



# Arkansas Private Option 1115 Demonstration Waiver

## Quarterly Report

January 1, 2014 to March 31, 2014



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

During the second quarter of the Arkansas Health Care Independence Program (Private Option) Waiver Demonstration, activities focused primarily on complying with legislative requirements. 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 included special language requiring the Department of Human Services to apply cost sharing and implement independence accounts to private option enrollees with incomes greater than 50% of the Federal Poverty Level (FPL) by February 1<sup>st</sup>, 2015.

In continuing to comply with federal regulations, the post award hearing was also held during the second quarter of the private option. There were approximately fifty people in attendance with roughly twenty people commenting on the success of the program. There was one negative comment about...

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

Through the second quarter of the Private Option, media coverage significantly decreased. There were three media inquiries. Two inquiries were about the accuracy of the data received from the federal portal and one inquiry was concerning the reduction in premium payments for May.

In addition to the normal media inquiries, there was one article concerning the post award forum.

**Eligibility and Enrollment:**

Nearly 84% of Arkansans eligible for the Private Option signed up in the first six months of the program. A total of 190,759 of the estimated 225,000 Arkansans who qualify for health insurance through the Private Option had applied and been determined eligible as of June 30, surpassing expectations of the level of acceptance in the program's first year.

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 24,483 sign-ups followed by Washington County with 9,345, Benton County with 8,020, Garland County with 7,399, Sebastian County with

6,503, Craighead County with 6,232, Jefferson County 6,176, Faulkner County with 5,997, Crittenden County with 4,895, White County with 4,663 and Saline County with 4,312.

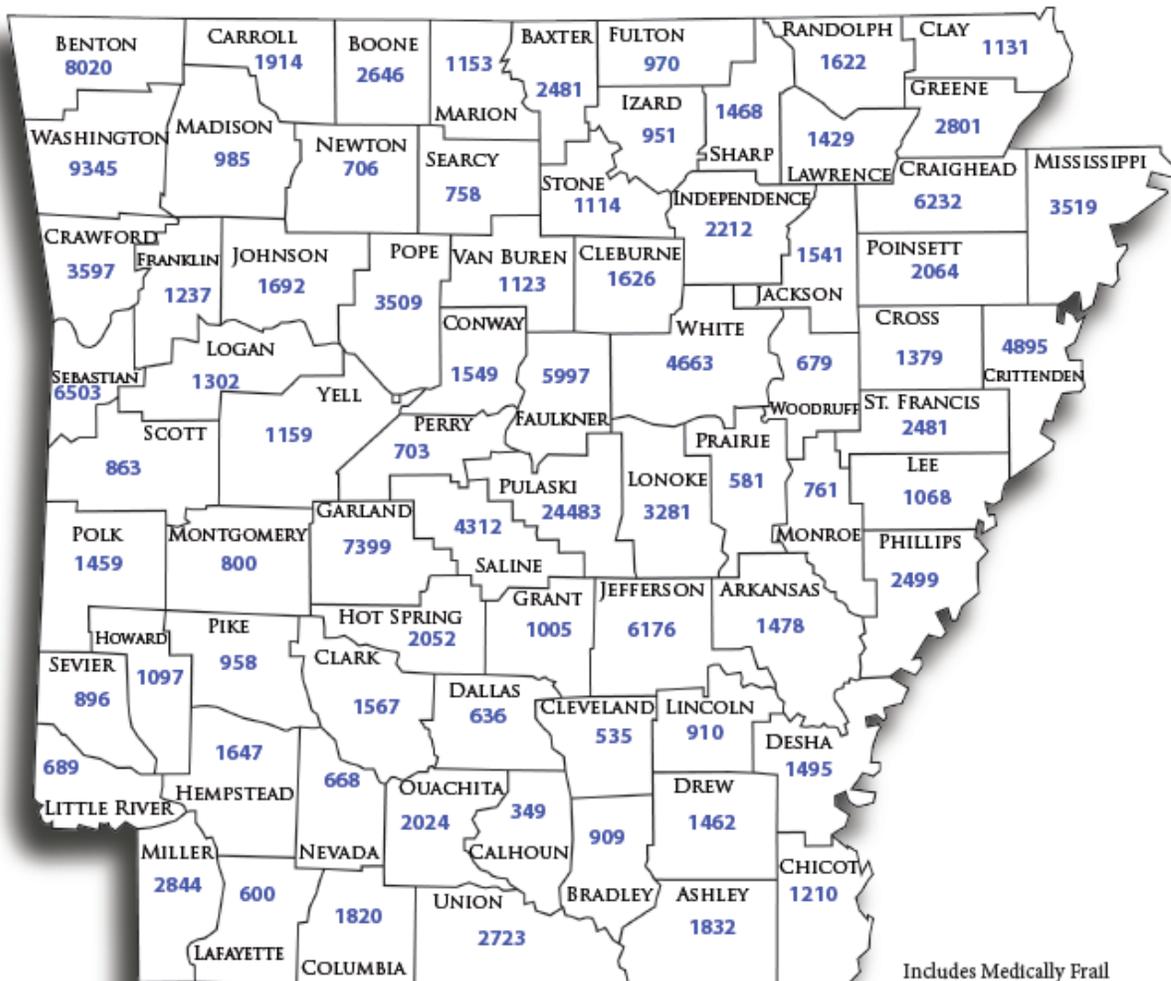
*See graphic on the following page for additional county level enrollment data.*

