Medicaid Transformation Savings Scorecard and Quarterly Report

September 1, 2017, Baseline Report

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HUMAN SERVICES

Reporting on Tracking Medicaid and Savings

- DHS is obligated to provide a quarterly report beginning with the first quarter of SFY18 that:
  - Includes a dashboard or scorecard to track savings from reforms approved by the Arkansas Health Reform Legislative Task Force (HCTF). The reforms target "at least $835 million" in savings from Traditional Medicaid.
  - Reports on all Medicaid programs to monitor spending and savings across programs.
  - Measures the impact on Medicaid spending and other quality/performance indicators from implementation of provider-led organized care in Arkansas.
- Act 802 requires DHS to submit to the Bureau of Legislative Research (BLR) an initial report September 1, 2017, to establish the baseline for the quarterly reports.
- Act 802 further provides:
  - "If projected savings in an amount less than five percent (5%) of the goal are not achieved during any two (2) consecutive quarters unrelated to non-claims based performance, the department **shall develop additional reforms to achieve the savings goals** (emphasis added.)"
  - "If legislative action is required to implement the additional reforms …, the Department may take the action to the Legislative Council or the Executive Subcommittee of the Legislative Council for immediate action."
- DHS will submit these quarterly reports to BLR on or before the thirtieth day following the end of a quarter. Thus the first quarterly report will be submitted to BLR by October 30, 2017.

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SECTION I: MEDICAID TRANSFORMATION SAVINGS SCORECARD

Tracking Savings in Traditional Medicaid

- Section I: Medicaid Transformation Savings Scorecard will track:
  - Annual savings against the 5% growth baseline
  - Savings in the 5 target areas as determined by the HCTF annual targets
    - Quarterly savings targets will be established for each of the five target areas, based off that area's annual savings target
    - These quarterly targets for the five target areas will be the trigger for Act 802's requirement for DHS to propose additional reforms

The Goal: $835 Million Traditional Medicaid Transformation Savings

- Senate Bill 96 of the 2015 Session established the Arkansas Health Reform Legislative Task Force (HCTF).
- The Task Force hired The Stephen Group (TSG) through a competitive bid process to provide consulting services.
- On December 16, 2015, Governor Asa Hutchinson recommended to the HCTF a goal of saving $835 million over a five-year period in the Medicaid program.
- The HCTF voted unanimously to "… find at least $835 million in savings without managed care, with the exception of dental."

Task Force Targets $835 Million in Transformation Savings in Traditional Medicaid

- TSG estimated Traditional Medicaid baseline spending would grow to $5.379 billion in SFY 2017.
  - At the time this work was done, TSG was working with SFY 2015 actual spending numbers. They estimated that Traditional Medicaid spending would increase 5% annually.
- The HCTF approved reforms to lower Traditional Medicaid spending by $835 million between SFY 2017 and SFY 2021.
  - Reforms were targeted in the following service areas:
    - Behavioral Health
    - Developmental Disabilities (excluding HDCs)
    - Long-Term Services & Supports (LTSS)
    - Pharmacy – All fee-for-service (FFS) Medicaid, not just Traditional
    - Dental (through managed care)
  - In the final report, TSG estimated that those reforms would save $820 million between SFY 2017-21
- Additionally, the HCTF also approved language on “value based purchasing strategies and some degree of provider risk.” TSG estimated that with such strategies the potential savings would increase to **$916 million** by SFY 2021.

HCTF Baseline Spending Models

Spending by Year & Program Dollars in Millions ($M)	SFY17	SFY18	SFY19	SFY20	SFY21	SFY17-21
*HCTF Baseline, Traditional Medicaid	$5,379	$5,648	$5,930	$6,227	$6,538	$29,722
‡HCTF "Current Model" Spending Traditional Medicaid only	$5,302	$5,495	$5,757	$6,026	$6,322	$28,902
‡HCTF "Current Model" Net Fiscal Impact of Reforms	**($77)**	**($153)**	**($173)**	**($201)**	**($216)**	**($820)**
‡HCTF "Current Model" with Provider-led	$5,302	$5,495	$5,757	$6,026	$6,227	$28,806
****HCTF Net Fiscal Impact of "Current Model" with Provider-led**	**($77)**	**($153)**	**($173)**	**($201)**	**($311)**	**($916)**

* HCTF assumed 5% annual growth in spending
‡ HCTF "Current Model" reflects revised annual spending based on achieving annual savings targets
** HCTF assumed Provider-Led would not show savings until SFY21

Source(s): Arkansas Health Care Reform Task Force – Final Report, The Stephens Group, 12/15/2016 p. 21

