Arkansas Health Care Reform Task Force

TSG Update Report

November 24, 2015

Follow up from 11/10/15 Task Force Meeting

- Pharmacy Savings
- Pharmacy Quality Improvements
- Vaccination Findings and Recommendations
- Lockout follow up
- Premium collection
- DRG Workgroup update
- Marketplace Plan Update
- Nursing Home Census/ Waiver age distribution
- Review of Care Management Models Contracting Issues
- Potential Models and Savings Assumptions/Estimates
- Ark Works Alternative Proposal (PCMH/Shared Savings)

TF Recommendations

Pharmacy Savings

- Re-contract the retail pharmacy network
  - Consider differential rates for underserved areas
  - Improve brand ingredient cost discounts
  - Improve brand and generic dispensing fees
  - Annual program savings up to $18.3 million
- Expand the PDL
  - Consider joining a multi-state rebate pool
  - Remove requirement for evidence-based reviews
  - Annual program savings up to $22.75 million

TF Recommendations

Pharmacy Quality Improvements

- Opioid Use and Management
  - Increase the use of pharmacy lock-in
  - Add prescriber lock-in
  - Allow DHS clinicians access to State Prescription Monitoring Program
- Eliminate pharmacy claim limits for maintenance medications
  - Create the maintenance medication list
  - Reevaluate the claim limit for non-maintenance medications

Vaccinations Findings

Primary Care Vaccinations

- Low vaccination rates
  - Children
  - Teens
  - Adults
- VFC
  - Vaccines are free to providers
  - Administration fee $9.56
- Adults vaccine & administration fee reimbursement combined
  - Not common in other states reviewed

Vaccination Findings (cont.)

Primary Care Vaccinations

- AR PO Carriers reimburse vaccine and administration fee separately
- CY 2014 vaccines counts
  - 11,010 adults
  - 186,475 children

TF Vaccinations Recommendations

Primary Care—Vaccinations

- Goal: Improve vaccination rates in Arkansas
- Update provider reimbursement
  - Separate the reimbursement of ingredient cost and administration fee for adult vaccines
  - Cover the ingredient cost
  - Offer a fair administration fee per vaccine administered
  - Re-evaluate the VFC administration fee $9.56
- Expect increased vaccination rates
  - Reevaluate progress periodically
  - Consider adding secondary measures

Lockout History Research

- Indiana - 7% of beneficiaries at 101-138% FPL (3,924) failed to make a required monthly contribution to the POWER account and were dis enrolled in 2012. The same report gave the percentage of members who were dis-enrolled for failure to pay the contribution for the previous years as: 1.7% for 2008, 3% for 2009, 3% for 2010, and 3.3% for 2011. The total number disenrolled over the 5-year demonstration period was 12,490 (source: 2012 Indiana Health Improvement Program Annual Report)

Year	Members who failed to make subsequent contributions and were disenrolled (from 2012 Annual Report)	
2008	1.7%	n/a
2009	3%	n/a
2010	3%	n/a
2011	3.3%	n/a
2012	7%	3,924
Total		12,490

Premium Collection

- **Indiana**
  - Health Plans are required to collect premiums
- **Iowa**
  - Premium collection was implemented in January 2015. As of November 1, 2015, ongoing operational costs have been approx $20,000 for IT monthly support, $40,817 for PO box maintenance and business reply postage, plus miscellaneous bank fees (e.g., returned checks for NSFs).
  - Premiums collected totaled $476,205 out of $1,399,645 invoiced.
  - Phase 1 implementation of premium collection was approximately $500,000. The implementation of the remaining component is expected to be an additional $500,000.
  - Premiums $10/month for incomes at 100-138% FPL waived with completion of 2 healthy behavior requirements within 2-months

- Source: Deanna Jones, Iowa Dept of Human Services, djones1@dhs.state.ia.us

DRG Workgroup Update

- Review
  - All-Patient Refined Diagnosis Related Groups are a way of classifying patients based on their diagnosis and severity
  - Payment using APR-DRGs generally aligns a different weight with each diagnosis and level of severity
  - Weights are multiplied by base rates which can be hospital specific or based on type of hospital
- Workgroup met 11/16
- Presentations from 3M (developer of APR-DRGs), UAMS, ACH, AHA, and BCBS

Marketplace Plan Updates

Marketplace Plans that Qualify for Subsidies

- There are two types of subsidies for individuals purchasing health insurance on the individual market (through the marketplace or otherwise)
  - Cost-sharing reduction (100-250% FPL)
  - Premium tax credits (250-400% FPL)
- Cost-sharing reductions are only available through the marketplace, and only on silver plans
- Premium tax credits can be applied to any metallic plan type

Marketplace Plan Updates (cont.)

Using Bronze Plans for Private Option

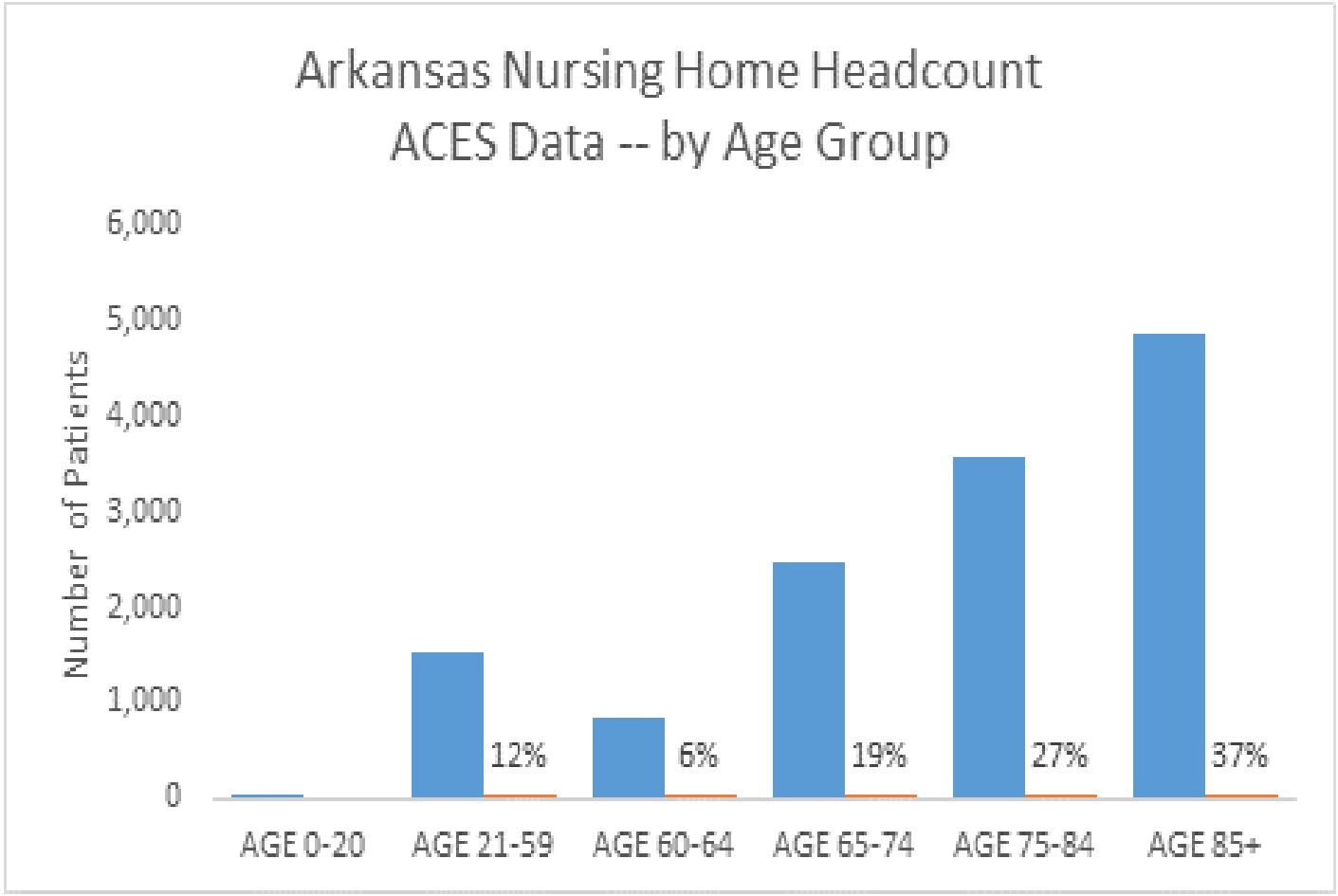
- The plans sold on the private option are silver plans, with the same plan design as silver plans sold through the marketplace.
- Bronze plans are valued at 60% of the actuarial value of the benefit; silver plans at 70%
- Assuming CMS maintains the same standards for maximum out of pocket for PO enrollees, the cost-sharing reduction would back-fill bronze plans up the same level as silver plans
- The CSR reconciliation would apply to the CSR component of payment, and medical loss ratio (MLR) reconciliation would apply to the premium component of payment
- Depending on the actual claims experience, some small savings could potentially be recognized, absent other costs

Marketplace Plan Updates (cont.)

