

**SECTION 1115(a) RESEARCH AND DEMONSTRATION
WAIVER APPLICATION
ARKANSAS DEPARTMENT OF HUMAN SERVICES
TEFRA DEMONSTRATION**

I. EXECUTIVE SUMMARY

The Arkansas Department of Human Services is proposing a Section 1115(a) demonstration waiver for a period of five (5) years to impose cost sharing requirements on children age 18 and under who are otherwise eligible for Medicaid under Section 134 of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), except where noted in the Eligibility Requirements section below. Parent(s), guardian(s) or custodian(s) whose children qualify for another Medicaid category with coverage comparable to the waiver services will be allowed to choose the regular Medicaid Program or the waiver program for their child. The proposed implementation date for the waiver is October 1, 2002.

The objective of DHS is to replace the TEFRA eligibility category with an alternative category. The Department appointed an advisory work group that includes TEFRA parents, advocates and physicians to provide input in designing the program. The following describes the proposed program:

- A. Families of eligible children will not be required to drop their existing insurance. Any family who voluntarily drops creditable health insurance coverage for the waiver child will be ineligible for waiver benefits for the child with a disability for a period of six (6) months from the date the insurance is dropped. Recipients who have dropped insurance since the last annual review will lose six (6) months of coverage beginning with the month after the month of discovery.
- B. There will be no cap on the number of children served.
- C. Cost sharing measures will be based on the total income of the custodial parent(s) as reflected on the most recently filed IRS Federal Tax Return (i.e., line 22 of the 2001 version of the 1040 or line 15 of the 2001 version of the 1040A). Documentation provided to ADHS will also include any late or amended returns.
- D. Recipients under the waiver will receive the full range of Medicaid benefits and services as described in the Arkansas Title XIX State Plan.
- E. A committee appointed by the Director of the Division of Medical Services (DMS) will meet as needed to review the program. The committee will be comprised of appropriate pediatric specialists, state staff, two parent representatives and two provider representatives.

II. Public Notice

A notice will be printed in the Arkansas Democrat-Gazette on _____ and allowed to run for seven consecutive days. The Democrat-Gazette is the only newspaper in Arkansas with statewide distribution. This notice includes a 30-day public comment period and instructions on how to obtain a copy of the waiver application.

III. The Environment

A. Overview of Current System

The population to be served by the waiver is currently receiving services under Section 134 of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA).

B. Experience with State Waivers

The state is currently operating the following waivers:

1. 1115(a)
 - a. ARKids First
 - b. Family Planning
2. 1915(b)
 - a. PCCM
 - b. Transportation
3. 1915(c)
 - a. Alternatives for Persons with Physical Disabilities
 - b. Elder Choices

The waivers listed above have been well received and there have been no major problems experienced with them.

C. **Input from Public Agencies/Advocates**

An advisory work group was established to provide input into the development of the waiver. The group included representatives from advocacy groups, other state agencies and parents of disabled children. See Attachment A for a list of the work group members.

D. **State Budget**

1. **What is the financial outlook of the current Medicaid program?**

The financial outlook for the Arkansas Medicaid program is better than that for a number of states (e.g., California, New Jersey, Mississippi and Missouri). As in many other states the finances will be tight for the next couple of years. Arkansas believes we can maintain essential services, including medically necessary services for children.

2. **Can the State sustain adequate financing for the life of the waiver?**

We believe, with known factors at this date, Arkansas can maintain funding for this waiver.

IV. Program Administration

The demonstration will be administered by the Division of Medical Services (DMS) and the Division of County Operations (DCO). Both agencies are divisions of the Arkansas Department of Human Services (DHS). Attached is a copy of the organizational chart for DHS (Attachment B), an organizational chart for DMS (Attachment C) and an organizational chart for DCO (Attachment D).

The Division of Medical Services (DMS) is responsible for ensuring compliance with the waiver in regard to services and provider participation.

The Division of County Operations (DCO) is responsible for the dissemination of eligibility policy and ensuring that DHS county offices comply with the waiver when making applicant eligibility determinations. The application process currently in place for TEFRA will be used, which includes taking the application, interviewing and requesting the information necessary for processing the case. DCO is responsible for processing waiver applications.

V. Eligibility

The following requirements must be met in order for a child to be included in the waiver.

A. Age

The child must be age 18 or younger;

B. Disability

The child must be disabled according to the SSI definition:

C. Citizenship

The child must be a U. S. citizen or a qualified alien;

D. Residency

The child must be an Arkansas resident;

F. Social Security Number

The child must have an SSN or apply for one;

G. Income

The child's gross countable income must be less than the current Long Term Care (LTC) income limit (\$1635 per month in 2002), i.e., the child would be Medicaid eligible if institutionalized. Parental income is not considered in the eligibility determination but is considered for the purpose of calculating the monthly premium. See Section VI B.

