



Bureau of Legislative Research

Arkansas Health Care Reform Task Force

TSG Update to the Task Force
August 19, 2015

Agenda

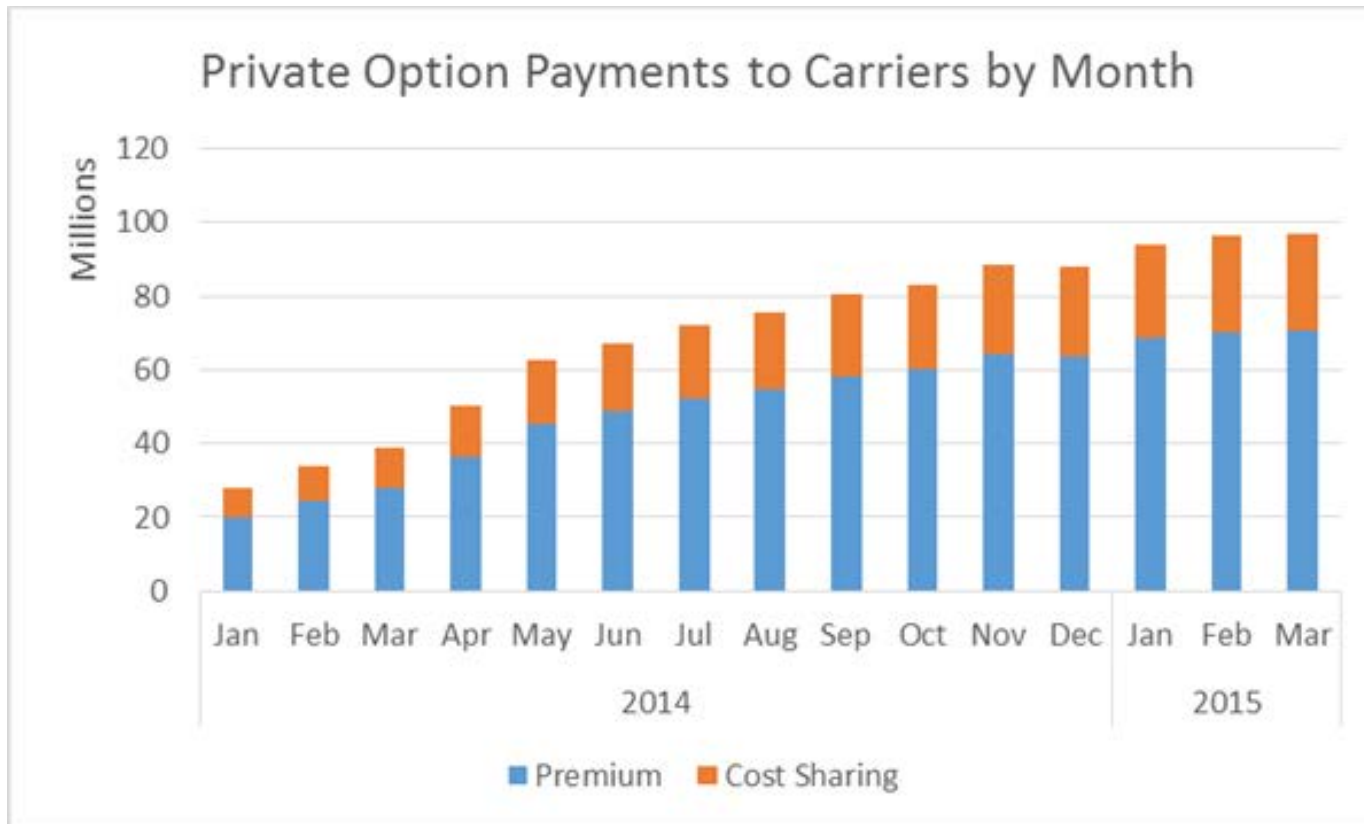
August 19

- Update on Private Option Claims Data Analysis
- Financial Forecast for Private Option and Traditional Medicaid
- High Cost Population Data
- Arkansas Medicaid Spending Comparison
- Update on State Waivers for Expanded Medicaid

Update on Claims Data Analysis

- TSG is in the middle of analyzing over 140 million lines of claims.
- Purpose: better understand the expansion population
 - How they compare to traditional Medicaid
 - What types of claims are carriers experience
 - What is the level of claims experience compared to traditional Medicaid FFS, and to the premiums (and cost share) as well as to the ACA required Medical Loss Ratio

Private Option Carriers are Receiving Cost Share Payments



Payments Add up to a PMPM Cost of \$484

	Members at 12/31	Member Months	Premiums Paid	PMPM based on Premium
Carrier 1	141,458	1,172,978	535,963,758	\$457
Carrier 2	39,430	337,403	196,095,108	\$581
Carrier 3	20,233	68,914	32,404,755	\$470
Overall	201,121	1,579,295	764,463,621	\$484

TSG Has Reviewed Claims to Estimate Carrier Costs and \$382 PMPM

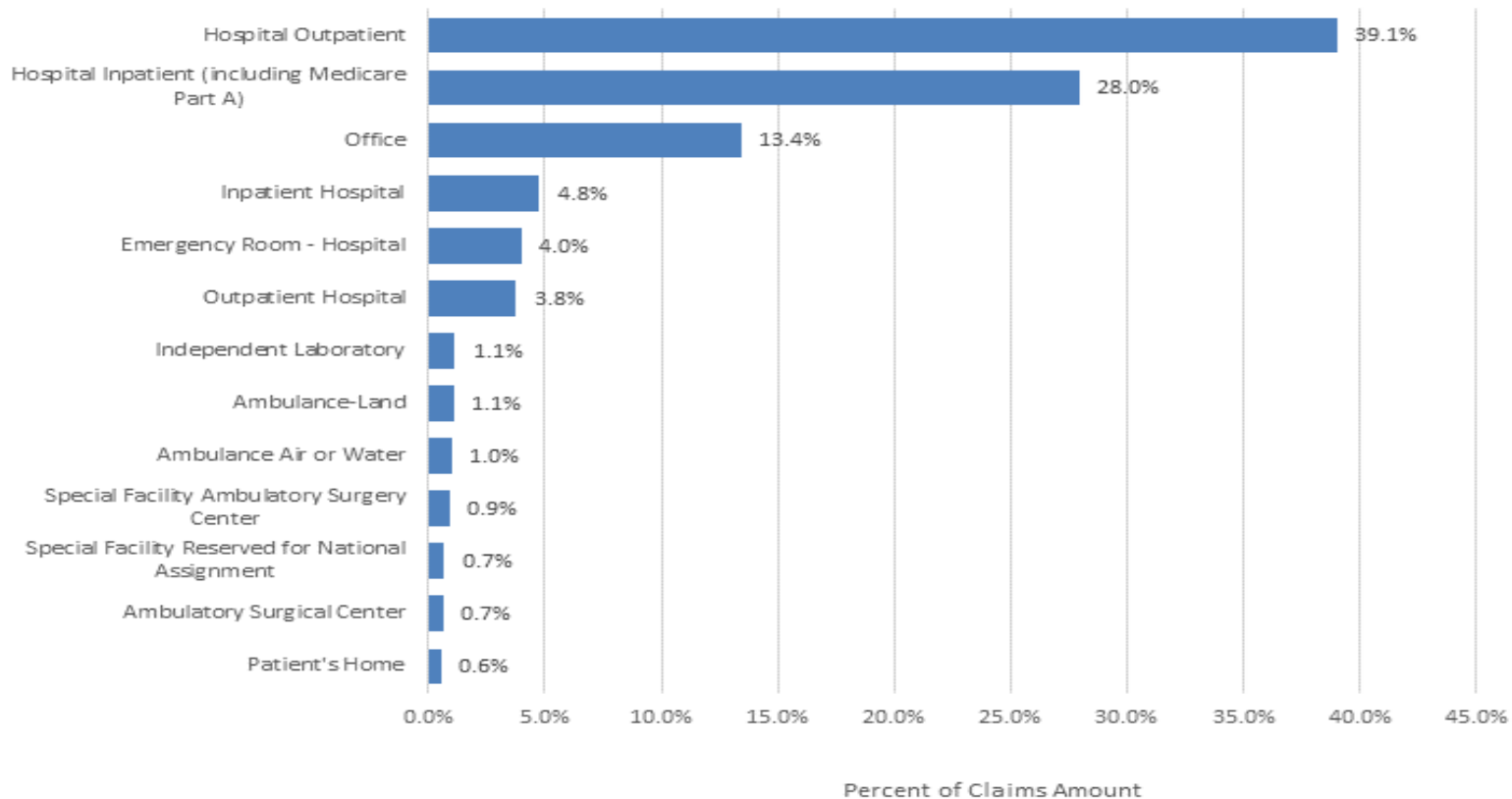
	PMPM based on Claims
Carrier 1	\$389.64
Carrier 2	\$339.66
Carrier 3	\$459.22
Total	\$382.00

