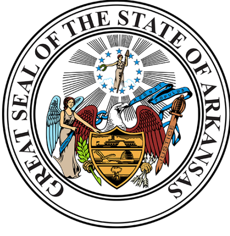

Arkansas Health and Opportunity for Me (ARHOME)

A Proposed Medicaid Section 1115 Demonstration Project

Section 1115 Demonstration Application

Summary

Arkansas Health and Opportunity For Me (ARHOME)
Section 1115 Demonstration Project Application
for Five-Year Period January 2022 — December 2026

Summary

The current "Arkansas Works" program provides coverage to 318,095 individuals (as of the end of March 2021) between the ages of 19 and 64 who are not enrolled in Medicare and who are either (1) childless adults who have household income at or below 138% of the federal poverty level (FPL) or (2) parents with income between 17% and 138% FPL. The current program expires December 31, 2021. The new ARHOME program provides eligibility to this "new adult group" determined to be eligible under Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act. The federal government funds 90% of the cost of the program and the state funds 10%. The principle feature of the current 1115 Waiver is to use Medicaid funds to purchase coverage from private health insurance plans that are Qualified Health Plans (QHPs) licensed by the Arkansas Insurance Department (AID). DHS purchases the lowest and second lowest cost silver plan for the Medicaid population and silver-level plans that fall within 10% of the lowest cost qualifying plan. DHS makes monthly capitated payments to the QHPs to cover the cost of premiums. It also makes advanced cost sharing reduction (ACSR) payments to the QHPs to reimburse providers to cover the cost of deductibles and copayments. The difference between the ACSR payments and actual cost sharing payments from the QHPs to providers is reconciled annually. Total payments to the QHPs on behalf of their members have an average value of approximately $7,000 per person per year.

Under the current 1115 waiver, the cost of care (premiums, deductibles, and copayments) for individuals at or below 100% of FPL is 100% subsidized by Medicaid; that is, there is no cost to the individual. Those with income above 100% FPL currently pay $13 per month for the premium and can be charged up to $240 annually for copayments to providers. Individuals who do not pay their premiums incur a debt to the state. DHS reconciles unpaid premiums with the QHPs and the state then recovers unpaid premium amounts (but not unpaid copayments) through the state income tax intercept system.

In March 2021, 85% of total Arkansas Works population received coverage through one of the QHPs. The remainder were covered through the FFS delivery system. When individuals are determined eligible, they begin coverage in the Arkansas Medicaid Fee-for-Service (FFS) delivery system. Individuals may self-identify as "medically frail." Approximately 21,000 individuals per month remain in FFS coverage in order to access additional benefits, particularly long-term services and supports (LTSS), that are not available through the QHPs. On a per member per month (PMPM) basis, the medically frail population is the highest cost population within the new adult group.

Another group of approximately 25,000-28,000 individuals per month are in FFS only temporarily awaiting enrollment into a QHP. Individuals may choose a QHP at time of enrollment. However, since 2020, if an individual has not picked a plan, DHS auto-assigns them into a QHP after 42 days. Approximately 80% of those who are enrolled in a QHP are auto-

assigned into a QHP. The expenditures for individuals while in FFS are not counted in the Demonstration.

The proposed 1115 Waiver continues to use QHPs to provide coverage for the majority of the new adult eligibility group. By purchasing private coverage through the QHPs, which also sell individual insurance coverage for the non-Medicaid population, the number of covered lives in the insurance pool is expanded. Over time, this helps lower overall costs for those in a stable pool. The Marketplace Average Benchmark Premiums in Arkansas are consistently lower than those in contiguous states and among the lowest silver plan premiums in the nation. Purchasing coverage in the individual Marketplace will enable Arkansas to evaluate whether QHPs add value to the state and their members compared to FFS. Private coverage combined with the proposed changes on cost sharing and reducing retroactive eligibility will also enable Arkansas to evaluate whether individuals value coverage as "insurance." Traditionally, Medicaid is considered medical assistance rather than insurance.
Section 1115 waivers must be budget neutral to the federal government. The cost to the federal government with the waiver cannot exceed its costs without the waiver projected over a five-year period. The proposed 1115 Waiver will continue to use the per capita cap methodology. The federal government will not match expenditures in excess of the cap. The State will accept risk based on per capita expenditures but not on enrollment. The budget neutrality PMPM limit in calendar year (CY) 2021 is $685.56. DHS has proposed a PMPM cap of $716.41 for CY 2022.

During the most recent session of the Arkansas General Assembly, Governor Asa Hutchinson and legislators collaborated to make further improvements to the Medicaid program for eligible adults. Under the authority of Act 530 of 2021, Arkansas proposes to continue to cover the new adult group for another five years through the Arkansas Health and Opportunity for Me ("ARHOME") program and extend and amend the Demonstration through December 31, 2026. The changes contained in the proposed 1115 waiver are further described as follows.

Background

Prior to the adoption of the new adult eligibility group, Arkansas had one of the lowest Medicaid eligibility thresholds for non-disabled, non-elderly adults in the nation and one of the highest rates of uninsurance. In 2013, a parent/caretaker relative with a dependent child and income above 17% FPL was not eligible for Medicaid.[1] A non-disabled adult less than 65 years of age without a dependent child had no pathway to Medicaid eligibility. Arkansas's 2013 decision to extend Medicaid coverage to the newly eligible adult group led to a 12.3 percentage point drop in the state's uninsured rate—from 22.5% in 2013 to 10.2% in 2016—the second largest decline in the nation.[2]
However, despite the gains in health insurance coverage, Arkansas continues to struggle to improve its rankings for measuring health outcomes. According to the most recently released *America's Health Ranking Annual Report*, Arkansas ranks 48th overall among the states. While Arkansas has improved in several categories, it has not kept pace with other states. It was ranked

[1] Under the 2021 Poverty Guidelines, 17% FPL for a household of 2 is $247 per month or $2,961 annually.
[2] https://news.gallup.com/poll/203501/kentucky-arkansas-post-largest-drops-uninsured-rates.aspx

48th in the nation in 2000, 2010, and again in 2019.[3] Expanding eligibility for health insurance coverage, of course, increases utilization of medical services. However, coverage itself has not been enough to achieve the improvements in health care status that the people of Arkansas expect.

Our health care challenges are even greater because Arkansas is a rural state. The health disparities between urban and rural areas demand national attention. Researchers describe the additional deaths experienced in rural counties, compared to urban counties, as the "rural mortality penalty." Studies have shown that the rural-urban mortality disparity continues to grow. Low-income, rural America is approximately two decades behind the health gains of urban America. Less than 20 percent of all Americans live in a rural area. Approximately 47% of enrollees in the current program live in a rural area.

Arkansas also ranks among the states with the highest poverty levels. The link between poverty and increased risk for disease and premature death has been clearly established. Since its beginning, Medicaid has been described as an anti-poverty program. At its origins, Medicaid was targeted to children, their mothers, individuals with disabilities, pregnant women, and the elderly. In other words, Medicaid was reserved for different groups of individuals who, at the time, likely could not acquire health insurance coverage on their own because they were not employed or were not considered to be employable. However, the majority of the adults in the 1115 Waiver are employable or are working, though underemployed.

In providing coverage to 19 to 64 year-olds with income below 138% of FPL, the group itself varies by age, income, and experiences. For example, in an October 2020 "snapshot" of enrollees:

- 57% of enrollees were women
- 37% of enrollees had a dependent child
- 19-24-year-olds represented the largest age cohort (20% of enrollees)
- 61-64-year-olds represented the smallest age cohort (5% of enrollees)
- Approximately 18,000 enrollees were formerly incarcerated
- Approximately 15,000 pregnant women are enrolled each year, one-third of whom have "high- risk" pregnancies

Given the correlation between poverty and poor health, reducing the incidence of poverty among the new adult eligibility group fits within the purposes and objectives of the Medicaid program. It is important to note that the state minimum wage has been increased since 2013 and is now $11 per hour (effective January 1, 2021). A single individual making minimum wage full-time full year around (2080 hours per year) would exceed the Medicaid eligibility threshold and would be eligible to receive subsidized coverage either through a Marketplace QHP available with federal tax credits or through an employer. The increase in the minimum wage, combined with the design of ARHOME, which gives the experience of insurance (including modest cost sharing), will help reduce the Medicaid "benefit cliff."

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[3] https://assets.americashealthrankings.org/app/uploads/ahr_2019annualreport.pdf p.50.

Section A: Program Description, Goals, and Objectives

In general, the state is requesting to continue the current adult eligibility group, the same benefit packages and the same service delivery systems (QHPs and FFS) as under the current program. The QHPs must meet the Essential Health Benefits (EHB) requirements under federal rules. In addition, 19 and 20-year-olds are eligible for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefits and individuals are also eligible for non-emergency transportation as a "wrap around" benefit through FFS.

Individuals in FFS receive an Alternative Benefit Package (ABP) that meets the requirements of Section 1937 for Medicaid benchmark plans. The benchmark plan is a Blue Cross Blue Shield plan that is supplemented with additional benefits.
Under the new ARHOME program, the state will add a new service delivery system for individuals in the new adult group with Serious Mental Illness (SMI) and Substance Use Disorder (SUD). Arkansas Medicaid has operated a comprehensive full-risk managed care model since March 2019 called the Provider-led Arkansas Shared Savings Entity (PASSE) program. Approximately 1,500 of the new adult group have been identified as meeting the criteria for the PASSE program and will be transitioned from FFS and enrolled into a PASSE. For comparison, approximately 50,000 Medicaid beneficiaries are presently enrolled in PASSE, including 11,000 adults with SMI/SUD. DHS has made several changes from the previous waiver authority that are described in this Section. The impact of these changes on beneficiaries is described further in Section B.

The most promising changes to improve the health status and economic independence of low-income Arkansans are those related to addressing Social Determinants of Health (SDOH). It is widely recognized that health status is closely linked to the five key areas of SDOH. These are defined in *Healthy People 2030* as:

a. Healthcare Access and Quality
b. Education Access and Quality
c. Social and Community Context
d. Economic Stability
e. Neighborhood and Built Environment

The new waiver will help address the healthcare access and economic stability SDOHs through incentives for health improvement and economic independence offered by the QHPs and through three types of community bridge organizations called Life360 HOMEs. The Life360 HOMEs are targeted to improving maternal and child health; supporting population health in rural areas by addressing social determinants of health; expanding provider capacity to give individuals with SMI/SUD more timely access to treatment; and creating opportunities for success for young adults who are veterans or former foster youths, were under the supervision of the Division of Youth Services, or were formerly incarcerated. The Life360 HOMEs will be anchored by hospitals around the state. Member participation in the QHP incentives and in the Life360 HOMEs is voluntary. ARHOME will use an expansive definition of intensive care coordination to connect their clients to community resources.

The QHPs will offer incentives to their members to reward them for participating in health improvement and economic independence initiatives. These are not additional "benefits" but

rather small rewards to encourage their members to use preventative care, achieve personal health goals, or participate in a wide variety of opportunities to participate in increasing employment, education, training, or skills development. The incentives will be subject to review by DHS.

Additional changes include:

- Increased QHP accountability for meeting annual targets for the Medicaid Core Set of Adult Health Care Quality Measures enforced by potential financial sanctions;
- Quarterly program monitoring by a joint executive-legislative oversight panel;
- Application of cost sharing up to the federally allowable amounts per service and the quarterly cost sharing cap of 5% of household income for enrollees;
- Reduction in retroactive eligibility from 90 days to 30 days from the date of application;
- Re-assignment of inactive QHP beneficiaries to FFS to be defined through future DHS rulemaking to be effective on or after January 1, 2023; and
- Removal of the March 2018 work requirement amendment. However, if federal law or regulations permit the use of a work and community engagement requirement as a condition of eligibility in the future, the State will seek to amend the Demonstration.

