THE STEPHEN GROUP

TSG Status Update

To: Arkansas Health Reform Legislative Task Force

Re: Health Care Reform/Medicaid Consulting Services

Da: September 28, 2016

PREPARED BY:

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

1. DHS TRADITIONAL MEDICAID SAVINGS PLAN: BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITIES UPDATE

The Stephen Group (TSG) continues to work with the Arkansas Department of Human Services (DHS), to further refine the savings plan and estimates for the behavioral health, developmental disabilities and other key Medicaid program areas. Since the August Task Force meeting TSG has met with representatives of DHS and provider organizations.

Our plan is to ensure the most reliable savings estimates for the Task Force so that those 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.

For this September 28th Task Force update, we are presenting the DHS estimated savings for the behavioral health area and identifying the status of the developmental disabilities initiatives and savings modeling that is on-going at DHS to be reported at the October Task Force meeting.

Behavioral Health

TSG has worked with the DHS Chief Financial Officer, the Division of Behavioral Services (DBHS) and the 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, CMS approvals, independent assessment process, 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 July 1, 2017.

DBHS has also been meeting with stakeholders throughout this process.

The following description of the Behavioral Health program changes that DHS is moving forward on were reported to the Task Force in our August report:

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 has worked 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, patient by patient
- 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
- Extracting the required 2014 and 2015 claims data by individual and by code in order to recast the costs under the proposed program changes
- Building the model to conduct the recast
- 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.

Behavioral Health Savings Estimates:

The following are the 5-year DHS savings estimates, net of investments, in the Behavioral Health area:

To refine savings estimates, both the Medicaid Program and Finance teams worked on independent calculations. They arrived at basically the same answer[1]. They started by back-casting how each of the above changes would have affected 2015 claims, code by code. This involved considering how each of children and adults would be grouped into the three service Tiers. Finance pulled all of the Behavioral Health claims for calendar 2015. Then, both Finance and Program analysts recalculated claims as if the new services model had been in place.

The result is a "steady state" model for one year, as shown in Table 1. Note that claims as now configured will be reduced by $244 million, and that $161 million in services will replace those, for a net steady-state savings of $83 million.

The model reflects most of the proposed changes; it does not yet reflect the impact of any investment in a defined care coordination model. The Agency has put a placeholder for this into the estimated forecast in Table 2. Taking into consideration investment for care coordination, the Agency estimates $293 million in net savings through FY 2021.

Table 1 – Steady State Behavioral Health Savings Model

	2015 Cost	Gross Savings from Reduced Claims	Investment in New Claims	Net Savings	Projected Steady State Cost
Independent assessment Impact		10,000,000	*		
Replace paraprofessional with professional services		21,000,000	18,000,000	3,000,000	
Dramatically reduce Dayhab (H2017) and shift from group to therapeutic communities		161,000,000	143,000,000	18,000,000	
Reduce inpatient		52,000,000		52,000,000	

[1] within $3 million of each other

Care coordination & collateral intervention			*		
	460,000,000	**244,000,000**	**161,000,000**	**83,000,000**	**377,000,000**

Investments in new services, such as substance abuse services, are included in the above redesign savings numbers. However, there are other projected costs that DHS intends to absorb that will impact the overall savings. TSG has estimated the cost of Individual Assessment at approximately $2 million per year. DHS also intends to pursue a care coordination model that has yet to be defined. Along with the cost of the Independent Assessment, DHS is estimating a cost of approximately $21,000,000 per year when the program is fully deployed. DHS has arrived at this care coordination estimate for behavioral health recipients as follows: There are 12,600 recipients in Tier 2. In addition, some (perhaps less expensive) coordination services may be needed for some in Tier 3. The DHS care coordination allowance provides $1,500 per year for estimated 13,000 care coordination cases. TSG does not have reason to believe that is not an appropriate estimation method – until the details of care coordination are settled. Finally, the additional administrative costs are estimated by DHS below to be approximately $2,000,000 per year.

Table 2 – Five Year Behavioral Health Savings Projection

	SFY 2018	2019	2020	2021	2022
Savings on Claims	69,000,000	83,000,000	83,000,000	83,000,000	83,000,000
Estimated Assessment & Care Coordination	15,000,000	21,000,000	21,000,000	21,000,000	21,000,000
Estimated Admin	1,000,000	2,000,000	2,000,000	2,000,000	2,000,000
	53,000,000	**60,000,000**	**60,000,000**	**60,000,000**	**60,000,000**

The estimation method and result appear reasonable with a few caveats:

- The estimate includes savings from inpatient psychiatric services. Unlike the Behavioral Health savings which were calculated code by code based on historical claims, inpatient savings are based on a percentage taken from a study done of other states. DHS estimates that inpatient will be reduced by $50 million on a base of 2015 claims of $150 million: a one third reduction. TSG does not have reason to think this is a bad estimate, only the caveat that it is less solid than most of the estimates.
- The estimate includes a budgetary estimate of potential RSPMI savings from the Division of Medicaid Services. TSG has every reason to believe that RSPMI costs will go down, but the estimate should be caveated.

- The estimate includes an estimate of the effect of OMIG changes of $35 million. This savings estimate was not arrived at by DHS.

DHS proposed these changes because it believes the changes will improve patient outcomes. DHS, however, anticipates potential push-back—which would only be natural from such important program changes.

The Agency plans to develop a set of outcome metrics in order to demonstrate going forward that care has not suffered from the proposed changes. In addition, DHS should track changes in claims at a more granular level over the coming years. This is both to assure the savings truly materialize, but also to validate the trade-off assumptions made at the core of the forecast.

Metrics have not yet been identified, and DHS has not identified the human or systems resources that would require. Note that DHS has included in the estimate an Administrative impact of $2 million. TSG has no reason to believe that would not be adequate for outcomes tracking as well as other administrative requirements.

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."

DDS is also meeting with stakeholders throughout the process.

