EXHIBIT E

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Office of Director

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January 29, 2016

Senator Cecile Bledsoe, Chair
Representative Kelley Linck, Chair
Public Health, Welfare and Labor Committee
315 State Capitol
Little Rock, AR 72201

Dear Senator Bledsoe and Representative Linck:

Attached is a letter from Arkansas Department of Human Services to the federal Centers for Medicaid and Medicare Services requesting federal assistance in protecting clients, providers and insurance carriers from financial penalties resulting from challenges in implementing the new federal and state eligibility systems.

As has been discussed in previous legislative hearings, challenges with implementing systems led to delays in processing renewals and case changes (e.g. changes in income, residency, and household composition). When those changes were eventually processed, if the change resulted in a client no longer being eligible for Medicaid Expansion coverage, the case was closed retroactively to the month that the client submitted the new information. The state then recouped from the insurance carriers any premium payments for months beyond the date of closure.

The retroactive termination of coverage and resulting premium recoupments were intended to ensure that clients were not covered for periods when they were ineligible. However, the unintended consequence is that in some cases carriers paid for claims and providers offered care only to later find that the individual receiving care did not have coverage.

Because all parties were acting in good faith, and because clients, providers or carriers should not be penalized for eligibility system issues, Arkansas has requested that the federal government allow some or all of the recouped premiums to be restored.

The situation described here is very limited in scope, affecting less than 0.5% of all premium payments, covering less than 2% of the Medicaid Expansion clients. And it is unclear how many of those 2% actually received any care. However, despite the relatively small numbers, the state believes that the appropriate remedy is for the federal government to allow for premium coverage to ensure that insurance carriers do not feel compelled to recoup from providers or that providers feel compelled to recoup from patients.

The attached letter follows months of work to find a satisfactory approach to resolving this problem. DHS and CMS have held regular conference calls to reach a common understanding of the nature and scope of the problem and attempt to find a workable solution. Simultaneously, DHS and the insurance carriers have worked to clearly identify the scope of the problem and to provide requested information to CMS. It is hoped that some level of resolution will be reached in the near future.

Sincerely,

John Selig
Director

Attachment

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services

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January 28, 2016

Ms. Vikki Wachino
Director, Center for Medicaid & CHIP Services
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Ms. Wachino:

Thank you for your continued support of Arkansas's innovative approach to expanding coverage to members of the new adult group. Arkansas's Health Care Independence Program (HCIP) covers roughly 225,000 low-income Arkansans, with approximately 90% of these individuals served through the State's current 1115 premium assistance demonstration waiver. Arkansas has been successful in providing needed health care services to this population, but like many other states, has also faced challenges related to developing and implementing new eligibility and enrollment systems.

Due to eligibility and enrollment limitations, Arkansas received a waiver under section 1902(e)(14)(A) of the Social Security Act from the Centers for Medicare & Medicaid Services (CMS) to delay renewals and change of circumstance functionality in the State's new system. Federal regulations at 42 CFR §435.930 require states to provide Medicaid coverage to all eligible individuals until they are found to be ineligible. Due to the aforementioned system limitations, change of circumstances were not processed until summer of 2015. This resulted in 4,317 HCIP enrollees with coverage ended retroactively for reasons other than death. These enrollees were considered eligible until change of circumstances functionality became operational in the new eligibility and enrollment system.

These eligibility limitations, coupled with the unique nature of Arkansas's premium assistance program, have resulted in a time-limited situation where premiums were recouped from issuers even though coverage had been provided. The total amount of payments recouped from issuers for these retroactive terminations was $7,023,103. This represents 0.47% of total payments made to issuers during this period. Arkansas asserts that these retroactive terminations were incorrect and proposes to reimburse participating issuers, who offered coverage in good faith, for those payments. In light of this situation, Arkansas proposes making time-limited supplemental payments to mitigate the negative consequences for issuers, providers, and Medicaid beneficiaries.

This approach would help prevent potential downstream negative impacts for issuers, providers, and beneficiaries. In accordance with Arkansas Insurance Department regulations, issuers may recoup paid claims from providers, who in turn, may seek payment for previously covered medical expenses from beneficiaries. Failure to allow premium payments based upon determination date will place Medicaid beneficiaries at financial risk.