Section I - Historical Narrative Summary of the Demonstration

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

**Introduction**

In September 2013, Arkansas was the first state in the nation to obtain approval from the Centers for Medicare and Medicaid Services (CMS) for a Section 1115 waiver to use premium assistance to purchase individual qualified health plans (QHPs) offered through the Health Insurance Marketplace (Marketplace) for individuals eligible for expanded coverage under Title XIX of the Social Security Act. Arkansas’s Health Care Independence Program (HCIP) extended QHP coverage to 240,000 individuals who are either (1) childless adults between the ages of 19 and 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.

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

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

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

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

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

\(^1\) The Health Reform Legislative Task Force was established under the Arkansas Health Reform Act of 2015.
ARKANSAS 1115 WAIVER EXTENSION APPLICATION

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

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

Overview of Preliminary Results of Arkansas’s Expansion Demonstration

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

- **Promoting continuity of coverage for individuals.** The Demonstration has contributed to expanded health plan participation in the Marketplace and achieved continuous availability of health plans and provider networks, with all but one carrier in one of the seven market regions continuing to offer plans year-to-year. With household income transitions across the 138% FPL threshold, families can stay enrolled in the same plan regardless of whether their coverage is subsidized through Medicaid or Advanced Premium Tax Credits.

- **Improving access to providers.** The Demonstration interim evaluation report, which can be found on the Arkansas Center for Health Improvement website, documents enhanced provider access for individuals in the Demonstration compared to those in the traditional Medicaid program. In addition, for most indicators assessed during the first year, individuals enrolled in QHPs achieved higher rates of obtaining preventive clinical services. Provider payment rates under QHPs are higher than those offered under the Medicaid State Plan and are correlated with increased availability of care, as documented in the interim evaluation report.

- **Smoothing the “seams” across the continuum of coverage.** Enrollment in the Demonstration has resulted in full QHP essential health benefits (EHBs) being available to Medicaid beneficiaries who previously had a limited benefit (e.g., pregnant women, those with breast and cervical cancer).

- **Furthering quality improvement and delivery system reform initiatives.** At the forefront of payment innovation and delivery system reform, Arkansas has required all carriers offering QHPs in the Marketplace to participate in the Arkansas Health Care Payment Improvement Initiative (AHCPII)—an innovative, multi-payer initiative to improve quality and reduce costs statewide. The Demonstration has accelerated and leveraged the AHCPII through two mechanisms. First, by increasing the number of carriers participating in the effort, the system transformation goals and objectives are

---

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

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

- **Creating a larger and younger risk pool.** Demonstration enrollees comprise approximately 80% of the Arkansas Marketplace and are on average younger than other Arkansas Marketplace enrollees. A healthier risk pool has driven down premium rates for all Marketplace enrollees.

- **Creating more competitive premium pricing for all individuals purchasing coverage through the Marketplace.** Since 2014, premium prices in Arkansas have increased at a slower rate than those nationally. From 2015 to 2016, premiums for the second lowest cost silver plan in Arkansas increased by an average of 4.3%, as compared to an average of 7.5% for all states using HealthCare.gov. From 2014 to 2015, premiums across all QHPs in the State decreased by an average of 2%.

- **Decreasing uncompensated care.** Arkansas has seen sharp declines in uncompensated care costs. From 2013 to 2014, there were substantial decreases in uninsured hospital admissions (49%), emergency room visits (39%), and visits at hospital outpatient clinics (46%). In addition, Arkansas hospitals experienced a 55% decrease in uncompensated care losses during this time.

### Demonstration Features

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

#### Demonstration Eligibility

**a) Eligibility Criteria**

To be eligible to participate in Arkansas Works through the Demonstration, an individual must:

1. be a childless adult between 19 and 65 years of age, with an income at or below 138% of the FPL who is not enrolled in Medicare and not incarcerated or
2. 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
3. be a United States citizen or a documented, qualified alien. However, individuals determined to be medically frail/have exceptional medical needs for which coverage through the Marketplace is determined to be impractical, overly complex, or would undermine continuity or effectiveness of care are not be eligible for the Demonstration, unless they have access to cost-effective employer-sponsored insurance (ESI) and elect to receive the alternative.

---

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

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

<table>
<thead>
<tr>
<th>Description</th>
<th>Income</th>
<th>Age</th>
<th>Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults in Section VIII Group</td>
<td>Childless Adults: 0-138% FPL</td>
<td>19-65</td>
<td>• Dual eligibles</td>
</tr>
<tr>
<td></td>
<td>Parents: 17-138% FPL</td>
<td></td>
<td>• Individuals who are medically frail/have exceptional medical needs who do not have access to cost-effective ESI</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Individuals who are medically frail/have exceptional medical needs who have access to cost-effective ESI and choose to receive standard Medicaid coverage under the State Plan</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Incarcerated individuals</td>
</tr>
</tbody>
</table>

b) Demonstration Enrollment Data
The State estimates that approximately 272,000 individuals will be enrolled in Arkansas Works by 2021.

