STATE OF ARKANSAS
MIKE BEEBE
GOVERNOR

August 2, 2013

The Honorable Kathleen Sebelius
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 application. Authorized by provisions in the Arkansas Health Care Independence Act of 2013, the demonstration will allow the use of premium assistance to purchase qualified health plan (QHP) coverage through the Health Insurance Marketplace.

The waiver application aligns with and builds upon the concept proposed in our February 2013 meeting and in the memo sent in March of 2013. The waiver application also reflects additional input from state legislators, public comments, and cooperative consultation with federal officials over the last several months. In conjunction with this waiver, we will be submitting State Plan Amendments to secure federal funding for the expansion group, including those individuals who have complex medical conditions and/or are medically frail and who will receive coverage through our traditional program.

In addition to improving provider access, reducing disruption across the continuum of coverage upon income fluctuation, and furthering quality improvement, our vision is to provide truly integrated coverage for low-income Arkansans. The demonstration will leverage the efficiencies of the private market to enhance continuity, access, and quality for beneficiaries and is expected to drive more competitive premium pricing for all individuals purchasing through the Marketplace by adding approximately 225,000 eligible individuals. Most important, the demonstration incorporates delivery-system improvement initiatives that have already received federal support, thereby augmenting the ability to achieve desired outcomes.

We appreciate the assistance your department has offered and look forward to your continued support as we implement the premium assistance model and other innovative approaches outlined in the Arkansas Health Care Independence Act.

Sincerely,

Mike Beebe

Ccs: Marilyn Tavenner, Administrator for the Center for Medicare & Medicaid Services
Cindy Mann, Director of the Center for Medicaid and CHIP Services

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Section I - Program Description

1) Provide a summary of the proposed Demonstration program, and how it will further the objectives of title XIX and/or title XXI of the Social Security Act (the Act).

Under the Demonstration, the State will use premium assistance to purchase qualified health plans (QHPs) offered in the individual market through the Marketplace for individuals eligible for coverage under Title XIX of the Social Security Act who are either (1) childless adults between the ages of 19 and 65 with incomes at or below 138% of the federal poverty level (FPL) who are not enrolled in Medicare or incarcerated[1] or (2) parents between the ages of 19 and 65 with incomes between 17 and 138% FPL who are not enrolled in Medicare or incarcerated (collectively "Private Option beneficiaries"). Private Option beneficiaries will receive the Alternative Benefit Plan (ABP) through a QHP that they select and have cost sharing obligations consistent with both the State Plan and with the cost-sharing rules applicable to individuals with comparable incomes in 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. Ultimately, the Demonstration will provide truly integrated coverage for low-income Arkansans, leveraging the efficiencies of the private market to improve continuity, access, and quality for Private Option beneficiaries. Additionally, by nearly doubling the size of the population enrolling in QHPs offered through the Marketplace, the Demonstration is expected to drive structural health care system reform and more competitive premium pricing for all individuals purchasing coverage through the Marketplace.

In future years, the State anticipates revising the waiver to include parents with incomes below 17% FPL and children. In addition, the State anticipates developing a pilot project to create health savings accounts to promote cost-effective use of the health care system.

2) Include the rationale for the Demonstration

This 1115 Demonstration waiver request supports implementation of Arkansas's Health Care Independence Act of 2013, which was signed into law by Governor Beebe on April 23, 2013. The Act clearly articulates the context, goals, and objectives for the Demonstration.

Arkansas is uniquely situated to serve as a laboratory of comprehensive and innovative healthcare reform that can reduce the state and federal obligations to entitlement spending. Arkansas has historically addressed state-specific needs to achieve personal responsibility and affordable health care for its citizens through initiatives such as the ARHealthNetworks partnership between the state and small businesses. The State has also initiated nationally recognized and transformative changes in the healthcare delivery system through alignment of

[1] The term "incarcerated" means "any individual who is an inmate of a public institution (except as a patient in a medical institution)."

payment incentives, health care delivery system improvements, enhanced rural health care access, initiatives to reduce waste, fraud and abuse, policies and plan structures to encourage the proper utilization of the healthcare system, and policies to advance disease prevention and health promotion.

The Health Care Independence Act calls on the Arkansas Department of Human Services to explore design options that reform the Medicaid Program so that it is a fiscally sustainable, cost-effective, personally responsible, and opportunity-driven program utilizing competitive and value-based purchasing to:

(1) Maximize the available service options;
(2) Promote accountability, personal responsibility, and transparency;
(3) Encourage and reward healthy outcomes and responsible choices; and
(4) Promote efficiencies that will deliver value to the taxpayers.

The Act determines that the State of Arkansas shall take an integrated and market-based approach to covering low-income Arkansans through offering new coverage opportunities, stimulating market competition, and offering alternatives to the existing Medicaid program. The specific purposes of the novel approach to coverage established in the Health Care Independent Act are to:

(1) Improve access to quality health care;
(2) Attract insurance carriers and enhance competition in the Arkansas insurance Marketplace;
(3) Promote individually-owned health insurance;
(4) Strengthen personal responsibility through cost-sharing;
(5) Improve continuity of coverage;
(6) Reduce the size of the state-administered Medicaid program;
(7) Encourage appropriate care, including early intervention, prevention, and wellness;
(8) Increase quality and delivery system efficiencies;
(9) Facilitate Arkansas's continued payment innovation, delivery system reform, and market-driven improvements;
(10) Discourage over-utilization; and
(11) Reduce waste, fraud, and abuse.

The Demonstration program described below in this 1115 waiver application is specifically designed to meet the requirements of the Health Care Independence Act of 2013.

Expanding Medicaid to nearly all individuals with incomes at or below 138% FPL, as set out in the Affordable Care Act, would present several challenges for Arkansas. First, the new adults are likely to have frequent income fluctuations that lead to changes in eligibility. In fact, studies indicate that more than 35% of adults will experience a change in eligibility within six months of

their eligibility determination.[2] Without carefully crafted policy and operational interventions, these frequent changes in eligibility could lead to (1) coverage gaps during which individuals lack any health coverage, even though they are eligible for coverage under Title XIX or Advanced Payment Tax Credits (collectively, along with CHIP, "Insurance Affordability Programs" or "IAPs")and/or (2) disruptive changes in benefits, provider networks, premiums, and cost-sharing as individuals transition from one IAP to another. In addition, by expanding Medicaid to include all individuals with incomes at or below 138% FPL, Arkansas would be increasing its Medicaid program by nearly 40%. The State's existing network of fee-for-service Medicaid providers is at capacity; as a result, Arkansas would be faced with the challenge of increasing providers' capacity to serve Medicaid beneficiaries to ensure adequate access to care. In short, absent the Demonstration, Arkansas's Medicaid expansion would rely on the existing Medicaid delivery system and perpetuate an inefficient, underfunded and inadequately coordinated approach to patient care. While reforms associated with Arkansas' Payment Improvement Initiative are designed to address the quality and cost of care, these reforms do not include increased payment rates needed to expand provider access for the 250,000 new adults that will enroll through the expansion.

The Demonstration is crafted to address these problems. By using premium assistance to purchase QHPs offered in the Marketplace, Arkansas will promote continuity of coverage and expand provider access, while improving efficiency and accelerating multi-payer cost-containment and quality improvement efforts.

- **Continuity of coverage** – For households with members eligible for coverage under Title XIX and Marketplace coverage as well as those who have income fluctuations that cause their eligibility to change year-to-year, the Demonstration will create continuity of health plans and provider networks. Households can stay enrolled in the same plan regardless of whether their coverage is subsidized through Medicaid, CHIP (after year one), or Advanced Payment Tax Credits.

- **Rational provider reimbursement and improved provider access** – Arkansas Medicaid provides rates of reimbursement lower than Medicare or commercial payers, causing some providers to forego participation in the program and others to "cross subsidize" their Medicaid patients by charging more to private insurers. The Demonstration will rationalize provider reimbursement across payers, expanding provider access and eliminating the need for providers to cross-subsidize.

- **Integration and efficiency** – Arkansas is taking an integrated and market-based approach to covering uninsured Arkansans, rather than relying on a system for insuring lower income families that is separate and duplicative. This transition to private markets is a more efficient way of covering Arkansans.

[2] Health Affairs, "Frequent Churning Predicted Between Medicaid and Exchanges," February 2011.

- **"All payer" health care reform** – Arkansas is at the forefront of payment innovation and delivery system reform, and the Demonstration will accelerate and leverage its Arkansas Health Care Payment Improvement Initiative by increasing the number of carriers participating in the effort, and the number of privately insured Arkansans who benefit from a direct application of these reforms.

3) Describe the hypotheses that will be tested/evaluated during the Demonstration's approval period and the plan by which the State will use to test them.

The Demonstration will authorize the delivery of health insurance benefits to a new group of low-income adults through a novel alternative to traditional Medicaid programs and will test the following hypotheses during the approval period:

Hypothesis	Evaluation Approach	Data Sources[3]
Access		
(1) Private Option beneficiaries will have appropriate access to care and will have equal or greater provider access than newly eligible adults would otherwise have in a traditional fee-for-service Medicaid system.	Compare differences in measured outcomes for A and B, while controlling for relevant factors, with the assumption that differences in B will be greater than differences in A: • A: Extent to which primary care and specialist access and consumer satisfaction varies between the Health Insurance Marketplace (HIM) and Private Option enrollees. • B: Extent to which primary care and specialist access and consumer satisfaction varies between the HIM and existing Medicaid Fee-for-Service for low-income adults. Access (e.g., wait times, drive times) and consumer	Arkansas Health Data Initiative physician masterfile State claims databases Hospital Discharge Data Medical Expenditure Panel Survey from AHRQ (MEPS) NCQA HEDIS CAHPS CDC- Behavioral Risk Factor Surveillance System

[3] Subject to availability.

Hypothesis	Evaluation Approach	Data Sources[3]
	satisfaction measurements will be based on available state and national level survey information and empirical data.	
(2) Private Option beneficiaries will have access to preventive care services at least as consistently as or more consistently than newly eligible adults would otherwise have in a traditional fee-for-service Medicaid system and beneficiaries in non-Premium Assistance expansions nationally.	Compare differences in measured outcomes for A and B, while controlling for relevant factors, with the assumption that differences in B will be greater than differences in A: • A: The extent to which the percentage of enrollees with an ambulatory or preventive care visit in the past year varies between the HIM and Private Option enrollees. • B: The extent to which the percentage of enrollees with an ambulatory or preventive care visit in the past year varies between the HIM and existing Medicaid Fee-for-Service for low-income adults.	State claims databases Medical Expenditure Panel Survey from AHRQ (MEPS) CAHPS CDC- Behavioral Risk Factor Surveillance System
(3) Private Option beneficiaries will have lower non-emergent use of emergency room services as compared to Medicaid beneficiaries in non-Premium Assistance expansions nationally.	To the extent that data is available from other states, compare the extent of non-emergent emergency department use to data from expansion states with similar program characteristics, or, alternatively, compare existing Medicaid versus Private Option utilization patterns.	Medicaid/QHP claims databases and available data from other states
(4) Churning—Private Option Beneficiaries will have fewer gaps	Compare churn rates between Private Option and evidence in	Enrollment data from

Hypothesis	Evaluation Approach	Data Sources[3]
in insurance coverage than Medicaid beneficiaries in non-Premium Assistance expansions nationally.	literature/other states experiences with traditional expansion Compare the extent to which the percentage of individuals with any period of uninsurance during the year varies between Private Option and HIM/traditional Arkansas Medicaid populations	Arkansas and other states MEPS
(5) *Churning:* Private Option beneficiaries will maintain continuous access to the same health plans and/or providers at higher rates than under a traditional Medicaid expansion.	Compare differences in measured outcomes for A and B, while controlling for relevant factors, with the assumption that differences in B will be greater than differences in A: A: Identify the extent to which individuals have access to the same plans and providers in the HIM and Private Option when income fluctuates and causes a change in paying source. B: Identify the extent to which individuals have access to the same plans and providers in the HIM and the existing Medicaid for low-income adults when income fluctuates and causes a change in paying source	HIM/Private Option enrollment data
Cost		
(1) *Churning:* Reduction in churning for Private Option Beneficiaries will lead to reduced	Comparison of administrative costs per capita expended for Private Option enrollees at	Enrollment/Administrative costs data from Arkansas and other states if data is

Hypothesis	Evaluation Approach	Data Sources[3]
administrative costs.	churn points versus administrative costs under traditional Medicaid expansion in Arkansas	available
(2) *Comparability*: Over the life of the demonstration, the cost for covering Private Option beneficiaries will be comparable to what the costs would have been for covering the same expansion group in Arkansas Medicaid fee-for-service, assuming adjustments to fee-for-service reimbursement to achieve access in the fee-for-service model.	TBD	
(3) *Medicaid Uncompensated Care*: Uncompensated care costs will go down as a result of higher levels of provider reimbursement and lower numbers of uninsured.	Analysis of Disproportionate Share Hospital Payments Comparison of take-up rate between Private Option and traditional fee-for service Medicaid expansions in other states	CMS data Private Option/other state enrollment data
(4) *Cost in the Arkansas Marketplace*: The Private Option will drive down overall premium costs in the Marketplace and will result in better quality than would otherwise have occurred absent the Private Option.	Actuarial analysis of the impact of increased volume and competitive pricing requirements for plans offered to Private Option beneficiaries	Claims data
Quality		
(1) *Quality Improvement:* Private Option enrollees will have lower rates of potentially preventable admissions than enrollees in Arkansas's Medicaid fee for	Analysis of hospital discharge data	Arkansas Department of Health data Arkansas Health Data Initiative

Hypothesis	Evaluation Approach	Data Sources[3]
service program.		
(2) *Quality in the Arkansas Marketplace:* The Private Option, inclusive of its requirement to participate in the Arkansas Payment Improvement Initiative (APII), will produce improved quality over time than would otherwise have occurred absent the Private Option	Analysis of Arkansas Payment Improvement Initiative PCMH quality metrics for preventive care and chronic disease management	Claims and clinical information

4) Describe where the Demonstration will operate, i.e., statewide, or in specific regions within the State. If the Demonstration will not operate statewide, please indicate the geographic areas/regions of the State where the Demonstration will operate

The Demonstration will operate statewide.

