Bureau of Legislative Research

Arkansas Health Care Reform Task Force

TSG Update Report

November 10, 2015

THE STEPHEN GROUP

Follow up from 10/20 Task Force Meeting

- Vaccine Research
- DRG Study
- Nursing Home Census
- HCIP Implementation Consideration
- Tennessee Primary Prevention Initiative
- Medicaid Expansion Lockout Provisions
- State Assistance Group Size Comparison
- Medically Frail Process in Other States
- Montana Expansion Waiver Approval

Arkansas Medicaid Vaccines

Arkansas Medicaid Vaccines		Special Population Impacted	Product Reimbursement from AR Medicaid	Approximate Product Cost UAMS Regional Programs	Administration Fee Paid by Medicaid	Billing Code
Pediatric	**Brand Name**					
VFC vaccines (0-18 years old)	"All of them"		$0	$0	$9.56 (EP/TJ modifier)	
Adult (vaccine type)	**Brand Name**					
Hepatitis B	Recombivax, Engerix-B		$ 57.58	$ 56.18	$0	90746
Hepatitis A	Havrix, Vaqta		$ 61.05	$ 68.19	$0	90632
Hep B / Hep A combo	Twinrix		$ 91.28	$ 108.50	$0	90636
Influenza (flu) injection	Fluzone, Afluria		$ 12.06	$ 9.62	$0	90658
Herpes Zoster (Shingles)	Zostavax		$ 129.20	$ 164.71	$0	90736
Pneumococcal polysaccharide 23	Pneumovax 23		$ 12.34	$ 77.45	$0	90732
Pneumococcal conjugant 13	Prevnar 13	HIV, asplenia, CKD, immunocompromised, Cochlear implant, etc.	$0	$ 162.65	$0	90670
Tetanus, diphtheria, pertussis (Tdap)	Adacel, Boostrix		$ 28.80	$ 43.99	$0	90715
Human papillomavirus (HPV) 9	Gardasil 9		$0	$ 193.66	$0	90649
Meningococcal conjugate	Menveo, Menactra	asplenia, persistent complement component deficiency	$ 65.60	$ 117.45	$0	90734
Haemophilus influenzae (Hib)	Pedvax HIB, Acthib	asplenia, HSCT transplant	$ 25.09	$ 26.18	$0	90645
Measles, mumps, rubella (MMR)	M-M-R II		$ 34.64	$ 64.50	$0	90707
Varicella (chicken pox)	Varivax		$ 51.53	$ 96.89	$0	90716

Arkansas Vaccination Rates and Policy

- Multi-faceted problem with no simple solution
- Improved vaccination rates improve individual and public health and likely lower population healthcare costs
- Collecting Data
  - DHS
  - Department of Health
  - PO Carriers
  - CDC
  - Other States
- Plan to analyze the findings
- Plan to benchmark against other states
- Plan to make a recommendations to Task Force

Diagnosis Related Groups

- What is a Diagnosis Related Group (DRG)?
  - Diagnosis-Related Groups (DRGs) are a patient classification scheme that provides a means of relating the type of patients a hospital treats to the costs the hospital incurs.
  - DRGs consist of classes of patients that are similar clinically and in terms of their consumption of hospital resources.

Diagnosis Related Groups

- What types of DRGs are there?
  - The two most common types of DRGs are:
    - Medicare Severity Diagnosis Related Group (MS-DRG); and
    - All-Patient Refined Diagnosis Related Group.
  - MS-DRG was developed by 3M under contract with CMS for the Medicare population.
  - APR-DG was developed by 3M in partnership with the National Association of Children's Hospitals and Research Institutions (NACHRI).
    - APR-DRGs include numerous obstetric and pediatric diagnoses and more sophisticated logic for severity and co-morbidities.

