Arkansas Traditional Medicaid Savings Reform Initiatives Presented to Health Care Reform Legislative Task Force June 8, 2016

Category Savings Initiative item listed	Action Needed (e.g., policy, rate, or rule change, admin action)	Implementation Timeline	Estimated 1-Year Cost Savings (Calendar Year 2017)	Brief Summary of Initiative
Behavioral Health Reforms				
1. Behavioral Health Transformation: Comprehensive revision of benefit to an Adult and Children/Youth evidence based/best practice benefit. (TSG recommendation). ***Overlaps with all other BH recommendations. Ensure double counting is avoided relative to other savings initiatives.**	•*Changes to: stakeholder process, p olicy, rules, and rates* •*Approval from: Arkansas legislature and CMS*	•*September 2016 – Release RFPs for Independent Assessment Entity, Care Coordination Entity, and Provider Certification/ Education entity* •*September 2016 – Submit changes to CMS as well as begin the State promulgation procedures (including public comment period)* •*December 2016 – Complete promulgation process of rule changes.* •*July 2017 – Begin implementation of new behavioral health program* •*January 1, 2018 – Complete implementation of new program*	•$52,324 million (11.26%): Managed Care (2018)† •$29,470 million (6.38%): Managed fee for service (2018)† •DHS comprehensive program management: $23,234 million (5%) annually† †*Estimates by The Stephen Group (TSG)*	*Require independent assessment for highest needs benefit eligibility (rehabilitative level services and intensive level services) and treatment planning, implement measurable outcomes, implement care coordination for clients eligible for highest needs benefit eligibility, require independent assessment for eligibility to RTCs and inpatient psychiatric services (excluding crisis situations).*
2. Redefine the definitions of: •Serious Emotional Disturbance (SED) for under 21 years of age and include evidence-based	•Policy and rule change. •DHS managed.	•*These changes will occur during the Behavioral Health Transformation in #1 above.* •*If completed outside of #1 above, the*	•$12 million† †*Estimates by TSG*	Redefine the SED and SMI category based on clinically-driven parameters; implement evidence based practices and metric based outcome measures

RSPMI services; and •*Seriously Mentally Ill (SMI) for individuals ages 21-64*		*changes must still be promulgated and a similar stakeholder process must occur. SED/SMI determination does not necessarily drive care in the current RSPMI program and would require development of appropriate service array based upon SED/SMI determination.*		
3. Reduce RSPMI Treatment Plan reviews from every 90 days *to once every 180 days.*	•Policy, rule, and contract change (Beacon). •DHS managed.	•*These changes will occur during the Behavioral Health Transformation in #1 above.* •*If completed outside of #1 above, the changes must still be promulgated and a similar stakeholder process must occur.* SED/SMI determination does not necessarily drive care in the current RSPMI program and would require development of appropriate service array based upon SED/SMI determination. .	•$4 million† † *Estimates by TSG*	Increased process efficiency *and reduction of administrative burden upon providers.*
4. Organize school, after school, and summer RSPMI children's services into two levels based on assessment, resources, and acuity; and •Link to redefinition of SED.	•Policy, rule, and contract change (Beacon). •DHS managed.	•*These changes will occur during the Behavioral Health Transformation in #1 above.* •*If completed outside of #1 above, the changes must still be promulgated and a similar stakeholder process must occur.*	•$6 million† †*Estimates by TSG*	Refine clinical eligibility for school associated-RSPMI services.
5. Reduce the number of MHP and MHPP Interventions from 8 daily units to 6 daily units for individuals receiving RSPMI services.	•Policy, rule, and contract change (Beacon). •DHS managed.	•*These changes will occur during the Behavioral Health Transformation in #1 above.* •*If completed outside of #1 above, the changes must still be promulgated and a similar stakeholder process must occur.*	•$9.5 million† †*Estimates by TSG*	Reduce utilization of RSPMI Collateral and MHP/MHPP Intervention units (90887 HA, 90887 HA UB)
6. Reduce Group Outpatient RSPMI benefit (90853) *from 6 daily units to 4 daily units per day* (excludes	•Policy, rule, and contract change (Beacon).	•*10/1/16* •*Promulgation process has begun for this change.*	•$4.8 million† †*Estimates by*	Reduce utilization of Group Outpatient RSPMI benefit (90853)

