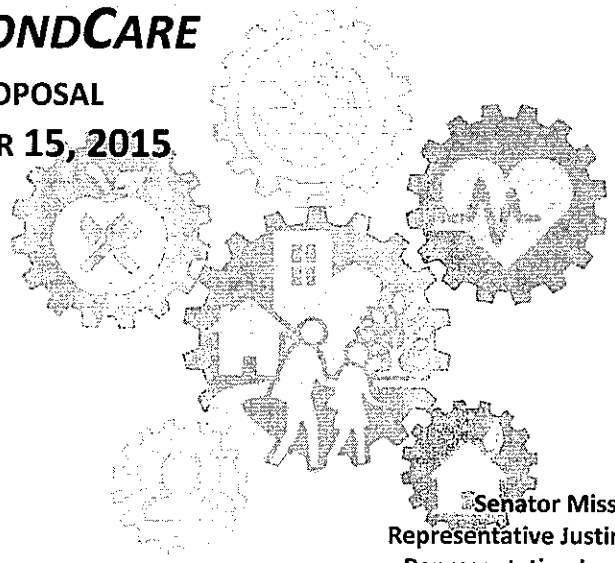
DIAMONDCARE

FINAL PROPOSAL

DECEMBER 15, 2015



Senator Missy Irvin
Representative Justin Boyd
Representative Joe Farrer
Representative Deborah Ferguson
& Representative Michelle Gray

Executive Summary

Objective

- The objective of the Health Care Reform Legislative Task Force is to search for innovative ways to reform health care in the State of Arkansas. This innovation will include maintaining coverage for the current health care beneficiary population while striving to lower the cost burden to the State and improving the overall health outcomes for Arkansans.

Executive Summary, Cont

Goals

- The goal of the Health Care Reform Legislative Task Force is to look for innovative solutions to improve health care in the State of Arkansas by implementing a unique health care model that meets the outlined objectives and provides the best quality and service to Arkansas residents. A three-way approach is critical to achieve success in any given model. All solutions and recommendations must meet the needs of the Beneficiary, the Provider, and the Taxpayer.

Executive Summary, Cont

Solution & Intent

- The intent of this proposal is to expand The Steven Group's first recommendation which is based on a PCMH model. Arkansas is currently ranked 49th in overall health. A balanced approach which includes promoting preventative care and cost containing reform is needed to both improve the health of Arkansas citizens as well as the financial sustainability of the Medicaid program.

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PRIMARY CARE:

- Expand and Enhance PCMH Model
- Stop further expansion of Episodes of Care
- Review Prior Approval processes for cost effectiveness
- Promote telemedicine for Specialist Services
- Allow wellness exams, wellness labs, and reimbursements to Providers for adult population on traditional Medicaid (currently not a covered service)
- Increase reimbursements to providers for vaccinations to improve overall health (Arkansas is currently 50th in vaccination rates and providers are either not reimbursed for vaccines or reimbursed well below invoice)
- 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)
- Increase or remove laboratory and radiology services cap for Medicaid PCMH beneficiaries (currently capped at $500 per year).
- Include limited reimbursements or visits for diabetes self-management (incentivize providers to educate beneficiaries)

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Arkansas Ranks 49th in Overall Health

- 44th in diabetes
- 47th in cardiovascular deaths
- 46th in cancer deaths
- 49th in infectious disease
- 50th in stroke deaths
- 48th in smoking
- 48th in physical inactivity
- 48th in obesity
  - 34.6% adults obese

- 44th in overall child health*
- 50th in child immunizations
- 49th in adolescent immunization
- 39th in infant mortality
- 39th in primary care physicians per capita
- 44th in preventable hospitilizations

Data courtesy of UAMS and provided by:

- *Source: Annie E. Casey Foundation's 2015 "Kids Count Data Book"
- Source for all other data: America's Health Rankings, 2014

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DEVELOPMENTAL DISABILITIES:

- Care Management Collaboration with an ASO (Administrative Services Organization)
- Independent Assessment
- PCMH Model
- Global Waiver
- Discharge from one program to another to eliminate duplicate/triplicate program billing (should not be dually enrolled)
- Develop supportive employment programs
- Analyze and streamline billing codes
- 1.0 – 2.0% Withholding in reimbursements – to be cost shared back to providers based on quality outcome measures
- Set up Trust fund for reimbursement withholdings

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BEHAVIORAL HEALTH:

- Care Management Collaboration with an ASO (Administrative Services Organization)
- Independent Assessment
- PCMH/Behavioral Health Home Model
- Global Waiver
- Apply a tiered approach based on diagnosis and level of treatment and incorporate school based services into the tiered referral system with care coordination
- Analyze and streamline Maximum Allowable Unit charges, group therapy duration times, and treatment plan frequency
- Treatment review plans changed from every 3 months to every 6 months
- 1.0 – 2.0% Withholding in reimbursement – to be cost shared back to providers based on quality outcome measures
- Set up Trust fund for reimbursement withholdings

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***Care Management** - Care management programs apply systems, science, incentives, and information to improve medical practice and assist consumers and their support system to become engaged in a collaborative process designed to manage medical/social/mental health conditions more effectively. The goal of care management is to achieve an optimal level of wellness and improve coordination of care while providing cost effective, non-duplicative services.