Goals and Objectives

The new features of ARHOME will enable Arkansas to achieve the following goals and objectives:

Goals:

- Reduce the maternal and infant mortality rates in the state;
- Promote the health, welfare, and stability of mothers and their infants after birth to reduce long-term costs;
- Reduce the additional risk for disease and premature death associated with living in a rural county;
- Strengthen financial stability of critical access hospitals and other small, rural hospitals, and enhance access to medical services in rural counties;
- Fill gaps in continuum of care for individuals with serious mental illness and substance use disorders;
- Increase the identification of Medicaid beneficiaries most at risk for poor health outcomes associated with poverty and increase their engagement in educational and employment opportunities;
- Increase active participation of beneficiaries in improving their health;
- Provide intensive care coordination for beneficiaries most at risk of long-term poor health to reduce inappropriate and preventable utilization of emergency departments and inpatient hospital settings;
- Increase the use of preventative care and health screenings; and
- Reduce the rate of growth in state and federal obligations for providing healthcare coverage to low-income adults.

Objectives:

- Improve Health Outcomes among Arkansans Especially in Maternal and Infant Health, Rural Health, Behavioral Health, and Chronic Disease.
- Provide Incentives and Supports to Assist Individuals, Especially Young Adults in Target Populations, to Move Out of Poverty

- Slow the Rate of Growth in Spending for the Program

The impact on beneficiaries for these objectives are described further in Section B.

Section B: The Proposed Health Care Delivery System and the Eligibility Requirements, Benefit Coverage and Cost Sharing

The principle feature of the current 1115 Waiver is to use Medicaid funds to purchase coverage from private health insurance plans that are Qualified Health Plans (QHPs) licensed by the Arkansas Insurance Department (AID). ARHOME will continue to purchase coverage from QHPs for the majority of program enrollees. The current benefit packages in QHPs and FFS will remain the same. The QHPs provide an Essential Benefit Plan that meets the requirements of coverage available through the federal individual insurance Marketplace.

The FFS population is comprised of two groups, the "medically frail" and the "interim group." There are approximately 21,000 medically frail and 25,000-28,000 "interim" each month. The medically frail receive additional benefits such as personal care to assist them with long-term services and supports (LTSS) needs. The interim group receives an alternative benefit package (ABP) that is based on benefit package available through Arkansas Blue Cross Blue Shield.
A new benefit package will be available to the adult eligibility group. Under ARHOME, approximately 1,500 individuals with serious mental illness (SMI) or substance use disorder (SUD) will be enrolled in the Provider-led Arkansas Shared Savings Entity (PASSE) program.

Under PASSE, individuals receive care coordination and an array of services available through Section 1915(i) of the Arkansas state plan.
The incentives offered by the QHPs are rewards for participation in health improvement initiatives or economic independence initiatives rather than "benefits." The care coordination provided through a Life360 HOME are available only through a hospital that is designated as a Life360 HOME.

The anticipated impact of each of the three waiver objectives on beneficiaries is described below.

Objective 1: Improve Health Outcomes among Arkansans Especially in Maternal and Infant Health, Rural Health, Behavioral Health, and Chronic Disease

Impact on Beneficiaries

All beneficiaries should benefit from the increased accountability for QHPs to meet health improvement targets. The health improvement incentives offered by QHPs will benefit those who choose to participate.

Women with high risk pregnancies who participate in one of the Maternal Life360 HOMEs will benefit from home visitation supports beginning during pregnancy through the first two years of the child's life. The Maternal Life360 HOME was created to address the state's low ranking in maternal and child health indicators. Medicaid finances more that 60 percent of all births in the state. To improve the state's ranking requires an emphasis on the Medicaid population. Medicaid spends approximately $140 million on costs related to poor birth outcomes. The Maternal Life360 HOMEs will be administered through hospitals throughout

the state that provide labor and deliver services. They will use a home visitation model to support the mother and child.

The Rural Life360 HOME will help address SDOH factors and will likely increase utilization of appropriate medical services, most especially for the target population, those in need of treatment due to behavioral health needs. There is a shortage of mental health professionals throughout much of the state. The screening for SDOHs and referral to local community resources provided by the Rural Life360 HOMEs will be available to all Arkansans regardless of age or eligibility for Medicaid. The Rural Life360 HOME will be administered through small hospitals in rural areas. Individuals who will be trained to become "coaches" are employed by the hospitals will go to their clients in the community and link their clients to medical services and coordinate nonmedical local community resources to address an individual's SDOH.

Success Life360 HOMEs will target young adults who are at the most risk of long-term poverty and its associated risks of poor health. In *Child Poverty and Adult Success*, research from the Urban Institute shows that, compared to their counterparts who also experienced poverty as children but were not "persistently" poor, persistently poor children are 13% less likely to complete their high school education by age 20; 29% less likely to enroll in post-secondary education by age 25; and 43% less likely to complete a four-year college degree by age 25. Persistently poor children, defined as those living half their lives or more below the poverty level, are 37% less likely to be consistently employed as young adults than their counterparts who experienced poverty as children but were not "persistently" poor. "Overall, these statistics show that children who have a long and persistent exposure to poverty are disadvantaged in their educational achievement and employment."[4]

The initial target populations for the Success Life360 HOMEs are described as follows:

- Young Adults Ages 19-27 Formerly in Foster Care

Being in foster care is an indicator for increased risk of being homeless, suffering from behavioral health conditions, being unemployed, and skipping college. "Youth who have been in foster care (YFC) are at high risk of many health problems in young adulthood including hypertension, diabetes, being a smoker, heart disease, stroke, attention deficit hyperactivity disorder, and asthma compared with peers who have not resided in foster care."[5]

- Young Adults Who Were Formerly Incarcerated or Under Supervision of the Division of Youth Services

The relationship between incarceration and long-term poverty is well established. Research at the American Action Forum also examines the relationship between incarceration and homelessness, the failure to pay child support, the inability to pay even small fines which may result in re-incarceration, and drug use. "Poverty and drug use perpetuate each other and often inhibit escape from the cycles of addiction and poverty; substance abuse may result from poverty

[4] https://www.urban.org/sites/default/files/publication/65766/2000369-Child-Poverty-and-Adult-Success.pdf
[5] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4243069/

as a person uses drugs or alcohol as a way to cope with their financial stresses, and alternatively, poverty can be the result of chronic and expensive drug abuse that leads to overwhelming debt.[6]

In March 2018, the Brookings Institution published "Work and Opportunity Before and After Incarceration" which shows the struggles of individuals before and after incarceration:

> The data show that ex-prisoners struggle in the labor market after their period of incarceration. In the first full calendar year after their release, only 55% have any reported earnings. Among those with jobs, their median annual earnings is $10,090 and only 20% earn more than $15,000 that year—an amount roughly equivalent to the earnings of a full-time worker at the federal minimum wage.
>
> The struggles of ex-prisoners after leaving prison are mirrored by their struggles prior to being incarcerated. Three years prior to incarceration, only 49% of prime-age men are employed, and, when employed, their median earnings were only $6,250. Only 13% earned more than $15,000. Tracking prisoners over time and comparing employment and earnings before and after incarceration we find surprisingly little difference in labor market outcomes like employment and earnings. This doesn't necessarily mean that incarceration has no effect on their earnings, which might otherwise have been increasing as workers age and as the economy emerged from recession or have been previously impaired by a prior conviction. Hence, we interpret this pattern less as evidence that incarceration has little effect on employment, but rather as an indication that *the challenges ex-prisoners face in the labor market start well before the period of incarceration we observe* (emphasis added).[7]

More than 40% of adults enrolled in Arkansas Works who were previously in Division of Youth Services (DYS) supervision became incarcerated as adults. Nearly 18,000 Arkansas Works enrollees are formerly incarcerated. Those ages 18-24 have the highest rates of recidivism (68% for males and 50% for females).

- Veterans Aged 19-30

Nationally, it is estimated that more than 40% of veterans enrolled in Medicaid had two or more chronic conditions; 11% have serious mental illness (SMI) and 12% have a substance use disorder (SUD). More than 10% of the Arkansas homeless population are veterans. Although working aged veterans in the labor force are less likely to be in poverty than non-veterans, the poverty rate for veterans is still significant and highest among the youngest aged veterans, veterans with a disability, female veterans, and racial and ethnic minority veterans.[8]

Individuals with SMI/SUD who will be enrolled in the PASSE program will benefit from care coordination and the additional specialized services under 1915(i) authority.

Objective 2: Provide Incentives and Supports to Assist Individuals, Especially Young Adults in Target Populations, to Move Out of Poverty

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[6] https://www.americanactionforum.org/research/incarceration-and-poverty-in-the-united-states/
[7] https://www.brookings.edu/wp-content/uploads/2018/03/es_20180314_looneyincarceration_final.pdf p.1.
[8] See: https://www.va.gov/vetdata/docs/SpecialReports/The_Veteran_Working_Poor.pdf

Impact on Beneficiaries

All QHP enrollees should benefit from the use of premium assistance and the experience of how insurance works. The use of existing QHPs who also provide individual insurance coverage through the Marketplace also enables individuals whose income increases above the Medicaid eligibility threshold to keep their same health plan with the same benefits and the same providers. The economic independence incentives offered by QHPs will benefit those who choose to participate. Incentives may include permitting the QHPs to waive cost sharing for members who participate in health improvement initiative and/or economic independence initiatives as approved by DHS.

The QHPs have an interest in maintaining member, especially young adults. They will engage their members to be "active" in their own health and economic interests.
The Success Life360 HOMEs are targeted to young adults most at risk of long-term poverty and the associated risks of disease and premature death. They will provide support to their clients to improve their life skills (education, training opportunities) and increase earnings through employment. Individuals who successfully complete a Success program will be eligible to receive assistance to maintain coverage for a period of time after their income increases above the Medicaid eligibility threshold.

Objective 3: Slow the Rate of Growth in Spending for the Program

The five policy means of slowing the rate of growth in spending and their impacts on beneficiaries are described as follows.

(1) *Temporary suspension of auto-assignment.* The principle means of slowing the rate of growth will be a new feature that permits DHS to temporarily suspend auto-assignment into the QHPs, if necessary, to meet the annual state budget targets. Savings are generated by avoiding premium payment to the QHP. While beneficiaries are in FFS, DHS will pay providers directly for the actual utilization of services.

The need for this temporary enrollment cap was triggered by the surge in enrollment due to the COVID-19 Public Health Emergency (PHE). Between March 2020 when the Public Health Emergency (PHE) began due to COVID-19 and March 2021, total Arkansas Works enrollment increased by more than 60,000, from 258,130 to 318,095, an increase of 23.2%. The surge in enrollment, or more accurately, the dramatic decrease in disenrollment, required the State to increase spending for the newly eligible adult group at a rate faster than other eligibility groups. The number of non-expansion adult populations in Medicaid increased 9.4% and the number of children in Medicaid and the Children's Health Insurance Program (CHIP) increased 6.6% in the same time period.

For further comparison, the monthly average enrollment by Calendar Years has been:

Monthly Average Enrollment

	CY 2018	CY 2019	CY 2020	March 2021
Total AR Works Beneficiaries	278,439	251,647	279,051	318,095
Enrolled as a Member of QHP	226,202	202,588	229,203	271,320
QHP Members as a Percent of AR Works Beneficiaries	81.2%	80.5%	82.1%	85.3%

For 2022, the State set the lower end of QHP enrollment at 80 percent of the total number of ARHOME beneficiaries based on historical data. As illustrated in Table 1, the insurance pool was still stable when the average QHP enrollment was as low as 202,588 so the temporary suspension should not negatively impact rates. Since CY 2017, monthly QHP enrollment typically accounted for 80 percent of total enrollment in the Arkansas Works program. In March 2021, QHP enrollment represented 85% of total enrollment.
The State may set different levels for maximum and minimum QHP enrollment in future years if the temporary suspension of the auto-assignment process, again becomes necessary, to meet its annual budget target.

