596
650	Malignant neoplasm of breast (femal	2,459,971
1749	Osteoarthrosis, unspecified whether	2,362,922
V700	Routine gynecological examination	2,345,017
3540	Normal delivery	2,334,827
V7231	Depressive disorder, not elsewhere	2,230,386
71946	Routine general medical examination	2,145,834
7295	Pain in joint, lower leg	2,103,077
71536	Urinary tract infection, site not s	2,100,584
6259	Carpal tunnel syndrome	2,068,805
7231	Essential hypertension, benign	2,060,375
30000	Bipolar I disorder, most recent epi	2,014,681
7245	Acute myocardial infarction, subend	2,004,990
Other Diagnoses		386,283,790
Pharmacy		98,173,400
Total		603,642,973

4.15.Access to New Providers

One stated objective of the HCIP is to increase access: to open up more providers to members of HCIP carrier plans than those members would have had access to, were they part of the traditional Medicaid program. It appears that HCIP is meeting that objective. Comparing providers is made difficult because carriers and DHS do not use consistent nomenclature. Each has unique provider numbers and names. This should be solved by using National Provider Identifier. However, TSG found that these were used inconsistently across the three payers.

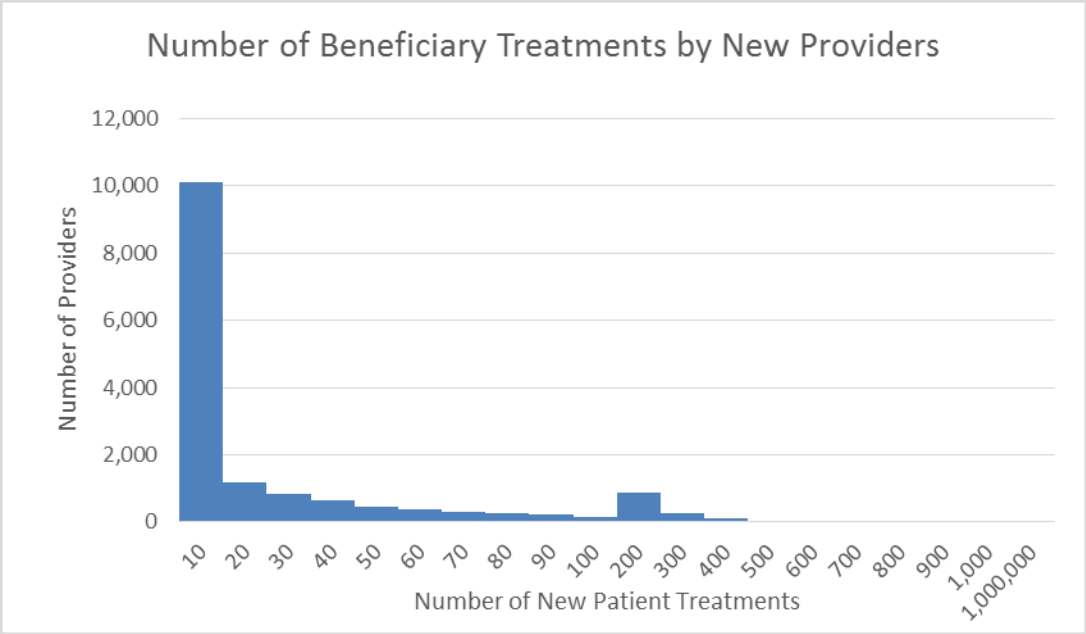
Notwithstanding the data issues, the evidence is strong that carriers have expanded the provider base. Carriers paid claims to 15,859[45] providers during 2014 (based on National Provider Identifier). In contrast, DHS paid FFS claims to 6,409 providers. Of the providers paid by carriers, 9,450 were providers who had no FFS claims paid in 2014. Put another way, HCIP includes 9,450 more providers to the expansion population than traditional Medicaid offers. Most of those providers are individual physicians.

Figure 9 shows that 64% of the patient visits (10,000 beneficiaries) were to providers that saw fewer than 10 patients under HCIP—small providers. 90% of the patient visits to new providers were to providers who saw fewer than 90 HCIP patients during the year. Thus, the Program has opened up a large number of providers. (Note: the bump between 100 and 200 is because the scale changes). Figure 9 and Table 9 show the 20 largest new providers (providers for which DHS paid no claims). Most of even the largest new providers are individual physicians.

[44] TSG analysis of claims according to the carriers extracts provided for the TSG assessment

[45] Numbers are quoted with precision even though TSG has observed that there are inconsistencies which suggest they are somewhat inaccurate. Nothing TSG has seen would suggest data inaccuracies in this regard detract from the finding. For example the carriers each paid claims to ARKANSAS METHODIST HOSPITAL, which is the same as DHS' ARKANSAS METHODIST MEDICAL CENTER. However, it is beyond the scope of this project to manually reconcile tens of thousands of names

Figure 9—Patients Served by New Providers[46]



[46] TSG analysis of claims according to the carriers extracts provided for the TSG assessment

Table 9—Largest New Providers[47]

NPI	Provider	New Claims Amount	Number of New Beneficiaries	Average per Beneficiary
1003144486		726,225	8,510	85
1679746622		257,504	4,541	57
1902809940		373,843	4,107	91
1497966808		545,680	4,023	136
1548370745		268,404	3,218	83
1154383636		190,110	3,083	62
1760676860		32,391	2,204	15
1962478180		1,818,588	1,892	961
1295959450		321,687	1,796	179
1780651117		255,509	1,764	145
1154489524		61,443	1,737	35
1033171467		147,410	1,667	88
1598866105		194,229	1,619	120
1487692695		38,151	1,554	25
1548206709		40,614	1,498	27
1265484646		61,821	1,482	42
1447296801		48,759	1,434	34
1144268178		52,813	1,430	37
1164508883		42,868	1,377	31
1386614097		426,868	1,344	318
1679527642		79,478	1,330	60

4.16. Time to First Primary Care Physician Visit

TSG sought to establish whether PO carriers were improving care by getting newly eligible members to visit a PCP soon after becoming a member. The objective is that new members are able to get connected to care in a physician's office rather than depending on the ER for their care. The expectation is that within the first month or so new members get established with a PCP.

Using claims data from the carriers, TSG was able to establish how long before each new member saw a physician. To study this question TSG looked at the initial eligibility date of each member. Once TSG established the initial data of eligibility, it also found the first doctor visit.

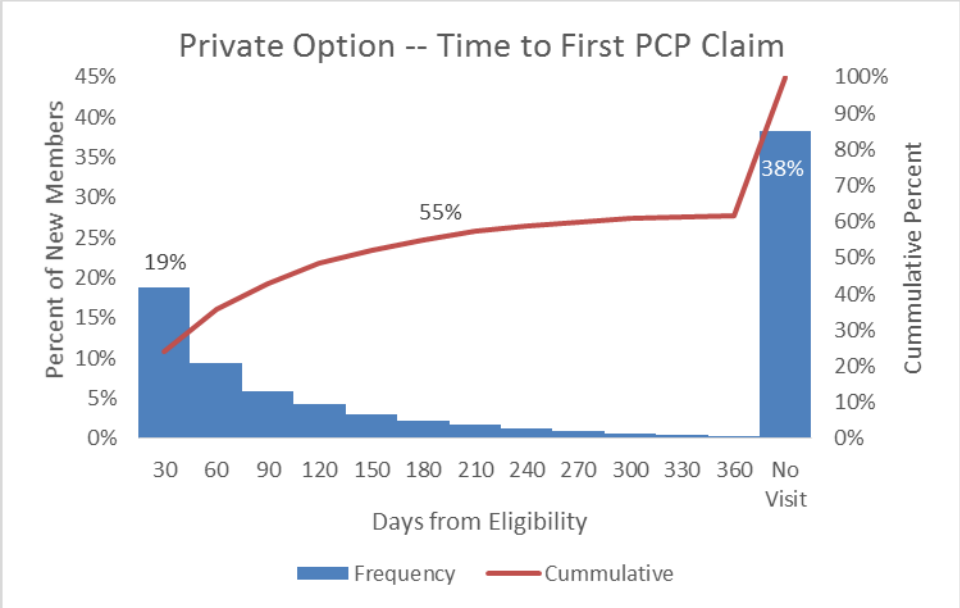
[47] TSG analysis of claims according to the carriers extracts provided for the TSG assessment

There is no doctor specialty "PCP". There is no procedure code specifically for a PCP visit. Therefore, TSG made the simplifying assumption that a first PCP visit is represented by a claim for an office visit of any type with an MD of any specialty. TSG's method makes a narrow assumption that only doctor visits in an office count as a PCP visit. TSG compared the eligibility date to the date of the first claim coded as a physician visit at an office (i.e. not at a hospital, ER or other institution). As with all its claims analysis, TSG used data provided by PO carriers covering services in 2014.

TSG found that many new members did visit a PCP within the first few months. However, many more did not. Figure 10 shows the number of new members that had a claim in a physician office in the first 30, 60, 90 days, and so forth.

Figure 10 shows that 38% of PO members had not had a claim for a visit to a physician in an office by the end of 2014. For those that had had an office visit, 19% visited within the first 30 days (first bar in the chart), and 55% within the first 6 months (the line, at 180 days). Thus, TSG found that 62% of PO members had seen an MD in an office before the end of 2014. For those members who did see a PCP, the average time to first office visit was 72 days.

Figure 10—PO members—time to first PCP visit



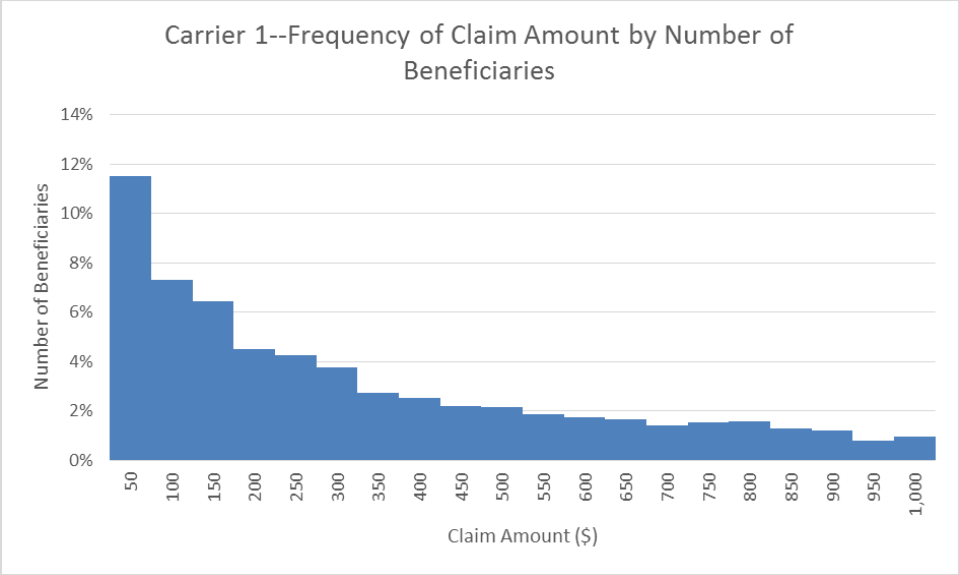
TSG thus finds that the PO has had moderate success in getting new members into a PCP's office. TSG understands that getting established with a PCP is a foundation of improving use of the healthcare system. TSG could interpret its findings in one of two ways. It could be that the new members are simply not in need of medical care—and chose to wait until they have a need before visiting a PCP. That would not be consistent with the notion that a PCP can guide the

member to help chart a course of health management—for staying out of the hospital. Another way to interpret the data is that these members are new to the paid healthcare system, and simply have a hard time getting used to the idea that they can now participate in preventative care and care management through a relationship with a PCP. In some cases they may not know how to find a PCP, or even have a strong desire to get linked up with one. Either way, TSG's findings are not aligned with its expectations that new PO members were getting quickly established with a PCP.

4.17.Claims by Size of Claim

Claims size is very long-tailed, meaning there are many claims for an amount less than $50. On the other hand, individual claims can also exceed $200,000. Figure 11 shows a histogram of one of the carriers' claim sizes. TSG observed that 12% of claims are less than $50 and 7% of claims are for amounts greater than $20,000. Each provider had outlier claims in the hundreds of thousands. TSG reviewed this for each of the carriers, and presents only one since the picture is quite similar across carriers.

Figure 11—Frequency distribution of claims by size of claim[48]

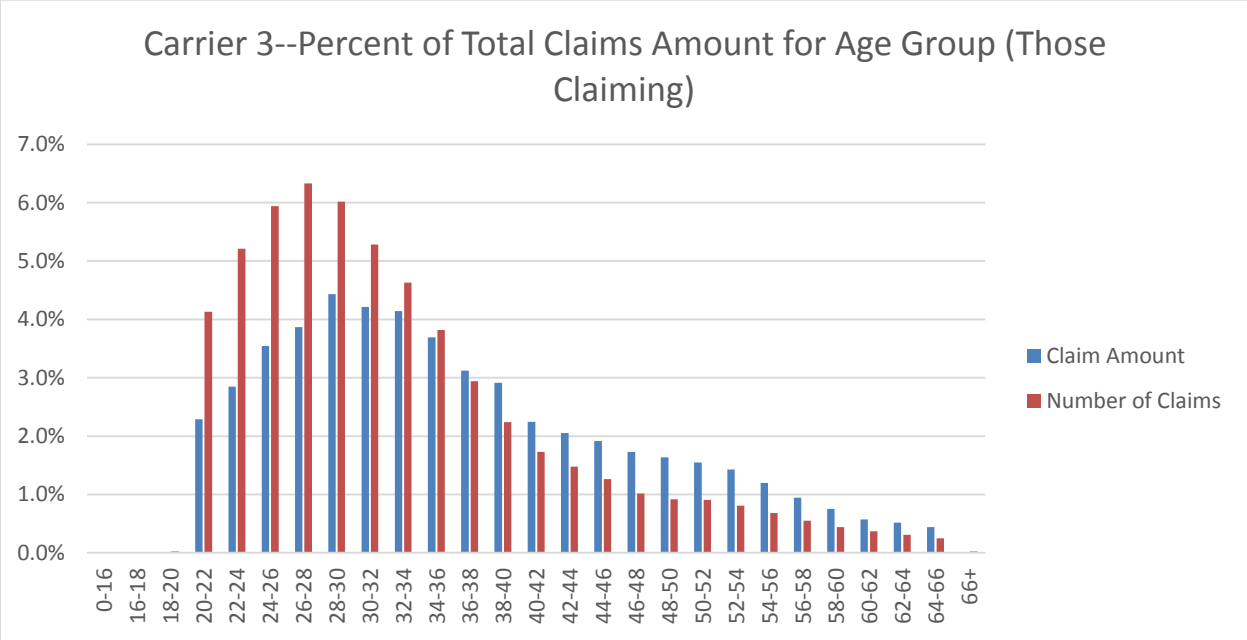


[48] TSG analysis of claims according to the carriers extracts provided for the TSG assessment

4.18.Claims by Age

Carriers demonstrated a similar pattern number of claims by age of beneficiary. Figure 12 shows the age distribution of Carrier 3. 46.6% of beneficiaries are less than 40 years old. Only 4.3% of the carrier's beneficiaries are over 50 years old.

Figure 12—Age distribution—by percent of beneficiaries and claims amount[49]



The pattern is similar when looking at claim amounts by age. Figure 13 shows after a modal age of 30, claims amounts are higher by percent than number of beneficiaries. Figure 14 shows that the carriers serve a much different population (by age) compared to traditional FFS Medicaid.

[49] TSG analysis of claims and members according to the carriers extracts provided for the TSG assessment

Figure 13—Average claim amount by age[50] [69]

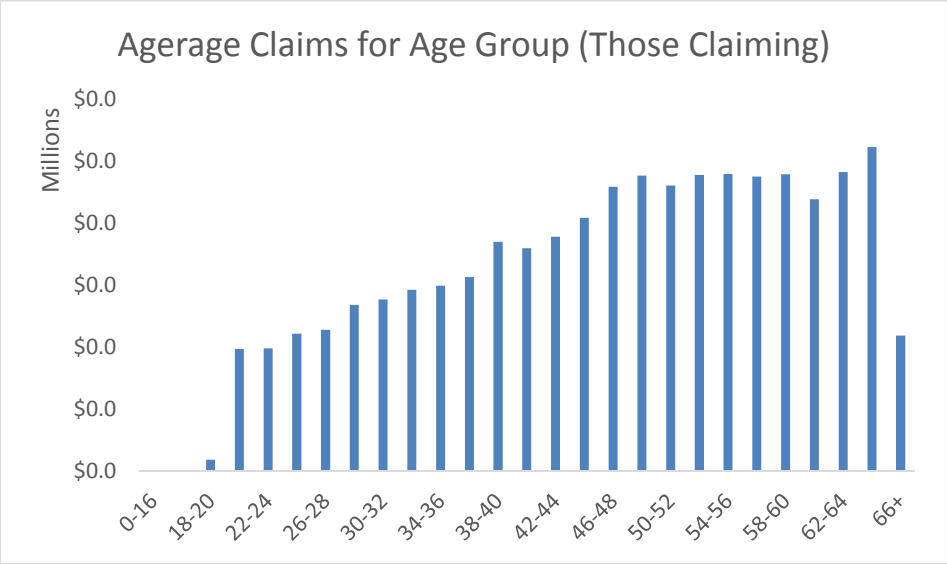
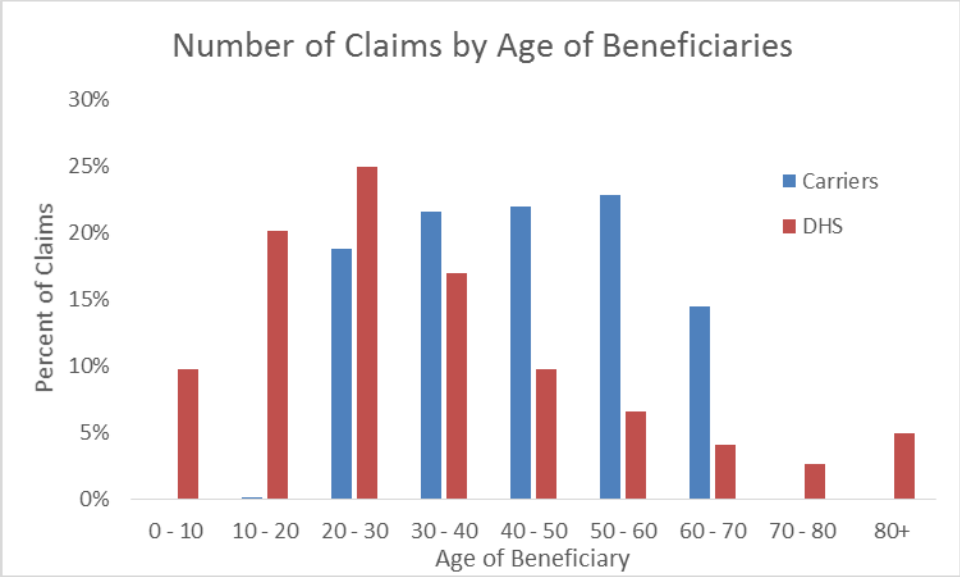


Figure 14—Claims by Age—Comparing FFS to HCIP



[50] TSG analysis of claims and members according to the carriers extracts provided for the TSG assessment

4.19.Special Assessment: Emergency Room Usage

A key objective of ACA and the PO is to reduce the use of unnecessary ED (or "ER") by appropriate use of a PCPs. Accordingly, TSG considered the impact of recent changes on the use of ER.

The National Picture

The federal Centers for Disease Control (CDC) is one group on record suggesting the need for ACA to reduce unnecessary ED use. Before ACA, the CDC reported the results of a survey suggesting poor use of ED. That survey reported that among adults aged 18–64 whose last hospital visit in the previous 12 months did not result in hospital admission[51]:

- 79.7% visited the emergency room for reasons reflecting lack of access to other providers, significantly more than the 66.0% of adults who visited because of seriousness of the medical problem[52]
- Only 54.5% of patients believed that only a hospital could help. 48% said the reason they visited the ED was that the doctor's office was not open

Reports such as these led policymakers to believe that increasing access to PCPs would improve ER usage patterns.

According to some recent research, in the United States, emergency department (ED) visit rates have steadily increased for more than a decade, with an estimated 131 million ED visits in 2011[53]. The ED visit rate increase is double what would be expected from US population growth alone. Studies suggest that increasing rates are primarily the result of an increase in illness-related diagnoses and not of additional trauma-related injuries.[54][55] Lack of private health insurance is often associated with elevated rates of ED use. In particular, uninsured people and Medicaid patients demonstrate the greatest increase in rates of ED use, compared to patients with private insurance. Some studies suggest that Medicaid patients have experienced decreasing access to primary care, which may prompt them to use the ED as a main source of health care.

---

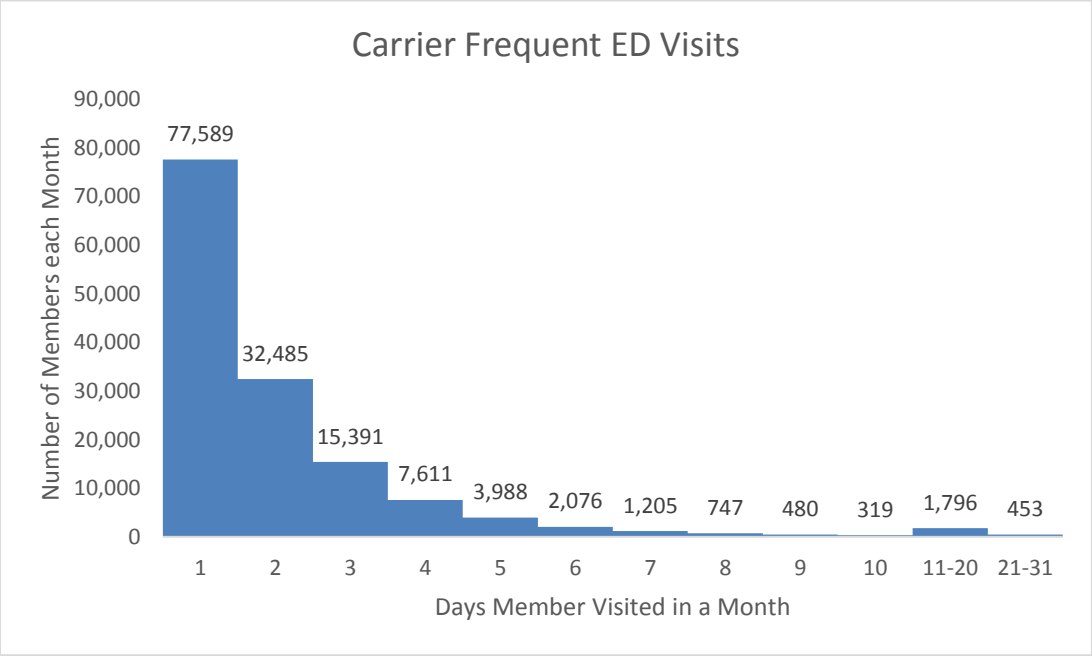
[51] http://www.cdc.gov/nchs/data/nhis/earlyrelease/emergency_room_use_january-june_2011.pdf viewed on August 6, 2015
[52] These reasons are not exclusive, so they do not sum to 100%
[53] Agency for Healthcare Research and Quality. Welcome to H-CUPnet [home page on the Internet]. Rockville (MD): AHRQ; [cited 2014 Jul 8]. Available from: http://hcupnet.ahrq.gov/
[54] Burt CW, McCaig LF. Trends in hospital emergency department utilization: United States, 1992–99. Vital H
[55] McCaig LF, Nawar EW. National Hospital Ambulatory Medical Care Survey: 2004 emergency department summary. Adv Data. 2006;(372): 1–29.

TSG conducted an assessment that considered the frequency by which PO beneficiaries use the Emergency Room (often called the Emergency Department or ED). To conduct the assessment, TSG had to determine what constituted an ED visit.

TSG endeavored to use end of service dates for claims in the ED. However, it found that various provider EDs submit claims over the course of several days—making a simple analysis seem to suggest that the individual was in the ED for 2-4 days in a row. While that is possible, it is generally not the case. To get around this, TSG considered a series of uninterrupted days of ED claims to be one actual ED visit. We applied this method to both traditional Medicaid and PO claims.

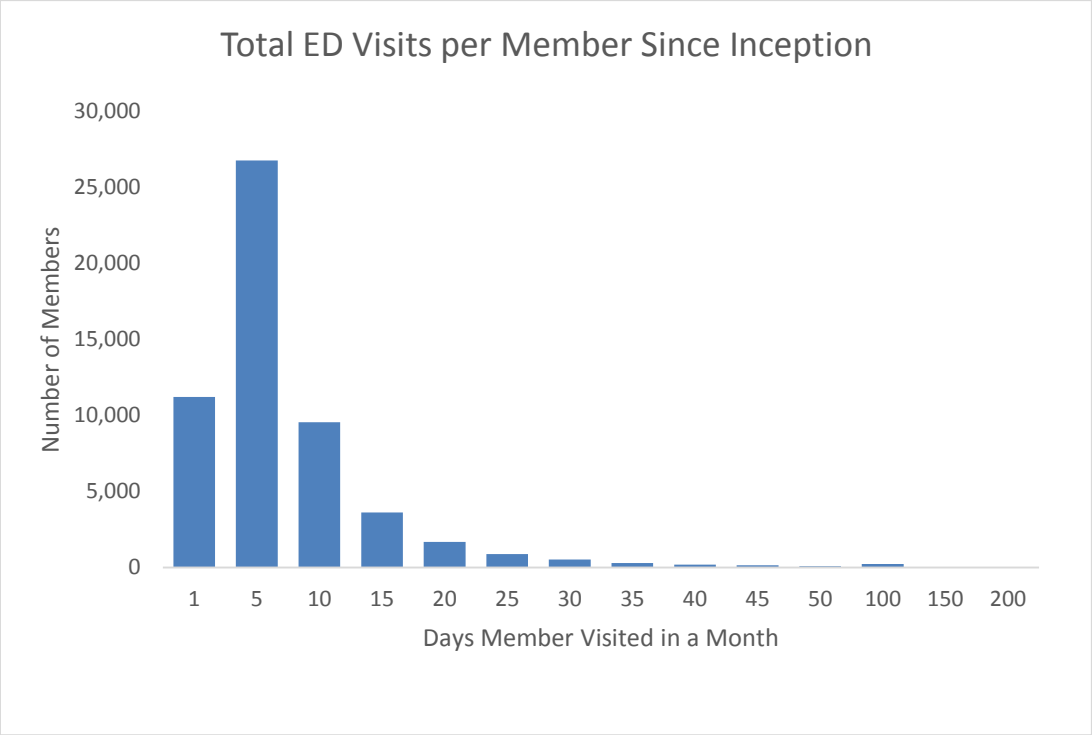
First, TSG looked at the PO, then at traditional Medicaid for comparison. The most important finding is that most PO members do not visit the ED. Only 55,000 members (27%) visited the ED anytime during calendar 2014. For those that did visit, TSG found a pattern of frequent visits (frequent flyers). Figure 15 shows that 77,589 times a PO beneficiary visited the ED only once in a month. In an additional 32,485 occasions a PO beneficiary visited a second time during the same month. TSG found that for PO beneficiaries that visited the ER, 36% of them visited at least 3 times in a month. Since only 27% ever visited the ED, that maps to 9% of total PO beneficiaries falling into a category of quite active ED use – more than 3 times in at least one month.

Figure 15—Number of repeat visits to the ED, PO



Looking across the whole of 2014, TSG considered how many PO beneficiaries visited the ER with what frequency. Figure 16 shows that 11,000 visited the ED once, 27,000 fewer than 5 times, and so forth. 8,000 beneficiaries visited the ED more than 10 times during the year.

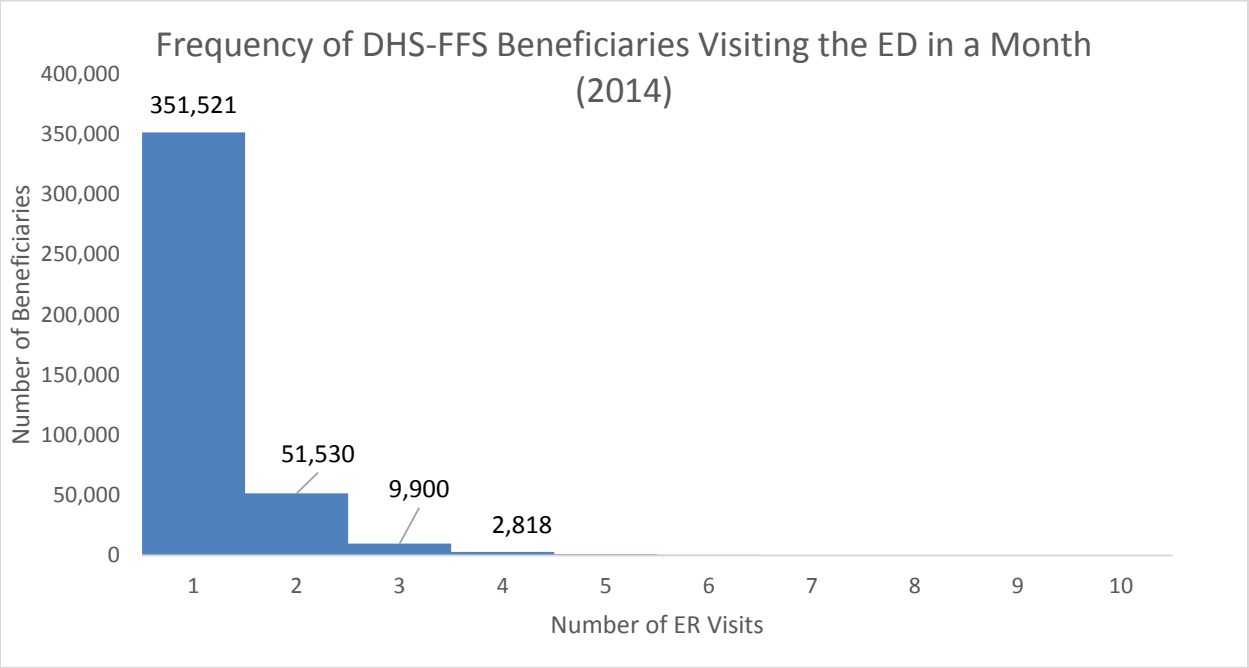
Figure 16—Frequency of total number of ED visits



In contrast, TSG found less frequent ED visits for traditional Medicaid. Figure 17 shows a distribution of visits for traditional Medicaid that has far fewer frequent visitors. One third of traditional Medicaid beneficiaries visited the ED at all—slightly higher than PO. On the other hand, very few visited more than once in a month.

TSG concludes from these findings that the PO is not yet achieving the goal of moving beneficiaries fully into using PCPs for access to the system—that many are still using the ED as their primary access point for healthcare

Figure 17—Number of repeat visits to the ED, traditional Medicaid



5. PRIVATE OPTION IMPACT ON STATE ECONOMY AND HEALTH CARE SECTOR

As shown in Table 10, the PO and several other components of the Affordable Care Act will influence the state economy and health care sector in significant ways. In the table below, the federal match for the PO is included to give a sense of the marginal federal funds associated with it. Over the five years, 2017-2021, the PO is projected to capture almost $9 billion in additional federal funds.

As noted in the previous section, the PO will also have an effect on the state budget due to some cost shifting from traditional Medicaid, with its 30% state share, to the PO, with a state share that increases over the period in question, but never goes above 10%. In addition, as a consequence of the PO, some direct spending on uncompensated care was removed from the state budget, and the state receives additional revenue through the premium tax. There are two budget impact projections included below, neither of which includes the macroeconomic effect of increased tax collections due to increased economic activity. The second also does not include the restoration of direct state appropriations for uncompensated care.

Table 10— Projected Aggregate PO Impact (SFY 2017-2021)

Projected Aggregate PO Impact (SFY 2017-2021)
(all figures millions $ unless otherwise indicated)

	2017	2018	2019	2020	2021	2017-2021
Federal match for PO[56]	1,678	1,720	1,799	1,862	1,937	8,996
Impact on state funds from removing PO (without macroeconomic effect)[57]	(89)	(39)	(21)	19	53	(78)
Impact on state funds from removing PO (without macroeconomic effect or restoration of state funded uncompensated care)[2]	(52)	0	19	61	98	125

The table also includes the projected impact of the PO on hospital uncompensated care. It is projected that, with the PO, hospitals will provide about $1.1 billion less in uncompensated care over the five years 2017-2021. Providers often suggest that they offset uncompensated care with higher rates to other payers, so lower levels of uncompensated care could lead to lower health insurance rates in the commercial market than might otherwise have been the case (Table 11).

Table 11—Impact on Hospital Uncompensated Care

Impact on Hospital Uncompensated Care

	2017	2018	2019	2020	2021	2017-2021
With PO[58]	135	141	148	156	164	744
Without PO[3]	329	345	362	380	400	1,816
Difference	194	204	214	225	236	1,072

In addition to the Affordable Care Act (ACA) authorizing significant federal funding for the expansion of Medicaid eligibility within each state, there were several other key provisions that were enacted that will have a significant fiscal impact on the Arkansas health care industry whether the PO is retained or not. Most significant among these additional ACA changes were the subsidies for individuals and small businesses for individuals between 138% and 400% of

[56] DHS/Optumas projections. Unpublished.
[57] TSG calculations based on DHS/Optumas projections.
[58] TSG calculations based on Arkansas Hospital Association survey data

FPL. These subsidies will account for an estimated $4.9 billion in additional federal funds coming into the state of Arkansas between 2017 and 2011. On the other side of the ledger, there will be a decrease in federal funds due to a medical device tax and decreased hospital payments through Medicare rate adjustments and the phase-out of the Medicare and Medicaid Disproportional Share Hospital (DSH) programs. These reductions in federal funding will result in a loss of approximately $10 billion of federal funds to the state of Arkansas between 2017 and 2021 (Table 12).

Table 12—Impacts of other ACA Changes

Impacts of other ACA Changes on Arkansas Health Care Providers[59]

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

(Numbers in parentheses are negative)

Finally, the presence of such a significant amount of additional federal funds in the state economy has an impact on the overall state economy, in terms of both GDP and jobs, as shown in Table 13. Between 2017 and 2021, it has been estimated that the PO will contribute an additional $3.2 billion to the state GDP and support over 6,000 jobs over that same period.

Table 13—Impact on Arkansas economy[60]

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

[59] TSG calculations based on CBO estimates.
Congressional Budget Office, letter to House Speaker John Boehner providing an estimate for H.R. 6079, repeal of Obamacare, July 24, 2012. As of December 21, 2012: http://www.cbo.gov/publication/43471
[60] RAND Corporation. *The Economic Impact of the ACA in Arkansas*. May 2014.
http://www.rand.org/content/dam/rand/pubs/research_reports/RR100/RR157/RAND_RR157.pdf

6. COMPARISON OF OTHER STATES' MEDICAID EXPANSION

As of this date 22 states plus the District of Columbia have expanded Medicaid through its traditional Medicaid program. Seven states, like Arkansas, have expanded Medicaid through waiver authority. Twenty one states have not expanded Medicaid under the ACA.

Premiums

CMS allows states to charge limited premiums for expansion population up to 2% of income. Other than in Arkansas, CMS has allowed 2% of income for those between 101% of FPL and 138% of FPL in Indiana, Michigan and Pennsylvania.[61] For incomes at 100% FPL and below, CMS has allowed charging $5 a month for a premium, but has not allowed a penalty for non-payment. CMS has also allowed individuals up to 100 % FPL to be charged 2% of income or $1.00 whichever is greater for an enhanced benefit package, or Medicaid level co-pays for a smaller package. The State of Iowa has requested charging 3% premium for 50 to 100% FPL but has not yet been approved. Indian's request to charge 2% FPL from 0 to 100% has also not been approved.

CMS has allowed states to condition coverage on payment of premiums, and has allowed states to require individuals to pay premiums before enrolling. In Indiana, CMS has permitted a six month lockout period for individuals who do not pay their premiums after a 60 day notice period. In Arkansas, Iowa, Michigan and Pennsylvania, CMS has approved these states as using uncollected premiums as a state Collectable debt.

Cost Sharing

States are charging co-payments consistent with Medicaid law. Some states use pre-paid accounts for cost sharing. CMS also allows states to incentivize healthy behaviors by forgiving co-pays and/or premiums. In Arkansas, monthly premiums are based on income paid into the Health Independence Accounts. These accounts are fully funded by the state and premium contributions are used to pay co-pays at the point of service, unless the enrollee fails to pay premiums, at which point he or she must pay out of pocket for co-pays approved at Medicaid levels.[62]

In Michigan, there is no cost sharing for the first 6 months but starting in month 7, the enrollee has monthly pre-paid cost sharing, based on pro-rated cost–sharing experience of the first 6 months. Thereafter, cost-sharing payments are adjusted up to the Medicaid law limit. Cost sharing payments are distributed to providers.[63]

---

[61] See Families USA at: http://familiesusa.org/product/state-medicaid-expansion-waivers
[62] Ibid
[63] Ibid

In Indiana, the monthly premium based on income is paid into an individual account. The individual account, called POWER account funds, are used to pay for the first $2500 in claims. Claims beyond that are fully covered by Medicaid managed care. In Indiana, there is a two year demonstration allowing cost sharing for non-emergency use of ER exceeding Medicaid limits that has been approved by CMS.[64]

Connecting to Work

States are pursuing ways to connect newly eligible adults to job search and to job training programs, but CMS has never permitted work or work engagement as a condition of eligibility. In fact, during a recent visit to meet with Federal HHS Secretary Sylvia Burwell, the Secretary reiterated this point.

Benefits and Coverage

CMS has allowed states to waive the requirements of reimbursement for non-emergency medical transportation, but they have not allowed states to waive Early and Periodic Screening and Diagnosis. CMS has granted limited waivers of retroactive coverage.

Summary Highlights of Selected State Expansion Waivers

Indiana

- Premiums contributions mandatory for incomes above 100% FPL
- Failure to make contributions - after 60 day notice you are locked out of program for 6 months
- Up to $25 co-payment for non-emergency use of ER
- If you are less than 100% FPL and you fail to make contributions to the POWER account maximum cost share applies
- No retroactive coverage
- Healthy behavior incentives
- Employment-related provisions – state refers individual to job training

Michigan

- Mandatory Premium for 100% FPL or more (2% of income)
- Failure to make contribution results in debt to state

Pennsylvania

- $8 co-payment for non-emergent use of ER (above 100% FPL)

[64] See more at: http://familiesusa.org/product/state-medicaid-expansion-waivers#table

- Incentives for work programs

Iowa

- $8 co-payment for non-emergent use of ER (above 100% FPL)

NH

- No Retroactive coverage
- State refers unemployed to Employment Department

Iowa

- Exclusively managed care for all of Medicaid, including newly eligible (former plan up to 100% FPL)
- Premiums of $10/month for 101% to 138% FPL
- Premiums of $5/month for 50% to 100% FPL after one year
- Complete wellness exam and health risk assessment, premiums waived

Montana Health Livelihood Partnership Act (pending)

- If 100% FPL and under and fail to pay premium – income tax offset
- 101% to 138% FPL and fail to pay premium - voluntary disenrollment after 90 days and income tax offset unless exempted
- Reenrollment upon payment of total debt
- Maximum co-payments allowed by law
- Co-payments not applicable to preventative health care, generic drugs and immunizations
- Work requirement as condition of eligibility (note: CMS has indicated to other states, including Arkansas, that this provision will not be approved)
- Asset Test – If assets over limit you pay a premium of $100 per month and $4/month for each $1000 over asset limit

Tennessee proposal

- Premium Assistance through Employer Sponsored Health Care
- Defined Contribution set by State
- Employer must cover 51% of costs
- Cost sharing requirements are waived
- Wraparound requirements are waived
- Waiver of retroactive eligibility
- Fully aligned with Managed Care Plans
- Premiums 2 % income for 101 to 138% FPL

- Non-payment of premium results in disenrollment after 60 day
- Co-pays are $75 per inpatient admission; $4 per outpatient service; $8 for non-emergent use ER and $1.50 for generics and $3.00 for brand prescription drugs

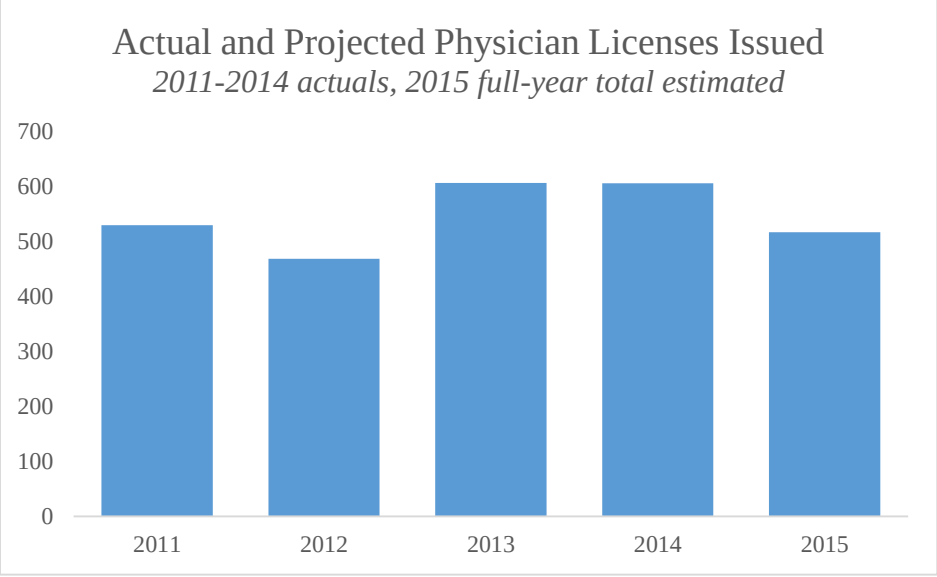
Finally, a few states have opt-out or exit clauses if the Federal government changes the funding relationship that is contained in current law. This allows these states to have the flexibility to change course if the finance arrangement changes and they are asked to devote additional funding through higher share of costs. For example, the law in New Hampshire states: "If at any time the federal match rate applied to medical assistance for newly eligible adults is less than (the current match rate)" the program "shall immediately be repealed …."

7. IMPACT OF THE HCIP ON RETENTION OF PHYSICIANS AND OTHER PROVIDERS

TSG conducted an examination of the impact of the health care independence program on retention of physicians and other ancillary health care providers in the state. The July interim report to the Task Force reviewed past studies that have been done on the health workforce in Arkansas, with a focus on physician workforce. As noted in that report, the past reports are not recent enough to provide insight into the question of whether the PO has created a more favorable environment for health workforce in Arkansas. Therefore, data on physician license applications received and licenses issued was requested and received from the Arkansas Medical Board.

Figure 18 shows the numbers of physician licenses issued.

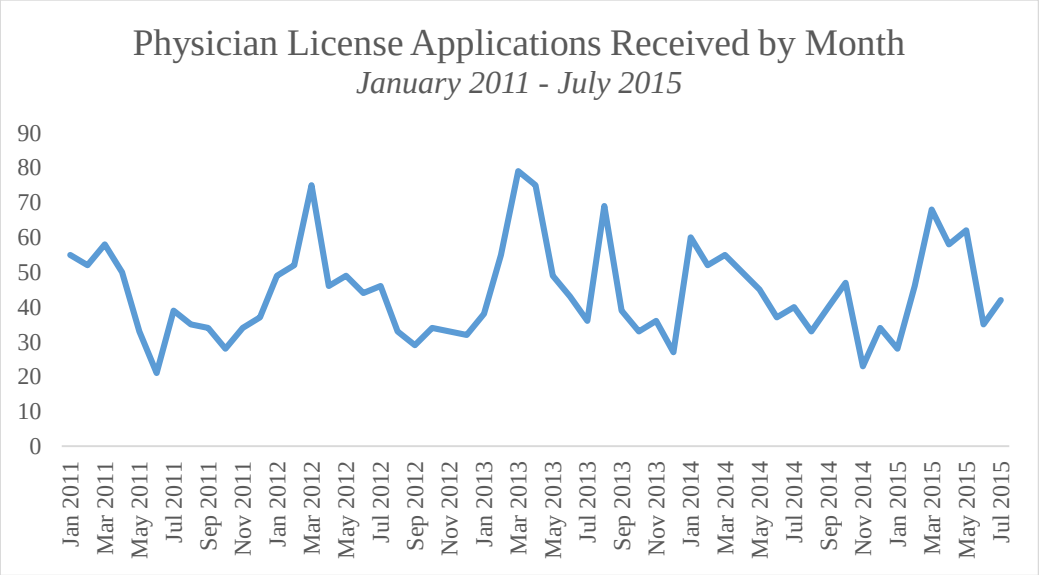
Figure 18—Actual and projected physician licenses issued, 2011-2014



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

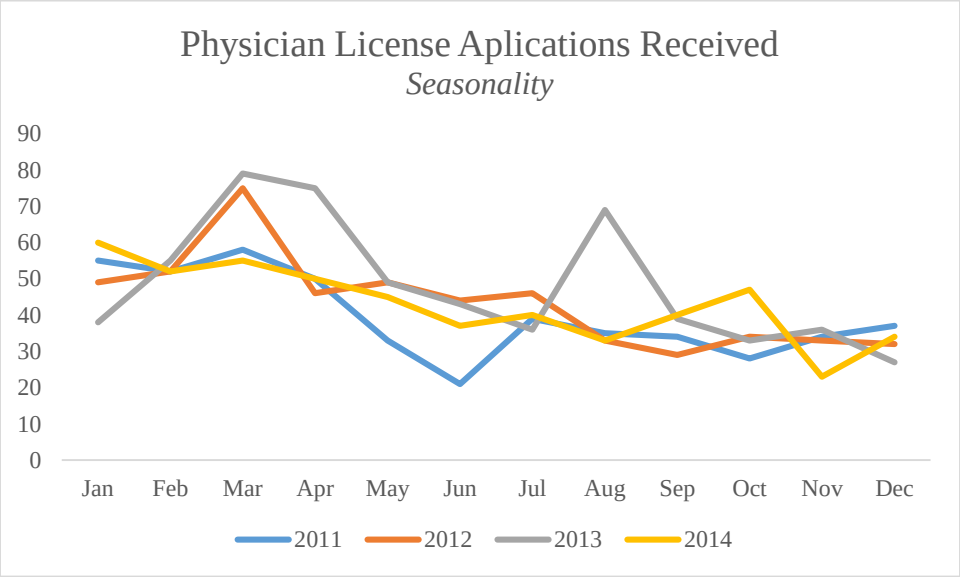
Figure 19 shows the number of license applications received by month, between January 2011 and July 2015.

Figure 19—Physician license applications received by month, 2011-2015



Although this data is more granular than the annual data, there still is no obvious change in the level or trend of the data around the time of the beginning of the PO in early 2014. This graph does suggest that the data exhibits seasonality – a repeating pattern that aligns with a time period, in this case the year. Graphing the multiple years on top of each other rather than in series shows that there are common trends across the years, but also reinforces the observation that there does not seem to be a discernible change in the pattern after the implementation of the PO (Figure 20).

Figure 20—Physician license applications received, comparison by month, 2011-2014



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

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

8. IMPACT OF THE HCIP ON HOSPITALS PERFORMANCE

TSG conducted an examination of the impact of the Health Care Independence Program on performance of hospitals within the state, including a comparison to performance of hospitals in states that do not have Medicaid expansion programs. As noted previously, Arkansas hospitals have experienced a decrease in the number of ER visits, admissions, and outpatient visits by uninsured Arkansans since the implementation of the PO, and a corresponding decrease in the amount of uncompensated care provided.[65] As was also previously noted, when comparing hospitals from national hospital systems between states that have expanded Medicaid and those

[65] Arkansas Hospital Association. Arkansas Private Option, Benefit to Arkansas Hospitals January 1 – December 31, 2014. Released: July 2015.

that have not, those hospitals in states that have expanded Medicaid eligibility provide a substantially smaller percentage of services to uninsured individuals.[66]

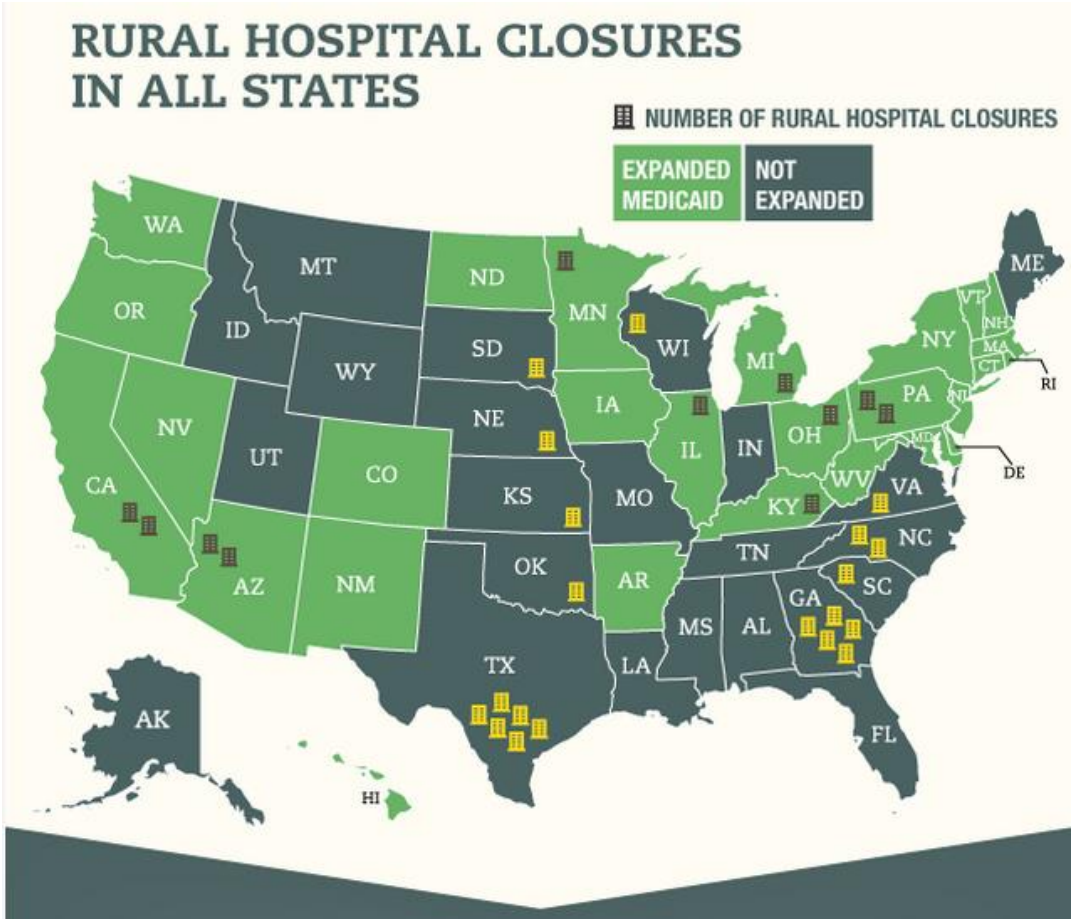
In addition, other studies of hospital performance comparing states that have expanded Medicaid and with those that have not find improved hospital financial performance in states that have expanded Medicaid. According to a study by Modern Healthcare, hospital bad debt grew more slowly in expansion states than in non-expansion states and hospital operating margins increased more in expansion states than in non-expansion states.[67]

A similar study by Moody's Investor Services came to similar conclusions.[68] Notably, hospital financial outlooks appear to be better across the board, not merely in expansion states, although the outlooks do seem to be better still in expansion states. One logical reason for better hospital performance, even in non-expansion states, might be due to the increase in health insurance coverage due to the subsidies for individuals and small businesses.

Finally, Figure 21 that there are more rural hospital closures occurring in states that have not expanded Medicaid:

[66] Robert Wood Johnson Foundation. The Impact of Medicaid Expansion on Uncompensated Care Costs: Early Results and Policy Implications for States. June 2015.
[67] Kutscher, Beth. Modern Healthcare. *Where Medicaid expansion matters: Small Illinois hospital expands while Missouri counterparts cut back*. June 2015. Available: http://www.modernhealthcare.com/article/20150606/MAGAZINE/306069979
[68] Kutscher, Beth. Modern Healthcare. *Outlook for not-for-profit hospitals gets first upgrade since 2008*. August 2015. Available: http://www.modernhealthcare.com/article/20150826/NEWS/150829911

Figure 21—US rural hospital closures



9. SHORT TERM AND LONG TERM IMPACTS OF PREMIUM ASSISTANCE

TSG conducted an examination of the short term and long term impacts of the use of premium assistance through the health care independence program on the private health insurance marketplace.

9.1. Carrier Competition

In 2014, the first year in which the public health insurance marketplaces were in operation, there were only 3 carriers offering health insurance in Arkansas on the marketplace, and only one selling statewide. In 2015, there were 4 carriers offering health insurance in Arkansas, all selling

statewide[69]. It has been reported that 6 carriers have submitted proposals to offer coverage for 2016.[70]

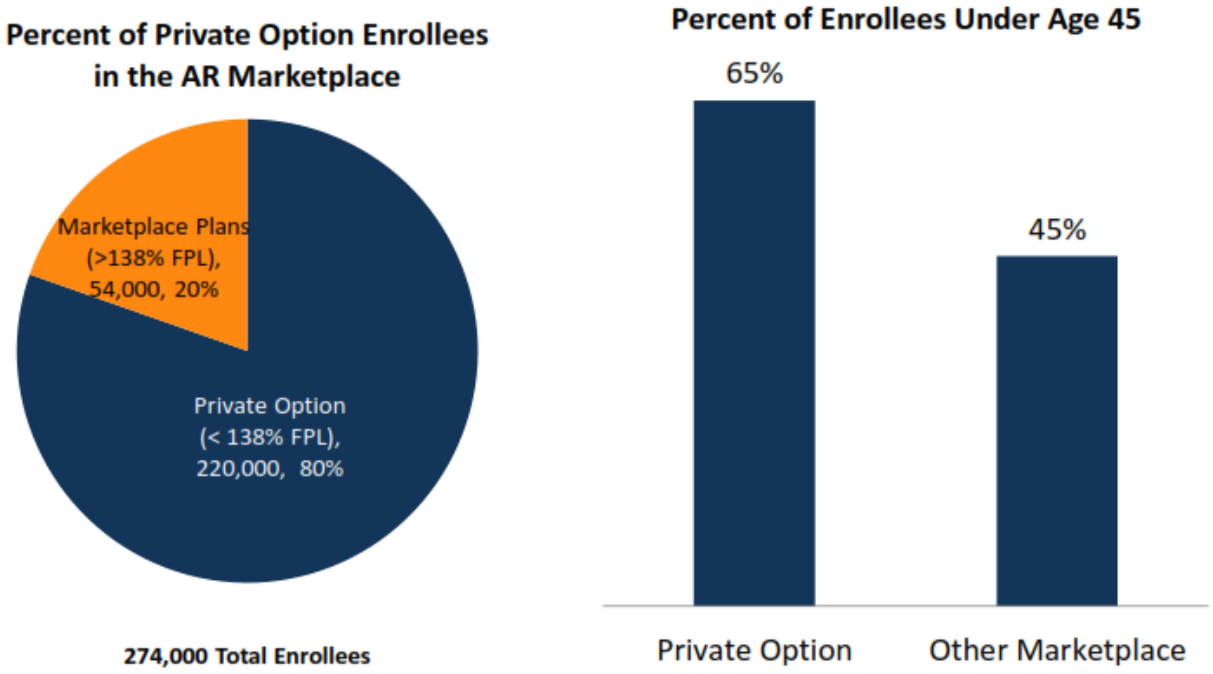
More recent multi-state analysis of those states for which 2016 marketplace plans have already been submitted to state insurance regulators shows that the number of carriers intending to participate in those states for 2016 is very similar to the level of carrier participation experienced in 2015.[71]

9.2. Actuarial Risk Pool

Individuals selecting health insurance through the marketplace via the PO are 80% of the total enrollment in the individual marketplace in Arkansas.[72] Approximately 65% of those enrolling in the Arkansas marketplace through the PO are younger than 45 years old, compared to 45% of those enrolling in the Arkansas marketplace (Figure 23). The population enrolling through the PO is a younger group, and likely healthier and lower cost.

[69]TSG analysis of FFM QHP data: https://www.healthcare.gov/health-plan-information/
[70] See http://kff.org/medicaid/issue-brief/a-look-at-the-private-option-in-arkansas/
[71] TSG analysis of data from KFF: http://kff.org/health-reform/issue-brief/analysis-of-2016-premium-changes-and-insurer-participation-in-the-affordable-care-acts-health-insurance-marketplaces/
[72] See http://kff.org/medicaid/issue-brief/a-look-at-the-private-option-in-arkansas/

Figure 22—Marketplace and PO Enrollees



Source: Kaiser Family Foundation. A Look at the PO in Arkansas.[73]

9.3. Marketplace Costs

A typical way to compare the costs of marketplace plans across states is by comparing the costs of the second-lowest cost silver plan for a particular kind of enrollee between specific large markets in each state, shown in Table 14. Between 2014 and 2015, while there was a significant amount of variation in the prices of the second-lowest cost silver plans across the states, there was virtually no change in the average cost of the second-lowest cost silver plans nationally for a 40 year old non-smoker. (Mathematically, the average national cost of the second-lowest cost silver plan dropped by about one half of one percent between 2014 and 2015.) The price for the second-lowest cost silver plan in Arkansas dropped by 2.3% between 2014 and 2015.[74]

[73] http://kff.org/medicaid/issue-brief/a-look-at-the-private-option-in-arkansas/
[74] http://kff.org/health-reform/issue-brief/analysis-of-2015-premium-changes-in-the-affordable-care-acts-health-insurance-marketplaces/

Table 14—PO monthly premiums for a 40 year old non-smoker - second lowest cost silver plan

	Monthly Premiums for a 40 Year Old Non-Smoker - Second Lowest Cost Silver Plan			
State	**Major City**	**2014**	**2015**	**% change from 2014**
Alabama	Birmingham	258	264	2.5%
Alaska	Anchorage	433	547	26.3%
Arizona	Phoenix	197	177	-10.0%
Arkansas	Little Rock	306	299	-2.3%
California	Los Angeles	255	257	0.8%
Colorado	Denver	250	211	-15.6%
Connecticut	Hartford	328	312	-5.0%
Delaware	Wilmington	289	301	4.1%
DC	Washington	242	242	-0.2%
Florida	Miami	269	274	1.8%
Georgia	Atlanta	251	255	1.8%
Hawaii	Honolulu	183	200	9.3%
Idaho	Boise	231	210	-9.3%
Illinois	Chicago	212	215	1.6%
Indiana	Indianapolis	354	329	-7.0%
Iowa	Cedar Rapids	255	246	-3.5%
Kansas	Wichita	224	218	-2.7%
Kentucky	Louisville	205	212	3.2%
Louisiana	New Orleans	311	296	-4.8%
Maine	Portland	295	282	-4.4%
Maryland	Baltimore	229	235	2.6%
Massachusetts	Boston	278	257	-7.5%
Michigan	Detroit	224	230	2.6%
Minnesota	Minneapolis	154	183	18.5%
Mississippi	Jackson	410	305	-25.5%
Missouri	St Louis	263	276	4.8%
Montana	Billings	258	241	-6.6%
Nebraska	Omaha	271	264	-2.6%
Nevada	Las Vegas	238	237	-0.6%
New Hampshire	Manchester	289	247	-14.6%
New Jersey	Newark	322	316	-1.9%
New Mexico	Albuquerque	194	171	-11.8%
New York	New York City	365	372	1.8%
North Carolina	Charlotte	307	326	6.4%
North Dakota	Fargo	271	272	0.3%
Ohio	Cleveland	249	247	-0.6%
Oklahoma	Oklah. City	201	219	8.8%
Oregon	Portland	201	213	6.1%

Pennsylvania	Philadelphia	300	268	-10.7%
Rhode Island	Providence	293	260	-11.2%
South Carolina	Columbia	269	276	2.7%
South Dakota	Sioux Falls	264	257	-2.8%
Tennessee	Nashville	188	203	7.8%
Texas	Houston	245	250	2.0%
Utah	Salt Lake City	209	215	2.7%
Vermont	Burlington	413	436	5.6%
Virginia	Richmond	253	260	2.7%
Washington	Seattle	281	254	-9.8%
West Virginia	Huntington	268	289	7.8%
Wisconsin	Milwaukee	315	333	5.7%
Wyoming	Cheyenne	395	407	3.1%

Source: Kaiser Family Foundation. Analysis of 2015 Premium Changes in the Affordable Care Act's Health Insurance Marketplaces.[75]

More recent analysis of those states for which proposed marketplace rates for 2016 have already been submitted to regulators suggests that rate changes from 2015 to 2016 may be higher than from 2014 to 2015. The marketplace rate changes from 2014 to 2015 for the second lowest cost silver plan were virtually flat, as averaged across the state, whereas the average rate change for the handful of states in which carriers have already filed their proposed rates shows a 4.5% growth, as averaged across those states.

