TSG Status Report # 3

To: Arkansas Health Reform Task Force
Re: Health Care Reform/Medicaid Consulting Services
Date: August 20, 2015

PREPARED BY:

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Appendices

Table of Appendices

THE STEPHEN GROUP

Summary of Medicaid Managed Care Plans Response to Task Force Questions
Prepared by The Stephen Group for The Arkansas Legislative Health Care Task Force
8-15-15

Ameri-Health	Molina	Magellan	Anthem	Centene	Meridien	United Health	Aetna
States operated in							
PA, SC, LA, DC, MI, NE, DC	State Plans: CA, FL, IL, MI, NM, OH, SC, TX, UT, WA, WI, PR; MMP Dual-Eligible: ID, LA, WV, NJ, ME, VI	IA, FL, NY, AZ, NE, PA, LA, VA,	CA, FL, GA, IN, KS, KY, LA, MA, MD, NV, NJ, NY, SC, TN, TX, VA, WA, WV, WI	AZ, CA, FL, GA, IL, IN, KS, LA, MA, MS, MO, NH, OH, SC, TX, WA, WI	MI, IL, IA	AZ, DE, FL, HI, IA, KS, LA, MD, MA, MI, MS, NE, NV, NJ, NM, NY, OH, PA, RI, TN, TX, WA, WI	AZ, FL, IL, IA, KY, LA, MD, MI, MO, NE, NJ, NY, OH, PA, TX VA, WV (Transition FFS – MC)
Core services provided							
Primary care; physical services; DME; emergency services; home health care; pharmacy; dental, vision, rehab, dialysis; nursing facility; physical/speech/ occupational therapy; hospital; translation/ interpretation; smoking cessation; fitness incentives; transportation	Physical, Behavioral Health, Chemical De-pendency, Dental, LTC, Transportation	Integrated Medical and Behavioral Health Services; Physical, LTSS Services	Medicaid Managed Care; Acute Care; Integrated physical/ behavioral health services , LTSS, Pharmacy	Medicaid Managed care; Acute Care; Physical services, behavioral health services; community based services; vision, dental; skilled nursing, assisted living, LTSS; advice line; pharmacy; non-emergency transportation	Physical and Behavioral Health Services (inpatient and outpatient), Pharmacy, Long Term Supports and Services, Home and Community Based, Dental	All Medicaid benefits	Managed Care Services for Medicaid, including acute care and waivers; integrated Medicare, LTSS, ABD, Dual eligi-bles, CHIP, including: operations, medical management, ancillary support; physical/behavioral health, pharmacy, dental, vision, transportation, LTSS
Population experience							
• Medicaid • SSI without Medicare • TANF • Optional coverage for women and infants • Children health • Foster children • HCBC Waiver	• TANF • Medicaid physical health/Acute care • Aged, Blind or Disabled (ABD) • Long-term Care (LTC) • CHIP • Medicare Advantage	• Medicaid physical health/Acute care • Long Term Care • Medicare Advantage • Prescription Drug (MAPD) plan	• Medicaid physical health/acute care • SSI/ABD • LTSS • Behavioral Health • Developmental Disability • CHIP • TANF	• Medicaid • LTC • TANF • CHIP • SSI/ABD • Child Welfare • Behavioral Health • Developmental Disability • Pregnant Women	• Medicaid • TANF • CHIP • Foster Care • SSI/ABD • ACA • Dual Eligible SNP • Child Welfare • Disabled	• Medicaid • TANF • CHIP • SSI/ABD • LTSS • Expansion • Dual Eligible SNP	• Medicaid physical health/acute care • SSI/ABD • LTSS • Behavioral Health • Developmental Disability • CHIP • TANF

• Breast Cervical Cancer • Assistance to Aged and Blind	Special Needs Plan (SNP) • QHP Marketplace	• Dual Eligible Special Needs Plan (DSNP) • Fully Integrated Duals • Adults and Children	• Foster Care • HIV	• Infants			
Improvement of access to and quality of services for populations served.							
• Integrated Care Management •Data analytics to establish provider network; •Interpretation/ translation services • Community outreach • Transportation services • Mobile health vans • Community wellness centers • Telehealth • Mobile technology • Rapid Response Outreach Teams	• Outcome-based Quality Assessment and Performance Improvement (QAPI) •Community Health Worker program and Community Connectors (NM) to improve access to services and support; •Pay for Value programs to reduce health disparities across all populations while rewarding participating providers for providing high-quality care	• Developed first Medicaid specialty health plan for persons with serious mental illness (FL) • Optimization Delivery System provides integrated service delivery • Increased qualified providers by 112% (LA) • Telehealth programs • Integrated Health Homes in Iowa O	Disease management program that has significantly reduced ER/inpatient admissions – 116% increase in outpatient BH visits in Tenn. 59% decrease in ED; 15% decrease in inpatient; 17% increase in screenings for diabetes (TN) • Telepsychiatry • Provider Collaboration Strategy to en-courage preventative and ongoing services reduced ED visits • Txt4health for appt/ screening reminders • CareMore increased access to primary care (TN) • Eliminated waitlist for home and community waiver programs (TX)	•Rural strategies – rural southwest Georgia •Comprehensive Diabetes Care • Improved transitions of care •Outreach activities for disease management • Increased pre-natal care • Reduced costs by providing phones to members in high risk care • Patient Review Coordination program	• Full range of primary and specialty care • Childhood immunizations • Health literacy • Available access to necessary services • Well-credentialed in-network providers • Member outreach	• Engaging providers for Medicaid populations • Supporting expanded hours and patient management • Improve services by using actionable data and technology for member engagement and clinical support • Performance incentives through contractual requirements	•Statewide provider networks •Outreach via community, agencies, faith-based services •Transportation •Mobile health care services •Aetna Metter Health app •Telehealth and Telemedicine •Integrated Care Management to reduce readmissions and provider alternatives to emergency care
State budget savings experience							
• PA: Where Keystone First Plan operates $2.7 billion saving over	• Florida able to reduce staff after	**Nebraska - reduced quarterly out-of-state placements for**	• Reduction of MMIS costs	• Asthma Mgmt Program: $2.6 million savings	• Overall program savings in Michigan over four year period		• Increased use of HCBS, reduced institutional care for

5 years (PA) for Medicaid Managed Care program called HealthChoices – AmeriHealthCaritas is a participant *Lewin Group* Study	rolling out Managed Care • Participant Plan in saving State of Texas $3.8 billion over 5 years versus the traditional Medicaid Fee For Service model (TX) Milliman Study	**children and adolescents by 90%. Louisiana - reduced out-of-** home/restrictive placement in the children's system-of-care program by 50 per cent; decreased hospital admissions by 18%, and reduced the length of stay in hospitals for adults by 13 per cent. Iowa - 18% reduction in mental health inpatient days, 12% reduction in medical emergency department visits	• Participant Plan in saving State of Texas $3.8 billion over 5 years versus the traditional Medicaid Fee For Service model (TX) Milliman Study • $100 million first year/$1.1 billion 5 year projected savings over 5 years (KS) – All Plans • 2.4% increase in MLTSS recipient costs vs. 18% increase in FFS HCBS and nursing home recipient costs (NY)	• ER Diversion Program: $500K annual savings • Reduced Inpatient Readmissions: $1.2 million savings expected • Pain Management Program $2.3 million savings • Start Smart for Your Baby: $23 million savings	from 2001 to 2002 went from 9% in 2001 to 19% in 2004 over the Fee For Services		LTSS populations in AZ, DE

Ameri-Health	Molina	Magellan	Anthem	Centene	Meridien	United Health	Aetna
Enhancement of PCMH program or changes							
• Work with physicians to align financial incentives and reimbursement policies – experience in this area • Provide support to providers through data analytics • Support and reimbursement for care managers • Provide resources to sustain medical home practices	• Promoting PCMH Growth through Recognition and Incentives • Monitoring PCMH Outcomes to Improve Member Outcomes	• Garner multi-payer engagement • Focused project leadership • Regular stake-holder input • Technical assistance/ collaboration • Team-based care • Require evaluation • Provide data for improvement	• Increased access to PCMH • Support providers with patient specific data • Improved screening for behavioral health conditions • Incentives and Pay for Performance for providers • Health home programs for high-risk/high cost members	• Emphasize care coordination and communication • Invest in medical homes • Support well-performing PCP practices and clinics	• Develop Meridien's PCMH model • Create medical homes for medically complex enrollees • Electronic tools, evidence based guidelines for chronic conditions, team-based care • Obtain PCMH certification • Enhanced payments through new billing codes and bonus payments	• Collaboration with providers and Value-based reimbursement that encourage active engagement and improved outcomes	• Enhance technology to allow real-time data analytics • Add quality measures such as medication adherence, inpatient readmissions • Reduce required panel size to promote provider participation
Experience with Aged, Blind and Disabled; High Cost Cases; reducing reliance on institutional care							
• Experience in Medicaid risk/non-risk programs and behavioral health services; Medicare Advantage D-SNP; SCHIP, Integrated Dual Demonstration MMPs • Subsidiary PerformCare provides 24/7 crisis management service • Mobile response and stabilization services for NJ – 98% of 20,000 youth remained in home • Integrated Care Management Model	• Provide managed integrated care and care coordination for 450,000 ABD, and 170,000 MLTSS members • Serve 55,000 members in 6 MMP demonstrations. • Reduced reliance on institutional care by 8-18% in OH, TX, NM	• MLTSS (NY) is designed to keep people out of institutions • Dual Eligibility Plans (NY) • Medicaid Health Plan for members with Serious Mental Illness (FL) • Reductions in residential care for behavioral health through Multi-systemic Therapy (42%), and other home and community based programs	• 882,000 SMI/ ABD members, 270,000 LTSS participants • Experience with Dual Eligible, ID/DD, Aids/HIV, ACA • Improved utilization of services to rebalance community and institutional services (KS) • 25% reduction in nursing home stays (TN) • Success transitioning MLTSS to community in KS, TX, TN • 2014 transitioned 120 people from	• Serve 414,000 ABD members across 14 states; • Experience with chronic medical conditions, developmental/ physical disabilities, serious mental illness thru whole person/person centered, intensive care management • LTSS programs in 9 states support transitions to community setting • Intellectual and Developmental Disability in 3 states	• Administers physical and pharmaceutical benefits for ABD (MI) • Administers Medicaid, Nursing, HCBS waivers, LTSS to Seniors and Persons with Disabilities (IL) • Provide intense intervention services for enrollees who are dually eligible or qualify for CMS Medicare Medicaid Alignment Initiatives • Transition of Care program reduces return to institutional care	• Operate MLTSS waiver programs for aged and disabled in 12 states • Adding complex populations, such as ID/DD • MLTSS programs have reduced reliance on institutional care	• Experience with ABD (13 states), I/DD, Dual-eligible, LTSS, SMI, providing a wide range of services • Experience with 1915 waiver populations • Use of HCBS has reduced use of institutional care in AZ, DE

addresses medical/ behavioral condi-tions to promote mental/ emotional health			institution in Kansas to community care • Texas – average 360 transitioning from nursing to community for past two years • TTennessee program 25% reduction in nursing home stays	• Arizona Plan decreased nursing home placements from 30% in 2009 to 23.6% today • Florida, in six months 59% August 2014 to 56.5% Feb 2015			

Ameri-Health	Molina	Magellan	Anthem	Centene	Meridien	United Health	Aetna
Experiences with PMPM over last five years							
Varies across states due to Medicaid expansion, specific risk adjustment scores, additional benefits and services provided, new mandated drugs	Slight increases in PMPM, attributed to changes in Medicaid fee schedule and expansion of managed care to new populations	Overall cost of care trend is 0-2%; higher in areas with man-dated provider fee increases	Aggregate Medicaid cost trends over last 5 years averaging 1-4%	Aggregate annual premium rate adjustment has ranged from -0.9% to +2.7%	ABD costs have increased 1.17%, compared to 7.73% increase for national Medicaid expenditures	Rate changes are commensurate with shifts in utilization	
Critical success factors for Arkansas to consider with Managed Care							
• Invest time for stakeholder input to program design • Focus on quality of care • Managing churn • Adequate funding	• Stakeholder input • Full Population-based model • Transitional approach to enrollment • Strategic delegation of roles • Care in most-integrated and least-restrictive setting • Member out-reach • Access to care	• Stakeholder Communication • Continuity of Care of at least 90 days • Employment support services for disabled members • Outreach/sup-port for providers during transition • Hierarchy for auto assignment for DD, BH, LTSS needs • Realistic implementation time-lines	• Collaboration and frequent communication between MCOs, state, and stakeholders • Development of rates by experienced actuarial firm • Flexibility for MCOs to develop value-based reimbursement and care models • Sufficient implementation timeframe • Require accreditation within 2 years	• Set capitation rates to anticipate in-creases in program requirements • Strong state-MCO partnership • Engaging community stake-holders • Include all services – no carve-outs	• Improved quality of care • Improved access to care • Overall cost savings to program • Reduction in inpatient admissions • Reduction in ER utilization	• Improved outcomes • Improved quality • High member and provider satisfaction • Savings • Impact on expected trends	• Carving in all Medicaid benefits • Weighting experience • No network sub-mission as part of RFP submission • Network adequacy requirements based on recipient population • Auto-assignment based initially on continuity, later on out-comes • MCOs pay 90% of Medicaid to out of network providers • Collaborative transition of care requirements • Formal inclusion of LTSS • Mandatory enrollment • Clear timelines and evaluations • Phase in support for I/DD

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Ameri-Health	Molina	Magellan	Anthem	Centene	Meridien	United Health	Aetna
Things NOT to do if moved to Medicaid Capitated Managed Care							
1. Stay away from fragmented system of care 2. Do not limit program participation 3. Do not allow populations to opt out 4. Do not overlook stakeholder buy-in 5. Do not put cost over quality	1. Have non-integrated care model with carve-outs 2. Implement without an experienced MCO partner 3. Implement without an advisory panel of consumers, stakeholders and providers 4. Do not move too quickly from FFS to Managed Care 5. Do not require rates that are not actuarially sound	1. Do not set reimbursement rates that do not account for full range of services 2. Do not implement on regional basis vs. statewide 3. Do not roll out quickly 4. Do not allow for populations to selectively op out 5. Do not manage program with short term contracts	1. Do not create silos of care by carving out services 2. Do not carve out populations 3. Do not bid the contract regionally 4. Do not limit MCO flexibility in developing model of care 5. Do not make for an uneven selection and operational criteria for bidding entries.	1. Do not regionalize the contract – Implement a state-wide approach 2. Do not carve out services 3. Do not limit MCO's management of formulary 4. Do not contract with more than 3 MCOs 5. Allow flexibility in operation and do not mandating detailed operational requirements	1. Do not carve out core services from the MCOs 2. Do not regionalize the program 3. Do not select a single entity to manage the MMC program 4. Do not have a state run formulary 5. Do not use an RFP for procurement of Managed Care Program but use the Ohio Request For Application Model used in 2012	1. Do not develop a fragmented approach 2. Do not establish unreasonable rates and savings 3. Do not establish fragmented, population-specific model 4. Do not create unreasonable program mandates	1. Do not allow for voluntary enrollment 2. Do not carve out populations or geographic areas 3. Do not carve out Medicaid covered services 4. Do not lose momentum with Arkansas' PCMH program 5. Do not forget pertinent Quality measures

Managed Care Plan Questions

Prepared by The Stephen Group and Submitted on Behalf of the Arkansas Legislative Health Care Task Force

1. Briefly describe your experience in other states where you have served as Medicaid Managed Care Organization serving the Medicaid population?
2. How long have you operated in that state?
3. What populations do you serve?
4. What have you done to improve access and the quality of services for the populations you serve?
5. What are the core services you provide in those states and what, if any, of the major Medicaid service areas has the state decided to carve out of Medicaid Managed Care? What has been the experience of any of these carve outs?
6. In states where you serve as Medicaid Managed Care Organization, do you have your own MMIS claims system and does the state also operate an MMIS at the same time? Are you able to help the state reduce MMIS costs in these states?
7. Where you have served as Medicaid Managed Care organization, how do you report cost and outcomes to the State in terms of population health and services rendered?
8. Where you have served as the state's Medicaid Managed Care Organization, have you been able to help the state reduce administrative expenses in their budgets based on rolling out Managed Care? If so, please provide specifics on the type of administrative savings? What do you think Arkansas would expect to save in terms of Administrative savings in moving to full risk capitated managed care for all services, including integrating all waiver services and populations? Please provide specifics.
9. Describe your experience in states that have rural populations without meaningful access to quality services. How have you made improvements in these areas? Do you use telehealth services and have they been effective?
10. In Arkansas, a number of physicians participate in the Patient-Centered Medical Home initiative in the non-high cost populations. How would you enhance this program, or change it in any way?
11. Arkansas has also developed an Episodes of Care initiative, which is part of the State Innovation Grant and is now operational in 14 episodes state-wide. Do you believe that this is the right approach for Arkansas? Would you change the current Episodes roll out in any way? What would you recommend Arkansas do with this on-going effort if it were to move to a full risk, capitated Managed Care environment.
12. In any of the states where you are serving high cost populations, please describe the populations and the services. For example, are you serving the aged, disabled and those with mental illness, and if so, are you also providing managed care services in the Waivers
13. What has been your experience with the high cost populations to date?
14. In the areas of Long Term Care Supports and Services for the entire elder, behavioral health and disability populations, does your company handle the assessments used to determine level of care or type of placement? If so, can you explain how you handle assessment, plan of care and ensure that the right services are given to the right people in the right settings?
15. Have you been able to reduce the state reliance on institutional care? Give specific examples
16. Have you been able to save the state money and, if so, how have the savings been measured? Give specific examples?

17. Describe the increases or decreases you have experienced in your yearly PMPMs for each of the last 5 years in states you have operated?
18. Have you been able to return any funds to the state based on experience, for example in rebates? If so, explain.
19. Can you point us to any studies in a state that have shown MMC savings? What are the best reports and why?
20. What are the critical success factors Arkansas should consider if they were to go to full risk, capitated managed care for all populations?
21. What should AR do to assure that they get the best premium/contract to assure savings?
22. What are the 5 things that Arkansas should absolutely NOT do if they were to contract out Medicaid Managed Care?
23. What are the differentiating factors in your services than the traditional Medicaid fee for service?
24. Please provide the Task Force with an understanding of pharmaceutical rebates earned by the plan for managing Medicaid lives? Provide at least a full year of data and if the rebates are not collected yet, provide the estimates based on contracts or invoiced amounts for rebates.

