EXHIBIT E-1

THE STEPHEN GROUP

Evaluation of Plan to Achieve Governor's Savings Estimate without Capitated Full Risk Managed Care

February 15, 2016

The Charge

At the Task Force meeting on December 16, 2015, the Task Force voted to support Governor Asa Hutchinson's request to achieve at least $835 Million in savings from Arkansas' traditional Medicaid program over a 5 year period. The Task Force voted in favor of a motion requesting that The Stephen Group (TSG) develop recommendations on a plan to achieve at least $835 million in savings without a capitated, full risk, managed care solution, with the exception of the dental program. The following contains TSG response to this charge.

Meetings and Discussions

Since the Task Force meeting on January 20, 2016, TSG has met on a number of occasions with representatives from the Arkansas Department of Human Services (DHS), Division of Medical Services (DMS), Division of Aging and Adult Services (DAAS), Division of Developmental Services (DDS), Division of Behavioral Health Services (DBHS), Office of Medicaid Inspector General (OMIG), and a number of state Medicaid providers, contractors, and associations, including:

- Mental Health Council of Arkansas
- Arkansas Children's Hospital
- UAMS
- Developmental Disabilities Provider Association
- Blue Cross of Arkansas
- Alliance for Health Improvement
- Mental Health Council of Arkansas
- Arkansas Behavioral Health Providers Association
- CHMS Providers Association of Arkansas
- Pharmacy Association
- Health Care Association
- AHCA

In addition, TSG conducted continued research on state best practice in the areas of Medicaid high cost management, with a focus on Managed Fee For Service (MFFS), Patient Centered Medical Home (PCMH) and Administrative Services Organization (ASO) models.

The Model and Strategy for Achieving Targeted Savings

Introduction

TSG has conducted research on a Managed Fee for Service (MFFFS) Administrative Services Organization (ASO) management strategy to address access, quality improvement, and cost savings within the Arkansas traditional Medicaid program including medical services, Behavioral Health, Developmental Disabilities, and Long Term Care services and waivers. The financial modeling process we used to determine savings is based on assessment of other state practices, industry standards and information, and meetings in Arkansas based on the "Diamond Care" key principles: 1) Medicaid Fee for Service payment model except Dental (managed care/PMPM); 2) PCMH model for all populations currently not covered by the existing PCMH/Episodes of Care; 3) Promote Wellness and Telemedicine for Specialists; 4) ASO model for DD, BH, and LTC waivers; 5) Independent assessment for DD, BH and LTC; and 6) a range of changes on lowering/adding volume to certain procedures/policies in PCMH and Pharmacy. There were, however, no specific caps or targets for volume of services for any population, no identified savings associated with specific recommendations, and no meaningful risk assigned to contractors and providers for not achieving benchmark quality and savings targets contained within the DiamondCare proposal. TSG has expanded on this plan here, in an effort to meet the goals and objectives of the savings plan

At the January 20th Task Force meeting TSG presented the Guiding Principles that would inform our recommended model development, operational aspects, and financial projections for the "PCMH/Health Home Non-Capitated, Full Risk Model for High Cost Populations." Subsequent to the January Task Force meeting, a number of key Arkansas provider groups and associations representing Medicaid's high cost populations met with TSG and provided us with some of their own detailed plans at achieving savings. Each was thoroughly reviewed and is contained herein as an attachment to this report. There is no doubt that the Governor's charge for specific savings targets, as well as the overall Task Force's focus and commitment to the need for change in this area, including enhanced accountability and improved quality, were major factors in fostering this environment of positive provider collaboration and support. The TSG Medicaid management structure and approach contained herein, therefore, is designed to include the key principles of the Diamond Care proposal, incorporate some or all of the specific provider savings plan ideas, and provide a reasonable path to achieving the estimated target of approximately one billion in traditional Medicaid program savings over a five year period (FY 2017 to FY 2021).

The Model

Operational aspects of the TSG Managed Fee For Service (MFFS) – Administrative Services model are as follows:

- Independent Assessment for BH, ID, and LTC waiver services
- Prior Authorization

- Individual person centered plan of care with consumer and Family/Circle of Friends involvement
- Individual budget for Home and Community Based waiver services (HCBS) based on assessed level of acuity and natural supports
- Utilization management
- Beneficiary/provider call center services
- High need/high cost case identification (data analytics) and care coordination across all providers
- Robust IT with data analytics and grouping/stratification capability
- Beneficiary and provider outreach, training, and preventive education
- Quality Improvement and CMS waiver reporting requirements
- Increased quality, appropriate use of services based on acuity, and responsibility for savings
- ASO Performance Measures tied to limited risk and incentives. The pathway to identifying program success includes identified quality metrics (HEDIS reporting should be considered) tied to benchmark based performance impact of the program, improved health status, and cost savings.
- Grievances and appeals (optional)
- Claims payment (optional)
- Provider network (optional)

Functional aspects of the MFFS targeted savings and quality improvement initiative are based on a competitive bid contracting process focused on ***the right service at the right time and at the right place.*** It is also based on efficiency, quality, and savings across all populations and services in the traditional Medicaid program, with the exception of the populations currently covered by the PCMH program, existing Episodes of Care and individuals residing in Human Development Centers (these were exempted in the Governor's charge). TSG assumed the Episodes of Care currently in place will not be expanded, although there may be reasons for DHS to come back to this question in the future. The savings target we have been asked to model and assess is to exceed $835 million over the five year period FY 2017-2021. Tabulated savings targets will include only Medicaid funds without additional managed care premium tax revenue. TSG savings estimates also include savings in addition to the MFFS model related to the pharmacy and dental program, as well as contract and enhanced public integrity savings. Aggregate savings estimates will be net of ASO administrative cost. Savings estimates will also address DHS savings resulting from current staff functions and contracted services being provided by ASO contractor(s) and the need for additional DHS resources/expertise to manage the new model of delivering all services through ASO contracts and existing health home/PCMH/Episodes of Care models.

TSG researched several states and vendors with experience and known outcomes with Managed Fee for Service ASO models, including administrative costs, administrative functions, and assessment and individual services planning, recognizing that the number of states who have used these non-capitated managed care models has primarily been in the PCMH/health home domain (9 states PCMH); behavioral health services domain (23 states with 7 in the process of shifting BH to integrated managed care); and one state with services for people with developmental disabilities.

The MFFS model TSG recommends to achieve the targeted savings and also enhance quality in the high cost Medicaid program for Arkansas is based on state plan (RSPMI) and Long Term Care and Developmental Disabilities waiver changes, including changes to levels of care, tiered payments based on acuity and safety factors, transition planning and priority of least restrictive environment. The model includes a global section 1115 waiver approach designed to increase Arkansas' flexibility to manage its Medicaid enterprise, provide additional Federal resources that do not require additional state match to address the DD waiting list to the degree savings permit, and provide targeted prevention services designed to keep people in their homes while avoiding premature institutionalization.

A critical aspect of the TSG recommended MFFS model is that the ASO management entity (or entities) and providers will be responsible for achieving a portion of the savings with a carefully designed gainshare for exemplary performance (assuming contract, access, and quality/outcomes compliance) and some portion of risk for performance falling under benchmark contracted targets. In order to achieve the targeted savings of $835 million to $1 billion within the FY 2017 to FY 2021 timeline, the managed fee for service ASO model must be developed, bid, contracted for, and implemented by the beginning of January 2018, and will also require that all necessary legislative, rule, SPA, and waiver requirements supporting the model be accepted by the Executive and Legislative branches in a timely manner. Delays in DHS planning and implementation and/or Executive/Legislative approval will result in decreased savings during the 5 year period.

In addition, in order for the savings target to be met, some portion of the savings in the high cost populations requires immediate action by DHS in the form of proposed rule/state plan and rate changes, as well as some statutory changes to the Medicaid Fairness Act (sample recommended change included in attachment).

Proposed Populations included in MFFS/ASO Model for Arkansas

MFFS Model will include the following Medicaid enrolled populations:

- Adults and children who meet the eligibility criteria for mental health rehabilitation services with high need. The model will recommend that the RSPMI program be replaced by an Adult and Children/Adolescent Evidence Based and Best Practice benefit, a revision of eligible diagnostic codes, and a revised definition of "Serious Emotional Disturbance." The model will further recommend a Section 2703 Health Home will be implemented for Serious and Persistently Mentally Ill Adults.
- People with developmental disabilities that meet the criteria for the Intermediate Care Facility institutional level of care, not currently residing in Human Development Centers, based on independent assessment.
- People with long term care needs who meet the Nursing Facility level of care or are at risk of this level of care based on independent assessment.
- High cost/complex cases enhanced care coordination – TSG suggests Arkansas use the criteria of high cost/complex cases used in the Pennsylvania ACCESS PLUS program: 3 or more ER

visits/inpatient hospitalizations in the same year based on 21 diseases stratified by cost from claims data.