Carriers' Largest Source of Claim Payments is Inpatient Hospitals

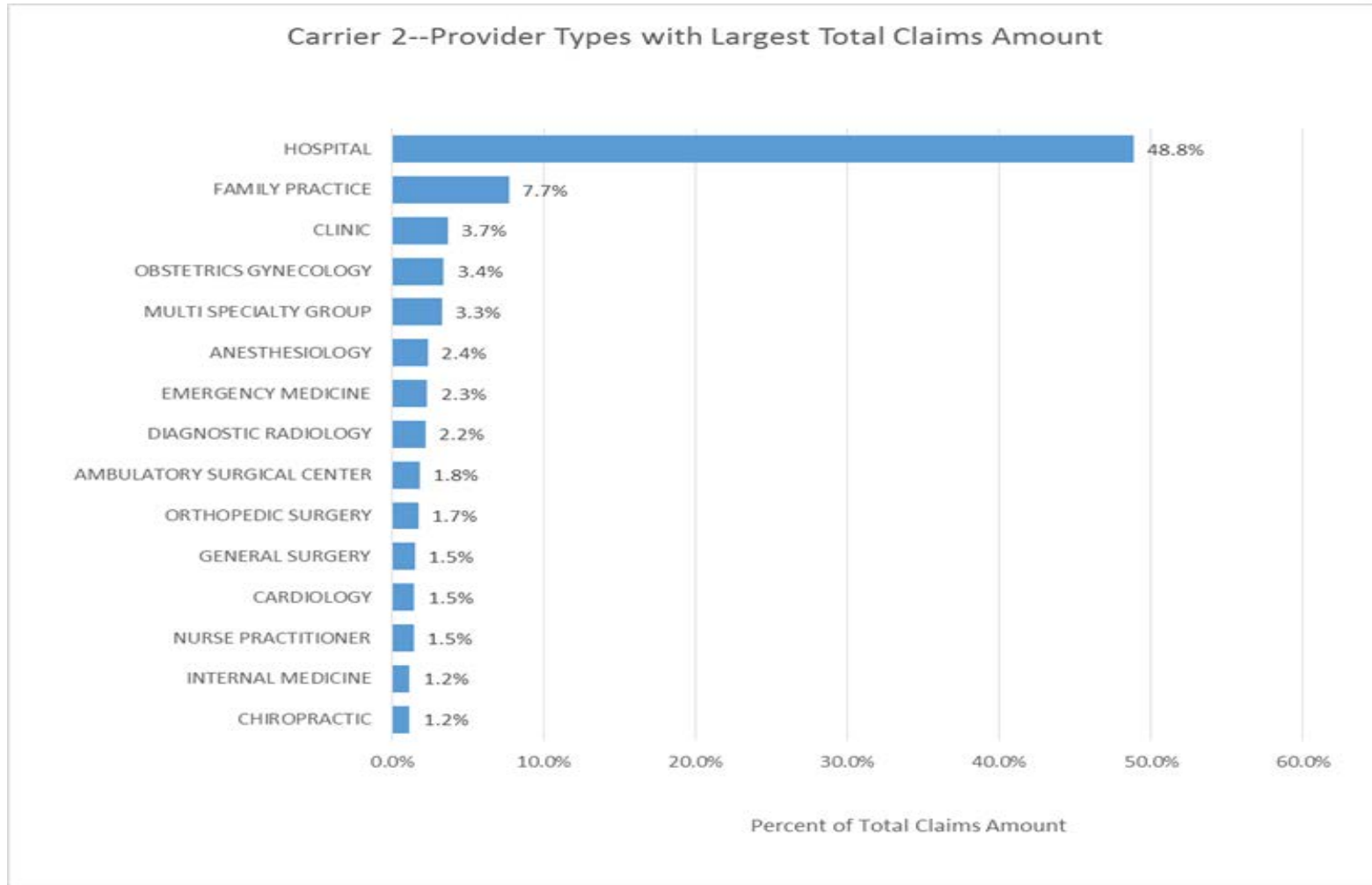
	Total	Percent of Carrier Claims
Inpatient Hospital	148,505,758	25%
Office	119,942,467	20%
Outpatient Hospital	114,976,853	19%
Pharmacy	98,173,400	16%
Emergency Room - Hospital	58,672,096	10%
Ambulatory Surgical Center	13,369,223	2%
Other	49,644,067	8%

Breakdown of Carrier 1 Claims Per Provider Type

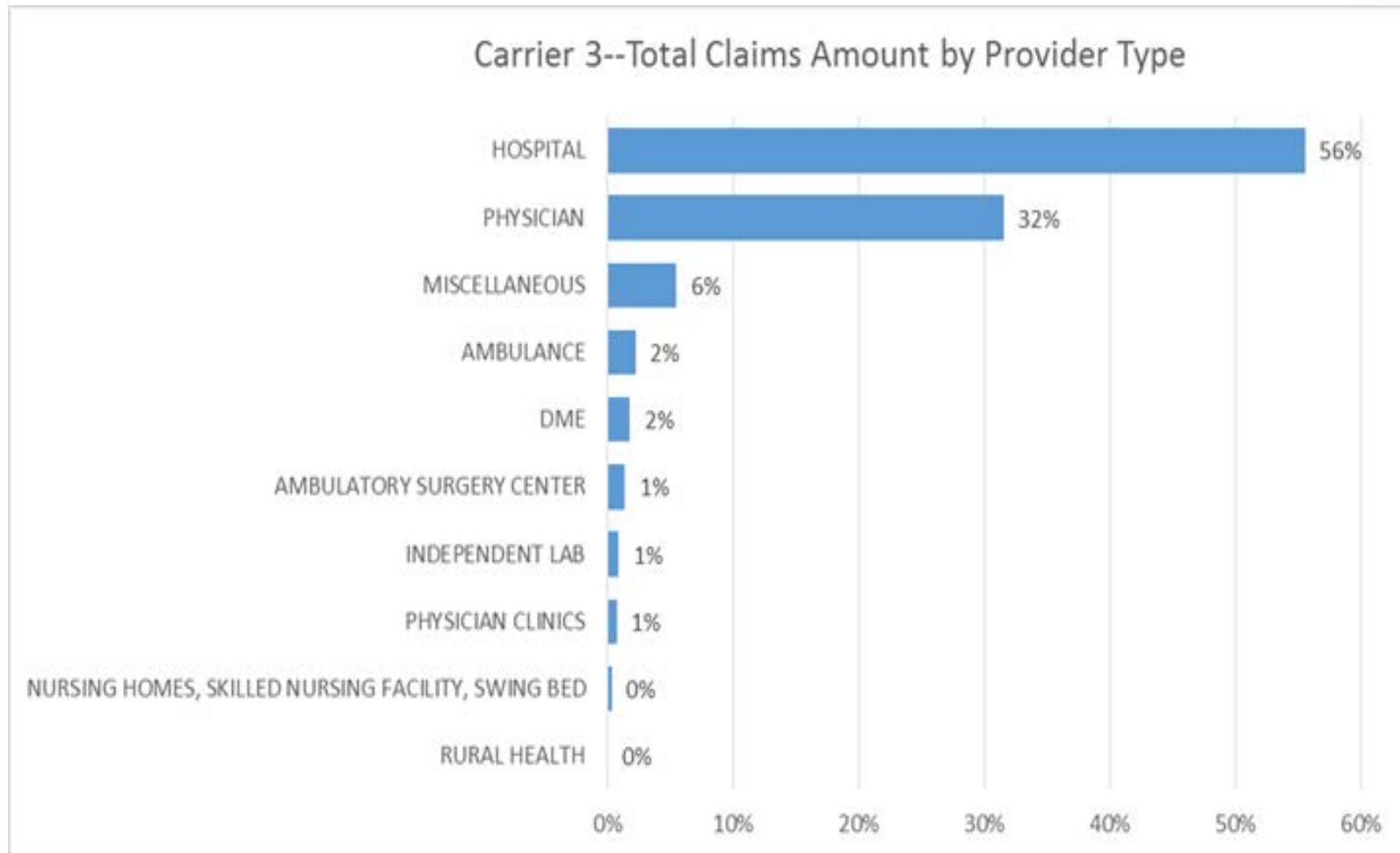
Carrier 1--Provider Types with Largest Total Claims Amount



