TSG Task Force Update

To: Arkansas Health Reform Task Force

Re: Follow up from previous Task Force Discussions and Meetings

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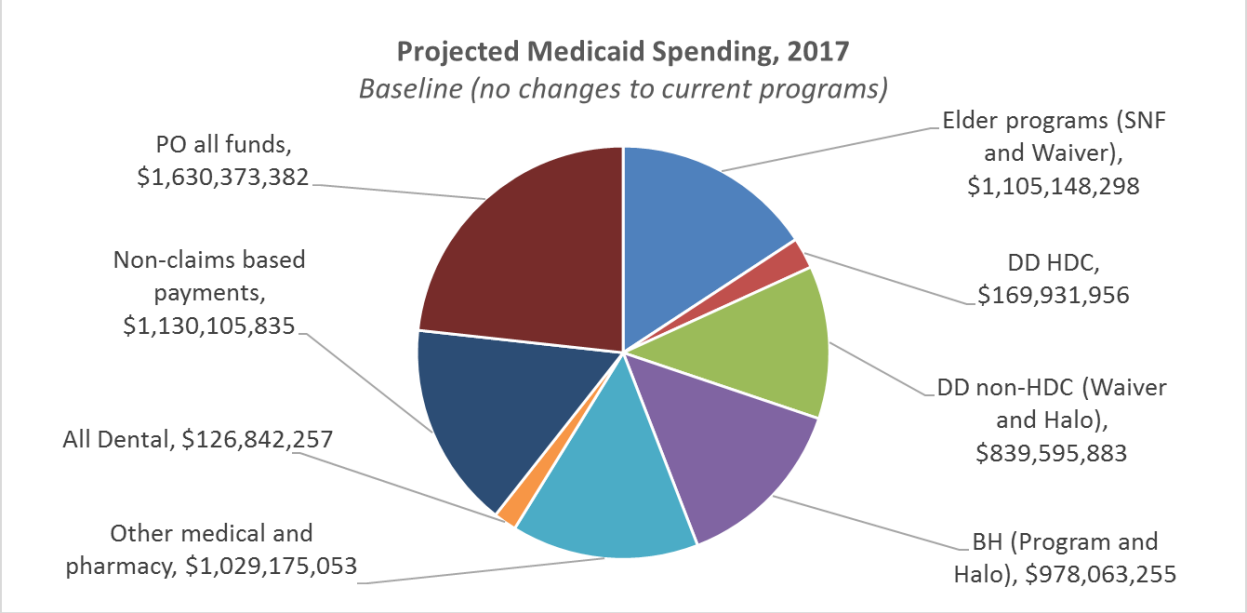
UPDATE

AR Medicaid Spending by Category

A question arose at the March 7th Task Force meeting about the distribution of Medicaid spending across the different program areas. The following pie-chart shows the projected spending by category for SFY2017.



Certain of the categories are constructed based on the major policy options under consideration, particularly the possibility of pursuing Medicaid managed care for behavioral health and DD. Therefore, in the pie chart below, the "DD non-HDC" and "BH" wedges include medical and pharmacy costs for these populations, whereas the medical and pharmacy costs for the elder and all other populations are included in the "Other medical and pharmacy" wedge.

EEF Backlog

TSG has been in contact with DHS to address a question by Representative Hammer regarding the most recent updated information on the EEF backlog.

Below are the pending Private Option application numbers from the Curam System. These numbers also include renewals from clients who are being moved from the DHS legacy system (ANSWER) to Curam. DHS is moving these individuals through the application process in Curam. DHS is not able to differentiate the differences for reporting purposes from its other pending applications at this time.

Month	**# Pending Applications**
November 2015	70,776
December 2015	55,495
January 2016	56,969
February 2016	55,996
March 2016 as of March 21st	48,091

A Closer Look at Private Option Beneficiaries

In the past, at the request of Senator Bledsoe and other members of the Task Force, TSG asked DHS for data to show a more complete picture of current Private Option beneficiaries. How many were in each category of Federal Poverty Level (FPL) and how many in each category were reportedly receiving other benefits and obtaining higher education, among other things. TSG received some data from DHS and was able to identify the following as of October of 2015.