Proposed Administrative Services Covered

DD Waiver Program Management

TSG recommends that the independent management of the DD Waiver, DDTS, and CHMS programs be based on the annual cycle of each person's plan of care, services delivery, audits and quality reviews, and annual or bi-annual reassessment. The annual waiver management cycle required of the Administrative Services Only entity is based on beneficiary engagement and should include:

- Independent initial and annual or bi-annual assessment based on a national standard instrument. We recommend the use of the Supports Intensity Scale (SIS) for the DD HCBS waiver, successfully implemented in North Carolina, Louisiana and other states. The SIS was the preference of the Arkansas DD provider community.
- Medical necessity determination of eligibility for services based on acuity, three levels of care, and safety/risk factors
- Independent individualized person services planning (with attention to multiple diagnoses).
- Individualized services budget based on the SIS assessment and level of care determination.
- Facilitation of the person's provider choices inclusive of family members, Circle of Support members
- Coordination with the person's case manager on a regular basis
- Independent annual/change in condition re-assessments
- Focus on supported employment
- Utilization review of claims that assures the appropriate services are being delivered in the correct amount based on the individual budget
- Provider quality assurance support
- Facilitating institutional diversion and transition action strategies
- Engaging HCBS providers as key partners in the coordination of the person's medical services, the person's PCMH, specialists, and pharmacist, but oversee the case management function either through their own care coordinators or by subcontracting this service to DD providers
- Technical assistance for provider remediation and improvement
- Participant experience/satisfaction survey that includes family members (CMS waiver requirement)
- Assuring individual budget adherence by provider spot audits; number determined by contract
- Call center for consumers and providers

The expected outcomes are:

- Standards based assessment, services planning, and individualized budgeting of cases specialized to each population

- Appropriate utilization based on medical necessity and medically assessed strengths and needs
- Increased home and community based services access
- Improved health status based on ASO and HCBS providers coordination with PCMH and specialists
- Cost savings based on utilization review and spot audits that assures staying within budget and preventing unnecessary variation in over utilization
- Improved quality of care for individuals receiving IDD waiver services who also have complex medical conditions based on ASO responsibility for high need/cost complex conditions identification and care coordination and partnership relationship with PCMH and HCBS providers
- ASO will assume several functions of DHS/DDS DD waiver management resulting in some efficiencies(see section on DHS administrative efficiencies)

The Developmental Disabilities Providers Association (DDPA) has submitted well thought-out approaches to improving the services delivery system for people with developmental disabilities, with increased efficiencies, and decreased costs resulting in savings. Important suggestions consistent with TSG recommendations include independent assessment that includes natural supports, plan of care based on levels of need/acuity, focus on supported employment, and innovative shared staffing based on incentives. See Appendix A.

In addition, the DDPA recommends well thought-out utilization controls to speech therapy, occupational therapy and physical therapy, changes to the DD home and community-based waiver program to accommodate shared staffing where appropriate, revisions to reimbursement methodology to reflect shared staffing rather than one-on-one, consideration of income-based co-pays and additional family responsibility to cover certain costs.

The CHMS Provider's Association of Arkansas has also submitted action oriented recommendations to increase the efficiency of the program resulting in savings. See Appendix B. Significantly, the proposal recommends utilization standards for services based on standardized testing, creating and implementing a set of dosing standards for Occupational Therapy (OT), Physical Therapy (PT), and Speech Language Pathologist (SLP) based on specific evaluation indicators, and the child's actual level of function and environmental factors, including retrospective review. The Association also recommends dual and triple licensing for CHMS, DDTC, and RSPMI providers be eliminated. Additionally the group recommends a universal developmental evaluation screening instrument be used by PCPs during EPSDT screens before referral for services.

The Stephen Group has discussed the proposed savings plans with each of the provider organizations and commends their effort to be an effective partner with state government in addressing the serious financial issues facing the state's Medicaid program. Given the thought behind each provider association's recommendations, we recommend that the appropriate DHS division meet with each provider association and report back to the Task Force at the March 7th meeting, or thereafter, on what DHS agrees can be done, how, by when, and the anticipated impact on beneficiaries and savings. The

Task Force should then ask DHS to provide an implementation plan that can be reviewed and monitored.

Behavioral Health

Mental Health Rehabilitation Option/RSPMI Services Management

- Independent initial assessment and annual reassessment based on a national standard instrument. We recommend the use of the LOCUS for adults and the CANS for children/adolescents. The LOCUS and CANS are public domain, well researched, and used in many states. The CANS is also used in several state Child Welfare systems, already used in Arkansas and recently adopted in Texas. Additional considerations for eligibility for this intensity of services include identified diagnoses such as used in Virginia, psychiatric hospitalizations, and number of civil commitment assessments during the past 12 months.
- Medical necessity determination of eligibility for services based on the assessment and level of need, individual living circumstances, and safety factors.
- Independent individualized person services planning (with attention to multiple diagnoses).
- Individualized services budget based on the LOCUS/CANS assessment and level of care determination.
- Facilitate the person's choice of providers
- Coordinates with the person's case manager on a regular basis (assumes Case Management for High Intensity Cases is included in the revision of the RSPMI benefit)
- Allows for time sensitive changes in level of need based on crisis situations
- Utilization review of claims that assures the appropriate services are being delivered in the correct amount
- Assure individual plan of care adherence by provider spot audits; number determined by contract
- Quality assurance and improvement
- Institutional diversion and transition action strategies in partnership with hospitals, mental health providers, and Health Homes
- Engage credentialed mental health providers as key partners in the coordination of the person's plan of care, medical services and Health Homes, specialists, and pharmacy with a goal of integrated services
- Technical assistance for provider training, remediation and improvement
- Call center for consumers and providers
- Assure individual budget adherence by provider spot audits; number determined by contract

The expected outcomes are:

- Standards based assessment, services planning, and individualized plans of care and cost based on intensity of need

- Improved quality of care as a result of increased assurance that individuals get the services they need that support Recovery and community stability for the amount of time they need them
- Improved health status based on ASO, the Health Home, and mental health providers' coordination of care
- Decreased unnecessary overutilization of outpatient and inpatient services resulting in savings
- Increased trust in the state's public mental health system

The Alliance for Health, the Mental Health Council of Arkansas, and the Arkansas Behavioral Health Providers Association (the Collaborative) have worked together to address the challenges facing Arkansas publicly funded behavioral health care system in a way that improves the benefit structure, improves effective utilization, and increases efficiency resulting in savings. See The Alliance for Health Care Improvement, Arkansas Behavioral Health Providers Association, and Mental Health Council of Arkansas Plan attached herein. Important suggestions consistent with TSG recommendations include changing the RSPMI benefit to an evidence based best practice model, addressing children/adolescent mental health separate from adults, and changing the definition of Serious Emotional Disturbance to increase the specificity of eligibility, resulting in a decrease in the number of children unnecessarily labeled with Serious Emotional Disturbance (SED) and up to a 20% reduction in children eligible for services. Recommendations also include using an assessment instrument other than the InterRai for adults and children that is a uniform document, clinically driven and addresses functional assessment. The Collaborative also points out that $38.3 million for Speech and Language Services of the $465 million spent for RSPMI services during Calendar Year 2014, as reported by TSG to the Task Force on 9/16/2015, is not billable by credentialed RSPMI providers. The service category is included in the state system as an RSPMI benefit but the credentials for eligible providers are different than RSPMI providers.

The Stephen Group commends the effort of these provider groups to be an effective partner with state government in addressing the serious financial issues facing the state's Medicaid program. Given the thought behind these recommendations, we recommend that the appropriate DHS division meet with the Alliance for Health and provider associations and report back to the Task Force at the March 7th meeting, or thereafter, on what DHS agrees can be done, how, by when, and the anticipated impact on beneficiaries and savings. The Task Force should then ask DHS to provide an implementation plan that can be reviewed and monitored.

Long Term Care

The Arkansas Health Care Association (AHCA) and the Arkansas Assisted Living Association (AALA) has recommended a Long Term Care Savings and Reform plan to the Governor and the Task Force that targets $250 million in savings after administrative costs over five years and is consistent with TSG recommendations in several significant ways: "Smart" Rebalancing", Independent Assessment, and a Three Tiered Levels of Care model (similar to the TennCare waiver model) including a Safety Determination element. See Arkansas Long Term Care Savings and Reform, Savings Plan of the Arkansas Health Care Association and Arkansas Assisted Living Association, dated February 2, 2016, attached herein. The level of care changes will result in level 1 being Nursing Facility level, Level 2 being Home

and Community Based Service level, and Level 3 a Prevention services level with a cap on the amount of prevention services available.

The suggested plan that is being worked on with DAAS includes a Transition "Bundle" of services with the Nursing Facility (NF) at risk, that provides attendant care, home modifications, and coordinated care based on an interdisciplinary team that targets smart rebalancing. In this innovative approach to rebalancing, the NF becomes a "bridge" between a hospital and a person's home. The plan also calls for a change in NF regulations to require all NFs to have a certified Social Services Director with training in person centered discharge planning. The plan also includes use of the MDS (Minimum Data Set) and DHS Form 703 for nursing facility assessment in an electronic format, and including enhanced assessment focus on Mental Status and functional abilities and goals. The InterRai assessment process for HCBS services currently conducted by DAAS nurses would remain in place.

More specifically, the current proposal calls for strengthening the assessment process for skilled nursing facility residents, in the new Tier level 1, by adding the 703 elements of the MDS assessment to expand the current assessment. Further, the proposal calls for strengthening the oversight of that assessment process to ensure impartiality and integrity in the assessment process. The cost for the contractor to oversee a sampling of these assessments will be borne by the NFs.

Level 2 and Level 3 individuals will now receive an independent assessment completed by the Department of Aging and Administrative Services (DAAS) nurse. The current independent assessment needs to be streamlined to ensure a more efficient, less time intensive process. Currently, it takes 2-3 hours to complete an assessment. Under the new criteria, those with significant physical and intellectual challenges (current skilled, and Intermediate 1 and 2) will be assessed by the NF. The remaining will be referred for an independent assessment by a DAAS nurse. The DAAS nurses will complete the assessment, assign the level of care and payment level, and complete the plan of care that meets the needs of the person served.

The current Intermediate 3 population could receive an independent assessment per their recommendation. A factor to consider is that the current Intermediate 3 population that reside in the nursing facility may have lost their home and the needed natural supports necessary to be served safely in a community setting. These individuals may continue to be assessed by the nursing facility using the enhanced assessment. If by using the enhanced assessment, it is determined individuals now meet the new Level 2 or 3 criteria, a plan to transition or grandfather these individuals must be considered. DAAS will require additional nurses to complete the independent assessments under the newly recommended assessment process. The cost for these services will be included in the TSG financial modeling for the non-capitated managed care plan

The key factor here is creating a new front door that manages screening, referral and completion of the assessments for all new admissions from a certain point moving forward. The AHCA proposal calls for creating an enhanced relationship with the current DAAS A-Plus team. This relationship is critical to ensure proper screening in the hospital or rehab setting takes place to ensure individuals are correctly referred for either a NF or independent DAAS assessment. Defining the details of this process is critical

to ensure non-skilled level individuals have the opportunity for an independent assessment, and choice for services under the new option, including home and community based care and assisted living.

