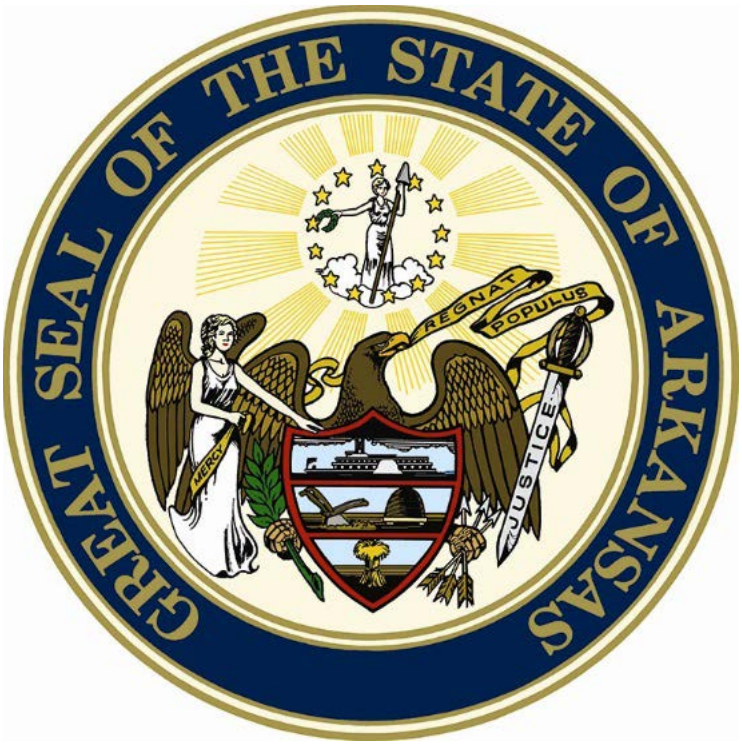


Arkansas Private Option 1115 Demonstration Waiver

Quarterly Report

July 1, 2014 to September 30, 2014

ARKANSAS DEPARTMENT OF HUMAN SERVICES

I. Executive Summary of Significant Activities of the Quarter:

During the third quarter of the Arkansas Private Option Waiver Demonstration, enrollment in the program continued to grow. As of September 30, 2014, 204,811 Arkansans had been determined eligible for participation in the Health Care Independence Program. 59% of eligible individuals are women; 81% have incomes below 100% of the federal poverty level (FPL); and 67% are between the ages of 19-44.

Activities of the quarter focused primarily on monitoring and day-to-day management of the program; operationalizing changes to the program for 2015 to meet legislative requirements; and working collaboratively with other state agencies to develop guidance needed for plan year 2015.

During the first quarter, 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 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. During the third quarter of the program, much effort was dedicated to operationalizing the proposed approach for the Independence Accounts and cost-sharing design.

Great strides were made this quarter to operationalize the legislative requirement of implementing the Health Independence Accounts. A vendor was selected and a contract was drafted and approved by the state legislature.

In efforts to educate Medicaid providers on the differences between the Alternative Benefit Plan that is the equivalent of the Medicaid State Plan and the Alternative Benefit Plan that is the equivalent to the Qualified Health Plan (QHP), DHS hosted provider education classes throughout the state.

With plan year 2014 coming to a close, much work has been done to prepare for plan year 2015. During this quarter, guidance was issued that clarified that the Division of Medical Service would only purchase each carrier's lowest cost Essential Health Benefit (EHB) only plan for Private Option enrollees. Additionally, the DHS finalized its approach to renewals during this quarter. In 2015, Private Option enrollees will have the opportunity to select among the participating carriers lowest-cost Essential Health Benefit only plans during the open enrollment period. The AID Commissioner released bulletin 13-2014 to outline requirements

of notices that will be sent to Private Option enrollees regarding the open enrollment period. DHS' Division of County Operations will make eligibility re-determinations on a rolling basis.

Additionally, DHS submitted the amended Special Terms and Conditions (STCs) to CMS, September 15. Prior to submission, in accordance to federal regulations, there was a thirty day comment period. During the comment, DHS received thirteen comments. Nine comments were concerning Health Independence Accounts, two were concerning non-emergency medical transportation and two were general comments.