Impact on Beneficiaries

This provision has no impact on beneficiaries already enrolled in a QHP. This provision has no impact on future new beneficiaries who make an active selection of a QHP. The individual's active choice of a QHP is consistent with the goals and objectives of the Demonstration in evaluating beneficiaries' value of coverage as insurance. Typically, health insurance coverage begins only after a short open enrollment period, the individual's selection of a plan and payment, with coverage beginning in the following month.
This provision will have an impact on future new beneficiaries who do not select their own plan and would have been auto-assigned will stay in FFS instead for an extended period of time.

(2) A QHP budget neutrality cap will be used to slow the rate of Medicaid expenditures.

The QHPs will know, prior to setting their rates for the following year the annual PMPM budget neutrality cap and that DHS will not pay them above the cap.

Impact on Beneficiaries

This provision has no impact on beneficiaries.

(3) Cost sharing. Although the principal purpose for the use of cost sharing is to demonstrate that individuals value their coverage and their health care professionals by participating in the cost of services, cost sharing will reduce federal and state expenditures.

More than 20 states apply some level of cost sharing to their adult Medicaid population as cost sharing is also used to mitigate against overutilization of services. As in the current Demonstration, DHS will make advanced cost sharing reduction payments (ACSR) to the QHPs and will reconcile the ACSR payments to actual payments. However, individual obligations to pay cost sharing will not be included in the reconciliations.

DHS will set premiums and cost sharing obligations by FPL bands in 20 point increments beginning at 0% FPL for all members in the QHPs to provide the same Actuarial Value (AV) across the FPL bands with a cap of 5% of income each quarter. The premiums and cost-sharing limits will be set based on the income of a single-person household at the lowest FPL level of each band. For example, individuals in 0-20% FPL band (approximately 50% of enrollees in the October 2020 "snapshot" shown in the table below) will have $0 cost sharing.

ARWorks Enrollees October 31, 2020 Snapshot

FPL Band	Unduplicated Enrollee Count	Percentage of ARWorks Enrollees
0-20%	146,248	50.63%
21-40%	17,748	6.14%
41-60%	22,100	7.65%
61-80%	25,845	8.95%
81-100%	26,883	9.31%
101-120%	23,939	8.29%
121-138%	16,490	5.71%
> 138%	9,605	3.33%
Grand Total	**288,858**	

Approximately 50,000 enrollees (14% of total enrollees at that time) would pay a premium. More than 9,600 individuals had income above 138% of FPL and should be disenrolled after the end of the PHE and should receive their subsidized coverage instead in the Marketplace or employer sponsored insurance.

The amounts for premiums and cost sharing will be updated annually to reflect changes (if any) in federal allowable amounts. DHS will post changes as they occur and go into effect but will not be required to submit amendments to the Demonstration for CMS approval or adjust budget neutrality caps.
ARHOME will require those individuals with income above 100% FPL to pay a share of the QHP premium beginning at 2.07% of a single person's household income in 2022. The premium percentage will be indexed annually to follow the Department of Treasury Applicable Percentage Table for each year.

Even with increased cost sharing obligations, ARHOME still provides significant protection against unaffordable costs. The amount of copayment by service is limited to the amounts allowable under Medicaid rules. Cost sharing will generally follow the federal allowable amounts. Exceptions are:

- No co-payments for an inpatient hospital stay, and
- No co-payments for ARHOME members who are medically frail or who are enrolled in a PASSE.

In 2022, these amounts will be:

- $4.70 for an outpatient service (physicians visits, therapies, labs, other professional services outside a hospital setting),

- $4.70 for a preferred drug,
- $9.40 for non-emergency use of the emergency department,
- $9.40 for a non-preferred drug, and
- $0 for an inpatient hospital stay ($87 is allowable under federal rules).

DHS will apply a cost sharing of $20 per day for a stay in a nursing facility. Cost sharing will not be applied for pregnancy-related services or certain preventative services such as family planning.

Individuals above 100% FPL are responsible for paying part of the premium, based on the member's FPL band. The maximum amounts for **premiums** for calendar year (CY) 2022 are provided below. The premiums will be paid on a monthly basis, so the annual amount is shown for illustration purposes only. The total cost sharing limit of 5% of income will be applied on a quarterly basis.

Maximum Premiums for CY 2022

FPL	0%-100%	101%-120%	120%+
Annual	$0	$269.28	$322.61
Monthly	$0	$22.44	$26.88
Quarterly	$0	$67.32	$80.64

Under ARHOME, a QHP cannot disenroll a member for not paying the premium. Any premiums not paid will be considered a debt to the carrier and DHS will not pay the QHP for unpaid premiums.

ARHOME members will pay copayments based on their FPL income bracket with an overall cap on premiums and copayments of 5% of household income per quarter. The maximum amounts for **copayments** in calendar year 2022 are provided below. The cap will be applied on a quarterly basis, so the annual and monthly amounts are shown for illustration purposes only.

Maximum Copayments for CY 2022

FPL	0-20%	21-40%	41-60%	61-80%	81-100%	101-120%	120%+
Annual	$0	$83.85	$163.70	$243.56	$323.42	$381.16	$456.63
Monthly	$0	$6.98	$13.64	$20.30	$26.95	$31.76	$38.05
Quarterly	$0	$20.96	$40.93	$60.89	$80.86	$95.29	$114.16

Under the ARHOME proposal, any co-payment that is not paid will be considered a debt to the provider and DHS will not pay the QHP for an individual's copayment obligation. A QHP cannot disenroll a member for not paying the copayment obligation. In conformance to Medicaid rules, a provider cannot refuse to serve an individual for nonpayment at the first point of service but is not obligated to serve the individual in the future.

Impact on Beneficiaries

The impact of cost sharing on beneficiaries will vary according to their FPL band.
DHS anticipates the provision on premiums will have an impact for individuals with income above 100% FPL for current beneficiaries and for those who will apply for the program in the

future, although the impacts between current and future beneficiaries may be different. Premiums already apply to this population so any deterrent to enrollment is already occurring. The premium amount paid by the individual in ARHOME will reflect the indexing of ACA premiums. The payment of premiums is not a condition of eligibility and therefore non-payment will not result in a loss of eligibility or loss of enrollment in a QHP. If significant numbers of beneficiaries do not pay their premiums, however, a lack of payment may impact future premium rates.

Many individuals who ultimately become enrolled in the Demonstration apply for coverage through HealthCare.gov. The website explains that premiums to pay for their coverage are designed to be "affordable," not "free." At the time of application, individuals may not know they could be become enrolled in Medicaid.
The Demonstration evaluation will consider whether the application of a premium will have an impact on the "take up" rate for new applicants. The use of a premium is critical to assess whether individuals value coverage as insurance.

The premium in the Demonstration must also be evaluated in the context of research on take-up rates. For example, the Congressional Budget Office (CBO) estimates that of the 29.8 million individuals who were uninsured in 2019, two-thirds are eligible for subsidized coverage.[9] Of the uninsured, 17% are eligible for Medicaid or CHIP. One paper estimates that of individuals with income between 138% and 200% FPL who are eligible for ACA subsidies, nearly 17 percent remain uninsured.[10] Overall, the literature on take-up rates of insurance post-ACA points to further need for research.

A recent CMS paper, "Affordability in the Marketplaces Remains an Issue for Moderate Income Americans," provides a useful comparison between the maximum amount a Demonstration enrollee will pay in premium and copayments to the average financial exposure of individuals by age and income levels.[11] According to CMS, an average 30-year-old with $20,000 in income could still face paying more than 14% of income for premium, deductible, and out-of-pocket expenses. The maximum percentage an ARHOME enrollee would pay for premium and copayments is 5% of household income. The ARHOME Demonstration therefore provides greater protection for individuals with income between 100% and 138% FPL than individuals at the same income level in states that did not expand Medicaid to the new adult group who purchase individual insurance coverage through the Marketplace.

(4) Reduction of retroactive eligibility.

ARHOME proposes to reduce the period for retroactive coverage from 90 days to 30 days prior to eligibility determination. The principle reason for this provision is again to help test future beneficiaries' understanding of fundamental insurance concepts which depend on obtaining insurance prior to the need for services. Retroactive coverage is found only in the Medicaid program. The change will have a small impact on reducing the rate of growth.

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[9] https://www.cbo.gov/system/files/2020-09/56504-Health-Insurance.pdf
[10] https://www.cbpp.org/research/health/improving-aca-subsidies-for-low-and-moderate-income-consumers-is-key-to-increasing
[11] See https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Impact-Premium-Affordability.pdf Appendix I

Impact on Beneficiaries

There is no impact on current beneficiaries and the impact on future beneficiaries is mixed. The direct impact of this provision is on providers who will not be reimbursed for medical claims beyond the 30-day retro period. However, this risk can be mitigated by the provider who can assist the individual to apply for coverage at the time they initially seek medical services. Together, hospitals and physician services account for the majority of claims that are paid retroactively. Moreover, the financial loss of unpaid claims incurred by hospitals can be reduced as bad debt.

There is an overall benefit to the program and other beneficiaries when individuals enroll prior to the need for medical services.

(5) Re-assignment of "inactive" beneficiaries to FFS.

Inactive status will reduce expenditures as payments to the QHPs for monthly premiums will be avoided.

ARHOME adds new incentives to encourage individuals enrolled in a QHP to be actively engaged in their own health and to access economic independence opportunities. An active QHP beneficiary is an individual who has taken any of one of many activities, including selection of their QHP, the use of coverage for a preventative screening or service, the appropriate use of coverage for a medical service, the completion of a health assessment, the positive response to a health improvement initiative (HII) or an economic independence initiative (EII) opportunity, and other such actions. If an individual declines such opportunities, ARHOME proposes to consider the QHP beneficiary to be "inactive" and DHS will reassign the beneficiary to FFS.

"Inactive" will be defined through future DHS rulemaking to be effective on or after January 1, 2023. Rulemaking will include the length of time a person is "inactive" as well as the steps an individual can take to return to QHP coverage which will include simply choosing a QHP. The principle reason for this provision is to enable beneficiaries to gain a better understanding of the importance of using insurance coverage appropriately.

Re-assignment shall not include failure to pay a premium or other cost sharing obligation of the individual. The reasons and criteria for re-assignment shall not include the medical condition of the individual.

Impact on Beneficiaries

This provision has no impact on individuals who are using their QHP coverage. The beneficiary who has been identified as inactive through data matching and the beneficiary's QHP will receive notification prior to re-assignment. The notification will identify the many activities and examples of activities that the individual may take to return to active status and QHP coverage which will include the selection of a QHP. The QHPs have an incentive to keep their members and help them use their coverage appropriately such as getting an annual wellness exam, getting vaccinated against COVID-19, or get a recommended screening for cancer.

Individuals who are re-assigned from a QHP to FFS will not lose coverage for medical services and will have the same Alternative Benefit Package (APB) as others in FFS awaiting enrollment in a QHP.

This policy change will have no impact in CY 2022. It may result in a small reduction in the future growth rate of expenditures as DHS will cover individuals through FFS and will therefore save the monthly premium paid to the QHP.

Section C: Estimate of the Expected Increase or Decrease in Annual Enrollment, Expenditures, and Financial Analysis of Changes

I. Enrollment

Medicaid enrollment is highly sensitive to changes in the national, state, and local economies. This is clearly illustrated in comparing enrollment in CY 2019 and CY 2020. In CY 2019, the unemployment rate in Arkansas ranged from 3.4% to 3.6%. Average monthly enrollment in the new adult group in 2019 was 251,647 and ranged from 245,198 at the low in February 2019 to the high of 259,518 beneficiaries in December 2019. The number of beneficiaries enrolled in a QHP ranged from 191,587 (February) to 210,531 (October). The average monthly enrollment in the QHPs for CY 2019 was 202,588.