HCTF Baseline for Net Savings in Targeted Areas

"Current Model" Savings and Costs by Year & Program Dollars in Millions ($M)	SFY17	SFY18	SFY19	SFY20	SFY21	SFY17-21
DD Savings – Therapy Caps	$0	$18	$18	$18	$18	$72
DD Savings – Changes to CHMS and DDTCS	$0	$14	$14	$14	$14	$56
DD Savings – Independent Assessment & Tiers/Waiver Changes	$0	$0	$0	$17	$17	$34
DD Cost – Independent Assessment	$0	$0	($2)	($2)	($2)	($6)
Net DD Savings	**$0**	**$32**	**$30**	**$47**	**$47**	**$156**
BH Savings – Updated Outpatient Benefits Policy	$12	$16	$33	$33	$33	$127
BH Savings – Inpatient	$0	$15	$25	$35	$50	$125
BH Cost – Independent Assessment	$0	($1)	($2)	($2)	($2)	($7)
BH Cost – Care Coordination	$0	($15)	($21)	($21)	($21)	($78)
Net BH Savings	**$12**	**$15**	**$35**	**$45**	**$60**	**$167**
Dental Savings – Capitated Managed Care	$0	$3	$5	$5	$5	$18
Dental Premium Tax	$0	$3	$3	$4	$4	$14
Net Dental All-Funds Impact	**$0**	**$6**	**$8**	**$9**	**$9**	**$32**
LTSS MOU (Note: TSG did not model; these numbers were arbitrary)	**$15**	**$50**	**$50**	**$50**	**$50**	**$215**
Pharmacy (These savings were for all FFS, not just Traditional)	**$50**	**$50**	**$50**	**$50**	**$50**	**$250**
Net Fiscal Impacts	**$77**	**$153**	**$173**	**$201**	**$216**	**$820**

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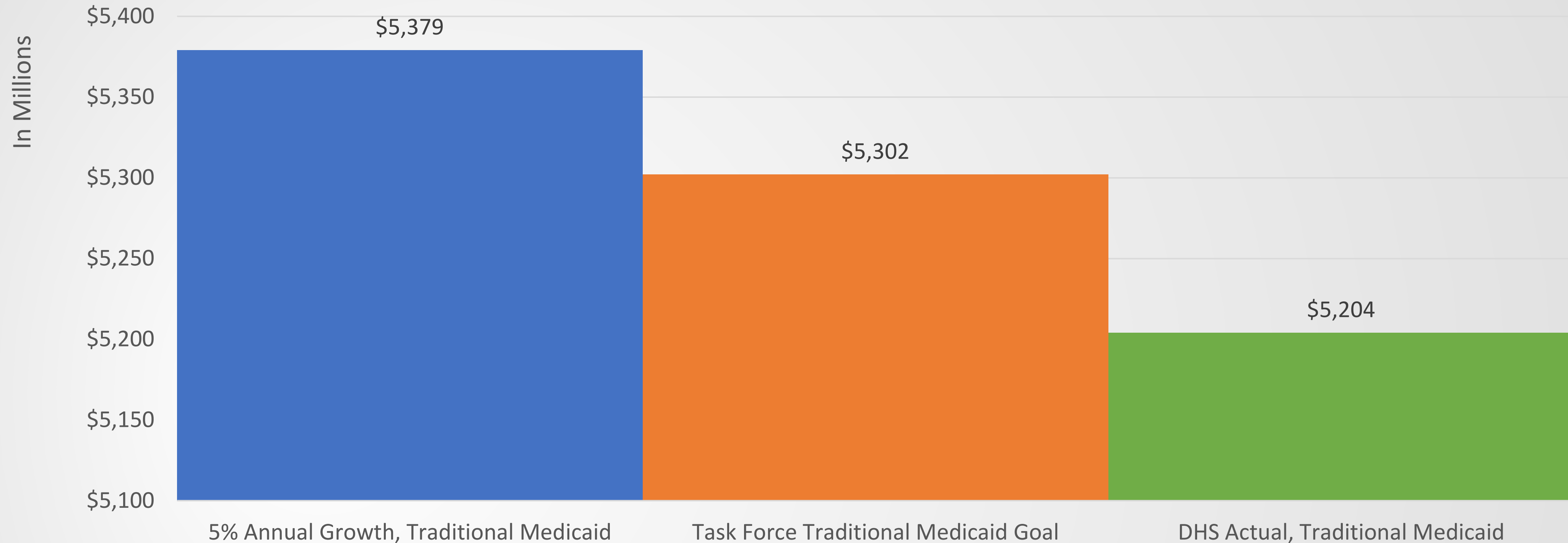
Source(s): Arkansas Health Care Reform Task Force – Final Report Savings Model Review, The Stephens Group, 12/15/2016 p. 23