The Arkansas Insurance Department recently approved the following rate changes for 2016 from 2015 rates for carriers offering individual coverage through the marketplace:

- Arkansas Blue Cross and Blue Shield – Increase of 7.15%
- Ambetter – Increase of 0.08%
- QualChoice – Decrease of 8.2%

9.4. Provider Payment Rates

There is no reliable, publicly available interstate or intrastate data on provider payment rates outside of public programs. There are, however, some frequently-used benchmarks that help to compare Medicaid rates to the rates used by other providers. Health care providers serving patients who are covered by commercial health insurance carriers through the PO will receive

[75]http://kff.org/health-reform/issue-brief/analysis-of-2015-premium-changes-in-the-affordable-care-acts-health-insurance-marketplaces/

payments for services that are consistent with, if not identical to, the payments they receive from the commercial payers for privately-insured patients who are not enrolled through the PO. Medicare payment rates are generally considered to be closer to commercial rates than Medicaid rates are.

The ratios between Medicaid and Medicare payment rates for each state were estimated by the Urban Institute in a 2012 study funded by the Kaiser Commission on Medicaid and the Uninsured using reasonable methods.[76] The Medicaid-to-Medicare fee index for all services in Arkansas was estimated to be 0.79; for primary care, 0.70; for obstetric care, 0.74; and for other services 1.11.

9.5. Health Care System Stability

Two measures of health care system stability will be assessed, both of which could reasonably be considered as 'canaries in the coal mine' due to their inherent economic fragility – physicians, who often practice in very small groups, and rural hospitals. As was previously noted in the case of physicians, there is not anything in the physician licensure trends to suggest that Arkansas is becoming a less attractive place to practice medicine. Similarly, as noted in the hospital section, while there have been a number of rural hospital closures in recent years in other states, the Arkansas hospital sector appears to be relatively strong and no rural hospitals in Arkansas have closed recently.

9.6. Federal Tax Credits for Individuals above 138% of the Federal Poverty Level

In addition to the provisions of the Affordable Care Act that affected state Medicaid programs, the ACA also established mechanisms for subsidizing the purchase of health insurance by individuals and certain small businesses. The total estimated inflow of federal funds to subsidize the purchase of health insurance by individuals and certain small businesses through health insurance exchanges is about $4.9 billion over the five years, 2017-2021.

[76] https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8398.pdf

Table 15— Estimated exchange subsidies for individuals and small employers

Estimated exchange subsidies for individuals and small employers[77] *($millions)*

2017	2018	2019	2020	2021	2017-2021
846	939	995	1,032	1,097	4,911

9.7. Client Outcomes

While it is still too soon to estimate the impact of the PO on client outcomes directly within the Arkansas context, findings from other states and programs can provide some indirect evidence of the likely impact of the PO on client outcomes in Arkansas.[78]

- Research by the Kaiser Family Foundation suggests that enrollment in Medicaid, as opposed to being uninsured, increases access to care, health care use, and self-reported health.[79]
- Research on the Oregon expansion of Medicaid prior to the ACA found that enrollment as part of the Medicaid expansion population increased the use of preventative services and nearly eliminated catastrophic out-of-pocket medical expenditures.[80] However, the study also indicated that there were no measurable health outcome differences between Medicaid and being uninsured.
- Mathematica Policy Research, Inc, identified numerous negative clinical outcomes associated with a lack of health insurance coverage, including lower immunization rates among children, greater risk of death when hospitalized as a child, higher rates of stroke and greater risk of related death, greater risk or missing work, and many others.[81]

[77] TSG calculations based on CBO estimates.
Congressional Budget Office, letter to House Speaker John Boehner providing an estimate for H.R. 6079, repeal of Obamacare, July 24, 2012. As of December 21, 2012: http://www.cbo.gov/publication/43471
[78] For further information, see: http://www.forbes.com/sites/theapothecary/2013/05/02/oregon-study-medicaid-had-no-significant-effect-on-health-outcomes-vs-being-uninsured/
[79] Kaiser Family Foundation. *What is Medicaid's Impact on Access to Care, Health Outcomes, and Quality of Care? Setting the Record Straight on the Evidence*. April 2013. Available: http://kff.org/report-section/what-is-medicaids-impact-on-access-to-care-health-outcomes-and-quality-of-care-setting-the-record-straight-on-the-evidence-issue-brief/
[80] Baicker K, Taubman SL, Allen HL, Bernstein M, Gruber JH, Newhouse JP, et al.: *The Oregon Experiment—Effects of Medicaid on clinical outcomes*. N Engl J Med. 2013, 368:1713-22
[81] Mathematica Policy Research, Inc. *How Does Insurance Coverage Improve Health Outcomes?* April 2010. Available: http://www.mathematica-mpr.com/~/media/publications/PDFs/health/reformhealthcare_ib1.pdf.

10. Review of Effectiveness of State Health Independence Account

Of the 45,839 cards issued, 10,806 have been activated. While there has been some fluctuation in the number of successful transactions over the last 6 months, the data do not show any substantial trend and the number of transactions over the last several months remains relatively steady around 4,000 transactions per month (Table 16).

Similarly, the number of contributions has fluctuated some, but appears to have stabilized around 2,500 per month. The call center activity has shown a consistent downward trend, with just under 1,200 calls in June, from a high of over 6,000 in January (Table 17).

Table 16—Call center activity

Month (all 2015)	Successful Transaction Count	Successful Transaction Amount	Contributions Count	Contribution Total
January	3907	$ 32,505.26	326	$ 3,613.00
February	4844	$ 42,432.00	3,114	$ 41,163.81
March	4284	$ 38,076.00	2,897	$ 39,355.75
April	3959	$ 34,090.00	2,765	$ 37,187.39
May	3749	$ 34,357.00	2,564	$ 34,041.65
June	4112	$ 37,308.00	2,480	$ 33,229.10
Total (year to date)	24,855	$ 218,768.26	14,146	$ 188,590.70

Table 17—Additional call center activity measures

Number of Cards Issued	45,839
Number of Cards Activated	10,806
Total Number of Participants Contributing	5,185

11. Uncompensated Care Analysis

The Arkansas Hospital Association conducted a survey of its membership in 2015 to gather information on uncompensated care costs, among other things. The survey requested data for 2013 (before the PO) and 2014. As shown in Table 18, admissions, ER visits, and outpatient visits by uninsured residents all dropped significantly between 2013 and 2014.

Table 18— Key findings regarding uninsured volumes

	Admissions	ER Visits	Outpatient Visits
2013	22,786	272,172	180,213
2014	11,698	166,604	97,801
Reduction	48.7%	38.8%	45.7%

These decreases in hospital uninsured volumes levels are consistent with decreases identified in a multi-state analysis that compared the changes in the percentages of uninsured at hospitals within national hospital systems between states that had done Medicaid expansions and those that had not.[82]

In addition, the amount of uncompensated care provided dropped significantly. Taking the difference between the levels of uncompensated care projected separately from the 2013 and 2014 levels at a 5% growth rate and aggregating the results over the next 5 years shows an estimated $1.1 billion less in uncompensated care being provided by Arkansas hospitals with the PO (Table 19).

Table 19— Projected Levels of Uncompensated Care Provided by Arkansas Hospitals ($ millions)

	2017	2018	2019	2020	2021	2017-2021
Without PO	329	345	362	380	400	1,816
With PO	135	141	148	156	164	744
Difference	194	204	214	225	236	1,072

12. IMPACT OF HCIP AND ITS TERMINATION

12.1. Impact on State Budget

The PO impacts the state budget in several different ways. The following table captures the projected impact on state funds of the PO. Table 20 makes the assumption that Arkansas would return its Medicaid program to its pre-PO status, reinstating populations moved into the higher reimbursement expansion eligible group and reestablishing uncompensated care payments that the State discontinued.

[82] Robert Wood Johnson Foundation. The Impact of Medicaid Expansion on Uncompensated Care Costs: Early Results and Policy Implications for States. June 2015.

Table 20—Projected aggregate PO impact (SFY 2017-2021)

Projected Aggregate Private Option Impact (SFY 2017-2021)							
(all figures millions $ unless otherwise indicated)							
		2017	2018	2019	2020	2021	2017-2021
Private option expenditures		1,721	1,820	1,924	2,035	2,152	9,652
Impact on State Funds							
Impact on state expenditures	**State match on Private Option**	43	100	125	173	215	656
	State fund savings from optional Medicaid waiver programs discontinued after the establishment of the PO	(22)	(23)	(25)	(26)	(27)	(123)
	State fund savings from cost-shifting from traditional Medicaid to PO	(39)	(41)	(43)	(45)	(47)	(214)
	Administrative costs	3	3	3	3	3	14
	Reductions in state fund outlays for uncompensated care	(37)	(39)	(41)	(43)	(45)	(203)
	Total impact on expenditures	**(52)**	**0**	**20**	**63**	**99**	**130**
Impact on state revenues	**Increase in premium tax revenue**	37	39	41	44	46	208
	Increase in collections from economically-sensitive taxes (4%)	67	69	72	74	77	360
	Total impact on revenues	**104**	**108**	**113**	**118**	**124**	**567**
Net impact on state funds		**156**	**108**	**93**	**56**	**25**	**438**

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

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

- ARHealthNetwork
- Family Planning
- Tuberculosis
- Breast and Cervical

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

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

- Medically needy
- Aged blind disabled
- SSI disability
- Pregnant women

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

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

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

The 'pregnant women' category is projected to see lower enrollment than would have otherwise been the case since some portion of the population of low-income women of child-bearing age will be enrolled in PO plans prior to getting pregnant. Once pregnant, if already covered under the PO, the women will remain enrolled in the PO plan, even though they would have historically become enrolled in traditional Medicaid.

In all of these cases, individuals who would otherwise have been enrolled in Medicaid become enrolled in the PO and their costs are covered at the higher federal matching rate.

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

The increase in collections from economically-sensitive taxes is the additional state taxes collected from the addition of new federal funds to the state economy. A typical approach to modeling the economic impact of new programs or investments is to apply a multiplier to the size of the anticipated expenditure, to capture the fact that some proportion of the new funds will be expended on local goods and services, and then the providers of those local goods and services will expend the received funds on other local goods and services, etc. In the calculations above, no multiplier is applied, which should result in a conservative estimate. Marginal tax revenues due to the additional federal expenditures are calculated as the total PO spending, less the state match, times a percentage factor representing a blended tax rate. In the calculations above, 4% is used as the blended tax rate, which compares favorably to the total forecast available general revenue for SFY 15 as a percentage of the SFY 15 forecast for all non-farm personal income ($5,150 million /$112.6 million=4.57%).

With those projections and assumptions, the total impact of the PO on state funds is projected to be positive for all years between 2017 and 2021, with an aggregate positive impact on state funds of $438 billion over those five years, assuming Arkansas does not return to pre-PO programming.

SECTION 2: FINDINGS SPECIFIC TO ARKANSAS' TRADITIONAL MEDICAID

13. MEDICAID BASIC FINANCIAL PICTURE

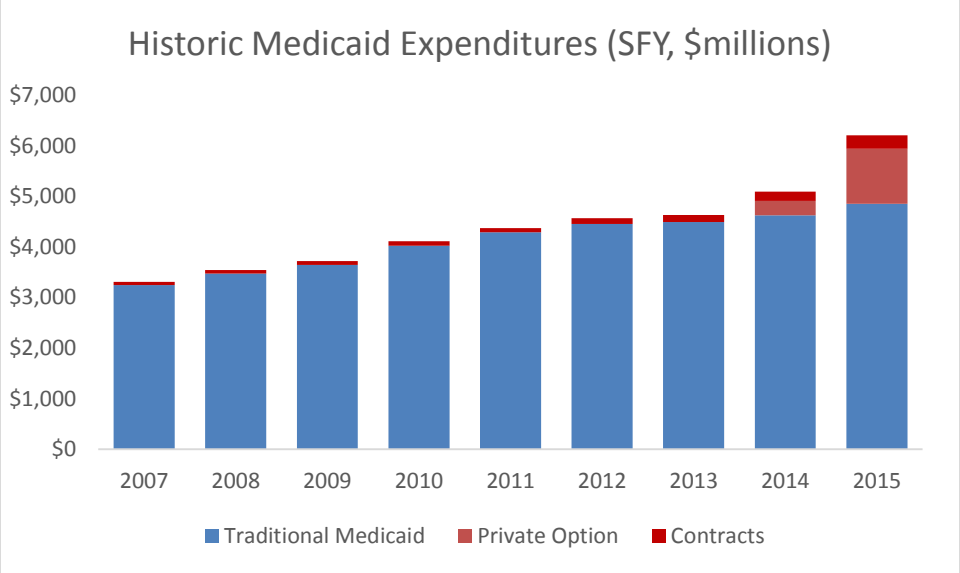
Medicaid in Arkansas can be characterized in two major groups: traditional Medicaid and the PO launched by the Health Care Innovation Act approved in 2013 and launched in 2014. Table 21 and Figure 21 show that Arkansas' total investment into Medicaid including the PO in 2015[83] was $6.2 billion.

[83] Note: most of the TSG report uses financial amounts and claims amounts incurred during Calendar 2014, because the project was conducted before SFY2015 ended. This Background is the only section that presents SFY2015 data

Table 21— Medicaid expenditures, SFY2007-2015 ($millions)[84]

($millions)	2007	2008	2009	2010	2011	2012	2013	2014	2015
Traditional Medicaid	3,244	3,473	3,644	4,025	4,289	4,456	4,493	4,627	4,855
PO	0	0	0	0	0	0	0	280	1,083
Contracts	65	69	80	88	81	112	140	183	269
Total	3,309	3,542	3,723	4,112	4,370	4,568	4,633	5,091	6,207

Figure 23—Medicaid and PO costs, 2007-2015[85] *($millions)*



In fiscal 2015, Medicaid invested 78% of the $6.2 billion total into traditional Medicaid and 17% into the PO. Fully 4% was used to retain outside contractors, which factor importantly into this TSG assessment.

Traditional Medicaid includes all the programs (largely Fee for Service) managed by the Department of Human Services before enactment of the HCIA. The PO includes the premium-based healthcare paid on behalf of the expansion population to three insurance companies as part of the HCIA. Medicaid contracts include several outside services providers not directly tied to

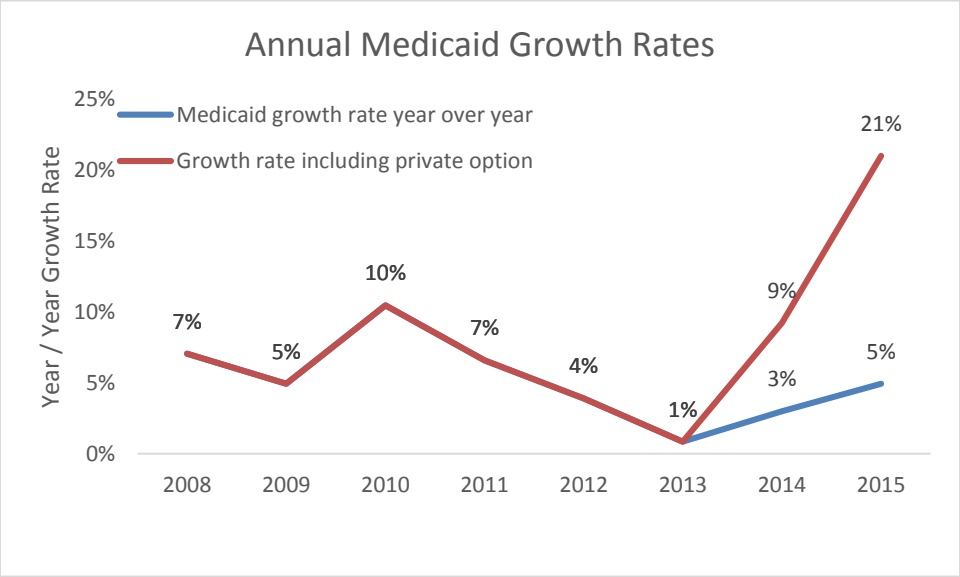
[84] TSG analysis of Agency accounting data presented in the DeComp report for 6/30/2015
[85] TSG analysis of Agency accounting data presented in the DeComp report for 6/30/2015

claims, including IT management and consultants that support development of the PCMH/Episodes of Care program.

13.1. Traditional Medicaid

Traditional Medicaid costs moderated from 2010 through 2012, then experienced modest resurgence. Figure 24 shows that the rate of Medicaid cost increase was significant in years 2008 through 2011, then slowed down until the introduction of the PO, as shown in Figure 24.

Figure 24 —Medicaid growth rates with and without the PO[86]



Non-Claims Payments are part of paying for medical care. They include various forms of payment to hospitals to adjust the amounts paid through individual claims. It is important to note that 16% of payments to all providers are made outside all the controls built into the MMIS claims processing system. Essentially, Medicaid pays hospitals through several processes outside the claims process. These have the implication that individual patient claims are more of an advancement on the final settlements payments. This report will delve deeper into this effect.

Traditional Medicaid provides various Categories of Service, as shown in Table 22. This demonstrates Medicaid's heavy focus on institutional (hospital and nursing home) care.

[86] TSG analysis of Agency accounting data presented in the DeComp report for 6/30/2015. The figure includes only medical costs, not contracts

Table 22—All Medicaid by Category of Service[87]

	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Hospital Services	425	892	995	1,020	1,262	1,353	1,419	1,473	1,561	1,680
Long Term Care	351	723	754	801	861	914	963	956	971	995
Mental Health	196	409	437	465	474	522	542	549	560	559
DD	170	355	372	398	430	466	494	496	517	541
Prescription Drug	174	334	358	364	341	336	355	351	373	442
Physician Services	136	274	280	286	297	306	294	295	307	343
Other Medical	66	131	141	159	173	187	197	208	213	232
Other Practitioners	24	79	88	102	127	130	148	144	149	162
Other	58	113	116	129	147	157	156	160	160	170
PO	0	0	0	0	0	0	0	0	280	1,083
Total	1,599	3,309	3,542	3,723	4,112	4,370	4,568	4,633	5,091	6,207

Medicaid largely serves the healthcare needs of high-risk, high-cost populations characterized as the "Aged, Blind and Disabled," or ABD. Table 23 shows calendar 2014 data so that it agrees with data used in the detailed analysis of ABD costs.

Table 23—Major Components of Traditional Medicaid, calendar 2014

	2014 Amount	Percent
Aged, Blind and Disabled		
Elderly	989,580,886	21%
Disabled	723,493,917	15%
Behavioral Health	464,686,509	10%
Other Medical Claims	1,845,685,703	38%
Non-Claims Payments	772,254,250	16%
Traditional Medicaid Claims	4,795,701,265	100%

(Note: later in this report TSG will present costs fully loaded with "halo effect," which will adjust these percentages, since the majority of the 'Other Medical Claims' costs actually represent medical costs for the elderly, and individuals with developmental disabled or severe and persistent mental illness.)

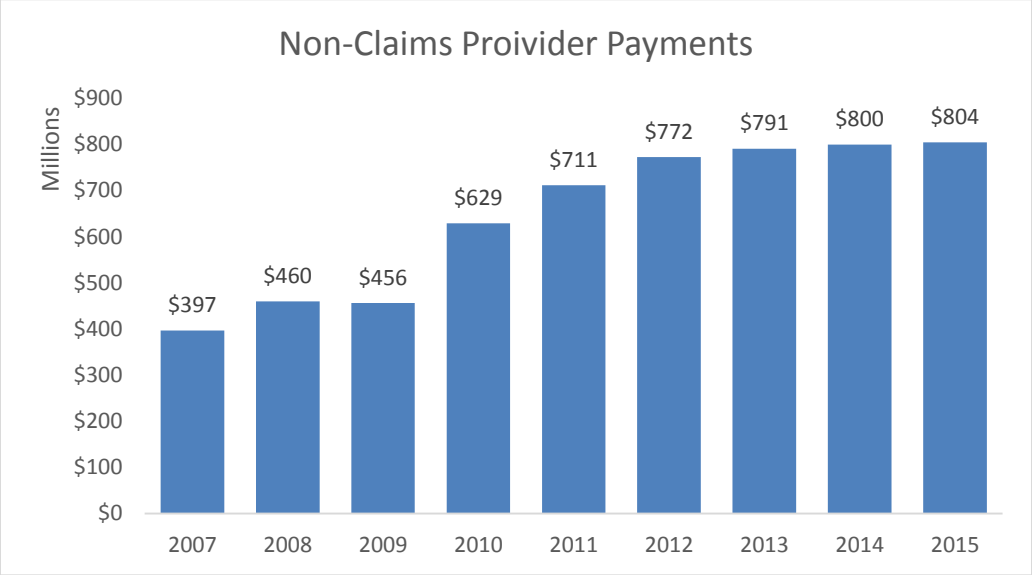
[87] TSG analysis of Agency accounting data presented in the DeComp report for 6/30/2015

Thus, while many previous analyses of Arkansas Medicaid have focused on costs other than for the Aged, Blind and Disabled, much of this TSG report will focus largely on the major elements of cost: the ABD population.

13.2.Payments other than Claims

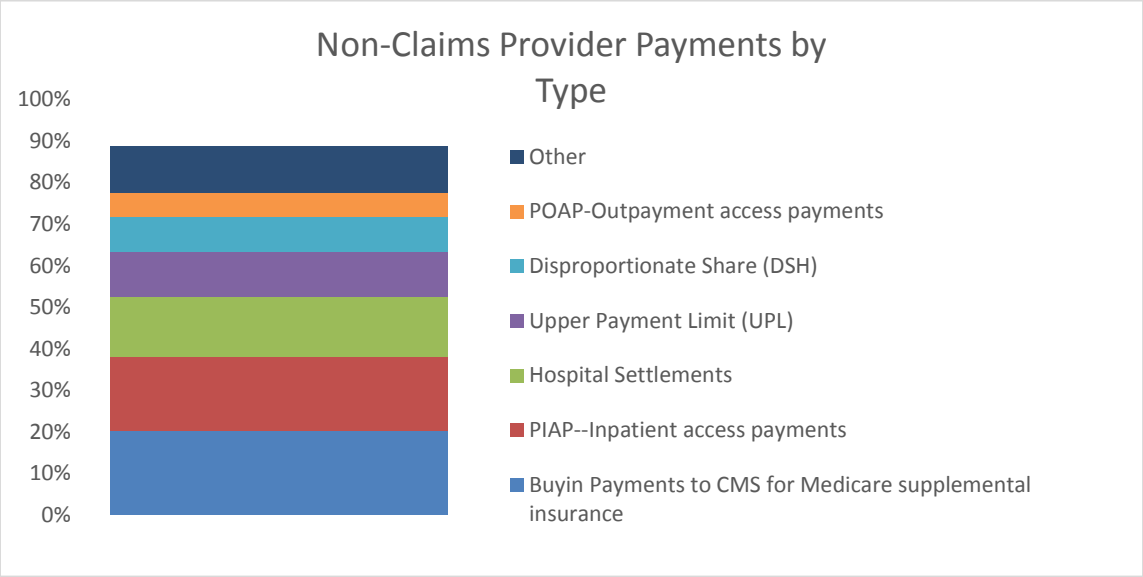
A significant Amount of Medicaid is paid outside the claims process. Medicaid claims are largely built around a set of rules reflected in the Medicaid Management Information System (MMIS) system. This includes "900[88]" edits and audits against which all claims are processed. Outside the controls provided by the MMIS, Arkansas paid $983 million, or just less than 20% of its Medicaid costs, through various contractual and other reimbursements to providers. There is no suggestion that these payments are for anything other than medical care, only that these may lack the stringent controls built into the rest of Medicaid costs. The breakdown of these payments is shown in Figure 25.

Figure 25—Payments other than Claims[89]



[88] This is a rough estimate offered by the MMIS leadership
[89] TSG analysis of Agency DeComp accounting report

Figure 26—Components of non-claims provider payments

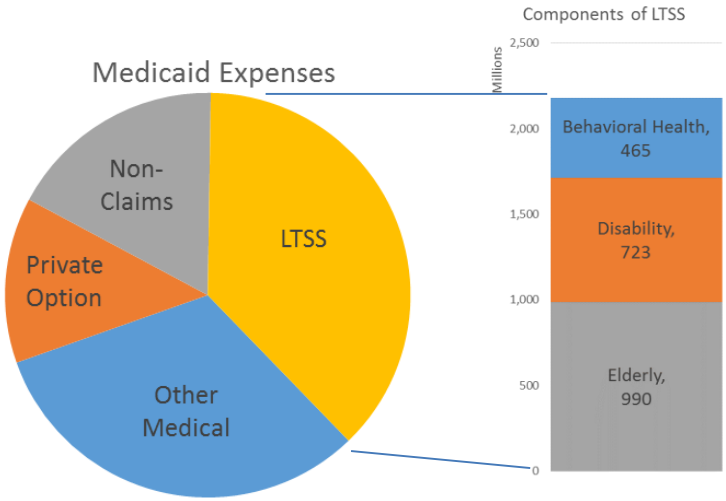


14. Long Term Services and Supports Detailed Financial Analysis

The majority of costs in Arkansas Medicaid are paid for Long Term Services and Supports (LTSS) on behalf of the Aged, Blind and Disabled (ABD). This category includes the Aged and Physically Disabled, people with Intellectual and Developmental disabilities, and adults with serious mental illness and children/adolescents with Serious Emotional Disturbance and related disorders.

Figure 27 shows that before medical costs (known as halo effect) LTSS costs are nearly as large as all other medical costs combined. In the figure, the PO is broken out separately, as it is not part of traditional Medicaid. Also, non-claims settlements and contracts are broken out to allow for valid comparison of the claims in the other categories.

Figure 27—LTSS as a share of total Medicaid, before halo effect



14.1.Halo Effect

Most Medicaid Aged, Blind, and Disabled patients require care in multiple settings, often for multiple diagnoses. The Agency has recognized that beneficiaries of any LTSS program have medical costs outside that program. This has come to be known as the "halo effect." TSG used its access to claims data to update the calculations of halo effect for those in the ABD population. Table 24 shows that the halo effect of medical costs adds substantial amounts to the direct program costs as tracked by the Agency accounting system. In total, halo effect brings the total of costs for the ABD population to $3 billion, 74% of total claims costs for Medicaid (calendar 2014). Yet, this care falls outside Person-Centered Medical Home or Episodes of Care.

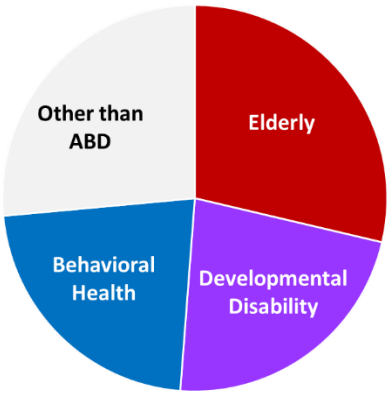
Table 24—Total costs of ABD population including halo costs

	Direct Program Costs	Halo Effect	Total	Percent of Claims
Elderly	$989,580,886	$163,729,046	$1,153,309,933	29%
Developmentally Disabled	$723,493,917	$183,455,886	$906,949,803	23%
Behavioral Health	$464,686,509	$433,988,499	$898,675,008	22%
Sum of Aged, Blind and Disabled			$2,958,934,744	**74%**
All Claims (without PO or contracts)			$4,023,136,382	100%

Thus, traditional Medicaid is best characterized as a program serving primarily those in the ABD category, as shown in Figure 28. However, as mentioned, the ABD have been left outside of key health value improvement programs including Person-Centered Medical Homes and Episodes of Care. Instead of placing its primary focus on the primary driver of Medicaid costs (the ABD

population), current focused care coordination efforts are on improving 26% of costs not incurred by this group.

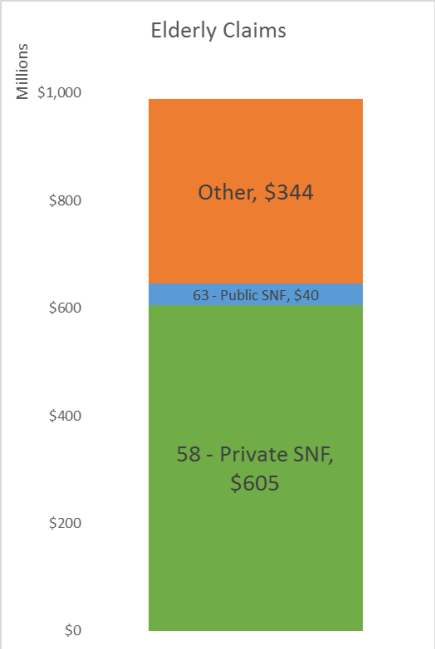
Figure 28—ABD accounts for 74% of Medicaid claims



14.2.Elder Care

Arkansas Medicaid pays $1 billion for the care of elders. Fully $605 million is for private nursing homes with another $60 million for public nursing homes and nursing home hospice. Figure 29 shows that two thirds of care for Arkansas' elders is paid to nursing homes.

Figure 29—Components of Elder Care in traditional Medicaid



58 - Private SNF	$605,391,718
53 - Personal Care - Regular	$98,025,956
97 - Elders Choices Waiver	$53,130,713
63 - Public SNF	$39,695,754
H2 - Nursing Home Hospice	$29,971,174
59 - Private SNF Crossover	$24,963,236
L4 - APD Agency Attendant Care, Co Employe	$23,085,386
L1 - APD Attendant Care	$21,072,004
I0 - Independent Choices Treatment Elderly	$19,961,565
AL - Assisted Living Facility	$17,809,236
24 - Home Health Services	$16,791,790
SR - AR Seniors	$7,422,863
PP - PACE	$6,387,966
73 - Private Duty Nursing EPSDT	$6,025,448
H1 - Hospice	$5,947,011
94 - EPSDT Prosthetic Device	$5,714,592
74 - Private Duty Nursing Services	$3,063,530
I9 - Independent Choices C/FI	$1,862,990
C3 - CSMT Age 60 and Older	$1,678,375
I8 - Independent Choices FMS Services	$1,326,548
I2 - Independent Choices New Trtmnt Elderly	$193,673
AX - Extension of 3 Prescriptions for Assisted	$59,359
	$989,580,886

The halo effect adds medical costs to the LTSS cost for each type of elder care. Figure 30 shows that while the halo effect for the non-institutional care settings is relatively higher compared to Public and Private SNFs (nursing homes), the total costs are substantially lower. The figure shows total, not per person costs. Figures 30 and 31 convert these costs to percent of total costs for that care type.

Figure 30—Total elder care program costs showing other medical (halo) costs

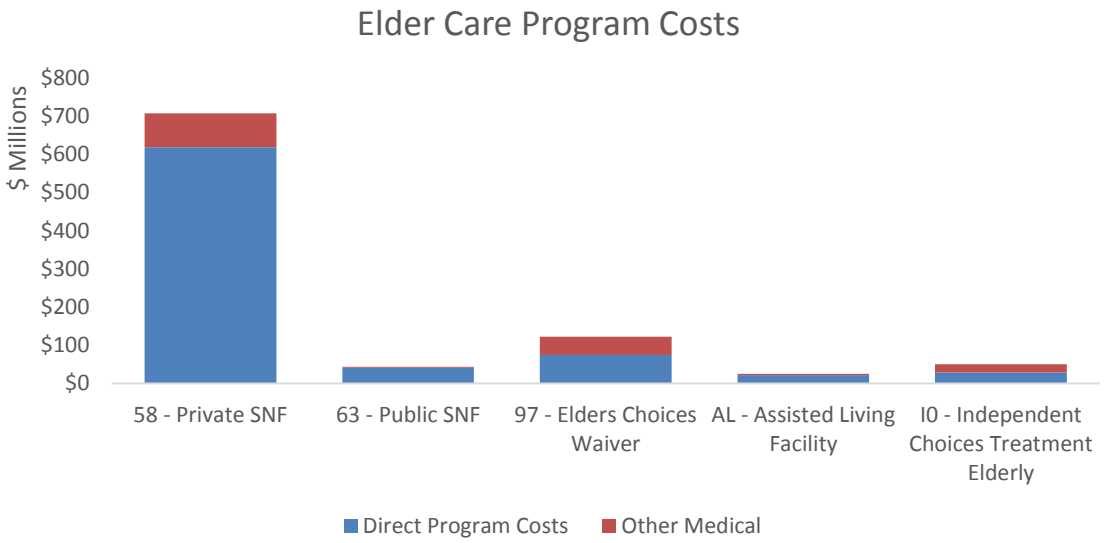
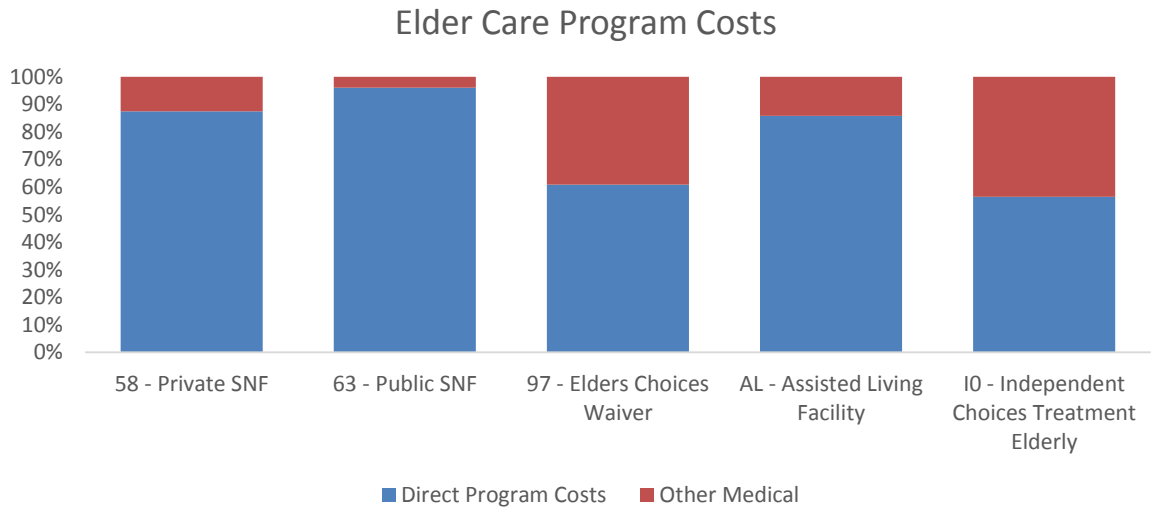


Figure 31—elder care program costs showing halo costs as a percent of total program costs



It is important to look at elder care on a per-person basis. TSG identified the number of elders in each type of care. During the year, the number of people served changes. TSG compared total calendar 2014 costs to the average of monthly number of elders in each program. Table 25

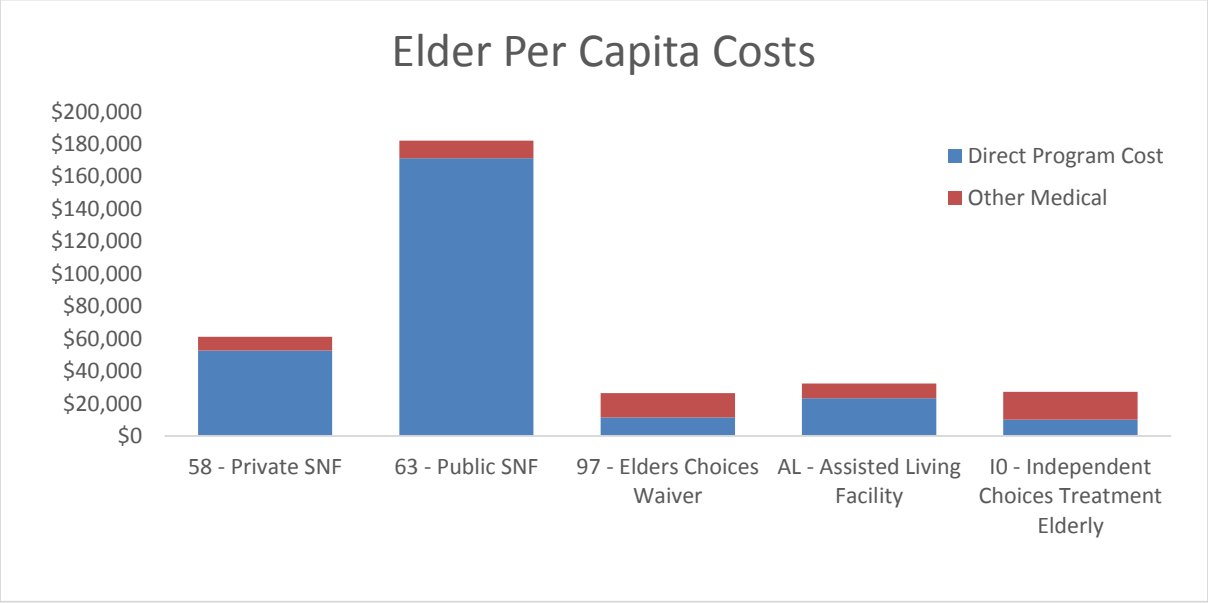
shows the result of the TSG analysis. Member months show how many total months of elder care were provided in each category during calendar 2014.

Table 25—Number of elders by program

2014 Elder Headcount (mid-month)	Average 2014	Member Months
H1 – Hospice	140	1,679
59 - Private SNF Crossover	1,582	18,982
H2 - Nursing Home Hospice	604	7,248
63 - Public SNF	237	2,848
58 - Private SNF	11,544	138,530
97 - Elders Choices Waiver	4,661	55,931
I0 - Independent Choices Treatment Elderly	1,853	22,230
53 - Personal Care - Regular	11,674	140,092
AL - Assisted Living Facility	775	9,299

Averaging total costs against the number of participants allowed TSG to calculate average costs per person in each program, including halo effect. This is shown in Figure 32. It shows that the cost for caring for an elder in a public nursing home is approximately $180,000 per year, more than 4 times the cost of caring for an elder in the Elder Choices Waiver.

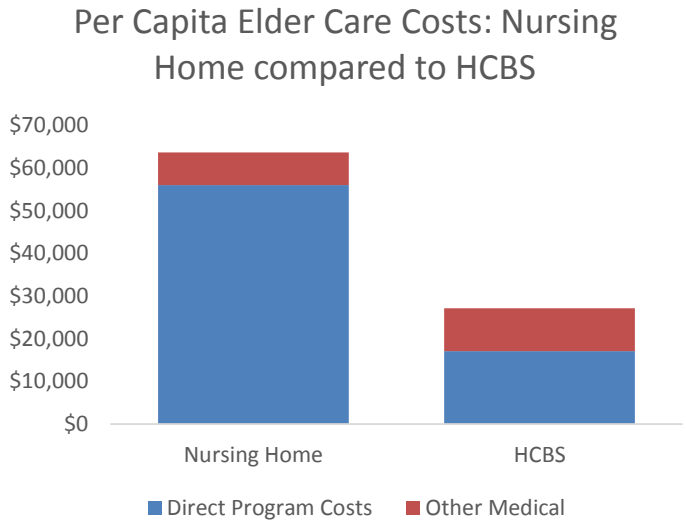
Figure 32—Elder care cost per capita care program costs, including halo effect



Combining the institutional care (nursing homes) and the waiver care (non-institutional), Figure 33 shows that caring for an elder in a private nursing home is just over $60,000 per year, more

than twice the amount for the cost for caring for an elder on the Elder Choices Waiver of over $26,000.

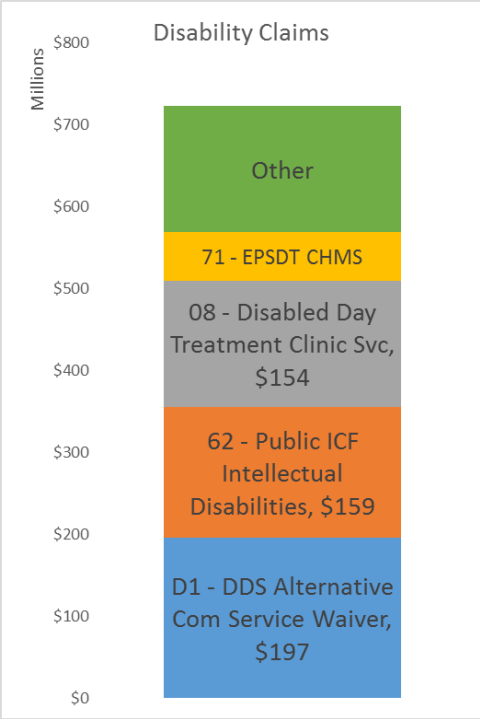
Figure 33—Comparing institutional and waiver care per capita



14.3.Care for those with Developmental Disabilities

Before halo effect, Medicaid pays $723 million for the care of Developmentally Disabled individuals. Figure 34 shows that a large portion of this care is through waivers and other community based care programs.

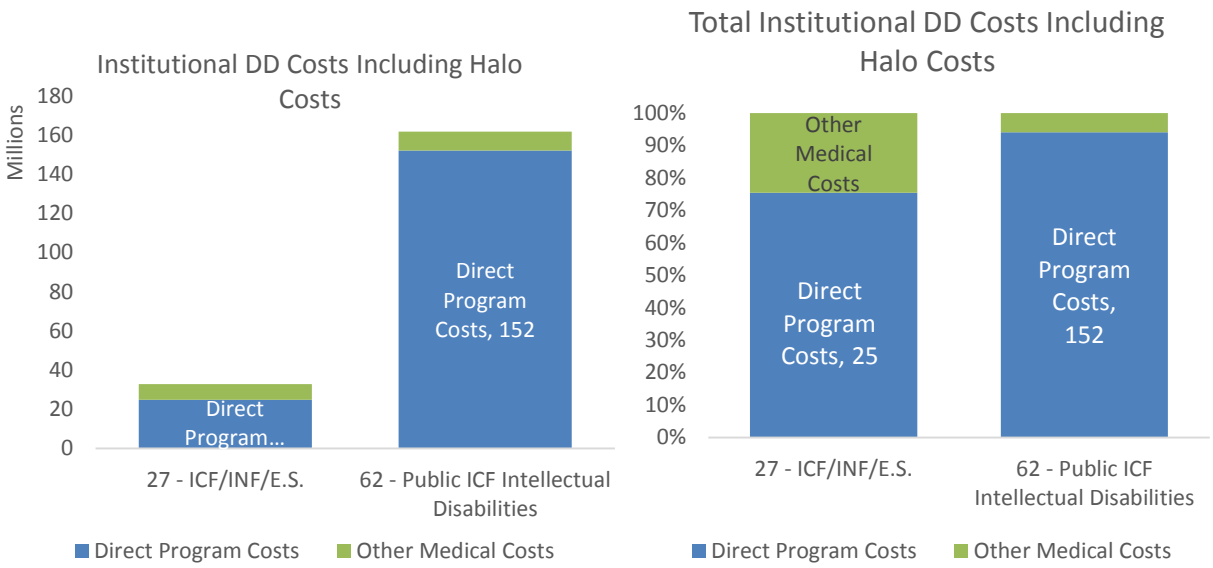
Figure 34—Care costs of the Developmentally Disabled without halo effect



D1 - DDS Alternative Com Service Waiver	$196,507,980
62 - Public ICF Intellectual Disabilities	$158,927,868
08 - Disabled Day Treatment Clinic Svc	$154,045,712
71 - EPSDT CHMS	$59,971,536
27 - ICF/INF/E.S.	24,594,450
15 - EPSDT Screening	18,511,306
E4 - Speech and Language Therapy - CHMS	16,084,798
T7 - DDTCS Transportation	15,502,254
E3 - Occupational Therapy - CHMS	12,873,920
E2 - Physical Therapy - CHMS	11,201,996
D7 - Rehab Servies School Based CHMS	9,917,245
C7 - Speech and Language Therapy School Ba	9,345,225
C6 - Occupational Therapy School Based Only	8,085,287
C5 - Physical Therapy School Based Only	4,583,060
14 - EPSDT Immunizations	4,180,774
I1 - Independent Choices Trtmnt Young Disab	3,254,075
AW - Autism Intensive Intervention Provider	2,711,720
95 - EPSDT Orthotic Appliances	2,442,558
D3 - Developmental Rehab Services	1,783,671
D4 - DYS Rehab Services	1,712,937
88 - Inpatient AR Teaching Crossover	1,649,498
72 - EPSDT Podiatry	1,396,968
C9 - Personal Care - School Based	1,124,608
93 - EPSDT DMS Expansion	1,050,666
RC - RSPD/ Residential Rehab Center	832,738
T4 - TCM/DYS	741,476
I3 - Independent Choices New Trtmnt Yng Dsl	384,601
80 - Therapy School District/ Esc Group	74,989
	723,493,917

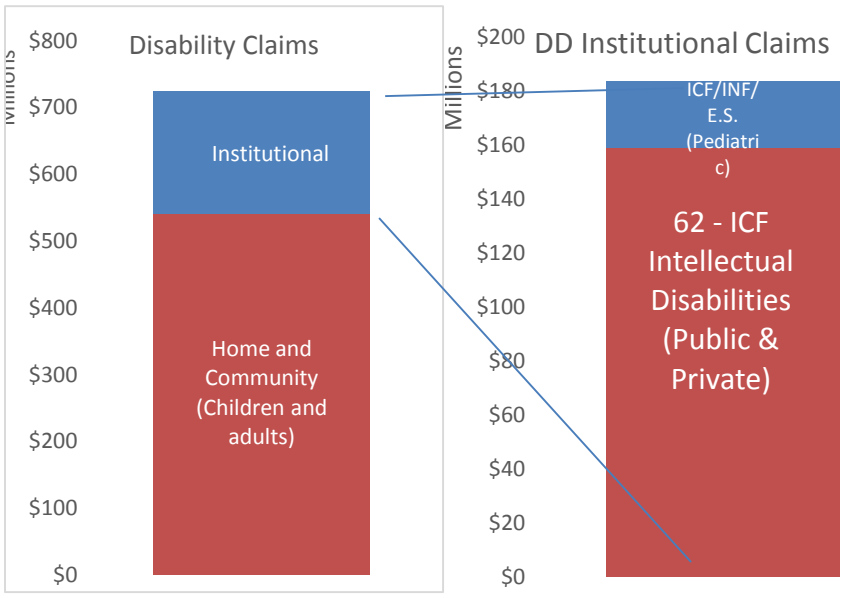
TSG looked closely at public and private Institutional Care Facilities (ICF). Actually, the costs accumulated by the Agency as "public" are for adult care and include 950 beds of public ICF and about 300 beds of private ICF. TSG added halo costs to these direct costs, as shown in Figure 40. Figure 35 also converts these to percent of total program costs, showing that while Adult (public) ICFs account for more program dollars, and people in pediatric ICFs experience larger halo effect.

Figure 35—Institutional care costs including halo effect, total program and percent of total



Institutional care (ICFs) account is only one third of total DD, Figure 36. Of that, public and private adult care is more than 80% and pediatric is 20%, also shown in Figure 36.

Figure 36—Components of total care for the developmentally disabled



TSG also reviewed the non-institutional costs of caring for the developmentally disabled. Figure 37 shows the sizes of each of the major programs, including their halo effect. Figure 38 converts

these costs into percent. This shows that while the two school-based programs have lower overall cost, their participants have the highest halo effect.

Figure 37—DD waiver costs by program, including halo effect

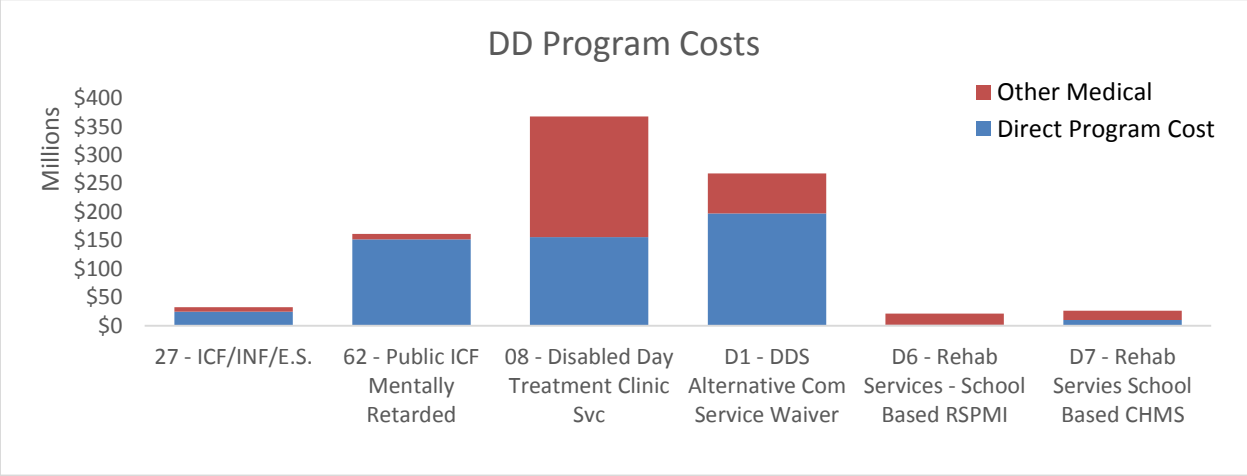
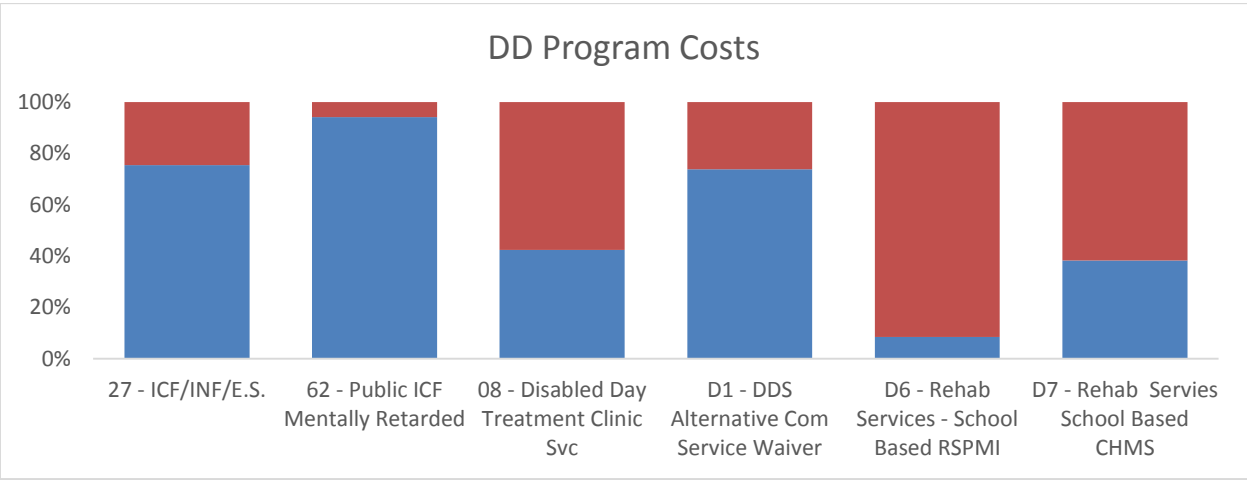


Figure 38—DD waiver costs by program, including halo effect, by percent



TSG accumulated the counts of people in each program for calendar 2014, as shown in Table 26. As with elders, this shows the total member months as well as the average participation level.

Table 26—Participants in DD institutional and waiver programs

	Average 2014	Member Months
08 - Disabled Day Treatment Clinic Svc	10,122	121,463
71 - EPSDT CHMS	4,262	51,144
D1 - DDS Alternative Com Service Waiver	3,886	46,634
D6 - Rehab Services - School Based RSPMI	482	5,783
D7 - Rehab Services School Based CHMS	573	6,307
E7 - Speech and Language Therapy - RSPMI	25	252
27 - ICF/INF/E.S. - Pediatric	202	2,418
62 - ICF Intellectual Disabilities	1,238	14,853

Putting program costs together with numbers of people served, TSG calculated the per person cost for ICFs compared to the key wavier programs, as shown in Figure 39. The figure highlights the ICFs combined per person cost. As the figure shows, ICFs cost $135,000 per person, while the Alternative Choices Waiver program costs on average a little over $69,000 per person per year. Thus institutional care costs almost twice as much per person as the ACS waiver programs.

Figure 39—Per person DD costs, comparing ICF to waiver programs

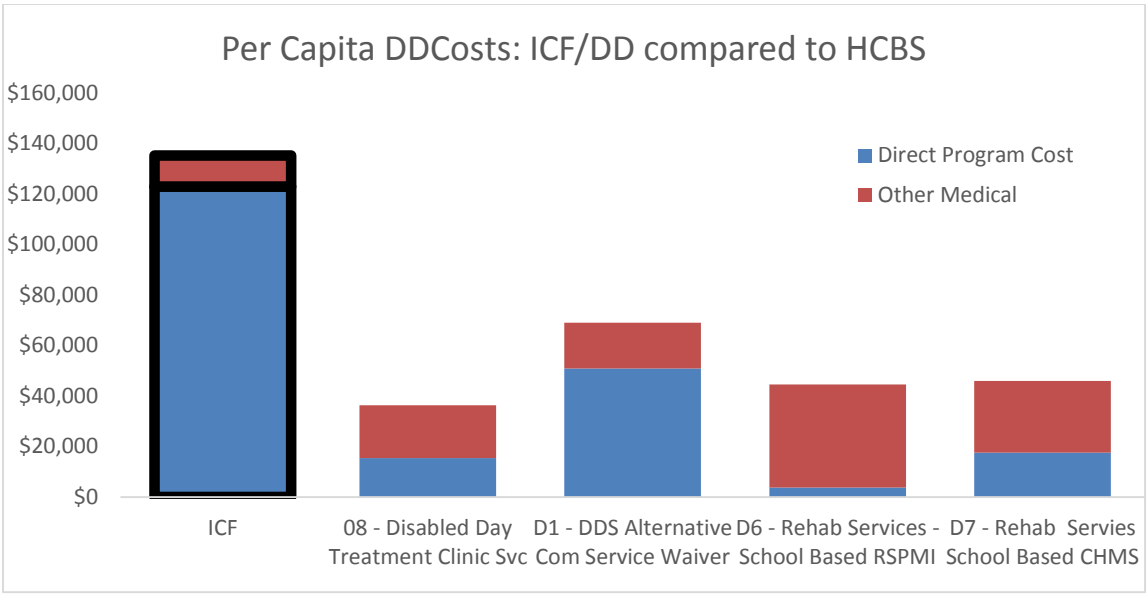
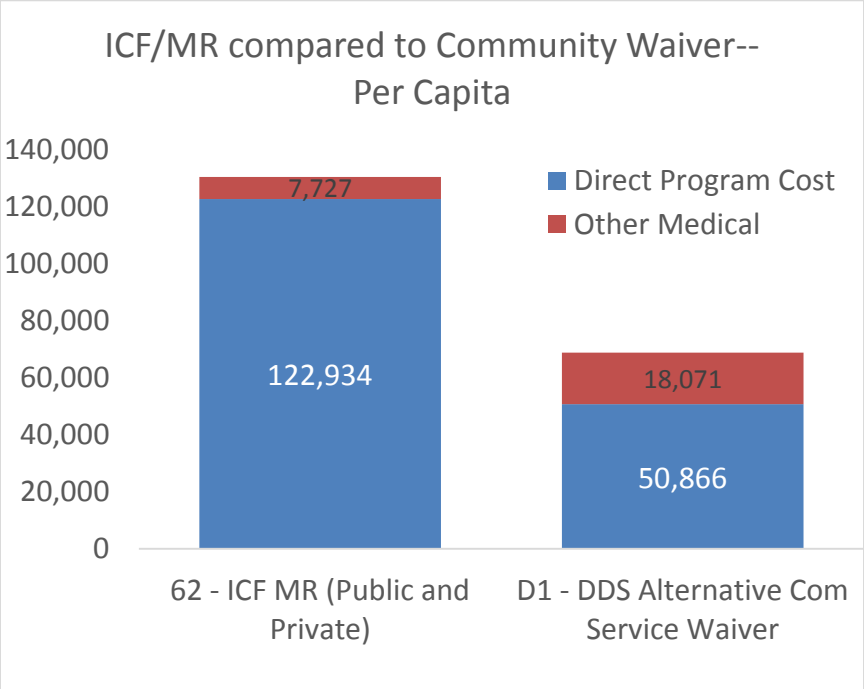
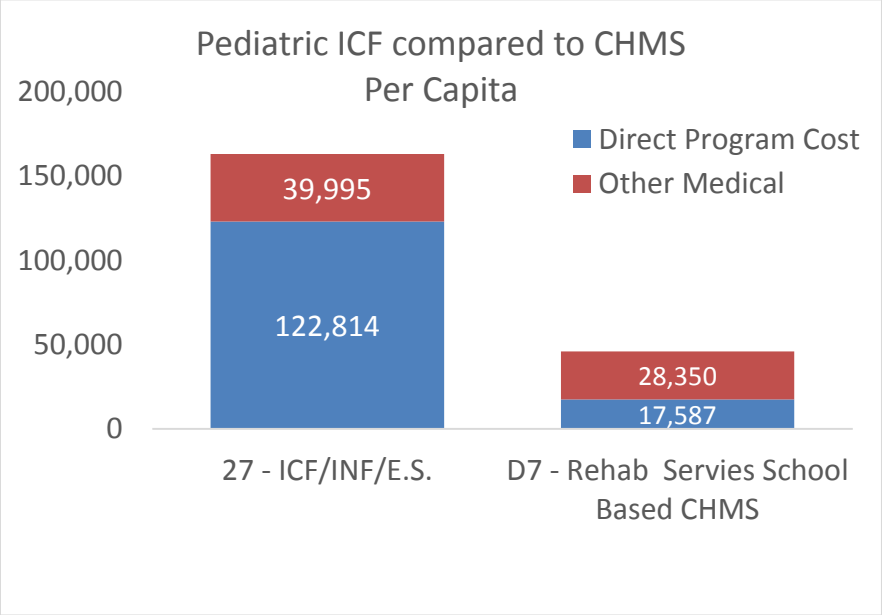


Figure 40—Adult DD care per person, comparing ICF and waiver programs



Likewise, Figure 41 compares the costs of ICF to waiver care for pediatric DD. The comparison is even more stark—the ICF level of care is nearly 4 times the cost of a waiver program. Note that rehab school services do not pay for residential or home based services and ICFs are 24/7.

Figure 41— Pediatric ICF compared to CHMS Per Capita

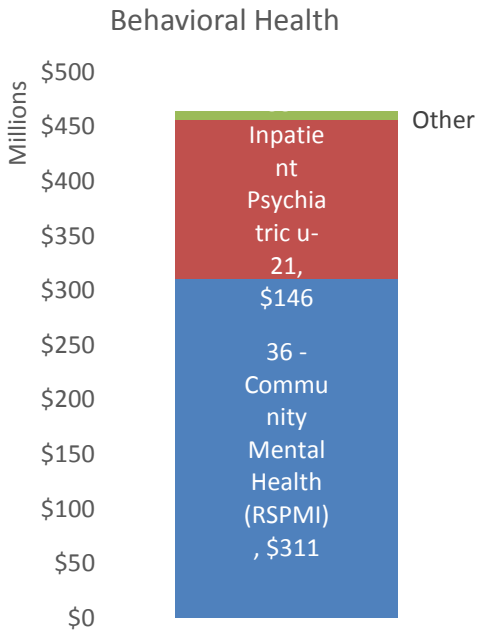


14.4.Behavioral Health Costs

In the category of Behavioral Health, TSG looked primarily at Inpatient Psychiatric claims and those for Rehabilitative Services for Persons with Mental Illness (RSPMI). RSPMI and Inpatient Psychiatric, including halo costs account for $900 million, 22% of traditional Medicaid.

RSPMI is the largest share of behavioral health. Figure 42 shows that well over half of behavioral health claims are for RSPMI.

