



Arkansas Private Option 1115 Demonstration Waiver

Quarterly Report

January 1, 2015 – March 31, 2015



Executive Summary:

The preeminent issue of the quarter was the newly elected administration's position on the Private Option. On January 22, 2015, Governor Hutchinson, in a speech outlining his healthcare reform vision, asked the state legislature to authorize funding of the program until the end of the current demonstration period and to create a legislative task force to recommend reforms to the entire Medicaid system by December 31, 2016. As such, an interim report will be released by December 31, 2015 and a final report will be released by December 31, 2016.

During the 90th General Assembly, the Governor's request was honored; the Legislature voted to approve the Division of Medical Services (DMS) budget which provided appropriation for the program for the biennium. Act 46 of 2015, the Health Reform Act, was passed and created a legislative taskforce to recommend an alternative healthcare coverage model and ensure the continued availability of healthcare services for the newly eligible adult group.

The Arkansas Health Reform Act also changed the participation requirements for Health Independence Accounts (HIAs). This legislation suspended cost-sharing requirements and participation requirements in the HIAs for Private Option enrollees with incomes below 100% of the federal poverty level. The Health Reform Act of 2015 is available at the following link:

<ftp://www.arkleg.state.ar.us/Bills/2015/Public/SB96.pdf>.

Despite the uncertainty regarding the future of the program, enrollment continued to grow with 242,103 individuals being enrolled in the program, as of March 31, 2015.

During this quarter, claims data was requested from the carriers for the Private Option enrollees for use by the evaluation team. After conversations regarding Health Insurance Portability and Accountability Act (HIPAA), the issuers agreed that the disclosure was allowable under the health care operations exemption of HIPAA and agreed to provide the requested information, as required under the terms of the Memorandum of Understanding between DHS, the issuers and the Insurance Department.

On March 11, 2015, newly appointed Insurance Commissioner, Allen Kerr, announced that the responsibilities of the Health Connector Division of the Arkansas Insurance Department (AID) would transition to the Arkansas Health Insurance Marketplace (AHIM). Arkansas is transitioning into a State Based Marketplace. AID/AHIM activities related to the transition of these activities were defined during this quarter.

As 2015 plan year began, so did decisions regarding the 2016 plan year. Division of Medical Services (DMS) developed a price-sensitive purchasing strategy for plan year 2016. This information was communicated to carriers in a Frequently Asked Questions Document, which can be found here: <https://static.ark.org/eeuploads/hbe/FAQs-3-13-15.pdf>.