Benefits
a) Benefit Package
Arkansas Works enrollees will receive the ABP, as defined in Arkansas’s State Plan. The State provides through its fee-for-service Medicaid program wrap-around benefits that are in the ABP but not covered by ESI or QHPs. For Arkansas Works enrollees covered through QHPs, the State provides wrap-around coverage for non-emergency transportation and Early Periodic Screening Diagnosis and Treatment (EPSDT) services for individuals participating in the Demonstration who are under age 21 (including pediatric vision and dental services, as well as other EPSDT

---

6 ESI premium assistance is a new feature of Arkansas Works. In the first year of ESI premium assistance, only small group, non-grandfathered plans for which the employer covers at least 25% of the premiums may be considered cost effective. In future years of ESI premium assistance, large group and small group grandfathered plans may also be considered cost effective.
services to the extent such services are not covered under the QHP). For Arkansas Works enrollees covered through ESI, the State seeks a waiver of the requirement to provide non-emergency transportation. Additionally, if family planning services are accessed at out-of-network providers, the State’s fee-for-service Medicaid program will cover those services for both ESI and QHP enrollees, as required under federal Medicaid law. Because of Arkansas’s Any Willing Provider Law, few such providers are outside of private insurance carrier networks.

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

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

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

**Premiums, Cost Sharing, and Independence Accounts**

a) Enrollees with Incomes at or Below 100% FPL
Individuals with incomes at or below 100% FPL will have no cost-sharing obligations in Arkansas Works.
b) Enrollees with Incomes Above 100% FPL
Under Arkansas Works, the State will institute premiums of up to 2% of household income for enrollees with incomes between 100 to 138% FPL. With the implementation of enrollee premiums, the State will eliminate Independence Accounts; Section II of this application describes the State’s approach for instituting premiums (and terminating the Independence Accounts). Individuals with incomes between 100 to 138% FPL will continue to be subject to point-of-service cost sharing consistent with Medicaid limits. Insurance carriers will assist the State in tracking Arkansas Works beneficiaries’ aggregate amount of cost sharing to ensure that they do not exceed the quarterly limit of 5% of household income.

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

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

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

Eligibility and Enrollment Processes

a) Identification of Individuals who are Medically Frail/Have Exceptional Medicaid Needs
Arkansas worked with researchers from the University of Michigan and the Agency for Healthcare Research & Quality to develop a Health Care Needs Questionnaire to assess whether an individual is medically frail/has exceptional medical needs. For individuals potentially eligible or eligible for Arkansas Works coverage through QHPs, this screening is administered annually at open enrollment. The State will utilize information collected through the single streamlined application to assess whether individuals potentially eligible for Arkansas Works coverage through ESI are medically frail/have exceptional medical needs. For both the
b) Enrollment Process
   i. **All enrollees**
   Individuals eligible for Arkansas Works will enroll through the following process:
   - Individuals submit the single streamlined application for insurance affordability programs—Medicaid, CHIP and Advanced Premium Tax Credits/Cost-Sharing Reductions—electronically, via phone, by mail, or in-person.
   - An eligibility determination is made through either the Federally Facilitated Marketplace (FFM) or the Arkansas Eligibility & Enrollment Framework (EEF).
   - Once individuals have been determined eligible for coverage under Title XIX, the State matches them against a list of employed individuals whose employers:
     - Offer cost-effective ESI, and
     - Participate in the ESI premium assistance program.
   - State validates individual’s employment status.

   ii. **Individuals who do not have access to cost-effective ESI through an employer participating in the ESI premium assistance program or are ages 19 to 20**
   - Individuals enter the State’s web-based portal and complete the Health Care Needs Questionnaire.
   - Based on the responses to the Health Care Needs Questionnaire, individuals will fall into one of the following two categories:
     - *Individuals who are not medically frail*. These individuals will be required to enroll in QHPs.
     - *Individuals who are medically frail*. These individuals will be given the choice between receiving the ABP or the standard Medicaid benefit package through fee-for-service Medicaid.
   - Individuals required to receive coverage through QHPs will shop and enroll in coverage through the following process:
     - Individuals will be directed on the web-based portal to a page where they may shop among QHPs available to Arkansas Works eligible individuals. They may select a plan on this portal.
     - MMIS captures their plan selection information and transmits the 834 enrollment transactions to the carriers.
     - Carriers issue insurance cards to Arkansas Works enrollees.
     - MMIS pays premiums on behalf of beneficiaries directly to the carriers.
     - MMIS premium payments continue until the individual is determined to no longer be eligible; the individual selects an alternative plan during the next open enrollment period; or the individual is determined to be more
effectively treated due to complexity of need through the fee-for-service Medicaid program.