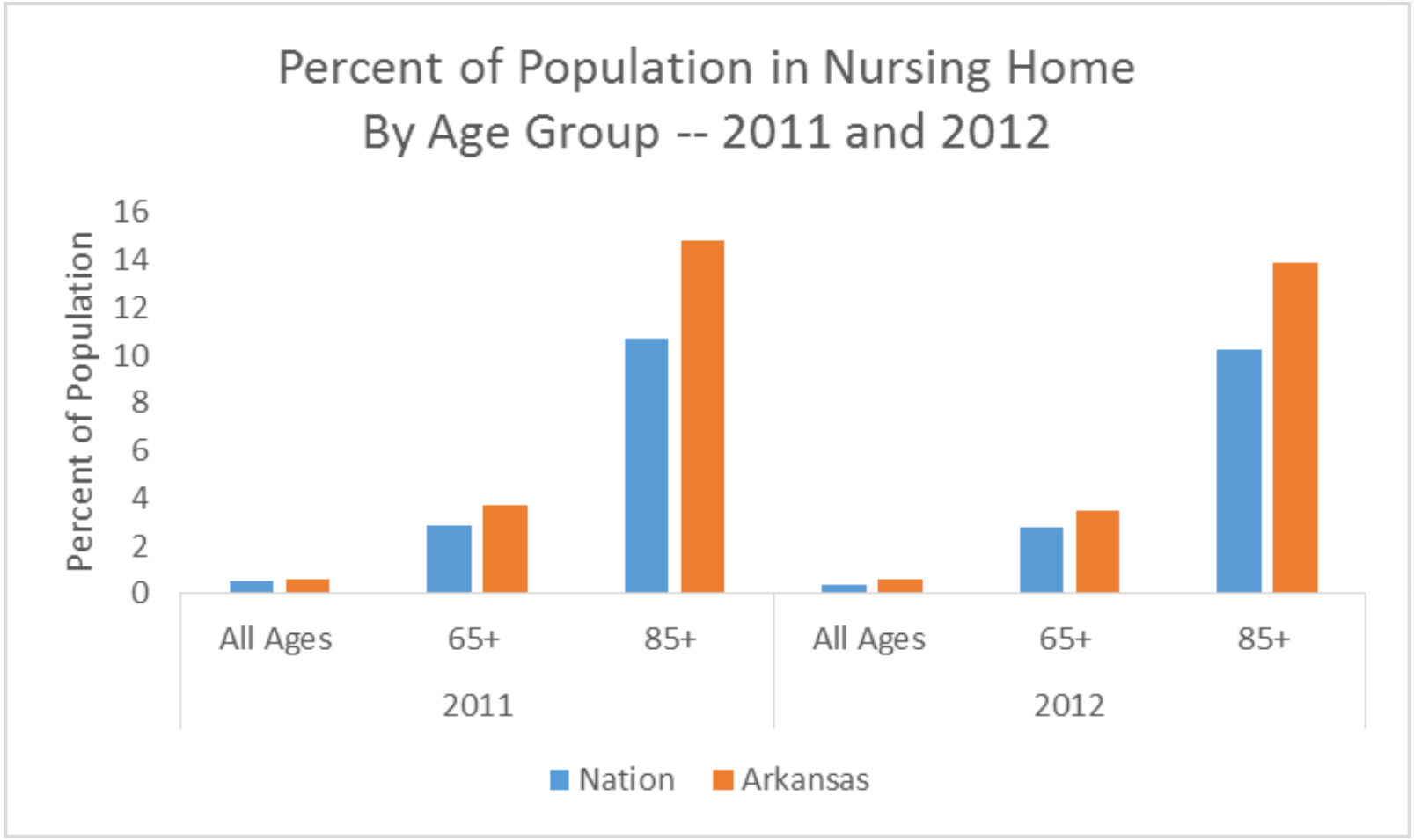
Using Bronze Plans for Private Option

- Using different plans than are already on the marketplace and eligible for subsidies (i.e., high-value silver plans) would require the following:
  - Carriers would need to develop new processes and systems for using the new plan structures
  - Carriers would need to go through a new regulatory filing
  - DHS would need to develop new procedures and make system changes for dealing with the new CSR structure
- Because carriers would incur new costs, they would price those costs into the premiums, pushing premiums up
- Any slight savings are likely to be offset by new costs
- We will be discussing with the carriers to get additional feedback

Arkansas Nursing Home Residents By Age Group (Source: Ark DHS)



Arkansas Population in Nursing Home 2011 and 2012 (source: CMS 2013 Nursing Home Data Compendium,)



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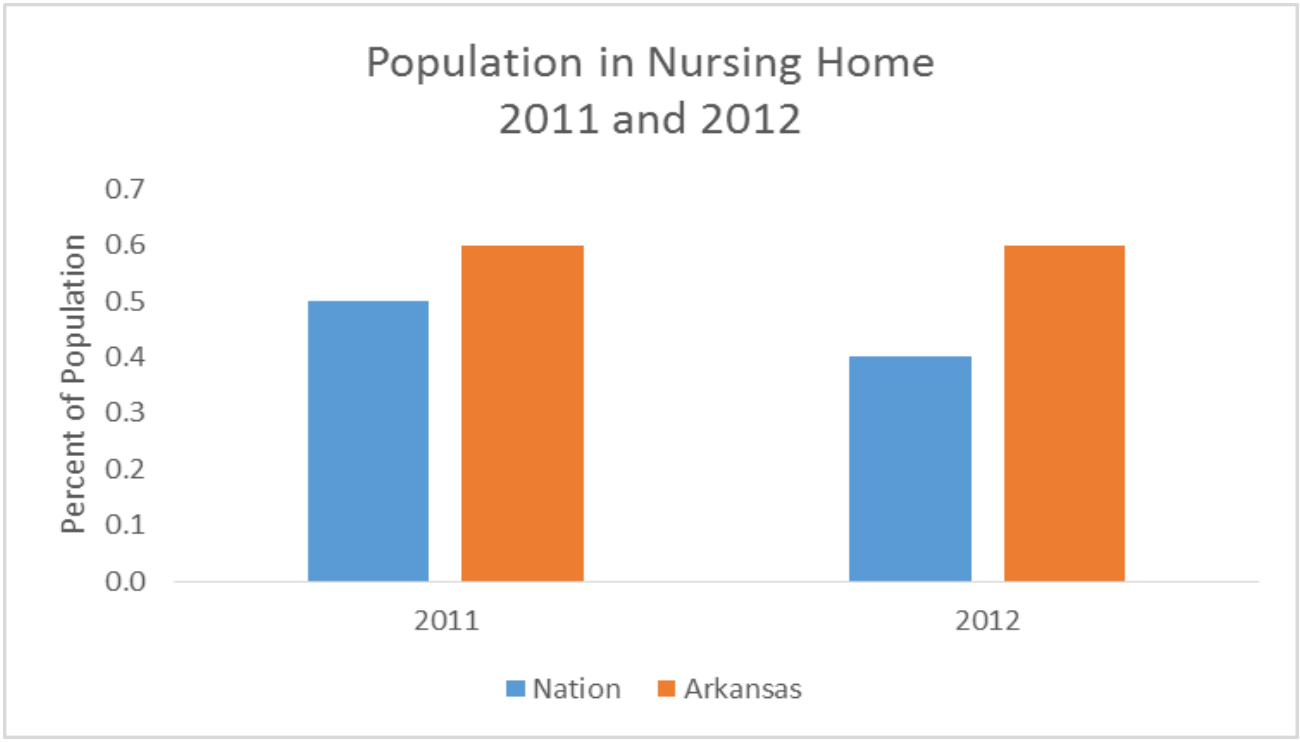
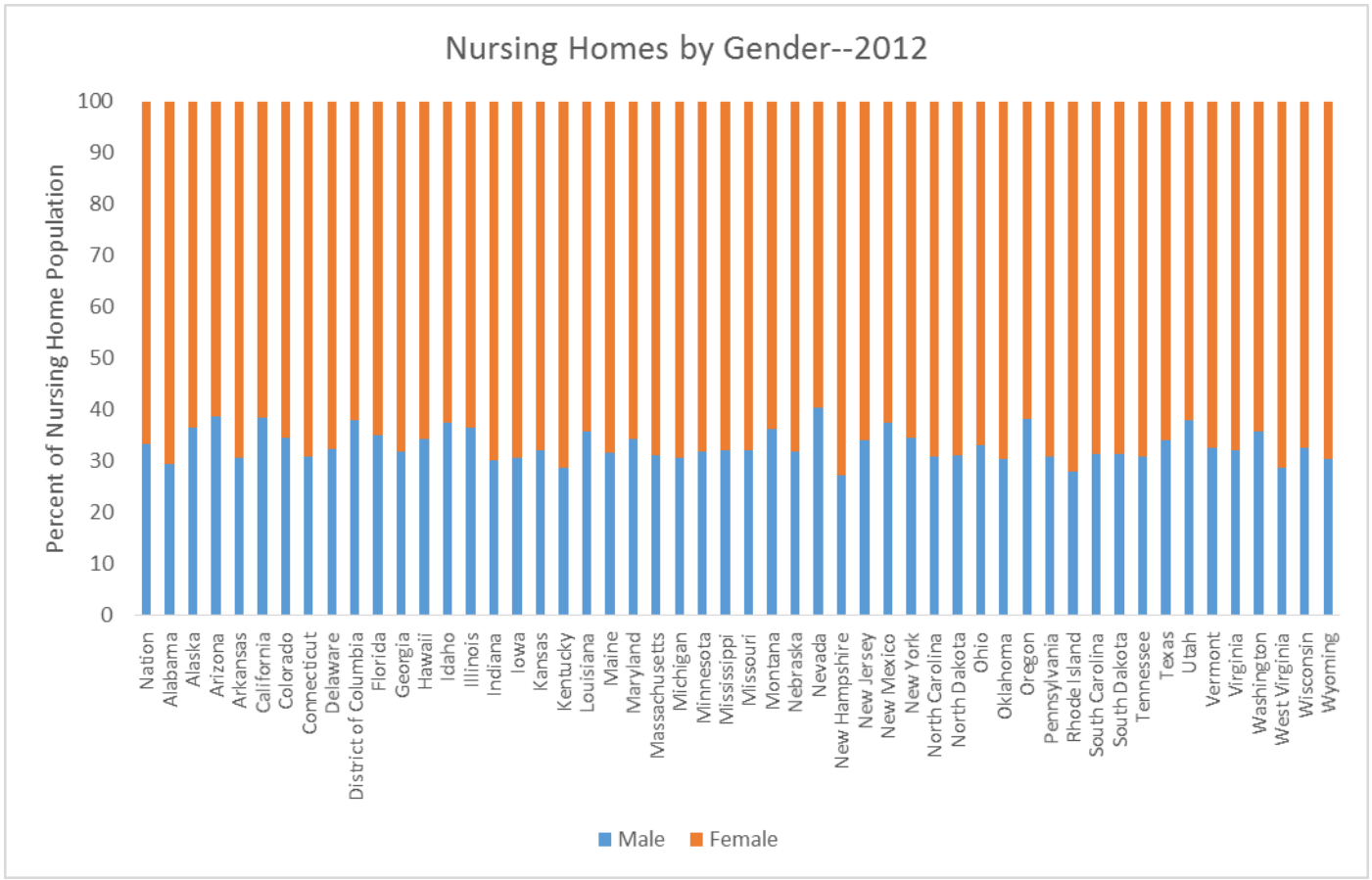
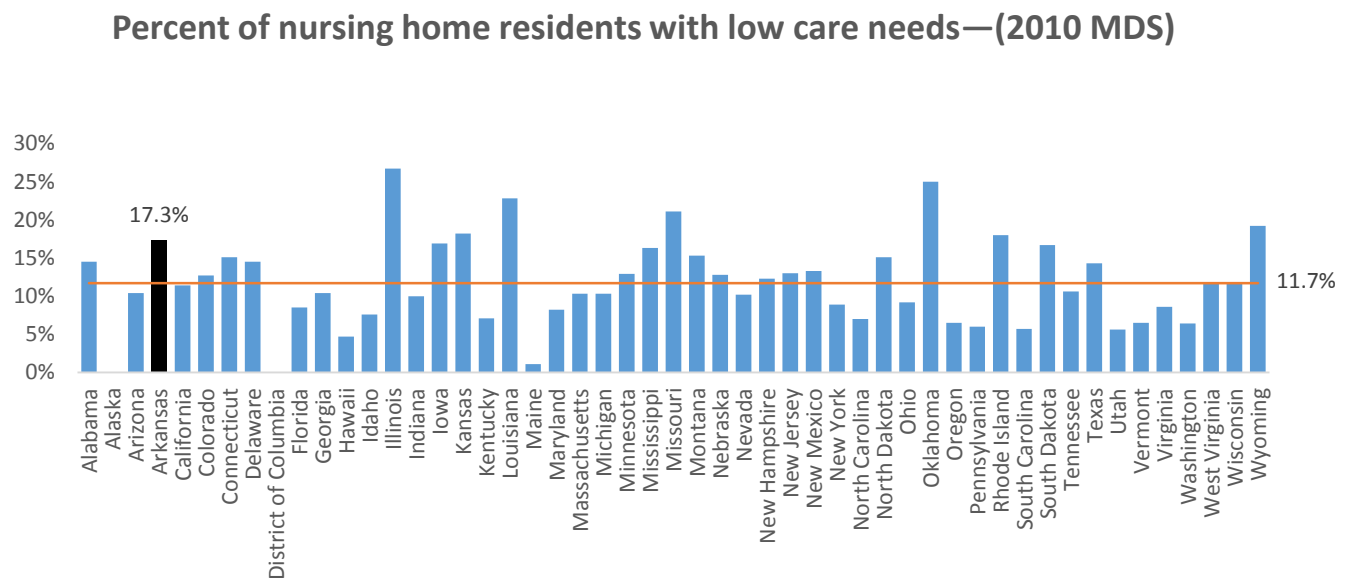