Key Features of Alternative State Medicaid Expansions
August 10, 2015

	Newly Eligible Program Design	Premiums[1]	Cost Sharing[2]	Healthy Behavior Incentives	Benefit Variations	Employment-Related Provisions	Health Savings-Like Account (HSA)	Health Insurance Premium Payment (HIPP)[3]
Arkansas	**Premium Assistance** - through which eligible individuals are enrolled in Marketplace Qualified Health Plans with Medicaid covering the costs of premiums and deductibles: • Mandatory choice for newly eligible adults with incomes from 0-138% FPL • Medically frail individuals are excluded	Yes (Waiver) • In the form of sliding scale contributions to Independence Account • Contributions to Independence Account voluntary • Contributions for individuals below 100% FPL suspended due to legislation • $10/month for individuals with incomes >100% FPL-115%; up to $17.50/month for individuals with incomes >115%-129% FPL; up to $25/month for individuals with incomes >129%-133% FPL	Yes (Waiver not required) • Waiver authorizes State to apply cost-sharing to a wide range of services for individuals with incomes from 50-138% FPL • Recent State legislation suspends cost-sharing for individuals with incomes below 100% FPL • Cost-sharing is subject to maximum permitted Medicaid cost-sharing levels • Individuals with incomes from 100-138% FPL pay cost-sharing through Independence Accounts • Those who fail to make Account contributions are subject to point of service cost-sharing	No	No coverage of non-emergency use of the emergency room (ER) (waiver not required)	No	Yes	No

Prepared for Arkansas Health Care Task Force by The Stephen Group, and adapted from research also conducted by Manatt for Arkansas DHS

[1] Federal Medicaid law does not permit premiums. However, CMS has granted waivers for states to charge limited premiums as described in this chart.
[2] Federal Medicaid law imposes limits on cost sharing based on income level. To date, CMS has not approved cost sharing beyond these limits.
[3] HIPP is premium assistance for employer-sponsored coverage. Under HIPP, Medicaid covers consumers' premiums and cost-sharing beyond Medicaid limits; acts as secondary insurer; and covers Medicaid benefits that are not in the employer-sponsored insurance benefit package.

	Newly Eligible Program Design	Premiums[4]	Cost Sharing[5]	Healthy Behavior Incentives	Benefit Variations	Employment-Related Provisions	Health Savings-Like Account (HSA)	Health Insurance Premium Payment (HIPP)[6]
Arizona (Proposed)	• To be eligible, members must: ○ Make timely payments. ○ Participate in the AHCCCS Works ○ program. ○ Meet the Healthy Arizona targets. • Employers, and the philanthropic community can make tax-deductible contributions into individual accounts.	• Yes. Up to 2% of annual household income. Included in monthly AHCCCS CARE payment is a monthly deposit set at 2% of income into a personal HSA. • Access to AHCCS CARE Account fund only for individual as can be used for approved non-covered benefits like dental, vision, and chiropractic	• Yes. Strategic Copays of up to 3% of annual household income are paid monthly to AHCCCS CARE for services already obtained. Copays not applied to certain services (primary care) and medications for disease management.	Targets that are required - promoting wellness For example, wellness exams, flu shots, glucose screenings, mammograms, tobacco cessation. Managing Chronic Disease: such as, diabetes, substance use disorders, asthma. Flexibility for plans to design		Must be employed, actively seeking employment, or enrolled in school/training.	AHCCCS CARE is like an HSA Employers can make contributions	

[4] Federal Medicaid law does not permit premiums. However, CMS has granted waivers for states to charge limited premiums as described in this chart.

[5] Federal Medicaid law imposes limits on cost sharing based on income level. To date, CMS has not approved cost sharing beyond these limits.

[6] HIPP is premium assistance for employer-sponsored coverage. Under HIPP, Medicaid covers consumers' premiums and cost-sharing beyond Medicaid limits; acts as secondary insurer; and covers Medicaid benefits that are not in the employer-sponsored insurance benefit package.

	Expansion Design	Premiums[1]	Cost Sharing[2]	Healthy Behavior Incentives	Benefit Variations	Employment-Related Provisions	Health Savings-Like Account (HSA)	Health Insurance Premium Payment (HIPP)[3]
Indiana	**High-Deductible Medicaid Managed Care (MMC) Plan with HAS-Like Account[7]:** • Newly eligible adults with incomes from 0-138% FPL • Previously eligible low-income parents and caretakers • Parents and caretakers eligible for Medicaid under Transitional Medical Assistance • Medically frail individuals are included **HIPP (Health Insurance Premium Payment Program)** – through which eligible individuals have the option of enrolled in cost-effective ESI, with Medicaid coverage the cost of premiums and deductibles (beginning after CMS approves operational protocol) • Voluntary for individuals ages 21 and older with incomes from 0-138% FPL • Medically frail are not eligible	Yes (waiver) • In the form of sliding scale contributions to the POWER account (similar to an HAS) • 2% of income for individuals with incomes >5% FPL • A minimum of $1 for individuals with incomes ≤5% FPL • Mandatory for individuals with incomes >100% FPL who are not medically frail; individuals who fail to pay monthly contributions within 60-day grace period will be dis-enrolled and will not be permitted to re-enroll for 6 months • Optional for individuals with incomes <100% FPL; individuals who make contributions receive an enhanced benefit package	Yes (two-year waiver) • Up to $25 copayment for non-emergency use of the ER • Newly eligible individuals with incomes <100% FPL, who do not contribute to POWER account (HAS) subject to maximum permitted Medicaid cost sharing for other services in addition to ER copayment above	Yes • May reduce or eliminate POWER account (HSA) contributions	• Offers three benefit packages; access to each package subject to income eligibility category, and contributions to the POWER account • No NEMT coverage for one year (waiver) • No retroactive coverage (waiver)	Yes • Outside of the demonstration, State refers interested individuals to Gateway to Work job training and job search program	Yes	Yes • State contributes $4000 to individual's POWER account (HSA) for payment of employer-sponsored plan premium • Enrollees contribute through monthly payroll deduction between $1 to 2% of income • Remaining POWER account funds used to pay copayments beyond Medicaid limits, deductibles, and out-of-pocket costs

[7] State currently uses Medicaid managed care.

	Expansion Design	Premiums[1]	Cost Sharing[2]	Healthy Behavior Incentives	Benefit Variations	Employment-Related Provisions	Health Savings-Like Account (HSA)	Health Insurance Premium Payment (HIPP)[3]
Iowa (Proposed)	**QHP Premium Assistance:** • Voluntary for newly eligible individuals with incomes from 100-138% FPL who do not have access to cost effective Employer Sponsored Insurance • Medically frail individuals are excluded **Iowa Wellness Plan (Medicaid Managed Care or FFS varying by county):** • Newly eligible adults with incomes below <100% FPL • New Proposal is to bring all under Medicaid Managed Care	Yes (waiver) • For individuals with incomes >50% FPL • Up to $5/month for individuals with incomes from 50-100% FPL; up to $10/month for individuals with incomes from 100-138% FPL • Individuals with incomes above 100% FPL may be dropped from coverage if they do not pay premiums for 90 days and do not request a hardship waiver • Payment is not a condition of eligibility for individuals with incomes from 50-100% FPL	Yes (waiver not required) • Individuals with incomes from 0-138% FPL • Limited to $8 co-payment for non-emergency use of the emergency room	Yes • May reduce premium obligations	NEMT originally waived for one year; waiver extended 7 months through July 2015 (waiver)	No	No	Yes • Voluntary for newly eligible adults with incomes from 0-138% FPL
Tennessee (Proposed)	Fully aligned with TennCare Managed Care Medicaid Program • Newly eligibles aged 19-20 enrolled in regular TennCare Medicaid and receive benefits through an MCO, Pharmacy Benefits Manager and Dental Benefits Manager. • Newly eligibles aged 21-64 have two plans available: • Volunteer Plan provides subsidized coverage for working poor in private insurance plans – limited to ESI plans in first year	2% of income for 101% - 138% FPL (waiver)	• $75 per inpatient admission • $4 per outpatient service • $8 for non-emergent use of ER • Pharmacy: $1.50 for gen, $3.00 for brand Medicaid cost sharing waived for Volunteer Plan	Earn credits in HIT accounts to reward healthy behaviors, which can be used for premiums/ copays	Requesting no benefit "wraps" for persons choosing the Volunteer Plan	Required for Volunteer Plan – Condition of Eligibility	HIT Ac-counts – state/ indivi-dual credits, opera-ted by MCOs	Volunteer Plan • Premium Assistance through Employer Sponsored Health Care • Defined Contribution set by State • Employer must cover 51% of costs • Cost sharing requirements are waived • Wraparound requirements are waived • Waiver of retroactive eligibility

	• Healthy Incentives Plan offers regular Medicaid benefits with additional cost-sharing and healthy behavior incentives.							
Montana (Proposed)	Third Party Administrator will contract with State to administer program and pay claims (Fee for Service Model)	Yes. 2% of income	• Maximum allowed by law • Not applicable to preventative care, generic drugs, immunizations			Yes – Condition of Eligibility		
Michigan	**Medicaid Managed Care (MMC)[8]**	Yes (waiver) • For individuals with incomes > 100% FPL • 2% of income • Payment is not a condition of eligibility; non-payment results in debt to State	Yes (waiver not required) • Individuals with incomes from 0-138% FPL • Wide range of services	Yes (waiver) • May reduce premium and cost-sharing obligations	None	No	Yes	No
New Hampshire	**HIPP** • Mandatory for newly eligible adults with incomes from 0-138% FPL **Bridge Plan – Medicaid Managed Care** • Newly eligible individuals with incomes from 0-138% FPL who do not have access to cost-effective ESI • Ends 12/31/15 **Bridge Plan – Voluntary QHP Premium Assistance (if cost – effective)** • Newly eligible adults with incomes from 0-138% FPL • Ends 12/31/15 **QHP Assistance** • Mandatory program beginning 1/1/16	No	Yes (waiver not required) • Individuals with incomes above100% FPL • Wide range of services	Yes (outside of waiver) • Legislation requires "personal responsibility" provisions, to greatest extent practicable	Retroactive coverage waived pending submission of sufficient data showing that the State is providing "seamless coverage" (waiver)	Yes • Unemployed referred to Department of Employment Security	No	Yes

[8] State used Medicaid managed care prior to expansion.

	• Newly eligible adults with incomes from 0-138% FPL who do not have access to cost-effective ESI • Medically frail individuals are excluded							

	Expansion Design	Premiums[1]	Cost Sharing[2]	Healthy Behavior Incentives	Benefit Variations	Employment-Related Provisions	Health Savings-Like Account (HSA)	Health Insurance Premium Payment (HIPP)[3]
Pennsylvania[9]	**MMC[10]**	Yes (waiver) • For individuals with incomes > 100% FPL • 2% of income • Individuals who fail to pay monthly premiums for 3 consecutive months will be dis-enrolled but will be allowed to reapply without a waiting period and without repayment of back premiums	Yes (waiver) • For individuals with incomes from 0-138% FPL • In 2016, individuals with incomes between 100-138% FPL who are subject to premiums will not be subject to cost sharing with the exception of an $8 co-pay for non-emergency use of the ER • All other cost sharing will be consistent with Medicaid law	Yes May reduce premium obligations for individuals with income > 100% FPL	NEMT waived for one year (waiver)	Yes • Outside of the demonstration plan (and not connected to Medicaid coverage), State intends to use state funding to establish incentives for job-training and work-related activities for individuals participating in the Encouraging Employment program	No	No

[9] State has announced that it will transition from implementing its Medicaid expansion under an 1115 waiver to a traditional Medicaid expansion. The State's waiver is expected to terminate on September 30, 2015

[10] State used Medicaid managed care prior to expansion.

AHCCCS CARE
CHOICE • ACCOUNTABILITY
RESPONSIBILITY • ENGAGEMENT

Douglas A. Ducey, Governor
Thomas J. Betlach, Director

Modernizing Arizona Medicaid:

AHCCCS CARE – Choice, Accountability, Responsibility, Engagement

With over 1.6 million Arizonans enrolled in AHCCCS, Medicaid has a far greater responsibility for impacting population health. Despite past innovation, we have an opportunity and obligation to do more. The goals of Modernizing Arizona Medicaid are to: (1) Engage Arizonans to take charge of their health; (2) Make Medicaid a temporary option; and (3) Promote a quality product at the most affordable price.

The AHCCCS CARE Program: A Bridge to Independence

Personal Responsibility is a tool in the AHCCCS CARE program to build a bridge to independence with the right mix of requirements and incentives.

AHCCCS CARE: Requiring Member Contributions.

- Strategic Copays[1] : Up to 3% of annual household income. Members will make monthly AHCCCS CARE payments reflecting copays for services already obtained. This also removes the burden of collecting the copay by providers at the point of service. Copays will not be applied to certain services such as primary care and medications for disease management.
- Premiums: Up to 2% of annual household income. Included in the monthly AHCCCS CARE payment is a monthly deposit set at 2% of income into a personal HSA.

The AHCCCS CARE Account: Giving People Tools to Manage Their Own Health.

- The AHCCCS CARE Account is like a Health Savings Account.
- Premium contributions go into the AHCCCS CARE Account.
- AHCCCS CARE Account funds are only for that individual and can be used for approved non-covered services, like dental, vision or chiropractic services.
- To be eligible, members must:
  - Make timely payments.
  - Participate in the AHCCCS Works program.
  - Meet the Healthy Arizona targets.
- Employers, and the philanthropic community can make tax-deductible contributions into individual accounts.

Personal Responsibility: Ensuring Member Contribution Requirements.

- Over 100% FPL: Members will be disenrolled from the AHCCCS program for a period of six months for failure to make AHCCCS CARE payments.
- Under 100%: Failure to pay is counted as a debt owed to the State.

Healthy Arizona: Promoting Healthy Behaviors.

- Healthy Arizona is a set of targets:
  - Promoting wellness: for example, wellness exams, flu shots, glucose screenings, mammograms, tobacco cessation.
  - Managing Chronic Disease: such as, diabetes, substance use disorders, asthma.
- Provides flexibility for Plans to design individualized targets.

The AHCCCS Works Program: Viewing AHCCCS as a Pit Stop.

AHCCCS Works builds greater partnerships with the business and philanthropic communities who share in the goal of healthy employees and healthy families.

AHCCCS Works: Getting Back to Work.

- AHCCCS Works requires individuals to be actively seeking employment.
- This requirement is satisfied if the individual is already employed or enrolled in school/training.

[1]Member contributions do not exceed 5% of annual household income.

- Partner with existing employment supports programs to provide members the tools they need to build their skills and find their confidence.
- Building a Personal Safety Net: Members can transition their AHCCCS CARE Account into a private Health Savings Account when they transition to new employment and off of AHCCCS.

Private Sector Partnerships: Engaging the Business and Philanthropic Community.

- Employers may make direct contributions into their employees' AHCCCS CARE Account.
- The Philanthropic community can make contributions for targeted purposes, such as smoking cessation or managing chronic disease.
- Private sector contributions are tax-deductible.

Today's Medicaid: A Modern Approach

Electronic Communication: Apps, Texts and More!

- Avoid an emergency room visit by using an app to look up your primary care doctor or find an urgent care near you.
- Manage chronic illnesses or conduct your own health screenings using an app.
- Receive text alerts for an appointment reminder or managing medication.
- Manage your account online, including annual renewals, address or income changes or use a chat feature to ask questions instead of waiting on hold or in long lines.

Value Based Purchasing: Paying for Quality, Not Quantity.

- Increase number of value based arrangements between health plans and providers.
- Build partnerships. When there is a quality product – i.e. good health outcomes are achieved – providers will be rewarded.

Building a True Health Care System: Reducing Fragmentation.

- Strengthen existing efforts for integrated care: alignment of dual eligible members; Children's Rehabilitative Services (CRS) program; and Regional Behavioral Health Authorities (RBHAs) offering physical and behavioral health services.
- Examine new opportunities to align incentives and achieve greater accountability.
- Support efforts to reduce stigma related to mental illness, substance use disorders, and physical or cognitive disabilities.
- Increase adoption of electronic health records and health information exchanges that will reduce duplication and offer better tools to manage patient care.

Fraud Prevention: Applying Modern Tools to Curbing Fraud, Waste and Abuse.

- Refine data analytics capacity related to program integrity.
- Support the AHCCCS Office of the Inspector General (OIG) with the tools and personnel to investigate bad actors within the Medicaid program.
- Confirm changes in family income using automated systems to ensure taxpayers are not paying for people who are over income for the program.

The Legislative Partnership

The Arizona Legislature is an important partner in this effort. Modernizing Arizona Medicaid will include legislative initiatives that:

- Limit lifetime enrollment to five years.
- Ensure copayment and premium obligations.
- Eliminate non-emergency transportation.

NOTICE OF IOWA DEPARTMENT OF HUMAN SERVICES
PUBLIC COMMENT PERIOD FOR CHANGES TO MEDICAID WAIVERS

Notice is hereby given that the Iowa Department of Human Services (DHS) will hold public hearings on the following waivers that will be submitted to the Centers for Medicare and Medicaid Services (CMS) to implement the Iowa High Quality Healthcare Initiative, as part of IA Health Link, the State's Medicaid Managed Care program. Through this initiative, the State will contract with private health organizations for delivery of high quality health care services for the majority of current populations and services in the Iowa Medicaid program.

§1915(b) High Quality Healthcare Initiative Waiver (New Waiver)
§1915(c) HCBS Intellectual Disabilities Waiver (Amendment)
§1915(c) HCBS Children's Mental Health Waiver (Amendment)
§1915(c) HCBS Elderly Waiver (Amendment)
§1115 Iowa Wellness Plan Demonstration Waiver (Amendment)
§1115 Family Planning Demonstration Waiver (Amendment)

Hearings offer an opportunity for the public to provide written or verbal comments about the above-mentioned waivers. All comments will be summarized and taken into consideration prior to submission to CMS. Hearings will be held at the following dates, times, and locations:

July 27, 2015
Scott Community College
Room 1501 or 2300
500 Belmont Rd.
Bettendorf, IA 52722
10:30 a.m. – 12:00 p.m.

August 3, 2015
Kirkwood Hotel
Room A
7725 Kirkwood Blvd
Cedar Rapids, IA 52404
2:30 p.m. – 4:00 p.m.

July 31, 2015
Wallace Building
Auditorium
502 E 9th St
Des Moines, IA 50319
1:30 p.m. – 3:00 p.m.

August 5, 2015
Western Iowa Tech Community College
Cargill Auditorium, Room D103
4647 Stone Ave
Sioux City, IA 51102
12:00 p.m. – 1:30 p.m.

