Arkansas Health Reform Legislative Task Force – TSG Update

June 8, 2016

Agenda

- Arkansas Works Waiver Application Budget Neutrality Analysis
- Carrier Requested Premium Increases
- Traditional Medicaid Savings Matrix
- Dental Managed Care RFP Timeline, Performance and Quality Standards
- Pharmacy Savings Update
- Opiods in Arkansas Medicaid
- Value Based Contracting in Medicaid
- EEF Project Monitoring Update
- State Developmental Centers Average Cost Comparison
- TSG Home and Community Based Care State Rate Comparison
- CMS New Medicaid Managed Care Rules

ARKANSAS WORKS WAIVER APPLICATION

Arkansas Works Waiver Application

Budget Neutrality Analysis

- Budget neutrality – Proposed activities under an 1115 waiver must not cost more than projected cost of services to the same population under traditional Medicaid
- For Private Option and Arkansas Works, budget neutrality is calculated on the basis of anticipated cost per-member, per-month (PMPM)
- The projected PMPM without the waiver for each year functions as the Budget Neutrality Cap (CAP) for that year

Arkansas Works Waiver Application

Budget Neutrality Analysis

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

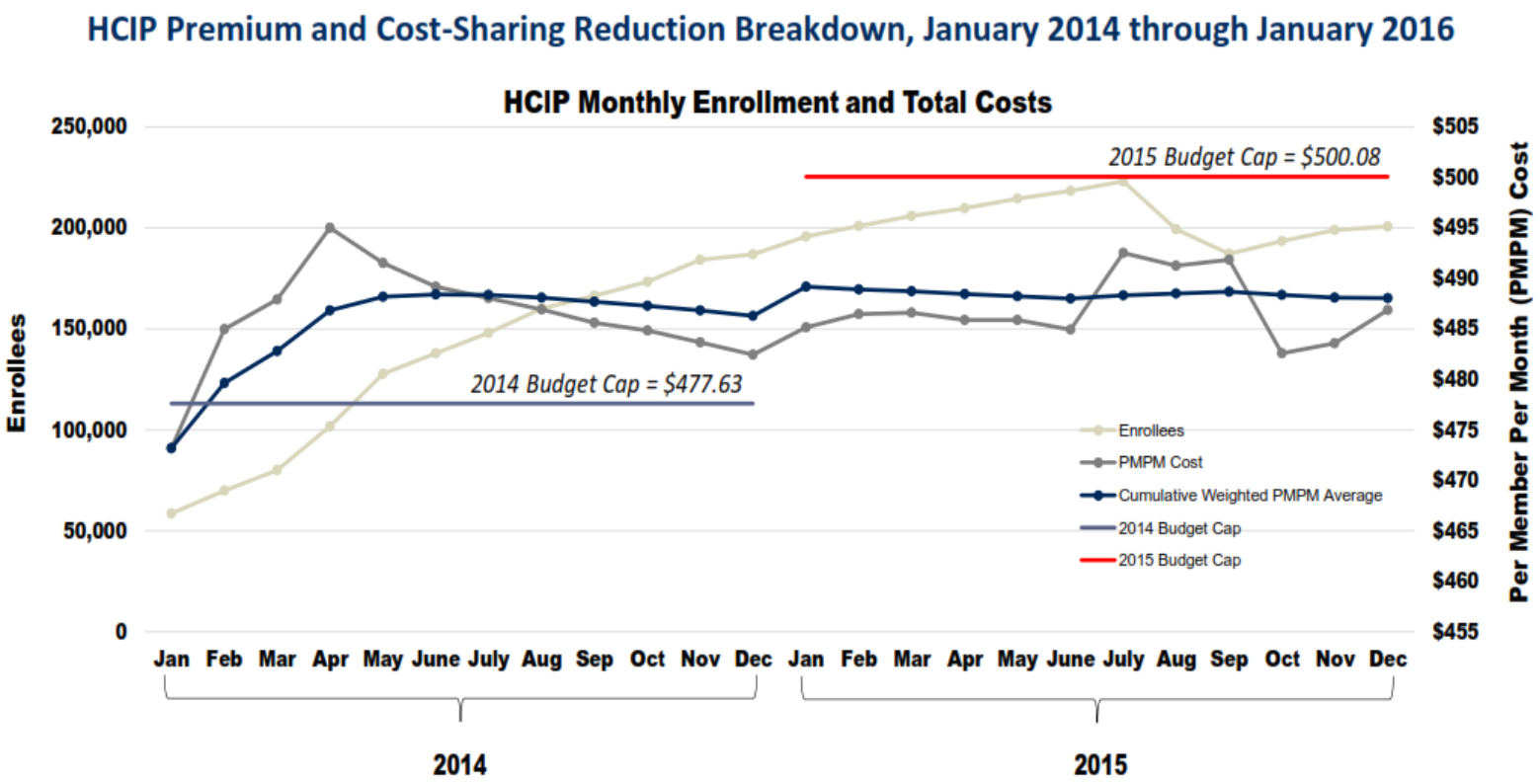
Arkansas Works Waiver Application

Budget Neutrality Analysis

- Key assumptions for PMPM projections, with and without waiver
