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Medicaid Expansion in Arkansas

In September 2013, the Centers for Medicare and Medicaid Services approved Arkansas' Section 1115 demonstration to implement the Affordable Care Act's (ACA's) Medicaid expansion by using Medicaid funds as premium assistance to purchase coverage in Marketplace Qualified Health Plans (QHPs) for newly eligible adults.[1] The demonstration covers parents from 17-138% of the federal poverty level (FPL, up to $16,242 per year for an individual in 2015) and childless adults from 0-138% FPL. As of January 2014, Arkansas' demonstration:

- Expands Medicaid by purchasing Marketplace QHP coverage for all newly eligible adults.
- Requires newly eligible adults to enroll in Marketplace QHPs to receive Medicaid services.
- Provides services that are outside the QHP benefit package, such as Early Periodic Screening Diagnosis and Treatment for 19 and 20 year olds, free choice of family planning provider, and non-emergency medical transportation, through the state's Medicaid fee-for-service delivery system.

In December 2014, CMS approved an amendment to Arkansas' demonstration, based on changes required by state legislation.[2] Previously, Arkansas' demonstration included cost-sharing at Medicaid state plan amounts at the point-of-service for beneficiaries from 100-138% FPL. As of January 2015, Arkansas' amended demonstration:

- Establishes health savings accounts to which non-medically frail beneficiaries from 50-138% FPL make monthly income-based contributions, ranging from $5 to $25 per month, to be used for co-payments and co-insurance. These contributions are not a condition of Medicaid eligibility.
- Imposes cost-sharing at the point-of-service at state plan amounts for beneficiaries above 100% FPL who do not make monthly account contributions.

Arkansas also sought waiver authority to limit non-emergency medical transportation (NEMT) to 8 trip legs per year for non-medically frail beneficiaries. Instead, the state will establish a prior authorization process for NEMT for newly eligible adults (which does not require waiver authority).

Arkansas is among the 29 states (including DC) implementing the Medicaid expansion to date, most of which are doing so through a state plan amendment. To date, CMS has approved waivers in Arkansas, Iowa, Indiana, Michigan, and Pennsylvania to implement the ACA's Medicaid expansion. New Hampshire has a waiver application pending with CMS, and Tennessee and Utah have proposals pending at the state level.

Other states expanding or seeking to expand Medicaid through Marketplace premium assistance include Iowa (optional for those from 101-138% FPL) and New Hampshire (pending waiver application would change expansion from direct coverage in the state's Medicaid program to Marketplace premium assistance beginning January 2016). Additional details about Arkansas' demonstration are included in Table 1.

Table 1: Arkansas' Section 1115 Medicaid Expansion Demonstration Waiver	
Element	**Arkansas (approved, as amended)**
Overview:	Uses Medicaid funds to pay Marketplace QHP premiums for all newly eligible adults statewide (estimated 200,000) under the ACA's Medicaid expansion. Waiver amendment establishes monthly cost-sharing contributions to health savings accounts for beneficiaries from 50-138% FPL and imposes cost-sharing at state plan amounts at the point-of-service for beneficiaries from 101-138% FPL who do not make monthly account contributions. Account contributions are not a condition of Medicaid eligibility.
Duration:	9/27/13 to 12/31/16 Eligibility effective 1/1/14
Demonstration Goals:	Cites promoting continuity of care, increasing access to care, and increasing Marketplace QHP enrollment.
Coverage Groups Subject to Premium Assistance:	Newly eligible parents ages 19-64 between 17-138% FPL, and newly eligible adults without dependent children ages 19-64 between 0-138% FPL. Anticipates amending waiver in 2015 or 2016 to add parents at or below 17% FPL and children (not included in current demonstration approval).
Enrollment:	QHP enrollment required for demonstration beneficiaries.
Populations Exempt from Premium Assistance:	People who are medically frail are exempt from premium assistance and have choice of FFS coverage of same ABP offered to new adult group or an ABP that includes Medicaid state plan benefit package. Those determined medically frail after QHP enrollment can be disenrolled from premium assistance and reassigned to other Medicaid coverage. Identified through state-established process. Waiver application describes 12 question online screening assessment, including health self-assessment, living situation, assistance with ADLs/IADLs, acute and psychiatric overnight hospital stays, and number of physician, physician extender or mental health professional visits. People with "exceptional medical needs" as identified through screening assessment, American Indian/Alaska Natives, pregnant women, and dual eligible beneficiaries also are exempt from premium assistance enrollment.
QHP Choice and Auto-Assignment:	Beneficiaries choose between at least 2 silver level Marketplace QHPs. If beneficiaries do not choose a plan, they will be automatically assigned to one. Beneficiary choice among all silver level plans in geographic area that offer only EHB. 30 days to change QHP after auto-assignment. Auto-assignment based on target minimum market share of demonstration beneficiaries in each QHP in region.
Premiums:	State pays monthly premiums directly to QHPs. Beneficiaries are not responsible for any premium costs.

