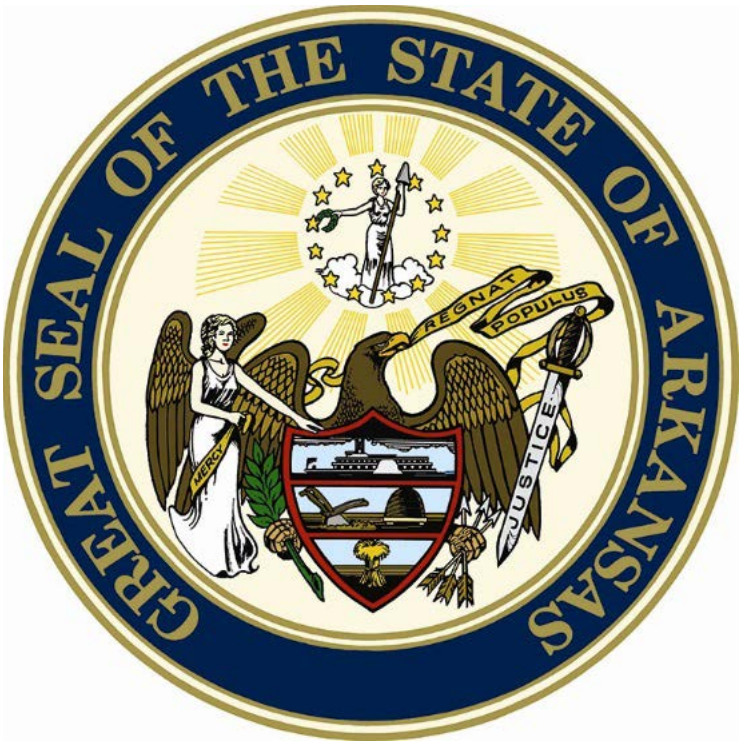


Arkansas Private Option 1115 Demonstration Waiver

2014 Annual Report

January 1, 2014 to December 31, 2014

ARKANSAS DEPARTMENT OF HUMAN SERVICES

I. Executive Summary of Significant Activities of the Year

Arkansas was the first state to receive federal approval for an alternative to Medicaid expansion. Under Arkansas's 1115 waiver demonstration for the Health Care Independence Program (HCIP or Private Option), the state is using premium assistance to purchase coverage from the Qualified Health Plans (QHPs) participating in the state's Marketplace to provide coverage to over 209,000 newly eligible adults; an additional 23,000 newly eligible adults have been determined to be medically frail and are receiving coverage under the state's fee-for-service system.

The state's enabling legislation for this Program, the Health Care Independence Act, specifically lists a number of purposes of the Act, including attracting insurance carriers and enhancing competition in the Arkansas insurance Marketplace and encouraging the appropriate use of care. Arkansas has demonstrated early successes in the first year of this demonstration program. Importantly, in its first year, the Program has contributed to the following positive trends: (1) increased competition in the individual insurance Marketplace; (2) a decrease in the overall premium rates for the individual Marketplace; (3) a dramatic decrease in the number of uninsured Arkansans, (4) a significant reduction in uncompensated care costs; and (5) a decrease in emergency room utilization rates.

Increased competition:

In the first year of the Program, four insurance carriers participated in Arkansas Health Insurance Marketplace. Only two of those carriers, Blue Cross & Blue Shield of Arkansas and Blue Cross & Blue Shield Multi-state, offered coverage statewide. In July of 2014, the Arkansas Insurance Department announced that five companies have filed to sell individual health insurance plans on Arkansas's Federally-facilitated Health Insurance Marketplace for the 2015 plan year. The issuers filing for qualified health plan certification are Arkansas Blue Cross Blue Shield, Celtic Insurance Company, National Blue Cross Blue Shield Multi-State, QCA Health Plan Inc., and QualChoice Life and Health Insurance Company, Inc. All of these issuers will offer statewide coverage for the 2015 plan year. The press release is available at the following link: http://ahc.arkansas.gov/press-releases/detail/aid-commissioner-announces-companies-filing-2015-plans-on-health-insurance.

Decreased premium rates:

Overall premium rates for the individual Marketplace for plan year 2015 dropped on average two percent from 2014 premium rates. In August, Governor Beebe announced that the Arkansas Insurance Department projected that insurance policies sold through the Arkansas Health Insurance Marketplace would have a net decrease of two percent in premium costs for 2015. This is significant because, historically, national insurance costs have typically risen by six to ten percent a year. On October 3, 2014, the Arkansas Insurance Department reconfirmed the earlier projection, that rates for the Arkansas Health Insurance Marketplace had a net decrease of two percent in premium costs for 2015. The rate projection was accurate and premium rates did not change during final rate review by the federal Department of Health & Human Services. Additional information available at the following links: https://static.ark.org/eeuploads/hbe/RatesDrop_release_8.24.14.pdf and

http://www.insurance.arkansas.gov/index_htm_files/pr2014-10-2.pdf.

Uninsured rate:

According to Gallup, Arkansas had the largest reduction of any state in its uninsured rate among adults between 2013 and 2014. The state's uninsured rate dropped from a rate of 22.5% uninsured in 2013 to a rate of 11.4% in 2014. Additional information available at: http://www.gallup.com/poll/181664/arkansas-kentucky-improvement-uninsured-rates.aspx?version=print.

Also, see Appendix I for additional information.

Uncompensated care costs:

According to a survey conducted by the Arkansas Hospital Association (AHA), Arkansas's hospitals experienced a 56.4% decrease in uncompensated care losses in the first half of 2014. This decrease resulted in a benefit of $69.2 million during this six month time period. The number of Arkansans hospitalized without insurance during this timeframe fell by 46.5% when compared with the same time period in 2013. Additional information available at: http://www.achi.net/Pages/News/Article.aspx?ID=56.

Appendix II contains additional information on the results of the Arkansas Hospital Association Survey.

Emergency room utilization:

The same AHA survey mentioned above reported that overall emergency room utilization only increased by 1.8% over the first six months of 2013. Hospitals saw the number of uninsured emergency room visits decline by 35.5% during this time. The decrease in the rate of the uninsured contributed to an almost 6% increase in total non-urgent hospital outpatient clinic visits. This indicates that individuals are seeking care in more appropriate settings, such as hospital outpatient clinics and physician offices. The number of uninsured seen in hospital outpatient clinics fell 36% percent during the first half of 2014. More information available in Appendix II.

