TSG Status Update

To: Arkansas Health Reform Legislative Task Force

Re: Health Care Reform/Medicaid Consulting Services

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PREPARED BY:

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1. DHS Traditional Medicaid Savings Plan Update

The Stephen Group (TSG) has worked with the Arkansas Department of Human Services (DHS) over the past couple of months to refine the savings plan and estimates for the behavioral health, developmental disabilities and other key Medicaid program areas. TSG has also met with representatives of DHS and provider organizations. Our plan is to ensure the most reliable savings estimates for the Task Force to include in its final the 5-year "net" savings plan that will be part of the Task Force final December 2016 report.

Specifically, TSG has worked with the DHS financial and program teams in the Divisions of Behavioral Services (DBHS), Medicaid Services (DMS), and Developmental Services (DDS) to facilitate and guide the development of a reliable financial model for the proposed traditional Medicaid savings and investment strategies. The particulars surrounding such savings and investment initiatives have been reported over the last few meetings of the Task Force and they all are part of the DHS Medicaid Transformation process.

Critically important to the savings in all of the long-term support service areas (behavioral health, developmental disabilities and long term care) are the proposed Rule changes to the Behavioral Health and Developmental Disability benefits, meeting timelines, the developmental disability tiered waiver changes being moved forward according to plan, CMS approvals, the independent assessment process being implemented before July 2017, the timely contracting for preauthorization and utilization review services, and any required beneficiary notices. These all must be aligned according to the DHS schedule to improve quality and assure the majority of savings in the Task Force model.

It is important to note that DHS has been meeting with stakeholders throughout this process, and the Director has also undertaken a department wide transformation of the DHS organization, including incorporating a shared services model and procurement best practices. These changes will contribute to achieving targeted savings estimates generated by the following model.

2. Strategies for Reducing Spending in the Traditional Medicaid Program

Three primary models for reducing spending in Arkansas' traditional Medicaid program will be reviewed below:

1) The "Current Model" – a set of benefit modifications and program adjustments that have been identified over the last 2 years as part of The Stephen Group's involvement with the Task Force.

2) A Provider-led "Collaborative Care Organization" (CCO) model that has been put forth by the agency for the behavioral health and developmental disability enrollee populations.
3) A capitated managed care model for the behavioral health and developmental disability enrollee populations that is being analyzed for comparison

In the following sections, the savings assumptions for the different models and the anticipated savings are described.

Current Model

The following table describes the cost saving strategy for each program under the "Current Model", and the assumptions regarding the timing of the cost savings and any administrative costs that will need to be borne by the agency to affect such changes.

	Savings Strategy	**Savings Timing**	**Admin Considerations and Costs**
DD	$18M per year in therapy caps; $17M/yr from independent assessment and tiers for waiver services	therapy caps begin July 1, 2017 (savings over 5 years); independent assessment tier savings start July 1, 2019	Independent Assessment
BH	Reform RSPMI benefit, updated outpatient policy, reduction in inpatient from independent assessment, investment in substance abuse	Begins July 1, 2017; savings over 5 years	$108M investment over 5 years for independent assessment and care coordination
Dental	$5M per year in savings from capitated managed care	Begins July 1, 2017	
Elder	Industry MOU to save $250M over 5 years	Begins FY 2017; savings evenly spread across 5 years; assume $50M/yr savings continues into SFY2022	Independent Assessment - Part of MOU/savings are net of additional costs
Low-cost	No program changes	Savings already captured under PCMH program	
Pharmacy	$250M in savings	Begins July 1, 2016; savings evenly spread across 5 years	

The following table shows the anticipated savings from the programmatic changes already being implemented.

