Arkansas Works Section 1115 Demonstration Waiver

ANNUAL REPORT

January 1 – December 31, 2021

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Annual Report Summary

This report covers the January 1 - December 31, 2021 annual reporting period for the Arkansas Works (AR Works) Demonstration and includes the fourth quarter report period, October 1 - December 31, 2021. Calendar Year 2021 (CY 2021) is the final demonstration year of the AR Works Section 1115 waiver. Arkansas initially expanded Medicaid in 2014 for adults up to 133% of the Federal Poverty Level (FPL) as enabled through the Affordable Care Act. The state's approach has improved health coverage for the adult expansion population under the state plan through private insurance plans, or Qualified Health Plans (QHPs), licensed by the Arkansas Insurance Department (AID). Through the AR Works demonstration, the Arkansas Department of Human Services (DHS) uses Medicaid funds to purchase coverage from QHPs through direct payments for premiums and cost sharing reduction for enrollees.

During CY 2021, the state continued to collaborate with carriers and other stakeholders to strengthen, optimize and align services and processes to achieve the intended outcomes of the AR Works demonstration and to ensure deliverables. AR Works highlights and accomplishments for CY 2021 included:

- Total enrollment ending December 2021 was 334,694 members ages 19 to 64.[1] The state followed the federal requirement to maintain enrollment due to the COVID-19 health emergency.
- DHS strengthened AR Works program operations through increased alignment and coordination of priority activities across partners
- The state approved and convened the first two meetings of a new joint executive and legislative policy committee that monitors QHP data metrics and recommends performance improvement targets. The committee was established through the Arkansas Health Opportunities for Me (ARHOME) Act in 2021.
- DHS finalized claims-based metrics in the Medicaid Adult Core Set for clinical performance monitoring of QHPs, collected the data necessary to establish baseline performance as assessed from CY 2019 and 2020 results, and finalized CY 2022 health plan performance targets.
- The state completed two significant evaluation deliverables including the AR Works Interim Evaluation Report and the 2020 client survey analysis.
- DHS conducted a public forum and outreach related to the AR Works demonstration activities.
- The state completed the Arkansas Health Opportunities for Me (ARHOME) program plan to succeed AR Works, which expired December 31, 2021. The state obtained legislative approval for ARHOME and submitted the waiver application to CMS in June 2021. The new ARHOME Demonstration, which began on January 1, 2022, will continue to improve on the integrated coverage for low-income Arkansans, leveraging the efficiencies and experience of the private insurance market to improve continuity, access and quality for ARHOME clients.
- DHS worked with CMS to finalize the ARHOME Waiver special terms and conditions (STCs) for the QHP model coverage features.

[1] individuals with a household income at or below 138% FPL or two parents with income between 17% and 138% FPL

Summary of CY 2021 Operational and Program Activities including Q4

General Operations: The DHS program team continued to implement, monitor and evaluate the AR Works program and deliverables to complete the demonstration. DHS held monthly AR Works QHP Operations Meetings in CY 2021, which included the carriers, AID, and other system and evaluation partners to address program needs. Additional meetings with the carriers were held as needed. These meetings focused on resolving member data transfer and system issues, general program improvements and readiness for the annual re-enrollment process. DHS worked with a newly identified carrier to become a QHP for the adult expansion group beginning in January 2022. The carrier, however, decided prior to the start of the 2022 plan year to not to participate in ARHOME. Also, intensive planning with the QHPs and vendors to make necessary system changes to transition from AR Works to ARHOME took place in Q3-4.

In April 2021, DHS completed its transition to a new streamlined public benefit eligibility portal (ARIES) statewide for the Medicaid program including AR Works. ARIES allows integration of the application process for Medicaid and other public benefits across programs that were formerly applied for through multiple eligibility systems/applications. Through ARIES, clients can manage their personal information, obtain updates on application status, re-enroll, report changes and other features. The system has many other enhanced functions to benefit clients and staff supporting the eligibility process.

Policy Updates: As 2021 was the final year of the AR Works demonstration, the state completed a new demonstration proposal (ARHOME). In March 2021, Arkansas Senate Bill 410 was introduced and signed into law as Act 530 of 2021 to create the ARHOME program. The ARHOME Waiver STCs were written and finalized with CMS in Q4.

QHP Quality Monitoring and Improvement Efforts: One significant accomplishment was implementing new processes for monitoring and performance improvement for the QHPs. DHS, in coordination with the health plans, the agency's data mining contractor, and other interested parties, selected 21 claims-based metrics in the Medicaid Adult Core Set for clinical performance measurement. These measures are used to monitor standardized indicators of quality of care related to primary and preventive care, maternal and perinatal care, care of acute and chronic conditions, and behavioral health care. DHS collected the data necessary to establish baseline performance as assessed from CY 2019 and 2020 results, and proposed CY 2022 health plan performance targets. DHS also worked to improve the timeliness and quality of QHP claims data, and established data sharing agreements and protocols to gather information from other state agencies on clinical outcomes, education and employment participation of adult expansion clients and birth outcomes of children born to adult clients.