The independent assessment conducted by DAAS nurses must be correctly completed, and the individual referred for Level two or three care must receive the right community services at the right cost. Thus, also part of the TSG recommendation will be for DHS to amend its current state plans to control access to all services by limiting over-utilization in the HCBS sector and ensuring that all services assessed do not exceed the assessed need of the person served. Currently, individuals on the waiver can assess multiple state plan services which drive up the cost of care in the community setting. Ultimately, all services will potentially be rolled into a global waiver, which will give the state greater control. In the short term, DHS could move to amend the current state plan to achieve this goal.

Savings estimates will also include the number of individuals that will be eligible for the preventative tier, the corresponding savings created by the shift to the preventative level of care and the reduction of over utilized services under the state plan for those on the waiver.

A Health Home and Care Coordination model is recommended by ACHA to be funded and supported by AHCA, and to include monitoring the health needs of the persons served in HCBS to slow the rate of growth into the high cost environments, and more effectively controlling halo costs. A per member per month payment must be established and this piece can be aligned with the MFSS components of the DD and BH plans. Under this model, Targeted Case Management under the state plan could be amended and these savings could be rolled into a new care coordination model. In addition, the self-directed counseling and fiscal management contract currently at DAAS for self- directed services needs to be considered and factored in. More details need to be worked out here on the AHCA plan, including CMS approval of the concept and the return on investment in relationship to the health home enhanced match returning to normal match rates. The model, however, is promising.

Finally, in their plan, the nursing homes recommend a 3-5% withhold as incentive to ensure estimates on savings and rebalancing is met. While the reforms do not impact the NF rates, savings are captured by slowing the rate of growth into the NF, streamlining the cost and over utilization that exists in the HBCS sector and ensuring cost in the community does not exceed NF care. Amending the state plans, managing the waiver and controlling allocation of resources to the assessed need is critical to ensuring transition to HCBS is a cost saving transition. Eighty percent of all Elders Choices beneficiaries receive personal care services under the state plan.

The Stephen Group commends the effort of AHCA and AALA to be an effective partner with state government in addressing the serious financial issues facing the state's Medicaid program. Given the thought behind their recommendations, we recommend that DHS, DMS, and DAAS meet with AHCA and AALA and report back to the Task Force at the March 7th meeting, or thereafter, on what DHS agrees can be done, how, by when, and the anticipated impact on beneficiaries and savings. DHS should also include the involvement and participation of the home and community based service providers. The Task Force should then ask DHS to provide an implementation plan that can be reviewed and monitored.

Home Care Providers

Regarding community providers, the support of the AAA's and other legitimate home care providers is critical to the model's success. The model appeals to community providers in several ways. First, the model makes a commitment to strengthen provider qualifications, and ensures only reputable qualified providers provide services. This is critical to ensure the states can strengthen the level of services on the HCBS side and be able to support potentially higher acuity patients in an HCBS environment. Next, effective discharge and transition planning will encourage opportunities for more individuals to have choices of service/placement in an HCBS environment. Finally, creating the new level 3, preventative level of care will provide an additional level that increases the numbers of individuals accessing non-institutional services. The number of individuals served may increase in the HCBS environment considering the fact state plans will be restructured to create a more efficient, less costly level of service.

Enhanced Care Coordination Program for High Cost/Complex Cases

- Comprehensive chronic care management coordination action strategies for individuals with multiple chronic care conditions in partnership with PCMH, Health Homes, and specialists in real time coordination with RSPMI, DD and LTC Home and Community Based Services providers
- Focus on the individual person/recipient with tailored care management services provided by the ASO in partnership with the person's PCMH/Health Home and community based providers that supports treatment plan adherence, medication adherence, and supports individual self responsibility based on disease related education and motivational follow up
- ASO identifies high cost/complex cases based on a contractually defined population requiring enhanced care coordination and use of stratification of diseases and cost through use of claims based data analytics
- Assists/educates/empowers the individual to take control over their own health care with a goal of independent self-management to the maximum extent possible
- Actively promotes and encourages personal responsibility
- Supports relationships with PCMH/Health Homes, specialists, and community services via training and problem identification and partnership solutions needs
- Targets transition services for target populations in partnership with Nursing Facilities and Home and Community Based Providers that assures coordination of follow-up care after hospitalizations or Medicaid/Medicare paid nursing facility rehabilitation stays
- Tracks, care coordinates, and considers alternatives for Medicaid paid inpatient psychiatric admissions and discharges for adults and inpatient and Residential Treatment Center admissions and discharges for children and adolescents
- Actively coordinates and communicates with PCMHs, Health Homes, FQHCs, and Community Health Centers on systemic and patient specific care coordination improvements and troubleshooting
- Call center for providers

The expected outcomes are:

- Improved clinical outcomes for high cost complex cases resulting in improved health status and decreased costs
- Augmentation of the PCMH program based on care coordination services of the ASO at the individual case level
- Improved coordination and population health focus by ASO facilitated partnership relationships among PCMH/Health Home, DD and LTC community providers, RSPMI providers, and complex high cost children served by DDTS and CHMS services
- Decreased duplication of unnecessary medical and pharmacy services and cost

Contracting Options for the Arkansas PCMH/Health Homes Managed Fee for Service Model

TSG has previously reported on the contracting challenges of DHS, the benefits and cost savings of decreasing the number of contracts DHS has to manage, and the need for subject and health services industry market based staffing/resources expertise at DHS as a focused contract management function. Additionally, how DHS contracts for the MFFS model (and the Managed Care model) will either enhance DHS/Medicaid policy integration going forward or support historical "silo" approaches to different aspects of the state's Medicaid program.

TSG recommends a single RFP/bid process based on an integrated contract format for each Administrative Service Only program element. Administrative costs are expected to be between 3% and 6% compared to 8% to 12% determined in a 2014 Milliman report on Managed Care.[1]Besides the key difference in risk assignment between the two models, managed care models require high cost claims payment, network development, and grievances and appeals as additional administrative services.

Specifically, the state would issue one RFP and request for cost proposal for the combined Enhanced Care Coordination Program for High Cost/Complex Cases, DD Waiver Program Management, and Mental Health Rehabilitation Option/RSPMI Services Management, plus specific plans to coordinate with PCMH/Health Homes, as a single bid and program and cost proposal.

In addition responding bidders would be required to submit a bid, program model, and cost proposal for each individual program component of the ASO model: one for Enhanced Care Coordination, one for DD Waiver Program Management, and one for the Mental Health Program Management.

This approach to defining, bidding, and contracting the MFFS/ASO model would provide Arkansas with the opportunity to make a decision on the quality and cost of a single integrated vendor approach. In addition, Arkansas would have the opportunity to make a decision on the quality and cost of the proposals for Enhanced Care Coordination, DD and Mental Health Program Management as individual systems and contracts. We believe this approach will enhance competition and allow the state to

[1] "Medicaid Risk Based Managed Care: Analysis of Administrative Costs for 2014"; Milliman, 6/22/2015

unbundle integrated bids for all ASO services and allow comparison among individual program bids, permitting a matrix bidding entity evaluation format.

MFFS/ASO Linkage to PCMH

The PCMH model for the Medicaid aged, blind, and disabled populations has been researched for several years with mixed results. The North Carolina PCMH model experience is worth noting[2]:

> "Beginning in 2007, CCNC created specialized chronic care programs to serve high-cost, vulnerable aged, blind, and disabled Medicaid recipients. Distinguishing elements of this initiative were the establishment of a pharmaceutical home; broad-scope disease management for combinations of chronic diseases; improvements in access to urgent care for special needs; comingling mental health care in primary care settings; patient/family/caregiver training for system navigation and self-management; transition management; and system-wide reporting on high-risk needs and continuing care services. These and other features mirror attributes necessary for successful disease management and medical homes for high-risk patients."

The care coordination challenge between the ASO entity managing high cost/complex cases and the DD waiver will require hard wired linkages with PCMH physicians, and perhaps EHR connectivity if achievable at no additional cost. If Arkansas chooses not to implement the Section 2703 Health Homes for Behavioral Health, consideration will need to be made to include this population in the PCMH model prior to going to bid for ASO services in order to assure maximum care coordination of all Medicaid MFFS services for the entire ABD population.

Discussion between current PCMH physicians for the non ABD population need to take place with DHS/DMS/DAAS/DDS and DBHS to assess the need to adapt the current model to meet the needs of a higher need and risk population, including a comprehensive planning process on what evidence based practice, support and training would be needed prior to the "go live" date that would support PCMH success in the delivery of quality cost efficient services. The current PMPM paid to PCMHs by DHS/DMS should be reevaluated in light of a higher risk population with more complex needs. Financial incentives for quality performance should be considered through rate set asides based on performance benchmarks or, perhaps, retroactive PMPM adjustments. Additionally, the RFP for Enhanced Care Coordination should require the vendor to engage an Advisory Council consisting of PCMH, DD and LTC HCBS, and Behavioral Health provider representatives and related advocacy groups.

[2] "Health Care Savings with Patient Centered Medical Home: Community Care of North Carolina's Experience"; H. Fillmore, C. Annette DuBard, et al; Population Health Management; p. 141; 6/1/2014

The Recommended Risk for MFFS Entity and for Providers

CMS permits state Medicaid programs to enter into contingency fee based contracts for Medicaid allowable administrative costs when three conditions are met: 1) the fee is contingent upon Medicaid cost avoidance in which the Federal Government retains its share of the savings (unless a Dual Eligibles model which permit Federal Government and State Government "gainshare"); 2) the administrative services contract "must" be awarded based upon a competitive RFP or IFB (Invitation to Bid) which is publicly advertised and widely distributed; and 3) savings upon which a contingency fee is based must be clearly defined and the scope of fee payments documented and approved by CMS.[3]

Generally speaking it appears states have at least two methods to bring some level of incentivized risk and gainshare into a Medicaid Administrative Services Only contract. The first method, similar to the Pennsylvania Access Plus program discussed below, ties the payment of ASO administrative fees identified in the contract to a dollar amount or percent of projected savings from a benchmark target. In fact, the ASO vendor puts their administrative fees at risk for savings performance in a somewhat reverse incentive model as there is no opportunity for gainshare should the target be exceeded. States and ASO vendors would have the ability to negotiate the degree of risk. It is important to note that the vendor would only be at risk of losing its own money to the limit of the amount/percent of administrative fees at risk. The state is still 100% at risk for above budget Medicaid program services expenditures in the MFFS/ASO model.

