Arkansas Health Care Reform Task Force

TSG Update Report #2
July 16, 2015

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Payment Improvement Initiative Overview

- Episodes of Care – retrospective analysis of reported quality measures and appropriate costs for certain delineated episodes of care, with gain-sharing or loss-sharing for principal accountable providers
- Patient-Centered Medical Homes – measurement of primary care physician progress on a number of process measures, with eventual gain-sharing to incentivize lower cost care
- Heath Homes – incentives for containing costs while maintaining quality for high needs populations (not implemented)

Payment Improvement Initiative
Patient-Centered Medical Home

- PCPs measured on a number of process measures associated with better, more efficient care.
- Care management payment to PCP for each patient for whom the PCP serves as PCMH.
- Moving toward gain-sharing.

Payment Improvement Initiative
Patient-Centered Medical Home

Initial Phase Process Measures
Identify team lead(s) for care coordination
Identify the top 10% of high-priority patients
Assess operations of practice and opportunities to improve
Develop and record strategies to implement care coordination and practice transformation
Identify and reduce medical neighborhood barriers to coordinated care at the practice level
Make available 24/7 access to care
Track same-day appointment requests

Payment Improvement Initiative
Patient-Centered Medical Home

- The vast majority of providers participating in the PCMH successfully attested to the initial phase process measures.
- Enrollment measures for the PCMH have exceeded expectations.
- More than 295,000 Medicaid beneficiaries are in the care of a PCP participating in the PCMH program.
- Participating payers have had positive experiences.
- Difficult to isolate effect of PCMH in observed changes in costs and practice patterns

Payment Improvement Initiative Episodes of Care

Active Episodes of Care (First Two Rounds)					
Episode	Principal Accountable Provider (PAP)	Direct episode spend ($M)	Number of episodes	Related spend for PAP ($M)	Estimated direct savings to date (%)
Upper Respiratory Infection (3 episodes)	PCP	13.6	180,404	Low direct, large via referrals	4-8
Attention Deficit Hyperactive Disorder (2 episodes)	Physician or RSPMI	39.1	9,933	440	15-25
Perinatal	OBGYN	87	19,052	117	Unknown
Congestive Heart Failure Exacerbation	Hospital	6.2	1,193	369	0-5
Total Joint Replacement	Orthopedic surgeon	5	475	14	5-10

Adapted from McKinsey document titled "Selected facts relating to episode impact for Arkansas Medicaid; June 18, 2015 – updated July 8 with volume numbers"

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Payment Improvement Initiative Episodes of Care

Active Episodes of Care (First Two Rounds)	
Episode	Observations relating to estimated direct cost savings
Upper Respiratory Infection (3 episodes)	• 17% drop in antibiotic prescribing rate. • Average episode cost flat despite ~10% increase in drug prices
Attention Deficit Hyperactive Disorder (2 episodes)	• Average episode cost fell by 22% in first year for individuals with valid episodes in both years. • 400 providers in other BH dx contacted re stimulant use.
Perinatal	• C-section rate reduced from 39% to 34%.
Congestive Heart Failure Exacerbation	• # episodes down from 141 to 101 • 30-day all-cause readmission rate decreased from 3.9% to 0% (~100 episodes) • Slight increases in infections (1.4% to 2.0%) and complications (6.4% to 7.9%)
Total Joint Replacement	• 30-day all-cause readmission rate up from 16.0% to 19.9% (~200 episodes) • Slight changes in infections (7.6% to 8.5%) and observation rate (43% to 40%)
Adapted from McKinsey document titled "Selected facts relating to episode impact for Arkansas Medicaid; June 18, 2015 – updated July 8 with volume numbers"	

Payment Improvement Initiative Episodes of Care

Active Episodes of Care (Remaining Rounds)				
Episode	Principal Accountable Provider (PAP)	Direct episode spend ($M)	Number of episodes	Related spend for PAP ($M)
Colonoscopy	Performing physician	1.3	1,308	17
Gallbladder Removal	General surgeon	1.6	718	19
Tonsillectomy	ENT	2.8	2,480	11
Oppositional Defiant Disorder	Physician or RSPMI	17.1	8,380	440
Coronary Artery Bypass Graft	Cardiothoracic surgeon	0.9	81	8
Asthma exacerbation	Hospital	2.4	3,383	369
Chronic Obstructive Pulmonary Disease Exacerbation	Hospital	2.3	972	369
Adapted from McKinsey document titled "Selected facts relating to episode impact for Arkansas Medicaid; June 18, 2015 – updated July 8 with volume numbers"				

