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July 14, 2023

VIA ELECTRONIC SUBMISSION

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

Re: ARHOME Section 1115 Demonstration Amendment

Dear Secretary Becerra,

The undersigned organizations appreciate the opportunity to comment on Arkansas' proposed amendment to the Arkansas Health and Opportunity for Me (ARHOME) Section 1115 Demonstration (Project No. 11-W-00365/4). While some provisions of the proposed amendment support the objectives of the Medicaid program and should be approved, we urge CMS to deny unrelated provisions that would invest state and federal resources in burdensome new administrative changes that will harm health care access, continuity of care, or the quality of care for Medicaid enrollees in Arkansas.

We are particularly concerned that the "Opportunities for Success" initiative does not promote the objectives of Medicaid, establishes unlawful and invasive criteria and barriers for maintenance of coverage, and is not an appropriate use of federal Medicaid funds. The state repeatedly describes the core purpose of the ARHOME demonstration as improving "economic independence," which is simply not the purpose of Medicaid. And while the state lists things like "continuity of care" and "improving access to providers" as other goals for ARHOME, implementation of the proposed amendment would have the opposite effect. It is also inconsistent with the President's Executive Orders 14009 on Strengthening Medicaid and the Affordable Care Act[1] and Executive Order 13985 on Advancing Racial Equity and Support for Underserved Communities because it increases systemic barriers to care.[2]

Expansion of Success Life360 HOME Eligibility

We support the state's proposal to expand the Success Life360 HOMEs up to age 59 for eligible enrollees to provide intensive care coordination services for this subset of ARHOME enrollees. We also support the state's proposal to remove the "at risk of homelessness" limitation from the veteran eligibility criteria for Success Life360 HOMEs. We agree with the state that this modification better reflects the state's intent to allow any veteran in need to have access to intensive care coordination services.

[1] Executive Order No. 14009, 86 Fed Reg 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 Fed Reg 7009 (2021), https://www.federalregister.gov/documents/2021/01/25/2021-01753/advancing-racial-equity-and-support-for-underserved-communities-through-the-federal-government.

"Opportunities for Success" Initiative

Under the state's proposal, expansion adults between ages 19 and 59 would be required to demonstrate "engagement" in the workforce. Requirements would be based on an individual's income as a percentage of the federal poverty line and the duration of enrollment in Medicaid and/or meeting state-defined criteria for "engagement," like being a parent/caregiver of a dependent under age six, being enrolled in a Life360 HOME, or "actively participating in one's own healthcare or with one's health plan." The state would flag people who, based on their incomes, are not *presumed* to be "engaging in the workforce" or are presumed working but remain consistently enrolled. If such individuals do not meet with an assigned "Success Coach" they would be moved from coverage in a qualified health plan (QHP) to coverage in the state's Medicaid fee-for-service (FFS) delivery system.

The "Opportunities for Success" initiative inappropriately conditions health care on factors that are in fact wholly unrelated to health care and will waste state and federal resources by setting up a new bureaucratic structure that will not improve health outcomes but will result in unwarranted government intrusion into the personal lives of Arkansans and promote disruptions in their continuity of care.

Although the state professes an interest in improving enrollees' "economic independence," evidence from the state's last experiment suggests that the AR Works demonstration did not do so and in fact was likely counterproductive, as discussed below. The state provides no meaningful evidence that its current proposal can be expected to increase employment, which is not an objective of Medicaid in any event.

Medicaid is a health care program, and while section 1115 gives the Secretary authority to authorize experimental approaches in furtherance of providing health coverage, this amendment would disrupt care and should not be approved.

1. **The Opportunities for Success Initiative Does Not Advance the Objectives of Medicaid**

In 2018, Arkansas required some low-income adults in the Medicaid expansion group to report 80 hours of work or community engagement activities to the Medicaid agency every month. Nearly 1 in 4 people subject to the requirement — more than 18,000 people — lost their coverage during the first seven months of the requirement, before a court invalidated the demonstration as inconsistent with the objectives of the Medicaid program. A study of Arkansas's short-lived experiment with Medicaid work requirements found that people who lost Medicaid coverage under the policy became uninsured but found no evidence that the policy increased employment.[3] The failure of the demonstration to increase employment held true over eighteen months of follow-up, and those subjected to it experienced adverse effects with respect to access to care.[4]

[3] Benjamin Sommers et al., "Medicaid Work Requirements – Results from the First Year in Arkansas," New England Journal of Medicine, Vol. 381, No. 11, September 19, 2019, 381:1073-1082, https://www.nejm.org/doi/full/10.1056/NEJMsr1901772.

