Bureau of Legislative Research

Arkansas Health Care Reform Task Force

TSG Update Report

January 20, 2016

Agenda

- Guiding principles for PCMH/Health Homes managed fee for service savings model
- TSG focus on High Cost PCMH and DiamondCare Recommendations
- Baseline Cost Savings Estimates and other categories of cost savings
- Pharmacy Recommendations Progress
- Dental Claims History
- Dental Managed Care
- Integrated Systems state “best practice”
- Section 1332 Waiver update
- Michigan Expansion Waiver aproval update

Guiding Principles for PCMH/Health Home Non-Capitated, Full Risk, Model for High Cost Populations

- Savings estimates will be based on allocation methodology that considers efficiency, savings and quality across all populations and services
- Savings target will be applied to entire Traditional Medicaid program
- Savings target will exceed $835 Million over five years (SFY 2017 to 2021)
- Savings target will include all funds, not including additional revenue from premium taxes
- Savings estimates will be independently verified
- Model will assume new management structure to administer long term care, behavioral health, developmentally disabled, and other high cost populations

TSG Guiding Principles (cont.)

- Model will include aspects of Diamond Care, such as linking Patient-Centered Medical Homes to medical, pharmacy and waiver services for high cost populations (Aged, Blind and Disabled), including:
  - Independent Assessment
  - Plan of Care
  - Claims payment
  - Utilization Management
  - High Cost Case Management
  - Call Center Services
  - Member Outreach
  - Provider Relations
  - Grievances and appeals
  - Quality improvement
  - Robust Info Technology & reporting

TSG Guiding Principles (cont.)

- Model may include:
  - Network development
  - Provider credentialing
  - Fraud, waste and abuse
- Model will assume State Plan/waiver changes, and may include tiered payments, changes to levels of care, rebalancing and changes to promote least restrictive settings
- Model will recommend a global Section 1115 Waiver and allow for maximum flexibility and federal financial participation
- Model will assume current contracts for similar services at DHS will cease to exist on go live date and will be absorbed within single management entity(s)
- Model may include additional prevention-related services

TSG Guiding Principles (cont.)

- Recommended administrative management entity(s) will share in both savings and losses (losses including being unable to meet contracted quality outcomes and agreed upon savings estimates)
- Management entity will be responsible for achieving a portion of savings and some portion of risk will be shared by providers
- Management entity will include aspects of management of complex Medicaid children not currently in PCMH program
- There will be recommended establishment of Centers of Excellence for certain high cost medical procedures
- Savings will take into considerations current DHS efficiency plans, including rule or program changes
- Necessary legislative or rule changes will be accepted by the legislature

TSG Guiding Principles (cont.)

- Savings estimates will include savings for enhanced public integrity functions
- Savings estimates will be net of administrative expense
- Timeline for savings estimates will ensure readiness
- Savings may also be derived from additional DHS initiatives not related to model
- Model will recommend the use of some savings for Developmental Disability Wait List Recipients

TSG High Cost PCMH and DiamondCare Recommendations

- Research state models for Behavioral Health, Developmental Disabilities and Community Based Long Term Care using Fee-For-Service(FFS)/Administrative Service Organization(ASO) models:
  - BH/DD: Care Management Collaboratives with ASO; independent assessment
  - Aging: Integrate waivers/Global Waiver; avoid duplication; benefit limits, caps, and tiers of service
  - TSG Research: State agency and vendor discussions; market research
  - Next Step for February TF Meeting: identify savings from similar state/vendor models based on Fee for Service payments from ASO type models

State Behavioral Health Systems: States in Transition

- Seven States are Shifting from Fee for Service/ASOs to some form of Regional Care Organizations or Managed Care

  - Alabama: FFS to 11 Regional Care Organizations at risk
  - Colorado: At risk BH ASO to integrated at risk Regional Care Collaboratives
  - Iowa: BH ASO to at risk integrated managed care: 3/16
  - Nebraska: BH ASO to at risk integrated managed care: 2017
  - NY: FFS to specialty at risk managed care plans: 2016-2017
  - North Carolina: BH Organizations to at risk integrated managed care: 2016-2017
  - WA: BH Organizations at risk to at risk managed care: 2017-2019

State Behavioral Health Systems: FFS, ASO, and PCMH Models

- Arkansas: ASO, Fee for Service, no risk
- Arizona: Regional Behavioral Health Authorities, ASO capitated at risk
- Connecticut: : Local Mental Health Authorities, fee for service
- District of Columbia: fee for service
- Hawaii: BH specialty capitated at risk ASO
- Maine: ASO utilization management, fee for service
- Massachusetts: Partial risk capitated ASO
- Montana: PCCM
- New Jersey: Fee for service

State Behavioral Health Systems: FFS, ASO, and PCMH Models

- North Dakota: PCMH
- Pennsylvania: Regional Behavioral Health Organizations, capitated payments
- South Dakota: PCMH
- Utah: Behavioral Health Organizations: capitated
- Vermont: state run to preferred agencies based on contract approval, capitated
- Virginia: Fee for service with an ASO
- Summary: 23 states/DC in some form of Fee for Service and ASO-related delivery models for Behavioral Health with/without some level of risk; 28 states in/moving to full risk managed care for Behavioral Health/Rehabilitation Option services.

