ARKANSAS DRAFT 1115 WAIVER FOR PUBLIC COMMENT

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

Arkansas is uniquely situated to serve as a laboratory of comprehensive and innovative healthcare reform that can reduce the state and federal obligations to entitlement spending. Arkansas has historically addressed state-specific needs to achieve personal responsibility and affordable health care for its citizens through initiatives such as the ARHealthNetworks partnership between the state and small businesses. The State has also initiated nationally recognized and transformative changes in the healthcare delivery system through alignment of payment incentives, health care delivery system improvements, enhanced rural health care access, initiatives to reduce waste, fraud and abuse, policies and plan structures to encourage the proper utilization of the healthcare system, and policies to advance disease prevention and health promotion.

The Health Care Independence Act calls on the Arkansas Department of Human Services to explore design options that reform the Medicaid Program so that it is a fiscally sustainable, cost-effective, personally responsible, and opportunity-driven program utilizing competitive and value-based purchasing to:
(1) Maximize the available service options;
(2) Promote accountability, personal responsibility, and transparency;
(3) Encourage and reward healthy outcomes and responsible choices; and
(4) Promote efficiencies that will deliver value to the taxpayers.

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

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

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

Section I - Program Description

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

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

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

2) Include the rationale for the Demonstration

Expanding Medicaid to nearly all individuals with incomes at or below 138% FPL, as set out in the Affordable Care Act, would present several challenges for Arkansas. First, the new adults are likely to have frequent income fluctuations that lead to changes in eligibility. In fact, studies indicate that more than 35% of adults will experience a change in eligibility within six months of their eligibility determination.[1] Without carefully crafted policy and operational interventions, these frequent changes in eligibility could lead to (1) coverage gaps during which individuals lack any health coverage, even though they are eligible for coverage under Title XIX or Advanced Premium Tax Credits (collectively, along with CHIP, "Insurance Affordability Programs" or "IAPs") and/or (2) disruptive changes in benefits, provider networks, premiums,

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

and cost-sharing as individuals transition from one IAP to another. In addition, by expanding Medicaid to include all individuals with incomes at or below 138% FPL, Arkansas would be increasing its Medicaid program by nearly 40%. The State's existing network of fee-for-service Medicaid providers is at capacity; as a result, Arkansas would be faced with the challenge of increasing providers' capacity to serve Medicaid beneficiaries to ensure adequate access to care. In short, absent the Demonstration, Arkansas's Medicaid expansion would rely on the existing Medicaid delivery system and perpetuate an inefficient, underfunded and inadequately coordinated approach to patient care. While reforms associated with Arkansas's Payment Improvement Initiative are designed to address the quality and cost of care, these reforms do not include increased payment rates needed to expand provider access for the 250,000 new adults that will enroll through the expansion.

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

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

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

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

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

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

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

Hypothesis	Evaluation Approach	Data Sources[2]
***Provider Access**:* Private Option beneficiaries will have greater provider access than newly eligible adults would otherwise have in a traditional fee-for-service system. Private Option beneficiaries will have provider access comparable to other individuals insured in the private market. Private Option beneficiaries will have more consistent access to preventive care services compared to Medicaid beneficiaries in non-Premium Assistance expansions nationally Private Option beneficiaries will have lower non-emergent use of emergency room services as compared to Medicaid beneficiaries in non-Premium Assistance expansions nationally.	• Compare traditional Medicaid and Private Option provider networks for primary and specialty care • % of individuals who reported how often they get care quickly • % of persons with hospital emergency department as usual source of care • % of individuals with a usual primary care provider • % of individuals with an ambulatory or preventive care visit in the past year • Compare denied Emergency Room claims in QHPs v. Fee- for-Service claims for non-emergency services provided in the Emergency Room	Arkansas Health Data Initiative Physician masterfile State claims databases Hospital Discharge Data Medical Expenditure Panel Survey from AHRQ (MEPS) NCQA HEDIS CAHPS CDC- Behavioral Risk Factor Surveillance System
***Churning**:* Private Option Beneficiaries will have fewer gaps in insurance coverage than Medicaid beneficiaries in non-Premium Assistance expansions nationally.	• Compare churn rates between Private Option and evidence in literature/other states experiences with traditional expansion	Enrollment data from Arkansas and other states MEPS

[2] Subject to availability.