- Budget Neutrality (cap) growth estimates
  - 4.7% PMPM growth factor
  - 2.5% enrollment growth factor
  - Effective 7.32% combined total cost growth factor
- Provides flexibility to Arkansas for staying under budget neutrality caps

Arkansas Works Waiver Application

Budget Neutrality Analysis



Arkansas Center for Health Improvement, "Arkansas Health Independence Program Section 1115 Demonstration Waiver Interim Report", March 30, 2016.

CARRIER REQUESTED PREMIUM INCREASES

Requested Premium Rate Increase for Plans in Individual Market

- Two Plans Requesting Increases above 10%:
  - QualChoice 23.69% and 23.78%
  - Arkansas Blue Cross and Blue Shield 14.7%
- Increases relate to total individual market not just PO, but PO is significant Majority of enrollment
- Reasons for seeking increase given by carriers:
  - Claims experience related to medical cost increases in second half of 2015 (enrollees gaining greater understanding on how to use new coverage – seeking more services than previously)
  - Enrollees in the PO had higher medical costs than enrollees in other commercial products, upon which their initial cost assumptions were based.
  - 2017 phase out of reinsurance and risk-corridor components of ACA, creating more direct risk for the carriers.

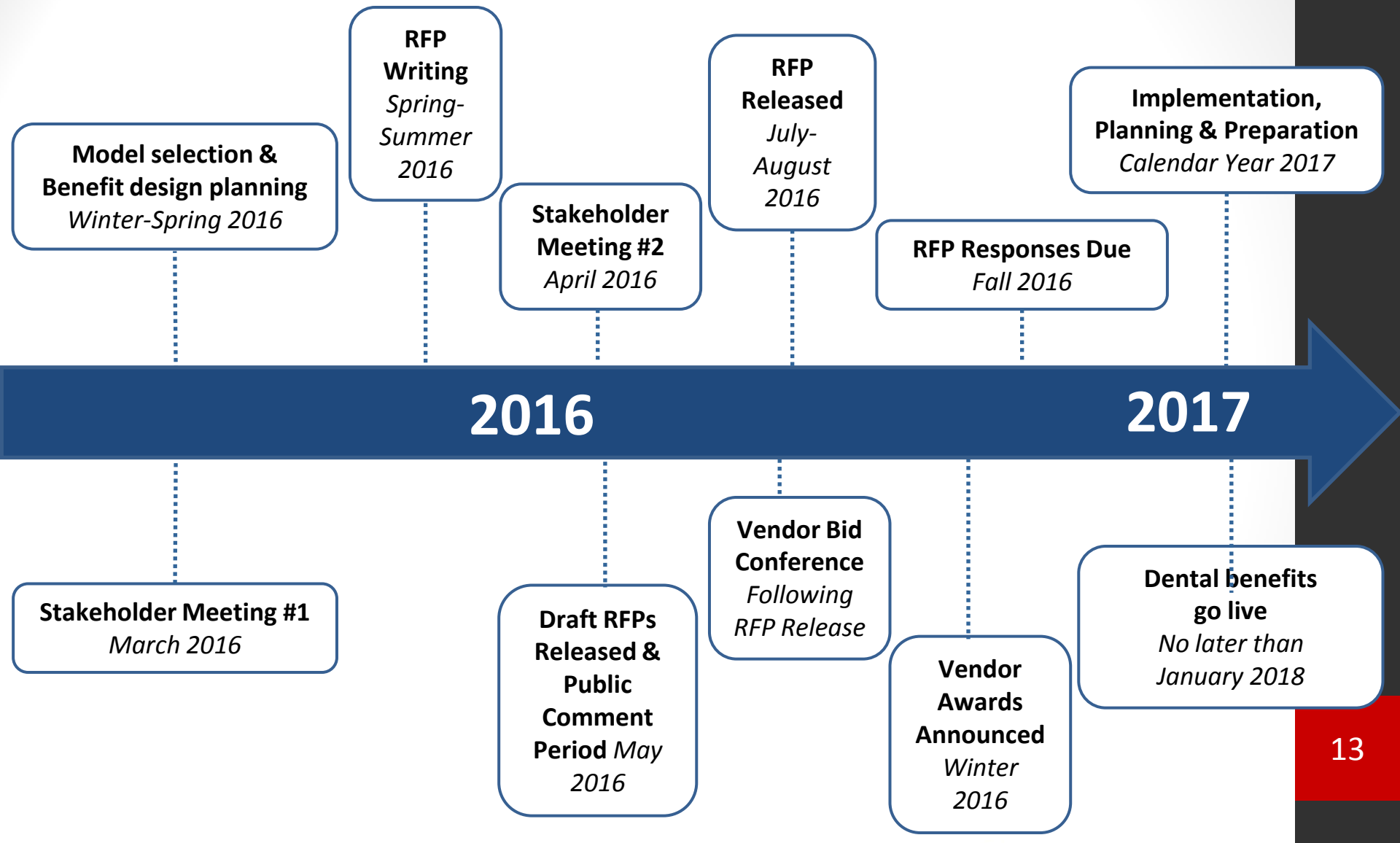
Requested Premium Rate Increase for Plans in Individual Market (cont.)