Arkansas Nursing Home Residents By Gender 2011 to 2012 (source: CMS 2013 Nursing Home Data Compendium,)



Percentage of Nursing Home Residents with Low Level of Care



- **Percentage of nursing home residents with low care needs:** Percentage of nursing home residents aged 65 and older who met the criteria of having low care needs. Low care status is met if a resident does not require physical assistance in any of the four late-loss ADLs (bed mobility, transferring, using the toilet, and eating) and is not classified in either the "Special Rehab" or "Clinically Complex" Resource Utilization Group (RUG-III) groups. Low care status may apply to a resident who is also classified in either of the lowest two of the 44 RUG-III groups. Analysis of 2010 MDS data as reported in LTCFocUS.org by V. Mor at Brown University, under a grant funded by the National Institute on Aging Program Project grant (#P01-AG027296, Shaping Long-Term Care in America). State-Level Care Data (CMS, MDS n.d.). Baseline data from same source.

Arkansas Population Age in ElderChoices and AAPD Waiver

- 5,286 unduplicated recipients in the ElderChoices waiver with ages ranging from 65 to 106 - Median age is 79
- 2,238 unduplicated recipients in the AAPD waiver with ages ranging from 21 to 64 - Median age is 52
- 7,524 unduplicated recipients in the combined waiver with the following age demographics:
  - Median age is 73
  - 42 are centurions with the oldest 106
  - 22 are age 99
  - 156 are between the ages of 95 – 98

  - Source: Ark DHS, November 2015

State Care Management/Medicaid Payment Reform Models: 2014

- Managed Care/Capitated Full Risk Based: 26 states: AZ, CA, DE, GA, HI, KS, KY, MI, MN, MO, NE, NV, NH, NM, NY, OH, OR, PA, SC, TX, TN, UT, VA, WA, WI, MS
- MCO and PCCM (Primary Care Case Management): 13 states: CA, CO, FL, IA, IL, IN, LA, MA, NV, ND, RI, WA, WV
- PCCM only: 9 states: AL, AR, ID, ME, MT, NC, OK, SD, VT
- No comprehensive MCO: 3 states: AL, CT, WY
- ACO in place: 8 states: CO, IA, IL, MN, OR, SC, UT, VT (CA, MD, ME, NJ, PA planned for 2015)

Some States Have Moved Away from Medicaid Managed Care

- Oklahoma
  - Established “SoonerCare”, a fully-capitated managed care program in 1995
  - Initially LTSS not included; added in 1999
  - Shut-down in 2004 after MCOs requested significant rate increases
  - Recent legislation (2015) directs the Oklahoma Health Care Authority to request proposals from independent vendors for the coordination of care for the ABD population

The Connecticut Medicaid Program

- From 1995-2010 the state used some form of managed care for children and low income families; ABD population/waivers have always been fee for service.
- In 2010, the state switched back to Fee For Service
- Based on concerns about access, profitability, and coordination challenges the state decided to terminate the managed care model and revert to fee for service for all populations based on a PCP-PCMH-Health Neighborhood model managed by a contracted Administrative Services Organization.
- The Community Health Network of Connecticut was contracted by DSS as the full Medicaid HUSKY program Administrative Services Organization on 1/1/12.

The Connecticut Medicaid Program

- From FY 2010 – FY 2014 CT annual rate of growth of total Medicaid budget was 5.9% compared to national rate of 5.2% and AR rate of 5.6%
- Total CT FY 2014 Medicaid budget: $7,231 billion
- Connecticut continues to have a comparatively expensive Medicaid Program:
  - FY 2014: Full Benefit Enrollee: CT: $8,122; AR: $6,258; US: $6,502
- Connecticut's 2014 population was 3,578 million people with a household median income of $70,161 compared to US average of $53,657 and Arkansas average of $44,922.

The Story in Kentucky

- 2013 problems with KY MCO contracting included excessive profitability, slow provider payments, complicated MCO practices for providers and beneficiaries, and access issues in the Appalachian region. The decision of the Kentucky Spirit MCO to "quit" its contract in 2013 led to major beneficiary confusion and litigation.
- The state re-bid the managed care system in 2014 and awarded new contracts that limited profitability, reframed claims payments, and simplified procedures to Anthem, Coventry, Humana, Passport, and WellCare on 7/1/2015.
- KY MCO Dashboard indicates that all MCOs are meeting member/physician specialty access proximity requirements, claims payments in 30/90 days, and prior authorization targets as of 10/1/2015.

Background and Current Status of Iowa Managed Care Initiative

- Gov. Terry Branstad announced plan to implement full Medicaid program managed care as part of 2014/2015 budget without prior Legislative or significant provider/stakeholder input; leveraged $51 million in projected budget savings.
- Iowa Medicaid Enterprise primarily staffed by contractors with few state government employees with comprehensive managed care experience, which caused delays.
- RFP process has been controversial; three losing bidders seeking legal action concerned about bidding process transparency.
- Managed care contracts signed by DHS 10/9/2015.
- CMS has addressed concerns to Iowa DHS on the time frames for full implementation, access, continuity and quality of care.

Background and Current Status of Iowa Managed Care Initiative

- As of 11/19/2015 Iowa announced that 42,000 providers have signed MCO contracts including 740 pharmacies, 2,571 MDs/DOs, 576 long term care and support facilities, and 4,500 home and community based services providers.
- The Iowa Hospital Association has filed for an injunctive relief delay of implementation with the Polk County District Court. Most hospitals have not yet signed MCO contracts.
- CMS has scheduled a “readiness review” of Iowa’s capacity to go live 1/1/2016 for the first week of December, 2015.

FY 2016 Medicaid Managed Care Projected Savings

- The Menges Group conducted a national study to estimate the savings of Medicaid capitated care coordination managed care programs for FY 2016 on behalf of the Association for Community Affiliated Plans.
- The study method included states with existing capitated managed care programs/contracts.
- Medicaid populations were organized by eligibility: TANF & related persons; ABD; Dual Eligibles; and Other Categories.
- The study used an estimate of FY 2016 total Medicaid expenditures of $535.4 billion with $237.2 billion, 44.3% of the total, in capitated managed care programs.
- The study used a mix of expected utilization, no savings from physicians/clinics, eligibility category mix, volume, MCO use of similar FFS rates.

