



Arkansas Private Option 1115 Demonstration Waiver

Quarterly Report

April 1, 2015-June 30, 2015



Executive Summary:

The second quarter of 2015 was primarily focused on preparing for plan year 2016 and beginning the process of eligibility redeterminations for current Health Care Independence Program enrollees.

On April 15, 2015, insurance carriers filed their rates for the 2016 plan year. At that time a new carrier, United HealthCare, filed rates to be included in the Arkansas marketplace. The entry of a new carrier suggests one strength of the HCIP, as one of the original goals of the program was to increase competition on the individual Marketplace. See: <http://www.arkansasonline.com/news/2015/apr/15/big-insurer-bids-to-join-state-s-hub-20/?f=latest>

In mid-April, the Health Reform Legislative Task Force convened to explore uncompensated care, including the impact of the HCIP in reducing hospitals' uncompensated care costs. During the hearing, several hospital executives testified about the impact Private Option had on their hospitals and reported that Private Option had dramatically decreased the amount of uncompensated care the hospitals experienced. See: <http://talkbusiness.net/2015/04/health-care-reform-task-force-begins-discussion/>

On April 22, 2015, the 90th General Assembly adjourned via sine die. Though Act 46 of 2015, preserved the HCIP until the end of 2016, there was a great deal of speculation over the future of the program beyond that date. Act 46 charged the Health Reform Task Force with recommending an alternative to the HCIP that would ensure the continued availability of healthcare services for the populations covered by the HCIP and to explore and recommend options to modernize the state's traditional Medicaid program. To this end, on March 31, 2015, the Health Reform Legislative Task Force released a Request For Proposal (RFP), for a consultant group to assist with this charge and to develop recommendations regarding potential reforms to the Arkansas Medicaid program. On May 7, 2015, the Health Reform Legislative Task Force voted to hire The Steven Group as its consulting group.

During this quarter, the Supreme Court decided *King v. Burwell*. In this case, the Supreme Court held that tax subsidies applied to individuals in states that utilized the Federal Facilitated Marketplace as well as states with State-Based Marketplaces. Arkansas Governor Hutchinson issued a statement on the case on June 25, in which he indicated that the decision maintained the status quo in Arkansas. He also noted the work of the Health Reform Legislative Task Force and signaled a cautious approach as Arkansas plans to transition to a State-Based Marketplace. Full statement available here: <http://governor.arkansas.gov/press-releases/detail/governor-asa-hutchinson-issues-statement-on-king-v-burwell>.

I. Eligibility and Enrollment

At the end of the second quarter of 2015, enrollment continued to increase, with more than 259,000 individuals determined eligible with 25,851 determined to be medically frail.

See graphic below for additional enrollment data.

Private Option Enrollment and Premium Information

Budget Cap approved by CMS for CY2015= \$500.08

	Number Determined Eligible as of last day of Month*	Number of Premiums Paid**	Medically Frail	Cost-sharing reduction payments (CSR)	Premium	Wraparound Costs	Average CSR Per Person	Average Premium Per Person	Average Wraparound Cost Per Person	Total Average Cost Per Person
January	233,518	195,783	23,516	\$25,508,151.10	\$68,503,807.95	\$973,426.24	\$130.29	\$349.90	\$4.97	\$485.16
February	239,350	200,884	23,857	\$26,248,599.58	\$70,489,194.23	\$988,378.53	\$130.67	\$350.90	\$4.92	\$486.49
March	242,103	205,882	24,347	\$26,896,652.57	\$72,250,018.41	\$1,037,256.55	\$130.64	\$350.93	\$4.94	\$486.51
April	250,799	209,896	24,793	\$27,418,676.74	\$73,651,889.01	\$910,738.93	\$130.63	\$350.90	\$4.25	\$485.78
May	254,749	214,461	25,196	\$28,017,823.73	\$75,268,019.34	\$922,949.26	\$130.64	\$350.96	\$4.23	\$485.83
June	259,335	218,376	25,815	\$28,474,137.68	\$76,492,301.12	\$931,810.99	\$130.39	\$350.28	\$4.27	\$484.94

*Includes medically frail

**At the beginning of each month premiums are paid for people who have completed enrollment by the 15th of the prior month. In June, for example, 218,376 individuals had completed enrollment (or were already enrolled) by May 15. Premiums for June coverage were paid in June.