Hypothesis	Evaluation Approach	Data Sources[2]
	• % of individuals with any period of uninsurance during the year	
***Churning**:* Private Option beneficiaries will maintain continuous access to the same health plans and/or providers at higher rates than under a traditional Medicaid expansion.	• Analysis of Marketplace subsidy-eligible and Private Option beneficiary changes in premium contributions to measure the % of Private Option/subsidy-eligible QHP enrollees that would have otherwise had to change coverage and/or providers	Marketplace/Private Option enrollment data
***Churning**:* Reduction in churning for Private Option Beneficiaries will lead to reduced administrative costs.	• Comparison of administrative costs per capita expended between traditional Medicaid and Private Option expansions	Enrollment/Administrative costs data from Arkansas and other states
***Cost**:* Over the life of the demonstration, the cost for covering Private Option beneficiaries will be comparable to what the costs would have been for covering the same expansion group in Arkansas Medicaid fee-for-service, assuming adjustments to fee-for-service reimbursement to achieve access in the fee-for-service model.	TBD	
***Quality Improvement**:* Private Option enrollees will have lower rates of potentially preventable admissions than enrollees in	Analysis of hospital discharge data	Arkansas Department of Health data Arkansas Health Data

Hypothesis	Evaluation Approach	Data Sources[2]
Arkansas's Medicaid fee for service program.		Initiative
Cost in the Arkansas Marketplace: The Private Option will drive down overall premium costs in the Marketplace and will result in better quality than would otherwise have occurred absent the Private Option.	Actuarial analysis of the impact of increased volume and competitive pricing requirements for plans offered to Private Option beneficiaries	Claims data
Quality in the Arkansas Marketplace*:* The Private Option, inclusive of its requirement to participate in the Arkansas Payment Improvement Initiative (APII), will produce improved quality over time than would otherwise have occurred absent the Private Option	Analysis of APII PCMH quality metrics for preventive care and chronic disease management	Claims and clinical information
Uncompensated Care*:* Uncompensated care costs will be driven down as a result of higher levels of provider reimbursement and fewer numbers of uninsured.	Analysis of Disproportionate Share Hospital Payments	CMS data

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

The Demonstration will operate statewide.

5) Include the proposed timeframe for the Demonstration

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

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

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

Section II – Demonstration Eligibility

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

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

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

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

Eligibility Chart

Mandatory State Plan Groups

Eligibility Group Name	Social Security and CFR Sections	Income Level

Optional State Plan Groups

Eligibility Group Name	Social Security and CFR Sections	Income Level

Expansion Populations

Eligibility Group Name	N/A	Income Level

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

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

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

There are no caps on enrollment in the Demonstration. To be eligible to participate in the Demonstration an individual must: (1) be a childless adult between 19 (including age 19) and 65 (excluding age 65) years of age, with an income at or below 138% of the federal poverty level who is not enrolled in Medicare **or** be a parent between 19 and 65 years of age, with an income between 17-138% FPL who is not enrolled in Medicare and (2) be a United States citizen or a documented, qualified alien. However, individuals determined to be medically frail/ having exceptional medical needs for which coverage through the Marketplace is determined to be impractical, overly complex, or would undermine continuity or effectiveness of care will not be eligible for the Demonstration.

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

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

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

5) To the extent that long term services and supports are furnished (either in institutions or the community), describe how the Demonstration will address post-eligibility treatment of income, if applicable. In addition, indicate whether the Demonstration will utilize spousal

impoverishment rules under section 1924, or will utilize regular post-eligibility rules under 42 CFR 435.726 (SSI State and section 1634) or under 42 CFR 435.735 (209b State)

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

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

The State proposes to institute 12-month continuous eligibility for all newly eligible adults whose income is assessed on a modified adjusted gross income basis. Applying 12-month continuous eligibility to the adult population will reduce churning.

