Arkansas Private Option 1115 Demonstration Waiver

Quarterly Report

October 1, 2014 to December 31, 2014

I. *Executive Summary of Significant Activities of the Quarter:*

During the fourth quarter of the Arkansas Private Option Waiver Demonstration, enrollment in the program continued to grow. As of December 31, 2014, 230,367 Arkansans had been determined eligible for participation in the Health Care Independence Program.

Activities of the quarter focused primarily on monitoring and day-to-day management of the program; operationalizing changes to the program for 2015 to meet legislative requirements; working collaboratively with other state agencies to develop guidance needed for plan year 2015; and amending the 1115 waiver special terms and conditions.

During the first quarter, the Arkansas General Assembly convened for a fiscal session, in which the Division of Medical Services' (DMS) budget was the preeminent issue. The appropriation bill, Act 257, included special language requiring DMS to make three revisions to the Private Option. Act 257 requires DMS to submit and seek approval of a state plan amendment or waiver, or both, for the following revisions to the Health Care Independence Program to be effective no later than February 1, 2015: (1) approval of a limited state designed non-emergency transportation benefit for Health Care Independence Program enrollees; (2) approval of a model to create and utilize Health Independence Accounts (HIAs); and (3) application of cost-sharing to Health Care Independence Program enrollees with incomes above 50% of the federal poverty level. During the third quarter of the program, much effort was dedicated to operationalizing the proposed approach for the Independence Accounts and cost-sharing design.

Great strides were made this quarter to continue to operationalize the legislative requirement of implementing the Health Independence Accounts. Operational protocols were drafted and submitted to CMS during this quarter. Additionally, weekly meetings were held with the state's fiscal intermediary and the HIA vendor to define data exchange requirements, develop testing schedules and create documentation of operational procedures, including the finalization of the business requirements document. Once this work was completed, the fiscal agent successfully transferred Private Option enrollee's files to the HIA vendor.

Additionally, a Request for Proposals (RFP) was released and current contracts were amended, for the newly designed non-emergency medical transportation system, to reflect the changes in the program.

With plan year 2014 coming to a close, much work has been done to prepare for plan year 2015. During this quarter, guidance was issued that clarified that DMS would only purchase each carrier's lowest cost Essential Health Benefit (EHB) only plan for Private Option enrollees. Additionally, DHS finalized the renewal process and bifurcated the

eligibility determination and plan selection processes. In 2015, Private Option enrollees will have the opportunity to select among the participating carriers lowest-cost Essential Health Benefit only plans during the open enrollment period. The Arkansas Insurance Department (AID) Commissioner released bulletin 13-2014 to outline requirements of notices that will be sent to Private Option enrollees regarding the open enrollment period. DHS' Division of County Operations will make eligibility re-determinations on a rolling basis. The bulletin can be found at the following link: http://insurance.arkansas.gov/legal/Bulletins/13-2014.pdf

Additionally, this quarter marked the beginning of open enrollment for Qualified Health Plans sold through the Marketplace. While individuals are able to apply for Private Option coverage at any time during the year, current enrollees had the opportunity to return to the state's portal (insureark.org) during the open enrollment period to re-evaluate their medical frailty status and choose among each carrier's essential health benefit only plan offered in their service area.

Significant Activities of the Quarter:

Implementation of the Health Care Independence Accounts

During this quarter, much progress has been made to design and plan for the implementation of the Health Independence Accounts (HIAs). The selected vendor completed technological development for implementation of the daily extract file from the Maintenance Management Information System (MMIS) on December 15, 2014. Content design and development of www.myindycard.org web portal was completed on December 24, 2014. Cards were ordered and mailed to participants December 29, 2014. The construction of a call center was also completed on December 29, 2014.

Additionally, the vendor contracted with a subcontractor to assist in the development of educational materials. These materials, including a user guide and quick reference guide, were released in December, a few weeks before the implementation date of the HIAs. The educational materials may be accessed from the following website: www.myindycard.org.

The program was launched January 1, 2015.

Designing the Limited Non-Emergency Medical Transportation Benefit

In addition to implementing the HIAs, the special language of Arkansas Division of Medical Service's (DMS) appropriation bill required the state to develop a limited state-designed non-emergency transportation benefit for newly eligible adults covered under the Health Care Independence Program, not including the medical frail population. Actuarial calculations have

been conducted to verify that the imposed limits would continue to meet the needs of the population served through this program. An actuarial firm calculated that eight one way legs would meet the needs of ninety-eight percent of the newly eligible population. Additionally, an extension of benefits process will be available to allow an enrollee to access more trips, if it is determined that they do not have access to transportation.