A more innovative approach to bringing limited risk and incentive for performance into an ASO contract is a model called "pseudo capitation".[4] In this method a PMPM cost for the covered populations and services included in the scope of a MFFS – ASO contract is used as a benchmark. The base administrative fee "includes a symmetrical increase or decrease depending on the contractor's success in meeting a target benefit cost per beneficiary" (PMPM).[5] PMPM costs below the target PMPM cost and within the contracted ASO's "incentive corridor" are paid to the ASO. PMPM costs below the ASO's "incentive corridor" contracted amount revert to the state. PMPM costs above the target PMPM cost and within the ASO's "loss corridor" are paid by the ASO through reduced PMPM payments. PMPM costs above the ASO's "loss corridor" are paid 100% by the state. The model provides disincentives for poor performance and incentives for better than contract compliance performance. In addition, by using a PMPM cost based method from the outset of a Managed Fee for Service – Administrative Services Only approach to value based purchasing, quality improvement, and cost savings, DHS will have experience managing from a PMPM framework should the state decide to implement managed care at some point in the future.

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[3] CMS Letter to regional Administrators: 11/20/2002; affirmed by California Department of Health Care Services: 1/27/2011, PPL010-002

[4] "Legal Analysis of a Medicaid "Managed Fee for Service" Model and a Medicaid Fee for Service Administrative Services Only (ASO) Model": Covington & Burling LLP

[5] Ibid, p. 9

Value based provider purchasing approaches to date have focused on capitation, bundled payments, and modified fee for service payments such as a Value Modifier are beyond the scope of managed fee for service models and not mentioned in the DiamondCare Proposal. For purposes of the financial modeling of the DiamondCare model, a 5% set aside from customary fees has been used as a modified incentive for cost savings from baseline costs. This approach does bring some measure of provider risk into the system. How the method of scaling the 5% set aside to actual practice should be structured around high cost complex case coordination and allow for a symmetrical upside for providers and PCPs above the savings threshold. Given the complexity of bringing this approach to scale, we recommend that DHS/DMS engage the provider and medical community in a strategic planning process to discuss the design of the 5% set aside approach and how it would impact (or not) the existing quality of services. The provider contracts here must allow for a clearly defined risk, which is both reasonable and structured to achieve targeted savings and successful practices, as well as allow for providers to share in savings.

How the MFFS Model Relates to Diamond Care

TSG's work on developing a Managed Fee for Service – Administrative Services model - for Arkansas is based on most of the key recommendations made in the DiamondCare Proposal. The similarities include expansion of the PCMH model (Health Homes for Behavioral Health) to populations currently not included in the PCMH program; exclude further expansion of the Episodes of Care; include an ASO-based management and independent assessment of Developmental Disabilities waiver and Behavioral Health services covered by RSPMI; provider reimbursement hold back for incentives for quality performance; a managed care model for dental services; empowering nursing facilities in transitioning more beneficiaries to home care following rehabilitation stays post hospitalization; and an increased focus on program integrity.

State Plan Rules and Waiver Changes

Behavioral Health:

TSG recommends that DHS/DBHS begin implementing the OMIG recommendations regarding the RSPMI Group Psychotherapy benefit (Code 90853), including reducing allowable daily payment from $82.80 per day ($13.80 per 15 minute unit) to $40.00 per day ($10.00 per 15 minute unit); capping allowable daily units of service at 4 (60 minutes) rather than the current 6 (90 minutes); and capping allowable sessions per year to 25 rather than current unlimited number of sessions per year. (Time Estimate: 3 to 6 months)

DHS, DBHS and DMS should also develop and enact a comprehensive plan to transform the current RSPMI benefit to an Evidence Based and Best Practice psychosocial rehabilitation benefit based on an Adult domain and a Children/Adolescent domain. (Time Estimate: 8 to 10 months)

TSG also recommends that DHS, DMS, and DBHS accelerate their dialogue with Beacon Health Options on what changes can be made to the current contract for the prior authorization process for RSPMI

benefits, including a Return on Investment analysis, which would result in efficiencies and savings starting by 7/1/2016.

Medicaid Manual/Medicaid Fairness Act

It is recommended that DHS/DMS work with providers on changes needed to the Medicaid Manual to include a specific definition of "Medical Necessity" based on state Medicaid medical best practice (there is no definition of "Medical Necessity" in section 191.001: Definitions). Moreover, the Act should be reviewed from the perspective of establishing a neutral platform for appeals, second opinions, and credentialed third party review of all aspects of the determination of Medical Necessity, and to ensure the use of evidence based practice and known best practice specific to the relationship between the determination of Medical Necessity and the proposed treatment scope, duration, and amount. TSG has had discussions with provider association representatives and has been encouraged by the willingness to consider particular changes to the Act that would meet some or all of these goals. The Task Force should encourage DHS to continue these discussions prior to moving forward on any practice changes. (Time Estimate: 2 to 4 months)

LTC and DD Home and Community Based Waivers

DHS/DAAS/DDS modernize the LTC and DD Home and Community Based Services waivers to include three levels of care (Tier 1: NF level of care: Tier 2: Qualify for NF, receive services and supports at home; Tier 3: do not quality for NF, but require moderate assistance to avoid need for NF level of care); tiered payments; and modification of the InterRai for LTC and the implementation of the SIS for DDS to accommodate the three levels of care and tiered payments. (Time estimate: 8 to 12 months)

Short Term Savings: Provider Group Recommendations

Leadership from the Long Term Care, Behavioral Health, Developmental Disabilities, and CHMS provider group community have stepped up to the plate and provided serious savings recommendations. DHS, DMS, DAAS, and DDS should schedule a conference meeting with each group for the purpose of determining how feasible each proposal is and what can be implemented by 1/1/2017, if not sooner, that will save costs without harm based on return on investment analyses.

Long Term – Global 1115 Waiver: 12 to 18 months

DHS takes an enterprise approach to planning, developing, and implementing an 1115 "Global Choice waiver" that either includes the entire Medicaid program or combines all aged, blind and disabled 1915 (c) waivers and the RSPMI benefit. Planning for a combined 1115 waiver should include consideration of the inclusion of an innovative Delivery System Reform Payment Program (DSRIP) model in Arkansas based on CMS' recent approval of a community mental health DSRIP program in New Hampshire and a pending DSRIP model for long term care in Virginia.

How the MFSS/ASO Model Differs from the Managed Care Model

As previously discussed, the hallmark financial benefits to a state using capitated at risk managed care contracts in their Medicaid programs are that, as prepaid health insurance plans, the managed care organizations are at 100% risk of expenditures above the total of capitated member months rates and the benefit of premium tax revenue (based on state law) during the life of the contract.

States are at 100% risk for over budget expenditures in MFSS/ASO contract models. ASO's do not provide medical services, contract with providers, or set rates and therefore does not meet the criteria of a managed care entity in 42 C.F.R. Sec. 438.2. An ASO is not a prepaid health plan and not subject to capital reserve requirements. ASO performance contingency fees (limited gain/risk) which TSG has recommended must be based on cost avoidance that CMS shares (i.e. decreased Medicaid expenditures, federal share), a competitive bid, and CMS approval of contingency fee payment model. The ASO model does not require actuarially sound rates approved by CMS.

Pharmacy Savings Outside of MFSS

Overview

The pharmacy program will contribute an estimated $32.5 million in annual savings to the overall savings target. Savings will grow with inflation. The following is a short review of the initiatives that that make up this savings. The initiatives which can be quantified now are as follows:

1. Prescription Drug List (PDL) Expansion
2. Central Admixture Pharmacy (CAP) Expansion
3. Antipsychotic Drug Management
4. Hemophilia Factor Drug Management

In addition, TSG recommends a reconfiguration of the State's Retail Pharmacy Reimbursement Formula. While savings associated with this reconfiguration are expected to be significant, these savings cannot be estimated until the completion of ongoing dispensing fee and ingredient cost surveys thus such savings are not included in our $32.5 million annual savings estimate.

Findings

PDL Expansion

DHS has completed its evaluation of potential vendors to improve the percentage of claims covered by supplemental rebates. Magellan will help the DHS expand coverage from the current 38% of claims to approximately 60% of claims and this expanded coverage will start 10/1/2016. The annual savings for this initiative are $10 million.

CAP Expansion

DHS has identified approximately 150 additional drugs to add to the current CAP program which saves money by establishing a ceiling price for drugs which are not generic or subject to State MAC or Federal FUL pricing. The new additions to the program are Limited Access Drugs, meaning they are not available

at every retail pharmacy due to cost, infrequency of use, or other specialized requirements. Many of these products are shipped into Arkansas by specialty pharmacies outside the state. This initiative will start 10/1/2016 and produce incremental annual savings of $1 million.

Antipsychotic Drug Management

There are several initiatives contributing to saving in the antipsychotic drug area. DHS is expected to lower its spend on Abilify (aripiprazole), a widely used atypical antipsychotic drug, with the availability of generics. Savings has begun to accrue and will total $19.5 million annually. DHS has also increased the age for manual review by a pediatric psychiatrist prior to approving antipsychotic drugs for children by adding 7 year olds in February 2016 and 8 and 9 year olds in April 2016. This will dramatically reduce the drug use and cost for this population by $1 million annually. These savings are net of any additional pediatric psychiatrist time required to review the cases.

Hemophilia Factor Drug Management

Over the last year, hemophilia factor drugs were one of the fastest growing drug classes in terms of drug spend for DHS. DHS designed an innovative way to manage the cost of these expensive drugs, improve quality and decrease waste. Through a limited number of highly qualified pharmacies, with lots of experience managing patients with hemophilia, waste reeducation programs will begin in the fourth quarter of 2016. TSG sought out best practices in waste reduction to size the impact of this initiative. The best performing pharmacies can eliminate 5-6% of drug cost through waste reduction. It is a process of matching the prescribed dose to the available product on hand. We have seen contractual guarantees of 2.5% waste reduction, but in practice 5% is a solid estimate of the value. With a current annual spend of over $20 million on these products, a 5% savings equals $1 million beginning in fourth quarter 2016.

