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State of Implementation Webinar Series

State Approaches to Medicaid Expansion Decisions

January 27, 2014, 1:00-2:30 p.m. Eastern

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Support for this project was provided by a grant from the Robert Wood Johnson Foundation
**Agenda**

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
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| 1:00-1:05 p.m. | **Introduction**  
Alan Weil, Executive Director, National Academy for State Health Policy (NASHP) |
| 1:05– 1:20 p.m. | **Overview of State Medicaid Expansion Decisions**  
- Kaitlin Sheedy, Policy Specialist, NASHP |
| 1:20–2:00 p.m. | **Implementation Insights from the States**  
**Moderator:** Alan Weil, NASHP  
**Panelists:**  
- Suzanne Bierman, Arkansas  
- Jason Helgerson, New York  
- Beth Lazare, Arizona |
| 2:00–2:25 p.m. | **Question and Answer**  
*Use the chat feature to submit your questions* |
| 2:25-2:30 p.m. | **Wrap-up** |
Overview of State Medicaid Expansion Decisions

Kaitlin Sheedy
Policy Specialist, State Refor(u)m
National Academy for State Health Policy
http://statereforum.org/user/ksheedy
Medicaid Expansion and the ACA

- Supreme Court ruling made ACA’s Medicaid expansion optional for states
- State flexibility to expand to 138% FPL
- Enhanced matching funds for expansion population
- No deadline for states to expand
- States may drop the expansion at any time
- Alternative Benefit Plan for expansion population
State Medicaid Expansion Decisions

Source: Tracking Marketplace and Medicaid/CHIP Enrollment by State: https://www.statereforum.org/tracking-health-coverage-enrollment-by-state

Key:
- 15 State-based marketplace states expanding Medicaid for 2014
- 1 State-based marketplace state not expanding Medicaid for 2014
- 11 Federal/partnership marketplace states expanding Medicaid for 2014
- 24 Federal/partnership marketplace states not expanding Medicaid for 2014
<table>
<thead>
<tr>
<th>Title</th>
<th>States</th>
<th>Date</th>
<th>Contributor</th>
<th>Topics</th>
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<tbody>
<tr>
<td>WY Legislative Committee Passes Medicaid Premium Assistance Bill</td>
<td>Wyoming</td>
<td>Jan. 15, 2014</td>
<td>Leo Quigley</td>
<td>Premium Assistance, Medicaid, Programs</td>
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<tr>
<td>CMS Approves Healthy Michigan Waiver</td>
<td>Michigan</td>
<td>Jan. 8, 2014</td>
<td>Kaitlin Sheedy</td>
<td>Medicaid, Programs</td>
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<td>Medicaid Expansion Through Premium Assistance: Arkansas, Iowa,</td>
<td>Arkansas, Iowa,</td>
<td>Jan. 16, 2014</td>
<td>Anita Cardwell</td>
<td>Premium Assistance, Medicaid, Programs</td>
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<td>Pennsylvania's Proposals Compared</td>
<td>Pennsylvania</td>
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<td>Healthy Michigan Waiver Submitted</td>
<td>Michigan</td>
<td>Nov. 20, 2013</td>
<td>Leo Quigley</td>
<td>Basic Health Program, Medicaid</td>
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<td>Iowa Health and Wellness CMS Approval Letter</td>
<td>Iowa</td>
<td>Dec. 12, 2013</td>
<td>State Refor(u)m</td>
<td>Premium Assistance, Medicaid, Programs</td>
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<td>Draft Healthy Pennsylvania Plan</td>
<td>Pennsylvania</td>
<td>Dec. 11, 2013</td>
<td>Kaitlin Sheedy</td>
<td>Premium Assistance, Medicaid, Programs</td>
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<td>AB 1115 Waiver Approved</td>
<td>Arkansas</td>
<td>Oct. 3, 2013</td>
<td>Kaitlin Sheedy</td>
<td>Premium Assistance, Exchange, Medicaid</td>
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<td>Iowa Health and Wellness CMS Approval Letter (Draft)</td>
<td>Iowa</td>
<td>Aug. 28, 2013</td>
<td>Kaitlin Sheedy</td>
<td>Premium Assistance, Exchange, Medicaid, Programs</td>
</tr>
</tbody>
</table>

