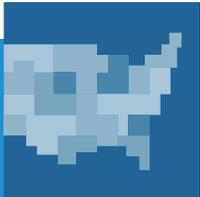


ISSUE BRIEF

# Medicaid Expansion through Premium Assistance:



July 2013

## Key Issues for Beneficiaries in Arkansas' Section 1115 Demonstration Waiver Proposal

### Executive Summary

As states weigh whether to expand their Medicaid programs as provided by the Affordable Care Act (ACA), a few states have considered using Medicaid funds as premium assistance to purchase Marketplace (formerly called Exchange) coverage for newly eligible Medicaid beneficiaries, as an alternative to providing coverage through their traditional Medicaid programs. The Department of Health and Human Services has indicated that it will consider approving a limited number of such demonstrations. To date, Arkansas is the first of two states to enact legislation authorizing the expansion of its Medicaid program through premium assistance, and on June 24, 2013, Arkansas released for public comment its draft § 1115 demonstration waiver application.

CMS recognizes that using premium assistance for Marketplace Qualified Health Plans (QHPs) could enable families to enroll in the same health plan when some family members are eligible for Medicaid or CHIP and others are eligible for Marketplace subsidies. In addition, premium assistance could promote continuity of coverage by potentially reducing the extent to which beneficiaries with incomes at the upper end of the Medicaid eligibility scale move back and forth between Medicaid and Marketplace coverage due to income fluctuations. However, CMS also has confirmed that individuals in state premium assistance programs continue to be entitled to all of the benefits and cost-sharing protections guaranteed to Medicaid beneficiaries under federal law. This means that states implementing premium assistance programs must provide wrap-around coverage to fill in any gaps in the benefits package between the private plan and Medicaid and must pay beneficiary cost-sharing in the private plan to the extent that it exceeds Medicaid cost-sharing limits. The cost of covering Medicaid beneficiaries through premium assistance programs also must be comparable to the cost of covering those beneficiaries directly through the state's traditional Medicaid program.

Arkansas proposes using Medicaid funds to pay the premiums for Marketplace QHPs to cover an estimated 225,000 beneficiaries newly eligible for Medicaid under the ACA's expansion. Arkansas would require newly eligible beneficiaries to participate in its premium assistance demonstration to receive Medicaid benefits. Beneficiaries would have a choice of at least two Marketplace QHPs and would be automatically assigned to a plan if they did not

select one. The state would provide wrap-around benefits on a fee-for-service (FFS) basis and pay beneficiaries' cost-sharing in the QHP to the extent that it exceeds Medicaid limits. People who are medically frail, people with exceptional medical needs, and people who are dually eligible for Medicaid and Medicare would be exempt from the demonstration and instead receive benefits through Arkansas' existing FFS delivery system. This issue brief provides background about Medicaid premium assistance in the individual health insurance market, summarizes major components of Arkansas' proposal, and considers key issues affecting beneficiaries.

## Introduction

As January 2014 approaches, states are determining whether to implement the Affordable Care Act's (ACA's) Medicaid expansion.<sup>1</sup> The ACA increases access to health insurance beginning in January 2014 in part by expanding Medicaid eligibility to 138% of the federal poverty level (FPL, \$15,856 per year for an individual in 2013). The ACA also creates new Affordable Insurance Marketplaces (formerly called Exchanges) with advance payment of premium tax credits to help purchase coverage for people with incomes between 100-400% FPL and cost-sharing reductions for people with incomes between 100-250% FPL. As states weigh whether to expand their Medicaid programs, a few states have considered using Medicaid funds as premium assistance to purchase Marketplace coverage for newly eligible Medicaid beneficiaries, as an alternative to providing coverage through their traditional Medicaid programs. The Department of Health and Human Services (HHS) has indicated that it "will consider approving a limited number of premium assistance demonstrations" to be effective during 2014 to 2016.<sup>2</sup>

To date, Arkansas and Iowa have enacted legislation authorizing the expansion of their Medicaid programs by using premium assistance to purchase Marketplace coverage for some or all newly eligible beneficiaries.<sup>3</sup> On June 24, 2013, Arkansas released for public comment its draft § 1115 demonstration waiver application seeking to implement the Medicaid expansion through premium assistance.<sup>4</sup> This issue brief provides background about Medicaid premium assistance in the individual health insurance market, summarizes major components of Arkansas' proposal, and considers key issues that will affect beneficiaries.

### **ARKANSAS' PROPOSED MEDICAID EXPANSION PREMIUM ASSISTANCE DEMONSTRATION**

States typically would implement the ACA's Medicaid expansion by submitting a state plan amendment to cover the newly eligible adult group (non-elderly non-pregnant adults without dependent children up to 138% FPL who are otherwise ineligible for Medicaid) and providing Medicaid to those beneficiaries through their existing delivery system, whether fee-for-service (FFS) or managed care. The ACA provides for two differences between the newly eligible adult group and other populations covered by the state's Medicaid program: first, the federal government will cover 100% of the states' costs of the coverage expansion from 2014 through 2016, gradually decreasing to 90% in 2020 and thereafter.<sup>5</sup> Second, states must provide Alternative Benefit Plan (ABP, formerly called benchmark) coverage to newly eligible adults in the expansion group. While the traditional Medicaid state plan benefits package includes certain mandatory federal benefits and additional optional benefits that the state elects to provide, an ABP is a set of covered services either based on one of three commercial insurance plans or determined appropriate by the HHS Secretary. (Certain groups cannot be required to enroll in ABP coverage and instead must have access to the

full Medicaid state plan benefits package.)<sup>6</sup> States may choose to offer an ABP that includes the same services as their state plan benefits package. However, ABPs may not necessarily include all of the benefits offered in the state plan benefits package, provided that the ten categories of essential health benefits required by the ACA are covered.

By contrast, Arkansas proposes using Medicaid funds to pay the premiums for Marketplace Qualified Health Plans (QHPs) to cover beneficiaries newly eligible for Medicaid under the ACA's expansion. Arkansas would require newly eligible beneficiaries to participate in its premium assistance demonstration to receive Medicaid benefits, which is one of the primary reasons that it must apply for a waiver rather than implementing premium assistance through a state plan option. Beneficiaries would have a choice of at least two Marketplace QHPs and would be automatically assigned to a plan if they did not select one. The state would provide wrap-around benefits on a FFS basis and pay beneficiaries' cost-sharing in the QHP to the extent that it exceeds Medicaid limits. People who are medically frail, people with exceptional medical needs, and people who are dually eligible for Medicaid and Medicare would be exempt from the demonstration and instead receive benefits through Arkansas' existing FFS delivery system.