[4] 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/abs/10.1377/hlthaff.2020.00538?journalCode=hlthaff.

The state rejects the argument that its Opportunities for Success initiative is a traditional work requirement, but the proposed amendment clearly seeks to treat people differently based on their work status (as determined by the state's faulty proxy method, discussed below), threatening a change in delivery system as a "stick" for individuals who don't demonstrate engagement, as defined by the state. Although Arkansas purports to have learned from the failures of its AR Works demonstration, and does not propose to terminate coverage for individuals, the new proposal would single people out based on their income and whether they comply with invasive government tracking of numerous aspects of their lives, and lead to different types of disruption – while adding administrative burdens for enrollees and the state. The new proposal also would erect these hurdles for a broader group of people than the AR Works waiver did; that demonstration exempted people who were living with a minor dependent child under the age of 18 but the new proposal adds parents with dependent children aged six and over to the new reporting scheme and expands the reach from adults under age 50 to those under age 59.

By using income, duration of time enrolled in Medicaid, and "engagement" as proxies for a "work requirement", the state is resurrecting its attempt to punish people with low-incomes who face myriad barriers to employment, including the lack of affordable child care, labor market imbalances, and transportation challenges that may make it harder for people to work at all or to earn enough to avoid having to meet the additional criteria set out in the state's proposal. Moreover, the state's proposal would disadvantage people in larger families, who would have to earn even more to avoid the most onerous elements of the new proposal. The state has not learned from the failures of its previous experience and instead is doubling down on its efforts to disrupt coverage for a category of people that the state has decided is not worthy. While the proposed demonstration will not directly *terminate* coverage, is will seriously *harm* coverage, and our comments focus on this impact to coverage.

The individuals who would be impacted by the proposed amendment already have coverage through the demonstration; while they will not lose Medicaid entirely, the main impact of the amendment would be a disruption of coverage, which does not promote the objectives of Medicaid.

As CMS reiterated in its approval of the ARHOME demonstration in November 2022, "a central objective of Medicaid is to furnish medical assistance."[5] By comparison, Arkansas says the goals of its waiver proposal are to "improve the health and well-being of individuals experiencing poverty" and to "support those individuals on their path to economic independence and obtaining health insurance coverage through employers or the individual market."[6] These are not proper objectives as the state should know from prior experience. In *Gresham v. Azar*, the D.C. Circuit Court of Appeals noted, "The statute and the case law demonstrate that the primary objective of Medicaid is to provide access to medical care. There might be secondary benefits that the government was hoping to incentivize, such as healthier outcomes for beneficiaries or more

[5] ARHOME Approval Letter from CMS to Dawn Stehle, Deputy Director for Health & Medicaid, Arkansas Department of Human Services, November 1, 2022, ar-arhome-ca-11012022.pdf (medicaid.gov).
[6] Public Notice for Proposed Amendment to Medicaid Section 1115 Demonstration Project, Arkansas Health and Opportunity for Me (ARHOME), page 5, included as Attachment 2 in Request to Amend the ARHOME Section 1115 Demonstration Project, Project No. 11-W-00365/4, June 1, 2023, https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ar-arhome-pa-06022023.pdf.

engagement in their health care, but the 'means [Congress] has deemed appropriate' is providing health care coverage."

The individuals who would be impacted by Opportunities for Success already have coverage; Arkansas is once again proposing a costly and invasive experiment that will disrupt coverage for thousands of enrollees in direct violation of the central objective of Medicaid. To make matters worse, while it relies on impermissible program goals such as "economic independence," the state offers no meaningful evidence or basis for concluding its amendment will achieve even those inapt goals. Ironically, the best way to achieve those goals is to support full, unencumbered expansion.