Traditional Medicaid: SFY17 Spending is Below Target



- Actual Traditional Medicaid spending was **$175 million** lower than the 5% Annual Growth Baseline.
- The HCTF approved reforms to lower Traditional Medicaid spending by $77 million "off the trend."
  - Actual reductions in the targeted areas were:
    - $68 million from Traditional Medicaid
    - An additional $25 million in Pharmacy from fee-for-service enrollees in Arkansas Works
    - HCTF reforms contributed to lower spending of $93 million in SFY2017

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Section 1: Traditional Medicaid Scorecard SFY18 By Quarter

Savings By Quarter										
Division/ Reform	Actual SFY17 Savings	Projected SFY17 Savings	SFY 18 Q1	SFY 18 Q2	SFY 18 Q3	SFY 18 Q4	Actual SFY 18 Savings	Projected SFY 18 Savings	SFY 18 Difference	Total Savings (SFY 17-21)
DD	$16	$0	$0	$0	$0	$0	$0	$32	$0	$16
BH	$25	$12	$0	$0	$0	$0	$0	$15	$0	$25
Dental	$0	$0	$0	$0	$0	$0	$0	$6	$0	$0
LTSS MOU	$2	$15	$0	$0	$0	$0	$0	$50	$0	$2
Pharmacy	$50*	$50	$0	$0	$0	$0	$0	$50	$0	$25
Total	**$93**	**$77**	**$0**	**$0**	**$0**	**$0**	**$0**	**$153**	**$0**	**$93**

Note(s): Savings will be calculated by showing the difference in spending between the previous state fiscal year (SFY) and the current state fiscal year (SFY). Savings will occur at various times due to divisions implementing new codes on different schedules.

***** Pharmacy achieved $50 million in savings from fee-for-service; half was credited to Arkansas Works beneficiaries; half to Traditional Medicaid Beneficiaries

Developmental Disabilities Services (DDS)

- DDS experienced a lower levels of spending than expected in:
  - Therapy services--$6.1 million
  - CHMS/DDTCS--$10.4 million
  - Waivers--$2.1 million
  - Subtotal--$18.6 million
- However, DDS experienced increased higher levels of spending than expected in:
  - ICFs--$2 million
  - Therefore, the savings attributed to DDS are $16.6 million

Long Term Support & Services (LTSS) MOU

- DHS and the stakeholder community agreed to focus on personal care as an area in need of reform.
- Personal care was $17 million lower than expected.
- Spending in private skilled nursing facilities was $4.6 million lower than expected.
  - But spending in the Independent Choices waiver was $12.2 million higher than expected.
  - Spending on other LTSS waivers was $7.6 million higher.
  - Thus, overall LTSS spending was only $1.8 million lower
- The annual targets originally set by the HCTF for LTSS were not based on modeling. Now that reforms are in place, DHS will work with the industry to revise annual targets to achieve the $250 million in savings by SFY 2021.

Pharmacy

- The Division of Medical Services continues to implement a series of changes to the pharmacy program including an expansion of the Preferred Drug List, changing the pharmacy reimbursement methodology, and increasing the medications on the competitive acquisition program.
- Savings will be measured by per capita spending and drug rebates.
- Pharmacy met its savings target of $50 million in fee-for-service reductions, with half coming from Traditional Medicaid spending and half from Arkansas Works beneficiaries in fee-for-service Medicaid.

Behavioral Health (BH)

- BH experienced $29.4 million in lower spending than expected in outpatient services.
- However, inpatient services were $4.7 million higher than expected.
    - Therefore, the net savings attributed to BH is $24.7 million.

Next Steps to Continue Reform Implementation: Program Manuals and Waiver Changes to Implement Transformation