At the end of March 2020, there were 258,130 beneficiaries in the new adult group, of which 211,927 were enrolled in a QHP. The Arkansas unemployment rate spiked in April 2020 at 10.0% due to the COVID pandemic. Enrollment in the new adult group between March 2020 and March 2021 grew by nearly 60,000 people. The unemployment rate in Arkansas has declined back to 4.4 percent in March 2021, but enrollment continues to grow because regular re-determinations and dis-enrollments have been suspended as a result of implementation of Section 6008 of the Families First Coronavirus Response Act (FFCRA). Monthly enrollment for the new adult group was 318,095 in March 2021, of which 271,320 were enrolled in a QHP.

The end of the PHE likely will have a significant impact on enrollment, although there are unresolved questions about timing and implementation. Enrollment in AR Works increased significantly because of the suspension of disenrollment during the COVID pandemic during 2020 and 2021. DHS believes this increase will be temporary, and enrollment will decrease at the end of the Public Health Emergency (PHE), which is assumed to continue through the end of CY 2021. QHP enrollment is expected to average 280,000 members per month early in Demonstration Year 1 (CY 2022) which will decrease to 230,000 members each month by the end of CY 2022. For Demonstration Year 2 and subsequent years, a 1.0% annual membership growth is assumed.

Projected Member Months CY 2022-2026

	CY 2022	CY 2023	CY 2024	CY 2025	CY 2026
QHP Enrollees	2,970,000	2,787,600	2,815,476	2,843,631	2,872,067

II. Expenditures

The "with waiver" projected costs for each demonstration year are calculated using CY 2019 PMPM costs as identified in the historical data projected forward at an annual PMPM trend rate of 5% and multiplied by the anticipated enrollment. The projections also include costs for the new Life360 HOMEs and apply expected cost reduction resulting from premium and cost sharing parameters.

Projected Demonstration Expenditures CY 2022-2026

	CY 2022	CY 2023	CY 2024	CY 2025	CY 2026
With Waiver	$2,101,538,321	$2,082,582,309	$2,213,409,789	$2,350,256,918	$2,493,308,145

III. Financial Analysis of Changes

It is a challenge to model financial impacts that are based on changes due to individual behaviors. Economists differ on how behavioral economics can be applied to individuals' use of health insurance and health care in general, and, particularly low-income populations' use of health insurance and health care.

As previously indicated, the greatest impact on the cost of the Demonstration will be the end of the Public Health Emergency (PHE) which will result in a significant reduction in enrollment as actions on redeterminations will be resumed.

For purposes of the policy changes comparisons, DHS set the Budget Neutrality (BN) limit at $716.41 Per Member Per Month (PMPM). DHS assumes additional costs will be added to the Demonstration.

- The annual cost of a Life360 HOME will likely range from $1 million-$1.25 million. While the Life360 HOMEs, particularly the Maternal Life360 HOMEs will likely result in savings, DHS has not counted any savings in the "with waiver" calculations. The number of Life360 HOMEs will increase over time as more hospitals elect to participate. DHS has estimated a cost of $2 PMPM in 2022 increasing to $7 PMPM cost in 2026.

DHS does not assume any level of savings will be added to the Demonstration in the following areas:

- Provisions related to addressing Social Determinants of Health including the HII and EII incentives to be offered by the QHPs.
- Reductions in spending due to improved health.
- Decreases in enrollment due to increased income.
- Decreases in enrollment due to premiums and cost sharing. As previously described, individuals cannot be disenrolled for failure to pay premiums and cost sharing. The 5% cap on member liability provides significant protection and affordability.

DHS assumes some small savings will occur in the following areas. However, no adjustments were made to the PMPM analysis as a result of these changes:

- Reduction in retroactive coverage

- Re-assignment of “inactive” QHP beneficiaries to FFS.

DHS assumes savings from increases in premiums and copayments. The PMPM savings due to member liability vary by FPL band and will range from $6.99 to $38.05. DHS will reduce its monthly capitated payments to the QHPs for cost sharing regardless of whether the QHPs and providers collect from the individuals.

Section D: The Hypothesis and Evaluation Parameters of the Demonstration

Arkansas proposes the following research hypotheses and design approaches for the ARHOME demonstration. The hypotheses below build on the current waiver by continuing to assess measures already approved in the current evaluation design and by adding hypotheses to evaluate the proposed new elements of ARHOME.

<table>
<tr><th colspan="2">Table 1: Demonstration Objectives, Hypotheses, and Evaluation Parameters</th></tr>
<tr><th>Proposed Hypotheses</th><th>Evaluation Parameters</th></tr>
<tr><td colspan="2"><u>Objective 1</u>: Improve Health Outcomes among Arkansans Especially in Maternal and Infant Health, Rural Health, Behavioral Health, and Chronic Disease.</td></tr>
<tr><td rowspan="4">A. QHP members will have equal or better continuity and access to care including primary care provider (PCP) and specialty physician networks and services compared to Medicaid FFS beneficiaries.</td><td>• Measures:
▪ Continuity of primary care provider (PCP) care
▪ Continuity of specialist care
• Data source: Administrative
• Comparison: FFS comparison groups</td></tr>
<tr><td>• Measures:
▪ PCP network adequacy
▪ PCP network accessibility
▪ Specialist network adequacy
▪ Specialist network accessibility
▪ Essential community providers (ECP) network adequacy
▪ ECP network accessibility
• Data source: Provider networks
• Comparison: FFS comparison groups</td></tr>
<tr><td>• Measures:
▪ Ease of getting necessary care
▪ Access to care and immunizations
• Data source: Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey
• Comparison: FFS comparison groups</td></tr>
<tr><td>• Measures: Access to care and immunizations
• Data source: Behavioral Risk Factor Surveillance Survey (BRFSS)
• Comparison: Adults 19-64 w/income <138%</td></tr>
</table>

Table 1: Demonstration Objectives, Hypotheses, and Evaluation Parameters	
Proposed Hypotheses	*Evaluation Parameters*
	FPL in comparison states
B. QHP members will increase the use of preventive and other primary care services compared to the baseline and will have equal or greater use compared to Medicaid FFS beneficiaries.	• Measures: ▪ Chlamydia Screening in Women ▪ Ages 21–24 (CHL-AD) ▪ Breast Cancer Screening (BCS-AD) ▪ Cervical Cancer Screening (CCSAD) ▪ Contraceptive Care – Postpartum Women Ages 21–44 (CCP-AD) ▪ Contraceptive Care – All Women Ages 21–44 (CCW-AD) ▪ Statin Therapy for Patients with Diabetes (SPD) ▪ Comprehensive Diabetes Care: Hemoglobin A1c Testing (HA1C-AD) ▪ Adults' Access to Preventive/Ambulatory Services (AAP) ▪ Asthma Medication Ratio: Ages 19–64 (AMR-AD) • Data source: Administrative • Comparison: FFS comparison groups
C. Young QHP members will have equal or better access to required Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services compared to Medicaid FFS beneficiaries.	• Measures: ▪ Adolescent Well-Care Visits (AWC) ▪ EPSDT Screening – Preventive Dental Visits ▪ EPSDT Screening – Preventive Vision • Data source: Administrative files • Comparison: Clients in treatment group 1-2 years prior to ARHOME enrollment
D. QHP members will have equal or better access to non-emergency transportation compared to Medicaid FFS beneficiaries.	• Measures: ▪ Any Utilization of Non-Emergency Transportation Services ▪ Utilization Counts of Non-Emergency Transportation Services • Data source: Administrative files • Comparison: FFS comparison group
E. QHP members will have equal or greater satisfaction in the care provided compared to Medicaid FFS beneficiaries.	• Measures: ▪ Average Rating of Health Plan ▪ Average Rating of Health Care ▪ Average Rating of Primary Care Provider (PCP) ▪ Average Rating of Specialist • Data source: CAHPS Health Plan Survey • Comparison: FFS comparison group

Table 1: Demonstration Objectives, Hypotheses, and Evaluation Parameters	
Proposed Hypotheses	*Evaluation Parameters*
F. QHP members will decrease the nonemergent use of emergency department services compared to the baseline and will lower use compared to Medicaid FFS beneficiaries.	• Measures: ▪ Non-Emergent Emergency Department (ED) Visits ▪ Emergent Emergency Department (ED) Visits • Data source: Administrative files • Comparison: FFS comparison group
G. QHP members will have a lower incidence of the use of potentially preventable emergency department services and a lower incidence of avoidable hospital admissions and re-admissions compared to the baseline and will have equal or lower use compared to Medicaid FFS beneficiaries.	• Measures: ▪ Preventable Emergency Department (ED) Visits ▪ Plan All-Cause Readmissions (PCR-AD) ▪ Diabetes Short-Term Complications Admission Rate (PQI01-AD) ▪ Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI05-AD) ▪ Health Failure Admission Rate (PQI08-AD) ▪ Asthma in Younger Adults Admission Rate (PQI15-AD) • Data source: Administrative • Comparison: FFS comparison group
H. QHP members will receive better quality of care compared to the baseline and will receive equal or better quality of care compared to Medicaid FFS beneficiaries	• Measures: ▪ Initiation and Engagement of Alcohol and Other Drug Abuse or ▪ Dependence Treatment (IET-AD) ▪ Antidepressant Medication Management (AMM-AD) ▪ Follow-Up After Hospitalization for Mental Illness (FUH-AD) ▪ Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD-AD) ▪ Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD) ▪ Concurrent Use of Opioids and Benzodiazepines (COB-AD) ▪ Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD) ▪ Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-AD) ▪ Follow-Up After Emergency Department

Table 1: Demonstration Objectives, Hypotheses, and Evaluation Parameters	
Proposed Hypotheses	*Evaluation Parameters*
	Visit for Mental Illness (FUM-AD) ▪ Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD) Persistence of Beta-blocker ▪ Treatment After a Heart Attack (PBH) ▪ Annual Monitoring for Patients on Persistent Medications (MPM-AD) ▪ Annual HIV/AIDS Viral Load Test ▪ C-Section Rate • Data source: Administrative • Comparison: FFS comparison group
I. Compared to similar ARHOME beneficiaries in rural areas without a Rural Life360 Home, ARHOME beneficiaries with SMI or SUD who receive services from a Rural Life360 Home will: 1. Have greater use of preventive and other primary care services. 2. Have greater satisfaction in the care provided. 3. Have lower non-emergent use of emergency department services. 4. Have lower use of potentially preventable emergency department services and lower incidence of preventable hospital admissions and re-admissions. 5. Receive better quality of care.	• Measures: Hypotheses B, E-H • Data sources: ▪ Administrative ▪ CAHPS Health Plan Survey • Comparison: Similar beneficiaries in counties w/o Rural Life360 Home
J. Compared to similar ARHOME beneficiaries in areas without a Maternal Life360 Home, ARHOME beneficiaries with high - risk pregnancies who receive services from a Maternal Life360 Home will: 1. Have greater use of preventive and other primary care services. Have greater satisfaction in the care provided. 2. Have lower non -emergent use	• Measures: ▪ Hypotheses B, E-H ▪ Low birth weight ▪ Very low birth weight ▪ Pre-term birth • Data sources: ▪ Administrative ▪ CAHPS Health Plan Survey ▪ Birth Certificates • Comparison: Similar beneficiaries in counties w/o Maternal Life360 Home

