Arkansas Works Section 1115 Demonstration Waiver

CLOSE OUT REPORT

January 1, 2017 – December 31, 2021

Executive Summary

On January 1, 2017, the state began Arkansas Works (AR Works) to continue to provide access to healthcare for uninsured, low-income adults up to 133% Federal Poverty level (FPL) who are not eligible for any other Medicaid programs. The demonstration, which expired on December 31, 2021, provided coverage for adults ages 19-64 through private insurance plans, or qualified health plans (QHPs) licensed by the Arkansas Insurance Department (AID). DHS evaluated how well the demonstration was able to address health outcomes and other measures for clients enrolled in the QHPs through an independent evaluator, with the initial findings summarized in this report and the final summative results to be completed in 2023.However, the value and benefit of this program in terms of improving access for this population and strengthening the overall healthcare delivery system is clear as is its potential to improve health outcomes. Through the Demonstration, low-income Arkansans in need of health insurance were able to access healthcare services to support their health through the QHPs, and the state continued to strengthen, optimize and align services and processes for the QHPs to improve access, enhance health outcomes and provide cost-effective care. During implementation, the Demonstration had revisions as described in this report.

The AR Works program operated $749.9 million below the budget neutrality limit of $12.747 billion for the five years of the program. The following table provides the total expenditures, member months and the calculated per member per month expenditure as of the end of March 2022. The table also provides the per member per month limit as specified in the Demonstration's Special Terms and Conditions.

	2017	2018	2019	2020	2021
	DY4	DY5	DY6	DY7	DY8
Expenditures	$1,670,608,122	$1,541,743,707	$1,482,257,892	$1,658,835,624	$2,143,871,540
Member months	3,143,965	2,714,418	2,432,883	2,802,062	3,434,914
PMPM	$531.37	$567.98	$609.26	$592.01	$624.14
Budget Neutrality Limit	$570.50	$597.32	$625.39	$654.79	$685.56

More than 570,000 unique people were able to enroll in AR Works over the course of the demonstration. The program also ensured continuous enrollment of any clients enrolled on or prior to the public health emergency as required through federal legislation. In 2021, the state began transitioning the AR Works program to the Arkansas Health and Opportunity for Me (ARHOME) program, the new 5-year 1115 Waiver that began January 1, 2021, and existing eligible clients continued to receive coverage through the program. The state began implementing new health improvement activities through the ARHOME Program in 2022.

Introduction

This final close out report for the AR Works Demonstration covers January 1, 2017 - December 31, 2021. The report summarizes the efforts under this Waiver to improve continuity of care, access to care, quality of care and health outcomes for the new adult group. The state leveraged the Marketplace QHPs to provide coverage for this group to achieve these goals and implement healthcare delivery system improvements. In 2013, the state first implemented this approach under a 3-year 1115 Waiver demonstration, the Health Care Independence Program (HCIP), and leveraged federal Medicaid funding to insure individual adults newly eligible through the Patient Care and Affordable Care Act (ACA) beginning January 1, 2014. The HCIP, which transitioned in December 2016 to AR Works, substantially lowered the uninsurance rate among non-elderly adults, positively impacting the state's hospitals and

other healthcare providers.[1][2]The state began the AR Works demonstration to continue coverage for this population through similar authorities as well as to test other changes to the program. The 2016 Arkansas Works Act added premiums for adults greater than 100% FPL and required client referrals to state job training and placement programs.

Goals and Components of the Waiver

Through the Waiver, the state sought to demonstrate several goals including:

1. Improving continuity of care for the adult expansion population enrolled in the QHPs
2. Improving access to care through the QHP provider network and increased access to preventative, primary and specialty services
3. Improving quality of care experienced by clients, use of preventative and other care and avoidance of emergency and hospitalization
4. Providing cost effective care through reduced utilization of more costly care and compared to other coverage provided in the private market or through the Fee for Service (FFS) system through traditional Medicaid

Through the demonstration, the state hypothesized that the client's knowledge of eligibility as well as understanding of coverage through the QHP and the availability of primary or specialty care through the QHP network would lead to improved access to care and a higher likelihood of obtaining care. Further, the state thought this would contribute to fewer gaps in coverage than if they had not been enrolled in AR Works and more likely to follow through on screenings and treatment. As a result, AR Works would improve health outcomes and the overall health of clients, and finally, the QHP model would be cost-effective overall.