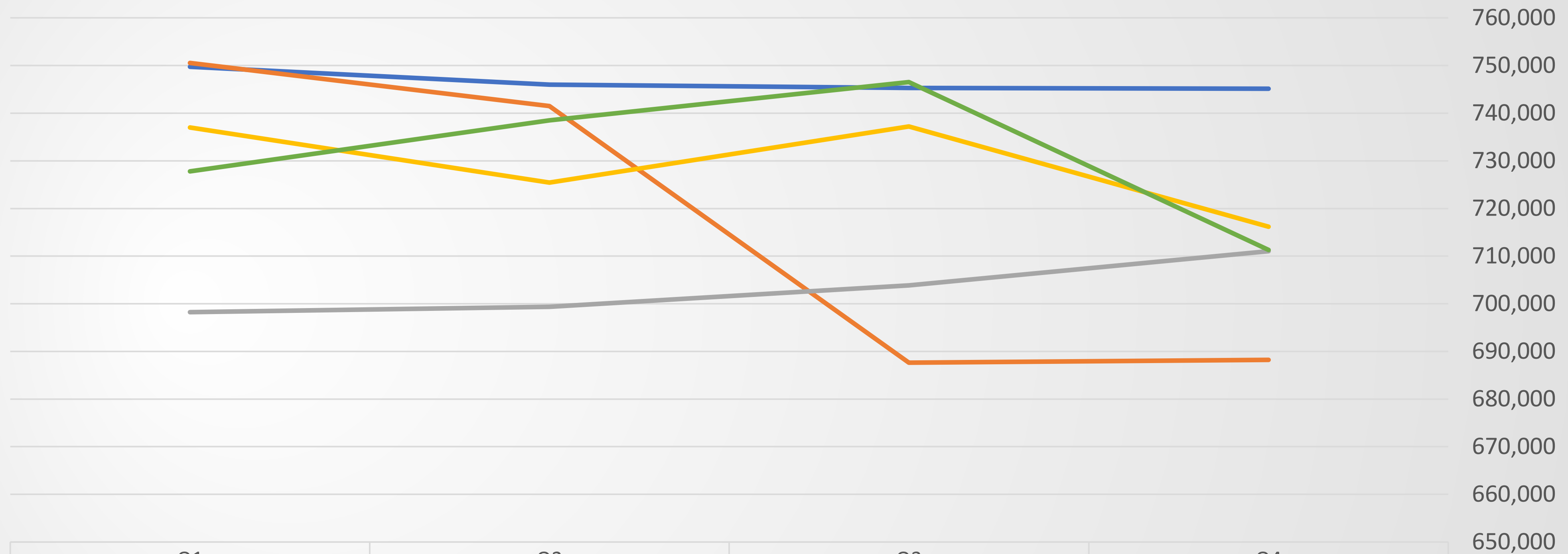
- CHMS provider manual updates and Medicaid State Plan Amendments (SPAs)
- DDTCS provider manual updates and Medicaid State Plan Amendments (SPAs)
- Independent Assessment manual (new) for personal care, waivers, private Intermediate Care Facilities, PASSE and Human Development Center Admissions
- Criminal background check requirements for providers
- 1915(b) waiver to implement the Provider-led Arkansas Shared Savings Entity (PASSE) program Phase 1
- Amendments to the 1915(c) Community and Employment Support waiver—provider manual and certification standards
- Therapy provider manual updates and Medicaid State Plan Amendments

SECTION II: ALL ARKANSAS MEDICAID ENROLLMENT AND SPENDING REPORT

Tracking Arkansas Medicaid Programs

- Section II of the quarterly tracking report will aggregate the information from these programs to show:
  - Spending on behalf of the various types of beneficiaries, including a review of the federal versus state spending on each group;
  - Enrollment changes for each of these beneficiary groups;
  - The cost per-person in each of these categories.
- Medicaid pays over $7 billion annually to medical providers through a number of distinct programs serving different beneficiary groups.
- DHS will also provide supplemental materials quarterly to allow those who want to take a deeper dive into the numbers behind the report to do so.

Traditional Medicaid Quarterly Enrollment SFY 2013-17



	Q1	Q2	Q3	Q4
2013	749,735	745,984	745,297	745,153
2014	750,563	741,522	687,614	688,219
2015	698,250	699,378	703,861	711,039
2016	737,000	725,446	737,230	716,165
2017	727,818	738,501	746,527	711,278

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Source(s): 4703 Scorecard – Ever Enrolled Eligibility by Category - Quarterly since Jul 2012_08222017

Arkansas Works Monthly Enrollment SFY 2017

Expenditures and Enrollees Included in the Arkansas Works 1115 Demonstration Waiver