Significant Activities of the Year:

During the first year of Arkansas's demonstration, enrollment in the Qualified Health Plans reached 230,367 by the end of the year. Ninety percent of newly eligible adults received coverage under the demonstration from the Qualified Health Plans (QHPs) offered by the four insurance carriers participating in Arkansas's Marketplace: Blue Cross of Arkansas, Blue Cross Blue Shield Multi-State, Ambetter of Arkansas and QualChoice.

Approximately 10% of the newly eligible adults were determined to be medically frail and received services through the state's fee-for-service Medicaid program.

During the second half of 2013, Arkansas Division of Medical Services (DMS) worked to build the systems infrastructure needed to implement this innovative program, which launched on January 1, 2014. Arkansas successfully built a web-portal to support the enrollment phase of the Private Option, commonly referred to as insureark.org. The insureark.org portal supports the state's Health Care Needs Questionnaire, which is used to determine an individual's medically frailty status and allows individuals to select among the high-value silver Marketplace plans available in their region of the state. The insurark.org portal was fully operational at the beginning of open enrollment on October 1, 2013 and continues to operate well.

In April of 2014, the Arkansas Insurance Department (AID) issued bulletin number 9-2014, which outlined the 2015 plan year requirements for Qualified Health Plan (QHP) 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 applied to the Private Option, as well as the Marketplace as a whole. The bulletin can be found here: http://www.insurance.arkansas.gov/Legal/Bulletins/9-2014.pdf.

Arguably, the most significant issue of the year for the HCIP was whether the Arkansas General Assembly would appropriate funding required to continue to operate the HCIP during the 2014 fiscal session. The Division of Medical Services (DMS) budget required a 75% super-majority vote in order for DMS to have the authority to continue to fund Medicaid programs, including the Private Option, beyond June 30, 2014. The Private Option funding debate was the preeminent issue of the fiscal session, but ultimately the DHS budget did receive the necessary super-majority votes needed to continue appropriation for Medicaid Programs, including the Private Option, for state fiscal year 2015.

The appropriations bill, Act 257, included special language requiring DHS to make three revisions to the Private Option. Act 257 required 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 (HIAs); and (3) application of cost-sharing to Health Care Independence Program enrollees with incomes above 50% of the federal poverty level.

During the first year, great strides were made to operationalize the requirements of Act 257. For the Health Independence Accounts (HIAs) a vendor was selected, a contract was drafted and approved by the state legislature. Additionally, to prevent barriers to accessing care, it was decided that the HIAs would serve as the cost sharing mechanism for Private Option enrollees with incomes below 100% of the federal poverty level (FPL). Lastly, contract amendments for the newly designed non-emergency medical transportation system were completed and effective February 1, 2015.

Besides operationalizing the requirements of Act 257, much effort was expended to educate providers on the program, including the Alternative Benefit Plan (ABP) that is the equivalent to the Qualified Health Plans (QHPs). Arkansas hosted several provider education classes throughout the state to educate providers on the differences of the ABP that is equivalent to the Medicaid state plan and the ABP that is the equivalent to the QHP offering.

Another significant activity during the first year of the demonstration was the approval of the Private Option Evaluation Design. Arkansas received federal approval of the evaluation design March 24, 2014. The principal purpose of the evaluation is to determine the cost-effectiveness of the demonstration; the demonstration will also consider the other impacts for Private Option enrollees, such as the impact on churning and on marketplace competition. In accordance with the Standard Terms & Conditions (STCs), the approved evaluation design was posted to the Division of Medical Service's website on March 26, 2014; it is available at the following link: https://www.medicaid.state.ar.us/Download/general/comment/HCIWEvalStrategy.pdf.

On May 15, 2014, data was released that showed the positive impact of the Private Option 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. Additional information is available at the following link: http://www.achi.net/Docs/220/.

On June 13, 2014, in accordance with the Special Terms and Conditions (STCs) of the demonstration waiver, Arkansas hosted a post award forum. Forty-seven people attended the forum and twenty-five comments were submitted. The comments were overwhelmingly positive and focused on the benefits of enhanced access to health care.

During the fall of 2014, gears shifted to prepare for plan year 2015. In plan year 2014, all QHPs participating in the Arkansas Health Insurance Marketplace contained 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. As a result, it was decided that for plan year 2015, with the exception of TMJ and hearing aids (state mandated offerings that became a part of the state's Benchmark plan), plans that contained only the essential health benefits would be available to Private Option enrollees and

DMS would use premium assistance only to purchase the lowest cost EHB only plans offered by each issuer.

On October 3, 2014, the Arkansas Insurance Commissioner announced via a press release that the rates for all Marketplace consumers in 2015 were projected to drop on average by approximately 2 percent from 2014. The press release can be found here: http://www.insurance.arkansas.gov/index_htm_files/pr2014-10-2.pdf

Arkansas Makes Time-Limited Supplemental Payments for Deliveries to Insurance Carriers

On March 26, 2014, the Arkansas Medicaid Director sent a letter to all participating insurance carriers explaining that some participants that were enrolled in the Private Option through the one-time Supplemental Nutrition Assistance Program (SNAP) facilitated enrollment strategy were not asked about pregnancy status. Consequently, some women were enrolled into QHPs while pregnant. In order to avoid disruption to both patients and providers and to align with CMS policy for the Marketplace as a whole, DMS maintained coverage under the Private Option for pregnant women in QHPs. To compensate carriers for the incremental and unexpected costs of deliveries of Private Option women, DMS paid Issuers a time-limited supplemental payment of $4,500 for each delivery. The supplemental payments were only paid for deliveries of Private Option enrollees between January 1, 2014 and June 30, 2014. Supplemental payments were made for 194 deliveries and totaled $873,000.

Arkansas Insurance Department Releases Bulletin 9-2014

On April 14, 2014, the Arkansas Insurance Department released bulletin 9-2014. The bulletin outlined the 2015 plan year requirements for Qualified Health Plan Certification. Since Arkansas uses premium assistance to purchase silver level plans from the Marketplace, the requirements outlined in the Bulletin apply to the Private Option, as well as the Marketplace as a whole.