Pharmacy Reimbursement Formula

A key pharmacy savings recommendation from TSG is to reconfigure the retail pharmacy reimbursement formula, addressing both the ingredient cost calculation and the professional dispensing fee paid. The CMS-required dispensing fee survey is complete but the analysis of acquisition cost reimbursement using NADAC will not be completed until March 2016. The timing of these important analyses prevents TSG from estimating the savings impact at this time. We are confident that there will be positive savings from this initiative and that they can be implemented around October 2016. We will update the total annual pharmacy savings once we know them.

Total Annual Savings*

Initiative	Annual Savings (Millions)	Savings Start Date
PDL Expansion	10.0	10/1/2016
CAP Expansion	1.0	10/1/2016
Antipsychotic Review – Move from Abilify to Generics	19.5	1/1/2016
Antipsychotic Review – Age Reviews	1.0	4/1/2016
Hemophilia Factor Drugs Review	1.0	10/1/2016

Total Savings	**32.5**	

* Does not include savings from reconfiguring retail pharmacy reimbursement formula.

Centers of Excellence

While developing the recommendations surrounding a plan to achieve the targeted savings without capitated managed care, TSG was also provided with other ideas and models by Arkansas health care providers that could achieve Medicaid program savings in the future. One of the concepts that has been proposed is to improve the quality of care for certain Arkansas Medicaid recipients by establishing centers for excellence within certain complex and high cost populations, specifically complex neonatal cases (for care throughout childhood and adolescence) and certain cancers. Although the cost implications of these proposed models are still being developed, it has been well-established within the academic literature that there is a clear and robust positive correlation between the volume of certain types of procedures and outcomes. Therefore, establishing a mechanism whereby certain complex types of conditions or patients were steered toward the centers of excellence has the potential to improve quality while lowering costs. The Task Force should continue to review these and other areas that could provide for enhanced savings and improve quality in the Arkansas Medicaid program for both children and adults.

Human Development Centers

In identifying his target for the $835 million in savings, Governor Hutchinson noted that Arkansas Human Development Centers (HDC) would be "excluded from the larger managed care initiative" but that he "would work for a plan to assure the sustainability of HDCs." TSG has not factored any changes to HDCs in its savings model, nor do we believe it is necessary to achieve the targeted savings. However, the Task Force should seek more information and data in this area to determine the future costs to sustain any one or more of the Centers, as well as the financial program costs as compared to the costs in a non-institutional setting, and the impact any transitions would have on individuals, families and the community.

Financial Model and Estimated Program Savings

The following table represents the baseline scenario. The SFY2017 estimates are based on SFY2015 actuals inflated at 5% annually and the SFY2018-2021 estimates continue the application of this inflation factor. In the baseline scenario, it is estimated that Arkansas Medicaid will spend approximately $29.7 billion over the five fiscal years 2017-2021.

Baseline Estimates of Medicaid Spending by SFY and Program						
Date range	7/1/16 - 6/30/17	7/1/2017 - 6/30/18	7/1/18 - 6/30/19	7/1/19 - 6/30/20	7/1/20 - 6/30/21	
SFY	SFY2017	SFY2018	SFY2019	SFY2020	SFY2021	SFY 2017-2021

Baseline						
Elderly non-SNF	381	400	420	441	463	2,105
SNF	724	760	798	838	880	4,001
DD non-HDC	638	670	703	739	776	3,526
BH program	519	545	572	601	631	2,868
HDC	170	178	187	197	207	939
All prescription drugs	363	381	400	420	441	2,005
All dental	127	133	140	147	154	701
All medical	1,327	1,393	1,463	1,536	1,613	7,332
non-claims based payments	1,130	1,187	1,246	1,308	1,374	6,245
Total	5,379	5,648	5,930	6,227	6,538	29,722

As previously discussed, the model being developed herein is a non-capitated managed care model. As such, the following tables break out the programs by savings strategy. The following table shows the programs in which different variations of the Medicaid Managed Fee-For-Service (MFFS) model is being proposed, and the corresponding savings estimates:

Estimated Medicaid Expenditures under Different Savings Strategies by SFY and Program *MFFS-Related Programs ($millions)*								
	SFY17	*SFY18*	*SFY19*	*SFY20*	*SFY21*	*SFY 17-21*	*Program Savings/ Costs*	*Description*
Elderly non-SNF	371	381	401	422	444	2,018	88	Proportional allotment of $250M over last 4.5 years of period, based on industry proposal for health homes and other DHS programmatic changes
SNF	706	724	762	802	844	3,839	163	
DD non-HDC	617	627	661	696	733	3,333	193	$193M 5-year savings, based on industry proposal for cost savings, with 50% phase-in year 1
BH program	493	490	515	541	568	2,607	261	MFFS, 10% estimated savings, with 50% phase-in year 1
MFFS Subtotal	2,187	2,222	2,338	2,460	2,588	11,796	704	

The following table shows possible cost-savings within other areas of the Arkansas Medicaid program that are not related to MFFS deployment:

Estimated Medicaid Expenditures under Different Savings Strategies by SFY and Program *Non-MFFS-Related Programs ($millions)*								
	SFY17	*SFY18*	*SFY19*	*SFY20*	*SFY21*	*SFY 17-21*	*Program Savings/ Costs*	*Description*
HDC	170	178	187	197	207	939	0	No savings planned at this time – Task Force further review recommended
All Prescrip-tion Drugs	333	349	368	388	409	1,846	160	$32.5M annual savings, based on TSG analysis of agency opportunities, with phase-in in first quarter of SFY17
All Dental	127	128	135	142	149	681	20	$20M flat savings, evenly distributed, capitated, based on industry proposal, begin July 1, 2018
All Medical	1,306	1,349	1,416	1,487	1,561	7,119	213	3.19% additional savings, with savings phase-in, based on expansion of PCMH, assuming similar opportunity as LA
Non-claims based payments	1,130	1,187	1,246	1,308	1,374	6,245	0	No savings planned
Programs not impacted by MFFS Subtotal	3,066	3,191	3,352	3,521	3,699	16,829	392	

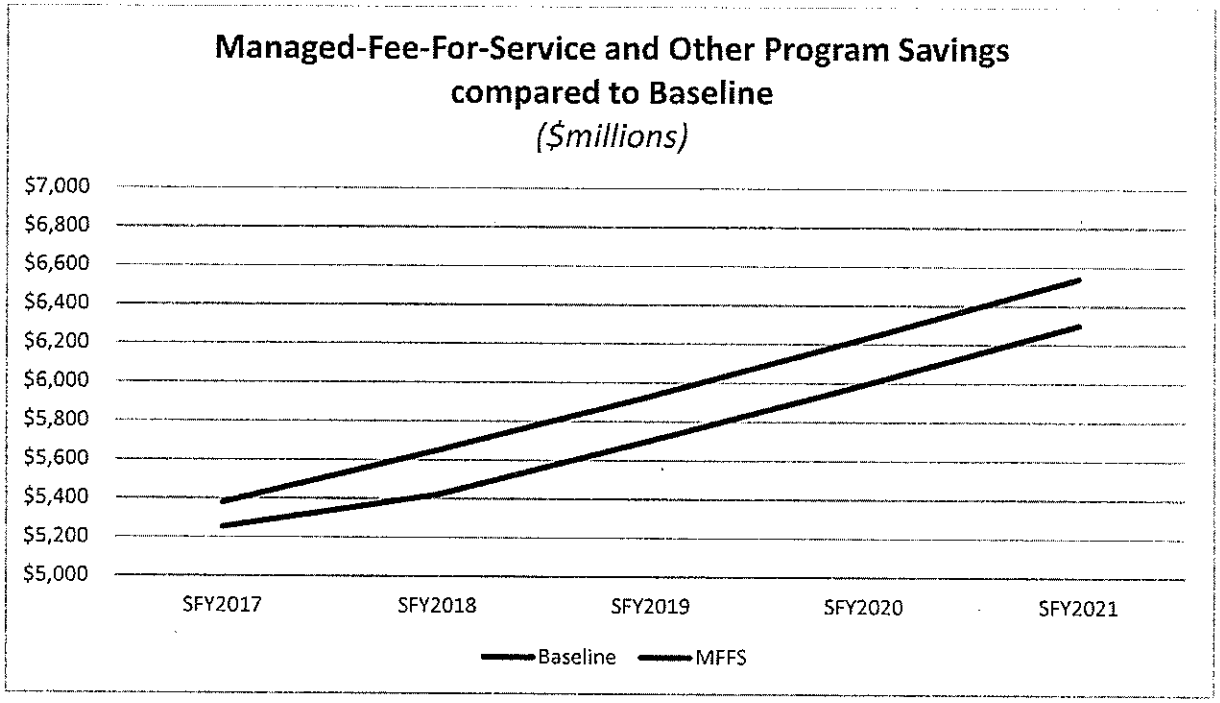
In addition to potential savings within each of the core Medicaid programs, there are also administrative costs and savings, in addition to new revenue induced by the aforementioned policy changes, as shown in the following table:

Administrative Costs and Savings from Proposed Program Changes *($millions)*								
	SFY17	*SFY18*	*SFY19*	*SFY20*	*SFY21*	*SFY 17-21*	*Program Savings/ Costs*	*Description*
Additional savings								
Reduced agency DD staffing	0	1	2	2	2	7		40 staff @ $50k/yr, w/ quick phase-in
DD case management fee	0	3	6	6	6	21		DD case mgmt fee - - 4,200 @ $118/day, w/ quick phase-in
Additional savings subtotal							28	
Additional costs								
DMS admin costs for MFFS	2	5	5	5	5	20		45 additional FTEs phase-in starting Jan 1, 2017
DAA admin costs for LTC program	1	1	1	1	1	5		10 nurses, phase-in starting Jan 1, 2017
Transitioned contract services	0	9	17	17	17	60		Costs from shifting certain contracts to MFFS entities; $68M 4 year spend pro-rated to 3.5 yrs
Additional costs subtotal							84	
Revenue impact								
Premium tax (dental)	3	3	3	4	4	17		
Revenue impact subtotal							17	

The total impact of the MFFS program savings, other program savings, corresponding administrative costs and savings, and new revenue is about $1,057 billion in all funds over the five years of the period in question. These savings include efforts of OMIG across all Medicaid populations to meet the Governor's goal of enhancing program integrity.