Breakdown of Carrier 2 Claims Per Provider Type



Breakdown of Carrier 3 Claims Per Provider Type



The Largest Payees of Claims are the Large Hospitals

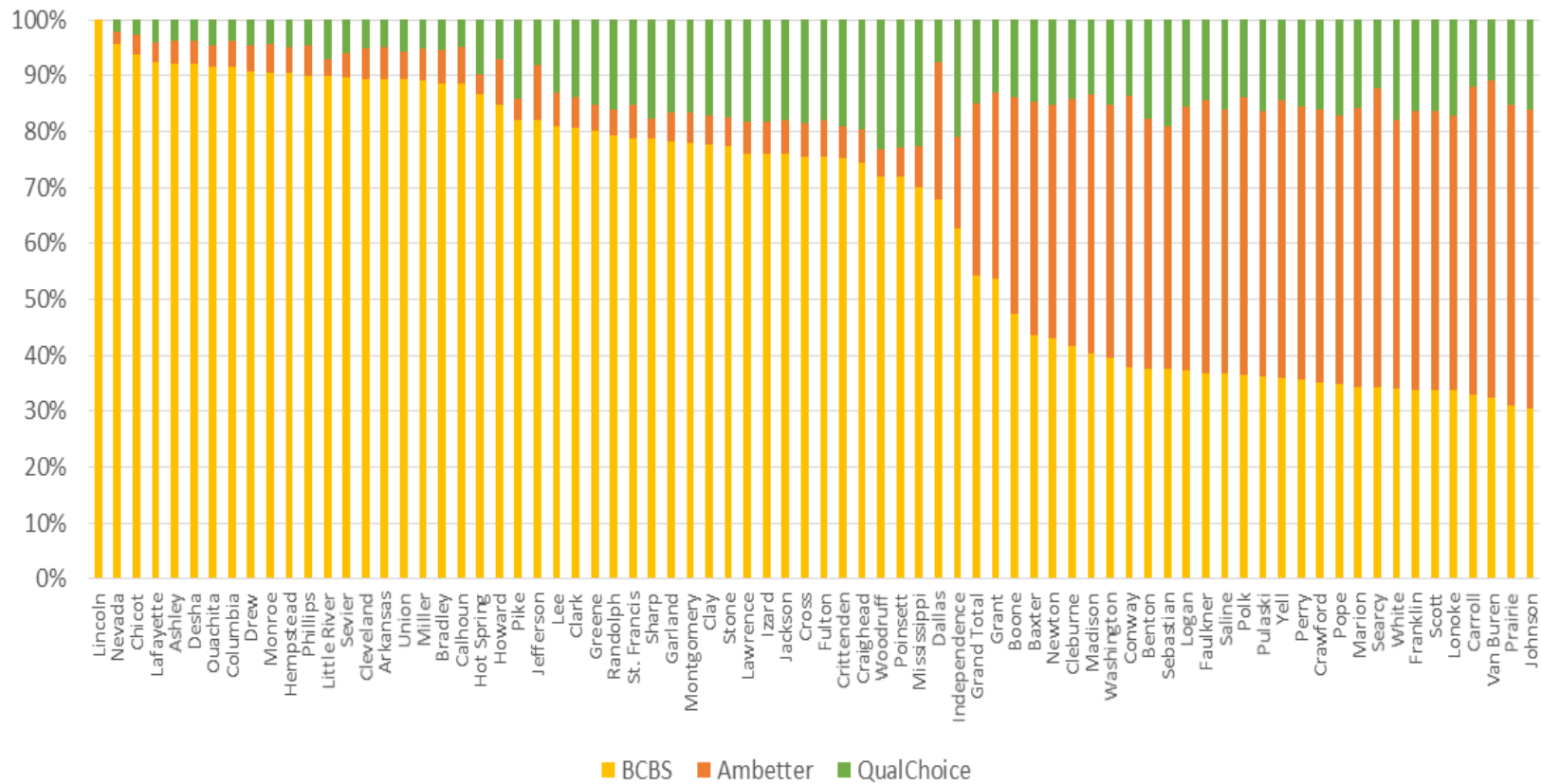
	Amount	Percent of Carrier Claims
UAMS-UNIV AR MED HOSPITAL	21,696,573	3.6%
BAPTIST HEALTH MED CTR LITTLE ROCK	19,567,107	3.2%
ST BERNARDS MEDICAL CENTER	14,509,431	2.4%
ST VINCENT INFIRMARY MEDICAL CENTER	13,187,430	2.2%
JEFFERSON REGI CENTER	9,696,803	1.6%
ST VINCENT HOSPITAL HOT SPRINGS	9,504,630	1.6%
WHITE RIVER MED CENTER	7,065,430	1.2%

The Largest Diagnoses are Acute Physical Conditions

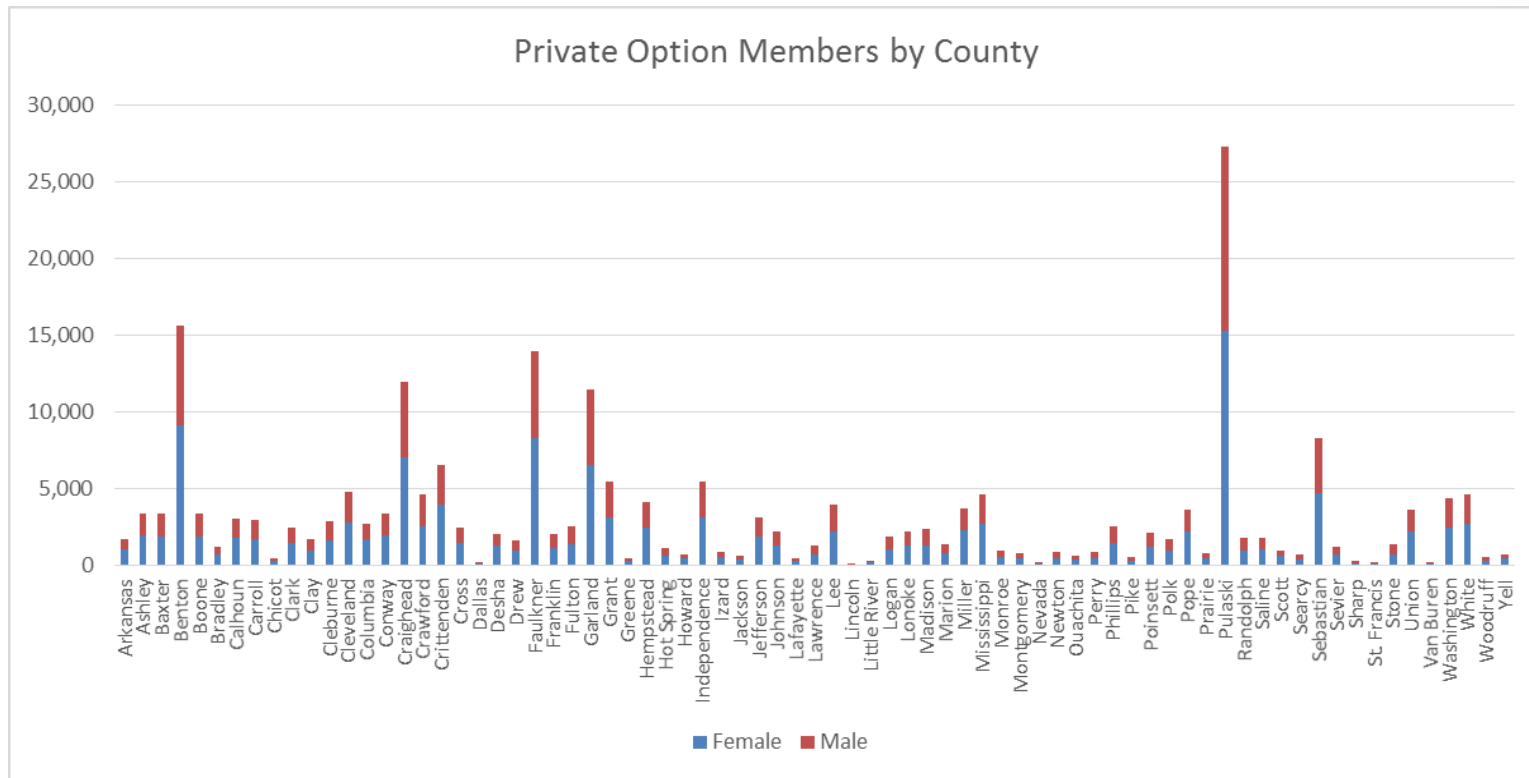
ICD-9	Description	Total
41401	Coronary atherosclerosis of native	9,117,395
78650	Chest pain, unspecified	7,637,595
389	Unspecified septicemia	5,806,359
7242	Lumbago	5,278,591
V5811	Encounter for antineoplastic chemot	5,102,586
4019	Abdominal pain, unspecified site	4,508,217
78900	Diabetes mellitus without mention o	4,326,602

