TSG Status Report # 2

To: Arkansas Health Reform Task Force

Re: Health Care Reform/Medicaid Consulting Services

Da: July 15, 2015

PREPARED BY:

THE STEPHEN GROUP
814 Elm Street, Suite 309
Manchester, NH, 03102
Main: (603)419-9592
www.stephengroupinc.com

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1. UPDATE SUMMARY

The Stephen Group (TSG) has continued an aggressive review of the status of Arkansas Medicaid, including both Traditional Medicaid and the Private Option. The completion date of the final report remains on schedule and is progressing with the assistance of many state agencies.

We would be remiss not to thank the many state employees at the Department of Human Services (DHS) and Insurance who have worked to help TSG compile an extraordinary amount of data. Also, we remain very appreciative of the assistance of the private insurance carriers who have shared information about Medicaid beneficiaries with us. The cooperation from these stakeholders, as well as many of the provider and client advocate groups has been remarkable.

Over the past month, our focus remains on our two-track review of both the data and the programmatic processes of the Medicaid program. While the assessment of program performance is continuing at a methodical pace, the data analysis is increasing rapidly, as the procedures are now in place for data collection, with the focus now on refining the quality of information so it is readily usable to support recommendations.

Some of our top findings over the past month involve a review of the top 1,000 high cost Traditional Medicaid cases across the state and how those cases are managed and using them as a point of comparison of medically frail newly eligible. While the specific analysis of the high cost Traditional Medicaid is ongoing, we note that the highest cost medically frail newly eligible patients fall far below the average cost of highest cost Traditional Medicaid patients.

TSG's review of the pharmacy program for Traditional Medicaid showed a number of opportunities for enhancing best practices to improve program performance and increase savings. Findings include the fact that Traditional Medicaid runs three redundant call centers doing similar work to support providers and beneficiaries' needs. This is one area where streamlining would result in both savings and more even results. At the same time, improving the efficiency and effectiveness in the preferred drug lists, as well as joining a multi-state rebate pool, would provide significant savings to the program. Finally, reviewing co-pay strategies is another way to reduce the cost of pharmacy spending.

TSG has begun a review of the Patient Centered Medical Home (PCMH) model as well as the Episodes of Care model of care currently being implemented in the Traditional Medicaid program. At this point, it is still too early in the process to conclude if the structure is producing savings in its totality to taxpayers or changing provider behavior. We will continue to analyze the program in the coming weeks to consider if it should be included in the Final Recommendations.

TSG's on-the-ground interviews and research to date, however, has been unable to define DHS' comprehensive approach and plan for care coordination for the high cost, multiple services population ("80% of spend goes for 20% of the Medicaid population"). While the PCMH model has elements of care coordination the model is essentially Primary Care focused and unconnected to the waiver(s) populations by design. We acknowledge, however, that DHS, at the request of the Governor's office, did issue and RFI to assess capitated, full risk, managed care principles in these high cost long term care support areas (aged and disabled) and TSG will be assessing such options and alternatives for the Task Force in future reports.

Our review of the eligibility and redetermination processes has found areas where tightening up standards can create opportunities for savings. Making a concerted effort to ensure annual redeterminations happens as close to the one year interval as possible will reduce ineligible beneficiaries. These scenarios include not only those who have seen their incomes changes, but also individuals who have moved out of state, those who have aged out of the system on their 65th birthday and, for those on the Private Option, individuals who are deceased (and for whom Medicaid is still paying monthly premiums).

Arkansas Health Independence Accounts appear to have low penetration at this point, with fewer than one in four of these accounts being activated to date. There is too little experience to draw any broad conclusions, but one noteworthy item is that cards that have been issued have been returned at a 9% rate.

TSG's review of the details of Traditional Medicaid's long-term population (behavioral health, developmental disability, long-term care) will continue over the next weeks and will be extensive. At this point, a number of emerging opportunities revolve around strengthening the assessment instrument to determine eligibility and level of care for these populations (where

DHS is currently working to implement a new tool), improving care for high cost cases, particularly those with co-occurring disabilities, and reducing reliance on high cost institutional care.

Moving forward, the collection and assessment of Medicaid claims data will begin to inform the results of the programmatic review – thus it will put meat on the bones of the assessments. We look forward to continuing to have this picture more fully filled out in our next update.

2. ACCOMPLISHMENTS

Interviews, Research and Related Discussions

We continue to meet with a number of individuals, department heads, providers, and Arkansas Medicaid stakeholders. We have provided a list of individuals we either met with and/or interviewed during the second month of the project in TSG Status Update # 2, Appendix.

We have also continued to conduct in-state and out-of-state research, including discussions with some out-of-state experts on various aspects of research policy. We have also provided a list of research and opinion articles reviewed in our TSG Status Update # 2 Appendix

Data Update

With the assistance of the Bureau of Legislative Research (BLR), TSG has set up a separate computer to support analysis of various data sets. Due to data security concerns, BLR set up a computer with appropriately secured access which is physically located in the state capital. All TSG analysis of state data containing sensitive information will take place on this secured computer.

The computer was made available on Friday, June 15th. TSG consultants loaded the necessary analysis tools onto the computer on June 16th.

The initial data, some private carrier information, was loaded onto the computer on June 19th. TSG analysis using this data began shortly thereafter.

The datasets currently loaded on the computer include:

From Blue Cross Blue Shield, NovoSys, and QualChoice:

- Medical Claims,
- Pharmacy Claims,
- Members,
- Providers

From DHS:

- Medical Claims,
- Pharmacy Claims,
- Recipients,
- Providers

TSG will be loading other data on this computer to support analysis in the coming weeks.

Pharmacy Claims Data

The pharmacy data was loaded to BLR on 7/7/15. Initial evaluation and analysis has not yet commenced.

Expectations of Claims Data

Our expectations of the claims data is to:

- Understand the premium-based Private Option population: by age, county, level of claim experience, medical conditions
- Compare carrier claims to premiums to understand experience rate
- Compare carrier claims to DHS claims for similar medical conditions
- Frequency of claims by beneficiary, provider, county. Compare these for carriers and DHS—are there different patterns?
- Evaluate claims across providers to consider adverse trends in rates and utilization
- Evaluate specific questions such as use of nursing homes
- Create an on-going tool that BLR can use to consider policy questions

Finance and Budget

We met on a number of occasions with DHS and some of its contractors to drill down on the most current expenditures for premium assistance, cost share, Medically Frail and other pertinent aspects of the Private Option program so as to give the Task Force a real time view of a per member per month estimate and an estimate of costs not otherwise matched (CNOM). We received a breakdown of some of the non-claims-based hospital costs from DHS rate setting.

We provided DHS with a list of detailed questions related to high utilizers in the Traditional Medicaid and Private Option program. We met with Optum regarding our questions and were able to drill down on the Top 1000 high utilizers for both the Traditional Medicaid program and the Private Option Medically frail.

TSG also continues to review other cost drivers and will report to the Task Force on same in the future.

Other State Departments and Agencies

Insurance Department

The Insurance Department was most helpful in assisting in obtaining the private carrier data to be handed over to the Bureau of Legislative Research (BLR). We also met with the Insurance Department relative to certain insurance regulations.

The Bureau of Legislative Research

The BLR is hosting and supporting the computer described above being used by The Stephen Group (TSG) to do analysis with sensitive data. Timothy Carlock, the BLR Chief Information Officer, has been continually available and helpful, including supporting TSG over the initial weekend to assist with setup problems, all of which were resolved in a day. If Mr. Carlock couldn't solve the problem he knew who to contact.

The Department of Workforce Services

TSG met with the Director of Workforce Services and his leadership staff to discuss access to the State's labor data base as part of our eligibility review. The Department has been very helpful in working with us to sort out issues related to access to the labor data base and new hire data base, which has a number of Federal restrictions and rules related to use. In particular, Ron Calkins, Assistant Director Unemployment Insurance, has been quite helpful working through various issues to enable use of that department's wage data.

Office of Medicaid Integrity

TSG met with the new Director of the Office of Medicaid Integrity Elizabeth Smith and her chief counsel Bart Dickson. The OMIG was able to share with us a number of concerns they have had with the eligibility system, including a couple of recent audits relative to premiums made by DHS to Private Option carriers after beneficiaries were no longer eligible for services. In a number of cases the beneficiaries were found to be deceased and also in some cases potentially ineligible due to being 65 years of age or older. We also discussed a number of organizational issues concerning the issue of fraud, waste and abuse in Arkansas Medicaid and we will continue to pursue these discussions and issues in the next update. We have found OMIG staff to be highly professional and effective in its pursuit to identify potential waste or fraudulent activity.

State Employees

TSG continued our conversations with Bob Alexander and also met with David Kisner from EBRX about innovative approaches they have implemented in the management of State Employees and Public School teachers and retirees. One innovation is use of reference pricing. Results of this pricing strategy have produced plan savings, member savings, and because drugs are cheaper, increased adherence. This may not work in the more regulated fee for service Medicaid drug program, without a waiver. One other innovation was the exploration of multistate buying pools. Initially, they are evaluating specialty pharmacy due to its high cost. We intend to continue this review.

Arkansas Department of Health

TSG spoke with the Arkansas Department of Health (ADH) regarding the direct patient care programs that they administer to determine the impact of the Private Option on their expenditures related to direct patient care programs. We also met with other staff from ADH regarding the health workforce reports that they publish in order to address the question in the

scope of work regarding the impact of the Private Option on recruitment and retention of health care workers.

Arkansas Medical Board

TSG met with the Arkansas Medical Board to determine whether the physician licensing data might be useful for assessing the question of health care provider retention and recruitment.

Community Health Centers of Arkansas

We met with the Community Health Centers of Arkansas regarding uncompensated care.

Arkansas Medical Society

TSG met with the Arkansas Medical Society regarding episodes of care, PCMH, and physician workforce issues.

Arkansas Center for Health Innovation (ACHI)

TSG met with ACHI to discuss their health workforce study in order to understand the data that they had used and determine which aspects of their methodology might be appropriate for our analysis.

Payment Improvement

TSG received a number of reports, presentations, and other documents from DHS regarding Episodes of Care. We fielded a survey of Arkansas physicians and hospitals regarding the Health Care Payment Improvement Initiative (HCPII). We received strong support distributing the survey from the Arkansas Medical Society, the Arkansas Academy of Family Physicians, and the Arkansas Hospital Association. Preliminary results of the categorical questions in the survey are attached.

