ARKANSAS DEPARTMENT OF HUMAN SERVICES

Arkansas Medicaid Sustainability Review

DRAFT

Arkansas Department of Human Services

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SECTION 1: INTRODUCTION

Arkansas Medicaid spent over $9 billion in State Fiscal Year (SFY) 2023, providing a wide range of health services to more than one million beneficiaries across the State. The annual cost of operating the Medicaid program has steadily increased, rising 41% between SFY 2018 and SFY 2023.[1] During this same period, Medicaid has grown from approximately 20% to approximately 23% of the State General Revenue fund forecast, causing concern about the sustainability of the Medicaid program and increasing strain on the overall State budget.[2]

Medicaid spending is driven by several factors, including enrollment and eligibility, beneficiaries' use of health care and long-term services and supports, policy decisions about payments and financing, benefit coverage, administration, and service delivery.[3] Medicaid agencies have more control over some of these factors than others. For example, states have little control over costs due to Medicaid enrollment growth during economic downturns when more people become eligible for Medicaid. In addition, during the COVID-19 Public Health Emergency, Congress enacted legislation requiring Medicaid programs to keep people enrolled in Medicaid in return for a temporary 6.2 percentage point increase in the Federal Medical Assistance Percentage. In addition, while states may elect to cover some optional Medicaid benefits, to receive federal matching dollars, states are required to cover certain mandatory benefits (e.g., inpatient and outpatient hospital services, home health services, transportation to medical care).[4]

The cost pressure on the Medicaid program has only been heightened by the Public Health Emergency's limitations around Medicaid disenrollment, which caused Arkansas Medicaid to reach peak enrollment during SFY 2023. With the end of the Public Health Emergency in May 2023, enrollment growth has subsided, and Arkansas experienced the first year-over-year decrease in enrollment at the end of SFY 2023 since the end of SFY 2019. As of December 1, 2023, total Medicaid enrollment was 852,343 beneficiaries.[5] Despite the recent reduction in

[1] Based on data provided by Optum.

[2] Based on Official Forecasts of General Revenue from the Arkansas Department of Finance and Administration. Retrieved from: https://www.dfa.arkansas.gov/budget/general-revenue/.

[3] Kaiser Family Foundation. (April 13, 2023). Medicaid Financing: The Basics. Retrieved from: Medicaid Financing: The Basics | KFF.

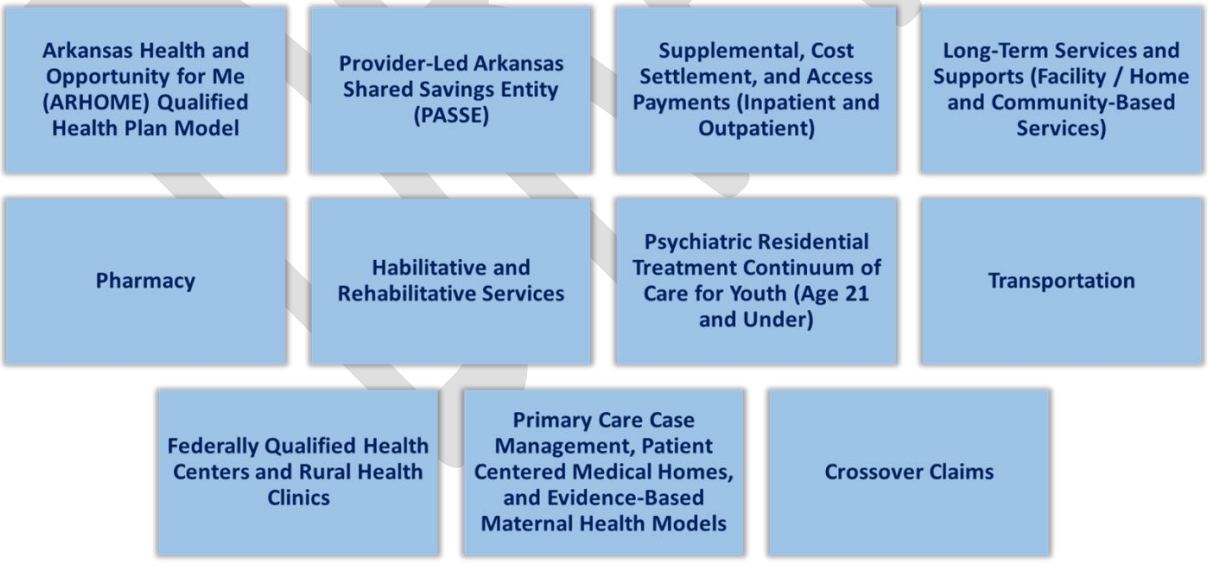
[4] Centers for Medicare & Medicaid Services. (n.d.). Mandatory & Optional Medicaid Benefits. Retrieved from: Mandatory & Optional Medicaid Benefits | Medicaid.

[5] Arkansas Department of Human Services. November 2023 Monthly Enrollment and Expenditure Report. Retrieved from: https://humanservices.arkansas.gov/wp-content/uploads/Monthly-Enrollment-and-Expenditure-Report_November-2023.pdf.

enrollment, it remains critical to examine opportunities to improve the sustainability of the Medicaid program. In addition, the Federal Medical Assistance Percentage will decrease from 72.0% to 71.14% beginning October 1, 2024, meaning that the federal matching contribution for medical services will decrease.[6] Using total medical services expenditures from SFY 2023 as an approximation, this will account for about $55 million in increased non-federal share spending due to the decreased Federal Medical Assistance Percentage.

The Arkansas Department of Human Services (DHS) conducted the Medicaid Sustainability Review from March to October 2023 to examine options to improve Medicaid program sustainability. While several factors contribute to Medicaid spending, as noted previously, this review focused on the programmatic areas where there are the most opportunities to begin to control spending over the next five years. Therefore, as part of this review, DHS evaluated key Arkansas Medicaid program areas, included in **Figure 1**, to understand the program's strengths and identify strategic options for the State to support Medicaid's long-term fiscal sustainability and improve access to care and health outcomes. This review focused on programmatic modifications to support the fiscal sustainability of Arkansas' Medicaid program and was not intended to evaluate individual provider rates. Once Arkansas Medicaid programmatic decisions are made, DHS may further consider modifications to provider rates. In addition, this review did not cover inpatient and outpatient hospital services (outside of supplemental, cost settlements, and access payments), as DHS is exploring options related to hospitals separately.

Figure 1. Medicaid Sustainability Review Program Areas



[6] Kaiser Family Foundation. (n.d.). Federal Medical Assistance Percentage for Medicaid and Multiplier. Retrieved from: Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier | KFF.

This review included data and documentation review, interviews with key informants from DHS and other Arkansas agencies, and a national scan of leading practices. This report provides strategic options for the program areas identified by DHS.

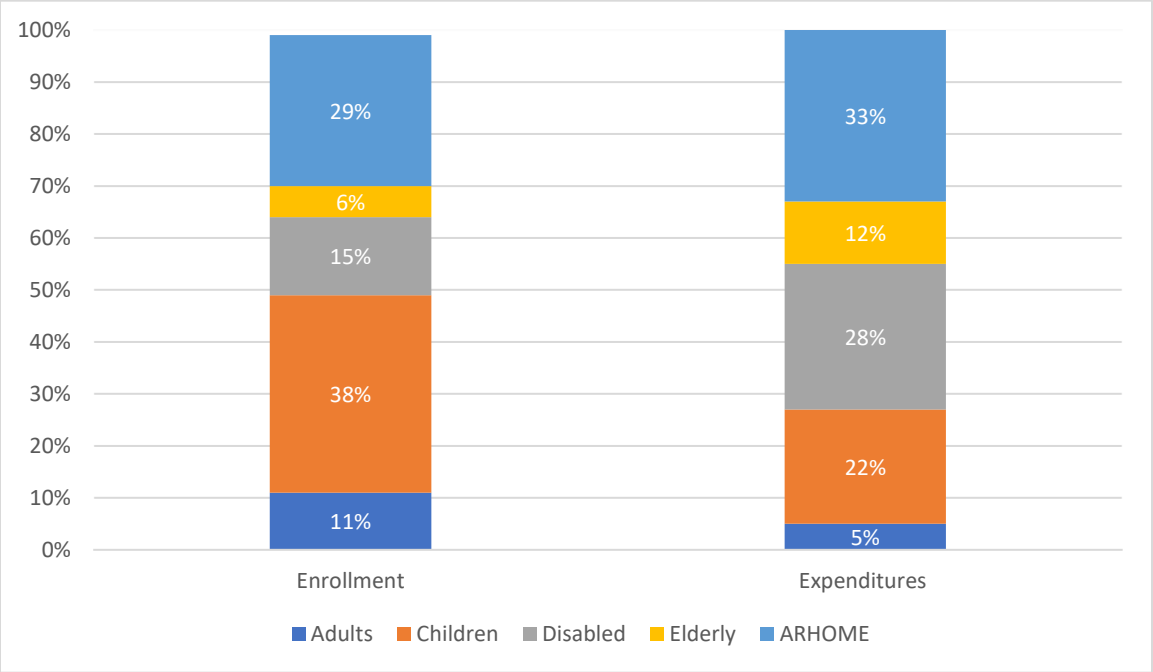
When reviewing Arkansas Medicaid's sustainability options, it is important to consider the pressures that Arkansas faces that contribute to Medicaid program spending. According to America's Health Ratings, which evaluates states on 49 measures across five categories of health: social and economic factors, physical environment, behaviors, clinical care, and health outcomes, Arkansas ranks number 48 out of 50.[7] Arkansas had the fifth highest poverty rate among states, with 16.8% of Arkansans in poverty during the past 12 months in 2022.[8] In addition, 41% of Arkansans live in rural counties.[9] Nationally, rural residents have worse health outcomes, are older, poorer, and sicker, and experience heightened barriers to accessing health care compared to those in urban areas.[10]

Overview of the Arkansas Medicaid Program

DHS provides various services for children and families, individuals with disabilities, adults (including the adult expansion population), and seniors. **Figure 2** shows the proportion of enrolled beneficiaries and Medicaid expenditures by population category in SFY 2023.

[7] America's Health Rankings. United Health Foundation. 2023 Annual Report. Retrieved from: ahr_2023annual_comprehensivereport_final2-web.pdf (americashealthrankings.org).
[8] United States Census Bureau. (December 2023). Poverty in States and Metropolitan Areas: 2022. Retrieved from: Poverty in States and Metropolitan Areas: 2022 (census.gov).
[9] University of Arkansas System Division of Agriculture. (2021). Rural Profile of Arkansas. Retrieved from: 2021 Rural Profile MP564 (uada.edu).
[10] Medicaid and CHIP Payment and Access Commission. (April 2021). Medicaid and Rural Health. Retrieved from: Medicaid and Rural Health (macpac.gov).

Figure 2. Medicaid Enrollment and Expenditures by Population Category, SFY 2023



*Enrollment is as of June 30, 2023. Expenditures include FFS claims data and capitations.

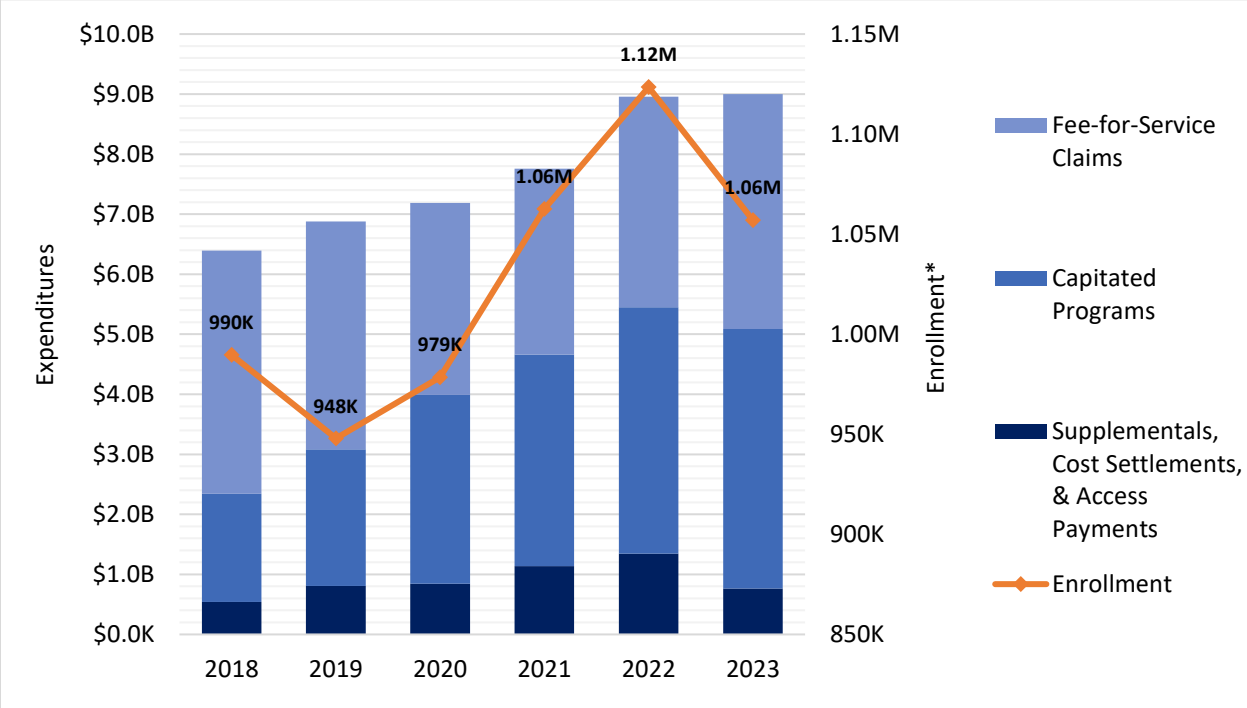
Arkansas Medicaid operates a traditional fee-for-service (FFS) model, and an organized care program called the Provider-led Arkansas Shared Savings Entity (PASSE) program. The PASSE program is for beneficiaries with complex behavioral needs and intellectual and developmental disabilities and helps coordinate and manage their care. Arkansas also operates ARHOME (Arkansas Health and Opportunity for Me), which serves the Medicaid expansion population through Qualified Health Plans. ARHOME is provided through the Marketplace, and Qualified Health Plans are paid monthly premiums. Beneficiaries not enrolled in the PASSE program or ARHOME receive most of their services through the FFS program.

A dental managed care program and a non-emergency transportation program also provide services to Medicaid beneficiaries (including those served by the PASSE program and the FFS program, as well as limited benefits to some ARHOME beneficiaries) on a capitated basis. In addition, Arkansas Medicaid makes supplemental and non-claims based payments, which include hospital access payments, cost settlements, Division of Medical Services contracts, and Medicare buy-in premiums, among other expenses. **Figure 3** below shows SFY 2018 – 2023 FFS and capitated program Medicaid expenditures, supplemental and non-claims-based payments, and Medicaid enrollment. Between SFY 2018 and SFY 2023:

- FFS claims expenditures decreased by 3%

- Capitated program expenditures increased by 140% (new capitated programs were implemented during this period, causing a shift in services being covered through capitated programs instead of FFS)
- Supplementals, cost settlements, and access payments increased by 42%
- Medicaid enrollment increased by 7%

Figure 3. SFY 2018 – 2023 Medicaid Expenditures and Enrollment*



*FFS claims data are summarized by the date of payment. Capitated program data are summarized by the date of capitation month and include ARHOME, INCHC, PASSE, dental, Non-emergency Transportation, Primary Care Case Management, and the Program of All-Inclusive Care for the Elderly. Non-claim based payments are excluded from expenditures. Enrollment numbers indicate enrollment as of June 30 of each SFY.

When looking at annual Medicaid spending per beneficiary from 2019 to 2023, Arkansas Medicaid's spending has been below the national average annual Medicaid spending per beneficiary, as reported in the Centers for Medicare & Medicaid Services (CMS) National Health Expenditure data. However, year-over-year (YOY) spending per beneficiary for Arkansas Medicaid has been increasing at a faster rate, while year-over-year enrollment changes have been smaller compared to Medicaid National Health Expenditure data. **Figure 4** below summarizes Medicaid expenditure trends for Arkansas Medicaid as compared to National Health Expenditure Medicaid trend data.

Figure 4. Medicaid Spending per Beneficiary Trends, Arkansas Medicaid compared to National Health Expenditures[11]

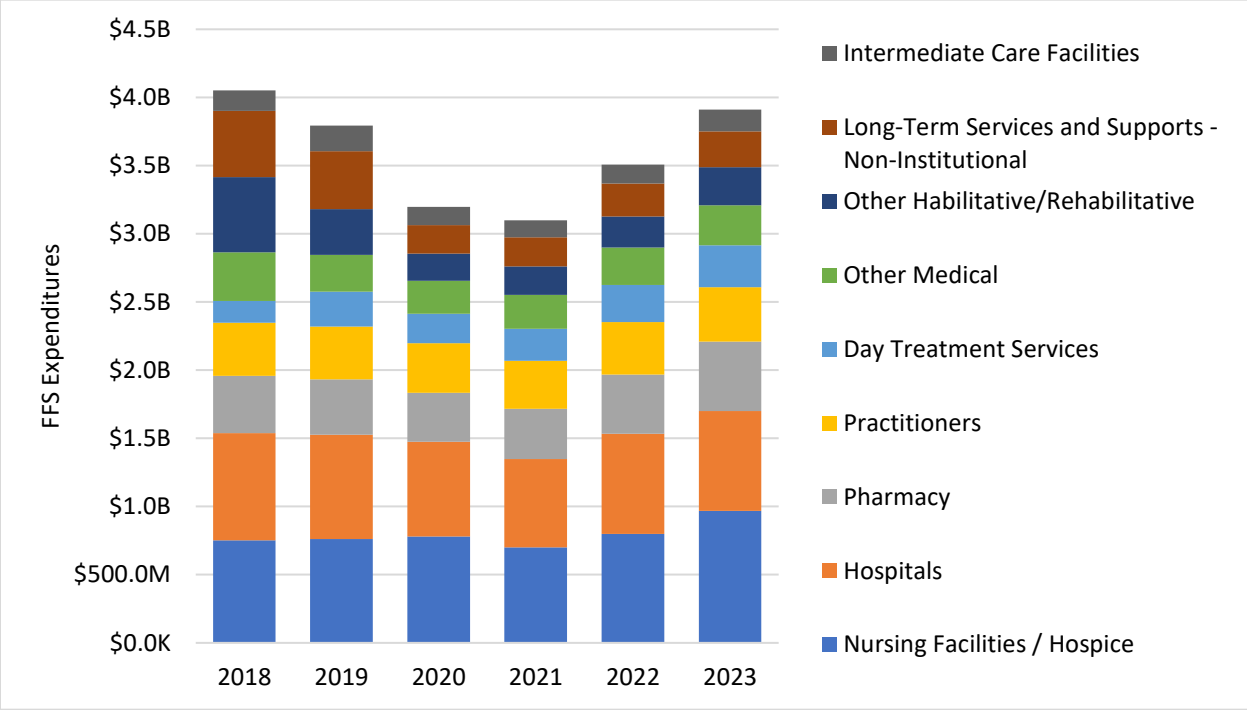
	2019	2020	2021	2022	2023
Arkansas Medicaid Data					
Annual Spending per Beneficiary	$6,046	$6,495	$6,914	$7,593	$7,280
YOY Spending per Beneficiary Change	8.9%	7.4%	6.5%	9.8%	-4.1%
YOY Enrollment Change	-1.2%	-2.7%	1.4%	5.1%	4.8%
Medicaid National Health Expenditure Data					
Annual Spending per Beneficiary	$8,460	$8,824	$8,666	$8,906	$9,316
YOY Spending per Beneficiary Change	4.1%	4.3%	-1.8%	2.8%	4.6%
YOY Enrollment Change	-0.9%	4.8%	11.2%	6.7%	-0.9%

Figure 5 below illustrates how FFS Medicaid expenditures by service have trended between SFY 2018 and SFY 2023. Following the implementation of the PASSE program in March 2019, FFS spending decreased during the remainder of SFY 2019 and into SFY 2020 as services for beneficiaries shifting from FFS to the PASSE program began to be covered as part of the new program rather than the FFS delivery system. FFS expenditure categories that experienced the greatest increases between SFY 2018 and SFY 2023 were:

- Day treatment services (94% increase)
- Nursing facilities/hospice (29% increase)
- Pharmacy (21% increase)

[11] Arkansas Medicaid data spending based on FFS claims (by date of payment), capitated program expenditures (by date of capitation month), and supplemental and non-claims based payments by SFY. Arkansas enrollment data based on the total number of beneficiaries ever enrolled in an SFY. National Health Expenditures data is based on Medicaid spending and enrollment by Calendar Year. Because different sources of data are used for Arkansas and national expenditures, the comparison is not completely analogous. Medicaid National Expenditure Data retrieved from: https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountsprojected. Table 17 National Health Expenditure Projections 2022-2031.

Figure 5. SFY 2018 – 2023 FFS Medicaid Expenditures by Service

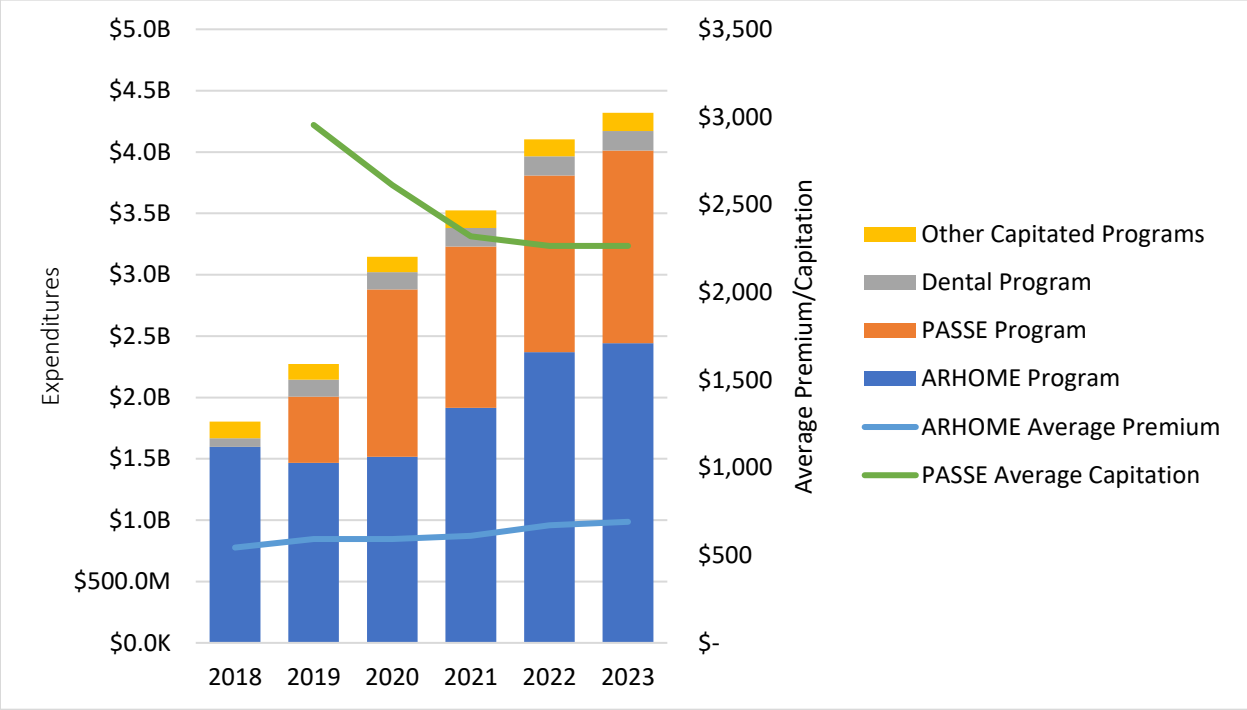


* FFS claims are summarized by the date of payment. This figure does not include non-claim financial transactions.

Figure 6 below illustrates how capitated program expenditures have trended between SFY 2018 and SFY 2023.

- **Dental Program.** The dental program began in January 2018, so SFY 2018 only includes six months of dental expenditures. The total expenditures of the dental program increased by 17% between SFY 2019 (the first full fiscal year of operations) and SFY 2023. However, the average capitation decreased by 8% during SFY 2018 and SFY 2023.
- **PASSE Program.** As noted above, the PASSE program was implemented in March 2019; therefore, SFY 2019 only includes four months of PASSE expenditures. PASSE program total expenditures increased by 15% between SFY 2020 (the first full fiscal year of operations) and SFY 2023. However, the average capitation decreased by 23% between SFY 2019 and SFY 2023.
- **ARHOME Program.** ARHOME program total expenditures increased by 53% between SFY 2018 and SFY 2023. This increase was partly driven by enrollment, which spiked during the public health emergency ending in May 2023. The average premium increased by 27% between SFY 2018 and SFY 2023.

Figure 6. SFY 2018 – 2023 Medicaid Expenditures by Capitated Program



* Capitated program data are summarized by the date of the capitation month. Dental average capitation amounts are not shown due to scale. Data are exclusive of post-payment adjustments.

SECTION 2: STRATEGIC OPTION OVERVIEW

The following sections outline strategic options identified during this review that may be considered further by DHS, the legislature, the Governor's Office, and other interested parties. The report presents an overview of the current state of each program or service area and provides potential options for consideration related to that program/service. The report describes each option, potential cost savings, implementation steps, implementation timeline, and leading practices from other states.

The strategic options included in this report:

- Are based on key informant interviews with DHS and other State agencies, data review/analysis (based on data provided by Optum/DHS), and leading practices. Data in this report was obtained from the State's Medicaid Management Information System, other DHS systems, and other publicly available sources. Any limitations, gaps, or errors in the data received may impact the analyses and options in this report.
- Represent a broad array of available options but are not recommendations.
- Do not encompass initiatives that DHS has confirmed it will implement or is in the process of implementing.[12]
- Are ordered by impact on Medicaid sustainability (greatest to least), within each section.

Cost savings were estimated for each option based on the information available at the time of this report. The estimates are based on assumptions and published experience from other states, when available. The level of detail available to inform the cost savings estimates varies by option. Further discussion and decision-making are required to develop precise cost savings

[12] For example, DHS is in the process of applying for a Section 1115 Demonstration Project, called Arkansas Reentry Connections for Health, to (1) cover all Medicaid services for incarcerated adults and juveniles who have been determined to be eligible for Medicaid up to 90 days beginning on the first day of incarceration in which benefits have been restarted and for another period of up to 90 days prior to release and (2) waive the Institution for Mental Disease exclusion in order to cover Medicaid services provided to Medicaid eligible adults ages 19-64 receiving treatment in qualifying Institutions for Mental Disease for up to 90 days beginning on the first day of admission and for another period of up to 90 days prior to the individuals transition back to community-based treatment. Because this Demonstration Project is in process, it is not included in this report.

estimates, as cost estimates for many options are dependent on programmatic decisions related to each option.

In addition to the options included within, DHS and the State also may consider making no changes to any given program area.

SECTION 3: ARHOME QUALIFIED HEALTH PLAN MODEL

On January 1, 2022, DHS replaced the Arkansas Works program and launched the ARHOME program, both of which are Qualified Health Plan models to leverage the efficiencies of the private market and serve the low-income Medicaid expansion population. While 37 states (including Arkansas) use Medicaid dollars to pay premiums for Employer-Sponsored Health Insurance for individuals and families when such coverage is cost-effective, Arkansas is the only state that uses Medicaid funds as premium assistance to purchase coverage in the individual market through Qualified Health Plans for the adult expansion group. Arkansas uses a Section 1115 demonstration to authorize this approach through the ARHOME program.

In SFY 2023, Arkansas Medicaid paid $2.48 billion, serving approximately 337,000 healthy adults ages 19-64 through ARHOME, with over 334,000 of those beneficiaries assigned to a Qualified Health Plan. The maintenance of effort requirement during the Public Health Emergency was a factor in costs and enrollment. Most remaining beneficiaries are served through the Medicaid FFS system as they await assignment to a Qualified Health Plan. Individuals in FFS awaiting enrollment in a Qualified Health Plan receive the same benefits as those offered by the Qualified Health Plans.

DHS receives a 90% federal match for ARHOME, meaning that the State share is 10% for most ARHOME program components—just over $260 million in State share in SFY 2023. Figure 7 below provides an overview of the ARHOME Qualified Health Plan model, including its eligibility requirements, program delivery, and payment structure.

Figure 7. ARHOME Qualified Health Plan Model Overview

Program Element	Description
Eligibility Requirements	• Incomes up to and including 138% of the federal poverty level. • Adults not eligible for any other category of Medicaid (ages 19-64 years).
Program Delivery	• ARHOME is authorized through a Section 1115 Medicaid demonstration waiver through December 31, 2026. • Through ARHOME, DHS purchases coverage from Qualified Health Plans certified by the Marketplace to provide essential health benefits to the Medicaid expansion population.

Program Element	Description
	• ARHOME providers are not required to be enrolled with Arkansas Medicaid, as they contract directly with the Qualified Health Plans. Beneficiaries who are considered medically frail are served through FFS Medicaid.
Payments	• DHS pays Qualified Health Plans monthly premiums and beneficiary cost-sharing (such as deductible and co-insurance) based on beneficiary income.

Payments

Qualified Health Plans are not subject to Medicaid managed care organization rules under 42 C.F.R. 438. Each spring, DHS releases "purchasing guidelines" for the next calendar year so that Qualified Health Plans can understand the terms of what DHS intends to purchase. DHS purchases the second-lowest silver plan. In the Fall, the carriers, Arkansas Insurance Department, and DHS execute a Memorandum of Understanding for the following calendar year. Payments to and from the Qualified Health Plans have four parts:

1. The monthly premium for each beneficiary,
2. Advanced cost-sharing reduction payments, which are set as a percentage of the premium; for 2023, the advanced cost-sharing reduction was 40% of the premium,
3. Reconciliation of the advanced cost-sharing reduction and the actual amount the Qualified Health Plan paid to providers for cost-sharing (minus any individual obligation for a copayment), and
4. Medical loss ratio rebate – if the medical loss ratio is less than 80%, the Qualified Health Plan must rebate the difference between revenue received and payments for benefits.

Qualified Health Plans submit the premiums they expect to charge for each plan they sell on the individual insurance Marketplace to the Arkansas Insurance Department and the federal government in the summer, effective the following January. The 2022 premiums DHS paid for each plan range from just under $310 per month for a 19-year-old non-smoker in one plan to more than $1,260 per month for a 64-year-old tobacco user in another. For 2023, the rates increased between 3% and 7%, depending on the carrier and the plan, compared with the 2022 rates.

