I. Arkansas Works

A. The task force accepts the budget analysis presented on February 17, 2016 and in previous task force meetings that discontinuing the current Health Care Independence Program will result in a substantial increase in state Medicaid and uncompensated care expenditures over the next four years and thereby further recommends that the legislature consider the Governor's Arkansas Works proposal as presented to the task force on February 17, 2016. We hereby request that the governor present legislation to be considered during a special session.

II. Medicaid Management Models for High Cost Populations

Management Models

The Task Force supports the drafting of legislation requiring one of the following High Cost Traditional Medicaid Management Models be implemented by the Arkansas DHS

A. **Governor Recommendation**: Capitated, Full Risk, Managed Care Model for Behavioral Health and Developmental Disabilities services, including medical, and excluding skilled nursing facilities, institutions, and other long term care populations and services. All Medicaid Long Term Care Populations and Services in Managed Fee For Service with Risk. (Note: The TSG report to the Task Force on February 17, 2016, *Evaluation of Plan to Achieve Governor's Savings Estimate Without Capitated Full Risk Managed Care*, included long term care community based services in capitated, full risk, managed care and, additional savings).

Estimated Savings (SFY 2017 to SFY 2021): $1.439 Billion
Note: $1.669 Billion (if long term care community based services included in capitated, full risk, managed care, per TSG analysis presented February 17, 2016)

B. **Senator Ingram Recommendation**: Capitated, Full Risk, Managed Care Model for Behavioral Health services, including medical, with all of Developmental Disabilities, and Long Term Care Populations and Services in Managed Fee For Service with Risk

Estimated Savings (SFY 2017 to SFY 2021): $1.152 Billion

C. **DiamondCare Recommendation with Risk**: All Long Term Supports and Services (high cost traditional Medicaid populations) in Managed Fee For Service, aligned with Patient Centered Medical Homes, with risk, consistent with the TSG report to the Task Force on February 17, 2016, *Evaluation of Plan to Achieve Governor's Savings Estimate Without Capitated Full Risk Managed Care.*

Estimated Savings (SFY 2017 to SFY 2021): $1.057 Billion

III. Related Provisions for Traditional Medicaid Management Reform

A. Key Assumptions Built In To High Cost Medicaid Management Model

The Task Force recognizes that its support of the High Cost Traditional Medicaid Management Model chosen, including the ability to meet the estimated savings targets, will require certain legislative, waiver, rule, administrative and program changes going forward, and as outlined in the TSG report to the Task Force on February 17, 2016 (Evaluation of Plan to Achieve Governor's Savings Estimate Without Capitated Full Risk Managed Care) and as presented by provider groups and associations referred to in the TSG report. Thus, the task force supports moving forward on the key Model assumptions that require legislation and provide the legislature with the opportunity to review and consider them to ensure the targets are met. The task force further supports DHS moving forward on any necessary waiver, state plan, rule or administrative change needed to ensure that the model's savings targets are met. Some of the key assumptions 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 Medicaid Management Information Systems (MMIS) without substantial delay and additional costs
- Rehabilitative Services for Persons with Mental Illness (RSPMI) and Community Mental Health Services (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
- Pregnant women and children in expanded Patient Centered Medical Home (PCMH)

Note: Legislative Action Required for Some of the Above

B. Medicaid Managed Care Organization Profit Controls

If the task force chooses to recommend legislation to require the implementation of a program of delivering Medicaid health services through capitated, full risk, managed care, the task force further recommends that the legislature adopt legislation directing DHS to establish mechanisms ensuring that the managed care organizations do not have incentives to decrease health services inappropriately, including Medical loss ratios requiring a certain percentage of premiums received to be paid out in claims payments with rebates remitted to the state if claims payment levels are not met, and experience rebates requiring cost savings beyond certain levels below premium receipts to be returned to the state.

Note: Legislative Action Required

C. Care Coordination for High-Cost Pregnant Women and Children

The task force recommends that the legislature adopt legislation directing DHS to establish a mechanism for identifying and coordinating the care of high-cost/complex cases in partnership with Patient Centered Medical Homes and the task force further recommends that the legislation be developed according to the principles of management by a qualified independent entity with a determined level of risk.

