THE STEPHEN GROUP

TSG Status Update

To: Arkansas Health Reform Legislative Task Force

Re: Health Care Reform/Medicaid Consulting Services

Da: July 11, 2016

PREPARED BY:

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

UPDATE SUMMARY

1. DEPARTMENT OF HUMAN SERVICES BEHAVIORAL HEALTH SAVINGS PLAN

Updated July 6, 2016

Behavioral Health is a $464 MM component of the Arkansas Medicaid Program. Calendar Year 2014 claims are summarized below:

	Residential Treatment	150,000,000
H2015	Intervention, Mental Health Paraprofessional	88,000,000
H0004	Behavioral Health Counseling & Therapy	78,000,000
90853	Group Psychotherapy	50,000,000
H2017	Rehabilitative Day Service	21,000,000
90887	Collateral Intervention, or Interpretation of Diagnosis	15,000,000
90847	Family Medical Psychotherapy with The Patient Present	14,000,000
90885	Master Treatment Plan	14,000,000
90791	Diagnostic Interview, Includes Evaluation and Reports	10,000,000
90792	Psych Evaluation	7,000,000
90846	Family Medical Psychotherapy	6,000,000
H2011	Crisis Intervention	3,000,000
99213	Established Patient Office or Other Outpatient Visit	3,000,000
96101	Psychological Testing with Interpretation and Report	2,000,000
99214	Established Patient Office or Other Outpatient	2,000,000
T2022	Counseling/Case Management	2,000,000
	Other	1,000,000
	Total	464,000,000

DBHS is in the process of transforming the RSPMI benefit into a system of care driven by an individual's level of acuity/severity that provides evidence based behavioral health services designed to improve a person's ability to function and increase their ability to self-manage their behavioral health illness. Overall cost of services will be reduced based on independent assessed levels of severity of condition, improved and managed appropriate use, and the monitoring of measurable outcomes and data. The plan is to transform the RSPMI benefit into a service delivery model based on an independent assessment, two tiers of service for higher acuity individuals and a Counseling/Clinic benefit for the lowest level of acuity. This will be achieved by:

- Individual assessments establishing level of acuity/level of need (Tiers)
- Individual plans of care/cost developed based on Tiers
- Care coordination, including inpatient psychiatric, Residential Treatment, and wrap around services
- Development of a health home for serious and persistently mentally ill adults
- Increase in appropriate use of services, attention to measurable outcomes, and reduction in higher cost residential/inpatient services

DBHS changes implement the Behavioral Health recommendations presented to the Health Care Reform Task Force by TSG[1]:

- Redefine the SED and SMI category based on clinically-driven parameters
- Implement evidence based practices and metric based outcome measures
- Implement independent assessment based on the LOCUS for adults and CANS for children/youth
- Reduce reliance on Inpatient Psychiatric Hospitalizations and Residential Treatment
- Improve coordination of behavioral health services for all children and youth in Arkansas' Child Welfare system
- Increase process efficiency and reduction of administrative burden upon providers
- Refine clinical eligibility for school associated-RSPMI services
- Reduce utilization of RSPMI Collateral and MHP/MHPP Intervention units (90887 HA, 90887 HA UB)
- Reduce utilization of Group Outpatient RSPMI benefit (90853)
- Eliminate therapeutic community clients from receiving multiple authorized services on the same day
- Ensure that multiple at school services rehabilitative level services and intensive level services in the school setting are necessary
- Assure that school- based programs are actually being operated during the summer while schools are closed or moved to another location without proper coding

DHS believes cost reductions of 12-16% will be achieved through several major changes to the current RSPMI benefit and improved utilization of Residential Treatment services based on independent assessment rather than provider assessment. DBHS has developed the Tiers of Service based on acuity it wishes to implement and the Behavioral Health Outpatient Services Section of the State Medicaid Policy Manual (200.000).

[1] From the TSG Savings Matrix, reviewed with the Task Force, June 8, 2016

Note: Currently proposed savings obtained from DHS are to be considered preliminary estimates that need to be further reviewed and will be finalized for future Task Force presentation. One issue involves any potential downstream costs that show up in other portions of the DHS budget, as well as offsets by costs associated with meeting the reform initiatives, including the RFP for Independent Assessments, care coordination and enhanced prior authorization process. It is also important to note that the first year financial results of the transformed system will establish the benchmark budget for year two, emphasizing the need for financial modeling of the proposed first year budget. This will all be reported on the "net/net" final 5 year-overall Traditional Medicaid Program savings matrix that TSG presents to the Task Force in the next few months.

