THE STEPHEN GROUP

TSG Status Update

To: Arkansas Health Reform Legislative Task Force

Re: Health Care Reform/Medicaid Consulting Services

Da: August 22, 2016

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1. DHS Traditional Medicaid Savings Plan: Behavioral Health and Developmental Disabilities Update

The Stephen Group (TSG) has been working with the Arkansas Department of Human Services (DHS), over the past few weeks to further refine the savings plan and estimates for the behavioral health, developmental disabilities and other key Medicaid program areas. Our plan is to ensure the most reliable savings estimates for the Task Force so that they can be incorporated into the 5-year "net" savings plan that will be part of the Task Force final December 2016 Report. TSG is working with DHS on various program and financial models to ensure that they meet this goal and hopes to have more concrete estimates for behavioral health and developmental disabilities for the Task Force at its meeting in September.

Behavioral Health

TSG has worked with DHS Division of Behavioral Services (DBHS) and Division of Medicaid Services (DMS) 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 to the savings are the proposed Rule changes to the Behavioral Health Outpatient benefits ("RSPMI"); CMS approvals; independent assessment, the timely contracting for preauthorization and utilization review services, and any required beneficiary notices. These all must be aligned according to the DHS schedule in order to improve quality and assure majority of savings starting 7/1/17.

DBHS has also been meeting with stakeholders throughout this process.

The following is a description of the Behavioral Health program changes that DHS is moving forward on and that have been previously reported to the Task Force:

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

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TSG is currently working with DHS on data analysis doing a cross-walk impact of proposed Behavioral Health program changes, assuming the new programs had been in place, comparing costs for 2014 & 2105 years. The plan involves:

- Calculating costs code by code, person by person
- Refining the proposed program
- Confirmation of savings
- Defining 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
- Building the model to conduct the recast

- Will report results at the September Task Force meeting—confirming the savings estimates on the base of $460 million program expenditures.
- Ensuring the savings estimate is reduced by downstream costs and costs to implement same.

Status: On track for reporting at the September Task Force meeting

Developmental Disability

TSG has met several times with DHS Division of Developmental Services (DDS) to discuss quality improvement and savings approaches related to DDTSC and CHMS programs based on TSG recommendations and savings target, Home and Community Services Based (HCSB) waiver construction related to levels of care, and DHS's approach to impacting the "waiting list."

There have been challenges with developing the data base analysis of the proposed changes to DDTSC/CHMS and the HCBS waiver, and TSG and DHS are meeting in the next few weeks to discuss the approach and model.

DDS has been included in the DHS Request For Information for the independent assessment (discussed later on in report) and related care management tools.

DDS is also meeting with stakeholders throughout the process.

The DDS program savings description is as follows:

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

Status: TSG will provide a report of savings estimates at the September Task Force meeting.

2. INDEPENDENT ASSESSMENT

Recommended Assessment Instruments for Behavioral Health and Developmental Disabilities

Background

The Stephen Group recommended that the Task Force consider as a final recommendation an Independent Assessment process at DHS for Long Term Care (LTC), Behavioral Health (BH), and Developmental Disability (DD) Medicaid services. This recommendation was made to ensure that the assessment process was independent from providers who also deliver the service and it assures that the individual receiving services is able to receive the right services, at the right cost and at the right setting. TSG also recommended that the assessment process utilize specific assessment instruments that other states have found to improve quality, assure person

centered planning, result in cost savings, and assure client choice of providers by the administration of the assessment by independent qualified professionals.

In Volume II of the TSG Recommendations Report we stated:

> "TSG strongly recommends that DHS ensure that every person who seeks to receive care in the ABD system receive an independent clinical assessment, using a evidence-based state of the art test to determine the needs, plan of care and cost for each individual who qualifies for service. Getting this assessment done right is absolutely essential to making sure that these beneficiaries are placed in the right setting, at the right time, to get the services they need in an efficient and effective manner." (Section 2: Building a 21st Century Medicaid Program, p. 8)

The Task Force highlighted and supported this recommendation in its December 2015 preliminary report. DHS has indicated a desire to move forward on the specific recommendation for each of the long term support services populations.