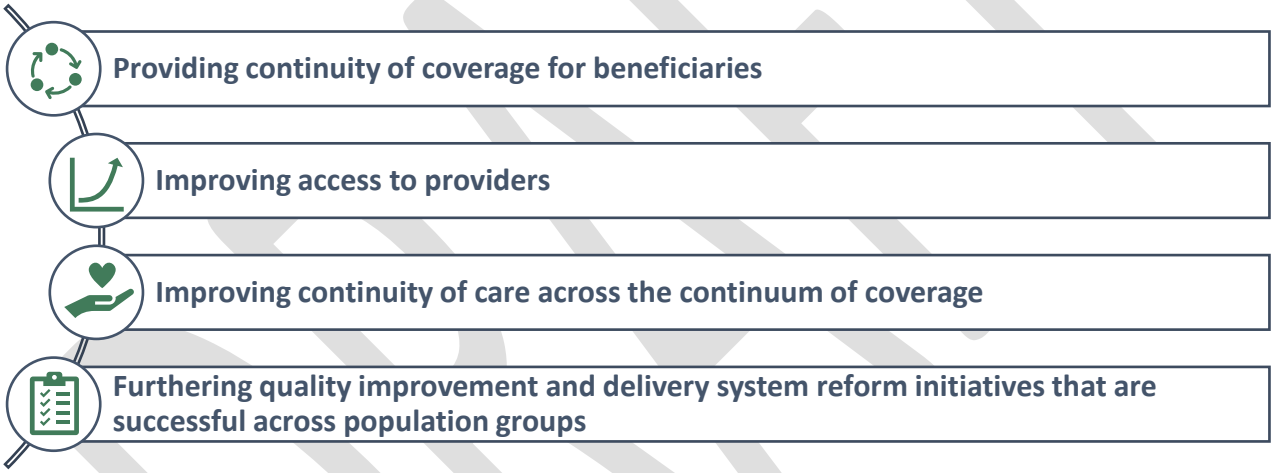
Quality Measures

DHS evaluates Qualified Health Plan performance on health quality metrics in primary care access and preventive care, maternal and perinatal care, acute and chronic conditions care, and behavioral health care. Overall, in 2022, Qualified Health Plan performance was mixed.[13]

- All or most Qualified Health Plans met the established targets for nine measures,
- No Qualified Health Plans met the established targets for seven measures, and
- There were overall mixed results for four measures.

ARHOME aims to support the State's continued Medicaid coverage efforts, as illustrated in **Figure 8**.

Figure 8. ARHOME Qualified Health Plan Model Goals



Historical Performance

In 2015, the Kaiser Commission on Medicaid and the Uninsured reported on the "private option" program, the precursor to the ARHOME and Arkansas Works programs.[14] Their report summarized the following data from the Arkansas Hospital Association for 2014, the first year of the "private option" program implementation. This data is also associated with more individuals receiving insurance coverage through Medicaid expansion during this time.

[13] Arkansas Department of Human Services. (December 15, 2023). ARHOME Health and Economic Outcomes Accountability Oversight Advisory Panel Quarterly Report. Retrieved from: https://humanservices.arkansas.gov/wp-content/uploads/Quarterly-report-12.5.23.pdf.
[14] Kaiser Family Foundation. (August 2015). A Look at the Private Option in Arkansas. [Webpage]. Retrieved from: https://files.kff.org/attachment/issue-brief-a-look-at-the-private-option-in-arkansas.

- Hospital inpatient visits by the uninsured dropped by 48.7%,
- Uninsured emergency room visits dropped by 38.8%,
- Uninsured outpatient clinic visits decreased by 45.7%, and
- Hospital uncompensated care losses related to uninsured care losses declined by 55.1% or $149 million.

According to a 2018 Arkansas Center for Health Improvement report, Qualified Health Plan beneficiaries had more timely access to services, with particular emphasis on access to specialty physicians. The Center found that more than twice as many Qualified Health Plan beneficiaries (21.2%) had a health care visit in the first 30 days compared to new Medicaid beneficiaries (8.2%). By 90 days, 41.8% of those enrolled in a Qualified Health Plan had at least one outpatient visit, compared to 29.6% of those enrolled in traditional Medicaid.[15]

According to the Office of the Assistant Secretary of Planning and Evaluation at the U.S. Department of Health and Human Services, the average monthly premium in Arkansas for the second-lowest-cost silver plan for a 27-year old ($311 in Plan Year 2019) was lower than all of the other 39 states using Healthcare.gov ($405 in Plan Year 2019) except for Indiana ($280), New Jersey ($289), and New Mexico ($300). Between Plan Year 2014 and Plan Year 2019, premiums increased 85% nationally compared to 29% in Arkansas.[16]

Strategic Options

Options 3.1, 3.2, 3.3, and 3.5 could be implemented alongside the existing Qualified Health Plan model. Options 3.4, 3.6, and 3.7 are alternatives to the Qualified Health Plan model. DHS and the State may also consider making no substantive changes to the ARHOME Qualified Health Plan model.

Option 3.1: Retain the ARHOME Qualified Health Plan model and strengthen controls.

Option 3.1 outlines strategies to retain the ARHOME Qualified Health Plan model while strengthening program controls to allow DHS to limit expenditures under ARHOME better. DHS may consider the following strategies to strengthen ARHOME program controls:

[15] Arkansas Center for Health Improvement. (Jun 30, 2018). Arkansas Health Care Independence Program ('Private Option') Sec*tion 1115 Demonstration Waiver Final Report*, [Webpage]. Retrieved from: https://achi.net/wp-content/uploads/2017/05/Final-Report-no-appendices.pdf.

[16] Office of the Assistant Secretary for Planning and Evaluation. (October 26, 2018). 2019 Health Plan Choice and Premiums in Healthcare.gov States. Retrieved from: 2019LandscapeBrief.pdf (hhs.gov).

- Require Qualified Health Plans to increase the medical loss ratio by 1% to 2% (from the current medical loss ratio of 80%), resulting in a higher minimum medical loss ratio,
- Update the medical loss ratio formula to remove any sales commission fees from the medical loss ratio denominator; this change could have an unintended impact on exchange rates if plans are cross-subsidizing these fees across their Marketplace and Qualified Health Plan members, and
- Declare limits for year-over-year growth of administrative costs due to budget neutrality; current budget neutrality requirements do not consider administrative costs separately.

These changes would be documented in the Memorandum of Understanding between DHS, the Arkansas Insurance Department, and the Qualified Health Plans.

	3.1 Retain the ARHOME Qualified Health Plan model and strengthen controls.
Potential Cost Savings	Approximately $1 million to $5 million annually in State share due to the ability to require the Qualified Health Plans to issue a rebate to DHS if they do not meet the higher medical loss ratio in a given year. Additional savings may be associated with removing sales commission fees from the medical loss ratio denominator and instituting year-over-year growth limits in administrative costs.
Implementation Steps	DHS would need to discuss with CMS whether the State can raise the medical loss ratio for Qualified Health Plans since Qualified Health Plans are commercial products run through the Marketplace, and the rules governing Qualified Health Plans are set federally. If approved, DHS would need to update the Memorandum of Understanding to clarify how medical loss ratio rebates would be calculated (including removal of sales commission fees from medical loss ratio denominator) and paid. The current Memorandum of Understanding requires managed care organizations to pay medical loss ratio rebates for Qualified Health Plan beneficiaries consistent with federal regulations. DHS would also need to update the Memorandum of Understanding to institute administrative cost growth limits.
Timeline	1-2 years.
Leading Practices	No comparators are available since the ARHOME Qualified Health Plan model is unique. Altering a federally set medical loss ratio may have unintended consequences, such as Qualified Health Plan withdrawal from the ARHOME program if margins are undesirable.

Option 3.2: Retain ARHOME and shift some cost share dollars into premium dollars.

DHS purchases the second-lowest-cost Silver Plan for ARHOME beneficiaries. In 2024, ARHOME will pay 100% of the monthly premium on behalf of beneficiaries and make monthly Advanced Cost Sharing Reduction payments to cover the cost of deductibles, coinsurance, and copayments, less any individual liability for modest copayments. The monthly Advanced Cost Sharing Reduction is calculated at 38% of the premium. The Advanced Cost Sharing Reduction is reconciled against actual provider cost-sharing payments.

Under this option, DHS would request that dollars be shifted from the Advanced Cost Sharing Reduction payment into the premium payment. Total expenditures would be budget neutral, but shifting dollars into the premium payment would allow the State to collect more premium tax, thereby increasing State revenue. Premium tax is based only on the premiums, not Advanced Cost Sharing Reduction payments.

It is unclear if CMS will approve this option, as no precedent exists. Arkansas is the only state that uses Medicaid funds as premium assistance to purchase Qualified Health Plans for the adult expansion group.

	Option 3.2: Retain ARHOME and shift some cost share dollars into premium dollars.
Potential Cost Savings	For every $1 million shifted from cost-sharing dollars into premium dollars, the State should gain $25,000 in tax revenue. Arkansas paid $760 million in cost-sharing reductions in SFY 2022. Shifting the full cost-sharing reduction payments into premium payments would not be practical. Further analysis is required to determine potential cost savings for this option.
Implementation Steps	It is unclear if CMS, the Arkansas Insurance Department, and the Qualified Health Plans would agree to this option.
Timeline	1-2 years.

	Option 3.2: Retain ARHOME and shift some cost share dollars into premium dollars.
Leading Practices	No comparators are available since the ARHOME Qualified Health Plan model is unique.

Option 3.3: Modify ARHOME auto-assignment process to better control spending and reward Qualified Health Plan performance.

The current ARHOME enrollment process allows eligible beneficiaries to select a preferred Qualified Health Plan. If beneficiaries do not choose a Qualified Health Plan by a specified deadline, the process auto-assigns beneficiaries to one of the Qualified Health Plans. Following auto-assignment, a beneficiary has 30 days to request another plan. Approximately 80% of beneficiaries are auto-assigned. Under this option, DHS would structure the logic to auto-assign beneficiaries to Qualified Health Plans based on several parameters. These parameters may include rewarding higher-performing Qualified Health Plans with more beneficiaries by adjusting auto-assignment based on quality scores. These parameters may also include delaying auto-assignment until a beneficiary has their first health care encounter so that DHS is not paying monthly premiums to Qualified Health Plans if the beneficiary is not using services. In the first three quarters of 2023, Qualified Health Plans reported at least one health care encounter for 69% of Qualified Health Plan beneficiaries. [17] Another parameter may consider the health outcomes of high utilizers to determine the appropriate placement.

[17] Arkansas Department of Human Services (Dec 2023), *ARHOME Health and Economic Outcomes Accountability Advisory Panel Quarterly Report*, [Webpage]. Retrieved from: https://humanservices.arkansas.gov/wp-content/uploads/Quarterly-report-12.5.23.pdf.

	Option 3.3: Modify ARHOME auto-assignment process to better control spending and reward Qualified Health Plan performance.
Potential Cost Savings	Annual State savings are estimated to be over $1 million. The savings would be impacted by the number of beneficiaries auto-assigned, the selected performance measures, assignment thresholds, and premium/acuity for the auto-assigned beneficiaries.
Implementation Steps	The ARHOME Section 1115 demonstration waiver states that DHS will advise CMS before implementing a change to the auto-assignment methodology. Therefore, DHS needs to communicate with CMS and receive approval for changes to the auto-assignment methodology. DHS would need to work with the fiscal agent to modify, test, and implement the auto-assignment methodology.
Timeline	One year.
Leading Practices	ARHOME is a unique program, and there are no other states that DHS can use for comparison for auto-assignment of Medicaid beneficiaries into Qualified Health Plans. However, some states have implemented performance-based auto-assignment methodologies in their traditional Medicaid managed care programs.

Option 3.4: Move ARHOME beneficiaries into a redesigned PASSE program that is structured to support both the existing PASSE population and the ARHOME expansion population, using Medicaid provider rates.

Under this option, DHS would transition ARHOME beneficiaries to the PASSE program, which DHS would redesign so that the PASSE program supports 1) the existing PASSE population, who are eligible for home and community-based services (HCBS) and intense care coordination, and 2) the adult expansion population who have different needs and a different benefit plan. The PASSE program provides Medicaid benefits to beneficiaries through a managed care system on an at-risk basis. Currently, the PASSE program serves beneficiaries who have complex behavioral health, developmental, or intellectual disabilities. DHS would ensure that the PASSE organizations do not lose their focus on serving these beneficiaries as initially intended with the

addition of the ARHOME expansion population.

Under this option, Medicaid providers would receive reimbursement for services for the adult expansion population using the Medicaid provider rates as the floor instead of the higher commercial reimbursement rates used in the ARHOME Qualified Health Plan model. There is the potential that this option could impact access to care, as providers would likely receive reduced rates for the Medicaid expansion population under the PASSE program. In addition, PASSE organizations are federally required to limit their provider network to Medicaid-enrolled providers, while this requirement does not apply to Qualified Health Plans. Therefore, the expansion population may not have access to the same providers they would have under the Qualified Health Plan model.

Withdrawing beneficiaries from the Qualified Health Plans and ending the current ARHOME Qualified Health Plan model may cause a significant impact on the remaining Marketplace population's premiums and insurance options.

Beyond the ARHOME beneficiaries that would be moved to the PASSE program under this option, DHS is also adding or planning to add beneficiaries to the PASSE program through the current process that moves Frail beneficiaries to the PASSE program and the proposed Arkansas Reentry Connections for Health program that would enroll beneficiaries in the PASSE program upon release from incarceration. If approved by CMS, the Arkansas Reentry Connections for Health Program would begin in January 2025. [18] In addition, **Section 4** of this report on PASSE also includes options that involve expanding the types of beneficiaries that would be eligible for the PASSE program.

	Option 3.4: Move ARHOME beneficiaries into a redesigned PASSE program that is structured to support both the existing PASSE population and the ARHOME expansion population, using Medicaid provider rates.
Potential Cost Savings	Based on DHS estimates developed for a legislative note in March 2023, moving away from the Qualified Health Plan model to an FFS program could cost up to $28 million annually.[19] However, under this option, where the Qualified Health Plan model would instead move into the PASSE program, the

[18] Arkansas Department of Human Services (Dec 2023), *A New Approach to Reentry*, [Webpage]. Retrieved from: https://humanservices.arkansas.gov/wp-content/uploads/Renetry-PP.pdf.

[19] Estimates from Senate Bill 278, which did not pass, indicate a shift from Qualified Health Plans to FFS could decrease overall spend by approximately $867M annually but also may increase state share by approximately $28M annually, due to a roughly $80M reduction in state and local general tax revenues and an approximate $52M reduction in state general revenue obligations.

	Option 3.4: Move ARHOME beneficiaries into a redesigned PASSE program that is structured to support both the existing PASSE population and the ARHOME expansion population, using Medicaid provider rates.
	$28 million in costs would be reduced because the managed care premium tax for the Medicaid expansion population would shift to the PASSE organizations. The fiscal impact after SFY 2024 will depend on multiple factors, including changes in health care inflation, enrollment, and utilization. More detailed actuarial analysis would be required to assess the full impact of this option.
Implementation Steps	DHS would need to allow current Qualified Health Plan contracts to expire, update the PASSE 1915(b) waiver, contract with PASSE organizations to cover the ARHOME population, and conduct readiness reviews. CMS approval would be required for the PASSE 1915(b) waiver updates and PASSE contract updates. If the program ends before December 31, 2026, DHS will need to work with CMS to terminate the ARHOME Section 1115 demonstration waiver. The ARHOME and PASSE statutes would need to be amended to allow PASSE organizations (rather than Qualified Health Plans) to cover beneficiaries. DHS would need to determine the benefit plan coverage for each portion of the redesigned PASSE program. For example, the expansion population would be excluded from receiving HCBS. DHS would also need to work with the fiscal agent to modify auto-assignment, notify eligible beneficiaries, establish encounter transmission and reporting, and host open enrollment. Moving the ARHOME population into a redesigned PASSE program would be a significant effort, and the benefit plan for the adult expansion population may likely change. DHS will require funding for additional staff to monitor increased enrollment in the PASSE program.
Timeline	2+ years before a re-designed PASSE program operates with the ARHOME population included.
Leading Practices	Of the 41 states that have implemented Medicaid expansion, 32 states are using managed care organizations to provide services to the Medicaid

	Option 3.4: Move ARHOME beneficiaries into a redesigned PASSE program that is structured to support both the existing PASSE population and the ARHOME expansion population, using Medicaid provider rates.
	expansion population.[20] [21] In most cases, these states were already operating Medicaid managed care programs before Medicaid expansion. Arkansas is the only state using Qualified Health Plans to deliver benefits to the Medicaid expansion population. The two other states that initially tried a Qualified Health Plan model have moved the Medicaid expansion population to their existing Medicaid managed care delivery system.

Option 3.5: Retain the ARHOME Qualified Health Plan model and increase hospital provider quality assurance fees to fund the program.

Through the ARHOME Qualified Health Plan model, Qualified Health Plans reimburse providers using commercial rates substantially higher than Medicaid rates. Therefore, providers receive a financial benefit from the ARHOME Qualified Health Plan model compared to other Arkansas Medicaid programs. Through this option, DHS would increase existing hospital provider quality assurance fees so that hospitals increase their contribution to ARHOME. Per federal regulation §20-77-1904(f)(1)(C), these fees cannot exceed 6%. The Arkansas hospital assessment has varied between 1.47% and 1.70% in SFYs 2020 through 2024. The current hospital assessment is based upon a percentage of net patient revenue needed to primarily generate the amount up to the State's share of the upper payment limit.

	Option 3.5: Retain the ARHOME Qualified Health Plan model and increase hospital provider quality assurance fees to fund the program.
Potential Cost Savings	This option would generate cost savings for the State. The level of cost savings would be based on projected quality assurance fee revenue used to reduce the State share of the ARHOME Qualified Health Plan model. Savings estimates would vary based on the revised hospital assessment percentage.

[20] Kaiser Family Foundation (Mar 01, 2023), *10 Things to Know About Medicaid Managed Care*, [Webpage]. Retrieved from: https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/.

[21] Kaiser Family Foundation (Oct 3, 2023), *Status of State Medicaid Expansion Decisions*, [Webpage]. Retrieved from: https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/.

	Option 3.5: Retain the ARHOME Qualified Health Plan model and increase hospital provider quality assurance fees to fund the program.
	Based upon the SFY 2023 provider quality assurance fee calculations, every half percent increase would net approximately $33 million.
Implementation Steps	The State law would need to be amended to increase the hospital quality assurance fee per §1903(w)(3)(A) of the Social Security Act.
Timeline	1-2 years.
Leading Practices	When initially implementing Medicaid expansion, eight states (Arkansas, Arizona, Colorado, Illinois, Indiana, Louisiana, New Hampshire, and Ohio) reported that they planned to use new or increased provider taxes/fees, or insurance premium taxes, to fund at least some of the state share of Medicaid expansion costs. Most states have a hospital provider tax to help finance the state share of Medicaid: • 43 states have a hospital tax • 17 states have hospital taxes over 3.5% • Six states have hospital taxes over 5.5% The Arkansas hospital assessment (tax) is lower, varying between 1.47% and 1.70% in SFYs 2020 – 2024. Of the 41 states (including DC) that have expanded Medicaid, 33 use provider taxes/fees to help finance Medicaid.

Option 3.6: Move ARHOME beneficiaries into traditional Medicaid managed care, separate from the PASSE program.

Under this option, DHS would transition ARHOME beneficiaries into a newly created traditional Medicaid managed care program. Under Medicaid managed care, DHS would make per member per month payments to managed care organizations that would provide benefits on an at-risk basis.

Under this option, Medicaid providers would receive reimbursement for services for the adult expansion population using the Medicaid provider rates as the floor instead of the higher commercial reimbursement rates used in the ARHOME Qualified Health Plan model. There is the potential that this option could impact access to care, as providers would likely receive reduced rates for the Medicaid expansion population under the traditional Medicaid managed care program. In addition, Medicaid managed care organizations are federally required to limit their provider network to Medicaid enrolled providers, while this requirement does not apply to Qualified Health Plans. Therefore, the expansion population may not have access to the same providers they would have under the Qualified Health Plan model.

Withdrawing beneficiaries from the Qualified Health Plans and ending the ARHOME Qualified Health Plan model may significantly impact the remaining Marketplace population's premiums and insurance options.

In addition, this option would be administratively burdensome for DHS, overseeing the Medicaid FFS delivery system, the PASSE program, and the new traditional Medicaid managed care program for the Medicaid expansion population, among other programs.

	Option 3.6: Move ARHOME beneficiaries into traditional Medicaid managed care, separate from the PASSE program.
Potential Cost Savings	Based on DHS estimates developed for a legislative note in March 2023, moving away from the Qualified Health Plan model into a FFS program could cost up to $28 million annually.[22] However, under this option, where the Qualified Health Plan model would instead move into a traditional Medicaid managed care program, the $28 million in costs would be reduced because the managed care premium tax for the Medicaid expansion population would shift to the new Medicaid managed care organizations. DHS will require additional staff funding to monitor the new traditional Medicaid managed care program. While the legislative note only estimates the cost impact of moving ARHOME beneficiaries to the FFS program, transitioning ARHOME beneficiaries to a traditional Medicaid managed care program separate from the PASSE program should have a similar cost impact. The cost impact should be similar because Medicaid managed care rate development (i.e., for a traditional Medicaid managed care program) considers FFS utilization and provider rates.

[22] Estimates from Senate Bill 278, which did not pass, indicate a shift from Qualified Health Plans to FFS could decrease overall spend by approximately $867M annually but also may increase state share by approximately $28M annually, due to a roughly $80M reduction in state and local general tax revenues and an approximate $52M reduction in state general revenue obligations.

	Option 3.6: Move ARHOME beneficiaries into traditional Medicaid managed care, separate from the PASSE program.
	However, Medicaid managed care organizations may need to pay above the FFS rates to attract a sufficient provider network. More detailed actuarial analysis would be required to assess the full impact of this option.
Implementation Steps	DHS would need to allow current Qualified Health Plan contracts to expire, submit a managed care waiver to CMS for review, and conduct new Medicaid managed care procurement and readiness reviews. DHS would need CMS approval for the managed care waiver updates, managed care contract, and readiness review findings before program implementation. If the program ends before December 31, 2026, DHS will need to work with CMS to terminate the ARHOME Section 1115 demonstration waiver. DHS would require a budget to add Division of Medical Services staff to manage and monitor a new managed care program and cover additional expenses related to external quality review, among other items. Also, the ARHOME law would need to be amended to allow managed care organizations to serve the Medicaid expansion population rather than Qualified Health Plans. DHS would also need to work with the fiscal agent to modify auto-assignment, notify eligible beneficiaries, and host open enrollment. Moving the ARHOME population into a traditional Medicaid managed care program would be a significant effort.
Timeline	2+ years before the implementation of the new Medicaid managed care program.
Leading Practices	Of the 41 states that have implemented Medicaid expansion, 32 states are using managed care organizations to provide services to the Medicaid expansion population.[23] [24] In most cases, these states were already operating Medicaid managed care programs before Medicaid expansion. Arkansas is the only state using Qualified Health Plans to deliver benefits to the Medicaid expansion population. Other states that initially tried a Qualified Health Plan model have moved the Medicaid expansion population in their existing Medicaid managed care delivery system.

[23] Kaiser Family Foundation (Mar 01, 2023), *10 Things to Know About Medicaid Managed Care*, [Webpage]. Retrieved from: https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/.

[24] Kaiser Family Foundation (Oct 3, 2023), *Status of State Medicaid Expansion Decisions*, [Webpage]. Retrieved from: https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/.

Option 3.7: Eliminate the ARHOME Qualified Health Plan model and transition eligible beneficiaries to the FFS program.

Under this option, DHS would eliminate the ARHOME Qualified Health Plan model and transition the Medicaid expansion population to the FFS program. Currently, ARHOME requires DHS oversight of the Qualified Health Plans, enrollment, and financial reconciliation processes. Since the Qualified Health Plans are commercial insurance products and the rules governing Qualified Health Plans are set federally, DHS has limited control over Qualified Health Plan premiums and requirements.

DHS also has limited access to encounter data under the ARHOME program, offering DHS inadequate insight into the ARHOME Qualified Health Plan model. Challenges with retroactive eligibility and beneficiary Federal Poverty Limit changes further complicate annual reconciliation. By eliminating the ARHOME Qualified Health Plan model and transitioning the covered beneficiaries to the FFS program, DHS would gain complete control of rates, covered benefits, financials, data, and reporting. There is the potential that this option could impact access to care, as providers would receive reduced rates for the Medicaid expansion population and services like substance use disorder care.

Senator Brian King and Representative Josh Miller filed Arkansas SB 278[25] on February 15, 2023, to terminate the ARHOME program and to transfer all beneficiaries in the ARHOME program to the traditional Arkansas Medicaid program. This bill died in the Senate Committee on May 1, 2023. Arkansas Senate Bill 278 estimated terminating the ARHOME program would adversely impact State funding.

If moving to an FFS delivery system, the State would forfeit the significant economic advantages provided by the Qualified Health Plans paying higher commercial rates to providers and would forfeit the 2.5% premium tax, which further reduces the actual match rate to be paid by the State. Commercial carriers pay the highest rates to providers and thus have the highest multiplier effect; that is, as money circulates through the State's economy, it has the most positive impact on employment, State and local tax revenues, etc. Medicaid rates provide the lowest multiplier effect, and Medicare is in the middle. Rural hospitals, small, and medium-

[25] Arkansas State Legislature. (2023*).* 94th General Assembly - Regular Session, 2023 [Webpage]. Retrieved from: https://www.arkleg.state.ar.us/Bills/Detail?id=SB278&ddBienniumSession=2023%2F2023R.

sized hospitals, in particular, rely on those higher commercial rates.

Under the FFS program, all Medicaid providers are federally required to be enrolled with Arkansas Medicaid, which is not required for the ARHOME Qualified Health Plan model. Therefore, the expansion population may not have access to the same providers they would have under the Qualified Health Plan model if they transitioned to the FFS program. Additionally, the Life360 and Opportunities for Success programs under the ARHOME Section 1115 demonstration waiver would cease if the ARHOME Section 1115 demonstration were to be terminated, so DHS would need to consider a different federal authority for these programs.

	Option 3.7: Eliminate the ARHOME Qualified Health Plan model and transition eligible beneficiaries to the FFS program.
Potential Cost Savings	Estimates from Senate Bill 278[26] indicate a shift from ARHOME to FFS could increase State share by approximately $28 million annually. This is primarily driven by reduced premium payments from Qualified Health Plans (estimated to decrease overall spending by roughly $867 million annually). The fiscal impact after SFY 2024 will depend on multiple factors, including changes in health care inflation, enrollment, and utilization. DHS estimates there would also be increased operational costs due to higher demands on State employee staffing, contracts, prior authorization workloads, including pharmacy and treatment, and claims payments to cover the increased FFS population.[27] More detailed actuarial analysis would be required to assess the full impact of this option.
Implementation Steps	If the program ends before December 31, 2026, DHS will need to work with CMS to terminate the ARHOME Section 1115 demonstration waiver. DHS would also need to obtain approval for the change in the delivery system for the ARHOME population. Finally, DHS would need to allow current Qualified Health Plan contracts to expire at the end of the yearly contracting period. The ARHOME law would also need to be amended to end the ARHOME Qualified Health Plan model. As program oversight and claims processing would shift from Qualified Health Plans to DHS staff and the fiscal agent, DHS would need to hire and train program management and claims personnel to conduct provider/beneficiary correspondence and education.

[26] Arkansas State Legislature. (2023*).* 94th General Assembly - Regular Session, 2023 [Webpage]. Retrieved from: https://www.arkleg.state.ar.us/Bills/Detail?id=SB278&ddBienniumSession=2023%2F2023R.

[27] Arkansas Department of Human Services. (2023). Arkansas Medicaid Program – Fiscal Impact Estimate for SB 278 [Webpage]. Retrieved from: https://www.arkleg.state.ar.us/Home/FTPDocument?path=%2FAssembly%2F2023%2F2023R%2FFiscal+Impacts%2FSB278-Other1.pdf.

	Option 3.7: Eliminate the ARHOME Qualified Health Plan model and transition eligible beneficiaries to the FFS program.
	DHS also would need to consider modifying the fiscal agent contract and working with staff to ensure the Medicaid Management Information System appropriately assigns these beneficiaries to FFS and that associated solutions have processing capabilities for the increased volume of FFS claims. Additional work will include configuring plans, business rules, and potential rate increases to support services authorized for the beneficiary population currently served by ARHOME. The Division of County Operations would need to assess whether this change would impact the Arkansas Integrated Eligibility System.
Timeline	1-2 years (or allow the ARHOME Qualified Health Plan model to expire on December 31, 2026).

SECTION 4: PROVIDER-LED ARKANSAS SHARED SAVINGS ENTITY MANAGED CARE PROGRAM

The PASSE program, one of only two such provider-led solutions nationwide, coordinates health care services for beneficiaries with behavioral health diagnoses and intellectual and/or developmental disability diagnoses through care management entities (implemented through 1915(i), 1915(b), and 1915(c) federal waiver). PASSE organizations are responsible for integrating physical health, behavioral health, and specialized developmental disability services for individuals who have intensive levels of treatment or care needs due to mental illness or intellectual and developmental disability. In SFY 2023, the PASSE program spent $1.57 billion, serving approximately 66,000 beneficiaries.[28] PASSE enrollment totaled just over 54,000 beneficiaries at the end of SFY 2023. PASSE enrollment further decreased to just over 44,000 beneficiaries in December 2023, following the end of the Public Health Emergency unwind process.

DHS found that the PASSE program generated approximately $67 million in savings from program inception through the first quarter of SFY 2021, surpassing savings goals.[29] DHS encourages PASSE organizations to offer additional or innovative services if those services decrease the overall cost of care and maintain/improve a beneficiary's functional level.

Figure 9 below provides an overview of the PASSE program, including eligibility requirements, program delivery, and payment structure.