The Health & Economic Outcomes Accountability Oversight Advisory Panel, established by Act 530 of 2021, consists of legislators, state agency leadership, and other stakeholders. DHS is to convene the panel quarterly. Two meetings were held in 2021, in September and December. At the December meeting, the committee reviewed the baseline performance on the claims-based measures and approved the proposed CY 2022 performance targets. In CY 2022, DHS will continue to work with the oversight panel, health plans and other stakeholders with the goal of establishing baseline performance on employment participation, birth outcomes, and other non-claims-based metrics gathered from data matching with other agencies.

PHE and Enrollment: DHS also continued to assure that AR Works members remained enrolled month to month as required due to the continued federal policy to maintain enrollments during the health emergency in collaboration with all partners.

Work Requirement Update: The work and community engagement (WCE) component of AR Works, in which members were to engage in employment or participate in employment preparation to increase income opportunities, remained on hold. This component had been paused since Spring 2019 due to ongoing litigation in federal courts. At the end of Q1 in CY 2021, CMS withdrew its approval of the WCE component of the demonstration.

CMS Technical Assistance Meetings: Meetings with CMS staff occurred on a monthly basis to review and finalize the interim evaluation and other deliverables for AR Works.

Community Forum: DHS held a virtual public forum on the AR Works Waiver on November 16, 2021, at 1:30 p.m. CST. The public forum was publicized on the DHS website and the DHS Medicaid Saves Lives Facebook page, and notices about the event were distributed to interested stakeholder groups. The public forum provided the following information:

- The purpose of the public forum
- An overview of the program
- Demographics of program participants
- A list of AR Works carriers and contact information for each
- A summary of the AR Works evaluation findings
- The various ways in which individuals could submit comments or questions

A total of 13 people attended the public forum in addition to DHS staff. There were no verbal comments or questions, but three people commented in the chat function. Two expressed their appreciation for the information provided in the presentation, and one asked for the name of the AR Works evaluator to be repeated.

Other Demonstration Deliverables: DHS submitted the three Quarterly Progress Reports for January 1-March 31, April 1-June 30, and July 1-September 30, 2021, as required. Quarter 4 progress is included in this 2021 Annual Report as requested by CMS. The required Interim Evaluation Report was submitted in Q2, and the client survey results are reported in this 2021 Annual Report.

AR Works Transition: At the end of Q4, DHS received the Special Terms and Conditions for the ARHOME Waiver to follow the expiring AR Works demonstration and worked with partners to prepare for the transition.

During the demonstration year, four new staff were hired, including the Assistant Director of Population Health, the Business Operations Manager and two program managers.

Local, state and national media coverage included updates on the AR Works work requirement decisions as well as the ARHOME Waiver proposal development and legislative passage.

Enrollment and Expenditures

In CY 2021, 83 to 89 percent of the AR Works population received coverage through one of the QHPs with less than 8 percent covered through fee for service Medicaid for medically frail clients. Individuals who identify as medically frail remain in traditional Medicaid access additional services, particularly community and home-based services and supports. All new enrollees receive coverage through Medicaid fee for service delivery system while awaiting enrollment in a QHP (noted under "Assignment Pending" in Table 1).

In December 2021, a total of 334,694 individuals were enrolled in AR Works, an increase of 7% from January 2021's enrollment of 312,200. Medically frail member enrollment was 20,969 in the last month of CY 2021. The total number of unique Medicaid clients enrolled in CY 2021 was 376,272. The state continued to follow the federal public health emergency policy to maintain enrollment of Medicaid clients, including the adult group, except under certain allowable conditions.

During 2021, DHS's Division of County of Operations (DCO) transitioned to a new integrated eligibility system (ARIES). The agency launched the new system in phases, beginning in December 2020, resulting in some eligibility processing occurring in the legacy system for part of the year and in the new ARIES system for the remaining part of the year. The shift resulted in some processing problems DCO has worked to address as well as some translation issues between the data produced in the legacy system and data produced in ARIES. Disenrollment data is one area DCO is continuing to address. DHS will work through the disenrollment data issues and submit the finalized numbers in a future quarterly report.