The DDS program savings descriptions identified in our August 2016 Task Force Report are 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:

Similar to TSG support of the behavioral health policy changes and projected savings, TSG is working closely with DHS, DMS, and DDS in support of the final DHS policy decisions that will set the foundation for and drive savings and best practice quality improvements in the developmental disability area. Medicaid policy has made progress for Speech, Occupational, and Physical Therapy that will impact the DDTSC and CHMS programs, benefits design, and cost savings. Financial modeling started under the guidance of the DHS Chief Financial Officer.

DHS is considering the final policy decisions regarding the date of implementation of the Independent Assessment, the levels of care and cost ranges and impact on individual plans of care. TSG believes these decisions must be made prior to projecting HCBS waiver savings.

2. INDEPENDENT ASSESSMENT

TSG was requested by the Arkansas Legislative Health Care Task Force to estimate the cost of independent assessments for the Behavioral Health and Developmental Disabilities Services (DDS) Medicaid program area. These assessments will be part of the Medicaid Transformation

currently in progress at the Arkansas DHS and are an integral part of the savings plan and estimates for the Behavioral Health, DDS and other key Medicaid program areas.

The implementation of independent assessments in the delivery of long term support services (LTSS) services is an *integral* building block of assuring services and costs are only driven by risk assessment, need for functional supports for quality 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.

TSG recommended the Task Force consider endorsing an independent assessment process for Long Term Care (LTC), BH and DDS Medicaid services in order to:

- Ensure that the assessment process was not conducted by providers who also would deliver direct services (CMS HCSB Rules requirement)
- Assure that the assessment process utilized specific assessment instruments that other states have found to improve quality
- Reassure the person centered planning process was occurring
- Result in cost savings, and;
- Safeguard client choice of providers by the administration of the assessment by independent qualified professionals.

The attached document contains cost estimates for three independent assessment instruments for Arkansas' Medicaid long term services and supports developed by TSG and provided to the Arkansas Department of Human Services. The document is entitled Cost Estimates of Independent Assessment Tools in Arkansas Medicaid Population, dated September 2016. the TSG report includes delivery methods and assumptions to the TF and DHS and should be used as discussion points as DHS continues its plan for the most appropriate delivery system for Arkansas.

3. DEVELOPMENTAL DISABILITY WAITING LIST FINANCE PROJECTIONS

Currently, there are approximately 2,900 individuals on the waiting list for the Alternative Community Services Waiver, which provides community-based services for individuals with developmental disabilities (DD) who have a functional level that would otherwise qualify them for institutional services through an Intermediate Care Facility (ICF).

Following are three suggested scenarios for addressing the DD waiting list. The first scenario estimates the cost of fully funding the waiting list, the second scenario estimates the cost of providing a limited benefit to all individuals on the waiting list, and the third scenario estimates the number of individuals who could be served under a full funding level using tobacco settlement surplus funds.

Fully Fund Waiting List

The average cost of all services (program and medical) for individuals on the DD waiver in 2014 was approximately $68,937. Although not receiving waiver services, the individuals on the waiting list did receive, on average, services costing the state $12,119 in that year.

In order to calculate the total cost that would be incurred to fully fund the waiting list, one must subtract the current expenditure levels on this population ($12,119 per year) from the cost of all services for those currently on the waiver ($68,937) and then multiply by the number currently on the waiting list.

Per-person annual cost for individuals on waiver (2014; program and medical)	$68,937
Per-person cost for individuals on the waiting list (2014; program and medical)	$12,119
Current waiting list census	~2,900

Applying these per-person amounts to the current waiting list results in an estimate, to full fund the waiting list at this time, of approximately $165 million all funds. If we assume a 5% annual increase in cost, inclusive of both enrollment growth and service unit cost growth, then the overall estimated marginal cost to fully fund the waiting list is as shown in the following table.

Cost of Fully Funding DD Waiting List *($millions)*						
	2017	**2018**	**2019**	**2020**	**2021**	**5-year**
All Funds	165	173	182	191	200	910
Federal Funds	115	121	127	134	140	637
General Fund	49	52	54	57	60	273

Provide Limited Benefit to Individuals on the Waiting List

Rather than providing the open-ended range of services and expenditures currently enjoyed by individuals currently on the waiver, the state could establish a limited benefit that covers services currently only available to individuals on the waiver, but with an expenditure cap of $12,000 per year.

TSG, along with DHS, had previously conducted a survey of individuals on the waiting list and reported the results of the survey to the Task Force at its March 2016 meeting. It must be noted, that the results of that survey showed that 97% of the families surveyed strongly favored the supported living benefit under the waiver, which enables beneficiaries to live in their own homes, with their family, or in an alternative residence. The cost of this benefit alone is approximately $50,000 per year, so it must be recognized that a capped benefit of $12,000 will only cover about 25% of the cost of this service.

Nevertheless, under this hypothetical program, the services covered by the limited benefit would be in addition to those currently being received by individuals on the waiting list. They could involve respite, supportive employment, adaptive equipment, vehicle modifications, specialized medical supplies, crisis support, case management, and community transitions. To estimate the marginal cost of adding this service, TSG used the capped service amount of ($12,000) and multiplied it by the total number on the waiting list (2,900), giving a total estimated marginal annual cost of approximately $35 million.

If we assume a 5% annual increase in cost, inclusive of both enrollment growth and service unit cost growth, then the overall estimated marginal cost to provide a limited benefit to all individuals currently on the waiting list is as shown in the following table.

Cost of Providing Limited Benefit to Individuals Currently on DD Waiting List *($millions)*						
	2017	**2018**	**2019**	**2020**	**2021**	**5-year**
All Funds	35	37	38	40	42	192
Federal Funds	24	26	27	28	30	135
General Fund	10	11	12	12	13	58

Partially Fund Waiting List with Tobacco Settlement Surplus

One option that has been proposed would be to use the tobacco settlement surplus funds (approximately $8.5 million) to partially fund the waiting list. Combined with the matching federal funds, this would result in approximately $28 million available for the waiting list. For a single year, this amount could pay for the full waiver benefit for about 500 individuals.