Month	Arkansas Works Enrollees	Premium Payments	Cost Sharing	Wrap Services	Arkansas Works	Premium Per Enrollee	Cost Sharing Per Enrollee	Wrap Services Per Enrollee	Cost Per Arkansas Works Per Enrollee	Budget Neutrality Cap
January 2017	273,008	$105,304,821.53	$39,644,688.50	$1,162,958.28	$146,112,468.31	$385.72	$145.21	$4.26	$535.19	$570.50
February	275,466	$105,998,221.72	$39,892,425.44	$1,107,910.16	$146,998,557.32	$384.80	$144.82	$4.02	$533.64	$570.50
March	268,623	$102,177,189.93	*$38,714,358.95*	$1,113,835.97	$142,005,384.85	$380.37	$144.12	$4.15	$528.64	$570.50
April	266,248	$101,385,929.66	$38,407,467.43	$1,031,029.77	$140,824,426.86	$380.80	$144.25	$3.87	$528.92	$570.50
May	264,613	$100,364,350.84	$38,026,350.08	$1,027,292.21	$139,417,993.13	$379.29	$143.71	$3.88	$526.88	$570.50
June	258,871	$93,609,342.08	$35,475,622.10	$1,002,534.48	$130,087,498.66	$361.61	$137.04	$3.87	$502.52	$570.50
July	257,694	$96,623,965.59	$36,617,952.49	$1,035,940.64	$134,277,858.72	$374.96	$142.10	$4.02	$521.07	$570.50
August	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$570.50
September	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$570.50
October	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$570.50
November	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$570.50
December	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$570.50

Enrollees Under The Federal Group VIII Classification

Month	Premiums Paid	Medically Frail	Other	Total
January 2017	273,008	22,889	38,216	334,113
February	275,466	23,633	33,132	332,231
March	268,623	22,977	30,872	322,472
April	266,248	23,362	31,985	321,595
May	264,613	23,169	28,854	316,636
June	258,871	22,886	26,915	308,672
July	257,694	23,180	26,281	307,155
August	0	0	0	0
September	0	0	0	0
October	0	0	0	0
November	0	0	0	0
December	0	0	0	0

Definitions

Data Source = Arkansas Medicaid Enterprise- Decision Support System

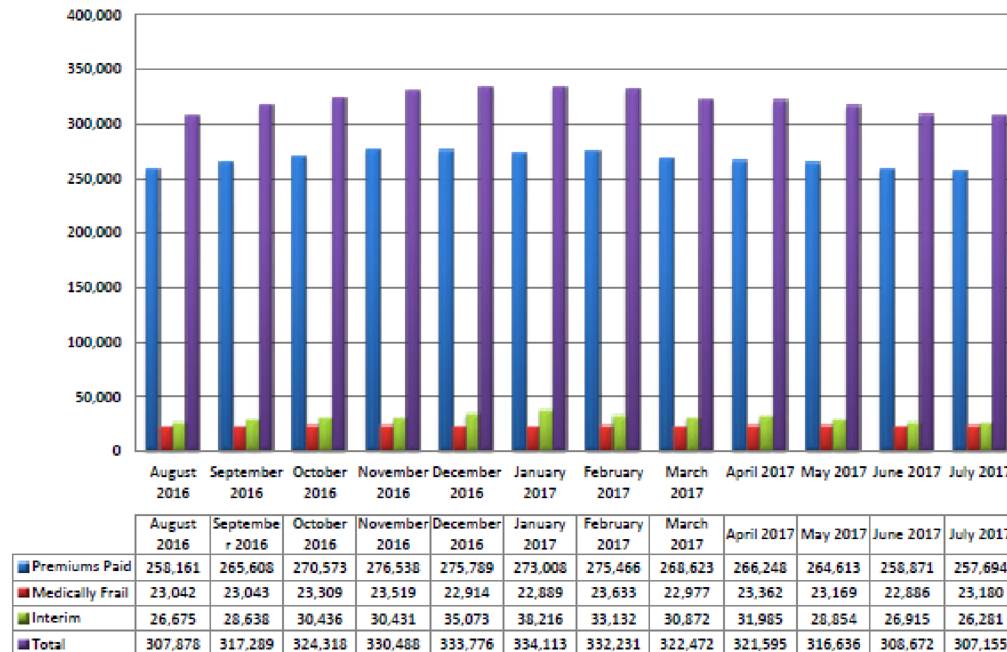
Enrollee Count = Total number of individuals within the Federal Group VIII category (DHS Category 06) at the end of the target month.

Premiums Paid = Individuals enrolled with a Premium or Cost Share payment in the target month under the approved Section 1115 Demonstration Waiver.

Medically Frail = All 06 recipients who do not have a Premium or Cost Share payment in the target month and have a Medically Frail indicator in MMIS.