Data

0 - 40% FPL (Note: 40% FPL is $392 dollars a month for household size of one and $808 dollars per month for household size of four)

There were 251,670 Private Option beneficiaries as of the final quarter in 2015. (Note: TSG noted in 273,346 unique Private Option recipients as of February 2016). Of the 251,670 beneficiaries, 123,759 (49%) were within the 0 to 40% of FPL category. Out of the 123,759, 1078 reported to be attending higher education, 1819 reported that they were receiving unemployment insurance benefits, 50,460 reported they were receiving SNAP benefits and 475 were receiving TANF benefits.

Of the 123,759 beneficiaries in the 0 to 40% FPL category, 91,667 (74%) reported they were living in a household size of one; 14,068 (11%) reported they were living in a household size of 2; 7,546 (6%) reported to live in a household size of 3; and, 10478 (8%) reported to live in households with four or more individuals. Note: 330 members reported living in households between 9 and 12 people.

50 - 100% FPL (Note: $981 dollars a month for household size of one and $2021dollars per month for household size of four)

Of the 251,670 Private Option Beneficiaries as of 2015, 61,169 or 24% had incomes within the 50 to 100% FPL category. Out of the 61,169, 798 reported to be attending higher education, 1316 reported that they were receiving unemployment insurance benefits, 22,174 reported they were receiving SNAP benefits and 229 were receiving TANF benefits.

Of the 61,169 Beneficiaries in the 50 to 100% FPL category, 17,798 (29%) reported they were living in a household size of one; 13,985 (23%) were living in a household size of 2; 11,484 (19%) reported to live in a household size of 3; and 17902 (29%) reported to live in households with four or more individuals.

100 - 138% FPL (Note: 138% FPL is $1353.55 dollars a month for household size of one and $2788.75 dollars per month for household size of four)

Of the 251,670 Private Option Beneficiaries as of 2015, 39,517 or 16% had incomes within the 100 to 138% FPL category. Out of the 39,517, 452 reported to be attending higher education, 920 reported that they were receiving unemployment insurance benefits, 7822 reported they were receiving SNAP benefits and 93 were receiving TANF benefits.

Of the 39,517 Beneficiaries in the 100 to 138% FPL category, 15,726 (40%) reported they were living in a household size of one; 10,282 (26%) were living in a household size of 2; 5935 (15%) reported to live in a household size of 3; and 7904 (20%) reported to live in households with four or more individuals.

Status of Individuals on Private Option Reporting Zero Income

About 40% of the individuals on the PO reported zero income. The following table summarizes some additional information that has been identified about these individuals.

PO enrollees reporting zero income	103,617
Also receiving SNAP	41,826
Also receiving UI benefits	1388
Also receiving Higher Ed Assistance	759
Also receiving TANF	397
Also receiving SNAP and TANF	280

Access to Employer Sponsored Insurance (ESI)

Task Force members had questions on whether access to affordable ESI was a disqualifying factor for the current Private Option Waiver. It is not. It is currently possible for an eligible

individual to enroll in the PO if they have access to ESI. This is currently not an eligibility factor.

The application for eligibility of Private Option has a question asking the individual whether they have access to ESI, and the question has recently been added to the online application. DHS has not started tracking responses and no action is taken against an individual or employer by DHS for any false information since the question is not a disqualifying factor of the Private Option.

In Arkansas Works, if an eligible individual has ESI and their employer elects to participate in Arkansas Works, the individual would be required to participate in the ESI premium assistance program and would be precluded from receiving coverage from Arkansas Works premium assistance component.

Premium Tax Impact When Private Option Beneficiary Moves to SHOP

A question was asked related to the impact of the Premium Tax when an individual Private Option beneficiary moves to the SHOP.

