UNITE US

July 12, 2021

Submitted via*: ORP@dhs.arkansas.gov*

Ms. Elizabeth Pitman
Director, Division of Medical Services
Arkansas Department of Human Services
Division of Medical Services
P.O. Box 1437, Slot S295,
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Re: Application for Proposed ARHOME 1115 Demonstration Project

Dear Director Pitman:

Thank you for the opportunity to provide input and recommendations on the State of Arkansas' application for the Proposed ARHOME 1115 Demonstration Project.

Founded in 2013, Unite Us is a technology company that provides an end-to-end solution to connect health and social care. Our goal is to ensure every individual, no matter who they are or where they live, can access the critical services they need to live healthy and productive lives.

Through our products and community-centered approach, Unite Us seeks to increase equitable access to health and social services, address the fragmentation of services that makes our health and social systems challenging to navigate, and confront institutionalized barriers to equity such as poverty, racism, and discrimination. Our diverse range of stakeholders include community based organizations, health plans, health systems, hospitals, and government entities.

Unite Us has successfully built and scaled coordinated care networks in 42 states across the country, with numerous state and local government partnerships such as with North Carolina's Department of Health and Human Services, Virginia's Department of Health, Governor Sununu's Office in New Hampshire, Rhode Island's Executive Office of Health and Human Services, Louisiana's Department of Children and Family Services and others.

ARHOME's Life360 HOME Model

Unites Us commends the Department of Human Services (DHS) for developing a statewide strategy to address social determinants of health for ARHOME enrollees. The proposed Life360 HOME program not only introduces enhanced care coordination as a new benefit, but also provides communities with the investments necessary to build capacity. The State's proposed use of the Community Bridge Organization (CBO) concept to target at-risk populations and offer intensive levels of intervention to address their social needs offers great promise, and demonstrates the State's important understanding that to deliver comprehensive **whole-person**

care requires broadening the traditional model of care coordination to include addressing the social needs of individuals.

Unite Us supports the State's **broad definition of care coordination** which emphasizes: a) screening and assessing needs for SDOH supports, and b) the development of a person-centered support plan to set the socioeconomic goals to be achieved, including the coordination between medical and nonmedical providers. We also support the State's desire to expand the traditional care coordination model to include the use of peer specialists, peer counselors, and 'community coaches' who can work directly with individuals and their families. Connections to social determinants of health interventions through community partners like these are critical to keeping people healthy.

The State's proposed **community-level investments** that cover start-up costs and ongoing monthly payments for community services will promote program sustainability over the long run. Paired with supportive Infrastructure like a shared technology platform, community anchors (hospitals) and social services providers will be able to collaborate efficiently and effectively over time.

We recommend that the state consider adopting **a scalable technology solution** that would enable collaboration and care coordination across health and human service sectors by supporting the ability to: (a) send and receive electronic referral, (b) seamlessly communicate in real-time, (c) securely share client information, and (d) track outcomes -- a solution that would not only support local implementations of the Life360 HOME Model but that could also work at scale and help facilitate a statewide implementation.

The Unite Us Platform currently serves as foundational, multi-sector, community-embedded infrastructure in over 42 states. The web-based technology platform not only allows previously siloed partners to collaborate and coordinate care, but also provides communities with the ability to:

- **Identify needs,** through our dynamic data-powered toolkit that proactively identifies individuals social care needs;
- **Enroll in services,** through referral tracking and completion, accountable care coordination, social needs screenings, and self-referral assistance request fulfillment;
- **Serve the individual,** through our community-wide and web-based platform that connects health, human and social service providers on a single network;
- **Measure network impact,** with real-time social care data analytics that empower local decision makers with key insights; and
- **Invest in social care,** through a comprehensive solution that enables social care funding and payment for specific interventions at scale.

Unite Us also has **broad experience working with state governments** and local health systems in building community driven care coordination networks. For example, in North Carolina, Unite Us supported the development of NCCARE360, a statewide system to coordinate whole-person care uniting traditional healthcare settings and organizations that address social determinants of health, such as food, housing, transportation, employment, and interpersonal safety. In North Carolina, Unite Us helps providers electronically connect those with identified needs to community resources and allows for feedback and follow-up at scale across the state.

Hospitals as 'Anchor' Organization in the LIfe360 HOME model.

Unite Us supports Arkansas' vision of placing **hospitals as anchor institutions** ("HOMEs") within its three (3) Life360 HOME Models (Rural, Maternal, and Success). Hospitals are a trusted community resource with strong financial accountability that can be incentivized to lead community-focused implementation of new programs. Hospitals are also the population health experts of their communities, who can leverage their existing infrastructure, including data systems, to support successful program implementations, which is particularly important in rural communities.

Unite Us has **extensive experience enabling hospital care teams** to more deeply partner with community and social care organizations that are able to fulfill non-healthcare needs in their communities. Unite Us' suite of interfaces and integration tools connect health and social care applications and empower communities with more seamless connectivity across platforms, leading to deeper connections and integrated referral workflows with community and social care providers.

Unite Us' use of a **Master Person Index (MPI)** enables identity resolution across multiple domains and systems to ensure that the person in question is the same patient, client, or member in different settings. MPIs support the creation of a single and complete record of care, minimizing the need for a client to retell their story and facilitating more seamless and comprehensive care management.

Unite Us' Interoperability team partners with EHR providers like Epic on advancing a vision for robust standards-based exchange for deeper workflow integration for whole-person care teams and creation of comprehensive health and social history for clients.

Qualified Health Plans and Life360 HOME

We support the State's efforts to impose **greater accountability on participating QHPs,** including holding them responsible for the broad standards included in the Medicaid Core Set of Adult Health Care Quality Measures. Strategies like tying QHP incentives and sanctions to these performance metrics, and encouraging the use of individual member incentive programs to reward participation in health improvement or economic independence initiatives, can certainly facilitate improved population health.

QHPs are well-positioned to ensure the successful implementation of the Life360 program. We encourage the State to provide them with clear guidance on how to offer this support. For example, QHPs can play an important role in incentivizing the engagement of other outpatient network providers such as PCPs, Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHC). Additional ways the Life360 HOME programs can be scaled with greater QHP support and involvement include:

QHP Community Investment: We commend the State for encouraging greater QHP support of the communities their members reside in to address quality of care. For example, the proposed ARHOME amendment allowing QHPs to direct up to 1% of premium revenues towards activities

that improve healthcare quality can be an impactful way of providing added support as communities build the networks and infrastructure needed to support Life360 programs.

Incorporating Life360 Into Value Based Payment Models: Health plans are increasingly incorporating access to social determinants of health and related social services in contracting efforts to help them meet quality of care benchmarks. The State could require QHPs to incorporate Life360 program participation among the VBP goals that QHPs set for contracted network providers.

QHP Member Communication: QHPs can leverage their considerable resources to promote Life360 HOME program participation as part of ongoing member engagement efforts. This may include some of the new 'direct-to-consumer' strategies health plans are using such as chat/app features, and virtual medical visits.

State Investment in SDOH and Capacity Building

Sustainable funding streams, like the one that the State is proposing via the Life360 HOME model, build capacity for community-based organizations, social services, and the local workforce. They also sustain equity strategies and enable long-term resilience especially in rural communities. In the health and social sector, local organizations have traditionally been tied to time-limited grant funding and often operate at a deficit, impacting both the service and resource quality, as well as workforce burnout and supply.

To facilitate sustainable improvements in our system of health and social services, **Unite Us has developed a Payments product specifically to enable funding entities to pay for social care at scale**, providing needed resources for organizational and workforce capacity building, and elevating the importance and value of community-based care. Tools like these, which track and invoice social care services for reimbursement, allow states to optimize Medicaid waiver services that address the social determinants of health and even offer the ability to braid multiple funding streams to deliver integrated and coordinated care.

Supporting Rural Communities

Unite Us works closely with rural community partners in all 42 states we currently operate in. We support Arkansas' view that health equity issues tied to rural areas are driven by complex and interconnected social, behavioral and structural factors that cannot be resolved by enhancing access to healthcare services alone. Our local community engagement teams partner with organizations and coalitions to do innovative work in rural communities. Some of the most common rural inequities we come across include lack of access to broadband and transportation services. Examples of our work in rural communities include:

- Our statewide network in North Carolina covers a geographic area that is **80% rural.** In the eight-county area surrounding Chowan, which has a population of less than 150,000 people, our team adjusted our engagement strategy to understand the community's distinct needs and brought together 50+ organizations connecting residents to resources.
- Our Unite West Virginia network includes **rural counties in the Appalachian Mountains** and the Eastern Panhandle, with one county having a total population of 8,500. To reach the most

rural individuals, we teamed up with Family Resource Networks, a local and trusted non-profit, and onboarded community-based providers.

- Our rural upstate New York network includes a partnership with ADK Wellness Connections network and Cornerstone Mobile Counseling, which operates an innovative mobile counseling program to address significant mental health gaps across the 24 county region. Providing at-home services, the program enables clients to have their needs met without having to travel or find an office with availability.

Access to Behavioral Health and Substance Use Disorder Services

Unite Us commends the State for focusing on improving access to behavioral health and substance use disorder services as part of their ARHOME program. We recognize that individuals with substance use disorders are often stigmatized and reluctant to seek services, compounding negative impacts on their health and quality of life. We know that an effective recovery support system cannot exist without a robust network of community partners and the infrastructure in place to support personalized, coordinated care. In our experience, the following elements have proven critical to success:

- Maintaining client dignity and privacy by utilizing protected viewing permissions that ensure 42 CFR Part 2 compliance and that only those providing substance use services to the client can see the details of their care history.
- Addressing substance use holistically by hosting a diverse range of organizations and programs that meet clients where they are. Programs and providers may include harm reduction agencies, outpatient clinics, inpatient treatment programs, needle exchange programs, overdose prevention classes, and group support.
- Developing individualized treatment plans that reflect a client's personal journey and incorporate clinical care and wraparound services such as vocational training, housing, counseling, and education.
- Connecting clients to mental and behavioral health services and coordinating with specialists who can address any psychological and/or emotional concerns.
- Promoting the use of evidence-based and evidence-informed programs like Medication-Assisted Treatment (MAT) and peer recovery support services.
- Strengthening community capacity building through outcome data that can identify co-occurring service gaps, such as a lack of hospital beds or limited food security resources in specific geographies.

Addressing Maternal Health and High Risk Pregnancies

We support ARHOME's community-driven approach to addressing maternal health and high risk pregnancies will have a significant impact in improving the State's maternal health indicators which are presently among the lowest in the country. The Maternal Life360 model, which incentivizes partnerships between birthing hospitals, community partners experienced in home visitation (e.g. Early Head Start), and QHPs will ensure support to women in their own homes during pregnancy and up to two years after the child is born.

Unite Us has extensive experience reducing disparities in maternal and early childhood health in communities we serve. We work with community-based organizations, health systems, and government partners to ensure all women, particularly those at risk of poor health outcomes, have a chance at a safe and healthy life. Our shared, community-wide infrastructure creates an ecosystem that allows health, human, and social service providers to:

- **Increase access to high-quality, clinical care** for mothers and their children, through credible social service partners in the community.
- **Address the social determinants of health** before health concerns arise, by linking pregnant women and mothers of young children to food, transportation, employment, and other social service providers.
- **Strengthen collaborations between clinical and social providers** by giving clinicians the tools they need to quickly and seamlessly refer high-risk patients to the non-clinical resources they need.
- **Leverage evidence-informed interventions** such as home visitation programs, breastfeeding support by lactation consultants, smoking cessation programming, prenatal care providers, and more.
- **Empower novel interventions** that address the unique needs of Black and Indigenous mothers and babies and inform new evidence-based practices.
- **Collaborate with public health departments** to support place-based advocacy and programming for more equitable access to care for underserved populations.
- **Share data** that may reveal insights around community-level inequities and lay the groundwork for the reallocation of investments.

Our success in facilitating community-wide maternal and child health programs are exemplified in Florida, where Unite Us partners with the First 1,000 Days of Sarasota, a community-based, multi-sector initiative supported by Sarasota Memorial Hospital to address maternal and child health inequities through an any-door approach to coordinate wraparound services through a single touchpoint. Schools, healthcare providers, food pantries, and other organizations serving families anywhere in the network may screen and connect families to multiple community resources, addressing whole person care for all family members. Concurrently, the platform allows stakeholders to understand the full range of needs experienced by this population.

Community Participation and Shared Governance

Unite Us recommends that ARHOME **integrate community participation into program implementation**, ensuring that local leaders are key actors guiding the decisions that ultimately affect their own communities. Strategies may include conducting community discovery sessions, key informant interviews, and developing shared advisory structures that allow for meaningful, on-going engagement. In our most mature networks, Unite Us introduces Community Network Advisory Boards (CNABs) that provide a **centralized workstream for collecting and disseminating network stakeholder feedback** and recommendations. CNABs are community-led, consisting of users and participants of Unite Us networks and offerings. The goals of a CNAB are to discuss community workflow challenges and solutions, and ensure local users are satisfied with their experience day-to-day. Government agencies may think of CNABs as similar to Patient Advisory Boards that are made up of patients and their families to provide feedback to administrations based on firsthand experience. Importantly, CNABs create a space

where network stakeholders are heard and coalesce around a collective sense of ownership and shared responsibility.

In Oregon, for example, Unite Us' local community engagement team established regional CNABs, composed of local organizations and community champions whose on-the-ground expertise informs and guides the priorities of the Connect Oregon statewide network. These regional advisory boards ultimately feed into and inform the statewide advisory board, which brings together community leaders across the state and ensures alignment around network decision-making. The Unite Us Oregon team has been working with CNAB members to prioritize five collective service and resource areas for the network, such as Early Childhood, WIC Services, Chronic Disease and Self Management Services, Spinal Injury Awareness, Housing and Utilities Assistance. Community leadership and investment in this form promotes sustainability and maximizes opportunity for longer-term impact across the care network.

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If you have any questions or if there is any additional information Unite Us can provide, please feel free to contact me at socrates.aguayo@uniteus.com.

Sincerely,

/s/ Socrates Aguayo

Socrates Aguayo
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LEUKEMIA & LYMPHOMA SOCIETY®

July 12, 2021

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Re. Arkansas Health and Opportunity for Me (ARHOME) Application for Proposed Section 1115 Demonstration Project

Dear Ms. Stehle:

At The Leukemia & Lymphoma Society (LLS), our mission is to cure leukemia, lymphoma, Hodgkin's disease and myeloma, and to improve the quality of life of patients and their families. We support that mission by advocating that blood cancer patients have sustainable access to quality, affordable, coordinated healthcare. On behalf of the thousands of Arkansans whose lives have been changed forever by blood cancer, we appreciate this opportunity to comment on the Arkansas Works Medicaid Section 1115 Demonstration Project proposal.

Medicaid covers 1 in 5 Americans, including low-income children, adults, seniors, and people with disabilities.[i] Many of these neighbors among us have complex and costly health care needs. Expanded access to Medicaid is essential to improving health and saving lives.

Specific to cancer, Medicaid expansion has helped close disparities in cancer treatment. The American Society of Clinical Oncology reported in 2019 that expansion states showed no significant difference in timely receipt of treatment between African American and white patients. The same can unfortunately not be said for non-expansion states.[ii] Expansion has also been associated with a reduced risk of hospital closures, especially in rural areas,[iii] and reduces the uncompensated care burden for public and rural hospitals.[iv]

The LLS Office of Public Policy's *Principles for Meaningful Coverage* give us an objective and constructive means of evaluating healthcare coverage proposals.[v] They inform our support for Medicaid expansion, and inform our concerns about the Arkansas Works draft plan's impact on timely, cost-effective access to stable coverage.

