

July 21, 2016

The Honorable Sylvia Mathews Burwell, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Burwell,

We write in response to your request for public comment on Arkansas' proposal to extend and amend their Section 1115 Medicaid demonstration project, known as Arkansas Works. Since the waiver's implementation, the uninsured rate for children and adults ages 0-64 declined from 18.7 percent in 2013 to 13.8 percent in 2014—translating to over 250,000 low-income Arkansans gaining access to health coverage. These impressive gains speak to Arkansas' commitment to improving healthcare access and coverage for its families.

Thank you for your consideration of the following comments.

Elimination of Independence Accounts

We support the elimination of monthly contributions to Independence Accounts. We agree that the administrative complexity of implementing and monitoring "MyIndyCards" does not advance the objectives of the Medicaid program or Arkansas Works.

Employer-sponsored insurance premium assistance program

The proposal creates a new premium assistance program intended to encourage the use of employer-sponsored insurance (ESI). We support the state's plan to provide fee-for-service coverage through Medicaid until enrollment in a Qualified Health Plan (QHP) or ESI becomes effective (p. 8). It will be important to ensure that beneficiaries are properly notified that fee-for-service coverage is available.

One question that needs to be clarified is whether the state plans to work with Arkansas' Insurance Department to establish Medicaid eligibility as a qualifying event for purposes of enrolling in ESI or whether enrollees will stay in Medicaid until the open enrollment period for the employer plan. As you know, P.L. 111-3 established eligibility for a Medicaid or CHIP premium assistance program as an event that triggers a 60-day special enrollment period. Again, outreach and education will be needed for both employers and beneficiaries to ensure that there is no gap in coverage.

Cost-effectiveness test: The proposed cost-effectiveness test is based on a minimum 25 percent employer contribution, which as an aggregate standard, as opposed to an individualized test, is very low. If a 25 percent contribution standard was employed on an individualized basis it is likely that high cost beneficiaries would meet the cost-effectiveness test. But when applied to the population at large, this is less

certain. As such we hope that CMS will require careful tracking of the cost-effectiveness data which should be based on an “apples to apples” comparison (i.e. premium costs, additional benefit costs for wrapped services, and administrative costs). We would also request that this information be made publicly available when it is compiled. Research has shown that states do a poor job tracking the costs of premium assistance programs.

We support the state’s decision to exclude 19 and 20 year olds from the new ESI program as we believe that it is very difficult to provide the EPSDT benefit through wraparound services.

The waiver proposal notes on page 10 that the new premium assistance program will be distinct from the state’s current Health Insurance Payment Program (HIP). It would be helpful to know more about the distinctions between the two programs besides the obvious difference in required premiums. One question that arises is how access to ESI would be coordinated when a child is in the state’s regular HIP program and the parent is eligible for Arkansas Works ESI premium assistance.

Finally, research has shown that materials conveying the availability of wrapped benefits are often inadequate. We urge CMS to review all beneficiary notices before they are finalized. The state should also seek public review of all notices at the state level from state-based organizations (including legal services advocates) working with low-income families.

Premiums and Cost Sharing

We do not support the proposed premiums and cost sharing for certain beneficiaries. Under Arkansas Works, beneficiaries with incomes above 100% FPL will be subject to monthly premiums. Carriers for those beneficiaries enrolled in QHPs will be responsible for collecting premiums, which creates an additional layer of administrative complexity.

Multiple studies indicate that charging premiums or imposing cost sharing creates barriers to access for those living at or slightly above the poverty line. Evaluations of Medicaid demonstrations in Oregon and Utah and of the state funded Basic Health program in Washington show the harmful effect premiums have had in decreasing enrollment of otherwise eligible low-income people. Given the abundance of studies on this issue, and similar state demonstrations (such as Iowa, Michigan and Indiana) that are currently being evaluated, Arkansas’ proposal to test how members comply with required premiums incentivized by healthy behaviors or increased benefits does not further the objectives of the Medicaid program.

Auto Assignment into QHPs

The proposed auto-assignment methodology assigns beneficiaries who do not make an active choice on a basis intended solely to equalize market share. We believe that existing provider relationships should be taken into account during the assignment

process to enhance continuity of care and minimize disruption of current provider-patient relationships.

Additionally, we believe this approach is a missed opportunity for the state to create incentives for plans to demonstrate excellence in the delivery of services by establishing auto assignment parameters based on quality indicators or other performance indicators. This would be a more strategic methodology than the proposed process and reflects current national objectives for the Medicaid program as outlined in the recent final regulation on Medicaid managed care.

Retroactive Eligibility

CMS should deny the waiver of retroactive eligibility, especially since presumptive eligibility is not in place in Arkansas. Retroactive eligibility is an important protection for beneficiaries who are in a financially vulnerable position. Arkansas' request to waive this requirement puts newly eligible beneficiaries at risk of medical debt and providers at risk for bad debt.

Clarity on incentive benefits and healthy behavior standards

The Arkansas Works proposal outlines a plan to incentivize timely premium payments through completion of healthy behaviors. However, the proposal provides very few specifics regarding what a new incentive benefit would include or how healthy behavior standards, aside from a visit to a PCP, would translate into success for Medicaid beneficiaries. CMS should request more detailed information regarding these practices, and ensure that any new incentives to obtain benefits remain in keeping with the state Medicaid program's larger goals and are not punitive. We would also encourage further opportunities for public comment on this aspect of the proposal as more details become available.

Expeditious termination of Arkansas Works

Arkansas is asking CMS to allow for expeditious termination of the demonstration if Congress reduces the enhanced Federal Medical Assistance Percentage (FMAP). There are already standard terms and conditions that govern how states activate and transition a phase-out plan. Since termination of this waiver would likely result in loss of coverage for many Arkansans, there are no grounds to change the standard terms in this regard.

Non-Emergency Medical Transportation

The Non-Emergency Medical Transportation Benefit (NEMT) is an important benefit in ensuring Medicaid beneficiaries' access to medically necessary and preventive care. According to data collected by the Community Transportation Association of America in 39 states, half of all NEMT trips were provided to obtain dialysis treatment (17.9 percent) or behavioral health services (31.9 percent). By waiving the NEMT benefit, the State could be creating barriers that prevent Medicaid beneficiaries from obtaining the primary, specialty, and preventive services that enable them to identify and address their health needs as they arise and prevent more costly care as undiagnosed medical problems worsen.

As we have commented in other state proposals, we believe that it is a mistake for CMS to waive this benefit – especially as we await more comprehensive evaluations in states such as Iowa where it has been waived.

Again, we thank you for the opportunity to provide input. Please contact Joan Alker (jca25@georgetown.edu) or Judith Solomon (Solomon@cbpp.org) for additional information.