We also met with a number of physicians in Mountain View to hear their thoughts and/or concerns about Payment Improvement in general and Episodes of Care and the roll out of Primary Care Medical Home, especially to the rural communities of Arkansas.

Information Systems and Contracts

TSG analyzed the 25 largest technology and non-technology contracts. Reviewed the standard terms and conditions, deliverables, performance indicators, and remedies for unacceptable performance. Followed the year-over-year history of multiple vendors and contracts to see the justification for any price increases and the controls DHS exerts over the vendors to maximize performance. TSG also reviewed the approach DHS uses to track vendor invoices against contract budgets and to manage both the federal and state budget components of every vendor contract.

We worked with Dawn Stehle and the McKinsey leadership team to define more precise deliverables for the current state fiscal year contract for APII.

We reviewed the procurement history for the Eligibility and Enrollment Framework (EEF) Project, the original RFP and its performance indicators and expectations of a system integrator. We then compared the original controls that were intended for this project with the current approach with the staff augmentation contractors.

TSG also attended the DHS Steering Committee meeting for the EEF Project. We observed the level of issues that are discussed with agency top leaders, the level of communication with CMS, the level of communication with other states using similar technical products, and the nature of the current issues. We reviewed the latest Advanced Planning Document Update submitted to the feds June 25, 2015.

We observed the organization in action as they respond to a number of priorities and challenges.

Eligibility System – Process

The Processes and Data used to determine Eligibility and to Renew Eligibility for DHS –DCO managed Medicaid and Private Option Services have been reviewed and documented. The preliminary status assessment for each DCO eligibility process has also been completed. (DAAS eligibility processes are still under review.)

Pharmacy Claims Summary

A detailed summary of the Medicaid Fee For Service (FFS) pharmacy program was received on 7/6/15 after the completion of the data use agreement with the State. TSG is meeting with Jason Derden from DHS to review the information.

Scrub

Lexis Nexis received the first of two files the week of 7/6/15. They expect the second early this week. Contract issues caused a delay but TSG does not think it will have an impact on timing of deliverable. TSG is also working with the Department of Workforce on the comparison of the wage data base with the DHS eligibility file for recipients with six months of service. TSG plans to have the results of the scrub in its final report.

3. PRELIMINARY OBSERVATIONS TO DATE

Note: These are preliminary observations to date and may or may not be part of TSG's final October 1, 2015 Report to the Task Force. They are being offered as an update to the Task Force and may be subject to change.

Analysis of High Utilizers

The Stephen Group requested information from DHS on the highest cost beneficiaries. In particular, TSG requested that DHS provide answers to a set of questions for the highest 1,000

beneficiaries in the traditional Medicaid program and highest cost 1,000 beneficiaries in the medically frail population.

Notably, when the traditional Medicaid program and medically frail populations are analyzed together, of the top 1,000 highest cost beneficiaries, 990 of them are in the traditional Medicaid program (i.e., 99% of the 1,000 highest cost beneficiaries in the FFS Medicaid system are enrolled via traditional Medicaid eligibility categories.) Thus, the remainder of this analysis focuses on the highest cost beneficiaries in the traditional Medicaid program.

Within the top 1,000 beneficiaries by cost, and focusing initially on the highest cost 100, the cases are primarily hemophiliacs, newborns receiving care in neonatal intensive care units, and individuals with congenital conditions. Expanding the review of diagnoses into the top 1,000 severe mental illness becomes predominant.

Almost exactly 2/3 of the 1,000 highest cost beneficiaries are either under the age of 1 or between the ages of 22 and 64.

More than 80% of 1,000 highest cost beneficiaries are disabled.

The total cost for the 1,000 highest cost beneficiaries was $322,742,223.12.

Total Paid Amt.	Claim Type w Description of type of service
$132,613,692.22	S - Inpatient and inpatient adjustment
$100,091,131.78	T - Nursing home and nursing home adjustment
$47,725,124.57	J - Medical and medical adjustment
$36,484,217.82	D - Drug and drug adjustment
$5,283,811.50	M - Outpatient and outpatient adjustment
$207,963.02	E - Professional crossover and professional crossover adjustment
$118,917.76	W - Outpatient crossover and outpatient crossover adjustment
$108,873.00	V - Inpatient crossover and inpatient crossover adjustment
$63,258.67	K - Dental and dental adjustment; screening and screening adjustment
$33,680.12	B – EPSDT
$11,552.66	X - Nursing home crossover and nursing home crossover adjustment
$322,742,223.12	**Total**

More than 2/3 of the 1,000 highest cost beneficiaries received at least some of their treatments from UAMS or Childrens Hospital.

Of the $138,125,294.48 in hospital payments (inpatient and outpatient, including crossovers and adjustments), $109,716,477.30 went to Children's and $8,051,344.10 went to UAMS.

Of the 1,000 highest cost beneficiaries, 218 were also eligible for Medicare.

The full responses are included in TSG Status Report # 2 Appendix.

Comparison of Top-1000 Traditional Medicaid versus Newly Eligible Medically Frail

	Highest Cost 1,000 Beneficiaries	
	Traditional Medicaid Eligibility Categories	**Expansion Population – Medically Frail**
Average	$322,742	$55,081
Total	$322,742,223	$54,971,008
High	$5,986,251	$546,025
Low	$219,225	$29,939

Additional facts:

- More than 90% of the 1,000 highest cost beneficiaries in the medically frail population had Medicaid expenditures of less than $100,000.
- None of the 1,000 highest cost beneficiaries in the traditional Medicaid eligibility categories had expenditures of less than $100,000.
- More than 90% of the 1,000 highest cost beneficiaries in the traditional Medicaid eligibility categories had expenditures between $200,000 and $500,000.
- Fifty of the 1,000 highest cost beneficiaries in the traditional Medicaid eligibility categories had expenditures of greater than $1 million.
- None of the 1,000 highest cost beneficiaries in the medically frail population had Medicaid expenditures of greater than $1 million.

Highest 100 Utilizers

In FY 2015, fifty four of the top 100 high utilizers had yearly Medicaid expenditures of greater than $600,000. They were as follows:

- NICU patients 21
- Congenital Heart Disease 7
- Hemophilia 6
- Comp. of Prematurity 6
- Cancer 5
- Genetic Syndrome 3
- Other Malformations 2
- "claim" – out of state? 2
- Transplant 1
- ICU Care 1
- Metabolic Disorder 1

The main activities associated with these diagnoses are, for the most part, not included in Episodes of Care, or the PCMH program. The observation is that these highest cost beneficiaries may not be having their care managed. Thus, there is an opportunity presented for some sort of care management overlay focused on the highest cost beneficiaries or on specific diagnoses or circumstances.

Private Option – Medically Frail

Originally DHS provided TSG with cost analysis showing the breakdown of monthly costs for calendar year 2014 for the Medically Frail to include the experience of $527.17 PMPM. Because this population is in the Traditional Medicaid program, a portion of the supplemental hospital payments must be attributed to them. Thus, TSG asked DHS to adjust the PMPM by allocating a portion of supplemental payments attribute to the Medically Frail population. After making such adjustment, DHS adjusted the PMPM from $527.17 to $664.72. It must be noted that DHS anticipates the 2015 experience to be higher as the population completes their ramp-in. See TSG Status Update # 2 Appendix for a breakdown of these costs, including the PMPM.

Definitions of Medically Frail

Federal Definition of Medically Frail 42 C.F.R. § 440.315(f)

> The individual is medically frail or otherwise an individual with special medical needs. For these purposes, the State's definition of individuals who are medically frail or otherwise have special medical needs must at least include those individuals described in §438.50(d)(3) of this chapter, individuals with disabling mental disorders (including children with serious emotional disturbances and adults with serious mental illness), individuals with chronic substance use disorders, individuals with serious and complex medical conditions, individuals with a physical, intellectual or developmental disability that significantly impairs their ability to perform 1 or more activities of daily living, or individuals with a disability determination based on Social Security criteria or in States that apply more restrictive criteria than the Supplemental Security Income program, the State plan criteria.

Medically Frail

- Between the constraints in federal rules and state statute, Arkansas Medicaid had no significant discretion to make policy choices with regard to coverage of medically frail individuals.
- Federal rules require that medically frail individuals are exempt from mandatory enrollment in the Alternative Benefit Plan (i.e. they must be permitted to enroll in the Medicaid state plan benefit)
- Federal rules define medically frail (see above for definition).
- Federal rules require that states must inform medically frail individuals that they may receive the ABP or the Standard benefit package before they enroll in the ABP. States must also inform medically frail individuals that they may disenroll from the ABP at any time.

- The State receives enhanced FMAP for all newly eligible adults, including the medically frail. The enhanced FMAP applies to the person, so it does not matter if the medically frail individual chooses to receive the Standard benefit package.

Arkansas legislation establishing the Private Option required that medically frail individuals be excluded from the Private Option.

Medically Frail State Comparisons

State Differences in the Application of Medical Frailty under the Affordable Care Act

CMS provides guidelines, but leaves it up to the states to determine the definition of medical frailty and the methods used to determine if an individual meets those criteria. This is salient in states that have expanded Medicaid, but do not provide traditional Medicaid to individuals in the expansion groups. Individuals considered medically frail are exempt from enrolling in alternative benefit plans.

11 states were found which have Medicaid expansion and offer an alternative benefit plan which has lower benefits or higher costs than standard Medicaid. These states are required by CMS to provide medically frail individuals the option to apply for standard Medicaid if they have special needs.

Principle Findings: There are substantial differences in how the 11 states assess medical frailty. Four primary methods of assessment were derived: self-report, data review, administrative and clinical (See table below). Note that several states use more than one method to determine medical frailty.