State Developmental Disabilities Systems: FFS, ASO, and PCMH Models

- TN, AZ, VT, MI, KS, LA, NH, TX: managed care
- Other states: Fee for Service through legacy IDD systems
- West Virginia FFS/ASO Model
  - Objective Third Party Review Assessment
  - Use national standard instruments
    - SIS, ICAP
  - Conduct face-to-face assessments as well as use medical records
- Prior Service Authorization
  - Provide medical necessity determination
  - Create authorization in MMIS/Fiscal System
  - Statistical budgetary model
    - For consumer-directed waivers and standard waivers
    - Ensures budget adherence

State Developmental Disabilities Systems: FFS, ASO and PCMH Models

- Provider Oversight
  - Annual desk review and onsite provider audits
  - Monitoring consumer budgets and managing variation
  - Consumer treatment record validation
  - Consumer Safety assurance
  - Billing and claims accuracy
- Quality Management
  - Data collection for Discovery phase
  - Technical Assistance for Remediation and Improvement phases
  - Participant Experience Survey (PES) administration
  - QA for Consumer Directed services

Traditional Medicaid Program

Cost-Savings Baseline

SFY	Medicaid Expenditures	Description
2015	$4,878,786,881	Actuals
2016	$5,122,726,225	5% annual growth
2017	$5,378,862,536	
2018	$5,647,805,663	
2019	$5,930,195,946	
2020	$6,226,705,743	
2021	$6,538,041,031	
2017-2021 Total	$29,721,610,919	

Traditional Medicaid Program

Cost-Savings by Lowering Growth Rate

SFY	Medicaid Expenditures	Description	Annual Savings
2017	$5,378,862,536	Projection from 2015 actuals at 5% annual growth	$0
2018	$5,594,017,038	4% annual growth	$53,788,625
2019	$5,817,777,719		$112,418,227
2020	$6,050,488,828		$176,216,916
2021	$6,292,508,381		$245,532,650
2017-2021 Total	$29,133,654,502		$587,956,418

Traditional Medicaid Program

Cost-Savings by Lowering Growth Rate

SFY	Medicaid Expenditures	Description	Annual Savings
2017	$5,378,862,536	Projection from 2015 actuals at 5% annual growth	$0
2018	$5,594,017,038	3% annual growth	$107,577,251
2019	$5,817,777,719		$223,760,682
2020	$6,050,488,828		$349,077,421
2021	$6,292,508,381		$484,083,858
2017-2021 Total	$29,133,654,502		$1,164,499,211

Traditional Medicaid Program

Cost-Savings Baseline by Group

Projected Traditional Medicaid Expenditures by Group *(millions; 5% growth rate; program and halo)*						
Year	**2017**	**2018**	**2019**	**2020**	**2021**	**2017-2021**
Elderly	$1,542	$1,619	$1,700	$1,785	$1,874	$8,520
Developmentally Disabled	$1,213	$1,273	$1,337	$1,404	$1,474	$6,700
Behavioral Health	$1,202	$1,262	$1,325	$1,391	$1,460	$6,639
All other	$1,423	$1,494	$1,569	$1,647	$1,729	$7,862
Total	$5,379	$5,648	$5,930	$6,227	$6,538	$29,722

Key assumptions:

- 5% growth rate
- Proportional growth
- Non-claims payments allocated across groups proportionally

Traditional Medicaid Program

Other Categories of Cost Savings

- In addition to savings established by care management and other population-oriented strategies, such as long-term care rebalancing, additional cost savings will be established through other strategies that cut across the populations/groups.
  - Program integrity
  - Drug purchasing efficiencies
  - Contract re-negotiations

Pharmacy Recommendation Progress

Progress on Pharmacy Recommendations

- Expand the PDL
- Re contract the retail pharmacy network
- Review Antipsychotic prescriptions for older children
- Improve quality and decease waste of hemophilia factor drugs
- Update on Vaccinations

Focus on initiatives which can be started immediately

Pharmacy Recommendation Progress (cont.)