# Private Option

As of June 30, 2014

**184,244** Eligibility Approvals

**176,691** Enrollment Complete



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	70,084	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 3/31/2014:**

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:**

Much work during this quarter has been dedicated to 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 focused 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.

The transition to market and resulting high-volume of beneficiary requests also necessitated an amendment to an existing contract with the Arkansas Foundation for Medical Care (AFMC) to meet the is increased demand. A Private Option beneficiary relations specialist from AFMC is now assigned to this project and divides work time between managing the call-center and working on-site with DMS' Coordination of Coverage unit. Additionally, AFMC facilitates bi-weekly Private Option training and information sharing sessions that are typically attended by representatives from the Arkansas Insurance Department (AID), the Division of County Operations, Division of Medical Services, HP Enterprise Services (the state's MMIS vendor and operator of the insureark.org portal), ConnectCare and ValueOptions®. ConnectCare, a program administrated by the Arkansas Department of Health, assists AR Medicaid and ARKids First families find a Medical Home by connecting them to a primary care doctor (PCP) and dental care. ValueOptions® is a QIO-like organization that assists DHS in administering the State's mental health care delivery system.

### ***QHP Operations and Performance***

#### *Non-Essential Health Benefits and State-Mandated Offerings:*

In the first plan year of the Demonstration, all Qualified Health Plans (QHPs) participating in the Arkansas Health Insurance Marketplace, a Federally Facilitated Marketplace Partnership that is referred to as the Arkansas Health Connector (AHC), contain at least some benefits beyond the mandatory Essential Health Benefits (EHBs). Two issuers included state mandated offerings, temporomandibular joint disorder (TMJ) and hearing aids, while another issuer included adult vision and dental benefits. These additional benefits were not included in the state's per-member-per-month waiver budget projections. With the exception of TMJ and hearing aids, these benefits will not be included in the plans available to Private Option enrollees in the second year of the demonstration. Due to Arkansas statutory language and the Center for Consumer Information & Insurance Oversight's (CCIIO) requirement that riders not be allowed with any filing, TMJ and hearing aids will be considered EHBs. CMS-CCIIO approved the option to include TMJ and hearing aids as part of Arkansas's EHB benchmark plan. Arkansas's EHB has been given approval to open early for this specific purpose of allowing the mandated offering to be changed to a mandatory benefit requirement.

#### *Supplemental Payments for Deliveries During The First Two Quarters of 2014:*

To compensate carriers for the incremental and unexpected costs of deliveries by Private Option women who enrolled through the SNAP-facilitated eligibility determination process, DMS will pay Issuers a time-limited supplemental payment of \$4,500. Two quarterly supplemental payments will be made to carriers during this time period – once after the end of

March 2014 and once after the end of June 2014. Payment will be made from DMS to Issuers via a check-based payment and not via an EFT payment.

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 QHPs. DMS has finalized and communicated to carriers the process for issuing these payments.