<u>Linking Cost-Sharing to Participation in Work, Community Engagement, and Health-Improvement Activities: a Costly Set of Barriers to Care</u>

It is unfortunate to see work requirements making a second appearance in the Arkansas Medicaid expansion discussion, rebranded as an "Economic Independence Initiative" inviting private insurers to provide cost-sharing discounts to enrollees who engage in work-related activities. Those same discounts are also being proposed for health-improvement activities, which have been shown in employer-based coverage settings to disproportionately penalize people who already face systemic barriers to achieving better health.[vi] There is no reason to expect a different outcome here.

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BEATING CANCER IS IN OUR BLOOD.

For the reasons outlined below, LLS asks that all requirements and incentives for work, community engagement, and health-improvement activities be removed, and that additional cost sharing and premium requirements not be placed on Arkansas Works enrollees.

In the absence of federal administrative support for work requirements and with the Supreme Court having canceled oral arguments on a related case, there is no legal footing to support this portion of the draft waiver. As a 2020 appellate court stated when it upheld the termination of Arkansas's previous attempt at implementing work requirements: "(T)he alternative objectives of better health outcomes and beneficiary independence are not consistent with Medicaid. The text of the statute includes one primary purpose, which is providing health care coverage without any restriction geared to healthy outcomes, financial independence or transition to commercial coverage."[vii]

This standard remains in effect and should be sufficient on its own to rule out the further pursuit of any work requirement proposal, but there are also serious policy outcomes concerning the use of work requirements. The Center on Budget and Policy Priorities has maintained a comprehensive document outlining how these kinds of proposals reduce access to care for targeted and non-targeted groups alike, increase financial hardships, and fail to increase employment levels.[viii] Even if work requirements were legally allowable under Medicaid – which they are not – they remain a flawed tool for generating their stated outcome objectives.

As noted above, a 2021 Georgetown University article outlined the health equity issues associated with wellness incentive programs. Between higher rates of chronic health conditions for people of color, and the increased incidence of food deserts and environmental hazards in low-income neighborhoods, "enrolling in a health-contingent wellness program can look less like a benefit and more like a penalty."[ix]

Cost sharing and premiums for Medicaid pose their own set of problems to enrollees. The draft application requests authority to charge premiums to individuals with incomes above 100 percent of the federal poverty level, and to charge copays for individuals with incomes above 20 percent of the federal poverty level. Increases in premiums and cost-sharing are likely to cause Medicaid enrollees to either lose access to coverage or decrease their adherence to treatment.[x] Additionally, studies project that increasing enrollees' premiums and cost-sharing would generate only limited savings for states and that, in some cases, those savings would be eliminated by increases in uncompensated care (e.g. increased use of the emergency department by individuals who now lack coverage) and increased administrative expenses.[xi]

Furthermore, evidence suggests expanded cost sharing may not result in the intended cost savings.[xii] A study of enrollees in Oregon's Medicaid program demonstrated that implementation of a copay on emergency services resulted in decreased utilization of such services but did not result in cost savings because of subsequent use of more intensive and expensive services.[xiii]

<u>Limiting Retroactive Eligibility Hurts Arkansans and their Health Care Systems</u>

This draft plan calls for a reduction in retroactive coverage from three months to one month. When someone enrolls in Medicaid, coverage is usually extended retroactively to the three months before enrollment, provided they were eligible at that time. That's helpful when a life event – such as a cancer diagnosis – triggers both medical expenses and coverage eligibility. Limiting retroactive coverage to one month increases the likelihood of people on Medicaid carrying major

medical debt and increases the odds that hospitals will not be compensated for the care they provide.[xiv] This change in policy should be removed from the waiver proposal.

Concerns Regarding Public Comment Review Timeline

On June 15, Governor Asa Hutchinson said at his weekly press conference that Arkansas would submit its draft plan for federal review on July 14. The draft plan is open for public comment at the state level until July 12, suggesting that the state would need only two days to review all public input and update its plan prior to meeting the governor's stated deadline. We would encourage the state to use more than 48 hours to digest and address the public's comments, many of which will likely be raising critical questions about the initial draft.

Conclusion

LLS is grateful that the Arkansas Works 1115 draft plan maintains the state's commitment to Medicaid expansion. The draft plan limits its own effectiveness, however, by departing at several points from the best practices and legal standards in place for Medicaid.

Work, community engagement and health-improvement provisions, cost sharing and premium increases, and limits on retroactive eligibility will create harmful and costly barriers to care for thousands of Arkansans, including the blood cancer patients LLS serves. We ask your agency to revise the draft plan to remedy these issues.

Sincerely,

Dana Bacon
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The Leukemia & Lymphoma Society
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[v] *The Leukemia & Lymphoma Society*, "Principles for Meaningful Coverage." https://www.lls.org/cancercost/principles

[vi] Zuckerbrod, J. "Workplace Wellness Programs Have Overlooked Health Equity." *Georgetown University Center for Children & Families*. February 22, 2021. https://ccf.georgetown.edu/2021/02/22/workplace-wellness-programs-have-overlooked-health-equity/

[vii] Gresham v. Azar, No. 19-5094 (D.C. Cir. 2020) https://healthlaw.org/wp-content/uploads/2020/02/Gresham-v.-Azar-DC-Circuit-Ruling-Feb-14.pdf

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[xi] Ibid.

[xii] See for example: Chernew M, Gibson TB, Yu-Isenberg K, Sokol MC, Rosen AB, Fendrick AM. „Effects of increased patient cost sharing on socioeconomic disparities in health care." *J Gen Intern Med*. 2008. Aug; 23(8):1131-6. Ku, L and Wachino, V. "The Effect of Increased Cost-Sharing in Medicaid: A Summary of Research Findings." *Center on Budget and Policy Priorities*. July 2005. http://www.cbpp.org/5-31-05health2.htm

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[xiv] Meyer H. "New Medicaid barrier: Waivers ending retrospective eligibility shift costs to providers, patients," *Modern Healthcare*, February 9, 2019. https://www.modernhealthcare.com/article/20190209/NEWS/190209936/new-medicaid-barrierwaivers-ending-retrospective-eligibility-shift-costs-to-providers-patients.

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BEATING CANCER IS IN OUR BLOOD.

American Lung Association.
Arkansas

July 12, 2021

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Re: ARHOME Section 1115 Demonstration Application

Dear Ms. Pitman:

The American Lung Association in Arkansas appreciates the opportunity to provide comments on Arkansas's Section 1115 Demonstration Application.

The American Lung Association is the oldest voluntary public health association in the United States, currently representing the 37 million Americans living with lung disease including asthma, lung cancer and COPD, including more than 530,000 Arkansas residents. The Lung Association is the leading organization working to save lives by improving lung health and preventing lung disease through research, education and advocacy.

The purpose of the Medicaid program is to provide healthcare coverage for low-income individuals and families, and the Lung Association is committed to ensuring that Arkansas's Medicaid program provides quality and affordable healthcare coverage. The Lung Association strongly supports Arkansas's continued commitment to Medicaid expansion. Reviews of more than 600 studies examining the impact of Medicaid expansion have found clear evidence that expansion is linked to increased access to coverage, improvements in many health indicators, and economic benefits for states and providers.[1] Research shows an association between Medicaid expansion and early stage cancer diagnosis, when cancer is often more treatable.[2] Medicaid expansion is also associated with a reduction in preventable hospitalizations, including for asthma and COPD.[3] Additionally, Medicaid expansion plays an important role in addressing health disparities — for example, one recent study found that states that expanded Medicaid under the ACA reduced racial disparities in timely treatment for cancer patients.[4] Clearly, Medicaid expansion is beneficial for patients with lung disease and other serious and chronic conditions.

Unfortunately, this proposal also includes several provisions that do not meet the objective to provide healthcare for low-income individuals. The Lung Association therefore offers the following comments on the ARHOME waiver.

<u>Retroactive Eligibility</u>
This proposal would continue to limit retroactive coverage to 30 days for the demonstration population. There are no exemptions, including for medically frail individuals. Retroactive eligibility in Medicaid

prevents gaps in coverage by typically covering individuals for up to 90 days prior to the month of application, assuming the individual is eligible for Medicaid coverage during that time frame. It is common that individuals are unaware they are eligible for Medicaid until a medical event or diagnosis occurs. Retroactive eligibility allows patients who have been diagnosed with a serious illness, such as lung cancer, to begin treatment without being burdened by medical debt prior to their official eligibility determination.

Medicaid paperwork can be burdensome and often confusing. A Medicaid enrollee may not have understood or received a notice of Medicaid renewal and only discovered the coverage lapse when picking up a prescription or going to see their doctor. Without retroactive eligibility, Medicaid enrollees could then face substantial costs at their doctor's office or pharmacy.

Health systems could also end up providing more uncompensated care. For example, when Ohio was considering a similar provision in 2016, a consulting firm advised the state that hospitals could accrue as much as $2.5 billion more in uncompensated care as a result of the waiver.[5] Increased uncompensated care costs are especially concerning as safety net hospitals and other providers continue to deal with the COVID-19 pandemic. Additionally, Arkansas currently has 11 rural hospitals that are vulnerable to closure.[6] Limiting retroactive coverage increases the financial hardships to rural hospitals that absorb uncompensated care costs. The Lung Association in Arkansas opposes the limitations on retroactive coverage for the demonstration population.

<u>Premiums and Cost-sharing</u>

Arkansas proposes to increase premiums for individuals with incomes at or above 100% of the federal poverty line. Premiums will likely discourage eligible people from enrolling in the program. For example, when Oregon implemented a premium in its Medicaid program, with a maximum premium of $20 per month, almost half of enrollees lost coverage.[7] Additional research on Michigan's Medicaid expansion program showed that modest increases of a few dollars in premiums resulted in disenrollment, especially among healthy individuals, from the program.[8] A gap in healthcare coverage could mean that a patient with lung cancer would have to pause treatment or someone with COPD might have to stop taking their medication, leading to an irreversible worsening of their condition.

The state is also requesting to impose copayments ranging from $5 to $20 on individuals with incomes at or above 21% of the federal poverty line ($225 per month for an individual). Research has shown that even relatively low levels of cost-sharing for low-income populations limit the use of necessary healthcare services.[9]

One of the copays included in the proposal is for non-emergency use of the emergency department. Patients should not be financially penalized for seeking help for any health problem. When people do experience severe symptoms, they should not try to self-diagnose their condition or worry that they cannot afford to seek care. Instead, they must have access to a quick diagnosis and treatment in an emergency department. A study of enrollees in Oregon's Medicaid program demonstrated that implementation of a copay on emergency services resulted in decreased utilization of such services but did not result in cost savings because of subsequent use of more intensive and expensive services.[10] This provides further evidence that copays may lead to inappropriate delays in needed care.

The Lung Association in Arkansas opposes the premiums and cost-sharing for the population covered under this demonstration.

Cap on Qualified Health Plan Enrollment

Arkansas is proposing to continue its model of using premium assistance to purchase coverage through qualified health plans (QHPs) on the state marketplace for most adults in the expansion population. The state is also seeking to cap monthly enrollment in these QHPs. The proposal would set a monthly maximum enrollment cap at no more than 80% of total expansion enrollment. Once the cap is reached, the state would suspend auto-assignment into QHPs for beneficiaries who do not choose a QHP and instead enroll those individuals in fee-for-service (FFS). However, beneficiaries that select a specific QHP would still be enrolled in that plan, regardless of the cap.

The Lung Association urges the state to explain how this proposal will not limit patients' access to care. The state has previously asserted that individuals enrolled in QHPs have better access to provider networks than counterparts enrolled in FFS. Additionally, the state is not proposing to expand the FFS provider network, but this proposal will likely increase enrollment in the FFS program. This means that both existing and new FFS enrollees could face long wait times to see providers. The state should also clarify how it will ensure that this proposal does not allow health plans to exclude individuals with more expensive health conditions.

QHP Incentive Programs

The state is proposing to allow QHPs to design "incentive programs" for enrollees, which could be related to health improvement or economic independence. The state does not provide a comprehensive list of what behaviors QHPs could offer incentives for but lists annual wellness exams and attending a job fair as examples. The health plans would be able to reduce or eliminate beneficiaries' cost-sharing obligations if enrollees participate in the incentives.

The Lung Association is concerned that this incentive program could be used to discriminate against individuals who use tobacco and have other chronic health conditions and potentially discourage them obtaining coverage. For example, some health plans may choose to reduce costs for non-tobacco users under the guise of an incentive for tobacco cessation. However, research is clear that tobacco surcharges have not been proven effective in helping smokers quit and reducing tobacco use. Studies from Health Affairs[11] and the Center for Health and Economics Policy at the Institute for Public Health at Washington University[12] have suggested that tobacco surcharges do not increase tobacco cessation but do lead individuals to forgo health insurance rather than paying the surcharge. Tobacco users often have expensive comorbidities. Charging a tobacco surcharge could cause those enrollees to go without coverage and access to preventive care (including tobacco cessation treatment), allowing comorbid health conditions to worsen and ultimately resulting in more expensive healthcare.

The state is ambiguous with regard to QHP incentive programs and leaves broad authority to individual plans to implement such programs. Without clear definitions, health plans might implement wellness programs which allow plans to financially discriminate based on health condition. The Lung Association is also concerned that the conditions typically targeted by wellness programs often occur more frequently in older adults and fall disproportionately on women and some racial and ethnic groups, raising the potential for wellness programs to discriminate based on age and gender and to exacerbate racial health disparities.

The Lung Association in Arkansas has serious concerns about these wellness incentives. At a minimum, the state should clarify these provisions so that we can more fully comment on their implications.

Evaluation

The Lung Association is concerned that this proposal does not include an interim evaluation of Arkansas Works, the state's previous demonstration waiver. Therefore, there is no evaluation data on the state's experience with premiums, limitations on retroactive coverage, and other key provisions included in the current waiver application. This is highly problematic because the state is asking for comment on extending its current demonstration, and evidence from an interim evaluation would help our organization to fully comment on the current request.

Once again, the Lung Association in Arkansas thanks you for your commitment to continuing Medicaid expansion. We urge you to revise the application as outlined above to ensure that it meets the objectives of the Medicaid program. Thank you for the opportunity to provide comments.

Sincerely,

Shannon Baker
Director, Advocacy
American Lung Association in Arkansas

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[1] Madeline Guth and Meghana Ammula. "Building on the Evidence Base: Studies on the Effects of Medicaid Expansion, February 2020 to March 2021." May 6, 2021. Available at: https://www.kff.org/medicaid/report/building-on-the-evidence-base-studies-on-the-effects-of-medicaid-expansion-february-2020-to-march-2021/.

[2] Aparna Soni, Kosali Simon, John Cawley, Lindsay Sabik, "Effect of Medicaid Expansions of 2014 on Overall and Early-Stage Cancer Diagnoses", American Journal of Public Health 108, no. 2 (February 1, 2018): pp. 216-218. Available at http://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2017.304166.

[3] Hefei Wen Kenton J. Johnston, Lindsay Allen, and Theresa M Waters. "Medicaid Expansion Associated with Reductions in Preventable Hospitalizations." November 2019. Health Affairs. Doi 10.1377/hlthaff.2019.00483

[4] American Society of Clinical Oncology, "Racial Disparities in Access to Timely Cancer Treatment Nearly Eliminated in States with Medicaid Expansion." American Society of Clinical Oncology Annual Meeting. June 2, 2019. Access at: https://www.asco.org/about-asco/press-center/news-releases/racial-disparities-access-timely-cancer-treatment-nearly

[5] Virgil Dickson, "Ohio Medicaid waiver could cost hospitals $2.5 billion", Modern Healthcare, April 22, 2016. (http://www.modernhealthcare.com/article/20160422/NEWS/160429965)

[6] https://www.ivantageindex.com/wp-content/uploads/2020/02/CCRH_Vulnerability-Research_FiNAL-02.14.20.pdf

[7] Id.