- Budget Impact:
  - Approximately $6 Million per year ($3 Million for FY 2017)
  - Assumes carriers maintain same market share
  - If approved, increase over the cap likely to be less than 5%.
- National Context:
  - As 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%.
- Next Step:
- AID has authority to reject increases
- Governor and AID have publically stated rate increases
- AID actively reviewing with its actuary

TRADITIONAL MEDICAID SAVINGS MATRIX

DENTAL MANAGED CARE DRAFT RFP TIMELINE, PERFORMANCE AND QUALITY STANDARDS

Timeline for Dental Managed Care RFP Release & Contracting
Source: Arkansas DHS



DRAFT DENTAL MANAGED CARE RFP PERFORMANCE STANDARDS

Network Adequacy

Component	Performance Standard	Liquidated Damages
Access to Care: Distance	➢ At least 90% of Beneficiaries have access to two or more Primary Care Dentists accepting new patients within 30 miles (urban) or 60 miles (rural) of residence ➢ At least 85% of Beneficiaries have access to at least one specialty provider within 60 miles of residence	$1,000 per percentage point per month for each standard that fails to meet requirement
Access to Care: Time	➢ Emergency care provided within 24 hours ➢ Urgent Care provided within 48 hours ➢ Therapeutic and diagnostic care within 14 days ➢ Referrals for specialty care no later than 30 days ➢ Non-urgent specialty care provided within 60 days of authorization	Up to $3,000 per incident for failure to meet each standard per month
Out-of-Network Provider Billing	➢ No more than 20% of outpatient services billed to Contractor may be by out-of-network providers	Up to $20,000 per quarter per geographic area

Call Center and Website

Component	Performance Standard	Liquidated Damages
Call Center: Answer and Abandonment Rates	➢ 95% of calls answered within 3 rings/15 seconds ➢ Number of busy signals not to exceed 5% of all incoming calls ➢ Wait time in cue no longer than 2 minutes for 95% of all incoming calls ➢ Abandoned call rate not to exceed 3% for any month	$500 per percentage point per month for each standard that fails to meet requirement
Call Center: Return Calls	➢ All return calls made within 1 Business Day ➢ For calls received during non-business hours, all calls to be made next Business Day	$500 per incident for failure to meet each standard per month
Website/Portal Availability	➢ Website and Portals must be on line 99% of time each month, except between 1:00 – 5:00 am Saturdays for necessary maintenance	$250 per tenth of percentage point below 99%

