STATE OF ARKANSAS
ASA HUTCHINSON
GOVERNOR

June 28, 2016

The Honorable Sylvia Mathews Burwell
Secretary of the U.S. Department of Health and Human Services
330 Independence Avenue, S.W., Room 4257
Washington, DC 20201

Dear Madam Secretary:

On behalf of the citizens of Arkansas, I am pleased to submit to the U.S. Department of Health and Human Services (DHHS) the enclosed Section 1115 demonstration waiver extension and amendment application. Authorized by provisions in the Arkansas Works Act of 2016, the demonstration will replace the current Health Care Independence Program when it expires on December 31, 2016, with Arkansas Works—a new approach to health coverage for Arkansans.

Arkansas's 1115 waiver demonstration has been successful in furthering the objectives of Title XIX and improving the health insurance Marketplace for all Arkansans—particularly the 240,000 covered through the Demonstration. To date, it has fulfilled its goals of promoting continuity of care, improving access to providers, smoothing the "seams" across the continuum of coverage, and furthering quality improvement and delivery system reform initiatives.

Building upon these accomplishments, I have worked with the Arkansas General Assembly to design Arkansas Works—a more innovative program that aims to strengthen the State's individual premium assistance model, while also instituting reforms to encourage employer-based insurance, incentivize work and work opportunities, promote personal responsibility, and enhance program integrity. Specifically, Arkansas is requesting to extend its 1115 waiver demonstration through December 31, 2021, with the following changes:

- Implementing a premium assistance program for employer-sponsored insurance
- Instituting premiums for Arkansas Works beneficiaries with incomes above 100% of the federal poverty level and terminating Independence Accounts

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- Incentivizing timely premium payment and completion of healthy behaviors
- Eliminating retroactive coverage
- Instituting procedures for expeditious termination of the waiver
- Providing for work referrals

We appreciate the longstanding partnership with your department, and we look forward to your continued support as we develop innovative approaches to providing high quality coverage and encouraging progression up the economic ladder.

Sincerely,

[redacted]

Asa Hutchinson

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Section I - Historical Narrative Summary of the Demonstration

Includes the objectives set forth at the time the demonstration was approved, evidence of how these objectives have or have not been met, and the future goals of the program.

Introduction

In September 2013, Arkansas was the first state in the nation to obtain approval from the Centers for Medicare and Medicaid Services (CMS) for a Section 1115 waiver to use premium assistance to purchase individual qualified health plans (QHPs) offered through the Health Insurance Marketplace (Marketplace) for individuals eligible for expanded coverage under Title XIX of the Social Security Act. Arkansas's Health Care Independence Program (HCIP) extended QHP coverage to 240,000 individuals who are either (1) childless adults between the ages of 19 and 64 with incomes below 138% of the federal poverty level (FPL) who are not enrolled in Medicare or (2) parents between the ages of 19 and 64 with incomes between 17 and 138% FPL who are not enrolled in Medicare.

Arkansas's 1115 waiver demonstration ("Demonstration") has been successful in furthering the objectives of Title XIX and improving the Marketplace for all Arkansans, but Governor Asa Hutchinson and the Arkansas General Assembly have opted for a more innovative program that strengthens the QHP premium assistance model by emphasizing personal responsibility, promoting work, and enhancing program integrity. To that end, Arkansas proposes to replace the HCIP when it expires on December 31, 2016 with Arkansas Works—a new approach to health coverage for Arkansans.

Arkansas Works was developed through a close collaboration between Governor Hutchinson and a bipartisan Health Reform Legislative Task Force[1] culminating in the enactment of the Arkansas Works Act of 2016 (the "Act"). The Act authorizes the Arkansas Works program to be implemented under an amendment to the State's existing 1115 waiver. Arkansas Works is intended to modernize the State's Medicaid program so that it is a fiscally sustainable, cost-effective, and opportunity-driven program. The program is designed to:

- Empower individuals to improve their economic security and achieve self-reliance;
- Build on private market competition and value-based purchasing models; and
- Strengthen the ability of employers to recruit and retain productive employees.

As required under the Arkansas Works Act, the State will continue using premium assistance to purchase QHPs offered through the individual market in the Marketplace for those eligible for expanded coverage under Title XIX, in addition to implementing new coverage features. The Act directs the State to implement strategies to provide health care for low-income and other vulnerable populations in a manner that will:

- Encourage employer-based insurance;
- Incentivize work and work opportunities;

[1] The Health Reform Legislative Task Force was established under the Arkansas Health Reform Act of 2015.

- Promote personal responsibility; and,
- Enhance program integrity.

If approved, this waiver request would authorize the State to implement the unique features of Arkansas Works and continue its 1115 Demonstration through 2021.

Overview of Preliminary Results of Arkansas's Expansion Demonstration

Preliminary evidence indicates that the Demonstration has achieved its goals of promoting coverage, improving provider access, integrating private and public programs, and further improving quality. Since implementation of the Affordable Care Act (ACA) in 2014, Arkansas has experienced a 12.9 percentage point decrease in uninsured residents—tied for the largest drop among all states.[2] The current Demonstration has leveraged the efficiencies of the private market to improve access and quality for Demonstration beneficiaries. To date, Arkansas's Demonstration has fulfilled its goals of:

- **Promoting continuity of coverage for individuals.** The Demonstration has contributed to expanded health plan participation in the Marketplace and achieved continuous availability of health plans and provider networks, with all but one carrier in one of the seven market regions continuing to offer plans year-to-year. With household income transitions across the 138% FPL threshold, families can stay enrolled in the same plan regardless of whether their coverage is subsidized through Medicaid or Advanced Premium Tax Credits.
- **Improving access to providers.** The Demonstration interim evaluation report, which can be found on the Arkansas Center for Health Improvement website, documents enhanced provider access for individuals in the Demonstration compared to those in the traditional Medicaid program. In addition, for most indicators assessed during the first year, individuals enrolled in QHPs achieved higher rates of obtaining preventive clinical services. Provider payment rates under QHPs are higher than those offered under the Medicaid State Plan and are correlated with increased availability of care, as documented in the interim evaluation report.
- **Smoothing the "seams" across the continuum of coverage.** Enrollment in the Demonstration has resulted in full QHP essential health benefits (EHBs) being available to Medicaid beneficiaries who previously had a limited benefit (e.g., pregnant women, those with breast and cervical cancer).
- **Furthering quality improvement and delivery system reform initiatives.** At the forefront of payment innovation and delivery system reform, Arkansas has required all carriers offering QHPs in the Marketplace to participate in the Arkansas Health Care Payment Improvement Initiative (AHCPII)—an innovative, multi-payer initiative to improve quality and reduce costs statewide. The Demonstration has accelerated and leveraged the AHCPII through two mechanisms. First, by increasing the number of carriers participating in the effort, the system transformation goals and objectives are

[2] Gallup, "Arkansas, Kentucky Set Pace in Reducing Uninsured Rate," Feb. 4, 2016, http://www.gallup.com/poll/189023/arkansas-kentucky-set-pace-reducing-uninsured-rate.aspx/.

being reinforced. Second, the number of individuals, approximately 350,000, benefiting from a direct application of these reforms is increased due to QHP participation.

The Demonstration has also succeeded in promoting competition, driving down prices, and decreasing uncompensated care costs in the Arkansas health care market. To date, its impact on the State has included:

- **Creating a larger and younger risk pool.** Demonstration enrollees comprise approximately 80% of the Arkansas Marketplace and are on average younger than other Arkansas Marketplace enrollees. A healthier risk pool has driven down premium rates for all Marketplace enrollees.
- **Creating more competitive premium pricing for all individuals purchasing coverage through the Marketplace.** Since 2014, premium prices in Arkansas have increased at a slower rate than those nationally. From 2015 to 2016, premiums for the second lowest cost silver plan in Arkansas increased by an average of 4.3%, as compared to an average of 7.5% for all states using HealthCare.gov.[3] From 2014 to 2015, premiums across all QHPs in the State decreased by an average of 2%.[4]
- **Decreasing uncompensated care.** Arkansas has seen sharp declines in uncompensated care costs. From 2013 to 2014, there were substantial decreases in uninsured hospital admissions (49%), emergency room visits (39%), and visits at hospital outpatient clinics (46%). In addition, Arkansas hospitals experienced a 55% decrease in uncompensated care losses during this time.[5]

Demonstration Features

The following section provides an overview of features of the Demonstration and notes how the State will approach each of these features under Arkansas Works.

Demonstration Eligibility

a) Eligibility Criteria

To be eligible to participate in Arkansas Works through the Demonstration, an individual must: (1) be a childless adult between 19 and 64 years of age, with an income at or below 138% of the FPL who is not enrolled in Medicare and not incarcerated **or** be a parent between 19 and 64 years of age, with an income between 17-138% FPL who is not enrolled in Medicare and not incarcerated and (2) be a United States citizen or a documented, qualified alien. However, individuals determined to be medically frail/have exceptional medical needs for which coverage through the Marketplace is determined to be impractical, overly complex, or would undermine continuity or effectiveness of care are not eligible for the Demonstration, unless they have access to cost-effective employer-sponsored insurance (ESI) and elect to receive the alternative

[3] CMS, "2016 Marketplace Affordability Snapshot," Oct. 26, 2015, https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-10-26-2.html.

[4] Arkansas Insurance Department, "2015 Projected Qualified Health Plan Individual Premium Rates for Arkansas," Oct. 3, 2014, https://static.ark.org/eeuploads/hbe/NEWS_RELEASE_2015_rate_release.pdf.

[5] Arkansas Hospital Association, "Private Option Eases Hospitals' Financial Struggles," July 2015, http://www.arkhospitals.org/Misc.%20Files/APO7-9-15.pdf.

benefit plan (ABP) through ESI.[6] When determining whether an individual is eligible for Arkansas Works, Arkansas applies the same eligibility standards and methodologies as those articulated in the State Plan.

Participation in the Demonstration is mandatory for eligible individuals. Most Arkansas Works eligible individuals will receive Title XIX coverage through the State's mandatory QHP premium assistance program. Arkansas Works eligible individuals ages 21 or over with access to cost-effective ESI through an employer that elects to participate in the State's ESI premium assistance program will be required to receive Title XIX coverage through their ESI plan. Those who decline coverage through QHPs or ESI premium assistance are not permitted to receive benefits through the State Plan.

Table 1. Eligibility for Arkansas Works Demonstration

Description	Income	Age	Exceptions[7]
Adults in Section VIII Group	*Childless Adults:* 0-138% FPL *Parents:* 17-138% FPL	19-64	▪ Dual eligibles ▪ Individuals who are medically frail/have exceptional medical needs who do not have access to cost-effective ESI ▪ Individuals who are medically frail/have exceptional medical needs who have access to cost-effective ESI through a participating employer and choose to receive standard Medicaid coverage under the State Plan ▪ Incarcerated individuals

b) Demonstration Enrollment Data

The State estimates that approximately 272,000 individuals will be enrolled in Arkansas Works by 2021.

Benefits

a) Benefit Package

Arkansas Works enrollees will receive the ABP, as defined in Arkansas's State Plan. The State provides through its fee-for-service Medicaid program wrap-around benefits that are in the ABP but not covered by ESI or QHPs. For Arkansas Works enrollees covered through QHPs, the State provides wrap-around coverage for non-emergency transportation and Early Periodic Screening

[6] ESI premium assistance is a new feature of Arkansas Works. In the first year of ESI premium assistance, only small group, non-grandfathered plans for which the employer covers at least 25% of the premiums may be considered cost effective. In future years of ESI premium assistance, large group and small group grandfathered plans may also be considered cost effective.

[7] The State's request to waive the requirement to provide retroactive coverage applies to the entire new adult group, including those individuals who are medically frail.

Diagnosis and Treatment (EPSDT) services for individuals participating in the Demonstration who are under age 21 (including pediatric vision and dental services, as well as other EPSDT services to the extent such services are not covered under the QHP). For Arkansas Works enrollees covered through ESI, the State seeks a waiver of the requirement to provide non-emergency transportation. Additionally, if family planning services are accessed at out-of-network providers, the State's fee-for-service Medicaid program will cover those services for both ESI and QHP enrollees, as required under federal Medicaid law. Because of Arkansas's Any Willing Provider Law, few such providers are outside of private insurance carrier networks.

To administer the wrap-around benefits described above, Arkansas Works beneficiaries have a Medicaid client identification number (CIN) through which providers may bill Medicaid for wrap-around benefits as necessary and secondary to their QHP or ESI coverage. Arkansas Works' eligibility notices include information about which services Arkansas Works beneficiaries may receive through fee-for-service Medicaid and how to access those services. Similar information is provided on Arkansas Medicaid's website. Staff at the Arkansas Medicaid beneficiary call centers are trained to provide information regarding the scope of wrap-around benefits and how to access them. Finally, Arkansas Medicaid has worked and will continue to work closely with carriers to ensure that the carriers' call center staffs are aware that Arkansas Works beneficiaries have access to certain services outside of their QHP or ESI coverage and that staff can direct the Arkansas Works beneficiaries to the appropriate resources to learn more about wrap-around services.

b) Appeals Process

Arkansas Works beneficiaries will use the appeals process established by their ESI or QHP to appeal denials of benefits covered under the ESI or QHP. (Arkansas Works beneficiaries will continue to use the Medicaid appeals process for denials of wrapped benefits.) All ESI and QHPs must comply with federal standards governing internal insurance coverage appeals. Additionally, all ESI and QHPs must comply with State standards governing external review of insurance coverage appeals, which in turn are approved as meeting the requirements imposed under the ACA. Arkansas Works beneficiaries will have access to two levels of appeals: an internal review process by their ESI or QHP and an external review process by a Qualified Independent Review Organization that has been selected by the Arkansas Insurance Department (AID).

If an enrollee is dissatisfied with the decision after the external appeal, he/she may request review by AID. Medicaid delegates the authority to conduct fair hearings for Arkansas Works enrollees to AID. AID is a part of the Executive Branch, and thus it is a sister agency to Medicaid. AID has the discretion to permit the individual to call witnesses and cross-examine witnesses. Consistent with the requirements for fair hearings, the Commissioner will permit Arkansas Works enrollees, in all cases, to call and cross-examine witnesses.

Premiums, Cost Sharing, and Independence Accounts

a) Enrollees with Incomes at or Below 100% FPL

Individuals with incomes at or below 100% FPL will have no cost-sharing obligations in Arkansas Works.

b) Enrollees with Incomes Above 100% FPL

Under Arkansas Works, the State will institute premiums of up to 2% of household income for enrollees with incomes between 100 to 138% FPL. With the implementation of enrollee premiums, the State will eliminate Independence Accounts; Section II of this application describes the State's approach for instituting premiums (and terminating the Independence Accounts). Individuals with incomes between 100 to 138% FPL will continue to be subject to point-of-service cost sharing consistent with Medicaid limits. The State will ensure that Arkansas Works beneficiaries' aggregate cost sharing does not exceed the quarterly limit of 5% of household income.

c) Exempt Populations

Pregnant women and American Indians/Alaskan Natives will be exempt from cost sharing under Arkansas Works.

d) Cost-Sharing Reductions & Cost-Sharing Wraps

For Arkansas Works enrollees covered through QHPs, the State pays QHP issuers advance monthly cost-sharing reduction (CSR) payments to cover the costs associated with the reduced cost sharing for Arkansas Works beneficiaries. The advance monthly CSR payments are calculated in the same way for individuals with incomes between 138 and 250% FPL who are eligible for federal CSRs and for individuals with incomes at or below 138% FPL enrolled in QHPs through Arkansas Works; the only difference is that the Department of Health and Human Services (HHS) makes the federal CSR payments and Arkansas Medicaid makes the Arkansas Works CSR payments. These payments are subject to reconciliation based on actual CSRs that are utilized. In the Spring of 2016, each QHP issuer reported actual CSR amounts for benefit years 2014 and 2015 to HHS (for members receiving APTCs/CSRs) and Arkansas Medicaid (for members enrolled in the Demonstration) to reconcile these amounts with the advance payments. The Arkansas Medicaid process for such reconciliations is modeled on the HHS process. The State will use the same reconciliation process in Arkansas Works.

As is discussed further below in Section II, for Arkansas Works enrollees covered through ESI, the State will wrap cost-sharing at the point of service. Enrollees will have an Arkansas Works card that specifies the Medicaid-permitted cost-sharing levels. At the point-of-service, enrollees will present both their ESI card and their Arkansas Works card. The provider will collect the Medicaid-permitted cost sharing from the enrollee and will bill the State for the balance.