Significant Activities of the Quarter:

Implementation of the Health Care Independence Accounts

During this quarter, much progress has been made to design and operationalize the Health Independence Accounts (HIA). A vendor has been selected and a contract approved. The vendor has begun technological development to receive, store, and transfer funds to providers, cards have been ordered and a website is being developed. Additionally, program has been branded "MyIndyCard".

The HIA vendor has also have been working with Arkansas' fiscal agent to discuss coding requirements that will enable the transfer of enrollee's files and funds between the two organizations.

Additionally, the vendor has contracted with a subcontractor to assist in the development of educational materials, which will be released in December, a few weeks before the implementation date of the HIAs.

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 have been conducted to verify that the benefit limits would continue to meet the needs of the population served through this program. Optumas, an actuarial firm, calculated that eight one way legs would meet the needs of ninety-eight percent of the newly eligible population. Additionally, policy decisions have been made to include an extension of benefits process, that would allow an enrollee to access more trips, if it is determined that they do not have access to a vehicle.

Additional changes include that the vendor accept the per-member per-month payment as payment in full, including all administrative costs, transportation costs, overhead, and profit, for

all services required under this contract. It also requires the State to send the Broker the number of Non-Emergency Medical Transportation (NET) trips that will cover newly eligible adults, as determined by the DMS fiscal agent on the last day of the month prior to the month of service for which the per-member per-month payment is calculated. The changes will result in the implementation of a limited non-emergency medical transportation system for the newly eligible adult population.

Provider Education Efforts

As a part of the Health Care Independence Program, newly eligible adults who are determined to be medically frail are sent a notice describing the different benefits available to them. They may choose between the Alternative Benefit Plan that is the equivalent of Medicaid state plan (traditional fee-for-service State Plan) and the Alternative Benefit Plan that is the fee-for-service equivalent of the Qualified Health Plans (QHP). They are provided information regarding the different services available in these plans and given information regarding the process for selecting between the two.

As a result of the different benefits, Arkansas's Quality Improvement Organization (QIO), the Arkansas Foundation of Medical Care, organized several provider educational sessions throughout the state. There were two sessions in Little Rock, Arkansas, to serve central Arkansas, the area with the greatest population. There were also sessions in Monticello, Jonesboro, Bentonville and Magnolia. Each session included a presentation, led by DHS, which delineated the differences between each plan.

Submission of the Special Terms and Conditions

On September 15th, DHS submitted the amended Special Terms and Conditions. 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 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. The Special Terms and Conditions were amended to add these three requirements.

Prior to Arkansas's submission of the Special Terms and Conditions, in accordance with federal regulations, there was a public comment period. During that period, thirteen comments were submitted. Nine comments were regarding the implementation of the Health Care

Independence Program. These commenters were concerned about the complexity of the program, individuals above the federal poverty level having cost sharing responsibilities if they did not participate in the program, the implementation date of the program, provider education, how this program would affect deductibles, whether the program would cover cost sharing obligations to out of network providers, whether the state would require the carriers to give the third party administrator contact information and how the carriers would handle refunds.

Two comments were regarding Non-Emergency Medical Transportation (NEMT). These two commenters were concerned that limiting the availability of NEMT would increase emergency room utilization and cause enrollees to forego medical treatment.

Additionally, one commenter raised concerns regarding the auto assignment methodology. Lastly, one commenter stated that the proposed changes to the waiver could create unfunded liabilities to the state.

