



Arkansas Private Option 1115 Demonstration Waiver

Quarterly Report

April 1, 2014 to June 30, 2014



I. Executive Summary of Significant Activities of the Quarter:

During the second quarter of the Arkansas Health Care Independence Program (HCIP) Waiver Demonstration, enrollment in the program continued to grow. As of June 30, 2014, 184,244 Arkansans had been determined eligible for participation in the Health Care Independence Program. 59% of eligible individuals are women; 82% have incomes below 100% of the federal poverty level (FPL); and 65% are between the ages of 19-44.

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

During the first quarter, the Arkansas General Assembly convened for a fiscal session, in which Arkansas Department of Human Services budget was the preeminent issue. The appropriations bill, Act 257, included special language requiring the Department of Human Services to make three revisions to the HCIP. 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. During this quarter, much effort was dedicated to developing a proposed approach for the Independence Accounts and cost-sharing design.

As required by the Special Terms & Conditions for the HCIP waiver demonstration, DHS held a post-award forum during this quarter. There were forty-seven people in attendance and twenty five that submitted comments. Comments were overwhelmingly positive and focused on the benefits of enhanced access to health care.

After receiving federal approval of the Private Option Evaluation plan last quarter, a team of researchers have assembled and have begun work on different components of the HCIP evaluation.

Data released this quarter showed the positive impact of the HCIP on emergency room utilization rates and uninsured hospital admissions. The Arkansas Hospital Association conducted a survey that found that hospitals across the state are experiencing declines in overall emergency room (ER) visits and ER utilization by uninsured patients.

Summary of First Quarter Media Inquiries and Coverage of the Arkansas Private Option:

Through the second quarter of the Private Option, media coverage remained high. Almost all issues described in the following section of this report, *Significant Activities of the Quarter*, received media attention. Links to media coverage are provided in that section, when available. Additionally, two media outlets covered stories describing the personal experiences of individuals benefitting from the coverage expansion. See <http://www.arktimes.com/arkansas/the-faces-of-health-care-expansion-in-arkansas/Content?oid=3284892> and http://www.nytimes.com/2014/06/09/business/economy/uninsured-on-the-wrong-side-of-a-state-line.html?_r=0.

Significant Activities of the Quarter:

Arkansas Insurance Department Releases Bulletin 9-2014

On April 14, 2014, the Arkansas Insurance Department issued bulletin number 9-2014, which outlines the 2015 plan year requirements for Qualified Health Plan Certification in the Arkansas Federally-Facilitated-Partnership Marketplace. Because Arkansas uses premium assistance to purchase silver level plans from the Marketplace (and does not purchase Medicaid-specific plans), the requirements outlined in the Bulletin apply to the Private Option, as well as to the Marketplace as a whole.

The Bulletin requires QHP issuers to enter into a Memorandum of Understanding (MOU) with the Arkansas Division of Medical Services (DMS) and the Arkansas Insurance Department (AID) which outlines coverage coordination procedures, data and reporting requirements.

The Bulletin outlines the standards for network adequacy. Arkansas's network adequacy requirements included standards such as time and distance targets for primary, behavioral health, and specialty providers; submission guidelines for GeoAccess maps, performance metrics, and network, access policies and procedures; and standards for online provider directories. Additional state network adequacy standards include the following: including school based providers as "other" essential community providers and submitting a list of school-based providers; and requiring that at least one FQHC or RHC in each regional service area of the plan network is offered in the Marketplace.

The Bulletin also requires that, in addition to federal requirements that at least one silver and at least one gold plan are offered in the individual market, QHPs in the Arkansas individual market are required 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 EHB-only silver-level plan on behalf of Private Option enrollees.

Appendix E of this bulletin outlines the high-value silver plan (94% A/V) variation cost-sharing requirements. The cost-sharing design complies with both Marketplace and Medicaid cost-sharing requirements.

Bulletin 9-2014 is available via the following link:

<http://www.insurance.arkansas.gov/Legal/Bulletins/9-2014.pdf>.