Grievances/Complaints and Claims Processing

Component	Performance Standard	Liquidated Damages
Investigation and Resolution of Grievances	Contractor must maintain sufficient staff to investigate and resolve Grievances within the following time frames: ➢ Emergency/urgent clinical issues within 24 hours or by close of next Business Day ➢ Non-Emergency/non-urgent clinical issues within 5 days ➢ Non-clinical issues within 30 days	$500 per incident for failure to meet each standard per month
Denial, Approval and Submission of Claims	Contractor must deny, or approve and submit for payment: ➢ 100% of paper claims within 30 calendar days ➢ 100% of electronic claims within 14 calendar days	$250 per percentage point per month for each standard that fails to meet requirement

Encounter Data and Reporting

Component	Performance Standard	Liquidated Damages
Encounter Data: Accuracy	➢ At least 99% of Encounter Data must be accurate	$1,000 per percentage point below standard per reporting period
Encounter Data: Timeliness	➢ All Encounter Data must be submitted within timeframes established in the Contract	$1,000 per day of delay
Report Submission	➢ Reports must be submitted within timeframes established in the Contract	$1,000 per day of delay

DRAFT DENTAL MANAGED CARE QUALITY MEASURES

Quality Measures

Category	Measure – per year	Goals & Targets
Use of Preventive Dental Services: Adults (21 and older)	Percentage of adult enrollees who had at least one preventive dental service *Excludes:* • *Enrollees enrolled less than 9 months*	Goal: 12% Current: 6.6% Yr 1 Target: 8.4% Yr 2 Target: 10.2% Yr 3 Target: 12%
Use of Preventive Dental Services: Children (under 21)	Percentage of child enrollees who had at least one preventive dental service *Excludes:* • *Enrollees enrolled less than 9 months* •*Enrollees under age one*	Goal: 64% Current: 54% Yr 1 Target: 57.3% Yr 2 Target: 60.6% Yr 3 Target: 64%

Quality Measures (continued)

Category	Measure – per measurement year	Goals & Targets
Use of Sealants for Children	Percentage of beneficiaries ages 6-14 who had at least one sealant service on one of the permanent first molars *Excludes:* • *Enrollees enrolled less than 9 months* •*Enrollees with all applicable teeth previously sealed, restored or extracted*	Goal: 24% Current: 12% Yr 1 Target: 16% Yr 2 Target: 20% Yr 3 Target: 24%
Dental Emergencies	Emergency room visits for dental care (per 1000 enrollees)	Goal: 5.5 Current: 6.72 Yr 1 Target: 6.32 Yr 2 Target 5.92 Yr 3 Target 5.5

PHARMACY SAVINGS UPDATE

Pharmacy Savings

Total Annual Savings	Savings $ millions	Effective Date
PDL expansion	$10	Q4 2016
CAP expansion	$1	Q4 2016
Comprehensive Antipsychotic Mgmt in adults (Abilify generic)	$19.5	2016
Antipsychotic review (7,8,&9year olds)	$1	Q4 2016
Hemophilia factor waste and clinical mgmt	$1	Q4 2016
Total	$32.5	

Does not include savings from reconfiguring retail pharmacy reimbursement formula.

Opioids in Arkansas Medicaid

- Problem Overview
- Federal, State, and Payor Initiatives
- Arkansas Medicaid
- Recommendations

Problem Overview

- Rapid growth in opioid use in US (5% of global population)
  - 90% hydrocodone (Vicodin)
  - 80% oxycodone (Percocet)
  - 65% hydromorphone (Dilaudid)
- Perception of non-addicting
- Deaths from overdose
  - Dominated by prescription products (90%)
  - Balance is shifting slowly towards illicit drugs

Simply too many opioids in peoples' homes

Federal State and Payor Initiatives

- Federal
  - CDC recommendations for prescribing opioid in chronic non-malignant pain
  - FDA tamper resistant focus
  - DEA expanding take-back programs
- States
  - Laws limiting supply and dose (especially in acute pain)
  - Stressing e-prescribing (only 7% of controlled substances)
  - Naloxone availability
  - PDMPs
- Payors
  - Cigna decrease opioid use 25% over 3 years
    - Patient and physician engagements