Note: Legislative Action Needed Consistent with Category II Decision

D. Nursing Facilities Provider Savings Plan with Trigger

The task force recommends and supports that Arkansas Long Term Care Savings Plan, submitted by the Arkansas Health Care Association (AHCA) and Arkansas Assisted Living Association, dated February 2, 2016 and presented to the task force on February 17, 2016. The task force further recommends and supports the savings goal of $250 Million from the long term care services contained in the plan, including the elements of smart rebalancing, independent assessment and tiered levels of care, including similar aspects of the plan contained in the TSG report to the Task Force on February 17, 2016 (Evaluation of Plan to Achieve Governor's Savings Estimate Without Capitated Full Risk Managed Care). The task force recommends that DHS work with Arkansas Health Care Association (AHCA) to determine the waiver, state plan and/or rule changes needed to implement the plan and identify yearly contractual holdbacks necessary for the skilled nursing facility providers to meet their yearly savings allocation. If after three full years of implementation, it is independently verified that the Plan has not produced $150 Million in savings, the task force recommends that DHS move forward on implementing a capitated full risk managed care solution for all of long term care.

Note: Legislative Action Required, as well as DHS State Plan, Rule and Waiver changes

E. Independent Medicaid Provider Rate Review

The task force recommends legislation that requires a yearly Medicaid provider rate review conducted by an independent actuarial or professional consulting firm, with experience in Medicaid rate methodology that compares Arkansas' Medicaid provider rates to those of other states and to provide an annual report of its findings to DHS and the legislature for review and consideration

Note: Legislative Action Required

F. State Data Integration/research and decision making

The State of Arkansas has a vested interest in developing a data system to assist the Governor, General Assembly, and other policymakers to make data-driven decisions that result in more efficient usage of taxpayer funds and better matching of state needs with state priorities. To accomplish this goal, the task force supports legislation exploring the feasibility of establishing such a data system in cooperation with a research-based public university with a proven track record of analytical research and data system development and implementation. The task force further supports legislation allowing for said entity to enter into contractual agreement/s with public universities, both within and outside Arkansas, state agencies, and/or other entities as appropriate to achieve these objectives.

Note: Legislative Action Required

G. Diagnosis Related Groups (DRG)

The task force recommends that the legislature adopt legislation directing DHS to convert from the current Medicaid hospital payment method to one based on diagnosis-related groups (DRGs) and the task force further recommends that the legislation also include a provision requiring significant opportunity for stakeholder participation in the process.

Note: Can be implemented through DHS Administrative, Rule and State Plan changes or through Legislation

H. Global Waiver

The task force recommends and supports legislation that requires DHS to consolidate all current traditional Medicaid program waivers and state plan amendments into a single Section 1115 Global Waiver that will provide for more streamlined administration, integration of services across populations, require personal responsibility, and provide the state with maximum flexibility.

Note: Legislation Required – can also be accomplished through DHS Administrative, Rule and Waiver Action Only

I. Medicaid Fairness Act

The task force supports legislation amending certain provisions of the Medicaid Fairness Act to allow prior authorizations to be based on recognized standards of evidence-based practice or professionally recognized standards for health care. Moreover, the task force supports legislation making it clear that DHS is not required to promulgate rules to incorporate recognized standards of evidence-based practice or professionally recognized standards of care that practitioners use in determining medical necessity or rendering medical decisions, diagnoses, or treatment

Note: Legislation Required

J. Developmental Disabilities Wait List

The Task Force recommends legislation requiring that a portion of the premium tax from the capitated managed care organizations revenue in the traditional Medicaid program be directed towards providing services to those on the Developmental Disability Waiting List and that DHS submit a plan to the legislature for providing such services. The task force also supports the Governor's desire to provide services for those currently waiting for waiver services on the Developmental Disabilities Waiting List.

Note: Legislation Required – can also be implemented through Administrative Action

K. Opioids

The task force supports and recommends the continued progress to allow clinical personnel at the state to be able to view the State Opiate Prescription Drug Monitoring Program database and recommends tightened claim edits around maximum quantity allowed per prescription fill and refill too soon.

Note: Legislation Required

L. Savings Targeted for Certain Rate Increases

The task force recommends that DHS submit a plan to the legislature whereby a portion of the premium tax from the capitated managed care organizations revenue in the traditional Medicaid program be directed towards rate increases for community based providers and physicians.

Note: DHS Administrative Action Only

M. Certified Agents Role

The task force recommends that DHS work with National Association of Independent Fee Appraisers (NAIFA) Arkansas and clarify the authority of state certified agents representing consumer/clients, with signed client authority, in all aspect of the enrollment for DHS in the programs and plan to replace the Private Option and the proposed employer based plans. It is understood agents will provide assistance governed by the State and Federal guideline they have abided by for years. The request should also allow that agents be included in the development of the DHS guidelines that will govern their role in the enrollment process for all of the new plans.