Resources from:
- Arkansas
- Iowa
- Michigan
- Pennsylvania
- Wyoming

State Medicaid Expansion Waivers:
https://www.statereforum.org/state-medicaid-expansion-waivers
Factors States are Considering in Expansion Decisions

- Who will enroll in Medicaid with or without the expansion?
- What benefits will states offer to the newly eligible?
- What is the affect on health care institutions, state agencies and the broader economy?

Tools and Resources:
- Tools and Policy Considerations for State Medicaid Expansion Analyses (NASHP)
Who Will Enroll?

Demographic data can illustrate how individuals might use health care system and the associated costs.

Newly eligible are a diverse group:

- **California**: individuals are mostly healthy even though they have limited access to care.
- **Colorado**: younger, less educated, in worse health and twice as likely to be uninsured compared to general state population.

Tools available to help undecided states estimate provider capacity, take-up and cost of Medicaid expansion.
Alternative Benefit Plan

- Alternative Benefit Plan (ABP):
  - Benchmarked to particular plan in the state
  - Ten Essential Health Benefits (EHBs)
  - Mental health parity
  - Non-emergency transportation, prescription drugs and family planning benefits
  - Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) for children and youth under age 21
States Consider Benefit Design in Medicaid Expansion Analyses

October 18, 2013 by Kaitlin Sheedy

States still considering whether or not to expand Medicaid are weighing fiscal considerations in their decisions. Fiscal aspects include enrollment projections, and the effect of Medicaid expansion on a state’s broader economy. Another key fiscal consideration is the effect of benefit design. States that choose to expand Medicaid have the flexibility to determine what benefits they will offer to the newly eligible population, and this decision has a direct impact on the overall cost of expanding the state’s Medicaid program.

The set of benefits offered to the new adult group (all non-elderly, non-pregnant adults with incomes at or below 138 percent FPL) is known as an Alternative Benefit Plan (ABP). These benefits can differ from those offered in traditional Medicaid, but they must be benchmarked to particular plans in the state and must cover all ten required Essential Health Benefits (EHBs) which are now required in non-grandfathered private insurance plans sold both on and off the exchange. ABPs must also comply with mental health parity and include non-emergency transportation, prescription drugs, and family planning benefits. In addition, for children and youth under age 21, states must ensure Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services are included. States can choose a different ABP for different groups of newly eligible individuals, or use the same plan for multiple groups. States are also able to use their traditional Medicaid benefits package as their ABP, as long as it provides coverage of these required services. Population demographics and cost are among some of the key factors states are examining as they determine what set of benefits is appropriate for newly eligible individuals.

Demographic data, including health characteristics, can help project how newly eligible individuals might utilize the health care system, what benefits they might need, and the expected costs. For example:

- A study of California’s newly eligible Medicaid population finds the group is mostly healthy, even though they now have limited access to care.
- In contrast, an analysis of the newly eligible individuals in Idaho found that this population is likely to have significant and chronic health conditions as well as prevalent mental health issues.
- An analysis from Colorado compared the newly eligible individuals to the general state population and found that the newly eligible individuals are younger, less educated, in...
Other Fiscal Considerations

- Potential for increased administrative costs for Medicaid agency
- Savings for state programs and agencies
- **Maryland**: $3.1 billion reduction in hospital costs
- **Ohio**: increased sales tax revenues and job growth

**Tools and Resources:**

- Medicaid Expansion: Framing and Planning a Financial Impact Analysis (State Health Reform Assistance Network)
Tracking Marketplace and Medicaid/CHIP Enrollment by State:
https://www.statereforum.org/tracking-health-coverage-enrollment-by-state
It's a SNAP to Get Children and Families Enrolled in Medicaid

December 12, 2013 by Keerti Kanchinadam

States have been hard at work building and deploying new enrollment systems and processes to meet the Affordable Care Act’s (ACA) requirements for streamlined access to coverage. To help states as they adopt major changes in their eligibility and enrollment processes, CMS issued a letter to state Medicaid directors outlining options for efficiently targeting and enrolling low-income individuals.