Change Description	CY 2014 Cost	Estimated Savings
Utilize independent assessment to determine need for rehabilitative/intensive services. Change current MH paraprofessional (H2015) services to evidence based interventions for persons with higher behavioral health needs and professional services for clients needing "Counseling" level of services. Includes addition of Certified Peer Specialists.	$88 MM	$25-45 MM
Reduce Day Rehab (H2017) and Group Therapy (H90853) to treat clients with high behavioral health needs by utilizing evidence based services and interventions.	$71 MM	$20-30 MM
Eliminate required Psychiatric Assessment for Behavioral Health clients receiving Counseling level of services	$7 MM	$4-5 MM
Reduce dependence on Residential Treatment	$150 MM	$10-15 MM
Eliminate Master Treatment Plan and review for Behavioral Health clients receiving only Counseling level of services.	$10 MM	$4-6 MM
Increase substance abuse (offset)		($10-15 MM)
Increase crisis intervention (offset)		($5-10 MM)
Costs for Administrative Services: Independent Assessment, Plans of Care, Referrals to providers, Outcomes Measurement, Monitoring		To Be Determined
Total savings estimate	$460 MM	$50-70 MM

The program will assure at least parity for outcomes and access:

Outcome Category	Metric

Client ability to function will stabilize and/or improve; client ability to self-manage symptoms and negative behaviors will improve.	Individuals will recover or stabilize ability to lead a more independent life and not fall into a higher Tier level at higher cost.
Population/client health status will improve based on care coordination and integrated behavioral health and primary care.	Comprehensive medical claims (i.e. behavioral health + "halo effect costs) will not increase for the population as a whole

Details on DHS Behavioral Health Savings Plan

Independent Assessment

The use of an independent assessment will result in the assignment of individuals to the level of care indicated by their severity of condition and life circumstances resulting in individualized plans of care that match services and cost to the person's needs resulting in the right services, in the right place, in the right amount and cost. Reassessment and change of condition monitoring will allow for adjustments upward if the person's condition deteriorates and adjustments downward as the person recovers and becomes better able to function independently.

Eliminate Intervention services by Mental Health Paraprofessionals (H2015)

Today, paraprofessionals provide: "Face-to-face medically necessary treatment activities provided to a beneficiary consisting of specific therapeutic interventions as prescribed on the master treatment plan to re-direct a beneficiary from a psychiatric or behavioral regression or to improve the beneficiary's progress toward specific goal(s) and outcomes." Based on the implementation of the three tiers of services, with assignment based on the Independent Assessment, DBHS intends to eliminate paraprofessional services for the highest levels of need and replace this service with the evidence based Certified Peer Support model.

Reduce Day Rehabilitation (H2017) and Group Therapy (H90853) Utilization

The current RSPMI benefit allows for Day Rehabilitation Services and Group Therapy to be delivered to any Medicaid enrolled person regardless of level of severity. The plan is to virtually eliminate these services and replace them with evidence based services, including enhanced home and community based services (Tiers II and III). Day Rehabilitation and Group Therapy will not be available for Tier I/Counseling level clients. Today, H2017 is billed at $2.40 per 15-minute unit, with a limit of 8 units per day. H90853 is billed $13.80 per 15-minute unit and is typically provided in groups of 5-10 individuals. OMIG has made important recommendations to the amount and duration of the Group Therapy benefit resulting in increased appropriate use and savings.

When group or day therapy is eliminated for individuals with the lowest level of need based on the independent assessment (Tier I/Counseling level) DBHS has planned that these services will be replaced by individual treatment modalities. Individual therapy (H0004) is billed at $27.30

per 15-minute unit with a maximum of 4 units per day, 48 units per year. The program intends to reduce the annual maximum to 24 units.

Replace required annual Psychiatric Diagnostic Assessments

Eliminate the requirement for a Psychiatric Diagnostic Assessment for all Behavioral Health clients receiving only Tier 1 Services/Counseling Level. This will reduce the administrative burden on providers who are currently required to conduct Psychiatric Diagnostic Assessments on all their clients.