A Request for Proposals (RFP) for the state's non-emergency medical transportation program was released on November 19, 2014. It was subsequently amended December 16 and is anticipated to close on February 12, 2015. The RFP outlines the requirements of the State to send the Broker the number of Non-Emergency Medical Transportation (NET) trips that will cover newly eligible adults, as determined by the DMS fiscal agent on the last day of the month prior to the month of service for which the per-member per-month payment is calculated. The RFP corresponds to the changes in the current contracts which will result in the implementation of a limited non-emergency medical transportation system for the newly eligible adult population, as required by state law.

Approval of the Special Terms and Conditions

On December 31, the amended Special Terms and Conditions were approved by Centers for Medicaid and Medicare Services (CMS). The appropriations bill, Act 257, included special language requiring DHS to make three revisions to the Private Option. Act 257 requires DHS to submit and seek approval of a state plan amendment or waiver, or both, for the following revisions to the Health Care Independence Program to be effective no later than February 1, 2015: (1) approval of a limited state designed non-emergency transportation benefit for Health Care Independence Program enrollees; (2) approval of a model to create and utilize Independence Accounts; and (3) application of cost-sharing to Health Care Independence Program enrollees with incomes above 50% of the federal poverty level. The Special Terms and Conditions were amended to allow the state to implement these requirements.

Eligibility and Enrollment:

Nearly 92% of Arkansans estimated to be eligible for the Private Option signed up in the first nine months of the program. A total of 230,367 of the estimated 250,000 Arkansans who were estimated to qualify for health coverage through the Health Care Independence Program had applied and been determined eligible as of December 31, 2014. Of those 230,367 determined to be eligible, 209,795 have completed the enrollment process and are receiving services.

People in all 75 counties in Arkansas have been approved to get insurance through the program. Pulaski County led the state with 31,127 sign-ups followed by Washington County with 11,656, Benton County with 10,366, Garland County with 9,071, Sebastian County with

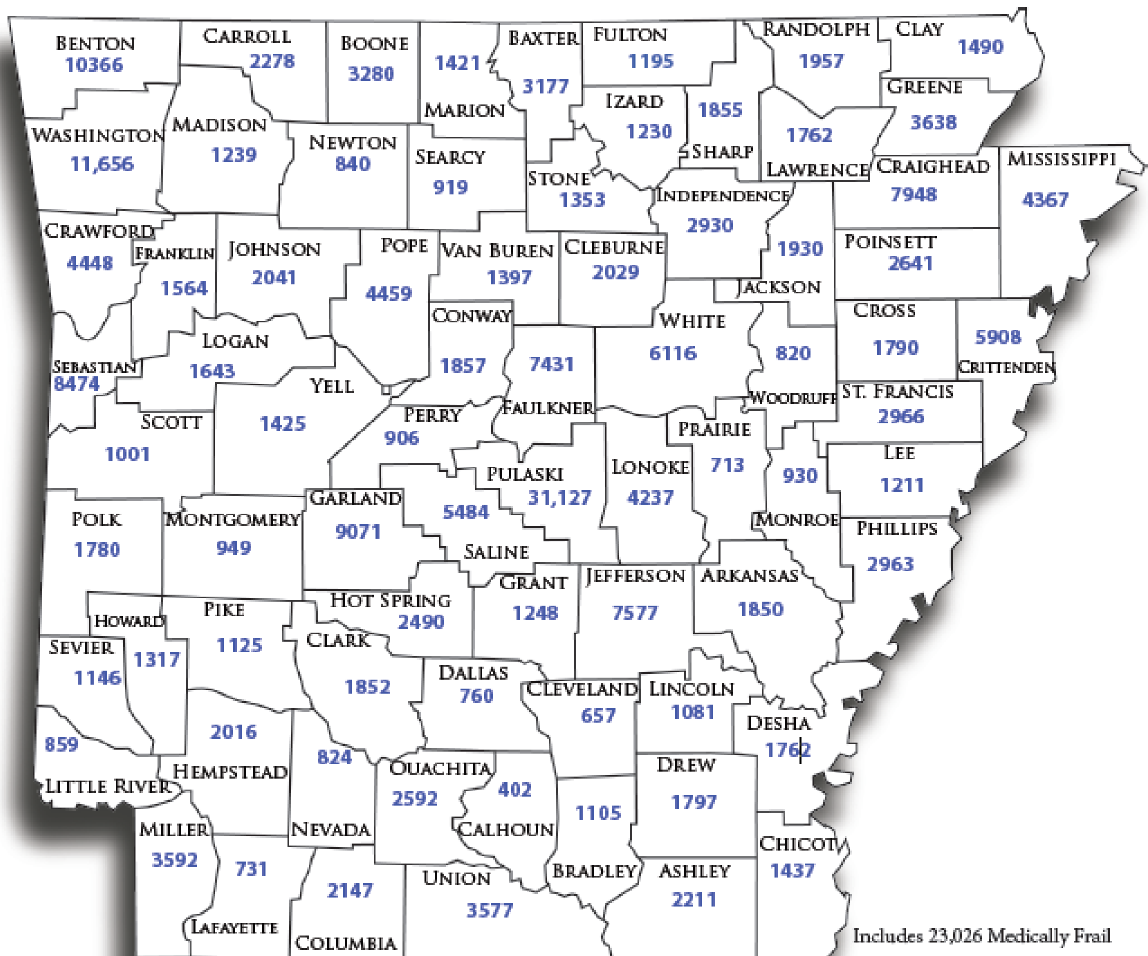
8,474, Craighead County with 7,948, Jefferson County 7,577, Faulkner County with 7,431, Crittenden County with 5,908, White County with 6,116 and Saline County with 5,484.