Other = All 06 recipients who do not have a Premium or Cost Share payment in the target month and are not included in the Medically Frail set. This group can include individuals with Interim statis,

Monthly Enrollment in Arkansas Works By Category



	August 2016	Septembe r 2016	October 2016	November 2016	December 2016	January 2017	February 2017	March 2017	April 2017	May 2017	June 2017	July 2017
Premiums Paid	258,161	265,608	270,573	276,538	275,789	273,008	275,466	268,623	266,248	264,613	258,871	257,694
Medically Frail	23,042	23,043	23,309	23,519	22,914	22,889	23,633	22,977	23,362	23,169	22,886	23,180
Interim	26,675	28,638	30,436	30,431	35,073	38,216	33,132	30,872	31,985	28,854	26,915	26,281
Total	307,878	317,289	324,318	330,488	333,776	334,113	332,231	322,472	321,595	316,636	308,672	307,155

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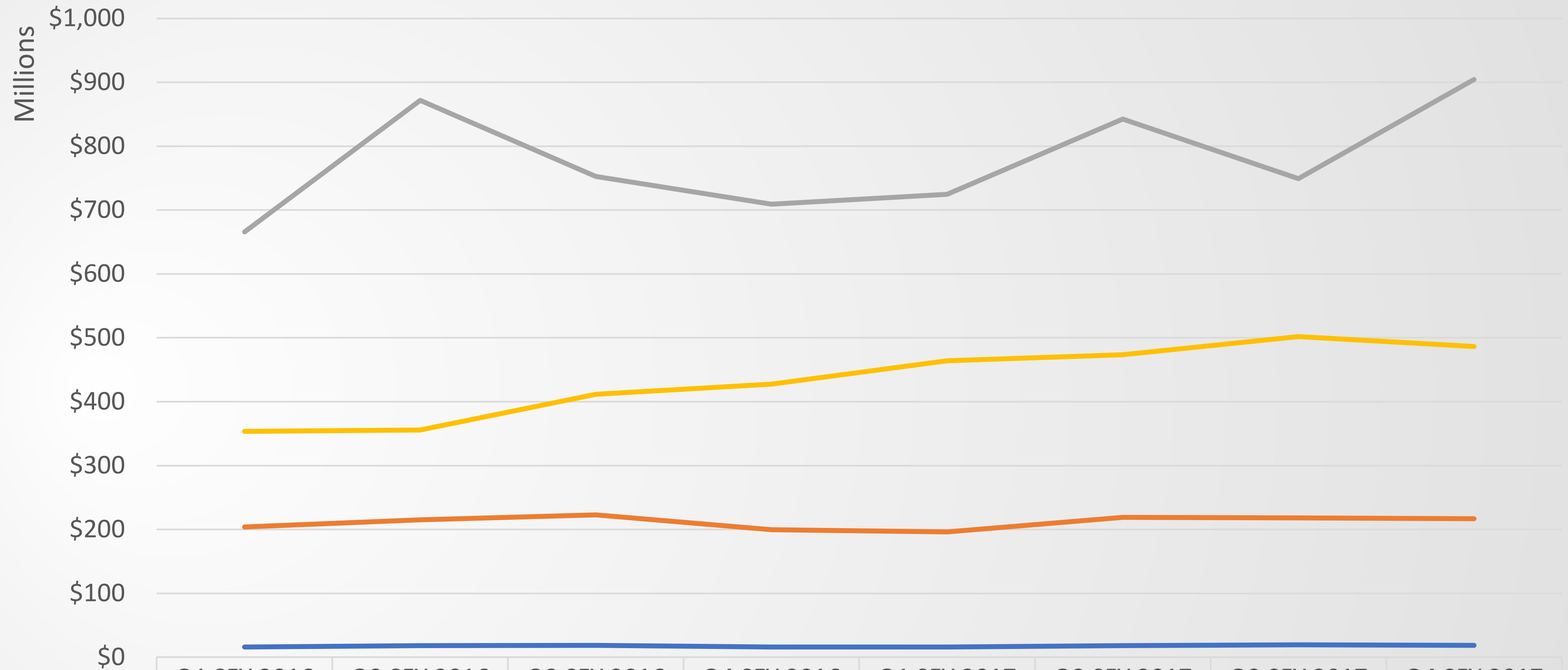
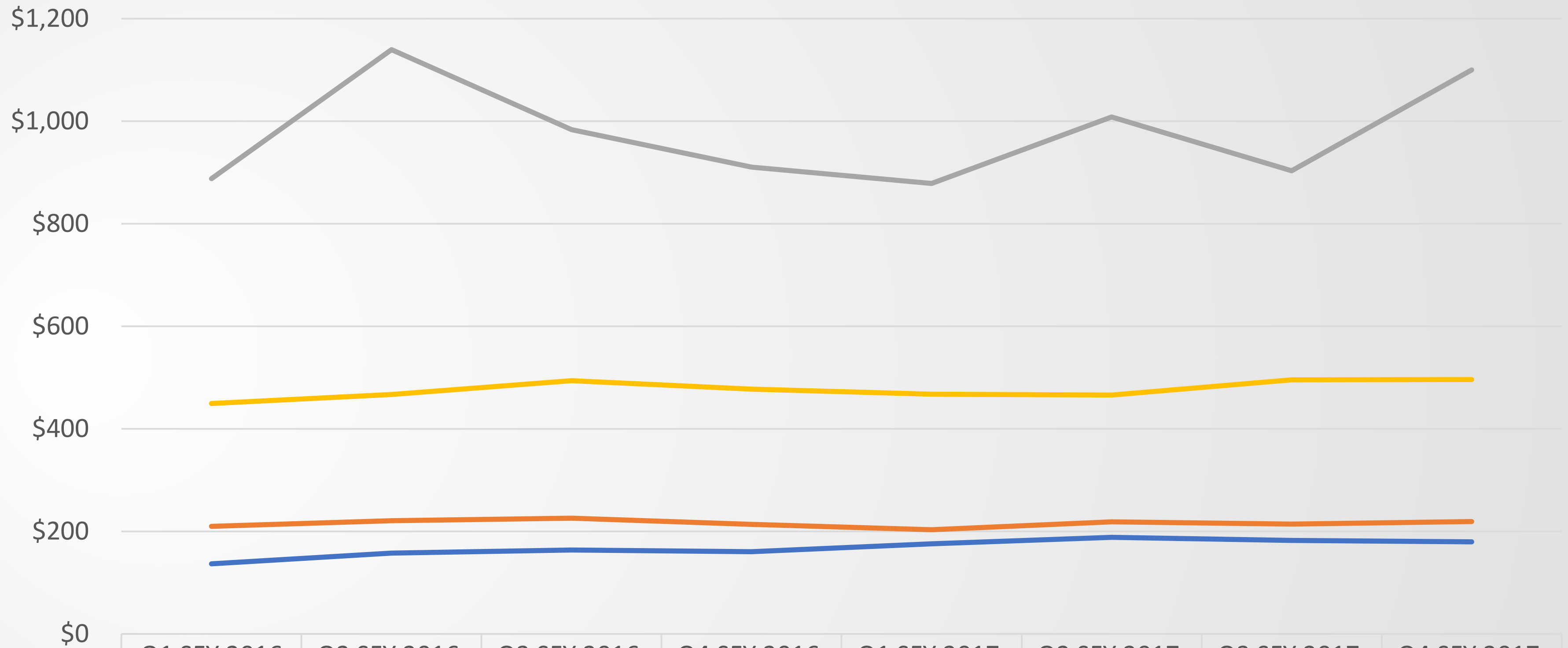
Source(s): Arkansas Works Report_20170811