Reduce dependence on Residential Treatment

The proposed system changes should reduce lengths of stay and admissions to Residential Treatment Services. This will be achieved by utilizing care coordination to manage transition of clients and to coordinate enhanced home and community based services for families and youth.

Eliminate Master Treatment Plan and Review for Clients Receiving Counseling Level (Tier I) services only

This will reduce the administrative burden on providers who are currently required to complete a Master Treatment Plan for all RSPMI clients every 90 days.

Integrate and Expand Substance Abuse Services

Currently, substance abuse services are limited and often unavailable. This initiative is intended to be a first step to address the growing problem of opioid misuse and addiction.

Improve the Crisis Intervention System

Currently, crisis intervention services are challenged by a lack of resources and variable response times. Service capacity will be enhanced to improve responses to crisis situations with a goal of reducing escalation and improve public safety.

2. NEW BUDGET NEUTRALITY PROJECTIONS FOR ARKANSAS WORKS

As recently reported in the media, the five-year (calendar years 2017-2021), all-funds projected cost for Arkansas Works is now being estimated by DHS at about $300 million more than previous estimates.

1115 Waivers in Arkansas

Like the Private Option, Arkansas Works is being implemented through a federal 1115 waiver, through which the federal funds that would have been used to support a traditional Medicaid expansion will be used for delivering similar services to the expansion population through a different mechanism (i.e., buying marketplace plans for recipients). Prior to approval by CMS, an 1115 waiver application must be released for public comment, revised based on those comments, as appropriate, and submitted to CMS for consideration. The Arkansas Works 1115

waiver application was released for public comment on May 19, 2016. The revised application was submitted to CMS on June 30, 2016.

Release Dates for Arkansas Works 1115 Waiver Application Versions	
Version	**Date Released**
Initial Arkansas Works 1115 Waiver Application Released for Public comment	May 19, 2016
Arkansas Works 1115 Waiver Application Submitted to CMS	June 30, 2016

Budget Neutrality

In order to be considered for approval, an 1115 waiver application must demonstrate that the alternative service delivery mechanism is budget neutral compared to the delivery of services through a traditional Medicaid expansion (i.e., the cost with the waiver is equal to, or less than, the cost without the waiver). The budget neutrality calculation included in the May draft estimated that the five-year, all-funds cost of Arkansas Works would be about $9.04 billion, whereas the corresponding estimate from the June application was $9.35 billion – about $308 million (or 3.4%) higher.

Estimated Costs for Arkansas Works 1115 Waiver Application Versions	
Version	**Estimated Five-Year, All-Funds Cost, with the Waiver**
Initial Arkansas Works 1115 Waiver Application Released for Public comment	$9.04 billion
Arkansas Works 1115 Waiver Application Submitted to CMS	$9.35 billion

Cost Drivers

As reported by DHS and their outside actuary Optumas, the primary reason for the change in estimate is the anticipated higher cost of drugs over the next few years. Whereas the original projection included in the May budget neutrality calculation assumed a 4.7% annual PMPM growth, the new June calculation assumed that the annual PMPM growth would be 6.5% between 2016 and 2017, decreasing by 0.5% per year over each of the following 3 years, and stabilizing at the previously assumed 4.7% annual growth between 2020 and 2021.

Annual Growth Rates for Arkansas Works 1115 Waiver Application Versions					
	Year-to-Year				
Version	**16->17**	**17->18**	**18->19**	**19->20**	**20->21**
Initial Arkansas Works 1115 Waiver Application Released for Public comment	4.7%	4.7%	4.7%	4.7%	4.7%
Arkansas Works 1115 Waiver Application Submitted to CMS	6.5%	6.0%	5.5%	5.0%	4.7%

Relationship to Carrier Rate Increase Requests

While not causally related to the requests by health insurance carriers in Arkansas to substantially increase their rates for calendar year 2017, some of the same underlying factors drove both. Both the expected cost increases for Arkansas Works and the rate increase requests by the carriers were driven, in part, by growth in drug spending higher than had been the case in the prior few years. However, rate increases by health insurance carriers were also driven by changes to the federal risk mitigation framework (i.e., the phasing-out of the reinsurance, risk corridors, and risk adjustment that were meant to stabilize the market during the first few years of the ACA marketplaces) and market dynamics in the private health insurance market.

