STATE OF ARKANSAS
ASA HUTCHINSON
GOVERNOR

July 19, 2021

Honorable Xavier Becerra
Secretary, U.S. Department of Health and Human Services
200 Independence Ave, SW
Washington, D.C. 20201

Dear Secretary Becerra,

On behalf of the people of Arkansas, I am pleased to submit an application for a Section 1115 Demonstration Project, "Arkansas Health and Opportunity for Me" ("ARHOME"). Since 2014, Arkansas has provided coverage to the Medicaid newly eligible adult group, the majority of whom receive coverage through private sector qualified health plans (QHPs). The proposed waiver continues to use premium assistance to provide coverage through QHPs.

In its most recent legislative session, the Arkansas General Assembly approved a number of program improvements. Key changes will permit Arkansas to address the Social Determinants of Health (SDOH) of low-income adults. As you know, the relationship between poverty and poor health outcomes and premature death is well established. As stated by the U.S. Department of Health and Human Services (HHS) in its Healthy People 2020 report:

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

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established relationship between poverty, socioeconomic status, and health outcomes—including increased risk for disease and premature death.

ARHOME has adopted the Community Bridge Organization (CBO) concept that was introduced by the Centers for Medicare and Medicaid Services (CMS) a few years ago. In the Arkansas version, Life360 HOMEs will be anchored by hospitals and directed towards improving rural health, maternal and child health, and the health of young adults most at risk of long-term poverty. Improving the health of these populations is critical to improving Arkansas's low ranking among the states in health outcomes. In addition, the QHPs will provide incentives to their members to participate in health improvement initiatives. We will measure health improvements through comparisons to the Medicaid adult core set and hold the QHPs accountable for meeting targets over the next five years.

For millions of Americans, health coverage 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 education, training, and job opportunities, and thereby achieve improvement in socioeconomic conditions, all while providing continuity of health care coverage through purchase of QHPs that can be obtained on the individual market after an individual moves off of Medicaid.

Approval of the ARHOME proposal will enable Arkansas to enlist the QHPs, hospitals, and community partners in addressing social determinants of health. ARHOME will build in new levels of accountability for achieving health improvements for which Arkansas can be measured against national benchmarks. As the current waiver expires December 31, 2021, we look forward to working with you on timely approval.

Sincerely,

[redacted]

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Arkansas Health and Opportunity for Me (ARHOME)

A Proposed Medicaid Section 1115 Demonstration Project

Section 1115 Demonstration Application

Summary

ARKANSAS DEPARTMENT OF HUMAN SERVICES

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

Summary

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

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

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

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

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

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

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

Background

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

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

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

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

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

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

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

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

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

Section A: Program Description, Goals, and Objectives

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

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

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

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

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

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

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

Additional changes include:

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

Goals and Objectives

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

Goals:

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

Objectives:

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

- Slow the Rate of Growth in Spending for the Program

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

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

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

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

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

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

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

Impact on Beneficiaries

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

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

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

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

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

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

- Young Adults Ages 19-27 Formerly in Foster Care

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

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

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

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

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

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

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

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

- Veterans Aged 19-30

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

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

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

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[6] https://www.americanactionforum.org/research/incarceration-and-poverty-in-the-united-states/

[7] https://www.brookings.edu/wp-content/uploads/2018/03/es_20180314_looneyincarceration_final.pdf p.1.

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

Impact on Beneficiaries

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

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

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

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

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

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

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

Monthly Average Enrollment

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

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

Impact on Beneficiaries

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

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

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

Impact on Beneficiaries

This provision has no impact on beneficiaries.

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

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

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

ARWorks Enrollees October 31, 2020 Snapshot

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

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

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

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

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

In 2022, these amounts will be:

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

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

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

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

Maximum Premiums for CY 2022

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

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

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

Maximum Copayments for CY 2022

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

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

Impact on Beneficiaries

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

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

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

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

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

(4) Reduction of retroactive eligibility.

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

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

Impact on Beneficiaries

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

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

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

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

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

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

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

Impact on Beneficiaries

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

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

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

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

I. Enrollment

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

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

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

Projected Member Months CY 2022-2026

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

II. Expenditures

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

Projected Demonstration Expenditures CY 2022-2026

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

III. Financial Analysis of Changes

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

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

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

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

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

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

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

- Reduction in retroactive coverage

- Re-assignment of "inactive" QHP beneficiaries to FFS.

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

Section D: The Hypothesis and Evaluation Parameters of the Demonstration

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

Table 1: Demonstration Objectives, Hypotheses, and Evaluation Parameters

Proposed Hypotheses	*Evaluation Parameters*
Objective 1: 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: ▪ Continuity of primary care provider (PCP) care ▪ Continuity of specialist care • Data source: Administrative • Comparison: FFS comparison groups
	• Measures: ▪ PCP network adequacy ▪ PCP network accessibility ▪ Specialist network adequacy ▪ Specialist network accessibility ▪ Essential community providers (ECP) network adequacy ▪ ECP network accessibility • Data source: Provider networks • Comparison: FFS comparison groups
	• Measures: ▪ Ease of getting necessary care ▪ Access to care and immunizations • Data source: Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey • Comparison: FFS comparison groups
	• Measures: Access to care and immunizations • Data source: Behavioral Risk Factor Surveillance Survey (BRFSS) • Comparison: Adults 19-64 w/income <138%

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

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

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

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

Table 1: Demonstration Objectives, Hypotheses, and Evaluation Parameters	
Proposed Hypotheses	*Evaluation Parameters*
	• Data source: Administrative • Comparison: None
C. Among QHP members who disenroll from ARHOME, the percent that disenroll due to increased income will increase over time.	• Measures: Percent of members that disenroll due to higher income above the baseline for "churn" rates • Data sources: ▪ Administrative ▪ New Survey • Comparison: None
D. Arkansas residents in rural areas with a Rural Life360 HOME will access local community resources to reduce unmet health-related social needs compared to residents in rural areas without a Rural Life360 Home.	• Measures: ▪ Income ▪ Employment ▪ Educational attainment ▪ Housing security/affordability (≤30% of income) ▪ Food security ▪ Safety ▪ Criminal justice system involvement ▪ Receipt of educational, employment, or other social services • Data sources: ▪ American Community Survey ▪ Area Health Resources File (AHRF) ▪ Statewide Longitudinal Data System (SLDS), county-level de-identified data • Comparison: Counties w/o Rural Life360 Homes
E. ARHOME beneficiaries with SMI or SUD who receive services from a Rural Life360 Home will have fewer health-related social needs and improved SDOH compared to similar ARHOME beneficiaries in rural areas without a Rural Life360 Home.	• Measures: ▪ Income ▪ Employment ▪ Educational attainment ▪ Housing security/affordability (≤30% of income) ▪ Food security ▪ Safety ▪ Criminal justice system involvement ▪ Receipt of educational, employment, or other social services • Data sources: ▪ Administrative ▪ Statewide Longitudinal Data System (SLDS) ▪ New Survey • Comparison: Similar beneficiaries in counties

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

Table 1: Demonstration Objectives, Hypotheses, and Evaluation Parameters	
Proposed Hypotheses	*Evaluation Parameters*
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: ▪ Arkansas program characteristics ▪ Arkansas regional average program characteristics ▪ Contiguous states' program characteristics ▪ PMPM growth rate • Data source: Arkansas Insurance Department • Comparison: Non-expansion states
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
	• Measures: Percent of QHP members who pay their premium (1) at least one month, (2) at least 6 months, and (3) all 12 months; members using HII and EII incentives; members selecting their own QHP; members seeing a PCP on an annual basis • Data source: Administrative • Comparison: Non-expansion states
D. QHP members will demonstrate they value QHP coverage as least as much as similar individuals in other states through active engagement in the insurance process: 1. QHP members will have fewer gaps in coverage, while still eligible for Medicaid and after earnings exceed Medicaid eligibility limits, than individuals with comparable income in states that did not expand Medicaid.	• 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
	• 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.

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

Section E: Specific Waiver and Expenditure Authorities

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

Waiver Authority

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

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

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

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

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

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

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

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

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

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

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

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

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

7. **Prior Authorization Section 1902(a)(54) insofar as it incorporates 1927(d)(5)**

   To permit Arkansas to deviate from the State Plan to require that requests for prior authorization for drugs to be addressed within 72 hours, and for expedited review in exigent circumstances within 24 hours, rather than 24 hours for all circumstances as currently required in State policy. A 72-hour supply of requested medication will be provided in the event of an emergency.

8. **Payment for Services in an Institution for Mental Diseases (IMD) Section 1905(a)**

   Under the State Plan, federal financial participation (FFP) is generally not allowable to pay for medical services in an IMD for an adult in an IMD that exceeds 16 beds. Waiver authority is needed to claim FFP.

9. **Community Investment/Medical Loss Ratio**

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

Expenditure Authority

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

1. **Premium Assistance and Cost Sharing Reduction Payments.** Expenditures for part or all of the cost of private insurance premiums in the individual market, and for payments to reduce cost share under such coverage for beneficiaries in the Demonstration.
2. **Economic Independence Initiative.** Expenditures to the extent necessary to enable Arkansas to develop a process for identifying individuals engaged in employment, education, and training activities.
3. **Community Bridge Organizations.** Expenditures for costs not otherwise matchable for all or some costs associated with creating and paying Community Bridge Organizations for the target populations identified in this application, in a manner inconsistent with requirements under Section 1902 of the Act. Although expenditures for care coordination and home visitation can be matched, the state is requesting funding for other items and activities that generally are not matchable. These include:
   - start-up costs
   - supplemental services that are related to SDOH but are nonmedical in nature
   - temporarily fund the cost health insurance for certain individuals who successfully complete a Success Life360 program and whose income increases above 138% FPL
4. **Premium Assistance.** Expenditures for costs not otherwise matchable for some costs associated with paying the individual's share of premium for coverage purchased through the individual insurance Marketplace or through an employer for a limited time for certain individuals who successfully complete a program offered under a Community Bridge Organization and whose income exceeds 138% of the Federal Poverty Level (FPL).

Requirements Not Applicable to the Expenditure Authority:

1. **Cost Effectiveness** **Section 1902(a)(4) and 42 CFR 435.1015(a)(4)**

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

Section F: Availability of Waiver Application for Public Comment

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

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

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

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

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

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

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

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

Retroactive Eligibility

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

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

DHS Response

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

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

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

<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.

<u>Evaluation</u>

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

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

DHS Response

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

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

Member Incentive Programs

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

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

DHS Response

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

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

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

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

DHS Response

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

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

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

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

DHS Response

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

Access to Care

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

DHS Response

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

Community Bridge Organization/Life360 HOME

Maternal Life360 HOME:

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

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

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

Life360 HOMEs implementation questions

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

DHS Response

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

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

Life360 HOMEs:

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

DHS Response

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

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

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

DHS Response

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

Transition to PASSE

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

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

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

DHS Response

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

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

<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.

Active Role for Arkansas' Community Mental Health Centers

DHS Response

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

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

DHS Response

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

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

DHS Response

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

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

DHS Response

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

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

DHS Response

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

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

DHS Response

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

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

DHS Response

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

Meetings/ Hearings 1230

Date: June 11, 2021
75429245f

Notice is hereby given that the assessment of benefits and damages of City of Little Rock Municipal Property Owners' Multipurpose Improvement District No. 2020-002 (Bear Den Mountain Project) has been filed in the office of the City Clerk of the City of Little Rock, Arkansas, where it is open to inspection. All persons wishing to be heard on the assessment will be heard by the Commissioners and the Assessor of the District commencing at 10:00 a.m. and continuing until all objections are heard, at the offices of Colliers International, Highway 10 Office Park, 16607 Cantrell Road, Suite 8, Little Rock, Arkansas 72223, on the 1st day of July 2021.

/s/ Bradford Gaines, Chairman
75425334f

NOTICE OF ADOPTION

TO: WILLIAM STRATTON WHITE, JR. , biological father of a male child,A.W.W, whose last known address is 920 Ward St., Benton, AR, 72015.

You are hereby notified that on May 24, 2021 a Petition for Adoption of A.W.W., a male child born to Christina Francis White on November 27, 2004 in Benton, AR, was filed in Pennington County, SD.

On May 24, 2021, the Court passed an Order fixing a hearing upon said Petition for July 19, 2021, at 10:00. The hearing will be held at 315 St. Joseph St., Rapid City, SD 57701.

If you do not respond to the court, all parental rights you may have with respect to the minor child will be lost and you will neither receive notice nor be entitled to object to the adoption of the child.

75425171z

NOTICE OF APPLICATION for PROPOSED ARHOME SECTION 1115 DEMONSTRATION PROJECT

Pursuant to 42 C.F.R. § 431.408, the Director of the Division of Medical Services (DMS) of the Department of Human Services (DHS) issues the following Notice of Application for a proposed Section 1115 Demonstration Project waiver for the ARHOME program.

During the most recent session of the Arkansas General Assembly, Governor Asa Hutchinson and legislators collaborated to make further improvements to the Medicaid program for non-elderly and adults without disabilities with income below 138% of the federal poverty, currently called Arkansas Works. Under the authority of Act 530, Arkansas proposes to continue to cover the new adult eligibility group for another five years through the Arkansas Health and Opportunity for Me Act of 2021 ("ARHOME") program and extend and amend the Demonstration through December 31, 2026. DMS now seeks comments on the proposed waiver authorities before submission to the Centers for Medicare & Medicaid Services (CMS) for consideration and approval.

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.

The new features of ARHOME 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;

-reduce the additional risk for disease and premature death associated with living in a rural county;

-strengthen financial stability of critical access hospitals and other small, rural hospitals, and enhance access to medical services in rural counties;

-fill gaps in continuum of care for individuals with serious mental illness and substance use disorders;

-increase the identification of Medicaid beneficiaries most at risk for poor health outcomes associated with poverty and increase their engagement in educational and employment opportunities;

-increase active participation of beneficiaries in improving their health;

-provide intensive care coordination for beneficiaries most at risk of long-term poor health to reduce inappropriate and preventable utilization of emergency departments and inpatient hospital settings;

-increase the use of preventative care and health screenings; and

-reduce the rate of growth in state and federal obligations for providing healthcare coverage to low-income adults.

DMS has made several changes from the previous waiver authority. The new waiver includes three types of community bridge organizations called Life360 HOMEs targeted to improving maternal and child health; supporting population health in rural areas by addressing social determinants of health; expanding provider capacity to give individuals with serious mental illness or substance use disorders more timely access to treatment; and creating opportunities for success for young adults who are veterans or former foster youths, were under the supervision of the Division of Youth Services, or were formerly incarcerated as adults.

Additional changes include:

-the use of incentives offered by qualified health plans to their members to increase use of preventative health screenings and services;

-the use of incentives offered by qualified health plans to their members to increase the use of employment, education, and training opportunities among enrollees;

-increased qualified health plan accountability for meeting annual Medicaid Core Set of Adult Health Care Quality Measures enforced by potential financial sanctions;

-quarterly program monitoring by a joint executive-legislative oversight panel;

-application of cost sharing up to the federally allowable amounts per service and the quarterly cost sharing cap of 5% of household income for enrollees; and

-enrollment in the PASSE program for individuals with serious mental illness or substance use disorder providing them with access to intensive care coordination and specialized services.

Other requested waiver authorities include continuing to provide premium assistance to purchase coverage offered by qualified health plans that participate in the individual insurance Marketplace in Arkansas and waiver authorities involving freedom of choice; payment to providers; premiums and cost sharing; retroactive eligibility; and prior authorizations.

In State Fiscal Year 2021, the total cost of the Arkansas Works program is expected to be $2.251 billion. The state share will be 10% of the total cost. The financial estimate for SFY 2022 is highly sensitive to changes in enrollment due to national and state economic conditions and the end of the Public Health Emergency (PHE). DHS is in the process of finalizing its estimates for the ARHOME program for SFY 2022 which is likely to be at or above the SFY 2021 level. The state share will be 10% of the total cost.

In conjunction with the submission of the 1115 waiver, DHS has created a mandated transition, phase-out, and termination plan according to federal rules and the Arkansas Works Demonstration's Special Terms and Conditions. Transition and phase-out will begin with the public comment period outlined in this notice. Termination and closure will only be implemented if CMS fails to approve the ARHOME Demonstration. The transition plan ensures there is no lapse in eligibility or coverage.

Effective for dates of service are on or after January 1, 2022.

The Arkansas Health and Opportunity for Me (ARHOME) Application for Proposed Section 1115 Demonstration Project and the Arkansas Works phase-out plan are available for review at the Department of Human Services (DHS) Office of Rules Promulgation, 2nd floor Donaghey Plaza South Building, 7th and Main Streets, P. O. Box 1437, Slot S295, Little Rock, Arkansas 72203 1437. You may also access and download the Application and this notice on the DHS website at https://humanservices.arkansas.gov/do-business-with-dhs/proposed-rules/.

Public comments may be submitted in writing at the above mailing address or at the following email address: ORP@dhs.arkansas.gov. All public comments must be received by DHS no later than July 12, 2021. Please note that public comments submitted in response to this notice are considered public documents. A public comment, including the commenter's name and any personal information contained within the public comment, will be made publicly available.

Two public hearings will be held for public comment:

1) The AR Behavioral Health Planning and Advisory Council will meet, by remote access only through a Zoom webinar open to the public, on June 21, 2021, from 12:00 to 1:00 p.m. A public hearing will be a part of the agenda. Public comments may be submitted at the hearing. Individuals can access this public hearing at https://us02web.zoom.us/j/89852067259. The webinar ID is 898 5206 7259. If you would like the electronic link, "one-tap" mobile information, listening only dial-in phone numbers, or international phone numbers, please contact ORP at ORP@dhs.arkansas.gov.

2) A second public hearing by remote access through a Zoom webinar will be held on June 22, 2021, at 4:00 p.m. Public comments may be submitted at the hearing. Individuals can access this public hearing at https://us02web.zoom.us/j/89251100312. The webinar ID is 892 5110 0312. If you would like the electronic link, "one-tap" mobile information, listening only dial-in phone numbers, or international phone numbers, please contact ORP at ORP@dhs.arkansas.gov.

If you need this material in a different format, such as large print, contact the Office of Rules Promulgation at 501-320-6266.

The Arkansas Department of Human Services is in compliance with Titles VI and VII of the Civil Rights Act and is operated and managed and delivers services without regard to religion, disability, political affiliation, veteran status, age, race, color or national origin. 4501960528

Elizabeth Pitman, Director
Division of Medical Services
7542911f

NOTICE OF PUBLIC HEARING
NORTH LITTLE ROCK BOARD OF ZONING ADJUSTMENT

On June 24, 2021, at 1:30 P.M. in the City Council Chambers, City Hall, 300 Main Street, NLR, AR 72114, pursuant to its own motion, the North Little Rock Board of Zoning Adjustment will hold a Public Hearing for a variance request under the authority North Little Rock Ordinance No 9263. Board of Zoning Adjustment Case #2021-18 request requires that the applicant serve notice to all property owners abutting 1718 Chandler Street, North Little Rock, AR 72114, legally described as Lots 12 - 14, Block 1, Holt's Industrial Addition to the City of North Little Rock, Pulaski County, AR. The specifics of the request are a variance request from the area provisions of Section 5.11.3 to allow the placement of a fence on a currently vacant lot. Board of Zoning Adjustment Case #2021-19 request requires that the applicant serve notice to all property owners abutting 101 - 111 Parkdale Street, North Little Rock, AR 72117, legally described as Lots 24 - 25, Block 0, Parkdale Addition to the City of North Little Rock, Pulaski County, AR. The specifics of the request are a variance request from the area provisions of Section 5.11.3 to allow the placement of a fence on a currently vacant lot. Board of Zoning Adjustment Case #2021-21 request requires that the applicant serve notice to all property owners abutting 6801 John F Kennedy Boulevard, North Little Rock, AR 72116, and legally described as Lot B-R1, Block 17, Indian Hills Subdivision to the City of North Little Rock, Pulaski County, AR. The specifics of the request are a variance request from Section 4.1.3 to allow a reduction in the 25-foot building setback requirement along Wigwam Road to allow for the construction of a new activities building. All pertinent data and information are available for inspection at the Planning Department offices, 120 Main Street, 2nd Floor, North Little Rock, AR, 72114. All interested parties are invited to review the application in said office and discuss the details with city staff. Information may also be obtained by emailing plans@nlr.ar.gov or calling 501.975.8835. All individuals interested therein may attend the Public Hearing and be heard at said time and place. Donna James, City Planner.

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NOTICE OF PUBLIC HEARING

Notice is hereby given that the City of Arkadelphia will hold a Public Hearing in the Board Room at Town Hall, 700 Clay Street, Arkadelphia, Arkansas the 15th day of June 2021 at 5:30 p.m. The purpose of the hearing is to consider a request of a petition filed by Ouachita Baptist University to vacate a street for the following described properties:

308 N 9th Street - A part of Lot 3 in Hardy & Barkman's Addition to the City of Arkadelphia, Clark County, Arkansas, according to the Plat thereof, recorded in Book G at Pages 422-423 of the Deed Records of Clark County, Arkansas, particularly described as commencing at the SE Corner of said Lot 3 and running THENCE West 100 feet; THENCE North 75 feet to the Point of Beginning, THENCE run North 60 feet; THENCE West 100 feet; THENCE South 60 feet; THENCE East 100 feet back to the Point of Beginning.

312 N. 9th Street - Commence at the SE Corner of Lot 3 of Hardy and Barkman's Survey Addition to the City of Arkadelphia, Clark County, Arkansas and run THENCE West 100 feet, THENCE North 135 feet to the Point of Beginning, THENCE run West 100 feet; THENCE North 50 feet; THENCE East 100 feet; THENCE South 50 feet to the Point of Beginning, being a plot of ground 50 feet North and South by 100 feet East and West.

316 N. 9th - Commencing at the SE corner of Lot 3 of Hardy and Barkman's Survey of the City of Arkadelphia, Clark County, Arkansas, and run THENCE West 100 feet; run THENCE North 185 feet to the Point of Beginning of this description; run THENCE West 100 feet; run THENCE North 50 feet; run THENCE East 100 feet; run THENCE South 50 feet to the Point of Beginning, being located partly in Lot 3 and partly in Lot 10, according to the recorded plat of said addition.

320 N. 9th Street - A part of Lot 10 in Hardy and Barkman's Addition to the City of Arkadelphia, Clark County, Arkansas, according to the plat thereof of record In Book G at Pages 422-423 of the Deed Records of Clark County, Arkansas, and particularly described as commencing at the SE corner of Lot 3 of said Hardy and Barkman's Addition and run THENCE West 100 feet; THENCE North 235 feet to the Point of Beginning; THENCE West 100 feet; THENCE North 50 feet; THENCE East 100 feet; THENCE South 50 feet to the Point of Beginning.

326 N. 9th Street - A part of Lot 10, Hardy and Barkman's Addition to the City of Arkadelphia, Clark County, Arkansas, described as commencing at the NW corner thereof and running THENCE East 11 feet; THENCE South 31 feet; THENCE East 90 feet to the SE corner of the George T. Blackmon lot, which Is the Point of Beginning; from THENCE run South 64 feet to the South line of the North Half (N1/2) of said Lot 10; THENCE West along the South line of the N1/2 of Lot 10, a distance of 85 feet, more or less, to 9th Street; THENCE North 64 feet; THENCE East 85 feet to the Point of Beginning.

330 N. 9th Street - AND ALSO a part of Lot 10 and Lot 15 of the said Hardy and Barkman's Addition to the City of Arkadelphia, Clark County, Arkansas, more particularly described as follows: Commencing at the Northwest corner of Lot 10 and run THENCE East 11 feet to the Point of Beginning; THENCE South 31 feet; THENCE East 90 feet; THENCE North 54 feet; THENCE West 90 feet; THENCE South 23 feet back to the Point of Beginning

Parcel 74-01198-000 - A part of Lot 15 of Hardy and Barkman's Addition to the City of Arkadelphia" Clark County, Arkansas, an a part of McMillan Street, which at this point is closed, more particularly described as follows: Commencing at the Northwest corner of Lot 10 of said Hardy and Barkman's Addition and run THENCE East 11 feet; THENCE North 23 feet to the Point of Beginning; THENCE North 64 feet; THENCE East 90 feet; THENCE South 64 feet; THENCE West 90 feet back to the Point of Beginning.

902 Hickory - A part of Lot 4 of Hardy and Barkman's Addition to the City of Arkadelphia, Clark County, Arkansas, particularly described as commencing at the SE corner of said Lot 4 and run THENCE North 100 feet; THENCE West 90 feet; THENCE South 100 foot; THENCE East 90 feet to the Point of Beginning.

9th Street - A part of Lot 4 of Hardy and Barkman's Addition to the City of Arkadelphia, Clark County, Arkansas, according to the plat of record In Book G at Pages 422-423 of the Deed Records of Clark County, Arkansas, described as commencing at the NE corner of said Lot 4 and run THENCE West 90 foot; THENCE South 80 foot; THENCE East 80 feet; THENCE North 90 feet to the Point of Beginning.

Description of replatted parcels: A parcel of land being a part of Lot 4 and Lot 9 and a part of a closed street lying between Lot 9 and Lot 16 of Hardy and Barkman's Addition to the City of Arkadelphia, Arkansas and being described as follows: Begin at the Southwest corner of said Lot 4, the point of beginning, THENCE North 00°14'13" West along the West lines of Lot 4 and Lot 9, A distance of 288.35 feet; THENCE North 84°29'35" East more of less along a rock wall and extension thereof, a distance of 130.54 feet; THENCE North 00°14'21" West, a distance of 78.19 feet to the North line of said Lot 9 this point also being the South line of said closed street; THENCE North 00°14'21" West, a distance of 74.82 feet to the South line of Lot 16, this point also being the North line of said closed street; THENCE North 89°37'57" East along the North line of said closed street, a distance of 120 feet; THENCE South 00°14'13" East, a distance of 76.45 feet to the South line of said closed street; THENCE North 89°35'21" West, a distance of 30.00 feet to the Northeast corner of said Lot 9; THENCE South 00°14'13" East, a distance of 190.00 feet to the Southeast corner of said Lot 9: THENCE North 89°35'21" West along the South line of said Lot 9, a distance of 96.00 feet; THENCE South 00°14'13" East, a distance of 190.00 feet to the South line of Lot 4; THENCE North 89°35'21" West, a distance of 124.00 feet to the point of beginning. Containing 63,393 square feet, more or less.

9th Street easement description: An easement being located in a closed street lying between Lot 9 and Lot 16 of Hardy and Barkman's Addition to the City of Arkadelphia, Arkansas, and being described as follows: begin at the Northeast corner of said Lot 9, THENCE South 00°14'13" East, a distance of 10.43 feet to a point on a curve concave to the Southeast having a radius of 25.00 feet and a central angle of 23°31'27" and being subtended by a chord which bears North 42°41'08" East 44.05 feet this point being on the Western side of the curb of Ninth Street; THENCE Northerly, Northeasterly, and Easterly along said curve, said curve being the Western and Northern back of curb on Ninth Street, a distance of 53.90 feet; THENCE leaving said back of curb South 00°14'13" East, a distance of 22.16 feet; THENCE North 89°35'21" West, a distance of 30.00 feet to the point of beginning.

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NOTICE OF PUBLIC HEARING WITH RESPECT TO NOT TO EXCEED $20,000,000 OF CHARTER SCHOOL REVENUE BONDS

NOTICE IS HEREBY GIVEN that on June 21, 2021, an in-person public hearing as required by Section 147(f) of the Internal Revenue Code of 1986 (the "Code"), will be held on behalf of the City of Springdale, Arkansas and Little Scholars of Arkansas Foundation with respect to the proposed issuance by the Arizona Industrial Development Authority, a nonprofit corporation designated as a political subdivision of the State of Arizona ("AZIDA"), of its Charter School Revenue Bonds, to be issued pursuant to a plan of financing within the meaning of Section 147(f)(2)(C) of the Code in one or more series or issues from time to time (the "Bonds"), in an amount not to exceed $20,000,000 with respect to the Project (as defined below). The hearing will commence at 10 a.m. CST or as soon thereafter as the matter can be heard, and will be held in the City Council Chambers on the First Floor of the Springdale City Hall located at 201 Spring Street, Springdale, Arkansas.

The Bonds are expected to be part of a larger issuance of bonds for the benefit of multiple charter schools in multiple states, all issued pursuant to Title 35, Chapter 5, Article 2 of the Arizona Revised Statutes, as amended, by AZIDA, incorporated with the approval of the Arizona Finance Authority pursuant to the provisions of the Constitution and laws of the State of Arizona, including the Industrial Development Financing Act, Title 35, Chapter 5, Articles 1 through 5, Arizona Revised Statutes, as amended (Sections 35-701 through 35-761, inclusive). The proceeds from the sale of the larger issuance of bonds will be loaned to Equitable Facilities Fund, Inc., a Delaware nonstock corporation described in Section 501(c)(3) of the Code ("EFF"), or Equitable School Revolving Fund, LLC, a Delaware limited liability company affiliate of EFF that is disregarded for federal tax purposes (together with EFF, the "Lender"). A portion of the proceeds from the sale of the Bonds will finance a loan by the Lender to Little Scholars of Arkansas, LLC (the "Corporation"). The Corporation is a duly organized and validly existing Arkansas limited liability company. The loan to the Corporation to be made by the Lender will (i) finance the acquisition, construction, expansion, remodeling, renovation, improvement, furnishing and/or equipping of the facility located at 203, 205 and 301 Holcomb Street, Springdale, Arkansas, ($8,000,000); (ii) finance the acquisition, construction, expansion, remodeling, renovation, improvement, furnishing and/or equipping of the facility located at 6711 W. Markham Street, Little Rock, Arkansas ($12,000,000) (together, the "Project"), that will be leased to and operated by Little Scholars of Arkansas Foundation ("LISA Academy"), a duly organized and validly existing Arkansas nonprofit corporation described in Section 501(c)(3) of the Code, and (iii) pay costs associated with the closing of the loan. The Project will initially be owned by the Corporation and leased to and operated by LISA Academy.