[8] Cliff, B., et al. Adverse Selection in Medicaid: Evidence from Discontinuous Program Rules. NBER Working Paper No. 28762. National Bureau of Economic Research. May 2021. Accessed at: https://www.nber.org/system/files/working_papers/w28762/w28762.pdf.

[9] Samantha Artiga, Petry Ubri, and Julia Zur, "The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings," Kaiser Family Foundation, June 2017. Available at: https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/.

[10] Wallace NT, McConnell KJ, et al. How Effective Are Copayments in Reducing Expenditures for Low-Income Adult Medicaid Beneficiaries? Experience from the Oregon Health Plan. Health Serv Res. 2008 April; 43(2): 515–530.

[11] Friedman, A.S., Schpero, W. L., Busch, S.H. Evidence Suggests That The ACA's Tobacco Surcharges Reduced Insurance Take-Up and Did Not Increase Smoking Cessation. Health Aff 2016; 35:1176-1183. doi: 10.1377/hlthaff.2015.1540 accessed at: http://content.healthaffairs.org/content/35/7/1176.abstract

[12]Monti, D., Kusemchak, M., Politi, M., Policy Brief: The Effects of Smoking on Health Insurance Decisions Under the Affordable Care Act. Center for Health and Economics Policy Institute for Public Health at Washington University. July 2016. Accessed at: https://publichealth.wustl.edu/wp-content/uploads/2016/07/The-Effects-of-Smoking-on-Health-Insurance-Decisions-under-the-ACA.pdf

July 12, 2021

Ms. Elizabeth Pittman
Director
Division of Medical Services
Arkansas Department of Human Services
P.O. Box 1437, Slot S295
Little Rock, AR 72203-1437

Dear Ms. Pittman:

I am writing to express the support of Excel by Eight for the Maternal Life360 HOME model that is proposed in the 1115 waiver request to the Centers for Medicare and Medicaid Services and to outline several recommendations for strengthening the request that will improve the likelihood of achieving the waiver's proposed outcomes.

At Excel by Eight, we envision an Arkansas where all children have access to quality health care and education that maximizes their full potential, regardless of gender, income, race/ethnicity, disability, or geography. For healthy development, infants and toddlers need quality health care, stimulating learning opportunities, and nurturing, responsive relationships. A system of support should be in place at or before birth to ensure every parent and child receives the needed information, assessments and referrals for a strong start. We believe that home visiting programs are a key strategy for providing these resources.

We are working with six communities around the state - Conway, Independence, Monroe, Sevier, and Union counties and the City of Little Rock - to achieve this vision by helping them develop a reliable grid of family, community, health, and education resources. After learning about the proposed waiver, those communities with birthing hospitals have already begun discussing how they might partner with the hospitals to expand existing, evidence-based home visiting models to improve health outcomes for vulnerable mothers, infants, and toddlers.

To ensure that the investments in Maternal Life360 HOMEs achieve the intended outcomes, we recommend the following:

1. Build on existing home visiting infrastructure. Arkansas already has a statewide home visiting network that provides training and technical assistance, evaluation, guidance, and ongoing quality improvement work to community-based programs. With support from public and private funding streams, home visiting already reaches children prenatal to age five across the state through evidence-based models. Starting a home visiting program is a complex process that needs expert guidance; the Maternal Life360 HOME model should build upon and support existing infrastructure as birthing hospitals establish programs.

2. Invest in evidence-based home visiting models. Using evidence-based programs, as required by Act 530 of 2021, is the best way to ensure outcomes and operations align with goals, such as reducing infant and maternal mortality. The U.S. Department of Health and Human Services (HHS) has developed a review process for home visiting programs called HomVEE. Nineteen models meet HHS criteria for evidence based early childhood home visiting programs. Several of these focus on the target audience for Maternal Life360 HOMEs and already exist in Arkansas -- Healthy Families America, Nurse Family Partnership, and SafeCare.

3. Allow enrollment after the birth of the child. While it is optimal to enroll women in home visiting during pregnancy, we recommend that families be allowed to enroll in Maternal Life360 HOMEs through the end of a child's first year of life, at minimum, to have maximum benefit on infant and maternal mortality. Health and social factors that impact health outcomes may not arise until after a child is born. Additionally, pediatricians and other primary care providers may recognize "high risk" factors such as maternal depression, unsafe sleep environments, or parental drug use during well-child visits.

4. Allow all pregnant and parenting women in Medicaid to enroll. Some of the most vulnerable pregnant women may not be enrolled in a Qualified Health Plan but instead be enrolled in traditional/pregnancy Medicaid or the new PASSE options outlined in the waiver. Allowing women across all expansion/Medicaid options to access the Maternal Life360 HOMEs would broaden the programs' reach and help achieve health outcome goals outlined in the waiver.

Thank you for the opportunity to provide feedback on the waiver. We look forward to working with DHS and our E8 communities to implement the Maternal Life360 HOME model over the next few years.

Sincerely,

Angela Duran
Executive Director

CYSTIC FIBROSIS FOUNDATION®

July 8, 2021

Elizabeth Pitman
Director
Division of Medical Services
Donaghey Plaza
P.O. Box 1437
Little Rock, AR 72203

Re: ARHOME Section 1115 Demonstration Application

Dear Ms. Pitman,

Thank you for the opportunity to comment on Arkansas's Section 1115 Demonstration Application. On behalf of people with cystic fibrosis (CF) living in Arkansas, we write to express our serious concerns with this waiver application. We oppose the state's proposal to limit retroactive eligibility and increase premiums. We fear these policies will jeopardize patient access to quality and affordable healthcare and therefore urge that Arkansas revise its waiver application to remove these harmful provisions.

Cystic fibrosis is a life-threatening genetic disease that affects more than 30,000 people in the United States, including about 300 in Arkansas. Roughly a third of adults living with CF in the state rely on Medicaid for some or all of their health care coverage. CF causes the body to produce thick, sticky mucus that clogs the lungs and digestive system, which can lead to life-threatening infections. As a complex, multi-system condition, CF requires targeted, specialized treatment and medications. If left untreated, infections and exacerbations caused by CF can result in irreversible lung damage and the associated symptoms of CF lead to early death, usually by respiratory failure.

Unfortunately, this proposal includes several provisions that do not meet the objective to provide accessible and affordable healthcare for people with CF. Therefore, the Cystic Fibrosis Foundation offers the following comments on the ARHOME waiver.

Retroactive Eligibility
This proposal would continue to limit retroactive coverage to 30 days for the Medicaid expansion population. There are no exemptions, including for medically frail individuals. Retroactive eligibility in Medicaid prevents gaps in coverage by typically covering individuals for up to 90 days prior to the month of application, assuming the individual is eligible for Medicaid coverage during that time frame. It is common that individuals are unaware they are eligible for Medicaid until a medical event or diagnosis occurs. Retroactive eligibility allows patients who have been diagnosed with a serious illness, such as cystic fibrosis, to begin treatment without being burdened by medical debt prior to their official eligibility determination.

Retroactive eligibility helps adults living with CF in Arkansas who rely on Medicaid avoid gaps in coverage and costly medical bills and is an especially important safeguard for those who have lost their job or are experiencing changes in their insurance status as a result of the COVID-19 pandemic. Without it, people with CF may face significant out-of-pocket costs. Cystic fibrosis care and treatments are costly, even with coverage. According to a

survey conducted by George Washington University of 1,800 people living with CF and their families, over 70 percent indicated that paying for health care has caused financial problems such as being contacted by a collection agency, having to file for bankruptcy, experiencing difficulty paying for basics like rent and utilities, or having to take a second job to make ends meet. And while 84 percent received some form of financial assistance in 2019 to pay for their care, almost half reported still having problems paying for at least one medication or service in that same year.

Cost-Sharing Requirements

Arkansas proposes to increase premiums for individuals with incomes at or above 100% of the federal poverty line. Premiums will likely discourage eligible people from enrolling in the program. For example, when Oregon implemented a premium in its Medicaid program, with a maximum premium of $20 per month, almost half of enrollees lost coverage.[1] Additional research on Michigan's Medicaid expansion program showed that modest increases of a few dollars in premiums resulted in disenrollment, especially among healthy individuals from the program.[2] An analysis of Indiana's Medicaid program also found that nearly 30 percent of enrollees either never enrolled in coverage or were disenrolled from coverage because they failed to make premium payments. The analysis found 22 percent of individuals who never enrolled because they did not make the first month's payment cited affordability concerns, and 22 percent said they were confused about the payment process.[8]

Research has also shown that even relatively low levels of cost-sharing for low-income populations limit the use of necessary healthcare services.[9] The program's cost sharing requirement for low-income beneficiaries would also have been a significant financial burden for patients. People with CF bear a significant cost burden and out-of-pocket costs can present a barrier to care. According to the afore mentioned survey of people living with CF and their families, while 98 percent of people with CF have some type of health insurance coverage, 58 percent have postponed or skipped necessary medical care or treatments due to cost concerns. Such actions seriously jeopardize the health of people with CF and can lead to costly hospitalizations and fatal lung infections.

The Cystic Fibrosis Foundation strongly recommends that Arkansas revise its waiver application as outlined to ensure that it meets the objectives of the Medicaid program. Thank you for the opportunity to provide comments.

Sincerely,

Mary B. Dwight
Chief Policy & Advocacy Officer
Senior Vice President, Policy & Advocacy
Cystic Fibrosis Foundation

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[1] Id.

[2] Cliff, B., et al. Adverse Selection in Medicaid: Evidence from Discontinuous Program Rules. NBER Working Paper No. 28762. National Bureau of Economic Research. May 2021. Accessed at: https://www.nber.org/system/files/working_papers/w28762/w28762.pdf.

National
Multiple Sclerosis
Society

July 9, 2021

Elizabeth Pitman
Director
Division of Medical Services
Donaghey Plaza
P.O. Box 1437
Little Rock, AR 72203

Re: ARHOME Section 1115 Demonstration Application

Dear Ms. Pitman:

The National Multiple Sclerosis Society appreciates the opportunity to provide comments on Arkansas's Section 1115 Demonstration Application.

Multiple sclerosis (MS) is an unpredictable, often disabling disease of the central nervous system that disrupts the flow of information within the brain, and between the brain and body. Symptoms range from numbness and tingling to blindness and the progress, severity and specific symptoms of MS in any one person cannot yet be predicted. There are an estimated one million people living with MS in the United States, but advances in research and treatment are leading to better understanding and moving us closer to a world free of MS.

The purpose of the Medicaid program is to provide healthcare coverage for low-income individuals and families, and the National MS Society is committed to ensuring that Arkansas's Medicaid program provides quality and affordable healthcare coverage. Specifically, Medicaid expansion is critical for patients with and at risk of serious, acute and chronic health conditions. Reviews of more than 600 studies examining the impact of Medicaid expansion have found clear evidence that expansion is linked to increased access to coverage, improvements in many health indicators, and economic benefits for states and providers.[1] Access to affordable, high quality health care is essential for people with MS to live their best lives, and health insurance coverage is essential for people to be able to get the care and treatments they need. Without health insurance, people living with MS do not have access to the services and treatments to manage symptoms and slow their disease course. The National MS Society supports Arkansas's continued commitment to Medicaid expansion.

Unfortunately, this proposal includes several provisions that do not meet the objective to provide healthcare for low-income individuals. Instead, the proposed waiver includes limitations on retroactive coverage and premiums and cost-sharing that will create financial and administrative barriers for patients. The National MS Society offers the following comments on the ARHOME waiver.

<u>Retroactive Eligibility</u>
This proposal would continue to limit retroactive coverage to 30 days for the demonstration population. There are no exemptions, including for medically frail individuals. Retroactive eligibility in Medicaid prevents gaps in coverage by typically covering individuals for up to 90 days prior to the month of

National Multiple Sclerosis Society

application, assuming the individual is eligible for Medicaid coverage during that time frame. It is common that individuals are unaware they are eligible for Medicaid until a medical event or diagnosis occurs. Retroactive eligibility allows patients who have been diagnosed with a serious illness, such as MS to begin treatment without being burdened by medical debt prior to their official eligibility determination.

Medicaid paperwork can be burdensome and often confusing. A Medicaid enrollee may not have understood or received a notice of Medicaid renewal and only discovered the coverage lapse when picking up a prescription or going to see their doctor. Without retroactive eligibility, Medicaid enrollees could then face substantial costs at their doctor's office or pharmacy.

Health systems could also end up providing more uncompensated care. For example, when Ohio was considering a similar provision in 2016, a consulting firm advised the state that hospitals could accrue as much as $2.5 billion more in uncompensated care as a result of the waiver.[2] Increased uncompensated care costs are especially concerning as safety net hospitals and other providers continue to deal with the COVID-19 pandemic. Additionally, Arkansas currently has 11 rural hospitals that are vulnerable to closure.[3] Limiting retroactive coverage increases the financial hardships to rural hospitals that absorb uncompensated care costs. The National MS Society opposes the limitations on retroactive coverage for the demonstration population.

Premiums and Cost-sharing

Arkansas proposes to increase premiums for individuals with incomes at or above 100% of the federal poverty line. Premiums will likely discourage eligible people from enrolling in the program. For example, when Oregon implemented a premium in its Medicaid program, with a maximum premium of $20 per month, almost half of enrollees lost coverage.[4] Additional research on Michigan's Medicaid expansion program showed that modest increases of a few dollars in premiums resulted in disenrollment, especially among healthy individuals from the program.[5] Studies show that early and ongoing treatment with a disease-modifying therapy (DMT) is the best way to modify the course of the disease, slow the accumulation of disability and protect the brain from damage due to MS. Adherence to medication is a key element of treatment effectiveness. Many MS DMTs are now available, including some generics, but the brand median price in 2020 was $91,835, with even generic medications often costing thousands of dollars. Without prescription drug coverage provided by Medicaid, medications to treat MS would be financially out of reach. Gaps in treatment can lead to disease progression and increased, possibly irreversible, disability.

The state is also requesting to impose copayments ranging from $5 to $20 on individuals with incomes at or above 21% of the federal poverty line ($225 per month for an individual). Research has shown that even relatively low levels of cost-sharing for low-income populations limit the use of necessary healthcare services.[6] Additionally, the state includes a copay for non-emergency use of the emergency department. Yet a study of enrollees in Oregon's Medicaid program demonstrated that implementation of a copay on emergency services resulted in decreased utilization of such services but did not result in cost savings because of subsequent use of more intensive and expensive services.[7] This provides further evidence that copays may lead to inappropriate delays in needed care. The National MS Society opposes the cost-sharing and premiums for the low-income population covered under this demonstration.

National
Multiple Sclerosis
Society

Evaluation

The National MS Society is concerned that this proposal does not include an interim evaluation of Arkansas Works, the state's previous demonstration waiver. Therefore, there is no evaluation data on the state's experience with premiums, limitations on retroactive coverage, and other key provisions included in the current waiver application. This is highly problematic because the state is asking for comment on extending its current demonstration, and evidence from an interim evaluation would help our organization to fully comment on the current request.

The National MS Society strongly recommends that Arkansas revise its waiver application as outlined to ensure that it meets the objectives of the Medicaid program. Thank you for the opportunity to provide comments.

Sincerely,

Christie Eckler

Christie Eckler, LMSW, CFRE
Executive Director, South Central
National Multiple Sclerosis Society

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[1] Madeline Guth and Meghana Ammula. "Building on the Evidence Base: Studies on the Effects of Medicaid Expansion, February 2020 to March 2021." May 6, 2021. Available at: https://www.kff.org/medicaid/report/building-on-the-evidence-base-studies-on-the-effects-of-medicaid-expansion-february-2020-to-march-2021/.