- In the event that an individual is determined eligible for QHP coverage through Arkansas Works, but does not select a plan, the State auto-assigns the enrollee to one of the available QHPs in the beneficiary’s county.

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

- State determines whether individual is medically frail based on response to applicable question on single streamlined application (question #9).
  - *Individuals who are not medically frail.* These individuals will be required to enroll in ESI premium assistance.
  - *Individuals who are medically frail.* These individuals will be given the choice between receiving the ABP through their ESI plan or the standard Medicaid benefit package through fee-for-service Medicaid.

- For individuals who are not medically frail and are required to receive coverage through their ESI plans:
  - The State will transfer their names to a third-party administrator (TPA), with which the State will contract to administer the ESI premium assistance program.
  - The TPA will work with the individual’s employer to effectuate enrollment in ESI premium assistance.
  - The ESI carriers will issue insurance cards to Arkansas Works enrollees.
  - The TPA will administer ESI premium assistance payments.

- For individuals who are medically frail:
  - The State will send individuals notices informing them of their choice between receiving the ABP through their ESI plan or the standard Medicaid benefit package in Medicaid fee-for-service.
  - For individuals who select the ABP, the State will transfer their names to a TPA, and the TPA will work with the individual’s employer to effectuate enrollment in ESI premium assistance. The ESI carriers will issue insurance cards to Arkansas Works enrollees.
  - For individuals who select the standard Medicaid benefit package, the State will effectuate coverage and the TPA will administer ESI premium assistance payments.

c) **Coverage Prior to QHP or ESI Enrollment**
The State will provide coverage through fee-for-service Medicaid from the date an individual is determined eligible for Medicaid until the individual’s enrollment in the QHP or ESI becomes effective.
d) QHP Plan Selection and Purchasing Guidelines
Under AID’s regulatory authority, the State assures that Arkansas Works beneficiaries enrolling in QHP coverage are able to choose from at least two high-value silver plans in each rating area of the State. Additionally, AID evaluates network adequacy, including QHP compliance with Essential Community Provider network requirements, as part of the QHP certification process. As a result, Arkansas Works beneficiaries covered through QHP premium assistance have access to the same networks as individuals who purchase coverage in the individual market, ensuring compliance with the requirement found in Section 1902(a)(30)(A) of the Social Security Act that Medicaid beneficiaries have access to care comparable to the access the general population in the geographic area has. Providers are reimbursed for care provided to Arkansas Works beneficiaries at the rates the providers have negotiated with the QHP.

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

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

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

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

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

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

- ESI premium assistance program (if offered cost-effective ESI)
[ARKANSAS 1115 WAIVER EXTENSION APPLICATION]

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

g) Memorandum of Understanding with QHP Carriers
Each year of the Demonstration, Arkansas Medicaid enters into a memorandum of understanding (MOU) with the QHP carriers to outline the process for verifying plan enrollment and paying premiums. Under the terms of the MOU, the QHP carrier provides a roster of its enrollees who are covered under Title XIX. The State verifies that the individuals listed on the roster are eligible for coverage under the Demonstration. After verifying this information, the MMIS transmits payment for premiums to the QHP carrier.

Section II - Changes Requested to the Demonstration

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

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

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

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

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

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

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

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

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

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

---

7 Premiums may be paid directly by an enrollee or on behalf of an enrollee by a third party, such as an enrollee’s employer or a not-for-profit organization.
Arkansas Works enrollees with incomes above 100% FPL will be subject to premiums of up to 2% of household income. For the purpose of administrative simplicity, the State will set premiums at a fixed amount, meaning that enrollees with incomes between 100-138% FPL will be subject to premiums of up to $19 per month, depending on household size.

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

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

Arkansas is conducting a comprehensive noticing and education campaign to inform beneficiaries of the termination of the Independence Account program. Arkansas is sending enrollees notices informing them that their MyIndyCards will be deactivated. The notices include information on:

- Timing of last required monthly Independence Account contribution and deactivation of MyIndyCards
- Toll-free phone number for the MyIndyCard call center for questions about deactivation of cards
- MyIndyCard and Arkansas Medicaid website addresses for additional information about deactivation of MyIndyCards
- Receipt and use of credits that have accumulated in the Independence Account

The State is working with its call center vendor to update the Independence Account call center scripts and the MyIndyCard.org and Arkansas Medicaid websites to provide enrollees information about the wind-down process.

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

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

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

Individuals will have the right to appeal any decision that they are not eligible for the incentive benefit, using the standard Medicaid appeals process.
5. **Eliminating Retroactive Coverage**
   To better align with commercial health insurance coverage, Arkansas is requesting a waiver of the requirement to provide three months retroactive coverage to Arkansas Works beneficiaries. Individuals will become eligible for Arkansas Works coverage at the point that they apply for coverage under Title XIX.