Figure 9. PASSE Program Overview

Program Element	Description
Eligibility Requirements	The PASSE program includes Medicaid beneficiaries meeting at least one of the following: • On the Community and Employment Support waiver • On the Community and Employment Support waiver waitlist receiving Medicaid State Plan services • Lives in a private Intermediate Care Facility for individuals with intellectual or developmental disabilities

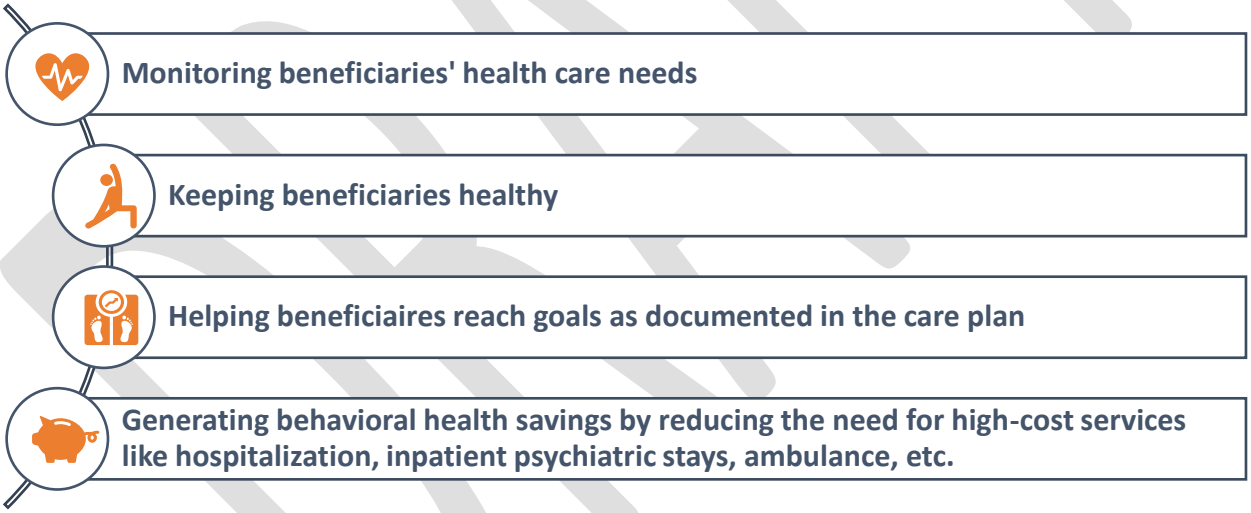
[28] Capitation data from Optum based on month of capitation.

[29] Arkansas Department of Human Services. (July 6, 2021). Medicaid Transformation Savings Scorecard and Quarterly Report. Retrieved from: https://humanservices.arkansas.gov/wp-content/uploads/Medicaid_Transformation_ScoreCard_Q1Q2SFY21.pdf.

Program Element	Description
	• Has a behavioral health diagnosis and needs services in addition to counseling and medication management
Program Delivery	There are currently four PASSE organizations. Each PASSE must maintain at least 51% ownership by enrolled Arkansas Medicaid providers. The PASSE organizations are considered risk-based provider organizations.
Payments	DHS pays the PASSE organizations an actuarially sound per member per month rate for each beneficiary at the beginning of each eligible month. The PASSE program is funded in part by a managed care premium tax.

The PASSE program's goals are illustrated in **Figure 10**.

Figure 10. PASSE Program Goals



Once a beneficiary is deemed eligible, DHS automatically enrolls eligible beneficiaries into a PASSE organization through an auto-enrollment process that proportionally distributes beneficiaries across active PASSE organizations. Beneficiaries typically exit the PASSE program when they move out of State, move to nursing/long-term care, transition care to a human

development center, no longer meet 1915(i) waiver criteria (e.g., risk status, level of care, treatment goals, functioning level), do not get an annual assessment, or upon death.

PASSE beneficiaries receive additional community-based services not otherwise available to FFS beneficiaries.

All services must be delivered based on an individual person-centered service plan based on an Independent Assessment by a third-party vendor, the health questionnaire given by the PASSE care coordinator, and other psychological and functional assessments. The person-centered service plan must have measurable goals and specific objectives, measure progress through data collection, and be created by the beneficiary's PASSE care coordinator in conjunction with the beneficiary, their caregivers, service providers, and other professionals. The PASSE program has a utilization management component whereby all PASSE organizations authorize services based on a beneficiary's medical necessity or other necessity measures for non-medical services such as HCBS.

Strategic Options

Options 4.1 and 4.2 are alternate options. Options 4.3 and 4.4 could be implemented concurrently. DHS and the State also may consider making no substantive changes to the PASSE program.

Option 4.1: Transition long-term services and supports (LTSS) programs and beneficiaries to the PASSE program.

As mentioned above, DHS found that the PASSE program generated approximately $67 million in savings from program inception through the first quarter of SFY 2021, surpassing savings goals.[30] The PASSE program serves some of the highest-need individuals with an intellectual or developmental disability and serious mental illness or serious emotional disturbance behavioral health diagnoses. Given the success DHS has experienced with the PASSE program to date, DHS may choose to transition the remaining LTSS programs and populations (including nursing facility services) from FFS into the managed care PASSE program, aligning all LTSS and HCBS benefit offerings under one managed care program. This option would result in all of Arkansas' LTSS programs listed in **Figure 11** below being included in the PASSE program.

[30] Arkansas Department of Human Services. (July 6, 2021). Medicaid Transformation Savings Scorecard and Quarterly Report. Retrieved from: https://humanservices.arkansas.gov/wp-content/uploads/Medicaid_Transformation_ScoreCard_Q1Q2SFY21.pdf.

Figure 11. LTSS and HCBS Services and Programs

Category	Services/Programs
PASSE Program	• Community and Employment Support 1915(c) Waiver • Behavioral Health Services within PASSE 1915(i) State Plan • Private Intermediate Care Facilities for Individuals with Intellectual Disabilities • Psychiatric Residential Treatment Facilities (PRTF)
1915(c) HCBS Waivers and State Plan Amendments	• Autism 1915(c) Waiver • Living Choices 1915(c) Waiver • AR Choices 1915(c) Waiver • IndependentChoices 1915(j) State Plan •
Medicaid State Plan HCBS	• Personal Care Services • Home Health • Private Duty Nursing • Hospice Care
Institutional Services	• Skilled Nursing Facility

Programs that cover LTSS and HCBS are commonly called managed long-term services and supports (MLTSS) programs. Under these programs, states pay capitation payments to managed care organizations, and those managed care organizations are responsible for paying for the LTSS that beneficiaries use. Many states' MLTSS programs aim to incentivize managed care organizations to encourage beneficiaries to remain in lower levels of care as appropriate, which is generally better for the beneficiaries and more cost-effective to states. MLTSS programs can also increase the use of value-based payments in LTSS and may allow for better care management for more complex populations. An expanded PASSE program that includes all LTSS and HCBS would offer more budget predictability while adding potential value to care delivery.

Recognizing the important role family caregivers play as major providers of care for populations requiring LTSS, MLTSS programs also offer an opportunity to provide enhanced support to caregivers. In 2020, an estimated 53 million adults in the United States served as caregivers. Data suggests that many take on a caregiving role without adequate services and supports in place, causing caregiver stress and poor outcomes for the care recipient.[31] States may encourage or require managed care organizations serving the LTSS population to provide

[31] AARP. (May 2020). Caregiving in the U.S. Retrieved from: https://www.aarp.org/content/dam/aarp/ppi/2020/05/full-report-caregiving-in-the-united-states.doi.10.26419-2Fppi.00103.001.pdf.

additional support for family caregivers, such as conducting comprehensive caregiver assessments that assess the caregivers' own needs and well-being, providing training and tools to caregivers, and offering respite care to prevent caregiver burnout.[32]

Therefore, including the remaining LTSS populations in the PASSE program could allow DHS to predict the budget more consistently, ensure beneficiaries receive services in the most appropriate and least restrictive setting, and provide additional support to caregivers.

States have approached MLTSS programs using varying models. Most MLTSS programs cover both Medicaid medical care and LTSS as part of a comprehensive benefit package. Other MLTSS programs provide only LTSS, separate from medical care.[33] DHS may elect to transition Medicaid medical services (e.g., hospital services, physician services) to the PASSE program for the remaining LTSS populations so that these beneficiaries receive comprehensive LTSS and medical services through the PASSE organizations. Including both LTSS and non-LTSS benefits under the same managed care arrangement may help to improve the overall beneficiary experience and quality of life due to improved care coordination. A small percentage of Medicaid beneficiaries use LTSS, but these beneficiaries account for a disproportionate share of Medicaid expenditures. Nationally, people who used Medicaid LTSS comprised 6% of Medicaid enrollment but 37% of Medicaid spending.[34]

Please see **Section 6** for more context on the importance of Medicaid LTSS system transformation due to the growing demand for LTSS.

	Option 4.1: Transition LTSS programs and beneficiaries to the PASSE program.
Potential Cost Savings	The cost impact of transitioning LTSS to managed care depends on several factors. Still, savings are generally driven primarily by delivering services to beneficiaries in more home-like settings, which is financially advantageous to the State and usually better for the individuals. The following estimates are based on savings from transitioning the AR Choices and Living Choices 1915(c) waivers and nursing facility services to an MLTSS program, such as the PASSE program. The model does not include transitioning medical services for those populations in the AR Choices and Living Choices 1915(c) waivers or populations receiving

[32] Long-Term Quality Alliance. Family Caregiver Strategy Action Guide for MLTSS Plans. Retrieved from: https://52b708f968.nxcli.io/wp-content/uploads/2023/08/Family-Caregiver-Strategy-Action-Guide-for-MLTSS-Plans_FINAL.pdf.

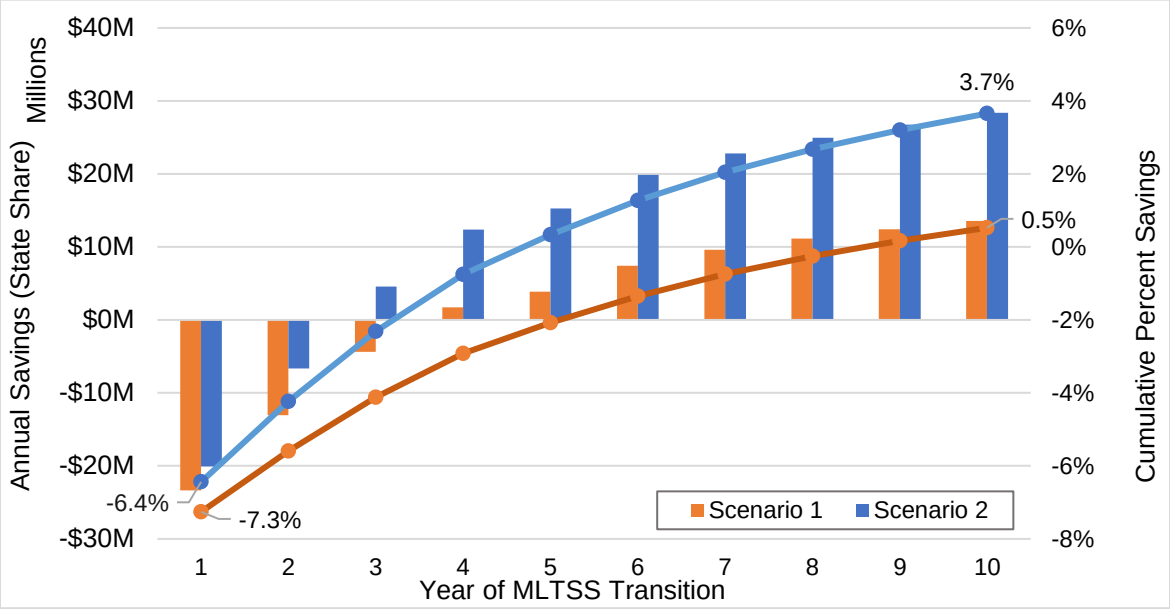
[33] ADvancing States. (2021). Demonstrating the Value of Medicaid MLTSS Programs. [Webpage]. Retrieved from: http://www.advancingstates.org/sites/nasuad/files/2021%20-%20Demonstrating%20the%20Value%20of%20MLTSS.pdf.

[34] Kaiser Family Foundation. (August 12, 2023). How Many People Use Medicaid Long-Term Services and Supports and How Much Does Medicaid Spend on Those People? Retrieved from: https://www.kff.org/medicaid/issue-brief/how-many-people-use-medicaid-long-term-services-and-supports-and-how-much-does-medicaid-spend-on-those-people/.

	Option 4.1: Transition LTSS programs and beneficiaries to the PASSE program.

	nursing facility services to MLTSS. Including medical services in the managed care arrangement has the potential to increase savings estimates further through improved provider negotiation, utilization management, and care coordination. Although savings will not be seen immediately, estimates show that over ten years following the transition to MLTSS, Arkansas could achieve cumulative savings ranging from 0.5% to 3.7% (or $19.0 million to $128.3 million in State share cumulative savings over the ten years), as illustrated in Figure 12. This calculation incorporates multiple assumptions:
	• Arkansas would likely experience an initial loss (i.e., increased costs) in at least the first year(s) of MLTSS due to additional administrative costs that apply to managed care. Given the initial expenses, it could take three to nine years to generate net savings from the transition. Based on experience with this population in other states, the model assumes HCBS costs are around 34 to 40% of nursing facility costs.
	• Scenario 1 in the figure below assumes:
	  ○ Nursing facility costs increase 3% annually
	  ○ HCBS costs increase by 1% annually
	  ○ Additional administrative expenses
	• Scenario 2 in the figure below assumes:
	  ○ Nursing facility costs increase 3% annually
	  ○ HCBS costs increase 0.8% annually
	  ○ Additional administrative expenses
	• The model assumes savings from delaying when beneficiaries would need nursing facility care and transitioning beneficiaries from hospitals or rehabilitation centers to the community; the transition rate is higher in the initial MLTSS years, and once the program matures, it slows down.
	
	Note that while the 2.5% premium tax (estimated to total around $30 million annually) is included in these figures as an additional cost, this amount would be returned to the State each year, offsetting future costs. Given that the MLTSS program would be subject to federal matching (Federal Medical Assistance Percentage of approximately 72%), the State can expect to contribute around $8.4 million annually ($30 million x (1-72%)) to account for the premium tax but recoup the entire $30 million annually. This considerably accelerates savings for the State but is outside the scope of the analysis shown here, which focuses on the program's direct costs.

Figure 12. MLTSS Estimated Savings[35]



	Option 4.1: Transition LTSS programs and beneficiaries to the PASSE program.
Implementation Steps	DHS would need to engage stakeholders about transitioning LTSS programs and beneficiaries to the PASSE program. DHS also would need to update federal authority vehicles for managed care, amend the PASSE contract, amend state statutes, and conduct readiness reviews. Before program implementation, CMS approval would be required for the federal authority vehicle, contracts, and readiness review findings. DHS also would need to update the 1915(c) waiver applications and obtain CMS approval. DHS would need to implement operational changes, including system changes. Transitioning LTSS programs and beneficiaries to the PASSE program would be a significant effort.
Timeline	2+ years before the transition of all LTSS programs and beneficiaries to the PASSE program.
Leading Practices	As of 2021, 22 states have MLTSS programs that have contributed to expanding HCBS access and promoting efficiency and quality of service delivery.[36] Roughly 85% of MLTSS programs provide a comprehensive benefits package that covers

[35] Savings estimates are based on transitioning the AR Choices and Living Choices 1915(c) waivers and nursing facility services to an MLTSS program, such as the PASSE program. The model does not include transitioning medical services for those populations in the AR Choices and Living Choices 1915(c) waivers or populations receiving nursing facility services to MLTSS. Including medical services in the managed care arrangement has the potential to further increase savings estimates though improved provider negotiation and utilization management.

[36] Advancing States. (2021). Demonstrating the Value of Medicaid MLTSS Programs. [Webpage]. Retrieved from: http://www.advancingstates.org/sites/nasuad/files/2021%20-%20Demonstrating%20the%20Value%20of%20MLTSS.pdf.

	Option 4.1: Transition LTSS programs and beneficiaries to the PASSE program.
	both medical care and LTSS. The remaining programs provide LTSS only through a limited benefit program separate from other medical care programs.[37] A 2021 study from the ADvancing States MLTSS Institute and the Center for Health Care Strategies found that while states report reducing the rate of growth of Medicaid expenditures, inadequate data exist to conclude that the MLTSS programs are cost-effective.[38]

Option 4.2: Transition LTSS programs and beneficiaries, excluding nursing facility services, to the PASSE program.

DHS may transition HCBS only to the PASSE program and continue to carve out nursing facility services (i.e., maintain nursing facility services in the FFS program). However, a disadvantage of this option is that if nursing facilities are not incorporated into the PASSE program along with all other LTSS programs and beneficiaries, the PASSE organizations may have less incentive to redirect high-cost beneficiaries from institutional care, limiting cost savings. However, the State could implement an incentive if the PASSE organizations improve the HCBS/LTSS mix.

In addition to transitioning HCBS to the PASSE program, DHS may elect to transition Medicaid medical services (e.g., hospital services, physician services) to the PASSE program for remaining LTSS populations so that these beneficiaries would receive comprehensive HCBS and medical services through the PASSE organizations.

Please see **Section 6** for more context on the importance of Medicaid LTSS system transformation and quality improvement due to the growing demand for LTSS.

	Option 4.2: Transition LTSS programs and beneficiaries, excluding nursing facility services, to the PASSE program.
Potential Cost Savings	Savings are unlikely to be achieved for HCBS under managed care, though medical managed care has proven cost-effective for Medicaid populations. Cost models demonstrate that the primary mechanism by which MLTSS programs achieve savings is by keeping beneficiaries in lower levels of care, transitioning beneficiaries from institutional care back to the community, and/or ensuring

[37] MLTSS Summative Evaluation Report. (2020). Retrieved from: https://www.medicaid.gov/sites/default/files/2021-01/mltss-summeval-rep.pdf.

[38] Advancing States. (2021). Demonstrating the Value of Medicaid MLTSS Programs. [Webpage]. Retrieved from: http://www.advancingstates.org/sites/nasuad/files/2021%20-%20Demonstrating%20the%20Value%20of%20MLTSS.pdf.

	Option 4.2: Transition LTSS programs and beneficiaries, excluding nursing facility services, to the PASSE program.
	access to community options, delaying institutionalization. Excluding institutional care in the MLTSS arrangement removes the incentive for the managed care organizations to equalize access to nursing facilities and HCBS settings. By transitioning only HCBS to MLTSS, Arkansas may experience between a 2% and 10% increase of the spend on the AR Choices and Living Choices 1915(c) HCBS (estimated to be between $500,000 to $2.3 million in increased State share costs annually), mainly due to increases in administrative costs. If Arkansas also transitioned medical services to MLTSS, savings could be achieved, offsetting some of the increased HCBS costs.
Implementation Steps	DHS would need to engage stakeholders about transitioning LTSS programs and beneficiaries to the PASSE program. DHS also would need to update federal authority vehicles for managed care, amend the PASSE contract, and conduct readiness reviews. Before program implementation, CMS approval would be required for the federal authority vehicle, contracts, and readiness review findings. DHS also would need to update the 1915(c) waiver applications and obtain CMS approval. DHS would need to update policies and procedures and implement operational changes in the program, including system changes. Transitioning HCBS programs and beneficiaries to the PASSE program would be a significant effort.
Timeline	2+ years before the transition of all HCBS programs and beneficiaries to the PASSE program.
Leading Practices	Full-risk-based MLTSS programs that exclude nursing facility services were not readily identified. However, one example of an alternative to a full-risk-based MLTSS program that includes both HCBS waiver and nursing facility services is the Integrated Care Network program implemented by Alabama Medicaid. The Integrated Care Network program uses a Primary Care Case Management delivery model to provide improved education and outreach to beneficiaries about the options to receive LTSS/HCBS. The program aims **to identify better** beneficiaries who could benefit from community options and alternatives to institutional stays and provide more comprehensive case management that better integrates the full range of medical and social services.

	Option 4.2: Transition LTSS programs and beneficiaries, excluding nursing facility services, to the PASSE program.
	This program coordinates closely with Alabama's Area Agencies on Aging and nursing facilities.[39] The statewide Integrated Care Network receives a short-term financial incentive if it improves the HCBS/LTSS mix, leading to long-term savings for the State.[40]

Option 4.3: Revise the PASSE criteria to include all individuals with an intellectual or developmental disability diagnosis.

Currently, a Medicaid beneficiary's services are managed and reimbursed by the PASSE organizations if the person:

- Is on the Community and Employment Support waiver,
- Is on the Community and Employment Support waiver wait list and gets Medicaid State Plan services,
- Lives in a private Intermediate Care Facility for individuals with an intellectual or developmental disability, and
- Has a behavioral health diagnosis and needs services in addition to counseling and medication management.

However, the current eligibility criteria do not capture *all* individuals with an intellectual or developmental disability diagnosis. Some individuals with an intellectual or developmental disability remain in the FFS delivery system. Under this option, DHS would revise the PASSE criteria to include all individuals with an intellectual or developmental disability diagnosis in the PASSE program. DHS may consider the following as it pertains to this option:

- Care coordination provided by PASSE organizations can lead to more efficient service utilization,
- Care coordination provided by PASSE organizations can lead to more efficient service utilization, and

[39] Alabama Medicaid Agency. (October 23, 2018). *Integrated Care Network.* [Webpage]. Retrieved from: https://medicaid.alabama.gov/documents/5.0_Managed_Care/5.2_Other_Managed_Care_Programs/5.2.4_ICNs/5.2.4_ICN_Fact_Sheet_10-23-18.pdf.

[40] Alabama Medicaid Agency. (October 23, 2018). *Integrated Care Network.* [Webpage]. Retrieved from:: https://medicaid.alabama.gov/documents/2.0_Newsroom/2.5_Media_Library/2.5.1_Slide_Presentations/2.5.1_ICN/2.5.1_ICN_Overview_10-23-18.pdf.

- Budget predictability for the Medicaid program.

	Option 4.3: Revise the PASSE criteria to include all individuals with an intellectual or developmental disability diagnosis.
Potential Cost Savings	If this option is considered for Early Intervention Day Treatment and Adult Developmental Day Treatment only, it is expected to result in limited or no cost savings. For example, most Early Intervention Day Treatment expenditures (~91%) and a little over half of the Adult Developmental Day Treatment service expenditures are paid through the FFS delivery system. Approximately 81% of total Medicaid spend for beneficiaries receiving Early Intervention Day Treatment and Adult Developmental Day Treatment is on day treatment-specific services. However, other programs such as applied behavioral analysis (ABA), occupational therapy, physical therapy, speech/language pathology, and personal care services show high levels of spending for clients with intellectual and developmental disabilities that could be better controlled in the PASSE model. For example, the current FFS Medicaid spend for ABA is $20 million annually. It is unclear that the PASSE organizations would be able to realize cost savings with day treatment beneficiaries that have intellectual or developmental disability diagnoses if most of their services are specific to day treatment services or could otherwise be controlled through revised service authorization processes or system edits to enhance program oversight and ensure services are going to individuals with the highest needs. Adding populations and services to the PASSE program will require paying managed care administrative fees and margins but would generate premium tax revenue. Considering this, there may be little to no cost savings. Although cost savings may be limited, incorporating all Medicaid beneficiaries with intellectual or developmental disability diagnoses into the PASSE program would 1) enable beneficiaries to access enhanced care coordination, which could also lead to more efficient service utilization, and 2) allow for a coordinated program that is targeted to meet beneficiaries' functional needs. This option would offer enhanced budget predictability.

	Option 4.3: Revise the PASSE criteria to include all individuals with an intellectual or developmental disability diagnosis.
Implementation Steps	DHS would have to amend the State statute and the PASSE managed care 1915(b) waiver and update the PASSE contract. CMS approval for changes to the PASSE managed care 1915(b) waiver and the PASSE contract updates would be required. DHS would also have to work with PASSE organizations to prepare to add day treatment beneficiaries to the program, including readiness reviews. Additionally, DHS would need to update and promulgate the provider manuals, update policies and procedures, and implement program operational changes, including system changes. It would also need to conduct stakeholder engagement and education efforts on the change.
Timeline	2+ years.
Leading Practices	Individuals with intellectual or developmental disabilities often require a specific, tailored set of services and supports to meet their needs best. Serving people with intellectual or developmental disabilities requires unique program development and management approaches. Therefore, it is favorable to serve all beneficiaries with the same functional deficits within one coordinated program targeted to meet their needs.

Option 4.4: Transition FFS beneficiaries with high utilization to the PASSE program or other programs/solutions to better manage their care.

DHS staff believe there are FFS beneficiaries with medically or socially complex needs and/or high expenditures who may be better managed within the PASSE program. Under this option, DHS would identify beneficiaries with specific characteristics contributing to high utilization and high expenditures and transition those beneficiaries from FFS to the PASSE program. Such beneficiaries may include but are not limited to, individuals with neurological conditions, pregnant women, and others covered under Arkansas' pending re-entry Section 1115 waiver application.

The PASSE organizations would be responsible for providing care coordination and care management services to these additional medically or socially complex populations. When

beneficiaries' care is better managed, utilization of higher-cost services may decrease.

	Option 4.4: Transition FFS beneficiaries with high utilization to the PASSE program or other programs/solutions to better manage their care.
Potential Cost Savings	This option has the potential to generate cost savings, as PASSE organizations would be incentivized to contain costs due to receiving per member per month payments for their covered population. According to initial external analysis, there are potential cost savings when transitioning high-cost individuals into managed care. Transitioning low-cost individuals into managed care is not expected to generate savings. More detailed actuarial analysis would be required to assess the full impact of this option.
Implementation Steps	DHS would need to analyze claims for high-utilizers whose care results in significant expenditures to determine the specific criteria for transitioning additional FFS beneficiaries to the PASSE program. DHS would have to amend the PASSE statute, update federal authority vehicles for managed care, amend the PASSE contract, and conduct readiness reviews. CMS approval would be required for the federal authority vehicles and the PASSE contract updates. Additionally, DHS would need to update and promulgate the provider manuals, update policies and procedures, and implement program operational changes, including system changes. DHS would also need to engage stakeholders and provide education about the change.
Timeline	2-3 years.

SECTION 5: SUPPLEMENTAL, COST SETTLEMENT, AND ACCESS PAYMENTS (INPATIENT AND OUTPATIENT)

DHS currently pays FFS inpatient cost settlements to eligible hospital Medicaid providers. Cost settlements are lump sum payments to a hospital provider to "shore up" the difference between what it costs to provide services to Medicaid FFS beneficiaries versus how much the hospital received from the Medicaid FFS rate payment program. These hospitals are paid FFS rates, often equating to less than 100% of hospital costs.

Per the Arkansas Medicaid State Plan provisions, DHS is currently required to make cost settlement payments to certain in-state and out-of-state providers. The State's general fund appropriation funds these cost settlement payments.

In SFY 2023, DHS paid $47 million in inpatient cost settlements and $149 million in outpatient cost settlements, for a total of $196 million in inpatient and outpatient cost settlements. This equals approximately 15% of total hospital reimbursement for the FFS population. The State share obligation required for these payments equates to $46–$56 million annually, which State General Revenue funds entirely. Most of these cost settlements (67% in SFY 2023) are distributed to the Arkansas Children's Hospital ($131 million in total inpatient and outpatient cost settlements). For a list of in-state and out-of-state hospital cost settlements, please see **Figure 14** and **Figure 15**, respectively. Out-of-state cost settlements for Arkansas Children's Hospital can be found in **Figure 16** and **Figure 17**.

All cost settlement/supplemental payment figures and estimates below are based on the currently approved Medicaid State Plan inpatient/outpatient hospital FFS payment rate methodologies. However, DHS is evaluating a potential transition of their inpatient hospital FFS rate payments from per diem based to a Diagnosis Related Group methodology and the current outpatient fee schedule to an Ambulatory Payment Classification methodology. As such, these changes will impact inpatient and outpatient cost settlements and supplemental payments. The figures and estimates below will be updated once provider-level payment models illustrating these changes are available.

Strategic Options

The options that follow could be implemented concurrently.

Option 5.1: End inpatient cost settlement process for in-state hospitals.

DHS may elect to eliminate cost settlements to in-state hospitals. For most hospitals, this would end the cost settlement process for claims for beneficiaries under one-year-old. Sixty-six in-state hospitals received inpatient cost settlements in SFY 2023. Ten in-state hospitals received inpatient cost settlement payments of $1 million or more, with Arkansas Children's Hospital and Baptist Health Little Rock both receiving over $5 million in inpatient cost settlement payments in SFY 2023.

As illustrated in **Figure 13**, inpatient in-state hospital cost settlements can significantly vary year over year. Increases in provider payments of this magnitude can significantly strain the State general fund. DHS may elect to shift inpatient cost settlements to an Upper Payment Limit (what Medicare would pay for services covered by the Arkansas Medicaid FFS program) payment to avoid retrospective cost settlement payments that can be difficult to budget.

Figure 13. Total Inpatient In-State Cost Settlements by SFY

Provider Type	2018	2019	2020	2021	2022	2023
Private	$9,283,905	$15,534,682	$17,705,233	$12,124,402	$12,295,409	$27,805,834
Public	$13,103,575	$13,210,387	$2,522,686	$34,585,243	$13,109,504	$1,031,515
Pediatric	$435,881	$0	$0	$0	$0	$0
Private Pediatric	$6,938	$2,752,399	$1,412,418	$35,490,061	$7,597,245	$8,613,530
Private Rehab	$60,714	$0	$0	$0	$0	$0
Total	**$22,891,013**	**$31,497,467**	**$21,640,337**	**$82,199,706**	**$33,002,158**	**$37,450,876**

Note: Totals may not be added due to rounding.

If desired, DHS may increase FFS rates to remain budget-neutral. In this case, in-state hospitals would receive increased payments through claims but would not receive separate cost settlement payments.

	Option 5.1: End inpatient cost settlement process for in-state hospitals.
Potential Cost Savings	Based on the SFY 2023 cost settlement payments and calculations in **Figure 14**, the State could realize $10.7 million in State savings annually if DHS does not replace the cost settlements with another form of payment. However, if DHS increases FFS rates or shifts inpatient cost settlements for in-state hospitals to an Upper Payment Limit payment, the cost savings would be reduced or eliminated. Ending this payment program would also eliminate the administrative costs of calculating and recalculating cost settlement payments and related non-federal share funding mechanisms.

Figure 14. SFY 2023 Inpatient Cost Settlements and Estimated State Share Obligation

Provider Name	Total Inpatient Cost Settlement	Estimated State Share Obligation[41]
Arkansas Children's Hospital	$8,126,056	$2,331,365
Baptist Health Little Rock	$5,571,378	$1,598,428
Washington Regional Medical Center	$3,179,379	$912,164
St. Bernards Hospital Inc.	$2,240,301	$642,742
Baptist Health Medical Center North Little Rock	$1,635,561	$469,242
White County Medical Center	$1,617,594	$464,088
White River Medical Center	$1,531,515	$439,392
Mercy Hospital Fort Smith	$1,402,831	$402,472
Jefferson Regional Medical Center	$1,104,682	$316,933
Mercy Hospital Rogers	$1,100,987	$315,873
Leo N. Levi Memorial Hospital	$977,685	$280,498
Chi St Vincent Hospital Hot Springs	$806,953	$231,515
University Hospital of Arkansas	$798,000	$228,946
Saline Memorial Hospital	$630,892	$181,003
Baptist Fort Smith	$628,373	$180,280
Medical Center of South Arkansas	$571,980	$164,101
Ouachita County Medical Center	$570,332	$163,628
Hot Springs National Park Hospital	$514,277	$147,546
Arkansas Childrens Northwest Inc.	$487,474	$139,856
Forrest City Arkansas Hospital Company LLC	$380,754	$109,238
Baptist Health Medical Center Stuttgart	$345,013	$98,984

[41] Based on Total Cost Settlement multiplied by (1 - Federal Medical Assistance Percentage [FMAP]). Did not include the FFCRA (COVID) temporary increase to FMAP.