[2] Virgil Dickson, "Ohio Medicaid waiver could cost hospitals $2.5 billion", Modern Healthcare, April 22, 2016. (http://www.modernhealthcare.com/article/20160422/NEWS/160429965)

[3] https://www.ivantageindex.com/wp-content/uploads/2020/02/CCRH_Vulnerability-Research_FiNAL-02.14.20.pdf

[4] Id.

[5] Cliff, B., et al. Adverse Selection in Medicaid: Evidence from Discontinuous Program Rules. NBER Working Paper No. 28762. National Bureau of Economic Research. May 2021. Accessed at: https://www.nber.org/system/files/working_papers/w28762/w28762.pdf.

[6] Samantha Artiga, Petry Ubri, and Julia Zur, "The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings," Kaiser Family Foundation, June 2017. Available at: https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/.

[7] Wallace NT, McConnell KJ, et al. How Effective Are Copayments in Reducing Expenditures for Low-Income Adult Medicaid Beneficiaries? Experience from the Oregon Health Plan. Health Serv Res. 2008 April; 43(2): 515–530.

American Cancer Society
Cancer Action Network
6525 N Meridian Suite 110
Oklahoma City, OK 73116
www.fightcancer.org

July 12, 2021

Elizabeth Pitman
Director, Division of Medical Services
Donaghey Plaza
P.O. Box 1437
Little Rock, AR 72203

Re: ARHOME Section 1115 Demonstration Waiver Renewal Request

Dear Director Pitman,

The American Cancer Society Cancer Action Network (ACS CAN) appreciates the opportunity to comment on Arkansas's proposal to renew and amend the state's 1115 demonstration waiver, renamed "Arkansas Health and Opportunity for Me (ARHOME). ACS CAN is making cancer a top priority for public officials and candidates at the federal, state, and local levels. ACS CAN empowers advocates across the country to make their voices heard and influence evidence-based public policy change, as well as legislative and regulatory solutions that will reduce the cancer burden. As the American Cancer Society's nonprofit, nonpartisan advocacy affiliate, ACS CAN is critical to the fight for a world without cancer.

ACS CAN supports the Arkansas Medicaid program goals of ensuring access to quality healthcare to members. However, the proposed cost sharing provisions could limit – rather than improve – access to care for some of the most vulnerable Arkansans, including those with cancer, cancer survivors, and those who will be diagnosed with the disease. We are also concerned about the reduced length of retroactive eligibility. We strongly urge the Division of Medical Services (or "the Division") to withdraw these provisions.

More than 17,980 Arkansas residents are expected to be diagnosed with cancer this year,[1] and there are more than 143,320 cancer survivors in the state[2] – many of whom rely on healthcare provided through the Medicaid program. ACS CAN wants to ensure that enrollees have adequate access and coverage under the Medicaid program, and that specific requirements do not create barriers to care for cancer patients, survivors, and those who will be diagnosed with cancer.

Following are our specific comments on Arkansas's 1115 waiver application:

Cost Sharing
We are concerned about the affordability of care for enrollees subject to premiums and/or copayments. Higher out-of-pocket costs decrease the likelihood that a lower income person would seek health care

[1] American Cancer Society. *Cancer Facts & Figures 2021*. Atlanta, GA: American Cancer Society; 2021.
[2] American Cancer Society. *Cancer Treatment & Survivorship Facts & Figures 2019-2021*. Atlanta, GA: American Cancer Society; 2019.

services, including preventive screenings.[3,4,5] Cancers that are found at an early stage through screening are less expensive to treat and lead to greater survival.[6] Uninsured and underinsured individuals already have lower screening rates resulting in a greater risk of being diagnosed at a later, more advanced stage of disease.[7] Proposals that place greater financial burden on the lowest income residents create barriers to care and could negatively impact Medicaid enrollees – particularly those individuals who are high service utilizers with complex medical conditions. Although enrollees determined to be Medically Frail are not subject to these cost sharing provisions, we are concerned that many cancer patients and survivors as well as others with complex and/or chronic health care needs will not be classified as Medically Frail, and therefore will be harmed by these policies.

Premiums and cost sharing can be particularly burdensome for a high utilizer of health care services, such as an individual in active cancer treatment or a recent survivor. Cancer patients in active treatment require many services shortly after diagnosis and thus incur a significant portion of cost sharing over a relatively short period of time.[8] It can be challenging for an individual – particularly an individual with limited means – to be able to afford their cost-sharing requirements. Likewise, a recent survivor may require frequent follow-up visits to prevent cancer recurrence. The seemingly nominal copayment amounts (e.g. $4.70 for an outpatient service, $9.40 for a non-preferred drug) could very quickly add up for a patient with multiple provider visits, treatments, and tests in a single week and represent high costs for households with very limited incomes.

Requiring enrollees to pay up to five percent of household income each quarter could result in many cancer patients and survivors delaying their treatment and could result in them forgoing their treatment or follow-up visits altogether. Although the payment of premiums and copayments is not a condition of eligibility, allowing providers to deny service for failure to pay cost-sharing could result in individuals losing access to their care during cancer treatment. We strongly urge the Division to withdraw the proposals to require low-income individuals, including those earning just 21 percent FPL, to pay cost-sharing up to five percent of household income.

We note that qualified health plans (QHPs) can exclude some enrollees from cost sharing provisions "as a reward" for participation in "health improvement or economic independence initiatives". We support efforts to incentivize health improvement but are concerned that enrollees who are not able to engage in these initiatives (because, for example, they can't take time off work) are charged cost-sharing punitively. As discussed above, this can deter enrollees from seeking or receiving needed healthcare, like routine screenings, and may actually accomplish the opposite of the stated goal of 'health improvement.' Additionally, the Division states that the purpose of implementing this

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[3] Solanki G, Schauffler HH, Miller LS. The direct and indirect effects of cost-sharing on the use of preventive services. *Health Services Research.* 2000; 34: 1331-50.

[4] Wharam JF, Graves AJ, Landon BE, Zhang F, Soumerai SB, Ross-Degnan D. Two-year trends in colorectal cancer screening after switch to a high-deductible health plan. *Med Care.* 2011; 49: 865-71.

[5] Trivedi AN, Rakowsi W, Ayanian JA. Effect of cost sharing on screening mammography in Medicare health plans. *N Eng J Med.* 2008; 358: 375-83.

[6] American Cancer Society. *Cancer prevention & early detection facts & figures 2019-2020*. Atlanta: American Cancer Society; 2019.

[7] Ibid.

[8] American Cancer Society Cancer Action Network. *The costs of cancer: Addressing patient costs*. Washington, DC: American Cancer Society Cancer Action Network: 2017.

initiative is to "demonstrate that the individual values coverage as health insurance and values the health care professional who provided the medical service." We note that this stated goal is very different from the primary goal of the Medicaid program, which is to provide affordable health insurance coverage. We encourage the Division to withdraw this piece of their proposal as it runs counter to the purpose of Medicaid.

Surcharge for Non-emergent Use of the Emergency Department
The Division's request to impose a $9.40 fee for each "non-emergent" or "inappropriate" use of the emergency department (ED) for those with incomes at and above 21 percent of FPL could increase costs for cancer patients. Imposing this surcharge may dissuade an individual from seeking care from an ED setting – even if the case is medically warranted. Cancer patients undergoing chemotherapy and/or radiation often have adverse drug reactions or other related health problems that require immediate care during evenings or weekends. If primary care settings and other facilities are not available, these patients are often directed to the ED. Penalizing enrollees, such as cancer patients, by requiring a surcharge for non-emergent use of the ED could become a significant financial hardship for these low-income patients.

We urge the Division to eliminate this provision of the waiver. If the Division does move forward this proposal, it must define the term "non-emergency" use of the ED, as a definition is not included in the waiver proposal. We urge the Division to make this definition narrow and clear, so large numbers of enrollees do not get penalized for seeking needed medical care. Additionally, when evaluating ED cost sharing requirements, we urge the Division to evaluate the impact it has on patients with complex chronic conditions, such as cancer, as well as enrollees who have limited access to healthcare facilities outside of the ED.

Reduce retroactive coverage to 30 days
Medicaid currently allows retroactive coverage if: 1) an individual was unaware of his or her eligibility for coverage at the time a service was delivered; or 2) during the period prospective enrollees were preparing the required documentation and Medicaid enrollment application. Policies that would reduce or eliminate retroactive eligibility could place a substantial financial burden on enrollees and cause significant disruptions in care, particularly for individuals battling cancer. Therefore, we are concerned about the Division's request to reduce retroactive eligibility to 30 days from the allowed 90 days.

Many uninsured or underinsured individuals who are newly diagnosed with a chronic condition already do not receive recommended services and follow-up care because of cost.[9,10] In 2017, one in five uninsured adults went without care because of cost.[11] Reducing retroactive eligibility could mean even more people are unable to afford care and forgo necessary care due to cost.
Safety net hospitals and providers also rely on retroactive eligibility for reimbursement of provided services, allowing these facilities to keep the doors open. For example, the Emergency Medical Treatment

[9] Hadley J. Insurance coverage, medical care use, and short-term health changes following an unintentional injury or the onset of a chronic condition. *JAMA*. 2007; 297(10): 1073-84.
[10] Foutz J, Damico A, Squires E, Garfield R. The uninsured: A primer – Key facts about health insurance and the uninsured under the Affordable Care Act. *The Henry J Kaiser Family Foundation*. Published January 25, 2019. Accessed November 2019. https://www.kff.org/report-section/the-uninsured-a-primer-key-facts-about-health-insurance-and-the-uninsured-under-the-affordable-care-act-how-does-lack-of-insurance-affect-access-to-health-care/.
[11] The Henry J. Kaiser Family Foundation. Key facts about the uninsured population. Updated December 7, 2018. Accessed November 2019. https://www.kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/.

and Labor Act (EMTALA) requires hospitals to stabilize and treat individuals in their emergency room, regardless of their insurance status or ability to pay.[12] Retroactive eligibility allows hospitals to be reimbursed if the individual treated is eligible for Medicaid coverage. Likewise, Federally Qualified Health Centers (FQHCs) offer services to all persons, regardless of that person's ability to pay or insurance status.[13] Community health centers also play a large role in ensuring low-income individuals receive cancer screenings, helping to save the state of Arkansas from the high costs of later stage cancer diagnosis and treatment. Therefore, we urge the Department to consider these providers and their contribution to Arkansas's safety net, as well as the patients who rely on Medicaid for health care coverage, before reducing retroactive eligibility for Medicaid enrollees.

Community Engagement Activities

We appreciate that this demonstration does not include work and community engagement (WCE) requirements, but are concerned that the state will seek to amend the Demonstration if federal law or regulations permit the use of these requirements as a condition of eligibility in the future. ACS CAN opposes tying access to affordable health care for lower income persons to employment or community engagement requirements, because cancer patients and survivors – as well as those with other complex chronic conditions – could be seriously disadvantaged and find themselves without Medicaid coverage because they are physically unable to comply. The state's previous experience with WCE requirements - where uninsured rates were driven up and employment actually declined in the state after the requirement went into effect[14] - demonstrates the impact this policy can have on reducing health coverage and not meeting the state's goal of incentivizing employment and increasing the number of employed Arkansas Works enrollees.[15]

Many cancer patients in active treatment are often unable to work or require significant work modifications due to their treatment.[16,17,18] Research suggests that between 40 and 85 percent of cancer patients stop working while receiving cancer treatment, with absences from work ranging from 45 days to six months depending on the treatment.[19] Recent cancer survivors often require frequent follow-up

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[12] Centers for Medicare & Medicaid Services. Emergency medical treatment & labor act (EMTALA). Updated March 2012. Accessed October 2019. https://www.cms.gov/regulations-and-guidance/legislation/emtala/.

[13] National Association of Community Health Centers. Maine health center fact sheet. Published March 2017. Accessed November 2019. http://www.nachc.org/wp-content/uploads/2016/03/ME_17.pdf.

[14] Sommers BD, Chen L, Blendon RJ, et al. Medicaid Work Requirements In Arkansas: Two-Year Impacts On Coverage, Employment, And Affordability Of Care. *Health Affairs.* 2020. DOI: 10.1377/hlthaff.2020.00538

[15] Ibid.

[16] Whitney RL, Bell JF, Reed SC, Lash R, Bold RJ, Kim KK, et al. Predictors of financial difficulties and work modifications among cancer survivors in the United States. *J Cancer Surviv.* 2016; 10:241. doi: 10.1007/s11764-015-0470-y.

[17] de Boer AG, Taskila T, Tamminga SJ, et al. Interventions to enhance return to work for cancer patients. *Cochrane Database Syst Rev.* 2011; 16(2): CD007569. doi: 10.1002/14651858.CD007569.pub2.

[18] Stergiou-Kita M, Pritlove C, van Eerd D, Holness LD, Kirsh B, Duncan A, Jones J. The provision of workplace accommodations following cancer: survivor, provider, and employer perspectives. *J Cancer Surviv*. 2016; 10:480. doi:10.1007/s11764-015-0492-5.

[19] Ramsey SD, Blough DK, Kirchhoff AC, et al. Washington State Cancer Patients Found to be at Greater Risk for Bankruptcy then People Without a Cancer Diagnosis," Health Affairs, 32, no. 6, (2013): 1143-1152.

visits[20] and suffer from multiple comorbidities linked to their cancer treatments.[21,22] Cancer survivors are often unable to work or are limited in the amount or kind of work they can participate in because of health problems related to their cancer diagnosis.[23,24] If work and community engagement is required as a condition of eligibility, many newly diagnosed and recent cancer survivors, as well as those with other chronic illnesses could find that they are ineligible for the lifesaving care and treatment services provided through the state's Medicaid program. We also note that imposing work or community engagement requirements on lower income individuals as a condition of coverage could impede individuals' access to prevention and early detection care, including cancer screenings and diagnostic testing.

Conclusion

We appreciate the opportunity to provide comments on the Arkansas demonstration waiver extension. The preservation of eligibility, coverage, and access to Medicaid remains critically important for many low-income state residents who depend on the program for cancer and chronic disease prevention, early detection, diagnostic, and treatment services. We ask the Division to weigh the impact of these proposals on low-income Arkansans' access to lifesaving health care coverage, particularly those individuals with cancer, cancer survivors, and those who will be diagnosed with cancer during their lifetime.

Maintaining access to quality, affordable, accessible, and comprehensive health care coverage and services is a matter of life and survivorship for thousands of low-income cancer patients and survivors. We look forward to working with you to ensure that ensure that coverage through Arkansas Medicaid meets the health care needs of eligible individuals and families and reduces the burden of cancer for lower income Arkansans. If you have any questions, please feel free to contact me at matt.glanville@cancer.org or (405) 301.6311.

Sincerely,

Matt Glanville

Matt Glanville
Arkansas Government Relations Director
American Cancer Society Cancer Action Network

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[20] National Cancer Institute. *Coping with cancer: Survivorship, follow-up medical care*. Accessed October 2019. https://www.cancer.gov/about-cancer/coping/survivorship/follow-up-care.

[21] Mehta LS, Watson KE, Barac A, Beckie TM, Bittner V, Cruz-Flores S, et al. Cardiovascular disease and breast cancer: Where these entities intersect: A scientific statement from the American Heart Association. *Circulation*. 2018; 137(7): CIR.0000000000000556.

[22] Dowling E, Yabroff R, Mariotto A, et al. Burden of illness in adult survivors of childhood cancers: Findings from a population-based national sample. *Cancer.* 2010; 116:3712-21.

[23] Ibid.