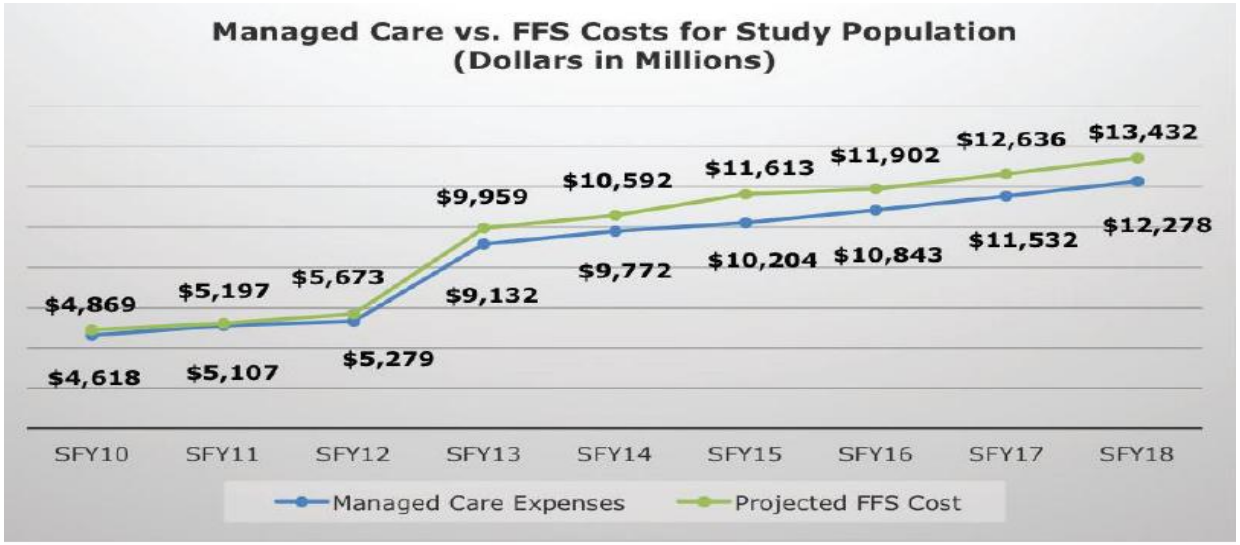
FY 2016 Medicaid Managed Care Projected Savings

- Findings of Neighboring States: Savings in decreased unnecessary ER use/hospitalizations, care coordination of multiple chronic conditions high cost cases including behavioral health and reduced use of unnecessary institutional care.

US/State	Estimated FY 2016 Capitated Managed Care Spending (Billions)	Per Cent Savings	Estimated FY 2016 Capitated Managed Care Savings (Millions)
US: 38 states	$237,325	2.7%	$6,366 (Billion)
Kansas	$1,710	4.1%	$69,296
Louisiana	$2,155	3.7%	$80,278
Missouri	$1,361	0.8%	$10,310
Mississippi	$1,579	3.5%	$55,417
Tennessee	$12,607	2.3%	$285,000
Texas	$19,006	2.9%	$548,964

Texas Medicaid Managed Care Savings

- Milliman study of Texas capitated managed care cost impact reported 5% to 10.7% reduced costs between SFY 2010 and SFY 2015 compared to estimated fee for service structure.
- Net savings estimated for the study period indicated $3.8 billion, 7.9%, total savings resulting in a $2 billion cost savings (10.2%)in the state's share of total costs.



Quality in Texas Medicaid Managed Care Programs

- Milliman/Sellers Dorsey conducted "A Review of Access to Services, Quality of Care, and Cost Effectiveness" of all Texas capitated managed care programs from 2009 through 2014.
- The study found that the MCOs provided strong network access adequacy to protect member's rights, engaged innovative solutions to provider specialty shortages and after hours urgent care, and offered no cost to the state added value beneficiary services targeting prevention and wellness.
- The Texas MCOs were found to have achieved:

➢ An average of 93% of child and adolescent members reporting having a PCP and 90% visiting their PCP during the year

Quality in Texas Medicaid Managed Care Programs

- Surpassed national performance expectations on child well visits and childhood immunizations
- No Interest List wait to access community based waiver services (LTC)
- High level of customer satisfaction with 83% of child members reporting overall positive experience with their health plan
- Cost savings for the state of 7.9% over fee for service
- Texas MCO children's health quality standards exceeded national standards in several key clinical conditions related to potential hospitalization:
- Asthma: Rates declined 22% from 2009 to 2011
- Diabetes Short-Term Complications: Rates declined from 25.18 per100,000 in 2009 to 18.58 per 100,000 in 2011, a 26% decrease

Quality in Texas Medicaid Managed Care Programs

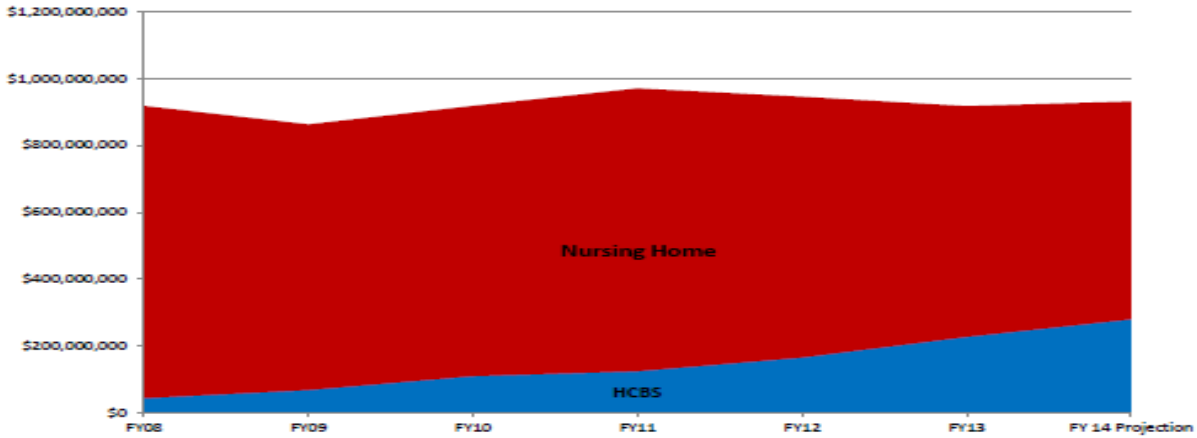
- Gastroenteritis: Rates decreased approximately 37% from 2009 to 2011. Moreover, rates of gastroenteritis in 2011 (45 per 100,000) fell substantially below HHSC Dashboard Standards (146 per 100,000)
- Urinary Tract Infection: Rates decreased by nearly 20% from 2009 to 2011. The 2011 rates (31) were significantly lower than the HHSC Dashboard Standard of 53 per 100,000
- Quality Standards for adults with disabilities resulted in:
- Diabetes Short-Term Complications rate decreased 31% between 2009-2011
- Bacterial Pneumonia rate decreased 19% between 2009-2011
- Urinary Tract Infection rate declined 31% between 2009- 2011

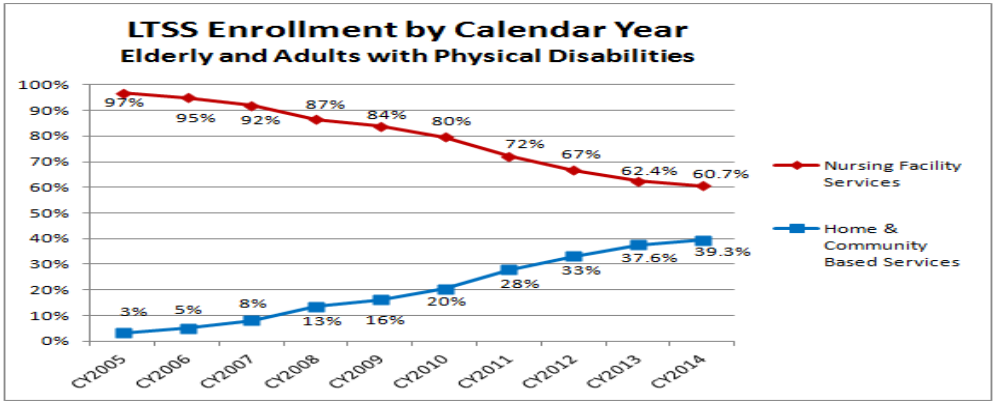
TennCare Quality and Cost Control

- TennCare currently exceeds HEDIS national averages in 64 of 99 measures.
- TennCare beneficiary satisfaction measure has exceeded 90% for the past six years.
- NCQA ranks TennCare MCOs at the “Commendable” level: based on HEDIS, CAHPS (AHRQ survey), and NCQA measures.
- In FY 2016 the TennCare capitated integrated managed care system saved $285 million compared to estimated fee for service system.
- TennCare’s comprehensive rebalancing of long term care, based on SB 4181, has resulted in budget neutrality in LTC and cost avoidance of $250 million between FY 2010 and FY 2014.

TennCare Quality and Cost Control

- TennCare LTC Budget Neutrality:





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Kansas Managed Care for LTSS Experience Update

- Presentation on Managed Long-Term Services and Supports in Kansas
- By Kari Bruffett, Secretary, Kansas Department for Aging and Disability Services - July 7, 2015

Why Reform?

(Source: Presentation By Kari Bruffett, Secretary, Kansas Department for Aging and Disability Services - July 7, 2015)

Kansas Medicaid and CHIP had used managed care models for children and families since the 1990s.

But Kansas Medicaid historically was not outcomes oriented.

The most complex consumers were in the fee-for-service model, with services defined by the programs they were in.

Fueled by fragmentation, costs rose at an annual rate of 7.4 percent over the decade of the 2000s. In Old Medicaid, budget concerns would trigger rate reductions and create waiting lists for certain services.

What Did Kansas Choose to Do?

Kansas developed KanCare, a coordinated managed care program for nearly all beneficiaries and services.

A centerpiece of KanCare was **integrating managed long term services and supports (MLTSS) with physical and behavioral health**.

After an initial one-year delay of the inclusion of MLTSS for members with intellectual or developmental disabilities (ID/DD), now all HCBS services are included.