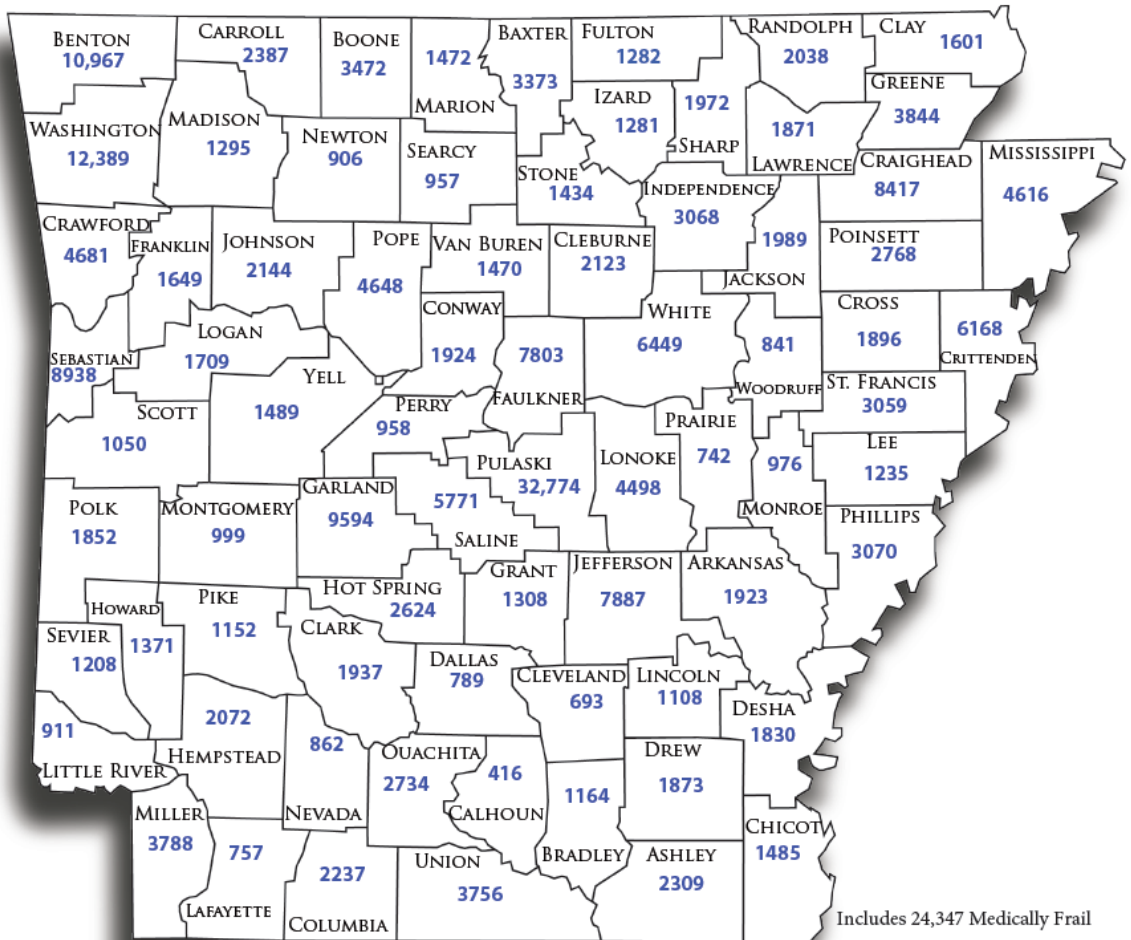
As 2014 came to an end, memorandum of understanding between carriers participating in the program, AID and the Department of Human Services (DHS) for the 2015 calendar year were renewed. During the first quarter of the year, three extensions were executed to allow time to complete negotiations. The MOU for the 2015-2016 plan year was executed on April 22, 2015.

I. Eligibility and Enrollment

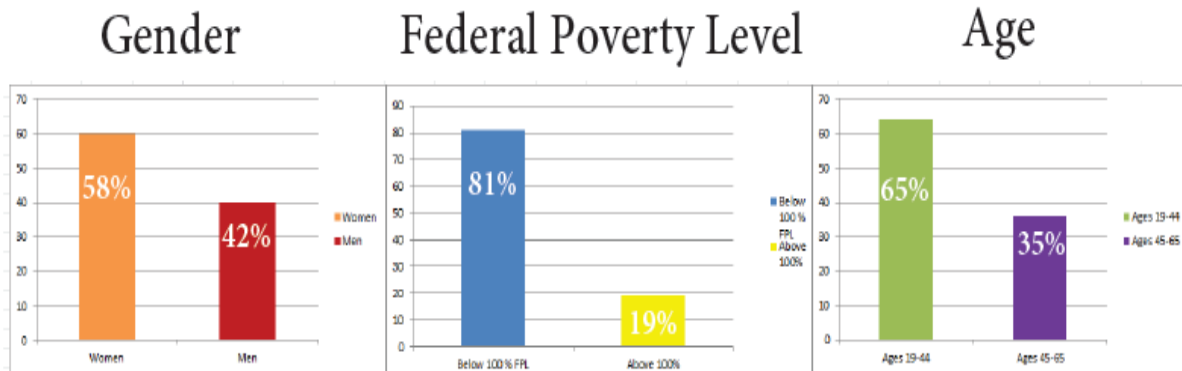
At the end of the first quarter of 2015, enrollment continued to increase, with more than 242,000 individuals determined eligible for the Private Option. Enrollment continued to grow in each county with Pulaski County continuing to lead the state with 32,774 enrolled.

See graphic below for additional county level enrollment data.

242,103 Eligibility Approvals
229,599 Enrollment Complete



Demographics for the population remain constant; the majority of enrollees are women, below 100% of FPL and between the ages of 19 to 44 years old.