5) Include the proposed timeframe for the Demonstration

The Demonstration will operate during calendar years 2014, 2015, and 2016.

6) Describe whether the Demonstration will affect and/or modify other components of the State's current Medicaid and CHIP programs outside of eligibility, benefits, cost sharing or delivery systems

No. The demonstration will not modify the State's current Medicaid and CHIP programs outside of eligibility, benefits, cost-sharing or delivery systems.

Section II – Demonstration Eligibility

1) Include a chart identifying any populations whose eligibility will be affected by the Demonstration (an example is provided below; note that populations whose eligibility is not proposed to be changed by the Demonstration do not need to be included).

Please refer to Medicaid Eligibility Groups: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/List-of-Eligibility-Groups.pdf when describing Medicaid State plan populations, and for an expansion eligibility group, please provide the state name for the groups that is sufficiently descriptive to explain the groups to the public.

The Demonstration will not affect any of the eligibility categories or criteria that are set forth in the State Plan.

Participation in the Demonstration, however, will be mandatory for Private Option-eligible individuals. Individuals who qualify for the Private Option will be required to receive coverage through QHPs, and those who decline coverage through QHPs will not be permitted to receive benefits through the State Plan.

Eligibility Chart

Mandatory State Plan Groups

Eligibility Group Name	Social Security and CFR Sections	Income Level

Optional State Plan Groups

Eligibility Group Name	Social Security and CFR Sections	Income Level

Expansion Populations

Eligibility Group Name	N/A	Income Level

2) Describe the standards and methodologies the state will use to determine eligibility for any populations whose eligibility is changed under the Demonstration, to the extent those standards or methodologies differ from the State plan.

When determining whether an individual is eligible for the Private Option, Arkansas will apply the same eligibility standards and methodologies as those articulated in the State Plan.

3) Specify any enrollment limits that apply for expansion populations under the Demonstration.

There are no caps on enrollment in the Demonstration. To be eligible to participate in the Demonstration an individual must: (1) be a childless adult between 19 and 65 years of age, with an income at or below 138% of the federal poverty level who is not enrolled in Medicare and not incarcerated **or** be a parent between 19 and 65 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 will not be eligible for the Demonstration.

Description	Income	Age	Exceptions
Adults in Section VIII Group	*Childless Adults:* 0-138% FPL *Parents:* 17-138% FPL	19-65	▪ Dual Eligibles ▪ Individuals who are medically frail/have exceptional medical needs. ▪ Incarcerated individuals

4) Provide the projected number of individuals who would be eligible for the Demonstration, and indicate if the projections are based on current state programs (i.e., Medicaid State plan, or populations covered using other waiver authority, such as 1915(c)). If applicable, please specify the size of the populations currently served in those programs.

Approximately 225,000 individuals will be eligible for the Demonstration. Currently, the State estimates that approximately 250,000 individuals will be newly eligible for or newly enrolled in Medicaid in Arkansas beginning in 2014. It is projected that 90% of newly eligible Medicaid beneficiaries will also be eligible for the Demonstration, with the remaining 10% of the newly eligibles receiving ABP or standard coverage under the State Plan.

5) To the extent that long term services and supports are furnished (either in institutions or the community), describe how the Demonstration will address post-eligibility treatment of income, if applicable. In addition, indicate whether the Demonstration will utilize spousal impoverishment rules under section 1924, or will utilize regular post-eligibility rules under 42 CFR 435.726 (SSI State and section 1634) or under 42 CFR 435.735 (209b State)

N/A. Long-term services and supports will not be provided through the Demonstration, since the ABP, as set forth in the State Plan, does not cover long-term services and supports.

6) Describe any changes in eligibility procedures the state will use for populations under the Demonstration, including any eligibility simplifications that require 1115 authority (such as continuous eligibility or express lane eligibility for adults or express lane eligibility for children after 2013).

N/A. The State will not institute continuous eligibility or express lane eligibility.

7) If applicable, describe any eligibility changes that the state is seeking to undertake for the purposes of transitioning Medicaid or CHIP eligibility standards to the methodologies or

standards applicable in 2014 (such as financial methodologies for determining eligibility based on modified adjusted gross income), or in light of other changes in 2014.

N/A

Section III – Demonstration Benefits and Cost Sharing Requirements

1) Indicate whether the benefits provided under the Demonstration differ from those provided under the Medicaid and/or CHIP State plan:

____ Yes __X__ No (if no, please skip questions 3 – 7)

2) Indicate whether the cost sharing requirements under the Demonstration differ from those provided under the Medicaid and/or CHIP State plan:

____ Yes __X__ No (if no, please skip questions 8 - 11)

Cost-sharing requirements for ABP will be the same regardless of whether the benefits are delivered under the State Plan or the Demonstration.

3) If changes are proposed, or if different benefit packages will apply to different eligibility groups affected by the Demonstration, please include a chart specifying the benefit package that each eligibility group will receive under the Demonstration (an example is provided):

Benefit Package Chart

Eligibility Group	Benefit Package

4) If electing benchmark-equivalent coverage for a population, please indicate which standard is being used:

___ Federal Employees Health Benefit Package
___ State Employee Coverage
___ Commercial Health Maintenance Organization
_X_ Secretary Approved

Since individuals in the new adult group are required to receive coverage through the Alternative Benefit Plan ("ABP"), the State is not electing ABP-equivalent coverage for a

population; instead, the State is providing the statutorily required benefit package. Arkansas's State Plan Amendment will outline its selection of a Secretary-approved ABP.

5) In addition to the Benefit Specifications and Qualifications form: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Interim1115-Benefit-Specifications-and-Provider-Qualifications.pdf, please complete the following chart if the Demonstration will provide benefits that differ from the Medicaid or CHIP State plan, (an example is provided).

N/A. Benefits are the same under the Demonstration and the State Plan.

Benefit Chart

Benefit	Description of Amount, Duration, and Scope	Reference

Benefits Not Provided

Benefit	Description of Amount, Duration, and Scope	Reference

Although the benefits in the ABP will be identical across the State Plan and the Demonstration, the appeals process relating to coverage determinations will differ. Under the Demonstration, Private Option beneficiaries will use their QHP appeals process to appeal denials of benefits covered under the QHP. (Private Option beneficiaries will continue to use the Medicaid appeals process for denials of wrapped benefits.) All QHPs must comply with federal standards governing internal insurance coverage appeals. Additionally, all 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 Affordable Care Act. Private Option beneficiaries will have access to the following two levels of appeals:

Internal Review

Each QHP must provide all enrollees with:

1) Notice identifying the claim or claims being denied;

2) A description of the reason for the denial;

3) Copies of the guidelines used to deny the claim; and

4) Notice that the recipient may request more explanation of the reason for the denial.

Any enrollee whose claim for health care is denied or is not acted upon with reasonable promptness may:

1) Appeal to the QHP; and

2) Present evidence and testimony to support the claim.

The QHP must render a decision regarding an internal appeal within:

1) 72 hours for denial of a claim for urgent care;

2) 30 days for non-urgent care that has not yet been delivered; and

3) 60 days for denials of services already delivered.

External Review

If the QHP does not render a decision within the timeframe specified above, or affirms the denial in whole or in part, the enrollee may request review, and in some cases expedited review, by a Qualified Independent Review Organization that has been selected by the Arkansas Insurance Department (AID). Each QIRO must use qualified and impartial clinical reviewers who are experts in the treatment of the enrollee's medical condition and have recent or current actual clinical experience treating patients similar to the enrollee. Additionally, the enrollee is permitted to submit a statement in writing to support its claim. The QIRO will render its decision in 45 days, or within 72 hours in the case of an expedited review.

In addition to, and separate from, the safeguards provided above, Arkansas enrollees may sue the QHP directly in state court for breach of contract. QHP enrollees may also file coverage complaints with AID. If AID determines that a claim for coverage was denied improperly, AID may bring an enforcement action against the issuer to require it to provide coverage. During that enforcement action, AID has the right to engage in discovery, conduct depositions, and cross-examine witnesses. AID may also permit the enrollee to engage in discovery, conduct depositions, and cross-examine witnesses.

6) Indicate whether Long Term Services and Supports will be provided.

___ Yes (if yes, please check the services that are being offered) _X_ No

In addition, please complete the: http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/List-of-LTSS-Benefits.pdf, and the: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Long-Term-Services-Benefit-Specifications-and-Provider-Qualifications.pdf.)

- ☐ **Homemaker**
- ☐ **Case Management**
- ☐ **Adult Day Health Services**
- ☐ **Habilitation – Supported Employment**
- ☐ **Habilitation – Day Habilitation**

- ☐ Habilitation – Other Habilitative
- ☐ Respite
- ☐ Psychosocial Rehabilitation
- ☐ Environmental Modifications (Home Accessibility Adaptations)
- ☐ Non-Medical Transportation
- ☐ Home Delivered Meals Personal
- ☐ Emergency Response
- ☐ Community Transition Services
- ☐ Day Supports (non-habilitative)
- ☐ Supported Living Arrangements
- ☐ Assisted Living
- ☐ Home Health Aide
- ☐ Personal Care Services
- ☐ Habilitation – Residential Habilitation
- ☐ Habilitation – Pre-Vocational
- ☐ Habilitation – Education (non-IDEA Services)
- ☐ Day Treatment (mental health service)
- ☐ Clinic Services
- ☐ Vehicle Modifications
- ☐ Special Medical Equipment (minor assistive devices)
- ☐ Assistive Technology
- ☐ Nursing Services
- ☐ Adult Foster Care
- ☐ Supported Employment
- ☐ Private Duty Nursing
- ☐ Adult Companion Services
- ☐ Supports for Consumer Direction/Participant Directed Goods and Services
- ☐ Other (please describe)

7) Indicate whether premium assistance for employer sponsored coverage will be available through the Demonstration.

___ Yes (if yes, please address the questions below)
_X_ No (if no, please skip this question)

a) Describe whether the state currently operates a premium assistance program and under which authority, and whether the state is modifying its existing program or creating a new program.

N/A

b) Include the minimum employer contribution amount.

N/A

c) Describe whether the Demonstration will provide wrap-around benefits and cost-sharing.

N/A

d) Indicate how the cost-effectiveness test will be met.

N/A

8) If different from the State plan, provide the premium amounts by eligibility group and income level.

There are no premiums under the Demonstration.

9) Include a table if the Demonstration will require copayments, coinsurance and/or deductibles that differ from the Medicaid State plan (an example is provided):

Consumer cost-sharing obligations under the Demonstration will be identical to those under the State Plan for all individuals receiving the ABP. The SPA describing the ABP will include the cost-sharing design for all individuals receiving the ABP. As will be described in the SPA, Private Option beneficiaries with incomes below 100% FPL will not have cost-sharing obligations in year one of the Demonstration; Arkansas plans to submit amendments to the waiver to implement cost-sharing for Demonstration participants with incomes from 50-100% FPL to be effective in years two and three of the Demonstration. Individuals with incomes of 100-138% FPL will be responsible for cost-sharing in amounts consistent with Medicaid cost-sharing rules. For individuals with income between 100-138% FPL, aggregate annual cost-sharing will be capped at 5% of 100% FPL ($604 for 2014)[4]. Demonstration participants will not be required to pay a deductible prior to receiving coverage. Providers will collect all applicable co-payments at the point of care. QHPs will monitor Private Option beneficiaries' aggregate amount of co-payments to ensure that they do not exceed the annual limit.

Arkansas will pay QHP issuers advance monthly cost-sharing reduction (CSR) payments to cover the costs associated with the reduced cost-sharing for Private Option beneficiaries. The advance monthly CSR payments will be calculated in the same way for individuals between 138 and 250% of the federal poverty level (FPL) who are eligible for federal CSRs and for individuals at or below 138% FPL enrolled in the Private Option; the only difference will be that HHS will make the federal CSR payments and Arkansas Medicaid will make the Private Option CSR payments. Under this method, issuers would, before each benefit year, estimate monthly allowed claims for essential health benefits for each standard silver plan and report this information to the Exchange (for APTC/CSR eligible enrollees) and Arkansas Medicaid (for Private Option enrollees). For the zero cost sharing plan variation, HHS or Medicaid will multiply this estimate by 1.12 to reflect induced utilization for the higher AV and then multiply that

[4] Arkansas will make adjustments to the cost-sharing cap for Private Option enrollees in two adult households.

product by the difference between zero cost sharing plan variation AV and standard silver plan AV (i.e. 0.3). The same formula is used for the high-value silver plan variant, using the same induced demand factor of 1.12 and substituting 0.24 for 0.3 for the AV factor. Issuers will receive per member per month payments during the benefit year on the basis of this formula. These payments will be subject to reconciliation at the conclusion of the benefit year based on actual CSRs that are utilized. If an issuer's actuary determines during the benefit year that the estimated advance CSR payments are significantly different than the CSR payments the issuer will be entitled to at reconciliation, the issuer may ask HHS or Arkansas Medicaid to adjust the advance payments. *See* 45 C.F.R. § 156.430; HHS Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. 15410, 15487-88, 15494-95 (Mar. 11, 2013).

At the conclusion of the benefit year, each QHP issuer will report actual cost-sharing reduction amounts to HHS (for members receiving APTCs/CSRs) and Arkansas Medicaid (for members enrolled in the Private Option) to reconcile CSR amounts with the advance payments. The Arkansas Medicaid process for such reconciliations will be modeled on the HHS process. HHS has announced that issuers may choose one of two methods to calculate the actual cost sharing reductions. The standard method requires the issuer to adjudicate each claim and determine the plan's liability twice: first calculating plan liability using the standard silver plan cost sharing and a second time with reduced cost sharing under the silver plan variant. The CSR payment the issuer is entitled to is the difference between the second number and the first. The simplified methodology does not require readjudication of claims. Instead, issuers will enter certain basic cost sharing parameters of its silver plans into a formula that will model the amount of CSR payments, based on total incurred claims. Issuers may choose either method, but a single issuer must apply the same method to all its plans. Furthermore, if an issuer selects the standard method in 2014, it may not select the simplified method in future years. 45 C.F.R. § 156.430(c).