One of these optional strategies is using income data from the Supplemental Nutrition Assistance Program (SNAP) to identify Medicaid-eligible individuals, many of whom are newly eligible for coverage in 2014. So far, targeted enrollment letters have been sent to SNAP recipients in five states opting to implement this strategy—Arkansas, Illinois, New Jersey, Oregon, and West Virginia. Most of these states are using this option to focus on enrolling eligible adults, but Arkansas and West Virginia have leveraged it to also target eligible but unenrolled children.

In Arkansas, as in most states, the eligibility level for SNAP is 130 percent of the federal poverty level (FPL). This eligibility level falls just below that of Arkansas’ Private Option Medicaid program for newly eligible adults with incomes under 138 percent FPL, and also below the state’s ARKids First Medicaid program eligibility of 216 percent FPL for low-income children. The alignment of eligibility makes SNAP an opportune source of information for states looking to enroll families living near or below the poverty line in health coverage.

As part of this targeted enrollment strategy, Arkansas mailed letters to 132,662 SNAP households, representing 145,370 adults and 9,050 children. These letters clearly identified all Medicaid-eligible individuals in the household based on information already provided to the Department of Human Services (DHS), which administers both SNAP and Medicaid. To enroll in coverage, letter recipients simply opted in on behalf of all eligible household members by signing and returning the letter to DHS.

Upon receiving the signed letters, the state automatically enrolled children in ARKids First and mailed an ID card for each child. For adults, the state mailed a second letter...
Tracking Medicaid Expansion Decisions: A Closer Look at Legislative Activity

States to watch in 2014:
- Kansas
- Maine
- Pennsylvania
- Utah
- Virginia
- Wyoming

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<tbody>
<tr>
<td>Yes: Expansion signed into law or strong likelihood of expansion</td>
<td>Statement regarding state's expansion decision from a Governor</td>
<td>State bills related to Medicaid expansion in the legislature</td>
<td>Requires some type of cost sharing for Medicaid expansion population</td>
<td>Requires expansion population to be enrolled in plans offered in the commercial market through the exchange</td>
<td>Special state financing mechanism or fund associated with Medicaid expansion</td>
<td>Requires that the state continue participation in the expansion if FMAP is reduced below a certain amount</td>
<td>Conducted directly by a government agency or contracted out by the state to another institution</td>
<td>Conducted by organizations and institutions independent of the state</td>
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<tr>
<td>Maybe: Legislature still in session and/or status of expansion uncertain</td>
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<tr>
<td>No: Not expanding or legislative session closed without passing expansion</td>
<td></td>
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*Chart updated January 10, 2014

At State Reformer, we are continuing to track state Medicaid expansion activities. This revised chart includes additional details on key elements of Medicaid expansion bills that have been introduced in state legislatures, such as proposals to provide coverage to the expansion population through qualified health plans on the exchange, special requirements related to cost sharing or care delivery, or options allowing a state to discontinue participation in the expansion. You'll also find direct links to statements from the governor or executive branch and fiscal and demographic analyses from the state or other institutions. This chart is a record of legislation introduced, but does not track the exact status of bills moving around in state legislatures, though we will include when bills pass chambers and/or are signed by a Governor.

