HEALTH CARE INDEPENDENCE PROGRAM EVALUATION: INTERIM RESULTS

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Arkansas Center for Health Improvement

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Section 1115 of the Social Security Act allows the Secretary of Health and Human Services to approve demonstration projects that promote Medicaid objectives. Through Section 1115 waivers, states have additional flexibility to design and improve programs and test innovative financing and care delivery models. In 2013, the Secretary approved a waiver application from Arkansas to implement a unique approach to expanding healthcare coverage to low-income Arkansans through the Health Care Independence Program (HCIP). Commonly known as the "Private Option," the HCIP uses Medicaid funds to purchase individual qualified health plans through the Health Insurance Marketplace for those eligible under the Patient Protection and Affordable Care Act's (PPACA) Medicaid expansion. Section 1115 waivers, including Arkansas's, require states to conduct independent evaluations examining the impacts of these demonstration projects on access, quality of care, and costs. This fact sheet discusses the HCIP evaluation design, data sources, comparison populations, and initial findings from the interim evaluation report.[1] To access the entire report, visit www.achi.net.

WAIVER EVALUATION DESIGN

Arkansas established the Health Care Independence Program (HCIP) in 2014 through a Section 1115 demonstration waiver allowing the state to use premium assistance to purchase private plans for Medicaid-eligible individuals. Arkansas Medicaid engaged the Arkansas Center for Health Improvement (ACHI) in collaboration with researchers from the University of Arkansas for Medical Sciences to conduct the HCIP evaluation and a national advisory committee to ensure scientific rigor of the assessment. ACHI submitted the HCIP evaluation design to the Centers for Medicare and Medicaid Services (CMS) in early 2014, which was approved and incorporated as an amendment to the waiver terms and conditions.

Data Sources

- Geographic mapping of providers
- Enrollment information
- Retrospective claims data
- Sample survey responses

Comparison Populations

- General Population: Newly-enrolled Medicaid and QHP enrollees who did not take a healthcare needs questionnaire
- Higher Needs Population: Newly-enrolled Medicaid and QHP enrollees who took the healthcare needs questionnaire and self-reported higher healthcare needs

The interim evaluation report examining the first year of experience in the HCIP was released in May 2016. The report compared individuals enrolled in qualified health plans (QHPs) through premium assistance and those enrolled in the traditional fee-for-service Medicaid program and addressed the following questions:

- What were differences across access, quality, and outcomes between those newly enrolled in Medicaid and those enrolled in QHPs?
- What were the differences in costs between Medicaid and premium assistance QHPs?
- What were the cost-effective aspects of premium assistance?
- The interim evaluation also provided a budget impact analysis on Medicaid program experience if the state had expanded coverage through traditional Medicaid rather than through premium assistance.

ACCESS

Geographic Network Adequacy: 30-minute drive time for primary care providers and a 60-minute drive time for specialty providers
Realized Access: Observed access for primary, specialty, and emergent care
Self-Reported Access: Results on access indicators from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey

Enrollment in Coverage

Through 2015, the program had approximately 250,000 individuals enrolled. An additional 25,000 individuals were considered to have exceptional healthcare needs and were enrolled in the traditional Medicaid program. Twenty thousand previously eligible but newly enrolled individuals also obtained Medicaid coverage.

Geographic Network Adequacy

- Both Medicaid and QHPs met the network adequacy assessment.
- The geographic proximity of available primary and specialty providers was similar for individuals in all of the comparison populations.

[1]All data and figures can be found in the full evaluation report.

Self-Reported Access

Table 1 displays the questions and responses from the CAHPS survey in which individuals in the comparison groups provided answers that were significantly different from each other.

Table 1. Differences in Perceived Access between Populations

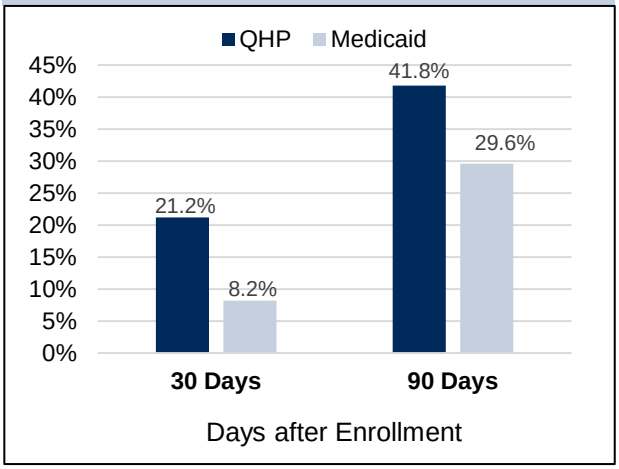
	General		High Needs	
Reported ALWAYS:	**Medicaid**	**QHP**	**Medicaid**	**QHP**
Received needed care right away	56.7%	64.2%	54.9%	64.2%
Got an appointment for a check-up	56.1%	62.9%	55.8%*	56.5%*
Easy to get needed care, tests, and treatment	45.9%	64.5%	48.4%	57.9%

*Not significantly different

OBSERVED UTILIZATION

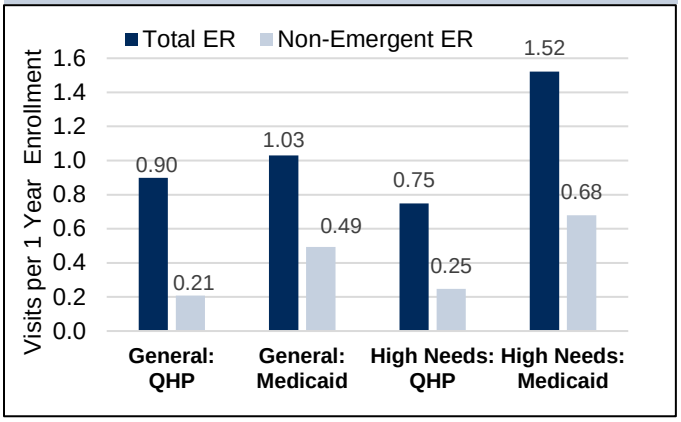
- In the general population, initiation of care following enrollment occurred more rapidly for enrollees in QHPs than for those in the Medicaid program (see Figure 1).

