THE STEPHEN GROUP

TSG Status Update

To: Arkansas Health Reform Legislative Task Force

Re: Health Care Reform/Medicaid Consulting Services

Da: June 8, 2016

PREPARED BY:

THE STEPHEN GROUP
814 Elm Street, Suite 309
Manchester, NH, 03102
Main: (603)419-9592
www.stephengroupinc.com

UPDATE SUMMARY

1. ARKANSAS WORKS WAIVER APPLICATION BUDGET NEUTRALITY ANALYSIS

One of the key requirements for a Medicaid 1115 waiver is that the program activities authorized under the waiver may not cost more than the health services would have cost if they had been delivered through the traditional Medicaid program (i.e., it should be budget neutral). For the purposes of the original Private Option waiver and the new Arkansas Works waiver application, the budget neutrality is calculated based on the anticipated average cost per enrollee on a monthly basis.

The following table shows the projected per-member, per-month (PMPM) cost for each year of the Private Option, both with and without the waiver. The projected PMPM amount without the waiver for each year functions as the budget neutrality cap (BNC) and the PMPM with the waiver should stay below the BNC.

Calendar Year	PMPM without Waiver	PMPM with Waiver
2014	$477.63	$492.88
2015	$500.08	$494.15
2016	$523.58	$505.69

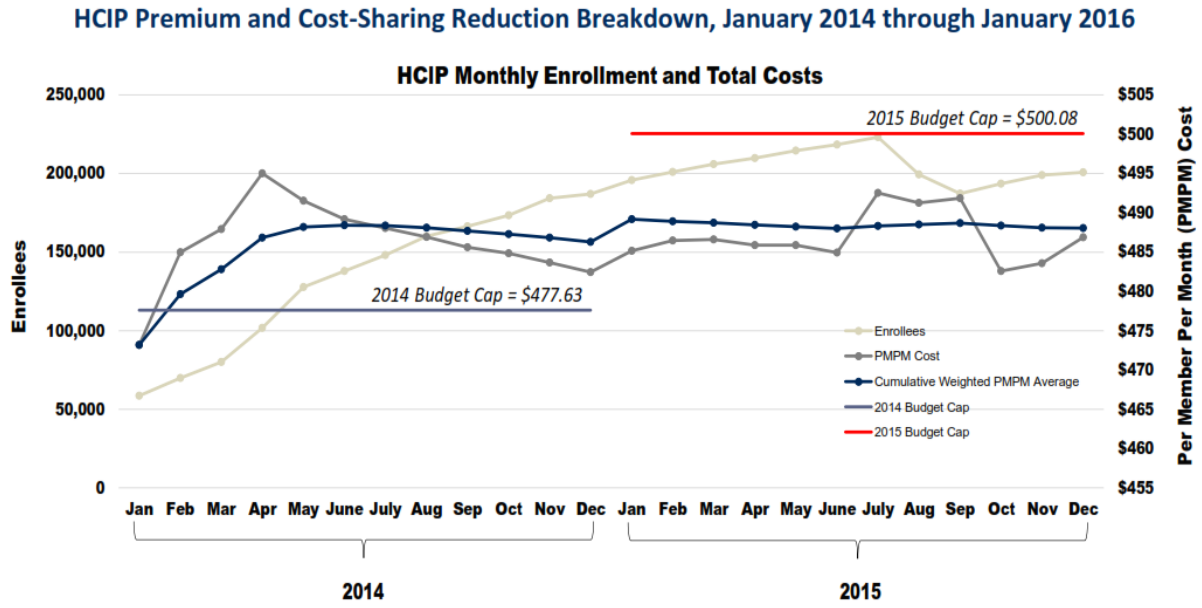
In both the original Private Option waiver application and the application for the Arkansas Works waiver, the projections for the PMPM rates, both with and without the waiver, assumed a 4.7% growth in PMPM costs and a 2.5% enrollment growth rate, for an effective overall cost growth rate of about 7.3%.

The BNC for each year of Arkansas Works is calculated in the same way, and with the same growth assumptions. The following table shows the projected PMPM for each year of Arkansas Works, both with and without the waiver.

Calendar Year	PMPM without Waiver	PMPM with Waiver
2017	$548.19	$528.97
2018	$573.96	$553.85

2019	$600.93	$579.90
2020	$629.18	$607.17
2021	$658.75	$635.72

The following figure is taken from the Private Option Interim Report recently released by the Arkansas Center for Health Improvement and shows the actual PMPM cost experience over the first two years of the Private Option, as well as the BNC for each of those years.



While the actual PMPM costs for 2014 were above the BNC for that year, they were below the BNC for 2015 and have been very stable from the middle of 2014 through the end of 2015.

Using a 7.3% growth factor for the budget neutrality component of the waiver application creates more flexibility for the state in keeping actual PMPM costs below the BNC.

2. REQUESTED PREMIUM RATE INCREASES FOR INDIVIDUAL HEALTH INSURANCE MARKETPLACE PLANS

Two of the largest health insurance carriers in the state have recently requested premium rate increases for calendar year 2017. These rates will apply to plans sold on the individual health insurance marketplace and offered through Arkansas Works. As such, there may be some state

budget impact if the rate increases are permitted. The purpose of this memo is to describe the potential budget impact of the requested rate increases and other relevant considerations.

Requested Rate Increases

QualChoice has requested rate increases of 23.69% and 23.78% for their two plan offerings in the individual market, and Arkansas Blue Cross and Blue Shield has requested rate increases of 14.7% for their two plan offerings in the individual market. Among the remaining carriers on the individual marketplace, Ambetter did not request an increase that was greater than 10% (the threshold for public disclosure at this stage), and United has announced its plans to withdraw from the Arkansas market (as well as many other markets).

Justifications for Rate Increases

TSG contacted the carriers requesting rate increases to ask about their justifications. Both carriers indicated that their medical costs had begun to increase in the second half of 2015 at rates greater than previously in the program and have continued to increase through the first part of 2016 and that the increased rates are necessary in order to cover the higher costs. They speculated that while many individuals had been enrolled in 2014 and the first half of 2015, by the second half of 2015, the enrollees were gaining a greater understanding of how to use their new coverage and were seeking more health services than previously. The carriers also indicated that the enrollees in the PO had higher medical costs than their enrollees in their other commercial products, upon which their initial cost assumptions were based. One of the carriers also noted that the reinsurance and risk-corridor components of the Affordable Care Act are phasing out in 2017, creating more direct risk for the carriers.

The claims experience that has led to these rate increase requests is based on total individual marketplace enrollment, not just the Private Option. However, it is important to note that a significant majority of the enrollment in the individual marketplace is through the Private Option, so each plan's overall experience with the individual marketplace is very likely the result of dynamics within the Private Option population.

Potential Budget Impact

If allowed to go forward, these rate increases could result in a general fund impact for SFY 2017 that is about $3 million higher than it would be under the latest DHS projections for SFY 2017 PO costs (1/2 of calendar year). This estimate assumes that the carriers all maintain the same market share, that the current enrollment through United is distributed to the remaining carriers according to their current market share, that costs for the medically frail and Ambetter rise at 5%, and that costs for the cost-sharing reduction increase at the same rates as the premiums.

The assumption that all of the carriers will maintain the same market share may be affected by the specific region-by-region premium increases requested by the carriers (the increases reported publicly are only statewide averages). DHS has a purchasing policy whereby only the lowest priced two plans offered by different carriers and any other plans within 10% of the second lowest are eligible for the PO. If these premium rates change which plans are eligible for the PO

under this purchasing policy, then the market share may shift and the impact may be lower than reported above.

National Context

Health insurance carriers in many states are requesting premium rate increases at levels not dissimilar to those requested by these Arkansas carriers. A May 2016 analysis of proposed rate increases across 9 states by Avalere Health, a health care consultancy, noted that rate increases from 2016 to 2017 for the average silver plan ranged from 6% to 44%, with an average requested rate increase of 16%. It was also recently reported that the largest insurer in Texas (Blue Cross Blue Shield of Texas) has requested an almost 60% rate increase, noting that they had lost almost $600 million on the individual marketplace in 2015 and just over $400 million in 2014.

Next Steps

These requests to increase rates are just the first step of a process. The Arkansas Insurance Department has the authority to reject these rate increase requests, but it is unknown what the response of the carriers would be to such an action. The Governor and Insurance Commissioner have publicly stated that these rates will not be approved. The Insurance Department is actively reviewing the rate increase requests with their outside actuaries.