Waiver Authorities

The AR Works demonstration included waivers of the following state plan and/or federal requirements under the Social Security Act

- **Freedom of Choice Section 1902(a)(23)(A)** to the extent necessary to enable Arkansas to limit beneficiaries' freedom of choice among providers to the providers participating in the network of the client's QHP. No waiver of freedom of choice was authorized for family planning providers.
- **Payment to Providers Section 1902(a)(13) and Section 1902(a)(30)** to the extent necessary to permit Arkansas to provide for payment to providers equal to the market-based rates determined by the QHP.
- **Prior Authorization Section 1902(a)(54) Section 1927(d)(5)** to permit to the state to require that requests for prior authorization for drugs be addressed in 72 instead of 24 hours.
- **Premiums Section 1902(a)(14)** to the extent necessary to enable Arkansas to collect monthly premium payments, for clients with incomes above 100% FPL.
- **Comparability Section 1902(a)(10)(B)** to the extent necessary to enable the state to impose targeted cost sharing

[1] A Look at the Private Option in Arkansas, Kaiser Issue Brief, August 2015. https://www.kff.org/medicaid/issue-brief/a-look-at-the-private-option-in-arkansas/

[2] Arkansas HCIP section 1115 Demonstration Waiver Final Evaluation Report, June 30, 2018, Arkansas Center for Health Improvement.

- **Retroactive Eligibility Section 1902(a)(34)** to enable the state to not provide beneficiaries in the adult expansion group retroactive eligibility up to 30 days prior to the date of the application for coverage under the demonstration. This provision was halted when the state reverted back to the December 2016 Special Terms and Conditions (STCs) per CMS guidance.
- **Payment of Cost Sharing Reduction to QHPs and Plan Costs:** The agreements with QHP issuers provided for advance monthly cost-sharing reduction (CSR) payments to cover the costs associated with the reduced cost sharing for clients. Such payments were subject to reconciliation at the conclusion of the benefit year based on actual expenditures by the QHP for cost-sharing reduction.

Benefits

DHS purchases the lowest and second lowest cost silver-level Marketplace plan for the Medicaid population and silver-level plans that fall within 10% of the lowest cost qualifying plan. Plan benefits include the essential health benefits (EHBs) required by the ACA. The QHPs are currently offered by two insurance carriers, Centene and Arkansas Blue Cross and Blue Shield (BCBS). Additional wrap-around benefits required for Medicaid clients, including non-emergency transportation and Early Periodic Screening Diagnosis and Treatment (EPSDT) services for ARWORKs clients under age 21 are provided through the Medicaid fee for service system.

Medically Frail clients receive coverage through fee for service (FFS) Medicaid. American Indian Alaskan Native (AIAN) individuals are offered the option to enroll into the QHP or receive FFS coverage.

Premiums and Cost Sharing

Under AR Works, DHS worked with other state agencies, including AID, the Arkansas General Assembly and the health plans to implement the new premiums and cost sharing policies as follows:

- Premiums and co-payments were applied to clients above 100% FPL.
- Client-paid premiums were $13 per month. The state paid the difference between the Marketplace plan premium for the silver plans less the client-paid premium amounts. In 2021, the total market value/rate of the silver plans ranged from just under $295 for a 19-year-old non-smoker to more than $1,200 for a 64-year old tobacco user.[3]Premiums differed only by tobacco use, age and QHP.
- Copays were $4 or $8 for most medical services, up to a maximum of $60 per quarter. The state covered the additional copayments for medical services that would be incurred for silver-level plans sold on the marketplace. DHS made monthly estimated payments to the QHPs to cover these costs, which were reconciled at the end of the year based on actual copays incurred.
- The state's agreement with the QHPs limited the total cost per individual to align to the budget neutrality per client per month (PMPM) cap.

