



# Arkansas Private Option 1115 Demonstration Waiver

## Quarterly Report

October 1, 2015 –December 31, 2015



***Executive Summary:***

During the last quarter of 2015, an assessment of the state's eligibility and enrollment system was released; 1095 forms were prepared; an extension to the Memorandum of Understanding was executed; and the state filed a request for an amendment extension of its current 1115 demonstration waiver for the Health Care Independence Program.

This quarter, a report assessing the state's eligibility and enrollment system was released. DHS selected IBM's Curam product in 2013 to serve as the engine for the state's eligibility and enrollment system; however, the state did not receive the functionality originally expected from this solution. Consequentially, the state contracted with Gartner, Inc. in July of 2015 to perform an assessment of the eligibility and enrollment system. Recommendations from the Gartner report included the following: (1) continued implementation of the Curam System; (2) hiring a systems integrator; (3) halting future development until executive agencies make significant enhancements; (4) mitigating development risk; and (5) enhancing the state's infrastructure and ability to execute large and complex health and human services information technology projects. The report is available from the following link: [http://ee-governor-2015.ark.org/images/uploads/Gartner\\_Report.pdf](http://ee-governor-2015.ark.org/images/uploads/Gartner_Report.pdf)

Arkansas is required by federal law to send 1095-b tax forms to all Medicaid beneficiaries with minimum essential coverage, including Health Care Independence Program enrollees. During this quarter, DHS worked to ensure the necessary preparatory work for a successful mail-out was completed.

Arkansas executes an annual three-way Memorandum of Understanding, between the Department of Human Services, the Insurance Department, and each issuer participating in the Marketplace. The 2015 MOU expired this quarter and a sixty day extension was executed on December 31, 2015.

In anticipation of an 1115 extension request, the Division of Medical Services (DMS) held two public forums to accept comments regarding an extension of the 1115 demonstration. The public hearings were held December 2 and December 8. In accordance with the Special Terms and Conditions of the waiver, on December 31, 2015, Governor Hutchinson sent a request to extend the 1115 demonstration waiver to Secretary Burwell.

## I. Eligibility and Enrollment

As of December 31, there were 262,987 newly eligible adults determined eligible, of these, 22,708 were medically frail and served through fee-for-service Medicaid; all others participate in the Demonstration.

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
July	263,387	223,067	25,838	\$29,532,988.36	\$79,374,085.18	\$953,686.25	\$132.40	\$355.83	\$4.28	\$492.50
August	237,921	199,327	22,992	\$26,309,933.26	\$70,668,816.97	\$945,106.27	\$131.99	\$354.54	\$4.74	\$491.27
September	234,168	187,246	21,634	\$24,747,988.40	\$66,496,542.46	\$848,573.94	\$132.17	\$355.13	\$4.53	\$491.83
October	238,224	193,478	22,709	\$25,086,385.25	\$67,361,398.58	\$919,812.65	\$129.66	\$348.16	\$4.75	\$482.57
November	249,539	198,917	22,839	\$25,839,039.93	\$69,439,735.82	\$913,760.22	\$129.90	\$349.09	\$4.59	\$483.58
December	262,987	200,703	22,708	\$26,246,395.82	\$70,554,873.80	\$913,318.88	\$130.77	\$351.54	\$4.55	\$486.86

\*Includes medically frail

## II. Press Activities for the Quarter:

On October 1<sup>st</sup>, Families USA released a study that noted that sixty percent of Private Option enrollees were low income workers. This study also highlighted the fact that most of those individuals were not eligible for traditional Medicaid and did not have access to affordable health insurance prior to the implementation of the Private Option. The study can be found here: <http://kasu.org/post/study-private-option-helping-working-arkansans>

As previously reported, Governor Hutchinson convened a Health Care Reform Task Force to recommend reforms to the Medicaid program. The Health Care Reform Task Force hired The Stephen Group, a consulting firm, to assist in this task. In October, The Stephen Group released a report that found that eliminating coverage for the new adult group would cost the state an estimated \$438 million. This estimate includes shifting costs to traditional Medicaid eligibility categories and restoring funding to hospitals for uncompensated care. An article discussing this report can be found here: <http://arkansasnews.com/news/arkansas/report-cost-arkansas-end-medicaid-expansion-would-be-substantial>

In addition to the estimate discussed above, The Stephen Group recommended that Private Option enrollees pay for a portion of their health care costs. Their recommendation included a lock-out provision that would prevent Private Option enrollees from receiving services if they did not meet their financial

obligations. An article discussing this recommendation can be found here:

<http://ualpublicradio.org/post/consultant-says-making-beneficiaries-pay-little-could-be-private-option-change#stream/0>

In November, Arkansas Center for Health Improvement released a report comparing hospitals in Arkansas to hospitals in Missouri, a state that did not expand Medicaid. The report concluded that hospitals in Arkansas are expanding services and hiring new employees while hospitals in Missouri are reducing services and laying off employees. An article discussing the report can be found here:

<http://ualpublicradio.org/post/achi-hospitals-faring-better-states-said-no-medicaid#stream/0>

In early December, Governor Hutchinson revealed his plan for terminating of the Private Option, and creating a new coverage program, called “Arkansas Works.” Several articles outlined the details of his plan. See: <http://ualpublicradio.org/post/hutchinson-arkansas-works-should-encourage-work-part-private-option-change#stream/0>

In late December, the Task Force issued its final report to Governor Hutchinson. In this report, several recommendations were made regarding the future of Medicaid, including continuing coverage for the new adult group. An article written about the Task Force’s final report can be found here:

<http://www.arktimes.com/ArkansasBlog/archives/2015/12/17/health-reform-legislative-task-force-issues-final-report>

### **III. Transition to Market Issues**

#### *Retroactive Terminations*

During this quarter, carriers began to voice concerns about retroactive terminations. Due to eligibility processing delays and challenges with state and federal eligibility systems, some enrollees were terminated retroactively, even when enrollees were still considered eligible under federal rules. This caused premiums to be recouped from carriers participating in the Marketplace. This caused downstream disruption and the carriers became concerned about recouping payments to providers. Communication was initiated with the Centers for Medicare & Medicaid Services (CMS), in an effort to resolve this issue.