Like all State Reformer research, this chart is a collaborative effort with you, the user. State Reformer captures the health reform comments, documents, and links submitted by health policy thinkers and doers all over the country. And our team periodically supplements, analyzes, and compiles this key content.

https://www.statereforum.org/tracking-Medicaid-expansion-legislative-activity
State Refor(u)m Medicaid Expansion Resources

- Discussion page on Medicaid:
  - [http://www.statereforum.org/discussions/Medicaid](http://www.statereforum.org/discussions/Medicaid)

- Chart on Medicaid expansion legislative decisions:

- Special collection of Medicaid expansion resources:
  - [https://www.statereforum.org/medicaid-expansion](https://www.statereforum.org/medicaid-expansion)

- Special collection of resources on alternatives to Medicaid expansion:
  - [https://www.statereforum.org/state-medicaid-expansion-waivers](https://www.statereforum.org/state-medicaid-expansion-waivers)

- Marketplace and Medicaid Enrollment map:

- Weekly Insight Blog Posts:
Describe the Medicaid expansion model in your state.

Tell us what your state is doing at statereforum.org.
Arizona’s Medicaid Income Eligibility

Proposition 204 sets minimum eligibility at 100% of FPL

1/ Excluding ALTCS (LTSS population)
2/ Under the Affordable Care Act (ACA), “Parents” with incomes between 100 and 138% qualify under the new “Adults” category, along with Childless Adults. Only those who are under age 60 and not eligible for Medicare qualify for the expansion.
3/ Individuals who have Medicare coverage do not qualify for expanded coverage under the ACA.
4/ Individuals with disabilities under age 65 may qualify for ACA expanded coverage in the new “Adults” category for the 2 years before they become eligible for Medicare.
5/ Previously covered under a state-only program up to 40% of FPL.
Governor Brewer’s Medicaid Plan

- In her 2013 State of the State, Governor Brewer called for the legislature to restore Proposition 204 coverage and provide coverage up to 133%.
- Coverage for about 300,000 statewide (only 57,000 of which is optional expansion) through existing Medicaid program.
- Provides ~ $1.7 billion in federal funds.
- As an early expansion state, Arizona has to contribute funding for prior expanded coverage (only 57K of 1.2M total enrollees get 100% FF).
- Hospital Assessment used to cover state costs (litigation).
Circuit Breakers

- Expansion is automatically repealed:
  - If expansion FMAP or transitional (early expander) FMAP decreases below 80%
  - If ACA is repealed
  - If CMS limits the amount of the hospital assessment and it is insufficient to cover costs
Medicaid Expansion

- New York has historically had one of the most expansive health care safety nets in the nation
- Prior to ACA, childless adults with income under 100% FPL had entitlement access to Medicaid and parents were eligible up to 150% FPL
- As a result, the ACA’s impact on Medicaid eligible was modest:
  - Expansion group = Childless adults with incomes between 100 -138% FPL; and
  - The state is also considering the Basic Health Program
- Total Newly Eligible = 77,000
Arkansas Health Care Independence Program

The Health Care Independence Act of 2013 calls on the Arkansas Department of Human Services to reform the Medicaid program to:

- Maximize the available service options;
- Promote accountability, personal responsibility and transparency;
- Encourage and reward healthy outcomes and responsible choices; and
- Promote efficiencies that will deliver value to the taxpayers
The Private Option: The Fundamentals

- Through the Act, the State established the Arkansas Health Care Independence Program, also referred to as the Private Option.
- The Private Option is an integrated and market-based approach to covering low-income Arkansans through private, qualified health plan (QHP) coverage in the Marketplace.
- The state is using premium assistance to purchase private QHP coverage using Title XIX funding.
The Private Option Offers Significant Benefits

- Individuals may remain with the same plan and providers as their income shifts
  - More than 35 percent of adults with incomes below 200% FPL will experience a change in eligibility within six months
- The size of the Marketplace will double, with the addition of 225,000 + Private Option enrollees
- Enrollees will be fully integrated into the Marketplace
- The enrollment of Private Option enrollees into QHPs will facilitate payment and delivery system reform
Private Option Today

- As of 1/18/14:
  - 129,186 – Total number of private option applicants from state and federal levels
  - Of those, 92,446 have been determined eligible for the private option so far
  - Of those determined eligible for the private option, 76,899 have completed the enrollment process (as of 1/20/14)
  - An additional 8,410 have been determined to be better served by traditional Medicaid for a total of 85,309 people who will now have coverage
  - This number includes 119,891 private option applicants through the State and 9,295 private option applicants received from FFM who have been determined eligible and their data has been processed by the state
How is your state coordinating with the Federally Facilitated or State Based Marketplace?