Copayment Chart

Eligibility Group	Benefit	Copayment Amount

10) Indicate if there are any exemptions from the proposed cost sharing.

Yes. All individuals who are statutorily required to be exempt from cost sharing will be exempt from cost sharing under the Demonstration, including pregnant women and American Indians/Alaskan Natives

Section IV – Delivery System and Payment Rates for Services

1) Indicate whether the delivery system used to provide benefits to Demonstration participants will differ from the Medicaid and/or CHIP State plan:

_X_ Yes

___ No (if no, please skip questions 2 – 7 and the applicable payment rate questions)

2) Describe the delivery system reforms that will occur as a result of the Demonstration, and if applicable, how they will support the broader goals for improving quality and value in the health care system. Specifically, include information on the proposed Demonstration's expected impact on quality, access, cost of care and potential to improve the health status of the populations covered by the Demonstration. Also include information on which populations and geographic areas will be affected by the reforms.

By leveraging premium assistance to purchase private coverage for Private Option beneficiaries, the Demonstration will improve quality and value in the healthcare system for all Arkansans. First, as a result of provisions included in the Arkansas Healthcare Independence Act which establishes the Private Option, all carriers offering QHPs in the Marketplace will be required to participate in the AHCPII—an innovative, multi-payer initiative to improve quality and reduce costs statewide. Because the Demonstration will add approximately 225,000 individuals to these carriers' enrollment rosters, the Demonstration dramatically expands the number of patients for whom providers are held accountable for the cost and quality of care.

Second, the Demonstration will improve access to care for Private Option beneficiaries by expanding the number of in-network providers. Because reimbursement rates in Medicaid have historically been lower than Medicare or commercial rates, many providers in Arkansas accept only limited numbers of Medicaid patients and expansion of the Medicaid network to absorb an expansion population would not succeed without meaningful increases in provider reimbursement. Private Option beneficiaries will have access to the full provider networks of their QHPs, which include many providers who do not currently participate in Medicaid. Moreover, had Arkansas expanded Medicaid without leveraging QHPs the number of Medicaid beneficiaries accessing care through the existing Medicaid fee-for-service network would increase by 40% creating access problems for all Medicaid beneficiaries.

Finally, by nearly doubling the number of individuals who will enroll in QHPs through the Marketplace, the Demonstration is expected to encourage carrier entry, expanded service areas, and competitive pricing in the Marketplace, thereby enabling QHP carriers to better leverage economies of scale to drive pricing down even further.

Taken together, the three factors described above will improve quality, promote access, and reduce costs statewide. All Arkansans, regardless of the underlying subsidy for their health insurance, will benefit from improved quality and reduced costs spurred by the Demonstration. And all Medicaid beneficiaries, including those served through fee-for-service Medicaid will

benefit from spreading the growing Medicaid population across a broader network of providers.

3) Indicate the delivery system that will be used in the Demonstration by checking one or more of the following boxes:

- ☐ **Managed care**
  - ☐ **Managed Care Organization (MCO)**
  - ☐ **Prepaid Inpatient Health Plans (PIHP)**
  - ☐ **Prepaid Ambulatory Health Plans (PAHP)**
- ☐ **Fee-for-service (including Integrated Care Models) Primary Care Case Management (PCCM)**
- ☐ **Health Homes**
- ☒ **Other (please describe)**

The Demonstration will use premium assistance to purchase QHP coverage for Private Option beneficiaries. Each Private Option beneficiary will have the option to choose between at least two high-value silver plans offered in the individual market through the Marketplace. The State will pay the full cost of QHP premiums; all cost-sharing in the high-value silver plans will comply with Medicaid requirements. Additionally, the State will provide through its fee-for-service Medicaid program wrap-around benefits that are required for the ABP but not covered by qualified health plans—namely, non-emergency transportation and Early Periodic Screening Diagnosis and Treatment 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). EPSDT services are relevant to the Private Option only because the Affordable Care Act defines 19 and 20 year olds as children for purposes of service benefit requirements, but adults for purposes of eligibility. If family planning services are accessed at out-of-network providers, the State's fee-for-service Medicaid program will cover those services, as required under federal Medicaid law. Because of Arkansas's Any Willing Provider Law, few, if any, such providers are expected to be outside of private insurance carrier networks.

4) If multiple delivery systems will be used, please include a table that depicts the delivery system that will be utilized in the Demonstration for each eligibility group that participates in the Demonstration (an example is provided). Please also include the appropriate authority if the Demonstration will use a delivery system (or is currently seeking one) that is currently authorized under the State plan, section 1915(a) option, section 1915(b) or section 1932 option:

Delivery System Chart

Eligibility Group	Delivery System	Authority

5) If the Demonstration will utilize a managed care delivery system:

The Demonstration is utilizing premium assistance to purchase QHPs in the individual market, and not Medicaid managed care plans, to deliver benefits. Although the Medicaid managed care regulations do not apply to the proposed premium assistance model, the State responds to the questions below to provide additional detail and context for its proposal to leverage qualified health plans as the delivery system for the Demonstration.

a) Indicate whether enrollment be voluntary or mandatory. If mandatory, is the state proposing to exempt and/or exclude populations?

For individuals who are eligible for the Private Option, enrollment in a QHP will be mandatory. Individuals who are determined to be medically frail/have exceptional medical needs are not eligible for the Private Option and such individuals will be excluded from enrolling in QHPs. Individuals excluded from enrolling in QHPs through the Private Option as a result of medical frailty/exceptional medical needs will be eligible for coverage under Title XIX and will have the option of receiving either the ABP or the standard Medicaid benefit package through the State Plan.

Arkansas will institute a process to determine whether an individual is medically frail/has exceptional medical needs—such as individuals who would benefit from long-term services and supports and targeted outreach and care coordination through the State's emerging plans to establish health homes and to provide services through the Community First Choice state plan option.

Arkansas is working with researchers from the University of Michigan and the Agency for Healthcare Research & Quality to develop a questionnaire with approximately twelve questions to assess whether an individual may be medically frail/have exceptional medical needs ("the Screening Tool"). The screening tool will include the following domains: health self-assessment; living situation; assistance with activities of daily living (ADLs) or Instrumental Activities of Daily Living (IADLs); overnight hospital stays (both acute and psychiatric); and number of physician, physician extender or mental health professional visits. The Screening Tool will be conducted online (unless an individual requests a paper copy) and will consist of yes/no and multiple choice answers. Responses will be entered into software that will calculate whether the person meets the medically frail/exceptional medical needs criteria. The screening tool methodology is a combination of threshold qualifying characteristics, such as the presence of an ADL or IADL, and a weighted scoring algorithm based on applicant responses to other screening questions that will initially be calibrated to identify the top ten percent expected costs among the newly eligible population. Downstream refinements to the questionnaire algorithm will occur as data accumulates and individual screening results are compared with actual utilization patterns.

The medical frailty/exceptional medical needs screening process is meant to be prospective at the time of enrollment and will be conducted annually by Arkansas Medicaid. Self-attestation to the questions in the Screening Tool will be accepted in year one. In the case of false negatives and for individuals with emerging medical needs that lead to a predictable and significant need for additional benefits during the plan year, Medicaid will develop a process for making mid-year transitions to traditional Medicaid. The State may also develop a process to monitor claims experience to identify individuals who were initially identified as medically frail/having exceptional medical needs but no longer appear to meet those criteria.

The exact details of the process will differ slightly depending on whether an individual applies for the Private Option through the federally facilitated marketplace (FFM) or through the State's eligibility system.

- *Individuals Applying Through FFM:* After the FFM determines that an individual is eligible for Medicaid, the State will send a notice informing the individual that he/she appears to be eligible for the Private Option. The notice will, among other things, direct individuals who appear Private Option eligible to the State portal where they will first see the Screening Tool described above. If the answers on the Screening Tool indicate that the individual is not medically frail/has exceptional medical needs, the individual will move on to shopping and enrollment through the State portal. If the results of the Screening Tool indicate that the individual is medically frail/has exceptional medical needs, instead of advancing to the shopping and enrollment pages, the individual will be given the option of receiving either standard Medicaid benefits or the ABP through fee-for-service Medicaid.

- *Individuals Applying Through the State Portal:* Immediately after an individual is determined to be Medicaid-eligible, the individual will be asked to complete the Screening Tool. Once the individual completes the Screening Tool, the individual will be directed to shopping and enrollment, if not determined to be medically frail/have exceptional medical needs, or will be given the option of receiving either standard Medicaid benefits or the ABP through fee-for-service Medicaid.

The State will comply with all requirements set forth in Section 1937 of the Social Security Act, including, but not limited to, ensuring that all individuals determined to be medically frail, as well as individuals in other ABP-exempt populations identified in Section 1937 of the Social Security Act, will be given the option to receive through fee-for-service Medicaid either the ABP or the standard Medicaid benefit package.

b) Indicate whether managed care will be statewide, or will operate in specific areas of the state.

The Demonstration will be statewide.

c) Indicate whether there will be a phased-in rollout of managed care (if managed care is not currently in operation or in specific geographic areas of the state).

There will not be a phased-in rollout. The Demonstration will begin statewide on January 1, 2014.

d) Describe how the state will assure choice of MCOs, access to care and provider network adequacy.

Through AID's plan management process, the State will assure that Private Option beneficiaries will be able to choose from at least two high-value silver plans in each rating area of the State. Private Option beneficiaries will be permitted to choose among all high-value silver plans offered in their geographic area, and thus all Private Option beneficiaries will have a choice of at least two qualified health plans. Additionally, AID will evaluate network adequacy, including QHP compliance with Essential Community Provider network requirements, as part of the qualified health plan certification process. As a result, Private Option beneficiaries will 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.

The State expects to implement policies over time that will further ensure cost-effective QHP purchasing. Given the expansion of health insurance coverage associate with the Private Option, uncompensated care is expected to decline significantly in 2014 and beyond, reducing the need for providers to "cost-shift", i.e., raise their contractual prices with private health insurance plans to make up for losses incurred by serving uninsured (or under-insured) patients. Also, the Private Option will result in the enrollment of a large number of Medicaid beneficiaries into QHPs, resulting in increased payments to providers for existing uninsured patients.

In sum, the Private Option helps transform and significantly expand the private insurance marketplace, and this new marketplace will establish competitive price points for provider reimbursement. As a result of these large shifts in payment and compensation for providers, actuaries projecting the expected costs of Arkansas's Private Option for DHS estimated that contractual rates of reimbursement for providers participating in QHPs that serve Private Option participants would be, on average, lower than existing provider contracts with commercial insurers today due to the reduced need for cost-shifting. (This general assumption does not necessarily imply the impact of the Private Option on commercial payer reimbursement to any specific provider.) To help ensure cost-effective use of taxpayer funds, the Private Option is employing a purchasing standard consistent with a transition to more competitive insurance markets

during Plan Year 2014, and in future Plan Years expects to develop and adopt additional strategies to ensure the purchase of both competitively-priced and cost-effective plans.

e) Describe how the managed care providers will be selected/procured

Qualified health plans will be selected through AID's QHP certification process. As noted above, Private Option beneficiaries will be able to choose among high-value silver plans available in their geographic region. Products with proposed premiums that the AID determines are outliers will not be certified to be offered on the Marketplace, ensuring that Private Option beneficiaries choose among only cost-effective QHPs. In the second and third years of the Demonstration, the State will review carrier competition and premiums and may establish more selective criteria for QHP eligibility for the Private Option to ensure both beneficiary choice and cost-effective purchasing that meets the terms and conditions of this waiver.

6) Indicate whether any services will not be included under the proposed delivery system and the rationale for the exclusion.

Wrap-Around Benefits

All services will be provided through QHPs, except for two services that are not fully covered under the QHP benefit package but that must be included in the ABP. Specifically, the State will provide a fee-for-service wrap around benefit for: (1) non-emergency medical transportation; and (2) Early Periodic Screening Diagnosis and Treatment for individuals under age 21 (to the extent the service is not otherwise included in the QHP benefit). In addition, if a Private Option beneficiary accesses family planning services through an out-of-network provider, those services will be covered through fee-for-service Medicaid, consistent with federal law.

Retroactive Coverage

Arkansas will also use the fee-for-service delivery system to provide retroactive coverage for the three months prior to the month in which an individual is determined eligible for Medicaid.

Coverage Prior To QHP 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 becomes effective. For individuals who select (or are auto-assigned) to a QHP between the first and fifteenth day of a month, QHP coverage will become effective as of the first day of the month following QHP selection (or auto-assignment). For individuals who select (or are auto-assigned) to a QHP between the sixteenth and last day of a month, QHP coverage will become effective as of the first day of the second month following QHP selection (or auto-assignment).

7) If the Demonstration will provide personal care and/or long term services and supports, please indicate whether self-direction opportunities are available under the Demonstration. If yes, please describe the opportunities that will be available, and also provide additional

information with respect to the person-centered services in the Demonstration and any financial management services that will be provided under the Demonstration

___ Yes
_X_ No

The Demonstration will not provide long-term services and supports or personal care.

8) If fee-for-service payment will be made for any services, specify any deviation from State plan provider payment rates. If the services are not otherwise covered under the State plan, please specify the rate methodology.

Providers will be reimbursed for care provided to Private Option beneficiaries at the rates the providers have negotiated with the QHP. The State anticipates that provider payment rates under QHPs will be at least as high as provider payment rates offered under the State Plan.