Provider Name	Total Inpatient Cost Settlement	Estimated State Share Obligation[42]
Drew Memorial Hospital Inc.	$298,010	$85,499
Delta Memorial Hospital	$259,021	$74,313
North Arkansas Regional Medical Center	$251,656	$72,200
Johnson Regional Medical Center	$247,871	$71,114
St. Vincent Infirmary Medical Center	$243,943	$69,987
Baptist Health Medical Center Arkadelphia	$224,035	$64,276
Phillips Hospital Company LLC	$219,438	$62,957
Arkansas Methodist Medical Center	$196,133	$56,271
Great River Medical Center	$193,288	$55,454
McGehee Hospital	$185,267	$53,153
Ashley Memorial Hospital	$181,135	$51,968
Chicot Memorial Medical Center	$169,490	$48,627
Magnolia Regional Health System Inc.	$140,050	$40,180
Bradley County Medical Center	$133,122	$38,193
Mena Hospital Commission	$132,763	$38,090
Russellville Holdings LLC	$106,023	$30,418
Ozarks Community Hospital Of Gravette	$99,579	$28,569
Unity Health Newport	$72,353	$20,758
Eureka Springs Hospital LLC	$65,796	$18,877
St. Anthonys Hospital Association	$62,207	$17,847
St. Bernard Community Hospital Crossridge	$59,938	$17,196
Conway Regional Medical Center Inc.	$49,966	$14,335
Ozark Health Medical Center	$48,015	$13,776
NEA Baptist Memorial Hospital	$47,619	$13,662
Piggott Community Hospital	$45,149	$12,953
Dewitt Hospital And Nursing Home	$39,961	$11,465
Izard County Medical Center LLC	$21,783	$6,250
Baptist Health Heber Springs	$18,710	$5,368
Little River Medical Center Inc.	$12,065	$3,461
Board of Governors of Dallas County Medical Center	$11,816	$3,390
Lawrence Memorial Health Foundation Inc.	$11,457	$3,287
Fulton County Hospital	$2,308	$662
Dardanelle Hospital Yell County	$2,213	$635
John Ed Chambers Memorial Hospital Inc.	$225	$65
Siloam Springs Arkansas Hospital Company LLC	($7,086)	($2,033)
Baxter County Regional Hospital	($11,898)	($3,414)
Mercy Hospital Berryville	($18,028)	($5,172)

[42] Based on Total Cost Settlement multiplied by (1 - Federal Medical Assistance Percentage [FMAP]). Did not include the FFCRA (COVID) temporary increase to FMAP.

Provider Name	Total Inpatient Cost Settlement	Estimated State Share Obligation[42]
Stone County Medical Center	($19,002)	($5,452)
Mercy Hospital Ozark	($19,876)	($5,702)
Mercy Hospital Booneville	($34,803)	($9,985)
Mercy Hospital Waldron	($37,789)	($10,842)
Howard Memorial Hospital	($42,929)	($12,316)
Mercy Hospital Paris	($67,563)	($19,384)
South Mississippi County Medical	($139,993)	($40,164)
Northwest Arkansas Hospitals LLC	($224,576)	($64,431)
Total	**$37,450,879**	**$10,744,657**

	Option 5.1: End inpatient cost settlement process for in-state hospitals.
Implementation Steps	DHS would need to submit a State Plan Amendment to Section 4.19A, which would require CMS Approval and go through a legislative promulgation process. If DHS increases FFS rates to remain budget neutral, it will need to work with the rate-setting team to update the inpatient rates.
Timeline	State Plan Amendments are effective on the first day of the fiscal quarter in which they are submitted to CMS. Arkansas could submit the State Plan Amendment to CMS during quarter 1 of SFY 2025 (July 1, 2024 – September 30, 2024).
Leading Practices	From a review of Medicaid State Plans performed by MACPAC in 2017, 16 state Medicaid agencies other than Arkansas perform cost settlements for hospital inpatient services.[43] In addition, of the 16 agencies, 15 limit the types of hospitals that receive cost settlement payments, including the following: • Iowa, Michigan, South Carolina, and Washington apply cost settlements only to rural hospitals. • North Dakota applies cost settlements only to children's and cancer hospitals. • Massachusetts applies cost settlements only to Safety Net hospitals. • Texas applies cost settlements only to children's specialty and state-owned teaching hospitals. Only Idaho and Tennessee Medicaid agencies, like Arkansas, perform cost settlements to all hospitals for inpatient services (for the limited FFS

[43] MACPAC. (2018). *Medicaid Inpatient Hospital Services Fee-for-Service Payment Policy Issue Brief* [Webpage]. Retrieved from: https://www.macpac.gov/wp-content/uploads/2016/03/Medicaid-Inpatient-Hospital-Services-Fee-for-Service-Payment-Policy.pdf.

	Option 5.1: End inpatient cost settlement process for in-state hospitals.
	population). States typically avoid including a Medicaid FFS cost settlement as part of their FFS payment program unless that payment is part of a certified public expenditure (state share funding mechanism where the public provider "certifies" their costs, and the state pays the provider no more than the federal share of the costs). Instead, most states prefer a Medicaid supplemental payment that pays up to the Medicare Upper Payment Limit. The Medicare Upper Payment Limit is often higher than what a cost settlement allows a state to pay up to. States typically fund the state share of any lump sum Medicaid FFS payment made to providers using a provider-funded state share funding mechanism, such as intergovernmental transfers, certified public expenditures, or provider taxes. It is best practice to address concerns about access to care before eliminating a payment program for Medicaid providers, such as cost settlement payments.

Option 5.2: End the cost settlement process for out-of-state hospitals.

DHS pays Medicaid FFS cost settlement payments to large hospital providers in bordering states that provide a significant amount of services to Arkansas Medicaid beneficiaries, especially in rural areas with limited access to in-state services. Twenty-six out-of-state hospitals received cost settlements in SFY 2023. Four out-of-state hospitals received cost settlement payments of $1 million or more, with Methodist Le Bonheur Healthcare Memphis Hospital, including a children's hospital, receiving the largest payment of $7 million.

DHS may elect to eliminate cost settlements with these out-of-state hospitals. Eliminating out-of-state hospital cost settlements would reduce the administrative effort of cost settling with these out-of-state providers and remove any time lag between the time services are performed and the final payment. Eliminating these cost settlements can impact access to care for beneficiaries receiving care at these out-of-state hospitals, particularly in border counties.

If desired, DHS may increase FFS rates to remain budget-neutral. In this case, out-of-state hospitals would receive increased payments through claims but would not receive separate cost settlement payments.

	Option 5.2: End the cost settlement process for out-of-state hospitals.
Potential Cost Savings	$4.2 million in State savings is estimated based on the calculation in **Figure 15** from SFY 2023 cost settlement payments if DHS does not replace the cost settlements with another form of payment. However, if DHS applies an increase in FFS rates for out-of-state hospitals, the cost savings would be reduced or eliminated depending on the size of the FFS rate increase.

Figure 15. SFY 23 Out-of-State Cost Settlements and Estimated State Share Obligation

Provider Name	Total Out-of-State Cost Settlement	Estimated State Share Obligation [44]
Methodist Le Bonheur Healthcare Memphis Hospital[45]	$7,031,362	$2,017,298
St Jude Childrens Research Hospital	$2,208,050	$633,490
Shelby County Health Care Corporation	$1,327,467	$380,850
Christus Health Ark La Tex	$1,191,465	$341,831
Childrens Mercy Hospital Kansas City	$652,754	$187,275
St Louis Childrens Hospital	$454,925	$130,518
Brim Healthcare of Texas LLC	$388,970	$111,595
Shriners Hospital for Children Missouri	$333,783	$95,762
Shriners Hospital for Children Louisiana	$259,877	$74,559
Baptist Memorial Hospital Memphis	$197,277	$56,599
Childrens Medical Center Dallas	$174,674	$50,114
A I Dupont Hospital for Children	$164,587	$47,220
Shriners Hospital for Children Texas	$153,304	$43,983
Poplar Bluff Regional Medical Center	$86,249	$24,745
Delta Regional Medical Center	$62,977	$18,068
Lester E Cox Medical Center	$53,548	$15,363
Childrens Hospital Medical Center Ohio	$49,115	$14,091
Childrens Mercy Hospital KS	$40,465	$11,609
Cook Childrens Medical Center	$20,994	$6,023
Delta Medical Center Memphis	$9,456	$2,713
Shriners Hospital for Children Ohio	$4,377	$1,256

[44] Based on Total Cost Settlement multiplied by (1 - Federal Medical Assistance Percentage (FMAP)). Did not include the FFCRA (COVID) temporary increase to FMAP.

[45] Methodist Healthcare Memphis Hospital includes a children's hospital and is a key provider of services for Medicaid beneficiaries who reside close to Arkansas' state border with the State of Tennessee.

Provider Name	Total Out-of-State Cost Settlement	Estimated State Share Obligation [44]
Childrens Medical Center Plano	$3,441	$987
East Tennessee Children's Hospital	$509	$146
Shriners Hospital for Children PA	$345	$99
Childrens Hospital DC	$115	$33
Saint Francis Hospital	($17,543)	($5,033)
Total	**$14,852,543**	**$4,261,195**

	Option 5.2: End the cost settlement process for out-of-state hospitals.
Implementation Steps	DHS would need to submit a State Plan Amendment to Sections 4.19A and 4.19B, which would require CMS Approval and undergo a legislative promulgation process. If DHS increases FFS rates to remain budget neutral, it will need to work with the rate-setting team to update the rates.
Timeline	State Plan Amendments are effective on the first day of the fiscal quarter in which they are submitted to CMS. Arkansas could submit the State Plan Amendment to CMS during quarter 1 of SFY 2025 (July 1, 2024 – September 30, 2024).
Leading Practices	Few state Medicaid agencies offer Medicaid FFS cost settlement payments, and even fewer states offer cost settlement payments to out-of-state hospitals. Instead, states pay these providers a Medicaid State Plan-approved FFS rate and, in some cases, a Medicaid disproportionate share hospital payment. Before eliminating a payment program for Medicaid providers, such as cost settlement payment, it is best to address any concerns about access to care.

Option 5.3: Shift hospital outpatient cost settlement for Arkansas Children's Hospital to an Upper Payment Limit payment.

The time and resources required to prepare and review cost settlement payments to Arkansas Children's Hospital have significantly strained DHS administrative spending. DHS may elect to shift outpatient cost settlements for Arkansas Children's Hospital to an Upper Payment Limit payment to avoid retrospective payments that can be difficult to budget and administratively burdensome.

	Option 5.3: Shift hospital outpatient cost settlement for Arkansas Children's Hospital to an Upper Payment Limit payment.
Potential Cost Savings	Based on **Figure 16**, cost settlement payments paid out during SFY 2023 for Arkansas Children's Hospital were for three fiscal years going as far back as SFY 2017. DHS must expend resources to prepare and review these cost settlement calculations. An Upper Payment Limit payment is a much simpler payment to calculate since it uses estimates and higher-level source data. Also, an Upper Payment Limit payment is only paid out once for each SFY, meaning there is no "tentative" and/or "final" Upper Payment Limit payment. Therefore, DHS could save on expensive administrative efforts to cost-settle Medicaid payments to Arkansas Children's Hospital.

Figure 16. Arkansas Children's Hospital Outpatient Cost Settlement

Settlement Type	Fiscal Year End Date	Paid Date	Payout Amount
2nd Additional Tentative Outpatient Over 1	6/30/2020	10/27/2022	$17,156,205
2nd Additional Tentative Outpatient Over 1 ACA	6/30/2020	10/27/2022	$148,587
Tentative Outpatient Over 1 Adult Expansion	6/30/2022	3/30/2023	$449,323
Final Outpatient Over 1	6/30/2017	8/18/2022	$1,040,762
Final Outpatient Over 1 Adult Expansion	6/30/2017	8/18/2022	$36,826
Tentative Outpatient Over 1	6/30/2022	3/30/2023	$73,197,540
Tentative Outpatient Over 1	6/30/2022	3/30/2023	$22,689,281
Tentative Outpatient Over 1 Adult Expansion	6/30/2022	3/30/2023	$122,776
2nd Additional Tentative Outpatient Over 1 ACA	6/30/2020	10/27/2022	$26,971
2nd Additional Tentative Outpatient Over 1	6/30/2020	10/27/2022	$7,735,289
Total			**$122,603,560**

	Option 5.3: Shift hospital outpatient cost settlement for Arkansas Children's Hospital to an Upper Payment Limit payment.
Implementation Steps	DHS would need to submit a State Plan Amendment to Section 4.19B, which would require CMS Approval and undergo a legislative promulgation process.
Timeline	State Plan Amendments are effective on the first day of the fiscal quarter in which they are submitted to CMS. Arkansas could submit the State Plan Amendment to CMS during quarter 1 of SFY 2025 (July 1, 2024 – September 30, 2024).

	Option 5.3: Shift hospital outpatient cost settlement for Arkansas Children's Hospital to an Upper Payment Limit payment.
Leading Practices	Given the large dollar amount of State general fund appropriation required to make this cost settlement payment to Arkansas Children's Hospital, DHS may consider an alternative to a cost settlement payment. States often write a Medicaid State Plan so that a specific dollar amount is paid to a single provider. For example, instead of a cost settlement, DHS could include an amount to be paid to Arkansas Children's Hospital that would "cap" their reimbursement at an amount the State general fund could absorb. Arkansas already has a similar State plan payment distribution methodology for privately owned Disproportionate Share Hospital providers.

Option 5.4: Require Arkansas Children's Hospital to fund the non-federal share of the Upper Payment Limit payment as other hospitals do.

Outpatient cost settlements to Arkansas Children's Hospital have been increasing yearly, as illustrated in **Figure 17,** more than any other provider payment. Outpatient cost settlements to Arkansas Children's Hospital totaled $596,800,828 from SFY 2018 – 2023, representing 78% of all outpatient cost settlements ($764,256,638) over the same period. The State share of the cost settlement payment to Arkansas Children's Hospital is funded by the State general fund appropriation. DHS may consider requiring Arkansas Children's Hospital to fund the non-federal share of the Upper Payment Limit payment (all other hospitals that receive an Upper Payment Limit payment already do in Arkansas) to decrease the use of State general funds.

	Option 5.4: Require Arkansas Children's Hospital to fund the non-federal share of the Upper Payment Limit payment as other hospitals do.
Potential Cost Savings	Based on a calculation of the State general fund obligation for SFY 2023, DHS would save approximately $35 million in State general fund appropriation if it shifted the outpatient cost settlement to an Upper Payment Limit payment and required Arkansas Children's Hospital to fund the full non-federal share of the Upper Payment Limit payment.

Figure 17. Arkansas Children's Hospital Outpatient Cost Settlement[46]

SFY	2018	2019	2020	2021	2022	2023
Total Cost Settlement	$74,811,341	$103,797,816	$89,385,357	$106,907,137	$99,295,617	$122,603,560
Estimated State General Fund Obligation*	$21,792,544	$30,609,976	$25,546,335	$30,757,183	$28,180,096	$35,174,961

	Option 5.4: Require Arkansas Children's Hospital to fund the non-federal share of the Upper Payment Limit payment as other hospitals do.
Implementation Steps	This option would require implementing or increasing a provider funding mechanism (donation and/or provider taxes).
Timeline	No revisions are needed to a State plan or any other federal authority for Arkansas Children's Hospital to begin participating in the State's existing tax program. Therefore, Arkansas Children's Hospital could begin participating as early as SFY 2025 (July 1, 2024, through June 30, 2025).
Leading Practices	The only State share funding mechanism that Arkansas Children's Hospital can participate in is a provider tax program. However, health care provider tax rules would require that Arkansas Children's Hospital either fully participate in the provider tax program or not participate at all. Some states, including Colorado, have successfully implemented a "bona-fide provider donation" that would allow a provider to ease into participating in a state share funding mechanism.

[46] Based on Total Cost Settlement multiplied by (1 - Federal Medical Assistance Percentage (FMAP)). Did not include the FFCRA (COVID) temporary increase to FMAP.

SECTION 6: LONG-TERM SERVICES AND SUPPORTS (FACILITY / HOME AND COMMUNITY-BASED SERVICES)

Long-term services and supports (LTSS) and home and community-based services (HCBS) are designed to meet a person's health and/or personal care needs and help people live independently and safely. People who receive LTSS and HCBS are often older adults, people with disabilities, or people with chronic health conditions or chronic mental illness. LTSS can be provided in a facility (e.g., a nursing facility) or the person's home or community (called HCBS). LTSS are expensive and generally not covered by Medicare. In 2021, the median LTSS annual costs in the United States were $108,405 for a private room in a nursing facility, $54,000 for an assisted living facility, and $61,776 for home health aide costs. In SFY 2023, private nursing facilities' average statewide per diem rate was $266.45. These figures represent what individuals might pay if they did not qualify for Medicaid.[47]

Growth in Aging Populations and LTSS Expenditures

Thousands of Arkansans benefit from Medicaid-covered LTSS, and the demand for these services will continue to increase as the aging population grows significantly in the coming years. According to the Administration for Community Living, the United States population aged 65 and older increased from 40.5 million in 2010 to 55.7 million in 2020 (a 38% increase) and is projected to reach 94.7 million in 2060.[48] The 85 and older population is projected to more than double from 2020 to 2040, from 6.7 million to 14.4 million. These demographic shifts underscore the need for DHS and other state Medicaid agencies to identify solutions to the ensuing implications on health care costs and resources. According to CMS' most recent Medicaid LTSS Annual Expenditures Report from Fiscal Year 2020, Arkansas Medicaid's LTSS expenditures were approximately $2.14 billion (which includes LTSS expenditures under the PASSE managed care program), comprising nearly one-third of Arkansas' total Medicaid expenditures.[49]

When looking at how LTSS expenditures are distributed between facility and home and

[47] Kaiser Family Foundation. (September 15, 2022). 10 Things About Long-Term Services and Supports. Retrieved from: https://www.kff.org/medicaid/issue-brief/10-things-about-long-term-services-and-supports-ltss/.

[48] Administration for Community Living. Profile of Older Americans 2021. Retrieved from: https://acl.gov/sites/default/files/Profile%20of%20OA/2021%20Profile%20of%20OA/2021ProfileOlderAmericans_508.pdf.

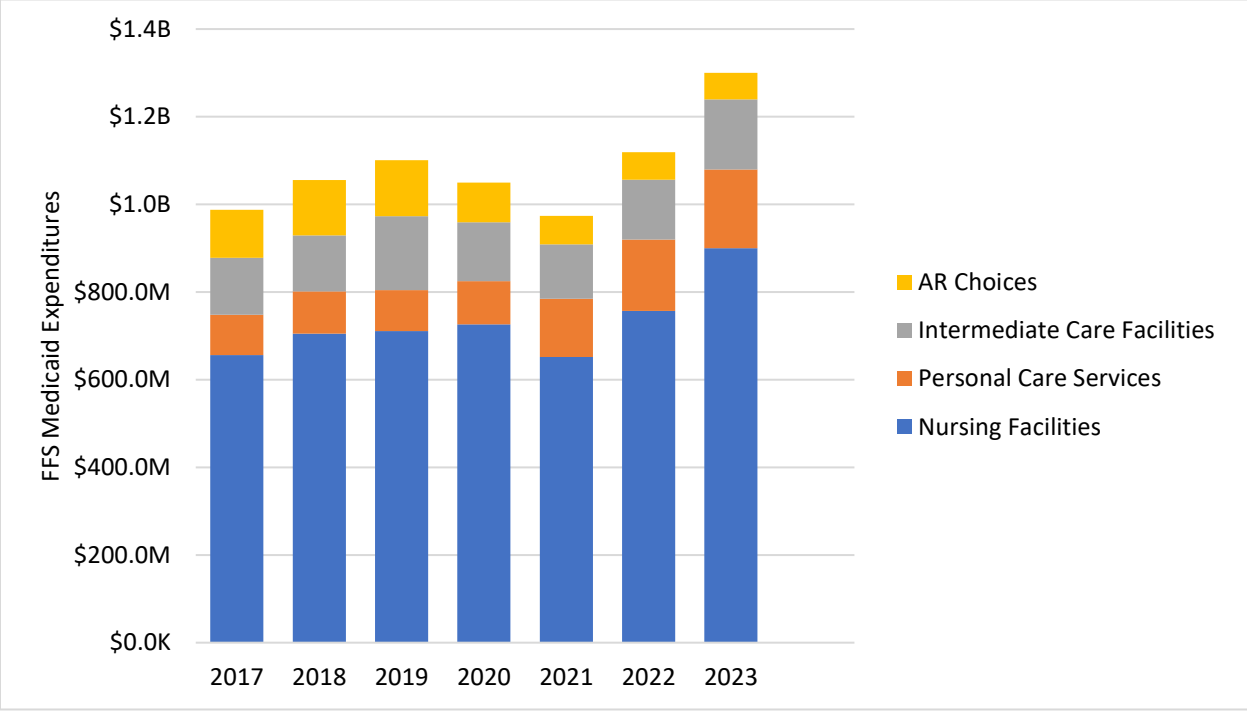
[49] Centers for Medicare & Medicaid Services. Medicaid Long Term Services and Supports Annual Expenditures Report – Federal Fiscal Year 2020. June 9, 2023. Retrieved from: https://www.medicaid.gov/sites/default/files/2023-10/ltssexpenditures2020.pdf.

community-based settings across both FFS and managed care programs, there is a nearly even split, with institutional settings accounting for 49.8% of Arkansas' LTSS expenditures and HCBS accounting for 50.2% of Arkansas' LTSS expenditures. The national average of LTSS expenditures for HCBS was 62.5% in FY 2020.

When looking at only FFS LTSS expenditures, nursing facility expenditures comprise the largest share of FFS LTSS expenditures for Arkansas' Medicaid program. **Figure 18** below illustrates FFS Medicaid LTSS expenditures for some of Arkansas Medicaid's highest LTSS spend categories. Between SFY 2017 and SFY 2023:

- FFS personal care services expenditures increased by 95%,
- FFS nursing facility expenditures increased by 37%,
- FFS intermediate care facility expenditures (State-run human development centers), increased by 23%, and
- AR Choices expenditures decreased by 44%.

Figure 18. SFY 2017 – 2023 FFS Medicaid Expenditures for Select LTSS



* FFS claims are summarized by the date of payment. This figure does not include non-claim financial transactions.

Workforce Shortages

As the demand for LTSS is growing, there have also been increasing workforce shortages among

LTSS providers, which have only been exacerbated by the COVID-19 Public Health Emergency. For example, the American Health Care Association and the National Center for Assisted Living report that nationally, the overall decline in the number of nursing homes accelerated by nearly four times during the pandemic.[50] HCBS workers have a turnover rate of 40% to 60% annually. A 2021 survey of HCBS agencies found that 77% have turned away referrals, and 84% have delayed programs due to staffing shortages.[51] The demand for HCBS providers is expected to grow due to the aging population, beneficiary preferences for living in the community, and other rebalancing initiatives. [52]

Arkansas LTSS System Performance

According to the American Association of Retired Persons LTSS Scorecard, which uses data from various sources to capture states' LTSS system performance, Arkansas' LTSS and HCBS system ranks 37th overall across the country. The Scorecard indicated Arkansas' best performance is in the "Affordability and Access" area and Arkansas' poorest performance is in "Community Integration."[53]

Arkansas has several pathways for people to receive institutional and non-institutional (i.e., HCBS) LTSS. Currently, many Arkansas Medicaid beneficiaries with intellectual or developmental disabilities or behavioral health diagnoses are served in the PASSE managed care program. All other long-term care programs are delivered via FFS.

Figure 19 includes Arkansas' LTSS and HCBS services and programs. This report does not include strategic options for all LTSS and HCBS services.

Figure 19. LTSS and HCBS Services and Programs

Category	Services/Programs
PASSE Program	• Community and Employment Support 1915(c) Waiver • Behavioral Health Services within PASSE 1915(i) State Plan • Private Intermediate Care Facilities for Individuals with Intellectual Disabilities

[50] American Health Care Association, National Center for Assisted Living. (August 23, 2023). New Report Finds Access to Nursing Home Care A Growing Crisis. Retrieved from: https://www.ahcancal.org/News-and-Communications/Press-Releases/Pages/New-Report-Finds-Access-To-Nursing-Home-Care-A-Growing-Crisis-.aspx.

[51] Medicaid and CHIP Payment and Access Commission. (March 2022). State Efforts to Address Medicaid Home- and Community-Based Services Workforce Shortages. Retrieved from: https://www.macpac.gov/wp-content/uploads/2022/03/MACPAC-brief-on-HCBS-workforce.pdf.

[52] Medicaid and CHIP Payment and Access Commission. (March 2022). State Efforts to Address Medicaid Home- and Community-Based Services Workforce Shortages. Retrieved from: https://www.macpac.gov/wp-content/uploads/2022/03/MACPAC-brief-on-HCBS-workforce.pdf.

[53] The American Association of Retired Persons. LTSS Scorecard – Arkansas. Retrieved from: https://ltsschoices.aarp.org/scorecard-report/2023/states/arkansas.

Category	Services/Programs
	• Psychiatric Residential Treatment Facilities (PRTF)
1915(c) HCBS Waivers and State Plan Amendments	• Autism 1915(c) Waiver • Living Choices 1915(c) Waiver • AR Choices 1915(c) Waiver • IndependentChoices 1915(j) State Plan
Medicaid State Plan HCBS	• Personal Care Services • Home Health • Private Duty Nursing • Hospice Care
Institutional Services	• Skilled Nursing Facility
Other HCBS	• Program of All-Inclusive Care for the Elderly

A. LTSS and HCBS: Section HCBS 1915(c) HCBS Waivers

Section 1915(c) HCBS waiver programs allow states to "waive" specific Medicaid program requirements to target services for people needing long-term care. Arkansas operates four 1915(c) HCBS waivers, described in **Figure 20** below. Two waivers are for the aged or disabled population, while two waivers are for individuals with an intellectual or developmental disability.

Figure 20. 1915(c) HCBS Waivers

Waiver	Description	Target Group	Operating Agency
AR Choices in Homecare	Provides adult day health, respite, adult day services, attendant care services, environmental accessibility adaptations/adaptive equipment, home-delivered meals, personal emergency response system, and prevocational services to individuals ages 65 or older and individuals with physical disabilities ages 21-64 years who meet a skilled nursing facility level of care. This waiver operates with a concurrent 1915(j) authority.	Aged or Disabled, or Both - General	Division of Aging, Adult, & Behavioral Health Services
AR Living Choices Assisted	Provides extended Medicaid State plan prescription drugs and living choices assisted living services to individuals ages 65 or older and individuals with physical disabilities ages 21-64	Aged or Disabled, or Both - General	Division of Aging, Adult, & Behavioral

Waiver	Description	Target Group	Operating Agency
Living Waiver	years who meet a skilled nursing facility level of care.		Health Services
AR Community and Employment Support	Provides respite, supported employment, supportive living, specialized medical supplies, adaptive equipment, community transition services, consultation, environmental modifications, and supplemental support services to individuals with autism, intellectual disabilities, or developmental disabilities ages 0 or older who meet an Intermediate Care Facilities for Individuals with Intellectual Disabilities level of care. This waiver operates with a concurrent 1915(b)(1) and 1915(b)(4) authority. This population is included in the PASSE program.	Intellectual Disability or Developmental Disability, or Both	Division of Developmental Disability Services
AR Autism Waiver	Provides consultative clinical and therapeutic services, individual assessment/treatment development/monitoring, lead therapy intervention, line therapy intervention, and therapeutic aides and behavioral reinforcers to individuals with autism ages 18 months to 8 years who meet an Intermediate Care Facilities for Individuals with Intellectual Disabilities level of care.	Intellectual Disability or Developmental Disability, or Both	Division of Develop-mental Disability Services

Strategic Options	The options below could be implemented concurrently.

Option 6.A.1: Enhance access to HCBS and "equalize the front door" by identifying opportunities to streamline the eligibility process and exploring expedited eligibility pathways.

Arkansans can receive LTSS via various settings (e.g., nursing facility or HCBS), programs (e.g., 1915(c) waivers or State Plan services), and through various DHS divisions. The eligibility process varies between institutional and HCBS programs. The main difference between HCBS and nursing facility initial program entry is that the HCBS programs have an "extra layer" – HCBS requires completion of the Arkansas Independent Assessment before service delivery can begin. The Arkansas Independent Assessment asks questions about the individual's health and functional needs to determine the service package. DHS staff report that completion of the Arkansas Independent Assessment (initially or upon change of condition) can add months to the process and delay services. Therefore, accessing HCBS programs can take several months longer than accessing nursing facilities, which indirectly disincentivizes HCBS use and results in an "uneven playing field."

Additionally, there are opportunities to review and streamline the eligibility processes across the HCBS programs, given reported differences in the order, timing, and procedures to determine eligibility across HCBS programs. For instance, depending on the HCBS waiver program, the Arkansas Independent Assessment may be completed before or after an individual is deemed eligible for the program. The eligibility variations across multiple programs (including institutional and HCBS) suggest the need to conduct an in-depth review of the eligibility process to ensure efficient, consistent, and timely eligibility processes and determinations.

Whereas home and community-based services for both BH and IDD have been put under the PASSE program, waivers for the physically disabled, aging, and elderly have continued to operate on an FFS basis. Waiver programs are an alternative to institutional care. However, DHS needs to comprehensively review the monetary tiers, service availability, and eligibility requirements to narrow the gap between HCBS and skilled nursing facilities.

Another method for enhancing access to HCBS is to incorporate expedited eligibility pathways that allow individuals to access HCBS timelier. There are several approaches to implement expedited HCBS eligibility, including but not limited to transitional eligibility and updates to the

"217 group."[54] The "217 group" authorizes Medicaid coverage for individuals who would be eligible if they were in a medical institution; would require an institutional level of care without the provision of HCBS; and will receive 1915(c) services.

In operating 1915(c) HCBS waivers, states commonly extend eligibility to individuals described in Section 1902(a)(10)(A)(ii)(VI), 42 C.F.R. §435.217 (the "217 group"). The "217 group" approach permits states to revise their 1915(i), 1915(k), or 1915(c) programs to adopt higher, effective income and resource eligibility standards for people who need HCBS. DHS is in the process of exploring how to use the "217 group" approach to implement a "Hospital to Home" program to expand access and enhance the availability of HCBS for Medicaid-eligible individuals who are at risk of institutionalization and/or currently have high utilization of hospital services, including emergency department services.