7) If applicable, describe any eligibility changes that the state is seeking to undertake for the purposes of transitioning Medicaid or CHIP eligibility standards to the methodologies or standards applicable in 2014 (such as financial methodologies for determining eligibility based on modified adjusted gross income), or in light of other changes in 2014.

N/A

Section III – Demonstration Benefits and Cost Sharing Requirements

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

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

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

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

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

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

Benefit Package Chart

Eligibility Group	Benefit Package

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

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

Since individuals in the new adult group are required to receive coverage through the Alternative Benefit Plan ("ABP"), the State is not electing ABP-equivalent coverage for a population; instead, the State is providing the statutorily required benefit package. Arkansas's State Plan Amendment (SPA) will outline its selection of a Secretary-approved ABP.

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

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

Benefit Chart

Benefit	Description of Amount, Duration, and Scope	Reference

Benefits Not Provided

Benefit	Description of Amount, Duration, and Scope	Reference

Although the benefits in the ABP will be identical across the State Plan and the Demonstration, the appeals process relating to coverage determinations will differ. Under the Demonstration, Private Option beneficiaries will use their QHP appeals process. All QHPs must comply with federal standards governing internal insurance coverage appeals. Additionally, all QHPs must

comply with state standards governing external review of insurance coverage appeals, which in turn are approved as meeting the requirements imposed under the Affordable Care Act. Private Option beneficiaries will have access to the following two levels of appeals:

Internal Review

Each QHP must provide all enrollees with:

1) Notice identifying the claim or claims being denied;

2) A description of the reason for the denial;

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

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

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

1) Appeal to the QHP; and

2) Present evidence and testimony to support the claim.

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

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

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

3) 60 days for denials of services already delivered.

External Review

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

In addition to, and separate from the safeguards provided above, Arkansas enrollees may sue the QHP directly in state court for breach of contract.

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

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

In addition, please complete the: http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/List-of-LTSS-Benefits.pdf, and the:

http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Long-Term-Services-Benefit-Specifications-and-Provider-Qualifications.pdf.)

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

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

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

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

N/A

b) Include the minimum employer contribution amount.

N/A

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

N/A

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

N/A

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

There are no premiums under the Demonstration.

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

Arkansas will be submitting a SPA in addition to the submission of waiver requests for this Demonstration which includes eligibility limits for the newly covered population, updated cost-sharing requirements and the state's selection of an ABP. Consumer cost-sharing obligations under the Demonstration will be identical to those under the State Plan for all individuals receiving the ABP. The SPA describing the ABP will include the cost-sharing design for all individuals receiving the ABP. As will be described in the SPA, Private Option beneficiaries with incomes below 100% FPL will not have cost-sharing obligations in year one of the Demonstration; Arkansas plans to submit amendments to the waiver to implement cost-sharing for Demonstration participants with incomes from 50-100% FPL to be effective in years two and three of the Demonstration. Individuals with incomes of 100-138% FPL will be responsible for cost-sharing in amounts consistent with both the State Plan and with the cost-sharing rules applicable to individuals with comparable incomes in the Marketplace. . For individuals with income between 100-138% FPL, aggregate annual cost-sharing will be capped at 5% of 100% FPL ($604 for 2014). Providers will collect all applicable co-payments at the point of care. QHPs will monitor Private Option beneficiaries' aggregate amount of co-payments to ensure that they do not exceed the annual limit.

