



# Arkansas Private Option 1115 Demonstration Waiver

## Quarterly Report

January 1, 2016-March 31, 2016



## *Executive Summary:*

During the first quarter of 2016, state leaders and health care policy makers studied, analyzed and dedicated much time and energy toward improving the Medicaid landscape in Arkansas. With 2016 being the last year of the current Section 1115 demonstration, preparations were made this quarter to apply for a waiver extension application with the Centers for Medicare and Medicaid Services (CMS).

To begin the process, administration officials produced a concept paper laying out a vision for the transformation of the Health Care Independence Program (Private Option). With an eye toward greater efficiency, Governor Hutchinson and legislators also decided to end the Healthcare Independence Accounts. Also, Governor Hutchinson, key legislators and administration health officials, met in Washington with Secretary Sylvia Burwell of the U.S. Department of Health and Human Services to discuss the future of Medicaid expansion in Arkansas.

The quarter also brought administrative changes in Arkansas Medicaid leadership. The director of the Arkansas Department of Human Services (DHS), John Selig, who had been planning to resign by the end of 2015, agreed to extend his tenure through the end of February until a replacement was finalized. Governor Hutchinson named a new director, Cindy Gillespie, a former healthcare official in the administration of former Massachusetts Governor Mitt Romney. She started in her new role on March 1, 2016.

Retroactive terminations continued to be an issue this quarter. The term refers to a situation in which the DHS terminated a client's coverage in the Medicaid expansion effective as of a date in the past, which resulted in recoupment by the state of funds Medicaid previously paid Qualified Health Plan carriers for months of coverage when the client was considered eligible. Carriers expressed great concern about retroactive terminations causing financial issues within their companies. As a result, DHS reached out to CMS to seek a resolution. In February, CMS gave permission to the state to use federal funding to reinstate premiums that carriers lost due to retroactive terminations.

Early this year, much discussion centered on whether Governor Hutchinson would convene a special legislative session to determine the future of Medicaid. The governor called a special session to begin on April 6.

Since the inception of the Private Option, the budget of the program has been a consistent topic of concern. However, this quarter brought good news when it was reported that for the first six months of state fiscal year 2016, the state spent \$101 million less than projected on the Private Option.

In February, Governor Hutchinson met with Secretary Burwell to present the framework of changes that Arkansas proposed for the Section 1115 amendment. On February 20, Secretary Burwell sent a letter to Governor Hutchinson expressing optimism about the innovative framework he presented while in Baltimore.

In 2015, the Health Reform Legislative Task Force began regular meetings at the state Capitol to determine the most efficient and innovative ways to serve Arkansas's populations in need of medical services. Among its duties, the taskforce was charged with determining whether to continue the Private Option and, if so, in what form. In March, the Task Force recommended that the Private Option as it is currently constituted, end on December 31, 2016. However, the Task Force also recommended that the

Medicaid expansion program in Arkansas would continue with premium assistance/Qualified Health Plan (QHP) model but under the name of “Arkansas Works.” Changes would include: 1) encouraging employer-based insurance, 2) incentivizing work with training referral requirements, 3) modest premiums charged for those making more than 100 percent FPL, and 4) eliminating retroactive eligibility.

***I. Eligibility and Enrollment***

As of March 31, there were 292,860 newly eligible adults determined eligible for the Medicaid expansion program in Arkansas. Of these, 23,691 were designated as medically frail and were served through fee-for-service Medicaid. The majority of the balance participate in the Section 1115 Demonstration and receive coverage through QHPs sold through the Health Insurance Marketplace. Others may have been determined eligible but not yet selected a QHP or been determined medically frail.

*See graphic below for additional enrollment data.*

<b>Private Option Enrollment and Premium Information</b>						
Year Month Paid	Medically Frail Recipient Count	Total Eligible Recipient Count	Total recipients served through a QHP	Amount Paid for QHP Premiums	Amount Paid for QHP client Cost Share	Amount Paid for Wrap Benefits
January	23,183	288,216	211,618	\$77,573,629.10	\$28,869,988.08	\$879,659.17
February	23,726	290,946	226,915	\$82,671,295.98	\$30,762,019.83	\$945,849.16
March	23,691	292,860	238,477	\$86,700,079.09	\$32,261,317.04	\$1,010,901.77

***II. Press Reports:***

One of the purposes of the Medicaid expansion program is to provide greater access to quality healthcare services. In January, the Commonwealth Fund released a study that compared access to care for low income adults in Arkansas and Kentucky to Texas, a state that did not expand Medicaid. A significant finding was that adults living with chronic illnesses who reported receiving regular care for those illnesses increased nearly 12 percentage points more in Arkansas and Kentucky than the same measure in Texas from 2013 to 2014. The report can be found here: <http://www.commonwealthfund.org/publications/in-the-literature/2016/jan/medicaid-expansions-improved-access-low-income>

Much attention was paid to Governor Hutchinson’s meeting with Secretary Burwell. Many articles were written about the future of the program, whether CMS would approve the changes the Governor wanted to make and whether the changes would get legislative support. An article discussing this meeting can be found here: <http://www.healthcarefinancenews.com/news/governor-seeks-new-concessions-cms-maintain-arkansas-medicaid-expansion>

On February 4, when Governor Hutchinson returned from meeting with Secretary Burwell, he stated that his main proposed changes to the private option remained in play. These consisted of incentivizing work,

greater individual responsibility, encouraging the utilization of employer-based insurance, and program integrity. The Governor reported that none of the four elements had been rejected, but he wanted to be able to “push the envelope” in each category to get as much as he could for Arkansas, to make the program successful. <http://katv.com/news/local/arkansas-governor-calls-meeting-good-start-on-medicaid>

On February 3, the Governor’s office issued a press release stating that Cindy Gillespie would be the new director of the Department of Human Services. <http://governor.arkansas.gov/press-releases/detail/governor-asa-hutchinson-names-cindy-gillespie-new-director-of-dhs>

In mid-February, Governor Hutchinson announced that he was considering calling a special legislative session in early April to discuss the future of Medicaid. He told the Health Reform Legislative Task Force that he would have a legislative package to present to lawmakers in mid-March.