Initiatives combine to decrease opioid misuse

Arkansas Medicaid

- Comparison
  - Progressively decreasing quantities
  - Clever edit on refill to soon (limits stockpiling)
  - Moving to MME (most sophisticated limit)
  - Medicaid clinicians access PDMP
  - Naloxone Act
- Recommendations
  - Require e-prescribing of controlled substances
  - Require PDMP consultation - Prescribing and Dispensing
  - Expand the successful drug take-back program

Still a long way to go

VALUE BASED CONTRACTING IN MEDICAID

Value-based contracting in Home Health

- January 1, 2016, CMS began implementing value-based contracting among all home health agencies in nine states: Massachusetts, Maryland, North Carolina, Florida, Washington, Arizona, Iowa, Nebraska, and Tennessee
- Mechanics to be determined, but the expectation is to create:
- A maximum payment adjustment (plus or minus) of:

Fiscal Year	At Risk
2018	3%
2019	5%
2020	6%
2021	7%
2022	8%

Examples of value-based contracting in Medicaid

- New York
  - April 2014 Waiver to allow $8 billion through Delivery System Reform Incentive Payment (DSRIP) program
  - Goal: 90% of managed care payments to providers using value-based payment methodologies
- California
  - January 2016, “Medi-Cal 2020” under an 1115 Waiver
  - goal of transforming the Medicaid delivery system to promote sustainable, value-based models of care
  - During the first three years of the demonstration, designated public hospital systems may earn up to $1.4 billion in federal funding, and district municipal hospitals may earn up to $400 billion. Will “transform” DSH payments

Examples of value-based contracting in Medicaid (cont.)

- Texas
  - Implement value-based contracting through MCOs: Pay for Quality (P4Q)
  - MCOs at risk for 4% of capitated payment
  - Bonus/penalty based on nine metrics in 2016:
    1. Well-Child Visits in the 3., 4., 5., and 6.years of Life (W34)
    2. Adolescent Well-Care Visits (AWC)
    3. Prenatal Care and Postpartum (PPC)
    4. Potentially Preventable Admissions (PPAs)
    5. Potential Preventable Readmissions (PPRs)
    6. Potential Preventable ED Visits (PPVs)
    7. Potentially Preventable Complications (PPCs)
    8. Antidepressant Medication Management (AMM)- Effective Acute Phase Treatment and Effective Continuation Phase Treatment
    9. HbA1c Control <8(CDC)

Examples of value-based contracting in Medicaid (cont.)

- Tennessee – value-based purchasing for:
  - Episodes of care (similar to Ark), implemented through MCOs
  - LTSS: a point system to adjust nursing home rates based on the facility's performance on key performance indicators
- South Carolina
  - Goal is 20 percent value-based provider payments by 2020
  - Implemented through MCOs
- Florida
  - Five-county reform demonstration began in 2006, 2013 extended to full state by amendment to the 1115 Waiver

Examples of value-based contracting in Medicaid (cont.)

Other States:

- New Jersey (started fall 2013 after delay, plans approved in spring 2014);
- Kansas (2015?); and
- Rhode Island (terms approved in January 2014 but have not started?)
- In CMS Value-based Purchasing innovations grant programs
  - Hawaii
  - Maryland
  - New Mexico
  - Oregon
  - Virginia
  - Washington

EEF PROJECT MONITORING UPDATE

TSG Monitoring of the EEF Project

- TSG met with DHS and Gartner to monitor the progress of EEF Project #6 – Competitive Procurement System Integrator Services and #2 Define/Ratify Vision. Current update:
  - 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 for the Systems Integrator of the Integrated Eligibility Management System, the DHS Information Systems Supports (ISS), and the Dental Only Managed Care for the Division of Medical Services (DMS)
  - The awarded "procurement" vendor to serve as an impartial third to ensure that proposal evaluation, award process, and subsequent contract is done in compliance with state procurement law and procurement best practices
  - 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.

