Arkansas Health and Opportunity for Me (ARHOME)
A Proposed Medicaid Section 1115 Demonstration Project

Section 1115 Demonstration Application

ARHOME
health & opportunity for me

ARKANSAS DEPARTMENT OF HUMAN SERVICES

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Application for Proposed Section 1115 Demonstration Project

Introduction

In 2013, Arkansas created a new program to provide health coverage to the new adult eligibility group added by the Affordable Care Act (ACA) for coverage under Title XIX of the Social Security Act ("Medicaid"). The original program, authorized by the Health Care Independence Act of 2013 (HCIP), also known as the "Private Option," included a sunset clause of December 31, 2016. As part of the program, Arkansas was the first state in the nation to obtain approval from the Centers for Medicare and Medicaid Services (CMS) to use Medicaid funding to purchase private insurance coverage for a portion of its new adult population through a Section 1115 Demonstration Project ("Demonstration").

The HCIP was subsequently replaced by the current program and Demonstration, "Arkansas Works," under the authority of the Arkansas Works Act of 2016, which expires December 31, 2021. Under the Demonstration, Arkansas Medicaid uses premium assistance to purchase coverage through individual qualified health plans (QHPs) offered through the Health Insurance Marketplace (Marketplace) for the majority of enrollees in this new adult eligibility group. As of March 2021, a total of 318,095 adults were enrolled in the Arkansas Works program, of which 271,320 (85%) were enrolled in a QHP for their health care coverage.

During the most recent session of the Arkansas General Assembly, Governor Asa Hutchinson and the legislators collaborated to make further improvements to the program through the "Arkansas Health and Opportunity for Me" Act of 2021 ("ARHOME"). Under the authority of Act 530, Arkansas proposes to continue to cover the new adult eligibility group for another five years and extend and amend the Demonstration through December 31, 2026.

The proposed Demonstration continues to ensure budget neutrality by establishing expenditure trend rates using the per capita cap methodology to project "without waiver" and "with waiver" expenditures. The State will accept risk based on per capita expenditures but not on enrollment.

This application is based on the guidance and various templates that the Centers for Medicare & Medicaid Services (CMS) has provided for a Demonstration Project under section 1115 of the Social Security Act (the Act).[1] The guidance and templates that were designed by CMS are intended to help states ensure the application contains the required elements for section 1115 demonstrations, as provided for under 42 CFR part 431 subpart G, and in particular the application procedures at 42 CFR 431.412(a), as well as to promote an efficient review process.

[1] All references to statutory sections made in this document are references to the Social Security Act, unless otherwise stated. Similarly, all references to regulations made in this document are references to regulations in title 42 of the Code of Federal Regulations (CFR), unless otherwise stated.

Structure and Content of Application

The framework for this application guidance and template is designed to facilitate the State's application development by identifying the type of information, through a series of questions and checklists, and provide additional information as attachments to the application template. The application enables the State to be consistent with regulations at 42 CFR 431.420 and 431.428.

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Section I – Program and Demonstration Overview

The current Arkansas Works program provides coverage to 318,095 individuals between the ages of 19 and 64 who are not enrolled in Medicare and with income below 138% of the federal poverty level (FPL) who are either (1) childless adults or (2) parents between with incomes between 17% and 138% FPL. The new ARHOME program provides eligibility to these same groups of individuals.

Under the United States system of health insurance, individuals and families with health insurance receive coverage from different sources—their employers, Medicaid, Medicare, the individual insurance market, and the military. Approximately 30 million individuals are uninsured. On December 19, 2009, the Congressional Budget Office (CBO) provided then Senate Majority Leader Harry Reid with its estimated impact of the Affordable Care Act (ACA) as amended. As CBO projected health insurance coverage out to 2019, it over-estimated the number of people who would be covered through the individual market and under-estimated the number of people who would be covered through Medicaid.[2][3] Millions of individuals expected to help enlarge and stabilize the individual insurance Marketplace are enrolled in Medicaid instead.

[2] See https://www.cbo.gov/sites/default/files/12-19-reid_letter_managers_correction_noted.pdf Table 3.

[3] Under the legislation, Medicaid expansion was compulsory, enforced by the loss of federal funding for a state's entire Medicaid program which makes CBO's under-estimate of Medicaid coverage even more significant.

In 2019, the percentage of uninsured in the U.S. was 11.1% compared to 11.5% in Arkansas. The source of coverage though, is quite different in comparing Arkansas to the U.S. totals (all ages). Nationally, employers provided 56.3% of all health insurance coverage in the U.S., but in Arkansas, employers provide only 47.8% of health insurance coverage. Medicaid accounted for 19.5% of health coverage nationally in 2019, but Medicaid accounted for 26.1% of health coverage in Arkansas. Medicare provides 4.9% of coverage in Arkansas compared to 2.9% nationally. The individual market covers 7.0% of the population nationally, but 6.4% in Arkansas.[4]

The source of insurance coverage has a significant impact on the cost of coverage, stability in insurance markets, and in the case of Medicaid, on the State budget. The source of coverage also has a significant impact on providers as well as state and local economies. In general, private insurance pays higher rates than Medicare and Medicaid. Premiums typically do not cover the entire cost of medical services. Part of the compensation to providers is paid by individuals through deductibles, co-insurance, or copayments. Such is not the case in Medicaid as beneficiaries pay little or nothing for the cost of their care. In Arkansas, Medicare and Medicaid account for the combined coverage of 31% of the state's population compared to 22.4% nationally. Only Louisiana (33.5%), New Mexico (37.2%), and West Virginia (32.7%) have higher rates of their populations covered through combined Medicare and Medicaid than Arkansas.

Prior to the adoption of the new eligibility group, Arkansas had one of the lowest Medicaid eligibility thresholds for non-disabled, non-elderly adults in the nation. In 2013, a parent/caretaker relative with a dependent child and income above 17% FPL was not eligible for Medicaid.[5] 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.[6] However, Arkansas also experienced one of the largest increases in Medicaid enrollment.

In addition to adopting the new adult group in Medicaid, Arkansas also has increased the State minimum wage. In 2014, the Arkansas minimum wage was $6.25 per hour. A single person working full-time, all-year around (2,080 hours) at the Arkansas minimum wage would make $13,000 per year, which was 111% of the Federal Poverty Level of $11,670 at that time, and would thus qualify for the Demonstration. However, in 2014 Arkansas voters raised the minimum wage to $8.50 beginning in 2017. In 2018, Arkansas voters again enacted a series of minimum wage increases: to $9.25 in 2019, $10 per hour effective January 2020, and $11 per hour effective January 2021. A single person working full-time, all-year at minimum wage now will make $22,880 per year or 178% of FPL and would not qualify for Medicaid.

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[4]. https://aspe.hhs.gov/system/files/pdf/265041/trends-in-the-us-uninsured.pdf Table 2. p. 10,11.
[5] Under the 2021 Poverty Guidelines, 17% FPL for a household of 2 is $247 per month or $2,961 annually.
[6] https://news.gallup.com/poll/203501/kentucky-arkansas-post-largest-drops-uninsured-rates.aspx

The increase in the Arkansas's minimum wage means the program population is more likely to increase their income above the Medicaid eligibility threshold and move into other sources of coverage—between Medicaid and the individual insurance market, or Medicaid and employer-sponsored insurance. As individuals increase their earnings, the distribution of types of coverage will more likely resemble those assumed by the CBO in its assessment of the impact on coverage and health care spending as a result of the ACA. This makes the use of premium assistance even more significant as it provides individuals with the experience of health insurance as they are on their way to move out of poverty.

ARHOME will continue to purchase coverage from QHPs for the majority of beneficiaries. Thus, an individual will be able to purchase through the individual Marketplace the same QHP with the same benefits and same provider network that they had while on Medicaid. This continuity of coverage is of national significance. As part of the next five-year Demonstration, the Arkansas Department of Human Services (DHS), the QHPs, and local community partners will educate beneficiaries on the important differences between health insurance and Medicaid medical assistance, as well as the short and long-term value added through QHP enrollment.

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 improvements in several conditions have been made, Arkansas has not kept pace with other states. It was ranked 48th in the nation in 2000, 2010, and again in 2019.[7]

Within Arkansas Works, there are consistent patterns of enrollment by age, geography, and income levels. For example, based on a snapshot of the enrollees in October 2020, the 19 to 24 year-old group is the largest age cohort (19.5%), and the 61 to 64 year-old group the smallest (5.3%). Females account for 57% of enrollees. About 50,000 enrollees (17.3%) are in households above 100% of FPL while more than half (50.6%) reported income below 20% of FPL. Approximately 40% have a dependent child in the household.[8]

The proposed Demonstration includes important strategies for addressing Social Determinants of Health (SDOH) in targeted populations. CMS, the Office of Disease Prevention and Health Promotion at the U.S. Department of Health and Human Services (HHS), states, and health plans have increasingly recognized the importance of identifying SDOH and assisting individuals overcome barriers to positive health outcomes. The correlation between poverty, poor health, and shortened life expectancy has been established so completely for decades as to be beyond question. As stated by HHS in its *Healthy People 2020* report:[9]

> *The prevalence of poverty in the United States is an important public health issue*. In 2015, approximately 43 million Americans lived in poverty. Although the U.S. Census Bureau uses a set of dollar value thresholds by family size and composition to determine

[7] https://assets.americashealthrankings.org/app/uploads/ahr_2019annualreport.pdf p.50.
[8] Figures are based on October 2020 snapshot of 288,858 enrollees at that time.
[9] https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/poverty

who is in poverty, poverty may be defined in a number of different ways, particularly by socioeconomic status (SES) (emphasis added).

Socioeconomic status can be determined by a family's income level, education level, and occupational status. In spite of the differences in definition between poverty and socioeconomic status, *researchers agree that there is a clear and established relationship between poverty, socioeconomic status, and health outcomes—including increased risk for disease and premature death* (emphasis added).

Addressing SDOH Through Community Bridge Organizations (CBOs)

Since 2017, the Center for Medicare and Medicaid Innovation (CMMI) has funded an initiative to "provide support to community bridge organizations to test promising service delivery approaches aimed at linking beneficiaries with community services that may address their health-related social needs (i.e., housing instability, food insecurity, utility needs, interpersonal violence, and transportation needs)."[10]

ARHOME proposes to adapt the CBO concept to target certain populations who may particularly benefit from intensive levels of intervention and care coordination to address their SDOH. These target populations are:

- Beneficiaries who live in rural counties, especially those with Serious Mental Illness (SMI) or Substance Use Disorder (SUD),
- Women with high risk pregnancies, and
- Young adults most at risk of long-term poverty and the associated risk of disease and premature death

In the proposed ARHOME version of a CBO, called a Life360 HOME, a hospital will employ its own staff or organize local partners that will assist a person achieve his/her health and socioeconomic goals. The hospital will receive direct funding from DHS through a cooperative agreement. The Life360 HOME will coordinate with the individual's medical providers but the cost of medical services are not covered by the Life360 HOME. Medical services continue to be paid by the individual's Qualified Health Plan (QHP), or direct Fee-For-Service reimbursement to providers.

These Life360 HOMEs will be based in hospitals around the state. The reasons for using hospitals as the "anchor" organization for this model include:

- Strong financial accountability
- Trusted community resource
- Respected employer
- Existing infrastructure
- Qualified management

The Demonstration adds a definition of "care coordination" as a new benefit that will be provided through these Life 360 HOMEs which is described in greater detail in Section III, "Benefit Package."

[10] https://innovation.cms.gov/innovation-models/ahcm

Improve Health Outcomes for Beneficiaries Who Live in Rural Arkansas, Especially for Those with Serious Mental Illness (SMI) or Substance Use Disorder (SUD)

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." According to "Growth and Persistence of Place-Based Mortality in the United States: The Rural Mortality Penalty, (*Cosby et al*.) published in January 2019, there were nearly 77 more deaths in rural areas per 100,000 people than in urban areas in 2004. The "penalty" had increased to nearly 135 deaths in 2016. The authors found that from the mid-1980s through 2016, "[t]he rural-urban mortality disparity was persistent, growing, and large when compared to other place-based disparities. The penalty had evolved into a high-poverty, rural penalty that rivaled the effects of education and exceeded the effects of race by 2016."[11] Moreover, "[t]he 2016 rate for rural low-income America was approximately 2 decades behind the levels observed in urban America."[12]

The authors conclude that *"[i]nterventions or policies to improve mortality rates may be ineffective if they focus only on health care access and do not closely consider the social and economic conditions of rural places*. The acceleration of the rural mortality penalty is associated with complex and interconnected social, behavioral, and structural factors, and identifying which factors are mutable is challenging" (emphasis added).[13]

Less than 20% of all Americans live in a rural area. Arkansas is one of just 11 states in which more than 40% of its total population live in a rural area. Of these 11 states, only Alabama, Arkansas, and Kentucky have a population greater than 3 million people. Thus, Arkansas is uniquely positioned to undertake a rural health initiative that could serve as a model for other federal and state initiatives.

In Arkansas, nearly half of the current enrollees in the Demonstration live in rural areas of the state. In the Rural Profile of Arkansas 2021, the University of Arkansas Division of Agriculture provided a data-driven picture of the state's rural population continuing to lag behind in several socioeconomic measures including declining population, declining employment, lower earnings per job, lower median household income, poor infrastructure, underachievement in schools, and lower health factor scores compared to urban counties.[14]

The National Advisory Committee on Rural Health and Human Services (NACRHHS) has provided recommendations to HHS as to how to address the SDOH in rural areas. In a January 2017 Policy Brief, the Committee stated: "[o]ver the years, the Committee has examined individual social determinants of health … and found that rural communities often fare worse than their urban and suburban counterparts. While the social determinants of health serves as a general policy construct, the Committee believes that there are distinct rural considerations that policymakers must keep in mind when deciding how to develop and align health and human service systems such that they are able to improve population health

[11] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6301407/pdf/AJPH.2018.304787.pdf p. 155.
[12] Ibid. p. 160.
[13] Ibid. p. 161.
[14] https://www.uaex.edu/publications/pdf/MP564.pdf

in rural communities. This will become increasingly important in the coming years as the social determinants of health framework becomes embedded into HHS efforts."[15]

NACRHHS observed, "[t]hough similar to how the relationship between health and zip code runs deeper than the issue of geographic isolation in rural areas, the close relationship between health and poverty is more complex."

"As with wealth, income, and poverty, educational attainment and employment also holds implications for the health status of individuals in rural communities. … Americans with fewer years of education have poorer health and live shorter lives, and that has never been more true."[16]

The Demonstration will address population health in rural areas and support rural hospitals. In the Rural Life360 model, hospitals in rural areas will employ staff to screen anyone in the community for SDOH and connect them to local medical and non-medical resources. Food, housing, and transportation have been the most frequently identified needs. The Rural initiative will specifically target individuals with SMI/SUD who are underserved in rural areas. The hospitals will also employ staff to provide an intensive level of care coordination, working directly with individuals with serious mental illness or substance use disorders.

The ACA reduced the number of people without health insurance. But like other rural states, Arkansas must expand the supply of mental health professionals to meet the demand for behavioral health services. Nearly every county in Arkansas has a shortage of mental health professionals.[17] The proposed Demonstration addresses specific challenges of accessing health care in rural areas, especially the shortages of behavioral health providers, by expanding the use of telemedicine and supporting the emergency medical system. It will increase the levels of more timely access to care and help fill gaps in the continuum of care, most especially for those in mental health crisis.

Improve Maternal and Child Health Outcomes Especially for Women with High Risk Pregnancies

It is widely recognized that the rates of maternal and infant mortality, and other adverse health outcomes related to high risk pregnancies, in the United States continue to be substantially higher than in other developed countries. Arkansas, unfortunately, ranks 49th in the nation in maternal and child health indicators.

Approximately 15,000 women on the current waiver give birth each year. Of these, about one-third are considered to have "high risk" pregnancies. The associated costs to Medicaid for pre-term deliveries, low-birthweight births, very-low birthweight births, and stays in neonatal intensive care units (NICU) are significant.