The Bulletin outlined 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, 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; submitting a list of school-based providers; and requiring that at least one Community Health Centers of Arkansas (FQHCs) or Rural Health Center (RHC) in each regional service area of the plan network is offered in the Marketplace.

The Bulletin also required 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 each carriers lowest cost 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.

Catholic Health Initiative Acquires Qual Choice

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.

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 Stehle, Medicaid's director of Health Care Innovation since April 2012, served as interim Medicaid Director, and was later appointed Medicaid Director.

The press release can be found at the following link:
http://humanservices.arkansas.gov/pressroom/PressRoomDocs/AllisonNRmay14.pdf

Data Released Showing Positive Impact of the Private Option Regarding ER Usage and Uninsured Hospital Admissions

On May 15, the Arkansas Hospital Association released preliminary survey data. The data indicated that hospitals across the state were experiencing a decline 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. 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.

On November 3, the Arkansas Hospital Association released additional survey data. This data specified that during the first six months of 2014, hospitals responding to the survey, roughly 80% of all hospitals care provided in the state, reported vast reductions in the number of uninsured patients being cared for across all service settings, including inpatient, emergency department and hospital outpatient clinics. For the period January to June, overall inpatient hospital admissions remained relatively unchanging compared with the same period in 2013, rising less than 1 percent. Within that minor increase, the number of uninsured hospitalized patients who had no other source of payment for their healthcare fell by 46.5% in 2014. More information is available at the following link:
http://www.arkhospitals.org/archive/notebookpdf/Notebook_11-03-14.pdf

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 Private Option Program coverage would end, effective May 31, because their information was pending verification and their applications were incorrectly included among applications of eligible individuals. Some of the individuals who received letters were, in fact, eligible for the Health Care Independence Program and were instructed to go to www.accessarkansas.gov and provide any additional information needed to complete the verification process. Others were instead eligible for coverage through the Federally Facilitated Marketplace and were instructed to return to www.healthcare.gov . Loss of Private Option coverage was a qualifying event that will allow individuals to return to the Marketplace for a special enrollment period. Individuals who completed the application process and were determined eligible for the Health Care Independence Program received retroactive Medicaid coverage and, therefore, did not have a gap in coverage.

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, in the form of a frequently asked questions document. This guidance clarified that Private Option eligible individuals would only be permitted to enroll in the lowest cost Essential Health Benefit (EHB)-only silver-level plan offered by each carrier participating in Arkansas's Health Insurance Marketplace. According to requirements in AID guidance (Bulletin 9-2014), all issuers were required to offer an EHB only silver plan in order to offer QHPs in the Marketplace. This guidance also signaled DHS' future intent with regard to purchasing strategies to reduce Marketplace concentration and increase the competiveness of the Marketplace in coverage year 2016 and beyond. The guidance is available at 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://www.medicaid.state.ar.us/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 that 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 the findings of a service learning project they conducted which included qualitative interviews of Marketplace participants to learn about the experiences of individuals obtaining insurance through the Arkansas Marketplace. They prepared a report entitled "Voices of the Newly Insured", which summarized the main themes from the 29 interviews they conducted and shares the stories of 11 Arkansans and their unique experiences. The full report is available at the following link: http://publichealth.uams.edu/files/2012/06/Voices-of-the-Newly-Insured.pdf.

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, Dr. Joseph Thompson, also made comments. He noted that the Private Option was being implemented as set forth in the terms and conditions of the waiver 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 working to implement the three changes to the Private Option as 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 & Conditions for the Private Option 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 clarified that in plan year 2015 it will purchase each carrier's lowest cost EHB-only plan on behalf of Private Option enrollees.

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

Implementation of Health Independence Accounts

In September, the Arkansas General Assembly approved the contract between DataPath, Inc. and DMS for the implementation of the Health Independence Accounts (HIA). Also during that month, DMS and DataPath collectively worked on branding the program, MyIndyCard. DataPath, Inc. completed technological development for implementation of the daily extract file from the Medicaid 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 call center was also completed on December 29, 2014.

Additionally, the vendor contracted with a subcontractor, Arkansas Foundation for Medical Care, 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 fully launched January 1, 2015.

Designing the Limited Non-Emergency Medical Transportation System

In addition to implementing the Health Independence Accounts, 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. Actuarial calculations were 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.

In January 2013, contracts between the state and non-emergency medical transportation providers were amended to reflect the limited non-emergency medical transportation design. The amendments were effective February 1, 2015.

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). As previously stated, the Arkansas General Assembly convened for a fiscal session, in which DHS budget was the preeminent issue. The appropriations bill, Act 257, included special language requiring DHS to make three revisions to the Private Option. Act 257 required 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:

By the end of the year nearly 92% of Arkansans estimated to be eligible for the Private Option had signed up for the program. A total of 230,367 of the estimated 250,000 Arkansans who are estimated to qualify for health coverage through the Health Care Independence Program had 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 coverage through the QHPs.