TSG Monitoring of the EEF Project

- The **System Integrator Vendor RFP** is on schedule to submit Draft RFP to CMS by July 1st, but that date could slip in the upcoming weeks
- DHS continues to work closely with Gartner on functional requirements
- DHS remains committed to holding a bidders conference to answer questions from interested vendors, but has not yet set a date for the conference
- DHS reports that the health and human services visioning document draft is complete and is currently being reviewed by the Governor's Office for approval

STATE DEVELOPMENT CENTER AVERAGE COST COMPARISON

Intermediate Care Facilities

- Optional Medicaid benefit
- Provide 24-hour residential services and active treatment
- Target population: persons with intellectual and developmental disabilities

Arkansas Human Development Centers

Background

Fiscal Year 2016 Census and Budget

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

Number of Large State ICFs

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: The Research and Training Center on Community Living, Institute on Community Integration, 2016 (data as of 6/30/2013).

State Trends

- 13 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).
- State updates:
  - Virginia: Agreed to close four of its five state ICFs as part of a settlement agreement with the Department of Justice. 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.
  - 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: One remaining facility planned to close by June 30, 2016.

10 States with Highest Resident Total, as of June 30, 2013

State	# Residents
Texas	3,547
New Jersey	2,413
Illinois	1,810
California	1,567
North Carolina	1,272
Mississippi	1,212
Pennsylvania	1,041
Ohio	952
Arkansas	934
Washington	808
U.S. Total	**23,084**

Source: The Research and Training Center on Community Living, Institute on Community Integration, 2016.

10 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.

- Arkansas average facility size: 186.8
- Nine states have between 150 – 250 average residents/facility: LA (234.0), IA (214.5), PA (208.2), UT (206.0), MS (202.0), WA (202.0), MA (172.0), KS 163.5), and VA (155.8).