rehab day services and therapeutic acute day services in a day treatment setting).	•DHS managed.		*TSG*	
7. Develop a therapeutic community program (SMI – 24 hours) per diem that includes daily services and treatment.	•Policy, rule, and contract change (Beacon). •DHS managed.	*•These changes will occur during the Behavioral Health Transformation in #1 above.* *•If completed outside of #1 above, the changes must still be promulgated and a similar stakeholder process must occur.*	•$2 million† *†Estimates by TSG*	Eliminates therapeutic community clients from receiving multiple authorized services on the same day.
8. Eliminate multiple claims on the same day for non-school based children and adults: H2015, H2017, H0004	*•Policy limiting units in combinations of codes without prior authorization and substantial proof of medical necessity, require treatment plan to specify and assess the benefit of multiple services. DHS managed.* *•Requires significant claims systems changes which cannot be implemented until after 5/31/2017 per DMS.*	*•The changes must be promulgated and a similar stakeholder process must occur as with Behavioral Health Transformation.* *•The Independent Assessment in the Behavioral Health Transformation would allow DHS to ensure that rehabilitative level services and intensive level services in the school setting are necessary.*	*•$4-$10 million†* *†Estimates by TSG*	*All three services address overlapping care needs on the same day; raises question as to whether patients are better served by claiming more than one of the services in a single day.*
9. Multiple school based claims on the same day: H0004, H2015, H2017, 90847, 90853	*•New policy limiting units in combination of codes on the same day without prior authorization; require treatment plan to specify and assess the benefit of multiple services. DHS managed.* *•Requires significant claims systems changes which cannot be implemented until after 5/31/2017 per DMS*	*•The changes must be promulgated and a similar stakeholder process must occur as with Behavioral Health Transformation.* *•The Independent Assessment in the Behavioral Health Transformation would allow DHS to ensure that rehabilitative level services and intensive level services in the school setting are necessary.*	*•Up to $10 million†* *†Estimates by TSG*	*TSG found 123,000 claims for multiple at school services on the same day amounting to $10 million of overlapping claims without policy controls over multiple billing in a day.*

10. School based services during the summer	*Assure that school- based programs are actually being operated during the summer while schools are closed or moved to another location without proper coding. Require school validation or audit. DHS managed.*	*•The changes must be promulgated and a similar stakeholder process must occur as with Behavioral Health Transformation.* *•The Independent Assessment in the Behavioral Health Transformation would allow DHS to ensure that rehabilitative level services and intensive level services in the school setting are necessary.*	•TBD† *†Estimates by TSG*	*TSG found that providers continue to claim for 77% of total school based claims during the summer months: June and July at the school based level, and half the school based level during August. Clearly, care is influenced by factors other than patients being in school.*
Behavioral Health State Institutions				
11. Arkansas State Hospital	Agency admin. action: Increase client face-to-face time by increasing nursing hours and decreasing psych tech overtime	In process: 7/1/16 Contracts will go into place on this date	*•Approximately $500,000*	Assumption for savings includes the full staffing at a higher cap level at current pay rates. With the lower unemployment rate, attracting qualified applicants has been more challenging.
12. Arkansas Health Center Public Safety/Security	DHS administrative action: replace Public Safety Dept. with LPNs and contracted security (Saline County Sheriff Dept.)	In process: 1/1/17	• $700,000	To achieve full savings amount, replacement positions for LPNs need to be filled and agency nursing services decreased by the equivalent FTEs. Savings is also dependent on not increasing other employment areas at AHC beyond current levels.
Developmental Disabilities Reforms				