State	Self-Report	Data Review	Administrative Review	Clinical Review
Arkansas	Online screening for conditions/service use predictive of exceptional needs in coming year	Claims monitoring to identify those no longer medically frail		
California			Criteria for Medicaid Long Term Services and Supports are equivalent to 'medical frailty' – no separate assessment	
Iowa	If receives Social Security Disability Insurance or asserts Activities of Daily Life limitations, individual completes "Medically Exempt Member Survey"	Survey score determines assignment to state plan Medicaid or Alternative Benefit Plan	Department of Human Services employees, mental health regional designees, or Iowa Department of Corrections employees may complete survey	Providers with current National Provider Identifier number may complete survey
Indiana	Application screens for qualifying conditions/			Managed Care Entity (MCE) verifies

	medical frailty indicators			medically frail status using claims, lab results etc., after enrollment. MCE also verifies annually after frailty established.
Massachusetts	Self-identification as having Special Health Care Needs (facilitated by informational materials)			
New Hampshire	Self-identification as having ADL limitations or reside in medical facility or nursing home			
New Jersey			Review of eligibility criteria, and hotline assistance by Medical Assistance Customer Center staff	"Medically Exempt Attestation" form completed by providers
New Mexico	Self-identification facilitated by Managed Care Organization (MCO) counseling		Review of eligibility criteria	MCOs complete health risk assessment (in 30 days)
North Dakota	Medically frail questionnaire		Medical professional review of responses	Client must be examined and submits report by physician
Pennsylvania	Self-administered questionnaire identifies medical and behavioral health needs	Questionnaire responses and claims data analyzed to determine assignment to coverage plan		
West Virginia	Self-identification facilitated by informational materials			

Source: State Differences in the Application of Medical Frailty under the Affordable Care Act, University of Massachusetts Medical School Disability Evaluation Services, 2015

Pharmacy

Prescription limits

One approach used in the State FFS drug plan to manage costs is limiting the number of prescriptions per beneficiary per month. There are various limits based on age and site of care. This may be causing medical costs to spike for patients unable to get needed medicine.

When viewed in terms of combined medical and pharmacy costs, savings in one silo may have cost impacts in the other silo. One best practice in this area is the value based plan design. This design features no copay for needed maintenance medications to improve compliance and

adherence. Prescription medicine is generally a low cost intervention, especially with long term generic prescriptions. If the limits on prescriptions were modified other important pharmacy concepts could flourish. Medication synchronization and appointment based pharmacy for maintenance drug users are examples.

PDL Expansion

There is a State rule in place which limits the PDL classes to only those classes in which there is an evidence-based review of efficacy and safety. This rule currently limits adding PDL classes, and the supplemental rebates associated with the preferred drugs in those classes, if the only difference among drugs in the class is price. The PDL strategy of 'evidence first, cost second' is great when there is evidence and a class review. With the current approach some costly drug classes and the coming wave of biosimilars will not be eligible for supplemental rebates.

In supplemental rebates, two factors drive rebates, size and control. The State has its own supplemental rebate agreements for the approximately 500k FFS beneficiaries. The best rebates go to entities with 3mm or more Medicaid beneficiaries. Control of the preferred drugs on the PDL through edits and prior authorization is the other factor which influences rebates. The State seems to be doing fine with control. To improve leverage from size, the state may want to consider joining one of the multistate supplemental rebate pools. We will survey to estimate the value of such a change and will include recommendations in our final report.

https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8233.pdf

The above study from The Kaiser Family Foundation discusses the topics in and around PDLs.

Redundant Call Centers

The UAMS College of Pharmacy, the Pharmacy Department at the State, and Magellan, all have call centers serving providers and beneficiaries in the FFS Medicaid pharmacy program. At a minimum, this represents duplicative administration and could be evaluated for consolidation through a competitive bid process. Through messaging in claims responses to pharmacies, the correct phone number is returned with a rejected claim. If the pharmacy needs to act, they call the number, if the prescriber needs to act, the pharmacy passes along the phone number to the prescriber.

The work is generally divided such that UAMS College of Pharmacy handles calls related to PDL non-preferred drug requests and select other clinical requests for drugs. Magellan handles mostly administrative calls related to claims processing, edits, or problems. The State is a catch all for all types of calls and callers. 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 form beneficiaries and providers.

Copayment differentials

Copayment differentials are proven behavior modifiers. When a buyer has a lot of money, the copay difference that will cause a behavior change may need to be larger than for a person

without a lot of money. For this person, seemingly small amounts of money are important and therefore small copay differentials will likely influence buying behaviors. The copay revenue itself may never be a way to save substantial money in the program, however, thoughtful copay differentials can dramatically influence the ingredient cost of different prescriptions and should be used in support of the PDL strategy. There are copays in the program ranging from $0.50 to $3.00 per monthly prescription. We will offer recommendations in our report around additional copays depending on how and if the PDL strategy changes.

Opiates

The US represents 4.5% of the globe's population, yet consumes 90% of all oral opiates in the world. Do we just have more pain? Opiates are subject to abuse and misuse including selling prescription medicines for cash. The current pharmacy claim edits are good and are reviewed periodically for improvement. The State has a database of opiate prescription fills accessed by prescribers and pharmacies to assist in appropriate clinical management of patients requiring opiate therapy.

The State Medicaid program is broadly responsible for the health of the Medicaid population and pays the bills, so certainly should have ready access to this database to optimize performance of duties. Apparently, they do not have access. Explore granting access to the statewide database for clinicians in the DHS.

The DHS also has a lock-in program for identified substance abusers. With appropriate notification, a beneficiary can be limited to only having Medicaid covered prescriptions filled at a single pharmacy. There are currently 70 beneficiaries so locked. We plan to further analyze and compare number and percent of opiate users, number and percent of opiate users reviewed for potential lock-in, and how other lock-in programs perform. The best practice in lock-in also has the beneficiary locked into one prescriber.

Vendor oversight

In March 2015, the State moved the pharmacy claims processing from HP to Magellan. 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. We are sure 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.

Payment Improvement

TSG Physician Survey Results

We fielded a survey of Arkansas physicians and hospitals to measure perceptions of the HCPII. The survey was developed in SurveyMonkey and was sent by the Arkansas Medical Society (3,300+ members), Arkansas Academy of Family Physicians (600+ members), and Arkansas

Hospital Association (98 members) to their members. As of Thursday, July 9, 2015, 250 responses had been submitted.

Preliminary results of the structured questions are included as a report in TSG Status Update # 2 Appendix.

We do not know how much overlap there is between the AMS and AAFP memberships, although it is likely high. Therefore, the actual number of unique individuals and organizations receiving the survey was between about 3,400 and 4,000. In either case, with about 250 responses, the response rate was below 10%. Thus, caution should be used when generalizing about the populations of physicians and hospitals from the results since there could be significant sampling bias.

Results

Of the approximately 250 respondents, about 67% were physicians, 16.5% represented hospitals, and the remainder were something else. A similar, and very high, percentage of all respondents indicated that they both did currently provide care to Medicaid recipients (about 94.3%) and also provided care to Medicaid recipients prior to 2014 (about 95.9%). A large percentage of respondents responded positively to questions about electronic health record use and electronic care plan use.

Almost three quarters of respondents were familiar with the EOC initiatives, while only about 37% were Primary Accountable Providers (PAPs) for any of the episodes. A large majority of respondents had not accessed the EOC reports. When asked about their perceptions of the impacts of the EOC initiative on the delivery of care, respondents were spread fairly evenly among all provided variations of agreement, neutrality, and disagreement with a moderate leaning toward the negative end of the scale.

Almost 80% of respondents were familiar with the PCMH initiative, with about 32% of the respondents indicating that they were participating as a PCMH. Respondents were similarly mixed in their stated perceptions of the impacts of the PCMH initiative on the delivery of care, with a slight positive leaning.

The majority of respondents indicated that they thought that using a vendor to coordinate the care for special needs and complex populations would neither improve the quality, nor decrease the cost of care.

More respondents agreed with a statement asking whether their organizations provided less uncompensated care than before 2014 than disagreed with the statement. Respondents were fairly evenly split on the question of whether the financial stability of the health care system in

Arkansas had improved since the establishment of the EOC and PCMH initiatives. Almost half of respondents disagreed with the statement that the EOC and PCMH initiatives would make them more likely to recommend pursuing a career in health care in Arkansas.

Patient Centered Medical Home

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. Initially, participating providers will receive a care management report for each patient for whom they serve as the PCMH. Ultimately, the goal is to incorporate gain-sharing policies to incentivize PCPs to guide treatment toward lower cost providers.

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

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 295,000 Medicaid beneficiaries in the care of a PCP participating in the PCMH program. 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.

Episodes-of-care

The following tables are adapted from calculations done by McKinsey. The first two tables 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.

The third table below is for 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 pass 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.

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	Unknown
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"					

Active Episodes of Care (First Two Rounds)	
Episode	**Observations relating to estimated direct cost savings**
Upper Respiratory Infection (3 episodes)	• 17% drop in antibiotic prescribing rate. • Average episode cost flat despite ~10% increase in drug prices.
Attention Deficit Hyperactive Disorder (2 episodes)	• 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.
Perinatal	• C-section rate reduced from 39% to 34%.
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"	

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.

Episode	Episode Launch Date
URI (3 episodes)	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.

Using 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 $6.7 and $11.7 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 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.
- McKinsey did not estimate the cost impact of the perinatal episode, so we used $0 as the conservative estimate and 13% reduction as the aggressive estimate (based on the observed 13% reduction in C-section rates).

With those assumptions and the direct episode spend for all of them, we calculated an annual potential savings range of $9.6M-$28.2M 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 manage 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. Therefore, it seems reasonable to adopt a theoretical lower bound for the allocation of their effort at a third and a conservative upper bound at half of their effort.

In addition to the McKinsey work, other vendors, including GDIT, Northrop Grumman, and HP were paid certain amounts to support the technical implementation.

For the purposes of this tentative comparison, we will only consider the costs associated with the McKinsey contract. At a third of the McKinsey contract cost from SFY12-SFY15 (the period associated with work toward the EOCs that are currently active), the total spend comes to just over $31 million. At half of the contract cost, the total spend for the episodes currently implemented comes to approximately $46.6 million. (Note: Again, this does not take into consideration the additional work on behalf of other vendors and the State's allocation of costs).

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 $9.6 and $28.2 million. Furthermore, as additionally described above, a conservative range for the cost of the development and design of the EOC programs currently implemented, is between $31 and 46

million. Given these ranges, and all of the assumptions within the corresponding calculations, the current set of episodes would break even within between 1 and 5 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.

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, then 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 substation – 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 Private Option 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, there is general agreement that the Episodes of Care payment model is delivering positive results for both the Medicaid population, as well as the Private Option population. For the Private Option membership, there is already evidence of claims expense reduction. For the Medicaid population, actual claims expense reduction has not yet been observed yet, 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 leveraging the learnings,

techniques and relationships from the more effective Private Option experience. For example, Arkansas Blue Cross has observed Primary Accountable Providers driving more cases toward institutions 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.