[15] https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/rural/publications/2017-social-determinants.pdf
[16] Ibid. p.3,4.
[17] https://www.healthy.arkansas.gov/images/uploads/pdf/Mental_Health_HPSA_Map_01-06-2021.pdf

Research shows that for populations most at risk for poor health, providing access to health care is not enough. CMS has described the link between poverty and poor maternal and child health outcomes as follows: "[p]oor birth outcomes are also influenced by the mother's broader familial and socio-economic resources, her social relationships, and her neighborhood environment. Women who have low incomes or low educational attainment and who live in neighborhoods with high poverty and deprivation are more likely than others to be in poor health and are at greater risk of delivering a preterm or low birth weight infant."[18]

For its maternal and child care initiative, DHS has reviewed the experience of other states and the evaluations of different efforts, especially the Strong Start for Mothers and Newborns initiative. Strong Start was a joint effort between CMS, the Health Resources and Services Administration (HRSA), and the Administration on Children and Families (ACF). The Strong Start initiative involved nearly 46,000 mothers and their children among 27 grant awardees and more than 200 sites over a period of four years. It was aimed at overcoming the "perceived weaknesses" in the "typical" prenatal care delivery models.
The evaluation of Strong Start describes these weaknesses:

> *Criticisms of typical care include that it is overly medical in focus, paying insufficient attention to psychosocial risks that contribute to poor birth outcomes, such as poverty, unsafe housing, food insecurity, intimate partner violence, and mental health*; overly interventionist (in that providers may induce labor or perform C-section deliveries without medical indication—rather than wait for natural labor—at the first hint that waiting could endanger the health of mother or infant); insufficiently focused on education on such critical issues as nutrition, exercise, childbirth preparation, breastfeeding and family planning; and lacking in continuity, in that pregnant women will usually be seen by many different health care providers over the course of their prenatal, delivery, and postpartum care, thus undermining the establishment of a strong, trusting relationship between each woman and her provider (emphasis added).[19]
>
> Moving forward, comprehensively attending to the broader needs faced by low-income women, including many social determinants of health, will be necessary to achieve reductions in preterm birth and other improved outcomes. *No model of care can sufficiently address the myriad needs of Medicaid-enrolled women, particularly those at higher risk, without broad community support and other robust social support systems* (emphasis added).[20]

The backbone of the Strong Start initiative was the use of specially trained staff to provide intensive education, psychosocial support, and connections to non-medical services that support healthy pregnancies. In Strong Start sites, staff were called "peer counselors" or

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[18] https://www.acf.hhs.gov/sites/default/files/documents/design_for_the_mother_infant_home_visiting_program_evaluation_strong_0.pdf p. 2.
[19] https://downloads.cms.gov/files/cmmi/strongstart-prenatal-finalevalrpt-v1.pdf p.130.
[20] Ibid. p. viii.

"care managers" whose function was to build trusted relationships with enrolled pregnant women and guide them through the medical and non-medical systems.

The most successful model resulted in:

- Lower rates of preterm births
- Lower rates of low birthweight
- Lower rates of C-section births
- Fewer infant emergency department visits and hospitalizations
- $2,000 in lower costs per mother-infant pairs during birth and the following year

In the Maternal Life360 HOME model, hospitals that offer labor and delivery services will employ their own staff, or enter into agreements with external partners experienced in home visitation, to take on the role of peer counselors/home visitors. These individuals will provide their support to the woman in her own home beginning during pregnancy and continuing up to two years after the child is born. Home visitation continues to be important post-partum, as evidenced through the Strong Start initiative.

Evidence-based home visitation programs have also demonstrated improvements in child development. Arkansas has a pilot program, "Safe Care," that features home visitation for its foster care population that shows promising results.

The QHPs will also be required to develop their own strategies for improving maternal and child health among their members.

Young Adults Most at Risk of Long-term Poverty and Poor Health

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."[21]

The purpose of the Success Life360 HOME is to present fresh opportunities to young adults who may need additional time and support to complete at least a high school education and develop sufficient skills to achieve full-time, full-year employment in order to avoid long-term poverty as adults. In the Success Life360 HOME model, hospitals will enter into agreements with external partners experienced in working with young adults most at risk of long-term poverty to build their skills to be physically, socially, and emotionally healthy in order to live in and contribute to their communities.

[21] https://www.urban.org/sites/default/files/publication/65766/2000369-Child-Poverty-and-Adult-Success.pdf

The initial target populations 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."[22]

- 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 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.[23]

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).[24]

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

[22] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4243069/
[23] https://www.americanactionforum.org/research/incarceration-and-poverty-in-the-united-states/
[24] https://www.brookings.edu/wp-content/uploads/2018/03/es_20180314_looneyincarceration_final.pdf p.1.

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.[25]

The Value Added by QHPs

The proposed Demonstration continues to use QHPs to provide coverage to the majority of beneficiaries. In previous evaluations, the QHPs have already demonstrated that access to care is the same as, or better than, regular Medicaid FFS. ARHOME will further demonstrate that beneficiaries receive added value by being enrolled in a private health insurance plan. Insurance companies are increasing the ways in which they engage their members including direct-to-consumer strategies such as chat features with health professionals, on-demand virtual general medical visits, and improving patient experiences. Thus, the adult Medicaid population have the same administrative supports offered by insurance companies as are available to individuals at higher income levels.

Under ARHOME, the QHPs will expand their value added services further to offer a variety of incentives to their members to participate in health improvement and economic independence opportunities. Most importantly, ARHOME expects that enrollees gain an added value simply as a member of a private health insurance plan. They should experience a positive, normative effect from being a member with an insurance card rather than someone with a Medicaid card. The insurance carriers themselves will take on a new identity of being more than an insurance company. The Demonstration includes a provision to encourage the QHPs to make investments in their communities.

Summary

The new features of the proposed Demonstration will enable Arkansas to:

- 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 associated with poverty.
- Address health-related social needs of beneficiaries in rural counties and reduce the additional risk for disease and premature death associated with living in a rural county.
- Strengthen the financial stability of the critical access hospitals and other small, rural hospitals, and enhance access to medical services in rural counties.

[25] See: https://www.va.gov/vetdata/docs/SpecialReports/The_Veteran_Working_Poor.pdf

- Fill gaps in the continuum of care for individuals with serious mental illness and substance use disorders, especially in rural counties.
- Increase the identification of Medicaid beneficiaries most at risk of long-term poverty and poor health outcomes associated with poverty, and increase their engagement in educational and employment opportunities and other supports that reduce the risk of poverty.
- Increase active participation among beneficiaries in improving their health and addressing the SDOH that affect their health.
- Provide intensive care coordination for beneficiaries most at risk of long-term poor health to reduce inappropriate or preventable utilization of emergency departments and inpatient hospital settings.
- Increase the use of preventive care and health screenings for early identification and treatment of diseases and chronic health conditions.
- Improve the connection of beneficiaries, especially young aduts in target populations to opportunities for full-time work and the attainment of economic independence to reduce long-term poverty associated with additional risk for disease and premature death.
- Evaluate whether beneficiaries enrolled in a QHP recognize and value the health coverage as insurance above and beyond Medicaid medical assistance.
- Reduce the rate of growth in state and federal obligations for providing healthcare coverage to low-income adults.

The major changes in ARHOME from the current waiver consist of:

- Three types of Life360 HOMEs targeted to improving maternal and child health, supporting population health in rural areas by addressing Social Determinants of Health (SDOH), expanding provider capacity to give individuals with serious mental illness or substance use disorders more timely access to treatment, and creating opportunities for success for young adults who are veterans, former foster youths, or formerly under the supervision of the Division of Youth Services (DYS) or were formerly incarcerated as adults.
- Health improvement opportunities, including the use of incentives by QHPs to meet most of the Medicaid Core Set of Adult Health Care Quality Measures.
- Economic independence opportunities, including the use of incentives to increase employment and education among enrollees.
- QHP accountability for meeting annual quality measures enforced by potential financial sanctions.
- Quarterly program monitoring by a joint legislative-executive oversight panel.
- The application of cost sharing up to the federally allowable amounts per service and the quarterly cost sharing cap of 5% of household income for all individuals.
- Enrollment of individuals with SMI or SUD so severe as to meet an institutional level of care into the PASSE program, where they can access intensive care coordination and specialized services.

A. Description of ARHOME Program and Demonstration Project

Individuals eligible for coverage under the Newly Eligible Adult Group are described at Section 1902(a)(10)(A)(i)(VIII) of the Act. Enrollees receive an "Alternative Benefit Plan" (ABP) through a QHP or FFS.

Sources of Coverage

Medicaid Fee-for-Service (FFS). After being determined eligible under the new adult group, all individuals start their coverage in Medicaid Fee-for-Service (FFS). Individuals who identify themselves as "medically frail" or are subsequently identified as medically frail remain in FFS for their coverage.

Individuals who are not medically frail are covered by FFS for a temporary period of time ("interim population") before enrollment into a Qualified Health Plan (QHP).

Qualified Health Plan (QHP). The State proposes to continue to provide premium assistance to purchase coverage offered by Qualified Health Plans (QHPs) that participate in the individual insurance Marketplace in Arkansas. The purchase of private QHP coverage in to cover premiums and cost sharing is not permitted under a State Plan and must be done through an 1115 Demonstration. The QHPs are regulated by the Arkansas Insurance Department (AID). DHS issues purchasing guidelines on an annual basis and purchases coverage through a Memorandum of Understanding (MOU) with AID and the insurers. The QHP population historically accounts for about 80% of all expansion adults on a monthly basis. However, QHP enrollment as a percentage of the total Arkansas Works population has been increasing during the Public Health Emergency in which regular eligibility re-determinations have been delayed. In March 2021, QHPs accounted for 85% of total enrollment in the Arkansas Works program.

Provider-led Arkansas Shared Savings Entity (PASSE). In the new ARHOME program, individuals will have the opportunity to have an Independent Assessment (IA) to determine whether they qualify for the Provider-led Arkansas Shared Savings Entity (PASSE) program. The PASSE program is a comprehensive managed care model that currently serves approximately 46,000 children and adults who meet an institutional level of care due to their behavioral health condition or their developmental or intellectual disability. The current PASSE program excludes the new adult group population but will be amended to make them eligible for the increased services available through the program. DHS estimates approximately 1,500 adults may be eligible for the current PASSE program.

Changes to the current enrollment processes into the QHPs are explained in greater detail in Section II, "Eligible Populations and Processes for Eligibility and Enrollment."

Waiver Authorities

The proposed Demonstration requires waivers from the Medicaid State Plan. These are summarized below and are explained in greater detail in Section VII, "Section 1115 Authorities."

Freedom of Choice

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 or PASSE. No waiver of freedom of choice is requested for family planning providers enrolled in the Arkansas Medicaid program.

Payment to Providers

QHPs and PASSEs 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.

Premiums

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 as they prepare members for the experience and responsibilities of purchasing commercial health insurance once their income has exceeded the Medicaid eligibility threshold. 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. The use of premiums and cost sharing is subject to a quarterly cap of 5% of household income and is described in greater detail in Section IV, "Premiums and Cost Sharing."

Copayments

The use of copayments is permitted for adults in Medicaid subject to certain restrictions and limitations and therefore waiver authority is not required. Under the ARHOME Demonstration, copayments will start at 21% FPL and generally be aligned with federal allowable amounts subject to an overall 5% of household income cap that is applied on a quarterly basis.

There are changes in the use of copayments in ARHOME from the current Arkansas Works Demonstration. The amount of individual copayments is set to the allowable amounts under Medicaid which are lower than was allowed in the current Demonstration. The copayment for an inpatient hospital stay, for example, has been reduced from $87 to $0. Copayments for visits to specialists have been lowered as well. Copayments are described in greater detail in Section IV.

Beneficiary participation in premiums and cost sharing is an important feature to demonstrate that the individual values coverage as health insurance and values the health care professional who provided the medical service.

The State needs Demonstration authority to apply premiums to those with income above 100% FPL, but it does not need Demonstration authority to apply the levels of copayments to beneficiaries at all income levels. 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.

These additional payments are made in the form of "cost-sharing reduction" payments. DHS estimates the amounts of cost-sharing beneficiaries will incur each month when receiving services from medical providers. DHS makes "Advance Cost Sharing Reduction payments ("ACSR") to the QHPs each month and the QHPs pay the providers for the amounts of cost sharing that would otherwise be the obligation of the beneficiaries. These ACSR payments are reconciled each month to the actual amount of cost sharing the QHPs pay out to providers.

Comparability

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 a high level of need for services due to their behavioral health 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 non-medical 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 healthy physically, socially, emotionally, and to thrive in their communities.

Waiver authority is needed to enable the State to impose targeted cost sharing on some but not all Medicaid beneficiaries in the same eligibility category. The program will exclude from cost sharing the Medically Frail and PASSE beneficiaries and the Demonstration will allow QHPs to exclude some beneficiaries from cost sharing as a reward for their participation in health improvement or economic independence initiatives.

Retroactive Eligibility

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 state received approval in the current Demonstration to limit 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.

Prior Authorization

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.

Other ARHOME Changes

Health Improvement Initiative (HII) and Economic Independence Initiative (EII) Incentives

As will be specified under the annual purchasing guidelines and MOU, the State will purchase QHPs that provide incentives to encourage their members to improve their health and economic status. The State will provide flexibility to the QHPs to design their incentive programs, which will likely be aligned with state-selected quality performance metrics. For example, the QHP may offer a Heath Improvement Incentive (HII) to their members to get a preventive screening or an annual wellness exam. The QHP may offer an incentive to attend a job fair as an Economic Independence Incentive (EII). DHS will encourage QHPs to tailor incentives to what will be most effective for their members.

QHP Accountability for Health Improvement

Under the Arkansas Works program, DHS provided premium-assistance payments to the QHPs regardless of the quality of care their members received. ARHOME aims to improve the health of beneficiaries by holding the QHPs accountable for their performance on state-selected health quality measures. QHPs will be required to submit claims data to use in calculating QHP-specific performance on each measure. DHS will hold the QHPs accountable for improving the health of their members by applying sanctions for failure to meet performance targets. Performance targets will be set by January 1, 2022, using 2019 data for the baseline measures. ARHOME will report QHP scores on the performance measures quarterly, beginning just in calendar year 2022. The types and levels of sanctions will be described in the Memorandum of Understanding (MOU) for CY 2023 and may be adjusted annually without the need for an amendment to the Demonstration.

Additional Supports for Targeted Populations

ARHOME will provide additional supportive services to targeted populations for which the State believes it could make a significant difference. Effective January 1, 2022, ARHOME will work with local hospitals, to be known as Life 360 HOMEs, to provide supportive services to certain high-risk Demonstration members.
ARHOME will create three types of Life 360 HOMEs:

1) Rural Life 360 HOMEs for rural populations and specifically for individuals with mental health and/or substance abuse diagnoses in rural areas;
2) Maternal Life 360 HOMEs for pregnant women who are considered high-risk pregnancies; and
3) Success Life 360 HOMEs for young adults most at risk for long-term poverty and poor health outcomes (i.e., young adults who are veterans or were in foster care, in the juvenile justice system, or incarcerated as adults).

Life 360 HOMEs will provide participants with intensive care coordination to connect them to needed health services and community supports, address social determinants of health, and actively engage them in promoting their own health. Beneficiary participation in a Life 360 HOME will be voluntary, and services will be supplemental to any medical services already covered by the beneficiary's QHP or Medicaid FFS. ARHOME will pay the Life 360 HOMEs for start-up costs, per member per month fees, and/or flat monthly fees to help the hospitals pay for the additional services. DHS will also award a success fee to the Success Life360 HOME for each client who completes and maintains their success plan.

Payment for Services in an Institution for Mental Diseases (IMD)

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.

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.

Planned Key Dates for Implementation

The current Demonstration expires December 31, 2021. The QHPs must file and finalize their Marketplace rates for Calendar Year (CY 2022) in the Summer/Fall of 2021. Because they will be at risk of per-capita expenditures that exceed Budget Neutrality, federal approval of the proposed Demonstration that aligns with the rate setting schedule is critical.

There is significant interest from hospitals to enroll as Life360 HOMEs in the summer of 2021 in order to begin operations on January 1, 2022. Appropriate planning, staff training, systems testing and development of community support will take a minimum of 3 months.

DHS anticipates only a few Life360 HOMEs will be prepared to begin January 1, 2022 and that more Life360 HOMEs will be added throughout 2022 and future years.
The new State executive-legislative Health and Economic Outcomes Accountability Oversight Advisory Panel ("Oversight Panel") will meet on a quarterly basis beginning in the later half of 2021. The Panel's key role in 2021 will be to review quality performance targets for the QHPs.

During 2022, DHS will work with the QHPs and community stakeholders to fully develop the operational changes necessary to effectuate the "inactive" beneficiary provision described in Section II. This provision will not be effective until CY 2023.

Impact on Stakeholders

Federal approval to continue to use QHPs as the primary vehicle to provide coverage for approximately 80% of the Demonstration's beneficiaries is crucial to all types of providers as the QHPs generally pay rates based on the commercial market rather than on Medicaid rates.

There will be significant stakeholder involvement of providers and consumer groups in the development of the Life360 HOMEs. Private sector community partners and public sector employment, education, and training programs will support the Health Improvement and Economic Independence Initiatives, including involvement in setting the annual quality performance targets.