II. Press Activities for the Quarter:

By the second quarter of 2015, the Health Reform Legislative Task Force’s review of Medicaid was well underway. One of the first issues addressed by the Task Force was the impact of the Private Option. Several hospital executives testified that the Private Option decreased their uncompensated care costs. One hospital executive stated that the Private Option made the difference between his hospital operating with a profit rather than deficit. Another executive testified that his hospital in Arkansas was doing much better than another hospital he owned in a neighboring state that did not expand Medicaid. Several stories were written about this taskforce meeting, such as: <http://arkansasnews.com/news/arkansas/task-force-hears-private-option-s-impact-hospitals>

One of the most prominent issues of this quarter was the selection of a consultant to assess the Medicaid program in its entirety. On May 7th, the Legislative Task Force voted to select The Steven Group. TSG will submit a final report on potential Medicaid reforms and recommendations to the Task Force by October 1, 2015. The work of the task force and TSG resulted in considerable amounts of press coverage, such as: <http://ualrpublicradio.org/post/arkansas-health-care-task-force-hires-consultant-1-million-plus>

According to Medicaid regulations, every Medicaid beneficiary must have their eligibility redetermined Arkansas received a 1902(e)(14)(A) waiver from CMS, which allowed the state to delay eligibility renewals by nine months as the state completed development and testing of critical functionalities in its new eligibility and enrollment system. There was several stories written about the eligibility renewal process. See: <http://www.nwaonline.com/news/2015/jun/13/dhs-set-to-check-medicaid-eligibility-2/?news-arkansas>

III. Transition to Market Issues

Medicaid beneficiaries are required to report change in circumstances to the DHS', Division of County Operations (DCO) within 30 days of the change. These changes can be change in income, new address, or changes in family size. Renewal/redetermination functionality was not available until mid-June of this year, the EEF was not able to process change in circumstances of beneficiaries. Since this functionality was delayed for 18 months, a significant backlog of changes that needed to be processed accumulated. In addition, DCO was only giving beneficiaries 10 days (instead of 30) to provide verification documents. As a result, a large number of beneficiaries lost their coverage. As a result, Governor Hutchinson requested all processing of redeterminations be temporarily suspended the time period for beneficiaries to provide documentation be extended.

State Based Marketplace

In response to the transition of functions from the Arkansas Insurance Department to Arkansas Health Insurance Marketplace (AHIM), DHS drafted a memorandum of understanding (MOU) that outlines the roles and responsibilities for both DHS and AHIM. To date, DHS is waiting for AHIM to respond with edits or signatures.

AHIM will be managing the Small Business Health Options Program (SHOP) for the 2016 plan year and the individual market for the 2017 plan year. To prepare for outreach and advertising, AHIM released an RFP and selected the advertising firm CJRW to assist with marketing and outreach services.

AHIM also selected hCentive in early May to implement the SHOP platform. HCentive will implement its cloud-based solution, WebInsure State Exchange. This platform will consists of portals for Arkansas employers and employees to select and enroll in health insurance plans, while also supporting the brokers and carriers that will deliver the plans and service to Arkansans. The solution uses the same technology that powers the Federally Facilitated Marketplace (FFM) SHOP, which is integrated with the federal data services hub, which will help make the transition from a partnership state to a state based exchange seamless. HCentive will also provide outreach and education to small business owners throughout the state.

Assessment of Curam

In June, the Arkansas Governor's Office announced that an outside vendor, The Gartner Group, would assess the functionality of the state's Eligibility and Enrollment system. This assessment will determine if the state continues to use this product or if it should pursue other alternatives. The final report is due next quarter. See: http://posting.arktimes.com/media/pdf/letter_to_general_assembly.pdf

IV. QHP Operations and Performance

Eligibility Renewals

In June, DHS' Division of County Operations began the eligibility renewal process. Because they did not provide verification during the required timeframes, some Private Option enrollees were terminated from the program. However, federal regulations allow ninety days for enrollees to provide the necessary documentation. As a result of the potential break in coverage, Private Option enrollees that are reinstated in this ninety day period will be reinstated with the Qualified Health Plan (QHP) coverage with their previous 2015 issuer.