Figure 1: First Outpatient Visit



- For emergency room (ER) use, Medicaid enrollees not only had a higher number of visits, but also their visits were approximately 60 percent more likely to be for non-emergent conditions, potentially reflecting the access barriers reported in Table 1 (see Figure 2).

Figure 2: Emergency Room Visits



- In the general and high needs populations, QHP enrollees were more likely to receive clinical preventive services compared to Medicaid enrollees.
  - 19.2% more QHP enrollees received flu shots than enrollees in Medicaid in the high needs population.
  - 8.4% more QHP enrollees with diabetes received hemoglobin A1c assessment than Medicaid enrollees in the general population.
- In the high needs population, QHP enrollees had a 43.2% lower rate of hospitalizations. If hospitalized, no differences in average length of stay were observed.

COST

Absolute Difference in Payment Rates

The difference in provider payment rates between Medicaid and the private payers as described in Table 2 is reflected in the overall cost of care.

Table 2. Payment Rates and Differences

	Medicaid	QHP	Difference	% Difference
Primary Care Physician	$53.07	$100.67	$47.60	89.69%
Advanced Practice Nurse	$41.90	$68.19	$26.29	62.75%
Cardiologist	$61.49	$126.36	$64.87	105.49%
General Surgery	$52.74	$109.2	$56.98	108.05%
Obstetrician/Gynecologist	$48.84	$92.72	$43.88	89.85%

Table 2 (continued). Payment Rates and Differences				
	Medicaid	QHP	Difference	% Difference
Oncologist	$62.56	$120.35	$57.79	93.57%
Ophthalmologist	$44.47	$118.05	$73.58	165.46%
Orthopedist	$50.75	$98.23	$47.49	93.57%
Psychologist/Psychiatrist	$44.25	$91.92	$47.67	107.74%

The actual per-member-per-month (PMPM) cost including cost-sharing reductions through premium assistance was $485.05. The cost of care for the same population had they been enrolled in traditional Medicaid was $272.01 PMPM including supplemental payments and administrative costs.

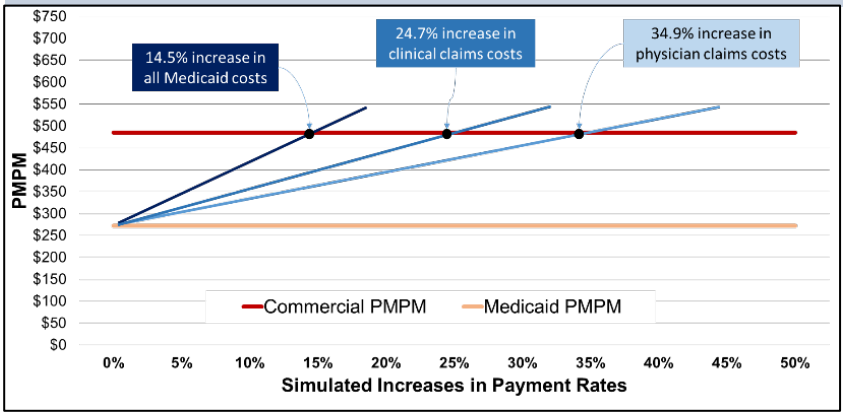
Budget Impact Analysis

To assess the impact of a ten-fold increase in the number of adults covered if a traditional Medicaid expansion had been pursued, three inflationary scenarios were considered for reimbursement rates:

1) All claims associated with wages
2) All claims restricted to major clinical services
3) All claims restricted to only physician

Figure 3 displays the increases in reimbursement rates under each of these scenarios.

Figure 3: Budget Neutrality Cut-Points



CONCLUSION

First year evaluation findings show that access, quality, and payment rates differed between the individuals enrolled in premium assistance versus those enrolled in traditional Medicaid. These differences provide insight into the variations in delivery system performance between the commercial sector and Medicaid and raise questions regarding the ability of Medicaid programs to meet the federal equal access requirements under current reimbursement rates.

The HCIP will continue until December 31, 2016, and the final evaluation report will be complete by the end of 2017. It will examine years two and three of the program and offer additional analyses (see text box). The HCIP will be replaced by a new program, Arkansas Works, on January 1, 2017, upon approval by CMS. Arkansas Works will retain the foundation of the HCIP—individual plan premium assistance—but will add features intended to strengthen employer-sponsored coverage and promote wellness and personal responsibility. The state will continue to be required to evaluate the program under the terms and conditions of the modified demonstration waiver.

Final Evaluation: Additional Analyses

- Continuity of coverage and care
- Comparison of alternative program quality and health outcome characteristics
- Observed differences in prevention
- Assessments on select populations including pregnant women and Early Period Screening Diagnosis and Treatment needs of 19 and 20 year olds
- Utilization and impact of Health Independence Accounts
- Impact on the health insurance marketplace
- Continued assessment of budgetary implications