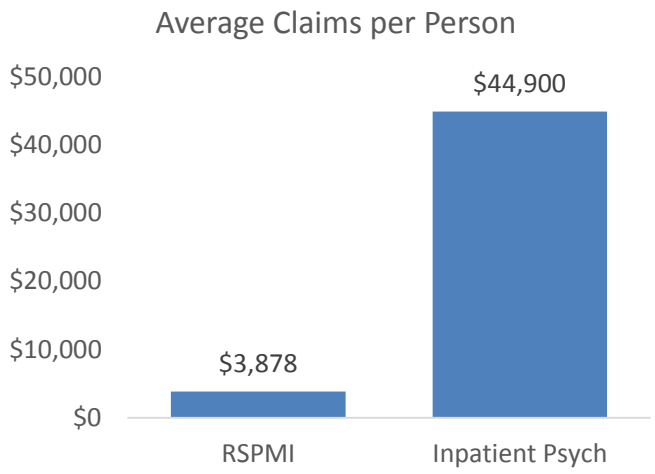
Figure 42—Components of behavioral health claims



Behavioral Health	Calendar 2014
36 - Community Mental Health (RSPMI)	$310,700,134
33 - Inpatient Psychiatric u-21	$145,777,457
81 - Psychologist	1,760,192
L6 - APD Counseling Case Management	1,751,957
D6 - Rehab Services - School Based RSPMI	1,643,147
32 - Inpatient Psychiatric Crossover u-21	1,527,431
L2 - APD-Environmental Adaptations	753,915
82 - Therapy Individual/Regular Crossover	324,484
SO - Sexual Offender Program	146,952
L5 - APD Traditional Agency Attendant Care	146,646
SA - Substance Abuse Treatment Services	77,408
T6 - School-Based Mental Health Services	38,516
E7 - Speech and Language Therapy - RSPMI	38,270
	$464,686,509

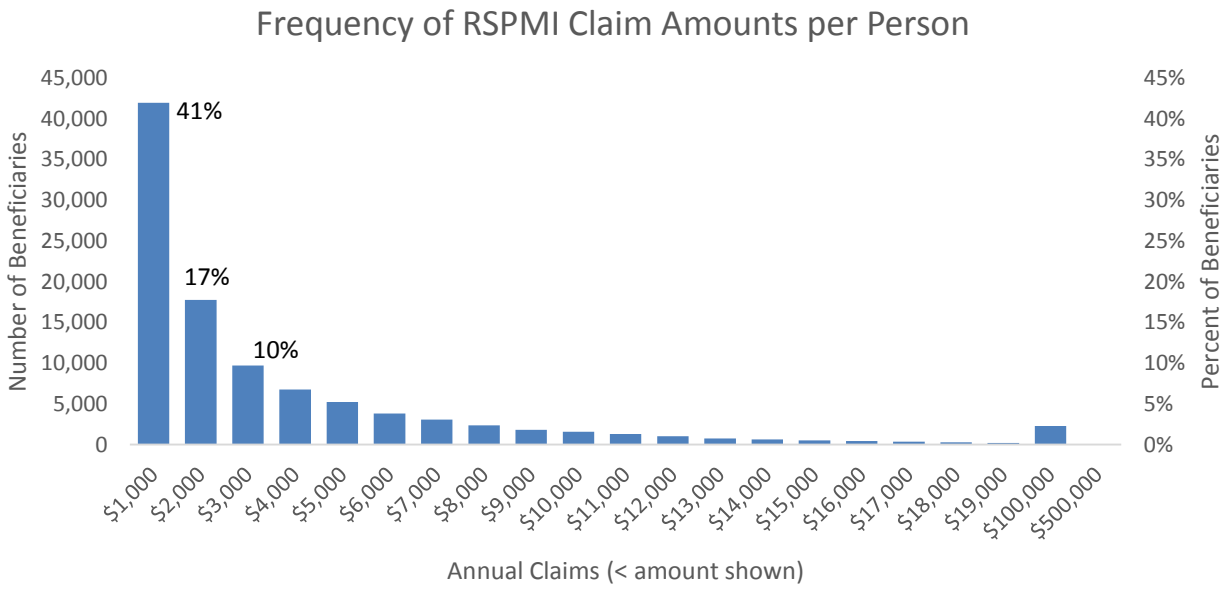
TSG assessed the per person costs of RSPMI and Inpatient Psych as shown in Figure 43. Clearly, beneficiaries spend far less per person on RSPMI compared to Inpatient Psych.

Figure 43—Behavioral health programs, per person comparison



TSG observed that RSPMI is generally a low-cost program, with 41% of beneficiaries responsible for claims less than $1,000 per year, Figure 44. However, 7,800 beneficiaries claimed more than $10,000 in 2014 for RSPMI, nearly 1,000 for more than $30,000 in the year.

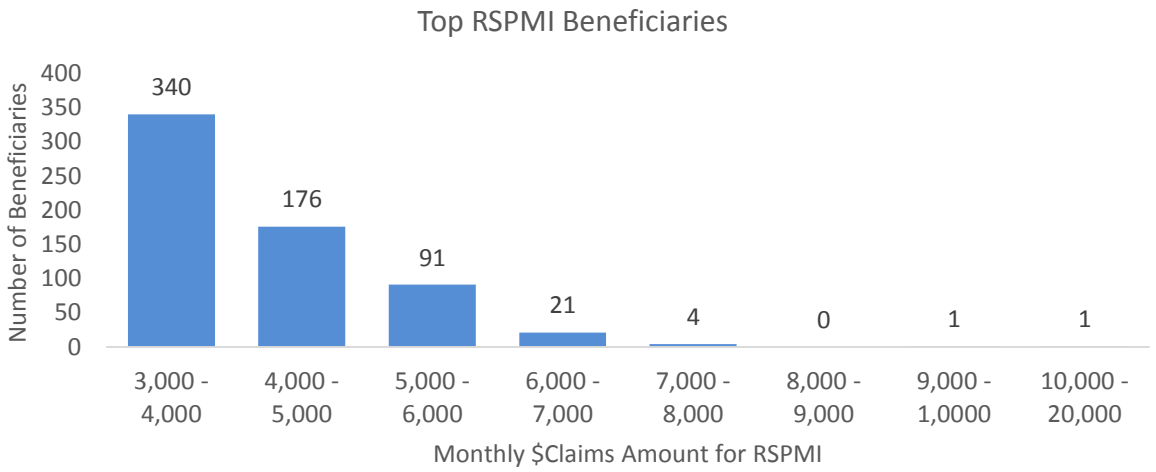
Figure 44—Frequency of per person RSPMI claims by annual claim amount



As with many of the Medicaid populations, annual claims per person for RSPMI has a "long tail" or many small claims and a few very large ones. Figure 45 shows the end of that long tail. TSG found that the highest 634 RSPMI users (more than $100 per day) account for $32 million in annual cost. Note that one beneficiary claimed more than $10,000 per month. TSG did not find

that DBHS is monitoring use in a manner that can account for the effectiveness of such high RSPMI use nor is the external prior authorization process monitoring low cost of service and high number of beneficiaries for seriousness of condition and continuity of care.

Figure 45—Largest RSPMI users



TSG considered whether there is a relationship between claims for RSPMI and for Inpatient Psych—are these complementary or substitutes. We found that RSPMI services tend to be used in combination, but higher RSPMI claims is associated with *higher* (not lower) Inpatient Psychiatric claims. Table 27 compares the first and fourth quartile of RSPMI beneficiaries. The average RSPMI claim amount in the first quartile was $281 while the average RSPMI in the fourth quartile was $11,587. At the same time, Inpatient Psych for the 1st quartile RSPMI beneficiaries was $105 (1/3 of the RSPMI amount), while Inpatient Psych for the 4th quartile of RSPMI beneficiaries was $47,083. Put another way, low-level RSPMI beneficiaries use little Inpatient Psych and high-level RSPMI beneficiaries claim a lot of Inpatient Psych. TSG found that the Agency did not have a clear message about the levels of use and, as noted in other sections of this report, DHS/DBHS does not require a standardized assessment instrument for the RSPMI benefit, such as the LOCUS for adults or CANS for children and adolescents.

Table 27—Comparing RSPMI with inpatient psych treatment

	Average Claims Amount		
	Overall Average	**1st Quartile of RSPMI**	**4th Quartile of RSPMI**
RSPMI	$3,878	$281	$11,587
Inpatient Psych	$44,900	$105	$47,083

15. DHS TRADITIONAL MEDICAID FUTURE FORECAST

TSG developed a forecast of potential Medicaid costs to the general fund. In doing so, we considered the most critical planning factors:

- Population growth, especially in the elderly and high-cost segments
- While baby boomers will develop into the Aged, the best predictions (US Admin on Aging) is that the Aged population will shift from 22% to 26% of total by 2020.That is 0.35% change per year.
- Aged population growth is more impactful on Arkansas Medicaid spending because of higher reliance on institutional care
- Federal Match and National Economy
- TSG believes it is prudent to use high end projections in forecasting – that it is better for Arkansas to have a model that plans for the "worst case"

We developed a realistic range of forecasts, based on the critical assumptions:

- CMS projects that for 2015 to 2024, Medicaid spending growth will increase 5.9% per year on average, "reflecting more gradual growth in enrollment as well as increased spending per beneficiary due to aging of the population."[90]
- "Health spending is projected to grow 1.1 percent faster than Gross Domestic Product (GDP) per year over this period; as a result, the health share of GDP is expected to rise from 17.4 percent in 2013 to 19.6 percent by 2024."
- Deloitte predicts national health care costs will increase over 6.5% over next five years

Table 28 shows TSG's projection of future traditional Medicaid costs, sourced from all funds, impact on general revenue and finally net change year to year.

[90] See https:/www.cms.gov/Research –Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/proj2014.pdf.

Table 28—TSG Financial Projection of the General Fund impact of traditional Medicaid

Medicaid Projected All Funds							
Growth Scenario	2015	2016	2017	2018	2019	2020	2021
5%	5,159,416,161	5,417,386,969	5,688,256,317	5,972,669,133	6,271,302,590	6,584,867,719	6,914,111,105
6%	5,159,416,161	5,468,981,130	5,797,119,998	6,144,947,198	6,513,644,030	6,904,462,672	7,318,730,432
7%	5,159,416,161	5,520,575,292	5,907,015,562	6,320,506,652	6,762,942,117	7,236,348,066	7,742,892,430
8%	5,159,416,161	5,572,169,454	6,017,943,010	6,499,378,451	7,019,328,727	7,580,875,025	8,187,345,027
9%	5,159,416,161	5,623,763,615	6,129,902,341	6,681,593,551	7,282,936,971	7,938,401,298	8,652,857,415
10%	5,159,416,161	5,675,357,777	6,242,893,554	6,867,182,910	7,553,901,201	8,309,291,321	9,140,220,453

Medicaid Projected General Revenue							
Growth Scenario	2015	2016	2017	2018	2019	2020	2021
5%	1,547,824,848	1,625,216,091	1,706,476,895	1,791,800,740	1,881,390,777	1,975,460,316	2,074,233,332
6%	1,547,824,848	1,640,694,339	1,739,135,999	1,843,484,159	1,954,093,209	2,071,338,802	2,195,619,130
7%	1,547,824,848	1,656,172,588	1,772,104,669	1,896,151,996	2,028,882,635	2,170,904,420	2,322,867,729
8%	1,547,824,848	1,671,650,836	1,805,382,903	1,949,813,535	2,105,798,618	2,274,262,507	2,456,203,508
9%	1,547,824,848	1,687,129,085	1,838,970,702	2,004,478,065	2,184,881,091	2,381,520,389	2,595,857,224
10%	1,547,824,848	1,702,607,333	1,872,868,066	2,060,154,873	2,266,170,360	2,492,787,396	2,742,066,136

Medicaid Projected General Revenue Increase over SFY15 level								
Growth Scenario	2015	2016	2017	2018	2019	2020	2021	Aggregate inceases over SFY15 level
5%	0	77,391,242	158,652,047	243,975,892	333,565,929	427,635,468	526,408,483	1,767,629,061
6%	0	92,869,491	191,311,151	295,659,311	406,268,361	523,513,953	647,794,281	2,157,416,549
7%	0	108,347,739	224,279,821	348,327,147	481,057,787	623,079,571	775,042,881	2,560,134,947
8%	0	123,825,988	257,558,055	401,988,687	557,973,770	726,437,659	908,378,660	2,976,162,818
9%	0	139,304,236	291,145,854	456,653,217	637,056,243	833,695,541	1,048,032,376	3,405,887,468
10%	0	154,782,485	325,043,218	512,330,025	718,345,512	944,962,548	1,194,241,288	3,849,705,076

Note: The above projections are based on all paid claims, contracts, and cost settlements.

TSG forecast suggests the potential of future significant budgetary constraints across a range of growth scenarios:

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

Thus, State leaders should put equal or greater focus on traditional Medicaid as on the expanded population.

In Table 29, TSG shows how Arkansas costs compare to select other states on the dimensions of both overall costs and costs for Long Term Support and Services (LTSS), the elders, those that are disabled and those with behavioral health conditions.

Table 29—Arkansas Medicaid costs compared to select other states[91]

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

The table shows that compared to other states, Arkansas is in the third quartile of overall spending for traditional Medicaid (rank 19) and in the top quartile (rank 12) for LTSS spending. This reflects the lack of focus on managing care for the LTSS populations.

This suggests a legislative strategy of focusing the Agency's attention on improving healthcare value (cost and outcomes) for those receiving LTSS care—introducing more aspects of care management to traditional Medicaid.

16. HOSPITAL RATE METHODOLOGY

There are several different mechanisms by which public and private payers in the health care sector reimburse hospitals for services. For inpatient services, the most common approach is to pay hospitals based on the diagnosis and relative acuity of the patient. This approach is commonly referred to by the name of the code set used to identify the diagnoses – diagnosis related groups (DRGs). Each DRG code corresponds to a particular level of severity of a particular diagnosis, and the typical payer approach is to have a single payment for all services required for the average patient with a particular severity of the particular diagnosis.

The key benefit of the DRG payment model for inpatient services is that this case rate payment is largely independent of a hospital's charges, or the number of days that a patient actually stays in the hospital, or the additional charges or costs that may be incurred during that inpatient stay.

[91]Source: Medicaid Expenditures for Long Term Services and Supports (LTSS) in FY 2013: Truven Health Analytics/Mathematica/CMS: 6/30/15

Another important benefit of the DRG payment model, having established virtually universal application and acceptance within Medicare, is that this model has become a powerful, standard benchmark mechanism that non-Medicare programs can leverage.

Owing to these benefits, the entire health care industry, carriers and providers alike, often speak about reimbursement topics in terms of %-of-Medicare. The DRG reimbursement models also incorporate adjustment factors, such as patient case severity, as well as the type of facility (teaching, tertiary, etc.), in order to factor resource and cost differences, and outlier cases. Thus, the model dramatically reduces the noise and friction that commonly arise during reimbursement negotiations where many providers claim that they have much sicker patients than other providers, and thus deserve higher reimbursement.

Approximately 80% of states have implemented some variant of the DRG reimbursement model for their Medicaid program, and the remaining states are planning, or at least evaluating, some type of DRG based payment methodology. Not surprisingly, the DRG reimbursement model has been implemented by the vast majority of commercial health insurance carriers, Medicare Advantage carriers, etc.

An alternative approach to DRG-based payments is to have a specific dollar amount payable per day. This approach is generally referred to as a 'per diem' payment structure. When per-diem approaches are used, they are generally coupled with very aggressive care management by the payers, in order to try to get as many patients as possible out of the hospital as quickly as possible, within appropriate clinical protocols. Both DRG and per-diem payment structures can be modified by including facility-specific base rates that the DRGs or per-diems are based on.

Finally, in some cases, particularly with public programs, some types of hospitals might be paid on a cost or cost-plus basis. Hospital payment based on a cost or cost-plus basis creates little incentive to control costs or reduce unnecessary hospitalizations or bed-days.

16.1. Additional Hospital Content

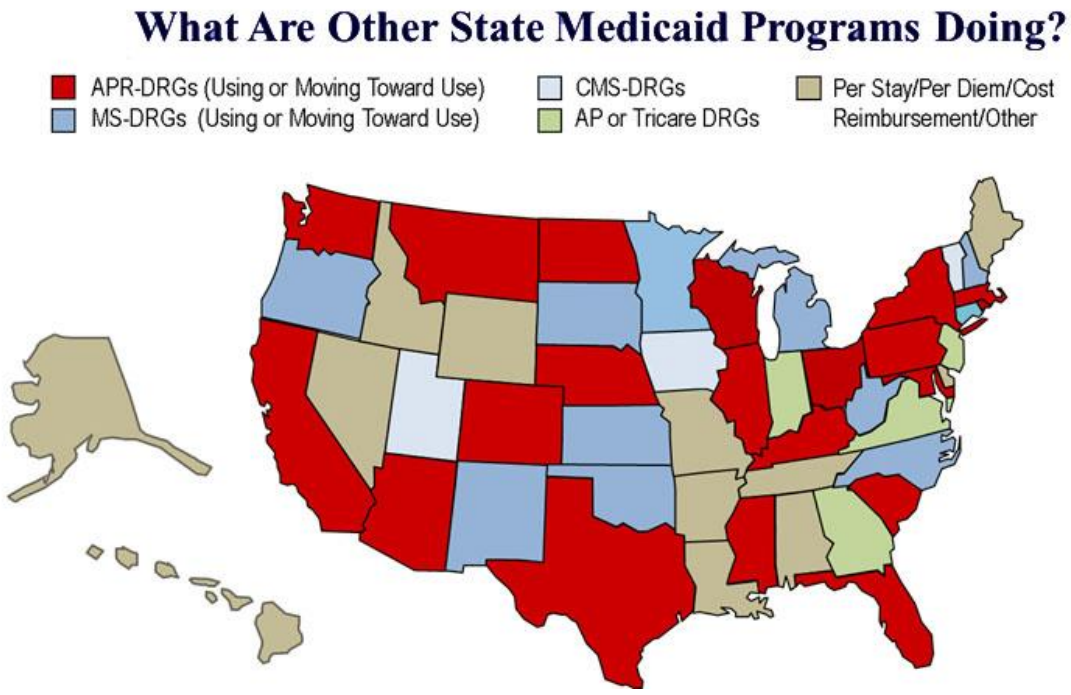
There are two major DRG payment structures – Medicare Severity (MS) DRGs and All-Payer Refined (APR) DRGs. The MS-DRG approach was developed to be specific to Medicare, while the APR-DRG approach was developed to be relevant for all payers. This distinction is particularly relevant for Medicaid since a large part of the covered population (pregnant women and children) is very different from the primary covered population for Medicare (the elderly). Therefore, the APR-DRG approach is generally considered to be a more appropriate approach for a population that includes a wide range of age groups, such as Medicaid.

16.2.Arkansas Hospitals

In Arkansas, hospitals are generally paid a maximum amount ($850) per diem, along with several different supplemental payments. Some Arkansas hospitals are paid on a cost-basis, with individual prospective per-diem rates based on past cost, and then cost-based reconciliation periodically within the fiscal year. Arkansas hospitals that are paid on a cost basis include the hospital associated with University of Arkansas for Medical Sciences (UAMS), Arkansas Children's Hospital, and 38 critical access hospitals (CAHs) throughout the state. In addition, Arkansas hospitals receive several additional supplemental payments, the most significant of which are the Upper Payment Limit (UPL) and Disproportionate Share Hospital (DSH) supplemental payments. UPL provides a supplemental payment to hospitals that increases their effective payment from the Medicaid rate to what they would have been paid for the same service by Medicare. The state match for UPL is a hospital provider tax. The Arkansas DSH supplemental payments go primarily to UAMS, with an inter-governmental transfer (IGT) of funds from UAMS to the state covering the state match.

The map in Figure 46 appeared in a presentation by the Arizona Health Care Cost Containment System from September 2014, regarding that state's shift toward APR-DRGs.

Figure 46—Multi-state comparison of approaches for using DRGs



16.3.DRG – Simulation and Collaborative Discussions with Hospitals

The TSG team conducted a DRG simulation to study the following:

A) How well could the current claim files be "grouped" using a standard DRG software package?
B) How would such a new payment DRG based model relate and compare to the current reimbursement methodology (per diem plus various cost settlements and supplemental payments)?
C) How can we work collaboratively with DHS and the hospital community to understand the best exploratory path to a case-payment reimbursement model?

TSG discussed its preliminary findings with several hospital representatives. We found that the vast majority of hospital claims were able to be successfully "grouped" into DRGs. The exception was Arkansas Children's Hospital, which had a high rejection rate due to its unique, high-risk pediatric case mix. For the sake of simplicity and expediency, we used the latest MS-DRG Grouper, but we believe that a more sophisticated DRG model, the APR-DRG, applied with more time and diligence, will offer the best results, and many of the cases at Arkansas Children's Hospital would group properly.

Comparing and relating the DRG results to the current payment model also provided ample opportunity to examine the various supplemental payment components that accompany the per diem reimbursement arrangement. The existing model has been constructed, negotiated, adjusted and refined over the years, and its complexity is quite daunting. TSG has been able to decipher a number of the key components, but there is much more to learn since the various inputs, outputs, offsets and exceptions often require the examination of each financial category and line item for each individual hospital. That will be necessary in order to clearly understand the current payment models and the potential impact of an alternative. TSG is confident that, based on the results and findings from this DRG Simulation effort, significant improvement to the current reimbursement model is quite achievable.

Perhaps the most promising indicator of the potential gains that can be achieved for the Medicaid program in Arkansas is the support that the hospital leaders have voiced in our conversations. The hospital representatives were very receptive in our discussions regarding the potential opportunity that a case-rate payment model could bring to the Medicaid program. TSG firmly believes that collaboration among the Task Force, DHS and the hospital community is absolutely critical to the success of this initiative.

TSG is very confident that there is significant opportunity for Arkansas to rebuild a Medicaid reimbursement methodology that can:

A) Provide incentives for hospitals who can deliver high quality care economically

B) Provider opportunities for the State to achieve meaningful savings by leveraging benchmarks and best practices around the country judiciously
C) Develop long-term partnerships between the State and the hospitals to achieve health care quality, access and accountability that the State can afford

16.4. Arkansas Children's Hospital

During the Assessment, TSG visited with leadership at Arkansas Children's Hospital and was impressed with their five year strategic plan.

- To continue to improve clinical excellence, ACH is reimagining and executing an ambulatory surgical solution to improve patient health, enhance patient experience and lower cost.
- Learning and sharing proven best practices with peer hospitals in logistics and resource management,
- To improve access to care across the state, ACH's Telemedicine program will reach every corner of the state at a lower cost, thus delivering ACH's clinical expertise to many patients who need it but who were unable to access that care in the past.
- ACH is committed to excel in Populations Health, Care Continuum and Data Analytics to improve outcomes, both clinically and economically.
- ACH will identify and engage those organizations, providers and payers that can move in concert toward Value-Based Care and Value-Based Payment.

It is worth highlighting that the last strategic objective is highly compatible with the TSG recommendations for Traditional Medicaid reform in Volume II of this Report, and also with moving to an APR-DRG reimbursement model. The TSG team believes wholeheartedly that collaboration and partnership between ACH and the other constituents of the state can deliver better results for both the medical institution and the community from both clinical and economic perspectives.

17. Payment Improvement Initiative

Beginning in 2011, the state of Arkansas, through the Department of Human Services (DHS) convened multiple payers and other stakeholders to develop the Health Care Payment Improvement Initiatives (HCPII). The purpose of the HCPII was to address perceived cost and quality issues associated with the Arkansas health care economy. The HCPII were originally intended to include three major initiatives:

- Patient-centered medical home (PCMH)
- Episodes of care (EOC)

- Health homes for high-cost populations (those requiring long-term services and supports due to age, physical disability, developmental disability, or serious and persistent mental illness)

The PCMH and EOC initiatives were developed through a multi-payer, multi-stakeholder process. The health homes initiative was explored by DHS, but never implemented. The most recent step in the process of trying to develop a strategy for managing high-needs populations was the release of a Request for Information (RFI) for managed services for the high-needs populations.

17.1. Arkansas Patient Centered Medical Home Program

Another aspect of the Arkansas Health Care Payment Improvement Initiative is the patient centered medical home (PCMH). The concept behind the PCMH is that primary care providers will be measured on a number of process measures associated with better, more efficient care.

The model is best described as where primary care is patient-centered, comprehensive, consists of a collaborative team approach, and is accessible to the patient. Through improved care coordination and communication, the goal of the medical home is to help patients stay healthy, increase the quality of care they receive, and reduce costs. Participating providers receive a care management report for each patient for whom they serve as the PCMH.

The PCMH program in Arkansas has been underway since October 2012, with the initial program sponsored under a Center for Medicare and Medicaid Innovation (CMMI) grant. This initial program consisted of 69 practices selected. The initial steps of the actual roll-out of the PCMH program involved providers changing their practice to ensure that the following steps were taken:

- Identify team lead(s) for care coordination
- Identify the top 10% of high-priority patients
- Assess operations of practice and opportunities to improve
- Develop and record strategies to implement care coordination and practice transformation
- Identify/reduce medical neighborhood barriers to coordinated care at the practice level
- Make available 24/7 access to care
- Track same-day appointment requests

Phase two expansion began in January of 2013, and built upon the efforts of phase one and participating practices receiving up-front payments that enable them to more proactively meet patient needs and practice transformation milestones, which include providing extended office hours and 24/7 access to medical assistance.

Plans operating through the Health Insurance Marketplace have also joined Medicaid in supporting PCMH practices in 2015.

In addition to financial support for care coordination and practice transformation in the form of per-member, per-month payments, PCMHs may receive gain sharing based on performance improvements, or based on high performance compared to statewide averages. To be eligible for shared savings a group of providers must have at least 5,000 attributable Medicaid beneficiaries and report performance on certain quality metrics above specified thresholds. Overall cost targets are developed for each shared-savings group based on historical costs for the patients and providers in the group. Shared-savings groups that experience overall costs for their attributable population that are below the cost targets share in part of the savings. The shared-savings approach taken in the Arkansas PCMH program does not have cost-sharing if costs for the attributable population exceed the upper cost thresholds.

The vast majority of providers participating in the PCMH successfully attested to these process measures. The enrollment measures for the PCMH have exceeded expectations with more than 70%, or 295,000 Medicaid beneficiaries, in the care of a PCP participating in the PCMH program after the first year. In addition, and according to DHS, the following benchmarks were reached:

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

There have been some positive payer experiences with the PCMH initiative, but it remains difficult to disentangle these findings from the effects of the different changes that have occurred in the Arkansas Medicaid environment over the last several years (e.g., PO) and broader, national trends in national health care expenditures.

17.2. Episodes of Care

The following tables are adapted from calculations done by McKinsey. The first two tables (Table 31 & 32) below represent Episodes of Care (EOC) for which reporting and risk-sharing was implemented within the first two rounds. These EOCs have been active for long enough to permit some preliminary calculations of the episode costs, frequencies, and clinical patterns for a year's worth of data on each episode.

Table 30 shows the more recently implemented EOCs. Although in some cases, these episodes have been active for more than a year, there has not been enough time passed since the end of their first year to allow for claims run-out and analysis.

The column titled 'Related spend for PAP' represents the total spend associated with other potential EOCs having the same PAP that have not yet been implemented.

Table 30— Active Episodes of Care (First Two Rounds)

Episode	Principal Accountable Provider (PAP)	Direct episode spend ($M)	Number of episodes	Related spend for PAP ($M)	Estimated direct savings to date (%)
Upper Respiratory Infection (3 episodes)	PCP	13.6	180,404	Low direct, large via referrals	4-8
Attention Deficit Hyperactive Disorder (2 episodes)	Physician or RSPMI	39.1	9,933	440	15-25
Perinatal	OBGYN	87	19,052	117	2-4
Congestive Heart Failure Exacerbation	Hospital	6.2	1,193	369	0-5
Total Joint Replacement	Orthopedic surgeon	5	475	14	5-10
Adapted from McKinsey document titled "Selected facts relating to episode impact for Arkansas Medicaid; June 18, 2015 – updated July 8 with volume numbers"					

Table 31— Active Episodes of Care (First Two Rounds)

Episode	Observations relating to estimated direct cost savings
Upper Respiratory Infection (3 episodes)	C-section rate reduced from 39% to 34%.
Attention Deficit Hyperactive Disorder (2 episodes)	17% drop in antibiotic prescribing rate. Average episode cost flat despite ~10% increase in drug prices.
Perinatal	Average episode cost fell by 22% in first year for individuals with valid episodes in both years. 400 providers in other BH dx contacted re stimulant use.
Congestive Heart Failure Exacerbation	# episodes down from 141 to 101 30-day all-cause readmission rate decreased from 3.9% to 0% (~100 episodes) Slight increases in infections (1.4% to 2.0%) and complications (6.4% to 7.9%)
Total Joint Replacement	30-day all-cause readmission rate up from 16.0% to 19.9% (~200 episodes) Slight changes in infections (7.6% to 8.5%) and observation rate (43% to 40%)
Adapted from McKinsey document titled "Selected facts relating to episode impact for Arkansas Medicaid; June 18, 2015 – updated July 8 with volume numbers"	

Table 32— Active Episodes of Care (Remaining Rounds)

Episode	Principal Accountable Provider (PAP)	Direct episode spend ($M)	Number of episodes	Related spend for PAP ($M)
Colonoscopy	Performing physician	1.3	1,308	17
Gallbladder Removal	General surgeon	1.6	718	19
Tonsillectomy	ENT	2.8	2,480	11
Oppositional Defiant Disorder	Physician or RSPMI	17.1	8,380	440
Coronary Artery Bypass Graft	Cardiothoracic surgeon	0.9	81	8
Asthma exacerbation	Hospital	2.4	3,383	369
Chronic Obstructive Pulmonary Disease Exacerbation	Hospital	2.3	972	369
Adapted from McKinsey document titled "Selected facts relating to episode impact for Arkansas Medicaid; June 18, 2015 – updated July 8 with volume numbers"				

Discussion

The episodes were rolled-out in several rounds beginning in July 2012, as shown in Table 33.

Table 33—Key milestones in Episodes of Care

Episode	Episode Launch Date
	Jul 2012
ADHD	Jul 2012
Perinatal	Jul 2012
CHF exacerbation	Oct 2012
TJR	Oct 2012
Colonoscopy	Jul 2013
Gallbladder removal	Jul 2013
Tonsillectomy	Jul 2013
ODD	Oct 2013
CABG	Oct 2013
Asthma exacerbation	Apr 2014
COPD exacerbation	Oct 2014

Savings Potentially Attributable to the EOC Program

The current annual spend on the episodes that have been implemented so far is just short of $180M. The total annual spend on all additional potential episodes for the Principal Accountable Providers (PAPs) involved with the episodes that have been implemented so far is almost $1B.

The range of estimates for the direct savings to date, along with the direct episode spend for those same episodes, yields an estimated range for the potential annual savings from the several episodes for which at least a year of data has been analyzed. For only those episodes that have been in place for at least a year and for which sufficient time has passed since the end of the first year for claims run-out and analysis, the savings potentially attributable to the EOC program is estimated to be between $8.4 and $15.2 million per year

If we assume that the episodes that are currently active, but that have not yet had enough time to be analyzed for potential impact, follow the same pattern of the EOCs from the first two rounds, we can estimate the savings potentially attributable to the EOC initiative.

For those EOCs that have been implemented, but for which not enough time has passed to allow for meaningful estimates of the savings potentially attributable to those episodes, the following assumptions were made:

- For those episodes in the latter waves that had the hospital as the PAP, we used the estimated impact range from the one hospital episode that was in the first batch.
- For the BH episode in the latter waves, we used the estimated impact range from the one BH episode in the first batch.
- For the episodes in the latter waves that were procedural, we used the estimated impact range from the one procedural episode in the first waves.

With those assumptions and the direct episode spend for all of them, we calculated an annual potential savings range of $8.7M-$20.3M for the currently implemented episodes, inclusive of the EOCs from the first two rounds for which more direct potential savings estimates are available.

Cost of the EOC Program

The total cost of the McKinsey engagement from SFY12-SFY15 has been $93,220,000. The McKinsey engagement has involved work on the EOC initiative, as well as PCMH and activities relating to strategies to managing costs for the LTSS, DD, and SPMI populations (e.g., development of the RFI for managed care for these populations).

For the McKinsey engagement, we can assume different allocations of effort to the EOC initiative. It appears that the majority of the work that McKinsey did was in support of the EOC initiative. In addition to the McKinsey work, other vendors, including General Dynamics Information Technology (GDIT), Northrop Grumman, and Hewlett Packard (HP) were paid

certain amounts to support the technical implementation. The costs of the EOC program can be broken out into initial development costs and ongoing maintenance costs. The initial development costs for the initial 14 EOCs are estimated at about $43 million, or about $3.1 million per episode, as shown in Table 34.

Table 34—Development costs for first 14 EOCs

	2012	2013	2014	Totals
McKinsey	9,900,000	11,200,000	10,500,000	31,600,000
GDIT			3,500,000	3,500,000
HP	1,898,124	2,466,408	3,534,642	7,899,174
Totals	11,798,124	13,666,408	17,534,642	42,999,174

While the EOC program has not been running for very long, the SFY 2015 maintenance costs for the first 14 EOCs provides a point of reference for potential recurring costs associated with the program.

Table 35— Maintenance costs for first 14 EOCs

	2015
GDIT	2,932,261
HP	4,405,016
Total	7,337,277

The total maintenance cost in 2015 for the first 14 EOCs was about $7.4 million. While the scale of the maintenance cost may change over time, it is reasonable to use this figure as the recurring cost for maintaining the EOC program at its current scale.

Estimated ROI for the EOC Program to Date

As discussed above, a reasonable range for the annual potential impact on spending of the EOC programs currently implemented, based on the assumptions noted, is between $8.7 and $20.3 million. Furthermore, as additionally described above, a reasonable estimate for the cost of the development and design of the EOC programs currently implemented, is $43 million. Given these ranges, and all of the assumptions within the corresponding calculations, the current set of episodes would break even within between 3 and 32 years, without considering a discount rate. Additionally, as noted, there may be additional costs borne by the agency, inclusion of which would increase the time to break even and there are costs associated with other vendors that should also be allocated to this effort. On the other hand, the initial costs are already expended and the ongoing maintenance cost of the program is less than the conservative savings estimate. In addition, other programs and payers have indicated that they believe that they have benefited

from the EOC initiative, suggesting that a limited calculation of ROI within the confines of the Medicaid financial experience may give only a partial picture of the true ROI.

Potential EOC Program Impact Mechanisms

There are several different mechanisms through which the EOCs might impact the cost and pattern of health services delivered to Medicaid recipients by providers involved with the EOCs.

The primary mechanism by which the EOC initiative appears to be designed to operate, is by creating incentives to reduce the cost of the episodes. However, there are several other potential mechanisms that might result.

- Episode avoidance (appropriate) – There may be some situations wherein a provider opts not to initiate the procedure or other clinical event that would serve as the trigger for an EOC because the provider recognizes that the patient may benefit more from an alternative therapy. (Example: Faced by an obese patient with significant joint issues, an orthopedic surgeon might have previously recommended knee or hip replacement. However, knowing that: 1) obese patients are more likely to suffer from complications, 2) clinical protocols recommend weight loss before knee or hip surgery for obese patients in order to reduce the likelihood of complications, and 3) that if complications occur, the surgeon might lose money through the EOC program, the surgeon might choose to pursue other therapies first, thus avoiding the episode.
- Episode avoidance (inappropriate) – Since, for each EOC, the EOC program excludes certain patients based on specific clinical criteria, often including comorbidities, then a PAP can exclude certain patients from the EOC calculations by modifying the diagnoses, either to no longer align with the EOC or to add comorbidities that exclude the patient.
- Service substitution– There may be cases where a provider chooses to substitute other services instead of those associated with a given EOC. For example, for the Total Joint Replacement EOC, a surgeon might opt for physical therapy and weight loss counseling. Absent the EOC program, these services might not have been provided (and reimbursed by Medicaid.)

The analyses conducted to date have focused on the potential impact of the EOC program on episode cost reduction and appropriate episode avoidance. Determining the full impact of the EOC initiative will require analysis of the entire Medicaid program spend, the analysis of which is, unfortunately, confounded by other factors.

Factors that confound the analysis of the impact of the EOC program

There are a number of factors that make it difficult to estimate the impact of the EOC program.

- The establishment of the PCMH program and the PO at times that overlapped with the implementation of the EOC initiative, all of which have the potential to impact Medicaid costs, makes it particularly difficult to isolate the impact of the EOC program.
- National macroeconomic factors may influence Medicaid caseload and spending. During the recovery from the recent recession, some portion of the Medicaid population could experience increases in income, making them no longer eligible for Medicaid, and thus reducing the overall Medicaid spend.
- Likely also related to the recession, national healthcare expenditures have experienced several years of relatively low and steady growth rates.

Factors that might make the EOC program more effective in the future

Some factors might make the EOC programs increasingly effective in the future, even without increasing the number of PAPs and without changing the structure of the risk-sharing:

- As PAPs grow more accustomed to the economic incentives and feedback loops (i.e., the individualized performance reports), there could be a "learning curve".
- As PAPS change their behavior in order to maximize their performance on the EOCs, there may be related behavior changes associated with procedures and situations that are not yet covered by any EOC, but still result in lower overall costs by diverting patients to lower-cost providers and services

Additional considerations

The development of the EOC program was funded primarily with federal and private funds. Some might suggest that ROI to the state should consider the sources of funds for the development and design of the program.

Based on feedback from Dr. Golden's team, as well as conversations with several Arkansas Blue Cross executives, TSG concluded that there is general agreement that the Episodes of Care payment model is delivering positive results for both the Medicaid population, as well as the PO population. For the PO membership, there is already evidence of claims expense reduction. For the Medicaid population, actual claims expense reduction has not yet been observed, but there have been signs that the *rate of growth* in claims expense is *declining*.

Potential next steps may include:

- Investigating the underlying mechanisms that could improve Medicaid's medical cost savings in the Episodes of Care payment model. Perhaps this investigation could include leveraging the learnings, techniques and relationships from the more effective PO experience. For example, Arkansas Blue Cross has observed Primary Accountable Providers driving more cases toward providers that are providing more affordable quality care, and thus meeting or beating budgetary targets of those Episodes of Care. That

desired motivation, behavior and outcome (all key objectives of the Episodes of Care program) should be applicable and replicable, to some extent, for the Medicaid population, and therefore should be studied and pursued.

- Positive results in certain types of Episodes should lead to consideration for more aggressive expansion in that related area. For example, if hip & knee surgery episodes have shown promise in cost & quality outcomes, suggesting that Orthopedic Surgeons have demonstrated themselves as competent and successful Primary Accountable Providers, then additional orthopedic cases should be added to the Episodes of Care program in order to leverage the skill and experience of those successful practitioners.
- The sharing of valuable information among PO carriers and DHS regarding successes and disappointments in payment models, techniques, experiences and outcomes could be very helpful to all parties to generate as much total value from the Episodes of Care program for all parties and the community. Policies, guidelines and relationships may need to be carefully designed and executed in order to promote this partnership behavior and to achieve this grander goal.
- Purely from the description of the reimbursement model and commentary from some noteworthy sources, the Episodes of Care model for Arkansas seems thoughtfully designed and constructed, with characteristics that focus on both medical cost and quality management. However, as with any well-designed model, adjustments to the model to further deliver better outcomes based on statistical evidence, stakeholder feedback, etc. will likely be necessary and advisable.

17.3. Additional Planned But Not Implemented DHS Payment Improvement Initiatives

Behavioral Health

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

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

- Substance Abuse services for children and adults

- Wraparound support services for children and their families
- Recovery Oriented Services for Adults
- Enhanced crisis stabilization and response services
- Peer Support and Family Support Partners for adults and children

The idea proposed by DHS was that the Behavioral Health Homes would provide intensive care coordination services for adults, children, and families identified to be high utilizers of behavioral health services. Additionally, Health Homes would serve as the single referral agencies for children's residential services. Phase two of the promulgation was intended to include policy amendments to dissolve the Rehabilitative Services for Persons with Mental Illness (RSPMI) program and change the requirements for admission to children's residential services to mandate referrals that come only from Health Homes.

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

Developmental Disabilities

In March of 2014, DHS submitted the Community First Choice Option (CFCO) State Plan Amendment to the Center for Medicare and Medicaid (CMS). At that time, CFCO was seen by DHS as a cost effective option to deliver home and community based services (HCBS) to DDS Waiver recipients and as well as recipients of other DHS waiver programs. Stakeholder groups consisting of parents/guardians of DDS consumers, Waiver providers and State staff met to discuss several cost effective cost control measures related to or running concurrent with CFCO. Those measures included development of DD Health Homes, Episodes (see below), and Assessment Based Payments, and the possibility of being capable of serving eligible DDS consumers currently on the DDS Waiver waitlist with the enhanced 6% federal match CFCO offered to all waiver consumers.

Legislative and stakeholder opposition for both CFCO and Episodes generally resulted in the CFCO SPA being withdrawn in early 2015. DDS has since moved forward with an Assessment Based Payment methodology for the current 1915(c) Waiver. According to DHS, because the DD Health Home design was based on moving case management services from the Waiver into CFCO, it would be impractical to move forward with the DD Health Home and that service category remains in the waiver for the time being.

18. PHYSICIAN SURVEY

18.1. Results of Physician Survey Synthesized

TSG conducted a survey of Arkansas health care providers between June 26 and August 14, 2015 to assess attitudes regarding the PO and Payment Improvement Initiatives, in particular the Episodes of Care (EOC) and Patient-Centered Medical Home (PCMH). The survey closed with 426 responses, including 287 representing physician offices, 62 representing hospitals, and 77 representing other points of care. The results of the survey and TSG's analysis is attached as Appendix 5.

19. ADMINISTRATION OF HIGH COST POPULATIONS INCLUDING LONG TERM CARE, BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITIES

The effective administration of state management of high cost complex populations requires an integrated and adaptable health and human services organizational structure, leadership across the organization, a shared vision that includes a partnership mentality with all stakeholders, the use of performance, outcomes, and quality data informed by predictive analytics. Validated independent program eligibility assessment, individual services planning aligned with state determined levels of care, and logic-based individual budgets are the starting line for any state's modernization efforts to re-balance their long term care systems from institutional based utilization to community based first option systems. Arkansas Division of Aging and Adult Services (DAAS) and Division of Developmental Services (DDS) services are based on 1915 (c) Home and Community Based Services (HCBS) waivers and the Division of Behavioral Health Services (DBHS) Rehabilitative Services for Persons with Mental Illness (RSPMI) are based on a state plan amendment. All DAAS, DDS, and DBHS services are currently paid fee for service.

19.1. Independent Universal Assessment in DHS, DAAS, DDS, and DBHS

Universal assessment models that include program eligibility and acuity based levels of care related to cost of needed services have become a state best practice and are being implemented through state managed care contract models that include aging and physical disabilities populations, people with intellectual and developmental disabilities, and adult and children/adolescents with significant mental illness/serious emotional disturbance.

New York, California, and Maine have been successful in implementing universal assessment models into their Medicaid Long Term Services and Supports Programs. Washington and Wisconsin have been successful in developing computer based algorithms associated with their universal assessment instruments that determine levels of care leading to plans of care and cost

based on acuity. This approach has been integrated into full benefit state Medicaid managed care plans such as Kansas and Tennessee.

The importance of the assessment process for Long Term Services and Supports (LTSS) for the ABD population seeking waiver and/or RSPMI services is important because it establishes the required medical necessity for program eligibility and a relationship between the level of care and cost. Acuity based assessment processes are a critical component of Medicaid modernization because they provide an objective and comparable understanding of the needs and strengths of each individual that assures eligible individuals receive the service(s) they need in the right amount, at the right time in the setting of their choice, and at the least cost matched to the person's needs.

DHS made the decision to plan, develop, and implement a "universal, independent, and comprehensive assessment" across the Divisions of Behavioral Health Services, Developmental Disability Services, Aging and Adult Services, and the Office of Long Term Care/Division of Medical Services in 2010/2011. Based on a national search and some stakeholder involvement DHS made the decision to implement the InterRai universal assessment suite of instruments, which has proved to be problematic.

There were differences of opinion among stakeholders on the use of the InterRai across all three populations including support for the use of the SIS for people with intellectual and developmental disabilities and the LOCUS for adults with serious mental illness and the CANS for children and youth. The InterRai organization is nonprofit, sponsored by the University of Michigan, and is used in several states and countries primarily in the long term care domain. There are 18 discrete InterRai assessment instruments including Long Term Care – Facility, MH – Facility (with Forensics component), Home Care, and Developmental Disabilities. Each instrument has identical core items shared across all instruments as well as population specific items. In the Arkansas application there are over 100 shared core items among the three instruments.

Based on a RFP process, DHS contracted with CHMack-MedCompass to implement the Information Technology platform for the InterRai assessment instruments across DAAS, DDS, and DBHS programs. The project met with unproductive outcomes resulting in DHS' termination of the contract. DHS then used an existing state contract (CoCentrix) to 1) complete the development of the digital home and portal for the InterRai project across DAAS, DDS, and DBHS; 2) develop a functional process for in the field completion and storage of the assessments; 3) develop a functional process for the system to assign levels of care based on the logic of each instrument; 4) develop an integrated individual plan of care; and 5) assign the individual services plan budget based on the assessed level of care. This project also met with timeline implementation issues.

In 2015, DHS halted the development of the InterRai within the DBHS system until further progress was made within the DAAS and DDS systems. At this time, DHS/DBHDS has not set a timeline to start and complete the implementation of the InterRai assessment system for the state's behavioral health system. The target completion date for the project has been reset to 2016 by DHS.

Should the project be completed DHS, DMS, DAAS, and DDS should develop service volume and cost benchmarks based on current practice and current cost for the purpose of analyzing and comparing the impact of implementing the InterRai on services volume and cost differences, patterns, and trends in the future.

The "Three Phases" of project development include: Phase One: systems functional capability to complete InterRai assessments for DAAS and DDS home and community based services; Phase Two: IT systems functional capability to develop the individual plan of care and budget based on the assessment and level of care; and Phase Three: Provider portal and data analytics.

Should the project not be completed by the time elected officials make their decision on their approach to Medicaid modernization, there would be reason to place the entire InterRai enterprise on hold pending decisions around maintaining a continuing fee for service approach, a managed fee for service approach, or a capitated full risk managed care approach for these vital high cost services.

19.2. Division of Aging and Adult Services/Division of Medical Services Office of Long Term Care

The Arkansas Medicaid system of Long Term Care for Older People and People with Physical Disabilities is organized within the Department of Human Services and is structured under two separate divisions: The Division of Medical Services – Office of Long Term Care, and the Division of Aging and Adult Services.

The basic logic for this organizational model appears to be based on institutional care being accessed and managed through the Office of Long Term Care and home and community based services accessed and managed through the Division of Aging and Adult Services.

DAAS has a goal of a "no wrong door" access system for Arkansans seeking LTC services. The Aging and Disability Resource Centers (ADRC) act as a "one stop shop" for people seeking information about LTC services. Access begins at a local DHS office for those not accessing services through hospital or nursing home stays. Once an individual completes an application for services, the local DHS office forwards the case to DAAS. A qualified DAAS nurse schedules a home meeting with the individual at their convenience. DAAS has streamlined the HCBS assessment process by the recent use of the InterRai assessment instrument in the field. The

nurse administers the assessment into a laptop device and immediately knows if the person is eligible for HCBS. A Plan of Care is determined and the DAAS nurse has the ability to inform and assist the client in the home with their freedom of choice options for HCBS services providers, and case manager provider. Functionality of the IT system supporting the InterRai assessment remains a question as of the date of this report.

DAAS provides services to older adults and adults with physical disabilities through the Elder Choices, Living Choices Assisted Living, Independent Choices waivers, Money Follows the Person, and A Plus programs. The point of entry for Nursing Facility (NF) level of care eligibility is provided by qualified nursing facility professionals across the state. NF staff administer the OLTC Form 703 assessment with the individual seeking services, most often in a hospital setting with the involvement of hospital discharge staff.

Often, the person is admitted to the NF that provided the qualified staff to conduct the assessment. The completed assessments are sent to OLTC in Little Rock where the medical necessity determination is made. Approximately 12,000 cases are processed each year by OLTC including initial and annual reassessments/change in condition. Denials can be appealed, reconsidered, or taken to court post appeal.

Currently there is no active transitional planning system accessible to an individual in a hospital or nursing facility upon completion of a successful episode of hospitalization or NF rehabilitative treatment. Although a person who is in need of services post discharge from a hospital is advised of "Community Options," their current needs post hospital discharge often require short term rehabilitation stays in NFs paid by Medicare. The lack of an effective transitional services model in a state's long term care system is a serious service gap.

Presumptive eligibility for NF level of care paid by Medicaid is effective on the date of NF facility admission and retroactive for 90 days. Presumptive eligibility for HCBS LTSS services from the date of hospital or NF discharge is not permissible given CMS barriers that could be addressed in an 1115 waiver.

An individual, who is being discharged from a hospital or nursing facility and would prefer to return home and could with immediate in-home support and, possibly, short term nursing services, cannot do so in a timely way in the current system, as the approved Form 703 for NF eligibility does not transfer to HCBS services. DAAS recognizes the need for active in hospital and NF transitional services and the need for pre-screening prior to NF placement through the "Money Follows the Patient" and the "A Plus" programs.

MFP covers Medicaid eligible individuals in Nursing Facilities, Intermediate Care Facilities for people with Intellectual/Developmental Disabilities, physically disabled individuals, and people with serious mental illness.

There is a significant opportunity for DHS to lead an integrated planning and implementation effort across DMS/OLTC, DAAS, DDS, and DBHS to improve Arkansas' transitional services for all ABD populations based on one vision, single point of entry, and integrated assessment process that prioritizes choice and access to HCBS services in a timely manner. TSG has been advised that Area Agencies on Aging provide limited unpaid transitional services when they are able.

The current model results in a fragmented approach to integrated care coordination given the ABD carve out from the PCMH and Episodes of Care models. An integrated model of LTC services includes an independent assessment of a person's program eligibility using the same assessment instrument for determination of level(s) of care for NF and HCBS services, continuing state determination of medical necessity, and includes an individual's preference to return home being documented at the initiation of their plan of care regardless of setting.

Discussions continue to take place within DHS between DAAS and OLTC/DMS regarding replacement of the NF/Form 703 assessment process with the LTSS InterRai, which should result in a single assessment process for institutional and home and community based living services and move medical necessity determination from OLTC to DAAS. DHS does not have an integrated Project Management Plan or schedule to resolve this important policy question and appears it ambiguous as a function of the IT project for the InterRai and Project Management Plan for the IT vendor, CoCentrix. TSG observations indicate that DAAS has well qualified nursing staff to administer the LTC InterRai for anyone seeking Long Term Care Medicaid services regardless of preferred or needed setting and this should be implemented within the current system.

Nursing facilities do report resident responses to the MDS "Question Q", which indicates a nursing home resident's interest in returning to the community, to DAAS, resulting in face to face follow-up. This process, however, requires the person start the application for HCBS services from the beginning of establishing HCSB program eligibility, an additional assessment and a time delay that could be avoided by the implementation of a single assessment instrument for NF and HCBS services at the person's initial application for LTSS services.

DAAS has stated there has been success in the implementation of Phase One of the LTC InterRai assessment instrument for home and community based services. The target dates for the contracted vendor to complete Phase Two (Plan of Care) and Phase Three (Cost tiers based on acuity levels) are in flux after five years plus of implementation planning. DHS has reset the "Production" target date for Phase Two of the InterRai implementation for November, 2015 and a target date of 2016 for implementation of the OLTC assessment.

Although there are variances across the state, DAAS is currently averaging between five and six days for completion of a new Elder Choices waiver application and assessment for services and

the same for an Alternatives for Adults with Physical Disabilities waiver application and assessment for services on a statewide basis.

DAAS has 10 business days by Rule to complete new waiver assessments and currently does not have a waiting list to complete new program eligibility assessments. TSG has been advised that financial eligibility determination is a problem for many individuals who have completed the HCBS InterRai assessment by DAAS and are waiting for financial eligibility determination. DAAS took over this function approximately 6 months ago and the new Director is committed to shortening the delay for the determinations.

As of 7/15, DAAS reports the financial eligibility backlog is 564 cases reportedly down from 900 cases when DAAS became responsible for this process. DAAS expects the backlog to be approximately 500 cases on 10/1/15 with resolution of all cases shortly thereafter as new staff are in the process of being hired. DAAS reports that 72.65% of all new case applications are processed within the 45 day requirement.

19.3.Division of Developmental Disabilities Services

The Division of Developmental Disabilities Services provides services for children and adults. These services include: Part C Early Intervention/Infant and Toddlers; Part B Early Childhood Services; Title V Children with Special Health Care Needs; Adaptive Equipment; DDS Waiver Services (Alternative Community Services ACS); DDS Children's Services; Developmental Day Treatment Clinic Services (DDTCS); and five Human Development Centers (ICF/ID). DDS operates Intake and Referral Unit services for children 0-21 and adults.

DDS provides services and supports for approximately 4,200 persons on the ACS waiver, 920 individuals residing in state Human Development Centers, approximately 330 persons residing in private ICF/IDs, and approximately 200 children residing in four pediatric programs. There are currently 107 private DDS case management providing organizations with many also providing DDS waiver services. Consumers and their families are provided an option for independent case management or provider based case management services.

DDS provides individual assessments based on the InterRai for the 4200 people receiving ACS services. Adults will be reassessed every three years thereafter. Approximately 900 children receiving services are assessed annually, resulting in a three year sequence of 4200 annual assessments in the first year, 900 assessments in each of the following two years, and the beginning of the sequence in year four with 4,200 assessments. Approximately 100 to 130 individuals are assessed and added to waiver services annually as vacancies become available, clearly an indicator of access to service issues.

As of the most recent data available, there are approximately 2,900 individuals on the ACS waiting list. The waiting list is reviewed every three years. Some individuals on the ACS waiting list receive non-ACS services based on their Medicaid eligibility for other categorical benefits such as the under 21 years of age group, and individuals with SSDI determinations. Current DDS policy prioritizes available waiver services for persons choosing to transition from Human Development Centers, nursing facilities, and Arkansas State Hospital. Given the relatively low annual turnover of persons receiving waiver services or institutional care (110 to 140 per year) there are extensive wait times for persons currently living in the community regardless of the type of services they seek.

Individuals and families seeking services and supports from DDS access their services at the DHS/DDS local county office. DDS provides a web-based portal for information for the Children's and Adult Intake and Referral units.

Individuals and families must complete pre-screening requirements prior to a DDS assessment taking place. These requirements include documentation of condition(s) that the individual or family is responsible for. DDS has a $25,000 fund for Medicaid eligible individuals to assist with this requirement.

Once the pre-screening process is completed the DDS assessment process begins. The first step of the program eligibility determination process includes the administration of the Reynolds, RAIS, or WAIS for IQ determination and the Vineland Adaptive Behavior Scale by contracted independent testing professionals (Pine Bluff Associates). Upon completion of the IQ and functional assessment testing the InterRAI assessment is administered by qualified DDS professionals if the person is found eligible for services. The InterRai assessment determines the individual's needs, strengths, and preferences as well as acuity levels anticipated to be tied to individual budgeting and services planning.

Applications for ICF/ID admission are processed on Form 703 and medical necessity is determined by the DMS Office of Long Term Care. According to DHS the assessment process of the DDS version of the InterRai is functional, "completed and in active use." Upon completion and analysis of the results of the InterRai assessment DDS qualified staff assist individuals to select services they are eligible for and choice of case manager. DDS expects to integrate the use of the InterRai assessment derived payment tiers into ACS waiver management in 2016. DDS qualified staff also provide assistance to individuals who are found ineligible for DDS services with referral to other DHS services and supports for which they may be eligible.

19.4.Division of Behavioral Health Services

The Division of Behavioral Health Services (DBHS) provides an array of services across Arkansas for children, adolescents, and adults. DBHS services and resources are targeted to several priority populations including Act 911/NGRI individuals; individuals civilly committed to the public mental health system based on dangerousness to others; forensic patients and community releases; adults with a Serious Mental Illness (SMI) based on physician certification; children/adolescents with Serious Emotional Disturbance (SED) based on physician certification; and other people seeking public services as remaining resources permit.

DBHS contracts with 15 community mental health centers that serve as the single point of entry into the Arkansas State Hospital based on the state's civil commitment statute and screening. ASH has a total of 222 beds organized around general adult (90 beds), forensics (96 beds), and adolescents (36 beds).

At 6.6 state psychiatric hospitals beds per 100,000 population Arkansas has one of the lowest number of available state psychiatric hospital beds in the country. The national average in 2013[92] was 13.2 beds per 100,000 people. Arizona, Iowa, Minnesota, New Mexico, North Carolina, and Vermont have a lower state psychiatric bed capacity per 100,000 than Arkansas.

In addition to Arkansas State Hospital, there are 8 free standing psychiatric hospitals with a total of 816 beds. The Division contracts and disburses funding to the CMHCs for local acute psychiatric inpatient hospitalization for non-covered individuals. The Division also operates the Arkansas Health Center, which is a 310 bed skilled nursing facility (SNF) focused on psychiatric illness, advanced dementia, and related health conditions. The case mix of this unique facility includes people who are ventilator dependent and individuals who have been unable to thrive in other institutional settings. TSG visited the AHC and toured all wards.

The Division funds a wide range of services for adults, children, and adolescents including alcohol and addiction services, rehabilitation services for people with serious mental illness, gambling addiction, and prevention. Currently approximately 70,000 children and 39,000 adult Arkansans are served by DBHS. There are approximately 712,000 children under 18 in Arkansas.[93] RSPMI services are provided under a CMS State Plan Amendment. Administrative services attached to the RSPMI benefit, such as prior authorization, utilization review, and medical necessity determination, are contracted by DMS.

DBHS certifies public (CMHCs) and credentialed private providers as eligible to deliver Rehabilitation Option services (RSPMI).

---

[92] National Research Institute/NASMHPD: FY 2013 State Profiles
[93] US Census Bureau. QuickFacts Beta

As of 2013, all 50 states plus the District of Columbia provide behavioral health services under the "Rehab option." Nineteen states plus DC manage the benefit through fee for service with some limits on eligibility, amount and duration (generally lacking in the Arkansas model), and eligible providers.

Thirty one states provide Rehab option services through managed care contracts: 14 states include the benefit in an integrated model with physical health; 14 states contract with local jurisdiction behavioral health provider systems in a limited Rehab option only benefit model, and two states with both models.[94] State managed care contracts add specific requirements for screening and standardized clinical assessment, establishment of medical necessity, and, importantly, documented evidence of clinical efficacy of the service(s) which impacts duration, which impacts cost.

There are currently 39 non-CMHC RSPMI providers with a moratorium on further growth. One of the unintended consequences of the moratorium is that the RSPMI benefit is monopolized by currently licensed RSPMI providers. One of the results of this model is that no entity or system of care is contractually obligated to provide crisis diversion services for higher cost inpatient services when the level of care is clinically short of danger to self or others.

DBHS was originally included in the DHS plan to implement the mental health version of the InterRai universal assessment instrument. A decision was made by DHS to suspend DBHS implementation in 2015. DBHS reports there is no timeline to start the development of use of the InterRai into the RSPMI system or for voluntary inpatient admissions at this time.

The lack of an independent standardized clinical assessment instrument supporting treatment planning and assuring effective minimal cost for adults and individuals under 21 years of age to access RSPMI services is a major driver of the growth in expenditures over the past several years with no discernable decrease in inpatient psychiatric services and child/adolescent residential services. There is a lack of a comprehensive public mental health strategy designed to support recovery within a community based managed continuum of care that results in effective diversion programs from unnecessary inpatient psychiatric hospitalization, residential program placements, and avoidable jail admissions for low level crimes associated with severe and persistent mental illness.

The RSPMI menu of benefits is lacking a fundamental platform of evidence based practices as well as any incentive or disincentive for comprehensive care coordination (adults) or integration of all Medicaid services for adults with serious mental illness and children and adolescents with

[94] "How Does Managed Care Affect Delivery of Medicaid Rehabilitation Option Services". Laura Morgan, Open Minds, 9/4/14

Serious Emotional Disturbance, victims of trauma, and related conditions. There does not appear to be a "systems of care" approach for high risk children and youth and their families.

Prior authorization and utilization review services are provided under contract between DMS and Value Options. This approach to contracting between the single state Medicaid agency on behalf of the single state Mental Health authority represents an organizational construction that does not drive the content of the contract by subject matter expertise in behavioral health. Value Options provides only administrative services including: Psychiatric inpatient services prior authorization for under 21 population; certification of need and determination of medical necessity for admission; continued stay and quality of care for inpatient psychiatric treatment by providers who are enrolled in the Arkansas Medicaid inpatient psychiatric program; care coordination for the under 21 population; discharge planning; outpatient utilization and quality control peer review including prior authorization; and on-site quality and program policy review.

Any RSPMI provider may "assess" an individual for Rehab Option services and forward the assessment and suggested plan of care to Value Options for their independent prior authorization approval. Value Options relies on the clinical narrative and submitted demographics, past known history of psychiatric illness, medication and diagnosis submitted by the RSPMI provider conducting the patient assessment (who would very likely deliver and bill for the approved services). There does not appear to be any IT process in place for either the RSPMI provider or Value Options to access MMIS claims or Arkansas State Hospital (ASH) utilization data in order to verify past history for inpatient or residential services paid by DMS or ASH.

Value Options provides care coordination services for up to 1,500 ("highest utilizers of high utilizers") beneficiaries a year for the under 21 years of age population. The goals of the Care Coordination program include increasing time living in the community, unification with family/significant others, decreased need for admission to acute inpatient and residential treatment, timely discharge planning and linkages into the community, increased utilization of outpatient services, and community supports and assistance in accessing the existing System of Care initiatives. The average follow up period is 5 months and discharge is based on clinical criteria. Currently any RSPMI provider may "assess" an individual for Rehab Option services and forward the assessment and suggested plan of care to Value Options for their independent prior authorization approval. (Note: TSG separately reviewed data on 1,000 of the beneficiaries with the largest claims amount in both traditional Medicaid and for the medically frail obtained from DHS. These are presented as Appendix 6.