***Care Management Framework** - The following framework (next slide) outlines and defines the key components of a comprehensive care management program and provides examples of tools and strategies that can be used by states in designing programs to effectively meet the needs of beneficiaries with complex and special needs.

*Source: http://www.chcs.org/media/Care_Management_Framework.pdf

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CHCS Center for Health Care Strategies, Inc.

Care Management Framework

Care Management Components	Definition	Tools / Strategies
Identification Stratification Prioritization	Identification, stratification, and prioritization should be used to identify consumers at the highest risk who offer the greatest potential for improvements in health outcomes. Programs should incorporate clinical and non-clinical sources of information to identify consumers who will most benefit from care management.	• Health risk assessments • Predictive models (algorithm-driven model that uses multiple inputs to predict high-risk opportunities for care management) • Surveys (e.g., Patient Health Questionnaire 9, Short Form 12) • Case finding (e.g., chart reviews, surveys) • Referrals (from member, provider, community)
Intervention	Interventions should be tailored to meet individual consumer need, respecting the role of the consumer to be a decision maker in the care planning process. Interventions should be designed to best serve the consumer, be multi-faceted, improve quality and cost effectiveness, and ensure coordination of care.	• Evidence-based practices • Interactive care plan, developed based on consumer-set priorities • Multidisciplinary care teams • "Go to" person • Medical home • Physical/behavioral health integration • Specialized patient engagement (e.g., self-management training)
Evaluation	Evaluation should include systematic measurement, testing, and analysis to ensure that tailored interventions improve quality, efficiency, and effectiveness. Careful and confident evaluation will build the evidence base in terms of what works for complex and special need populations.	• Program evaluations • Rapid-cycle micro experiments (e.g., continuous quality improvement, testing, and program adjustments) • Representative measures of quality (e.g., HEDIS, CAHPS) • Representative measures of cost (e.g., ROI calculations)
Payment/Financing	Payment/financing should be aligned to support improvements in care management by rewarding consumers and providers for participating in interventions/evaluations and establishing accountability for quality and cost.	• Pay for performance at multiple levels (e.g., health plan, provider, and consumer level) • Shave in program savings (gainsharing) • Case management/medical home payments

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AGING:

- Global waiver – Could create bundling of services and eliminate duplicate services where appropriate (ElderChoices, AAPD-Alternative for Adults with Physical Disabilities, Independent Choices, LCAL-Living Choices Assisted Living)
- Define benefit limits and conduct assessments
- Place cap on beneficiaries
- Place tiers on services

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LONG TERM CARE:

- PCMH Model
- Utilize existing infrastructure of rural nursing facilities to provide care coordination and home & community based services
- Work to transition more beneficiaries to home care following rehab stays
- Eliminate provisional rates
- Cap liability insurance reimbursement
- Increase the threshold for population based methodology

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PHARMACY:

- Expand preferred drug list and include behavioral health meds (anti-psychotic)
- Explore multi-state prescription drug list (value based purchasing)
- Give Medicaid access to prescription monitoring program
- Explore multi-state prescription drug list (value based purchasing)
- Move manual reviews by licensed psychiatrist from age 6 to 7, and eventually up to age 10 with evidence of continued higher cost avoidance
- Add another 100 drugs to the CAP (Competitive Acquisition Program)
- Remove prescription drug limits on maintenance medications
- Include reimbursement to pharmacy for immunizations, with certain criteria and referrals
- Explore the more transparent NADAC (National Average Drug Acquisition Cost) pricing model

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DENTAL:

- Managed Care, to include:
  - Full Risk
  - PMPM based on actuarially sound rate
  - Program Management
  - Providers compensated on a Fee for Service basis
  - Evidence Based

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HOSPITALS:

- Implement DRG (Diagnosis Related Group) Model
  - A Diagnosis-Related Group (DRG) is a statistical system of classifying any inpatient stay into groups for the purposes of payment. The DRG classification system divides possible diagnoses into more than 20 major body systems and subdivides them into almost 500 groups for the purpose of Medicare reimbursement.
- Levelize reimbursement rates among state-supported institutions and private institutions

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OTHER:

- Develop Arkansas Works program, with proper EEF and Redetermination system approaches
- Provide each beneficiary with a "Health Scorecard" to promote wellness
- Create Legislative Oversight Panel for implementation and transition
- Restructure DHS organizational chart to include:
  - Medicaid Unit that reports directly to the Governor
  - Add a Contract Procurement and Oversight Division
- Legislative support for salary and line item max increase for DHS Director
- Utilize current services contract with TSG to negotiate waivers
- 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
- Promote Healthy Active Arkansas

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OTHER:

- Implement the nSPARC Model (National Strategic Planning and Analysis Research Center)
  - Mississippi developed this system with federal funding and they have offered to share the system with Arkansas at no cost
  - This Model will also help with Economic Development and Labor Market Analysis

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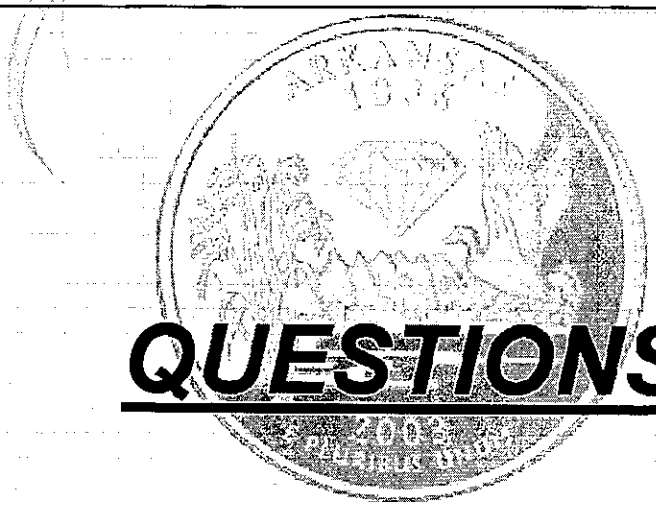
Arkansas solutions and innovation in Health Care
Built IN Arkansas & Built FOR Arkansas

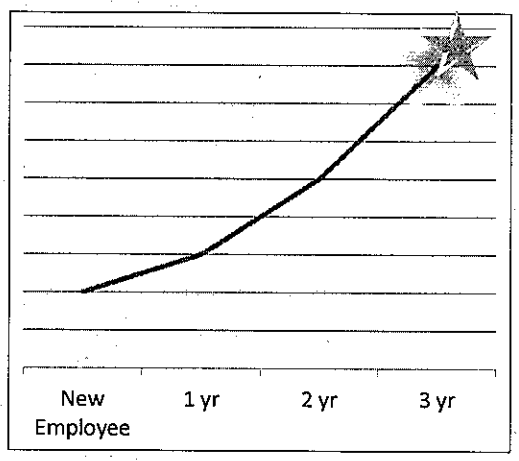


QUESTIONS

NEW WORK

New Work

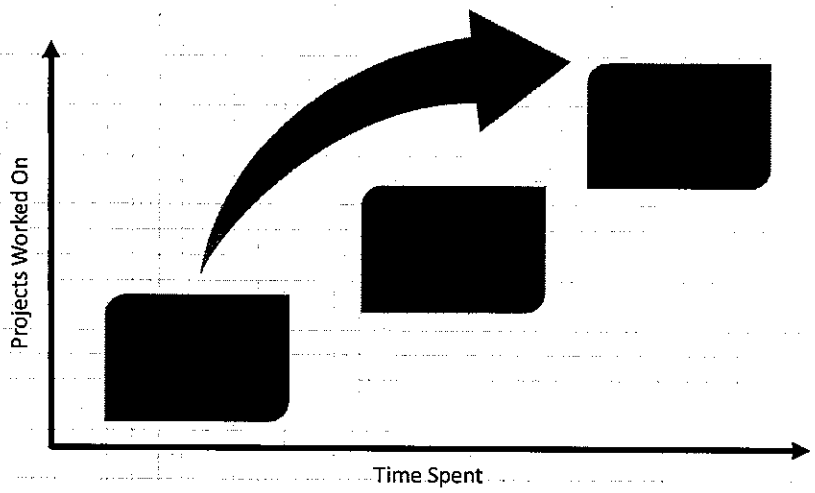
The technology learning curve



Who's Who

Lead	Contact information
Jim	Jim@company.com
Dee	Dee@gcompany.com
Mavis	Mavis@company.com
Doug	Doug@company.com

Working Toward Mastery



Doing Your Best Work

- Working from home
- Working offsite
- Technology requirements

Case Study

- Jeremy
  - His first day
  - Mistakes made
  - Successes achieved
  - The moral of the story

Discussion

- What we can learn from Jeremy
- Best practices
- Take-aways

Summary

- Define your challenges
  - Technological as well as personal
- Set realistic expectation
  - Mastery is not achieved overnight
- Keep your eye on the goal
  - Mentorship programs