Eligibility and Enrollment Processes

a) Identification of Individuals who are Medically Frail/Have Exceptional Medicaid Needs

The State will assess whether individuals potentially eligible for Arkansas Works coverage are medically frail/have exceptional medical needs. For both the QHP and ESI premium assistance programs, the State has developed a process for making mid-year transitions to traditional Medicaid for individuals obtaining false negatives and for individuals with emerging medical

needs that lead to a predictable and significant need for additional benefits during the plan year.

b) Enrollment Process

i. ***All enrollees***

Individuals eligible for Arkansas Works will enroll through the following process:

- Individuals submit the single streamlined application for insurance affordability programs—Medicaid, CHIP and Advanced Premium Tax Credits/Cost-Sharing Reductions—electronically, via phone, by mail, or in-person.
- An eligibility determination is made through either the Federally Facilitated Marketplace (FFM) or the Arkansas Eligibility & Enrollment Framework (EEF).
- State determines whether individual is medically frail.
- State conducts choice counseling for individuals who have screened medically frail.
- The State matches them against a list of employed individuals whose employers:
    - Offer cost-effective ESI, and
    - Participate in the ESI premium assistance program.

ii. ***Individuals who do not have access to cost-effective ESI through an employer participating in the ESI premium assistance program or are ages 19 to 20***

- According to an individual's medical frailty status:
    - *Individuals who are not medically frail.* These individuals will be required to enroll in QHPs.
    - *Individuals who are medically frail.* These individuals will receive either the ABP or the standard Medicaid benefit package through fee-for-service Medicaid.
- Individuals required to receive coverage through QHPs will shop and enroll in coverage through the following process:
    - Individuals will be directed on the web-based portal to a page where they may shop among QHPs available to Arkansas Works eligible individuals. They may select a plan on this portal.
    - MMIS captures their plan selection information and transmits the 834 enrollment transactions to the carriers.
    - Carriers issue insurance cards to Arkansas Works enrollees.
    - MMIS pays premiums on behalf of beneficiaries directly to the carriers.
    - MMIS premium payments continue until the individual is determined to no longer be eligible; the individual selects an alternative plan during the next open enrollment period; or the individual is determined to be more effectively treated due to complexity of need through the fee-for-service Medicaid program.
    - In the event that an individual is determined eligible for QHP coverage through Arkansas Works, but does not select a plan, the State auto-

assigns the enrollee to one of the available QHPs in the beneficiary's county.

iii. ***Individuals ages 21 and over who have access to cost-effective ESI through an employer participating in the ESI premium assistance program***

- According to an individual's medical frailty status:
  - *Individuals who are not medically frail.* These individuals will be required to enroll in ESI premium assistance.
  - *Individuals who are medically frail.* Individuals who have selected the ABP will be required to receive coverage through their ESI plan. Individuals who have selected standard Medicaid benefit package will receive coverage through Medicaid fee-for-service.
- For all individuals required to receive coverage through ESI:
  - The State's vendor administering the ESI premium assistance program will work with the individual's employer to effectuate enrollment in ESI premium assistance.
  - The ESI carriers will issue insurance cards to Arkansas Works enrollees.
  - The vendor will administer ESI premium assistance payments.

c) Coverage Prior to QHP or ESI Enrollment

The State will provide coverage through fee-for-service Medicaid from the date an individual is determined eligible for Medicaid until the individual's enrollment in the QHP or ESI becomes effective.

d) QHP Plan Selection and Purchasing Guidelines

Under AID's regulatory authority, the State assures that Arkansas Works beneficiaries enrolling in QHP coverage are able to choose from at least two high-value silver plans in each rating area of the State. Additionally, AID evaluates network adequacy, including QHP compliance with Essential Community Provider network requirements, as part of the QHP certification process. As a result, Arkansas Works beneficiaries covered through QHP premium assistance have access to the same networks as individuals who purchase coverage in the individual market, ensuring compliance with the requirement found in Section 1902(a)(30)(A) of the Social Security Act that Medicaid beneficiaries have access to care comparable to the access the general population in the geographic area has. Providers are reimbursed for care provided to Arkansas Works beneficiaries at the rates the providers have negotiated with the QHP.

The State has implemented policies to further ensure cost-effective QHP purchasing and judicious use of taxpayer funds. The State is employing purchasing guidelines to ensure the purchase of both competitively-priced and cost-effective plans. The State's approach to ensuring that ESI coverage is cost-effective is outlined in Section II.

e) Auto-Assignment Methodology

Arkansas Works beneficiaries who do not select a QHP within 42 days are assigned a QHP using the State's auto-assignment methodology. The State auto-assigns these individuals only to those plans that meet its purchasing guidelines and are committed to remaining in the Marketplace. Individuals are auto-assigned to the lowest cost qualifying silver-level plan covering only EHBs for each carrier in their service area. Auto-assignments are distributed among qualifying issuers offering AID-certified, EHB-only, silver-level QHPs with the aim of achieving a target minimum market share of Arkansas Works enrollees for each issuer in a service area. The target minimum market share in a service area varies based on the number of competing issuers as follows:

- Two issuers: 33% of Arkansas Works participants in that service area;
- Three issuers: 25% of Arkansas Works participants in that service area;
- Four issuers: 20% of Arkansas Works participants in that service area;
- More than four issuers: 10% of Arkansas Works participants in that service area.

Individuals will be auto-assigned to issuers until the issuers enroll the lesser of the number of individuals needed to hit the target minimum market share or the maximum number of enrollees permitted by AID.

Individuals who are auto-assigned are notified of their assignment and are given a thirty-day period to request enrollment in another plan, consistent with the timeframes for changing coverage that are currently found in Arkansas's commercial market.

f) Notices

Upon enrollment in coverage offered under Title XIX, Arkansas Works beneficiaries receive a notice from Arkansas Medicaid advising them on:

- ESI premium assistance program (if offered cost-effective ESI)
- QHP plan selection process (if not offered cost-effective ESI)
- How to access services until ESI or QHP enrollment is effective
- How to access wrapped benefits
- Appeals
- Exemption from the ABP

g) Memorandum of Understanding with QHP Carriers

Each year of the Demonstration, Arkansas Medicaid enters into a memorandum of understanding (MOU) with the QHP carriers to outline the process for verifying plan enrollment and paying premiums. Under the terms of the MOU, the QHP carrier provides a roster of its enrollees who are covered under Title XIX. After verifying this information, the MMIS transmits payment for premiums to the QHP carrier.

Section II - Changes Requested to the Demonstration

If changes are requested, a narrative of the changes being requested along with the objective of the change and the desired outcomes.

Arkansas is seeking to implement the following changes to its Demonstration to incentivize work; increase personal responsibility; enhance program integrity; and support employer-based insurance coverage.

1. **Implementing a Premium Assistance Program for ESI**
   One of the fundamental goals of Arkansas Works is to strengthen the State's employer-based insurance market as a whole. Arkansas intends to create a mandatory Arkansas Works ESI premium assistance program— distinct from Arkansas's existing Health Insurance Premium Payment program—to decrease churn between ESI and QHP coverage as individuals' incomes fluctuate.

   In the first year of ESI premium assistance, employers offering small group, non-grandfathered plans for which the employer covers at least 25% of the premiums may opt in to the ESI premium assistance program. These plans may be considered cost effective. Employers interested in participating in the ESI premium assistance program will notify the State or its designee that that their plans meet cost-effectiveness criteria defined by the State. (These will be the only plans considered cost-effective for the purposes of ESI premium assistance.) In future years of ESI premium assistance, employers offering large group and small group grandfathered plans may also be permitted to opt in to the program provided their plans are cost effective. As the ESI premium assistance program extends to large employers, the State will modify its cost-effectiveness criteria.

   Individuals ages 21 and older with access to cost-effective ESI through employers that participate in the ESI premium assistance program will be required to enroll in coverage through ESI premium assistance; individuals who are 19- or 20-years old will not be eligible for ESI premium assistance coverage. Medically frail individuals/those with exceptional medical needs will be required to enroll in ESI premium assistance if they have selected the ABP; medically frail individuals who have selected the standard Medicaid benefit package will not be eligible to receive coverage through ESI premium assistance. In future years of the program, the State may expand the population eligible for ESI premium assistance to spouses or dependents of Medicaid-eligible individuals with access to cost-effective ESI.

   As required by federal Medicaid law, the State's fee-for-service Medicaid program will wrap family planning services that are accessed at out-of-network providers. The State will seek a waiver of the federal requirement to provide non-emergency transportation services for Arkansas Works enrollees receiving coverage through ESI premium assistance.

Arkansas Works enrollees obtaining coverage through ESI premium assistance will be subject to the same premiums as Arkansas Works enrollees receiving coverage through QHPs (i.e., individuals enrolled in ESI premium assistance with incomes above 100% FPL will be subject to premiums of up to 2% of household income as described in more detail below). Participating employers will be required to cover at least 25% of the ESI premiums. The State will cover up to 75% of the total cost of the ESI premiums. Individuals with incomes above 100% FPL who are enrolled in Arkansas Works ESI premium assistance coverage will be subject to point-of-service cost sharing at the same levels as individuals with incomes above 100% FPL who are enrolled in Arkansas Works QHP coverage. The State will wrap any cost sharing in the enrollee's ESI plan beyond Medicaid limits. Individuals with incomes at or below 100% FPL who are enrolled in ESI premium assistance will not be subject to cost sharing; the State will wrap all cost sharing imposed through the ESI plan.

All individuals enrolled in coverage through ESI premium assistance will receive two insurance cards—an ESI plan card and an Arkansas Works card. All enrollees will use the Arkansas Works card to cover their ESI plan deductible. Individuals with incomes above 100% FPL will use the Arkansas Works card to cover cost sharing above Medicaid-permissible amounts. Individuals with incomes at or below 100% FPL will use the Arkansas Works card to cover all cost sharing.

2. Instituting Premiums for Arkansas Works Beneficiaries with Incomes above 100% FPL

To encourage personal responsibility, Arkansas will require that Arkansas Works enrollees with incomes above 100% FPL pay monthly premiums.[8] New adults outside of Arkansas Works (e.g., medically frail new adults receiving coverage through the fee-for-service Medicaid program or individuals who have not yet enrolled in a QHP) will not be subject to premiums.

Arkansas Works enrollees with incomes above 100% FPL will be subject to premiums of up to 2% of household income. For the purpose of administrative simplicity, the State will set premiums at a fixed amount, meaning that enrollees with incomes between 100-138% FPL will be subject to premiums of up to 2% of household income.

Individuals who do not pay their premiums in a timely manner (within a 90-day grace period) will incur a debt to the State. Carriers will be responsible for collecting premiums from Arkansas Works enrollees covered through QHP premium assistance. The State will adjust its monthly advance CSR payment to carriers to reflect the possibility of unpaid premiums. At the end of each plan year, the State will account for unpaid premiums through the CSR reconciliation process. For individuals enrolled in ESI premium assistance, premiums will be paid through a paycheck deduction.

[8] Premiums may be paid directly by an enrollee or on behalf of an enrollee by a third party, such as an enrollee's employer or a not-for-profit organization.

3. Terminating Independence Accounts

Arkansas will require monthly premiums for individuals with incomes above 100% FPL in lieu of monthly contributions to Independence Accounts previously authorized under the Demonstration.

Arkansas has conducted a comprehensive noticing and education campaign to inform beneficiaries of the termination of the Independence Account program. Arkansas has sent enrollees notices informing them that their MyIndyCards will be deactivated. The notices included information on:

- Timing of last required monthly Independence Account contribution and deactivation of MyIndyCards
- Toll-free phone number and email address for MyIndyCard customer service for questions about deactivation of cards
- Receipt of credits that have accumulated in the Independence Account

4. Incentivizing Timely Premium Payment and Completion of Healthy Behaviors

Arkansas seeks to encourage personal responsibility and further the objectives of the State's Healthy, Active Arkansas initiative. Under Arkansas Works, Arkansas will create a new incentive benefit (e.g., dental services) for the new adult population. This benefit will only be available to enrollees who make timely premium payments (if required) and achieve healthy behavior standards.

- ***Arkansas Works enrollees with incomes above 100% FPL.*** Arkansas Works enrollees with incomes above 100% FPL who make three consecutive months of timely premium payments (i.e., within a 90-day grace period) will be eligible to receive an incentive benefit. To retain this incentive benefit, these enrollees must pay all premiums timely and must visit a primary care provider (PCP) during each calendar year (assuming at least six months of enrollment in Arkansas Works during that calendar year). For individuals covered through QHP premium assistance, carriers will monitor whether enrollees are paying premiums timely and whether individuals have visited a PCP. In the event that an individual enrolled in QHP coverage has failed to pay premiums timely or failed to see a PCP, carriers will inform Arkansas Medicaid. For individuals covered through ESI premium assistance, premiums will be paid through a paycheck deduction. As a result, all ESI premium assistance enrollees with incomes above 100% FPL will be making timely premium payments. Individuals enrolled in ESI premium assistance coverage will attest to whether they have visited a PCP during each calendar year. Arkansas Medicaid will issue notices to those who have either failed to pay premiums timely or who failed to visit a PCP informing them that they will no longer be eligible for the incentive benefit. They will be disenrolled from the incentive benefit as of the first of the next month for failure to pay premiums and as of January 1 for failure to visit a PCP. To regain access to the incentive benefit, individuals must pay all back due premiums. QHP carriers will monitor whether individuals have paid back due premiums and inform Arkansas

Medicaid when an Arkansas Works enrollee has repaid premiums owed. Individuals who have repaid premiums will be permitted to re-enroll in in the incentive benefit at the beginning the following plan year, assuming they have visited a PCP.

- ***Arkansas Works enrollees with incomes at or below 100% FPL.*** Arkansas Works enrollees with incomes at or below 100% FPL will be eligible for an incentive benefit at the time of Arkansas Works implementation (for currently enrolled new adults) or at the time of Arkansas Works enrollment (for new enrollees). To retain this incentive benefit, Arkansas Works enrollees must visit a PCP during each calendar year (assuming at least six months of enrollment in Arkansas Works during that calendar year). Prior to open enrollment, QHP carriers will determine whether individuals who have been enrolled in Arkansas Works for at least six months have visited a PCP during that calendar year. Carriers will inform Arkansas Medicaid of any individual covered through QHP premium assistance who has failed to visit a PCP during the calendar year. Individuals covered through ESI premium assistance will attest to whether they have visited a PCP during each calendar year. Arkansas Medicaid will issue notices to those who failed to visit a PCP informing them that they will no longer be eligible for the incentive benefit. They will be disenrolled from the incentive benefit effective January 1 of the new coverage year and will be unable to receive the incentive benefit until the beginning of the next coverage year, provided that they visit a PCP as required.

Individuals will have the right to appeal any decision that they are not eligible for the incentive benefit, using the standard Medicaid appeals process.

5. Eliminating Retroactive Coverage

To better align with commercial health insurance coverage, Arkansas is requesting a waiver of the requirement to provide three months retroactive coverage to beneficiaries in the new adult group. Individuals in the new adult group will become eligible for coverage under Title XIX at the time of application.

6. Instituting Procedures for Expeditious Termination of Waiver

To give Arkansas the flexibility to terminate its waiver expeditiously in the event that the federal government reduces the Federal Medical Assistance Percentage (FMAP) for the new adult group, the State plans to submit to CMS a waiver transition and phase-out plan shortly after waiver approval. Once approved, the transition and phase-out plan would then sit "on the shelf" unless and until a reduction in FMAP causes the State to terminate the Demonstration.

Within 30 days of a reduction in FMAP for the new adult group, the State would notify CMS of its intent to activate the transition and phase-out plan. After notifying CMS of its intent to terminate the Demonstration, the State would immediately begin (1) community outreach; (2) producing the approved notices; and (3) conducting administrative reviews of Medicaid eligibility for affected beneficiaries to determine whether they qualify for Medicaid through

another eligibility category and to ensure ongoing coverage for eligible beneficiaries. Coverage under the Demonstration would terminate within 120 days of a reduction in FMAP.

7. Providing Work Referrals

Finally, all eligible Arkansas Works beneficiaries will receive information regarding and referrals to work and work training opportunities through the Department of Workforce Services. Ultimately, as individuals receiving this referral become employed, the State expects that many will transition out of the Arkansas Works program to ESI and private, individual market coverage.

Section III - Requested Waivers and Expenditure Authorities

A list and programmatic description of the waivers and expenditure authorities that are being requested for the extension period, or a statement that the State is requesting the same waiver and expenditure authorities as those approved in the current demonstration.

1) Provide a list of proposed waivers and expenditure authorities.

Waivers

- § 1902(a)(23)(A): To make premium assistance for QHPs in the Marketplace and for ESI mandatory for Demonstration enrollees and to permit the State to limit beneficiaries' freedom of choice among providers to the providers participating in the network of the beneficiary's QHP or ESI.
- § 1902(a)(13) and § 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 or ESI providing primary coverage for services under Arkansas Works.
- § 1902(a)(54) insofar as it incorporates Section 1927(d)(5): To permit the State to require that requests for prior authorization for drugs be addressed within 72 hours, rather than 24 hours. A 72-hour supply of the requested medication will be provided in the event of an emergency.
- § 1902(a)(10)(B): To the extent necessary to enable the State to impose targeted cost sharing on individuals in the eligibility group found at Section 1902(a)(10)(A)(i)(VIII) of the Act.
- § 1902(a)(14) insofar as it incorporates § 1916 and §1916A: To the extent necessary to enable the State to collect monthly premiums for individuals with incomes between 100 and 138 percent of the federal poverty level.
- § 1902(a)(34): To enable the State not to provide medical coverage to beneficiaries in the new adult group for any time prior to the first day of the month in which an individual applies.

- § 1902(a)(4) insofar as it incorporates 42 CFR § 431.53: To the extent necessary to relieve Arkansas of the requirement to assure transportation to and from medical providers for Arkansas Works beneficiaries enrolled in ESI premium assistance.

Expenditure Authorities

- Premium Assistance and Cost Sharing Reduction Payments Expenditures. For part or all of the cost of private insurance premiums, and for payments to reduce cost sharing for certain individuals eligible under the approved State Plan new adult group described in section 1902(a)(10)(A)(i)(XVIII) of the Act.
- ESI Premium Assistance Payments. To cover up to 75% of the cost of ESI premiums for individuals participating in the Arkansas Works ESI premium assistance program.
- Health Credit Expenditures. To issue health credits to eligible enrollees who made a required number of contributions prior to Independence Account termination.

2) Describe why the State is requesting the waiver or expenditure authority, and how it will be used.