Payment Improvement - Bundled, Case Payment Model

TSG is initiating analysis to examine the potential savings opportunity of applying a case payment reimbursement model for a large number of inpatient and outpatient services. While there may be some overlap between a bundle/case payment model and Episodes of Care, the advantages of case payments are:

- The “case payment” model is widely accepted by payers and providers for many Commercial, Medicare and Medicaid populations. In fact, the simplistic per diem or discount-off-charge models are rarely practiced due to the inherent problem of paying more to providers who do more and charge more. Therefore, Arkansas’s current Fee-for-Service and Per Diem payment arrangements represent an opportunity to explore different models.
- About 75% of state Medicaid departments pay for acute inpatient care through some type of case payment model based on Diagnostic Related Group (DRG), which imposes some

risk on the provider since hospital stays that exceed the DRG's presumed length of stay generate no additional revenue to the provider (hospital or physician). Thus, Arkansas's Medicaid program represents an opportunity to explore a DRG payment model.

- DRGs could be applied to case types not covered by Episodes of Care, and DRGs could also be considered for case types where Episodes of Care have not delivered the desired results, only after a period of experience and observation, of course.
- A DRG-based reimbursement model is relatively simple to implement and can be applied to a wide range of inpatient services, as well as some outpatient care (surgery, gastroenterology, radiology, etc.). This advantage would allow DRGs to improve the economics of Arkansas's Medicaid payment methodology quickly and permanently, or, temporarily until the more sophisticated Episodes of Care models are designed and executed as long-term replacements.

Payment Improvement - Medicare/Medicaid Crossover Payments

TSG is initiating study on the practice of Arkansas Medicaid's payment of deductibles and coinsurances for Medicare patients. As a secondary insurer, under coordination of benefit guidelines, it is not uncommon for Medicaid, as a secondary payer (where Medicare is primary), to be liable for the deductible and coinsurance. However, TSG will be looking to other state examples to determine if there is an opportunity for Arkansas to use other models that provide additional savings potential.

Eligibility Process

Note: These are preliminary observations to date and may or may not be part of TSG's final October 1, 2015 Report to the Task Force. They are being offered as an update to the Task Force and may be subject to change.

Eligibility Redetermination Process

Background Information

The Federal requirement is for an Annual redetermination of Income. Currently Arkansas DHS is operating under a waiver to extend that time limit. This waiver was provided to Arkansas to provide time for the required new information systems to be developed.

It should be noted that the current income verification requirement is federally mandated to be annual - explicitly not longer, nor shorter than annually.

Only Income Change is explicitly considered in this annual redetermination process. By Federal policy, SSN and Citizenship or Alien status is not validated again as part of the annual redetermination (SSN and Citizenship/Alien Status is checked for initial eligibility).

The income verification, again by Federal Policy, follows an explicit formula based on the poverty level for number of individuals in a particular family. This policy defines a "Reasonably

Compatible" standard for comparing an enrollee's nominal income with any other verifying information about their income amount.

This standard has some complexities in the details of its implementation but roughly corresponds to a 10% plus or minus guideline. So if a client/family had a nominal income of $20,000 at the time they were initially enrolled then at the time of renewal their income must be verified to be within plus or minus 10% of $20,000 to be accepted for renewal – so in a range of $18,000 to $22,000.

Approximately 85% of Arkansas workers are covered by state unemployment insurance. 15% of workers meet one of twenty-two types of exemption from participating in the unemployment insurance program. Thus, a high percentage - but not all - state workers will be included in the Work Force database.

The Work Force data is based on quarterly employer wage reports. This information is due to the state by one month after the end of each calendar quarter. Some employers use online reporting which provides much more timely information and some employers are late providing this information.

Then the process to load the data into the Work Force UI database takes approximately one more month. So substantial updated data covering a large majority of the state workers is available in the Work Force database on a quarterly basis, lagging the calendar quarters by two months – or, in other words, in June / September / December / March of each year, reflecting wage status at the end of March / June / September/ December respectively.

So the current eligibility redetermination process is using Work Force data current as of the end of March of this year.

The New Hire Registry is used by the Department of Work Force Services for unemployment insurance application and enrollment management but is not used by DHS for income eligibility review. Income eligibility review requires specific income information on specific dates and the New Hire Registry does not provide the required information.

Process

A number of client families were enrolled for services before October 2013 when the expansion in coverage began. These clients have continued to be served from the legacy DHS system. They are now being converted to the new IBM/Curam system by being asked to reapply through the Access Arkansas portal or fill out a form with the necessary information.

These are being processed in groups of 25,000 families. The first group is in process and the second group should be initiated soon. These applications have their income reviewed using the same requirements all the other clients being renewed must meet. These legacy clients are given 30 days to complete this transition process.

The first step in the actual renewal review process is to identify clients who can be approved for renewal on an "ex parte" basis, meaning that the client's income level can be verified through another current information source. That other source of information could be income entered for TANF or SNAP qualification or Income reported for Unemployment insurance purposes.

Comparing the client's nominal income in the DHS database with the Work Force Unemployment Insurance (UI) database is then a primary independent method for the state to verify income for the eligibility redetermination process. When the annual due date for renewal for a client occurs in a given calendar month the client's nominal income in the DHS database is compared to the most recent Work Force income data (described above) and there are three possible outcomes to that comparison:

1) The comparison of the DHS income and the Work Force database income meet the federal Reasonably Compatible standard so the client is approved for renewal and a letter is sent to the client indicating that they have been renewed.
2) The comparison of the DHS income and the Work Force database income does NOT meet the federal Reasonably Compatible standard so the client is sent a letter requiring verification of income.
3) The comparison of the DHS income and the Work Force database income cannot be done because the client's information is not in the Work Force database. In this case, the client is also sent a letter requiring verification of income.

All Clients are sent a letter as part of their renewal process. The clients who were approved ex parte, based on confirming information, are sent a letter about their renewal. This letter states the income amount and the family size that was used as a basis for their renewal and the client is reminded to notify DHS if there has been a change. Unless the client reports a change of income status they are now approved for another year.

The clients who were not approved ex parte are sent a letter requiring them to send appropriate income verification information within 10 calendar days. Five days are added to account for postal time as well as scanning and routing the information internally in DHS, so there is a total of 15 days from when a renewal letter is sent and when change of income or verification of income information must be returned.

Appropriate documentation for verification of income would typically be current paystubs, or a signed employer confirmation of income – Verification of Earnings form, or a tax return for self-employed clients.

In some cases, the client's case worker can grant the client additional time if, in the case worker's judgment, there is a legitimate requirement for additional time.

Then if required documentation of an income level that meets the federal reasonably compatible requirement is provided by the client within the nominal required time period, or within the case worker authorized extra time, the client is renewed.

If the required documentation is NOT provided within the allotted time then DHS mails the client an Adverse Action Notice stating that the client will be dis-enrolled as of the end of the calendar month. The client has 10 days to respond to the notice of adverse action with an appeal. The calendar month of the dis-enrollment is the calendar month when they failed to respond or when their appeal was denied.

Re-enrollment, with no loss in coverage, is allowed if the client provides the required income documentation within 90 days from their termination of coverage. If the client does not provide the required information within 90 days they must they must reapply and meet the initial, not just the renewal, eligibility requirements, and the break in coverage will stand.

Note that 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.

And if there is not a positive comparison with the Unemployment Insurance data then the enrollee must respond to the income verification notice. If a verification notice letter is returned from an out of state address DHS takes action within a day to initiate closure.

Current Status Numbers – as of July 12th

The software under development has matured so that the backlog of annual redeterminations began to be addressed in initial verification and test mode in May of this year and in operational earnest in June.

The current plan is to complete the backlog recovery by the end of August, meeting the federal waiver schedule requirement of backlog recovery by the end of September.

As of July 12, 2015

Counts	%	Description
589,000		Number of clients in Renewal backlog
*** 150,100**	*** 25%**	Number/% of clients/families for whom renewal process has begun
		Number and Percentage is greater when all totaled as individuals
58,600		Number of Individual Cases Completed Ex Parte
18,300	**12%**	Number/% of Total Cases Closed to Date
15,755		Number of Closed Cases Closed for failure to provide Verification

Once the backlog of renewals has been handled the routine process will be for annual renewals to be initiated 10 days from the end of the 11th month of the renewal period.

Ongoing Change of Circumstance Redetermination:

Other than the annual income review described above, there are five methods by which an enrollee's Change of Circumstance can cause a redetermination of their eligibility for services:

1) Self-reported Change of Circumstance;
2) Cross System Change reporting by Medicaid, TANF or Food Stamps;
3) Aging out of Medicaid Qualification;
4) Client Death;
5) Client Incarceration.

1. Self-Reported Change of Circumstance

Every notice sent out to enrollees includes a notice that they are required to report changes of circumstance within 10 days and that failure to report could result in prosecution for fraud.

Typical changes self-reported by the enrollee would commonly include:

- Income,
- Household Composition,
- Residency,
- or Name Change.

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.

There are no reported unusual backlogs or problems with this process at this time.

2. Cross-System Change reported by TANF, or SNAP

   Changes made in these other programs currently, by policy and practice, are used to also update the medical services client information as the change occurs.

3. Aging out of Medicaid 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 they will then be qualified for Medicare. The clients are qualified for to avoid transition overlap the clients are dis-enrolled from Medicaid in the month thy turn 65 because they do qualify for Medicare in the month they turn 65.

Some clients who are 65 and older meet poverty requirements and may stay on Medicaid. 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 Private Option services may be eligible for Medicare, where premiums are paid by Medicaid dollars. Medicare Savings and the normal qualification for Medicaid past age 65 are handled separately because one is managed through the legacy system and the other is managed through the newly developed system.

There are no reported unusual backlogs or problems with this process at this time.

4. Client Death

On a Monthly basis, DHS uses the report from the Department of Health to compare the list of deceased with DHS enrollees to identify any who have died, whose cases then need to be closed. Also, some next of kin will self-report about the client death. The number of deaths is approximately 100 per month.

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 paid out post death is recovered to the end of that calendar month.

The Department of Health report is primarily based on Funeral Home reporting. If a death is reported late DHS will act to recoup the premiums paid to the Carrier. DHS enters the deceased change of status into Curam which information is then automatically transferred to MMIS and then HP conveys the needed adjustment by date of death to the appropriate carrier.

This comparison of DHS roles with the deceased list will become more automated as the Department of Health's new information system comes on line.

There was a backlog associated with the general systems and process overload in 2013 and 1014. This backlog was eliminated by the end of 2014.

5. Client Incarceration

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.

This is will be an automated process of comparison in the new Curam system but is still handled manually for clients whose records are maintained in the legacy "Answer" system.

Every penal facility if 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.