Two Carriers Dominate the Market in their Territories

Private Option Carrier Market Share by County



There are a few Heavy Concentrations of Private Option Members

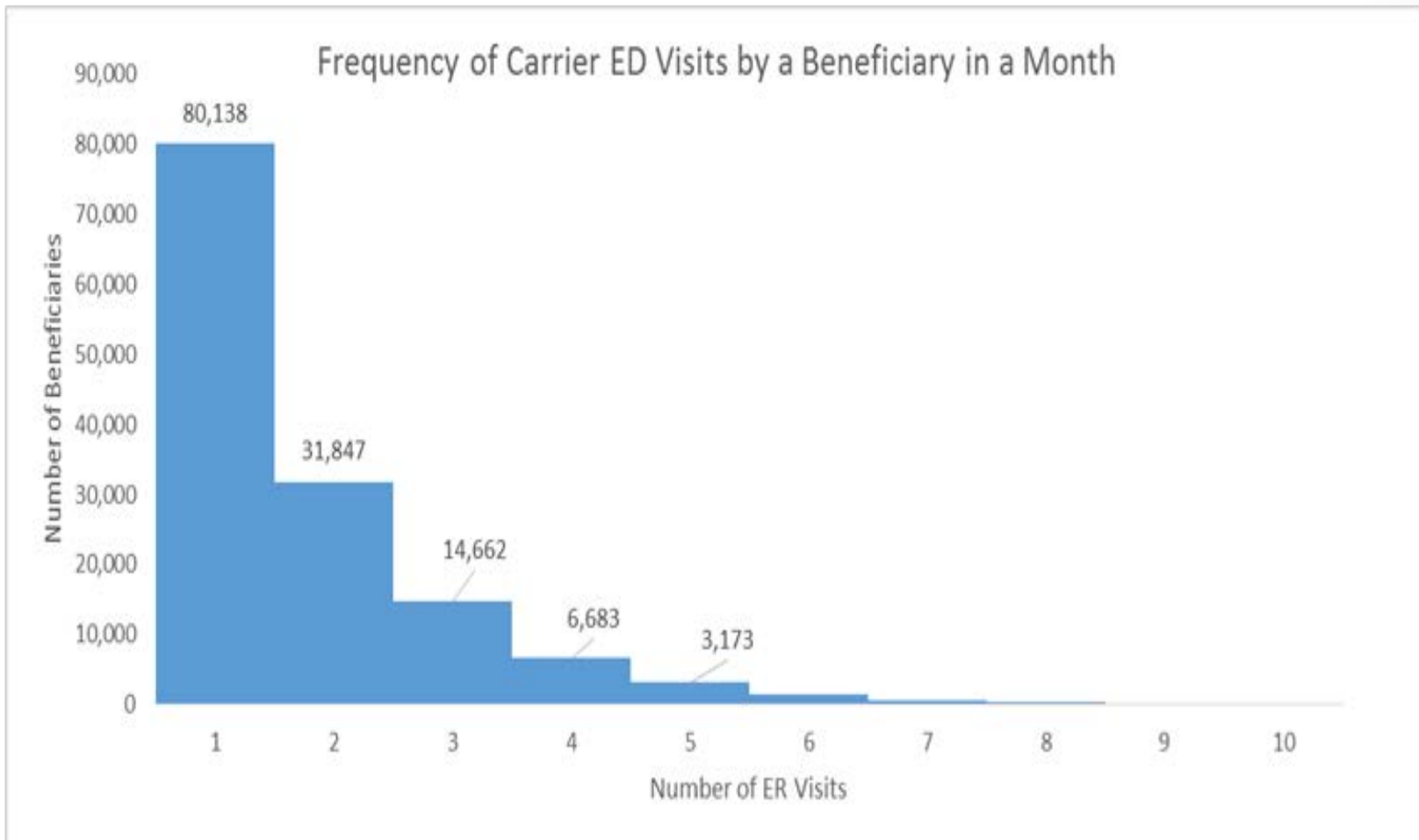


Emergency Department (ED) Concentration

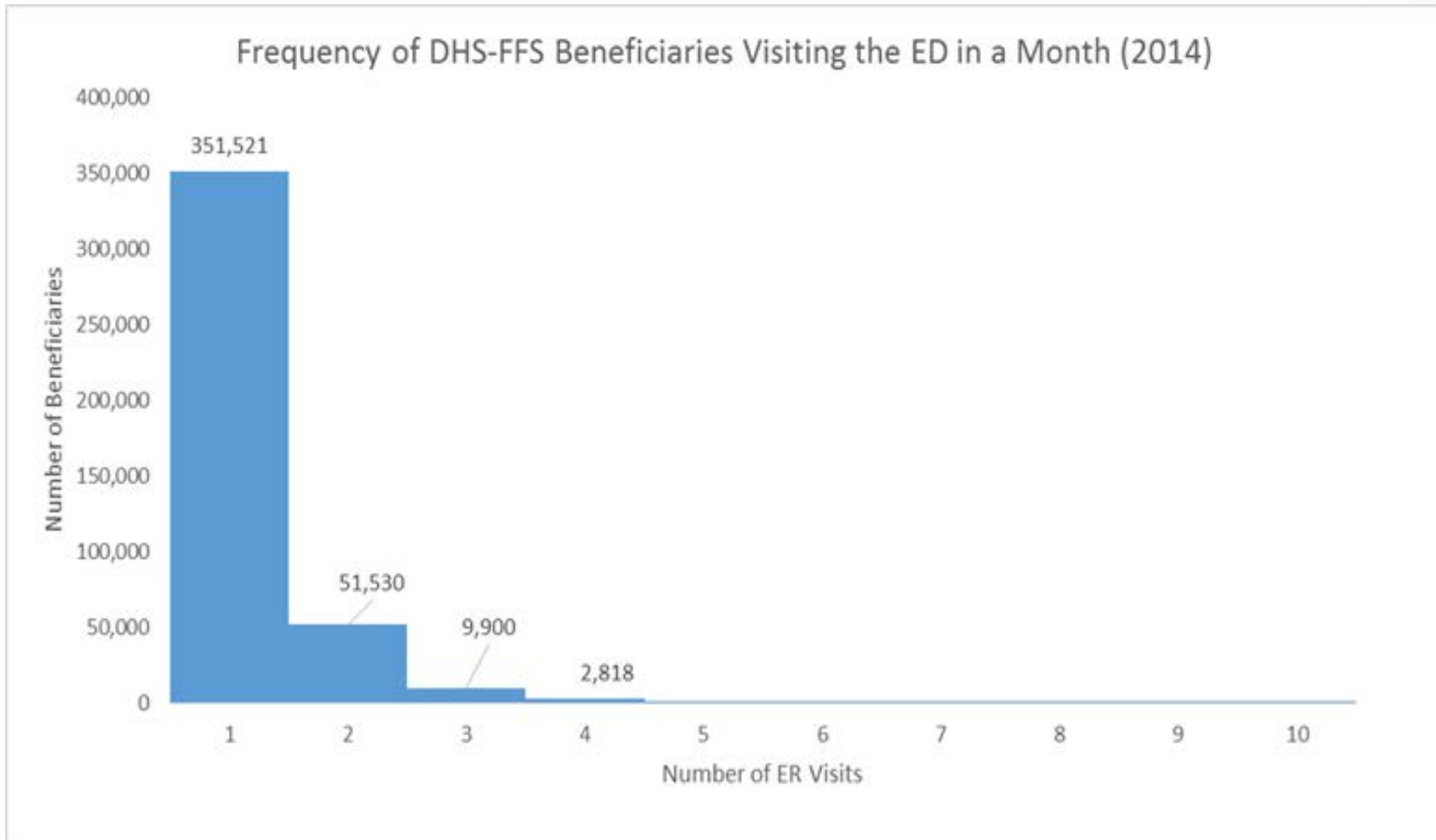
TSG will look at ED from the perspectives of:

- Frequent flyers (today)
- ED costs per member
- ED visits per member (e.g. per population)
- ED visits by PCP

Carriers are Experiencing Higher ED Repeat Visits Than Traditional Medicaid



Traditional Medicaid has Fewer Repeat Visits in a Month



Private Option Members per FPL

FPL	Med Frail	QHP	Total	%
0 - 50%	14,348	105,084	119,432	53.7
50.1 - 100%	5,314	56,474	61,788	27.8
100.1 – 115%	1,566	17,063	18,629	8.3
115.1 – 129%	1,267	14,076	15,343	7
129.1 – 138%	609	6,186	6,795	.03
Unknown	1	16	17	
Total	23,102	198,904	222,006	

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- Update on Private Option Claims Data Analysis
- **Financial Forecast for Private Option and Traditional Medicaid**
- Long Term Care and Behavioral Health Data – continued high cost population data
- State by State Comparisons
- Update on State Waivers for Expanded Medicaid

Critical Planning Factors

TSG is working to offer the most realistic range of forecasts, based on the critical assumptions:

- Populations growth, especially in the elder and high-cost segments
- While baby boomers will develop into the Aged, the best predictions (US Admin on Aging) is that the Aged population will shift from 22% to 26% of total by 2020, that is 0.35% change per year.
- Aged population growth is more impactful on Arkansas Medicaid spending because of higher reliance on institution
- Federal Match and National Economy
- TSG believes prudent to use high end projections in forecasting

CMS Projecting Health Care Spending to be over 5% per year through 2021

- CMS projecting for 2015 to 2024, Medicaid spending growth will increase 5.9% per year on average, “reflecting more gradual growth in enrollment as well as increased spending per beneficiary due to aging of the population.” See <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/proj2014.pdf>.
- “Health spending is projected to grow 1.1 percent faster than Gross Domestic Product (GDP) per year over this period; as a result, the health share of GDP is expected to rise from 17.4 percent in 2013 to 19.6 percent by 2024.”
- Deloitte predicts national health care costs will increase over 6.5% over next five years

Private Option Forecast 2017 - 2021

Projected Aggregate Private Option Impact (SFY 2017-2021)							
<i>(all figures millions \$ unless otherwise indicated)</i>							
		2017	2018	2019	2020	2021	2017-2021
Private option expenditures		1,721	1,820	1,924	2,035	2,152	9,652
Impact on State Funds							
Impact on state expenditures	State match on Private Option	43	100	125	173	215	656
	State fund savings from optional Medicaid waiver programs discontinued after the establishment of the PO	(22)	(23)	(25)	(26)	(27)	(123)
	State fund savings from cost-shifting from traditional Medicaid to PO	(39)	(41)	(43)	(45)	(47)	(214)
	Administrative costs	3	3	3	3	3	14
	Reductions in state fund outlays for uncompensated care	(37)	(39)	(41)	(43)	(45)	(203)
	Total impact on expenditures	(52)	0	20	63	99	130
	Impact on state revenues	Increase in premium tax revenue	37	39	41	44	46
Increase in collections from economically-sensitive taxes (4%)		67	69	72	74	77	360
Total impact on revenues		104	108	113	118	124	567
Net impact on state funds	156	108	93	56	25	438	

Finance Factors of Private Option

- State general fund savings from optional Medicaid programs discontinued after the establishment of the private option:
 - ARHealthNetwork
 - Family Planning
 - Tuberculosis
 - Breast and Cervical
- Cost Shifting from traditional Medicaid to the private option:
 - Medically needy
 - Aged blind disabled
 - SSI disability
 - Pregnant women
- Uncompensated Care
- Premium Tax
- State Tax collections on additional federal dollars

Traditional Medicaid Forecast

Medicaid Projected All Funds								
Growth Scenario	2015	2016	2017	2018	2019	2020	2021	
5%	5,119,522,073	5,375,498,177	5,644,273,086	5,926,486,740	6,222,811,077	6,533,951,631	6,860,649,213	
6%	5,119,522,073	5,426,693,398	5,752,295,002	6,097,432,702	6,463,278,664	6,851,075,384	7,262,139,907	
7%	5,119,522,073	5,477,888,619	5,861,340,822	6,271,634,679	6,710,649,107	7,180,394,544	7,683,022,162	
8%	5,119,522,073	5,529,083,839	5,971,410,546	6,449,123,390	6,965,053,261	7,522,257,522	8,124,038,124	
9%	5,119,522,073	5,580,279,060	6,082,504,175	6,629,929,551	7,226,623,211	7,877,019,300	8,585,951,037	
10%	5,119,522,073	5,631,474,281	6,194,621,709	6,814,083,880	7,495,492,268	8,245,041,494	9,069,545,644	
Medicaid Projected General Revenue								
Growth Scenario	2015	2016	2017	2018	2019	2020	2021	
5%	1,535,856,622	1,612,649,453	1,693,281,926	1,777,946,022	1,866,843,323	1,960,185,489	2,058,194,764	
6%	1,535,856,622	1,628,008,019	1,725,688,500	1,829,229,811	1,938,983,599	2,055,322,615	2,178,641,972	
7%	1,535,856,622	1,643,366,586	1,758,402,247	1,881,490,404	2,013,194,732	2,154,118,363	2,304,906,649	
8%	1,535,856,622	1,658,725,152	1,791,423,164	1,934,737,017	2,089,515,978	2,256,677,257	2,437,211,437	
9%	1,535,856,622	1,674,083,718	1,824,751,253	1,988,978,865	2,167,986,963	2,363,105,790	2,575,785,311	
10%	1,535,856,622	1,689,442,284	1,858,386,513	2,044,225,164	2,248,647,680	2,473,512,448	2,720,863,693	
Medicaid Projected General Revenue Increase over SFY15 level								
Growth Scenario	2015	2016	2017	2018	2019	2020	2021	Aggregate increases over SFY15 level
5%	0	76,792,831	157,425,304	242,089,400	330,986,701	424,328,867	522,338,142	1,753,961,245
6%	0	92,151,397	189,831,878	293,373,189	403,126,977	519,465,993	642,785,350	2,140,734,785
7%	0	107,509,964	222,545,625	345,633,782	477,338,110	618,261,741	769,050,027	2,540,339,248
8%	0	122,868,530	255,566,542	398,880,395	553,659,356	720,820,635	901,354,815	2,953,150,273
9%	0	138,227,096	288,894,631	453,122,243	632,130,341	827,249,168	1,039,928,689	3,379,552,168
10%	0	153,585,662	322,529,891	508,368,542	712,791,058	937,655,826	1,185,007,071	3,819,938,050

Traditional Medicaid Will Outstrip any State Fiscal Impact of Private Option

- Amount of additional general funds needed to sustain the traditional Medicaid program beginning in calendar year 2016 to 2021, will be approximately \$1.75 billion dollars of general funds, or greater if the higher range estimates for growth become a reality
- Without change, this could put the state in the situation of looking to find \$75 million to \$100 million in new revenue each year simply to sustain the program
- State leaders should put equal or greater focus on traditional Medicaid as on the expanded population.

