



Bureau of Legislative Research

Arkansas Health Care Reform Task Force

TSG Update Report
March 7, 2017

Agenda

- **Item D: TSG Update Activities**
 - Private Option Eligibility Update (November 2015 to February 2016)
 - Private Option Impact Chart Analysis Update
 - Pharmacy Spend Trend Comparison
 - State Developmentally Disabled Spending Comparison

Private Option Recipient Count

November 2015 to February 2016

	Nov-15	Dec-15	Jan-16	Feb-16
Recip IDs that appear in Current and Prior month	236,428	240,329	248,108	263,731
Recip IDs dropped from Prior Month	3,966	3,806	6,224	3,493
Recip IDs added from Prior Month	7,707	14,003	19,116	9,515
Total Unique Recipient Count	244,135	254,332	267,224	273,246

Note: Report was run 02/17/2016. Feb is a partial month, but PO Premium payments have been made.

Impact of Private Option on State Funds

Assumptions

- Medicaid groups for which there has been a decrease in expenditures since the PO was established (medically needy, ABD, SSI, and pregnant women) would see expenditures rise again to pre-PO levels;
- All of the waiver programs in place prior to the establishment of the PO (ARHealthNetwork, family planning, tuberculosis, and breast and cervical) would be re-established at their prior levels;
- Uncompensated care funding provided by the state (mostly to UAMS) would be replenished to its prior level;
- Premium tax revenues associated with the PO would go away; and
- General tax revenues have been impacted by the influx of additional federal funds associated with the PO.

Impact of Private Option on State Funds

Results

Projected Aggregate Private Option Impact (SFY 2017-2021)							
<i>(all figures millions \$ unless otherwise indicated)</i>							
		2017	2018	2019	2020	2021	2017-2021
Private option expenditures		1,630	1,712	1,797	1,887	1,982	9,009
Impact on State Funds							
Impact on state expenditures	State match on Private Option	41	92	114	157	193	598
	State fund savings from optional Medicaid waiver programs discontinued after the establishment of the PO	(21)	(22)	(23)	(25)	(26)	(117)
	State fund savings from cost-shifting from traditional Medicaid to PO	(91)	(96)	(101)	(106)	(111)	(504)
	Administrative costs	3	3	3	3	3	14
	Reductions in state fund outlays for uncompensated care	(37)	(39)	(41)	(43)	(45)	(203)
	Total impact on expenditures	(106)	(62)	(47)	(13)	15	(213)
Impact on state revenues	Increase in premium tax revenue	37	39	41	44	46	208
	Increase in collections from economically-sensitive taxes (4%)	64	65	67	69	72	336
	Total impact on revenues	101	104	109	113	118	544
Net impact on state funds		206	166	156	126	103	757

Impact of Private Option on State Funds

Estimating a More Conservative Impact

- Assumptions for a more conservative estimate of the impact of the PO on state funds
 - ARHealthNetwork is not re-established (approx. \$83m 5-year total);
 - Only half of the savings due to the decrease in expenditures for the SSI groups is attributed to the PO (approx. \$108m 5-year total); and
 - None of the state funded outlays for uncompensated care are reinstated (approx. \$203m 5-year total).
- 5-year impact with these assumptions – \$363 million
- Range – \$363-757 million 5-year general fund impact