Arkansas makes time-limited supplemental payments for deliveries to insurance carriers

As outlined in a March 26, 2014 letter from Arkansas Medicaid Director Andy Allison, in order to avoid disruption to both patients and providers and to align with CMS policy for the Marketplace as a whole, DMS will maintain coverage under the Private Option for pregnant women in Qualified Health Plans (QHPs). To compensate carriers for the incremental and unexpected costs of deliveries to Private Option women who enrolled through the Supplemental Nutrition Assistance Program (SNAP) facilitated eligibility determination process, DMS will pay Issuers a time-limited supplemental payment of \$4,500. The supplemental payment will only be paid for deliveries to Private Option enrollees between January 1, 2014 and June 30, 2014. This limited time period accounts for the absence of a question regarding pregnancy for SNAP-facilitated enrollments. During this quarter, DMS made supplemental payments to the Issuers for 52 deliveries.

Related media coverage: “Insurers didn’t expect ‘expecting’.” *Arkansas Democrat Gazette*, April 4.

Catholic Health Initiatives Acquires QualChoice

QualChoice, one of the four carriers participating in the Arkansas Marketplace, was acquired by Catholic Health Initiatives (CHI). The application by CHI to buy QualChoice Health was approved by the Arkansas Insurance Department on Tuesday, April 29 and the sale was finalized on Thursday, May 1, 2014. Following the finalization of this transaction, QualChoice’s cap on enrollment in Arkansas’s Private Option portal (insureark.org) was lifted. DMS capped QualChoice’s enrollment at 1,280 enrollees in November, due to a request by QualChoice to keep its overall Marketplace enrollment limited to 10,000 enrollees.

Related media coverage: “State approves sale of QualChoice.” and “Catholic Health Acquires QualChoice.” *Arkansas Democrat Gazette*, April 30 and May 2.

Andy Allison Announces Decision to Leave State Medicaid Post Effective June 1

On May 2, the Arkansas Department of Human Services issued a press release announcing that Medicaid Director Andy Allison would leave his position June 1 in order to pursue other

opportunities outside state government. Dawn Zekis, Medicaid's director of Health Care Innovation since April 2012, will serve as interim Medicaid director.

Related media coverage: "State Medicaid Director to Resign." *Arkansas Democrat Gazette*, May 2.

Data Released showing positive impact of the Private Option regarding ER Usage and Uninsured Hospital Admissions

Preliminary survey data of 42 hospitals collected by the Arkansas Hospital Association and released Thursday, May 15, indicate that hospitals across the state are experiencing declines in overall emergency room (ER) visits and ER utilization by uninsured patients. When compared to the first quarter of 2013, hospital respondents saw a 2 percent reduction in ER visits overall for the first quarter of 2014. During the same period, respondents saw a 24 percent reduction in ER visits by the uninsured and a 30 percent reduction in uninsured hospital admissions in the first quarter of 2014. These reductions have largely been attributed to the Private Option. More information is available from the Arkansas Center for Health Improvement, at the following link: <http://www.achi.net/Pages/News/Article.aspx?ID=33>.

Related media coverage: "Arkansas hospital survey: since enactment of private option, ER visits and number of uninsured patients down." *Arkansas Times*, May 15. Available from: <http://www.arktimes.com/ArkansasBlog/archives/2014/05/15/arkansas-hospital-survey-since-enactment-of-private-option-er-visits-and-number-of-uninsured-patients-down>.

DHS sent notices to 4,798 Health Care Independence Program Enrollees notifying them of cancelled coverage under the Health Care Independence Program

On May 29, DHS announced that it had notified 4,798 individuals that their Health Care Independence Program coverage will end effective May 31 because their information was pending verification and was incorrectly included among applications of eligible individuals. Some of the individuals who received letters may, in fact, be eligible for the Health Care Independence Program and were instructed to go to www.accessarkansas.gov and provide any information needed to complete the verification process. Others may instead be eligible for coverage through the Federally Facilitated Marketplace and should return to www.healthcare.gov. Loss of Health Care Independence Program coverage is a qualifying event that will allow individuals to return to www.healthcare.gov even though the open enrollment period has ended. Individuals who complete the application process and are determined eligible for the Health Care Independence Program will receive retroactive Medicaid coverage and, therefore, will not have a gap in coverage.

Related media coverage: “Eligibility verification not completed for nearly 5,000 Private Option beneficiaries; coverage will end May 31 until process is complete.” *Arkansas Times*, May 29. Available from: <http://www.arktimes.com/ArkansasBlog/archives/2014/05/29/nearly-5000-private-option-beneficiaries-did-not-complete-eligibility-verification-coverage-will-end-may-31-until-process-is-complete>.

