September 6, 2013

The Honorable Kathleen Sebelius
Secretary of Health and Human Services
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

RE: Comments on Arkansas Health Care Independence Program

Dear Secretary Sebelius:

We appreciate the opportunity to comment on the proposed Arkansas Health Care Independence Program ("private option"), a section 1115 demonstration that was submitted by the Governor of Arkansas on August 2, 2013.

As long time analysts of both the Medicaid program in general, and the section 1115 process in particular, our organizations offer these comments to support your department's efforts to move forward with approval of the Arkansas proposal. We appreciate the state's intent to accept federal funding to move forward to expand coverage to low-income parents and adults through Medicaid.

The state's approach to purchase coverage using premium assistance for these newly eligible beneficiaries through the emerging Qualified Heath Plans (QHPs) is an interesting and unique approach that, in our view, merits careful consideration and scrutiny. Indeed, the intent of Section 1115 demonstrations is to experiment with new concepts for the Medicaid program, and the Arkansas proposal is correctly being pursued through this avenue.

We do have a number of concerns about some aspects of the proposal. As explained below, some of these issues are specific to the Arkansas proposal and some reflect more general concerns about section 1115 proposals that we have raised in the past. We also write to underscore our support for certain key features of the Arkansas proposal.

Section 1 Program Description

Moving children into the demonstration in future years should not be considered until the "private option" is fully evaluated. In its description of the populations that will be enrolled in the "private option," the state indicates that it intends to move the lowest-income parents and children into the demonstration "in future years" by "revising" the waiver. Because the "private option" is largely untested and because ARKids has a strong track record in providing health coverage to children, CMS should not consider an amendment to the waiver to include children until final results of this three year waiver have been thoroughly evaluated.

Moreover, we have urged CMS in the past to apply the transparency and public notice provisions set forth at 42 CFR §431.400 *et seq.* to proposals for amendments of Section 1115 demonstrations. The state's intent to file an amendment to include children underscores the need to subject amendments of substantive significance to public notice and comment provisions required under the Medicaid statute and regulations.

Finally, 19- and 20-year olds should not be included in the demonstration. CMS guidance issued on March 29, 2013, states that only populations with benefit packages that are easily aligned with the Essential Health Benefits that QHPs will provide should be included in premium assistance arrangements like the Arkansas "private option." Children entitled to Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services are not in this category.

The waiver proposal fails to adequately ensure that demonstration participants will receive the benefits and protections required by the Medicaid statute and regulations. 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, at minimum, carrying out the responsibility of the Medicaid single state agency requires a contractual relationship between Arkansas and the QHPs.

One of the purposes of the demonstration proposal is to "reduce the size of the state-administered Medicaid program." The intent to decrease the number of people enrolled in Medicaid is reflected in the treatment of "private option" participants as being outside the Medicaid program. The proposal states that the Arkansas Medicaid agency does not plan to have a contractual relationship with the QHPs participating in the demonstration except for the purposes of paying premiums to the QHPs. The March 2013 CMS guidance on premium assistance is clear that beneficiaries who enroll in QHPs through a premium assistance demonstration like that proposed by Arkansas are Medicaid beneficiaries. Regardless of the demonstration, the Arkansas Department of Human Services is 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? If, for example, a health plan fails to provide a covered benefit, how will the Arkansas Medicaid agency ensure that the benefit is provided? In some situations, particularly for 19- and 20-year olds (should they remain in the demonstration), there could be significant disputes regarding the services that should to be provided through wraparound EPSDT coverage and what should be provided by the QHP. Without a

contractual relationship defining the responsibility of the QHP, Arkansas would have no way of requiring that the QHP provide services it is required to cover. The distinction Arkansas proposes to make between coverage of emergency services and non-emergency services delivered in the emergency room raises similar concerns. If the state is allowed to exclude coverage of non-emergency care delivered in the emergency room, then how would the state ensure that the QHPs pay for care when it is an emergency and not shift such costs to beneficiaries?

The hypothesis and evaluation approach should be improved. Properly conceived Section 1115 demonstrations are experiments that have been found "likely to assist in promoting the objectives of title XIX." Because they are designed to test new approaches, they should be carefully evaluated to assess whether they do in fact further the purposes of the Medicaid statute. The Arkansas proposal certainly merits careful evaluation and we are pleased that the state intends to carry out a multi-dimensional evaluation.

We believe, however, that the hypotheses and evaluation plan should be amended. The Arkansas proposal to put thousands of adults into private health plans represents a major change in how Medicaid benefits are generally delivered. Well-crafted hypotheses and a well-designed evaluation are critical to assess whether the demonstration does, in fact, further the objectives of the Medicaid statute.