If the intent of this proposal is to provide some benefit to everyone on the waiting list, then the cap for new benefit costs would be about $9,770 per individual per year. Because it is not clear whether this would be a stable source of state funds on an ongoing basis, only single year estimates are provided below

Number of individuals on waiting list who could be covered with full waiver benefit	499
Annual limited benefit cap if all individuals currently on the waiting list are provided with some benefit	$9,770

Assumptions

These estimates assume that the cost of providing services to individuals currently on the waiting list will be the same, on average, as the cost of providing services to individuals currently on the waiver. It is possible that the individuals currently on the waiting list function at a higher average level than those on the waiver, since one of the pathways to get onto the waiver is first to reside in an Institutional Care Facility (ICF). It could be the case that for those DD individuals who function at a lower level, their families are more likely to place them in an ICF.

The projections above also assume that the average increase in costs is limited to 5%, inclusive of both enrollment and service unit cost. It is possible that the provision of a limited benefit to the individuals on the waiting list could result in a "woodwork" effect whereby the number of individuals applying for this benefit grows faster than it has historically since applying for a benefit may be a more attractive draw than just signing up for a waiting list.

4. Development Disability Wait List Methods of Funding in other States Including Trends

TSG was asked at the last Task Force meeting to provide a brief review of other states that have implemented changes and or/additions to Developmental Disabilities waiver programs and include the following information when discovered or made available: a summary of the program; cost trends; allocated spending and cost cap amounts; impacts to the waiting list, and the overall impact to services.

Tennessee

Employment and Community First Choice Waiver Program

As of July 1, 2016, individuals with intellectual and other developmental disabilities in Tennessee have been able to apply for long-term services and supports through a new waiver program called Employment and Community First CHOICES (ECF).

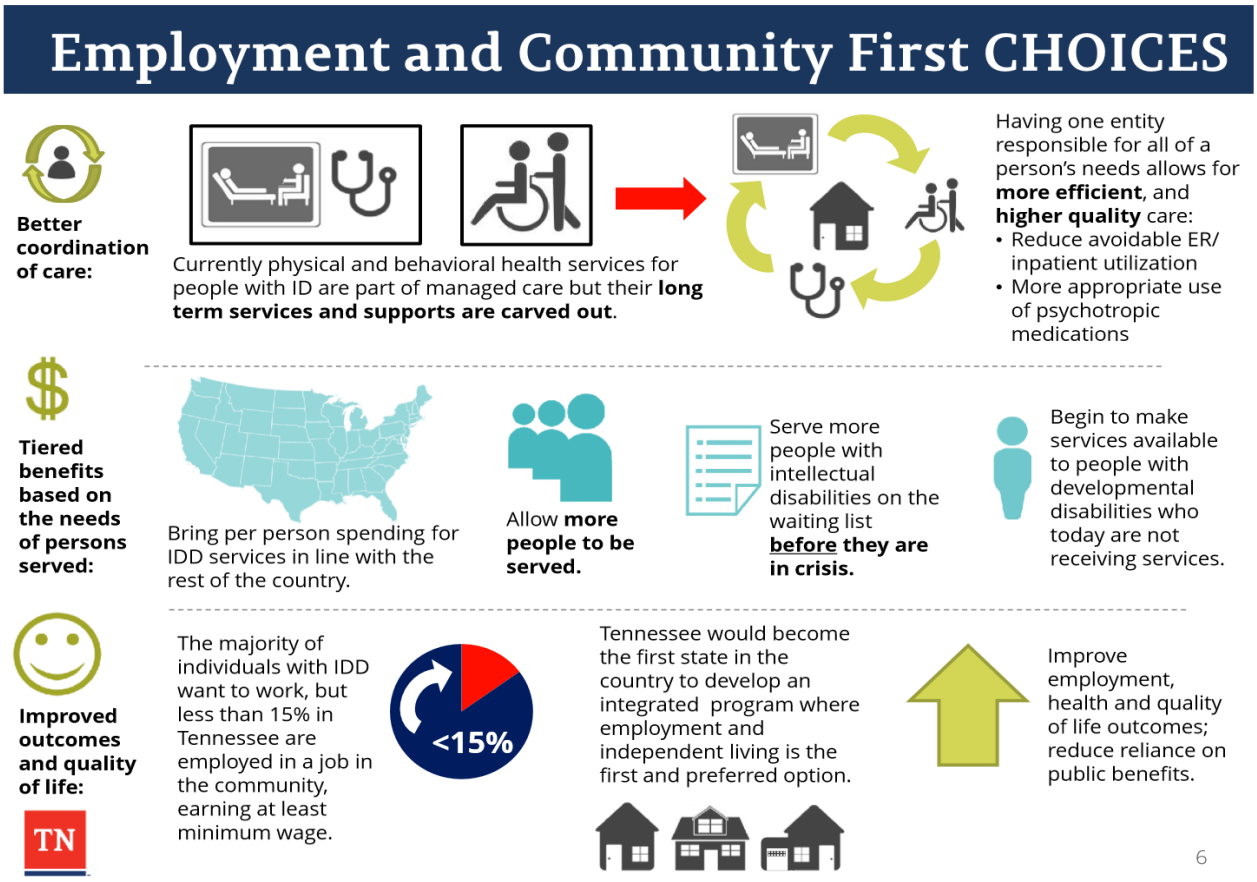
TennCare created the new program in an effort to ensure it will provide the services and supports people and their families say they need most. The overarching goal is to provide services and supports more cost-effectively with a long-term goal of serving more people including those on the waiting list and people with other kinds of developmental disabilities.

ECF will provide long-term services and supports for people with intellectual and other developmental disabilities *who are not currently receiving services*. People in current waivers through are not be impacted, but can choose to move to the new program later on.

Initially, the new ECF program will be available only for people who are not receiving services. It will take time to be able to serve all of the people who need support. Initial enrollment will target groups that were identified by stakeholders including people with aging caregivers (defined by state law as age 75 or older), young adults transitioning from school, and other people who need employment supports. *Approximately 1,700 people will be enrolled in the first year of the program.*

There are three tiers of service based on assessment. For the 1st Tier *Essential Family Supports* there is a cost cap of $15,000 not counting the cost of minor home modifications. For Tier 2 *Essential Supports for Employment and Independent Living* the cost cap is $30,000 per recipient, excluding emergency needs up to $6,000. For Tier 3, *Comprehensive Supports* the cap ranges from $45,000 to $60,000 - depending on medical and behavioral needs.