Arkansas Department of Human Services (DHS) and the Arkansas Insurance Department (AID) issue joint guidance

On June 5, DHS and AID issued joint guidance regarding plan management frequently asked questions. This guidance clarifies that Private Option eligible individuals will only be permitted to enroll in Essential Health Benefit (EHB)-only silver-level plans. According to requirements in AID guidance (Bulletin 9-2014), all issuers must offer an EHB only silver plan in order to offer QHPs in the Marketplace. This guidance also signals DHS’ future intent with regard to purchasing strategies to reduce Marketplace concentration and increase the competitiveness of the Marketplace in coverage year 2016 and beyond. The guidance is available from the following link: https://static.ark.org/eeuploads/hbe/PM_FAQ_Purchasing_Guidelines.pdf.

DHS hosts post-award implementation forum for the Health Care Independence Program

The Arkansas Department of Human Services (DHS) hosted a post- award forum for the Health Care Independence Program at the University of Arkansas for Medical Sciences on Friday, June 13, 2014. The purpose of the forum was to provide the public an opportunity to provide meaningful comment on the implementation of the Arkansas Health Care Independence Program.

Comments received during the forum were overwhelmingly supportive of the Health Care Independence Program. A total of 47 individuals attended, with 25 providing comments. A summary of comments is included below. All comments received from the post-award forum may be accessed at the following link:

<https://medicaid.mmis.arkansas.gov/Download/general/comment/PrivOptComments.pdf>

Several commenters described the positive impact Arkansas’s hospitals are seeing from the Health Care Independence Program. The Vice President of the Hospital Association noted that the Private Option helped to offset upcoming Medicare cuts and reduced hospitals’ uncompensated care costs. Several rural hospital administrators submitted comments, both orally and written. They indicated that Private Option was the critical factor that made the difference for rural hospitals between taking a loss for the year and making a profit.

Students from the Fay W. Boozman College of Public Health described a service learning project in which they conducted qualitative interviews to learn about the experiences of individuals

obtaining insurance through the Arkansas Marketplace. They prepared a report entitled “Voices of the Newly Insured”, which summarizes the main themes from the 29 interviews and shares the stories of 11 Arkansans and their unique experiences. The full report is available from the following link: <http://publichealth.uams.edu/files/2012/06/Voices-of-the-Newly-Insured.pdf>.

The Health Policy Director of Arkansas Advocates for Children and Families expressed strong support for the Private Option.

A representative from the Arkansas Enterprises for the Developmentally Disabled commented that they supported the Private Option as a means to ensure working citizens of Arkansas have access to needed healthcare. He encouraged the legislature to continue to program as it assisted citizens, hospitals and small businesses.

The Arkansas Surgeon General made comments. He noted that the Private Option was being implemented as set forth in the terms and conditions and as requested by Arkansas General Assembly. He commented that he was pleased with the implementation of the program.

An additional commenter noted the Private Option was playing an important role in preventing misuse of the emergency room.

Legislative Developments:

DHS began preliminary work needed to implement the three changes to the Health Care Independence Program required by Act 257 of 2014. 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.

Medicaid Director Andy Allison described the preliminary approach to the Independence Accounts at the Public Health Committee Meeting on April 24, 2014. Additionally, Private Option budget estimates were discussed at this meeting. Steve Schramm, founder and CEO of Optumas, an actuarial consulting firm under contract to DHS, testified regarding the cost estimates used to calculate the budget neutrality limit. DHS issued a press release on April 23, 2014 addressing this topic and summarizing Optumas’ finding that spending on health insurance premiums remain in line with the budget approved in the Special Terms and Conditions for the Health Care Independence Program and will not exceed budget targets after allowable adjustments are made, if needed.

On May 15, a number of hospital administrators and a representative from the Arkansas Hospital Association testified before a subcommittee of the Legislative Council Committee and reported results from a survey conducted by the Arkansas Hospital Association regarding emergency room utilization and uninsured hospital admissions. The survey results showed that, when compared to the first quarter of 2013, hospital respondents saw a 2 percent reduction in ER visits overall for the first quarter of 2014. During the same period, respondents saw a 24 percent reduction in ER visits by the uninsured and a 30 percent reduction in uninsured hospital admissions in the first quarter of 2014.