Impact of Other ACA Features

on Arkansas Health Care Providers

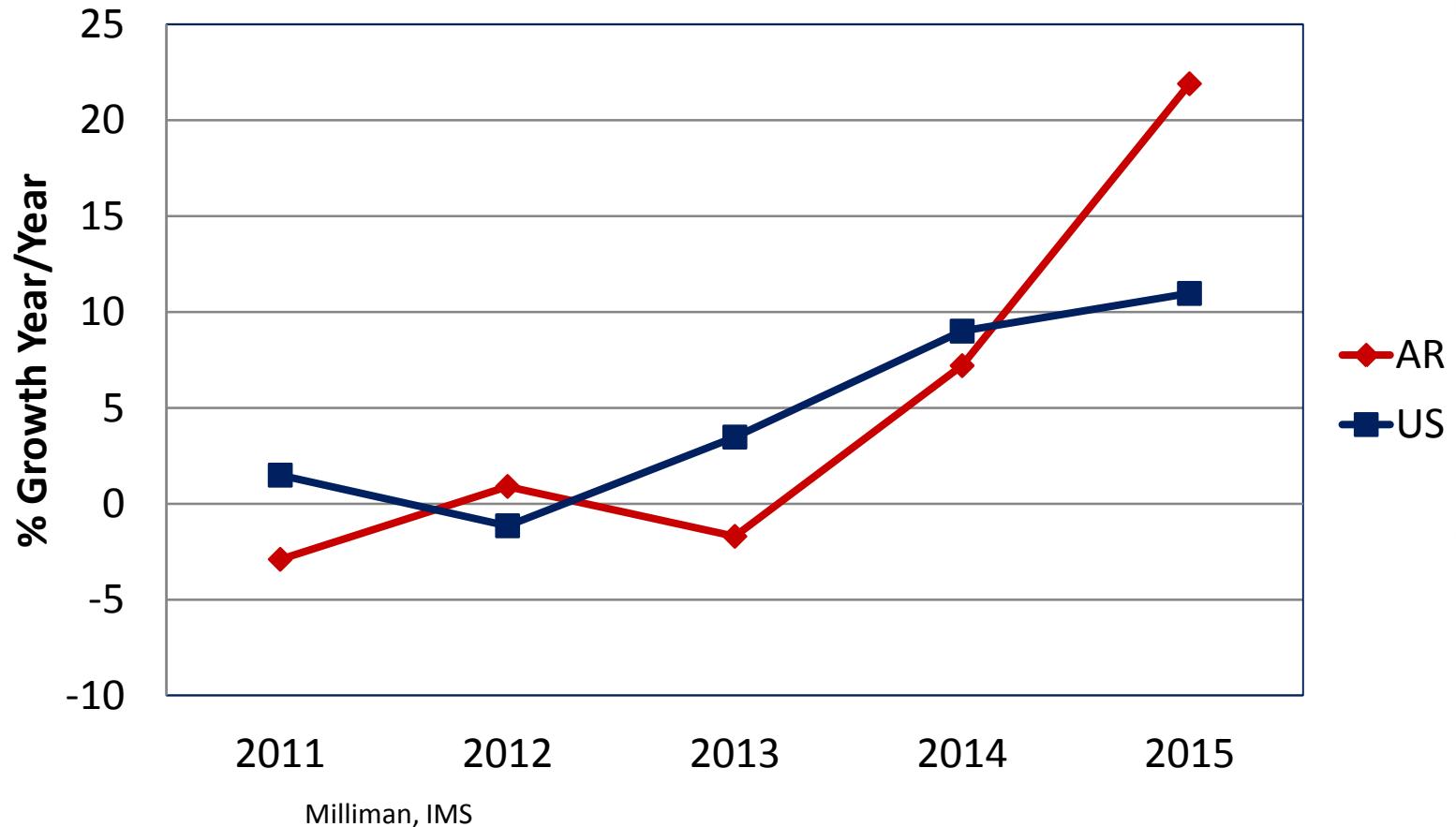
Impacts of ACA on Arkansas Health Care Providers

(\$millions)

	2017	2018	2019	2020	2021	2017- 2021
Federal match for PO	1,590	1,620	1,683	1,730	1,788	8,411
State match for PO	41	92	114	157	193	598
Total PO funds	1,630	1,712	1,797	1,887	1,982	9,009
Increase in other federal funds flowing into AR due to ACA (exchange subsidies)	846	939	995	1,032	1,097	4,911
Decrease in federal funds flowing into AR due to ACA (taxes and rate effects)	(1,386)	(1,730)	(2,055)	(2,279)	(2,539)	(9,989)
Net impact of other ACA changes	(539)	(791)	(1,060)	(1,246)	(1,442)	(5,078)