Diagnosis Related Groups

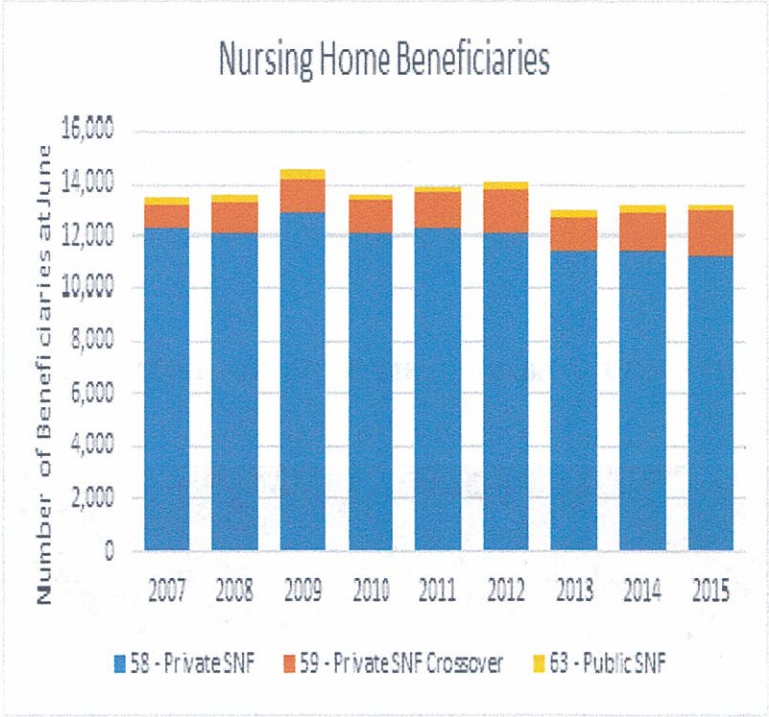
- Who uses DRGs?
  - The majority of state Medicaid programs now use APR-DRGs for inpatient hospital payment.
  - Other payers in Arkansas, including Blue Cross/Blue Shield of Arkansas already use the APR-DRG payment structure.
  - More than half of the hospitals in Arkansas already license the APR-DRG software.

Diagnosis Related Groups

- How are DRGs used?
  - There is a multiplier associated with each DRG that is generally multiplied by some base rate to establish the payment rate for the encounter.
  - Different base rates can be established by hospital type, region, or other characteristics.

Historical Nursing Home Census

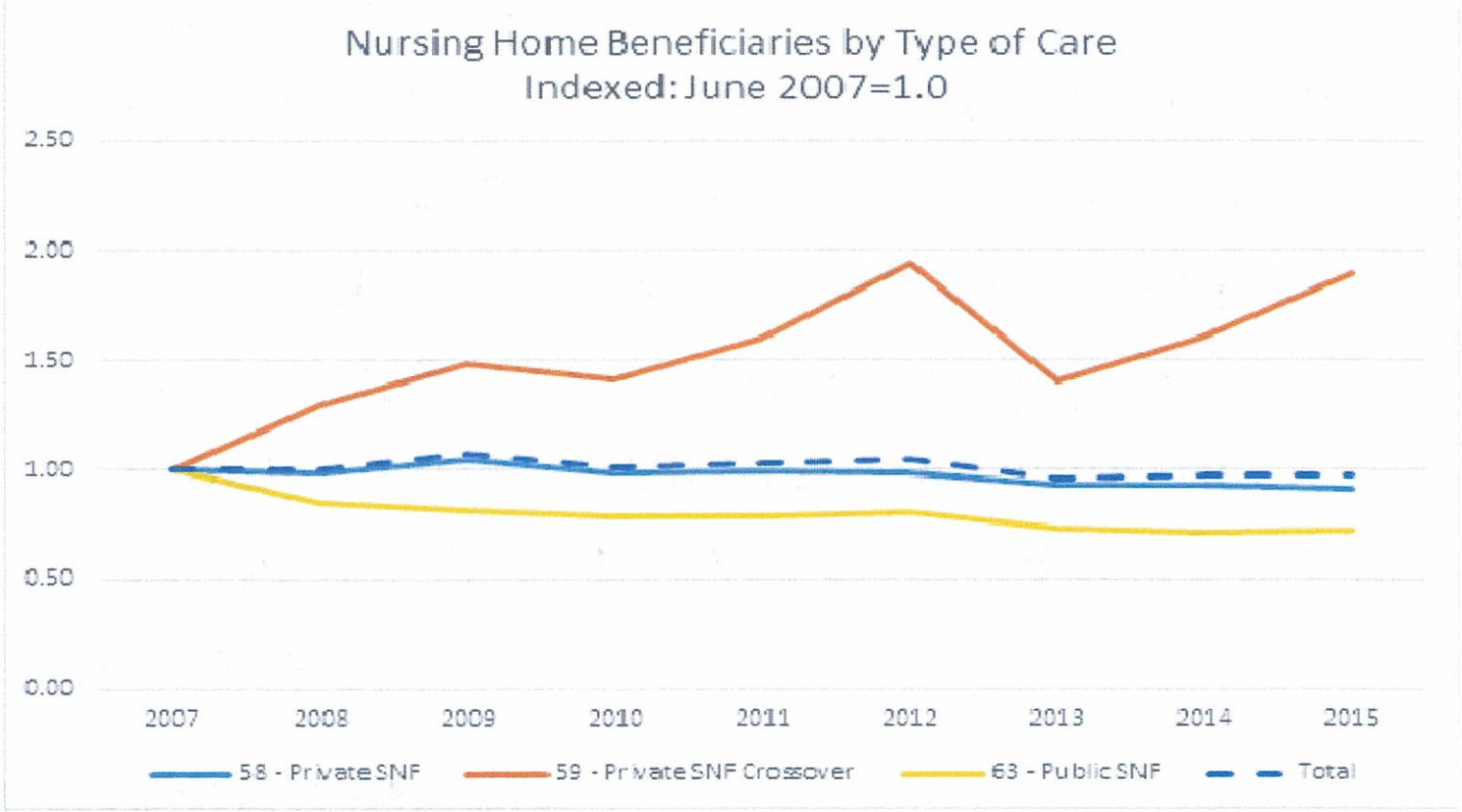
- Overall, the number of Nursing Home beneficiaries is down 400 beds on a basis of 15,000 in total since 2007
- That is a 3% decline in 7 years, which is ½% decline per year (CAGR)
- Private SNF is the largest component, 77% of total beneficiaries at June 2015.



