Arkansas Health Care Reform Task Force

TSG Update – Behavioral Health Savings

August 2016

AGENDA

- Update on Behavioral Health and Developmental Disabilities Savings Initiatives
- Independent Assessment Instruments Under Review
- Patient Centered Medical Home Savings Update
- Medically Frail Definition/Process/Claims/Cost
- Update on PO Enrollment
- Health Insurance Rates: Arkansas and National Picture
- Opioids: Continued Research and Recommendations
- EEF Monitoring Update
- Birch Tree Meeting Update

Update on Behavioral Health and Developmental Disabilities Savings Initiatives

- DHS successfully issued an RFI for independent assessment and related care management tools and has received 7 responses. Working hard on moving to the Request for Proposals stage.
- TSG doing national intelligence gathering to provide the Task Force and DHS estimated costs for these services.
- Critically important that all factors required to achieve BHS and DDS benefits improvements and achieve the savings targets are approved and implemented by 7/1/17.
- First round of rule approvals prior to end of December 2016
- TSG expects to have more concrete savings numbers by September Task Force meeting for both BHS and DDS.

Behavioral Health RSPMI Benefits Changes and Savings

- TSG has worked on the ground with DHS, MDS, and DBHS to facilitate and guide the development of a claims based financial model of past RSPMI costs compared to proposed Outpatient Behavioral Health Services for the purposes of determining savings and need for adjustments
- Critically important that proposed Rules changes to the Behavioral Health Outpatient benefits ("RSPMI"); CMS approvals; independent assessment, preauthorization and utilization review services are contracted, and any required beneficiary notices are aligned according to the DHS schedule in order to improve quality and assure majority of savings starting 7/1/17
- DBHS has been meeting with stakeholders throughout this process

DHS Initiatives to Improve Mental Health Services and Achieve Savings

Change Description
Implement independent assessment (LOCUS/CANS), preauthorization, and utilization management ASO services. (Cost)
Eliminate intervention by Mental Health Paraprofessionals (H2015). Replace with evidence-based interactions for clients in Tiers II and III only
Dramatically reduce Day Rehab (H2017) and Group Therapy (H90853). These are not effective tools of rehab and should be replaced with fewer, more effective Individual therapy treatments
Replace required annual Psychiatric diagnostic assessment with independent assessment—except where clinically necessary based on referral. Except for Tier II
Reduce dependence on Residential Treatment
Replace Master Treatment Plans for all but Tier II
Add a Therapeutic Communities per diem benefit to reduce costs On Group Psychotherapy and Day Rehab
Cost of Independent Assessment, Pre Authorization, Utilization Review under TSG review

Process

- Cross-walk impact of proposed Behavioral Health program changes, assuming the new programs had been in place, compared to 2014 & 2015 costs
- Calculate costs code by code, person by person
- Result:
  - Refinements to the proposed program
  - Confirmation of savings

Status

- Have defined in principle how the program changes will impact costs code by code. This will enable the detailed model
- Have extracted the required 2014 and 2015 claims data by person by code in order to recast the costs under the proposed program changes
- Now building the model to conduct the recast
- Will report results at the September Task Force meeting—confirming the savings on a base of $460MM
- On track for reporting at the September Task Force meeting

DHS Initiatives to Improve DDS Services and Achieve Savings

- TSG has met several times with DDS to discuss quality improvement and savings approaches related to DDTSC and CHMS programs based on TSG recommendations and savings target, HCSB waiver construction related to levels of care, and DHS approach to impacting the “waiting list”
- Challenges with developing a data based analysis of proposed changes to DDTSC/CHMS and HCBS waiver
- DDS included in DHS RFI for independent assessment and related care management tools
- DDS meeting with stakeholders throughout the process

DHS Initiatives to Improve DDS Services and Achieve Savings

Change Description
Implement independent assessment (SIS for Adults and Children), preauthorization, and utilization management ASO services (Cost)
Final decisions to be made on the current HCSB waiver, construction of a new HCSB, levels of care, settings compliance, and independent case management
Final decisions on the number of units and time of each unit for DDTSC and CHMS programs
DDS working closely with DDPA, DDTSC, CHMS and other stakeholders

Independent Assessment Instruments Under Review: LOCUS

- The LOCUS is a sixteen page behavioral health Adult assessment instrument developed by the American Academy of Community Psychiatrists I
- Provides clinicians with a multi-dimensional assessment tool that provides a standardized, tested, and normed structured decision making process resulting in the necessary information to determine levels of needed care, needed services, the person's environmental stressors, and necessary information to develop an individualized services and recovery plan. Iowa, Louisiana, Illinois, Washington, Maine, and the District of Columbia are among the states currently using the LOCUS in their Medicaid Behavioral Health programs.