The Bonds will be special limited obligations of AZIDA payable solely from the loan repayments to be made by the Lender to AZIDA, and certain funds and accounts established by the bond indenture for the Bonds. The principal of and interest on the Bonds will not constitute obligations of the Corporation, the City of Springdale, Arkansas, the State of Arkansas or any political subdivision thereof, Arizona Industrial Development Authority, the Arizona Finance Authority, the State of Arizona or any political subdivision thereof. The Bonds will not constitute a debt or a loan of credit or a pledge of the full faith and credit or taxing power of the City of Springdale, Arkansas, the State of Arkansas or any political subdivision thereof, Arizona Industrial Development Authority, the Arizona Finance Authority, the State of Arizona or any political subdivision thereof, within the meaning of any state constitutional provision or statutory limitation and shall never constitute or give rise to a pecuniary liability of the City of Springdale, Arkansas, the State of Arkansas, Arizona Industrial Development Authority, the Arizona Finance Authority, the State of Arizona or any political subdivision thereof.

The public hearing will be conducted in a manner that provides a reasonable opportunity for persons with differing views on both the issuance of the Bonds and the refinancing of the Project to be heard and to present their oral and written comments. Written comments should be delivered at the public hearing or mailed to the attention of the City Attorney, 201 Spring Street, Springdale, AR 72764, for receipt not later than the date and time of the hearing. Anyone requiring an accommodation consistent with the Americans with Disabilities Act should contact Arizona Industrial Development Authority representatives at (480) 429-5000 at least two (2) business days in advance of the hearing. This notice is published and the hearing is held in satisfaction of the requirements of Section 147(f) of the Code.

75429271f

PUBLIC NOTICE

THERE WILL BE A PUBLIC HEARING HELD AT MAUMELLE CITY HALL ON THURSDAY, JUNE 24, 2021 AT 6:30 P.M., 550 EDGEWOOD DRIVE, MAUMELLE, ARKANSAS TO REQUEST A VARIANCE OF THE SIDE YARD SETBACK FROM 10 FOOT TO 15 FOOT (94-414(a)(1)a) AND A VARIANCE OF THE REQUIRED 100 FOOT MINIMUM LOT FRONTAGE (94-414(b)(1) FOR THE 0.89 ACRES OF PROPERTY LOCATED AT 1800 MURPHY DRIVE.

THE PUBLIC WILL BE INVITED TO ATTEND.

75428495z

The Port of Little Rock monthly Board of Directors' meeting will be held at noon, on Wednesday, June 16, 2021, at the Arkansas River Resource Center, located at 10600 Industrial Harbor Drive, Little Rock, Arkansas 72206.

75427166z

Alcohol Permits 1240

NOTICE OF FILING APPLICATION FOR PERMIT TO SELL ALCOHOLIC BEVERAGES FOR CONSUMPTION ON THE PREMISES

Notice is hereby given that the undersigned has filed an application with the Alcoholic Beverage Control Division of the State of Arkansas for a permit to sell alcoholic beverages for consumption on the premises described as: 303 Phillip Rd., North Little Rock, Pulaski County.

Said application was filed on June 9, 2021. The undersigned states that he/she is a resident of Arkansas, of good moral character; that he/she has never been convicted of a felony or other crime involving moral turpitude; that no license to sell alcoholic beverages by the undersigned has been revoked within five (5) years last past; and, that the undersigned has never been convicted of violating the laws of this State, or any other State, relative to the sale of controlled beverages.

/s/Earl Brown
The Nuthouse Comedy Lounge
Sworn to before me this 9th day of June, 2021
/s/Yvette Hines
Notary Public
My Commission Expires: 2-20-29

75428286z

Environmental Permits 1250

ARKANSAS DEPARTMENT OF ENERGY AND ENVIRONMENT DIVISION OF ENVIRONMENTAL QUALITY NOTICE OF ENFORCEMENT ACTIONS

Public notice is hereby given that the Division of Environmental Quality (DEQ) has entered into the Consent Administrative Orders and has issued the Notices of Violation listed below. Documents for these enforcement matters can be made available for inspection or copying by contacting the Division of Environmental Quality, 5301 Northshore Drive, North Little Rock, Arkansas 72118-5317. There may be a charge to cover photocopying costs for some documents. Copies of enforcement documents, including those referenced in this notice, also are available for viewing on the DEQ website at http://www.adeq.state.ar.us/legal/cao_info.asp. Further, DEQ is accepting written comments from the public regarding these matters. Such comments must be sent to Division of Environmental Quality, at the above address, within 30 days after publication of this Notice. If a comment on any proposed Consent Administrative Order is received by DEQ within this time period, in accordance with Act 163 of 1993, the person submitting the comment may request the Arkansas Pollution Control and Ecology Commission to set aside the order in the matter by filing a petition with the Commission Secretary. If a comment on any Notice of Violation is received by DEQ within this time period, the person submitting the comment will be given notice of any hearings held on the matter and shall have the right to intervene in any hearing in the matter by filing a petition for intervention with the Commission Secretary. Any such petition must be filed in accordance with applicable regulations and sent to the Commission Secretary, 3800 Richards Rd., North Little Rock, AR 72117.

CONSENT ADMINISTRATIVE ORDERS

Upper Southwest Arkansas Regional Solid Waste Management District, Howard County, Office of Air Quality, $1,200.00 Penalty, LIS No. 21-049

Georgia-Pacific Consumer Operations, LLC, Ashley County, Office of Air Quality, $1,200.00 Penalty, LIS No. 21-050

West Fraser, Inc., Pope County, Office of Air Quality, $720.00 Penalty, LIS No. 21-051

Hooks Construction, LLC, Pulaski County, Office of Air Quality, $400.00 Penalty, LIS No. 21-052

Stephens Paper Company, L.L.C., Ouachita County, Office of Water Quality, $5,820.00 Penalty, LIS No. 21-053

Jim Yeager d/b/a Yeager Apartments, Union County, Office of Water Quality, $650.00 Penalty, LIS No. 21-054

Interfor U.S. Inc., Drew County, Office of Water Quality, $500.00 Penalty, LIS No. 21-055

City of Paris, Logan County, Office of Water Quality, $9,800.00 Penalty, LIS No. 21-056

AMENDMENT NO. 001 TO CONSENT ADMINISTRATIVE ORDERS

City of Mountain Pine, Garland County, Office of Water Quality, No Penalty, LIS No. 18-034-001

Robbie's Truck Repair, LTD, White County, Office of Land Resources, $1,000.00 Penalty, LIS No. 20-171-001

AMENDMENT NO. 002 TO CONSENT ADMINISTRATIVE ORDER

City of Huntington, Sebastian County, Office of Water Quality, No Penalty, LIS No. 16-099-002

Dated this 13th day of June 2021

Becky W. Keogh, Director
Division of Environmental Quality
75429411f

Notice of Application
For NPDES Permit AR0050547

Under the provisions of Act 163 of the 1993 Arkansas Legislature, this is to give notice the Department of Energy and Environment - Division of Environmental Quality - Office of Water Quality has received a renewal application on May 30, 2021 for an NPDES Permit No. AR0050547 from the following facility:

Two Rivers Harbor Property Owners Association, Inc.
PO Box 242112
Little Rock, AR 72223

The application has been deemed administratively complete and is undergoing technical review by the Office of Water Quality for compliance with State and Federal regulations. The facility under consideration is located as follows: Isbell Lane, Little Rock, in Pulaski County, Arkansas.

Interested persons desiring to request a public hearing on the application may do so in writing. The Division shall have the discretion to decide whether to hold a public hearing, unless otherwise required by law or regulation. If a hearing is scheduled, adequate public notice will be given in this newspaper. All requests shall be submitted in writing and must include the reasons for the necessity of a public hearing. All requests should be received by DEQ within 10 business days of the date of this notice and should be submitted to:

Anmol Jain
Department of Energy and Environment - Division of Environmental Quality
Office of Water Quality, NPDES Permits Branch
5301 Northshore Drive
North Little Rock, AR 72118-5317
Telephone: (501) 682-0622
75429018f

Notice of Application
For NPDES Permit AR0043931

Under the provisions of Act 163 of the 1993 Arkansas Legislature, this is to give notice the Department of Energy and Environment - Division of Environmental Quality - Office of Water Quality has received a renewal application on May 13, 2021, with additional information received June 2, 2021, for an NPDES Permit No. AR0043931 from the following facility:

Granite Hill MHP LLC- Granite Hill
P.O. Box 101
Garwood, NJ 07027

The application has been deemed administratively complete and is undergoing technical review by the Office of Water Quality for compliance with State and Federal regulations. The facility under consideration is located as follows: 1700 West Dixon Road, Little Rock, in Pulaski County, Arkansas.

Interested persons desiring to request a public hearing on the application may do so in writing. The Division shall have the discretion to decide whether to hold a public hearing, unless otherwise required by law or regulation. If a hearing is scheduled, adequate public notice will be given in this newspaper. All requests shall be submitted in writing and must include the reasons for the necessity of a public hearing. All requests should be received by DEQ within 10 business days of the date of this notice and should be submitted to:

Anmol Jain
Department of Energy and Environment - Division of Environmental Quality
Office of Water Quality, NPDES Permits Branch
5301 Northshore Drive
North Little Rock, AR 72118-5317
Telephone: (501) 682-0622
75429014z

Notice of Application for Renewal, No-Discharge Permit 4632-WR-5

Under the provisions of Act 163 of the 1993 Arkansas Legislature, this is to give notice that the Arkansas Department of Energy and Environment - Division of Environmental Quality (DEQ), Office of Water Quality has received an application for renewal on 5/28/2021, for a no-discharge permit, Permit No. 4632-WR-5, for the storage of water treatment plant residuals and biosolids. The permit application was submitted from the following applicant:

North Little Rock Wastewater Utility
PO Box 17898

SCAN to view items to buy/sell

CLASSIFIEDS E

Arkansas Democrat Gazette

ARKANSAS ONLINE www.arkansasonline.com

MONDAY, JUNE 14, 2021

ANNOUNCEMENTS

Cemetery Lots 105

FOR SALE by Owner

PINECREST MEMORIAL Park, Lakeview Garden, spaces 3,4,5 & 6. $1,500 ea. 501-350-8191

Personal Opinions 118

COTTON CAN'T separate the weevil from the boll.

AUTOS

Antique Vehicles 210

MUST See!

FORD 1930 Coup with flathead V-8. $13,500. Call 903-824-4769 for more details

Great DEAL

FORD 1949 Truck, V-8 $3,500. Call 903-824-4769 for details.

Automobile Accessories 215

WOW!

CASH FOR Autos Running Or Not Up To $1,500. 501-240-1146 If no answer leave message.

Automobiles 225

Great DEAL

CHEVROLET 2002 Cavalier, $1,300 obo. Call 501-349-0110 Little Rock

TOYOTA 2012 Camry. $4500. 102000 mi. 5017477244.

Trucks 4x2 240

✓CHECK IT OUT!

FORD 2010 F-150 large Crew Cab with cover bed, 90K miles. Call 501-626-8808 for details

Trailers 258

Great DEAL

DIAMOND 2002 Trailer, Road Clipper, flat bed, 24" utility, $7,500. 501-278-7191

RECREATION

Power Boats 303

WACO 14' Flatbottom Boat, 9.9 Evinrude motor & trailer, $1,500. Call 501-847-0953

PETS & LIVESTOCK

Cats 705

BOBTAIL KITTENS. Party coat calico female $500. 501-679-1799

Dogs 710

AKC LABRADOR Retriever Puppies. Black and chocolate puppies. AKC registered with full rights. Ready immediately. Fully vaccinated and de-wormed. Parents on site. Mother is white, approx 45lbs, father is chocolate, approx 65lbs. Proof of lineage. Males are limited. $500. 501-400-6700

AKC STANDARD Male Poodles. $1,000. Text 479-216-0834

AUSTRALIAN SHEPHERDS Minis Reg. $500. All colors. 501-844-5356, Malvern.

BEAGLE PUPPIES, AKC, have 6 For Sale. 7 week old, has 1st shots, (2) Males, (4) Females. Call 870-490-2014

BELGIUM MALINOIS Mix Personal Protection Dogs, 6 mo. old. $200. Call 501-988-1003

BLUE HEELER . Blue Heeler pups.
READY JUNE 16 $250. 8705507829

BORDER COLLIES, 12 weeks old, shots & wormed, $200. Text only please 501-249-0328

BOSTON TERRIER Male Puppy, AKC, shots & ready to go. Will be small, $600. 501-208-4288

BOSTORN TERRIER Puppies. CKC Reg. Ready to go June 17th. 2 Females & 2 Males. $500 ea. 870-942-0778 or 870-484-1399

CHESAPEAKE BAY Retriever Pups. 7 wks., Parents on premises. $300. 501-259-4973

CHIHUAHUA: Will pay $1,100. Has to be female. Must be weaned off of mother after 8 weeks. Must have protection against heart worm. Must have papers. Must be dewormed. Call 501-276-5523

ENGLISH CREAM Golden Retriever Puppies. AKC 1st shots & dewormed. $800. 479-244-9630 Eureka

F1B GOLDENDOODLE. Beautiful F1B Goldendoodle puppies available for sale. 6 weeks old. $1200. 870-371-0380

LABRADOR. FOR Sale AKC registered Black Lab puppies 7 weeks old 3 females and 2 males. Call for more information. $100000. 870-946-6184

MALTIPOO PUPPIES. Adorable CKC registered babies! Pics/Info on KellyPup.com $800. -$1600

MINI GOLDENDOODLE Puppies, 5 Males, 2 Females. Ready for adoption June 7th. Text 501-802-5242 for Info.

MOUNTAIN FEIST Puppies, 2 mo. old, 1st shots & wormed. Make excellent squirrel dogs or great pets. $200. Call 870-319-0611 Biscoe

RED HEELER Puppies, 7 wks., old, parents on premises, $100. Call 501-991-2001

TOY/MINI POODLE Babies. Super cute reds, CKC. Pics/Info on KellyPup.com $850. -1550

YORKIE-Boston Mix-Blue Heeler Mix & Maltipoo pup babies spoiled $295 501-961-1910 NLR

Livestock & Poultry 720

CHAROLAIS 19 Registered Replacement Heifers. Home Raised, Gentle. Born fall of 2020. Polled Bangs, Black Legs, BS Gold 1 Shot, Long Range Dewormer. $1,000 per head. Buyer take all. 985-513-0809

CHAROLAIS COWS 15, pasture exposed to $3,500 Bulls of Nov. 2020. $1,300 ea. 501-580-8742

BUY IT/SELL IT

Antiques & Collectibles 808

Great DEAL

TYPEWRITER, 1950's. $40. Vintage Records, 45's, $1. Vintage Table, $20. 501-681-0875

Articles Sale 810

1/16" THICK etched clear glass panes. Text for pics, etc. $15. 870-897-4016

10,000 BOOKS . Selling 10,000 books by the bag $5. 5012393627

MAYTAG GAS dryer. $150. 501-414-1336

OLD ENAMEL butcher shop hanging light fixture. Text for pics, etc. $125. 870-897-4016

Farm Equipment 837

CUB FARMALL Tractor, runs good, front & back cultivator, $1,800. Call 501-472-0730 Greenbrier Ark.

Furniture 840

DEN FURNITURE . Price reduced $600. 5015518012

Guns & Ammunition 843

NEW ENGLAND Pardner 12ga.. 3in. Mod. Single-shot, ex. cond. $175. 501-944-6491

RUGER .22 LR/Mag. Ruger New Model Single-Six .22 LR/Mag, ex. cond. $600. 501-944-6491

SIG M400 10.5" M-Lok Handguard with Barrel Nut and Hardware. $80. 479-981-6439

Home Appliances 846

WASHER & DRYER sets, $300 & up. Upright & Chest Freezers, $250 & Up. 501-618-1948

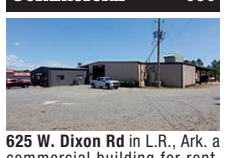
RENTALS

Apartments, Furnished 903

CABOT AREA, 30' Camper with 30' add on with full size bath room, walk in shower, furnished, utility paid, $600 month + $300 dep. Call 501-606-2615

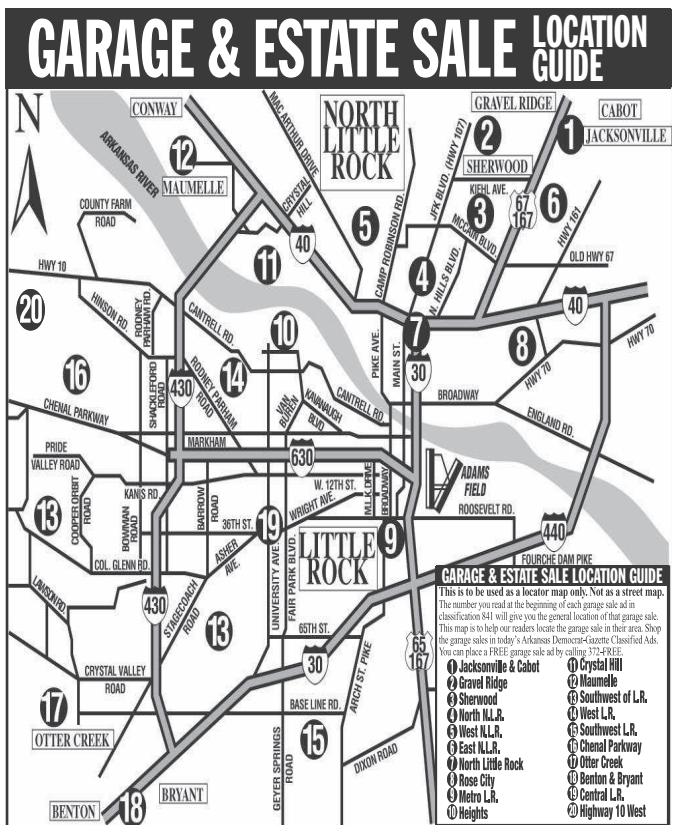
LR, CENTRAL High School Area. 1 & 2BR Apts. All Util Pd. No pets. Must show proof of income. Dep. Req. Rent by wkly. Security dep. req. 501-541-7202

Industrial, Commercial 950

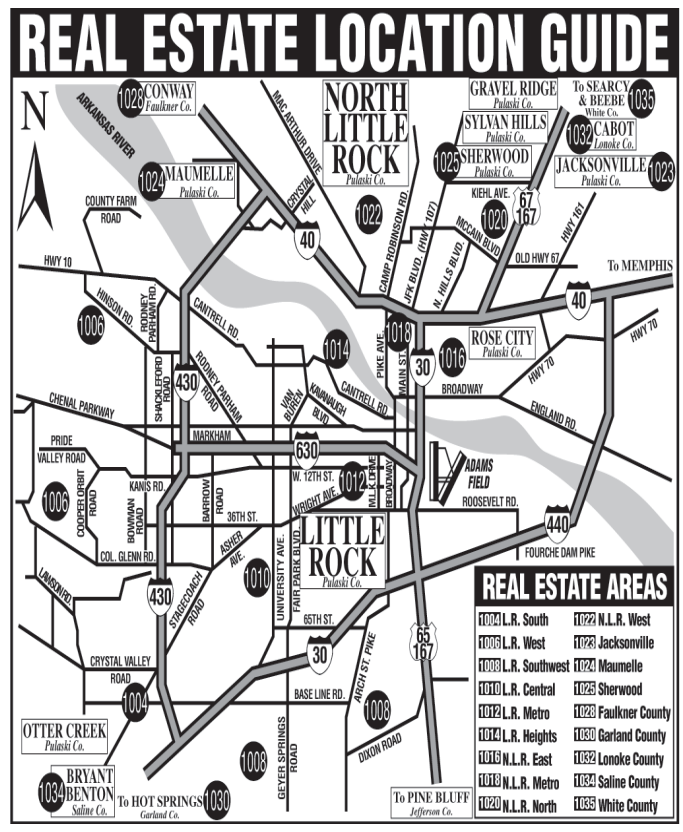


625 W. Dixon Rd in L.R., Ark. a commercial building for rent. Fenched, 1/2 mi. off I-530. 6 offices, 3 bathrms, breakrm, small kitc. area. 22k total sf. Main warehouse is heated & cooled. Extra storage bldg in back. Room for 18 wheelers to turn around. Looking for long term contract. $8,500/mo. rent plus utilities. More info 501-490-1028.

GARAGE & ESTATE SALE LOCATION GUIDE



REAL ESTATE LOCATION GUIDE



Rooms / Board 980

LR, UTILS pd. $125 wk. + 125 dep. 1817 S. Schiller St. & 2008 W. 22nd St. 501-960-7009

ROOM FOR RENT. Washer, Dryer & Internet incl. All Utilities Pd. $175 a wk. 501-475-6484

REAL ESTATE

Jacksonville 1023

MUST See!

JACKSONVILLE HOUSE For Sale By Owner, 3 BR., 1 1/2 BA, fenced back yard, storage shed, bonus room, large laundry room, $79,900. 501-626-7342

Resort / Waterfront Property 1040

GREERS FERRY Bondair Lake Property For Sale includes priv. 3,000 ft. runway house & hanger for Airplane use. $439,900. Rick, 501-258-0538

Lots & Acreage 1042

LOCUST GROVE. Deer Valley Annex 20+/- acres at Locust Grove. All wooded. Nice views. Southside water. Divided into Four Five-acre tracts. Lots of road frontage. Member of owner LLC is a licensed real estate agent. Contact Johnny Mitchum, Keller Williams Realty, 12814 Cantrell RD. Little Rock, 72223 $79900. 501-940-3231.

✓CHECK IT OUT!

FOR SALE BY Owner, AS IS, 9.61 acres, 13201 Kanis Road. 41,8611.6 sf. Appr. $840,000. Asking price $720,000. M.B. Lee 501-960-9735

Mfg. Homes for Sale by Size 1105

J&M HOMES announces its Red Tag Sale. Stock units, doubles & singles reduced by thousands. Call for details 870-535-1524.

Mfg. Homes for Sale by Size 1105

NEW, USED and Repo Manufactured Homes starting at $1,000. Call 870-535-1524.

LEGAL NOTICES

Probate Notices 1220

In the Circuit Court of Pulaski County, Arkansas
Probate Division
In the Matter of the Estate of Charles A Schlesier, Deceased.
No. 60PR-21-920

Name of decedent: Charles A. Schlesier

Last known address: 12601 Ironton Cut-Off, Little Rock, AR 72206

Date of death: 01-15-2013

On 3-14-21, an affidavit for collection of small estate by distributee was filed with respect to the estate of Charles A. Schlesier, deceased, with the clerk of the probate division of the circuit court of Pulaski County, Arkansas, under Ark. Code Ann. § 28-41-101.

The legal description of the real property listed in the affidavit is as follows: North Half (N 1/2) of the Southeast quarter (SE 1/2) of the Northeast quarter (NE 1/2) of the section 16 of Township 1 South, Ranch 12 West, Pulaski Cty, Arkansas.

All persons having claims against the estate must exhibit them, properly verified, to the distributee or his or her attorney within three (3) months from the date of the first publication of this notice or they shall be forever barred and precluded from any benefit of the estate.

The name, mailing address, and telephone number of the distributee or distributee's attorney is:

Timothy Charles Shlesier
12601 Ironton Cut-Off, Little Rock, AR 72206
501-708-5447

This notice first published May 30, 2021.

75422315z

Professional 540

Professional 540

NOTICE OF APPLICATION for PROPOSED ARHOME SECTION 1115 DEMONSTRATION PROJECT

Pursuant to 42 C.F.R. § 431.408, the Director of the Division of Medical Services (DMS) of the Department of Human Services (DHS) issues the following Notice of Application for a proposed Section 1115 Demonstration Project waiver for the ARHOME program.

During the most recent session of the Arkansas General Assembly, Governor Asa Hutchinson and legislators collaborated to make further improvements to the Medicaid program for non-elderly and adults without disabilities with income below 138% of the federal poverty, currently called Arkansas Works. Under the authority of Act 530, Arkansas proposes to continue to cover the new adult eligibility group for another five years through the Arkansas Health and Opportunity for Me Act of 2021 ("ARHOME") program and extend and amend the Demonstration through December 31, 2026. DMS now seeks comments on the proposed waiver authorities before submission to the Centers for Medicare & Medicaid Services (CMS) for consideration and approval.

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.

The new features of ARHOME 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;

-reduce the additional risk for disease and premature death associated with living in a rural county;

-strengthen financial stability of critical access hospitals and other small, rural hospitals, and enhance access to medical services in rural counties;

-fill gaps in continuum of care for individuals with serious mental illness and substance use disorders;

-increase the identification of Medicaid beneficiaries most at risk for poor health outcomes associated with poverty and increase their engagement in educational and employment opportunities;

-increase active participation of beneficiaries in improving their health;

-provide intensive care coordination for beneficiaries most at risk of long-term poor health to reduce inappropriate and preventable utilization of emergency departments and inpatient hospital settings;

-increase the use of preventative care and health screenings; and

-reduce the rate of growth in state and federal obligations for providing healthcare coverage to low-income adults.

DMS has made several changes from the previous waiver authority. The new waiver includes three types of community bridge organizations called Life360 HOMEs targeted to improving maternal and child health; supporting population health in rural areas by addressing social determinants of health; expanding provider capacity to give individuals with serious mental illness or substance use disorders more timely access to treatment; and creating opportunities for success for young adults who are veterans or former foster youths, were under the supervision of the Division of Youth Services, or were formerly incarcerated as adults.

Additional changes include:

-the use of incentives offered by qualified health plans to their members to increase use of preventative health screenings and services;

-the use of incentives offered by qualified health plans to their members to increase the use of employment, education, and training opportunities among enrollees;

-increased qualified health plan accountability for meeting annual Medicaid Core Set of Adult Health Care Quality Measures enforced by potential financial sanctions;

-quarterly program monitoring by a joint executive-legislative oversight panel;

-application of cost sharing up to the federally allowable amounts per service and the quarterly cost sharing cap of 5% of household income for enrollees; and

-enrollment in the PASSE program for individuals with serious mental illness or substance use disorder providing them with access to intensive care coordination and specialized services.

Other requested waiver authorities include continuing to provide premium assistance to purchase coverage offered by qualified health plans that participate in the individual insurance Marketplace in Arkansas and waiver authorities involving freedom of choice; payment to providers; premiums and cost sharing; retroactive eligibility; and prior authorizations.

In State Fiscal Year 2021, the total cost of the Arkansas Works program is expected to be $2.251 billion. The state share will be 10% of the total cost. The financial estimate for SFY 2022 is highly sensitive to changes in enrollment due to national and state economic conditions and the end of the Public Health Emergency (PHE). DHS is in the process of finalizing its estimates for the ARHOME program for SFY 2022 which is likely to be at or above the SFY 2021 level. The state share will be 10% of the total cost.

In conjunction with the submission of the 1115 waiver, DHS has created a mandated transition, phase-out, and termination plan according to federal rules and the Arkansas Works Demonstration's Special Terms and Conditions. Transition and phase-out will begin with the public comment period outlined in this notice. Termination and closure will only be implemented if CMS fails to approve the ARHOME Demonstration. The transition plan ensures there is no lapse in eligibility or coverage.

Effective for dates of service are on or after January 1, 2022.

The Arkansas Health and Opportunity for Me (ARHOME) Application for Proposed Section 1115 Demonstration Project and the Arkansas Works phase-out plan are available for review at the Department of Human Services (DHS) Office of Rules Promulgation, 2nd floor Donaghey Plaza South Building, 7th and Main Streets, P. O. Box 1437, Slot S295, Little Rock, Arkansas 72203 1437. You may also access and download the Application and this notice on the DHS website at https://humanservices.arkansas.gov/do-business-with-dhs/proposed-rules/.

Public comments may be submitted in writing at the above mailing address or at the following email address: ORP@dhs.arkansas.gov. All public comments must be received by DHS no later than July 12, 2021. Please note that public comments submitted in response to this notice are considered public documents. A public comment, including the commenter's name and any personal information contained within the public comment, will be made publicly available.

Two public hearings will be held for public comment:

1) The AR Behavioral Health Planning and Advisory Council will meet, by remote access only through a Zoom webinar open to the public, on June 21, 2021.

Managing Editor/ Sport Writer

The *McDonald County Press* weekly newspaper is looking for a managing editor/sports writer to cover the growing communities of Southwest Missouri.

The person in this position will have the following job duties:

- Manage a full-time reporter and correspondents, including assigning stories, planning weekly sections, editing copy and photos, proofing pages, planning future editions and special sections.
- Cover the sports beat in the area, which includes McDonald County High School athletics, local youth sports and recreational activities.
- Shoot photos for assigned stories, sports events and for use as stand-alone art.
- Work with other weekly papers in the area and the daily paper, *Northwest Arkansas Democrat-Gazette*, to provide engaging, timely content for print and digital editions.
- Organize and edit obituaries.
- Other duties as assigned.

Some assignments will be on nights and weekends. **This is a safety sensitive position.**

The successful applicant will have experience writing for a weekly or daily a newspaper, and have a working knowledge of accepted journalism standards and practices, including AP style. Experience with sports writing and the ability to operate a camera also is preferred.

The M*cDonald County Press* is one of seven weekly newspapers in the region owned and operated by the *Northwest Arkansas Democrat-Gazette*, a daily newspaper that covers the region. All are part of WEHCO Media. Drug-free workplace. EOE.

Send resumes and work samples to
Graham Thomas
gthomas@nwadg.com

McDONALD COUNTY PRESS | Northwest Arkansas Democrat Gazette

Meetings/ Hearings 1230

from 12:00 to 1:00 p.m. A public hearing will be a part of the agenda. Public comments may be submitted at the hearing. Individuals can access this public hearing at https://us02web.zoom.us/j/89852067259. The webinar ID is 898 5206 7259. If you would like the electronic link, "one-tap" mobile information, listening only dial-in phone numbers, or international phone numbers, please contact ORP at ORP@dhs.arkansas.gov.