With ECF, Tennessee has become the first state in the country to develop and implement a home and community-based services program that coordinates all health and long-term services and supports, aligning incentives toward promoting and supporting integrated, competitive employment and independent living as the first and preferred option for people with intellectual and developmental disabilities.



Offered Services

Three benefit groups were designed to offer available services and supports based on each person's specific assessed needs and goals. The benefit groups are called:

- **Essential Family Supports**, which targets people of all ages who live at home with their families;
- **Essential Supports for Employment and Independent Living**, which targets people who are 21 or older who are living or want to live independently and pursue employment and community living goals; and

- **Comprehensive Supports for Employment and Community Living**, which targets people who are 21 or older who need a more comprehensive level of support to meet their employment and community living goals.

The employment supports target a "pathway" to employment and career planning, focused on services that meet people wherever they are on their career path: from exploring their interests and skills, to on-the-job supports, to career advancement. Also, many new self-advocacy supports will be offered to empower individuals and families toward independence and integration, like Peer to Peer and Family to Family Supports, help with navigating health insurance forms and accessing decision-making supports.

For people who need more comprehensive supports, the program includes a benefit package that recognizes exceptional medical and behavioral needs, and offers residential services that may include up to 24-hour support, in addition to the employment and community services offered in the other benefit packages.

ECF is operated by TennCare health plans (Managed Care Organizations or "MCOs"). In an effort to improve service coordination, all people receiving services and supports will have a "Support Coordinator" who role includes assessing and coordinating things like goals related to employment, community living, and health and wellness; access to physical and behavioral health services and Long-Term Services and Supports; the role of one's natural and social supports; and the person's choices and preferences with respect to services, settings and delivery options.

People enrolled in the program can use providers contracting with their MCO, or may be able to hire their own workers through consumer direction, which allows people to recruit, hire and train their own workers instead of using workers from a provider agency for certain services.

Costs

The Governor recommended ECF with an appropriation of $19 million and eight positions. Tennessee was also able to apply a reallocation of $5.1 million in existing state funds bringing the total appropriation for ECF CHOICES to $24.1 million. Costs trends for the program have not been established as the program is in in infancy.

Indiana

Family Supports Waiver (FSW)

This waiver provides Medicaid Home and Community-Based Services (HCBS) to participants in a range of community settings as an alternative to care in an intermediate care facility. Participants may choose to live in their own home, family home, or community setting appropriate to their needs. See the chart below:

Family Supports Waiver	
Target Population	The waiver serves persons with a developmental disability, intellectual disability or autism and who have substantial functional limitations, as defined under "Persons with related conditions" in 42 CFR 435.1010.
Services	• Adult Day Services • Behavior Management • Case Management • Community Habilitation • Electronic Monitoring • Environmental Modification • Equipment • Facility Based Support • Facility Habilitation • Family & Caregiver Training • Intensive Behavioral Intervention • Music Therapy • Occupational Therapy • Speech Therapy • Structured Family Caregiving • Supported • Recreational Therapy • Rent & Food for Unrelated Live-In Caregiver • Residential Habilitation Services • Respite Nursing Care • Specialized Medical • Participant Assistance and Care • Personal Response System • Pre-Vocational • Psychological
Expenditure Caps	Capped at $16,545
Waitlist information	Current waitlist is about *1300 individuals.* Families on waitlist can access state-funded respite services (Caregiver Supports funds), which are applied for Annually.
Delivery Model	Fee for Service Model

Costs

Costs trends for the program are being collected by state officials and will be reported by TSG once the trends are reported by the state of Indiana.

Kentucky

Michelle P Waiver (MPW)

The Michelle P. Waiver is a home and community-based waiver program of the Kentucky Medicaid program developed as an alternative to institutional care for people with intellectual or developmental disabilities. The waiver allows individuals to remain in their homes with services and supports.

Michelle P. Waiver	
Target Population	People with a developmental or intellectual disability who require a protected environment while learning living skills, educational experiences, awareness of their environment **and** meet Medicaid financial eligibility requirements are eligible. The MPW currently serves approximately 9,500 people.
Services	• Case Management • Adult Day Training • Supported Employment • Community Living Supports • Behavior Supports • Occupational Therapy (**members over 21**) • Physical Therapy (**members over 21**) • Speech Therapy (**members over 21**) • Respite • Homemaker Service • Personal Care • Attendant Care • Environmental/Minor Home Adaptation
Expenditure Caps	Services delivered in units are limited to 40 hours per week annually. Dollar amount services are limited to amounts that range from $500 to $4,000.
Waitlist information	There is a waitlist but individuals can receive State Plan services if approved for Medicaid. People needing emergency or urgent care services are given priority.
Delivery Model	Fee for Service Model

Costs

Costs trends for the program are being collected by state officials and will be reported by TSG once the trends are reported by the state of Kentucky.

Missouri

Support Waiver

The Support Waiver began in July 2003, for individuals with Intellectual and developmental disabilities who *have a place to live in the community, usually with family.*

Support Waiver	
Target Population	The person must meet ICF/ID level of care and must be at risk of needing ICF/ID services if waiver services are not provided. The Support Waiver serves over 1,400 individuals.

Services	• Assistive Technology • Behavior Analysis Service Behavior • Communication Skills Instruction • Community Specialist • Counseling • Independent Living Skills Development • In Home Respite • Job Discovery • Job Preparation • Occupational • Out of Home Respite • Physical Therapy • Personal Assistant (allows self-direction option) • Personal Assistant-Medical/Behavioral (allows self-direction option) • Person Centered Strategies Consultation • Co-Worker Supports • Crisis Intervention • Environmental Accessibility Adaptations / Vehicle Modifications • Group Community Employment • Individual Community • Professional Assessment and Monitoring (Registered Nurse, Licensed Practical Nurse, Registered Dietician) • Specialized Medical Equipment and Supplies (Adaptive Equipment) • Speech Therapy • Support Broker (allows self-direction option) • Transportation
Expenditure Caps	This waiver has an individual annual cap on the total amount of services a person can receive of $28,000.
Waitlist information	No waitlist information provided. TSG is waiting on waitlist information from the State and will report the information once received.
Delivery Model	Fee for Service

Costs

Costs trends for the program are being collected by state officials and will be reported by TSG once the trends are reported by the state of Missouri.