Arkansas will pay QHP issuers advance monthly cost-sharing reduction (CSR) payments to cover the costs associated with the reduced cost-sharing for Private Option beneficiaries. The advance monthly CSR payments will be calculated in the same way for individuals between 138 and 250% of the federal poverty level (FPL) who are eligible for federal CSRs and for individuals at or below 138% FPL enrolled in the Private Option; the only difference will be that HHS will make the federal CSR payments and Arkansas Medicaid will make the Private Option CSR payments. Under this method, issuers would, before each benefit year, estimate monthly allowed claims for essential health benefits for each standard silver plan and report this information to the Marketplace (for APTC/CSR eligible enrollees) and Arkansas Medicaid (for Private Option enrollees). For the zero cost sharing plan variation, HHS or Medicaid will multiply this estimate by 1.12 to reflect induced utilization for the higher AV and then multiply that product by the difference between zero cost sharing plan variation AV and standard silver plan AV (i.e. 0.3). The same formula is used for the high-value silver plan variant, using the same induced demand factor of 1.12 and substituting 0.24 for 0.3 for the AV factor. Issuers will receive per member per month payments during the benefit year on the basis of this formula. These payments will be subject to reconciliation at the conclusion of the benefit year based on actual CSRs that are utilized. If an issuer's actuary determines during the benefit year that the estimated advance CSR payments are significantly different than the CSR payments the issuer will be entitled to at reconciliation, the issuer may ask HHS or Arkansas Medicaid to adjust the advance payments. *See* 45 C.F.R. § 156.430; HHS Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. 15410, 15487-88, 15494-95 (Mar. 11, 2013).

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

Copayment Chart

Eligibility Group	Benefit	Copayment Amount

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

Yes. All individuals who are statutorily required to be exempt from cost sharing will be exempt from cost sharing under the Demonstration.

Section IV – Delivery System and Payment Rates for Services

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

_X_ Yes

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

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

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

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

Finally, by nearly doubling the number of individuals who will enroll in QHPs through the Marketplace, the Demonstration is expected to encourage carrier entry, expanded service

areas, and competitive pricing in the Marketplace, thereby enabling QHP carriers to better leverage economies of scale to drive pricing down even further.

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

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

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

The Demonstration will use premium assistance to purchase QHP coverage for Private Option beneficiaries. Each Private Option beneficiary will have the option to choose between at least two high-value silver plans offered in the individual market through the Marketplace. The State will pay the full cost of QHP premiums; all cost-sharing in the high-value silver plans will comply with Medicaid requirements. Additionally, the State will provide through its fee-for-service Medicaid program wrap-around benefits that are required for the ABP but not covered by qualified health plans—namely, non-emergency transportation and Early Periodic Screening Diagnosis and Treatment services for individuals participating in the Demonstration who are under age 21 (to the extent such services are not covered under the QHP). EPSDT services are relevant to the Private Option only because the Affordable Care Act defines 19 and 20 year olds as children for purposes of service benefit requirements, but adults for purposes of eligibility. If family planning services are accessed at out-of-network providers, the State's fee-for-service Medicaid program will cover those services, as required under federal Medicaid law. Because of Arkansas's Any Willing Provider Law, few, if any, such providers are expected to be outside of private insurance carrier networks.

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

Delivery System Chart

Eligibility Group	Delivery System	Authority

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

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

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

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

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

Arkansas has engaged consultants from the University of Michigan to develop a questionnaire with fifteen to twenty questions to assess whether an individual may be medically frail/have exceptional medical needs ("the Screening Tool"). The Screening Tool will be conducted online (unless an individual requests a paper copy) and will consist of yes/no answers to a short series of questions that focus on a person's use of long term supports and services and mental health resources, and presence of complex medical conditions. Responses will be entered into software that will calculate whether the person meets the medically frail/exceptional medical needs criteria. Downstream refinements to the questionnaire algorithm will occur as data accumulates and individual screening results are compared with actual utilization patterns.

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

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

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

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

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

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

The Demonstration will be statewide.

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

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

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

Through AID's plan management process, the State will assure that Private Option beneficiaries will be able to choose from at least two high-value silver plans in each service/rating area of the State. Private Option beneficiaries will be permitted to choose among all high-value silver plans offered in their geographic area, and thus all Private Option beneficiaries will have a choice of at least two qualified health plans. Additionally, AID will evaluate network adequacy, including QHP compliance with Essential Community Provider network requirements, as part of the qualified health plan certification process. As a result, Private Option beneficiaries will have access to the same networks as individuals who purchase coverage in the individual market, ensuring compliance with the requirement found in Section 1902(a)(30)(A) of the Social Security Act that Medicaid beneficiaries have access to care comparable to the access the general population in the geographic area has.