2) A second public hearing by remote access through a Zoom webinar will be held on June 22, 2021, at 4:00 p.m. Public comments may be submitted at the hearing. Individuals can access this public hearing at https://us02web.zoom.us/j/89251100312. The webinar ID is 892 5110 0312. If you would like the electronic link, "one-tap" mobile information, listening only dial-in phone numbers, or international phone numbers, please contact ORP at ORP@dhs.arkansas.gov.

If you need this material in a different format, such as large print, contact the Office of Rules Promulgation at 501-320-6266.

The Arkansas Department of Human Services is in compliance with Titles VI and VII of the Civil Rights Act and is operated and managed and delivers services without regard to religion, disability, political affiliation, veteran status, age, race, color or national origin. 4501960528

Elizabeth Pitman, Director
Division of Medical Services
7542911f

Alcohol Permits 1240

NOTICE OF FILING APPLICATION FOR PERMIT TO SELL ALCOHOLIC BEVERAGES FOR CONSUMPTION ON THE PREMISES IN LARGE ATTENDANCE FACILITY

Notice is hereby given that the undersigned has filed an application with the Alcoholic Beverage Control Division of the State of Arkansas for a permit to sell alcoholic beverages for consumption on the premises, described as: 7318 Windsong Drive, Maumelle, Pulaski County.

Alcohol Permits 1240

Said application was filed on May 12, 2021. The undersigned states that he/she is a resident of Arkansas, of good moral character; that he/she has never been convicted of a felony or other crime involving moral turpitude; that no license to sell alcoholic beverages by the undersigned has been revoked within five (5) years last past; and, that the undersigned has never been convicted of violating the laws of this State, or any other State, relative to the sale of controlled beverages.

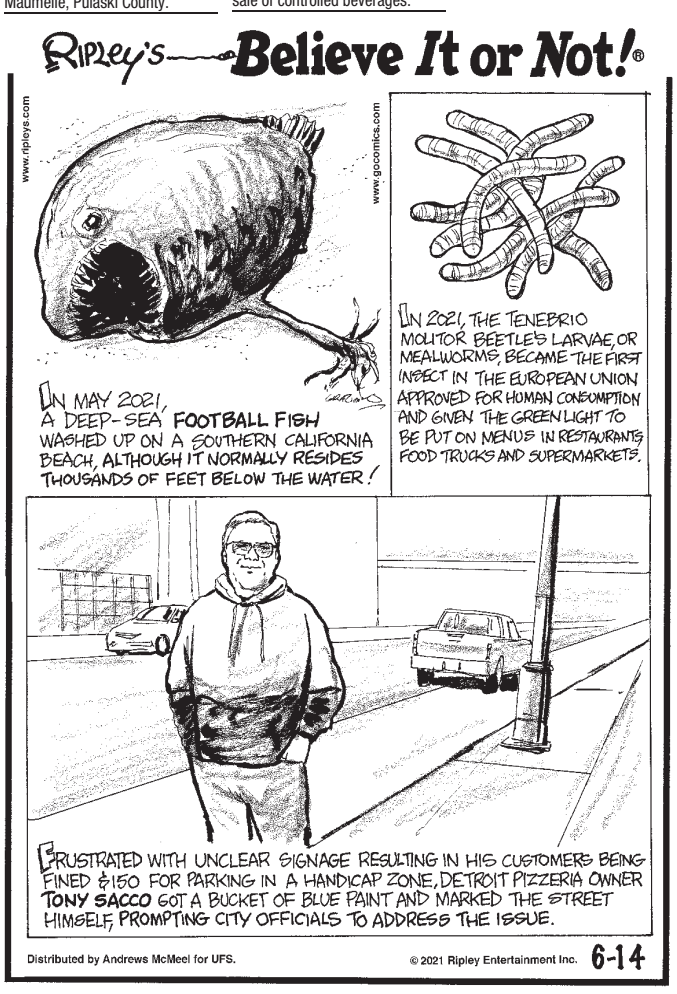
Alcohol Permits 1240

/s/G. K. Timmons
Name of Applicant
Team Summit
Name of Business

Sworn to before me this 13th of May, 2021.

/s/Trudy Smith
Notary Public

My Commission Expires: 4/30/2022
75426664z



Classified Ad Information

To Place Your Ad

FREE ADS:
Visit **www.freeadsarkansas.com**

PAID ADS CALL:
Weekdays from 8 am. to 5 p.m.
LR METRO: 501-372-3733
TOLL FREE: 1-800-342-3375
FAX: 501-378-3591

VISIT: 9 a.m. to 4 p.m. weekdays at
121 E. Capitol Ave. at Scott Street
Little Rock, AR

MAIL: Classified Arkansas
Arkansas Democrat-Gazette
121 E. Capitol Ave. at Scott Street
Little Rock, AR

COMMERCIAL ACCOUNTS:
Liner and display ads
Call **501-378-3434** or
toll free **1-800-345-2395**

Free Ad Details

FREE AD INCLUDES:
3 lines for 3 days in print and unlimited text online for 30 days

FREE AD EXCLUDES:
- Farm Equipment
- Heavy Equipment
- Garage Sales
- Dogs
- Rentals & Real Estate
- Statewide Ads

UPGRADE YOUR FREE AD:
Attention Getters, Gray Screens, Box Ad, Extra Days in print, Add Photo.
Upgrades starting at $5.

Some restrictions apply.
Please call for details.

Deadlines

CLASSIFIED LINE & DISPLAY ADS

For Sunday.....3 p.m Friday
For Monday and Tuesday.....5 p.m. Friday
Wednesday-Saturday, two days prior at 5 p.m.

SUNDAY REAL ESTATE

2 p.m. Wednesday

LEGAL ADVERTISING

For Sunday-Tuesday.....Noon, Friday
Wednesday-Saturday, two days prior at noon

LEGAL FAX: 501-918-4547

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Have your credit card ready when you call to place your advertisement.

We accept
American Express, Discover, Master Card, Visa

BILLING INFORMATION
For information about your account call:

501-378-3400 or 1-888-650-8535

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HOME IMPROVEMENT, BUSINESS & PROFESSIONAL SERVICES

To Place Your Ad Here Call (501) 378-3434 Or 1-800-345-2395, Weekdays 7:30 am - 5 pm

Bush Hog 1321

K & L
☞ *BUSH HOGGING*
☞ *TRACTOR WORK*
☞ *LAWNCARE*
☞ *MOVING & HAULING*
☞ *TEAR DOWN*
Call For More Information
870-602-0519

Concrete Work 1330

CONCRETE WORK DONE!
☞ ***Sidewalks***
☞ ***Driveways***
☞ ***Patios, etc.***
•30 Years Experience
•Reasonable Rates
•Free Estimates in Pine Bluff Only
870-329-0828
870-872-0451

Electrical 1343

ELECTRICAL SERVICES, INC.
Over 30 years exp.
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- Generators
- Residential and Commercial

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(501) 580-6002

Electrical 1343

Service Calls &Meter Loops
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•Commercial
•NLR Area
Dewey Goshien Electric Service
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Garden & Lawn Care 1354

Coleman's Lawncare Service
- Spring Cleanup
- Mulching, Pruning, Bushes, Flower Beds, Leave, Mowing
- Complete Lawncare & Lawn Maintenance Service
- Hauling
- Free Estimates

Serving Little Rock, NLR, Benton, Bryant, Sherwood & Jacksonville Areas
BBB Rated A+
501-960-2175

•TRACTOR WORK
•TILLING
•SMALL GARDEN TILLING
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•BRUSHHOG
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Hauling 1357

HAULING OF ALL KINDS
•Clean Gutters
•Tree Trimming
•Lay Sod
•Interior/Exterior Painting
Call 501-563-2680

Home Improvement 1359

Honest Builders
Offer great quality home improvements, fair affordable pricing, we GUARANTEE all work and stand behind everything with a one year warranty. We specialize in WINDOWS • DOORS • SIDING • DECKS • ROOFING •LANDSCAPING • LAWN SERVICE • INTERIOR & EXTERIOR PAINTING • FLOORING • DRYWALL. No job is too big or too small, we're grateful for all of our customers and take pride in working for you. Call Nicholas (501) 413-4040 for a FREE estimate on all jobs and projects.

PRO BUILDERS
INTERIOR + EXTERIOR REMODELING
- Painting
- Siding
- Repairs
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- Bathrooms
- Kitchens
- Walk-In Showers
- Roofing & Repairs
- Treated Wood Deck

Call For Your Free Estimate
*Seniors & Military Discounts
501-940-0367

Home Improvement 1359

Specializing in Small Jobs & Repairs
- Drywall & Paint
- Popcorn Ceilings
- Texture (all types)
- Carpentry & Trim

Serving Central AR
Call Darrell
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Roofing 1386

ROOF LEAK DOCTOR
30 YEARS IN INDUSTRY
Will Repair Flat, Metal & Shingle Roofs. Chimney Systems, Installation & Repairs. Free Roof Inspections
FREE ESTIMATES!
Licensed•Bonded•Insured
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Place Your Ad Here And Get Results.
We reach over 300,000 in Print & Online Readers per day.
"Our Audience, Your Customers!"
Call 378-3434

SCAN to view items to buy/sell

CLASSIFIEDS F

Arkansas Democrat Gazette

ARKANSAS ONLINE www.arkansasonline.com

TUESDAY, JUNE 15, 2021

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Trucks 4x2 240

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RV Supplies & Storage 328

CURT A25. 5th Wheel Hitch fits GM HD Series Trucks w/factory prep. $850. 501-767-1905

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BOBTAIL KITTENS. Party coat calico female $500. 501-679-1799

Dogs 710

BEAGLE PUPPIES, AKC, have 6 For Sale. 7 week old, has 1st shots, (2) Males, (4) Females. Call 870-490-2014

Professional 540

Dogs 710

BELGIUM MALINOIS Mix Personal Protection Dogs, 6 mo. old. $200. Call 501-988-1003

BORDER COLLIES, 12 weeks old, shots & wormed, $200. Text only please 501-249-0328

BOSTON TERRIER Male Puppy, AKC, shots & ready to go. Will be small, $600. 501-208-4288

CHESAPEAKE BAY Retriever Pups. 7 wks., Parents on premises. $300. 501-259-4973

CHIHUAHUA: Will pay $1,100. Has to be female. Must be weaned off of mother after 8 weeks. Must have protection against heart worm. Must have papers. Must be dewormed. Call 501-276-5523

ENGLISH CREAM Golden Retriever Puppies. AKC 1st shots & dewormed. $800. 479-244-9630 Eureka

F1B GOLDENDOODLE. Beautiful F1B Goldendoodle puppies available for sale. 6 weeks old. $1200. 870-371-0380

LABRADOR. FOR Sale AKC registered Black Lab puppies 7 weeks old 3 females and 2 males. Call for more information. $100000. 870-946-6184

MALTIPOO PUPPIES. Adorable CKC registered babies! Pics/Info on KellyPup.com $800. -$1600

MINI DACHSUND. puppies. Males only. $800. 5012361532

MINI GOLDENDOODLE Puppies, 5 Males, 2 Females. Ready for adoption June 7th. Text 501-802-5242 for Info.

RED HEELER Puppies, 7 wks., old, parents on premises, $100. Call 501-991-2001

TOY/MINI POODLE Babies. Super cute reds, CKC. Pics/Info on KellyPup.com $850. -1550

YORKIE- Boston Mix-Blue Heeler Mix & Maltipoo pup babies spoiled $295 501-961-1910 NLR

Livestock & Poultry 720

CHAROLAIS 19 Registered Replacement Heifers. Home Raised, Gentle. Born fall of 2020. Polled Bangs, Black Legs, BS Gold 1 Shot, Long Range Dewormer. $1,000 per head. Buyer take all. 985-513-0809

CHAROLAIS COWS 15, pasture exposed to $3,500 Bulls of Nov. 2020. $1,300 ea. 501-580-8742

BUY IT/SELL IT

Antiques & Collectibles 808

Great DEAL

TYPEWRITER, 1950's. $40. Vintage Records, 45's, $1. Vintage Table, $20. 501-681-0875

Articles Sale 810

1/16" THICK etched clear glass panes. Text for pics, etc. $15. 870-897-4016

MAYTAG GAS dryer. $150. 501-414-1336

OLD ENAMEL butcher shop hanging light fixture. Text for pics, etc. $125. 870-897-4016

Professional 540

Farm Equipment 837

CUB FARMALL Tractor, runs good, front & back cultivator, $1,800. Call 501-472-0730 Greenbrier Ark.

Furniture 840

DEN FURNITURE . Price reduced $600. 5015518012

Guns & Ammunition 843

NEW ENGLAND Pardner 12ga.. 3in. Mod. Single-shot, ex. cond. $175. 501-944-6491

Democrat-Gazette Classified gets around the Natural State. Altus, Arkadelphia, Batesville, Bentonville, Berryville, Brinkley, Clarksville, Conway, El Dorado, Eureka Springs, Fayetteville, Forrest City, Fort Smith, Glenwood, Harrison, Heber Springs, Helena, Hot Springs, Jacksonville, Jonesboro, Little Rock, Magnolia, Malvern, Mena, Morrilton, Springdale, Pine Bluff. Democrat-Gazzette Classified

RUGER .22 LR/Mag. Ruger New Model Single-Six .22 LR/Mag, ex. cond. $600. 501-944-6491

Home Appliances 846

WASHER & DRYER sets, $300 & up. Upright & Chest Freezers, $250 & Up. 501-618-1948

Lawn, Garden Supplies 850

JOHN DEERE Z-375R. Zero turn mower, 54" deck, 70 hrs, $2950. 501-767-1905

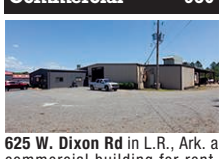
RENTALS

Apartments, Furnished 903

CABOT AREA, 30' Camper with 30' add on with full size bath room, walk in shower, furnished, utility paid, $600 month + $300 dep. Call 501-606-2615

LR, CENTRAL High School Area. 1 & 2BR Apts. All Util Pd. No pets. Must show proof of income. Dep. Req. Rent by wkly. Security dep. req. 501-541-7202

Industrial, Commercial 950



625 W. Dixon Rd in L.R., Ark. a commercial building for rent. Fenched, 1/2 mi. off I-530. 6 offices, 3 bathrms, breakrm, small kitc. area. 22k total sf. Main warehouse is heated & cooled. Extra storage bldg in back. Room for 18 wheelers to turn around. Looking for long term contract. $8,500/mo. rent plus utilities. More info 501-490-1028.

Rooms / Board 980

LR, UTILS pd. $125 wk. + 125 dep. 1817 S. Schiller St. & 2008 W. 22nd St. 501-960-7009

ROOM FOR RENT. Washer, Dryer & Internet incl. All Utilities Pd. $175 a wk. 501-475-6484

REAL ESTATE

Jacksonville 1023

MUST See!

JACKSONVILLE HOUSE For Sale By Owner, 3 BR., 1 1/2 BA, fenced back yard, storage shed, bonus room, large laundry room, $79,900. 501-626-7342

Resort / Waterfront Property 1040

GREERS FERRY Bondair Lake Property For Sale includes priv. 3,000 ft. runway house & hanger for Airplane use. $439,900. Rick, 501-258-0538

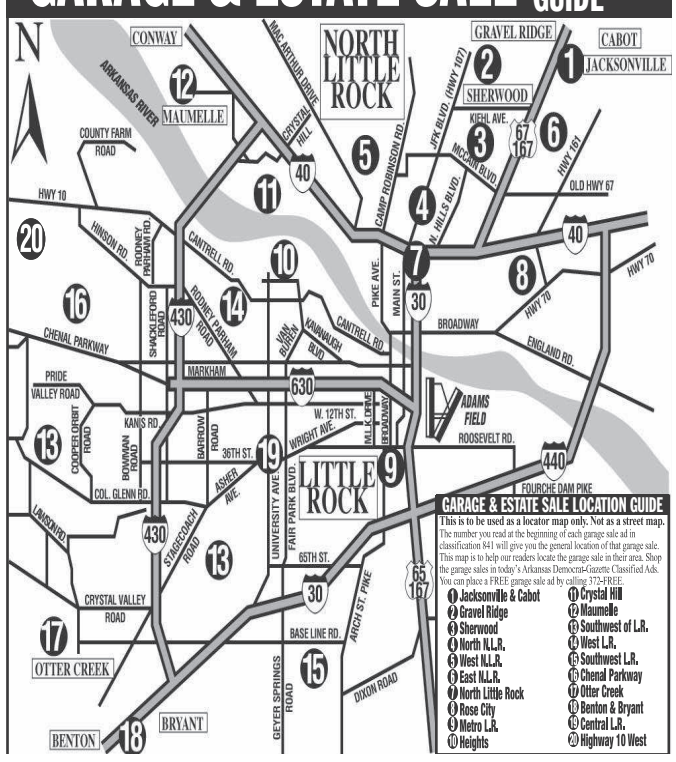
Lots & Acreage 1042

LOCUST GROVE. Deer Valley Annex 20+/- acres at Locust Grove. All wooded. Nice views. Southside water. Divided into Four Five-acre tracts. Lots of road frontage. Member of owner LLC is a licensed real estate agent. Contact Johnny Mitchum, Keller Williams Realty, 12814 Cantrell RD. Little Rock, 72223 $79900. 501-940-3231.

✓CHECK IT OUT!

FOR SALE BY Owner, AS IS, 9.61 acres, 13201 Kanis Road. 41,8611.6 sf. Appr. $840,000. Asking price $720,000. M.B. Lee 501-960-9735

GARAGE & ESTATE SALE LOCATION GUIDE

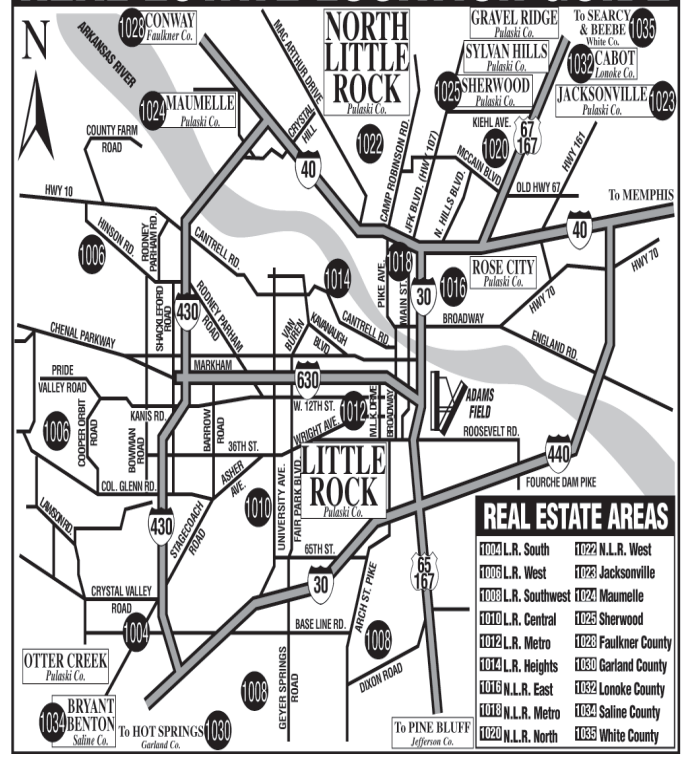


GARAGE & ESTATE SALE LOCATION GUIDE

This is to be used as a locator map only. Not as a street map. The number you read at the beginning of each garage sale ad in classification 841 will give you the general location of that garage sale. This map is to help our readers locate the garage sale in their area. Shop the garage sales in today's Arkansas Democrat-Gazette Classified Ads. You can place a FREE garage sale ad by calling 372-FREE.

1 Jacksonville & Cabot
2 Gravel Ridge
3 Sherwood
4 North L.R.
5 West L.R.
6 East N.L.R.
7 North Little Rock
8 Rose City
9 Metro L.R.
10 Heights
11 Crystal Hill
12 Maumelle
13 Southwest of L.R.
14 West L.R.
15 Southwest L.R.
16 Chenal Parkway
17 Otter Creek
18 Benton & Bryant
19 Central L.R.
20 Highway 10 West

REAL ESTATE LOCATION GUIDE



REAL ESTATE AREAS

1004 L.R. South
1006 L.R. West
1008 L.R. Southwest
1010 L.R. Central
1012 L.R. Metro
1014 L.R. Heights
1016 N.L.R. East
1018 N.L.R. Metro
1020 N.L.R. North
1022 N.L.R. West
1023 Jacksonville
1024 Maumelle
1025 Sherwood
1028 Faulkner County
1030 Garland County
1032 Lonoke County
1034 Saline County
1035 White County

MANUFACTURED HOMES

Mfg. Homes for Sale by Size 1105

J&M HOMES announces its Red Tag Sale. Stock units, doubles & singles reduced by thousands. Call for details 870-535-1524.

NEW, USED and Repo Manufactured Homes starting at $1,000. Call 870-535-1524.

LEGAL NOTICES

Bids/Requests 1210

Invitation to Bid
Little Rock Water Reclamation Authority Bid 21-016
Towable Trailer Mounted Boom Lift

The Procurement Department of Little Rock Water Reclamation Authority (LRWRA) will accept sealed bids until 2:30 p.m., Central Time, June 25, 2021 for a Towable Trailer Mounted Boom Lift.

The solicitation is available on the AR Bid website at https://Arkansas.lonwave.net or upon request by contacting the Procurement Department at Procurement@lrwra.com or at 501-688-1459 between the hours of 8:00 a.m. and 4:30 p.m., Monday through Friday.

Little Rock Water Reclamation Authority shall have the right to reject any and all bid responses and to waive any and all informalities.

Little Rock Water Reclamation Authority encourages disadvantaged, small, minority, and woman owned business enterprises to submit a response to this solicitation.

Create a Supplier Profile to receive bid notifications. Vendors are encouraged to create a supplier profile in the AR Bid Online Procurement System ("AR Bid"). AR Bid allows vendors to register to receive bid notifications from multiple central Arkansas governmental entities, including LRWRA. Once a supplier profile has been created, the vendor should receive email notifications as bids, addenda, and all other bid information are posted to the website. The vendor's selection of categories will determine types of bids for which notification will be received. Information on how to register is located on the AR Bid website at https://Arkansas.lonwave.net. A supplier profile is not required to view bid opportunities and download solicitation documents.

Tiffany Bilon
Procurement Department
75429283f

Bids/Requests 1210

Notice to Bidders

Notice is hereby given that on the 8th day of June, 2021, sealed bids addressed to Saline County, Arkansas, will be received at the Saline County Judges Office at 200 N. Main St., Suite 117, Benton, Arkansas 72015, until 2:00 p.m., for the conversion of an existing building to a pavilion and construction of a new roof in Paron, Arkansas located at Hwy 9 and Smithers Road. The sealed bids will then be opened and publicly read aloud. The work includes all labor, material, and equipment required to perform the work as described in the project plans and specifications.

The attention of bidders is called to the fact that Act 150 of 1965 (as amended), Arkansas Statutes, states that a Contractor must be licensed by the State Licensing Board for Contractors before he may undertake work when the cost thereof in Arkansas is Twenty Thousand Dollars ($20,000.00) or more.

Saline County, Arkansas is an Equal Opportunity Employer and does not discriminate on the basis of race, color, religion, sex, national origin, marital or veteran status, political status, disability status or other legally protected status. Pursuant to Arkansas Code Annotated §22-9-203: Saline County, Arkansas encourages all qualified small, minority and women business enterprises to propose on and receive contracts for goods, services, and construction.

Saline County, Arkansas is not responsible for lost or misguided bids.

Plans, specifications, proposal forms, and other contract documents may be obtained from the Saline County Purchasing Department, via email request to Angel Koder at angel.koder@salinecounty.org . Plans and specifications may be purchased at Southern Reprographics styer@southernrepro.com.

The Saline County Judge shall have the right to reject any and all bids received.

Saline County, Arkansas
Jeff Arey, Saline County Judge
75428118f

Bids/Requests 1210

Request for Proposal (RFP) – Financial Compliance and Audit Services

The Little Rock Housing Authority D/B/A Metropolitan Housing Alliance "MHA" requests the submission of written proposals from professionals to provide Financial Compliance and Audit Services. The proposals will service all sites owned and operated by MHA, its soleHello, owned entity Central Arkansas Housing Corporation and its affiliates. The proposal is due no later than 2:00 p.m. (CST), July 13, 2021, submit by email to njarmon@mhapha.org and jjohnson@mhapha.org .

This request for proposal contains specific submission requirements, anticipated scope and period of service, as well as terms, conditions and other pertinent information for submitting a proposal. The office hours are Monday through Friday 8:00 a.m. to 5:30 p.m. (CST). A free copy of the RFP document can be obtained starting June 14, 2021, by the following.

1. Visit MHA website at http://lrhousing.org/ , click on the tab, Business with MHA.
2. Collect a copy in person at:
Metropolitan Housing Alliance
100 South Arch Street
Little Rock, AR 72201
75429109f

Probate Notices 1220

In the Circuit Court of Pulaski County, Arkansas
Probate Division

In the Matter of the Estate of Charles A Schlesier, Deceased.
No. 60PR-21-920

Name of decedent: Charles A. Schlesier

Last known address: 12601 Ironton Cut-Off, Little Rock, AR 72206

Date of death: 01-15-2013

On 3-14-21, an affidavit for collection of small estate by distributee was filed with respect to the estate of Charles A. Schlesier, deceased, with the clerk of the probate division of the circuit court of Pulaski County, Arkansas, under Ark. Code Ann. § 28-41-101.

The legal description of the real property listed in the affidavit is as follows: North Half (N 1/2) of the Southeast quarter (SE 1/2) of the Northeast quarter (NE 1/2) of the section 16 of Township 1 South, Ranch 12 West, Pulaski Cty, Arkansas.

All persons having claims against the estate must exhibit them, properly verified, to the distributee or his or her attorney within three (3) months from the date of the first publication of this notice or they shall be forever barred and precluded from any benefit of the estate.

The name, mailing address, and telephone number of the distributee or distributee's attorney is:

Timothy Charles Shlesier
12601 Ironton Cut-Off, Little Rock, AR 72206
501-708-5447

This notice first published May 30, 2021.
75422315z

Meetings/ Hearings 1230

NOTICE OF APPLICATION for PROPOSED ARHOME SECTION 1115 DEMONSTRATION PROJECT

Pursuant to 42 C.F.R. § 431.408, the Director of the Division of Medical Services (DMS) of the Department of Human Services (DHS) issues the following Notice of Application for a proposed Section 1115 Demonstration Project waiver for the ARHOME program.

During the most recent session of the Arkansas General Assembly, Governor Asa Hutchinson and legislators collaborated to make further improvements to the Medicaid program for non-elderly and adults without disabilities with income below 138% of the federal poverty, currently called Arkansas Works. Under the authority of Act 530, Arkansas proposes to continue to cover the new adult eligibility group for another five years through the Arkansas Health and Opportunity for Me Act of 2021 ("ARHOME") program and extend and amend the Demonstration through December 31, 2026. DMS now seeks comments on the proposed waiver authorities before submission to the Centers for Medicare & Medicaid Services (CMS) for consideration and approval.

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.

The new features of ARHOME 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;

-reduce the additional risk for disease and premature death associated with living in a rural county;

-strengthen financial stability of critical access hospitals and other small, rural hospitals, and enhance access to medical services in rural counties;

-fill gaps in continuum of care for individuals with serious mental illness and substance use disorders;

-increase the identification of Medicaid beneficiaries most at risk for poor health outcomes associated with poverty and increase their engagement in educational and employment opportunities;

-increase active participation of beneficiaries in improving their health;

-provide intensive care coordination for beneficiaries most at risk of long-term poor health to reduce inappropriate and preventable utilization of emergency departments and inpatient hospital settings;

-increase the use of preventative care and health screenings; and

-reduce the rate of growth in state and federal obligations for providing healthcare coverage to low-income adults.

DMS has made several changes from the previous waiver authority. The new waiver includes three types of community bridge organizations called Life360 HOMEs targeted to improving maternal and child health; supporting population health in rural areas by addressing social determinants of health; expanding provider capacity to give individuals with serious mental illness or substance use disorders more timely access to treatment; and creating opportunities for success for young adults who are veterans or former foster youths, were under the supervision of the Division of Youth Services, or were formerly incarcerated as adults.

Additional changes include:

-the use of incentives offered by qualified health plans to their members to increase use of preventative health screenings and services;

-the use of incentives offered by qualified health plans to their members to increase the use of employment, education, and training opportunities among enrollees;

-increased qualified health plan accountability for meeting annual Medicaid Core Set of Adult Health Care Quality Measures enforced by potential financial sanctions;

-quarterly program monitoring by a joint executive-legislative oversight panel;

-application of cost sharing up to the federally allowable amounts per service and the quarterly cost sharing cap of 5% of household income for enrollees; and

-enrollment in the PASSE program for individuals with serious mental illness or substance use disorder providing them with access to intensive care coordination and specialized services.

Other requested waiver authorities include continuing to provide premium assistance to purchase coverage offered by qualified health plans that participate in the individual insurance Marketplace in Arkansas and waiver authorities involving freedom of choice; payment to providers; premiums and cost sharing; retroactive eligibility; and prior authorizations.

In State Fiscal Year 2021, the total cost of the Arkansas Works program is expected to be $2.251 billion. The state share will be 10% of the total cost. The financial estimate for SFY 2022 is highly sensitive to changes in enrollment due to national and state economic conditions and the end of the Public Health Emergency (PHE). DHS is in the process of finalizing its estimates for the ARHOME program for SFY 2022 which is likely to be at or above the SFY 2021 level. The state share will be 10% of the total cost.