Table 2. Arkansas Waiver and Expenditure Authority Requests

Waiver/ Expenditure Authority	Use for Waiver/Expenditure Authority	Reason for Waiver/Expenditure Authority Request	Currently Approved Waiver/ Expenditure Authority Request?
Waivers			
§ 1902(a)(23)(A)	To make premium assistance for QHPs in the Marketplace or ESI mandatory for Demonstration enrollees and to permit the State to limit beneficiaries' freedom of choice among providers to the providers participating in the network of the Arkansas Works beneficiary's QHP or ESI plan.	This waiver authority will allow the State to require that populations identified in this application receive coverage through the Demonstration, and not through the State Plan. This waiver authority will also allow the State to align the network available to Arkansas Works beneficiaries with the network offered to QHP and ESI enrollees who are not Medicaid beneficiaries.	Modified request

Waiver/ Expenditure Authority	Use for Waiver/Expenditure Authority	Reason for Waiver/Expenditure Authority Request	Currently Approved Waiver/ Expenditure Authority Request?
§ 1902(a)(13) and § 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 or ESI providing primary coverage for services under Arkansas Works.	This waiver authority will allow the State to leverage payment rates negotiated in the commercial market.	Modified request
§ 1902(a)(54) insofar as it incorporates Section 1927(d)(5)	To permit the State to require that requests for prior authorization for drugs be addressed within 72 hours, rather than 24 hours. A 72-hour supply of the requested medication will be provided in the event of an emergency.	This waiver authority will allow the State to align prior authorization standards for Arkansas Works beneficiaries with standards in the commercial market.	Currently approved
§ 1902(a)(10)(B)	To the extent necessary to enable the State to impose targeted cost sharing on individuals in the eligibility group found at Section 1902(a)(10)(A)(i)(VIII) of the Act	This waiver will allow the State to impose cost sharing only on the Arkansas Works population.	Modified request
§ 1902(a)(14) insofar as it incorporates § 1916 and §1916A	To the extent necessary to enable the State to collect monthly premiums for individuals with incomes between 100 and 138 percent of the FPL.	This waiver authority will allow the State to align premium requirements for Arkansas Works beneficiaries with those in the commercial market.	Modified request
§ 1902(a)(34)	To enable the State not to provide medical coverage to beneficiaries in the new adult group for any time prior to the first day of the month in which an individual	This waiver authority will allow the State to align the start date of coverage for beneficiaries in the new adult group with standards in the commercial market.	New request

Waiver/ Expenditure Authority	Use for Waiver/Expenditure Authority	Reason for Waiver/Expenditure Authority Request	Currently Approved Waiver/ Expenditure Authority Request?
	applies.		
§ 1902(a)(4) insofar as it incorporates 42 CFR 431.53	To the extent necessary to relieve Arkansas of the requirement to assure transportation to and from medical providers for Arkansas Works beneficiaries enrolled in ESI premium assistance.	This waiver authority will allow the State to align benefits for Arkansas Works beneficiaries enrolled in coverage through ESI premium assistance to benefits offered to other individuals enrolled in ESI plans.	New request
Expenditure Authorities			
Premium Assistance and Cost Sharing Reduction Payments Expenditures	For part or all of the cost of private insurance premiums, and for payments to reduce cost sharing for certain individuals eligible under the approved State Plan new adult group described in Section 1902(a)(10)(A)(i)(XVIII) of the Social Security Act.	This expenditure authority will allow the State to reduce cost sharing for certain individuals eligible under the approved State Plan new adult group described in Section 1902(a)(10)(A)(i)(XVIII) of the Social Security Act.	Currently approved
ESI Premium Assistance Payments	To pay up to 75% of premiums for ESI.	This expenditure authority will allow the State to pay up to 75% of premiums for ESI.	New request
Health Credit Expenditures	To issue health credits to eligible enrollees who made a required number of contributions prior to Independence Account termination.	This expenditure authority will allow the State to issue health credits to eligible enrollees who made a required number of contributions prior to Independence Account termination.	New request

Section IV - Summaries of External Quality Review Organization (EQRO) Reports, Managed Care Organization (MCO) and State Quality Assurance Monitoring

Summaries of External Quality Review Organization (EQRO) reports, managed care organization (MCO) and State quality assurance monitoring, and any other documentation of the quality of and access to care provided under the demonstration, such as the CMS Form 416 EPSDT/CHIP report.

Because Arkansas uses QHPs to provide coverage under the Demonstration, much of the quality initiative activities for Demonstration enrollees are tied to ACA quality requirements for QHPs. All QHPs must be accredited in categories including clinical quality measures and patient experience ratings. Additionally, QHPs must implement a quality improvement strategy to prevent hospital readmissions, improve health outcomes, reduce health disparities, and achieve other quality improvement goals. According to the timeline set by federal guidance, all QHPs will be required to report to the Marketplace, enrollees, and prospective enrollees on health plan performance quality measures according to the federally-developed quality rating system.

In 2015, Arkansas's Federally Facilitated Marketplace partnership engaged in a QHP quality rating pilot using 2014 survey information and medical information from patient encounters with a doctor or hospital that QHPs gathered as part of their accreditation requirements. The report generated from the pilot contained ratings for each QHP based on patient experience and recommended care provided on a rating scale of 0% - 100%. For patient experience, patients were asked about how they felt about the care they received from their doctors and their health insurance provider—i.e., provider quality, access to care, customer service, and value of plan. For recommended care provided, ratings were based on measures that focused on: (1) whether the appropriate tests were given to the appropriate patients; (2) whether medications were properly managed; and (3) quality of any follow-up care. The report included ratings by category and overall ratings for each QHP. It was made available via the AID website prior to 2016 plan year open enrollment.

In 2015, the Arkansas Federally Facilitated Marketplace partnership also engaged in a broader evaluation of the year one (2014) Marketplace governance, outreach and education and QHP activities, including perspectives via survey from HCIP enrollees and other QHP enrollees.[9] Authored by the University of Arkansas for Medical Sciences' College of Public Health, the evaluation examined the effectiveness of processes and procedures used in implementing the Marketplace in Arkansas and the outcomes achieved. Surveys of patients, hospitals, clinics, and behavioral health providers were conducted. Key outcomes of interest for purposes of this section of the Demonstration waiver extension application are as follows:

[9] University of Arkansas for Medical Sciences, Fay W. Boozman College of Public Health & Arkansas Foundation for Medical Care, *Arkansas State Partnership Health Insurance Marketplace: Year One Evaluation,* 2015.

- For Marketplace enrollees, approximately 53% had insurance in the six months prior to obtaining health insurance coverage in the Marketplace compared to 27% in the Demonstration.
- Demonstration enrollees were much less likely to have had any health insurance coverage since becoming an adult, with 45.1% reporting receiving health insurance coverage for the first time since turning 18 years of age. In contrast, 20.1% of enrollees in the Marketplace reported receiving insurance for the first time as an adult.
- In terms of impact on health care providers, hospitals benefited from decreased uncompensated care costs with 77.8% of responding hospitals reporting a decrease following implementation.
- Approximately 22-27% of clinics and behavioral health providers reported a decrease in uncompensated care costs.
- Most hospitals reported no change in patient volume following Marketplace implementation, and more hospitals reported a decrease in volume compared to an increase in volume.
- Twenty-five percent of clinics reported increases in patient volume, while 11% of behavioral providers reported an increase compared to 6% that reported a decrease in volume.

Beginning in 2015, QHPs were required to participate in the Arkansas Patient-Centered Medical Home (PCMH) program. QHP enrollees including Demonstration enrollees were attributed to a PCMH either by choice or a QHP-elected method. PCMH clinics are provided with per-member per-month (PMPM) support to implement a team-based care delivery model and comprehensively manage enrollees' health needs by meeting milestones in practice transformation and achieving quality standards. To receive PMPM support, PCMH clinics must meet practice transformation activities by required deadlines including:

- Ensuring that at least 80% of high-priority enrollees have a care plan with documentation of current problems, a plan of care integrating contributions from the health care team including behavioral health, instructions for follow-up, and assessment of progress.
- Providing 24/7 live voice access to care from an on-call medical professional.
- Reporting clinical quality measure data for controlling high blood pressure, diabetes indicators, and weight assessment for children and adolescents (body-mass index).

Quality measures and targets in the PCMH program include:

- Ensuring that at least 76% of high-priority of enrollees were seen by the attributed PCMH at least twice in the past 12 months.
- Ensuring that at least 40% of enrollees who had an acute inpatient hospital stay were seen by the attributed PCMH within 10 days of discharge.
- Ensuring that at least 49% of congestive heart failure beneficiaries were prescribed beta-blockers.

The improved care coordination through the PCMH program across participating public and private payers has resulted in increased pediatric wellness visits, hemoglobin A1c testing,

breast cancer screenings, improved attention deficit hyperactive disorder (ADHD) management, and thyroid medication management.

Section V - Financial Data

Financial data demonstrating the State's historical and projected expenditures for the requested period of the extension, as well as cumulatively over the lifetime of the demonstration. This includes a financial analysis of changes to the demonstration requested by the State.

The budget neutrality approach recognizes that the population covered by this Demonstration, known as "Arkansas Works beneficiaries," represents a hypothetical population for budget neutrality purposes. Hypothetical populations are individuals that otherwise could have been made eligible for Medicaid under: 1) section 1902(r)(2), 2) 1931(b), or 3) 1902(a)(10)(A)(i)(VIII) (as modified by Section 2001 of the ACA), via a State Plan Amendment. The calendar year 2016 (CY16) budget neutral PMPM and the PMPM cost of emerging CY16 experience are projected forward at the following trend rates: 6.5% from CY16 to CY17, 6.0% from CY17 to CY18, 5.5% from CY18 to CY19, 5.0% from CY19 to CY20, and 4.7% from CY20 to CY21. Trend rates have increased over the rate used in the initial waiver application due to the large growth in pharmacy cost and utilization that is occurring nationwide.

Projected enrollment is identical in the without waiver and with waiver scenarios since the Demonstration does not expand eligibility and is not expected to increase take-up amongst the expansion-eligible population. Enrollment growth has been modeled at 2.5% annually, based on actual experience under the Arkansas waiver combined with the expansion population growth experience of other states (Maryland, North Dakota, Colorado, and Oregon).

To determine the hypothetical enrollment associated with the Arkansas Works beneficiaries, Optumas reviewed current enrollment in Arkansas's HCIP. This enrollment was projected forward at an annual growth rate of 2.5%. The annual growth rate is based on review of Arkansas program enrollment trends as well as the experience of other expansion states, including Maryland, North Dakota, Colorado, and Oregon. As mentioned previously, the same enrollment growth rate is applied to the with waiver and without waiver scenarios.

To determine the potential cost for this population, Optumas utilized the previous budget neutral amounts and the emerging experience. The without waiver amounts are calculated using the previous budget neutral without waiver amounts and projecting them forward. The annual trend rates are: 6.5% from CY16 to CY17, 6.0% from CY17 to CY18, 5.5% from CY18 to CY19, 5.0% from CY19 to CY20, and 4.7% from CY20 to CY21—for an aggregate trend of 5.54% over the next five years of the Demonstration. Trend rates have increased from the previous submission to account for the nationwide increase in pharmacy costs and utilization. The ultimate trend at the end of the extension period is the same figure that was used in the initial budget neutrality submission, reflecting the return of pharmacy trend rates to pre-2012 levels.

The State's actuaries, Optumas, reviewed experience from across the country to determine the appropriate trend rate, and found that the 4.7% growth rate in the previous waiver submission did not adequately account for recent pharmacy cost and utilization growth. States across the nation are seeing pharmacy costs grow at a double-digit rate annually, and the original waiver's 4.7% growth rate is not sufficiently robust to account for observed pharmacy increases. As pharmacy growth normalizes, trend rates return to the magnitude of the previous submission. The trend rate is supported by review of the experience other states. Optumas discussed the rate of cost growth with the Arkansas Department of Human Services, and the assumed non-pharmacy growth rate of 4.5% is in line with their experience. Optumas also reviewed pharmacy and non-pharmacy cost growth rates for other states, such as Nebraska, Oregon, Maryland, and Colorado, and determined a double-digit pharmacy trend rate is consistent with other states' experiences. The with waiver cost projections apply the same annual growth rate to the emerging experience under the waiver.

The with waiver cost projection also incorporates the anticipated collection of member co-premiums. Optumas modeled a collection amount of premiums up to 2% of household income from all individuals with incomes over 100% FPL.[1] Adjusting for the portion of the HCIP enrollees with incomes over 100% FPL and an assumed collection rate results in the collection amount being valued at an average of $0.49 PMPM to $0.52 PMPM across the Demonstration timeframe. The collection rate used in modeling is based on reviewing the experience of other states with a member co-premium. Other aspects of the program cost, such as the advance CSR payments and the services provided via a fee-for-service wrap, are handled identically as the original budget neutrality submission. The other new features of Arkansas Works are not expected to have a cost impact on the Demonstration for the new adult group, so no adjustment is made to the with waiver scenario. Combining the projected enrollment with the expected premium yielded the projected costs for the hypothetical population in both the without and with waiver scenarios. Additional detail on the budget neutrality projections is attached as Appendix A.

Section VI - Evaluation

An evaluation report of the demonstration, inclusive of evaluation activities and findings to date, plans for evaluation activities during the extension period, and if changes are requested, identification of research hypotheses related to the changes and an evaluation design for addressing the proposed revisions.

The interim evaluation report for the Demonstration is available on the Arkansas Center for Health Improvement website. A preliminary summative report for the HCIP is due 180 days after the transition from the HCIP to Arkansas Works on December 31, 2016, with a final summative report due 360 days after the transition date of December 31, 2016. The final

[1] Enrollees with incomes between 100-138% FPL will be subject to premiums of up to 2% of household income. Optumas based its budget neutrality projections on a two-person household.

summative report will include an executive summary, Demonstration description, study design, discussion of findings and conclusions, policy implications, discussion of interaction with other State initiatives, and derivative research publications to demonstrate scientific and academic rigor.

Evaluation activities during the extension period will include a continuation of assessment of the research questions and hypotheses related to QHP premium assistance that address the goals of improving access, reducing churn, and improving quality of care, thereby leading to enhanced health outcomes. Experience from the interim evaluation report regarding available data and evaluation approach has led to a consolidation and refinement of hypotheses for QHP premium assistance as described the table below. Additional research questions and hypotheses will assess new features of Arkansas Works including, mandatory ESI premium assistance, premium exposure for Arkansas Works beneficiaries with incomes between 100-138% FPL, access to incentive benefits, and elimination of retroactive coverage. The following are among the hypotheses to be considered in development of the evaluation design and will be included in the design as appropriate:

Table 3. Evaluation Hypotheses under Consideration

Hypothesis	Evaluation Approach	Data Sources
QHP Premium Assistance Continued Hypotheses		
1. QHP premium assistance beneficiaries will have equal or better access to health care compared with what they would have otherwise had in the traditional Medicaid fee-for-service system over time.	Compare differences in perceived and realized measures of access between beneficiaries enrolled in QHPs and those in traditional fee-for-service Medicaid. Measures will include perceptions of timeliness and ease of access to primary care physicians and specialists, transportation barriers, and time to first visit.	i. CAHPS survey ii. QHP and Medicaid claims data
2. QHP premium assistance beneficiaries will have equal or better care and outcomes compared with what they would have otherwise had in the traditional Medicaid fee-for-service system over time.	Compare differences in receipt of needed preventive, emergent, and specialty care and utilization of non-emergent emergency room or preventive hospital visits between beneficiaries enrolled in QHPs and those in traditional fee-for-service Medicaid. Measures include established HEDIS metrics for appropriate screening, other quality indicators, and actual utilization of health care services.	i. CAHPS survey ii. QHP and Medicaid claims data

Hypothesis	Evaluation Approach	Data Sources
3. QHP premium assistance beneficiaries will have better continuity of care compared with what they would have otherwise had in the traditional fee-for-service Medicaid system over time.	Compare differences in attrition and churn between beneficiaries enrolled in QHPs and those in traditional fee-for-service Medicaid. Measures include: • Percentage of the enrolled population dropped from coverage who did not re-enroll, and • Months of gaps in coverage and the associated health care consequences of these gaps in coverage.	i. Insurance transition survey ii. Monthly enrollment data file
Waiver Extension Hypotheses		
ESI Premium Assistance-Specific Hypotheses		
4. Use of ESI premium assistance will result in reduced costs to Medicaid compared to costs through QHP premium assistance.	Program impact assessment based upon employer participation and allocations of premium assistance	i. Enrollment and premium payment data
5. Availability of ESI premium assistance will recruit employers to newly offer ESI.	Gather employer and employee perceptions and realities of the benefits of coverage through ESI compared to providing the same benefits through QHP premium assistance.	i. Qualitative interviews and focus groups with small group employers ii. Premium payment and benefit utilization data
6. Continuity of coverage under ESI premium assistance will be improved compared to QHP premium assistance.	Compare attrition and churn between QHP and ESI premium assistance.	i. Enrollment data ii. Premium payment data
Arkansas Works Full Population Hypotheses		
7. The incentive benefits in Arkansas Works will: a) Increase participation rates for premium contributions compared to historical experience with Independence Accounts; and b) Increase wellness visit utilization.	Compare rates of 2015-16 Independence Account participation vs. 2017-21 premium payment participation; compare 2015-16 vs. 2017-21 wellness visit utilization rates.	i. Premium collection and transaction data ii. QHP and Medicaid provider and claims data

Hypothesis	Evaluation Approach	Data Sources
8. Arkansas Works QHP and ESI premium assistance beneficiaries will have equal or fewer gaps in insurance coverage compared with what they would have otherwise had in the traditional fee-for-service Medicaid system over time.	Compare attrition and churn between premium assistance beneficiaries covered through QHPs or ESI and traditional fee-for-service Medicaid beneficiaries over time.	i. Enrollment data ii. Premium payment data
9. Arkansas Works beneficiaries receiving coverage through either QHP or ESI premium assistance will maintain continuous access to the same providers.	Compare provider access for QHP and ESI premium assistance beneficiaries to those enrolled in traditional fee-for-service Medicaid.	i. CAHPS survey ii. QHP and Medicaid claims data

Section VII - Compliance with Public Notice Process

Documentation of the State's compliance with the public notice process set forth in §431.408 of this subpart, including the post-award public input process described in §431.420(c) of this subpart, with a report of the issues raised by the public during the comment period and how the State considered the comments when developing the demonstration extension application.