Medicaid Quarterly Expenditures SFY 2016-17



	Q1 SFY 2016	Q2 SFY 2016	Q3 SFY 2016	Q4 SFY 2016	Q1 SFY 2017	Q2 SFY 2017	Q3 SFY 2017	Q4 SFY 2017
ARKids A	$15,805,457	$18,338,411	$18,506,856	$16,054,137	$16,104,063	$18,247,666	$19,353,944	$18,487,326
ARKids B	$204,060,643	$214,982,523	$222,791,714	$199,613,765	$196,019,909	$218,967,955	$218,273,791	$216,662,224
Other Traditional Medicaid	$665,609,570	$871,826,790	$752,647,100	$709,157,596	$724,632,193	$842,564,107	$749,035,003	$904,544,961
Arkansas Works	$353,443,863	$355,712,161	$411,519,344	$427,302,423	$463,828,570	$473,603,763	$502,094,919	$486,588,792

Medicaid Quarterly Per-Member Per-Month (PMPM) SFY 2016-17



	Q1 SFY 2016	Q2 SFY 2016	Q3 SFY 2016	Q4 SFY 2016	Q1 SFY 2017	Q2 SFY 2017	Q3 SFY 2017	Q4 SFY 2017
ARKids A	$137	$158	$164	$161	$176	$188	$183	$180
ARKids B	$210	$221	$226	$214	$204	$219	$214	$220
Other Traditional Medicaid	$888	$1,140	$984	$911	$878	$1,009	$904	$1,100
Arkansas Works	$450	$467	$494	$478	$468	$466	$496	$496

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SECTION III: PROVIDER-LED PROGRAM REPORT

Medicaid Provider-led Organized Care

- Act 802 (Collins and Hendren) requires DHS to "monitor all Medicaid savings realized by the department, including savings achieved through the delivery of health care by risk-based provider organizations within the Arkansas Medicaid Program."
- The five-year program savings plan shall measure:
  - Increased care management and care coordination;
  - Value-based purchasing strategies;
  - Reductions in duplication of health care services;
  - Reductions in delivery of unnecessary health care services
  - The degree of risk assumed by risked-based provider organizations; and the amount of projected savings realized as part of the eight hundred thirty-five million dollars ($835,000,000) in savings requested by the Governor.
- It also requires DHS to "…measure the success of implementation and continuing operation, including the success attributed to the Medicaid provider-led organized care system."