For those wishing to attend a hearing by telephone, toll free conference call capabilities will be made available for the August 3 and 5 dates. Callers will need to dial 1-866-685-1580, and enter 515-725-1031# when prompted for a conference code.

This notice provides details about the DHS waiver submissions and serves to open the 35-day public comment period. The comment period closes Monday, August 24, 2015.

PROPOSAL & HISTORY

DHS has continually sought to improve Medicaid and the Children's Health Insurance Program (CHIP) and beneficiary choice, accountability, quality of care, and health outcomes. DHS has

also encouraged the provision of community-based services over institutional care where appropriate. The State seeks to build on its experience and improve the coordination of care, which is often available at different points throughout the Medicaid eligibility cycle and patient experience, through implementation of the Iowa High Quality Healthcare Initiative (Initiative). In recent months, this Initiative has also been referred to publicly as the Governor's "Medicaid Modernization Initiative."

The Initiative is intended to integrate care and gain efficiencies across the health care delivery system. In turn, the initiative intends to decrease costs through the reduction of unnecessary and duplicative services. Under the Initiative, the majority of Iowa Medicaid beneficiaries will be enrolled in a managed care organization (MCO). MCOs are private health organizations that provide and pay for health care services through an organized network of providers. MCOs use established guidelines to assure member services are appropriate and delivered at the right time, in the right way, and in the right setting. By contracting with MCOs for delivery of high quality health care services, beneficiaries' care will be better coordinated, resulting in improved access, quality, and health outcomes.

On February 16, 2015, DHS released a preliminary Request for Proposals (RFP) for the Initiative. This release was followed by the development of a dedicated web page, and a series of public meetings. Stakeholders and members of the public were invited to attend meetings held in Cedar Rapids, Des Moines, Davenport, Iowa City, Council Bluffs, Mason City, and Sioux City. In total, close to 1,000 people attended and provided DHS with valuable comments and questions. This public engagement strategy was intended to solicit stakeholder feedback on key program design elements and MCO contract requirements. Several amendments to the RFP have been released incorporating changes based on stakeholder feedback. Additional opportunity to comment on the Initiative is provided through this notice.

GOALS & OBJECTIVES

DHS currently enrolls a portion of the Medicaid and Iowa Wellness Plan populations in managed care arrangements. Depending on a beneficiary's geographic location and the service provided, these arrangements may include a primary care case manager, a managed care organization (MCO), a prepaid ambulatory health plan, a prepaid inpatient health plan, a separate commercial plan, or a fee-for-service model. The operation of these multiple programs and different care management approaches for each population contributes to a fragmented model of care. Where managed care arrangements are currently employed, services such as behavioral health, medical services and transportation are provided by separate entities, which limits the coordination of care among providers as well as the ability to financially incentivize active management of patients' health care. In addition, by excluding Medicaid members from managed care when they become eligible for Home and Community-Based Services (HCBS) waivers or long-term facility care, there ceases to be a financial incentive to prevent institutionalization. Similarly, for persons enrolled in the Iowa Medicaid primary care case management option, there is no single entity responsible for overall care management, nor financial incentives to encourage integration or discourage duplication of services.

The Initiative seeks to address the shortcomings of the current model by uniting health care delivery under one system and allowing all Medicaid enrolled family members to receive coverage from the same MCO. Specifically, the Initiative goals include:

1. Creation of a single system of care that delivers efficient, coordinated, health care and promotes accountability in health care coordination;
2. Improvement in the quality of care and health outcomes for members;
3. Integration of care across the health care delivery system;
4. Emphasis of member choice and increased access to care;
5. Increased program efficiencies and budget accountability;
6. Continued rebalancing efforts to provide community-based rather than institutional care, when appropriate;
7. Holding MCOs responsible for outcomes.

To integrate care across the delivery system, the Initiative has been designed to include a comprehensive and integrated service package. Dental benefits, school-based services, and Iowa Veterans Home services will continue to be delivered as they are today, and are not part of the MCO benefit package. Inclusion of all non-dental covered benefits will provide incentives for coordination of care, oversight of care delivery across all available settings, and reduced duplication of services. The inclusion will also promote integration and efficiency, and prevent fragmentation of services. Further, by holding MCOs accountable for all Medicaid covered benefits, there will be incentives for continuing to rebalance the system toward community-based versus institutional care when needs can be safely met in the community. This change will not prevent eligible individuals from having access to the full Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit.

ELIGIBILITY

The majority of Iowa Medicaid members will be eligible for the Initiative, including:

1. Children;
2. Iowa Health and Wellness Plan members (i.e., Iowa Wellness Plan and Iowa Marketplace Choice Plan);
3. Long term care residents; and
4. HCBS Waiver enrollees.

A few populations, however, will be excluded from coverage under the MCOs. Excluded populations are:

1. Medically needy;
2. Medicaid beneficiaries for the period of retroactive eligibility;
3. Persons eligible for the Program of All-Inclusive Care for the Elderly (PACE) who voluntarily elect PACE coverage;
4. Programs where Medicaid already pays premiums (e.g., Health Insurance Premium Payment Program (HIPP), eligible for Medicare Savings Program only); and

5. Undocumented immigrants receiving time-limited coverage of certain emergency medical conditions;

American Indian and Alaskan Native (AI/AN) populations will have the option of enrolling with an MCO.

ENROLLMENT & FISCAL PROJECTIONS

The Initiative is projected to include approximately 600,000 individuals. The Initiative is expected to save $51.3M in the first six months of State Fiscal Year 2016. Savings are attributed to the improved management of the health care needs of enrollees, and include factors such as prevention of unnecessary hospitalizations, providing preventive care and reducing duplication of services. Projected savings are not based on a reduction in medically necessary services.

BENEFITS

Under the Initiative, MCOs will be responsible for delivering all Medicaid covered benefits, with the exception of dental benefits. MCOs will deliver physical health, behavioral health, and long-term services and supports in a highly coordinated manner. The system is intended to integrate care and improve quality outcomes and efficiencies, while at the same time reducing unnecessary and duplicative services. Excluded populations will continue to receive services through the fee-for-service delivery system outlined in the Medicaid State Plan.

FEDERAL AUTHORITIES

DHS is working with CMS to obtain the necessary federal authority to implement the Initiative. This will require the submission of a variety of waivers as outlined in this section. DHS is seeking a January 1, 2016, effective date for all waivers.

§1915(b) High Quality Healthcare Initiative Waiver (New Waiver)

DHS is submitting for CMS approval a new, five-year, §1915(b) Waiver. This authority will permit the State to establish a statewide managed care delivery system. The State will contract with managed care organizations for delivery of high quality health care services for the majority of current populations and services in the Iowa Medicaid program. Enrollees will have the choice of at least two MCOs.

MCOs will be required to maintain a network sufficient to offer members a choice of providers to the extent possible and appropriate. If a member enrolls with the MCO and is already established with a provider who is not a part of the network, the MCO must make every effort to arrange for the member to continue with the same provider if the member so desires. The MCO must also extend contract offers to all Medicaid providers during initial transition, as designated in the request for proposals. This allows for continuity of care and stability in the provider network through the transition. The State will provide continuous oversight and monitoring of network adequacy through performance indicators. The indicators will focus on specific time and distance measures and the provider number, mix, and geographic distribution, including

general access standards. MCOs must provide the State written notice at least ninety calendar days in advance of their inability to maintain a sufficient network in any county in Iowa.

The State will ensure enrollee continuity of care by requiring that MCOs honor existing authorizations for covered benefits for a minimum of ninety calendar days, without regard to whether such services are being provided by contract or non-contract providers. In addition, MCOs are required to coordinate the exchange of enrollee health care information if an enrollee chooses to switch from one MCO to another. This will be done to ensure that the member's services and care coordination are seamless and without disruption.

MCOs will be required to develop Quality Management/Quality Improvement (QM/QI) programs with ongoing comprehensive quality assessment and performance improvement activities aimed at improving the delivery of health care services to members. As a key component of these QM/QI programs, MCOs will be responsible for developing incentive programs for both providers and members, with the ultimate goal of improving member health outcomes. MCOs will also be required to develop critical incident reporting and management in accordance with State requirements, as well as convene a Stakeholder Advisory Board to engage consumers, their representatives, and providers. Results of MCO QM/QI activities will be used to improve the quality of physical health, behavioral health, and long-term care service delivery with appropriate input from providers and members. Finally, the State will implement a comprehensive quality management and oversight strategy including, but not limited to:

- Monitoring and reporting on MCO finances
- Member and provider helpline performance
- Claims payment
- Prior authorization
- Care plan development
- Grievances and appeals
- Health risk screenings
- Network composition
- Geo-access ratios

§1915(c) HCBS Waivers (Amendments)

The State currently operates seven HCBS waivers. These programs provide services and supports to Medicaid beneficiaries in their home or community who would otherwise require care in an institution. Targeted groups include children with serious emotional disturbances, elderly persons, individuals with physical or intellectual disabilities, and individuals with HIV/AIDS or brain injuries. Member eligibility requirements vary based on the specific program, and services must be cost effective. Each program is subject to a program-specific, maximum number of enrollees.

To address the enrollment of individuals on HCBS waivers into managed care, DHS will be submitting for CMS approval, amendments to all seven State HCBS waiver programs. However, all of the State's current HCBS waivers, with the exception of the Intellectual Disability, Children's Mental Health, and Elderly Waivers made available pursuant to this notice, are

currently under review by CMS. The four waivers currently under review are unrelated to the Initiative and were submitted for renewal and/or approval of settings transition plans in the fall of 2014. As such, DHS is only publishing amendments to its Intellectual Disability, Children's Mental Health, and Elderly Waivers at this time. These amendments will establish a managed care delivery system for all three waivers under concurrent authority with the §1915(b) High Quality Healthcare Initiative Waiver.

When CMS finalizes its pending review of the State's other four HCBS waivers, DHS will modify them to incorporate the managed care components included in the Intellectual Disability, Children's Mental Health, and Elderly Waivers, and make all four available for public comment. The managed care descriptions, such as MCO roles and responsibilities, included in the published waivers will be the same across all of the State's HCBS waivers.

§1115 Iowa Wellness Plan Demonstration Waiver (Amendment)

DHS is submitting for CMS approval, an amendment to the §1115 Iowa Wellness Plan Demonstration Waiver that seeks to:

1. Modify eligibility to include those persons at or below 133% FPL that were previously eligible for the §1115 Marketplace Choice Demonstration; and
2. Establish a managed care delivery system for §1115 Iowa Wellness Plan Demonstration Waiver under concurrent authority with the 1915(b) High Quality Healthcare Initiative Waiver.

Regarding modified eligibility, the §1115 Iowa Marketplace Choice Demonstration Waiver covers monthly premium costs for adults age 19 to 64, with incomes from 101-133% of the Federal Poverty Level. Historically, members could elect to receive coverage through one of two qualified health plans—CoOportunity Health and Coventry Health Care of Iowa. CoOportunity withdrew from the Demonstration in November 2014. The State was also informed earlier this year that Coventry will not be accepting any new members in 2015 and does not intend to continue providing Marketplace coverage to Medicaid members after Iowa moves to a managed care delivery system. By modifying the §1115 Iowa Wellness Plan Demonstration Waiver eligibility, the State will ensure that this population continues to receive services. The §1115 Iowa Marketplace Choice Demonstration Waiver will not be amended or terminated as a result of this proposed amendment to the §1115 Iowa Wellness Plan Demonstration Waiver. However, individuals eligible for the §1115 Iowa Marketplace Choice Demonstration Waiver will now be able to access services through the §1115 Iowa Wellness Plan Demonstration Waiver.

Regarding delivery system, the §1115 Iowa Wellness Plan Demonstration Waiver currently provides health care coverage through use of primary care provider (PCP) coordination, Accountable Care Organizations (ACOs), and managed care models. Models vary by geographic region and are dependent on ACO and/or managed care delivery system availability. However, the majority of Demonstration participants have access to a PCP that provides referrals and care coordination, and focuses on quality outcomes. The proposed amendment will establish

a managed care delivery system for the §1115 Iowa Wellness Plan Demonstration Waiver under concurrent authority with the §1915(b) High Quality Healthcare Initiative Waiver.

There are no proposed changes to the §1115 Iowa Wellness Plan Demonstration Waiver enrollment, benefits, enrollee rights, cost sharing, evaluation design, sources of nonfederal share of funding, budget neutrality, or other comparable program elements.

§1115 Family Planning Demonstration Waiver (Amendment)

The §1115 Iowa Family Planning Network Demonstration Waiver is a limited-benefit Medicaid program that provides high-quality and confidential family planning services to both men and women age 12 to 54, with incomes at or below 300% of FPL. Currently, these waiver services are provided through a fee-for-service delivery system. This Waiver will be amended to establish a managed care delivery system for §1115 Family Planning Network Demonstration Waiver under concurrent authority with the 1915(b) High Quality Healthcare Initiative Waiver. There are no proposed changes to the §1115 Iowa Family Planning Network Demonstration enrollment, benefits, enrollee rights, cost sharing, evaluation design, sources of nonfederal share of funding, budget neutrality, or other comparable program elements.

IMPLEMENTATION

Statewide MCO enrollment in the Initiative will be effective January 1, 2016. The State will begin accepting MCO selections from current Medicaid members beginning in fall 2015. Participants and providers will be notified in advance of the transition through letters and general public announcements. Information provided will include relevant changes in service delivery, MCO assignment and contact information, procedures for electing a different MCO, and member rights. To facilitate the MCO selection process, members will receive enrollment notices that include a tentative MCO assignment based on an algorithm designed to:

1. Distribute the population evenly among the MCOs; and
2. Assign all members of a particular family to the same MCO.

As all MCOs are required to extend contract offers to all current Iowa Medicaid enrolled providers, existing provider-member relationships should be available as the program is implemented. The notice will also include information regarding all available MCO options and will provide the opportunity for enrollees to make an alternative selection prior to the tentative assignment becoming effective. The timeline for sending these notices will be staggered based on Medicaid eligibility groups. To allow additional time and assistance for members receiving long-term services and supports, these notices will first be sent to individuals in an institution, individuals enrolled in a §1915(c) waiver, and individuals receiving §1915(i) habilitation services under the Iowa Medicaid State Plan. The Enrollment Broker will take MCO selections and provide choice counseling to assist members in selecting an MCO. Members will be fully enrolled based on their tentative assignment if alternative choice is not made by the required response date listed in the notice. Once fully enrolled, members will have the opportunity to change MCOs in the first ninety days of enrollment without cause.

WAIVER & EXPENDITURE AUTHORITIES

While existing waiver and expenditure authorities will not be modified, the following will be added pursuant to the new §1915(b) High Quality Healthcare Initiative Waiver.

1902(a)(10)(B) Comparability of Services – This section of the Act requires all services for categorically needy individuals to be equal in amount, duration, and scope.

1902(a)(23) Freedom of Choice – This Section of the Act requires Medicaid State plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State.

REVIEW OF DOCUMENTS & SUBMISSION OF COMMENTS

This notice, waiver documents, and information about the Iowa High Quality Healthcare Initiative are available at: http://dhs.iowa.gov/ime/about/initiatives/MedicaidModernization. To reach all stakeholders, non-electronic copies of all of the aforementioned items will be made available for review at a DHS Field Office. A complete listing of DHS Filed Offices is provided as an Attachment to this notice. Written comments may be addressed to Rick Riley, Department of Human Services, Iowa Medicaid Enterprise, 100 Army Post Road, Des Moines, IA 50315. Comments may also be sent via electronic mail to the attention of: DHS, High Quality Healthcare Initiative at ModernizationWaiverComment@dhs.state.ia.us. All comments must be received by Monday, August 24, 2015. After the comment period has ended, a summary of comments received will be made available at: http://dhs.iowa.gov/ime/about/initiatives/MedicaidModernization.