Arkansas recognizes the value of the State's FQHCs/RHCs and the important role they play in serving Medicaid and uninsured patients. To assure their continuing viability, Arkansas Medicaid, in consultation with the FQHCs/RHCs, intends to develop an alternative payment methodology to reimburse FQHCs for serving Private Option enrollees, as permitted under Section 1902(bb). During 2014, FQHCs/RHCs will be reimbursed for services provided to Private Option enrollees by QHPs at commercial rates consistent with Arkansas law and market dynamics, with supplemental payments made by the Arkansas Medicaid. Arkansas Medicaid will require FQHCs to provide historic and prospective cost and utilization data to enable the development of an alternative payment methodology that moves away from a flat fee-for-service, per-visit payment framework and toward a methodology that accounts for the intensity of the services provided, and the delivery of cost-effective, quality care to Private Option enrollees. Additionally, the alternative payment methodology will reflect the expansion of coverage under Title XIX, including efficiencies created by expansion and changes in utilization patterns as individuals move from uninsured to insured status. The State intends to implement this alternative payment methodology as early as possible after initiation of the Demonstration. Arkansas believes that, working with the FQHCs/RHCs, it can develop a sound payment methodology that reflects the value of the FQHCs/RHCs and advances the goals of the Private Option and a value-based payment and delivery system; however, if an alternative payment methodology cannot be developed on a timely basis, Arkansas reserves the right to seek a waiver of FQHC reimbursement rules during year one of the waiver and/or for years two and three of the Demonstration.

9) If payment is being made through managed care entities on a capitated basis, specify the methodology for setting capitation rates, and any deviations from the payment and contracting requirements under 42 CFR Part 438.

N/A

10) If quality-based supplemental payments are being made to any providers or class of providers, please describe the methodologies, including the quality markers that will be measured and the data that will be collected.

Arkansas Medicaid will not make supplemental payments directly to providers through the Demonstration. All QHP carriers, however, will be required to participate in the AHCPII by assigning enrollees a primary care provider, supporting patient-centered medical homes, and accessing clinical performance data for providers, and thus providers caring for Private Option beneficiaries will be eligible to receive payments under applicable components of the AHCPII.

The AHCPII is intended to shift the delivery system in Arkansas from one that primarily rewards volume to one that rewards quality and affordability. This statewide, multi-payer initiative is designed to be practical and data-driven in its approach to promoting patient-centered, clinically appropriate care. The AHCPII comprises a comprehensive approach to payment reform phased-in over the next several years. Two of those components are already being implemented on a multi-payer basis:

- ***Episode-Based Care Delivery: Retrospective Risk Sharing.*** For specified medical episodes, such as episodes of congestive heart failure or total joint replacement, participating payers have established comprehensive retrospective episode-based payment. Each payer designates one or more providers as the Principal Accountable Provider (PAP) for the episode of care. The PAP is responsible for the overall quality and cost effectiveness of all care included in the episode. Payers then calculate each PAP's average costs and quality across all of episodes delivered during the year. Payers compare the average costs and quality against performance thresholds specifically set by each payer. If a PAP achieves an average episode cost below a "commendable" threshold and meets quality requirements, the PAP is eligible to receive a portion of the savings. Conversely, if a PAP's performance reflects an average cost in excess of the "acceptable" threshold, the PAP is responsible for a share of costs in excess of the threshold. PAPs not meeting quality targets are not eligible for shared savings.

- ***Medical homes***. Payers participating in the AHCPII will support primary care transformation in the form of patient-centered medical homes through care coordination fees and shared savings. Medical homes will be paid care coordination fees on a per member per month (PMPM) basis. The PMPM fees will be linked to demonstrated practice transformation, based on outcomes used in the Comprehensive Primary Care initiative and eventually expanded to include nationally recognized metrics (*e.g.*, AHRQ) for pediatric care. The AHCPII will also measure the value created by a provider, on a risk-adjusted basis, based on both (a) absolute performance and (b) performance improvement, and reward the provider based on the greater of the two amounts.

A third component is available through the Medicaid program and would be included in the benefits that a medically frail/exceptional needs individual could access:

- ***Health homes.*** Health home payment will cover the full range of health home responsibilities and will include a PMPM fee. A portion of the PMPM will be at risk based on process and outcome metrics and only paid when these metrics show that an acceptable level of care management and coordination has been delivered. PMPM payments will be risk adjusted based on the results of a universal assessment of a person's level of developmental disability, long-term services and supports, or behavioral health needs and their medical complexity. In addition, episode-based payments will be made for care of specific conditions.

Through each of these programs, the AHCPII aims to redesign the payment and delivery system to promote quality improvement and affordability. Providers who can successfully provide high-quality care while controlling costs will be eligible to receive payments in excess of their ordinary reimbursement.

Section V – Implementation of Demonstration

1) Describe the implementation schedule. If implementation is a phase-in approach, please specify the phases, including starting and completion dates by major component/milestone.

Applications for the expansion population will begin on October 1, 2013 for Private Option QHP enrollment effective January 1, 2014. A proposed implementation timeframe is included below:

Milestone	Timeframe
Issue public notice of waiver	June 24, 2013
Accept comments on waiver	June 24 – July 24, 2013
Hold public hearings on waiver	July 2 – 9, 2013
Submit waiver application to CMS	August 5, 2013
Receive waiver approval	By October 1, 2013
Open enrollment period	October 1, 2013 – March 31, 2014
Post medically frail/exceptional medical needs screening tool on website	October 2013
Launch shopping and enrollment function on State Portal	October 2013
Coverage under Private Option becomes effective	January 1, 2014

2) Describe how potential Demonstration participants will be notified/enrolled into the Demonstration.

Notices

Upon enrollment in Medicaid funded coverage, Private Option beneficiaries will receive a notice from Arkansas Medicaid advising them of the following:

- *QHP Plan Selection.* The notice will include, among other things, information regarding how Private Option beneficiaries can select a QHP, including advice on selecting the plan that will best address their health needs and information on the State's auto-enrollment process in the event that the beneficiary does not select a plan.

- *Access To Services Until QHP Enrollment is Effective.* The notice will include the Medicaid client identification number (CIN) and information on how beneficiaries can use the CIN number to access services until their QHP enrollment is effective.

- *Wrapped Benefits.* The notice will also include information on how beneficiaries can use the CIN number to access wrapped benefits. The notice will include specific information regarding wrapped benefits, including what services are covered directly through fee-for-service Medicaid, what phone numbers to call or websites to visit to access wrapped services, and any cost-sharing for wrapped services.

- *Appeals.* The notice will also include information regarding the grievance and appeals process. Specifically, the notice will inform Private Option beneficiaries that, for all services covered by the QHP, the beneficiary should begin by filing a grievance or appeal pursuant to the QHP's grievance and appeals process.

- *Exemption from the Alternative Benefit Plan.* The notice will include information describing how Private Option beneficiaries who believe they may be exempt from the ABP, including pregnant women and the medically frail, can request a determination of whether they are exempt from the ABP and, if they are exempt, choose between receiving coverage through the standard Medicaid benefit package or the ABP. The notice will include information on the difference in benefits under the ABP as compared to the standard (State Plan) benefit package. The exemption process is described in Section IV.5.a.

Enrollment

Individuals eligible for QHP enrollment through the Private Option will begin to enroll during the open enrollment period (October 1, 2013 –March 31, 2014) through the following process:

- Individuals will submit a joint 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 will be made either through the FFM or the Arkansas Eligibility & Enrollment Framework (EEF).

- Once individuals have been determined eligible for coverage under Title XIX, they will enter the State's web-based portal. They will then have an opportunity to complete the Medical Frailty/Exceptional Medical Needs Screening Tool.
- Individuals who are determined eligible to receive coverage through the Private Option will enter the State's web-based portal to shop among QHPs available to Private Option eligible individuals and to select a QHP.
- The MMIS will capture their plan selection information and will transmit the 834 enrollment transactions to the carriers.
- Carriers will issue insurance cards to Private Option enrollees.
- MMIS will pay premiums on behalf of beneficiaries directly to the carriers.
- MMIS premium payments will 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 coverage through the Private Option, but does not select a plan, the State will auto-assign the enrollee to one of the available QHPs in the beneficiary's county.

Auto-assignment

The State's goal is to minimize the number of Private Option participants who do not complete the QHP selection process, and therefore need to be auto-assigned. However, particularly in 2014, operational aspects of the enrollment process may result in a significant number of individuals being auto-assigned.

The State anticipates that the majority of Private Option eligible individuals who apply for Medicaid directly through the state portal (EEF) will complete the eligibility and enrollment process, including QHP selection.

Importantly, due to the inability of the FFM to support shopping and enrollment of Arkansas Private Option eligible individuals who apply for coverage through the FFM portal, the State must rely on the EEF to effectuate QHP selection and enrollment. As a result of this disjointed consumer experience, significantly higher levels of auto-assignment are expected for those Private Option beneficiaries who apply for coverage through the FFM. For Private Option beneficiaries who do not select a QHP, the eligible individual will be assigned a QHP and notify the new enrollee of the effective date of his or her QHP enrollment.

In Plan Year 2014, Private Option auto-assignments will be distributed among issuers offering certified silver-level QHPs certified by AID with the aim of achieving a target minimum market share of Private Option enrollees for each issuer in a rating region. Specifically, the target minimum market share for an Issuer offering a high-value silver QHP in a rating region will vary based on the number of competing issuers as follows:

- Two issuers: 33% of Private Option participants in that region.
- Three issuers: 25% of Private Option participants in that region.
- Four issuers: 20% of Private Option participants in that region.
- More than four issuers: 10% of Private Option participants in that region.

AID and Arkansas Medicaid will collaborate to refine and revise the auto-assignment methodology for Plan Years 2015 and 2016, based on factors including QHP premium costs, quality and performance experience.

Individuals who are auto-assigned will be notified of their assignment and will be 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.

Access To Wrap Around Benefits

In addition to receiving an insurance card from the applicable QHP carrier, Private Option beneficiaries will have a Medicaid client identification number (CIN) through which providers may bill Medicaid for wrap-around benefits. The notice containing the CIN will include information about which services Private Option beneficiaries may receive through fee-for-service Medicaid and how to access those services. Similar information will be provided on Arkansas Medicaid's website. Staff at the Arkansas Medicaid beneficiary call centers will be trained to provide information regarding the scope of wrap-around benefits and how to access them. Finally, Arkansas Medicaid will work closely with carriers to ensure that the carriers' call center staff is aware that Private Option beneficiaries have access to certain services outside of the QHP and that staff can direct the Private Option beneficiaries to the appropriate resources to learn more about wrap-around services.

3) If applicable, describe how the state will contract with managed care organizations to provide Demonstration benefits, including whether the state needs to conduct a procurement action.

No procurement action is needed.

Arkansas Medicaid will not contract directly with the QHPs. Instead, Arkansas Medicaid will enter into a memorandum of understanding (MOU) with the plans to outline the process for verifying plan enrollment and paying premiums. Under the terms of the MOU, the QHP will provide a roster of its enrollees who are Private Option beneficiaries. The State will verify that the individuals listed on the roster are Private Option beneficiaries. The MMIS will then transmit payment for premiums to the QHP.

Section VI – Demonstration Financing and Budget Neutrality

Please complete the Demonstration financing and budget neutrality forms, respectively, and include with the narrative discussion. The Financing Form: http://www.medicaid.gov/Medicaid- CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Interim1115-Demo-Financing-Form.pdf includes a set of standard financing questions typically raised in new section 1115 demonstrations; not all will

be applicable to every demonstration application. The Budget Neutrality form and spreadsheet: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Interim1115-Budget-Neutrality-Form.pdf includes a set of questions with respect to historical expenditure data as well as projected Demonstration expenditures.

The Budget Neutrality approach recognizes that the population covered by this Demonstration, known as "Private Option 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. Because they could have been made eligible without a waiver, savings are not available. As a result, the projected enrollment and costs for the Private Option Beneficiaries are shown as identical in the without waiver and with waiver scenarios.

Specifically, this waiver will cover individuals eligible for coverage under Title XIX of the Social Security Act who are either (1) childless adults between the ages of 19 and 65 with incomes at or below 138% of the federal poverty level (FPL) who are not enrolled in Medicare or incarcerated or (2) parents between the ages of 19 and 65 with incomes between 17 and 138% FPL who are not enrolled in Medicare. The State of Arkansas intends to use premium assistance to purchase qualified health plans (QHPs) offered in the individual market through the Marketplace. These Private Option beneficiaries will receive the Alternative Benefit Plan (ABP) and have cost sharing obligations consistent with the State Plan. To determine the hypothetical enrollment associated with the Private Option Beneficiaries, the State's actuaries, Optumas, reviewed estimates for uninsured populations by income band (corresponding the income eligibility for the Medicaid expansion by Federal Poverty Level) provided by the Arkansas Center for Health Improvement and then adjusted them for overlap with current Arkansas Medicaid eligibility categories and the resulting woodwork effect expected as a result of the ACA. Optumas then projected the costs for this hypothetical population by reviewing the access and quality of care standards required under 1902(a)(30)(a) and determining that the most appropriate benchmark for network access and quality of care would be the commercial reimbursement anticipated to be used on the Marketplace. Using 2 years of Arkansas Medicaid data for utilization, Optumas applied the commercial reimbursement anticipated to be used on the Marketplace to the projected utilization, adjusted for approved cost-sharing, trend, comprehensive private market care coordination, reinsurance, and non-medical load (administration and profit/risk/contingencies) to determine the estimated premium for the Private Option beneficiaries. Combining the projected enrollment with the expected premium yielded the projected costs for the hypothetical population in both the without and with waiver scenarios.

Section VII – List of Proposed Waivers and Expenditure Authorities

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

- § 1902(a)(17): To permit the State to provide different delivery systems for different populations of Medicaid beneficiaries. The State is not requesting a waiver of comparability with respect to benefits, eligibility, or cost-sharing.
- § 1902(a)(23): To make premium assistance for QHPs in the Marketplace mandatory for Private Option beneficiaries and to permit the State to limit beneficiaries' freedom of choice among providers to the providers participating in the network of the Private Option beneficiary's QHP.
- § 1902(a)(54): 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.