Given the program eligibility process for RSPMI services does not include a standardized clinical assessment instrument for any covered population it is difficult to see how unnecessary overutilization is consistently identified and avoided. Value Options may approve the assessment and plan of care for six months with a 90 day treatment plan review required by CMS.

This service requires an annual psychiatric evaluation. Astonishingly, there are only daily limits on certain codes for Outpatient services, such as an RSPMI provider cannot bill more than 6 units of group therapy in a day. There is no evidence-based mental health practice that includes 6 units of group therapy a day and appears subject to potential misuse and overutilization. There are no limits on outpatient units per authorization period which is a clear incentive for overutilization.

Additionally, there are no limits on both inpatient psychiatric and residential services for the 21 and under child/adolescent population and no discernable "hard wired" community based approach to comprehensive and coordinated post discharge plans of care. School-based RSPMI services do not appear to be constructed around a shared program orientation with DOE and local schools and we question if these services are integrated into the Individualized Education Plans (IEPs) of children and youth with disabilities.

The adult inpatient psychiatric benefit is limited by a set number of State Plan annual inpatient days and is not subject to prior authorization, which is highly unusual for the most expensive level of care. Value Options reports they approve 95% of submitted RSPMI authorization requests. This level of approval is substantial given the lack of a standardized assessment that measures a person's level of psychiatric acuity/need and progress towards treatment goals. Of the 39 Outpatient RSPMI adult services, 12 services require prior authorization. Of the 28 RSPMI services for the under 21 population, 15 require prior authorization. Services that do not require a prior authorization are limited to annual use with an override based on documented need.

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

The PCMH model excluded the SMI population. DBHS developed a mental health focused health home model in 2014 but planning was halted due to a lack of consensus and has not been reconsidered within DHS/DMS. The DBHS model health home, with significant similarity to the successful Missouri model[95], should be considered in comparison with the PCMH model and/or an integrated full risk care management model.

[95] "Health Homes in Missouri". Joe Parks, MD. integration.samhsa.gov

DBHS is concerned about quality services and a lack of incentive to avoid inpatient utilization or encourage timely discharge with the current policy approach to RSPMI services and cost. Revising the RSPMI benefit to decrease reliance on individual outpatient treatment to include evidence-based practices such as Assertive Community Treatment (ACT) would improve measurable outcomes, decrease unnecessary hospitalizations, and support more integrated behavioral health service delivery.

ACT provides a professional and peer based team that works with high risk and complex needs clients in the community/streets 24/7 that has been proven to increase community tenure while decreasing emergency room use and psychiatric inpatient utilization. SAMHSA considers ACT an evidence based practice (SMA08-4345) applicable for civil and forensic populations in the community.

Case management services for the SMI and SED populations were discontinued several years ago and replaced with "Intervention" services in the RSPMI program. Intervention services are billed in 15 minute increments and do not appear to be designed to provide assistance and support to the high acuity population in the community in a clinically defined manner that includes incentives to avoid hospitalization or decrease fragmented service delivery.

The proposed transformation of the RSPMI benefit DBHS proposed in 2014 included three tiers of service based on an independent assessment and care plan process (using the BH model of the InterRai) from a non-provider contracted entity. The first tier of service was outpatient oriented and time limited for low level assessed acuity. The second level included redesigned evidence based practices home and community based services indicating mid-level need acuity. The third level of service was designed around certified behavioral health home care coordination and services delivery for the highest level of acuity. All service levels were designed to divert from expensive inpatient and residential services to less expensive community alternatives.

A recent report on the issue of mentally ill adults in jails and resulting costs within Arkansas reflects national attention to this issue. Concern about the appropriate treatment and cost of having a large number of adults with mental illness in jail instead of being treated within a mental health crisis and diversion model was the subject of the recent report "A Brief Cost Analysis of Arkansas Mental Health and Prison Reform." Sponsored by the Arkansas Public Policy Institute, the report points out that the cost to house and provide very limited treatment, if any, is $23,000 per year to house and provide limited services to a mentally ill adult in an Arkansas correctional facility or jail compared to $10,000 per year in a mental health crisis management program model.

The US Department of Justice, Bureau of Justice Statistics, estimates that nationally at least 20% of state prisoners and 21% of people in local jails have a mental illness problem, often co-occurring with substance abuse problems. The estimate is as high as 40%-45% depending on the

population served by individual state correctional facilities. Community approaches across the country include both diversion and re-entry interventions designed to avoid jail entry for people with mental illness for low level misdemeanor crimes, and community interventions designed to address recidivism. Community partnerships approaches to jail diversions in San Antonio/Bexar County, Texas, are considered a national model[96] and the Five Stage Interceptor Model in King County, WA includes the county run adult mental health system as a key component for crisis stabilization services "on the street"/mobile crisis team. States such as Utah, Illinois, California, and Ohio have had some success in addressing jail diversion for people with mental illness and low level crimes through substantial coverage of the population served by Mental Health Courts.[97]

19.5. Care Coordination and High Cost Populations

The Arkansas Medicaid enterprise has an extraordinary opportunity to adapt and integrate the positive outcomes other states have achieved through the adoption of a comprehensive integrated care coordination model across the aging and physically disabled, intellectual/developmental disabilities, and seriously mentally ill populations. This threshold undertaking requires the right DHS organizational structure, leadership, a shared partnership across all administrative services within the organization, and a state of the art approach to integrated care coordination that includes the state bureaucracy, consumers and families, providers, and community based organizations working in partnership towards a common goal.

The Agency of Healthcare Research and Quality defines care coordination and attributes as:

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

[96] "Blueprint for Success: The Bexar County Model Toolkit: How to Set Up a Jail Diversion Program in Your Community". National Association of Counties
[97] "Mental Health Diversion Practices: A Survey of the States". Treatment Advocacy Center, 2013

- Linking to community resources.
- Working to align resources with patient and population needs.

The Public Policy Institute (PPI) of AARP conducted a study[98] of 18 states who have implemented Managed Long Term Services and Supports (MLTSS) delivery system models based on managed care methods and competitively bid Managed Care Organization (MCO) contracts. The study report was recently released (7/15), reviewed by CMS, and is the most recent research into the rapidly increasing number of states who are transforming their traditional uncoordinated fee for service HCBS LTSS waiver programs into comprehensive integrated medical, pharmacy, HCBS waivers, innovative prevention measures, and related state plan amendment services through at risk managed care models (MLTSS).

The PPI conducted in-depth case studies of the Illinois and Ohio contracts and delivery systems as well as an in-depth contract review of the MLTSS models in Arizona, California, Delaware, Florida, Hawaii, Kansas, Massachusetts, Minnesota, New Jersey, New Mexico, New York, Ohio, Rhode Island, Tennessee, Texas, Virginia, and Wisconsin. The value of this study was that the PPI was able to identify emerging trends in how care coordination for the LTSS populations is being implemented while MLTSS is rapidly expanding across the country. For example, Iowa and Pennsylvania are currently in the process of transforming their LTSS systems and all medical services to a managed care model. Washington recently released a draft 1115 demonstration waiver that integrates all Medicaid services into one integrated care coordination managed care contracting model similar to the comprehensiveness of the TennCare model but with the addition of Accountable Care Organizations, community based care delivery, attention to the social determinants of health, and innovative LTSS prevention strategies while targeting cost increases 2% below the national medical inflation rate throughout the five year demonstration. The Washington 1115 model targets reduced avoidable intensive services, improvements in population health, and acceleration of value based payment strategies as key ingredients in achieving cost growth 2% below national trends.[99]

The past five years of innovative demonstration projects that many states have implemented with funds provided by CMS State Innovation Models (SIM) funding has been a catalyst for the development of state integrated managed care models that address the whole person through integrated care coordination based on Managed Long Term Services and Supports (MLTSS) through comprehensive managed care contracting and payment models.

---

[98] "Care Coordination in Managed Long Term Services and Supports (MLTSS)". Public Policy Institute of AARP. July, 2015

[99] "The Plan for Medicaid Transformation – Application for a Medicaid Transformation Waiver". Washington Health Care Authority at: hca.wa.gov

Given this relatively rapid change in state methods for contracting, delivering, and paying for integrated care coordination within Medicaid LTSS models, the Public Policy Institute's findings on how integrated care coordination is being structured in state managed care contracts and developing in the field is valuable information for state policy makers and administrators to consider in future planning.

The study found three trends on the methods LTSS MCOs were implementing care coordination at the community level of service delivery. The first trend was the "In House" model where the MCO provides care coordination with Plan staff, primarily credentialed social workers and nurses. This model tends to connect with traditional waiver based case management. The second model is based on a "Shared Functions" design where health plans subcontract with existing community providers, such as case management, and retain other aspects of care coordination, such as medical services, and integrates with community partners through IT based shared data and case information. The third less used model involves a health plan that delegates all care coordination activities to a health system or provider already engaged with the client(s). [100]

The Shared Functions model of MLTSS care coordination provides the opportunity for states to reconfigure their existing LTSS provider participants through an innovative business model that is based on operational and contractual partnerships. In this model, the health plan structures comprehensive care coordination through a team approach.

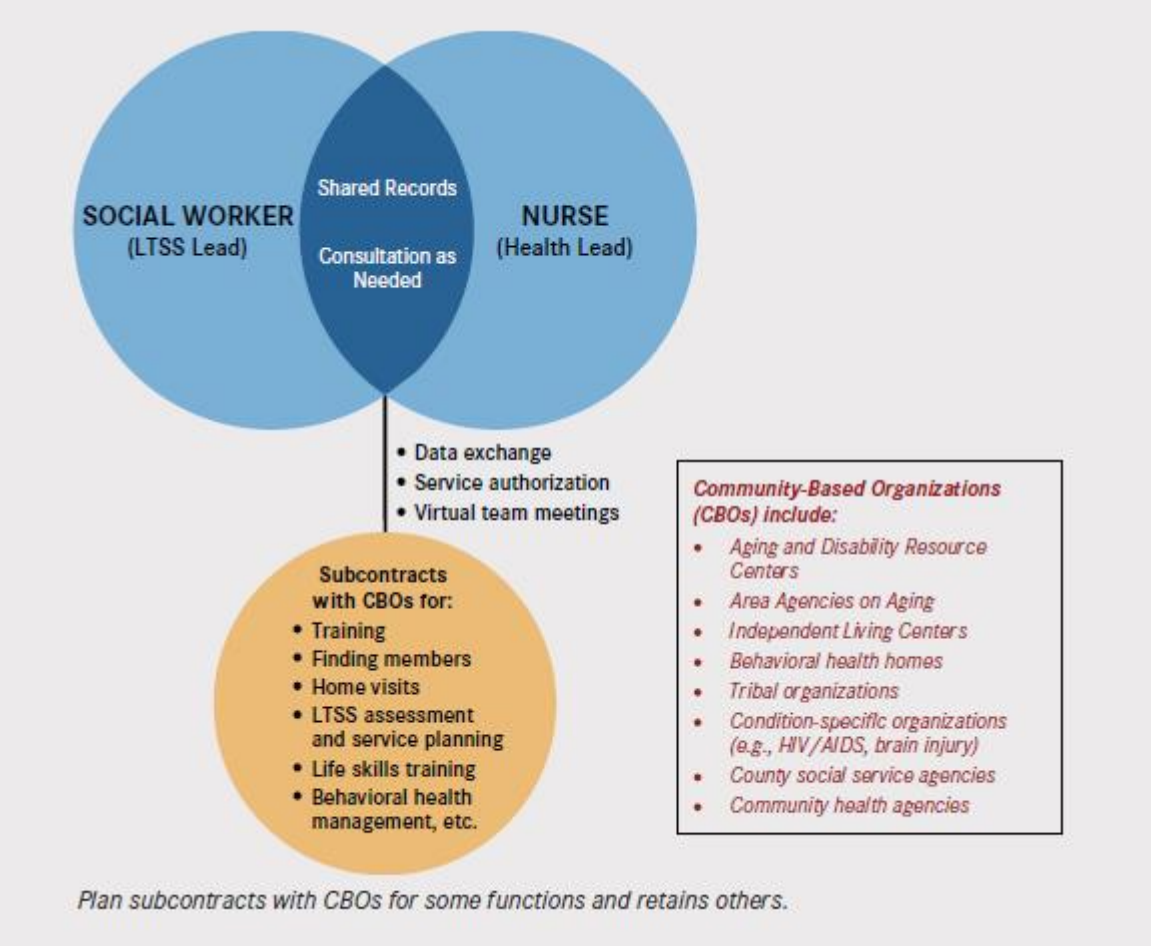
The health plan is operationally responsible for care coordination activities via a credentialed social worker and/or nurse working in tandem with the social worker responsible for community based (in some contracts nursing facilities as well) LTSS services and the credentialed nurse responsible for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

The plan contracts with community based organizations ("CBOs") for services such as training, finding and accessing members in need, home visits and traditional waiver services, LTSS assessment and plans of care, life skills and prevention training, and behavioral health management. It is shown graphically in Figure 48. Community based organizations include Aging and Disability Resource Centers (ADRCs), Area Agencies on Aging, Independent Living Centers, Behavioral Health homes, specialty services organizations, county social service agencies, Community Health Agencies. CBOs depend on the structure of the traditional LTSS state and community system while achieving care coordination through a single responsible care coordination role within the MCO, systems integration of community providers via MCO

[100] Ibid. p. 5-8

network connections, shared standardized protocols, and shared individual case and system performance data[101].

Figure 47—Shared functions model



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

[101] "Care Coordination in Managed Long-Term Services and Supports: AARP/Public Policy Institute. p. 6. July, 2015

proposition that effectively coordinated care results in improved health outcomes and reduces costs.

19.6. Medicaid Modernization: Developing Home and Community Based Services Capacity

Policy makers, stakeholders, and providers often ask that if a state intends to modernize their Medicaid Long Term Services and Supports benefits to provide greater choice and access to home and community based options, how will the state be able to assure there will be an adequate market supply to meet increased demand.

In FY 2008, total national Medicaid expenditures for Home and Community Based Services was $22.443 billion. By FY 2013, total Medicaid expenditures for the same population grew to $29.453 billion.[102]

In FY 2008, total Medicaid expenditures for Older People and People with Physical Disabilities was $8.006 billion. By FY 2013, total Medicaid expenditures for the same population grew to $10.690 billion.[103]

Between FY 2008 and FY 2013, the percentage of Medicaid Home and Community Based Services grew from 43% in FY 2008 to 51.3% in FY 2013 of all Medicaid Long Term Services for all covered populations.[104] Given the growth in the aging population and the increase in the number of states "modernizing" their state Medicaid programs by including LTSS in managed care models, the demand and supply for home and community based services has grown.

Recently, the Arkansas Department of Health's announced its intention to cease operations of its Home Health Services program based on the results of a detailed study that started two years ago. DOH engaged the BKD CPA's and Advisors group to conduct a study of the viability of the department's line of business for Personal Care, Home Health, Respite, Mother-Infant program, and case management with a focus on cost and trends. The study found that between FY 2011 and FY 2015, there was a 28% decline in persons served from 18,700 to 13,200 while state employees declined by 19% from approximately 2,900 to 2,400 for the same time period.

Total labor costs of the DOH Home Health program had climbed to 84% of revenue with 37% benefits cost in 2015. AR private provider agencies cost of labor was 63% of revenue with 19% in benefits costs and the national industry average was 75% of revenue for labor costs with 15%

[102] "Medicaid Expenditures for LTSS in FY 2013". CMS, Mathematica, Truven Health Analytics: 6/30/15: Table Z

[103] Ibid. Table AA
[104] Ibid. p. 9

benefits cost also in 2015. Clearly, DOH costs were unsustainable on a fixed cost basis and current rate structure. BDK recommended that DOH "Divest the Home Care operations through either outright closure of the Home Care program or a potential sale of the Home Care Program" in their Final report to DOH on 4/6/15.

There has been concern that this announcement could be a potential barrier to further expansion of Home and Community Based Services options in Arkansas. The DOH Home Care program and home care providers across the country have been impacted by Medicare rate reductions of 10% between FY 2011-FY2014 and an additional 1% reduction each year from 2014 through 2017 as a result of the PPACA.

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

States that have implemented Medicaid modernization of their Long Term Services and Supports such as Tennessee, Texas, and Ohio have been able to achieve a strong and continuous growth of home and community based services providers through business development strategies that include effective and cost efficient rates, partnerships with the nursing home industry to expand their line of business to include HCBS services with a focus on Assisted Living, and strong data analytics through care coordination practices of the MCOs. HCBS market development across the country has been accomplished through market response from a spectrum of provider organizational models, including for profit (state, regional, and national providers), not for profit HCBS providers, and public entities.[105]

States that primarily utilize national provider contractors in their MLTSS systems include DE, HI, NM, TX and WA.[106] States that primarily utilize local providers in their MLTSS systems include CA, MI, MN, NC, PA, and WI.[107] States that primarily utilize a mix of local and national contractors in their MLTSS systems include AZ, FL, MA, NY, and TN.[108] States that have implemented Managed Long Term Services and Supports systems through capitated at risk managed care models have included market responsive contracting methods, such as a global

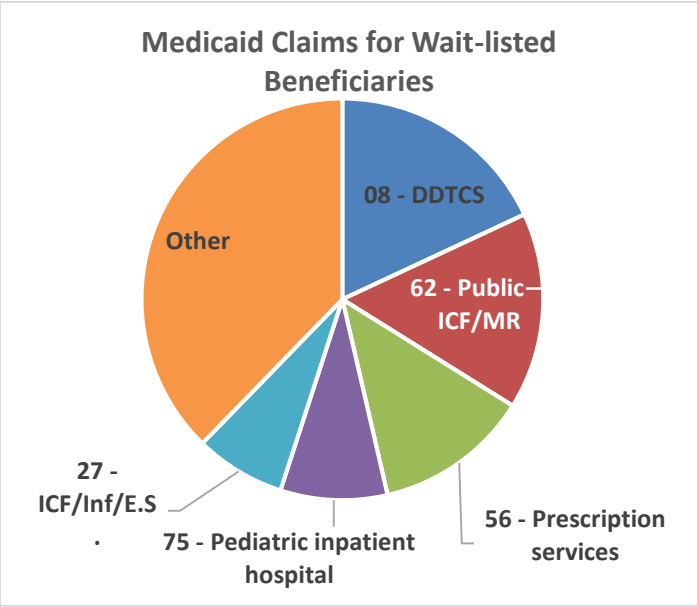
[105] "The Growth of Managed Long Term Services and Supports (MLTSS) Programs: A 2012 Update". CMS, Truven Health Analytics: July, 2012: p. 12
[106] Ibid. p. 11
[107] Ibid. p. 12
[108] Ibid. p.12

budget for institutional and HCBS services, performance incentives, and outcome requirements to successfully achieve the objective of developing more community based choices for eligible recipients.

19.7.Developmental Disability Waiting List

Given the stark contrast in cost of serving people under the two programs, TSG look specifically at the question of the wait list for adult DD waivers. The wait list includes people with developmental disabilities that have not been allowed into the waiver program, because the waiver program has not been sized to the apparent need. The question is how much it would cost to increase the waiver cap. Some have resisted this notion by looking at total waiver costs. In fact however, most of those on the waiver wait list are already receiving some care. According to the agency, 2,900 people are on the wait list. TSG found that 2,640 of those already incur Medicaid costs. Figure 49 shows the breakdown of their costs.

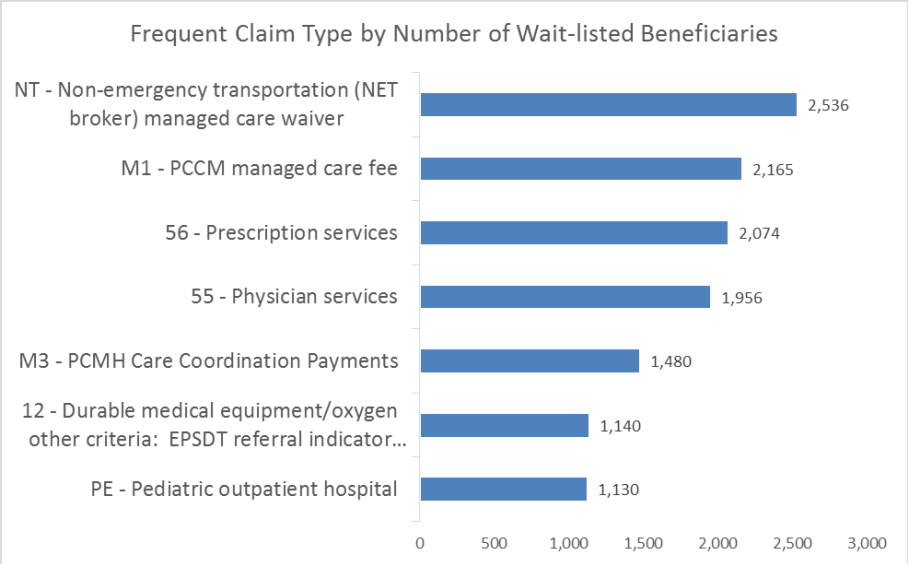
Figure 48—Medicaid claims for those on the Adult DD waiver wait list



	Claims Total	Benefi-ciaries
08 - DDTCS	5,776,912	779
62 - Public—ICF/MR	5,065,694	52
56 - Prescription services	3,997,213	2,074
75 - Pediatric inpatient hospital	2,754,106	193
27 - ICF/Inf/E.S.	2,331,912	31
73 - Private duty nursing EPSDT	1,249,047	21
12 - Durable medical equipment/oxygen	1,121,738	1,140
T7 - DDTCS transportation	904,083	425
L4 - APD Agency Attendant Care, Co-Employer	888,025	42
B5 - Speech and Language Therapy General	765,035	491
33 - Inpatient Psychiatric U21	718,402	47
53 - Personal Care - Regular	668,448	231
Other	5,753,848	
Total	31,994,462	2,640

Figure 50 shows the most frequent types of care provided to individuals on the wait list. It shows that those on the wait list are already receiving many of the medical services available to them if they were receiving waiver services. Thus, thus cost of adding them to the waiver are much lower than simply looking at the total cost per person times the number on the wait list.

Figure 49—Top medical claim types for individual on DD wait list



Some other issues TSG observes should be recognized when considering re-sizing the waiver program to eliminate the wait list include:

- Ensure that funding requested takes into consideration the cost of community services that are already being rendered, such as state plan amendment personal care services or day habilitation clinical services.
- Ensure that payment for "supportive living" is appropriate
- Ensure right service, right time and right place – the reason why the standardized assessment is so important to the entire LTSS system
- Question whether the 20% administrative costs for providers is appropriate – whether incentives are aligned with needs
- Examining if the 4265 waiver cap can be eliminated under a more global Section 1115 Waiver without costing more
- Global 1115 Waiver could integrate "supportive living" and "supportive employment" with flexibility to meet needs

19.8. Community First Choice Option

TSG considered the implications of pursuing a Community First Choice Option (CFCO) waiver under section 1915 (k): ACA Section 2401. CFCO would offer:

- Optional new state flexibility in providing HCBS services
- CFCO is a state plan amendment resulting in an entitlement

- Provides states enhanced 6% federal match for "amounts expended under section 1915 (k)"
- Is not a "pass" on Olmstead related requirements
- No prohibition from individuals receiving 1915 (c), Money Follows the Person, and CFC services at the same time

CMS estimated that 25 states would choose CFCO option. To date, only 6 states have started CFCO. CMS must submit evaluation reports on the effectiveness, impact, and comparative costs of CFCO to Congress on 12/31/15

States that have implemented CFCO include:

- California: 7/1/2013: Limits services to 283 hours per month
- Maryland: 1/1/2014: Cost caps on non-HCBS services (home delivered meals; assistive technology, environmental assessments)
- Montana: 10/1/2013: Limits attendant services to 84 hours every two weeks; IADL services not to exceed 1/3rd total CFC hours or 10 hours per two week period; skills acquisition not to exceed 25 hours every three months
- Oregon: 7/1/2013: Cost caps on home modifications and assistive technology; 18 outcome measures
- Washington: 8/30/2015: Functional eligibility for Personal Care is higher; reinvest savings to address DD waiting list
- Texas: 6/1/2015: Retained existing Personal Care and 1915 (c) waivers for I/DD population; persons receiving HCBS (c) services through Star Plus managed care ineligible for CFCO

However, it must be recognized that states can design HCBS services similar to CFCO under a Section 1115 waiver that does not result in a new entitlement (e.g. TennCare)

20. ARKANSAS MEDICAID PROGRAM CASE MANAGEMENT SERVICES: DAAS, DDS, AND DBHS

Case management services are available in the DAAS and DDS home and community based services programs. Case management services are not included in the RSPMI benefits package that serves as the community services platform for DBHS. Currently DHS/DAAS/DDS does not have an IT capacity to track beneficiaries across program codes. The creation of the DMS Data Warehouse should provide DHS the ability to track beneficiaries across facility based care, waiver enrollment, and other services such as case management. See TSG Appendix 7 for additional information related to Medicaid case management tracking across social services programs.

Real time duplication of available case management is improbable based on eligibility for the service being triggered by specific waiver program enrollments. It is important that IT edits and cross divisional communication assure that beneficiaries are not enrolled in duplicative case management services, care coordination, or PCMH services.

The Alternative Community Services Waiver (DDS) defines case management services as: "services that assist participants in gaining access to needed waiver and other state plan services; as well as, medical, social, educational and other generic services, regardless of the funding source for the services to which access is available."

The Alternative for Adults with Physical Disabilities Waiver (DAAS) defines case management service as: "counseling support management providers support the work of the contracted fiscal intermediary by assisting clients with completion, and distribution to designated parties, of all necessary federal and state forms required for clients to be employers and for persons to be certified as attendant care providers, and necessary forms for hiring a new attendant."

The Elder Choices Waiver (DAAS) defines the Targeted Case Management (State Plan benefit) service as:

> "Medicaid clients age 60 or older who have limited functional capabilities and need assistance with the coordination of multiple services and/or resources may be eligible for this service. Case management services will assist Medicaid recipients in gaining access to needed medical, social, educational and other services."

The "Data Book" recently prepared for the DHS Managed Care RFI by McKinsey indicates that in FY 2014 6,893 individuals received state plan targeted case management services and Elder Choices waiver services and 2,597 individuals received case management services from the Alternatives for Adults with Physical Disabilities waiver.

The national data on state expenditures on Medicaid reimbursed case management services available through the "Medicaid Expenditures for Long Term Services and Supports (LTSS)" report issued annually by Truven Health Analytics, Mathematica, and CMS excludes targeted case management and case management provided through managed care organizations thereby making state comparisons somewhat meaningless. Nevertheless, the Arkansas investment in case management is one of the lowest among its neighboring states[109].

Should Arkansas modernize its Medicaid LTSS system additional expenditures should not be the first consideration for increasing the effectiveness of case management services. Research shows that caseloads in the range of 1 to 9-20 cases are the most effective use of the service in avoiding

[109] Source: Medicaid Expenditures for Long Term Services and Supports (LTSS) in FY 2013: Truven Health Analytics, Mathematica, CMS: 6/30/15: Table O

unnecessary hospitalizations if the case workers are connected to the care coordination services provided by managed care companies, the PCMH model, or the behavioral health population specific health home model. The use of the information available from the standardized DAAS and DDS InterRai assessment process on a person's overall level of need(s) could be used as a method of triaging the number of cases assigned to individual case manager caseloads. It would follow that case managers with lower caseloads would have individuals with a higher level of acuity and emergent risks for institutionalization and case managers with higher caseloads would have individuals who are stable, have good natural and professional supports, and lower risks of emergent institutionalization. Another approach could include a balanced case mix of high need and stable cases per case manager based on a standard of caseload distribution. Choice of case manager needs to be an element of any case management benefit redesign.

21. STATE COMPARISON INTO APPROACHES FOR LOWER SPENDING

TSG analyzed other state Medicaid programs to determine what the key ingredients were in lowering spending. We found that over the past five years, many states have implemented a continuous Medicaid policy improvement strategy through the integration of essential health services and Long Term Services and Supports (LTSS) based on integrated full-risk care management contracting and payment strategies. Populations covered by LTSS include the aged and people with physical disabilities, people with intellectual and developmental disabilities, and adults with serious mental illness and children/adolescents with serious emotional disturbance and related conditions. States and their elected officials have a range of options and payment models permitted by CMS and open to some negotiation on the details through the use of 1115 comprehensive waivers.

21.1. State Options to Modernize Medicaid Programs serving the Indigent, Aged, and Disabled populations:

"Medicaid modernization" is basically a strategy and method for state elected officials to determine the policy and Medicaid program improvement models they decide will have the best opportunity to result in quality, outcomes, and cost to taxpayers they want their Medicaid programs to achieve. The primary objectives for Medicaid modernization are:

- Improve quality and access
- Promote provider accountability for outcomes through incentives based on metrics
- To the extent possible support individual beneficiary accountability for healthy behaviors
- Design and implement a system of delivery and payment methods that improve budget predictability and, potentially, economic sustainability
- Introduce risk into their Medicaid programs

In 2007, the Institute for Health Improvement launched the "Triple Aim" initiative that was designed to improve health system performance. The IHI was organized in 1991 as an outgrowth of a 1980s National Demonstration Project on Quality Improvement in HealthCare. As a result of certain aspects of the PPACA and innovation models such as Accountable Care Organizations, the "Triple Aim" has become part of the policy making considerations for CMS and many states engaged in Medicaid Modernization. The three elements of the "Triple Aim" are:

- Improve the patient experience of care delivery (quality and patient experience)
- Improve population health (defined as system designs that address an entire populations health status and reduction of disparities)
- Reduce the per capita cost of health care

Upon passage of the ACA in 2010, all states were faced with the policy questions the Act presented to states while continuing to need to consider the recent experience of states to reduce the use of state tax dollars, or substantially bend the growth curve downward, for their Medicaid programs as a result of the economic downturn of 2008-2010.

In effect, states were "modernizing" their Medicaid programs before the ACA went into effect with major attention focused on: 1) long term care populations due to growing demand for services, the substantial amount of LTC Medicaid spending associated with medical/pharmacy costs, and demographic trends; 2) high cost individuals with multiple chronic care conditions enhanced by the states growing capacity to take advantage of IT based inter-relational data bases that are interoperable with their MMIS systems; 3) growing attention to the impact of mental illness as a cost driver across a state's Medicaid program; and, 4) the growing acceptance of states to include the Aged, Blind, and Disabled populations into a maturing full risk managed care industry based on competitive RFPs and "value based" state contracting with data driven oversight.

In 2004, there were 8 states engaged in some form of managed care within their long term care programs. By 2014, approximately 26 states had utilized managed care models for their long term care populations including people with intellectual and developmental disabilities for the first time in 2013 (Kansas)[110]. Emerging state approaches to their Medicaid programs included individual state tailored strategies designed around the options embedded in fundamental CMS Delivery System and Payment Models that were and are available in the context of "health reform".

State interest in improving their LTSS Medicaid programs and improving cost control has resulted in an increase in the use of 1115 and 1915 (b)/(c) waivers. Many states targeting improvements in their Medicaid Long Term Services and Supports (MLTSS) systems focused on increasing home and community based services options, decreasing reliance on institutional levels of care, some

[110] "Medicaid Expenditures for LTSS in FY 2013". CMS, Mathematica, Truven Health Analytics: 6/30/15. p. 4

addressed waiver waiting lists, improving access and quality, and assuring budget stability. Within these integrated approaches several states also included the work that had been accomplished in their Patient Centered Medical Home demonstrations (WA, TN, CA, and NY).

In November 2014, the Kaiser Family Foundation reported that 19 capitated Medicaid MLTSS waivers were approved by CMS. Twelve states received CMS approval for 1115 demonstration waivers (AZ, CA, DE, HI, KS, NJ, MN, NY, RI, TN, TX, VT) and six states received approval for 1915(b)/(c) waivers (FL, IL, MI (2 waivers), MN, OH, WI). States framed their waiver approaches to MLTSS based on CMS guidance of 5/2013 that addressed:

- Adequate planning
- Stakeholder Engagement
- Enhanced provision of Home and Community Based Services
- Alignment of payment structure and goals
- Support for beneficiaries to access the system
- Person centered processes (in alignment with the HCBS Rule)
- Comprehensive integrated service packages
- Qualified providers
- Participant protections
- Quality metrics

21.2.Medicaid Delivery System and Payment Models

States do have options on how they design their modernized Medicaid service delivery systems of care[111]. Many states are creating unique system designs that implement service delivery features such as PCMH, Episodes of Care, and Accountable Care Organizations through integrated managed care contracting models along with payment reform such as pay-for-performance and shared risk/gain. Medicare's recent focus on bundled payments will certainly be an on-going policy consideration as states continue to seek the best solutions for their unique Medicaid programs and health systems.

Medicaid Managed Care

- Primary Care Case Management (PCCM)
- Risk-Based Managed Care/Managed Care Organization (RBMC/MCO)
- Prepaid Health Plan (PHP)
- Managed Long-Term Services and Supports (MLTSS)

[111]"Medicaid Delivery System and Payment Reform: A Guide to Key Terms and Concepts". Kaiser Commission on Medicaid and the Uninsured; 6/2015

Other Delivery System Models

- Patient-Centered Medical Home (PCMH)
- Health Home (HH)
- Episodes of Care
- Accountable Care Organization (ACO)

Medicaid Payment Models

- Fee-for-Service (FFS)
- Capitation
- Care Management Fee
- Pay-for-Performance (P4P)
- Shared Savings Arrangements (Gain-Sharing)
- Shared Risk Arrangements (Risk-Sharing)
- Episode of Care (EOC) Payment
- Global Bundling
- Delivery System Reform Incentive Payment (DSRIP: Hospital/Community systems at risk)

Table 36— Comprehensive Medicaid Payment Reform Models Operational in 2014[112]

Managed Care (Risk based)	MCO and PCCM	PCCM Only	No Comprehensive MCO	ACO in Place
Arizona California Delaware Georgia Hawaii Kansas Kentucky Michigan Minnesota Mississippi Missouri Nebraska Nevada New Hampshire New Mexico New York Ohio Oregon	California Colorado Florida Iowa Illinois Indiana Louisiana Massachusetts Nevada North Dakota Rhode Island Washington West Virginia	Alabama Arkansas Idaho Maine Montana North Carolina Oklahoma South Dakota Vermont	Alaska Connecticut Wyoming	Colorado Iowa Illinois Minnesota Oregon S. Carolina Utah Vermont (CA, MD, ME, NJ,PA: 2015)

[112]Kaiser Family Foundation/National Association of Medicaid Directors/Health Management Associates: 10/14: adapted by The Stephen Group

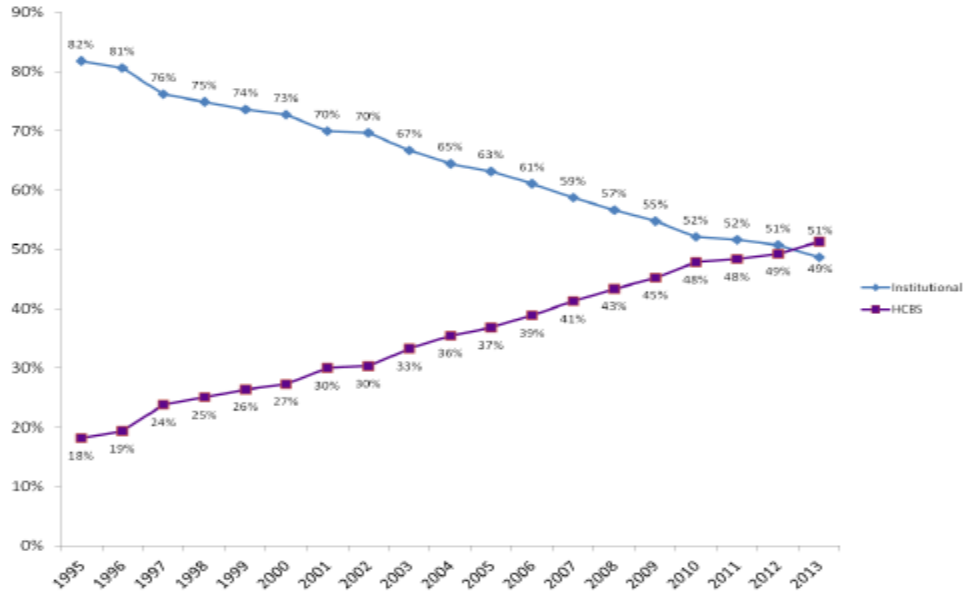
Pennsylvania South Carolina Tennessee Texas Utah Virginia Washington Wisconsin				

National Trends for Medicaid Long Term Services and Supports

FY 2013 was a threshold year for Medicaid Long Term Services and Supports across the country. For the first time since the inception of the Medicaid program HCBS services represented the largest share of total LTSS spending. HCBS expenditures totaled $75 billion at 51.3 % and institutional spending totaled $71 billion at 48.7% of total FY 2013 LTSS expenditures of $146 billion[113]. HCBS services for people with Intellectual/Developmental Disabilities totaled 72% of total expenditures and 28% for ICF institutional services for this population. HCBS services for the aged and physically disabled population represented 40% of total expenditures and 60% for NF institutional services for this population. Figure 51 shows the relationship between the expenditure of funds for institutional levels of care and home and community based levels of care illustrates that on the national level an annual rate of change of approximately 2% increased use of HCBS has occurred across the country.[114]

[113] "Medicaid Expenditures for LTSS in FY 2013". CMS, Mathematica, Truven Health Analytics: 6/30/15. p. 3
[114] Ibid. p. 7

Figure 50—Medicaid HCBS expenditures as a percentage of total LTSS, FY1995-2013



The difference between the use of HCBS LTSS for people with Intellectual/Developmental Disabilities and people who are aged and/or physically disabled is worth noting. Currently there are approximately 635,000 individuals with ID served by Medicaid LTSS across the country.[115] There are now 14 states that serve all individuals in the community and do not have any state ICF/IDs.[116] They are: Alabama, Alaska, District of Columbia, Hawaii, Indiana, Maine, Michigan, New Hampshire, New Mexico, Oregon, Rhode Island, Vermont, and West Virginia. The combined estimated population of these 14 states in 2014 was 41,247 million people.[117] Additionally there are 11 states with only one remaining state ICF/IDs.

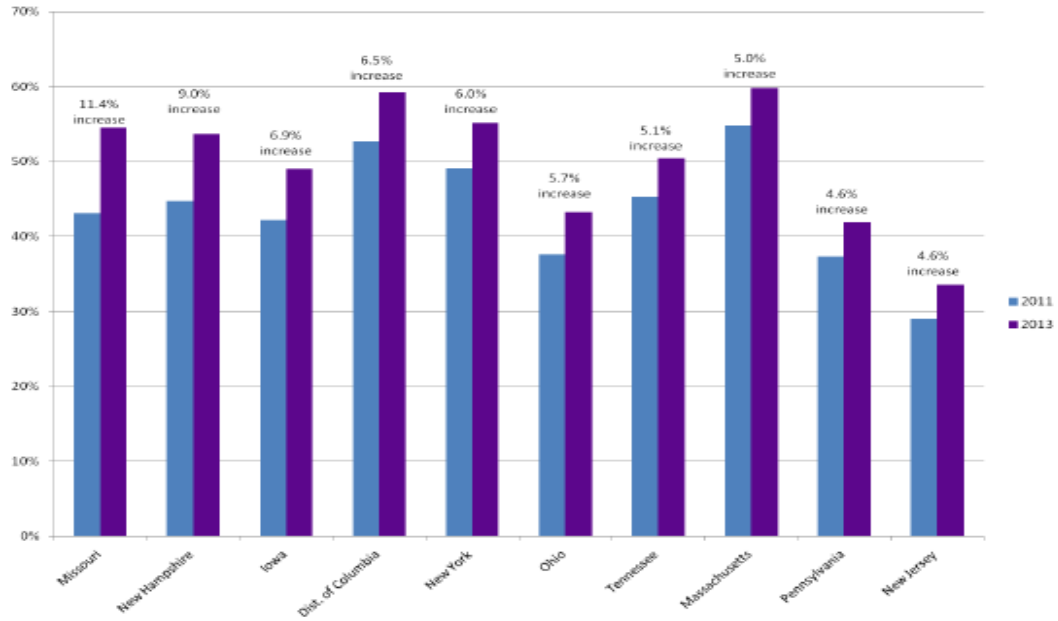
The Center for Disease Control and Prevention (CDC) estimated that there were 15,700 nursing home facilities and 1.7 million licensed beds in FY 2103.[118] The Kaiser Family Foundation estimated that Medicaid paid 63%, private pay paid 22%, and Medicare paid 14% of all nursing home expenditures in the United States in 2011.[119] It is important to note that medical conditions and a lack of available community support, which is the purpose of HCBS waiver services, drive NF admissions while admissions to ICF/IDs are not solely driven by medical conditions. Additionally, a majority of family members within the Intellectual and Developmental Disabilities community across the country have assertively sought the right to home and

[115] "State of the States in Developmental Disabilities". University of Colorado: stateofthestates.org
[116] "Case for Inclusion: 2014". United Cerebral Palsy. P. 6
[117] US Census Bureau. QuickFacts Beta
[118] Center for Disease Control and Prevention: Long Term Services in the United States. 4/15
[119] "Overview of Nursing Facility Capacity, Financing and Ownership in 2011". Kaiser Family Foundation. April, 2013

community based services for their family members instead of institutional care through advocacy and litigation as attested by the recent agreement of the Commonwealth of Virginia with the Department of Justice to close all of their five state ICF/IDs over the next several years.

Figure 52 shows that many states exceeded the national average of 2% increased HCBS between FY 2011 and FY 2013 based on legislation, transformative plans and action strategies to re-balance their LTSS programs to home and community based services. Ten states led the country in transforming their LTTS systems from a higher utilization of institutional levels of care to higher utilization of home and community based services.[120]

Figure 51—States with the greatest increase in Medicaid HCBS expenditures as a percentage of total LTSS expenditures, FY2011-2013



Since states started implementing managed care contracting strategies in the 1980's the Medicaid ABD and LTSS populations had been "carved out" of managed care with the exception of trailblazer states such as Arizona, Wisconsin, and Hawaii. Between FY 2012 and FY 2013 there was an increase in managed care LTSS expenditures across the country from $10 billion to $14.4

[120] "Medicaid Expenditures for LTSS in FY 2013". CMS, Mathematica, Truven Health Analytics: 6/30/15: p. 9

billion, representing a 44% increase in one year.[121] This trend is expected to continue to grow rapidly over the next two years.

The National Association of States United for Aging and Disabilities (NASUAD) reported in 2014 there were 18 states with managed LTTS systems with 10 more planning to do so in 2015-2016.[122] Iowa recently awarded comprehensive managed care contracts for their entire Medicaid population and Pennsylvania is expected to contract for comprehensive MLTSS in 2015.

Arkansas Long Term Care Services and Supports

Arkansas is ranked highly for the level of public expenditures and tax burden per resident it provides for citizens in need of Long Term Care Services and Supports for people who qualify for Medicaid paid services. In FY 2013 Arkansas ranked 19th in the country on total Medicaid costs per state resident and 12th in the country on total LTSS costs per state resident. National averages can be misleading in some respects yet Arkansas' per resident costs for LTSS rank as the highest per state resident compared to neighboring states (Table 36).

Table 37—Costs per State Resident of Total Medicaid and Total LTSS, FY2013[123]

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

Given Arkansas' comparatively high overall Medicaid expenditure on behalf of people in need of Long Term Services and Supports the development of future policy decisions should focus on the significant imbalance between Institutional and Home and Community Based Services levels of care.

Arkansas' total institutional costs for all populations were $963.733 million in FY 2013, placing the state 12th highest in the nation on per state resident cost of $325.72 compared to the national

[121] "Medicaid Expenditures for LTSS in FY 2013". CMS, Mathematica, Truven Health Analytics: 6/30/15: p. 4
[122] "2104 Survey of the States". NASUAD, p. 5
[123] Medicaid Expenditures for Long Term Services and Supports (LTSS) in FY 2013: Truven Health Analytics, Mathematica, CMS: 6/30/15: * Table AL; ** Table Y; *** ASPE FMAP 2013 Report

average of $226.13 per resident cost[124]. Total Nursing Facility costs were $641.411 million in FY 2013, placing the state 13th highest in the nation on state resident cost of $216.78 compared to the national average of $169.28 per resident cost[125]. Total Intermediate Care Facility costs for persons with Intellectual and Developmental Disabilities was $163.192 million in FY 2013, placing the state 12th highest in the nation on state resident cost of $55.16 compared to the national average of $37.89 per resident cost[126].

Arkansas' Home and Community Based Services costs for all populations were $294.605 million in FY 2013, placing the state 34th highest in the nation on per state resident cost of $99.57 compared to the national average of $130.85 per resident cost[127]. Total HCBS services costs for Older People and People with Physical Disabilities was $116.814 million, placing the state 21st highest in the nation on per state resident cost of $39.48 compared to the national average of $34.03 per resident cost[128]. Total HCBS costs for People with Intellectual and Developmental Disabilities was $177.790 million in FY 2013, placing the state 39th highest in the nation on per state resident cost of $60.09 compared to the national average of $93.76 per resident cost[129].

In FY 2013, Arkansas expended $90.423 million in Personal Care services, placing the state 18th highest in the nation on per state resident cost of $30.56 per state compared to national average of $38.00 per resident cost[130].

In FY 2013, Arkansas expended $65.974 million in Home Care services, placing the state 10th highest in the nation on per state resident cost of $22.30 per state compared to the national average of $15.51 per resident cost[131].

In FY 2013, Arkansas expended a total of $758.225 million for Older People and People with Physical Disabilities. The distribution for institutional care was $641.411 million (84.6%) and $116.814 million for HCBS services (15.4%). The national distribution for the same population was 59.8% for institutional care and 40.2% for HCBS services and supports during FY 2013[132].

In FY 2013, Arkansas expended a total of $340.982 million for People with Intellectual and Developmental Disabilities. The distribution for institutional care was $163.192 million (47.9%) and $177.790 million for HCBS services and supports (52.1%). The national distribution for the

[124] Ibid. Table D
[125] Ibid. Table E
[126] Ibid. Table F
[127] Ibid. Table K
[128] Ibid. Table AA
[129] Ibid. Table Z
[130] Ibid. Table L
[131] Ibid. Table M
[132] Ibid. Table AP

same population was 27.7% for institutional care and 73.3% for HCBS services and supports during FY 2013[133].

The national comparative data tells us that the Arkansas system for Long Term Services and Supports is overly dependent on institutional care for all populations. The state is 24.8% more dependent on the use of Nursing Facilities for Older People and People with Physical Disabilities and 20.2% more dependent on Intermediate Care Facilities for People with Intellectual and Developmental Disabilities than the national averages of all states for FY 2013.

These discrepancies are expensive to the taxpayers of Arkansas and limit choices for community living for people and their families. State dependency on the institutional level of care also presents a quality of life issue for many as reflected in independent assessments of each state's Long Term Care systems of care.

The AARP, with assistance from the Scan and Commonwealth Foundations, issues an annual report on the status of Long Term Care for the Aged across the states. Aptly titled "State Long Term Services and Supports Scorecard 2014: Raising Expectations"[134], the report assesses each states performance on five domains that represent attributes of a high quality state Long Term Care system: Affordability and Access; Choice of Setting and Providers; Quality of Life and Quality of Care; Support for Family Caregivers; and Effective Transitions.

In 2014, Arkansas ranked 40th overall among the states and the District of Columbia. Arkansas ranked 28th on the Affordability and Access domain; 28th on the Choice of Setting and Provider domain; 47th on the Quality of Life and Quality of Care domain; 16th on the Support for Family Caregivers domain; and 49th on the Effective Transitions domain.

The AARP of Arkansas conducted a telephone survey of 1200 citizens who voted over the age of 50 on their preferences regarding long term care services, supports, and settings. The survey was conducted between 6/24 and 7/1/2014 and included 742 retirees and 458 non-retirees randomly selected. Interestingly, 41% of the 1200 surveyed had been former caregivers and 19% were current caregivers of family members. An overwhelming 91% of the random survey group favored "shifting additional federal funding from nursing homes to home based care." The survey was conducted by Hart Research Associates on behalf of AARP on a scientific basis that yielded a margin of error of +/- 2.9%.[135]

---

[133] Ibid. Table AQ
[134] "Raising Expectations 2014: A State Scorecard on Long term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers". www.longtermscorecard.org

[135] "Arkansas Voters Age 50+ and the 2014 Election". AARP/Hart Research Associates. 2014

United Cerebral Palsy issues an annual report on each state's overall comparative performance on key quality measures that support choices for home and community based living for people with intellectual and developmental disabilities.

"The Case for Inclusion – 2014"[136] analyzed five quality domains across all states. Each domain was designated a weighted factored in the state's final ranking. The five domains focus on: People with disabilities will live in and participate in their communities - Promoting Independence; People with disabilities will have satisfying lives and valued social roles- Promoting Productivity; People with disabilities will have sufficient access to needed support, and control over that support so that the assistance they receive contributes to lifestyles they desire – Keeping Families Together and Reaching Those in Need; People will be safe and healthy in the environments in which they live - Tracking Health, Safety, and Quality of Life.

Arkansas ranked 50th on the Promoting Independence domain (50% weight); 2nd on the Tracking Health and Safety/Quality of Life domain (14% weight); 48th on the Keeping Families Together domain (8% weight); 40th on Promoting Productivity domain (12% weight); and 28th on the Reaching Those in Need domain (16% weight). In 2014 Arkansas ranked 45th among the states and the District of Columbia. This year's report notes that 18 states now meet the 80% standard of individuals living in home like settings and that "political will and sound Medicaid policies"[137]are needed for progress, not always additional funding.

The report points out that the best performing states are large and small in population, rich and poorer in terms of family median income, have high and low tax burdens, and high and low spending. For example[138], Oregon ranks first in the country in the use of HCBS services at 78.9% of all persons served at a cost of $336.91 per state resident. Arizona ranks fourth in the country in the use of HCBS services at 68.3% of all persons served at a cost of $161.99 per state resident. Washington ranks fifth in the country in the use of HCBS services at 61.2% of all persons served at a cost of $230.44 per state resident.[139]

National Trends for Patient Centered Medical Homes, Health Homes, and Accountable Care Organizations

The concept of a "medical home" appears to have been brought into the health services policy innovation arena by the American Academy of Pediatrics in 1967. During the 1990's The

---

[136] "The Case for Inclusion – 2014". United Cerebral Palsy
[137] Ibid. p. 2
[138]"Medicaid Expenditures for Long Term Services and Supports (LTSS) in FY 2013". Truven Health Analytics, Mathematica, CMS: 6/30/15: Table J
[139]DSRIP: Delivery System Reform Incentive Payment: usually a part of a broader 1115 waiver; provides states additional funding to support hospitals and other providers (community partnership requirements) to develop metric based quality improvements designed to improve quality that results in identified savings over the life of the waiver.

Institute of Medicine brought attention to family medicine and the value of a health home between a Primary Care Physician and individual patients. In 2007 the Person Centered Medical Home (PCMH) model of primary care delivery was supported by the American College of Family Physicians, American College of Pediatrics, American College of Physicians and the American Osteopathic Association.

The PCMH model was identified as a delivery model based on better access, coordination of care, quality and safety within a Primary Care practice.[140] Generally speaking, the PCMH model is focused on individual PCPs and individual patients treated within a care coordination approach with specialty care and the need for hospitalization/Emergency Department levels of care.

The recent use of the "health home" model of coordinated care based on Section 2703 of the Affordable Care Act has been somewhat confusing for different interests concerned with the delivery of Medicaid services. The major difference between the PCMH and "health home model" is that the PCMH model is designed for individual patients regardless of level of need(s) and the "health home" model is designed to provide comprehensive services coordination through a team based delivery model that includes a PCP and other providers and needed social services and supports. The health home model is designed for people with two or more chronic care conditions or one chronic care condition and at risk of another including serious mental illness. The health home is more amenable to a comprehensive payment model that the FFS driven PCMH model. Nevertheless both models share the values of improved access, coordination of care (with some differences on scope between the two models), prevention, quality, and safety.

The Accountable Care Organization model is defined by CMS as "groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients. The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors."[141] The CMS model to date has focused on Medicare, although 15 states have recently implemented Medicaid-based ACO models.[142] Medicare results to date have been decidedly mixed. Recently CMS acknowledged that 2014 results for Medicare ACO models resulted in 196 saving Medicare money and 157 costing more than the benchmark. The scope of all Medicare ACOs during 2014 included $6 billion in benchmark expenditures,

[140] "Patient Centered Medical Homes." Robert Graham Center. American Association of Family Physicians. 11/2007
[141] "Accountable Care Organizations". Medicare. cms.gov
[142] "Rise and Future of Medicaid ACOs". Leavitt Partners. 9/2015

353 ACOs, and 6 million covered lives. Additionally, only 19 of the 32 high risk ACOs remained in the program in 2016, although several shifted to the lower risk model.[143]

The Agency for Healthcare Research and Quality conducted a detailed analysis of 498 studies on the PCMH model between 2000 and 2010. Many of the studies were eliminated due to process and methodological concerns, leaving 14 studies for detailed analysis on cost, quality, and benchmark outcomes. The findings were decidedly mixed on cost savings, saw improvement on the reduction of unnecessary hospitalization, and were mixed on reducing unnecessary Emergency Department utilization. Interestingly the analytical synthesis of the cost savings data indicated savings were achieved within the sickest cohort of patients, speaking to the value on integrated care with the PCMH practice and externally with other specialty groups and caregivers.[144]

The North Carolina PCMH model is one of the most studied and provides lessons learned on the importance of the integration of care coordination across all Medicaid services. Based on the Wilson County Health Plan (1983) that provided a primary care physician referral for each enrolled beneficiary, the PCMH type model developed across the state in several years through the Carolina Access model (1989). This model was based on a $3 per member per month fee for each enrolled beneficiary (women and children) enrolled with a PCP and focused on quality improvement and cost containment.

Between 1997 and 2001, the NC PCMH model moved forward across the state based on the formation of PCP networks and agreements. By 2011, the Community Care North Carolina associated networks (14) covered all 100 counties with 1,000,000 enrolled Medicaid beneficiaries for inpatient, outpatient, pharmacy, and related services.

Cost savings studies of the CCNC model have indicated significant savings across the years but not without controversy and methods. CCNC reports estimated savings between $708 and $758 million for the SFY 2005-2009.[145] Clearly, the CCNC PCMH model has improved overall quality, decreased hospitalizations, and improved several health status HEDIS measures.

The August 20th, 2015 State Auditor's Report required by the General Assembly "suggests savings of $78 per quarter per member, approximately $312 per year in 2009 inflation adjusted dollars."[146] The challenge with the budget impact of the suggested cost savings is reflected in the State Auditors statement: "Our findings do not speak to the impact of CCNC relative to other

[143] "Medicare Yet to Save Money through Heralded Payment Model". Kaiser Health News. 9/2015
[144] "Early Evidence on the Person Centered Medical Home." AHRQ/Mathematica. 2/2013
[145] "A History of Community Care North Carolina". CCNC: communitycarenc.com
[146] NC State Auditors Report on Community Care North Carolina. 8/20/15. Executive Summary

possible strategies. Our comparison, and hence savings, is relative to North Carolina Medicaid outside of CCNC".[147]

The program model, however, excluded the $15 billion North Carolina's Medicaid program's eight waivers covering the elderly and physically disabled, people with intellectual and developmental disabilities, and adults with serious mental illness and children/adolescents with serious emotional disturbance and related disorders. Regardless of the debate concerning the actual savings of the CCNC/PCMH model of coverage, the North Carolina Medicaid program experienced deficits between $335 million and $600 million per year between 2010 and 2014.[148]

After several years of debate about the future policy of the state's Medicaid program, the North Carolina General Assembly passed amended House Bill 372: "An Act to Transform and Reorganize North Carolina's Medicaid and NC Health Choice Program" on 9/22/15. This bill creates the Joint Legislative Oversight Committee (7 members each from the House and Senate) over the state's Medicaid program, DHHS, and DHB; requires that the Division of Health Benefits be created in DHHS and the Department of Medical Assistance be eliminated; requires that a Director of the Division of Health Benefits be appointed by the Governor with a four year term; that the Division of DHHS renegotiate the administrative rate of the CCNC contract downward by 15% until capitated at risk contracts go into effect; requires DHB to prepare all necessary waivers, State Plan Amendments and CMS approval for the NC Medicaid program to be delivered by three state wide capitated at risk Prepaid Health Plans and Provider Led Entities (PLEs) in regions determined by the Division of Health Benefits; requires that DHB contract with the three Prepaid Health Plans, based on a RFP, and associated PLEs 18 months after CMS approval of required waivers and SPAs, requires that DHB use the 1115 CMS waiver model as NCs transformative waiver; and requires DHB to report progress to the Joint Legislative Oversight Committee on March 1, 2016.

Arkansas is one of nine states that has implemented the PCMH model as the primary method, along with several Episodes of Care, of implementing Medicaid payment reform and addressing the "Triple Aim" goals of cost containment or reduction, improve the patient experience, and improve the health of the population.

Started in 2013, the PCMH model includes 295,000 Medicaid beneficiaries, excludes the high cost Aged, Blind, and Disabled population by design, has limited risk, and excludes all waivers. The timeline for full implementation apparently is three to five years. The Arkansas PCMH model has seen positive results indicated by $19.7 million in cost avoidance, $12.1 million in

[147] Ibid. p. 15
[148] The Times News: 9/18/2015

primary care investments, and $7.6 million in shared savings between the state and providers.[149] The Arkansas PCMH model is based on care coordination, attention to transition of care, PCP practice transformation, and improved access based on 24/7 beneficiary telephone access.

The status of the PCMH, health home for the behavioral health population, and Accountable Care Organization models designed to address improved quality and cost containment across the country is reflected in the broad distribution of individual state approaches to the use of these models. Across the country, state Medicaid policy has clearly shifted towards the importance of quality, risk, and comprehensive care coordination for high cost/high risk populations that includes all waiver services being addressed through integrated managed care contracting models. Tennessee, Texas, Washington, and New York are requiring their current managed care contractors to integrate the PCMH model for all beneficiaries within the next three years and Mississippi, Louisiana, and New Hampshire are on the verge of doing so. North Carolina will require PCMH integration into comprehensive integrated managed care contracts upon passage of HB 372.

Examples of Successful State Medicaid Modernization Models

Tennessee

Tennessee was the first state in the nation to achieve comprehensive services delivery and enrollment of all beneficiaries in a managed care model. The TennCare managed care model began in 1994 and was beset with financial problems almost from the outset primarily driven by expansion of the covered population and a dilution of the benefits of cost containment through capitation due to the large number of managed care plans (12) in the program.[150]

Initially, all services were not "carved in" to an integrated managed care strategy resulting in avoidable fragmentation of services delivery, confusion for the user, and the need to manage multiple managed care contracts for different services. Additionally, the program was plagued by several lawsuits that eventually were resolved.

In 2004, the state made dramatic improvements to improve the sustainability of TennCare by decreasing the optionally covered eligible populations and reforming the managed care models by decreasing the number of plans from 12 to 4 with priority emphasis on measured quality improvement and cost containment.

By 2015, TennCare was contracting with three statewide managed care plans, has completely integrated all services and supports, continued to decrease expenditures to trend by 3.3%and

[149] "PCMH 2014 Preliminary Performance Overview: Discussion Draft." Arkansas Department of Human Services. 6/26/2015
[150] Tennessee Health Care Finance and Administration FY 2016 Budget Presentation for Legislative Hearings. p. 9

achieved a 93% beneficiary rate of satisfaction.[151] After a decade plus of the implementation of comprehensive integrated managed care at risk contracting for Medicaid services instead of the traditional fee for service method prior to 2004, TennCare continues to cost the state less than the trend for traditional fee for service Medicaid and commercial insurance. The GAO reported in 2014 that TennCare had the fourth lowest expenditure per enrollee nationwide (Commercial: 6.8%; national Medicaid: 6.7%; TennCare: 5.5%).[152]In 2005, 97% of all persons served by TennCare long term care services resided in nursing facilities.

