October 22, 2021

Secretary Xavier Becerra
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Re: Arkansas Health and Opportunity for Me (ARHOME) Demonstration

Dear Secretary Becerra,

The undersigned organizations appreciate the opportunity to comment on Arkansas's proposed section 1115 demonstration project, Arkansas Health and Opportunity for Me ("ARHOME"). We support Arkansas's decision to continue providing coverage to the adult expansion population. However, we have concerns with a number of the proposed provisions in the demonstration request including imposing premiums, limiting retroactive coverage to 30 days, and the punitive use of incentives (including a new variation of work requirement).

Our concerns focus on the parts of the proposal that will make it harder for people to stay enrolled and get the care they need. These parts of the proposal do not promote the objectives of Medicaid, and should not be approved. They are also inconsistent with the President's Executive Order 14009 on Strengthening Medicaid and the Affordable Care Act, which requires review and eventual suspension or rescission of agency actions that undermine Medicaid.[1] Moreover, ARHOME would likely increase systemic barriers that underserved communities in Arkansas experience in obtaining coverage and access to care, in violation of the President's Executive Order 13985 on Advancing Racial Equity and Support for Underserved Communities.[2]

We urge you to approve the continuation of Arkansas's Medicaid expansion, but reject the parts of the demonstration proposal that reduce access to coverage and care and worsen health equity.

Numerous Provisions of ARHOME Do Not Promote the Objectives of Medicaid

Section 1115 of the Social Security Act allows states to implement demonstration projects that promote the objectives of the Medicaid program. The objective of the program, as stated in the Medicaid Act, is to "furnish medical assistance … and rehabilitation and other services." Research shows that numerous provisions of the ARHOME demonstration should not be approved because they *reduce* access to medical assistance.

Arkansas admits its demonstration proposals are in pursuit of three objectives not described in the Medicaid Act, including moving individuals "out of poverty," slowing Medicaid spending, and improving health outcomes. These objectives cannot be the proper basis for section 1115 demonstrations, and certainly can't justify proposals that contradict the explicit statutory objective of furnishing medical assistance. Federal courts have ruled that "[a] simple benefits cut, which might

[1] Executive Order No. 14009, 86 CFR 7793 (2021), https://www.federalregister.gov/documents/2021/02/02/2021-02252/strengthening-medicaid-and-the-affordable-care-act.
[2] Executive Order No. 13985, 86 CFR 7009 (2021), https://www.federalregister.gov/documents/2021/01/25/2021-01753/advancing-racial-equity-and-support-for-underserved-communities-through-the-federal-government.

save money, but has no research or experimental goal, would not satisfy" the section 1115 requirement for an experiment.[3] Moreover, Medicaid law restricts authority to waive sections of the Medicaid statute to those waivers "necessary" to carry out the project. Arkansas has provided no evidence or reasonable basis to conclude that several of the requested waivers are *necessary*, or even helpful, to the project of furnishing coverage.

Increased Premiums Will Decrease Coverage and Access to Care

Arkansas's proposal would increase monthly premiums for enrollees with incomes above 100 percent of the poverty line from $13 to a range of $22 to $27 per month based on income.

Extensive research shows that premiums significantly reduce low-income people's participation in health coverage programs.[4] These studies show that the lower a person's income, the less likely they are to enroll and the more likely they are to drop coverage due to premium obligations. People who lose coverage most often end up uninsured and unable to obtain needed health care services.

Arkansas suggests that premiums are "critical to assess whether individuals value coverage as insurance." The "central objective" of the Medicaid program is to furnish Medicaid assistance to enrollees. Whether people think Medicaid is insurance or something else is besides the point and irrelevant to Medicaid's objective of providing coverage. In any case, evidence from experiments in other states clearly shows that charging premiums makes it more likely that Medicaid beneficiaries lose their health coverage and become uninsured, or that they are less likely to sign up for coverage in the first place. With the overwhelming amount of evidence showing the harmful impact of premiums, there is no further need to test their impact. An experiment that is likely to fail and result in people losing coverage and create barriers to care shouldn't be approved under section 1115.