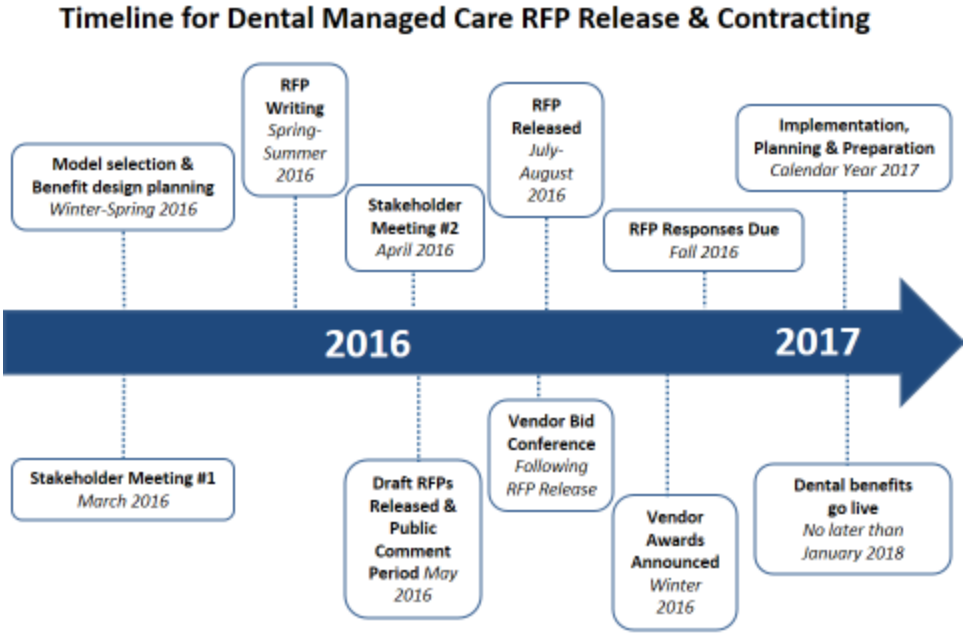
There is also a potential interaction between these rate increases, if approved, and the budget neutrality cap in the Arkansas Works waiver that is currently being developed and negotiated. For calendar year 2015, Arkansas was about 5% below the cap, which inflates at about 5% per year. We don't yet know how the PO cost experience for calendar year 2016 will turn out, and the budget neutrality cap methodology hasn't been finalized for the new waiver, which will begin in 2017.

However, if a similar budget neutrality cap structure is approved for the new waiver and the 2016 experience is similar to 2015, and the rate increases proposed by both carriers are approved, it is likely that Arkansas Works average costs will at some point during the calendar year exceed the budget neutrality cap. Assuming the current carrier plans remain eligible for Arkansas Works, the increase over the cap is likely to be less than 5%.

It is important to recognize that there are a number of assumptions built into this analysis and major changes remain possible that could significantly alter the outcome. In particular, the review of the proposed rates by AID and the negotiation of the Arkansas Works waiver between DHS and CMS are still underway and even minor variations in those processes from the assumptions contained herein could change the conclusions significantly.

3. DHS Draft Dental Managed Care RFP

DHS has issued the following timeline for the dental managed care RFP that will be released in July or August of 2016:



In addition, over the past few months, Arkansas DHS has convened Medicaid Dental Stakeholder meetings to discuss current efforts to restructure the Arkansas Medicaid dental program, in order to shift from a fee-for-service model to a managed care model. Arkansas DHS had issued an original draft RFP and released it for public review and after hearing comments from stakeholders, it has made a significant number of changes through a very collaborative process.

The following is from Arkansas DHS and summarizes key takeaways it has received from stakeholders:

- Stakeholders underscored the importance of obtaining buy-in from the dental provider community throughout the reform development and implementation process. Representatives from the Arkansas State Dental Association emphasized specifically that the dental program should be managed consistent with commercial standards and take into account the unique attributes of dental providers compared to medical providers (e.g., small office size, distinct billing complexities).
- Provider stakeholders urged that a fee-for-service payment model should remain in place for dental providers, with capitation only applicable to the selected vendor.
- Several stakeholders emphasized the need for transportation and care coordination to ensure that patients are able to utilize dental care appropriately.
- Several stakeholders noted that the State must carefully consider how it defines access for the purposes of evaluating network adequacy, suggesting that access should be defined as more than simply meeting specific time and distance standards and emphasizing the need for specific standards for pediatric providers.

- Representatives from community health centers expressed concerns about credentialing processes and provider payment rates.
- Stakeholders encouraged the State to consider the unique needs of specific populations, such as medically complex children.
- Several stakeholders suggested that it may be beneficial to encourage vendors to be proactive in identifying additional value-added benefit or locations of service that would supplement the current dental package.
- Several stakeholders underscored the link between oral and physical health, noting that dental program savings could consequently accrue as a result of dental reform in the Medicaid physical health program. These stakeholders encouraged the State to increase data collection efforts to enhance the State's ability to track and analyze savings and utilization, and improve risk stratification.

Although DHS is still reviewing input and in the process of making final edits to the Draft RFP before its final release, TSG provides the following highlights from the most current Draft RFP as follows (please note that this is not the final RFP and, thus, the language is still subject to change):

DHS changed the original Draft to allow for "multiple" contractors, but DHS retains authority to select "one or more" vendors. However, RFP says that the intention is to award to "multiple vendors."

The services will cover "[a]ll Beneficiaries who receive dental services through Medicaid, except for individuals residing in Human Development Centers or individuals who are eligible for Medicaid only after incurring medical expenses that cause them to "spend down" to Medicaid eligibility levels.

Regarding covering the Arkansas Works population, the RFP draft provides that in the event the state elects to provide dental benefits through Arkansas Works population, eligible individuals "would be the Beneficiaries under the Contract."

Contractors selected for the dental program "will be required to offer a full complement of managed care functions." This means:

- Establishing and managing a dental provider network
- Credentialing and contracting with providers
- Establishing prior authorization and utilization management
- Identifying, investigating and referring suspected fraud cases to OMIG
- Having a program of quality assurance and improvement
- Processing and paying claims as well as adjudicating disputes
- Managing third party liability
- Educating and providing outreach to prospective members

- Providing quality customer service

The initial term of the contract will be for a four year period starting on the day of commencement, which is the date that the contract is approved by the legislature. The Office of State Procurement is in charge of the procurement and will select the vendors and negotiate the terms. They will also reserve the right to offer four one year term renewals before the services would have to be re-procured. Thus, the total term will be for no more than seven years.

Any appeal of a grievance shall be governed by DHS procedure (see Section 160 of the Arkansas Medicaid Provider Manual)

All pricing must fall within the rate ranges contained in the RFP – which will cover Premium Rate Ranges.

Regarding the award process: Each vendor will be given points for the Technical Proposal and for the Cost Proposal. The points will be totaled and the vendors with "highest ranking" shall move forward to next step in solicitation process.

Negotiations.

1. If the State so chooses, it shall have the right to conduct negotiations with the highest ranking vendors. All negotiations shall be conducted at the sole discretion of the State. The State shall solely determine the items to be negotiated.

2. If negotiations fail to result in a contract, the State shall declare the vendor as non-responsive and will begin the negotiation process with the next highest ranking vendor. The negotiation process will be repeated until anticipated successful vendors have been determined, or until such time the State decides not to move forward with an award.

Once a vendor is selected, the anticipated award will be posted for a period of 14 days prior to the issuance of a contract.

The RFP will contain the following "Minimum Requirements:"

- Responsibility for "arranging for and paying for all Covered Services rendered to Beneficiaries"
- Complying with all of the managed care covered services outlined above
- Responsibility "for arranging for and processing claims for all Covered Services rendered to the Spend Down Population. The Contractor will not be at financial risk for the Spend Down Population." The spend down population is defined as "individuals

who are eligible for Medicaid coverage only after incurring medical expenses that reduce their incomes to Medicaid eligibility levels."

- At least 5 years experience covering dental benefits in the Medicaid population or the vendor must provide a response that snows "evidence of commensurate experience."
- Must disclose any on-going litigation or litigation that has been resolved over the last 5 years related to covering dental benefits in a Medicaid program
- Must either have or will have Certificate of Authority from Arkansas Insurance Department within 120 days of go live
- Meet all federal criteria for enrolling Medicaid individuals and covering them
- Must also be financially solvent

The RFP contains a lengthy section on the actual Scope of Work that bidders or contractors will be required to follow in submitting a bid. This scope of work will be part of their contract obligation, should they be selected. Each Scope section is outlined with specificity in the draft RFP and we have highlighted some of the more pertinent as follows:

Medically Necessary Covered Services

The Contractor shall provide all Medically Necessary Covered Services to Beneficiaries, subject to any benefit limits defined by DHS for certain Beneficiary populations. Medically Necessary Covered Services are described in an attachment to the RFP. If a new covered service is added by DHS within the first two years of the contract, the contractor will not bear financial risk for the first two (2) years. During the first two (2) years after a new Covered Service is added, however, the Contractor shall pay claims for such new Covered Services at a rate specified by DHS. After two (2) years, the costs for the new Covered Services will be included into the capitation rate.

Value-Added Services

Vendors may propose to offer Value-Added Services (VAS), defined as additional Covered Services beyond those required under this RFP, subject to written approval by DHS. Any approved VAS must be offered at no additional cost to DHS, Beneficiaries, or Providers.

a. The Contractor will not receive additional compensation for any VAS offered, and may not report VAS costs as Allowable Costs under the Contract. VAS costs will not be factored into rate setting.
b. The Contractor must not pass on the cost of the VAS to Beneficiaries or Providers.

Access to Care

During the Contract Term, the Contractor's Provider Network must be sufficient for all Medically Necessary Covered Services to be available to Beneficiaries on a timely basis, consistent with appropriate dental guidelines, generally accepted practice parameters, and the Contract's requirements. The Contractor shall include in its network the following classes of Providers in numbers that are sufficient to furnish services described in this RFP in accordance with time, geographic and other standards described in the RFP:

i. Dentists and dental hygienists, pediatric dentists, orthodontists, periodontists, oral surgeons, and endodontists;

ii. Dentists and other dental professionals described above with demonstrated experience in the provision of services to children with acute and chronic medical conditions or special circumstances, including but not limited to cardiovascular conditions, HIV infection, cancer, developmental disability, or behavioral disorder; and

iii. Other recognized dental professionals who are trained in dental care and oral health and experienced in performing triage for such care.