	Option 6.A.1: Enhance access to HCBS and "equalize the front door" by identifying opportunities to streamline the eligibility process and exploring expedited eligibility pathways.
Potential Cost Savings	There is potential for long-term savings from equalizing the front door for institutional care and HCBS settings with a streamlined eligibility process. Expedited eligibility pathways provide more opportunities for individuals to be served in the community, potentially reducing the State's costly spending on nursing facilities and hospital stays.
Implementation Steps	DHS would need to conduct an in-depth State assessment of the HCBS eligibility processes and services to identify and implement efficiencies (including changes to operational processes) and new services required for the State Plan. DHS would also need to determine the expedited eligibility pathway approach, make the necessary policy and programmatic updates, conduct stakeholder engagement, and develop the materials needed for CMS approval. Finally, increasing access to HCBS would require the State to consider provider workforce and waiver capacity challenges.
Timeline	1-2 years to implement any changes; the current State assessment could begin immediately.
Leading Practices	The federal government does not require particular assessment tools to determine LTSS eligibility. Studies show that most states use more than one tool, usually for different populations. However, to promote efforts for beneficiaries to live in the most appropriate, least restrictive setting, states may choose to

[54] Transitional eligibility is used to deem a beneficiary eligible for services based on a small number of requirements, prior to a complete Medicaid eligibility application review. DHS staff reported that Arkansas nursing facilities currently use transitional eligibility.

	Option 6.A.1: Enhance access to HCBS and "equalize the front door" by identifying opportunities to streamline the eligibility process and exploring expedited eligibility pathways.
	implement standardized assessment processes across LTSS programs.[55] States that have used transitional or presumptive eligibility have found low-risk rewards in identifying eligible beneficiaries. Indiana uses a separate application for presumptive eligibility, including specific income limits and metrics that can be quickly verified to confirm presumptive eligibility.[56] Washington uses Section 1115 waiver authority for presumptive eligibility and splits the risk of this eligibility with the federal government to help keep beneficiaries in the least restrictive setting possible.[57]

Option 6.A.2: Incorporate value-based payment in HCBS reimbursement.

Value-based payment refers to programs that reimburse providers based on the service's value and quality. Adding value-based payment into Arkansas Medicaid's HCBS programs could support DHS' efforts in providing quality care, address challenges the State is facing in care delivery (including workforce challenges), and increase access to data on care delivery.

Value-based payments for HCBS reimbursement could cover incentives for providers for areas including but not limited to complying and using state systems, such as adding electronic visit verification requirements or adding pay-for-reporting incentives; encouraging providers to take additional training; referring and recruiting new providers into the workforce; encouraging beneficiaries to obtain supported employment; and reducing beneficiary falls.

[55] MACPAC. (2016). Functional Assessments for Long-Term Services and Supports. [Webpage]. Retrieved from: https://www.macpac.gov/publication/functional-assessments-for-long-term-services-and-supports/.

[56] Indiana Medicaid for Providers. (n.d.). Qualified Provide Presumptive Eligibility. Retrieved: https://www.in.gov/medicaid/providers/business-transactions/qualified-provider-presumptive-eligibility-pe/.

[57] Kaiser Family Foundation. (n.d.) State Options to Expand Medicaid HCBS: Examples & Evaluations of Section 1115 Waivers [Webpage]. Retrieved from: https://www.kff.org/medicaid/issue-brief/state-options-to-expand-medicaid-hcbs-examples-evaluations-of-section-1115-waivers/.

	Option 6.A.2: Incorporate value-based payment in HCBS reimbursement.
Potential Cost Savings	Cost savings are dependent on value-based payment program design. While there may be a financial outlay in establishing a value-based payment program, using value-based payment may increase the data and knowledge of programs. It will allow the State to make targeted and systematic changes to improve programs and address fiscal challenges, including mis- or overspending on certain services. For HCBS beneficiaries who are dually eligible for Medicaid and Medicare, savings from reducing hospital visits accrue to Medicare rather than Medicaid, which can present challenges in designing value-based payment models that would financially benefit Arkansas' Medicaid program.[58]
Implementation Steps	DHS would have to work with rate-setting staff to identify the value-based payment program structure and value-based payment targets/incentives based on State priorities (e.g., direct care worker retention and turnover rates, training, career development incentives). DHS also would need to conduct stakeholder engagement activities regarding value-based payment initiatives and develop value-based payment policies and processes. DHS would need to update provider manuals based on the value-based payment program structure. Provider manual updates also would need to go through a legislative promulgation process. Finally, depending on how value-based payment is implemented, this effort may require systems updates to facilitate value-based payment measure reporting.
Timeline	1-2 years.
Leading Practices	Several states are incorporating value-based payment in HCBS. For example, Missouri has incorporated nine incentive payments for HCBS waiver providers that focus on workforce retention, direct support professional training, and compliance with electronic visit verification, among other areas. These value-based payments have supported the reduction of overall spending on service delivery and have provided the State with additional data on services that did not previously have adequate data collection processes. [59]

[58] Center for Health Care Strategies. Achieving Value in Medicaid Home- and Community-Based Care: Considerations for Managed Long-Term Services and Supports Programs. Retrieved from: https://www.chcs.org/media/Achieving-Value-in-Medicaid-Home-and-Community-Based-Care_091818.pdf.

[59] Missouri Department of Mental Health. (n.d.). Value Based Payments. [Webpage]. Retrieved from: https://dmh.mo.gov/dev-disabilities/value-based-payments.

Option 6.A.3: Review Medicaid program entry points to ensure correct program placement and appropriate service delivery in alignment with “no wrong door” philosophies, which promote a single, coordinated system to access services.

DHS staff report that individuals entering the Medicaid programs are sometimes only considered for the program to which they apply, even if other programs would be beneficial or even more appropriate. This sometimes leads to individuals' underlying needs not being met, resulting in more costly services downstream. Additionally, DHS believes the PASSE program may not capture all eligible individuals due to the entry points through which individuals join the program. For example, individuals with intellectual or developmental disabilities are only considered for the PASSE program if they have applied for the Community and Employment Support waiver.

Implementing an integrated model would help ensure that the appropriate programs serve individuals and may be able to address more of their needs. Shifting to a “no wrong door” model will require significant coordination across DHS divisions.

DHS is in the process of enhancing its “no wrong door” infrastructure. DHS is currently developing a Request for Proposal to solicit a vendor to establish a contact center for DHS beneficiaries that would serve as that no wrong door and have a singular phone line. The contact center will increase the staff and resources available to take calls and conduct information and referral activities.

	Option 6.A.3: Review Medicaid program entry points to ensure correct program placement and appropriate service delivery in alignment with “no wrong door” philosophies which promote a single, coordinated system to access services.
Potential Cost Savings	The direct fiscal impact is limited. Although ensuring individuals are served adequately and appropriately may result in indirect cost savings, the direct cost savings may be limited.

	Option 6.A.3: Review Medicaid program entry points to ensure correct program placement and appropriate service delivery in alignment with "no wrong door" philosophies which promote a single, coordinated system to access services.
Implementation Steps	DHS would need to conduct an in-depth assessment of Arkansas Medicaid eligibility processes across programs to identify areas for improvement and work across DHS divisions to implement operational changes. DHS would then have to conduct stakeholder engagement on any resulting changes to eligibility processes.
Timeline	2+ years.
Leading Practices	The "no wrong door model" promotes a streamlined, person-centered, coordinated system for individuals to access LTSS.[60] The foundation of a "no wrong door" model is built on four key functions, which require close collaboration between state agencies involved in long-term care: state governance and administration; public outreach and coordination with key referral sources; person-centered counseling; and streamlined eligibility for public programs.

B. LTSS and HCBS: Medicaid State Plan HCBS: Personal Care

Personal care services are provided to eligible beneficiaries to help them stay in their own homes and communities rather than live in institutional settings (e.g., nursing facilities). To be eligible for personal care services, beneficiaries must require hands-on assistance with at least one activity of daily living. Daily living activities include walking, feeding, dressing, toileting, bathing, and transferring. Beneficiaries' personal care support needs are assessed through a functional independent assessment, which informs the development of an individualized care plan. Personal care aides may provide hands-on support with the following activities:

- Bathing
- Bladder and bowel requirements
- Dressing
- Eating
- Incidental housekeeping
- Laundry
- Mobility and ambulation
- Personal hygiene
- Shopping for personal maintenance items
- Taking medication

Personal care services are available under the Medicaid State Plan, the AR Choices Waiver, and

[60] No Wrong Door. (n.d.). Why no Wrong Door. [Webpage]. Retrieved: https://nwd.acl.gov/our-story.html.

the IndependentChoices Program. Arkansas Medicaid personal care expenditures increased from approximately $92.2 million to $179.6 million between SFY 2017 and SFY 2023, which, in part, may be due to the COVID-19 pandemic.[61]

Option 6.B.1: Develop a monitoring system for State Plan personal care services.

State plan personal care services serve multiple populations. As a result, several DHS divisions are involved in personal care services operations. Historically, there has not been a clear delineation of responsibilities nor formal oversight of the personal care services program, and the services can be provided in multiple settings, including homes, group homes, and schools. Establishing a monitoring system, including formal oversight processes, could enhance administrative efficiencies, improve the quality of care, and yield cost savings.

	Option 6.B.1: Develop a monitoring system for State Plan personal care services.
Potential Cost Savings	State savings of less than $300,000 annually are estimated, assuming 0.5% savings on SFY 2023 FFS personal care expenditures. The savings would result from streamlining oversight and organizing administrative elements of personal care services, especially the prior authorization process.
Implementation Steps	DHS would need to develop a monitoring system, update internal operational processes, and identify existing or new staff to oversee and manage the program.
Timeline	Less than one year.

C. LTSS and HCBS: Institutional Services: Skilled Nursing Facilities

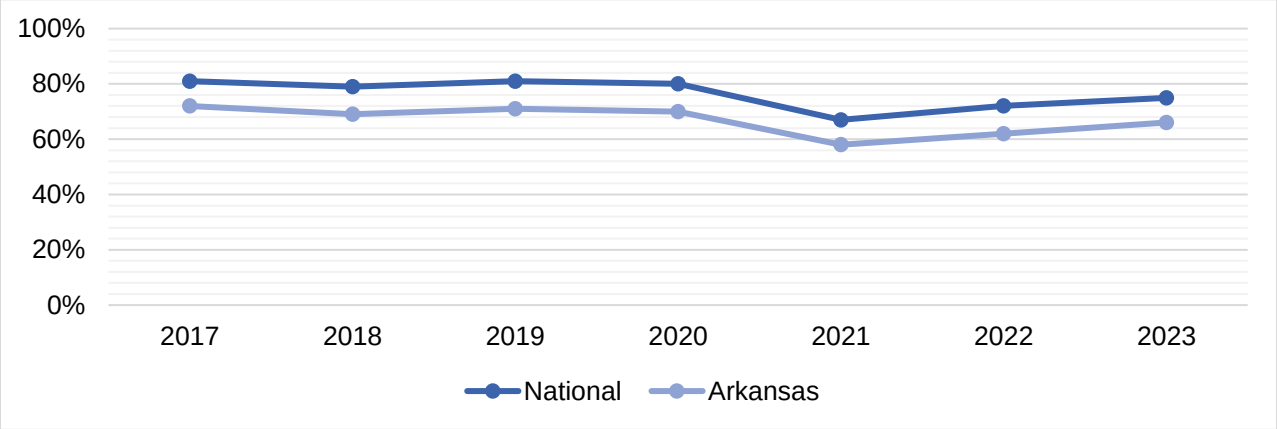
Nursing facilities are institutions that provide medically necessary care 24 hours per day for residents who require skilled nursing care, rehabilitation services, or health-related care and services. In addition to being income- and resource-eligible, the nursing facility resident must be aged, blind, or a beneficiary with disabilities and must require medical care of a certain level

[61] FFS data from Optum based on date of payment.

to have nursing facility services covered under Medicaid. [62]

Nursing facilities comprise a large proportion of LTSS expenditures, accounting for $900.2 million in SFY 2023.[63] Arkansas' nursing facility occupancy rates have consistently stayed below the national average, as illustrated in **Figure 21** below. In July 2023, Arkansas' average Statewide occupancy rate was 66%, ranking 44th among all states. Occupancy reflects the percentage of a facility's beds occupied by patients at a given time. Nursing facilities are most efficient when they operate at or near their bed capacity.

Figure 21. Nursing Facility Occupancy Rates[64]



According to the American Association of Retired Persons LTSS Scorecard, Arkansas nursing facilities had mixed performance:[65]

- Arkansas was one of ten states that received full credit for the number of residents in Green House® communities plus state and local policies that facilitate Green House® development. The Green House® model of care provides nursing facility services in a small, home-like setting, which has been found to improve residents' health outcomes.
- Arkansas' nursing facility staffing levels ranked 12th nationwide (with 3.5 direct care staff hours per resident per day).
- Arkansas' nursing facility staff turnover was 56.3% (ranked 35th nationwide).

[62] Arkansas Department of Human Services. *Long-Term Services and Supports (LTSS) Medicaid Assistance. Facilities.* Retrieved from: https://humanservices.arkansas.gov/divisions-shared-services/aging-adult-behavioral-health-services/find-home-community-based-services-for-adults-seniors/long-term-services-and-supports-ltss-medicaid-assistance/.

[63] FFS data from Optum based on date of payment.

[64] Kaiser Family Foundation. (2022). Certified Nursing Facility Occupancy Rate [Webpage]. Retrieved from: https://www.kff.org/other/state-indicator/nursing-facility-occupancy-rates/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[65] The American Association of Retired Persons. LTSS Scorecard – Arkansas. Retrieved from: https://ltsschoices.aarp.org/scorecard-report/2023/states/arkansas.

- Approximately 14.4% of Arkansas' nursing facility residents have low care needs, indicating an opportunity to serve these individuals in the community (ranked 35th in the nation).
- 12.1% of Arkansas nursing facility residents live in 5-star rated facilities (per the CMS Nursing Home Care Compare Quality Start ratings) (ranked 31st nationwide).

Nursing facility Medicaid reimbursement rates are cost-based and facility-specific. Rates consist of four major cost components: direct care, indirect administrative and operating, fair market rental, and quality assurance fees. The quality assurance fee is calculated using patient days and aggregate annual gross receipts. Nursing facilities submit annual cost reports to DHS, and DHS adjusts nursing facility rates annually.[66]

Strategic Options

The options below could be implemented concurrently.

Option 6.C.1: Incorporate value-based payment into nursing facility payment methodology to support value and quality of care.

Value-based payment is a model of reimbursement based on the value and quality of services that providers deliver. It incentivizes providers to deliver high-quality care by tying their performance on quality measures to their payments. Over time, the use of value-based payment may streamline and improve the efficacy of care delivery within nursing facilities, potentially leading to cost savings.

In developing a value-based payment program, states need to create an incentive pool (via new or existing funds), identify performance measures, create a performance assessment process, and establish a link between quality measure performance and payments. Funds are then distributed based on providers' level of achievement on a series of quality measures selected by the state. The measures can be designed to reflect policy initiatives and direction the state would like to achieve.

[66] Arkansas Department of Human Services. *Office of Long-Term Care Cost Reimbursement Rules.* Retrieved from: https://humanservices.arkansas.gov/divisions-shared-services/medical-services/helpful-information-for-providers/manuals/oltc-prov/.

For example, DHS can leverage value-based payment to target specific areas of interest for Arkansas nursing facilities, including staff retention and turnover rates, training and career development incentives, direct patient care outcomes (e.g., patient falls, bed ulcers), and incentives focused on nursing facilities' quality rating scores. Value-based payment could also encourage nursing facilities to upgrade their accommodations and move towards newer models of care that offer a more "home-like" setting and promote privacy and independence.

The Arkansas Health Care Association has started identifying potential approaches to value-based payment programs and has drafted a proposal describing the overall program design elements for DHS' consideration. The proposal incorporates creating an incentive pool by withholding a percentage of Medicaid payments and then redistributing the withheld funds based on each nursing facility's quality achievement. The proposal also describes potential quality measures primarily based on existing CMS quality measures, which focus on patient care and outcomes.

	Option 6.C.1: Incorporate value-based payment into nursing facility payment methodology to support value and quality of care.
Potential Cost Savings	Cost savings are highly dependent on the value-based payment program design. However, for example, a 1% annual cost savings of SFY 2023 nursing facility expenditures would result in approximately $2.5 million in State savings annually. For nursing facility beneficiaries dually eligible for Medicaid and Medicare, savings from reducing hospital visits accrue to Medicare rather than Medicaid. This can present challenges in designing value-based payment models that benefit Arkansas' Medicaid program financially.[67]
Implementation Steps	To implement value-based payment, DHS would need to review the State's needs and goals while working with key stakeholders to align on a value-based payment program structure. DHS would need to identify performance measures and benchmarks, determine how value-based payments would be funded (i.e., through additional funds or withholds), and create an incentive structure for nursing facilities. DHS would need to submit a State Plan Amendment for nursing facility reimbursement changes, and CMS would need to approve the State Plan Amendment. The State Plan Amendment would need to go through a legislative promulgation process.
Timeline	DHS could begin discussing the design of a value-based payment program as soon as possible. Implementation and impact will not occur for 2+ years.

[67] MACPAC. Principles for Assessing Medicaid Nursing Facility Payment Policies. Retrieved from: https://www.macpac.gov/wp-content/uploads/2023/03/Chapter-2-Principles-for-Assessing-Medicaid-Nursing-Facility-Payment-Policies.pdf.

	Option 6.C.1: Incorporate value-based payment into nursing facility payment methodology to support value and quality of care.
Leading Practices	The Center for Health Policy Evaluation in Long-Term Care has identified 30 unique nursing facility Medicaid value-based payment programs across 24 states. Approximately one-third of existing nursing facility value-based payment programs used the withhold payment method to distribute funds, which allows states to implement payments without drawing on additional funding.

Option 6.C.2: Assess Arkansas' nursing facility landscape to understand the current state and identify opportunities for improvement.

As described above, Arkansas nursing facility occupancy rates trend below the national average, and nursing facility quality and performance show mixed results. DHS can conduct an in-depth assessment of the nursing facility landscape to understand this information better and identify opportunities for improvement.

As part of this assessment, DHS may review any or all of the following:

- Financial performance of nursing facilities in relation to occupancy rates. For example, when a nursing facility has a lower occupancy rate, its costs are distributed over fewer residents, straining nursing facility finances and leading to potential closures.
- Adequacy of the number of nursing facilities across the State, given geographic distribution and population density.
- Alternative ways to use nursing facilities and explore diversified business lines to serve populations in community settings. As the need for aging in place grows, there are opportunities for nursing facilities to evolve approaches to service delivery.
- Opportunities to leverage reimbursement approaches and incentives as mentioned in the options above.

	Option 6.C.2: Assess Arkansas' nursing facility landscape to understand the current state and identify opportunities for improvement.
Potential Cost Savings	The assessment itself would not generate any cost savings. However, the findings and associated program modifications identified because of the assessment may lead to cost savings or expenses. Depending on the scope of the assessment, it may cost between $200,000 and $400,000 to complete.
Implementation Steps	DHS would need to identify the staff and resources for conducting the assessment, determine the goals and priorities of the assessment, and collaborate with key stakeholders (e.g., Arkansas Health Care Association).
Timeline	DHS could begin assessment discussions as soon as possible.

SECTION 7: PHARMACY

Expenditures for pharmaceuticals through Arkansas' Medicaid Pharmacy Benefit Plan in SFY 2023 were $509.4 million, representing 6% of the total Arkansas Medicaid budget and a 17% increase from SFY 2022. Since SFY 2017, pharmaceutical expenditures have increased by over 22%.[68] These increases have been driven by multiple factors, including an increased number of beneficiaries served, prescriptions filled, high-cost specialty drug utilization, and the conversion of therapies from the medical benefit plan to the pharmacy benefit plan.

DHS has undertaken several initiatives to "bend the curve" of pharmaceutical expenditures, including:

- Entering the Magellan National Medicaid Pooling Initiative in January 2023. The National Medicaid Pooling Initiative is comprised of 13 states and the District of Columbia, with supplemental rebate agreements with over 100 pharmaceutical manufacturers. Purchasing pools like the National Medicaid Pooling Initiative is an effective way to provide savings to state Medicaid programs.
- Receiving CMS approval in 2022 to negotiate value-based payment arrangements with pharmaceutical manufacturers (see option 7.2 for additional details).

The strategic options outlined below provide additional opportunities to support Arkansas' efforts to bend the cost curve.

Strategic Options	The options below could be implemented concurrently.

[68] FFS data from Optum based on date of payment.

Option 7.1: Allow 90-day refills for certain maintenance medications (e.g., cholesterol, diuretics, blood pressure medications).

Arkansas currently limits prescriptions to a 30-day supply. However, many states allow for 90-day supplies of certain drugs, particularly maintenance medications. A 2012 CMS study that looked at patients prescribed certain maintenance medications found that across four different drug categories (statins, antihypertensives, selective serotonin reuptake inhibitors, and oral hypoglycemic medications) and compared to 30-day refills, patients with 90-day refills had greater medication adherence, persistence, and savings, and nominal wastage.[69]

DHS recently began work to implement this option, including drafting the policy, which would cover all maintenance drugs for the adult population and diabetic medications for the pediatric population, and initiating discussions with the pharmacy benefit administrator. However, implementation efforts were paused to discuss further concerns raised by key pharmacy stakeholders about an anticipated reduction in dispending fee revenue resulting from this policy.

	Option 7.1: Allow 90-day refills for certain maintenance medications (e.g., cholesterol, diuretics, blood pressure medications).
Potential Cost Savings	Approximately $1.9 million in State savings annually based on internal DHS estimates, which consider the reduced number of dispensing fee payments from moving to a 90-day supply, adjusted for medication waste.[70]
Implementation Steps	DHS has drafted an initial policy and initiated discussions with the pharmacy benefit administrator. However, final implementation will require legislative changes.
Timeline	DHS could realize the impact within one year.

[69] Taitel, Michael, et al. *Medication Days' Supply, Adherence, Wastage, and Cost Among Chronic Patients in Medicaid*. Centers for Medicare & Medicaid Services, Medicare & Medicaid Research Review 2012: Vol 2, No. 3. [Webpage]. Retrieved from https://www.cms.gov/mmrr/Downloads/MMRR2012_002_03_A04.pdf

[70] "Medication waste" occurs when a beneficiary switches a drug type or strength within the same therapeutic class before the expected refill date.

	Option 7.1: Allow 90-day refills for certain maintenance medications (e.g., cholesterol, diuretics, blood pressure medications).
Leading Practices	Although there is not a comprehensive survey that identified which states offer 90-day supplies, several studies published by the Kaiser Family Foundation and the Department of Health and Human Services Office of Inspector General found that many states made changes to their prescription drug programs to increase access in response to the COVID-19 Public Health Emergency.[71] [72] For example, of the 24 states the Office of Inspector General examined, 18 states responded that they had implemented policies to allow pharmacies to dispense 90-day (or more) supplies of certain prescription drugs. Before the Public Health Emergency, three states already allowed 90-day (or more) supplies.[73] With the wind-down of the Public Health Emergency, it is still too soon to determine which states will maintain or discontinue this policy change. Examples of states that have implemented policies allowing for 90-day (or more) supplies of certain drugs include: • Arizona: 90-day refills are available for chronic illnesses, when a member will be out of a provider's service area for an extended period, or if the medication is prescribed for contraception[74] • Colorado: Unless otherwise communicated in the Prescription Drug List, maintenance medications may be filled for up to a 100-day supply[75] • Mississippi: Voluntary 90-day drug maintenance list, which includes certain medications used for chronic conditions and ongoing maintenance therapies;[76] participation in the program is optional for both patients and pharmacies • Missouri: For beneficiaries eligible for any of the FFS programs, select medications require a 90-day supply per dispensing once a beneficiary has demonstrated stability on a given medication for at least 60 days[77] • Ohio: A drug supply of under 120 days can be dispensed at a time for drugs to treat chronic conditions[78] Most of the policies reviewed pertain to 90-day supplies of medications for the treatment of chronic conditions and ongoing maintenance therapies.

[71] Kaiser Family Foundation. (April 30, 2020). *States are Shifting How They Cover Prescription Drugs in Response to COVID-19.* [Webpage]. Retrieved from: https://www.kff.org/policy-watch/states-are-shifting-how-they-cover-prescription-drugs-in-response-to-covid-19/

[72] Department of Health and Human Services Office of Inspector General. (October 2021). *Changes Made to States' Medicaid Programs to Ensure Beneficiary Access to Prescriptions During the COVID-19 Pandemic.* [Webpage]. Retrieved from: https://oig.hhs.gov/oas/reports/region6/62004007.pdf

Option 7.2: Pursue value-based payment arrangements with drug manufacturers for certain high-cost drugs.

Arkansas received CMS approval in 2022 for a value-based pharmaceutical payment arrangement but has not yet implemented any arrangements. Value-based payments within Medicaid pharmacy programs are relatively new, but states, including Arkansas, seek to expand. The need for value-based payment in drug purchasing has become more important with the advent of new high-cost gene therapies, which, while providing the possibility of curing diseases, can approach or exceed a million dollars for a course of therapy.[79]

The current pharmaceutical reimbursement system was designed to reimburse for less expensive treatments, many of which are taken routinely to manage chronic disease, as opposed to some of the newer high-dollar drug therapies that may cure disease. While these new treatments are expensive, curing the disease may help reduce overall health care costs. Health insurers are seeking new ways to cover and pay for these high-cost drugs without substantial increases to insurance premiums.[80]

Value-based payment arrangements are one way states and insurers are exploring to do this. The nature of value-based payment arrangements varies but can, for example, provide an upfront discount on a drug with the manufacturer's commitment to provide rebates to the state if the drug does not perform against agreed-upon measures.

[73] Department of Health and Human Services Office of Inspector General. (October 2021). *Changes Made to States' Medicaid Programs to Ensure Beneficiary Access to Prescriptions During the COVID-19 Pandemic.* [Webpage]. Retrieved from: https://oig.hhs.gov/oas/reports/region6/62004007.pdf

[74] Arizona Health Care Cost Containment System. (2021). *310-V – Prescription Medications/Pharmacy Services* [Webpage]. Retrieved from: https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/300/310-V.pdf

[75] Colorado Department of Health Care Policy and Financing. (n.d.). *Pharmacy Billing Manual* [Webpage]. Retrieved from: https://hcpf.colorado.gov/pharmacy-billing-manual

[76] Mississippi Division of Medicaid. (2019). *Medicaid updates Voluntary 90-Day Drug Maintenance List for Providers* [Webpage]. [Webpage]. Retrieved from: https://medicaid.ms.gov/medicaid-updates-voluntary-90-day-drug-maintenance-list-for-providers/

[77] MO HealthNet. (2022). *State of Missouri Pharmacy Manual* [Webpage]. Retrieved from: https://manuals.momed.com/collections/collection_pha/print.pdf

[78] Ohio Department of Medicaid. (n.d.). *Prescriptions* [Webpage]. Retrieved from: https://medicaid.ohio.gov/families-and-individuals/srvcs/prescriptions

[79] Verma, Seema, et al. "Value-Based Purchasing Rule for Medicaid Rx Drugs: Continuing to Shift from FFS towards Accountability." Health Affairs, 18 Jan. 2021. Retrieved from: https://www.healthaffairs.org/do/10.1377/forefront.20210119.109892/.

[80] Verma, Seema, et al. "Value-Based Purchasing Rule for Medicaid Rx Drugs: Continuing to Shift from FFS towards Accountability." Health Affairs, 18 Jan. 2021 Retrieved from: https://www.healthaffairs.org/do/10.1377/forefront.20210119.109892/.

	Option 7.2: Pursue value-based payment arrangements with drug manufacturers for certain high-cost drugs.
Potential Cost Savings	The financial impact will vary based on the number and type of arrangements that the DHS may negotiate with pharmaceutical manufacturers. However, value-based payment arrangements can provide financial protection to DHS when considering whether to place high-cost gene therapies on the preferred drug list. These high-cost therapies may also provide downstream cost avoidance related to future medical expenses for beneficiaries prescribed these drugs. CMS projects that value-based payment approaches could save up to $225 million in State and federal dollars through 2025 nationwide.[81]
Implementation Steps	Arkansas already has CMS approval to enter value-based payment arrangements. To move forward, DHS would need to work to identify and then negotiate the terms of these arrangements with manufacturers. DHS may benefit from engaging a pharmacoeconomic specialist (see Option 7.4) to support this process.
Timeline	Planning work could begin immediately. The total time to identify and successfully negotiate value-based payment arrangements would be approximately 1-2 years.
Leading Practices	To date, state adoption of value-based payment arrangements has been limited. However, that is anticipated to change with modifications CMS finalized to the Medicaid Drug Rebate Program in a final rule published December 21, 2020. The new rule, Establishing Minimum Standards in Medicaid State Drug Utilization Review and Supporting Value-Based Purchasing for Drugs Covered in Medicaid, Revising Medicaid Drug Rebate and Third-Party Liability Requirements, removes regulatory barriers that had historically discouraged adoption of value-based payment arrangements and established the following definition for value-based payment:[82] Value-based payment arrangement means an arrangement or agreement intended to align pricing and/or payments to an observed or expected therapeutic or clinical value in a select population and includes, but is not limited to:

[81] Press Release. "CMS Issues Final Rule to Empower States, Manufacturers, and Private Payers to Create New Payment Methods for Innovative New Therapies Based on Patient Outcome." Centers for Medicare & Medicaid Services, 21 Dec. 2020. Retrieved from: https://www.cms.gov/newsroom/press-releases/cms-issues-final-rule-empower-states-manufacturers-and-private-payers-create-new-payment-methods.

[82] 42 CFR § 447.502

	Option 7.2: Pursue value-based payment arrangements with drug manufacturers for certain high-cost drugs.
	• Evidence-based measures, which substantially link the cost of a covered outpatient drug to existing evidence of effectiveness and potential value for specific uses of that product, and/or • Outcomes-based measures substantially link payment for the covered outpatient drug to the drug's actual performance in patients or a population or a reduction in other medical expenses. Following the final rule, CMS issued technical guidance in 2022 for states adopting value-based drug payment arrangements. **Figure 22** below provides examples of such arrangements implemented by Massachusetts, Oklahoma, and Washington.