Retroactive Coverage is Crucial for Beneficiaries and Providers

Arkansas's proposal to extend its waiver of retroactive coverage would limit Medicaid reimbursement for medical costs incurred by most Medicaid beneficiaries to only 30 days prior to the date of application. Under the law, Medicaid payments are available for these expenses for a full 3 months prior to the month of application, if the beneficiary was eligible for Medicaid during this period. Retroactive coverage, which has been a feature of Medicaid since 1972, provides financial security to low-income beneficiaries and helps prevent medical bankruptcy. For example, data from Indiana shows how important retroactive coverage is for low-income parents in the state -- a group that wouldn't be expected to have large medical costs, but in fact incurred significant medical costs prior to enrollment. Medicaid paid $1,561 on average on behalf of parents in Indiana who incurred medical costs prior to enrolling in Medicaid.[5] Waiving retroactive eligibility exposes low-income

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[3] Beno v. Shalala, 30 F. 3d 1057, 1069 (9th Cir. 1994).
[4] Samantha Artiga, Petry Ubri, and Julia Zur, "The Effects of Premiums and Cost-Sharing on Low-Income Populations: Updated Review of Research Findings," The Kaiser Family Foundation, June 2017, http://files.kff.org/attachment/Issue-Brief-The-Effects-of-Premiums-and-Cost-Sharing-on-Low-Income-Populations.
[5] July 29, 2016 letter from the Centers of Medicare and Medicaid Services to the state of Indiana, available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-lockouts-redetermination-07292016.pdf.

people to medical debt, and this is more likely to affect people of color who have greater levels of medical debt.[6]

In addition to helping people get the care they need, retroactive coverage increases the financial stability of hospitals and other safety net providers by allowing them to be reimbursed for care they have provided during the three-month period that would otherwise have gone as uncompensated care. Without full retroactive coverage in place, a hospital would no longer get paid for an emergency appendectomy or setting a broken bone for adults who are uninsured but Medicaid-eligible at the time of their accident. Providers in Arkansas have also expressed concern over the state's request to reduce retroactive coverage, which can result in huge costs for providers and patients alike. The Arkansas Hospital Association wrote that preserving retroactive coverage could help "reduce costly repeated hospital admissions and prevent an otherwise-eligible beneficiary to be saddled with large amounts of health care debt that could have been avoided."[7]

Moreover, Medicaid beneficiaries will end up with significant medical debt, undermining their family's financial stability. With the coronavirus pandemic, individuals face greater risk of health problems and incurring significant medical debt from the limits on retroactive coverage. Beneficiaries may end up responsible for thousands of dollars in COVID-19 treatment and other resultant health care costs.[8]

Arkansas states that the "ARHOME Demonstration seeks to acclimate individuals to having insurance but retroactive eligibility is inconsistent with the way insurance coverage works." However, the legal basis for approving section 1115 waivers is furnishing health coverage, not acclimating individuals to insurance. On its face, reducing retroactive coverage is the opposite of furnishing coverage. The state's justification also ignores the reality that Medicaid *is* health insurance – and Medicaid is in fact the largest insurer in the country.

Arkansas's Proposed Incentive Program Creates Unnecessary Barriers to Care, Including Harmful Work Requirements

Arkansas has requested permission to implement a complicated and undefined "incentive" system for enrollees. Failing to comply with the incentives might lead to higher cost-sharing or premiums.[9] The incentives might also lead to "rewards" and extra enrollment time after an enrollee's income increases. The state also proposes to deny QHP enrollment to individuals who fail to comply with incentives (discussed below). There are numerous problems with the proposed ARHOME incentives.