Enrollment

Individuals are eligible for AR Works if they are between ages 19 and 64, are below 138% FPL, and are not otherwise eligible to enroll in any other Medicaid program category. During the Waiver the state enrolled a total of 570,000 unique individuals including the Medically Frail. By the end of the demonstration, enrollment stood at 336,407.The following summarizes the demographics of the population enrolled at the end of the demonstration:

[3] The rate for a client who uses tobacco is 20% higher except for the 19 and 20 year old age.

- Income: A total of 41% (139,289) of clients were under 20%.Most clients (72% to 76%) stayed within the same income band from year to year.
- Gender: A total of 56% of enrollees were female and 44% were male. Enrollees skew younger, with the largest group being ages 19 to 24; the 45- to 64-year-old group had the fewest enrollees.
- Other: About 44%, were single individuals (150,140), 39% had dependent children, and 5% were formerly incarcerated.
- Enrollment duration of these enrollees[4]For those enrolled between 2018 to 2021, clients were enrolled most often from 0 to 6 months, 7 to 13 months and 42 or more months (each had more than 100,000 clients with the highest 7 to 13 months with just over 120,000 individuals).

Enrollment increased during 2020 and 2021 primarily due to the public health emergency caused by the pandemic. In January 2020, the U.S. declared a public health emergency due to COVID-19 and the federal Families First Coronavirus Response Act required continuous enrollment for individuals eligible for Medicaid on or after March 18, 2020.The state ensured that AR Works clients remained enrolled month to month as required under the PHE throughout the duration of the Waiver.

Appeals and Grievances

Clients were able to appeal eligibility decisions through DHS's hearing process. Assistance with AR Works eligibility and benefits was also provided through DHS's Department of County Operations statewide. Individuals denied eligibility also received written notice and information to file an appeal to review their case. Clients could appeal any dispute of QHP services and benefits through the QHPs' appeals process or through an external process overseen by the AID. In 2021, 24 AID processed 24 external reviews. Of those, nine were granted, 12 were denied and two were pending at the end of the last quarter reported.

Clients also received assistance with updating their contact information or moving between plans or getting answers to other questions through a client beneficiary line and targeted outreach through DHS's contractor AFMC.

Implementation Milestones and Significant Events

The state worked with partners including the carriers, AID contractors and stakeholders to address program needs and to implement, monitor and evaluate each of the AR Works program deliverables for the demonstration.

Work requirements

In 2017, the state began planning for the required work and work preparation activities, called Work and Community Engagement WCE, that had been approved through the AR Works Act and subsequent legislative action in 2017. [5] This requirement was approved by CMS through an amended Waiver in 2018. Implementation activities included substantial client and stakeholder outreach, establishing a portal to report work or work preparation activities, sending notices about the requirement to all affected clients, and setting up data reporting to track the results. Phasing in implementation for the impacted groups started in 2018 (July to December 2018) and continued until March 2019. The state halted the WCE due to a lawsuit filed in the U.S. District Court against the U.S. Department of Health &

[4] ARHOME presentation to the Health & Outcomes state Advisory Committee, March 14th. Data reported in January 2022 enrollees.
[5] AR Works 1115 Demonstration waiver Annual Progress Report 2017

Human Services (the state joined the case as defendant). On March 27, 2019, the D.C. Federal District Court vacated the U.S. Department of Health and Human Services waiver approving the Arkansas Works WCE requirement. The WCE reporting requirement for Arkansas Works clients was suspended as a result of that ruling, which the state appealed to the U.S. Court of Appeals. On February 14, 2020, the U.S. Court of Appeals for the D.C. Circuit affirmed the lower court's ruling. In March 2021, CMS officially withdrew its approval for the portion of the state's waiver regarding the community engagement requirement.

QHP Quality Monitoring and Improvement Efforts

As part of the transition to ARHOME from AR Works, the state implemented efforts 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 metrics in the Medicaid Adult Core Set to help monitor standardized indicators of quality of 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.