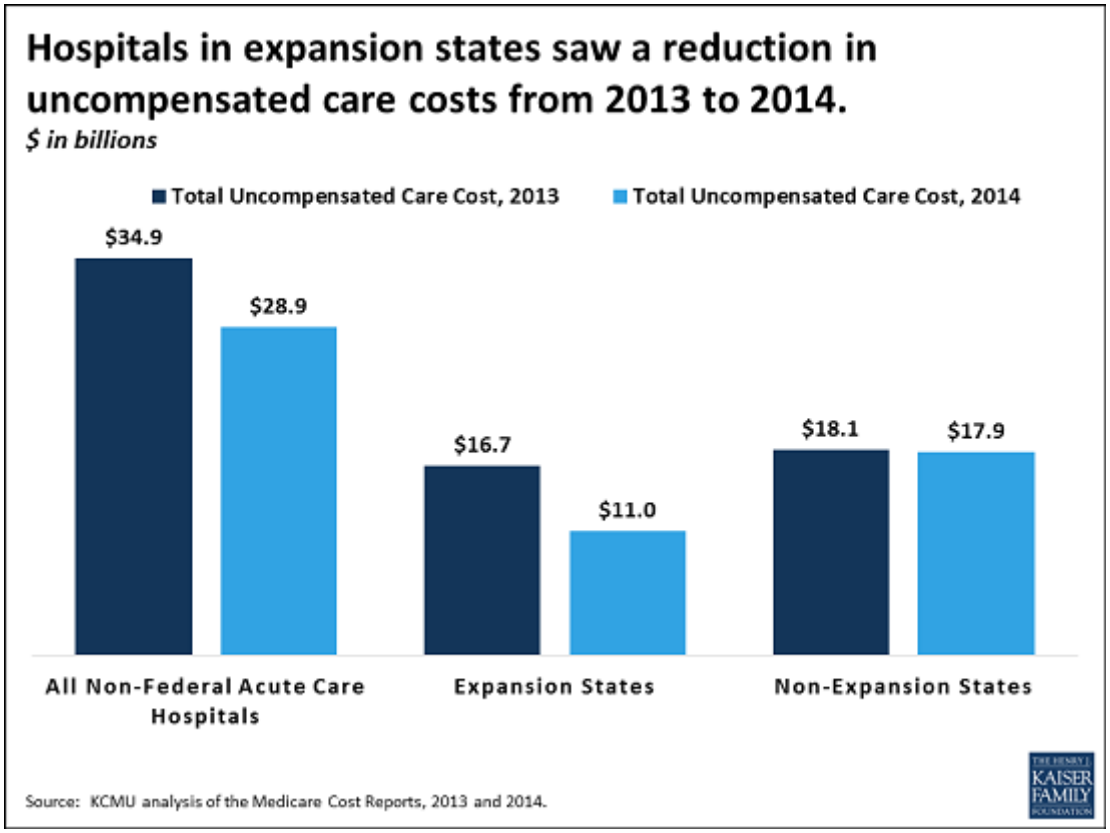
3. NATIONAL ANALYSIS OF HOSPITAL UNCOMPENSATED CARE

In previous updates, TSG has reported on the decrease in hospital uncompensated care in Arkansas since the establishment of the Private Option. In particular, TSG reported on a study commissioned by the Arkansas Hospital Association (AHA), based on a survey of their members' uncompensated care experience before and after the establishment of the PO. The AHA study results suggested that net uncompensated care losses by Arkansas hospitals in 2013 were about $270 million, while in 2014 (the first year of the PO), they were about $116 million.

Previously Reported Hospital Uncompensated Care Costs in Arkansas		
Year	**2013**	**2014**
Hospital Net Uncompensated Care Costs in Arkansas	$270 million	$116 million

While the AHA has indicated that their partners who conducted the study were careful to convert all reported charge amounts to costs, and that the amounts reported accurately represent their

experience, there remained some skepticism about the results since they were self-reported by the hospitals. Recently, the Kaiser Family Foundation (KFF), a well-known and respected non-profit research organization that focuses on health policy issues, has issued a report on hospital uncompensated care across the country that is consistent with the numbers reported by AHA. The following figure, from the KFF report, shows the changes in hospital uncompensated care across the country between 2013 and 2014, and breaks out the changes between states that undertook Medicaid expansions and those that did not. In states that expanded Medicaid, hospital uncompensated care dropped significantly, whereas in states that did not expand Medicaid, hospital uncompensated care remained essentially unchanged.