Expand the PDL

- Increase claim coverage from 38% to 50-60%
- Value approximately $9-10mm annually
- Timing
  - Complete multi-state pool evaluation — January ‘16
  - Submit State Plan Amendment to CMS — April ’16
  - Implement after CMS approval — Q 4 “16

Re contract the retail pharmacy network

- Value up to $18.3mm annually
- Timing
  - Complete Dispensing fee survey — January ’16
  - Complete NADAC analysis — March ‘16
  - Submit State Plan Amendment to CMS — April ‘16

Pharmacy Recommendation Progress (Cont.)

Review Antipsychotic prescriptions for older children

- Manual medical review currently up to age 6
  - Informed consent and metabolic monitoring
- Begin review up to age 7 — February ‘16
- Begin review up to age 9 — April ‘16
- Propose up to age 10 to DUR Board — April ’16
- If approved begin review up to age 10 — July ‘16 est.
- Consider review up to age 12 — 2017 est.

- Foster and non-foster care children

Pharmacy Recommendation Progress (Cont.)

Improve quality and decease waste of hemophilia factor drugs

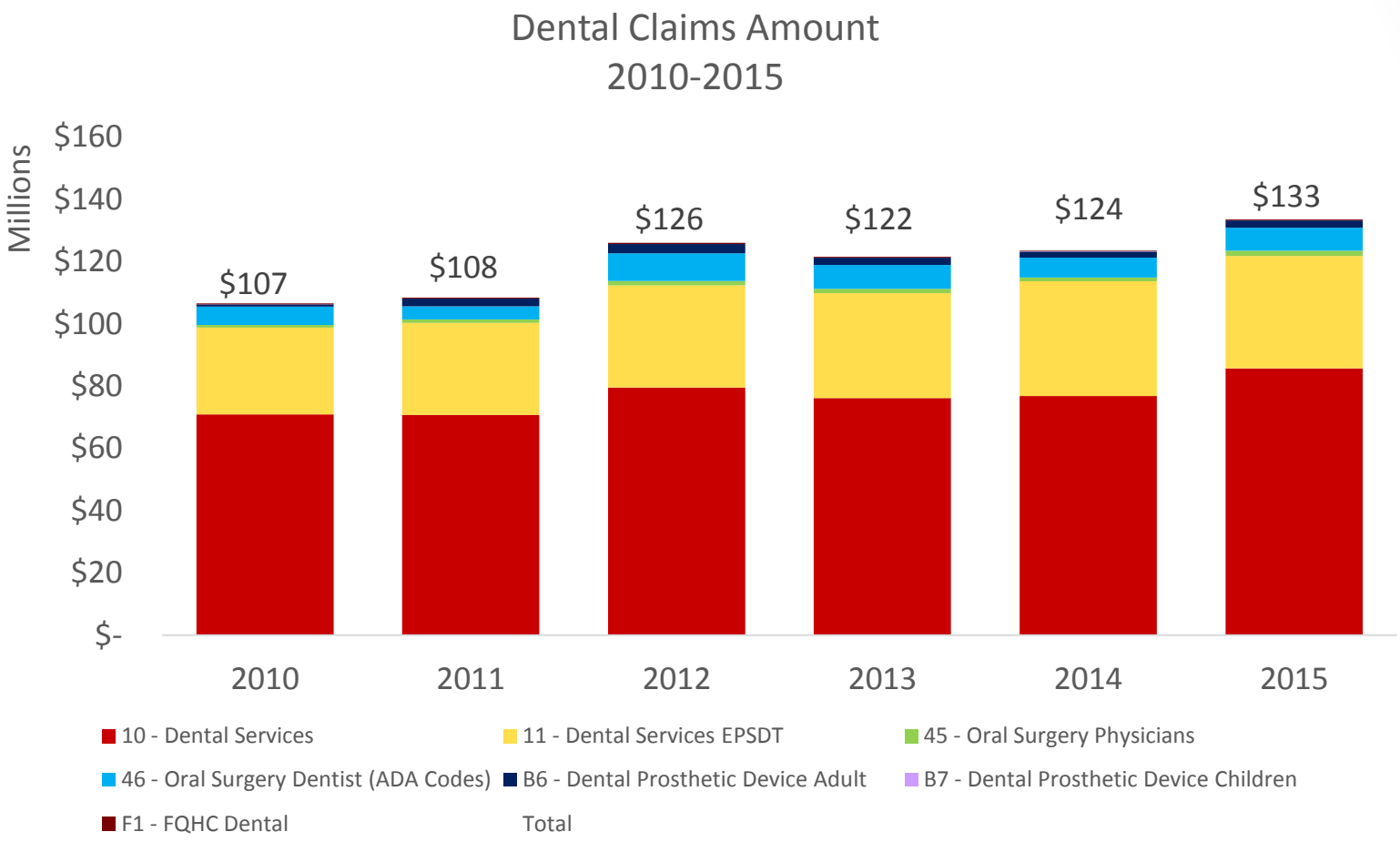
- Hemophilia drugs currently on CAP list
- Plan to narrow pharmacies which dispense drugs
  - Increase quality of care
  - Decrease waste and diversion potential
  - Timing: likely requires rule promulgation
- TSG working to try and quantify the value of decreased waste

