Arkansas Health Care Reform Task Force

TSG Update Report

February 17, 2016

Agenda

- Behavioral Health Analysis Updates from January 20, 2016 Meeting
- Updated Private Option Forecast
- TSG Evaluation of Plan to Achieve Governor's Savings Estimate without Capitated Full Risk Managed Care
- Estimated Comparison to Capitated Full Risk Managed Care
- Other Updates

The Question

The Stephen Group was asked to investigate additional questions concerning Behavioral Health claims:

1. Are multiple programs (RSPMI, CHMS, DDTCS*) billed in the same day and/or on the same child routinely?
2. Consider the effect of modifiers. For example 97530 is for Occupational Therapy services. Add U1 modifier it becomes Day Treatment. Change that to U2 it becomes DD. What is the effect of including modifiers in our analysis

Rehabilitative Services for Persons with Mental Illness (RSPMI), Child Health Management Services (CHMS), Developmental Day Treatment Clinic Services (DDTCS)

Question 1: Findings

- In total, multiple claims across the three program in one day represents 3% of total claims, $17MM out of $554MM
- 3,431 recipients had multiple claims across the three programs on a day
  - No apparent systemic pattern
  - Fewer than 1,000 with very high claims for the year
- 5 providers account for 78% of multiple claims across the programs
- Determining whether there is actual abuse will require looking at hundreds of services patterns, and into patient medical files

Providers are potentially charging through two programs to avoid limits—in a small number of cases. Without clear policy and meaningful controls, this is *could become* a substantial cost issue

78% of Multiple Claims Across the Three Programs were Paid to 5 Vendors

	Paid Claim Amount	
Provider A	$7,032,578	41%
Provider B	2,633,867	15%
Provider C	1,657,352	10%
Provider D	1,125,287	6%
Provider E	1,076,741	6%
Other	3,827,328	22%
Total	$17,353,153	100%

Question 2: Finding

- The lack of built-in logic to the codes and modifiers does not impact the analysis of multiple day claims
- Unfortunately, the BH codes are not designed with inherent logic:
  - Even the agency struggles to understand the meaning of combinations of program, code and modifier
  - The Manual includes a description of codes and modifiers, but these descriptions cannot really distinguish them
- This might be in part because the Agency has created codes outside the normal ICD code structure
- When the Agency moves to ICD-10-CM, care should be taken not to create codes/modifiers that are not part of the nationally-accepting coding schema

Recommendations

- BH services claimed on the basis of service time is a $455MM business. The Agency needs better visibility and policy to avoid further abuse
- Agency should have personal assigned to review claims for questions such as these. The Agency currently lacks personnel, tools and methods to investigate this question
- Specifically, the Agency should:
  - Regularly review all BH claims data for unusual patterns. Modern pattern recognition software could enable this on a systematic basis
  - Review recipient case files on a sampling basis to assure that services patterns are supported by outcomes as described in Master Treatment Plans
  - Develop policy that sets appropriate limits on BH claims across the 3 programs

August 2015 Private Option Forecast 2017 - 2021

Projected Aggregate Private Option Impact (SFY 2017-2021) *(all figures millions $ unless otherwise indicated)*		2017	2018	2019	2020	2021	2017-2021
Private option expenditures		1,721	1,820	1,924	2,035	2,152	9,652
Impact on State Funds							
Impact on state expenditures	**State match on Private Option**	43	100	125	173	215	656
	State fund savings from optional Medicaid waiver programs discontinued after the establishment of the PO	(22)	(23)	(25)	(26)	(27)	(123)
	State fund savings from cost-shifting from traditional Medicaid to PO	(39)	(41)	(43)	(45)	(47)	(214)
	Administrative costs	3	3	3	3	3	14
	Reductions in state fund outlays for uncompensated care	(37)	(39)	(41)	(43)	(45)	(203)
	Total impact on expenditures	**(52)**	**0**	**20**	**63**	**99**	**130**
Impact on state revenues	**Increase in premium tax revenue**	37	39	41	44	46	208
	Increase in collections from economically-sensitive taxes (4%)	67	69	72	74	77	360
	Total impact on revenues	**104**	**108**	**113**	**118**	**124**	**567**
Net impact on state funds		**156**	**108**	**93**	**56**	**25**	**438**