Act 895, set to go into effect in August of this year, requires that inmates be allowed to begin processing their application for services 45 days prior to parole. Act 895 also requires Corrections to provide better Incarceration reporting to DHS. The information currently directly accessible from Corrections reports Convictions, not incarceration, so is not useable for this DHS purpose.

Office of Medicaid Integrity Audit

During one of our discussions with OMIG, it was brought to our attention that OMIG had recently conducted a program review and determined that over $500,000 was paid out in premiums to carriers for beneficiaries after their death. These payments were not for claims but instead for monthly premiums. DHS and the carriers accepted the findings and all the parties have been responsive and appear to be working on addressing the eligibility issues.

We also asked DHS for the total amount of claims paid to deceased beneficiaries and recoupment during the inception of the Qualified Health Program, and DHS CFO advised us that total amount of recoupments for FY 2015 for this reason was over $17 million (see TSG Status Update # 2 Appendix for monthly breakdown of recoupments for premiums paid to carriers after beneficiaries death). The carriers were very willing to pay back the premium amounts paid by DHS and accept the audit findings.

OMIG then asked DHS to assure that a corrective action plan had been put in place so that future payments are not made after the death of a beneficiary. DHS has assured OMIG that such a plan is in place as of the end of May 2015. However, based on a recent OMIG review this past month, OMIG was able to identify that some of the deceased beneficiaries' Medicaid cases were re-opened after they were closed due to its findings. It is our understanding that DCO has to monitor and determine that a recipient is no longer eligible and close out the recipient in the MMIS system in order for the system to stop any future payments. OMIG notified DHS of this issue and DHS has indicated it has made the system changes.

Moreover, in May of this year, OMIG found over 300 Private Option recipients that turned 65 during the 2014 year, but premium payments did not end when they turned 65. The recipients remained enrolled until end eligibility dates were entered, regardless of their 65th birthday. OMIG did not find claims paid beyond the end of eligibility dates, but premiums were

paid beyond their 65th birthday. It must be noted that some individuals will not be eligible for Medicare after their 65th birthday, though their Medicaid eligibility should have expired. Nevertheless, during a recent exchange with TSG, OMIG pointed out that it was "not convinced that the system in place is properly excluding or closing out Private Option recipients who no longer should be eligible."

TSG has discussed these eligibility issues with DHS leadership and they have indicated that there is an appropriate plan in place to address all of these OMIG concerns. TSG will continue to monitor these eligibility issues and will report back to the Task Force its findings. TSG also is in the process of conducting interviews with other state Medicaid programs to determine how they handle these eligibility issues, including the real time connectivity and information processing capabilities of the state system.

Eligibility and Enrollment Framework Project

There are a number of areas where DHS continues to make progress in resolving issues. They are working to establish a better foundation for the future work in the EEF Project. There are several specific areas of progress TSG observed.

Curam Product

The IBM Curam software is the core technology supporting the EEF Project. 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 Curam product does not presently have the functionality to support retroactive Medicaid eligibility, newborns, and the work associated with Prospects Phase II. Negotiations with IBM are in-progress on each of these particular issues.

DHS has hired Gartner to assess the bigger picture of whether Curam is the right product for DHS to continue to rely on. As of this status report, their work is just beginning. In the meantime, the project team is following a "stay the course" approach. DHS is also participating in quarterly calls with five other states who use the Curam product. These calls do not include IBM personnel, so the states can candidly share experiences. Missouri re-signed their contract with IBM just this week. Maryland, while transferring much of Connecticut's software still uses the Curam "rules" engine.

PMO

Cognosante assumed the role of EEF PMO as of July 1. They have a plan to phase in more and more rigor in the management of the day-to-day work, the identification and resolution of risks and issues, and the overall transparency of the project status. They will produce a GANTT chart for the entire project, showing the schedule for each component, as of next week. This will be shared with Legislature as soon as it is available.

Federal Funding

DHS filed an updated Advanced Planning Document with CMS to obtain funding for the next federal fiscal year. The FFY2016 funding is:

Total Computable	$69,108,559
Federal Share	$59,709,497
State Share	$ 9,399,102

This brings the project totals to:

Total Computable	$188,445,236
Federal Share	$164,474,542
State Share	$ 23,970,694

The FFY2015 Proposed Activity Schedule as follows:

Project Schedule	Estimated Start Date	Estimated Finish Date
Release 1.6.1 ANSWER renewal Development	3/25/15	6/15/15
Service Pack 17- Defect resolution for CoC	8/7/15	6/4/15
Service Pack 18- Defect resolution for MAGI renewals – through	7/22/15	7/8/15
Release 1.8	3/25/15	6/30/15
MAGI UAT	10/1/14	9/30/15
Data Conversion Statewide ETL – through dry run 2	10/1/14	9/4/15
IBM Production Defect Corrections	10/1/14	9/30/15
MAGI Report development	10/1/14	9/30/15
SNAP Development	10/1/14	8/30/15
SNAP UAT	9/1/15	12/31/15
IRS Security Audit	7/1/15	9/30/15

The Proposed Activity Schedule for FFY2016 is as follows:

Project Schedule	Estimated Start Date	Estimated Finish Date
Service Pack 18- Defect resolution for MAGI renewals – through deployment to TFP	10/1/15	10/21/15
MAGI Development – additional functionality development	10/1/15	6/30/16
MAGI UAT	10/1/15	12/31/15
Document Management Development and Implementation	10/1/15	9/30/16
MAGI Reports and DataMart Development	10/1/15	6/30/16
Ad-Hoc Reporting Request Development	3/23/15	11/18/15
Data Conversion Statewide ETL – through production	9/4/15	1/12/16
IBM Production Defect Corrections	10/1/15	9/12/16
MAGI Report development and implementation	10/1/15	12/31/15
SNAP Pilot	1/1/16	3/31/16
IRS Security Audit	7/1/16	9/30/16
Traditional Medicaid Development (planning package)	4/1/16	9/30/16
SNAP Statewide Rollout	4/1/16	4/1/16

Scope/Budget Control on Existing Work

Project Leadership continues to manage the key vendors in a not-to-exceed budget mentality. While not a contractual requirement, both vendors seem to understand they must follow this approach to remain in good standing with DHS. Leadership is keenly focused on schedule and budget and is more flexible on the details of scope. This approach means there is good momentum in pushing the project forward and delivering something, but there are likely to be compromises in the details of the functions delivered. The PMO is committed to highlighting these compromises to DHS leadership to make sure they are known and approved.

EEF Contract Further Operational Observations

Procurement Processes

DHS is working on a procurement for the future Medicaid work to obtain a systems integrator and launch this phase of work under a better contract. The timeline for this procurement is estimated to be a year. There are three risks to be managed in this approach:

1) The requirements in the RFP need to be both complete and flexible. The requirements have been defined for the traditional Medicaid functions. These should be carefully reviewed for completeness and the maximum amount of detail and precision possible with today's knowledge. There should be equivalent attention paid to the approach for anticipating and handling changes. On the Federal and State level, there are multiple things changes that will affect the work the vendor needs to do. There will be continued dependencies between the Curam software product and the work the Systems Integrator needs to do. The mechanism for getting fairly priced change orders must be as good as the price for the predictable work.
2) DHS is looking to use the some of the RFP's that have served the agency well as a starting point for the draft of the new RFP. It might be wise to look at other agency best practices or other state best practices to manage some of the bigger challenges associated with this effort – such as the interdependency between IBM's Curam product and the Systems Integrator's work.
3) There is a gap in the timeframe between the end date of the current 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. New Mexico and Florida are both examples of where this works well and allows agencies to expedite onboarding of a pre-qualified vendor to do a particular type of work.

Contracts

McKinsey Contract

McKinsey responded to the concerns the Legislative Task Force identified and proposed a number of deliverables for their current fiscal year contract. TSG took these deliverables a couple of steps farther and proposes a level of clarity around the financial payment and schedule for each deliverable. TSG comments are shown below.

It is important for DHS to retain the flexibility to change course of the work during the fiscal year. If DHS starts the year assuming a list of 10 episodes they wish to pursue, they should retain the authority to substitute a different episode during the year.

TSG also assumes that McKinsey will not be paid until the Department accepts a deliverable. This 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 doesn't get paid until they get it right, they are highly motivated to produce high quality deliverables in a timely fashion.

As of the time of this status report, TSG is aware that negotiations with McKinsey on the contract continue and McKinsey seems willing to accept the TSG recommendations. We will continue to work with Dawn Stehle and her staff at DHS on a final decision that meets the Task Force concerns and immediately apprise the Task Force of the results.

See TSG Status Update # 2 Appendix for TSG spreadsheet sent to Dawn Stehle at DHS in response to negotiated items with corresponding TSG comments.

Top 25 Contracts

TSG reviewed the top 25 vendor contracts to see how DHS procured these vendors, how they spend changes from year to year, what the deliverables are, what the performance indicators are, and what the remedies for unacceptable performance are. There are some standard clauses that are very favorable to the State including the cancellation provisions, dispute resolution, control over subcontractors, indemnification, and payment of legal fees.

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 the provision that the contract may be terminated for poor performance. Most contracts lack specificity around the withholding or reducing of payments. On a consistent basis, DHS manages vendors on a year-by-year basis.

While the state procurement allows a contract to cover a period up to seven years, DHS manages the vendor one year at a time. This allows DHS to keep the vendors on a fairly short leash with the constant incentive to extend the work for another year without the vendor incurring the cost of a competitive rebid.

DHS has some very strong examples of specific deliverables and consequences for missing deliverables. They also have some 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 of 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.

In TSG's opinion, the weakest portion of the contracts is the way the performance indicators are written. With a few notable exceptions, most of the performance indicators read more like a Statement of Work than a quantitative quality standard for how the work is to be performed. We understand the importance of keeping the contract scope broad enough that the agency can direct the vendor to do the work required and to accommodate changes without triggering a protest

from another vendor or triggering a need for an additional procurement. However, there should be a better way to provide this agency control over the work without abandoning the specificity around performance indicators.

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 Private Option Health Care Independence Accounts.

It appears the Agency occasionally uses sole source awards for purposes of efficiently onboarding a contractor to get work done quickly. This allows the Agency to quickly meet deadlines but may not always ensure the best value for the taxpayer dollars in the long run.

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

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

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

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, as well as the amounts invoiced and paid to the vendor.

The contracts included in the review are listed in a table in the TSG Status Update # 2 Appendix.

Arkansas 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.

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.