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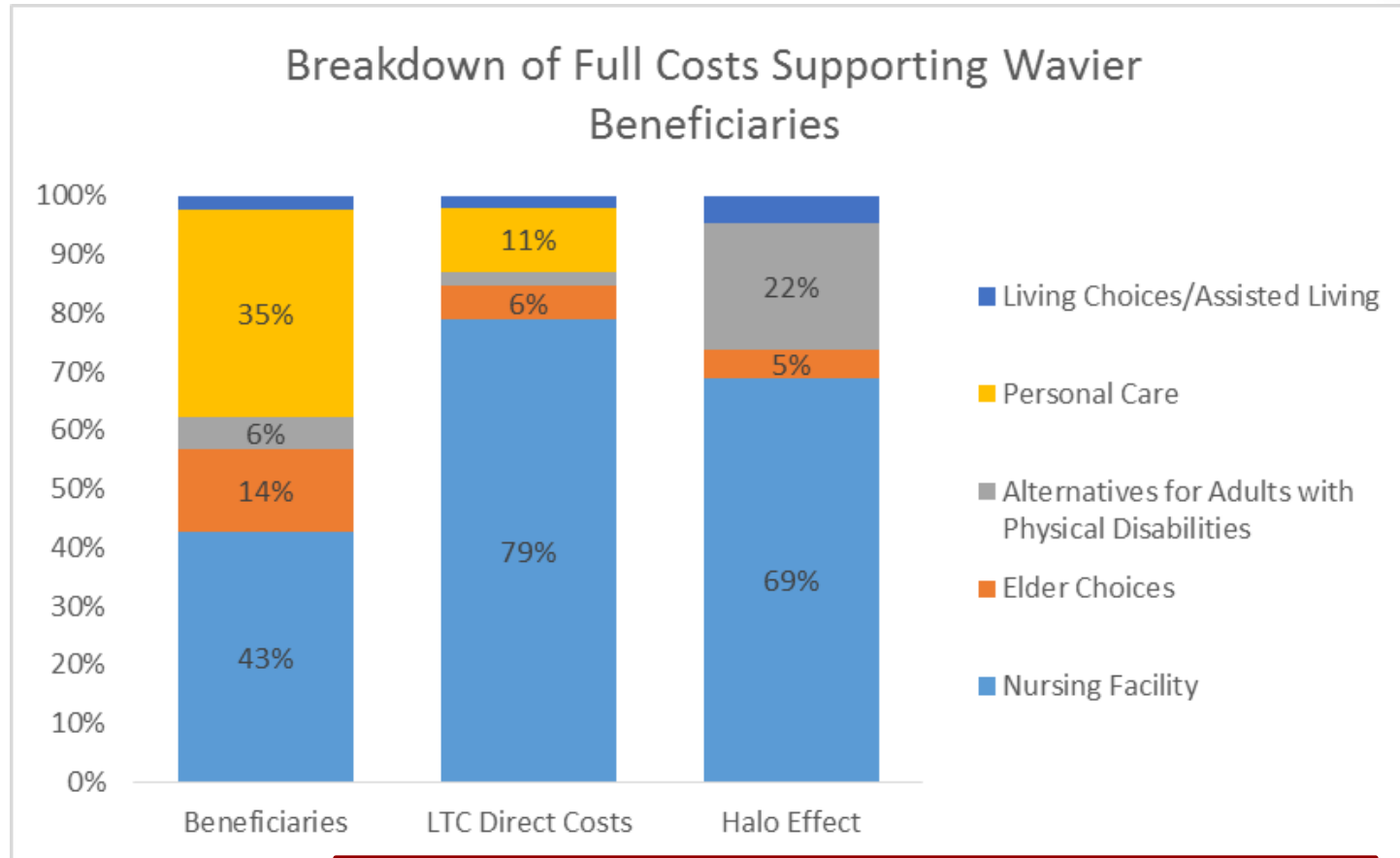
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Traditional Medicaid High Cost Population Data

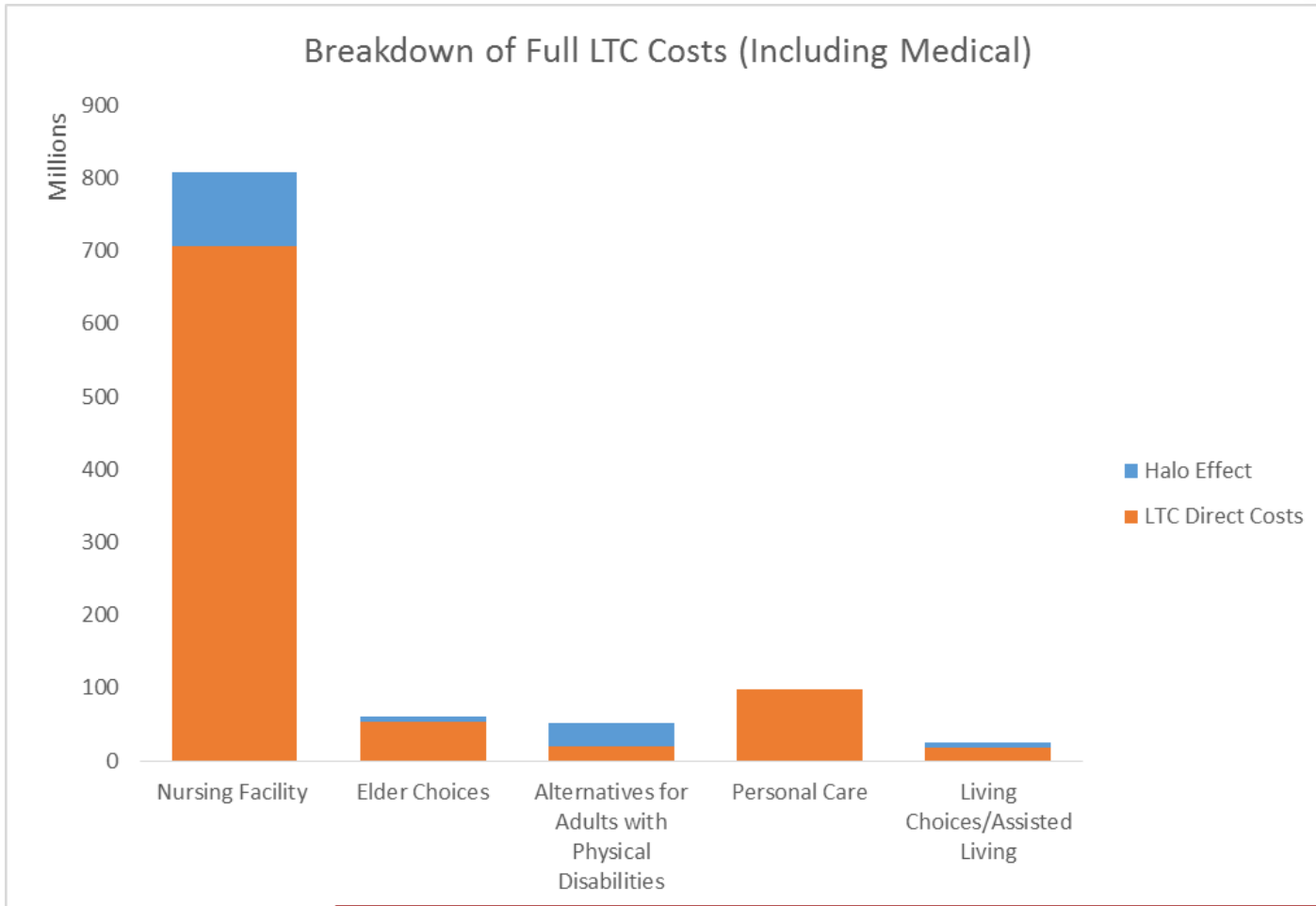
- In 2013, DHS reported data in relation to Payment Improvement Initiative that identified Arkansas as spending too much on high-cost Nursing Home care, rather than Assisted Living or Home and Community based settings
- TSG has updated the analysis, to find that the situation persists
- In fact, DHS has no comprehensive approach and plan for care coordination for the high cost, multiple services population (“80% of spend goes for 20% of the Medicaid population”)
- While the PCMH model has elements of care coordination the model is essentially Primary Care focused and unconnected to the waiver(s) populations by design