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

   Within 30 days of a reduction in FMAP for the new adult group, the State would notify CMS of its intent to activate the transition and phase-out plan. After notifying CMS of its intent to terminate the Demonstration, the State would immediately begin (1) community outreach; (2) producing the approved notices; and (3) conducting administrative reviews of Medicaid eligibility for affected beneficiaries to determine whether they qualify for Medicaid through another eligibility category and to ensure ongoing coverage for eligible beneficiaries. Coverage under the Demonstration would terminate within 120 days of a reduction in FMAP.

7. **Providing Work Referrals**
   Finally, outside of the Demonstration, the State will refer all individuals with no income to job training and job search programs. Additionally, all eligible Arkansas Works beneficiaries will receive information regarding work training opportunities, outreach, and education about work and work training opportunities through the Department of Workforce Services. Ultimately, as individuals receiving this referral become employed, the State expects that many will transition out of the Arkansas Works program to ESI and private, individual market coverage.

**Section III - Requested Waivers and Expenditure Authorities**

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

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

- § 1902(a)(23)(A): To make premium assistance for QHPs in the Marketplace and for ESI mandatory for Demonstration enrollees and to permit the State to limit beneficiaries’ freedom of choice among providers to the providers participating in the network of the beneficiary’s QHP or ESI.
- § 1902(a)(13) and § 1902(a)(30): To the extent necessary to permit Arkansas to provide for payment to providers equal to the market-based rates determined by the QHP or ESI providing primary coverage for services under Arkansas Works.
- § 1902(a)(54) insofar as it incorporates Section 1927(d)(5): To permit the State to require that requests for prior authorization for drugs be addressed within 72 hours, rather than 24 hours. A 72-hour supply of the requested medication will be provided in the event of an emergency.
- § 1902(a)(10)(B): To the extent necessary to enable the State to impose targeted cost sharing on individuals in the eligibility group found at Section 1902(a)(10)(A)(i)(VIII) of the Act.
- § 1902(a)(14) insofar as it incorporates § 1916 and §1916A: To the extent necessary to enable the State to collect monthly premiums for individuals with incomes between 100 and 138 percent of the federal poverty level.
- § 1902(a)(34): To enable the State not to provide medical coverage to Arkansas Works beneficiaries for any time prior to the first day of the month in which an individual applies.
- § 1902(a)(4) insofar as it incorporates 42 CFR § 431.53: To the extent necessary to relieve Arkansas of the requirement to assure transportation to and from medical providers for Arkansas Works beneficiaries enrolled in ESI premium assistance.

Expenditure Authorities

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

2) Describe why the State is requesting the waiver or expenditure authority, and how it will be used.
## Table 2. Arkansas Waiver and Expenditure Authority Requests

<table>
<thead>
<tr>
<th>Waiver/Expenditure Authority</th>
<th>Use for Waiver/Expenditure Authority</th>
<th>Reason for Waiver/Expenditure Authority Request</th>
<th>Currently Approved Waiver/Expenditure Authority Request?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Waivers</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>§ 1902(a)(23)(A)</td>
<td>To make premium assistance for QHPs in the Marketplace or ESI mandatory for Demonstration enrollees and to permit the State to limit beneficiaries' freedom of choice among providers to the providers participating in the network of the Arkansas Works beneficiary’s QHP or ESI plan.</td>
<td>This waiver authority will allow the State to require that populations identified in this application receive coverage through the Demonstration, and not through the State Plan. This waiver authority will also allow the State to align the network available to Arkansas Works beneficiaries with the network offered to QHP and ESI enrollees who are not Medicaid beneficiaries.</td>
<td>Modified request</td>
</tr>
<tr>
<td>§ 1902(a)(13) and § 1902(a)(30)</td>
<td>To the extent necessary to permit Arkansas to provide for payment to providers equal to the market-based rates determined by the QHP or ESI providing primary coverage for services under Arkansas Works.</td>
<td>This waiver authority will allow the State to leverage payment rates negotiated in the commercial market.</td>
<td>Modified request</td>
</tr>
<tr>
<td>§ 1902(a)(54) insofar as it incorporates Section 1927(d)(5)</td>
<td>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.</td>
<td>This waiver authority will allow the State to align prior authorization standards for Arkansas Works beneficiaries with standards in the commercial market.</td>
<td>Currently approved</td>
</tr>
<tr>
<td>§ 1902(a)(10)(B)</td>
<td>To the extent necessary to enable the State to impose targeted cost sharing on</td>
<td>This waiver will allow the State to impose cost sharing only on the Arkansas Works</td>
<td>Modified request</td>
</tr>
</tbody>
</table>
## Waiver/Expenditure Authority