(Source: Presentation By Kari Bruffett, Secretary, Kansas Department for Aging and Disability Services - July 7, 2015)

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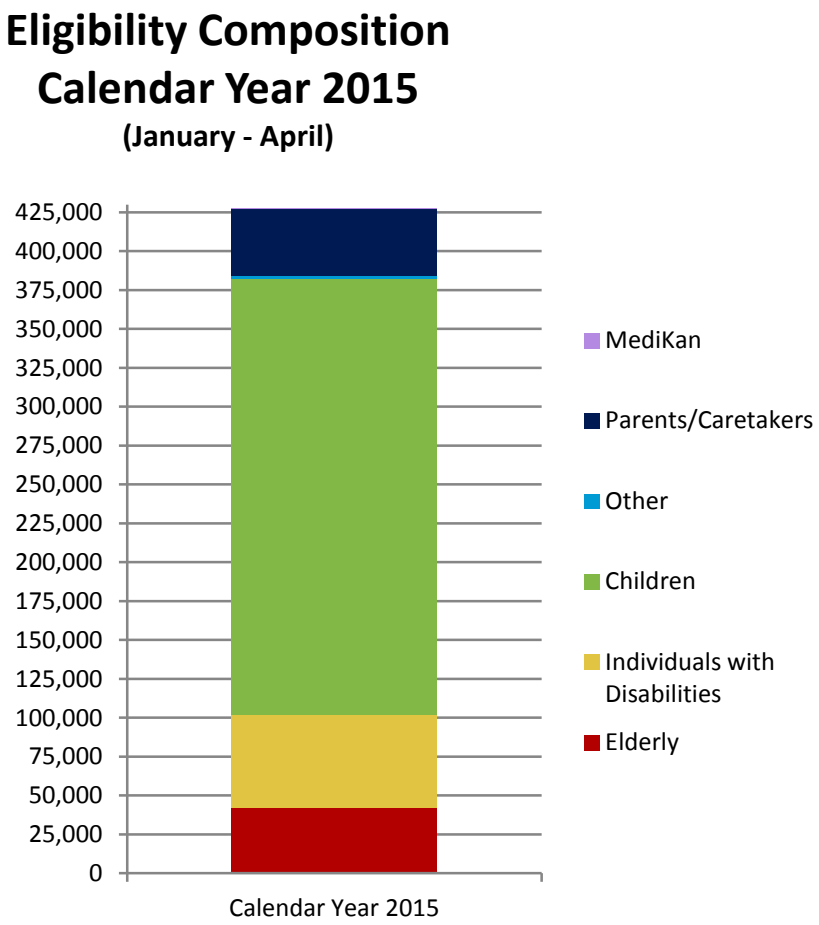
Who is Eligible?

(Source: Presentation By Kari Bruffett, Secretary, Kansas Department for Aging and Disability Services - July 7, 2015)



Who is Eligible?

More than 100,000 beneficiaries qualify as seniors or people with disabilities. (Source: Presentation By Kari Bruffett, Secretary, Kansas Department for Aging and Disability Services - July 7, 2015)

CY 2012	CY 2013	CY 2014
101,358	102,769	104,597

Timeline

- Summer 2011: Medicaid Public Forums/Webconferences
- November 2011: KanCare announced; RFP released
- January 2012: KanCare concept paper
- June 2012: KanCare contracts signed: **Statewide**
- August 2012: Section 1115 demonstration application
- Summer and Fall 2012: Educational tours across Kansas
- Sept-Oct 2012: Readiness reviews
- January 2013: KanCare Go-live
- Summer 2013: Public meetings; submission of amendment
- November 2013: I/DD readiness reviews
- February 2014: I/DD LTSS Go-live

(Source: Presentation By Kari Bruffett, Secretary, Kansas Department for Aging and Disability Services - July 7, 2015)

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How Was MLTSS Implemented?

- MLTSS run concurrently on the KanCare Section 1115 demonstration and seven 1915(c) waivers.

- While KanCare predated the 2013 CMS guidance on MLTSS, many of the key elements addressed in the guidance are reflected in the KanCare model.

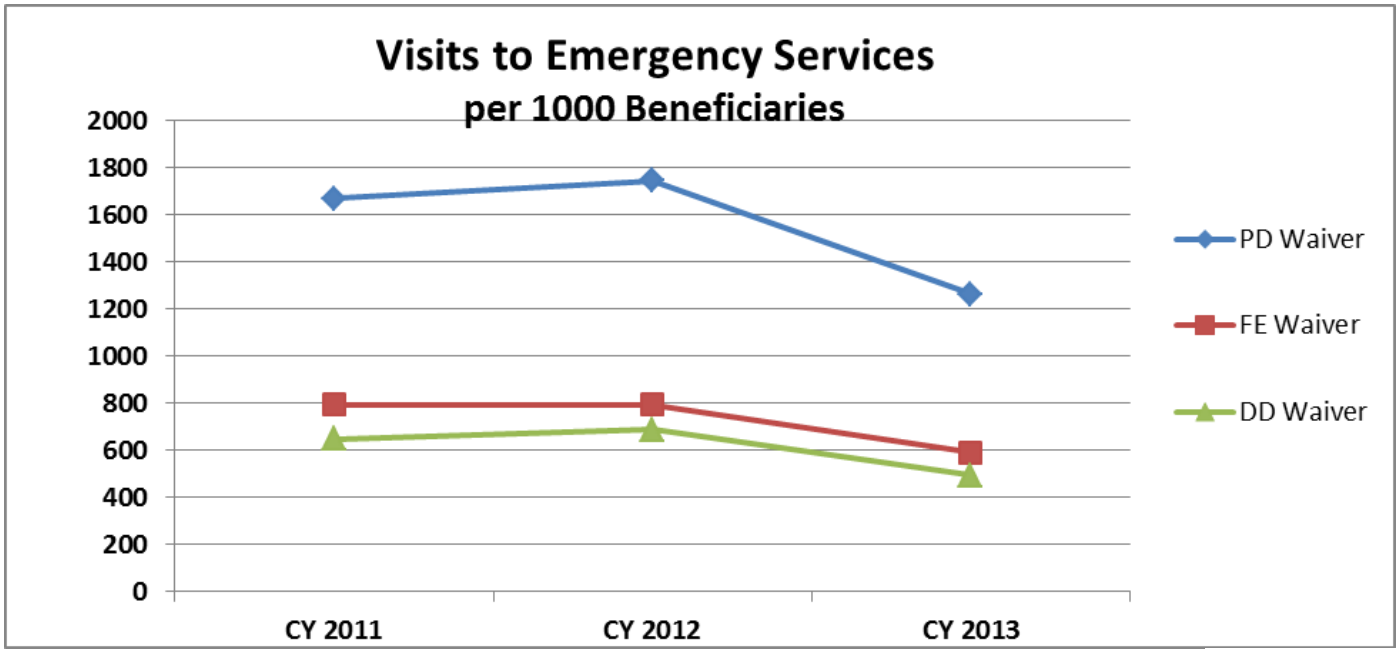
  Examples: Readiness reviews, rapid response calls, ombudsman, educational tours, blended rate cells and performance measures to incentivize community integration

(Source: Presentation By Kari Bruffett, Secretary, Kansas Department for Aging and Disability Services - July 7, 2015)

How Is It Working?

Snapshots:

- In just the first year, Emergency Room usage for HCBS Waiver program participants was reduced by 27%.
- (Source: Presentation By Kari Bruffett, Secretary, Kansas Department for Aging and Disability Services - July 7, 2015)



How is it Working?

- Primary Care utilization increased 31%.

- Also saw increased use of:
  - Dental
  - Vision
  - FQHCs/RHCs

- Decreased days:
  - Inpatient hospital

(Source: Presentation By Kari Bruffett, Secretary, Kansas Department for Aging and Disability Services - July 7, 2015)

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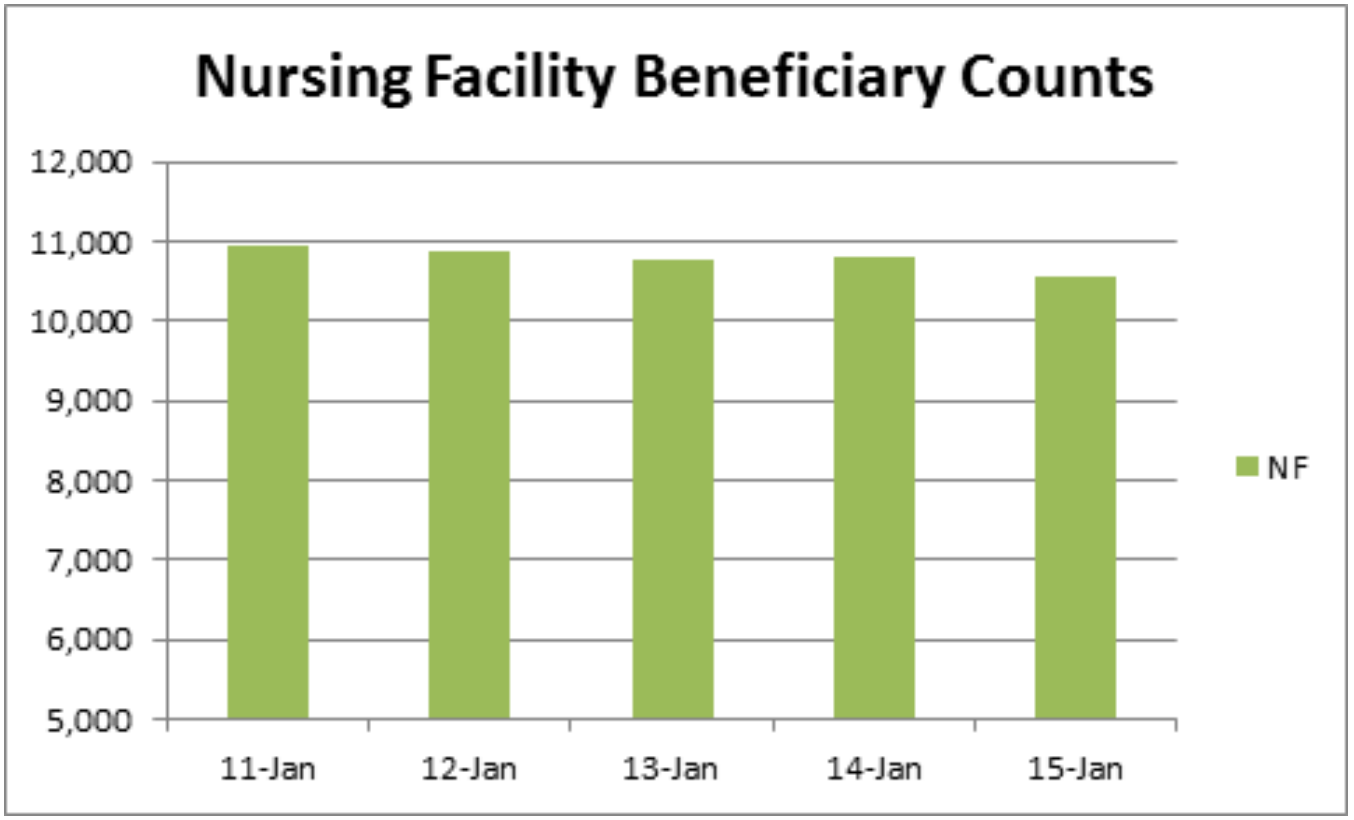
How Can We Improve?