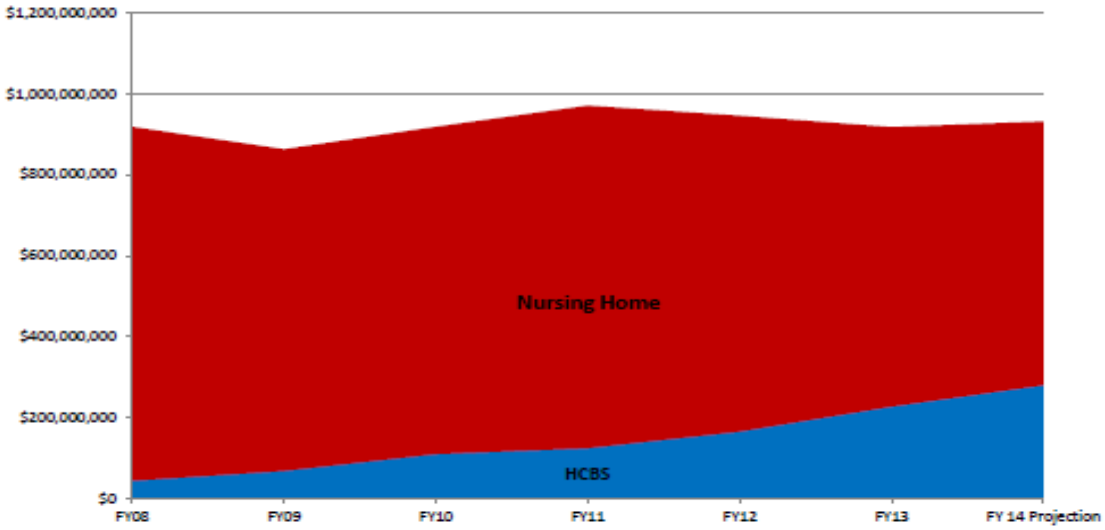
Former Governor Phil Bredesen led a statewide coalition that supported transformation of Tennessee's Long Term Care system culminating in the passage of Senate Bill 4181, the Tennessee Long-Term Care Choices Act of 2008. The bill instituted a Global Budget for medical and long term care services; created the Select Oversight Committee comprised of 5 members appointed by the Speaker of the Senate and 5 members appointed by the Speaker of the House; targeted the reduction of systems fragmentation and an integrated continuum of care; reformed regulations and coverage; required an integrated services managed care contracting requirement based on RFPs; identified reimbursement strategies tied to revised assessment based levels of care; hard wired a single point of entry model; instituted a preventive level of care designed to maintain a person's health status and capacity to live independently prior to their deterioration of condition requiring full benefits Long Term Care Services; mandated all Nursing Facilities be accepted into Managed Care networks; and had the state continue to set NF rates to avoid initial cost shifting within the capitated rate model by the MCOs.

The financial requirement of SB 4181 was "budget neutrality". The bill was designed to increase "Choices" for people that met the nursing home level of care requirements to remain living at home or in community living. The Choices LTSS program establishes program eligibility based on a tiered acuity based assessment for three levels of benefits. The Choices 1 program provides for the Nursing Facility level of care. The Choices 2 program provides a menu of services that includes: community residential; Personal Care: 2 visits per day; Attendant Care: 1080 hours per year; home delivered meals: one per day; Personal Emergency Response System; Adult Day Care services: 2080 hours per year; In home respite: 216 hours per year; Inpatient respite: 9 days per year; Assistive Technology: $900 limit; Minor home modifications: $6,000 per project; $10,000 annual limit; $20,000 lifetime limit; Pest Control: 9 units per year. The Choices 3 program (Figure 53) provides the same level of benefits as Choices 2 with the exception of the Community residential benefit and has a cap of $15,000 per year on all benefits. Choices 3 is designed as a preventive benefit to assure longevity in the community and maintenance of current adult daily living skills as assessed. TennCare reports that since the inception of MLTSS through integrated managed care contracts the increased use of home and community based

[151] Ibid
[152] Ibid. p. 2

living, including the preventive level of care, has resulted in cost avoidance of $250 million total Medicaid funds to date compared to the historical growth trend of nursing home utilization prior to passage and implementation of the legislation. The budget neutrality factor is represented by the generally flat line of total expenditures as more eligible individuals choose home and community based services.[153]

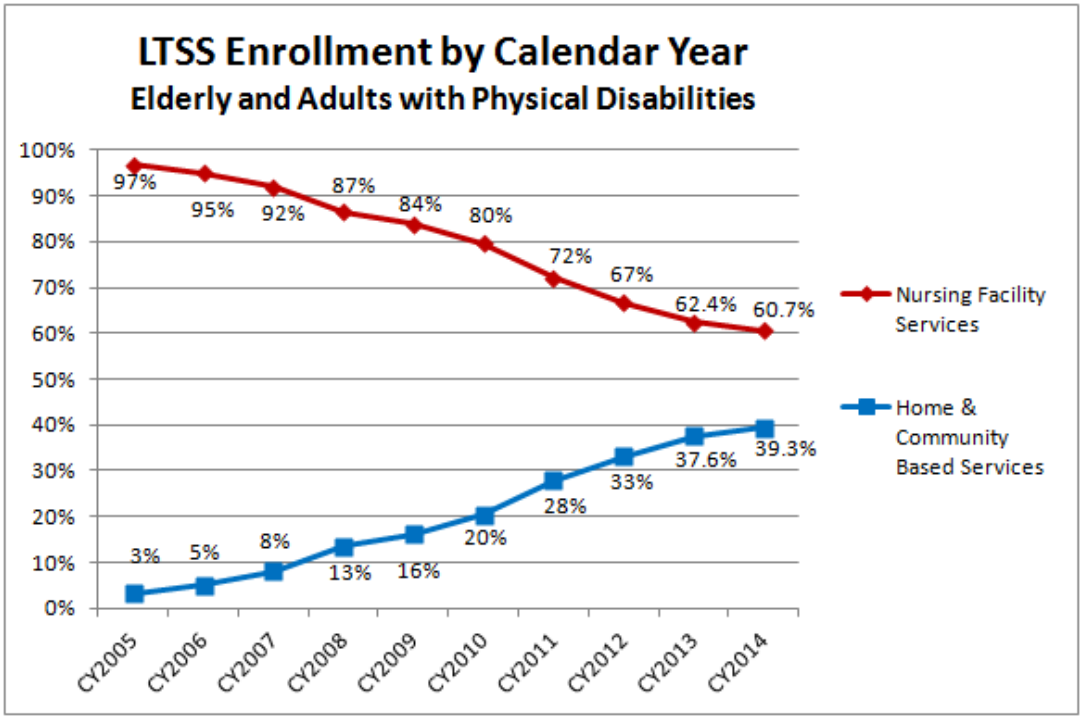
Figure 52—CHOICES Expenditures



Tennessee's successful transformation of their Long Term Care Services and Supports system from an institutional dependent system of care to home and community based services has set a national model for successful MLTSS implementation. Between the implementation of SB 4181 in 2010 and August, 2015, Tennessee has achieved a 20.3% increase in the choice of home and community services (Figure 54).[154]

[153] TennCare Graphic: 8/17/15
[154] **www.tn.gov/tenncare/**topic/ltss-**governors-dashboard**-graphs

Figure 53—Tennessee LTSS Enrollment, 2005-2014



Texas

Texas was one of the first states in the country to have the vision of a comprehensive managed care capitated at risk approach to their entire Medicaid program. Starting in 1993 with a managed care pilot in the Austin/Travis County region of the state, today's Texas Medicaid program is provided through managed care organizations in all areas of the state, including all rural/frontier regions.

Today, virtually all Texas Medicaid beneficiaries are enrolled in and access their services and supports through distinct managed care "Star" programs, all of which have at least two choices of managed care plans available to them. The "Star" plans cover children, newborns, pregnant women, and some family categories. The "Star Health" statewide plan covers child welfare children and adolescents the state has legal responsibility for in a unique carve out model designed to address the needs of this special population including a "Health Passport" individual child/adolescent integrated medical information record available confidentially to the child welfare case worker.

The "Star Plus"plans cover all other Texas Medicaid beneficiaries for all services, including behavioral health, long term care Nursing Facilities and related waivers, medical and pharmacy services for people with Intellectual and Developmental Disabilities and all medical services for all other Aged, Blind, and Disabled Populations. The only services remaining FFS are the state

run Intermediate Care Facilities for People with Intellectual and Developmental Disabilities and related waivers.

Recently, the state Legislature passed SB 7 that requires a capitated at risk pilot for the IDD waivers to be completed by FY 2019 with current law requiring all IDD waivers to become part of Star Plus in FY 2021 unless the Legislature decides on an alternative model based on the outcome of the pilots. Additionally, the Star Plus contracts now require contracted MCOs to also be CMS certified Dual Eligible Special Needs Plans ("D-SNPs") so that the entire state has Medicaid and Medicare Dual Eligibles coverage.

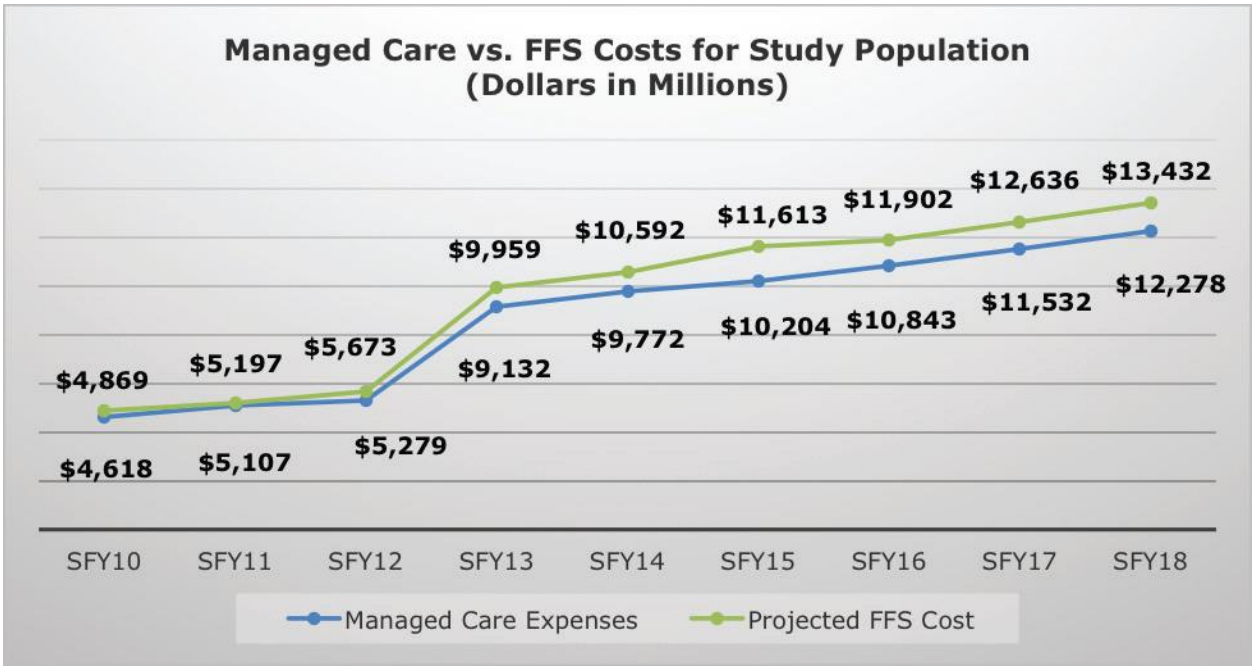
The Texas vision of a comprehensive managed care model for the entire Medicaid program has been achieved over time as the program has been "modernized" by the timing of adding complex benefits such as long term care, behavioral health, and, most recently, services for People with Intellectual and Developmental Disabilities. The goals of the continuous modernization of the Texas Medicaid program have been approriate access, quality services, and cost containment.

In February, 2015, Milliman, a national actuarial firm, released a "Client Report" on behalf of the Texas Association of Health Plans. The purpose of the report was "to estimate the impact the MCOs in Texas have had on Medicaid costs in recent periods and to project the ongoing cost impact".[155] The method of assessment used by Milliman is similar to many state budget planning models: comparison of historical program costs to projected costs expected from a fee for service model. Essentially this approach entails a projection of trend forward from historcial managed care costs to medical inflation informed projected costs within a fee for service model.

Milliman's findings from their analysis of the costs of the Texas Medicaid managed care program compared to projected fee for service model based costs are informative and noteworthy (Figure 55. Milliman concluded that: "For the six year period from SFY 2010 to SFY 2015 we estimate that the managed care capitation structure in the Star and Star Plus programs have resulted in a Medicaid All Funds cost reduction in the range of 5% to 10.7% when compared to estimated expenditures on a fee-for-service structure. This range applies to our cost impact study populations, which covered approximately $44.1 billion of Texas State Medicaid All Funds spending over this period of time. Our best estimate is that this results in savings of nearly $3.8 billion, or 7.9% over six years. Taking into account Federal Medicaid matching (FMAP) and premium tax revenue, we estimate that managed care has reduced the state portion of Medicaid funding by 7.4% to 13% over this same period for programs covered in the study. This results in a best estimate of $2 billion in savings to the state, or 10.2% of the state's share of projected FFS expense."[156]

[155] "Texas Medicaid Managed Care Cost Impact Study". Milliman. 2/2015. p. 3
[156] Ibid. p. 1

Figure 54—Texas managed care vs. FFS costs, study population[157]



The Texas vision for comprehensive at risk capitated managed care Medicaid services integration includes a priority focus on access, care coordination, and demonstrated quality based on measurement. The Texas Health and Human Services Comission (HHSC), which administers the state Medicaid program, uses a robust managed care contracting business model designed to assure MCO accountability and transparency.

Sellers Dorsey, a national consulting firm, in partnership with Milliman, recently issued a report[158] on the quality aspects of the Texas managed care model. The study focused on access to services, quality of care, and cost effectiveness. The report identified contractual measurable standards that included: network adequacy; timely claims payment; timely access to care; outreach to members for prevention and follow up when warranted; identification of areas for Quality Improvement; cultural competency; care management and continuity of care; intensive care coordination for Star Plus aged, blind, and disabled populations; provider incentives for identified benchmarks including pay for performance; Quality Assurance and Performance Improvement; integration of physical health, behavioral health, and Long Term Services, and Supports; and, person centered planning. The Texas managed care contracts include individual

[157] Source: "Texas Medicaid Managed Care Cost Impact Study". Milliman. 2/2015
[158] "Medicaid Managed Care in Texas: A Review of Access to Services, Quality of Care, and Cost Effectiveness". Sellers Dorsey, Milliman. 2/2105

MCO Performance Indicator Dashboards, individual MCO Requirement Reports that HHSC lists on their website, and MCO Report Cards on performance and process measures listed on individual MCO websites.

Additionally, HHSC requires all MCOs to conduct and release the results of an annual survey on Member Satisfaction. Reports. The report stated that "Texas MCOs have improved the quality of care for both children and adults in Medicaid managed care"[159] and cited specific reductions in hospitalizations through disease management and a 93% assisgnment of children/adolescents to PCP health homes resulting in well child visits (ESDPT standards) and immunizations above the national averages.[160]

Ohio

Ohio has been working on providing more options for home and community based services since at least 2008.

In FY 2008, Ohio spent $2.560 billion on nursing facilities and $572.185 million on home and community based services. In FY 2013, Ohio spent $2.450 billion on nursing facilities and $686.914 million on home and community based services. In FY 2008, Ohio spent $691.993 million on public and private intermediate care facilities for people with developmental disabilities and $840.768 million on home and community based services. In FY 2013, Ohio spent $746.599 million on public and private intermediate care facilities for people with intellectual and developmental disabilities and $1.352 billion on home and community based services. Over the FY 2008 to FY 2013 period of time, Ohio increased its use of HCBS services compared to institutional care for all LTSS populations from 29.6% to 43.3%. (Arkansas increased its use of HCBS services compared to institutional care for all LTSS populations from 27.7% to 48.1% during the same period of time[161]).

What makes Ohio an interesting state to consider from the perspective of "Medicaid Modernization" are the strategies that the state has implemented since 2012/2013. An Office of Health Transformation[162] was created in the Executive Branch in 2011 for the purpose of bypassing prior silo based health and human services state agencies' practice by the appointment of a single health and human services transformative director with direct authority over the health and human services Leadership Team, an integrated Policy Team, a singularly managed Consultant(s) Team, and comprehensive Stakeholder Participation governing the Medicaid enterprise and state health and human services agencies.

---

[159] Ibid. p. 80
[160] Ibid. p. 81
[161] "Medicaid Expenditures for LTSS in FY 2013". CMS, Mathematica, Truven Health Analytics: all data from Table AO and Table 36
[162] Governor's Office of Health Transformation: healthtransformation.ohio.gov

The model integrated budget, policy, planning, implementation, rules, and communications across the Medicaid program and all health and human services. Three systemic transformative initiatives were identified as the goals of the Office of Health Transformation.

Medicaid modernization focused on Ohio's model of Medicaid expansion, a reform of nursing facility reimbursement from costs-based to price-based with incentives for quality, the prioritization of home and community based services, the rebuilding of the capacity of the state's behavioral health care system, the enhancement of developmental disabilities services available in the community, and a metric and payment based improvement of the state's Medicaid managed care plans performance and outcomes.

The second priority initiative was to **Streamline Health and Human Services.** This initiative focused on supporting Human Services innovation, implementing a new Medicaid claims IT system compatible with data mining and predictive analytics, the creation of a Cabinet level Medicaid Department, the consolidation of mental health and addiction services, the simplification and integration of eligibility determination processes, the active coordination of all health and human services programs for children, and shared services across local jurisdictions.

The third major transformative initiative was **Pay for Value.** This critical effort in some ways tied other efforts together and focused on effective payment strategies that increased access, avoided volume driven payment models, and tied performance, incentive and outcomes to payment. These initiatives were based on provider partnership discussions supporting alignment of payment to value through innovation, providing access to patient-centered medical homes that are responsible for the whole person's care, the implementation of episode based payments, the coordination of the health information technology infrastructure, the coordination of the health sector workforce development programs, and the use of regional payment reform inititiatives where their use makes sense.

The Ohio Medicaid program provides full benefits to 80% of eligible recipients through Medicaid managed care organizations. Results are starting to pay off for Ohio's comprehensive model of Medicaid Modernization and their approach to transforming health and human services. As a result of reforming nursing facilities payments from a cost basis to a price basis, the state saved $360 million over a two year period.[163] The Scripps Gerontology Center of Miami University recently reported in a study that quality standards in Ohio nursing homes from 2007 to 2105 were not appreciably impacted by Ohio's change in reimbursement from a cost to a price

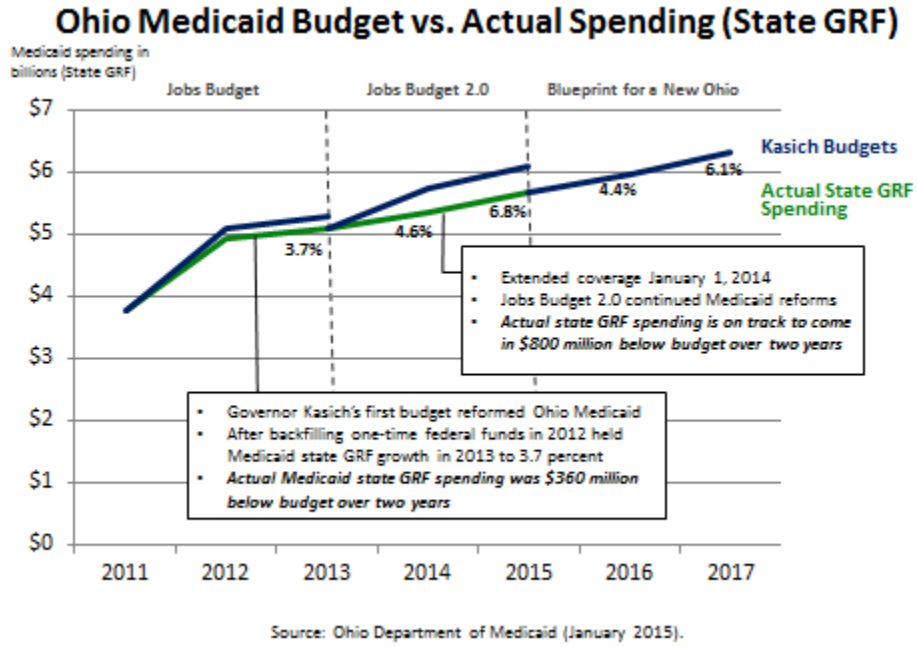
[163] "2016/2017 Budget Detail: Reform Nursing Facility Payments". healthtransformation.ohio.gov

basis.[164] For FY 2015 the state recently announced that of a total Medicaid program budget of $25.5 million the state saved $1.8 billion representing a 7.6% savings.[165]

The Ohio Office of Health Transformation prioritized the continuation of increasing the use of home and community based services in LTSS, enhancing community based Developmental Disabilities services, rebuilding the community behavioral health system, and increasing access to housing for specific populations as budget based priortities for Medicaid Modernization in the 2016/2017 budget cycle.

Additionally, improved population health planning, reduction in infant mortatlity, and reduced tobacco use were targeted as Health systems improvement. Figure 56 shows actual state budget savings attributed to Health Transformation and Medicaid Modernization amounted to $800 million over the FY 2014/2015 budget cycle[166]. Ohio's FMAP for 2014/2015 was 63.02%.[167]

Figure 55—Ohio Medicaid budget vs. actual spending, 2011-2017



Source: Ohio Department of Medicaid (January 2015).

[164] "Hoe Does Medicaid Reimbursement Impact the Quality of Ohio Nursing Homes". Scripps Gerontology Center, Miami University. John Bowliss, Robert Applebaum. 3/31/15. p. 22
[165] "Report: Medicaid Costs $2 billion less than expected. Herald-News. 8/13/15
[166] Ohio Office of Health Transformation. "Modernize Medicaid: Overall Medicaid Budget Impact: 2016/2017"
[167] ASPE FMAP 2014 Report

Kansas

Medicaid modernization in Kansas focused on transforming the state's entire Medicaid program into a capitated at risk integrated managed care model in 2012. The state made the decision to use an "all in" implementation strategy for the purposes of reducing fragmentation through a comprehensive plan and reduce transition costs should they have implemented managed care on a program by program basis.

The inclusion of Kansas' programs for the Aged, Blind, and Disabled population into the managed care model supported by the Governor drew considerable attention and some national controversy from the Intellectual and Developmental Disabilities community as the Kansas planning model would include all medical and pharmacy, institutional, and home and community based services and supports for this population as well as all other LTSS populations. After considerable negotiations with advocacy and family groups and CMS, Kansas received approval to "go live" for a fully integrated managed care waiver in FY 2013.

Medicaid modernization efforts have been positive to date in several key policy areas. The overall state budget impact for FY 2016 and 2017 is expected to be $50 million in state funds[168] savings in both years.[169] The impact on the state's Intellectual and Developmental Disabilities system resulted in a surprising overall increase in services across the system, represented by 3,254 out of the 12,000 HCBS clients receiving an increase in services during the first year (FY 2014) of the managed care services delivery model ("KanCare"), representing 27% of all clients receiving an increase in services.

A total of 1,300 out of the 12,000 HCBS clients received a reduction in services and another 400 voluntary reduced their services. A total of 11% of all clients had their services involuntarily decreased as a result of reassessment and updated plans of care[170]. The provider payment denial rate from program inception through 1/9/15 was 2.57% for HCSB claims and 4.08% for targeted case management claims for a total of approximately $295,000 million billed claims for all services, $271,500 million paid claims for all services, and $13,708 million denied claims for all services.

In an August 28th interview with The Stephen Group, Mr. Michael Randol, the Director of the Kansas Division of Health Care Financing shared the following background, observations, and progress of KanCare to date:

- KanCare has had integrated managed care contracting in place for 2 ½ years

[168] ASPE FMAP 2016 Report: Kansas: 55.96%
[169] "Comparison Report: The FY 2016 Governor's Budget Report with Legislative Authorization". p. 8
[170] "KanCare Update Presentation": Joint Committee Meeting of the Kansas Senate Health and Welfare Committee and House Health and Welfare Committee. 1/20/15

- The state considers the managed care experience to be "very successful from the state's standpoint: "We have decreased ER utilization, decreased inpatient hospitalization, and increased primary care utilization."
- "We have been successful in bending the cost curve."
- DHCF manages three MCO contracts. "Wouldn't want to be in a position where the department is managing 100 contracts."
- KanCare "built in an incentive structure in the rate methodology to incentivize home and community based care and the MCOs get it".
- Regarding the DD wait list: "We were required by law to target MCO savings in DD to the wait list. Since the inception of managed care we have allocated $64 million in general funds and $140 million in total funds to remove folks from the DD wait list. And, at the same time, we have overall bent the cost curve – even while applying savings to the wait list."
- "Prior to KanCare our costs were averaging a 7.5% increase per year. One year after KanCare they were reduced to 5% and that is where they are today."
- "When we moved the DD program – acute care and waivers – into managed care we saw a 27% reduction in ER utilization in the first year."
- Administrative changes: "We redesigned our staff so that they are more contract managers than program managers. We redesigned to more contract management oversight. We were no longer doing all the credentialing and licensing. The big change was culture. We had to train our agency that we were not a fee for service operation any more but overseeing managed care entities. We just now hired a consultant to go over our organization."
- "You need to understand there are going to be changes in finance and data analytics and that needs to be beefed up."

Michigan

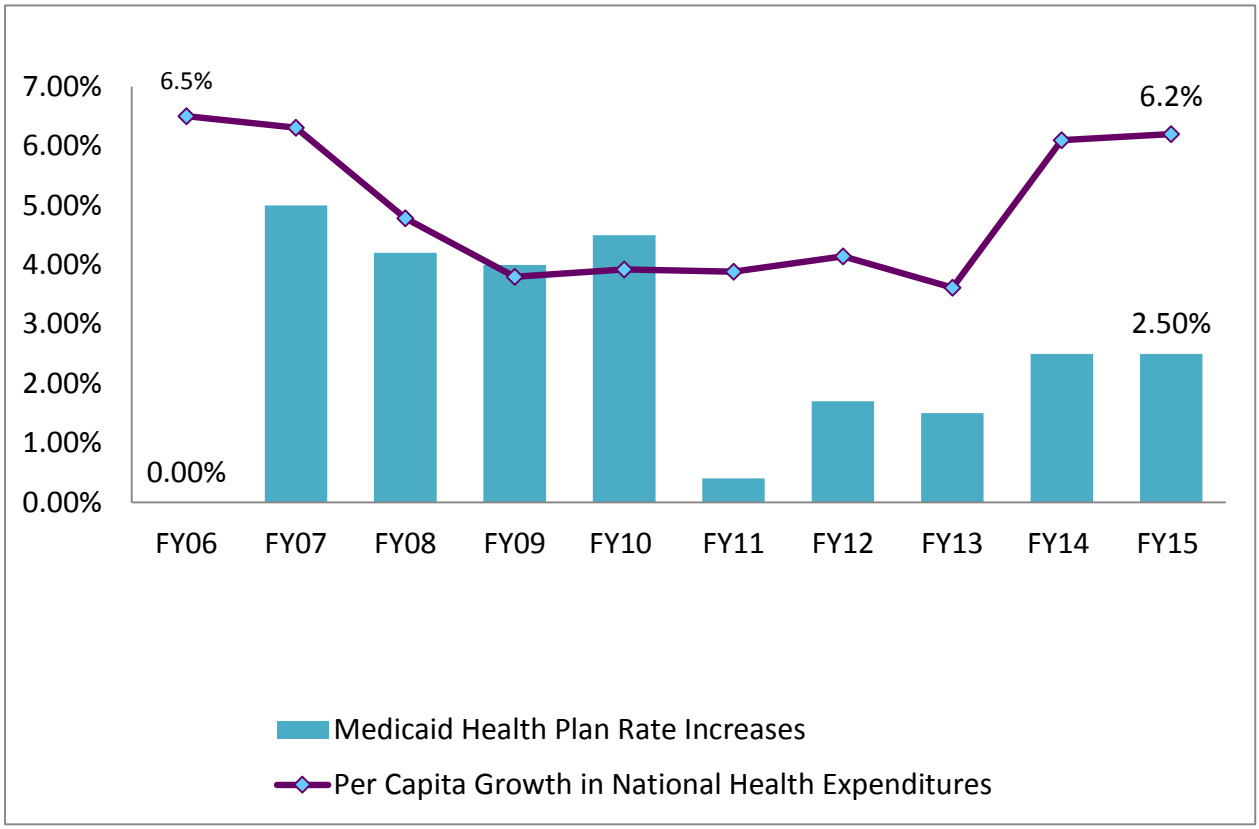
The Michigan Medicaid program was one of the first in the nation to implement the use of risk bearing contracts into its business model back in 1973 through contracts with state based Health Maintenance Organizations. By 1995, Medicaid beneficiaries were enrolled in a mix of HMOs, Clinic Plan models based on a Medicaid capitated rate for primary and specialty care with the state paying FFS for hospital inpatient costs, and Physican Sponsored Plans based on a small monthly capitation rate to Primary Care Physicians similar to the PCMH model.

In 1998, the Governor and Legislature made a full commitment to the HMO based system through at risk capitated Qualified Health Plan contracting. When this initiative was started there were 33 QHPs in the Michigan Medicaid program; today there are 13 QHPs covering the entire state. The system is fully privatized with all plans representing a mix of profit and non-profit organizations, national and local based plans.

The Michigan Medicaid program has focused on the goals of care coordination, integrated services delivery, quality standards connected to performance payments based on national quality benchmarks, and cost containment. The program has been able to substantially contain

costs compared to medical inflation over the past several years.[171] Figure 57 shows that in FY 2015, the difference between Medicaid managed care rate increases and national health expenditures per capita growth was 3.7% (6.2%-2.5%) on a budget of approximately $14 billion. The Governor's Executive Budget for SFY 2016 to SFY 2017 included a 1.9% reduction in the total cost of the Medicaid program from $14,118 billion to $13,850 billion total dollars[172]. The FY 2016, Michigan FMAP rate is 65.60%[173], resulting in state savings of approximately $175 million.

Figure 56—Michigan Medicaid growth rate: year over year, 2007-2015



Mississippi

On September 18th The Stephen Group met with Mississippi Medicaid Director Mr. David Dzielak, Ph.D. and Mr. Will Krump, Deputy Administrator. Mississippi has taken several years to move towards an integrated Medicaid managed care contracting model based on increments of

[171] "Medicaid 101". Michigan Dept. of Community Health. 2/12/15
[172] "Executive Budget Bill: SFY 9/30/16 – 9/30/17. p. 46
[173] ASPE FMAP 2016 Report

15% of the beneficiary population and optional (prior to 2012); 45% of the beneficiary population and mandatory (2012); 45% of currently enrolled beneficiaries plus all children under 19 and mandatory (2014); and all inpatient and mental health carved into managed care (2015).

State officials recommend the piecemeal approach is not the way to go as it results in a constant state of change and increased transition costs for the state and MCOs. They have noted that as the state has proceeded to expand managed care, the provider culture has shifted from being against the model to finding ways to work with the state to make managed care "work". The goal of the agency is that all services and beneficiaries will be in managed care by 2016-2017. The state's experience with managed care contracting is that the first year is "getting the trains on track" and the second year to "getting the trains to run on time."

To date, the state has achieved a 6.98%/$15 million reduction in cost for the covered population compared to FFS in 2011; a 6.87%/$14.2 million reduction in cost for the covered population compared to FFS in 2012; and a 10.3%/$23.1 million reduction compared to FFS in 2013. Contracted MCOs have reported significnat reductions in ER visits from 2011 to 2014, establishing medical homes (82.2% in 2013); and timely payments from the inception of the program based on HEDIS measures. The state is planning the inclusion of all waivers into managed care in 2016-2017. The Mississippi Division of Medicaid has 325 FTE staff managing a total budget of approximately $5 billion and approximately 785,000 total Medicaid and CHIP beneficiaries.

Lousisiana

Louisiana has also used a phase-in approach of implementing managed care contracting somewhat similar to Mississippi. Bayou Health was implemented in January 2012 covering primary care, health services and ancillary services. There are four MCOs contracted to the Bayou Health Medicaid Plan. Pharmacy was carved into Bayou Health in December, 2012. Behavioral Health is scheduled to be carved into Bayou Health in December, 2015.

The Louisiana Department of Health and Hospitals released an RFP earlier in 2014 designed to expand the Bayou Health managed care plan to include 1915 (c) waiver recipients, children on a waiting list for 1915 (c) waiver services between the ages of 3 and 21, and beneficiaries who choose hospice care (formerly a FFS service). Louisiana has found that on average Bayou Health MCOs have saved $13 PMPM over shared savings plans and is working directly with the PrePaid Health Plans to directly engage providers in health status improvement strategies and cost containment. Bayou Health currently serves approximately 60% of Louisiana's 900,000 Medicaid beneficiaries.

On July 17, 2014 the Louisisana Department of Health and Hospitals annouced that:

> "At its inception, DHH anticipated that Bayou Health would save $135.9 million in the program's first full year of implementation. Those savings were achieved, and ongoing savings are validated by a recent comparison of Bayou Health to legacy Medicaid costs, which indicates that one model of managed care saves the State nearly $30 per recipient per month for its members, a greater than 12 percent reduction in costs."[174]

Medicaid Modernization and Stakeholder Input

Public participation in any state's planning efforts to modernize their Medicaid programs is critically important in assuring transparency, trust, and support, as well as providing a forum for legitimate policy disagreement and discussion. CMS requires that states submit their plans and actions for Stakeholder input with any waiver submission. States need to consider, plan, and communicate their approach to Stakeholder input at the beginning of transformative modernization efforts.

The National Council on Disabilities issued a consensus document on "Guiding Principles for Successfully Enrolling People with Disabilities into Managed Care"[175]. The Guiding Principles include: Community Living; Personal Control; Person Centered Practice; Self Direction; Choice; Employment Opportunities; Support for Family Caregivers; Stakeholder Involvement in Planning, Operations, and Oversight; Cross Disability focus; Readiness Assessment and Phase in Schedule from System in Place to Managed Care System; Adequate Provider Networks; Emphasis on Transition to Community Services; Competency and Expertise; Operational Responsibility and Oversight; Use of State of the Art Information Technology; Continuous Innovation and Quality Improvement; Reinvesting Savings to Address Waiting Lists.

In addition to the Guiding Principles, the National Council on Disabilities emphasizes their stakeholder recommendations[176] regarding Medicaid managed care models for state governments and CMS' consideration:

- The central organizing goal of system reform must be to help people with disabilities to live full, healthy, participatory lives in the community.
- Managed care systems must be designed to support and implement person centered practices, consumer choice, and self-direction.
- Working-age enrollees with disabilities must receive the supports necessary to secure and retain competitive employment.
- Families should receive the assistance they need to effectively support and advocate on behalf of people with disabilities.

---

[174] "State Improving Bayou Health in Next Round of Contracts". Louisiana Department of Health and Hospitals. 7/17/2014
[175] National Council on Disabilities. "Chapter III: Guiding Principles"
[176] Ibid. 3/18/13

- States must ensure that key disability stakeholders are fully engaged in designing, implementing, and monitoring the outcomes and effectiveness of Medicaid managed care services.
- Managed care delivery systems must be capable of addressing the diverse needs of all plan enrollees on an individualized basis.
- States should complete a readiness assessment before determining the subgroups of people with disabilities to be enrolled in a managed care plan.
- The provider network of each managed care organization should be sufficiently robust and diverse to meet the health care, behavioral health, and where applicable, long-term support needs of all enrollees with disabilities.
- States planning to enroll Medicaid recipients in managed long-term services and supports plans should be required by the Centers for Medicare and Medicaid Services (CMS) to cover both institutional and home and community-based services and supports under their respective plans.
- The existing reservoir of disability-specific expertise, both within and outside of state government, should be fully engaged in designing service delivery and financing strategies and in performing key roles within the restructured system.
- Responsibility for day-to-day oversight of the managed care delivery system should be assigned to highly qualified state and Federal Government personnel, with the authority to proactively administer the plan in the public interest.
- States should design, develop, and maintain state-of-the-art management information systems with the capabilities essential to operating an effective managed care delivery system.
- States electing to compensate managed care contractors through a capitated payment system should adopt a fair, equitable, and transparent methodology for calculating and adjusting payment rates.
- Rates should be sufficient to allow a managed care contractor to (a) afford beneficiaries a choice among qualified providers and (b) address all of the service and support needs among plan enrollees with disabilities.
- The Federal Government and the states should actively promote innovation in long-term services and supports for people with disabilities.
- CMS should rigorously enforce the Affordable Care Act “maintenance of effort” provisions in granting health and long-term service reform waivers and mandate that any savings achieved through reduced reliance on institutional care be reinvested in home and community-based service expansions and improvements.
- Primary and specialty health services must be effectively coordinated with any long-term services and supports that an individual might require.
- Participants in managed care plans must have access to the durable medical equipment and assistive technology they need to function independently and live in the least restrictive setting.
- The state must have in place a comprehensive quality management system that not only ensures the health and safety of vulnerable beneficiaries, but also measures the effectiveness of services in assisting individuals to achieve personal goals.

- All health care services and supports must be furnished in Americans with Disability Act (ADA)-compliant physical facilities and programs.
- Enrollees should be permitted to retain existing physicians, other health practitioners, personal care workers, and support agencies that are willing to adhere to plan rules and payment schedules.
- Enrollees with disabilities should be fully informed of their rights and obligations under the plan, as well as the steps necessary to access needed services in accordance with the requirements of the Social Security Act.
- Grievance and appeal procedures should be established that take into account physical, intellectual, behavioral, and sensory barriers to safeguarding individual rights. (National Council on Disabilities: 3/18/13)

In response to long standing stakeholder concerns voiced to CMS about Home and Community Based Services policy, as well as state concerns about CMS policy ambiguity, a new Rule was issued in November, 2014 by CMS specific to HCBS policy, state requirements, and unification of several requirements located throughout 42 CFR (Part 430: Grants to States for Medical Assistance). The recent rule attempts to bring together a complex distribution of related requirements specifically under 42 CFR (430, 431, 435, 436, 440, 441, and 445).

Medicaid modernization planning initiatives provide states the opportunity to focus their future planning and implementation efforts on enhancing home and community based services with a comprehensive understanding of CMS requirements, opportunities, and continuing questions they may have that could indicate a need for expanded waiver authority to further develop HCBS choices. Highlights of the revised Rule include:

- State Plan Home and Community-Based Services **(**Case Management Services; Homemaker services; home health aide services; personal care services; adult day health services; habilitation services (which include expanded habilitation services as specified in § 440.180(c)); respite care services; and, subject to the conditions in § 440.180(d)(2), for individuals with chronic mental illness: day treatment or other partial hospitalization services; psychosocial rehabilitation services (known as the 'Rehab" option); clinic services (whether or not furnished in a facility); other services requested by the agency and approved by the Secretary as consistent with the purpose of the benefit
- 5-Year Period for Waivers, Provider Payment Realignment
- Home and Community-Based Setting Requirements for Community First Choice and Home and Community-Based Services (HCBS) Waiver
- Defined and described the requirements for home and community-based settings appropriate for the provision of HCBS under section 1915(c) HCBS waivers, section 1915(i) State Plan HCBS and section 1915(k) (Community First Choice) authorities
- Defined person-centered planning requirements across the section 1915(c) and 1915(i) HCBS authorities

- Provides states with the option to combine coverage for multiple target populations into one waiver under section 1915(c), to facilitate streamlined administration of HCBS waivers and to facilitate use of waiver design that focuses on functional needs
- Allows states to use a five-year renewal cycle to align concurrent waivers and state plan amendments that serve individuals eligible for both Medicaid and Medicare, such as 1915(b) and 1915(c)
- Provides CMS with additional compliance options beyond waiver termination for 1915(c) HCBS waiver programs
- Allows for other services requested by the agency and approved by the Secretary as consistent with the purpose of the benefit
- Clarified the long standing question of the use of Medicaid funds for room and board with specific language that "FFP is not available for the cost of room and board in State plan HCBS". The change made specific exclusions for respite services, adult day health, and unrelated caregivers in households. The Rule also clarified independent assessment and independent case management requirements for HCBS services.

22. TASK FORCE MANAGED CARE ORGANIZATION QUESTIONS

The Arkansas Health Reform Task Force prioritized researching the Medicaid managed care organization industry as a possible policy consideration for its due diligence on options to improve and modernize the Arkansas Medicaid program. TSG was asked to develop a survey of the nation's experienced Medicaid managed care organizations with state contractual responsibilities for high cost populations. In consultation with the Task Force, TSG developed a survey of 24 questions and a list of MCOs for the Task Force's consideration. The questions covered a wide range of information of interest to the Task Force, including experience in other states, populations served, approach to access and quality, whether the MCOs saved any state funds, experience and approach to PCMH and Episodes of Care payment reform models, experience with Medicaid Long Term Services and Supports, and what they suggested states should avoid in their consideration of managed care models. The Bureau of Legislative Research contacted the MCOs on behalf of the Task Force, requested they complete the TSG survey, and provided them the opportunity to present to the Task Force in Little Rock at their August 20th meeting. As expected, the contacted MCOs[177] responded to the survey and presented to the Task Force in Little Rock on August 20th.

TSG has summarized the MCO responses and has created a comprehensive eight page Summary matrix for Task Force members that is found at Appendix 8.

[177] Aetna; AmeriHealth Caritas; Anthem; Centene; Magellan; Meridian; Molina; Shared Health; United Health; WellCare

22.1.Dental Care

Poor oral health affects a majority of adults in the United States. Almost all (92%) adults age 20 to 64 have had dental caries, commonly referred to as cavities, in their permanent teeth.[178].[179] Poor oral health is especially widespread among those with low incomes:

- Adults with incomes below 100 percent of the federal poverty level (FPL) are three times more likely to have untreated dental caries—commonly known as cavities—than adults with incomes above 400 percent FPL.
- Thirty-seven percent of adults age 65 and older with incomes below 100 percent FPL had complete tooth loss compared to 16 percent of those with incomes at or above 200 percent FPL.
- Individuals with a range of chronic conditions are more susceptible to oral disease. Oral disease can also exacerbate chronic disease symptoms. Poor oral health can limit communication, social interaction, and employability.
- Medicaid programs are required to cover dental services for children and youth under age21 but there are no minimum coverage requirements for adults. As a result, adult dental benefits vary widely across states.
- Initiatives to improve access to dental services include using mobile clinics and telehealth technologies, increasing the number of providers serving Medicaid enrollees, and funding demonstrations to encourage Medicaid enrollees to increase dental utilization.
- About 1 in 4 children have untreated tooth-decay. The rate among low-income children is more than twice that for children in more affluent homes (31% versus 14%)

Arkansas Medicaid has for many years demonstrated solid performance in getting children involved with dental care. CMS conducted a study of several states to determine rates of care being provided to youth under Medicaid. This study is summarized in Figures 58 and 59. They report that Arkansas achieves similar levels of participation in dental preventative and treatment care, compared to other states. TSG is not aware of national standards, but Arkansas is at least at average for the states studied.

[178] National Institute of Dental and Craniofacial Research (NIDCR), National Institutes of Health. 2015. Dental caries in permanent (adult) teeth. http://www.nidcr.nih.gov/DataStatistics/FindDataByTopic/DentalCaries/DentalCariesAdults20to64.htm

[179] Kaiser Commission on Medicaid and the Uninsured (Kaiser). Oral health and low-income nonelderly adults: A review of coverage and access. Washington, DC: Kaiser Family Foundation. https://kaiserfamilyfoundation.files.wordpress.com/2013/03/7798-02.pdf

Figure 57—Dental Use among Medicaid-Enrolled Children 1 to 17 Years[180]

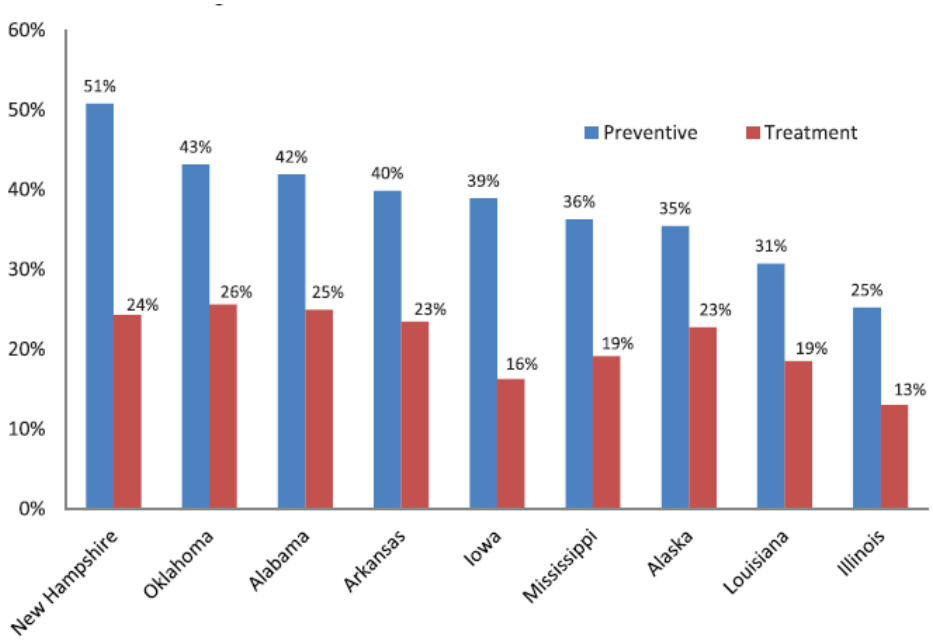
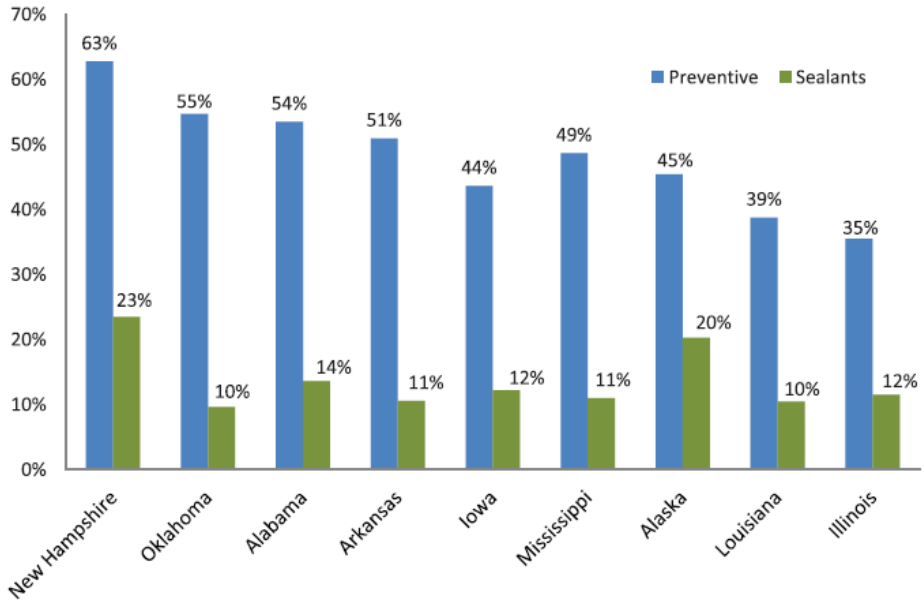


Figure 58—Dental Service Use among Medicaid-Enrolled Children 6 to 9 Years



The American Dental Association reported dental ER visits doubled from 1.1 million in 2000 to 2.2 million in 2012 nationally, but this includes adults. Nationwide these numbers equate to one

[180] CMS report at https://www.cms.gov/research-statistics-data-and-systems/computer-data-and-systems/medicaiddatasourcesgeninfo/downloads/max_ib9_dentalcare.pdf

visit every 15 seconds. Sound oral health is critical to preventing chronic diseases that affect the body such as heart disease and diabetes.

Medicaid dental costs have remained strong for several years, as shown in Table 38.

Table 38—Medicaid dental expenditure

	2010	2011	2012	2013	2014
	73,521,692	73,032,982	78,614,203	75,930,700	81,221,350
11 - Dental Services EPSDT	29,074,101	31,067,342	33,479,866	34,228,625	39,091,675
45 - Oral Surgery Physicians	1,038,271	1,224,382	1,490,350	1,176,427	1,458,206
46 - Oral Surgery Dentist (ADA Codes)	5,263,750	6,676,759	8,096,272	6,693,934	7,102,905
B6 - Dental Prosthetic Device Adult	1,847,570	2,991,877	2,766,983	2,002,372	2,135,181
B7 - Dental Prosthetic Device Children	38,728	24,835	48,476	33,182	27,509
Total Dental	**110,784,111**	**115,018,177**	**124,496,150**	**120,065,239**	**131,036,826**

While Medicaid has been spending at predictable levels, and involving both children and adults at typical levels, TSG did not observe a program for *improving* dental health. Dental care is not included in Episodes of Care, PCMH or other programs. Dental care does not appear to have a care management emphasis within traditional Medicaid.

Thus, it is important that Arkansas Medicaid look to other state practices that have involved improvement to oral health outcomes, introduction of clinically focused care solutions, the building of robust provider networks, while at the same time maintaining fiscally responsible approaches. The Arkansas State Dental Association has also informed us that stability of dental expertise in reviewing claims and educating providers on correct billing patterns and addressing provider issues and concerns is a critical component of ensuring a network of providers willing to accept dental Medicaid patients.

SECTION 3: FINDINGS ACROSS PROGRAMS

23. HEALTH DISPARITY

The Center for Disease Control and Prevention lists comparative information and data on health disparities across all ethnic groups as identified by the US Census. The CDC national data on health disparities indicates that heart disease, cancer, stroke, diabetes, and unintentional injuries

are the leading causes of death among African Americans, resulting in shorter comparative life spans.[181]

Arkansas ranks 49th among the states in overall "population health" based on indicators such as incidence of diabetes (44th), cardiovascular deaths (47th), infectious disease (49th), deaths by stroke (50th), and obesity (48th).[182] Overall child health is also alarmingly challenged with Arkansas ranking 44th in overall child health, 50th in child immunization, 39th in infant mortality, and 44th in preventable hospitalizations.[183]

The National Healthcare Quality and Disparities Report of 2014[184] measures all states on a wide range of clinical measures based on NHQR reporting requirements. The summary report for Arkansas ranked the state as average and improving in Patient Safety, average and improving in Person Centered Care, average and improving in Care Coordination (PCP practice), weak and decreasing in quality of Effective Treatment, and weak and decreasing in quality for Healthy Living. A detailed review of all quality measures for all ethnic groups indicates that Arkansas achieved a 42% compliance rate on a total of 197 quality measures collected in the state.[185]

A 2014 study conducted at UAMS commissioned by the Arkansas Minority Health Commission found that if minority health disparities were eliminated there would be a savings of $516.6 million in health care costs, $160.6 million saved from fewer lost work days, and a $1.7 billion savings from fewer premature deaths.[186]

TSG attended community meetings in Pine Bluff and Forrest City as the guest of local legislators to hear from community members, physicians, hospital and FQHC/Community Health Centers administrators, and pastors. We have met with the Director of the Arkansas Minority Health Commission.

Health care professionals and community members have shared a consistent voice that the PO has had a positive impact on their communities with many people and families having health coverage for the first time in their lives. Physicians and community members recognize a need for culturally relevant health education before and after an individual obtains coverage. Many people have used local Emergency Rooms as their sole source of primary care services for years

[181] "Examples of Important Health Disparities": Center for Disease Control and Prevention
[182] America's Health Rankings: 2014
[183] "Kids Count Data Book: 2015: Annie E Casey Foundation
[184] "National Healthcare Quality and Disparities Report: 2014": Agency for Healthcare Research and Quality: 5/2015
[185] "Quality Measures Compared to Achievable Benchmarks: 2014": Agency for Healthcare Research and Quality: 5/2015
[186] "Economic Cost of Health Inequalities in Arkansas". Mick Tifford PhD, Chenghi Li PhD, Sharla Sharp PhD, UAMS. 4/2014

and have little experience in accessing primary care, let alone specialty care, now that they have health insurance. Education and community based assistance on the process of accessing primary care when needed will assure that people who seek to access a doctor can do so in a timely way that avoids continued unnecessary use of the local Emergency Room. Arkansas could improve individual and population health status by helping newly insured individuals learn how to "navigate" the health care system to access the right services at the right time thereby addressing access disparity over time. Proven programs, such as the Arkansas based Community Connector model[187] can be brought to scale at very low cost, perhaps as a value added support service required by state Medicaid Modernization contracting practices, to assist people to learn how the health care system works, access needed care, become independent in navigating the health care system, increase self-responsibility, stay in their homes, and avoid unnecessary costs. The key is a community based approach.

24. PROGRAM INTEGRITY

In 2013, Arkansas Act 1499 was signed into law creating the Arkansas Medicaid Inspector General's Office (OMIG) office. The purpose of the Act was to create a new state agency in order to consolidate staff and other Medicaid fraud detection prevention and recovery functions into a single office; create a more efficient and accountable structure; reorganize and streamline the state's process for detecting and combating Medicaid fraud and abuse; and to maximize the recovery of improper Medicaid payments. See Ark. Code Ann. §20-77-2501.

With the creation of OMIG, DHS staff focused on program integrity were transferred to the supervision and direction of the Arkansas Medicaid Inspector General. OMIG fulfills the program integrity functions as required by CMS under 42 CFR §455 et al. All states that participate in the federal Medicaid program are required to maintain a program integrity function to ensure compliance, efficiency, and accountability within the Medicaid Program by detecting and preventing fraud, waste, and abuse.

The OMIG duties outlined in statute are to conduct and supervise activities to prevent, detect, and investigate medical assistance program fraud and abuse; refer appropriate cases for criminal prosecution; recover improperly expended medical assistance funds; audit medical assistance program functions; and establish a medical assistance fraud and abuse prevention program. See Ark. Code Ann. §20-77-2505. All other Medicaid program integrity activities not assigned directly to OMIG remain with DHS and are carried out in their normal manner by DHS.

[187] "When Health Workers Matched Those with Needs to Home and Community Services". Health Affairs, 30, No. 7 (2011): 1366-1374

The duties of OMIG, therefore, as they relate to program integrity, are very broad and go well beyond identification and prevention of fraud. They are also charged with preventing abuse within the program. Arkansas DHS continues to conduct in-house utilization review, MMIS claims payment, Decision Support System – a CMS certification requirement for Claims system integrity - third party recovery, and has contractors that are looking at predictive analytics and financial indicators. DHS also makes common referrals to OMIG when it finds any evidence of fraud. We did not find, however, that DHS is making routine and common referrals for matters that it considers abuse of program funds. Moreover, we found that there were occasions where referrals could have been made and were not, and referrals were made to outside vendors to review billing patterns rather than submit them to OMIG, presumably because of the low level of resources at OMIG.

Some of our other key findings include:

- OMIG has dedicated staff who understand that the mission and scope of the agency is to look beyond fraud and prevent waste and abuse, a vision that the newly appointed OMIG fully embraces
- There are a large number of vendor contracts at DHS that have some role in the issue of payment integrity – HMS for Third Party Liability (TPL recoveries were $23.4 million in 2014), HP for MMIS, Curram for Eligibility, Value Options for behavioral health review, Optum for analytics, but none are incentivized to complete program integrity activities
- Optum that has data analytic capabilities has been used by OMIG in the past with the focus of verifying fraud as opposed to identifying waste and abuse
- There is limited oversight at DHS into billing in the long term care and support services (LTSS) area
- Facility and provider level audits are limited
- Audits of providers and associated care plans are limited
- There are some opportunities lost between DHS and OMIG – and at DHS there is no clear owner of payment integrity
- Recoveries at OMIG for fraud are well below the level of a number of other states. For example, excluding recoveries from the Medicaid Fraud Control Unit at the Attorney General's Office, OMIG's annual recoveries per capita were $.71 ($2.1 million), whereas Florida was $1.58 ($31.4 million), Arizona $5.57 ($37.5 million), and Georgia $3.09 ($31.2 million).

When it comes to state-of-art technology that can detect patterns of fraud, we found that DHS does not provide the "enhanced predictive capabilities" that we have seen in other states. Nor do those capabilities currently exist at OMIG. In fact, many states have significantly invested in technology and vendors that are dedicated to payment integrity and these programs are also required each year to show a high rate of return. Thus, in-house analytic capabilities are an integral part of states with high performing payment integrity functions. These states have made significant investments in provider audits, post payment analytics, and pre-payment predictive

analytics. States that have been successful in establishing best practice in the area of payment integrity have focused these high end analytical tools on some of the following activities:

- Automated detection and alerting,
- Continuous monitoring of Medicaid program transactions in real time,
- Identification of potential fraud patterns, based on sophisticated algorithms that identify potential noncompliance, and improper payments, both prospectively and retrospectively,
- Detection of non-transactional fraud, such as Medicaid program eligibility issues and identity theft,
- Use of state-of-the-art predictive modeling, complex pattern analysis, link analysis, text mining and geospatial analysis, etc.,
- Feedback and self-learning capabilities that allow the technology to adapt to changing schemes and trends, and,
- Demonstrated experience hosting sensitive and regulated State data.

During our Assessment, we met with the newly appointed Office of Medicaid Inspector General, Elizabeth Thomas Smith and her staff and she reiterated the need for enhanced fraud analytic tools that can also detect and prevent waste and abuse related to billing. This vision was recently echoed by Inspector Smith in the Healthcare Journal of Little Rock:

"Often outliers in billing are identified through data mining. My plan is to utilize the resources rather than to simply rely upon complaints. These analytical resources are provided by state contractors as well as federal contractors, which will assist in identifying billing outside of the normal range."[188]

25. VERIFICATION OF ELIGIBILITY

Summary Background

Like many states who have attempted to quickly implement many large and small changes to their health care systems after the passing of the Affordable Care Act (ACA) and the consequent state Health Care Reform legislation, Arkansas has experienced many challenges. The Medicaid Expansion option chosen by Arkansas increased the financial eligibility range up to a nominal 133% of the Federal Poverty Level (FPL) (effectively 138% given how the income limit is

[188] Healthcare Journal of Little Rock, September/October 2015 p. 30 Conversation with newly appointed OMIG Elizabeth Thomas Smith, available at: http://www.healthcarejournallr.com/HJLR/2015-sept-oct/2015-sept-oct/#1/z

calculated). Consequently the state has enrolled approximately a quarter million more individuals into the state's HCIP program.

Arkansas's legislation to manage the expanded Medicaid population is largely implemented through private medical insurance firms and providers under the Health Care Independence Program, also commonly known as the PO. This program is 100% federally funded through 2016, with the state taking increasing financial responsibility until the state is paying 10% of the cost in 2021. A small portion of the expanded population was identified as "medically frail" and was made eligible for traditional Medicaid services. Various adjustments to other state Medicaid services were part of the new program.

Even considering the federally authorized Targeted Enrollment Strategies which allowed relatively easy enrollment of large numbers of clients, using pre-existing SNAP eligibility for example, the Arkansas Department of Human Services experienced a significantly increased workload with almost no offsetting increase in resources as the additional Medicaid clients were enrolled.

Two key early expectations that failed to be met exacerbated the situation. One was the expectation that using the federal front end application to verify the eligibility of applicants would provide the state with a mostly vetted population to then bring this group into the state Medicaid program. The federal capability turned out to not be able to provide that service at that time and the state had to build the capacity to review the new expanded Medicaid applicants using the new calculation – known as Modified Adjusted Gross Income (MAGI) - along with a number of other new requirements.

The second expectation that failed to be met was that the new Curam software system would be able to automatically screen a large majority of applicants just using automated validation of the various requirements, from legal residency through income qualification. This automated path through the enrollment process is informally known as the "No Touch" path because the applicant is cleared or rejected without manual review by a state worker.

Arkansas and IBM have been in both formal and informal disagreement about the cause of this and other issues with the Curam system for over a year. However these issues are ultimately settled legally, the impact for DHS was a much higher volume of applicants that had to be managed manually.

So at the time of this review the state, and particularly the Department of Human Services (DHS), is still in the middle of a difficult transition from the legacy Medicaid administration systems, primarily the "ANSWER" system and the new systems, primarily the IBM "CURAM" software. The data structures in these two systems are fundamentally different in some ways, meeting the design needs of different eras. This makes even manually constructing summary

reports across the two systems difficult. An example is that all information in the new system is organized around individuals, but some similar information in the legacy system is organized around families.

The new Curam system is only specified to handle some categories of Medicaid clients – the clients whose eligibility is covered by the new MAGI methods (discussed later). There are a number of traditional Medicaid groups that have special and diverse eligibility requirements. The DHS PMO office is working on an RFP for the necessary system modifications. This will entail another round of IBM/Curam enhancements and cannot be expected to be completed any time soon.

There have been delays in the completion of the development of the new IBM/Curam application which left the state unable to process the required annual eligibility reviews for the PO population. Arkansas, and other states in similar straits, applied for a short term waiver of the annual review requirement, and were granted that waiver. The normal requirement this waiver set aside is as follows:

> *§ 435.916 Periodic renewal of Medicaid eligibility.*
> *(a) Renewal of individuals whose Medicaid eligibility is based on modified adjusted gross income methods (MAGI).*
> *(1) Except as provided in paragraph (d) of this section, the eligibility of Medicaid beneficiaries whose financial eligibility is determined using MAGI-based income must be renewed once every 12 months, and no more frequently than once every 12 months.*

Even though the CMS federal oversight allowed this delay in review of eligibility, there was a negative consequence in that clients who had increased their income or no longer qualified for the program for other reasons continued to receive services. So the government was paying for medical care for some number of clients who no longer should have been receiving services.

When this contract began in late spring of 2015, this issue of the delay in reviewing eligibility dominated the public discussion. Shortly after this review was initiated the Curam system had matured to the point where renewals of eligibility could begin to be processed. The goal, in alignment with commitments to Federal Center for Medicare and Medicaid Services (CMS) authority, was to eliminate the backlog of annual renewal reviews sometime in the fall of 2015, often spoken of as an end of September deadline, although more careful review of the agreement indicated that annual reviews for the backlogged cases were to be initiated in that timeframe, not necessarily completed.