Savings by year and program	SFY17	SFY18	SFY19	SFY20	SFY21	SFY22	SFY17-21	SFY18-22
DD Savings - Therapy Caps	$0	$18	$18	$18	$18	$18	$72	$90
DD Savings - Independent Assessment and Tiers/Waiver Changes	$0	$0	$0	$17	$17	$17	$34	$51
DD Cost - Independent Assessment	$0	$0	$0	$2	$2	$2	$4	$6
Net DD Savings	$0	$18	$18	$33	$33	$33	$102	$135
BH Savings - Updated Outpatient Benefits Policy	$15	$16	$33	$33	$33	$33	$130	$148
BH Savings - Inpatient	$0	$15	$25	$35	$50	$50	$125	$175
BH Cost - Independent Assessment	$0	$1	$2	$2	$2	$2	$7	$9
BH Cost - Care Coordination	$0	$15	$21	$21	$21	$21	$78	$99
Net BH Savings	$15	$15	$35	$45	$60	$60	$170	$215
Dental Savings - Capitated Managed Care	$0	$5	$5	$5	$5	$5	$20	$25
Dental Premium Tax	$0	$3	$3	$4	$4	$4	$14	$18
Net Dental All-Funds Impact	$0	$8	$8	$9	$9	$9	$34	$43
Elder Savings	$15	$50	$50	$50	$50	$50	$215	$250
Low-Cost Populations	$0	$0	$0	$0	$0	$0	$0	$0
Pharmacy	$50	$50	$50	$50	$50	$50	$250	$250
Net Fiscal Impact	**$80**	**$141**	**$161**	**$187**	**$202**	**$202**	**$771**	**$893**

If the current programmatic cost saving opportunities that have already been identified are implemented, Arkansas stands to save approximately $900 million between SFY2018 and SFY2022.

Provider-Led CCO Model

DHS has put forward the concept of provider-led coordinated care organizations for the BH and DD programs. The following table describes TSG's best up-to-date estimate for the cost saving assumptions for the CCO-based approach proposed by DHS. Please note, that this could change as issues related to timeline and level of risk begin to become more clear.

	Savings Strategy	Savings Timing	Admin Considerations and Costs
Current strategy	All savings from current strategy as above	As above	As above
DD Provider-led CCO model	Care coordination for DD halo (additional medical services) services	5% savings off of halo spend starting year 4	Savings net of admin costs (admin under APCCO/RCCO payment)
BH Provider-led CCO model	Care coordination for BH halo (additional	5% savings off of halo spend starting year 4	Savings net of admin costs (admin under APCCO/RCCO payment)

	medical services) services		

The following table describes an estimate on the projected cost savings from the provider-led CCO model. The starting point for these cost savings are the cost savings from the programmatic changes already identified and described in the previous tables. There remains an opportunity for additional savings within the DD and BH programs through greater care coordination, specifically with respect to the medical and pharmacy benefits (the "halo" spend for the BH and DD populations).

Savings by year and program	SFY17	SFY18	SFY19	SFY20	SFY21	SFY22	SFY17-21	SFY18-22
All cost savings from current model	$80	$141	$161	$187	$202	$202	$771	$893
DD Provider-Led CCO Model Savings	$0	$0	$0	$0	$12	$13	$12	$25
DD Provider-Led CCO Model Premium Tax	$0	$0	$0	$0	$26	$27	$26	$52
Net additional DD all funds impact	$0	$0	$0	$0	$38	$40	$38	$77
BH Provider-Led CCO Model Savings	$0	$0	$0	$0	$28	$29	$28	$57
BH Provider-Led CCO Model Premium Tax	$0	$0	$0	$0	$30	$31	$30	$61
Net additional BH all funds impact	$0	$0	$0	$0	$58	$61	$58	$118
Net Fiscal Impact	**$80**	**$141**	**$161**	**$187**	**$297**	**$302**	**$867**	**$1,089**

If the DD and BH provider-led CCO models, and the current programmatic cost saving opportunities that have already been identified are implemented, Arkansas stands to save approximately $1,095 million between SFY2018 and SFY2022. Additionally, if the provider-led CCO initiative is implemented earlier than during FY 2021, Arkansas can achieve additional savings off trend.

Capitated Managed Care Model

TSG has developed the following projections of capitated Medicaid managed care for the BH and DD populations as a comparison to the provider-led CCO model. The following table describes the cost saving assumptions for the capitated managed care approach.