Contractors are required to ensure that its providers provide Covered Services to Beneficiaries under this Contract at the same quality level and practice standards and with the same level of dignity and respect as provided to non-Medicaid patients.

The Network must also be responsive to the linguistic, cultural, and other unique needs of any minority or disabled individuals, or other special population in Arkansas Medicaid.

Unless otherwise specified in the Contract, DHS will require that the Contractor meet the following specific access standards:

c. At least 90% of Beneficiaries must have access to two or more Primary Care Dentists who are accepting new patients within 30 miles of the Member's residence in urban counties and 60 miles of the Beneficiary's residence in rural counties.

d. At least 85% of all Beneficiaries must have access to at least one specialty provider within 60 miles of the Beneficiary's residence.

e. Urgent care, including urgent specialty care, must be provided within 24 hours.

f. Therapeutic and diagnostic care must be provided within 14 days.

g. Primary Care Dentists must make referrals for specialty care on a timely basis, based on the urgency of the Beneficiary's dental condition, but no later than 30 days.

h. Non-urgent specialty care must be provided within 60 days of authorization.

In addition, the Contractor shall maintain a sufficient Network for each Beneficiary to have a Primary Care Dentist (PCD). When new Beneficiaries enroll in Medicaid, the Contractor shall offer them a choice of PCDs in their geographic area.

If a Medically Necessary Covered Service is not available through a Network Provider, the Contractor must allow a referral to an out-of-network provider. A request for such referral may be made by a Network Provider or the Beneficiary.

The Contractor must regularly and systematically monitor and verify that Medically Necessary Covered Services furnished by Network Providers are available and accessible

Provider Credentialing

The contractor shall ensure that all Network Providers are licensed, credentialed, and eligible to render services in the Medicaid program under applicable State and federal laws.

The contractor shall enter into written contracts with properly credentialed Providers who participate in the Network. These Provider Agreements must be in writing, must comply with applicable federal and state laws and regulations, and must include the minimum requirements specified in the RFP

The contractor will be prohibited from:

a. Requiring a Provider or Provider group to enter into an exclusive contracting arrangement with the Contractor as a condition for Network participation.

b. Requiring Providers to participate in the Contractor's other lines of business as a condition of joining the Contractor's Network for Arkansas Medicaid.

c. Reimbursing Providers at rates lower than prevailing rates in the Arkansas Medicaid fee-for-service system.

Provider Relations and Education

The contractor shall have a specific provider relations representative assigned to each dentist within the Network. These staff should be easy to contact and should be able to visit Provider offices when necessary, but no less than once a year for all dentists and mobile dental units. Provider relations staff shall respond to Provider inquiries within one business day. These staff must have the ability to provide individual training and education as needed and as requested by Providers.

Outreach to Consumers

The Contractor shall submit an outreach plan to the Contract Monitor which outlines objectives and strategies that will increase awareness of the importance of dental care, the availability of dental benefits, and increase utilization to meet DHS goals for all Beneficiaries. In addition, the Contractor shall target specific efforts to children and adults with special health care needs, pregnant women, and those Beneficiaries who have not seen the dentist in a 12-month period of time. DHS may require the Contractor to coordinate its efforts with outreach projects being conducted by DHS or other State agencies.

The Contractor shall also be required to conduct regularly scheduled outreach activities, on a quarterly basis of each Contract year, designed to inform Beneficiaries about the availability of dental services and to meet or exceed DHS-established utilization goals.

Coordination with Public Health and Other Entities

The Contractor will also be required to work closely and cooperatively with DHS, local health departments, and FQHCs.

Beneficiary and Provider Assistance

The Contractor will also be required to operate a toll-free Call Center to provide accurate and timely assistance to Beneficiaries and Providers, including appointment setting and handling Grievances and Appeals. The contractor will be required to meet performance measures on timely call center response and follow up. The contractor shall also create and maintain an easily accessible website of information for Beneficiaries and Providers.

Grievance and Appeal Handling.

The Contractor will utilize DHS-approved policies and procedures for recording, investigating, resolving, and analyzing all Grievances and Appeals, received telephonically or written, within State-established time frames. Grievances and Appeals include reconsiderations of denials and down-coding of prior authorization requests. The Department will conduct any Administrative Hearings requested after the Beneficiary, or the Provider appealing on the Beneficiary's behalf, has exhausted a single level of appeals, and the Contractor shall be bound by any decision made during the State's Administrative Hearing.

Preauthorization and Utilization Management

In arranging for the provision of Medically Necessary Covered Services to Beneficiaries, the Contractor shall be required to ensure that all Medically Necessary diagnostic, preventive, restorative, surgical, endodontic, periodontic, emergency, and adjunctive dental services that are administered by or under the direct supervision of a licensed dentist are provided to children who are eligible for EPSDT services in accordance with the EPSDT federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989, whether or

not such services are Covered Services under Arkansas Medicaid. Services for children should be approved in accordance with the periodicity standards of the AAPD in order to meet the EPSDT standard. See Attachment F for AAPD's Periodicity of Examination, Preventive Dental Services and Oral Treatment for Children; and authorize the provision of orthodontics to Beneficiaries under the age of 21 when the orthodontic treatment plan meets all of the criteria set by Arkansas Medicaid.

The Contractor shall be required to make a determination of Medical Necessity on a case-by-case basis for services requiring preauthorization.

The Contractor shall have the ability to place tentative limits on a service; however, such limits shall be exceeded for children eligible for EPSDT services when such services are determined to be Medically Necessary based on a Beneficiary's individual needs.

The contractor shall also not require prior authorization for any Medically Necessary pediatric preventive services, diagnostic dental services, patients who present a specific symptomatic problem such as dental pain, or dental emergencies such as trauma or acute infection.

Contractor Office and Staffing

The Contractor must maintain a physical office in Pulaski County, Arkansas. At minimum, the following staff shall be located in the Arkansas office: Project Director, Dental Director, Provider relations staff, and outreach staff. The contractor is also required to have a staffing plan that assures that all persons, whether they are employees, agents, subcontractors, Providers, or anyone acting for or on behalf of the Contractor, are legally authorized to render services under applicable Arkansas law and/or regulations. The Contractor shall not have an employment, consulting or any other agreement with a person that has been debarred or suspended by any federal or State agency for the provision of items or services related to the entity's contractual obligation with the State.

Quality Assurance and Improvement

The Contractor shall develop an internal quality assurance and improvement program that is comprehensive and routinely and systematically monitors access, availability and utilization of services, customer satisfaction, Provider Network adequacy, and any other aspects of the Contractor's operation that affect Beneficiary care.

Eligibility

The Contractor shall maintain and utilize an enrollment system with the ability to accept and process daily eligibility files and full replacement data files provided by DHS in order to verify active enrollment in Arkansas Medicaid prior to authorizing or paying for any dental services. The full replacement file occurs at the discretion of DHS. The Contractor must use the data

contained in the Department files to replace the Contractor's existing eligibility files. At least 30 days prior to the Go-Live Date, the Contractor shall develop a system to accept and load an initial full file of Beneficiary eligibility data from DHS. Additionally, the Contractor shall develop a system to accept and update daily Beneficiary eligibility data from DHS.

Claims Processing

The Contractor shall develop and maintain an accurate and efficient system to receive and adjudicate claims for Medically Necessary dental services. The Contractor shall operate its claims processing system in accordance with all applicable State and Federal requirements, including the Arkansas Medicaid Fairness Act.

The Contractor shall also timely review claims and submit timely payment according to provisions of the draft RFP. Deny or approve, and submit for payment. Specifically, deny or approve:

i. 100% of paper claims within 30 calendar days of receipt; and
ii. 100% of electronic claims within 14 calendar days of receipt;

Coordination of Benefits & Third Party Liability

Because the Medicaid program is payer of last resort, the contractor must operate a third party liability system that has adequate resources to ensure that their parties meet their legal obligation to pay claims before the Medicaid program pays for the care of an individual eligible for Medicaid.

Fraud and Abuse

The Contractor shall establish an audit plan, to be submitted for approval to the Contract Monitor by the Go-Live Date, to monitor quality and prevent fraud and abuse for all network Providers. In the plan, the Contractor shall describe its interface with the Office of the Medicaid Inspector General and the Office of the Attorney General Medicaid Fraud Control Unit (MFCU), as appropriate, and shall agree to cooperate with State and federal entities in investigations of suspected fraud and abuse. The Contractor shall describe its plans to perform audits and other reviews of dental and billing records to ensure that only Medically Necessary services are reimbursed, and shall develop and implement approved audit tools and protocols

4. PHARMACY SAVINGS INITIATIVE UPDATE

Savings Updates

This is an update on the primary pharmacy savings initiatives that TSG has been tracking for the Task Force together with the DHS pharmacy department.