(Source: Presentation By Kari Bruffett, Secretary, Kansas Department for Aging and Disability Services - July 7, 2015)



Waiting List: Current Efforts

Since the inception of KanCare, 3,100 people from the Physical Disability and Intellectual/Developmental Disability waiting lists have been offered services.

PD Waiting List

- 1,448 people are currently on waiting list
- Services have been offered to individuals who have been on the waiting list through May 2014

I/DD Waiting List

- 3,319 people are currently on waiting list
- The "underserved" waiting list has been eliminated

(Source: Presentation By Kari Bruffett, Secretary, Kansas Department for Aging and Disability Services - July 7, 2015)

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ID/DD Transition

Enhanced implementation protections:

- Provider- and consumer-focused education sessions and issue logs
- Friends and Family engagement in design of consumer communications
- Extended continuity of care period
- Easing of select systems edits during transition
- Collaborative care planning process
- State review of proposed reductions in plans of care

(Source: Presentation By Kari Bruffett, Secretary, Kansas Department for Aging and Disability Services - July 7, 2015)

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How is it Working?

- Low denial rate – 1.5% statewide for I/DD services, excluding duplicate claims denials
- Timeliness of claims processing – Average 6.4 days for HCBS/IDD, 5.7 days TCM/IDD
- Plan of Care – Reductions proposed and reviewed for <2.5% I/DD members in 1½ years
- Decreased institutionalization
- (Source: Presentation By Kari Bruffett, Secretary, Kansas Department for Aging and Disability Services - July 7, 2015)

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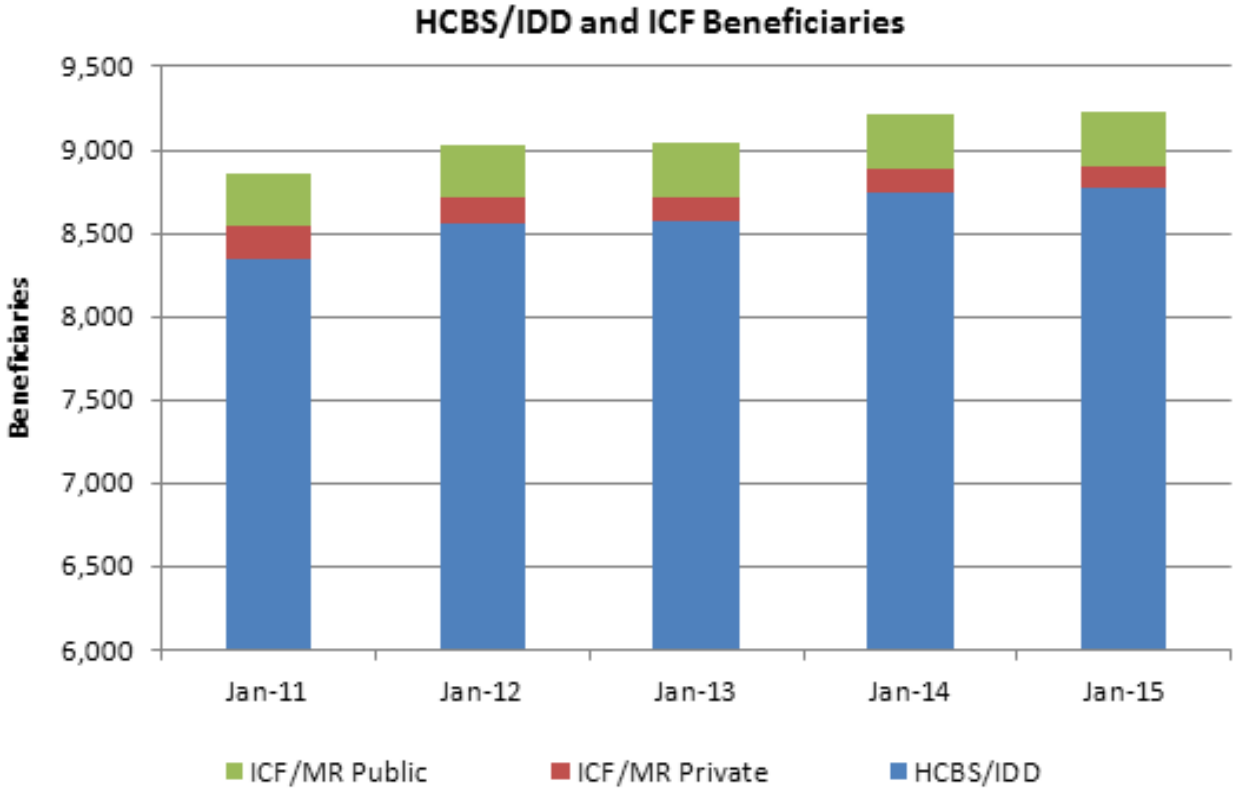
How is it Working?

(Source: Presentation By Kari Bruffett, Secretary, Kansas Department for Aging and Disability Services - July 7, 2015)



New Wave of Challenges & Opportunities

- HCBS settings rule
- Proposed Medicaid managed care rule
- Opportunities to build on the person-centered nature of KanCare
  - Through first four months of CY 2015, MCOs had provided almost $1.4 million of “in lieu of” services to more than 600 members.

(Source: Presentation By Kari Bruffett, Secretary, Kansas Department for Aging and Disability Services - July 7, 2015)

More Resources

For more information about KanCare:

www.kancare.ks.gov

Other State Examples of Documented Managed Care Cost Savings

- Kansas: Governor's budget for FY 2016 includes $50 million in state funds Medicaid match as a result of implementation of full integrated managed care contracting. Savings have been targeted to address the IDD HCBS waiting list.
- Ohio's FY 2012/2103 Medicaid budget results were $360 million in state match funds below budget. Based on full implementation of managed care in FY 2015 Ohio's Medicaid budget results were $1.8 billion below the appropriated budget of $25.5 billion, 7.6%.
- Louisiana: The state's Medicaid capitated managed care covered 600,000 of 900,000 covered lives in FY 2014. the state achieved a total savings of $135.9 million in FY 2014, a 12% reduction.

Care Management Contracting Issues: Incentives and Sanctions

- Incentives and Sanctions are contracting tools in a risk based contract that states employ to achieve performance objectives related to clinical, evidence based practice and health status improvements and compliance.
- Generally, financial incentives are used to motivate pre-determined clinical outcomes such as unnecessary institutional utilization, child and adult well care visits (PCMH), evidence based practice for identified conditions (Episodes of Care), and a growing emphasis on population health outcomes such as diabetes self management and infection reduction.
- Sanctions are generally monetary penalties for non adherence to contract compliance requirements such as paying claims in the prescribed time period, failure to provide medically necessary care, late filing of financial/HEDIS reports, etc.

Review of Care Management Models Contained in TSG's Savings Estimates

- Baseline – Current program framework; partial managed FFS, no capitated managed care
- Scenario 1 – All managed FFS
- Scenario 2 – Managed FFS for low-cost populations, capitated managed care for high-cost populations
- Scenario 3 – Capitated managed care for all populations

- Note: Managed FFS includes PCMH and health homes, but potentially other models as well, including versions using private management companies under non-capitated models. In the TSG recommendations the managed FFS model (PCMH), includes value-based purchasing/shared savings ***and shared risk***

Potential Care Management Models and TSG Assumptions/Estimates

- Main assumption based on recent analysis from Louisiana of both a shared-savings model that is similar to the Arkansas PCMH initiative, and a capitated managed care model
- Louisiana findings
  - Shared savings model saved about 6.8% compared to the traditional fee-for-service model
  - Capitated managed care saved about 12.7% compared to the traditional fee-for-service model
- Cost-savings estimates of shared savings, PCMH, and related programs; and capitated managed care models from other states are consistent with those found in Louisiana.

Potential Care Management Models

Modeling Assumptions

- Louisiana estimates used here
  - Estimates of cost-saving for shared savings and capitated managed care are from the same state
  - Estimates are developed using the same methodology
  - Medicaid population in Louisiana is similar to that in Arkansas
- HCPII is likely already capturing some of the potential savings from a shared-savings or PCMH model
  - For estimating the marginal impact of an expansion of the HCPII, it is assumed that about half of the potential savings from that model (about 3.4%) remain to be captured.
  - For the capitated managed care estimate, it is assumed about 9.3% in additional savings to be captured.