<table>
<thead>
<tr>
<th>Waiver/Expenditure Authority</th>
<th>Reason for Waiver/Expenditure Authority Request</th>
<th>Currently Approved Waiver/Expenditure Authority Request?</th>
</tr>
</thead>
<tbody>
<tr>
<td>§ 1902(a)(14) insofar as it incorporates § 1916 and § 1916A</td>
<td>To the extent necessary to enable the State to collect monthly premiums for individuals with incomes between 100 and 138 percent of the FPL.</td>
<td>Modified request</td>
</tr>
<tr>
<td>§ 1902(a)(34)</td>
<td>To enable the State not to provide medical coverage to Arkansas Works beneficiaries for any time prior to the first day of the month in which an individual applies.</td>
<td>New request</td>
</tr>
<tr>
<td>§ 1902(a)(4) insofar as it incorporates 42 CFR 431.53</td>
<td>To the extent necessary to relieve Arkansas of the requirement to assure transportation to and from medical providers for Arkansas Works beneficiaries enrolled in ESI premium assistance.</td>
<td>New request</td>
</tr>
</tbody>
</table>

### Expenditure Authorities

<table>
<thead>
<tr>
<th>Expenditure Authorities</th>
<th>Reason for Expenditure Authority Request</th>
<th>Currently Approved Expenditure Authority Request?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Premium Assistance and Cost Sharing Reduction Payments Expenditures</td>
<td>For part or all of the cost of private insurance premiums, and for payments to reduce cost sharing for certain individuals eligible under the approved State Plan new adult group described in Section 1902(a)(10)(A)(i)(XVIII) of the Social Security Act.</td>
<td>Currently approved</td>
</tr>
</tbody>
</table>
### Waiver/Expenditure Authority

<table>
<thead>
<tr>
<th>Waiver/Expenditure Authority</th>
<th>Use for Waiver/Expenditure Authority</th>
<th>Reason for Waiver/Expenditure Authority Request</th>
<th>Currently Approved Waiver/Expenditure Authority Request?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Security Act.</td>
<td></td>
<td>This expenditure authority will allow the State to pay up to 75% of premiums for ESI.</td>
<td></td>
</tr>
<tr>
<td>ESI Premium Assistance Payments</td>
<td>To pay up to 75% of premiums for ESI.</td>
<td>This expenditure authority will allow the State to pay up to 75% of premiums for ESI.</td>
<td>New request</td>
</tr>
<tr>
<td>Limited-Purpose Health Credit Expenditures</td>
<td>To issue limited-purpose health credits to eligible enrollees who made a required number of contributions prior to Independence Account termination.</td>
<td>This expenditure authority will allow the State to issue limited-purpose health credits to eligible enrollees who made a required number of contributions prior to Independence Account termination.</td>
<td>New request</td>
</tr>
</tbody>
</table>

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

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

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

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

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

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

Beginning in 2015, QHPs were required to participate in the Arkansas Patient-Centered Medical Home (PCMH) program. QHP enrollees including Demonstration enrollees were attributed to a PCMH either by choice or a QHP-elected method. PCMH clinics are provided with per-member per-month (PMPM) support to implement a team-based care delivery model and

---

comprehensively manage enrollees’ health needs by meeting milestones in practice transformation and achieving quality standards. To receive PMPM support, PCMH clinics must meet practice transformation activities by required deadlines including:

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

Quality measures and targets in the PCMH program include:

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

The improved care coordination through the PCMH program across participating public and private payers has resulted in increased pediatric wellness visits, hemoglobin A1c testing, breast cancer screenings, improved attention deficit hyperactive disorder (ADHD) management, and thyroid medication management.

Section V - Financial Data

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

The budget neutrality approach recognizes that the population covered by this Demonstration, known as “Arkansas Works beneficiaries,” represents a hypothetical population for budget neutrality purposes. Hypothetical populations are individuals that otherwise could have been made eligible for Medicaid under: 1) section 1902(r)(2), 2) 1931(b), or 3) 1902(a)(10)(A)(i)(VIII) (as modified by Section 2001 of the ACA), via a State Plan Amendment. The calendar year 2016 (CY16) budget neutral PMPM and the PMPM cost of emerging CY16 experience are projected forward at the same annual cost growth rate of 4.7% annually as in the original waiver submission. This is the same figure that was used in the initial budget neutrality submission, and is appropriate to carry forward to the waiver extension as it is in line with current cost trends in Arkansas. The State’s actuaries, Optumas, reviewed experience from across the nation and found that the 4.7% growth rate was consistent with other states’ experience as well. Similarly, projected enrollment is identical in the without waiver and with waiver scenarios.
since the Demonstration does not expand eligibility and is not expected to increase take-up amongst the expansion-eligible population. Enrollment growth has been modeled at 2.5% annually, based on actual experience under the Arkansas waiver combined with the expansion population growth experience of other states (Maryland, North Dakota, Colorado, and Oregon).