Additionally, TSG is currently working collaboratively with DHS to deliver to the Task Force its 5-year savings plan that will achieve substantial future savings in the traditional Medicaid program. The implementation of independent assessments in the delivery of LTC, BH and DD services is an integral building block of assuring services and costs are only driven by risk assessment, need for functional supports for quality adult daily living, environmental factors, and natural supports that support an individualized plan of care based on medical necessity and the independent determination of acuity and level of care.

DHS Request For Information

On July 13, 2016 DHS issued an RFI for the purpose of "seeking information regarding best practices for the management of independent standardized assessments or other related tools and case management functions for Arkansans receiving DHS services in one or more of the following qualified programs: behavioral health (BH), intellectual and developmental disabilities (DD), youth served in the foster care systems (CF), youth involved in the juvenile justice system (YS), and aging and physically disabled adult populations (AA)." DHS received seven responses on 7/27/16. TSG acknowledges that DHS has taken a positive view of the Task Force

preliminary recommendation on the importance of independent assessment across all Medicaid ABD and high risk populations.

Independent Assessment Instruments Under Review

Behavioral Health Services

The LOCUS Assessment Tool (18+ years of age)

The LOCUS is a sixteen page behavioral health assessment instrument developed by the American Academy of Community Psychiatrists in an effort to provide 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.

The instrument is administered by a trained clinician in a face to face interview with the client. The LOCUS is based on a Dimensional Rating System resulting that includes six evaluation parameters (dimensions): 1. Risk of Harm; 2. Functional Status; 3. Medical, Addictive and Psychiatric Co-Morbidity; 4. Recovery Environment: Sub-Scale: A-Stressors B-Supports; 5. Treatment and Recovery History; and, 6. Engagement (of the patient). Each Dimension factor is scored based on the accumulation of five questions per dimension including clinical information, current living environment, and past medical history. Levels of Care include: Maintenance and Recovery, Brief Intensive Outpatient Services, Medically Monitored Community Services, Medically Monitored Diversion Services, and Medically Monitored Inpatient/Residential Services (adapted by the State of Washington, Thurston County RSN). A Locus Navigator report includes LOCUS score, anticipated average length of services, Authorization level (Intensity), Initial Authorization, Re-Authorization criteria, and clinical review criteria.

Another page of the Navigator includes authorized services modalities, frequency (and cost). The Navigator services as an on-line monitoring tool for the person's clinician and the pre and re-authorization process. The LOCUS is a dynamic tool and may be re-administered by significant changes in condition, including environmental factors. The clinician may also include a different

scoring and rational than that produced by the instrument. The comprehensive LOCUS assessment tool for adults is public domain and available on-line at cost. The recent DHS RFI for Independent Assessment Services indicated several national companies currently use the LOCUS and other assessment instruments and these instruments are embedded in their current IT systems.

The CANS Assessment Tool (Child and Adolescent Needs and Strengths (5 to 17 years of age)

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. Strengths are assessed on a scale that is based on: Core strength; Strength you can use in planning; Identified strength that requires support; No evidence. The CANS can be normed and adapted to individual states with the assistance of the Praed Foundation. There is a cost for state adaptation and norming. The recent DHS RFI for Independent Assessment Services indicated several national companies currently use the LOCUS and other assessment instruments and these instruments are embedded in their current IT systems.

Developmental Disabilities Services

Supports Intensity Scale (SIS) Assessment Tool: Adults (16 + years of age) Children (5-15 years of age)

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). 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 must be trained in the application of the SIS and 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.

The SIS interview measures support requirements in 57 life activities and 28 Medical and Behavioral Health services/supports needs. Supports needs are measured in (A) home living; (B) community living; (C) lifelong learning; (D) employment; (E) health and safety; and Other categories including medical and behavioral health supports and protection and advocacy. The SIS measures supports need from the perspective of Frequency over Time (Day, Week, Month); Amount (time needed for specific types of supports); and Types of Support (such as monitoring, verbal gestures, lifting, etc.). The Total Supports Index integrates the support needs for Daily Support, Daily Support Time, and the Frequency of Support into a score that state IID programs equate with Levels of Care delineated in their Home and Community Based Waivers (1915c). Based on the SIS assessed Level of Care (Supports Intensity Level) determination a person's individual plan of care is developed (based on person centered planning and independent choice of providers) and an individual budget is developed, reviewed/modified and approved, provider choices made and then services begin.