Finance Factors of Private Option

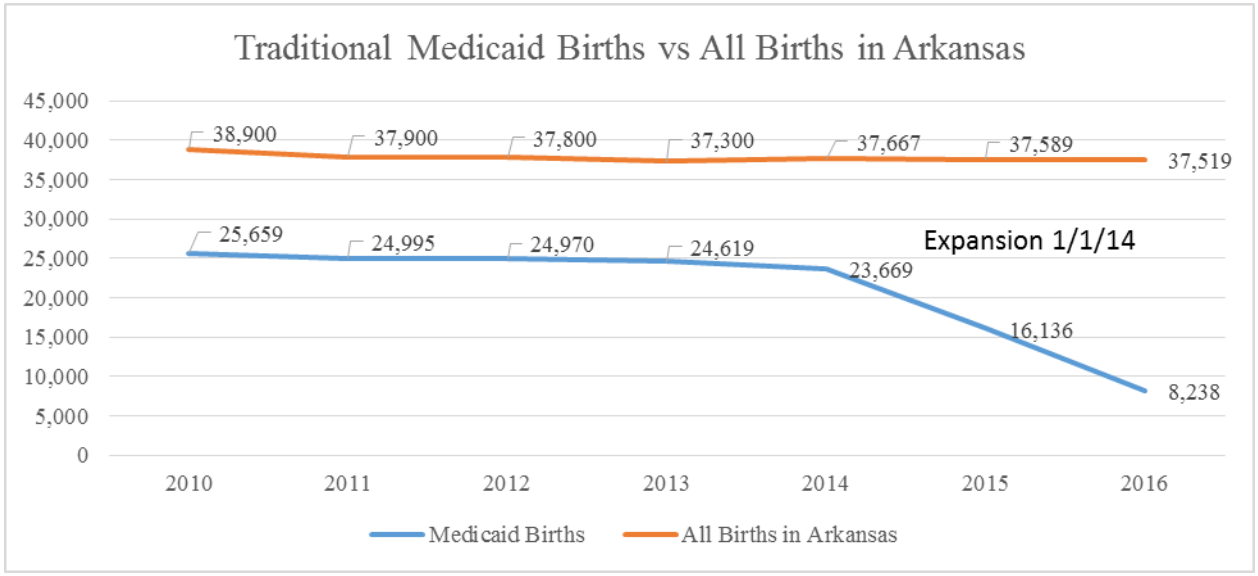
- State general fund savings from optional Medicaid programs discontinued after the establishment of the private option:
  - ARHealthNetwork
  - Family Planning
  - Tuberculosis
  - Breast and Cervical
- Cost Shifting from traditional Medicaid to the private option:
  - Medically needy
  - Aged blind disabled
  - SSI disability
  - Pregnant women
- Uncompensated Care
- Premium Tax
- State Tax collections on additional federal dollars

January 2016 Private Option Forecast 2017 - 2021

Projected Aggregate Private Option Impact (SFY 2017-2021)							
(all figures millions $ unless otherwise indicated)							
		2017	2018	2019	2020	2021	2017-2021
Private option expenditures (all funds)		1,721	1,820	1,924	2,035	2,152	9,652
Impact on State Funds							
Impact on state expenditures	**State match on Private Option**	43	100	125	173	215	656
	State fund savings from optional Medicaid waiver programs discontinued after the establishment of the PO	(21)	(22)	(23)	(25)	(26)	(117)
	State fund savings from cost-shifting from traditional Medicaid to PO	(91)	(96)	(101)	(106)	(111)	(504)
	Administrative costs	3	3	3	3	3	14
	Reductions in state fund outlays for uncompensated care	(37)	(39)	(41)	(43)	(45)	(203)
	Total impact on expenditures	**(104)**	**(54)**	**(37)**	**3**	**37**	**(154)**
Impact on state revenues	**Increase in premium tax revenue**	22	23	25	26	27	123
	Increase in collections from economically-sensitive taxes (4%)	67	69	72	74	77	360
	Total impact on revenues	**89**	**92**	**97**	**100**	**105**	**483**
Net impact on state funds		**193**	**146**	**133**	**97**	**68**	**637**