*Memorandum of Understanding (MOU) Amended to Describe Mid-year Transition Process:*

During this quarter, DMS, AID and the Issuers amended the MOU for the Private Option to outline the process for and describe the circumstances under which a Private Option enrollee could transition from the QHP to fee-for-service Medicaid during the course of the plan year. The relevant provision of the MOU amendment states:

On or before June 30, 2014, the Issuer Plan may identify and notify DMS of certain Issuer Enrollees who may be eligible for coverage under State Medicaid services for the “medically frail” who have current or ongoing needs for health services not covered by the Issuer Plan but which may be available under State Medicaid services. *Enrollee Notice: The Issuer Plan shall provide the Issuer Enrollee with written notification that it has identified the Issuer Enrollee as possibly eligible for State Medicaid services simultaneous to the Issuer Plan’s notification to DMS. This notice shall explain that the Issuer Enrollee may be medically frail as a result of current or ongoing needs for health services, and may qualify for services that are not available under the Issuer Plan but which may be available through State Medicaid services. DMS shall provide to the Issuer Plan contact information (name or position title, telephone number and address) of the individual at DMS who will be responsible for processing medically frail requests and advising the Issuer Enrollee how to apply for coverage for State Medicaid services. The Issuer Plan shall provide the DMS contact information to the Issuer Enrollee in the Issuer Plan notification. The notice may require additional language to be submitted under a format as required by DMS or AID.* The Issuer Plan shall attest to DMS and to the Issuer Enrollee that the Issuer Enrollee is expected to request a service not covered by the qualified health plan and the Issuer anticipates a hardship on the Issuer Enrollee . Upon approval or agreement by DMS and upon written consent or authorization of the Issuer Enrollee, the Issuer Plan may dis-enroll the Issuer Enrollee, upon such terms and conditions, as are agreed to between DMS, the Issuer Plan and Issuer Enrollee on a case by case basis. In the event of approval by DMS and dis-enrollment by the Issuer Plan: 1) the Issuer Plan shall provide the Issuer Enrollee with written notice advising the enrollee of the cancellation; and 2) DMS shall: a) notify the Issuer Enrollee in writing of its determination regarding the Issuer Enrollee’s qualifications for coverage under State Medicaid services; and b) identify any effective dates for coverage changes. The effective date of the termination of the Issuer Plan coverage shall be the last day of the month in which both the DMS determination the Issuer Enrollee’s medically frail status and the Issuer Enrollee’s approval of the plan change have occurred.

*QualChoice Acquisition by Catholic Health Initiatives:*

QualChoice of Arkansas, one of the four carriers participating in Arkansas Health Insurance Marketplace, was purchased by Catholic Health Initiatives. The acquisition was announced on April 2, 2014.

***Stakeholder outreach:***

During the first quarter of the Private Option, a number of meetings were held with various stakeholder groups, including the Department of Corrections and the Association of County Jails; the Community Health Centers of Arkansas (FQHCs); Arkansas Advocates for Children and Families; the Arkansas and American Cancer Societies; the Arkansas Hospital Association; representatives from BreastCare, a program administered by the Arkansas Department of Health that provides breast and cervical cancer screening for eligible Arkansas women; and the University of Arkansas for Medical Services (UAMS, Arkansas's only comprehensive academic health center). During this quarter, stakeholders primarily wanted to develop a better understanding of new coverage opportunities available under the Private Option and disseminate eligibility and enrollment information in order to seamlessly transition beneficiaries from the historic limited-benefit Medicaid programs (e.g. ARHealthNetworks, TB coverage, the breast and cervical program and family planning services) to the Private Option.

DMS actively participates in the work coordinated by Arkansas Health Connector (AHC) by serving on a number of committees including the Plan Management, Consumer Assistance and Steering Committees. This provides another forum for exchanging information regarding the Private Option and provides an additional opportunity to address stakeholder concerns. AID also convenes a monthly meeting with insurance carriers to discuss QHP operations and IT issues.

***Audits***

Arkansas's Private Option was the subject of a Special Report conducted by the Division of Legislative Audit (DLA) for the sixty day period from October through November of 2013. The objective of the review was to answer questions raised by the Legislative Joint Auditing Committee by obtaining and verifying information about the Private Option program. The following questions were addressed in the Special Report:

1. What is the enrollment process for the Private Option?
2. What is the assignment process for the Private Option?
  - a. What factors are used to determine the plan to which an individual is assigned?
  - b. Are assigned individuals spread evenly across the available insurance providers, or is some other method used?
  - c. Are individuals assigned to plans within a certain region of the State? If so, how many regions are there, and how were they determined?