Tell us what your state is doing at statereforum.org
Implementing the Health Insurance Exchange

- New York State of Health (NYSOH) represents the Empire State’s unique approach to ACA implementation.

- NYSOH Exchange system has been built to ensure that New York’s face “no wrong door” to health care access.

- “No wrong door” is achieved by allowing people regardless of income to apply through a single web portal or through a single call center for both Medicaid as well as Qualified Health Plans through the exchange.
Implementing the Health Insurance Exchange (continued)

- NYSOH is also the system brokers and navigators use to assist people access affordable health insurance.

- NYSOH is managed within the New York State Department of Health – a single state agency which leverages both in-house expertise as well as existing systems/vendors which have contributed directly to our early success.

- So far, implementation has been successful- over 320K people have enrolled in affordable health insurance so far. Our first year goal was approximately 300K.
# Medicaid Restoration

## Enrollment Numbers – 1/1/14

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<tr>
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<th>12-1-13</th>
<th>1-1-14</th>
<th>Change</th>
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<tr>
<td>Prop 204 Restoration</td>
<td>67,770</td>
<td>96,834</td>
<td>29,064</td>
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<td>Adult Expansion</td>
<td>-</td>
<td>1,369</td>
<td>1,369</td>
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<td>KidsCare</td>
<td>46,761</td>
<td>42,684</td>
<td>(4,077)</td>
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<tr>
<td>Family Planning</td>
<td>5,105</td>
<td>-</td>
<td>(5,105)</td>
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<tr>
<td>AHCCCS for Families &amp; Children (1931)</td>
<td>672,135</td>
<td>655,368</td>
<td>(16,767)</td>
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<tr>
<td>All Other</td>
<td>505,379</td>
<td>501,954</td>
<td>(3,425)</td>
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<td><strong>Total Enrollment</strong></td>
<td><strong>1,297,150</strong></td>
<td><strong>1,298,209</strong></td>
<td><strong>1,059</strong></td>
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</tbody>
</table>

- More approvals and denials going out regularly
- Roughly 2/3 of CHIP kids converting to Medicaid (not in above numbers)
Coordination with the FFM

- Federal transfer redesign challenges
- Sending Account Transfers to FFM – about 20,000 (as of early January)
- FFM to State
  - Testing as of 1-10-14
    - Intake only at this point
    - Processing - TBD
Ongoing Challenges

- 51K on Flat File
- Status of applicants on file
  - Not all actually assessed as eligible
- Data challenges
- CMS messaging to applicants
Private Option Integrates Coverage

The Arkansas Health Connector connects Arkansans to the Health Insurance Marketplace where individuals, families and small employers can shop for, select and enroll in high quality, affordable private health plans that meet their specific needs at competitive prices.

State will use premium assistance to purchase QHPs for individuals eligible for coverage under Title XIX of Social Security Act (Medicaid).
What did your state consider when developing its Medicaid Alternative Benefit Plan?

Tell us what your state is doing at statereforum.org.
Alternative Benefit Plan

- Benefit package for adults will align to existing Medicaid State Plan benefit package
  - Well exams
  - HPV vaccine for adults ages 21-26
  - Habilitation
  - 25-day hospital limit
AR Alternative Benefit Plan

- The Private Option provides ABP coverage, not standard Medicaid coverage.