TSG Assumptions on Provider-led Hybrid Model and PASSE Milestones

- TSG--5% Savings off halo spend for DD population starting in year 4 (SFY21), net of administrative costs
- TSG--5% Savings off halo spend for BH population starting in year 4 (SFY21), net of administrative costs
- Act 775, "To Create the Medicaid Provider-led Organized Care Act" (Pilkington) was signed into law on March 31, 2017. Rules were promulgated to implement Phase 1 (care coordination only) beginning October 1, 2017.
- 5 organizations filed Letters of Intent with the Arkansas Insurance Department (AID) to become a Provider-led Arkansas Shared Savings Entity (PASSE).
- On August 18, DHS requested PASSEs to submit their provider networks by September 8, 2017.
- Negotiations with CMS on 1915(b) waiver should be completed in September 2017.
- PASSEs will provide care coordination only beginning October 1, 2017 and will be paid for providing care coordination. While some savings should be achieved, they are likely to be small and DHS is not expecting any savings between October 1, 2017, and December 31, 2018.
- Savings will begin January 1, 2019, (in SFY20) when PASSEs accept full risk, six months earlier than TSG model.

Provider-led Organized Care Milestones

- The Arkansas Insurance Department has promulgated regulations for risk-based organizations known as Provider-led Arkansas Shared Savings Entity (PASSE).
- 5 organizations have filed Letters of Intent to participate:
  - Empower Healthcare Solutions, Inc.
  - Arkansas Total Care
  - Arkansas Advanced Care, Inc.
  - Forevercare, Inc.
  - Arkansas Provider Coalition
- DHS has promulgated the PASSE manual that includes critical information including the attribution methodology for matching individuals with their providers.
- DHS has requested each prospective PASSE to submit documentation of its provider networks by September 8.
- Phase 1 begins October 1, 2017 when the first individuals will be enrolled into PASSEs.
- The PASSE will be responsible only for care coordination during Phase 1. Individuals will continue to receive services on a fee-for-service basis.
- DHS does not project any savings for Phase 1.
- Phase 2 begins January 1, 2019, when the PASSEs will accept full-risk for all services.

PASSE Enrollment SFY 2018 and SFY 2019 By Quarter

Enrollment By Quarter							
	SFY 18 Q2	SFY 18 Q3	SFY 18 Q4	SFY 19 Q1	SFY 19 Q2	SFY 19 Q3	SFY 19 Q4
PASSE 1	$0	$0	$0	$0	$0	$0	$0
PASSE 2	$0	$0	$0	$0	$0	$0	$0
PASSE 3	$0	$0	$0	$0	$0	$0	$0
PASSE 4	$0	$0	$0	$0	$0	$0	$0
PASSE 5	$0	$0	$0	$0	$0	$0	$0
Total	$0	$0	$0	$0	$0	$0	$0

PASSE Expenditures SFY 2019 and SFY 2020 By Quarter

Expenditures By Quarter								
	SFY 19 Q3	SFY 19 Q4	SFY 20 Q1	SFY 20 Q2	SFY 20 Q3	SFY 20 Q4	Total SFY 19 Spending	Total SFY 20 Spending
PASSE 1	$0	$0	$0	$0	$0	$0	$0	$0
PASSE 2	$0	$0	$0	$0	$0	$0	$0	$0
PASSE 3	$0	$0	$0	$0	$0	$0	$0	$0
PASSE 4	$0	$0	$0	$0	$0	$0	$0	$0
PASSE 5	$0	$0	$0	$0	$0	$0	$0	$0
Total	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**

PASSE Savings SFY 2019 By Quarter

Expenditures By Quarter									
	Projected SFY 19 Q3	Actual SFY 19 Q3	Projected SFY 19 Q3	Actual SFY 19 Q4	Projected SFY 19 Q4	Actual SFY 19 Q4	Projected SFY 19 Spending	Actual SFY 19 Spending	SFY 19 Difference
PASSE 1	$0	$0	$0	$0	$0	$0	$0	$0	$0
PASSE 2	$0	$0	$0	$0	$0	$0	$0	$0	$0
PASSE 3	$0	$0	$0	$0	$0	$0	$0	$0	$0
PASSE 4	$0	$0	$0	$0	$0	$0	$0	$0	$0
PASSE 5	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total	$0	$0	$0	$0	$0	$0	$0	$0	$0