B. Project Goals and Objectives – The Proposed Demonstration Promotes the Objectives of the Medicaid Program

The ARHOME program has three overarching goals:

1) improve the health outcomes among Arkansans especially in maternal and infant health, rural health, behavioral health, and those with chronic diseases;
2) provide incentives and supports to assist individuals, especially young adults in target populations, and to move out of poverty; and
3) slow the rate of growth in federal and state spending on the program so the Demonstration will be financially sustainable. All of these are consistent with the objectives of the Medicaid program.

Goal 1 to improve health outcomes is described at length in Subsection A. This Subsection B will focus in particular on the second goal, to assist individuals move out of poverty. This goal is consistent with the objectives of the Medicaid program because of the link between poverty and poor health. Reducing the incidence of poverty is a national objective as described in *Healthy People 2030* which established a target of reducing the proportion of persons below the poverty threshold from 11.8% in 2018 to 8.0% in 2030. National goals are met only if state actions are taken to implement them.

The three-year average poverty rate in Arkansas is 15% compared to the national average of 11.5%.[26] Only four states (Louisiana, Mississippi, New Mexico, and West Virginia) have higher poverty rates than Arkansas. The nexus between poverty, poor health, and premature death must be viewed from both directions; poor health causes poverty and poverty causes

[26] https://www.census.gov/library/publications/2020/demo/p60-270.html

poor health. It follows that using Medicaid to help individuals escape poverty is integral to its aim of improving their health.

The proposed Demonstration will align with several of the *Healthy People 2030* objectives including:

- Reduce the proportion of people living in poverty
- Increase employment in working-age people
- Reduce the proportion of young adults who aren't in school or working
- Increase the proportion of children living with at least 1 parent who works full-time[27]

Lowering the Medicaid "Benefit Cliff"

To meet the *Healthy People 2030* objective to "reduce the proportion of people in poverty," Arkansas must address what economists call the "hidden tax" on individuals at or near the poverty line as they increase their earnings. The relationship between increased earnings and decreased benefits has also been described as a "benefit cliff" or the "Medicaid cliff." The Center for Law and Social Policy ("CLASP") explains the "cliff:"

> Many programs aimed at basic needs (such as the Supplemental Nutritional Assistance Program (SNAP)—and Medicaid) are *means-tested*, meaning that they are only available to those with low incomes. … By definition, people lose eligibility for means-tested programs as their income rise. The specific design of a program is important because it significantly affects whether low-wage workers will transition off programs gradually as their earnings increase or experience a sharp reduction in benefits. When a small increase in earnings pushes someone just over the benefit limit, leading to an abrupt loss of benefits, they experience what is called a "cliff effect." Benefit cliffs can leave families no better—and in some cases much worse—than before a wage increase.[28]

In a March 2016 paper from the Centers on Budget and Policy Priorities (CBPP), *It Pays to Work: Work Incentives and the Safety Net*, the authors state, "adults in poverty are significantly better off if they get a job, work more hours, or receive a wage hike."[29] The dignity of work is a shared core American value as expressed by the Center for American Progress: "Work itself is fundamental to how human beings realize their destiny in this world." "Work, whether a paid job or unpaid work in the home, as a caregiver, or in a volunteer capacity is fundamental to human nature and its expression. This connection between work and human dignity lies at the core of progressive values."[30]

The American Enterprise Institute (AEI), in its April 2020 paper *Health and Poverty, The Case for Work*, expresses a similar perspective: "… work is essential to health and well-

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[27] https://health.gov/healthypeople/objectives-and-data/browse-objectives/economic-stability/reduce-proportion-people-living-poverty-sdoh-01

[28] https://www.clasp.org/sites/default/files/publications/2017/08/From-Rhetoric-to-Reality-What-it-takes-for-Public-Benefits-to-Work-Better-for-Workers.pdf p.1

[29] https://www.cbpp.org/research/federal-tax/it-pays-to-work-work-incentives-and-the-safety-net

[30] https://www.americanprogress.org/issues/religion/news/2009/02/24/5614/progressive-fundamentals-the-dignity-of-work/

being, especially for prime-age people who find themselves poor. By ignoring the importance of employment, government policies do a disservice to the people they purport to serve. The recognition that the act of work itself—not only the income it provides—is necessary for overall health requires a shift in how policymakers design safety-net programs in the US."[31]

The decades-long debate at the federal, state, and local levels over whether the safety net of public assistance programs is well designed to achieve the goal of full-time, all-year employment continues yet today. The CBPP describes a "work-based safety net" that has "substantially increased incentives to work for people in poverty." Moreover, CBPP describes the benefits of raising the federal minimum wage from $7.25 to $10.10 an hour and details how the Affordable Care Act (ACA) achieved a reduction in the health coverage "benefit cliff."

CBPP quotes the authors of $2.00 a Day: Living on Almost Nothing in America, "[e]verything we've learned about the $2-a-day poor suggests that *it is typically the opportunity to work that is lacking*, not the will, and that *ensuring work opportunity* would do no end of good (emphasis added)."[32]

At $11 per hour wage, the difference between eligibility and ineligibility for Medicaid is just one hour of work per month. By assisting those who are underemployed, ARHOME will lower the cliff for individuals and help them to realize the long-term benefits of full employment while making a much smoother transition from Medicaid eligibility into subsidized individual health insurance or employer-sponsored health insurance.

The movement of individuals as their income increases from Medicaid to other sources of coverage is not theoretical. In December 2019, prior to the impact of the Public Health Emergency (PHE) on enrollment, more than 64,000 (23.5%) of the total new adult eligibility groups had income above 100% FPL. In December 2020, the number of individuals with income above 100% FPL was over 75,000 (24%). Nearly 39,000 indivduals have income between 81% and 100% FPL.

As is typically understood, health insurance serves two major purposes—to gain access to necessary medical services and to protect against unforeseen and unpredictable financial losses. Insurance requires participation from a person when he/she *does not* have an immediate medical need. Sharing risk is central to the very concept of insurance. Getting tens of millions of healthy lives into the insurance pool was precisely the point of the ACA. Arkansas is unique among states in that it created a larger individual insurance pool by combining Medicaid and non-Medicaid lives. Through premium assistance, Arkansas has added, on average, about 230,000 people to be covered by the QHPs to spread risk in the individual market. It is also well established that insurance coverage increases medical utilization. ARHOME is an opportunity to understand how continuity of coverage can reduce adverse selection and smooth differences in utilization, both of which are important to

[31] https://www.aei.org/wp-content/uploads/2020/04/Health-and-Poverty-The-Case-for-Work.pdf?x91208 p.4.
[32] CBPP. p.10

stablize insurance pools. Premiums in the individual insurance market are consistently lower in Arkansas than the national average and those in surrounding states.[33]

For millions of Americans, health insurance potentially serves a third purpose: it is essential for moving out of poverty. To reduce the effects of the Medicaid "benefit cliff," individuals need the security of knowing they will still have health care coverage after they progress from unemployment to under-employment to full employment. This Demonstration enlists the added value of health insurance companies to go beyond what they traditionally provide to unlock new opportunities for people in poverty by providing them with incentives to access to education, training, and job opportunities, and thereby achieve improvement in socioeconomic conditions.

ARHOME will connect beneficiaries to public and private opportunities in education, training, and employment. The QHPs will offer incentives to their members to access such opportunities.

ACA Added to the Objectives and Purposes of Medicaid

Medicaid historically has not been considered health insurance but rather medical assistance. However, according to U.S. Supreme Court Chief Justice John Roberts writing for the majority in the June 28, 2012 decision in the landmark case, *NFIB v. Sebelius*, the ACA did not just add a new eligibility group to Medicaid, it created a new program: "[i]t [Medicaid] is no longer a program to care for the neediest among us, but rather an element of a comprehensive national plan to provide universal health insurance coverage."[34]

The objectives and purposes of Medicaid for the working-age adult population made newly eligible by the Affordable Care Act (ACA) can be traced back to the American version of social insurance established by the Social Security Act more than 85 years ago. Conceived as "social insurance," workers are "insured" by their contributions into the Social Security Trust Funds that in turn give them the right to a future benefit. The economic security of 65 million people who currently depend on monthly benefits paid out from the Trust Funds—the elderly, individuals with disabilities, and survivors of deceased workers—are contingent upon the 180 million workers paying into the system. Without the contributions of workers and their employers, our system of social insurance would collapse. Moving people from unemployment to under-employment to full employment is also critical to our national system of social insurance as the ratio of workers to beneficiaries continues to decline. An individual's own future retirement benefits are determined by the amount of contributions a person makes over his/her work history.

Thirty years after the Social Security Act was passed, Medicaid was added to the Act as Title XIX, "Grants to States for Medical Assistance Programs." 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,

[33] https://www.kff.org/health-reform/state-indicator/average-marketplace-premiums-by-metal-tier/view/print/?currentTimeframe=0&print=true&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[34] https://www.supremecourt.gov/opinions/11pdf/11-393c3a2.pdf p.53,54.

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. In 1980, 25 years after Medicaid was enacted, Medicaid covered less than 20 million people or about 8.6% of the total U.S. population.

Section 1901 of Medicaid provides, *"[f]or the purpose of enabling each State, as far as practicable under the conditions in such State to furnish medical assistance* on behalf of families with dependent children and of aged, blind, or disabled individuals whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and *other services to help such families and individuals attain or retain capability for independence* …" (emphasis added).

Because Medicaid is a grant to a state, each state participates in determining the purposes and objectives for its use. When the authorities of the state under Title XIX and the authority of the HHS Secretary under Title XI are read together, the purpose of Medicaid has multiple objectives as defined by the Governor, on behalf of the citizens of the state and with the consent of the Legislature. A Section 1115 Demonstration Project is a joint venture between the HHS Secretary and the State.

The original purpose of Medicaid made no reference to the newly eligible population created by the ACA because this group of people was excluded by definition. There simply was no pathway to Medicaid eligibility for a non-elderly, non-disabled adult without dependent children. When the new eligibility group was created by the ACA in 2010, Congress did not amend Section 1901. But the purposes of Medicaid must reasonably include this new group of working age, non-disabled adults. Given the correlation between poverty and poor health, reducing the incidence of poverty through increasing employment must be part of the purposes and objectives of Medicaid. Because of how our social insurance system is structured, increasing employment is also important for the individual's own future benefits.

The Secretary of HHS, as head of most of the anti-poverty programs funded by the federal government and administered by the states, has a library of information to inform his judgment about the negative effects of poverty on health and longevity when based on decades of research of his own agency. It is widely recognized, even if not completely understood, that people will cycle in and out of poverty for various lengths of time. Researchers at the Urban Institute have found that, "[n]ot surprisingly, the longer a person has been poor, the less likely he or she is to escape poverty."[35]

A critical piece to the Secretary's authority under Title XI is that Demonstrations must be evaluated. The importance of evaluation was described by President Bill Clinton shortly after he took office. President Clinton assured governors he would provide more waivers and greater flexibility in state experimentation. But taking a step further, he promised to authorize waivers for experiment under policies he did not agree with so long as there was "honest" evaluation. "That's the only thing I ask of you, if we say okay, we're going to have more waivers and you're going to experiment in projects that use federal dollars, let's measure the experiment, let's be honest about it. And if it works, let's tell everybody it

[35] https://www.urban.org/sites/default/files/publication/30636/411956-Transitioning-In-and-Out-of-Poverty.PDF

works so we can all do it, and if it doesn't let's have the courage to quit and admit it didn't."[36]

As Table 1 shows, the ACA had a dramatic impact on Medicaid enrollment, adding 20 million people even without the compulsory provision on states to expand coverage that was struck down in the *NFIB v. Sebelius* decision. The growth in Medicaid and CHIP enrollment between 2010 and 2018 exceeded the growth in total U.S. population. Nearly one in four Americans are enrolled in Medicaid or its companion program, the State Children's Health Insurance Program (CHIP) in the United States.

Year	Medicaid & CHIP Enrollees	U.S. Population	Medicaid & CHIP as Percent of Total Population
1975	20.2	215.9	9.35%
1980	19.6	227.2	8.63%
1985	19.8	237.9	8.32%
1990	22.8	249.5	9.14%
1995	32.8	262.8	12.29%
2000	36.4	281.4	12.93%
2005	50.2	296.4	16.94%
2010	59.5	309.8	19.21%
2015	75.3	320.6	23.48%
2018	79.9	327.2	24.42%

Table 1—Comparison of Medicaid and CHIP Enrollment to U.S. Population
(Numbers of Enrollees and Population in Millions)[37]

Medicaid is part of the overall health insurance system in a fundamentally new way, no longer separate from it. In the ARHOME design, individuals can maintain coverage with the same essential health benefits as they move from Medicaid to tax subsidies for their source of financial assistance. Since enactment of the ACA, many advocates have since promoted the idea that Medicaid is no longer just "medical assistance," but now the nation's *health insurance program* for people with low income.[38] Indeed, since 2011, Medicaid rules have described it as an "insurance affordability program." But do the individuals themselves in this new adult eligibility group view coverage as insurance, treat it as insurance, and value it as insurance including by paying for a small part of their coverage? To determine whether these beneficiaries find coverage to be "affordable" is consistent with the objectives of the program.

It is of national significance to evaluate whether this new adult group views Medicaid as health insurance. Simply calling Medicaid "insurance" does not make it so. The actions of the participants in the program will prove or disprove the matter. Arkansas is uniquely situated to find out. It is now the only state that uses Medicaid funds as premium assistance

[36] https://www.irp.wisc.edu/publications/dps/pdfs/dp106695.pdf p. 36.
[37] Table 1 was created from CMS and Census data
[38] For example, see https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-setting-the-facts-straight/

to purchase coverage from private QHPs that also offer products in the individual insurance market. An individual can move seamlessly from Medicaid to the individual insurance market and keep the same essential health benefits and the same access to providers.

Even with subsidies that are available through employers and federal tax credits, individuals around the country make decisions about affordability and value for themselves. The premiums and cost sharing provisions described in Section IV will test whether individuals value their coverage as "affordable."

DHS has reviewed research on the use of premiums and cost sharing in Medicaid including recent studies based on the experiences of Massachusetts and Michigan. The Massachusetts study in particular that analyzes low-income individuals' willingness to pay (WTP) for health insurance raises important issues not just about Medicaid but how public subsidies in the ACA are structured.[39] There are important differences in the ARHOME design and the experiences of other states that used premiums and cost sharing in Medicaid. Overall, the research and literature on this new adult eligibility group suggests the need for additional study. ARHOME will be particularly useful as a model to demonstrate how to reduce the Medicaid "benefit cliff" while maintaining take-up rates as good or better than the take-up rates of individual insurance coverage through the Marketplace with tax credit subsidies among individuals with income between 100% and 150% of FPL. The evaluation of ARHOME will specifically compare take-up rates and WTP for low-income individuals.

To address the three ARHOME goals, the State will use the Demonstration to evaluate the following hypotheses:

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.
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.
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.
D. QHP members will have equal or greater satisfaction in the care provided compared to Medicaid FFS beneficiaries.
E. QHP members will decrease the non-emergent use of emergency department services compared to the baseline and will lower use compared to Medicaid FFS beneficiaries.
F. 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.
G. 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.

[39] https://www.nber.org/system/files/working_papers/w23668/w23668.pdf

H. 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. Have better health outcomes due to treatment adherence.

I. 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.
    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.
    6. Have improved birth outcomes for their infants.

J. Compared to similar ARHOME beneficiaries in areas without a Success Life360 Home, young ARHOME beneficiaries most at risk of 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. Have better health outcomes due to treatment adherence.

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

Program elements / Mechanisms of change:

- Premium Assistance Model
- An Economic Independence Initiative in which QHPs will offer incentives to their members to participate in employment, education, and training opportunities.
- Rural, Maternal, and Success Life360 Homes

Hypotheses

A. Among QHP members with income at or below 20% FPL, the percent that increase income to above 20% FPL will increase over time.
B. Among QHP members with income at or below 100% FPL, the percent that increase income to above 100% FPL will increase over time.

C. Among QHP members who disenroll from ARHOME, the percent that disenroll due to increased income will increase over time.
D. Arkansas residents in rural areas with a Rural Life360 HOME will reduce their unmet health-related social needs and will have fewer unmet health-related social needs over time due to their ability to access local community resources compared to residents in rural areas in the rest of the state without a Rural Life360 Home.
E. ARHOME beneficiaries with SMI or SUD who receive services from a Rural Life360 Home will have fewer health-related social needs and improved social determinants of health (SDOH) compared to similar ARHOME beneficiaries in rural areas without 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.
G. Young ARHOME beneficiaries most at risk of long-term poverty who receive services from a Success Life360 Home will improve their socioeconomic status compared to similar ARHOME beneficiaries who do not participate in a Success Life360 Home.
H. ARHOME beneficiaries who were formerly incarcerated who receive services from a Success Life360 HOME will have lower recidivism rates compared to similar ARHOME beneficiaries who do not participate in a Success Life360 HOME.