Historical Nursing Home Census Data (2007 to 2015)

Beneficiaries at June:	2007	2008	2009	2010	2011	2012	2013	2014	2015	2015/2010	CAGR	% of Total
58 - Private SNF	12,303	12,117	12,856	12,068	12,239	12,073	11,447	11,455	11,218	-7.0%	-1.1%	77%
59 - Private SNF Crossover	909	1,176	1,351	1,284	1,454	1,765	1,275	1,460	1,725	34.3%	5.6%	12%
63 - Public SNF	330	279	269	258	260	265	242	236	237	-8.1%	-2.3%	2%
Total	14,910	15,040	15,866	14,973	15,231	15,345	14,189	14,365	14,504	-3.1%	-0.5%	100%

Nursing Home Beneficiaries By Type of Care Indexed (2007 to 2015)



Private Option Implementation Considerations

- Two questions
  - Might the state benefit from pegging the PO premium to a lower actuarial value or structuring it as a high-deductible plan?
  - Would it be possible to put the premium amount onto a health savings account or similar account and allow the enrollee to purchase a plan?

Private Option Implementation Considerations

Premium and Cost-Sharing Reduction Breakdown		
3.5%	Additional cost-sharing reduction for PO enrollees from 0% to 100% FPL	Subject to CSR reconciliation
2.5%	Deductible buy-down for PO enrollees from 101% to 138% FPL	
24.0%	Cost-sharing reduction (CSR) for individuals from 139% to 150% FPL	
70.0%	Premium	Subject to medical loss ratio (MLR)

[1] Based on 'Arkansas Center for Health Improvement. *Health Care Independence Program: Premium and Cost-Sharing Reduction Breakdown*. June 2015.'

Private Option Implementation Considerations

- Might the state benefit from pegging the PO premium to a lower actuarial value or structuring it as a high-deductible plan?
  - Both the aggregate premium amount and the CSR are subject to reconciliation
  - CMS is unlikely to waive the CSR
  - CSR reconciliation is "dollar-for-dollar" while MLR allows for admin costs and profit
  - There could be some small savings to changing but additional analysis is needed, and there could be policy reasons to keep PO plans aligned with marketplace plans
  - Simpler on carriers and state if PO plans are aligned with marketplace plans

Private Option Implementation Considerations

- Would it be possible to put the premium amount onto a health savings account or similar account and allow the enrollee to purchase a plan?
  - Enrollee awareness of PO plan prices could put downward pressure on rates
  - Shared saving structure would need to be carefully constructed to avoid higher costs

Tennessee Primary Prevention Initiative

- Department of Health Initiative starting in 2012
- Focused on Prevention/Health Education: Tobacco Use, Obesity, Teen Pregnancy, Infant Mortality, Substance Use/Abuse, Occupational Injuries, Health Care Associated Infections, and increased Immunizations
- Based on grass roots community team based initiative; choice of Prevention goal; use of existing resources; support from DOH

Tennessee Primary Prevention Initiative

- DOH requires 5% of all employees annual time, regardless of position, to work with and assist PPI Community Based Team Initiatives
- There have been 386 completed projects of 735 total projects across TN's 95 counties to date
- DOH provides Module Toolkits and staff support to all PPI projects
- Connection to TennCare/Medicaid at the local level
- "Bright Spots" highlights successful, replicable projects