Figure 22. Examples of State Pharmacy Value-Based Payment Arrangements

State	Description
Massachusetts	Massachusetts has a value-based payment arrangement for Zolgensma, a new gene therapy for treating spinal muscular atrophy in infants. The agreement includes an upfront discount off the $2.1 million per patient price and the manufacturer's commitment to provide rebates to the State if the drug does not perform against agreed-upon outcome measures.[83]
Oklahoma	Oklahoma has value-based arrangements using supplemental rebate agreements for products that manufacturers agree upon with the State. Oklahoma currently has agreements on long-acting injectable antipsychotics, an epilepsy drug, and an antibiotic used mainly in the emergency room. The State's value-based arrangements relate to financial outcomes, including adherence, costs, and hospitalizations. If the drug fails to meet specific benchmarks, the manufacturer will make additional payments to the State through a supplemental rebate.[84]
Washington	Washington negotiated a guaranteed net unit price for a hepatitis C antiviral drug up to a certain threshold, after which the cost to the State is nominal.[85]

[83] National Academy for State Health Policy. (2020). *CMS Proposes Rule to Support Value-Based Purchasing for Drugs* [Webpage]. Retrieved from: https://nashp.org/cms-proposes-rule-to-support-value-based-purchasing-for-drugs/.

[84] Gifford, Kathleen, et al. "How State Medicaid Programs are Managing Prescription Drug Costs: Results from a State Medicaid Pharmacy Survey for State Fiscal Years 2019 and 2020." Kaiser Family Foundation, 29 Apr 2020. Retrieved: https://www.kff.org/medicaid/report/how-state-medicaid-programs-are-managing-prescription-drug-costs-results-from-a-state-medicaid-pharmacy-survey-for-state-fiscal-years-2019-and-2020/.

[85] Gifford, Kathleen, et al. (2020) How State Medicaid Programs are Managing Prescription Drug Costs: Results from a State Medicaid Pharmacy Survey for State Fiscal Years 2019 and 2020." Kaiser Family Foundation. [Webpage]. Retrieved from: https://www.kff.org/medicaid/report/how-state-medicaid-programs-are-managing-prescription-drug-costs-results-from-a-state-medicaid-pharmacy-survey-for-state-fiscal-years-2019-and-2020/.

Option 7.3: Standardize pricing, rebates, and policies for certain drugs that can either be self-administered or administered in an outpatient clinic.

Some types of drugs can be administered by the patient (i.e., "self-administered") or by a physician in a hospital setting. Transactions for self-administered drugs occur through the pharmacy benefit administrator, while transactions for drugs administered in a hospital setting occur through the medical plan. There is an opportunity to align and standardize pricing, rebates, and prior authorization policies for drugs like Neupogen, Neulasta, Procrit, Epogen, and their biosimilar equivalents that can be self-administered or administered in a clinic.[86] DHS staff noted cases where Arkansas may be paying more for the same drug provided through the medical plan than the pharmacy benefit plan and vice versa. Standardized pricing offers an opportunity for cost savings.

	Option 7.3: Standardize pricing, rebates, and policies for certain drugs that can either be self-administered or administered in an outpatient clinic.
Potential Cost Savings	Cost savings will depend on the number and types of drugs DHS targets for alignment and the current pricing differentials for those drugs, but they could exceed $1 million annually in State savings. Additional programmatic decisions and analysis are required for a precise cost savings estimate.
Implementation Steps	Implementation of this option would require strong communication and policy standardization between the pharmacy and medical benefit programs. Since the Arkansas Division of Medical Services oversees the pharmacy and medical benefit programs, the necessary structure for communication and coordination is in place.
Timeline	Work could start immediately and take 1-2 years to fully implement, depending on the number of drugs targeted for standardization.
Leading Practices	Studies have shown high-cost variability between specialty drugs administered through the pharmacy benefit versus the medical benefit **and** differences in utilization management and prior authorization requirements. Additionally, medications managed under the pharmacy benefit have less cost variability due to National Drug Codes, which are more precise than the J codes used for billing

[86] Neupogen and Neulasta are white blood cell stimulating growth factors prescribed to patients receiving chemotherapy to reduce the potential for infections. Procrit and Epogen used to treat anemia.

	Option 7.3: Standardize pricing, rebates, and policies for certain drugs that can either be self-administered or administered in an outpatient clinic.
	the medical benefit. These differences can lead to **misaligning** financial and utilization incentives for beneficiaries and physicians. The goal should be to have the same price paid for a drug regardless of where that drug is dispensed or administered.[87]

Option 7.4: Engage pharmacoeconomic specialist to comprehensively review drug costs and inform drug coverage decisions.

DHS staff noted the need to engage a pharmacoeconomics specialist to comprehensively review drug cost categories across pharmacy and medical benefit plans to inform and update preferred drug list policies and practices that yield optimal results. Common areas of focus for a pharmacoeconomic specialist include high-cost specialty drugs and other therapeutic classes that are leading causes of paid claims in the Arkansas Medicaid program, such as medications that treat hemophilia. These specialists can also support the State's negotiations of value-based payment arrangements with pharmaceutical manufacturers.

	Option 7.4: Engage pharmacoeconomic specialist to comprehensively review drug costs and inform drug coverage decisions.
Potential Cost Savings	Specific cost savings estimates are difficult to quantify; however, engaging a pharmacoeconomic specialist may improve the State's ability to bend the curve on rapidly increasing drug expense through evidence-based guidelines, utilization review, and negotiating value-based payments. It is estimated that hiring or contracting for a pharmacoeconomic specialist would cost approximately $250,000 per year (including benefits if hiring the specialist).
Implementation Steps	DHS would need to identify and either hire or contract a pharmacoeconomic specialist. DHS' contract with the pharmacy benefit administrator allows for this option.

[87] Pharmaceutical Strategies Group, "Understanding Specialty Pharmacy Management and Cost Control," p. 7 (June 2010). Retrieved from: https://www.shrm.org/resourcesandtools/hr-topics/benefits/documents/understanding_specialty_pharmacy_management_and_cost_control_final.pdf.

	Option 7.4: Engage pharmacoeconomic specialist to comprehensively review drug costs and inform drug coverage decisions.
Timeline	DHS could immediately start identifying and hiring/contracting for a pharmacoeconomic specialist. Review times depend on several factors, but in general, DHS could expect reviewing a single drug to take approximately three months, including time for the initial review, internal approval of proposed changes, and subsequent implementation of those changes. With the appropriate resources, DHS could expect to review between four and six strategic drugs annually.
Leading Practices	Many new high-cost specialty drugs brought to market may cost hundreds of thousands, if not millions of dollars, for treatment. Still, they may be curative, thus avoiding future medical costs. States increasingly need to conduct sophisticated cost-benefit analyses to support decisions on how to cover these drugs, which require the expertise of a pharmacoeconomic specialist. For example, the Oklahoma Healthcare Authority contracts with the Oklahoma College of Pharmacy for operational, consulting, and educational services to support administering pharmacy benefits to Oklahoma SoonerCare members. These services include data analysis, reporting projections, and trends in pharmaceutical utilization and economic outcomes.[88]

Option 7.5: Adopt and promote biosimilars into preferred drugs list for brand name equivalents to reduce paid claims and net costs.

A biosimilar drug has a structure that is like, but not the same as, a brand name biologic, but without any meaningful difference in efficacy.[89] Arkansas Medicaid had claims for some name-brand biologic drugs such as Humira, Lantus, Procrit, Enbrel, Epogen, Neupogen, and Neulasta, which have biosimilar equivalents. Some biosimilars are considered interchangeable by the Food and Drug Administration. The adoption of biosimilars provides Arkansas with a significant cost savings opportunity. For example, a 2017 American Journal of Managed Care study noted that biosimilars of the brand drug Neupogen could save health insurers millions of dollars each year. As of October 2020, median monthly treatment costs in the United States were $8,987 for

[88] The University of Oklahoma Health Sciences Center College of Pharmacy, "Pharmacy Management Consultants." Retrieved from: Pharmacy Management Consultants - OU College of Pharmacy (ouhsc.edu).

[89] American Cancer Society, "What Are Biosimilar Drugs?" Retrieved from: https://www.cancer.org/cancer/managing-cancer/treatment-types/biosimilar-drugs/what-are-biosimilars.html.

biosimilars and $11,503 for the reference products (i.e., associated name-brand drugs).[90] [91]

	Option 7.5: Adopt and promote biosimilars into preferred drugs list for brand name equivalents to reduce paid claims and net costs.
Potential Cost Savings	Cost savings would depend on the number of biosimilars promoted and the associated adoption rate. A more precise cost savings estimate would require programmatic decisions regarding which disease states and associated biosimilars to target, including analyses of the net cost savings opportunities, after rebates, compared to the name-brand drug.
Implementation Steps	DHS would need to work with its pharmacy benefit administrator to determine which biosimilars to adopt and then develop communication strategies to promote their adoption. That would require physician authorization for the therapeutic interchange. The Arkansas Medicaid Drug Utilization Review Board and the Arkansas Medicaid Drug Review Committee would need to be involved in the review and approval.
Timeline	Work could start immediately, but depending on the number of biosimilar drugs targeted for adoption and promotion, it would take between 1 and 2 years to fully implement and realize full savings.
Leading Practices	Commercial payer leading practices are trending toward conversion from brand name biological drugs to their biosimilar equivalents and in some situations, they are interchangeable (e.g., Lantus). For example, in 2022, MagellenRx Management noted how payers and providers are embracing biosimilars by citing several oncology biosimilars that had captured more than 80% market share compared to their referenced (i.e., brand name) products.[92]

Option 7.6: Allow pharmacy benefit administrator dispensing of certain provider-administered medications (e.g., implantable contraception).

Moving certain specialty drugs from the medical benefit plan to the pharmacy benefit plan is commonly referred to as “white bagging”. It involves the distribution of patient-specific medication, like implantable contraceptives or oncology drugs, from a specialty pharmacy to

[90] Mattina, Christina “Payer Cost Savings from Filgrastim Biosimilars Could Reach $2 Million Annually,” American Journal of Managed Care (March 23, 2017). Retrieved from: https://www.centerforbiosimilars.com/view/payer-cost-savings-from-filgrastim-biosimilars-could-reach-2-million-annually-.

[91] Gebhart, Fred “A Biosimilar Wave Looms Large over US Biologics Market,” Drug Topics Journal (April 13, 2023). Retrieved from: https://www.drugtopics.com/view/a-biosimilar-wave-looms-large-over-us-biologics-market.

[92] MagellanRx Management, “Medical Pharmacy Trend Report: 2022 Twelfth Edition,” p. 17. Retrieved from: www1.magellanrx.com/documents/2022/12/medical-pharmacy-trend-report-2022.pdf/.

the physician's office, hospital, or clinic for administration. Specialty pharmacies can typically obtain lower negotiated drug prices because of their association with large national payers with market leverage.[93] This approach can help reduce costs and improve rebate tracking. DHS may pursue this option for specialty drugs, such as implantable contraception, as this would be a relatively straightforward option to implement and one that, if successful, could serve as a springboard for pursuing other medications.

	Option 7.6: Allow pharmacy benefit administrator dispensing of certain provider-administered medications (e.g., implantable contraception).
Potential Cost Savings	Cost savings would depend on the number and type of specialty drugs moved to the pharmacy benefit, but they are likely less than $1 million annually in State savings for implantable contraceptives. Additional programmatic decisions and analysis are required for a precise cost savings estimate.
Implementation Steps	In coordination with the State's pharmacy benefit administrator, DHS would need to update pharmacy benefit policies, including prior authorization policies, and make associated changes to provider manuals. Provider manual updates would need to undergo a legislative promulgation process.
Timeline	Work could start immediately and take 1-2 years to implement fully.
Leading Practices	A 2023 white paper by the Institute for Clinical and Economic Review cited white bagging as a "common and growing practice" and that in 2022, 27% of oncology drugs administered in physician offices through commercial insurance were subject to white bagging policies. The Institute for Clinical and Economic Review paper also cites that specialty pharmacy network representatives reported an increase in dollars coming through white bagging policies in recent years.[94]

[93]Pearson, Caroline, et al, "White Bagging, Brown Bagging, and Site of Services Policies: Best Practices in Addressing Provider Markup in the Commercial Insurance Market," Institute for Clinical and Economic Review (April 19. 2023), p. 13. Retrieved from: https://icer.org/wp-content/uploads/2023/04/ICER-White-Paper-_-White-Bagging-Brown-Bagging-and-Site-of-Service-Policies.pdf.

[94] Pearson, Caroline, et al, "White Bagging, Brown Bagging, and Site of Services Policies: Best Practices in Addressing Provider Markup in the Commercial Insurance Market," Institute for Clinical and Economic Review (April 19. 2023), p. 13. Retrieved from: https://icer.org/wp-content/uploads/2023/04/ICER-White-Paper-_-White-Bagging-Brown-Bagging-and-Site-of-Service-Policies.pdf.

SECTION 8: HABILITATIVE AND REHABILITATIVE SERVICES

Arkansas Medicaid offers habilitative and rehabilitative services to eligible beneficiaries. Options related to Habilitative and Rehabilitative Services are divided into the following sections:

- **Section 8.A.** Habilitative and Rehabilitative Services: Physical Therapy, Occupational Therapy, and Speech Pathology
- **Section 8.B.** Habilitative and Rehabilitative Services: Early Intervention Day Treatment & Adult Developmental Day Treatment

A. Habilitative and Rehabilitative Services: Physical Therapy, Occupational Therapy, and Speech Pathology

Arkansas Medicaid covers physical therapy, occupational therapy, and speech-language pathology services. Physical therapy helps people improve their movement and physical function, manage pain and other chronic conditions, and recover from and prevent injury and chronic disease.[95] Occupational therapy focuses on improving one's ability to perform and participate in daily activities.[96] Speech-language pathology services identify, assess, and treat speech, language, and swallowing disorders.[97]

Therapies can be either habilitative or rehabilitative. Habilitative services help a person keep, learn, or improve skills or functioning for daily living. Rehabilitative services help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because of being sick, hurt, or disabled.[98]

Physical therapy, occupational therapy, and speech-language pathology can be accessed through several Arkansas Medicaid programs:

[95] American Physical Therapy Association. *The Physical Therapy Profession:* Retrieved from: https://www.apta.org/contentassets/5a330c03bbe24a999608030270ced59c/physical-therapy-overview-high-early-college.pdf.
[96] American Occupational Therapy Association. *What is occupational therapy?* Retrieved from: https://www.aota.org/about/what-is-ot.
[97] American Speech-Language-Hearing Association (ASHA). *About ASHA*. Retrieved from: https://www.asha.org/about/.
[98] American Occupational Therapy Association. *How to Define Habilitation and Rehabilitation.* Retrieved from: https://www.aota.org/advocacy/issues/health-care-reform/health-care-reform---eval-tool-habilitative-rehabilitative#:~:text=Habilitative%20services%20help%20a%20person,sick%2C%20hurt%2C%20or%20disabled.

- Individuals under 21 years old access therapies through the Early and Periodic Screening, Diagnostic, and Treatment program

- Individuals 21 years and older access therapies through one of the following:
  - Hospital/Critical Access Hospital /End-Stage Renal Disease (rehabilitative)
  - Home Health (rehabilitative)
  - Hospice (rehabilitative)
  - Physician / Independent Lab / Certified Registered Nurse Anesthetist / Radiation Therapy Center (rehabilitative)
  - Adult Developmental Day Treatment (habilitative)

For beneficiaries under 21 years of age participating in Early and Periodic Screening, Diagnostic, and Treatment program, therapy services must be medically necessary as demonstrated by a comprehensive assessment in the area of deficit. Reimbursement is based on a fee schedule. Beneficiaries can receive up to six units (90 minutes) of therapy per week without prior authorization; requests for more than 90 minutes weekly require prior authorization and continue to require medical necessity.

Strategic Options

The options below could be implemented concurrently.

Option 8.A.1: Enhance utilization management processes by requiring all physical therapy, occupational therapy, and speech language pathology to be submitted for prior authorization on the front-end and strengthening vendor oversight processes.

Expenditure data shows that FFS therapy expenses increased 59% from SFY 2017 to SFY 2023 to approximately $152 million.[99] DHS staff report that reimbursement rates and authorized units increased during this period, contributing to the growth in expenses.

According to the Arkansas Medicaid Provider Manual, prior authorization is required if habilitative therapy beneficiaries need more than 90 minutes (6 units) for each therapy type per week. DHS indicated that the prior authorization vendor has been approving 99% of prior

[99] FFS data from Optum based on date of payment.

authorizations (for habilitative therapies), which may suggest the need to review the criteria used for prior authorization decisions.

DHS can enhance utilization management by:

- Ensuring medical necessity for services by requiring physical therapy, occupational therapy, and speech language pathology services to be submitted for prior authorization on the front-end rather than waiting for a threshold to be met. This includes requiring medical necessity documentation before the start of services. Revising the prior authorization process also enhances program oversight and lessens the potential for beneficiaries to receive duplicative services across programs.
- Working with contracted prior authorization vendors to understand their existing processes and confirm that their processes and documentation align with DHS standards.

	Option 8.A.1: Enhance utilization management processes by requiring all physical therapy, occupational therapy, and speech language pathology to be submitted for prior authorization on the front-end and strengthening vendor oversight processes.
Potential Cost Savings	Less than $500,000 in State savings annually are estimated, assuming 1% cost savings on SFY 2023 FFS therapy expenditures due to reduced utilization of services that are not medically necessary. Cost savings would be lower if the existing high prior authorization approval rate remained the same.
Implementation Steps	DHS would have to update its internal DHS policy, provider manual, DHS and vendor prior authorization process, and vendor contract and conduct stakeholder education efforts regarding the change. Provider manual updates would need to go through the legislative promulgation process.
Timeline	Process and internal policy updates could begin immediately, but the impact will take 1-2 years to realize.
Leading Practices	Therapies and related services typically require front-end prior authorization to promote safe, timely, evidence-based, and efficient care. Arkansas Medicaid does not require front-end prior authorizations for all therapies. Reviewed states that require initial prior authorizations for therapies include Florida, Georgia, Mississippi, Missouri, and Oklahoma.

Option 8.A.2: Allow eligible beneficiaries to access rehabilitative physical and occupational therapy in outpatient clinic settings.

As described above, rehabilitative therapies help individuals work to restore functions and abilities that may have been impaired because of illness or injury. Arkansas Medicaid currently allows adults to receive rehabilitative therapies in hospital-based settings only.

DHS can consider extending coverage for these rehabilitative therapies to outpatient, clinic-based providers to enhance timely access to care.

	Option 8.A.2: Allow eligible beneficiaries to access rehabilitative physical and occupational therapy in outpatient clinic settings.
Potential Cost Savings	Cost savings are unclear at this time. However, by enhancing access to therapies and allowing beneficiaries to receive care earlier, research suggests that timely and adequate therapy can lead to fewer interventions (e.g., imaging, injections) and lower care costs.
Implementation Steps	DHS will need to update policies and manuals, work with clinic-based providers to establish Medicaid enrollment if needed, and update systems to allow therapies to be billed in clinic-based settings.
Timeline	Updates to process and internal policy could begin immediately.
Leading Practices	Research shows that enhanced access to rehabilitative physical therapy can lead to lower total costs of care over time, decrease the need for surgical interventions, and reduce the need for long-term use of opioids and pain medications.[100,101,102,103]

[100] Rhon DI, Snodgrass SJ, Cleland JA, et al. Comparison of downstream health care utilization, costs, and long-term opioid use for physical therapist management versus opioid therapy management after arthroscopic hip surgery. Phys Ther. 2018;98:348–356.
[101] Horn M and Fritz J. 2018. Timing of physical therapy consultation on 1-year healthcare utilization and costs in patients seeking care for neck pain: a retrospective cohort. BMC Health Services Research.
[102] Sun E, Moshfegh J, Rishel C, Cook C, Goode A, George S. 2018. Association of Early Physical Therapy With Long-term Opioid Use Among Opioid-Naive Patients With Musculoskeletal Pain. JAMA Network Open.
[103] Liu X, Hanney WJ, Masaracchio M, et al. Immediate physical therapy initiation in patients with acute low back pain is associated with a reduction in downstream health care utilization and costs. Phys Ther. 2018;98:336–347.

B. Habilitative and Rehabilitative Services: Early Intervention Day Treatment & Adult Developmental Day Treatment

Arkansas Medicaid offers day treatment services for adults and children with developmental delays or disabilities.

The Early Intervention Day Treatment benefit in Arkansas is a clinic-based day treatment center where children with developmental delays or disabilities receive developmental evaluations and habilitative, therapeutic, and nursing services. Early Intervention Day Treatment providers are licensed pediatric day treatment clinics that are run by early childhood specialists. Early Intervention Day Treatment is a traditional FFS Medicaid State Plan service.

Early Intervention Day Treatment serves approximately 25,000 children from birth to six years old during the school year and children up to age 21 with an intellectual disability diagnosis in the summer. Based on SFY 2023 data, 93% of Early Intervention Day Treatment expenditures are paid through FFS, and the remaining 7% are covered through the PASSE managed care program. Early Intervention Day Treatment FFS expenditures reached approximately $237 million in SFY 2023, an increase of about 22% since SFY 2019.[104]

Similarly, the Adult Developmental Day Treatment benefit in Arkansas is a clinic-based day treatment center where adults with intellectual or developmental disabilities receive habilitative, prevocational, therapeutic, vocational, and nursing services. Adult Developmental Day Treatment is a traditional Medicaid State Plan service.

Based on claims and encounters, about 4,700 beneficiaries receive Adult Developmental Day Treatment services annually. Based on SFY 2023 data, 67% of Adult Developmental Day Treatment expenditures are paid through FFS, and the PASSE managed care program covers the remaining 33%. Adult Developmental Day Treatment FFS expenditures reached approximately $71 million in SFY 2023, an increase of about 14% since SFY 2019.[105]

[104] FFS data from Optum based on date of payment.

[105] FFS data from Optum based on date of payment.

Option 8.B.1: Review and revise eligibility and service authorization processes to enhance program oversight and ensure services go to individuals with the highest needs.

There are opportunities to tighten prior authorization requirements, initial service eligibility processes, and other program elements to support enhanced program oversight and cost containment.

Initial Eligibility – Developmental Screens

Currently, as part of the initial eligibility process for Early Intervention Day Treatment, a beneficiary who has yet to reach school age must receive a developmental screen administered by DHS' contracted vendor, the results of which may indicate the child should be referred for further evaluation to determine eligibility for Early Intervention Day Treatment services.

Starting April 1, 2024, the responsibility for conducting the age-appropriate developmental screen will shift from the contracted vendor to the beneficiary's primary care provider as part of the Early and Periodic Screening, Diagnostic, and Treatment program. Based on the results of the developmental screen, the primary care provider may refer beneficiaries for further evaluation for Early Intervention Day Treatment services. Primary care provider prescriptions for all services must be written on an annual basis.

Initial Eligibility – Medically Necessary Speech-Language Pathology, Occupational Therapy, Physical Therapy, or Nursing Services

In addition to meeting the developmental evaluation scoring thresholds, beneficiaries must have a medical necessity for one of the following services: physical therapy, occupational therapy, speech therapy, or nursing services, and functional deficits identified on a full developmental evaluation. Depending on the effect of other programmatic changes to Early Intervention Day Treatment, DHS may consider strengthening this Early Intervention Day Treatment eligibility component to require beneficiaries to have medical necessity for two of these services in the future.

Prior Authorization

According to the Arkansas Early Intervention Day Treatment Medicaid Provider Manual, prior authorization is required for the following:

- Over five hours of day habilitative services in a single day,
- Over 90 minutes per week of each therapy type,
- Over one hour of nursing services in a single day, and
- Over eight total combined hours of services in a single day.

Similarly, prior authorization is required for more than 90 minutes per week for each therapy type (e.g., physical therapy, speech therapy, occupational therapy). Those receiving less than 90 minutes each week receive a retrospective review. The prior authorization vendor for habilitative therapies has approved 99% of therapy prior authorization requests. The standard under Early and Periodic Screening, Diagnostic, and Treatment mandates approval of primary care provider prescriptions for services that can be rehabilitative and/or habilitative. DHS is looking to insert best practice standards for allowable habilitative services to age-appropriate children and in the correct settings.

DHS can enhance utilization management by:

- Ensuring medical necessity for services by requiring Early Intervention Day Treatment services to be submitted for prior authorization on the front end rather than waiting for a threshold to be met. This includes requiring medical necessity documentation before the start of services. Revising the prior authorization process also enhances program oversight and lessens the potential for beneficiaries to receive duplicative services across programs, and
- Working with contracted prior authorization vendors to understand their existing processes and confirm their processes and documentation align with DHS standards.

Considerations

- ✓ Potential cost savings due to strengthened utilization management and streamlined developmental screening process.
- ✓ Enhanced program oversight and vendor accountability.
- ✘ The administrative burden of State staff to implement increased prior authorization processes.
- ✘ Public perception of the program changes.

	Option 8.B.1: Review and revise eligibility and service authorization processes to enhance program oversight and ensure services are going to individuals with the highest needs.
Potential Cost Savings	Approximately $660,000 to $1.3 million in State savings annually. This estimate assumes 1-2% cost savings on SFY 2023 Early Intervention Day Treatment FFS expenditures due to enhanced program oversight and strengthened utilization management.
Implementation Steps	DHS would have to update its internal DHS policy (e.g., provider manual, DHS and vendor prior authorization process, and vendor contract) and conduct stakeholder education efforts regarding the change. Provider manual updates would need to go through a legislative promulgation process.
Timeline	Process and internal policy updates could begin immediately; however, the full impact would not be realized for about 1-2 years.
Leading Practices	Based on subject matter experience with other states, therapies, and related services typically require prior authorization on the front end to contain costs and authorize services most efficiently and effectively. Reviewed states that require prior authorizations for therapies include Florida, Georgia, Mississippi, Missouri, and Oklahoma.

SECTION 9: PSYCHIATRIC RESIDENTIAL TREATMENT CONTINUUM OF CARE FOR YOUTH (AGE 21 AND UNDER)

Arkansas has been working on building a robust psychiatric residential continuum of care for youth ages 21 and under. Many of these psychiatric residential treatment services are used by both the Division of Medical Services and the Division of Children and Family Services (DCFS) for the populations they serve, and who often "share" a population of youth. For example, most children involved in child welfare are Medicaid eligible as a result of child welfare involvement or were Medicaid beneficiaries before child welfare involvement.

The federal mandates of both the Division of Medical Services and DCFS dovetail with Medicaid's requirements under the Early and Periodic Screening, Diagnostic and Treatment program to ensure access to needed treatment services to correct or ameliorate health conditions; and child welfare's mandate to support a child's safety, permanency, and well-being, with well-being requirements including measures on mental health and access to needed services and supports. There is sometimes a lack of coordination, policy alignment, and operational clarity between Medicaid and child welfare requirements, which can lead to challenges including competing continuums of care, loss of Medicaid match when child welfare pays for Medicaid coverable services, and competition vs alignment in rate setting and provider networks.

Current psychiatric residential treatment continuum of care services for youth available in the State (though not all covered by Medicaid) include inpatient psychiatric hospitals and units, psychiatric residential treatment facilities (PRTFs), Community Reintegration Programs, Qualified Residential Treatment Programs (QRTPs), and therapeutic foster care.

- **Psychiatric hospitals and psychiatric units** (these treatment services are also sometimes referred to as "sub-acute" services). These facilities provide inpatient psychiatric residential treatment services to treat residents' psychiatric conditions on an inpatient basis. This service can only be provided to PASSE members with prior authorization based on medical necessity.
- **PRTFs** provide non-acute treatment services to treat the psychiatric condition of residents on an inpatient basis. The facilities are standalone entities that provide a range of comprehensive services to treat the psychiatric condition of residents on an inpatient basis under the direction of a physician. The purpose of comprehensive

services offered is to improve the resident's condition or prevent further regression so that the services will no longer be needed. This service can only be provided to PASSE members with prior authorization based on medical necessity.

- **Community Reintegration Programs** serve as an intermediate level of care between the discharge from inpatient psychiatric facilities to HCBS behavioral health services. The program provides twenty-four hours per day of intensive therapeutic care in a small group home setting for children and youth with emotional and/or behavioral problems that cannot be remedied by less intensive treatment. The program is intended to prevent acute or sub-acute hospitalization or incarceration of youth. Currently, Community Reintegration is a Medicaid HCBS service that is only paid for under the PASSE program. Community Support System Providers (CSSP) is a new provider type certified to provide HCBS for Medicaid beneficiaries with behavioral health and intellectual and developmental disability service needs; CSSP Enhanced level providers may offer residential Community Integration services.[106] This service can only be provided to PASSE members with prior authorization based on medical necessity.
- **Qualified Residential Treatment Programs** were developed under the federal Family First Prevention Services Act and are currently only available through DCFS (not a Medicaid-covered service). The Qualified Residential Treatment Programs are designed to serve youth with behavioral health needs requiring temporary placement outside their home.
- **Therapeutic Foster Care** is a specialized form of foster care that provides a wraparound plan for children needing more intensive case management to meet their needs. It is a family-based service delivery approach supported by licensed mental health professionals that provides individual treatment for children, youth, and their families. Therapeutic foster care is currently only available through DCFS (it is not a Medicaid-covered service).

Strategic Options

The options below could be implemented concurrently.

[106] Arkansas Department of Human Services. (May 15, 2023). Community Support System Provider Training. Retrieved from: https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fhumanservices.arkansas.gov%2Fwp-content%2Fuploads%2FCSSP-Provider-Training-Deck_FINAL.pptx&wdOrigin=BROWSELINK.

Option 9.1: Build upon residential continuum of care to include step down services from inpatient psychiatric residential treatment and consider braided funding strategies.

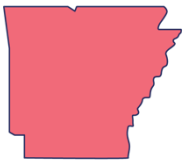
DHS should continue to build a residential continuum of care to meet the needs of youth with behavioral health needs. As discussed above, step-down options are needed for youth who no longer meet medical necessity criteria for inpatient psychiatric care. Residential step-down options from sub-acute care could include Community Reintegration Programs and Qualified Residential Treatment Programs.

DHS has been developing a Community Reintegration Program that would serve as an intermediate level of care between the discharge from inpatient psychiatric facilities to HCBS behavioral health services. The program will provide 24 hours per day of intensive therapeutic care in a small group home setting for youth with emotional and/or behavioral problems that cannot be remedied by less intensive treatment. The program is intended to prevent acute or sub-acute hospitalization or incarceration of youth. Community Reintegration is a Medicaid HCBS service paid for under the PASSE program. Currently, Community Reintegration programs have not successfully recruited providers nor distinguished the program from Qualified Residential Treatment Programs. As part of future investment, Arkansas is working to build out this program so it functions as the step down from PRTFs into a Qualified Residential Treatment Program.