Potential Care Management Models

Modeling Assumptions

- Baseline model assumes 5% across-the-board growth rate
- All of the models assume about a 2 year ramp-up period beginning immediately, with cost-savings beginning to accrue in SFY2018

Potential Care Management Models

Savings Estimates

Projected Medicaid Expenditures and Savings with Different Program Structures ($millions)							
SFY		2017	2018	2019	2020	2021	Total (2017-2021)
Baseline all-funds spending - current program framework; partial managed FFS, no capitated managed care		5,688	5,973	6,271	6,585	6,914	31,431
All -funds savings against baseline							
Scenario 1 - All managed FFS	Savings	0	164	173	181	190	708
Scenario 2 - managed FFS for low-cost populations, capitated managed care for high-cost populations	Savings	0	373	391	411	431	1,606
	Premium tax	0	80	84	89	93	347
	Total all fund impact	0	453	476	500	525	1,953
Scenario 3 - capitated managed care for all populations	Savings	0	448	470	493	518	1,929
	Premium tax	0	109	115	121	127	471
	Total all fund impact	0	557	585	614	645	2,400

Common Service-Level Cost-Savings

Overview

- Savings from capitated managed care and managed fee-for-service often come from management of different services, including the following:
  - Long-term services and supports in the form of rebalancing
  - Drugs through more aggressive price negotiation or prior authorization
  - Decreased use of the emergency department
  - Proper Behavioral Health and Developmental Disability utilization – right service, right time and right place
- Other service-level cost-savings can be captured regardless of the care management strategy and even without a care management strategy
  - Program integrity
  - Drugs through broader PDL
  - Administrative and contracting efficiencies

Common Service-Level Cost-Savings

Rebalancing LTSS

	Nursing Facilities				Community-based Care				Total cost $millions
	Census	Cost per capita	Total cost, SNF $millions	% of all LTSS	Census	Cost per capita	Total Cost, community $millions	% of all LTSS	
Estimated 2015	11,958	64,295	757	65%	14,847	27,453	408	35%	1,165
2021 without rebalancing	14,278	73,131	1,044	65%	17,995	31,226	562	35%	1,606
2021 with rebalancing	9,695	73,131	709	50%	22,568	31,226	705	50%	1,414

Common Service-Level Cost-Savings

Rebalancing LTSS

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2021 with rebalancing	9,695	73,131	709	50%	22,568	31,226	705	50%	1,414

14,278/11,958 – 1 = 0.194 ~ 19%

2015-2021 -> 6 years

1.03^6 – 1 = 0.194 ~ 19%

Common Service-Level Cost-Savings

Rebalancing LTSS

Arkansas LTSS Expenditures ($millions)						
	2017	2018	2019	2020	2021	2017-2021
All LTSS without rebalancing	1,318	1,385	1,455	1,529	1,606	5,975
All LTSS with rebalancing	1,318	1,330	1,350	1,377	1,414	5,471
Savings (all funds)	0	55	105	151	192	504

Common Service-Level Cost-Savings

Contracts

	FY16 Contract Spend	Change in a PCMH model	Change in an MCO model
FY16 Spend on the top 25 contracts	$62,691,762		
Savings from discontinuing contracts (already planned by DHS)		$18,929,554	$18,929,554
Savings from renegotiating contracts		$7,046,064	$ 4,100,000
Savings from reducing overhead costs		$1,796,970	$ 1,176,461
Costs shifted to an MCO			$16,191,357
Total Savings		$27,772,588	$27 to $40 M

[1] In the case of MCO, some intra-agency contracts go away. The savings from reducing overhead costs is less than the PCMH model because the entire contract moves to the MCO.

Common Service-Level Cost-Savings

Pharmacy

Savings Opportunity	Range of Annual Savings
Brand and Generic Drugs	
Estimated annual savings if DHS reduced the effective brand discount rate. (Range 0 to 2 percentage points)	$0.0 to $2.8M
Estimated annual savings if DHS decreased the brand dispensing fee. (Range of reduction is 0-$3)	$0.0 to $1.4M
Estimated annual savings if DHS decreased the generic dispensing fee. (Range of reduction is 0-$3)	$0.0 to $14.1M
Pharmacy Retail Network Re-contracting Subtotal	Up to $18.3M
PDL Expansion	Range of Annual Savings
For every 1% increase in Federal rebate return DHS could see additional rebates of $3.25 million annually (Range 0 – 4 percentage points)	$0.0 to $13 M
For every 1 percentage point increase in the number of claims covered by the PDL , DHS could see an additional $375K in supplemental rebates (Range 0-26 percentage points)	$0.0 to $9.75 M
PDL Subtotal	Up to $22.75 M
Grand Total Annual Pharmacy Savings Estimates	Up to $41.05 M

Common Service-Level Cost-Savings

Other Services

- Program integrity – $25 Million enhanced recoveries and cost avoidance (2017-2021)
- Restructure of behavioral health benefit – Not included as part of TSG rebalancing savings (Note: assumed to be part of managed fee-for-service (PCMH) and capitated managed care program savings)
- Developmental Disability rebalancing savings not included in rebalancing long term care savings estimates (Note: assumed to be part of managed fee-for-service (PCMH) or capitated managed care program savings)

Common Service-Level Cost-Savings

Total of Quantified Service-Level Cost-Savings

- These potential savings are not additive with the 'top-down' savings estimates for capitated managed care and managed fee-for-service
- The service-level cost-savings itemized below demonstrate how overall cost-savings attributable to capitated managed care or managed fee-for-service can be achieved

Service Line	Savings Range (2017-2021)
Rebalancing LTSS	$504 million
Contracts	$40 million - $110 million
Pharmacy	$205.25 million
Total	$749.25 million – $819.25 million

Alternate Proposal (Arkansas Works)

High-Level Program Features

Recommendation	Notes
Implement Mandatory Employer-Sponsored Premium Assistance	In TSG recommendations
Implement Premiums for Income with more than 50% of FPL	In TSG recommendations
Work Training Referrals Required for Unemployed or Underemployed	In TSG recommendations

Alternate Proposal (Arkansas Works)

High-Level Program Features

Recommendation	Notes
Strengthen Program Integrity of Traditional Medicaid and Arkansas Works	In TSG recommendations

Integrate and Promote Healthy Active Arkansas
• Provide health education with support from UA Extension Offices through the Healthy Arkansas Plan
  • Provide new enrollee Medicaid orientation
  • Possibly model education after Minority Health Commission protocol
	Some costs, potentially some savings long term. Not enough information or evidence to quantify.

Alternate Proposal (Arkansas Works)

Primary Care

Recommendation	Notes
Expand PCMH model (proven cost avoidance of 34 Million in 1st year of implementation)	Included in TSG managed FFS option
Include wellness exams and reimbursements to physicians for adult population on traditional Medicaid (currently not a covered service)	Not included in TSG recommendations and assume this will add costs to the traditional Medicaid program but may include long term savings based on reduced ER utilization
Stop further expansion of Episodes of Care	TSG Recommends to develop and deploy additional EOCs for specialty care only, assuming PCMH, particularly procedures. Unsure whether this will have any impact on savings estimates provided switch to value-based purchasing with risk

Alternate Proposal (Arkansas Works)

Primary Care

Recommendation	Notes
Increase reimbursements to providers for vaccinations to improve overall health (Arkansas is currently 50th in vaccination rates)	This recommendation will add costs to traditional Medicaid but may be off set by reduced hospitalization or complications by adult population (Difficult to estimate long term or short term savings standing alone without more detailed information)
Remove cap on number of office visits for Medicaid PCMH beneficiaries (currently at 12 per year; This fits in the PCMH model and will decrease hospitalizations and back end cost)	Some costs, potentially some savings long term. (Difficult to estimate long term or short term savings standing alone without more detailed information).
Increase or remove laboratory services cap for Medicaid PCMH beneficiaries (currently at $500 per year).	Some costs, potentially some savings long term. (Difficult to estimate long term or short term savings standing alone without more detailed information

Alternate Proposal (Arkansas Works)

Primary Care

Recommendation	Notes
Include limited reimbursements or visits for diabetes self-management (incentivize providers to educate beneficiaries)	Some new costs, possibly long term savings. Not enough information or evidence to quantify.
Review Prior Approval processes for cost effectiveness	Assume as part of TSG PCMH model and value-based purchasing
Promote telemedicine for Specialist Services	Some new costs, possibly long term savings. Not enough information or evidence to quantify.

Alternate Proposal (Arkansas Works)

Developmental Disabilities

Recommendation	Notes
Independent Assessment	Included in TSG recommendations
PCMH model led by local DD Providers in conjunction with Physicians	Included in TSG recommendations
Reform ACS Waiver - keep current 1915c Waiver, but reform	TSG recommendations prefer a Global Section 1115 Waiver, but reforming existing Waiver will increase likelihood to achieve PCMH savings

Alternate Proposal (Arkansas Works)

Developmental Disabilities

Recommendation	Notes
Revoke DDTCS as State Plan Amendment	Under TSG recommendations this would be accomplished through Global Section 1115 Waiver
Apply for a 1915i waiver to bundle and include current services (CHMS, DDTCS, Transportation, ST, PT, OT) based on assessed needs	TSG recommendations prefer a Global Section 1115 Waiver to accomplish same goal – would be no different in managed fee for service or capitated managed care
Develop supportive employment programs	In TSG recommendations and would include incentives in contract, either under managed fee for service or capitated managed care

Alternate Proposal (Arkansas Works)

Behavioral Health/RSPMI

Recommendation	Notes
Independent Assessment	Included in TSG recommendations
Implement Behavioral Health Home under PCP (PCMH model)	Included in TSG recommendations
Revoke State Plan Amendment	TSG prefers Global Section 1115 Waiver to achieve similar goal – although need more information here on intent
Apply for 1915i waiver (State can control costs and place caps on services)	TSG prefers Global Section 1115 Waiver to achieve similar goal – although need more information here on intent

Alternate Proposal (Arkansas Works)

Behavioral Health/RSPMI

Recommendation	Notes
Beneficiary must have diagnosis of mental illness and will require referral	Included in TSG Recommendations
Apply a tiered approach based on diagnosis and level of treatment and incorporate school based services into the tiered referral system with care coordination	Under TSG recommendations this would be accomplished through Global Section 1115 Waiver to achieve same intent – would be part of both managed fee for service and/or capitated managed care
Allow PCP to bill for behavioral health services in their offices	Some new costs, possibly long term savings. Not enough information or evidence to quantify.