Healthy Indiana Plan 2.0: POWER Account Lock Out Provision

- First $2,500 of covered medical expenses paid out of POWER account. Members make small contributions; state pays remaining amount. Full amount available upon enrollment. Annual remaining funds roll over for HIP Plus members if up to date on POWER Account contributions
- HIP Plus: (Mandatory for over 100% to 138% FPL; voluntary for under 100% FPL)
- Benefits: Comprehensive, including vision and dental.
- Cost Sharing: Must pay monthly POWER account contribution; approximately 2% of income
- No copayment for services (Exception: ER use for routine care)
- HIP Plus members above 100% FPL who fail to pay POWER account contributions within a 60 day grace period are disenrolled and "locked out" from re-enrolling for 6 months

Healthy Indiana Plan 2.0 Lockout

- Indiana is the first and only state to receive CMS approval for a Medicaid expansion plan that includes a lock-out policy for non-payment of premiums
- The current plan is derived from a successful demonstration that has been in place since 2007
- A similar request made by Pennsylvania and was denied
- According to the 2012 Annual Report, 12,490 (12%) members were disenrolled/locked out of coverage over the 5-year demonstration period for failure to make a required contribution. During CY2012, 3,924 out of a total 56,245 members were disenrolled/locked out for failure to pay contributions.

Healthy Indiana Plan 2.0 Lockout (cont.)

- Original time period was 12 months for non-payment of premium and then state reduced it to 6 months.
- Payment rate today is 94% compliance
- Lockout provision has had "Low impact" on beneficiaries
- "Very effective in terms of incentivizing making of payments"
- "Was done below 100% FPL in the original Waiver program and was real effective"
- Indiana chose to retain it for 100 and above and not below 100 "because they created different penalties"
- Michigan has contacted Indiana to see how it is working because their premium payment rates without lockout are low

Source: Seema Verma – State of Indiana HIP Consultant 11/6/15

Healthy Indiana Plan 2.0 Lockout

- Total Enrollees above 100% FPL 27,828/264,004 (10.5%)

Table 8 HIP Closures over 100% FPL – Top 5 Reasons February 1, 2015-July 31, 2015	
Number of Closures *S	Reason for Closure
2,317	Income exceeds program eligibility standards
1,801	Receipt of or increase in earned or self-employed income
949	Failure to provide all required information
848	Failure to make payment to POWER Account
231	Receipt of or increase in unearned income

Source: State of Indiana HIP Quarterly CMS Report 10/8/15

Oregon and Rhode Island Lockout Results

- **Oregon**
  - 2003 Oregon Section 1115 waiver allowed for a 6 month lockout for non-payment of premiums for enrollees in Oregon's Health Plan (OHP) Standard
  - 46% drop in OHP Standard enrollment in March – December 2003, compared to a 3% drop the previous year
  - Enrollment dropped from 104,000 in January 2003 to 49,000 in December 2003, to 24,000 by June 2005
  - A 2003 study reported that 22% of those who left the program cited Owing Back Premiums as one of the reasons
  - People who lost coverage were four to five times as likely to use the ER for care than people who remained enrolled
- **Rhode Island**
  - Rhode Island imposed premiums and lock-out periods for the state's Medicaid program for low-income children, parents and pregnant women in 2002
  - Within 3 months, 18% of families subject to premiums were locked out of the program for non-payment

Montana Expansion Waiver

- CMS Approves Montana 5 year Medicaid Expansion Waiver November 2, 2015
- Authority granted to charge premiums of 2% of income for individuals from 50% FPL to 133% who are not medically frail
- Non-payment of premiums for individuals below 100% FPL will not result in disenrollment
- Individuals 100% FPL and above may be disenrolled after notice and grace period
- Individuals may reenroll upon payment of arrears
- Cost sharing subject to aggregate cap of up to 5% of household income
- Medically necessary health screenings and preventive health care services, including primary, secondary, and tertiary preventive care and medications and services to help beneficiaries manage chronic conditions exempt from cost share

Montana Expansion Waiver (cont.)

- Demonstration enrollees with incomes between 50 and 133 percent of the FPL who are not medically frail will access health care services through defined provider network managed by third party administrator
- Under 50% FPL will receive standard Medicaid benefits under Fee For Service
- Twelve-Month Continuous Eligibility Period with a downward adjustment in claimed expenditures for federal matching at regular matching rate after deemed ineligible due to redetermination

Montana Expansion Waiver Objectives

- Objectives of Waiver cited as follows:
  - "Premiums and copayment liability will encourage HELP Program enrollees to be discerning health care purchasers, take personal responsibility for their health care decisions and develop health-conscious behaviors as consumers of health care services"
- Over the life of the demonstration, Montana seeks to demonstrate the following:
  - "Premiums will not pose a barrier to accessing care for HELP Program beneficiaries.
  - "HELP Program enrollees will exhibit health-conscious health care behaviors without harming beneficiary health."
  - 12 month continuous eligibility will promote continuity of coverage and reduce churn rates."