Overview of Eligibility Processes

The primary criteria determining services available to an applicant is their income. Other basic information such as identity, age, lawful residency, incarceration status, and recognized special needs fill out the eligibility criteria. Some applicants whose considered income is too high are

required to provide for their own insurance. Applicants who qualify for some type of medical services assistance will typically end up in one of the following four broad categories.

1. Premium Tax Credit Subsidy – where their medical insurance premium cost is offset through tax credits;
2. Health Care Independence/PO – where the client's premium for services from a private insurance carrier is covered by the program;
3. Traditional Adult or Child Medicaid – where medical care is provided by traditional fee for service;
4. One of various special needs programs, including Medically Frail status.

Whether an Arkansas resident uses the Federal Portal (healthcare.gov) or the ACCESS Arkansas Portal (access.arkansas.gov) the steps and qualification reviews for Medicaid health care assistance in Arkansas are the same. Once qualified through the Federal or Arkansas portal, applicants are directed to apply through the insurark.org website, where their medical status is ascertained and they are directed to either the Health Care Independence/PO program or to Traditional Medicaid services.

Mailed paper forms and call center support is also available as an option for these applications, as well as direct support with DHS/DCO staff in any county DCO office.

Current Private Option Eligibility

Almost all applicant information is verified through independent sources. Some of that verification is through automated database checks, some is through manual review of relevant databases, and some verification is through manual review of documentation. **One important exception that may prove important to consider is that Arkansas residency is by self-reporting only.** Methods to strengthen some of the verifications are discussed in our recommendations.

NOTE: The Federal Portal qualification reviews were not considered to be fully operational until 2015. So it is certainly plausible that there exist instances of individuals who passed qualification earlier who would not pass qualification now.

Identity and Lawful Residence Qualification

Current Process: The Federal Portal system is used. If the Federal cross check against multiple databases shows any inconsistency of Identity information then documentation must be supplied.

US Citizens currently residing in the US are, of course, lawful residents. Although there is no federal funding to cover some groups of immigrants (except for payment for limited emergency services), there are many categories of non-citizens who are also considered to be lawful residents for Medicaid services application, a common example being Lawful Permanent Residents/Green Card Holders who have reached the end of their 5 year waiting period.

The required documentation if there is an inconsistency is shown in Appendix 9.

Financial Qualification

TRADITIONAL MEDICAID: Unlike the new MAGI qualifications described directly below, traditional Medicaid requirements were, and, where still applied, are complexly varied across all the different programs and state implementations of those programs, including a detailed list of income disregards, and some ready asset limits.

LTSS ELIGIBILITY:

Current Issues: The Division of Aging and Adult Services (DAAS) which manages LTSS eligibility is dealing with a number of known challenges. The responsibility for managing this eligibility work was transferred to their organization just over a year ago. The general DHS overload due to the ACA implementation somewhat affected this group and problems with the transition of the eligibility responsibility to their organization clearly affected performance. The general backlog statistics are poor and the implications for specific cases of individuals can be serious.

Some individuals applying for the following programs are experiencing unacceptable delays:

- Long Term Care in skilled nursing facilities (LTC);
- Assisted Living Facility waiver (ALF);
- Elder Choices' Home and Community Based Services (HCBS) waiver;
- Alternatives for Adults with Physical Disabilities (AAPD) HCBS waiver;
- The Program for All-Inclusive Care for the Elderly (PACE) program.

The internally generated statistics are currently being revised to eliminate some systematic error, this is described below. But current (end of August 2015) reporting shows the Division meeting application timeliness goals for 73% of cases and completing re-evaluation timeliness goals for only 45% of cases.

There are federally mandated performance goals specified by 42 C.F.R. § 435.911, but the software being used by the DAAS does not allow DAAS to accurately capture that performance, primarily because delays in processing that are due to client delays in providing information, which is a common event, cannot be taken into account.

The department continues to report timeliness targets which do not take into account these externally generated delays. The information still has trending value even if the numbers don't exactly match the federal targets. DAAS is actively exploring ways, both by process change and software change, to improve the correlation of the internal performance numbers and the federal requirements.

The backlog is now being addressed with the temporary hiring of former experienced staff to clear the backlog. Some of those hires have already been made with the balance to come on board in October. A recent internal report showed the backlog at 564 applications and estimated that the backlog would be cleared by the end of the year. A realignment of resources across the six state regions to better match caseloads was also recently done.

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

For example, a case worker will review 3 recent months of provided bank statements. The applicant is asked to report on any money or property that has been transferred in the last five years. If the applicant does report such transfer of assets they are asked to provide documentation about that transfer. But at this time only limited external services are being used for asset verification so much of the information is essentially self-attested only. Other options are actively being explored by DHS/DAAS.

The Division is working on implementing a third party asset verification system, using Acuity, as an extension of their contract with HMS. The current planned go-live date is by February 2016.

LTSS applications also require a review of any third party insurance resources. There is a form (EMS-662) where an applicant is asked to identify other parties, such as BC/BS or AARP, who might have some support liability; the issue of other payers who have some liability is generally called Third Party Liability (TPL). Medicaid and Medicare are legally required to be the payer of last resort, after other legitimate sources have been exhausted. HMS, a firm that provides a service which helps states find and access TPL sources, currently looks for data matches for all clients in the MMIS system. However, this does not yield much of value for the LTSS/non-MAGI population because they are mostly children and other categories that would not have private insurance.

MAGI: The applicant's relevant income is calculated using the Modified Adjusted Gross Income (MAGI) formula which was implemented for the expanded Medicaid population on January 1, 2014. "MAGI" is sometimes loosely used as a way to refer to this expanded Medicaid population driven by the Affordable Care Act (ACA). MAGI is a revised simplified standard method to calculate an applicant's useable income for Medicaid and other federal programs, CHIP for example. Some of the MAGI population are still traditional Medicaid clients and are not eligible for the PO. So, in casual usage, someone may mention the "MAGI population" meaning the PO population, but they are not the same thing.

The key changes brought to eligibility qualification by using MAGI is simplification of income disregards, which used to be a complicated list, to just one standard 5% income disregard, **and the removal of asset/resource limits** (however Long Term Service and Support services used by MAGI beneficiaries do have real property, asset transfer, estate recovery, as well as other normal constraints for Long Term Care services). Household composition rules were standardized to mirror federal tax filing rules. MAGI is also used to determine eligibility for Premium Tax Subsidy Credits for those who do not qualify for Medicaid.

FPL: Once the applicant's Income has been determined, their Income is then compared to the current Federal Poverty Level (FPL) guidelines. Table 39 shows annual and monthly FPL guidelines for Arkansas in 2015 are shown in the tables below. So, for example, an Arkansas family of 3 making $1,674 or less per month is below the Federal Poverty Level.

Table 39—100% of FPL

Annual FPL

FAMILY SIZE	100%
1	11,770.00
2	15,930.00
3	20,090.00
4	24,250.00
5	28,410.00
6	32,570.00
7	36,730.00
8	40,890.00

Monthly FPL

FAMILY SIZE	100%
1	980.83
2	1,327.50
3	1,674.17
4	2,020.83
5	2,367.50
6	2,714.17
7	3,060.83
8	3,407.50

PO CRITERIA: The distinguishing requirement for the Arkansas Health Care Independence/PO eligibility is that the applicant's income is too high to qualify for traditional Medicaid but their income is less than 138% of FPL. So a family of 3's annual income would need to be less than 138% of FPL for a family of 3, or $27,724 a year (20,090 * 1.38 = 27,724), which is less than $2,310 per month.

Current Process: The Federal Portal process for income verification is used for initial enrollment. Federal IRS and SSA data is used for that vetting process. (The quality of that data is good for the time it was captured but the information is often long out of date for current qualification purposes.) In many other cases, self-employment included, income can only be verified by manual review of documentation.

Documentation that could satisfy Income inconsistencies determined by the Federal Portal is shown in Appendix 9.

Redetermination

Current Process: There are redeterminations based on Changes of Circumstance and redeterminations based on the mandated annual renewal.

Examples of Changes of Circumstance which currently may cause a redetermination are:

- Self-Reported changes such as family composition, name, marriage, birth, death, income, etc.;
- Reported Certified Death;
- Reported Incarceration;
- Cross-Program reference where a DHS worker may instigate a redetermination for Medicaid eligibility based on information obtained in support of another program, such as SNAP or TEA.
- Aging out of Medicaid Qualification

Other opportunities for proactive redetermination will be discussed in the recommendations.

AGING OUT OF QUALIFICATION: DHS monthly sends all clients who are two months away from age 65 notice to apply for Medicare as they will then, with some exceptions below, not be qualified for Medicaid, but will then be qualified for Medicare. To avoid transition overlap the clients are dis-enrolled from Medicaid in the month they turn 65 because they do qualify for Medicare in the month they turn 65.

Some clients who are 65 and older meet poverty requirements to stay on Medicaid. Medicaid support can continue to provide partial coverage for premiums and other medical out-of-pocket costs not covered by Medicare. In 2015, qualified Medicare beneficiaries whose income is below FPL+$20 qualify – for example, $1,001 for an individual and $1,348 for a couple. DHS makes this determination as part of this process and only sends the transition information to the clients that will not continue to qualify for Medicaid.

Clients under the poverty limit receiving PO services may be eligible for Medicare Savings, where Medicare premiums are paid by Medicaid dollars. Medicare Savings and the normal qualification for Medicaid past age 65 are handled separately currently because one is managed through the legacy system and the other is managed through the newly developed system.

INCARCERATED BENEFICIARIES: Incarcerated citizens obviously have their normal medical care covered by penal system services. In addition, it is explicitly illegal for a person to receive Medicaid services while incarcerated. Coverage stops immediately for beneficiaries receiving traditional Medicaid. Private Insurance payments have coverage through the end of the month they become incarcerated.

If the State continues to pay the PO premiums for someone who is in Jail or Prison, the state can probably recoup from the carrier under most circumstances because no services were actually

rendered, but recouping itself has costs. So the goal is to expeditiously identify incarcerated beneficiaries and stop services before an over-payment has occurred.

Current Process: Arkansas Department of Corrections incarcerated population information is reported to the SSA. SSA maintains a composite incarceration report which DHS cross-checks monthly to identify any clients who are incarcerated. Services are then immediately terminated for all identified as incarcerated. The information accessible directly from Corrections reports is not useable for this DHS purpose.

Every penal facility in the state is not included in the reviewed information. However, DHS opinion is that the typical length of incarceration in a local jail whose information is not reflected in the SSA composite information would be less time than the normal one month period to process a change in any case.

INCARCERATION TRANSITION SUPPORT: In order to make a smooth re-entry back to communities, most believe that people released from incarceration should be enrolled in the social services for which they qualify. Act 895, set to go into effect at the time of this report, requires that inmates be allowed to begin processing their application for services 45 days prior to release. Act 895 also requires Corrections to provide better Incarceration reporting to DHS.

The Arkansas access portal asks about incarcerated status, including their release date. If the applicant is incarcerated but is within 45 days of their release date, they are allowed to apply and their application is sent to an appropriate caseworker who will manually review the applicant's status and complete the application once the applicant is released.

The provided services include Mental Health counseling. Various parolee aid and assistance efforts have little to work with unless the administrative enrollment process has been completed. Many former inmates don't have the understanding of the system or general resources to manage the enrollment process themselves. The high rate of various forms of debilitating mental illness in the incarcerated population is well known.

Incarceration records used by the Federal Portal and in the state institutions have a lag time in their reporting. So, formerly incarcerated individuals making application may have to use records like those on the list below to document the fact that they are no longer incarcerated.

- Official release papers from the institution or Department of Corrections
- Parole papers
- Unexpired state ID, driver's license, work ID, or passport
- Paystubs
- Federal, state, or local benefit letter
- Clinic, doctor, or hospital records for services provided
- Medical claim explanation of benefits provided

- School record/schedule showing enrollment (i.e. for college students)
- Bank or credit card statement showing transaction history (showing only the name of the individual in question; no joint accounts)
- Military records
- Cell phone bill (showing only the name of the individual in question)
- Lease (must be an active lease where the individual is currently residing)
- Signed notarized statement from the individual with alleged false incarceration inconsistency indicating they're living in the community and includes their name, date of birth, and address
- Written statement from someone within the community which states the name, date of birth, address, phone number, their relationship with the individual with alleged false incarceration inconsistency, and that the individual is present and participating within the community
- Rent receipts (showing only the name of the individual with the false incarceration inconsistency)
- A written explanation of circumstances as to why the applicant doesn't have documentation

DECEASED BENEFICIARIES: Data Management of benefit cessation for the deceased seems to be improving relative to status when this issue was raised by the Medicaid Inspector General in 2014 and early 2015. However, our subcontracted review of third party information indicates there may be an ongoing problem (discussed below in the Risk Factor Analysis Section).

Current Process: Monthly the Department of Health (DOH) matches up their current deceased information with the list of current enrollees to identify any current enrollees who have died (an earlier interim report said this match up was done by DHS/DCO, but DCO management later clarified that the matchup is done by the DOH). Also, some next of kin will self-report about the client death. The number of deaths is approximately 100 per month. This comparison of DHS roles with the deceased list is expected to become automated when the Department of Health's new information system comes on line, which date is not currently known.

Social Security also maintains records of dates of death but that information is less timely than the Department of Health information. The case is closed as of the Date of Death. Any premium is recovered to the end of that calendar month.

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

Carrier Notification and Retroactive Recoupment:

The larger related issue of Carrier notification and retroactive recoupment for deceased beneficiaries is still being investigated by the Medicaid IG. At the time of this report, communications and the liability assignment for any relevant beneficiary change of circumstance notification to private carriers is an active ongoing discussion between DHS and Arkansas's private carriers.

ANNUAL REDETERMINATION:

Current Process: The annual redetermination is done for all beneficiaries and focuses on relevant changes in income. Beneficiaries are notified with the associated paperwork that they are required to notify DHS about any other changes of circumstance, but income is the only criteria actively considered. Once the known backlog is eliminated, renewals will be initiated for all beneficiaries 10 days from the end of the 11th month of the renewal period, a year since the last determination was done.

The first step, because it is low cost and effective, in the renewal process is to apply ex parte reviews to beneficiaries who are up for their annual renewal. If they are enrolled in either TEA/TANF or SNAP, which has at least as stringent requirements for maximum income as PO requirements, then the beneficiary can be approved without further review. Household size must match in addition to the income requirement. This comparison is done automatically in the new IBM/Curam system. TSG assessed whether timing issues and other qualification factors could offset the value and legitimacy of this process, but, although the odd outlier case might exist, no material problem was found.

As 85% of state workers are covered by the Workforce Services managed unemployment insurance program, and as employers are required by law to update the income information held by the program, that database is an excellent source of information to use for verification. So the second step in the process is to compare the most recent income data from Workforce Services with the nominal income stored in the DHS database.

NOTE: There is some indirect and partial, but substantial, verification of address or residency in using the Unemployment Insurance database to verify income. Any positive comparison strongly implies state residency, although only Federal data unavailable to the state exactly locates employees.

NOTE: There is no indication, and no one was able to confirm for TSG, if multiple employers for a given individual are aggregated together to show the total income for that individual. We don't know if this would prove to be a material issue.

A standard formula based on the FPL for this comparison called "reasonable compatibility", which approximates a 10% variation from the nominal income in the DHS data, is applied to the comparison of the two pieces of information. If the new Workforce Services income is greater than the nominal income for the beneficiary and it outside the range of "reasonable compatibility" then a redetermination notice is sent to the client who has 30 days to provide documentation of their current income.

If the Workforce Services reported income is within range or is lower than the nominal income in the DHS database, DHS sends a letter indicating that the beneficiary's case has been re-determined and the beneficiary has been found qualified for another year of Medicaid services.

That letter, like other notifications to beneficiaries, includes the standard notice that the beneficiary is required to notify DHS if any of the information is inaccurate, and within 10 days if a change in circumstances occurs. They are also notified that failure to report a change in circumstances could result in prosecution for fraud. The enrollee may report their changed circumstances by phone or by sending in a form by mail or filling out a form at a county office. The changed information is then entered into the system by a "Change Worker" and any consequential change in the client's status is implemented the next calendar month.

If Workforce Services has no reported income from the most recent quarterly report for a beneficiary, then no conclusion can be drawn about the beneficiary's income because they could be part of the 15% whose income is not captured in this database (there are 22 types of employment that are officially exempt from the unemployment insurance requirement). So, in this case, DHS must deliver a standard notice of redetermination, with the client having the normal 30 days to respond with appropriate documentation. The federal statute requires that this notice of redetermination include pre-populated information to facilitate quick and accurate processing. The new Arkansas system does not yet have this capability but the requirement is understood and is part of planned development.

If the beneficiary does not return any information, or the information returned clearly indicates they do meet the qualification they are sent a notice of adverse action explaining that they no longer qualify for the program. If there income has exceeded the allowable level their case information is forwarded to the Federal Portal and the client is instructed to log into the federal portal to apply for Premium Tax Credit support. There is then a 30 day period within which the beneficiary may contest the decision and make arrangements to provide corroborating information.

NOTE: Any verification notice letters that are returned from an out of state address are acted on to terminate coverage immediately by DHS.

The actual date of terminating services depends on the calendar and the administrative requirements of processing that change, but it is generally swift – generally at the end of the current calendar month. If a termination is determined within the last 10 days of a month the actual termination will be processed to be effective at the end of the following month.

A DHS worker reviewing a case can take whatever time is deemed appropriate and necessary to gather and review income documentation. Additional time may be required to research other assistance programs or exchanges.

The terminated beneficiary has 90 days within which they can submit appropriate qualifying information about their income and reinitiate services without having to reapply if the new information is approved. After 90 days they must reapply as a new applicant.

25.1.LexisNexis Risk Factor Analysis

TSG sub-contracted with LexisNexis to review traditional Medicaid and the PO expanded Medicaid populations across multiple categories of potential risk including:

- Existence of the identity
- Non-Obvious dual participation
- Deceased
- Incarceration
- High-risk of identity theft or fraud
- Out of state address
- No record of State residency
- Ownership and value of real property

LexisNexis requested basic beneficiary identity data for the populations of both Medicaid groups from DHS.

25.2.Traditional Medicaid and Private Option (PO) Populations

LexisNexis received incomplete files from DHS, covering 447,013 participants in the traditional Medicaid program and 236,228 participants in the PO. LexisNexis scrubbed the data of duplicates and minors, and used their algorithms to determine which participants they could evaluate for risk factors (for which they designate a LexID). Results are shown in Table 40.

Table 40—Summary of Lexis-Nexis issues with eligibility data provided by DHS

	Medicaid Population	PO
Total Input Records	477,013	236,228
Duplicate Client IDs	102,478	9,973
Minors (Under 18)	40,157	0
Total Unique Adult Client IDs	334,108	226,255
Total Unique Adult LexIDs	325,124	224,782
Possible Dual Applicants	160	267

Note: ***The individual case records reviewed by Lexis-Nexis for the purpose of this Audit were obtained from DOC and may contain case records for individuals that no longer are part of the current eligibility data base. The results of this review are based on an audit of the Traditional Medicaid and PO eligibility data set forwarded to Lexis-Nexis at a given point in time.***

The counts below are based on specific individual records that meet the categorical or statistical criteria for particular risk factors within a specific time window. Identifying risk factor groups is the first step. Prior to any adverse action being taken against any of these individual "flagged" records resulting in the removal of the individual from Medicaid or other benefits programs, the results would need to be carefully reviewed, and investigated by DHS as part of a due diligence process to confirm the findings. Reviewing current potential problems is useful but the real payoff will come from re-designing the front end systems to better minimize abuse and inaccurate information entering the system in the first place. The overview diagram 25-1, on the next page shows the number of beneficiaries whose information falls within one of the 7 identified risk categories. The overlap between risk categories is also indicated in a graphical form. For example, all of the beneficiaries for whom no record of state residency has been found also are members of the group with out of state addresses.

The provisional count for each risk factor is as follows:

1.	Deceased	495
2.	Dual Participants	427
3.	High Risk Identities	20,194
4.	Incarcerated	1,198
5.	No Record of State Residency	6,753
6.	Out of State Addresses	42,891
7.	Property Values > 100k	12,622

LexisNexis also broke down the number of people appearing in each risk category into their beneficiary program, looking at the percent of individuals who fell in the risk category against

the overall percent of participants in the benefit program. For example, SSI Disabled Individuals make up roughly 12% of all Medicaid recipients but represent 23% of the Deceased participants.

Benefit programs:

- SOBRA Pregnant Women
- Adult Expansion
- SSI Disabled Individual
- ARKids
- SMB
- Disabled Individuals-QMB
- Aged Individual-QMB
- Long Term Care-Aged Individuals

Figure 59—Summary of Lexis Nexis Risk Factor Findings

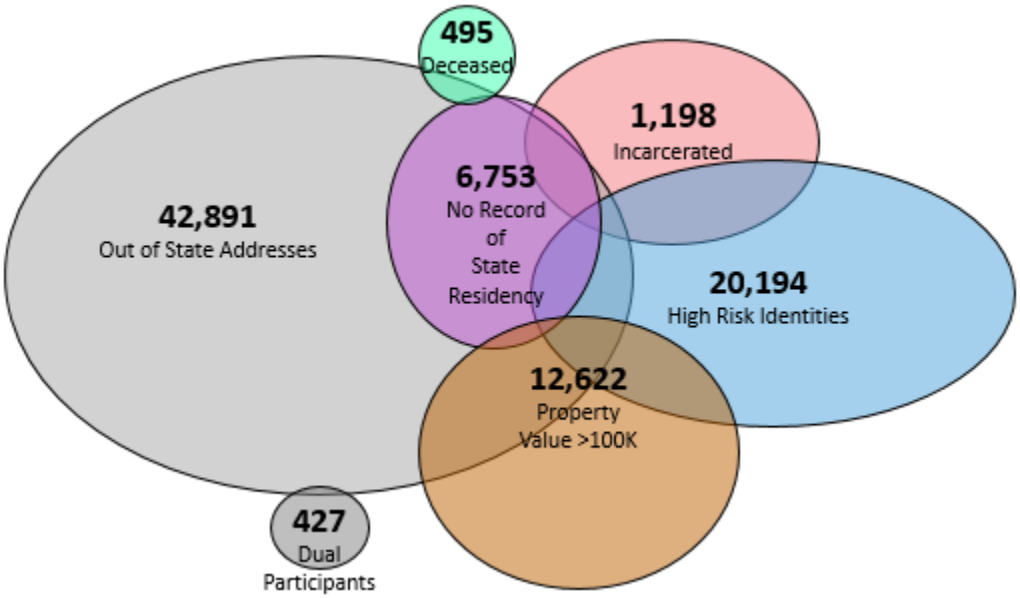


Table 41—Possible Dual Participation: 427

Raw Number		Percent of Total	
Traditional	PO	Traditional	PO
160	267	0.05%	0.12%

In each file LexisNexis identified individuals that the state likely sees as two individuals, whereas they see one. However, LexisNexis has seen this one identity at both locations in public

record with both name variations on multiple occasions. This could be due to multiple issues from data quality to fraud.

Table 42— Deceased: 495

Raw Number		Percent of Total	
Traditional	PO	Traditional	PO
367	128	0.11%	0.06%

In both files some subjects are identified as deceased prior to their program authorization date and others as deceased after. 343 of the 495, however, were deceased more than 2 years.

SSI Disabled Individuals make up roughly 12% of all Medicaid recipients but represent 23% of the Deceased participants. Long Term Care-Aged Individuals make up roughly 3.5% of all Medicaid recipients but represent 15% of the Deceased participants.

Table 43— Incarcerated: 1,198

Raw Number		Percent of Total	
Traditional	PO	Traditional	PO
408	790	0.13%	0.35%

These total numbers filtered out those individuals who are on probation, parole, house arrest or anyone outside the prison walls. It does not include County information in Arkansas as that is not a data source LexisNexis currently receives information from.

Participants in Adult Expansion make up roughly 23% of all Medicaid recipients but represent almost 60% of the Incarcerated participants.

Figures 67 and 68 present a breakdown of the release dates for the 408 incarcerated traditional and 790 PO participants.

Figure 60--Release dates for the 408 incarcerated traditional participants

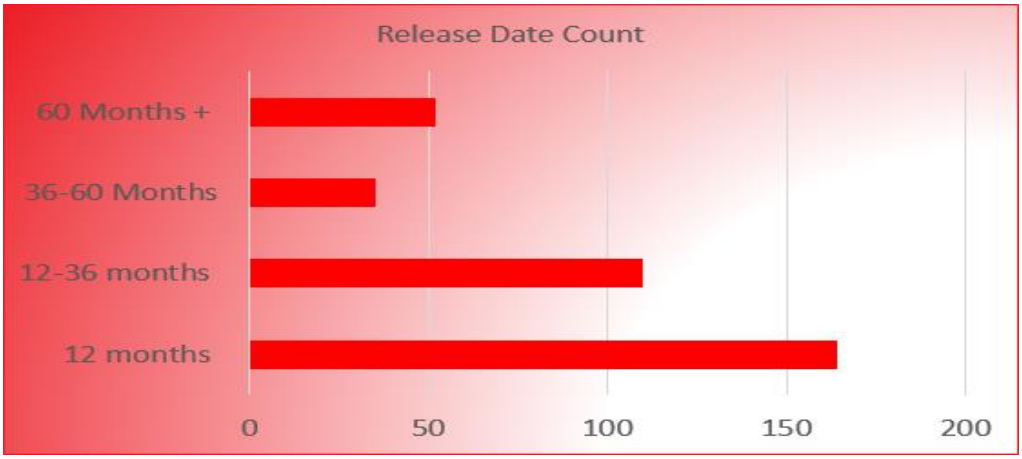
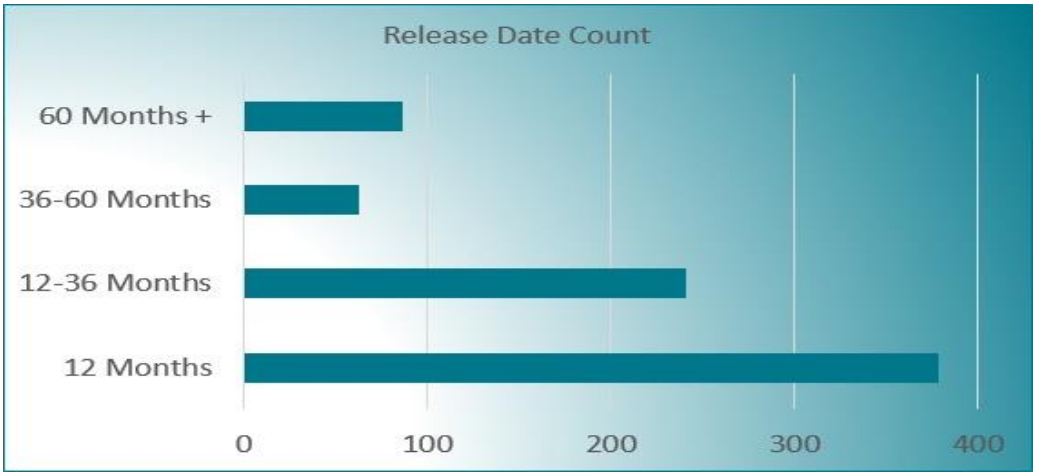


Figure 61—Release dates for the 790 incarcerated PO participants



25.3.Better Address Found by LexisNexis

LexisNexis found newer addresses than the ones supplied by DHS for 155,300 traditional Medicaid participants, and for 108,877 PO participants. This includes both in state as well as out of state addresses.

There appears to be no program that is extremely disproportionately impacted by this particular risk attribute.

Out-of-State Addresses

Table 44—Out of state addresses: 42,891

Raw Number		Percent of Total	
Traditional	PO	Traditional	PO
22,781	20,110	7.01%	8.89%

The total number 42,891 represents how many individuals on Medicaid LexisNexis found with a best address outside the state of Arkansas. This includes 6,753 with NO record of Arkansas residency. For three quarters of the traditional participants, LexisNexis can track the out-of-state address prior to Medicaid authorization. For PO participants, LexisNexis sees 87% out-of-state address prior to Medicaid authorization. For traditional Medicaid participants, Figures 63 and 64 depict the state-by-state breakdown of the addresses for traditional Medicaid and PO, respectively.

Figure 62—State-by-state breakdown of traditional Medicaid addresses

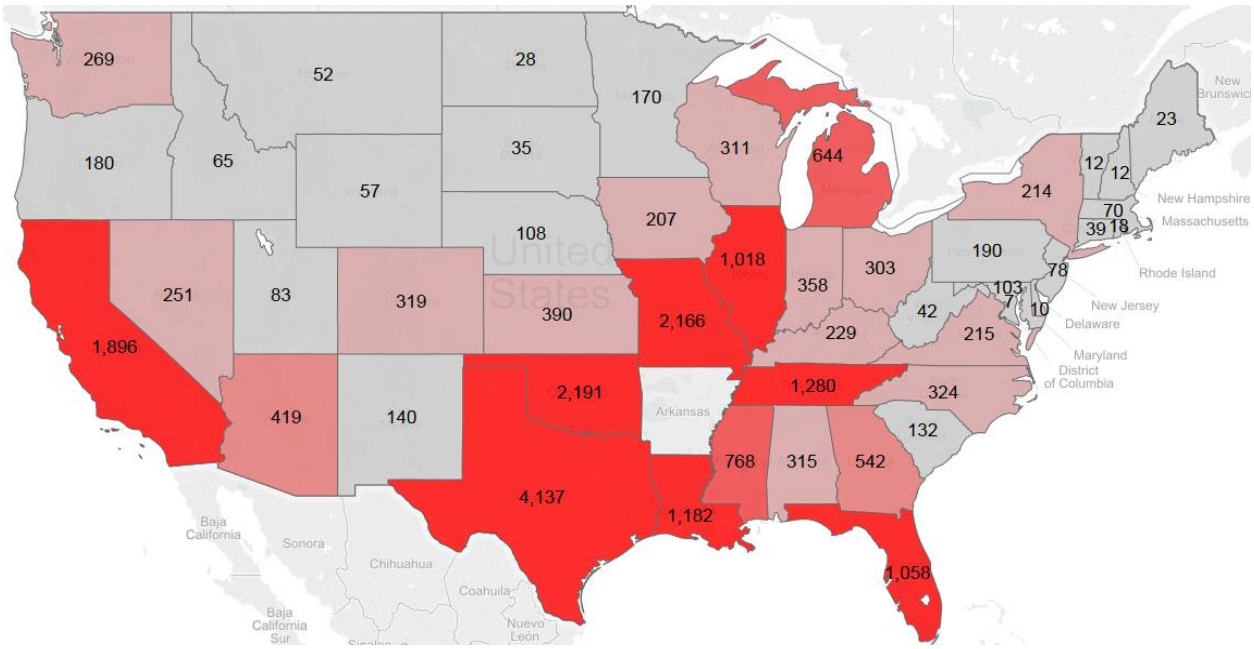
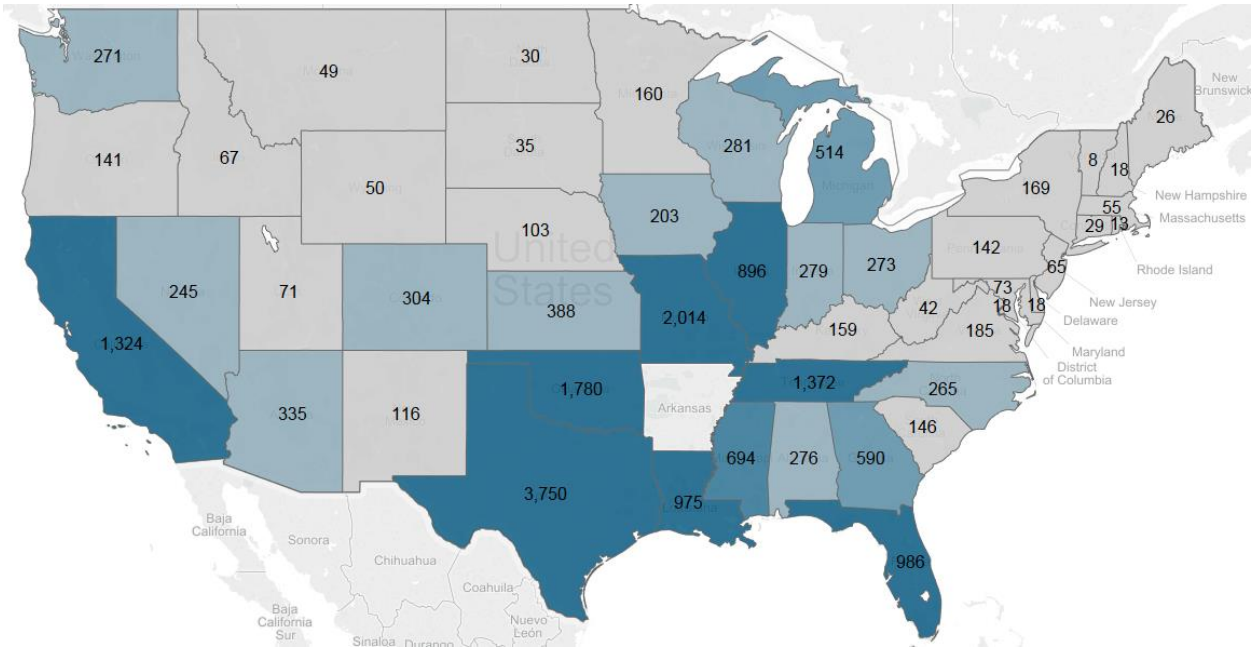


Figure 63—State-by-state breakdown of PO addresses



High Risk Identities

Table 44 shows Lexis-Nexis' findings concerning high-risk identities.

Table 45—High risk identities: 20,194

Raw Number		Percent of Total	
Traditional	**PO**	**Traditional**	**PO**
16,262	3,932	5.00%	1.74%

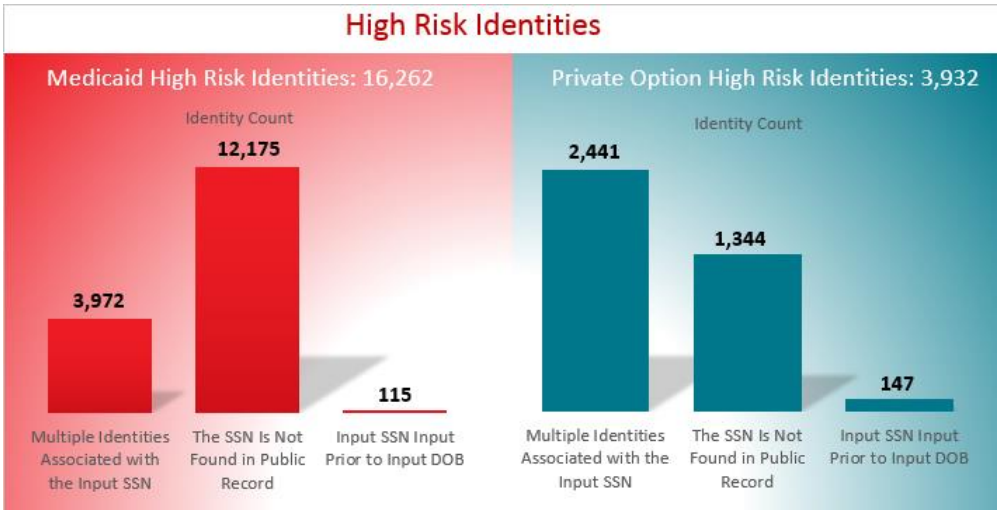
Based on their experience, LexisNexis grouped together 3 different risks attributes making up a "High Risk Identities" category.

- The first "Multiple Identities associated with the Input SSN" indicates that the input SSN may have been compromised and has been linked to many individuals in public record.
- The second "SSN not found in public record" indicates that LexisNexis has no public record linked to that SSN. In most instances a subject's SSN should be seen in public record. However, instances such as a severely disabled individual may not have been seen in public record.
- The third "Input SSN input Prior to Input DOB" indicates that the input SSN was issued by the Social Security Administration prior to the subject's input Date of Birth. In essence a subject who was born in 1983 should not be giving AR an SSN that was issued in 1952.

SOBRA Pregnant Women make up roughly 27% of all Medicaid recipients but represent 43% of the participants who fall in one of the three high risk identity groups

Figure 65 shows a graphical breakdown of the individuals in each group:

Figure 64—Breakdown of high-risk identities



LexisNexis highlighted three risk indicators: No record of State Residency, Input Address is a PO Box, and Deceased Prior to Authorization Date.

Table 45 presents the numbers for residency and PO Box.

Table 46—PO Box findings for traditional Medicaid and PO

Medicaid Program	Private Option
No Record of State Residency: 3,543	No Record of State Residency: 3,210
• Input Address is a PO Box: 128	• Input Address is a PO Box: 322

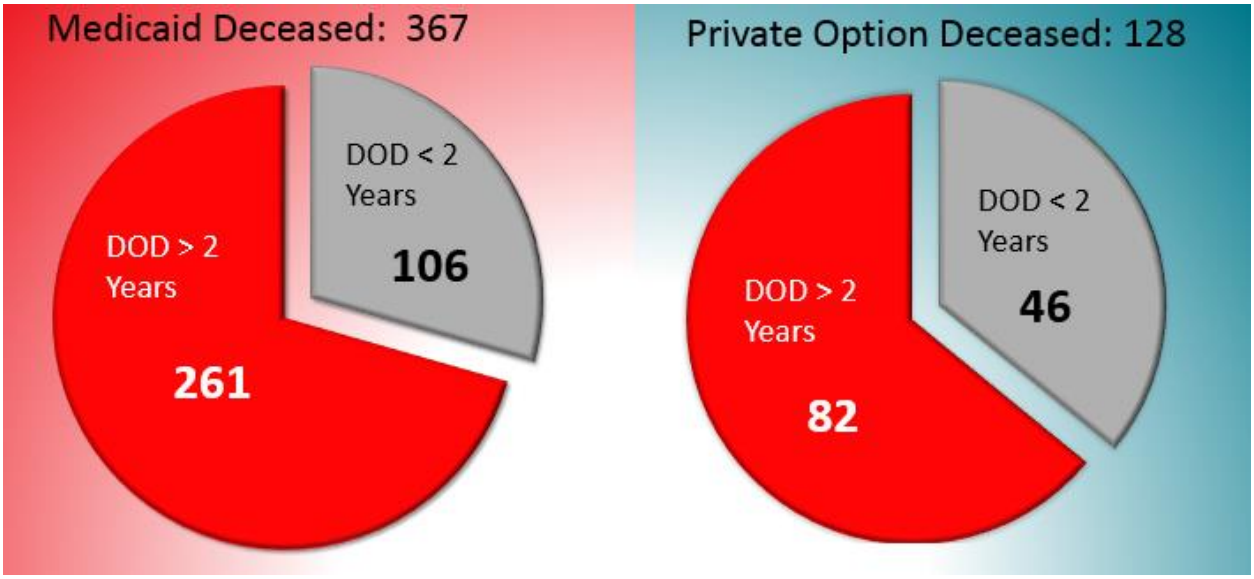
These findings were developed as follows:

- No Record of State Residency indicates that a subject has no Public Records indicating they have been in the state of Arkansas.
- LexisNexis then added the filter for individuals that utilized only a PO Box for their input address.
- For the PO stat, Lexis-Nexis found 3,210 individuals who have no public record connecting them to AR. Of that, 322 individuals indicated their address as a PO Box.

For Deceased Prior to Authorization Date:

LexisNexis found subjects that were deceased a couple years before they were authorized to receive Medicaid as shown in Figure 66. These individuals were complete matches on Names, DOBs, SSNs and Addresses.

Figure 65—Deceased beneficiaries, traditional Medicaid and PO



Property Value

LexisNexis found 12,622 participants whose property values exceeded $100,000. Though there is no property value test for eligibility in the Medicaid program, it does indicate that an individual might have more income than reported. For example, LN found two Medicaid participants who had recently purchased expensive properties in Florida and New Jersey, for $419,000 and $749,900, respectively.

Table 47—Property ownership, traditional Medicaid and PO

Property Ownership	
Medicaid Property Assessment > $100K: **7,169 of 32,158 Property Owners**	Private Option Property Assessment > $100K: **5,453 of 20,836 property Owners**

SOBRA Pregnant Woman (25% of participants, 35% of high-value property ownership) and ARKids B (5% of participants, 22% of high-value property ownership) are disproportionately affected by the Property Ownership Risk Attribute.

25.4.Long Term Care Asset Verification Review

TSG sub-contracted with Acuity Services to review 3,000 Long Term Care case files managed by DHS/DAAS; most of these cases are Elder Choices Waiver or Nursing Facility managed cases where the client is generally advised by professionals about what types of asset disposition are legal. Acuity sent out over 20,000 requests for account balances to banks electronically and almost 99% responded. Accounts included: checking, savings, CDs, and money market.

883 of the 3,000 cases did have accounts – 1,309 accounts. Many of these accounts qualified for review, appearing to exceed nominal asset limits at some point in the time span used.

A sampling of these reported instances showed that 100% of the very high outliers and 70% of the balance of the sampled population appeared to have satisfactory legal justification for their account balances, due to a number of normal considerations, including: spend downs, miller trusts, special needs trusts, spousal impoverishment splits, and burial contracts.

30% of the sampled group will require further review by DAAS Program Eligibility Specialists. The majority of these cases will likely be marginal historical violations of the asset limits where meaningful recoupment is unlikely.

However, if even a small % of clients turn out to warrant eligibility review and/or recoupment efforts that could be 50 clients out of this reviewed population and could have a material impact. Cases of recipient suspected fraud may be handled by the DHS Fraud Unit within the Office of Quality Assurance and referred to OMIG.

DAAS is already planning to implement automated asset verification, as required by CMS, in the first quarter of 2016. DAAS management has already observed that this tool will increase the Division's ability to find and correct routine abuses, such as a miller trustee not paying as required, or a client windfall not being reported.

NOTE: Acuity just reviews national financial accounts. Undisclosed Real Property or other types of assets, such as equities, would not be found using the Acuity reports. Program Eligibility Specialists may discover some undisclosed real property assets through review of the records in the current county of residence or in another county previously lived in by the client. But routine review of full state property records, more or less external property records, is not reasonably possible with current tools.

26. COST OF PRESCRIPTION MEDICATIONS

TSG conducted an investigation into the cost of prescription medications and recommendation for the reduction of those costs including both traditional Medicaid and the PO. To do this, TSG

analyzed Medicaid pharmacy programs both of the traditional Medicaid program and the programs operated by PO carriers in search of savings or efficiencies. Data was requested and provided to us by DHS and the PO carriers. Data was received in early July 2015 and included individual paid claims for CY 2014 from all sources and a summary report from DHS. A query plan was drafted, see Appendix 10. Certain analyses compared the DHS program with the PO carriers, yet others, such as the Preferred Drug List (PDL) efficiency analysis was performed by comparing Arkansas PDL with other states. The analysis covered the following areas of pharmacy.

- Cost Analysis
- Opioid Use
- DHS Claim Limits
- DHS PDL
- Operational Insights

We analyzed the paid claims data to ascertain pharmacy program metrics which allowed for program characterization and comparison both inside and outside the State of Arkansas. We created and followed a query plan shown here.

TSG performed work to support direct program cost savings recommendations and program operational improvements which could result in pharmacy program cost saving or overall program savings. Data was gathered by conducting interviews with pharmacy program managers and executives at DHS and the PO carriers. We also conducted interviews with local and national vendors providing services to the State FFS Medicaid program. We met with PBMs who serve the PO carriers and with Magellan Rx, the current pharmacy vendor to DHS. To round out the interviews we met with the State Pharmacists Association and with representatives from Arkansas State Employees/Public School Teachers benefit program.

In addition to meetings with the entire Task Force, some members took time to meet with us individually. We appreciate everyone's cooperation. First, we will cover findings related to direct program costs savings including cost analysis (network discounts), opioid use, DHS claim limits, and DHS PDL, then we will follow with a section on insights that cover savings opportunities in pharmacy program operations.

26.1.Cost Analysis- Using TSG's comparable list of drugs

We collected and analyzed paid pharmacy claims for CY 2014. Our findings mirror other conclusions from studies that report managed care plans can control pharmacy costs better than the State. Managed care plans are better at controlling the underlying drug cost and dispensing fee. Even with the substantial drug cost reduction available from OBRA and supplemental

rebates for the State (somewhat offset by State overhead), the managed care plans appear to function more efficiently. Managed care plans need to operate efficiently to remain competitive.

We created a comparable list of drugs from the 2014 claims data provided by DHS and PO carriers, which each had a complete year of paid pharmacy claims data. The data was grouped by plan and by drug class and included drug class description, total amount paid, count of claims, and average cost per claim. We used our expertise to remove claims in therapeutic classes that would skew the cost comparison analysis between DHS and the individual PO carriers. The comparable list includes 99 % of claims and 80% of costs. Though very few claims were removed from the list, those that were removed represented very high cost drugs. If left in the list, these few, high-dollar claims would have skewed averages in the analysis. We endeavored to get an apples-to-apples comparison of elements that make up the underlying cost of prescriptions. Tables 47 and 48 show the results of our analysis.

Table 48— Average Amount Paid per Claim by Plan[189]

	Brand Drugs	Generic Drugs
	Avg. amount paid per claim before rebates	Avg. amount paid per claim before rebates
DHS	$301	$32
BCBS	$210	$19
Ambetter	$186	$14
QualChoice	$173	$14

Note: includes ingredient cost, dispensing fee, tax (if applicable) minus any member cost share

Table 49— Average Dispensing Fee per Retail Prescription[190]

	Brand Drugs	Generic Drugs
DHS	$5.40	$4.85
BCBS	$1.18	$1.16
Ambetter	$1.58	$1.24
QualChoice	$0.99	$1.01

Our analysis of the underlying cost components of drug cost reveals PO carriers are significantly better at effectively managing the underlying amount paid and dispensing fees. The DHS average for amount paid in 2014 for comparable claims was $301 for brand drugs and $32 for generic drugs. The average of the three PO carriers combined on these same measures was $190 for brand drugs and $15.66 for generic drugs.

[189] TSG analysis based on consultant comparable drug list 2014
[190] TSG analysis based on consultant comparable drug list 2014

These findings are more striking when we calculated the average day supply contained in the average prescription for each plan. The average day supply for the PO carriers was 24 days per prescription while the average day supply in the DHS claims was 22. The significance of this difference is that with 10% less product in the average prescription the DHS per day price differential is actually 10% greater than just the mathematical difference per PO carrier prescription.

The PO carriers manage underlying drug costs and dispensing fees better than DHS for both brand and generic drugs, despite PO carriers having a slightly higher average day supply for prescription claims analyzed in our consultant comparable data set.

The average dispensing fee paid per retail claim was also lower for the PO carriers than for the State-run plan. The DHS average dispensing fee was $5.40 per brand prescription while the average of the three PO carriers was significantly lower at $1.25 for brand drugs. For generic drugs, the DHS average was $4.85 while the average of the three PO carriers was $1.14.

26.2. Illustrative brand and generic prescription paid by all payers to demonstrate the underlying cost differences

To further illustrate the differences between DHS and the PO carriers in their ability to manage underlying drug costs, we sought to compare individual claims for the same drugs, filled within narrow date ranges for equal day supply. We show the results for three brand drugs in the following tables.

For Abilify 5mg tablets, quantity 30 tablets, the State cost was $26.89 per tablet while the average of the three PO carriers was $26.32 per tablet. On direct comparison, as shown in the table below, all three PO plans individually performed better than the State.

For Vyvanse 30 mg, quantity 30 capsules, the State cost was $7.03 per capsule while the average of the three PO carriers was $6.69 per capsule. On direct comparison, as shown in the table below, all three PO plans individually performed better than the State.

For Januvia 100mg, quantity 30 tablets, the State cost was $10.53 per tablet while the average of the three PO carriers was $10.23 per tablet. On direct comparison, as shown in the table below, all three PO plans individually performed better than the State.

For generic drugs, omeprazole 20mg delayed release capsule, quantity 30, the State cost was $0.45 per capsule while the average of the three PO plans was $0.40 per capsule. On direct comparison, as shown in the table below, two of the three PO plans individually performed worse than the State. However the significant difference between the State and the BCBS cost demonstrates that pharmacies will accept lower reimbursement rates for this drug.

Hydrocodone 10mg/acetaminophen 325mg tablets, quantity 30, the State cost was $0.41 per tablet while the average of the three PO plans was $0.34 per capsule. On direct comparison, as shown in Table 50, two of the three PO plans individually performed better than the State but the largest of the three PO carriers performed worse than the State.

Table 50—Branded drugs

Carrier	NDC	Drug Name	Strength	FILL Date	Day Supply	Cost per Day	Quantity	Cost per Pill
Ambetter	59148000713	ABILIFY TAB 5MG	5 MG	12/30/2014	30	$26.46	30	$26.46
QualChoice	59148000713	ABILIFY TAB 5MG	5 MG	12/31/2020	30	$25.89	30	$25.89
Blue Cross Blue Shield	59148000713	ABILIFY TAB 5MG	5 MG	30-Dec-14	30	$26.72	30	$26.61
DHS	59148000713	ABILIFY TAB 5MG	5 MG	31-Dec-14	30	$26.89	30	$26.89

Carrier	NDC	Drug Name	Strength	FILL Date	Day Supply	Cost per Day	Quantity	Cost per Pill
Ambetter	59417010310	VYVANSE CAP 30MG	30 MG	12/31/2014	30	$6.71	30	$6.71
QualChoice	59417010310	VYVANSE CAP 30MG	30 MG	12/11/2014	30	$6.66	30	$6.66
Blue Cross Blue Shield	59417010310	VYVANSE CAP 30MG	30 MG	14-Dec-14	30	$6.72	30	$6.72
DHS	59417010310	VYVANSE CAP 30MG	30 MG	14-Dec-14	30	$7.03	30	$7.03

Carrier	NDC	Drug Name	Strength	FILL Date	Day Supply	Cost per Day	Quantity	Cost per Pill
Ambetter	6027731	JANUVIA TAB 100MG	100 MG	12/31/2014	30	$10.30	30	$10.30
QualChoice	6027731	JANUVIA TAB 100MG	100 MG	12/22/2014	30	$10.05	30	$10.05
Blue Cross Blue Shield	6027731	JANUVIA TAB 100MG	100MG	29-Dec-14	30	$10.35	30	$10.35
DHS	6027731	JANUVIA TAB 100MG	100MG	29-Dec-14	30	$10.53	30	$10.53

Table 51—Generic drugs

Carrier	NDC	Drug Name	Strength	FILL Date	Day Supply	Cost per Day	Quantity	Cost per Pill
Ambetter	62175011843	Omeprazole Cap Delayed Release	20 MG	12/30/2014	30	$0.54	30	$0.54
QualChoice	62175011843	OMEPRAZOLE CAP 20MG	20 MG	12/30/2014	30	$0.52	30	$0.52
Blue Cross Blue Shield	62175011843	OMEPRAZOLE CAP DELAYED RELEASE	20 MG	12/31/2014	30	$0.14	30	$0.14
DHS	62175011843	OMEPRAZOLE	20 MG	12/31/2014	30	$0.45	30	$0.45

Carrier	NDC	Drug Name	Strength	Fill Date	Day Supply	Cost per Day	Quantity	Cost per Pill
Ambetter	00603388732	Hydrocodone-Acetaminophen Tab	10-325MG	12/31/2014	30	$0.43	60	$0.22
QualChoice	00603388732	HYDROCO/APAP TAB	10-325MG	12/31/2014	30	$0.42	60	$0.21
BCBS	00603388732	HYDROCODONE-ACETAMINOPHEN TAB	10-325MG	31-Dec-14	30	$1.16	60	$0.58
DHS	00603388732	HYDROCODONE/ACETAMINOPHEN	10MG-325MG	31-Dec-14	30	$0.82	60	$0.41

26.3.Opioids

Opioids are a class of pain-management drugs that contain natural or synthetic chemicals based on morphine, the active component of opium. Distribution of these drugs is highly controlled due to the abuse potential. These narcotics effectively mimic the pain-relieving chemicals that the body produces naturally. The tables below include drugs in the following drug classes: H3A-Analgesics, Narcotics, Opioids (like hydrocodone, oxycodone) and H3U, Narcotic Analgesic and Non-salicylate Analgesic Combination (codeine with Tylenol products).

We analyzed the pharmacy claims data provided by the State and the PO carriers to determine the prevalence of opioid use by Plan. We looked at both the percent of opioid claims across all claims and the number and percent of utilizers and eligibles with at least one claim for an opioid drug. The PO carriers had roughly double the prevalence of opioid claims as a percent of all claims when compared to DHS. The PO carriers also had a higher percent of drug utilizers with at least one opioid claim as compared to DHS. The difference is less pronounced when expressed as a percent of all eligible members which is largely explained by the difference in average age: State 24 years old and PO carriers 42 years old.

We looked deeper at those beneficiaries who received at least a 90-day supply of opioids within CY 2014. Members using at least 90 days of opioid would indicate drug use for something other than acute pain from trauma or a medical/dental procedure. In rare cases, opioids are used for chronic pain, including cancer pain, but long-term use is often associated with fraud, misuse or abuse. So we looked at users with at least a 90-day supply to see if their use of prescribers or dispensing pharmacies showed patterns of suspected misuse.

Just in the DHS plan, there are 1,844 beneficiaries who visited at least four different doctors for opioid prescriptions and 1,718 beneficiaries who had opioid prescriptions filled by at least four different dispensing pharmacies. By themselves either of these measures would be cause for further investigation, but 562 beneficiaries actually used at least four different prescribers and at least four different pharmacies to get their opioids. The State has an opportunity to limit the number of prescribers and or pharmacies that these beneficiaries can visit. The State currently has 70 beneficiaries locked into a single pharmacy for opioid dispensing.

The average age of these relatively high opioid utilizers is only remarkable in the DHS plan wherein the average age of all prescription utilizers is 24 years old, based on the consultant comparable drug list, but the average age is much higher for the high opioid utilizing beneficiaries at 47 years old. It is well understood that opioid abusers are older as reflected by the average age of opioid utilizers in all four plans.

Table 52— Opioid Claims Utilization (2014) by Plan

	Number of Opioid Claims	Total Claims	Opioid Claims as % of all claims	Number of Unique Members with narcotic claim	Total Unique Utilizers	Unique members with opioid claims as % of total utilizing members	Number of Eligible Members	Unique member with opioid claims as % of Eligible Members
DHS	273,284	5,278,822	5%	128,180	483,710	27%	502,000	26%
BCBS	200,516	1,790,674	11%	47,591	92,428	51%	141,458	34%
Ambetter	42,999	424,724	10%	9,920	23,426	42%	39,430	25%
QualChoice	3,461	24,013	14%	1,272	3,277	39%	20,226	6%

Table 53— Opioid Users Who Exceeded 90 Day Supply in 2014

	# of Utilizers w/ day supply (DS) > 90	Unique members w/ > 90 DS Opioid claims as % of Eligible Members	Avg. Age all prescription utilizers *	Avg. Age of Opioid utilizers	Utilizers w/ 4 or more Prescribers	Utilizers w/ 4 or more Pharmacies	Utilizers w/ 4 or more Pharmacies and 4 or more Prescribers
DHS	20,611	4%	24	47	1,844	1,718	562
BCBS	10,938	8%	45	45	3,210	1,615	1,187
Ambetter	2320	6%	43	44	402	252	147
QualChoice	164	1%	38	41	57	14	10

*Avg. Age Utilizers is based on Consultant comparable drug list

Table 54— Top Conditions: Opioid Users Who Exceed 90 Day Supply in 2014

DHS diagnosis code- Primary description	BCBS diagnosis code- Primary description	Ambetter diagnosis code- Primary description
Other unknown and unspecified cause of m	Lumbago	Lumbago
Person outside bus injured in collision	Unspecified essential hypertension	Unspecified backache
Diab mellitus w/o mention compli, type i	Unspecified backache	Unspecified essential hypertension
Major depressive affective disorder, rec	Need for prophylactic vaccination a	Long-term (current) use of other me
Unspecified essential hypertension	Long-term (current) use of other me	Abdominal pain, unspecified site
Lumbago	Pain in soft tissues of limb	Pain in soft tissues of limb
Diabetes mellitis	Chest pain, unspecified	Cervicalgia
Unspecified chest pain	Abdominal pain, unspecified site	Need for prophylactic vaccination a
Chronic airway obstruction, not elsewher	Cervicalgia	Chest pain, unspecified
Abdominal pain	Degeneration of lumbar or lumbosacr	Pain in joint, lower leg
Abdominal pain unspecified site	Pain in joint, lower leg	Degeneration of lumbar or lumbosacr
Driver of bus injured in collision w 2/3	Essential hypertension, benign	Other malaise and fatigue
Backache, unspecified	Thoracic or lumbosacral neuritis or	Headache
Benign essential hypertension	Other malaise and fatigue	Routine general medical examination
Depressive disorder, not elsewhere class	Headache	Other chronic pain
Schizo-affective type schizophrenia, uns	Diabetes mellitus without mention o	Pain in joint, shoulder region
Long-term use of other medications	Lumbosacral spondylosis without mye	Thoracic or lumbosacral neuritis or
Lumbosacral spondylosis without myelopat	Pain in joint, shoulder region	Acute bronchitis
Incontinence of urine	Displacement of lumbar intervertebr	Osteoarthrosis, unspecified whether
Urinary incontinence unspecified	Cough	Cough
Pain in joint involving lower leg	Osteoarthrosis, unspecified whether	Anxiety state, unspecified
Anxiety state, unspecified	Anxiety state, unspecified	Essential hypertension, benign
Headache	Routine general medical examination	Depressive disorder, not elsewhere
Pain in limb	Other chronic pain	Diabetes mellitus without mention o

We researched to see the types of conditions reported in the medical claims for the high utilizing beneficiaries. Specifically, we pulled primary diagnoses and their prevalence from the medical claims of these beneficiaries. The top conditions we found do not support long-term use of opioids. A very small percent of the diagnoses were for cancer.

In fact, 3.7% of DHS beneficiaries in the high utilizing study group had a primary cancer diagnosis. For the PO carriers the average was 1.5% of members in this study group had a primary cancer diagnosis. The vast majority of opioid use by the high utilizers was for non-malignant pain.

Clinical personnel at the State cannot currently view the State Opiate Prescription Drug Monitoring Program database. Since the State is the payer of the pharmacy benefit, we believe State personnel should have the ability to view this data in support of its retrospective DUR programs, without compromising compliance to HIPPA privacy rules. Visibility to this important beneficiary-level data should allow the State to improve management of this population by possibly locking in more beneficiaries in to one prescriber and/or one dispensing pharmacy.

26.4.DHS Claim Limits

We analyzed utilization patterns for DHS, looking at the number of claims per member per year, to assess how the current claims limit of 3 - 6 claims per person per month impacts the DHS populations compared to the PO carriers. We used 2014 claims (full year) and removed claims for members who are under age 18 or are identified as receiving services in a nursing home. The PO carriers do not have claim limits. Only 1.6% of DHS beneficiaries hit or approached the limit assuming 502,000 eligible DHS beneficiaries. These member's expenditures make up over 40% of total drug expenditures and 17% of total drug claims.

Using drug class as a proxy for medical conditions, this sub-set of the population requires consistent access to maintenance drug therapy for chronic conditions like mental health, cardiovascular disease, and asthma. The top conditions are listed in the table below. Creating barriers for beneficiaries to easily access their prescription medications to treat their chronic, often progressive, conditions will cause unintended costs in the medical claims of these members. Interruptions to needed drug treatments could cause preventable complications and result in unneeded doctor visits, ER visits, or hospitalizations.

The practice of using claim limits is inconsistent with healthcare industry best practices. A best practice pharmacy program administers progressive utilization management programs to ensure beneficiaries receive medications that are appropriate for their condition(s), are effective, are safe and the beneficiary can be compliant to the regimen. The industry takes steps to help

beneficiaries and their prescribers adhere to their appropriate chronic medication treatment regimen to avoid unnecessary medical costs due to non-compliance or under-dosing of therapy. These value-based benefit designs often feature no co-pay for designated chronic use medications and clinical services to assist members with managing their drug regimens and medical conditions

Health Affairs recently published a study in the September 2015 issue supporting policy changes in Medicaid programs to improve access to medications for patients who have chronic diseases. Here is the citation and abstract:[191]

We used data on more than 1.5 million Medicaid enrollees to examine the impact of changes in prescription drug use on medical costs. For three distinct groups of enrollees, we estimated the effects of aggregate prescription drug use—and, more specifically, the use of medications to treat eight chronic non-communicable diseases—on total nondrug, inpatient, outpatient, and other Medicaid spending. We found that a 1 percent increase in overall prescription drug use was associated with decreases in total nondrug Medicaid costs by 0.108 percent for blind or disabled adults, 0.167 percent for other adults, and 0.041 percent for children. Reductions in combined inpatient and outpatient spending from increased drug utilization in Medicaid were similar to an estimate for Medicare by the Congressional Budget Office. Moving forward, policy makers evaluating proposed changes that alter medication use among the nearly seventy million Medicaid recipients should consider the net effects on program spending to ensure that scarce federal and state health care dollars are allocated efficiently.