Independent Assessment Instruments Under Review: CANS

- The CANS assessment tool measures strengths as well as mental health risk and needs factors for children 5 to 17 years of age.
- The CANS is a public domain instrument and is supported by the Praed Foundation. It is used in fifty states for child welfare, mental health, juvenile justice and early intervention applications. It is currently used by Child Welfare in Arkansas. The tool has 42 questions that are designed to assess the child and the child's family environment that measure risk behaviors, behaviors/emotions, and child functioning. Needs are assessed on a scale that is based on: No evidence; Prevention/Monitoring; Action (services plan indicated); and Immediate/Intensive action.

Independent Assessment Instruments Under Review: SIS for DD

- The SIS for Adults (A) and Children (C) was developed over a five-year period by the American Association on Intellectual and Developmental Disabilities (AIDD). Currently used in 24 states.
- The SIS was designed and tested to serve as an assessment tool that evaluates and measures the practical support needs of an individual with an intellectual/developmental disability.
- The SIS is administered by a team based interview with at least one family member, guardian, or chosen friend in attendance with the person being interviewed. The instrument consists of an 8-page interview that measures supports needs in 87 areas of life activities and medical and behavioral supports needs. Professionals (minimum 4-year degree with training and state identified qualifications) who administer the SIS are guided by a 128-page User's Manual that strongly encourages the person's participation in the interview process. The SIS is not based on "right" and "wrong" responses.

Patient-Centered Medical Home

Current Program Structure

- Practice must have at least 300 Medicaid beneficiaries
- Practice must complete a number of practice transformation activities
- Practices receive risk-adjusted care coordination payments
- Practices with at least 5,000 Medicaid beneficiaries, either individually or as part of a pool, are eligible to participate in the shared savings program
- Certain costs and populations are excluded for the purpose of calculating savings

Patient-Centered Medical Home

Participation

	Practices	% Enrolled	PCPs	% Enrolled	Beneficiaries	% Enrolled
2014	123 / 259	47%	659 / 1074	61%	295K/386k	76%
2015	142 / 250	57%	780 / 1074	73%	317k/386k	80%
2016	179 / 250	72%	878 / 1010	87%	330k/414k	80%

- Denominators represent the total number of eligible practices, PCPs, and beneficiaries under current program structure

Patient-Centered Medical Home

Results – 2015

Beneficiaries	318,254
Estimated Raw Cost ($m)	$938.7
Predicted TCOC ($m)	$664.1
Actual TCOC ($m)	$623.8
Cost Avoidance ($m)	$40.3
Care Coordination Payments ($m)	$14.8
Estimated Shared Savings Payments ($m)	$10.8
Net Savings ($m)	$14.7
Net Savings (%)	2.21%

Raw cost – cost before removing excluded services; TCOC – total cost of care

Patient-Centered Medical Home

Potential Program Changes

- Increase the number of beneficiaries managed by PCMH practices by 25%
  - Increase recruiting efforts
  - Lower the required number of Medicaid beneficiaries per practice
  - Permit FQHCs to serve as PCMHs
- Increase the effectiveness of PCMH cost containment by 25%
  - Share information about EOC performance by PAPs
- Increase the services being managed
  - Move lowest 25% acuity of behavioral health services into PCMH