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% FPL who are not enrolled in Medicare or incarcerated or (2) parents/caretaker-relatives between the ages of 19 and 65 with incomes between 17 and 138% FPL who are not enrolled in Medicare. The State of Arkansas will use premium assistance to purchase either cost-effective ESI (if available) or QHPs offered in the individual market through the Marketplace. These beneficiaries will receive the ABP and have cost-sharing obligations consistent with the State Plan.

To determine the hypothetical enrollment associated with the Arkansas Works beneficiaries, Optumus reviewed current enrollment in Arkansas’s HCIP. This enrollment was projected forward at an annual growth rate of 2.5%. The annual growth rate is based on review of Arkansas program enrollment trends as well as the experience of other expansion states, including Maryland, North Dakota, Colorado, and Oregon. As mentioned previously, the same enrollment growth rate is applied to the with waiver and without waiver scenarios. To determine the potential cost for this population, Optumus utilized the previous budget neutral amounts and the emerging experience. The without waiver amounts are calculated using the previous budget neutral without waiver amounts and projecting them forward at an annual trend of 4.7%. The trend rate of 4.7% is identical to the previous submission.

Optumus discussed the rate of cost growth with the Arkansas Department of Human Services, and the 4.7% growth rate is in line with their experience. Optumus also reviewed cost growth rates for other states, such as Nebraska, Alabama, Oregon, Maryland, and Colorado, and determined the 4.7% growth rate was consistent with other states’ experiences. The with waiver cost projections apply the same 4.7% annual growth rate to the emerging experience under the waiver. The without waiver cost projection also incorporates the anticipated collection of member co-premiums. Optumus modeled a collection amount of $13 PMPM from all individuals with incomes over 100% FPL. Adjusting for the portion of the HCIP enrollees with incomes over 100% FPL and an assumed collection rate results in the collection amount being valued at an average of $0.49 PMPM to $0.52 PMPM across the Demonstration timeframe. The collection rate used in modeling is based on reviewing the experience of other states with a member co-premium. Other aspects of the program cost, such as the advance CSR payments and the services provided via a fee-for-service wrap, are handled identically as the original budget neutrality submission. The other new features of Arkansas Works are not expected to have a cost impact on the Demonstration for the new adult group, so no adjustment is made to the with waiver scenario. Combining the projected enrollment with the expected premium

---

9 Enrollees with incomes between 100-138% FPL will be subject to premiums of up to $19 per month, depending on household size. Optumus based its budget neutrality projections on a two-person household.
yielded the projected costs for the hypothetical population in both the without and with waiver scenarios. Additional detail on the budget neutrality projections is attached as Appendix A.

Section VI - Evaluation

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

The interim evaluation report for the Demonstration is available on the Arkansas Center for Health Improvement website. A preliminary summative report for the HCIP is due 180 days after the transition from the HCIP to Arkansas Works on December 31, 2016, with a final summative report due 360 days after the transition date of December 31, 2016. The final summative report will include an executive summary, Demonstration description, study design, discussion of findings and conclusions, policy implications, discussion of interaction with other State initiatives, and derivative research publications to demonstrate scientific and academic rigor.

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

<table>
<thead>
<tr>
<th>Hypothesis</th>
<th>Evaluation Approach</th>
<th>Data Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>QHP Premium Assistance Continued Hypotheses</td>
<td>Compare differences in perceived and realized measures of access between beneficiaries enrolled in QHPs and those in traditional fee-for-service Medicaid. Measures will include perceptions of timeliness and ease of access to primary care</td>
<td>i. CAHPS survey ii. QHP and Medicaid claims data</td>
</tr>
<tr>
<td>Hypothesis</td>
<td>Evaluation Approach</td>
<td>Data Sources</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------</td>
</tr>
</tbody>
</table>
| 2. QHP premium assistance beneficiaries will have equal or better care and outcomes compared with what they would have otherwise had in the traditional Medicaid fee-for-service system over time. | Compare differences in receipt of needed preventive, emergent, and specialty care and utilization of non-emergent emergency room or preventive hospital visits between beneficiaries enrolled in QHPs and those in traditional fee-for-service Medicaid. Measures include established HEDIS metrics for appropriate screening, other quality indicators, and actual utilization of health care services. | i. CAHPS survey  
ii. QHP and Medicaid claims data |
| 3. QHP premium assistance beneficiaries will have better continuity of care compared with what they would have otherwise had in the traditional fee-for-service Medicaid system over time. | Compare differences in attrition and churn between beneficiaries enrolled in QHPs and those in traditional fee-for-service Medicaid. Measures include:  
- Percentage of the enrolled population dropped from coverage who did not re-enroll, and  
- Months of gaps in coverage and the associated health care consequences of these gaps in coverage. | i. Insurance transition survey  
ii. Monthly enrollment data file |