Vaccination update

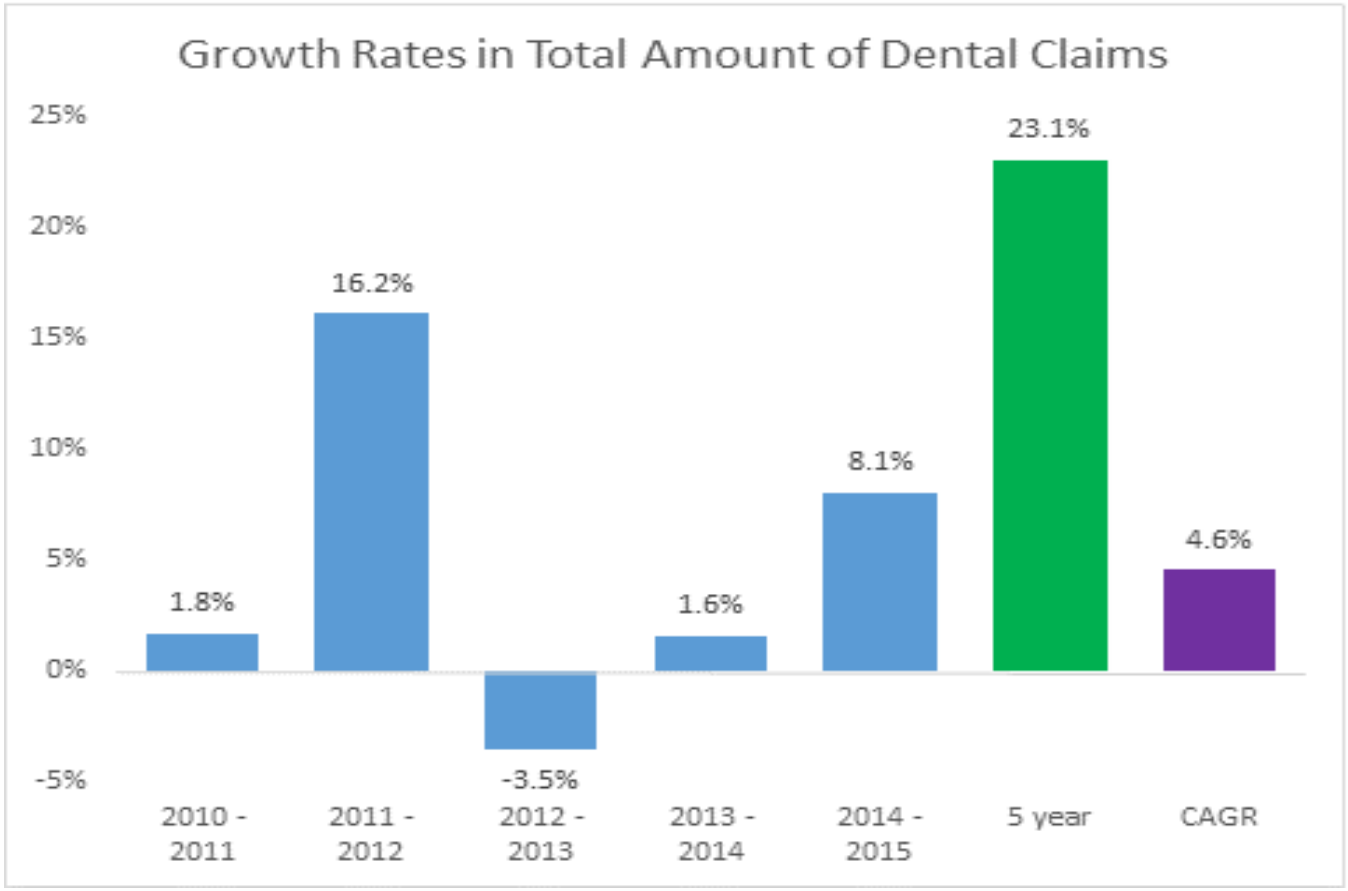
- Influenza 50.5% >6 month olds 2014/2015 flu season
- Childhood trio MMR, TDaP, and chicken pox AR<89%