Pharmacy Spend Trend Comparison

Arkansas Medicaid vs. US Drug Trend



Drivers of Pharmacy Trend

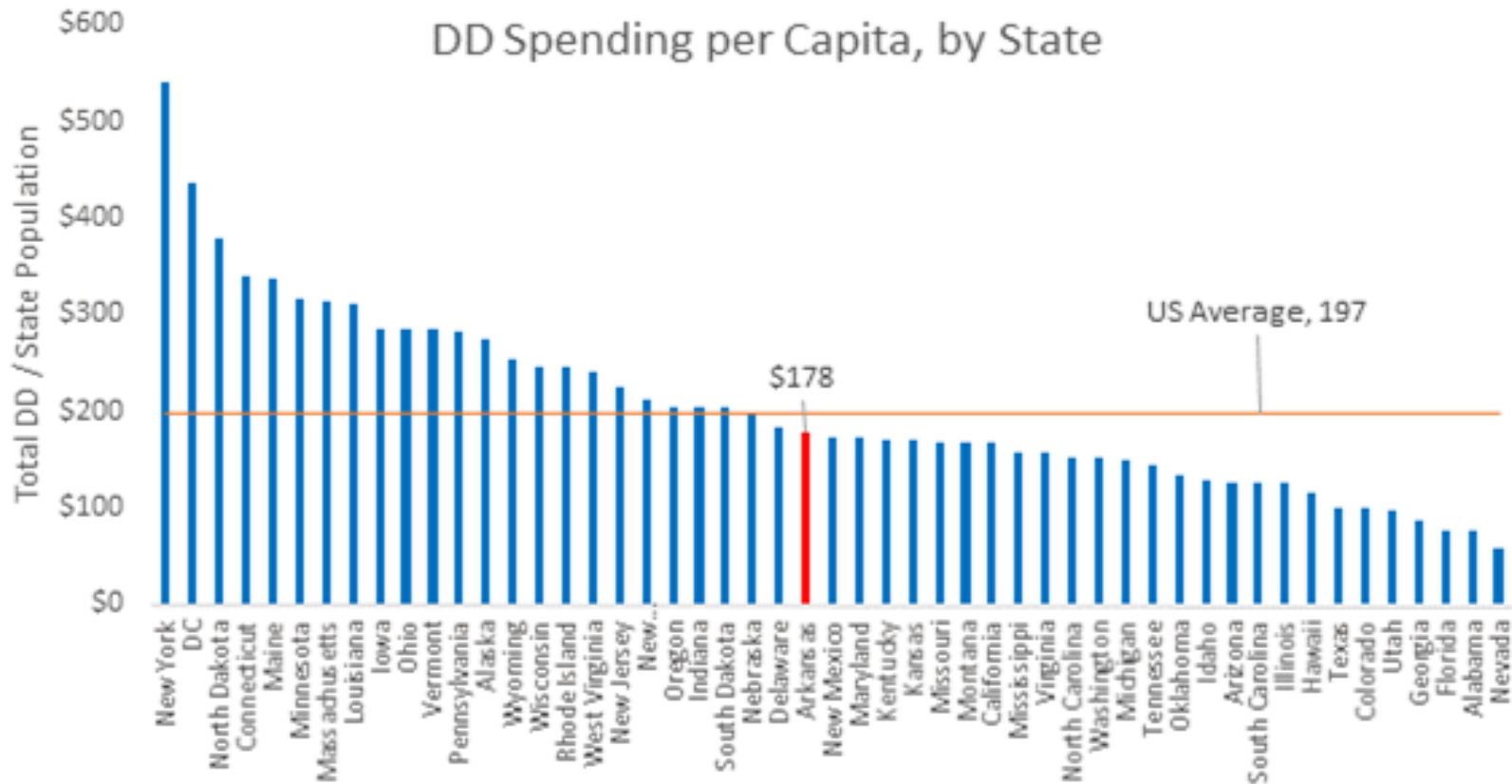
- Three Drivers of increase in Drug Spend Trend
 - Brand drug inflation
 - More prescriptions
 - Change in drug mix to include specialty drugs

	SFY13	SFY14	SFY15
Average cost of Rx	\$64	\$68	\$73
Average cost brand	\$253	\$295	\$342
Average cost generic	\$24	\$24	\$25