In conjunction with the submission of the 1115 waiver, DHS has created a mandated transition, phase-out, and termination plan according to federal rules and the Arkansas Works Demonstration's Special Terms and Conditions. Transition and phase-out will begin with the

Meetings/ Hearings 1230

public comment period outlined in this notice. Termination and closure will only be implemented if CMS fails to approve the ARHOME Demonstration. The transition plan ensures there is no lapse in eligibility or coverage.

Effective for dates of service are on or after January 1, 2022.

The Arkansas Health and Opportunity for Me (ARHOME) Application for Proposed Section 1115 Demonstration Project and the Arkansas Works phase-out plan are available for review at the Department of Human Services (DHS) Office of Rules Promulgation, 2nd floor Donaghey Plaza South Building, 7th and Main Streets, P. O. Box 1437, Slot S295, Little Rock, Arkansas 72203 1437. You may also access and download the Application and this notice on the DHS website at https://humanservices.arkansas.gov/do-business-with-dhs/proposed-rules/.

Public comments may be submitted in writing at the above mailing address or at the following email address: ORP@dhs.arkansas.gov. All public comments must be received by DHS no later than July 12, 2021. Please note that public comments submitted in response to this notice are considered public documents. A public comment, including the commenter's name and any personal information contained within the public comment, will be made publicly available.

Two public hearings will be held for public comment:

1) The AR Behavioral Health Planning and Advisory Council will meet, by remote access only through a Zoom webinar open to the public, on June 21, 2021, from 12:00 to 1:00 p.m. A public hearing will be a part of the agenda. Public comments may be submitted at the hearing.

Meetings/ Hearings 1230

Individuals can access this public hearing at https://us02web.zoom.us/j/89852067259. The webinar ID is 898 5206 7259. If you would like the electronic link, "one-tap" mobile information, listening only dial-in phone numbers, or international phone numbers, please contact ORP at ORP@dhs.arkansas.gov.

2) A second public hearing by remote access through a Zoom webinar will be held on June 22, 2021, at 4:00 p.m. Public comments may be submitted at the hearing. Individuals can access this public hearing at https://us02web.zoom.us/j/89251100312. The webinar ID is 892 5110 0312. If you would like the electronic link, "one-tap" mobile information, listening only dial-in phone numbers, or international phone numbers, please contact ORP at ORP@dhs.arkansas.gov.

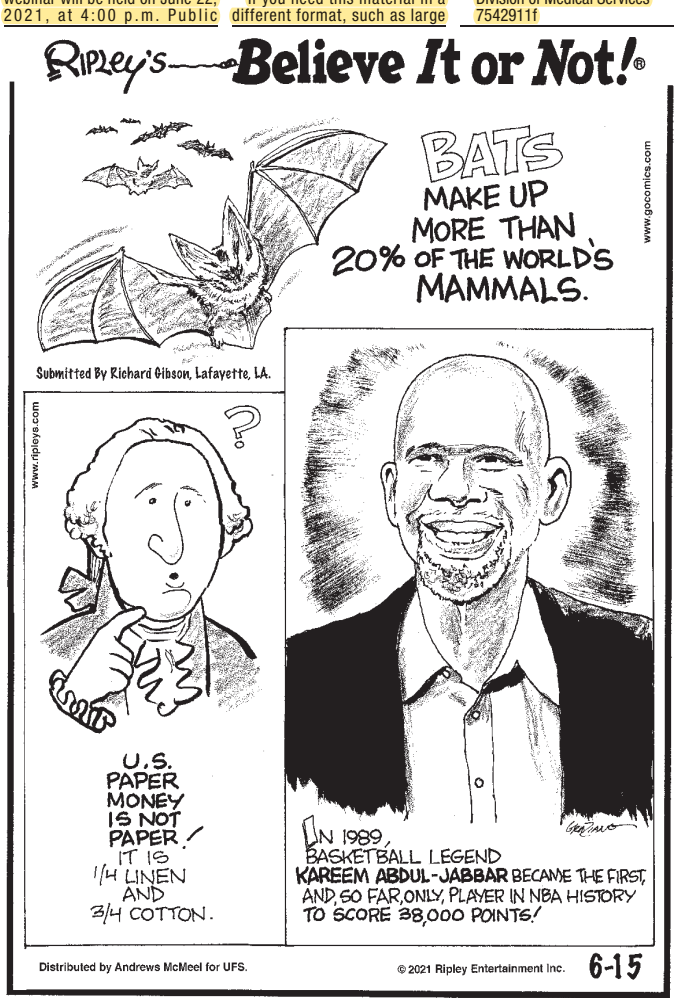
If you need this material in a different format, such as large print, contact the Office of Rules Promulgation at 501-320-6266.

The Arkansas Department of Human Services is in compliance with Titles VI and VII of the Civil Rights Act and is operated and managed and delivers services without regard to religion, disability, political affiliation, veteran status, age, race, color or national origin. 4501960528

Elizabeth Pitman, Director
Division of Medical Services
7542911f

Meetings/ Hearings 1230

Grain trucks, moving sales, sleeper sofas, bedroom suites, cell phones, foundation repair, wallpaper and painting contractors, strollers, children's toys, scrap lumber, post hole diggers, antennas, men's shirts and pants, carport sales, riding mowers, guitars, sewing machines, vacuum cleaners, dryers, exercise bikes, flutes, and more. It's all here in Classified.



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FAX: 501-378-3591

VISIT: 9 a.m. to 4 p.m. weekdays at
121 E. Capitol Ave. at Scott Street
Little Rock, AR

MAIL: Classified Arkansas
Arkansas Democrat-Gazette
121 E. Capitol Ave. at Scott Street
Little Rock, AR

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Wednesday-Saturday, two days prior at 5 p.m.

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July 12, 2021

Ms. Elizabeth Pittman
Director
Division of Medical Services
Arkansas Department of Human Services
P.O. Box 1437, Slot S295
Little Rock, AR 72203-1437

Dear Ms. Pittman:

I am writing to express the support of Excel by Eight for the Maternal Life360 HOME model that is proposed in the 1115 waiver request to the Centers for Medicare and Medicaid Services and to outline several recommendations for strengthening the request that will improve the likelihood of achieving the waiver's proposed outcomes.

At Excel by Eight, we envision an Arkansas where all children have access to quality health care and education that maximizes their full potential, regardless of gender, income, race/ethnicity, disability, or geography. For healthy development, infants and toddlers need quality health care, stimulating learning opportunities, and nurturing, responsive relationships. A system of support should be in place at or before birth to ensure every parent and child receives the needed information, assessments and referrals for a strong start. We believe that home visiting programs are a key strategy for providing these resources.

We are working with six communities around the state - Conway, Independence, Monroe, Sevier, and Union counties and the City of Little Rock - to achieve this vision by helping them develop a reliable grid of family, community, health, and education resources. After learning about the proposed waiver, those communities with birthing hospitals have already begun discussing how they might partner with the hospitals to expand existing, evidence-based home visiting models to improve health outcomes for vulnerable mothers, infants, and toddlers.

To ensure that the investments in Maternal Life360 HOMEs achieve the intended outcomes, we recommend the following:

1. Build on existing home visiting infrastructure. Arkansas already has a statewide home visiting network that provides training and technical assistance, evaluation, guidance, and ongoing quality improvement work to community-based programs. With support from public and private funding streams, home visiting already reaches children prenatal to age five across the state through evidence-based models. Starting a home visiting program is a complex process that needs expert guidance; the Maternal Life360 HOME model should build upon and support existing infrastructure as birthing hospitals establish programs.

2. Invest in evidence-based home visiting models. 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. The U.S. Department of Health and Human Services (HHS) has developed a review process for home visiting programs called HomVEE. Nineteen models meet HHS criteria for evidence based early childhood home visiting programs. Several of these focus on the target audience for Maternal Life360 HOMEs and already exist in Arkansas -- Healthy Families America, Nurse Family Partnership, and SafeCare.

3. Allow enrollment after the birth of the child. While it is optimal to enroll women in home visiting during pregnancy, we recommend that families 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 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.

4. Allow all pregnant and parenting women in Medicaid to enroll. 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 programs' reach and help achieve health outcome goals outlined in the waiver.

Thank you for the opportunity to provide feedback on the waiver. We look forward to working with DHS and our E8 communities to implement the Maternal Life360 HOME model over the next few years.

Sincerely,

Angela Duran
Executive Director

July 08, 2021

Elizabeth Pitman
Director
Division of Medical Services
Donaghey Plaza
P.O. Box 1437
Little Rock, AR 72203

Re: ARHOME Section 1115 Demonstration Application

Dear Ms. Pitman:

The National Organization for Rare Disorders (NORD) appreciates the opportunity to submit comments on the draft proposal for Arkansas's Section 1115 Demonstration Application. NORD is a unique federation of voluntary health organizations dedicated to helping the 25-30 million Americans living with a rare disease. We believe that all patients should have access to quality, accessible, and affordable health coverage that is best suited to their medical needs.

Many patients with rare disorders have complex and often costly health care needs and depend on access to quality and affordable health care. Medicaid coverage often serves as a lifeline to rare disease patients, who may find their lives upended by the debilitating nature of their diseases. According to the NORD's recent *30-Year Barriers to Access Survey*, 76% of rare disease patients report some or great financial burden and 62% of adults have had to miss work because of their rare disease.[i] For all patients with a rare condition, the Medicaid program provides assurance that if their disease increases in severity and they are unable to work, they will still be able to access necessary treatment. This aspect of the Medicaid program is especially vital during difficult economic times.

NORD is committed to ensuring that Arkansas's Medicaid program provides quality and affordable health care coverage and supports Arkansas's continued commitment to Medicaid expansion. Unfortunately, this draft proposal includes several provisions that do not meet Medicaid's objective to provide health care for low-income individuals. NORD opposes the provisions within this draft waiver to limit retroactive coverage and impose premiums and cost sharing onto Medicaid beneficiaries. Our detailed comments on the ARHOME waiver are as follows:

<u>Retroactive Eligibility</u>
This proposal would continue to limit retroactive coverage to 30 days for the demonstration population. There are no exemptions, including for medically frail individuals. It is common that individuals are unaware they are eligible for Medicaid until a medical event or diagnosis occurs. This is especially common in the rare disease community, as many rare disease patients face long

diagnostic journeys and are not diagnosed until later in life. Retroactive eligibility in Medicaid prevents gaps in coverage by typically covering individuals for up to 90 days prior to the month of application, assuming the individual is eligible for Medicaid coverage during that time frame. Therefore, retroactive eligibility allows patients who have been diagnosed with a serious illness, such as a rare disease, to begin treatment without being burdened by medical debt prior to their official eligibility determination.

Furthermore, Medicaid paperwork can be burdensome and often confusing. A Medicaid enrollee may not have understood or received a notice of Medicaid renewal and only discovered the coverage lapse when picking up a prescription or going to see their doctor. Without retroactive eligibility, Medicaid enrollees could then face substantial costs at their doctor's office or pharmacy.

Without retroactive eligibility in place health systems could end up providing more uncompensated care. For example, when Ohio considered a similar provision in 2016, a consulting firm advised the state that hospitals could accrue as much as $2.5 billion more in uncompensated care as a result of the waiver.[ii] Arkansas currently has 11 rural hospitals that are vulnerable to closure.[iii] Limiting retroactive coverage increases the financial hardships to rural hospitals that absorb uncompensated care costs. NORD opposes the limitations on retroactive coverage for the demonstration population.

Premiums and Cost-sharing

Arkansas proposes to increase premiums for individuals with incomes at or above 100% of the federal poverty line. Premiums will likely discourage eligible people from enrolling in the program. For example, when Oregon implemented a premium in its Medicaid program, with a maximum premium of $20 per month, almost half of enrollees lost coverage.[iv] A sudden interruption in care can be devastating for patients with rare diseases, who often depend on regular visits with providers or must take daily medications to manage their conditions.

The state is also requesting to impose copayments ranging from $5 to $20 on individuals with incomes at or above 21% of the federal poverty line ($225 per month for an individual). Research has shown that even relatively low levels of cost-sharing for low-income populations limit the use of necessary health care services.[v] Additionally, the state includes a copay for non-emergency use of the emergency department. Yet a study of enrollees in Oregon's Medicaid program demonstrated that implementation of a copay on emergency services resulted in decreased utilization of such services but did not result in cost savings because of subsequent use of more intensive and expensive services.[vi] This provides further evidence that copays may lead to inappropriate delays in needed care. NORD opposes cost-sharing and premiums for the low-income population covered under this demonstration.

Evaluation

NORD is concerned that this proposal does not include an interim evaluation of Arkansas Works, the state's previous demonstration waiver. Therefore, there is no evaluation data on the

state's experience with premiums, limitations on retroactive coverage, and other key provisions included in the current waiver application. This is highly problematic because the state is asking for comment on extending its current demonstration, and evidence from an interim evaluation would help our organization to fully comment on the current request.

Conclusion

Affordable health care coverage is critical to ensuring that rare diseases patients, and others with serious and chronic conditions, can access needed health care services. Unfortunately, this 1115 waiver proposal would place damaging administrative and financial barriers on health coverage by limiting retroactive coverage and imposing premiums and cost-sharing onto beneficiaries. Therefore, NORD strongly recommends that Arkansas revise its waiver application as outlined to ensure that it meets the objectives of the Medicaid program.

Thank you again for the opportunity to submit comments. For questions regarding NORD or the above comments please contact Corinne Alberts at calberts@raredisease.org.

Sincerely,

[redacted]

Alyss Patel
State Policy Manager, Western Region
National Organization for Rare Disorders

[i] National Organization for Rare Disorders. "30-Year Barriers to Access Survey" https://rarediseases.org/wp-content/uploads/2020/11/NRD-2088-Barriers-30-Yr-Survey-Report_FNL-2.pdf

[ii] Virgil Dickson, "Ohio Medicaid waiver could cost hospitals $2.5 billion", Modern Healthcare, April 22, 2016. (http://www.modernhealthcare.com/article/20160422/NEWS/160429965)

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[iv] Samantha Artiga, Petry Ubri, and Julia Zur, "The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings," Kaiser Family Foundation, June 2017. Available at: https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/.

[v] Id.

[vi] Wallace NT, McConnell KJ, et al. How Effective Are Copayments in Reducing Expenditures for Low-Income Adult Medicaid Beneficiaries? Experience from the Oregon Health Plan. Health Serv Res. 2008 April; 43(2): 515–530.

LEUKEMIA & LYMPHOMA SOCIETY®

July 12, 2021

Dawn Stehle
Deputy Director, Health and Medicaid
Arkansas Department of Human Services
Donaghey Plaza
P.O. Box 1437
Little Rock, AR 72203

Re. Arkansas Health and Opportunity for Me (ARHOME) Application for Proposed Section 1115 Demonstration Project

Dear Ms. Stehle:

At The Leukemia & Lymphoma Society (LLS), our mission is to cure leukemia, lymphoma, Hodgkin's disease and myeloma, and to improve the quality of life of patients and their families. We support that mission by advocating that blood cancer patients have sustainable access to quality, affordable, coordinated healthcare. On behalf of the thousands of Arkansans whose lives have been changed forever by blood cancer, we appreciate this opportunity to comment on the Arkansas Works Medicaid Section 1115 Demonstration Project proposal.

Medicaid covers 1 in 5 Americans, including low-income children, adults, seniors, and people with disabilities.[i] Many of these neighbors among us have complex and costly health care needs. Expanded access to Medicaid is essential to improving health and saving lives.

Specific to cancer, Medicaid expansion has helped close disparities in cancer treatment. The American Society of Clinical Oncology reported in 2019 that expansion states showed no significant difference in timely receipt of treatment between African American and white patients. The same can unfortunately not be said for non-expansion states.[ii] Expansion has also been associated with a reduced risk of hospital closures, especially in rural areas,[iii] and reduces the uncompensated care burden for public and rural hospitals.[iv]

The LLS Office of Public Policy's *Principles for Meaningful Coverage* give us an objective and constructive means of evaluating healthcare coverage proposals.[v] They inform our support for Medicaid expansion, and inform our concerns about the Arkansas Works draft plan's impact on timely, cost-effective access to stable coverage.

<u>Linking Cost-Sharing to Participation in Work, Community Engagement, and Health-Improvement Activities: a Costly Set of Barriers to Care</u>

It is unfortunate to see work requirements making a second appearance in the Arkansas Medicaid expansion discussion, rebranded as an "Economic Independence Initiative" inviting private insurers to provide cost-sharing discounts to enrollees who engage in work-related activities. Those same discounts are also being proposed 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.[vi] There is no reason to expect a different outcome here.

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For the reasons outlined below, LLS asks that all requirements and incentives for work, community engagement, and health-improvement activities be removed, and that additional cost sharing and premium requirements not be placed on Arkansas Works enrollees.

In the absence of federal administrative support for work requirements and with the Supreme Court having canceled oral arguments on a related case, there is no legal footing to support this portion of the draft waiver. As a 2020 appellate court stated when it upheld the termination of Arkansas's previous attempt at implementing work requirements: "(T)he alternative objectives of better health outcomes and beneficiary independence are not consistent with Medicaid. The text of the statute includes one primary purpose, which is providing health care coverage without any restriction geared to healthy outcomes, financial independence or transition to commercial coverage."[vii]

This standard remains in effect and should be sufficient on its own to rule out the further pursuit of any work requirement proposal, but there are also serious policy outcomes concerning the use of work requirements. The Center on Budget and Policy Priorities has maintained a comprehensive document outlining how these kinds of proposals reduce access to care for targeted and non-targeted groups alike, increase financial hardships, and fail to increase employment levels.[viii] Even if work requirements were legally allowable under Medicaid – which they are not – they remain a flawed tool for generating their stated outcome objectives.

As noted above, a 2021 Georgetown University article outlined the health equity issues associated with wellness incentive programs. Between higher rates of chronic health conditions for people of color, and the increased incidence of food deserts and environmental hazards in low-income neighborhoods, "enrolling in a health-contingent wellness program can look less like a benefit and more like a penalty."[ix]

Cost sharing and premiums for Medicaid pose their own set of problems to enrollees. The draft application requests authority to charge premiums to individuals with incomes above 100 percent of the federal poverty level, and to charge copays for individuals with incomes above 20 percent of the federal poverty level. Increases in premiums and cost-sharing are likely to cause Medicaid enrollees to either lose access to coverage or decrease their adherence to treatment.[x] Additionally, studies project that increasing enrollees' premiums and cost-sharing would generate only limited savings for states and that, in some cases, those savings would be eliminated by increases in uncompensated care (e.g. increased use of the emergency department by individuals who now lack coverage) and increased administrative expenses.[xi]

Furthermore, evidence suggests expanded cost sharing may not result in the intended cost savings.[xii] A study of enrollees in Oregon's Medicaid program demonstrated that implementation of a copay on emergency services resulted in decreased utilization of such services but did not result in cost savings because of subsequent use of more intensive and expensive services.[xiii]

<u>Limiting Retroactive Eligibility Hurts Arkansans and their Health Care Systems</u>

This draft plan calls for a reduction in retroactive coverage from three months to one month. When someone enrolls in Medicaid, coverage is usually extended retroactively to the three months before enrollment, provided they were eligible at that time. That's helpful when a life event – such as a cancer diagnosis – triggers both medical expenses and coverage eligibility. Limiting retroactive coverage to one month increases the likelihood of people on Medicaid carrying major

medical debt and increases the odds that hospitals will not be compensated for the care they provide.[xiv] This change in policy should be removed from the waiver proposal.

Concerns Regarding Public Comment Review Timeline

On June 15, Governor Asa Hutchinson said at his weekly press conference that Arkansas would submit its draft plan for federal review on July 14. The draft plan is open for public comment at the state level until July 12, suggesting that the state would need only two days to review all public input and update its plan prior to meeting the governor's stated deadline. We would encourage the state to use more than 48 hours to digest and address the public's comments, many of which will likely be raising critical questions about the initial draft.

Conclusion

LLS is grateful that the Arkansas Works 1115 draft plan maintains the state's commitment to Medicaid expansion. The draft plan limits its own effectiveness, however, by departing at several points from the best practices and legal standards in place for Medicaid.

Work, community engagement and health-improvement provisions, cost sharing and premium increases, and limits on retroactive eligibility will create harmful and costly barriers to care for thousands of Arkansans, including the blood cancer patients LLS serves. We ask your agency to revise the draft plan to remedy these issues.

Sincerely,

[redacted]

Dana Bacon
Regional Director, Government Affairs
The Leukemia & Lymphoma Society
dana.bacon@lls.org

[i] Rachel Garfield, Robin Rudowitz, and Anthony Damico, "Understanding the Intersection of Medicaid and Work," *Kaiser Family Foundation*, January 2018. https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/

[ii] *American Society of Clinical Oncology*, June 2, 2019. https://www.asco.org/about-asco/press-center/news-releases/racial-disparities-access-timely-cancer-treatment-nearly

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[v] *The Leukemia & Lymphoma Society*, "Principles for Meaningful Coverage." https://www.lls.org/cancercost/principles

[vi] Zuckerbrod, J. "Workplace Wellness Programs Have Overlooked Health Equity." *Georgetown University Center for Children & Families*. February 22, 2021. https://ccf.georgetown.edu/2021/02/22/workplace-wellness-programs-have-overlooked-health-equity/

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[viii] Wagner J. and Schubel J. "States' Experiences Confirm Harmful Effects of Medicaid Work Requirements" *Center on Budget and Policy Priorities*. November 18, 2020. https://www.cbpp.org/research/health/states-experiences-confirm-harmful-effects-of-medicaid-work-requirements

[ix] Zuckerbrod.

[x] Artiga S., Ubri P., and Zur J. "The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings." *Kaiser Family Foundation.* June 1, 2017. https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/

[xi] Ibid.

[xii] See for example: Chernew M, Gibson TB, Yu-Isenberg K, Sokol MC, Rosen AB, Fendrick AM. „Effects of increased patient cost sharing on socioeconomic disparities in health care." *J Gen Intern Med*. 2008. Aug; 23(8):1131-6. Ku, L and Wachino, V. "The Effect of Increased Cost-Sharing in Medicaid: A Summary of Research Findings." *Center on Budget and Policy Priorities*. July 2005. http://www.cbpp.org/5-31-05health2.htm

[xiii] Wallace NT, McConnell KJ, et al. "How Effective Are Copayments in Reducing Expenditures for Low-Income Adult Medicaid Beneficiaries? Experience from the Oregon Health Plan." *Health Serv Res*. 2008 April; 43(2): 515–530.

[xiv] Meyer H. "New Medicaid barrier: Waivers ending retrospective eligibility shift costs to providers, patients," *Modern Healthcare*, February 9, 2019. https://www.modernhealthcare.com/article/20190209/NEWS/190209936/new-medicaid-barrierwaivers-ending-retrospective-eligibility-shift-costs-to-providers-patients.

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BEATING CANCER IS IN OUR BLOOD.

July 12, 2021

Ms. Cindy Gillespie
Secretary, Department of Human Services
PO Box 1437, Slot S201
Little Rock, AR 72203

Dear Secretary Gillespie:

The Arkansas Center for Health Improvement (ACHI) appreciates the opportunity to provide comment on the Arkansas Health and Opportunity for Me (ARHOME) demonstration waiver program, the proposed overhaul of Arkansas's Medicaid expansion program known currently as Arkansas Works. ACHI is an independent, non-partisan health policy organization dedicated to improving the health of Arkansans. The proposed five-year ARHOME waiver represents a continuation of the state's innovative efforts over the last eight years to provide affordable, quality coverage to low-income Arkansans through the Medicaid program, and we are supportive of that goal, as well as new opportunities to address social needs in target populations through Life360 HOMEs.

We are pleased to see that ARHOME — like its predecessor programs — has at its core the premium assistance model, which uses Medicaid funding to purchase individual qualified health plans (QHPs) available on the Health Insurance Marketplace instead of administering coverage through the Medicaid fee-for-service program. The federally required evaluation of the premium assistance model in the Health Care Independence Program showed that Medicaid enrollees in QHPs experienced better perceived and actual access than enrollees in fee-for-service. The use of premium assistance has also benefitted the individual insurance market in Arkansas by promoting enhanced competition and stabilizing premiums.

While we recognize that the proposal to "reassign" beneficiaries who are "inactive" from QHPs to the Medicaid fee-for-service program has some budgetary benefit, the reassignment waiver feature also raises some concerns. First, being reassigned could certainly be viewed as a penalty by the beneficiary. After all, the stigma of Medicaid has been documented and is among the many reasons that Arkansas initially opted for a premium assistance model. Second, as a basic tenet of insurance, the QHPs rely on beneficiaries with low or no utilization to offset high utilization among other beneficiaries. Wholesale reassignment of beneficiaries without utilization could be detrimental to this balance of risk and result in higher QHP premiums for the program. Finally, the reassignment feature — which the waiver proposes to test to understand whether beneficiaries "in a QHP recognize and value the health coverage as insurance above and beyond Medicaid medical assistance" — sparks broader questions about compliance with federal "equal access" requirements, particularly when there is objective evidence that access differences between the care delivery strategies exist. We welcome the opportunity for input into the operationalization of "inactive" beneficiary provisions before the proposed implementation date in 2023, and we hope that the Medicaid reimbursement adequacy review currently underway informs the broader "equal access" questions raised by this proposed feature.

ACHI
INSPIRING HEALTHY ACTS

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We commend the Department of Human Services for incorporating the Life360 HOME concept into the waiver proposal to provide more intensive levels of intervention, care coordination, and linkages to community-based services for at-risk populations. The targeted populations for Life360 HOMEs have consistently experienced health disparities and profound social needs that serve as a barrier to improved outcomes. We are hopeful that there will be robust participation in the Life360 HOMEs by both providers and enrollees, and that the Life360 HOMEs will include evidenced-based interventions that have been shown to improve health outcomes. We would also invite state officials to explore promising models such as the Following Baby Back Home program developed by the University of Arkansas for Medical Sciences' Department of Pediatrics, which has been shown to prevent three in four infant deaths, improve immunization completion, and increase the completion of needed healthcare utilization among high-risk newborns.

We are also supportive of new quality measurement provisions for the QHPs, which will provide both an opportunity for quality improvement within the ARHOME program and a comparator for QHP performance in the subsidized population above income eligibility levels for Medicaid expansion. As waiver components continue to evolve from previous iterations and throughout the life of the waiver, we would urge regular compliance monitoring and rigorous state and federal evaluations that carefully assess results against stated objectives to inform both state and national awareness. Opportunities exist to learn from waiver strategies that are successful, as well as those that fall short of expectations or have unintended consequences. Regarding the latter, the following waiver provisions merit heightened scrutiny:

- Cost-sharing exposure for individuals with household incomes beginning at 21% of the federal poverty level, or roughly $2,700 annually for a single individual and $5,500 for a household of four. Even relatively small levels of cost-sharing are associated with reduced use of care, including necessary services.
- The ability of providers to refuse service following one instance of non-payment. This could certainly have the potential to limit access for needed services and could divert those with the inability to pay to safety net providers, such as federally qualified health centers, which must provide services without regard to an individual's ability to pay.
- The limit on retroactive eligibility to 30 days. This waiver feature was previously approved by the Centers for Medicare and Medicaid Services and implemented as part of Arkansas Works but was discontinued. The interim evaluation of Arkansas Works was unable to fully assess this waiver feature.

ACHI encourages the Centers for Medicare and Medicaid Services to approve the state's waiver proposal request to continue Medicaid expansion coverage in Arkansas. Thank you again for the opportunity to provide comment on the ARHOME proposal.

Sincerely,

J. Craig Wilson, JD, MPA
ACHI, Director of Health Policy

July 9, 2021

ACHI HEALTH POLICY BOARD

ACHI's Health Policy Board identifies and establishes strategic priorities, provides direction and guidance, and serves as a forum for the exchange of ideas.

Ms. Cindy Gillespie
Secretary, Department of Human Services
PO Box 1437, Slot S201
Little Rock, AR 72203

Dear Secretary Gillespie:

The Arkansas Center for Health Improvement's (ACHI) Health Policy Board appreciates the opportunity to provide comment on the Arkansas Health and Opportunity for Me (ARHOME) demonstration waiver program, the proposed overhaul of Arkansas's Medicaid expansion program known currently as Arkansas Works. Consisting of 21 voting members from across the state who bring diverse perspectives and interests on health, the ACHI Health Policy Board identifies and establishes strategic priorities and provides direction and guidance for the organization. The proposed five-year ARHOME waiver represents a continuation of the state's innovative efforts over the last eight years to provide affordable, quality coverage to low-income Arkansans through the Medicaid program, and we are supportive of that goal, as well as new opportunities to address social needs in target populations through Life360 HOMEs.

First, we are pleased to see that ARHOME—like its predecessor programs—has at its core the premium assistance model, which uses Medicaid funding to purchase individual qualified health plans (QHPs) available on the Health Insurance Marketplace instead of administering coverage through the Medicaid fee-for-service program. The federally required evaluation of the premium assistance model in the Health Care Independence Program showed that Medicaid enrollees in QHPs experienced better access — both perceived and actual — and higher-quality care than enrollees in fee-for-service. The use of premium assistance has also benefitted the individual insurance market in Arkansas by promoting enhanced competition and stabilizing premiums.

Second, we commend the Department of Human Services for incorporating Life360 HOME concept into the waiver proposal to provide more intensive levels of intervention, care coordination, and linkages to community-based services for at-risk populations. The targeted populations for Life360 HOMEs have consistently experienced health disparities and profound social needs that serve as a barrier to improved outcomes. We are hopeful that there will be robust participation in the Life360 HOMEs by both providers and enrollees, and that the Life360 HOMEs will include evidenced-based interventions that have been shown to improve health outcomes.

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As waiver components continue to evolve from previous iterations and throughout the life of the waiver, we would urge regular compliance monitoring and rigorous state and federal evaluations that carefully assess results against stated objectives to inform both state and national awareness. Opportunities exist to learn from waiver strategies that are successful, as well as those that fall short of expectations or have unintended consequences.