Table 1 AR Works Monthly Enrollment and Disenrollment, Members with Paid Premium and Costs

Month	Total Enrolled	Assignment Pending	Medically Frail	Members with a Paid Premium	Premium* Expenditures	Advance Cost Share Reduction Payments*	Wrap Costs*
January	312,200	25,764	20,869	265,567	$126,953,180	$50,448,984	$935,870
February	315,218	26,793	20,783	267,642	$133,874,952	$49,805,407	$948,982
March	318,525	22,100	20,953	275,472	$127,765,681	$51,360,003	$968,382
April	321,747	24,116	21,285	276,346	$122,420,704	$49,687,855	$974,333
May	322,655	21,219	21,345	280,091	$120,161,064	$48,924,746	$988,715
June	323,627	13,150	21,389	289,088	$129,024,536	$51,850,485	$997,863
July	326,095	13,030	21,492	291,573	$129,296,022	$51,905,171	$1,000,831
August	328,754	13,821	21,439	293,494	$129,982,075	$52,133,302	$1,011,411
September	330,456	14,411	21,145	294,900	$131,679,934	$52,772,715	$1,024,887
October	332,747	14,774	21,091	296,882	$131,721,723	$52,820,311	$1,008,550
November	333,263	14,821	20,941	297,501	$132,121,914	$52,975,841	$1,045,615
December	334,694	7,367**	20,969	306,358	$146,177,105	$57,131,412	$1,049,770

*Cost rounded to whole dollar amount

**The Assignment Pending count is based on the total enrolled, less members with a paid premium and medically frail. In December, the state made payments to the QHPs to adjust for missed premium payments in 2019 and 2020, which increased the number of members with a paid premium that month. This increase resulted in a smaller than typical Assignment Pending count.

DHS purchases the lowest and second lowest cost silver plan for the Medicaid population and silver-level plans that fall within 10% of the lowest cost qualifying plan. Monthly capitated payments to the QHPs cover the cost of premiums and other cost sharing reduction payments. The difference between the Advanced Cost Share Reduction (ACSR) payments and actual copays incurred is reconciled annually. In Q4, the state paid $410,020,742 for member premiums and $162,927,564 for cost sharing reduction payments. Wrap costs, which include Non-Emergency Medical Transportation (NET) and Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, totaled $3,103, 935. Premium expenditures for the full year totaled approximately $1.43 billion with cost sharing reductions of nearly $621.8 million and wrap costs of $11.95 million. The cost sharing reduction amount does not include the final reconciliation with the QHPs for CY 2021. The final reconciliation payments to the QHPs will be capped at the budget neutrality level.

Budget Neutrality Analysis and Figures

The current Memorandum of Understanding (MOU) with the QHPs limits the total cost per individual to the budget neutrality per member per month (PMPM) cap. The program operated below the budget neutrality cap of $685.56 during Q4 and for each month in CY 2021.

Table 2 AR Works Budget Neutrality and Per Member Cost CY 2021

Month	Premium Cost	Advance Cost Share Payment	Wrap Costs	Total Cost*	Budget Neutrality
January	$478.05	$189.97	$3.52	$671.54	$685.56
February	$462.84	$186.09	$3.55	$652.47	$685.56
March	$463.81	$186.44	$3.52	$653.77	$685.56
April	$443.00	$179.80	$3.53	$626.33	$685.56
May	$429.01	$174.67	$3.53	$607.21	$685.56
June	$446.32	$179.36	$3.45	$629.13	$685.56
July	$443.44	$178.02	$3.43	$624.89	$685.56
August	$442.88	$177.63	$3.45	$623.95	$685.56
September	$446.52	$178.95	$3.48	$628.95	$685.56
October	$443.68	$177.92	$3.40	$625.00	$685.56
November	$444.11	$178.07	$3.51	$625.69	$685.56
December	$477.14	$186.49	$3.43	$667.06	$685.56

*Total PMPM cost does not include the final Cost Settlement Reconciliation with the carriers, which will occur after June 2022.

Member Education

DHS partner, the Arkansas Foundation for Medical Care (AFMC), assisted AR Works members with general program information, ensured their contact information was current, discussed the importance of choosing a QHP or primary care provider and provided choice counseling. A total of 7,797 AR Works and other Medicaid enrolled members contacted the call center in CY 2021 to receive support with their benefits. Member call totals ranged from about 550 in one month to nearly 900 in another.