A person's SIS is updated when necessary based on a person's "change in condition" such as medical and behavioral health issues that have significantly changed since the administration of the most recent SIS. The SIS has been "normed", that is designed and measured on a person's support needs in comparison with other people with Intellectual and Developmental Disabilities. Inter-rater reliability has been rated at .87, considered "excellent" for adaptive behavior scales.

Currently 24 states have implemented the use of the SIS in their Intellectual and Developmental Disabilities Services and Medicaid programs: CO, DC, GA, IA, KY, LA, ME, MD, MI, MO, NV, NH, NM, NC, ND, OH, OK, OR, PA, RI, TN, UT, VA, WA. There are several Canadian provinces and 8 countries currently using the SIS.

There are costs associated with the use of the SIS from AIDD and. The recent DHS RFI for Independent Assessment Services indicated several national companies currently use the SIS and other assessment instruments and these instruments are embedded in their current IT systems.

(Sources: Developmental Disabilities Training Institute, School of Social Work: UNC Chapel Hill in partnership with the North Carolina Department of Medical Assistance and the American Association of Intellectual and Developmental Disabilities.)

Costs Associated with Independent Assessment

The Stephen Group will be providing the Task Force with an estimate of the cost of the independent assessments for all of Medicaid long term supports and services based on a review of other state practices and contracts with similar models at the September Task Force meeting. The amount of program savings will then be reduced by the amount of the DHS expenditures for the independent assessments and this will be provided to the Task Force in the final "net" 5-year savings plan.

3. Opportunities for Increasing Cost Savings under Patient-Centered Medical Home

The Patient-Centered Medical Home initiative has been in place for several years now and appears to be reducing costs. There are several ways that the PCMH initiative can be extended in order to increase the costs savings.

Current Program Structure

Under the current program structure, in order to be eligible, a practice must have at least 300 Medicaid beneficiaries and must complete a number of practice transformation activities. In exchange for meeting these eligibility and participation requirements, practices receive monthly 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.

Participation

The following table shows the level of practice, PCP, and beneficiary participation in the program over the past several years.

Year	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%

The numbers shown above for practices, PCPs, and beneficiaries represent the number of participating entities of each type over the number of eligible entities of each type.

Results

The following table shows the estimated financial results from 2015. With 318,254 beneficiaries participating, with a predicted total costs of care (TCOC) of $664.1 million, the overall savings net of care coordination and shared savings payments is $14.7 million, or about 2.2%. The raw cost is the total cost before removing any services that are programmatically excluded from cost savings calculations. TCOC is the total cost of all medical and pharmaceutical services minus any excluded services. As of the publication of the DHS report from which some of these figures are based, shared savings payments had not yet been made. Therefore, the estimate for the shared savings payments shown here is proportional to the level of the shared savings payments in 2014.

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%

Potential Program Savings

There are several opportunities to increase the PCMH program savings. Since the program savings are a function of the number of participating beneficiaries, the effectiveness of the cost containment efforts, and the volume of services being managed, adjusting each of these factors can yield potential additional savings. DHS could increase the number of beneficiaries managed by PCMH practices by increasing recruiting efforts, lowering the required number of Medicaid beneficiaries per practice, and permitting FQHCs to serve as PCMHs. DHS could increase the effectiveness of PCMH cost containment by sharing information about the performance by principal accountable providers (PAPs) in the episode of care (EOC) program, thereby enabling the PCMHs to steer their patients toward lower cost, higher quality EOC participants. DHS could increase the services being managed by moving low acuity behavioral health services into the PCMH.

Projected Savings

The following table shows the cumulative impact of making each of these changes.