State Medicaid Expansion Assistance Group Size Comparison

NHHPP Members by FPL Group and Assistance Group Size, 10/22/15							
Source: NH MMIS as of 10-22-2015							
Federal Poverty Level Group	Assistance Group Size					Total	Percent of Total
	1	2	3	4	5+		
0	15,437	1,486	505	290	158	17,876	41.1%
1-24	981	210	141	83	74	1,489	3.4%
25-49	1,220	356	217	176	170	2,139	4.9%
50-74	1,730	895	595	576	550	4,346	10.0%
75-99	2,537	1,521	956	867	795	6,676	15.3%
100-124	2,771	1,569	1,116	963	812	7,231	16.6%
125+	1,449	839	553	460	435	3,736	8.6%
Total	26,125	6,876	4,083	3,415	2,994	43,493	100.0%
Percent of Total	60.1%	15.8%	9.4%	7.9%	6.9%	100.0%	

State Medicaid Expansion Assistance Group Size Comparison

Table 1 HIP 2.0 Enrollment 7/31/2015									
% FPL	Basic				Plus				Total
	State	Regular	Total	Percentage	State	Regular	Total	Percentage	
<23%	43,609	14,535	58,144	37.99%	52,367	42,543	94,910	62.01%	153,054
23%-50%	2,090	3,428	5,518	24.1%	3,217	14,133	17,350	75.9%	22,868
51%-75%	1,849	5,050	6,899	22.9%	3,334	19,860	23,194	77.1%	30,093
76%-100%	1,469	4,894	6,363	21.1%	2,944	20,854	23,798	78.9%	30,161
Total <101%	49,017	27,907	76,924	32.57%	61,862	97,390	159,252	67.43%	236,176
101%-138%	1,080	478	1,558	6.0%	3,228	21,261	24,489	94.0%	26,047
>138%	762	5	767	43.1%	861	153	1,014	56.9%	1,781
Grand Total	50,859	28,390	79,249	30.02%	65,951	118,804	184,755	69.98%	264,004

Other State Process for Medically Frail Determinations

New Jersey

- Medically Exempt Attestation Form sent to provider identified by individual.
- Medical provider required to fill out form and submit to State
- Form reviewed by state
- If determined frail, state staff will outreach the individual to discuss their options
- Eligibility is documented in the eligibility system and a letter sent to the individual confirming their choice and their ability to be reevaluated at any point during their 12 month eligibility period

Other State Process for Medically Frail Determinations (cont.)

North Dakota

- Auto-enrollment into North Dakota Medicaid Expansion (total 20,000)
- Physician attestation was a required from the beginning of Medicaid Expansion in North Dakota, as the State did not want to rely on only Self-attestation.
- Questionnaires filled out by provider and submitted to State and reviewed by a Medical Professional (1 RN in state) and scored
- State Physician is only involved in unusual eligibility determinations
- If they do not meet the criteria for Medically Frail, RN sends a letter saying they don't meet criteria and their appeal rights
- Some submit Questionnaire to get vision and dental benefits not available under Expansion – these do not qualify

Other State Process for Medically Frail Determinations (cont.)

North Dakota

- If they do meet the criteria for Medically Frail, they are asked to have their provider sign the assessment or provide supporting documentation
- Providers, hospitals, nursing homes, social workers, caseworkers often initiate the process of the Medically Frail Questionnaire if they know someone will need longer or permanent long term care – they are familiar with available benefits from Traditional Medicaid, what qualified the applicant, and these requests are generally legitimate and are approved
- If a separate physician visit is necessary it is paid by the patient, but usually it is handled as part of some other billable visit

- Currently it is a cumbersome process for the RN to notify the county eligibility workers that someone is Medically Frail

Continue Task Research

- Pharmacy
  - Vaccine rate research
  - OMIG – Opiod
- More data on HCIP population (SNAP/TANF/Unemployment Benefits)
- Work engagement and automated verification with Workforce
- Public Integrity Barriers
- Eligibility Hub – DHS short term and long term plan and reach out to DFA
- Task Force Recommendation Project Management Spreadsheet (admin/waiver/statute/rule/)
- Meet with Carriers to understand expansion of SHOP concerns