Resources

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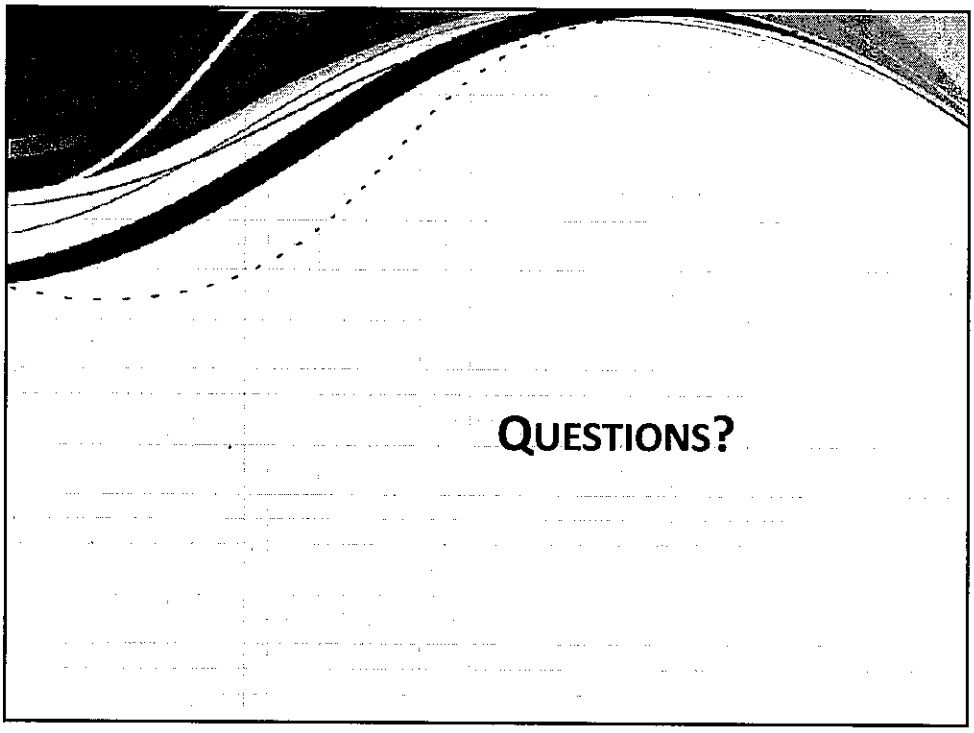
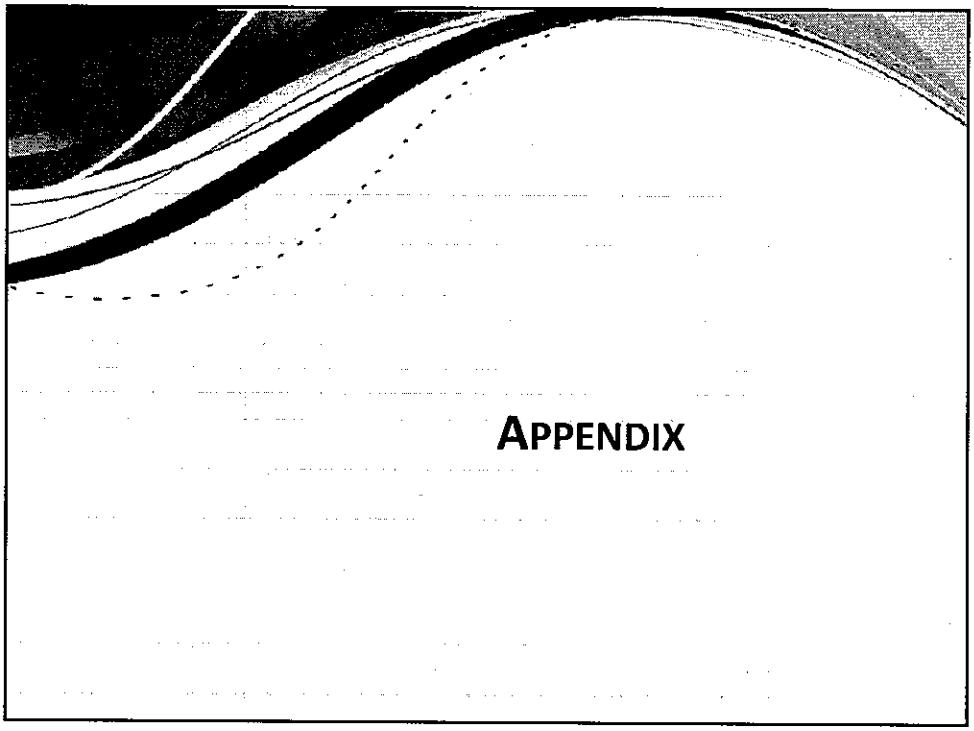
  <hyperlink here>
- <Additional reading material text here>
  <hyperlink here>
- This slide deck and related resources:
  <hyperlink here>




APPENDIX