The ACHI Health Policy Board encourages the Centers for Medicare and Medicaid Services to approve the state's waiver proposal request to continue Medicaid expansion coverage in Arkansas. Thank you again for the opportunity to provide comment on the ARHOME proposal.

Sincerely,

Annabelle Imber Tuck, JD
Chair, ACHI Health Policy Board

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*The statements expressed herein represent the collective observations and opinions of the ACHI Health Policy Board and should not be attributed to any individual board member in their personal or professional capacity.

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July 11, 2021

Ms. Elizabeth Pitman
Director
Division of Medical Services
Arkansas Department of Human Services
P.O. Box 1437, Slot S295
Little Rock, AR 72203-1437

Re: Application for Proposed ARHOME 1115 Demonstration Project

Dear Ms. Pitman:

Arkansas Community Organizations (ACO) and the Arkansas Community Institute (ACI) are two non-profit membership organizations of low-income Arkansans working for policies that improve the health of our communities through greater access to health care and through addressing social determinants of health such as unhealthy housing, harmful judicial policies and racial discrimination. Our organizations supported the Affordable Care Act (ACA) as a step forward in our work to win universal access to affordable, quality health coverage. During the first enrollment period some of our staff worked as navigators to help people enroll in health insurance through the Marketplace. We opposed the 2018 work requirements and assisted national press outlets in finding people harmed by this policy. We are strongly encouraging our members and communities to receive any of the COVID 19 vaccinations available.

We are writing to express our opposition to several provisions of the ARHOME 1115 demonstration project. The project proposes to increase the cost of health coverage and reduce retroactive coverage at a time when the number of COVID 19 cases, hospitalizations and deaths are on the rise and Arkansas state government has a budget surplus of nearly $1 billion. The rise in the Arkansas Works Qualified Health Plan (QHP) enrollment as a result of the pandemic should be something we welcome instead of a reason for capping the number of QHPs. The enrollment increase gives us the assurance that people who lost their jobs and hours of employment have the coverage they need during the pandemic at little or no cost to them.

ACO and ACI oppose the cut in retroactive eligibility from three months to one month. Although Arkansas's Medicaid expansion program has been in existence since 2013, there are still people who do not know about the program in part because the Arkansas legislature cut the health care navigator program and efforts to promote the program by state government. Our organization has been surveying people who have Medicai
d on their experiences with applying and renewing the program. In one rural county we have encountered people who were not aware that they could get health coverage through the program.

The three month retroactive period is especially helpful for new enrollees who have chronic conditions. One of the people we enrolled in the " private option" (as it was known during the first enrollment period) had tumors in her stomach and accumulated several medical bills from previous doctor's visits. The three months of retroactive coverage helped reduce her medical debt while getting the medical care she needed.

Medical debt is problem in Arkansas especially for communities of color as indicated by the Urban Institute's interactive debt map and our own study of household debt in Arkansas here. The three months retroactive eligibility could be very helpful in preventing an increase in the debt burdens experienced by many low-income households.

ACO and ACI oppose the increases in cost sharing and premiums in the ARHOME waiver proposal. Households at 138% of the federal poverty or below are low-income and well below the state median household income of $47,597. The goal of Medicaid is to provide health coverage to people who could not otherwise afford it.

Under the proposed waiver the insurance company would have the responsibility of collecting the increased premium. A person with an income of $13,000 per year is likely struggling to pay rent, utilities and other household costs. The increased premium would be burdensome for a person that already has difficulties paying for necessities such as food, clothing, heating in the winter and shelter. If someone does not pay one or more of the premiums, what actions would the insurance company take to collect it? Would the provider send the unpaid balance to a debt collection company which would likely cause the cost of the unpaid premiums to increase? We oppose charging any premiums for Medicaid funded health insurance for people with incomes between 100% and 138% of the poverty line.

We also oppose the cost sharing or co-pays in the proposed ARHOME waiver and especially the drop to 20% of the federal poverty line that would trigger the co-pays. The proposal would leave it up to the health care provider to collect the co-pay and allow the provider to deny future care due to non-payment. In our opinion it is wrong to impose cost sharing for needed health care and medicine on people who have very little income. Even if a provider continues to see patients if they cannot make the co-pay, the potential for significant medical debt exists.

We are opposed to the proposed ARHOME 1115 Demonstration Project and urge the Centers for Medicare and Medicaid Services to reject it..

Sincerely,

Neil Sealy

Neil Sealy on behalf of the Arkansas Community Organizations and Arkansas Community Institute
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American Lung Association.
Arkansas

July 12, 2021

Elizabeth Pitman
Director
Division of Medical Services
Donaghey Plaza
P.O. Box 1437
Little Rock, AR 72203

Re: ARHOME Section 1115 Demonstration Application

Dear Ms. Pitman:

The American Lung Association in Arkansas appreciates the opportunity to provide comments on Arkansas's Section 1115 Demonstration Application.

The American Lung Association is the oldest voluntary public health association in the United States, currently representing the 37 million Americans living with lung disease including asthma, lung cancer and COPD, including more than 530,000 Arkansas residents. The Lung Association is the leading organization working to save lives by improving lung health and preventing lung disease through research, education and advocacy.

The purpose of the Medicaid program is to provide healthcare coverage for low-income individuals and families, and the Lung Association is committed to ensuring that Arkansas's Medicaid program provides quality and affordable healthcare coverage. The Lung Association strongly supports Arkansas's continued commitment to Medicaid expansion. Reviews of more than 600 studies examining the impact of Medicaid expansion have found clear evidence that expansion is linked to increased access to coverage, improvements in many health indicators, and economic benefits for states and providers.[1] Research shows an association between Medicaid expansion and early stage cancer diagnosis, when cancer is often more treatable.[2] Medicaid expansion is also associated with a reduction in preventable hospitalizations, including for asthma and COPD.[3] Additionally, Medicaid expansion plays an important role in addressing health disparities — for example, one recent study found that states that expanded Medicaid under the ACA reduced racial disparities in timely treatment for cancer patients.[4] Clearly, Medicaid expansion is beneficial for patients with lung disease and other serious and chronic conditions.

Unfortunately, this proposal also includes several provisions that do not meet the objective to provide healthcare for low-income individuals. The Lung Association therefore offers the following comments on the ARHOME waiver.

<u>Retroactive Eligibility</u>
This proposal would continue to limit retroactive coverage to 30 days for the demonstration population. There are no exemptions, including for medically frail individuals. Retroactive eligibility in Medicaid

prevents gaps in coverage by typically covering individuals for up to 90 days prior to the month of application, assuming the individual is eligible for Medicaid coverage during that time frame. It is common that individuals are unaware they are eligible for Medicaid until a medical event or diagnosis occurs. Retroactive eligibility allows patients who have been diagnosed with a serious illness, such as lung cancer, to begin treatment without being burdened by medical debt prior to their official eligibility determination.

Medicaid paperwork can be burdensome and often confusing. A Medicaid enrollee may not have understood or received a notice of Medicaid renewal and only discovered the coverage lapse when picking up a prescription or going to see their doctor. Without retroactive eligibility, Medicaid enrollees could then face substantial costs at their doctor's office or pharmacy.

Health systems could also end up providing more uncompensated care. For example, when Ohio was considering a similar provision in 2016, a consulting firm advised the state that hospitals could accrue as much as $2.5 billion more in uncompensated care as a result of the waiver.[5] Increased uncompensated care costs are especially concerning as safety net hospitals and other providers continue to deal with the COVID-19 pandemic. Additionally, Arkansas currently has 11 rural hospitals that are vulnerable to closure.[6] Limiting retroactive coverage increases the financial hardships to rural hospitals that absorb uncompensated care costs. The Lung Association in Arkansas opposes the limitations on retroactive coverage for the demonstration population.

<u>Premiums and Cost-sharing</u>

Arkansas proposes to increase premiums for individuals with incomes at or above 100% of the federal poverty line. Premiums will likely discourage eligible people from enrolling in the program. For example, when Oregon implemented a premium in its Medicaid program, with a maximum premium of $20 per month, almost half of enrollees lost coverage.[7] Additional research on Michigan's Medicaid expansion program showed that modest increases of a few dollars in premiums resulted in disenrollment, especially among healthy individuals, from the program.[8] A gap in healthcare coverage could mean that a patient with lung cancer would have to pause treatment or someone with COPD might have to stop taking their medication, leading to an irreversible worsening of their condition.

The state is also requesting to impose copayments ranging from $5 to $20 on individuals with incomes at or above 21% of the federal poverty line ($225 per month for an individual). Research has shown that even relatively low levels of cost-sharing for low-income populations limit the use of necessary healthcare services.[9]

One of the copays included in the proposal is for non-emergency use of the emergency department. Patients should not be financially penalized for seeking help for any health problem. When people do experience severe symptoms, they should not try to self-diagnose their condition or worry that they cannot afford to seek care. Instead, they must have access to a quick diagnosis and treatment in an emergency department. A study of enrollees in Oregon's Medicaid program demonstrated that implementation of a copay on emergency services resulted in decreased utilization of such services but did not result in cost savings because of subsequent use of more intensive and expensive services.[10] This provides further evidence that copays may lead to inappropriate delays in needed care.

The Lung Association in Arkansas opposes the premiums and cost-sharing for the population covered under this demonstration.

Cap on Qualified Health Plan Enrollment

Arkansas is proposing to continue its model of using premium assistance to purchase coverage through qualified health plans (QHPs) on the state marketplace for most adults in the expansion population. The state is also seeking to cap monthly enrollment in these QHPs. The proposal would set a monthly maximum enrollment cap at no more than 80% of total expansion enrollment. Once the cap is reached, the state would suspend auto-assignment into QHPs for beneficiaries who do not choose a QHP and instead enroll those individuals in fee-for-service (FFS). However, beneficiaries that select a specific QHP would still be enrolled in that plan, regardless of the cap.

The Lung Association urges the state to explain how this proposal will not limit patients' access to care. The state has previously asserted that individuals enrolled in QHPs have better access to provider networks than counterparts enrolled in FFS. Additionally, the state is not proposing to expand the FFS provider network, but this proposal will likely increase enrollment in the FFS program. This means that both existing and new FFS enrollees could face long wait times to see providers. The state should also clarify how it will ensure that this proposal does not allow health plans to exclude individuals with more expensive health conditions.

QHP Incentive Programs

The state is proposing to allow QHPs to design "incentive programs" for enrollees, which could be related to health improvement or economic independence. 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.

The Lung Association is 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. For example, some health plans may choose to reduce costs for non-tobacco users under the guise of an incentive for tobacco cessation. However, research is clear that tobacco surcharges have not been proven effective in helping smokers quit and reducing tobacco use. Studies from Health Affairs[11] and the Center for Health and Economics Policy at the Institute for Public Health at Washington University[12] have suggested that tobacco surcharges do not increase tobacco cessation but do lead individuals to forgo health insurance rather than paying the surcharge. Tobacco users often have expensive comorbidities. Charging a tobacco surcharge could cause those enrollees to go without coverage and access to preventive care (including tobacco cessation treatment), allowing comorbid health conditions to worsen and ultimately resulting in more expensive healthcare.

The state is ambiguous with regard to QHP incentive programs and leaves broad authority to individual plans to implement such programs. Without clear definitions, health plans might implement wellness programs which allow plans to financially discriminate based on health condition. The Lung Association is also concerned that the conditions typically targeted by wellness programs often occur more frequently in older adults and fall disproportionately on women and some racial and ethnic groups, raising the potential for wellness programs to discriminate based on age and gender and to exacerbate racial health disparities.

The Lung Association in Arkansas has serious concerns about these wellness incentives. At a minimum, the state should clarify these provisions so that we can more fully comment on their implications.

Evaluation

The Lung Association is concerned that this proposal does not include an interim evaluation of Arkansas Works, the state's previous demonstration waiver. Therefore, there is no evaluation data on the state's experience with premiums, limitations on retroactive coverage, and other key provisions included in the current waiver application. This is highly problematic because the state is asking for comment on extending its current demonstration, and evidence from an interim evaluation would help our organization to fully comment on the current request.

Once again, the Lung Association in Arkansas thanks you for your commitment to continuing Medicaid expansion. We urge you to revise the application as outlined above to ensure that it meets the objectives of the Medicaid program. Thank you for the opportunity to provide comments.

Sincerely,

Shannon Baker
Director, Advocacy
American Lung Association in Arkansas

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[1] Madeline Guth and Meghana Ammula. "Building on the Evidence Base: Studies on the Effects of Medicaid Expansion, February 2020 to March 2021." May 6, 2021. Available at: https://www.kff.org/medicaid/report/building-on-the-evidence-base-studies-on-the-effects-of-medicaid-expansion-february-2020-to-march-2021/.

[2] Aparna Soni, Kosali Simon, John Cawley, Lindsay Sabik, "Effect of Medicaid Expansions of 2014 on Overall and Early-Stage Cancer Diagnoses", American Journal of Public Health 108, no. 2 (February 1, 2018): pp. 216-218. Available at http://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2017.304166.

[3] Hefei Wen Kenton J. Johnston, Lindsay Allen, and Theresa M Waters. "Medicaid Expansion Associated with Reductions in Preventable Hospitalizations." November 2019. Health Affairs. Doi 10.1377/hlthaff.2019.00483

[4] American Society of Clinical Oncology, "Racial Disparities in Access to Timely Cancer Treatment Nearly Eliminated in States with Medicaid Expansion." American Society of Clinical Oncology Annual Meeting. June 2, 2019. Access at: https://www.asco.org/about-asco/press-center/news-releases/racial-disparities-access-timely-cancer-treatment-nearly

[5] Virgil Dickson, "Ohio Medicaid waiver could cost hospitals $2.5 billion", Modern Healthcare, April 22, 2016. (http://www.modernhealthcare.com/article/20160422/NEWS/160429965)

[6] https://www.ivantageindex.com/wp-content/uploads/2020/02/CCRH_Vulnerability-Research_FiNAL-02.14.20.pdf

[7] Id.

[8] Cliff, B., et al. Adverse Selection in Medicaid: Evidence from Discontinuous Program Rules. NBER Working Paper No. 28762. National Bureau of Economic Research. May 2021. Accessed at: https://www.nber.org/system/files/working_papers/w28762/w28762.pdf.

[9] Samantha Artiga, Petry Ubri, and Julia Zur, "The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings," Kaiser Family Foundation, June 2017. Available at: https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/.

[10] Wallace NT, McConnell KJ, et al. How Effective Are Copayments in Reducing Expenditures for Low-Income Adult Medicaid Beneficiaries? Experience from the Oregon Health Plan. Health Serv Res. 2008 April; 43(2): 515–530.

[11] Friedman, A.S., Schpero, W. L., Busch, S.H. Evidence Suggests That The ACA's Tobacco Surcharges Reduced Insurance Take-Up and Did Not Increase Smoking Cessation. Health Aff 2016; 35:1176-1183. doi: 10.1377/hlthaff.2015.1540 accessed at: http://content.healthaffairs.org/content/35/7/1176.abstract

[12] Monti, D., Kusemchak, M., Politi, M., Policy Brief: The Effects of Smoking on Health Insurance Decisions Under the Affordable Care Act. Center for Health and Economics Policy Institute for Public Health at Washington University. July 2016. Accessed at: https://publichealth.wustl.edu/wp-content/uploads/2016/07/The-Effects-of-Smoking-on-Health-Insurance-Decisions-under-the-ACA.pdf

July 9, 2021

Cindy Gillespie, Secretary
Arkansas Department of Human Services
P.O. Box 1437, Slot S295,
Little Rock, AR 72203-1437

RE: Notice of Application for Proposed ARHOME Section 1115 Demonstration Project

Dear Secretary Gillespie:

Arkansas Advocates for Children and Families appreciates the opportunity to offer comments on the Arkansas Department of Human Services (DHS) notice of application for proposed "Arkansas Health and Opportunity for Me (ARHOME)" section 1115 demonstration project.

Arkansas Advocates for Children and Families (AACF) is a statewide, multi-issue non-profit, child and family policy research and advocacy organization. Our mission is to ensure that every child has the resources and opportunities they need to live healthy and productive lives and to realize their full potential.

Arkansas has been a national leader as an early adopter of Medicaid expansion under the Affordable Care Act to provide healthcare coverage to adults with no other source of coverage. Since 2014, thousands of families in Arkansas have gained access to otherwise unavailable healthcare coverage through Medicaid expansion. Once again, the state is choosing to continue these services for over 300,000 of our fellow Arkansans. While we support the state continuing to provide coverage to hundreds of thousands of Arkansans, we oppose the requests that will create barriers to care and put beneficiaries at risk, and we urge the state to remove these provisions from its proposal.

Premiums
Premiums create a barrier to coverage for individuals with low incomes. The proposal would continue imposing premiums on beneficiaries and requests to increase these premiums. The state acknowledges that premiums have the effect of deterring enrollment in the following statement from the proposal:

> "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 this population so any deterrent to enrollment is already occurring."

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.[1] Individuals not enrolling due to premiums does not mean that they somehow "value" insurance less; it likely means they cannot afford the premium.

Evidence from other states further highlights that premiums reduce enrollment and beneficiaries with low incomes struggle to make required payments. The Iowa Healthy Behaviors Interim Evaluation found that 52 percent of survey respondents (individuals who were disenrolled for failure to pay premiums) did not know that they owed a premium payment and 44 percent reported that they did not have enough money to pay.[2] Montana enrollees also struggled to pay monthly premiums; only 54 percent of enrollees subject to premiums with incomes above 100% FPL made their premium payments in June 2017.[3]

A recent working paper from the National Bureau of Economic Research on Michigan's Medicaid expansion showed healthier individuals were more likely to voluntarily disenroll from coverage due to premiums (those without chronic conditions and less medical spending), indicating that healthier beneficiaries were more sensitive to premium increases.[4] Given the body of research indicating the negative effects of premiums on coverage for beneficiaries with low-incomes, the state should not increase premiums nor should it continue imposing premiums on this population in general.

Copayments

Imposing copayments on individuals with incomes as low as 21% FPL will likely result in beneficiaries forgoing care. The KFF literature review on premiums and co-payments indicate even small copayments ($1-$5) decrease use of necessary care.[5] Indiana's evaluation of its "Healthy Indiana Plan" demonstration provides more evidence of copayments being a barrier to care. The evaluation showed that beneficiaries subject to copayments (parents and childless adults with incomes below 100% FPL) were less likely to use primary and preventative care services than individuals who were not subject to copayments -- the state

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[1] Samantha Artiga, Petry Ubri, and Julia Zur, "The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings," Kaiser Family Foundation, June 2017, https://files.kff.org/attachment/Issue-Brief-The-Effects-of-Premiums-and-Cost-Sharing-on-Low-Income-Populations.

[2] University of Iowa, "Healthy Behaviors Program Evaluation Interim Summative Report," April 2019, https://dhs.iowa.gov/sites/default/files/Healthy%20Behaviors%20Interim%20Evaluation.pdf?062620192054.

[3] The Urban Institute and Social & Scientific Systems, Inc., "Federal Evaluation: Montana Health and Economic Livelihood Partnership Plan," https://www.medicaid.gov/medicaid/downloads/mt-help-focus-group-site-visit-rpt.pdf.

[4] Betsy Q. Cliff, *et. al.*, "Adverse Selection in Medicaid: Evidence from Discontinuous Program Rules," National Bureau of Economic Research Working Paper Series, May 2021, https://www.nber.org/system/files/working_papers/w28762/w28762.pdf.

[5] Artiga, *et. al.*

expressed concern at the potential that copayments "are contributing to this difference."[6] Copayments also increase financial burdens on beneficiaries, especially those on the lower end of the income range.

The application says the providers will be allowed to deny beneficiaries for not paying copayments after the first occurrence of non-payment. 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.

Limit Retroactive Coverage

The proposed request to continue to limit retroactive coverage to 30 days puts beneficiaries and Arkansas providers at risk. Vulnerable Arkansans should be provided full 90-day retroactive coverage to reimburse for costs of medical services incurred for up to three months prior to applying for Medicaid coverage. Eliminating two months of retroactive coverage exposes beneficiaries to medical debt, increasing potential for financial harm.

Limiting retroactive coverage to 30 days leaves beneficiaries unprotected from medical bills that could be financially devastating. The state offers no exemptions from its waiver of retroactive coverage; this puts individuals with disabilities (who are not eligible for Medicaid under the aged, blind, or disabled group) or medically frail beneficiaries at the greatest financial risk as these groups tend to have higher medical costs.

Without retroactive coverage, costs of providing services in the two to three months prior to a beneficiary enrolling in coverage may become uncompensated care for providers. Thus, reducing the retroactive coverage period also hurts providers in Arkansas, especially hospitals. 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.

QHP Incentive Programs

The proposal would allow QHPs to offer beneficiaries incentives, such as waiving premiums, to participate in health or employment initiatives. The ARHOME demonstration proposal identifies two incentive programs QHPs may use: Health Improvement Initiatives and Economic Independence Initiatives. However, there is no description of what these incentives will be or how they will be monitored and evaluated to avoid adverse outcomes such as discrimination against beneficiaries who may be unable to participate in the incentive program. 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.

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[6] The Lewin Group, "Healthy Indiana Plan Interim Evaluation Report: Final for CMS Review," December 2019, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/in-healthy-indiana-plan-support-20-pa8.pdf#page=92.

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. AACF is extremely concerned about the following statements in the proposal implying a disparity between how those holding QHP insurance cards and those with Medicaid cards will be able to access care -- the impact will perhaps be even greater on those who are medically frail and have no option to participate in the QHPs:

- "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."

- "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."

- "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."

- "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."

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 payment 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.

Suspension of Auto-Assignment in QHPs/Reassignment of "Inactive" QHP Beneficiaries

The proposal requests to cap enrollment in QHPs by suspending auto-assignment when a maximum monthly enrollment is reached. Individuals who do not select a QHP once the cap is reached would be enrolled in FFS. The proposal also describes a process by which yet-to-be-defined "inactive" QHP beneficiaries will be reassigned to FFS. Given the comments we raised above on access in FFS, we have concerns about these proposals. 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.

Community Bridge Organizations
The proposed demonstration describes three models to be used to serve targeted populations among the total ARHOME beneficiaries: the Rural Life360 Home, the Success Life360 Home, and the Maternal Life360 Home, all of which are to be administered by Community Bridge Organizations (CBOs). The proposal states that only certain communities will be served by CBOs. The Maternal Life360 HOME home-visiting component presents an opportunity for the expansion of much needed home-visiting programs to a vulnerable population.

While we support the state's efforts to address critical health issues in the state through these Life360 Homes, we have questions about how these programs would be implemented.

- *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?*

Thank you for the opportunity to share our concerns with you as we look forward to engaging in further discussions about the AR HOME Medicaid Expansion Demonstration.

Sincerely,

[redacted]
Rich Huddleston, Executive Director
rhuddleston@aradvocates.org
501-343-3429

[redacted]
Loretta Alexander, Health Policy Director
lalexander@aradvocates.org
501-350-5086

Name: Dr. Paul Vellozo
Date: June 19, 2021
Comment: I OPPOSE the proposed restrictions (ARHOME) that will make it harder for poor people to access health insurance. Please stop trying to make poor people's life harder. Dr. Paul Vellozo

Name: Stephanie Pifer—ABHPAC—Arkansas Behavioral Health Planning and Advisory Council Vice Chair
Date: June 22, 2021
Comment: After the hearing yesterday the only thing I could think of that we may have issues with are the people, such as veterans, are the real "Get off My Lawn" sort of people. I know that I have a distrust of government entities myself and I can only imagine how a veteran feels. Even if you say you are "offering a service" that may say to someone "do this class or service or the court will make you." I suppose we can call this "service hesitancy." Thank you all for listening.

Name: Brandi Bland
Date: June 21, 2021
Comment: I am Brandi Bland, I am a board-certified patient advocate with VP medical consulting in Benton Arkansas, and I just wanted to comment on the Rural Life 360 Homes, and I think that is going to be very beneficial, especially in Saline County and in Garland County where I have worked with a very large number of underserved patients with mental illness disorders, primarily, and we have not had any acute crisis units or any services available to them, and especially with me, being a patient advocate trying to coordinate and offer them those additional resources that they need so I'm very excited about this about this program.

Name: Donna Morey—Arkansas Retired Teachers Association
Date: July 1, 2021
Comment: The Arkansas Retired Teachers Association support the expansion of ARHome. The cost and quality of care are much better if individuals can remain in their homes versus being confined to a nursing home. The patients, family members and friends all have a better quality of life being in familiar settings.
The State of Arkansas should develop skill training for individuals to become certified care givers. Again, individuals in communities near where the patients reside would be a huge savings both for the State and provide good jobs for individuals in many rural areas. The State should develop and maintain an accessible list of individuals who have completed a license as a caregiver. This should be by county and local communities. There should be a standard rate of pay for these caregivers plus mileage expenses for traveling to the residences which may be very remote.
We hope the federal government approves the changes but with the funds already approved a bulk of it should be to identify and train caregivers not to private company providers but at Community Colleges or Schools of nursing This is an opportunity for a win -win for Arkansans needing care and for local residents to be trained to provide that care while earning a living wage.

Dear Ms. Pitman,

The Arkansas Chapter of the American Academy of Pediatrics (ARAAP) is the state's membership organization for pediatricians, representing more than 440 members across Arkansas. On behalf of our members, ARAAP wishes to submit comments on the state's Proposed ARHOME Section 1115 Demonstration Project waiver. Our detailed comments will focus on the Maternal Life360 HOMEs' home visiting services, access to care, and the economic independence provisions of the waiver application. Our comments are rooted in our mission, "to attain optimal physical, mental, and social health and well-being for all children," by improving access to comprehensive health care and social supports that help children and their families thrive.

Broadly, we are supportive of the continuation of health care coverage for non-elderly adults, many of whom are parents or caregivers for the young patients our member pediatricians treat in their clinics and communities. When parents have coverage and access health care, their children do, too. We also generally support the innovative Life360 HOMEs that seek to address a variety of social determinants of health for Arkansas families, though questions remain about implementation details and the process for ensuring access to these across the state.

Maternal Life360 HOMEs. We strongly support this expansion of evidence-based home visiting by up to 5,000 slots to a targeted group of families in Arkansas. Home visiting programs across Arkansas benefit from incredible infrastructure provided by a statewide home visiting network that provides training and technical assistance, evaluation, guidance, start-up support, and ongoing quality improvement work to community-based programs. With support from public and private funding streams, home visiting already reaches children in every county. Evidence-based models currently serve children prenatal to age five. ARHOME's Maternal Life360 HOMEs should build upon and support that infrastructure as birthing hospitals establish programs for ARHOME recipients. The Arkansas Better Chance home visiting programs and Maternal Infant Early Childhood Home Visiting (MIECHV) partnership show the success of this model. **Maternal Life360 HOMEs can launch more effectively with centralized, experienced infrastructure that is not described in the waiver.**

To achieve the stated impacts of lowering infant mortality rates, home visiting programs must be made widely accessible and successfully managed. **Using evidence-based programs, as required in Act 530 of 2021 language, is the best way to ensure outcomes and operations align with program goals.** HomVEE lists programs we recommend exploring here: https://homvee.acf.hhs.gov/HRSA-Models-Eligible-MIECHV-Grantees. 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.

Lastly, enrollment must be nimble to meet the needs of the target population. 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. Some of the most vulnerable

pregnant women may not be enrolled in a Qualified Health Plan (QHP) but instead be enrolled in traditional/pregnancy Medicaid or the new PASSE options outlined in the waiver. Allowing women across all expansion coverage options or Pregnancy Medicaid to access the Maternal Life360 HOMEs would broaden the programs' reach and help achieve health outcome goals outlined in the waiver. It would also simplify eligibility from a consumer perspective.

Access to Care. More than half of children in Arkansas and many individuals with disabilities depend on Medicaid fee-for-service (FFS) coverage to ensure equitable their access to health care. This demonstration seeks to show that individuals with access to private QHP plans have equal or better access to care than individuals with Medicaid FFS access. We respectfully **request that the results of this evaluation be used broadly to ensure that Medicaid FFS rates provide equitable access to health care for all populations served by Arkansas Medicaid**, including pregnant women's Medicaid and ARKids First A and ARKids First B, as enrollees in these categories have no private option for coverage. We also support continued transparency about efforts to ensure that 19- and 20-year-olds are made aware of and have access to full EPSDT benefits in addition to the more limited QHP benefit packages.

Economic Independence Opportunities. We support efforts to help families move toward economic independence. However, the **premium increases and additional copayments outlined in the waiver will diminish access to care for individuals near or below the poverty line, many of whom are families with children.** Research demonstrates that premiums serve as a barrier to obtaining and maintaining Medicaid for those with low incomes. Premiums result in increases in disenrollment, shorter lengths of enrollment, and serve as a deterrent to those eligible from enrolling. A 2015 report shows that "families living in poverty, and particularly in deep poverty, have few resources available after they pay for the most basic necessities, even before other critical expenditures such as health care, childcare, and transportation are taken into account." It concludes that low-income individuals are particularly sensitive to modest or nominal increases in medical out-of-pocket costs, including premiums. This provision of charging premiums for low-income individuals, which has been shown to be a barrier to care, runs counter to the overall theme of this proposal, which is to help people who are living in poverty.

Thank you for the opportunity to submit comments. Arkansas pediatricians look forward to collaborating with Arkansas Medicaid and partners during the rule-development process and implementation of ARHOME.

