

September 6, 2013

Dear Secretary Sebelius,

The undersigned organizations appreciate the opportunity to comment on the Arkansas Health Care Independence Program (“Private Option”) Demonstration proposal. We fully support Arkansas’ decision to accept federal Medicaid funding to move forward with the extension of coverage to low-income parents and adults. However, we do have concerns with specific aspects of the proposal that can and should be addressed during the approval process. While some of our concerns are specific to the Arkansas proposal, others are more general issues relating to Section 1115 proposals that we have raised in the past.

The state’s approach to purchase coverage for newly eligible beneficiaries in the new marketplace with Medicaid funds using a Medicaid premium assistance option is an interesting and unique approach that, in our view, merits careful consideration and scrutiny. Indeed the intent of Section 1115 demonstration authority is to permit states to experiment with new concepts for the Medicaid program, and Arkansas’ approach is correctly being pursued through this avenue.

For many years, our organizations have advocated for greater public input and transparency in the Section 1115 process. Much improvement has occurred in that regard for which we commend you and your department.

Transparency: There are certain aspects of Arkansas’ application that, in our view, do not meet the expectations for public disclosure as outlined in 42 CFR §431.412(a). These include:

- **The process and criteria that will determine whether a newly eligible beneficiary is “medically frail.”** The proposal does not provide sufficient information regarding the criteria that will be used to determine whether an individual is “medically frail” and therefore should not be enrolled in the “Private Option.” According to the proposal, a process is being developed that will utilize a screening tool to determine whether an individual may be “medically frail/have exceptional needs.” However, the proposal never specifies the definition that will be used to make the determination. Instead it alludes to an algorithm calibrated to “to identify the top ten percent expected costs among the newly eligible population.” Determining in advance how many people in a newly covered population will be medically frail is inconsistent with the Medicaid statute and regulations, which require all who meet the definition to be included regardless of their expected health care costs. Some individuals with disabilities, for example, who should be considered medically frail under the regulatory definition, may not have high expected health care costs, but they are still entitled to a determination that they are medically frail. Arkansas should confirm that it will treat all individuals who meet the definition of medically frail in accordance with the

requirements of the Medicaid statute and regulations, not just those who are identified based on an arbitrary predetermined percentage of the population.

- **Budget neutrality.** The proposal is also deficient in explaining how Arkansas proposes to meet the requirement that section 1115 waivers be budget-neutral to the federal government—that the federal government will spend no more under the waiver than without the waiver. The proposal merely summarizes the approach used by the state’s actuaries and asserts that the projected costs for the demonstration are equal to the costs of enrolling beneficiaries in traditional Medicaid. More detail on the actuarial analysis and the assumptions that underlie the analysis should be provided. The General Accountability Office (GAO) recently criticized HHS for a lack of transparency as well as its approach in determining budget neutrality. The Arkansas proposal has the same shortcomings as the demonstration projects discussed in the GAO report.
- **Use of amendment process to make major changes in demonstration projects without public input is problematic.** We have urged CMS in the past to apply the transparency and public notice requirements set forth in 42 CFR §431.408-431.416 to amendments of Section 1115 demonstrations. The Arkansas proposal says that the state intends to request an amendment to move children into the demonstration at a later date. Amendments of substantive significance should be subject to the important public notice and comment provisions provided for in the Affordable Care Act, and the state should be informed that public input will be required should it decide to move in this direction.

Issues affecting children: Moving children into the demonstration in future years should not be considered until the private option is fully evaluated. The “private option” is untested, and ArKids has a strong track record in serving children. CMS should not consider moving children into the demonstration until the final evaluation of this three year waiver is available.

19 and 20 year olds: Guidance issued by CMS on March 29, 2013, states that only “individuals whose benefits are closely aligned with the benefits available on the Marketplace” should be included in premium assistance demonstrations. The state is requesting that 19 and 20 year- olds who are entitled to receive Early Periodic Screening Diagnosis and Treatment (EPSDT) benefits be included. EPSDT services not included in the QHP benefit would be provided through fee-for-service. The lack of alignment between EPSDT and QHP benefits means that 19 and 20-year olds should not be included in the demonstration.

Cost-effectiveness: Federal regulations recently finalized by CMS define cost-effectiveness at §435.1015, stating that the total cost of purchasing private coverage must be “comparable” to the cost of providing coverage directly through Medicaid.

CMS should carefully examine the cost-effectiveness of the state's approach particularly because certain features of the demonstration raise questions as to the comparability of costs with traditional Medicaid. For example, the newly eligible beneficiaries who will remain in traditional Medicaid are those who are medically frail and are more expensive to cover. Moreover, private coverage is typically more expensive than Medicaid.

Status of demonstration participants as Medicaid beneficiaries. One of the purposes of the waiver proposal is to “reduce the size of the state-administered Medicaid program,” which is reflected in the treatment of “Private Option” participants as being outside the Medicaid program. The Arkansas Medicaid agency does not plan to have a contractual relationship with the Qualified Health Plans (QHPs) participating in the demonstration except for the purposes of paying premiums. The March 2013 guidance on premium assistance is clear that beneficiaries enrolling in QHPs are still Medicaid beneficiaries. Even under a waiver, the Arkansas Medicaid agency is still the single state agency, and it remains responsible for oversight, monitoring and ensuring that all beneficiaries receive the benefits and protections afforded by the Medicaid statute.

It is difficult to see how the Arkansas Medicaid agency can carry out its responsibility as the single state agency without a relationship to the QHPs delivering services. For example, if the QHP network does not provide a beneficiary with access to federally qualified health center or rural health clinic services as guaranteed under section 1937(b)(4) of the Social Security Act, how would the beneficiary enforce his or her right to those services? More broadly, how will the Medicaid agency ensure that services are being delivered in a manner that does not discriminate against Medicaid beneficiaries or that the services meet quality and adequacy standards? While premium assistance allows for federal matching funds to be used for premiums paid to private health plans, it does not abrogate the rights of beneficiaries to applicable protections afforded by the Medicaid statute. CMS should ensure that the state is able to effectively monitor and oversee the provision of services to Private Option participants by the QHPs. In our view, this requires at minimum a contractual relationship between the Medicaid agency and the QHPs.

Cost-sharing: We strongly support the state's intent to maintain Medicaid cost-sharing protections for Medicaid beneficiaries as they enter QHPs.

Thank you for your willingness to consider our comments. If you would like any additional information, please contact Joan Alker (jca25@georgetown.edu) or Judy Solomon (Solomon@cbpp.org).

American Association on Health and Disability
American Cancer Society Cancer Action Network (ACS CAN)
Association for Gerontology and Human Development in Historical Black Colleges and Universities
Association of University Centers on Disabilities

Bazon Center for Mental Health Law
Center on Budget and Policy Priorities
Children's Defense Fund
Community Access National Network
Community Catalyst
Doctors for America – Arkansas
Epilepsy Foundation
Families USA
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