13. Comprehensive revision of the DDS HCBS waiver, DDTCS, CHMS, stand alone and school based policies and billing practices, independent assessment for program eligibility based on functional need, treatment planning, and institute outcome measures related to continuing medical necessity. *Ensure **double counting is avoided** relative to other savings initiatives.	Stakeholder process, Waiver, policy, rule, and rate changes. CMS approval.	•*August 2017 – Stakeholder meetings will commence to discuss 1115 Tiered Demonstration Waiver and DDTCS future changes* •*September 2017 – Release RFPs for Independent Assessment Entity and Case Management Entity* •*September 2017 – Submit changes to CMS as well as begin the State promulgation procedures (including public comment period)* •*December 2017 – Complete promulgation process of rule changes.* •*July 2017 – Begin implementation of new Development Disability program* •*July 2018 – To allow for yearly reassessment, complete implementation will be achieved by July of 2018.*	•Managed Care: $63,570 million (11.26%) (2018)† •Managed fee for service: $36,019 (6.38%) million (2018)† •DHS comprehensive program management: $28,228 million (5%) annually† †*Estimates by TSG*	•Require independent assessment for benefit eligibility and treatment planning, implement measurable outcomes related to the treatment plan, implement three levels of care including a preventive level, align DD HCBS waiver with Personal Care and other Medicaid benefits to avoid duplication. •*DDS Comment: There seems to be continued confusion surrounding Personal Care based on comments in the document. Personal Care is a service available under the Medicaid State Plan. Supporting Living is a service available under the DDS Waiver. They are completely different services. They are not duplicative.*
As stated previously, DDS is drafting a demonstration waiver, modeled after a waiver designed by TN, that has a tiered based payment system. For this waiver, DDS plans to utilize the SIS assessment tool as well as a health/safety assessment to determine an individual's tier level. Once in place, individuals who meet the current "institutional level of care" eligibility requirement for both our current 1915(c) waiver and Human Development Center admission will be eligible for the demonstration waiver. At that point, we will restrict enrollment on the current 1915(c). DDS continues to work with Dr. Lisa Mills on changing the current model of our DDTCS system. Currently, day treatment for developmental disabilities is housed under the Medicaid State Plan. As defined, the DDTCS model discourages supported employment and promotes a clinic based setting. DDS is working with Dr. Mills to develop a model that will transform our current DDTCS model to a model that promotes integrated employment in the community.				
14. Children's OT, PT, ST (0-21 years)	Policy, rule, and service definition changes. DHS managed.	1/1/17	•Up to $21.6 million† †*Estimates by TSG*	•Create "dosing standards"; implement standardized testing; eliminate duplicated services •*DDS Comment: Dosing standards are being reviewed (need timeframe for this review? Will it be in effect January 1, 2017?)*

15. Children's Day Habilitation: (0- 21 years) Eligibility Standards Improvements	Policy, rule, and screening for eligibility. DHS managed.	•These changes will occur during the Development Disabilities Transformation in #1 above. •If completed outside of #1 above, the changes must still be promulgated and a similar stakeholder process must occur.	•Up to $7.125 million† †*Estimates by TSG*	Children's Day Habilitation: define eligibility standards; eliminate dual licensure; require universal standardized screening and annual eligibility reevaluation
16. Home and Community Based Services Waiver Modernization	Policy, rule, and waiver changes. DHS managed	*These changes will occur during the Development Disabilities Transformation in #1 above.* *If completed outside of #1 above, the changes must still be promulgated and a similar stakeholder process must occur.*	$9.872 million with 12 months of savings† $7.404 million with 9 months of	Independent assessment; enforce institutional level of care, revise reimbursement to shared staffing, allow host homes, include natural supports.
DDS Comment: As for the statement "enforce institutional level of care," states define "Institutional Level of Care." In Arkansas, our definition of ILC includes both categorical requirements (cerebral palsy, intellectual disability, autism, seizure disorder, and other if it is similar to the previous four) and adaptive behavior deficits. Arkansas initially defined ILC for our Human Development Center consumers. Once a waiver was established in Arkansas for DDS, the criteria exactly matched that of the HDC's so that it acted as alternative to the Centers. That was and continues to be a federal requirement.				
17. TEFRA *DDS Comment: DDS has not been involved in any discussion pertaining to TEFRA rates* *Ask to remove from DDS Reforms section of document*	Policy, rule, and waiver change. DHS managed.	•1/1/17 •4/1/17	$1,074,170: 12 months† $805,628: 9 months† †*Estimates by TSG*	Implement co-pays of $10 per visit and 5% increase in premiums
Developmental Disabilities State Institutions				
18. All HDCs: contract consolidation	DHS administrative action	In process: 1/1/17	TBD	
19. Agency review of all HDC staffing models	DHS administrative action	In process: 1/1/17	TBD	
20. Agency use of independent assessment for all new proposed HDC	DHS administrative action	In process: 1/1/17	TBD	

Division of Aging and Adult Services Reforms

21. *Long Term Care Savings Reform*	• Stakeholder process, policy, and rule changes; Legislative approval, CMS approval • DHS administrative action and state plan amendment	*MOU was signed May 20, 2016*	• $250 million over 5 years • $20 million calendar 2017	*OLTC Comment: Streamline and modernize assessment process/three tier level of care/Nursing Home focusing on Transitions to Community-LTC health home with connection to PCMH; amend reimbursement methodology to limit when enhanced provisional rate is paid for change of ownership and to cap liability insurance cost reimbursement.*

DAAS Comment:
Level 1-NF (Nursing Facility) Skilled Level of Care
Level 2-Institutional HCBS Service level of care
Level 3-Preventative Tier
For Skilled NH Level of Care 1 Beneficiaries: Strengthen the assessment process by improving the MDS process, and requiring the MDS as part of the assessment. Ensure that it is evidence based. Add an audit function to protect integrity and validity of the assessment process;
For all Beneficiaries: Create an effective transition process that offers choice and includes a safety determination to ensure those served in home/community settings have adequate supports and service needs can be met in a cost effective manner.