Communication with Carriers

DHS has been working to coordinate closely with issuers during the eligibility renewal process. A bi-weekly call has been scheduled to address the concerns of the carriers and update them with any new information on the HCIP and the eligibility renewal process.

V. Audits

There were no audits of the Private Option conducted during the first quarter of 2015.

VI. Lawsuits

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

VII. Access/Delivery Network

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

Arkansas Center for Health Improvement (ACHI) was selected to complete the evaluation for the Private Option program. During this quarter, much work has been conducted to fulfill the requirements of the evaluation. ACHI has begun working with carriers to establish the process for submitting evaluation data. Additionally, ACHI has received data requested from Arkansas Medicaid and DHS Division of County Operations.

ACHI has also developed a survey for enrollees, which includes questions adapted from the Consumer Assessment of HealthCare Providers and Systems (CAHPS), SF-12 and other national standard indicators and has begun running basic descriptive analyses on program enrollment files to help identify characteristics that could be used as sampling criteria for the survey.

A contract has been finalized with the Arkansas Foundation of Medical Care (AFMC) to collect the survey and submit the results through the University of Arkansas for Medical Science (UAMS) system and the development of the geographic information system (GIS) is underway.

ACHI has additionally conducted individual conference calls with each of the National Advisory Committee members to introduce them to the evaluation team and explore their areas of expertise related to the goals of the Private Option evaluation.

VIII. Quality Assurance

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

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

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

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

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

IX. Complaints/Grievances:

Pursuant to the Intergovernmental Cooperation Act of 1968 and under the terms of a Memorandum of Understanding by and between the DHS and the AID, Arkansas has delegated medical necessity appeals to AID. AID reported receiving three complaints from Private Option enrollees during this quarter. Two complaints have been resolved with the carrier's position being upheld. There is one complaint that is still pending deposition.

X. Utilization

Year to date, \$705,285,302.82 has been paid for the Private Option population. Of this amount, \$436,655,230.06 was paid to the issuers for premiums and \$162,564,041.40 was paid for advanced cost share reductions. Wrap cost, including Non-Emergency Medical Transportation and Early and Periodic Screening, Diagnostic and Treatment (EPSDT) totaled \$ \$5,738,516.62.

XI. Health Independence Accounts

The Arkansas Health Independence Account (HIA) is a program available for Private Option enrollees with incomes above 100% of the FPL. The HIAs allow participating enrollees to pay in advance to cover cost-sharing requirements, which include co-pays and coinsurance and, further, provide a unique educational opportunity for low-income participants to learn about commercial health insurance principles through the use of financial incentives and a low-risk cost sharing program. DHS has established uniform standards and expectations for the HIA's operation through operational protocols and by contract as appropriate.

The 2015 Arkansas General Assembly suspended the application of any additional cost sharing requirements that were to be effective on or after January 31, 2015, under the Health Care Independence Program to Medicaid beneficiaries with incomes up to 100% of the federal poverty level. As a result, STCs and operational protocols are being amended to reflect the legislative mandates.

HIA Payments

HCIP enrollees with incomes greater than 100% FPL pay their Qualified Health Plans (QHP) copayments and coinsurance obligations through the HIA. There are 3 payment levels depending on the HCIP participant's income. The levels are outlined below.

INCOME RANGE	>100% -115% FPL	>115%-129% FPL	>129%-133% FPL
CONTRIBUTION	\$10	\$15	\$15

The Third Party Administrator (TPA) provides multiple options for HCIP participants to remit monthly contributions. These options include online payments, check, cashier's check and money orders. There are no restrictions on who can make the monthly payment into the HIA or how many payments can be made at one time.

Monthly statements mailed to the HCIP enrollees inform the participant that payments are due by the 20th of the following month. This information can also be obtained online by checking the HIA or by phone contact with the TPA. The TPA operates a call center from 8am to 4:30pm and receives on average 293 calls a day.

As of June 30, 2015 there are 44,889 HIA cards issued with 10,806 cards activated. Of the 10,806 cards activated there have been a total of 14,146 contributions made for a total amount of \$188,590 and 24,855 successful transactions.