1) Start and end dates of the state's public comment period.

The State's comment period was from May 18, 2016 to June 17, 2016.

2) Certification that the state provided public notice of the application, along with a link to the state's web site and a notice in the state's Administrative Record or newspaper of widest circulation 30 days prior to submitting the application to CMS.

Arkansas certifies that it provided public notice of the application on the State's Medicaid website (https://www.medicaid.state.ar.us/) beginning on May 18, 2016. Arkansas also certifies that it provided notice of the proposed Demonstration in the *Arkansas Democrat-Gazette*—the newspaper of widest circulation in Arkansas—on May 18, 19, and 20. A copy of the notice that appeared in the newspaper is included here in Section VIII.

3) Certification that the state convened at least 2 public hearings, of which one hearing included teleconferencing and/or web capability, 20 days prior to submitting the application to CMS, including dates and a brief description of the hearings conducted.

Arkansas certifies that it convened two public hearings at least twenty days prior to submitting the Demonstration application to CMS. Specifically, Arkansas held the following hearings:

- *Little Rock – May 26, 2016, from 11 am – 1 pm.* Dawn Stehle, Arkansas's Medicaid Director, provided an overview of the Demonstration. Individuals could also access this public hearing by teleconference and webinar.
- *Pine Bluff – June 1, 2016 from 5:30 pm – 7:30 pm*. Dawn Stehle provided an overview of the Demonstration. Individuals could also access this public hearing by teleconference and webinar.

4) Certification that the state used an electronic mailing list or similar mechanism to notify the public. (If not an electronic mailing list, please describe the mechanism that was used.)

Arkansas certifies that it used an electronic mailing list to provide notice of the proposed Demonstration to the public. Specifically, Arkansas Medicaid provided notice through email lists of key stakeholders, including payers, providers, and advocates. Arkansas also posted the link to the application on the Department of Human Services' Twitter feed.

5) Comments received by the state during the 30-day public notice period.

Arkansas received nine comments during the public notice period.

6) Summary of the state's responses to submitted comments, and whether or how the state incorporated them into the final application.

We attach here at Appendix B a document summarizing and responding to the comments received. In addition, we have included all public comments received in Appendix C.

7) Certification that the state conducted tribal consultation in accordance with the consultation process outlined in the state's approved Medicaid State plan, or at least 60 days prior to submitting this Demonstration application if the Demonstration has or would have a direct effect on Indians, tribes, on Indian health programs, or on urban Indian health organizations, including dates and method of consultation.

Arkansas contains no federally recognized tribes or Indian health programs. As a result, tribal consultation was not required.

Section VIII – Public Notice

The Arkansas Department of Human Services (DHS), Division of Medical Services (DMS) is providing public notice of its intent to submit to the Centers for Medicare and Medicaid Services (CMS) a written application requesting approval to replace the existing program

authorized under Arkansas's Health Care Independence Program Demonstration with Arkansas Works.

Arkansas's 1115 waiver demonstration ("Demonstration") has been successful in furthering the objectives of Title XIX and improving the health insurance Marketplace for all Arkansans—particularly the 240,000 covered through the Demonstration—and Governor Asa Hutchinson and the Arkansas General Assembly have opted for a more innovative program that strengthens the individual premium assistance model by emphasizing personal responsibility, promoting work, and enhancing program integrity. To that end, Arkansas proposes to replace its current Health Care Independence Program when it expires on December 31, 2016 with Arkansas Works—a new approach to health coverage for Arkansans.

To implement Arkansas Works, the State will use premium assistance to purchase either cost-effective employer-sponsored insurance (ESI) or qualified health plans (QHPs) offered in the individual market through the Marketplace for individuals eligible for expanded coverage under Title XIX of the Social Security Act who are either (1) childless adults between the ages of 19 and 65 with incomes below 138% of the federal poverty level (FPL) who are not enrolled in Medicare or (2) parents between the ages of 19 and 65 with incomes between 17 and 138% FPL who are not enrolled in Medicare. Individuals in two groups—(1) those who are medically frail or (2) other individuals with exceptional medical needs for whom coverage through the Marketplace is determined to be impractical, overly complex, or would undermine continuity or effectiveness of care—will not participate in the Demonstration, unless they have access to cost-effective ESI and choose to receive the Alternative Benefit Plan (ABP). All individuals covered through the Demonstration are referred to as "Arkansas Works beneficiaries."

Arkansas Works beneficiaries will receive the ABP through either their ESI or the QHP that they select. Arkansas Works beneficiaries with incomes above 100% FPL will continue to pay cost-sharing, consistent with the State Plan. Arkansas Works beneficiaries with incomes above 100% FPL will no longer be required to contribute to Independence Accounts; instead, they will be required to pay premiums, consistent with the premiums for populations with comparable incomes purchasing coverage through the Marketplace.

The Demonstration will further the objectives of Title XIX by promoting continuity of coverage for individuals (and in the longer run, families), improving access to providers, smoothing the "seams" across the continuum of coverage, and furthering quality improvement and delivery system reform initiatives. Additionally, the Demonstration will:

- Encourage employer-based insurance;
- Incentivize work and work opportunities;
- Promote personal responsibility; and
- Enhance program integrity.

The Demonstration will be statewide and will operate during calendar years 2017 through 2021. The State anticipates that approximately 272,000 individuals will enroll in the Demonstration by 2021. The State expects that, over the life of the Demonstration, covering

Arkansas Works beneficiaries will be comparable to what the costs would have been for covering the same group of Arkansas adults using traditional Medicaid.

The Demonstration will test hypotheses related to access to care, quality of care, churning, cost-comparability, availability of ESI, incentive benefits, and the elimination of retroactive coverage.

The State will request the following waivers and expenditure authorities to operate the Demonstration:

Waivers

- § 1902(a)(23)(A): To make premium assistance for QHPs in the Marketplace and for ESI mandatory for Demonstration enrollees and to permit the State to limit beneficiaries' freedom of choice among providers to the providers participating in the network of the beneficiary's QHP or ESI.
- § 1902(a)(13) and § 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 Qualified Health Plan or ESI providing primary coverage for services under Arkansas Works.
- § 1902(a)(54) insofar as it incorporates Section 1927(d)(5): To permit the State to require that requests for prior authorization for drugs be addressed within 72 hours, rather than 24 hours. A 72-hour supply of the requested medication will be provided in the event of an emergency.
- § 1902(a)(10)(B): To the extent necessary to enable the State to impose targeted cost sharing on individuals in the eligibility group found at Section 1902(a)(10)(A)(i)(VIII) of the Act.
- § 1902(a)(14) insofar as it incorporates § 1916 and §1916A: To the extent necessary to enable the State to collect monthly premiums for individuals with incomes between 100 and 138 percent of the federal poverty level (FPL).
- § 1902(a)(34): To enable the State not to provide medical coverage to Arkansas Works beneficiaries for any time prior to the first day of the month in which an individual applies.
- § 1902(a)(4) insofar as it incorporates 42 CFR § 431.53: To the extent necessary to relieve Arkansas of the requirement to assure transportation to and from medical providers for Arkansas Works beneficiaries enrolled in ESI premium assistance.

Expenditure Authorities

- Premium Assistance and Cost Sharing Reduction Payments Expenditures. For part or all of the cost of private insurance premiums, and for payments to reduce cost sharing for certain individuals eligible under the approved State Plan new adult group described in section 1902(a)(10)(A)(i)(XVIII) of the Act.
- ESI Premium Assistance Payments. To cover up to 75% of the cost of ESI premiums for individuals participating in the Arkansas Works ESI premium assistance program.

- Limited-Purpose Health Credit Expenditures. To issue limited-purpose health credits to eligible enrollees who made a required number of contributions prior to Independence Account termination.

The State continues to evaluate whether it will request other waivers or expenditure authorities.

The complete version of the current draft of the Demonstration application will be available for public review as of Wednesday, May 18, at **https://www.medicaid.state.ar.us/General/comment/demowaivers.aspx.** The Demonstration application may also be viewed from 8 AM – 4:30 PM Monday through Friday at:

Arkansas Department of Human Services
700 Main Street
Little Rock, AR 72201
Contacts: Becky Murphy or Jean Hecker

Public comments may be submitted until midnight on June 17, 2016. Comments may be submitted by email to **HCIW@Arkansas.gov** or by regular mail to PO Box 1437, S-295, Little Rock, AR 72203-1437.

To view comments that others have submitted, please visit **https://www.medicaid.state.ar.us/general/comment/comment.aspx**
Comments may also be viewed from 8 AM – 4:30 PM Monday through Friday at:

Arkansas Department of Human Services
700 Main Street
Little Rock, AR 72201
Contacts: Becky Murphy or Jean Hecker

The State will host two public hearings during the public comment period.

Little Rock
Thursday, May 26, 2016
11:00 AM – 1:00 PM
University of Arkansas
Cooperative Extension Service
2301 S University Avenue
Little Rock, Arkansas, 72204

Pine Bluff
Wednesday, June 1, 2016
5:30 – 7:30 PM
Jefferson Regional Medical Center

Classrooms J & R
1600 W 40th Avenue
Pine Bluff, Arkansas, 71603

Individuals may access the hearing by webinar. To participate by webinar, please register at: https://attendee.gotowebinar.com/register/5714384405162657281

Dawn Stehle
Director
Division of Medical Services

4501545928 EL

APPENDIX A

BUDGET NEUTRALITY SUBMISSION

ARKANSAS 1115 WAIVER EXTENSION APPLICATION
APPENDIX A

Original Figures

	Budget Neutrality Without Waiver			
	CY14	**CY15**	**CY16**	**Three Year Total**
Member Months	1,567,481	2,405,931	2,881,476	6,854,888
Medicaid Services PMPM	$ 477.63	$ 500.08	$ 523.58	$ 504.83

	With Waiver			
	CY14	**CY15**	**CY16**	**Three Year Total**
Member Months	1,567,481	2,405,931	2,881,476	6,854,888
QHP Services PMPM	$ 487.90	$ 489.48	$ 501.89	$ 494.34
Wrap Services PMPM	$ 4.98	$ 4.67	$ 3.80	$ 4.37
Total PMPM	$ 492.88	$ 494.15	$ 505.69	$ 498.71
Over/(Under) Cap PMPM	$ 15.25	$ (5.93)	$ (17.89)	$ (6.12)
Percent Difference from Cap	3.2%	-1.2%	-3.4%	-1.2%

Extension Figures

	Budget Neutrality Without Waiver						
	CY17	**CY18**	**CY19**	**CY20**	**CY21**	**Five Year Total**	**Eight Year Total**
Member Months	2,953,513	3,027,351	3,103,034	3,180,610	3,260,126	15,524,634	22,379,522
Medicaid Services PMPM	$ 557.62	$ 591.07	$ 623.58	$ 654.76	$ 685.54	$ 624.09	$ 587.56

	With Waiver						
	CY17	**CY18**	**CY19**	**CY20**	**CY21**	**Five Year Total**	**Eight Year Total**
Member Months	2,953,513	3,027,351	3,103,034	3,180,610	3,260,126	15,524,634	22,379,522
QHP Services PMPM	$ 534.51	$ 566.59	$ 597.75	$ 627.64	$ 657.13	$ 598.24	$ 566.41
Wrap Services PMPM	$ 4.05	$ 4.29	$ 4.53	$ 4.75	$ 4.97	$ 4.53	$ 4.48
Less Member Cost Share	$ 0.49	$ 0.49	$ 0.50	$ 0.51	$ 0.52	$ 0.50	$ 0.35
Total PMPM	$ 538.08	$ 570.38	$ 601.77	$ 631.88	$ 661.59	$ 602.26	$ 570.54
Over/(Under) Cap PMPM	$ (19.54)	$ (20.69)	$ (21.81)	$ (22.88)	$ (23.94)	$ (21.83)	$ (17.02)
Percent Difference from Cap	-3.5%	-3.5%	-3.5%	-3.5%	-3.5%	-3.5%	-2.9%

Assumptions						
CY	16 -> 17	17 -> 18	18 -> 19	19 -> 20	20 -> 21	Five Year Total
Without Waiver Trend	6.5%	6.0%	5.5%	5.0%	4.7%	5.54%
With Waiver Trend	6.5%	6.0%	5.5%	5.0%	4.7%	5.54%
Enrollment Growth	2.5%	2.5%	2.5%	2.5%	2.5%	2.50%
Member Cost Share Growth	1.5%	1.5%	1.5%	1.5%	1.5%	1.50%

Aggregate Waiver Calculations

	Without Waiver				
	Through CY17	**Through CY18**	**Through CY19**	**Through CY20**	**Through CY21**
	9,808,401	12,835,752	15,938,786	19,119,396	22,379,522
	$ 520.72	$ 537.32	$ 554.11	$ 570.85	$ 587.56

	With Waiver				
	Through CY17	**Through CY18**	**Through CY19**	**Through CY20**	**Through CY21**
	9,808,401	12,835,752	15,938,786	19,119,396	22,379,522
	$ 506.44	$ 520.62	$ 535.64	$ 550.94	$ 566.41
	$ 4.28	$ 4.28	$ 4.33	$ 4.40	$ 4.48
	$ 0.15	$ 0.23	$ 0.28	$ 0.32	$ 0.35
	$ 510.56	$ 524.67	$ 539.68	$ 555.02	$ 570.54
	$ (10.16)	$ (12.64)	$ (14.43)	$ (15.83)	$ (17.02)
	-2.0%	-2.4%	-2.6%	-2.8%	-2.9%

ARKANSAS 1115 WAIVER EXTENSION APPLICATION
APPENDIX A

	Trend Support				
	CY17	CY18	CY19	CY20	CY21
Service Type	Trend Rate	Trend Rate	Trend Rate	Trend Rate	Trend Rate
Pharmacy	11.00%	9.50%	7.75%	6.00%	5.00%
Medical	4.50%	4.50%	4.50%	4.50%	4.50%
Aggregate	6.50%	6.00%	5.50%	5.00%	4.70%

Pharmacy is weighted at 30% and Medical at 70% to calculate the Aggregate

APPENDIX B

RESPONSES TO PUBLIC COMMENTS ON ARKANSAS WORKS 1115 WAIVER EXTENSION APPLICATION

APPENDIX B
Responses to Public Comments on Arkansas Works 1115 Waiver Extension Application

Premium Assistance for Employer-Sponsored Insurance

Comment: Several commenters were supportive of the State's efforts to encourage employers to provide insurance for their employees through a premium assistance program for employer-sponsored insurance (ESI).

Response: The State appreciates commenters' support of its plans to implement a premium assistance program for ESI.

Comment: Several commenters were concerned that the State will have challenges administering a premium assistance program for ESI. Several commenters also expressed concerns about the fact that Arkansas Works beneficiaries receiving coverage through ESI would have two cards—one for their ESI and one for Medicaid—potentially leading to enrollee and provider confusion. One commenter specifically requested clarification that all providers in the ESI network, regardless of whether they participate in Medicaid, will charge enrollees only the Medicaid-level cost-sharing.

Response: The State is currently working closely with vendors and other state agencies to develop a plan to implement the ESI premium assistance program in a streamlined and seamless manner. The State intends to educate ESI premium assistance enrollees about the proper use of the two cards, and the State will, through its vendor, provide call center support for ESI premium assistance enrollees and providers with questions. Finally, the State will work closely with providers to ensure that ESI premium assistance enrollees have access to a broad number of providers, while remaining protected from cost-sharing above Medicaid levels.

Comment: One commenter urged the State to **not** expand the ESI premium assistance program to include dependents in the future; instead favoring retaining the current ARKids First program.

Response: The State appreciates this comment and will consider carefully any changes to coverage for children in the future.

Comment: One commenter expressed concerns about mid-year plan changes as employers begin participating in the ESI premium assistance program. The commenter suggested that the State allow QHP premium assistance enrollees who gain access to cost-effective ESI remain in their QHP until the annual re-enrollment period occurs.

Response: The State acknowledges that the launch of the ESI premium assistance program may require some QHP enrollees to change plans mid-year. The State will work closely with carriers, employers, and its vendor to ensure a smooth transition for these enrollees.

Comment: One commenter suggested that the State consider amending insurance rules to allow small group employers participating in Arkansas Works to waive any waiting period for individuals eligible for ESI premium assistance to minimize churn caused by the ESI premium assistance program. If waiving the waiting period is not possible, the commenter suggested providing coverage for enrollees through fee-for-service—rather than enroll them in a QHP only to shift them to ESI soon thereafter.

Response: The State will seek ways to minimize churn between QHPs and ESI. The State will take this suggestion under advisement.

Comment: One commenter requested clarification of whether an employer can begin participating in Arkansas Works at any time, or whether employers will be limited to a sign up period.