Note: DHS Administrative Action Only

N. Pharmacy Carve In

Should the Task Force vote to pursue the fully capitated Managed Care Medicaid reform package for certain populations, the task force further supports and recommends that all pharmacy management and costs be carved in to the managed care program for the management of that covered population.

Note: DHS Administrative Action Only

O. Dental

The task force supports moving forward with capitated, full-risk, Managed Care management model for all dental services, and further supports DHS placing limits through contract on the amount of profit that may be retained by the dental MCO using a "Graduated Experience Rebate Sharing Method" similar to the method used in the State of Texas.

Note: DHS Administrative Action Only

P. Value-Based Purchasing

The task force recommends that DHS develop and implement a strategy of value-based purchasing for health services, wherever feasible and cost-effective, with the following characteristics:

a) Providers should be accountable for some portion of the total cost of care for their patients.
b) Accountability for some portion of the total cost of care should include both shared savings and shared risk for average costs above certain thresholds.
c) Providers should be receive higher payments for high quality care and outcomes.

Note: DHS Administrative Action Only

Q. Behavioral Health Benefit Redesign

The task force recommends and supports the Arkansas Department of Human Services moving forward transforming the Rehabilitative Services for Persons with Mental Illness (RSPMI) benefit into an evidence based/best practice Adult and Children/Adolescent Mental Health Rehabilitation Option benefit similar to states like Virginia and Washington. Access to the revised benefit should be based on identified diagnoses and an independent assessment based on the "Level of Care Utilization System (LOCUS)" for adults and "Child and Adolescent Needs and Strengths (CANS)" for children. Individual Plans of Care and level of service (duration, amount, and scope) would be based on acuity and level of severity indicated by the independent assessment and the person's immediate risk factors. In revising the benefit, the task force further recommends and supports DHS assure that the revised Mental Health Rehabilitation Option services package is coordinated with admissions/discharges from Arkansas State Hospital, private psychiatric hospitals and Residential Treatment Centers. The design of the coordinating

function should include options for least restrictive alternatives and lower cost. The task force further recommends and supports the requirement that DHS include "real life" Outcome Measures, including Consumer Satisfaction, based on National Committee for Quality Assurance/Healthcare Effectiveness Data and Information Set (NCQA/HEDIS) and Substance Abuse and Mental Health Services Administration (SAMHSA) measures. DHS should also be required to develop and implement a multi-department coordination capability that "wraps around" the behavioral health needs of eligible children served by the Division of Children and Family Services across Inpatient, Residential Services, and Outpatient/Home Based services.

The task force supports the requirement that the revision of the Rehabilitative Services for Persons with Mental Illness (RSPMI) benefit be completed prior to initiation of the contract for the new Medicaid Management model chosen by the task force. The task force further supports and recommends that the Office of Medicaid Inspector General be involved in the Rehabilitative Services for Persons with Mental Illness (RSPMI) benefit revision process and that the revisions be adequately prioritized by DHS, with stakeholder input so as to be in place within eight months.

Note: DHS Rule and Administrative Action Only

R. Behavioral Health Provider Savings Plan

The task force recommends that DHS begin discussions with the Alliance for Health, the Mental Health Council of Arkansas, and the Arkansas Behavioral Health Providers Association regarding their projected savings for SFY 2017-2021 (provided to the task force on February 17, 2016) and determine if any additional rule, plan or policy changes should be made along with or prior to the planning of the revised Rehabilitative Services for Persons with Mental Illness (RSPMI) benefit and related services, and report back to the task force on its progress.

Note: DHS Administrative, Rule, Waiver and State Plan Action

S. Developmental Disabilities

The task force recommends and supports the Arkansas Department of Human Services moving forward with a comprehensive revision of the Developmentally Disabled Services (DDS) Alternative Community Services waiver that is based on independent assessment, three levels of care, an institutional cost limit, tiered payments, and focuses on employment and community choices. The three levels of care should include an Institutional level of care, an Institutional level of care with choice of home and community based services including self-determination, and a preventive level of care. Program eligibility would be determined by an initial and annual/bi-annual assessment conducted by an independent qualified professional. The task force further supports and recommends the use of the SIS (Supports Intensity Scale) Adult/Children plus natural supports adapted to align with the three levels of care (similar to the TENNCARE Long Term Services and Supports (LTSS) Pre-Admission Enrollment (PAE) process), and recommends benefits "caps" based on the level of care independent assessment, natural supports, assessed safety risk factors and tiered to the Institutional cost limit. Person

centered planning, consumer choice, family/Circle of Support involvement, transition strategies, and choice of case manager should be principles of the waiver revision. The task force further supports and recommends that the revisions be adequately prioritized by DHS, with stakeholder input so as to be in place within twelve months.