According to the Arkansas Insurance Department, currently, Act 1500 allows for SHOP to collect an assessment each year for its sustainability. Within that Act, the assessment then allows for a credit to be taken against all premium tax (not just taxes related to the sale of a particular policy). The 2016 SHOP assessment is 3%. The premium tax is 2.5%. Currently, Arkansas Insurance Department collects the premium tax on Private Option plans and puts that money in the Health Care Independent (HCIP) Trust Fund; additional premium tax funds go to certain line items such as police retirement or firemen's fund, but mainly it is given to the general revenue fund. If the Private Option beneficiary were to move to the SHOP, the premium tax collected on that plan would be offset more than 100%. Thus, this means that not only would the HCIP Trust Fund not receive the premium tax that it currently receives, but the general revenue fund would experience a decrease as well.

Consent Decrees

Certain members of the Task Force have asked TSG about the impact of prior judicial consent decrees in the past and whether they would have any impact on current reform efforts. TSG asked the Bureau of Legislative Research (BLR) to provide a legal analysis to assist the Task Force on the impact of the Arkansas Consent Decrees related to Health and Human Services prior judgments. The following are excerpts from legal research provided by BLR Legislative Staff Attorney, Jessica Beel:

Once the parties sign the consent decree and the court approves the consent decree, the consent decree becomes similar to a judgment or order for child custody or in a divorce which can only

be altered or modified by the court. If either party violates the consent decree, the other party may sue for contempt and/or breach of the decree. Decrees of this nature were often seen in the prison cases, social work cases, and school desegregation cases such as Lake View.

Modification or nullification of a consent decree generally requires either a new action/lawsuit or a Rule 60 Motion for modification or relief from the decree. Under Rule 60 of the Federal Rules of Civil Procedure, a decree or judgment may be modified or released for any of the following reasons:

1. Mistake, inadvertence, surprise, or excusable neglect;
2. Newly discovered evidence that, with reasonable diligence, could not have been discovered in time to move for a new trial under Rule 59(b);
3. Fraud (whether previously called intrinsic or extrinsic), misrepresentation, or Misconduct by an opposing party;
4. The judgment is void;
5. The judgment has been satisfied, released or discharged; it is based on an earlier judgment that has been reversed or vacated; or applying it prospectively is no longer equitable; or
6. Any other reason that justifies relief.

The 8th Circuit Court has held that consent decrees must "be modified if ... one or more of the obligations placed upon the parties has become impermissible under federal law." City of Duluth v. Fond du Lac Band of Lake Superior Chippewa, 785 F.3d 1207, 1211 (8th Cir. 2015) quoting *Rufo v. Inmates of the Suffolk Cnty. Jail*, 502 U.S. 367, 388, 112 S.Ct. 748, 116 L.Ed.2d 867 (1992).

The 9th Circuit Court has held that modification of consent decree or injunction may be warranted on "no longer equitable" grounds when changed factual conditions make compliance substantially more onerous, when decree or injunction proves to be unworkable because of unforeseen obstacles, or when enforcement of decree without modification would be detrimental to public interest. Modification of consent decree or injunction is necessary if consent decree or injunction becomes impermissible under federal law. Flores v. Arizona, 516 F.3d 1140, 229 Ed. Law Rep. 427, 38 A.L.R. Fed. 2d 609 (9th Cir. 2008).

In Armstrong v. Exceptional Child Center, Inc., 135 S.Ct. 1378 (2015), the United States Supreme Court held that the Supremacy Clause does not confer a private right of action and that Medicaid providers cannot sue for injunctive relief requiring compliance with 42 U.S.C. § 1396a(a)(30)(A). The majority opinion includes a fourth section stating that 42 U.S.C. § 1396a(a)(30)(A) lacks the rights-creating language needed to imply a private right of action to

enforce the provision. Note: only four (4) justices joined with this finding in Part IV of the opinion.