Anna Strong, MPH, MPS
Executive Director
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https://arkansasaap.org/


The
American Academy
of Pediatrics
2020
Outstanding Chapter
Award
Medium Category
Arkansas Chapter

American Cancer Society
Cancer Action Network
6525 N Meridian Suite 110
Oklahoma City, OK 73116
www.fightcancer.org

July 12, 2021

Elizabeth Pitman
Director, Division of Medical Services
Donaghey Plaza
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Little Rock, AR 72203

Re: ARHOME Section 1115 Demonstration Waiver Renewal Request

Dear Director Pitman,

The American Cancer Society Cancer Action Network (ACS CAN) appreciates the opportunity to comment on Arkansas's proposal to renew and amend the state's 1115 demonstration waiver, renamed "Arkansas Health and Opportunity for Me (ARHOME). ACS CAN is making cancer a top priority for public officials and candidates at the federal, state, and local levels. ACS CAN empowers advocates across the country to make their voices heard and influence evidence-based public policy change, as well as legislative and regulatory solutions that will reduce the cancer burden. As the American Cancer Society's nonprofit, nonpartisan advocacy affiliate, ACS CAN is critical to the fight for a world without cancer.

ACS CAN supports the Arkansas Medicaid program goals of ensuring access to quality healthcare to members. However, the proposed cost sharing provisions could limit – rather than improve – access to care for some of the most vulnerable Arkansans, including those with cancer, cancer survivors, and those who will be diagnosed with the disease. We are also concerned about the reduced length of retroactive eligibility. We strongly urge the Division of Medical Services (or "the Division") to withdraw these provisions.

More than 17,980 Arkansas residents are expected to be diagnosed with cancer this year,[1] and there are more than 143,320 cancer survivors in the state[2] – many of whom rely on healthcare provided through the Medicaid program. ACS CAN wants to ensure that enrollees have adequate access and coverage under the Medicaid program, and that specific requirements do not create barriers to care for cancer patients, survivors, and those who will be diagnosed with cancer.

Following are our specific comments on Arkansas's 1115 waiver application:

Cost Sharing
We are concerned about the affordability of care for enrollees subject to premiums and/or copayments. Higher out-of-pocket costs decrease the likelihood that a lower income person would seek health care

[1] American Cancer Society. *Cancer Facts & Figures 2021*. Atlanta, GA: American Cancer Society; 2021.
[2] American Cancer Society. *Cancer Treatment & Survivorship Facts & Figures 2019-2021*. Atlanta, GA: American Cancer Society; 2019.

services, including preventive screenings.[3,4,5] Cancers that are found at an early stage through screening are less expensive to treat and lead to greater survival.[6] Uninsured and underinsured individuals already have lower screening rates resulting in a greater risk of being diagnosed at a later, more advanced stage of disease.[7] Proposals that place greater financial burden on the lowest income residents create barriers to care and could negatively impact Medicaid enrollees – particularly those individuals who are high service utilizers with complex medical conditions. Although enrollees determined to be Medically Frail are not subject to these cost sharing provisions, we are concerned that many cancer patients and survivors as well as others with complex and/or chronic health care needs will not be classified as Medically Frail, and therefore will be harmed by these policies.

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. Cancer patients in active treatment require many services shortly after diagnosis and thus incur a significant portion of cost sharing over a relatively short period of time.[8] It can be challenging for an individual – particularly an individual with limited means – to be able to afford their cost-sharing requirements. Likewise, a recent survivor may require frequent follow-up visits to prevent cancer recurrence. The seemingly nominal copayment amounts (e.g. $4.70 for an outpatient service, $9.40 for a non-preferred drug) could very quickly add up for a patient with multiple provider visits, treatments, and tests in a single week and represent high costs for households with very limited incomes.

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. Although the payment of premiums and copayments is not a condition of eligibility, allowing providers to deny service for failure to pay cost-sharing could result in individuals losing access to their care during cancer treatment. We strongly urge the Division to withdraw the proposals to require low-income individuals, including those earning just 21 percent FPL, to pay cost-sharing up to five percent of household income.

We note that qualified health plans (QHPs) can exclude some enrollees from cost sharing provisions "as a reward" for participation in "health improvement or economic independence initiatives". We support efforts to incentivize health improvement but are concerned that enrollees who are not able to engage in these initiatives (because, for example, they can't take time off work) are charged cost-sharing punitively. As discussed above, this can deter enrollees from seeking or receiving needed healthcare, like routine screenings, and may actually accomplish the opposite of the stated goal of 'health improvement.' Additionally, the Division states that the purpose of implementing this

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[3] Solanki G, Schauffler HH, Miller LS. The direct and indirect effects of cost-sharing on the use of preventive services. *Health Services Research.* 2000; 34: 1331-50.

[4] Wharam JF, Graves AJ, Landon BE, Zhang F, Soumerai SB, Ross-Degnan D. Two-year trends in colorectal cancer screening after switch to a high-deductible health plan. *Med Care.* 2011; 49: 865-71.

[5] Trivedi AN, Rakowsi W, Ayanian JA. Effect of cost sharing on screening mammography in Medicare health plans. *N Eng J Med.* 2008; 358: 375-83.

[6] American Cancer Society. *Cancer prevention & early detection facts & figures 2019-2020*. Atlanta: American Cancer Society; 2019.

[7] Ibid.

[8] American Cancer Society Cancer Action Network. *The costs of cancer: Addressing patient costs*. Washington, DC: American Cancer Society Cancer Action Network: 2017.

initiative is to "demonstrate that the individual values coverage as health insurance and values the health care professional who provided the medical service." We note that this stated goal is very different from the primary goal of the Medicaid program, which is to provide affordable health insurance coverage. We encourage the Division to withdraw this piece of their proposal as it runs counter to the purpose of Medicaid.

Surcharge for Non-emergent Use of the Emergency Department
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. Penalizing enrollees, such as cancer patients, by requiring a surcharge for non-emergent use of the ED could become a significant financial hardship for these low-income patients.

We urge the Division to eliminate this provision of the waiver. If the Division does move forward this proposal, it must define the term "non-emergency" use of the ED, as a definition is not included in the waiver proposal. We urge the Division to make this definition narrow and clear, so large numbers of enrollees do not get penalized for seeking needed medical care. Additionally, when evaluating ED cost sharing requirements, we urge the Division to evaluate the impact it has on patients with complex chronic conditions, such as cancer, as well as enrollees who have limited access to healthcare facilities outside of the ED.

Reduce retroactive coverage to 30 days
Medicaid currently allows retroactive coverage if: 1) an individual was unaware of his or her eligibility for coverage at the time a service was delivered; or 2) during the period prospective enrollees were preparing the required documentation and Medicaid enrollment application. Policies that would reduce or eliminate retroactive eligibility could place a substantial financial burden on enrollees and cause significant disruptions in care, particularly for individuals battling cancer. Therefore, we are concerned about the Division's request to reduce retroactive eligibility to 30 days from the allowed 90 days.

Many uninsured or underinsured individuals who are newly diagnosed with a chronic condition already do not receive recommended services and follow-up care because of cost.[9,10] In 2017, one in five uninsured adults went without care because of cost.[11] Reducing retroactive eligibility could mean even more people are unable to afford care and forgo necessary care due to cost.
Safety net hospitals and providers also rely on retroactive eligibility for reimbursement of provided services, allowing these facilities to keep the doors open. For example, the Emergency Medical Treatment

[9] Hadley J. Insurance coverage, medical care use, and short-term health changes following an unintentional injury or the onset of a chronic condition. *JAMA*. 2007; 297(10): 1073-84.
[10] Foutz J, Damico A, Squires E, Garfield R. The uninsured: A primer – Key facts about health insurance and the uninsured under the Affordable Care Act. *The Henry J Kaiser Family Foundation*. Published January 25, 2019. Accessed November 2019. https://www.kff.org/report-section/the-uninsured-a-primer-key-facts-about-health-insurance-and-the-uninsured-under-the-affordable-care-act-how-does-lack-of-insurance-affect-access-to-health-care/.
[11] The Henry J. Kaiser Family Foundation. Key facts about the uninsured population. Updated December 7, 2018. Accessed November 2019. https://www.kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/.

and Labor Act (EMTALA) requires hospitals to stabilize and treat individuals in their emergency room, regardless of their insurance status or ability to pay.[12] Retroactive eligibility allows hospitals to be reimbursed if the individual treated is eligible for Medicaid coverage. Likewise, Federally Qualified Health Centers (FQHCs) offer services to all persons, regardless of that person's ability to pay or insurance status.[13] Community health centers also play a large role in ensuring low-income individuals receive cancer screenings, helping to save the state of Arkansas from the high costs of later stage cancer diagnosis and treatment. Therefore, we urge the Department to consider these providers and their contribution to Arkansas's safety net, as well as the patients who rely on Medicaid for health care coverage, before reducing retroactive eligibility for Medicaid enrollees.

Community Engagement Activities

We appreciate that this demonstration does not include work and community engagement (WCE) requirements, but are concerned that the state will seek to amend the Demonstration if federal law or regulations permit the use of these requirements as a condition of eligibility in the future. ACS CAN opposes tying access to affordable health care for lower income persons to employment or community engagement requirements, because cancer patients and survivors – as well as those with other complex chronic conditions – could be seriously disadvantaged and find themselves without Medicaid coverage because they are physically unable to comply. The state's previous experience with WCE requirements - where uninsured rates were driven up and employment actually declined in the state after the requirement went into effect[14] - demonstrates the impact this policy can have on reducing health coverage and not meeting the state's goal of incentivizing employment and increasing the number of employed Arkansas Works enrollees.[15]

Many cancer patients in active treatment are often unable to work or require significant work modifications due to their treatment.[16,17,18] Research suggests that between 40 and 85 percent of cancer patients stop working while receiving cancer treatment, with absences from work ranging from 45 days to six months depending on the treatment.[19] Recent cancer survivors often require frequent follow-up

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[12] Centers for Medicare & Medicaid Services. Emergency medical treatment & labor act (EMTALA). Updated March 2012. Accessed October 2019. https://www.cms.gov/regulations-and-guidance/legislation/emtala/.

[13] National Association of Community Health Centers. Maine health center fact sheet. Published March 2017. Accessed November 2019. http://www.nachc.org/wp-content/uploads/2016/03/ME_17.pdf.

[14] Sommers BD, Chen L, Blendon RJ, et al. Medicaid Work Requirements In Arkansas: Two-Year Impacts On Coverage, Employment, And Affordability Of Care. *Health Affairs.* 2020. DOI: 10.1377/hlthaff.2020.00538

[15] Ibid.

[16] Whitney RL, Bell JF, Reed SC, Lash R, Bold RJ, Kim KK, et al. Predictors of financial difficulties and work modifications among cancer survivors in the United States. *J Cancer Surviv.* 2016; 10:241. doi: 10.1007/s11764-015-0470-y.

[17] de Boer AG, Taskila T, Tamminga SJ, et al. Interventions to enhance return to work for cancer patients. *Cochrane Database Syst Rev.* 2011; 16(2): CD007569. doi: 10.1002/14651858.CD007569.pub2.

[18] Stergiou-Kita M, Pritlove C, van Eerd D, Holness LD, Kirsh B, Duncan A, Jones J. The provision of workplace accommodations following cancer: survivor, provider, and employer perspectives. *J Cancer Surviv*. 2016; 10:480. doi:10.1007/s11764-015-0492-5.

[19] Ramsey SD, Blough DK, Kirchhoff AC, et al. Washington State Cancer Patients Found to be at Greater Risk for Bankruptcy then People Without a Cancer Diagnosis," Health Affairs, 32, no. 6, (2013): 1143-1152.

visits[20] and suffer from multiple comorbidities linked to their cancer treatments.[21,22] Cancer survivors are often unable to work or are limited in the amount or kind of work they can participate in because of health problems related to their cancer diagnosis.[23,24] If work and community engagement is required as a condition of eligibility, many newly diagnosed and recent cancer survivors, as well as those with other chronic illnesses could find that they are ineligible for the lifesaving care and treatment services provided through the state's Medicaid program. We also note that imposing work or community engagement requirements on lower income individuals as a condition of coverage could impede individuals' access to prevention and early detection care, including cancer screenings and diagnostic testing.

Conclusion

We appreciate the opportunity to provide comments on the Arkansas demonstration waiver extension. The preservation of eligibility, coverage, and access to Medicaid remains critically important for many low-income state residents who depend on the program for cancer and chronic disease prevention, early detection, diagnostic, and treatment services. We ask the Division to weigh the impact of these proposals on low-income Arkansans' access to lifesaving health care coverage, particularly those individuals with cancer, cancer survivors, and those who will be diagnosed with cancer during their lifetime.

Maintaining access to quality, affordable, accessible, and comprehensive health care coverage and services is a matter of life and survivorship for thousands of low-income cancer patients and survivors. We look forward to working with you to ensure that ensure that coverage through Arkansas Medicaid meets the health care needs of eligible individuals and families and reduces the burden of cancer for lower income Arkansans. If you have any questions, please feel free to contact me at matt.glanville@cancer.org or (405) 301.6311.

Sincerely,

[redacted]

Matt Glanville
Arkansas Government Relations Director
American Cancer Society Cancer Action Network

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[20] National Cancer Institute. *Coping with cancer: Survivorship, follow-up medical care*. Accessed October 2019. https://www.cancer.gov/about-cancer/coping/survivorship/follow-up-care.

[21] Mehta LS, Watson KE, Barac A, Beckie TM, Bittner V, Cruz-Flores S, et al. Cardiovascular disease and breast cancer: Where these entities intersect: A scientific statement from the American Heart Association. *Circulation*. 2018; 137(7): CIR.0000000000000556.

[22] Dowling E, Yabroff R, Mariotto A, et al. Burden of illness in adult survivors of childhood cancers: Findings from a population-based national sample. *Cancer.* 2010; 116:3712-21.

[23] Ibid.

[24] Guy GP Jr, Berkowitz Z, Ekwueme DU, Rim SH, Yabroff R. Annual economic burden of productivity losses among adult survivors of childhood cancers. *Pediatrics*. 2016; 138(s1):e20154268; Zheng Z, Yabroff KR, Guy GP Jr, et al. Annual medical expenditures and productivity loss among colorectal, female breast, and prostate cancer survivors in the United States. *JNCI J Natl Cancer Inst.* 2016; 108(5):djv382; and Kent EE, Davidoff A, de Moor JS, et al. Impact of sociodemographic characteristics on underemployment in a longitudinal, nationally representative study of cancer survivors: Evidence for the importance of gender and marital status. *J Psychosoc Oncol*. 2018; 36(3):287-303.

Arkansas Children's
HOSPITALS · RESEARCH · FOUNDATION

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July 9, 2021

Arkansas Children's Response to Request for Public Comment for
Arkansas Health and Opportunity for Me (ARHOME Program)

To: DHS Office of Rule Promulgation
ORP@dhs.arkansas.gov

Arkansas Children's is encouraged by the continuation of coverage for low-income adults through the proposed ARHOME program. Health care coverage for adults positively impacts children's health. Over the years, Arkansas Children's has consistently supported coverage expansion, and the proposed ARHOME program particularly resonates with our organization due to the emphasis on improving maternal and infant health by increasing evidence-based home visiting through Maternal Life 360 HOMEs. Quality home visiting services reduce costly problems, including low-weight births, emergency room visits, and children in the social welfare, mental health, and juvenile justice corrections systems. Home visiting yields powerful short and long-term effects for the families who participate.

As a longtime supporter and contributor to home visiting, Arkansas Children's houses the Arkansas Home Visiting Network (AHVN). The AHVN is a collaborative effort with state agencies, private donors, federal funders, and local implementing agencies to develop, expand, evaluate, and provide leadership to home visiting services throughout our state.

The AHVN facilitates activities among its members to raise public awareness, expand and sustain home visiting services, provide supplemental training, collect and share data, and to share relevant policy and research information. The AHVN currently supports Arkansas children and families through 9 different home visiting models:

- Arkansas Early Head Start
- Family Connects Union County
- Following Baby Back Home
- Healthy Families America
- HIPPY Arkansas
- Nurse-Family Partnership
- Parents as Teachers
- SafeCare Arkansas

Each model serves families prenatally until their children reach kindergarten and is managed by a State Model Lead who is housed at the AHVN. The State Model Lead is responsible for ensuring home visiting sites are in compliance with guidelines established by all funding sources. This goal is achieved by providing technical training on model fidelity requirements, helping

sites solve complex challenges involved with program implementation and recruitment, and financial guidance when appropriate. Model specific training is completed regionally, and all home visiting programs across the state have access to a free annual AHVN Training Conference, annual Winter Institute, and the annual AHVN Leadership Retreat.

The AHVN also provides consultation and technical assistance for new and existing home visiting programs/models in the following areas:

- Continuous Quality Improvement: statewide infrastructure, local program technical assistance, improvement of the continuum of care
- Organizational, Infrastructure, and Leadership Development
- Comprehensive and ongoing training aligned with the key benchmarks established nationally for effective home visitors.
- Ages and Stages Questionnaire (ASQ) Developmental Screening Training (All State Leads & AHVN Trainers are nationally certified ASQ Trainers)
- Disseminate information to each home visiting site directly about new information from our national networks and models
- Directly communicate to all home visiting models across the state through social media such as Facebook, Instagram, Twitter, Pinterest, and YouTube.

Though not a birthing hospital, as an organization firmly invested in home visiting, Arkansas Children's looks forward to working closely with the Department of Human Services and hospitals to use the already established infrastructure of the AHVN to bring high quality home-visiting services to more families across Arkansas through the ARHOME program.

Sincerely,

[redacted]

Brent Thompson
Executive Vice President
Chief Legal Officer

UNITE US

July 12, 2021

Submitted via*: ORP@dhs.arkansas.gov*

Ms. Elizabeth Pitman
Director, Division of Medical Services
Arkansas Department of Human Services
Division of Medical Services
P.O. Box 1437, Slot S295,
Little Rock, AR 72203-1437

Re: Application for Proposed ARHOME 1115 Demonstration Project

Dear Director Pitman:

Thank you for the opportunity to provide input and recommendations on the State of Arkansas' application for the Proposed ARHOME 1115 Demonstration Project.

Founded in 2013, Unite Us is a technology company that provides an end-to-end solution to connect health and social care. Our goal is to ensure every individual, no matter who they are or where they live, can access the critical services they need to live healthy and productive lives.

Through our products and community-centered approach, Unite Us seeks to increase equitable access to health and social services, address the fragmentation of services that makes our health and social systems challenging to navigate, and confront institutionalized barriers to equity such as poverty, racism, and discrimination. Our diverse range of stakeholders include community based organizations, health plans, health systems, hospitals, and government entities.

Unite Us has successfully built and scaled coordinated care networks in 42 states across the country, with numerous state and local government partnerships such as with North Carolina's Department of Health and Human Services, Virginia's Department of Health, Governor Sununu's Office in New Hampshire, Rhode Island's Executive Office of Health and Human Services, Louisiana's Department of Children and Family Services and others.

ARHOME's Life360 HOME Model

Unites Us commends the Department of Human Services (DHS) for developing a statewide strategy to address social determinants of health for ARHOME enrollees. The proposed Life360 HOME program not only introduces enhanced care coordination as a new benefit, but also provides communities with the investments necessary to build capacity. The State's proposed use of the Community Bridge Organization (CBO) concept to target at-risk populations and offer intensive levels of intervention to address their social needs offers great promise, and demonstrates the State's important understanding that to deliver comprehensive **whole-person**

care requires broadening the traditional model of care coordination to include addressing the social needs of individuals.

Unite Us supports the State's **broad definition of care coordination** which emphasizes: a) screening and assessing needs for SDOH supports, and b) the development of a person-centered support plan to set the socioeconomic goals to be achieved, including the coordination between medical and nonmedical providers. We also support the State's desire to expand the traditional care coordination model to include the use of peer specialists, peer counselors, and 'community coaches' who can work directly with individuals and their families. Connections to social determinants of health interventions through community partners like these are critical to keeping people healthy.

The State's proposed **community-level investments** that cover start-up costs and ongoing monthly payments for community services will promote program sustainability over the long run. Paired with supportive Infrastructure like a shared technology platform, community anchors (hospitals) and social services providers will be able to collaborate efficiently and effectively over time.

We recommend that the state consider adopting **a scalable technology solution** that would enable collaboration and care coordination across health and human service sectors by supporting the ability to: (a) send and receive electronic referral, (b) seamlessly communicate in real-time, (c) securely share client information, and (d) track outcomes -- a solution that would not only support local implementations of the Life360 HOME Model but that could also work at scale and help facilitate a statewide implementation.

The Unite Us Platform currently serves as foundational, multi-sector, community-embedded infrastructure in over 42 states. The web-based technology platform not only allows previously siloed partners to collaborate and coordinate care, but also provides communities with the ability to:

- **Identify needs,** through our dynamic data-powered toolkit that proactively identifies individuals social care needs;
- **Enroll in services,** through referral tracking and completion, accountable care coordination, social needs screenings, and self-referral assistance request fulfillment;
- **Serve the individual,** through our community-wide and web-based platform that connects health, human and social service providers on a single network;
- **Measure network impact,** with real-time social care data analytics that empower local decision makers with key insights; and
- **Invest in social care,** through a comprehensive solution that enables social care funding and payment for specific interventions at scale.

Unite Us also has **broad experience working with state governments** and local health systems in building community driven care coordination networks. For example, in North Carolina, Unite Us supported the development of NCCARE360, a statewide system to coordinate whole-person care uniting traditional healthcare settings and organizations that address social determinants of health, such as food, housing, transportation, employment, and interpersonal safety. In North Carolina, Unite Us helps providers electronically connect those with identified needs to community resources and allows for feedback and follow-up at scale across the state.

Hospitals as 'Anchor' Organization in the LIfe360 HOME model.

Unite Us supports Arkansas' vision of placing **hospitals as anchor institutions** ("HOMEs") within its three (3) Life360 HOME Models (Rural, Maternal, and Success). Hospitals are a trusted community resource with strong financial accountability that can be incentivized to lead community-focused implementation of new programs. Hospitals are also the population health experts of their communities, who can leverage their existing infrastructure, including data systems, to support successful program implementations, which is particularly important in rural communities.

Unite Us has **extensive experience enabling hospital care teams** to more deeply partner with community and social care organizations that are able to fulfill non-healthcare needs in their communities. Unite Us' suite of interfaces and integration tools connect health and social care applications and empower communities with more seamless connectivity across platforms, leading to deeper connections and integrated referral workflows with community and social care providers.

Unite Us' use of a **Master Person Index (MPI)** enables identity resolution across multiple domains and systems to ensure that the person in question is the same patient, client, or member in different settings. MPIs support the creation of a single and complete record of care, minimizing the need for a client to retell their story and facilitating more seamless and comprehensive care management.

Unite Us' Interoperability team partners with EHR providers like Epic on advancing a vision for robust standards-based exchange for deeper workflow integration for whole-person care teams and creation of comprehensive health and social history for clients.

Qualified Health Plans and Life360 HOME

We support the State's efforts to impose **greater accountability on participating QHPs,** including holding them responsible for the broad standards included in the Medicaid Core Set of Adult Health Care Quality Measures. Strategies like tying QHP incentives and sanctions to these performance metrics, and encouraging the use of individual member incentive programs to reward participation in health improvement or economic independence initiatives, can certainly facilitate improved population health.

QHPs are well-positioned to ensure the successful implementation of the Life360 program. We encourage the State to provide them with clear guidance on how to offer this support. For example, QHPs can play an important role in incentivizing the engagement of other outpatient network providers such as PCPs, Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHC). Additional ways the Life360 HOME programs can be scaled with greater QHP support and involvement include:

QHP Community Investment: We commend the State for encouraging greater QHP support of the communities their members reside in to address quality of care. For example, the proposed ARHOME amendment allowing QHPs to direct up to 1% of premium revenues towards activities

that improve healthcare quality can be an impactful way of providing added support as communities build the networks and infrastructure needed to support Life360 programs.

Incorporating Life360 Into Value Based Payment Models: Health plans are increasingly incorporating access to social determinants of health and related social services in contracting efforts to help them meet quality of care benchmarks. The State could require QHPs to incorporate Life360 program participation among the VBP goals that QHPs set for contracted network providers.

QHP Member Communication: QHPs can leverage their considerable resources to promote Life360 HOME program participation as part of ongoing member engagement efforts. This may include some of the new 'direct-to-consumer' strategies health plans are using such as chat/app features, and virtual medical visits.

State Investment in SDOH and Capacity Building

Sustainable funding streams, like the one that the State is proposing via the Life360 HOME model, build capacity for community-based organizations, social services, and the local workforce. They also sustain equity strategies and enable long-term resilience especially in rural communities. In the health and social sector, local organizations have traditionally been tied to time-limited grant funding and often operate at a deficit, impacting both the service and resource quality, as well as workforce burnout and supply.

To facilitate sustainable improvements in our system of health and social services, **Unite Us has developed a Payments product specifically to enable funding entities to pay for social care at scale**, providing needed resources for organizational and workforce capacity building, and elevating the importance and value of community-based care. Tools like these, which track and invoice social care services for reimbursement, allow states to optimize Medicaid waiver services that address the social determinants of health and even offer the ability to braid multiple funding streams to deliver integrated and coordinated care.

Supporting Rural Communities

Unite Us works closely with rural community partners in all 42 states we currently operate in. We support Arkansas' view that health equity issues tied to rural areas are driven by complex and interconnected social, behavioral and structural factors that cannot be resolved by enhancing access to healthcare services alone. Our local community engagement teams partner with organizations and coalitions to do innovative work in rural communities. Some of the most common rural inequities we come across include lack of access to broadband and transportation services. Examples of our work in rural communities include:

- Our statewide network in North Carolina covers a geographic area that is **80% rural.** In the eight-county area surrounding Chowan, which has a population of less than 150,000 people, our team adjusted our engagement strategy to understand the community's distinct needs and brought together 50+ organizations connecting residents to resources.
- Our Unite West Virginia network includes **rural counties in the Appalachian Mountains** and the Eastern Panhandle, with one county having a total population of 8,500. To reach the most

rural individuals, we teamed up with Family Resource Networks, a local and trusted non-profit, and onboarded community-based providers.

- Our rural upstate New York network includes a partnership with ADK Wellness Connections network and Cornerstone Mobile Counseling, which operates an innovative mobile counseling program to address significant mental health gaps across the 24 county region. Providing at-home services, the program enables clients to have their needs met without having to travel or find an office with availability.

Access to Behavioral Health and Substance Use Disorder Services

Unite Us commends the State for focusing on improving access to behavioral health and substance use disorder services as part of their ARHOME program. We recognize that individuals with substance use disorders are often stigmatized and reluctant to seek services, compounding negative impacts on their health and quality of life. We know that an effective recovery support system cannot exist without a robust network of community partners and the infrastructure in place to support personalized, coordinated care. In our experience, the following elements have proven critical to success:

- Maintaining client dignity and privacy by utilizing protected viewing permissions that ensure 42 CFR Part 2 compliance and that only those providing substance use services to the client can see the details of their care history.
- Addressing substance use holistically by hosting a diverse range of organizations and programs that meet clients where they are. Programs and providers may include harm reduction agencies, outpatient clinics, inpatient treatment programs, needle exchange programs, overdose prevention classes, and group support.
- Developing individualized treatment plans that reflect a client's personal journey and incorporate clinical care and wraparound services such as vocational training, housing, counseling, and education.
- Connecting clients to mental and behavioral health services and coordinating with specialists who can address any psychological and/or emotional concerns.
- Promoting the use of evidence-based and evidence-informed programs like Medication-Assisted Treatment (MAT) and peer recovery support services.
- Strengthening community capacity building through outcome data that can identify co-occurring service gaps, such as a lack of hospital beds or limited food security resources in specific geographies.

Addressing Maternal Health and High Risk Pregnancies

We support ARHOME's community-driven approach to addressing maternal health and high risk pregnancies will have a significant impact in improving the State's maternal health indicators which are presently among the lowest in the country. The Maternal Life360 model, which incentivizes partnerships between birthing hospitals, community partners experienced in home visitation (e.g. Early Head Start), and QHPs will ensure support to women in their own homes during pregnancy and up to two years after the child is born.

Unite Us has extensive experience reducing disparities in maternal and early childhood health in communities we serve. We work with community-based organizations, health systems, and government partners to ensure all women, particularly those at risk of poor health outcomes, have a chance at a safe and healthy life. Our shared, community-wide infrastructure creates an ecosystem that allows health, human, and social service providers to:

- **Increase access to high-quality, clinical care** for mothers and their children, through credible social service partners in the community.
- **Address the social determinants of health** before health concerns arise, by linking pregnant women and mothers of young children to food, transportation, employment, and other social service providers.
- **Strengthen collaborations between clinical and social providers** by giving clinicians the tools they need to quickly and seamlessly refer high-risk patients to the non-clinical resources they need.
- **Leverage evidence-informed interventions** such as home visitation programs, breastfeeding support by lactation consultants, smoking cessation programming, prenatal care providers, and more.
- **Empower novel interventions** that address the unique needs of Black and Indigenous mothers and babies and inform new evidence-based practices.
- **Collaborate with public health departments** to support place-based advocacy and programming for more equitable access to care for underserved populations.
- **Share data** that may reveal insights around community-level inequities and lay the groundwork for the reallocation of investments.

Our success in facilitating community-wide maternal and child health programs are exemplified in Florida, where Unite Us partners with the First 1,000 Days of Sarasota, a community-based, multi-sector initiative supported by Sarasota Memorial Hospital to address maternal and child health inequities through an any-door approach to coordinate wraparound services through a single touchpoint. Schools, healthcare providers, food pantries, and other organizations serving families anywhere in the network may screen and connect families to multiple community resources, addressing whole person care for all family members. Concurrently, the platform allows stakeholders to understand the full range of needs experienced by this population.

Community Participation and Shared Governance

Unite Us recommends that ARHOME **integrate community participation into program implementation**, ensuring that local leaders are key actors guiding the decisions that ultimately affect their own communities. Strategies may include conducting community discovery sessions, key informant interviews, and developing shared advisory structures that allow for meaningful, on-going engagement. In our most mature networks, Unite Us introduces Community Network Advisory Boards (CNABs) that provide a **centralized workstream for collecting and disseminating network stakeholder feedback** and recommendations. CNABs are community-led, consisting of users and participants of Unite Us networks and offerings. The goals of a CNAB are to discuss community workflow challenges and solutions, and ensure local users are satisfied with their experience day-to-day. Government agencies may think of CNABs as similar to Patient Advisory Boards that are made up of patients and their families to provide feedback to administrations based on firsthand experience. Importantly, CNABs create a space

where network stakeholders are heard and coalesce around a collective sense of ownership and shared responsibility.