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

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

Note: Since January 2015, 4000 HIA Cards have been returned because of a bad address associated with the beneficiary. This is a 9% bad address rate and is within the similar range provided to TSG for the Private Option by Arkansas Blue Cross and Blue Shield. TSG recommends that the Task Force ensure that there is some form of immediate notification from the HIA vendor to carriers and/or the Department when they are unable to locate a beneficiary due to a bad address so that the issue could be addressed expeditiously.

Organization

DHS is organized primarily by functional area. The Director's direct reports include:

- A Deputy Director over Behavioral Health, Medical Services, Aging and Adult Services, Developmental Disabilities, and County Operations
- A Deputy Director over Services for the Blind, Youth Services, Children & Family Services, Community Service & Nonprofit Support, and Child Care & Early Childhood Education
- Finance & Administration
- Policy & Legal Services
- Systems & Technology
- Communications, Policy and Planning, Quality Assurance, Emergency Operations, Client Protection and Advocacy

This functional orientation is typical of State Agencies. It allows hiring of subject matter experts who have the experience in their particular specialty. It allows people to have deep expertise in their area. The downside is that it doesn't always foster collaboration and cooperation across the functional areas.

By nature, organizations develop silos who tend to have their own strong preferences about the way things should be done. In the old days, when everything was done on paper, it was acceptable for an individual part of the organization to have their own forms, processes, and data to support their area.

In today's world, it becomes cost prohibitive for technology to support the different divisions maintaining their old, unique ways. In addition, today's customer expects an integrated experience. A person's experience with different DHS services will be perceived as fractured because the different divisions have their own processes and practices. The care is not integrated and coordinated. In addition, the policy and rules making decisions are not integrated and coordinated.

The agency needs to create an integrated vision for the future and to move each division into a more collaborative, shared mindset. There are opportunities to save money and provide better service to the clients. One example of this is the Co-Centrix project. The intent of this technology tool is to support assessment. It was originally intended to support four divisions. In fact, the Department purchased the number of licenses they did based on assumptions that all divisions would utilize this software. However, the Behavioral Health and Long-Term Care components are on hold pending the product working for just Aging. TSG understands that the four divisions originally differed on which product they wanted to use to accomplish this similar function and that it required an IT Steering Committee meeting to decide not to allow each division to hire a separate vendor and launch a project designed to meet their own unique needs.

Long Term Services, Supports, and Independent Assessment

DSH Divisions of Aging and Adult Services, Developmental Disability Services, Division of Behavioral Health Services and Division of Medical Services – Office of Long Term Care

On 1/16/14, CMS issued new Rules for Home and Community Base Services. Given the scope of the new Rule CMS required "Transition Plans" from all states and allowed for up to five years for states to meet the standards and requirements over. The new Rule was extensively negotiated with CMS by families, states, providers, advocacy organizations and others from across the country. The new Rule (under Part 430: Grants to States for Medical Assistance) attempted to bring together a complex distribution of related requirements specifically under 42 CFR (430, 431, 435, 436, 440, 441, and 445). The new Rule specifically addresses:

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 Reassignment

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 use of Medicaid funds for room and board and specific "FFP is not available for the cost of room and board in State plan HCBS" and specific exclusions respite services, adult day health, and unrelated caregivers in households

One important issue the Rule clarified was the question of whether the criteria for an independent assessment and development of that individual's service plan (and resulting cost) was met if the assessing entity was also a provider engaged and paid for the delivery of care to that individual. Section 441.730 (4) (Provider Qualifications) states that a conflict of interest exists if the entity conducting the "independent assessment as required by Section 441.720 has a "financial interest, as defined in Section 411.354 of this chapter, in any entity that is paid to provide care for the individual."

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

Starting in 2010/2011, DHS began the planning, development, and implementation of 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 embedded in the Division of Medical Services.

Many states, such as New York, California, and Maine have been successful in implementing universal assessment models into their Medicaid Long Term Care Programs. Washington and Wisconsin have been successful in developing computer based algorithms associated with their universal assessment instruments into developing levels of care based plans of care and cost.

Universal assessments that are designed to determine medical necessity and levels of care that inform development of the individual services plan and related cost variable or tiered payments are known as "a best practice" model in state Medicaid programs . This approach has been integrated into full benefit state Medicaid managed care plans such as Kansas and Tennessee.

Arkansas DHS, based on a national and stakeholder planning effort, made the decision to utilize the universal assessment suite of instruments known as the InterRai. The InterRai organization is nonprofit, sponsored by the University of Michigan and utilized in a growing number of states and internationally.

There are 18 discrete InterRai assessment instruments including LTC – Facility, MH – Facility (with Forensics component), Home Care, and Developmental Disabilities. Each instrument has 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. It is important to note that there are other validated individual assessment instruments for Long Term Care, Developmental Disabilities, and Behavioral/Mental Health that states have developed and implemented in their systems of care, such as the SIS instrument for

Intellectual/Developmental Disabilities recommended by several Arkansas DD providers during the planning process.

In order to implement the InterRai universal assessment platform across DAAS, DDS, and DBHS, DHS decided to contract with CH Mack/MedCompass, based on a RFP process, to develop the digital home and portal for the InterRai suite of assessments. This project met with unacceptable outcomes and DHS terminated 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 has also been problematic and the final determination of success, continuation, or termination should be known in the next several weeks according to DAAS. The project started in 2010/2011 from the planning phase and the target completion date appears unknown at this time.

TSG, at this point in our work, is unclear on how the "Three Phases" of the IT systems implementation InterRai across DMS, DAAS and DDS (DBHS appears to be on a complete hold) is being coordinated on an operational level, what are each phases' process goals that would be used to measure timeliness, how will overall success be measured, and what will be the final cost to the state. The "Three Phases" include:

- Phase One: systems functional capability to complete InterRai assessments for HCBS LTC and DD
- Phase Two: systems functional capability to develop the individual plan of care and budget based on the assessment and level of care
- Phase Three: Provider portal and data analytics

Independent assessment, individual services planning aligned with assessed levels of care, and logic based individual budgets are critical components of any state's targeted initiative to re-balance their long term care systems from institutional based utilization to community based first option systems.

Findings to Date

TSG wishes to acknowledge the high degree of enthusiasm at DAAS and DDS to successfully complete the Three Phases of InterRai implementation and go live in the field as the expectations are high that quality, outcomes, consumer satisfaction, cost efficiency will be improved. TSG also wishes to acknowledge the goal of DBHS to resolve the current policy gap regarding independent assessment for both inpatient and outpatient services for children, adolescents, and adults.

DHS has relied on an IT contractor (CoCentrix) to provide the platform for the successful implementation of the InterRai standardized assessments for DAAS, DDS, and DBHS. We have reviewed the CoCentrix Release Plan and are unable to track deliverables specific to each divisions population specific InterRai assessment, the timelines for each divisions three phases (assessment go live, plans of care go live, tiered payment models go live) of necessary development, testing, and training.

The use of a standardized assessment for DBHS services, specifically inpatient psychiatric and RSPMI services was apparently halted in March, 2015. DAAS also halted the plan of care functionality in March, 2015 as well. At this time there does appear to be a timeline to develop and implement the InterRai instrument for behavioral health services.

TSG has noted that Value Options does not utilize a standardized assessment instrument or form to provide prior authorization services for inpatient psychiatric and RSPMI services and relies on clinician narrative statements, which are subjective by nature. We have discussed the implementation of the InterRai with the University of Michigan professionals involved with the installation of the InterRai suite of standardized assessment instruments. It is unclear if a project management model of scheduled communications and discussions among DHS, CoCentrix, and the University of Michigan (B Fries, ML James) took place before CoCentrix began developing their system building approaches to digitizing the InterRai instruments, plan of care and algorithmic logic of the tiered payment model systems operability in the field, reports, and internal logic of the enterprise. There does not appear to have been a project team environment embedded in the project from the outset.

DHS is currently withholding $300K of the $9.1 million invested to date with Co-Centrix. This does not include the money DHS has contracted with Cognosante to PMO this project and Northrup Grumman to support the technology. DHS has a full time Cognostante position serving as Project Manager and Northrup Grumman resources serving as systems integrator. Assumedly, both entities provide services based on the Project Charter and detailed work plans signed off by the three division directors. Scope, milestones and payment to Cognosante are not tied together in the state cooperate purchasing agreement.

Phase 1 DAAS state nurse testing is expected to begin the second week in July and extend over the following two weeks. TSG is unclear if the Phase 2 and 3 APD implementation plan is in sync with the current Co-Centrix contract. We are also unclear if the University of Michigan is involved in a meaningful way with these phases of project development.

If the scheduled testing phase yields positive results than the question of proceeding on Phase 2 and 3 of the project, including DDS functionality, bringing DBHS back into the original design and revisiting the CoCentrix Release Plan and schedule becomes clearer. If the results are significantly problematic than there would be good cause for reconsideration of the current Project Plan, varied contractors, and continued expenditure of available or future funds.

We have also found, based on numerous meetings and observations, that there appears to be a "silo" approach to the management of each of these three divisions, although there has been recent action from DAAS, DDS, and DBHS to meet together to address the implementation of the InterRai and issues with CoCentrix. 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 to avoid an organizational silo mentality given the umbrella structure in place.

Additionally, the investment in cross division management practices results in the ability of an "umbrella" Department to actively address complex and high cost cases regardless of point of service, supports the goal of a singular vision for health status improvement for all Arkansans eligible for services, and prioritizes appropriate cost containment and integrated program integrity actions while 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.

TSG on-the-ground interviews and research to date has been unable to date to define DHS' comprehensive approach and plan for care coordination for the high cost, multiple services population ("80% of spend goes for 20% of the Medicaid population"). While the PCMH model has elements of care coordination the model is essentially Primary Care focused and unconnected to the waiver(s) populations by design.

The Balanced Incentives Program grant model had some positive elements of care coordination for exactly the right populations but was unconnected to the PCMH model and lacked a robust laser-like case management capacity across the BIP populations (DAAS, DDS, and DBHS). The Stephen Group Final Report will include best practice care coordination models that are based on integrated and comprehensive approaches and payment models for effective care coordination for high need/high cost complex populations.

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

Given the rural nature of large regions of Arkansas the availability and types of "Telemedicine" available through the state's Medicaid program has been brought to our attention by advocates and providers alike. Since the advent of the web and the health care market's innovative investment in medical services based "apps" and electronic monitoring (with the caveat of "buyer beware"; documented evidence of effectiveness advised) state decision makers and Medicaid agencies have an explosion of choices.