	Savings Strategy	Savings Timing	Admin Considerations and Costs
Current strategy	All savings from current strategy as above	As above	As above
DD Capitated Managed Care	Care coordination for DD halo (additional medical) services	8.07% savings off of halo spend starting year 3	Savings net of admin costs (admin under MCO payment)

BH Capitated Managed Care	Care coordination for BH halo (additional medical) services	8.07% savings off of halo spend starting year 3	Savings net of admin costs (admin under MCO payment)

Note: TSG is relying on the same savings projections identified in earlier Task Force meetings but the total savings for the capitated managed care model have been adjusted due to revised timeline.

The following table describes the projected cost savings from the capitated managed care model. As above, the starting point for these cost savings are the cost savings from the programmatic changes already identified and described in the previous tables.

Savings by year and program	SFY17	SFY18	SFY19	SFY20	SFY21	SFY22	SFY17-21	SFY18-22
All cost savings from current model	$80	$141	$161	$187	$202	$202	$771	$893
DD Capitated Managed Care Savings	$0	$0	$0	$19	$20	$21	$39	$59
DD Capitated Managed Care Premium Tax	$0	$0	$0	$24	$26	$27	$50	$77
Net DD additional all funds impact	$0	$0	$0	$43	$45	$48	$88	$136
BH Capitated Managed Care Savings	$0	$0	$0	$3	$45	$47	$48	$96
BH Capitated Managed Care Premium Tax	$0	$0	$0	$28	$30	$31	$58	$89
Net additional BH all funds impact	$0	$0	$0	$32	$75	$78	$107	$185
Net Fiscal Impact	**$80**	**$141**	**$161**	**$262**	**$322**	**$328**	**$966**	**$1,214**

If the DD and BH capitated managed care models, and the current programmatic cost saving opportunities that have already been identified are implemented, Arkansas stands to save approximately $1,220 million between SFY2018 and SFY2022.

3. APPROACHES TO IMPLEMENTING MEDICAID STRATEGIES

At a high level, there are a couple of different approaches to implementing payment reforms in Medicaid for a given eligibility group – either gradually, or all at once.

Gradual Implementation

Under a gradual implementation approach, a preferred payment strategy might be identified, and then implemented, with voluntary provider participation leading to a slowly growing proportion of the provider community participating. Miscellaneous agency encouragement and incentives are certainly possible, but, under this approach, a new program is structured around voluntary participation and organic growth.

One benefit of this approach is that, because it isn't mandatory and will necessarily involve a relatively small initial pool of participating providers, it can be implemented relatively quickly. Due to its voluntary nature and initial small scope, a program like this can be established with less provider resistance than a mandatory or across-the-board program change would face. One

drawback of this approach is that any cost-savings associated with its implementation will also grow slowly along with provider participation.

Examples of this kind of approach include the Arkansas Patient-Centered Medical Home (PCMH) program and programs in Colorado and Oregon that are similar to the CCO model being proposed by DHS. Planning for the Colorado Accountable Care Collaborative began in 2008, with implementation beginning in 2011 with one practice and 500 enrollees. Over the subsequent 5 years, participation grew to include about 75% of Medicaid enrollees participating in 2016 and it is now producing a net annual decrease in spending of approximately 1% per year

Rapid Transition

Under a 'rapid transition' approach, a program will be developed and then deployed, all at once, across a set of providers and enrollees. An example of this is a managed care deployment wherein generally a certain set of enrollees and patients are transitioned into the managed care delivery model all at once, with little choice on either side (although enrollees will generally retain their ability to choose among managed care organizations.) Pursuant to this 'rapid transition' approach, cost savings begin to be recognized at a large scale all at once, although it is likely that this kind of systemic transformation will require a longer planning and implementation period since it will be particularly important that there are as few problems as possible once it starts.

A recent addition to the Texas Medicaid managed care landscape provides a good example of this kind of approach. Although Texas has been administering large portions of its Medicaid program through managed care organizations for many years, some populations have remained in fee-for-service. Texas recently went through the process of adding children with disabilities to its managed care strategy through a program called STAR Kids. The RFP for STAR Kids was released July 2014, with proposals due October 2014. Evaluation of the proposals and negotiation of contracts took the better part of a year, with contracts effective September 2015. Operations were originally scheduled to begin September 2016, but were delayed until November 2016. The overall timeline for rolling-out STAR Kids also included additional time prior to the release of the RFP for development of the model, CMS approval, and development of the RFP itself. So, for a state with significant experience with managed care, and a mature Medicaid managed care market, it took between 2 and 3 years from making the policy decision to deploy managed care to this population and having the MCOs begin paying claims for this population.