What Has Changed

- Higher projected cost shifting from traditional Medicaid to PO (which increases the impact of the PO on the General Fund) and lower projected premium tax receipts due to revised estimates from DFA (which decreases the impact of the PO on the General Fund.)



The Charge

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 Model

- Assessment of other state practices, industry standards and information
- Meetings in Arkansas with providers
- Assessment of provider savings plans
- Assessment of “Diamond Care“ key principles:
  - Medicaid Fee for Service payment model except Dental (managed care/PMPM);
  - PCMH model for all populations currently not covered by the existing PCMH/Episodes of Care;
  - Promote Wellness and Telemedicine for Specialists;
  - Managed Fee For Service/ASO model for DD, BH, and LTC waivers;
  - Independent assessment for DD, BH and LTC; and
  - a range of changes on lowering/adding volume to certain procedures/policies in PCMH and Pharmacy.

Proposed Administrative Services for People with Developmental Disabilities

- 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 adults and children 5 to 15 years of age
- Medical necessity determination of eligibility for services based on acuity, waiver based 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

Proposed Administrative Services for People with Developmental Disabilities

- 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

Proposed Administrative Services for Behavioral Health Services RSPMI/Revised Benefit

- 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.
- 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 authorization 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

Proposed Administrative Services for Behavioral Health Services RSPMI/Revised Benefit

- 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

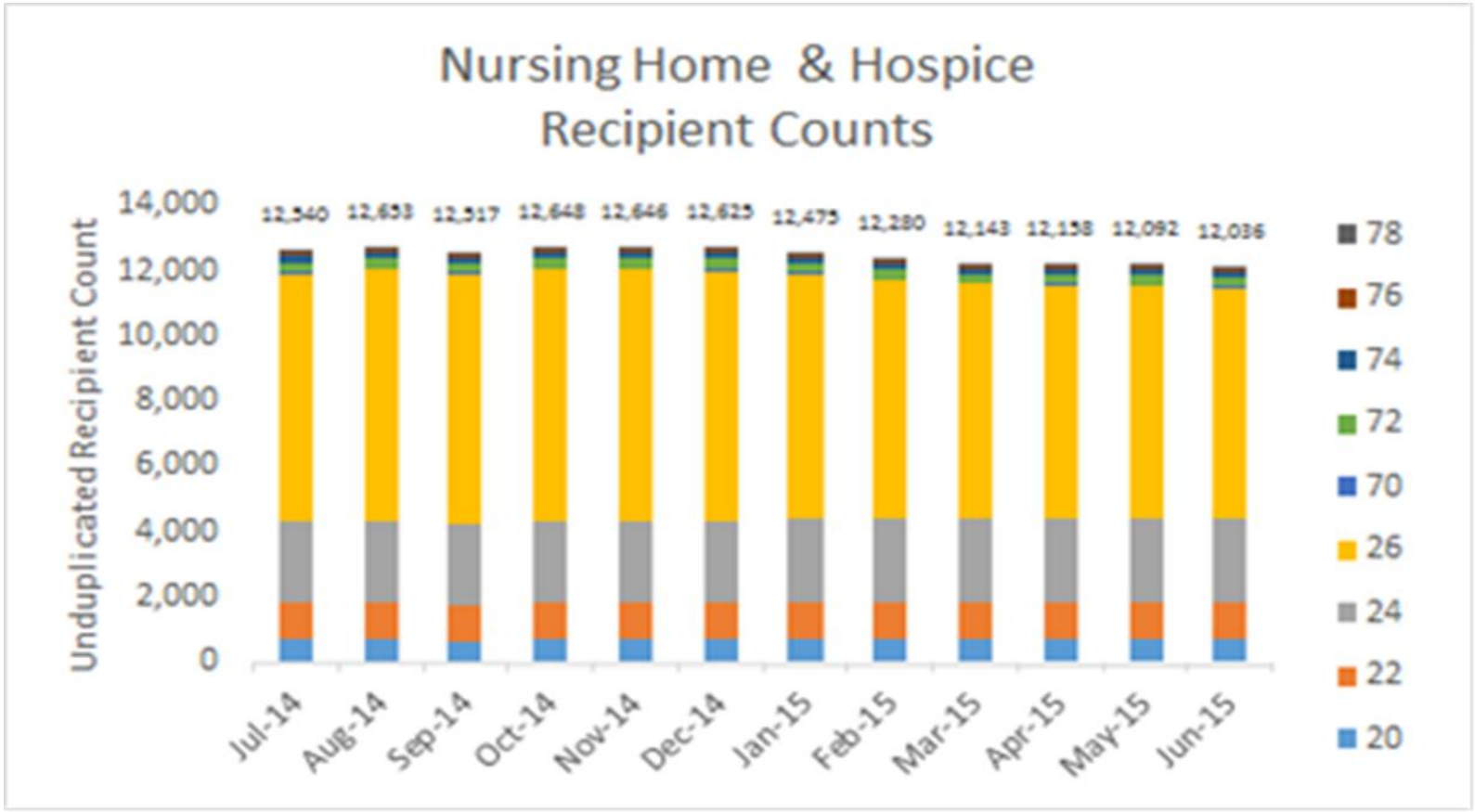
Administrative Services for Enhanced Care Coordination for High Cost/Complex Cases