Nursing Homes Represent a Disproportionate Share of the LTC \$



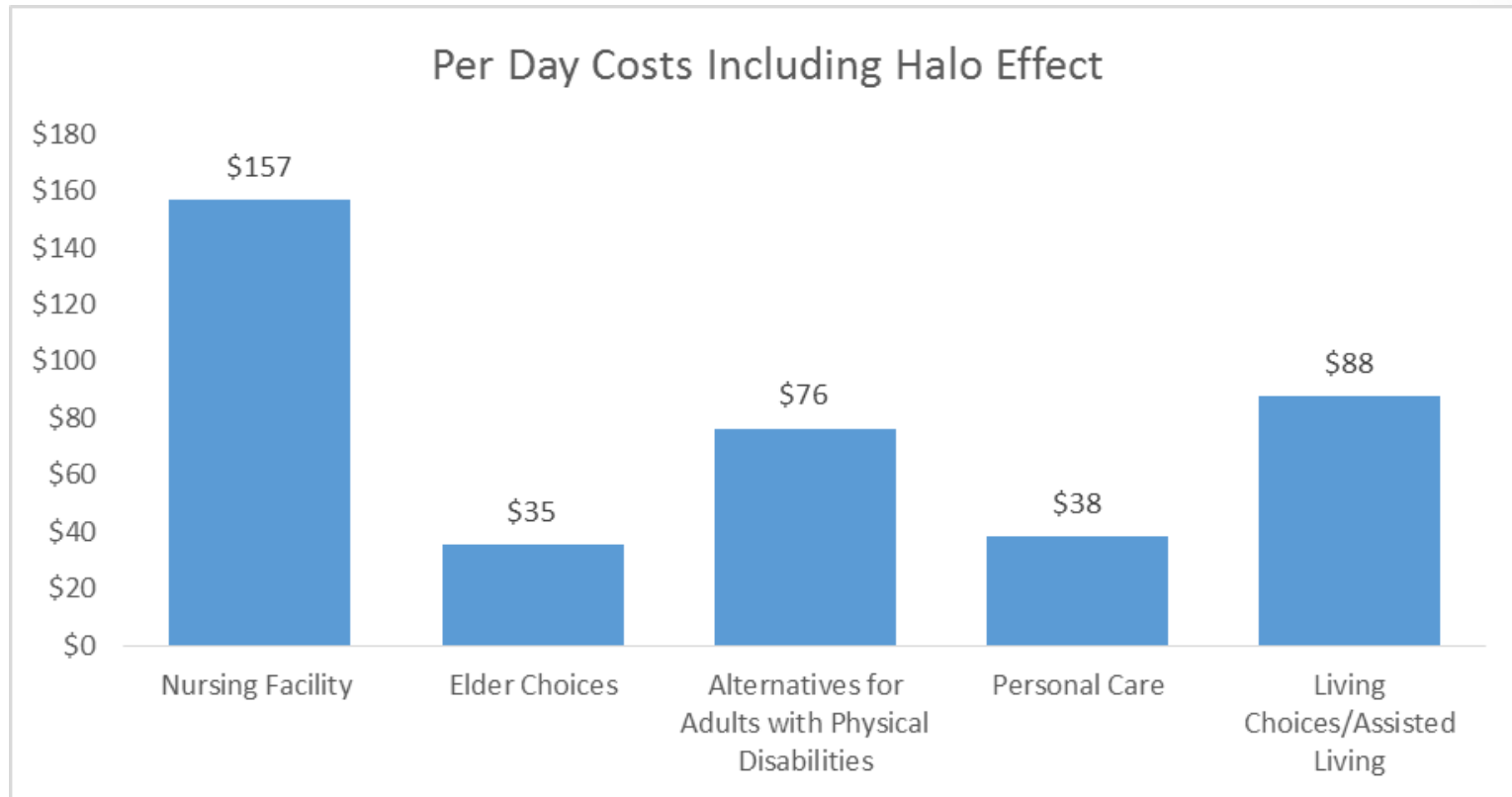
43% of the people consuming 79% of the direct costs—with no offset in Halo costs

Nursing Homes



Nursing Homes consume \$800MM annually, dwarfing all other forms of LTSS care

Nursing Homes are More Expensive Even After Considering the Halo Costs



5x the cost of Elder Choices and 2x the cost of Assisted Living...Yet AR continues to overuse them

Home and Community Based Services

- Recent Health Department announcement to cease Home Health operations is an opportunity to grow the provider market
- Rates have not been raised since 2008/2009 for many HCBS services and Assisted Living
- Medicaid modernization will have to address rates and NF payment reform
- Workforce development opportunities for partnerships with community colleges

Rehabilitative Services for Persons with Serious Mental Illness (RSPMI)

- 50 states + DC have MH Rehab Option Services
- 19 states FFS - 32 states managed care models
- RSPMI spending growing in Arkansas at unsustainable rate
- No standardized clinical assessments for behavioral health in Arkansas Medicaid
- RSPMI has virtually no benefits limits per authorization period, including inpatient/residential for under 21 population
- Value Options denial rate of 5% for all outpatient prior authorization requests

RSPMI

- No effective inpatient hospitalization, residential care or jail diversion systems in place
- RSPMI moratorium on new providers has resulted in a monopoly model in a non preferred provider model
- Lack of evidence based practices for adults and children/adolescents
- Lack of care coordination for all services for high need and expense population

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Arkansas Medicaid Spending Comparison

- Total Medicaid Spending per State Resident: \$1,408 (19th US)
- Total US Medicaid Spending per State Resident: \$1,369
- LTSS (LTC, IDD, BH Rehab) Spending per State Resident:
 - ❑ AR: \$628 (12th US) US: \$464: all LTSS
 - ❑ AR NH: \$217 (13th US): \$642 million (85%)
 - ❑ AR Aged/PD HCBS Community: \$39 (21st US): \$117 million (15%)
 - ❑ AR ICF/IDD: \$55 (12th US): \$163 million (48%)
 - ❑ AR IDD HCBS Community: \$60 (39th US): \$177 million (52%)
 - ❑ AR MH/SPMI Rehab: \$132 (1st US): \$390 million

All data sourced from FY 2013 Truven/Mathematica/CMS LTSS Report

Arkansas Medicaid Spending Comparison (cont.)