II. Press Activities for the Quarter:

As 2015 began, the press was very interested in the newly elected governor’s position on the Private Option. However, he did not address the issue immediately and there were several stories written focusing on this topic. See: <http://www.arkansasonline.com/news/2015/jan/06/hutchinson-still-quiet-medicaid-private-option/>. Governor Hutchinson announced that he would make a speech at the end of January.

As announced, Governor Hutchinson delivered a speech on the future of the Private Option on January 22nd at UAMS. There was significant press coverage of this speech. See: <http://www.4029tv.com/news/gov-hutchinson-to-make-major-speech-regarding-health-care-reform/30856168>.

Media coverage of the Private Option during this quarter also reflected the decreasing per member per month cost of the program. See: <http://www.arktimes.com/ArkansasBlog/archives/2015/03/25/private-option-per-capita-costs-flat-in-2015-state-now-well-below-budget-targets>

III. Transition to Market Issues

To comply with Special Terms and Conditions (STCs), as 2015 began, Arkansas Medicaid began conversations and negotiations with the participating carriers to determine the process for providing the claims level encounter data required for the evaluation. A process was determined and data analysis is set to begin next quarter.

State Based Marketplace

On March 11, 2015, newly appointed Arkansas Insurance Commissioner announced that the Health Connector Division of AID would dissolve June 30th and non-regulatory functions would transition to AHIM.

The Health Connector Division was originally created to establish and implement the new Health Insurance Marketplace in Arkansas in accordance with the Affordable Care Act of 2010. Since Arkansas is a State Partnership Marketplace, the Health Connector Division is responsible for certifying and monitoring health insurance plans sold through the federal insurance marketplace. The Health Connector Division was federally funded through grants from the US Department of Health and Human Services.

AID and AHIM have been working to determine which functions would remain with AID and which functions would transition to AHIM, with AID retaining regulatory functions and with other functions, including plan management and consumer assistance transitioning to AHIM. Additionally, federal grants are in the process of being transferred from AID to AHIM to fund the necessary functions. The transition will be effective as of July 1, 2015.

IV. Qualified Health Plans (QHPs) Operations and Performance

Price Sensitive Purchasing

In early March, joint guidance from DHS and the Arkansas Insurance Department (AID) was issued as an FAQ document and sent to the carriers to inform them of price sensitive purchasing strategy for plan year 2016. This guidance explained that DMS will purchase the lowest cost EHB-only silver-level plan offered in the service area, the next lowest cost EHB only silver level plan offered in the service area that is offered by a different carrier than the lowest cost EHB-only silver-level plan, and any other carrier's lowest cost EHB only silver-level plan, so long as such plan's cost falls within ten percent of the second lowest cost EHB-only silver-level plan available to Private Option eligibles in the service area.

This guidance was released on March 5, 2015 and is available from:

<https://static.ark.org/eeuploads/hbe/FAQs-3-13-15.pdf>.

Memorandum of Understanding (MOU)

During the last quarter of 2014, several meetings were held to negotiate the terms of the MOU for plan year 2016. As of December 31st, 2014, the three-way MOU between each carrier, AID and DMS expired. Negotiations for a new MOU were not complete and on December 19, 2014, a thirty day extension was signed. On January 27, 2015, a second extension was signed and on March 30th the third and final extension was signed. The last extension was to expire on May 11th, but a new MOU was executed prior to that date on April 22nd, 2015.

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 Medical Sciences (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 four complaints from Private Option enrollees during this quarter. All of these complaints have been resolved with the carrier’s position being upheld.

X. Utilization

Expenditures for the demonstration totaled \$292,895,485 in this quarter. Of this amount, \$289,896,424 was paid to the issuers participating in the Marketplace. This amount includes both premium and cost-share reduction payments. Wrap cost, including Non-Emergency Medical Transportation and Early and Periodic Screening, Diagnostic and Treatment (EPSDT) during this period totaled \$2,999,061.

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 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.

As of March 31, 2015 there are 43,273 HIA cards issued with 10,399 cards activated.