Next on the residential continuum of care are Qualified Residential Treatment Programs. These treatment services were developed under the Family First Prevention Services Act and are currently only available through DCFS (not a Medicaid-covered service). Qualified Residential Treatment Programs are paid with State general revenue for children in DCFS custody. They are intended to serve youth in foster care with behavioral health needs who require temporary placement outside of their home/foster home and as a step-down from Community Reintegration.

As part of the process to transition children from sub-acute care to Community Reintegration to Qualified Residential Treatment Programs and to ensure appropriate placement of youth, DHS should engage to align the residential continuum of care criteria, including:

- Service definition (purpose of service),
- Covered population,
- Eligibility criteria (medical need),



- Allowable providers,
- Recommended rates,
- Staffing requirements, and
- Quality metrics.

As part of their alignment, DHS could consider braided funding strategies to jointly purchase services to manage treatment as a single continuum of services and maximize federal financial participation for both Medicaid and Title IV-E.

There has been much national discussion around Qualified Residential Treatment Programs and federal regulations around Institutions for Mental Disease, limiting Medicaid federal financial participation for Qualified Residential Treatment Programs if they qualify as an Institution for Mental Disease.[107] The federal government defines Institutions for Mental Disease as any facility (including a hospital or other institution) with more than 16 beds primarily engaged in providing diagnosis, treatment, or care of persons with mental disease, including medical attention, nursing care, and related services. Current Arkansas policy requires Qualified Residential Treatment Programs to have less than 16 beds, avoiding the Institutions for Mental Disease issue.

	Option 9.1: Build upon residential continuum of care to include step down services from inpatient psychiatric residential treatment and consider braided funding strategies.
Potential Cost Savings	Opportunities exist to maximize federal financial participation for Medicaid and Title IV-E. Appropriate step-down services will allow more efficient use of services and residential beds and help the State better meet youth's behavioral health needs.
Implementation Steps	DHS would need to align criteria across the residential continuum of care and develop a strategy for braiding funding. Once policies are aligned, DHS would need to make necessary policy and programmatic updates. Additionally, DHS would need to conduct stakeholder engagement and educational efforts to address the change.
Timeline	Implementation may take 1 to 2 years.

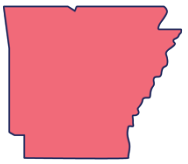
[107] Medicaid and CHIP Payment and Access Commission. (August 2021). Medicaid Coverage of Qualified Residential Treatment Programs for Children in Foster Care. Retrieved from: https://www.macpac.gov/wp-content/uploads/2021/08/Medicaid-Coverage-of-Qualified-Residential-Treatment-Programs-for-Children-in-Foster-Care.pdf.

	Option 9.1: Build upon residential continuum of care to include step down services from inpatient psychiatric residential treatment and consider braided funding strategies.
Leading Practices	Many states are creating a shared vision for a continuum of care for all residential services across payors to maximize federal funding, ensure no gaps, and avoid duplication of services. In addition to avoiding gaps in care and duplication of services, alignment reduces or eliminates disagreements across state agencies over who should pay for a service. Without alignment, states have experienced competing rate-setting processes and competition for access to a limited set of providers.

Option 9.2: Align inpatient psychiatric and PRTF utilization and funding and examine medical necessity criteria.

While inpatient psychiatric and PRTF services are Medicaid-covered services in Arkansas, DCFS also uses these providers for services. This occurs when DCFS youth are no longer found medically in need of inpatient psychiatric or PRTF treatment by PASSE organizations and when DCFS is unable to secure an immediate step-down option. However, the reimbursement rate for the PRTF beds is not the same across Medicaid and DCFS. This can lead to providers selecting clients or "cherry-picking" who they will serve, inadvertently setting up competition between State agencies for providers and could unintentionally influence medical necessity discussions. It is recommended that Medicaid and DCFS align their reimbursement rates to remove the "cherry-picking" incentive.

Challenges around medical necessity criteria appear to be contributing to this problem. Inadvertent gaps have been created between Medicaid's definition of medical necessity and the DCFS congregate placement criteria. This can lead to a loss of Medicaid federal financial participation when DCFS pays for Medicaid coverable services due to gaps between Medicaid's medical necessity definition and the DCFS congregate placement criteria. The gaps can be reduced and even eliminated when the two agencies collaborate to develop mutual criteria for the services they can purchase with their dollars. Coordinated solutions will provide greater clarity regarding when a child is no longer medically in need of a service, enhance DCFS' ability to plan for a child's step-down needs proactively, reduce challenges between sister agencies, and enhance the State's ability to understand agency costs for services to this population predictably.



To sustain long-term coordination and timely access for children, DHS could establish a single pathway for access to PRTF services that separates medical necessity determination from a provider's acceptance of a particular client, allowing for more rapid determination of medical necessity with a referral to a provider that has reported an open bed when the child fits their program's population of focus profile. This would allow providers autonomy over deciding which populations they can best serve while getting Arkansas closer to the goal of no eject/no reject of children in these processes.

The federal government strictly regulates the State's ability to access federal financial participation for inpatient psychiatric residential treatment services. Under current federal regulations, DHS can claim federal financial participation for medically necessary inpatient psychiatric services for individuals under age 21 provided in psychiatric hospitals, psychiatric units, and PRTFs as defined in 42 C.F.R. § 441. Federal regulation classifies all other settings that provide inpatient psychiatric services as Institutions for Mental Disease.

	Option 9.2: Align inpatient psychiatric and PRTF utilization and funding and examine medical necessity criteria.
Potential Cost Savings	There are opportunities to maximize federal financial participation for both Medicaid and Title IV-E, particularly when State general funds are being used for services that Medicaid could cover and receive federal financial participation.
Implementation Steps	DHS would need to maximize coordination between the Division of Medical Services and DCFS around medical necessity criteria and payment rates. Once policies are aligned, DHS would need to make necessary policy and programmatic updates. Additionally, DHS would need to conduct stakeholder engagement and educational efforts to address the change.
Timeline	1-2 years.

Option 9.3: Integrate therapeutic foster care model in the residential continuum of care and leverage Medicaid funding.

Therapeutic foster care is an out-of-home setting that offers structured therapeutic services to address the behavioral health needs of youth. This setting is more structured than a traditional foster care home but is a much less restrictive form of therapeutic care compared to an inpatient setting. Therapeutic foster care caregivers are specially trained to provide services to

youth and must complete ongoing training.

States are including the therapeutic foster care model in their psychiatric residential continuum of care as a diversion from more restrictive and costly residential settings. Therapeutic foster care can also be used to address step-down care. As youth are completing treatment in high-cost residential settings, they can transition to a therapeutic foster care setting. States are also adopting the therapeutic foster care model due to the ability to get funding from multiple streams. Medicaid can fund therapeutic foster care services determined to be medically necessary. Additionally, services can be funded through Title IV-E.

	Option 9.3: Integrate therapeutic foster care model in the continuum of care.
Potential Cost Savings	There are opportunities to maximize federal financial participation for Medicaid and Title IV-E, as both could fund therapeutic foster care. As noted above, therapeutic foster care can also serve as a diversion from the most restrictive and costly residential settings.
Implementation Steps	DHS would need to analyze how best to integrate therapeutic foster care services into the current continuum of care. It would also need to determine the need for expanding therapeutic foster care services currently available based on inclusion in Medicaid or through a braided approach with State funds and the use of existing Medicaid service codes. Once determined, DHS would need to make necessary policy and programmatic updates. Additionally, DHS would need to conduct educational efforts to address the change.
Timeline	1-2 years.
Leading Practices	To leverage Medicaid funding, State Medicaid agencies have typically identified therapeutic foster care as either a Medicaid state plan rehabilitative service ("rehab option"), targeted care management service, or waiver service. Even if therapeutic foster care is not an explicit service within a state plan, clinical, therapeutic, and supportive (e.g., care coordination, peer support, skill building, crisis response) services may still be covered as Early and Periodic Screening, Diagnostic, and Treatment program or other benefits.[108]

[108] Medicaid and CHIP Payment and Access Commission. Mandated Report on Therapeutic Foster Care. Retrieved from: https://www.macpac.gov/wp-content/uploads/2019/06/Mandated-Report-on-Therapeutic-Foster-Care.pdf.

SECTION 10: TRANSPORTATION

Arkansas Medicaid provides non-emergency transportation services through the following programs:

- **Non-emergency Transportation**, which pays the broker a per member per month capitation for all beneficiaries, regardless of whether they use the transportation services; beneficiaries may schedule reservations for rides to and from doctor's appointments, and
- **Day Treatment Transportation,** which pays the broker per ride for trips between a beneficiary's residence and day treatment facility.

Figure 23 below compares the two transportation programs.

Figure 23. Transportation Program Comparison

	Non-Emergency Transportation	Day Transportation Treatment
Benefit	Non-emergency (non-ambulance) transportation to/from doctor's appointments, pharmacy, visit to child during inpatient stay; includes Saturday rides for chemo, radiation, and dialysis; beneficiary makes 48-hour advance reservation for rides.	Rides to/from Early Intervention Day Treatment and Adult Developmental Day Treatment, collectively referred to as day treatment.
Delivery Model	Regional Broker	Regional Broker
Payment Methodology	DHS pays the broker an average of $3.57 per member per month for each eligible beneficiary. The State actuary determines the rate annually using cost report data, and it varies per region.	Day Treatment Transportation has two payment methodologies: • Provider Type 24 (Early Intervention/Adult Development) can directly bill the State by submitting claims with code A0120. Effective August 1, 2022, the Division of Developmental Disabilities Services reimburses providers on a per person, per

	Non-Emergency Transportation	Day Transportation Treatment
		mile basis at the lesser of the billed charges or the maximum Medicaid charge of $1.39 per person per mile allowed; or • Brokers send Excel-based reports containing trip count, mileage, and paid amount to the Division of Developmental Disabilities Services; following a detailed review and approval, the Division of Developmental Disabilities Services authorizes payment.
Expenditures (SFY 2023)	$42,716,786	$33,114,152
Eligible Beneficiaries	1,020,000	29,700 (25,000 children in Early Intervention Day Treatment and 4,700 adults in Adult Developmental Day Treatment, but not all will use transportation services)
Cost to Beneficiary	None	
Brokers	1. Area Agency on Aging 2. Central Arkansas Development Council 3. Verida (formerly Southeast Transportation)	

Arkansas is believed to be the only State in the nation with a Day Treatment Transportation program in which the State is responsible for providing rides between the beneficiary's residence and the prescribed day treatment facility. As described above, the regional Day Treatment Transportation brokers are the same three vendors covering Non-emergency Transportation in Arkansas. Day Treatment Transportation is currently available for Early Intervention Day Treatment and Adult Developmental Day Treatment. **Figure 24** below compares the day treatment programs.

Figure 24. Day Treatment Program Comparison

Early Intervention Day Treatment	Adult Developmental Day Treatment
• Early Intervention Day Treatment offers evaluation and therapeutic, developmental, and preventative services provided by a licensed pediatric day treatment clinic that early childhood specialists run. • Children ages 0-6 are eligible for services year-round, while children ages 6-21 may receive services only throughout the summer months.	• Adult Developmental Day Treatment offers assessments and habilitative, supervised living, prevocational, therapeutic, and educational services provided by a licensed adult day treatment clinic. • Beneficiaries must be either 21 and older or between 18 and 21 years of age with a diploma or certificate of completion, and they must have a developmental disability diagnosis that originated before the age of 22.

Day Treatment Transportation may be reimbursed when beneficiaries receive transportation services to and from an Early Intervention Day Treatment or Adult Developmental Day Treatment facility. DHS reimburses for Day Treatment Transportation if all the following are met:

1. A licensed provider provides the transportation,
2. The beneficiary transported is receiving either Early Intervention Day Treatment or Adult Developmental Day Treatment services from the facility that is providing the transportation service, and
3. Transportation is provided only to or from the provider facility.

The strategic options identified for the transportation program are due to several inefficiencies in the current transportation program. DHS feels this program has insufficient monitoring, leading to overpayment, a vehicle shortage, limiting available rides, and is failing to meet the needs of the beneficiaries.

Strategic Options

The options below could be implemented alone or concurrently.

Option 10.1: Merge Non-emergency Transportation and Day Treatment Transportation programs under one transportation contract.

Under this option, DHS would combine Non-emergency Transportation and Day Treatment Transportation into a single transportation program governed by a single contract. Merging the two programs would reduce the administrative burden associated with operating two separate transportation contracts while providing cost savings opportunities. This option should also simplify potential additions of other populations/payers into Non-emergency Transportation.

The primary goals of this option are to align transportation programs, ensure consistent service, and reduce administrative burden due to the different payment methodologies used for the Non-emergency Transportation and Day Treatment Transportation programs. Non-emergency Transportation is paid via capitation payments (per member per month) and results in encounters from the brokers, which are both processed through the Medicaid Management Information System (MMIS). Day Treatment Transportation is paid through the MMIS in one of two ways: (1) claim entry with payment through the MMIS, or (2) some ride reporting is manual with non-standard "claims" requests via email, manually reviewed in Excel by the Division of Developmental Disability Services Chief Financial Officer, then followed by off-cycle manual payments.

This option further encourages equal priority for Non-emergency Transportation and Day Treatment Transportation riders as the same vendors have both Non-emergency Transportation and Day Treatment Transportation in their region(s), and vendors would be paid using the same methodology for all riders. In addition, merging the two transportation programs under one contract may streamline transportation services for beneficiaries using Non-emergency Transportation and Day Treatment Transportation. The single payment methodology created under this option could be either a per member per month or a pick-up fee + mileage payment.

	Option 10.1: Merge Non-emergency Transportation and Day Treatment Transportation under one transportation contract.
Potential Cost Savings	Annual State savings are estimated to be less than $500,000 due to efficiencies achieved from moving to a single contract and single payment methodology. The savings estimate assumes that the single payment methodology would be a per member per month payment. The savings estimate assumes a 25% reduction in Day Treatment Transportation administrative costs when moving to a per member per month payment methodology. The level of savings would vary based on the percentage of administrative costs built into the Day Treatment Transportation rates and the extent to which Day Treatment Transportation administrative costs would actually be reduced.
Implementation Steps	DHS would need to: • Work with its actuary to determine the appropriate per member per month or [pickup fee + mileage], • Amend Non-emergency Transportation and Day Treatment Transportation contracts to create a single contract covering all requirements and responsibilities, • Amend the 1915(b) Non-emergency Transportation waiver and obtain approval from CMS, and • Ensure drivers are prepared to serve riders with a variety of abilities. For example, Adult Developmental Day Treatment riders have intellectual disabilities, and Early Intervention Day Treatment riders have developmental disabilities. Non-emergency Transportation drivers may not be trained, and vehicles may not be equipped for these riders.
Timeline	1-2 years.

Option 10.2: Retain separate Non-emergency Transportation and Day Treatment Transportation programs, but transition from a regional model to a Statewide model.

Under this option, DHS would retain separate Non-emergency Transportation and Day Treatment Transportation programs. However, DHS would allow Non-emergency Transportation and Day Treatment Transportation vendors to provide transportation services in all counties/regions throughout Arkansas rather than limiting them to their current contracted region(s). Moving from a regional model to a Statewide model has the potential to increase

access due to fewer missed rides and appointments. Allowing brokers/drivers to serve a larger area should help reduce stranded riders in busier regions of the State.

	Option 10.2: Retain separate Non-emergency Transportation and Day Treatment Transportation programs, but transition from a regional model to a Statewide model.
Potential Cost Savings	This option is estimated to be budget neutral as the number of brokers, Non-emergency Transportation-eligible beneficiaries, and Day Treatment Transportation trips would not necessarily change. However, the final impact would be based on parameters included in actuarial calculations.
Implementation Steps	DHS would need to: • Amend the Non-emergency Transportation and Day Treatment Transportation contracts, • Work with its actuary to develop Statewide rates, and • Amend the 1915(b) Non-emergency Transportation waiver and obtain approval from CMS.
Timeline	1-2 years.

Option 10.3: For beneficiaries enrolled in the PASSE program, make PASSE organizations responsible for all transportation services.

Under this option, PASSE organizations would become responsible for transportation services for PASSE beneficiaries. This means the transportation cost would shift to the PASSE capitation rate, and the PASSE organizations would assume the administration of the transportation program for their beneficiaries. The daily rate for behavioral health day rehabilitation facilities already factors in using their own transportation.

	Option 10.3: For beneficiaries enrolled in the PASSE program, make PASSE organizations responsible for all transportation services.
Potential Cost Savings	Potential cost savings depend upon 1) the difference between the current Non-emergency Transportation rates, Day Treatment Transportation rates, and the updated PASSE per member per month payment to account for coverage of all transportation services, 2) reduced DHS administrative burden due to manual tracking and payment for Day Treatment Transportation services for PASSE beneficiaries, and 3) allowing PASSE organizations to implement cost savings strategies that will not negatively impact quality of care.
Implementation Steps	DHS would need to: • Amend the PASSE statute, • Amend the Day Treatment Transportation contracts, • Amend the 1915(b) Non-emergency Transportation waiver and obtain approval from CMS, and • Communicate changes with brokers and impacted PASSE organizations and determine updates to the PASSE per member per month capitation payment to account for added transportation services.
Timeline	1-2 years.

Option 10.4: Implement recommendations from the Non-Emergency Transportation Rideshare Expansion Study Workgroup.

In early 2023, the Arkansas General Assembly passed Act 484, directing DHS to convene the Non-Emergency Transportation Rideshare Expansion Study Workgroup. The Act mandated that the workgroup focus on:

1. Need for expanded rideshare services to health care facilities for Medicaid beneficiaries
2. Benefits of using rideshare services as compared to traditional non-emergency transportation providers
3. Cost, including potential cost savings, of expanded rideshare services within the Non-emergency Transportation program

4. Use of other operational and Non-emergency Transportation program flexibilities to expand services and improve cost-effectiveness[109]

Following a four-month study involving participants from DHS, Uber, Lyft, Arkansas Foundation for Medical Care, and each of the Non-emergency Transportation brokers, the workgroup recommended to:

- Deploy transportation network companies (e.g., taxis, Uber, Lyft) in Craighead and Washington counties,
- Align requirements for use of transportation network companies within the Arkansas Medicaid Non-Emergency Transportation program to the Arkansas Transportation Network Company Services Act, A.C.A. § 23-13-701 (2020),
- Change program policy so that scheduled transportation network companies' trips do not require approval by the Division of Medical Services,
- Consider whether rural coverage by current providers could be improved by paying for deadhead mileage (miles driven without a passenger) rather than adding new providers,
- Allow brokers to deploy public transit apps that facilitate payment for passes so that beneficiaries do not have to wait for passes sent via mail,
- Consider funding wheelchair-accommodated vehicles through grants, and
- Consider ensuring that the safety requirements for transportation network companies align with those for other transportation providers participating in the program.

	Option 10.4: Implement recommendations from the Non-Emergency Transportation Rideshare Expansion Study Workgroup.
Potential Cost Savings	Studies show that the primary results of such program modifications include improvements in health outcomes and patient experience, decreases in unfulfilled trips, missed appointments, emergency department utilization, and cost savings in some cases. The report notes that cost savings can be realized when the transportation network has enough drivers and vehicles to avoid rescheduling trips.
Implementation Steps	DHS must make policy decisions and update the Non-Emergency Transportation contract to clarify any inconsistencies regarding driver qualifications (e.g., highway certification, drug testing, drug/alcohol use, convictions) and vehicle requirements (e.g., insurance, safety, and security) for transportation network companies as compared to those for Non-Emergency Transportation providers.

[109] Arkansas Department of Human Services. (Dec 31, 2023) *Final Report of the Non-Emergency Transportation Rideshare Study Workgroup.*

	Option 10.4: Implement recommendations from the Non-Emergency Transportation Rideshare Expansion Study Workgroup.
	DHS must determine if the use of transportation network companies must be approved and on what basis/frequency to ensure rides are not provided to those with expired benefits, minors or incapacitated riders without an escort, nursing home residents, or those being transported to/from Adult Developmental Day Treatment or Early Intervention Day Treatment.
Timeline	1 - 2 years.

SECTION 11: FEDERALLY QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS

Federally Qualified Health Centers (FQHCs) are community-based health care providers offering services in underserved areas. FQHCs must provide primary and preventative care services and may offer other services included in a state's Medicaid plan, such as dental, behavioral health, and vision services. Rural Health Clinics (RHCs) provide outpatient primary care in rural areas designated as a health professional shortage area or a medically underserved area. While FQHCs are like RHCs, the two types of facilities differ based on federal regulations related to location, shortage area, corporate structure, board of director requirements, and clinical staffing requirements.

FQHC FFS expenditures reached approximately $54 million in SFY 2023, an increase of about 72% since SFY 2017. RHC FFS expenditures reached approximately $27 million in SFY 2023, an increase of about 58% since SFY 2017.[110]

Regulatory Requirements

Under CMS guidelines, FQHCs and RHCs are eligible for enhanced Medicaid reimbursement. Under federal statute, they must receive cost-based reimbursement through an encounter or "all-inclusive" rate.

The Medicare, Medicaid, and State Children's Health Insurance Program Benefits Improvement and Protection Act of 2000 requires all state Medicaid agencies to establish a baseline prospective payment system rate for each FQHC and RHC. Under this Act, states can establish an alternative payment methodology if the reimbursement is equal to or greater than the prospective payment system rate and the facility consents to receive the alternative payment methodology rate. If an FQHC or RHC receives less reimbursement than they would have been eligible for under the prospective payment system rate, the facility must receive the difference as part of an additional payment. CMS requires approval of alternative payment methodologies

[110] FFS data from Optum based on date of payment.

through a State Plan Amendment.[111]

DHS reimburses FQHCs and RHCs for "core services" encounters and "other ambulatory services" encounters. Encounters are face-to-face (could include telehealth) contacts between an FQHC or RHC patient and a health care professional whose services are covered by the State Plan.[112] For "core services" encounters, FQHCs and RHCs are reimbursed at a facility-specific rate under the prospective payment system on a per-encounter basis. The prospective payment system encounter rate must be identical for each billable patient visit (e.g., the same encounter rate for a cold visit, broken arm, or annual physical). Other ambulatory services are State Plan-covered services beyond the core primary care services such as dental or optometry services. Other ambulatory services encounters are reimbursed off their respective fee schedule.

FQHCs also have the option of reimbursement using an alternative payment methodology. The FQHC alternative payment methodology provides an interim encounter rate for Medicaid-covered services with an annual cost settlement at 100% of reasonable costs. DHS cost settles with FQHCs for services that the FQHC service definition includes, and that Medicaid covers.

The current cost settlement process is administratively burdensome for DHS, expensive, difficult to budget for, and does not incentivize FQHCs to control costs. Shifting to a prospective payment system or an updated alternative payment methodology encounter rate would help FQHCs start controlling costs.

Strategic Options	Options 11.1 and 11.2 are alternate options. Option 11.3 could be implemented concurrently with either option 11.1 or option 11.2.

[111] MACPAC. *Medicaid Payment Policy for Federally Qualified Health Centers.* [Webpage]. Retrieved from: https://www.macpac.gov/wp-content/uploads/2017/12/Medicaid-Payment-Policy-for-Federally-Qualified-Health-Centers.pdf.

[112] Arkansas Department of Health Services, Federally Qualified Health Center Section II. [Webpage]. Retrieved from: https://humanservices.arkansas.gov/wp-content/uploads/FQHC_II.doc#:~:text=An%20FQHC%20encounter%20is%20a,XIX%20(Medicaid)%20State%20Plan.

Option 11.1: End the cost settlement alternative payment methodology for FQHCs and repurpose the funding into a new alternative payment methodology that encourages cost savings.

Under this option, DHS would end the cost settlement alternative payment methodology. DHS could then move all, or a portion of, the dollars used for the cost settlement alternative payment methodology into an updated alternative payment methodology that encourages cost savings. DHS could rebase FQHC encounter rates using updated fiscal years to better reflect current FQHC costs. As part of this process, DHS should review what services are included in the encounter rate and which services are appropriate to continue to carve out and reimburse separately. This review may also encompass allowable places of services and provider types for services.

	Option 11.1: End the cost settlement alternative payment methodology for FQHCs and repurpose the funding into a new alternative payment methodology that encourages cost savings.
Potential Cost Savings	Limited upfront cost savings are estimated, but eliminating cost settlement and moving to an alternative payment methodology has the potential for future cost savings, as FQHC reimbursement would be limited to the new alternative payment methodology encounter rate. An updated alternative payment methodology would also decrease DHS' administrative burden and allow DHS to better estimate annual FQHC expenditures.
Implementation Steps	DHS would need to conduct discussions with the FQHCs, identify alternative payment methodologies, and update the State Plan around FQHC payment rates. The State Plan Amendment would require CMS approval. DHS would also need to update the provider manual. The State Plan Amendment and the provider manual updates would need to undergo a legislative promulgation process.
Timeline	State Plan Amendments are effective on the first day of the fiscal quarter in which they are submitted to CMS. DHS could submit the State Plan Amendment to CMS during quarter 1 of SFY 2025 (July 1, 2024 – September 30, 2024).

	Option 11.1: End the cost settlement alternative payment methodology for FQHCs and repurpose the funding into a new alternative payment methodology that encourages cost savings.
Leading Practices	More than 20 states use an alternative payment methodology for Medicaid FQHC reimbursement. Over the past ten years, several states have received CMS approval for an alternative payment methodology that uses updated fiscal year cost reports for rebasing purposes. This ensures that FQHC rates accurately reflect the cost of providing services. For example, over the past five years, CMS has approved alternative payment methodologies in Minnesota, Montana, and New Hampshire to rebase encounter rates using updated fiscal years.[113] [114] [115] Using an updated alternative payment methodology for Medicaid FQHC reimbursement allows states to update FQHC rates while eliminating the need for a cost settlement process. Using a cost settlement process with FQHCs is rare. Of the states that use an alternative payment methodology for reimbursement, North Carolina is the only state other than Arkansas that offers cost settlement supplemental payments to FQHCs.

Option 11.2: End the cost settlement alternative payment methodology for FQHCs and repurpose the funding into a new value-based payment alternative payment methodology to drive quality improvements.

The current cost settlement process is time-consuming and expensive and does not incentivize FQHCs to control costs. A value-based payment alternative payment methodology could help control costs and encourage FQHCs to focus on quality initiatives. DHS could use the prospective payment system as a base rate and then add a quality payment for meeting quality metrics. If a prospective payment system is used as the base rate, it would eliminate the need

[113] Minnesota Department of Human Services. (2022). Federally Qualified Health Center and Rural Health Clinics [Webpage]. https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=DHS16_155131.

[114] Medicaid State Plan Amendments. (2019). State Plan Amendment (SPA) #: 20-0018 [Webpage]. Retrieved from: https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/NH/NH-20-0018_1.pdf.

[115] Medicaid State Plan Amendments. (2019). State Plan Amendment (SPA) #: 19- 0007 [Webpage]. Retrieved from: https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/MT/MT-19-0007.pdf.

for an annual reconciliation process. Under federal statute, FQHCs must receive at least the prospective payment system rate.

	Option 11.2: End the cost settlement alternative payment methodology for FQHCs and repurpose the funding into a new value-based payment alternative payment methodology to drive quality improvements.
Potential Cost Savings	Limited upfront cost savings are estimated, but eliminating cost settlement and moving to an alternative payment methodology with quality incentives has the potential for future cost savings as FQHC reimbursement would be limited to the new alternative payment methodology encounter rate and associated quality payments. An updated alternative payment methodology would also decrease DHS' administrative burden and allow DHS to estimate annual FQHC expenditures better.
Implementation Steps	DHS would need to discuss alternative payment methodologies with the FQHCs and update the State Plan regarding FQHC rates. The State Plan Amendment would require CMS approval, and DHS would need to update the provider manual. The State Plan Amendment and the provider manual updates would need to go through a legislative promulgation process.
Timeline	State Plan Amendments are effective on the first day of the fiscal quarter in which they are submitted to CMS. DHS could submit the State Plan Amendment to CMS during quarter 1 of SFY 2025 (July 1, 2024 – September 30, 2024).
Leading Practices	Several states have implemented FQHC Medicaid value-based payment alternative payment methodologies that tie reimbursement to quality incentives to encourage best clinical practices and promote better patient health outcomes. For example: • Idaho Medicaid integrated FQHCs into the State's Health Connections Value Care program, where primary care providers receive FFS reimbursement plus a per member per month care management fee. FQHCs participate as an accountable primary care organization and are required to contain Medicaid costs and improve quality.[116] • Oregon Medicaid implemented a value-based payment alternative payment methodology in which FQHCs receive a per member per month payment for all members attributed to the FQHC. Quality measures such as colorectal cancer screening, depression screening,

[116] NASHP. (2019). Idaho Develops a Medicaid Value-Based Payment Model for its FQHCs, Based on Cost and Quality [Webpage]. Retrieved from: https://nashp.org/idaho-develops-a-medicaid-value-based-payment-model-for-its-fqhcs-based-on-cost-and-quality/.

	Option 11.2: End the cost settlement alternative payment methodology for FQHCs and repurpose the funding into a new value-based payment alternative payment methodology to drive quality improvements.
	diabetes poor control, and hypertension are tracked quarterly.[117] [118] Washington Medicaid has implemented several value-based payment alternative payment methodologies, including allowing FQHCs to act as Patient Centered Medical Homes with the opportunity for FQHCs to rebase their encounter rate using an updated cost report. Washington Medicaid monitored the quality of care using performance measures, including comprehensive diabetes care, childhood immunization status, well-child visits, and medication management for children with asthma.[119]

Option 11.3: Apply updated FQHC alternative payment methodology to RHCs.

DHS is interested in driving reimbursement parity between FQHCs and RHCs. RHCs currently receive reimbursement via a prospective payment system rate. If a new alternative payment methodology is implemented for FQHCs, the alternative payment methodology reimbursement rate option could be extended to include RHCs to help achieve reimbursement parity between them.

	Option 11.3: Apply updated FQHC alternative payment methodology to RHCs.
Potential Cost Savings	If the alternative payment methodology is extended to RHCs, expenditures may increase as the alternative payment methodology must be higher than the prospective payment system rate.
	DHS would need to discuss alternative payment methodologies with the RHCs and update the State Plan regarding RHC payment rates. The State Plan Amendment would require CMS approval. DHS would also need to update the

[117] MACPAC. (2017). *Medicaid Payment Policy for Federally Qualified Health Centers.* [Webpage]. Retrieved from: https://www.macpac.gov/wp-content/uploads/2017/12/Medicaid-Payment-Policy-for-Federally-Qualified-Health-Centers.pdf.

[118] Oregon.Gov. (2020). *Oregon APM Program FAQ* [Webpage]. Retrieved from: https://www.oregon.gov/oha/HSD/OHP/Tools/APM%20FAQs.pdf.