  Herd protection => 90% (AR and CO missed)
- TSG to determine split between Public Health and providers

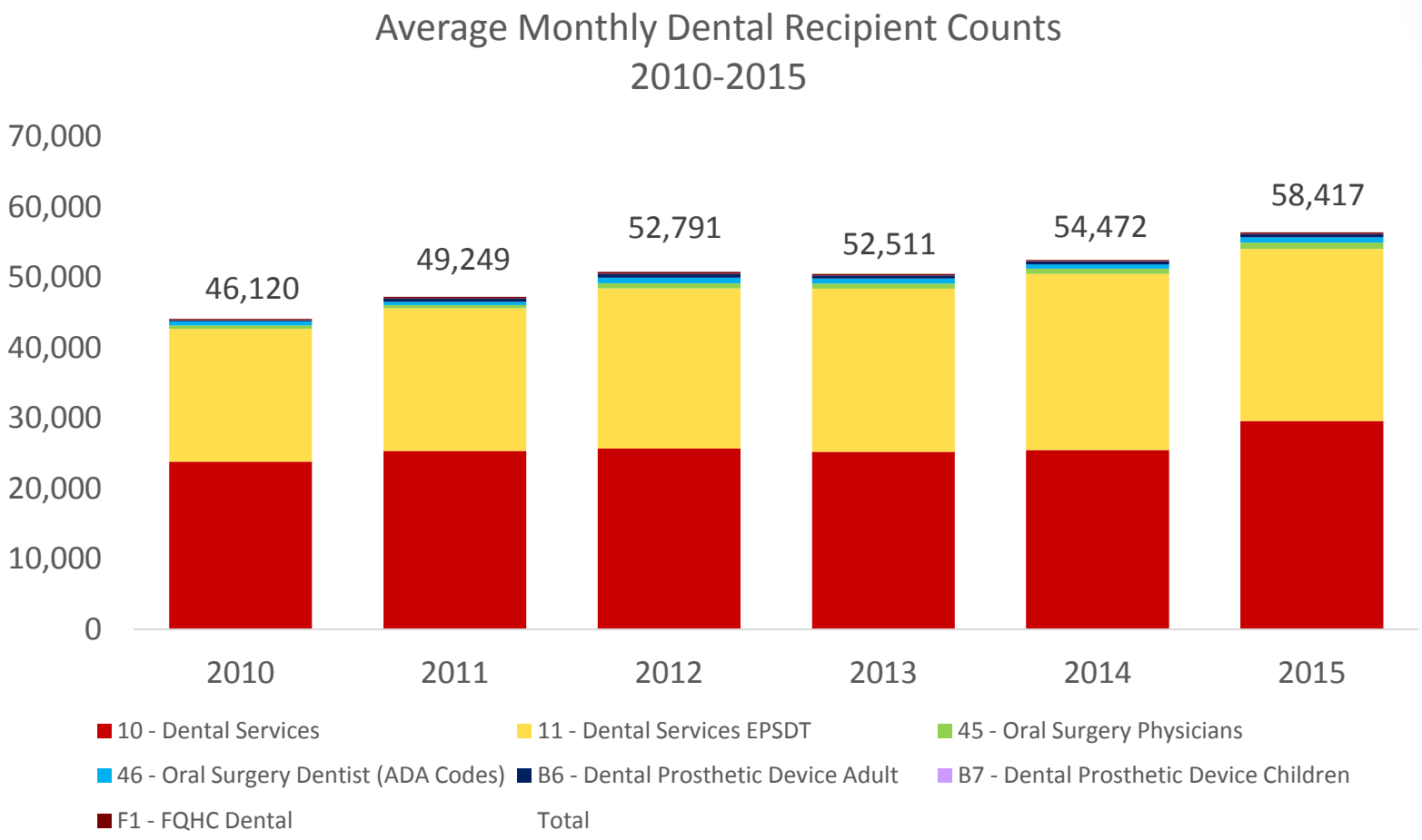
Dental Claims History



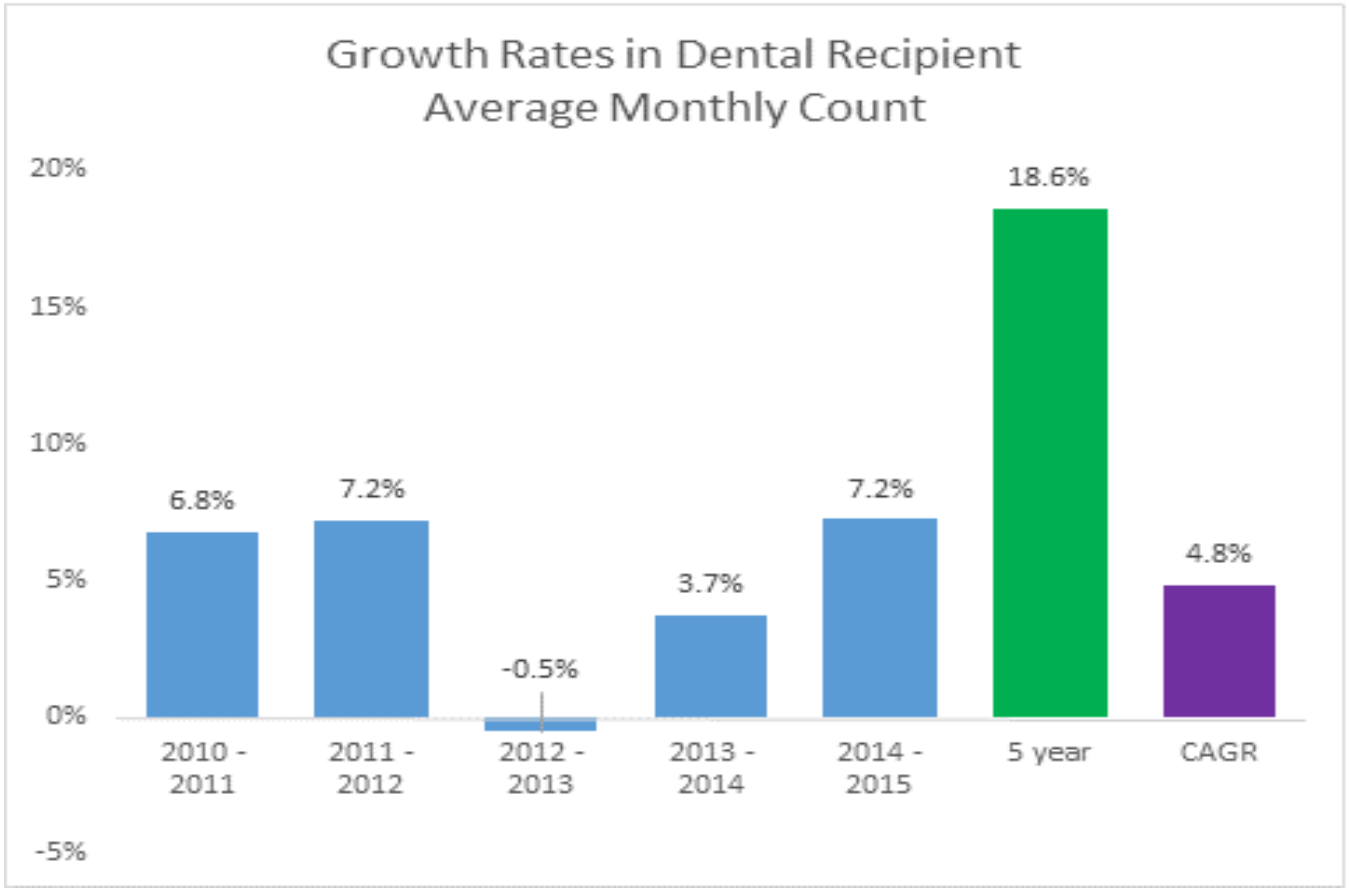
Dental Claim Growth Rates



Dental Recipients Increasing



Dental Recipients Growth Rates



Dental Managed Care

- Administration of all Medicaid dental benefits on a full risk capitated basis. In this case the state would compensate the dental managed care organization (MCO) using an actuarially sound per member per month rate that is set forth in an RFP and the process would be competitively bid (CMS requirement).
- CMS would probably require at least two companies selected to cover the entire state
- Providers would be compensated on a fee for service basis
- The RFP should include incentives to meet benchmark cost savings within the program, provide for full risk in not meeting the benchmark and also allow for shared savings arrangements where there is the promotion of access and quality prevention services.

Dental Managed Care (cont.)