## **MEDICAID PREMIUM ASSISTANCE AUTHORITY**

Prior to the ACA, the use of Medicaid funds as premium assistance to purchase private insurance coverage for Medicaid beneficiaries has been available to states through several state plan options as well as § 1115 demonstration waiver authority.<sup>7</sup> While other statutory provisions authorizing premium assistance are explicitly limited to employer-sponsored group coverage, the Centers for Medicare and Medicaid Services (CMS) has authorized the use of Medicaid funds as premium assistance to purchase coverage in the individual market in a small number of states through § 1905(a) of the Social Security Act.<sup>8</sup> (A Government Accountability Office (GAO) report found that, as of 2009, six states reported operating a § 1905(a) premium assistance program to purchase individual market coverage.)<sup>9</sup>

As a few states considered using Medicaid as premium assistance to implement the ACA's Medicaid expansion, HHS issued recent guidance confirming that individuals in state premium assistance programs “remain Medicaid beneficiaries and continue to be entitled to all benefits and cost-sharing protections.”<sup>10</sup> All of the premium assistance state plan options require states to provide wrap-around coverage to fill in any gaps in the benefits package between the private plan and Medicaid. CMS also recently finalized regulations that confirm that, under premium assistance provided pursuant to § 1905(a), “Medicaid-eligible individuals enrolled in a private health plan would remain qualified for all benefits for which the individual is covered under the state plan. . . and a state opting to provide premium assistance support for enrollment in an individual health plan would have to provide covered benefits not covered under the private policy.”<sup>11</sup>

States pursuing premium assistance also must pay beneficiary cost-sharing in the private plan to the extent that it exceeds Medicaid cost-sharing limits. States offering Medicaid premium assistance to purchase coverage in individual market plans “need to ensure that individuals do not incur cost sharing charges in excess of amounts” allowed under federal Medicaid law.<sup>12</sup>

In addition, states must demonstrate that the cost of covering a Medicaid beneficiary in a private market plan through premium assistance is “comparable to the cost of providing direct coverage under the [Medicaid] state plan.”<sup>13</sup> This cost effectiveness test includes administrative expenses and the cost of providing wrap-around benefits and paying beneficiary cost-sharing in excess of what is permitted under federal Medicaid law.<sup>14</sup>

CMS’s recent regulations afford states the option to use Medicaid funds as premium assistance under § 1905(a) to purchase individual market coverage, including through Marketplace QHPs, to implement the ACA’s Medicaid expansion.<sup>15</sup> States may implement premium assistance through a state plan option, without a waiver, but must allow beneficiaries to “choose an alternative to private insurance to receive Medicaid benefits.”<sup>16</sup> Using premium assistance for Marketplace QHPs could enable families to enroll in the same health plan when some family members are eligible for Medicaid or CHIP and others are eligible for Marketplace subsidies.<sup>17</sup> In addition, premium assistance could promote continuity of coverage by potentially reducing the extent to which beneficiaries with incomes at the upper end of the Medicaid eligibility scale move back and forth between Medicaid and Marketplace coverage due to income fluctuations.<sup>18</sup>

In addition to the premium assistance state plan option, the Secretary “will consider approving a limited number of premium assistance demonstrations. . . on a case by case basis.”<sup>19</sup> States would need to apply for a demonstration waiver to implement premium assistance in ways that differ from the parameters set out in CMS’s premium assistance state plan option regulations. For example, states that want to require beneficiaries to enroll in premium assistance would need waiver approval from CMS because the state plan option requires that beneficiaries be able to choose whether to enroll in premium assistance.

Premium assistance demonstration applications will be considered only if they meet certain qualifications: first, beneficiaries must have a choice of at least two QHPs. Second, the state must “make arrangements with the QHPs to provide any necessary wrap around benefits and cost sharing. . . for example through a supplemental premium. . . [to] ensure[] that coverage is seamless. . . .”<sup>20</sup> Next, premium assistance demonstrations should be “limited to individuals whose benefits are closely aligned with the benefits available on the Marketplace” and should not include populations exempt from ABP coverage, such as people who are medically frail.<sup>21</sup> Finally, premium assistance demonstrations must end by December 2016.<sup>22</sup> Because beneficiaries with incomes at the upper end of the Medicaid eligibility scale may move back and forth between Medicaid and Marketplace coverage as their income fluctuates, and because this population also is subject to higher Medicaid cost-sharing limits than other groups, HHS may be more likely to approve premium assistance demonstrations that target newly eligible beneficiaries with incomes between 100-138% FPL.<sup>23</sup>

## **KEY ISSUES AFFECTING BENEFICIARIES IN ARKANSAS’ PROPOSED DEMONSTRATION**

Arkansas’s proposal raises important issues in several areas that will affect beneficiaries. These include the goals that the demonstration seeks to test, the groups that will be covered by the demonstration, how beneficiaries will enroll in the demonstration, the populations that will be exempt from the demonstration, the logistics of plan choice and auto-assignment, the scope and accessibility of covered benefits, the system for appealing coverage denials, cost-sharing requirements, financing and cost-effectiveness, and state Medicaid agency oversight of QHPs. Major provisions of Arkansas’ proposal are summarized in Table 1, and the rest of this brief provides additional detail about Arkansas’ proposal and presents key questions to consider as the waiver is negotiated with CMS.

**TABLE 1:  
KEY ELEMENTS IN ARKANSAS’ PREMIUM ASSISTANCE DEMONSTRATION WAIVER APPLICATION**

<b>Overview:</b>	Arkansas proposes using Medicaid funds to pay premiums for Marketplace Qualified Health Plans (QHPs) for newly eligible Medicaid beneficiaries under the ACA’s expansion from 2014-2016. In 2015 or 2016, Arkansas also anticipates developing a pilot project with health savings accounts for beneficiaries.
<b>Demonstration Goals:</b>	Arkansas cites promoting continuity of care, increasing access to care, and increasing Marketplace QHP enrollment as among the goals it seeks to test in its demonstration.
<b>Coverage Groups:</b>	In 2014, Arkansas seeks to include parents ages 19-65 with incomes from 17% to 138% FPL and adults without dependent children ages 19-65 from zero to 138% FPL. Arkansas anticipates amending its waiver in 2015 or 2016 to include parents with incomes at or below 17% FPL and children.
<b>Enrollment:</b>	Arkansas seeks to make premium assistance mandatory for an estimated 225,000 newly eligible beneficiaries statewide. Enrollment will not be phased-in or capped. Arkansas will adopt 12 months continuous eligibility for newly eligible beneficiaries.
<b>Exempt Populations:</b>	Arkansas will exempt people who are medically frail, people with exceptional medical needs and dual eligible beneficiaries from its demonstration. Exempt beneficiaries will be identified through an online screening assessment.
<b>Plan Choice and Auto-Assignment:</b>	Beneficiaries will have a choice of at least two “high value silver” Marketplace QHPs. If beneficiaries do not choose a plan, they will be automatically assigned to one.
<b>Benefits:</b>	Marketplace QHPs will provide services in the Medicaid Alternative Benefit Plan to demonstration enrollees. Drug coverage will be limited to the QHP formulary. Arkansas will provide wrap-around benefits on a FFS basis.
<b>Appeals of Coverage Denials:</b>	Arkansas proposes that demonstration enrollees use the QHP grievance and appeals process, instead of the state fair hearing process, for coverage denials.
<b>Cost-Sharing:</b>	Beneficiaries with incomes below 100% FPL will not have cost-sharing obligations in 2014, but Arkansas plans to amend its waiver to include cost-sharing for beneficiaries with incomes between 50-100% FPL in 2015 and 2016. Beneficiaries with incomes between 100-138% FPL will have cost-sharing obligations consistent with Medicaid state plan and Marketplace QHP rules. Arkansas will make advance monthly cost-sharing reduction payments to QHPs, and providers will collect the cost-sharing amounts for which beneficiaries are responsible (up to Medicaid cost-sharing limits) at the point of service. Arkansas will not require cost-sharing for beneficiaries who are exempt under federal Medicaid law.
<b>Financing:</b>	Arkansas estimates that the costs of covering the demonstration population will be the same with the waiver as without the waiver. The state’s application does not provide specific financing estimates.
<b>Oversight:</b>	Arkansas will enter into a memorandum of understanding (MOU) with QHPs to outline the process for verifying enrollment and paying premiums. Arkansas’ application does not indicate that the MOUs will include any provisions for state Medicaid agency oversight of QHPs.