See graphic below for additional county level enrollment data.

As of December 30, 2014

230,367 Eligibility Approvals

209,795 Enrollment Complete



The table below provides medical frailty breakdowns and enrollment in the fee-for-service Alternative Benefit Plan (FFS ABP). The FFS ABP is the fee-for-service equivalent of the Qualified Health Plans. The ABP State Plan is the ABP that is the equivalent of the Medicaid State Plan.

Exempt Population Enrollment from 10/1/2013 to 12/31/14:

Through December 2014	Medically Frail Determinations (Average %)	ABP-State Plan	ABP-FFS equivalent of QHP
	23,026 (10%)	20,192	2,834

Transition to Market Issues:

DMS and AID worked closely with the participating carriers during this quarter to develop the process for submitting data needed for the Private Option evaluation. DMS has contracted with the Arkansas Center for Health Improvement (ACHI) to conduct this evaluation. The carriers expressed privacy concerns regarding whether they may share claims data for Medicaid beneficiaries enrolled in the Qualified Health Plans (QHPs) with Arkansas DHS and whether the transfer of these data is permitted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Arkansas DHS' position is that under the terms of the demonstration and as described in the state's Memorandum of Understanding with the carriers, Arkansas DHS is required to have these data to complete the evaluation of the Private Option, as required under the terms of the demonstration and is an integral part of the health care operations of the Medicaid program.

QHP Operations and Performance

Due to variation in QHPs during plan year 2014, DMS made the decision to purchase only the lowest cost EHB only plan from each carrier in each service region in plan year 2015. During the last quarter of 2014, all Private Option enrollees were disenrolled from their 2014 plan and reenrolled into the lowest cost EHB of their current carrier, unless another carrier was affirmatively selected by visiting insureark.org during the open enrollment period. While some participants proactively chose a different carrier, most participants did not. These enrollees were successfully transitioned into carriers' lowest cost EHB only plans on December 16, 2014. This transition was seamless for enrollees. Participants received new insurance cards, prior to the January 1 effective date.

Stakeholder outreach:

During the last quarter of the year, the Arkansas General Assembly held monthly public health committee meetings. At these committee meetings, the Arkansas Medicaid Director, DHS Director and Arkansas's Surgeon General provided updates on the progress of the demonstration and received feedback from state legislators.

In addition to communicating with state legislators and providers, a consumer assistance advisory committee meets monthly. This committee is comprised of consumer advocacy groups, AID and DHS. The committee meets to address concerns of consumers and discuss processes that would enhance the consumer's experience.

Lastly, meetings and conference calls are held with participating carriers as issues arise, usually at least once a quarter.

Audits

During the last quarter of 2014, the Bureau of Legislative Audit conducted an audit on the Private Option program. On December 12, 2014, their final report was released. It can be found here: http://www.legaudit.state.ar.us/. This report was an update to a report released June 2014 and focused on updates regarding the creation of the state based exchange, health insurance marketplace, special language requirements, auto-assignments, individuals enrolled in the program, projected cost of the program, and cost-sharing.