- 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

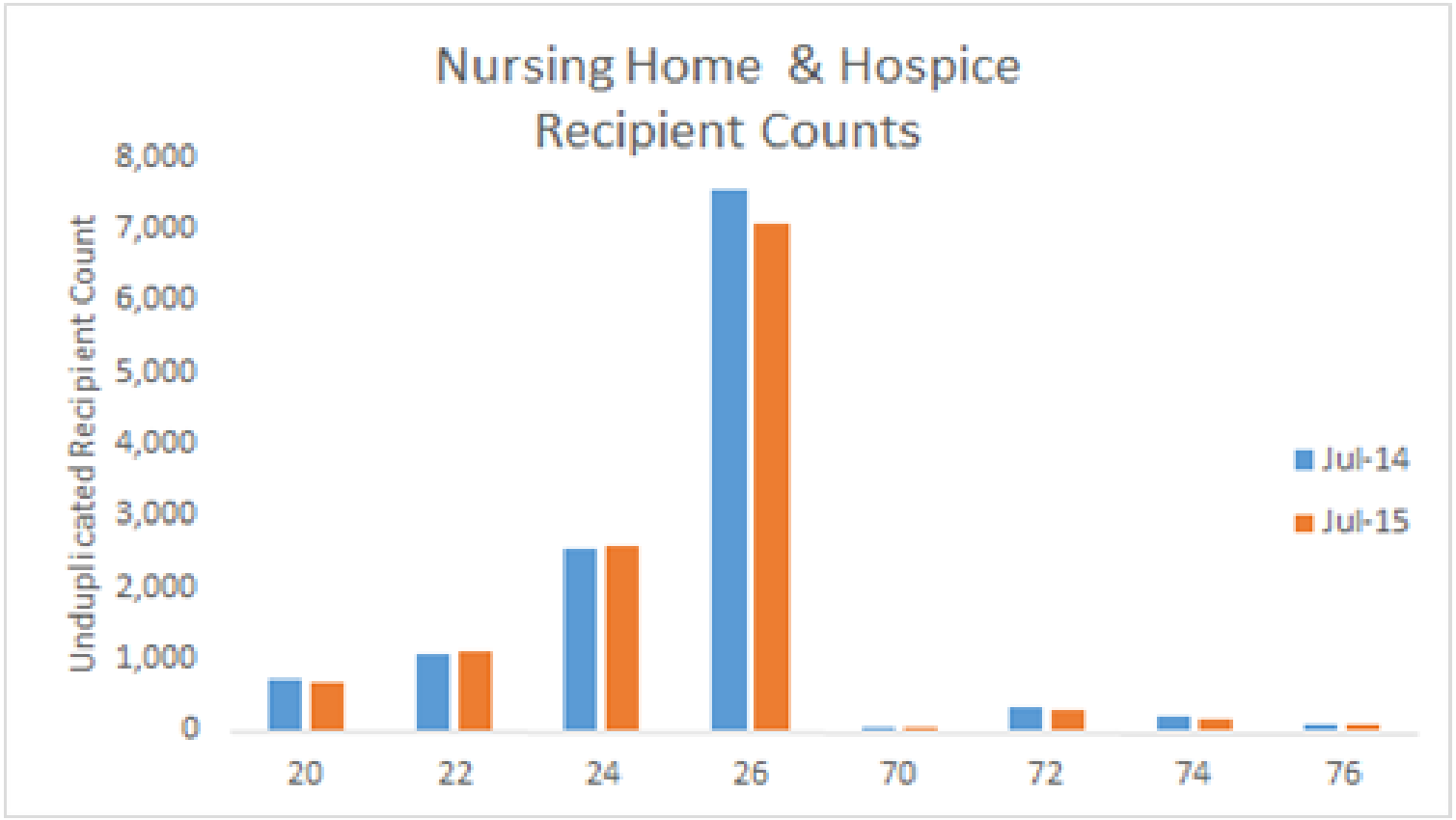
Administrative Services for Enhanced Care Coordination for High Cost/Complex Cases

- 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

Nursing Home Assessments Show Substantial Number of Nursing Home Residents at Lowest Acuity Level



Comparison of Skilled (20) and Intermediate Levels I (22), II (24) and III (26)



Administrative Services for Long Term Care

- Smart" Rebalancing"
- Three Tiered Levels of Care including a Safety Determination element.
- Level 1 Nursing Facility level, Level 2 Home and Community Based Service level, and Level 3 a Prevention services with a cap
- Transition Planning - "Bundle" of services with the Nursing Facility (NF) at risk, that provides attendant care, home modifications, and coordinated care. NF becomes a "bridge" between a hospital and home
- NFs to have a certified Social Services Director with training in person centered discharge planning.
- 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.

Administrative Services for Long Term Care (cont.)

- Independent Audit
- Level 2 and Level 3 individuals receive an independent assessment completed by the DAAS nurse.
- The DAAS nurses assign the level of care and payment level, and complete the plan of care that meets the needs of the person served.
- A new front door that manages screening, referral and completion of the assessments for all new admissions from a certain point moving forward.
- State plan amendments to limiting over-utilization in the HCBS sector and ensuring that all services assessed do not exceed the assessed need
- Ultimately, all services to be rolled into a global waiver
- A Health Home and Care Coordination model that monitors the health needs of the persons served in HCBS
- 3-5% nursing facility withhold as incentive to ensure savings and rebalancing
- Expand Focus on diversion strategy and on home care front and strengthen provider credentials and the level of services on the HCBS side

Cost Containment Strategies

Traditional Medicaid Cost Containment Strategies by Program	
Program	Strategy
Elderly non-SNF	Independent assessment, plan-of-care changes, health homes, savings guaranteed by provider payment withhold
SNF	Independent assessment, plan-of-care changes, health homes, savings guaranteed by provider payment withhold
DD non-HDC	Managed fee-for-service
BH program	Managed fee-for-service
HDC	No changes recommended
All prescription drugs	Network and PDL changes, generic antipsychotics
All dental	Capitated managed care
All medical	Expanded PCMH
Non-claims based payments	No changes recommended