[24] Guy GP Jr, Berkowitz Z, Ekwueme DU, Rim SH, Yabroff R. Annual economic burden of productivity losses among adult survivors of childhood cancers. *Pediatrics*. 2016; 138(s1):e20154268; Zheng Z, Yabroff KR, Guy GP Jr, et al. Annual medical expenditures and productivity loss among colorectal, female breast, and prostate cancer survivors in the United States. *JNCI J Natl Cancer Inst.* 2016; 108(5):djv382; and Kent EE, Davidoff A, de Moor JS, et al. Impact of sociodemographic characteristics on underemployment in a longitudinal, nationally representative study of cancer survivors: Evidence for the importance of gender and marital status. *J Psychosoc Oncol*. 2018; 36(3):287-303.

July 12, 2021

Elizabeth Pitman
Director
Division of Medical Services
Donaghey Plaza
P.O. Box 1437
Little Rock, AR 72203

Re: ARHOME Section 1115 Demonstration Application

Dear Ms. Pitman:

The AIDS Institute, a nonprofit dedicated to protecting access to healthcare for people living with HIV and hepatitis, appreciates the opportunity to provide comments on Arkansas's Section 1115 Demonstration Application.

Medicaid is an extremely important source of health care coverage for people living with, and at risk for, HIV/AIDS and hepatitis. Forty-two percent of adults living with HIV are covered by Medicaid, compared to just thirteen percent of the general population.[1] Ensuring uninterrupted access to effective HIV care and treatment is incredibly important to the health of people living with HIV and to the public's health.[2] When HIV is effectively managed and individuals stay in treatment and virally suppressed, there is no risk of transmission.[3] Ensuring broad access to Medicaid coverage will ensure people living with HIV stay health, but also is an investment in Arkansas' public health.

The Medicaid program is intended to provide healthcare coverage for low-income individuals and families, and The AIDS Institute is committed to ensuring that Arkansas's Medicaid program provides quality and affordable healthcare coverage. The implications of the proposed waiver amendments pose significant risks to Arkansans living with serious and chronic conditions, but they also stand to upend the long-term goal to end HIV in the US.

In 2019, President Trump declared his Administration's commitment to Ending the HIV Epidemic (EHE) in the US by 2030. This bold plan leverages critical scientific advances in prevention, diagnosis, and treatment, but is reliant on a coordinated response from the public health infrastructure and health insurance coverage systems. HIV has disproportionately burdened the South, with over half of all new

[1] *Medicaid and HIV*, Kaiser Family Foundation. Oct. 1, 2019. https://www.kff.org/hivaids/fact-sheet/medicaid-and-hiv/

[2] Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the use of antiretroviral agents in HIV-1-infected adults and adolescents. Department of Health and Human Services. http://www.aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf

[3] Eisinger RW, Dieffenbach CW, Fauci AS. *HIV Viral Load and Transmissibility of HIV Infection: Undetectable Equals Untransmittable*. JAMA. January 10, 2019 321(5):451–452

HIV diagnoses in the United States occurring in Southern states like Arkansas.[4] In fact, HHS identified Arkansas as one of the 7 target states in phase 1 of the EHE initiative to receive additional resources due to the overwhelming rate of rural HIV transmission. In 2018, approximately 7,000 people in Arkansas were living with HIV; an estimated 1,325 individuals are unaware they have HIV.[5] Imposing barriers to care, like premium payments and copayments as proposed in the 1115 waiver application, will keep people from getting the coverage they need, and ensure the failure to meet the goals of the EHE initiative.

Simultaneously, as HIV continues to affect the lives of people throughout Arkansas, the state has been very hard hit by the hepatitis epidemic. There are approximately 21,800 people living with hepatitis C in the state. From 2013-2016, the state reported a hepatitis C rates higher than those of the US.[6] Hepatitis C is a curable disease and Medicaid can be the solution to eliminating HCV.

Additionally, Medicaid expansion is critical for all patients with and at risk of serious, acute and chronic health conditions, but can have downstream benefits for the state's health system. Reviews of more than 600 studies examining the impact of Medicaid expansion have found clear evidence that expansion is linked to increased access to coverage, improvements in many health indicators, and economic benefits for states and providers.[7] New research from the University of Illinois Urbana-Champagne shows that as a result of Medicaid expansion there was an uptick in HIV diagnosis – this translates to engaging new populations in on-going primary care, keeping emergency room visits to a minimum and healthcare system costs low.[8] The AIDS Institute supports Arkansas's continued commitment to Medicaid expansion.

However, this proposal includes several provisions that do not meet the objective to provide healthcare for low-income individuals. Instead, the proposed waiver includes limitations on retroactive coverage and premiums and cost-sharing that will create financial and administrative barriers for patients. The AIDS Institute offers the following comments on the ARHOME waiver.

Retroactive Eligibility

This proposal would continue to limit retroactive coverage to 30 days for the demonstration population. There are no exemptions, including for medically frail individuals. Retroactive eligibility in Medicaid prevents gaps in coverage by typically covering individuals for up to 90 days prior to the month of application, assuming the individual is eligible for Medicaid coverage during that time frame. It is common that individuals are unaware they are eligible for Medicaid until a medical event or diagnosis occurs. Retroactive eligibility allows patients who have been diagnosed with a serious illness, such as HIV and hepatitis to begin treatment without being burdened by medical debt prior to their official eligibility determination.

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[4] *HIV in the United States by Region*, CDC.https://www.cdc.gov/hiv/statistics/overview/geographicdistribution.html

[5] *Estimated HIV Incidence and Prevalence In the United States 2014-2018.* HIV Surveillance Reports. CDC V25, No1. https://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-supplemental-report-vol-25-1.pdf

[6] HepVu. Local Data, Arkansas. (retrieved July 12, 2021) https://hepvu.org/local-data/arkansas/

[7] Madeline Guth and Meghana Ammula. "Building on the Evidence Base: Studies on the Effects of Medicaid Expansion, February 2020 to March 2021." May 6, 2021. Available at: https://www.kff.org/medicaid/report/building-on-the-evidence-base-studies-on-the-effects-of-medicaid-expansion-february-2020-to-march-2021/.

[8] H. Nelson, Medicaid Expansion Helped Detect Undiagnosed HIV Infections. (Private Payer News. January 27, 2021). https://healthpayerintelligence.com/news/medicaid-expansion-helped-detect-undiagnosed-hiv-infections

Medicaid paperwork can be burdensome and often confusing. A Medicaid enrollee may not have understood or received a notice of Medicaid renewal and only discovered the coverage lapse when picking up a prescription or going to see their doctor. Without retroactive eligibility, Medicaid enrollees could then face substantial costs at their doctor's office or pharmacy.

Health systems could also end up providing more uncompensated care. For example, when Ohio was considering a similar provision in 2016, a consulting firm advised the state that hospitals could accrue as much as $2.5 billion more in uncompensated care as a result of the waiver.[9] Increased uncompensated care costs are especially concerning as safety net hospitals and other providers continue to deal with the COVID-19 pandemic. Additionally, Arkansas currently has 11 rural hospitals that are vulnerable to closure.[10] Limiting retroactive coverage increases the financial hardships to rural hospitals that absorb uncompensated care costs. The AIDS Institute opposes the limitations on retroactive coverage for the demonstration population.

Premiums and Cost-sharing

Arkansas proposes to increase premiums for individuals with incomes at or above 100% of the federal poverty line. Premiums will likely discourage eligible people from enrolling in the program. For example, when Oregon implemented a premium in its Medicaid program, with a maximum premium of $20 per month, almost half of enrollees lost coverage. Additional research on Michigan's Medicaid expansion program showed that modest increases of a few dollars in premiums resulted in disenrollment, especially among healthy individuals from the program. As previously mentioned, Medicaid is the primary source of insurance coverage for people living with HIV. Referring back to the EHE plan, the goals of the initiative are to test, diagnose, and link individuals to care as rapidly as possible.[11] Imposing premiums will automatically create a default waiting period for many individuals who cannot or do not know how to pay their initial premium. This will cause individuals to be dropped at a critical point in the HIV care continuum – linkage to care.

The state is also requesting to impose copayments ranging from $5 to $20 on individuals with incomes at or above 21% of the federal poverty line ($225 per month for an individual). Research has shown that even relatively low levels of cost-sharing for low-income populations limit the use of necessary healthcare services.[12] Additionally, the state includes a copay for non-emergency use of the emergency department. Yet a study of enrollees in Oregon's Medicaid program demonstrated that implementation of a copay on emergency services resulted in decreased utilization of such services but did not result in cost savings because of subsequent use of more intensive and expensive services.[13] This provides further evidence that copays may lead to inappropriate delays in needed care. Requiring a copayment will undoubtedly lead to many individuals living with HIV to drop coverage, miss treatments, and thereby

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[9] Virgil Dickson, "Ohio Medicaid waiver could cost hospitals $2.5 billion", Modern Healthcare, April 22, 2016. (http://www.modernhealthcare.com/article/20160422/NEWS/160429965)

[10] https://www.ivantageindex.com/wp-content/uploads/2020/02/CCRH_Vulnerability-Research_FiNAL-02.14.20.pdf

[11] Ending the HIV Epidemic, Key Strategies. https://www.hiv.gov/federal-response/ending-the-hiv-epidemic/key-strategies

[12] Samantha Artiga, Petry Ubri, and Julia Zur, "The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings," Kaiser Family Foundation, June 2017. Available at: https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/.

[13] Wallace NT, McConnell KJ, et al. How Effective Are Copayments in Reducing Expenditures for Low-Income Adult Medicaid Beneficiaries? Experience from the Oregon Health Plan. Health Serv Res. 2008 April; 43(2): 515–530.

causing detrimental and irreversible disease progression. The AIDS Institute opposes the cost-sharing and premiums for the low-income population covered under this demonstration.

Evaluation

We are very concerned that this proposal does not include an interim evaluation of Arkansas Works, the state's previous demonstration waiver. Therefore, there is no evaluation data on the state's experience with premiums, limitations on retroactive coverage, and other key provisions included in the current waiver application. This is highly problematic because the state is asking for comment on extending its current demonstration, and evidence from an interim evaluation would help our organization to fully comment on the current request.

The AIDS Institute strongly recommends that Arkansas revise its waiver application as outlined to ensure that it meets the objectives of the Medicaid program. Thank you for the opportunity to provide comments.

Sincerely,

Stephanie Hengst,
Manager, Policy & Research
The AIDS Institute

Mental Health Council of Arkansas

Organizations

Birch Tree Communities
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(501)315-3344

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Centers for Youth and Families
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Counseling Associates.
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Counseling Clinic
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Delta Counseling Associates
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Mid-South Health Systems
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Ouachita Behavioral Health & Wellness
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Ozark Guidance
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South Arkansas Regional Health Center
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Southwest Arkansas Counseling & MHC
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Western Arkansas Counseling & Guidance Center
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July 12, 2021

ARHOME 1115 Demonstration Public Comments

Via email to ORP@dhs.arkansas.gov

To Whom It May Concern:

The Mental Health Council of Arkansas (MHCA) appreciates the opportunity to provide public comments related to the proposed ARHOME 1115 Demonstration Waiver. As behavioral health providers offering comprehensive mental health (MH) and substance use disorder (SUD) services, we believe our comments to have unique relevance on the basis of our experience and expertise working with Medicaid beneficiaries. Specifically, we have expertise to lend to the **"Rural Life 360 Home**" population addressed in the waiver.

Qualifications to Comment:

- Collectively, MHCA organizations have a physical service location in every county of Arkansas
- We also offer extensive capacity for telehealth access across the entire state
- Crisis services are available 24/7/365 within emergency departments, jails, schools, DCFS and the broader community
- Community Mental Health Center (CMHC) organizations are contractually obligated to serve as the state's designated *single point of entry* for involuntary commitments, as well as, fulfill the role of fiduciary for state funds used to ensure inpatient care to individuals who are indigent
- We employ hundreds of prescribers, licensed mental health professionals, Licensed Alcoholism and Drug Abuse Counselors (LADAC), Associate Alcoholism and Drug Abuse Counselor (LAADAC), qualified behavioral health professionals and peer specialists
- Annually, we serve tens of thousands of children and adults who have significant MH and SUD needs
- We are all mission-driven, non-profit organizations with a commitment to provide a full continuum of care to individuals with high risks and high needs
- We have strong relationships within the communities we've been servicing for more than 50 years

Public Comments:

- We appreciate the Institution for Mental Disease (IMD) Coverage and believe it will improve access for individuals with Substance Use Disorders that require residential care. We ask that funding for the SUD population include payment for the full continuum of SUD services (e.g. detoxification services, residential treatment and specialized women's services)
- Reduction of retroactive eligibility raises a concern about whether the retroactive eligibility provision (limiting the retroactive eligibility from 90 days to 30 days) would also apply to the SMI population who receive behavioral health services through Medicaid Spend Down coverage. If it were to be applied to the Spend Down population it would have an adverse effect on this population in accessing critical services

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- The reduced eligibility issue is especially problematic if this applies to Medicaid Spenddowns because DHS will not process a spenddown without 3 months of bank records starting from the first date of service for the requested period. This will be an access issue for providers of Therapeutic Communities for Tier 2 or Tier 3 Medicare recipients needing to rely on Medicaid eligibility via ARHOME rather than from traditional Medicaid
- At present, SAMHSA has granted seven (7) Certified Community Behavioral Health Clinic (CCBHC) grants to CMHCs in AR. We believe there are key roles for CMHCs and CCBHC grants that have been overlooked in the 1115 demonstration waiver as currently proposed
- The nine key areas for the CCBHC model of comprehensive care, which is also the Gold Standard for delivery of mental health and SUD care nationally, includes: 1.) Crisis MH services, including 24-hour mobile crisis teams, emergency crisis intervention services and crisis stabilization responding to crisis 24/7/365, 2.) Screening, assessment, and diagnosis, including risk assessment, 3.) Patient-centered treatment planning/crisis planning, 4.) Outpatient MH /SA services, 5.) Outpatient clinic primary care screening/monitoring of key health indicators and health risk given integrated BH and primary health care services, 6.) ACT teams, targeted case management, 7.) Psychiatric rehabilitative services, 8.) Peer support/counselor services/family support and 9.) Intensive Care coordination and focus on those community members and veterans located in rural areas
- Simply put, the CMHCs and CCBHC Expansion grants provide a foundation that Rural Access Hospitals do not and likely cannot
    - CMHCs already have capacity and capability to provide evidence-based practices for the priority population identified for **"Rural Life 360 Home**" including access in every rural county and established telehealth options including connectivity to many rural jails
    - CMHCs have a rich history of doing community-based work over the past 50 years
    - CCBHC is paving the way for behavioral health care to be integrated with primary care
    - CCBHC expansion grants also provide for mobile crisis services and assertive community treatment teams
- Although workforce is a concern for all behavioral health providers, CMHCs have a large cadre of licensed MH and SUD professionals with a passion for assisting the most seriously ill individuals
- CMHCs provide cost-effective treatment alternatives when compared to inpatient settings
- There seems to be a noteworthy absence of analytical data to support the proposed waiver plan to rely on rural hospitals to have appropriate experience or the willingness to develop necessary capacity to effectively provide the envisioned demonstration services
- We suggest the intensive care coordination be implemented by CMHCs

- Access to psychiatric inpatient care is a problem in Arkansas, yet the capacity of rural hospitals to fill this gap with quality care is unproven
- It is unlikely that rural hospitals would be able to provide facilities that meet safety standards required for psychiatric inpatient care without substantial physical modifications and added expense
- The proposed cost sharing (increased premiums & copays) is problematic. It is a deterrent to care for individuals and families with drastically limited discretionary income. Offering an incentive program is a positive component of the plan; as is the focus on removal of barriers to care, such as social determinants of health
- The cost-sharing expectation in the outpatient setting will likely prevent care seeking and erode access to care as providers will limit referrals
- In contrast, the proposed absence of a co-payment for an inpatient hospital stay will make this intensive and cost care more accessible
- Has a waiver of the current *independent assessment* requirement been considered? It is a barrier to access especially for individuals with serious and persistent mental illness
- Has administrative burden of the proposed plan been calculated? How will the targeted population be educated about the varying aspects and nuances of the plan? Without a clear understanding of the plan, eligibility for premium assistance, incentives and cost sharing, it is likely that individuals will forego needed care

The MHCA is committed to improving population health, reducing costs and ensuring access to quality care. We desire to be collaborative and innovative as evidenced by our efforts with CCBHC to be a central part of bringing viable solutions that are designed to produce independently evaluated results. We have a record of bringing improvements to Arkansas such as school-based MH services, drug and mental health courts, first episode psychosis programs, trauma-informed care, forensics and efforts with jail diversion. We hope are comments will be given serious consideration.