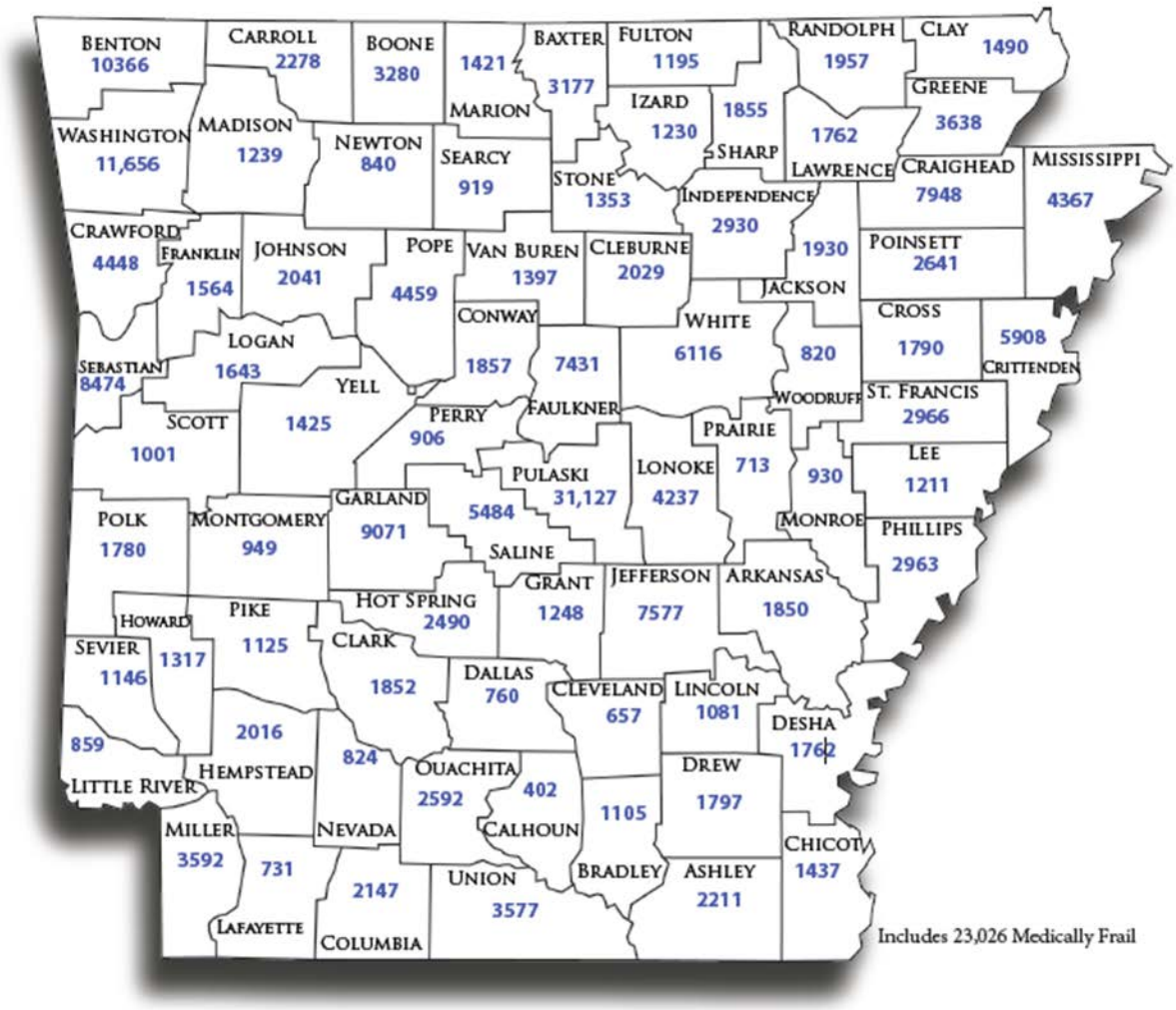
People in all 75 counties in Arkansas have been approved to get insurance through the program. Pulaski County led the state with 31,127 sign-ups followed by Washington County with 11,656, Benton County with 10,366, Garland County with 9,071, Sebastian County with 8,474, Craighead County with 7,948, Jefferson 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).

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

Spend by Month

	1/1/2014	2/1/2014	3/1/2014	4/1/2014	5/1/2014	6/1/2014	7/1/2014	8/1/2014	9/1/2014	10/1/2014	11/1/2014	12/1/2014	Total
Premium	$ 84,597,165	$ 27,418,678	$ 31,974,720	$ 35,950,204	$ 44,306,657	$ 53,663,251	$ 57,024,485	$ 60,890,291	$ 65,080,800	$ 67,472,892	$ 70,038,290	$ 74,291,290	$ 672,708,632
CSR	$ 24,783,535	$ 15,166,405	$ 16,677,021	$ 18,047,420	$ 21,010,731	$ 24,425,410	$ 25,783,881	$ 27,252,003	$ 28,801,464	$ 29,583,963	$ 30,437,770	$ 31,748,636	$ 293,718,239
QHP Total	$ 109,380,699	$ 42,585,083	$ 48,651,741	$ 53,997,624	$ 65,317,388	$ 78,088,661	$ 82,808,366	$ 88,142,294	$ 93,882,264	$ 97,056,855	$ 100,475,970	$ 106,039,926	$ 966,426,871
Supp.	$ 202	$ 360,475	$ 432,530	$ 456,573	$ 579,939	$ 725,414	$ 705,550	$ 753,968	$ 818,331	$ 978,247	$ 980,736	$ 1,042,935	$ 7,834,901
Total	$ 109,380,902	$ 42,945,558	$ 49,084,271	$ 54,454,197	$ 65,897,327	$ 78,814,075	$ 83,513,917	$ 88,896,262	$ 94,700,595	$ 98,035,102	$ 101,456,705	$ 107,082,862	$ 974,261,772

Spend PMPM

	1/1/2014	2/1/2014	3/1/2014	4/1/2014	5/1/2014	6/1/2014	7/1/2014	8/1/2014	9/1/2014	10/1/2014	11/1/2014	12/1/2014	Total
Premium	$ 342.82	$ 350.10	$ 353.29	$ 357.70	$ 357.62	$ 355.11	$ 354.76	$ 354.20	$ 353.49	$ 353.26	$ 354.02	$ 354.39	$ 354.01
CSR	$ 134.69	$ 134.27	$ 134.24	$ 134.76	$ 134.72	$ 134.68	$ 134.79	$ 134.47	$ 133.92	$ 133.45	$ 132.40	$ 132.27	$ 133.88
QHP Total	$ 477.51	$ 484.37	$ 487.52	$ 492.45	$ 492.34	$ 489.79	$ 489.55	$ 488.67	$ 487.41	$ 486.72	$ 486.42	$ 486.66	$ 487.89
Supp.	$ 0.00	$ 5.25	$ 5.48	$ 4.54	$ 4.61	$ 5.33	$ 4.81	$ 4.75	$ 4.96	$ 5.69	$ 5.35	$ 5.60	$ 4.96
Total	$ 477.52	$ 489.62	$ 493.01	$ 496.99	$ 496.94	$ 495.12	$ 494.35	$ 493.43	$ 492.37	$ 492.41	$ 491.78	$ 492.26	$ 492.85