- Rehab option growth rate: FY 11: 45%; FY 12: 4%; FY 13: 25%
- IDD: Total spend: \$ 341 million; if 80% Community:\$273 million; (assumes 80% of people served) 20% ICF: \$68 million; increase HCBS: \$96 million
- UCP Case for Inclusion 2014: AR 47th, been at bottom since 2007; 14 states no state ICFs; 219 of 354 state ICFs closed since 1960
- AARP/Scan/Commonwealth 2014 LTC State Scorecard: AR ranked 40th; low in quality of life, few choices, and lacking effective transitions

Comparison to Surrounding States

	Total Medicaid Costs: Per State Resident	State Ranking*	Total LTSS Medicaid Costs: Per State Resident	State Ranking**	FY 2013 FMAP***
Arkansas	\$1,408	19	\$628	12	70.17%
Mississippi	1,583	13	504	19	73.43%
Louisiana	1,510	15	520	18	61.24%
Missouri	1,467	16	484	22	61.37%
Kansas	886	48	371	32	56.51%
Tennessee	1,337	20	368	33	66.13%
Oklahoma	1,247	27	344	39	64%
Texas	1,055	37	302	43	59.3%
US	\$1,369	NA	\$464	NA	NA

Source: Medicaid Expenditures for Long Term Services and Supports (LTSS) in FY 2013: Truven Health Analytics/Mathematica/CMS: 6/30/15: * Table AL; ** Table Y; *** ASPE FMAP 2013 Report

Medicaid Modernization Efforts

- Ohio announced a 7.6% total Medicaid budget savings of \$1.8 billion for FY 2015.
- Ohio has saved \$360 million over two years based on nursing facility payment reform
- Ohio embarked on Medicaid modernization in 2011.
- TennCare avoided \$250 million in additional nursing facility costs based on increased HCSB for past two years
- FY 2013 first year HCBS topped Institutional Care across the country for LTSS

Maintaining HCIP And Controlling Medicaid Spending Under ANY Assumption or Circumstance Will Require:

- Spending Constraints
- Innovation
- Laser Focused and Effective Management
- Ability to Control High Cost Spending
- “Community First” approach versus Institutional focus
- Effective Care Coordination and Care Management
- Personal Responsibility
- Focus on Public Integrity
- Support for Employers
- Promoting Independence

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Arkansas HCIP Waiver Comparison

- No Healthy Behavior Incentive Program
- No Mandatory Premium Contributions
- No Employment-Related Mandatory or Even Voluntary Programs
- No Meaningful Health Savings-type Program – contributions to Independence Plan are Voluntary
- Retroactive Coverage
- No Co-payment at all for non-emergent use of ER (note: Difference of opinion with carriers on whether this is not a covered benefit)
- Co-payment for PCP visit but no co-payment for use of ER

Key Features of Alternative Medicaid State Expansions

- **Indiana**

- Premiums contributions mandatory for incomes above 100% FPL
- Failure to contribute after 60 day notice – 6 month lock out
- Up to \$25 co-payment for non-emergency use of ER
- Less than 100% FPL failure to contribute to POWER account maximum cost share applies
- No retroactive coverage
- Healthy behavior incentives
- Employment-related provisions – state refers individual to job training

- **Michigan**

- Mandatory Premium 100% FPL or more (2% of income)
- Failure to make contribution results in debt to state

- **Penn**

- \$8 co-payment for non emergent use of ER (above 100% FPL)
- Incentives for work programs

- **Iowa**

- \$8 co-payment for non emergent use of ER (above 100% FPL)

- **NH**

- Retroactive coverage waived
- State refers unemployed to Employment Dept.

Arizona Recent Expansion Waiver Submission

- **Vision:** Require estimated 350,000 expansion population to take more responsibility for their health coverage through co-pays and incentives for work
- **Copays**
 - Up to 3% of household income for non-emergent ER usage
 - Another 2% to an HSA that could be tapped for value added benefits
- **Wellness**
 - Meet health goals such as wellness and flu shots
- **Work Requirement**
 - Be actively engaged in looking for work and use state job search services
- **5 year time limit**

Iowa Proposal

- **Iowa Wellness Plan**
 - Exclusively managed care for all of Medicaid, including newly eligible up to 100% FPL
- **Iowa Marketplace Choice Plan**
 - 101 to 138% FPL covered like Arkansas by Insurance Carriers in private market
- **Premium**
 - \$10 month 100 to 138% FPL
 - \$5 month for 50 to 100% FPL after one year
- **Wellness**
 - Complete wellness exam and health risk assessment premiums waived

Montana Health Livelihood Partnership Act

- **Third Party Administrator will contract with State to administer program and pay claims (Fee for Service Model)**
- **Premium**
 - 2% of income for everyone
 - If 100% FPL and under and fail to pay – income tax offset
 - 101% to 138% FPL and fail to pay voluntary disenrollment after 90 days and income tax offset unless exempted
 - Reenrollment upon payment of total debt
- **Co-pays**
 - Maximum allowed by law
 - Not applicable to preventative health care, generic drugs and immunizations
- **Work Requirement as Condition of Eligibility**
- **Asset Test**
 - \$100 per month and \$4/month for each \$1000 over asset limit

Insure Tennessee Proposal (21 to 64)

- **Volunteer**

- Premium Assistance through Employer Sponsored Health Care
- Defined Contribution set by State
- Employer must cover 51% of costs
- Cost sharing requirements are waived
- Wraparound requirements are waived
- Waiver of retroactive eligibility

- **Healthy Incentive**

- Fully aligned with TennCare MCOs
- HIT Accounts – state/individual credits
- Not redeemable
- Premiums 2 % income for 101 to 138% FPL
- Non payment – disenrollment after 60 day
- Co-pays
 - \$75 per inpatient admission
 - Outpatient \$4 per service
 - \$8 for non emergent use ER
 - \$1.50 for gen and \$3.00 Brd

State Contingency Clauses Examples

- **Montana**

- If Federal Match is set below that current established in ACA, continuation of coverage is contingent on:
 - (1) the appropriation of additional state general fund or other action by the legislature;
 - (2) the ability of the department to increase premiums assessed under [section 7] to pay the difference;
 - or
 - (3) a combination of legislative action and premium increases as necessary to provide for the increased state match obligation.

- **New Hampshire**

- “If at any time the federal match rate applied to medical assistance for newly eligible adults is less than (the current match rate)” the program “shall immediately be repealed”

Arkansas Medicaid Manages at Least 9 Waivers

- Arkansas Health Care Independence Program: 1115
- Arkansas Elder Choices: 1915 (c)
- Arkansas Tax Equity & Fiscal Responsibility: 1115
- Alternative Community Services: 1915 (c)
- Alternatives for People with Physical Disabilities: 1915 (c)
- Non-Emergency Transportation: 1915 (b4)
- AR Autism: 1915 (c)
- ARKidsB: 1115
- AR Living Choices Assisted Living: 1915 (c)

Note: Does not include State Plan Amendments

Rhode Island Global 1115 Compact Waiver

- Covers all Title XIX Medicaid eligible individuals
- State manages one 1115 Waiver with administrative efficiencies
- Focus of original waiver on deinstitutionalization
- 5 year global budget
- Aged, blind and disabled Medicaid population obtain right service at right time in right setting
- Spending cap creates culture of efficiency driving program savings and large Medicaid cost avoidance
- Nursing home admissions reduced due to managed care strategies and changes in levels of care
- Focus on prevention

TennCare II 1115 Waiver

- Covers all Title XIX Medicaid eligible individuals, except those only covered for Medicare premiums.
- All Medicaid eligibles, with exception of those eligible for TennCare Select, are enrolled in managed care including PBM, DBM, NFs, and ICFs.
- TennCare Select covers children with SSI, in state custody, residing in NFs/ICFs; option to select TennCare managed care.
- TennCare CHOICES is a service provision within managed care contracts that serves people in NFs, those with NF level of care needs treated in the community, those at risk of NF eligibility, and those at Interim Risk. All levels of care require SSI determination except those in a NF (entitlement service).

TennCare II 1115 Waiver

- 12 MCOs covered the state in 1994; 6 MCOs covered the state in 2004; 3 MCOs cover the state in 2015
- Total FY 2016 budget: \$10.5 billion
- In 2008 Tennessee passed the LTC Community Choices Act designed to transform LTC integrated with managed care.
- In 2008 87% of LTC was provided in NFs; 13% was provided HCBS
- In 2014 60.7% of LTC was provided in NFs; 39.3% provided HCBS with the trend continuing to HCBS at 4-5% per year

Minority Health Disparities

- Arkansas communities recognize the need for education and navigation for people accessing health insurance for the first time
- Continued lack of access to primary care continues to result in people accessing care through ERs. Needs to be recognition that for many people ERs represents primary care.
- Community based approaches work best to change health seeking or avoidance behavior for people unfamiliar with the health care system