Submitted by:
Mikki Stier, Medicaid Director
Iowa Medicaid Enterprise
Iowa Department of Human Services

Attachment: DHS Field Office Locations

County	Building Name	Building Address	City	Zip
Benton	Benton County DHS	114 E 4th Street	Vinton	52349
Black Hawk	Black Hawk County DHS	1407 Independence Ave.	Waterloo	50704
Buchanan	Buchanan County DHS	1415 1st Street West	Independence	50644
Buena Vista	Buena Vista County DHS	311 E. 5th Street	Storm Lake	50588
Butler	Butler County DHS	713 Elm Street	Allison	50602
Carroll	Carroll County DHS	608 N Court Street, Ste. C	Carroll	51401
Cass	Cass County DHS	601 Walnut Street	Atlantic	50022
Cerro Gordo	Cerro Gordo County DHS	Mohawk Square, 22 N Georgia Ave, Ste. 1	Mason City	50401
Clarke	Clarke County DHS	109 S Main	Osceola	50213
Clay	Clay County DHS	1900 North Grand Ave. Ste. E-8	Spencer	51301
Clinton	Clinton County DHS	121 Sixth Ave S.	Clinton	52733
Dallas	Dallas County DHS	210 N 10th Street	Adel	50003
Des Moines	Des Moines County DHS	560 Division Street, Suite 200	Burlington	52601
Dickinson	Dickinson County DHS	Dickinson County Courthouse 1802 Hill Ave, Suite 2401	Spirit Lake	51360
Dubuque	Dubuque County DHS	410 Nesler Center, 799 Main Street	Dubuque	52004
Emmet	Emmet County DHS	220 S 1st Street	Estherville	51334
Fayette	Fayette County DHS	129 A North Vine	West Union	52175
Floyd	Floyd County DHS	1206 S Main Street	Charles City	50616
Hamilton	Hamilton County DHS	2300 Superior Street	Webster City	50595
Harrison	Harrison County DHS	204 E 6th St	Logan	51546
Henry	Henry County DHS	205 W Madison Street	Mt. Pleasant	52641
Jasper	Jasper County DHS	115 N 2nd Ave E. Suite H	Newton	50208
Jefferson	Jefferson County DHS	304 South Maple	Fairfield	52556
Johnson	Johnson County DHS	855 S. Dubuque Street	Iowa City	52240
Lee	Lee County DHS	933 Avenue H	Ft. Madison	52627
Lee	Lee County DHS	307 Bank Street	Keokuk	52632
Linn	Linn County DHS	411 3rd Street SE, Suite 600	Cedar Rapids	52401
Linn	Linn County DHS, Harambee House	404 17th Street Southeast	Cedar Rapids	52403
Mahaska	Mahaska County DHS	410 S 11th Street	Oskaloosa	52577
Marshall	Marshall County DHS	206 W State Street	Marshalltown	50158
Montgomery	Montgomery County DHS	1109 Highland Ave	Red Oak	51566
Muscatine	Muscatine County DHS	3210 Harmony Lane	Muscatine	52653

O’Brien	O'Brien County DHS	160 Second Street Se	Primghar	51245
Polk	Polk County DHS	Polk County River Place, 2309 Euclid Ave	Des Moines	50310
Polk	Polk County DHS- Carpenter Office	1900-1914 Carpenter	Des Moines	50314
Polk	Centralized Service Intake Unit	401 SW 7th St, Suite G	Des Moines	50309
Pottawattamie	Pottawattamie County DHS	417 E Kanesville Blvd.	Council Bluffs	51503
Pottawattamie	Income Maintenance Customer Call Center	300 W Broadway, Suite 110	Council Bluffs	51503
Scott	Scott County DHS	600 W. 4th St. 2nd & 3rd Floors	Davenport	52801
Sioux	Sioux County DHS	215 Central Ave. Se	Orange City	50141
Story	Story County DHS	126 S Kellogg Ave, Suite 101	Ames	50010
Union	Union County DHS (SVC)	304 N Pine St	Creston	50801
Union	Union County DHS	300 N Pine St	Creston	50801
Wapello	Wapello County DHS	120 E Main St	Ottumwa	52501
Warren	Warren County DHS	1005 South Jefferson Way	Indianola	50125
Webster	Webster County DHS	330 1st Ave. N	Fort Dodge	50501
Winneshiek	Winneshiek County DHS	2307 US Highway 52 South	Decorah	52101
Woodbury	Woodbury County DHS	Trosper-Hoyt Co Svc Bld., 822 Douglas St	Sioux City	51101

HEALTHY INDIANA PLAN 2.0 SECTION 1115 MEDICAID DEMONSTRATION FACT SHEET

January 27, 2015

Name of Section 1115 Demonstration: Healthy Indiana Plan 2.0
Waiver Number: 11-W-00296/5
Date Proposal Submitted: August 21, 2014
Date Approved: January 27, 2015
Date Implemented: February 1, 2015
Date Expires: January 31, 2018

BACKGROUND

On August 21, 2014, the State of Indiana submitted a request to CMS for the "Healthy Indiana Plan 2.0" (HIP) section 1115 demonstration. This demonstration extends coverage to adults in Indiana with incomes through 133 percent of the federal poverty level (FPL) beginning February 1, 2015. The goal of the demonstration is to achieve the following to promote the objectives of title XIX:

- Promoting increased access to health care services;
- Encouraging healthy behaviors and appropriate care, including early intervention, prevention, and wellness;
- Increasing quality of care and efficiency of the health care delivery system; and
- Promoting private market coverage and family coverage options through HIP Link to reduce network and provider fragmentation within families.

Over the 3-year period, Indiana seeks to demonstrate the following:

- Whether a monthly payment obligation linked to a POWER account will result in more efficient use of health care services;
- Whether the incentives established in this demonstration for beneficiaries to obtain preventive services and engage in healthy behaviors will result in better health outcomes and lower overall health care costs; and
- Whether POWER account contributions in lieu of cost sharing for individuals participating in the HIP Plus Plan will affect enrollment, utilization, and the use of preventive and other services by beneficiaries.

Two primary routes to coverage are established under the demonstration: HIP Plus for those who contribute to the Personal Wellness and Responsibility (POWER) account, and HIP Basic for those who do not make such contributions. The state shall make contributions to POWER accounts for individuals enrolled in HIP Plus and HIP Basic. The POWER Account will be used to pay for some of beneficiaries' health care expenses covered under the demonstration. Through the use of such accounts the state intends to promote the efficient use of healthcare, including encouraging preventive care and discouraging unnecessary care.

ELIGIBILITY

The demonstration covers individuals in the following groups: 1931 parents and caretaker relatives, adults with incomes at or below 133 percent of the federal poverty level (FPL) plus a 5 percent income disregard, and the Transitional Medical Assistance (TMA).

BENEFITS

Both HIP Plus and HIP Basic will provide coverage of a full alternative benefit plan (ABP) for individuals in the new adult group, authorized through an amendment to the state plan. Individuals in the HIP Plus ABP will have access to additional benefits not available in the HIP Basic (ABP) although all individuals, whether enrolled in Plus or Basic, will receive all essential health benefits required by law. The demonstration provides authority for the state to not offer non-emergency medical transportation (NEMT) for the new adult group during the first year of the demonstration; this authority may be extended subject to evaluation regarding the impact of this policy on access to care.

COST SHARING

The demonstration authorizes the state to collect monthly premiums (contributions to the POWER account) from individuals up to 133 percent of the FPL in an amount not to exceed 2 percent of household income, except that the POWER account contributions from individuals with income below 5 percent of the FPL will be no more than $1 per month. POWER account contributions are required as a condition of eligibility for individuals with incomes above 100 percent of the FPL but not for individuals with lower incomes, who will enroll in HIP Basic if they do not make POWER account contributions.

Individuals covered under the demonstration, regardless of income, who make POWER account contributions shall be enrolled in HIP Plus. Those enrolled in HIP Plus will not be subject to cost sharing, with the exception of a copayment for nonemergency use of emergency department services, as discussed below. Adults with incomes at or below 100 percent of the FPL who do not choose to make contributions will be enrolled in HIP Basic and will be subject to co-payments at levels permitted under federal Medicaid rules.

Individuals with incomes above 100 percent of the FPL, who begin but subsequently cease making POWER account contributions will, after a 60 day grace period, be disenrolled from HIP 2.0 coverage and disqualified from such coverage for six months. Exceptions to this “lock out,” which applied to all beneficiaries in the existing HIP demonstration, will be afforded to individuals who are medically frail and those with specific circumstances as described in the special terms and conditions. Because payment of premiums (contributions to the POWER account) is not a requirement for coverage for individuals with incomes at or below 100 percent of the FPL, if such

individuals begin but cease making payments, they will not lose coverage (or be subject to a lock out) but will be automatically enrolled, without a new application or gap in coverage, into HIP Basic (instead of HIP Plus).

Also reflecting the unique design of HIP 2.0, coverage will be effective: 1) the first day in the month in which an individual makes a POWER account contribution; or, for those with incomes at or below 100 percent of the FPL who do not make a POWER account contribution, coverage will start 2) the first of the month in which the 60 days payment period expires. Expanded access to presumptive eligibility processes will be available at qualified entities throughout the state for individuals seeking immediate coverage, and a "fast track" method for billing and paying POWER account contributions will be available to all individuals under the demonstration to expedite coverage.

Under the demonstration all beneficiaries will be subject to a copayment for non-emergent use of the Emergency Department (ED). We have granted the state authority to demonstrate whether a graduated co-payment—$8 for the first instance and $25 for recurrent non-emergent use of the ED, with education and referrals to primary care providers—will reduce unnecessary ED use and improve beneficiaries' use of health care in the most appropriate setting. Per federal law regarding experimental approaches to cost sharing, this authority requires a control group for evaluation and is granted for a period of two years.

DELIVERY SYSTEM

Services for the demonstration will be provided primarily using managed care organizations. Under the demonstration, the state will also offer a voluntary premium assistance program called HIP Link for individuals above age 21 with access to cost effective health care coverage through employer sponsored insurance (ESI) that has met qualification criteria specified in the STCs. Individuals electing the HIP Link program will receive full ABP coverage, but their ESI plan will pay primary to Medicaid for all such services; individuals will be able to use POWER account funds to cover any out-of-pocket costs above Medicaid permissible limits.

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Waiver Amendment Request
TennCare Demonstration Amendment #25
INSURE TENNESSEE

Purpose

Pursuant to discussions between Governor Bill Haslam and U.S. Health and Human Services Secretary Sylvia Burwell, and contingent upon authorization of the Tennessee General Assembly, Tennessee is requesting an amendment to the TennCare demonstration for the purpose of adding a new component to be called "Insure Tennessee." This new component will operate as a two year pilot program intended to demonstrate an alternative plan for providing services to persons in the optional Medicaid eligibility category described in Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act. The two year period will begin on the date that the program is implemented and available to enrollees.

We are aware that there are many low income uninsured persons in our state who either do not have access to subsidized coverage in the Federally Facilitated Marketplace or who cannot afford the coverage that is available to them. Preliminary estimates are that more than 200,000 people are in this group.

We are also concerned about the health status of Tennesseans. Tennessee ranks as one of the five worst states in both smoking and obesity.[1] A national survey published in 2014 concluded that "Tennessee residents were among the most likely to have a variety of physical health problems in 2013, including diabetes, high cholesterol, high blood pressure and chronic pain."[2] At least some of these physical health problems can be attributed to poor health behaviors such as infrequent exercise, smoking, and inadequate management of daily stress.

We believe that both challenges—lack of access to insurance and poor health behaviors—can be addressed by Insure Tennessee. This alternative approach is the logical next step in Tennessee's payment and delivery system reform initiative, which was launched by Governor Bill Haslam in 2013 to shift health care spending towards paying for value rather than paying for volume. This initiative creates financial incentives for providers to furnish high quality care in an efficient and appropriate manner so as to reduce costs and improve health outcomes. Recently Tennessee was awarded a $65 million State Innovation Models (SIM) grant from the Centers for Medicare and Medicaid Services to further support the goal of making health care in Tennessee a value-based system focused on efficiency, quality of care, and the patient experience.

Insure Tennessee builds on this reform initiative by creating new participant incentives that align with the existing provider incentives. Insure Tennessee is designed to align incentives at the consumer level by promoting personal responsibility so that both patient and provider will

[1] *America's Health Rankings.* United Health Foundation. 2014.
[2] *Gallup-Healthways Well-Being Index.*2014.

be working toward the common goal of improved health outcomes. Insure Tennessee will not only provide coverage for low-income Tennesseans, but it will prepare these members for a transition to private market coverage by promoting participant engagement and personal responsibility and by incentivizing appropriate use of the health care system.

Overview of Proposed Amendment

The target population for this amendment is the so-called "VIII" group, which is the optional Medicaid eligibility category described in Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act.

Individuals in this group are often referred to as "Newly Eligibles," which is the term we will use for them in this proposal. They are between the ages of 19 and 64, are not otherwise eligible for Medicaid, and have family incomes that do not exceed 138 percent of the Federal Poverty Level. Federal matching dollars are available for services to persons in this population at the 100 percent level through December 31, 2016, dropping to 95 percent in 2017, and eventually to 90 percent in 2020.

Insure Tennessee will have several distinct parts. One part will be tailored to 19- and 20-year olds, who are considered children for Medicaid purposes. The main proposal will cover adults 21-64 and will offer them their choice of two plans: the Volunteer Plan and the Healthy Incentives Plan. Those in the first part will move into the program covered by the main proposal when they turn age 21.

The Volunteer Plan will provide subsidized coverage for the working poor in private insurance plans. In the first year of Insure Tennessee, private health plans will be limited to Employer-Sponsored Insurance (ESI) plans. The Healthy Incentives Plan will offer regular Medicaid benefits but with the addition of new cost-sharing requirements and special accounts that will enable members to receive rewards for engaging in healthy behaviors.

In the following pages of this amendment request, we will address the following subjects:

I. Basic Concept
II. The Volunteer Plan
III. The Healthy Incentives Plan
IV. Choosing and Moving Between Plans
V. Post-Eligibility Treatment of Income (PETI) and Estate Recovery
VI. Cost-Sharing
VII. Appeals Procedures
VIII. Modification of the Unreimbursed Hospital Cost Pool
IX. Program Support and Opt-Out Provision
X. List of Waivers Requested

Finally, we will address the remaining topics required by Paragraph #7 of the Special Terms and Conditions for any waiver amendment request. These topics are:

- An explanation of the public process used by the state to reach a decision regarding the requested amendment
- A description of how the evaluation design will be modified to incorporate amendment provisions
- Data analysis identifying the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement

I. Basic Concept

Insure Tennessee is distinct from the regular Medicaid program in several important ways. It will leverage opportunities in the private market, such as Employer-Sponsored Insurance that is already available to certain applicants, and it will seek to reward behaviors that lead to better health, increased personal responsibility, and reduced health care costs.

We will start by dividing the population into two groups.

1. **Persons ages 19 and 20.** Newly Eligibles under the age of 21 are entitled to all allowable Medicaid benefits including EPSDT (Early and Periodic Screening, Diagnosis, and Treatment). We are proposing to enroll all members of the Insure Tennessee population who are under 21 into the regular TennCare Medicaid program, where they will get the same benefits as all other TennCare Medicaid enrollees who are under age 21. They will receive their medical and behavioral benefits through a TennCare Managed Care Organization (MCO), as well as their Long-term Services and Supports (LTSS) if they have physical disabilities requiring special medical care. They will access their pharmacy benefits through the TennCare Pharmacy Benefits Manager (PBM), and their dental benefits through the TennCare Dental Benefits Manager (DBM).

2. **Persons ages 21-64.** There will be two new plans available to people in this population: the **Volunteer Plan** and the **Healthy Incentives Plan**. Each plan will include new service delivery models.

A discussion of each plan is presented below.

II. The Volunteer Plan

The Volunteer Plan is a premium assistance plan. It is a plan for persons who, with assistance from Insure Tennessee, could participate in qualified private insurance plans.

In the first year of the Insure Tennessee program, qualified private insurance plans will be limited to plans available to individuals through their work, or Employer-Sponsored Insurance (ESI for short). About 54 percent of the population of Newly Eligibles are currently working or

have worked within the past year[3] and may therefore have an opportunity to join the Volunteer Plan.

Volunteer Plan members will receive coverage through their ESI plan rather than through TennCare. Insure Tennessee will provide support for this arrangement by making a *defined contribution* each month toward the costs of ESI coverage for each Volunteer Plan member. The state or its contractor may make a direct payment to the employer or insurer for the member's share of the premium, and/or may make direct payments to providers for the member's share of deductibles and copays, and/or may reimburse the member for expenses incurred in the form of premiums, deductibles, and/or copays. Operational details will be finalized with input from employers.

The member will be responsible for all costs associated with the ESI plan other than those covered by the state's defined contribution (and the portion of the premium paid by the employer). Medicaid's cost sharing requirements will not apply to Volunteer Plan enrollees; the state is seeking a waiver of these requirements under Section 1916(f) of the Social Security Act. There will thus be no need for the state to track copays for members of the Volunteer Plan.

Qualifying criteria. In order for an ESI plan to be an eligible option under the Volunteer Plan, the employer contribution must cover at least 50 percent of the premium cost. Small group plans[4] that are neither self-insured plans nor grandfathered plans are generally required to meet certain ACA requirements (e.g., coverage of Essential Health Benefits and preventive services). We are seeking CMS approval to automatically approve these small group plans when the employer contribution threshold is met. In addition to meeting the employer contribution threshold, large group plans[5] will be asked to attest to coverage of all Essential Health Benefits prior to being approved as an option under the Volunteer Plan.

Benefit wraps. States operating Medicaid premium assistance programs such as the Volunteer Plan generally "wrap" benefits covered by Medicaid but not covered by the private plan so that the member continues to have access to all Medicaid benefits, even though he is enrolled in a premium assistance plan with its specific set of benefits. Because Insure Tennessee members have a clear choice of plans, we are requesting that there be no Medicaid benefit "wraps" for persons choosing the Volunteer Plan. The state will make options counseling available to members to help them decide which plan is best for their individual circumstances.

Cost effectiveness test. The Volunteer Plan will be a cost-effective premium assistance program. Two primary factors are considered in evaluating cost-effectiveness on an individual basis: the cost of the "baseline" and the cost of the premium assistance program.

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[3] Familles USA, "Medicaid Expansion in Tennessee: Health Insurance for Working Individuals and Families," Issue Brief, August 2014.

[4] ACA defines small group plans as those with fewer than 50 Full-Time Equivalent employees. Effective January 1, 2016, small group plans will be those with fewer than 100 FTE employees.

[5] ACA defines large group plans as those with 50 or more FTE employees. Effective January 1, 2016, large group plans will be those with 100 or more FTE employees.

- *Baseline* = the average per person cost to TennCare of serving a person of similar age, sex, and eligibility characteristics in the Healthy Incentives Plan.
- *Premium assistance program* = the cost of the defined contribution + any other costs TennCare may incur on behalf of a member in the Volunteer Plan.

If the per-person cost of the premium assistance program is less than the per-person cost of the baseline, then the program by definition is cost effective for that member.

The amount of the defined contribution is still to be determined in accordance with the recommendations of independent actuaries.

III. The Healthy Incentives Plan

The Healthy Incentives Plan will be an Alternative Benefit Plan (ABP) that is fully aligned with the TennCare benefit package.[6] Because the Healthy Incentives Plan covers all TennCare/State Plan benefits, and because any adult participating in Insure Tennessee can enroll in the Healthy Incentives Plan at any time, there is no need to have a separate mechanism for identifying persons who are Medically Frail[7] and providing them with access to State Plan benefits. Anyone who believes that he is Medically Frail can simply request enrollment in the Healthy Incentives Plan and gain access to these benefits.

The Healthy Incentives Plan will be a product offered by the Managed Care Organizations participating in the TennCare program, with covered outpatient prescription drugs being furnished through the Pharmacy Benefits Manager contracted with the TennCare program.

HIT (Healthy Incentives for Tennesseans) Accounts. A new feature to be offered by the Healthy Incentives Plan will be HIT Accounts, which will be similar to Health Reimbursement Accounts. The HIT Account concept will be operationalized by the MCOs.

The individual HIT Account will be pre-loaded with a small sum at the beginning of coverage. Members can "earn" additional credits for their HIT Account by engaging in certain desirable behaviors and enrolling in participation-based initiatives such as an annual health risk assessment or certain population-based health programs. Credits can then be used by members to offset their premiums and copays.

In making decisions about strategies for identifying and rewarding selected behaviors, we will require that the MCOs make use of:

- Credits for accessible/achievable actions/behaviors related to improved health and/or appropriate utilization of healthcare services.
- Member engagement in use of account credits for cost-sharing obligations.

[6] The "Alternative Benefit Plan" refers to coverage described in 42 CFR Part 440, Subpart C.
[7] See 42 CFR § 440.315(f).

- An easily understandable and administratively simple process.