Slow the Rate of Growth in State Spending for the Demonstration Population.

Program elements / Mechanisms of change:

A. Premium Assistance Model
B. Health Improvement Initiative
C. QHP members with income above 100% FPL will contribute to the cost of their coverage through monthly premiums and reduce the amount of premium subsidies paid through the State.
D. QHP members will contribute to the cost of their care through point-of-service copayments up to 5% of household income.
E. Rural and Maternal Life360 Homes

Hypotheses

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.
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.
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.

2. 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.

D. 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.

E. 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.

C. Modifications to Medicaid State Plan – Describe any other State Plan program features that the demonstration would modify to permit the State to implement the demonstration flexibilities described in application section I.A. as well as any corresponding State Plan amendments the State will need to effectuate these State Plan program changes.

ARHOME will modify the State Plan or other waivers of authority in the following areas:

- Use of copayments
- Services provided through an IMD
- Enrollment in a PASSE. After Arkansas Works was amended and extended in 2016, the State subsequently established coverage through full-risk Provider-Led Arkansas Shared Savings Entity (PASSEs) for individuals with a behavioral health diagnosis and in need of services beyond counseling and medication management. There are currently three PASSEs that provide coverage to approximately 46,000 children and adults. The PASSEs provide comprehensive services and are subject to the Medicaid managed care organization regulations. Under ARHOME, individuals who are identified through an Independent Assessment (IA) as needing SMI/SUD services will be enrolled in a PASSE—rather than being assigned to a QHP—and will receive all services through that PASSE in accordance with the PASSE 1915(b)(4) waiver, the 1915(i) Arkansas Community Services State Plan Amendment, and the Arkansas PASSE Provider Manual.

D. Modifications to Existing Section 1115 Demonstration – Identify by project name and number any existing section 1115 demonstration the State proposes to transition, in whole or in part, into the proposed Demonstration. Describe the existing section 1115 demonstration feature(s) that the proposed Demonstration would modify, including identifying the individuals who would be eligible for coverage under the proposed Demonstration who are already eligible for coverage under the existing demonstration(s). Describe whether and how the State proposes to modify or terminate current section 1115 demonstrations should this application for a Demonstration be approved.

ARHOME will modify Arkansas's existing 1115 demonstration, Arkansas Works, Project Number 11-W-00287/6 in the following areas:

Premiums and Copayments

Arkansas Works requires individuals with household income above 100% FPL to pay premiums for their QHP coverage and copayments. ARHOME will continue requiring those above 100% FPL to pay a percentage of household income for the premium, but will increase the member's share to reflect the Department of Treasury Applicable Percentage Table published each year. All ARHOME members will pay copayments subject to federally allow per service amounts and not more than 5% of household income per quarter.

Under Arkansas Works, if members did not pay their premiums, that debt was owed to the State. Arkansas paid the QHPs for the premiums owed, and collected outstanding premiums from members through a tax intercept process. Under ARHOME, any premiums and copayments not paid to the QHPs or providers will be considered a debt to the carrier or provider. The State will discontinue the use the tax intercept process to collect unpaid premiums.

ARHOME proposes to apply copayments to individuals with household income above 20% FPL that align with federally allowed amounts with an overally cap of 5% including any premium. Copayments are obligations of the individual. Medicaid payments to a provider are generally "payment in full," and providers may not balance bill to a Medicaid beneficiary. Waiver authority is necessary to make payments to providers in excess of what can be charged to the beneficiary.

Health Improvement Initiative and Economic Independence Initiative Incentives

As described each year in the annual purchasing guidelines and Memorandum of Understanding (MOU), QHPs will offer incentives to their members to use opportunities to improve the health of their members and move towards economic independence. QHPs will tailor incentives to individual members or member groups, and they will be allowed to reduce or waive members' premium and/or cost sharing obligations as one type of incentive.

QHP Accountability for Health Improvement

Under Arkansas Works, QHPs received premium assistance payments but were not accountable under the MOU for the quality of care members received. ARHOME aims to improve the health of members by holding the QHPs accountable for their performance on health quality measures. QHPs will be required to submit claims data to determine QHP-specific performance on each measure. QHPs will be subject to sanctions for failure to meet performance targets, ensuring they are held accountable for improving the health of their members.

Additional Supports for Targeted Populations

ARHOME will provide additional supportive services to targeted populations for which the State believes it could make a significant difference. This is an entirely new component not offered in any form in the current Arkansas Works Demonstration. DHS will work with local

hospitals and community partners to form entities around the state called Life360 HOMEs, that will provide supportive services to certain high-risk Demonstration beneficiaries ARHOME will create three types of Life360 HOMEs as previously described:

1) Rural Life360 HOMEs
2) Maternal Life360 HOMEs
3) Success Life360 HOMEs

Life360 HOMEs will provide participants with care coordination and supports, connect them to needed health services and community supports, address social determinants of health, and actively engage them in promoting their own health care. Member participation in a Life360 HOME will be voluntary and services will be supplemental to any medical services already covered by their QHP. ARHOME will pay the Life360 HOMEs for start-up costs, per member per month fees, and/or flat monthly fees to help the hospitals pay for the additional services. DHS will also award a success fee to the Success Life360 HOME for each client who completes and maintains their success plan.

As an additional incentive to the Success Life360 HOME participants achieve their education, employment, and community living goals, the Demonstration proposes to pay the employee share of premium for employer sponsored health insurance or the premium for individual insurance available in the Marketplace for a temporary period to help lower the "Medicaid cliff" these young adults face and make the transition to economic independence.

Identification of "Inactive" Beneficiaries to be Re-assigned to FFS

The Demonstration population is currently compose of individuals who are enrolled in a QHP. In the ARHOME program the Demonstration population will also include inactive beneficiaries who are re-assigned to FFS. DHS will define this inactive population and the process and procedures for the inactive group through state rulemaking. This provision will take effect on or after January 1, 2023. The expenditures for the inactive beneficiaries in FFS may be counted as Demonstration expenditures. This inactive group is described in greater detail in Section II.

Limiting Expenditure Growth

In order to help ensure the annual budget target for the ARHOME program is not exceeded, DHS will establish an enrollment range for the ARHOME program in advance of each calendar year. DHS shall inform the QHPs of the minimum and maximum monthly enrollment targets in the annual purchasing guidelines. The State may temporarily suspend auto-assignment of newly eligible individuals into a QHP if necessary to meet the annual budget target. This suspension does not apply to a newly eligible individual who actively selects a QHP. The operational procedures for administering the enrollment targets will be specified in the Memorandum of Understanding (MOU).

Work and Community Engagement (WCE) Requirements

Under the Arkansas Works amendment approved March 2018, members were required to engage in work, education, or community service activities for at least 80 hours per month and report their compliance as a condition of maintaining Medicaid eligbility. This provision

was suspended due to litigation in March 2019 may still be reviewed by the US Supreme Court. The proposed Demonstration does not include these provisions. 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.

Section II – Eligible Populations and Processes for Eligibility and Enrollment

The State will cover all adults ages 19-64 who qualify for Medicaid on a basis other than disability or need for long-term care services and supports and who are not covered in the State Plan, described in the new adult group at section 1902(a)(10)(A)(i)(VIII) of the Act and 42 CFR 435.119 (the new adult group), and who have income at or below 133 percent of the Federal Poverty Level (FPL) with an effective rate of 138% FPL.

At the end of March 2021, there were a total of 318,095 beneficiaries enrolled in the new adult group. Of these, 271,320 (85%) received their coverage and benefits through a QHP. The other 46,775 beneficiaries received their coverage through the Medicaid Fee-for-Service (FFS) system and their benefits are provided through the Alternative Benefit Plan (ABP) defined under Section 1937 authority. The expenditures made on these individuals are outside the premiums, cost sharing reduction payments, wrap around benefits, and reconciliation payments made to the QHPs and therefore are not Demonstration expenditures. The FFS population currently consists of three populations:

1) **Medically Frail Individuals.** There are approximately 21,000 individuals each month who are medically frail and are covered through the FFS system. Arkansas has instituted a process to determine whether a beneficiary is medically frail. The process is described in the Alternative Benefit Plan (ABP) State Plan. ARHOME beneficiaries will be excluded from enrolling in QHPs as a result of a determination of medical frailty as defined in the Arkansas State Plan will have the option of receiving direct coverage through the State of either the same ABP offered to the members or an ABP that includes all benefits otherwise available under the approved Medicaid State Plan (the standard Medicaid benefit package).

2) **American Indian/Alaska Native Individuals.** Members identified as American Indian or Alaskan Native (AI/AN) will not be required to enroll in QHPs in this Demonstration but can choose to opt into a QHP. Members who are AI/AN and who have not opted into a QHP will receive the ABP through FFS. An AI/AN member will be able to access covered benefits through Indian Health Services (IHS), Tribal or Urban Indian Organizations (collectively, I/T/U facilities are entitled to payment notwithstanding network restrictions).

3) **Interim Individuals Who are Not Medically Frail.** An interim beneficiary is an individual who is covered by the ABP through the FFS system and who is not medically frail. This group of individuals remain in FFS until they either select a QHP and are enrolled in the QHP of their choice or if they do not make a QHP selection, are auto-assigned into a QHP. Individuals who are auto-assigned have 30 days to switch to a different QHP. Due to fluctuations in Medicaid

applications, the FFS-Interim population ranges from 25,000 to 30,000 individuals each month.

The new ARHOME program will add a new benefit package and service delivery system for individuals within the new adult eligibility group who are identified to have with Serious Mental Illness (SMI) or Substance Use Disorder (SUD).
These are:

1) **Individuals with Behavioral Health Needs for Additional Services.** If a beneficiary has a serious mental illness (SMI) or substance use disorder (SUD), the individual may be referred for an Independent Assessment (IA). If the evaluation indicates the individual may need additional services and may benefit from intensive care coordination, the beneficiary will be enrolled in the Provider-Led Arkansas Shared Savings Entity (PASSE) program and receive all services through a PASSE in accordance with the PASSE 1915(b)(4) waiver, the 1915(i) Arkansas Community Services State Plan Amendment, and the Arkansas PASSE Provider Manual. The PASSE program is a full-risk comprehensive Medicaid managed care model. Premiums paid to the PASSEs are outside the premiums and cost sharing reduction payments made to the QHPs and therefore are not Demonstration expenditures. DHS estimates approximately 1,500 individuals currently within the FFS medically frail group may be enrolled in a PASSE.

A. Demonstration Population(s) – The State should identify below the population(s) it intends to cover under the Demonstration.

The Demonstration population currently is composed of those individuals who are enrolled in a Qualified Health Plan (QHP. Individuals who are enrolled in a QHP will continue as the Demonstration population in the new ARHOME program. As of the end of March 2021, there was a total of 318,095 beneficiaries in the new adult eligibility group, of which 271,320 beneficiaries (85%) were enrolled in a QHP.

The Demonstration population will also include inactive beneficiaries who are re-assigned to FFS. The purpose of identifying these inactive individuals is to educate them about the value of coverage through an insurance product and opportunities available to them to improve their health and socioeconomic status especially through the incentives offered through the Health Improvement Initiative (HII) and the Economic Independence Initiative (EII). If these individuals choose not to take advantage of any of such opportunities over a period of time, they may be re-assigned into FFS. An individual will be re-enrolled in a QHP when the individual takes any one of many possible actions, including making a choice to enroll in a QHP, to demonstrate that coverage through an insurance product is valued. DHS will define this inactive population and the process and procedures for the inactive group through state rulemaking. This provision will take effect on or after January 1, 2023. The expenditures for the inactive beneficiaries in FFS may be counted as Demonstration expenditures.
This provision is described in greater detail in B, “Enrollment Processes.”

B. Enrollment Processes – The State should identify the approach it intends to take for processing beneficiary eligibility and enrollment under the Demonstration.

The State will follow requirements of section 1943 of the Act (as implemented in regulation at 42 CFR part 435 subpart J) for this demonstration EXCEPT as described below with the intended purpose of improving administrative efficiency of the State's eligibility and enrollment processes:

The State proposes to modify 42 CFR 435.915, "Effective Date," to reduce the effective date of eligibility to 30 days prior to the date of application. Retroactive eligibility is inconsistent with the principles of insurance. In general, individuals seeking coverage through their employers or the individual insurance Marketplace have a limited period of time in which to apply for coverage that begins at a future time. In the ARHOME program, individuals will be permitted to apply for Medicaid coverage at anytime during the year. The individual will also be permitted to requests retroactive coverage for 30 days prior to the date of application.

QHP Selection

The QHPs into which ARHOME members enroll are certified through the Arkansas Insurance Department (AID). The criteria for QHPs available for selection by the member are determined by the Medicaid agency and described in annual purchasing guidelines. DHS enters into a Memorandum of Understanding (MOU) with each QHP available for selection.

Auto-Assignment

In the event that a member is determined eligible for coverage through the ARHOME QHP premium assistance program, but does not select a QHP in the specified time, the State will auto-assign the member into one of the available QHPs in the member's rating area. Members who are auto-assigned will be notified of their QHP assignment and the effective date of QHP enrollment and will be given a thirty (30) day period from the date of enrollment to request enrollment in another plan.

ARHOME QHP auto-assignments will be distributed proportionately among QHPs based on the number of QHPs in good standing with AID that meet the Purchasing Guidelines released by DHS not later than April 30 each year.

Temporary Suspension of Auto Assignment

Beginning January 1, 2022, the State may modify the auto-assignment enrollment process into a QHP from the current Demonstration for those individuals who do not choose a QHP within the permitted time period. Auto-assignment of enrollment into a QHP may be modified, if necessary, to meet its annual budget target.

For Calendar Year (CY) 2022, maximum monthly QHP enrollment will be capped at 320,000 beneficiaries. However, individuals who become eligible throughout the year and choose their QHP will be enrolled into the QHP regardless of the number of people enrolled in a QHP at that time. DHS will not "disenroll" individuals already in a QHP to get below the cap. If QHP enrollment reaches the maximum monthly enrollment level, DHS will temporarily suspend auto assignment for those who do not choose a QHP until QHP enrollment is not more than 80 percent of total enrollment. For reference, QHP enrollment has historically been approximately 80 percent of total enrollment. This provision does not

impact eligibility for Medicaid. During this period of suspension, these beneficiaries will be covered by the ABP in FFS.

The need for this temporary enrollment cap was triggered by the unexpected 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 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:

	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%

Table 2—Monthly Average Enrollment

The State set the lower end of enrollment at 80 percent of the total number of ARHOME beneficiaries based on historical data. 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 is developing a specific plan for the end of the PHE that will be coordinated with the QHPs.

This temporary suspension of auto-assignment does not impact beneficiaries who are determined to be eligible and make a selection of a QHP. The active choice of a QHP is a goal of the Demonstration and the individual will be enrolled into that QHP according to the regular process.

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.

Re-assignment of Inactive QHP Beneficiary to Coverage Through FFS

DHS will further define an active and inactive QHP beneficiary through the state rule-making process to be effective on or after January 1, 2023. DHS will notify CMS 60 days prior to the effective date of any change to the definition. An active QHP beneficiary is an individual who has taken any of one of many activities, including the selection of their QHP, the use of coverage for a preventative screening or service, the use of coverage for a medical service, the completion of a health assessment, the positive response to an HII or EII

opportunity, and other such actions. The identification of activities will be done through data matches with QHPs and state agencies and will not require any reporting by the beneficiary. The beneficiary who has been identified as inactive and the QHP will receive notification prior to the 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. This provision applies only to re-assignment of inactive QHP beneficiaries to FFS coverage and shall not have any impact on eligibility for the ARHOME program or any other Medicaid program. 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.

Notices.

