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**Arkansas Health Care Independence Program
(‘Private Option’)
Section 1115 Demonstration Waiver
Final Report**

June 30, 2018

Executive Summary

Background

In 2013, like many other states across the country, Arkansas faced a complex series of political challenges following the U.S Supreme Court decision on the Patient Protection and Affordable Care (PPACA) Act. Unlike any other state in the South, however, Arkansas was able to successfully navigate these challenges to pursue a novel approach to Medicaid expansion through the commercial sector. Through a Section 1115 demonstration waiver, the state utilized premium assistance to secure private health insurance, offered on the newly formed individual health insurance marketplace (the Marketplace), for individuals between 19 and 64 years of age with incomes at or below 138 percent of the federal poverty level (FPL).ⁱ

In 2014, Arkansas successfully established the Health Care Independence Program (HCIP),ⁱⁱ commonly referred to as the “Private Option,” as designed under the terms and conditions of the Section 1115 demonstration waiver. Through 2015, the estimated target-enrollment population of approximately 250,000 was met. Approximately 25,000 additional individuals eligible under the PPACA — and deemed to have exceptional healthcare needs — were enrolled in the traditional Medicaid program. Finally, approximately 20,000 previously eligible but newly enrolled individuals also obtained Medicaid coverage. By the end of 2016, the Private Option population totaled approximately 280,000.

Arkansas’s healthcare providers have reported significant clinical and financial effects under the HCIP. In 2014, federally qualified community health centers (FQHCs) reported increased success in attaining needed specialty referrals for their clients.ⁱⁱⁱ The Arkansas Hospital Association (AHA) reported significant annualized reductions in uninsured outpatient visits (45.7 percent reduction), emergency room (ER) visits (38.8 percent reduction), and hospital admissions (48.7 percent reduction).^{iv} The state’s public teaching hospital reported a reduction in uninsured admissions, from 16 percent to 3 percent, during the same time period.^v These reductions persisted through 2016.

Competitiveness and consumer choice in the Marketplace have increased across the seven market regions in the state with approximately 80 percent of the covered lives in the Marketplace enrolled through the Private Option. In 2014, individuals in three out of the seven regions of the state — those marked by extreme poverty — only had access to Arkansas Blue Cross and Blue Shield and Blue Cross Blue Shield Multi-State plans. By 2016, five carriers were offering coverage across all seven market regions, with one market region having access to six carriers. A sixth carrier operated in a single region restricted by Medicaid’s purchasing guidance limiting premium assistance to those plans within 10 percent of the second-lowest cost silver plan in the market region. Over the three year period, all plans experienced single digit rate increases.

For 2014, the estimated budget neutrality cap (BNC) was exceeded during the initial enrollment phase of the program. The enrollment of younger individuals over time (affecting net premiums), the rebate of medical-loss ratio (MLR) payments by one carrier not meeting the minimum MLR requirements in 2014, and inflationary expectations brought cumulative program costs within the estimated BNC 2015 limit of \$500.08 per member per month (PMPM) and well under the 2016 limit of \$523.58 PMPM.

Summary of Findings Based on Evaluation Hypotheses

The HCIP programmatic goals and objectives included successful enrollment, enhanced access to quality health care, improved quality of care and outcomes, and enhanced continuity of coverage and care at times of re-enrollment and during income fluctuations. These goals and objectives were to be achieved within a cost-effective

framework for the Medicaid program, compared with what would have occurred if the state had provided coverage to the same expansion group in Arkansas’s traditional Medicaid fee-for-service (FFS) delivery system.

The state’s required evaluation design under the terms and conditions of the Private Option waiver was negotiated within 135 days of approval of the waiver on Sept. 27, 2013. The terms and conditions required the evaluation to meet prevailing standards of scientific rigor, use the best available data, use controls and adjustments for reporting limitations of the data, and discuss generalizability of results. Additional requirements included a robust discussion of cost effectiveness. The state was required to submit a final Interim Evaluation Report within 180 days of the end of the second year of the demonstration. That report is available at www.achi.net.

The evaluation was conducted independently and with oversight of a National Advisory Committee consisting of established leaders in major academic and medical centers around the country. The evaluation employed the most current and well-established research design techniques to optimize confidence in observed findings. There were two principle comparisons — the experiences of those with “Higher Needs” and that of the “General Population.”

The Higher Needs population examined the approximately one-half of the newly eligible expansion population who took a medical frailty screener to detect prior conditions and utilization. This information was used to identify and compare similar individuals with higher needs that were placed in the traditional Medicaid program versus those placed in QHPs through a quasi-experimental regression discontinuity approach.

The General Population consisted of the one-half of newly eligible that did not take the screener and were placed in QHPs. They were paired with the approximately 40,000 newly enrolled adult Medicaid beneficiaries (woodwork effect) and were matched using advanced propensity score techniques with appropriate statistical tests applied.