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	2,201	397,818	875.8	2.77%	1.3

behavioral health services into PCMH					
Total Potential New Savings					9.5

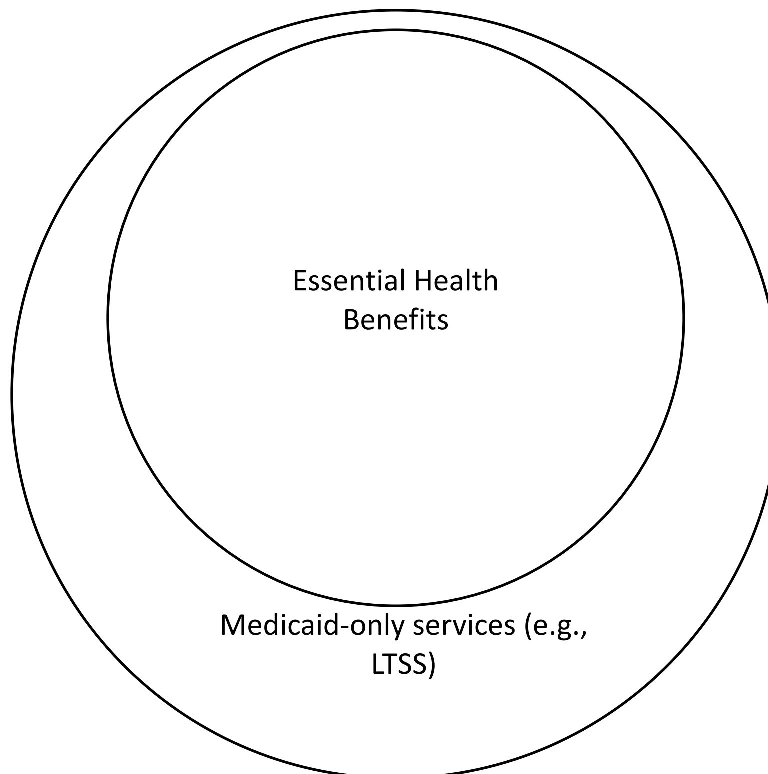
As previously stated, TCOC is the total cost of care. PMPY is the per-member, per month cost. Overall, the three changes discussed above could lead to a total of $9.5 million in additional annual savings, or an increase of about 65% in the amount saved over the current PCMH program.

4. MEDICALLY FRAIL

At the July meeting of the Task Force, the issue was raised as to how the DHS construes the definition of Medically Frail, how the process works related to an individual moving from the Private Option Qualified Health Plan (QHP) to the traditional Medicaid benefit program, and any data regarding same. Individuals who are deemed financially eligible for the Private Option (and Arkansas Works as the program transitions) may be eligible to be enrolled in traditional, fee-for-service Medicaid if they are 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 Private Option (PO), but eligibility for PO is the same as eligibility for the Medicaid expansion population. So, there is a need for a mechanism to provide Medicaid services that are not included in the EHBs to the expansion population when needed



Definition

The definition used by DHS comes from CMS regulations. A medically frail enrollee is one who is:

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.

Med Frail Definition Factors:

- Between the constraints in federal rules and state statute, Arkansas Medicaid has no significant discretion to make policy choices with regard to coverage of medically frail individuals.
- Federal rules require that medically frail individuals are exempt from mandatory enrollment in the Alternative Benefit Plan (i.e. they must be permitted to enroll in the Medicaid state plan benefit)
- Federal rules define medically frail (see above for definition).
- Federal rules require that states must inform medically frail individuals that they may receive the ABP or the Standard benefit package before they enroll in the ABP. States must also inform medically frail individuals that they may disenroll from the ABP at any time.

- The State receives enhanced FMAP for all newly eligible adults, including the medically frail. The enhanced FMAP applies to the person, so it does not matter if the medically frail individual chooses to receive the Standard benefit package.

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. The main purpose for having this option is to ensure that all individuals enrolled as part of the expansion population have access to the full range of Medicaid services, even those not covered by a QHP. The definition does not take into account any diagnosis. There are two pathways through which a beneficiary can be designated medically frail – the medically frail questionnaire, which is included as part of the health plan selection process; and a mid-year transition review.

Medically frail questionnaire

Eligibility for the PO is separate from plan selection and the 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. Currently, about 70% of enrollees are auto-assigned, although that process will be changing so new enrollees will have to do the questionnaire as part of eligibility.

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 Review Update

TSG has reviewed 2015 claims for the medically frail population within the Medicaid expansion population. As expected, overall costs per beneficiary were higher than in the PO generally and the diagnoses, places of service, and types of service were consistent with the definition of 'medically frail'.

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.

Note: Because this population is in the Traditional Medicaid program, a portion of the supplemental hospital payments must be attributed to them. So, in order to obtain the most accurate PMPM for the medically frail, a portion of supplemental payments would need to be attributed. TSG has asked DHS for an estimate of this impact on the Medically Frail PMPM.