Summary of Savings (Costs) from Proposed Program Changes *($millions)*	
Cost/Savings Category	*Impact*
MFFS savings	704
Other program savings	392
Admin savings	28
Admin costs	(84)
Revenue impact	17
Total Impact	1,057

The following graph compares the trends for the baseline scenario to the managed fee-for-service scenario.



Summary: MFFS savings in relation to baseline

	SFY2017	SFY2018	SFY2019	SFY2020	SFY2021	SFY 2017-2021
Baseline	$5,379	$5,648	$5,930	$6,227	$6,538	$29,722
MFFS/Other	$5,253	$5,420	$5,701	$5,993	$6,298	$28,665

Behavioral Health

In the behavioral health area, it is anticipated that, with a combination of rule and rate changes to restructure some of the core behavioral health benefits, in addition to the implementation of universal independent assessments, that it will be possible to recognize 10% savings compared to the baseline trend. These changes will all be implemented by a managed fee-for-service entity.

Developmental Disabilities

For developmental disability services outside of the state Human Development Centers, the savings estimate is based on a 5-year savings proposal developed by industry participants that anticipated a $193 million 5-year savings focused on developing and requiring an independent standardized assessment for both adult and children populations served within DDTCS and under CHMS. Require and strengthen prior authorization of services. Eliminate the ability for children to receive duplicated therapy services between center-based and stand-alone therapy providers, the creation of tiers of services and other changes identified in the previous MFSS Model section of the TSG report and also contained in the provider association proposals attached as appendices to this report. For the purposes of this analysis, the 5-year savings estimate is applied over 4.5 years based on the assumption that there

would need to be some ramp-up time by the agency. This analysis does not include any recommendations for cost-savings with respect to Human Development Centers. These changes will all be implemented by a managed fee-for-service entity.

Long Term Care

This analysis includes $250 million in savings for programs that primarily serve the elderly including skilled nursing facilities, and waivers and state plan services serving the elder population, based on a proposal developed by industry participants. The core elements of the proposal include independent assessments and health homes. Savings will be ensured by a financial "withhold", to be used for value-based payments and/or shared savings payments. While the details of these programmatic changes have not yet been developed, it is anticipated that these changes will be implemented within the philosophy of managed fee-for-service, with some entity or entities accountable for overall costs.

PCMH

The savings strategy for the medical component of the Medicaid program, including both the medical component for the high cost populations (behavioral health, developmental disabilities, and elderly) and the traditionally low-cost Medicaid populations (primarily pregnant women and kids) will be the expansion of the PCMH program into all of these populations and across all primary care providers. Based on the assumption that the current PCMH program is recognizing about half of its potential savings, this model applies an additional 3.19% savings to the medical spending.

The development of the PCMH expansion to the ABD population and Health Home model for the Aged/Physically Disabled and the Serious and Persistently Mentally Ill populations should include involvement of Arkansas Advanced Practitioner Nurses (APRN) connected with the High Cost/Complex Cases MFFS administrative entity, the PCMHs, and the health homes. Scope of practice would be based on current requirements for designated medical supervision and innovative ideas related to increased access. The involvement of APRNs with high cost populations and enhanced care coordination for chronically ill Medicaid beneficiaries has resulted in cost savings for states.

Pharmacy

This analysis assumes approximately $160 million in prescription drug savings over the 5 years being analyzed through the following interventions: PDL expansion, CAP expansion, Antipsychotic (Abilify generic), Antipsychotic review (7, 8, & 9yo), and hemophilia factor drugs. Most of the changes necessary to recognize these savings will be introduced prior to the period under review and so most of the savings will be recognized for the duration of the period.

Dental

This analysis assumed that there would be at least $20 million in savings to the dental program due to the establishment of dental managed care. TSG recommends that DHS consider adopting a similar methodology to that used in Texas with Medicaid managed care companies that establishes a gain share ceiling for non-Medical Loss ratio expenditures.

Administrative Costs and Savings

It is anticipated that the agencies will be able to recognize some administrative savings through the implementation of managed fee-for-service models as functions previously performed by the agencies are subsumed by the managed fee-for-service entity or entities. At the same time, in some programs, new costs will emerge associated with the management of the new contracts and oversight of the new programs. In particular, the above analysis assumes that some staff associated with DD program oversight will no longer be needed, whereas some new staff will be required for performing independent assessments for the programs focused on the elderly.

Premium Tax

In addition to program and administrative savings, there will also be another positive impact to the general fund from the proposed programs in the form of the premium tax. The shift of dental services into a capitated managed care arrangement will route a set of Medicaid payments through one or more insurance companies, creating new state revenue through the premium tax (2.5%).

General Fund Breakdown Savings Breakdown

The following table shows the estimated general fund components of the program savings previously discussed. In most cases, program all-funds savings are reflected in general fund savings through the normal state match rate, although there are some notable exceptions. Savings due to lower spending on skilled nursing facilities (SNF) saves the state general fund only a little more than half as much as other program savings due to the fact that SNFs are subject to a bed tax ("quality assurance fee") which then serves as part of the state match. The other exception in these estimates is the administrative costs. Some admin costs are reimbursed at 75% federal, while others are reimbursed only at 50% federal. This analysis assumes that the admin costs are matched at the same matching rate as program services. While the aggregate effective state matching rate across all of the administrative savings and costs is likely to be slightly different than 30%, given the small scale of the savings and costs in question, it is assumed that the impact of the difference will be negligible.

General Fund Components of Program Changes			
Program	**Program Savings (Costs)**	Effective State Match %	General Fund savings
Elderly non-SNF	88	30%	26
SNF	163	16.27%	26
DD non-HDC	193	30%	58
BH program	261	30%	78
HDC	0		
All prescription drugs	160	30%	48
All dental	20	30%	6
All medical	213	30%	64
Non-claims based payments			

Admin savings subtotal	28	30%	8
Admin costs subtotal	(84)	30%	(25)
Premium tax (Dental)	17	30%	5
Total All-Fund Impact	1,057		294

Specific State Experiences with Similar MFFS Models

The general approach used in this analysis to estimate potential Medicaid savings across different programs was, first, to determine if any savings target or approach had been agreed-to by industry participants. In such cases, as long as the savings targets and approach to meeting them were deemed to be reasonable, then those savings targets/estimates were used. In those cases where industry participants did not identify a particular approach to recognizing savings, or in cases where they affected industry was too diffuse to make such an endeavor reasonable or likely, empirical results from Medicaid savings strategies from other states were used.

Louisiana

A set of savings estimates from Louisiana were identified as being particularly useful, since they included a direct comparison between regular Medicaid fee-for-service, Medicaid patient-centered medical home, and capitated Medicaid managed care. Since each state context is different, having a set of estimates across the different models from a single state was particularly compelling. The estimates from the Louisiana experience were compared against estimate from other states, to ensure that they did not represent atypical measures, but they were found to be consistent with savings estimates from other states.

In particular, the Louisiana analysis estimated that PCMH (a variation on managed fee-for-service) saved the state about 6.4% when compared to unmanaged fee-for-service, and that capitated managed care saved the state about 11.3% when compared to unmanaged fee-for-service. Since Arkansas already has deployed PCMH to part of its Medicaid providers and population, it would not be reasonable to apply these full cost saving levels to current Arkansas Medicaid spending. We assumed that about half of the potential PCMH cost-savings has been recognized in Arkansas already. Therefore, when estimating MFFS savings in the current Arkansas Medicaid population, only half of the Louisiana savings amount was applied (i.e., about 3.2%). (Note: in cases where the savings impact of Medicaid managed care is to be estimated, the same amount of cost saving potential should be assumed and rather than applying a cost-saving percentage of 11.3%, a cost-savings percentage of 8.1% should be applied.

Pennsylvania

The Department of Public Welfare (State Medicaid agency) contracted for a managed fee for service program in a 16 county area (300,000 beneficiaries) from 2006 until 2013 that did require mandatory managed care enrollment at that time. The program, known as the Pennsylvania ACCESS PLUS FFS Medicaid Enhanced Case Management and Disease Management Program, was designed to improve and stabilize Medicaid expenditures, provide access to disease management and care coordination service to high cost beneficiaries identified through claims data stratification, and

improve health quality. The design of the Access Plus program for the high cost population was based on increasing care coordination across multiple providers/settings/levels of care, decrease unnecessary ER use, hospitalizations, readmissions, effectively manage poly-pharmacy and adherence, and effective client engagement for Disease Management practices. The contract required a guaranteed rate of return (ROI) of 6.7%, including vendor administrative services. Aged, Blind, and Disabled plus TANF beneficiaries were enrolled in the program Dual eligibles (Medicaid and Medicare) and TANF beneficiaries were excluded. Vendor services provided included a Primary Care Case Management program through primary care health homes, disease management for 21 diseases based on profile identification and stratification of members (based on key indicators of 3 or more ER visits and/or 3 or more inpatient episodes and cost), and care coordination for high cost cases across multiple services (e. g. Behavioral Health, waivers, hospital services) focused on clinical outcomes and cost. The program model was based on priority setting of highest need clients receiving intensive care coordination, continuous assessment of the covered population for services utilization and high cost, with all clients receiving access to preventive self- help resources and support. Specific care coordination services for high cost cases were follow-up after acute event/office visits, medication and treatment plan adherence monitoring, use of HEDIS measures to determine need for provider interventions.

