

# Arkansas Medicaid Expansion Waiver

## Overview

Arkansas received federal approval for a three-year Medicaid premium assistance demonstration waiver for 2014 through 2016 on September 27, 2013, with coverage beginning January 1, 2014. The demonstration, entitled Arkansas Health Care Independence Program (Private Option), allows the state to provide coverage to new adult group through premium assistance in health insurance exchange plans.

## Populations Covered

The demonstration covers adults age 19 to 64 without dependent children and parents above the state's pre-ACA eligibility levels, with incomes at or below 138 percent of the federal poverty level (FPL). Medically frail individuals are excluded from the demonstration and receive traditional Medicaid coverage unless they choose to opt into coverage through an exchange plan.

## Benefits

Enrollees get their benefits through the exchange plan in which they enroll. They may receive benefits that are not available in the exchange plan package through the state Medicaid agency, including out-of-network family planning services, and Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for 19- and 20-year-olds. Non-emergency medical transportation (NEMT), while still provided, requires prior authorization. Plans must address providers' prescription drugs prior authorization requests within 72 hours instead of 24 as was previously required under Arkansas' state policy. Retroactive coverage (coverage for the three months prior to the month in which an individual is determined eligible) will be provided through Arkansas's fee-for-service Medicaid program.

## Premiums and Cost Sharing

In a waiver amendment approved on December 31, 2014, Arkansas was given permission to establish Independence Accounts to collect monthly contributions from beneficiaries with incomes above 50 percent FPL; however, the state has opted not to implement these provisions. Currently, there is no cost sharing for beneficiaries with incomes below 100 percent FPL.



Beneficiaries with incomes at or above 100 percent FPL are subject to cost sharing based on a sliding scale tied to income and no household pays more than 2 percent of income toward these accounts. Although the state has approval to require monthly contributions of up to \$25 for those with higher incomes, in operation the state does not require contributions in excess of \$15 per month (Table 1). No individual can be declined or lose eligibility for failure to pay cost sharing or contribute to the Independence Accounts, though if the enrollee does not contribute to their Independence Account, they must pay a copayment or co-insurance out of pocket at the point of service. If they fail to do so, they can be denied the service at that time. Additionally, the cost sharing amounts must be consistent with federal Medicaid requirements that no enrollee can pay more than 5 percent of income.

**Table 1: Independence Account Contribution Amounts**

Income range	Monthly contribution	Use of Independence Account
>50% to 100% FPL	\$5	No cost sharing.
>100% to 115% FPL	\$10	Participants will use their Independence Account to pay cost sharing. Individuals who do not make contributions will pay at the point of service and can be denied services at the point of service for failure to pay.
>115% to 129% FPL	\$17.50	
>129% to 138% FPL	\$25	

Individuals who contribute to their Independence Account for any six months within a calendar year receive a credit that can be used to pay future premiums for exchange coverage, employer-sponsored insurance, or Medicare, should the individual lose Medicaid eligibility. Individuals accrue the lesser of their monthly payment or \$15 for each timely contribution, up to \$200 and the credit must be used within two years.

## Premium Assistance

Individuals enrolled in the waiver receive coverage through an exchange plan, with Medicaid providing any missing benefits and paying additional cost sharing. Beneficiaries have the option of selecting an exchange plan, may choose among all silver-level exchange plans offered in their geographic area, with a choice of at least two plans. Those who do not select a plan will be auto-assigned to one. Enrollees receive coverage through the state's fee-for-service Medicaid until enrollment in the exchange plan is finalized.

## Delivery System

Enrollees have access to the same networks as others enrolled in exchange plans. Services described above not provided through the exchange plan will be provided by the Medicaid fee-for-service delivery system. Premium assistance enrollees also must have access to at least one exchange plan that contracts with at least one federally qualified health center or rural health center.

For a summary of the Section 1115 waivers used to expand Medicaid to the new adult group please see [Expanding Medicaid to the New Adult Group through Section 1115 Waivers](#).



## References

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2014. Section 1115 of the Social Security Act Medicaid demonstration: Amendment to the Arkansas Health Care Independence Program (Private Option). December 31. Baltimore, MD: CMS. <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/ar-private-option-ca.pdf>.

Dickson, V. 2015. Arkansas cancels cost-sharing for poorest in Medicaid expansion. *Modern Healthcare*, June 8.