Observations

It is difficult to determine which of these approaches would better represent APCCO/RCCO model, given the lack of details. The regional CCO component would seem to be similar to the related models implemented in Oregon and Colorado, which could lend itself to a gradual, organic growth approach. However, the state-level APCCO seems to have more in common with a managed care organization and appears to be integral to the operation of the whole

strategy, so the timeline associated with implementation for the whole program will probably be more like the 'rapid transition' approach described above.

The cost-saving models described above assume something more like the 'rapid transition' approach, with full cost-saving impact occurring at a point in time, but only after a period of development and implementation. Even if we assume a gradual implementation approach, cost-savings will begin to occur earlier, but will be more limited initially. It is likely that the dollar amount of savings would be similar from a slow-growth approach with an earlier start date.

4. REMAINING RECOMMENDATIONS FOR TASK FORCE CONSIDERATION

Revised November 15, 2016

A. Behavioral Health Benefit Redesign

The Task Force recommends and supports the Arkansas Department of Human Services moving forward transforming the Rehabilitative Services for Persons with Mental Illness (RSPMI) benefit into an evidence based/best practice Adult and Children/Adolescent Mental Health Rehabilitation Option benefit and that access to the revised benefit should be based on identified diagnoses and an independent assessment.

B. Developmental Disabilities

The Task Force recommends and supports the Arkansas Department of Human Services moving forward with a new waiver for a comprehensive revision of the Developmentally Disabled Services (DDS) Alternative Community Services waiver that is based on independent assessment, three levels of care, an institutional cost limit, tiered payments, and focuses on employment and community choices.

C. Nursing Home

The Task Force supports the memorandum of understanding entered into by the Arkansas Department of Human Services and Arkansas Health Care Association on May 20, 2016 to achieve $250 Million in savings over a 5-year period through improved, high quality, person-centered, and cost-efficient Long Term Services and Support care delivery reform. The Task Force supports reforms to ensure supports and services in the community are cost effective, effectively serve transitions among care settings, and eliminate fragmentation and duplication in service coordination and delivery. Other reforms contained in the memorandum of agreement, including independent assessment, tiered levels of care, acuity-based and risk adjusted, and effective care management, coordination, and transition strategies, designed to enhance the most cost effective and quality enriched care are also supported.

D. Care Management Approach

The Task Force recommends and supports the Arkansas Department of Human Services developing and implementing a comprehensive approach that provides care management and coordination to all behavioral health and non-Human Development Center intellectual and developmentally disabled populations eligible for Medicaid services. Care management includes the identification, stratification, and prioritization of high risk and complex individuals for the coordination of evidence based services, supports, and interventions that are provided in a cost effective and non-duplicated plan of care, and include provider payment accountability and risk for outcomes and quality.

E. Adoption and Tracking of 5 year DHS Medicaid Savings Plan

The Task Force recommends and supports that the Arkansas Department of Human Services develop and implement a Five-Year Medicaid Program Savings Plan that is in excess of the $835 million in net savings to trend proposed by Governor Asa Hutchinson starting no later than July 1, 2017. Savings must be achieved through an increase in care management and coordination resulting in improved outcomes, quality, appropriate utilization based on need, reduction of duplication and unnecessary services, and the introduction of value based purchasing strategies and some degree of provider risk. The Department of Human Services will provide a Comprehensive Medicaid Budget Savings Dashboard Report tracking savings to trend to the Bureau of Legislative Research every quarter commencing September 1, 2017 and thereafter for five years.

F. Developmental Disabilities Wait List

The Task Force recommends that DHS develop a plan to provide services to those on the Developmental Disability Waiting List, either through a benefit structure that is capped with tiered levels of payment for some services, or through the Governor's plan to use Tobacco Settlement Funds to provide services for those currently waiting for waiver services on the Developmental Disabilities Waiting List.