Sincerely,

Rusti Holwick, LPE-I LADAC AADC
President
Rusti.Holwick@wacgc.org

July 9, 2021

Cindy Gillespie, Secretary
Arkansas Department of Human Services
P.O. Box 1437, Slot S295,
Little Rock, AR 72203-1437

RE: Notice of Application for Proposed ARHOME Section 1115 Demonstration Project

Dear Secretary Gillespie:

Arkansas Advocates for Children and Families appreciates the opportunity to offer comments on the Arkansas Department of Human Services (DHS) notice of application for proposed "Arkansas Health and Opportunity for Me (ARHOME)" section 1115 demonstration project.

Arkansas Advocates for Children and Families (AACF) is a statewide, multi-issue non-profit, child and family policy research and advocacy organization. Our mission is to ensure that every child has the resources and opportunities they need to live healthy and productive lives and to realize their full potential.

Arkansas has been a national leader as an early adopter of Medicaid expansion under the Affordable Care Act to provide healthcare coverage to adults with no other source of coverage. Since 2014, thousands of families in Arkansas have gained access to otherwise unavailable healthcare coverage through Medicaid expansion. Once again, the state is choosing to continue these services for over 300,000 of our fellow Arkansans. While we support the state continuing to provide coverage to hundreds of thousands of Arkansans, we oppose the requests that will create barriers to care and put beneficiaries at risk, and we urge the state to remove these provisions from its proposal.

Premiums
Premiums create a barrier to coverage for individuals with low incomes. The proposal would continue imposing premiums on beneficiaries and requests to increase these premiums. The state acknowledges that premiums have the effect of deterring enrollment in the following statement from the proposal:

> "The only policy change that DHS anticipates may impact enrollment is the provision on premiums for individuals with income above 100% FPL who will apply for the program in the future. Premiums already apply to this population so any deterrent to enrollment is already occurring."

Findings from a Kaiser Family Foundation (KFF) review of the literature show abundant evidence that premiums result in more beneficiaries becoming uninsured, especially those with lower incomes, leading to greater unmet health needs.[1] Individuals not enrolling due to premiums does not mean that they somehow "value" insurance less; it likely means they cannot afford the premium.

Evidence from other states further highlights that premiums reduce enrollment and beneficiaries with low incomes struggle to make required payments. The Iowa Healthy Behaviors Interim Evaluation found that 52 percent of survey respondents (individuals who were disenrolled for failure to pay premiums) did not know that they owed a premium payment and 44 percent reported that they did not have enough money to pay.[2] Montana enrollees also struggled to pay monthly premiums; only 54 percent of enrollees subject to premiums with incomes above 100% FPL made their premium payments in June 2017.[3]

A recent working paper from the National Bureau of Economic Research on Michigan's Medicaid expansion showed healthier individuals were more likely to voluntarily disenroll from coverage due to premiums (those without chronic conditions and less medical spending), indicating that healthier beneficiaries were more sensitive to premium increases.[4] Given the body of research indicating the negative effects of premiums on coverage for beneficiaries with low-incomes, the state should not increase premiums nor should it continue imposing premiums on this population in general.

Copayments

Imposing copayments on individuals with incomes as low as 21% FPL will likely result in beneficiaries forgoing care. The KFF literature review on premiums and co-payments indicate even small copayments ($1-$5) decrease use of necessary care.[5] Indiana's evaluation of its "Healthy Indiana Plan" demonstration provides more evidence of copayments being a barrier to care. The evaluation showed that beneficiaries subject to copayments (parents and childless adults with incomes below 100% FPL) were less likely to use primary and preventative care services than individuals who were not subject to copayments -- the state

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[1] Samantha Artiga, Petry Ubri, and Julia Zur, "The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings," Kaiser Family Foundation, June 2017, https://files.kff.org/attachment/Issue-Brief-The-Effects-of-Premiums-and-Cost-Sharing-on-Low-Income-Populations.

[2] University of Iowa, "Healthy Behaviors Program Evaluation Interim Summative Report," April 2019, https://dhs.iowa.gov/sites/default/files/Healthy%20Behaviors%20Interim%20Evaluation.pdf?062620192054.

[3] The Urban Institute and Social & Scientific Systems, Inc., "Federal Evaluation: Montana Health and Economic Livelihood Partnership Plan," https://www.medicaid.gov/medicaid/downloads/mt-help-focus-group-site-visit-rpt.pdf.

[4] Betsy Q. Cliff, *et. al.*, "Adverse Selection in Medicaid: Evidence from Discontinuous Program Rules," National Bureau of Economic Research Working Paper Series, May 2021, https://www.nber.org/system/files/working_papers/w28762/w28762.pdf.

[5] Artiga, *et. al.*

expressed concern at the potential that copayments "are contributing to this difference."[6] Copayments also increase financial burdens on beneficiaries, especially those on the lower end of the income range.

The application says the providers will be allowed to deny beneficiaries for not paying copayments after the first occurrence of non-payment. This is not allowed under federal regulations for individuals under 100% FPL (42 CFR 447.52(e)(1)). And even if it were permitted under federal law, this practice should not be allowed as it would prevent beneficiaries from receiving necessary medical services.

Limit Retroactive Coverage

The proposed request to continue to limit retroactive coverage to 30 days puts beneficiaries and Arkansas providers at risk. Vulnerable Arkansans should be provided full 90-day retroactive coverage to reimburse for costs of medical services incurred for up to three months prior to applying for Medicaid coverage. Eliminating two months of retroactive coverage exposes beneficiaries to medical debt, increasing potential for financial harm.

Limiting retroactive coverage to 30 days leaves beneficiaries unprotected from medical bills that could be financially devastating. The state offers no exemptions from its waiver of retroactive coverage; this puts individuals with disabilities (who are not eligible for Medicaid under the aged, blind, or disabled group) or medically frail beneficiaries at the greatest financial risk as these groups tend to have higher medical costs.

Without retroactive coverage, costs of providing services in the two to three months prior to a beneficiary enrolling in coverage may become uncompensated care for providers. Thus, reducing the retroactive coverage period also hurts providers in Arkansas, especially hospitals. Rural hospitals often do not have the ability to absorb these uncompensated care costs and may be put at further risk of closing. AR Works also included a limit on retroactive coverage, but the state has failed to evaluate its impact. There is no need to test this further and as such, it should be removed from the proposal.

QHP Incentive Programs

The proposal would allow QHPs to offer beneficiaries incentives, such as waiving premiums, to participate in health or employment initiatives. The ARHOME demonstration proposal identifies two incentive programs QHPs may use: Health Improvement Initiatives and Economic Independence Initiatives. However, there is no description of what these incentives will be or how they will be monitored and evaluated to avoid adverse outcomes such as discrimination against beneficiaries who may be unable to participate in the incentive program. We are concerned that giving QHPs complete autonomy to develop incentive programs will result in cherry-picking healthier beneficiaries, especially given the proposed initiative to "hold QHPs accountable" by imposing sanctions on QHPs that fail to "improve the health" of their members.

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[6] The Lewin Group, "Healthy Indiana Plan Interim Evaluation Report: Final for CMS Review," December 2019, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/in-healthy-indiana-plan-support-20-pa8.pdf#page=92.

Access to Care

The ARHOME demonstration proposes for most Medicaid expansion beneficiaries to be covered by Qualified Health Plans (QHPs), while others will be covered by Medicaid fee-for-service (FFS). Accordingly, some providers will be reimbursed by QHPs and others will be reimbursed by the state through FFS. We urge you to consider the loss of meaningful access to care based on this operational structure of beneficiaries being covered by both QHPs and FFS. Additionally, as the share of AR HOME beneficiaries in FFS rises, there will be negative fiscal impacts on all providers due to the low FFS payment rates. This may cause even more access issues in FFS as providers decline to participate. AACF is extremely concerned about the following statements in the proposal implying a disparity between how those holding QHP insurance cards and those with Medicaid cards will be able to access care -- the impact will perhaps be even greater on those who are medically frail and have no option to participate in the QHPs:

- "Most importantly, ARHOME expects that enrollees gain an added value simply as a member of a private health insurance plan. They should experience a positive, normative effect from being a member with an insurance card rather than someone with a Medicaid card."

- "QHP members will have equal or better continuity and access to care including primary care provider (PCP) and specialty physician networks and services compared to Medicaid FFS beneficiaries."

- "QHP members will receive better quality of care compared to the baseline and will receive equal or better quality of care compared to Medicaid FFS beneficiaries."

- "Young QHP members will have equal or better access to required Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services compared to Medicaid FFS beneficiaries."

Federal Medicaid laws require equal access to care regardless of the delivery system. Therefore, given the statements in the proposal indicating that access to care is better in QHPs than in FFS, DHS has a responsibility to improve access in FFS. This could be done by increasing FFS provider payment rates, working to add more primary and specialty care providers to the FFS networks, and carefully monitoring access to ensure the measures taken are effective.

Suspension of Auto-Assignment in QHPs/Reassignment of "Inactive" QHP Beneficiaries

The proposal requests to cap enrollment in QHPs by suspending auto-assignment when a maximum monthly enrollment is reached. Individuals who do not select a QHP once the cap is reached would be enrolled in FFS. The proposal also describes a process by which yet-to-be-defined "inactive" QHP beneficiaries will be reassigned to FFS. Given the comments we raised above on access in FFS, we have concerns about these proposals. At a minimum, the state should ensure that capping QHP enrollment and reassignment will not have an adverse effect on access to care for beneficiaries. We request that you provide additional data on

this proposal including the race, ethnicity, language and gender of the beneficiaries that will most likely be impacted by this change and moved to FFS.

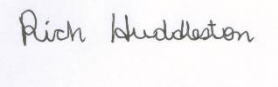
Community Bridge Organizations
The proposed demonstration describes three models to be used to serve targeted populations among the total ARHOME beneficiaries: the Rural Life360 Home, the Success Life360 Home, and the Maternal Life360 Home, all of which are to be administered by Community Bridge Organizations (CBOs). The proposal states that only certain communities will be served by CBOs. The Maternal Life360 HOME home-visiting component presents an opportunity for the expansion of much needed home-visiting programs to a vulnerable population.

While we support the state's efforts to address critical health issues in the state through these Life360 Homes, we have questions about how these programs would be implemented.

- *How will DHS decide which communities to fund CBOs in?*
- *Will a beneficiary who meets the criteria for all three Life360 Homes be served by all three at the same time? Or, will their participation be limited based on PMPM guidelines?*
- *How will hospitals create the infrastructure to support these programs?*
- *How will traditional PW coverage and the ARHOME models work together? Will pregnant women who are served by the Maternal Life360 Home have limits on retroactive coverage and be subject to premiums if their income is above 100% FPL?*
- *How will you ensure the hospitals and their local partners choose evidence-based home visiting programs, so that families get what they need, and Medicaid achieves the outcomes they are proposing in the waiver?*

Thank you for the opportunity to share our concerns with you as we look forward to engaging in further discussions about the AR HOME Medicaid Expansion Demonstration.

Sincerely,



Rich Huddleston, Executive Director
rhuddleston@aradvocates.org
501-343-3429

Loretta Alexander, Health Policy Director
lalexander@aradvocates.org
501-350-5086

From: Donna Morey
To: ORP
Subject: Public Comments on ARHome Medicaid expansion
Date: Thursday, July 1, 2021 1:41:51 PM

[EXTERNAL SENDER]

The ARkansas Retired Teachers Association support the expansion of ARHome. The cost and quality of care are much better if individuals can remain in their homes versus being confined to a nursing home. The patients, family members and friends all have a better quality of life being in familiar settings.

The State of ARkansas should develop skill training for individuals to become certified care givers. Again individuals in communities near where the patients reside would be a huge savings both for the State and provide good jobs for individuals in many rural areas. The State should develop and maintain an accessible list of individuals who have completed a license as a caregiver. This should be by county and local communities. There should be a standard rate of pay for these caregivers plus mileage expenses for traveling to the residences which maybe very remote.

We hope the federal government approves the changes but with the funds already approved a bulk of it should be to identify and train caregivers not to private company providers but at Community Colleges or Schools of nursing This is an opportunity for a win -win for Arkansans needing care and for local residents to be trained to provide that care while earning a living wage.

Respectfully,
Donna Morey
ARkansas Retired Teachers Association
1200 Commerce St. suite 103
Little Rock, AR. 72202
501-375-2958

Sent from my iPad

July 08, 2021

Elizabeth Pitman
Director
Division of Medical Services
Donaghey Plaza
P.O. Box 1437
Little Rock, AR 72203

Re: ARHOME Section 1115 Demonstration Application

Dear Ms. Pitman:

The National Organization for Rare Disorders (NORD) appreciates the opportunity to submit comments on the draft proposal for Arkansas's Section 1115 Demonstration Application. NORD is a unique federation of voluntary health organizations dedicated to helping the 25-30 million Americans living with a rare disease. We believe that all patients should have access to quality, accessible, and affordable health coverage that is best suited to their medical needs.

Many patients with rare disorders have complex and often costly health care needs and depend on access to quality and affordable health care. Medicaid coverage often serves as a lifeline to rare disease patients, who may find their lives upended by the debilitating nature of their diseases. According to the NORD's recent *30-Year Barriers to Access Survey*, 76% of rare disease patients report some or great financial burden and 62% of adults have had to miss work because of their rare disease.[i] For all patients with a rare condition, the Medicaid program provides assurance that if their disease increases in severity and they are unable to work, they will still be able to access necessary treatment. This aspect of the Medicaid program is especially vital during difficult economic times.

NORD is committed to ensuring that Arkansas's Medicaid program provides quality and affordable health care coverage and supports Arkansas's continued commitment to Medicaid expansion. Unfortunately, this draft proposal includes several provisions that do not meet Medicaid's objective to provide health care for low-income individuals. NORD opposes the provisions within this draft waiver to limit retroactive coverage and impose premiums and cost sharing onto Medicaid beneficiaries. Our detailed comments on the ARHOME waiver are as follows:

<u>Retroactive Eligibility</u>
This proposal would continue to limit retroactive coverage to 30 days for the demonstration population. There are no exemptions, including for medically frail individuals. It is common that individuals are unaware they are eligible for Medicaid until a medical event or diagnosis occurs. This is especially common in the rare disease community, as many rare disease patients face long

diagnostic journeys and are not diagnosed until later in life. Retroactive eligibility in Medicaid prevents gaps in coverage by typically covering individuals for up to 90 days prior to the month of application, assuming the individual is eligible for Medicaid coverage during that time frame. Therefore, retroactive eligibility allows patients who have been diagnosed with a serious illness, such as a rare disease, to begin treatment without being burdened by medical debt prior to their official eligibility determination.