PDL Expansion

DHS is beginning the new therapeutic class reviews which will complete the expansion of supplemental rebate claim coverage from 38% to approximately 60%. Due to changes in the PDL process and makeup, 5 new therapeutic classes will be reviewed in August and rebate bids are currently being sought from drug companies. Five more will be reviewed at the next quarterly meeting. At the same time, supplemental rebate contracts are being restructured to mirror the industry standard of basing the rebate calculation on wholesale acquisition cost (WAC) of the rebated drug. DHS is seeking approval from CMS for these changes. This approval is expected. When fully expanded, the additional supplemental rebates will total an estimated $10mm annually. Some expanded rebates could accrue in late 2016. Arkansas will explore and work to implement physician endorsed PDL. Sometime in 2017 physicians will be able to declare support for the PDL on a website. At this point, when dispensing pharmacists verify a prescriber's PDL support, they will be able to then perform a therapeutic substitution without any additional administrative costs or delays. This is expected to improve PDL compliance.

CAP Expansion

DHS has identified approximately 150 additional drugs to add to the current CAP program. This measure is projected to save money by establishing a ceiling price for those drugs which are not generic or subject to State MAC or Federal Upper Limit (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. Dispensing pharmacies will be reimbursed at wholesale acquisition cost (WAC) minus 3 percent or invoice cost. Many of these products are shipped into Arkansas by specialty pharmacies outside the State. This initiative will be included in the State Plan Amendment to CMS and approval is expected. Estimated annual savings of $1 million will begin toward the end of 2016 or early2017.

Antipsychotic Drug Management

There are several initiatives contributing to savings in the antipsychotic drug area. The use of long- acting injectable antipsychotic drugs seems like a positive step towards improving compliance in a drug category where small lapses in adherence can have dire consequences. DHS experience demonstrates up to 30% non-adherence by patients using these expensive products. When this is discovered, patients are switched to oral treatment at a much lower cost, improved outcomes and patient safety. Another example is expected to lower drug spend on Abilify (aripiprazole), a widely used atypical antipsychotic drug, with the availability of generic aripiprazole. Savings has begun to accrue and will is projected to total $19.5 million in calendar year 2017. DHS has also begun increasing the age for manual review by a pediatric psychiatrist prior to approving antipsychotic drugs from less than 7 years old up to 10 years old by the end of 2016. This will dramatically reduce the drug use and cost for this population by $1 million per year. 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 representing over $20mm. As part of the State Plan Amendment to CMS, DHS is requesting approval of an innovative way to manage the cost of these expensive drugs, improve quality and decrease waste. The request will rationalize professional fees paid to dispensing pharmacies. While not compromising the any willing provider provisions, DHS will identify a limited number of highly qualified pharmacies with experience managing patients with hemophilia and a waste reeducation program will begin toward the end of 2016 or early 2017. Annual savings of $1mm is expected.

Retail Pharmacy Reimbursement Reconfiguration

As part of the State Plan Amendment, planned submission in July 2016, DHS will request approval of a new reimbursement formula for pharmacies based on the new CMS requirement of acquisition cost based reimbursement. The new formulae are expected to feature acquisition cost reimbursements, generally higher dispensing fees and reimbursement differentials for PDL and generic drugs. Recently, CMS and the State rolled out new pricing associated with the Federal Upper Limit (FUL) drug list. We are confident that there will be positive savings from these initiatives and that they can be implemented toward the end of 2016 or early 2017. We will update the annual pharmacy savings once known.

Combined Call Centers

On July 1, 2016 all former pharmacy call centers are being consolidated and will now be operated by Magellan. Magellan is providing more services supporting the PDL and many of the calls to the call center are for PDL exception requests, making Magellan a natural choice for the consolidated work. In terms of economic impact, all former UAMS call center staff were offered positions with the new call center and many accepted. This consolidation will produce administrative efficiency.

5. OPIOIDS IN ARKANSAS MEDICAID

The following is a quick report card on how Arkansas Medicaid is progressing in the battle to manage opioid abuse, while still preserving access for patients requiring these powerful drugs.

Overview of the Problem

Since the launch of OxyContin in 1996, use of opioids rose steadily in the United States and now, from Prince to our Veterans, we see the effects of opioid use in the news and the emergency room every day. By 2010, the United States, with about five percent of the world's population, was consuming ninety-nine percent of the world's hydrocodone (the narcotic in Vicodin), along with eighty percent of the oxycodone (in Percocet and OxyContin), and sixty-five percent of the hydromorphone (in Dilaudid).

How did this happen? Physicians are obviously trying to do the right thing for their patients but a one-hundred-word letter to the editor published in 1980 in the *New England Journal of Medicine*, reported that less than one percent of patients at Boston University Medical Center who received narcotics while hospitalized became addicted. However, this does not translate to outpatient care, and combined with drug company product promotion, is a chief source of much of the current overuse of opioids. Maybe inpatients did not get addicted in 1980, but outpatients certainly are addicted today.

Over 90 percent of the prescription drugs causing overdoses are not accessed on the black market but through prescriptions for you, your family or friends highlighting the importance of cleaning out the medicine cabinet at home. Recently however, overdoses from illicit drugs are on the rise and prescription drug abuse is moderating. Further evidence of slight opioid moderation was found on the front page of the New York Times (5/21/16) which reported that "the number of opioid prescriptions in the United States is finally falling, the first sustained drop since OxyContin [oxycodone] hit the market in 1996." A good sign, but just a start, and more needs to be done.

Recent Federal and State and Payor Initiatives

TSG studied activities in the marketplace aimed at the opioid problem. We looked at Federal, State and Payor initiatives to get a sense of what currently is being done.

In March of this year the CDC published 12 recommendations for prescribing of opioids in non-malignant chronic pain management, addressing duration, product selection, dosing and more. This is only a guideline, but can serve as an important resource to prescribers and policy makers. Meanwhile the FDA is working to approve tamper resistant formulations to limit non-oral abuse of prescription opioids and still ensure access to a variety of options to prescribers and patients. The DEA is working to expand the successful take-back programs from a twice annual event to everyday availability, including certain pharmacies.

States are addressing the issue with more tactical laws and regulations, mostly focusing on limiting supply and dose, stressing e prescribing for narcotics, the availability of naloxone (opioid reversal agent) and promotion of prescription drug monitoring program databases.

Especially as it relates to acute pain management from injuries, surgeries and dental procedures, states have moved to limit either the days' supply or a more sophisticated limitation on allowable morphine milligram equivalents (MME) prescribed. Some states have also moved to define chronic pain management limiting unfettered prescribing of opioids to 3 or 6 months, then requiring more intensive patient management such as pain contracts and random urine testing. Delaware, Maine, Massachusetts, Rhode Island, New York, Ohio, and Washington all limit opioid quantities or MMEs.

Most prescribing is regulated by a state's medical practice act. Electronic prescribing of controlled substances reduces fraud and keeps patients from getting multiple prescriptions for the same drug. Three states have mandatory e-prescribing for controlled substances. All states allow e-prescribing

for controlled substances; still, only 7% of doctors do so, according to Surescripts the e-prescribing giant.

Another state-specific initiative is the availability of naloxone, which can reverse the effects of opioids and save the life of severely overdosed patients. Fourteen states passed laws expanding access to naloxone in 2015. All but 8 states have a naloxone law of some type addressing availability of the drug and or immunity for health care professionals and lay public.

Lastly, prescription drug monitoring programs (PDMPs) are state databases recoding controlled substance prescribing and dispensing. The programs are not linked nationally, which is a weakness exploited by drug seekers, and states vary widely on requiring prescribers and dispensers to consult the database as a routine part of care for patients requiring controlled substances. Forty nine states (all but Missouri) have PDMPs in place.

Cigna, the large national insurance carrier recently announced a goal of decreasing opioid use 25% over the next 3 years. The payor plans to use a combination of physician and patient engagements to achieve the goal.

How does Arkansas Medicaid compare?

Arkansas Medicaid has continued to tighten limits on opioid availability. Recently, DHS changed the quantity limit on short acting opioids from 124 units/month to 93 (April 2016 went to 90) units per month. This is not expected to cause any repercussions in the market. Another clever claim edit implemented is the cumulative early refill allowing only 15 days extra supply within 186 calendar days. Some patients could consistently refill opioid prescriptions early allowing them to stockpile extra doses. This edit will reduce and manage the loophole. Soon, DHS will be ready to introduce a 300 MME/day limit which is the most sophisticated limit any state is currently imposing.

Consistent with a prior TSG recommendation to the Task Force, DHS clinical staff will soon have access to the State PDMP.

Moreover, Arkansas has a naloxone access act. Health care providers are expected to act with reasonable care, but have immunity from criminal and civil actions. The lay public also has immunity from criminal and civil liability. Medicaid covers naloxone when prescribed by an enrolled Arkansas Medicaid prescriber (or via a standing order). Vials of generic injectable naloxone and syringes are reimbursed to dispensing pharmacies, though some of the newer products require prior authorization.

The State also has a successful drug take-back program.

Summary and Recommendations

Opioid overuse, misuse and abuse remain significant threats to public health in the US and in Arkansas. There are positive efforts from Federal and State legislatures, and payors which are

beginning to show signs of positive impact, but there is a long way to go. Arkansas Medicaid is controlling access to opioids in a logical and progressive manner and seems poised to continue to add new and sophisticated drug utilization management tools as they emerge.

The State could consider mandatory e-prescribing for controlled drugs, and requirements to consult the State PDMP for prescribers and dispensers of controlled substances. Also, the drug take-back program could be expanded in frequency and number of locations for drop-off.