Use of HIT Accounts by members with incomes below poverty. Members with incomes below the poverty level will not have premiums but will have pharmacy copays to which HIT Account funds could be applied. Additionally, we propose to deduct from these members' HIT Accounts the amount that they would have paid if they had the same copays as the members above the poverty level, but to permit the member to use whatever remains at the end of the year to be reimbursed for out-of-pocket expenditures for specified items and services that TennCare does not cover for adults, such as over-the-counter drugs and dental care. This way, lower income members will have very similar incentives (both to engage in healthy behaviors to earn money into their account and to use services appropriately) as the members above the poverty level.

Other features of HIT Accounts. The member will not "own" the credits in the HIT Account, and the account will not be redeemable for cash or anything other than uses specified by the state. There will be a maximum balance that can be accrued in the HIT Account, and once the account is exhausted, the member will be responsible for premiums and all copays up to the aggregate cost sharing cap, which will be calculated on a quarterly basis.

Members will receive quarterly statements detailing activity in their HIT Accounts, similar to Explanations of Benefits (EOBs). At the end of the year, any credits remaining in the HIT Account may roll over to the following year, provided the member has complied with all requirements associated with the account.

Concerns or complaints. Persons who have concerns or complaints about matters relating to their HIT accounts will have a telephone number they can call at their MCOs to resolve their concerns or complaints. MCO call center staff will have protocols for responding to these concerns or complaints and will work with the member to resolve these issues. This may include reviewing a member's HIT Account and related documentation to verify that completed wellness activities have been recorded and credited. In some cases, call center staff may determine that the member needs assistance in understanding what the HIT Account is and how to use it; in those cases, the staff will follow up with additional education and outreach.

IV. Choosing and Moving Between Plans

New enrollment. Newly Eligibles ages 21-64 who have access to qualified ESI plans will be given the opportunity to select either the Healthy Incentives Plan or the Volunteer Plan at the time they enroll in Insure Tennessee. Persons who do not have access to a qualified ESI plan, either because they are not working or because their employer does not offer an ESI plan that meets Insure Tennessee's requirements, may enroll directly into the Healthy Incentives Plan.

Options counseling services. The state will furnish, as part of Insure Tennessee, an Options counseling service to assist persons who need help deciding which plan is better for them.

Moving between plans. Individuals in the Volunteer Plan have the discretion to move into the Healthy Incentives Plan at any time. Individuals will continue to have access to Options Counseling services to help them determine if or when they should switch plans.

While individuals can transfer at any time to the Healthy Incentives Plan, members of the Healthy Incentives Plan will only be able to transfer to the Volunteer Plan during an open enrollment period for the ESI plan or when there is a qualifying event triggering a special enrollment period. When a person in the program for 19- and 20-year olds turns 21 years of age, that will be considered a "qualifying event" that will allow that person to enroll in the Volunteer Plan, if he chooses.

V. Post-Eligibility Treatment of Income (PETI) and Estate Recovery

PETI. Some Newly Eligibles may have medical needs that would make them eligible for Nursing Facility care. CMS currently permits states to exempt people in this group from the post-eligibility treatment of income (PETI) that is normally required of persons entering Nursing Facilities.[8] We believe that it would be fundamentally unfair to exempt Newly Eligibles from the (PETI) process that is applicable to all other Long-Term Services and Supports (LTSS) enrollees and that is described at 42 CFR Part 435, Subpart H. Therefore, we are requesting waiver authority to be able to require use of a PETI process for those Newly Eligibles who have been found medically qualified to receive Nursing Facility care.

Estate recovery. With respect to estate recovery, CMS policy allows states to seek recovery from certain MAGI eligibles who use LTSS.[9] It is Tennessee's intent to pursue available recovery under existing policies and procedures.

VI. Cost-Sharing

A summary of premium and cost-sharing requirements is presented in the table below.

Premium and Cost-Sharing Requirements in Insure Tennessee

Group	Premiums	Deductibles and Copays
Volunteer Plan members	The member's share of ESI Plan premiums will be covered by the state through the state's defined contribution	ESI plan deductibles and copays will be applicable and may be covered at least in part by the state through the state's defined contribution

[8] CMS State Medicaid Director Letter #14-001, February 21, 2014, page 6.
[9] Ibid.

Group	Premiums	Deductibles and Copays
Healthy Incentives Plan members	Approximately $20 (2014)[10]	Medical copays:[11] Inpatient - $75 per admission; Outpatient - $4 per service; Non-emergency use of the ER - $8 per occasion Pharmacy copays:[12] $1.50 for generics; $3.00 for brand name drugs

Cost sharing in the Volunteer Plan. Once the state's defined contribution has been spent, the member will be responsible for any remaining cost sharing, even if that means the member will pay cost sharing in excess of the Medicaid limits. There will thus be no need for the state to track copays for members of the Volunteer Plan, since there is no aggregate annual limit.

We are requesting a waiver of the Medicaid cost sharing requirements for these purposes under Section 1916(f) of the Social Security Act. Cost sharing is one of the factors that the state's Options Counseling service (described above in Part VI) will assist Insure Tennessee applicants in evaluating when they make their choices of plans.

Cost sharing in the Healthy Incentives Plan. Copays will be enforced for persons with incomes above poverty, meaning that providers may refuse to deliver services to these members when they fail to make required copays.

In addition to copays, members of the Healthy Incentives Plan whose incomes are above the federal poverty level will be required to pay a monthly premium. Implementing this provision will require a waiver, as the Medicaid statute limits the imposition of premiums to individuals with incomes above 150 percent of the Federal Poverty Level.

Consistent with 42 CFR § 447.55(b)(2), the state will disenroll persons who have failed to pay premiums for 60 days or more. We recognize that CMS has not approved to date a provision whereby a state could impose a time limit before individuals in such circumstances could re-enroll. We understand that such a provision has been requested by Indiana, and if that provision should be approved, we reserve the right to request a similar provision in our demonstration.

[10] The premium is applicable only to persons with incomes above 100 percent of poverty. The amount of the premium is 2 percent of poverty. In 2014, the poverty level for one person is $972.50 per month. The premium that would accompany this poverty level is 2 percent of $973.50, or $19.45. (Federal regulations do not allow premiums for Medicaid enrollees with incomes below 150 percent of poverty; we are requesting a waiver to require premiums for those with incomes above 100 percent of poverty.)

[11] Consistent with federal regulations, medical copays are applicable only to those members with incomes above 100 percent of poverty.

[12] Pharmacy copays are applicable to members at any income level.

VII. Appeals Procedures

Appeals in the Healthy Incentives Plan. Appeals related to Healthy Incentives Plan services will be handled in a manner consistent with the existing TennCare appeals process.

Appeals in the Volunteer Plan. Volunteer Plan members desiring to file appeals of an ESI benefit decision must do so through their ESI plan. Members who remain unsatisfied with a final decision from their ESI plan appeal may choose to move to the Healthy Incentives Plan. Members contemplating a move to the Healthy Incentives Plan following benefit denial will have access to Options Counseling services (See Part VI). Counselors will be able to verify whether the service the member is seeking is a covered benefit in the Healthy Incentives Plan. They will not, however, be able to advise the member as to whether or not the Healthy Incentives Plan would consider the service to be medically necessary in the member's particular situation.

Volunteer Plan members will not be able to access the Medicaid appeals process for ESI benefit decisions.

VIII. Modification of the Unreimbursed Hospital Cost Pool

We are proposing to increase the maximum of the Unreimbursed Hospital Cost Pool to $600 million to offset documented unreimbursed cost.

IX. Program Support and Opt Out Provision

It is expected that expenditures for Insure Tennessee will be matched with 100 percent federal dollars through December 31, 2016. On January 1, 2017, the federal match rate will adjust to 95 percent.

Tennessee hospitals have committed to supporting Insure Tennessee through an increase in a state assessment on hospitals, so there will be no impact on the state's budget even when the federal match rate declines.

Insure Tennessee will end if either of the following events occurs: (1) the federal match rate available for the program is reduced below the amount available under ACA as its exists on January 1, 2015, or (2) revenues available from the assessment on hospitals fails to cover any remaining state share of expenditures in the event of a reduction in the federal match rate.

X. List of Waivers Requested

The State asks CMS to add the following waivers of Title XIX requirements to the TennCare II demonstration pursuant to Section 1115(a)(1) of the Social Security Act:

1) Amount, Duration, Scope and Comparability. Section 1902(a)(10)(B)

To the extent necessary to allow Insure Tennessee members to choose to participate in the Volunteer Plan and receive the benefits provided through an employer-sponsored insurance plan, without Medicaid wrap-around benefits, and to allow the state to offer different benefit packages to Insure Tennessee members, depending on the plan option in which they choose to participate.

2) Premiums. Sections 1902(a)(14), 1916, and 1916A

To the extent necessary to enable Tennessee to charge premiums to Insure Tennessee members with incomes between 100-138 percent of the FPL.

3) Cost Sharing. Sections 1902(a)(14), 1916, and 1916A

To the extent necessary to allow Volunteer Plan members to enroll in employer-sponsored coverage with cost sharing that exceeds the Medicaid allowable levels, and to the extent necessary allow Tennessee to forego the tracking of cost sharing for Volunteer Plan members.

4) Statewideness/Uniformity. Section 1902(a)(1)

To the extent necessary to allow Volunteer Plan members to choose employer-sponsored coverage that is not offered statewide.

5) Methods of Administration: Transportation. Section 1902(a)(4) insofar as it incorporates 42 C.F.R § 431.53

To the extent necessary to enable Tennessee not to assure non-emergency transportation to and from providers for the Volunteer Plan.

6) Freedom of Choice. Section 1902(a)(23)

To allow Tennessee to limit the choice of providers for Volunteer Plan members to only those providers participating in the employer-sponsored coverage selected by the member.

7) Healthy Incentive Plan Benefits. Section 1902(k)(1)

To the extent necessary to permit the Healthy Incentives Plan to mirror coverage in the regular TennCare program.

8) Post-Eligibility Treatment of Income. 42 C.F.R. Part 435, Subpart H

To allow Tennessee to apply post-eligibility treatment of income rules in 42 C.F.R. Part 435, Subpart H to Insure Tennessee members.

9) Appeals. Section 1902(a)(3)

To the extent necessary to relieve Tennessee of the obligation to provide appeals in compliance with the requirements in 42 C.F.R. Part 431, Subpart E for benefits decisions made by employer-sponsored plans for Volunteer Plan members.

10) Retroactive Eligibility. Section 1902(a)(34)

To enable the state not to extend eligibility for Insure Tennessee prior to the date that an application for assistance is made.

The State asks CMS to add the following expenditure authorities to the TennCare II demonstration pursuant to Section 1115(a)(2) of the Social Security Act:

1) Employer-sponsored insurance. For expenditures for premium assistance for employer-sponsored coverage, without Medicaid wrap-around benefits, for Volunteer Plan members that does not offer Alternative Benefit Plan or state plan benefits.

2) Pool payments. For expenditures for Graduate Medical Education, Essential Access Hospital, Critical Access Hospital, Meharry Medical College, Unreimbursed Public Hospital Costs for Certified Public Expenditures, Unreimbursed Hospital Cost, and Public Hospital Supplemental Payment pool payments to the extent specified in paragraph 55.d.-h. and j.-l. (Extent of Federal Financial Participation for the Demonstration) of TennCare II's STCs, through December 31, 2016.

XI. Other Components of the Amendment Request

An explanation of the public process used by the state. The state will comply with the public process described in Paragraph #15 of the Special Terms and Conditions.

Description of how the evaluation design will be modified to incorporate the amendment provisions. The state believes that the current evaluation design, with its emphasis on global objectives and specific performance measures, is appropriate for the Insure Tennessee population.

Data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. To be added upon completion of actuarial analysis.

AN ACT CREATING THE MONTANA HEALTH AND ECONOMIC LIVELIHOOD PARTNERSHIP ACT TO EXPAND HEALTH CARE COVERAGE TO ADDITIONAL INDIVIDUALS, IMPROVE ACCESS TO HEALTH CARE SERVICES, AND CONTROL HEALTH CARE COSTS; ESTABLISHING A HEALTH CARE COVERAGE PROGRAM TO PROVIDE CERTAIN LOW-INCOME MONTANANS WITH ACCESS TO HEALTH CARE SERVICES USING MEDICAID FUNDS AND AN ARRANGEMENT WITH A THIRD-PARTY ADMINISTRATOR; IMPLEMENTING CERTAIN MEDICAID REFORMS; PROVIDING STATUTORY APPROPRIATIONS FOR COSTS OF PROVIDING HEALTH CARE SERVICES; PROVIDING SUPPORT FOR HEALTH CARE DELIVERY ACROSS MONTANA; PROVIDING WORKFORCE DEVELOPMENT OPPORTUNITIES FOR PROGRAM PARTICIPANTS; ESTABLISHING TIME LIMITS FOR SERVICE OF PROCESS IN MEDICAL MALPRACTICE CLAIMS; ESTABLISHING AN OVERSIGHT COMMITTEE; PROVIDING DEFINITIONS; PROVIDING RULEMAKING AUTHORITY; PROVIDING APPROPRIATIONS; AMENDING SECTIONS 17-7-502 AND 27-2-205, MCA; AND PROVIDING EFFECTIVE DATES AND A TERMINATION DATE.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

Section 1. Short title. [Sections 1 through 13], [sections 14 through 17], and [section 19] may be cited as the "Montana Health and Economic Livelihood Partnership (HELP) Act".

Section 2. Montana HELP Act program -- legislative findings and purpose. (1) There is a Montana Health and Economic Livelihood Partnership Act program established through a collaborative effort of the department of public health and human services and the department of labor and industry to:

(a) provide coverage of health care services for low-income Montanans;

(b) improve the readiness of program participants to enter the workforce or obtain better-paying jobs; and

(c) reduce the dependence of Montanans on public assistance programs.

(2) The legislature finds that improving the delivery of health care services to Montanans requires state

government, health care providers, patient advocates, and other parties interested in high-quality, affordable health care to collaborate in order to:

(a) increase the availability of high-quality health care to Montanans;

(b) provide greater value for the tax dollars spent on the Montana medicaid program;

(c) reduce health care costs;

(d) provide incentives that encourage Montanans to take greater responsibility for their personal health;

(e) boost Montana's economy by reducing the costs of uncompensated care; and

(f) reduce or minimize the shifting of payment for unreimbursed health care costs to patients with health insurance.

(3) The legislature further finds that providing greater value for the dollars spent on the medicaid program requires considering options for delivering services in a more efficient and cost-effective manner, including but not limited to:

(a) offering incentives to encourage health care providers to achieve measurable performance outcomes;

(b) improving the coordination of care among health care providers who participate in the medicaid program;

(c) reducing preventable hospital readmissions; and

(d) exploring methods of medicaid payment that promote quality of care and efficiencies.

(4) The legislature further finds that assessing workforce readiness and providing necessary job training or skill development for individuals who need assistance with health care costs could help those individuals obtain employment that has health care coverage benefits or that would allow them to purchase their own health insurance coverage.

(5) The legislature further finds that:

(a) it is important to implement additional fraud, waste, and abuse safeguards to protect and preserve the integrity of the medicaid program and the unemployment insurance program for individuals who qualify for the programs; and

(b) state policymakers have an interest in testing the effectiveness of wellness incentives in order to collect and analyze information about the correlation between wellness incentives and health status.

(6) The purposes of the act are to:

(a) modify and enhance Montana's health care delivery system to provide access to high-quality,

affordable health care for all Montana citizens; and

(b) provide low-income Montanans with opportunities to improve their readiness for work or to obtain higher-paying jobs.

(7) The department of labor and industry and the department of public health and human services shall maximize the use of existing resources in administering the program.

Section 3. Definitions. As used in [sections 1 through 13], the following definitions apply:

(1) "Department" means the department of public health and human services provided for in 2-15-2201.

(2) "HELP Act" or "act" means the Montana Health and Economic Livelihood Partnership Act provided for in [sections 1 through 13] and [sections 14 through 17].

(3) "Member" means an individual enrolled in the Montana medicaid program pursuant to 53-6-131 or receiving medicaid-funded services pursuant to [section 4].

(4) "Program participant" or "participant" means an individual enrolled in the Montana Health and Economic Livelihood Partnership Act program established in [sections 1 through 13] and [sections 14 through 17].

Section 4. Montana HELP Act program -- eligibility for coverage of health care services -- statutory appropriations -- federal special revenue. (1) An individual is eligible for coverage of health care services provided pursuant to [sections 1 through 13] if the individual meets the requirements of 42 U.S.C. 1396a(a)(10)(A)(i)(VIII).

(2) Funds necessary to implement [sections 1 through 13], including benefits and administrative costs, are statutorily appropriated, as provided in 17-7-502, from the general fund to the department of public health and human services.

(3) There is an account in the federal special revenue fund to the credit of the department of public health and human services for the payment of costs, including benefits and administrative costs, of providing health care services to individuals who are eligible for coverage pursuant to subsection (1).

(4) The federal medical assistance percentage received pursuant to 42 U.S.C. 1396d(y) must be deposited in the account provided for in subsection (3).

(5) Money in the account is statutorily appropriated, as provided in 17-7-502, to the department of public

health and human services for the purpose provided in subsection (3).

Section 5. Montana HELP Act program -- delivery of health care services -- third-party administrator -- rulemaking. (1) The department shall contract as provided in Title 18, chapter 4, with one or more third-party administrators to assist in administering the delivery of health care services to members eligible under [section 4], including but not limited to:

(a) establishing networks of health care providers;

(b) paying claims submitted by health care providers;

(c) collecting the premiums provided for in [section 7];

(d) coordinating care;

(e) helping to administer the program; and

(f) helping to administer the medicaid program reforms as specified in [section 8].

(2) The department shall determine the basic health care services to be provided through the arrangement with a third-party administrator.

(3) (a) The department may exempt certain individuals who are eligible for medicaid-funded services pursuant to [section 4] from receiving health care services through the arrangement with a third-party administrator if the individuals would be served more appropriately through the medical assistance program established in Title 53, chapter 6, part 1, because the individuals:

(i) have exceptional health care needs, including but not limited to medical, mental health, or developmental conditions;

(ii) live in a geographical area, including an Indian reservation, for which the third-party administrator has been unable to make arrangements with sufficient health care providers to offer services to the individuals; or

(iii) need continuity of care that would not be available or cost-effective through the arrangement with the third-party administrator; or

(iv) are otherwise exempt under federal law.

(b) The department shall:

(i) adopt rules establishing criteria for determining whether a member is exempt from receiving health care services through an arrangement with a third-party administrator; and

(ii) provide coverage for exempted individuals through the medical assistance program established in Title

53, chapter 6, part 1.

(4) For members participating in the arrangement with the third-party administrator, the department shall directly cover any service required under federal or state law that is not available through the arrangement with the third-party administrator.