This report reflects the experience and findings from the three-year waiver for the Private Option, and major findings are summarized below, grouped by questions of interest.

1. *What were differences across access, quality, and outcomes between those enrolled in Medicaid and those enrolled in commercial Qualified Health Plans (QHPs)?*

A major assumption grounded in Arkansas’s use of premium assistance through the Marketplace was that by utilizing the delivery system available to the privately enrolled individuals in the Marketplace, the availability and accessibility of both primary care providers (PCPs) and specialists would be greater than what would have been expected if Arkansas had utilized a traditional Medicaid expansion strategy. A three-year enrollment comparison of Medicaid and commercial QHP beneficiaries in both the cohort with Higher Needs and that in the General Population revealed:

- The geographic proximity of available primary and specialty providers were similar for those served by Medicaid and the QHP networks, and both met network adequacy requirements of the Arkansas Insurance Department.
- Initiation of care occurred more rapidly for enrollees in QHPs than for those in the Medicaid program following enrollment.
- In 2014, differences in the accessibility of both primary care and specialty providers were reported, with QHP enrollees experiencing increased ability to get needed “care, tests, and treatment” and receiving “an appointment for a check-up or routine care as soon as needed,” compared to their Medicaid counterparts.

- Perceived access differences improved after 18 months in the program for the General Population. However, for individuals in the Higher Needs Population, Medicaid enrollees continued to report more difficulty “receiving care when they needed it right away” and did not always “find it easy to get the care, tests, and treatments they need,” compared to QHP enrollees (range of differences 31-36 percent).
- For Emergency Room (ER) use, differences were only observed within the General Population, in which Medicaid enrollees experienced more ER visits in total, for both emergent and non-emergent reasons, compared to QHP enrollees over the three years enrolled.
- With the exception of QHP enrollees experiencing longer hospital stays compared to Medicaid enrollees, there are no consistent differences across hospitalization measures.
- For clinical services assessed for both populations — and for most measures studied — differences in care and clinical service delivery were observed.
- QHP enrollees were significantly more likely to receive individual clinical preventive services and were more likely to receive all recommended screenings (a range of 24-94 percent relative differences for the General Population).
- QHP enrollees were significantly more likely to receive appropriate disease management services and more likely to adhere to appropriate medication management than Medicaid enrollees (a range of 31-55 percent relative differences for the General Population).
- For pregnancy related care, no clinically significant differences were observed in the initiation of prenatal services, complications of maternity care, or birth outcomes between QHP and Medicaid enrollees.
- With respect to non-emergency medical transportation, no differences were observed for the General Population. However, for the Higher Needs Population, those in QHPs were 15 percent less likely to miss a visit due to transportation issues.
- Opioid use, while similar in the first year, diverged significantly in subsequent years, with increasing numbers of prescriptions, high dose utilization, and concomitant benzodiazepine use in the QHPs, compared to Medicaid enrollees.
- With respect to Early Periodic, Screening, Diagnosis, and Treatment (EPSDT) services, we found no indication that needed services were not available to individuals in premium assistance.
- With respect to continuity of enrollment, both Medicaid and QHP enrollees experienced few disruptions in coverage, with the exception being a mass eligibility redetermination undertaken in the summer of 2015.
- There were no statistically significant differences in mortality within the first three years of the program.

2. *What were the differences in costs between Medicaid and premium assistance?*

The cost of providing coverage for Medicaid beneficiaries through premium assistance in QHPs was expected to be greater than providing coverage through the traditional Medicaid FFS system. Exploration and characterization of the contrasts between the two programs provided a better understanding of the observed variations in access, utilization, and clinical impacts described above. In addition, dramatic

differences in payment rates were observed, with QHP rates consistently exceeding those in the Medicaid program:

- Physician payment rates across outpatient services were approximately 95 percent higher in each of the three years under study for enrollees in a QHP compared to their Medicaid counterparts (e.g., In 2016, the weighted average per PCP visit was \$94.03 for a QHP compared to \$47.69 for Medicaid);
- For inpatient hospital stays, average QHP payments averaged \$12,270 per discharge compared to Medicaid payments of \$7,778 (a 53 percent difference); and
- In 2016, administrative costs were estimated to be \$91.65 PMPM for QHPs and \$64.33 PMPM for Medicaid (a 29.8 percent difference).

Utilization differences were also observed, but not at the same magnitude as payment differentials. Medicaid beneficiaries, under the traditional FFS system, experienced increased ER visits and hospitalizations. Conversely, QHP beneficiaries received more outpatient visit contacts, and by 2016, almost twice as many prescriptions.