State DD Spending Per Capita

Source: "The State of the States in Intellectual and Developmental Disabilities"/Coleman Institute: Univ. of Colorado

Source: US Census Bureau: Annual estimates of the Resident Population: 7/1/2013



Agenda

- **Item E: TSG Update on Eligibility and Enrollment Framework Program Assessment**

TSG Monitoring of the EEF Project

- TSG met with DHS and Gartner to monitor the progress of EEF Project #6 – Competitive Procurement System Integrator Services and #2 Define/Ratify Vision. Findings to date:
 - Meeting with CMS 2/24 & 2/25 went well; CMS on-board with approach
 - Work on the SI Vendor requirements continues
 - DHS working through current application and renewal backlog
 - Visioning meetings ongoing
- The following schedule has been published and appears to continue to be on track

Project Phases		Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sept-16	Oct-16	Nov-16	Dec-16
1	Project Initiation and Current State Validation Including Vision and Business Case	■											
2	Requirements	■	■	■									
3	Procurement Strategy			■									
4	Procurement Support for RFP to Issuance for Federal Review			■	■	■	■						
5	Post Federal Approvals RFP Issuance to Street						■	■	■				
6	Vendors' Proposal Development Time and Submission								■	■			
7	Proposal Evaluation Process Through Orals and Vendor Selection										■	■	
8	Contract Finalization and Federal Approval of Contract												■

TSG Monitoring of the EEF Project

- Currently two primary problems with current DHS eligibility operations for MAGI recipients:
 - A large backlog of cases from the FFM that can't be quickly processed due to missing or inconsistent data; this backlog slowly being worked through and the data issues getting resolved
 - Regular Medicaid renewals also have a backlog that are slowly being working through.
- Application/renewal processing through the Curum system is improving as additional fixes continue to be put into place
- With Gartner's assistance, DHS is making progress on requirements for the RFP as well as the enterprise visioning.

Agenda

- **Item F: TSG Update on Information Technology Contract**

Status of InterRai Assessment Tools for DAAS, DDS, DBHS (TSG Update In Oct, 2015)

- DHS chose InterRai program eligibility assessments instruments for HCBS waivers managed by DAAS, and DDS and RSPMI managed by DBHS in 2010/11. Project been underway at least 5 years.
- First project IT contractor CH Mack/MedCompass signed in 2011; terminated 2014.
- Second project IT contractor CoCentrix signed in 2014.
- Three phases of InterRai implementation:
 - ☐ 1) Assessment;
 - ☐ 2) Plans of Care;
 - ☐ 3) Individual service plan budget based on tiered assessment level of care.

Current Status of InterRai Universal Assessment Implementation – (10/15)

- DAAS: all three phases of functionality under development; assessment phase functionality being tested. Assessment functionality target date completion: 8/15; Phase Two and Three to follow acceptance of Phase One functionality.
- DDS: Assessment functionality completed 2/15; Phase Two Plan of Care delayed 3/15 - re-start date unknown; Phase Three tiered payments delayed to 2016.
- DBHS: “not actively” engaged in the project; to be reconsidered when DAAS and DDS work has been completed.
- Unclear involvement of the University of Michigan/InterRai organization with project management and contractor work: team member or not?
- Project phase closure is currently planned for 5/2016

TSG Recommendation

- Task Force continue to review contract negotiations
- Task Force assure that any additional work and payments for Independent and Universal Assessment in the future are done under process that includes specific deliverables, work requirements and fixed cost and also furthers intent of Task Force decision on management model related to Independent Assessment
- DHS should update Task Force on any future negotiations

Agenda

- **Item G: Task Force Discussion, Votes, and Decisions**
 - 1. Arkansas Works**
 - 2. Medicaid Management Models for High Cost Populations**
 - 3. Related Provisions**

I. Arkansas Works

The task force accepts the budget analysis presented on February 17, 2016 and in previous task force meetings that discontinuing the current Health Care Independence Program will result in a substantial increase in state Medicaid and uncompensated care expenditures over the next four years and thereby further recommends that the legislature consider the Governor's Arkansas Works proposal as presented to the task force on February 17, 2016. We hereby request that the governor present legislation to be considered during a special session