Table 3 AR Works Member Education Support Provided in CY 2021

Month	Number of Calls Received	AR Works Member Calls Support	Referred to Another AR State Agency	Request to Change QHP**	Request Cancellation**	Demographic Changes**	Transfer to QHP**
January	877	N/A*	N/A*	N/A*	N/A	N/A	N/A
February	608	N/A*	N/A*	N/A*	N/A	N/A	N/A
March	598	N/A*	N/A*	N/A*	N/A	N/A	N/A
April	631	204	392	N/A	N/A	N/A	N/A
May	658	246	361	N/A	N/A	N/A	N/A
June	743	381	309	N/A	N/A	N/A	N/A
July	595	318	266	0	0	0	4
August	619	263	344	1	0	0	3
September	542	244	294	1	0	0	2
October	589	308	281	1	0	0	1
November	600	299	301	0	0	0	0
December	737	391	346	0	0	0	0
TOTAL	**7,797**	**2,654**	**2,894**	**3**	**0**	**0**	**10**

*Data reporting changes started in Q2. Using different call categorization system, the vendor reported in Q1, 1,374 general education calls and referrals of 1,101 callers to community resources prior to the change.

**Data metrics began being captured in Q3.

Appeals

AR Works members utilize the appeals process established by their QHP to appeal denials of benefits covered under the QHP which must comply with federal and state standards. Members can request additional external review or appeal of a QHP's decision once they have utilized all appeal processes available through the QHP. Members submit an external review request to the AID office who reviews and determines the outcome. Table 4 shows the number of reviews the AID processed in CY 2021, including Q4 and Q 1-3 updated outcomes.

Table 4 AR Works Appeals and Outcomes

Month	External Reviews Processed*	Granted	Denied	Dismissed	Pending
January	3	1 (partially)	2	0	0
February	2	1	1	0	0
March	0	0	0	0	0
April	3	1	2	0	0
May	2	0	2	0	0
June	1	1	0	0	0
July	4	3	1	0	0
August	1	1	0	0	0
September	1	0	1	0	0
October	3	2	1	0	0
November	1	0	1	0	0
December	3	0	1	0	2
TOTAL	24	9	12	0	2

*A review for which all required paperwork was submitted to process the review per AR Works policies.

Evaluation Progress Update

General Dynamics Information Technology (GDIT), the evaluation contractor is responsible for completing the AR Works program evaluation objectives and timelines in coordination with DHS and partners. The purpose of the evaluation is to determine whether AR Works enrollees will have equal or better care than they would have had in the Medicaid fee-for service system and to assess other system reform impacts. Key milestones accomplished in CY 2021 included:

- Finalized the evaluation design
- Submitted the draft Interim Evaluation and final Interim Evaluation Report
- Completed analysis of 2020 Client Satisfaction Survey
- Planned for the Summative Evaluation to be completed in June 2023

The AR Works evaluation is examining the following outcomes and measures related to the goals of the demonstration

Outcome	Measures
Improving continuity of care	• Gaps in insurance coverage • Maintenance of continuous access to the same health plans • Maintenance of continuous access to the same providers
Improving access to care	• Network adequacy • Access to care including primary care providers and specialty physician networks and services • Preventive care services including screenings • Non-emergent emergency department visits • Early Periodic Screening, Diagnosis, and Treatment Services
Improving quality of care	• Use of preventive and health care services • Experience with the care provided • Use of emergency room services (including emergent and non-emergent use) • Potentially preventable emergency department and hospital admissions
Providing cost effective care	• Arkansas program characteristics, such as number of plans and lowest premium cost • Ability to meet budget neutrality • Inpatient utilization

Summary of CY 2021 Evaluation Team Meetings

The evaluation team met monthly throughout CY 2021 to plan and implement evaluation activities. In Q4 DHS, GDIT and other vendors met monthly to identify and resolve issues and provide feedback on key areas. In CY 2021, meetings discussed receipt of the quarterly data from the QHPs and any issues with the data, requesting 2020 and 2021 data from AID, and processing 2020 Behavioral Risk Factor Surveillance System (BRFSS) data. The team also reviewed progress on 2020 metric data runs, the 2020 Client Satisfaction Survey results and materials, planning for the non-Emergency Transportation (NET) interviews, and compiling COVID-19/PHE materials for relevance and understanding any impacts relative to the evaluation.

Interim Evaluation Findings

The interim evaluation report was submitted at the end of Q2, and a revised report was submitted at the end of Q3. The following sections provide interim findings on health outcomes, access to care, cost of care and quality of care for the members in QHPs in the AR Works program. Results for the final demonstration years will be included in the Summative Evaluation Report due in 2023.

Access to Care

The interim evaluation measures access to care by measuring network adequacy and access, essential community providers, and access to preventive care and appropriate treatment. The evaluation does not assess other factors, such as the ratio of providers to clients or wait times for scheduling appointments with providers.

Network adequacy was assessed by geospatial analysis to identify the proportion of Arkansas without a PCP within 30 miles or without one of six in-network specialists within 60 miles. Results are provided in the following table. There are essentially no areas in the state without a primary care provider within 30 miles and without a behavioral health/substance use disorder provider, cardiologist, and OB/GYN within 60 miles. There are very small portions of the state (2% or less) without an endocrinologist, oncologist, or pulmonologist within 60 miles.