Furthermore, Medicaid paperwork can be burdensome and often confusing. A Medicaid enrollee may not have understood or received a notice of Medicaid renewal and only discovered the coverage lapse when picking up a prescription or going to see their doctor. Without retroactive eligibility, Medicaid enrollees could then face substantial costs at their doctor's office or pharmacy.

Without retroactive eligibility in place health systems could end up providing more uncompensated care. For example, when Ohio considered a similar provision in 2016, a consulting firm advised the state that hospitals could accrue as much as $2.5 billion more in uncompensated care as a result of the waiver.[ii] Arkansas currently has 11 rural hospitals that are vulnerable to closure.[iii] Limiting retroactive coverage increases the financial hardships to rural hospitals that absorb uncompensated care costs. NORD opposes the limitations on retroactive coverage for the demonstration population.

Premiums and Cost-sharing

Arkansas proposes to increase premiums for individuals with incomes at or above 100% of the federal poverty line. Premiums will likely discourage eligible people from enrolling in the program. For example, when Oregon implemented a premium in its Medicaid program, with a maximum premium of $20 per month, almost half of enrollees lost coverage.[iv] A sudden interruption in care can be devastating for patients with rare diseases, who often depend on regular visits with providers or must take daily medications to manage their conditions.

The state is also requesting to impose copayments ranging from $5 to $20 on individuals with incomes at or above 21% of the federal poverty line ($225 per month for an individual). Research has shown that even relatively low levels of cost-sharing for low-income populations limit the use of necessary health care services.[v] Additionally, the state includes a copay for non-emergency use of the emergency department. Yet a study of enrollees in Oregon's Medicaid program demonstrated that implementation of a copay on emergency services resulted in decreased utilization of such services but did not result in cost savings because of subsequent use of more intensive and expensive services.[vi] This provides further evidence that copays may lead to inappropriate delays in needed care. NORD opposes cost-sharing and premiums for the low-income population covered under this demonstration.

Evaluation

NORD is concerned that this proposal does not include an interim evaluation of Arkansas Works, the state's previous demonstration waiver. Therefore, there is no evaluation data on the

state's experience with premiums, limitations on retroactive coverage, and other key provisions included in the current waiver application. This is highly problematic because the state is asking for comment on extending its current demonstration, and evidence from an interim evaluation would help our organization to fully comment on the current request.

Conclusion

Affordable health care coverage is critical to ensuring that rare diseases patients, and others with serious and chronic conditions, can access needed health care services. Unfortunately, this 1115 waiver proposal would place damaging administrative and financial barriers on health coverage by limiting retroactive coverage and imposing premiums and cost-sharing onto beneficiaries. Therefore, NORD strongly recommends that Arkansas revise its waiver application as outlined to ensure that it meets the objectives of the Medicaid program.

Thank you again for the opportunity to submit comments. For questions regarding NORD or the above comments please contact Corinne Alberts at calberts@raredisease.org.

Sincerely,

Alyss Patel

Alyss Patel
State Policy Manager, Western Region
National Organization for Rare Disorders

[i] National Organization for Rare Disorders. "30-Year Barriers to Access Survey" https://rarediseases.org/wp-content/uploads/2020/11/NRD-2088-Barriers-30-Yr-Survey-Report_FNL-2.pdf

[ii] Virgil Dickson, "Ohio Medicaid waiver could cost hospitals $2.5 billion", Modern Healthcare, April 22, 2016. (http://www.modernhealthcare.com/article/20160422/NEWS/160429965)

[iii] The Chartis Center for Rural Health. The Rural Health Safety Net Under Pressure: Rural Hospital Vulnerability. February 2020. https://www.ivantageindex.com/wp-content/uploads/2020/02/CCRH_Vulnerability-Research_FiNAL-02.14.20.pdf

[iv] Samantha Artiga, Petry Ubri, and Julia Zur, "The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings," Kaiser Family Foundation, June 2017. Available at: https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/.

[v] Id.

[vi] Wallace NT, McConnell KJ, et al. How Effective Are Copayments in Reducing Expenditures for Low-Income Adult Medicaid Beneficiaries? Experience from the Oregon Health Plan. Health Serv Res. 2008 April; 43(2): 515–530.

From: Stephy Pi Has Things to Say
To: ORP
Subject: Fwd: Public Comment for ARHOME
Date: Tuesday, June 22, 2021 9:24:03 AM

[EXTERNAL SENDER]

(i apologize I sent that from my phone and it didn't have my signature attached.)

After the hearing yesterday the only thing I could think of that we may have issues with are the people, such as veterans, are the real "Get off My Lawn" sort of people. I know that I have a distrust of government entities myself and I can only imagine how a veteran feels. Even if you say you are "offering a service" that may say to someone "do this class or service or the court will make you." I suppose we can call this "service hesitancy." Thank you all for listening,

Stephanie Pifer
ABHPAC-Arkansas Behavioral Health Planning and Advisory Council
Vice-Chair
Active Member of:
SWE-Society of Women Engineers
CASAA-Consumer Advocates for Smoke-Free Alternatives
NORML-National Organisation for the Reform of Marijuana Laws
NAMI-National Alliance for Mental Illness

---------- Forwarded message ---------
From: **Stephy Pi Has Things to Say** <stephepifer@gmail.com>
Date: Tue, Jun 22, 2021 at 9:17 AM
Subject: Public Comment for ARHOME
To: <orp@dhs.arkansas.gov>, Paula Stone <Paula.Stone@dhs.arkansas.gov>, Bridget Atkins <Bridget.Atkins@dhs.arkansas.gov>, Steven Blackwood <srblackwood@gmail.com>

After the hearing yesterday the only thing I could think of that we may have issues with are the people, such as veterans, are the real "Get off My Lawn" sort of people. I know that I have a distrust of government entities myself and I can only imagine how a veteran feels. Even if you say you are "offering a service" that may say to someone "do this class or service or the court will make you." I suppose we can call this "service hesitancy." Thank you all for listening,

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July 12, 2021

Department of Human Services
Office of Rules Promulgation
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Little Rock, AR 72203

Sent via email to ORP@dhs.arkansas.gov

Re: Comments on Notice of Application for Proposed ARHOME Project

Legal Aid of Arkansas writes to offer comment on the ARHOME proposal issued on June 11, 2021.

Legal Aid serves thousands of low-income Arkansans every year and is intimately familiar with the pressures that poverty places on our clients' lives. With respect to Medicaid, Legal Aid has assisted thousands of clients over the years with various aspects of Arkansas's Medicaid programs. Legal Aid's accumulated experience and all available data show that the ARHOME proposal would likely harm our client communities by discouraging Medicaid enrollment and frustrating use of Medicaid services.

DHS seeks approval of the ARHOME proposal through Section 1115 of the Social Security Act. The ARHOME proposal—individual aspects and as a whole—runs counter to the Medicaid program's objective to "furnish medical assistance." Moreover, the proposal lacks any legitimate experimental purpose.

I. Premiums discourage Medicaid enrollment and access to medically necessary care.

Under the ARHOME proposal, Arkansas would continue to impose premiums on Medicaid Expansion enrollees above 100% of the federal poverty line and would increase the amount of the premiums. Extensive research proves that premiums and co-pays deter and reduce Medicaid enrollment and access to medically necessary health care among low-income individuals. Extant literature captures the essential impact of premiums:

- "[P]remiums in Medicaid and CHIP lead to a reduction in coverage among both children and adults. Numerous studies find that premiums increase disenrollment from Medicaid and CHIP among adults and children, shorten lengths of Medicaid and CHIP enrollment, and deter eligible adults and children

from enrolling in Medicaid and CHIP." Samantha Artiga, Petry Ubri, and Julia Zur, Kaiser Family Found., *The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings* (2017), https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populationsupdated-review-of-research-findings/.

- "…[T]hose who become uninsured following premium increases face increased barriers to accessing care, have greater unmet health needs, and face increased financial burdens." *Id.*

- "Increases in premiums were associated with increased disenrollment rates in 7 studies that permitted comparison." Brendan Saloner et al*., Medicaid and CHIP Premiums and Access to Care: A Systematic Review*, 137 Pediatrics e20152440 (2016), http://pediatrics.aappublications.org/content/137/3/e20152440

While the ARHOME proposal does not provide for termination of enrollees who do not pay the premium, the mere act of imposing or increasing premiums will likely lead to declining enrollment. First, it is not clear that people will understand that the inability to pay premiums will not cause termination. After all, DHS has not successfully communicated any nuanced Medicaid program requirements—such as work requirements—in the past. But, even if a beneficiary comes to understand that they will not be terminated from the coverage, the beneficiary knows that they will incur a debt. When people are struggling to make ends meet, they do not want to have bills they know they cannot pay. Thus, the prospect of additional debt alone is enough to discourage enrollment.

A recent study of Michigan Medicaid enrollees confirms this. Similar to the ARHOME proposal, Michigan imposed premiums on Medicaid Expansion enrollees with incomes over 100% of the federal poverty line. Enrollees could not be terminated from Medicaid due to non-payment. Nonetheless, the study found that "facing a premium increases disenrollment by 11.7 percentage points" and that, "[f]or every $1 increase in monthly premiums, we find an increase in disenrollment of 0.7 percentage points." Betsy Q. Cliff et al., *Adverse Selection in Medicaid: Evidence from Discontinuous Program Rules*, NBER Working Paper No. 28762, May 2021, https://www.nber.org/papers/w28762.

Moving to the legal framework, statutory provisions preventing Arkansas from charging these premiums are outside of 42 U.S.C. § 1396a and, thus, cannot be waived under Section 1115. *See* 42 U.S.C. §§ 1315(a)(1), 1396o, 1396o-1.

II. Imposing co-pays discourages use of Medicaid to obtain medically necessary care.

The ARHOME proposal would newly impose co-pays on any Medicaid Expansion beneficiary between 20% and 100% of the federal poverty line. As with premiums, co-pays limit access to medically necessary health care among low-income individuals. Research demonstrates that co-pays reduce access to a variety of services. As the Kaiser Family Foundation noted:

- "…[E]ven relatively small levels of cost sharing, in the range of $1 to $5, are associated with reduced use of care, including necessary services." "Reduced utilization of services" includes "vaccinations, prescription drugs, mental health visits, preventive and primary care, inpatient and outpatient care, and decreased adherence to medications." Samantha Artiga et al., Kaiser Family Found., *The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review*

of Research Findings (2017), https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populationsupdated-review-of-research-findings/.

A recent study evaluating the effect of co-pays on prescription drug usage in Medicare illustrates this dynamic starkly. There, the authors concluded that "small increases in cost cause patients to cut back on drugs with large benefits, ultimately causing their death." Perversely, the "most striking" effects of those cutbacks "are seen in patients with the greatest treatable health risks, in whom they are likely to be particularly destructive." Amitabh Chandra et al., *The Health Costs of Cost-Sharing*, NBER Working Paper 28439, February 2021, https://www.nber.org/papers/w28439. There is no reason to believe that the dynamic would be any different for Medicaid Expansion beneficiaries, who have lower median incomes than Medicare beneficiaries. *Compare* ARHOME Proposal page 43 (showing that the median income of Medicaid Expansion beneficiaries as of 12/31/19 was between 40 to 60% of FPL) *with* Gretchen Jacobson et al., Kaiser Family Foundation, *Income and Assets of Medicare Beneficiaries, 2016-2035* (April 2017), https://files.kff.org/attachment/Issue-Brief-Income-and-Assets-of-Medicare-Beneficiaries-2016-2035 (showing that the median income of Medicare beneficiaries in 2016 was $26,200 or 220% of the 2016 FPL).

Much like with premiums, the mere threat of debt will deter people from seeking necessary services. Additionally, the impact of co-pays can be even more direct: the ARHOME proposal expressly grants medical providers the ability to refuse to provide a service due to non-payment.

DHS's proposal design is confused, requiring a low-income beneficiary to have excess money on hand to pay for needed medical services that may affect their ability to earn money. In contrast, providing Medicaid with the fewest possible barriers to access and use can enable low-income Arkansans to get the care needed to be able to work and otherwise participate in family and community life.

III. The proposed cap on premiums and co-pays does not mitigate the impact of disenrollment and decreased access to care.

DHS proposes to limit the overall amount of co-pays and premiums to 5% of a beneficiary's income over a calendar quarter. Such cost caps miss the point. As the studies cited above show, *even minimal cost increases* lead to disenrollment and decreased access to care.

Again, the studies make intuitive sense. Medicaid beneficiaries have highly limited income with which to meet life's needs apart from health care: rent, food, transportation, childcare, schooling, and so forth. Requiring even a few dollars per month of additional health care costs places an unsupportable strain on already strapped budgets. It is not that Medicaid beneficiaries have excess discretionary income that they simply choose not to spend on health care. Rather, they do not have the extra money in the first place.

Cost caps do not change this dynamic and, thus, will not mitigate the harm caused to beneficiaries.

IV. Reduction of retroactive coverage improperly limits coverage.

DHS proposes to limit retroactive coverage to 30 days prior to the date of application. There is no justification for this reduction consistent with furnishing medical assistance. Knowledge of Medicaid can be sparse. Medicaid eligibility rules can be complex. Medical distress and other responsibilities, such as childcare, can limit an individual's ability to apply within the reduced timeframe. Yet, under DHS's proposal, not doing so could come with unlimited costs to the individual for which the Medicaid Act otherwise requires coverage.

One client's experience—a single father raising two young boys—shows the importance of retroactive eligibility. At first, his income from working was too much for Medicaid. He fell deathly ill, was in the hospital, had multiple surgeries, and was home sick after that. He had to stop working. He did not have readily available childcare. During that time, he incurred over $60,000 in medical bills. His loss of income meant that he qualified for Medicaid, but, because of the health problems and lack of knowledge, he didn't apply until a couple months later. Without retroactive coverage, he would have huge debts affecting him and his children for years.

V. The so-called "Economic Independence Initiative" does not furnish medical assistance.

DHS proposes a new iteration of work requirements under the guise of the so-called "Economic Independence Initiative," through which DHS would provide for reductions in premiums or co-pays for individuals who comply with unspecified requirements that vaguely purport to promote education and employment. The lack of specifics on the functioning of the Economic Independence Initiative impairs the public's ability to offer meaningful comment.

Whatever the specifics, Medicaid is a health care program, not a work program. Work requirements are inconsistent with Medicaid's objective of furnishing medical assistance. The state's implementation of work requirements for Medicaid in 2018 and 2019 showed them to cause massive coverage loss. Over 18,000 beneficiaries lost coverage in the only five months where terminations were possible. DHS's own statistics showed low rates of compliance with the onerous reporting system, particularly among those beneficiaries who were not automatically exempted. Indeed, Legal Aid assisted many individuals facing termination despite meeting the conditions imposed by the work requirements. Here, it is just as likely that beneficiaries will be unable to meet whatever requirements the Economic Independence Initiative imposes. As such, even if beneficiaries' coverage is not directly taken away, the Initiative will result in greater difficulty in obtaining medical assistance by forcing people to pay more through co-pays and premiums.

As repeatedly emphasized over several years, lack of work amongst Medicaid beneficiaries is not a problem rooted in fact. In 2019, 62% of Medicaid Expansion beneficiaries in Arkansas were already working. Those who were not working had an illness or disability, caretaking responsibilities, or attended school. Rachel Garfield et al., Kaiser Family Found., *Work Among Medicaid Adults*, Kaiser Family Foundation, Appendix 2 (Feb. 11, 2021), https://www.kff.org/report-section/work-among-medicaid-adults-implications-of-economic-downturn-and-work-requirements-appendix-2/

Moreover, that unlawful policy did not achieve what it claimed to. Research based on the Arkansas work requirements has shown that work requirements "did not increase employment over eighteen months of follow-up." Benjamin Sommers et al., *Medicaid Work Requirements in Arkansas: Two-Year Impacts on Coverage, Employment, and Affordability of Care*, Health Affairs Vol. 39, No. 9, https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.00538. Rather, the work requirements resulted in many beneficiaries losing their health care coverage. These people demonstrated increased medical debt, delayed care, and delayed medications. *Id.* Of course, Medicaid helps people get the health care needed to be able to work. A policy like work requirements that results in decreased or delayed care would worsen people's health and make them less able to work.