## ***Demonstration Goals***

**Arkansas cites promoting continuity of care, increasing access to care, and increasing Marketplace QHP enrollment as among the goals that it seeks to test in its demonstration.**<sup>24</sup> (Section 1115 demonstrations allow states to use Medicaid funds in ways that are not otherwise allowed under federal rules for “experimental, pilot, or demonstration” projects which, in the view of the HHS Secretary, are “likely to assist in promoting the objectives of” the program.<sup>25</sup> The specific statutory provisions that Arkansas seeks to waive and the hypotheses that it proposes to test in its demonstration are summarized in the Appendix.) Arkansas’ proposal states that it seeks to alleviate coverage gaps and differences in benefits and provider networks as individuals move back and forth between Medicaid and Marketplace coverage due to changes in income.<sup>26</sup> The state notes that the Medicaid expansion will increase its Medicaid program enrollment by 40 percent, or approximately 250,000 newly eligible adults, while the existing Medicaid FFS provider network already is “at capacity.”<sup>27</sup> Arkansas anticipates that the QHP provider network will include “many providers who do not currently participate in Medicaid.”<sup>28</sup> The state also notes that the demonstration will nearly double the size of the population enrolled in its Marketplace QHPs, which it believes will encourage insurers to enter the market and provide economies of scale.<sup>29</sup> Arkansas’ Marketplace QHPs also will be required to participate in the Arkansas Health Care Payment Improvement Initiative, which requires delivery system reforms such as patient-centered medical homes, episode-based payments with retrospective risk-sharing with providers, health homes, and assessments of providers’ clinical performance data.<sup>30</sup>

- » How will the hypotheses that Arkansas seeks to test through its demonstration be evaluated to determine the demonstration’s impact on continuity of care, access to care, and costs? What data will be collected for this analysis?

## ***Coverage Groups***

**Arkansas proposes that its demonstration in 2014 will include adults who are newly eligible for coverage through the ACA’s Medicaid expansion.** Arkansas’ Medicaid program currently covers parents with incomes up to 17% FPL (\$1,953 per year for an individual in 2013). Adults without dependent children currently are ineligible for Medicaid in Arkansas, regardless of income. Therefore, individuals newly eligible for Medicaid in Arkansas due to the expansion include adults without dependent children ages 19 to 65 with incomes from zero to 138% FPL and parents ages 19 to 65 with incomes between 17% and 138% FPL.<sup>31</sup>

**Arkansas anticipates amending its waiver in 2015 or 2016 to include parents with incomes below 17% FPL (who currently are eligible for Medicaid in Arkansas) and children.**<sup>32</sup> (While Arkansas’ state enabling legislation refers to the Arkansas Kids First (CHIP) program and “populations under Medicaid from zero percent (0%) [sic] of the federal poverty level to seventeen percent (17%) of the federal poverty level,”<sup>33</sup> the draft waiver application does not specify whether only CHIP-eligible children would be included in the demonstration in the future, or whether Medicaid-eligible children also might be included. Including Medicaid beneficiaries under age 21 in a premium assistance program requires that the state effectively provide wrap-around coverage to ensure that children receive the full scope of the Early and Periodic Screening Diagnosis and Treatment (EPSDT) benefit to which they are entitled under federal Medicaid law.)<sup>34</sup> In 2015 or 2016, the state also anticipates developing a pilot project to create health savings accounts for beneficiaries as part of its demonstration.<sup>35</sup> (No additional details about this pilot project are provided in the draft waiver application).

- » Which populations will be included in Arkansas’ demonstration over time, and with what effect on access to benefits and keeping families together in the same plan? How will Arkansas’ health savings accounts proposal affect beneficiaries?

## ***Demonstration Enrollment***

**One of the main reasons that Arkansas needs Section 1115 demonstration authority to implement its Medicaid expansion is that the state wants to make premium assistance mandatory for affected beneficiaries.**<sup>36</sup> As described above, states may implement premium assistance through a state plan option without a waiver, but they must offer beneficiaries a choice between premium assistance for private insurance coverage and the traditional Medicaid program.<sup>37</sup>

**Arkansas estimates that approximately 225,000 beneficiaries, or 90 percent of the newly eligible population, will be enrolled in its premium assistance demonstration.**<sup>38</sup> Arkansas proposes that its demonstration will be statewide in 2014, 2015, and 2016.<sup>39</sup> It does not propose phasing in enrollment over a period of time.<sup>40</sup> Demonstration enrollment will not be capped so all eligible beneficiaries will be able to receive coverage.<sup>41</sup>

**Arkansas will adopt 12 months continuous eligibility for newly eligible Medicaid beneficiaries as part of its demonstration.**<sup>42</sup> This policy option allows states to minimize coverage gaps that would otherwise occur when beneficiaries lose coverage due to small fluctuations in income. More than half of the states (32) currently elect the option to provide 12 months continuous eligibility for children, which has been shown to improve retention and reduce administrative costs associated with re-enrollment.<sup>43</sup> Twelve months continuous eligibility for adults requires Section 1115 demonstration authority and is one of the policy options to facilitate Medicaid and CHIP enrollment and renewal in 2014 recently highlighted by CMS.<sup>44</sup>

- » What effect will mandatory demonstration enrollment and 12 months continuous eligibility have on beneficiaries?

## ***Exempt Populations***

**Arkansas' proposal indicates that people who are medically frail, people with exceptional medical needs,<sup>45</sup> and dual eligible beneficiaries will be exempt from demonstration enrollment.**<sup>46</sup> The state estimates that approximately 25,000 people, or 10 percent of the newly eligible population, will be exempt from the demonstration and instead receive Medicaid coverage through the FFS delivery system.<sup>47</sup> As noted above, the ACA provides that beneficiaries newly eligible under the Medicaid expansion will receive ABP coverage, although certain categories of beneficiaries are exempt from mandatory ABP enrollment under federal law. Exempt beneficiaries will have the option of receiving the ABP or the state plan benefits package through Arkansas' Medicaid FFS delivery system.<sup>48</sup>

**Arkansas proposes that medically frail beneficiaries and those with exceptional medical needs will be identified through an online screening assessment, with a paper version available upon beneficiary request.**<sup>49</sup> The assessment will include 15 to 20 "yes/no" questions focused on beneficiary use of long-term services and supports (LTSS) and mental health services and the presence of complex medical conditions.<sup>50</sup> Self-attestation will be accepted for the screening assessment responses in 2014;<sup>51</sup> Arkansas' proposal does not indicate whether it would seek to require additional verification in 2015 and 2016. The screening would be conducted prospectively at the time of Medicaid enrollment and repeated annually by the state Medicaid agency.<sup>52</sup> A computer software algorithm will determine whether a beneficiary meets the exemption criteria, based on her assessment responses.<sup>53</sup> The state's proposal does not explain how a beneficiary can appeal the assessment if she disagrees with the outcome. Arkansas anticipates posting the screening assessment on its website in October 2013,<sup>54</sup> which does not provide time before the start of the open enrollment period for public review and feedback on the questions.