Patient-Centered Medical Home

Potential Program Changes and Projected Savings

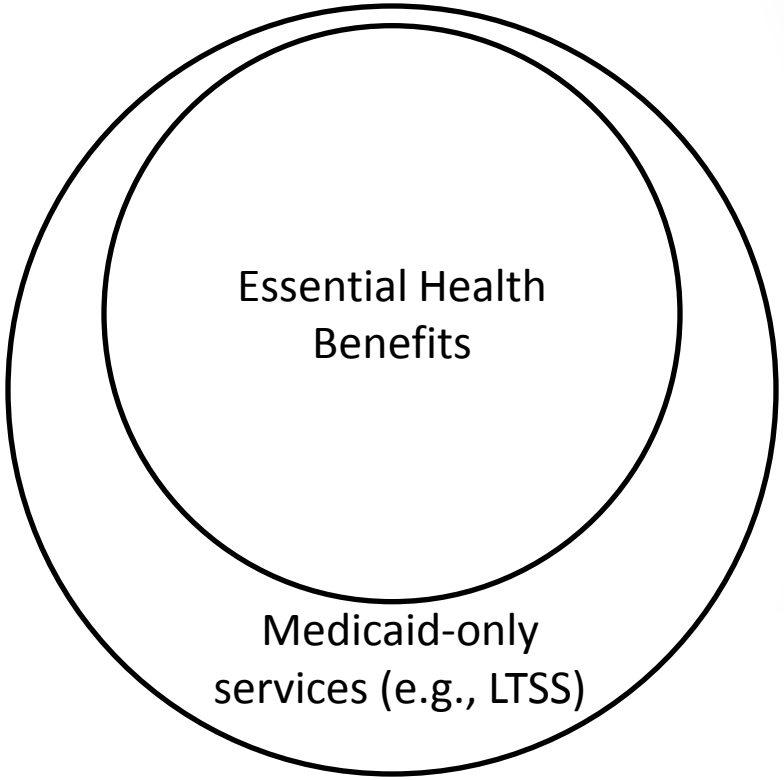
Change Description	Predicted PMPY	Beneficiaries	Predicted TCOC ($m)	Estimated savings (%)	Estimated Savings ($m)
Current PCMH program	2,087	318,254	664.1	2.21%	14.7
Increase the number of beneficiaries managed by PCMH practices by 25%	2,087	397,818	830.1	2.21%	3.7
Increase the effectiveness of PCMH cost containment by 25%	2,087	397,818	830.1	2.77%	4.6
Increase the services being managed by moving 25% of behavioral health services into PCMH	2,201	397,818	875.8	2.77%	1.3
Total Potential New Savings					9.5

PMPY: per-member, per-year cost; TCOC – total cost of care

Medically Frail

Purpose

- Some services covered by Medicaid are not part of essential health benefits (EHBs) covered by qualified health plans (QHPs) offered through the PO
- Eligibility for Private Option is same as eligibility for Medicaid expansion population
- Need for a mechanism to provide Medicaid services not part of EHBs to expansion population where needed



Medically Frail

Definition

1) a child with serious emotional disturbances,

2) an individual with disabling mental disorders (including children with serious emotional disturbances and adults with serious mental illness),

3) an individual with chronic substance use disorders,

with serious and complex medical conditions,

4) an individual with a physical, intellectual or developmental disability that significantly impairs the ability to perform 1 or more activities of daily living,

5) An individual with a disability determination based on Social Security criteria.

6) An individual who is also eligible for Medicare,

7) An Indian as defined in 42 C.F.R. § 438.14(a), except as permitted under 42 C.F.R. § 438.14(d).

8) A child under 19 years of age who is:

(i) Eligible for SSI under Title XVI;

(ii) Eligible under section 1902(e)(3) of the Act;

(iii) In foster care or other out-of-home placement;

(iv) Receiving foster care or adoption assistance; or

(v) Receiving services through a family-centered, community-based, coordinated care system that receives grant funds under section 501(a)(1)(D) of Title V, and is defined by the State in terms of either program participation or special health care needs.

Medically Frail

Process

- Beneficiaries who are eligible for Medicaid as part of the expansion population, but who are deemed 'medically frail' are enrolled in traditional, fee-for-service Medicaid
- Main interest is to determine whether there are any services that they might need but won't be able to get from a QHP
- Definition does not take into account any diagnosis
- Two pathways into medically frail designation
  - Medically frail questionnaire
  - Mid-year transition

Medically Frail

Process

- Medically frail questionnaire
  - PO eligibility is separate from plan selection and medically frail questionnaire
  - PO eligibility is done first, through one portal, and then plan selection and medically frail questionnaire are on another
  - If enrollees only do PO eligibility and don't go to the other portal for plan selection and the medically frail questionnaire, they are auto-assigned to a plan
  - 70% of enrollees are auto-assigned
  - That process is changing so they will have to do questionnaire as part of eligibility