Indeed, Medicaid coverage – without the policies that Arkansas seeks to implement – has been shown to support employment. Surveys of Medicaid expansion enrollees in Ohio and Michigan, for example, show that coverage has made it easier for people who are unemployed to find work, and for people who have a job to maintain their employment. A recent study examining the impact of Michigan's Medicaid expansion found that 69 percent of enrollees said having health insurance through Medicaid helped them do a better job at work and the majority of those who were out of work reported that having Medicaid made them better able to look for a job.[7] Another Michigan study shows that expansion particularly benefits people with chronic health conditions — finding that 76 percent of survey respondents with a behavioral health condition who were employed reported that having Medicaid coverage improved their ability to perform well at work.[8] And studies have found that Medicaid expansion is a powerful anti-poverty tool as it reduced medical debt by $1,140 per person among those who gained Medicaid coverage[9] and reduced evictions among low-income renters.[10] Some of the state's goals can thus be achieved simply by assuring that the state's Medicaid enrollees can access the care they need.

We are also concerned that the amendment will make reassignment decisions based on length of time on Medicaid and income. Reassigning individuals based on income – and whether or not someone is *assumed* to be working – is also inconsistent with the goals of the Medicaid program. The Arkansas proposal is so burdensome for enrollees that even people deemed to be fully employed are eventually subject to additional administrative burdens and "Coaching." Reassigning people or subjecting them to onerous standards based on income that never rises high enough to exceed Medicaid income eligiblity standards misunderstands a critical point about the nature of low-wage work: many low-wage workers have static salaries that are unlikely to rise above a certain level, even after years of work, and may not ever lead to an offer of employer sponsored coverage. Finally, while this amendment will not increase employment and will in fact disrupt continuity of care, it will accomplish the state's true objective: gaming the system to cut costs. The state is attempting to "have its cake and eat it too" by using capitated managed care through marketplace plans to cover

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[7] Tipirneni, R. et al. "Changes in Health and Ability to Work Among Medicaid Expansion Enrollees: A Mixed Methods Study" Journal of General Internal Medicine, December 5th, 2018.
[8] Tipirneni, R. et al., "Association of Expanded Medicaid Coverage with Health and Job-Related Outcomes Among Enrollees with Behavioral Health Disorders," Psychiatric Services, September 25, 2019, https://ps.psychiatryonline.org/doi/10.1176/appi.ps.201900179.
[9] Luojia Hu, et al., "The Effect of the Affordable Care Act Medicaid Expansions on Financial Wellbeing," Journal of Public Economics, May 2018, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6208351/
[10] Heidi Allen, et al., "Can Medicaid Expansion Prevent Housing Evictions?," Health Affairs, September 2019, https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2018.05071.

the expansion population but then selecting out inexpensive enrollees (i.e., those not using care) and transitioning them to fee-for-service.

This way, it shifts the risks of expensive enrollees to QHP plans and pays only for the actual FFS costs of low utilizers, rather than paying higher capitation rates for people who are not using services. The budget neutrality estimate attached to the state's application shows that the average per member per month cost in FFS is "assumed to be roughly 45% of the QHP cost, due to provider reimbursement and delivery system differences."[11] The state indicates that there is an estimated total reduction of approximately $60 million dollars to the demonstration's current budget neutrality limits; the Milliman estimate attached to the state's applications indicates that, in the aggregate, the estimated savings from unengaged individuals moving from QHPs to FFS plus increased spending on Health Related Social Needs (HRSN) and Success Coaches will result in a net *reduction* of roughly $89 million over the five-year waiver period.[12]

CMS should not approve such a scheme, nor is saving money by cutting Medicaid spending a valid demonstration objective.[13] In addition, the state provides no analysis of how this cost-shift onto QHPs will impact the capitation costs for the expansion enrollees that remain in QHPs and Marketplace QHP enrollees. If Arkansas is concerned about the cost of its QHP-based Medicaid expansion, a simpler solution is to transition the entire expansion population to FFS Medicaid and work to bolster provider payment rates system wide to assure access for *all* enrollees.

2. The Opportunities for Success Amendment Has No Logic to Its Experiment

Section 1115 demonstrations must have an experimental purpose. While investments in HRSNs have an experimental purpose, there is no experimental purpose in conditioning QHP enrollment on undefined "engagement" with a Success Coach. The state's misguided approach is based on incentivizing changes in behavior as a consequence of a possible penalty for those who do not meet its new rules – yet at the same time claiming they will suffer no penalty because the FFS system is no worse. The state cannot have it both ways. The only predictable outcomes are: continuity of care will be disrupted and the state will save money (by moving low-utilizers to fee-for-service).