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

Waiver Authority	Use for Waiver	Reason for Waiver Request
§ 1902(a)(17)	To permit the State to provide coverage through different delivery systems for different populations of Medicaid beneficiaries. Specifically, to permit the State to provide coverage for Private Option eligible Medicaid beneficiaries through QHPs offered in the individual market. The State is not requesting a waiver of comparability with respect to benefits, eligibility, or cost-sharing.	This waiver authority will allow the State to test using premium assistance to provide coverage for QHPs offered in the individual market through the Marketplace or a subset of Medicaid beneficiaries.
§ 1902(a)(23)	To make premium assistance for QHPs in the Marketplace mandatory for Private Option beneficiaries and to permit the State to limit beneficiaries' freedom of choice among providers to the providers participating in the network of the Private Option beneficiary's QHP.	This waiver authority will allow the State to require that Private Option eligible beneficiaries 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 Private Option beneficiaries with the network offered to QHP

Waiver Authority	Use for Waiver	Reason for Waiver Request
		enrollees who are not Medicaid beneficiaries.
§ 1902(a)(54)	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 Private Option beneficiaries with standards in the commercial market.

Section VIII – Public Notice

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

The State's comment period was June 24, 2013 to July 24, 2013.

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 June 24, 2013. Arkansas also certifies that it provided notice of the proposed Demonstration in the *Arkansas Democrat-Gazette*—the newspaper of widest circulation in Arkansas—on June 24, 25, and 26. A copy of the notice that appeared in the newspaper is attached here at Appendix A.

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 three public hearings at least twenty days prior to submitting the Demonstration application to CMS. Specifically, Arkansas held the following hearings:

- *Little Rock – July 2, 2013 from 10 am – 12 pm.* Andy Allison, Arkansas's Medicaid Director, provided an overview of the Demonstration in a one-hour presentation. Members of the public provided comments for the remainder of the hearing. All members of the public that requested the opportunity to provide public comments were able to do so. Individuals could also access this public hearing by teleconference and webinar.

- *Fort Smith – July 8, 2013 from 11 am – 1 pm.* Andy Allison provided an overview of the Demonstration in a one-hour presentation. Members of the public provided comments for the remainder of the hearing. All members of the public that requested the opportunity to provide public comments were able to do so.
- *Monticello – July 9, 2012 from 9 am – 11 am.* At the request of state legislators, Arkansas Medicaid added a third public hearing in the southern portion of the state. Like the other hearings, Andy Allison provided an overview of the Demonstration in a one-hour presentation. Members of the public provided comments for the remainder of the hearing. All members of the public that requested the opportunity to provide public comments were able to do so.

In addition to these three public hearings, Arkansas Medicaid also testified about the proposed Demonstration at a session of the Public Health Committee of the Arkansas Legislature. The hearing, held on June 27, 2013, was open to the public and was listed on the Public Health Committee's public schedule.

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, as well as legislators. Arkansas Medicaid also provided a second notice by email to these groups to publicize the third hearing that was added to ensure participation by residents of the southern region of Arkansas.

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

Arkansas received 408 comments during the public notice period. Of the 408 comments, 389 were nearly identical letters.

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.

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 IX – Demonstration Administration

Please provide the contact information for the state's point of contact for the Demonstration application.

Name and Title: Andy Allison, Director, Division of Medical Services, Arkansas Department of Human Services
Telephone Number: (501) 683-4997
Email Address: Andy.Allison@arkansas.gov

Appendix A

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 of Medicare and Medicaid Services (CMS) a written application to request approval of a Health Care Independence 1115 Demonstration waiver and to hold public hearings to receive comments on this Demonstration.

To implement the Arkansas Health Care Independence Act, the State will use premium assistance to purchase 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 (collectively "Private Option beneficiaries"). 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.

Private Option beneficiaries will receive the Alternative Benefit Plan (ABP) through a QHP that they select and have cost sharing obligations consistent with both the State Plan and with the cost-sharing rules applicable to individuals with comparable incomes in 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. Ultimately, the Demonstration will provide truly integrated coverage for low-income Arkansans, leveraging the efficiencies of the private market to improve continuity, access, and quality for Private Option beneficiaries. Additionally, by nearly doubling the size of the population enrolling in QHPs offered through the Marketplace, the Demonstration is expected to drive health care system reform and more competitive premium pricing for all individuals purchasing coverage through the Marketplace.

The Demonstration will be statewide and will operate during calendar years 2014, 2015, and 2016. The State anticipates that approximately 225,000 individuals will be eligible for the Demonstration. The State expects that, over the life of the Demonstration, covering Private Option 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 provider access, churning, emergency room use, cost-comparability, usage of Medicaid wrap benefits, quality improvement, preventive services, and uncompensated care costs.

The State will request the following waivers to operate the Demonstration:

- § 1902(a)(17): To permit the State to provide different delivery systems for different populations of Medicaid beneficiaries. The State is not requesting a waiver of comparability with respect to benefits, eligibility, or cost-sharing.
- § 1902(a)(23): To make premium assistance for QHPs in the Marketplace mandatory for Private Option beneficiaries and to permit the State to limit beneficiaries' freedom of choice among providers to the providers participating in the network of the Private Option beneficiary's QHP.

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

The complete version of the current draft of the Demonstration application is available for public review at https://www.medicaid.state.ar.us/Download/general/comment/InitialHCIWApp.doc. 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 July 24, 2013. 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/Download/general/comment/HCIWComments.doc.

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
July 2, 2013
10 AM – 12 PM CST
University of Arkansas for Medical Sciences

Fort Smith
July 8, 2013
11 AM – 1 PM CST
University of Arkansas - Fort Smith

I. Dodd Wilson Building - Room 126
4301 W Markham
Little Rock, Arkansas 72205

Math-Science Building - Room 101
5210 Grand Avenue
Fort Smith, Arkansas 72904

Individuals may access the hearing on July 2, 2013 by webinar. To participate by webinar, please register at:
https://afmcevents.webex.com/afmcevents/onstage/g.php?t=a&d=664738225.

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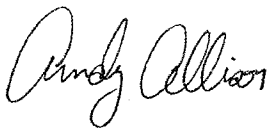

Andy Allison, PhD
Director, Arkansas Medicaid
Department of Human Services

Appendix B

Public Comments and Responses

Federally Qualified Health Centers

Comment: Several commenters requested that Arkansas eliminate its proposed waiver of 1902(a)(15) to permit federally qualified health centers (FQHC) and rural health centers (RHC) to be reimbursed at market-based rates negotiated with QHP carriers, supplemented by incentive payments available through the Arkansas Health Care Payment Improvement Initiative (AHCPII). Commenters stated that the requirement to pay FQHCs and RHCs the prospective payment system (PPS) rate is intended, in part, to ensure access to FQHCs. Additionally, several commenters emphasized that waiving the PPS rate is not necessary to carry out the Demonstration, and that a waiver of the PPS rate will not save the State money due to enhanced federal funding for newly eligible Medicaid beneficiaries. Finally, several commenters emphasized that FQHCS/RHCs provide high-quality healthcare for their patients and, in many instances, are certified as Level 3 Patient-Centered Medical Homes.

Response: We recognize that FQHCs and RHCs are important sources of high-quality care for many low-income Arkansans and serve as critical access points for the uninsured and underinsured. Arkansas is committed to ensuring that FQHCs/RHCs are included in the networks of QHPs through the Arkansas Insurance Department's review of network adequacy (including essential community provider requirements) and enforcement of the State's any willing provider law.

Upon further consideration, Arkansas Medicaid has decided to eliminate its request to waive the FQHC reimbursement rules. Instead, Arkansas Medicaid, in consultation with the FQHCs/RHCs, intends to develop an alternative payment methodology to reimburse FQHCs for serving Private Option enrollees, as permitted under Section 1902(bb). During 2014, FQHCs/RHCs will be reimbursed for services provided to Private Option enrollees by QHPs at commercial rates consistent with Arkansas law and market dynamics, with supplemental payments made by the Arkansas Medicaid. Arkansas Medicaid will require FQHCs to provide historic and prospective cost and utilization data to enable the development of an alternative payment methodology that moves away from a flat fee-for-service, per-visit payment framework and toward a methodology that accounts for the intensity of the services provided, and the delivery of cost-effective, quality care to Private Option enrollees. Additionally, the alternative payment methodology will reflect the expansion of coverage under Title XIX, including efficiencies created by expansion and changes in utilization patterns as individuals move from uninsured to insured status. The State intends to implement this alternative payment methodology as early as possible after initiation of the Demonstration. Arkansas believes that, working with the FQHCs/RHCs, it can develop a sound payment methodology that reflects the value of the FQHCs/RHCs and advances the goals of the Private Option and a value-based payment and delivery system; however, if an alternative payment methodology cannot be developed on a timely basis, Arkansas reserves the right to seek a waiver of FQHC

reimbursement rules during year one of the waiver and/or for years two and three of the Demonstration.

Comment: One commenter expressed concern that the request to waive the right of Medicaid beneficiaries to have freedom of choice among providers would negatively affect FQHCs and RHCs. Specifically, the commenter expressed concern that FQHCs and RHCs would need to join the networks of the private plans providing coverage under the Demonstration to continue to treat Private Option enrollees. The commenter stated that FQHCs and RHCs could be required, as a condition of joining plans' networks, to participate in programs in which FQHCs and RHCs do not currently participate, such as the AHCPII.

Response: Plans may establish their own criteria for network participation, which may include requiring that providers participate in the AHCPII—which is intended to improve care for all patients. Providers will be free to assess whether they are able to comply with the conditions of participation set forth in the plans' provider contracts.

Comment: Several commenters urged that the State not limit access to FQHC and RHC services for individuals enrolled in the Private Option.

Response: Arkansas is committed to ensuring that FQHCs/RHCs are included in QHP networks through the Arkansas Insurance Department's review of network adequacy (including essential community provider requirements) and enforcement of the State's any willing provider law. Additionally, nearly all services that FQHCs/RHCs provide will be covered through the QHP's benefit package (including, among others, primary and preventive care) or through medical home payments under the AHCPII (including, among others, case management, outreach, and medical education). The State therefore anticipates that Private Option enrollees will have access to the full range of FQHC/RHC services that must be covered under federal Medicaid law.

Comment: Several commenters questioned whether the Secretary of Health and Human Services has the legal authority to waive the requirement to pay the PPS rate to FQHCs/RHCs since, the commenters argue, a waiver of the PPS rate does not further the purposes of Title XIX and endangers the well-being of Medicaid beneficiaries.

Response: As noted above, Arkansas has revised the waiver to eliminate the request to waive FQHC reimbursement rules.

Eligibility and Enrollment

Comment: Several commenters expressed both support for and concerns regarding the State's proposal to provide 12-month continuous eligibility for Private Option enrollees.

Response: We thank the commenters for their interest in our 12-month continuous coverage proposal. Based on further conversation with CMS regarding the requirements of administering 12-month continuous coverage, Arkansas has decided not to seek a waiver for 12-month

continuous for the first year of the Demonstration. We leave open the possibility of revisiting this issue in future years of the Demonstration.

Comment: One commenter expressed support for 12-month continuous eligibility for children from 6 to 12 months.

Response: We thank the commenter for this idea, but since children will not be eligible for the Demonstration in 2014, we will revisit this issue in future years of the Demonstration.

Comment: One commenter requested that Arkansas permit retroactive enrollment in Medicaid for individuals receiving coverage through the Demonstration.

Response: The draft waiver application states that Arkansas will provide retroactive coverage for three months prior to when the beneficiary is determined eligible for the Private Option and that such coverage will be provided through the Medicaid Agency (*i.e.*, there will be no retroactive enrollment in QHPs for the retroactive coverage period). Arkansas intends to retain retroactive coverage in the final waiver application.

Comment: One commenter expressed concern that some parents who would be newly eligible for Medicaid would not be permitted to enroll in the Private Option. Specifically, the draft waiver application states that individuals with incomes above 17% FPL will have coverage through the Demonstration in 2014. The commenter noted that non-working parents, however, must have incomes below 13% FPL to be eligible for Medicaid currently, and thus non-working parents with incomes between 13-17% FPL would be newly eligible for Medicaid but not eligible for the Private Option.

Response:
The State will not enroll parents with incomes below 17% FPL in the Private Option in 2014. Non-working parents with incomes from 13-17% FPL will be eligible for benefits under Title XIX, and the State will provide such benefits through its traditional Medicaid program.

Comment: One commenter requested that the State defer enrolling children in the Private Option.

Response: Arkansas will not enroll children in the Private Option in 2014. Prior to enrolling children in the Private Option, the State will issue a notice of its proposed changes to the Demonstration and afford the public the opportunity to provide additional comments.

Comment: Several commenters expressed concern that the eligibility and enrollment process described in the draft waiver application could prove burdensome for families in which individuals are eligible for multiple insurance affordability programs (*e.g.*, advance payment tax credits, Medicaid, and CHIP). Additionally, commenters expressed concern that individuals with inflexible work hours or limited internet access may have problems completing the enrollment process. Commenters also included several other suggestions related to eligibility and

enrollment system, including, among others, suggestions to target outreach efforts to individuals who are likely newly eligible for coverage under Title XIX, to extend the "opt-out" of the auto-assignment process to 60-90 days, and to modify the auto-assignment process to account for existing provider relationships.