As noted above, we are concerned that the demonstration purports to test reducing the size of the Medicaid program. The participants in the "private option" remain Medicaid beneficiaries, so this purpose should be deleted.

While the remaining purposes are acceptable, the approach of comparing "private option" enrollees to those in fee-for-service is problematic. The adults in the fee-for-service program are either parents in deep poverty—those with incomes below 17 percent of the poverty line—or adults who are medically frail. Comparing all "private option" enrollees to these groups is not an "apples to apples" comparison. While comparing the "private option" participants to others enrolled in QHPs holds more promise, it does not necessarily show whether the QHPs are providing good access and high quality services because such a comparison lacks a benchmark designed to measure quality. In other words, services could be of low quality for both groups. The experience of participants in the "private option" should be compared to objective performance standards such as HEDIS and other benchmarks that have been developed to assess whether health coverage provides access to high quality services.

It is also disturbing that the hypothesis appears to be that those in the "private option" will have greater access to quality services given that extremely poor parents and medically frail adults will remain in the fee-for-service program. CMS should require that the state ensure that those in its traditional Medicaid program also receive access to quality health coverage as part of the terms and conditions of the demonstration.

The following specific suggestions would also improve the evaluation section of the proposal:

- The concern about non-comparable populations raised above (i.e. a sicker population in traditional Medicaid) also applies to the evaluation of quality improvement on pages 7 to 8 with respect to private option participants having lower rates of potentially preventable admissions.

- The evaluation approach regarding cost lacks key details. To comply with the transparency requirements, this important section of the application should provide more details. Among other things, this section should include a thorough definition of administrative costs in the private option versus traditional Medicaid.

- Finally, the assumption that a decrease in uncompensated care costs would be the result of the private option does not take into account that expanding Medicaid in and of itself (which does not require a waiver) and other provisions of the Affordable Care Act will substantially reduce the number of uninsured persons and decrease uncompensated care.

Section II Demonstration eligibility

At page 10, Arkansas indicates that it is not planning to adopt 12-month continuous eligibility for newly eligible beneficiaries, a policy that was included in the proposal reviewed at the state level. Given that one of the major rationales for the private option is to minimize churning, we believe this is a counterproductive policy change and urge CMS and the state to work together to reinstate this important component of the demonstration.

Section III Demonstration Benefits and Cost-sharing

We support the state's intent not to charge premiums.

The proposal indicates that a state plan amendment (SPA) will be submitted to describe the Alternative Benefit Plan the state will adopt as well as the cost-sharing design. We believe this SPA should be made available for public comment as required by the Medicaid regulations at 42 CFR §440.386. The proposal states that cost-sharing obligations will be identical to those in the state plan, but since the SPA has not been made available, the cost-sharing design is not available for public review and comment.

Further, the proposal indicates in this section that a waiver amendment will be submitted for years two and three of the demonstration that will require additional cost-sharing for persons with incomes between 50 and 100 percent of the poverty line. Such an amendment should trigger required public notice and transparency provisions. The Medicaid statute and regulations establish additional cost-sharing protections for beneficiaries with incomes below the poverty line. Should cost-sharing be imposed on such beneficiaries, CMS should assure that the additional protections in the regulations apply, including the prohibition on denials of service for non-payment at 42 CFR §447.52(e).

Regardless of income, regulations at 42 CFR §447.56 set an aggregate a limit on cost-sharing and premiums for families at five percent of family income, Beneficiaries must be allowed to request a reassessment of this limit when their circumstances change. Arkansas should provide more detail on how it will adjust the cap for families with multiple beneficiaries and how beneficiaries can request a new assessment.

Arkansas should not be allowed to exclude coverage of visits to the emergency room for non-emergency services for private option enrollees. Arkansas proposes to exclude coverage of non-emergency services provided in the emergency room from coverage on the ground these services are not part of the essential health benefits provided by the QHPs. However, exclusion of coverage for such services would violate Medicaid rules, which give states flexibility to impose higher cost-sharing on services delivered in the emergency room that don't meet the definition of an emergency, but not to exclude them altogether. By excluding the services, Arkansas would essentially impose cost-sharing equal to the cost of the visit. Moreover, the type of services provided in the emergency room –physician's services in most instances—is still covered under the ABP. The state could impose cost-sharing on such services, but should not be allowed to exclude coverage altogether.