3. *What were the cost-effective aspects of premium assistance?*

Cost-effectiveness for the purposes of this evaluation considered any benefits associated with care delivered through QHPs at increased payment rates. To assess cost-effectiveness, total program costs for enrolled individuals in QHPs were directly compared to their Medicaid counterparts. Ratios of improvement in care to associated costs were developed (e.g., access improvements, clinical, and utilization differentials compared to payment rate differentials).

In 2016, the weighted average payment to QHPs (premium and cost-sharing reductions) was \$486 PMPM or \$5,832 per year, compared to Medicaid costs of \$317 PMPM or \$3,804 per year for each enrollee (using existing Medicaid payment rates). Using the difference of \$167 PMPM, select ratios of improvement to access reflect the following:

- For colorectal cancer screening in the General Population, the QHP cohort had a 94 percent higher relative difference in screening rates. Thus, the marginal improvement is suggested to be an increase of 5.6 percent per observed 10 percent increase in program costs associated with use of premium assistance.
- For the proportion who received all indicated clinical preventive services in the General Population, the QHP relative difference of 25 percent greater than Medicaid suggests a 1.4 percent improvement in clinical performance per observed 10 percent increase in program costs.
- For individuals with Higher Needs, QHP enrollees were 26 percent more likely to self-report “always getting care when needed right away” and 18 percent more likely to find it “easy to get the care, tests, and treatment needed.” This suggests a 1.1 percent improvement in access, per observed 10 percent increase in program costs.
- For individuals with Higher Needs, Medicaid enrollees experienced fewer outpatient events and a concurrent higher rate of ER visits and hospitalizations. For each observed 10 percent increase in program costs, QHPs were projected to achieve seven more physician office visits and avoid 2.5 ER visits per 100 person years.

- There were no clinical indicators in which Medicaid was favored.
- Importantly, enrollees in QHPs received twice as many prescriptions than their Medicaid counterparts. For each 10 percent increase in program costs, QHPs were projected to cover 78 additional prescriptions per 100 person years.

Over the three-year evaluation, PMPM claims costs for QHPs increased, a trend which was associated with both increased utilization rates and provider rate increases. The established Medicaid rate schedule does not incorporate inflationary adjustments, so no comparable increases were observed during the evaluation. Continued divergence in experience, utilization, and payment rates will likely affect ratios of improvement in care to associated program costs.

4. *What would the Medicaid program have experienced if a traditional Medicaid expansion had been adopted?*

A core component of this demonstration evaluation is an examination of the hypothetical costs of covering the entire expansion population through Arkansas’s traditional Medicaid program and identifying the programmatic changes that would be necessary to achieve a similar outcome to that experienced through premium assistance. In 2013, prior to the PPACA expansion, Arkansas had one of the lowest Medicaid eligibility thresholds for non-disabled adults in the U.S., covering only 24,955 non-disabled adults with a full benefits package.

In 2014, following PPACA expansion, an additional 267,482 individuals were covered:

- approximately 17,300 (6.5 percent) previously eligible but newly enrolled;
- approximately 25,000 (9.3 percent) PPACA eligible but with exceptional healthcare needs;
- and 225,000 (84.2 percent) PPACA eligible with premiums purchased on the individual marketplace.

These 267,482 individuals represented 16.0 percent of the total 19- to 64-year-old population in the state.

In 2016, this number increased to 330,943 covered lives:

- approximately 22,375 (6.8 percent) PPACA eligible but with exceptional healthcare needs;
- 32,427 (9.8 percent) interim status before enrollment in a QHP;
- and 276,141 (83.4 percent) PPACA eligible with premiums purchased on the individual marketplace.^{vi}

These 330,943 individuals represent 19.1 percent of the working-aged adults within the state.

Thus, because of the high rates of uninsurance and low Medicaid eligibility prior to the PPACA, Medicaid has experienced a 13-fold increase in coverage for the non-disabled 19- to 64-year-old population.

Traditional microeconomics principles would suggest that increased demand through the expansion of the Medicaid program would place increasing price pressure on the rate structure of the existing Medicaid program. The observed differences in payment rates between QHPs and Medicaid described above could lead to unsustainable access differentials for Medicaid enrollees. Any potential increase in payment rates would affect not only the new expansion population, but also enrollees under the same payment rate schedule across the entire Medicaid program. To model the potential effects, a budgetary impact analysis was conducted on increasing payment rates across the Medicaid program.

Three increasingly fiscally conservative scenarios were simulated for alternative expansion options through the existing Medicaid FFS system, the counterfactual, to provide policymakers with conditions under which necessary increases to achieve equitable access could be considered. They

included: 1) claims potentially associated with wage-sensitive services; 2) restricted claims associated with major medical services; and 3) restricted to claims associated only with physician billed services.