#### *The Gartner Report*

Earlier this year, the Governor’s office hired The Gartner Group to conduct an independent assessment of the Eligibility and Enrollment Framework. In November, the Gartner Report was released. In the report, the Gartner Group recommended the following:

1. DHS should not move forward with any further development under the current implementation approach until the Executive Agency makes significant enhancements of capabilities, including:
  - a. Updating the Governor’s and legislature’s vision for health and human services. The vision can then determine the appropriate IT solution for its clients
  - b. Procuring the services of a Systems Integrator (SI) under a fixed price, deliverable based contract in a fair and open solicitation that considers alternate software engines
  - c. Enhancing IT program management across the whole of state government, not just at DHS.

- d. Strengthening Enterprise Architecture requirements to make sure new EEF development is to state standards.
- e. Enhancing strategic vendor management capabilities to make sure that vendors have the correct tools and meet goals
- 2. The Curam solution can be a viable choice, however, to mitigate development risks:
  - a. There should be no further deployment of the Curam solution
  - b. All development activities should be stopped
  - c. Only MAGI Medicaid Maintenance and Operations, critical issue resolution and prioritized enhancements to address CMS mandates should continue, until such time that a new Systems Integrator is selected
- 3. DHS should go to market for a Systems Integrator (SI). The new procurement effort must include a number of critical goals:
  - a. The SI RFP's scope would be for Traditional and MAGI Medicaid, CHIP, SNAP and TANF.
  - b. The procurement should be an open competitive process for a fixed price deliverable based approach allowing the market place to provide the State with a best value approach to SI services and technical solution for the software engine.
  - c. The scope would also include full data conversion and retirement of the legacy systems
- 4. DHS needs to improve its ability to execute such a large and complex health and human services technology project by
  - a. Promoting organizational change management in order to redesign DHS business processes that change with new technology
  - b. Revamping the governance process with identification of key stakeholders as well as defined focus and mandates. Governance of the project may include Governor's Office representatives as well as personnel from key Executive Agencies
  - c. Enhancing the DHS Program Management Office with the right mix of internal and external resources to oversee implementation.
  - d. Defining technology standards across all program areas.

#### ***IV. QHP Operations and Performance***

##### *Open Enrollment*

Interaction with the Qualified Health Plan (QHP) carriers primarily focused on the eligibility redetermination process and on preparing for the upcoming open enrollment period, which began on November 1 and ends January 31<sup>st</sup>. DHS updated the insureark.org portal to insure that necessary information was available for plan selection for plan year 2016.

DHS also worked closely with the Arkansas Insurance Department (AID) to coordinate notice language to be included in carriers' notices to Private Option enrollees concerning open enrollment.

##### *Communication with Carriers*

DHS has been working to coordinate with carriers during the eligibility redetermination process. A bi-weekly phone call is held to address concerns and to provide updates regarding the HCIP and the eligibility renewal process.

## ***Audits***

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

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

Anita Walker, a resident of Lee County, sued DHS in October, alleging that the agency had not fulfilled its obligation to timely determine her eligibility for the Health Care Independence Program. U.S. District Judge Kristine Baker issued a preliminary injunction directing the agency to make a determination of Walker's eligibility with "reasonable promptness" and to reinstate her request to DHS for a hearing on her application. DHS could not make a determination of eligibility at that time because it had not received necessary information from the federal health insurance Marketplace, and it dismissed the hearing request because no record of the case was presented. DHS plans to appeal the decision.

### ***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.

Arkansas Center for Health Improvement (ACHI) was selected to complete the evaluation for the Private Option program. During this quarter, ACHI has hosted several evaluation meetings, with focus primarily being on assessing the cost effectiveness of the HCIP. These meetings included members of the National Advisory Committee (NAC).

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

CAPHS data was analyzed during this quarter and ACHI began drafting 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 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 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

\*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.

**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, Arkansas has delegated medical necessity appeals to AID. AID received seventeen complaints from Private Option enrollees this quarter. Nine complaints have been resolved with the carrier's position upheld and two complaints were settled. Two complaints were resolved by overturning the company's position and four were pending disposition.

**IX. Utilization**

Year to date (1/1-12/31), total cost for the newly eligible population was \$1,427,111,626.14 Of this amount, \$860,550,682.87 was paid to the issuers for premiums and \$320,326,772.42 was paid for advanced cost sharing reductions. Wrap costs, including Non-Emergency Medical Transportation and Early and Periodic Screening, Diagnostic and Treatment (EPSDT) totaled \$11,258,818.71.

**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. Further, this program provides a unique educational opportunity for low-income participants to learn about commercial health insurance principles through the use of financial incentives. DHS has established uniform standards and expectations for the HIA program through operational protocols.

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, the operational protocol has been amended to reflect this legislative change.

*XI. HIA Payments*

HCIP enrollees with incomes greater than 100% FPL may 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 averaged 66 calls a day this quarter.

As of December 31, 2015, 51,434 HIA cards have been issued and 14,528 cards have been activated. Of the 14,528 cards activated, 29,007 contributions have been made totaling \$ \$384,394.58 and 42,888 successful transactions.