3. Re-Assigning Individuals to Fee-for-Service Coverage Creates Discrepancies in Access to Care and is a Veiled Attempt to Save Money

Arkansas proposes to re-assign individuals deemed to be "unengaged" from QHP coverage to FFS. Arkansas currently enrolls most ARHOME enrollees into a QHP, based on the state's prior assertion that a demonstration was needed due to access problems in the state's FFS system. As we previously commented, if Arkansas is concerned about some QHP enrollees underutilizing services, the solution is not to jettison those individuals into FFS.[14] The state should implement more

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[11] Letter from Gregory Herrle, Principal and Consulting Actuary, Milliman, to Kristi Putnam, Secretary, Arkansas Department of Human Services, April 4, 2023, https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ar-arhome-pa-06022023.pdf.

[12] *Ibid.*

[13] Federal courts have ruled that "[a] simple benefits cut, which might save money, but has no research or experimental goal, would not satisfy" the section 1115 requirement for an experiment. *Beno v. Shalala*, 30 F. 3d 1057, 1069 (9th Cir. 1994).

[14] Letter to Secretary Becerra Re: Arkansas Health and Opportunity for Me (ARHOME) Demonstration, October 22, 2021, https://ccf.georgetown.edu/wp-content/uploads/2017/10/Arkansas_SignOn_Comment_Letter_FINAL.pdf.

requirements for QHPs, including outreach and care coordination requirements, to ensure individuals get needed care.

The state's previous and current proposals are thinly veiled attempts to cut state costs by moving people out of QHPs so that the state isn't on the hook to pay monthly capitated costs for people who are not utilizing services they are entitled to. As noted above, the average per member per month cost in FFS is almost half the cost of QHP coverage.

Indeed, with this proposal the state appears to be acknowledging that it maintains a substandard FFS delivery system, and seeks to use this 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 notes that the re-assignment mechanism will lead to cost-savings. As discussed earlier, section 1115 authority cannot be used to merely save money without an experimental purpose.[15] HHS must carefully guard against a state creating a parallel second-class Medicaid program for individuals it deems less worthy and based on factors that are unrelated to health care.

4. Re-Assigning Individuals to Fee-for-Service Coverage Will Likely Jeopardize Continuity of Care

Like commenters at the state level, we believe CMS should not approve the Opportunities for Success amendment because it will disrupt the care of people who are currently receiving care through a QHP when they are moved to the fee-for-service delivery system. Arkansas provides a wholly inadequate explanation in response to concerns raised in public comments that individuals in the midst of active treatment could experience disruptions in coverage.

Although the state indicates that individuals "in active treatment for a serious, life-threatening disease" will not be moved from QHPs to FFS, as written this is a narrow exception that would benefit a small share of enrollees who depend on their existing provider networks, care teams, and treatment options, or otherwise rely on care management services provided by their QHP. The state also offers an exception for individuals "receiving recommended preventive services." This appears to be a behavioral incentive policy that *may* incentivize some individuals to receive preventive services (most enrollees likely will not know about or understand the policy), but it too will exempt only a small group of enrollees who meet the requirement. Ultimately, the exceptions are far too narrow to prevent disruptions for most enrollees who depend upon their QHP coverage. For example, individuals receiving routine services to manage a chronic illness would not necessarily meet the criteria and would see their care upended. And, even for those enrollees that *do* meet the narrow criteria, administrative errors and fiscal disincentives to identify all such persons are likely and many people could be forced to find new doctors while they are in the midst of ongoing treatment. The state's exception process presumes that the state will effectively identify the available exception, and that enrollees will understand it. Arkansas' prior work requirement demonstration *demonstrated* this is not what will happen in practice.[16]

There are several other notable gaps in the state's response to public concerns about continuity of care if the proposed amendment were approved. First, the state does not acknowledge, much less

[15] *Beno v. Shalala*, 30 F. 3d 1057, 1069 (9th Cir. 1994).
[16] Sommers et al, Health Affairs, op cit.

do enough due diligence to analyze, the network distinctions between *Marketplace* managed care plans (QHPs) and *Medicaid* fee-for-service. Without this analysis, the state cannot actually know the impact on continuity of care. Second, even when a provider does participate in both a QHP and fee-for-service, the provider may not accept patients on equal terms. Third, transition away from the QHP could impact treatment plans, including (for example) prior authorization processes an individual has gone through to access a treatment. For example, an individual may have gone through a complicated prior authorization process to access a service, only to lose that authorization when transitioned to fee-for-service.