3. For those individuals who have been assigned to a health care plan through the Private Option:
  - a. Is there a deductible? If so, is the individual or Medicaid required to pay the deductible, or is it covered by the plan?
  - b. Is there a co-pay? If so, is the individual or Medicaid required to pay the co-pay, or is it covered by the plan?
4. How are individuals determined to be medically frail for purposes of the Private Option? What medical conditions are used to identify individuals considered medically frail?
5. Can demographic information associated with Medicaid and the Private Option, including age, sex, race, location, and income level, be determined?
6. Are any cross reference methods in place to determine total amount of state assistance an individual receives from various services?
7. If a person or provider is convicted of Medicaid fraud, how would his or her ability to maintain insurance or provide services be affected?
8. What procedure was used to estimate the cost for the wrap around services and how were those estimates verified?
9. Are the procedures used to enroll and assign individuals to the Private Option in compliance with Arkansas law and the Health Care Independence 1115 Demonstration Waiver?
10. Are SNAP program eligibility requirements the same as Medicaid eligibility requirements? If not, how do they differ? Is income verification used, and does each program have an asset limit?
11. Does auto enrollment conform with the requirements of ACA, or is that a decision or option exercised under the Private Option Waiver?
12. During the period covered by this special report:
  - a. How many people have been assigned to a health care plan through the Private Option?
  - b. How many people have enrolled in a health care plan through the Private Option?
  - c. How many people have enrolled in a health care plan through the exchange who were not eligible to enroll through the Private Option?
    - i. What are the demographics (age / sex / race / location / income level) of this group?
13. What are the average insurance costs for individuals enrolled in the Private Option?
14. It has been stated that individuals who are eligible for the Private Option will enroll in Silver-level plans. What is the range of cost for these plans?
15. What are the percentages of state and federal costs for the Medicaid program and the Private Option?
16. What is the rate of return on various enrollment/assignment efforts used by the State?
17. What are the projections for increased cost to the State as the plan runs out in the future, and what methods support these projections?

The final version of the Special Report of the Legislative Joint Auditing Committee report for the Private Option was released on January 30, 2014. The conclusion of the Special Report was that “based on DLA review, enrollment and auto-assignment procedures appeared to comply with Arkansas law and the waiver.”

### ***Lawsuits***

There have been no lawsuits filed related to the Private Option Demonstration.

### ***Legislative Developments***

As previously mentioned, the Arkansas General Assembly met during this quarter for a fiscal session. On Tuesday, March 4, the General Assembly passed Act 257, the appropriation for the Division of Medical Services for the 2014-2015 state fiscal year. Governor Mike Beebe signed this act into law on Friday, March 7, 2014. This Act authorizes funding for the Private Option for the 2014-2105 state fiscal year.

Act 257 contains Special Language that requires three revisions to the Private Option. Section 17, which outlines the required programmatic changes, is below:

(c)(1) The Department of Human Services shall 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:

(A) Approval of a limited state-designed nonemergency transportation benefit for persons covered under the Health Care Independence Program;

(B) Approval of a model to allow non-aged, nondisabled persons eligible to participate in the Health Care Independence Program to enroll in a program that will create and utilize independence accounts that enroll in a program that will create and utilize independence accounts that operate similarly to a health savings account or medical savings account; and

(C) That cost sharing under the Health Care Independence Program shall apply to beneficiaries with incomes above fifty percent (50%) of the federal poverty level.

## ***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 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.

During this quarter, AID received a question about the adequacy of limited-network plans participating in the Marketplace. The issue has been resolved with the Insurance Commissioner having concluded that all plans as currently approved conform to Arkansas's Any Willing Provider law.

### **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 does not yet have a process in place that separates Marketplace plans for the purpose of identifying complaints or grievances.

**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 ensures that an EHB-only plan will be available from every participating carrier for purchase through the Private Option.

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. As a result, DMS intends to submit an adjustment to its without waiver baseline prior to October per term 62 of the Special Terms and Conditions (STCs) for the Private Option Demonstration.

**VI. Utilization:**

During the first quarter of 2014, expenditures for the newly-eligible adult group totaled \$125,875,257. Of this amount, \$100,556,715 was paid to the four carriers participating in the Marketplace. This amount includes both premium and cost-share reduction payments on behalf of 81,208 Private Option enrollees. As of April 3, total EPSDT services were \$3,627.66, family planning services \$4,219.80 and NET costs were \$799,170.58.

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.