**Arkansas’ proposal indicates that the state will develop a “mid-year transition process” for people who are erroneously not identified as medically frail and people whose medical needs change during the plan year.**<sup>55</sup> Consequently, it is not clear whether beneficiaries will be able to leave the demonstration and access the traditional FFS Medicaid program whenever their health care needs change or whether they will be limited to leaving the demonstration only at a certain point in the year.<sup>56</sup> The ability to access Medicaid on a FFS basis is important for this population to the extent that certain benefits, such as LTSS, and providers, such as those with expertise in certain disabilities, may not be available through the ABP provided by the QHP. For example, Arkansas indicates that its ABP will not include LTSS.<sup>57</sup>

- » How effective will the screening assessment be in identifying people who are medically frail and people with exceptional medical needs who are exempt from the demonstration? How easily will beneficiaries who are erroneously not identified as exempt or whose needs change be able to transfer to the FFS delivery system?

### ***Plan Choice and Auto-Assignment***

**Arkansas proposes that beneficiaries in its demonstration will have a choice of at least two “high-value silver” Marketplace plans.**<sup>58</sup> (Marketplace QHPs are classified according to their actuarial value, and silver level plans must cover 70 percent of the actuarial value of the plan benefits package;<sup>59</sup> however, cost-sharing reductions are available for people with incomes between 100-250% FPL, as explained below.) In 2014, beneficiaries could choose among all high-value silver plans available in their geographic area.<sup>60</sup> In 2015 and 2016, Arkansas may establish criteria to select the plans available to premium assistance beneficiaries.<sup>61</sup> Arkansas proposes that it will send a notice to demonstration beneficiaries that includes “advice on selecting the plan that will best address their health needs;”<sup>62</sup> the waiver application does not indicate whether additional assistance with plan selection, such as in-person enrollment counseling, will be available to beneficiaries.

**If beneficiaries do not choose a plan, they will be automatically assigned to a plan in their county,<sup>63</sup> and Arkansas expects a “significant number” of automatic plan assignments particularly in 2014.**<sup>64</sup> Arkansas also anticipates that auto-assignments will be “significantly higher” for people who apply for benefits through the federally facilitated Marketplace (FFM).<sup>65</sup> This is due to the FFM’s inability to support plan selection and enrollment for demonstration beneficiaries, which will create a break in the single streamlined eligibility and enrollment process envisioned by the ACA. Instead of immediately being able to select and enroll in a QHP after being determined eligible for Medicaid by the FFM, beneficiaries who apply through the FFM instead will be sent to the state Medicaid eligibility and enrollment portal to complete those parts of the process.<sup>66</sup> Beneficiaries who are automatically assigned to a plan can switch plans within 30 days.<sup>67</sup>

- » What will the extent of beneficiary choices among QHPs be? How will beneficiaries make plan choices and what assistance will be available to help them in doing so? What effect will auto-assignments have on access to and continuity of care?

### ***Benefits***

**Arkansas’ proposal provides for Marketplace QHPs to cover the services included in the Medicaid ABP for demonstration beneficiaries.** Arkansas’ proposal indicates that its ABP will be “the same” as its Medicaid state plan benefits package;<sup>68</sup> however, the proposal later describes a notice to beneficiaries as including “information on the difference in benefits under the ABP as compared to the standard (State Plan) benefit package.”<sup>69</sup>

**Arkansas proposes that prescription drug coverage for demonstration beneficiaries be limited to the drugs on the QHP’s formulary.** This means that there are likely to be differences in the covered drugs available to demonstration beneficiaries, depending upon which QHP they select. While Arkansas seeks demonstration waiver authority to implement the scope of its proposed prescription drug benefit, the waiver application does not indicate how this will affect Medicaid prescription drug rebate provisions.<sup>70</sup> Arkansas also seeks demonstration waiver authority to limit federally qualified health center and rural health clinic reimbursement rates to the amounts that those providers negotiate with the QHP instead of the prospective payment system amount.<sup>71</sup> In addition, Arkansas’ proposal refers to “guidelines” that QHPs will use in making coverage decisions; the extent to which those guidelines will differ from the state’s definition of Medicaid medical necessity, which is the federal standard for determining eligibility for covered benefits, is unclear.

**The state proposes fulfilling its obligation to provide wrap-around benefits to demonstration beneficiaries by offering those benefits on a FFS basis.**<sup>72</sup> Arkansas proposes that information about wrap-around benefits will be available in the notice sent to demonstration beneficiaries, on the state Medicaid program website, and from the state Medicaid agency and QHP call centers.<sup>73</sup> Arkansas has identified non-emergency transportation, EPSDT services for beneficiaries under age 21 (to the extent that these services are not covered by the QHP), and out-of-network family planning providers as the services that will require wrap-around coverage.<sup>74</sup> Arkansas also will cover demonstration beneficiaries on a FFS basis until their QHP enrollment is effective<sup>75</sup> and during the three month retroactive period prior to Medicaid eligibility.<sup>76</sup>

- » Will there be any differences in covered benefits between Arkansas’ Medicaid ABP and its state plan benefits package? How will prescription drug coverage differ among QHPs? What standards will demonstration QHPs use to make coverage decisions, and how will those “guidelines” differ from the Medicaid medical necessity determination? How will beneficiaries know about wrap-around benefits and how readily will they be able to access those services? Will coverage be “seamless?”

### ***Appeals of Coverage Determinations***

**Arkansas proposes that demonstration beneficiaries use the QHP appeals process instead of the state fair hearing process if they disagree with coverage determinations.**<sup>77</sup> The QHP must provide beneficiaries with notice of coverage denials, including the reasons for the decision, a copy of the “guidelines” used to deny the claim, and a statement that beneficiaries may request additional explanation of the reasons for the denial.<sup>78</sup> The appeals process will include an internal review of the coverage denial by the QHP with the opportunity for beneficiaries to present evidence and testimony in support of coverage.<sup>79</sup> If the internal review upholds the denial or if the QHP does not act within the required timeframes, beneficiaries may seek external review by a Qualified Independent Review Organization (QIRO) selected by the state insurance department.<sup>80</sup> The QIRO must include “qualified and impartial clinical reviewers who are experts in the treatment of the enrollee’s medical condition and have recent or current actual clinical experience treating patients similar to the enrollee.”<sup>81</sup>

**Arkansas’ proposed appeals process for demonstration beneficiaries appears to differ from the existing Medicaid appeals process in important ways.** For example, Arkansas’ proposal does not specify whether QHPs will be responsible for providing continued benefits while appeals are pending as required under federal Medicaid law, nor does it confirm the availability of certain procedural rights to which Medicaid beneficiaries are entitled under federal law, such as the opportunity to be represented by counsel or another person of the beneficiary’s choice, to examine the contents of their case file and all documents and records to be used at the hearing, to

bring witnesses, and to cross-examine adverse witnesses.<sup>82</sup> While beneficiaries may submit a written statement to support their QIRO appeal,<sup>83</sup> Arkansas' proposal does not indicate that the QIRO process will afford beneficiaries the opportunity for a hearing to review the denial.<sup>84</sup> These and other features of the Medicaid appeals process are important because beneficiaries' claims to services under the Medicaid Act are protected by the Due Process Clause of the U.S. Constitution.<sup>85</sup>

- » Will the appeals system for QHP coverage denials encompass all of the notice and hearing rights to which Medicaid beneficiaries are entitled under federal law?