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Payment Improvement Initiative Episodes of Care

- Episode roll-out

Episode	Episode Launch Date
URI (3 episodes)	Jul 2012
ADHD	Jul 2012
Perinatal	Jul 2012
CHF exacerbation	Oct 2012
TJR	Oct 2012
Colonoscopy	Jul 2013
Gallbladder removal	Jul 2013
Tonsillectomy	Jul 2013
ODD	Oct 2013
CABG	Oct 2013
Asthma exacerbation	Apr 2014
COPD exacerbation	Oct 2014

Payment Improvement Initiative
Episodes of Care

Scale of EOC Program	
Current annual spend on all episodes that have been implemented	$179.3 million
Total annual spend on all additional potential episodes for PAPs involved with the episodes that have been implemented	$995 million

Annual Savings Potentially Attributable to the EOC Program			
	Affected Spend	Low Cost Projection	High Cost Projection
Episodes that have been in place for at least one year and analyzed – 7 episodes	$63.9 million	$6.7 million	$11.7 million
All implemented episodes – 14 episodes (with savings assumptions based on existing episodes)	$179.3 million	$6.9 million	$28.2 million

Payment Improvement Initiative
Episodes of Care

Major Costs for EOC Program (design, development, and implementation to date)	
McKinsey contract (EOC allocation only)	$39 million (SFY12-15)
GDIT	$3.5 million (SFY14 only)
HP amendment (MMIS)	$20.1 million (SFY12-15)
Total	$62.6 million

Episode Cost Analysis	
Total number of active episodes (designed, developed, and implemented	14
Estimated cost per episode (design, development, and implementation)	$4.5 million
Estimated annual savings per episode	$1-1.7 million

Payment Improvement Initiative Episodes of Care

- Potential EOC program impact mechanisms
  - Episode cost reduction – Lower costs for episodes
  - Episode avoidance (appropriate) – Providers not initiating episodes on borderline or high-risk cases
  - Episode avoidance (inappropriate) – Providers adding diagnoses or changing diagnoses to avoid triggering episodes
  - Service substitution – Providing or prescribing health services other than those that might trigger an episode

Payment Improvement Initiative
Episodes of Care

Factors that confound the analysis of the impact of the EOC program
EOC, PCMH, and PO rolled-out at similar times
National macroeconomic factors may change the number and type of beneficiaries in traditional Medicaid
Recent low growth in national health expenditures

Factors that might increase the effectiveness of the EOC program in the future
Learning curve
Induced cost-savings for other procedures and diagnoses

Episodes of Care: Summary of Early Findings

- The EOC Model was thoughtfully designed and constructed, with characteristics that focus on both medical cost & quality, with upside & downside impact for PAP.
- Measurable positive results, bending or flattening of the cost curve, have been observed.
- Sharing of information among PO Payers and DHS could generate greater value from EOCs to all parties
- Key concerns are the time and cost of EOC development, expansion, implementation and operational maintenance.

Potential to simulate DRG Payment Model with claims data

- There is an opportunity to evaluate what a DRG payment model may yield compared to the current reimbursement method.
- DRGs may serve as placeholders until EOCs are established, or they can serve as a complimentary model where EOCs may not be necessary or optimal.
- Speed and reasonable cost of DRG implementation would allow for potential savings sooner.
- Universal acceptance by providers with Medicare and Commercial patients is also an advantage.

Other Areas to Investigate

- High Cost Cases – Review of current models and alternative strategies.
- Behavioral Health – Initiate comparisons of cost & quality against other models from others states.
- Medicare/Medicaid Crossover Payments – Investigate opportunities and compare against practices of other states.
- Other Areas of Potential Opportunity – Inappropriate Emergency Room Utilization, etc.