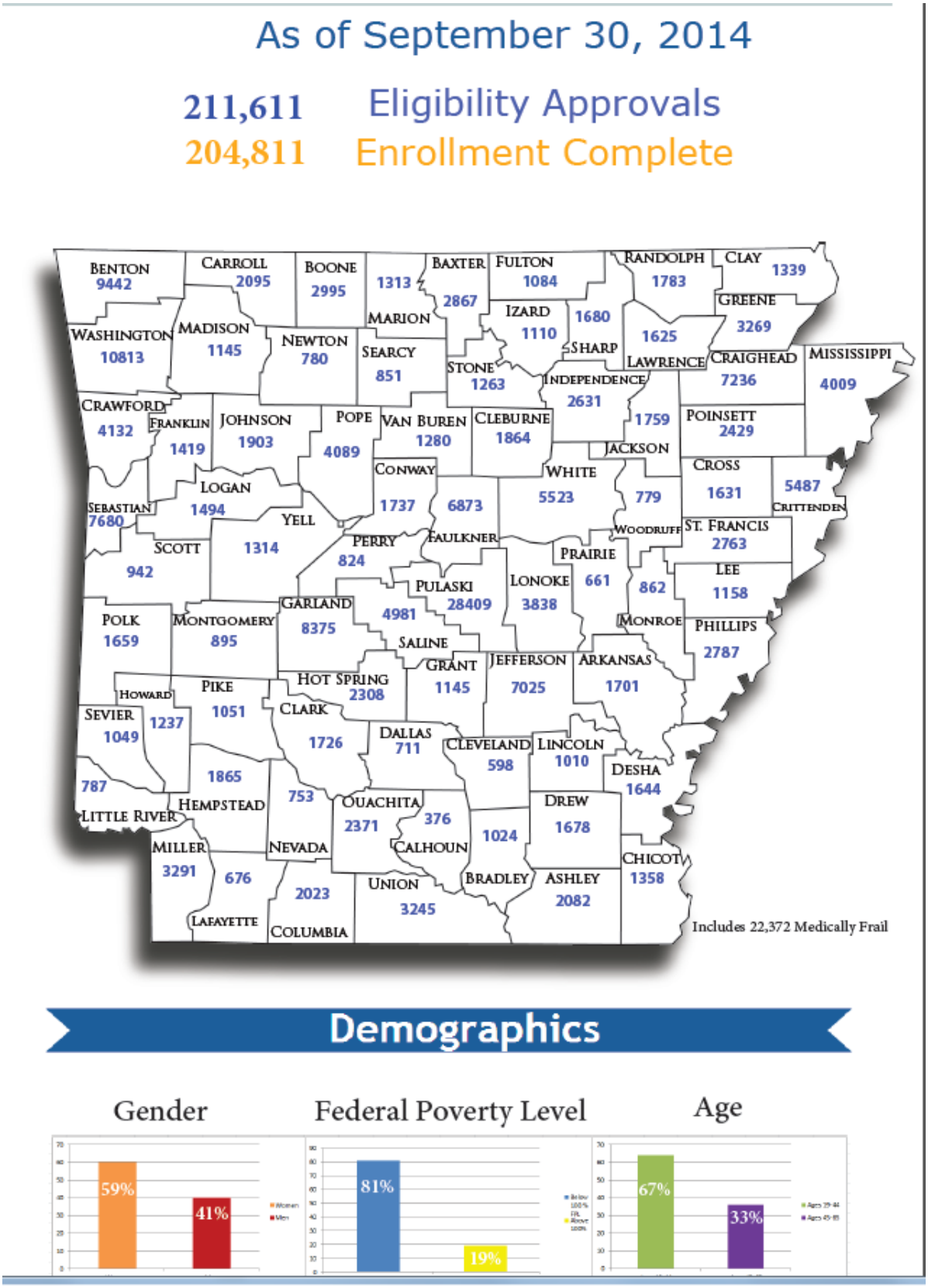
Eligibility and Enrollment:

Nearly 84% of Arkansans estimated to be eligible for the Private Option signed up in the first nine months of the program. A total of 211,611 of the estimated 250,000 Arkansans who are estimated to qualify for health coverage through the Health Care Independence Program had applied and been determined eligible as of September 30, 2014.

An analysis of demographic information of those in the Private Option showed that most – 81 percent – had incomes too low to qualify for insurance through the Arkansas Health Insurance Marketplace. Statewide, 67 percent of Arkansans in the program were between 19-44 years old, a much younger demographic category than those getting coverage through the federal insurance marketplaces.

People in all 75 counties in Arkansas have been approved to get insurance through the program. Pulaski County led the state with 28,409 sign-ups followed by Washington County with 10,813, Benton County with 9,442, Garland County with 8,375, Sebastian County with 7,680, Craighead County with 7,236, Jefferson County 7,025, Faulkner County with 6,873, Crittenden County with 5,487, White County with 5,523 and Saline County with 4,981.

See graphic below for additional county level enrollment data.