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

In sum, the Private Option helps transform and significantly expand the private insurance Marketplace, and this new Marketplace will establish competitive price points for provider reimbursement. As a result of these large shifts in payment and compensation for providers, actuaries projecting the expected costs of Arkansas's Private Option for DHS estimated that contractual rates of reimbursement for providers participating in QHPs that serve Private Option participants would be, on average, at least 5% less than existing provider contracts with commercial insurers today due to the reduced need for cost-shifting. To help ensure cost-effective use of taxpayer funds, the Private Option is employing a purchasing standard consistent with a transition to more competitive insurance markets during Plan Year 2014, and in future Plan Years expects to develop and adopt additional strategies to ensure the purchase of both competitively-priced and cost-effective plans.

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

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

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

Wrap-Around Benefits

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

Retroactive Coverage

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

Coverage Prior To QHP Enrollment

The State will provide coverage through fee-for-service Medicaid from the date an individual is determined eligible for Medicaid until the individual's enrollment in the QHP becomes effective. For individuals who select (or are auto-assigned) to a QHP between the first and fifteenth day of a month, QHP coverage will become effective as of the first day of the month following QHP selection (or auto-assignment). For individuals who select (or are auto-assigned) to a QHP between the sixteenth and last day of a month, QHP coverage will become effective no later than the first day of the second month following QHP selection (or auto-assignment).

7) If the Demonstration will provide personal care and/or long term services and supports, please indicate whether self-direction opportunities are available under the Demonstration. If yes, please describe the opportunities that will be available, and also provide additional information with respect to the person-centered services in the Demonstration and any financial management services that will be provided under the Demonstration

___ Yes
_X_ No

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

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

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

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

N/A

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

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

The AHCPII is intended to shift the delivery system in Arkansas from one that primarily rewards volume to one that rewards quality and affordability. This statewide, multi-payer initiative is designed to be practical and data-driven in its approach to promoting patient-centered, clinically appropriate care. The AHCPII comprises four related, but distinct, components. The four components, described below, will be phased-in over the next several years.

- ***Episode-Based Care Delivery: Retrospective Risk Sharing.*** For specified medical episodes, such as episodes of congestive heart failure or total joint replacement, participating payers have established comprehensive retrospective episode-based payment. Each payer designates one or more providers as the Principal Accountable Provider (PAP) for the episode of care. The PAP is responsible for the overall quality and cost effectiveness of all care included in the episode. Payers then calculate each PAP's average costs and quality across all of episodes delivered during the year. Payers compare the average costs and quality against performance thresholds specifically set by each payer. If a PAP achieves an average episode cost below a "commendable"

threshold and meets quality requirements, the PAP is eligible to receive a portion of the savings. Conversely, if a PAP's performance reflects an average cost in excess of the "acceptable" threshold, the PAP is responsible for a share of costs in excess of the threshold. PAPs not meeting quality targets are not eligible for shared savings.

- ***Episodes-Based Care Delivery: Assessment-Based Episodes***. Payment for episodes for special populations with developmental disabilities and long-term services and supports will be based on individual assessments of support and health care needs. The assessment will result in the determination of a "level of need" for each person. This level of need will be matched to a dollar amount to be paid for services. The lead provider, selected in consultation with the patient and the patient's family, would be responsible for ensuring that services across all the individuals for whom they are leads are delivered within the total budget and according to each individual's plan of care.

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

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

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

Section V – Implementation of Demonstration

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

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

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

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

Notices

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

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

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

- *Wrapped Benefits.* The notice will also include information on how beneficiaries can use the CIN number to access wrapped benefits. The notice will include specific information regarding wrapped benefits, including what services are covered directly through fee-for-

service Medicaid, what phone numbers to call or websites to visit to access wrapped services, and any cost-sharing for wrapped services.