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Arkansas Health Care Reform Task Force: EEF Project and Eligibility Renewal

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EEF Project

- IBM recommitted to the continued investment in the Curam product
- PMO started 7/1/15 and is preparing a Gantt chart with dependencies
- Federal APD updated with $188 mil total project funding
- Procurement for Traditional Medicaid work moving forward with a July 2016 start date for new contracts
- Extensions to two sole source contracts required to get from current end dates to the July 2016 start date

EEF Project – Correction to Status Report

- The status report pulled dates from an older document. Here are the correct dates for when these Code Releases went into Production
  - Release 1.6.1 on 6/15/15
  - SP 17 on 6/4/15
  - SP 18 on 7/8/15
  - Release 1.8 on 6/30/15

Eligibility Renewal/Change–Process

Six ways Change in Eligibility Status can Happen:

1. Self-Reported Change
2. Cross System Change Reporting
3. Aging out of Medicaid Qualification
4. Beneficiary Death
5. Beneficiary Incarceration
6. Annual Renewal Review

Eligibility Renewal/Change–Status & Notes

The Annual Renewal Process - Preliminary Observations:

- Renewal is Based On Income Amount
- Standard is Federal "Reasonable Compatibility" - approximately within 10%
- To save time and cost DHS attempts to use other information sources when possible (ex parte) rather than manual Case Worker review of documents.
- Primary source is the Unemployment Insurance database managed by the Department of Workforce Services
- Secondary source is Income information from other assistance programs: TANF/TEA or SNAP
- If the beneficiary is deemed Reasonably Compatible they are renewed, but still sent a letter indicating they must report any relevant change.

Eligibility Renewal/Change–Status & Notes

Annual Renewal Process *continued*

- If the beneficiary was not renewed through one of the ex parte soures a manual verification process is initiated.
- They receive a letter with notification that they have 10 days to provide documentation verifying their income amount. (15 days with processing time)
- Some individual cases are granted more time by Case Workers if justified.
- If the beneficiary provides the information they are renewed.
- If they do not provide the information within the time limit the client is sent a notice of Adverse Action which notifies the client they have 10 days to file an appeal.
- Actual dis-enrollment occurs at the end of the month when they failed to respond successfully or their appeal was denied.

Eligibility Renewal/Change–Status & Notes

Annual Renewal process *continued*

- The client then has 90 days to provide the appropriate documentation and re-enroll with no loss in coverage.
- After 90 days the client must apply as a new applicant and they cannot retroactively recover their coverage for the interim period.
- **Observation:** Reviewing Income of Beneficiaries more often may provide significant savings for the state. This option is being assessed by TSG as part of its scrub and will be part of our Final Report.
- Difficulties:
  - May be need for a Federal Waiver;
  - Accurate costs of reviewing more often needs to be considered;

Eligibility Renewal/Change–Status & Notes

Beneficiary Death Match

- Monthly DHS provides list of Beneficiaries to Dept. of Health (DoH)
- DoH compares beneficiaries to deceased list – sends match list back to DHS
- Approximtaely 100 deceased beneficiaries per month
- Case closed administratively at end of Month,
- Case closed for payment at Date of Death
- Some cases wait on delays in actual certification
- Medicaid OMIG identified 125 deceased beneficiaries and approximately $430,000 overpayments recovered, ~70,000 remaining
- DCO asked to assure OMIG of corrective action plan
- Automated system between DoH and DCO is not currently in EEF plan
- There are a handful of cases still under active review
- TSG will continue to review and issue will be part of our scrub and findings

Eligibility Renewal/Change–Status & Notes

Potential Issue of Concern: Beneficiary Incarceration

- Dept of Corrections reports incarceration data for Federal Incarceration database. Federal/SSA maintains a composite incarceration report.
- DHS cross checks beneficiaries in the legacy database against the incarceration report.
- DHS plans to cross check beneficiaries in the new IBM/Curam database at some point in the future, but not on the near term immediate planning list.
- TSG will be reviewing this issue as part of its scrub to identify whether there are issues of concern and opportunities for ensuring premiums are not paid to carriers during incarceration.

Eligibility Renewal/Change–Status Update

Annual Renewal – Backlog Recovery

Count	%	Description
594,000		Total to be Renewed if Caught up by eo September
225,400	38%	Renewals Initiated
62,300	10%	Renewed
24,500	4%	Coverage Terminated
138,700	23%	Renewals in Progress

** Note: CANNOT extrapolate eventual totals using above percentages because mix is not random & ultimate outcome after 90 days adjustments NOT known!*

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Arkansas Health Care Reform Task Force: Contracts Observations

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Top 13 Contracts, by Total Value