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[6] Leonardo Cuello, "Retroactive Coverage Waivers: Coverage Lost and Nothing Learned" Georgetown University Center for Children and Families, October 4, 2021. https://ccf.georgetown.edu/2021/10/04/retroactive-coverage-waivers-coverage-lost-and-nothing-learned/

[7] Arkansas Hospital Association Comment Letter to Arkansas Department of Human Services, July 12, 2021, https://humanservices.arkansas.gov/wp-content/uploads/ARHOME-Public-Comments.pdf.

[8] Paul Shafter, Nicole Huberfeld, and Ezra Golberstein, "Medicaid Retroactive Eligibility Waivers Will Leave Thousands Responsible For Treatment Costs," Health Affairs, May 8, 2020, https://www.healthaffairs.org/do/10.1377/hblog20200506.111318/full/.

[9] It is unclear whether the state intends to includes premiums. The federal application mentions only cost-sharing and is silent as to premiums. However, the state level application specifically included premiums.

These incentives do not promote the objective of Medicaid, which is to help furnish health coverage. The central objective identified by the state, providing "incentives and supports to assist individuals…to move out of poverty," has nothing to do with furnishing health coverage. More specifically, the incentives include "Economic Independence Incentives," for individuals "engaged in employment, education, and training activities." These activities are also unrelated to health coverage.

Furthermore, the incentives will not be effective because most individuals will not know about them, and those who do learn of the requirements are unlikely to understand them – barring a massive educational effort by the state. Arkansas already experimented with a work requirement in 2018 which was ineffective and harmful.[10] Although exemptions and exceptions were available, most individuals did not know about them or understand them, and nearly 20,000 lost their health insurance.[11] The state has never provided – in advance of the 2019 work requirements, subsequent to them, or in conjunction with this new ARHOME work requirement – evidence to support the contention that work requirements might lead to meaningful employment or that they did in fact lead to such employment. Studies show the state's experiment did not increase employment and led to serious harms for individuals who lost coverage.[12] This is consistent with voluminous evidence that work requirements are ineffective and harmful.[13]

CMS also should deny this waiver request because the incentives are not intelligible or defined. In some places, the state suggests that QHPs and Life360 HOMEs will design the incentives subject to state review. However, the state also requests expenditure authority to "to develop a process for identifying individuals" eligible for economic incentives, implying the state may be designing the process. The state's incentives are vague and undefined, which makes it impossible for commenters and CMS to evaluate them.

Finally, these incentives are likely to be discriminatory in practice. Individuals will be less likely to learn about, understand, or be able to complete the required activities based on physical and behavioral health disabilities, English proficiency, and other factors. For example, individuals in rural areas with limited employment opportunities may have a hard time meeting work incentives.

Re-Assigning Individuals to Fee-For-Service Coverage Creates Discrepancies in Access to Care

In addition to the incentives described above, Arkansas also proposes to re-assign individuals deemed to be "inactive" from QHP coverage to fee-for-service (FFS). All of the concerns described above (failure to promote the objectives of Medicaid, lack of consumer notice about the policy, lack

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[10] While the current proposal does not terminate eligibility based on noncompliance, it can lead to any number of punishments, including increased cost-sharing and re-assignment to fee-for-service.

[11] Jennifer Wagner and Jessica Schubel, "States' Experiences Confirm Harmful Effects of Medicaid Work Requirements," Center on Budget and Policy Priorities (Nov. 18, 2020), https://www.cbpp.org/research/health/states-experiences-confirm-harmful-effects-of-medicaid-work-requirements.

[12] Benjamin D. Sommers, et al., "Medicaid Work Requirements In Arkansas: Two-Year Impacts On Coverage, Employment, And Affordability Of Care," *Health Affairs,* September 2020, https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.00538.

[13] Judy Solomon, "Medicaid Work Requirements Can't Be Fixed," Center on Budget and Policy Priorities (Jan. 10, 2019), https://www.cbpp.org/research/health/medicaid-work-requirements-cant-be-fixed.

of evidence basis for the policy, etc.) apply to this overlapping incentive mechanism, along with additional concerns.