Note: DHS Administrative, Rule, Waiver and State Plan Action

T. Developmental Disability Provider Savings Plan

The task force recommends that DHS begin discussions with the Developmental Disabilities Provider Association regarding projected savings for SFY 2017-2021 (provided to the task force on February 17, 2016) and determine if any additional rule, plan or policy changes should be made along with or prior to the planning for the comprehensive revision of the Developmentally Disabled Services (DDS) Alternative Community Services waiver and report back to the task force.

Note: DHS Administrative, Rule, Waiver and State Plan Action

U. Therapy Location of Services State Plan Change

The task force recommends and supports DHS revision of state plan that prohibits Medicaid recipients over 21 years of age from receiving physical, occupational and speech therapy in a non-hospital based setting so as to allow for additional appropriate settings outside hospitals

Note: DHS Administrative, Rule and State Plan Action

V. Pharmacy Savings

The Task Force supports and recommends continuing the following ongoing quality and cost saving efforts in pharmacy at DHS, many of which are in progress and make up an estimated $160mm in savings over the 5 year period from FY 2017 to FY 2021:

1. Preferred Drug List (PDL) expansion (estimated $10 million in annual savings)
    - Expand the Preferred Drug List (PDL) without the unnecessary hurdle of evidence based clinical data in therapeutic classes where none is available.
    - Drug Effectiveness Review Project (DERP) waive the strict “evidence based requirement” for new therapeutic classes
        - Still want evidence when available, but sometimes it’s just cost difference
        - Drug Effectiveness Review Project (DERP) will not be renewed after State Fiscal Year (SFY)17
    - Consider multi-state rebate pools
2. Expand antipsychotic reviews for children
    - From just up to 6yo to include 7-9yos (estimated $1 million in annual savings)
    - Up to age 10 by 7/1/2016
    - Up to age 12 by 2017
    - Metabolic monitoring
    - Manual case review

    - Informed consent
    - Abilify generic (estimated $19.5 million in annual savings)
3. Competitive Acquisition Program (CAP) expansion (estimated $1 million in annual savings)
    - Add 150 limited access drugs to the program
4. Improve quality and decease waste of hemophilia factor drugs (estimated $1 million in annual savings)
    - Quality and performance based pharmacy identification and selection
    - Decrease waste 5% cost reduction
5. Review of retail pharmacy reimbursements for(estimated savings pending analyses):
    - Dispensing fees
        - Center for Medicare and Medicaid Services (CMS) required survey
    - Ingredient costs
        - National Average Drug Acquisition Cost (NADAC) analysis

Note: DHS Administrative and Rule Changes

W. Prescription limits per month

The task force supports the removal of the monthly prescription claim limit for approved maintenance medications used in approved chronic conditions. The task force recommends that DHS create and maintain the maintenance drug list and evaluate any changes needed to monthly prescription claim limits for non-maintenance medications.

Note: DHS Administrative and Rule Changes

X. Call center redundancy

The task force supports and recommends the continued progress toward reviewing the consolidation of disparate call centers supporting the pharmacy program. This effort is currently in progress.

Note: DHS Administrative Action Only

Y. Vaccination rate improvement

The task force recommends that provider reimbursement for adult vaccines and professional administration fees be separated and further recommends that the Vaccines For Children (VFC) professional administration fee be evaluated for increase to promote and incentivize vaccinations.

Note: DHS Administrative Action Only

Z. Centers of Excellence

The task force recommends that DHS develop a plan to:

a) Identify centers of excellence for certain conditions or patients; and
b) To establish appropriate mechanisms for guiding Medicaid patients with the corresponding conditions or the corresponding types of Medicaid patients to the centers of excellence for treatment.

1) Centers of excellence should be:
    a) Traditional providers of health services in the Arkansas Medicaid program that provide high volumes of certain health services; and
    b) Selected based on the evidence that they provide high-value care, measured as better outcomes at lower costs.
2) Initial conditions or patients for which centers of excellence should be designated should include the following:
    a) Certain cancers; and
    b) Complex neonatal cases, including for long-term care coordination and treatment post-discharge

Note: DHS Administrative Action Only