(5) The department shall:

(a) seek federal authorization from the U.S. department of health and human services through a waiver authorized by 42 U.S.C. 1315 and other waivers or through other means, as may be necessary, to implement all of the provisions of [sections 1 through 13] and [sections 14 through 17]; and

(b) implement access to the health care services in accordance with the requirements necessary to receive the federal medical assistance percentage provided for by 42 U.S.C. 1396d(y).

(6) The department may provide medicaid-funded services to members eligible pursuant to [section 4] only upon federal approval of any necessary waivers.

Section 6. Copayments -- exemptions -- report. (1) A program participant shall make copayments to health care providers for health care services received pursuant to [sections 1 through 13].

(2) Except as provided in subsection (3), the department shall adopt a copayment schedule that reflects the maximum copayment amount allowed under federal law. The total amount of copayments collected under this section must be capped at the maximum amount allowed by federal law and regulations.

(3) The department may not require a copayment for:

(a) preventive health care services;

(b) generic pharmaceutical drugs;

(c) immunizations provided according to a schedule established by the department that reflects guidelines issued by the centers for disease control and prevention; or

(d) medically necessary health screenings ordered by a health care provider.

(4) Each health care provider participating in the third-party arrangement shall report the following information annually to the oversight committee on the Montana Health and Economic Livelihood Partnership Act:

(a) the total amount of copayments that the provider was unable to collect from participants; and

(b) the efforts the health care provider made to collect the copayments.

Section 7. Premiums -- collection of overdue premiums -- nonpayment as voluntary disenrollment -- reenrollment -- exemptions. (1) (a) A program participant shall pay an annual premium, billed monthly, equal to 2% of the participant's income as determined in accordance with 42 U.S.C. 1396a(e)(14).

(b) Premiums paid pursuant to this section must be deposited in the general fund.

(2) Within 30 days of a participant's failure to make a required payment, the third-party administrator shall notify the participant and the department that payment is overdue and that all overdue premiums must be paid within 90 days of the date the notification was sent.

(3) (a) If a participant with an income of 100% of the federal poverty level or less fails to make payment for overdue premiums, the department shall provide notice to the department of revenue of the participant's failure to pay. The department of revenue shall collect the amount due for nonpayment by assessing the amount against the participant's annual income tax in accordance with Title 15, chapters 1 and 30.

(b) The debt remains until paid and may be collected through assessments against future income tax returns or through a civil action initiated by the state.

(4) If a participant with an income of more than 100% but not more than 138% of the federal poverty level fails to make the overdue payments within 90 days of the date the notification was sent, the department shall:

(a) follow the procedure established in subsection (3) for collection of the unpaid premiums; and

(b) consider the failure to pay to be a voluntary disenrollment from the program. The department may reenroll a participant in the program upon payment of the total amount of overdue payments.

(5) If a participant who has failed to pay the premiums does not indicate that the participant no longer wishes to participate in the program, the department may reenroll the person in the program when the department of revenue assesses the unpaid premium through the participant's income taxes.

(6) Participants who meet two of the following criteria are not subject to the voluntary disenrollment provisions of this section:

(a) discharge from United States military service within the previous 12 months;

(b) enrollment for credit in any Montana university system unit, a tribal college, or any other accredited college within Montana offering at least an associate degree, subject to the provisions of subsection (7);

(c) participation in a workforce program or activity established under [sections 14 through 17]; or

(d) participation in any of the following healthy behavior plans developed by a health care provider or third-party administrator or approved by the department:

(i) a medicaid health home;

(ii) a patient-centered medical home;

(iii) a cardiovascular disease, obesity, or diabetes prevention program;

(iv) a program restricting the participant to obtaining primary care services from a designated provider and obtaining prescriptions from a designated pharmacy;

(v) a medicaid primary care case management program established by the department;

(vi) a tobacco use prevention or cessation program;

(vii) a medicaid waiver program providing coverage for family planning services;

(viii) a substance abuse treatment program; or

(ix) a care coordination or health improvement plan administered by the third-party administrator.

(7) A participant seeking an exemption under subsection (6) is not eligible for the education exemption provided for in subsection (6)(b) for more than 4 years.

Section 8. Medicaid program reforms. (1) To ensure that the Montana medicaid program is administered efficiently and effectively, the department shall strengthen existing programs that manage the way members obtain approval for medical services and shall establish additional programs designed to reduce costs and improve medical outcomes. The efforts may include but are not limited to:

(a) establishing by rule requirements designed to strengthen the relationship between physicians and members enrolled in existing primary care case management programs;

(b) strengthening data-sharing arrangements with providers to reduce inappropriate use of emergency room services and overuse of other services;

(c) expanding to additional members any existing programs in which case managers and providers work with members with high-risk medical conditions to provide preventive care and advice and to make referrals for medical services;

(d) establishing, within existing funds, one or more pilot programs to improve the health of members, including but not limited to efforts to increase pain management, decrease emergency department overuse, and prevent drug or alcohol addiction or abuse;

(e) reviewing existing primary care case management programs to evaluate and improve their effectiveness;

(f) reducing fraud, waste, and abuse in the medicaid program before, during, and after enrollment by enhancing technology system support to provide knowledge-based authentication for verifying the identity and financial status of individuals seeking benefits, including the use of public records to confirm identity and flag changes in demographics; and

(g) engaging members with chronic or other medical or behavioral health conditions in coordinated care models that more closely monitor and manage a member's health to reduce costs or improve medical outcomes. These coordinated care models may include but are not limited to:

(i) patient-centered medical homes;

(ii) accountable care organizations;

(iii) managed care organizations as defined in 42 CFR 438.2;

(iv) health improvement programs;

(v) health homes for behavioral health or other chronic conditions; and

(vi) changes to current service delivery methods.

(2) The department may ask a third-party administrator under contract with the department to assist in efforts undertaken pursuant to subsection (1) when the activity can appropriately be handled by the third-party administrator.

(3) A care coordination entity used to deliver medicaid services shall meet all state standards for operation, including but not limited to solvency, consumer protection, nondiscrimination, network adequacy, care model design, and fraud and abuse standards.

Section 9. Health care services payment schedules. (1) The department of corrections and the department of public health and human services shall reimburse health care service for individuals identified in subsection (2) at the rates adopted by the department for the medicaid program under Title 53, chapter 6, part 1, if the health care services are not otherwise covered by medicaid, medicare, a health insurer, or another private or governmental program that pays for health care costs.

(2) This section applies to individuals:

(a) in the custody of the department of corrections; or

(b) who are residents, by commitment or otherwise, of the Montana state hospital, the Montana mental health nursing care center, the Montana chemical dependency center, and the Montana developmental center.

Section 10. Reduction in federal medical assistance percentage. If the federal medical assistance percentage for medical services provided to individuals eligible for medicaid-funded services pursuant to [section 4] is set below the levels established in 42 U.S.C. 1396d(y)(1) on [the effective date of this act], the continuation of coverage under [sections 1 through 13] is contingent on:

(1) the appropriation of additional state general fund or other action by the legislature;

(2) the ability of the department to increase premiums assessed under [section 7] to pay the difference; or

(3) a combination of legislative action and premium increases as necessary to provide for the increased state match obligation.

Section 11. Montana HELP Act oversight committee -- membership. (1) There is an oversight committee on the Montana Health and Economic Livelihood Partnership Act made up of members of the legislature and of other Montana citizens.

(2) The committee consists of nine voting members appointed no later than May 30, 2015, as follows:

(a) two senators, one appointed by the president of the senate and one appointed by the senate minority leader;

(b) two representatives, one appointed by the speaker of the house and one appointed by the house minority leader; and

(c) five individuals appointed by the governor as follows:

(i) one representative of a hospital as defined in 50-5-101;

(ii) one representative of a critical access hospital as defined in 50-5-101;

(iii) one primary care physician;

(iv) one representative of the state auditor's office; and

(v) one member of the general public or a staff member of the governor's office.

(3) The state medicaid director or the director's designee, the commissioner of labor and industry or the commissioner's designee, and a designee of the third-party administrator are ex officio members of the committee.

(4) The presiding officer and vice presiding officer must be elected by a majority of the committee

members.

(5) The presiding officer shall establish the meeting schedule. The council shall meet at least quarterly.

(6) (a) Except as provided in subsection (6)(b), members are entitled to receive compensation and expenses as provided in 5-2-302.

(b) Ex officio members are not entitled to compensation or reimbursement of expenses.

(7) (a) Except as provided in subsection (7)(b), members shall serve 4-year terms. Vacancies on the committee must be filled by the same appointing authority.

(b) A member who was appointed while a senator or a representative but who is no longer serving in the legislature must be replaced by the appointing authority.

(8) The committee is attached to the department for administrative purposes, including staffing.

(9) The committee may contract for services that will help members carry out their duties, subject to available funding and in accordance with the provisions of Title 18, chapter 4.

Section 12. Duties of Montana HELP Act oversight committee -- reports. (1) To provide reports and make recommendations to the legislature, the oversight committee on the Montana Health and Economic Livelihood Partnership Act shall review:

(a) data from and activities by the department of public health and human services and the department of labor and industry related to the health care and workforce development activities undertaken pursuant to the HELP Act;

(b) the Montana medicaid program; and

(c) the delivery of health care services in Montana.

(2) The departments shall report the following information to the oversight committee quarterly:

(a) the number of individuals who were determined eligible for medicaid-funded services pursuant to [section 4];

(b) demographic information on program participants;

(c) the average length of time that participants remained eligible for medical assistance;

(d) the number of participants who completed an employment or reemployment assessment;

(e) the number of participants who took part in workforce development activities;

(f) the number of participants subject to the fee provided for in [section 18] and the total amount of fees

collected;

(g) the level of participant engagement in wellness activities or incentives offered by health care providers or the third-party administrator;

(h) the number of participants who reduced their dependency on the HELP Act program, either voluntarily or because of increased income levels; and

(i) the total cost of providing services under [sections 1 through 13] and [sections 14 through 17], including related administrative costs.

(3) The committee shall review and provide comment on administrative rules proposed for carrying out activities under [sections 1 through 13] and [sections 14 through 17]. The committee may ask the appropriate administrative rule review committee to object to a proposed rule as provided in 2-4-406.

(4) The committee shall:

(a) review how implementation of the act is being carried out, including the collection of copayments and premiums for health care services;

(b) evaluate how health care services are delivered and whether new approaches could improve delivery of care, including but not limited to the use of medical homes and coordinated care organizations;

(c) review ideas to reduce or minimize the shifting of the payment of unreimbursed health care costs to patients with health insurance;

(d) evaluate whether providing incentives to health care providers for meeting measurable benchmarks may improve the delivery of health care services;

(e) review options for reducing the inappropriate use of emergency department services;

(f) review ways to monitor for the excessive or inappropriate use of prescription drugs;

(g) examine ways to:

(i) promote the appropriate use of health care services, particularly laboratory and diagnostic imaging services;

(ii) increase the availability of mental health services;

(iii) reduce fraud and waste in the medicaid program; and

(iv) improve the sharing of data among health care providers to identify patterns in the use of health care services across payment sources;

(h) receive regular reports from the department on the department's efforts to pursue contracting options

for administering services to members eligible for medicaid-funded services pursuant to [section 4];

(i) coordinate its efforts with any legislative committees that are working on matters related to health care and the delivery of health care services; and

(j) recommend future funding options for the HELP Act program to future legislatures.

(5) The committee shall summarize and present its findings and recommendations in a final report to the governor and to the legislative finance committee no later than August 15 of each even-numbered year. Copies of the report must be provided to the children, families, health, and human services interim committee.

Section 13. Rulemaking authority. (1) The department may adopt rules as necessary to carry out [sections 1 through 13].

(2) The department and the department of labor and industry may, in coordination, adopt rules as necessary for the implementation of the employment and reemployment assessments and workforce development activities provided for in [sections 14 through 17].

Section 14. Montana HELP Act workforce development -- legislative findings -- purpose. (1) The legislature finds that:

(a) Montana has a disproportionately high number of individuals who are eligible for medicaid compared to surrounding states;

(b) Montanans value independence and self-sufficiency;

(c) investing in Montana citizens is a legislative priority;

(d) participants in the HELP Act program are largely low-wage workers; and

(e) an opportunity exists to match individuals who need self-sustaining employment with the jobs the economy needs, including newly created health care jobs.

(2) The purpose of [sections 14 through 17] is to create a collaborative effort between the department of labor and industry and the department of public health and human services to:

(a) identify workforce development opportunities for program participants;

(b) gather information from state agencies on existing workforce development programs and opportunities; and

(c) establish a comprehensive plan for coordinating efforts and resources to provide workforce

development opportunities.

(3) The department of labor and industry shall implement a workforce development program that:

(a) focuses on specific labor force needs within the state of Montana;

(b) has the goal of reducing the number of people depending on social programs, including the HELP Act program; and

(c) increases the earning capacity, economic stability, and self-sufficiency of program participants so that, among other benefits, they are able to purchase their own health insurance coverage.

Section 15. Definitions. As used in [sections 14 through 17], the following definitions apply:

(1) "Department" means the department of labor and industry provided for in 2-15-1701.

(2) "HELP Act" or "act" means the Montana Health and Economic Livelihood Partnership Act provided for in [sections 1 through 13] and [sections 14 through 17].

(3) "Program participant" means an individual participating in the HELP Act program.

Section 16. Montana HELP Act workforce development -- participation -- report. (1) The department shall provide individuals receiving assistance for health care services pursuant to [sections 1 through 13] with the option of participating in an employment or reemployment assessment and in the workforce development program provided for in [section 14]. The assessment must identify any probable barriers to employment that exist for the member.

(2) (a) The department of labor and industry shall notify the department of public health and human services when a participant has received all services and assistance under subsection (1) that can reasonably be provided to the individual.

(b) The department of labor and industry is not required to provide further services under this section after it has provided the notification provided for in subsection (2)(a).

(c) A participant who is no longer receiving services under this section does not meet the criteria of [section 7(6)(c)] for the exemption granted under [section 7(6)].

(3) The department shall report the following information to the oversight committee provided for in [section 11]:

(a) the activities undertaken to establish a workforce development program for program participants; and

(b) the number of participants in the workforce development program and the number of participants who have obtained employment or higher-paying employment.

(4) To the extent possible, the department of public health and human services shall offset the cost of workforce development activities provided under this section by using temporary assistance for needy families reserve funds.

(5) The department shall reduce fraud, waste, and abuse in determining and reviewing eligibility for unemployment insurance benefits by enhancing technology system support to provide knowledge-based authentication for verifying the identity and employment status of individuals seeking benefits, including the use of public records to confirm identity and to flag changes in demographics.

Section 17. Rulemaking authority. The department may adopt rules to carry out the purposes of [sections 14 through 17] and may coordinate as necessary with the department of public health and human services in adoption of the rules.

Section 18. Taxpayer integrity fee. (1) The department shall assess a fee as provided in subsection (2) for a taxpayer who:

(a) is a participant in the Montana Health and Economic Livelihood Partnership Act provided for in [sections 1 through 13] and [sections 14 through 17]; and

(b) has assets that exceed:

(i) a primary residence and attached property valued above the limit established for homesteads under 70-32-104;

(ii) one light vehicle; and

(iii) a total of $50,000 in cash and cash equivalent.

(2) The fee is $100 a month plus an additional $4 a month for each $1,000 in assets above the amounts established in subsection (1)(b).

(3) The department shall coordinate with the department of public health and human services to obtain the information necessary to administer this section.

(4) Fees collected pursuant to this section must be deposited in the general fund.

(5) The fee remains until paid and may be collected through assessments against future income tax

returns or through a civil action initiated by the state.

(6) For the purposes of this section, the following definitions apply:

(a) (i) "Cash equivalent" means cash, including any money issued by the United States or by the sovereign government of another country, and, if reasonably convertible into cash with 1 year:

(A) personal property, including but not limited to vehicles, precious metal as defined in 30-10-103, jewelry, artwork, and gemstones; and

(B) personal property, including but not limited to certificates of deposit, certificates of stock, government or corporate bonds or notes, promissory notes, licenses, copyrights, patents, trademarks, contracts, software, and franchises.

(ii) Real estate and improvements to real estate are not cash equivalents.

(b) "Light vehicle" has the meaning provided in 61-1-101.

Section 19. Medical malpractice claims -- time limit. A plaintiff in a medical malpractice action shall accomplish service within 6 months after filing the complaint. If the plaintiff fails to do so, the court, on motion or on its own initiative, shall dismiss the action without prejudice unless the defendant has made an appearance.

Section 20. Section 17-7-502, MCA, is amended to read:

"17-7-502. Statutory appropriations -- definition -- requisites for validity. (1) A statutory appropriation is an appropriation made by permanent law that authorizes spending by a state agency without the need for a biennial legislative appropriation or budget amendment.

(2) Except as provided in subsection (4), to be effective, a statutory appropriation must comply with both of the following provisions:

(a) The law containing the statutory authority must be listed in subsection (3).

(b) The law or portion of the law making a statutory appropriation must specifically state that a statutory appropriation is made as provided in this section.

(3) The following laws are the only laws containing statutory appropriations: 2-15-247; 2-17-105; 5-11-120; 5-11-407; 5-13-403; 7-4-2502; 10-1-108; 10-1-1202; 10-1-1303; 10-2-603; 10-3-203; 10-3-310; 10-3-312; 10-3-314; 10-4-301; 15-1-121; 15-1-218; 15-35-108; 15-36-332; 15-37-117; 15-39-110; 15-65-121; 15-70-101; 15-70-369; 15-70-601; 16-11-509; 17-3-106; 17-3-112; 17-3-212; 17-3-222; 17-3-241; 17-6-101;

18-11-112; 19-3-319; 19-6-404; 19-6-410; 19-9-702; 19-13-604; 19-17-301; 19-18-512; 19-19-305; 19-19-506; 19-20-604; 19-20-607; 19-21-203; 20-8-107; 20-9-534; 20-9-622; 20-26-1503; 22-1-327; 22-3-1004; 23-4-105; 23-5-306; 23-5-409; 23-5-612; 23-7-301; 23-7-402; 30-10-1004; 37-43-204; 37-51-501; 39-1-105; 39-71-503; 41-5-2011; 42-2-105; 44-4-1101; 44-12-206; 44-13-102; 53-1-109; 53-1-215; 53-2-208; [section 4]; 53-9-113; 53-24-108; 53-24-206; 60-11-115; 61-3-415; 69-3-870; 75-1-1101; 75-5-1108; 75-6-214; 75-11-313; 76-13-150; 76-13-416; 77-1-108; 77-2-362; 80-2-222; 80-4-416; 80-11-518; 81-1-112; 81-7-106; 81-10-103; 82-11-161; 85-20-1504; 85-20-1505; 87-1-603; 90-1-115; 90-1-205; 90-1-504; 90-3-1003; 90-6-331; and 90-9-306.