- The RFP would include a dental home for all enrollees in the plan and would include the following critical elements:
  - Claims payment
  - Credentialing
  - Utilization management
  - Case management
  - Call center
  - Network development
  - Member outreach and education
  - Grievances and appeals
  - Quality improvements
  - Information technology
  - Fraud, waste and abuse protection

Integrated Systems: State Innovations

- Pre-screening to determine program eligibility with links to application
- Single application customized for benefits requested
- Incorporate real-time decisions for MAGI based coverage
- Member portal to view application status, report changes in circumstances, review benefits, and renew
- Business rules engines incorporate rules for multiple programs to evaluate applicant information and shorten eligibility process
- Integrated call centers that route callers to appropriate staff
- Electronic data matching through state hubs
- Enhanced document imaging and management systems

Integrated Systems: Innovations (cont.)

- Data management and analytics merging data from multiple sources to support decision-making and improve outcomes
- Mobile apps for a dynamic provider directory, real-time digital medical ID cards, and updating account information

Integrated Systems: North Carolina

- Integrated 17 DHHS programs, including Child Care, Food and Nutrition, TANF, Medicaid, Work First, Energy Assistance
- Additional successful implementation to integrate SNAP, TANF and Special Assistance with MAGI Medicaid application
- Programs in Child Services and Aging and Adult Services to be implemented 2017
- Includes Case Management Integration, ePASS, Document Management, Online Verification, Service Delivery Interface
- State access to comprehensive, current data integrated across systems for accountability and decision-making
- Counties can track cases across program and county lines
- Incorporates fraud detection software to flag suspicious billing

Integrated System: New Mexico

- Determines eligibility for all state –administered programs, including SNAP, TANF, Cash Assistance, Refugee Cash, Energy Assistance, Medicare Savings and Medicaid
- Includes modules for all agency business units, including Restitutions, Fair Hearings, Supervisor reviews, work programs for SNAP and TANF, and Investigations
- Self-service website allows initial application and access to case information, as well as recertification, case changes, correspondence and basic case maintenance
- Automated rules consider eligibility based on receipt of other programs

Integrated Systems: New Mexico (cont.)

- Challenges and Advice for Implementation
  - Use best resources from field offices
  - Seasoned workers adjusting to additional information gathering and trusting new system to determine eligibility
  - Allow time for data conversion and clarify roles with vendor
  - Need testing with live data for reports and interface partners
  - Allow time for organization knowledge transfer
  - Clean up notices before converting to new system
  - Transferring code from another state and tacking on makes for challenges in support and making changes downstream

Integrated Systems: Pennsylvania

- Single application for Health Care Coverage, SNAP, Cash Assistance, LTC, home and community services for individuals with IDD, Energy Assistance, reduced school meals, Child Care Works
- Integrates MAGI methods and exchanges data with other online eligibility systems
- High level eligibility screening offers opportunity to add health care to applicants for non-health programs
- Individuals can submit verification documents electronically

Integrated Systems: Pennsylvania (cont.)

- Lessons learned
  - No matter how simple a particular enrollment or renewal strategy may seem, it will never work for everyone. There must be a range of mechanisms and choices available.
  - Flexibility to make mid-course process corrections is key.
  - Small scale testing of new practices enabled development of workable structures for moving forward.
  - Community and consumer advocates play a critical role in securing on-going improvements.

Integrated Systems: Considerations

- Importance of executive-level leadership and collaboration across involved agencies to provide governance
- Critical role of business process re-engineering as driver of technology projects
- Careful consideration of how to best capitalize on enhanced funding opportunities and cost allocation waiver
- Expectation that data and analytics will help adjust integration for better results and future planning.
- Source: *State Innovations in Horizontal Integration: Leveraging Technology for Health and Human Services*, Center on Budget and Policy Priorities, March 2015

PPACA Section 1332 Waivers

Overview

- Permits states to request waivers of certain provisions of PPACA, beginning in 2017.
- Permits states to propose alternative uses of federal funds that would have been spent on subsidies and tax credits
- Provisions that may be waived under a 1332 waiver
  - Individual mandate
  - Employer mandate
  - Benefits and subsidies
  - Marketplaces and Qualified Health Plans

PPACA Section 1332 Waivers

Overview

- Provisions that may not be waived under a 1332 waiver
  - Prohibition on medical underwriting using pre-existing conditions
  - Rating bands
  - Guaranteed issue
  - Numerous other provisions

PPACA Section 1332 Waivers

Overview

- Waiver criteria
  - Coverage must be as comprehensive as marketplace coverage
  - Coverage must be as affordable to individuals as marketplace coverage
  - Must cover at least as many people as PPACA without the waiver
  - Must not increase the federal deficit

PPACA Section 1332 Waivers

State Activity

- As of December 2015, six states had enacted legislative measures related to 1332 waivers
  - Hawaii
  - Minnesota
  - Ohio
  - Rhode Island
  - Texas
- Intent and binding nature of these bills vary considerably