	Contractor Name	Contract	Total Value	2016 $
1	HP Enterprise Services, LLC	MMIS Core	203,000,000	27,708,092
2	HP Enterprise Services, LLC	MMIS Fiscal Agent	200,000,000	57,106,070
3	Palco	Self Directed Service Budget Counseling Support	55,477,760	9,235,460
4	Magellan	MMIS Pharmacy	43,325,000	7,497,588
5	Arkansas Foundation for Medical Care	To develop, review, implement & update criteria for utilization for PA's and extensions of benefits	39,240,137	6,524,687
6	UAMS Dept of Obstetrics & Gynecology	Center for Distance Health - Formally (ANGELS) & (SAVE)	31,372,304	31,372,304
7	Value Options Inc.	Mental Health Determination - Outpatient	30,614,849	4,765,594
8	General Dynamics Information Technology Inc (GDIT)	Analytical Episode	30,000,000	4,330,000
9	Health Management Systems, Inc.	Third Party Liability & Recovery Services (TPL)	29,171,660	4,707,380
10	Palco	Self Directed Service Budget Financial Management Services	24,112,200	2,454,600
11	Cognosante, LLC	MMIS PMO	18,134,893	5,395,727
12	AFMC	Medicaid Beneficiary Relations and Non Emergency Transportation (NET) Administration	16,200,925	4,023,577
13	McKinsey and Company	AR Health Care Payment Improvement Initiative	15,400,000	15,400,000

Top Contracts: 14 - 25

	Contractor Name	Contract	Total Value	2016 $
14	ValueOptions Inc.	Mental Health Determination - Inpatient	14,898,576	2,724,788
15	Optum	MMIS Decision Support System (DSS)	13,690,718	13,690,718
16	AFMC	Medicaid Quality Improvement	12,000,000	2,729,382
17	Office Of Health Technology - OHIT	PCMH Model	11,191,221	5,595,611
18	AFMC	AR Innovative Performance Program (AIPP) for Long Term Care facilities	10,469,618	1,545,508
19	AFMC	Medicaid Provider Representative	10,139,885	2,064,512
20	Cognosante, LLC	DHS IT Project Management Office	9,642,211	9,642,211
21	Datapath	Private Option Health Care Independence Accounts	8,200,000	8,200,000
22	AFMC	Retrospective Reviews of physical, speech, and occupational therapies and PA's for personnal care for under age 21	8,062,908	1,151,844
23	Pine Bluff Psy. Associates	DDS Procurement of Independent Assessors School Age Assessments	6,281,550	930,600
24	AR Dept of Health	Medicaid Outreach & Education ConnectCare and provide information in the Primary Care Case Management (PCCM) program & support ARKids 1st info line	6,000,000	2,862,302
25	Health Services Advisory Group, Inc.	Medicaid Data Mining and Program Evaluation	5,606,984	896,764

Observations on Top 25 Contracts

- TSG reviewed the top 25 contracts to see how DHS procured these vendors, how the spend changes from year to year, what the deliverables are, what the performance indicators are, and what the remedies for unacceptable performance are.
- Standard clauses which are very favorable to the State include cancellation provisions, dispute resolution, subcontractor control, indemnification, and payment of legal fees.
- All contracts have the requirement for the vendor to submit and implement a corrective action plan for any issues within the scope of the contract.
- All contracts have the option to withhold or reduce payment. Most contracts lack specificity around the withholding or reducing of payments.

Observations on Top 25 Contracts cont.

- DHS consistently manages vendors on a year-by-year basis over the course of the seven years a procurement can cover.
- DHS has some strong examples of contracts with specific deliverables and consequences for missing deliverables.
- DHS has some great examples of making vendors live up to the promises they made in their proposals.
- Unfortunately, DHS also has many examples of performance indicators that are little more than a statement of work (or scope statement) and do not demand a quantitative, quality oriented standard for how the work is to be delivered.
- Of the 25 contracts reviewed, 18 were a result of a competitive bid, four were sole source and three were intergovernmental agency agreements. Given the dollar amount of these contracts, it is surprising to see the sole source contracts to HP, McKinsey, Cognosante, and Datapath.

McKinsey Contract

- McKinsey outlined a deliverable framework for their work this fiscal year
- TSG responded with a more detailed document with 53 separate deliverables
- Recommend clarity around what happens if DHS does not move forward on all 10 episodes of care
- Recommend more clarity, or even competitive procurement on potential RFP work and the $1.5 mil "as determined by DHS" bucket of money
- McKinsey and DHS reviewed TSG recommendations and agreed to most changes. Still finalizing wording changes, how DHS will authorize work, how McKinsey gets paid for work done to date if DHS doesn't proceed, and the content of the $1.5 mil deliverable.