(4) There is a statutory appropriation to pay the principal, interest, premiums, and costs of issuing, paying, and securing all bonds, notes, or other obligations, as due, that have been authorized and issued pursuant to the laws of Montana. Agencies that have entered into agreements authorized by the laws of Montana to pay the state treasurer, for deposit in accordance with 17-2-101 through 17-2-107, as determined by the state treasurer, an amount sufficient to pay the principal and interest as due on the bonds or notes have statutory appropriation authority for the payments. (In subsection (3): pursuant to sec. 10, Ch. 360, L. 1999, the inclusion of 19-20-604 terminates contingently when the amortization period for the teachers' retirement system's unfunded liability is 10 years or less; pursuant to sec. 10, Ch. 10, Sp. L. May 2000, secs. 3 and 6, Ch. 481, L. 2003, and sec. 2, Ch. 459, L. 2009, the inclusion of 15-35-108 terminates June 30, 2019; pursuant to sec. 73, Ch. 44, L. 2007, the inclusion of 19-6-410 terminates contingently upon the death of the last recipient eligible under 19-6-709(2) for the supplemental benefit provided by 19-6-709; pursuant to sec. 14, Ch. 374, L. 2009, the inclusion of 53-9-113 terminates June 30, 2015; pursuant to sec. 5, Ch. 442, L. 2009, the inclusion of 90-6-331 terminates June 30, 2019; pursuant to sec. 16, Ch. 58, L. 2011, the inclusion of 30-10-1004 terminates June 30, 2017; pursuant to sec. 6, Ch. 61, L. 2011, the inclusion of 76-13-416 terminates June 30, 2019; pursuant to sec. 13, Ch. 339, L. 2011, the inclusion of 81-1-112 and 81-7-106 terminates June 30, 2017; pursuant to sec. 11(2), Ch. 17, L. 2013, the inclusion of 17-3-112 terminates on occurrence of contingency; pursuant to secs. 3 and 5, Ch. 244, L. 2013, the inclusion of 22-1-327 is effective July 1, 2015, and terminates July 1, 2017; and pursuant to sec. 10, Ch. 413, L. 2013, the inclusion of 2-15-247, 39-1-105, 53-1-215, and 53-2-208 terminates June 30, 2015.)"

Section 21. Section 27-2-205, MCA, is amended to read:

"27-2-205. Actions for medical malpractice. (1) Action in tort or contract for injury or death against a

physician or surgeon, physician assistant, dentist, dental hygienist, registered nurse, advanced practice registered nurse, nursing home or hospital administrator, dispensing optician, optometrist, licensed physical therapist, podiatrist, psychologist, osteopath, chiropractor, clinical laboratory bioanalyst, clinical laboratory technologist, pharmacist, veterinarian, a licensed hospital or long-term care facility, or licensed medical professional corporation, based upon alleged professional negligence or for rendering professional services without consent or for an act, error, or omission, must, except as provided in subsection (2), be commenced within ~~3~~ 2 years after the date of injury or within ~~3~~ 2 years after the plaintiff discovers or through the use of reasonable diligence should have discovered the injury, whichever occurs last, but in no case may an action be commenced after 5 years from the date of injury. However, this time limitation is tolled for any period during which there has been a failure to disclose any act, error, or omission upon which an action is based and that is known to the defendant or through the use of reasonable diligence subsequent to the act, error, or omission would have been known to the defendant.

(2) Notwithstanding the provisions of 27-2-401, in an action for death or injury of a minor who was under the age of 4 on the date of the minor's injury, the period of limitations in subsection (1) begins to run when the minor reaches the minor's eighth birthday or dies, whichever occurs first, and the time for commencement of the action is tolled during any period during which the minor does not reside with a parent or guardian."

Section 22. Appropriations. (1) There is appropriated from the state general fund for the biennium beginning July 1, 2015, the following:

(a) $1,761,476 to the department of labor and industry for the purposes of [sections 14 through 17]; and

(b) $393,213 to the department of revenue for the purposes of [section 18].

(2) These appropriations are to be considered base funding for the preparation of the 2019 biennium budget.

Section 23. Transition. (1) For the successful and appropriate implementation of [sections 1 through 13], the department of public health and human services may initiate eligibility processing and other measures necessary for implementation of [sections 4 and 5] prior to the date that health care services provided pursuant to [section 5] are covered.

(2) The department may implement coverage of health care services for individuals eligible pursuant to

[section 4] only after:

(a) the department has obtained the approvals and waivers needed from the U.S. department of health and human services to receive the federal medical assistance percentage provided for in 42 U.S.C. 1396d(y) for individuals eligible for coverage pursuant to [section 4] and to provide services in accordance with [sections 1 through 17]; and

(b) all necessary administrative arrangements, including contract services, are in place.

Section 24. Codification instruction. (1) [Sections 1 through 13] are intended to be codified as an integral part of Title 53, chapter 6, and the provisions of Title 53, chapter 6, apply to [sections 1 through 13].

(2) [Sections 14 through 17] are intended to be codified as an integral part of Title 39, and the provisions of Title 39 apply to [sections 14 through 17].

(3) [Section 18] is intended to be codified as an integral part of Title 15, chapter 30, and the provisions of Title 15, chapter 30, apply to [section 18].

(4) [Section 19] is intended to be codified as an integral part of Title 25, chapter 3, part 1, and the provisions of Title 25, chapter 3, part 1, apply to [section 19].

Section 25. Saving clause. [Sections 19 and 20] do not affect rights and duties that matured, penalties that were incurred, or proceedings that were begun before [the effective date of this act].

Section 26. Nonseverability. Except as provided in subsection (2), it is the intent of the legislature that each part of [this act] is essentially dependent upon every other part, and if one part is held unconstitutional or invalid, all other parts are invalid.

(2) If [section 19 or 20] is held unconstitutional, all other parts are valid.

Section 27. Effective date -- contingent effective date. (1) Except as provided in subsection (2), [this act] is effective upon approval by the U.S. department of health and human services of all waivers and approvals necessary to provide medicaid-funded services to individuals eligible pursuant to [section 4] in the manner provided for in [sections 1 through 17].

(2) [Sections 11, 19, 20, and 21] and this section are effective on passage and approval.

(3) The governor shall notify the code commissioner on the occurrence of the contingency provided for in subsection (1).

Section 28. Termination. (1) [This act] terminates June 30, 2019.

(2) The department may reapply for the same waiver received to implement the Montana Health and Economic Livelihood Partnership Act program if the waiver expires before June 30, 2019.

- END -

I hereby certify that the within bill,

SB 0405, originated in the Senate.

Secretary of the Senate

President of the Senate

Signed this _____ day

of _____, 2015.

Speaker of the House

Signed this _____ day

of _____, 2015.

SENATE BILL NO. 405

INTRODUCED BY E. BUTTREY, D. ANKNEY, T. BERRY, T. BROWN, M. CAFERRO, C. CLARK, P. CONNELL, R. COOK, G. CUSTER, S. FITZPATRICK, F. GARNER, R. HOLLANDSWORTH, B. HOVEN, C. HUNTER, L. JONES, W. MCKAMEY, G. MEYERS, P. NOONAN, R. RIPLEY, D. SALOMON, J. SESSO, R. SHAW, N. SWANDAL, B. TUTVEDT, J. WELBORN

AN ACT CREATING THE MONTANA HEALTH AND ECONOMIC LIVELIHOOD PARTNERSHIP ACT TO EXPAND HEALTH CARE COVERAGE TO ADDITIONAL INDIVIDUALS, IMPROVE ACCESS TO HEALTH CARE SERVICES, AND CONTROL HEALTH CARE COSTS; ESTABLISHING A HEALTH CARE COVERAGE PROGRAM TO PROVIDE CERTAIN LOW-INCOME MONTANANS WITH ACCESS TO HEALTH CARE SERVICES USING MEDICAID FUNDS AND AN ARRANGEMENT WITH A THIRD-PARTY ADMINISTRATOR; IMPLEMENTING CERTAIN MEDICAID REFORMS; PROVIDING STATUTORY APPROPRIATIONS FOR COSTS OF PROVIDING HEALTH CARE SERVICES; PROVIDING SUPPORT FOR HEALTH CARE DELIVERY ACROSS MONTANA; PROVIDING WORKFORCE DEVELOPMENT OPPORTUNITIES FOR PROGRAM PARTICIPANTS; ESTABLISHING TIME LIMITS FOR SERVICE OF PROCESS IN MEDICAL MALPRACTICE CLAIMS; ESTABLISHING AN OVERSIGHT COMMITTEE; PROVIDING DEFINITIONS; PROVIDING RULEMAKING AUTHORITY; PROVIDING APPROPRIATIONS; AMENDING SECTIONS 17-7-502 AND 27-2-205, MCA; AND PROVIDING EFFECTIVE DATES AND A TERMINATION DATE.

State of New Hampshire

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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NICHOLAS A. TOUMPAS
COMMISSIONER

November 7, 2014

The Honorable Mary Jane Wallner, Chairman
Fiscal Committee of the General Court
Legislative Office Building, 104 North State Street
Concord, NH 03301

Requested Action

Pursuant to the requirements of the New Hampshire Health Protection Act (SB 413), codified at RSA 126-A:5,XXII-XXVI, the New Hampshire Department of Health and Human Services requests approval of the enclosed waiver application to submit to the Centers of Medicare and Medicaid Services for the implementation of the Premium Assistance Program under the New Hampshire Health Protection Program. The approval of this waiver by CMS will allow the New Hampshire Health Protection population to be enrolled in private Qualified Health Plans on the federal marketplace in 2016.

Premium Assistance Program

Under SB 413, as long as CMS approves a premium assistance waiver on or before March 31, 2015, the Voluntary Bridge to Marketplace Program will continue through December 31, 2015, and newly eligible adults who are not in the mandatory HIPP program and who are not deemed to be "medically frail," will begin enrollment into private Qualified Health Plans on the federal marketplace in New Hampshire in October 2015. Coverage under QHPs on the marketplace would begin on January 1, 2016. The purchase of QHPs on the federal marketplace will be paid for with 100% federal funds through December 31, 2016. In accordance with the provisions of SB 413, the Department's application seeks a waiver solely for calendar year 2016.

The enclosed waiver application also includes copies of the public notice issued for the draft waiver, the proposed standard copayment plan for the program, copies of the written public comments received by the Department and the Department's responses to those public comments. We have also enclosed a three page summary of the major waiver features.

We look forward to presenting this waiver to the Committee next Monday.

Sincerely,

Nicholas A. Toumpas, Commissioner

Jeffrey A. Meyers, Director
Intergovernmental Affairs

Enclosures

cc: Jeffry A. Pattison
Members, Fiscal Committee

Description of New Hampshire's Medicaid QHP Premium Assistance Waiver Proposal
For Fiscal Committee Meeting

As contemplated by Senate Bill 413, New Hampshire intends to submit an 1115 waiver for CMS approval to establish a mandatory Medicaid QHP premium assistance program. Below is a timeline for submission and approval of the waiver.

Timeline of Key Waiver Submission Activities

Date	Activity
October 1, 2014	Start of Public Notice Period, including two public hearings
October 30, 2014	Review of waiver proposal with Legislative Leadership
October 31, 2014	End of Public Notice Period
November 10, 2014	Meeting with the Fiscal Committee of the General Court for waiver review and approval
December 1, 2014	Submission of waiver to CMS
March 31, 2015	Approval of waiver by CMS

Major Components of New Hampshire Waiver Proposal for Mandatory QHP Premium Assistance

Waiver Duration

- The waiver duration will be one year, from January 1 through December 31, 2016. If the Legislature reauthorizes the program prior to the end of the 2016 Legislative Session in June 2016, New Hampshire would seek to extend the proposed time frame for the demonstration consistent with the terms of such reauthorization.

Populations

- New Hampshire Health Protection Program (NH HPP) new adults – parents with incomes between 47% and 133% FPL and childless adults with incomes <133% FPL, aged 19-64 – will be required to enroll in qualified health plans (QHPs) through the demonstration. Excluded populations will include:
    - Individuals who are HIPP eligible
    - Individuals identified as medically frail based on self-reported health issues that impair activities of daily living.

Benefits

- The NH HPP new adults will receive the Alternative Benefit Plan, which includes the ten essential health benefits, vision, limited dental and limited additional Medicaid-required benefits.
- Medicaid will wrap benefits outside of the essential health benefits that the QHPs provide (including federally mandated Early Periodic Screening, Diagnosis and Treatment services for 19 and 20 year olds and non-emergency medical transportation) on a fee-for-service basis.

Premiums & Deductibles

- Beneficiaries will not be required to pay premiums or deductibles. Federal dollars will cover QHP premiums and deductibles and be paid directly to QHP carriers.

Co-Payments

- NH HPP new adults with incomes <100% FPL will not be subject to co-payments for any service.
- NH HPP new adults with incomes 100-133% FPL will be subject to co-payments on certain services as defined by a standard cost-sharing design. See page 4 for list of services and associated co-payment levels.

Choice of QHPs

- NH HPP new adults with incomes <100% FPL will enroll in 100% actuarial value (AV) Silver-level QHPs.[1]
- The Department of Health and Human Services and Insurance Department anticipate that NH HPP new adults with incomes 100-133% FPL will select from any cost-effective 94% AV Silver-level QHP with the standard cost-sharing design that is available in their geographic region.
- NH HPP new adults enrolled in Medicaid managed care organizations (in the NH HPP "Bridge program") that offer QHPs on the Marketplace in 2016 will be auto-assigned to their MCO's QHP product. Thereafter, these individuals will be given an opportunity to change plans.
- If an enrollee's Bridge program MCO does not offer a QHP in the enrollee's geographic region, the enrollee will be required to select and enroll in a QHP offered to them in the New Hampshire Marketplace.
- The State will auto-assign individuals who do not select a QHP to a plan offered in their geographic region.

Carrier Participation

- Carriers will be required, through certification criteria, to accept Medicaid beneficiaries as enrollees, including individuals enrolling outside of the open enrollment period.

Enrollment Process

- New Hampshire intends to request a waiver of retroactive coverage such that an enrollee's Medicaid coverage will begin on the date of application.
- The State will leverage its current structure for enrollee selection of Medicaid managed care organizations (through the State portal, NHEASY, on the phone and by mail) to establish a shopping and enrollment process for enrollees.

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[1] "Actuarial value" describes how much of the average cost of services is covered by the insurance plan. All silver plans are designed to cover approximately 70% of the average cost of services. However, insurance carriers offering Marketplace plans must develop cost-sharing variations on their silver plans designed for low-income consumers. The "100% actuarial value" plan has no cost-sharing that the enrollee must pay; the plan covers 70% of the cost of services, and the state will pay the carrier for the 30% of cost-sharing that would otherwise be the enrollee's responsibility. The "94% actuarial value" plan has approximately 70% of costs covered by the carrier and 24% of costs covered by the State. The remaining 6% of costs is covered by the enrollee (in the form of co-payments).

Anticipated Waiver Requests

- § 1902(a)(17): To permit the State to provide different delivery systems for different populations of Medicaid beneficiaries.
- § 1902(a)(17): To permit the State to vary cost sharing requirements for individuals in the Demonstration with incomes above 100% FPL from cost sharing to which they would otherwise be subject under the State Plan.
- § 1902(a)(23): To make premium assistance for QHPs in the Marketplace mandatory for QHP Premium Assistance beneficiaries and to permit the State to limit beneficiaries' choice among providers to the providers participating in the network of the QHP Premium Assistance beneficiary's QHP.
- § 1902(a)(34): To permit the State to provide coverage beginning on the application date.
- § 1902(a)(54): To permit the State to require that requests for prior authorization for on formulary 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. Off formulary drugs will be subject to a 48-hour prior authorization period in accordance with RSA 420-J:7-b,II.

The State may identify additional waiver requests as it continues negotiations with CMS.

The Rhode Island Global Waiver Flexibility. Approved by CMS January 16, 2009

Excerpts from the Waiver:

Rhode Island has flexibility to make changes to its demonstration based on how the changes align with the categories defined below and the corresponding process in this Section paragraph 18 Process for Changes to the Demonstration. The category of changes described below are for changes to the program as described in the STCs. Initiatives described in the STCs are approved upon approval of the demonstration.

Categories of Changes and General Requirements for Each Category. When making changes, the State must characterize the change in one of the three following categories. CMS has 15 calendar days after receiving notification of the change (either informally for Category I or formally for Categories II and III) to notify the State of an incorrect characterization of a programmatic change. To the extent the State and CMS are unable to reach mutual agreement on the characterization of the programmatic change, the CMS characterization shall be binding and non-appealable as to the procedure to be followed.

a) **Category I Change**: Is a change which is administrative in nature for which the State has current authority under the State plan or demonstration, and which does not affect beneficiary eligibility, benefits, overall healthcare delivery systems, payment methodologies or cost sharing. The State must notify CMS of such changes either in writing or orally in the periodic review calls and update reports as specified in the General Reporting Section paragraphs 71 through 73. Implementation of these changes does not require approval by CMS.

Examples of Category I changes include, but are not limited to:

- Changes to the instruments used to determine the level of care
- Changes to the Assessment and Coordination Organization Structure
- Changes to general operating procedures
- Changes to provider network methodologies (provider enrollment procedures, but not delivery system changes)
- Changes to prior authorization procedures
- Adding any HCBS service that has a core definition in the 1915(c) Instructions/Technical Guidance if the State intends to use the core definition.
- Modifying an HCBS service definition to adopt the core definition.

b) **Category II Change**: Is a change that could be made as a State Plan Amendment or through authority in sections 1915(b), 1915(c), 1915(i) or 1915(j) without any change in either the STCs, or the section 1115 waiver and expenditure authorities. These changes may affect benefit packages, overall healthcare delivery systems, cost sharing levels, and post-eligibility contributions to the cost of care. Such changes do not, however, include changes that affect beneficiary eligibility (including changes to the level of spenddown eligibility). The State must comply with its existing State Plan Amendment public notice process prior to implementation. The State must also notify CMS in writing of Category II changes prior to implementation, and must furnish CMS with appropriate assurances and justification, that include but are not limited to the following:

i) That the change is consistent with the protections to health and welfare as appropriate to title XIX of the Act, including justification;

ii) That the change results in appropriate efficient and effective operation of the program, including justification and response to funding questions;

iii) That the changes would be permissible as a State Plan or section 1915 waiver amendment; and that the change is otherwise consistent with sections 1902, 1903, 1905, and 1906, current Federal regulations, and CMS policy; and

iv) Assessment of the cost of the change.