Average Age by Month

1/1/2014	2/1/2014	3/1/2014	4/1/2014	5/1/2014	6/1/2014	7/1/2014	8/1/2014	9/1/2014	10/1/2014	11/1/2014	12/1/2014	Total
42.00	46.38	38.72	39.13	39.17	39.24	39.10	38.87	38.79	38.69	38.54	38.45	38.43

Member per Month

1/1/2014	2/1/2014	3/1/2014	4/1/2014	5/1/2014	6/1/2014	7/1/2014	8/1/2014	9/1/2014	10/1/2014	11/1/2014	12/1/2014	Total
57,321	68,709	78,903	100,557	125,900	135,987	146,749	158,596	165,009	171,920	183,150	186,321	1,579,127

Transition to Market Issues:

During the first year of the demonstration, the state focused on identifying and designing systems changes needed to operationalize 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) required significant systems redesign. Much work was done to define the business requirements for a new plan code to support FFS ABP and manual processes were developed to operationalize the FFS ABP.

Additional support was needed to address the high-volume of beneficiary requests. DMS amended an existing contract with the Arkansas Foundation for Medical Care (AFMC) to meet the increased demand for consumer assistance. Additionally, AFMC facilitated bi-weekly Private Option training and information sharing sessions that were 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 Quality Improvement Organization that assists DHS in administering the State's mental health care delivery system.

Developing a renewal strategy for HCIP enrollees was an additional area of focus during the year. A policy decision was made to de-link eligibility renewal and the plan renewal processes. Private Option enrollees will have their eligibility for participation in the program renewed annually. Additionally, Private Option enrollees were notified to go to insureak.org, during the open enrollment period, November 15-February 15, to complete the Health Care Needs Questionnaire and to have the opportunity to select a different plan. Only each carrier's lowest cost EHB-only silver plans were available for selection on the insureark.org portal. The plan, if chosen before December 15, went into effect January 1, 2015. If a HCIP enrollee did not return to the insureark.org portal to choose a plan, they were automatically enrolled into the lowest cost Essential Health Benefits (EHB) only plan of their current carrier.

Stakeholder Outreach:

Throughout the year, a number of meetings were held with various stakeholder groups, including the Department of Corrections and the Association of County Jails; Arkansas Insurance Department, 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 Medical Sciences (UAMS, Arkansas's only comprehensive academic health center).

Initially, these meetings were to ensure that stakeholders had a complete understanding of new coverage opportunities under the Private Option and to disseminate eligibility and enrollment information. In addition to stakeholder meetings, DMS actively participated in the State Marketplace by serving on a number of committees coordinated by the Arkansas Insurance Department's Health Connector Division. DMS representatives are members of the Plan Management, Consumer Assistance and Steering Committee and attend monthly meetings, which provided another forum for exchanging information regarding the Private Option and provided an additional opportunity to address stakeholder concerns. AID also convened monthly meetings with insurance carriers to discuss QHP operations and IT issues.

Besides stakeholder meetings and AID meetings, there are monthly Public Health Committee meetings, in which Arkansas Surgeon General, DHS Director and Medicaid director provided updates on the progress of the demonstration and received feedback from state legislators.

Along with regularly scheduled stakeholder outreach, the 1115 Waiver transparency regulations require that each demonstration state hosts a post-award hearing. In compliance with these regulations, DMS posted the public notice of the post-award hearing in a prominent place on the DMS website May 10, 2014 and held the post-award hearing on June 13, 2014. As previously stated, there were forty-seven people in attendance with twenty-five submitting comments. Comments were overwhelmingly positive and focused on the benefits of increasing access to care.

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."

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 the report released in 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 costs of the program, and cost sharing.

Lawsuits

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

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. 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. 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 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

Arkansas Center for Health Improvement (ACHI) was selected to complete the evaluation for the Private Option program. In August, the Arkansas General Assembly approved the contract between ACHI and DMS. Since then, ACHI has assembled a team and began to work with insurance carriers to obtain the necessary data to complete the evaluation.

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.

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 available in future evaluation reports.

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 delegated coverage appeals to the Arkansas Insurance Department (AID). In 2014, AID reported receiving eleven complaints. Eight of those complaints were resolved with the carrier's position being upheld; one resulted in the company position overturned. Two complaints are still unresolved.

Budget Neutrality/Fiscal Issues:

	Budget Neutrality Without Waiver			
	CY14	CY15	CY16	Three Year Total
Member Months	1,579,122	2,403,080	2,427,111	6,409,313
Medicaid Services PMPM	$ 477.63	$ 500.08	$ 523.58	$ 503.45

QHP Services PMPM are subject to MLR Reconciliation as well as CSR Reconciliation. Final figures will not match the experience to date.

Proj. Enrollment Growth: 1%

	With Waiver			
	CY14	CY15	CY16	Three Year Total
Member Months	1,579,122	2,403,080	2,427,111	6,409,313
Average Enrollees per Month	131,594	200,257	202,259	178,036
QHP Services PMPM	$ 487.89	$ 484.50	$ 486.08	$ 485.94
Wrap Services PMPM	$ 4.96	$ 4.99	$ 5.29	$ 5.10
Total PMPM	$ 492.85	$ 489.50	$ 491.37	$ 491.03
Over/(Under) Cap PMPM	$ 15.22	$ (10.58)	$ (32.21)	$ (12.42)
Percent Difference from Cap	3.19%	-2.12%	-6.15%	-2.47%

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.

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

In response to these issues, a policy decision was made to purchase EHB only plans for private option enrollees in plan year 2015. As such, guidance from AID to Issuers for the 2015 coverage year (Bulletin 9-2014) required 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.

In accordance with the Standard Terms and Conditions of the 1115 demonstration waiver, Arkansas had 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.

***Administrative Costs**:*

Because of the use of premium assistance, the vast majority of administrative costs are included in the premiums paid from DMS to the participating carriers. Outside of these costs, DMS has contracts with the following vendors in corresponding amounts: Hewlett Packer (HP) for the continued support of insureark.org, in the amount of $686,239.09; Manatt, Phelps, and Phillips for continued operational and implementation guidance, in the amount of $1,329,277.20; Optumas for continued actuarial guidance,

in the amount of $381,062.50 and AFMC for beneficiary relations support, in the amount of $1,367,957.00

Utilization:

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.