This said, the bottom line for CMS is that telemedicine is a "cost effective alternative" to face to face encounters and is not considered a medical service per se. Additionally, CMS allows states several administrative choices on how to implement "Telemedicine" based services:

Medical Codes**:** States may select from a variety of HCPCS codes (T1014 and Q3014), CPT codes and modifiers (GT, U1-UD) in order to identify, track and reimburse for telemedicine services.

States are not required to submit a (separate) SPA for coverage or reimbursement of telemedicine services, if they decide to reimburse for telemedicine services the same way/amount that they pay for face-to-face services/visits/consultations.

States must submit a (separate) reimbursement SPA if they want to provide reimbursement for telemedicine services or components of telemedicine differently than is currently being reimbursed for face-to-face services.

States may submit a coverage SPA to better describe the telemedicine services they choose to cover, such as which providers/practitioners are; where it is provided; how it is provided, etc. In this case, and in order to avoid unnecessary SPA submissions, it is recommended that a brief description of the framework of telemedicine be placed in an introductory section of the State Plan and then a reference made to telemedicine coverage in the applicable benefit sections of the State Plan. For example, in the physician section it might say that dermatology services can be delivered via telemedicine provided all state requirements related to telemedicine as described in the state plan are otherwise met.

Division of Aging and Adult Services:

The current organizational structure of DHS includes NH assessments being conducted by qualified staff from nursing homes (that often admit the individual they are assessing) based on Form 703.

Medical necessity is determined by the DMS Office of Long Term Care, which also conducts required surveys of nursing homes.

DAAS is currently engaged in the implementation of Phase One of the Home Care InterRai for home and community based waiver services.

DAAS nurses conduct the InterRai assessment for HCBS services and determine medical necessity and levels of care. The current "Production" target date is 8/2015 with an imminent decision expected to be made by DAAS on the functionality of the CoCentrix product by the end of July, 2015.

The contracted target dates for CoCentrix to complete Phases Two and Three of the InterRai are unknown at this time. DHS has stated they anticipate a "Production" target date for Phase Two/Plans of Care by November, 2015, and a target date of "2016" for implementation of the OLTC assessment.

TSG is unable to determine when the CoCentrix Release Plan (See TSG Status Report # 2 Appendix is expected to complete the development and user testing process for the implementation of the DAAS InterRai Plans of Care and tiered payment methodology.

Although there are variances across the state, DAAS is currently averaging 5.93 days for completion of a new Elder Choices waiver application and assessment for services and 5.93 days for an Alternatives for Adults with Physical Disabilities waiver application and assessment for services on a statewide basis. TSG notes that DAAS has 10 business days by Rule to complete new waiver assessments and currently does not have a waiting list to complete new assessments.

Division of Developmental Disabilities Services

The Division utilizes the Reynolds/RAIS/WAIS for IQ determination and Vineland Adaptive Behavior Scale administered by independent testing professionals. Once areas of need are determined the InterRAI is administered to determine needs, strengths, and preferences as well as acuity levels anticipated to be tied to individual budgeting and services planning. Applications for ICF/IDD admission are processed on Form 703 and medical necessity is determined by the DMS Office of Long Term Care.

According to DHS the assessment functionality of the DDS version of the InterRai is functional, "completed and in active use".

DDS has delayed the implementation of the Plan Functionality as of March, 2015.

TSG is unable to determine when the DHS CoCentrix Release Plan (See TSG Status Report # 2 Appendix) is expected to complete the development and user testing process for the implementation of the DDS InterRai Plans of Care and tiered payment methodology.

DDS currently has a "waiting list" of approximately 2,500 persons requesting home and community based services. Current policy prioritizes available waiver services for persons wishing to transition from Human Development Centers, nursing facilities, and Arkansas State Hospital. Given the relatively low turnover of persons receiving waiver services there are extensive wait times for persons currently living in the community.

Division of Behavioral Health Services

According to DHS the implementation of the InterRai instrument for mental health services is not currently underway pending the completion of the development and implementation of the InterRai in the DAAS and DDS operational systems and field work.

According to the DHS CoCentrix Release Plan DBHS has not been included since project inception in June, 2014, nor is there any indication of when DBHS will be included in the current Release Plan and a target date for functionality.

DBHS currently contracts with Value Options of Arkansas for the following prior authorization services:

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

The current inpatient/outpatient prior authorization process that DBHS has contracted with Value Options is currently not based on the use of a standardized assessment tool by clinicians/providers in the field. As a result there are only two levels of care: inpatient or outpatient/RSPMI (99% of OP services).

Value Options reports that their licensed clinicians and supervising MDs making prior authorization determinations rely on the narrative sections of the prior authorization requests and point out that current documentation requirements are called for in DBHS Outpatient Provider Codes: 252.110.

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

The "any willing provider" criteria for RSPMI services has resulted in increased utilization but not necessarily coordinated care. There is concern about quality services and a lack of incentive to avoid inpatient utilization or timely discharge.

Value Options noted a recent 69% reduction in the authorization of ADHD cases.

TSG recognizes that there are evidence based approaches to treating mental health issues in primary care settings. The Diamond Program/Impact study (Jürgen Unutzer, MD, MPH, et al: University of Washington) is an evidence based primary care setting integration model that focuses on depression and has been brought to scale in Minnesota. This said, TSG has not found evidence that the PCMH model is targeted to address the psychiatric and social supports needs of people with severe and persistent mental illness who have multiple chronic care conditions (such as diabetes and obesity) and are high utilizers of inpatient psychiatric services. DBHS did explore the opportunities for a Behavioral Health Home model based on three levels of care (low, medium, high) that could be constructed to be compatible with the PCMH model. This model has proven to be highly successful in states such as Missouri.

TSG also notes that the state Medicaid program does not provide a benefit for Assertive Community Treatment, a documented evidence based practice that supports recovery and 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.

A recent report on the issue of mentally ill adults in jails and resulting costs within Arkansas was brought to TSG's attention. 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 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 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. Many believe the percentage is as high as 40%-55% depending on the type of correctional facility.

The TSG Final Report will include specific recommendations of state and community best practices models that address mental illness crisis management, jail diversion, use of mental health courts/substance abuse courts, and community re-entry models.

Case Management Services, DAAS, DDS, DBHS

Medicaid State Expenditures for Case Management	Expenditures Per Resident	Rank	Total Expenditures
Arkansas	$0.86	40	$2,522,319
Tennessee	16.64	6	107,415,447
Mississippi	16.28	7	48,583,503
Alabama	13.36	12	64,415,780
Oklahoma	11.77	15	44,900,325
Kansas	10.48	17	30,246,141
Missouri	10.26	18	61,790,623
Kentucky	10.11	19	44,267,834
Louisiana	5.00	29	23,027,718
USA	$8.53	NA	NA

Source: Medicaid Expenditures for Long term Services and Supports: FY 2012. CMS/Truven Health Analytics

Case management services are available in the DAAS and DDS LTC systems. There are no case management services available in the DBHS system regardless of severity of condition or age.

Alternative Community Services Waiver (DDS) case management definition: “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”.

Alternative for Adults with Physical Disabilities Waiver (DAAS) case management service definition: “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.”

Elder Choices Waiver (DAAS): Targeted Case Management (State Plan benefit) service definition:

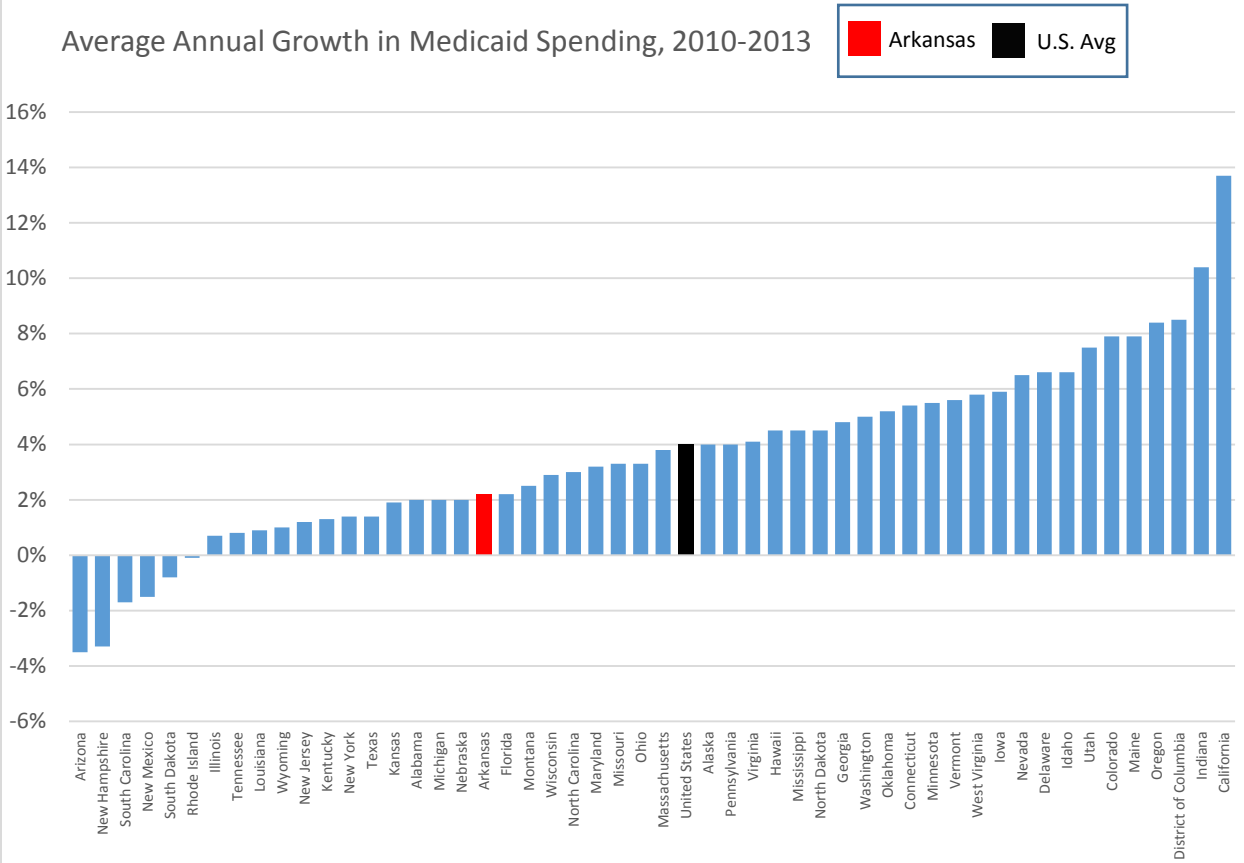
> "Medicaid clients age 60 or older who have limited functional capabilities and need assistance with the coordination of multiple services and/or resources may be eligible for this service. Case management services will assist Medicaid recipients in gaining access to needed medical, social, educational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

The "Data Book" recently prepared for the DHS Managed Care RFI by McKinsey indicates that in FY 2014 6893 individuals received state plan targeted case management services and Elder Choices waiver services and 2597 individuals received case management services from the Alternatives for Adults with Physical Disabilities waiver. TSG Task Force Report #1 indicates that $3,739,954 was expended on Medicaid paid case management services for FY 2014.