In short, the state's amendment will cause serious disruptions in care, which is likely to lead to bad health outcomes.

5. The Opportunities for Success Initiative Will Create Burdens and Invasive Demands on Enrollees.

Relative to Arkansas's previous request to move enrollees from QHPs to FFS (which CMS did not act on),[17] Arkansas' current proposal adds a "Success Coach" component to its request. We are concerned about this proposal for many reasons.

Research shows that states that created similarly complex incentives programs designed to elicit behavioral changes had trouble identifying and engaging Medicaid enrollees to participate due to inaccurate contact information, changes in enrollees' eligibility or health status, and difficulties identifying eligible individuals.[18,19]

Although the application indicates that the state will use data matching to avoid new reporting burdens, the proposal merely shifts the reporting burden to enrollees who would, under the amendment, be required to have a "monthly contact" with their coaches (presumably during business hours) and report activities to their coaches. We note, again, that by design the proposal would (after some time) require this administrative hassle for even full-time workers, on a permanent and on-going basis. It would be inappropriate for enrollees to suffer penalties for missing meetings or required reports, particularly if there are no accommodations for people who cannot meet during business hours.

We are also concerned that Success Coaches will use subjective criteria to determine engagement, which could unfairly disadvantage enrollees, particularly enrollees with limited English proficiency or who are from different cultural, racial, or ethnic backgrounds.

As with Arkansas's failed experiment with work reporting requirements, awareness of the Opportunities for Success initiative is likely to remain poor, which will compromise compliance and mean that people suffer consequences for not complying with a program they may not even realize applies to them. Researchers studying the AR Works waiver found that many impacted enrollees

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[17] Our comments on Arkansas' 2021 proposal are found here: https://ccf.georgetown.edu/wp-content/uploads/2017/10/Arkansas_SignOn_Comment_Letter_FINAL.pdf.

[18] Hannah Katch and Judith Solomon, "Restrictions on Access to Care Don't Improve Medicaid Beneficiaries' Health: Incentives for Healthy Behaviors Have Mixed Results," CBPP, December 11, 2018, https://www.cbpp.org/research/health/restrictions-on-access-to-care-dont-improve-medicaid-beneficiaries-health.

[19] Melinda Buntin, John Graves, and Nikki Viverette, "Cost Sharing, Payment Enforcement, and Healthy Behavior Programs in Medicaid: Lessons from Pioneering States," Vanderbilt University, June 2017.

were not aware of the requirements, which impacted reporting and compliance.[20] The same phenomenon is likely here. We know from the AR Works experience that publicizing new requirements requires significant investments in outreach and communications materials to ensure that people are aware of new requirements and their new responsibilities; otherwise, lack of awareness is likely to mean that people will not satisfy the terms of the new approach.[21] The state's application does not detail any plans for such investments, beyond indicating that the interventions will include "proactive outreach" once people have been identified as subject to the new provisions of the amendment (e.g., based on their income or the amount of time they have been enrolled). Any incentive strategy conditioned on changes in behavior and "choices" must include significant resources to ensure that enrollees, potential enrollees, and the providers that serve them have a full understanding of the complexities of the system. This would require an extremely significant investment that is not present in this proposal.

6. The Opportunities for Success Initiative Does Not Truly Invest in Addressing Health Related Social Needs

Arkansas presents the Opportunities for Success Initiative as an investment in HRSNs. As discussed earlier, we support the other, *unrelated* ARHOME elements related to social needs. However, penalties tied to an individuals' income and "engagement" are completely unrelated to the state's stated desire to help address unmet social needs. In addition, the only component of the Opportunities for Success Initiative that potentially adds any services is the "Success Coach," and this is not the central purpose of the initiative. CMS must not allow its important efforts to address HRSNs (including Arkansas's real HRSN programs) to be co-opted by a misguided amendment with a trivial HRSN component. This is a far cry from important state investments to expand access to new services. And while we support the state's interest in addressing HRSN, any investments in HRSN can be made without jeopardizing enrollees' continuity of care.