Eligibility System Planning and Implementation

During 2020 and 2021 the state implemented a new eligibility system, ARIES, which became fully operational statewide for Medicaid, including AR Works, during the last year of the demonstration. The system will allow better integration and streamlining of Medicaid eligibility with the application and enrollment processes for other public benefits including Supplemental Nutrition Assistance Program (SNAP) and the state's TANF program. The new system will allow clients to manage their personal data, gain application updates, report changes, re-enroll and support staff management and communication with clients about their eligibility and benefits.

Community Forums

DHS held an in-person post-award forum in March 2017 and two additional forums in May and June 2017 to provide an opportunity for stakeholders to learn about implementation plans and provide feedback. DHS convened another forum on the AR Works Waiver on November 16, 2021, to provide information on the demographics of the program participants, information on the carriers, and a summary of the evaluation findings.

Policy and Demonstration Transition

As 2021 was the final year of the AR Works demonstration, the state completed a new demonstration proposal (ARHOME), which included the state's transition plan for AR Works. 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 at the end of 2021, and the new demonstration began on January 1, 2022.

DHS worked on developing the ARHOME program and preparing for the transition for nearly two years. For existing eligible clients, there was no lapse in eligibility or coverage. Clients were able to continue to receive their QHP coverage with no changes. As part of this plan, DHS implemented an outreach and education strategy to educate the public on the rebranding of the Demonstration as ARHOME. DHS updated the website with a new ARHOME logo, an explanation of the program name change and assurances that eligible clients' benefits had not changed. DHS pushed the same messaging on social media, and official notices were updated to reflect the change. The transition plan coincided with the public comment period for the ARHOME Demonstration, which included information about the ARHOME Demonstration's start date of January 1, 2022.

DHS also prepared to implement program changes that remain under CMS review, including a new copay structure and implementation of the Life360 HOMEs. MMIS system changes were developed to allow for the move to the new copay structure, even though the premiums and copays in place in 2022 remain the same as the final year of Arkansas Works. DHS also met with dozens of stakeholder groups to discuss and collect input on proposed plans for the Life360 HOMEs. The agency also developed draft policies for potential promulgation if CMS approves the Life360 HOME program.

DHS also began meeting with members selected for the ARHOME Health and Economic Outcomes Accountability Oversight Advisory Panel, a joint legislative and executive branch panel responsible for helping DHS set health outcome targets for the QHPs and reviewing the QHPs' annual strategic plans for meeting those targets. The group met twice during 2021 to review baseline health outcome data, to discuss the QHPs' strategic plans and to set health outcome metric targets for 2022 performance.

Evaluation and Interim Evaluation Findings

General Dynamics Information Technology (GDIT), the evaluation contractor who was selected in 2019 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. The final Interim Evaluation Report for 2017-2019 was submitted in 2021. This section summarizes the results for, access to care, continuity of care, cost of care, quality of care and health outcomes for the clients in QHPs in the AR Works program. Results for the final demonstration years will be included in the Summative Evaluation Report in 2023.

<u>Access to Care</u>

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	0.0000	0.0000

2017 Proportion (Square Miles)	2018 Proportion (Square Miles)	2019 Proportion (Square Miles)
(0.00)	(0.00)	(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)
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% 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					

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
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

<u>Continuity of Care</u>

The interim evaluation measures continuity of care in terms of whether Arkansas Works clients had fewer gaps in health care coverage and maintain continuous access to their health plan and providers. The measures examined were the average length of gaps in coverage, the percent of clients with less than two gaps in coverage, continuous enrollment in a health plan, continuity of primary care provider

(PCP) care, and continuity of specialist care. Measures were obtained through eligibility and enrollment data and linked to claims data as needed.

Average Length of Gaps in Coverage was determined by the duration of gaps, in days, in all coverage for Arkansas Works clients against the number of gaps in all coverage. The Arkansas Works group had significantly shorter gaps in coverage in all measurement years than the comparison population, with the difference being 23 days in MY17, 6.5 days in MY18, and 8.7 days in MY19.