Arkansas currently enrolls most Arkansas Works enrollees into a qualified health plan (QHP). Individuals who are medically frail are enrolled in FFS. To the extent Arkansas is concerned with some QHP enrollees underutilizing services, the solution is not to jettison those individuals into FFS. The state should implement more requirements for QHPs, including outreach and care coordination requirements, to ensure individuals get the needed care. Moving such individuals to fee-for-service will not solve the problem – they will continue to go without coordination or supports.

Through this proposal the state appears to be acknowledging that it maintains a substandard FFS delivery system, and using that as a punishment for individuals who don't meet the various behaviors – some totally unrelated to health care or even health – that it wants to promote. The state's discussions about the benefits of QHP premium assistance and saving money by capping QHP enrollment both acknowledge a FFS system that is underfunded and underperforming. CMS should require the state to address the problem in its FFS system, instead of approving the use of fee-for-service reassignment as a punitive measure. The state proposes the re-assignment mechanism as it principle cost-saving measure. As discussed earlier, section 1115 authority cannot be used to merely save money without an experimental purpose.[14] HHS must carefully guard against a state creating a parallel second-class Medicaid program for individuals it deems less worthy. Equally troubling is the notion that the state might be allowing FFS to underperform while it is the default system for medically frail individuals.

"Inactive" status is not defined in the application; rather, the state says it will be "defined through future DHS rulemaking." CMS should not allow the state to define such critical terms of a waiver after approval, much less through a process that is not subject to CMS review. However, the state does suggest the definition will include "Economic Independence Incentives" which, as discussed above, do not furnish health coverage. Thus, CMS already knows enough to know the definition will not meet the requirement for an 1115 waiver.

In addition to re-assigning individuals based on being "inactive," Arkansas proposes to also institute a cap on QHP enrollment. If the cap is reached, that state would stop auto-assigning individuals to QHPs when they fail to select a plan. This raises several concerns. First, the high rate of individuals not selecting a QHP (80% according to the state's application) itself implies the state's notice process is not functioning well. (And this is yet another reason the state's proposed incentives will fail.) Second, the suggestion that this mechanism would be the "principle means of slowing the rate of growth" for the program raises concerns and would seem to confirm that the state's FFS system is underfunded. We note that one of the assumptions built into Arkansas's original premium assistance budget neutrality calculation was the assumption that, without the use of QHPs, the state would have to make a large investment in provider rates.[15] Therefore, if the state now wants to cap QHP enrollment, triggering the cap should also trigger increased investment in FFS. Ultimately, HHS should evaluate the adequacy of Arkansas FFS rates, and how they compare to the QHP rates, prior to considering any such QHP cap.

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[14] See supra, note 3.

[15] "Medicaid Demonstrations: HHS's Approval Process for Arkansas's Medicaid Expansion Waiver Raises Cost Concerns," Government Accountability Office, September 2014, https://www.gao.gov/products/gao-14-689r.

Conclusion

Thank you for your willingness to consider our comments. While we recommend approval of Arkansas continued Medicaid expansion, we urge you to reject the state's request to implement premiums, reduce retroactive coverage, and impose harmful incentive systems on beneficiaries.

Our comments include numerous citations to supporting research, including direct links to the research for HHS' benefit in reviewing our comments. We direct HHS to each of the studies cited and made available to the agency through active hyperlinks, and we request that the full text of each of the studies cited, along with the full text of our comments, be considered part of the administrative record in this matter for purposes of the Administrative Procedure Act.

If you need additional information, please contact Joan Alker (jca25@georgetown.edu) or Judith Solomon (Solomon@cbpp.org).

Arkansas Advocates for Children and Families
Center on Budget and Policy Priorities
Epilepsy Foundation
Families USA
First Focus on Children
Georgetown University Center for Children and Families
Justice in Aging
National Association of Pediatric Nurse Practitioners
National Multiple Sclerosis Society
Primary Care Development Corporation