Response: We thank the commenters for underscoring the importance of creating a streamlined and accessible eligibility and enrollment process. All eligibility determinations will comply with federal standards, and individuals will be able to request an eligibility determination through a single-streamlined application that may be completed online, by phone, in person, or submitted by mail. Arkansas continues to develop its process for enrolling individuals eligible for coverage in the Private Option, but, at a minimum, the State will ensure that Private Option enrollees have notice of the process for selecting a qualified health plan (QHP) and that such process is not overly burdensome. Although the plan selection process will be as simple as possible, the State recognizes that a significant number of Private Option enrollees will likely be auto-assigned in the first year of the Demonstration. Throughout the Demonstration, Arkansas will continue to refine the plan selection process to enable increasing numbers of Arkansans to affirmatively select their plan, including the opportunity to change plans for a limited period of time after auto-assignment.

Comment: Several commenters encouraged the State to develop consumer outreach and assistance programs to ensure individuals can enroll in the appropriate programs. Commenters also requested that Arkansas ensure consumer outreach and assistance programs not steer beneficiaries to any particular plan.

Response: Arkansas intends to develop a consumer outreach and assistance plan to ensure that eligible individuals can enroll in the Private Option and have the information needed to make informed choices prior to QHP selection. Arkansas will prohibit consumer assisters from steering individuals to a particular QHP.

Comment: Several commenters requested additional information on the medically frail screening process and tool. Commenters also asked whether the public will have the opportunity to comment on the definition of "medically frail" or the contents of the screening tool. Commenters also asked whether Medicaid will monitor claims to determine whether an individual should be classified as medically frail.

Response: The State continues to work closely with experts at the University of Michigan and at the Agency for Healthcare Research & Quality to develop a screening tool to identify individuals who may be medically frail. We will provide additional information on the screening tool as it becomes available. Currently, the State anticipates that the screening tool will address the following domains: health self-assessment; living situation; assistance with activities of daily living (ADLs) or Instrumental Activities of Daily Living (IADLs); overnight hospital stays (both acute and psychiatric); and number of physician, physician extender or mental health professional visits. The Screening Tool will be conducted online (unless an individual requests a paper copy) and will consist of yes/no answers to a short series of questions that focus on a

person's use of long term supports and services and mental health resources, and presence of complex medical conditions. Responses will be entered into software that will calculate whether the person meets the medically frail/exceptional medical needs criteria. The screening tool methodology is a combination of threshold qualifying characteristics, such as the presence of an ADL or IADL and a weighted scoring algorithm based on applicant responses to other screening questions, initially calibrated to identify the top ten percent expected costs among the newly eligible population. Downstream refinements to the questionnaire algorithm will occur as data accumulates and individual screening results are compared with actual utilization patterns.

The State does not currently intend to have a separate comment period regarding the definition of medically frail. The State will, however, provide a notice and comment period for the State Plan Amendment required to implement the Alternative Benefit Plan, and the State Plan Amendment will include additional details regarding how the State intends to implement the medically frail exemption. Arkansas intends to develop a mid-year process to identify individuals who were not initially identified as medically frail, but who may be or become medically frail. Additionally, individuals will have the right to request a re-determination of whether they are medically frail at any point during the year. Finally, the State will establish a process to re-evaluate medical frailty each year.

Comment: One commenter requested that individuals have a right to appeal the determination of whether they are medically frail.

Response: We do not anticipate having a process to appeal a medically frail determination. However, individuals will be able to request a redetermination of whether they are medically frail at any time during the coverage year. In the case of individuals with emerging medical needs that lead to a predictable and significant need for additional benefits during the plan year, Medicaid will develop a process for making mid-year transitions to traditional Medicaid. The State may also develop a process to monitor claims experience to identify individuals who were initially identified as medically frail/having exceptional medical needs but no longer appear to meet those criteria.

Comment: One commenter suggested that the medically frail screening tool incorporate questions regarding social determinants of health.

Response: We acknowledge the importance of social determinants of health and the value of identifying populations at risk for poor health outcomes. The medically frail screening tool, however, will be targeted solely at identifying individuals who fall within the federal definition of medically frail or 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 and these individuals will not be eligible for the Demonstration.

Comment: One commenter requested that the State establish a timeline for announcing operational details related to the eligibility and enrollment system for the Demonstration, as well as mechanisms to pay plans.

Response: The State continues to refine the eligibility and enrollment processes, and the State intends to release additional details as they become available. Although the State will not have a formal comment process related to the eligibility and enrollment system, the State welcomes input from stakeholders. Additionally, the State intends to work closely with QHPs to ensure that the enrollment and payment processes run as smoothly as possible.

Comment: One commenter noted that the Demonstration excludes some Arkansans, including some lawful permanent residents, who would likely benefit from coverage under the Private Option.

Response: We appreciate the commenter's concern for the well-being of all Arkansans. Federal law prohibits the use of federal Medicaid funds for residents with certain immigration statuses. The Demonstration was drafted to comply with the requirements for federal funding.

Benefits & Cost-Sharing

Comment: One commenter noted that the draft waiver application stated that Private Option enrollees who are 19 or 20 years old would be able to receive Early Periodic Screening, Diagnosis, and Treatment Services (EPSDT) through fee-for-service Medicaid. The commenter noted that the draft waiver application refers only to dental and vision services when discussing EPSDT, but that EPSDT covers a broader range of services. The commenter requested additional details on how the State would provide access to the full range of EPSDT services.

Response: The draft waiver application references dental and vision services as an example of the EPSDT services that will most commonly provided to 19- and 20-year old Private Option enrollees through fee-for-service Medicaid. The State anticipates that most EPSDT services other than dental and vision services will be covered by the QHPs. In the event that a 19- or 20-year old Private Option enrollee requests a service (other than dental and vision) that is not covered by the QHP, Arkansas Medicaid will review the request for services on a case-by-case basis to determine whether the service must be covered under EPSDT. We have revised the waiver application to clarify that 19- and 20-year olds will have access to the full range of EPSDT services.

Comment: Several commenters expressed concerns with Arkansas's proposed request for a waiver to enable Private Option enrollees to be limited to their QHPs' formularies. Commenters stated that some Private Option enrollees may be unable to access drugs they are currently taking—particularly specialty biologicals—if their plans' formularies do not cover those drugs.

Response: Due to a clarification included in final rules released by the federal government on July 5, 2013,[5] Arkansas will no longer need to request a waiver to limit Private Option enrollees to their QHPs' formularies. Under federal Medicaid law, the benefit package known as the Alternative Benefit Plan may include a closed formulary of drugs, based on the formulary of the reference plan selected to develop the Alternative Benefit Plan. Because Arkansas will use the same plan to define the benefit package of QHPs and the Alternative Benefit Plan, the formularies for the Alternative Benefit Plan and QHPs will be subject to the same requirements, and thus a waiver is not required.

Comment: One commenter asked whether individuals who are newly eligible for Medicaid but who are identified as medically frail and who elect to receive the benefit package offered under the State Plan, rather than the Alternative Benefit Plan, will receive the benefit package currently offered to individuals who are categorically eligible for Medicaid or the package offered to individuals who are medically needy.

Response: Individuals who are newly eligible for Medicaid but who are identified as medically frail and who elect to receive the benefit package offered under the State Plan will receive the benefit package offered to individuals who are categorically eligible for Medicaid.

Comment: One commenter asked whether Private Option enrollees will be able to receive inpatient psychiatric services.

Response: Inpatient psychiatric services will be covered for Private Option enrollees.

Comment: One commenter flagged that the draft waiver application refers to monitoring Private Option enrollee cost-sharing on an annual, rather than quarterly or monthly, basis and tracking cost-sharing against an individual, rather than family, cap. The commenter suggested that the approach proposed in the waiver might be inconsistent with federal Medicaid laws governing cost-sharing.

Response: We appreciate the feedback regarding the importance of beneficiary cost-sharing protections. The State is working with the federal government to develop an approach to monitor cost-sharing for Private Option enrollees. The State's approach will comply fully with the Medicaid rules governing limits on cost-sharing. We note that the State had contemplated requesting a waiver from the federal government of the requirements regarding limitations on cost-sharing, and therefore included the proposed waiver request in the draft application. We have since determined that such waiver is not necessary to implement the Private Option.

Comment: One commenter noted that federal Medicaid law requires that pregnant women be exempt from cost-sharing for maternity-related services. The commenter also flagged that all Medicaid beneficiaries receive family planning services with no-cost sharing.

[5] 78 Fed. Reg. 42,159 (July 15, 2013).

Response: We thank the commenter for emphasizing the particular importance of these two cost-sharing exemptions. The Demonstration will comply with all requirements relating to cost-sharing, unless requesting a waiver. Specifically, the State will comply with the requirement that pregnant women pay no cost-sharing for maternity-related services. The State is currently developing an operational process to effectuate this cost-sharing exemption. QHPs will cover family planning services at no cost-sharing to comply with the federal requirement to cover preventive services at no cost-sharing.

Comment: One commenter flagged that the proposed cost-sharing design imposes cost-sharing on emergency room use, in violation of federal Medicaid law. Additionally, the commenter notes that non-emergency use of the emergency room may be subject to a copay of not more than $8—less than the $20 in the cost-sharing design.

Response: Arkansas Medicaid will ensure that Private Option enrollees are not liable for any cost-sharing for emergency use of the emergency room, consistent with federal law. Non-emergency use of the emergency room is not a covered benefit under the Alternative Benefit Plan, since non-emergency use of the emergency room is neither an Essential Health Benefit nor a mandated service in the Alternative Benefit Plan. As is noted in the waiver application, the State will provide educational materials describing the appropriate use of the emergency room and will notify beneficiaries that non-emergency use of the emergency room is not covered under the Alternative Benefit Plan. Arkansas Medicaid will also monitor non-emergency use of the emergency room.

Comment: One commenter expressed concern about the State's plan to apply cost-sharing for individuals with incomes from 50-100% FPL in year 2 of the Demonstration.

Response: To impose cost-sharing on individuals with incomes from 50-100% FPL, Arkansas will be required to submit an amended waiver application and provide the public with notice of and an opportunity to comment on the amended waiver. Arkansas has not yet developed its proposal for how to impose cost-sharing on this group, and we will keep these comments under advisement as we design the proposal.

Comment: Several commenters asked for clarification on whether Private Option enrollees would be required to pay the deductible included in the standard cost-sharing design for the high-value silver plan.

Response: We thank the commenters for flagging this ambiguity. We have revised the waiver to clarify that Private Option enrollees will not be required to pay the deductible. Arkansas Medicaid will wrap the deductible for all Private Option enrollees.

Comment: Several commenters asked for additional information about the design of the Alternative Benefit Plan, including whether the Alternative Benefit Plan will be the same in fee-for-service Medicaid and in the Private Option.

Response: The State is currently drafting the State Plan Amendment adopting the Alternative Benefit Plan. The State will issue a public notice of and provide an opportunity to comment on the State Plan Amendment, consistent with the requirements of federal law. The Alternative Benefit Plan will include the same benefits in fee-for-service Medicaid as in the Private Option.

Comment: One commenter asked whether Arkansas would use the same process to contract with non-emergency medical transportation vendors to serve Private Option enrollees as it does for vendors serving traditional fee-for-service Medicaid enrollees.

Response: Arkansas Medicaid will use its existing network of vendors to provide non-emergency medical transportation to Private Option enrollees.

Comment: One commenter expressed concern that the Demonstration will cover contraception and sterilization, as well as abortion services in some circumstances.

Response: The benefits covered through the Demonstration comply with federal requirements. Contraception, sterilization, and abortion services in some limited circumstances are Essential Health Benefits, and therefore, they must be covered by the Alternative Benefit Plan. We note that abortions are covered by the Alternative Benefit Plan only if:

1. they are at the direction of a physician;
2. they are performed in an in-patient hospital or outpatient hospital setting; and
3. circumstances comply with the Hyde Amendment, i.e., specifically in cases where the life of the mother is endangered or where the pregnancy is the result of rape or incest.

Comment: One commenter asked for additional details on the notices discussing eligibility determinations, QHP plan selection, the medically frail screening process, access to wrapped benefits, and selecting the Alternative Benefit Plan or traditional Medicaid benefit package (if applicable).

Response: The State continues to develop the notices that will be issued to beneficiaries addressing these topics. All notices will comply with federal law and regulation. Although the State does not intend to have a formal notice and comment process regarding the notices, the State welcomes suggestions on the content or structure of its notices.

Comment: One commenter asked if Medicaid beneficiaries would have separate cards to access both benefits covered under the QHP and benefits provided by Medicaid through a fee-for-service wrap.

Response: Arkansas intends for Private Option enrollees to have a single card to access benefits covered through the QHP and through a fee-for-service Medicaid wrap. If this approach proves operationally infeasible, however, the State will consider issuing a separate card to access wrapped benefits.

Provider Networks

Comment: One commenter noted that Private Option enrollees may not have in-network coverage for school-based health care providers and other types of providers that are not commonly in the networks of commercial plans.

Response: We recognize that Private Option enrollees will not have in-network coverage for all providers and provider-types throughout Arkansas, but we nevertheless believe that Private Option enrollees will have ample choice of providers within their QHPs' networks. We note that all QHPs will be required to demonstrate that they have adequate networks of providers, including sufficient numbers of essential community providers that commonly serve low-income and medically underserved patients.

Comment: One commenter expressed concern that Private Option enrollees would have existing provider relationships disrupted if their current provider does not participate in the QHPs' network.

Response: During the plan selection process, Private Option enrollees will have access to information about the providers in the networks of each QHP. With this information, Private Option enrollees with long-standing provider relationships can choose to enroll in plans in which their providers participate. For Private Option enrollees who are auto-assigned to a plan, they will have thirty days to select a different plan if the enrollee's preferred providers are not in the plan's network. We also reiterate that because of Arkansas's Any Willing Provider law, providers will have the opportunity to participate in plan networks if they are willing to agree to the terms and conditions offered by the carriers.

Comment: One commenter encouraged the state to provide out-of-network coverage for Private Option enrollees.

Response: Arkansas continues to develop a plan to address out-of-network coverage for Private Option enrollees that complies with federal and state laws. We note that even without out-of-network coverage, Private Option enrollees will have access to a robust network of participating providers.