6. ELIGIBILITY AND ENROLLMENT FRAMEWORK SYSTEM AND RFP MONITORING UPDATE

Highlights of the Project #6 – Competitive Procurement System Integrator Services include:

Procurement Assistance RFP

DHS in conjunction with the Office of State Procurement, published a Request for Proposal (RFP) for a vendor to assist DHS with the state procurement process and ensuring that all state procurement rules will be complied with for the following procurements:

- Systems Integrator of the Integrated Eligibility Management System
- DHS Information Systems Supports (ISS)
- Dental Only Managed Care for the Division of Medical Services (DMS)

DHS desires to contract with a vendor to serve as an impartial third party "fairness officer" to ensure that the proposal evaluation, award process, and subsequent contract is done in compliance with state procurement law and procurement best practices. This vendor will also be tasked with creating and maintaining a documentation trail throughout the procurement process to support DHS in responding to any bid protests that may arise. Proposals have been submitted and DHS is in the process of evaluating them and awarding a vendor. DHS hopes to be able to announce the winning vendor by mid-June.

System Integrator (SI) Vendor RFP Update

DHS is on schedule to submit the draft SI RFP to CMS by July 1^{s} and they continue to work closely with Gartner on functional requirements. DHS remains committed to holding a bidders conference to answer questions for interested vendors, but has not yet set a date for that conference.

DHS also reports that the health and human services visioning document draft is complete and is currently being reviewed by the Governor's Office for approval.

7. COST ANALYSIS OF LARGE, STATE-OPERATED INTERMEDIATE CARE FACILITIES

At the March 29, 2016, meeting of the Human Development Center (HDC) Subcommittee of the Health Reform Legislative Task Force, Co-chaired by Senator Jason Rapert and Representative Kim Hammer, testimony was presented by DHS regarding the average cost of care in Arkansas' five HDCs. The Co-Chairs requested the TSG compare the average cost of care in the Arkansas facilities with similar institutional facilities across the country. The following analysis addresses that question:

Background

The Intermediate Care Facilities for individuals with intellectual and developmental disabilities (ICF) benefit is an optional Medicaid benefit that provides twenty-four hour residential care and active treatment services for persons with intellectual and developmental disabilities. States operate approximately 160 large ICFs, or those with 16 or more beds. Over the past forty years, the population residing in these institutions has declined and the population of persons receiving Medicaid community-based services have expanded. A significant factor in the expansion of community-based services is the cost differential in serving persons across settings. See May 2016 National Conference of State Legislatures policy brief.[1]

Arkansas Human Development Centers

Arkansas operates five large Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs) known as Human Development Centers (HDCs). The HDCs served 903 persons with a total budget of $118.5 million in fiscal year 2016. The census and average annual budget per facilities varies, and this information is shown in the figure below.

Fiscal Year 2016 Census and Budget, by Human Development Center

	2016			
	Census	**Annual Budget**	**Average Annual Spending / Resident**	**Estimated Spending Per Resident, Per Diem**
Arkadelphia	114	$ 14,787,267	$ 129,712.87	$ 355.38
Booneville	124	$ 15,770,030	$ 127,177.66	$ 348.43
Conway	466	$ 63,616,978	$ 136,517.12	$ 374.02
Jonesboro	106	$ 12,364,386	$ 116,645.15	$ 319.58
Warren	93	$ 11,973,784	$ 128,750.37	$ 352.74
Total	903	$ 118,512,445	$ 131,243.02	$ 359.57

Source: Arkansas Department of Human Services, provided 4/15/16.

[1] Hemp et al., "U.S. Disability Services and Spending," National Conference of State Legislatures Policy Brief, May 2016.

Note: The budget data provided is inclusive of all funding sources. It includes direct and indirect costs, including administrative and allocated costs.

National Comparison

In order to compare the budget for Arkansas' HDCs to the ICFs operated in other states, TSG used national data to identify states that operate a similar number of and/or similarly-sized ICFs as Arkansas. Data used were the most recently available national data from the 2016 annual fact book produced by the Research and Training Center on Community Living, Institute on Community Integration, at the University of Minnesota (data are through June 30, 2013).[2]

Nationally, as of June 30, 2013, there were 160 large (defined as having 16 or more beds), state-run ICFs. The following figure identifies groups of states organized by the number of large ICFs in operation.

Number of Large, State-Run ICFs, by State, as of June 30, 2013

Facilities in Operation	Count of States	States
0	14	Alabama, Alaska, Arizona, District of Columbia, Hawaii, Indiana, Maine, Michigan, Minnesota, New Hampshire, New Mexico, Oregon, Rhode Island, Vermont
1 to 5	29	Arkansas, California, Colorado, Delaware, Florida, Georgia, Idaho, Iowa, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Montana, Nebraska, Nevada, North Carolina, North Dakota, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, Utah, Virginia, Washington, West Virginia, Wisconsin, Wyoming
6 to 10	6	Connecticut, Illinois, Missouri, Mississippi, New Jersey, Ohio
11 to 15	1	Texas
16 to 20	0	
21 to 25	0	
26 to 30	1	New York

Source: RISP, 2016.

As shown, thirteen states and the District of Columbia did not have any large, state-operated ICFs as of June 30, 2013. Since 2013, additional states have closed facilities and some now no longer operate any facilities (i.e., Oklahoma).

- Virginia has agreed to close four of its five state ICFs as part of a settlement agreement with the Department of Justice that also addresses the 5,000 individuals currently on the waiting list. The Northern Virginia Training Center officially closed on 3/31/16 and the state's overall state ICF facility census has dropped from 1,200 in 2010 to 515 at present.

[2] Research and Training Center on Community Living, Institute on Community Integration, Residential Information Systems Project (RISP), "In-Home and Residential Long-Term Supports and Services for Parents with Intellectual or Developmental Disability Status and Trends Through 2013," 2016, https://risp.umn.edu/.

- Connecticut recently announced plans to close the 500 bed Southbury state ICF facility by 2017/2018.
- California recently announced plans to close the Sonoma, Fairview, and Porterville State ICFs by 2021, with Sonoma scheduled to close in 2018.
- Tennessee has one remaining facility (Greene Valley) but plans to close it by June 30, 2016.[3]

Across the U.S., 23,084 persons reside in large, state-run ICFs as of 2013. The ten states with the highest total number of residents of large, state-run ICFs are shown in the following figure. Arkansas has the ninth highest total system census.

Ten States with Highest Residents Total Large, State-run ICFs, as of June 30, 2013

State	# Residents
TX	3,547
NJ	2,413
IL	1,810
CA	1,567
NC	1,272
MS	1,212
PA	1,041
OH	952
AR	**934**
WA	808
U.S. Total	**23,084**

Source: RISP, 2016.

There are seven states with a comparable number of residents in their large, state-run ICFs as Arkansas (defined as having 500 to 1,000 total residents). These states include Ohio (952), Washington (808), Virginia (779), South Carolina (721), Florida (685), Connecticut (552), and Massachusetts (516).

The national average is 144.3 persons per facility, as of June 30, 2013. The average facility size in Arkansas is higher than the national average, at 186.8 persons, but several other states operate larger facilities than Arkansas.

[3] News Channel 11, "Tennessee one step away from dismissal of Clover Bottom, Greene Valley lawsuit," 01/21/16, http://wjhl.com/2016/01/21/tennessee-one-step-away-from-dismissal-of-clover-bottom-greene-valley-lawsuit/

Ten States with the Highest Average Facility Census, as of June 30, 2013

State	Avg. Residents / Facility
New Jersey	344.7
Florida	342.5
North Carolina	318.0
California	313.4
Texas	272.8
Illinois	258.6
Louisiana	234.0
Iowa	214.5
Pennsylvania	208.2
Utah	206.0
U.S. Average	**144.3**

Source: RISP, 2016.

Nine states, in addition to Arkansas, have between 150 – 250 average residents/facility. These states (with average facility census) include Louisiana (234.0), Iowa (214.5), Pennsylvania (208.2), Utah (206.0), Mississippi (202.0), Washington (202.0), Massachusetts (172.0), Kansas (163.5), and Virginia (155.8).

National average per diem spending was $701/resident (adjusted to $255,865/year) in fiscal year 2013. Arkansas spent the fourth lowest of thirty-eight states furnishing data to the University of Colorado's Coleman Institute for Cognitive Disabilities.