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Cost-Sharing and Health Savings Accounts:	No cost-sharing for beneficiaries below 50% FPL. Beneficiaries from 50-138% FPL will make monthly contributions, no greater than 2% of income, to health savings ("Independence") accounts. Monthly contributions are $5 for beneficiaries 50-100% FPL, $10 for those from 101-115% FPL, $17.50 for those from 116-129% FPL, and $25 for those over 130-133% FPL. The state will fund the account to cover beneficiaries' QHP co-payment and co-insurance obligations beyond Medicaid state plan limits, and a third party administrator will facilitate payments to providers. Beneficiaries will receive a credit or debit card to access account funds to pay co-payments and co-insurance to providers. Cost-sharing is not a condition of Medicaid eligibility and is limited to 5% of monthly or quarterly income. No cost-sharing for beneficiaries who are exempt under federal Medicaid law, including those who are medically frail and those with exceptional medical needs as determined through the Arkansas health care screening questionnaire. Beneficiaries from 101-138% FPL who fail to make monthly account contributions are responsible for Medicaid state plan level co-payments and co-insurance at the point of service, and providers can deny services for failure to pay cost-sharing. Beneficiaries from 50-100% FPL who fail to make monthly account contributions will use their account debit/credit card to pay providers for co-payments and co-insurance and will be billed by the third-party administrator for co-payments at Medicaid state plan amounts for services received. If there are insufficient account funds to cover the bill and it remains unpaid, these beneficiaries will incur a debt to the state, unless the beneficiary self-attests to financial hardship. Beneficiaries who make at least 6 non-consecutive monthly account contributions in a calendar year receive account credits that can be used to offset future QHP premiums (after enrollment in the Medicaid private option ends), employee contributions to ESI, or Medicare premiums (for those over age 64). The credits will be distributed as cash once the beneficiary is no longer eligible for Medicaid as a new adult, if the beneficiary continues to reside in Arkansas. For each month that they make a timely account contribution, beneficiaries accrue the lesser of their monthly contribution amount or $15, regardless of the amount of co-payments or co-insurance charged to the card. Credits are capped at $200 and must be used within 2 years of accrual. Account contributions begin after CMS approval of the state's Independence Account protocol, and an initial account contribution is required prior to the end of the 2nd month after QHP coverage is effective.
Benefits:	
QHP benefits package:	QHPs provide services in the state's Medicaid Alternative Benefits Package (ABP) for newly eligible adults. ABP is the same as Medicaid state plan benefits package.
Federally qualified and rural health centers (FQHC/RHC):	Beneficiaries will have access to at least 1 QHP that contracts with at least one FQHC/RHC. Waiver application indicates that state will develop an alternative FQHC/RHC payment methodology that moves from FFS per visit payments to those that account for service intensity and reduction in the uninsured. If unable to do so timely, state reserves right to seek waiver of FQHC/RHC reimbursement rules.
Prescription drugs:	Limited to the QHP formulary. Prior authorization within 72 hours instead of 24 hours.

Table 1: Arkansas' Section 1115 Medicaid Expansion Demonstration Waiver	
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Family planning providers:	State covers out-of-network family planning providers on FFS basis.
Wrap-around benefits:	Provided on a FFS basis (non-emergency medical transportation and EPSDT). State to establish prior authorization process for non-emergency medical transportation.
Retroactive coverage:	Provides 3 months' coverage prior to application date on FFS basis.
Appeals:	Demonstration enrollees use the state fair hearing process for all appeals. (AR has approved SPA delegating Medicaid fair hearings for medical necessity and coverage issues for the new adults to state department of insurance.[3])
Financing:	Estimates that the cost of covering the demonstration population will be the same with the waiver as without the waiver: $118 million in CY 2014, $126.4 million in CY 2015, and $135.4 million in CY 2016.
Cost-Effectiveness:	May use state-developed tests of cost-effectiveness for premium assistance that differ from those otherwise permissible.
Oversight:	State Medicaid agency and state insurance departments will enter into MOU or agreement with QHPs regarding enrollment, payment of premiums and cost-sharing reductions, reporting and data requirements, notices, and audits.
Status:	Demonstration approved 9/27/13 and amendment approved 12/31/14. Within 6 months of implementation and annually thereafter, state must hold forum for public comment.
Evaluation:	State submitted draft evaluation design approved by CMS.[4] Evaluation shall be conducted by an independent entity.
Reporting:	State must submit quarterly and annual reports to CMS.

Endnotes:

[1] Ark. Health Care Independence Program (Private Option), CMS Special Terms and Conditions (Sept. 27, 13), available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/Health-Care-Independence-Program-Private-Option/ar-private-option-app-ltr-09272013.pdf; *see also* Ark. Medicaid, Health Care Independence (a/k/a Private Options) § 1115 Waiver – FINAL (Aug. 2, 2013), available at https://www.medicaid.state.ar.us/general/comment/demowaivers.aspx.

[2] Ark. Act 257, § 17 (Feb. 18, 2014), available at http://www.arkleg.state.ar.us/assembly/2013/2014F/Pages/BillInformation.aspx?measureno=SB111; Ark. Health Care Independence Program (Private Option) CMS Special Terms and Conditions #11-W-00287/6 (Jan. 1, 2015), available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/ar-private-option-ca.pdf.

[3] Ark. State Plan Amendment #13-0013 MM4 (July 15, 2014), available at http://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/AR/AR-13-0013-MM4.pdf.

[4] Arkansas Health Care Independence Program ("Private Option") Approved Evaluation for Section 1115 Demonstration Waiver, (February 20, 2014), available at https://www.medicaid.state.ar.us/Download/general/comment/HCIWEvalStrategy.pdf; CMS approval letter: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/Health-Care-Independence-Program-Private-Option/ar-private-option-eval-design-appvl-ltr-03242014.pdf.