### Waiver Extension Hypotheses

**ESI Premium Assistance-Specific Hypotheses**

<table>
<thead>
<tr>
<th>Hypothesis</th>
<th>Evaluation Approach</th>
<th>Data Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Use of ESI premium assistance will result in reduced costs to Medicaid compared to costs through QHP premium assistance.</td>
<td>Program impact assessment based upon employer participation and allocations of premium assistance</td>
<td>i. Enrollment and premium payment data</td>
</tr>
</tbody>
</table>
| 5. Availability of ESI premium assistance will recruit employers to newly offer ESI. | Gather employer and employee perceptions and realities of the benefits of coverage through ESI compared to providing the same benefits through QHP premium assistance. | i. Qualitative interviews and focus groups with small group employers  
ii. Premium payment and |
### Hypothesis Evaluation Approach Data Sources

<table>
<thead>
<tr>
<th>Hypothesis</th>
<th>Evaluation Approach</th>
<th>Data Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Continuity of coverage under ESI premium assistance will be improved compared to QHP premium assistance.</td>
<td>Compare attrition and churn between QHP and ESI premium assistance.</td>
<td>benefit utilization data</td>
</tr>
</tbody>
</table>
| 7. The incentive benefits in Arkansas Works will:                          | Compare rates of 2015-16 Independence Account participation vs. 2017-21 premium payment participation; compare 2015-16 vs. 2017-21 wellness visit utilization rates. | i. Premium collection and transaction data  
 ii. QHP and Medicaid provider and claims data |
| a) Increase participation rates for premium contributions compared to historical experience with Independence Accounts; and | i. Enrollment data  
 ii. Premium payment data |
| b) Increase wellness visit utilization.                                    | i. Enrollment data  
 ii. Premium payment data |
| 8. Arkansas Works QHP and ESI premium assistance beneficiaries will have equal or fewer gaps in insurance coverage compared with what they would have otherwise had in the traditional fee-for-service Medicaid system over time. | Compare attrition and churn between premium assistance beneficiaries covered through QHPs or ESI and traditional fee-for-service Medicaid beneficiaries over time. | i. Enrollment data  
 ii. Premium payment data |
| 9. Arkansas Works beneficiaries receiving coverage through either QHP or ESI premium assistance will maintain continuous access to the same providers. | Compare provider access for QHP and ESI premium assistance beneficiaries to those enrolled in traditional fee-for-service Medicaid. | i. CAHPS survey  
 ii. QHP and Medicaid claims data |

## Section VII - Compliance with Public Notice Process

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

Arkansas will complete this portion of the application after its 30-day public comment period. The State’s 30-day public comment period is from May 18, 2016 to June 17, 2016.
Section VIII – Public Notice

The Arkansas Department of Human Services (DHS), Division of Medical Services (DMS) is providing public notice of its intent to submit to the Centers for Medicare and Medicaid Services (CMS) a written application requesting approval to replace the existing program authorized under Arkansas’s Health Care Independence Program Demonstration with Arkansas Works.

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

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

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

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

- Encourage employer-based insurance;
- Incentivize work and work opportunities;
ARKANSAS 1115 WAIVER EXTENSION APPLICATION

- Promote personal responsibility; and
- Enhance program integrity.

The Demonstration will be statewide and will operate during calendar years 2017 through 2021. The State anticipates that approximately 272,000 individuals will enroll in the Demonstration by 2021. The State expects that, over the life of the Demonstration, covering Arkansas Works beneficiaries will be comparable to what the costs would have been for covering the same group of Arkansas adults using traditional Medicaid.

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

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

**Waivers**

- § 1902(a)(23)(A): To make premium assistance for QHPs in the Marketplace and for ESI mandatory for Demonstration enrollees and to permit the State to limit beneficiaries’ freedom of choice among providers to the providers participating in the network of the beneficiary’s QHP or ESI.
- § 1902(a)(13) and § 1902(a)(30): To the extent necessary to permit Arkansas to provide for payment to providers equal to the market-based rates determined by the Qualified Health Plan or ESI providing primary coverage for services under Arkansas Works.
- § 1902(a)(54) insofar as it incorporates Section 1927(d)(5): To permit the State to require that requests for prior authorization for drugs be addressed within 72 hours, rather than 24 hours. A 72-hour supply of the requested medication will be provided in the event of an emergency.
- § 1902(a)(10)(B): To the extent necessary to enable the State to impose targeted cost sharing on individuals in the eligibility group found at Section 1902(a)(10)(A)(i)(VIII) of the Act.
- § 1902(a)(14) insofar as it incorporates § 1916 and §1916A: To the extent necessary to enable the State to collect monthly premiums for individuals with incomes between 100 and 138 percent of the federal poverty level (FPL).
- § 1902(a)(34): To enable the State not to provide medical coverage to Arkansas Works beneficiaries for any time prior to the first day of the month in which an individual applies.
- § 1902(a)(4) insofar as it incorporates 42 CFR § 431.53: To the extent necessary to relieve Arkansas of the requirement to assure transportation to and from medical providers for Arkansas Works beneficiaries enrolled in ESI premium assistance.