Table 1: Demonstration Objectives, Hypotheses, and Evaluation Parameters	
Proposed Hypotheses	*Evaluation Parameters*
of emergency department services. 3. Have lower use of potentially preventable emergency department services and lower preventable hospital admissions and re -admissions. 4. Receive better quality of care. 5. Have improved birth outcomes for their infants.	
K. Compared to similar ARHOME beneficiaries in areas without a Success Life360 Home, ARHOME beneficiaries most at risk for long - term poverty who receive services from a Success Life360 Home will: 1. Have greater use of preventive and other primary care services. 2. Have greater satisfaction in the care provided. 3. Have lower non -emergent use of emergency department services. 4. Have lower use of potentially preventable emergency department services and lower preventable hospital admissions and re -admissions. 5. Receive better quality of care.	• Measures: Hypotheses B, E-H • Data sources: ▪ Administrative ▪ CAHPS Health Plan Survey • Comparison: Similar beneficiaries in counties w/o Success Life360 Home
Objective 2: Provide Incentives and Supports to Assist Individuals, Especially Young Adults in Target Populations, to Move Out of Poverty	
A. Among QHP members with income at or below 20% FPL, the percent that increase income to above 20% FPL will increase over time.	• Measures: Percent of members at or under 20% FPL at initial measurement that are above 20% FPL at follow up measurement, among those still enrolled at the follow-up measurement • Data source: Administrative • Comparison: None
B. Among QHP members with income at or below 100% FPL, the percent that increase income to above 100% FPL will increase over time.	• Measures: Percent of members at or under 100% FPL at initial measurement that are above 100% FPL at follow up measurement, among those still enrolled at the follow-up measurement

Table 1: Demonstration Objectives, Hypotheses, and Evaluation Parameters	
Proposed Hypotheses	*Evaluation Parameters*
	• Data source: Administrative • Comparison: None

C. Among QHP members who disenroll from ARHOME, the percent that disenroll due to increased income will increase over time.	• Measures: Percent of members that disenroll due to higher income above the baseline for "churn" rates
	• Data sources:
	  ▪ Administrative
	  ▪ New Survey
	• Comparison: None

D. Arkansas residents in rural areas with a Rural Life360 HOME will access local community resources to reduce unmet health-related social needs compared to residents in rural areas without a Rural Life360 Home.	• Measures:
	  ▪ Income
	  ▪ Employment
	  ▪ Educational attainment
	  ▪ Housing security/affordability (≤30% of income)
	  ▪ Food security
	  ▪ Safety
	  ▪ Criminal justice system involvement
	  ▪ Receipt of educational, employment, or other social services
	• Data sources:
	  ▪ American Community Survey
	  ▪ Area Health Resources File (AHRF)
	  ▪ Statewide Longitudinal Data System (SLDS), county-level de-identified data
	• Comparison: Counties w/o Rural Life360 Homes

E. ARHOME beneficiaries with SMI or SUD who receive services from a Rural Life360 Home will have fewer health-related social needs and improved SDOH compared to similar ARHOME beneficiaries in rural areas without a Rural Life360 Home.	• Measures:
	  ▪ Income
	  ▪ Employment
	  ▪ Educational attainment
	  ▪ Housing security/affordability (≤30% of income)
	  ▪ Food security
	  ▪ Safety
	  ▪ Criminal justice system involvement
	  ▪ Receipt of educational, employment, or other social services
	• Data sources:
	  ▪ Administrative
	  ▪ Statewide Longitudinal Data System (SLDS)
	  ▪ New Survey
	• Comparison: Similar beneficiaries in counties

Table 1: Demonstration Objectives, Hypotheses, and Evaluation Parameters	
Proposed Hypotheses	*Evaluation Parameters*
	w/o a Rural Life360 Home
F. ARHOME beneficiaries with high-risk pregnancies who receive services from a Maternal Life360 Home will have fewer health-related social needs and improved SDOH for the mother and infant compared to similar ARHOME beneficiaries in areas without a Maternal Life360 Home.	• Measures: ▪ Income ▪ Employment ▪ Educational attainment ▪ Housing security/affordability (≤30% of income) ▪ Food security ▪ Safety ▪ Child welfare system involvement ▪ Interpersonal violence ▪ Receipt of educational, employment, or other social services • Data source: ▪ Administrative ▪ Statewide Longitudinal Data System (SLDS) ▪ New Survey • Comparison: Similar beneficiaries in counties w/o a Maternal Life360 Home
G. Young ARHOME beneficiaries most at risk of long-term poverty who receive services from a Success Life360 Home will be more successful in living in their community compared to similar ARHOME beneficiaries in areas without a Success Life360 Home.	• Measures: ▪ Income ▪ Employment ▪ Educational attainment ▪ Housing security/affordability (≤30% of income) ▪ Food security ▪ Safety ▪ Child welfare system involvement ▪ Receipt of educational, employment, or other social services • Data source: ▪ Administrative ▪ Statewide Longitudinal Data System (SLDS) ▪ New Survey • Comparison: Similar beneficiaries in counties w/o a Maternal Life360 Home
Objective 3: Slow the Rate of Growth in Spending for the Program	
A. The rate of growth in per member per month (PMPM) QHP costs will be no higher than the rate of growth in PMPM costs in Arkansas Medicaid FFS.	• Measure: Meets budget neutrality • Data source: Administrative financial data • Comparison: Medicaid FFS

<table>
<tr><th colspan="2">Table 1: Demonstration Objectives, Hypotheses, and Evaluation Parameters</th></tr>
<tr><th>Proposed Hypotheses</th><th>Evaluation Parameters</th></tr>
<tr><td>B. PMPM premiums will increase at a lower rate compared to PMPM costs in comparable states that expanded Medicaid and provide coverage through means other than premium assistance.</td><td>• Measures:
▪ Arkansas program characteristics
▪ Arkansas regional average program characteristics
▪ Contiguous states' program characteristics
▪ PMPM growth rate
• Data source: Arkansas Insurance Department
• Comparison: Non-expansion states</td></tr>
<tr><td rowspan="2">C. QHP members will demonstrate they value QHP coverage as least as much as similar individuals in other states through active engagement in the insurance process:
1. The percent of Arkansas residents age 19-64 with income from 100-120% and 121-138% will have higher take-up and retention rates than individuals at the same income levels in states that did not expand Medicaid and are eligible to receive federal tax credit subsidies to purchase coverage through the individual insurance Marketplace.</td><td>• Measure: Monthly new enrollment
• Data source: Administrative
• Comparison: Non-expansion states</td></tr>
<tr><td>• Measures: Percent of QHP members who pay their premium (1) at least one month, (2) at least 6 months, and (3) all 12 months; members using HII and EII incentives; members selecting their own QHP; members seeing a PCP on an annual basis
• Data source: Administrative
• Comparison: Non-expansion states</td></tr>
<tr><td rowspan="2">D. QHP members will demonstrate they value QHP coverage as least as much as similar individuals in other states through active engagement in the insurance process:
1. QHP members will have fewer gaps in coverage, while still eligible for Medicaid and after earnings exceed Medicaid eligibility limits, than individuals with comparable income in states that did not expand Medicaid.</td><td>• Measures:
▪ Average length of gaps in coverage
▪ Percent of clients with less than two gaps in coverage
• Data sources:
▪ Administrative
▪ Data from other states
• Comparison: Non-expansion states</td></tr>
<tr><td>• Measures:
▪ Percent of members that disenroll due to high income
▪ Percent of disenrolled members that take up private health insurance
▪ Percent of disenrolled members that take up private health insurance that maintain the same health insurance plan they had under ARHOME.</td></tr>
</table>

Table 1: Demonstration Objectives, Hypotheses, and Evaluation Parameters	
Proposed Hypotheses	*Evaluation Parameters*
	• Data source: ▪ Administrative ▪ All Payers Claims Database ▪ New Survey ▪ Data from other states • Comparison: Non-expansion states
E. ARHOME beneficiaries with a serious mental illness (SMI) or substance use disorder (SUD) who live in rural areas with a Rural Life360 Home will have lower total health care costs compared to similar ARHOME beneficiaries in rural areas without a Rural Life360 Home.	• Measure: Cost of claims/encounters per individual per year • Data source: Administrative • Comparison: Similar beneficiaries in counties w/o Rural Life360 Home
F. ARHOME beneficiaries with high-risk pregnancies who receive services from a Maternal Life360 Home will have lower total health care cost for the mother and infant through the first two years of life compared to similar ARHOME beneficiaries in areas without a Maternal Life360 Home.	• Measure: Cost of claims/encounters per individual per year • Data source: Administrative • Comparison: Similar beneficiaries in counties w/o Maternal Life360 Home

Section E: Specific Waiver and Expenditure Authorities

The proposed Demonstration requires waivers from the Medicaid State Plan. A waiver allows a state to administer its program differently from what is described in its state plan.

Waiver Authority

1. **Freedom of Choice** **Section 1902(a)(23)(A)**

   Under the State Plan, a beneficiary's freedom of choice of provider cannot be restricted. Waiver authority is needed to limit beneficiaries' freedom of choice among providers to the providers participating in the network of the beneficiary's QHP. No waiver of freedom of choice is requested for family planning providers enrolled in the Arkansas Medicaid program.

2. **Payment to Providers** **Section 1902(a)(13) and Section 1902(a)(30)**

   QHPs are not restricted to the State Plan fee schedules. Waiver authority is necessary to provide for payments to providers equal to the rates determined by the QHP or for its members.

3. **Premiums** **Section 1902(a)(14) insofar as it incorporates Sections 1916 and 1916A**

Under the State Plan, Medicaid enrollees with incomes below 150% FPL may not be charged premiums. Therefore, authority to charge premiums starting at 100% FPL is necessary. Because individuals are enrolled in insurance products, it is important to maintain the premium provisions. Such authority was approved in the 2013 and 2016 Demonstrations. The amount of premiums will be updated to reflect the indexed amounts set by the U.S. Treasury for individual contributions for coverage purchased in the individual insurance Marketplace.

4. **Copayments** **Section 1902(a)30; 447.15**

The specified copayments are within the allowable amounts under Medicaid rules. However, Medicaid rules also specify that a Medicaid payment to a provider is payment in full and that the provider is prohibited from balance billing the beneficiary. Thus, the State needs Demonstration authority to reimburse providers for cost sharing *above* what a provider would otherwise receive for a service provided to a Medicaid beneficiary.

5. **Comparability** **Section1902(a)(10)(B)**

Waiver authority is needed to permit differences in benefit packages and services: 1) Individuals who are medically frail will receive an Alternative Benefit Plan under FFS that includes additional benefits under the State Plan such as personal care; 2) Individuals that have been identified through the Independent Assessment (IA) process with a high level of BH care needs will be enrolled in a PASSE that provides comprehensive medical services including services under 1915(i) authority; 3) Individuals served through a Life360 HOME will receive intensive care coordination to address their health-related SDOHs. Care Coordination activities include screening and assessing the individual's needs for SDOH supports. When supports are needed, a person-centered support plan will be developed to set socioeconomic goals, coordinate with external medical and nonmedical providers, and to connect clients with community partners. These activities may be directed by community "coaches," peer specialists, peer counselors, or home visitors who work directly with individuals and their families to improve their skills to be physically, socially, and emotionally healthy and to thrive in their communities.

Waiver authority is needed to enable the State to impose targeted cost sharing, that is, on some Medicaid beneficiaries in the same eligibility category but not all. The Demonstration will exclude certain beneficiaries in the new adult eligibility group from cost sharing-- the Medically Frail in FFS, those enrolled in a Provider-led Arkansas Shared Savings Entity (PASSE) program, Native Americans, and will allow QHPs to exclude some beneficiaries on a limited basis from cost sharing as a reward for their participation in health improvement or economic independence initiatives.

6. **Retroactive Eligibility** **Section 1902(a)(34)**

Under the State Plan, individuals determined eligible for Medicaid can seek payment for medical services for up to 90 days prior to the date eligibility was determined. Waiver authority is necessary to limit this period of retroactive coverage. The current Demonstration limits retroactive coverage to 30 days prior to date of application. The State seeks approval to extend this provision in ARHOME. The ARHOME Demonstration seeks to acclimate individuals to having insurance but retroactive eligibility is inconsistent with the way insurance coverage works. Due to the anticipated churn as a result of the end of the Public Health Emergency, the effective date of this provision will be delayed until July 1, 2022.