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

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

Enrollment

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

- Individuals will submit a single application for insurance affordability programs—Medicaid, CHIP and Advanced Premium Tax Credits/Cost Sharing Reductions—electronically, via phone, by mail, or in-person.
- An eligibility determination will be made either through the FFM or the Arkansas Eligibility & Enrollment Framework (EEF).
- Once individuals have been determined eligible for coverage under Title XIX, they will enter the State's web-based portal. They will then have an opportunity to complete the Medical Frailty/Exceptional Medical Needs Screening Tool.
- Individuals who are determined eligible to receive coverage through the Private Option will enter the State's eligibility/enrollment system to shop among QHPs available to Private Option eligible individuals and to select a QHP.
- The MMIS will capture their plan selection information and will transmit the 834 enrollment transactions to the carriers.
- Carriers will issue insurance cards to Private Option enrollees.
- MMIS will pay premiums on behalf of beneficiaries directly to the carriers.
- MMIS premium payments will continue until the individual is determined to no longer be eligible; the individual selects an alternative plan during the next open enrollment period; or the individual is determined to be more effectively treated due to complexity of need through the fee-for-service Medicaid program.
- In the event that an individual is determined eligible for coverage through the Private Option, but does not select a plan, the State will auto-assign the enrollee to one of the available QHPs in the beneficiary's county.

Auto-assignment

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

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

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

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

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

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

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

Access To Wrap Around Benefits

In addition to receiving an insurance card from the applicable QHP carrier, Private Option beneficiaries will have a Medicaid client identification number (CIN) through which providers may bill Medicaid for wrap-around benefits. The notice containing the CIN will include information about which services Private Option beneficiaries may receive through fee-for-service Medicaid and how to access those services. Similar information will be provided on Arkansas Medicaid's website. Staff at the Arkansas Medicaid beneficiary call centers be trained to provide information regarding the scope of wrap-around benefits and how to access them.

Finally, Arkansas Medicaid will work closely with carriers to ensure that the carriers' call center staff is aware that Private Option beneficiaries have access to certain services outside of the QHP and that carrier's staff can direct the Private Option beneficiaries to the appropriate resources to learn more about wrap-around services.

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

No procurement action is needed.

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

Section VI – Demonstration Financing and Budget Neutrality

Please complete the Demonstration financing and budget neutrality forms, respectively, and include with the narrative discussion. The Financing Form: http://www.medicaid.gov/Medicaid- CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Interim1115-Demo-Financing-Form.pdf includes a set of standard financing questions typically raised in new section 1115 demonstrations; not all will be applicable to every demonstration application. The Budget Neutrality form and spreadsheet: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Interim1115-Budget-Neutrality-Form.pdf includes a set of questions with respect to historical expenditure data as well as projected Demonstration expenditures.

The Budget Neutrality approach recognizes that the population covered by this Demonstration, known as "Private Option beneficiaries", represents a hypothetical population for Budget Neutrality purposes. Hypothetical populations are individuals that otherwise could have been made eligible for Medicaid under: 1) section 1902(r)(2), 2) 1931(b), or 3) 1902(a)(10)(A)(i)(VIII)) (as modified by Section 2001 of the ACA), via a SPA . Because they could have been made eligible without a waiver, savings are not available. As a result, the projected enrollment and costs for the Private Option Beneficiaries are shown as identical in the without waiver and with waiver scenarios.

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

Section VII – List of Proposed Waivers and Expenditure Authorities

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

- § 1902(a)(14): To enable the State to apply the 5% cap on cost-sharing on an annual, rather than quarterly, basis.
- § 1902(a)(15): To permit the State to limit reimbursement for federally qualified health centers (FQHC) and rural health centers (RHC) to the amount the FQHC/RHC negotiated with the QHP carrier, rather than the amount established under the prospective payment system.
- § 1902(a)(17): To permit the State to provide different delivery systems for different populations of Medicaid beneficiaries. The State is not requesting a waiver of comparability with respect to benefits, eligibility, or cost-sharing.
- § 1902(a)(23): To make premium assistance for QHPs in the Marketplace mandatory for Private Option beneficiaries and to permit the State to limit beneficiaries' freedom of

choice among providers to the providers participating in the network of the Private Option beneficiary's QHP.