5. Private Option Claims Analysis Component Breakdown

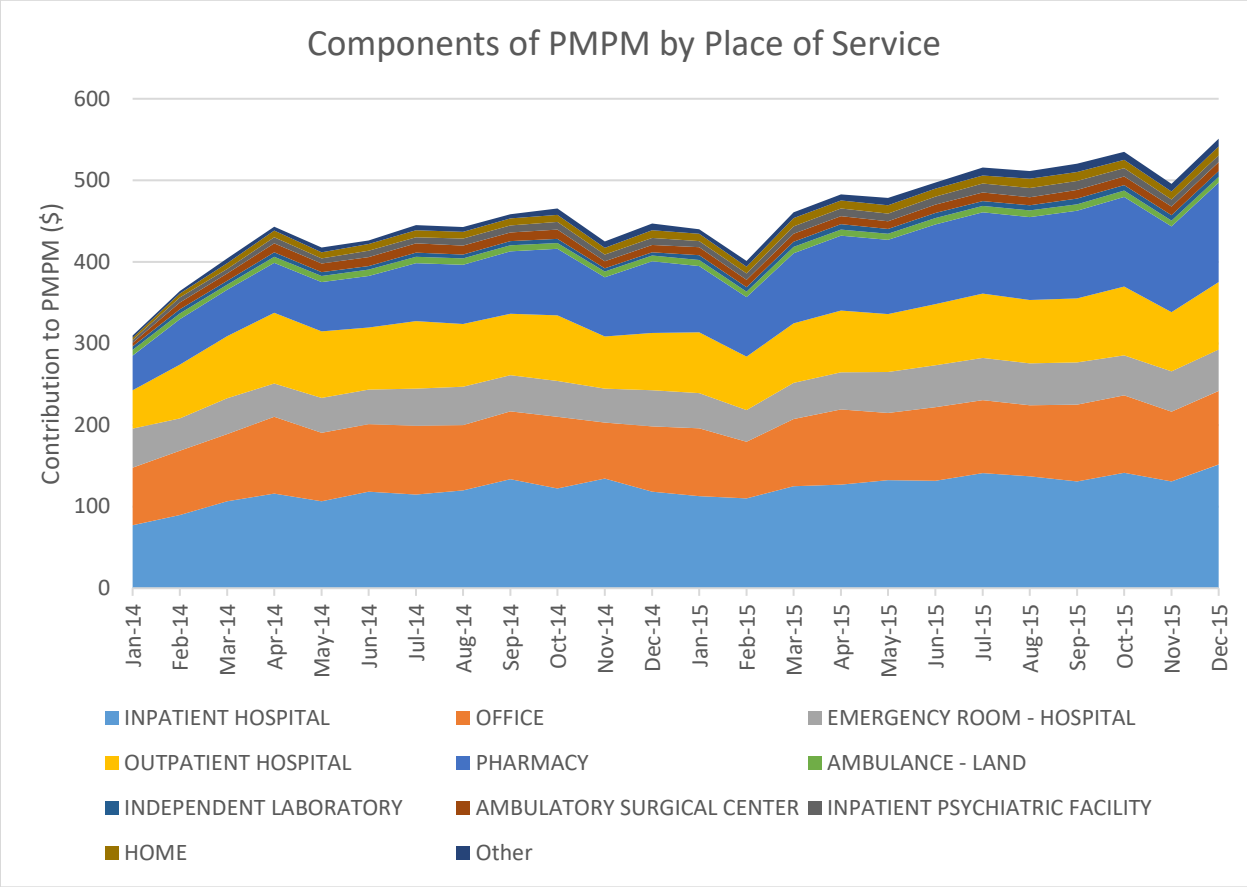
Recently, the health insurance carriers providing products on the individual marketplace requested rate increases for the 2017 plan year. One of the points of interest has been the drivers of the medical service cost increases. While we do not have information from calendar year 2016, we have been able to analyze data from calendar years 2014 and 2015 from two of the major carriers, which sheds some light on the major cost drivers.

Arkansas Blue Cross and Blue Shield

As the largest carrier in the state, the cost trends experienced by Arkansas BCBS disproportionately affect the overall experience of the Arkansas individual marketplace and the private option.