In Oregon, for example, Unite Us' local community engagement team established regional CNABs, composed of local organizations and community champions whose on-the-ground expertise informs and guides the priorities of the Connect Oregon statewide network. These regional advisory boards ultimately feed into and inform the statewide advisory board, which brings together community leaders across the state and ensures alignment around network decision-making. The Unite Us Oregon team has been working with CNAB members to prioritize five collective service and resource areas for the network, such as Early Childhood, WIC Services, Chronic Disease and Self Management Services, Spinal Injury Awareness, Housing and Utilities Assistance. Community leadership and investment in this form promotes sustainability and maximizes opportunity for longer-term impact across the care network.

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If you have any questions or if there is any additional information Unite Us can provide, please feel free to contact me at socrates.aguayo@uniteus.com.

Sincerely,

/s/ Socrates Aguayo

Socrates Aguayo
Policy Director
socrates.aguayo@uniteus.com

ARKANSAS HOSPITAL ASSOCIATION

July 12, 2021

Ms. Cindy Gillespie
Secretary
Arkansas Department of Human Services
PO Box 1437, S-295
Little Rock, AR 72203-1437

Ms. Elizabeth Pitman
Director
Arkansas Medicaid
PO Box 1437, S-295
Little Rock, AR 72203-1437

Submitted electronically to ORP@dhs.arkansas.gov

RE: **Arkansas's Medicaid Expansion (ARHOME), Section 1115 Waiver Application**

Dear Secretary Gillespie:

The Arkansas Hospital Association (AHA) is a membership organization that proudly represents more than one hundred health care facilities and their more than 50,000 employees as they strive to care for all Arkansans. The Association works to support, safeguard, and assist our members in providing safe, high-quality, patient-centered care in a rapidly evolving – and highly regulated – health care environment. The AHA sincerely appreciates the opportunity to comment on the section 1115 demonstration waiver application for Medicaid Expansion – called Arkansas Health and Opportunity for Me (ARHOME) – as proposed by the Arkansas Department of Human Services under the requirements of 42 CFR part 431 subpart G and the application procedures under 42 CFR 431.412(a).

Further, the AHA applauds the outstanding efforts of Governor Asa Hutchinson, your leadership team at the Department of Human Services, the 93rd General Assembly of the Arkansas Legislature, and the long list of stakeholders who worked collaboratively to ensure that Arkansans under 138 percent of the federal poverty level remain eligible to access Arkansas's health care system.

Access to Care

Since Arkansas's 2013 implementation of the Arkansas Health Care Independence Program, known as the Arkansas Private Option, Arkansas has provided premium assistance to support the purchase of coverage from Qualified Health Plans (QHPs) offered in the individual market through the Marketplace by beneficiaries eligible under the expanded adult group described at Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act, which were both (1) childless adults ages 19 through 64 with incomes at or below 138 percent of the federal poverty level (FPL) or (2) parents and other caretakers between the ages of 19 through 64 with incomes between 17 percent and 138 percent of the FPL. The Arkansas Private Option and each subsequent iteration of the program met or exceeded the objectives in Title XIX of promoting continuity of coverage for individuals, improving access to providers, enhancing the continuum of coverage, and furthering quality improvement and delivery system reform initiatives.

Specifically, a Kaiser Family Foundation study found that Arkansas's uninsured rate among non-elderly adults dropped from 27.5 percent to 15.6 percent between 2013 and 2014, which correlated to a 55 percent drop in uncompensated care in Arkansas's hospitals and expanded access to care in community-based settings and specialty care for beneficiaries.[1]

Because of the premium assistance model, Arkansas's adult Medicaid Expansion population has not fallen prey to the practices of Medicaid Managed Care companies that limit a patient's access to care by rationing patient services or limiting network providers either through reimbursement rates that do not cover the cost of care or that increase the cost of care delivery due to inefficient administrative processes. Likewise, the premium assistance model has proven much more favorable to providers than traditional Medicaid rates, as Arkansas Medicaid hospital *per diem* inpatient rates have remained stagnant for more than 20 years and hospital fee-for-service outpatient rates were last cut in 1992 and never restored.

Therefore, the AHA enthusiastically supports ARHOME's proposal for the continuation of Qualified Health Plan coverage for Arkansas's Expanded adult population under the premium assistance model.

Onboarding and Ensuring Coverage

Medicaid eligibility is determined by the Department of Human Services in accordance with federal and state laws and regulations. The eligibility determination for Medicaid must remain a distinct process from qualified health plan enrollment or PASSE managed care plan enrollment. Currently, upon being determined Medicaid eligible under the new adult group, all beneficiaries begin their coverage in Medicaid fee for service.

Because the Medicaid eligibility determination is the sole responsibility of DHS, AHA requests that DHS implement the federal requirement for presumptive eligibility detailed in 42 CFR 435.1110. As an alternative, the AHA respectfully requests that DHS reinstitute 90-day retroactive eligibility, which was originally in place as a waiver from presumptive eligibility in the 2013 demonstration waiver. The current demonstration limits retroactive coverage to 30 days prior to the date of application.

[1] https://www.kff.org/medicaid/issue-brief/a-look-at-the-private-option-in-arkansas/

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.

Streamlining Enrollment and the Member Experience

Once DHS determines a new adult group applicant eligible for Medicaid, individuals who identify themselves as "medically frail" or are subsequently identified as medically frail remain in fee-for-service for their coverage, but individuals who are not medically frail are covered by fee-for-service for a temporary period of time before enrollment into a qualified health plan.

The ARHOME waiver application further seeks to administratively move beneficiaries among fee-for-service Medicaid (even if not determined medically frail), qualified health plans, and the Provider-Led Arkansas Shared Savings Entity (PASSE) managed care plans. While the AHA applauds the Department of Human Services for seeking stakeholder input prior to implementation of this reassignment and assures that this reassignment process will not occur prior to 2023 and not without approval sought through the state rule-making process, continuity of care is at significant risk.

We are concerned that the proposed cost-sharing increases could cause individuals to drop Medicaid coverage, and we disagree with the premise that premiums are necessary to "assess whether individuals value coverage as insurance." Medicaid's primary purpose is to provide access to health care services for low-income individuals, and it is unlikely that reductions in participation due to increased cost-sharing reflect individuals devaluing coverage, rather than the necessity of making painful economic choices among competing priorities. The AHA does appreciate that there is no proposed cost-sharing for inpatient hospital stays, which could have caused adverse effects such as avoidance of addressing serious medical issues.

Similarly, 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.[2] 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.

[2] https://www.startribune.com/disparities-dog-system-to-distribute-disability-services/563636552/

The application is also silent on the periodicity of coverage for beneficiaries. In keeping with the goal of acclimating individuals with insurance, once a beneficiary is assigned into a qualified health plan, a beneficiary should remain in that plan for a full 12 months to ensure continuity of care and proper evaluation of the plan's quality improvement performance. In addition, an efficient and beneficiary-friendly appeals process must be created to allow a beneficiary who was reassigned into a plan to select the coverage best suited to that beneficiary.

Safeguards to Ensure Continuity of Care

The demonstration waiver application states that churn describes movement of individuals on and off the Medicaid program within a single year and over multiple years. Since March 11, 2020, when the national public health emergency was declared, the churn in the Medicaid program has been minimal, in accordance with federal laws and regulations. Prior to that time, however, beneficiaries were highly susceptible to losing coverage in a number of ways unrelated to their eligibility for Medicaid, such as disenrollment due to returned mail – sometimes due to participants not notifying the state of a move and other times due to problems with the State's records despite a participant reporting a change of address.[3] The State's previous experience with work requirements also highlighted the unexpected difficulties that administrative barriers, such as various required reporting, can pose to Medicaid participants, causing many to lose coverage despite continued eligibility.[4]

While a number of required member notices are referenced in the demonstration waiver application, we strongly urge DHS to handle these notices carefully to minimize the risk of participants being inappropriately reassigned to fee-for-service or disenrolled despite continued eligibility. Specifically, we 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.

While outside the scope of comments on this proposed rule, we urge DHS to also use these strategies, as well as *ex parte* renewals that take advantage of all useful data sources to automate renewals, consistent with 42 CFR § 435.916, to avoid administrative disenrollments during the mass redeterminations following the end of the federal Public Health Emergency.

[3] https://files.kff.org/attachment/Issue-Brief-Recent-Medicaid-CHIP-Enrollment-Declines-and-Barriers-to-Maintaining-Coverage

[4] https://www.healthaffairs.org/do/10.1377/hblog20180904.979085/full/

Improving Social Determinants of Health

Arkansas hospitals are not only the backbone of the Arkansas health care system through the delivery of emergency services, inpatient care, and outpatient care, hospitals are also already key components to the health of the communities where they serve. Hospitals fully recognize the importance of social, environmental, and behavioral factors as well as genetic and health care factors that impact a person's health. Arkansas also recognizes that CMS has not typically allowed non-medical services to be reimbursed through Medicaid; therefore, the AHA applauds DHS for seeking funding for hospitals that volunteer to serve as entities – what the waiver defines as Community Bridge Organizations or Life360 Homes – to identify and connect beneficiaries to social services, including integrating these services into their care delivery models, encouraging partnerships with community-based organizations, tracking social needs, and incentivizing a more holistic approach.

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.

Evaluation of Life360 HOMEs

We appreciate DHS considering many possible distal outcomes that may be addressable with the Life360 HOMEmodel but are concerned about both the attributability of some the SDOH-related Domain 2 measures and the overall methodological approach. Without specific expected Life360 HOMEactivities, 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.[5] For the other Domain 2 measures, difference-in-difference 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.

The Arkansas Hospital Association and its members are offering these comments in a spirit of collaboration with the goal of successful and timely implementation of these new regulations by DHS, and we stand ready to work with the Department and other stakeholders to address the issues raised in our letter and to ensure the program's overall success for Arkansas's hospitals and, most importantly, the patients and families that our hospitals are so honored to serve.

Bo Ryall
President & CEO, Arkansas Hospital Association

[5] https://www.bls.gov/news.release/wkyeng.t03.htm

CYSTIC FIBROSIS FOUNDATION®

July 8, 2021

Elizabeth Pitman
Director
Division of Medical Services
Donaghey Plaza
P.O. Box 1437
Little Rock, AR 72203

Re: ARHOME Section 1115 Demonstration Application

Dear Ms. Pitman,

Thank you for the opportunity to comment on Arkansas's Section 1115 Demonstration Application. On behalf of people with cystic fibrosis (CF) living in Arkansas, we write to express our serious concerns with this waiver application. We oppose the state's proposal to limit retroactive eligibility and increase premiums. We fear these policies will jeopardize patient access to quality and affordable healthcare and therefore urge that Arkansas revise its waiver application to remove these harmful provisions.

Cystic fibrosis is a life-threatening genetic disease that affects more than 30,000 people in the United States, including about 300 in Arkansas. Roughly a third of adults living with CF in the state rely on Medicaid for some or all of their health care coverage. CF causes the body to produce thick, sticky mucus that clogs the lungs and digestive system, which can lead to life-threatening infections. As a complex, multi-system condition, CF requires targeted, specialized treatment and medications. If left untreated, infections and exacerbations caused by CF can result in irreversible lung damage and the associated symptoms of CF lead to early death, usually by respiratory failure.

Unfortunately, this proposal includes several provisions that do not meet the objective to provide accessible and affordable healthcare for people with CF. Therefore, the Cystic Fibrosis Foundation offers the following comments on the ARHOME waiver.

Retroactive Eligibility
This proposal would continue to limit retroactive coverage to 30 days for the Medicaid expansion population. There are no exemptions, including for medically frail individuals. Retroactive eligibility in Medicaid prevents gaps in coverage by typically covering individuals for up to 90 days prior to the month of application, assuming the individual is eligible for Medicaid coverage during that time frame. It is common that individuals are unaware they are eligible for Medicaid until a medical event or diagnosis occurs. Retroactive eligibility allows patients who have been diagnosed with a serious illness, such as cystic fibrosis, to begin treatment without being burdened by medical debt prior to their official eligibility determination.

Retroactive eligibility helps adults living with CF in Arkansas who rely on Medicaid avoid gaps in coverage and costly medical bills and is an especially important safeguard for those who have lost their job or are experiencing changes in their insurance status as a result of the COVID-19 pandemic. Without it, people with CF may face significant out-of-pocket costs. Cystic fibrosis care and treatments are costly, even with coverage. According to a

survey conducted by George Washington University of 1,800 people living with CF and their families, over 70 percent indicated that paying for health care has caused financial problems such as being contacted by a collection agency, having to file for bankruptcy, experiencing difficulty paying for basics like rent and utilities, or having to take a second job to make ends meet. And while 84 percent received some form of financial assistance in 2019 to pay for their care, almost half reported still having problems paying for at least one medication or service in that same year.

Cost-Sharing Requirements

Arkansas proposes to increase premiums for individuals with incomes at or above 100% of the federal poverty line. Premiums will likely discourage eligible people from enrolling in the program. For example, when Oregon implemented a premium in its Medicaid program, with a maximum premium of $20 per month, almost half of enrollees lost coverage.[1] Additional research on Michigan's Medicaid expansion program showed that modest increases of a few dollars in premiums resulted in disenrollment, especially among healthy individuals from the program.[2] An analysis of Indiana's Medicaid program also found that nearly 30 percent of enrollees either never enrolled in coverage or were disenrolled from coverage because they failed to make premium payments. The analysis found 22 percent of individuals who never enrolled because they did not make the first month's payment cited affordability concerns, and 22 percent said they were confused about the payment process.[8]

Research has also shown that even relatively low levels of cost-sharing for low-income populations limit the use of necessary healthcare services.[9] The program's cost sharing requirement for low-income beneficiaries would also have been a significant financial burden for patients. People with CF bear a significant cost burden and out-of-pocket costs can present a barrier to care. According to the afore mentioned survey of people living with CF and their families, while 98 percent of people with CF have some type of health insurance coverage, 58 percent have postponed or skipped necessary medical care or treatments due to cost concerns. Such actions seriously jeopardize the health of people with CF and can lead to costly hospitalizations and fatal lung infections.

The Cystic Fibrosis Foundation strongly recommends that Arkansas revise its waiver application as outlined to ensure that it meets the objectives of the Medicaid program. Thank you for the opportunity to provide comments.

Sincerely,

Mary B. Dwight
Chief Policy & Advocacy Officer
Senior Vice President, Policy & Advocacy
Cystic Fibrosis Foundation

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[1] Id.

[2] Cliff, B., et al. Adverse Selection in Medicaid: Evidence from Discontinuous Program Rules. NBER Working Paper No. 28762. National Bureau of Economic Research. May 2021. Accessed at: https://www.nber.org/system/files/working_papers/w28762/w28762.pdf.

VIA EMAIL ORP@dhs.arkansas.gov

July 12, 2021

Elizabeth Pitman, Director
Division of Medical Services
Donaghey Plaza, P.O. Box 1437
Little Rock, AR 72203

RE: ARHOME Section 1115 Demonstration Application

Dear Ms. Pitman:

Hemophilia Federation of America (HFA) and the National Hemophilia Foundation (NHF) are submitting the following comments in response to the proposed extension and amendments to the federal Section 1115 waiver for the Arkansas Health and Opportunity for Me (ARHOME) demonstration.

Who we are
HFA and NHF are non-profit organizations representing individuals with bleeding disorders nationwide. Our missions are to ensure that persons with inherited bleeding disorders such as hemophilia have timely access to quality medical care, therapies, and services, regardless of their financial circumstances or place of residence.

About bleeding disorders
Hemophilia is a rare, genetic bleeding disorder affecting about 20,000 Americans that impairs the ability of blood to clot properly. Without treatment, people with hemophilia bleed internally. This is sometimes due to trauma but also simply as a result of everyday activities. Bleeds can lead to severe joint damage and permanent disability, or even – with respect to bleeds in the head, throat, or abdomen – death. Related conditions include von Willebrand disease (VWD), another inherited bleeding disorder, which is estimated to affect more than three million Americans.

Patients with bleeding disorders have complex, lifelong medical needs. They depend on prescription medications (clotting factor or other new treatments) to treat or avoid painful bleeding episodes that can lead to advanced medical issues. Current treatment is highly effective and allow individuals to lead healthy and productive lives. However, this treatment is also extremely expensive, costing anywhere from $250,000 to $1 million or more per year depending on the severity of the disorder and whether complications such as an inhibitor are present. As a result, low-income individuals and families coping with bleeding disorders are at great risk if they lack affordable health insurance. Medicaid provides essential coverage for this segment of the bleeding disorders population.

Waiver application fails to comport with Medicaid objectives
The purpose of the Medicaid program is to provide healthcare coverage for low-income individuals and families. Medicaid expansion is critical for patients with and at risk of serious, acute and chronic health conditions. Reviews of more than 600 studies examining the impact of Medicaid expansion have found clear evidence that expansion is linked to increased access to coverage, improvements in many health indicators, and economic benefits for states and providers.[i]

Unfortunately, the ARHOME 1115 proposal includes several provisions that do not meet Medicaid's statutory objective to provide healthcare for low-income individuals. Instead, the proposed waiver

includes limitations on retroactive coverage, as well as premiums and cost-sharing that will create financial and administrative barriers for patients. These fail to comport with the purpose and objectives of Medicaid, as detailed below.

Retroactive Eligibility

This proposal would continue to limit retroactive coverage to 30 days for the demonstration population. There are no exemptions, even for medically frail individuals.

Retroactive eligibility in Medicaid prevents gaps in coverage by typically covering individuals for up to 90 days prior to the month of application, assuming the individual is eligible for Medicaid coverage during that time frame. It is common that individuals are unaware they are eligible for Medicaid until a medical event or diagnosis occurs. Retroactive eligibility allows patients who have been diagnosed with a bleeding disorder or other serious condition to begin treatment without being burdened by medical debt prior to their official eligibility determination.

Medicaid paperwork can be burdensome and often confusing. A Medicaid enrollee may not have understood or received a notice of Medicaid renewal and only discovered the coverage lapse when picking up a prescription or going to see their doctor. Without retroactive eligibility, Medicaid enrollees could then face substantial costs at their doctor's office or pharmacy.

Health systems could also end up providing more uncompensated care. For example, when Ohio was considering a similar provision in 2016, a consulting firm advised the state that hospitals could accrue as much as $2.5 billion more in uncompensated care as a result of the waiver.[ii] Increased uncompensated care costs are especially concerning as safety net hospitals and other providers continue to deal with the COVID-19 pandemic. Additionally, Arkansas currently has 11 rural hospitals that are vulnerable to closure.[iii] Limiting retroactive coverage increases the financial hardships to rural hospitals that absorb uncompensated care costs. Our organizations oppose the limitations on retroactive coverage for the demonstration population.

Premiums and Cost-sharing

Arkansas proposes to increase premiums for individuals with incomes at or above 100 percent of the federal poverty line. Premiums will likely discourage eligible people from enrolling in the program. For example, when Oregon implemented a premium in its Medicaid program, with a maximum premium of $20 per month, almost half of enrollees lost coverage.[iv] Additional research on Michigan's Medicaid expansion program showed that modest increases of a few dollars in premiums resulted in disenrollment from the program, especially among healthy individuals.[v] For individuals living with an inherited bleeding disorder, even temporary delays or gaps in coverage can be devastating. Interruptions in coverage and treatment could result in joint- or even life-threatening bleeding episodes, with an intolerably high human toll (as well as higher state spending for care in an ER setting).

The state is also requesting to impose copayments ranging from $5-20 on individuals with incomes at or above 21 percent of the federal poverty line ($225 per month for an individual). Research has shown that even relatively low levels of cost-sharing for low-income populations limit the use of necessary healthcare services.[vi] Additionally, the state includes a copay for non-emergency use of the emergency department. Yet a study of enrollees in Oregon's Medicaid program demonstrated that implementation of a copay on emergency services resulted in decreased utilization of such services but did not result in cost savings because of subsequent use of more intensive and expensive services.[vii] This provides further evidence that copays may lead to inappropriate delays in needed care. Our organizations oppose the cost-sharing and premiums for the low-income population covered under this demonstration.

Evaluation

HFA and NHF are also concerned that this proposal does not include an interim evaluation of Arkansas Works, the state's previous demonstration waiver. Therefore, there is no evaluation data on the state's experience with premiums, limitations on retroactive coverage, and other key provisions included in the current waiver application. This is highly problematic because the state is asking for comment on extending its current demonstration and evidence from an interim evaluation would help our organizations fully comment on the current request.

As result, HFA and NHF strongly recommend that Arkansas revise its waiver application as detailed above, in order to ensure that it meets the objectives of the Medicaid program.

Sincerely,

[redacted]

Sonji Wilkes, Vice President for Policy and Advocacy
Hemophilia Federation of America
s.wilkes@hemophiliafed.org

[redacted]

Nathan Schaefer, MSW, Vice President for Public Policy
National Hemophilia Foundation
nschaefer@hemophilia.org

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[i] Madeline Guth and Meghana Ammula. "Building on the Evidence Base: Studies on the Effects of Medicaid Expansion, February 2020 to March 2021." May 6, 2021. Available at: https://www.kff.org/medicaid/report/building-on-the-evidence-base-studies-on-the-effects-of-medicaid-expansion-february-2020-to-march-2021/.

[ii] Virgil Dickson, "Ohio Medicaid waiver could cost hospitals $2.5 billion", Modern Healthcare, April 22, 2016. (http://www.modernhealthcare.com/article/20160422/NEWS/160429965)

[iii] https://www.ivantageindex.com/wp-content/uploads/2020/02/CCRH_Vulnerability-Research_FiNAL-02.14.20.pdf

[iv] Id.

[v] Cliff, B., et al. Adverse Selection in Medicaid: Evidence from Discontinuous Program Rules. NBER Working Paper No. 28762. National Bureau of Economic Research. May 2021. Accessed at: https://www.nber.org/system/files/working_papers/w28762/w28762.pdf.

[vi] Samantha Artiga, Petry Ubri, and Julia Zur, "The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings," Kaiser Family Foundation, June 2017. Available at: https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/.

[vii] Wallace NT, McConnell KJ, et al. How Effective Are Copayments in Reducing Expenditures for Low-Income Adult Medicaid Beneficiaries? Experience from the Oregon Health Plan. Health Serv Res. 2008 April; 43(2): 515–530.

Mental Health Council of Arkansas

Organizations

Birch Tree Communities
Benton, Arkansas
(501)315-3344

Burrell Behavioral Health
Rogers, Arkansas
(417) 761-5050

Centers for Youth and Families
Little Rock, Arkansas
(501)666-8686.

Counseling Associates.
Conway, Arkansas
(501)327-4889

Counseling Clinic
Benton, Arkansas
(501)315-4224

Delta Counseling Associates
Monticello, Arkansas
(870)367-9732

Mid-South Health Systems
Jonesboro, Arkansas
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Ouachita Behavioral Health & Wellness
Hot Springs, Arkansas
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Ozark Guidance
Springdale, Arkansas
(479)750-2020

Professional Counseling Associates
North Little Rock, AR 72117
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Southeast Arkansas Behavioral Healthcare System
Pine Bluff, Arkansas
(870)534-1834

South Arkansas Regional Health Center
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Southwest Arkansas Counseling & MHC
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(870)773-4655

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(479)452-6650

July 12, 2021

ARHOME 1115 Demonstration Public Comments

Via email to ORP@dhs.arkansas.gov

To Whom It May Concern:

The Mental Health Council of Arkansas (MHCA) appreciates the opportunity to provide public comments related to the proposed ARHOME 1115 Demonstration Waiver. As behavioral health providers offering comprehensive mental health (MH) and substance use disorder (SUD) services, we believe our comments to have unique relevance on the basis of our experience and expertise working with Medicaid beneficiaries. Specifically, we have expertise to lend to the **"Rural Life 360 Home**" population addressed in the waiver.

Qualifications to Comment:

- Collectively, MHCA organizations have a physical service location in every county of Arkansas
- We also offer extensive capacity for telehealth access across the entire state
- Crisis services are available 24/7/365 within emergency departments, jails, schools, DCFS and the broader community
- Community Mental Health Center (CMHC) organizations are contractually obligated to serve as the state's designated *single point of entry* for involuntary commitments, as well as, fulfill the role of fiduciary for state funds used to ensure inpatient care to individuals who are indigent
- We employ hundreds of prescribers, licensed mental health professionals, Licensed Alcoholism and Drug Abuse Counselors (LADAC), Associate Alcoholism and Drug Abuse Counselor (LAADAC), qualified behavioral health professionals and peer specialists
- Annually, we serve tens of thousands of children and adults who have significant MH and SUD needs
- We are all mission-driven, non-profit organizations with a commitment to provide a full continuum of care to individuals with high risks and high needs
- We have strong relationships within the communities we've been servicing for more than 50 years

Public Comments:

- 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)
- Reduction of retroactive eligibility raises a concern about whether the retroactive eligibility provision (limiting the retroactive eligibility from 90 days to 30 days) would also apply to the SMI population who receive behavioral health services through Medicaid Spend Down coverage. If it were to be applied to the Spend Down population it would have an adverse effect on this population in accessing critical services

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- The reduced eligibility issue is especially problematic if this applies to Medicaid Spenddowns because DHS will not process a spenddown without 3 months of bank records starting from the first date of service for the requested period. This will be an access issue for providers of Therapeutic Communities for Tier 2 or Tier 3 Medicare recipients needing to rely on Medicaid eligibility via ARHOME rather than from traditional Medicaid
- At present, SAMHSA has granted seven (7) Certified Community Behavioral Health Clinic (CCBHC) grants to CMHCs in AR. We believe there are key roles for CMHCs and CCBHC grants that have been overlooked in the 1115 demonstration waiver as currently proposed
- The nine key areas for the CCBHC model of comprehensive care, which is also the Gold Standard for delivery of mental health and SUD care nationally, includes: 1.) Crisis MH services, including 24-hour mobile crisis teams, emergency crisis intervention services and crisis stabilization responding to crisis 24/7/365, 2.) Screening, assessment, and diagnosis, including risk assessment, 3.) Patient-centered treatment planning/crisis planning, 4.) Outpatient MH /SA services, 5.) Outpatient clinic primary care screening/monitoring of key health indicators and health risk given integrated BH and primary health care services, 6.) ACT teams, targeted case management, 7.) Psychiatric rehabilitative services, 8.) Peer support/counselor services/family support and 9.) Intensive Care coordination and focus on those community members and veterans located in rural areas
- Simply put, the CMHCs and CCBHC Expansion grants provide a foundation that Rural Access Hospitals do not and likely cannot
    - CMHCs already have capacity and capability to provide evidence-based practices for the priority population identified for **"Rural Life 360 Home**" including access in every rural county and established telehealth options including connectivity to many rural jails
    - CMHCs have a rich history of doing community-based work over the past 50 years
    - CCBHC is paving the way for behavioral health care to be integrated with primary care
    - CCBHC expansion grants also provide for mobile crisis services and assertive community treatment teams
- Although workforce is a concern for all behavioral health providers, CMHCs have a large cadre of licensed MH and SUD professionals with a passion for assisting the most seriously ill individuals
- CMHCs provide cost-effective treatment alternatives when compared to inpatient settings
- There seems to be a noteworthy absence of analytical data to support the proposed waiver plan to rely on rural hospitals to have appropriate experience or the willingness to develop necessary capacity to effectively provide the envisioned demonstration services
- We suggest the intensive care coordination be implemented by CMHCs

- Access to psychiatric inpatient care is a problem in Arkansas, yet the capacity of rural hospitals to fill this gap with quality care is unproven
- It is unlikely that rural hospitals would be able to provide facilities that meet safety standards required for psychiatric inpatient care without substantial physical modifications and added expense
- The proposed cost sharing (increased premiums & copays) is problematic. It is a deterrent to care for individuals and families with drastically limited discretionary income. Offering an incentive program is a positive component of the plan; as is the focus on removal of barriers to care, such as social determinants of health
- The cost-sharing expectation in the outpatient setting will likely prevent care seeking and erode access to care as providers will limit referrals
- In contrast, the proposed absence of a co-payment for an inpatient hospital stay will make this intensive and cost care more accessible
- Has a waiver of the current *independent assessment* requirement been considered? It is a barrier to access especially for individuals with serious and persistent mental illness
- Has administrative burden of the proposed plan been calculated? How will the targeted population be educated about the varying aspects and nuances of the plan? Without a clear understanding of the plan, eligibility for premium assistance, incentives and cost sharing, it is likely that individuals will forego needed care

The MHCA is committed to improving population health, reducing costs and ensuring access to quality care. We desire to be collaborative and innovative as evidenced by our efforts with CCBHC to be a central part of bringing viable solutions that are designed to produce independently evaluated results. We have a record of bringing improvements to Arkansas such as school-based MH services, drug and mental health courts, first episode psychosis programs, trauma-informed care, forensics and efforts with jail diversion. We hope are comments will be given serious consideration.

Sincerely,

Rusti Holwick, LPE-I LADAC AADC
President
Rusti.Holwick@wacgc.org

National
Multiple Sclerosis
Society

July 9, 2021

Elizabeth Pitman
Director
Division of Medical Services
Donaghey Plaza
P.O. Box 1437
Little Rock, AR 72203

Re: ARHOME Section 1115 Demonstration Application

Dear Ms. Pitman:

The National Multiple Sclerosis Society appreciates the opportunity to provide comments on Arkansas's Section 1115 Demonstration Application.

Multiple sclerosis (MS) is an unpredictable, often disabling disease of the central nervous system that disrupts the flow of information within the brain, and between the brain and body. Symptoms range from numbness and tingling to blindness and the progress, severity and specific symptoms of MS in any one person cannot yet be predicted. There are an estimated one million people living with MS in the United States, but advances in research and treatment are leading to better understanding and moving us closer to a world free of MS.