Medically Frail

Process

- Mid-year transition
  - If a PO carrier, physician, or beneficiary believes that the beneficiary will be better served through traditional Medicaid, then they can request a mid-year transition review by sending relevant information to DHS
  - DHS then sends the information about the beneficiary to AFMC, which has a contracted network of physicians who review the information and make a recommendation
  - AFMC sends the recommendation back to DHS for a final decision
  - Over the past 2 years, 138 mid-year transitions have been requested, all by carriers, of which 9 have not been approved
  - Most situations involved a catastrophic life event, which created a new demand for LTSS not covered by the QHPs

Medically Frail

Claims Overview – 2015

For the medically frail category, between July 2014 and July 2016, the average enrollment was 23,121 and the average weighted PMPM as reported in the DHS data reviewed was $550.89. For reference, as reported by DHS, in July 2016, the PO enrollment was 258,161 and the PMPM was $496.69.

Medically Frail

Analysis of PO Claims for Possible Medically Frail Recipients

- Review of PO claims by place and type of service identified very small proportion of claims that might be associated with medically frail
- Home health, nursing facility, and home care claims from BCBS and Ambetter for 2014 and 2015 together accounted for less than one quarter of one percent of the total claims amounts (about $3 million out of the approximately $1.2 billion)

Medically Frail

Analysis of Cost and Additional Facts

- More than 90% of the 1,000 highest cost beneficiaries in the medically frail population had Medicaid expenditures of less than $100,000.
- None of the 1,000 highest cost beneficiaries in the traditional Medicaid eligibility categories had expenditures of less than $100,000.
- More than 90% of the 1,000 highest cost beneficiaries in the traditional Medicaid eligibility categories had expenditures between $200,000 and $500,000.
- Fifty of the 1,000 highest cost beneficiaries in the traditional Medicaid eligibility categories had expenditures of greater than $1 million.
- None of the 1,000 highest cost beneficiaries in the medically frail population had Medicaid expenditures of greater than $1 million.

Medically Frail

Most Common Diagnoses

- Major depressive affective disorder, rec
- Diab mellitus w/o mention compli, type i
- Lumbosacral spondylosis without myelopat
- Cutaneous diseases due to other mycobact
- Depressive disorder, not elsewhere class
- Malignant neoplasm of breast (female), u
- Unspecified chest pain
- Obstructive sleep apnea (adult) (pediatr
- Unspecified essential hypertension
- Lumbago

Medically Frail

Most Common Place of Service

- Office
- Inpatient hospital
- Outpatient hospital
- Home
- Emergency room - hospital
- Other Place Of Service
- Ambulance - land
- Ambulatory surgical center
- Independent laboratory
- Skilled nursing facility

Medically Frail

Most Common Type of Service

- Medical care/private duty nursing
- Outpatient hospital
- Surgery
- Other medical service
- RSPMI
- DME home health/oxygen
- Complete procedure
- Professional component
- Adult Dental
- Transportation

Medically Frail

General Observations

- Lots of diagnoses, places of service, and types of service associated with:
  - Behavioral health
  - Activities of daily living
- As expected
- Consistent with definition of medically frail and policy purpose for having medically frail designation

Private Option

Update on Enrollment Trends

2016	Number of recipients with premiums paid	Average Cost PMPM ($)
Jan	213,026	503.14
Feb	228,064	498.78
Mar	239,225	506.64
Apr	238,050	495.89
May	243,269	494.51
Jun	250,885	497.26
Jul	258,161	496.69

- 2016 budget cap – $523.58 PMPM

Health Insurance Rates

Recent Rate Increase Requests in Perspective

- Requested rate increases
  - ARBCBS – 14.7% for each of their two plan offerings
  - QualChoice – 23.69% and 23.78% for their two plan offerings
  - Ambetter – less than 10% (the mandatory public reporting threshold)

Health Insurance Rates

Recent Rate Increase Requests in Perspective

- National comparisons
  - Avalere study (May 2016, 9 states)
    - Average silver plan increase ranged from 6% to 44%, with 9% average
  - Texas news reports
    - BCBSTX requested almost 60% rate increase
    - Claimed they lost almost $600 million in 2015 and just over $400 million in 2014 on individual marketplace

Health Insurance Rates

Recent Rate Increase Requests in Perspective

- National comparisons (cont.)
  - Kaiser Family Foundation (July 2016; 16 major urban areas)
    - Lowest cost silver plan increases ranged from -6% to 23%, with weighted average 7%
    - Second lowest cost silver plan increases ranged from -8% to 23%, with weighted average 3%
  - Independent analysis (acasignups.net; 50 states)
    - Weighted average requested rate increase 23%
    - Considered all metallic types and regions