2017 Proportion (Square Miles)	2018 Proportion (Square Miles)	2019 Proportion (Square Miles)
Proportion of service area *without* primary care coverage within 30 miles		
0.0000 (0.00)	0.0000 (0.00)	0.0000 (0.00)
Proportion of service area *without* a BH/SUD provider within 60 miles		
0.0000 (0.00)	0.0000 (0.00)	0.0000 (0.00)
Proportion of service area *without* a cardiologist within 60 miles		
0.0000 (0.00)	0.0000 (0.00)	0.0000 (0.00)
Proportion of service area *without* an endocrinologist within 60 miles		
0.1053 (5,601.79)	0.1214 (6,453.95)	0.1342 (7,135.15)
Proportion of service area *without* an OB/GYN within 60 miles		
0.0000 (0.00)	0.0000 (0.00)	0.0000 (0.00)
Proportion of service area *without* an oncologist within 60 miles		
0.0036 (191.09)	0.0000 (0.00)	0.0000 (0.00)
Proportion of service area *without* a pulmonologist within 60 miles		
0.0165 (874.93)	0.0188 (1,001.89)	0.0179 (953.91)

Network Access was assessed by geospatial analysis to identify the proportion of QHP enrollees who resided within 30 miles of a PCP or within 60 miles of one of six in-network specialists. Results are provided in the following table.

2017 Proportion (crude n)	2018 Proportion (crude n)	2019 Proportion (crude n)
Proportion of enrollees within 30 miles of a primary care physician		
1.0 (222,282)	1.0 (205,144)	1.0 (183,425)
Proportion of enrollees within 60 miles of a BH/SUD provider		
1.0 (222,282)	1.0 (205,144)	1.0 (183,425)

2017 Proportion (crude n)	2018 Proportion (crude n)	2019 Proportion (crude n)
Proportion of enrollees within 60 miles of a cardiologist		
1.0 (222,282)	1.0 (205,144)	1.0 (183,425)
Proportion of enrollees within 60 miles of an endocrinologist		
0.9120 (202,732)	0.9254 (189,835)	0.9216 (169,039)
Proportion of enrollees within 60 miles of an OB/GYN		
1.0 (222,282)	1.0 (205,144)	1.0 (183,425)
Proportion of enrollees within 60 miles of an oncologist		
0.9985 (221,951)	1.0 (205,144)	1.0 (183,425)
Proportion of enrollees within 60 miles of a pulmonologist		
0.9949 (221,149)	0.9948 (204,068)	0.9952 (182,548)

Essential Community Providers (ECPs) are defined as providers that serve predominantly low-income, medically underserved individuals. The Affordable Care Act requires QHPs to have a sufficient number and geographic distribution of ECPs, where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in the plans' service area, in accordance with federal network adequacy standards described in 45 Code of Federal Regulations (CFR) 156.235. To satisfy the ECP standard, QHP issuers must contract with at least 20 percent of available ECPs in each plan's service area to participate in the plan's provider network.

The following table provides the percentage of the total EPCs the QHPs reported in submission of the "ECP Network Adequacy Template." All issuers greatly exceeded the minimum threshold set forth by CMS for ECP network adequacy.

Measure	2017 Estimated % of ECPs	2018 Estimated % of ECPs	2019 Estimated % of ECPs
Total ECPs Available	221	224	230
Blue Cross Blue Shield	100%	100%	93.5%
Centene	100%	96.4%	100%
QualChoice	100%	100%	100%

Access to Care and Immunizations

Core questions from the Behavioral Risk Factor Surveillance System (BRFSS) on Health Care Access (any coverage, personal doctor, routine checkup, medical cost) and Immunization (flu shot/spray) were analyzed pre- and post-Medicaid expansion for Arkansas. Survey responses were dichotomized yes/no.

Data were extracted for all nonelderly adults (18–64) surveyed 2011–2019. Respondent household size and income were used to calculate an imputed percentage of the FPL. Analyses were restricted to respondents residing in households earning <138% FPL.

TIME PERIOD[1]			ESTIMATED DIFFERENCES[2]		
Baseline 2011-2013	Early Expansion 2014-2016	Late Expansion 2017-2019	Early Expansion – Baseline	Late Expansion – Baseline	Late Expansion – Early Expansion
Have Health Care Coverage					
0.508	0.765	0.809	0.262	0.304	0.042
Have Personal Doctor					
0.649	0.703	0.723	0.069	0.082	0.013
Last Routine Checkup					
0.510	0.611	0.696	0.117	0.199	0.082
Avoided Care Due to Cost					
0.430	0.306	0.277	-0.117	-0.149	-0.032
Flu Vaccine					
0.265	0.310	0.269	0.046	0.002	-0.044

Access to Preventive Care and Appropriate Treatment

The AR Works evaluation assesses the program's access to preventive care and appropriate treatment using the following measures:

- ***Breast Cancer Screening:*** In women ages 50-64, the percentage who had a mammogram during or in the 15 months prior to the measurement year.