II. Medicaid Management Models for High Cost Populations

1. **Governor Recommendation:** *Capitated, Full Risk, Managed Care Model for Behavioral Health and Developmental Disabilities services, including medical, and excluding skilled nursing facilities, institutions, and other long term care populations and services.*
2. **Senator Ingram Recommendation:** *Capitated, Full Risk, Managed Care Model for Behavioral Health services, including medical, with all of Developmental Disabilities, and Long Term Care Populations and Services in Managed Fee For Service with Risk*
3. **DiamondCare Recommendation with Risk:** *All Long Term Supports and Services (high cost traditional Medicaid populations) in Managed Fee For Service, aligned with Patient Centered Medical Homes, with risk*

Medicaid Management Models for High Cost Populations

Proposed Model Comparison – Program Features

Proposed Cost-Saving Strategies for Arkansas' Traditional Medicaid Program			
Populations/ Programs	Governor's Proposal	Sen. Ingram's Proposal	DiamondCare (MFFS) with Risk
Elderly, Non-SNF	LTC Industry Plan		
SNF	LTC Industry Plan		
DD, non-HDC	Capitated	MFFS	MFFS
HDC	No changes recommended		
BH	Capitated	Capitated	MFFS
Other Populations	Expanded PCMH		

Medicaid Management Models for High Cost Populations (cont.)

Proposed Model Comparison – Program Features (cont.)

Proposed Cost-Saving Strategies for Arkansas' Traditional Medicaid Program			
Populations/ Programs	Governor's Proposal	Sen. Ingram's Proposal	DiamondCare (MFFS) with Risk
Prescription Drugs	Savings incorporated within Elderly, Non-SNF; DD, non-HDC; and Other Populations	Savings incorporated within Elderly, Non-SNF; DD, non-HDC; and Other Populations	Abilify generic; CAP expansion; PDL expansion; antipsychotic review; hemophilia management
Dental	Capitated		
Admin Savings	Reduced agency DD staffing; eliminated DD case management fee		
Admin Costs	DMS admin for managed care; technology costs	DMS admin for BH managed care/MFFS; DAA admin costs for LTC program; technology costs	DMS admin for MFFS; DAA admin costs for LTC program; technology costs
Premium Tax	2.5% of all capitated payments; varies based on programs included		

Medicaid Management Models for High Cost Populations (cont.)

Proposed Model Comparison – Savings Estimates

Projected Savings from Proposed Cost-Saving Strategies (SFY 2017-2021; \$millions)			
Populations/ Programs	Governor's Proposal	Sen. Ingram's Proposal	MFFS with Risk
Elderly, Non-SNF	\$88	\$88	\$88
SNF	\$163	\$163	\$163
DD, non-HDC	\$423	\$193	\$193
HDC	\$0	\$0	\$0
BH	\$568	\$568	\$261
Other Populations	\$79	\$79	\$213
Prescription Drugs	\$0	\$0	\$160
Dental	\$20	\$20	\$20
Admin Savings	\$28	\$28	\$28
Admin Costs	\$80	\$84	\$84
Premium Tax	\$150	\$97	\$17
Total	\$1,439	\$1,152	\$1,057

Estimated General Fund Savings

Populations/ Programs	Effective General Fund Match Rate	General Fund Savings		
		Governor's Proposal	Sen. Ingram's Proposal	MFFS with Risk
Elderly, Non-SNF	30%	\$26	\$26	\$26
SNF	16.28%	\$27	\$27	\$27
DD, non-HDC	30%	\$127	\$58	\$58
HDC	30%	\$0	\$0	\$0
BH	30%	\$170	\$170	\$78
Other Populations	30%	\$24	\$24	\$64
Prescription Drugs	30%	\$0	\$0	\$48
Dental	30%	\$6	\$6	\$6
Admin Savings	30%	\$8	\$8	\$8
Admin Costs	30%	\$24	\$25	\$25
Premium Tax	30%	\$45	\$29	\$5
Total		\$457	\$374	\$346

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III. Related Provisions For Traditional Medicaid Management Reform