[191] "Medicaid Patients Who Use More Prescription Drugs Have Lower Costs For Other Medical Services, Study Suggests."; Health Affairs Vol. 34 no.9 September (2015): pages 1586-1593

26.5.Unique Member Counts: DHS Claim Limits in 2014 Claims (full year)

Table 55—72 RX claims (equals the limit)

	Distinct Members	Distinct Claims and % of Total Claims	Paid Amount and % of Total Paid Amount	Claims Paid Per Member	Total Claims*	Total Paid Amount*
DHS	632	45,404 (0.09%)	$4,749,683 (1.3%)	$7,515	5.3 million	368.9 million
BCBS	185	13,320 (0.7%)	$544,073 (0.9%)	$2,941	1.9 million	63.1 million
Ambetter	31	2,232 (0.6%	$81,036 (0.7%)	$2,614	403 thousand	12 million
QualChoice	Negligible	n/a	n/a	n/a	n/a	n/a

Table 56—61-71 RX claims (approaching the limit)

	Distinct Members	Distinct Claims and % of Total Claims	Paid Amount and % of Total Paid Amount	Claims Paid Per Member	Total Claims*	Total Paid Amount*
DHS	5,914	389,700 (7.4%)	$36,532,193 (9.9%)	$6,177	5.3 million	368.9 million
BCBS	2,276	149,175 (7.9%)	$5,392,549 (8.5%)	$2,369	1.9 million	63.1 million
Ambetter	428	27,940 (6.9%)	$811,387 (6.8%)	$1,896	403 thousand	12 million
QualChoice	Negligible	n/a	n/a	n/a	n/a	n/a

*Total claims, Total Paid Amount: data source Pharmacy Program Overview report

Table 57— Top Therapeutic Class Descriptions by Number of Claims: DHS

HIC3 Therapeutic Class Description
Analgesics, Narcotics, Opioids
Anticonvulsants
Penicillin
Antihistamines - 2nd Generation
Second Generation Antidepressants
Beta Adrenergic Agents, Short Acting Beta Agonists, Long Acting Beta Agonists
Adrenergics, Aromatic Non- Catecholamines (Amphetamine)
Antihistamine - 1st Generation
Anti-Narcolepsy/Anti-Hyperkinesis Agents (methylphenidate products)
Hypotensives-Sympatholytic (includes clonidine)
Macrolides
NSAIDs, Cyclooxygenase Inhibitors
Antianxiety Drugs
Glucocorticoids, Inhaled & Oral Corticosteroids
Atypical Antipsychiatricotic, Antipsychiatricotic
Topical Antiinflammatory Preparations
Nose Preparations, Antiinflammatory Steroids
Antiemetic/Antivertigo agents
Inhaled Corticosteroids (Glucocorticoids,Orally Inhaled)
Histamine H2 Receptor Inhibitors
Contraceptives, Oral
Hypotensives-Angiotensin Converting Enzyme Blockers
Antihyperlipidemic- HMG COA reductase inhibitors
Absorbable Sulfonamides
Proton Pump Inhibitors

26.6.Preferred Drug List (PDL)

We compared DHS' PDL against PDLs for 24 other state FFS Medicaid programs. Our analysis compared the percentage of claims and costs covered by PDL supplemental rebate contracts sorted by brand and generic claims. Of the states compared, nineteen states participate in a multi-state rebate pool and 5 were managed by the state.

Arkansas DHS' PDL impacts just 38% of Medicaid claims, while, the average impact of claims covered across the 24 states compared is 64% of Medicaid claims. In other words, in the Arkansas DHS program, 4 out of 10 claims hit the PDL supplemental rebate agreements versus 6 out of 10 in the other states compared. Florida manages over 90% of their claims through the

PDL, though in our view, even though this is an impressive coverage rate, there are some rare or nominally priced products where the work to cover them in the PDL is just not worth the supplemental rebate returns. A goal of approximately 80% would represent a good balance of claims coverage compared to the value generated and the additional effort in contracting.

Nearly 85% of pharmacy claims are for generic drugs in DHS which is the same as the average across the 24 other states we compared. Generic drug spend as a percent of total drug spend at DHS is approximately 30%, while the average of all states reviewed is 22%. There are two causes for the difference, one is that the mix of generic drugs in DHS tends to be for more expensive generic drugs, and second is the cost per pill of the generics dispensed in the DHS program is higher on average when compared to the other states.

DHS gets two types of pharmaceutical company drug rebates in the program, federally mandated and supplemental rebates. The Federal Rebate returns 48% of drug spend ($51 million per quarter) where the average across 24 states compared is 52%. DHS Federal Rebate percent would be higher if the state used lower cost generic drugs and expanded the PDL.

Estimated Annual increase in Federal rebates realized by DHS for Federal Rebate Return by Expanding the DHS PDL

Table 58— Estimated annual increase in federal rebates

Current Federal Rebate Return	Average Federal Rebate Return across 24 states	Sensitivity Estimate
48%	52%	For every 1% increase in Federal rebate return DHS could see additional rebates of $3.25 million annually

The DHS PDL currently covers 38% of all claims paid in the FFS program. Comparable states had an average of 64% of claims covered by their respective PDLs. Best practice in this area is closer to 80% of claims covered by the State's PDL and could be considered a stretch goal of PDL expansion.

Estimated Annual increase in rebates realized by DHS for Supplemental Rebate Return by Expanding the DHS PDL

Table 59—Estimated annual increase in rebates

Current Percentage of claims covered by DHS PDL	Percentage of claims covered by PDL across 24 states	Sensitivity Estimate
38% (below average)	64% (average); Industry best practice is approximately 78%	For every 1 percentage point increase in the number of claims covered by the PDL , DHS could see an additional $375K in supplemental rebates

One contributing factor to the DHS PDL having limited claim coverage is the State's rule or law regarding evidence based evaluations (DERP); this type of practice impedes PDL expansion. The specific change should allow for contracting PDL classes in which there is no demonstrable clinical difference yet choosing preferred drugs would increase rebate yield. Many States default to lowest net price analysis when there is a perceived lack of compelling evidence of comparative clinical benefit among products eligible for PDL inclusion. States also rely on their PBM to do therapeutic class reviews and few states supplement this information with Drug Effectiveness Review Project (DERP) which provides the exhaustive evidence-based comparative drug class review reports that are used in the State's PDL review process. These findings are supported by a Kaiser Family Foundations study found at: https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8233.pdf.

Looking ahead into a pharmacy market with biosimilar products, the State's current approach to PDL class inclusion will likely put the State at a disadvantage in managing the cost of biologics and their biosimilars; biosimilars are approved based on showing the lack of demonstrable clinically meaningful differences from the reference biologic product. Here is the FDA definition of a biosimilar product:

A biosimilar product is a biological product that is approved based on a showing that it is highly similar to an FDA-approved biological product, known as a reference product, and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Only minor differences in clinically inactive components are allowable in biosimilar products.

The State does not participate in a multi-state rebate pool. Joining a multi-state rebate pool, and there are several, is another way to broaden the PDL with no direct pharmaceutical contracting effort for the State and improved rebate yield.

26.7.Operational Insights

Three separate call centers serving providers and beneficiaries handle prior authorizations and PDL exceptions: Magellan, UAMS College of Pharmacy's EBRx, and the State. The work is logically divided and does not appear to overlap; however, there may be opportunities to conduct these calls with less than three call centers. At a minimum, this represents duplicative administration and contracting and could be evaluated for consolidation.

Through messaging in pharmacy claims processing responses to pharmacies, the phone number for the appropriate type of edit is returned with a rejected claim. If the pharmacy can resolve the edit, they call the appropriate call center. If the prescriber needs to be involved in the resolution, the pharmacy passes along the call center phone number to the prescriber. The work is split such that UAMS College of Pharmacy handles calls related to PDL non-preferred drug requests and certain other clinical requests. Magellan handles mostly administrative calls related to claims processing problems or edits. The State would need significant resources to handle all the calls efficiently within the State so outsourcing makes a lot of sense. What is in question is whether two separate vendors are needed to handle calls from beneficiaries and providers.

27. FEDERALLY QUALIFIED HEALTH CENTERS

Federally Qualified Health Centers (FQHCs) are organized under Section 330 of the Public Health Services Act. In order to receive FQHC designation they must serve underserved areas or populations, offer a sliding fee scale, offer clinics that provide comprehensive services, have a Quality Assurance program, primary physical, dental, behavioral health care and be governed by a Board of Directors. FQHCs must provide care regardless of a patient's ability to pay. FQHCs receive some federal funding as part of their designation and are eligible for enhanced Medicare and Medicaid payments.. There are 12 FQHC/Community Care organizations in Arkansas with over 100 FQHC clinic locations throughout the state. FQHCs provide General Medical, Prenatal/Perinatal care, Dental, Mental Health/Substance Abuse, and Pharmacy services. Additionally they provide community health education and outreach. All of Arkansas' FQHCs are contracted with one or more PO carriers as network providers. Arkansas FQHCs serve as a critical part of the health care safety net based on their rural presence in many medically underserved areas, their mission to eliminate health disparities, their role in the state's Medicaid program, and 100% access policies regardless of ability to pay reflected in the amount of uncompensated care. In 2013, FQHCs in Arkansas provided health care services to 163,797 Arkansans through 561,130 visits.[192] In 2013, the total amount of uncompensated care provided

[192] Community Health Centers of Arkansas. *Facts about Arkansas Community Health Centers.*

to Arkansans through FQHCs was more than $23.8 million. In 2014, the total value of uncompensated care provided was more than $15.9 million.

Table 60— Changes in Arkansas FQHC Experience between 2013 and 2014

Changes in Arkansas FQHC Experience between 2013 and 2014 (coinciding with establishment of the PO)[193]		
	2013	2014
Number of uninsured patients	65,362	42,015
Full charges	$35,165,668	$26,502,085
Charges collected	$11,355,383	$10,575,391
Charges discounted-sliding fee	$19,026,101	$11,892,698
Unpaid balance of charges	$4,784,184	$4,033,996
Uncompensated care (sum of charges discounted-sliding fee and unpaid balance of charges)	$23,810,285	$15,926,694

28. Eligibility Systems Supporting Medicaid and Expansion

Like many states, Arkansas has experienced difficulties implementing the technology to support eligibility and enrollment under the new federal legislation. TSG was asked to specifically dive into the contracts covering the Eligibility and Enrollment Framework (EEF) Project to understand the history and context and determine the lessons learned for future work.

28.1. Procurement History – Eligibility and Enrollment Framework Project

The EEF Project began with a Feasibility Study in 2011. The original vision included full integration with a future MMIS, as well as full integration with Arkansas Health Information Exchange, Arkansas Data Verification System, Federal Data Hub for verification, and Federally Facilitated Exchange.

The procurement process in 2012 experienced a number of challenges. The original vendor selected for the EEF work negotiated with the State for four months before negotiations fell apart. The State procurement laws, and the specific approach followed on this procurement, did not allow DHS to default to their second choice vendor.

[193] Community Health Centers of Arkansas. *Cost of Self-Pay Patient Care*.

DHS and the Office of State Procurement supported the use of State of Pennsylvania Staff Augmentation (Time and Materials contract) to onboard the subcontractors that the #1 and #2 choice vendors had proposed to use. EngagePoint and eSystems were engaged to do work to configure the Cúram software (an IBM product). The State took most of the risks and the vendor took very little risk for managing scope, managing schedule, or managing costs.

The original organization chart for the EEF Project included First Data as an Independent Verification and Validation Vendor, Computer Aid Inc (CAI) as the Project Management Office, EngagePoint for technical leadership and externally focused configuration of the Cúram product as well as business process reengineering and training, and eSystems for internally focused configuration of Cúram as well as notices and reporting.

The PMO contract with CAI was an addition to an existing contract the State of Pennsylvania had with CAI. The contract was signed January 2011 with an expectation the SOW would be signed prior to engagement. The contract specified a cost plus markup percentage and quarterly reporting.

The EEF project went live with the web site October 1, 2013. The release 1.5 went into production in November 2014 and still has unresolved issues. Release 1.5 was supposed to implement "change of circumstance" processing where existing applications could be modified. This release exposed major data reconciliation issues between the ANSWER, MMIS, and Cúram systems.

There was a major restructuring of the EEF project in January 2015 and further course corrections made in July 2015. Cognosante is now in a PMO role and will use a percentage complete methodology to measure progress against schedule and budget rather than reporting the hours worked on a task. They have a plan to phase in more and more rigor in the management of the day-to-day work, to identify and resolve risks and issues, and increase the overall transparency of the project status. They will produce a Gantt chart for the entire project, showing the schedule for each component. TSG understands the current contracts are now deliverable and performance based where the vendors take slightly more risk.

RedMane has been engaged to do the work to support SNAP. This work is a combination of reliance on the Cúram software, where possible, and custom code to support Arkansas' requirements and timeline. IBM intends to support SNAP long-term but has not committed to a date. Meanwhile, the State is paying RedMane to develop custom code that will be superseded when IBM eventually puts the SNAP support in its product. The State has also decided to combine two releases into a single release. Per federal requirements, the SNAP functionality will be piloted in 3 counties before going live statewide. The RedMane team has identified technical architecture risks with the brokering architecture. The team also indicated they won't know the full implication for project cost until the end of the design phase.

The IBM Cúram software is the core technology supporting the EEF Project although DHS has made over 100 customizations to the core product. Under the current structure, DHS is fundamentally dependent on IBM to determine whether and when IBM will include new functionality in the software product. There is a debate over who pays to develop each of the required functions that do not previously exist in the out-of-the-box software. The Cúram product does not presently have the functionality to support Retro Medicaid, newborns, and the work associated with Prospects Phase II. Negotiations with IBM are in-progress on each of these particular issues.

DHS recently hired Gartner to assess the bigger picture of whether Cúram is the right product for DHS and provide advice on the governance and project structure for the future. While the Gartner work is in progress, the project team is following a "stay the course" approach. DHS is also participating in quarterly calls with five other states that use the Cúram product. These calls do not include IBM personnel, so the states can candidly share experiences. Missouri re-signed their contract with IBM. Maryland, while transferring much of Connecticut's software, still uses the Cúram "rules" engine.

DHS has filed an updated Advanced Planning Directive (APDU) with the federal authorities with funding for federal fiscal year 2016 to be $69.1 million of which $59.7 million comes from federal sources and $9.4 million comes from the State.

28.2.Current Strengths and Challenges with the Eligibility System

Even though this TSG work does not encompass a detailed functionality review of the EEF project, some general observations can be made. The EEF system is now operational for managing basic enrollment and re-enrollment process for Arkansas's expanded Medicaid population. The problems and issues associated with the backlog of eligibility renewal reviews, since DHS began processing renewals in May/June 2015, have not been due to the Cúram product. However, the Cúram software, with customizations done to date, still does not manage all basic Medicaid requirements.

For example, Medicaid benefits cannot be legally provided for the incarcerated, but the Cúram system, as of the time of this review, was not designed to make comparisons between beneficiaries and the incarcerated population to remove incarcerated beneficiaries from receiving services. A semi-manual work around is being considered for implementation later this fall after the backlog of renewals has been handled, and an automated connection with state incarceration data is a long term goal.

Paying PO clients service provider fees for incarcerated clients is a violation of federal law and exposes the state to recovery actions by the Federal Government. Our analysis and research

shows that are likely hundreds of incarcerated beneficiaries on the roles at any given time, so the financial impact could be material.

TSG did not review the detailed functionality of the EEF program nor the Cúram product. We mention this one example to clarify the point that even where the EEF system is operational, it is far from an elegant solution. It must be supported with manual DHS processes to fully meet Arkansas' requirements.

28.3.Future Plans for the Next Procurement for the EEF Project

DHS plans to conduct a competitive procurement process to award the work for future phases of this project. The timeline for competitive procurement creates a gap between the end date of the current vendor contracts and the start date of the newly procured vendors. Most of the current contracts end December 2015 while the new procurement allows for a July 2016 start date. Consequently, the State must find a way to bridge this time period.

At present, DHS is considering a six month sole source extension of the contract for eSystems and First Data. In other states, there are a number of different procurement mechanisms that allow agencies to choose from a pre-selected list of vendors where the rate card for management consulting and technical consulting services has already been competitively bid. Arkansas will need to be mindful of Federal requirements for competitive procurements and ensure that whatever approach selected meets guidelines for federal matching.

28.4.Ability of the EEF System to Support Future Directions

Even if Arkansas procurement processes are improved and effective development governance is implemented, there remains the question of whether the current planning is flexible enough to handle expected future changes.

Our working presumption for long term planning is that fundamental economies of scale will drive both federal and state human services systems to use more standardized, integrated and centralized enrollment and eligibility policies and systems. There are endless details at every level from the guiding laws and regulations through operational implementation that will have to be managed; but the potential cost savings by reducing redundancy, limiting waste and fraud, and improving service delivery through a more integrated understanding of the needs of the people being served is so compelling that the integration vision will remain as a guide.

Given this presumption, the EEF development program should be reviewed for its designed ability to support an ongoing drive toward integrated management of basic Applicant and

Beneficiary identity and core attribute information, above and beyond the simple ability to adapt to process and regulatory changes.

The future will require an integrated applicant/beneficiary data warehouse that is then used as needed by different welfare and work requirement programs. The separate ongoing Gartner review of EEF may take this long term design perspective into account. Our observation is simply that not including this future requirement perspective could result in unnecessarily expensive redesign and redevelopment a few years from now.

28.5.Risks to Manage Going Forward

The recently implemented Program Management Office (PMO) implemented by DHS will mitigate against major unexpected schedule and functionality failures and this is good. But a PMO, although critical for good management by the contracting agency, is not the same as a Systems Integrator.

An effective PMO manages status clarity and communications as well as contractual relationships and, if they are a particularly active PMO, drives cross-project problem resolution. A Systems Integrator owns the overall design and integration, providing the systems engineering role for the multiple related and integrated programs.

Our opinion is that the EEF and related projects are clearly in need of a true systems integrator function, and that proceeding without one – even at this late date - will inevitably cost the state more headaches and more money. The lack of this overview role, by an appropriately experienced party, along with the missing or weak PMO function, is the root cause of much of the difficulties these projects have experienced over the last few years.

There is nothing special about Arkansas in this regard. A quick review of large state government software development programs, never mind federal efforts, clearly shows that these large cross-system projects are significantly beyond the scope of any internal state IT department, even if they are quite competent for their normal tasks. Their experience is typically limited to much smaller programs and does not sufficiently scale to efforts of this size.

29. ORGANIZATION AND STAFFING CAPABILITIES

TSG conducted an investigation into DHS' organization and staffing capabilities, comparing Arkansas to administration of Medicaid programs in other states.

29.1. Comparison of the Arkansas Medicaid administration in other states

The Stephen Group believes that the fundamental requirements for states to successfully modernize Medicaid programs for all eligible populations include a commitment to comprehensive systems integration and payment reform that achieves services integration, care coordination for high cost complex cases designed for individual specific conditions in a population health context, quality, and cost containment. The Medicaid improvement initiative should be based on a goal and action plan designed to achieve comprehensive services integration and care coordination that targets health status improvement for individuals and populations at the least cost; includes an organizational and business development action strategy that empowers state Medicaid agencies to move beyond setting rules, paying claims and responding to CMS; and leadership that is adaptable, accountable, and willing to bear reasonable risks to achieve effective innovation based on insightful data analysis.

State Medicaid modernization planning needs to focus on connecting eligibility, access to a high skilled, competitive, and financially stable partnership provider community, payment models that incentivize high quality outcomes by paying for provider performance in the right setting at the right time, and the right cost and health education that improves the empowerment and self-responsibility of beneficiaries to engage in healthy behaviors by tying the integration of vision and shared policy across all health and human services agencies/departments. A comprehensive modernization vision for a state's Medicaid program must include a state of the art use of technology and cross systems data, including program integrity, as a fundamental element of a modernization effort. A robust and transparent program integrity effort targeting eligibility and enrollment, fraud, abuse, and misuse will assure the appropriate use of taxpayer dollars and gain the public trust for the state Medicaid program.

States that have effectively modernized and reorganized their Medicaid and related health and human services programs have studied and implemented organizational models that were designed to provide the structural basis for maximum success of their modernization efforts.

Over the past several years Kansas, Oregon, and Washington have integrated the state Medicaid and Employee Benefits enterprises within one organizational structure, thereby leveraging the state's purchasing strategies and ability to contract for integrated care coordination models associated with payment reform. California eliminated the free standing Department of Mental Health in 2012 and replaced it with the Department of Health Care Services (which includes Cal-Med) for community based services for all populations and the Department of State Psychiatric Hospitals, of which there are nine.

States engaged in reframing their health and human services systems with a recognition of the importance of Medicaid as a funder and potential point of integration have implemented slightly different organizational structures to manage the ABD population related services of Aging and

Disability Services, Intellectual and Developmental Disabilities Services, and Behavioral Health Services. We do not believe one size fits all; therefore it is critical that individual states assure they have considered the organizational structure of their Medicaid enterprise and health and human services departments and agencies based on state values they believe will work best for them in assuring a successful Medicaid program modernization initiative that produces integrated high quality care and cost containment.

The National Collaboration for the Integration of Health and Human Services is an affiliate of the American Public Health Services Association (APHSA). The National Collaboration leadership and membership include state and local government health and human services leaders, a large number of health and human services industry business entities, federal government representatives and state population specific associations from across the country. A 2013 survey of the states by the National Collaborative produced a business model named the "Health and Human Services Maturity Model for the States"[194]. The basic elements of the business model include:

- Opportunity Recognition: Improved services delivery, improved health outcomes, improved population health status, improved quality, improved cost control
- Focus on clients, needs, self-responsibility supported by health education, and how services are delivered, managed, and assessed across the client's health needs supported by care coordination
- Performance Improvement: use of data based outcomes and process measures
- Cost savings/"bending the cost curve" based on innovative payment models focused on appropriate utilization in the least expensive most preferable setting
- Workforce development: modernization based on integration strategies requires states having the necessary expertise across the task focused integration efforts such as shared policy development, ability to frame, analyze and translate inter-relational data bases internally and externally, expertise to develop and manage complex contracts; expertise to assure enterprise wide accountability and program integrity

The model includes four levels of HHS Maturity[195]:

- Regulative: Delivering services to constituents for which they are eligible while complying with categorical policy and program regulations
- Collaborative: Ensuring the appropriate mix of existing services for constituents working across agency and programmatic boundaries
- Integrative: Addressing and solving the root causes of client needs and challenges by seamlessly coordinating and integrating services

[194] "Health and Human Services Integration Maturity Model". APHSA. 2013
[195] Ibid

- Generative: Generating healthy communities by co-creating solutions for multi-dimensional family and socio-economic challenges and opportunities (includes social determinants of health)

The key elements that are action oriented across the four levels of HHS Maturity[196] include:

- Enterprise Wide Vision and Mission
- Governance
- Integrated infrastructure
- Adaptive and Capable Leadership throughout the organization
- Consumer Access Channels
- Coordinated services delivery regardless of CMS rules (SPAs, waivers, etc.) and external funding sources supporting the Medicaid enterprise to the maximum extent possible (e.g. IVE, Juvenile Justice)
- Sustainable Outcomes for individual consumers and the general population
- Effective Use of Measures and data throughout the enterprise
- Sustainable and consistent consumer/family role

The NWI 2013/2014[197] survey of the states on the health and human services integration project yielded the following recommendations as needed for successful health and human services integration initiatives:

- Ensure adaptive leadership skills are part of the organization's culture
- Implement change management processes to help move an organization along an evolutionary path of shared goals
- Equip the workforce to function effectively in a technologically-oriented environment
- Make use of business process reengineering (BPR) activities to match agency resources and infrastructure with evolving organizational priorities
- Embed project management skills throughout the organization and assure translation to all levels of the organization
- Implement far-reaching service delivery practices that include care coordination and collaborative practices
- Manage critical progressive partnerships across the H/HS domain to achieve the transformative goals of the organization.

29.2. The Arkansas Department of Human Services

The Arkansas Department of Human Services is a loosely configured "umbrella" state organizational model consisting of: The Office of the Director; Division of Behavioral Health

[196] Ibid
[197] NWI/APHSA: Business/Maturity Model

Services; Division of Child Care and Early Childhood Education; Division of Child and Family Services; Division of Community Services and Nonprofit Support; Division of Developmental Disabilities Services; Division of Medical Services; Division of Services for the Blind; Division of Youth Services; Office of Chief Counsel; Office of Finance and Administration; and the Office of Quality Assurance. DHS reports that Executive Staff meetings are held monthly. DHS has a number of standing and ad hoc Committee meetings across divisions including the IT Steering Committee, Chief Financial Officers, Provider Quality Oversight, Long Term Services, and Payment Integrity.

There is a cross division team meeting focused on high risk children/adolescents served by the Division of Child and Family Services and includes external system participants such as Value Options (focused on inpatient/residential/care coordination needs). DHS does not report the use of written agreements or Memorandums of Agreement between and among DHS divisions or other state agencies such the Departments of Health, Education, Corrections, and Workforce Services that may serve the same individual through different systems.

Based on meetings and observations internally and conversations with external stakeholders, TSG has found that there is an internal and external perception of a "silo" environment within DHS impacting the management of DMS, DAAS, DDS, and DBHS. We did observe that there has been recent action from DAAS, DDS, and DBHS to meet together to address the implementation of the InterRai and issues with CoCentrix, however this welcome team work appears related to ongoing contractual and performance issues with vendors.

TSG believes it is imperative that "umbrella" non-integrated state HHS agency models, such as the Arkansas Department of Human Services, provide an integrated leadership and policy making platform. Management practices such as standing cross division meetings and articulated shared policy development and implementation for access, quality, and budgeting, communications, and program integrity are key components that avoid an organizational silo mentality and, most importantly, catalyze care coordination across division boundaries, including Child Welfare, for shared high need/high cost clients. Additionally, the investment in cross division management practices results in the ability of an "umbrella" Agency to act as a systems team that prioritizes complex and high cost cases regardless of point of service, supports the goal of a singular vision for population health status improvement for all Arkansans eligible for services, and prioritizes appropriate cost containment and integrated program integrity actions while assuring access to needed services and protecting taxpayer dollars from overutilization or misuse.

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

DHS/DMS/DAAS leadership indicates the need for a comprehensive approach and plan for care coordination for high cost, multiple services population ("80% of spend goes for 20% of the Medicaid population") and all DAAS and DDS waiver recipients and DBHS/RSPMI clients. While the PCMH design has elements of care coordination, the model is essentially Primary Care focused and unconnected to the ABD and waiver(s) populations by design. DHS has an outstanding opportunity to bring the knowledge gained through the successful launch of the PCMH model to scale across the ABD and waiver populations by committing to transform existing management, contracting and service delivery practices of medical and waiver services to a value based approach that provides care coordination across services delivery in all settings, resulting in a seamless service delivery pathway that integrates all care, services, and supports of medical and LTSS services across all eligible populations.

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

The Arkansas Department of Human Services is the largest agency in the state. They manage a $5 Billion operation. Their mission encompasses protecting the vulnerable, fostering independence and promoting better health. As their web site indicates, their beliefs[198] include:

- Every person matters.
- Families matter.
- Empowered people help themselves.
- People deserve access to good health care.
- We have a responsibility to provide knowledge and services that work.
- Partnering with families and communities is essential to the health and well-being of Arkansans.
- Quality of our services depends upon a knowledgeable and motivated workforce.

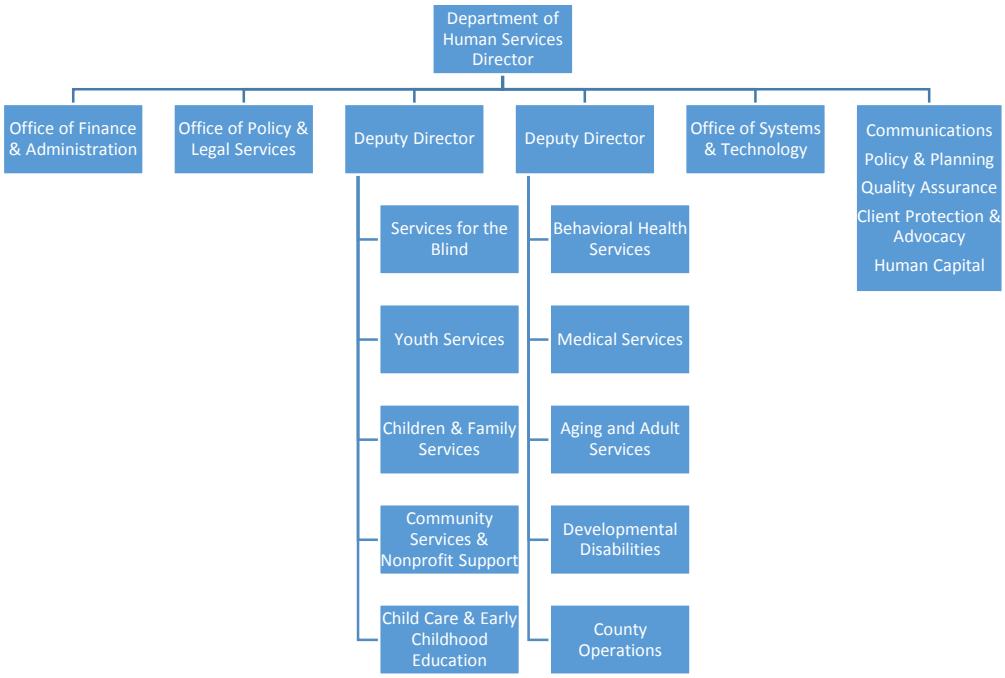
29.3.Existing Organization

The organization, as of April 2015, is shown in Figure 67 below. [199] There are two Deputy Directors who report directly to the overall Department Director. In addition, there are several

[198] www.humanservices.arkansas.gov
[199] DHS org chart, as redrawn by TSG without titles and names

direct reports to the Agency Director with responsibility for the more internal functions of Finance, Policy, Systems and Technology, Quality Assurance, and Human Capital. One Deputy Director oversees the services for the blind, for youth, for child welfare, for community/nonprofit, and for child care/early childhood education. The other Deputy Director supervises Behavioral Health, Medical Services, Aging and Adult Services, Developmental Disabilities, and County Operations.

Figure 66—DHS Organization Table



The current organization is largely designed around functional skills. This approach is consistent with the majority of organizations in the United States. It allows the agency to hire people with deep skills in a particular area and focus their skill on a particular service. For example, the Division of Children and Family Services concentrates on child safety and permanency. The Division of Behavioral Health serves the population with mental health needs regardless of age. Likewise, the Division of Developmental Disabilities serves the people who need help with these services regardless of the location or age. This approach is helpful in building deep skills, in working closely with providers of a particular service, in understanding the federal funding, and in complying with legislation around a particular need. State agencies frequently use this functional orientation to their organization as it is easier to find people with one deep skill rather than a cross-section of experience in several areas.

Every organizational design has pros and cons. The disadvantage of a functionally oriented organization is that different parts of the organization deal with the same clients. This means

that a given client may have to interface with different DHS employees. For example, a person who needs behavioral health and medical services has two points of contact within the agency. A large provider, such as a hospital, must navigate different parts of DHS to understand all the policy requirements. Suppliers may have multiple contracts with different parts of the agency to provide different services.

Typically functionally oriented organizations are less customer service oriented. They may not optimize geographic locations. TSG believes the current organization structure is not sufficiently integrated from a customer point of view. It is lacking in collaboration across the organization, particularly in the areas of care coordination, program integrity, procurement, and shared services.

29.4.Staff Capabilities

DHS is a $5 billion operation. The existing personnel work hard to do their best to manage the operation and they supplement the skills of their internal staff with a significant number of external contractors. This creates a long-term dependency on certain skill sets and an awkward relationship in holding the vendor to the best possible performance standard.

In particular, DHS is weak in the follow skill areas: Integration, Program Integrity, Procurement, and Vendor Management.

Integration

As discussed in other sections of this report, a disproportionate share of Medicaid costs are spent on a small share of recipients. This creates an opportunity to save money and improve the quality of care for these stakeholders. However, it requires tight coordination and integration between the various medical services serving each population. Acting independently is frequently easier than acting as a high performing team. It is a separate skill set for a leader to create and manage a highly interdependent team.

Procurement

DHS has very few people with availability to write RFP's. This task frequently falls to the people who are fully consumed in the current operational details and do not have the time or vision to fully determine what the State should ask for in the future. As a result, the State does not sufficiently plan for the evolution of their needs throughout the seven year life of a new contract or does not maximize the results for the money spent.

Vendor Management

The State lacks a sufficient number of resources with the skills to negotiate successfully with large, sophisticated vendors and to tightly enforce the terms and conditions of the large, complex contracts. As the State tackles Health Care Reform, the skills in this area will be even more

essential. The size and complexity of the contracts will likely grow larger and the State must have vendor oversight to monitor the contracts, enforce terms, and resolve issues quickly. This requires the personnel charged with managing the vendors to be knowledgeable and empowered to make decisions.

30. VENDOR MANAGEMENT

30.1. Scope of Contract Review

TSG reviewed the 25 largest existing vendor contracts to understand how DHS procured vendors, established and managed deliverables, defined and managed performance indicators, managed the spend under the contracts, and addressed unacceptable vendor performance. TSG looked at the total value of the contract, the method of procurement, the change in spending levels from year to year, the DHS staff managing the contract, and the value the State receives for the services provided. TSG interviewed selected DHS staff and vendor personnel to understand the practical details of some of the selected contracts and to identify opportunities for improvement.

30.2. Findings

The State procurement practices, and the DHS application of these practices to the largest contracts, include many standard favorable contract terms and conditions. These include a standard cancellation provision where the State can terminate a contract if necessary. They include a good dispute resolution process, State control over the service provider's use of subcontractors, strong indemnification terms, and a provision of payment of legal fees in the event of a dispute.

All contracts have a requirement for the vendor to submit and implement a corrective action plan for any issues within the scope of the contract. All contracts have the option to withhold or reduce payment and a provision that the contract may be terminated for poor performance. Most contracts are vague on the details of withholding or reducing payments. On a consistent basis, DHS manages vendors on a year by year basis. While the state procurement allows a contract to cover up to seven years, DHS manages the vendors one year at a time. This allows DHS to keep the vendors motivated to extend the work for another year and knowing they need to constantly re-earn the business.

DHS has some very strong examples of specific deliverables and consequences for missing deliverables. They also have some great examples of making the vendors live up to the promises they made in their proposals. Two notable examples are the Optum Contract for the Decision

Support System where there is a liquidated damage of $500 per milestone per work day for each day the deliverable is late. Also in this contract, any Severity Level 1 defect carries a liquidated damage of $500 per 4 hours the Corrective Action Plan is not provided. In the case of the Health Management Systems Contract, the vendor is responsible for providing third party liability and recovery services for Medicaid, and they are required to recover as much as they projected they would in their proposal.

DHS provided a multi-year view of the money paid of the top 25 contract vendors. TSG reviewed the year over year increases and found a clear explanation for any increases. Vendors were typically not allowed to increase prices for same work performed in a subsequent contract year. DHS did authorize scope extensions or respond to changes in volume based on unit pricing contained in a few of the contracts. Performance indicators were updated from year to year if the scope changed.

TSG understands that DHS uses a number of different contracting vehicles for different situations and that the Legislature changed the procurement process in the last session. We are aware of the different processes for contracting under an RFP, for contracting sole source with a particular vendor, and for Intergovernmental contracts.

Of the 25 contracts analyzed, 18 were competitively bid, four were sole source awards, and three were intergovernmental agency agreements. The four sole source awards were to HP for the MMIS Fiscal Agent Contract, McKinsey for the AR Health Care Payment Improvement Initiative, Cognosante for the IT Project Management, and DataPath for the PO Health Care Independence Accounts. It appears the Agency occasionally uses sole source awards for purposes of efficiently onboarding a contractor. This allows the Agency to meet Federal and State deadlines but may not always ensure the best value for the taxpayer dollars in the long run.

TSG also reviewed the process for approving vendor invoices and for tracking actual invoice amounts against the contract budget for the year and against the Federal and State funding sources. The financial tracking is a labor intensive exercise with a custom spreadsheet for every contract. DHS must manually track dates, warranty amounts, the budget and actual amount for each deliverable, the federal matching funds, and the amounts invoiced and paid to the vendor.

The contracts included in the review are listed in Table 61 below.

Table 61—Contracts review

Contract Number	Contractor Name	Contract	Total Value
1	HP Enterprise Services, LLC	MMIS Core	$203,000,000
2	HP Enterprise Services, LLC	MMIS Fiscal Agent	$200,000,000
3	Palco	Self-Directed Service Budget Counseling Support	$55,477,760

Contract Number	Contractor Name	Contract	Total Value
4	Magellan	MMIS Pharmacy	$43,325,000
5	Arkansas Foundation for Medical Care	To develop, review, implement & update criteria for utilization for PA's and extensions of benefits	$39,240,137
6	UAMS Dept. of Obstetrics & Gynecology	Center for Distance Health - Formally (ANGELS) & (SAVE)	$31,372,304
7	ValueOptions Inc.	Mental Health Determination - Outpatient	$30,614,849
8	General Dynamics Information Technology Inc (GDIT)	Analytical Episode	$30,000,000
9	Health Management Systems, Inc.	Third Party Liability & Recovery Services	$29,171,660
10	Palco	Self-Directed Service Budget Financial Management Services	$24,112,200
11	Cognosante, LLC	MMIS PMO	$18,134,893
12	AFMC	Medicaid Beneficiary Relations and Non-Emergency Transportation Administration	$16,200,925
13	McKinsey and Company Washington	AR Health Care Payment Improvement Initiative	$15,400,000
14	ValueOptions Inc.	Mental Health Determination - Inpatient	$14,898,576
15	Optum	MMIS Decision Support System (DSS)	$13,690,718
16	AFMC	Medicaid Quality Improvement	$12,000,000
17	Office Of Health Technology - OHIT	PCMH Model	$11,191,221
18	AFMC	AR Innovative Performance Program (AIPP) for Long Term Care facilities	$10,469,618
19	AFMC	Medicaid Provider Representative	$10,139,885
20	Cognosante, LLC	DHS IT Project Management Office	$9,642,211
21	DataPath	PO Health Care Independence Accounts	$8,200,000
22	AFMC	Retrospective Reviews of physical, speech, and occupational therapies and	$8,062,908

Contract Number	Contractor Name	Contract	Total Value
		PA's for personal care for under age 21	
23	Pine Bluff Psychological Associates	DDS Procurement of Independent Assessors School Age Assessments	$6,281,550
24	AR Dept. of Health	Medicaid Outreach & Education ConnectCare and provide information in the Primary Care Case Management (PCCM) program & support ARKids 1st info line	$6,000,000
25	Health Services Advisory Group, Inc.	Medicaid Data Mining and Program Evaluation	$5,606,984

Contract Findings – Eligibility and Enrollment Framework Project

These findings are discussed in the section dedicated to this Project.

Contract Findings – HP

There are two large HP contracts. One contract is for services associated with the existing MMIS system and one contract is for development of the new MMIS to meet federal specifications. The MMIS system is largely a claims processing engine. HP provides the system, staffs the call center, and processes 98% of the claims within two weeks. The "old" contract goes away when the new system and processes are fully deployed in June 2017. There will be on-going payments to HP for the maintenance and operational support for processing claims once the new system goes live.

Contract Findings – Magellan

The Magellan work, coupled with the HP contract and the Optum contract, is part of the MMIS "Core" system. Altogether, these systems and supporting personnel handle claims processing, data analytics, client service and supporting services to process the volume of claims DHS handles. In March 2015, the State moved the pharmacy claims processing from HP to Magellan. It includes claims adjudication, access to the First Data Bank files, a rebate team, and a Call Center Help Desk. Unlike the previous consolidated approach where one MMIS vendor processed everything, the current approach is more modular and the Magellan contract is dedicated to pharmacy only.

Magellan is an experienced Medicaid vendor serving nearly half the states in the country. Their services are administrative in nature and run on a system platform used by many other state programs without problems. TSG is confident this past performance was explored in procurement. It is not standard operating procedure in commercial or Medicaid pharmacy

programs to have an outside PMO function, in this case Cognosante, overseeing a vendor such as Magellan. Vendor selection and implementation are complete; we question the value of continued PMO oversight of this vendor.

Cognosante appears to have been involved in the RFP process to select Magellan, the new FFS pharmacy administrative vendor. Next they oversaw the implementation of the vendor which they helped select, and finally, they are involved in a PMO role to oversee the ongoing performance of this same vendor. Conflicts of interest should by explored and mitigated.

Contract Findings – AFMC

AFMC has a number of contracts with DHS. These include services to develop, review, implement and update criteria for prior authorizations, to be the Medicaid Provider Representative, to conduct the AR Innovative Performance Program (AIPP) for Long Term Care Facilities, and to perform retrospective reviews of physical, speech, and occupational therapies and prior authorizations for personal care for under age 21.

The largest AFMC contract covers hospital stays longer than four days and calls for prior authorization for continuing stays. AFMC supports DHS in verifying that children sent out of state due to access issues have legitimate reasons for needing to go out of state. This contract provides support to primary care and would likely be outside the populations targeted for managed care.

DHS has found these contracts to be valuable in improving the quality of care in the state. For example, Arkansas was #1 in the nation in 2007 in the use of restraints in long term care facilities. Under the long term care contract, AFMC provided nurses to coach their peers and reduce the use of restraints from 23% to .8%. The use of anti-psychotics has gone down from 20.4% to 17.2% and Arkansas is now third in the nation in the rate of reduction of these drugs.

Contract Findings – UAMS

This contract provides distance health services targeted at high risk pregnancies and stroke victims. This contract is unique to DHS in that 75% of the funding comes from federal sources and 25% comes from UAMS. DHS manages the contract but the money does not come out of the agency's budget. The goal of this contract is to limit the drive time to 50 minutes for a patient to get to a telemedicine site for a consult. There are 90 sites around the state. Smaller hospitals are able to conference with larger hospitals and use this technology. This contract contains a significant indirect charge even though it is an interagency state contract. There are examples where other states have capped the amount of indirect charges one agency can bill another agency.

Contract Findings – ValueOptions

There are two ValueOptions contracts – one for inpatient psychiatric services and one for outpatient services. In most states, ValueOptions serves as a managed care coordinator. The utilization management work they do in Arkansas is a unique model for them. There are a number of revisions to the service model that DHS has sponsored over the last few years. They worked for five years on a behavioral health model only to have the providers and legislature say no.

The Medicaid Fairness Act contains specific language about changes the agency is allowed to make and about the standards for fairness it must demonstrate with any proposed changes. A previous section of this report discusses proposed recommendations to the behavioral health model that may affect this contract. If Arkansas moves to a managed care model, this contract will likely be transitioned to that new model.

Contract Findings – GDIT

This contract provides the episode payment system which includes the analytic payment capabilities to support the episodes designed by McKinsey. GDIT receives a claims file from HP and runs it through their claims engine. The analytics include individual provider reports showing quality and financials. This information is sent to HP and to BCBS for presentation on their portal. There have been 455 million claims processed though this engine and 3.7 million episodes formed before exclusions are applied. DHS perceives the analytics to be extremely useful in identifying outlier providers and assisting in managing costs.

Contract Findings – Health Management Systems

This contract supports the third party liability and recovery process. Specifically, this process helps Medicaid avoid paying for something that some other party is responsible for. In the event Medicaid has already paid a claim, this process recoups the money from the other party. The vast majority of money collected comes from commercial insurance. The vendor is paid a very small percentage of the money they collect from third parties. The payback on this contract is significant as collections far outweigh the money spent on this contract. There is on-going work to interface this process to the new EEF Project and the Cúram software.

Contract Findings – Cognosante

Cognosante provides Program Management Office (PMO) services under two contracts which support a larger number of actual projects. Under the MMIS PMO contract, Cognosante provides support to the HP, Magellan and Optum work. They provide coordination services, another set of eyes into the project status, and support for obtaining Federal CMS certification to assure federal funding after the systems development work is completed. Under the IT Project Management office contract, Cognosante provides support to the EEF project, the Universal Assessment CH Mack contract, and other smaller initiatives. Cognosante provides personnel who are PMP certified – an industry standard for project and program management. They

provide a bridge between business personnel and the vendors in assuring that requirements are met. DHS perceives they significantly reduce the risk of project failure.

The observations about the Cognosante oversight of the Magellan contract were discussed earlier in the section. The skill sets provided by Cognosante could conceivably be filled by State personnel if the State could find and retain people with this skill at State salaries and if the individual agencies had enough large projects for the individuals to continue to hone their skills by repeatedly working with large vendors on high risk development projects. At present, DHS does not have any sufficient staff with the skill set to perform this work.

Contract Findings – McKinsey

TSG responded to the questions the Legislative Task Force raised during the review of the McKinsey contract. TSG identified and proposed a number of more detailed deliverables for the McKinsey current fiscal year contract. TSG proposed a level of clarity around the financial payment and schedule for each deliverable. This approach protects the State from poor quality deliverables as the State's Project Manager would review a deliverable and require rework before it is accepted. Whenever a vendor does not get paid until they get a deliverable accepted, they are highly motivated to produce high quality deliverables in a timely fashion. McKinsey responded quickly and favorably to the proposed deliverables and worked with DHS to finalize a detailed deliverable and payment schedule for the work in this fiscal year.

Contract Findings – Optum

The Optum contract is part of the MMIS core system. It will look at claims from two different providers and perform data analytics and predictive analytics. The system should be operational in June 2016.

Contract Findings – DataPath

This contract supports the Health Care Independence Program (HCIP)/PO. The timeframe and approach to HCIP's is a direct result of the Arkansas legislation for this program. There were initial fees paid to this vendor to develop the system, stand up a web site, create educational collateral, and stand up a call center. HCIP recipients were sent a MasterCard that they activate via a portal, www.myindycard.org, or by calling the call center.

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

Contract Findings – Pine Bluff Psychological Associates

Under this contract, Pine Bluff conducts independent assessments on the persons who are added to the Arkansas Alternative Community Services waiver list. This contract calls for a payment amount per assessment. Should Arkansas move to a managed care environment, this work would likely be done by the managed care provider. TSG discussed with DHS whether there may be an opportunity for streamlining the process for completing the initial and subsequent assessment on the individuals in this program while still meeting CMS guidelines.

Contract Findings – Health Services Advisory Group

This contract provides a small number of on-site personnel and an access to additional off-site personnel to do Medicaid Data Mining and Program Evaluations. These evaluations are required by CMS for programs like CHIP and ARKLA. These individuals pull the data from the MMIS system. This service is contracted to a private sector firm, rather than performed by State employees, due to the limited number of positions DHS has and the difficulty of hiring an employee with this skill set at the level the State is willing to pay.

31. Descriptions and Comparisons of Successful Medicaid Block Grant Programs

TSG conducted an investigation into descriptions and comparisons of successful Medicaid block grant programs. The Request For Proposal issued by the Bureau of Legislative Research asked for a review of all successful Medicaid block grant programs in the United States. Our analysis of Medicaid programs across the country could not identify any state where CMS has approved such a payment structure.

32. Process Of Legislative Approval for State Plan Amendments

TSG developed findings on process for legislative review and approval for state plan amendments and other Medicaid rules. Recently, the Arkansas Legislature amended the legislative review process for Medicaid rule changes in Act 1258 of 2015. Pursuant to such Act, the promulgation and legislative review requirements apply to any type of agency statement, policy, etc. that meets the definition of a "rule" under the Arkansas Administrative Procedure Act. That definition of a “rule” is very broad: "an agency statement of general applicability and future effect that implements, interprets, or prescribes law or policy, or describes the organization, procedure, or practice of an agency and includes, but is not limited to, the amendment or repeal of a prior rule." Ark. Code Ann. § 25-15-202(9)(A).

According to DHS, this definition encompasses programmatic changes enacted in written form, such as Medicaid state plan amendments and Medicaid waiver applications or renewals.

The basic contours of the promulgation process are set forth in Ark. Code Ann. § 25-15-204 (page 34, line 29 of the Act). The process for legislative approval is set forth in Ark. Code Ann. § 10-3-309 (page 7, line 17 of the Act). The basic process is as follows:

1) The promulgation process begins when the Department publishes notice of the proposed rule change in the statewide newspaper. Publication initiates a 30-day public comment period.
2) The Department must file a copy of the rule, including a markup version, a summary, a legislative questionnaire, and a fiscal impact statement, with the Secretary of State, the Bureau of Legislative Research, the Arkansas State Library, and the Arkansas Legislative Council.
3) If the rule has a fiscal impact of more than $100,000 (whether to the state or to a private entity), the agency must make certain written findings to be filed with the fiscal impact statement. Ark. Code Ann. § 25-15-204(e)(4).
4) Upon the expiration of the public comment period (which must be no less than 30 days from when the rule was filed with Legislative Council), the rule must be reviewed by the Administrative Rules and Regulations Subcommittee of the Legislative Council.
5) For a rule to be reviewed by the Subcommittee, the Department must submit to the Subcommittee, no later than the 15th of the month prior to the Subcommittee meeting, a summary of public comments received and the Department's response; a revised markup showing any subsequent changes to the rule; and "any additional information requested by" Subcommittee staff or the Legislative Council.
6) Either the Subcommittee or the full Legislative Council may choose to refer the rule to another legislative committee for consideration.
7) If the rule must also be reviewed by another legislative committee (see below), the Subcommittee ordinarily will not review the rule until the other committee has done so.
8) Following review by the Subcommittee, the report of the Subcommittee's review must be adopted by the full Legislative Council before the rule may be considered approved.
9) Upon legislative approval, the Department must file the rule with the Secretary of State. The rule becomes effective 10 days after filing.

In addition to the requirements in those statutes that apply to rules promulgated by most state agencies, there are other additional requirements that are specific to Medicaid and DHS:

- Any rule change or reimbursement rate change that will obligate general revenues of the state must be approved by the Governor and the Chief Fiscal Officer of the State. Ark. Code Ann. §§ 20-76-212 & 20-77-110.
- Any rule change related to episodes of care must be submitted to the Healthcare Quality and Payment Policy Advisory Committee for review at least 45 days before the Department begins the promulgation process. Ark. Code Ann. § 20-77-2205.

- Any rule change related to the Health Care Independence Program (PO) must be submitted to the Arkansas Legislative Council at least 30 days before the Department begins the promulgation process. Ark. Code Ann. § 20-77-2405(g).

Finally, there are additional requirements contained in special language in the Medicaid appropriation bill approved by the Legislature:

- Any rate methodology changes are subject to prior approval by the Arkansas Legislative Council. Act 41 of 2015, § 11(b). Similar special language has been in every Medicaid appropriation since at least 1999.
- Virtually any rule related to Medicaid (specifically, any rule "impacting state Medicaid costs") must be submitted to and reviewed by the House and Senate Committees on Public Health, Welfare, and Labor. Act 41 of 2015, § 15. Similar special language has been in every Medicaid appropriation since at least 2010.

Please note that these requirements concern only ordinary promulgation; the process for adopting an emergency rule (i.e., a rule that becomes effective immediately without the requirement of a public comment period) involves a separate process and, in sum, emergency rules are temporary and may not extend for more than 120 days.

33. AD HOC REPORTING

TSG conducted a review of ad hoc reports regarding Medicaid claims data independent of current business object software used by DHS. The Agency has invested in the capability to provide ad hoc reporting at the request of Agency management, BLR, and other agencies. That capability has many effective aspects:

- Data collection resources – the Agency has retained external consulting firms including HP, Optum, Northrup Grumman and others to conduct analysis and support basic IT operations.
- Data warehouse – the Agency has two interrelated data warehouses, including the Enterprise Data Warehouse and the Medicaid Data Warehouse.
- Data tools – the primary tool for obtaining data from the data warehouses is Cognos – one of the top-selling, enterprise class data tools.
- Data security – the Agency protects its data well. It has processes to assure HIPAA compliance and to otherwise protect data against misuse.
- Clarifying the request – the Agency uses a formal approval process to make sure that the request is well understood.
- Resource allocation – the Agency resources have assignments other than the "next request." To make them most efficient, they are assigned a variety of projects to ensure that they make best use of their time.

The challenge is whether those strengths allow the Agency to meet the need for ad hoc reporting. TSG heard anecdotal reports regarding ad hoc reports with numbers that are not dependable, and delays in reporting out the requested information.

The process used for regular reporting is not applicable for Ad Hoc reporting. Some of these regular reports include the annual Medicaid Program Overview[200] and the many reports made public on the web site:

- Arkansas Medicaid Reports and Data for Public Access
- Affordable Care Act Information for the Public
- Arkansas Health Care Payment Improvement Initiative
- Annual Reports for Arkansas Medicaid 1115(a) Demonstration Waivers
- CMS Health Care Independence Program Quarterly Reports
- Division of Developmental Disabilities Services Requested Documents (including HCBS Waivers Annual Reports)
- HEDIS Reports
- RSPMI SFY 2010 Program Analysis

Each of these reports is carefully scrutinized to assure accuracy—on an infrequent (e.g. annual) basis. Each is built using the method used in the prior period or according to a method that is spelled out and required for compliance. Thus, the process of preparing these reports is not suited for ad hoc reporting. Ad hoc reports are not spelled out in advance, and they are not based on a prior report. They require by their nature a different set of skills from regular Agency reporting.

In order for the rest of Medicaid data to be as dependable as cash, someone must be looking at it on a regular basis. Much of the types of information requested in ad hoc reports is different from "cash" in that it is not a hard-and-fast number. The cash balance is a number that agrees to the bank. In contrast, a query about the dollar-value of claims for pregnant mothers is different. That is a set of data that is best described with statistics such as average, quartile, variance, etc. Typically, when looking at ad hoc numbers the purpose is for understanding relationships and trends, often for forecasting. That sort of data gathering and analysis requires different tools, processes, and analyst capabilities. That sort of analysis must be thought through each time, not prepared according to a prescribed method.

[200] Available at: https://www.medicaid.state.ar.us/Download/general/MOBSFY2014.pdf

33.1. An Archetype of a New Approach for Ad-Hoc Reporting

During the past year, the Agency has developed a new tool for ad hoc reporting, the DeComp report. This is different from the Enterprise and Medicaid Data Warehouses in that it is designed to pre-digest the data. It is unique in that it:

- Provides pre-established views into the data. These assure that the data is viewed in a correct manner, that the user does not make a mistake about specifying or reporting
- Has embodied the many rules that a user has to know about in order to report the data. It has taken a year of concerted effort and many generations of work. However, TSG is told that the DeComp now ties to the cash reporting
- Allows pre-established views to be changed as needed. The user interface is Excel, so users comfortable with this ubiquitous tool can adjust the reports
- Provides limited ability to do custom reporting using Excel's pivot table

The DeComp report is a very limited window into Agency data—claims amounts and numbers of beneficiaries. It is not a comprehensive tool for replacing Cognos—in fact it is built on Cognos queries. Rather, TSG showcases it as an example of some aspects of a better ad hoc query tool for the Agency:

Ways in which the DeComp represents a useful path toward better ad hoc data use:

- Based on a tool many people understand: Excel may not be the best tool in the toolbox—but 720 million people use it
- Developed and managed through a process that might be called "chauffer driven". A Northrup Grumman data analyst partnered with the CFO on a near- full time basis over an extended period to develop it. Thus, the long-term, chauffer relationship means the CFO need not develop Cognos ability or deep knowledge of the data—and the data analyst can leverage the CFO's program understanding
- Numbers are proven. Through many iterations, issues with the data and the Cognos queries have been worked out. This cannot be done using a one-off approach to queries
- The data ties to known facts. While this is straightforward in accounting, is a worthy objective is operational performance, health outcomes, etc.

Opportunities for improving upon DeComp as a model:

- DeComp is "owned" by one person. He has a stated objective to make it more generally available. However, as a general approach it reflects and falls victim to the data ownership culture. The CFO also has a "day job". We believe he has the talent to work with systems people to extend the concept into other areas of data—but he already has a job…one which is not necessarily aligned with supporting ad hoc reporting of other types of data.

- Excel is a limited tool for data presentation. That is not what it was designed for. Other tools are less ubiquitous, but more capable as a presentation tool: Qlik and Tableau

33.2.Overall Findings about Ad Hoc Reporting

The Agency has a weak foundation on which to improve ad-hoc reporting to support internal needs, BLR or other agencies. The weaknesses are:

- Regular ad hoc queries are usually due to special projects using outside consultants at high cost and there is not an evidence-based approach to use ad hoc queries internally to look at operational and health outcomes data to develop Agency programs or assess their performance.
- Only a few internal people are chartered with *exploring* data. The Agency lacks a widespread culture demanding regular improvements to the processes of recording and extracting data. As a result, the complicated files are understood by very few people and even fewer people are working to improve the data
- Data resources are outside contractors hired to respond to specific data requests; the Agency lacks sufficient internal capability to conduct ad hoc reporting, and the vendors lack charter to explore the data
- The Agency is prevented by the salary structure from hiring the best data analysts. Instead, it has retained the services of outside consultants. The Agency pays millions of dollars to outside consultants who execute data requests as they are instructed to do. Thus, the Agency has managed their resources in a manner that has limited their ability to develop an Agency-wide interest and ability to deliver ad hoc reports.

33.3.Section 1115 Demonstration Waivers

The following is from the CMS Website:

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

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

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

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

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

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

Public Comments

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

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

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

Therefore, CMS strongly encourages comments to be submitted within the 30-day Federal comment period.

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

Observations about the Rhode Island 1115 Waiver

- The RI Global Waiver covers all Title XIX Medicaid eligible individuals. The State manages one 1115 Waiver with administrative efficiencies. The focus of the original waiver was on providing the right service in the right place; that is in the least restrictive setting. It placed primary emphasis, therefore, on enhancing community based care and providing prevention level of care for seniors that are at risk of institutionalization, so as to decrease reliance on costly nursing facility care. The Waiver also allowed for state flexibility in the administration of the Medicaid program and allowed for more personal responsibility to be implemented in the program.
- There was a 5 year global budget with a spending cap that created a culture of efficiency driving program savings and large Medicaid cost avoidance. The Waiver was approved by CMS on January 16, 2009. Excerpts from the Waiver – specifically the section on Demonstration and Process Flexibility was contained in TSG Status Report # 3 Appendix 11.

33.4.Section 1332 Demonstration Waivers

Section 1332 waivers allow states the option of requesting waivers from certain provisions of the ACA from DHHS and the Treasury Department.

Section 1332 waivers allow for innovative state approaches to the Individual Mandate, Benefits and Subsidies, the Employer Mandate, and Exchanges and Qualified Health Plans (QHPs). States may modify or eliminate the Individual Mandate tax on individuals who fail to maintain health coverage. The rules governing Benefits and Subsidies may be modified regarding what benefits and subsidies must be provided within section 1332 coverage requirements. States may seek to modify or eliminate the Employer Mandate penalty for large employers who fail to offer affordable coverage to their full time employees. States may modify or eliminate Qualified Health Plan certification requirements and the use of the Exchange as the vehicle for determining eligibility for subsidies and enrolling eligible individuals in coverage.

There are as yet undetermined limits, or 'guardrails", on how flexible states will be permitted to be that are identified in the ACA. Under a 1332 waiver states will be required to assure

comparable scope of coverage, comprehensive coverage, affordable coverage, and be budget neutral. States must provide coverage to at least as many individuals who would be provided coverage without a 1332 waiver. The state must provide coverage that is at least as comprehensive as that offered through an Exchange and the proposed 1332 coverage must be certified by the Chief CMS Actuary. Average cost and cost sharing requirements of proposed 1332 coverage must be at "least as affordable" as that provided through an Exchange. State 1332 waiver models must be budget neutral in terms of not resulting in an increase in the Federal Budget.

The final rules and regulations around the design, development, and implementation of Section 1332 Waivers for state innovation are codified in 31 Code of Federal Regulations (CFR) Part 33. The rule states that the Secretary of HHS may authorize a waiver for state innovation that would begin on or after plan year January 1, 2017. The rules clarify that states may choose to submit a single application to HHS under Section 1332, but the state may also choose to submit its 1332 Waiver in coordination with and under one or more of the existing waiver processes applicable under titles XVII, XIX, and XXI of the Social Security Act. Section 1332 waivers must be submitted to DHHS/Treasury in electronic format. Upon receipt DHHS begins a review of the application package for completeness, which must be completed within 45 days of submission. Once HHS has determined that the application is indeed complete, a 180 day public comment period will ensue.

Section 31 CFR Part 33 identifies the following conditions as documentation of completeness:

- Written evidence of the state's compliance with the public notice requirements set forth in 31 CFR Part 33; public hearings need to take place before submission of the 1332 waiver application
- A comprehensive description of the state legislation and program to implement a plan meeting the requirements of a waiver under Section 1332
- A copy of the enacted state legislation that provides the state with the authority to implement the proposed waiver
- A list of the provisions of the law that the state seeks to waive, including a description of the reason for the specific requests
- The analyses, actuarial certifications, data and assumptions are provided to the Secretary

Supporting documentation includes:

- Actuarial analysis/certification Compliance confirmation
- Economic analysis Impact on population
- 10-year budget plan Key assumptions
- Impact on Arkansas market

Additional application information includes:

- Administrative Burden
- Out-of-State Health Care Services
- Impact on Non-Waiver Provisions
- State Reporting
- Waste, Fraud, and Abuse

Federal Public Notice and Approval Process: The final federal decision on the approval of the 1332 waiver application will come no later than 180 days after the HHS determination of a complete application (clock starts when HHS determines a complete application).