H. Assets

The child's countable assets cannot exceed \$2000. The assets of the parent(s) are not considered.

I. Payment of Premiums – The parent(s) will be required to pay monthly premiums through bank drafts or quarterly payments in advance. For new recipients, premiums will be applied beginning with the month of approval. Premiums will not be charged for covered months prior to the month of approval. When approved, EDS will send a notice to the parent(s) giving the option of authorizing an automatic bank draft or making quarterly payments in advance.

For those parents who choose to pay through monthly bank drafts, EDS will draft the account for the month of approval and the following month. After which, EDS will make monthly drafts to the account in the month prior to the covered month. EDS will send monthly notices to the parent when the bank account has been drafted.

For those who choose quarterly payments, the parent must initially pay for the month of approval and the three following months. After which, EDS will send quarterly notices requesting premium payment in the month prior to the covered quarter. If eligibility ends during the quarter, any premiums already paid for months after the month of closure will be reimbursed to the family.

Failure to provide bank draft information or make the initial quarterly payment will render the child ineligible and the case will be closed after advance notice. For ongoing cases, if the premium is not paid for three (3) months (either the bank account has had insufficient funds to draft or the parent has not made the quarterly payment), the case will be closed. Monthly aged reports will be sent to each county showing the cases with overdue premiums and the number of payments in arrears. The county caseworker will send an advance notice of case closure to those that are 3 months in arrears and close the case if the premium is not paid within the notice period. During months that premiums are in arrears, the child will remain eligible and providers will be paid.

If a case is closed due to non-payment of the premium, the parent must reapply and eligibility will be re-determined at the point of reapplication. If a new application is made within 12 months from the date of case closure, premiums will be due for the three (3) months of arrearages.

K. Dropped Health Insurance Coverage

A child can receive TEFRA Waiver services and retain health insurance. Any family who voluntarily drops creditable health insurance coverage for the waiver child will be ineligible for waiver benefits for the child with a disability for a period of six (6) months from the date the insurance is dropped. At the yearly reevaluation, if it is determined that health insurance coverage was voluntarily dropped after the case was approved, the case will be closed for six (6) months beginning with the month following the month of discovery.

The six-month period of ineligibility will apply unless one of the following conditions is met:

1. The health insurance is a non-group or non-employer sponsored plan.
2. The health insurance was lost through termination of employment for any reason.
3. The health insurance was lost through no fault of the custodial parent(s), guardian or custodian. For example, the employer ceases to provide employer sponsored health insurance, the non-custodial parent carried the insurance and dropped it, the maximum benefit limit for the child has been reached, etc.

L. Medical Necessity

The child must either meet the medical necessity requirement for institutional placement, or level of care, or be at risk, in the future, for institutional placement. The determination of medical necessity will also be based upon services that improve, maintain or prevent regression of the child's health status and be based upon the child's medical, health and family situation. The entire family home life must be considered when determining the needs of the child and family impact (i.e., family with more than one child with a disability as described in number 6 above). The Medical Necessity Determinations Team will be comprised of appropriate pediatric specialists with relevant experience in dealing with children with chronic illnesses.

For the purpose of this waiver, the institutional placement or level of care will include:

1. An acute care facility including acute care mental health facilities; or
2. A skilled nursing facility; or
3. Residential placement at the ICF/MR level of care; or
4. Alternative Home placement as a child if risk of placement is due to the medical condition of the child.

- H. The child must have access to medical care in the home. It must be deemed appropriate to provide such care outside an institution; and
- I. The estimated cost of care in the home must not exceed the estimated cost of care if the child were in an institution.

VI. Benefits

A. Benefit Package

Eligible children will receive the full range of Medicaid services through the waiver.

B. Premiums

All waiver recipients will pay a monthly premium. The amount of the premium will be based on the custodial parent(s) total income as reported on the applicable Federal Income Tax Return (i.e., line 22 of the 2001 version of the 1040 or line 15 of the 2001 version of the 1040A) less the following deductions:

1. Six hundred dollars (\$600) per child (biological or adopted) who lives in the home of the waiver child and is listed as a dependent child on the applicable Federal Income Tax Return of the parents (i.e., line 7.c on the 2001 version of form 1040 or 1040A; and
2. Excess Medical and dental expenses as itemized on Schedule A of the Federal Income Tax Return of the parent(s) (i.e., line 4 on the 2001 version of Schedule A).