The budget impact analysis revealed that costs to the Medicaid program would exceed the increased costs associated with premium assistance:

- if wage-sensitive payment rates had increased by 29 percent;
- if claim payments associated with clinical services had increased by 45 percent; or
- if physician-only claim payments had increased by 64 percent;

Importantly, under the most conservative scenario of increases restricted to physician-only claims, the physician rate increase at which the Medicaid program costs exceed those of premium assistance remains 36 percent below the commercial payment rates observed. This suggests the likelihood of continued differential access despite increased payments.

These findings suggest that with the 13-fold increase in enrollment of 19- to 64-year-olds, plausible required increases in Medicaid payment rates across the entire program would exceed the costs associated with purchasing commercial coverage through premium assistance.

Conclusion

The three-year evaluation of the Private Option is the first direct comparison of commercial insurance with Medicaid since Medicaid's inception in 1965. Through Arkansas's use of premium assistance, and as a consequence of the rigorous CMS evaluation requirements of the waiver, previously unfeasible direct comparisons of system performance have been enabled.

Arkansas Medicaid achieves comparable participation in its network, compared to QHPs, for both primary and specialty providers. However, likely due to markedly higher provider payment rates and more active enrollee management, the network adequacy and clinical performance of the QHPs exceeds that of Medicaid. These differences have an impact on the uptake of clinical preventive services, appropriate disease management, and utilization of emergency room services. For those with Higher Needs, perceived barriers to getting care when needed and getting necessary tests and treatments are persistent for Medicaid.

For pregnancy, where Medicaid previously covered a majority of deliveries and had invested significant performance improvement efforts, no advantage was observed for treatment in the commercial sector at higher reimbursement rates. In addition, Medicaid achieved reduced opioid consumption compared to the commercial sector, likely due to more assertive programmatic restrictions.

In the first three years of the program, no differences in mortality were observed between enrollees in Medicaid and those in the commercial sector.

Systemic effects on the Arkansas healthcare landscape through the use of premium assistance was significant. By guaranteeing purchase for over 250,000 individuals and establishing purchasing guidelines, at a time when surrounding states were facing major challenges in the stability of their markets, the Arkansas Health Insurance Marketplace experienced exceptional stability, marked increase in competition, and single-digit rate increases across the three years. In addition, Arkansas has experienced no hospital closures — with service expansion in some underserved areas — further distinguishing its overall system stability from neighboring states and from the rest of the country.

Finally, while the costs of premium assistance exceed those modeled under a static Medicaid expansion scenario, it is unlikely that Arkansas Medicaid would have been able to absorb a 13-fold increase in enrollees and meet the federal equal access requirements, under which the state is subject to judiciary review, without considerable adjustment to provider rates. Although political discourse has highlighted concerns about the differences in absolute cost between commercial and Medicaid alternatives, Medicaid expansion scenarios under which similar clinical experiences would be achieved suggest budgetary outcomes that may mitigate these concerns.

These findings may have limited applicability to other states. Few states had the restrictive Medicaid eligibility threshold, resulting in dramatic increases in coverage through expansion. In addition, provider rate differentials between Medicaid and commercial plans are also unlikely to exceed those in Arkansas.

However, these findings do support direct comparisons of both commercial and Medicaid costs and performance across states. These differential payment rates and associated results raise questions regarding the ability of Medicaid programs nationwide to meet the federal equal access requirements through delivery system strategies that pay providers significantly lower rates.

The innovative use of premium assistance and the integrated relationship between the individual Marketplace and the Arkansas Medicaid program merit continued observation. The demonstration waiver through which Arkansas implemented the Private Option was extended in January of 2017, enabling the successor premium assistance program, “Arkansas Works.” With work requirements, workforce training, and/or community service for a subset of enrollees implemented in June 2018, further evaluation of the use of premium assistance and the impact on upward social mobility is warranted.

ⁱ The Centers for Medicare & Medicaid Services [Letter] to Andy Allison, Arkansas Department of Human Services. September 2013. <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/Health-Care-Independence-Program-Private-Option/ar-private-option-app-ltr-09272013.pdf>.

ⁱⁱ Ark. Code § 2-77-2405 (2014).

ⁱⁱⁱ Susan Ward-Jones, MD. Personal Communication. March 12, 2015.

^{iv} Arkansas Hospital Association. APO’s Hospital Impact Strong in 2014. *The Notebook*. 2015;22(22):1. http://www.arkhospitals.org/archive/notebookpdf/Notebook_07-27-15.pdf.

^v Dan Rahn, M.D., Testimony before Health Reform Legislative Taskforce. August 20, 2015.

^{vi} Arkansas Department of Human Services (DHS). (2016, December 31). Arkansas Private Option 1115 Demonstration Waiver. Quarterly Report October 1, 2016-December 31, 2016 [Report]. Retrieved from <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/Health-Care-Independence-Program-Private-Option/ar-works-qtrly-rpt-oct-dec-2016.pdf>