CMS will not provide Federal matching funds for activities affected by unapproved but implemented Category II changes.

Examples of Category II changes include, but are not limited to:

- Changes to the ICF/MR, hospital or nursing home level of care criteria that are applied prospectively (not to existing long term care or HCBS recipients);
- Adding any HCBS service for which the State intends to use a definition other than the core definition. (The service definition must be included with the assurances.);
- Modifying any HCBS service definition unless it is to adopt the core definition;
- Adding an "other" HCBS service that does not have a core definition. (The service definition must be included with the assurances.);
- Removing any HCBS service that is at that time being used by any participants;
- Change/modify or end RIte Share premium assistance options for otherwise eligible individuals;
- Changes to payment methodologies for Medicaid covered services including, but not limited to DRG payments to hospitals or acuity based payments to nursing homes;
- Healthy Choice Accounts Initiatives;
- Addition or elimination of optional State plan benefits;
- Changes in the amount, duration and scope of State plan benefits that do not affect the overall sufficiency of the benefit;
- Benefit changes in accordance with the DRA Benchmark flexibility; and
- Cost-Sharing Changes up to the DRA limits unless otherwise defined in the STCs or currently waived.

c) **Category III Change**: Is a change requiring modifications to the current waiver or expenditure authorities including descriptive language within those authorities and the STCs, and any other change that is not clearly described within Categories I and II. In addition, a programmatic change may be categorized as a Category III change by the State to obtain reconsideration after unsuccessfully pursuing approval of the change under Category II. The State must comply with the section 1115 demonstration public notice process as described in paragraph 14 of these STCs. The State must notify CMS in writing of Category III changes, and submit an amendment to the demonstration as described in paragraph 18: Process for Changes to the Demonstration. Category III changes shall not be implemented until after approval of the amendment by CMS.

Examples of Category III changes:

- All Eligibility Changes
- Changes in EPSDT
- Spend down level changes
- Aggregate cost-sharing changes that are not consistent with DRA cost sharing flexibility (would exceed 5 percent of family income unless, otherwise specified in these STCs);
- Benefit changes are not in accordance with DRA benchmark flexibility;
- Post-eligibility treatment of income; and
- Amendments requesting changes to the budget neutrality cap.

Process for Changes to the Demonstration. The State must submit the corresponding notification to CMS for any changes it makes to the demonstration as characterized in the Category I, II or III definitions section depending on the level of change. CMS will inform the State within 15 calendar days of any correction to the State's characterization of a change, which shall be binding and non-appealable as to the procedure for the change. The State must also have a public notice process as described below for Category II and III changes to the demonstration.

a) Process for Category I Changes: The State must notify CMS of any changes to the demonstration defined as a Category I change 30 calendar days before implementing the change. The State must also report these changes in the quarterly and annual reports for purposes of monitoring the demonstration. The State does not need CMS approval for changes to the demonstration that are Category I changes.

i) If CMS determines at any time subsequent to State implementation of a Category I change that it is not consistent with State assurances, or is contrary to Federal statutes, regulations or CMS policy then CMS reserves the right to take action to request prompt State corrective action as a condition of continued operation of the demonstration. If the State does not take appropriate action CMS reserves the right to end the demonstration per Paragraph 10 of these STCs.

b) Process for Category II Changes: The State will notify CMS of any changes to the demonstration defined as a Category II change. This notification will include assurances that the change is consistent with Federal statutes, regulations and CMS policy.

No federal funding shall be available for unapproved demonstration activities affected by a Category II change.

The State must submit the notification and assurances 45 calendar days prior to the date set by the State for implementing the change. CMS will not provide Federal matching funds for unapproved Category II changes. After receipt of the State's written notification, CMS will notify the State:

i) within 45 calendar days of receipt if the assurances supporting the change are approved; or

ii) within 45 calendar days of receipt if the assurances do not establish that the change is consistent with Federal statutes, regulations and CMS policy. As part of the notification CMS will describe the missing information, necessary corrective actions and/or additional assurances the State must pursue to make the change consistent.

iii) During days 46 and beyond CMS will be available to work with the State. During this time period the State can provide to CMS additional justification or assurance in order to clarify the appropriateness of the change.

iv) During days 46 through 75 the State upon taking appropriate action, must submit a written statement to CMS indicating how the State has addressed CMS concerns on the assurances. Within 15 calendar days of the date of the additional submission CMS will notify the State if the assurances are approved.

v) By day 90 if the assurances have not been approved by CMS, then the State may obtain reconsideration by pursuing the change again as a revised Category II change if the State has additional information or as a Category III change.

vi) If CMS determines at any time subsequent to State implementation of an approved Category II change that the assurances are no longer valid, CMS shall request prompt State corrective action as a condition of continued operation of the demonstration.

vii)After implementation FFP is available for approved changes.

c) **Process for Category III Changes**. The State must submit an amendment to the demonstration as defined in the paragraphs below.

i) All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The State must not implement changes to these elements without prior approval by CMS. Amendments to the Demonstration are not retroactive and FFP will not be available for changes to the Demonstration that have not been approved through the amendment process set forth in paragraph c) ii) below. The State will notify CMS of proposed Demonstration changes at the monthly monitoring call, as well as in the written quarterly report, to determine if a formal amendment is necessary.

ii) Requests to amend the Demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. Amendment requests must be reviewed by the Federal Review Team and must include, but are not limited to, the following:

(1) An explanation of the public process used by the State consistent with the requirements of paragraph 14 to reach a decision regarding the requested amendment;

(2) A data analysis which identifies the specific “with waiver” impact of the proposed amendment on the current budget neutrality expenditure cap. Such analysis must include current “with waiver” and “without waiver” status on both a summary and detailed level through the current extension approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the “with waiver” expenditure total as a result of the proposed amendment which isolates (by Eligibility Group) the impact of the amendment;

(3) An up-to-date SCHIP Allotment Neutrality worksheet;

(4) A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation including a conforming title XIX and/or title XXI State plan amendment if necessary; and

(5) If applicable, a description of how the evaluation design must be modified to incorporate the amendment provisions.

Meetings in Pine Bluff, AR: 7/26/15

TSG Meeting with Physicians, OT, and Minority Health Professionals

- Participants:
  - Rep. Vivian Flowers (meeting took place at Ms. Flowers' residence in Pine Bluff)
  - Rep Ken Ferguson
  - El Manuel Kelley, MD: Family Medicine
  - Lee Davis, MD: Cardiologist
  - Cedric Watts: OTR
  - John Flowers, MD: Pediatrician
  - Martha Flowers, MD: Family Medicine
  - Brian King: Executive Director Arkansas Minority Health Commission
  - Ray Hanley: CEO: AFMC

- Comments and Issues
  - Private Option has been a "boon to Arkansas, hospitals, MDs"; a "savior" for many families who only used to get care in ERs; local hospital (JRMC: Jefferson Regional Medical Center operates 371 beds/non-profit: 2014) turned a profit for the first time in years after first year of PO; has helped seriously ill people get care who used to have to spend down.
  - OT is more available due to PO; under Medicaid used to have to be connected with hospital care (except children); under PO it is a "real benefit".
  - PO has been a "blessing" for the Community Health Center; now allows us to make referrals to specialists because the person has coverage. CHCs help with enrollment
  - Due to PO entire families now have coverage: parents and kids
  - Dr. Martha Flowers brought up concern about requirement to have 300 Medicaid patients to qualify for PCMH. Other MDs agreed the number was too high and that they have been treating Medicaid folks for years. Request forthcoming to lower the threshold. Ray Hanley offered to pass this along to DHS.
  - MD suggestion that physicians be paid for patient counseling; time spent with patient that does not have a billable code; question on why this time would not be covered within the scope of the respective office visit code; the time spent on counseling may be longer than office visit code. The group felt it is very important to teach patients how to engage with their MDs and how to use the health care system the right way
  - Discussion about educating the patients to take better charge of their own health, a lot of support for this around the table and a couple of good ideas.

  One of the suggestions was that patients need to be better prepared for a visit with the physician, come prepared to engage in conversation, to ask questions, to have them written down in advance or if necessary bring a friend or relative to help.

  Discussion of print materials for patients….they stressed need that information be "educationally friendly"…and one pediatrician suggested there be separate material for children about a certain age from that given parents/adults.

  Acknowledgement around the table that a 'lot of Medicaid beneficiaries not responsible in terms of managing health care which makes educating patients with new PO or Medicaid benefits all the more important.
  - **Mental Health** is an issue: "can't get people into mental health services" with Southeast AR Behavioral Health Care; one MD had the pre-suicidal teens and could not get them into treatment in any reasonable time.
  - **MAJOR problem and frustration** with how long it takes to get an infant/child into the Dennis Developmental Center/Arkansas Children's Hospital for developmental screens; only sees 7

kids a day; takes 6 months for an appointment which is too long considering age and need for screen to determine treatment plans and benefits.

- The comment was made that 6 of 9 UAMS grads from community could not get place for residency slots and hence not yet licensed. Part of issue is believed to be the way J1Visa programs work that that provides foreign graduates from India and Pakistan unfair advantage over local UAMS grads due to difference between 6 year foreign medical school requirements and 8 year medical school requirements in America. Results in rural Arkansas medical system have impacted having UAMS grads from the delta returning home to practice. Cultural knowledge and sensitivity is an issue with grads and they are unlikely to stay in AR when their residencies are completed.
- Lack of Psychiatrists in the Delta; acknowledged a broader problem than just locally.

Community Forum Meeting on Health Care Reform (Old Sears Bldg; 6th & Poplar; Pine Bluff)

Background: The Jefferson County Legislative Delegation organized five Community Forums on Health Care reform, Medicaid Reform, Private Option, Prescription Drugs, and Care Access. This was the first meeting of the series.

- Participants
  - Rep. Vivian Flowers
  - Rep. Ken Ferguson
  - Rep. Camille Bennett
  - Lee Turner, Pine Bluff DHS Office (Panel Participant)
  - Dr. Joseph Bates (Department of Health) (Panel Participant)
  - Michael King (Arkansas Department of Minority Health Affairs (Panel Participant)
  - Richard Kellogg (The Stephen Group)
  - Approximately 35 -40 community members including several of the MDs at prior meeting with TSG; Jefferson Regional Medical Center was not represented.

- Comments and Issues
  - Each Representative was introduced and allowed 5-10 minutes to speak. Rep. Flowers discussed the importance of the ACA for Arkansas and Pine Bluff, the importance of people having health insurance coverage, many for the first time. Rep. Ferguson discussed recent progress made by the state working together on the Private Option. Rep. Bennett also discussed the importance of the Private Option to people in her district and concern about DHS only allowing 10 days turnaround on PO reauthorization. All stressed the need for working together in the Legislature to maintain progress to date.
  - Each Panel member was allowed 5-10 minutes to speak which was followed with about 75 minutes of Q&A from the audience.
    - ✓ Lee Turner from the Pine Bluff DHS Office shared that his office was the recipient Mail Center office for all 75 Arkansas counties during the PO reauthorization process, apparently without a preplanned increase in staffing capacity. Several “crates” of mail have been returned apparently unopened. He shared data that indicated that of 9,000 cases mailed for reauthorization approximately 1300 were removed from enrollment; DHS was waiting for responses from approximately 5200 cases and the remaining cases were in process.
    - ✓ Dr. Bates provided state wide statistics on chronic care disease in Arkansas and the relationship with smoking. Made a very strong case for prevention and healthy responsible behaviors.
    - ✓ Michael King shared information about the various projects the Commission was engaged, including support of healthy eating. The “Food Desert” (lack of healthy food available in poor areas of the state and within the Pine Bluff community) was discussed. Reps. Bennett and Flowers voiced strong support for addressing the Food Desert problem with individual and community efforts such as individual home

gardens and local Farmers Markets. Discussion of need for “minor modifications” to cultural food related salt and use of fatback and possible healthy alternatives.

- ✓ TSG was asked to discuss the creation of the Health Reform Task Force, the construction of the work of the RFP specific to the Private Option and Medicaid modernization, and TSG’s approach to meeting with many Arkansans representing all participants in the Arkansas Health System, monthly Task Force reports and the time line for the Final Report. Mentioned focus on high use of institutions, behavioral health services, care coordination for people with multiple conditions.
- ✓ Audience questions tended to focus on:
    - DHS PO reauthorization generated a lot of questions. People were concerned that they did not know how long they had to respond, ten days was too short for a lot of people, DHS state call center(s) “have been horrible for years” – this comment received considerable applause. Mr. Turner did a very admirable job of explaining how the process worked, apologized for the lack of capacity at times due to increase in calls due to Private Option responsibilities (sounded like his calls in Pine Bluff have gone up from 2.000 to 3,000 a week without additional assigned staff; apparently DHS has asked staff to “volunteer” additional time to assist Call Centers; need more clarification). Mr. Turner was quite clear that no one should be treated rudely on the phone and gave his personal office number/extension to the audience for people to call if they felt they were rudely treated, which, as PB supervisor, he would not tolerate.
    - Several questions to TSG focused on concerns about keeping the Private Option after the current authorization runs out. Shared the process of making recommendations to the Health Reform Task Force in Final Report due Oct. 1, 2015. One question involved the delays of Developmental Screens at the Dennis Center and could be done about it.
    - Several audience members addressed concerns about the potential loss the Private Option for themselves; their families and, from a local Pastor, their congregations.

Task Force/Public Meeting for Arkansas Medicaid
August 13, 2015
Forrest City Medical Center

Panelist:
Reginald Murdock-Rep
Deborah Ferguson-Rep
Naomi Cottoms-Tri County Rural Health Network Inc
Clifton Collier-Lee Co Coop
Kevin Decker –CEO Forrest City Medical Center
Tracy Matthews-ADH Administrator
Denita Ross-Mid South Health Systems
Becky Andrews-AFMC/MMCS
Keith Ingram-Senator
Milton Nicks-Rep
Marshall Wright-Rep
TSG Participants (John Stephen and Richard Kellogg)

Reginald Murdock wanted to hear from each panelist and below is comments:

Kevin Decker-Forrest City Medical Center:
Benefits have been positive, bad debt reduced, more patients with coverage, positive direct impact and allows more benefits to be offered to patients. Since private option started no cuts have been made. Patient are staying in area for their healthcare and not going to Memphis. It allows us to keep doors open.

Clifton Collier-Lee Co Coop:
Good for clinics, higher % of patients with coverage, more covered lives, patient can now access care, better controlled diseases such as diabetes/hypertension. Cons: patients need education they don't know anything about coverage or navigating the system and they don't come to the doctor until almost dead. Program is GOOD!

Naomi Cottoms-Tri County Rural Health Network:
We are community members helping lay members; telling members and helping with resources to help sign up with Medicaid; works in 15 counties with elderly and disabled; patients need help with enrollment and access

Tracy Matthews-ADH Administrator-St Francis Co:
Allows people to get services that couldn't get before and helped to recoup some of costs to give services. They have lots of internal changes because of private option-EHR, now billings or services, and retraining staff and much more.

Denita Ross-Mid South Health Systems:
Influx of patient now able to access care and patients please. They have always run out of funds and now can provide services to those patients. Patients don't understand Medicaid and a lot of times had pre-existing conditions or limited visits/medication slots; Education needed to beneficiaries to help mental health patients

Dr. Susan Ward Jones-East Arkansas Family Health Centers:
Before private option they had 51% uninsured now they have 32% uninsured, has allowed more specialty referrals and equipment needed. They have been able to build new site in West Memphis although there is currently no hospital in West Memphis. Blue Cross is major private option company in their area and works well with them. Difficulties: All providers don't know about private option benefits and no out of state providers. Private Option enrollees lacking knowledge on enrollment and no coverage for dental or transportation. They also don't come to the office until they get sick. Private Option has been beneficial to all of their facilities.

Deborah Ferguson-House of Representatives:
Need more educational outreach to enrollees; Budget Challenges, Patient can access more physicians

Keith Ingram-Senator:
The Stephen Group making sense of numbers, High hurdle to keep up private option, Task Force is a great idea to gather input from everyone

TSG:
Early indication in review of PO data shows when individuals sign up for private option they have high use of Emergency Room or hospital as initial claim.
Question: How are individuals in the area educated on the proper and improper use of ER? Answer: Lack of care coordination to Private Option enrollees. What is sense of urgency to motivate patients to access care through PCP?

Naomi Cottoms-Tri County Rural Health:
Wants to be set up as provider to help patients and educate patients not to go to the ER but not sure how to do that since not currently education on preventative care.

Clifton Collier-Lee Co Coop:
Patients practice crisis health care and education is important. Their clinics are trying to do intervention by having health fairs with some of the local farming groups but they don't have time to do it. We have to go to the people.

Tracy Matthews-ADH Administrator St. Francis Co:
Patients have insurance go to PCP and are referred to specialist but need care coordination. Education is the key (how to use, what it covers, disease, medications and Medicine as a whole)

Dr. Susan Ward Jones-East Arkansas Family Health:

Agrees that patients are in crisis mode but they have nontraditional hours (Saturday). They do try to educate patients but things to have to change.

Kevin Decker-Forrest City Medical Center:
Issues: lack of pcp access in Delta
Transportation and ER used as pcp in this area

Denita Ross-Mid South Health Systems:
Issues: Hospital Closed and not enough PCP's. Patients come to facility and they have to call ambulance to send patients to Forrest City Hospital

Clifton Collier-Lee Co Coop:
Issue: EHR's don't communicate

Audience Questions:

1. What do you do if pcp can't see you? What do you do for care "go to er"?
2. Dr. Banaji stated we have lack of care coordination and providers because the fee schedule is low. The supplemental payment program helped but that was stopped. Deborah Ferguson stated that governor placed the supplement payments on hold until task force can make recommendations. Dr. Banaji state pcp's closing panels because not paid enough money.
   He also asked what happens to private option patients with no longer have private option? Dr. Banaji also stated Medicaid needs to cover wellness screens for adults, increase number of office visits limits and prescriptions and require less authorizations.
   Dr. Banaji states that PCMH program is good and is a good return on investment. They have 5 in their pooling group for shared savings in this area. Physicians in early would open doors if reimbursement improves.

Note: TSG would like to thank Becky Andres from AFMC for her major contribution to these notes.