ARHOME members will receive a notice or notices from Arkansas Medicaid or its designee advising them of the following:

a. QHP Selection. The notice will include information regarding how ARHOME members can select a QHP and information on the State's auto-assignment process in the event the member does not select a plan.
b. State Premiums and Cost sharing. The notice will include information about the member's premium and cost sharing obligations, as well as the quarterly cap on premiums and cost sharing.
c. Access to Services until QHP Enrollment is Effective. The notice will include the Medicaid Identification Number (MID) and information on how members can use their MID to access services until their QHP enrollment is effective.
d. Wrapped Benefits. The notice will also include information on how members can access wrapped benefits, or services that are provided directly by fee-for-service Medicaid. The notice will identify which services are wrapped benefits and the phone number to call or the website to visit to access wrapped benefits.
e. Grievances and Appeals. The notice will also include information on grievance and appeal rights and how to access the grievance and appeal process. Grievances and Appeals are described in greater detail in Section VIII, "Fair Hearing Rights."
f. Identification of Medically Frail and Behavioral Health PASSE Members. The notice will include information describing how ARHOME beneficiaries who believe they are medically frail or in need of Behavioral Health Services that are provided through a PASSE can request a determination of whether they are exempt from ABP and fall into one of these two categories. The notice will also include ABP options.
g. Timely and Adequate Notice Concerning Adverse Actions. The notice will give members timely and adequate notice of proposed action to terminate, discontinue or suspend their eligibility or to reduce or discontinue services they may receive under Medicaid regulations.

C. Enrollment Projections – Please specify the data source(s), methodology, and supporting analysis used, including an explanation of the assumptions used and any limitations on the data, as applicable, to derive the enrollment counts.

The proposed Demonstration will use a per capita methodology to establish Budget Neutrality (BN). The State will not assume risk on enrollment. Enrollment projections are

important as they are used to set "without waiver" ("WOW") and "with waiver ("WW") expenditures over the new five-year period. Total member months are determined at the end of the five year Demonstration period to calculate the amount of payment owed to the federal government if the BN per capita amount is exceeded.

In its June 2016 application for the current Demonstration, DHS projected enrollment in the Demonstration would grow 2.5% annually and increase from 2,953,513 member months in CY 2017 to 3,260,126 in CY 2021. Member months are used to account for the fluctuation in enrollment within a 12-month period as month-to-month enrollment varies. Some beneficiaries are enrolled for all 12 months within the same calendar year while others are enrolled for shorter periods of time. Table 2 below illustrates the differences in projected enrollment and actual enrollment in AR Works.

Year	Projected Member Months	Actual Member Months
CY 2017	2,953,513	3,143,965
CY 2018	3,027,351	2,714,418
CY 2019	3,103,034	2,432,883
CY 2020	3,180,610	2,802,062
CY 2021	3,260,126	Not complete

Table 3—Projected and Actual Arkansas Works Demonstration Enrollment 2017-2021

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. Monthly 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 will likely have a significant impact on enrollment, although there are unresolved questions about timing and implementation. After PHE ends, DHS will reset the member month estimate for CY 2022. Beyond 2022, DHS estimates annual growth rate will reflect normal population growth. DHS intends to use CMS National Health Expenditure (NHE) data on Medicaid enrollment as a guide to inform projections for CYs 2023-2026. Enrollment projections are described in greater detail in Section VI, "Financing and Cost Projections."

Impact of Churn on Enrollment and Dis-enrollment

Every Section 1115 Demonstration is required to be evaluated. Section IX describes the "Performance Baseline Data" for the new ARHOME program and Section X describes the "Evaluation" for the new ARHOME program. Understanding how "churn" impacts enrollment will be important to the proper evaluation of ARHOME. Churn is well known to the Medicaid program and researchers. It describes movement of individuals on and off the program within a single year and over multiple years. Observing that churn occurred does not provide an explanation for why churn occurred. As previously stated, Medicaid enrollment is highly sensitive to the economy. The end of the PHE will have a significant impact on churn. Changes in policies and operations can also have an impact on churn. Table 4 provides enrollment data that illustrates the churn that has taken place in the Arkansas Works program between CY 2017 and CY 2020.

	Unduplicated Count of Enrollees	Average Monthly Enrollment	Enrolled in the Full CY (Jan. 1-Dec. 31)	Newly Enrolled in the CY	Previously Enrolled, Returned
CY 2017	434,012	325,987	224,079	87,542	13,348
CY 2018	398,741	291,320	179,213	76,509	22,123
CY 2019	367,611	266,048	173,176	68,355	43,220
CY 2020	357,727	285,841	222,263	56,063	38,280

Table 4—Churn in Arkansas Works CY 2017-2020

Over this four-year period, there were 172,900 (27.2%) individuals enrolled for at least one month in all four years and 174,389 (24.5%) who were enrolled in only one calendar year. The enrollment numbers in each year include unique circumstances:

- During 2017, DHS caught up on its re-determinations backlog and improved its eligibility accuracy and timeliness.
- During 2018, the Work and Community Engagement (WCE) notifications began in June 2018. The earliest month in which someone could have been disenrolled for noncompliance was September 2018 as individuals could not be disenrolled until three months of noncompliance.
    - In CY 2018, 134,116 individuals disenrolled from AR Works. Of these, 44,730 (33.3%) returned in 2018, 2019, or 2020.
    - Nearly 88% of those who disenrolled in 2018 left for reasons other than WCE.
    - 18,281 (13.6%) disenrolled due to increased household income.
    - 16,583 (12.4%) were disenrolled due to non-compliance with the WCE.
    - 7,364 of those disenrolled due to WCE non-compliance returned to Medicaid coverage within 12 months of disenrollment (44.4% of disenrolled for non-compliance)
- During 2019, the WCE were in effect from January to March. No one was disenrolled for non-compliance as individuals could not be disenrolled until three months of non-compliance.
    - In CY 2019, 95,685 individuals disenrolled from AR Works. Of these, 22,173 (23.2%) returned in CY 2019 or CY 2020.

- During 2020, the PHE due to COVID-19 dramatically reduced disenrollments. The number of people enrolled for the entire CY 2020 was nearly 50,000 higher than those enrolled for the entire CY 2019.
    - In CY 2020, 49,507 individuals disenrolled from AR Works.

The evaluation of ARHOME will include contemporaneous interviews with a sample of individuals who disenroll and will leverage the state's All-Payers Claims Database (APCD) to determine whether those who disenroll obtain another source of coverage for health insurance.

ARHOME Policy Changes That May Impact Enrollment

The most significant impact on enrollment will be the end of the PHE, which will result in redetermination actions. After that time, enrollment is expected to reflect historical levels. Proposed changes to the Demonstration are not changes to conditions of eligibility. Participation in the three types of Life360 HOMEs is voluntary. Beneficiaries' use of incentives to access health and economic independence initiatives is voluntary. Copayments do not impact eligibility for the program or enrollment in a QHP.

The only policy change that DHS anticipates may impact enrollment is the provision on premiums for individuals with income above 100% FPL who will apply for the program in the future. Premiums already apply to the this population so any deterrent to enrollment is already occurring. The premium amount paid by the individual in ARHOME will be a small increase above the current amount that reflects 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, 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. It is also vital to help beneficiaries bridge the Medicaid "benefit cliff."

There is little research on the impact of premiums on enrollment that is informative to the adult population covered by the Demonstration. 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.[40] 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

[40] https://www.cbo.gov/system/files/2020-09/56504-Health-Insurance.pdf

eligible for ACA subsidies, nearly 17 percent remain uninsured.[41] 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.[42] 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.

Sharing the cost of coverage is an important element of health insurance and demonstrates the individual values coverage. If cost to the individual is the only consideration, ARHOME makes coverage even more "affordable" and therefore should have a higher take-up rate than individuals at the same income levels who receive subsidies only for their premiums.

The American health insurance system is also based on some level of active participation by individuals in exercising choice. Giving individuals a choice among health plans is an important element to competition, which is necessary to hold down costs.

Under the current Demonstration, 80% of individuals do not make an active choice of their QHPs and are instead auto-assigned. In 2023, DHS expects to implement processes and procedures for identifying "inactive" beneficiaries. These inactive beneficiaries still will be in the Demonstration population but covered through FFS. The evaluation will include whether individuals value insurance coverage by taking one of many actions, including simply choosing a QHP to return to QHP coverage.

D. Eligibility and Enrollment Design Flexibilities –The State should indicate the provision(s) that it is requesting to <u>not apply</u> to the demonstration in order to permit the State to implement the program flexibilities made available under the Demonstration initiative through the use of section 1115(a)(2) authority.

Waiver authorities that are requested for the Demonstration are covered in Section VII, "Section 1115 Authorities."

[41] https://www.cbpp.org/research/health/improving-aca-subsidies-for-low-and-moderate-income-consumers-is-key-to-increasing

[42] See https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Impact-Premium-Affordability.pdf Appendix I

Section III – Benefit Package

For populations covered under this Demonstration initiative, benefits generally will be expected to align with coverage available through the individual health insurance market, such as qualified health plans (QHPs) offered through the Exchange in the state or in another state. States may also propose other benefit options for providing comprehensive coverage that meet larger health reform and Medicaid objectives. The State should complete the applicable sections below that correspond with the benefits package it proposes to provide under the Demonstration.

A. Essential Health Benefits Package. The State is aligning the benefit package for this demonstration population with the EHB-benchmark plan used by the State's Department of Insurance for purposes of the individual market in the state by providing the coverage described in that EHB-benchmark plan, in a manner that complies with the EHB requirements for the individual insurance market under 45 CFR 156.100 through 156.125, including the regulation at 45 CFR 156.115(a)(3) applying the requirements of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) as implemented at 45 CFR 146.136, and with the annual and lifetime dollar limit prohibition at 45 CFR 147.126. The benefits provided under an alternative benefit plan (ABP) for the new adult group are reflected in the Arkansas ABP State Plan.

B. Additional ARHOME Benefits and Services. Members affected by this Demonstration will receive additional "wrap around" benefits as set forth in Section 1905(y)(2)(B) of the Act and 42 CFR § 433.204(a)(2). These benefits are described in Arkansas's Medicaid State Plan. The State will provide, through FFS Medicaid, wrap benefits that are required for the ABP, but not covered by the QHPs. These benefits consist of NEMT and Early Periodic Screening, Diagnosis and Treatment (EPSDT). The State will fulfill its responsibilities for coverage of 19 and 20 year olds with respect to EPSDT services that are described in the requirements of Sections 1905(a)(4)(b) (services), 1902(a)(43) (administrative requirements), and 1905(r) (definitions). The State will establish prior authorization for NEMT in the ABP. Beneficiaries served by the Indian Health Services (IHS) or Tribal facilities and medically frail beneficiaries will be exempt from such requirements.

C. Access to Wrap Benefits. In addition to receiving an insurance card from the applicable QHP issuer, ARHOME members will have a Medicaid identification number (MID) through which providers may bill for wrap benefits. The notice containing the MID will include information about which services ARHOME members may receive through FFS Medicaid and how to access those services. This information is also posted on DHS's Medicaid website and will be provided through information at DHS call centers and through QHP issuers.

D. Access to Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs). ARHOME members will have access to at least one QHP in each rating area that contracts with at least one FQHC and RHC. Payment will be based on a value-based payment (VBP) methodology consistent with regulations applicable to QHPs at 45 CFR 156.235(e).

E. Prescription Drug Coverage. State will provide a prescription drug benefit in accordance with section 1927 of the Act.

F. Institution for Mental Disease (IMD) IMD Coverage. The State is requesting Section 1115(a)(2) authority to provide services to individuals in an IMD for the purpose of providing them treatment for Serious Mental Illness (SMI) or Substance Use Disorder.

G. Care Coordination through Community Bridge Organizations. DHS will enter into cooperative agreements with three types of Community Bridge Organizations (CBOs) for the targeted populations identified in this application. These CBOs will be known as Life 360 HOMEs. ARHOME members enrolled in QHPs and eligible to receive Life 360 HOME services will have access to Life 360 HOMEs participating in their area. The CBOs will receive direct payment from DHS to provide intensive care coordination to the target populations previously described in Section I. The new care coordination benefit is not provided by nor funded through QHPs but will be counted as Demonstration expenditures.

Care coordination includes screening and assessing the individual's needs for SDOH supports, the development of a person-centered support plan to set the socioeconomic goals to be achieved, coordination with external medical and nonmedical providers, effective communication with clients and community partners, follow-up, and community transitions. These activities may be directed by community "coaches," peer specialists, peer counselors, and home visitors who work directly with individuals and their families to improve their skills to be physically, socially, and emotionally healthy to live successfully in their communities. This service will be available only through a Life360 HOME. A Life360 HOME must be a hospital. The hospital may provide care coordination through its own employees or through cooperative agreements with local partners as defined by DHS.

Care Coordination Benefits	
Name of Benefit	**Service Description, Limitations, and Provider Qualifications**
Care Coordination through Rural Life 360 HOME	Hospitals enrolled as Rural Life360 HOMEs will provide SDOH screening and referral to local community resources to anyone in the community. They will employ "coaches" or peers to assist ARHOME beneficiaries with a serious mental illness (SMI) or substance use disorder (SUD) and with getting medical treatment and with meeting health-related social needs.

Care Coordination through Maternal Life 360 HOME	Hospitals enrolled as Maternal Life 360 HOMEs will provide or will contract with a partner to provide home-visiting services to members with high-risk pregnancies. Qualified beneficiaries are eligible to begin receiving home visiting services during pregnancy and for two years following the birth.
Care Coordination through Success Life 360 HOME	Hospitals enrolled as Success Life360 HOMEs will partner with one or more non-profit community service organizations to provide proven support models to young adults to help them address health-related social needs, such as finding safe and stable housing, being effective parents and finding a path to long-term economic independence through work and education.

H. Incentives. The QHPs will offer incentives to reward their members for participating in the Health Improvement Initiative or the Economic Independence Initiative. 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 available to participate in increasing employment, education, training, or skills development. These will be described in the annual purchasing guidelines and the annual Memorandum of Understanding.

Section IV – Premiums and Cost Sharing

A. Beneficiary Protections – States may have broad flexibility to establish premiums and cost sharing structures. We would expect states to adhere to the following overarching limitations:

- **Aggregate out-of-pocket costs incurred by beneficiaries covered under the Demonstration would not exceed five percent of the beneficiary's household income, measured on a monthly or quarterly basis.**
- **Premiums and cost sharing charges for individuals needing treatment for substance use disorder and individuals living with HIV as well as cost sharing charges for prescription drugs needed to treat mental health conditions would not exceed amounts permitted under the statute and implementing regulations. States similarly would not be permitted to suspend enrollment for such individuals for failure to pay premiums or cost sharing, even if authorized for other individuals under the demonstration.**

The state should check one of the below options to confirm whether it intends to implement cost sharing requirements (i.e., enrollment fees, premiums, cost sharing or similar charges) for individuals targeted by this Demonstration initiative.

☐	**NO**, this demonstration will not have any beneficiary requirements for premiums or cost sharing. If the State checks this box, it should proceed to section V of this application.

☒	**YES**, this demonstration will have beneficiary requirements for premiums, deductibles, co-payments, and/or similar cost sharing charges. If the State checks this box, it should also complete subsection B and C of this application section.

B. Beneficiary Cost sharing Structure – The State should identify the premium and/or cost sharing structure that it intends to implement during the course of the approved demonstration period. If the State is anticipating using a range of premium and/or cost sharing options over the course of the approved demonstration period, the State should identify the range of options as indicated in the designated boxes below.

DHS will set premiums and cost sharing obligations by FPL bands in 20 point increments beginning at 0% FPL to 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. Members in the same FPL band will pay at the lowest level in the band.

ARHOME will require those individuals with income above 100% FPL to pay a share of the QHP premium beginning at 2.07% of an individual's household income in 2022. The premium percentage will be indexed annually to follow the Department of Treasury Applicable Percentage Table for each year.

The amounts for premiums and cost sharing will be updated when necessary to reflect changes 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. 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
- $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 who are enrolled in FFS as medically frail and those enrolled in a PASSE will not be subject to cost sharing and/or premiums.

The distribution of beneficiaries by FPL band can vary month-to-month. The tables below show the distribution at three different points in time:

Distribution of ARWorks Enrollees By FPL Band

FPL Band	Unduplicated Enrollee Count	Percentage of ARWorks Enrollees
0-20%	122,759	39.22%
21-40%	17,055	5.45%
41-60%	25,180	8.05%
61-80%	33,670	10.76%
81-100%	38,893	12.43%
101-120%	37,751	12.06%
121-138%	29,861	9.54%
> 138%	7,797	2.49%
Grand Total	**312,966**	

Table 5—ARWorks Enrollees who were enrolled on 12/31/2020

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**	

Table 6—ARWorks Enrollees October 31, 2020 Snapshot

FPL Band	Unduplicated Enrollee Count	Percentage of ARWorks Enrollees
0-20%	104,569	38.34%
21-40%	13,501	4.95%
41-60%	22,174	8.13%
61-80%	31,760	11.64%
81-100%	36,522	13.39%
101-120%	35,124	12.88%
121-138%	27,144	9.95%
> 138%	1,975	0.72%
Grand Total	**272,769**	

Table 7—ARWorks Enrollees who were enrolled on 12/31/2019

Premium/Cost sharing Design/Flexibilities. The State should describe the proposed premium and/or cost sharing structure to be implemented under this Demonstration.

☒ Premiums

ARHOME will require individuals above 100% FPL to pay part of the premium, based on the member's FPL band. The amounts for calendar year 2022 are provided below.

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

Under ARHOME, any premiums not paid will be considered a debt to the carrier. The State will no longer use the tax intercept process to collect unpaid premiums as in the current program.

Premiums and cost sharing cannot and will not be applied to ARHOME members who are medically frail or who are enrolled in a PASSE. QHPs will be permitted to waive premiums for members who meet health improvement initiative and/or economic independence initiative requirements as approved by DHS as an incentive to participate in an initiative.

☒ Co-payments

ARHOME members will pay co-payments based on their FPL income bracket with an overall 5% cap on household income per quarter. The maximum annual amounts for copayments in calendar year 2022 are provided below.

0-20%	21-40%	41-60%	61-80%	81-100%	101-120%	120%+
$0	$83.85	$163.70	$243.56	$323.42	$381.16	$456.63

Under ARHOME, any co-payment that is not paid will be considered a debt to the provider. The combined 5% cap on premiums and copayments on household income will be applied on a quarterly basis. Cost sharing will generally follow the federal allowable amounts. Exceptions are:

- No co-payments for an inpatient hospital stay
- No co-payments will be permitted for ARHOME members who are medically frail or who are enrolled in a PASSE.
- 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. QHPs will be permitted to waive cost sharing for members who participate in health improvement initiative and/or economic independence initiatives as approved by DHS.

C. Beneficiary Consequences for Non-payment – Describe any consequences for beneficiary non-payment of premiums and/or cost sharing charges.

Payment of cost sharing is not a condition of eligibility. Medicaid rules for the use of copayments will apply. A provider cannot refuse to provide service for non-payment at the first occurrence but can refuse to provide a future service due to non-payment. Non-payment of premium and/or cost sharing will be considered a debt to the QHP or to the provider. QHPs will not be permitted to disenroll members for failure to pay premium or cost sharing.

D. Calculating Beneficiary Cost sharing – Describe the State's process for calculating the five percent limit on a monthly or quarterly basis and ensuring that beneficiaries do not incur cost sharing that exceeds five percent of the beneficiary' household income. Premiums and cost sharing incurred by the beneficiary, spouse, children and other members of the beneficiary's household, as defined in 42 CFR 435.603(f), will be counted toward the five percent limit.

Individuals will be distributed into premium and cost sharing bands based on their reported household FPL. The bands will be divided into 20 percentage point increments (e.g., 0-20%, 21-40%, etc.). The income amount for the calculations will be based on the income for a household at the lowest end of each band. Table 7, shown previously, is duplicated here to show the distribution of beneficiaries on December 31, 2020. Because everyone's amount of cost sharing in each FPL band is calculated at the lowest level, more than 39% would not have had a cost sharing obligation at that time. More than 20% of beneficiaries had income above 100% and would have premium and copayments apply.

FPL Band	Unduplicated Enrollee Count	Percentage of ARWorks Enrollees
0-20%	122,759	39.22%
21-40%	17,055	5.45%
41-60%	25,180	8.05%
61-80%	33,670	10.76%
81-100%	38,893	12.43%
101-120%	37,751	12.06%
121-138%	29,861	9.54%
> 138%	7,797	2.49%
Grand Total	**312,966**	

Table 8—ARWorks Enrollees who were enrolled on 12/31/2020

Members in the same FPL band will pay at the lowest level in the band. For example, a member with a household income of 110% would fall in the 101%-120% FPL band and would be charged a premium of 2% of the income for a single household at 101% FPL and up to 3% of that income for other cost sharing. As a result, there will be two premium amounts established each year (2% of 101% FPL and 121% FPL) and six amounts for maximum cost sharing.

Each year DHS will use the updated federal FPL to establish the allowable monthly premiums and the maximum quarterly cost sharing amounts that members can incur. QHPs will sign a memorandum of understanding agreeing not to charge more than the established monthly premium rate or the maximum cost sharing amount based on the member's FPL band. QHPs will track each beneficiary's cost sharing obligation and Maximum Out-Of-Pocket levels per quarter. When a beneficiary's maximum amount of has been reached in a quarter, providers will be alerted by the QHP payment system to not collect a copayment for the remainder of the quarter. The QHP will instead make the payment to the provider. These amounts will be reported to DHS in the CSR reconciliation process and paid to the QHP.

E. Applicable Federal Premium/Cost sharing Design Standards – Pursuant to the expenditure authority offered under this demonstration initiative, the expenditures under the approved Demonstration will be regarded as expenditures under the Medicaid State Plan. The below table lists common standard requirements pertaining to cost sharing that we expect would be applicable under the demonstration and that states would be expected to administer in a manner analogous to the processes utilized for the administration of the Medicaid State Plan.

	Standard Premium/Cost sharing Design Provisions Applicable to this Section 1115(a) Demonstration Opportunity
☒	The State will have safeguards to ensure that its process as described in section IV.D above is properly calculating and ensuring adherence to the requirement that beneficiaries do not incur cost sharing that exceeds the five percent limit on a monthly or quarterly basis.
☒	The State will have a process for providing beneficiary and public notice of premiums, cost sharing and similar charges under the demonstration consistent with the notice requirements described in 42 CFR 447.57.

For the provision(s) checked above, the State is proposing the following demonstration-specific approach for compliance as follows:

Safeguards for ensuring cost sharing meets requirements: Premium levels and cost sharing maximums will be established in the memorandum of understanding signed by participating QHPs, along with penalties for exceeding the caps and a requirement to refund any member for excessive premium or cost sharing charged.

Notices. ARHOME members will receive a notice or notices from the QHPs, Arkansas Medicaid or its designee that includes information about the member's premium and co-payment obligations, as well as the quarterly cap on premiums and cost sharing. Premium and co-payment maximums will be posted on the ARHOME website.

F. Goals and Objectives of Demonstration – The State should also describe the rationale for how the use of cost sharing is necessary for the State to meet the intended goals and objectives of the demonstration.

Beneficiary participation in premiums and cost sharing is an important feature to demonstrate that the individual values coverage as health insurance and values the health care professional who provided the medical service.

The State needs Demonstration authority to apply premiums to those with income above 100% FPL but it does not need Demonstration authority to apply the levels of copayments to beneficiaries at all income levels. 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.

These additional payments are made in the form of "cost sharing reduction" payments. DHS estimates each month the amount of cost sharing beneficiaries will incur when receiving services from medical providers. DHS makes "Advance Cost Sharing Reduction payments ("ACSR") to the QHPs each month and the QHPs pay the providers for the amounts of cost sharing that would otherwise be the obligation of the beneficiaries. These ACSR payments are reconciled each month to the actual amount of cost sharing the QHPs pay out to providers.

In private insurance, and, in Medicare, the premium accounts for only part of the total cost of coverage. An individual would typically also pay a deductible and co-insurance for coverage. As previously shown in Table 7, nearly one in four beneficiaries enrolled have income above 100% FPL. As their earnings continue to increase, they will move into private sector coverage for which they will be required to pay cost sharing in order to maintain and use coverage.

This section of the Demonstration goes to the central parts of the ACA framework—expanding the health insurance pool and increasing the affordability of health insurance. As previously described in Section I, health insurance serves two major purposes—to gain access to necessary medical services and to protect against unforeseen and unpredictable financial losses. Insurance requires participation from a person when he/she *does not* have an immediate medical need. Sharing risk is central to the very concept of insurance.

The second part is affordability. Even with subsidies that are available through employers and federal tax credits, individuals around the country make decisions about affordability and value for themselves. Since enactment of the ACA, many advocates have since promoted the idea that Medicaid is no longer just "medical assistance," but now the nation's *health insurance program* for people with low income.[43] Indeed, since 2011, Medicaid rules have described it as an "insurance affordability program." But do the individuals themselves in this new adult eligibility group view coverage as insurance, treat it as insurance, and value it as insurance including by paying for a small part of their coverage? To determine whether these beneficiaries find coverage to be "affordable" is consistent with the objectives of the program.

[43] For example, see https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-setting-the-facts-straight/

Section V – Delivery System and Payment Models

A. Delivery System Type – The State should check which delivery system(s) it intends to use for the Demonstration population:

	Delivery System
☐	**Managed Care** ☐ Managed Care Organization (MCO) ☐ Prepaid Inpatient Health Plan (PIHP) ☐ Prepaid Ambulatory Health Plan (PAHP) ☐ Primary Care Case Management (PCCM)/PCCM-Entities
☒	**Fee-for-Service (FFS)** ☒ Section 1902(a)(23) and implementing regulations at 42 CFR 431.51, which allows a beneficiary to obtain services from any institution, agency, community pharmacy, or person qualified to perform the services and who undertakes to provide such services. ☐ Restrict a beneficiary (except in emergency circumstances) to obtaining services from any provider or practitioner who provides services in compliance with the State's written standards for reimbursement, quality, and utilization of covered services, provided that the State's standards are consistent with accessible, high-quality delivery, and efficient and economic provision of covered services. *Please describe here the services that are subject to this approach:*
☒	**Premium Assistance**

B. Enrollment Strategies – For a state using managed care or premium assistance delivery system(s), it should describe below how the eligibility groups will be enrolled.

Qualified Health Plans (QHPs). The State will use premium assistance to support the purchase of coverage for ARHOME beneficiaries through Marketplace QHPs.

Choice of QHPs. Each ARHOME member required to enroll in a QHP will have the option to choose between at least two QHPs in the appropriate metal level in the member's rating area that are offered in the individual market through the Marketplace. The State will choose which metal level plans

should be purchased based on the best interests of the State. The State will pay the full cost of QHP premiums, minus the member-paid premium.

a. ARHOME members will be permitted to choose among all qualified QHPs that are offered in their geographic area and that meet the purchasing guidelines established by DHS, in conjunction with Arkansas Insurance Department (AID), for that calendar year.
b. ARHOME members will have access to the same networks as other members enrolling in QHPs through the individual Marketplace.

Memorandum of Understanding (MOU) for QHP Premium Assistance. The Arkansas Department of Human Services (DHS) has entered into a memorandum of understanding (MOU) with each QHP that enrolls members. Areas that are addressed in the MOU include, but are not limited to:

a. Enrollment of members in populations covered by the Demonstration;
b. Payment of premiums and cost sharing reductions (CSRs), including the process for collecting and tracking member-paid premiums and cost sharing;
c. Reporting and data requirements necessary to monitor and evaluate the Demonstration, including performance quality metrics;
d. Requirement for QHPs to provide, consistent with federal and state laws, claims and other data as requested to support state and federal evaluations, including any corresponding state arrangements needed to disclose and share data, as required by 42 CFR § 431.420(f)(2), to CMS or CMS's evaluation contractors;
e. Notice requirements; and
f. Audit rights.

C. Exceptions to Managed Care and Premium Assistance Enrollment of Beneficiaries in the Demonstration – The State should describe below any demonstration populations that are excluded from the enrollment strategies in subsection B.

Individuals who are "inactive" may be re-enrolled in FFS. This provision is described in greater detail in Section II. This provision will take effect on or after January 1, 2023.

D. Other New Adult Eligibility Group Beneficiaries not in the Demonstration – The State should describe any beneficiaries in the new adult eligibility group not in the Demonstration.

As of the end of March 2021, there are a total of 320,865 individuals who have been determined eligible for Arkansas Medicaid under the new adult eligibility group. Of these individuals, 46,775 (15%) were covered through FFS. Expenditures on behalf of these individuals are not counted in the Demonstration. The ARHOME program will also provide coverage to individuals in the new adult eligibility group who are not in the Demonstration. These are listed below and described in greater detail in Section II.

- **Medically Frail Individuals.**
- **Individuals in With Behavioral Health Needs.**
- **American Indian/Alaska Native Individuals.**
- **Interim Individuals.**

E. Services Included in Each Delivery System – The State should list the services/benefits included in the demonstration's delivery system and note any differences by eligibility category.

Type	Population(s) Covered	Services Included
FFS	Individuals who are inactive and re-enrolled in FFS. This provision will be effective on or after January 1, 2023.	Members enrolled in FFS will receive ABP benefits as set forth in Section 1905(y)(2)(B) of the Act and 42 CFR § 433.204(a)(2). These benefits are described in Arkansas's Medicaid State Plan.
Premium Assistance	Except for individuals specified in FFS and Other, adults aged 19 through 64 eligible under the State Plan under 1902(a)(10)(A)(i)(VIII) of the Act, 42 CFR Section 435.119	**ARHOME Benefits.** Members affected by this Demonstration will receive benefits as set forth in Section 1905(y)(2)(B) of the Act and 42 CFR §433.204(a)(2). These benefits are described in Arkansas's Medicaid State Plan. **Alternative Benefit Plan.** The benefits provided under an alternative benefit plan (ABP) for the new adult group are reflected in the Arkansas ABP State Plan. **Medicaid Wrap Benefits.** The State will provide, through FFS Medicaid, wrap benefits that are required for the ABP, but not covered by the QHPs. These benefits include NEMT and Early Periodic Screening, Diagnosis and Treatment (EPSDT). • **Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Access.** The State must fulfill its responsibilities for coverage, outreach and assistance with respect to EPSDT services that are described in the requirements of Sections 1905(a)(4)(b) (services), 1902(a)(43) (administrative requirements), and 1905(r) (definitions). • **Access to NEMT.** The State will establish prior authorization for NEMT in the ABP. Members served by the Indian Health Services (IHS) or Tribal facilities and medically frail members will be exempt from such requirements. • **Access to Wrap Benefits.** In addition to receiving an insurance card from the applicable QHP issuer, ARHOME members will have a Medicaid identification number (MID) through which providers may bill for wrap benefits. The notice containing the MID will include information about which services ARHOME members may receive through FFS Medicaid and how to access those services. This information is also posted on DHS's Medicaid website and will be provided through information at the DHS call centers and through QHP issuers.

Section VI – Financing and Cost Projections

A. Non-Federal Share Source(s).

Non-Federal Share Source(s). All sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. The state should identify below, the source of non-federal share for each type of payment to be made under the demonstration, including specifying whether each source is a state general fund appropriation from the legislature to the Medicaid agency, intergovernmental transfers (IGTs), certified public expenditures (CPEs), health care-related taxes, or another mechanism. Include a full description of the financing arrangement(s) to be used.

The sources of non-federal funding for the ARHOME program are:

1. State general fund appropriation from the legislature to the Medicaid agency.
2. Revenue derived from 2.5 percent premium tax on health insurance products from the Qualified Health Plans.

B. Expenditure History for Relevant Population(s) and Services – The state should identify the total computable net expenditures from the Medicaid Budget and Expenditure System (MBES), Form CMS-64 for the most recent eight consecutive quarters after December 31, 2016 for which CMS has issued a finalized grant award to the state. This should be delineated for each population covered by the demonstration. Expenditures apply to a quarter based on the date the original payment is made, consistent with 45 CFR 95.13(b). Prior period adjustments and collections/offsets should be attributed to the quarter in which the original expenditure was made. Net expenditures include current quarter expenditures, prior period adjustments, and collections and offsets.

These historical expenditures are provided in the following Table.

CY Quarter	QHP Population Expenditures
Q1 2018	$401,619,750
Q2 2018	$414,320,573
Q3 2018	$387,758,566
Q4 2018	$350,695,570
Q1 2019	$359,404,106
Q2 2019	$378,838,330
Q3 2019	$376,355,886
Q4 2019	$380,446,183

Table 9—Historical Expenditures for the Demonstration

C. Expenditure Projections for Targeted Demonstration Population(s) – The state should provide its total cost projections for coverage of the targeted demonstration population(s) in annual aggregate totals for each demonstration year (DY) of this proposed demonstration; as supported by the historical expenditure data the state reported above in subsection B of this application section.

Targeted Population	DY01 (2022)	DY02 (2023)	DY03 (2024)	DY04 (2025)	DY05 (2026)

QHP enrollees With Waiver	$2,101,538,321	$2,082,582,309	$2,213,409,789	$2,350,256,918	$2,493,308,145
Without Waiver	$2,255,456,731	$2,271,730,930	$2,462,218,836	$2,668,679,326	$2,892,452,034

In the box below, the state should describe the analysis used to derive the above cost projections for each targeted demonstration population.

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.

The "without waiver" projected costs for each demonstration year are calculated using CY 2019 PMPM costs as identified in the historical data projected at the annual PMPM trend rate of 7.3% and multiplied by the anticipated enrollment. The 7.3% represents the actual PMPM trend from CY 2018 to CY 2019. This trend rate compares to the trend rate of over 20% for the Newly Eligible Adult Group in the FFS delivery system. The "without waiver" projections do not include any costs for the Life360 HOMEs or any cost reductions attributable to member premium and cost sharing.

Table 10—Projected Expenditures CY 2022-CY 2026

D. Member Month Enrollment Data – This subsection should only be completed by states requesting "per capita cap" financing for this demonstration. The state should identify the total number of enrollee member months for the targeted demonstration population(s) that correspond to the base period expenditures reported by the state in subsection B of this application section.

Member Month Enrollment Projection for Targeted Demonstration Population(s)

In the table below, the state should provide its total enrollee member month projection for the targeted demonstration population(s) for each demonstration year (DY) of this proposed demonstration. These projections should correspond with the unduplicated person count projections provided in section II of this application.

Targeted Population	DY01 (2022)	DY02 (2023)	DY03 (2024)	DY04 (2025)	DY05 (2026)
QHP enrollees	2,970,000	2,787,600	2,815,476	2,843,631	2,872,067

Table 11—Projected Member Months CY 2022-2026

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. Membership is the same with or without the waiver.

Historical QHP member months by quarter are shown in Table 11 below:

Historical Period	QHP Member Months
Q01 2018	698,177
Q02 2018	718,195
Q03 2018	682,224
Q04 2018	615,822
Q01 2019	580,659
Q02 2019	602,820
Q03 2019	619,012
Q04 2019	630,393

Table 12—Historical Member Months CY 2018-2019

The historical membership data reflects DHS' internal tracking of membership by quarter for individuals enrolled in the QHPs. This level of enrollment detail is not available in the CMS 64 reports, but is consistent with the enrollment historically reported to CMS by DHS as part of the quarterly budget neutrality monitoring reports.

Section VII – Section 1115 Authorities

The Medicaid program flexibilities requested by the State in this Demonstration application are designed to be provided specifically pursuant to expenditure authority under section 1115(a)(2) of the Act, without the need for section 1115(a)(1) waiver authorities. The State should describe any component of the proposed policy options or approaches to program administration and design identified in this application template that the State believes additional authorities may be necessary to authorize the Demonstration.

EXPENDITURE 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.

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.

WAIVER LIST

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.

Section VIII – Fair Hearing Rights

The State should choose one of the following options for providing fair hearing rights for the newly eligible adult group including those within the proposed Demonstration.	
☒	The State will comply with all notice and fair hearing provisions in 42 CFR part 431 subpart E for all applicants, eligibility determinations, and eligibility redeterminations for which the Department of Human Services is solely responsible. DHS is also solely responsible for taking actions that impact beneficiaries during their enrollment in FFS. The State proposes to utilize the internal and external grievances and appeals processes of the QHP for their members. QHPs must comply with federal and state standards governing internal and external insurance coverage appeals. The State proposes to utilize the internal grievances and external appeals processes of PASSEs for their members. PASSEs must comply with federal and state standards governing Medicaid managed care organizations with oversight by the Arkansas Insurance Department and the Department of Health Services. Because of the stringent federal and state requirements for QHPs and Medicaid managed care organizations with oversight by the Arkansas Insurance Department and the Department of Health Services, the rights of all beneficiaries are strongly protected.
☐	As described below, the State is proposing the following fair hearing process, as an alternative to 42 CFR part 431 subpart E requirements, with the purpose of improving upon the fair hearing process outlined in these regulatory provisions. The State's description should include an explanation of how the State believes this alternative approach will improve upon the State's fair hearing process and will still afford to individuals applying for or receiving coverage in the Demonstration constitutional and statutory protections that include, but are not limited to, such basic elements as the right to advance notice of a termination or other adverse action; clearly explaining the reason for the action; a timely fair hearing before an impartial arbiter; the opportunity to be represented by counsel at the hearing and to present evidence, including the right to call witnesses; the right to know opposing evidence and cross examine witnesses; and a requirement that the tribunal hearing the case prepare a record of the evidence presented, make a decision based solely upon the evidence presented at the hearing, and produce written findings of fact and reasons for its decision).

	Other requirements rooted in laws other than the Medicaid statute, such as accessibility requirements for individuals living with disabilities or individuals with limited English proficiency also would apply to a Demonstration under section 1115(a)(2) authority.

Section IX – Performance Baseline Data

Baseline Data – **The State should indicate below the documentation it is providing to describe its baseline performance data and any additional data the State Plans to use as part of this proposed Demonstration. This includes baseline performance data on CMS' mandatory subset of the Medicaid Adult Core Set quality measures as well as baseline data on CMS' set of continuous performance indicators as described in the Demonstration SMDL guidance. The specific baseline data submission requirements will vary depending on whether the State is proposing coverage of individuals that will be newly eligible under this demonstration, individuals already eligible for coverage, or a combination.**

If the State is including in this demonstration individuals **already eligible for coverage**, for whom baseline data should be available, check the box(es) below to indicate the information that the State is providing as an attachment to this application.	
☒	The State is providing as attachment ___ the baseline performance data for the mandatory subset of the Medicaid Adult Core Set quality measures described in Appendix D of the Demonstration SMDL guidance.
☐	The State is providing as attachment ___ the baseline performance data on the continuous performance indicators that it intends to use for timely indicators of potential issues impacting beneficiary access to coverage or care as described in Appendix H of the HAO demonstration SMDL guidance.

If the State is proposing coverage of individuals under this demonstration that will be **newly eligible**, check the box(es) below to indicate the information that the State is providing as an attachment to this application.	
☐	The State is providing as attachment ___ its plan and timeline for how it will collect the baseline performance data for the mandatory subset of the Medicaid Adult Core Set quality measures described in Appendix D of the HAO demonstration SMDL guidance.
☐	The State is providing as attachment ___ its plan and timeline for how it will collect the baseline performance data on the continuous performance indicators that it intends to use for timely indicators of potential issues impacting beneficiary access to coverage or care as described in Appendix H of the HAO demonstration SMDL guidance.

Additional Information. Provide any additional information the State believes is important for CMS to understand its intended approach for performance measurement and the data it will use to establish baseline performance.

DHS reports baseline values for the Medicaid Adult Core Measures listed below. DHS will assess progress from those baseline values as part of ARHOME monitoring and evaluation.

Adult Core Measures to be Used for ARHOME Monitoring & Evaluation with Established ARHOME Baseline Values

Medicaid Adult Core Measure Name	Abbrev.	Data Source	CY2019 Performance (Baseline)
Primary Care Access and Preventive Care			
Chlamydia Screening in Women Ages 21–24	CHL-AD	Administrative	
Cervical Cancer Screening	CCS-AD	Administrative	
Breast Cancer Screening	BCS-AD	Administrative	
Maternal and Perinatal Health			
Contraceptive Care – Postpartum Women Ages 21–44	CCP-AD	Administrative	
Contraceptive Care – All Women Ages 21–44	CCW-AD	Administrative	
Care of Acute and Chronic Conditions			
PQI 01: Diabetes Short-Term Complications Admission Rate (admit/100,000 months)	PQI01-AD	Administrative	
PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (admit/100,000 months)	PQI05-AD	Administrative	
PQI 08: Heart Failure Admission Rate (admit/100,000 months)	PQI08-AD	Administrative	
PQI 15: Asthma in Younger Adults Admission Rate (admit/100,000 months)	PQI15-AD	Administrative	
Plan All-Cause Readmissions	PCR	Administrative	
Asthma Medication Ratio: Ages 19–64	AMR-AD	Administrative	
Behavioral Health Care			
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	IET-AD	Administrative	
Antidepressant Medication Management	AMM-AD	Administrative	
Follow-Up After Hospitalization for Mental Illness: Age 19-64*	FUH-AD	Administrative	
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	SSD-AD	Administrative	
Use of Opioids at High Dosage in Persons Without Cancer	OHD-AD	Administrative	
Concurrent Use of Opioids and Benzodiazepines	COB-AD	Administrative	
Use of Pharmacotherapy for Opioid Use Disorder	OUD-AD	Administrative	
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	FUA-AD	Administrative	
Follow-Up After Emergency Department Visit for Mental Illness	FUM-AD	Administrative	
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	SAA	Administrative	

*Different from Adult Core Measure, *Age 18 and Older*

DHS is working to obtain data from external sources. Once the data is obtained, DHS plans to establish a baseline for the following additional measures, and assess progress from those baseline values as part of ARHOME monitoring and evaluation:

Measures to be Used for ARHOME Monitoring & Evaluation with ARHOME Baseline Values to be Established

Medicaid Adult Core Measure Name or Other Name	Abbrev.	Proposed Data Source
Primary Care Access and Preventive Care		
Flu Vaccinations for Adults Ages 18 to 64	FVA-AD	Electronic Medical Records (EMR) through State Health Alliance for Records Exchange (SHARE)
Screening for Depression and Follow-Up Plan: Age 18 and Older	CDF-AD	EMR through SHARE
Maternal and Perinatal Health		
PC-01: Elective Delivery	PC01-AD	Pending data source
Prenatal and Postpartum Care: Postpartum Care	PPC-AD	EMR through SHARE or LabCorp data
Child core measure - Prenatal and Postpartum Care: Timeliness of Prenatal Care	PPC-CH	EMR through SHARE or LabCorp data
Child core measure – Live Births Weighing Less than 2,500 Grams	LBW-CH	Birth certificate through Division for Vital Statistics (DVS)
Not a core measure - Very low birth weight		Birth certificate through DVS
Not a core measure - Pre-term birth		Birth certificate through DVS
Care of Acute and Chronic Conditions		
Controlling High Blood Pressure	CBP-AD	EMR through SHARE
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	HPC-AD	LabCorp data
HIV Viral Load Suppression	HVL-AD	EMR through SHARE
Behavioral Health Care		
Medical Assistance with Smoking and Tobacco Use Cessation	MSC-AD	EMR through SHARE or LabCorp data
Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9%)	HPCMI-AD	LabCorp data
Social Determinants of Health (**Not Core Measures**)		
Income		Statewide Longitudinal Data System (SLDS)
Employment		SLDS
Education (Enrollment and Completion)		SLDS
Receipt of educational, employment, or other social services		SLDS or Administrative data
Criminal Justice Involvement		SLDS or Administrative data
Child Welfare System Involvement		Administrative data
Housing security/affordability (≤30% of income)		Enrollment files, new enrollment screening, or New survey
Food security		Current Population Survey Food Security Supplement, New enrollment screening, or New survey
Safety		New enrollment screening or New survey
Interpersonal violence		New enrollment screening or New survey
Commercial Insurance Receipt Upon Disenrollment		All-Payers Claims Database & New survey

Section X – Evaluation

Evaluation Design – The State should provide research hypotheses and proposed evaluation parameters for testing the outcomes of the Demonstration associated with the proposed goals and objectives listed in section I.B of this application. To assist the State in completing this section, the State may refer to CMS' published guidance on how to develop evaluations that

align with CMS' expectations for rigorous evaluation by clicking the following link: https://www.medicaid.gov/medicaid/downloads/developing-the-evaluation-design.pdf.

Three Measurable Goals for the ARHOME Demonstration

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

   Program elements / Mechanisms of change:

   - A Health Improvement Initiative through which the QHPs will demonstrate the added value of insurance compared to medical assistance by educating their members on the benefits of insurance and offering incentives for using insurance coverage appropriately and improving health, resulting in less use of emergency department, fewer avoidable hospitalizations, and fewer hospital re-admissions; DHS will hold QHPs accountable for meeting improvement targets in clinical service use and outcome measures.
   - The Premium Assistance Model in which more timely access to medical care compared to medical assistance will enable beneficiaries to return to work and increase their income, in which the risk of insurance coverage is spread among beneficiaries who use different levels of service, and that permits the possibility for individuals, after disenrolling from ARHOME, to keep the same health insurance coverage in the private market as they had through ARHOME.
   - Rural Life360 Homes in which hospitals will screen and refer all Arkansans for health-related social needs and assist ARHOME clients with Serious Mental Illness (SMI) or Substance Use Disorder (SUD) with getting medical treatment and obtaining other services and supports to meet their health-related social needs through intensive care coordination to reduce the health disparities between rural and urban health outcomes.
   - Maternal Life360 Homes in which hospitals will employ staff or enter into a cooperative agreement with a strategic partner to provide a home visitation program to women with high-risk pregnancies from pregnancy through the first 24 months of life of the child. Home visitation will improve the health of mothers and their infants. Home visitation programs have helped make children safer and families more self-sufficient.
   - Success Life360 Homes in which hospitals will connect young adults in target populations with experienced community service organizations that provide intensive support to help them address health-related social needs, including accessing opportunities for employment, education, and training opportunities and live successfully in their communities. For enrollees who complete their Success program and increase their income above 138% FPL, DHS will contribute to their cost for health insurance coverage for a limited period of time.

   Hypotheses

   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.

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.
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.
D. QHP members will have equal or better access to non-emergency transportation compared to Medicaid FFS beneficiaries.
E. QHP members will have equal or greater satisfaction in the care provided compared to Medicaid FFS beneficiaries.
F. QHP members will decrease the non-emergent use of emergency department services compared to the baseline and will lower use compared to Medicaid FFS beneficiaries.
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.
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.
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.
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.
    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.
    6. Have improved birth outcomes for their infants.
K. Compared to similar ARHOME beneficiaries in areas without a Success Life360 Home, young ARHOME beneficiaries most at risk of 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

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

Program elements / Mechanisms of change:

- Premium Assistance Model
- An Economic Independence Initiative in which QHPs will offer incentives to their members to participate in employment, education, and training opportunities.
- Rural, Maternal, and Success Life360 Homes

Hypotheses

A. Among QHP members with income at or below 20% FPL, the percent that increase income to above 20% FPL will increase over time.
B. Among QHP members with income at or below 100% FPL, the percent that increase income to above 100% FPL will increase over time.
C. Among QHP members who disenroll from ARHOME, the percent that disenroll due to increased income will increase over time.
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.
E. ARHOME beneficiaries with SMI or SUD who receive services from a Rural Life360 Home will have fewer health-related social needs and improved social determinants of health (SDOH) compared to similar ARHOME beneficiaries in rural areas without 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.
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.

3. Slow the Rate of Growth in Spending for the Demonstration Population.

Program elements / Mechanisms of change:

- Premium Assistance Model
- Health Improvement Initiative
- QHP members with income above 100% of the federal poverty level (FPL) will contribute to the cost of their coverage through monthly premiums and reduce the amount of premium subsidies paid through the State.

- QHP members at all income levels will contribute to the cost of their care through point-of-service copayments up to 5% of household income.
- Rural and Maternal Life360 Homes

Hypotheses

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.

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.

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.
    2. 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.

D. 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.

E. 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.

Objective/Goal	Hypothesis	Evaluation Parameters/Methodology
1. Improve Health Outcomes through: • Health Improvement Initiative • Premium Assistance Model • Rural, Maternal, and Success Life360 Homes		
Improve Health Outcomes among Arkansans Especially in • **Maternal and Infant Health** • **Rural Health,** • **Behavioral Health, and** • **Chronic Disease.**	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.	• Measures: o Continuity of primary care provider (PCP) care o Continuity of specialist care • Data source: Administrative • Comparison: FFS comparison groups (parent/caretaker and former foster care) • Method: Difference in group means/percentages
“	A.	• Measures: o PCP network adequacy o PCP network accessibility o Specialist network adequacy o Specialist network accessibility o Essential community providers (ECP) network adequacy o Essential community providers (ECP) network accessibility • Data source: Provider networks • Comparison: FFS comparison groups • Method: Geospatial analysis

“	A.	• Measures: o Ease of getting necessary care: ▪ Got care for illness/injury as soon as needed ▪ Got non-urgent appointment as soon as needed ▪ How often it was easy to get necessary care, tests, or treatment ▪ Have a personal doctor ▪ Got appointment with specialists as soon as needed ▪ Needed interpreter to help speak with doctors or other health providers ▪ How often got an interpreter when needed one ▪ Days wait time between making appointment and seeing provider ▪ How often had to wait for appointment because of provider’s lack of hours/availability ▪ Easy to get a referral to a specialist o Access to care and immunizations: ▪ Have health care coverage ▪ Have a personal doctor ▪ Last routine checkup ▪ Avoided care due to cost ▪ Flu vaccine • Data source: Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey • Comparison: FFS comparison groups • Method: Comparison of answer frequencies
“	A.	• Measures: o Access to care and immunizations: ▪ Have health care coverage ▪ Have a personal doctor ▪ Last routine checkup ▪ Avoided care due to cost ▪ Flu vaccine • Data source: Behavioral Risk Factor Surveillance Survey (BRFSS) • Comparison: Adults 19-64 w/income <138% FPL in comparison states • Method: Difference-in-differences (*BRFSS*)

“	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: o Chlamydia Screening in Women Ages 21–24 (CHL-AD) o Breast Cancer Screening (BCS-AD) o Cervical Cancer Screening (CCS-AD) o Contraceptive Care – Postpartum Women Ages 21–44 (CCP-AD) o Contraceptive Care – All Women Ages 21–44 (CCW-AD) o Statin Therapy for Patients with Diabetes (SPD) o Comprehensive Diabetes Care: Hemoglobin A1c Testing (HA1C-AD) o Adults’ Access to Preventive/Ambulatory Services (AAP) o Asthma Medication Ratio: Ages 19–64 (AMR-AD) • Data source: Administrative • Comparison: FFS comparison groups • Method: Difference-in-differences
“	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: o Adolescent Well-Care Visits (AWC) o EPSDT Screening – Preventive Dental Visits o EPSDT Screening – Preventive Vision • Data source: Administrative • Comparison: Clients in treatment group 1-2 years prior to ARHOME enrollment • Method: Pre-post comparison
“	D. QHP members will have equal or better access to non-emergency transportation compared to Medicaid FFS beneficiaries.	• Measures: o Any Utilization of Non-Emergency Transportation Services o Utilization Counts of Non-Emergency Transportation Services • Data source: Administrative • Comparison: FFS comparison group • Method: Logistic regression
“	E. QHP members will have equal or greater satisfaction in the care provided compared to Medicaid FFS beneficiaries.	• Measures: o Average Rating of Health Plan o Average Rating of Health Care o Average Rating of Primary Care Provider (PCP) o Average Rating of Specialist • Data source: CAHPS Health Plan Survey • Comparison: FFS comparison group • Method: Comparison of answer frequency categories

“	F. QHP members will decrease the non-emergent 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
		• Comparison: FFS comparison group
		• Method: Difference in group means, rates, or ratios

“	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
		• Method: Difference in group means, rates, or ratios

“	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 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
		• Method: Difference in group means, rates, or ratios

“	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: o Hypotheses B, E-H • Data sources: o Administrative o CAHPS Health Plan Survey • Comparison: Similar beneficiaries in counties w/o Rural Life360 Home • Method: Difference in difference
“	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. 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 6. Have improved birth outcomes for their infants.	• Measures: o Hypotheses B, E-H o Low birth weight o Very low birth weight o Pre-term birth • Data sources: o Administrative o CAHPS Health Plan Survey o Birth Certificates • Comparison: Similar beneficiaries in counties w/o Maternal Life360 Home • Method: Difference in difference
“	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: o Hypotheses B, E-H • Data sources: o Administrative o CAHPS Health Plan Survey • Comparison: Similar beneficiaries in counties w/o Success Life360 Home • Method: Difference in difference

2. Provide Incentives and Supports to Decrease Poverty through: • Premium Assistance Model • Economic Independence Initiative • Rural, Maternal, and Success Life360 Homes		
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: o 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 • Method: Pre-post comparison
"	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: o 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 • Data source: Administrative • Comparison: None • Method: Pre-post comparison
"	C. Among QHP members who disenroll from ARHOME, the percent that disenroll due to increased income will increase over time.	• Measures: o Percent of members that disenroll due to high income • Data sources: o Administrative o New Survey • Comparison: None • Method: Pre-post comparison
"	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: o Income o Employment o Educational attainment o Housing security/affordability (≤30% of income) o Food security o Safety o Criminal justice system involvement o Receipt of educational, employment, or other social services • Data sources: o American Community Survey o Area Health Resources File (AHRF) o Statewide Longitudinal Data System (SLDS), county-level de-identified data • Comparison: Counties w/o Rural Life360 Homes • Method: Difference in difference

“	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: o Income o Employment o Educational attainment o Housing security/affordability (≤30% of income) o Food security o Safety o Criminal justice system involvement o Receipt of educational, employment, or other social services • Data sources: o Administrative o Statewide Longitudinal Data System (SLDS) o New Survey • Comparison: Similar beneficiaries in counties w/o a Rural Life360 Home • Method: Difference in difference
“	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: o Income o Employment o Educational attainment o Housing security/affordability (≤30% of income) o Food security o Safety o Child welfare system involvement o Interpersonal violence o Receipt of educational, employment, or other social services • Data source: Administrative, Statewide Longitudinal Data System, & New Survey • Comparison: Similar beneficiaries in counties w/o a Maternal Life360 Home • Method: Difference in difference

“	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: o Income o Employment o Educational attainment o Housing security/affordability (≤30% of income) o Food security o Safety o Criminal justice system involvement o Child welfare system involvement o Receipt of educational, employment, or other social services • Data sources: o Administrative o Statewide Longitudinal Data System o New Survey • Comparison: Similar beneficiaries in counties w/o a Success Life360 Home • Method: Difference in difference
3. Slow the Growth in Spending through*:* • Premium Assistance Model • Health Improvement Initiative • Monthly premiums • Point-of-service copayments • Rural and Maternal Life360 Homes		
Slow the Rate of Growth in Spending for the Demonstration Population	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 • Method:
“	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.	• Measures: o Arkansas program characteristics o Arkansas regional average program characteristics o Contiguous states’ program characteristics o PMPM growth rate • Data source: Arkansas Insurance Department • Comparison: Non-expansion states • Method: Descriptive
“	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.	• Measure: Monthly new enrollment • Data source: Administrative • Comparison: Non-expansion states • Method:

“	C1.	• Measures: ○ Percent of QHP members who pay their premium (1) at least one month, (2) at least 6 months, and (3) all 12 months • Data source: Administrative • Comparison: Non-expansion states • Method:

“	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:
	2. 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.
		• 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
		• Method:

“	C2.	• 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.
		• Data source:
		  ○ Administrative
		  ○ All Payers Claims Database
		  ○ New Survey
		  ○ Data from other states
		• Comparison: Non-expansion states
		• Method:

“	D. 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 • Method: Difference in difference
“	E. 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 • Method: Difference in difference

Section XI – Adequacy of Infrastructure

A. Information Technology (IT) Infrastructure – States will be expected to ensure the availability of adequate resources for implementation and monitoring of this demonstration including education, outreach, and enrollment; maintaining eligibility systems applicable to the demonstration; compliance with any applicable cost sharing requirements; and reporting on financial and other demonstration components. The State should describe how it has developed, or plans to develop, the information technology (IT) systems capability needed to support this demonstration and meet the reporting requirements.

DHS has evaluated the State's current existing information technology (IT) system and has determined there are a variety of necessary enhancements which will be required for the implementation and monitoring of this demonstration. The State has submitted an Implementation Advanced Planning Document (IAPD) to CMS separately that has identified enhancements to the State's IT infrastructure.

The State's current IT system has successfully monitored the existing 1115 demonstration since 2014. While there are some high-level changes identified in the attached document of which the State expects to include within the IAPD, the overall implementation of the 1115 application will largely focus on enhancing existing systems that are already functioning.

The State's current IT system will continue to monitor and track the data necessary to meet the reporting requirements of this Demonstration. Any adjustments necessary to reporting requirements of this Demonstration will be made in accordance with the STCs of this Demonstration.

B. Transition Planning – States will be expected to have a plan for transition and orderly close-out if the Demonstration, in whole or in part, is being suspended or terminated prior to the date of expiration, or not being extended beyond the date of expiration. The State should describe how it has developed, or plans to develop, a transition plan that aligns with each of the listed minimum requirements:

Transition Plan Requirement	State Process
Description of how the State will comply with all notice requirements found in 42 CFR 431.206, 431.210 and 431.213.	**The State will comply will all applicable CFR requirements regarding notice in the case that this Demonstration is being terminated or closed prior to the date of expiration.**
Description of how the State will notify affected beneficiaries, including leveraging community outreach activities or community resources that are available. Including providing notice that enrollment of new individuals into the demonstration will be suspended during the last six months of the demonstration.	**In the case that this Demonstration is being terminated or closed prior to the date of expiration, the State will send notices via mail to all affected beneficiaries. The State will also leverage a variety of existing community resources, including Department of Human Services Division of County Operations local offices. In the case of this Demonstration being terminated or closed prior to the date of expiration, a transition team with officials the**

	Department of Human Services (and any other necessary identified State agencies) will be created to ensure an orderly close-out.
Description of the proposed content of beneficiary notices or sample notices that will be sent to affected beneficiaries.	**Notices sent to affected beneficiaries in the case of this Demonstration being terminated or closed prior to the date of expiration would include all CFR required information. (42 CFR 431.206, 431.210, 431.213)**
Description of how the State will assure all appeal and hearing rights are afforded to demonstration participants as outlined in 42 CFR 431.220 and 431.221; including maintaining benefits as required by 42 CFR 431.230 if a demonstration participant requests a hearing before the date of action.	**In accordance with existing CFR and Arkansas State Law, the State will assure all appeal and hearing rights are afforded to demonstration participants (as outlined in 42 CFR 431.220 and 431.221; including maintaining benefits as required by 42 CFR 431.230) if a demonstration participant requests a hearing before the date of action.**
Description of the State's process for conducting renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category (42 CFR 435.916).	**In the case that this Demonstration is being terminated or closed prior to the date of expiration, the State will determine the most appropriate way in which to conduct Medicaid eligibility renewals for all affected beneficiaries to determine if they qualify for Medicaid eligibility under a different eligibility category. This information and timelines would be provided to affected beneficiaries as well as CMS if this situation occurred.**
If suspension or early termination is being initiated by the State, description of how the State will notify CMS in writing of the effective date and reason(s) for any suspension or early termination initiated by the State at least 120 days before the effective date of the demonstration's suspension or termination.	**If the State initiates suspension or early termination of the Demonstration, the State would formally submit a notification to the acting CMS Administrator at least 120 days before the effective date of the demonstration's suspension or termination.**
Description of how the State will track and ensure that demonstration expenditures claimed for FFP are limited to normal closeout costs associated with suspension or terminating the demonstration such as administrative costs of disenrolling participants.	**All demonstration expenditure costs claimed for FFP would be limited to normal closeout costs associated with suspension or termination of the Demonstration.**
If the State is requesting exemption from public notice procedures pursuant to 42 CFR 431.416(g), description of the qualifying circumstances for which the State is requesting CMS to expedite or waive federal and/or state public notice requirements.	**N/A**

Section XII – Programmatic Changes

Program Options Not Subject to Prior CMS Approval: States may maximize its ability to make administrative and programmatic changes after the Demonstration is approved, without need for additional CMS approval, by describing below a range of policy options or approaches to the design or operation of the demonstration that it may consider implementing over the course of the demonstration approval period. CMS will incorporate in the Special Terms and Conditions (STCs) the range of changes to the policy, design or operation of the Demonstration that is being authorized as part of the demonstration approval. States would be expected to provide notice to CMS, an opportunity for public notice and comment, and tribal consultation (if applicable) at least 60 days in advance of implementing a planned change. If the State intends to revise its planned programmatic change, within approved STC parameters, in response to public comments received, states are expected to provide CMS with written notification at least 30 days prior to implementation of such revised change(s).

As indicated in Section II, the processes and procedures for identifying inactive individuals will be defined by state rulemaking. The processes and procedures will take effect on or after January 1, 2023.

As indicated in Section III, the qualifications and criteria of the Life360 HOMEs will be further developed through state procedures and will not require an amendment(s) to go into effect.

As indicated in Section IV, amounts for premiums and copayments will be updated as necessary to reflect changes in federal amounts. The State shall update the new amounts on the State website for ARHOME. The State shall not be required to seek an amendment for approval to make the changes.

The State is not requesting changes in policies or operations that would require a waiver of authority not covered by the proposed application. Normal administrative actions to make the policies covered by the proposed application operational such as reporting, data collection, monitoring are typically outlined in Special Terms and Conditions (STCs).

Please note that any programmatic options not approved in the demonstration STCs will require a demonstration amendment, subject to the federal transparency requirements set forth in 42 CFR part 431 subpart G, and (if applicable) tribal consultation requirements as outlined in the State's approved Medicaid State Plan or CMS' July 17, 2001 State Medicaid Director Letter (#01-024).

Section XIII – Documentation of State Public Notice and Transparency Efforts

States are expected to comply with the federal transparency requirements set forth at 42 CFR part 431 subpart G prior to submission of this demonstration application to CMS. Consistent with 42 CFR 431.408(b) and the CMS Tribal Consultation Policy, states developing Demonstration applications will be expected to hold meaningful consultation on a government-to-government basis with federally recognized tribes located in their state, in order to develop the details of how a Demonstration would be implemented and apply to tribal beneficiaries. In particular, under 42 CFR 431.408(b), states with federally recognized Indian tribes, Indian health programs, and/or urban Indian health organizations must consult with tribes and solicit advice from Indian health programs and urban Indian health organizations in the state, prior to submitting a demonstration

application to CMS, if the Demonstration would have a direct effect on Indians, tribes, Indian health programs, or urban Indian health organizations.

The State should describe how it complied with these requirements prior to submission to CMS. The description should include the following: 1) a description of all mechanisms used by the State to publish its public notice and the structured formats used to solicit input from interested parties; 2) documentation of the State's full public notice, abbreviated public notice, and tribal consultation notice (if applicable); 3) the active link(s) to the State's website where the public notice documents and public input procedures were made available to the public; and 4) a report of the issues raised during the State public comment period that includes the number of comments received, types of commenters (individual, professional organizations, etc.), common themes or trends of comments received, and the correlation to how these comments were addressed via changes to the State's proposed application or implementation of the demonstration.

(1) The Arkansas Department of Human Services published the *Notice of Application for Proposed ARHOME Section 1115 Demonstration Project* public notice in the *Arkansas Democrat-Gazette* on Sunday, June 13, Monday June 14, and Tuesday, June 15, 2021. The *Arkansas Democrat-Gazette* is the only statewide daily newspaper in Arkansas. The public notice contained information on the two public hearings scheduled for June 21, 2021 at 12:00 noon, and June 22, 2021 at 4:00 p.m. The public notice allowed for a 30-day comment period, requesting comments by July 12, 2021. The public notice and draft waiver were also posted on the DHS website (see link below). The public notice provided the commenter with both an email address and P. O. Box address to send comments. Please see (4) below regarding the comments received pursuant to the above instructions.
The public hearing information was also published to the Arkansas DHS public calendar. Please see links below.
The public hearings met the requirements of 42 C.F.R. 431.408(a)(3). The first hearing on June 21, 2021, was before the AR Behavioral Health Planning and Advisory Council Meeting: Public Hearing for the Arkansas Health and Opportunity for Me (ARHOME) Program. The second hearing on June 22, 2021, was conducted by the Arkansas Department of Human Services.

(2) The links to the full public notice are contained below. The documentation of the abbreviated public notice mentioned above is provided with this application and is named "02 - ADG Publication-ARHOME (June 13-15)".

(3) Links

(a) Proposed Rule and Notice landing page:
https://humanservices.arkansas.gov/do-business-with-dhs/proposed-rules/

(b) Arkansas Health And Opportunity For Me (ARHOME) Program And Arkansas Works Transition Plan Notice page:
https://humanservices.arkansas.gov/rules/arhome/
This page contains active links to:

(i) the notice (https://humanservices.arkansas.gov/wp-content/uploads/AHOME-Packet-for-Posting.pdf)

(ii) contact email
(iii) public hearing information
(iv) transition plan (https://humanservices.arkansas.gov/wp-content/uploads/AR-Works-Phase-Out-Plan.pdf) and Arkansas Works Medicaid page (https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81021)
(v) application (https://humanservices.arkansas.gov/wp-content/uploads/ARHOME-Waiver-Application.pdf)

(c) Calendar links:

https://humanservices.arkansas.gov/events/ar-behavioral-health-planning-and-advisory-council-meeting-public-hearing-for-the-arkansas-health-and-opportunity-for-me-arhome-program/

https://humanservices.arkansas.gov/events/arkansas-health-and-opportunity-for-me-arhome-program-public-hearing/

(4)

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

Summary

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. 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. This Section consolidates and summarizes comments in opposition to specific provisions in the applications. The comments of individuals and individual organizations are also included at the end of this Section.
DHS has carefully considered each comment. The DHS responses to the comments 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.

<u>Premium, Copay, Cost Share</u>

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 p rely on rural hospitals to have appropriate experience or the willingness to develop necessary ca 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 hosp fill this gap with quality care is unproven
- It is unlikely that rural hospitals would be able to provide facilities that meet safety standards re 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.

<u>Communication to Beneficiaries</u>

- 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.

Section XIV – State Contact Information

The State should identify the State representative(s) that CMS can contact with any questions regarding this application submission.

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