7. **Prior Authorization Section 1902(a)(54) insofar as it incorporates 1927(d)(5)**
   To permit Arkansas to deviate from the State Plan to require that requests for prior authorization for drugs to be addressed within 72 hours, and for expedited review in exigent circumstances within 24 hours, rather than 24 hours for all circumstances as currently required in State policy. A 72-hour supply of requested medication will be provided in the event of an emergency.

8. **Payment for Services in an Institution for Mental Diseases (IMD) Section 1905(a)**
   Under the State Plan, federal financial participation (FFP) is generally not allowable to pay for medical services in an IMD for an adult in an IMD that exceeds 16 beds. Waiver authority is needed to claim FFP.

9. **Community Investment/Medical Loss Ratio**
   To encourage the QHPs to make community investments as defined in 45 C.F.R. 158.150 as "Activities that Improve Health Care Quality" as approved by DHS, the QHPs will be permitted to spend up to 1% of premium revenues on projects to benefit the community. Such expenditures will be counted as benefit expenditures rather than administrative costs in the calculation of a QHP's Medical Loss Ratio.

Expenditure Authority

DHS is also seeking authority to receive federal funding for costs not otherwise matchable (CNOM) by the federal government through state plan authority.
The following expenditure authorities shall enable Arkansas to implement the ARHOME Section 1115 demonstration:

1. **Premium Assistance and Cost Sharing Reduction Payments.** Expenditures for part or all of the cost of private insurance premiums in the individual market, and for payments to reduce cost share under such coverage for beneficiaries in the Demonstration.

2. **Economic Independence Initiative.** Expenditures to the extent necessary to enable Arkansas to develop a process for identifying individuals engaged in employment, education, and training activities.

3. **Community Bridge Organizations.** Expenditures for costs not otherwise matchable for all or some costs associated with creating and paying Community Bridge Organizations for the target populations identified in this application, in a manner inconsistent with requirements under Section 1902 of the Act. Although expenditures for care coordination and home visitation can be matched, the state is requesting funding for other items and activities that generally are not matchable. These include:
   - start-up costs
   - supplemental services that are related to SDOH but are nonmedical in nature
   - temporarily fund the cost health insurance for certain individuals who successfully complete a Success Life360 program and whose income increases above 138% FPL

4. **Premium Assistance.** Expenditures for costs not otherwise matchable for some costs associated with paying the individual's share of premium for coverage purchased through the individual insurance Marketplace or through an employer for a limited time for certain individuals who successfully complete a program offered under a Community Bridge Organization and whose income exceeds 138% of the Federal Poverty Level (FPL).

Requirements Not Applicable to the Expenditure Authority:

1. **Cost Effectiveness** **Section 1902(a)(4) and 42 CFR 435.1015(a)(4)**
   To the extent necessary to permit the State to offer, with respect to members through qualified health plans, premium assistance and cost sharing reduction payments that are determined to be cost effective using state developed tests of cost effectiveness that differ from otherwise permissible tests for cost effectiveness.
   Additionally, to the extent necessary to permit the State to offer Community Bridge Organization (CBO) through ARHOME services to special populations that are determined to be cost effective using state developed tests for cost effectiveness that differ from otherwise permissible tests for cost effectiveness.

Section F: Availability of Waiver Application for Public Comment

On June 13, 2021, the Arkansas Department of Human Services (DHS) released the draft application for the ARHOME Section 1115 Demonstration Project for public comment. The application for a Section 1115 Demonstration Project ("1115 Waiver") for Arkansas Health and Opportunity for Me (ARHOME) has been posted online since June 13, 2021. The Department of Human Services (DHS) held the first public hearing on June 21, 2021 and the second on June 22, 2021. The first public comment period ended on July 12, 2021. During the 30-day public comment period, DHS held two public hearings on the draft application. DHS received 23 timely comments on the draft application. On July 19, 2021, Governor Asa Hutchinson submitted the application on behalf of the people of Arkansas to the Honorable Xavier Becerra, Secretary of the U.S. Department of Health and Human Services.

On August 4, 2021, the Centers for Medicare & Medicaid Services (CMS) advised the state that a summary of the application was needed to fully satisfy the CMS Final Rule on transparency and public notice procedures for Section 1115 Demonstration Projects. Accordingly, DHS extended the public comment period an additional thirty (30) days to fully meet the Documentation of Public Notice Requirements under 42 C.F.R. Section 431.408.

The extended public comment period occurred August 15, 2021 through September 13, 2021. Public comments were submitted in writing to the Department of Human Services (DHS) Office of Rules Promulgation, 2nd floor Donaghey Plaza South Building, 7th and Main Streets, P. O. Box 1437, Slot S295, Little Rock, Arkansas 72203-1437 or at the following email address: ORP@dhs.arkansas.gov.

DHS received sixteen (16) timely comments in the second state public comment period. Fourteen (14) of the comments advocated for "an active role" for Community Mental Health Centers. Two of the sixteen (16) also expressed opposition to the reduction in the period of retroactive coverage and to the use of cost sharing. One expressed support for the waiver. Fourteen (14) of the comments advocated for "an active role" for Community Mental Health Centers. Two of the sixteen (16) also expressed opposition to the reduction in the period of retroactive coverage and to the use of copayments. One recommended that the Maternal Life360 HOME not be limited to pregnant women based on risk; the commenter also recommended clarification that individuals enrolled in a Maternal Life360 HOME not be subject to premiums

or cost sharing; that the state should adopt the state plan option to extend Medicaid coverage for pregnant women from 60 days to one year postpartum; that no premiums or cost sharing be implemented; and that there should be no work and community engagement requirement. One expressed support for the waiver. No changes were made to the application as a result of the comments. A copy of DHS's proposed waiver application is available for review at: https://humanservices.arkansas.gov/rules/arhome

Public Comments Received on Application for ARHOME Section 1115 Demonstration Project and Arkansas Department of Human Services Responses

This Section consolidates and summarizes comments in opposition to specific provisions in the applications. The comments of individuals and individual organizations are also included as attachments. DHS has carefully considered each comment. The DHS responses to the comments in the two public comment periods are described below.

As described in the application, the Medicaid provisions of the Affordable Care Act (ACA) represent a significant change from Medicaid's historical role in providing medical assistance to children, people with disabilities, the elderly and low-income parents with dependent children. In general, the ARHOME proposal is designed to test several hypotheses related to addressing the Social Determinants of Health, especially economic security, the relationship between long-term poverty and the associated increased risk of chronic diseases and premature death, and as to whether individuals will treat and value coverage as insurance and by contributing a share of the cost of coverage.

Retroactive Eligibility

Request to reinstate retroactive eligibility from proposed 30-days to Medicaid requirement of 90-days retroactive coverage. Rational for opposition to 30-day retroactive eligibility include:

- Concerns around continuity of care due to loss of coverage when beneficiary doesn't understand renewal process or does not receive notice.
- Limiting retroactive coverage to one month increases the likelihood of people on Medicaid carrying major medical debt and increase the odds that hospitals will not be compensated for care.
- Concern with no exception for increase length of retroactive coverage for Medically Frail population.
- Rural hospitals often do not have the ability to absorb these uncompensated care costs and may be put at further risk of closing.
- AR Works also included a limit on retroactive coverage, but the state has failed to evaluate its impact. There is no need to test this further and as such, it should be removed from the proposal.
- Requiring implementation of presumptive eligibility or reinstating 90-day retroactive coverage will more aptly enhance hospital discharge coordination options for patient care planning, which can reduce costly repeated hospital admissions and prevent an otherwise-eligible beneficiary to be saddled with large amounts of health care debt that could have been avoided.

DHS Response

The concept of any type of insurance, including health insurance, is to purchase coverage prior to needing coverage. Insurance is designed to protect against a future and unforeseen event. For the new adult eligibility group, the majority of whom have some level of income, including 20% who have income above 100% of the federal poverty level, encouraging them to join the insurance pool prior to incurring medical expenses is important. It is noteworthy that an individual can apply for Medicaid at any time during the year, which provides an individual with an advantage compared to employer coverage or individual coverage through the Marketplace, which limits applications to an open enrollment period.

Under the application, a hospital or another other type of provider will still have 30 days from the date of application to help an individual enroll in order to receive payment from Medicaid retroactively. The provider has the incentive to educate the individual about the importance of enrolling in Medicaid to obtain coverage and seek timely payment from DHS. Uncompensated care has been reduced dramatically since the state adopted the new adult eligibility group in 2014. Overall, providers will be substantially better off financially under ARHOME which continues to use premium assistance to purchase coverage for the majority of enrollees even with this provision.

DHS discontinued the reduction in the retroactive period in March 2019 due to litigation. The policy therefore has not been evaluated as part of AR Works. This provision will be part of the ARHOME evaluation.

Premium, Copay, Cost Share

Oppose increases in cost sharing and premiums. Rationale for opposition to co-payments for individuals at or above 21% FPL include:

- Citing research that even relatively low levels of cost-sharing for low-income populations limit the use of necessary healthcare services. Oppose copay for non-emergency use of ED cite studies decreased utilization of ED services but did not result in cost savings because of subsequent use of more intensive and expensive services.
- The Division's request to impose a $9.40 fee for each "non-emergent" or "inappropriate" use of the emergency department (ED) for those with incomes at and above 21 percent of FPL could increase costs for cancer patients. Imposing this surcharge may dissuade an individual from seeking care from an ED setting – even if the case is medically warranted. Cancer patients undergoing chemotherapy and/or radiation often have adverse drug reactions or other related health problems that require immediate care during evenings or weekends. If primary care settings and other facilities are not available, these patients are often directed to the ED.
- Increased premiums for individuals at and above 100% FPL likely to discourage eligible people from enrolling. Cite study that shows modest increases of a few dollars in premiums resulted in disenrollment, especially among healthy individuals, from the program.
- Higher out-of-pocket costs decrease the likelihood that a lower income person would seek health care including preventive screenings.
- Premiums and cost sharing can be particularly burdensome for a high utilizer of health care services, such as an individual in active cancer treatment or a recent survivor.

- Requiring enrollees to pay up to five percent of household income each quarter could result in many cancer patients and survivors delaying their treatment and could result in them forgoing their treatment or follow-up visits altogether.
- Findings from a Kaiser Family Foundation (KFF) review of the literature show abundant evidence that premiums result in more beneficiaries becoming uninsured, especially those with lower incomes, leading to greater unmet health needs.
- Individuals not enrolling due to premiums does not mean that they somehow "value" insurance less; it likely means they cannot afford the premium. "…[T]hose who become uninsured following premium increases face increased barriers to accessing care, have greater unmet health needs, and face increased financial burdens."

DHS Response

The application describes the importance of individuals sharing a nominal part of the cost of coverage at length, so it does not need to be repeated here. Individuals will determine whether they value insurance coverage as affordable and their relationship with the health care professionals through their willingness to contribute financially.

The provisions on nominal copayments, which are allowable under federal rules, still provide substantial protections for individuals which make coverage affordable. The modest increase in premiums as a percentage of income reflect what is allowable under the Affordable Care Act (ACA) for individuals with income above 100% of the federal level (FPL). Moreover, ARHOME will limit premiums and cost sharing below the levels allowed by the federal Marketplace.

Although commenters cite research on cost sharing in the Medicaid program, there is little research that is directly related to premiums and copayments on the ARHOME population. Previous studies and other state Demonstrations on premiums and cost sharing are significantly different than the ARHOME design.

The premium and copayments will be subject to rigorous evaluation, including through comparison of take-up rates. As described in the application, as many as two-thirds of the uninsured population likely qualify for subsidies through tax credits, through employers, or through Medicaid. Gaining a better understanding of what individuals consider to be affordable is therefore of national significance.