Average daily cost per resident per large, state-run ICF, FY 2013

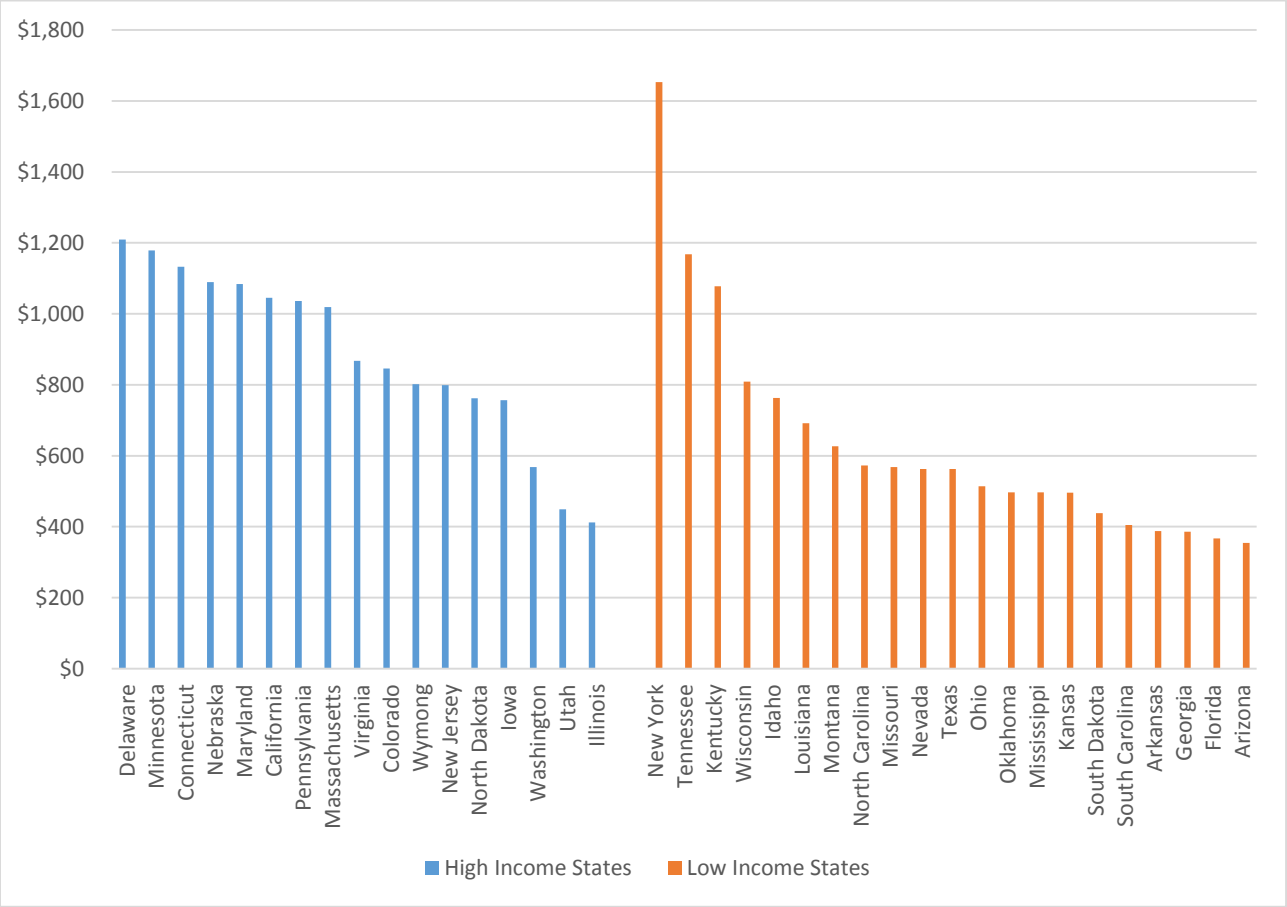
	Average Daily Spending	Estimated Annual Spending
New York	$1,653	$603,345
Delaware	$1,209	$441,285
Minnesota	$1,179	$430,335
Tennessee	$1,168	$426,320
Connecticut	$1,133	$413,545
Nebraska	$1,089	$397,485
Maryland	$1,084	$395,660
Kentucky	$1,078	$393,470
California	$1,045	$381,425
Pennsylvania	$1,036	$378,140
Massachusetts	$1,019	$371,935
Virginia	$868	$316,820
Colorado	$846	$308,790
Wisconsin	$809	$295,285
Wyoming	$802	$292,730
New Jersey	$799	$291,635
Idaho	$763	$278,495
North Dakota	$762	$278,130
Iowa	$757	$276,305
Louisiana	$692	$252,580
Montana	$627	$228,855
North Carolina	$573	$209,145
Missouri	$568	$207,320
Washington	$568	$207,320
Nevada	$563	$205,495
Texas	$563	$205,495
Ohio	$514	$187,610
Mississippi	$497	$181,405
Oklahoma	$497	$181,405
Kansas	$496	$181,040
Utah	$449	$163,885
South Dakota	$438	$159,870
Illinois	$412	$150,380
South Carolina	$405	$147,825
Arkansas	$388	$141,620
Georgia	$386	$140,890
Florida	$367	$133,955
Arizona	$354	$129,210
United States	**$701**	**$255,865**

Source: Braddock et al, "The State of the States in Intellectual and Developmental Disabilities: Emerging from the Great Recession," February 10, 2015.

Notes: States may differ in the methodology used to provide this information. The table excludes states that did not furnish data and states that do not operate any large, state-run ICFs. TSG calculated estimated annual cost by multiplying the per diem cost by 365 days. TSG adjusted the per diem rates to the estimated annual total for comparative purposes only.

To facilitate comparisons of expenditures across states, the following figure reports per diem expenditures and states are sorted by their 2013 Median Income. For purposes of this figure, the high income states are those with a median income above the U.S. median income and the low income states were states with a median income below the U.S. median income. The 2013 Median U.S. income was $53,585. Generally, most of the highest spending states also have high incomes and most of the lowest spending states have median incomes below the U.S. Median Income.

Average State FY 2013 Daily Spending, by 2013 Median Income

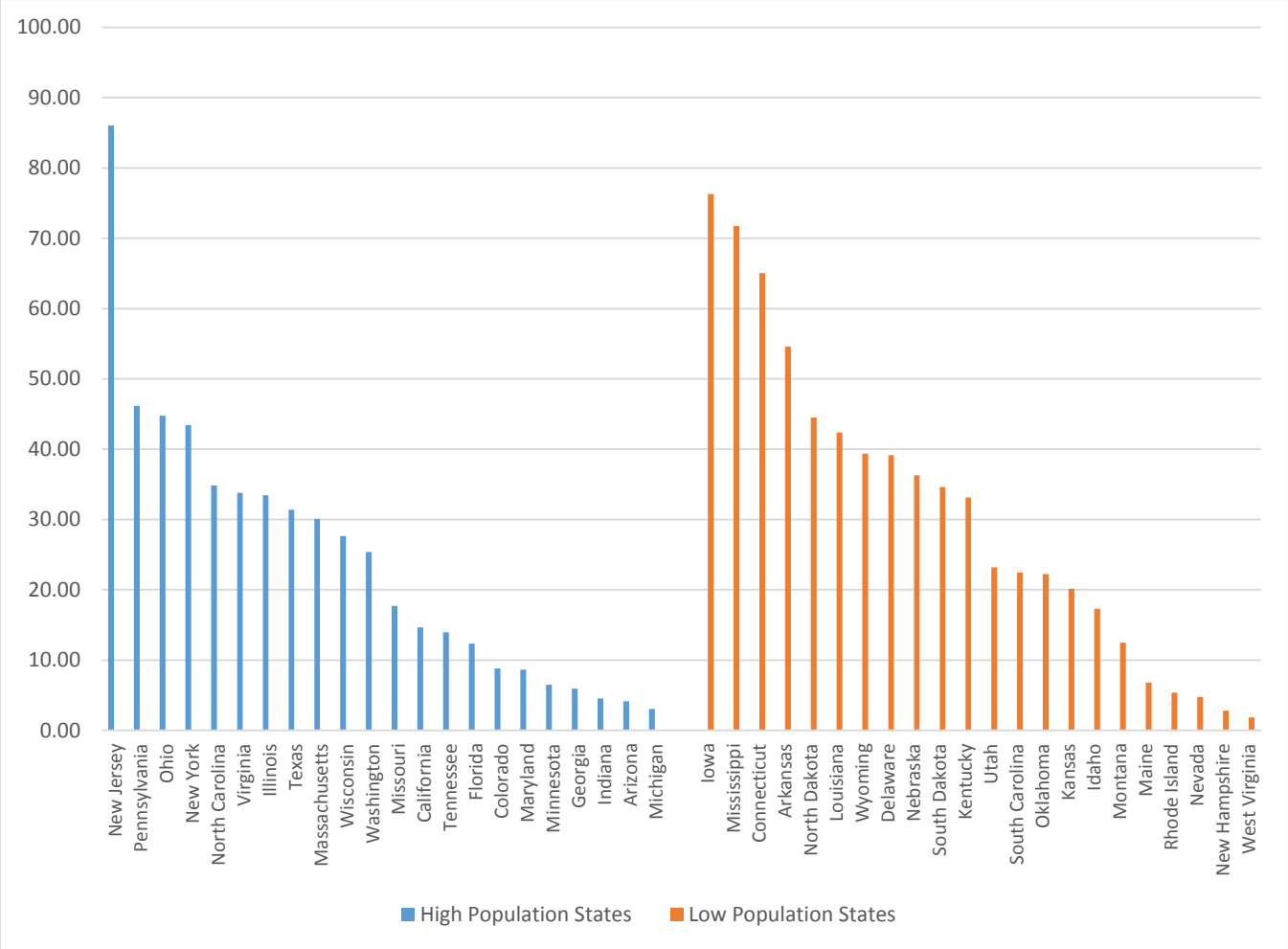


Source: University of Colorado, 2015. U.S. Median Income data from U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplements.

Another way to examine the spending data is to consider state IDD institutional spending per capita. The following figure shows per capita spending (based on 2013 population and FY13 spending) and groups states by their populations. For the purposes of this figure, states with no institutional spending were excluded. Remaining states were ranked by their population and the highest 22 are classified as “high population states” and the lowest 22 are classified as “low population states.” The U.S. average per capita was $25.94 in 2013. When examining the data this way, Arkansas spends more per capita than most states, including similarly populated states.