Comparing these reductions in hospital uncompensated care costs between the Arkansas experience, as represented by the AHA study, and the national experience of all expansion states provides a relatively similar picture.

Comparison between Hospital Net Uncompensated Care Costs in Arkansas and the United States			
Year	**2013**	**2014**	**% change**
Hospital Net Uncompensated Care Costs in Arkansas	$270 million	$116 million	-57%
Hospital Net Uncompensated Care Costs in All States with Medicaid Expansions	$16.7 billion	$11 billion	-34%
Hospital Net Uncompensated Care Costs in All States without Medicaid Expansions	$18.1 billion	$17.9 billion	-1%

Hospital net uncompensated care costs in Arkansas decreased by a higher percentage than for the set of all Medicaid expansion states. This difference is not surprising given that Arkansas had a relatively high uninsured rate prior to the ACA compared to other states that have undertaken a Medicaid expansion (i.e., Arkansas had a disproportionately high level of uncompensated care for its size given its high level of uninsured).

4. PHARMACY SAVINGS UPDATES

There are a few notable updates on the expected savings from the Medicaid pharmacy program.

Retail Pharmacy Reimbursement Reconfiguration

As part of the State Plan Amendment, planned submission in July 2016, DHS will request approval of a reimbursement formula for pharmacies based on the new CMS requirement of acquisition cost based reimbursement with higher dispensing fees tiered to favor PDL and generic drugs. We have estimated the net value of the reimbursement reconfiguration at $20 million in savings per year. As this is a required reimbursement format from CMS, we expect agency approval and departmental implementation toward the end of 2016 or early 2017.

Hemophilia Factor Drug Management

According to CMS, request for the modifications to hemophilia drug management cannot be requested through the State Plan Amendment. This could cause a short delay in request, approval

and implementation of this savings initiative. We are now expecting this program to begin in early 2017, but the projected savings of $1 million per year are still solid, just delayed a bit.

Combined Call Centers

On July 1, 2016 all former pharmacy call centers began operations in a consolidated center operated by Magellan. The launch was well executed. This consolidation will produce administrative efficiency.

5. OPIOIDS

Background

At its June 8th update to the Arkansas Medicaid Reform Task Force, TSG provided a report of the current state of the opioid epidemic. This report included a summary of recent federal, state and payor initiatives, an assessment of Arkansas' efforts to manage the problem, as well three high-level recommendations for further strengthening the state's response that the Medicaid Reform Task Force could consider for advancement to the legislature. Following its testimony, TSG was asked to provide additional support and specificity for each of its three recommendations. The following provides TSG's June 8 recommendations followed by additional support and specificity for each.

Recommendation 1: The State could consider "requirements to consult the State PDMP for prescribers and dispensers of controlled substances"

In 2012, Kentucky became the first state to require prescribers to search the state PDMP before prescribing opioid painkillers, sedatives or other potentially harmful and addictive drugs. At present, 49 states have functioning PDMPs and as of September of 2015, Twenty-nine (29) states have mandatory access provisions where a state has – by statute, rule, or board policy – mandated that a prescriber or dispenser query the state's prescription monitoring program for information regarding a patient in circumstances that vary from state to state.

In Kentucky, hydrocodone (Vicodin) prescribing dropped 13 percent, oxycodone (Percocet) dropped 12 percent, oxymorphone (Opana) dropped 36 percent and tramadol (Ultram) dropped 12 percent between 2012 and 2013, the first year the law was implemented, according to an analysis by the University of Kentucky's College of Pharmacy. Since the law was passed, overdose hospitalizations declined 26 percent, and prescription opioid deaths dropped 25 percent, the first reduction in nearly a decade, according to a March 2016 report by Shatterproof, a national advocacy organization that promotes prevention and treatment of drug addiction.

In March of this year and as a means to address the opioid epidemic, The US Centers for Disease Control and Prevention took the unusual step of publishing clinical guidelines for opioid prescribing. CDC's guidelines included the following recommendation:

"Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months."

TSG recommends that the Task Force propose to the State legislature an amendment to the Arkansas Code to require prescribers and dispensers of controlled drugs to consult the state's PDMP when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months consistent with CDC guidelines.