State Category of Service	Total Paid Amount

Appendix I:

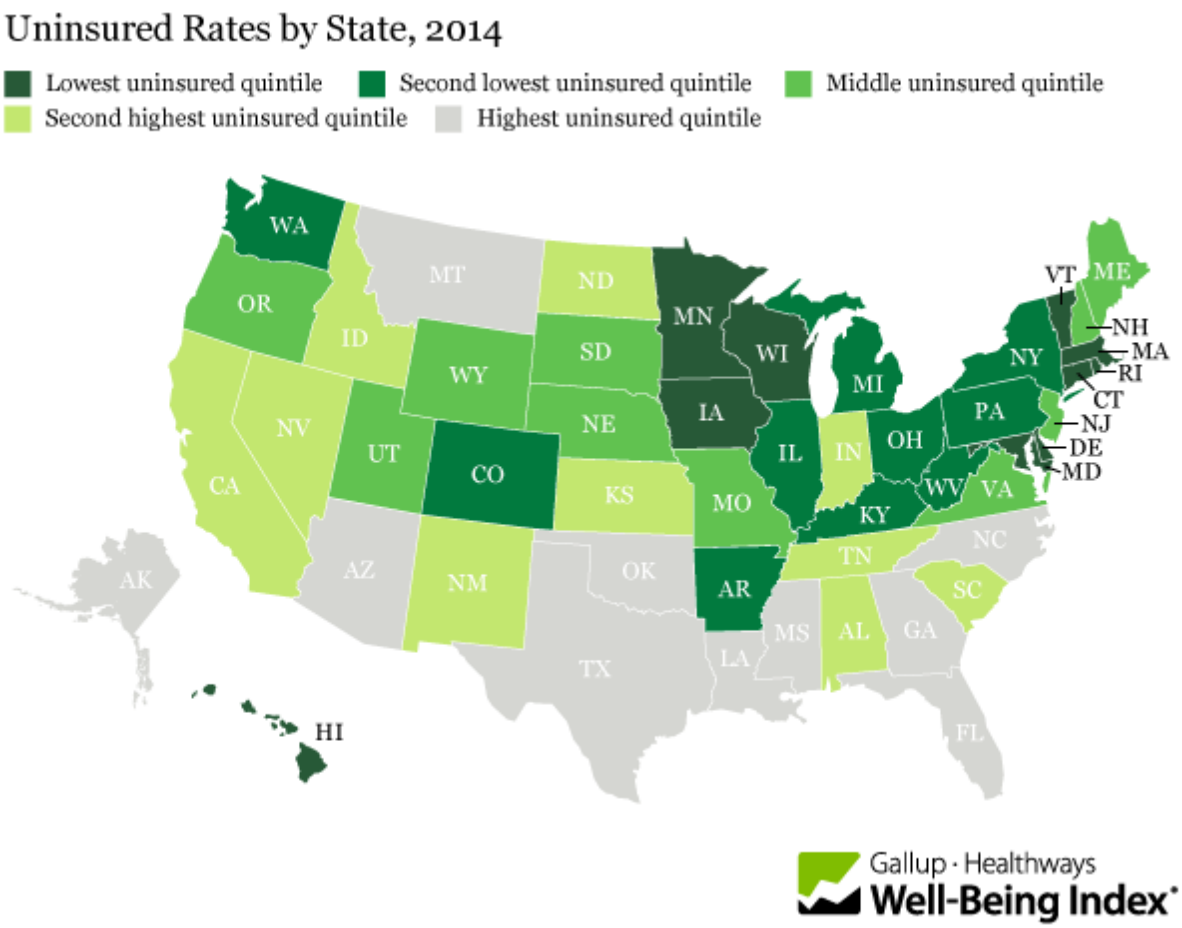
States With Largest Reductions in Percentage Uninsured, 2013 vs. 2014

"Do you have health insurance coverage?" (% No)

	% Uninsured, 2013	% Uninsured, 2014	Change in uninsured (pct. pts.)	Medicaid expansion AND state exchange/ partnership in 2014
Arkansas	22.5	11.4	-11.1	Yes
Kentucky	20.4	9.8	-10.6	Yes
Oregon	19.4	11.7	-7.7	Yes
Washington	16.8	10.1	-6.7	Yes
West Virginia	17.6	10.9	-6.7	Yes
California	21.6	15.3	-6.3	Yes
Connecticut	12.3	6.0	-6.3	Yes
Colorado	17.0	11.2	-5.8	Yes
Maryland	12.9	7.8	-5.1	Yes
Montana	20.7	15.8	-4.9	No
New Mexico	20.2	15.3	-4.9	Yes

Gallup-Healthways Well-Being Index

GALLUP


Uninsured Rates by State, 2014
Lowest uninsured quintile
Second lowest uninsured quintile
Middle uninsured quintile
Second highest uninsured quintile
Highest uninsured quintile
WA
OR
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WY
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MN
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ME
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Gallup · Healthways
Well-Being Index

Appendix II

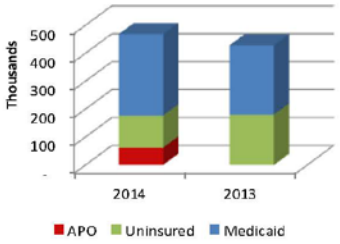
ARKANSAS PRIVATE OPTION

Benefit to Arkansas Hospitals through June 30, 2014

With the assistance of the Arkansas Chapter of the Healthcare Financial Management Association (HFMA), the Arkansas Hospital Association conducted a survey of Arkansas hospitals to determine the financial impact of the private option for the first six months of its implementation. **Responding hospitals represent nearly 80% of all Arkansas hospital patient service by revenue and admissions.**