The 8th Circuit Court has not issued a ruling regarding issues similar to *Armstrong* or citing the *Armstrong*. It is unclear whether the court would find that the *Armstrong* case is applicable in this situation because the suit was filed as an action under 42 U.S.C. § 1983.

The State of Kentucky Medicaid Managed Care Program History

Senator Dismang requested that TSG conduct research on the background of the State of Kentucky's Medicaid program experience with Managed Care. It had been reported that Kentucky previously has problems with the implementation of Managed Care and has recently enhanced the accountability of the program. TSG has completed its research and provided its report to BLR, for distribution to the entire Task Force.

Consumer Experience with Managed Care

Senator Elliott asked at a prior Task Force meeting for TSG to identify research articles with consumer experiences with Managed Care. We provide the following in response to the question:

The most widely used measure of consumer experience with managed care is the Consumer Assessment of Healthcare Providers and Systems (CAHPS), a regularly published systematic survey published through the Agency for Healthcare Research and Quality (AHRC). This survey has been in place over 20 years, with measures included in the Core set of Quality Measures for CHIPRA and CMS Adult Medicaid. Results are reported by health plans to NCQA as part of their accreditation and are required by 32 of 36 states with capitated Medicaid managed care programs. Other versions of the CAHPS survey accommodate other delivery systems (FFS, hospitals), and entities can add questions and calculate results differently, so that CAHPS results reported to different entities may not be strictly comparable.

A 2012 review of literature by the Robert Wood Johnson Foundation noted the challenges in finding nationwide data on the effects of Medicaid managed care. Because Medicaid is a diverse collection of state administered programs, complicated by variations in enrollment processes, carve-outs and rate setting methodologies, it is difficult to find comparable data sets across states. Existing reports are often prepared on behalf of health plan organizations or only report on data from a particular state.

The Association for Community Affiliated Plans, a trade organization representing not-for-profit Safety Net Plans, reported CAHPS data to show that overall, enrollees in Medicaid managed care health plans nationwide were more likely to give their plan the highest ratings than those enrolled in commercial HMO or PPO plans. See

(http://www.communityplans.net/Portals/0/Fact%20Sheets/ACAP%20-%20CAHPS%20Comparison%20of%20Managed%20Care%20Plans.pdf)

- 52.5% of Medicaid managed care members gave their plans rating of 9 or 10, vs. 38.3% for Commercial plans (2009 Medicaid and CHIP Payment and Access Commission survey).
- 54.7% of Medicaid plan member gave ratings of 9 or 10, vs. 40.3% for commercial HMOs and 35% for commercial PPOs (2010 NCQA survey).
- 93% of parents 'very' or 'somewhat' satisfied with quality of their children's care (2011 CMS survey of parents' satisfaction with Children's Medicaid and CHIP Coverage).
- Approximately 71% Medicaid managed care enrollees nationwide indicate satisfaction with their plan, vs. 62% of commercial plan members (2011 New York Quality Assurance Reporting Requirements data).

(**Note**: Most of the data reporting here is for managed care plans participating in the Medicaid program covering non-aged, blind and disabled members).

In 2014 the New York State Department of Health used the CAHPS Children with Chronic Conditions Survey to ask parents/caretakers of child members of Medicaid and CHIP managed care plans about their experiences and overall satisfaction with access to care, health care providers and health plans. See (https://www.health.ny.gov/health_care/managed_care/medicaid_satisfaction_report_2015/docs/c_statewide_2015.pdf).

- 83.08% of respondents rated their child's health plan with a rating of 8, 9, or 10
- 85.21% of respondents rated their child's health care with a rating of 8, 9, or 10

CAHPS surveys of enrollees in Florida's Managed Medical Assistance (MMA) program also showed high levels of satisfaction with the overall plan, quality of care received and doctors, as well as on measures such as ease of getting needed care, getting care quickly, how well doctors communicate, customer service and shared decision making (https://www.ahca.myflorida.com/medicaid/statewide_mc/pdf/SMMC_Quality_and Performance_Snapshot.pdf).