Alternate Proposal (Arkansas Works)

Aging

Recommendation	Notes
Revoke personal care state plan amendment (State can control costs and place caps on services)	TSG recommendations would accomplish same goal under Global Section 1115 Waiver
Apply for waiver that would create bundling of services and eliminate duplicate services (ElderChoices, AAPD-Alternative for Adults with Physical Disabilities, Independent Choices, LCAL-Living Choices Assisted Living)	TSG recommendations would accomplish same goal under Global Section 1115 Waiver

Alternate Proposal (Arkansas Works)

Aging

Recommendation	Notes
Define benefit limits and conduct assessments	Not sure how this differs from earlier Recommendations – same would apply to both managed fee for service and capitated managed care
Place cap on beneficiaries	Not enough information
Place tiers on services	Not sure how this differs from earlier Recommendations – same would apply to both managed fee for service and capitated managed care

Alternate Proposal (Arkansas Works)

Long Term Care

Recommendation	Notes
PCMH model with care coordinated between Medical Director, Nursing Facility, and Community Based Services	Included in TSG recommendations
Utilize existing infrastructure of rural nursing facilities to provide care coordination and home & community based services	Included in TSG recommendations
Work to transition more beneficiaries to home care following rehab stays	Included in TSG recommendations

Alternate Proposal (Arkansas Works)

Long Term Care

Recommendation	Notes
Eliminate provisional rates	Not enough information but would not materially change savings estimates
Cap liability insurance reimbursement	TSG recommendation includes reviewing the issue of amount providers pay towards liability insurance and impact it is having on rates- Need more information here to identify any savings estimates or impact
Increase the threshold for population based methodology	Not enough information but would not materially change savings estimates

Alternate Proposal (Arkansas Works)

Pharmacy

Recommendation	Notes
Expand prescription drug list, including behavioral health meds (anti-psychotic)	Included in TSG recommendations
Give Medicaid access to prescription monitoring program	Included in TSG recommendations?
Explore multi-state prescription drug list (value based purchasing)	Included in TSG recommendations?
Move manual reviews by licensed psychiatrist from age 6 to 7, and eventually up to age 10 with evidence of continued higher cost avoidance	Could lead to additional savings but would need more detailed information - Savings here would apply to both managed fee for service and capitated managed care

Alternate Proposal (Arkansas Works)

Pharmacy

Recommendation	Notes
Add another 100 drugs to the CAP (Competitive Acquisition Program)	This initiative is already under way at DHS and would involve savings in either managed fee for service or capitated managed care
Remove prescription drug limits on maintenance medications	Some costs, potentially some savings long term. Not enough information or evidence to quantify standing alone.
Include reimbursement to pharmacy for immunizations, with certain criteria and referrals	Some costs, potentially some savings long term. Not enough information or evidence to quantify standing alone.

Alternate Proposal (Arkansas Works)

Dental

Recommendation	Notes
Managed Care, to include: • Dental Homes • Case Management • TPA Fee for Service	In TSG recommendation and would include savings in either managed fee for service or capitated managed care - TSG doing deeper review of dental managed care versus fee for service/TPL model

Alternate Proposal (Arkansas Works)

Hospitals

Recommendation	Notes
Implement DRG (Diagnosis Related Group) Model	Savings here would depend on policy decisions. Not enough information or evidence to quantify. Same savings would apply in managed fee for service or capitated managed care. TF study group reviewing this issue
Levelize reimbursement rates among state-supported institutions and private institutions	TSG needs more information here to determine short term or long term savings. Same savings would apply in managed fee for service or capitated managed care

Alternate Proposal (Arkansas Works)

Other

Recommendation	Notes
Develop Arkansas Works program, with proper EEF and Redetermination system approaches	Similar to TSG T-HIP
Provide each beneficiary with a "Health Scorecard" to promote wellness	Included in TSG recommendations
Create Legislative Oversight Panel for implementation and transition	Included in TSG recommendation

Alternate Proposal (Arkansas Works)

Other

Recommendation	Notes
Create an Implementation Team that consists of DHS employees, and policy experts	TSG assumes that TF will ensure competent implementation team under any scenario
Restructure DHS organizational chart to include: • Medicaid Unit that reports directly to the Governor • Add a Contract Procurement and Oversight Division	Similar to TSG recommendation
Legislative support for salary and line item max increase for DHS Director	Included in TSG recommendations

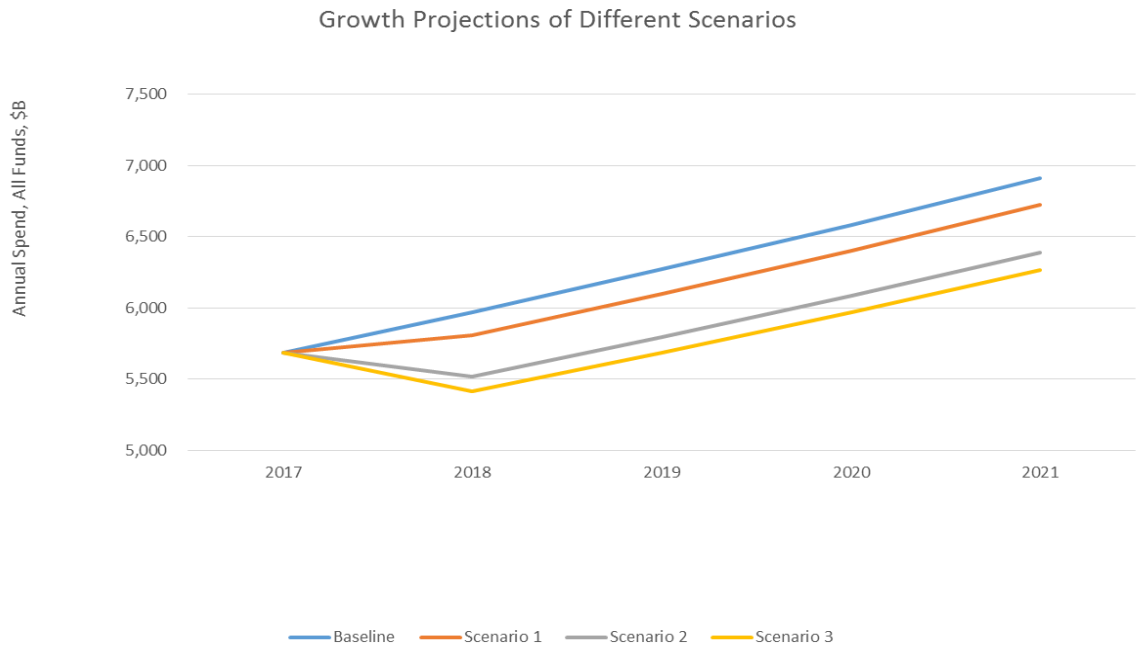
Alternate Proposal (Arkansas Works) Savings Estimate

- Not enough information to estimate cost impacts of a # of items
- However, the core recommendations that will drive the macro cost trend are reflected in the PCMH estimates for the TSG model (PCMH across the board for low-cost populations, health homes and independent assessments across the board for high cost populations)
- Thus, our opinion is that the service-line savings that TSG included for managed fee-for-service (PCMH) could also be mechanisms for saving money in the Arkansas Works model
- The same TSG managed fee-for-service (PCMH) savings estimate would apply to Arkansas Works – provided there are shared savings ***and shared risk*** across the board

Alternate Proposal (Arkansas Works) Savings Estimate

- However, TSG PCMH model explicitly includes upside and downside risk across the board, so in order to meet the TSG targeted estimate it must be assumed and recognized that each of the key provider components in the value-based contracting will share savings ***and share risk.***
- ***Note: Some of the Arkansas Works items are potential new cost drivers*** (ex***:*** removing caps on lines of service) – these policies are generally put in place to contain costs, so our preliminary assumption would be that removing them would increase costs. But, costing these out would require input data from the agency
- TSG assumes that any savings from PCMH model could be used for any of these additional costs

Potential Care Management Model Savings Estimates With Scenario 1 Being Arkansas Works (PCMH Shared Savings Model)



Care Management Contracting Issues to Consider: State Employees

- Different care management models will have different administrative implications for the agency
- McKinsey did some preliminary estimates of the typical number of state employees involved in managing different care management models
- Capitated managed care – McKinsey estimated that capitated managed care for the high needs populations (BH, DD, LTSS) would require an additional 20-30 FTEs, primarily augmented vendor management positions, but could lead to reductions in staff in other areas.
- Health homes – McKinsey estimated that managing the independent assessments and health homes for the three high needs populations would require about 80-120 new FTEs.

Care Management Contracting Issues to Consider: Administrative Implications

- Capitated managed care
  - Under a capitated managed care model, enrollees in all eligibility categories and regions must always have a choice between at least two MCOs
  - Numerous state policy decisions about how capitated managed care contracts are structured (e.g., regionally, by enrollee type, etc.)
  - For a state like Arkansas, it is common to have about four MCOs

Care Management Contracting Issues to Consider: Administrative Implications (cont.)

- PCMH and health homes
  - Under a PCMH and health home model, including high-needs populations, performance-based contracts would need to be in place with:
    - All PCMH groups bearing risk
      - Under the current approach, a PCMH group must have at least 5,000 Medicaid patients to qualify for the risk-based model)
      - Assuming average number of Medicaid patients within a group is twice that, there would be over 60 PCMH risk contracts to manage
    - All nursing homes bearing risk – over 130 nursing homes in AR
    - All DD providers bearing risk – harder to estimate because very dependent on program structure, but likely over 100
    - All BH providers bearing risk – likewise difficult to estimate and dependent on program structure, but also likely over 100
  - Overall, approximately 400 risk-based contracts to manage

Controlling Issue

- Who should manage these contracts to ensure:
  - Quality Performance
  - Access
  - Savings
  - Shared Risk
  - Provider Gainshare
  - Transparency
  - Improved Health Outcomes
  - Accountability

??????????????

Continue Task Research

- 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
- Gartner Report Review for TF (EEF)
- Decision Making Project Management Matrix Tracking - Task Force Recommendation Project Management tracking Spreadsheet (admin/waiver/statute/rule/)
- Assist in decision making
- Draft TF report at end of December