### ***Cost-Sharing***

**While Arkansas proposes that demonstration beneficiaries with incomes below 100% FPL will not have cost-sharing obligations in 2014, Arkansas plans to amend its waiver to include cost-sharing in 2015 and 2016 for beneficiaries with incomes between 50-100% FPL (\$5,745-11,490 per year for an individual in 2013).**<sup>86</sup> Arkansas proposes that demonstration beneficiaries with incomes between 100-138% FPL will be responsible for cost-sharing consistent with Medicaid and Marketplace rules.<sup>87</sup> The ACA provides for cost-sharing reductions for Marketplace QHP coverage for people with incomes between 100-250% FPL; for people with incomes between 100-150% FPL, QHPs must cover 94 percent of the cost of benefits.<sup>88</sup> Medicaid cost-sharing rules allow states to require "nominal" cost-sharing for most services for beneficiaries with incomes up to 100% FPL and up to 10% of the service cost for most services for beneficiaries with incomes between 101-150% FPL.<sup>89</sup> Arkansas will not require cost-sharing for beneficiaries who are exempt under federal Medicaid law.<sup>90</sup>

**Arkansas proposes that it will make advance monthly cost-sharing reduction payments to QHPs on behalf of demonstration beneficiaries, and providers will collect the cost-sharing amounts for which beneficiaries are responsible (up to the Medicaid cost-sharing limit) when services are provided.**<sup>91</sup> Aggregate annual beneficiary cost-sharing will be capped at 5% of the FPL (which Arkansas estimates at \$604 per year in 2014).<sup>92</sup> Arkansas proposes that QHPs will be responsible for monitoring beneficiary copayments to ensure that the annual limit is not exceeded.<sup>93</sup> The state will pay the full cost of plan premiums for demonstration beneficiaries.<sup>94</sup>

- » What impact will cost-sharing, especially for populations below the FPL, have on access to care? What amount of cost-sharing will Arkansas propose for beneficiaries with incomes between 50-100% FPL?

### ***Financing, Demonstration Budget-Neutrality, and Premium Assistance Cost-Effectiveness***

**Arkansas estimates that the costs of covering the demonstration population through its waiver will be the same as without the waiver.**<sup>95</sup> (In addition to the requirement that premium assistance programs be cost-effective, through long-standing administrative policy, CMS requires that Section 1115 demonstrations must be budget neutral to the federal government.) The federal cost of Marketplace coverage is expected to be higher than the federal cost of Medicaid coverage: in July 2012, the Congressional Budget Office estimated that it would cost the federal government \$9,000 per year in 2022 to provide subsidies for Marketplace coverage to an individual with income between 100-138% FPL, whereas it would cost the federal government an estimated \$6,000 per year in 2022 to cover such a person through the Medicaid expansion.<sup>96</sup> HHS's recent premium assistance guidance indicates that it will consider states' savings estimates based on reductions in the movement of beneficiaries back and forth between Medicaid and Marketplace coverage due to income fluctuations and increased competition in Marketplace coverage due to additional QHP enrollees as a result of premium assistance.<sup>97</sup>

**Arkansas' waiver application does not provide specific financing estimates to address Section 1115 budget neutrality or the federal requirement that premium assistance be cost effective.** It does indicate that its actuaries estimated the costs for the Medicaid expansion population using private market reimbursement rates expected to be used in the Marketplace as the benchmark for adequate access.<sup>98</sup> It also estimates that QHP provider reimbursement rates as a result of the demonstration will be “on average, at least 5% less than existing provider contracts with commercial insurers today” due to the decrease in the number of uninsured people, leading to a decrease in provider “cost-shifting” by raising private health plan rates to compensate for uninsured or under-insured patients.<sup>99</sup>

- » Will premium assistance be cost-effective compared to expanding Arkansas' traditional Medicaid program? Which factors will be considered in making this determination?

### ***Relationship between State Medicaid Agency and Marketplace QHPs and Oversight***

**Arkansas' proposal indicates that the state Medicaid agency will not contract directly with Marketplace QHPs.**<sup>100</sup> Instead, the state will enter into a memorandum of understanding (MOU) with QHPs to outline the process for verifying enrollment and paying premiums.<sup>101</sup> Arkansas' proposal does not indicate that the MOUs will contain any additional provisions, such as those to ensure plan oversight or to monitor care quality or service utilization.

- » How will the state Medicaid agency oversee QHPs in the demonstration and ensure access to care and care quality?

## **LOOKING AHEAD**

Arkansas will accept public comments on its draft waiver application through July 24, 2013.<sup>102</sup> The state anticipates submitting its waiver application to CMS by August 2, 2013,<sup>103</sup> after which the application will be subject to another public comment period at the federal level. As the public comment process and CMS's review of the waiver application moves forward, it will be important to consider the key issues presented in this brief to ensure that beneficiaries receive the coverage and services to which they are entitled under the Medicaid program.

This issue brief was prepared by MaryBeth Musumeci of the Kaiser Family Foundation's Commission on Medicaid and the Uninsured.

## **APPENDIX: STATUTORY PROVISIONS THAT ARKANSAS SEEKS TO WAIVE AND HYPOTHESES THAT ARKANSAS PROPOSES TO TEST IN ITS PREMIUM ASSISTANCE DEMONSTRATION**

### **Arkansas seeks § 1115 waiver authority to:<sup>104</sup>**

- Apply the 5% cost-sharing cap on an annual rather than a quarterly basis - § 1902(a)(14)
- Limit federally qualified health center (FQHC) and rural health center (RHC) reimbursement to the amount that the FQHC/RHC negotiates with the QHP carrier, rather than the prospective payment system amount - § 1902(a)(15)
- Provide different delivery systems for different beneficiary groups - § 1902(a)(17)
- Require mandatory participation in premium assistance for demonstration beneficiaries and limit demonstration beneficiaries' free choice of provider - § 1902(a)(23)
- Limit demonstration beneficiaries' drug coverage to the QHP formulary - § 1902(a)(54)
- Allow drug prior authorizations for demonstration beneficiaries to be addressed in 72 hours rather than 24 hours, with a 72 hour supply to be provided in emergencies - § 1902(a)(54)

### **Arkansas proposes to test the following propositions in its demonstration:<sup>105</sup>**

#### **Provider Access:**

1. Whether the demonstration will create greater provider access than newly eligible adults otherwise would have in the traditional FFS delivery system.
2. Whether demonstration beneficiaries will have provider access comparable to other privately insured individuals.
3. Whether demonstration beneficiaries will have more consistent access to preventive care services compared to Medicaid beneficiaries in non-premium assistance expansions nationally.
4. Whether demonstration beneficiaries will have lower rates of non-emergent use of the emergency room compared to Medicaid beneficiaries in non-premium assistance expansions nationally.

#### **Churning:**

5. Whether demonstration beneficiaries will have fewer gaps in coverage than Medicaid beneficiaries in non-premium assistance expansions nationally.
6. Whether demonstration beneficiaries will maintain continuous access to the same plans and/or providers at higher rates than under a traditional Medicaid expansion.
7. Whether reduction in churning will lead to reduced administrative costs.