Waivers				
22. DHS Community based care – Nursing Home Diversion plan	• Policy and rule change. • DHS Managed.	In process 1/1/17 These	•Part of $250 Million over 5 years	

DAAS Comment: Strengthen provider qualifications. For Level of Care 2 and 3 beneficiaries streamline and modernize the current assessment tool. Utilize the assessment to determine eligibility, level of care, and authorization of all services (including waiver and state plan services) to ensure services are efficient, cost effective and designed meet the assessed need of persons served;
Create an effective transition process that offers choice and includes a safety determination to ensure those served in home/community settings have adequate supports and service needs can be met in a cost effective manner.

Division of Medical Services

Payment Integrity Unit

23. Payment Integrity Unit	DHS Administrative action	Will begin July 1, 2016	TBD	This Unit will be led by John Park

Hospitals				
24. NICU payment integrity: DMS-Reimbursed NICU claims – reviewed by AFMC for coding integrity, medical necessity, intensity of services and length of stay – includes DRG (Diagnosis Related Group) validation reviews	DHS Administrative action – operational since July 2015	Operating and functional since July 2015	TBD	*Brief Program Summary/Overview: Records are randomly selected each quarter and reviewed for accuracy and appropriateness of coding, medical necessity and intensity of services/length of stay. After review, approvals/denials are reported to DMS with potential recoupments. Providers are notified of determination and may be requested to submit adjusted claims, requested documents, treatment justifications, corrective action plans (CAPs), etc. Data will be gathered to possibly help establish criteria for treatment of similar NICU cases.*

Contracts				
25. Re-negotiate Contracts	DHS Administrative action	Already underway	TBD	Part of TSG and Task Force recommendations
Organization				
26. Modify organizational structure in Medicaid for integration and efficiency	DHS Administrative action	Already underway	TBD	Part of TSG and Task Force recommendations
Pharmacy				
27. PDL expansion	CMS approval of manufacturer contract approach Request in May	Begins 10/1/16	$10 million† †*Estimates by TSG*	*Expand the Preferred Drug List to maximize State Supplemental Rebate contracting and collection*
28. CAP expansion: add 150 new drugs to the CAP price list	Program expansion – *SPA for reimbursement methodology with CMS*	10/1/16	$1 million† †*Estimates by TSG*	*Brief Summary: Change the reimbursement methodology for pharmacy claims for limited distribution medications. This will be wrapped into the overall pricing methodology change to actual acquisition cost (AAC) and professional fee to pharmacies. State Plan Amendment submission to CMS to change reimbursement methodology to pharmacies will occur in June 2016. Implementation timeline will be determined by CMS response.*
29. Expand antipsychotic drug reviews for children from age < 6 to <10	DUR Board Approval	Up to age 10 as of 12/16	$1 million† †*Estimates by TSG*	*This will expand the manual review program for antipsychotic medications in children by an in-house pediatric psychiatrist*
30. Abilify Generic as part of the complete manual review antipsychotic program	No change Rory	1/1/16	$19.5 million† †*Estimates by TSG*	*Generic upper limit establish on Abilify and manual review on injectable forms of Antipsychotic medication including injectable Ability. This has been completed*
31. Improve quality and decease waste of hemophilia factor drugs	State Plan Amendment and present to Public Health/Policy change only	10/1/16	$1 million† †*Estimates by TSG*	*This is to change the current reimbursement model to a model based on actual acquisition cost plus*