Response: The State anticipates allowing employers to begin participating in Arkansas Works at any time. The State may revise its policy in future years.

Comment: One commenter requested clarification of whether an employer can withdraw from participation in Arkansas Works at any time. Relatedly, the commenter asked how the State will address an employer that fails to make timely premium payments, leading to the cancellation of the small group policy.

Response: The State will require that all participating employers enter in to a Memorandum of Understanding, which will outline key requirements, such as the employer's withdrawal rights and penalties for failure to pay premiums.

Comment: One commenter suggested that the State develop an outreach and enrollment strategy specifically for small business owners, including involving insurance agents with expertise assisting small group consumers.

Response: The State agrees that effective communication with small employers about the Arkansas Works program will be important and will consider how agents' expertise may be best used in implementing this program.

Comment: One commenter made several suggestions related to the ESI premium assistance enrollment process, including engaging QHPs in identifying potential sources of third-party coverage.

Response: The State continues to develop its approach to implementing the ESI premium assistance program, including how it will confirm whether an individual has access to cost-effective ESI. As suggested, the State will evaluate how to use (and strengthen) its existing third-party liability processes to identify potential ESI premium assistance enrollees.

Comment: One commenter suggested that the State make the ESI premium assistance program mandatory for employers to maximize the State's ability to leverage ESI.

Response: The State does not intend to make the program mandatory for employers.

Premiums and Cost-Sharing

Comment: Four commenters expressed concerns about the State's proposal to require premiums for Arkansas Works enrollees with incomes above 100% FPL. The commenters indicated that the proposed premium amounts could place a significant financial burden on beneficiaries.

Response: By charging premiums, the State intends to promote personal responsibility and align with commercial coverage to the extent possible. The State acknowledges that some low-income individuals may have challenges paying monthly premiums, especially if they incur other unanticipated out-of-pocket expenses. Accordingly, the State will ensure that individuals remain eligible for coverage, even if they miss a premium payment. To reward those individuals who pay premiums (and complete certain healthy behaviors), the State will provide additional incentive benefits.

Comment: One commenter recommended against requiring deductibles or co-payments for services.

Response: No Arkansas Works beneficiaries will be subject to deductibles. The State believes that co-payments are a critical tool to promote personal responsibility and discourage inappropriate utilization and has required that individuals in the new adult group with incomes above 100% FPL pay co-payments since 2014.

Comment: One commenter noted that enrollees may misinterpret notices of past due premiums as meaning that they are no longer eligible for coverage under Arkansas Works, rather than that they may not be eligible for incentive benefits. The commenter underscored the need for clear enrollee communications to minimize potential confusion.

Response: The State agrees that clear enrollee communication will be critical.

Comment: One commenter asked the State to consider requiring co-payments for emergency room use while eliminating co-payments on primary care visits to encourage enrollees to receive care at appropriate settings.

Response: Federal Medicaid law will not permit the State to impose cost-sharing on emergency room use.[1] The State will explore ways to encourage enrollees to seek care in appropriate settings.

[1] Co-payments are only permitted on non-emergency use of the emergency room, which is not a covered benefit under Arkansas's Alternative Benefit Plan.

Benefits

Comment: One commenter asked for additional details on the "healthy behavior" required to earn incentive benefits.

Response: The State has tentatively determined to require one primary care provider visit during each calendar year. The State continues to refine its approach to incentive benefits.

Comment: Two commenters indicated support for providing dental coverage, and one commenter suggested that the State make dental coverage part of Medicaid benefit package for the new adult group—rather than an incentive benefit.

Response: The State agrees that oral health is important. The State is still evaluating which benefits to provide as incentive benefits.

Comment: Two commenters opposed the State's proposal to eliminate coverage for non-emergency medical transportation for individuals enrolled in ESI premium assistance, citing challenges of low-income individuals to travel to medical appointments and the risk of an additional financial burden on those without cars.

Response: The State expects that most individuals with access to ESI have sufficient transportation options, since most need transportation to get to and from work. As a result, the State expects that eliminating non-emergency medical transportation for individuals with access to ESI will not negatively impact beneficiary access to services.

Eligibility

Comment: Several commenters expressed concern with the State's proposal to eliminate retroactive eligibility. Commenters indicated that the State's systems challenges and inability to implement fully a presumptive eligibility program further underscore the need to maintain retroactive eligibility. Commenters also noted the potential negative financial impact on providers due to eliminating retroactive coverage.

Response: The State is in its third year of providing coverage to the new adult group and continues to improve its eligibility systems to ensure access to coverage and minimize gaps in coverage. The State believes that the need for retroactive eligibility is limited.

Comment: One commenter expressed concern that eligibility for coverage in Arkansas Works does **not** include an asset test. The commenter noted that individuals with high wealth but low income will not qualify for Arkansas Works, while individuals with low wealth but relatively higher income will not qualify.

Response: Asset tests are prohibited under federal Medicaid law for individuals in many eligibility categories, including those in the Arkansas Works population.

Comment: One commenter suggested that the State create a single redetermination period for a family, rather than have different redetermination periods for different family members depending on the program covering them. The commenter noted that some families could have children enrolled in ARKids First, one parent in QHP premium assistance, and one parent in ESI premium assistance, leading to three different renewal periods and processes.

Response: The State appreciates this comment and is working to reduce the administrative challenges facing families covered through multiple coverage programs. The State will consider the future feasibility of creating a single redetermination period for the entire family.

Comment: One commenter suggested that the State work with health plans, vendors, and insurance agents to improve eligibility and renewal processes to minimize churn. The commenter also suggested that the State measure the administrative costs associated with churn to inform process improvements.

Response: Reducing churn is a major objective of the Arkansas Works program, and the State will continue to work closely with stakeholders to develop strategies to minimize churn.

Comment: One commenter requested clarification of when eligibility would begin, if the State did not provide retroactive coverage.

Response: If the State were no longer required to offer retroactive coverage, coverage would begin as of the first day of the month in which the individual applies for coverage. For example, if an individual applies for coverage on September 20, they would have eligibility dating back to September 1, but no earlier.

General Comments

Comment: Nearly all commenters were very supportive of the Arkansas Works program. One commenter provided a personal anecdote about how coverage had improved his and his wife's lives. Another commenter noted the significant positive impact that expanded coverage had on providers throughout the State.

Response: The State appreciates the support for the State's Demonstration program. The State appreciates hearing from enrollees and provider about the positive impact of coverage, and the State looks forward to working with a broad range of stakeholders to make Arkansas Works a success.

Comment: One commenter provided support for offering life skills counseling to individuals seeking employment, rather than requiring them to participate in mandatory job search activities. Another commenter encouraged the State to collaborate with education and community organizations to support enrollees in gaining employment and developing careers.

Response: The State agrees that it is critical to support Arkansans in building the skills necessary to become employed. The State does not intend to link coverage under Title XIX with participation in any mandatory job search activities.

Comment: One commenter supported providing medically necessary case management to higher need individuals.

Response: The State agrees that it is important to ensure that Arkansas Works enrollees can navigate the complex healthcare system and will work with stakeholders to determine how best to provide appropriate support. Most individuals who are medically frail/have exceptional medical needs will be served through fee-for-service Medicaid.

Comment: One commenter encouraged the State to work with experts in health literacy to develop enrollee notices and educational materials.

Response: The State appreciates the suggestion and will consider working with experts to further refine notices.

Comment: One commenter indicated that the projected cost trend of 4.7% may not accurately reflect trends in healthcare costs for the new adult group. The commenter suggested a trend of between 6-7% annual growth.

Response: The State appreciates this feedback. After analyzing healthcare utilization among the new adult group, including the use of prescription drugs, the State has updated the budget neutrality trend in the final Demonstration application.

Comment: One commenter encouraged the State to enhance its program integrity efforts in Arkansas Works, especially in QHP premium assistance, to ensure that providers are billing appropriately.

Response: The State agrees that program integrity is essential to the success of Arkansas Works. The State will evaluate whether its program integrity policies require updating to reflect the unique features of the Arkansas Works program.

APPENDIX C

PUBLIC COMMENTS ON ARKANSAS WORKS 1115 WAIVER EXTENSION APPLICATION

From: Jacobson, David <HDJacobson@arkbluecross.com>
Sent: Friday, June 17, 2016 12:28 PM
To: DHS DMS HCIW
Cc: Parker, Kristin R
Subject: Arkansas Works Public Comment
Attachments: Arkansas Works Waiver Extension Public Comment - Arkansas BCBS - June 17 2016.pdf

Division of Medical Services:

We appreciate the opportunity to provide the attached comments and suggestions for the Arkansas Works Waiver Extension Application.

Best of luck with the approval process and we look forward to helping you and the state implement an innovative program to improve the health, workforce and economy of Arkansas.

David Jacobson
Vice President, Strategy & Business Development

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Arkansas BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

Comments and Suggestions on
Arkansas Works 1115 Waiver Extension Application

Introduction

As a committed partner to the success of Arkansas Works, Arkansas Blue Cross Blue Shield (ABCBS) appreciates the continued national leadership and extraordinary effort by DHS to design Arkansas Works as described in the waiver extension application. We recognize that the extension application conforms to the CMS requirements for renewal and is not intended to address many of the operational details that will be important to a successful implementation. However, given the importance of this application document and CMS' consideration of this request, we have included several specific program comments and suggestions that we believe are relevant to both this immediate discussion and the long term program planning. We hope these comments will be helpful as you continue to develop Arkansas Works, and are happy to answer any questions you may have. ABCBS appreciates the opportunity to provide this input and we look forward to collaborating with you and other stakeholders in the coming months to continue the success of this important health care program for Arkansans.

As a Private Option/Arkansas Works participating QHP, a significant small employer health insurance plan and fellow Arkansans committed to the health, economy and citizens in our state, we offer the following comments and suggestions for your consideration.

Improve Enrollment Transitions and Participant Understanding

Challenges with churning are not unique to Arkansas; virtually every Medicaid program in the country has struggled with this problem, and we appreciate the efforts and interest DHS has demonstrated in identifying ways to minimize transitions between health plans, and the continued focus on this issue by including churning in the proposed Arkansas Works evaluation strategy. The success of the HCIP demonstrates how important these new health care options have been for improving access to health care, and we want to do everything possible to support continued success under Arkansas Works.

While we realize some level of churn is inevitable, we believe development of a comprehensive enrollee communication and education campaign and easy-to-understand enrollment materials will be critical to ensure a smooth transition. In addition to the assistance ABCBS and other QHPs can provide, Arkansas is fortunate to have many experienced insurance agents, advocacy representatives, and providers who work with the customers who will participate in Arkansas Works, and can provide valuable assistance with development and distribution of educational materials to ensure Arkansans have access to the information they need. ABCBS is eager to provide our help with this initiative, as well as several other suggestions provided below that we hope will be useful as DHS considers opportunities to minimize churning.

Comments

Like other public plans and as demonstrated in HCIP, Arkansas Works enrollees will continue to experience change that occurs due to income fluctuations as individuals change jobs, experience reductions or increases in hours and pay, seasonal shifts in work, changes in household arrangements and financial support, and other personal circumstances that lead to shifts in coverage, all of which contribute to the current churn between Medicaid, HCIP, and subsidized QHP coverage. With the Arkansas Works premium payment requirements and the new ESI premium subsidy program intially focused on the small group market, additional churn may occur as follows:

- Although we realize that individuals will not be dis-enrolled for non-payment of premiums, some individuals may be confused by the implications of non-payment or "past due notices" and may not complete the reapplication process based on the belief they are no longer eligible for the program. Others could discontinue using their plan if they think coverage is no longer effective. This could be particularly problematic in the small group ESI market as individuals with chronic conditions might not receive treatment they still have access to, resulting in more missed work due to health issues. An effective communication plan will be critical to ensure enrollees understand their coverage has not changed and continue to see their PCP and use their health benefits.
- Some families covered by Arkansas Works will have a mix of coverage types with inconsistent enrollment periods and varying re-determination dates. A family that shares identical qualifying income information could have children in traditional Medicaid, one adult in an Arkansas Works QHP and another in an ESI premium assistance plan. The complexity of navigating these programs and the renewal requirements will be challenging for many and is likely to contribute to temporary episodes of uninsurance as individuals do not understand the varying re-enrollment requirements or fail to meet deadlines for completing the process for three separate programs.

Suggestions

While churning between health plans cannot be entirely eliminated, minimizing the occurrence and the consequences of churning is important to maintain continued coverage and health care, and reduce costs for both the State and QHPs. While the initial structure of the program places specific boundaries around what is acceptable ESI coverage, this will become a more significant issue as Arkansas Works expands beyond the small group market into large group and self-funded group health plans. As both an Arkansas Works participating QHP and a small employer benefit plan for employers who are likely to choose to participate in the new ESI program, we offer the following suggestions for your consideration:

- Work with health plans, the Third Party Administrator (TPA), insurance agents and other stakeholders to develop the State's waiver evaluation strategy related to eligibility information, enrollment communications, and measuring the occurrence and impact of churn on enrollees, DHS, and QHPs and small employer health plans. Include an evaluation of the process, enrollee touchpoints, and administrative costs associated with premium and cost sharing processing, incentives reward tracking and reporting, reconciliation tracking and reporting, and other costs identified by the strategy team. Based on findings, develop targeted strategies to address contributing factors that can be controlled or minimized.
- For individuals enrolled in a QHP who subsequently have access to ESI, allow them to remain in the QHP until the annual re-enrollment period occurs. This will improve the continuity of care by

providing enrollees an adequate time period for the transition, and will reduce costs associated with enrollment changes.

- For families with members in multiple programs (including Medicaid, Arkansas Works and/or ESI premium subsidies), coordinate re-eligibility determinations to create one single renewal period for all family members. While this will require some additional effort by DHS, the long term benefits of improving the process for enrollees, reducing lapses of coverage, and reducing DHS and QHP administrative costs associated with multiple renewals and churn should be worth the effort. Agents can play a valuable role in the area.
- Ensure any premium past-due notifications sent by Arkansas Works or QHPs **clearly state** the individual will not lose coverage and should continue to use his/her health plan benefits. Studies have shown that consumer behavior is driven by people's perceptions of costs and penalties, whether accurate or not[1]. While we do not want to minimize the importance of premium payments and the personal responsibility it encourages, we also want to ensure individuals do not mistakenly believe they have lost coverage or fail to complete re-eligibility forms based on the perception they no longer qualify for coverage, which defeats the entire purpose of Arkansas Works.
- Work with QHPs, the TPA, small groups and agents to track administrative activity and costs associated with transitioning members between the various programs. Based on findings, consider continuous process improvements and enhanced administrative efficiencies to improve enrollment transitions between programs.
- Conduct periodic but regularly scheduled focus groups, stakeholder meetings and/or surveys of individuals who have experienced churn to identify contributing factors and potential solutions.
- Create a working group with QHPs, ESI health plans representatives, insurance agents, small employers and stakeholders to assist DHS in the development of a comprehensive Outreach and Education Program targeted to specific groups, such as employers, employees, agents, current HCIP enrollees and the general public. Use the work group to also identify opportunities to reduce churn and increase ESI uptake.
- Work with QHPs, small employer health insurers, providers and stakeholders to develop a policy to minimize disruptions of care and allow continuity of care for enrollees transitioning from one plan to another.

Eligibility and Enrollment Processes

Enrollment Requirements and Restrictions

Comments

As operational requirements are developed, we encourage DHS to address reconciliation of Arkansas Works enrollment periods and waiting periods under ESI with the requirement to effectuate coverage of new Arkansas Works enrollees beginning on the first day of the month in which a member applies for coverage. Include consideration that most small businesses have under ACA a a waiting period that cannot exceed 90 days from date of employment before an employee is eligible for enrollment. A typical small group employer will have a 60 day waiting period for full time new hires.

[1] Short PF, K Swartz, N Uberoi, and D Graefe. 2011. Realizing Health Reform's Potential: Maintaining Coverage, Affordability, and Shared Responsibility When Income and Employment Change. New York: The Commonwealth Fund.

Suggestions

- Consider if DHS will ask employers and small employer health insurers to disregard the waiting period for enrollment in the ESI for Arkansas Works enrollees. If so, applicable Arkansas Insurance Department regulations may need to be amended.
- If not, DHS could temporarily enroll individuals in fee-for-service Medicaid, or allow the individual to select a QHP. If this is the approach, we again note this practice would contribute to the enrollment transition process previously discussed.

Enrollment of New Small Employers in ESI Premium Assistance

Comments

On page 10, Section II 1. *Implementing a Premium Assistance Program for ESI*, the extension application explains that "In the first year of ESI premium assistance," eligible small employers interested in participating in the ESI premium assistance program will notify the State that their plan meets cost-effectiveness criteria (i.e., the employer covers at least 25% of the premiums) and opt in to participate in the ESI premium assistance program. The State then matches individuals who are eligible for Arkansas Works against a list of participating ESI employers. However, the extension application does not indicate if employers can apply at **any time** during the first year to become participating ESI employers, or if their enrollment is limited to a specific time frame prior to the beginning of the ESI program.

Suggestions

Depending on the answer to this question, the following may apply:

- If an employer is allowed to join at any time, we suggest DHS consider allowing employees who are already enrolled in an Arkansas Works QHP to remain in their QHP until their next re-enrollment date, rather than requiring the individual to switch to the newly available ESI plan immediately.