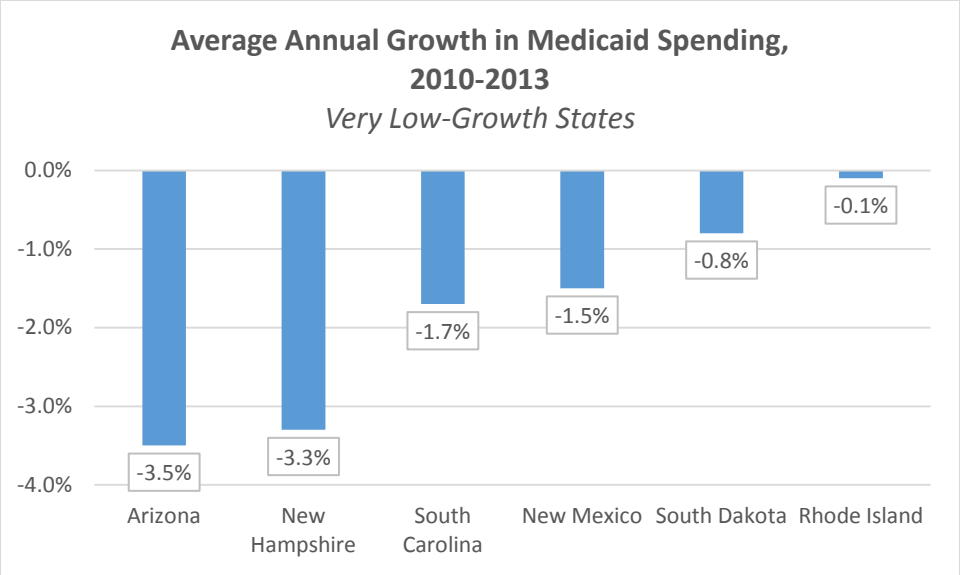
Specific program eligibility requirements that include case management services avoid the possibility of duplicate case management payments for the same individual.

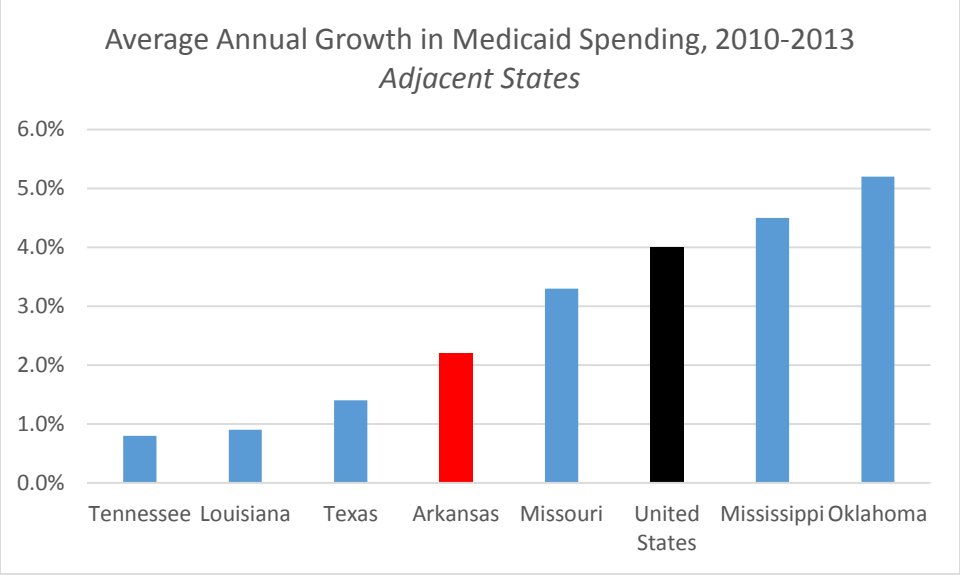
The TSG Final Report will include recommendations on opportunities for the Arkansas Medicaid program to extend the use of carefully defined case management services that support home and community based living, avoid unnecessary institutionalization, and limit overutilization.

State By State Comparisons on Annual Growth



Source: Kaiser Family Foundation, Average Annual Growth in Medicaid Spending; http://kff.org/medicaid/state-indicator/growth-in-medicaid-spending/





Options to modernize Medicaid Programs serving the indigent, aged, and disabled: Preliminary Analysis and Observations

Background:

"Medicaid modernization" is essentially an overarching strategy for state elected officials to determine the policy and improvement models they determine will have the best opportunity to result in the 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
- 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

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 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 PPACA in 2010, there was a convergence of the need for all states to consider the policy questions of the Act 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 financial crisis 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 systems due to growing demand for services, the substantial amount of LTC Medicaid spending, and demographic trends; 2) high cost individuals with multiple chronic care conditions enhanced by the states growing capacity to take advantage of IT based developed or contracted inter-relational data bases 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 and 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 approaches to their long term care populations including people with intellectual and developmental disabilities for the first time in 2013 (Kansas). 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".

As an example, in 2004 there were 8 states that delivered LTC services in a "managed care" model. By 2014 it was estimated that 26 states had implemented "Managed Long Term Services and Supports" models (Source: CMS/Truven Health Analytics: "Growth of Managed LTSS": 6/12)

State interest in improving their LTC Medicaid programs while 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, improving access and quality, and assuring budget stability.

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 package
- Qualified providers
- Participant protections
- Quality

Medicaid Delivery System Models

Below is a listing of the various Medicaid service delivery system models of care from across the country.

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)

Other Delivery System Models

- Patient-Centered Medical Home (PCMH)
- Health Home (HH)
- 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)

(Source: "Medicaid Delivery System and Payment Reform: A Guide to Key Terms and Concepts": Kaiser Commission on Medicaid and the Uninsured; 6/2015)

Comprehensive Medicaid Payment Reform Models Operational in 2014

(Sourced from: Kaiser Family Foundation/National Association of Medicaid Directors/Health Management Associates: 10/14: adapted by The Stephen Group)

Managed Care (Risk based)	MCO and PCCM	PCCM Only	No Comprehensive MCO	ACO in Place	DSRIP* in Place
Arizona California Delaware Georgia Hawaii Kansas Kentucky Michigan Minnesota Mississippi Missouri Nebraska Nevada New Hampshire New Mexico New York Ohio Oregon Pennsylvania South Carolina Tennessee Texas Utah Virginia Washington Wisconsin	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 planned in 2015)	California Kansas Mass. New Jersey Texas (NY planned in 2015)

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.

Section 1332 Waiver

The Stephen Group participated in Section 1332 related conversation with the state of Michigan's Medicaid Policy Director's Office, since the last Health reform task Force meeting. Michigan's current 1115 waiver for their market based approach to expansion actually ends before Arkansas' 12/31/16 date. The Michigan Medicaid program has spoken with CMS about 1332 waiver ideas. The conversation was reported to be very broad and noncommittal as they felt CMS was still considering ramifications post the Burwell decision prior to their issuing any information, rules changes, or Medicaid Director's letters on the 1332 waiver, if any.

Health Workforce

One of the areas of investigation in this study is the question of what effect the payment improvement initiatives and private option have had on the recruitment and retention of health care providers. On this question, our analysis and evaluation has focused primarily on physician recruitment and retention.

There have been multiple studies on physician workforce issues in Arkansas over the last 5 years including the following:

- *Arkansas Health Workforce Strategic Plan: A Roadmap for Change* – Published April 2012; Report from the Arkansas Health Workforce Initiative, chartered by Governor Beebe, staffed by ACHI.
- *Arkansas Health Care Workforce: A Guide for Policy Action* – Published March 2013; Produced by ACHI with funding from the Blue and You Foundation.
- *Arkansas Health Professions Manpower Statistics 2013* – Annual compendium of health workforce stats by geography and health profession.

The existing analyses of health workforce in Arkansas are not timely enough to attempt to answer the questions of whether the payment improvement initiatives and private option have improved the recruitment and retention of physicians.

Anecdotally, the current practice environment for physicians is more favorable than it was prior to the implementation of the payment improvement initiatives and private option, particularly for doctors practicing in primary care.

Further analysis of this question will include review and analysis of physician licensing data from the Arkansas Medical Board.

4. ISSUES/CONCERNS

Regarding the EEF project, as described in the status above, the Department is in a better place than it was a year ago, but they are a long way from the successful completion of this complex project.

In addition, the federal requirement to conduct income verification just annually, not shorter, constrains the state's ability to consider shorter time periods for income verification review. TSG is conducting an analysis to determine if shorter intervals of time between income verifications would be beneficial to the state.

Given worst case timing, using current income validation methods, a client could have had a significant eligibility change, even have become ineligible, for as long as 16 months before the system would be able to alert DHS that the case needed review. This raises the obvious question of would the costs of decreasing this latency save money for the state? Would increasing the currency of the income validation information save the state more than it would cost?

By current state regulation, and possibly also according to some Federal guidelines, Workforce Services Unemployment Insurance income and wage data cannot be shared with outside contractors in a way that would allow individual identification of enrollee income. Workforce Services has been working diligently with TSG to develop a method to get the aggregate information required for TSG to complete their analysis for the Task Force. We believe we have come up with a method that will provide the necessary information but we won't know for sure a few more weeks so the issue remains on our concern list.

The Blue Cross Blue Shield Medicaid ID information has been requested but has not yet been received.

Concern about DHS achieving a comprehensive solution for DAAS, DDS, and DBHD use of InterRai assessments for program services determination given issues with CoCentrix and delayed implementation across the board. Consideration for a Plan B needs to be considered quickly if DAAS assessment functionality proves ineffective and unacceptable by DAAS.

Did you want to mention our concern that, despite its elegant design and some positive early results, EOCs may not yield enough economic value at a pace to deliver adequate cost savings in time to meet the state's budget requirements?