#### **Cost:**

8. Whether, over the life of the demonstration, costs for covering demonstration beneficiaries will be comparable to what costs would have been for FFS Medicaid coverage, assuming adjustments to FFS provider reimbursement to achieve access for the expansion population.

**Quality Improvement:**

9. Whether demonstration beneficiaries will have lower rates of potentially preventable hospital admissions than beneficiaries in Arkansas' FFS program.

**Marketplace Costs:**

10. Whether the demonstration will lower overall Marketplace premium costs and result in better quality than without the demonstration.

**Marketplace Care Quality:**

11. Whether the demonstration and QHP's required participation in Arkansas' Payment Improvement Initiative will produce improved quality over time than without the demonstration.

**Uncompensated Care:**

12. Whether uncompensated care costs will be lower due to higher provider reimbursement and less uninsured.

# Endnotes

- <sup>1</sup> The Supreme Court's ruling on the ACA maintains the Medicaid expansion but limits the Secretary's authority to enforce it, effectively making implementation of the expansion a state choice. If a state does not implement the expansion, the Secretary cannot withhold existing federal program funds. Kaiser Commission on Medicaid and the Uninsured, *Implementing the ACA's Medicaid-Related Health Reform Provisions After the Supreme Court's Decision* (Aug. 2012), available at <http://kff.org/health-reform/issue-brief/implementing-the-acas-medicaid-related-health-reform/>. For more information about state implementation of the ACA's Medicaid expansion, see Kaiser Commission on Medicaid and the Uninsured, *Status of State Action on the Medicaid Expansion Decision, as of June 20, 2013*, available at <http://www.kff.org/medicaid/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>.
- <sup>2</sup> HHS, *Medicaid and the Affordable Care Act: Premium Assistance* at Question 3 (March 2013), available at <http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/FAQ-03-29-13-Premium-Assistance.pdf> (hereinafter HHS Guidance).
- <sup>3</sup> Ark. Act 1497 (April 23, 2013), available at <http://www.arkleg.state.ar.us/assembly/2013/2013R/Pages/BillInformation.aspx?measureno=SB1020>; Iowa Sen. File 446, § 177 (May 23, 2013), available at [http://coolice.legis.iowa.gov/linc/85/external/SF446\\_Enrolled.html](http://coolice.legis.iowa.gov/linc/85/external/SF446_Enrolled.html). Prior to the passage of its legislation, Iowa filed a § 1115 demonstration waiver application, which differed from the compromise reached in its enabling legislation. As a result, Iowa will be filing two new waiver applications, one for beneficiaries with incomes up to the FPL and the other for beneficiaries with incomes between 101-138% FPL. For an overview of Iowa's revised proposal, see Iowa Dep't of Health & Human Servs., *Iowa Health and Wellness Plan* (June 2013), available at <http://www.dhs.state.ia.us/uploads/IHAWP%20Overview%2006%2011%2013.pdf>. (Due to the scope of the changes between its original waiver application and the enabling legislation, CMS has determined that Iowa must repeat the § 1115 waiver public notice process. The state is currently revising its waiver application. Iowa Dep't of Health & Human Servs., *Iowa Medicaid Enterprise, Iowa Health and Wellness Plan Summary* (updated June 13, 2013), <http://www.ime.state.ia.us/healthy-iowa-plan-summary.html>).
- <sup>4</sup> Arkansas Medicaid, Health Care Independence (a/k/a Private Options) § 1115 Waiver, available at <https://www.medicaid.state.ar.us/general/comment/demowaivers.aspx> (hereinafter Ark. Draft Waiver Application).
- <sup>5</sup> The federal matching rate for the ACA's Medicaid expansion exceeds the states' regular federal matching rates, which range from 50% to over 73% in 2013, depending upon a state's per capita personal income relative to the national average. Kaiser Commission on Medicaid and the Uninsured, *Medicaid: A Primer: Key Information on the Nation's Health Coverage Program for Low-Income People* (March 2013), available at <http://kff.org/medicaid/issue-brief/medicaid-a-primer/>; see generally Kaiser Commission on Medicaid and the Uninsured, *Medicaid Financing: An Overview of the Federal Medicaid Matching Rate (FMAP)* (Sept. 2012), available at <http://kff.org/health-reform/issue-brief/medicaid-financing-an-overview-of-the-federal/>.
- <sup>6</sup> See Kaiser Family Foundation, *Explaining Health Reform: Benefits and Cost-Sharing for Adult Medicaid Beneficiaries* (Aug. 2010), available at <http://www.kff.org/medicaid/issue-brief/explaining-health-reform-benefits-and-cost-sharing-for-adult-medicaid-beneficiaries/>; see also 42 C.F.R. §440.330(d). The ACA preserves the existing exemptions from mandatory ABP enrollment for people newly eligible for coverage under the Medicaid expansion. Section 1937 of the Social Security Act, codified at 42 U.S.C. § 1396a(k)(1).
- <sup>7</sup> For additional background on the use of Medicaid funds as premium assistance, see Kaiser Commission on Medicaid and the Uninsured, *Premium Assistance in Medicaid and CHIP: An Overview of Current Options and Implications of the Affordable Care Act* (March 2013), available at <http://www.kff.org/medicaid/issue-brief/premium-assistance-in-medicaid-and-chip-an-overview-of-current-options-and-implications-of-the-affordable-care-act/>.
- <sup>8</sup> Section 1905(a) defines the expenditures for which Medicaid funds may be used as including, *inter alia*, "other insurance premiums for medical or any other type of remedial care or the cost thereof;" the statute does not provide any additional detail about the use of this authority for premium assistance. *But see* Government Accountability Office, *Enrollment, Benefits, Expenditures, and Other Characteristics of State Premium Assistance Programs*, GAO-10-258R at 4 (Jan. 19, 2010), available at <http://www.gao.gov/new.items/d10258r.pdf> (observing that "Section 1905(a) of the SSA allows states to use Medicaid funds to subsidize premiums for group or nongroup health coverage. In this report, we define nongroup health coverage as coverage purchased from the individual market."). CMS recently finalized regulations regarding Medicaid premium assistance, including a provision to permit states to use Medicaid as premium assistance to purchase individual market coverage under § 1905(a). 42 C.F.R. § 1015(a), 78 *Fed. Reg.* 42160, 42303-42304 (July 15, 2013), available at <https://www.federalregister.gov/articles/2013/07/15/2013-16271/essential-health-benefits-in-alternative-benefit-plans-eligibility-notices-fair-hearing-and-appeal>.
- <sup>9</sup> The states were Iowa, Minnesota, New Jersey, North Dakota, Utah, and Washington. GAO Report at 15-16, Table 3. Twenty-one states reported offering premium assistance for nongroup coverage, although the source of the authority used to do so is unclear in the GAO report. *Id.* at 17-18, Table 4; see also *id.* at 6 (noting that "[a]ccording to CMS officials, section 1115 waivers have been used to permit states to provide premium assistance. . . to subsidize the cost of nongroup health coverage").
- <sup>10</sup> HHS Guidance at Question 2.