- ***Cervical Cancer Screening:*** Cervical cytology performed during the measurement year or the two years prior, or for women at least 30 years old, cervical cytology/HPV co-testing during the measurement year or the four years prior.

- ***Statin Therapy for Patients with Diabetes*** In clients 40-64 years of age with diabetes, the percentage who were dispensed a statin medication during the measurement year

- ***Comprehensive Diabetes Care: Hemoglobin A1c Testing:*** Clients with a diagnosis of type 1 or type 2 diabetes in the measurement year or the year prior who have had an HbA1c test during the measurement year.

- ***Adult Access to Preventative/Ambulatory Health Services:*** A client with an ambulatory or preventive care visit during the measurement year.

- ***Non-Emergent Emergency Department (ED) Visits:*** Percentage of visits to the emergency department classified as non-emergent by the NYU algorithm.

- ***Emergent Emergency Department (ED) Visits:*** Percentage of visits to the emergency department classified as emergent by the NYU algorithm.

The measures described in the table are:

- **Inverse probability weighted with regression adjustment** (IPWREG): Robust results from models that adjusted for selection, confounders, and post-treatment covariates

- **Inverse probability weighting with ratio and scale adjustments** (IPWS): Results from models that adjusted for selection.

Measure		MY17	MY18	MY19
Raw	Breast Cancer Screening	0.4642	0.4956	0.5065
IPWREG	Cervical Cancer Screening	0.4300	0.4583	0.4508
IPWS	Statin Therapy for Patients with Diabetes	0.4935	0.5438	0.5775
IPWREG	Comprehensive Diabetes Care: Hemoglobin A1c Testing	0.8029	0.8217	0.8321
IPWREG	Adult Access to Preventative/Ambulatory Health Services	0.6927	0.7381	0.7469
IPWREG	Non-Emergent Emergency Department (ED) Visits	0.3323	0.3300	0.3252
IPWREG	Emergent Emergency Department (ED) Visits	0.6677	0.6700	0.6748

Additional access to care measures include the following:

Adolescent Well-Care Visits: Adolescent Well-Care (AWC) Visits were used to assess client access to the EPSDT benefit of an annual well-child screening while enrolled in Arkansas Works. Clients eligible for the measure denominator were ages 19-20 and enrolled in a QHP during the measurement year, in addition to having previous enrollment in fee-for-service Medicaid in the previous year or two years prior to the measurement year. Each year was subject to a continuous enrollment requirement of at most 1 gap in coverage of 45 days or less.

EPSDT Screening – Preventive Dental Visits: The proportion of clients receiving a preventive dental visit was assessed for the same sample of clients eligible for the EPSDT AWC measure.

EPSDT Screening – Preventive Vision: The proportion of clients receiving a preventive vision visit was assessed for the same sample of clients eligible for the EPSDT AWC measure.

Period	2017	2018	2019
Adolescent Well Care Visits	0.1346	0.1606	0.1774
EPSDT Screening-Preventive Dental Visit	0.1339	0.2000	0.2169
EPSDT Screening-Preventive Vision	0.0935	0.0743	0.0842

Quality of Care

The AR Works evaluation assesses the program's quality of care and health outcomes using the following measures:

- ***Preventable Emergency Department (ED) Visits:*** Percentage of emergency department visits per year were classified by the NYU algorithm as preventable ED visits

- ***Plan All-Cause Readmissions:*** The number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days of discharge

- ***Diabetes Short-Term Complications Admission Rate:*** The rate of inpatient hospital admissions for short-term complications of diabetes in clients age 18 and up

- ***Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate:*** In clients aged 40 or older, the rates of inpatient hospital admissions for COPD

- ***Heart Failure Admission Rate:*** In clients ages 18 or older, the rate of inpatient admissions for heart failure

- ***Asthma in Younger Adults Admission Rate:*** In adults ages 18 to 39, the number of inpatient admissions for asthma per 100,000 client months.

- ***Follow-Up After Hospitalization for Mental Illness after 7 Days: I***n acute inpatient discharges for selected mental illness or intentional self-harm, the percentage followed by a visit with a mental health practitioner within 7 days

- ***Follow-Up After Hospitalization for Mental Illness after 30 Days:*** In acute inpatient discharges for selected mental illness or intentional self-harm, the percentage followed by a visit with a mental health practitioner within 30 days.

