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THE ARKANSAS HEALTH CARE INDEPENDENCE ACT OF 2013 AND THE IMPOSITION OF CMS SPECIAL TERMS AND CONDITIONS ON THE PRIVATE OPTION

The Arkansas Health Care Independence Act of 2013 gave the Department of Human Services broad authority to seek federal waivers necessary to implement the program known as the private option. However, the authority of DHS is not unlimited. The waiver must be consistent with the provisions of the Health Care Independence Act of 2013. (*See ACA § 20-77-2405 (a)(2)(A)(i)*)

To implement Arkansas' private option, the state filed an application for a 1115 Waiver from Medicaid requirements. The application was approved, but as a condition for approval, CMS attached terms and conditions. The CMS document is identified as Centers for Medicare and Medicaid Special Terms and Conditions, Document Number 11-W-00287/6. By implementing the program, state officials accepted the CMS terms and conditions.

Some requirements in the CMS Special Terms and Conditions appear to be in conflict with the intent and limitations of the Health Care Independence Act of 2013.

1. Arkansas law includes financial triggers to automatically terminate the program if federal funding drops below certain thresholds, but by following the Arkansas law the state would be in breach of the CMS Terms and Conditions and be at risk for federal penalties. Arkansas Code § 20-77-2405 (h) requires the quick termination of the program if medical assistance percentages fall below a specific percentage. If the threshold is not met the program ***"automatically terminates within one hundred twenty (120) days."*** However, the CMS Special Terms and Conditions is in conflict with Arkansas law by imposing numerous requirements that must be met before the state may terminate the program, including lengthy notice, approval of a plan by CMS, appeals procedures for enrollees, etc. None of the requirements CMS purports to impose could be accomplished within the time Arkansas' financial triggers require termination. Some of the CMS Terms and Conditions are discussed below.

2. The Arkansas law intended the state to have the flexibility to end the program with notice but CMS purports to restrict Arkansas' ability to terminate the program. The

drafters of the Health Care Independence Act of 2013 included a number of provisions that show that the state was to be given much flexibility in terminating the program.

- As mentioned above, if federal medical assistance percentages fall below a specific threshold, the program ***"automatically terminates <u>within</u> one hundred twenty (120) days."*** *(ACA § 20-77-2405 (h))*
- People who enroll in the program must <u>affirmatively acknowledge</u> that the "***program is subject to cancellation upon appropriate notice***". *(ACA § 20-77-2405 (i)(2))* Appropriate notice is not defined. It could refer to the type of notice or length of notice or both. However, if it concerns length of notice, we already know that termination can occur within a period no longer than one hundred twenty (120) days, as in the case of federal medical assistance percentages falling below the threshold of support. Requiring an enrollee to make this acknowledgment supports the view that the act intended to allow the state flexibility to terminate the program with notice.
- DHS is given authority to make Medicaid State Plan Amendments necessary to implement the program in a manner consistent with the law, but is only authorized to submit Medicaid State Plan Amendments " ***that are optional and therefore may be revoked by the state at its discretion.***" *(ACA § 20-77-2405 (a)(2)(A)(ii)(B))*
- The Health Care Independence Act of 2013 sets a termination date for the law at June 30, 2017 but acknowledges that the General Assembly may change the date by law. ***"This subchapter shall be in effect until June 30, 2017, unless amended or extended by the General Assembly."*** *(ACA § 20-77-2408)* Such an amendment could authorize an extension many years into the future or even terminate the program immediately.

Termination of the program is seen very differently in the CMS Special Terms and Conditions accepted by state officials as a condition for the waiver. The terms and conditions limiting the state's ability to terminate the program appear to be in conflict with the intent of the act. Instead of cancellation upon notice, CMS purports to impose numerous requirements including the need to seek <u>CMS approval</u>. The CMS Special Terms and Conditions concerning termination of the program:

1. Require a minimum of seven (7) months of termination notice; but this period before termination could be much longer in trying to meet all CMS requirements. The seven (7) month notice includes a thirty (30) day public comment period before submitting written notice to CMS and a six (6) month written notice to CMS. *(Terms and Conditions (9)(a))*;
2. Require Arkansas to obtain CMS approval of a transition and phase-out plan. It could be argued that CMS has given itself a de facto veto power by allowing CMS to reject termination plans. *(Terms and Conditions (9)(b))*
3. Prohibit Arkansas from even beginning implementation of phase-out activities until fourteen (14) days after CMS has approved the plan. *(Terms and Conditions (9)(b))*
4. Requires the transition and phase-out plan to include the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the State will conduct administrative reviews of Medicaid eligibility prior to the termination of the program for the affected beneficiaries, and ensure ongoing coverage for those beneficiaries determined eligible, as

well as any community outreach activities including community resources that are available. . *(Terms and Conditions (9)(c))*

5. Provide that if an enrollee is appealing Medicaid status at the time the program is scheduled to end, that the enrollee is entitled to continued benefits under the program during the remainder of the appeal process. *(Terms and Conditions (9)(d))*

3. When does a program become an entitlement program and therefore violate the Arkansas Law? The Health Care Independence Act of 2013 requires an enrollee to affirmatively acknowledge that "***The program is not a perpetual federal or state right or a guaranteed entitlement***" and that "***The program is not an entitlement program***." *(ACA § 20-77-2405 (i)(2) and (i)(3))* There would be no purpose in requiring this acknowledgement unless the intent of the act is to prohibit the program from becoming an entitlement program.