Evaluation

- Concern that proposal does not include an interim evaluation of AR Works so no evaluation data on state's experience and state is asking for comment on new program without ability for public to review current demonstration.
- We appreciate DHS considering many possible distal outcomes that may be addressable with the Life360 HOME model but are concerned about both the attributability of some the SDOH-related Domain 2 measures and the overall methodological approach. Without specific expected Life360 HOME activities, it is difficult to assess to what extent changes those measures, such as change in employment and criminal justice system involvement, could be attributable to the actions of the health care system,

leading to concerns about the possibility of spurious findings. Methodologically, there are some issues with comparability between study groups. The most problematic are measures 2A, 2B, and 2C, which propose a pre-post comparison of changes in income with no comparison group. Without a comparison and especially since income generally increases with age – and therefore, many participants will show improvement in these measures regardless of any programmatic effect – these measures are not useful. For the other Domain 2 measures, difference-indifference study design alone may not be sufficient to account for differences in the underlying characteristics of the nonrandomly assigned groups, since it will not account for unobserved or time-variant confounders.

DHS Response

Two evaluations are available to inform public comments. The impact of the use of premium assistance as the central feature of the original waiver was published in 2018. The interim evaluation of ARWorks , which also uses premium assistance, can be accessed on the DHS website Arkansas-Works-Interim-Evaluation-20210630-Final.pdf, where it has been available since June 30, 2021.

We appreciate the comments on the evaluation design of the different populations that will access services through different pathways. We agree with the importance of determining appropriate comparison groups for the evaluation and will work with CMS on the final design of the evaluation. ARHOME includes major changes, such as addressing Social Determinants of Health, accountability of Qualified Health Plans (QHPs), the use of incentives to participate in health improvement and economic independence initiatives and opportunities as well as the new Life360 HOMEs. In addition, individuals with significant behavioral health needs will be enrolled in the Provider-led Arkansas Shared Savings Entity (PASSE) program. We agree that given these different methods of intervention with the different target populations, using the most appropriate methodologies will be key to conducting the evaluation.

Member Incentive Programs

- Oppose inviting private insurers to provide cost-sharing discounts to enrollees who engage in work related activities.
- Oppose discounts for health-improvement activities which have been shown in employer-based coverage settings to disproportionately penalize people who already face systemic barriers to achieving better health.
- Concerns health equity issues associated with wellness incentive programs because of higher rates of chronic health conditions for people of color and increased incidence of food deserts and environmental hazards in low income neighborhoods could lead to wellness programs that can look more like a penalty. The state does not provide a comprehensive list of what behaviors QHPs could offer incentives for but lists annual wellness exams and attending a job fair as examples.
- The health plans would be able to reduce or eliminate beneficiaries' cost-sharing obligations if enrollees participate in the incentives and concerned that this incentive program could be used to discriminate against individuals who use tobacco and have other chronic health conditions and potentially discourage them obtaining coverage. At a minimum, the state should clarify these provisions so that we can more fully comment on their implications.

- We are concerned that giving QHPs complete autonomy to develop incentive programs will result in cherry-picking healthier beneficiaries, especially given the proposed initiative to "hold QHPs accountable" by imposing sanctions on QHPs that fail to "improve the health" of their members.

DHS Response

Many of the comments on the incentive programs reflect misunderstandings about how such incentives will be designed by the QHPs. QHPs will not have "complete autonomy," nor will they be permitted to "cherry pick" beneficiaries. Individuals either pick their own health plans or are auto-assigned by DHS. Individuals cannot be disenrolled by the health plans for not participating in incentive programs.

There is an increasing use of incentives in public and private health plans across the country. DHS has provided a few examples of health and economic incentives a QHP may employ but will allow flexibility to QHPs in choosing incentives that are most effective for their members. The QHPs will be accountable for meeting performance measures. They will be required to provide annual Quality Assessment and Performance Improvement Strategic Plans, which will be reviewed by the new Accountability Oversight Panel. Thus, there will be ample opportunities for further review of how the QHPs use incentives and for public input.

<u>Reassignment Inactive to Medicaid FFS</u>

- Concerns that reassignment could be viewed as a penalty by the beneficiary and wholesale reassignment of beneficiaries without utilization could be detrimental to this balance or risk and result in higher QHP premiums for the program.
- Question about compliance with federal "equal access" requirements particularly when there is objective evidence that access differences between the care deliver strategies exist.
- DHS proposes to move Medicaid Expansion beneficiaries to an "inactive status" based on undefined events. This change in status would result in removal from a QHP and placement in the state's fee-for-service (FFS) Medicaid program. The lack of specifics on the functioning of this "inactive status" designation impairs the public's ability to offer meaningful comment.

DHS Response

As clearly stated, this provision will not be operational in the first year of the Demonstration and will be developed with the opportunity for public comment. The term "inactive" is used to describe an individual who is not utilizing services so concerns about this provision as a penalty or noncompliance with equal access should be alleviated.

<u>Provider Refuse Service After One Non-payment</u>

Rationale for opposing ability for health care provider to refuse service to patient who was unable to make one co-payment includes:

- Concern that this could have the potential to limit access for needed services and could divert those with the inability to pay to safety net providers such as FQHCs.
- This is not allowed under federal regulations for individuals under 100% FPL (42 CFR 447.52(e)(1)). And even if it were permitted under federal law, this practice should not be allowed as it would prevent beneficiaries from receiving necessary medical services.

DHS Response

The policies outlined for copayments are consistent with federal rules for the Medicaid population. More than 20 states require copayments for the adult population in a manner that is consistent with federal rules.
FQHCs typically charged copayments for their uninsured population prior to the ACA. FQHCs and all health care providers have experienced significant financial gains due to the original and current Demonstration. Higher reimbursement rates through the QHPs will most likely result in providers continuing to serve individuals even if they do not make the nominal copayment.

Access to Care

- The ARHOME demonstration proposes for most Medicaid expansion beneficiaries to be covered by Qualified Health Plans (QHPs), while others will be covered by Medicaid fee-for-service (FFS). Accordingly, some providers will be reimbursed by QHPs and others will be reimbursed by the state through FFS. We urge you to consider the loss of meaningful access to care based on this operational structure of beneficiaries being covered by both QHPs and FFS. Additionally, as the share of AR HOME beneficiaries in FFS rises, there will be negative fiscal impacts on all providers due to the low FFS payment rates. This may cause even more access issues in FFS as providers decline to participate.
- Federal Medicaid laws require equal access to care regardless of the delivery system. Therefore, given the statements in the proposal indicating that access to care is better in QHPs than in FFS, DHS has a responsibility to improve access in FFS. This could be done by increasing FFS provider rates, working to add more primary and specialty care providers to the FFS networks, and carefully monitoring access to ensure the measures taken are effective.

DHS Response

Commenters are raising an issue with a provision that has been part of the Demonstration since the original waiver was approved by the Obama Administration. Access to care in the traditional Medicaid program is a significant issue that DHS and the legislature have been addressing. Governor Asa Hutchinson signed Executive Order 19-02, which requires DHS to review Medicaid FFS reimbursement rates at least once every four years, in an effort to ensure reimbursement rates result in robust Medicaid provider networks. Medicaid FFS rates have been increased for key medical professionals including physicians. DHS will continue to monitor the issue of access to care and act accordingly.

Community Bridge Organization/Life360 HOME

Maternal Life360 HOME:

- Maternal Life360 HOME model should build upon and support existing infrastructure as birthing hospitals establish programs. Using evidence-based programs, as required by Act 530 of 2021, is the best way to ensure outcomes and operations align with goals, such as reducing infant and maternal mortality.
- Some of the most vulnerable pregnant women may not be enrolled in a Qualified Health Plan but instead be enrolled in traditional pregnancy Medicaid or the new PASSE options outlined in the waiver. Allowing women across all expansion Medicaid options to access the Maternal Life360 HOMEs would broaden the programs̄ reach and

help achieve health outcome goals outlined in the waiver. It would also simplify eligibility from a consumer perspective

- **Maternal Life360 HOMEs can launch more effectively with centralized, experienced infrastructure that is not described in the waiver.** One concern we have is that the Strong Start program mentioned in the waiver is not on HomVEE's evidence-based list, nor is it currently in operation in Arkansas. Programs such as Healthy Families America, SafeCare, or Nurse Family Partnership may provide a better fit locally.
- Maternal Life360 programs could provide services and also refer families to existing longer-term programs in the state.
- While it is optimal to enroll women in home visiting during pregnancy, **families should be allowed to enroll in Maternal Life360 HOMEs through the end of a child's first year of life**, at minimum, to have maximum benefit on infant mortality and maternal mortality. Health and social factors that impact health outcomes may not arise until after a child is born. Additionally, pediatricians and other primary care providers may recognize "high risk" factors such as maternal depression, unsafe sleep environments, or parental drug use during well-child visits during a child's first year of life. Having the ability to refer families with infants to Maternal Life360 HOMEs from primary care is essential.

Life360 HOMEs implementation questions

- How will DHS decide which communities to fund CBOs in?
- Will a beneficiary who meets the criteria for all three Life360 Homes be served by all three at the same time? Or, will their participation be limited based on PMPM guidelines?
- How will hospitals create the infrastructure to support these programs?
- How will traditional PW coverage and the ARHOME models work together?
- Will pregnant women who are served by the Maternal Life360 Home have limits on retroactive coverage and be subject to premiums if their income is above 100% FPL?
- How will you ensure the hospitals and their local partners choose evidence-based home visiting programs, so that families get what they need, and Medicaid achieves the outcomes they are proposing in the waiver?

DHS Response

DHS appreciates the overall support for the concept of the Life360 HOMEs. The questions and comments on funding and the number of Life360 HOMEs will be worked through with CMS. The comments on the Life360 HOMEs address details that go well beyond what is typically described in a waiver application or even the operational design described in the Special Terms and Conditions of an approved waiver. Such details are being developed and will be open to future public discussion. Based on the evaluations of national and state models, DHS acknowledges the need for balance between direction to providers and flexibility for them to make adjustments over time for interventions that are most effective.

The State is currently developing rules for Life360 HOMEs and will work with communities and providers to develop rules that support the implementation of the program. These questions will be answered through this rulemaking process and will be released for public comment at a later date.

Life360 HOMEs:

- The timeline for the implementation of the Life360 HOMEs, coupled with the opaqueness of the ARHOME program development, lack of transparent quality metrics, unknown potential reimbursement, unknown delineated or collaborative responsibilities of the Life360 Home versus the qualified health plan, PASSE managed care plan, etc., makes the proposal lofty and, in the middle of hospitals' continued response to record numbers of very sick patients throughout the pandemic, premature.
- The AHA and its members stand ready to work diligently with stakeholders to flesh out Success Life360Homes, Maternity Life360 HOMEs, and Rural Life360 HOMEs as introduced in the waiver application. It will be imperative that start up costs and ongoing payments be satisfactory to not only promote the development of resources, but also to build the critical infrastructure in Arkansas communities to serve patients and communities.
- Taking on a responsibility of this size without careful planning and stakeholder involvement – especially without soliciting potential beneficiary input – would be daunting under the best circumstances. The planning and implementation timeline must be created in a realistic manner that seeks stakeholder experience and expertise and prioritizes potential beneficiaries' input. We urge DHS not to set implementation dates that are premature and look forward to learning more about specific expected activities and the provision of adequate funding and support.

DHS Response

DHS appreciates the overall support for the concept of the Rural Life360 HOMEs. The comments on the Life360 HOMEs are details that go well beyond what is typically described in a waiver application or even the operational design described in the Special Terms and Conditions of an approved waiver. Such details are being developed and will be open to future public discussion.