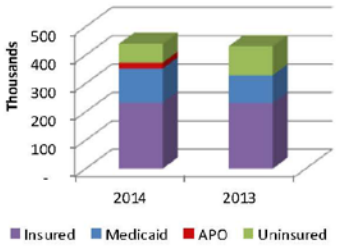
Total Utilization

APO replaces uninsured volume



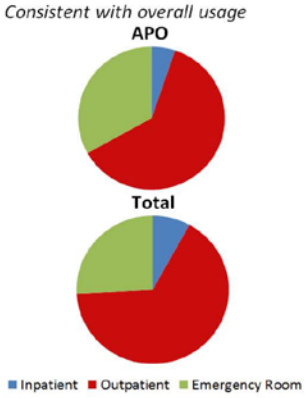
ER Visits

Only 1.8% Increase



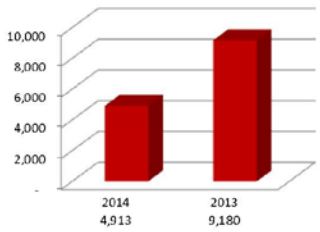
APO Utilization

Consistent with overall usage

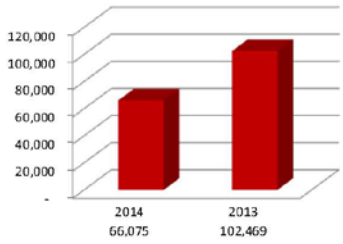


Significant Reductions in Uninsured Volumes:

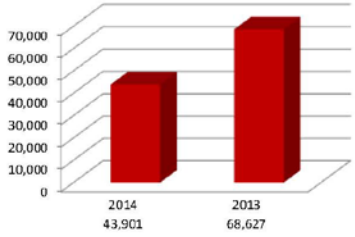
Admissions – *Down 46.5%*



ER Visits – *Down 35.5%*



Outpatient Visits – *Down 36.0%*



The Arkansas Private Option (APO) has provided significant benefits to hospitals in the state at a crucial time. The losses responding hospitals incurred caring for low income Arkansans have decreased by **$69 million**, offsetting continued Medicare reimbursement cuts.

The following is a summary of the financial impact for services to low income patients:

(in millions)	Six Months Ended June 30, 2014	2013	Change	Change, %
Payments[1]				
APO[2]	58.0	-	58.0	-
Uninsured	21.4	22.0	(0.6)	-2.9%
Total payments	79.4	22.0	57.4	260.9%
Cost[3]				
APO	57.5	-	57.5	-
Uninsured	75.3	144.6	(69.3)	-48.0%
Total cost	132.8	144.6	(11.8)	-8.2%
Net loss	$ (53.4)	$ (122.6)	**$ 69.2**	-56.4%

(1) Payments include an estimate of expected payments not yet received as of the survey date for services rendered prior to July 1, 2014.
(2) 80% of Arkansas Insurance Exchange patients were estimated to be attributable to APO based on enrollment data provided by the Arkansas Department of Human Services.
(3) Based on individual hospital cost-to-charge ratios.

Health Care Independence Program and Budget Neutrality

ACHI
Arkansas Center for Health Improvement

March 2015

Arkansas's use of a premium assistance model to finance health care coverage for low-income Arkansans has brought praise from advocates for the state's innovative approach, replication from other states seeking an alternative to traditional Medicaid expansion, and scrutiny from those wanting to ensure cost containment.[1,2] Arkansas's model—formally called the Health Care Independence Program[3]—required a federally approved Section 1115[4] demonstration waiver for implementation. Demonstration waivers under Section 1115 of the Social Security Act provide states with federal matching funds for projects that test new approaches in how Medicaid programs operate. A requirement of Arkansas's demonstration waiver is that it is "cost-effective" when compared to the cost of providing coverage for the population in traditional Medicaid. A second requirement—one that must be demonstrated prior to waiver approval—is budget neutrality. In other words, the cost of the waiver program cannot exceed federal spending that would have otherwise occurred absent the waiver. This fact sheet provides general information about budget neutrality and its assessment, scrutiny of Arkansas's budget neutrality assessment and spending relative to budget neutrality caps, and progress on state spending under the waiver to date.

1115 BUDGET NEUTRALITY

Demonstration Waiver Definitions

- *Budget neutrality cap:* per-member per-month cost threshold over the period of the waiver
- *Cost-sharing reduction (CSR) payments:* upfront payments to carriers to reduce out-of-pocket costs for beneficiaries to Medicaid cost levels
- *Premiums*: amount paid for the insurance plan
- *Wrap-around costs*: costs for required services directly covered by Medicaid, e.g., non-emergency medical transportation
- *Per-member per-month (PMPM):* sum of premiums, CSR payments, and wrap-around costs divided by the number of waiver beneficiaries
- *Member months:* The number of waiver beneficiaries participating each month
- *Medical-loss ratio (MLR):* requires carriers to spend at least 80 percent of premiums on medical care only and 20 percent on administration, marketing, etc.
- *Reconciliation:* process of assessing the difference between the upfront premium and CSR payments and the actual costs
- *Qualified Health Plans (QHPs):* plans available through the Health Insurance Marketplace
- *Essential Health Benefits (EHBs):* health care services that QHPs must cover

Section 1115 demonstration waivers require budget neutrality. In other words, federal spending under the waiver must not exceed projected federal spending without the waiver.[5] If the cumulative spending at the end of the three-year waiver period exceeds the total projected budget neutrality cap for the same time frame, Arkansas will be responsible to pay the federal government for the budget deficit.[6] The federal government establishes budget neutrality by placing a cap on federal matching funds during the demonstration period of the waiver and by including those caps in the state's waiver agreement.[7]

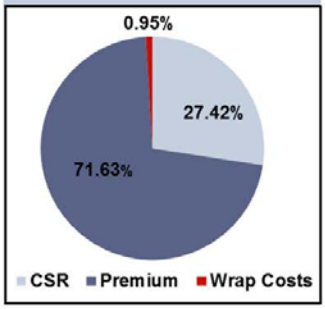
The U.S. Department of Health and Human Services (HHS) requires states' demonstration waiver applications to include a justification of cost projections with a description of methods and data sources for the projections.[5] HHS allows the projections to be hypothetical costs when using appropriate methods. States must provide the following in the waiver application:[8]

- Budget projections both with and without waiver costs for the time period covered by the waiver:
  - *2014 to 2017 for Arkansas*
  - *For budget neutrality, the separate projections must match*
- An estimate of and methods for cost trends from year to year.
- An estimate of per-member per-month (PMPM) costs and of the number of member months—this considers projected demographics of the population and member utilization.