The purpose of the Medicaid program is to provide healthcare coverage for low-income individuals and families, and the National MS Society is committed to ensuring that Arkansas's Medicaid program provides quality and affordable healthcare coverage. Specifically, Medicaid expansion is critical for patients with and at risk of serious, acute and chronic health conditions. Reviews of more than 600 studies examining the impact of Medicaid expansion have found clear evidence that expansion is linked to increased access to coverage, improvements in many health indicators, and economic benefits for states and providers.[1] Access to affordable, high quality health care is essential for people with MS to live their best lives, and health insurance coverage is essential for people to be able to get the care and treatments they need. Without health insurance, people living with MS do not have access to the services and treatments to manage symptoms and slow their disease course. The National MS Society supports Arkansas's continued commitment to Medicaid expansion.

Unfortunately, this proposal includes several provisions that do not meet the objective to provide healthcare for low-income individuals. Instead, the proposed waiver includes limitations on retroactive coverage and premiums and cost-sharing that will create financial and administrative barriers for patients. The National MS Society offers the following comments on the ARHOME waiver.

<u>Retroactive Eligibility</u>
This proposal would continue to limit retroactive coverage to 30 days for the demonstration population. There are no exemptions, including for medically frail individuals. Retroactive eligibility in Medicaid prevents gaps in coverage by typically covering individuals for up to 90 days prior to the month of

National Multiple Sclerosis Society

application, assuming the individual is eligible for Medicaid coverage during that time frame. It is common that individuals are unaware they are eligible for Medicaid until a medical event or diagnosis occurs. Retroactive eligibility allows patients who have been diagnosed with a serious illness, such as MS to begin treatment without being burdened by medical debt prior to their official eligibility determination.

Medicaid paperwork can be burdensome and often confusing. A Medicaid enrollee may not have understood or received a notice of Medicaid renewal and only discovered the coverage lapse when picking up a prescription or going to see their doctor. Without retroactive eligibility, Medicaid enrollees could then face substantial costs at their doctor's office or pharmacy.

Health systems could also end up providing more uncompensated care. For example, when Ohio was considering a similar provision in 2016, a consulting firm advised the state that hospitals could accrue as much as $2.5 billion more in uncompensated care as a result of the waiver.[2] Increased uncompensated care costs are especially concerning as safety net hospitals and other providers continue to deal with the COVID-19 pandemic. Additionally, Arkansas currently has 11 rural hospitals that are vulnerable to closure.[3] Limiting retroactive coverage increases the financial hardships to rural hospitals that absorb uncompensated care costs. The National MS Society opposes the limitations on retroactive coverage for the demonstration population.

Premiums and Cost-sharing

Arkansas proposes to increase premiums for individuals with incomes at or above 100% of the federal poverty line. Premiums will likely discourage eligible people from enrolling in the program. For example, when Oregon implemented a premium in its Medicaid program, with a maximum premium of $20 per month, almost half of enrollees lost coverage.[4] Additional research on Michigan's Medicaid expansion program showed that modest increases of a few dollars in premiums resulted in disenrollment, especially among healthy individuals from the program.[5] Studies show that early and ongoing treatment with a disease-modifying therapy (DMT) is the best way to modify the course of the disease, slow the accumulation of disability and protect the brain from damage due to MS. Adherence to medication is a key element of treatment effectiveness. Many MS DMTs are now available, including some generics, but the brand median price in 2020 was $91,835, with even generic medications often costing thousands of dollars. Without prescription drug coverage provided by Medicaid, medications to treat MS would be financially out of reach. Gaps in treatment can lead to disease progression and increased, possibly irreversible, disability.

The state is also requesting to impose copayments ranging from $5 to $20 on individuals with incomes at or above 21% of the federal poverty line ($225 per month for an individual). Research has shown that even relatively low levels of cost-sharing for low-income populations limit the use of necessary healthcare services.[6] Additionally, the state includes a copay for non-emergency use of the emergency department. Yet a study of enrollees in Oregon's Medicaid program demonstrated that implementation of a copay on emergency services resulted in decreased utilization of such services but did not result in cost savings because of subsequent use of more intensive and expensive services.[7] This provides further evidence that copays may lead to inappropriate delays in needed care. The National MS Society opposes the cost-sharing and premiums for the low-income population covered under this demonstration.

National
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Evaluation

The National MS Society is concerned that this proposal does not include an interim evaluation of Arkansas Works, the state's previous demonstration waiver. Therefore, there is no evaluation data on the state's experience with premiums, limitations on retroactive coverage, and other key provisions included in the current waiver application. This is highly problematic because the state is asking for comment on extending its current demonstration, and evidence from an interim evaluation would help our organization to fully comment on the current request.

The National MS Society strongly recommends that Arkansas revise its waiver application as outlined to ensure that it meets the objectives of the Medicaid program. Thank you for the opportunity to provide comments.

Sincerely,

Christie Eckler

Christie Eckler, LMSW, CFRE
Executive Director, South Central
National Multiple Sclerosis Society

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[1] Madeline Guth and Meghana Ammula. "Building on the Evidence Base: Studies on the Effects of Medicaid Expansion, February 2020 to March 2021." May 6, 2021. Available at: https://www.kff.org/medicaid/report/building-on-the-evidence-base-studies-on-the-effects-of-medicaid-expansion-february-2020-to-march-2021/.

[2] Virgil Dickson, "Ohio Medicaid waiver could cost hospitals $2.5 billion", Modern Healthcare, April 22, 2016. (http://www.modernhealthcare.com/article/20160422/NEWS/160429965)

[3] https://www.ivantageindex.com/wp-content/uploads/2020/02/CCRH_Vulnerability-Research_FiNAL-02.14.20.pdf

[4] Id.

[5] Cliff, B., et al. Adverse Selection in Medicaid: Evidence from Discontinuous Program Rules. NBER Working Paper No. 28762. National Bureau of Economic Research. May 2021. Accessed at: https://www.nber.org/system/files/working_papers/w28762/w28762.pdf.

[6] Samantha Artiga, Petry Ubri, and Julia Zur, "The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings," Kaiser Family Foundation, June 2017. Available at: https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/.

[7] Wallace NT, McConnell KJ, et al. How Effective Are Copayments in Reducing Expenditures for Low-Income Adult Medicaid Beneficiaries? Experience from the Oregon Health Plan. Health Serv Res. 2008 April; 43(2): 515–530.

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July 12, 2021

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Sent via email to ORP@dhs.arkansas.gov

Re: Comments on Notice of Application for Proposed ARHOME Project

Legal Aid of Arkansas writes to offer comment on the ARHOME proposal issued on June 11, 2021.

Legal Aid serves thousands of low-income Arkansans every year and is intimately familiar with the pressures that poverty places on our clients' lives. With respect to Medicaid, Legal Aid has assisted thousands of clients over the years with various aspects of Arkansas's Medicaid programs. Legal Aid's accumulated experience and all available data show that the ARHOME proposal would likely harm our client communities by discouraging Medicaid enrollment and frustrating use of Medicaid services.

DHS seeks approval of the ARHOME proposal through Section 1115 of the Social Security Act. The ARHOME proposal—individual aspects and as a whole—runs counter to the Medicaid program's objective to "furnish medical assistance." Moreover, the proposal lacks any legitimate experimental purpose.

I. Premiums discourage Medicaid enrollment and access to medically necessary care.

Under the ARHOME proposal, Arkansas would continue to impose premiums on Medicaid Expansion enrollees above 100% of the federal poverty line and would increase the amount of the premiums. Extensive research proves that premiums and co-pays deter and reduce Medicaid enrollment and access to medically necessary health care among low-income individuals. Extant literature captures the essential impact of premiums:

- "[P]remiums in Medicaid and CHIP lead to a reduction in coverage among both children and adults. Numerous studies find that premiums increase disenrollment from Medicaid and CHIP among adults and children, shorten lengths of Medicaid and CHIP enrollment, and deter eligible adults and children

from enrolling in Medicaid and CHIP." Samantha Artiga, Petry Ubri, and Julia Zur, Kaiser Family Found., *The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings* (2017), https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populationsupdated-review-of-research-findings/.

- "…[T]hose who become uninsured following premium increases face increased barriers to accessing care, have greater unmet health needs, and face increased financial burdens." *Id.*

- "Increases in premiums were associated with increased disenrollment rates in 7 studies that permitted comparison." Brendan Saloner et al*., Medicaid and CHIP Premiums and Access to Care: A Systematic Review*, 137 Pediatrics e20152440 (2016), http://pediatrics.aappublications.org/content/137/3/e20152440

While the ARHOME proposal does not provide for termination of enrollees who do not pay the premium, the mere act of imposing or increasing premiums will likely lead to declining enrollment. First, it is not clear that people will understand that the inability to pay premiums will not cause termination. After all, DHS has not successfully communicated any nuanced Medicaid program requirements—such as work requirements—in the past. But, even if a beneficiary comes to understand that they will not be terminated from the coverage, the beneficiary knows that they will incur a debt. When people are struggling to make ends meet, they do not want to have bills they know they cannot pay. Thus, the prospect of additional debt alone is enough to discourage enrollment.

A recent study of Michigan Medicaid enrollees confirms this. Similar to the ARHOME proposal, Michigan imposed premiums on Medicaid Expansion enrollees with incomes over 100% of the federal poverty line. Enrollees could not be terminated from Medicaid due to non-payment. Nonetheless, the study found that "facing a premium increases disenrollment by 11.7 percentage points" and that, "[f]or every $1 increase in monthly premiums, we find an increase in disenrollment of 0.7 percentage points." Betsy Q. Cliff et al., *Adverse Selection in Medicaid: Evidence from Discontinuous Program Rules*, NBER Working Paper No. 28762, May 2021, https://www.nber.org/papers/w28762.

Moving to the legal framework, statutory provisions preventing Arkansas from charging these premiums are outside of 42 U.S.C. § 1396a and, thus, cannot be waived under Section 1115. *See* 42 U.S.C. §§ 1315(a)(1), 1396o, 1396o-1.

II. Imposing co-pays discourages use of Medicaid to obtain medically necessary care.

The ARHOME proposal would newly impose co-pays on any Medicaid Expansion beneficiary between 20% and 100% of the federal poverty line. As with premiums, co-pays limit access to medically necessary health care among low-income individuals. Research demonstrates that co-pays reduce access to a variety of services. As the Kaiser Family Foundation noted:

- "…[E]ven relatively small levels of cost sharing, in the range of $1 to $5, are associated with reduced use of care, including necessary services." "Reduced utilization of services" includes "vaccinations, prescription drugs, mental health visits, preventive and primary care, inpatient and outpatient care, and decreased adherence to medications." Samantha Artiga et al., Kaiser Family Found., *The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review*

of Research Findings (2017), https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populationsupdated-review-of-research-findings/.

A recent study evaluating the effect of co-pays on prescription drug usage in Medicare illustrates this dynamic starkly. There, the authors concluded that "small increases in cost cause patients to cut back on drugs with large benefits, ultimately causing their death." Perversely, the "most striking" effects of those cutbacks "are seen in patients with the greatest treatable health risks, in whom they are likely to be particularly destructive." Amitabh Chandra et al., *The Health Costs of Cost-Sharing*, NBER Working Paper 28439, February 2021, https://www.nber.org/papers/w28439. There is no reason to believe that the dynamic would be any different for Medicaid Expansion beneficiaries, who have lower median incomes than Medicare beneficiaries. *Compare* ARHOME Proposal page 43 (showing that the median income of Medicaid Expansion beneficiaries as of 12/31/19 was between 40 to 60% of FPL) *with* Gretchen Jacobson et al., Kaiser Family Foundation, *Income and Assets of Medicare Beneficiaries, 2016-2035* (April 2017), https://files.kff.org/attachment/Issue-Brief-Income-and-Assets-of-Medicare-Beneficiaries-2016-2035 (showing that the median income of Medicare beneficiaries in 2016 was $26,200 or 220% of the 2016 FPL).

Much like with premiums, the mere threat of debt will deter people from seeking necessary services. Additionally, the impact of co-pays can be even more direct: the ARHOME proposal expressly grants medical providers the ability to refuse to provide a service due to non-payment.

DHS's proposal design is confused, requiring a low-income beneficiary to have excess money on hand to pay for needed medical services that may affect their ability to earn money. In contrast, providing Medicaid with the fewest possible barriers to access and use can enable low-income Arkansans to get the care needed to be able to work and otherwise participate in family and community life.

III. The proposed cap on premiums and co-pays does not mitigate the impact of disenrollment and decreased access to care.

DHS proposes to limit the overall amount of co-pays and premiums to 5% of a beneficiary's income over a calendar quarter. Such cost caps miss the point. As the studies cited above show, *even minimal cost increases* lead to disenrollment and decreased access to care.

Again, the studies make intuitive sense. Medicaid beneficiaries have highly limited income with which to meet life's needs apart from health care: rent, food, transportation, childcare, schooling, and so forth. Requiring even a few dollars per month of additional health care costs places an unsupportable strain on already strapped budgets. It is not that Medicaid beneficiaries have excess discretionary income that they simply choose not to spend on health care. Rather, they do not have the extra money in the first place.

Cost caps do not change this dynamic and, thus, will not mitigate the harm caused to beneficiaries.

IV. Reduction of retroactive coverage improperly limits coverage.

DHS proposes to limit retroactive coverage to 30 days prior to the date of application. There is no justification for this reduction consistent with furnishing medical assistance. Knowledge of Medicaid can be sparse. Medicaid eligibility rules can be complex. Medical distress and other responsibilities, such as childcare, can limit an individual's ability to apply within the reduced timeframe. Yet, under DHS's proposal, not doing so could come with unlimited costs to the individual for which the Medicaid Act otherwise requires coverage.

One client's experience—a single father raising two young boys—shows the importance of retroactive eligibility. At first, his income from working was too much for Medicaid. He fell deathly ill, was in the hospital, had multiple surgeries, and was home sick after that. He had to stop working. He did not have readily available childcare. During that time, he incurred over $60,000 in medical bills. His loss of income meant that he qualified for Medicaid, but, because of the health problems and lack of knowledge, he didn't apply until a couple months later. Without retroactive coverage, he would have huge debts affecting him and his children for years.

V. The so-called "Economic Independence Initiative" does not furnish medical assistance.

DHS proposes a new iteration of work requirements under the guise of the so-called "Economic Independence Initiative," through which DHS would provide for reductions in premiums or co-pays for individuals who comply with unspecified requirements that vaguely purport to promote education and employment. The lack of specifics on the functioning of the Economic Independence Initiative impairs the public's ability to offer meaningful comment.

Whatever the specifics, Medicaid is a health care program, not a work program. Work requirements are inconsistent with Medicaid's objective of furnishing medical assistance. The state's implementation of work requirements for Medicaid in 2018 and 2019 showed them to cause massive coverage loss. Over 18,000 beneficiaries lost coverage in the only five months where terminations were possible. DHS's own statistics showed low rates of compliance with the onerous reporting system, particularly among those beneficiaries who were not automatically exempted. Indeed, Legal Aid assisted many individuals facing termination despite meeting the conditions imposed by the work requirements. Here, it is just as likely that beneficiaries will be unable to meet whatever requirements the Economic Independence Initiative imposes. As such, even if beneficiaries' coverage is not directly taken away, the Initiative will result in greater difficulty in obtaining medical assistance by forcing people to pay more through co-pays and premiums.

As repeatedly emphasized over several years, lack of work amongst Medicaid beneficiaries is not a problem rooted in fact. In 2019, 62% of Medicaid Expansion beneficiaries in Arkansas were already working. Those who were not working had an illness or disability, caretaking responsibilities, or attended school. Rachel Garfield et al., Kaiser Family Found., *Work Among Medicaid Adults*, Kaiser Family Foundation, Appendix 2 (Feb. 11, 2021), https://www.kff.org/report-section/work-among-medicaid-adults-implications-of-economic-downturn-and-work-requirements-appendix-2/

Moreover, that unlawful policy did not achieve what it claimed to. Research based on the Arkansas work requirements has shown that work requirements "did not increase employment over eighteen months of follow-up." Benjamin Sommers et al., *Medicaid Work Requirements in Arkansas: Two-Year Impacts on Coverage, Employment, and Affordability of Care*, Health Affairs Vol. 39, No. 9, https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.00538. Rather, the work requirements resulted in many beneficiaries losing their health care coverage. These people demonstrated increased medical debt, delayed care, and delayed medications. *Id.* Of course, Medicaid helps people get the health care needed to be able to work. A policy like work requirements that results in decreased or delayed care would worsen people's health and make them less able to work.

In sum, any so-called Economic Independence Initiative will not further Medicaid's objective of furnishing medical assistance. Rather, the agency is hiking costs on nearly all beneficiaries and then forcing them to jump through an administrative hoop already proven to be a policy failure so that the new costs may be

slightly reduced. The end result, though, is still higher costs on beneficiaries, which, as shown above in Items I through III, will decrease enrollment and access to care.

VI. The "inactive" status and related change in coverage disrupts beneficiaries' care.

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.

Movement from a QHP to FFS has caused massive disruptions in care to dozens of Legal Aid's clients. We saw this when Medicaid Expansion beneficiaries enrolled in QHPs were newly designated Medically Frail. Suddenly, people lost access to doctors and medications covered by the QHP that were not covered by FFS. With regards to doctors, some clients had to forego long-scheduled surgeries because the surgeon was part of a QHP network but not a FFS provider. With regard to medications, the FFS system not only covers different prescription drugs for given conditions than a QHP, but also covers fewer prescriptions (limited to a total of six per month). The loss of access to prescribed medications was particularly grievous for people with several chronic conditions requiring detailed medication management. Despite the threat of disruption, DHS's supposed guardrails for such transitions—advanced notice and the ability to opt out of Medically Frails status—did not exist in practice. Individuals could not resolve the issue without Legal Aid's assistance.

In light of the care disruptions caused by shifting a beneficiary from a QHP to FFS, expanding the situations in which such transfers may occur does not further Medicaid's objective of furnishing medical assistance. Rather, the proposal just adds administrative complexity.

VII. Limiting auto-enrollment increases administrative complexity for beneficiaries.

As described just above, movement between FFS and QHP usually involves disruptive changes to beneficiary care. 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.

Enrollment in a QHP is not an easy or intuitive process. A beneficiary first must understand what enrollment means and then use an online portal to enroll. Of course, inadequate access to the internet and having inadequate skills or knowledge to use the internet are barriers to enrollment. To the extent someone can enroll by phone, calling DHS or its related vendors (such as the Arkansas Foundation for Medical Care) often requires extensive hold times to address a substantive issue.[1] DHS's own proposal acknowledges the difficulty of enrolling in a QHP, stating on page 38 (or page 46 of the PDF), "Under the current Demonstration, 80% of individuals do not make an active choice of their QHPs and are instead auto-assigned."

[1] Although AFMC may have a staff member answer the phone within a reasonable timeframe, that initial staff member cannot help with the substantive issue the beneficiary is calling about. Rather, the initial staff member merely transfers the caller to someone else for substantive assistance. In Legal Aid's experience helping beneficiaries with AFMC-related matters, the hold times for that transfer routinely run between 30 and 60 minutes.

Auto-assignment without limitations provides the most continuity to beneficiaries by enrolling them in a QHP—through which they will receive all ongoing care—as soon as possible.

VIII. Forcing Medicaid Expansion beneficiaries into PASSEs does not further Medicaid's objectives.

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 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.

IX. The proffered justification for the proposal does not serve an experimental purpose.

Of course, Section 1115 requires "an experimental, pilot, or demonstration project" that "is likely to assist in promoting the objectives" of Medicaid. The discussion above shows that DHS's proposal is unlikely to assist in promoting Medicaid's objective of furnishing medical assistance because it imposes additional costs and administrative complexity on beneficiaries that will lead to decreased enrollment and use of medically necessary services.

At the same, DHS's proposal also falls short of the requirements for an experimental purpose. DHS does not establish that evaluating whether Medicaid beneficiaries "view Medicaid as health insurance" connects in any way to the furnishing of medical assistance. Moreover, to the extent there is or ever has been any legitimate experimental purpose, the state has already been charging beneficiaries premiums and co-pays for several years. Whatever insights were to be gained should already have been gained. Expanding co-pays to a poorer segment of the Medicaid Expansion population and raising premiums on the segment already owing them does not further any legitimate experimental purpose.

Sincerely,

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Kevin De Liban, Director of Advocacy
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July 12, 2021

Elizabeth Pitman
Director
Division of Medical Services
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Re: ARHOME Section 1115 Demonstration Application

Dear Ms. Pitman:

The AIDS Institute, a nonprofit dedicated to protecting access to healthcare for people living with HIV and hepatitis, appreciates the opportunity to provide comments on Arkansas's Section 1115 Demonstration Application.

Medicaid is an extremely important source of health care coverage for people living with, and at risk for, HIV/AIDS and hepatitis. Forty-two percent of adults living with HIV are covered by Medicaid, compared to just thirteen percent of the general population.[1] Ensuring uninterrupted access to effective HIV care and treatment is incredibly important to the health of people living with HIV and to the public's health.[2] When HIV is effectively managed and individuals stay in treatment and virally suppressed, there is no risk of transmission.[3] Ensuring broad access to Medicaid coverage will ensure people living with HIV stay health, but also is an investment in Arkansas' public health.

The Medicaid program is intended to provide healthcare coverage for low-income individuals and families, and The AIDS Institute is committed to ensuring that Arkansas's Medicaid program provides quality and affordable healthcare coverage. The implications of the proposed waiver amendments pose significant risks to Arkansans living with serious and chronic conditions, but they also stand to upend the long-term goal to end HIV in the US.

In 2019, President Trump declared his Administration's commitment to Ending the HIV Epidemic (EHE) in the US by 2030. This bold plan leverages critical scientific advances in prevention, diagnosis, and treatment, but is reliant on a coordinated response from the public health infrastructure and health insurance coverage systems. HIV has disproportionately burdened the South, with over half of all new

[1] *Medicaid and HIV*, Kaiser Family Foundation. Oct. 1, 2019. https://www.kff.org/hivaids/fact-sheet/medicaid-and-hiv/

[2] Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the use of antiretroviral agents in HIV-1-infected adults and adolescents. Department of Health and Human Services. http://www.aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf

[3] Eisinger RW, Dieffenbach CW, Fauci AS. *HIV Viral Load and Transmissibility of HIV Infection: Undetectable Equals Untransmittable*. JAMA. January 10, 2019 321(5):451–452

HIV diagnoses in the United States occurring in Southern states like Arkansas.[4] In fact, HHS identified Arkansas as one of the 7 target states in phase 1 of the EHE initiative to receive additional resources due to the overwhelming rate of rural HIV transmission. In 2018, approximately 7,000 people in Arkansas were living with HIV; an estimated 1,325 individuals are unaware they have HIV.[5] Imposing barriers to care, like premium payments and copayments as proposed in the 1115 waiver application, will keep people from getting the coverage they need, and ensure the failure to meet the goals of the EHE initiative.

Simultaneously, as HIV continues to affect the lives of people throughout Arkansas, the state has been very hard hit by the hepatitis epidemic. There are approximately 21,800 people living with hepatitis C in the state. From 2013-2016, the state reported a hepatitis C rates higher than those of the US.[6] Hepatitis C is a curable disease and Medicaid can be the solution to eliminating HCV.

Additionally, Medicaid expansion is critical for all patients with and at risk of serious, acute and chronic health conditions, but can have downstream benefits for the state's health system. Reviews of more than 600 studies examining the impact of Medicaid expansion have found clear evidence that expansion is linked to increased access to coverage, improvements in many health indicators, and economic benefits for states and providers.[7] New research from the University of Illinois Urbana-Champagne shows that as a result of Medicaid expansion there was an uptick in HIV diagnosis – this translates to engaging new populations in on-going primary care, keeping emergency room visits to a minimum and healthcare system costs low.[8] The AIDS Institute supports Arkansas's continued commitment to Medicaid expansion.

However, this proposal includes several provisions that do not meet the objective to provide healthcare for low-income individuals. Instead, the proposed waiver includes limitations on retroactive coverage and premiums and cost-sharing that will create financial and administrative barriers for patients. The AIDS Institute offers the following comments on the ARHOME waiver.

Retroactive Eligibility

This proposal would continue to limit retroactive coverage to 30 days for the demonstration population. There are no exemptions, including for medically frail individuals. Retroactive eligibility in Medicaid prevents gaps in coverage by typically covering individuals for up to 90 days prior to the month of application, assuming the individual is eligible for Medicaid coverage during that time frame. It is common that individuals are unaware they are eligible for Medicaid until a medical event or diagnosis occurs. Retroactive eligibility allows patients who have been diagnosed with a serious illness, such as HIV and hepatitis to begin treatment without being burdened by medical debt prior to their official eligibility determination.

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[4] *HIV in the United States by Region*, CDC.https://www.cdc.gov/hiv/statistics/overview/geographicdistribution.html

[5] *Estimated HIV Incidence and Prevalence In the United States 2014-2018.* HIV Surveillance Reports. CDC V25, No1. https://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-supplemental-report-vol-25-1.pdf

[6] HepVu. Local Data, Arkansas. (retrieved July 12, 2021) https://hepvu.org/local-data/arkansas/

[7] Madeline Guth and Meghana Ammula. "Building on the Evidence Base: Studies on the Effects of Medicaid Expansion, February 2020 to March 2021." May 6, 2021. Available at: https://www.kff.org/medicaid/report/building-on-the-evidence-base-studies-on-the-effects-of-medicaid-expansion-february-2020-to-march-2021/.

[8] H. Nelson, Medicaid Expansion Helped Detect Undiagnosed HIV Infections. (Private Payer News. January 27, 2021). https://healthpayerintelligence.com/news/medicaid-expansion-helped-detect-undiagnosed-hiv-infections

Medicaid paperwork can be burdensome and often confusing. A Medicaid enrollee may not have understood or received a notice of Medicaid renewal and only discovered the coverage lapse when picking up a prescription or going to see their doctor. Without retroactive eligibility, Medicaid enrollees could then face substantial costs at their doctor's office or pharmacy.

Health systems could also end up providing more uncompensated care. For example, when Ohio was considering a similar provision in 2016, a consulting firm advised the state that hospitals could accrue as much as $2.5 billion more in uncompensated care as a result of the waiver.[9] Increased uncompensated care costs are especially concerning as safety net hospitals and other providers continue to deal with the COVID-19 pandemic. Additionally, Arkansas currently has 11 rural hospitals that are vulnerable to closure.[10] Limiting retroactive coverage increases the financial hardships to rural hospitals that absorb uncompensated care costs. The AIDS Institute opposes the limitations on retroactive coverage for the demonstration population.

Premiums and Cost-sharing

Arkansas proposes to increase premiums for individuals with incomes at or above 100% of the federal poverty line. Premiums will likely discourage eligible people from enrolling in the program. For example, when Oregon implemented a premium in its Medicaid program, with a maximum premium of $20 per month, almost half of enrollees lost coverage. Additional research on Michigan's Medicaid expansion program showed that modest increases of a few dollars in premiums resulted in disenrollment, especially among healthy individuals from the program. As previously mentioned, Medicaid is the primary source of insurance coverage for people living with HIV. Referring back to the EHE plan, the goals of the initiative are to test, diagnose, and link individuals to care as rapidly as possible.[11] Imposing premiums will automatically create a default waiting period for many individuals who cannot or do not know how to pay their initial premium. This will cause individuals to be dropped at a critical point in the HIV care continuum – linkage to care.

The state is also requesting to impose copayments ranging from $5 to $20 on individuals with incomes at or above 21% of the federal poverty line ($225 per month for an individual). Research has shown that even relatively low levels of cost-sharing for low-income populations limit the use of necessary healthcare services.[12] Additionally, the state includes a copay for non-emergency use of the emergency department. Yet a study of enrollees in Oregon's Medicaid program demonstrated that implementation of a copay on emergency services resulted in decreased utilization of such services but did not result in cost savings because of subsequent use of more intensive and expensive services.[13] This provides further evidence that copays may lead to inappropriate delays in needed care. Requiring a copayment will undoubtedly lead to many individuals living with HIV to drop coverage, miss treatments, and thereby

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[9] Virgil Dickson, "Ohio Medicaid waiver could cost hospitals $2.5 billion", Modern Healthcare, April 22, 2016. (http://www.modernhealthcare.com/article/20160422/NEWS/160429965)

[10] https://www.ivantageindex.com/wp-content/uploads/2020/02/CCRH_Vulnerability-Research_FiNAL-02.14.20.pdf

[11] Ending the HIV Epidemic, Key Strategies. https://www.hiv.gov/federal-response/ending-the-hiv-epidemic/key-strategies

[12] Samantha Artiga, Petry Ubri, and Julia Zur, "The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings," Kaiser Family Foundation, June 2017. Available at: https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/.

[13] Wallace NT, McConnell KJ, et al. How Effective Are Copayments in Reducing Expenditures for Low-Income Adult Medicaid Beneficiaries? Experience from the Oregon Health Plan. Health Serv Res. 2008 April; 43(2): 515–530.

causing detrimental and irreversible disease progression. The AIDS Institute opposes the cost-sharing and premiums for the low-income population covered under this demonstration.

Evaluation

We are very concerned that this proposal does not include an interim evaluation of Arkansas Works, the state's previous demonstration waiver. Therefore, there is no evaluation data on the state's experience with premiums, limitations on retroactive coverage, and other key provisions included in the current waiver application. This is highly problematic because the state is asking for comment on extending its current demonstration, and evidence from an interim evaluation would help our organization to fully comment on the current request.

The AIDS Institute strongly recommends that Arkansas revise its waiver application as outlined to ensure that it meets the objectives of the Medicaid program. Thank you for the opportunity to provide comments.

Sincerely,

Stephanie Hengst,
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The AIDS Institute