- Rural Life360 HOME CMHCs and CCBHC Expansion grants provide a foundation that Rural Access Hospitals do not and likely cannot provide.
- CMHCs already have capacity and capability to provide evidence-based practices for the priority population identified for **"Rural Life360 Home**" including access in every rural county and established telehealth options including connectivity to many rural jails
- CCBHC expansion grants also provide for mobile crisis services and assertive community treatment teams
- Although workforce is a concern for all behavioral health providers, CMHCs have a large cadre of licensed MH and SUD professionals with a passion for assisting the most seriously ill individuals
- CMHCs provide cost-effective treatment alternatives when compared to inpatient settings
- There seems to be a noteworthy absence of analytical data to support the proposed waiver plan to rely on rural hospitals to have appropriate experience or the willingness to develop necessary capacity to effectively provide the envisioned demonstration services
- We suggest the intensive care coordination be implemented by CMHCs
- Access to psychiatric inpatient care is a problem in Arkansas, yet the capacity of rural hospitals to fill this gap with quality care is unproven
- It is unlikely that rural hospitals would be able to provide facilities that meet safety standards

required for psychiatric inpatient care without substantial physical modifications and added expense

DHS Response

DHS acknowledges the contributions and roles of the CMHCs. At the same time, the application also describes the need to significantly expand capacity and continue to build out the continuum of care. While the rural hospital will be the "hub" for the Rural Life360 HOME, the program will coordinate services for individuals throughout the community including health care services, and services to address health related social needs. The Rural Life360 HOME will need to work closely with all community providers, including Community Mental Health Centers, to be successful. AR Department of Human Services Division of Aging, Adult, and Behavioral Health Services and Division of Medical Services will work together to ensure that funding streams are aligned to expand behavioral health service provision in rural Arkansas by enhancing existing services and improving access to needed services.

Transition to PASSE

The ARHOME proposal seeks to force Medicaid Expansion beneficiaries with mental health conditions into the Provider-led Arkansas Shared Savings Entities (PASSEs). This is problematic for several reasons. First, there are a host of problems around the Optum-based assessment used to determine entry into the PASSEs and the related determinations for people already subject to it. The assessment is not validated. The assessment has been administered in inappropriate ways for people with mental health conditions already subject to it over the last several years. Mental health providers and clients reported that assessments were often conducted quickly with vague explanations for their purpose in settings and circumstances that did not foster rapport with the person being interviewed. And, the results were not reliable, as many people with chronic mental health conditions were determined to be insufficiently severe to warrant a continuation of services, causing massive disruptions in their care. In one case, such a disruption directly caused the psychiatric hospitalization of one of Legal Aid's clients whose life had previously been stable. Second, the PASSE networks do [not] match existing Medicaid Expansion networks. As a result, placement in a PASSE for mental health conditions also means an upheaval in an individual's treatment for everything else. As described above in Section VI, changes in a person's covered providers and medications brings great disruptions and instability. For people who have serious mental health conditions, such a disruption could be even more difficult to navigate. Moreover, some beneficiaries report having appointments in distant locales or having to wait for months, signs that the PASSE networks are not adequate. Again, such problems may be even more difficult for and disruptive to people with severe mental illness. Third, this is unnecessary. PASSEs do not offer any specialized services to people with severe mental health conditions that cannot also be offered through the existing Medicaid Expansions framework. It would be both less disruptive to beneficiaries and less administratively complex to do so.

AHA is concerned about the intention to proactively evaluate the general expansion population for reassignment to the PASSE managed care model. Enrollment into a PASSE is subject to an assessment developed by the state of Minnesota, which has not been scientifically established as valid or reliable. While DHS reports having experienced relatively few appeals, that is not sufficient to show that the assessment is valid or

appropriate to use with the population that it is currently being used with, let alone a larger population of Medicaid expansion participants more generally. Further, the draft application does not include information on the specific criteria that would be used to remove participants from QHP coverage and reassign them to a PASSE. We have significant concerns that DHS's plans to reassign individuals to PASSE managed care plans could affect many more individuals than they project, leading to problems with continuity of care and negative impact on patients. We request that reassignment to the PASSE model require meeting higher acuity "Tier 2 or 3"-type criteria measured with an instrument that has been scientifically validated and whose scientific reliability has been established, and that these PASSE eligibility criteria be explicitly specified in the application.

DHS Response

DHS acknowledges the transition from fee-for-service to capitation under the PASSE program has been a challenge for some providers. DHS and its Independent Assessment vendor, Optum, continue to work with providers and beneficiaries to ensure timely and accurate assessments are conducted. Nearly 150,000 Behavioral Health Independent Assessments have been completed since the IA program began. The PASSE program currently serves more than 11,600 adults with serious mental illness out of a total PASSE enrollment of more than 46,000 individuals. DHS estimates that the number of individuals to be transitioned into a PASSE will represent less than one percent of total beneficiaries in the new adult eligibility group.

The individuals identified in the waiver application that will be transitioned into a PASSE are first identified as Medically Frail and receive services through FFS. The PASSE program offers a number of services, including Home and Community Based Services (HCBS) and care coordination, for which they are not currently eligible. Newly identified individuals would first meet eligibility for the Medically Frail category before being referred by their Behavioral Health service provider for a Behavioral Health Independent Assessment and potential enrollment in the PASSE program. The Medically Frail group and the PASSE group are exempt from cost sharing.

Communication to Beneficiaries

- Urge DHS to handle required member notices carefully to minimize the risk of participants being inappropriately reassigned to fee-for-service or disenrolled despite continued eligibility. Specifically ask that DHS allow multiple potential pathways (e.g., in person, by telephone, by accessible 24/7 online option, and by mail) to communicate with beneficiaries and to receive back any needed responses; adopt a reasonable compatibility threshold for inconsistencies between self-attested income and external data sources; accept a reasonable explanation for any inconsistencies rather than requiring paper documentation; proactively identify changes of address using external data sources (e.g., U.S. Postal Service's National Change of Address system, QHP enrollee records, SNAP/TANF enrollment records, and records from other state agencies); follow up on returned mail and attempt other contact before disenrollment; and allow participants to have at least 30 days to respond to notices or requests for information, consistent with federal rules. These reasonable measures will help ensure that participants do not wrongly lose essential health coverage. In addition, notices and communications from qualified health plans and PASSE managed care plans should meet and exceed the standards of traditional Medicaid communications.

DHS Response

We agree with comments to strengthen and enhance communications with beneficiaries. We believe beneficiary notices, change of address, enrollment records, and other such operational matters are being greatly enhanced as the new Arkansas Integrated Eligibility System (ARIES) is being completed statewide.

Auto Enrollment and Cap on Qualified Health Plan Enrollment

- Limiting auto-enrollment means a beneficiary's transition to QHP coverage will be delayed indefinitely. This adds administrative complexity to the program. A new beneficiary may qualify for Medicaid Expansion, not enroll in a QHP, start receiving care and prescriptions through FFS, later move to a QHP, and then find that doctors or prescriptions covered under FFS are not covered through the QHP.
- Oppose capping monthly enrollment by setting a monthly maximum enrollment cap at no more than 80% of total expansion enrollment and suspending auto-assignment into QHPs for beneficiaries who do not choose a QHP and instead enroll those individuals in fee-for-service (FFS). Urges the state to explain how this proposal will not limit patients' access to care. At a minimum, the state should ensure that capping QHP enrollment and reassignment will not have an adverse effect on access to care for beneficiaries. We request that you provide additional data on this proposal including the race, ethnicity, language and gender of the beneficiaries that will most likely be impacted by this change and moved to FFS.

DHS Response

This provision is a financial "safety valve" which is temporary and will be used only if necessary, to remain with the state budget target. This provision does not affect the individual's right to select his or her own QHP. The suspension of auto-assignment from FFS to a QHP will be administratively simple. It involves only delaying action that DHS takes to make assignment for a short period of time. The potential for disruption in care during the transition from FFS to a QHP that was described in the comment, is a possibility under the program as it exists today as individuals are first enrolled in FFS then moved into a QHP. To ensure a healthy insurance pool, the resumption of auto-assignment after a period of suspension must be random, therefore it would not be based on race, gender, age, utilization of services or any other characteristic during the FFS period.

SUD Coverage

- We appreciate the Institution for Mental Disease (IMD) Coverage and believe it will improve access for individuals with Substance Use Disorders that require residential care. We ask that funding for the SUD population include payment for the full continuum of SUD services (e.g. detoxification services, residential treatment and specialized women's services).

DHS Response

We agree such funding for the full continuum of care is important to successful treatment and recovery. Access to the full continuum of care is a challenge in both the private and public sectors. Approval of ARHOME will enhance greater access.

Active Role for Arkansas' Community Mental Health Centers

DHS Response

DHS would like to emphasize that under the ARHOME proposal and the Rural Life360 HOMEs in particular, the Community Mental Health Centers (CMHC) will continue to provide direct patient care services to Medicaid beneficiaries. Clients of Life360 HOMEs will continue to receive their medical services through their local medical professionals, including CMHCs. The CMHCs will bill for the Qualified Health Plans (QHPs) or Medicaid Fee-for-Service (FFS) or a Provider-led Arkansas Shared Savings Entity (PASSE) for their services. The CMHCs can also open additional acute crisis units if they choose to do so. The new role taken on by the Rural Life360 HOME is to provide intensive care coordination through "coaches" to ensure their clients will receive medical services through their local medical professionals as well as to address Social Determinants of Health (SDOH). We recognize that some CMHCs are also adopting new models of care. DHS welcomes exploring how each Community Mental Health Center local programming can be used to work with the Life360 HOME initiative. We encourage the CMHCs to work with the Rural Life360 HOMEs, especially to build capacity throughout the state as Arkansas faces a shortage of mental health professionals. We anticipate that the continued use of telemedicine will provide a vital connection of patients to mental health professionals.

Do Not Limit eligibility for the Maternal Life360 HOME model based on risk

DHS Response

DHS would like to emphasize the role of physicians to refer pregnant women to the Maternal Life360 HOME; the importance of targeting scarce resources to those most at risk for poor health outcomes for the mother and child; the importance of targeting scarce resources to those families most at risk for the child's first two years of life; and that CMS also emphasized targeting home visitation to pregnant women based on risk in the projects it funded to improve maternal and child health. DHS is open to further expansion of Maternal Life360 HOMEs in the future based on experience and capacity.

Clarify that individuals enrolled in the Maternal Life360 HOME model will not be subject to premiums or other forms of cost sharing

DHS Response

We note that Medicaid rules already prohibit cost sharing for pregnancy-related services and DHS did not request those rules to be waived. DHS agrees with the comment and will make that clarification.

Adopt the new state plan option to extend Medicaid coverage for pregnant women from 60 days to one year postpartum

DHS Response

Women maintain coverage by being shifted from the pregnant woman eligibility category to the new adult group eligibility category. Therefore, we do not believe this change is necessary to continue coverage after the postpartum period. Keeping a woman in regular Medicaid would not improve coverage for the woman.

Do not seek to implement premiums and other forms of cost sharing

DHS Response

As described in the application, DHS believes premiums and cost sharing are important to the concept of insurance and is an important element of reducing the Medicaid "benefit cliff" which will benefit individuals in the long term. Premiums and copayments for individuals with income above 100% FPL has been a part of waiver for several years. The nominal copayment amounts (limited to $4.70 in most cases; $9.40 for non-emergency use of a hospital emergency department or for a non-preferred drug) and the overall 5% cap of household income are in alignment with the federal rules for Medicaid.

Do not seek to provide only 30 days of retroactive coverage rather than 90

DHS Response

A key element of the waiver is to evaluate whether individuals view coverage as insurance. It is important for individuals to enroll prospectively. As described in the application, retroactive coverage is not found in other forms of health insurance. Individuals are able to apply for Medicaid at anytime in a year which provides greater access to coverage than in Medicare, employer coverage, or the individual market.

Do not seek to implement work and community engagement requirements in the future

DHS Response

The waiver application does not include a work requirement. The waiver itself would have to be amended to include a work and community engagement requirement in the future.