Section IV Delivery System and Payment Rates for Services

The process and criteria that will determine whether a newly eligible beneficiary is "medically frail" should be clarified to ensure that all individuals who meet the federal regulatory criteria are allowed to remain in the traditional Medicaid program. The final regulations defining alternative benefit plans for people in the new adult eligibility category provide that individuals who are "medically frail" as defined in the regulations must be given a choice of the traditional Medicaid benefit package and the alternative benefit plan (ABP) that would otherwise be available to that individual. The Arkansas proposal would not enroll these individuals in the demonstration program, but would give them a choice of receiving "either the ABP or the standard Medicaid benefit package through the State Plan." This appears to be consistent with the regulations, although no detail has been provided on the ABP that would be offered as an alternative to the standard Medicaid benefit package.

We support providing "medically frail" individuals with traditional Medicaid benefits to ensure that they can receive the full scope of Medicaid benefits including long-term services and supports. We assume that most individuals who are "medically frail" will choose to receive traditional Medicaid benefits in the fee-for-service program. Yet, the state's approach of giving these individuals a choice of receiving an ABP in fee-for-service undermines the rationale and cost-effectiveness of the demonstration. If the demonstration is intended to improve access to quality health care, particularly through broader provider networks, why wouldn't those with the greatest need be given the choice of receiving traditional Medicaid in fee-for-service or the ABP through the "private option" rather than the ABP through fee-for-service? If the hypothesis is that those enrolled in the demonstration will have lower rates of preventable hospital admissions than those in

traditional Medicaid, can the hypothesis be truly tested if those who are the sickest remain in traditional Medicaid?

Moreover, the proposal does not provide sufficient information regarding the criteria that will be used to determine whether an individual is "medically frail" and therefore ineligible for the demonstration. It is not clear whether the approach proposed by the state will actually identify those who are "medically frail" within the definition set forth in Medicaid regulations at 42 CFR §440.315(f).

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 this determination. Instead, it alludes to an algorithm calibrated "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. Nonetheless, they are still entitled to a determination that they are "medically frail." Other individuals may have high medical costs, but not meet the regulatory definition of "medically frail."

Arkansas should confirm that it will treat as "medically frail" all individuals who meet the definition set forth in the Medicaid statute and regulations, not just those who are identified based on an arbitrary predetermined percentage of the population. The state should also explain how excluding "medically frail" individuals from the demonstration is consistent with the stated purposes of the demonstration and how their exclusion is cost-effective. Using a definition that is based on the cost of services undermines the rationale that the demonstration will be cost-effective.

Section V Implementation of the Demonstration

Eligibility determinations should be available through multiple pathways. We strongly support the state's plan to allow eligibility determinations to be made through either the FFM or the Arkansas Eligibility and Enrollment Framework.

Auto-assignment should account for past provider use and provide for adequate time to switch plans. We understand that auto-assignments may be initially higher than desired, and we agree with the state's goal to minimize auto-assignments. However, we are concerned that the criteria for auto-assignment do not reflect factors that are of importance to consumers but rather looks only at market share. For example, continuity of provider relationships – which are of utmost importance to health care consumers – will not be considered when auto-assignments are made. And those who are auto-assigned will have only 30 days to opt out, which is too short a period for choice.

SECTION VI Demonstration Financing and Budget Neutrality

The proposal does not provide sufficient detail to show that the demonstration will meet the budget neutrality requirement. Arkansas has not provided sufficient information to evaluate whether its proposal will be budget neutral. 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. The Government Accountability Office (GAO) recently criticized HHS for a lack of transparency in determining budget neutrality. The GAO also raised concerns regarding the use of unproven hypotheses as to the costs of providing coverage without the waiver. The Arkansas proposal has the same shortcomings as the demonstration projects discussed in the GAO report in basing its claim that the demonstration will be budget neutral on the hypothesis that it would have cost the same with and without the waiver without providing the underlying data to substantiate its claim. CMS should request more information from the state so that the budget neutrality of the proposal can be fully evaluated.

SECTION VII Proposed Waivers and Expenditure Authorities

***The requirements of section 1927 of the Social Security Act should not be waived*.** Section 1927 of the Social Security Act requires that prior authorization requests for prescription drugs be handled within 24 hours in Medicaid and that beneficiaries receive a 72-hour supply of a drug in emergency situations. Arkansas seeks to waive this rule. The rationale for waiving the requirement of a 24-hour response—that it is necessary to align with the commercial market—is not persuasive given that pharmacies and pharmacy benefit programs already are required to respond to prior authorization requests within 24 hours for traditional Medicaid.

Thank you very much for your attention to these comments. We are happy to provide additional information upon request.

Sincerely,

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cc: Marilyn Tavenner, Administrator
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