Data for this figure was provided by the University of Colorado, which houses the State of the States project.

IDD Institutional Spending per capita, 2013



Source: Rick Kemp, University of Colorado, 2016.

Analysis

Although Arkansas' average daily expenditures for its state-operated ICFs are among the nation's lowest, when comparing this spending to the U.S. average or other states, it is important to consider several factors. First, it is important to take into account variances in the cost of living across the U.S. As previously stated, the higher spending states tended to be higher income states and lower spending states tended to be lower income.

Next, average spending can vary for many reasons. Total expenditures are a function of marginal per resident costs and fixed system costs. Total spending on marginal costs depends on how many people are served in the system and how much the state is willing to pay for these costs

(i.e., on direct care staff salaries). As shown above, Arkansas pays less per hour than some of its neighboring states (Kansas and Missouri).

Additionally, some fixed costs exist around state administration of the program and these costs are not affected by the number of facilities in operation or the number of residents (i.e., statewide management staff). Other fixed costs are affected by the number of facilities a state has in operation and/or the number of residents (i.e., facility costs, local management staff).

Given these relationships, when it comes to average per resident costs, states with a higher system census have more people across which to spread the system-wide, allocated, and facility-specific fixed costs, which lowers the average per person spending. Arkansas was in the top ten states in terms of highest total system census as of June 30, 2013. States that are in the process of downsizing or closing facilities tend to see their average cost per person increase because until the point at which a facility closure occurs, the state continues to incur certain costs (i.e., facility costs, certain staffing costs) and has fewer residents across which to spread these costs. Several states in the above figure that spend more per person than Arkansas either have had or have upcoming facility closures (examples include but are not limited to Minnesota, New Jersey, Oklahoma, and Tennessee).

Finally, another factor relates to the state's cost allocation methodology. States vary in what administrative expenditures they are permitted to include in their daily rate for purpose of drawing federal funds by the Centers for Medicare and Medicaid Services (CMS). If a state allocates such costs based on staff headcount and the state operates a large number of facilities, necessitating a large number of staff, its total expenditures may be greater than in a state that does not, which would increase the average cost per resident.

Conclusion

Arkansas invests significant resources in the operation of its 5 ICF facilities that taken together serve about 903 persons. This analysis seeks to put Arkansas' spending in context with spending in other states. Arkansas spends less on average per day for its residents than most other states (34th out of 38 states reporting data). However, its spending is comparable to some other states with similar median incomes and its per capita is greater than most other states. This analysis does not compare spending on IDD institutional and community-based services; these issues will be explored by the HDC subcommittee in the future in more detail.

8. NEW CMS MANAGED CARE RULE

On May 6, 2016, CMS issued a new set of rules regarding Medicaid managed care. This final rule is the first update to Medicaid and CHIP managed care regulations since 2002. Today, many Medicaid services are delivered via managed care arrangements, which are risk-based

arrangements for the delivery of covered services. Since its re-authorization in 2009, the federal framework for CHIP also includes significant managed care components. In 1998, only about 41% of Medicaid enrollees received Medicaid through capitated managed care plans. That percentage has grown to 73.5% in 2013. In addition, 25 states use managed care for the delivery of CHIP services, with another 2.7 million children enrolled in CHIP managed care plans. The following analysis includes a high-level summary of the new Medicaid managed care rules, as well as a deeper dive into a couple of the provisions that may be of particular interest to Arkansas policy-makers.

Key Goals of the New Rule

The key goals of the new rule, as described by CMS, include the following:

- Delivery system reform
- Modernization and improving the quality of care
- Strengthen beneficiary experience
- Payment and accountability improvements
- Alignment with other insurers

Key Dates for the New Rule

While some of the provisions have an effective date as early as July 5, 2016, most of the new provisions phase-in over 3 years, starting with contracts on or after July 1, 2017.

Delivery System Reform

To further support state and federal delivery system reforms, the final rule provides flexibility for states to have value-based purchasing models, delivery system reform initiatives, or provider reimbursement requirements in the managed care contract; and strengthens existing quality improvement approaches with respect to managed care plans.

Examples of delivery system reform provisions in the final rule include permitting capitation payments for enrollees with a short-term stay in an Institution for Mental Disease (IMD) and value-based purchasing.

Institution for Mental Disease

The final rule permits a state to make a monthly capitation payment to the managed care plan for an enrollee, aged 21-64, that has a short term stay in an IMD as long as it is for a short term stay (no more than 15 days within the month) and establishes rate setting requirements for utilization and price of covered services rendered in alternative setting of the IMD. The rule defines "In lieu of services" (ILOS) as medically appropriate and cost effective alternatives to state plan services or settings and establishes contractual requirements and rate setting requirements for ILOS. These provisions apply as of the effective date of the final rule.

Approaches to Payment

The final rule formalizes a number of mechanisms already in place in many states relating to approaches to payment. The final rule clarifies state payment-related tools for managed care

plan performance, including establishing requirements for withhold arrangements and retaining requirements for incentive arrangements. The final rule also acknowledges that states may require managed care plans to engage in value-based purchasing initiatives, permits states to set minimum and maximum network provider reimbursement levels for network providers that provide a particular service, and established a transition period for pass-through payments to hospitals, physicians and nursing facilities. These provisions apply to rating periods for contracts starting on or after July 1, 2017

Modernization and Improving the Quality of Care

The final rule recognizes advances in State and managed care plan practices and federal oversight interests, including network adequacy, information standards, and quality of care.

Network Adequacy

The final rule requires states to develop and implement time and distance standards for primary care (adult and pediatric), specialty care (adult and pediatric), behavioral health (adult and pediatric), OB/GYN, hospital, pharmacy, and pediatric dental. The rule also requires states to develop and implement network adequacy standards for Managed Long Term Support Services (MLTSS) programs, including for providers that travel to the enrollee to render services, and requires managed care plans to certify the adequacy of the networks at least annually. These provisions apply to any rating period for contracts starting on or after July 1, 2018

Information Requirements

The rule requires states to operate a website that provides specific managed care information including each managed care plan's handbook, provider directory, and formulary. The rule also requires states to develop definitions for key terms and model handbook and notice templates for use by the managed care plans, and permits states and managed care plans to provide required information electronically if the information is available in paper form upon request and free of charge. These provisions apply to any rating period for contracts starting on or after July 1, 2017.

Quality Rating System

The rule requires states to implement a quality rating system (QRS) for Medicaid and CHIP managed care plans and to report plan performance for MCOs, PIHPs, and PAHPs. CMS expects to implement the QRS over 5 years including a public engagement process to develop a proposed QRS framework and methodology using summary indicators adopted by the Marketplace QRS, and the publication of the proposed QRS in the Federal Register with comment period, followed by notice of the final Medicaid and CHIP QRS. States will have flexibility to adopt alternative QRS, with CMS approval. States must implement a QRS no later than 3 years from the date of a final notice published in the Federal Register

Quality of Care

The rule extends the managed care quality strategy and external quality review (EQR) to other entities whose contracts include financial incentives and adds two new elements to states' managed care quality strategies related to health disparities and long term services and support.

The rule also adds new mandatory EQR activity to validate network adequacy and improves the transparency of quality information.

Strengthen Beneficiary Experience

The rule strengthens the beneficiary experience of care and key beneficiary protections by improving the enrollment process, establishing a new beneficiary support system, including choice counseling, and formalizing requirements relating to managed long-term services and supports.

Enrollment and Supports

Enrollment

The rule affirms that states will retain flexibility to design their enrollment processes to best meet population needs and programmatic goals and that states will be required to provide notices to explain implications of enrollees' choices as well as all disenrollment opportunities.

Supports

The rule establishes a beneficiary support system – an independent system to provide choice counseling and assist enrollees post-enrollment.

Managed Long-term Services and Supports

The rule implements elements of CMS' May 2013 MLTSS guidance, such as requiring States to establish and maintain a structure for stakeholder engagement in planning and oversight of MLTSS program and requiring that enrollees with LTSS needs are involved in person- centered treatment and service planning. The rule also ensures there is more accurate and timely data gathering and sharing among managed care plans and providers, and requires transition plans when a beneficiary moves from FFS to managed care or into a new managed care plan.

Payment and accountability improvements

The final rule retains flexibility to meet state goals and reflect local market characteristics while ensuring rigor and transparency in the rate setting process and clarifying and enhancing state and managed care plan expectations for program integrity. Examples of the payment and accountability improvements include better defining actuarial soundness and transparency in the rate setting process.

Actuarially sound capitation rates

The rule establishes standards for the documentation and transparency of the rate setting process to facilitate federal review and approval of the rate certification and permits states to increase or decrease the certified capitation rate by 1.5% (overall 3% range) without submission of a new rate certification. The new rule also requires that differences among capitation rates for covered populations must be based on valid rate development standards and permits certain mid-contract year rate changes due to the application of approved risk adjustment methodologies without additional contract and rate certification approval.

Program integrity

The rule requires managed care plans to implement and maintain administrative and managerial procedures to prevent fraud, waste and abuse. The rule also requires that network providers will be screened, enrolled and revalidated as done in FFS and for managed care contracts to address treatment of recovered overpayments by managed care plans and to take these amounts into account in the rate setting process.