32. Reconfigure retail pharmacy reimbursement	State Plan Amendment	12/15/16	TBD	*a professional fee for pharmacies. The State Plan Amendment submission to CMS will occur in June 2016 and will address limited distribution medications, hemophilia/factor product, and all other pharmacy claim*
33. Hemophilia factor management	DHS Administrative action	Ready to go	TBD	
Program Integrity and Verification				
34. Automated Asset Verification	Operational in January, 2016.	Operating and Functional as of January, 2016	TBD	Functioning very well and have been contacted by CMS and California to share our implementation success details. We are apparently one of only a handful of programs in the nation that has managed to go live with Asset Verification. No further action is needed to
35. Enterprise Benefit Integrity Hub	State and DHS Administrative action and request for funding/APD	Not in process yet	TBD	Part of TSG and Task Force recommendations
36. Enhanced and more routine Medicaid eligibility Verification checks	DHS Administrative action	DHS reviewing for possible roll out with future EEF system changes	TBD	Part of TSG and Task Force recommendations

Patient Centered Medical Home (PCMH)				
37. Expand PCMH to additional enrollees and services	DHS Administrative action/rules	1/1/17	Up to $10 million† †*Estimates by TSG*	DHS should expand the PCMH program to include additional primary care providers and Medicaid beneficiaries, and the medical costs for beneficiaries currently categorically excluded from the PCMH program (e.g., DD enrollees).
The issue of expansion of PCMH related to the inclusion of other populations is directly related to the development of the Health Home model. The work on the Health Home is currently under way. Once the work on the Health home is completed, then the Medical Home and Health Home can further develop integration of this two models. This would allow for inclusion of more services and more beneficiaries in these two care models.				

38. *DMS should expand the PCMH program to include additional primary care providers and Medicaid beneficiaries by reducing the number of minimum beneficiaries needed to join the PCMH program*	*Actions needed include draft/promulgate PCMH SPA modifications and Procedure Manual changes; modify MMIS as noted below*	*2017-18*	*TBD*	*See notes below*
Currently, the program limits participation to practices which have only a minimum of 300 beneficiaries (approximately 412,000 beneficiaries), of that number 330,000 (80%) already participate in the program. No program changes are required to include the remaining 82,000 beneficiaries. The "marketing" effort is currently underway to encourage the remaining practices to join the program. *However; the inclusion of the remaining beneficiaries (57,000) which are in practices with less than 300 beneficiaries does pose several significant problems. The current design ties cost savings to the improvement in quality of care. The practices are evaluated on several different quality categories, as long, as they have a minimum of 25 beneficiaries in each one of those categories. If they don't have the minimum, the corresponding category is excluded. It is very likely that practices with less than 300 beneficiaries will not at all be evaluated on their quality of care. Clearly, such is unacceptable, consequently, a much different design of the program would have to be established. This design would need to be approved by CMS (a very lengthy process), and currently such new model could not be quickly implemented due to the MMIS coding freeze.* *(*all numbers are approximate as they relate to ever changing size of PCCM population currently estimated at 469,000 beneficiaries.)*				
39. *DMS should include costs currently categorically excluded*	*Same as above*	*2017-18*	*TBD*	*See notes below*
The main reason for the exclusion of several categories was the complexity of the cost avoidance calculation, including an appropriate risk adjustment. The inclusion of these populations would require a much more sophisticated risk adjustment methodology than currently used (Johns Hopkins grouper). Please see comments below regarding current program limitations. Similarly to the above suggested expansion, this design would need to be approved by CMS, and would need to be implemented after expiration of the MMIS coding freeze (fall of 2017).				
General Notes to PCMH: Current success of this program is related to its unique design. The design and the implementation of this design allowed the program to accomplish more than other similar programs nationwide. The cost avoidance accomplished by this program compares favorably to what otherwise would be accomplished by a managed care company. *However, the "cheaper" (as compared to a managed care company) administration of the program limits its ability to incorporate substantial changes to the program. Currently the core administration of the program is limited to 3 DMS employees and 3 contractors (HPE, GDHS, AHIN), one of which, AHIN is performing the essential portal functions at no cost to DMS. HPE and its subcontractor GDHS are performing its functions at the upper limits of their capacity.* *In order for this program to do more, or to do it with greater assurance of sustainability, substantially more resources need to be committed to this program , both on the DMS side (more employees and different types of employees, i.e. health economists, IT managers) and on the IT vendor side. In simple terms if this program is to be a viable alternative to a managed care company, it needs to have resources similar to what a managed care company would utilize.*				

Overall notes from PDQA:
>Implementation date of 1/1/17 is ambitious from a promulgation standpoint, but still do-able if work begins quickly to finalize;
>The CMS Access Rule will require us to demonstrate that reductions in services will not hinder beneficiary access to medically-necessary care;