National Medicaid Actuarial Report

Overview

- Medicaid expenditures are estimated to have increased 12.1% to $554.3 billion in 2015.
- Average Medicaid enrollment is estimated to have increased 7.7 percent to 68.9 million people in 2015.
- Over the next 10 years, expenditures are projected to increase at an average annual rate of 6.4% and to reach $920.5 billion by 2024.
- Average enrollment is projected to increase at an average annual rate of 1.9 % over the next 10 years and to reach 77.5 million in 2024.
- Per-enrollee costs for newly eligible adults were initially projected to decrease from 2014 to 2015 but are now projected to increase

Opioids in Arkansas – TSG conducted further study in three areas

1. Cost implications to providers for implementing mandatory e-prescribing for controlled substances (EPCS)
2. Enforcement of the Prescription Drug Monitoring Program (PDMP) in Kentucky
3. Estimation of potential cost savings associated with Opioid-related recommendations

Cost Implications for E-prescribing and Prescription Drug Monitoring Program

- Desk Research and Interviews from NY State Officials
  - Min $400 per year for physician practice for E-prescribing systems upgrade
  - Training of Physicians and Administrative Staff
  - Additional Administrative Costs

- Note: Providers may attempt to make these additional costs up through rate increases or will go into uncompensated care

Kentucky Prescription Drug Monitoring Program (PDMP) enforcement

- Registration
  - Enforcement is straightforward the state program manager compares KASPER account information to licensee lists from licensure boards to identify providers out of compliance
  - Most licensure boards simply indicate that a licensee who is not in compliance is subject to disciplinary sanctions by that board
    - The Kentucky Board of Dentistry specifies that a licensee who fails to register with KASPER has 30 days to become compliant after which the dentist will be fined a minimum of $500 to a maximum of $10,000

Kentucky PDMP enforcement continued…

- Enforcement of query requirement
  - Pharmacists are not required to query the system, just maintain registration
  - No penalties specified in statute but non-compliance is subject to sanctions or disciplinary action by the appropriate licensure board
  - Kentucky currently enforces compliance in a reactive mode Difficulties exist, e.g., delegation of PDMP query rights complicates compliance for multiple physician practices
  - Kentucky continues to explore more proactive analyses to strengthen enforcement of the requirement

Estimation of potential cost savings associated with recommendations

- In addition to expected healthcare quality improvement--reduction in opioid addiction and opioid related deaths--State may be able to save over $3 million annually*

Recommendation	Potential Savings (Annual)
Mandatory consultation with the State PDMP prior to the prescribing of controlled substances (possible 30% reduction in use)	$3,000,000
Mandatory e-prescribing of controlled substances (possible 5% elimination of paper forged prescriptions)	$500,000
Total Savings Estimate (Annual)	**$3,500,000**

- Estimates based upon approximately $10 million state expenditure on prescriptions for opioids in SFY2015

Pharmacy savings in Medicaid program

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	Q1 2017
Retail Pharmacy Reimbursement Reconfiguration	$20	Q4 2016
PDMP and EPCS for Opioids	$3.5	?
Total	$52.5 ($56 if opioids)	

TSG Monitoring of the EEF Project

- TSG continues to monitor the progress of EEF Project #6 – Competitive Procurement System Integrator Services. Current update:
  - The Integrated Eligibility-Benefits Management (IE-BM) RFP is being finalized and is expected to be sent to CMS by the end of the month. The RFP seeks a vendor to propose a solution for the integrated eligibility system. Vendors may propose a take-over of the current Curam system or a new solution.
  - The Information Support Services (ISS) RFP was sent to CMS for review Friday, August 12, 2016. This RFP seeks a vendor to provide information technology services and supports to the Department of Human Services.
  - DHS has vendors in place and is making significant progress with reducing the backlog as well as providing improvements to the current integrated eligibility system.

TSG Monitoring of the EEF Project

- **Dental Managed Care RFP Update**
  - DHS has released a draft RFP and recently posted the FAQ's from the questions that were received. The FAQ can be found at: http://www.dfa.arkansas.gov/offices/procurement/Documents/DHSDraftRFPMC3.pdf
  - DHS working to resolve some final questions and expects to have the RFP released by the end of August.

Birch Tree Update