TSG further notes that the application of such a provision does not and should not pertain to the prescribing and dispensing of short-term prescriptions nor to the prescribing and dispensing of opioids in acute or non-ambulatory environments or in the delivery of end-of-life or palliative care.

Recommendation 2: *"The State may want to consider mandatory e-prescribing requirement with appropriate penalties and fines for controlled drugs, after a period of legislative encouragement to meet appropriate e-prescribing milestones, supported by the professional societies and associations."*

SureScripts estimates that currently, 90% of pharmacies nationwide are able to receive and process electronic prescriptions and that more than 75% of prescribers possess the functionality to send electronic prescriptions. Even so, it is reported that a vast majority of prescriptions for controlled drugs are transacted via handwritten prescription – a means far more susceptible than e-prescribing to forgery, fraud, waste, and abuse. Benefits of e-prescribing to prescribers include but are not limited to:

- Check patient's medication history for potentially harmful drug interactions
- Reduce risk of medication errors caused by illegible handwriting or missed drug allergies
- Confirm patient's prescription benefits
- Refills are easier for prescribers, pharmacies and patients

In March of this year, a New York State law went into effect requiring all physicians to e-prescribe controlled substances. While this is not the first such law in the country — Minnesota has had a mandatory e-prescribing statute since 2011 — it is the first with enforcement provisions, including fines and other penalties for prescribers who fail to comply with the law. While the New York State law is relatively new (March 27, 2016), industry experts believe that e-prescribing is an important tool that, with consideration for potential risks, represents a significant opportunity for reining in the current opioid abuse epidemic.

TSG recommends that the Task Force propose as part of its final recommendations that the legislature consider mandatory e-prescribing requirements for prescribers of controlled

substances, with appropriate enforcement, after a period of legislative encouragement to meet appropriate e-prescribing milestones. We also recommend that the state work with professional societies and associations to determine the most appropriate e-prescribing milestones. For example, Arkansas prescribers could be first encouraged to voluntarily meet a goal of 50% compliance by the end of 2017, and 75% compliance by the end of 2018. The reasonableness of the milestones can be determined after a collaborative process with stakeholders. If Arkansas elects to move in the direction of mandatory e-prescribing, then we recommend the same waivers process identified below.

We believe this recommendation is advisable, especially if consideration is given in the legislation to address the following risks:

Risk	Mitigation
Market is not ready to institute and thus prescribers and dispensers are not able to comply	Make provision effective in the future (e.g. one year) to afford prescribers and dispensers time to comply with the requirement by adding e-prescribing technology.
	In the interim, encourage e-prescribing for controlled substances via communication to prescribers and dispensers through State Licensing Boards and professional associations (e.g. Arkansas Medical Board and the State Pharmacy Association).
Legislation impedes appropriate prescribing, dispensing and use of controlled substances	Waiver process should consider and address circumstances where appropriate prescribing and dispensing is placed at-risk as a result of the provision. Institute waiver process, much as is in force or under consideration in other states, to relax this requirement under certain conditions such as in rural areas where enforcement could cause unanticipated access issues.

Recommendation 3: "The drug take-back program could be expanded in frequency and number of locations for drop-off"

In April of 2012, The White House Office of National Drug Control Policy (ONDCP) released data from its National Survey on Drug Use and Health (NSDUH) revealing that more than 70 percent of people who first misuse prescription drugs get them from their friends, relatives or simply take them without asking.

The US Drug Enforcement Agency (DEA) anonymous drug take back program dates back to 2010. Since that time, eleven events have secured and disposed of close to 6 million pounds of unwanted, unneeded or expired medications for safe disposal with Arkansas emerging as one of the most successful state programs in terms of tonnage recovered per capita.

A recent study reports that "nearly 60 percent of Americans have leftover narcotics in their homes, and 20 percent have shared those with another person," according to a survey 1,032 people published in JAMA Internal Medicine. The survey "shows that nearly three-quarters said they provided the opiates to someone else to help that individual manage pain,"

In 2014, the DEA expanded the program to allow hospitals and clinics with on-site pharmacies to collect excess prescriptions including controlled substances for disposal on an ongoing basis. Today, through a partnership with the Rotary Clubs of Arkansas, the state has initiated a program to establish year-round take back sites.

TSG recommends that the Task Force propose continued expansion to the state's drug take-back program to establish and publicize sites for year-round return of unused, unneeded, unwanted, and expired prescription medications including controlled substances.