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 9/30/2014:

Through September 2014	Medically Frail determinations	Medically Frail Determinations (Average %)	ABP-State Plan	ABP-FFS equivalent of QHP
	22,372	10.57%	19,736	2,636

Transition to Market Issues:

Developing a renewal strategy for Private Option enrollees has been an area of focus during this quarter. A policy decision was made to use premium assistance to purchase each carrier's lowest cost EHB only plan for Private Option enrollees. As a result, during open enrollment Private Option enrollees will have the opportunity to choose between each carriers lowest cost EHB only silver level plan.

QHP Operations and Performance

Bulletin 13-2014 was released by the Arkansas Insurance Department

The Commissioner of the Arkansas Insurance Department released bulletin 13-2014 on September 30, 2014. In this bulletin, language was provided to the carriers requiring the inclusion of verbatim language in the notices carriers would be sending to Private Option enrollees to describe the renewal process for plan year 2015. The notice language also informed the Private Option enrollees that they would be switched to an EHB only plan, if they took no action. The bulletin can be found here: http://www.insurance.arkansas.gov/Legal/Bulletins/13-2014.pdf.

Stakeholder outreach:

During the third quarter of the demonstration, the Arkansas General Assembly held monthly public health committee meetings. At these committee meetings, the Arkansas Medicaid Director, DHS Director and Arkansas's Surgeon General provided updates on the progress of the demonstration and received feedback from state legislators.

Additionally, provider education sessions were held throughout the state. The classes focused on the differences between the Alternative Benefit Plan that is the equivalent of the Medicaid State Plan and the Alternative Benefit Plan that is the equivalent of the QHP. These sessions

educated providers on how to identify which program the participant is enrolled in, the difference in benefits, and who to contact with questions.

In addition to communicating with state legislators and providers, a consumer assistance advisory committee meets monthly. This committee is comprised of consumer advocacy groups, AID and DHS. The committee meets to address concerns of consumers and discuss processes that would enhance the consumer's experience.

Audits

There have been no audits conducted during the second quarter of the Private Option Demonstration.

Lawsuits

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

II. Access/Delivery Network:

One of the key objectives of Arkansas's evaluation of the Private Option Demonstration is to measure whether the premium assistance service delivery model 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 a contract with ACHI was drafted and approved by the state legislature. ACHI has begun to work with the insurance carriers on how to obtain the necessary data to complete the evaluation.

III. Quality Assurance:

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

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

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

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

IV. 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 five complaints from Private Option enrollees during this quarter. Four of these complaints have been resolved with the company position substantiated; and one resulted in the company position being overturned.

Budget Neutrality/Fiscal Issues:

At this time, the only anticipated fiscal issue relates to the fact that, in this plan year, Issuers participating in the Private Option have included benefits that are not Essential Health Benefits to high-value silver plans offered in the Marketplace. As previously mentioned, these benefits were not expected to be available and were not included in the state's per-member-per-month cost used to estimate the waiver budget limit. Guidance from AID to Issuers for the 2015 coverage year (Bulletin 9-2014) requires 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 lowest cost EHB-only silver-level plan on behalf of Private Option enrollees.

Optumas, an actuarial consulting firm, has confirmed that the average age of enrollees in QHPs through the Private Option has been higher in the first nine months of 2014 than was assumed in the preparation of Arkansas's without waiver baseline.

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

Utilization:

Through the third quarter of 2014, expenditures for the newly eligible adult group totaled $230,484,556.47. Of this amount, $228,217,283.54 was paid to the four carriers participating in the Marketplace. This amount includes both premium and cost-share reduction payments. Wrap cost, including Non-Emergency Medical Transportation and EPSDT, during this quarter totaled $2,267,272.93.

Note: The reporting process for supplemental expenditures is currently being finalized; the data above is based on the best information currently available.

Claims and encounter-level information regarding QHP utilization will not be available to the State until the first quarter of 2015. This information will be included as a key component of the Private Option evaluation. Cost-effectiveness will be evaluated using findings above in combination with the following costs determinations: (a) administrative costs for Private Option enrollees, including those who become eligible for Marketplace coverage; (b) overall premium costs in the Marketplace; and (c) cost for covering Private Option enrollees compared with costs expected for covering the same expansion group in Arkansas fee-for-service Medicaid.