Cost by Place of Service

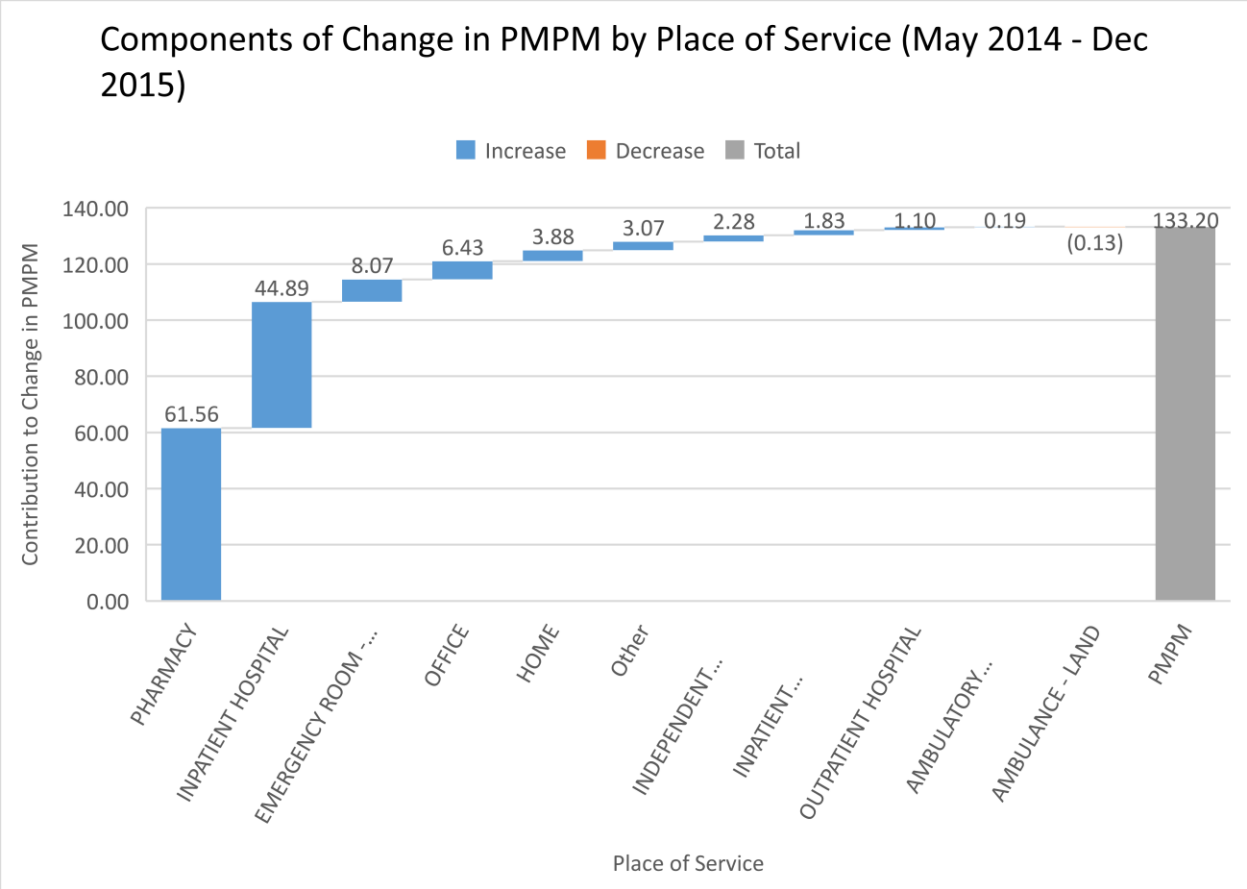
The following figure shows the breakdown of the per-member, per-month (PMPM) cost for services (excluding administrative costs and other non-service costs) for 2014 and 2015. The categories are sorted based on the size of the contribution to the PMPM cost in January 2014.



While many of the PMPM costs by place of service remained pretty stable throughout this period, a couple of the categories showed significant growth. In particular, pharmacy and inpatient hospital spending experienced substantial growth throughout this period.

Components of Change in PMPM by Place of Service

The following figure shows the contribution to the change in PMPM between May 2014 and December 2015. For this figure and analysis, May 2014 was chosen as the starting point because, as can be seen in the prior figure, the first four months of the program saw significant PMPM claims cost growth, which may be an artifact of the enrollment approach rather than a meaningful underlying change in the utilization or cost trends.



Almost the entire increase in PMPM cost is driven by increases in pharmacy and inpatient hospital claims.

Further Component Analysis

The increases in PMPM costs for pharmacy and inpatient hospital claims may be driven by a combination of both average claim volumes per enrollee, and average claims cost. The following tables show the relative contributions of costs per claim and claims per enrollee for both pharmacy and inpatient hospital.

Inpatient Hospital			
	May-14	Dec-15	% change
Average Cost per Claim	$1,330	$1,659	24.73%
Claims per Enrollee	0.08	0.09	13.93%

Pharmacy			
	May-14	Dec-15	% change
Average Cost per Claim	$35	$53	52.01%
Claims per Enrollee	1.73	2.29	32.86%

In both cases, the increase in cost was driven by a combination of average cost per claim and claims per enrollee. In both cases, the primary driver of the increase in the marginal contribution

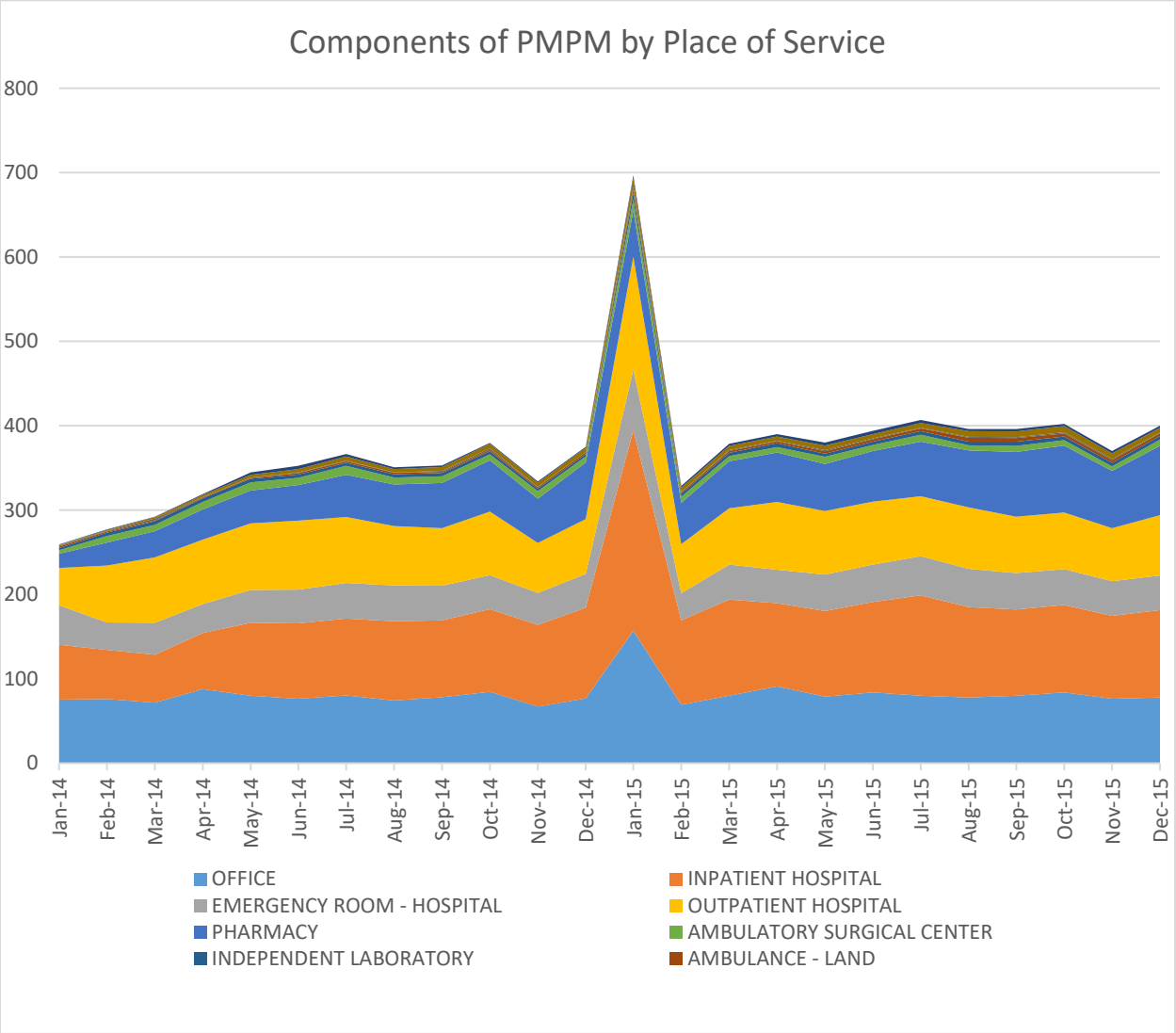
to the PMPM cost growth was the average cost per claim, which, in both cases, experienced a growth rate about twice that of the growth in number of claims per enrollee.