- 74% of adults/ 72% of parents rated overall plan satisfaction as 8 or higher on a 10 point scale
- 76% of adults/85% of parents rated quality of care received as 8 or higher on a 10 point scale

A 2012 study prepared by the University of South Carolina analyzed CAHPS results on Quality, Access to Care and Consumer Satisfaction for Medicaid managed care and fee-for-service health

plans in South Carolina. The study found that overall Medicaid managed care health plans received better ratings for quality than fee-for-service plans. (https://www.scdhhs.gov/sites/default/files/CY2011SCMedicaidHealthCarePerformanceReportW.pdf).

- Most established (managed care) plans achieved at or above 75th percentile rating for overall health care, while fee-for-service was between 50th - 74thpercentile.
- Most plans for child health care received an overall rating of 90th percentile.
- Most plans achieved the 90th percentile on measures related to personal doctors, specialists and communication from doctors.

In 2014-2015 CMS conducted a nationwide CAHPS patient experience survey of 1.2 million Adult Medicaid Enrollees (NAM CAHPS) to attain national and state-by-state measures of timely access to care, barriers to care, satisfaction with providers, ratings of customer service, and accessibility and usability of program information. This first-of-its kind survey will provide baseline information on the experiences of low-income adults during the early stages of implementation of the Affordable Care Act and will be used to inform CMS and state efforts to improve health care delivery for Medicaid enrollees. Subgroups included enrollees in managed care and fee-for-service plans. Results are to be published in the spring 2016. See https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Nationwide-Adult-Medicaid-CAHPS.html, http://www.norc.org/Research/Projects/Pages/nationwide-adult-medicaid-cahps.aspx

Summary of: Medicaid Managed Care: Costs, Access and Quality of Care
Robert Wood Johnson Foundation, 2012

A 2012 review of literature from 1998-2011 by the Robert Wood Johnson Foundation on the success of Medicaid managed care addressed three questions: whether Medicaid managed care resulted in savings for states, provided better access to health care, and provided better quality of care. The study found that because Medicaid is a diverse collection of state administered programs, complicated by variations in marketing and enrollment processes, carve-outs and rate setting methodologies, it is difficult to find comparable data sets across states on cost, access and quality. See (http://www.rwjf.org/content/dam/farm/reports/reports/2012/rwjf401106)

More specifically, the study found that:

- Cost: There were no clear cost savings for states associated with managed care. Reports concluding that managed care resulting in savings, including the oft-cited Lewin Group report, cited studies that were done on behalf of health plan organizations and/or were not peer reviewed. Successful savings in particular states appeared to be primarily due to

reductions from relatively high fee-for-service reimbursement rates, rather than managed care techniques.

- Access: Although some national studies and several state-based studies found improved access to care and reduced ER use and hospitalization, other studies found access reduced or unchanged under managed care. In general, Medicaid managed care sometimes improves access to the usual source for primary care over ER and hospital ambulatory utilization.
- Quality: There were no recent peer-reviewed studies on the clinical effectiveness of disease and care management programs in Medicaid managed care health plans. One 2011 study using HEDIS data found that provider sponsored managed care plans scored higher than for-profit plans on a range of quality measure, while for-profit plans had lower medical costs. The literature did not show that pregnant beneficiaries have healthier babies than their FFS counterparts.

The study discusses various reasons why results vary or why changes to Medicaid managed care have a mixed impact on cost, access and quality.

The study concludes that while most policy-makers believe that most improvements in access, quality, care coordination and savings can be achieved by providing care to the high-cost chronically ill and dual eligible populations, the available literature suggests that managed care is not a magical panacea: policy-makers should be conservative in their estimates of the benefits of Medicaid managed care and take into account the trade-offs between costs, access and quality.

Very few studies compare and contrast outcomes in different states' approaches to Medicaid managed care or variations in management performance to determine why some initiatives work better than others. In addition, academics and other researchers tend to ignore HEDIS and CHAP scores cited by state officials to tout the benefits of Medicaid managed care.