At the May 27 Public Health Committee meeting DHS and AID officials discussed and described the process by which the inclusion of benefits beyond the Essential Health Benefits (specifically vision and dental benefits) were available in some regions of the state to Private Option enrollees but were not available statewide in plan year 2014. In plan year 2014, one carrier that provided coverage in only certain areas of the state, had certified high-value silver plans that included these additional benefits. DMS has clarified that in plan year 2015 it will purchase EHB-only plans on behalf of Health Care Independence Program (HCIP) enrollees.

In June, Surgeon General Joe Thompson and Interim Medicaid Director Dawn Zekis provided additional information to the Public Health Committee regarding the proposed approach to implementing cost-sharing for HCIP enrollees with incomes greater than 50% of the Federal Poverty Level; the goals of the Independence Accounts; and the emerging plan to design a limited non-emergency transportation benefit for HCIP enrollees.

Eligibility and Enrollment:

Nearly 74% of Arkansans estimated to be eligible for the Private Option signed up in the first six months of the program. A total of 184,244 of the estimated 250,000 Arkansans who are estimated to qualify for health coverage through the Health Care Independence Program had applied and been determined eligible as of June 30.

An analysis of demographic information of those in the Private Option showed that most – 82 percent – had incomes too low to qualify for insurance through the Arkansas Health Insurance Marketplace.

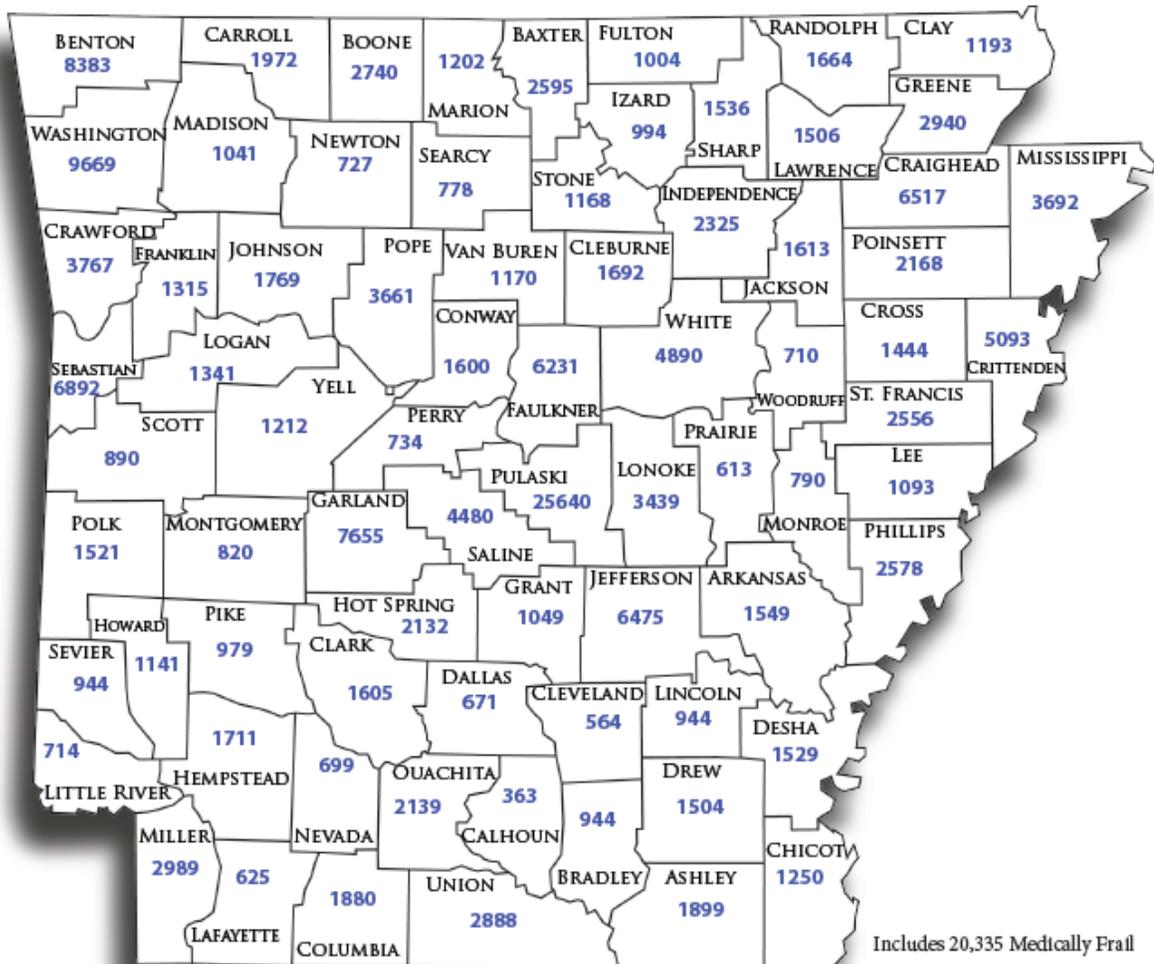
Statewide, 59 percent of Arkansans in the program are women and the average age of enrollees is 35 years old, a somewhat younger population than those getting coverage through the federal insurance marketplaces.