Comment: One commenter expressed concern with language in the draft application suggesting that reductions in provider rates would be beneficial. The commenter noted that some providers are currently reimbursed at less than cost and that further rate reductions could threaten the provider's viability.

Response: We acknowledge the commenter's statement that provider reimbursement levels vary by plan and by provider. We have revised the waiver application to avoid any suggestion that all commercial reimbursement to providers could be reduced.

Comment: One commenter requested clarification regarding whether Private Option enrollees could receive services from nurse practitioners, since the draft of the waiver application refers

to "providers" in some places and "physicians" in others. The commenter also supports providing care through nurse-managed clinics.

Response: We thank the commenter for flagging this ambiguity. Private Option enrollees will be permitted to receive covered services from any licensed health care professional (including a nurse-managed clinic), so long as the services are within the professional's scope of practice and the professional participates in the QHP's network. We have revised the waiver application to replace references to "physicians" with references to "providers."

Evaluation Plan

Comment: One commenter noted that the evaluation methodology for assessing whether providing coverage under the Demonstration is comparable to what it would have cost under traditional, fee-for-service Medicaid is not described in the draft waiver application.

Response: Arkansas continues to work with the Centers for Medicare and Medicaid Services to develop an appropriate evaluation approach for determining whether the cost of coverage under the Demonstration is comparable to the cost of providing similar coverage under traditional, fee-for-service Medicaid. The State's formal waiver submission to CMS includes a discussion of cost-comparability.

Comment: One commenter recommended that Arkansas revise its plan to evaluate the Demonstration. Specifically, the commenter suggested that Arkansas not use traditional Medicaid expansion states as a point of comparison, since those states' programs differ substantially from Arkansas's Medicaid program.

Response: The State continues to discuss the Demonstration evaluation plan with the Centers for Medicare and Medicaid Services. Although we agree that the Medicaid programs in traditional expansion states may differ considerably from the current Arkansas Medicaid program, we also recognize that services and populations covered under the Demonstration differ significantly from those of the current Arkansas Medicaid program. Arkansas continues to work with the federal government to identify the most appropriate comparison group to evaluate the Demonstration. We will keep the commenter's suggestions regarding the comparison group under advisement as we continue to refine the evaluation plan with the federal government.

Comment: Several commenters expressed concern that, as part of its evaluation of the Demonstration, Arkansas would track healthcare utilization and spending for Private Option enrollees, infringing on the privacy of Private Option enrollees.

Response: To evaluate the Demonstration effectively, Arkansas will need to track and analyze data relating to healthcare utilization and spending. During this process, Arkansas will limit, to the extent practicable, its use of individually identifiable health information, and Arkansas will ensure that all individually identifiable health information is protected in a manner consistent with federal and state privacy laws.

Appeals

Comment: Several commenters suggested that Private Option enrollees have the right to access the Medicaid coverage appeals process.

Response: Arkansas continues to discuss with the federal government its approach regarding coverage appeals for Private Option enrollees. As is noted in the current draft of the waiver application, the State proposes to use the QHPs' robust internal and external appeals processes. Because of the stringent federal and state requirements governing QHPs' internal and external appeals and the oversight by the Arkansas Insurance Department, the State believes that the internal and external appeals processes of QHPs will protect the rights of Private Option enrollees. Accordingly, we have not modified the waiver application to provide Private Option enrollees with the right to access the Medicaid coverage appeals process.

Comment: One commenter asked whether providers would continue to have rights to appeal denials of coverage under the Medicaid Fairness Act.

Response: Since the Medicaid Fairness Act is a state law, the waiver application to CMS does not address whether the Medicaid Fairness Act would continue to apply. Counsel to Arkansas Medicaid has determined that Medicaid Fairness Act does not apply to Private Option enrollees.

Comment: One commenter supports using the QHP appeals process to address coverage appeals for Private Option enrollees.

Response: We thank the commenter for their support.

Premium Assistance, Generally

Comment: Several commenters expressed their support for the Demonstration.

Response: We thank the commenters for their support of this innovative Demonstration.

Comment: One commenter noted that a recent GAO report finding that few states have successfully implemented premium assistance programs.

Response: Although the GAO report referenced describes the challenges states have faced when implementing premium assistance programs, the Demonstration differs significantly from the premium assistance programs described in the report. Historically, premium assistance has not been used in the individual market as Arkansas proposes to do through its Demonstration. The GAO study referenced focuses on premium assistance in the group market. Also, the premium assistance programs studied in the GAO report were considerably smaller than the Demonstration proposal, and thus those smaller premium assistance programs were unable to leverage economies of scale in administration. Additionally, the premium assistance programs referenced in the GAO study provided premium assistance for employer-sponsored coverage,

meaning that beneficiaries would receive premium assistance for the specific package of benefits offered by their employers. In these premium assistance programs, the Medicaid agency must review each employer-sponsored benefit package to determine what services need to be wrapped, leading to administrative challenges. By contrast, under the Demonstration, the State will be providing premium assistance to purchase a single benefit—the QHP benefit package. Furthermore, Arkansas's Demonstration is specifically designed to minimize the need for wrap-around services through the universal screening process for those with medical frailty/exceptional needs. For these reasons, the GAO study is not directly applicable to the use of premium assistance outlined in the Demonstration waiver.

Comment: One commenter suggested that Arkansas establish a program to provide premium assistance for employer-sponsored coverage.

Response: Arkansas is open to considering other innovative approaches to providing access to high-quality coverage for individuals eligible for coverage under Title XIX, including a premium assistance program for employer-sponsored coverage. We note that Arkansas currently has a small program to provide premium assistance for employer-sponsored coverage. Because of the operational challenges related to premium assistance programs for employer-sponsored coverage, Arkansas declines to expand at this time the Demonstration to include a broader premium assistance program for employer-sponsored coverage.

Other

Comment: One commenter encouraged Arkansas to retain Medicaid as the payer of last resort.

Response: Federal law requires that Medicaid is the payer of last resort, and Arkansas intends to ensure that the Demonstration complies with this requirement.

Comment: One commenter requested that the State impose the same program integrity requirements on QHPs enrolling Private Option beneficiaries as it does on Medicaid providers.

Response: QHPs enrolling Private Option beneficiaries will be subject to robust oversight by the Arkansas Insurance Department. The State does not currently intend to apply Medicaid-specific program integrity requirements directly to QHPs. The State, however, will monitor the program integrity of the Demonstration.

Comment: One commenter expressed concern that there would be no direct contract between Medicaid and the QHPs covering Private Option enrollees.

Response: The State currently does not intend to have a direct contract between the QHPs and Arkansas Medicaid; instead, the State intends to have a memorandum of understanding in place among AID, Arkansas Medicaid, and the QHPs to establish processes related to payment of premiums, cost-sharing wraps, and other reporting.

Comment: One commenter asked whether discharges for Private Option enrollees would count as "Medicaid discharges" for federal cost reporting purposes.

Response: Unless CMS requires otherwise, discharges for Private Option enrollees will count as "Medicaid discharges" for federal reporting purposes.

Comment: One commenter expressed concern that the Demonstration might affect funding for graduate medical education.

Response: We agree with the commenter about the importance of training the next generation of physicians. The State intends to work with the hospitals to develop an approach to funding graduate medical education.

Comment: One commenter requested that Arkansas maintain eligibility for individuals who are medically needy.

Response: The Demonstration will not alter eligibility standards for individuals who are medically needy, but Arkansas Medicaid may alter eligibility standards through a State Plan Amendment.

Comment: One commenter requested that Arkansas create a temporary disability standard so that individuals with short-term, but serious, health conditions can access Medicaid coverage.

Response: We thank the commenter for this interesting idea. The Demonstration will not change eligibility criteria for Medicaid, and thus we do not believe that the Demonstration waiver application is the best vehicle to consider this idea more fully.

Comment: One commenter noted that the draft waiver application stated that Arkansas would consider amending the waiver application to move children from the current ARKids "B" program into the Private Option. The commenter expressed concern that the waiver amendment would not be subject to the same transparency requirements as the initial waiver application.

Response: As the commenter notes, the Demonstration will not affect children enrolled in ARKids "B" until Arkansas requests (and the federal government approves) an amendment to the Demonstration. Arkansas will provide public notice of and an opportunity to comment on any significant amendment to the Demonstration, including an amendment to expand the Demonstration to include children in ARKids "B."

Comment: One commenter noted that plans covering Private Option enrollees should be subject to quality and data reporting standards that mirror those in Medicaid.

Response: We agree that QHPs should be subject to robust quality and data reporting standards. QHPs will be required to comply with federal requirements governing quality and

data reporting, though those requirements have not yet been released, as well as additional quality requirements that may be jointly developed by AID and Arkansas Medicaid. Additionally, Arkansas will monitor quality and utilization data as part of its evaluation of the Demonstration.

Comment: Several commenters stated that they were concerned that the Private Option would lead to rationing of care if payers reimburse providers for each episode of care, rather than for each individual service the provider renders.

Response: We thank the commenters for underscoring the importance of ensuring access to all medically necessary services. QHPs will negotiate payment terms, including whether payments will be on a fee-for-service or per episode basis, with providers in their networks. Medical episodes established through AHCPII do not bundle reimbursements as implied. Further, QHPs are not required to participate in episodes of care under existing guidance from the Arkansas Insurance Department (AID). To the extent that QHPs are required to participate in payment reforms as a part of the AHCPII, plans will continue to be required to cover all medically necessary services in the plan's benefit package, and Private Option enrollees will retain the right to appeal denials of coverage. Additionally, QHPs will be required to report on various quality measures, including enrollee satisfaction.

Comment: Several commenters expressed concern that Congress will reduce the federal government's portion of the cost of coverage for individuals newly eligible for coverage under Title XIX, thereby imposing a significant financial burden on the State.

Response: We appreciate the concern for the fiscal health of the State. The draft waiver application is based on the federal funding levels for individuals who are newly eligible for coverage under Title XIX that are established in current law. We will continue to monitor developments in Congress that could affect the federal matching rate for Private Option enrollees. Additionally, the Arkansas Health Care Independence Act includes provisions to terminate the Demonstration in the event that Congress reduces funding for Private Option enrollees.

Comment: One commenter noted that one of the arguments in support of the Arkansas Healthcare Independence Act was that fewer employers would be subject to the employer shared responsibility payment if the State expanded coverage under Title XIX to include individuals with incomes up to 138% FPL. The commenter stated that since the federal government has announced that it is delaying implementation of the employer shared responsibility payment until 2015, the Arkansas Healthcare Independence Act should not be implemented in 2014.

Response: As the commenter notes, the argument that fewer employers would be subject to the employer shared responsibility payment if the State expanded coverage under Title XIX to include individuals with income up to 138% FPL was among the many arguments in support of the Arkansas Health Care Independence Act. The recent announcement by the federal government to delay implementation of the employer shared responsibility payment until 2015

merely suspends its effect on Arkansas employers; it does not eliminate it. Additionally, the Arkansas Healthcare Independence Act does not prohibit implementation in the event of a delay of the employer shared responsibility payment.

Budget Neutrality Spreadsheet

	Budget Neutrality Without Waiver		
	CY14	CY15	CY16
Member Months	250,000	255,000	260,100
Medicaid Services* PMPM	$ 472.19	$ 495.79	$ 520.58
Total Expense	$ 118,046,422	$ 126,427,718	$ 135,404,086

** Medicaid Services (consistent with Alternative Benefit Plan), excluding Long Term Supports and Services (LTSS)*

	With Waiver		
	CY14	CY15	CY16
Member Months	250,000	255,000	260,100
QHP Services** PMPM	$ 463.60	$ 486.78	$ 511.12
Wrap Services*** PMPM	$ 8.58	$ 9.01	$ 9.46
Total PMPM	$ 472.19	$ 495.79	$ 520.58
Total QHP Expense	$ 115,901,172	$ 124,130,155	$ 132,943,396
Total Wrap Expense	$ 2,145,250	$ 2,297,563	$ 2,460,690
Total Expense	$ 118,046,422	$ 126,427,718	$ 135,404,086

*** QHP Services (consistent with Alternative Benefit Plan), excluding LTSS*

**** Wrap Services covers Medicaid services provided FFS (e.g. NEMT) to Private Option QHP enrollees*

Required Forms

Demonstration Financing Form

Please complete this form to accompany Section VI of the application in order to describe the financing of the Demonstration.

The State proposes to finance the non-federal share of expenditures under the Demonstration using the following (please check all that are applicable):

☑ State General Funds

☐ Voluntary intergovernmental transfers from governmental entities. (Please specify and provide a funding diagram in the narrative section – Section VI of the application).

☐ Voluntary certified public expenditures from governmental entities. (Please specify and provide a funding diagram in the narrative section – Section VI of the application).

☐ Provider taxes. (Provide description the narrative section – Section VI of the application).

☐ Other (If the State is interested in other funding or financing arrangements, please describe. Some examples could include, but are not limited to, safety net care pools, designated state health programs, Accountable Care Organization-like structures, bundled payments, etc.)

Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State Plan. To ensure that program dollars are used only to pay for Medicaid services, we are asking States to confirm to CMS that providers retain 100 per cent of the payments for services rendered or coverage provided.

Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, DRG, DSH, fee schedule, global payments, supplemental payments, enhanced payments, capitation payments, other), including the Federal and non-Federal share (NFS)?

☑ Yes ☐ No

If no, provide an explanation of the provider payment arrangement.

Do any providers (including managed care organizations [MCOs], prepaid inpatient health plans [PIHPs] and prepaid ambulatory health plans [PAHPs]) participate in such activities as intergovernmental transfers (IGTs) or certified public expenditure (CPE) payments, or is any portion of payments are returned to the State, local governmental entity, or other intermediary organizations?

☐ Yes ☑ No

If providers are required to return any portion of any payment, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount of percentage of payments that are returned, and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.). Please indicate the period that the following data is from.

Section 1902(a) (2) provides that the lack of adequate funds from other sources will not result in the lowering of the amount, duration, scope, or quality of care and services available under the plan.