Other Considerations

- Contracting Options
- MFFS/ACO PCMH Linkage
- Risk
  - MFFS/ASO model will have risk
  - Tie payment of ASO Administrative Fee to % of savings and quality (Penn Access Plus MFSS program)
  - In this case state is still on hook for 100% of risk above Medicaid budget amounts
  - Pseudo Capitation - Tie pmpm costs to “loss corridor” or incentive corridor.”
  - 5 % holdback or set aside with payment based on performance measures being met – savings and quality
  - Provider risk can include same holdback
- State Plan/Rule/Waiver changes

Centers of Excellence

- Steer certain high-cost patients to high-volume, high-quality providers
  - Complex neonatal care
  - Certain cancers
- Potential cost-saving opportunity
- Still under review
- Working with UAMS and ACH

Implementation Timeline

- Baseline time period for the savings projection
  - SFY 2017 – SFY 2021 (July 1, 2016 – June 30, 2021)
- Implementation considerations
  - Federal – State plan amendments or waivers
  - State agency – Developing RFPs, evaluating proposals, and contracting
  - State legislative – Rule, rate, and other policy changes
- Annual potential savings phase-in
  - Most programs – 50% in SFY 2017; 100% all other fiscal years
  - Dental managed care – 0% in SFY 2017; 100% all other fiscal years

Traditional Medicaid Spending Baseline

Baseline Estimates of Medicaid Spending by SFY and Program *($millions)*	
	SFY 2017-2021
Elderly non-SNF	2,105
SNF	4,001
DD non-HDC	3,526
BH program	2,868
HDC	939
All prescription drugs	2,005
All dental	701
All medical	7,332
Non-claims based payments	6,245
Total	29,722

Projected Savings

MFFS and Other Program Savings

	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2017-2021	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 programmatic changes
SNF	706	724	762	802	844	3,839	163	
DD non-HDC	617	627	661	696	733	3,333	193	Pro-rata savings based on $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 based on professional judgment, with 50% phase-in year 1
MFFS Subtotal	2,187	2,222	2,338	2,460	2,588	11,796	704	

Projected Savings

MFFS and Other Program Savings

Other Program Savings	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2017-2021	Program Savings/ Costs	Description
HDC	170	178	187	197	207	939	0	No savings planned
All prescription 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
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	

Projected Savings

MFFS and Other Program Savings

	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2017-2021	Program Savings/ Costs	Description
Additional savings								
Reduced agency staffing	0	1	2	2	2	7		40 staff, phase-in starting Jan 1, 2018
DD case management fee	0	3	6	6	6	21		DD case mgmt fee -- 4,200 @ $118/day, w/ phase-in starting Jan 1, 2018
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		Technology costs
Additional costs subtotal							84	
Revenue impact								
Premium tax (Dental)	3	3	3	4	4	17	17	
Total All-Fund Impact							1,057	