For calendar year 2009 the Access Plus Program outperformed all managed care plans on Emergency Room Utilization at 41 visits per 1,000 beneficiaries compared with all managed care plans over 60 visits per 1,000 with the highest being 91 visits per 1,000.[6] From November, 2008 to September, 2011 the Access Plus program resulted in a decrease of overall cost from $292 PMPM to $275 PMPM, a decrease of 5.8%.[7] For CY 2009 Department of Public Welfare data reported that the Access Plus program resulted in a 1.2% hospital readmission rate, a 2.1% 14 day hospital readmission rate, and a 5.3 % hospital readmission rate. All three outcomes were substantially less costly than traditional fee for service to managing the PA Medicaid program.

In 2011 The Lewin Group, sponsored by the Medicaid managed care plans of Pennsylvania, released a report that evaluated the differences between the costs of the state's Medicaid managed care plans (Health Choices), the Access Plus managed fee for service model, and traditional Medicaid fee for service. The report, based on the use of DPW data sources concluded[8]:

> "We estimate that [capitated managed care] HealthChoices saves the State roughly double the savings of ACCESS Plus without including the impact of the gross receipts tax. Once the tax savings are factored in, [capitated managed care] HealthChoices is projected to achieve roughly triple the savings that can be achieved in the ACCESS Plus setting."

[6] PA Department of Public Welfare 2009 External Quality Review Report: 7/7/2010
[7] Reviewed by PA Department of Public Welfare and Mercer
[8] "An Evaluation of Medicaid Savings from Pennsylvania's Health Choices Program"; The Lewin Group; p. 18; 5/2011

The report included an informative matrix on the Cost Containment features of managed care, managed fee for service, and traditional Medicaid fee for service[9]:

Exhibit 3: Summary Comparison of Cost Containment Features of Various Medicaid Models

Rating Key: ● Model strongly provides this attribute ◐ Model partially provides this attribute ○ Model does not have this attribute			
Cost Containment Techniques	FFS	ACCESS Plus	HealthChoices
General Attributes			
Channels Patient Volume to Low-Cost Settings and to Cost-Effective Providers	○	○	●
Avoids Unnecessary Services	○	◐	●
Creates and Uses Network of Providers	○	◐	●
Directly Pays Providers for Health Care Services	●	○	●
Requires Lower-Cost Services Where Available	○	◐	●
Vendor At Risk for Medical Costs	○	◐	●
Achieves Favorable Unit Prices for Medical Services	●	●	●
Specific Attributes			
Primary Care Physician Required	○	●	●
Prior Authorization for Costly Services	○	◐	●
Referrals Required for Outpatient Specialty Care	○	◐	●
Disease Management	○	●	●
Case Management	○	◐	●
Enrollee & Provider Outreach and Education	○	◐	●
Management of Prescription Drug Mix & Usage	○	○	●
Can Pay for Uncovered Services on Exception Basis	○	○	●
Provider Profiling/Reporting, Quality Measurement, and Monitoring	○	◐	●

Behavioral Health

At the 1/20/16 meeting of the Health Reform Task Force TSG[10] reported that 23 states and the District of Columbia had some form of managed fee for service/ASO model for their Medicaid Behavioral Health benefits with seven states transitioning these services into managed care. Several states have included an integrated health home with their efforts to assure appropriate use and access to "Rehab option" benefits while controlling costs.

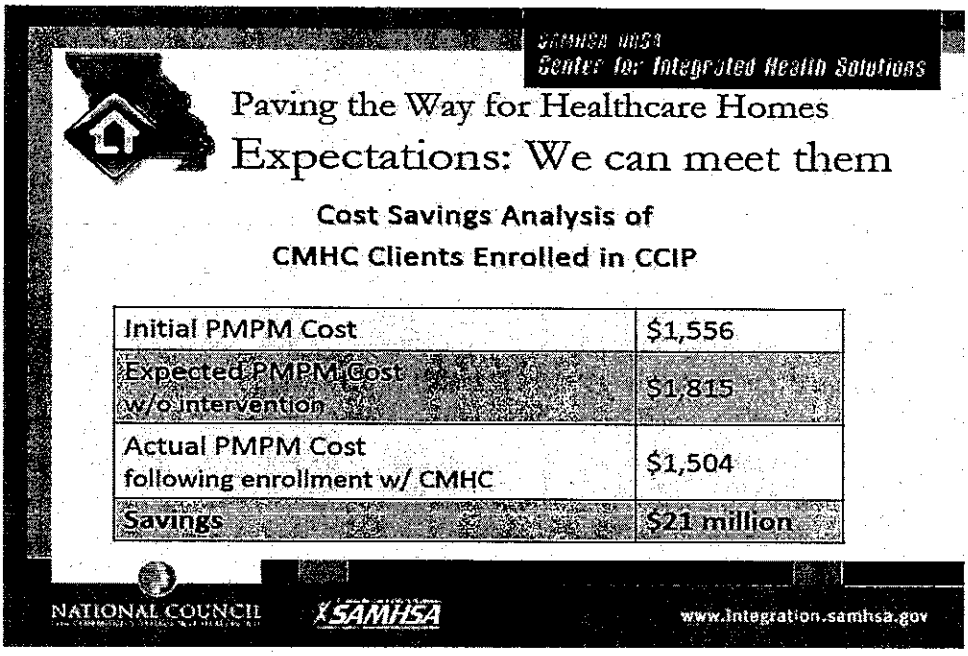
Missouri

Missouri was the first state in the country to receive CMS approval for a Section 2703 Health Home program for community mental health. Section 2703 provides states 90/10 federal matching rates for the first eight quarters with the match rate reverting back to the regular state match thereafter. The Missouri model was created through a collaborative planning process resulting in health designations

[9] Ibid, p. 11
[10] TSG Update, 1/20/16, slide 11

for participating physician practices, FQHCs, Rural Health Clinics, and designated Community Mental Health Centers. The focus of the health home initiative was to enhance high quality integration and coordination between primary care and mental health providers, improve cost effectiveness and achieve savings, enhance care coordination, and improve individual and population health related to chronic conditions. Medicaid eligible individuals who quality for health home services include people with two chronic conditions, one chronic condition and at risk of a second, or a person with a severe and persistent mental illness. Five chronic conditions are covered by the Missouri health home model: asthma, diabetes, cardiovascular illness including hypertension, tobacco use, and a person with developmental disabilities. Benchmark metrics are established in each person's individual treatment plan and progress is measured and entered into the EHR system provided by MoHealthNet, the state's Medicaid program. The goals of the health home in Missouri include reduced use of inpatient and ER services, enhance nurse liaison and physician consultation for complex cases, enhance coordination among all health home participants, enhance transition services between institutions and the community, and empower health home clients with self-care education knowledge and motivation. As of 2013 there were 28 physician practices, 19 FQHCs with 70 clinics, 5 public hospitals with 22 sites, 1 Rural Health Clinic, and 28 CMHCs with 50 clinics participating in the Missouri Behavioral Health – Health Home program. Individual cost is established on a per member per month methodology and all providers are paid fee for service. The Missouri health home model requires an increased burden for data collection across program participants and are somewhat adjusted between clinical and administrative services.

The Missouri Behavioral Health -Health Home Initiative established cost savings goals[11] from the outset based on:



[11] "Health Homes in Missouri", Joe Parks, MD, 2014, SAMHSA/National Council

The Missouri Department of Mental Health and Mo HealthNet (Medicaid agency) reported that the net savings from the Health Home initiative from the outset totaled $38 million for all enrollees in the program.[12] Of the total amount saved a total of $22.3 million was attributed to "DM 3700" individuals who represent health home enrollees identified with over $38,000 in annual Medicaid costs. Cost reduction for this high need/high cost group was $614.80 PMPM.

Virginia

On 12/1/2013 the Virginia Department of Medical Assistance Services awarded a contract to an Administrative Services Only to manage all Medicaid state plan behavioral health services for eligible members meeting the criteria for the state MH-Psychiatric Rehabilitation Option benefit and the state plan MH services, inpatient and outpatient, for those eligible members not enrolled in managed care plans requiring less intense services. Covered lives include approximately 600,000 people for MH SPA Clinic service and 300,000 people for the MH-Psychiatric Rehabilitation Option benefit. The CMS approved 1115 waiver for this initiative did not require administrative services to be included in the five year budget neutrality calculation but does require ASO costs to be included on the waiver Form 64 financial reporting form.

Vendor contract requirements include:

- A toll-free 24-hour centralized member and provider call center
- Easy access to information, referrals and assistance
- Member outreach and education
- Quality improvement initiatives
- Care coordination of clinical services

DMAS services and processes transitioned to the ACO vendor include:

- Behavioral health service authorization requests;
- Member eligibility verification;
- Credentialing and enrollment of all Medicaid fee-for service behavioral health providers
- Claims processing for covered behavioral health services
- Appeals related to any adverse service authorization determination issued by DMAS/BHSA

MH/Psychiatric Rehabilitation services and related SPA services covered under the contract include:

- EPSDT Behavioral Therapy Services
- Community Mental Health Rehabilitative Services (CMHRS) (such as Intensive In Home, Therapeutic Day Treatment, and Mental Health Supports for children and adults)
- Targeted Case Management
- Treatment Foster Care Case Management
- Residential Treatment (Levels A, B & C)
- Substance Abuse Services

[12] "Progress Report: Missouri CMHC Health Care Homes", p. 54, DMH, MoHealthNet, 11/1/2013

- Inpatient and Outpatient Psychiatric and Substance Abuse Treatment Services (such as medication management, and individual, family, and group therapies) for non-MCO enrolled members
- Exclusions Inpatient and outpatient psychiatric services for members enrolled in a Managed Care

The provider network in Virginia for the MH-Psychiatric Rehabilitation Option includes more than 4,900 providers in over 8,000 provider service locations. The VA model has the ASO responsible for network management.