Please describe how the NFS of each type of Medicaid payment (normal per diem, DRG, fee schedule, global, supplemental, enhanced payments, capitation payments, other) is funded.

Please describe whether the NFS comes from appropriations from the legislature to the Medicaid agency, through IGT agreements, CPEs, provider taxes, or any other mechanism used by the State to provide NFS. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either an IGT or CPE. In this case, please identify the agency to which the funds are appropriated.

Please provide an estimate of total expenditures and NFS amounts for each type of Medicaid payment. Please indicate the period that the following data is from:

If any of the NFS is being provided using IGTs or CPEs, please fully describe the matching arrangement, including when the state agency receives the transferred amounts from the local governmental entity transferring the funds.

If CPEs are used, please describe the methodology used by the State to verify that the total expenditures being certified are eligible for Federal matching funds is in accordance with 42 CFR 433.51(b).

For any payment funded by CPEs or IGTs, please provide the following, and indicate the period that the data is from:

Name of Entity Transferring/ Certifying Funds	Type of Entity (State, County, City)	Amount Transferred or Certified	Does the entity have taxing authority?	Did the entity receive appropriations?	Amount of appropriations

Section 1902(a) (30)(A) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a) (1) and 2105(a)(1) provide for Federal financial participation to States for expenditures for services under an approved State Plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type, and indicate the time period that that the data is from.

Provider Type	Supplemental or Enhance Payment Amount

Please provide a detailed description of the methodology used by the State to estimate the upper payment limit for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated).

Does any governmental provider or contractor receive payments (normal per diem, DRG, fee schedule, global, supplemental, enhanced, and other) that, in the aggregate, exceed its reasonable costs of providing services?

☐ Yes ☑ No

If yes, provide an explanation.

In the case of MCOs, PIHPs, PAHPs, are there any actual or potential payments which supplement or otherwise exceed the amount certified as actuarially sound as required under 42 CFR 438.6(c)? (These payments could be for such things as incentive arrangements with contractors, risk sharing mechanisms such as stop-loss limits or risk corridors, or direct payments to providers such as DSH hospitals, academic medical centers, or FQHCs.)

☐ Yes ☐ No ☑ Not Applicable

If so, how do these arrangements comply with the limits on payments in §438.6(c)(5) and §438.60 of the regulations?

If payments exceed the cost of services (as defined above), does the State recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

☐ Yes ☑ No

Use of other Federal Funds

Are other federal funds, from CMS or another federal agency, being used for the Demonstration program? ☐ Yes ☑ No

If yes, provide a list below of grants the State is receiving from CMS or other federal agencies. CMS must ensure these funds are not being used as a source of the non-federal share, unless such use is permitted under federal law. In addition, this will help to identify potential areas of duplicative efforts and highlight that this demonstration is building off of an existing grant or program.

Source of Federal Funds	Amount of Federal Funds	Period of Funding

Budget Neutrality Form

Section 1115 Medicaid Demonstrations should be budget neutral. This means the Demonstration cannot cost the federal government more than what would have otherwise been spent absent the Demonstration. In this section, the state must provide its explanation of how the Demonstration program will achieve budget neutrality and the data to support its rationale.

New Demonstration Request: The following form provides guidance on some of the most commonly used data elements for demonstrating budget neutrality. CMS is available to provide technical assistance to individual states to identify any other elements needed to demonstrate budget neutrality for their specific request. Use the accompanying Excel Workbook to submit supporting data, following the instructions below. All expenditure totals in the Excel Workbook are total computable expenditures (both federal and state shares combined), unless indicated otherwise.

I. Without- and With-Waiver Projections for Historical Medicaid Populations

A. Recent Historical Actual or Estimated Data

Provide historic data, actual or estimated, for the last five years pertaining to the Medicaid Populations or sub-Populations (Populations broken out by cost categories) in the Demonstration program.

The "Historical Data" tab from the Table Shell contains a structured template for entering these data. There are slots for three Medicaid Populations; more slots should be added as needed. The year headers "HY 1," "HY 2," etc., should be replaced with the actual historical years.

The Medicaid Populations submitted for budget neutrality purposes should correspond to the Populations reported in Section II. If not identical, a crosswalk must be provided that relates the budget neutrality Populations to the Section II populations. Use the tables below to provide descriptions of the populations defined for budget neutrality, and the cross-walk to Section II.

States that are submitting amendments or extension requests and that wish to add new Medicaid populations can use the "Historical Data" tab to provide 5 years of historical data for the new populations.

Population/Sub-Population Name:	TANF 18+
Brief Description	Non-disabled, non-child, non-Dual population
Relationship to Section II	Comparable population to non-Medically Frail Medicaid expansion population

Population/Sub-Population Name:	
Brief Description	
Relationship to Section II	

Population/Sub-Population Name:	
Brief Description	
Relationship to Section II	

Population/Sub-Population Name:	
Brief Description	
Relationship to Section II	

Explain the sources and methodology used for the actual and/or estimated historical data. If actual data have been provided, explain the source of the data (MMIS data, other state system Medicaid data, other program data, etc.) and the program(s) and source(s) of program funding that the data represent. Indicate if the data represent all Medicaid expenditures for the population. For example, are they inclusive of long-term care expenditures? Were the expenditures reported on the CMS-64? If the data provided are a combination of actual and estimated data, provide the dates pertaining to each type of data. If any of the data are estimated, provide a detailed explanation concerning how the estimated data were developed.

B. Bridge Period

Based on the ending date of the most recent year of historic data and the proposed Demonstration implementation date, a bridge period will apply to this proposal. Estimates of Demonstration costs must be trended across this bridge period when calculating the projected first year of PMPM costs without the waiver.

In the blanks below, enter the last day of the most recent historical year, and the last day of the year immediately preceding the first Demonstration Year. The number of months between these dates is the length of the bridge period. Depending on the length of the available historical data series and data quality, each demonstration population could have its own unique bridge period.

Enter the number of months in the bridge period in the "WOW" tab of the Excel Workbook, in the grayed cell under "MONTHS OF AGING." The spreadsheet is programmed to project Demonstration Year PMPM expenditures and member month totals using historical trend rates and the length of bridge period, and assumes that the same bridge period applies to all calculations. Applicants should feel free to alter these programming features as needed.

Demonstration Bridge Period: 12/31/11 to 12/31/13

C. Without-Waiver Trend Rates, PMPM costs and Member Months with Justification

The WOW tab of the Excel Workbook is where the state displays its projections for what the cost of coverage for included Medicaid populations would be in the absence of the demonstration. A block of cells is provided to display the WOW estimates for each Medicaid population specified. Next to "Pop Type," the correct option should be selected to identify each group as a Medicaid population.

The workbook is programmed to project without-waiver (WOW) PMPM expenditures and member months using the most recent historical data, historical enrollment and per capita cost trends, and the length of bridge period specified. CMS policy is to use the lower of the state's historical trends and President's Budget trends to determine the WOW baseline.

Note that the workbook includes a projected Demonstration Year 0 (DY 00), which is an estimate of the last full year immediately prior to the projected demonstration start date. DY 00 is included to provide a common "jumping off point" for both WOW and with waiver (WW) projections.

D. Risk

CMS will provide technical assistance to states to establish an appropriate budget neutrality methodology for their demonstration request. Potential methodologies include:

PER CAPITA METHOD: The state will be at risk for the per capita (PMPM) cost of individuals served by the Demonstration, to the extent these costs exceed those that would have been incurred absent the Demonstration (based on data shown and to be agreed to above). The state shall be at risk to repay CMS for the federal share of any costs in excess of the "Without Demonstration" cost, based on historical data shown above, which are the sum of the estimated PMPM costs times the number of member months by Population. The state shall not be at risk for the number of member months of participation in the Demonstration, to the extent that they may increase above initial projections.

AGGREGATE METHOD: The state will be at risk for both the number of member months used under the Demonstration, as well as the per capita cost for Demonstration participants; to the extent these exceed the "without waiver" costs and member months that are agreed to based on the data provided above.

E. Historical Medicaid Populations: With-Waiver PMPM Cost and Member Month Projections

The "WW" tab of the Excel Workbook is for use by the State to enter its projected WW PMPM cost and member month projections for historical populations. In general, these can be different from the proposed without-waiver baseline. If the State's demonstration is designed to reduce

PMPM costs, the number of member months by category and year should be the same here as in the without-waiver projection. (This is the default formulation used in the Excel Workbook.)

F. Justification for With-Waiver Trend Rates, PMPM Costs and Member Months

The State must provide below a justification for the proposed with-waiver trend rate and the methodology used by the State to arrive at the proposed trend rate, estimates of PMPM costs, and number of member months.

II. Cost Projections for New Populations

This section is to report cost projections for new title XIX Populations. These could be Populations or sub-Populations that will be added to the state's Medicaid program under the Demonstration, including "Expansion Populations" that are not provided for in the Act but are created under the Demonstration.

In the table below, list all of the New Populations and explain their relationship to the eligibility groups listed in Section II.

Population Name		Brief Description	Cross-Walk to Section II
Medicaid Expansion		Childless adults <138% or parents 17-138%	Same population as Section II

Justification for New Populations' Trend Rate, PMPM and Member Month Projections

The state must provide below a justification for the proposed trend rate, estimates of PMPM costs, and number of member months for new populations, including a description of the data sources and estimation methodology used to produce the estimates. Historical data provided to support projections for new populations can be displayed in the Excel Workbook's Historic Data tab.

Some state proposals may include populations that could be made eligible through a State plan amendment, but instead will be offered coverage strictly through the Demonstration. These populations are referred to as "hypotheticals" and CMS is available to provide technical assistance to states considering whether a Demonstration population could be treated as a hypothetical population.

III. Disproportionate Share Hospital Expenditure Offset

Is the state is proposing to use a reduction in Disproportionate Share Hospital (DSH) Claims to offset Demonstration costs in the calculation of budget neutrality for the Demonstration?

☐ Yes ☑ No

If yes, the state must provide data to demonstrate that the combination of Demonstration expenditures and the remaining DSH expenditures will not exceed the lower of the state's historical DSH spending amount or the state's DSH Allotment for each year of the Demonstration. The state may provide Adjusted DSH Claim Amounts if additional DSH claims are pending due to claims lag or other reasons.

In the DSH tab of the Excel Workbook, enter the state's DSH allotments and actual DSH spending for the five most recent Federal fiscal years in Panel 1. All figures entered should represent the federal share of DSH allotments and spending.

Provide an explanation for any Adjusted DSH Claim Amounts:

In Panel 2 of the Excel Workbook, enter projected DSH allotments for the federal fiscal years that will overlap the proposed Demonstration period, and in the following row, enter projections for what DSH spending would be in the absence of the demonstration. All figures entered should represent the federal share of DSH allotments and spending.

The Excel Workbook is set up to allow for the possibility that Demonstration Years will not coincide with federal fiscal years. If this is the case, and the Demonstration is proposed to last for five full years, then the Demonstration will be in existence for parts of six federal fiscal years. FFY 00 is the federal fiscal year during which the Demonstration is proposed to begin, and FFY 05 is the federal fiscal year that contains the Demonstration's proposed end date. CMS encourages states that use DSH diversion in their budget neutrality model to define Demonstration Years so that they align with the Federal fiscal years. (If Demonstration Years do align with Federal fiscal years, it is not necessary to populate the column for FFY 00.)

In Panel 3 of the Excel Workbook, the rows are set up to be used as follows. All amounts entered in Panel 3 are Federal share.

- State DSH Allotment: Formulas in the Excel Workbook automatically enter the same DSH allotment projects as are shown in Panel 2.
- State DSH Claim Amount: Enter the amounts that the state projects will be spent on DSH payments to hospitals for each federal fiscal year that overlaps with the proposed demonstration period.
- Maximum DSH Allotment Available for Diversion: If the state wishes to propose a dollar limit on the amount of potential DSH spending that is diverted each year, enter those amounts here. If no such limit is proposed, leave blank.
- Total DSH Allotment Diverted: The Excel Workbook is structured to populate the cells in this row from amounts entered in Panel 4. CMS's default assumption is that DSH diversion spending will align with the Federal fiscal year DSH allotments based on date of service. The Excel Workbook allocates DSH diversion spending from one or two overlapping Demonstration Years to each Federal fiscal year DSH allotment.
- DSH Allotment Available for DSH Diversion Less Amount Diverted: This row provides a check to ensure that diverted DSH spending does not exceed the Maximum DSH Allotment amount specified by the State. If no Maximum DSH Allotment, delete the formulas in this row.

- DSH Allotment Projected to be Unused: This row provides a check to ensure that the combination of diverted DSH spending plus DSH payments to hospitals does not exceed the DSH allotment each year.

Panel 4 of the Excel Workbook provides space for the state to indicate amounts of DSH diversion spending are planned for each Demonstration Year, and specify how much of that amount is to be assigned to the overlapping Federal fiscal years. DSH diversion spending is entered here as a total computable expenditures. An FMAP rate is needed for each total computable spending amount entered to enable it to be converted into a federal share equivalent that will appear in Panel 3. The amounts shown in the Total Demo Spending From Diverted DSH row automatically appear in the Summary tab in the Without Waiver panel.

Explanation of Estimates, Methodology and Data

IV. Summary of Budget Neutrality

The Excel Workbook's Summary tab shows an initial assessment of budget neutrality for the Demonstration. Formulas are included that reference cells in the WOW, WW, and DSH tabs so that projected WOW and WW expenditures for each category of expenditure appear in tabular form and can be summarized by Demonstration Year, and for the entire proposed duration of the Demonstration. The Variance shown for the entire duration of the demonstration must be non-negative.

As indicated above, spending estimates for Other WOW Categories and Other WW Categories should be entered directly into the Summary tab where indicated.

V. Additional Information to Demonstrate Budget Neutrality

Provide any additional information the State believes is necessary for CMS to complete its analysis of the budget neutrality submission.