- ***Adherence to Antipsychotic Medications for Individuals with Schizophrenia:*** Clients with schizophrenia or schizoaffective disorder were significantly more likely to have remained on an antipsychotic medication for at least 80% of their treatment

- ***Persistence of Beta-Blocker Treatment After a Heart Attack:*** Clients hospitalized for an acute myocardial infarction from July 1 of the year prior to the measurement year to June 30 of the measurement year

- ***Annual Monitoring for Patients on Persistent Medications- Angiotensin Converting Enzyme (ACE) Inhibitors or Angiotensin Receptor Blockers (ARB):*** Among clients who received at least 180 days of ambulatory medication therapy for an ACE inhibitor or ARB, the percentage of those who also received at least 1 therapeutic monitoring event in the measurement year.
- ***Annual Monitoring for Patients on Persistent Medications- Diuretics:*** Among clients who received at least 180 days of ambulatory medication therapy for a diuretic, the percentage of those who also received at least 1 therapeutic monitoring event in the measurement year.
- ***Annual Monitoring for Patients on Persistent Medications- Total:*** Among clients who received at least 180 days of ambulatory medication therapy for an ACE inhibitor, ARB, or diuretic, the percentage of those who also received at least 1 therapeutic monitoring event in the measurement year.
- ***Annual HIV/AIDS Viral Load Test:*** The proportions of HIV-diagnosed clients who received an HIV viral load test
- ***C-Section Rate:*** The percentage of single live births delivered via Caesarean section

Measure		MY17	MY18	MY19
IPWS	Preventable Emergency Department (ED) Visits	0.0903	0.0919	0.0909
IPWREG	Plan All-Cause Readmissions	0.0422	0.0456	0.0500
IPWREG	Diabetes Short-Term Complications Admission Rate (per 100,000 client months)	11.4148	14.1728	18.3300
IPWS	Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (per 100,000 client months)	13.3421	15.9217	15.6258
IPWREG	Heart Failure Admission Rate (per 100,000 client months)	6.0870	7.4015	10.8341
IPWREG	Asthma in Younger Adults Admission Rate (per 100,000 client months)	3.9119	4.3225	3.8256
IPWREG	Follow Up After Hospitalization for Mental Illness After 7 Days	0.1759	0.2110	0.1956
IPWREG	Follow Up After Hospitalization for Mental Illness After 30 Days	0.3690	0.3900	0.4182
IPWREG	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	0.3976	0.3837	0.3795
Raw	Persistence of Beta Blocker Treatment After a Heart Attack	0.3332	0.3974	0.4341
IPWREG	Annual Monitoring for Patients on Persistent Medications-Angiotensin Converting Enzyme (ACE) Inhibitors or Angiotensin Receptor Blockers (ARB)	0.8236	0.8378	0.8473
IPWREG	Annual Monitoring for Patients on Persistent Medications-Diuretics	0.8227	0.8369	0.8338
IPWREG	Annual Monitoring for Patients on Persistent Medications-Total	0.8216	0.8379	0.8404
Raw	Annual HIV/AIDS Viral Load Test	0.6876	0.6596	0.6878
IPWREG	C-Section Rate	0.2925	0.3092	0.2810

Providing Cost Effective Care

The AR Works demonstration utilizes the commercial QHPs offered on the health insurance marketplace as the foundation for the demonstration. AR Works clients are enrolled in silver-level QHPs, with premium assistance and cost support from Medicaid. The actuarial values (AV) for QHPs are fixed by the ACA and the Final Actuarial Calculator Methodology released annually by CMS. The AV did not vary for AR Works members, and the same plan richness was available for all QHP clients. All plans offered on the Arkansas marketplace must be within the allowable AV ranges to be certified by the AID as a QHP.

Areas evaluated for cost of care were 1) Arkansas-specific health insurance exchange program characteristics including the number of plans, actuarial risk, average second lowest cost silver premium (SLCSP) by Arkansas region, and 2) Arkansas-specific health insurance exchange program characteristics, which include the number of plans, actuarial risk, and average SLCSP.

		2017	2018	2019
	Total Number of Plans Offered	176	179	174
Actuarial Risk	Number of Gold, Silver, Expanded Bronze, Bronze, Catastrophic	40, 80, n/a, 42, 14	20, 111, 7, 28, 7	33, 106, 14, 14, 7
SLCSP (4.a.1)	Statewide Average	$281	$364	$378
SLCSP by Region (4.a.2)	Service Area 1	$314	$378	$379
	Service Area 2	$292	$352	$379
	Service Area 3	$297	$357	$377
	Service Area 4	$292	$351	$379
	Service Area 5	$307	$371	$379
	Service Area 6	$317	$382	$340
	Service Area 7	$283	$340	$379

The AR Works evaluation also conducted a high-level analysis of the states bordering Arkansas. The following data points were examined for each of the six states contiguous to Arkansas.