Projected Savings

Summary

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

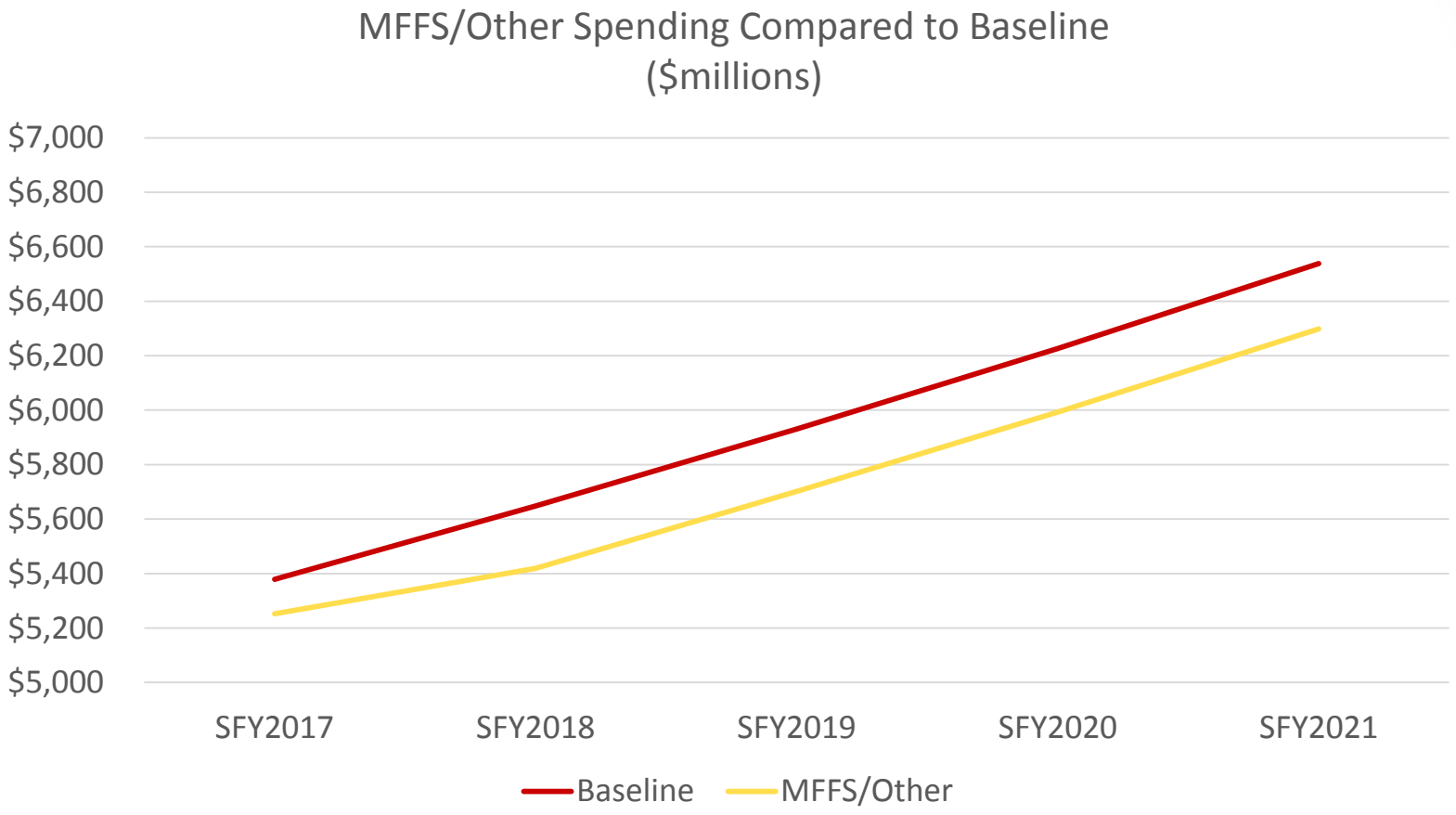
Projected Savings

Summary

	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

Projected Savings

Projection



Projected Savings

General Fund Components

General Fund Components of Program Changes ($millions)			
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		295

Projected Savings

Capitated Model

	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2017-2021	Program savings	Description
All elderly costs except SNF	554	549	552	579	608	2,842	273	MCO, starting halfway through SFY18; industry efforts starting halfway through SFY17
SNF costs	706	724	762	802	844	3,839	163	65% of $250M target savings, starting halfway through SFY17
All DD costs except HDC	821	814	825	866	909	4,235	423	MCO, starting halfway through SFY18; rule and rate changes starting halfway through SFY17
HDC	170	178	187	197	207	939	0	No savings
All BH costs	947	935	982	1,031	1,083	4,978	568	MCO, starting halfway through SFY18; rule and rate changes starting halfway through SFY17
All low cost pops	944	988	1,029	1,067	1,111	5,138	79	PCMH
Non-claims-based payments	1,130	1,187	1,246	1,308	1,374	6,245	0	Nothing
Program subtotal	5,273	5,375	5,582	5,850	6,135	28,216	1,506	