Employer Disenrollment or Cancellation of Coverage

Comments and Suggestions

We encourage DHS to consider the following plan administration scenarios; we will be happy to collaborate on decisions that are appropriate for an ESI market:

- Once enrolled in the ESI program, can an employer voluntarily withdraw from participation in the ESI premium assistance program? If so, are there any limitations or restrictions?
- If an **employer** fails to remit timely premiums to the insurance carrier, and the policy is cancelled, will the employees participating in ESI automatically be transitioned to the standard Arkansas Works, or with they have to re-apply for Arkansas Works? For purposes of the **incentive benefit**, will employees be penalized for failure of the **employer** to timely remit premium payments?

Enrollee and Employer Education

Comments

As discussed above, implementation of a comprehensive employee and employer education program will be critical to ensure the success of the ESI premium assistance program and minimize the potential for disruptions in benefits. Education materials will have to be developed that meet the needs of both current HCIP enrollees who must understand how their coverage is changing under ESI, as well as new enrollees who have no experience with HCIP or Arkansas Works and may have never had a health insurance plan. Employers and agents will expect a simple, easy and responsive open enrollment and ongoing benefit administration process.

Suggestions

We encourage DHS to consider the following plan administration scenarios and will be glad to work with you to provide additional information on options that are appropriate for an ESI market.

- Enrollees may not be aware of or understand the requirement to present two separate insurance cards when obtaining health services, which will create administrative challenges for providers, enrollees and health plans. In some cases (especially for new patients), providers may refuse to provide services without both cards, delaying enrollees' access to necessary care. In addition to a clear, simple communication program specifically targeted to ESI enrollees, also include a provider education and communications program that instructs them how to handle situations where an enrollee doesn't present both cards. For example, encourage providers to copy both cards during the patient's initial visit so the information is available if the enrollee forgets a card in the future. Provider education will be especially important since some providers in an employer health plan network may not be Medicaid providers.
- Enrollees and the provider community may not understand the concept of "wrap benefits" and may not be aware of services covered under the Arkansas Works ESI plan if they are relying solely on the summary of benefits provided by their employer health plan. Conveying this information in a simple, easy to understand explanation will be critical to ensuring members and providers are aware of the full scope of benefits available to them under Arkansas Works – ESI benefits.
- Enrollees who are transitioning from HCIP to ESI under Arkansas Works may have other family members who will continue to be covered under their current Arkansas Works QHP. These enrollees will need to understand that the change to ESI only impacts their health coverage; other family members will not be affected by the change, and should continue seeing their existing health care providers.
- To assist enrollees transitioning from HCIP to ESI, we recommend developing targeted information materials to help them understand the differences in their new coverage and provide a simple Q&A for questions they are likely to have. The materials should address such things as differences in provider networks, any differences in benefits, and the availability of wrap services. Enrollees will also need access to customer support services from both DHS and the ESI plan support staff who are trained to address the questions individuals will have. These changes can be challenging for individuals who have limited experience with the health care system, particularly those with chronic conditions or individuals who are currently involved in a care plan for a serious illness.
- New education materials and an outreach strategy should also be developed for small business owners. As a small employer health benefit plan provider in Arkansas, ABCBS has extensive

experience working with small businesses owners throughout the state. The majority of these owners wear many hats as small employers, and are usually overwhelmed by the complexities of purchasing a group health benefit plan. We have learned that those who offer insurance do so because they care about their employees and want to do "the right thing," but require a great deal of assistance when selecting a health plan. The added complexity of understanding the implications of the premium assistance plan will require additional time with each small employer, and development of financial proposals tailored to each individual business' individual circumstances. Additionally, we anticipate that most employers will want assistance with explaining the ESI premium assistance to employees they believe may be eligible.

Because of the relationship they have with small employers and their experience working with employee benefit plans, insurance agents bring a valuable perspective to this process and should be included as partners working with DHS, QHPs and the TPA to ensure a coordinated strategy for educating and working with employers and employees.

To facilitate employers' understanding of the program and ensure a consistent, uniform messaging strategy throughout the state, we offer our services to DHS to assist in the development of employer and employee educational materials to ensure the information is clear, written in easily understood terms, and comprehensive in the explanation of how the program works. We have a highly trained, experienced group of agents who specialize in working with small business owners and urge DHS to use our expertise to develop user-friendly materials that sufficiently address the many questions employers and employees will have. Doing so will significantly reduce the volume of questions posed to DHS staff during the roll-out of the new program, will smooth the transition process for enrollees, and will likely increase initial participation in the ESI program.

Additional Provisions/Comments

Cost-Sharing Reductions & Cost Sharing Wraps

Because of the complexities of the cost sharing reconciliation process, we suggest that DHS work with QHPs to discuss the implementation of this important process to identify any concerns or problems and minimize operational issues that may occur. While we understand the concept is very similar to the HCIP process, differences between the two programs may require some modification due to program variations.

Eliminating Retroactive Coverage

On page 14, the application indicates that "individuals will become eligible for Arkansas Works coverage at the point that they apply for coverage under Title XIX." Later, on page 15 under "Waivers", 6th bullet, you request an exemption from the requirement to provide coverage "any time prior to the first day of the month in which an individual applies." Similar information is included in the table on page 17, under the *Use for Waiver/Expenditure Authority for §1902(a)(34*). These two statements appear to conflict; in the first, it appears coverage is effective on the day a person applies; in the second and in the table, it appears the intent is to make coverage effective the first day of the month in which an individual applies. To ensure consistency and avoid any confusion, we suggestion you consider refining the language as appropriate based on your intent.

Improving Program Benefit Design

As the participation in Arkansas Works continues to grow, addressing existing benefit structure and plan design requirements that encourage inappropriate use of care or are not cost-effective becomes increasingly important. Based on recent Legislative discussions and the State's increasing focus on Medicaid reform, we strongly recommend that DHS work with participating QHPs to review existing program design provisions to ensure requirements incentivize and reward employees for appropriate, responsible behavior. While there are numerous specific changes that should be addressed, an example is the requirement for enrollees to make co-payments for PCP visits and **no** co-payment requirement for Emergency Room (ER) visits. While the co-payment requirements may seem minor, the message to enrollees is that ER visits are acceptable and encouraged by the absence of a co-pay requirement. We want to increase the use of primary and send the message to enrollees that an ER visit is not a substitute for a visit to your PCP and should only be used for emergency situations.

While we do not want to discourage enrollees from accessing ER services when appropriate, we suggest imposing a small ER co-payment requirement that should be at least equal to, if not more than, PCP co-payment requirements. Ideally, we suggest removing co-payment requirements for all PCP visits as a clear message to enrollees that their first choice for care should be the PCP when appropriate. We also suggest evaluating co-pays for urgent care centers or clinics with extended office hours to ensure co-payment costs are also lower than those for ER services. Along with these changes, we would also like to see an ongoing, collaborative effort between DHS, QHPs, and providers to improve education of enrollees regarding the appropriate utilization of health plan benefits, with a focus on the importance of visiting their PCP.

This is just one obvious benefit design change that is consistent with the Arkansas Works philosophy of improving patient responsibility. ABCBS welcomes the opportunity to provide recommendations for additional plan design changes that we believe will further encourage the appropriate utilization of health care, improve cost effectiveness, and further promote the Arkansas Works goals of emphasizing personal responsibility, promoting work, and enhancing program integrity.

Trend Assumptions

In Section V, you propose an annual cost growth rate of 4.7%, consistent with the current waiver and suggest considering a higher trend assumption based on claims and utilization experience. As the market has evolved, enrollees have become more knowledgeable about getting coverage and how to access care in the system after they are covered. This has increased utilization and among a higher prevalence of individuals with greater health care needs. Arkansas' experience with Medicaid Expansion and Exchanges is similar to most other states and, in fact, had less cost increases to-date.

A trend in the 6-7% range may be more reflective of the market for the next few years. We would be glad to provide additional data and analysis to support this recommendation. Based on our financial experience, MLR, cost trends, and our own future projections, we would welcome the opportunity to meet with DHS and Optumas to discuss this decision prior to submission of the application to CMS.

In addition to medical trend, there are other factors that will drive increases in rates during the proposed waiver period. First, the ACA health insurer fee is scheduled to resume in 2018 and then increase. Second, the period of the initial waiver, 2014-2016, was supported by the federal transitional reinsurance program, which expires in 2017. This suggests a specific change to the 2017 rate levels

would be appropriate. Third, when Medicaid begins to apply quarterly out-of-pocket maximums within this program, cost-sharing reduction payments will have to increase. This increase should be included in the overall budget targets, even though this will not affect Marketplace premiums. Lastly, the State has previously reported that the original demographic composition projected for the initial waiver period ended up understating the Budget Neutral costs. Corrected demographic assumptions should be applied to establish a better 2017 budget neutral calculation."

Workforce Development

While we understand that federal requirements limit the direct linkage of Medicaid programs to work requirements, we believe that there are appropriate ways to effectively align with the "works" part of Arkansas Works. This would include collaborating with state, education and community organizations to support members with employment and career development. We look forward to the opportunity to provide leadership in this area.

Conclusion

As previously stated, we are impressed with Arkansas' innovative leadership and know that DHS understands the challenges of launching such a new program and sincerely appreciate your ongoing engagement with ABCBS and other stakeholders. We realize much of the work on implementation is just beginning, and many important decisions will be made in the days ahead. As the largest health plan in Arkansas, the largest QHP in both the Private Option and the Arkansas Exchange, a leader in the small employer market, and a partner with the State's health care practice and payment transformation programs, Arkansas Blue Cross Blue Shield is committed to supporting the State through this transition period and continuing our partnership in the years ahead. As you continue to develop the operational and go-to-market plans for Arkansas Works, we look forward to working with you to build a successful program and provide critical services to improve the health, workforce and economy for all Arkansans.

Thank you for the opportunity to provide these comments. Please let us know if you have any questions or would like additional information on any of the suggestions or comments.

From: Giamfortone, Joseph <joseph.giamfortone@hms.com>
Sent: Friday, June 17, 2016 11:55 AM
To: DHS DMS HCIW
Subject: Arkansas Works Public Comments-RW-NW (003).docx
Attachments: Arkansas Works Public Comments-RW-NW (003).docx

HMS is pleased to have the opportunity to provide our comments on Arkansas Medicaid's 1115 Demonstration Waiver application. Please see our comments that are attached.

Thank you for this opportunity to provide our views on this important topic.

Sincerely,

Joseph E. Giamfortone
Government Relations Director
HMS

June 17, 2016

Division of Medical Services
Program Development and Quality Assurance
P.O. Box 1437 (Slot S295)
Little Rock, Arkansas 72203-1437

RE: Comments on the Proposed Extension for and Potential Modification to the 1115 Demonstration Waiver for the Health Care Independence Program

Health Management Systems, Inc. (HMS), is pleased to submit comments to the Arkansas Division of Medical Services, for consideration as it gathers information on the proposed extension to the Section 1115 waiver for the Health Care Independence Program known as *Arkansas Works*.

In accordance with guiding principles detailed in the 2016 Arkansas Works Act, HMS recommends several ideas in order to further promote and maximize employer based insurance and enhance program integrity.

Promoting & Maximizing Employer Based Insurance

In the waiver application, the Division describes the enrollment process, which includes a step to identify whether a Title XIX eligible individual is employed by a participating employer for purposes of assessing that individual's eligibility for the mandatory Employer Sponsored Insurance (ESI) Premium Assistance Program. Indeed, this process will help to identify individuals who have access to ESI, but are not currently enrolled in that ESI. However, there is no detail on how to confirm ESI that is self-reported in the application; activity to search for undisclosed ESI at application and throughout the coverage period; or the role of the qualified health plans (QHPs) in ascertaining and maximizing ESI throughout an applicant's coverage period.

Nationally, on average, over 10% of Medicaid members have additional forms of health insurance coverage. While having other health insurance coverage and being on Medicaid is permissible, both federal and state law, §1902(a) (25) of the Social Security Act and Arkansas General Statutes § 20-77-306, respectively, require that Medicaid pay last.

As such, HMS recommends the following additional steps to further promote and maximize ESI throughout various intervals in the Arkansas Works program while ensuring that Medicaid pays last.

Recommendations

1. Electronically validate applicant self-reported health insurance information at the point of enrollment.
2. Electronically search for undisclosed health insurance coverage at the point of applicant enrollment.
3. Ensure ongoing checks for changes to a Medicaid members' other health insurance coverage.

4. Develop a process by which QHPs must routinely leverage ESI when known, and continue to search for unknown ESI throughout the beneficiary's enrollment in the QHP.
5. Make the ESI Premium Assistance Program mandatory for employers.

Each of the above listed recommendations are detailed as follows:

1. **Validate Self-Reported Applicant Health Insurance Information**
   Today, as part of the application process, applicants' self-report enrollment in other health insurance coverage, albeit an employer sponsored plan, a spouse's plan, Medicare, COBRA, etc. Self-attestation is routinely accepted by states for its face value. However, in order for the insurance to be meaningful, and it is maximized as early in the process as possible, **HMS recommends such disclosed health insurance information be electronically validated at the point of enrollment**. This will allow Medicaid to be the secondary payer immediately upon consumption of services.

2. **Search for Undisclosed Health Insurance Information at Enrollment**
   Sometimes applicants do not realize they have other health insurance coverage, or they choose not to disclose the other health insurance out of fear of being disqualified for Medicaid. Hence, states including Arkansas, already employ processes to search for undisclosed health insurance coverage on behalf of Medicaid beneficiaries. However, today, there is approximately a lag time between 45-90 days from when an applicant is determined Medicaid eligible before a search is conducted for other health insurance coverage. Consequently, due to this lag time, Medicaid is often forced to seek retrospective recoveries for the most significant and costly consumption period.

   Furthermore, the lag time from the point of enrollment to the identification of, and coordination with, other health insurance coverage does not become any less problematic in the Arkansas Works model. In its waiver application, Arkansas proposes that any Arkansas Works beneficiary who does not select a QHP within 42 days will be auto-assigned a QHP, providing up to 42 days of interim fee-for-service (FFS) coverage.

   For these reasons, **HMS recommends that Arkansas move the prospective identification of other health insurance coverage as close to the point of enrollment as possible**. As an added benefit, the state will be able to reduce the pay and chase activity by validating disclosed coverage at enrollment and searching for undisclosed coverage at enrollment. This is very important because, while highly effective, unfortunately pay and chase efforts do not result in the recovery of all claims that should have been the responsibility of another health insurer.

   In fact, a federal audit report issued in January, 2013 by the Department of Health and Human Services, Office of Inspector General, states that challenges remain in recovery of overpayments due to other health insurance coverage. According to the report, "As of June 30, 2011, 44 States cumulatively reported $4.1 billion that they believe is owed by third parties and is at risk of not being recovered."

3. **Ensure Ongoing Checks for Changes to Other Insurance Coverage**
   Medicaid applicants' access to other health insurance coverage is dynamic. As their economic and employment situations change, so does their access to health insurance coverage, particularly ESI. Therefore, identifying health insurance coverage solely at time of application does not account for a Medicaid member's movement in and out of other health insurance coverage over time. For these

reasons, **HMS encourages the Division to continue to routinely search for changes to a Medicaid members enrollment in other health insurance coverage.**

4. **QHPs Must Play an Active Role in Promoting and Maximizing ESI**

The current and proposed waiver is silent on the role that QHPs will play in identifying and coordinating with other health insurance coverage for their enrollees.

Over the past 15 years, states have increasingly relied upon Medicaid Managed Care Organizations (MCOs) to provide services to the Medicaid population. In these instances, Medicaid must still remain the payer of last resort. Arkansas Works role for QHPs can be likened to the usage of MCOs by other states and policies must be in pace to ensure the QHPs are searching for unknown and coordinating with known, other health insurance coverage.

There are numerous models that Arkansas could elect as detailed in an August, 1997 State Medicaid Director letter and referenced immediately below. All of these models are evident across states today and will be just as important for Arkansas to consider in its Arkansas Works program:

1. Exclude or dis-enroll individuals with known TPL from enrollment in MCOs (QHPs in Arkansas' case).
2. Allow individuals with TPL to receive coverage through MCOs (QHPs), with the state retaining TPL responsibility.
3. Require Medicaid MCOs (QHPs) to assume TPL responsibilities through a reduction in capitation payments reflecting the amount of projected TPL the plan should recover or has historically recovered.
4. Exclude or dis-enroll individuals with commercial managed care TPL coverage. Allow individuals with noncommercial (i.e., Medicare) managed care TPL coverage to receive Medicaid services through the MCO (QHP), with the MCO (QHP) assuming TPL responsibilities, but the state retaining responsibility for tort and estate recoveries.

HMS recommends that the Arkansas Division of Medical Services:

1. Select a model for TPL as described above.
2. Ensure that clear language identifying the QHP's TPL responsibilities is included in the waiver and MOU between the state and the QHP.
3. If delegating any TPL responsibilities to the QHPs:
   a. Account for TPL in the capitation rate setting process and ensure proper payment incentives are in place to reflect and maximize QHP TPL efforts.
   b. Require TPL results reporting from the QHPs and detail reporting requirements in the final MOU between the QHP and the state.
   c. Ensure proper oversight by the state through TPL safety net reviews, no sooner than one year from the date of service.

5. **Make the ESI Premium Assistance Program Mandatory for Employers**

HMS applauds the state of Arkansas for its proposal to include a mandatory ESI Premium Assistance Program as part of this waiver application. This requirement will help to ensure that Arkansas Medicaid will remain the payer of last resort and help to maximize ESI.