Average monthly PMPM costs represent the budget neutrality caps established in the waiver. Figure 1 provides preliminary calculations for the distribution of PMPM costs for plan year 2014.[9]

The budget neutrality caps established for the Arkansas waiver plan years are $472.19 in 2014, $495.79 in 2015, and $520.58 in 2016. The caps reflect a trend rate of a 5 percent increase from year to year.[8]

Figure 1: 2014 Contributions of PMPM Cost Variables[9]



ARKANSAS'S BUDGET CAP TRENDS

Table 1 provides preliminary average PMPM costs for the Arkansas waiver from January 2014 to February 2015, with month-to-month changes in costs.[9] Figure 2 displays the average PMPM cost trend relative to the budget cap from January 2014 to Februrary 2015.[9] The PMPM costs were above the budget cap for 2014, which was primarily due to an assumption in the projection that the age of the population would be slightly younger.[10] Waiver expenditures have steadily declined since April 2014, and are well below the budget cap since the beginning of 2015.

Preliminary costs are subject to reconciliation and will be revised once data on actual costs are available. The reconciliation will consider the following:

- MLR: If expenditures for medical claims and for activities that improve the quality of care are lower than 80 percent of the premium prices, then the state will receive a rebate from the carriers.[6]
  - For the 2014 plan year, MLR determinations are expected by mid-2015.[7]
- CSR payments: If actual costs are lower than the upfront CSR payments, the state will receive a rebate from the carriers. If actual costs are higher than the upfront CSR payments, the state will owe the carriers.[6,9]
  - For the 2014 plan year, CSR reconciliations are not expected until mid-2016.[9]

Figure 2: Current PMPM Cost Trends and Yearly Budget Neutrality Caps[9]

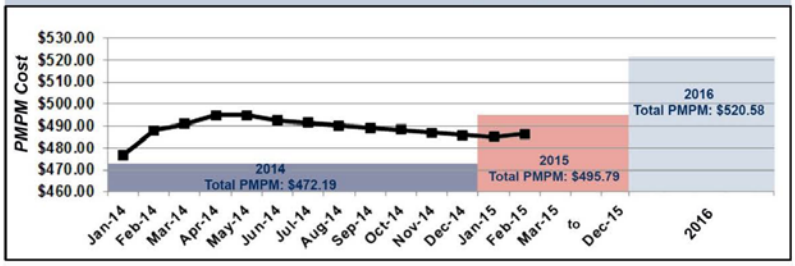


Table 1: PMPM Trends and Changes[9]

	PMPM	ΔPMPM*
Jan-14	$476.56	
Feb-14	$488.10	$11.53
Mar-14	$490.98	$2.88
Apr-14	$495.09	$4.11
May-14	$494.94	-$0.15
Jun-14	$492.58	-$2.36
Jul-14	$491.44	-$1.13
Aug-14	$490.30	-$1.28
Sep-14	$489.03	-$1.28
Oct-14	$488.26	-$0.77
Nov-14	$487.07	-$1.18
Dec-14	$485.84	-$1.23
Jan-15	$485.10	-$0.74
Feb-15	$486.47	$1.37

**The PMPM change is the change from the previous month*

BUDGET NEUTRALITY OBSERVATIONS

There has been significant local and national interest in the Arkansas waiver's budget neutrality projection, the state's expenditures toward budget neutrality, and the HHS methods for examining budget neutrality. Perhaps the most notable inspection of the Arkansas waiver's budget neutrality was from a report generated by the Government Accountability Office (GAO). The report investigated Arkansas's waiver submission, and concluded that HHS did not ensure budget neutrality due to allowing "inappropriate methods" of determining the budget caps.[5] More specifically, the report found fault with approval of a budget cap based, in part, on an assumption that the state Medicaid program would have had to significantly increase provider reimbursement rates to care for beneficiaries under a traditional Medicaid scenario.

HHS responded that the state's projections and their approval were consistent with the agency's policy that budget neutrality should be based on the best available data, and that Arkansas provided an explanation of how its program would achieve budget neutrality and the data to support its rationale. Arkansas officials responded that the GAO report was a continuing disagreement with HHS about the process for assessing budget neutrality and that the report failed to consider whether Medicaid rates would have to increase with a traditional expansion of coverage.[11]

Other opponents criticize the transparency cost estimates and the 2014 expenditures that exceeded projected costs.[12,13] With costs below projections thus far in 2015 and assessment of MLR and reconciliation in the coming months, the actual costs of the program remain to be seen, although the trajectory is promising.

CONCLUSION

In April 2014, the PMPM costs for Arkansas's HCIP grew to their highest point, and each month since, costs have been on the decline. Factors contributing to relatively flat premium costs from 2014 to 2015—and, therefore, a relatively flat average PMPM cost—include a restriction of plan offerings available to HCIP participants and expanded carrier competition in the state. In a continuing effort to contain costs, the state will implement plan-purchasing guidelines for plan year 2016. The state will purchase EHB-only plans that are no more than 10 percent more expensive than the second-lowest plan offered in the region.

Although the HCIP will continue as anticipated by the waiver through December 31, 2016, the program will cease by the terms of the Arkansas Health Care Reform Act of 2015, which created a task force to explore new coverage options and efficiencies.[14] That is the point at which HCIP budget neutrality will become more apparent. Arkansas's miscalculations on the budget cap in the first year and changes to the program that allowed the state to decrease spending reflects the difficulty and risk of subjecting the state to a capped budget, whether global or per person. The Health Care Task Force should consider this risk when deliberating about the future of Medicaid in Arkansas.

Aside from budget neutrality, the HCIP evaluation testing the program's cost-effectiveness is an important component to assess program success. That evaluation will weigh program costs against improved access, quality, outcomes, and continuity of care and coverage experienced by the beneficiaries.

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[2] "Anti-Private-Option Republicans Learn to Love the Low-Cost Medicaid Program." *Arkansas Times*, September 2014. Accessed March 20, 2015, http://www.arktimes.com/ArkansasBlog/archives/2014/09/26/anti-private-option-republicans-learn-to-love-the-low-cost-medicaid-program.

[3] *Act 1497* and *Act 1498* of 2013.

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