- Total population of the state
- Number of companies on state health exchange
- Proportion of Medicaid clients to total population
- Proportion of commercial insurance clients to total population
- Proportion of QHP population to total population

	Arkansas	Louisiana	Mississippi	Missouri	Oklahoma	Tennessee	Texas
Total Population	3,017,804	4,648,794	2,976,149	6,137,428	3,956,971	6,829,174	28,995,881
Number of Companies on Exchange	3	4	2	4	2	5	8
2018 Medicaid Clients, number and % of total population	796,600 26.4%	1,323,500 28.5%	674,000 22.6%	888,000 14.5%	673,300 17%	1,359,800 19.9%	4,724,500 16.3%
2018 Commercial Insurance Clients, number and % of total population	1,223,300 40.5%	1,918,200 41.3%	1,249,500 42%	3,101,200 50.5%	1,756,000 44.4%	3,070,000 50%	13,234,000 45.6%
2018 QHP Clients, number and % of total population[2]	68,100 2.3%	109,855 2.4%	83,649 2.8%	243,382 4%	140,184 3.5%	228,646 3.4%	1,126,838 3.9%

Source: https://www.kff.org/other/state-indicator/total-population/?dataView=1&currentTimeframe=1&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
Source for Total QHP Enrollees - Marketplace Enrollment, 2014-2021 | KFF

The assessment of cost of care also included a review of budget neutrality and inpatient utilization by AR Works members for the years the Interim Evaluation examined.

Budget Neutrality

	2017	2018	2019
Number of Paid Premium Member Months	3,143,965	2,714,418	2,432,883
Premium Expenditures	$1,183,532,438.81	$1,268,351,951.50	$1,088,706,551.53
Advance Cost Share Payments	$447,430,159.75	$270,651,782.11	$397,384,530.76
Wrap Costs	$12,774,314.78	$9,844,810.45	$8,665,953.71
Premium Reconciliations	$3,447,947.13	$2,896,400.19	$3,162,177.16
Net Payments Per Individual with a Paid Premium	$521.73	$569.53	$613.10
Budget Neutrality Cap	$570.50	$597.32	$625.39
Budget Neutrality Comparison	-9%	-5%	-2%

[2] Defined as "Number of Individuals Who Selected a Marketplace Plan represents the total number of people who selected or were automatically reenrolled into a Marketplace medical plan (regardless of whether the consumer paid the premium) as of the end of the open enrollment period."

Inpatient Utilization

AR Works members had lower inpatient utilization than the comparison group across all three years including maternity, surgery and pharmacy services.

Measure	Inpatient Utilization Total	MY17	MY18	MY19
IPWREG	Comparison Rate	8.3598	8.8408	10.8642
	Target Rate	6.1558	5.8854	6.6832

AR Works Client 2019 Survey Results

This section of the report contains results from the member surveys,[3] which was conducted as part of the AR Works evaluation to be included with the results of the Summative Evaluation. The survey was administered by mail between June 2020 and December 2020. The survey asked AR Works members about their experiences with QHPs and QHP services as well as other questions.

Members Who Responded Favorably (Usually or Always) about QHP Experience

Getting needed care	**n**	
Last 6 months, ease of access to care	265	92.5
Last 6 months, appointment to see specialist	145	83.4
Getting care quickly		
Last 6 months, ease of access to urgent care as soon as possible	147	87.8
Last 6 months, routine care at office/clinic as soon as possible	230	81.3
How well doctors communicate		
Last 6 months, personal doctor listen carefully	232	97.0
Last 6 months, personal doctor show respect	232	96.1
Last 6 months, personal doctor spend enough time	232	96.1
Health plan customer service		
Last 6 months, plan's customer service gave information needed	94	84.0
Last 6 months, plan's customer service staff treat client with courtesy and respect	94	92.6

Member Ratings of QHP and QHP Providers

	n	**Average (rating 0-10)**
Rating of their **health plan**	345	8.64
Rating of their **health care**	265	8.88
Rating of their **personal doctor**	280	9.14
Rating of their **specialist**	137	9.04

[33]Client Engagement Satisfaction surveys were administered using the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey, Adult Medicaid 5.0, core questions with the addition of three supplemental items and two questions specific to the Arkansas Works evaluation.

Member Rating of Their Own Health

	Excellent or Very Good	Good	Fair or Poor
Overall Health Status n=347	29.4%	42.1%	28.5%
Mental Health Status n=347	38.9%	32.3%	28.8%