What makes a program an entitlement program? The definition can be debated, but it appears to include some type of rights to benefits under a government program. Medicaid is an example of an entitlement program. It appears that the drafters wanted to keep the private option from taking on the rights based characteristics of Medicaid. This may have been of special concern to the drafters because the private option is a form of Medicaid expansion through a waiver. What is of concern here is to what extent the rights under the CMS Terms and Conditions cause the program to take on characteristics of an entitlement program. The CMS Special Terms and Conditions provide that:

1. In terminating the program, the State must provide for administrative review to determine if private option participants qualify for Medicaid eligibility under a different eligibility category. *(Terms and Conditions (9)(d))* The state must notify the participants of this right.
2. If a private option participant requests a hearing on Medicaid status before the date of termination of the program, the State must maintain the person's private option benefits during the appeal. *(Terms and Conditions (9)(c) and (9)(d))* This appeal process could extend after the scheduled termination of the program and therefore require continued benefits after the scheduled termination date of the program.

4. How does the CMS budget neutrality expenditure cap interact with the federal funding requirement of the Arkansas act? The CMS requirement for budget neutrality does not in itself conflict with the Arkansas law. It is mentioned here because of its potential interaction with the financial triggers in the Arkansas law for terminating the program. The Arkansas law requires federal funding for the program to be above minimum federal medical assistance percentages listed in the act (including 100% in 2014 and 2015 and slightly lower percentages in future years). If the percentage falls below the required level the program is automatically terminated. *(ACA § 20-77-2405 (h))* The CMS Terms and Conditions include a budget neutrality expenditure cap. *(Terms and Conditions (55))* In theory the state's obligations, including responsibility under budget neutrality could cause the federal percentage to fall below the

financial trigger percentage. Budget neutrality provisions are not uncommon, but the percentage limits in the Arkansas act do not provide for an exception from the financial triggers for additional obligations due to a budget neutrality expenditure cap.

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See "**The Arkansas Health Care Independence Act of 2013**" version prior to codification below, above references after codified:

20-77-2105. Administration of the Health Care Independence Program.

(a) The Department of Human Services shall:

(1) Create and administer the Health Care Independence Program; and

(2)(A) Submit and apply for any:

(i) Federal waivers necessary to implement the program in a manner consistent with this subchapter, including without limitation approval for a comprehensive waiver under Section 1115 of the Social Security Act, 42 U.S.C. § 1315; and

(ii)(a) Medicaid State Plan Amendments necessary to implement the program in a manner consistent with this subchapter.

(b) The Department of Human Services shall submit only those Medicaid State Plan Amendments under subdivision (a)(2)(A)(ii)(a) of this section that are optional and therefore **may be revoked by the state at its discretion**.

(B)(i) As part of its actions under subdivision (a)(2)(A) of this section, the Department of Human Services shall confirm that employers shall not be subject to the penalties, including without limitation an assessable payment, under Section 1513 of Pub. L. No. 111-148, as existing on January 1, 2013, concerning shared responsibility, for employees who are eligible individuals if the employees:

(a) Are enrolled in the program; and

(b) Enroll in a Qualified Health Plan through the Health Insurance Marketplace.

(ii) If the Department of Human Services is unable to confirm provisions under subdivision (a)(2)(B)(i) of this section, the program shall not be implemented.

(b)(1) Implementation of the program is conditioned upon the receipt of necessary federal approvals.

(2) If the Department of Human Services does not receive the necessary federal approvals, the program shall not be implemented.

(c) The program shall include premium assistance for eligible individuals to enable their enrollment in a Qualified Health Plan through the Health Insurance Marketplace.

(d)(1) The Department of Human Services is specifically authorized to pay premiums and supplemental cost-sharing subsidies directly to the Qualified Health Plans for enrolled eligible individuals.

(2) The intent of the payments under subdivision (d)(1) of this 2 section is to increase participation and competition in the health insurance market, intensify price pressures, and reduce costs for both publicly and privately funded health care.

(omitted (d)-(g))

(h) The program authorized under this subchapter shall terminate within one hundred twenty (120) days after a reduction in any of the following federal medical assistance percentages:

(1) One hundred percent (100%) in 2014, 2015, 1
or 2016;

(2) Ninety-five percent (95%) in 2017;

(3) Ninety-four percent (94%) in 2018;

(4) Ninety-three percent (93%) in 2019; and

(5) Ninety percent (90%) in 2020 or any year after 2020.

(i) An eligible individual enrolled in the program shall affirmatively acknowledge that:

(1) The program is not a perpetual federal or state right or a guaranteed entitlement;

(2) The program is subject to cancellation upon appropriate
notice; and

(3) The program is not an entitlement program.

20-77-2108. Effective date.

This subchapter shall be in effect until June 30, 2017, unless amended or extended by the General Assembly.

SECTION 3. NOT TO BE CODIFIED. (a) The implementation of this act is suspended until an appropriation for the implementation of this act is passed by a three-fourths vote of both houses of the Eighty-Ninth General Assembly.

(b) If an appropriation for the implementation of this act is not passed by the Eighty-Ninth General Assembly, this act is void.

SECTION 4. NOT TO BE CODIFIED. The enactment and adoption of this act 13 shall supersede Section 21 of HB1219 of the Eighty-Ninth General Assembly, if Section 21 of HB1219 of the Eighty-Ninth General Assembly is enacted and adopted.

SECTION 5. EMERGENCY CLAUSE. It is found and determined by the General Assembly of the State of Arkansas that the Health Care Independence 19 Program requires private insurance companies to create, present to the Department of Human Services for approval, implement, and market a new kind of insurance policy; and that the private insurance companies need certainty about the law creating the Health Care Independence Program before fully investing time, funds, personnel, and other resources to the development of the new insurance policies. Therefore, an emergency is declared to exist, and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on:

(1) The date of its approval by the Governor;

(2) If the bill is neither approved nor vetoed by the Governor, 29 the expiration of the period of time during which the Governor may veto the bill; or

(3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto.