ARKANSAS TEFRA-LIKE
Section 1115
Project Number 11W001636

QUARTERLY & ANNUAL REPORT

October 1, 2021-December 31, 2021
January 1, 2021- December 31, 2021

❖ Preface

State	Arkansas
Demonstration Name	Arkansas TEFRA-like Section 1115 Demonstration
Approval Date	May 9, 2018
Approval Period	January 1, 2018-December 31, 2022
Demonstration Goals and Objectives	The State's goal is to provide medical services to disabled children eligible for Medicaid under section 134 of the Tax Equity and Fiscal Responsibility Act (TEFRA) through the State's TEFRA-like 1115 demonstration waiver. Prior to this demonstration waiver, Arkansas opted to place eligible disabled children in traditional Medicaid by assigning them to a new aid category within its Medicaid State Plan. While this arrangement allowed the children to remain in their homes, it ultimately placed an unsustainable financial burden on the State during a time when budget limitations were becoming more restrictive. To address the financial viability of the program, the State chose to transition the disabled children from traditional Medicaid to a TEFRA-like, Section 1115 demonstration waiver program. The State's objective was to replace the Medicaid state plan optional TEFRA aid category with a TEFRA-like demonstration. The State, with its budgetary limitations, wanted to continue to provide services to this population of children, but needed to reduce the State's financial obligations. The State chose to require a sliding-scale family premium. If the TEFRA child's family had health insurance coverage for the child from another source, the family was, and still is, allowed to retain that insurance.

❖ Executive Summary

Report Requirements

This section communicates the following information:

- Key achievements, highlights, issues, and/or risks identified during the current reporting period;
- Key changes since the last monitoring report, including the implementation of new program components;
- Programmatic improvements (e.g., increased outreach or any beneficiary or provider education efforts);
- Unexpected changes (e.g., unexpected increases or decreases in enrollment or complaints, etc.).

The TEFRA-like demonstration waiver program is a cost-sharing Medicaid program that enables certain children with a disability to receive care in their homes rather than in an institution. Using the flexibility available within a Demonstration Waiver, Arkansas was able to develop and implement a sliding-scale premium fee structure based on a family's income. This effectively passes a portion of the cost to the eligible child's family. Families with annual incomes of less than $25,000 are exempted from the premium requirement. While premium requirements are set based on household income, program eligibility is determined solely on the assets and resources of the child.

Calendar year 2021 marks the 19th year of the TEFRA-like demonstration. The request for renewal for the current TEFRA-like Demonstration Waiver (with no program change) was provided to Centers for Medicare & Medicaid Services (CMS) on June 30, 2017. The review/approval process for the extension renewal application was not completed by the December 31, 2017 end date of the May 12, 2015 – December 31, 2017 demonstration period. Therefore, initially, CMS approved an extension of the demonstration through April 30, 2018. This allowed additional time to complete the review/renewal process, and it allowed time for the new renewal period for the Special Terms & Conditions (STC) to be finalized. On October 18, 2017, Arkansas submitted a follow-up request to extend the demonstration for a three-year period (with no program changes). The TEFRA extension renewal was approved on May 9, 2018, for a demonstration period from May 9, 2018 – December 31, 2022.

Highlighted TEFRA program activities for 2021 include the following:

- The TEFRA program served more than 6,000 clients during the year, while maintaining a per member per month cost well below the budget neutrality limits.
- The TEFRA program continued to maintain enrollments throughout the public health emergency, but faced some slowdowns in application processing due, in part, to an eligibility system conversion and an increase in eligibility staff vacancies.
- TEFRA clients' most frequently used services in 2021 included Early Intervention Day Treatment, speech therapy and occupational therapy.
- DHS submitted the program's Interim Evaluation in 2021, which found the TEFRA-like population outperformed the non-TEFRA-like population on measures including the receipt of therapy services and proportion of days covered for prescriptions, and client satisfaction scores outperformed or were not significantly different from the comparison surveys on getting care quickly, communication with doctors and overall health care.
- The 2021 TEFRA beneficiary survey found clients highly rated both their ability to quickly access care and the care they receive from providers, but survey responses identified opportunities for improvement in the program's customer service for both eligibility issues and premium payments.
- The TEFRA program implemented changes to beneficiary notices and invoices to allow greater access to account information, improve ease of use and enhance the information provided.

❖ Enrollment

Report Requirements

This section provides information about the following:

- Relevant trends the Arkansas TEFRA data show in enrollment (including unique enrollment for the year), eligibility, and disenrollment;
- The impact of the demonstration in providing insurance coverage to beneficiaries and uninsured populations;
- Progress with aligning the TEFRA demonstration's initial and renewal application processes with federal requirements at 42 CFR §435.911 and §435.916, including a report of timeframes for individuals actively pending TEFRA demonstration eligibility determinations, the total number of TEFRA applications processed, the number processed within 90 days, and the mean, minimum and maximum days that TEFRA applications were pending in the previous quarter;
- Progress with providing TEFRA-related notices in alignment with federal requirements at 42 CFR §431.211, §435.917 and §435.918, including notices related to family changes in income for premium reconsideration; and
- Information on anticipated program changes that may impact enrollment-related metrics.

Eligibility

To be eligible for the TEFRA-like demonstration, a child must meet the requirements for medical necessity, appropriateness of care, and financial need.

Medical necessity: The TEFRA-like demonstration waiver provides coverage to children ages 18 and under with substantial disabilities. The child must be disabled according to the Supplemental Security Income (SSI) definition of disability. If a disability has not been established by Social Security Administration (SSA), it must be determined by the State's Medical Review Team (MRT). The child(ren) of families applying to participate in the TEFRA-like demonstration waiver are also evaluated for likely eligibility in Arkansas Title XIX Medicaid state plan programs.

Appropriateness of care: Beneficiaries must meet the medical necessity requirement for institutional placement, but their needed medical services must be appropriate to provide outside an institution. The estimated cost of care in the home must not exceed the estimated cost of care if the child were in an institution.

Financial need: Beneficiaries must have income and resources that do not exceed established limits. The income limit for TEFRA applicants/beneficiaries is three times

the SSI/SPA (which calculates to $2,523 per month). Only the child's income is considered. Parental income is not considered in the eligibility determination but is considered for the purpose of calculating monthly premium. The resource limit is $2,000.

Enrollment

In 2021, Arkansas Medicaid served more than 6,000 unique clients through the TEFRA program.

Quarter	TEFRA Clients
1 (Jan.-March)	5,881
2 (Apr.-June)	5,950
3 (July-Sept.)	5,795
4 (Oct.-Dec.)	5,632
Unique Clients in 2021	**6,089**

Application Processing

DHS's current policies regarding the initial and renewal application for TEFRA align with the federal requirements at 42 CFR §435.911 (Determination of Eligibility) and §435.916 (Periodic Renewal of Medicaid Eligibility). See the following policies provided in Appendix A.

- Medical Services Policy O-257 Time Limits to Dispose of Application
- Medical Services Policy B-315 TEFRA
- Medical Services Policy C-230 TEFRA Application Process -
- Medical Services Policy C-232 TEFRA Eligibility Determination
- Medical Services Policy C-233 Disability Determination
- Medical Services Policy C-234 Determining Appropriateness of Care for TEFRA
- Medical Services Policy C-235 Disposition of TEFRA Application
- Medical Services Policy I-540 Alternating TEFRA and SSI Eligibility
- Medical Services Policy I-325 TEFRA Renewals

The table below shows TEFRA application processing times during each quarter of 2021.

	Total Applications Processed	Processed within 90 Days	Mean Processing Time	Min Processing Time (days)	Max Processing Time (days)
QTR 1 (JAN-MAR)	143	141	45.69	3	99
QTR 2 (APR-JUNE)	388	347	62.89	3	244
QTR 3 (JUL-SEP)	373	74	105.24	2	199
QTR 4 (OCT-DEC)	378	38	114.81	1	766

During the first two quarters of 2021, 92% of TEFRA applications were processed within the 90-day requirement specified by 42 CFR §435.911 and DHS Medical Services Policy O-257. The processing time for TEFRA applications slowed in the third and fourth quarters of 2021. The transition to the new ARIES eligibility system is a contributing factor to the processing slowdown, as well as increased turnover and vacancies in eligibility staff due to the pandemic. To address these concerns, DHS has focused on streamlining the hiring process and has been able to reduce caseworker vacancies since July. New caseworkers are being trained and will become more proficient. DHS also brought in temporary contracted casework support to assist until staffing is brought to more normal levels.

The following table shows the percentage of initial application notices and renewal notices sent at least 10 days prior to action date in compliance with CFR 42 §431.211. Our data systems were not able to track the number of TEFRA notices specifically related to *income changes* being mailed at least 10 days prior to the date of the action, so we are unable to respond to that question at this time. As the Division of County of Operations has moved to a new integrated eligibility system (ARIES), information concerning notices will be more readily available in the future. DHS continues to work to improve the timeliness of its notifications.

	Total Applications Processed	Percentage of notices sent at least 10 days prior to the Action Date
QTR 1 (JAN-MAR)	143	87.9%
QTR 2 (APR-JUNE)	388	85.3%
QTR 3 (JUL-SEP)	373	94.7%
QTR 4 (OCT-DEC)	378	92.6%

Disenrollments

During 2021, DHS's Division of County of Operations (DCO) transitioned to a new integrated eligibility system (ARIES). The agency launched the new system in phases, beginning in December 2020, resulting in some eligibility processing occurring in the legacy system for part of the year and in the new ARIES system for the remaining part of the year. The shift resulted in some processing problems DCO has worked to address as well as some translation issues between the data produced in the legacy system and data produced in ARIES. Disenrollment data is one area DCO is continuing to address. DHS will work through the disenrollment data issues and submit the finalized numbers in a future quarterly report.

Beneficiary Insurance Coverage

TEFRA program policies allow children enrolled in the TEFRA-like demonstration to maintain other creditable health insurance coverage, and the majority of program clients do have third party liability.

Quarter	TEFRA Enrollees with Third Party Liability
1	4,540
2	4,490
3	4,406
4	4,269

The following table provides a summary of the issues identified with TEFRA eligibility and enrollment during 2021.

Summary of Issue	Date and Report in Which Issue Was First Reported	Estimated Number of Impacted Beneficiaries	Known or Suspected Cause(s) of Issue (if applicable)	Remediation Plan and Timeline for Resolution (if applicable)/Status Update if Issue Previously Reported*
On 12/14/21, some TEFRA cases were switched from TEFRA to ARKids A in error.	December 2021	204	Caused by error related to conversion from legacy eligibility system to new eligibility system, ARIES.	A system update was performed on 12/29/21 and affected TEFRA clients were reinstated. DHS sent messages to notify clients they had been reinstated. Note: Children were not without coverage during this time. ARKids A and TEFRA have the same benefit package.

Summary of Issue	Date and Report in Which Issue Was First Reported	Estimated Number of Impacted Beneficiaries	Known or Suspected Cause(s) of Issue (if applicable)	Remediation Plan and Timeline for Resolution (if applicable)/Status Update if Issue Previously Reported*
TEFRA application processing slowed	Q3 of 2021		The transition to the new ARIES eligibility system and increased turnover and vacancies in eligibility staff due to the pandemic.	DHS has streamlined the hiring process to reduce caseworker vacancies and hired temporary contracted casework support.

Anticipated Changes to Enrollment

DHS anticipates a decrease in TEFRA enrollment in 2022 when the public health emergency ends. Like other Medicaid programs, enrollment in the TEFRA program will likely decrease when eligibility standards are reintroduced for current enrollees and those who are no longer eligible are disenrolled.

❖ Benefits

Report Requirements

This section of the report provides information on:

- Relevant trends the TEFRA data show in benefit access, utilization, premium cost-sharing and delivery network, including statistics on provider enrollment.
- Statistics on denials of requested services.
- Any new benefit-related issues and updates on previously reported issues.
- Anticipated program changes that may impact benefits.

Benefit Access and Utilization

Individuals enrolled in the TEFRA-like demonstration waiver receive the full range of State Medicaid benefits and services. The most utilized services for TEFRA clients in 2021 are listed in the following table.

Top Services	# of Claims for TEFRA Clients
Child Health Management Services/Early Intervention Day Treatment (CHMS/EIDT)	187,429
SPEECH/LANGUAGE THERAPY GENERAL	66,844
OCCUPATION THERAPY GENERAL	62,061
PRESCRIPTION SERVICES	48,091
PHYSICAL THERAPY GENERAL	41,702
SPEECH/LANGUAGE THERAPY CHMS/EIDT	39,842
OCCUPATIONAL THERAPY CHMS/EIDT	33,365

Top Services	# of Claims for TEFRA Clients
PHYSICIAN SERVICES	26,365
PHYSICAL THERAPY CHMS/EIDT	24,480
AUTISM-EPSDT	22,003
SPEECH/LANGUAGE THERAPY SCHOOL BASED	10,557
PEDIATRIC OUTPATIENT HOSPITAL	10,203
OCCUPATIONAL THERAPY SCHOOL BASED	9,511
DURABLE MEDICAL EQUIPMENT (DME)/OXYGEN	6,848
PHYSICAL THERAPY SCHOOL BASED	5,912
OUTPATIENT HOSPITAL	5,064
THERAPY - INDIVIDUAL/REGULAR GROUP	4,204
MENTAL HEALTH CLINIC - RSPMI	4,165
DME-EXPANSION-EPSDT	2,959

Health Care Delivery Network

Services provided under the TEFRA-like demonstration waiver are delivered through the State's existing network of Medicaid providers. TEFRA beneficiaries are served by a variety of health care providers across the state with at least one provider serving TEFRA clients in every county. The following health care provider types filed at least one claim for a TEFRA beneficiary in 2021.

In-State Provider Type	# of Providers with at least one TEFRA Claim in 2021
PHYSICIAN, MD	156
PHYSICIAN, MD (GROUP)	577
PHYSICIAN, DO	8
PHYSICIAN, DO (GROUP)	23
HOSPITAL	72
AUTISM	1
PHARMACY	620
DENTAL	22
INDEPENDENT LABORATORY	10
INDEPENDENT RADIOLOGY	1
ICF FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES	1
HOME HEALTH	4
TRANSPORTATION	39
PROSTHETIC SERVICES	98
PODIATRIST	2
CHIROPRACTOR	25
MENTAL AND BEHAVIORAL HEALTH	11
HEARING SERVICES	13
THERAPY	60
OPTOMETRIST/OPTICIAN	208
OPTICAL DISPENSING CONTRACTOR	1

In-State Provider Type	# of Providers with at least one TEFRA Claim in 2021
CLINICS	110
PSYCHIATRIC FACILITY - INPATIENT	15
REHABILITATION CENTER (RSPMI)	122
AMBULATORY SURGICAL CENTER	7
RURAL HEALTH CLINIC	53
HEALTH DEPARTMENT	2
DENTAL GROUP	282
PERSONAL CARE	67
HYPERALIMENTATION	5
FAMILY PLANNING	1
VENTILATOR EQUIPMENT	9
PRIVATE DUTY NURSING	7
THERAPY - REGULAR GROUP	224
THERAPY SCHOOL DISTRICT-ED SVC COOP	159
MENTAL AND BEHAVIORAL HEALTH GROUP	27
HOSPICE	5
PODIATRY GROUP	17
FEDERALLY QUALIFIED HEALTH CENTER	59
NURSE PRACTITIONER	4
SCHOOL-BASED VISION AND HEARING SCREENER	40
NURSE PRACTITIONER GROUP	14
TCM ORGANIZATION-FACILITY	3
ACS WAIVER SUPPORTIVE LIVING/RESPITE/SUPPORT	6
AHEC PCP GROUP	6
ACS WAIVER CONSULTATION SERVICE	1
ACS ENVIRONMENTAL MODS-ADAPTIVE EQUIPMENT	1
ACS WAIVER SPECIALIZED MEDICAL SUPPLIES	1
TCM-CS	1
DEVELOPMENTAL REHABILITATION SERVICES	14
ORAL SURGEON, INDIVIDUAL	2
ORAL SURGEON, GROUP	22
AHEC-MCPG PCP GROUP	1
AUTISM BEHAVIOR TREATMENT PROVIDER EPSDT	40
SCHOOL-BASED MENTAL HEALTH	1
COMMUNITY SUPPORT SYSTEMS PROVIDER	1
OTHER	1

Claims Denial

Of the claims filed in 2021, about 1.5% were denied. The vast majority of those were for pharmacy services. The table below provides the three provider types for which claims were denied for TEFRA clients and the reasons for those denials.

	THIS PAYMENT, SUPPLEMENTED BY A PREVIOUS PAYMENT MADE BY MEDICARE, CONSTITUTES	DUPLICATE OF CLAIM PAID	DENIED ADJUSTMENT RESULTING FROM AUTOMATED ELIGIBILITY VERIFICATION & CLAIM SUBMISSION REVERSAL OF A PAID CLAIM.	ADJUSTMENT VOID	TPL VOID ADJUSTMENT	PRICING ADJUSTMENT - INPATIENT PER-DIEM PRICING.	PROCESSED PER POLICY	**Total**
Denied Medical Claims								
HOSPITAL	1	2		18	2	2	1	**23**
PHARMACY			9,398					**9,398**
PSYCHIATRIC FACILITY - INPATIENT				2				**2**
Beneficiaries with Denied Medical Claims								
HOSPITAL	1	2		14	2	2	1	**19**
PHARMACY			1,903					**1,903**
PSYCHIATRIC FACILITY - INPATIENT				2				**2**

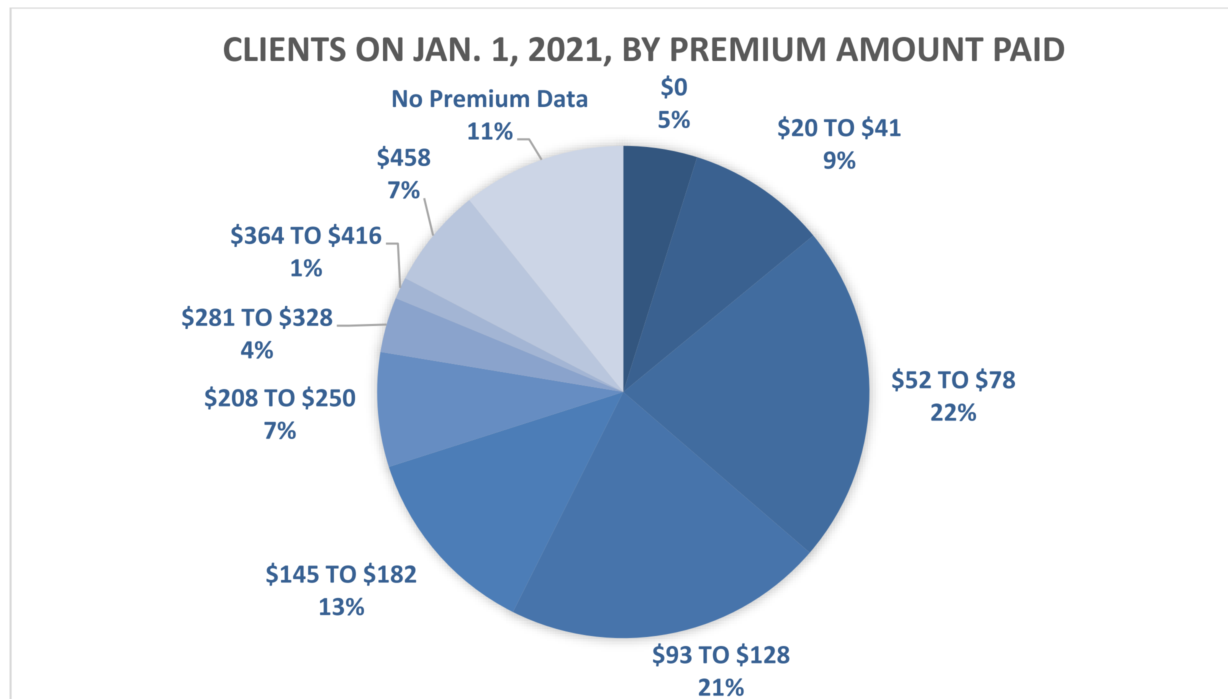
Premium Cost-Sharing

The TEFRA-like demonstration waiver allows the State to require a sliding-scale premium for eligible children based on the income of the custodial parent(s). A monthly premium can be assessed only if the family income is above 150% of the federal poverty level (FPL) and more than $25,000 (see charts below). There are no co-payments charged for services to TEFRA children, and a family's total annual out-of-pocket cost sharing cannot exceed 5% of the family's gross income.

The table below provides the TEFRA monthly premium range for TEFRA families' various income ranges. The maximum premium assessed is $5,500 per year, for incomes above $200,000 annually. Families are not charged additional premium if they have more than one child in the TEFRA program.

Annual Income		Monthly Premiums		
From	To	Percent %	From	To
$0	$25,000	0.0%	$0	$0
$25,001	$50,000	1.00%	$20	$41
$50,001	$75,000	1.25%	$52	$78
$75,001	$100,000	1.50%	$93	$125
$100,001	$125,000	1.75%	$145	$182
$125,001	$150,000	2.00%	$208	$250
$150,001	$175,000	2.25%	$281	$328
$175,001	$200,000	2.50%	$364	$416
$200,001	Unlimited	2.75%	$458	$458

The majority of clients (65%) paid premiums between $20 and $182 per month.



In DHS's 2021 TEFRA Beneficiary Survey, just 7% of respondents said the premiums were "a big financial burden." The other 93% said it was a small financial burden or not a burden at all. (See Quality section of this report for more information about the 2021 TEFRA Beneficiary Survey.)

For some clients, no premium data were available for the date the numbers were obtained. There are two main factors resulting in clients with no premium data:

- The client's eligibility was approved less than a month before the date the data were obtained. According to Division of County Operations policy F-172, premiums begin a month after eligibility is approved.
- The client shifted between TEFRA coverage and SSI. Some children who receive SSI may intermittently lose their SSI due to fluctuating parental income and may be eligible for TEFRA in the non-SSI months. According to DCO policy I-540, children with alternating TEFRA and SSI eligibility will not be assessed a premium for the TEFRA months.

New Benefit-Related Issues

The state is unaware of any new benefit-related issues in 2021.

Summary of Issue	Date and Report in Which Issue Was First Reported	Estimated number of Impacted Beneficiaries	Known or Suspected Cause(s) of Issue (if applicable)	Remediation Plan and Timeline for Resolution (if applicable)/Status Update if Issue Previously Reported*
None				

Anticipated Changes to Benefits

Several changes planned for Medicaid program benefits in 2022 that may affect TEFRA beneficiaries include:

- The number of provider visits allowed for beneficiaries with an assigned primary care provider will increase from 12 to 16. This change is scheduled for implementation July 1, 2022.
- Advance Practice Registered Nurses will be allowed to serve Medicaid clients as primary care providers, which is scheduled to start July 1, 2022.

❖ Demonstration-Related Appeals

Report Requirements

This section of the report describes:

- The results of grievances and appeals.
- The existence or results of any audits, investigations or lawsuits that impact the demonstration.
- Appeals-related issues and updates on previously reported issues.
- Any anticipated program changes that may impact appeals-related metrics.

Demonstration Appeals

The following table provides data on the appeals requests received by the DHS Office of Appeals and Hearings. Appeals are listed in the following three categories:

- **Medicaid/MRT/TEFRA** cases involve children who have not been determined to be disabled.
- **Medicaid/TEFRA** cases involve clients who have exceeded the cost of care limit or have premium issues.
- **TEFRA** cases involve eligibility issues not covered by the other two categories (i.e., income or resources).

	Appeals Received	Found in Favor of Client	Found in Favor of Agency	With-drawn	Aban-doned by Client	Open and Pending
Q1 January-March	**8**	**1**	**2**	**5**		
Medicaid/MRT/TEFRA	0	0	0	0	0	0
Medicaid TEFRA	3	0	1	2	0	0
TEFRA	5	1	1	3	0	0
Q2 April-June	**14**	**0**	**1**	**13**		
Medicaid/MRT/TEFRA	1	0	0	1	0	0
Medicaid TEFRA	0	0	0	0	0	0
TEFRA	13	0	1	12	0	0
Q3 July-September	**9**			**9**		
Medicaid/MRT/TEFRA	0	0	0	0	0	0
Medicaid TEFRA	0	0	0	0	0	0
TEFRA	9	0	0	9	0	0
Q4 October-December	**4**			**4**		
Medicaid/MRT/TEFRA	0	0	0	0	0	0
Medicaid TEFRA	0	0	0	0	0	0
TEFRA	4	0	0	4	0	0
Total 2021	**35**	**1**	**3**	**31**	**0**	**0**

Grievances

The Arkansas Medicaid program uses its vendor, Arkansas Foundation for Medical Care (AFMC), to accept and process grievances and complaints for all program types, including TEFRA. However, for most of 2021, AFMC did not have a process in place to categorize and filter grievances and complaints by the type of Medicaid program at issue. In October 2021, AFMC established a tracking process that now allows for the identification of grievances and complaints related to the TEFRA program. AFMC did not receive any TEFRA grievances after it began categorizing complaints by program in 2021.

Investigations, Lawsuits and Audits

DHS is not aware of any investigations, lawsuits or audits affecting the TEFRA program in 2021.

Appeals Related Issues

Summary of Issue	Date and Report in Which Issue Was First Reported	Estimated number of Impacted Beneficiaries	Known or Suspected Cause(s) of Issue (if applicable)	Remediation Plan and Timeline for Resolution (if applicable)/Status Update if Issue Previously Reported*
None				

Anticipated Appeal-Related Program Changes

DHS does not anticipate any appeals-related program changes.

❖ Quality

Report Requirements

This section of the report describes:

- Quality activities occurring over the current demonstration reporting period, any new quality-related issues, and updates on previously reported issues;
- Results of beneficiary satisfaction surveys;
- The status of the health care delivery system under the demonstration with respect to issues and/or complaints identified by beneficiaries.
- Progress with improving TEFRA-specific customer service response rate; particularly regarding inquiries related to family changes in income for premium reconsideration; and

- Any anticipated program changes that may impact quality-related metrics.

During 2021, DHS vendor AFMC conducted a TEFRA beneficiary survey to gauge beneficiary satisfaction with the program and the health care system. A sample of 1,650 TEFRA clients was randomly selected to receive the survey. A total of 465 TEFRA clients returned surveys were available for analysis, providing a response rate of 29.4% of an analyzable sample size of 1,579. TEFRA survey respondents highly rated both their ability to access care quickly and the care they receive from providers. Clients rated their access to special therapies (speech, occupational and physical therapies) particularly high. The beneficiary survey found the number of respondents reporting as “no problem” the ability to see a personal doctor or nurse, get prescriptions, and receive urgent care increased after enrolling in the TEFRA program compared with their experience before enrolling. Additionally, more than 70% of respondents rated the TEFRA program overall as an 8 or higher on a scale of 0-10.

	2019	**2020**	**2021**
Composite Scores (Respondents who answered “usually” or “always” to questions in each category. Percentages for category questions are averaged for composite percentage.)			
Getting care quickly	95%	92%	96%
How well doctors communicate	95%	94%	95%
Customer service	66%	76%	74%
Special equipment and supplies	64%	71%	73%
Special therapies	90%	91%	90%
Ratings Percent of respondents who gave an 8, 9, or 10 on a scale of 0 to 10.			
Rating of health care professional	92%	93%	93%
Rating of health care	90%	90%	93%
Rating of treatment or counseling	70%	81%	76%
Rating of TEFRA program	73%	76%	71%
Rating of customer service	39%	52%	44%
Rating of TEFRA application process	53%	55%	54%

While TEFRA clients who responded to the 2021 Beneficiary Satisfaction Survey highly rated their health care and their ability to access care, some components of the TEFRA program did not score as high. Just 44.1% of clients who responded to the survey and had an interaction with TEFRA customer service unit rated their customer service experience 8 or higher. While most gave customer service high marks for courteous treatment, only 61.2% said they received the help they needed. Clients noted the most frequent problems were related to long wait times, frequent transfers and staff who could not answer their questions. TEFRA survey respondents also rated the TEFRA application process lower than other aspects of the program. About 33% of respondents

said they “never” or “sometimes” have enough time to complete the TEFRA renewal packet before the deadline.

The customer service centers TEFRA beneficiaries reported contacting the most are the Division of County Operations (DCO), which handles eligibility, and the TEFRA Premium Unit, which handles premium payment. Responses to the TEFRA beneficiary survey have been shared with DCO and the TEFRA Premium Unit, including a breakdown of respondents’ scores for the two units individually. In 2021, DHS also initiated monthly meetings between the Division of Medical Services (DMS), DCO and the TEFRA Premium Unit to discuss and resolve TEFRA beneficiary issues and facilitate better communication between the three areas. These meetings will also ensure policy information and implementation are streamlined and that DHS provides the same information to beneficiaries across the organization.

The TEFRA beneficiary survey asks a variety of questions about customer service and about TEFRA premium, but it did not include a question specific to inquiries related to family changes in income for premium reconsideration. DHS has requested that a question be added to the 2022 TEFRA survey to allow the agency to better gauge any issues specific to that issue.

Summary of Issue	Date and Report in Which Issue Was First Reported	Estimated number of Impacted Beneficiaries	Known or Suspected Cause(s) of Issue (if applicable)	Remediation Plan and Timeline for Resolution (if applicable)/Status Update if Issue Previously Reported*
No specific quality issues beyond the customer service issues described above				

Anticipated Program Changes

DHS does not anticipate any program changes that may impact quality-related metrics.

Financial/Budget Neutrality-Related Program Changes

Report Requirements

This section of the report provides the following:

- The financial performance of the demonstration;
- An analysis of budget neutrality for 2021 and any new financial/budget neutrality-related issues;
- The number of member months for 2021;
- A statement certifying the accuracy of the member months; and
- Any anticipated program changes that may impact financial/budget neutrality metrics.

The PMPM ceiling (total computable, net of premiums paid by demonstration enrollees) for the 2021 demonstration year was established at $1,260.16. During 2021, the demonstration achieved an actual PMPM of $714.88. (Additional expenditures are expected as claims for 2021 dates of service continue to be processed.)

Total program expenditures	$56,620,220
Premiums collected	$6,503,116
Net expenditures	$50,117,104
Member months	70,106
2021 PMPM	$714.88

By submitting this report, DHS certifies that the member month data described above and in the accompanying budget neutrality workbook is accurate.

Summary of Issue, including fiscal impact and impacted MEGs	Date and Report in Which Issue Was First Reported	Known or Suspected Cause(s) of Issue (if applicable)	Remediation Plan and Timeline for Resolution (if applicable)/Status Update if Issue Previously Reported*
No budget neutrality issues identified			

Anticipated Program Changes

DHS anticipates TEFRA enrollment will decline when the public health emergency ends, which may lead to a decrease in program expenditures. However, the agency does not anticipate any changes that will affect its ability to meet future PMPM budget neutrality limits.

❖ Demonstration Operations and Policy

Report Requirements

This section of the report highlights the following:

- Significant demonstration operations or policy considerations that could positively or negatively impact beneficiary enrollment, access to services, timely provision of services, budget neutrality, or any other provision that has potential for beneficiary impacts.
- Any policy or administrative difficulties in the operation of the demonstration.
- Any State legislative developments that may impact the demonstration.
- Progress toward improving information made available (minimally at time of initial application and at annual renewal) on TEFRA services, benefits, participating providers, changes to the sliding scale of monthly premiums required for families with income above 150 percent of the FPL, and instructions for how to pay any applicable premium or to request a change in how the family pays any applicable premium.
- Any activity that may accelerate or create delays or impediments in achieving the demonstration's approved goals or objectives.

Changes in key state personnel or organizational structure

In 2021, the TEFRA program was managed within the DHS Division of Medical Services by new staff, Nell Smith, a DMS Assistant Director, and Hilton Taylor, Business Operations Manager.

State legislative developments that may impact the demonstration

Act 569 of 2021 allows Advance Practice Registered Nurses to serve Medicaid clients as primary care providers, which could expand the number of health care professionals available to serve TEFRA clients as their primary care provider. This provision will be implemented beginning July 1, 2022.

Systems issues or challenges that could impact the demonstration

The state's eligibility system was converted to a new system called ARIES in 2021. While the switch to ARIES will result in long-term efficiencies, the conversion has contributed to delays in application processing and resulted in minor errors. See the enrollment section above for issues related to the eligibility system.

Policy or administrative difficulties in operating the demonstration

The DHS Division of County Operations experienced an increase in turnover and vacancies in eligibility staff due to the pandemic. To address these concerns, DHS has focused on streamlining the hiring process and has been able to reduce caseworker vacancies since July. New caseworkers are being trained and will become more

proficient. DHS also brought in temporary contracted casework support to assist until staffing is brought to more normal levels.

Progress toward improving TEFRA information available to beneficiaries

In 2021, the TEFRA program implemented the following communications improvements and system enhancements.

- Invoices were updated to be more user friendly. The frequency of invoicing was changed from quarterly billing to monthly.
- When a client's premium changes to zero, but a past due balance is still owed, a TEFRA past due letter is system-generated and sent to the guardian.
- Guardians can now request a summary of cash receipts from the TEFRA Premium Unit.
- Payments in arrears 12 months or more after TEFRA closure are forgiven.
- The TEFRA program's welcome letter now includes instructions to return the payment selection form and initial payment within 20 days.
- Reports are now generated to help track guardians who did not return the premium selection form and/or the initial TEFRA premium.

❖ Implementation Update

Report Requirements

This section of the report provides implementation updates on relevant aspects of the demonstration, as identified either during the approval process, in previous monitoring calls, or other implementation reviews or discussions pursuant to 42 CFR §431.420(b). This section also reports on any changes in implementation plans since the demonstration was approved.

During 2021, CMS asked DHS provide written quarterly reports on the TEFRA program for discussion during quarterly monitoring calls. DHS submitted one report covering Q1 and Q2 of 2021 and a second report covering Q3. CMS also asked DHS to revise and resubmit its 2019 and 2020 annual reports. DHS resubmitted the revised reports and, after receiving feedback from CMS, is working on adding the requested information to the reports.

❖ Demonstration Evaluation Update

Report Requirements

This section of the report highlights:

- The status of the evaluation and information regarding progress in achieving demonstration evaluation criteria, including updates on evaluation work and timeline.
- Information about outcomes of care, quality of care, and access to care for demonstration populations as described in the demonstration evaluation.
- The results/impact of any demonstration programmatic area defined by CMS that is unique to the demonstration design or evaluation hypothesis.

Interim Evaluation Results

DHS submitted its draft interim evaluation of the TEFRA program to CMS on December 29, 2021. The interim evaluation measured the demonstration's performance toward achieving the following four goals:

Goal 1: *Ensuring that demonstration enrollees have equal or better access to health services compared to the Medicaid fee-for-service population.*

Goal 2: *Ensuring demonstration enrollees have access to timely and appropriate preventive care.*

Goal 3: *Ensuring enrollment in the demonstration increases beneficiaries' perceived access to health care services and experience in the quality of care received.*

Goal 4: *Ensuring premium contributions are affordable, that they do not create a barrier to health care access, and that the proportion of beneficiaries who experience a lockout period for nonpayment of premiums is relatively low.*

The Interim Evaluation compared the TEFRA-like demonstration enrollees with a group of patients with specific medical conditions within the TEFRA-like target group. The evaluation used claims-based measures and beneficiary survey responses to examine the demonstration's outcomes and beneficiaries' experience with accessibility, therapy services, overall health care, premiums, and other relevant aspects of the program.

Of the nine claims-based measures for comparison between the TEFRA-like population vs. the non-TEFRA-like population, the TEFRA-like population outperformed the non-TEFRA-like population on the following measures:

- Percentage of beneficiaries receiving therapy services
- Proportion of days covered (PDC) for prescriptions, threshold of 50%
- Percentage of beneficiaries taking at least two anti-seizure prescriptions
- Percentage of beneficiaries with Third Party Liability (TPL) coverage
- Durable Medical Equipment (DME) coverage

Of the three claims-based measures, where comparison between performance periods was completed on the TEFRA-like population only, the TEFRA-like population showed a growth in performance between 2018 and 2019 in the following measures:

- First health care visit to PCP within 60 days
- Average length (in months) of TEFRA-like segments

Of the survey-based measures for comparison between the TEFRA Beneficiary Satisfaction Survey, the ARKids First A and ARKids First B Beneficiary Satisfaction Surveys, and the TEFRA Disenrollee Beneficiary Survey, the TEFRA-like satisfaction scores outperformed or were not significantly different than the comparison surveys on the following measures:

- Getting care quickly
- How well doctors communicate
- Overall health care

When comparing their experience before their TEFRA coverage, TEFRA beneficiaries reported fewer problems with the following after receiving TEFRA coverage:

- Seeing a personal doctor or nurse
- Getting prescriptions
- Getting urgent care

Of the survey-based measures, where comparison between performance periods was completed on TEFRA surveys only, the TEFRA scores showed no significant difference between 2019 vs. 2018 TEFRA surveys as favorable performance, except for physical therapy services, in the following measures:

- Therapy services
- Premium barriers (a big financial burden)

Results presented in the interim evaluation show that the demonstration was effective in achieving the majority of goals and objectives established at the beginning of the current TEFRA-like demonstration.

Anticipated Changes

DHS is considering changes to its TEFRA evaluation design to enhance its methodology, if approved by CMS. The potential changes include:

1) Changing the comparison population to include the PASSE population to determine if the primary medical and behavioral health conditions are similar compared to the TEFRA-like population.

2) Exploring other data sources including other payors' medical claims from the Arkansas All-Payer Claims Database (APCD) for the TEFRA-like population.

3) Adding a longitudinal analysis by trending the TEFRA-like population over time.

The table below lists anticipated evaluation-related deliverables and their due dates.

Type of Evaluation Deliverable	Due Date	State Notes or Comments	Description of Any Anticipated Issues
Interim Evaluation Report	Submitted 12/29/2021	NA	NA
Summative Evaluation Report	6/30/2024	The state is considering adjusting its evaluation design to include relevant populations, additional data sources and longitudinal analysis.	Evaluation design changes would be subject to CMS approval

❖ Other Demonstation Reporting

Report Requirement:

This section of the report provides pertinent information not captured in the above sections or in related appendixes.

Demonstration Waiver Renewal

The current TEFRA-like demonstration ends December 31, 2022, and CMS requires the renewal application to be submitted by June 30, 2022. The application is being drafted, and CMS has met with DHS several times to provide guidance on completing that work.

The table below lists any other deliverables related to this demonstration and associated due dates.

Type of Other Post-Approval Deliverable	Due Date	State Notes or Comments	Description of Any Anticipated Issues for CMS Technical Assistance
Quarterly Reports	10 days prior to quarterly calls currently scheduled for 4/4/22, 7/7/22 and 10/6/22		None
Demonstration Application for Renewal	6/30/22		None
Close Out Report	120 days before waiver expires on 12/31/22		None

❖ Post Award Public Forum

Report Requirements

This section of the report provides a summary of the annual post-award public forum held pursuant to 42 CFR §431.420(c) including any resulting action items or issues and all public comments received regarding the progress of the demonstration project.

DHS held a virtual public forum on the TEFRA Waiver on November 17, 2021, at 1:00 p.m. CST. The public forum was publicized on the DHS website and the DHS Medicaid Saves Lives Facebook page, and notices about the event were distributed to interested stakeholder groups. The public forum provided the following information:

- The purpose of the public forum
- An overview of the program
- Demographics of program participants
- A list of eligibility requirements
- TEFRA enrollment summary
- Health care quality, outcomes and access
- TEFRA contact Information
- The various ways in which individuals could submit comments or questions.

There were no verbal comments or questions, but several participants asked questions in the chat function. The questions centered on the following topics:

- Reasons for lengthy application process
- Solutions for full voicemail boxes in TEFRA call centers

Some participants requested to see information in the slide deck again.

❖ Notable State Achievements and/or Innovations

Report Requirements

This section of the report provides a summary of achievements and/or innovations in demonstration enrollment, benefits, operations, and policies pursuant to the hypotheses of the demonstration or that served to provide better care for individuals, better health for populations, and/or reduce per-capita cost.

During 2021, the TEFRA program had the following notable achievements.

- The TEFRA program served more than 6,000 clients during the year, while maintaining a per member per month cost well below the budget neutrality limits.
- The TEFRA program's Interim Evaluation found the TEFRA-like population outperformed the non-TEFRA-like population on measures including the receipt

of therapy services and proportion of days covered for prescriptions, and client satisfaction scores outperformed or were not significantly different from the comparison surveys on getting care quickly, communication with doctors and overall health care.

- The 2021 TEFRA beneficiary survey found clients highly rated both their ability to quickly access care and the care they receive from providers.
- The TEFRA program implemented changes to beneficiary notices and invoices to allow greater access to account information, improve ease of use and enhance the information provided.

Appendix A: TEFRA Policies

Medical Services Policy O-257 Time Limits to Dispose of Application

Except for those cases that require a disability determination, all Medically Needy cases will be disposed of within 45 days from the date of application by one of the following actions: approval, denial, or withdrawal. AD Medically Needy cases, when an MRT disability determination is required, will be disposed of within 90 days from the date of application by one of the following actions: approval, denial, or withdrawal

Medical Services Policy B-315 TEFRA

This group consists of children 18 years of age or younger with disabilities that must meet the medical necessity requirement for institutional placement in a hospital, a skilled nursing facility, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), or be at risk for future institutional placement. Medical services must be available to provide care to the child in the home, and it must be appropriate to provide such care outside an institution. The income limit is three (3) times the current SSI payment standard. Only the child's income is considered. Parental income is not considered in the eligibility determination but is considered for the purpose of calculating the monthly premium. For information regarding TEFRA premiums and calculation, refer to MS F-170-172. The resource limit is $2000. Only the child's resources are considered. Parental resources are disregarded. Recipients of TEFRA Waiver receive the full range of Medicaid benefits and services.

Medical Services Policy C-230 TEFRA Application Process -

TEFRA applications (DCO-0444) will be available at local DHS offices or by mail, through hospitals, including Arkansas Children's Hospital, and Federally Qualified Health Centers. Information will be available through the Division of Developmental Disabilities (DDS) Services Coordinators and Providers. Information will also be available on the DHS/DMS website. To complete the eligibility determination, the following steps must be completed:

• The application must be made by an adult responsible for the care of the child.

• A DMS 2602, Physician's Assessment of Eligibility, must be completed by the child's physician to determine Medical Necessity and Appropriateness of Care. If disability has not previously been established by the Social Security Administration, a Medical Review Team (MRT) disability review must be completed.

Medical Services Policy C-232 TEFRA Eligibility Determination

Except for the Appropriateness of Care requirement, eligibility will be determined by the eligibility worker in the same manner as Long-Term Services and Supports (LTSS) cases. A child who would not be eligible or potentially eligible for Medicaid in an institution cannot be considered for TEFRA. If the child's countable income is less than the current LTSS income limit (Appendix S) and the child's countable resources are less than the current resource limit, he/she will meet the TEFRA income and resource

requirements. Parental income and resources will be disregarded when determining eligibility. However, parental income will be considered when calculating the monthly premium amount. Refer to MS F-170 - MS F-172.

Medical Services Policy C-233 Disability Determination

To qualify for TEFRA, a child must be considered an individual with a disability according to the SSI regulations that govern children with disabilities. Disability for a child will either be established by the Social Security Administration (SSA) or the DHS Medical Review Team (MRT). If a child received SSI within one year prior to making TEFRA Waiver application but was terminated for reasons other than lack of disability, (e.g. parental income or resources), documentation will be obtained for the case record. A disability decision made by SSA on a specific disability is controlling for that disability, until the decision is changed by SSA. The child will be considered an individual with a disability based on the previous SSA disability determination. Refer to MS F-120-129.

Medical Services Policy C-234 Determining Appropriateness of Care for TEFRA

Based on information provided on the DMS 2602, Physician's Assessment of Eligibility, and any medical records submitted, the TEFRA Committee will determine medical necessity and if the applicant meets the Appropriateness of Care criteria. If the applicant is having difficulty obtaining the Physician's Assessment of Eligibility, the County Office should provide assistance to obtain the required form.

Medical Services Policy C-235 Disposition of TEFRA Application

If at any point in the eligibility determination the child fails to meet eligibility requirements, the application will be denied. The begin date for TEFRA Waiver eligibility will be the date of application unless retroactive coverage is needed. If needed, the eligibility begin date can be as early as three months prior to the date of application, provided all eligibility requirements are met. A child cannot be approved for retroactive coverage before the onset of his/her disability as he/she would not meet the TEFRA disability or medical necessity requirements prior to the onset of disability. A child who had been residing in an institution would not be eligible for any retroactive coverage while still residing in the institution as TEFRA Waiver coverage is for non-institutionalized children only. For any retroactive coverage needed, it can be assumed that medical necessity and appropriateness of care have been met unless there is evidence to the contrary.

Medical Services Policy I-540 Alternating TEFRA and SSI Eligibility

Some children who receive SSI may intermittently lose their SSI due to fluctuating parental income and may be eligible for TEFRA in the non-SSI months. In these instances, the eligibility worker must redetermine TEFRA eligibility for each month in which the child is not SSI eligible. Children with alternating TEFRA and SSI eligibility will not be assessed a premium for the TEFRA months. If fluctuating parental income causes a child's SSI eligibility status to change from month-to-month and less than 10 months have passed since the last full TEFRA Waiver certification or renewal, only a new DCO-9700 (TEFRA and Autism Application for Assistance) and a redetermination of

income and resource eligibility are required to reopen the TEFRA Waiver case. Redetermination of other eligibility factors will not be required.

Medical Services Policy I-325 TEFRA Renewals

TEFRA Waiver cases will be renewed every 12 months. To ensure that renewals are completed by the end of the twelfth month, the renewal process should be started in the 9th month from the date of the last approval or renewal. The eligibility worker will generate the appropriate renewal forms and send the packet to the individual's guardian or authorized representative. The due date for return of the TEFRA renewal packet will be the last day of the 10th month. If the child's SSI eligibility has fluctuated due to changing parental income since the last certification or renewal, medical necessity and appropriateness of care will not be determined until the case is in, or nearing, the 9th month since completion of the last TEFRA renewal or certification. At renewal, all eligibility factors including appropriateness of care will be redetermined. A MRT disability redetermination may or may not be necessary at the time the TEFRA case is reevaluated. A reexamination by MRT is necessary when indicated on the DCO-0109, or one year after the initial certification for TEFRA when the certification was made based on a previous SSI determination of disability and there has been no SSI payment or subsequent redetermination by SSA.

EXAMPLE: A child received SSI for six months in 2018 and then lost SSI due to increased parental income. The parent applies for TEFRA in September 2018 and the case is certified in November 2018 based on the previous SSI disability determination. The child has not received SSI benefits since certified. At the annual renewal in 2019, a MRT disability determination is required.

A review by MRT is also necessary if the eligibility worker becomes aware of significant improvement and/or employment at or near the SGA level. Refer to MS F-125.

Refer to Appendix O for a list of required renewal forms. In addition, the premium amount will be redetermined at renewal. If the premium changes, the parent will be notified of the new amount by the TEFRA Premium Unit.