People in all 75 counties in Arkansas have been approved to get insurance through the program. Pulaski County led the state with 25,640 sign-ups followed by Washington County with 9,669, Benton County with 8,383, Garland County with 7,655, Sebastian County with

6,892, Craighead County with 6,517, Jefferson County 6,475, Faulkner County with 6,231, Crittenden County with 5,093, White County with 4,890 and Saline County with 4,480.

See graphic below for additional county level enrollment data.

As of July 31, 2014
192,210 Eligibility Approvals



The tables below provide additional demographic information on Private Option enrollees, detailed enrollment by carrier, type of enrollment (plan selection v. auto-assignments), medical frailty breakdowns and enrollment in the fee-for-service Alternative Benefit Plan (FFS ABP).

Demographics:

Through June 2014	Age			Income		Gender	
	19-30	31-45	46-65	Under 100% FPL	101-138% FPL	Male	Female
	62,175	62,234	59,835	150,770	33,474	75,084	109,160

Cumulative data as of 6/30/14. Data source: MMIS.

Private Plan Enrollment through 6/30/14:

Through June 2014	Total Plan Enrollments			Enrollments by Carrier			
	Self-selections	Soft Auto Assignments	Locked Auto-Assignments	Ambetter	Arkansas BCBS	Multi-state BCBS	Qual Choice
	68,653	4,684	88,531	35,320	67,042	54,307	5,199

Cumulative data as of 6/30/14. Data source: MMIS.

Exempt Population Enrollment from 10/1/2013 to 6/30/2014:

Through June 2014	Medically Frail determinations	Medically Frail Determinations (Average %)	ABP-State Plan	ABP-FFS equivalent of QHP
	19,508	10.58%	17,143	2,365

Transition to Market Issues:

During this quarter, a primary area of focus has been on identifying and addressing issues arising from the implementation of the requirements of the 1115 Demonstration Waiver and the Health Care Independence Act. To that end, the state has continued to focus on developing systems and operating procedures for the Alternative Benefit Plan that is the fee-for-service equivalent of the Qualified Health Plan (FFS QHP) offering. Programming changes needed to automate the fee-for-service Alternative Benefit Plan (FFS ABP) require significant systems re-design. Much work has been done to define the business requirements for a new plan code to support the FFS ABP and manual processes have been developed to operationalize the FFS ABP in calendar year 2014.

Additionally, operationalizing the Independence Accounts and applying cost-sharing to HCIP enrollees with incomes greater than 50% FPL will require the transition of these individuals with incomes between 50-100% FPL from 100% actuarial value health insurance plans to 94% actuarial value health insurance plans.

Developing a renewal strategy for HCIP enrollees has been an additional area of focus during this quarter. A policy decision was made to de-link eligibility renewal from the plan renewal process. HCIP enrollees will have their eligibility for participation in the program renewed annually, on the anniversary of the original eligibility date determination. Additionally, HCIP enrollees will be notified to go to the HCIP portal, insureark.org, during the Open Enrollment period to complete the Health Care Needs Questionnaire and for the opportunity to select a different plan, if desired. Only EHB-only silver plans will be available for selection on the insureark.org portal. The plan chosen during open enrollment will go into effect January 1, 2015. If a HCIP enrollee does not return to the insureark.org portal to choose a plan, they will be automatically enrolled into the Essential Health Benefits (EHB) only plan of their current carrier.