Lawsuits

There have been no lawsuits filed related to the Health Care Independence Program.

II. Access/Delivery Network:

One of the key objectives of Arkansas's evaluation of the Private Option Demonstration is to measure whether the premium assistance service delivery model improves access to needed health care services. Specifically, the evaluation will measure whether Private Option enrollees have equal or better *access to* health care compared with what they would have otherwise had in the Medicaid fee-for-service system over time.

Arkansas Center for Health Improvement (ACHI) was selected to complete the evaluation for the Private Option program. During this quarter, ACHI has begun working with carriers to establish the process for submitting evaluation data.

III. Quality Assurance:

Arkansas's Private Option evaluation also will assess the quality of care provided to Private Option enrollees by evaluating whether enrollees have equal or better *care and outcomes* compared with what they would have otherwise had in the Medicaid fee-for-service system over time. Health care and outcomes will be evaluated using the following measures:

a. Use of preventive and health care services
b. Experience with the care provided
c. Use of emergency room services* (including emergent and non-emergent use)
d. Potentially preventable emergency department and hospital admissions*

The evaluation also will determine whether enrollees have better continuity of care compared with what they would have otherwise had in the Medicaid fee-for-service system over time. Continuity will be evaluated using the following measures:

a. Gaps in insurance coverage
b. Maintenance of continuous access to the same health plans
c. Maintenance of continuous access to the same providers

*At this time, data is not available to measure the Private Option's impact on quality, but this information will be included in the evaluation for the Private Option program.

IV. Complaints/Grievances:

Pursuant to the Intergovernmental Cooperation Act of 1968 and under the terms of a Memorandum of Understanding by and between the DHS and the AID, Arkansas has delegated medical necessity appeals to AID. AID reported receiving seven complaints from Private Option enrollees during this quarter. Four of these complaints have been resolved with the carrier's position being upheld. The other three complaints are still open, pending disposition.

Budget Neutrality/Fiscal Issues:

At this time, the only anticipated fiscal issue relates to the fact that, in this plan year, Issuers participating in the Private Option have included benefits that are not Essential Health Benefits to high-value silver plans offered in the Marketplace. As previously mentioned, these benefits were not expected to be available and were not included in the state's per-member-per-month cost used to estimate the waiver budget limit. Guidance from AID to Issuers for the 2015

coverage year (Bulletin 9-2014) requires QHPs participating in the Arkansas individual market to include at least one silver-level plan that contains only the EHBs included in the state base-benchmark plan. For plan year 2015, DMS will purchase only the lowest cost EHB-only silver-level plan on behalf of Private Option enrollees.

The bulletin can be found at the following link: http://insurance.arkansas.gov/legal/Bulletins/9-2014.pdf

DMS' actuarial consultants also have confirmed that the average age of enrollees in QHPs through the Private Option during the first seven months of 2014, was 38.8 years, which was higher than the projected age in the preparation of Arkansas's without waiver baseline, which was 37 years.

In accordance with the Standard Terms and Conditions of the 1115 demonstration waiver, Arkansas has the ability to request an adjustment of the projected per-member per month rate. In September, state leadership decided that Arkansas would not request an adjustment in the per-member per-month rate. This decision was the result of the average age of the newly eligible adult population continuing to decrease and a decision to purchase EHB only plans for plan year 2015. With these changes in the market, state leadership were ensured that the prices of the plans for plan year 2015 would drop enough to offset the unexpected cost of plan year 2014.

Utilization:

Through the fourth quarter of 2014, expenditures for the newly eligible adult group totaled $265,295,655.96. Of this amount, $262,291,214.76 was paid to the four carriers participating in the Marketplace. This amount includes both premium and cost-share reduction payments. Wrap cost, including Non-Emergency Medical Transportation and Early and Periodic Screening, Diagnostic and Treatment (EPSDT) during this quarter totaled $3,004,441.20.

Note: The reporting process for supplemental expenditures is currently being finalized; the data above is based on the best information currently available.

Claims and encounter-level information regarding QHP utilization will not be available to the State until the first quarter of 2015. This information will be included as a key component of the Private Option evaluation. Cost-effectiveness will be evaluated using findings above in combination with the following costs determinations: (a) administrative costs for Private Option enrollees, including those who become eligible for Marketplace coverage; (b) overall premium costs in the Marketplace; and (c) cost for covering Private Option enrollees compared with costs expected for covering the same expansion group in Arkansas fee-for-service Medicaid.