Medicaid agencies implement premium assistance programs to pay for Medicaid beneficiaries' commercial premium contributions when the beneficiaries' annual medical expenses outweigh the

cost of their annual premium contribution. Such programs save states millions each year by appropriately redirecting the health insurance costs to the responsible commercial insurer and maintains Medicaid's payer of last resort status. Beneficiaries frequently find these programs attractive because in many cases, the whole family can receive coverage under the commercial insurance policy, at no additional cost to them or to Medicaid. Additionally, beneficiaries generally have access to more providers because commercial insurers have historically enjoyed greater provider participation than experienced by Medicaid. At the same time, providers also find premium assistance programs attractive because reimbursement rates are generally higher under commercial insurance coverage as compared to Medicaid reimbursement rates.

The most successful premium assistance programs nationally mandate not only beneficiary participation, but also, employer participation. Without a mandate for both, success of the premium assistance program is significantly stymied. An employer mandate in the Arkansas ESI Premium Assistance Program is not a mandate to offer health insurance coverage to employees, rather it is a mandate requiring employers to share health insurance coverage information with the state in order to determine if Medicaid applicants and members have access to ESI, but are not enrolled.

Historical opposition to the employer mandate has been riddled with fallacies. Opponents have alleged that such programs increase costs to employers by shifting the coverage responsibility from Medicaid to the employer, particularly when such programs seek to identify the most costly Medicaid beneficiaries.

First, it's important to note that the employer is already offering health insurance coverage to the Medicaid applicant/beneficiary, but for whatever reason the Medicaid applicant/beneficiary is not enrolled in the ESI. Second, cost effectiveness tests often leverage historical utilization data to ensure it makes financial sense for Medicaid to pay the employee's premium share for the ESI. In the case of Arkansas Works, utilization will not be part of the cost effectiveness test. As a result, any argument of dumping high cost Medicaid beneficiaries back onto the employer is simply not accurate.

Lastly, concerns that by adding these otherwise eligible members onto their ESI will increase costs for the employer should also be rejected. The Affordable Care Act contained numerous rating rules that limit an insurer's ability to increase premium costs for employers and again, these employees, and dual Medicaid beneficiaries, were already entitled to participate in the ESI.

HMS highly recommends that Arkansas mandate employer participation in the ESI Premium Assistance Program. Additionally, should Arkansas maintain a phased in approach to the ESI Premium Assistance Program, **HMS recommends that the state start implementation of the ESI Premium Assistance Program with large employers, rather than small as currently proposed in the draft waiver.** This will help create a more sustainable program, and maximize the savings to the state in the most efficient way possible.

Enhancing Program Integrity

Program Integrity Roles and Responsibilities Given that QHPs are similar to MCOs, and QHP coverage is funded by state and federal taxpayer dollars, **HMS strongly recommends that Arkansas revisit what program integrity looks like in Arkansas Works - what efforts must be conducted to ensure taxpayer dollars are appropriately spent and by whom.**

States and MCOs have struggled with these questions for years and several state and national reports highlight the challenges with program integrity in a managed care environment, which is again directly pertinent and conveys to Arkansas Works use of QHPs. In a December 2011 report by the Department of Health and Human Services Office of Inspector General (OIG), *Medicaid Managed Care: Fraud and Abuse Concerns Remain Despite Safeguards, it* noted the key vulnerability as services billed by providers, but never actually rendered. In this same report, the MCOs and States expressed concerns about provider and beneficiary fraud and abuse, including rendering services that are not medically necessary, upcoding by providers, questionable beneficiary eligibility, and pharmaceutical abuse by beneficiaries.

In June 2014, the Government Accountability Office (GAO) released a report, *Medicaid Program Integrity Increased Oversight Needed to Ensure Integrity of Growing Managed Care Expenditures*, highlighting significant gaps in state and federal efforts to ensure Medicaid managed care program integrity. The report did not detail how states or the federal government should specifically apply program integrity oversight, but rather focused more generally on areas that need more oversight, including a recommendation to require states to audit payments to and by MCOs. The report also recommended that CMS update guidance on MMC program integrity and provide audit tools and assistance to states for this purpose.

In May 2016, CMS released final rules, that in part, provide additional guidance on the roles and responsibilities for program integrity in a Medicaid managed care environment. *Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability* proposes some basic program integrity roles by party. For example, MCOs have to report overpayments to the states within 60 days; states have to screen and enroll all MCO network providers, review the accuracy and completeness of encounter data, and validate medical loss ratio (MLR) annual reports, just to name a few. **HMS recommends that Arkansas leverage the new MCO rules to devise a principled, strategic approach for that includes**:

1. Seeking subject matter expertise to develop a compliant, comprehensive, transparent and collaborative program integrity approach in Arkansas Works.

Oversight in a managed care-like environment is distinctly different than oversight in FFS. Expertise is needed to understand and mitigate against pitfalls and leverage lessons learned from more mature managed care and managed care-like models.

2. Implementing wide-ranging, but coordinated program integrity strategies concurrently with the launch of Arkansas Works.

Many states focus on operations when rolling out Medicaid managed care and Medicaid managed care-like programs, but equal effort should be applied to the administration, including the application of program integrity initiatives. Doing so ensures that the inherent promises of managed care, and in Arkansas' case, QHP coverage, which includes better, more cost effective care, are in fact realized.

At the same time, many states take an initial, narrow approach to program integrity in a managed care environment which hinder these promises. For example, states sometimes hinge program integrity efforts on the timely reporting of encounter data, but do little, if any, analysis of the encounter data or review the analysis done by the MCOs. A broader approach to program integrity that includes substantive contract

compliance, quality measures and ongoing reviews of payments to QHPs and payments by QHPs is highly recommended.

3. Ensuring clear delineation of program integrity responsibilities between the QHPs and state staff and/or state contractors through MOUs and/or statutory and/or regulatory guidance.

There is an appropriate role for each of these entities, but it's imperative for ease of administration and efficiency that the roles and responsibilities be clearly defined, coordinated and results shared. Without this, duplication and provider and payer abrasion is likely. Care to beneficiaries may also be compromised. Furthermore, areas in need of additional oversight may go undetected without clear and transparent roles and responsibilities.

4. Providing adequate remuneration and incentives to all entities responsible for oversight.

Any worthwhile program integrity initiative drives significant return on investment; however, upfront and ongoing resources are required to maintain these efforts. It's important that states recognize these costs and account for them both in terms of ensuring the rightful assignment of these responsibilities, as well as properly remunerating the responsible entity for carrying out assigned responsibilities.

5. Imposing sanctions for noncompliance.

Like many compliance programs, application of both incentives and disincentives is necessary to ensure the assigned responsibilities are completed accurately, and if not, there are tools available to change behavior.

HMS applauds Arkansas for their vision in moving the Medicaid program forward through Arkansas Works. We appreciate the opportunity to submit these comments and look forward to providing any additional information that the Division may need to assist them in this process.

Sincerely,

Joseph E. Giamfortone
Director, State Government Relations

From: Marquita Little <mlittle@aradvocates.org>
Sent: Friday, June 17, 2016 10:14 AM
To: DHS DMS HCIW
Cc: Rich Huddleston; Dawn Stehle
Subject: 1115 Waiver Comments from AACF
Attachments: AR Works Comments_AACF 6.17.16.pdf

Attached please find comments from Arkansas Advocates for Children and Families on the 1115 demonstration waiver. Thank you for the opportunity to submit comments on the Arkansas Works plan. We look forward to continuing to work together to ensure all children and families in Arkansas can live healthy, productive lives.

Thanks,

Marquita Little

Marquita Little | Health Policy Director
Arkansas Advocates for Children and Families
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June 17, 2016

Dawn Stehle, Division of Medical Services Director
Arkansas Department of Human Services
P. O. Box 1437, Slot S295
Little Rock, Arkansas 72203-1437

Ms. Stehle:

Arkansas Advocates for Children and Families (AACF) applauds the work to continue the Medicaid expansion program in Arkansas. Because of the great success of the Private Option, Arkansas leads the nation in reducing the number of uninsured adults. Over 250,000 low-income Arkansans now have comprehensive health coverage, many for the first time. Moving forward, the transition to Arkansas Works will safeguard access to coverage for hundreds of thousands of hard-working families.

AACF also appreciates the thoughtful process that allowed stakeholders to have an active voice in shaping the program and offering Governor Hutchinson and legislators important feedback through the Health Reform Legislative Task Force. This demonstrates the commitment from leaders in our state to ensure all Arkansans, including the most vulnerable, have access to care regardless of their income and also a commitment to transparency and public engagement.

There are several concerns that we would like to highlight as the state moves forward with the implementation of Arkansas Works.

Employer Sponsored Insurance (ESI)

Our key concern regarding introducing subsidized ESI as a feature of the Arkansas Works program is the need for careful coordination to ensure the program is easy for enrollees to understand, navigate, and access their full benefits package. Many of the individuals enrolling in ESI have previously had to make contributions through an Independence Account. DHS should ensure these individuals are appropriately informed about changes to their coverage and counseled about how to pay the monthly premium, access doctors in the network, and other key changes. We learned a great deal about the importance of a simple and well-coordinated process from the complicated and costly implementation of the Independence Accounts. Both the necessary resources and time must be allocated to develop the needed IT platform and a coordinated system. For example, DHS should also explore solutions that will not require enrollees to carry two cards, both the ESI card and Arkansas Works

card, to avoid any confusion for providers and enrollees. This approach may be the best option today to ensure wraparound benefits are accessible, but DHS should consider the possibility of rolling out a single card with a special designation for Arkansas Works enrollees in the future.

We also are very concerned about the ability for beneficiaries to access benefits and cost-sharing protections provided as a wraparound to their ESI coverage. We appreciate the state's commitment to ensuring that benefit and cost-sharing protections are made available to beneficiaries. However, research has shown that there are reasons to be concerned about the implementation of premium assistance programs that wrap around employer-sponsored coverage. In particular we wish to clarify that all providers in the employer's network, regardless of whether they participate in the Medicaid program, will be required to charge Medicaid's lower cost-sharing levels and educated on the need to do so. This is important since Medicaid consistently offers enrollees more affordable coverage than ESI.

In addition, accessing services that may not be available under ESI may prove challenging for beneficiaries. Again, it is important to ensure that an ESI participant is not required to go to a Medicaid participating provider for a covered service and that providers who have not previously worked with Medicaid will understand that wraparound services are available and how to bill using a patient's client identification number.

DHS should also articulate how transitions will be managed if an enrollee becomes unemployed and is no longer qualified to be covered by ESI. This will require a seamless transition to a QHP to ensure there are no gaps in coverage.

The state should not seek a waiver to avoid providing non-emergency transportation to enrollees covered through ESI. Research shows that lack of transportation reduces utilization of health care services among low-income people. While many families may rely on alternative methods, like public transportation for their routine travel to and from work, their access to transportation to doctor's appointments may still be limited. In addition, in most parts of the state, public transit is not even available. Non-emergency transportation is a critical benefit that can help to prevent chronic conditions, such as diabetes and cardiovascular disease, from worsening.

The waiver indicates ESI sponsored coverage may be expanded to spouses or dependents of Medicaid-eligible individuals in the future. We strongly recommend DHS maintain the current ARKids First program because it's working for kids and families. The ARKids First program has been hugely successful in reducing rates of uninsured children in our state to under 5 percent and ensuring they receive comprehensive, affordable coverage. We have serious concerns about the likelihood of successfully providing the EPSDT benefit for kids through an ESI wraparound. There is no clear rationale for disrupting coverage for kids. Unless it can be demonstrated that this would be a cost-effective option that does not reduce access to coverage or care, the ARKids program should continue to function as it does today.

90 Day Retroactive Eligibility

Medical emergencies are unpredictable and costly. The 90-day retroactive eligibility policy helps safeguard low-income families from incurring medical debts that they are unable to pay. Health care providers and the state also benefit from retroactive eligibility. Doctors and clinics are not left with unpaid bills for treatment they've provided, and the state has been able to reduce uncompensated care spending. Though the proposal to eliminate retroactive eligibility would create similar enrollment processes for Arkansas Works and insurance carriers, the financial risk of removing retroactive coverage outweighs any potential benefit. It is even more critical because of significant delays families currently experience between the time they complete the application and are successfully enrolled in a health plan. Finally, 90-day retroactive eligibility is essential, since the state has not implemented presumptive eligibility, which would allow individuals in need of care to enroll quickly and avoid the administrative delays that plague our system today.

Premiums for Enrollees

Although the state currently requires some enrollees to make payments to an Independence Account, the proposal to establish fixed monthly contributions (up to $19) would function like premiums. Federal regulations prohibit premiums for individuals earning less than 150% FPL. Also, extensive research shows that even small fees can be a barrier to enrolling in coverage and accessing treatment. Furthermore, enrollees will incur a debt to the state if the premiums are not paid. While this is an improvement from more dangerous proposals to lock individuals out of coverage, it will still create a hardship for many low-income families and depress enrollment.

In addition to the concerns raised above, AACF is proud of the steps our state has taken to continue to improve the health of enrollees. Offering incentive benefits to encourage enrollees to receive preventative care is an important feature of Arkansas Works. With adequate coordination and consumer outreach and education, this is a promising policy to support the health and well-being of Arkansans. We would also strongly encourage the state to engage AACF and organizations with expertise in health literacy to assist with the development and review of enrollee notices and educational materials. Consumer education will be critical to the successful implementation of these policy changes.

AACF is proud of the progress in Arkansas to maintain affordable coverage for uninsured adults, and we think it is vitally important to support the successful implementation of Arkansas Works.

We look forward to continuing to work together to ensure all children and families in Arkansas can live healthy, productive lives. Thank you for the opportunity to submit comments on the Arkansas Works demonstration waiver.

Respectfully,

[redacted]

Rich Huddleston
Executive Director
Arkansas Advocates for Children and Families

[redacted]

Marquita Little
Health Care Policy Director
Arkansas Advocates for Children and Families

From: Stephanie Malone <smalone@chc-ar.org>
Sent: Thursday, June 16, 2016 12:29 PM
To: DHS DMS HCIW
Subject: AR Works Waiver 1115 Comments
Attachments: Arkansas Works Waiver - CHCA Response 06-2016.pdf

Please see the attachments for comments regarding the 1115 Waiver. Please feel free to contact me with any questions or concerns.
Thank you

Stephanie Malone
Policy/Advocacy Director
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501-492-8388
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Community Health Centers of Arkansas, Inc.
ARKANSAS PRIMARY CARE ASSOCIATION
Expanding Access to Affordable Quality Health Care

June 16, 2016

Ms. Dawn Stehle
Arkansas Department of Human Services
Division of Medical Services
Program Development and Quality Assurance
P.O. Box 1437 (Slot S295)
Little Rock, Arkansas 72203-1437

Dear Ms. Stehle,

On May 18, 2016, the Arkansas Department of Human Services, (DHS), Division of Medical Services (DMS) issued public notice of its intent to submit to the Centers of Medicare and Medicaid Services (CMS) a written application to request approval from the Secretary of the Department of Health and Human Services of the Arkansas Works Waiver which is a Demonstration Waiver under Section 1115 of the Social Security Act.

On behalf of the Community Health Centers of Arkansas, Inc. (CHCA) and our 11 member community health centers (also known as FQHCs) and their over 70 locations, please accept the following comments on the Arkansas Works Proposed Section 1115 Waiver. As providers of primary and preventive care services to nearly 165,000 low income uninsured and underinsured Arkansans, CHCA and its members applaud the State of Arkansas for its passage of the Arkansas Works legislation during the 90th General Assembly.

Under Section II, Changes Requested to the Demonstration, Item 1 "Implementing a Premium Assistance Program for ESI" will require all individuals enrolled in coverage through Employer Sponsored Insured premium assistance to receive two insurance cards – an ESI plan card and an Arkansas Works card. While the concept is commendable, it is the details that taunt us. Since this program appears to be a voluntary based program there is concern as to exactly how this would all work, especially with the issuance of two separate insurance cards. We have found that simplicity works best with our patient population, and anything that reduces confusion is beneficial. DHS has recently struggled with the eligibility and verification system required under existing CMS requirements and we are concerned with adding another "voluntary" set of verifications scenarios to check against. Again, the details of exactly how a dual insurance card system would be implemented greatly concerns us.

Item 2 " Instituting Premiums for Arkansas Works Beneficiaries with Incomes above 100% FPL" contain some creativity in the offering of incentive benefits for those that pay timely premiums. We applaud the recognition of healthy behaviors, though for clarification, such should be clearly defined. Placing an additional financial burden on this patient population, even though minor in the eyes of you and I that make well in excess of the federal poverty level, can impact access to medical care to our most vulnerable in need of medical care. And, we feel strongly that dental care should be a standard medical care not an "incentive". Many overall health problems can be attributed to oral health and we are concerned that using dental care as an "incentive" is sending absolutely the wrong message about the importance of oral health. If you want to add an incentive, add teeth whitening, or membership to a fitness center.

Under Section III, Waiver 1902(a)(34) "to enable the State not to provide medical coverage to Arkansas Works, beneficiaries for any time prior to the first day of the month in which individual applies" puts an extra burden on the providers that we are sure is unintended. Many of the patients first come to see us without all the proper paperwork for enrollment in insurance coverage, though we work directly with each individual the first time we see them. Medicaid has worked very closely with us and many other providers as we worked through "presumptive eligibility" classification and eventually get proper documentation on our patients. Without such a window of time to get this paperwork done, Medicaid providers will not be able to take patients, and access to care for this patient population will be affected.