- Arkansas is aligning its ABP with the Base Benchmark Plan, which includes:
  - QHP benefit package, including 10 Essential Health Benefits (EHBs).
  - Additional Medicaid-specific benefits through fee-for-service Medicaid, not QHPs:
    - Non-emergency transportation
    - Dental and vision services for 19 & 20 year olds

- Private Option enrollees will access all benefits through one insurance card.

- Private Option enrollees will use QHP coverage appeals process.
Private Option Eligible Individuals in 2014

- Childless adults ages 19-64 with incomes at or below 138% FPL
- Parents ages 19-64 with incomes between 17% and 138% FPL
- Who are not on Medicare
- Who are not disabled
- Who have not been determined to be more effectively covered under the standard Medicaid program, such as an individual who is medically frail or other individuals for whom coverage through the Health Insurance Marketplace is determined to be impractical, overly complex or would undermine continuity or effectiveness of care

FEDERAL MEDICALLY FRAIL DEFINITION IS THE STARTING POINT

- A disabling mental disorder
- Serious and complex medical conditions
- Physical, intellectual or developmental disability that significantly impairs their ability to perform one or more activities of daily living
- A disability determination
Arkansas worked with disability research experts and the Agency for Healthcare Research and Quality to develop a Healthcare Needs Questionnaire

- **Purpose**: identify individuals who are medically frail or other individuals for whom coverage through the Health Insurance Marketplace is determined to be impractical, overly complex or would undermine continuity or effectiveness of care

- **Automated, prospective on-line screening tool** that identifies both (a) applicants who self-report conditions which automatically qualify them as exempt, e.g. ADL needs; and (b) applicants whose responses to the health care service use questions lead to a prediction (through an automated algorithm) that they will have exceptional needs in the coming year

- **Exempt individuals**, including the medically frail, do not receive benefits from the Private Option, but rather receive services from fee-for-service Medicaid

- **Notices and choice counseling** will assist exempt populations in selecting between standard Medicaid and the Alternative Benefit Plan in fee-for-service
What are some implications and opportunities for delivery system reform in your state?

Tell us what your state is doing at statereforum.org
Many strategies currently being pursued nationally have been implemented in Arizona

- Managed care
  - Acute
  - Long Term Care
- Home- and community-based placement
- Dual member alignment
Strategies

- Stakeholder meetings/Culture of learning
  - Other States
  - McKinsey
  - Health Plans
  - ACOs
- Baseline measure of value spend by MCOs
- Participation in Catalyst for Payment Reform
- Expand transparency
Contract Year 14

- Acute:
  - 5% shared savings requirements
  - 1% value cap withhold value with distribution based on limited set of existing performance measures

- ALTCS:
  - Pilots

- APR-DRG Transitions

- Integration Efforts
Contract Year 15

- Expand on CY 14 strategies regarding shared savings, value-based purchasing
- Transparency efforts
- E-Prescribe initiatives
  - Enforcing prescription origination information on all pharmacy encounters (hard-edit 1/1/14)
Integration for Members with Serious Mental Illness

Single MCO

- Medicaid Behavioral Health
- Medicaid Physical Health
- Medicare D-SNP
- Housing & Employment
Care Coordination

- American Indian population
  - Continuing to refine care coordination models and data sharing with select facilities
  - Expanding to include behavioral health resource
- Super Utilizer Efforts
  - Behavioral Health/Health plan coordination
- Correctional Opportunities
Medicaid Redesign Team (MRT) Recap

THE MRT WORKED IN TWO PHASES

- Phase 1: Provided a blueprint for lowering Medicaid spending in state fiscal year 2011-12 by $2.2 billion.
- Phase 2: Developed a comprehensive multi-year action plan to fundamentally reform the Medicaid program.