Most Common Diagnoses

Following are the ten most common diagnoses among the claims for the medically frail in 2015:

- 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) (pediat)
- Unspecified essential hypertension
- Lumbago

Again, consistent with the definition of medically frail, most of the top diagnoses are associated with behavioral health or conditions that might reasonably be expected to affect activities of daily living (e.g., orthopedic and cardiovascular issues.)

Most Common Place of Service

Following are the ten most common places of service among the claims for the medically frail in 2015:

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

Among these are places of service not typically seen in a commercial population, such as the home or skilled nursing facility. While there may be circumstances in which a beneficiary enrolled in the PO might receive services in the home or in a skilled nursing facility, they would not be among the most common places of service. This list also shows a significant amount of hospital care.

Most Common Type of Service

Following are the ten most common types of service among the claims for the medically frail in 2015:

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

- Professional component
- Adult Dental
- Transportation

Private duty nursing, RSPMI, and DME home health are all services not likely to be among the top types of service in the PO. The inclusion of these services among the most common types of service provided to medically frail enrollees is consistent with the medically frail definition and the policy framework behind it.

General Observations

As might be expected from the medically frail definition, there are lots of diagnoses, places of service, and types of service associated with behavioral health and activities of daily living. This is consistent with the definition of medically frail and the policy purpose for having the medically frail designation.

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)

Prior TSG Analysis and Additional facts:

TSG had conducted prior analysis for the Task Force comparing the costs of Medically Frail to the highest cost traditional Medicaid beneficiaries and found:

- 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.

5. Update on Private Option Enrollment

The following table shows enrollment in the Private Option for the first 7 months of calendar year 2016.

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

The average PMPM for all months so far in 2016 have been well below the budget cap in the waiver of $523.58 for 2016.

6. Individual Marketplace Health Insurance Rate Increase Requests in Perspective

Health insurance carriers on the individual marketplace have requested rate increases for calendar year 2017. These rate increases are within the range of ***requested increases*** reported for carriers in other states.

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).

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.

An analysis by the Kaiser Family Foundation (KFF), updated July 28, 2016, found that the requested rate increases for the lowest cost silver plan in 16 major urban areas (none in Arkansas) ranged from -6% (Indianapolis, IN; Providence, RI; and Seattle, WA) to 23% (Nashville, TN), with a weighted average increase request of 7%. The corresponding analysis of the second-lowest priced silver plan showed a range from -8% (Providence, RI) to 23% (Nashville, TN), with a weighted average increase request of 3%. The relevant of the lowest price and second-lowest price silver plans is relevant because they are the most popular plans and because the second-lowest price silver plan is used as the benchmark for the Private Option.

A different analysis by an independent website (acasignups.net) has concluded that the weighted average requested individual market rate increase across the country was 23%. This analysis differs from the KFF analysis in that it considers all metallic types and all regions of the country, weighted by plan selections and populations. Again, these are requested rate increases and currently under review in many states.

National Medicaid Actuarial Report

In July of this year, the CMS Office of the Actuary released the 2015 national actuarial report for Medicaid. According to the report, Medicaid expenditures are estimated to have increased 12.1% to $554.3 billion in 2015 and 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

7. ELIGIBILITY ENHANCEMENT FRAMEWORK UPDATE

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.

8. 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 is working to resolve some final questions and expects to have the RFP released by the end of August.

9. PHARMACY OPIOID UPDATE

In June and July, TSG developed a set of recommendations for consideration by the Arkansas Medicaid Reform Task Force for further strengthening the State's response to the overprescribing and misuse of opiates. These recommendations were as follows:

- *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.*

- *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. It was further recommended that the state work with professional societies and associations to determine the most appropriate e-prescribing milestones.*
- *That the Task Force propose an 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.*

Following its presentation, TSG was asked to further support its recommendations. Specifically, TSG was asked to provide additional research in three areas: 1) Cost implications to providers of e-prescribing for controlled substances (EPCS); 2) Prescription Drug Monitoring Program (PDMP) enforcement measures in Kentucky, the first state to require prescribers to search the state PDMP before prescribing opioid painkillers, sedatives or other potentially harmful and addictive drugs ; and 3) Estimated cost savings to the State associated with a potential reduction in opioid prescribing from these two recommendations. TSG's findings in these three areas are provided below:

Cost implications to providers of e-prescribing for controlled substances (EPCS)

Desk research and interviews with officials from the State of New York (1st in the Nation with a mandatory EPCS law) as well as vendors of EPCS, e-Prescribing, and Electronic Medical Record (EMR) solutions revealed the following insights:

- Costs to prescribers for implementing EPCS are subject to negotiation but can be expected to be approximately $400 per year for a physician practice. For most physician practices, EPCS implementation requires the "switching-on" of functionality already embedded in the physician's EMR or e-prescribing system and requires little change to existing systems or workflows besides implementing two-factor authentication.
- For small, rural, or other health care providers who do not currently employ EMRs or e-prescribing systems, there are low-cost, stand-alone EPCS solutions that can ensure compliance with an EPCS requirement, however, such solutions generally require training of physicians and administrative staff. These systems also generally require new and distinct process steps, including data entry, above and beyond the physician's/practice's pre-requirement workflow. Vendors noted a measurable uptick in the sale of the stand-alone solution to meet the requirement in New York.
- Officials from The State of New York report that more prohibitive to physicians for EPCS implementation than systems/software cost is the training of health care providers in its understanding, requirements, and use especially for providers seeking to implement stand-alone solutions.

Note: TSG recognizes that there can be additional administrative costs that would be borne by the providers and that providers may seek to make up these additional cost increases through rate increases or they will go into uncompensated care.

Prescription Drug Monitoring Program (PDMP) enforcement measures from Kentucky:

There are two requirements associated with the State's mandatory PDMP registration and usage legislation from 2012:

- The first is compliance with the requirement for prescribers and pharmacists to register with the Kentucky All Schedule Prescription Electronic Reporting System (KASPER). Enforcement of this requirement is straightforward because the state program manager

can compare KASPER account information with licensee lists from the appropriate licensure boards to identify providers who are 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.

- The second area of compliance is with the requirement for prescribers to query KASPER before prescribing controlled substances. (Pharmacists are not required to query the system, just maintain their registration.) There are no penalties specified in statute, but once again, non-compliance is subject to sanctions or disciplinary action by the appropriate licensure board. Kentucky currently enforces compliance in a reactive mode. For example, if the Drug Enforcement Branch that houses KASPER opens an investigation on a prescriber, it will review KASPER to determine whether the prescriber has been querying the system as required. Similarly, if any of Kentucky's licensure boards are reviewing or investigating a prescriber, the state will provide to that Board information on whether the prescriber has registered and has been querying KASPER as required. According to Mr. David Hopkins, Program Manager for the KASPER, Kentucky would like to be more proactive in usage compliance enforcement but there are several challenges. For example, since the state allows delegation of KASPER accounts, in a practice with multiple physicians, one delegate may exist under each practitioner's account. Thus, within the system it can appear that other practitioners in the practice are not requesting KASPER reports, even though they are properly reviewing reports prior to prescribing. The State is now examining ways to review KASPER data to identify patients who are receiving controlled substance prescriptions, but on whom no KASPER reports have been requested, indicating possible non-compliance. Mr. Hopkins reports that the state is continuing to explore ways to carry out more proactive analyses as a way to strengthen enforcement of the requirement.

Note: TSG recognizes that there can be additional administrative costs that would be borne by the providers and that providers may seek to make up these additional cost increases through rate increases or they will go into uncompensated care.

Cost Savings Could Be Realized by Reduction in Opioid Prescribing

TSG is providing estimates of potential cost savings should the State adopt recommendations pertaining to mandatory consultation with the state's PDMP prior to prescribing controlled substances and a shift in prescribing practices similar to the e-prescribing of controlled substances as mentioned above as follows:

Recommendation	Potential Savings (Per Year)
Mandatory consultation with the State PDMP prior to the prescribing of controlled substances	3,000,000
Mandatory e-prescribing of controlled substances	500,000
Total Savings Estimate (Per Year)	**3,500,000**

Basis for Estimate – Mandatory PDMP Consultation

A June, 2016 study published in Health Affairs found that "the implementation of a prescription drug monitoring program was associated with more than a 30 percent reduction in the rate of prescribing of Schedule II opioids. According to officials from the Arkansas Medicaid Program, the State spent just under $10 million on opioid prescriptions in SFY 2015. This was up from $7.13 million the previous year. Using the estimate of a 30% reduction in the state's SFY 2015 opioid spend, Arkansas could realize as much as $3 million per year in savings associated with mandatory consultation of the state's PDMP prior to the prescribing of opioids.