<http://pbcommercial.com/news/state/hutchinson-eyeing-early-april-special-session-medicaid>

In late-February, the Department of Human Services announced that the Private Option expenses were below the per-member-per-month budget neutrality limit. The original projection for the first six months of state fiscal year 2016 was \$813.7 million, however the actual expenses were \$712.7 million; \$101 million less than projected. <http://swtimes.com/news/state-news/dhs-private-option-expenses-below-budget>

On February 22, the Governor’s Office announced that a special legislative session would convene April 6 to consider bills creating a new form of Medicaid expansion in Arkansas. Legislators would return for the fiscal session to appropriate funds for the program on April 13.

<http://katv.com/news/political/special-legislative-session-to-be-held-april-6>

In early March, the Stephen Group, a consultant hired by the Health Reform Legislative Task Force, updated its projections on how much the Private Option would save the state. The original projections stated that Private Option would save the state \$438 million. But after reviewing data from state fiscal year 2015 and half of state fiscal year 2016, the savings projection was increased to \$757 million over the five-year period of state fiscal years 2017 to 2021.

<http://www.arktimes.com/ArkansasBlog/archives/2016/03/07/updated-numbers-private-option-will-save-state-budget-757-million-consultant-says>

On March 7, the Health Reform Legislative Task Force recommended that the Legislature implement “Arkansas Works,” the Governor’s proposal to continue coverage for the new adults, but with significant changes. <http://www.arktimes.com/ArkansasBlog/archives/2016/03/07/task-force-recommends-continuation-of-the-private-option>

Retroactive terminations received media coverage. During this quarter the federal government gave the approval for Arkansas to pay carriers premiums that were recouped by the state from carriers because of retroactive terminations. <http://arkansasnews.com/news/arkansas/state-gets-ok-reinstate-federally-funded-premiums-private-option>

### ***III. QHP Operations and Performance***

#### *Open Enrollment*

Open enrollment in the Health Insurance Marketplace continued into this quarter, ending January 31. No problems were reported.

#### *Communication with Carriers*

DHS has been working to coordinate closely with carriers during the eligibility redetermination process. A regular phone call is scheduled to address the concerns and to provide updates regarding the Private Option and the eligibility renewal process. This call occurs bi-weekly, with email communication in the interim.

### ***IV. Audits***

There were no audits of the Private Option conducted during the first quarter of 2016.

### ***V. Lawsuits***

There were no lawsuits filed during this quarter.

### ***VI. 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.

The 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 held several evaluation meetings, mainly focusing on cost effectiveness. These meetings included members of the National Advisory Committee (NAC).

Additionally, the Arkansas Foundation for Medical Care (AFMC) was subcontracted to conduct a survey. During this quarter the survey was mailed and responses were compiled. In addition to the survey being mailed, telephone calls were made to follow up with individuals that did not return their survey via mail. Lastly, ACHI received an electronic archive from AFMC with all surveys administered for future analytical purposes.

Meetings were held to analyze the Consumer Assessment of Healthcare Providers and Systems (CAHPS) data and to begin creating the interim report. Members of the evaluation team sent the Center for Advanced Spatial Technologies (CAST) group files for decoding, which were returned with geocoded information.

## **VII. Quality Assurance**

Arkansas's Private Option evaluation will assess the quality of care provided to Private Option enrollees by analyzing whether enrollees have equal or better care and outcomes over time compared with what they would have had otherwise in the Medicaid fee-for-service system. 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 will explore 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

## **VIII. 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 Arkansas Insurance Department (AID), medical necessity appeals are handled by AID. AID data indicated the receipt of 240 complaints or consumer assistance inquiries from Private Option enrollees during this quarter. Six complaints have been resolved with the carrier's position upheld; four complaints were settled.

## **IX. Utilization**

During the first quarter of 2016, the total cost for the newly eligible population was \$341,674,739.22. Of this amount, \$246,945,004.17 was paid to the issuers for premiums and \$91,893,324.95 was paid for advanced cost sharing reductions. Wrap costs, including Non-Emergency Medical Transportation and Early and Periodic Screening, Diagnostic and Treatment (EPSDT) totaled \$2,836,410.10

## **X. 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.

The 2015 Arkansas General Assembly suspended the application of any additional cost sharing requirements. As a result, the Special Terms and Conditions with CMS for the Section 1115 waiver and operational protocols have been amended to reflect the legislative mandates.

***XI. HIA Payments***

HCIP enrollees with incomes greater than 100% FPL pay their QHP copayments and coinsurance obligations through the HIA. There are three income levels with two payment amounts 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 averaged 66 calls a day this quarter.

As of the end of the first quarter 2016, there were 50,840 cards issued, including 9,181 new cards issued with 1,931 being activated. There were 12,580 successful transactions totaling \$114,881.10. During the quarter, 7,961 contributions were accepted totaling \$108,780.96.