Encounter data

The Affordable Care Act and this rule condition federal matching funds on timely, accurate, and complete reporting of encounter data. For contracts starting on or after July 1, 2017, States must require that managed care plans collect and submit encounter data sufficient to identify the provider rendering the service, submit all encounter data necessary for the State to meet its reporting obligation to CMS, and submit encounter data in appropriate industry standard formats.

Alignment with other insurers

The rule aligns Medicaid and CHIP managed care requirements with the private market and Medicare Advantage requirements to smooth beneficiary coverage transitions and ease the administrative burdens of managed care plans that participate across publicly-funded programs and the commercial market, including in the areas of medical loss ratio (MLR), and appeals and grievances.

Medical Loss Ratio

The rule requires managed care plans to calculate and report their MLR experience for each contract year and requires states to set actuarially sound rates to achieve a MLR of at least 85%. The rule also allows states to have the flexibility to set a standard higher than 85% and/or impose a remittance requirement and ensures that expenditures for program integrity activities in the MLR calculation will align with a future standard adopted in the private market rules.

Appeals and Grievances

The rule aligns definitions and timeframes for resolution of appeals with the private market and Medicare Advantage and extends managed care appeals and grievance requirements to Pre-paid Ambulatory Health Plans (PAHPs). The rule also requires managed care plans to perform one level of internal appeal for enrollees to use before proceeding to a State Fair Hearing and allows states to have the option to offer enrollees an external review so long as that process does not extend overall timeframes for the appeals process. These provisions apply to rating periods for contracts starting on or after July 1, 2017

Aligning CHIP with Medicaid

The rule further aligns CHIP managed care with Medicaid provisions related to the following: medical loss ratio, information requirements, disenrollment, conflict of interest, continued services to enrollee, network adequacy, enrollee rights & protections, quality measurement and improvement, external quality review, grievances, program integrity, and sanctions.

Key Topics – A Deeper Dive

The following topics are included within the summary of the new Medicaid managed care rule above, but may be of particular interest to Arkansas policy makers and are thus described in greater detail below.

"IMD Exclusion": Increased State Flexibility

Background:

Title XIX 1905(a) (29), enacted in 1965, excluded Medicaid Federal Financial Participation Payments (FFP) to the states for services rendered in Institutes for Mental Disease (IMD). At the time of passage of Title XIX almost all inpatient psychiatric services were provided in state psychiatric hospitals. (In 1970 there were 315 state psychiatric hospitals with total residents of approximately 500,000 individuals. In 2012 there were 207 state psychiatric hospitals with total residents of approximately 40,000 individuals. Source: NASMHPD: 7/2014)

Prior to the 4/25/16 CMS release of the final rule for Medicaid Managed Care Rules CMS was essentially prohibited by federal law from providing FFP to the states for inpatient psychiatric services regardless of need, fairness, or "parity" with three significant exceptions. In 1972 CMS permitted FFP for individuals less than 21 years of age served in an IMD as a state option. In 1988 CMS permitted FFP to the states for IMDs under 16 beds. In 2001 CMS finalized the regulatory framework permitting FFP to the states for psychiatric residential treatment facilities (PRTF) for individuals less than 21 years of age.

What Has Changed

In 2012 the state of Washington received CMS approval for a 1915 (b) waiver (Medicaid Managed care) for behavioral health services (Psychiatric and SUD) that included FFP for short term stays in IMDs up to 15 days based on the concept of alternative setting to services in the state Medicaid plan. Several other states sought CMS approval for a similar approach to IMD short term stay FFP through 1115 demonstration waivers that included managed care models.

In the new rule CMS has increased state flexibility for managed care enrollees by repealing the IMD exclusion for adults 21-64 who receive services in an IMD. The work around the Title XIX IMD exclusion is based on the concept of "in lieu of service" defined as cost effective and medically appropriate alternative services in an alternative setting to services in the state Medicaid plan. In order to make this work a state must list IMD services in the State Plan as "possible in lieu of service" and the state must include the IMD "in lieu of service" provision in their managed care contracts and capitation payment. The Rule allows MCOs the choice of whether or not to provide IMD "in lieu of services" to specific enrollees based on medically need criteria and the enrollee has the right to refuse IMD in lieu of services. The exclusion only pertains to individuals enrolled in a managed care plan under CFR 42 438 and is not applicable to other sections of CFR 42

"Section 438.6 (e) of the final rule clarifies that states can receive FFP and make a capitation payment on behalf of an enrollee that spends part of the month as a patient in an IMD if the following conditions are met:

- The provision of this service must meet the four following conditions for "in lieu of" services, as stated in Section 438.3(e) (2).
    1. The state determines that the alternative service or setting is a medically appropriate and cost-effective substitute for the covered service or setting under the state plan.
    2. The enrollee is not required by the managed care organization (MCO), prepaid inpatient health plan (PIHP), or prepaid ambulatory health plan (PAHP) to use the alternative service or setting.
    3. The services are authorized and identified in the MCO, PIHP, or PAHP contract, and will be offered to enrollees at the option of the MCO, PIHP, or PAHP.
    4. The utilization and actual cost of "in lieu of" services is taken into account in developing the component of the capitation rates that represents the covered state plan services.

- The facility must be a hospital providing psychiatric or substance use disorder inpatient care or a subacute facility providing psychiatric or substance use disorder crisis residential services.

- The length of stay cannot exceed 15 days during a given month (capitation payment period).

- IMD utilization may be included in the development of a managed care capitation rate, *but utilization must be priced at the cost of same services included under the state plan* (note: further discussion is provided in the next section of this paper).

- The utilization of IMDs as an "in lieu of" service is optional at many levels:

- States have the option to authorize it through their managed care contracts.

- MCEs have the option to offer it to their enrollees.

- Enrollees have the option of accepting it in lieu of state plan services.

While FFP is being introduced for short-term IMD stays for adults of ages 21 to 64, changes in the usage of IMD is highly discretionary for both states and managed care entities (MCEs), given that the services must meet the conditions of an "in lieu of" service."[4]

[4] Milliman: "IMD as an "in lieu of" service"; 5/18/16

Additionally, states have discretion over the designation of facility based psychiatric and SUD services as Institutes for Mental Disease as follows:

- The facility is licensed as a psychiatric facility.
- The facility is accredited as a psychiatric facility.
- The facility is under the jurisdiction of the state's mental health authority. (This criterion does not apply to facilities under mental health authority that are not providing services to mentally ill persons.).
- The facility specializes in providing psychiatric/psychological care and treatment. This may be ascertained through review of patients' records. It may also be indicated by the fact that an unusually large proportion of the staff has specialized psychiatric/psychological training or that a large proportion of the patients is receiving psychopharmacological drugs.
- The current need for institutionalization for more than 50% of all the patients in the facility results from mental diseases.

Managed Long Term Services and Supports (MLTSS)

Background:

Prior to the financial recession of 2008/2009 only eight states (AZ, FL, MA, MI, MN, NY, TX, and WI) had implemented some form of managed care for Medicaid enrollees who were eligible for "long term care services", such as the elderly, and people with physical disabilities and intellectual/developmental disabilities. By 2012 an additional twelve states (CA, DE, IL, KS, NC, NM, OH, PA, RI, TN, VA, and WA) implemented some form of managed care for Medicaid enrollees who were eligible for "long term care services". Given the rapid growth of states implementing managed care approaches for the vulnerable aged, blind, and disabled Medicaid eligible population CMS issued the memorandum "Guidance to States using 1115 Demonstrations and 1915 (b) Waivers for Managed Long Term Services and Supports Programs" on 5/20/2013. CMS state guidance included ten framework provisions required of states wishing to implement managed long term care services and supports based on risk bearing managed care contracts:

- Adequate planning
- Stakeholder engagement
- Enhanced provision of home and community-based services
- Alignment of payment structures and goals
- Support for beneficiaries
- Comprehensive integrated service package
- Qualified providers
- Participant protections
- Quality services and assurance

The final rule, which only pertains to CFR 42 438 – Managed Care, included these ten provisions as requirements of state MLTSS programs under 1115 Demonstration and 1915 (b) waivers with additional clarification based on the rule making process. CMS did not provide a definition of the scope/menu of services states would be required to provide through MLTSS programs but did clarify two important principles regarding consumer choice and program eligibility assessment within Managed Long Term Services and Supports programs.

The first principle clarified the scope of consumer choice: ""long term services and supports (LTSS) means services and supports provided to beneficiaries of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the beneficiary to live or work in the setting of their choice, which may include the individual's home, a worksite, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting."[5]

The second principle clarified the issue of the program eligibility assessment process within a managed care model: "We/CMS appreciate the opportunity to clarify how the assessment referenced in the 2013 MLTSS Guidance is different than the assessment proposed in §428.208(c) (2). The 2013 MLTSS Guidance prohibited managed care plan involvement in functional assessments conducted prior to enrollment for the purpose of determining initial eligibility for services. The assessments in §428.208(c) (2) are conducted by managed care plans after enrollment and are assessments of their own enrollees. We do not perceive the same conflict of interest in having MCOs, PIHPs and PAHPs assess individuals already enrolled in their plans to determine the appropriate care to be provided by the plan."[6]

[5] CMS 2390 – F, p. 572
[6] CMS 2390 – F, p. 554