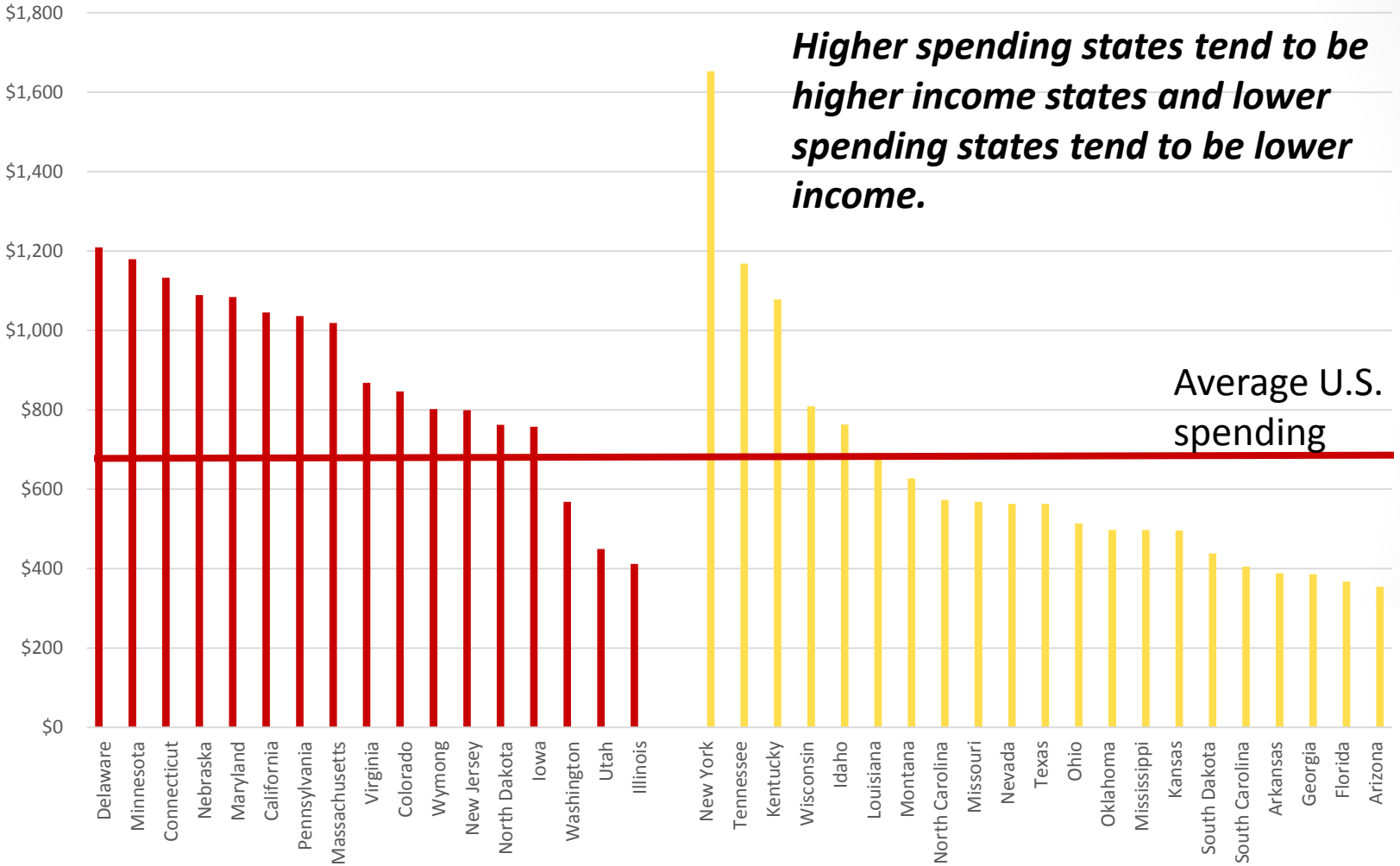
Average Daily Spending, FY13

	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

	Average Daily Spending	Estimated Annual Spending
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," 2015.