QHP Operations and Performance

Plan Management F.A. Q. released

In preparing for the upcoming plan year, the carriers participating in the Arkansas Marketplace had several questions concerning renewals. As a result, Arkansas Medicaid and the Arkansas Insurance Department released guidance addressing these issues. This guidance outlines the renewal process for Private Option Enrollees and provides insurance carriers with guidance needed to prepare for plan year 2015. The guidance is available from the following link: https://static.ark.org/eeuploads/hbe/PM_FAQ_Purchasing_Guidelines.pdf.

Stakeholder outreach:

The 1115 Waiver transparency regulations require that each demonstration state host a post-award hearing. In compliance with the regulations, DMS posted the public notice of the post-award hearing on a prominent place on the DMS website on May 10, 2014 and held the post-award hearing on June 13, 2014. As previously mentioned, there were forty-seven people in attendance with twenty-five submitting comments.

Audits

There have been no audits conducted during the second quarter of the Private Option Demonstration.

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 HCIP Demonstration is to measure whether the premium assistance service delivery model improved 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. Access will be evaluated using the following measures:

- a. Use of primary care and specialty physician services, including analysis of provider networks;
- b. Use of emergency room services (including emergent and non-emergent use);
- c. Potentially preventable emergency department and hospital admissions;
- d. EPSDT benefits access for young, eligible adults;
- e. Non-emergency transportation access;

At this time, data is not available to measure the Private Option's impact on access, but this will be thoroughly studied as one of the four key categories of the program's evaluation.

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 ultimately be available.

IV. Complaints/Grievances:

DHS has not received any formal complaints or grievances related to the Private Option Demonstration program. Additionally, AID has not received any complaints from Private Option enrollees this quarter.

- a. Provide the number, type and resolution of complaints and grievances**
- b. Include a discussion of the State's analysis of complaints and grievances and any changes made or planned to address problem areas**

V. 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 EHB-only silver-level plan on behalf of Private Option enrollees.

DMS' actuarial consultants also have confirmed that the average age of enrollees in QHPs through the Private Option has been higher in the first four months of 2014 than was assumed in the preparation of Arkansas's without waiver baseline.

Utilization:

Through the second quarter of 2014, expenditures for the newly-eligible adult group totaled \$365,419,407. Of this amount, \$280,699,082 was paid to the four carriers participating in the Marketplace. This amount includes both premium and cost-share reduction payments on behalf of 137,925 Private Option enrollees. As of June 30, total EPSDT services were \$1,320,591 family planning services \$580,294 and NET costs were \$4,237,074.

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

Arkansas Health Care Independence Program
QHP Monthly Payments and Wraparound Costs
July 31, 2014

	Enrollees	CSR	Premium	Total Premium Plus CSR Cost	Average Premium Per Person	Average CSR Per Person	Total Average Cost Per Person
January	58,515	\$7,873,260.69	\$20,014,741.27	\$27,888,001.96	\$342.04	\$134.55	\$476.60
February	69,895	\$9,379,805.50	\$24,394,867.70	\$33,774,673.20	\$349.02	\$134.20	\$483.22
March	80,049	\$10,739,642.26	\$28,154,397.93	\$38,894,040.19	\$351.71	\$134.16	\$485.88
April	102,364	\$13,829,139.00	\$36,492,038.00	\$50,321,177.00	\$356.49	\$135.10	\$491.59
May	127,766	\$17,206,000.44	\$45,424,103.81	\$62,630,104.25	\$355.53	\$134.67	\$490.19
June	137,925	\$18,574,246.76	\$48,616,838.85	\$67,191,085.61	\$352.49	\$134.67	\$487.16
July	148,092	\$19,962,782.86	\$52,091,184.63	\$72,053,967.49	\$351.75	\$134.80	\$486.55

QHP = Qualified Health Plan

CSR = Cost Sharing Reduction

Month	Total Wraparound Costs	Average Wraparound Costs Per Person
January	\$202.35	\$0.00
February	\$360,942.69	\$5.16
March	\$433,126.56	\$5.41
April	\$457,189.44	\$4.47
May	\$581,048.10	\$4.55
June	\$727,107.37	\$5.27
July	\$707,722.82	\$4.78

Wraparound = Non-Emergency Medical Transportation (NEMT) and Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) for 19 and 20 year old enrollees

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.