Basis for Estimate – Mandatory e-Prescribing

According to Paul Uhrig, Chief Legal Officer at SureScripts, the conveyer of over 90% of e-prescriptions in the US, between 3 and 9% of opioid abusers make use of forged paper prescriptions to secure opioids illegally. By eliminating the use of paper prescriptions, e-prescribing would eliminate this channel for accessing opioids illegally. TSG arrived at its $500,000/per year savings estimate by assuming a conservative 5% estimate for the reduction in the state's annual opioid spend by eliminating paper forgeries.

10. BIRCH TREE UPDATE

At the Task Force Meeting of July 11th members were informed by Birch Tree Communities Inc. that the dates of the proposed changes to the Group Psychotherapy benefit by the Office of the Medicaid Inspector General (10/16) and the proposed changes to the RSPMI benefits (7/17) were in conflict. As a result, Birch Tree informed the Task Force they would lose a significant amount of revenue and cause them to cut or close programs. TSG was asked to look into the matter and report back to the Task Force at the August meeting.

Background

Birch Tree Communities provides person centered recovery based supportive housing, supported employment, natural supports, crisis residential services, and care management to adults with severe and persistent mental illness and high risk behaviors – Forensics/911 population.
Birch Tree provides a therapeutic community residential services program primarily funded through the RSPMI outpatient benefit structure (SSI and donations) due to the inability of the state to create a residential/therapeutic community benefit in the state plan despite a number of efforts to do so. These services include: Group Psychotherapy, Intervention MHPP, Intervention MHP, Individual Psychotherapy, Collateral Intervention MHPP, Collateral Intervention MHP, Rehabilitation Day, and crisis intervention. Birch Tree essentially self-funds a 16 bed Crisis Residential program (Hope House) that diverts residents in psychiatric crisis from ASH, Medicaid paid psychiatric hospitalization, jails, and potential homelessness. Upon study it is clear that a loss of residential capacity and crisis center beds will impact ASH, jails, and Medicaid inpatient psychiatric hospital costs in a negative way based on the degree of lost capacity. Birch Tree currently serves about 450 forensic-911 residents court ordered to community status.

Update Report

On July 27th TSG met with Elizabeth Smith (OMIG Director), Bart Dickson (OMIG), Mark White, Dawn Stehle, Charlie Green, and respective members of their staff in Little Rock. The group discussed the calendar difference between the implementation of the OMIG recommended Group Psychotherapy benefits change and DHS's management of the rules changes process required to implement the transformed "RSPMI" benefits package, which includes a Therapeutic

Community benefit for adults. The institution of the Therapeutic Residential Services benefit will resolve Birch Tree and similar provider's challenges with the current RSPMI benefits array. It will also result in a decrease in Birch Tree billing for outpatient Behavioral Health services and support appropriate use of funds. DHS plans to achieve the necessary Legislative Rules approval for the revised BH benefits package for completion in Dec. 2016. DHS plans to implement the approved Rules/benefits on July 1, 2017. Rules approval and revised benefits implementation are critical components of the BH savings plan. After a robust discussion of impact and options the group determined that the OMIG recommendations should move forward as scheduled. A meeting was then held with Birch Tree, DHS, OMIG and TSG on July 28th to further discuss the potential impact of the October 1st, 2016 implementation of the reduction in the Group Psychotherapy rate and annual units of service proposed by OMIG and the July 1st, 2017 proposed implementation of the revised Arkansas Medicaid Behavioral Health benefits. Representatives from Birch Tree explained the potential program impact of an anticipated loss of revenue during the period of time between October 2016 and July 2017. After discussion there was general agreement by all that the proposed rule changes may not have as significant an impact as not all Birch Tree clients would exhaust the October 1, 2016 revised number of allowable units of Group Psychotherapy at the same time, given the fact a majority of these clients are high risk and in the community on 911 orders, and the evidence for medical necessity is substantial.