Projected Savings

Capitated Model

	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2017-2021	Program savings	Description
Additional savings								
Reduced agency staffing		1	2	2	2	7	7	40 staff, phase-in starting halfway through SFY 2018
DD case management fee		3	6	6	6	21	21	DD case mgmt fee -- 4,200 @ $118/day, w/ phase-in starting Jan 1, 2018
Additional costs								
DMS admin costs for MFFS	2	5	5	5	5	20	(20)	45 additional FTES phase-in starting Jan 1, 2017
Transitioned contract services/ technology		9	17	17	17	60	(60)	Technology costs
Revenue impact								
Premium tax		29	59	62	65	215	215	
Total all-fund impact							1669	

Potential Savings

Different Growth Rates

Medicaid Spending and Saving at Different Growth Rates *($millions)*				
	5%	4%	3%	2%
2017	$5,379	$5,379	$5,379	$5,379
2018	$5,648	$5,594	$5,540	$5,486
2019	$5,930	$5,818	$5,706	$5,596
2020	$6,227	$6,050	$5,878	$5,708
2021	$6,538	$6,293	$6,054	$5,822
2017-2021 Total	$29,722	$29,134	$28,557	$27,992
Difference		$588	$1,164	$1,730

Key Assumptions

- 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

ASO Not Managed Care

- State is at 100% risk for contracted above benchmark spend
- Managed Care budget certainty based on actuarial sound rates
- Managed Care MLR at 85% per CMS proposed Rule
- ASO model does not provide medical services, contract with providers, or sets rates; does not meet criteria of a managed care entity (42 C.F.R. Sec 438.2)
- MCO delivers medical services through contracted network, can set/negotiate rates up or down and value based purchase within the boundaries of the state contract, covers all medical services through same model, PCMH or otherwise, and care coordinates across all populations.
- ASO not a prepaid health plan and not subject to capital reserves
- ASO contingency (gain/risk) fees based on cost avoidance that CMS shares; a competitive bid, and CMS approves contingency fee payment model
- ASO does not require actuarially sound rates approved by CMS
- ASO admin is between 3 and 6% and MCO admin is between 8 and 10%

Corrections and Mental Health Treatment

- "The Processing and Treatment of Mentally Ill Persons in the Criminal Justice System", Urban Institute (3/2015)
- Report collects the definition of mental illness in the criminal context for all states, analyzes the extent of the problem in local jails, state and federal prison, and researches available data on costs at the state level.
- The report notes that "little empirical research" exists on the cost of mental illness in corrections settings or in the community but does cite several examples concerning costs. Knowledge gained from state examples indicates that state correctional systems that provide mental health services in prison can result in lower recidivism rates ***if there is continuity of care into the community upon release***.
- Several states, such as Washington and Minnesota, have systems in place that assure prisoners with mental illness who are eligible for Medicaid upon release are pre-enrolled prior to release to assure eligibility for mental health treatment within 5 to 7 days of release.
-

CMS Medical Loss Ratio (MLR) Requirements for Managed Care Contracts

- 5/26/15 – CMS published rules requiring 85%/15% MLR for capitated full risk Medicaid Managed Care contracts
- Rule scheduled to take effect 1/1/17
- Rule noted that 28 states were already above 85/15 MLR
- National Association of Medicaid Directors requested major changes to the proposed rule citing that each state was different and that the MLR ratio should be left up to each individual state
- CMS has stopped receiving comment and has not yet finalized rule
- ACA requires a, 80%/20% MLR ratio for individual and small group essential benefits products