- This is the first effort of its kind in New York State
- By soliciting public input and bringing affected stakeholders together, this process has resulted in a collaboration which reduces costs while focusing on improving quality and reforming New York’s Medicaid system
Key Elements of the Plan

- Most sweeping Medicaid reform plan in state history
- Pulls together the work of the MRT into a single action plan
- Plan is closely tied to successful implementation of the federal Affordable Care Act (ACA)
- The plan also embraces the CMS “triple aim” of: Improving care, improving health, and reducing costs
The MRT is Bending the Cost Curve

- Lowered total Medicaid spending by $4 billion in Year 1
- Lived within the Global Spending Cap for two full years
- Finished Year Two $200 million under the Global Spending Cap
- Thanks to the MRT the state was able to absorb a $1.1 billion federal revenue loss due to a change in Medicaid financing for DD services
- Savings has been especially significant in New York City
NY Total Medicaid Spending Statewide for All Categories of Service Under the Global Spending Cap (2003-2012)

<table>
<thead>
<tr>
<th>Year</th>
<th># of Recipients</th>
<th>Cost per Recipient</th>
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<tbody>
<tr>
<td>2003</td>
<td>4,267,570</td>
<td>$7,633</td>
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<tr>
<td>2004</td>
<td>4,594,667</td>
<td>$7,656</td>
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<tr>
<td>2005</td>
<td>4,733,616</td>
<td>$7,785</td>
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<tr>
<td>2006</td>
<td>4,730,166</td>
<td>$7,709</td>
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<td>2007</td>
<td>4,622,780</td>
<td>$8,157</td>
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<td>2008</td>
<td>4,657,232</td>
<td>$8,463</td>
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<tr>
<td>2009</td>
<td>4,911,387</td>
<td>$8,491</td>
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<td>2010</td>
<td>5,212,394</td>
<td>$8,378</td>
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<tr>
<td>2011</td>
<td>5,397,354</td>
<td>$8,260</td>
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<tr>
<td>2012</td>
<td>5,593,741</td>
<td>$7,954</td>
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</tbody>
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*Projected Spending Absent MRT Initiatives was derived by using the average annual growth rate between 2003 and 2010 of 4.28%.
Health Homes Are Reducing Inpatient Utilization & ER Use

- Health Homes are in their early days.
- Patients with little or no historic connection to traditional health care are benefiting the most.
- Preliminary results are very promising. We are seeing reductions in both ER visits and inpatient stays.
Inpatient Service Cost for a Subset of Health Home Enrolled Members

- Includes individuals continuously enrolled in Medicaid with no case management services in calendar 2011 who enrolled in Health Home Services in the first nine months of 2012. N = 3,653 individuals.
Demonstration will accelerate and leverage the Arkansas Health Care Payment Improvement Initiative (AHCPII) by increasing the number of carriers participating in the effort, and the number of privately insured Arkansans who benefit from these reforms.

All QHP carriers will be required to participate in AHCPII by assigning enrollees a primary care physician, supporting patient-centered medical homes, and accessing clinical performance data for providers beginning in 2015.

AHCPII is intended to shift the delivery system in Arkansas from one that primarily rewards volume to one that rewards quality and affordability.
How is your state addressing provider capacity issues?

Tell us what your state is doing at statereforum.org
Provider Capacity

- A broad collaboration of stakeholders, including policymakers, state agencies, private sector businesses, advocacy organizations, clinicians, health industry associations, and many others are engaged in a coordinated effort called the Arkansas Health System Improvement Initiative.

- Work under this initiative has included a focus on planning for a health workforce that provides appropriate access to medical services, particularly in underserved areas.

- As a result of efforts undertaken in this Initiative, we have identified a statewide shortage of primary care providers even when physician extenders are included.

- Bigger issue of maldistribution of providers in the state.

- The Private Option is a first step toward making rural practice more attractive, so that with more of the population having a paying source providers can have a viable business model.
Question and Answer

Submit your questions in the chat box on the left
Knowledge Network

Experts will be available to answer your questions!
Post them now on State Refor(u)m in our Medicaid discussion

Shuchita Madan
State Affairs Manager
Medicaid Health Plans of America

Robin Rudowitz
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