Ambetter

The case of Ambetter is interesting in contrast to that of Arkansas BCBS because it is a smaller carrier, but also because it did not request as large a rate increase, so differences in the relative changes in the claims costs may be indicative or pro-active efforts being taken by Ambetter to contain costs (or could also just be selection bias or chance).

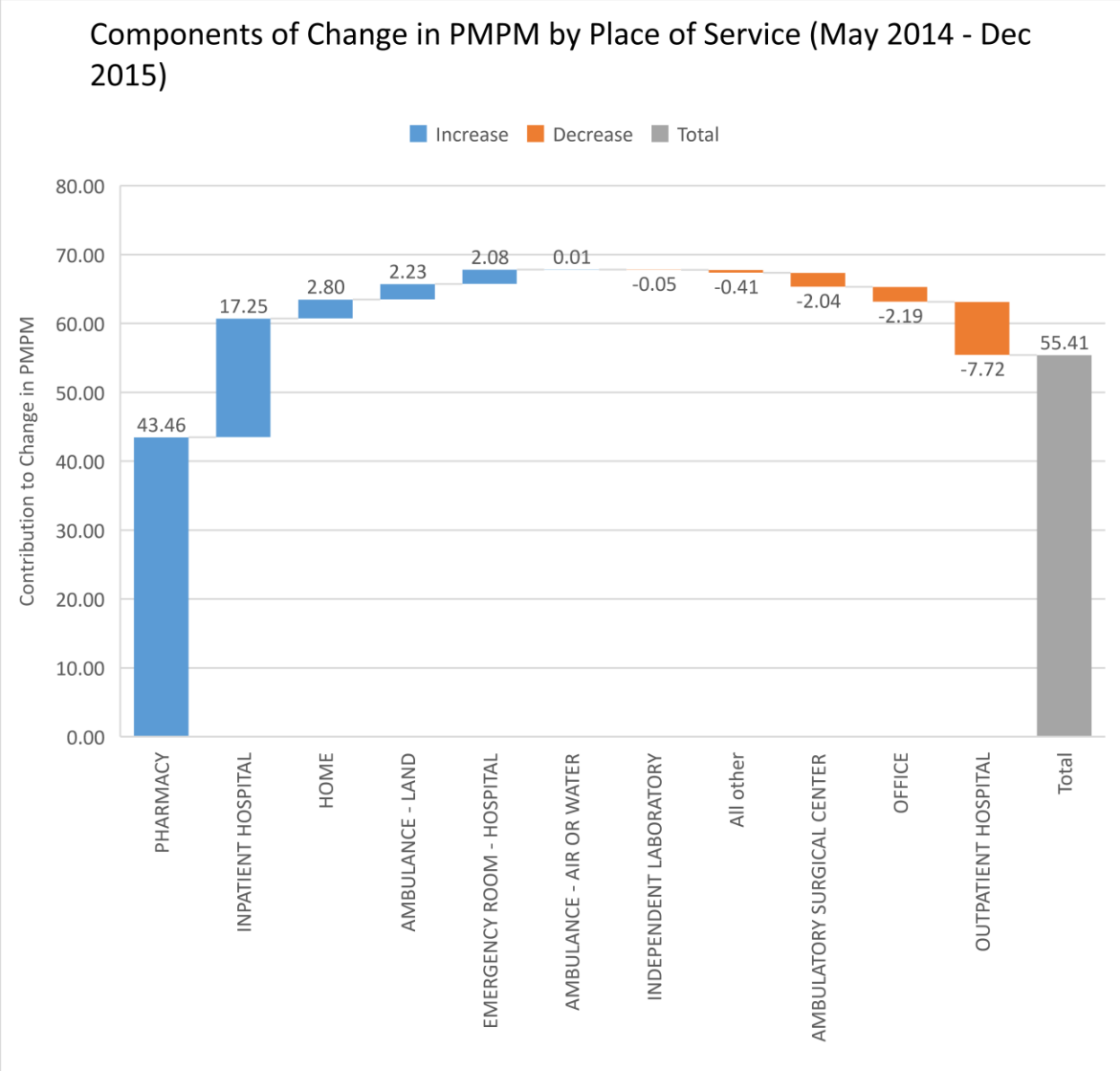
Cost by Place of Service

The following figure shows components of the PMPM cost by place of service over time. The spike in January 2015 appears to be an artifact of some program or policy feature or an anomaly in the data, but is unlikely to represent an actual increase in costs at that point in time of that magnitude. Examining the broader trends results in similar findings as in the case of Arkansas BCBS. The largest drivers of the change appear to be pharmacy and inpatient hospital.