Measure	MY17	MY18	MY19
IPWREG	90.65	90.30	87.33

Percent of Clients with Less than Two Gaps in Coverage was determined by the percent of clients with less than two gaps in coverage.

Measure	MY17	MY18	MY19
IPWREG	0.9987	0.9973	0.9973

Continuous Enrollment in a Health Plan is defined as the average number of days in a row enrolled in a health plan.

To fairly compare Arkansas Works client enrollment length in QHPs to comparison clients in traditional Medicaid, the coverage segments in fee for service Medicaid—just prior to QHP enrollment, most of which were 1 to 3 months in length—were excluded from calculations of average enrollment length.

In all measurement years, the Arkansas Works group had significantly shorter continuous enrollment periods at the health plan level. The difference between the Arkansas Works and the comparison groups was 41 days in MY17, 58 days in MY18, and 46 days in MY19.

Measure	MY17	MY18	MY19
IPWREG	298.49	285.01	296.03

Continuity of PCP Care, or the consistent use of the same primary care provider over time, or the proportion of primary care visits with the same PCP, was determined by the proportion of total PCP visits with the same provider.

PCPs were defined for this measure as individuals with a provider specialty of general practice, family practice, internal medicine, OB-GYN, pediatrics, or geriatrics, or nurse practitioners.

Over 65% of primary care visits in the Arkansas Works group were with the same provider, compared to about 70% in the comparison group.

Measure	MY17	MY18	MY19
IPWS	0.6678	0.6668	0.6602

Arkansas Medicaid policy requires some clients in traditional Medicaid to have a primary care provider, through which primary care and referrals to specialists are made. QHPs allowed nurse practitioners and physician assistants to serve as PCPs, and visits to urgent care clinics were covered. This may have resulted in QHP clients receiving primary care services from more providers.

Continuity of Specialist Care was determined by calculating the largest proportion of a client's visits with the same specialist, within the measure-determined specialist type (aka Usual Provider of Care). Clients eligible for the denominator had a minimum of two visits with specialist(s) of the same type. On average, clients with more than 1 visit to a cardiologist generally saw the same cardiologist for over 90% of visits, although in MY17 the comparison group rate of 87% was significantly lower than the Arkansas Works group rate of 93% in the same year.

Measure		MY17	MY18	MY19
IPWREG	Cardiology	0.9260	0.9258	0.9157
IPWREG	Endocrinology	0.9797	0.9743	0.9747
IPWREG	Gastroenterologist	0.9310	0.9344	0.9382
IPWREG	Oncologist	0.9607	0.9451	0.9580
IPWREG	Pulmonologist	0.9544	0.9476	0.9419

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

Measure		MY17	MY18	MY19
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 clients, 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	Statewide Average	$281	$364	$378
SLCSP by Region	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[6]	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¤tTimeframe=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 inpatient utilization by AR Works clients for the years the Interim Evaluation examined.

[6] 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 clients 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 client survey,[7] 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 clients about their experiences with QHPs and QHP services as well as other questions.

Clients 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

Client 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

[7][7]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.

Client 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%

Conclusions

Providing coverage to the adult group through Medicaid remains a priority to the state due to its value and impact on the covered population and the healthcare delivery system. The coverage model available through AR Works demonstrated benefits in terms of access to care and continuity of care. Clients appear able to receive primary and specialty care when needed and have shorter gaps in coverage. However, Arkansas Works did not appear to be materially impacting the overall quality of care. DHS is addressing this shortcoming by implementing new health improvement initiatives through the ARHOME demonstration, and the state already has begun implementing quality monitoring of the QHPs through required health outcome targets and oversight by a joint legislative-executive branch Advisory Panel.

References

1.) **AR Works 1115 Demonstration Quarterly Progress Reports** 2017 – 2021.

2.) **AR Works 1115 Demonstration Annual Progress Reports**, 2017– 2021.

3.) **AR Works Waiver Extension Request and Approval**, June 2017 and December 2018.

4.) **HCIP Demonstration Summative Evaluation Report**, June 2018.

5.) **AR Works 1115 Demonstration Waiver Standard Terms and Conditions**, and other Waiver documentation located: https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81021