PPACA Section 1332 Waivers

Recent Federal Guidance

- In December 2015, US Dept of HHS issued guidance on the 1332 waivers
  - Narrowed applicability
  - Precludes achieving budget neutrality across waivers (e.g., by including 1115 and 1332 waiver expenditures and savings within the same budget neutrality calculation)
  - Federal exchange will not be able to accommodate differential state policies, including 1332 waivers
  - Appears to preclude eliminating individual and employer mandates due to inability of IRS to accommodate differential state policies

PPACA Section 1332 Waivers

State Activity

State	Hawaii
Bill/Status	2015: H 576 Passed signed 7/1/2015 as Act No. 2015184
Summary	Provides resources to develop a 1332 waiver from certain provisions of the ACA. Act 158 of 2014, established a state innovation waiver task force to develop a health care reform plan that meets the requirements for obtaining a state innovation waiver that complies with the ACA. The plan to be developed by the task force for the waiver is expected to build on the success of chapter 393, Hawaii's Prepaid Health Care Act.

Source: National Conference of State Legislatures; Health Innovation Section 1332 Waivers: State Legislation as of 2015

PPACA Section 1332 Waivers

State Activity

State	Minnesota
Bill/Status	2015: S 1458; passed signed 5/22/2015 as Ch. 71
Summary	Requires the governor to convene a task force on health care financing to advise the governor and legislature on strategies that will increase access to and improve the quality of health care for Minnesotans. "The task force shall consider opportunities, including alternatives to MNsure, options under section 1332" of the ACA, and options under a section 1115 waiver.

Source: National Conference of State Legislatures; Health Innovation Section 1332 Waivers: State Legislation as of 2015

PPACA Section 1332 Waivers

State Activity

State	Ohio
Bill/Status	2015: H 64 passed; signed 6/30/2015, PL 2015-141
Summary	Budget section, provides that the superintendent of insurance shall apply to the United States secretary of health and human services and the United States secretary of the treasury for an innovative waiver regarding health insurance coverage in this state as authorized by section 1332 of the ACA. The superintendent shall include in the application a request for waivers of the employer and individual mandates in sections. The application shall provide for the establishment of a system that provides access to affordable health insurance coverage for the residents of this state.

Source: National Conference of State Legislatures; Health Innovation Section 1332 Waivers: State Legislation as of 2015

PPACA Section 1332 Waivers

State Activity

State	Rhode Island
Bill/Status	2105: H 5900 Passed; signed 6/30/2015
Summary	Provides that to "take advantage of economies of scale and to lower costs, the exchange is hereby authorized to pursue opportunities to jointly negotiate, procure or otherwise purchase exchange services with or partner with another state or multiple states and to pursue a Federal Affordable Care Act 1332 Waiver."

Source: National Conference of State Legislatures; Health Innovation Section 1332 Waivers: State Legislation as of 2015

PPACA Section 1332 Waivers

State Activity

State	Texas
Bill/Status	2105: H 2304; passed House and Senate; signed 6/17/2015 as Ch. 837
Summary	The Health and Human Services Commission "shall develop and implement a comprehensive, coordinated operational plan to ensure a consistent approach across the major quality initiatives of the health and human services system for improving the quality of health care. […] (c) The operational plan under this section may evaluate: […] Section 1332 of 42 U.S.C. Section 18052 […]"

Source: National Conference of State Legislatures; Health Innovation Section 1332 Waivers: State Legislation as of 2015

Michigan 1115 Expansion Waiver

- All beneficiaries make monthly payments to health savings account based on average of previous 6 months' copayments
- Beneficiaries at 100-138% FPL make monthly premium payments to health savings account not to exceed 2% of income
- Combined premiums and cost-sharing not to exceed 5% of family income
- Health savings account contributions above 2% of income can be reduced by healthy behaviors and health risk assessment
- Pre-existing MCOs and Pre-paid Inpatient Health Plans used for mental health and substance abuse services
- Failure to pay premiums or contributions does not affect eligibility, enrollment or access to services

Michigan 1115 Expansion Waiver (cont.)

- Health plans cover all expenses up to an amount based on expected annual contribution
- Beginning April 2018, beneficiaries above 100% FPL and not medically frail much choose between a Qualified Health Plan on the marketplace (with premium assistance and cost-sharing subsidies) or Healthy Michigan Medicaid coverage
- Beginning April 2018, beneficiaries under Healthy Michigan Medicaid coverage must undergo health risk assessment and meet healthy behavior requirements
- Health risk assessment includes questions on overall health and healthy behavior and physician attestation of member's understanding and willingness to make needed changes.