Average FY 13 Daily Spending, by 2013 Median Income

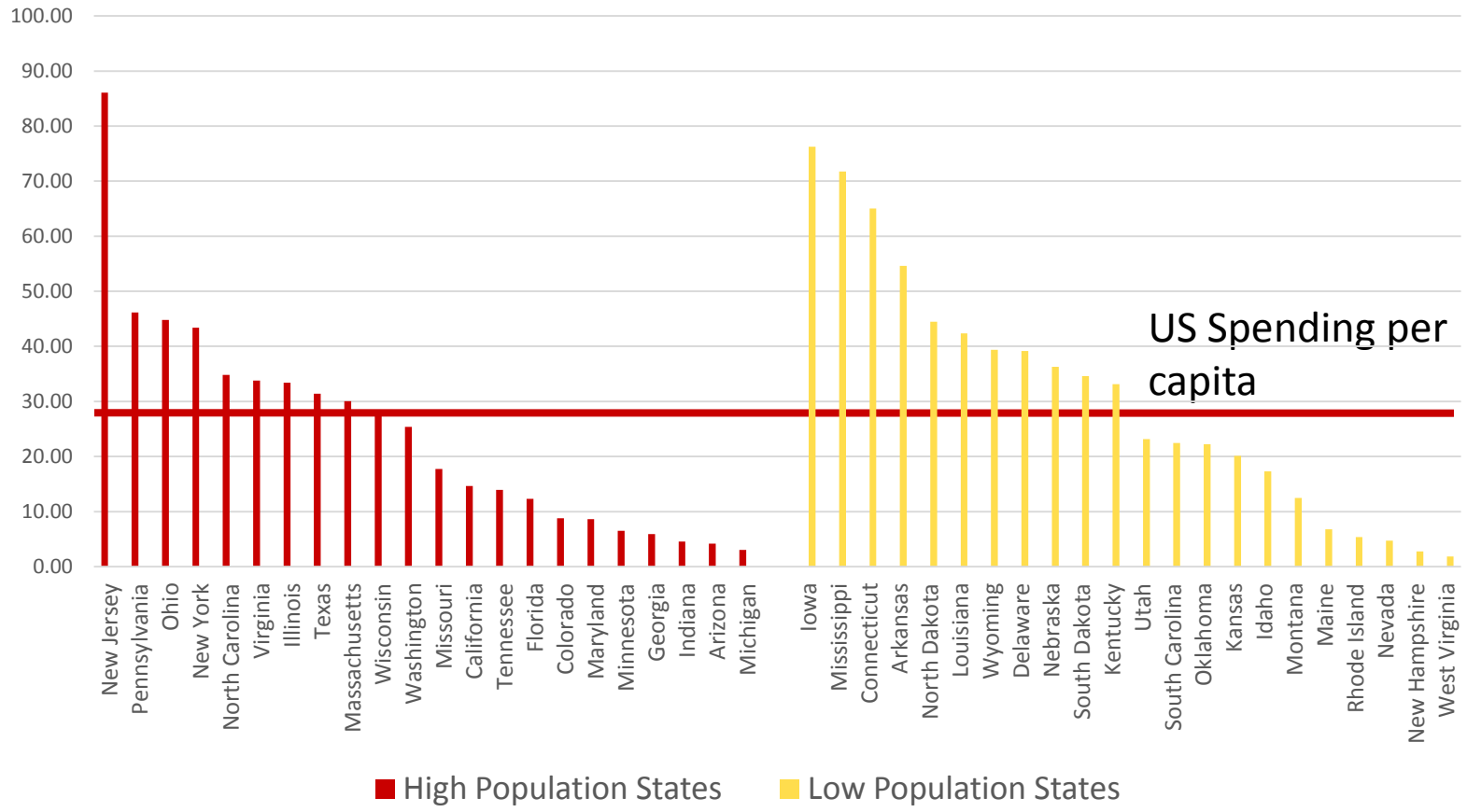


Source: University of Colorado, 2015. U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplements.

THE STEPHEN GROUP

Spending on IDD Institutional Services, per capita (FY13)

(in dollars)



Source: Rick Kemp, University of Colorado, 2016.

Analysis

- Total spending includes marginal and fixed costs. Average cost includes the total spending divided by the number of residents.
- States that are downsizing/closing facilities typically experience an increase in the average cost as the number of residents decreases.
- Several states 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).
- Arkansas has 5 facilities and is ranked 9 in total residents, which influences total spending but also ***allows the state to spread fixed costs across more people*** (decreasing average cost).
- Another factor relates to the state's cost allocation methodology. Some states may allocate more administrative expenses to their state facilities than others.

Marginal	Fixed
• Function of # residents, # facilities a state • Examples: consumable supplies and food, direct care staff	• Not affected by # facilities or # residents • Examples: Facility costs, certain administrative costs

TSG HOME AND COMMUNITY BASED CARE STATE RATE COMPARISON

CMS NEW MEDICAID MANAGED CARE RULES

New Medicaid Managed Rules

Background

- In May 2016, CMS published a broad new rule structuring Medicaid managed care (MMC)
- This was the first major revision to the MMC regulatory framework since 2002
- In 1998, 12.6 million (41%) of Medicaid beneficiaries received Medicaid through capitation managed care plans
- In 2013, 45.9 million (73.5%) of Medicaid beneficiaries received Medicaid through managed care
- Phased implementation of new provisions primarily over 3 years, starting with contracts on or after July 1, 2017

New Medicaid Managed Rules

Key Goals

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

New Medicaid Managed Rules

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
  - Strengthens existing quality improvement approaches with respect to managed care plans
- **Examples**
  - Capitation Payments for Enrollees with a Short-Term Stay in an Institution for Mental Disease
  - Value-Based Purchasing

New Medicaid Managed Rules

Modernization and Improving the Quality of Care

- Recognizes advancements in State and managed care plan practices and federal oversight interests
- **Examples**
  - Network Adequacy
  - Information Standards
  - Quality of Care

New Medicaid Managed Rules

Strengthen Beneficiary Experience

- Strengthens the beneficiary experience of care and key beneficiary protections
- **Examples**
  - Enrollment Process
  - Beneficiary Support System, Including Choice Counseling
  - Managed Long-Term Services and Supports (MLTSS)

New Medicaid Managed Rules

Payment and Accountability Improvements

- The final rule retains state flexibility to meet state goals and reflect local market characteristics while:
  - Ensuring rigor and transparency in the rate setting process
  - Clarifying and enhancing state and managed care plan expectations for program integrity
- **Examples**
  - Better defining Actuarial Soundness
  - Transparency in the Rate Setting Process and Approval
  - Program Integrity
  - Encounter Data

New Medicaid Managed Rules

Alignment with Other Insurers

- Aligns Medicaid and CHIP managed care requirements with the private market or Medicare Advantage requirements to:
  - Smooth beneficiary coverage transitions
  - Ease administrative burdens of managed care plans that participate across publicly-funded programs and the commercial market
- **Examples**
  - Medical Loss Ratio (MLR)
  - Appeals and Grievances