SECTION 4: GLOSSARY

The following provides a look-up of the key terms used in this report, and in the discussions that have taken place during the TSG assessment project.

AARP	American Association of Retired Persons
ABD	Aged, Blind and Disabled programs and beneficiaries
ACA (or PPACA)	Patient Protection and Affordable Care Act of 2010
ACEP	American College of Emergency Physicians
ACHE	American College of Healthcare Executives (ACHE) an international professional society of 30,000 healthcare executives who lead our nation's hospitals, healthcare systems, and other healthcare organizations
ACO	Accountable Care Organization
Actuarially Sound	The federal statutory standard to which capitation payments made by state Medicaid programs under risk contracts to managed care organizations (MCOs) are held. See Capitation Payment, MCO, Risk Contract.
ADA	American Dental Association (ADA) is a professional association of dentists committed to the public's oral health, ethics, science and professional advancement.
ADA	The Americans with Disabilities Act (ADA) is a wide-ranging civil rights law that prohibits discrimination based on disability. It is similar to the Civil Rights Act of 1964, which makes it illegal to discriminate because of race, sex, religion, national origin and other characteristics.
ADC	Adult Day Care (ADC) provides daily structured programs in a community setting, with activities plus health-related and rehabilitation services for older adults who are physically or emotionally disabled and need a protective environment. Care is provided during daytime hours and the individual returns to his or her home for the night. Adult day care is offered at a special facility or as a service of another type of care facility, such as a nursing home or assisted living residence.
ADHD	Attention Deficit Hyperactivity Disorder
ADRC	Aging and Disability Resource Centers
ADS	Alternate Delivery System (ADS) health services that are more cost-effective than inpatient, acute-care hospitals, such as skilled and intermediary nursing facilities, hospice programs and in-home services.
AFDC	Aid to Families with Dependent Children (AFDC) is a program administered and funded by Federal and State governments to provide financial assistance to needy families. In an average state, more than half (55 percent) of the total cost of AFDC payments are funded by the Federal government. The States provide the balance of these payments, manage the program and determine who receives benefits and how much they get.
AFMC	Arkansas Foundation for Medical Care
AHCPII	Arkansas Health Care Payment Improvement Initiative
AHRQ	Agency for Healthcare Research and Quality
AIPP	Arkansas Innovative Performance Program

AL	Assisted Living Waiver
ALOS	Average Length of Stay (ALOS) in hospitals it is calculated by dividing the sum of inpatient days by the number of patients within the diagnosis-related group category. Inpatient days are calculated by subtracting day of admission from day of discharge, so persons entering and leaving a hospital on the same day have a length of stay of zero.
AMA	The American Medical Association (
AMP	Average Manufacturer Price. The average price paid to a drug manufacturer in the U.S. by wholesalers for drugs distributed to retail pharmacies. Used in calculating the amount of the rebate participating manufacturers are required to pay on covered outpatient drugs purchased by state Medicaid programs.
APCs	Ambulatory Payment Classifications
APDU	Advanced Planning Directive
APHSA	American Public Health Services Association. The National Collaboration leadership and membership including state and local government health and human services leaders
APR-DRG	All Patient Refined - Diagnosis Related Groups. Has a much more rigorous and refined severity adjustment compared to DRG
AR	Accounts Receivable (AR) is the area that funds are paid to reimburse Medicaid.
ARRA	American Recovery and Reinvestment Act
ARS	Automated Response System
ASC	An Ambulatory Surgical Center (ASC) is a licensed facility that is used mainly for performing outpatient surgery, has a staff of physicians, has continuous physician and nursing care by registered nurses and does not provide for overnight stays.
ASH	Arkansas State Hospital
AWP	Any Willing Provider
BBA	The Balanced Budget Act (BBA) signed into law by the President on Aug. 5, 1997 contains the largest reductions in federal Medicaid spending in Medicaid since 1981. The legislation is projected to achieve gross federal Medicaid savings of $17 billion over the next five years and $61.4 billion over the next ten years.
BCBS	Blue Cross Blue Shield of Arkansas
Beneficiary	An individual who is eligible for and enrolled in the Medicaid program in the state in which he or she resides. Millions of individuals are eligible for Medicaid but not enrolled and are therefore not program beneficiaries.
Best Price	The lowest price on a prescription drug available from a manufacturer to any wholesaler, retail pharmacy, provider, or managed care organization, subject to certain exceptions. Used in calculating the amount of the rebate participating manufacturers are required to pay on covered outpatient drugs (other than generic drugs) purchased by state Medicaid programs.
BIP	Balancing Initiatives Program
BKD	CPA firm that provides audit tax and consulting services in Little Rock
BLR	Arkansas' Bureau of Legislative Research
Boren Amendment	The requirement in federal Medicaid law from 1980 until 1997 that states pay for inpatient hospital and nursing facility services using rates that are “reasonable and

	adequate" to meet the costs that must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with federal and state quality and safety standards.
BPM	Business Process Management
BPR	Business process reengineering
CABG	Coronary artery bypass graft. A form of bypass surgery
CAH	Critical Access Hospital (CAH) a rural limited medical services hospital that provides short-term inpatient and emergency hospital services.
CAI	Computer Aid Inc. Independent Verification and Validation Vendor
Caid/Care	Caid-Care, Inc. Specializes in assisting families with placement into Managed Home Care Services facilities
CANS	Child and Adolescent Needs and Strengths Assessment instrument. Developed by J. Lyons. MD; open domain; copyright held by Buddin Praed Foundation
CAP	Corrective Action Plan (CAP) documentation for implementing activities structured to remedy a problem, and what will happen if the problem is not resolved. Includes a specific time frame for the remedy to be implemented.
Capitation Payment	A payment made by a state Medicaid agency under a risk contract, generally to a managed care organization (MCO). The payment is made on a monthly basis at a fixed amount on behalf of each Medicaid beneficiary enrolled in the MCO. In exchange for the capitation payment, the MCO agrees to provide (or arrange for the provision of) services covered under the contract with the state Medicaid agency to enrolled Medicaid beneficiaries. See fee-for-service, MCO, Risk Contract.
CARES	Comprehensive Adult Resources Evaluation System. Preadmission assessment of strengths and needs of individuals at risk for institutional settings, plan of care, expanded case management capabilities
Carve Out	The term used to describe the exclusion of certain services to which Medicaid beneficiaries are entitled from a risk contract between a state Medicaid agency and an MCO
Categorical Eligibility	A phrase describing Medicaid's policy of restricting eligibility to individuals in certain groups or categories, such as children, the aged, or individuals with disabilities. Certain categories of individuals
Categorically Needy	A phrase describing certain groups of Medicaid beneficiaries who qualify for the basic mandatory package of Medicaid benefits. For example, Arkansas Medicaid is required to cover pregnant women and infants with incomes at or below 133 percent of the Federal Poverty Level (FPL)
CBO	Community Based Organizations for services such as training, finding and accessing members in need, home visits and traditional waiver services
CCD	Continuity of Care Document (CCD) is a spreadsheet-based document containing the encoding, structure and semantics of a patient's clinical summary document for exchange.
CCM	Certified Case Manager
CCNC	Community Care North Carolina
CCO	Coordinated Care Organizations
CDC	US Centers for Disease Control and Prevention

CDT	The Current Dental Terminology (CDT) is a publication copyrighted by the American Dental Association (ADA) that lists codes for billing for dental procedures and supplies. The CDT is included in HCPCS level II.
Center for Medicaid and State Operations (CMSO)	The agency within the Centers for Medicare and Medicaid Services (CMS) with responsibility for administering Medicaid and the Children's Health Insurance Program (SCHIP).
Centers for Medicare and Medicaid Services (CMS)	The agency in the Department of Health and Human Services with responsibility for administering the Medicaid, Medicare, and State Children's Health Insurance programs at the federal level. Formerly known as the Health Care Financing Administration (HCFA).
CFCO	Community First Choice Option is a Medicaid-funded program that could provide a broad range of home and community-based services and supports for elders
CFO	Chief Financial Office
CFR	Code of Federal Regulations
CG	Class Group Code required on the Medicaid claim form.
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) a federally funded health program that provides beneficiaries with medical care supplemental to that available in military and Public Health Service (PHS) facilities.
Children's Health Insurance Program (SCHIP)	Enacted in the 1997 Balanced Budget Act as Title XXI of the Social Security Act, SCHIP is a federal-state matching program of health care coverage for uninsured low-income children. In contrast to Medicaid, SCHIP is a block grant to the states; eligible low-income children have no individual entitlement to a minimum package of health care benefits
CHIP	The Children's Health Insurance Program (CHIP) is a joint federal and state program that provides health insurance coverage to low-income uninsured children.
CHIRPA	Comprehensive Health Insurance Risk Pool Association
CIM	Carrier Information Module (CIM) data on insurance companies with whom Medicaid beneficiaries have medical coverage.
CISR	MIT's Center for Information Systems Research
Civil Money Penalty (CMP)	An intermediate sanction (i.e., less drastic than exclusion from participation in the program) applied to participating providers and managed care plans that are found to have engaged in program fraud or have violated certain program requirements.
CLIA	Clinical Laboratory Improvement Congress passed the Clinical Laboratory Improvement Amendments (CLIA) in 1988 establishing quality standards for all laboratory testing to ensure the accuracy, reliability and timeliness of patient test results regardless of where the test was performed. Centers for Medicare & Medicaid Services (CMS) assumes primary responsibility for financial management operations of the CLIA program.
CMHC	Community Mental Health Center (CMHC) a comprehensive mental health center which provides outpatient therapy and emergency mental health services.
CMMI	Center for Medicare and Medicaid Innovation, part of CMS
CMN	Certificate of Medical Necessity (CMN) a form required by Medicare authorizing the use of certain medical services and equipment prescribed by a physician.

CMS	Center for Medicare and Medicaid Services is the federal agency which administers the Medicare program and works in partnership with the States to administer Medicaid, the State Children's Health Insurance Program (SCHIP), and health insurance portability standards. In addition to these programs, CMS has other responsibilities, including the administrative simplification standards for the Health Insurance Portability and Accountability Act of 1996 (HIPPA), quality standards in health care facilities through its survey and certification activity, and clinical laboratory quality standards.
CMS 1500	Form prescribed by CMS for the Medicare program for claims from physicians and suppliers, except for ambulance services
CMSA	Case Management Society of America
CNP or NP	Certified Nurse Practitioner (CNP) is a registered nurse (RN) who has completed an advanced training program in a medical specialty such as pediatrics or internal medicine
COB	Coordination of Benefits (COB) a common provision in most benefit plans. It applies when a member has more than one health coverage plan in effect at the time services are rendered.
COBRA	Consolidated Omnibus Budget Reconciliation Act of 1985 a federal law, enforced by the US Department of Labor, Pension and Welfare Benefits Administration, which provides continuation of group health coverage that otherwise might be terminated. The law contains provisions giving certain former employees, retirees, spouses and dependent children the right to temporary continuation of health coverage at group rates.
Comparability	A rule of Medicaid benefits design that requires a state to offer services in the same amount, duration, and scope to one group of categorically needy individuals (e.g., poverty-related children) as it offers to another group of categorically needy individuals (e.g., elderly SSI recipients). See Amount, Duration, and Scope; Categorically Needy.
Continuous Eligibility	An option available to states under federal Medicaid law whereby children enrolled in Medicaid may remain eligible for a continuous period of 12 months, regardless of intervening changes in family income or status.
Copayment	A fixed dollar amount paid by a Medicaid beneficiary at the time of receiving a covered service from a participating provider. Copayments, like other forms of beneficiary cost-sharing (e.g., deductibles, coinsurance), may be imposed by state Medicaid programs only upon certain groups of beneficiaries, only with respect to certain services, and only in nominal amounts as specified in federal regulation.
COPD	Chronic Obstructive Pulmonary Disease
COS	Category of Service (COS) code required on the Medicaid claim form.
CPS	Child Protective Services
CPT	Current Procedural Terminology (CPT) book contains codes approved for use by medical providers to request payment for a particular medical service.
CQM	Clinical Quality Measures
CR	Carrier Term (CT) applied to a medical insurance company with who a Medicaid beneficiary has coverage.
CRBA	Consular Report of Birth Abroad

CRH	Center for Rural Health
CRNA	Certified Registered Nurse Anesthetist an advanced practice nurse who administers anesthesia.
CRRN	Certified Rehabilitation Registered Nurse
CSA	See CMSA
CSR	Computer System Request (CSR) the means by which requests from authorized Medicaid staff for enhancements and modifications to the MMIS are submitted to the Fiscal Agent.
CSR	Cost-Sharing Reduction: advance payments made by Private Option members (akin to co-pay)
DAAS	Division of Aging and Adult Services
DAC	Disabled Adult Child
DBHS	Arkansas Division of Behavioral Health Services
DCLH	Disabled Child Living at Home (DCLH), better known as the Katie Beckett Program, the Disabled Child Living at Home is a special program where children who do not meet eligibility for other Medicaid programs due to their parents' high income or assets can qualify for Medicaid if the child meets certain defined criteria.
DD	Developmentally Disabled
DDS	Developmentally Disabled Services
DDTC	Developmental Day Treatment Clinic
DDTCS	Developmental Day Treatment Clinic Services
De-Linking	The informal term used to refer to breaking the historic link between eligibility for cash assistance under Aid to Families with Dependent Children (AFDC) and eligibility for Medicaid. The process of de-linking began in the mid-1980s with the enactment of optional eligibility groups of poverty-related pregnant women and children and continued with the repeal of the AFDC program in 1996 and the enactment of a new section 1931 eligibility group. See Poverty-Related, Section 1931.
Departmental Appeals Board (DAB)	The agency within the Department of Health and Human Services that adjudicates disputes between CMS and state Medicaid agencies regarding disallowances of federal matching payments and hears appeals of CMS or OIG decisions to impose civil money penalties or exclusions on providers.
DERP	Drug Effectiveness Review Project
DHA	Delta Health Alliance
DHB	North Carolina Division of Health Benefits
DHCF	Department of Health Care Finance (DHCF), formerly the Medical Assistance Administration under the Department of Health, is the District of Columbia's state Medicaid agency
DHH	Department of Health & Hospitals, State of Louisiana
DHHS	U.S. Department of Health and Human Services
DHS	Arkansas Department of Human Services
DHS/DBHDS	Virginia Behavioral Health and Development Services

Disallowance	A determination by CMS not to provide federal Medicaid matching payments to a state in connection with an expenditure made by the state's Medicaid program because the expenditure does not meet federal requirements for matching payments. States may appeal CMS disallowances to the Departmental Appeals Board (DAB) and to federal court. See Departmental Appeals Board. Disregards
Disproportionate Share Hospital (DSH) Payments	Payments made by a state's Medicaid program to hospitals that the state designates as serving a "disproportionate share" of low-income or uninsured patients. These payments are in addition to the regular payments such hospitals receive for providing inpatient care to Medicaid beneficiaries. States have some discretion in determining which hospitals qualify for DSH payments and how much they receive. The amount of federal matching funds that a state can use to make payments to DSH hospitals in any given year is capped at an amount specified in the federal Medicaid statute.
DME	Durable Medical Equipment (DME) is equipment that can be used over and over again; is ordinarily used for medical purposes; and is generally not useful to a person who isn't sick, injured or disabled.
DMH	Department of Mental Health
DMS	Arkansas Division of Medicaid Services, Office of Long Term Care
DMS/OLTC	Arkansas Division of Medicaid Services
DMV	Arkansas Department of Motor Vehicles
DO	Doctor of Osteopathy is a doctor with a degree in osteopathy which is therapy based on the assumption that restoring health is best accomplished by manipulating the skeleton and muscles.
DOB	Date of Birth
DOD	Date of Death, the date upon which a person's death occurs.
DOE	Date of Eligibility
DOH	Arkansas Department of Health
DOI	Department of Insurance responsible for admitting, licensing, and regulating insurance companies as well as regulating the various kinds of insurance sold in the state, in addition to the companies and agents selling it.
DOS	Date of Service, is the date a beneficiary received a medical service.
DRA	Deficit Reduction Act of 2005
DRG	Diagnosis Related Groups, is a system of classification of diagnoses and procedures based on the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM).
Drug Use Review (DUR)	The program of prospective and retrospective review of prescriptions paid for by a state Medicaid program that each state is required to conduct in order to ensure that prescriptions are appropriate, medically necessary, and not likely to result in adverse medical outcomes.
DSH	See Disproportionate Share Hospital Payments
DSRIP	Delivery System Reform Incentive Payment
DSS	Decision Support System
Dual Eligibles	A term used to describe an individual who is eligible both for Medicare and for full Medicaid coverage, including nursing home services and prescription drugs, as well

	as for payment of Medicare premiums, deductibles, and co-insurance. Some Medicare beneficiaries are eligible for Medicaid payments for some or all of their Medicare premiums, deductibles, and co-insurance requirements, but not for Medicaid nursing home or prescription drug benefits.
DUR	Drug Utilization Review Board a quality assurance body which seeks to assure appropriate drug therapy to include optimal patient outcomes and appropriate education for physicians, pharmacists, and the patient
E&D	Elderly and Disabled
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services	One of the services that states are required to include in their basic benefits package for all Medicaid-eligible children under age 21. EPSDT services include periodic screenings to identify physical and mental conditions as well as vision, hearing, and dental problems. EPSDT services also include follow-up diagnostic and treatment services to correct conditions identified during a screening, without regard to whether the state Medicaid plan covers those services with respect to adult beneficiaries.
ED	Emergency Department, Emergency Room
EDI	Electronic Data Interchange is the electronic transmission of structured data between organizations.
EEF	Arkansas Eligibility & Enrollment Framework, a project to develop a new eligibility processing system
EFT	Electronic Funds Transfer is the transfer of money initiated through electronic terminal, automated teller machine, computer, telephone or magnetic tape.
EHR	Electronic Health Records
EMR	Electronic Medical Records
Enrollment Broker	The term used to describe an organization, usually a private entity, that contracts with a state Medicaid agency to inform Medicaid beneficiaries about, enroll them in, and disenroll them from MCOs and PCCMs participating in the state's Medicaid program.
Entitlement	A program that imposes a legal obligation on the federal government to any person, business, or unit of government that meets the criteria set in law.
EOB	Explanation of Benefits (EOB) statement of the action taken on claims filed by medical providers for services rendered for the treatment of a patient.
EOC	Episodes of Care
EOMB	Explanation of Medicaid Benefits (EOMB) statement sent to a Medicaid beneficiary detailing services submitted/action taken on claims filed by Medicaid providers for services rendered to a Medicaid beneficiary.
EPO	Exclusive Provider Organization (EPO) limited healthcare provision: a health insurance plan that will reimburse the insured only for care received from particular providers.
ePrescribing	Electronic Prescribing, entails the process of electronically transmitting an error-free prescription from a prescriber to a pharmacy for fulfillment.
EPSDT	See Early and Periodic Screening, Diagnosis and Treatment
EQRO	See External Quality Review Organization
ER	Emergency Room (ER), is a room in a hospital or clinic staffed and equipped to provide emergency care to persons requiring immediate medical treatment.

Error Rates	Refers to the percentage of Medicaid payments made by a state on the basis of erroneous Medicaid eligibility determinations. For this purpose, an error occurs when an individual who is not in fact eligible is incorrectly enrolled in the program and a payment is made on that individual's behalf to a provider or plan. States are subject to the loss of federal Medicaid matching funds if their "error rate"
ESC	Electronic Submission Claims a claim that is submitted via electronic media.
ESDPT	mandated child health component of Medicaid
Estate Recovery	The requirement that state Medicaid programs seek to collect from the estate of a deceased Medicaid beneficiary the amounts paid on the individual's behalf for nursing facility services, home and community-based services, and related hospital and prescription drug services.
Exclusion	A sanction imposed upon providers or managed care plans for certain fraudulent conduct, usually by the Office of Inspector General (OIG) or a state Medicaid fraud control unit (MFCU). An excluded provider or plan may not receive Medicaid reimbursement during the period of exclusion, which varies with the nature and severity of the offense. See MFCU, OIG.
External Quality Review Organization (EQRO)	A private entity that conducts the required annual, external independent reviews of the quality and accessibility of services for which state Medicaid agencies have entered into risk contracts with Medicaid MCOs. See MCO, Risk Contract.
F&A	Fraud and Abuse
FA	Fiscal Agent
Fair Hearing	Because Medicaid is an entitlement, individuals have a statutory right to appeal denials or terminations of Medicaid benefits to an independent arbiter. The fair hearing is the administrative procedure that provides this independent review with respect to individuals who apply for Medicaid and are denied enrollment, individuals enrolled in Medicaid whose enrollment is terminated, and Medicaid beneficiaries who are denied a covered benefit or service.
FDA	The Food and Drug Administration (FDA) agency of the Public Health Service division of the U.S. Department of Health and Human Services is charged with protecting public health by ensuring that foods are safe and pure, cosmetics and other chemical substances harmless and products safe, effective and honestly labeled.
Federal Financial Participation (FFP)	The technical term for federal Medicaid matching funds paid to states for allowable expenditures for Medicaid services or administrative costs. States receive FFP for expenditures for services at different rates, or FMAPs, depending on their per capita incomes. FFP for administrative expenditures also varies in its rate, depending upon the type of administrative cost. See FMAP.
Federal Medical Assistance Percentage (FMAP)	The statutory term for the federal Medicaid matching rate
Federal Poverty Level (FPL)	The federal government's working definition of poverty that is used as the reference point for the income standard for Medicaid eligibility for certain

	categories of beneficiaries. Adjusted annually for inflation and published by the Department of Health and Human Services in the form of Poverty Guidelines.
Federally Qualified Health Center (FQHC)	Primary care and other ambulatory care services provided by community health centers and migrant health centers funded under section 330 of the Public Health Service Act, as well as by "look alike" clinics that meet the requirements for federal funding but do not actually receive federal grant funds. FQHC status also applies to health programs operated by Indian tribes and tribal organizations or by urban Indian organizations.States are required to include services provided by FQHCs in their basic Medicaid benefits package.
Fee-For-Service	A traditional method of paying for medical services under which doctors and hospitals are paid for each service they provide. Bills are either paid by the patient who then submits them to the insurance company or are submitted by the provider to the patient's insurance carrier for reimbursement.
FFM	Federally-Facilitated Marketplace (FFM). Implementation of ACA in states that have chosen not to build their own Marketplace
FFP	Federal Financial Participation. The federal government pays states for a specified percentage of program expenditures, called the Federal Medical Assistance Percentage (FMAP).
FFS	Fee for Service (FFS) pertaining to the charging of fees for specific services rendered in health care, as distinguished from participating in a prepaid medical practice.
FHA	Federal Health Architecture (FHA), an E-Government Line of Business initiative managed by the Office of the National Coordinator for Health IT. FHA was formed to coordinate health IT activities among the more than 20 Federal Agencies that provide health and healthcare services to citizens.
Financial Eligibility	In order to qualify for Medicaid, an individual must meet both categorical and financial eligibility requirements. Financial eligibility requirements vary from state to state and from category to category, but they generally include limits on the amount of income and the amount of resources an individual is allowed to have in order to qualify for coverage.
FMAP	Federal Medical Assistance Percentage. The percentage rates used to determine the matching funds rate allocated annually to certain medical and social service programs
FNP	Family Nurse Practitioner
Formulary	States that elect to cover prescription drugs in their Medicaid programs may limit the drug products covered through the use of a formulary, a listing of the specific drugs for which a state will make payment without prior authorization. States may exclude from their formularies specific drugs of manufacturers participating in the Medicaid rebate programs only if certain criteria are met and only if the excluded drug is made available through a prior authorization program.
FPL	Federal Poverty Level
FPW	Family Planning Waiver (FPW) a Medicaid program for women 15-44 years of age that covers selected family planning services and supplies.
FQHC	Federally Qualified Health Clinic (FQHC) is a center that provides health care to a medically under-served populations.
FTE	Full Time Equivalent. Measure of staffing

FY	Fiscal Year
GDIT	General Dynamics Information Technology
GF	General Fund
GINA	Genetic Information Nondiscrimination Act of 2008
GMLOS	Geometric Mean Length of Stay
GUI	Graphical User Interface
H/HS	Health and Human Services
HBE	Health Benefit Exchange
HCBC	Home and Community Based Care
HCBS	Home and Community Based Services provides individualized assistance with daily living activities to people with disabilities through Medicaid's optional personal care services program.
HCIA	Health Care Improvement Act
HCIP	Health Communications Internship Program
HCPCS	The Healthcare Common Procedure Coding System (HCPCS) is the required code set for substances, equipment, supplies and other items used in health care.
HCPII	Arkansas Health Care Payment Improvement Initiative
HDS	Health Data System
Health Insurance Portability and Accountability Act of 1996 (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, which requires each state's Medicaid management information system (MMIS) to have the capacity to exchange data with the Medicare program and contains "Administrative Simplification" provisions that require state Medicaid programs to use standard, national codes for electronic transactions relating to the processing of health claims.
HEDIS	Healthcare Effectiveness Data and Information Set. A tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service
HEIDIS	Health Plan Employer Data and Information Set
HH	Home Health (HH) services cover a broad range of services including: high tech pharmacy services, skilled professional and paraprofessional services, custodial care, and medical equipment provided or delivered to the home.
HHA	A Home Health Agency (HHA) is a public or private agency that provides skilled nursing care, physical therapy, speech therapy and other therapeutic services in the patient's home.
HHS	The Department of Health and Human Services (HHS) is the United States department that administers all federal programs dealing with health and welfare.
HHSC	Health and Human Services Hierarchical Condition Categories risk adjustment model
HIC	Hierarchical Ingredient Code ("HIC") was created by First Data Bank. The HIC is a 6-character code that identifies the drug
HIPAA	The Health Insurance Portability and Accountability Act of 1996
HIT	Health Information Technology

HITECH	The Health Information Technology for Economic and Clinical Health Act, enacted as part of the American Recovery and Reinvestment Act of 2009
HMA	Health Management Associates
HMO	A Health Management Organization (HMO) is group insurance that entitles members to services of participating hospitals and clinics and physicians.
Home- and Community-Based Services (HCBS) Waiver	Also known as the "1915(c) waiver" after the enabling section in the Social Security Act, this waiver authorizes by CMS in order to ensure that the facilities meet quality requirements and that the surveys of these facilities conducted by state survey agencies are adequate.
HRSA	The Health Resources Services Administration (HRSA) is a research grant to collect and analyze data that describe the characteristics of the uninsured.
HSP	Hospice (HSP) used in terminology associated with beneficiary's lock in segment for Home and Community Based Services.
IAPD	Implementation Advance Planning Document
ICD	International Classification of Diseases
ICD-10	International Classification of Diseases, tenth revision
ICD-9-CM	International Classification of Diseases Ninth Edition Clinical Modification
ICF	An Intermediate Care Facility is a health care facility that provides care and services to individuals who do not need skilled nursing care, but whose mental or physical condition requires more than custodial care and services in an institutional setting.
ICF/ID	Institutional Care Facilities for Intermediate care
ICF/MR	Intermediate Care Facilities for the Mentally Retarded or related conditions provides twenty-four hour supervision and training, and is regulated through requirements established by Medicaid.
ICN	An Internal Control Number (CN) is a unique identifier for a claim line assigned by the MMIS.
ICU	An Intensive Care Unit (ICU) is a hospital unit staffed and equipped to provide intensive care.
ID/DD	Intellectual Disabilities/ Developmental Disabilities Waiver
IDEA	Individuals with Disabilities Education Act (IDEA) is the federal law which safeguards a child with a disability's right to a free and appropriate public education.
IEP	An Individualized Education Plan (IEP) is a written document that outlines a child's education. As the name implies, the educational program should be tailored to the individual student to provide maximum educational benefit.
IFSP	Individualized Family Service Plan see EI/TCM
IHE	Integration the Healthcare Enterprise (IHE) is an initiative by healthcare professionals and industry to improve the way computer systems in healthcare share information. IHE promotes the coordinated use of established standards such as DICOIM and HL7 to address specific clinical needs in support of optimal patient care.
IHS	Indian Health Services
IP	Inpatient is a term for patients who receives lodging and food, as well as treatment, in a hospital or an infirmary.
IT	Information Technology

IV&V	Independent Verification and Validation
IV-E	Federal foster care program
IWG	Interagency Working Group
JCHO	The Joint Commission on Accreditation of Healthcare Organizations (JCHO) is the predominant health care standards-setting and accrediting organization in the U.S. Their mission is to continually improve the safety and quality of patient care by providing accreditation, education and consultation services.
LBO	Legislative Budget Office
LCSW	Licensed Certified Social Worker (LCSW) individuals having an education that includes a Masters degree in social work (M.S.W.) and post M.S.W. supervised experience in clinical social work.
LOCUS	Level of Care Utilization System Assessment instrument: American Association of Community Psychiatrists
LOS	Length of Stay (LOS) is calculated by dividing the sum of inpatient days by the number of patients within the DRG category.
LPN	Licensed Practical Nurse
LTC	Long Term Care (LTC) includes any chronic or disabling condition which requires nursing care or constant supervision.
LTSS	Medicaid Managed Long Term Services and Supports
MAGI	Modified Adjusted Gross Income
Managed Care Entity (MCE)	The federal statutory term for a managed care plan participating in Medicaid. There are two types of MCEs: managed care organizations (MCOs) and primary care case managers (PCCMs). MCEs may be public or private.
Managed Care Organization (MCO)	An MCO is an entity that has entered into a risk contract with a state Medicaid agency to provide a specified package of benefits to Medicaid enrollees in exchange for an actuarially sound monthly capitation payment on behalf of each enrollee. See Actuarially Sound, Capitation Payment and Risk Contract.
Mandatory	State participation in the Medicaid program is voluntary. However, if a state elects to participate, as all do, the state must at a minimum offer coverage for certain services to certain populations. These eligibility groups and services are referred to as “mandatory” in order to distinguish them from the eligibility groups and services that a state may, at its option, cover with federal Medicaid matching funds. See Optional.
MAO	Medical Assistance Only (MAO) is medical assistance for Aged or Disabled Medicaid beneficiaries residing in nursing facilities who pay part of the cost of their care with Medicaid paying the remaining amount.
MARS	Management and Administrative Reporting Subsystem
MCO	See Managed Care Organization
MD	A physician, medical doctor
Means Testing	The policy of basing eligibility for benefits upon an individual’s lack of means, as measured by his or her income or resources. Means testing by definition requires the disclosure of personal financial information by an applicant as a condition of eligibility.

Medicaid Fraud Control Unit (MFCU)	A state agency independent of the state Medicaid agency responsible for investigating and prosecuting fraud and patient neglect and abuse under state law.
Medicaid Management Information System (MMIS)	A state's computer systems for tracking Medicaid enrollment, claims processing, and payment information.
Medical Assistance	The term used in the federal Medicaid statute (Title XIX of the Social Security Act) to refer to payment for items and services covered under a state's Medicaid program on behalf of individuals eligible for benefits.
Medically Needy	A term used to describe an optional Medicaid eligibility group made up of individuals who qualify for coverage because of high medical expenses, commonly hospital or nursing home care. These individuals meet Medicaid's categorical requirements
Medicare Buy-in	The informal term referring to the payment of Medicare Part B premiums on behalf of low income Medicare beneficiaries who qualify for full Medicaid coverage (dual eligibles) or just for assistance with Medicare premiums and cost-sharing (Qualified Medicare Beneficiary, Specified Low-Income Beneficiaries, and Qualifying Individual).
MEDS/MEDSX	Medicaid Eligibility Determination System Expansion
MEDX	Medical Electronic Data Exchange
MEHRS/eScript	Medicaid Electronic Health Records System and ePrescribing System
MES	Medicaid Enterprise Solution
Methodology	The rules that a state uses in counting an individual's income or resources in determining whether he or she meets its Medicaid eligibility standards. For certain eligibility categories, states have the flexibility to disregard some or all of an individual's income and resources in determining whether the individual qualifies for Medicaid. See Disregards, Standard.
MFCU	The Medicaid Fraud Control Unit (MFCU) is the law enforcement agency under the State Attorney General staffed by attorneys, auditors, and investigators trained in the complex subject of health care fraud. The Unit shares pertinent information with other state and federal agencies so that appropriate administrative sanctions can be implemented against health care providers who abuse the Medicaid program or residents of health care facilities.
MFP	Money Follows the Person. The Money Follows the Person (MFP) Rebalancing Demonstration Grant helps states rebalance their Medicaid long-term care systems
MID	Medicaid Id Number
MITA	Medicaid Information Technology Architecture (MITA) initiative is a national framework designed to support improved systems development and healthcare management for the Medicaid enterprise.
MLR	Medical Loss Ratio. Method the Affordable Care Act uses to restrict administrative costs of insurance carriers
MLTSS	Managed Long Term Services and Supports, see LTSS
MMA	The Medicare Modernization Act (MMA) calls for Medicare to pay for two drugs in each therapeutic class.

MMIS	The Medicaid Management Information Systems (MMIS) is the data files, computer systems and computer subsystems which handle the electronic administration processes of the Medicaid program.
MN	Medical Necessity (MN) or Medically Necessary Analysis determines appropriateness of services rendered to ensure quality of care.
MNR	Medical Necessity Referral (MNR) is a nurse who has enough training to be licensed by a state to provide routine care for the sick.
MR/DD	Mental Retardation and/or Developmental Disabilities (MR/DD) legislation granted the Secretary of the United States Department of Health and Human Services (DHHS) authority to waive federal regulations that previously limited Medicaid reimbursement to institutional long-term care settings. No other change in federal law to date surpasses this legislation in terms of its significance for reforming the delivery of long-term care services.
MS	Medical Supply (MS) are goods and equipment utilized for the treatment and care of persons with an illness, disease or disability.
MS-DRG	Medicare's MS-DRG Version 31
MTM	Medical Transportation Management
NAAC	Net Average Allowable Costs
NAMI	National Alliance for the Mentally Ill (NAMI) is a nonprofit, grassroots, self-help, support and advocacy organization of consumers, families and friends of people with severe mental illnesses
NASMD	National Association of State Medicaid Directors (NASMD) is a bipartisan, professional, nonprofit organization of representatives of state Medicaid agencies
NASUAD	National Association of States United for Aging and Disabilities
NDC	The National Drug Code (NDC) system was originally established as an essential part of an out-of-hospital drug reimbursement program under Medicare. The NDC serves as a universal product identifier for human drugs.
NEMT	Non-Emergency Medical Transportation
NET	Non-Emergency Transportation is prearranged transportation provided for medical appointments.
NF	A Nursing Facility (NF) is a nursing home which provides nursing and/or rehabilitation services to patients who need medical care that cannot be provided in the patient's home.
NHQR	National Healthcare Quality & Disparities Reports
NIST	National Institute of Standards Technology
NP	A Nurse Practitioner (NP) is a registered nurse who has received special training and can perform many of the duties of a physician.
NPI	National Provider Identifier
NPS	National Prevention Strategy, a CMS program
NQS	National Quality Strategy, a CMS program
NSAIDs	Nonsteroidal anti-inflammatory drugs (NSAIDs) drugs used to treat inflammation
NWI	National Workgroup on Integration, American Public Human Services Association

O&P	Orthotics and Prosthetics (O&P) is the surgical or dental specialty concerned with the design, construction and fitting of an artificial device to replace a missing part of the body or to support or brace weak or ineffective joints or muscles.
OBRA	On Nov. 5, 1990 the President signed into law the Omnibus Budget Reconciliation Act of 1990 (OBRA 90), P.L. 101-508.
ODD	Oppositional Defiant Disorder, one of the Episodes of Care
Office for Civil Rights (OCR)	The agency within the Department of Health and Human Services with responsibility for monitoring and enforcing compliance with federal anti-discrimination laws by providers and managed care entities participating in Medicaid as well as state Medicaid agencies and their contractors.
Office of Inspector General (OIG)	The agency within the Department of Health and Human Services with responsibility for monitoring and enforcing compliance with federal fraud and abuse laws by providers and managed care entities participating in Medicaid.
OIG	The Office of the Inspector General is the investigative arm of the Federal Trade Commission.
OLTC	Arkansas Office of Long Term Care
OMIG	Arkansas Medicaid Inspector General's Office
ONC	The Office of the National Coordinator of Health Information Technology (ONC) is an office under the U.S. Department of Health and Human Services established as part of the HITECH Act of 2009 to support the adoption of health information technology to improve healthcare.
OP	A hospital Out Patient (OP) is a patient who receives treatment, in a hospital or an infirmary but no lodging and food.
Optional	The term used to describe Medicaid eligibility groups or service categories that states may cover if they so choose and for which they may receive federal Medicaid matching payments at their regular matching rate, or FMAP. About two thirds of all federal Medicaid funds are used to match the cost of optional services for mandatory or optional groups and all services for optional populations.
OSHA	Occupational Safety and Health Act is a government agency in the Department of Labor to maintain a safe and healthy work environment.
OSP	Arkansas Office of State Procurement
P&T	The Pharmacy & Therapeutics (P&T) Committee conducts in-depth evaluations of available drugs and recommend appropriate drugs for preferred status and makes recommendations to the Medicaid Executive Director regarding prior authorization criteria for these drugs and classes.
PA	Physician's Assistant
PA	Prior Authorization (PA) is certification for drugs and medical services which exceed the benefit limits afforded under the Medicaid program.
PAC	Pricing Action Code (PAC) is a code required on the Medicaid claim form.
PACE	See Program for All-Inclusive Care for the Elderly
PAM	Payment Accuracy Measurement (PAM) Project/Grant is a method to estimate improper payments for the Medicaid program in response to the Government Performance and Results Act of 1993 (GPRA), Public Law No. 103-62, (1993). The PAM model uses a claims-based sample and review methodology and has been designed to estimate a State-specific payment error rate that is within +/-3 percent

	of the true population error rate with 95 percent confidence. Moreover, through weighted aggregation, the State-specific estimates can be used to make national level improper payment estimates for the Medicaid and CHIP programs.
PAP	Principal Accountable Provider
PAPD	Planning Advanced Planning Document
PBM	Pharmacy Benefits Management (PBM) is the procurement of prescription drugs at a negotiated rate for dispensation within a state to covered individuals, the administration or management of prescription drug benefits provided by a covered entity for the benefit of covered individuals, or any services provided with regard to the administration of pharmacy benefits.
PCCM	Primary Care Case Management (PCCM) is a Medicaid managed care program that provides case management through a client's primary care provider (PCP).
PCMH	Patient Centered Medical Home
PCP	A Primary Care Physician or Primary Care Provider (PCP) is a physician who provides primary care. The primary care physician acts as a gatekeeper to the medical system.
PDCS	Prescription Drug Card System
PDL	Preferred Drug List. A list of effective prescription drugs within therapeutic drug classes
PDN	Private Duty Nurse/Nursing (PND) is a nurse who is not a member of a hospital staff, but is hired by the client or his/her family on a fee-for-service basis to care for the client. A nurse who specializes in the care of patients with diseases of a particular class.
Peer Review Organization (PRO)	An entity that, under contract with a state Medicaid agency, reviews the utilization or quality of services provided to Medicaid beneficiaries either by fee-for-service providers or managed care entities. PROs must meet federal performance standards. CMS recently renamed PROs "Quality Improvement Organizations." Personal Needs Allowance (PNA)
PET scans	Positron Emission Tomography scan. A type of imaging test
PHI	Protected Health Information
PHP	Prepaid Health Plan
PHR	Personal Health Record
PHRM/ISS	Perinatal High Risk Management/Infant Services System (PHRM/ISS) is a multidisciplinary case management program established to help improve access to health care and to provide enhanced services to certain Medicaid-eligible pregnant/postpartum women and infants. The enhanced services for this target population include case management, psychosocial and nutritional counseling/assessments, home visits and health education.
PI	Program Integrity (PI) is a DOM bureau which identities and stops fraud and abuse in the Medicaid program by beneficiaries and providers.
PLEs	Provider Led Entities
PMO	Project Management Office
PMP	Project Management Professional Certification

PMPM	Per Member Per Month (PMPM) is the relative measure (the ratio) by which most expense and revenue, and many utilization comparisons are made.
PO	Private Option, under HCIA
POC	A Plan of Care (POC) is a written plan that directs what type of services and treatment are received.
Poverty-Level Groups	The popular term for eligibility groups, both mandatory and optional, for whom Medicaid income eligibility is determined on the basis of a percentage of the federal poverty level (FPL) (e.g., pregnant women and infants with family incomes at or below 133 percent of the FPL). See De-Linking, Federal Poverty Level.
PPACA	See ACA
PPACA (or ACA)	Patient Protection and Affordable Care Act of 2010
PPI	Public Policy Institute (PPI) of AARP
PPO	Preferred Provider Organization (PPO) is a network of medical providers.
PPS	Prospective Payment System
PQRI	The Physician Quality Reporting Initiative (PQRI) is a voluntary program that provides a financial incentive to physicians and other eligible professionals who successfully report quality data related to services provided under the Medicare Physician Fee Schedule (MPFS).
Preadmission Screening and Annual Resident Review (PASARR)	The federal requirement that states must screen all individuals with mental illness or mental retardation prior to admission to a Medicaid nursing facility and review at least annually all residents with mental illness or mental retardation in such facilities, to determine whether the individual or resident requires the level of care provided by the facility.
Presumptive Eligibility	The option available to states to extend limited Medicaid coverage (with federal matching payments) to certain groups of individuals from the point a qualified provider determines that the individual's income does not exceed the eligibility threshold until a formal determination of eligibility is made by the state Medicaid agency. The groups to whom states may offer Medicaid coverage during a presumptive eligibility period are pregnant women, children, and women diagnosed with breast or cervical cancer.
Primary Care Case Manager (PCCM)	PCCMs are physicians, physician groups, or entities having arrangements with physicians that contract with state Medicaid agencies to coordinate and monitor the use of covered primary care services by enrolled beneficiaries.
Prior Authorization	A mechanism that state Medicaid agencies may at their option use to control use of covered items (such as durable medical equipment or prescription drugs) or services (such as inpatient hospital care). When an item or service is subject to prior authorization, the state Medicaid agency will not pay unless approval for the item or service is obtained in advance by the beneficiary's treating provider, either from state agency personnel or from a state fiscal agent or other contractor.
Program of All-Inclusive Care for the Elderly (PACE)	A benefit that states may at their option offer to Medicaid beneficiaries age 55 or older who have been determined to require the level of care provided by a nursing facility.
Provider Tax	A tax, fee, assessment, or other mandatory payment required of health care providers by a state.

PRTF	A Psychiatric Residential Treatment Facility (PRTF) is a facility which provides psychiatric treatment for children under age 21 with mental/emotional/behavioral problems who do not require emergency or acute psychiatric care but who's symptoms are severe enough to require supervision/intervention on a 24 hour basis.
PT	Physical Therapy (PT) is therapy that uses physical agents: exercise and massage and other modalities.
PTOS	Procedure Type of Service
QA	Quality Assurance (QA) is an ongoing process that ensures the delivery of agreed standards.
QCA	QualChoice Holdings, Inc., is the parent company of QCA Health Plan, Inc., and QualChoice Life and Health Insurance Company, Inc., (collectively 'QualChoice').
QHP	Qualified Health Plan, Private Option carriers are QHPs
QI	Qualified Individuals
QIO	A Quality Improvement Organization (QIO) ensures quality assurance methods that emphasize the organization and systems: focuses on "process" rather than the individual; recognizes both internal and external "customers"; promotes the need for objective data to analyze and improve processes.
QMB	Qualified Medicare Beneficiaries (QMB) is a category of eligibility which pays Medicare premiums, deductibles and coinsurance for eligible individuals. To be eligible, a person must be eligible for Medicare, Part A (Hospital Insurance) and have a total monthly income that does not exceed the allowed maximum.
Qualified Medicare Beneficiary (QMB)	A Medicare beneficiary with income or assets too high to qualify for full coverage under the Medicaid program as a dual eligible, but whose income is at or below 100 percent of the federal poverty line (FPL) and whose countable resources do not exceed $4000. QMBs are eligible to have Medicaid pay all of their Medicare cost-sharing requirements, including monthly premiums for Part B coverage, and all required deductibles and coinsurance (up to Medicaid payment amounts).
Qualifying Individual (QI)	Between January 1998 and December 2002, States are required to pay all or a portion of Medicare premiums on behalf of a limited number of Medicare beneficiaries known as "Qualifying Individuals," or QIs
Quality Control (QC)	Also known as Medicaid Eligibility Quality Control (MEQC), quality control is the term applied to CMS's statutory duty to monitor state and local Medicaid eligibility determinations
Quality Improvement System for Managed Care (QISMC)	Standards and guidelines issued by CMS that direct managed care organizations to operate internal programs of quality assessment and performance improvement and collect and report data reflecting its performance. QISMC standards and guidelines are mandatory for Medicare+Choice plans but are optional for state Medicaid agencies to use in measuring and improving quality of Medicaid MCOs.
QWDI	Qualified Working Disabled Individual
RA	Remittance Advise (RA) formats for explaining the payments of health care claims.
RAC	Recovery Audit Contractor
RBMC/MCO	Risk-Based Managed Care/Managed Care Organization
Rebate	The amounts paid by manufacturers to state Medicaid programs for outpatient prescription drugs purchased by the programs on behalf of eligible beneficiaries on

	a fee-for-service basis. Rebates are calculated on the basis of the average manufacturer price (AMP) for each drug and, in the case of brand name drugs, on the basis of the manufacturer's best price. A manufacturer must agree to pay rebates in order for federal Medicaid matching funds to be paid to states for the costs of the manufacturer's drug products. See Average Manufacturer Price, Best Price, Formulary.
Resources	Sometimes referred to as assets, resources are items of economic value that are not income. Resources include financial instruments such as savings accounts and certificates of deposit, personal property such as an automobile (above a specified value), and real estate (other than an individual's home)
RFI	A Request for information (RFI) is a formal request distributed to potential bidders and/or professional experts for information regarding a specific system, program, process or service.
RFP	A Request for Proposal (RFP) is a solicitation inviting proposals from vendors who believe they can provide products to satisfy an agency's needs.
RHC	A Rural Health Clinic (RHC) is an outpatient facility that is primarily engaged in furnishing physicians' and other medical and health services that also meets other requirements designated to ensure the health and safety of individuals served by the clinic. The clinic must be located in a medically under-served area that is not urbanized as defined by the U.S. Bureau of Census.
Risk Contract	A contract between a state Medicaid agency and an MCO or other managed care entity (MCE) under which the entity agrees to provide, or arrange for the provision of, a specified set of services to enrolled beneficiaries in exchange for a fixed monthly capitation payment on behalf of each enrollee. By entering into such a contract, the MCO is assuming the financial risk of providing covered health services to the enrolled population.
RN	A Registered Nurse is a graduate nurse who has passed examinations for registration.
ROI	Return on Investment
RR	A Responsible Relative (RR) is a relative of a Medicaid beneficiary who assumes responsibility for conducting business on behalf of the beneficiary.
RR	Retro-Recovery (RR) is recovery of Medicaid funds from some third party after Medicaid has paid for medical services received by a Medicaid beneficiary.
RSPMI	Rehabilitative Services for Persons with Mental Illness
R-squared	Statistical measure of how close the data are to the fitted regression line
RTC	University of Minnesota, through the affiliated Research and Training Center on Community Living
RTF	A Resident Trust Fund (RTF) may belong to residents of Long Term Care facilities who may elect to allow a facility to manage a portion of their personal funds. These funds are audited by DOM on a regular basis to ensure facilities properly account for their funds in accordance with federal regulations.
Rural Health Clinic (RHC)	States are required to include services provided by RHCs in their basic Medicaid benefits package. RHC services are ambulatory care services (including physicians' services and physician assistant and nurse practitioner services) furnished by an entity that is certified as a rural health clinic for Medicare purposes. An RHC must

	either be located in a rural area that is a federally-designated shortage area or be determined to be essential to the delivery of primary care services in the geographic area it serves.
RX or Rx	Pharmaceutical
SACWIS	Medicaid Eligibility Determination System
SAMHSA	Substance Abuse and Mental Health Services Administration
Section 1115 Waiver	Under section 1115 of the Social Security Act, the Secretary of HHS is authorized to waive compliance with many of the requirements of the Medicaid statute to enable states to demonstrate different approaches to "promoting the objectives of" the Medicaid program while continuing to receive federal Medicaid matching funds. In 2001, 19 states were operating Medicaid section 1115 waivers affecting some or all of their eligible populations and involving $27 billion in federal matching funds, or one fifth of all federal Medicaid spending that year. The waivers, which are granted (or renewed) for 5-year periods, are administered by CMS. See also Health Insurance Flexibility and Accountability Waivers.
Section 1902(r)(2) "Less Restrictive" Methodologies	Under section 1902(r)(2) of the Social Security Act, states have flexibility, in determining an individual's Medicaid eligibility, to use methodologies for counting income and resources that are less restrictive than those used in the cash assistance programs for families (TANF) or the elderly and disabled (SSI). Using these less restrictive methodologies, states may disregard some or all of an individual's income or resources in determining whether the individual meets the applicable eligibility standard (e.g., 100 percent of the federal poverty level). As a result, a state can under section 1902(r)(2) expand the numbers of individuals eligible for Medicaid without changing the eligibility standards.
Section 1915(b) Waiver	Under section 1915(b) of the Social Security Act, the Secretary of HHS is authorized to waive compliance with the "freedom of choice" and "statewideness" requirements of federal Medicaid law in order to allow states to operate mandatory managed care programs in all or portions of the state while continuing to receive federal Medicaid matching funds. The waivers, which are granted (or renewed) for 2-year periods, are administered by CMS.
Section 1931 Eligibility	Under section 1931 of the Social Security Act, states must extend Medicaid eligibility to parents (and older children) in families who meet the eligibility requirements that were in effect under their state's Aid to Families with Dependent Children (AFDC) program as of July 16, 1996. States have the option under section 1931 to raise the eligibility levels for these parents through the use of "less restrictive" income and resource methodologies (see de-linking).
Section 1932 State Plan Option	Under section 1932 of the Social Security Act, states may require Medicaid beneficiaries to enroll in managed care entities (MCEs) by submitting an approvable state plan amendment (SPA) to CMS. Unlike section 1915(b) or 1115 waivers, section 1932 SPAs need not be periodically renewed by CMS.
SED	Serious Emotional Disturbance
SFTP	Secure File Transfer Protocol
SFY	State Fiscal Year (Arkansas' ends June30)
SHRS	The School Health Related Services (SHRS) Program was designed to identify children who have a learning problem because of a medical problem which requires

	special services. Once the child is identified an IEP (Individual Education Plan) listing services they need is then completed by the school. The schools have employed people with special training to assist children with special needs.
SMI	Serious Mental Illness
Single State Agency	The agency within state government designated as responsible for administration of the state Medicaid plan. The single state agency is not required to administer the entire Medicaid program; it may delegate most administrative functions to other state (or local) agencies or private contractors (or both).
SIR	System Information Request (SIR) is a request submitted to the Medicaid for electronic solutions and data analysis.
SIS	Supports Intensity Scale: American Association on Intellectual and Developmental Disabilities
SLMB	A Specified Low Income Medicare Beneficiary (SLMB) is a Medicaid category of eligibility which pays Medicare, Part B premium for qualified individuals. To be eligible, individuals must be age 65 or over or disabled, have income and resources below the maximum limits.
SLR	State Level Repository
SMB	Specified Low-Income Medicare Beneficiary
SME	Subject Matter Expert
SMHP	State Medicaid Health Information Technology Plan
SNAP	Supplemental Nutrition Assistance Program
SNF	A Skilled Nursing Facility (SNF) is a nursing home which provides skilled nursing and/or skilled rehabilitation services to patients who need skilled medical care that cannot be provided in a custodial level nursing home or in the patient's home.
SOBRA	Sixth Omnibus Budget Reconciliation Act--coverage for pregnant women under Medicaid
SOP	Standard Operating Procedures (SOP) are a set of fixed instructions or steps for carrying out usually routine operations.
SOW	Statement of Work
SPA	A State Plan Amendment (SPA) is an alteration in the provisions under the State Plan.
SPAs	State Plan Amendments. Sent to the Centers for Medicare and Medicaid Services (CMS) for review and approval
Specified Low Income Medicare Beneficiary (SLMB)	A Medicare beneficiary with income or assets too high to qualify for full coverage under the Medicaid program as a dual eligible, but whose income is above 100 percent and not in excess of 120 percent of the federal poverty line (FPL) and whose countable resources do not exceed $4000. SLMBs, like QMBs are eligible to have Medicaid pay their Medicare monthly premiums, but unlike QMBs are not eligible for Medicaid payment for their Medicare cost-sharing obligations. See also Dual Eligible, Federal Poverty Level, and Qualified Medicare Beneficiary.
Spend-Down	For most Medicaid eligibility categories, having countable income above a specified amount will disqualify an individual from Medicaid. However, in some eligibility categories
Spousal Impoverishment	The term used to describe the set of eligibility rules that states are required to apply in the case where a Medicaid beneficiary resides in a nursing facility and his

	or her spouse remains in the community. The rules, which specify minimum amounts of income and resources each spouse is allowed to retain without jeopardizing the institutionalized spouse's eligibility for Medicaid benefits, are designed to prevent the impoverishment of the community spouse.
SPR	Summary Profile Report (SPR) is a statistical report of a Medicaid provider's or a Medicaid beneficiary's actions for a specific period of time which compares their behavior to the norm established for that period of time.
SSA	Social Security Administration (SSA) is the federal agency which administers payment of Social Security benefits and Supplemental Security Income (SSI).
SSDI	Social Security Disability Insurance program. It is tied to the Social Security retirement program, but is for workers who become disabled before retirement age.
SSI	Supplemental Security Income (SSI) is income provided by the U.S. government to needy aged, blind and disabled persons and administered by the Social Security Administration.
SSN	Social Security Number
Standard	As used in the context of Medicaid eligibility determinations, the dollar amount of income or resources that an individual is allowed to have and qualify for Medicaid. For example, states must cover all pregnant women with family incomes at or below 133 percent of the federal poverty level (FPL), or $14,630 ($1,219 per month) for a family of 3 in 2001. In determining whether a pregnant woman meets this income standard, a state must count her income; the methodology that the state applies will determine what types of income are counted and what income (if any) is disregarded.
State Medicaid Plan	Under Title XIX of the Social Security Act, no federal Medicaid funds are available to a state unless it has submitted to the Secretary of HHS, and the Secretary has approved, its state Medicaid plan (and all amendments to the state plan). The state Medicaid plan must meet 64 federal statutory requirements.
State Plan Amendment (SPA)	A state that wishes to change its Medicaid eligibility criteria or its covered benefits or its provider reimbursement rates must amend its state Medicaid plan to reflect the proposed change.
Statewideness	The requirement that states electing to participate in Medicaid must operate their programs throughout the state and may not exclude individuals residing in, or providers operating in, particular counties or municipalities. This requirement may be waived under section 1115, 1915(b), and 1915(c) waivers.
Supplemental Security Income (SSI)	A federal entitlement program that provides cash assistance to lowincome aged, blind, and disabled individuals.
SURS	Surveillance and Utilization Review Subsystem (SURS) of the MMIS
Survey and Certification	The term for the process of surveying nursing facilities to determine whether they meet the requirements for participation in Medicaid (and Medicare). The process involves state survey agencies conducting inspections and CMS surveyors conducting "look behind" inspections. Facilities that do not meet the requirements are subject to various administrative sanctions, including civil money penalties; in extreme cases, a facility's participation in Medicaid may be terminated.

TANF	Temporary Assistance to Needy Families (TANF) is an assistance program for families.
TBI/SCI	Traumatic Brain Injury/Spinal Cord Injury is an acquired injury to the brain or spinal column caused by an external physical force, resulting in total or partial functional disability or psychosocial impairment, or both, that adversely affects educational performance. The term applies to open and closed head injuries resulting in impairments in one or more areas, such as cognition; language; memory; attention; reasoning; abstract thinking; judgment; problem-solving; sensory, perceptual, and motor abilities; psychosocial behavior; physical functions; information processing; and speech. The term does not apply to brain injuries that are congenital or degenerative, or brain injuries induced by birth trauma.
TCM	Targeted Case Management
TCN	A Transaction Control Number (TCN) is a unique identifier for a claim line assigned by the MMIS.
TCP/IP	Transmission Control Protocol and Internet Protocol (TCP/IP) is commonly known together as the Internet Protocol Suite.
TEA/TANF	TANF is the federal Temporary Assistance to Needy Families project. TEA is a federally funded Arkansas program and provides time-limited cash assistance to needy families with (or expecting) children
Temporary Assistance for Needy Families (TANF)	A block grant program that makes federal matching funds available to states for cash and other assistance to low income families with children. TANF was established by the 1996 welfare law that repealed its predecessor, the Aid to Families with Dependent Children (AFDC) program. Prior to this repeal, states were required to extend Medicaid coverage to all families with children receiving AFDC benefits. States may but are not required to extend Medicaid coverage to all families receiving TANF benefits; states must, however, extend Medicaid to families with children who meet the eligibility criteria that states had in effect under their AFDC programs as of July 16, 1996.
Third Party Liability (TPL)	The term used by the Medicaid program to refer to another source of payment for covered services provided to a Medicaid beneficiary.
TIN	Taxpayer Identification Number
Title XIX	Title XIX of the Social Security Act, 42 U.S.C. 1396 et seq., is the federal statute that authorizes the Medicaid program. Related titles of the Social Security Act are Title IV-A (TANF), Title IV-E (Foster Care and Adoption Assistance), Title V (MCH block grant), Title XVI (SSI), Title XVIII (Medicare), and Title XXI (SCHIP).
TJR	Total Joint Replacement, one of the Episodes of Care
TMA	Transitional Medical Assistance
TOS	Type of Service (TOS) is a code required on the Medicaid claim form.
TPL	Third Party Liability (TPL) insurance coverage a Medicaid beneficiary has which the provider must file before submitting the claim to Medicaid as the payer of last resort.
Transfer of Assets	Refers to the practice of disposing of countable resources such as savings, stocks, bonds, and other real or personal property for less than fair market value in order to qualify for Medicaid coverage. When such transfers occur, it is usually in

	connection with the anticipated or actual need for long-term nursing home care. Federal law limits (but does not entirely prohibit) such transfers.
Transitional Medical Assistance (TMA)	Refers to Medicaid coverage for families with children leaving welfare to become self-supporting through work. States are required to continue Medicaid benefits to families who lose their cash assistance due to an increase in earnings. The transitional coverage extends for up to 12 months as long as the family continues to report earnings.
TSG	The Stephen Group, author of this report
UAMS	University of Arkansas Medical System
UAT	User Acceptance Testing
UM/QIO	Utilization Management and Quality Improvement Organization
UPL	Upper Payment Limit: The Upper Payment Limit (UPL) is a federal limit placed on fee-for-service reimbursement of Medicaid
Upper Payment Limit (UPL)	Limits set forth in CMS regulations on the amount of Medicaid payments a state may make to hospitals, nursing facilities, and other classes of providers and plans. Payments in excess of the UPLs do not qualify for federal Medicaid matching funds.
UR	Utilization Review (UR) is the process by which a plan determines whether a specific medical or surgical service is appropriate and/or medically necessary.
VA	Veteran's Affairs
Vaccines for Children (VFC) Program	A program under which the federal government, through the Centers for Disease Control and Prevention, purchases and distributes pediatric vaccines to states at no charge and the state in turn arranges for the immunization of Medicaid-eligible and uninsured children through public or private physicians, clinics, and other authorized providers.
VBP	Value Based Purchasing factor
VFC	Vaccines for Children is a federally funded and state-operated program that began October 1994. The program provides vaccines free of charge to VFC eligible children through public and private providers. Providers are reimbursed by Medicaid for shot administration only.
WAIS	Wechsler's Adult Intelligence Scale
Waivers	Various statutory authorities under which the Secretary of HHS may, upon the request of a state, allow the state to receive federal Medicaid matching funds for its expenditures even though it is no longer in compliance with certain requirements or limitations of the federal Medicaid statute. In the case of program waivers such as the 1915(c) waiver for home- and community-based services, states may receive federal matching funds for services for which federal matching funds are not otherwise available. In the case of demonstration waivers such as the section 1115 waivers, states may receive federal matching funds for covering certain categories of individuals for which federal matching funds are not otherwise available. Under Section 1915(b) waivers, states may restrict the choice of providers that Medicaid beneficiaries would otherwise have.
WIC	The Women, Infants, Children (WIC) nutrition program provides free food and nutrition information to help keep pregnant women, infants and children under the age of five, healthy and strong

YTD	Year To Date. Current year and ending today. Can refer to SFY or calendar year