**Expenditure Authorities**

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

- ESI Premium Assistance Payments. To cover up to 75% of the cost of ESI premiums for individuals participating in the Arkansas Works ESI premium assistance program.
- Limited-Purpose Health Credit Expenditures. To issue limited-purpose health credits to eligible enrollees who made a required number of contributions prior to Independence Account termination.

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

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

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

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

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

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

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

*Little Rock*
Thursday, May 26, 2016
11:00 AM – 1:00 PM
University of Arkansas
Cooperative Extension Service
2301 S University Avenue
Little Rock, Arkansas, 72204
Pine Bluff
Wednesday, June 1, 2016
5:30 – 7:30 PM
Jefferson Regional Medical Center
Classrooms J & R
1600 W 40th Avenue
Pine Bluff, Arkansas, 71603

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

Dawn Stehle
Director
Division of Medical Services

4501545928 EL
### Original Figures

<table>
<thead>
<tr>
<th></th>
<th>Without Waiver</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th>Three Year Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Months</td>
<td>1,567,481</td>
<td>2,405,931</td>
<td>2,881,476</td>
<td>6,854,888</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicaid Services PMPM</td>
<td>$ 477.63</td>
<td>$ 500.08</td>
<td>$ 523.58</td>
<td>$ 504.83</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Extension Figures

<table>
<thead>
<tr>
<th></th>
<th>Without Waiver</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th>Three Year Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Months</td>
<td>2,953,513</td>
<td>3,027,351</td>
<td>3,103,034</td>
<td>3,180,619</td>
<td>3,260,126</td>
<td>15,524,634</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicaid Services PMPM</td>
<td>$ 548.19</td>
<td>$ 573.96</td>
<td>$ 600.93</td>
<td>$ 629.18</td>
<td>$ 658.75</td>
<td>$ 603.57</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Appendix: Budget Neutrality Spreadsheet

#### Without Waiver

<table>
<thead>
<tr>
<th>Year</th>
<th>CY14</th>
<th>CY15</th>
<th>CY16</th>
<th>Three Year Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Months</td>
<td>1,567,481</td>
<td>2,405,931</td>
<td>2,881,476</td>
<td>6,854,888</td>
</tr>
<tr>
<td>Medicaid Services PMPM</td>
<td>$ 477.63</td>
<td>$ 500.08</td>
<td>$ 523.58</td>
<td>$ 504.83</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year</th>
<th>CY17</th>
<th>CY18</th>
<th>CY19</th>
<th>CY20</th>
<th>CY21</th>
<th>Five Year Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Months</td>
<td>2,953,513</td>
<td>3,027,351</td>
<td>3,103,034</td>
<td>3,180,619</td>
<td>3,260,126</td>
<td>15,524,634</td>
</tr>
<tr>
<td>Medicaid Services PMPM</td>
<td>$ 548.19</td>
<td>$ 573.96</td>
<td>$ 600.93</td>
<td>$ 629.18</td>
<td>$ 658.75</td>
<td>$ 603.57</td>
</tr>
</tbody>
</table>

#### With Waiver

<table>
<thead>
<tr>
<th>Year</th>
<th>CY14</th>
<th>CY15</th>
<th>CY16</th>
<th>Three Year Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Months</td>
<td>1,567,481</td>
<td>2,405,931</td>
<td>2,881,476</td>
<td>6,854,888</td>
</tr>
<tr>
<td>Medicaid Services PMPM</td>
<td>$ 477.63</td>
<td>$ 500.08</td>
<td>$ 523.58</td>
<td>$ 504.83</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year</th>
<th>CY17</th>
<th>CY18</th>
<th>CY19</th>
<th>CY20</th>
<th>CY21</th>
<th>Five Year Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Months</td>
<td>2,953,513</td>
<td>3,027,351</td>
<td>3,103,034</td>
<td>3,180,619</td>
<td>3,260,126</td>
<td>15,524,634</td>
</tr>
<tr>
<td>Medicaid Services PMPM</td>
<td>$ 548.19</td>
<td>$ 573.96</td>
<td>$ 600.93</td>
<td>$ 629.18</td>
<td>$ 658.75</td>
<td>$ 603.57</td>
</tr>
</tbody>
</table>

### Assumptions

| Without Waiver Trend | 4.7% |
| With Waiver Trend | 4.7% |
| Enrollment Growth | 2.5% |
| Member Cost Share Growth | 1.5% |

### Member Cost Share Assumptions

- Individuals at/above 100% FPL: 46,000
- Contribution PMPM: $13
- Collection Rate: 20%
- Collection Amount: $1,435,200