NOTE: A stepparent living in the home will be considered a custodial parent and his or her income will be included in determining the premium.

See Attachment F for the amount of the premiums to be paid. The maximum annual premium amount to be paid by any family is \$5,500. **Families that have more than one child receiving TEFRA waiver benefits and services will pay only one premium for all children based on Attachment F.** There will be no increase in premium for additional waiver children.

For late or amended returns that result in an increased premium, the increase shall be retroactive to the date that the initial return would have been due in the absence of an extension. Failure to supply required tax information shall render the child ineligible.

The premium will begin in the month eligibility is approved. The premium will be charged on a monthly basis and will not be pro-rated. Income will be reviewed annually, for purposes of calculating the premium; or, when there is a change that will make a difference of more than 10% in annual household income. An adjustment can be made to the premium during the year if the parents report a significant change in excess of 10% of expected annual income. Income that fluctuates due to the type of employment, e.g. teachers, farmers, etc., will not affect the monthly premium. The premium can only be adjusted at a maximum of once every 6 months.

The parent(s) will be required to pay monthly premiums through bank drafts or quarterly payments in advance. The premium must be paid in the month preceding the covered month or quarter. The child's case will not be closed and providers will continue to be reimbursed for covered services if the premium is not paid for three (3) months.

If after three (3) months, premiums are in arrears, coverage will be terminated following appropriate advance notice. If payment of all premiums in arrears is not made and the case closes, then the parent must reapply and eligibility will be determined at the point of application.

If the case has been closed less than 12 months because of premium payments in arrears, the three (3) months past due premiums must be paid before the child can again be approved for TEFRA Waiver services.

If a case is closed 12 months or more because of premium payments in arrears, payment of the past due premiums will not be required.

C. **Special Populations**

The population served by this waiver is made up of individuals age 18 and under.

VII. Delivery System

All services for the waiver population will be delivered through the current network of enrolled Medicaid providers.

Each recipient in the waiver population must receive Medicaid services through a primary care physician (PCP).

Reimbursement for services provided to the waiver population will be based on the current Medicaid fee schedule.

VIII. Access**A. Capacity**

The ADHS Primary Care Case Management (PCCM) Waiver Program, 1915(b)(1) AR-01.R2, known as ConnectCare offers 1800 physicians statewide, who have a caseload availability of approximately 1,000,000 patients. Access availability is five to one.

B. Outreach/Enrollment

Applications will be available at local DHS offices or by mail, through hospitals, including Arkansas Children's Hospital, and Federally Qualified Health Centers (FQHC). Information will be available through First Connections, Division of Developmental Disabilities (DDS) Services Coordinators and providers. Information will also be available on the DHS/DMS website. This allows for a wide range of points of access into the program.

IX. Quality

The same grievance system in effect under the regular Medicaid program will apply to the waiver population. Recipients have available a formal appeal process under 42 CFR Part 431, Subpart E.

Arkansas Foundation for Medical Care, Inc. (AFMC) reviews allegations of substandard medical care for the Arkansas Medicaid Program.

A. Eligibility

1. A quality control program for waiver participants that meets the requirements of Section 1903(u) will be implemented if necessary.
2. Applicants and recipients have available to them a formal appeal process under 42 CFR Part 431, Subpart E, to assure that they are not inappropriately denied enrollment or medical care or terminated from the program.

B. Surveillance and Utilization Review Subsystem (SURS)

1. The State's SURS is used to identify aberrant provider practices for education and potential sanction purposes.
2. To assure quality of services, SURS reviews payment files to identify over or under recipient utilization and patterns of aberrant provider behavior.

C. Arkansas Foundation for Medical Care, Inc. (AFMC)

1. The SURS review is supplemented by an endeavor between the Division of Medical Services and AFMC to identify physicians whose practices are outside the norm.
2. The State implements appropriate education efforts based on trends that become apparent through the efforts of SURS and AFMC. AFMC conducts any provider education efforts on behalf of the State.
3. AFMC delivers specific improvement goals to the providers as necessary.

X. Financial Issues

See Attachments F through F-2.

XI. Systems Support

The Medicaid Management Information System (MMIS) will be modified to recognize the waiver recipients.

XII. Implementation Time Frames

The proposed effective date for implementation of the TEFRA Waiver Demonstration Program is October 1, 2002.

XIII Evaluation and Reporting

The evaluation will be based on two objectives:

- A. Cost neutrality, and
- B. Access to quality care

XIV. Waivers

Section 1916(a)(2)(A) – Cost Sharing

A monthly premium will be required of waiver participants as outlined in Section VI of the application.