And, lastly, under Section III, Waiver 1902(a)(4) insofar as it incorporates 42 CFR 431.53: "To the extent necessary to relieve Arkansas of the requirement to assure transportation to and from medical providers for Arkansas Works beneficiaries enrolled in ESI premium assistance". FQHCs are extremely concerned about the removal of non-emergency transportation as many of our clients rely on this service, especially when it comes to receiving specialty care not available in rural Arkansas. This will create an out of pocket burden on the already struggling class, due to this burden many will stay home and avoid receiving proper care because they cannot afford a trip to the doctor, causing their health to deteriorate and in the long run will cost the state more money. We strongly request this language be removed all together.

Thank you for your attention to our comments. Should you need any clarification to any of our comments, please do not hesitate to contact Community Health Centers of Arkansas at 501.492-8384.

Sincerely,

[redacted]

Mary Leath
Chief Executive Officer

From: Shanna Hanson <shanson@humanarc.com>
Sent: Thursday, June 16, 2016 12:03 PM
To: DHS DMS HCIW
Subject: Waiver Comments
Attachments: Arkansas Works Waiver Comments-Human Arc.doc

Director Stehle,

Please accept the attached Comments on the Arkansas 1115 Waiver Extension Application.
We are available for consultation if we can be of any assistance in this process.

Respectfully Submitted,

Shanna Hanson, FHFMA
Manager, Business Knowledge
Human Arc
Phone: 800.278.5135, x7167 | Fax: 816.363.3535
1001 E 101st Terrace, Suite 210 | Kansas City, MO 64131
shanson@humanarc.com | www.humanarc.com

June 16, 2016

Dawn Stehle, Director
Division of Medical Services
Program Development and Quality Assurance
P.O. Box 1437 (Slot S295)
Little Rock, Arkansas 72203-1437
HCIW@Arkansas.gov

RE: ARKANSAS 1115 WAIVER EXTENSION APPLICATION

Dear Director Stehle:

Thank you for the opportunity to Comment on the Arkansas 1115 Waiver Extension Application (Arkansas Works), published for comment on May 18, 2016 at medicaid.state.ar.us.

I started Human Arc in 1984 with the sole purpose of bridging the gap between available government programs and their intended beneficiaries. Human Arc has expanded over the past 32 years to help hospitals and health plans connect their patients and members to governmental programs and community services. We have helped well over a million people in unfortunate circumstances enroll in Medicaid and have helped many millions find food, clothing, shelter, prescriptions and more. Human Arc has 550+ associates serving the low-income, disabled and elderly population for customers across 40 states. We are a for-profit organization financed by the value received by our customers. **We believe our long history of working with the low income population gives our voice credibility.**

We appreciate the intention of Arkansas Works to emphasize personal responsibility, promote work, and enhance program integrity. **Our greatest concern** with Arkansas Works is the elimination of retroactive eligibility for the expansion population.

RECOMMENDATION

- We propose that the application process be adjusted to allow for 90-days retroactive coverage from submission of application (as it is in current law - 42 U.S.C. §1396(a)(34)), allowing for provider reimbursement during the 90-day period prior to application if an applicant has medical bills during the current month or prior period. Below is a detailed explanation supporting our recommendation.

WAIVER OF RETROACTIVE COVERAGE

The ramifications of the Arkansas Works waiver, as written, will substantially impact the low-income expansion population of the state, particularly those that are uninsured, eligible for Medicaid and in need of health care services. It will also adversely impact the medical providers trying to serve them. Gaps of time without medical coverage for the low income population that are eligible and applying for Medicaid will be significant. Every day we experience situations where uninsured individuals present at a hospital requiring emergency medical treatment and many times are unable to manage an application process due to mental health issues, lack of capability, illness and a myriad of other reasons. In many cases they are unaware of their eligibility for a Medicaid program.

Retroactive eligibility was first enacted in 1972 to protect persons who are eligible for Medicaid but do not apply for assistance until after they have received care, either because they did not know about the Medicaid eligibility requirements, or because the sudden nature of their illness prevented their applying. The provision was amended in 1973 to provide retroactive coverage for persons who died before eligibility could be claimed.[1] This is codified at 42 U.S.C. §1396(a)(34). The Social Security Program Operations Manual System (POMS) states that "Retroactivity is very important.[2]" Is it any less important for the Arkansas Works intended beneficiaries? We believe it is important, even critical, for **all** Medicaid applicants to have access to retroactive Medicaid coverage both for the reasons stated by Congress when it was legislated as well as those we have outlined below.

The following comments and rationale will illustrate that the Arkansas 1115 Waiver Extension Application **does not meet the following criteria** used by the Center for Medicare and Medicaid Services to determine whether Medicaid program objectives are met relative to providing retroactive coverage:

- Increase and strengthen overall coverage of low-income individuals in the state.
- Improve health outcomes for Medicaid and other low-income populations in the state.

Gap in coverage

- **Gap could be days to months or more:** The gap in coverage that will be created by the elimination of retroactive coverage could be devastating to those newly enrolled Arkansas Works recipients who received services prior to their start date. This gap could be substantial, particularly if an individual is denied, requests an appeal which is sustained and eventually overturned. The time frame for application processing could be days to weeks to months or more. Since there is not adequate coverage after a health care emergency, due to the delay from the application process the likelihood of following the intended continuum of care is reduced and health outcomes will be impacted.

Medical Debt

- **Collections, bankruptcies:** Lacking insurance coverage puts people at risk of medical debt. In 2014, according to the Kaiser Family Foundation analysis of 2014 Kaiser Survey of Low-Income Americans and the Affordable Care Act nearly a third (32 percent) of uninsured adults said they were carrying medical debt. Medical debts contribute to over half (52 percent) of debt collections actions that appear on consumer credit reports in the United States and contribute to almost half of all bankruptcies in the United States. Uninsured people are more at risk of falling into medical bankruptcy than people with insurance.[3]

- **Stress:** Collection agencies will be pursuing more people; further stressing the financial, physical and mental health of uninsured and underinsured adults.

The following comments and rationale will illustrate that the Arkansas Works 1115 Demonstration Waiver **does not meet the following criterion** used by the Centers for Medicare and Medicaid Services to determine whether Medicaid program objectives are met:

- Increase access to, stabilize, and strengthen providers and provider networks available to serve Medicaid and low-income populations in the state.

Financial

- **Lost reimbursement:** Millions of dollars annually could be lost in Medicaid reimbursement to hospitals alone, not including other medical providers. Lost Medicaid reimbursement de-stabilizes providers by shifting the cost of care back to the hospitals.

- **Increased expenses and write-offs:** Providers will experience an increase in charity care, and bad debt. The elimination of 90-day retroactive eligibility and reimbursement for serving Arkansas Works beneficiaries will add stress to self-pay collections. Providers must have a margin to continue providing care. Arkansas Works will not strengthen providers or their networks if they cannot pay their bills. No margin, no mission.

CONCLUSION

Human Arc believes the evidence shows that the bulk of the savings will come at the expense of the low income uninsured expansion group through the elimination (waiver) of retroactive Medicaid coverage. The estimated savings are really a shifting of costs to the low income uninsured and the medical providers that serve them.

To reiterate, our greatest concerns with the Arkansas Works Program 1115 Demonstration Waiver is the **Waiver of retroactive eligibility.**

We believe we have demonstrated that the waiver of retroactive coverage in the Arkansas Works program do **not meet the criteria used by the Centers for Medicare and Medicaid Services to determine whether Medicaid program objectives are met.**

We recommend that the application process be adjusted to allow for 90-days retroactive coverage from submission of application, allowing for provider reimbursement during this same time period.

We are available for consultation at your request. Thank you again for the opportunity to be heard in this Comment process.

Respectfully,

Michael J Baird
Chief Executive Officer
Human Arc
1457 E 40th Street
Cleveland, Ohio 44103
mb@humanarc.com
216.426.3510 direct
216.849.8493 mobile

References

[1] 99 Pa. Commonwealth Ct. 345 (1986), 514 A.2d 204, William Martin, Petitioner v. Commonwealth of Pennsylvania, Department of Public Welfare, Respondent. No. 2351 C.D. 1984. Commonwealth Court of Pennsylvania. Argued March 11, 1986. July 30, 1986. https://scholar.google.com/scholar_case?case=8264689460606004823&q=1396a(34)&hl=en&as_sdt=6,36 percent20-percent20r[13]#r[13]

[2] SI 01715.001 Medicaid and the Aged, Blind and Disabled C. 3., Program Operations Manual System (POMS), Social Security Administration, https://secure.ssa.gov/poms.nsf/lnx/0501715001

[3] *Ibid*

From: Bo Ryall <boryall@arkhospitals.org>
Sent: Monday, June 13, 2016 12:35 PM
To: DHS DMS HCIW
Subject: Comments on Arkansas Works Waiver
Attachments: 6-13-16 Arkansas Works Regulations Letter.pdf

Attached, please find comments on the Arkansas Works Waiver application submitted on behalf of the Arkansas Hospital Association.

Thanks,

Bo Ryall
Arkansas Hospital Association

ROBERT "BO" RYALL
President & CEO

June 13, 2016

Ms. Cindy Gillespie, Director
Arkansas Department of Human Services
P. O. Box 1437 (Slot S295)
Little Rock, Arkansas 72203-1437

Dear Ms. Gillespie:

The Arkansas Hospital Association (AHA), on behalf of its 100 member organizations and their combined 45,000-plus employees, expresses its appreciation for the opportunity to comment on the potential impact of proposed regulations that would implement the new Arkansas Works program.

As a membership organization with a mission to safeguard hospitals' operational effectiveness in advancing the health and well-being of their communities, the AHA is strongly supportive of the Arkansas Works program now being developed to continue Arkansas's unique and highly successful approach for providing affordable healthcare coverage for eligible low-income Arkansans. We are confident that Arkansas Works will continue to build and improve upon the successes of the Arkansas Private Option, which has helped Arkansas hospitals to retain their ability to serve patients throughout our state.

Specifically, the AHA applauds Governor Asa Hutchinson and the Arkansas Legislature for engineering Arkansas Works, which promises to maintain access to affordable healthcare for our poorest citizens and to strengthen the qualified health plan premium assistance model by emphasizing personal responsibility, promoting work, and enhancing program integrity. As Arkansas's healthcare system continues to improve and as the uncompensated care absorbed by hospitals is reduced, our hospitals stand a better chance to remain financially viable – even in the face of losing more than $2.5 billion in federal cuts related to Medicare payment cuts that have been implemented nationally through the Affordable Care Act (2010), the Budget Control Act of 2011 (sequestration), two separate Tax Acts in 2012, and various regulation changes.

However, the AHA has two major concerns with the Arkansas 1115 waiver extension application. First, and most importantly, the AHA would request to strike or modify §1902(a)(34) that would prohibit medical coverage to Arkansas Works beneficiaries for any time prior to the first day of the month in which the individual applies.

Unfortunately, the Arkansas Department of Human Services (DHS), Division of Medical Services, has been unable to implement the federal requirement for presumptive eligibility detailed in 42 CFR 435.1110. In practice, in place of presumptive eligibility, the department has allowed a 90-day period of retroactive coverage for beneficiaries who are deemed eligible for Private Option plans during the past two years. Should §1902(a)(34) be implemented, we are concerned that an otherwise-eligible beneficiary will be saddled with large amounts of healthcare debt that could have been avoided.

While the AHA encourages DHS to implement the already federally required provisions of "presumptive eligibility," an option would be to put in place an appropriate time-period of at least 60 days of retroactive

coverage. One of these solutions would not only be more beneficial to the patient, but would also more aptly enhance hospital discharge coordination options for patient care planning, which can reduce costly repeated hospital admissions. Retroactive coverage of at least 60 days or implementation of presumptive eligibility are far superior to the current proposal set forth in §1902(a)(34).

Also, while the AHA applauds the voluntary option for employers to be incentivized to offer insurance to their employees, the AHA has concerns that the current eligibility and enrollment systems within DHS are not able to efficiently perform the tasks that will be required to implement the details included in the proposed waivers. Specifically for the ESI population, the AHA is concerned that the patient experience will be less than ideal – due to cumbersome administrative processes – and will result in poor patient satisfaction scores. For example, it is anticipated that a patient who has selected to keep his employer-sponsored insurance with wrap-around benefits from Medicaid would need multiple healthcare identification cards in order for a healthcare provider to be able to receive appropriate payments for caring for that patient. Once the patient is seen, the provider would have the added burden to discern which bills go to the patient versus Medicaid versus the employer sponsored insurance.

The rise of consumerism is having a major influence on healthcare delivery. As a result, patient satisfaction is becoming very important as a hospital quality measure and is more closely tied to reimbursements from public and private payer groups more than ever before. Because the hospital admissions process, which already is heavily laden with inefficiencies brought about by administrative burdens that actually harm the patient care experience, the AHA requests that DHS help to relieve patients and providers of these burdens at the point of care.

As noted by Secretary Burwell in her letter dated April 5, 2016, addressing the well-documented inadequacies with the existing eligibility determination and enrollment systems would be a step in that direction. Adding additional tasks and functionality to an existing system, as required under the waiver request, is counterproductive to creating a more efficient system, at best. Therefore, the AHA asks that DHS improve its enrollment and eligibility systems with the end-users in mind so that employers are truly incentivized to keep their employees insured.

Arkansas's hospitals, which employ about 45,000 Arkansans with a payroll of about $5 billion, go to great lengths to provide needed services to the people in our state in a high quality, cost effective manner. The AHA and its members look forward to continuing to work with Governor Hutchinson, the legislature, both the government and private sectors, and our patients to improve the health of people, leading to healthier families, healthier hospitals, and stronger communities in Arkansas.

Once again, thank you for this opportunity to make our concerns known.

Sincerely,

[redacted]

Bo Ryall
President/CEO

BR/ae

419 Natural Resources Drive • Little Rock, Arkansas 72205 • (501) 224-7878 • Facsimile (501) 224-0519

From: Skip Estes <skipestes@sbcglobal.net>
Sent: Thursday, June 09, 2016 8:12 PM
To: DHS DMS HCIW
Subject: Private Option

Why should anyone make any comments on the private option or changes to it? It is already a done deal, or that's how it appears. It is absolutely shameful that the option allows for people with a large amount of assets to qualify for Medicaid while others, in particular retired people, cannot qualify, simply because they may have monthly income slightly over the amount which automatically disqualifies them!!! Therefore, you can have a neighbor who has real estate worth several million dollars but who has a monthly income of below the $2,000/monthly qualifying limit alongside a retired person who may have monthly income slightly above the qualifying limit but not much in savings. Isn't it nice that retired people get to pay over $1,200/mo. for healthcare coverage and drugs that requires them to withdraw money from their IRAs just to pay for their health insurance and drugs. Meanwhile, Joe Blow with the real estate qualifies for Medicaid?!?! What about this situation makes it a good deal for people who have worked their entire lives and who finally get to retire, but who have to immediately use their savings to pay for health insurance and drug costs?????

From: Roland Robinson <rolandr47@yahoo.com>
Sent: Saturday, May 28, 2016 5:04 AM
To: DHS DMS HCIW
Subject: Medicaid Expansion

I fully support Expansion, I'm not in favor of requirements for deductibles or co-pays. I do support strenuous eligibility screening and life skills counseling availability as opposed to mandatory job seeking requirements or registration for employment.
I do favor case management from a strictly medical necessity standpoint.
Thanks

Sent from my iPad

From: Richard Bing <richbing@sbcglobal.net>
Sent: Friday, May 27, 2016 2:20 PM
To: DHS DMS HCIW
Subject: Private Option Changes Feedback

Amy

I read the article about you not receiving any feedback on the Private Option changes in the paper today. I think that's disappointing because I think the private option and the Affordable Care Act are truly a positive improvement for the country and Arkansas.

Prior to 2014 my wife and I had health insurance through her employment. She left her company in 2013 because of her extreme medical conditions. The high priced Cobra health insurance they made available ran out and we were left without medical insurance. Luckily, the ACA / PO kicked in and we were able to get affordable medical insurance through Healthcare.gov. She currently still obtains her Medical insurance through healthcare.gov. I have turned 65 and I am now on Medicare. She is not 65 yet and will need to be on the Private Option medical insurance for 2+ more years.

I have worked full time since I was 22 years old, after graduating from college. I contributed significantly in taxes and social security for 43 years. She graduated in '84 from Nursing School with a RN degree. She worked as an RN or RN Manager for almost 30 years, again contributing significantly. Unfortunately she had to leave the profession due to arthritis and Crohn's. She is not illegible for SS or retirement yet, but I hope we can survive financially until she turns 65 / 66. We do have income and probably not be legible for a much assistance this year.

- **Paying an additional $19 per month is not appreciated. It's just another "gotcha" for people that truly need assistance paying for medical insurance. Most people have contributed substantially and this seemed like an insult.**
- **Yes, let's ensure that all employers provide medical insurance. I think this was for the smaller employers and they need to realize that if you have a business you've got to plan for this. Take some ownership.**
- **Have we gotten Wal-Mart and other big companies to belly up to the bar yet and provide medical insurance for all ee's if they want it and quit playing the PT game.**
- **Dental insurance is a great option. To purchase it your self is expensive too.**

My wife and I are truly grateful the Affordable Care Act is up and running. There are changes that need to be done but the overall structure is good. Now, if we could get "all" politicians to earnestly make the changes that need to be made. We are happy too that the state of Arkansas realized the Private Option needed continuing. There would have been a lot of unhappy voters if they had trashed it.

Overall all insurance price will lower if everyone has insurance. The more in the better. Yes, we do need to address the games that individuals, medical providers, insurance companies, hospitals and state governments play. Better things take time.

Thanks for soliciting feedback

Richard Bingenheimer

501.851.6801