Data provided by the ASO vendor to DMAS indicates an 18% reduction in thirty day MH hospital readmissions; general hospital admissions decreased by 18% per 1,000 beneficiaries, emergency room visits decreased by 103 visits per 1,000 beneficiaries, and seven day follow up after hospitalization increased by 33%. The FY 2015 budget for the MH-Psychiatric Rehabilitation Option was $554,951 million for a total state population of 8.2 million and a Medicaid beneficiary population of 1.2 million.[13]

Developmental Disabilities

West Virginia

The West Virginia Bureau for Medical Services (BMS) operates an Intellectual/Developmental Disabilities HCBS waiver. The program served 4,634 individuals during FY 2015 at a cost of $385 million at an average cost of $83,100 per person. In FY 2010 the program served 4,534 individuals at a cost of $315 million at an average cost of $70,000 per person. In 2012 state policy increased allowable hours and hourly wage for a family member providing direct care services in their home and an increase in the number of Individually Supported Settings (ISS) requiring 24 hour coverage for people no longer living in their family home drove an increase in the average cost per person to over $80,000 per waiver slot. Average cost for an ISS setting is $190,047 per setting. The State of West Virginia addressed both cost drivers through the waiver management and renewal process and changes in state policy.

In the West Virginia model, initial eligibility assessments are made by an Independent Psychologist chosen from the APS Network Members. APS Healthcare (the ASO) is responsible for conducting Annual Functional Assessments. Assessments are used to determine member yearly budgets and by the Medicaid Eligibility Contracted Agency to determine eligibility. (http://www.dhhr.wv.gov/bms/Programs/Documents/IDD%20Waiver/Provider%20Information/Training/PT.pdf)

Independent Assessments

The foundation for the program is an assessment approach that collects information using standardized tools and expert observation. This face to face assessment with members and their chosen respondents

[13] Virginia Department of Behavioral Health and Developmental Services

(parents/family members; paid staff persons and natural supports) includes a Structured Interview during which the member and respondents are educated about the Waiver program. Tools used to assess an individual's service needs include the Adaptive Behavior Scale II (ABS II) and the Inventory for Client and Agency Planning (ICAP). The findings (in conjunction with the structured interview) are the basis for determining the potential member's level of functioning in the following areas as currently required for program eligibility: self-care; behavioral issues; receptive or expressive language; learning; mobility; self-determination; and capacity for independent living.

Statistical Budgeting

A budgeting model is developed through analysis of assessment data (as the independent variable) and claims data (as the dependent variable) and extensively tested. Through the annual assessment of each program member, comprehensive data is compiled pertaining to members' abilities, strengths, and support needs. Statistical analysis of this data results in customized algorithms for adults and children. Through the application of these algorithms against each member's unique assessment data, an individualized budget is determined. Consumer and their chosen Case Managers are then notified of the budget amount and assessment results a minimum of 45 days prior to the individual's planning team meeting (usually annually and as needed). Following the planning meeting and subsequent quarterly or critical juncture meetings, services and supports may be purchased with the member's budget.

Service Authorization

Purchase requests are submitted for review and authorization. All purchase requests receive a response within five business days of date received. The vendor's information system processes data in real time allowing providers to receive notification of authorized services within moments of approval by a Registration Coordinator.

The member's Case Manager may submit purchase requests resulting from annual, quarterly and critical juncture team meetings. There is no limitation regarding the frequency with which Case Managers may submit purchase requests or request to modify existing purchase requests. When a request for services exceeds the member's annual budget amount, the information system prompts the Case Manager to enter text justifying the need to exceed the budget. The Case Manager also must confirm that all requested services are addressed on the member's Individual Program Plan document.

All requests for services that exceed the member's budget allocation are reviewed by a Registration Coordinator prior to authorization. When necessary, additional documentation is requested from the Case Manager—i.e. physician's orders, progress notes, etc. Requests identified as emergent including those for crisis respite, crisis 2:1 and nursing services are expedited and/or retrospectively authorized to avoid delay of service delivery. Extensions or modifications of authorizations for services are performed as necessary due to legitimate circumstances such as member or guardian illness/hospitalization, changes in living setting or member circumstances, etc. There are interpretive guidelines for such exceptions to ensure they are applied fairly and consistently to all program members.

Retrospective Validation

Quality and utilization reviews of waiver providers should occur on at least a 24-month cycle as specified in waiver documents. These reviews address CMS quality assurance standards and state requirements. Provider reviews are performed through a combination of on-site and desk documentation audits; member/legal guardian and provider staff interviews and program visits. Providers receive technical assistance as needed throughout the review process. A quarterly review schedule is developed and shared with the Agency 90 days in advance of providers' scheduled review dates.

Upon completion of each provider review, there is a face-to-face exit summation with staff chosen by the provider to attend. A comprehensive written exit report is made available to provider staff at the time of the exit summation and an electronic version of the exit report will be sent to the provider's Executive Director and Waiver Contact Person within 10 business days of the exit date. The exit report includes the provider's overall score as well as sub-scores and details of each area reviewed

Key Assumptions

In order for the MFFS model to achieve the targeted savings, there are a number of key assumptions, to include the following:

- Efficient DHS project management, including timely deliverables
- Expeditious legislative review of rules and streamlined oversight
- Changes to Med Fairness Act
- Rule, State Plan and Waiver changes
- Rate changes
- Technology changes to legacy systems and MMIS can be done without substantial delay and additional costs
- RSPMI and CMHS benefit changes
- Appropriate provider risk, including holdback and gain share to enhance incentives for quality and savings
- Independent auditing to ensure appropriate baselines, yearly readjustments in holdbacks and savings targets, appropriate trigger for MFSS to capitated Managed Care
- Timely and focused legislative review of program operation metrics, balanced scorecard approach and appropriate legislative intervention

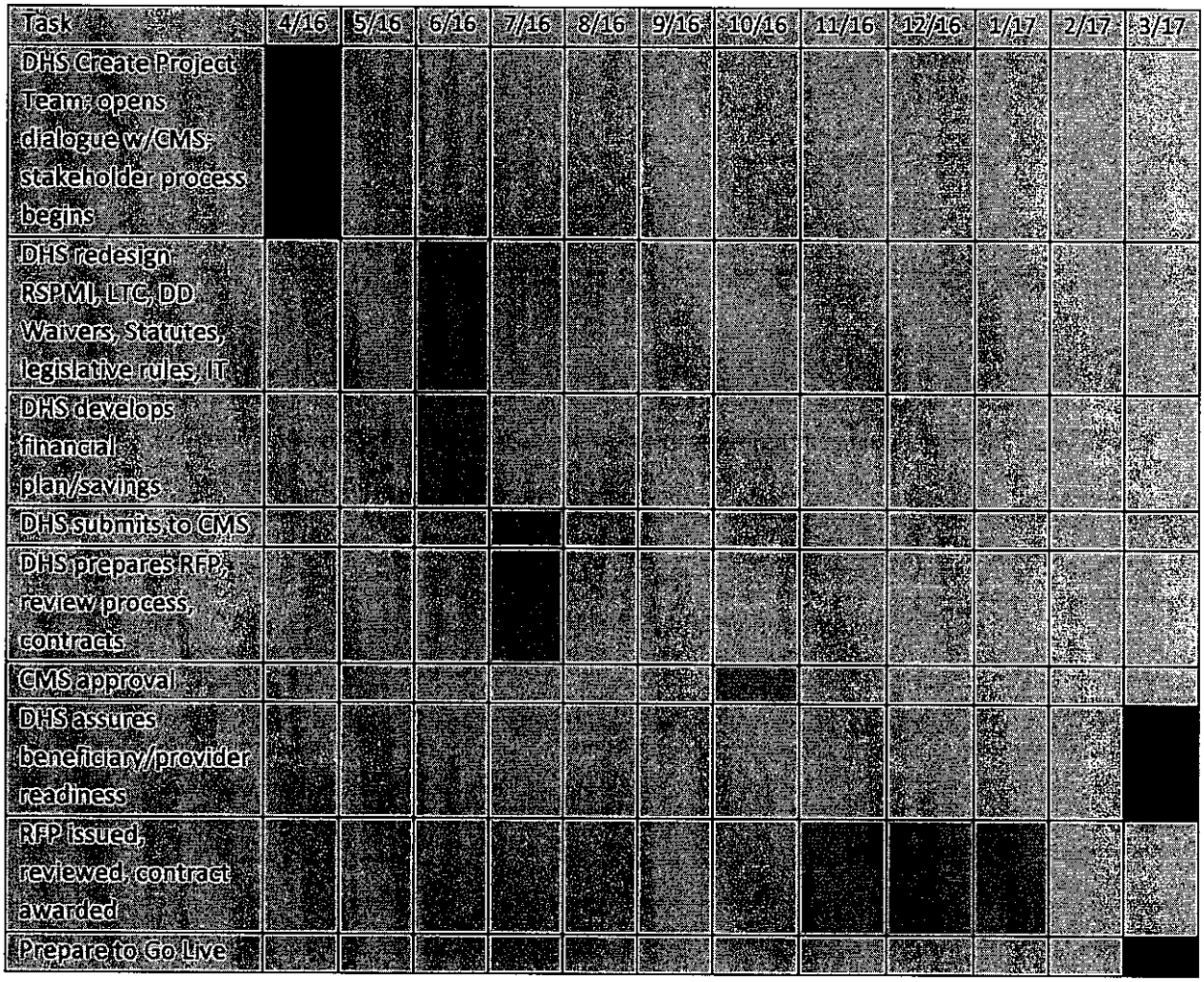
Implementation Timeline

The overall timeline contemplated by the savings projections is SFY 2017-2021, which begins July 1, 2016. The savings projections anticipate that, for most of the programs, it will be possible to begin accruing savings by the middle of SFY2017 (i.e., Jan 1, 2017) through rule and rate changes or immediate industry action. The capitated managed care for dental services is assumed to begin July 1, 2018. The state will have to allow for appropriate time until the full roll out of the MFFS/ASO model for behavioral

health and developmental disabilities in place, and we have assumed these management services will begin on January 1, 2018.

Action Steps Needed to Make This Happen

The following is a sample of a preliminary high level MFFS Implementation Plan



Note Related to Savings

In its October 2015 Report, TSG recommended that the Task Force consider using some portion of savings to increase certain provider rates and to reduce the Developmental Disability wait list. TSG makes no specific recommendations here, but does believe that in order to offer meaningful rate

increases and efforts toward DD Wait list funding that there will need to be additional savings beyond those identified in this report.