- § 1902(a)(54): To permit the State to limit a Private Option beneficiary to receiving coverage for drugs on the formulary of the Private Option beneficiary's QHP.
- § 1902(a)(54): To permit the State to require that requests for prior authorization for drugs be addressed within 72 hours, rather than 24 hours. A 72-hour supply of the requested medication will be provided in the event of an emergency.

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

Waiver Authority	Use for Waiver	Reason for Waiver Request
§ 1902(a)(14)	To enable the State to apply the 5% cap on cost-sharing on an annual, rather than quarterly, basis.	This waiver authority will allow the State to align with how carriers will apply the annual cost-sharing limit for commercial coverage in the individual market.
§ 1902(a)(15)	To permit the State to limit reimbursement for federally qualified health centers (FQHC) and rural health centers (RHC) to the amount the FQHC/RHC negotiated with the QHP carrier, rather than the amount established under the prospective payment system.	This waiver authority will allow the State to limit its financial exposure and align reimbursement to FQHCs/RHCs for Private Option beneficiaries with QHPs' contracted rates.
§ 1902(a)(17)	To permit the State to provide coverage through different delivery systems for different populations of Medicaid beneficiaries. Specifically, to permit the State to provide coverage for Private Option eligible Medicaid beneficiaries through QHPs offered in the individual market. The State is not requesting a waiver of comparability with respect to benefits, eligibility, or cost-sharing.	This waiver authority will allow the State to test using premium assistance to provide coverage for QHPs offered in the individual market through the Marketplace or a subset of Medicaid beneficiaries.
§ 1902(a)(23)	To make premium assistance for QHPs in the Marketplace mandatory for Private Option beneficiaries and to permit the State to limit beneficiaries' freedom of choice among providers to the providers participating in the	This waiver authority will allow the State to require that Private Option eligible beneficiaries receive coverage through the Demonstration, and not through the State Plan. This waiver authority will also allow the state to

Waiver Authority	Use for Waiver	Reason for Waiver Request
	network of the Private Option beneficiary's QHP.	align the network available to Private Option beneficiaries with the network offered to QHP enrollees who are not Medicaid beneficiaries.
§ 1902(a)(54)	To permit the State to limit a Private Option beneficiary to receiving coverage for drugs on the formulary of the Private Option beneficiary's QHP.	This waiver authority will allow the State to align the prescription drug benefit for Private Option beneficiaries with the prescription drug benefit offered to QHP enrollees who are not Medicaid beneficiaries.
§ 1902(a)(54)	To permit the State to require that requests for prior authorization for drugs be addressed within 72 hours, rather than 24 hours. A 72-hour supply of the requested medication will be provided in the event of an emergency.	This waiver authority will allow the State to align prior authorization standards for Private Option beneficiaries with standards in the commercial market.

Section VIII – Public Notice

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

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

2) Certification that the state provided public notice of the application, along with a link to the state's web site and a notice in the state's Administrative Record or newspaper of widest circulation 30 days prior to submitting the application to CMS.

3) Certification that the state convened at least 2 public hearings, of which one hearing included teleconferencing and/or web capability, 20 days prior to submitting the application to CMS, including dates and a brief description of the hearings conducted.

4) Certification that the state used an electronic mailing list or similar mechanism to notify the public. (If not an electronic mailing list, please describe the mechanism that was used.)

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

6) Summary of the state's responses to submitted comments, and whether or how the state incorporated them into the final application.

7) Certification that the state conducted tribal consultation in accordance with the consultation process outlined in the state's approved Medicaid State plan, or at least 60 days

prior to submitting this Demonstration application if the Demonstration has or would have a direct effect on Indians, tribes, on Indian health programs, or on urban Indian health organizations, including dates and method of consultation.

Section IX – Demonstration Administration

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

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