- <sup>11</sup> 78 *Fed. Reg.* 4594-4727, 4624 (Jan. 22, 2013), available at <http://www.gpo.gov/fdsys/pkg/FR-2013-01-22/pdf/2013-00659.pdf>; *see also* 42 C.F.R. § 1015(a)(2). HHS’s guidance also confirms that states using premium assistance “must have mechanisms in place to ‘wrap-around’ private coverage to the extent that benefits are less and cost sharing requirements are greater than those in Medicaid.” HHS Guidance at Question 2. The GAO has observed that “a reported issue with premium assistance programs is that there may be disparities in the benefits and cost-sharing protections offered to enrollees in such programs compared with those in direct [Medicaid] coverage.” GAO Report at 2. Responses from state officials in 34 out of 45 premium assistance programs surveyed by the GAO in 2009 revealed that “they did not monitor access to care or utilization of services for individuals enrolled in the premium assistance programs.” *Id.* at 9. Out of the remaining 11 states, 3 reported monitoring access to care, and ten reported monitoring service utilization. *Id.* at 33-34, Table 13; *see also* Kaiser Commission on Medicaid and the Uninsured, *Premium Assistance in Medicaid and CHIP: An Overview of Current Options and Implications of the Affordable Care Act* at 9 (March 2013), available at <http://www.kff.org/medicaid/issue-brief/premium-assistance-in-medicaid-and-chip-an-overview-of-current-options-and-implications-of-the-affordable-care-act/> (noting that “[a]necdotal evidence suggests that beneficiaries may not be aware of their right to wraparound benefits, and states generally have not tracked access to and utilization of services in their premium assistance programs, so it is not known how well wraparounds are working today”).
- <sup>12</sup> 78 *Fed. Reg.* at 4624; *see also* 42 C.F.R. § 1015(a)(3). For example, in the Medicaid expansion context, cost-sharing in Marketplace QHPs is likely to be higher than what Medicaid permits, which would require states to provide wrap-around coverage for beneficiary cost-sharing.
- <sup>13</sup> 78 *Fed. Reg.* at 4624; *see also* 42 C.F.R. § 1015(a)(4). While the text of § 1905(a) does not refer to cost-effectiveness, CMS’s regulation applies this standard to premium assistance used to purchase individual coverage under § 1905(a). *Id.* The GAO observed that “[r]eports also note that premium assistance programs may not be cost-effective – that is, premium assistance may be more expensive than providing direct coverage through states’ Medicaid and CHIP programs.” GAO Report at 2.
- <sup>14</sup> 42 C.F.R. § 1015(a)(4).
- <sup>15</sup> 42 C.F.R. § 1015(a); *see also* 78 *Fed. Reg.* at 4624, 4696.
- <sup>16</sup> HHS Guidance at Question 2; *see also* 42 C.F.R. § 1015(b). States “must inform an individual that it is the individual’s choice to receive either direct coverage under the Medicaid State plan or coverage through premium assistance for an individual health plan. . . and must provide the individual with information on how to access any additional benefits and cost sharing assistance not provided by the issuer.” 42 C.F.R. § 1015(b).
- <sup>17</sup> 78 *Fed. Reg.* 42184 (July 15, 2013).
- <sup>18</sup> *Id.*
- <sup>19</sup> HHS Guidance at Question 3.
- <sup>20</sup> *Id.*
- <sup>21</sup> *Id.*
- <sup>22</sup> HHS intends for the results of the limited number of premium assistance demonstrations to “inform policy for the State Innovation waivers that start in 2017.” *Id.*
- <sup>23</sup> HHS Guidance at Question 2, HHS’s Guidance refers to 133% FPL. The ACA expands Medicaid eligibility to 133% FPL and includes an income disregard of 5% FPL, effectively making the income limit 138% FPL. 42 U.S.C. § 1396a(e)(14)(I).
- <sup>24</sup> Ark. Draft Waiver Application at 2, 15-16.
- <sup>25</sup> For more information about Section 1115 demonstration waivers, *see* Kaiser Commission on Medicaid and the Uninsured, *An Overview of Recent Section 1115 Medicaid Demonstration Waiver Activity* (May 2012), available at <http://www.kff.org/medicaid/issue-brief/an-overview-of-recent-section-1115-medicaid/>.
- <sup>26</sup> Ark. Draft Waiver Application at 2.
- <sup>27</sup> *Id.* at 2, 3, 15.
- <sup>28</sup> *Id.* at 15.
- <sup>29</sup> *Id.* at 2, 15-16.
- <sup>30</sup> *Id.* at 3, 15, 21-22.
- <sup>31</sup> *Id.* at 2.
- <sup>32</sup> *Id.*
- <sup>33</sup> Ark. Act 1497, adding Ark. C. § 20-77-2105(e).
- <sup>34</sup> Under EPSDT, state Medicaid programs must provide all beneficiaries under age 21 with screening, vision, dental, hearing, and “other necessary health care, diagnostic services, treatment, and other measures. . . to correct or ameliorate” physical and mental health conditions “whether or not such service are covered under the State plan.” 42 U.S.C. § § 1396a(a)(43); 1396d(r).
- <sup>35</sup> Ark. Draft Waiver Application at 2.
- <sup>36</sup> *Id.* at 7.
- <sup>37</sup> HHS Guidance at Question 2.

- <sup>38</sup> Ark. Draft Waiver Application at 8.
- <sup>39</sup> *Id.* at 6.
- <sup>40</sup> *Id.* at 19.
- <sup>41</sup> *Id.* at 8.
- <sup>42</sup> *Id.* at 9.
- <sup>43</sup> Kaiser Commission on Medicaid and the Uninsured, *Key Lessons from Medicaid and CHIP for Outreach and Enrollment Under the Affordable Care Act* at 10 (June 2013), available at <http://kff.org/medicaid/issue-brief/key-lessons-from-medicaid-and-chip-for-outreach-and-enrollment-under-the-affordable-care-act/>.
- <sup>44</sup> CMS, State Health Official/State Medicaid Director Letter, *Facilitating Medicaid and CHIP Enrollment and Renewal in 2014* (May 17, 2013), available at <http://medicaid.gov/Federal-Policy-Guidance/Downloads/SHO-13-003.pdf>.
- <sup>45</sup> Arkansas' proposal indicates that this group may include people who could benefit from long-term services and supports, health home services, or Community First Choice attendant care services and supports. Ark. Draft Waiver Application at 17.
- <sup>46</sup> Ark. Draft Waiver Application at 8, 17. Specifically, Arkansas proposes that individuals who are determined to be medically frail or to have exceptional medical needs for which Marketplace coverage is impractical or overly complex or would undermine continuity or effectiveness of care will not be eligible for the premium assistance demonstration. Arkansas also indicates that it will comply with the other § 1937 ABP exemptions. *Id.* at 18.
- <sup>47</sup> *Id.* at 8.
- <sup>48</sup> *Id.* at 17.
- <sup>49</sup> Arkansas is working with consultants from the University of Michigan to develop the screening assessment. *Id.*; *see also id.* at 24.
- <sup>50</sup> *Id.* at 17.
- <sup>51</sup> *Id.* at 18.
- <sup>52</sup> *Id.*
- <sup>53</sup> *Id.* at 17.
- <sup>54</sup> *Id.* at 23.
- <sup>55</sup> Specifically, the state's proposal refers to "individuals with emerging medical needs that lead to a predictable and significant need for additional benefits during plan year." *Id.* at 18.
- <sup>56</sup> *But see id.* at 24 ("premium payments will continue until . . . the individual is determined to be more effectively treated due to complexity of need through the fee-for-service Medicaid program").
- <sup>57</sup> *Id.* at 11.
- <sup>58</sup> *Id.* at 16, 19.
- <sup>59</sup> 42 U.S.C. § 18022(d)(1)(B).
- <sup>60</sup> Ark. Draft Waiver Application at 19.
- <sup>61</sup> *Id.* at 20.
- <sup>62</sup> *Id.* at 23.
- <sup>63</sup> *Id.* at 24. In 2014, Arkansas proposes that beneficiaries who are automatically assigned to plans will be distributed among plans to achieve a target minimum market share of enrollees for each issuer in a service area. The targets will be as follows: 2 issuers in region, 33% of demonstration beneficiaries; 3 issuers in region, 25% of demonstration beneficiaries, 4 issuers in region, 20% of demonstration beneficiaries; more than 4 issuers in region, 10% of demonstration beneficiaries. The state anticipates refining the auto-assignment methodology for 2015 and 2016 based on plan premium costs, quality, and performance. *Id.* at 25.
- <sup>64</sup> *Id.* at 25.
- <sup>65</sup> *Id.* at 25. States have the option of operating their own Marketplace or partnering with HHS to run a Marketplace; states choosing neither option will default to the FFM. For more information, *see* Kaiser Family Foundation, *Establishing Health Insurance Exchanges: An Overview of State Efforts* (Nov. 2012), available at <http://kff.org/health-reform/issue-brief/establishing-health-insurance-exchanges-an-overview-of/>.
- <sup>66</sup> Ark. Draft Waiver Application at 18, 24, 25.
- <sup>67</sup> *Id.* at 25.
- <sup>68</sup> *Id.* at 10. Arkansas will submit a state plan amendment regarding its ABP selection. *Id.* at 13.
- <sup>69</sup> *Id.* at 24. The proposal also refers to exempt beneficiaries' choice between the ABP or the state plan benefits package, both of which would be delivered FFS. *Id.* at 18. The proposal also refers to health home services and Community First Choice attendant care services and supports, in the context of identifying exempt beneficiaries, both of which are state plan services for qualifying beneficiaries. *Id.* at 17.
- <sup>70</sup> Federal Medicaid law generally requires prescription drug manufacturers to have rebate agreements for Medicaid-covered drugs. 42 U.S.C. § 1396r-8(a)-(c).