Components of Change in PMPM by Place of Service

Drilling down into the data another level shows the relative contributions of the different places of service to the change in PMPM, again between May 2014 and December 2015. As noted previously, the largest contributors to the increase in PMPM were pharmacy and inpatient hospital. Furthermore, while the absolute numbers are different, this figure looks very similar to the corresponding figure for BCBS.



Further Component Analysis

Although the increase in PMPM cost for Ambetter was driven by increases in spending on pharmacy and inpatient hospital costs, as in the case of Arkansas BCBS, the relative contributions of utilization and per-unit costs were moderately different.

Inpatient Hospital			
	May-14	Dec-15	% change
Average Cost per Claim	$1,304	$1,385	6.22%
Claims per Enrollee	0.0662	0.0748	12.95%

For Ambetter, the increase in the contribution of inpatient hospital costs to the overall spend was driven more by increase in number of claims per enrollee than in average cost per claim, although both increased.

Prescription Drugs			
	May-14	Dec-15	% change
Average Cost per Claim	$33	$57	75.63%
Claims per Enrollee	1.19	1.44	20.60%

The increase in the contribution of prescription drugs to the overall spend over the time period was even more disproportionately due to the increase in cost per claim than in the case of Arkansas BCBS.

6. INDIVIDUAL MARKETPLACE RATE INCREASES IN EXPANSION AND NON-EXPANSION STATES

A recent report from the Office of the Assistant Secretary for Planning and Evaluation in the US Department of Health and Human Services found that states that, in states that expanded Medicaid, individual marketplace premiums were about 7% lower than in states that did not expand Medicaid. The analysis compared rates in counties on either sides of borders between states where one state expanded Medicaid and the other did not.

This approach was used in order to control for as many other population-level variables as possible since it is assumed that populations that live in close proximity to one another, even though on opposite sides of a state border, are very similar. The analysis also attempted to control for market dynamics on either side of the borders that might have affected premium levels.

The mechanism that the authors of the study suggest may have driven this difference is the exclusion of the population between 100% and 138% FPL from the marketplace in expansion states. The population between 100% and 138% FPL is potentially eligible for either the Medicaid expansion or the marketplace, but is generally assumed to be more likely to choose the Medicaid expansion due to greater affordability. Therefore, in expansion states, the marketplace population is generally those above 138% FPL, whereas in non-expansion states, the marketplace is generally those above 100% FPL. There is a recognized correlation between health and income, so those with lower incomes are likely to be in worse health and have higher costs.

The generalizability of this study to the Arkansas situation is limited, however, because of the way that Arkansas expanded Medicaid eligibility. Since the Arkansas Medicaid eligibility expansion was implemented through the 1115 waiver, through which the expansion population is enrolled in marketplace plans, the expansion population and marketplace populations are already in the same risk pool. Put another way, Arkansas' expansion of Medicaid eligibility up to 138% FPL did not result in the population between 100% and 138% FPL being removed from the marketplace risk pool the way it would have if the expansion was implemented through fee-for-service Medicaid.

7. SELECT EXAMPLES OF PRIVATE CARRIER INNOVATION TO REDUCE HEALTH CARE COSTS

While many health insurance carriers providing services through the individual marketplace have requested increased rates or lost money, there have been some examples of carriers adopting innovative cost-containment strategies that allow them to earn profits, even in the individual insurance marketplaces. This section will describe several innovative strategies adopted by carriers in Florida and Michigan, respectively.

Florida Blue Cross and Blue Shield

Florida Blue Cross and Blue Shield made an underwriting profit of over $400 million on about 500,000 covered lives in the Florida health insurance marketplace in 2015, a significant increase from their also positive underwriting profit in 2014. Florida BCBS has received positive attention from the press for this achievement, including coverage in Forbes and Modern Healthcare. Several strategies adopted by Florida BCBS may have helped them achieve the cost containment required for this level of underwriting profits.

Retail Centers – Florida BCBS opened a network of 20 retail centers throughout the state to help people get properly enrolled and offer free health screenings.

Care Managers – New enrollees are assigned a care manager, usually a nurse, who makes sure that the enrollee gets recommended screenings and helps to address any health issues in outpatient settings before more expensive situations arise.

Narrow Networks – Florida BCBS also maintains a narrow network of high-performing providers, which supports additional cost containment.

Priority Health

Priority Health is the insurance of arm of Spectrum Health, not-for-profit integrated health care organization in Michigan. Their strategies to increase value include the following:

Focusing on chronic disease – Priority Health uses care managers to coordinate care for enrollees with chronic disease and claims data to stratify patients so that they can focus on those who are the sickest.

Designing a care model for elderly patients – Priority Health designed a home-based care delivery model for their elderly patients, through which they use a geriatrician, a nurse practitioner, a social worker, and a care manager. Candidates for the home-based care model are identified through data analysis.

Developing telemedicine capabilities – Priority Health developed a telemedicine service through which its enrollees can be in touch with a clinician at any time to receive advice and provide consultations.

8. UPDATE ON PCMH SAVINGS ESTIMATES

In the August report, TSG included several ways that the patient-centered medical home (PCMH) program could be adjusted to potentially increase the cost savings.

- Increasing the number of beneficiaries covered by PCMH by lowering the required number of beneficiaries served by a practice to include more PCPs
- Increasing the effectiveness of PCMH by providing PCPs with information about the cost-effectiveness of Principal Accountable Providers associated with Episodes of Care.
- Increasing the services managed by PCMH by including low-level behavioral health services in the primary care office.

DHS is already implementing certain program changes to increase the cost and clinical effectiveness of the PCMH program, including the following:

- Lowering the required number of beneficiaries served by a practice, which will make more PCPs eligible and align with the federal Comprehensive Primary Care Plus (CPC+) initiative.
- Doing additional outreach to bring more PCPs into the program.
- Authorizing billing for behavioral health services on the same day and in the same location as primary care services.

While the agency anticipates that these initiatives will result in additional cost savings, they have not identified the specific level of savings anticipated.