Even if the state invested more money in HRSN, it is still a fundamental problem that the amendment conditions care continuity on meeting arbitrary beneficiary engagement hurdles. CMS should not allow states to condition access to *health care* based on arbitrary factors (such as employment status assumptions based on income), particularly ones totally unrelated to health.

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[20] For example, data for the month of February 2019 — shortly before the approval of Arkansas' work requirement policy was vacated — showed that 87 percent of those subject to the work requirements were exempt from reporting. Of the remaining share required to demonstrate compliance, nearly 9 in 10 did not report any work activities — for example, by not creating online accounts or navigating the online portal — likely reflecting widespread lack of awareness and complex and burdensome reporting requirements. Robin Rudowitz *et al.*, "February State Data for Medicaid Work Requirements in Arkansas," KFF, March 25, 2019, https://files.kff.org/attachment/State-Data-for-Medicaid-Work-Requirements-in-Arkansas; MaryBeth Musumeci *et al.*, "An Early Look at Implementation of Medicaid Work Requirements in Arkansas, KFF, October 8, 2018, https://www.kff.org/report-section/an-early-look-at-implementation-of-medicaid-work-requirements-in-arkansas-key-findings-9243/.

[21] See, e.g., Jessica Green, "Medicaid Recipients' Early Experience with the Arkansas Medicaid Work Requirement," Health Affairs Forefront, September 5, 2018, https://www.healthaffairs.org/do/10.1377/forefront.20180904.979085/full/; Ian Hill and Emily Burroughs, "Lessons from Launching Medicaid Work Requirements in Arkansas," Urban Institute, October 2019, https://www.urban.org/sites/default/files/publication/101113/lessons_from_launching_medicaid_work_requirements_in_arkansas.pdf.

The application itself includes few details about the Success Coaches; the state elaborates a bit more in its response to public comments received which we appreciate, but we remain concerned that the state has not fully explained how it will assure that Success Coaches have the experience to serve their intended function, which includes effectively serving as an unaccountable *gatekeeper* for QHP enrollment. This experience would need to include specialized skills such as training in working with victims of domestic violence and other trauma, language skills etc. Arkansas should be required to provide additional detail about the qualification required for Success Coaches, the proposed caseload that each coach will carry, particularly in light of on-going support needed for unwinding, and the manner in which coaches will reach out to enrollees. *Even the most qualified coaches should not have the power to decide whether a person covered by Medicaid is allowed to continue in the same delivery system.* Finally, the state assumes Coaches will be able to connect individuals to "supports," but there is no evidence of investments in or actual availability of any supports.

At its core, this amendment appears designed to set up a two-tier structure in which "deserving" enrollees receive the benefit of a delivery system that the state has historically preferred for low-income adults while those whom the state classifies as less engaged are relegated to fee-for-service. If the state is truly committed to HRSN, it could advance that priority by supporting current QHP enrollees, including offering Coaching if it so chooses, without the disruption that this amendment will create.

7. CMS Should Wait Until Unwinding Ends Before Considering this Amendment

Arkansas, like other states, is going through a process of redetermining eligibility for all enrollees that is one of the most challenging administrative undertakings the program has ever faced. It is a period of great confusion for Medicaid enrollees. Arkansas has launched forward on perhaps the most hasty, unrealistic, and irresponsible timeline in the country, leading to some of the worst outcomes, including for children. There will be serious and unpredictable consequences for Medicaid in Arkansas in the coming year. CMS should not allow the state to add, in the midst of the unwinding chaos, a confusing incentive structure that will disrupt continuity of care and confusion for enrollees. Moreover, CMS should not do this because Arkansas' enrollee support mechanisms are *already* overloaded with unwinding-related problems, so there will be no support available to assist enrollees confused by the superfluous delivery system changes.

Conclusion

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

Thank you for the consideration of our comments. If you would like any additional information, please contact Joan Alker (jca25@georgetown.edu) or Allison Orris (aorris@cbpp.org).

Sincerely,

Bazelon Center for Mental Health Law
Center for Law and Social Policy (CLASP)
Center on Budget and Policy Priorities
Community Catalyst
Cystic Fibrosis Foundation
Epilepsy Foundation America
Georgetown University Center for Children and Families
Medicare Rights Center
National Association of Pediatric Nurse Practitioners
Primary Care Development Corporation