- <sup>71</sup> Ark. Draft Waiver Application at 28. Medicaid reimbursement rates for federally qualified health center and rural health clinic services are prescribed at 42 U.S.C. § 1396a(bb).
- <sup>72</sup> Ark. Draft Waiver Application at 16, 20.
- <sup>73</sup> *Id.* at 23-24; 25-26. Specifically, Arkansas proposes that notices include what services are covered, phone numbers to call or websites to visit to access wrap-around benefits, and any cost-sharing for those services. *Id.* at 23-24.
- <sup>74</sup> *Id.*
- <sup>75</sup> *Id.* at 20. If beneficiaries select or are auto-assigned to a QHP between the 16<sup>th</sup> and last day of the month in which they are determined eligible for Medicaid, QHP coverage is effective by the first day of the second month after the month of their QHP selection. *Id.*
- <sup>76</sup> *Id.*
- <sup>77</sup> *Id.* at 10, 24.
- <sup>78</sup> *Id.* at 11.
- <sup>79</sup> *Id.*
- <sup>80</sup> *Id.*
- <sup>81</sup> *Id.*
- <sup>82</sup> See 42 C.F.R. § 431.206(b)(3); 431.230; 431.242.
- <sup>83</sup> Ark. Draft Waiver Application at 11.
- <sup>84</sup> *Cf.* 42 U.S.C. § 1396a(a)(3).
- <sup>85</sup> For more information about Medicaid appeals, see Kaiser Commission on Medicaid and the Uninsured, *A Guide to the Medicaid Appeals Process* (March 2012), available at <http://www.kff.org/medicaid/issue-brief/a-guide-to-the-medicaid-appeals-process/>.
- <sup>86</sup> Ark. Draft Waiver Application at 13. Arkansas will submit a state plan amendment regarding “updated cost-sharing requirements.” *Id.*
- <sup>87</sup> *Id.* at 2, 13, 16.
- <sup>88</sup> 42 U.S.C. § 18071(c)(2)(A).
- <sup>89</sup> CMS has recently finalized regulations that increase the “nominal” cost-sharing dollar amount. 78 *Fed. Reg.* 42160-42322 (July 15, 2013), available at <https://www.federalregister.gov/articles/2013/07/15/2013-16271/essential-health-benefits-in-alternative-benefit-plans-eligibility-notices-fair-hearing-and-appeal>; see also 78 *Fed. Reg.* 4594-4724 (Jan. 22, 2013), available at <http://www.gpo.gov/fdsys/pkg/FR-2013-01-22/pdf/2013-00659.pdf>. For a summary of current and proposed cost-sharing rules, see Kaiser Commission on Medicaid and the Uninsured, *Premiums and Cost-Sharing in Medicaid* (Feb. 2013), available at <http://www.kff.org/medicaid/issue-brief/premiums-and-cost-sharing-in-medicaid/>.
- <sup>90</sup> Ark. Draft Waiver Application at 15.
- <sup>91</sup> *Id.* at 13, 14.
- <sup>92</sup> *Id.* at 13.
- <sup>93</sup> *Id.*
- <sup>94</sup> *Id.* at 13, 16.
- <sup>95</sup> *Id.* at 26.
- <sup>96</sup> Congressional Budget Office, *Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision* at 4 (July 2012), available at <http://www.cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf>.
- <sup>97</sup> HHS Guidance at Question 3.
- <sup>98</sup> Adjustments were made for “approved cost sharing, trend, comprehensive private market care coordination, reinsurance, and non-medical load (administration and profit/risk/contingencies).” Ark. Draft Waiver Application at 27.
- <sup>99</sup> *Id.* at 19.
- <sup>100</sup> *Id.* at 26.
- <sup>101</sup> *Id.*
- <sup>102</sup> *Id.* at 23. Public comment is sought pursuant to the § 1115 waiver transparency provisions added by the ACA. For more information, see Kaiser Commission on Medicaid and the Uninsured, *The New Review and Approval Process Rule for Section 115 Medicaid and CHIP Demonstration Waivers* (March 2012), available at <http://www.kff.org/health-reform/fact-sheet/the-new-review-and-approval-process-rule/>.
- <sup>103</sup> Ark. Draft Waiver Application at 23.
- <sup>104</sup> *Id.* at 27-29.
- <sup>105</sup> *Id.* at 4-6.



THE KAISER COMMISSION ON  
**Medicaid and the Uninsured**

**THE HENRY J. KAISER FAMILY FOUNDATION**

**Headquarters**

2400 Sand Hill Road  
Menlo Park, CA 94025  
Phone 650-854-9400 Fax 650-854-4800

**Washington Offices and  
Barbara Jordan Conference Center**

1330 G Street, NW  
Washington, DC 20005  
Phone 202-347-5270 Fax 202-347-5274

[www.kff.org](http://www.kff.org)

This publication (#8459) is available on the Kaiser Family Foundation's website at [www.kff.org](http://www.kff.org).

The Kaiser Family Foundation, a leader in health policy analysis, health journalism and communication, is dedicated to filling the need for trusted, independent information on the major health issues facing our nation and its people. The Foundation is a non-profit private operating foundation, based in Menlo Park, California.