[119] NACHC (2018) *Spotlight on Health Center Payment Reform: Washington State's FQHC Alternative Payment Methodology* [Webpage]. Retrieved from: https://www.nachc.org/wp-content/uploads/2018/05/NACHC-WA-APM-Case-Study-2018.pdf.

	Option 11.3: Apply updated FQHC alternative payment methodology to RHCs.
Implementation Steps	provider manual. The State Plan Amendment and the provider manual updates would need to go through a legislative promulgation process.
Timeline	State Plan Amendments are effective on the first day of the fiscal quarter in which they are submitted to CMS. DHS could submit the State Plan Amendment to CMS during quarter 1 of SFY 2025 (July 1, 2024 – September 30, 2024).
Leading Practices	FQHCs and RHCs are clinic-based primary health care providers in medically underserved areas eligible for an enhanced Medicaid encounter rate under guidelines established by CMS. The Medicare, Medicaid, and State Children's Health Insurance Program Benefits Improvement and Protection Act of 2000 mandated a prospective payment system encounter rate for all FQHCs and RHCs and provided the option for an alternative payment methodology encounter rate. As the federal reimbursement requirements for the prospective payment system apply to both FQHCs and RHCs, some state Medicaid agencies that provide an option for an alternative payment methodology encounter rate option extend the alternative payment methodology to both FQHCs and RHCs to drive reimbursement parity between the facilities. For example, Minnesota, Montana, and New Hampshire all extended their alternative payment methodology encounter rate option to both FQHCs and RHCs.[120,121,122]

[120] Minnesota Department of Human Services. (2022). Federally Qualified Health Center and Rural Health Clinics [Webpage]. Retrieved from: https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=DHS16_155131.

[121] Medicaid State Plan Amendments. (2019). State Plan Amendment (SPA) #: 20-0018 [Webpage]. Retrieved from: https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/NH/NH-20-0018_1.pdf.

[122] Medicaid State Plan Amendments. (2019). State Plan Amendment (SPA) #: 19- 0007 [Webpage]. Retrieved from: https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/MT/MT-19-0007.pdf.

SECTION 12: PRIMARY CARE CASE MANAGEMENT, PATIENT CENTERED MEDICAL HOMES, AND EVIDENCE-BASED MATERNAL HEALTH MODELS

Arkansas Medicaid offers two capitated programs for primary care providers: the mandatory Primary Care Case Management program and the voluntary Patient Centered Medical Home program.

Arkansas is also engaging in evidence-based practices to improve maternal health outcomes across the State, including for the Medicaid population.

This section includes options related to the Primary Care Case Management and Patient Centered Medical Home programs and options for expanding upon evidence-based maternal health programs.

A. Primary Care Case Management and Patient Centered Medical Home Programs

Figure 25 below provides an overview of Primary Care Case Management and Patient Centered Medical Home programs. In SFY 2023, DHS paid $37.7 million in capitated payments for the Primary Care Case Management and Patient Centered Medical Home programs.[123]

Figure 25. Overview of Primary Care Case Management / Patient Centered Medical Home

	Primary Care Case Management	Patient Centered Medical Home
Overview	Program for beneficiaries with a primary care provider who is paid to provide case management services. Services include but are not limited to health education and initiating referrals to specialty physicians, hospital care, and other medically necessary services. Primary care providers are required to participate in the Primary Care Case Management Program unless they qualify for a limited set of exceptions.	Program to control the cost of care, enhance the patient's care experience, and improve the population's health. Patient Centered Medical Homes are responsible for increasing access to services, coordinating care with other providers, and are accountable for care outcomes. Primary care providers may participate in the Patient Centered Medical Home program voluntarily.

[123] Capitation data from Optum based on date of capitation month.

	Primary Care Case Management	Patient Centered Medical Home
Payment	$3.00 per member per month.	A monthly coordination payment (from $1 to $35, depending on the beneficiary's risk score) for each beneficiary in the Patient Centered Medical Home's panel. To be eligible for the monthly coordination fee, Patient Centered Medical Homes must document that they perform certain activities, such as identifying the top 10% of high-priority patients, creating care plans for their high-priority patients, providing beneficiaries access to care 24/7, and indicating if they have an established process for patient and family engagement. They also must meet targets for specified core metrics. Patient Centered Medical Homes can also earn performance-based incentive payments if they meet specific performance criteria related to emergency department rates, inpatient rates, and a focus measure.
Provider Types	Any primary care provider	Primary care providers committed to a team-based approach for their panel of patients. Patient Centered Medical Home providers must be enrolled in the Primary Care Case Management program.
SFY 2023 Number of Providers	Approximately 1,560	Approximately 1,000

Strategic Options	Options 12.A.1, 12.A.2, and 12.A.3 are alternate options and would not be implemented concurrently.

Option 12.A.1: Retain both the Primary Care Case Management and Patient Centered Medical Home programs and strengthen the incentives for Patient Centered Medical Homes.

Patient Centered Medical Home providers currently receive per member per month payments regardless of beneficiary engagement with the provider. DHS also awards bonuses to Patient Centered Medical Homes meeting core metrics and in the top tier of outcomes for annually defined measurements. DHS may further enhance the existing incentives and quality metrics to strengthen integrated care delivery in the primary care setting.

For example, DHS may consider incentives for Patient Centered Medical Home providers to implement models such as:

- HealthySteps, a pediatric primary care program that supports parents, babies, and toddlers so they are prepared across developmental, mental, physical, and social needs. DHS has identified HealthySteps as an evidence-based pediatric practice transformation program that Patient Centered Medical Home providers may implement to receive an enhanced monthly coordination payment.
- The Collaborative Care Model, which provides team treatment for individuals with mental health needs with goals of increasing access to mental health care, reducing costs, and improving outcomes.[124] The Arkansas Division of Aging, Adult, and Behavioral Health Services received a grant from the Substance Abuse and Mental Health Services Administration to implement the behavioral health collaborative care model among rural residents with chronic medical and co-occurring behavioral health conditions. The grant's project period runs from September 2023 through September 2028.

This standalone option would not be combined with options 12.A.2 or 12.A.3.

[124] Agency for Healthcare Research and Quality. (N.D.). The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes [webpage]. Retrieved from: Collaborative Care Model Medicaid Health Homes | The Academy (ahrq.gov).

	Option 12.A.1: Retain both the Primary Care Case Management and Patient Centered Medical Home programs and strengthen the incentives for Patient Centered Medical Homes.
Potential Cost Savings	This option can potentially create additional program costs in the short term if additional funding is included in the Patient Centered Medical Home incentive pool. It would take time for the new incentives and transformation models to impact access and other outcome measures, particularly if providers are required to develop new capabilities. However, there is the potential to generate savings over the long term.
Implementation Steps	DHS would need to determine appropriate modifications to Patient Centered Medical Home incentives and consider updates to the rate structure. If quality measures are enhanced, DHS would need to develop measures and update reporting for the Patient Centered Medical Home providers. Enhanced metrics would need to be developed with projected cost savings to ensure a return on investment. Any changes to required documentation would need to be coordinated with the Quality Care Insight Provider Portal. DHS would need to update the provider manual and issue an updated Patient Centered Medical Home program policy addendum. Provider manual updates would need to go through a legislative promulgation process.
Timeline	2+ years.
Leading Practices	As mentioned above, two potential primary care models that DHS could consider incentivizing Patient Centered Medical Homes to implement within their primary care practice are the Collaborative Care Model and the HealthySteps program. According to a brief developed for CMS, more than 70 randomized controlled trials have shown Collaborative Care Models to be more effective and cost-effective than usual care for common mental disorders such as depression.[125] In addition, HealthySteps reports that it has conducted multiple return-on-investment analyses at the state, health system, and site levels and has determined the average annual Medicaid return on investment to be 163% across these analyses.[126]

[125] Centers for Medicare and Medicaid Services. (May 2013). The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes. Retrieved from: HH_IRC_Collaborative_Care_Model__052113_2.pdf (chcs.org).
[126] HealthySteps. (September 8, 2021). HealthySteps Return on Investment [webpage]. Retrieved from: HealthySteps Return on Investment - HealthySteps.

Option 12.A.2: Retain both the Primary Care Case Management and Patient Centered Medical Home programs and add incentives for Primary Care Case Management providers.

Primary Care Case Management providers currently receive per member per month payments regardless of beneficiary engagement with the provider and do not currently receive any incentives. Under this option, DHS may add incentives and quality metrics to the Primary Care Case Management program.

For example, DHS may consider incentives for Primary Care Case Management providers to implement models such as:

- HealthySteps is a pediatric primary care program that supports parents, babies, and toddlers to prepare them for developmental, mental, physical, and social needs. As noted in option 12.A.1 above, DHS has identified HealthySteps as an evidence-based pediatric practice transformation program that Patient Centered Medical Home providers may implement to receive an enhanced monthly coordination payment.
- The Collaborative Care Model, which provides treatment for individuals with mental health needs delivered by a team that includes a primary care provider, case management staff, and a psychiatric consultant, with goals of increasing access to mental health care, reducing costs, and improving outcomes.[127] As noted in option 12.A.1 above, the Arkansas Division of Aging, Adult, and Behavioral Health Services received a Substance Abuse and Mental Health Administration grant to implement the behavioral health collaborative care model.

However, because the Patient Centered Medical Home program is currently the more advanced primary care provider program in Arkansas, adding incentives may be preferable (see option 12.A.1) if DHS retains the Primary Care Case Management program as the foundational primary care provider program. This is a standalone option, so it would not be combined with options 12.A.1 or 12.A.3.

[127] Agency for Healthcare Research and Quality. (N.D.). The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes [webpage]. Retrieved from: Collaborative Care Model Medicaid Health Homes | The Academy (ahrq.gov).

	Option 12.A.2: Retain both the Primary Care Case Management and Patient Centered Medical Home programs and add incentives for Primary Care Case Management providers.
Potential Cost Savings	This option can potentially create additional program costs in the short term, as implementing new financial incentives could generate more costs. It would take time for the new incentives to impact access and other outcome measures, particularly if providers are required to develop new capabilities. However, there is the potential to generate savings over the long term.
Implementation Steps	DHS would need to determine appropriate Primary Care Case Management incentives and the associated incentive amounts. DHS would need to develop quality measures and update reporting for the Primary Care Case Management providers. New metrics and incentives would need to be developed with projected cost savings to ensure a return on investment. Any changes to required documentation would need to be coordinated with the Quality Care Insight Provider Portal or another submission method. DHS would need to submit a State Plan Amendment for changes related to the payment structure for the Primary Care Case Management program, and CMS would need to approve the State Plan Amendment. DHS would need to update the provider manual. The State Plan Amendment and the provider manual updates would need to go through a legislative promulgation process.
Timeline	2+ years.

Option 12.A.3: Merge the Patient Centered Medical Home and Primary Care Case Management programs.

Under this option, DHS would merge the Patient Centered Medical Home and Primary Care Case Management programs into a single program offering payment incentives for primary care providers if they meet more advanced primary care practices. The two programs share some similar requirements (e.g., requirements for 24/7 access), which may cause duplicative activities between the two programs.

Combining the Patient Centered Medical Home and Primary Care Case Management programs is an opportunity to simplify the number of primary care capitation programs and streamline the process for both primary care providers and DHS. Combining the programs may also

encourage primary care providers to move to more advanced primary care practices by requiring them to fulfill additional obligations in return for a coordination payment.

In addition, there is an opportunity to review both the requirements and quality metrics used as part of the Patient Centered Medical Home program to move away from requirements to simply document whether the providers have a particular plan in place (i.e., one of the current activity requirements for Patient Centered Medical Homes is to indicate if primary care providers have an established process for patient and family engagement, but if they do not have a process, that does not cause a failure of the activity) and require more advanced activities that will better support beneficiaries in receiving coordinated and integrated care.

This option can potentially improve beneficiary outcomes through better management of conditions and enhanced engagement with patients. This option may result in resistance from Primary Care Case Management providers who are accustomed to receiving a Primary Care Case Management per member per month payment for a more limited set of responsibilities. For example, DHS received complaints from primary care providers when CMS required DHS to end similar payments to primary care providers for Medicaid beneficiaries who were enrolled in the PASSE program. CMS considers Primary Care Case Management payments and PASSE capitation payments duplicative, as both payments are for care coordination activities.

Depending on program changes implemented, this option may reduce the number of primary care providers that receive a per member per month payment (because fewer primary care providers would agree to meet the more advanced requirements) and direct those payments to Patient Centered Medical Home providers that are conducting more advanced activities to support the management of their patients.

This standalone option would not be combined with options 12.A.1 or 12.A.2.

	Option 12.A.3: Merge the Patient Centered Medical Home and Primary Care Case Management programs.
Potential Cost Savings	This option is expected to have limited cost savings initially, as the Primary Care Case Management program per member per month payments may be combined into a single per member per month coordination payment delivered to the Patient Centered Medical Homes. Over time, as Patient Centered Medical Homes are required to adhere to more advanced primary care activities and meet elevated quality measure targets, there is the potential to slow the growth of costs associated with higher levels of care (e.g., emergency department visits, inpatient admissions) due to improved care coordination for beneficiaries. This option is also expected to reduce DHS'

	Option 12.A.3: Merge the Patient Centered Medical Home and Primary Care Case Management programs.
	administrative burden due to streamlining the two programs.
Implementation Steps	DHS would need to evaluate modifications to the Patient Centered Medical Home coordination payments, quality incentive structure, activity requirements, and quality metrics. Any changes to required documentation would need to be coordinated with the Quality Care Insight Provider Portal. DHS would need to submit a State Plan Amendment for changes related to merging the Primary Care Case Management and Patient Centered Medical Home programs and obtain CMS approval. DHS would need to update the provider manual. The State Plan Amendment and the provider manual updates would need to go through a legislative promulgation process.
Timeline	2+ years.
Leading Practices	More states have begun to leverage their Primary Care Case Management programs to further encourage and support primary care providers to improve care delivery and care coordination for Medicaid beneficiaries and house the primary care requirements in a single primary care capitated program.[128] For example, in 2021, Idaho Medicaid implemented changes to its Healthy Connections Primary Care Case Management program to implement a three-tiered Patient Centered Medical Home program where per member per month payments vary depending on provider requirements. To achieve the third tier, providers must maintain Patient Centered Medical Home accreditation from The National Committee for Quality Assurance or another national accreditation.[129] In addition, in 2020, the Oklahoma Health Care Authority proposed redesigning their Patient Centered Medical Home program in which primary care providers would no longer receive a case management fee if they did not meet more advanced primary care standards.[130]

[128] National Academy for State Health Policy. (August 30, 2021). Primary Care Case Management in Medicaid: A Strategy for Supporting Primary Care in Rural Areas. Retrieved from: https://nashp.org/primary-care-case-management-in-medicaid-a-strategy-for-supporting-primary-care-in-rural-areas/#:~:text=However%2C%20as%20of%202018%2C%2013,primary%20care%20providers%20(PCPs).

[129] Idaho Department of Health & Welfare. Healthy Connections PCMH Tier Program Explanation. Retrieved from: https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=14290&dbid=0&repo=PUBLIC-DOCUMENTS&cr=1.

[130] Oklahoma Health Care Authority. (January 2020). SoonerCare PCMH Redesign Stakeholder Presentation. Retrieved from: https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Foklahoma.gov%2Fcontent%2Fdam%2Fok%2Fen%2Fokhca%2Fdocuments%2FPCMH%2520Stakeholder%2520PPT%2520-%2520Jan%25202020.pptx&wdOrigin=BROWSELINK.

B. Evidence-Based Maternal Health Programs

In Arkansas, approximately 39% of births are financed by FFS Medicaid.[131] Therefore, the Medicaid program plays an essential role in maternal health. In Arkansas, as well as nationally, there has been a heightened focus on strategies to improve maternal health and reduce maternal mortality. According to the Centers for Disease Control and Prevention, Arkansas' maternal mortality rate is the highest of any state, at 43.5 deaths per 100,000 live births, compared to the U.S. average of 23.5 deaths per 100,000 live births.[132]

In 2022, Arkansas received $1.2 million in funding from the Centers for Disease Control and Prevention, which facilitated the establishment of the Arkansas Perinatal Quality Collaborative at the University of Arkansas for Medical Sciences. The Arkansas Perinatal Quality Collaborative collaborates with the Arkansas Department of Health to improve maternal and infant health outcomes by implementing evidence-based practices to improve quality of care and prevent maternal deaths.[133]

Arkansas also joined the Alliance for Innovation on Maternal Health (AIM) in 2022.[134] AIM is a national quality improvement initiative that supports best practices to make births safer, improve maternal health outcomes, such as mortality and postpartum infection, and save lives. AIM has developed patient safety bundles, which are structured ways of improving care processes and patient outcomes.[135] The core AIM patient safety bundles are:

- Obstetric hemorrhage,
- Severe hypertension in pregnancy,
- Safe reduction of primary Cesarean birth,
- Cardiac conditions in obstetric care,
- Care for pregnant and postpartum people with substance use disorder,
- Perinatal mental health conditions,
- Postpartum discharge transition, and
- Sepsis in obstetrical care.

[131] Kaiser Family Foundation. (2022). Births Financed by Medicaid. Retrieved from: https://www.kff.org/medicaid/state-indicator/births-financed-by-medicaid/?activeTab=map&currentTimeframe=0&selectedDistributions=percent-of-births-financed-by-medicaid&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[132] Centers for Disease Control and Prevention. Maternal deaths and mortality rates: each state, the District of Columbia, United States, 2018-2021. Retrieved from: https://www.cdc.gov/nchs/maternal-mortality/MMR-2018-2021-State-Data.pdf.

[133] Arkansas Department of Health. (December 2023). Arkansas Maternal and Perinatal Outcomes Quality Review Committee Legislative Report. Retrieved from: https://www.healthy.arkansas.gov/images/uploads/pdf/2023_MPOQRC_Legislative_Report.pdf.

[134] Alliance for Innovation on Maternal Health. (n.d.). Enrolled States and Jurisdictions. Retrieved from: https://saferbirth.org/about-us/enrolled-states-and-jurisdictions/.

[135] Alliance for Innovation on Maternal Health. (n.d.). Patient Safety Bundles. Retrieved from: https://saferbirth.org/patient-safety-bundles/.

Arkansas is currently participating in the safe reduction of primary Cesarean birth safety bundle. These efforts are broader than the State's Medicaid program and seek to improve outcomes for all pregnant women in the State.

In its December 2023 Legislative Report, the Arkansas Maternal Mortality Review Committee recommended that systems should increase the use of safety bundles and that birthing facilities should standardize practice and procedures through the use of safety bundles and increase education regarding the identification of early maternal warning signs for complications and unusual circumstances.[136] The report also recommended that providers have increased education on Septic and Group A Streptococci bundles.

Option 12.B.1: Develop a value-based payment model for maternal health.

DHS may consider building on the State's efforts to improve maternal health quality and outcomes by developing a value-based payment model for pregnancy and postpartum care. Three types of value-based payment models used by state Medicaid agencies for pregnancy and postpartum care are pay for performance, pregnancy medical homes, and episodes of care.[137] Under a pay-for-performance model, DHS could pay providers a financial incentive to meet specific quality targets, which could be linked to the AIM safety bundles. The payments would be calculated retrospectively based on past performance. The AIM patient safety bundles include measures to track progress, organized by structure, process, and outcome measures. DHS could consider leveraging a subset of these AIM measures for a maternal health pay-for-performance program.

In December 2023, CMS announced the new Transforming Maternal Health Model, designed to improve maternal health for people enrolled in Medicaid and the Children's Health Insurance Program. The model is intended to improve outcomes and experiences for mothers and their newborns and reduce overall program expenditures. One of the pillars of the Transforming Maternal Health Model is implementing patient safety bundles.[138] The Transforming Maternal

[136] Arkansas Department of Health. (December 2023). Arkansas Maternal Mortality Review Committee Legislative Report. Retrieved from: https://www.healthy.arkansas.gov/images/uploads/pdf/MMRC_Legislative_Report_2023.pdf.

[137] Medicaid and CHIP Payment and Access Commission. (September 2021). Value-based Payment for Maternity Care in Medicaid: Findings in Five States. Retrieved from: https://www.macpac.gov/wp-content/uploads/2021/09/Value-Based-Payment-for-Maternity-Care-in-Medicaid-Findings-from-Five-States.pdf.

[138] Centers for Medicare & Medicaid Services. Transforming Maternal Health Model. Retrieved from: https://www.cms.gov/priorities/innovation/innovation-models/transforming-maternal-health-tmah-model.

Health Model is planned to begin in January 2025. DHS may apply to participate in this CMS model or develop its own value-based payment model linked to the AIM safety bundles, as noted above.

DHS may also consider implementing value-based payments through a pregnancy medical home delivery model. Pregnancy medical homes are delivery models that provide enhanced care coordination, focusing on clinical, behavioral, and social aspects of care to improve maternal health outcomes. This model is like a Patient Centered Medical Home model but is specifically designed for prenatal and postpartum care. Pregnancy medical homes may use a variety of payment approaches, including bonus payments, shared savings models, or capitation models. Pregnancy medical home models may be implemented within managed care and FFS delivery systems.[139]

DHS previously operated an episodes of care program in which the delivering provider and all other providers involved in the patient's perinatal care were paid on an FFS basis for individual services throughout the pregnancy. In addition, on a retrospective basis, the delivering provider was required to pay the State if the average episode cost was higher than a certain threshold or was eligible to share in the savings if the average costs were below a certain threshold. The episodes of care program was sunset in 2021.

	12.B.1.a. Implement a pay-for-performance value-based payment model for maternal health.	**12.B.1.b. Implement a pregnancy medical home value-based payment model for maternal health.**
Potential Cost Savings	This option is expected to have limited cost savings in the short term. Maternal health pay-for-performance programs have been designed to improve provider performance and health outcomes, rather than directly focus on cost.[140]	This option is expected to have limited cost savings in the short term. Pregnancy medical homes have been designed to improve provider performance and health outcomes, rather than directly focus on cost.[141]

[139] Medicaid and CHIP Payment and Access Commission. (September 2021). Value-based Payment for Maternity Care in Medicaid: Findings in Five States. Retrieved from: https://www.macpac.gov/wp-content/uploads/2021/09/Value-Based-Payment-for-Maternity-Care-in-Medicaid-Findings-from-Five-States.pdf.

[140] Medicaid and CHIP Payment and Access Commission. (September 2021). Value-based Payment for Maternity Care in Medicaid: Findings in Five States. Retrieved from: https://www.macpac.gov/wp-content/uploads/2021/09/Value-Based-Payment-for-Maternity-Care-in-Medicaid-Findings-from-Five-States.pdf.

[141] Medicaid and CHIP Payment and Access Commission. (September 2021). Value-based Payment for Maternity Care in Medicaid: Findings in Five States. Retrieved from: https://www.macpac.gov/wp-content/uploads/2021/09/Value-Based-Payment-for-Maternity-Care-in-Medicaid-Findings-from-Five-States.pdf.

	12.B.1.a. Implement a pay-for-performance value-based payment model for maternal health.	12.B.1.b. Implement a pregnancy medical home value-based payment model for maternal health.
Implementation Steps	DHS would need to collaborate with the Arkansas Perinatal Quality Collaborative and other stakeholders to design the pay-for-performance program, including quality metrics, payment approach, and other activity requirements. DHS would need to submit a State Plan Amendment and obtain CMS approval. DHS would need to update the provider manual. The State Plan Amendment and the provider manual updates would need to go through a legislative promulgation process.	DHS would need to collaborate with the Arkansas Perinatal Quality Collaborative and other stakeholders to design a pregnancy medical home program. DHS would need to create policies for provide eligibility, activity requirements, quality metrics, and payment approaches. DHS would need to submit a State Plan Amendment and obtain CMS approval. DHS would need to update the provider manual. The State Plan Amendment and the provider manual updates would need to go through a legislative promulgation process.
Timeline	2+ years.	2+ years.
Leading Practices	As of March 2020, 14 states were using a pay-for-performance model for maternal health.[142] Evidence is mixed about whether the programs are improving quality measures; however, stakeholders report that reviewing data and sharing performance information better engages providers in quality improvement efforts.[143]	As of March 2020, four states were using a pregnancy medical home delivery model.[144] A medical home pilot resulted in better outcomes, fewer emergency department visits, fewer Cesarean sections, and an increased likelihood of attending a postpartum visit. North Carolina's pregnancy medical home program resulted in a

[142] Medicaid and CHIP Payment and Access Commission. (March 2020). Inventory of State-Level Medicaid Policies, Programs, and Initiatives to Improve Maternity Care and Options. Retrieved from: Inventory of State-Level Medicaid Policies, Programs, and Initiatives to Improve Maternity Care and Outcomes : MACPAC.

[143] Medicaid and CHIP Payment and Access Commission. (September 2021). North Carolina Pregnancy Medical Home. Retrieved from: https://www.macpac.gov/wp-content/uploads/2021/09/North-Carolina-Pregnancy-Medical-Home.pdf.

[144] Medicaid and CHIP Payment and Access Commission. (March 2020). Inventory of State-Level Medicaid Policies, Programs, and Initiatives to Improve Maternity Care and Options. Retrieved from: Inventory of State-Level Medicaid Policies, Programs, and Initiatives to Improve Maternity Care and Outcomes : MACPAC.

	12.B.1.a. Implement a pay-for-performance value-based payment model for maternal health.	12.B.1.b. Implement a pregnancy medical home value-based payment model for maternal health.
		nearly 7% decrease in the low birthweight rate among the Medicaid population. Some evidence suggests that pregnancy medical homes are not as effective as other models, like group prenatal care, in preventing maternal morbidity and mortality and reducing overall health care costs.[145]

[145] The Commonwealth Fund. (March 4, 2021). Community-based Models to Improve Maternal Health Outcomes and Promote Health Equity. Retrieved from: https://www.commonwealthfund.org/publications/issue-briefs/2021/mar/community-models-improve-maternal-outcomes-equity#:~:text=Pregnancy%20Medical%20Homes,-What%20They%20Are&text=Evidence%20of%20Effectiveness%3A%20A%20medical,of%20attending%20a%20postpartum%20visit.

SECTION 13: CROSSOVER CLAIMS

State Medicaid agencies are legally obligated to pay Medicare costs for Medicare beneficiaries also eligible for some type of Medicaid assistance. These individuals fall into two categories: those who are Qualified Medicare Beneficiaries and those who receive Medicaid coverage while being above the 100% federal poverty level, which is the ceiling for Qualified Medicare Beneficiary eligibility. For Qualified Medicare Beneficiaries, all cost-sharing relating to Part A and Part B is the state's responsibility, regardless of whether a service is also a Medicaid-covered service. For non-Qualified Medicare Beneficiaries, states must pay up to the Medicaid rate for Medicaid services rendered by Medicaid providers in excess of any third-party liability.[146]

While Medicaid programs are not required to pay the full Medicare coinsurance and deductibles for Medicaid enrollees dually enrolled in Medicare, in the past, some states made full payments to providers for the Medicare cost-sharing amounts anyway. This meant that providers would receive the same payment for Medicare-Medicaid enrollees and Medicare-only enrollees in the state and made Medicare-Medicaid enrollees more attractive for providers. There has been a shift away from full payment policies, and states have begun to employ a "lesser of" payment policy, in which a provider receives no more than the Medicaid-approved rate.[147]

Arkansas uses a full payment claims policy for hospital outpatient and physician services and nursing facility services. This may result in DHS paying more than the Medicaid-approved rate for these services. Arkansas uses the lesser of claims policy for Medicare-Medicaid Beneficiaries for hospital inpatient services.

Option 13.1: Reimburse Medicare Part B claims using a "lesser of" payment policy.

DHS could update its reimbursement policies to reimburse for Medicare Part B claims using lesser of logic. Under this policy, DHS would compare the requested Medicare cost-sharing to the difference between Arkansas' Medicaid rate and the Medicare payment amount and pay

[146] Medicare Advocacy. (n.d.). *Medicare Cost-Sharing for Dual Eligibles: Who Pays What for Whom?* [Webpage]. Retrieved from: https://medicareadvocacy.org/medicare-cost-sharing-for-dual-eligibles-who-pays-what-for-whom/.

[147] MACPAC. (2014). *Effect of State Medicaid Payment Policies for Medicare Cost Sharing on Access to Care for Dual Eligibles* [Webpage]. Retrieved from: Effect of State Medicaid Payment Policies for Medicare Cost Sharing on Access to Care for Dual Eligibles (macpac.gov).

the lesser amount. If Medicare pays more than the Medicaid rate for a particular service, Arkansas Medicaid would not be required to pay anything additional.[148]

This option will likely receive resistance from stakeholders, such as hospital and provider associations. When the State moved to lesser of logic for Part A claims 2016, Part B claims were originally included, but were ultimately removed from the policy change before being implemented.

Medicaid/Medicare crossover claim payments are included in calculating the hospital-specific disproportionate share hospital limit. If the crossover claim payments to an eligible disproportionate share hospital provider were to decrease, the disproportionate share hospital limit would invariably increase, allowing the State to increase disproportionate share hospital payments. Given how disproportionate share hospital payments are currently distributed to disproportionate share hospital providers, the University of Arkansas for Medical Sciences is the only provider that would potentially see an increase in disproportionate share hospital payments due to implementing a lesser of logic reimbursement policy.

It is important to note that even though disproportionate share hospital payments would potentially increase, the overall fiscal impact to the disproportionate share hospital provider would not be budget neutral. This is because the providers fund the State share of disproportionate share hospital payments, whereas Medicaid payments on crossover claims are funded by State general fund appropriation.

	Option 13.1: Reimburse Medicare Part B claims using a "lesser of" payment policy.
Potential Cost Savings	There are estimated annual State savings of $5.5 million to $8.5 million due to paying no more than the Medicaid rate for eligible Part B services, as opposed to the current full payment claims policy.
Implementation Steps	DHS would need to submit a State Plan Amendment and obtain CMS approval. DHS would need to update the provider manual. The State Plan Amendment and the provider manual updates would need to go through a legislative promulgation process. DHS would also need to conduct stakeholder engagement and educational efforts related to the change.

[148] Medicaid and CHIP Payment and Access Commission. (September 2018). *State Medicaid Payment Policies for Medicare Cost Sharing.* [Webpage]. Retrieved from: https://www.macpac.gov/publication/state-medicaid-payment-policies-for-medicare-cost-sharing/.

	Option 13.1: Reimburse Medicare Part B claims using a "lesser of" payment policy.
Timeline	1-2 years.
Leading Practices	According to a September 2018 state policy compendia from the Medicaid and Children's Health Insurance Program Payment and Access Commission, most states use a lesser crossover claims policy for hospital inpatient, hospital outpatient, nursing facilities, and physician services. Thirty-nine states use the lesser logic for hospital outpatient claims, and 44 states use the lesser logic for physician services claims.