G. Value-Based Purchasing

The Task Force recommends that DHS develop and implement strategies of value-based purchasing for health services, wherever feasible and cost-effective, with the following characteristics: a) Providers should be accountable for some portion of the total cost of care for their patients. b) Accountability for some portion of the total cost of care should include both shared savings and shared risk for average costs above certain thresholds. c) Providers should be receiving higher payments for high quality care and outcomes.

H. Increase State Vaccination Rates

The Task Force recommends that Public Health reevaluate vaccination reimbursement to all providers, including separating the ingredient reimbursement from the professional administration fee for adult vaccinations, and reevaluate the professional administration fee for the free vaccines distributed in the vaccines for children (VFC) program.

I. Monthly Prescription Limits

The Task Force recommends the removal of the monthly prescription limit for approved maintenance medications used in approved chronic conditions and maintenance of the limit for all other drugs.

J. Combating the Opioid Crisis

The Task Force has several recommendations to help combat the opioid epidemic in Arkansas. First, allow DHS clinical staff to access the State Prescription Drug Management Program (PDMP). Second, recommend that DHS pharmacy group continue to tighten opioid dispensing limits, measure quantities in morphine milligram equivalents, and tightly manage early refill requests. Third, the Task Force recommends expanding the frequency and number of drug take-back locations. Fourth encourage prescribers to consult the PDMP prior to prescribing drugs of abuse.

K. State Data Integration/research and decision making.

The State of Arkansas has a vested interest in developing a data system to assist the Governor, General Assembly, and other policymakers to make data-driven decisions that result in more efficient usage of taxpayer funds and better matching of state needs with state priorities. To accomplish this goal, the Task Force recommends that the state explore the feasibility of establishing such a data system in cooperation with a research-based public university with a proven track record of analytical research and data system development and implementation.

L. Eligibility Integrity

The Task Force supports the use of both state and publicly available data bases to promote public integrity in the Medicaid eligibility process, through an electronic identity, asset and income verification solution pre-and post-eligibility.

M. Certified Agents Role

The Task Force recommends that DHS work with National Association of Insurance and Financial Advisors (NAIFA) and clarify the authority of Exchange Certified Producer (certified agents who are compensated from Insurance plan premiums) to represent and speak on behalf of applicants, when given the proper signed authority and consent by applicants, with DHS on any matter involving enrollment and eligibility for the Private Option or the proposed alternative to replace it. It is understood that such Exchange Certified Agents will provide assistance governed by the State and Federal guideline as they have abided by for years. The Certified Agents should

be included in the development of the DHS guidelines that will govern their role in the enrollment process for all the new plans.

N. Independent Medicaid Provider Rate Review

The Task Force recommends a yearly Medicaid provider rate review conducted by an independent actuarial or professional consulting firm, with experience in Medicaid rate methodology that compares Arkansas' Medicaid provider rates to those of other state Medicaid programs, and Medicare and commercial insurance as well, and to provide an annual report of its findings to DHS and the legislature for review and consideration.

O. Medicaid Fairness Act

The Task Force supports amending certain provisions of the Medicaid Fairness Act to allow prior authorizations to be based on recognized standards of evidence-based practice or professionally recognized standards for health care. Moreover, the Task Force supports legislation making it clear that DHS is not required to promulgate rules to incorporate recognized standards of evidence-based practice or professionally recognized standards of care that practitioners use in determining medical necessity or rendering medical decisions, diagnoses, or treatment

P. Health Disparities and Access

The Task Force supports cost effective policies that serve to reduce health disparities, increase access to health care and allow for appropriate use of health care services for those eligible for Medicaid

Q. Task Force Committee Recommendations

DRG

The Task Force supports that Arkansas Department of Human Services, to the extent possible, and after collaboration with the Arkansas Hospital Association, converting hospital reimbursement systems under the Traditional Medicaid programs to a diagnosis-related groups (DRG) methodology that will allow DHS to more accurately classify specific patient populations and account for severity of patient illness and mortality risk. The Task Force also supports DHS promulgating rules to achieve this purpose that shall address how supplemental payments would be considered, whether transition funding should be provided and whether certain providers should be carved out.

HDC

Shared with TF at the October 24, 2016 meeting.