In sum, any so-called Economic Independence Initiative will not further Medicaid's objective of furnishing medical assistance. Rather, the agency is hiking costs on nearly all beneficiaries and then forcing them to jump through an administrative hoop already proven to be a policy failure so that the new costs may be

slightly reduced. The end result, though, is still higher costs on beneficiaries, which, as shown above in Items I through III, will decrease enrollment and access to care.

VI. The "inactive" status and related change in coverage disrupts beneficiaries' care.

DHS proposes to move Medicaid Expansion beneficiaries to an "inactive status" based on undefined events. This change in status would result in removal from a QHP and placement in the state's fee-for-service (FFS) Medicaid program. The lack of specifics on the functioning of this "inactive status" designation impairs the public's ability to offer meaningful comment.

Movement from a QHP to FFS has caused massive disruptions in care to dozens of Legal Aid's clients. We saw this when Medicaid Expansion beneficiaries enrolled in QHPs were newly designated Medically Frail. Suddenly, people lost access to doctors and medications covered by the QHP that were not covered by FFS. With regards to doctors, some clients had to forego long-scheduled surgeries because the surgeon was part of a QHP network but not a FFS provider. With regard to medications, the FFS system not only covers different prescription drugs for given conditions than a QHP, but also covers fewer prescriptions (limited to a total of six per month). The loss of access to prescribed medications was particularly grievous for people with several chronic conditions requiring detailed medication management. Despite the threat of disruption, DHS's supposed guardrails for such transitions—advanced notice and the ability to opt out of Medically Frails status—did not exist in practice. Individuals could not resolve the issue without Legal Aid's assistance.

In light of the care disruptions caused by shifting a beneficiary from a QHP to FFS, expanding the situations in which such transfers may occur does not further Medicaid's objective of furnishing medical assistance. Rather, the proposal just adds administrative complexity.

VII. Limiting auto-enrollment increases administrative complexity for beneficiaries.

As described just above, movement between FFS and QHP usually involves disruptive changes to beneficiary care. Limiting auto-enrollment means a beneficiary's transition to QHP coverage will be delayed indefinitely. This adds administrative complexity to the program. A new beneficiary may qualify for Medicaid Expansion, not enroll in a QHP, start receiving care and prescriptions through FFS, later move to a QHP, and then find that doctors or prescriptions covered under FFS are not covered through the QHP.

Enrollment in a QHP is not an easy or intuitive process. A beneficiary first must understand what enrollment means and then use an online portal to enroll. Of course, inadequate access to the internet and having inadequate skills or knowledge to use the internet are barriers to enrollment. To the extent someone can enroll by phone, calling DHS or its related vendors (such as the Arkansas Foundation for Medical Care) often requires extensive hold times to address a substantive issue.[1] DHS's own proposal acknowledges the difficulty of enrolling in a QHP, stating on page 38 (or page 46 of the PDF), "Under the current Demonstration, 80% of individuals do not make an active choice of their QHPs and are instead auto-assigned."

[1] Although AFMC may have a staff member answer the phone within a reasonable timeframe, that initial staff member cannot help with the substantive issue the beneficiary is calling about. Rather, the initial staff member merely transfers the caller to someone else for substantive assistance. In Legal Aid's experience helping beneficiaries with AFMC-related matters, the hold times for that transfer routinely run between 30 and 60 minutes.

Auto-assignment without limitations provides the most continuity to beneficiaries by enrolling them in a QHP—through which they will receive all ongoing care—as soon as possible.

VIII. Forcing Medicaid Expansion beneficiaries into PASSEs does not further Medicaid's objectives.

The ARHOME proposal seeks to force Medicaid Expansion beneficiaries with mental health conditions into the Provider-led Arkansas Shared Savings Entities (PASSEs). This is problematic for several reasons.

First, there are a host of problems around the Optum-based assessment used to determine entry into the PASSEs and the related determinations for people already subject to it. The assessment is not validated. The assessment has been administered in inappropriate ways for people with mental health conditions already subject to it over the last several years. Mental health providers and clients reported that assessments were often conducted quickly with vague explanations for their purpose in settings and circumstances that did not foster rapport with the person being interviewed. And, the results were not reliable, as many people with chronic mental health conditions were determined to be insufficiently severe to warrant a continuation of services, causing massive disruptions in their care. In one case, such a disruption directly caused the psychiatric hospitalization of one of Legal Aid's clients whose life had previously been stable.

Second, the PASSE networks do match existing Medicaid Expansion networks. As a result, placement in a PASSE for mental health conditions also means an upheaval in an individual's treatment for everything else. As described above in Section VI, changes in a person's covered providers and medications brings great disruptions and instability. For people who have serious mental health conditions, such a disruption could be even more difficult to navigate. Moreover, some beneficiaries report having appointments in distant locales or having to wait for months, signs that the PASSE networks are not adequate. Again, such problems may be even more difficult for and disruptive to people with severe mental illness.

Third, this is unnecessary. PASSEs do not offer any specialized services to people with severe mental health conditions that cannot also be offered through the existing Medicaid Expansions framework. It would be both less disruptive to beneficiaries and less administratively complex to do so.

IX. The proffered justification for the proposal does not serve an experimental purpose.

Of course, Section 1115 requires "an experimental, pilot, or demonstration project" that "is likely to assist in promoting the objectives" of Medicaid. The discussion above shows that DHS's proposal is unlikely to assist in promoting Medicaid's objective of furnishing medical assistance because it imposes additional costs and administrative complexity on beneficiaries that will lead to decreased enrollment and use of medically necessary services.

At the same, DHS's proposal also falls short of the requirements for an experimental purpose. DHS does not establish that evaluating whether Medicaid beneficiaries "view Medicaid as health insurance" connects in any way to the furnishing of medical assistance. Moreover, to the extent there is or ever has been any legitimate experimental purpose, the state has already been charging beneficiaries premiums and co-pays for several years. Whatever insights were to be gained should already have been gained. Expanding co-pays to a poorer segment of the Medicaid Expansion population and raising premiums on the segment already owing them does not further any legitimate experimental purpose.

Sincerely,

Lee Richardson, Executive Director
Kevin De Liban, Director of Advocacy
Legal Aid of Arkansas
310 Mid-Continent Plaza, Suite 420
West Memphis, AR 72301

ARKANSAS HOSPITAL ASSOCIATION

July 12, 2021

Ms. Cindy Gillespie
Secretary
Arkansas Department of Human Services
PO Box 1437, S-295
Little Rock, AR 72203-1437

Ms. Elizabeth Pitman
Director
Arkansas Medicaid
PO Box 1437, S-295
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Submitted electronically to ORP@dhs.arkansas.gov

RE: **Arkansas's Medicaid Expansion (ARHOME), Section 1115 Waiver Application**

Dear Secretary Gillespie:

The Arkansas Hospital Association (AHA) is a membership organization that proudly represents more than one hundred health care facilities and their more than 50,000 employees as they strive to care for all Arkansans. The Association works to support, safeguard, and assist our members in providing safe, high-quality, patient-centered care in a rapidly evolving – and highly regulated – health care environment. The AHA sincerely appreciates the opportunity to comment on the section 1115 demonstration waiver application for Medicaid Expansion – called Arkansas Health and Opportunity for Me (ARHOME) – as proposed by the Arkansas Department of Human Services under the requirements of 42 CFR part 431 subpart G and the application procedures under 42 CFR 431.412(a).

Further, the AHA applauds the outstanding efforts of Governor Asa Hutchinson, your leadership team at the Department of Human Services, the 93rd General Assembly of the Arkansas Legislature, and the long list of stakeholders who worked collaboratively to ensure that Arkansans under 138 percent of the federal poverty level remain eligible to access Arkansas's health care system.

Access to Care

Since Arkansas's 2013 implementation of the Arkansas Health Care Independence Program, known as the Arkansas Private Option, Arkansas has provided premium assistance to support the purchase of coverage from Qualified Health Plans (QHPs) offered in the individual market through the Marketplace by beneficiaries eligible under the expanded adult group described at Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act, which were both (1) childless adults ages 19 through 64 with incomes at or below 138 percent of the federal poverty level (FPL) or (2) parents and other caretakers between the ages of 19 through 64 with incomes between 17 percent and 138 percent of the FPL. The Arkansas Private Option and each subsequent iteration of the program met or exceeded the objectives in Title XIX of promoting continuity of coverage for individuals, improving access to providers, enhancing the continuum of coverage, and furthering quality improvement and delivery system reform initiatives.

Specifically, a Kaiser Family Foundation study found that Arkansas's uninsured rate among non-elderly adults dropped from 27.5 percent to 15.6 percent between 2013 and 2014, which correlated to a 55 percent drop in uncompensated care in Arkansas's hospitals and expanded access to care in community-based settings and specialty care for beneficiaries.[1]

Because of the premium assistance model, Arkansas's adult Medicaid Expansion population has not fallen prey to the practices of Medicaid Managed Care companies that limit a patient's access to care by rationing patient services or limiting network providers either through reimbursement rates that do not cover the cost of care or that increase the cost of care delivery due to inefficient administrative processes. Likewise, the premium assistance model has proven much more favorable to providers than traditional Medicaid rates, as Arkansas Medicaid hospital *per diem* inpatient rates have remained stagnant for more than 20 years and hospital fee-for-service outpatient rates were last cut in 1992 and never restored.

Therefore, the AHA enthusiastically supports ARHOME's proposal for the continuation of Qualified Health Plan coverage for Arkansas's Expanded adult population under the premium assistance model.

Onboarding and Ensuring Coverage

Medicaid eligibility is determined by the Department of Human Services in accordance with federal and state laws and regulations. The eligibility determination for Medicaid must remain a distinct process from qualified health plan enrollment or PASSE managed care plan enrollment. Currently, upon being determined Medicaid eligible under the new adult group, all beneficiaries begin their coverage in Medicaid fee for service.

Because the Medicaid eligibility determination is the sole responsibility of DHS, AHA requests that DHS implement the federal requirement for presumptive eligibility detailed in 42 CFR 435.1110. As an alternative, the AHA respectfully requests that DHS reinstitute 90-day retroactive eligibility, which was originally in place as a waiver from presumptive eligibility in the 2013 demonstration waiver. The current demonstration limits retroactive coverage to 30 days prior to the date of application.

[1] https://www.kff.org/medicaid/issue-brief/a-look-at-the-private-option-in-arkansas/

Requiring implementation of presumptive eligibility or reinstating 90-day retroactive coverage will more aptly enhance hospital discharge coordination options for patient care planning, which can 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.

Streamlining Enrollment and the Member Experience

Once DHS determines a new adult group applicant eligible for Medicaid, individuals who identify themselves as "medically frail" or are subsequently identified as medically frail remain in fee-for-service for their coverage, but individuals who are not medically frail are covered by fee-for-service for a temporary period of time before enrollment into a qualified health plan.

The ARHOME waiver application further seeks to administratively move beneficiaries among fee-for-service Medicaid (even if not determined medically frail), qualified health plans, and the Provider-Led Arkansas Shared Savings Entity (PASSE) managed care plans. While the AHA applauds the Department of Human Services for seeking stakeholder input prior to implementation of this reassignment and assures that this reassignment process will not occur prior to 2023 and not without approval sought through the state rule-making process, continuity of care is at significant risk.

We are concerned that the proposed cost-sharing increases could cause individuals to drop Medicaid coverage, and we disagree with the premise that premiums are necessary to "assess whether individuals value coverage as insurance." Medicaid's primary purpose is to provide access to health care services for low-income individuals, and it is unlikely that reductions in participation due to increased cost-sharing reflect individuals devaluing coverage, rather than the necessity of making painful economic choices among competing priorities. The AHA does appreciate that there is no proposed cost-sharing for inpatient hospital stays, which could have caused adverse effects such as avoidance of addressing serious medical issues.

Similarly, AHA is concerned about the intention to proactively evaluate the general expansion population for reassignment to the PASSE managed care model. Enrollment into a PASSE is subject to an assessment developed by the state of Minnesota, which has not been scientifically established as valid or reliable.[2] While DHS reports having experienced relatively few appeals, that is not sufficient to show that the assessment is valid or appropriate to use with the population that it is currently being used with, let alone a larger population of Medicaid expansion participants more generally. Further, the draft application does not include information on the specific criteria that would be used to remove participants from QHP coverage and reassign them to a PASSE. We have significant concerns that DHS's plans to reassign individuals to PASSE managed care plans could affect many more individuals than they project, leading to problems with continuity of care and negative impact on patients. We request that reassignment to the PASSE model require meeting higher acuity "Tier 2 or 3"-type criteria measured with an instrument that has been scientifically validated and whose scientific reliability has been established, and that these PASSE eligibility criteria be explicitly specified in the application.

[2] https://www.startribune.com/disparities-dog-system-to-distribute-disability-services/563636552/

The application is also silent on the periodicity of coverage for beneficiaries. In keeping with the goal of acclimating individuals with insurance, once a beneficiary is assigned into a qualified health plan, a beneficiary should remain in that plan for a full 12 months to ensure continuity of care and proper evaluation of the plan's quality improvement performance. In addition, an efficient and beneficiary-friendly appeals process must be created to allow a beneficiary who was reassigned into a plan to select the coverage best suited to that beneficiary.

Safeguards to Ensure Continuity of Care

The demonstration waiver application states that churn describes movement of individuals on and off the Medicaid program within a single year and over multiple years. Since March 11, 2020, when the national public health emergency was declared, the churn in the Medicaid program has been minimal, in accordance with federal laws and regulations. Prior to that time, however, beneficiaries were highly susceptible to losing coverage in a number of ways unrelated to their eligibility for Medicaid, such as disenrollment due to returned mail – sometimes due to participants not notifying the state of a move and other times due to problems with the State's records despite a participant reporting a change of address.[3] The State's previous experience with work requirements also highlighted the unexpected difficulties that administrative barriers, such as various required reporting, can pose to Medicaid participants, causing many to lose coverage despite continued eligibility.[4]

While a number of required member notices are referenced in the demonstration waiver application, we strongly urge DHS to handle these notices carefully to minimize the risk of participants being inappropriately reassigned to fee-for-service or disenrolled despite continued eligibility. Specifically, we ask that DHS allow multiple potential pathways (e.g., in person, by telephone, by accessible 24/7 online option, and by mail) to communicate with beneficiaries and to receive back any needed responses; adopt a reasonable compatibility threshold for inconsistencies between self-attested income and external data sources; accept a reasonable explanation for any inconsistencies rather than requiring paper documentation; proactively identify changes of address using external data sources (e.g., U.S. Postal Service's National Change of Address system, QHP enrollee records, SNAP/TANF enrollment records, and records from other state agencies); follow up on returned mail and attempt other contact before disenrollment; and allow participants to have at least 30 days to respond to notices or requests for information, consistent with federal rules. These reasonable measures will help ensure that participants do not wrongly lose essential health coverage. In addition, notices and communications from qualified health plans and PASSE managed care plans should meet and exceed the standards of traditional Medicaid communications.

While outside the scope of comments on this proposed rule, we urge DHS to also use these strategies, as well as *ex parte* renewals that take advantage of all useful data sources to automate renewals, consistent with 42 CFR § 435.916, to avoid administrative disenrollments during the mass redeterminations following the end of the federal Public Health Emergency.

[3] https://files.kff.org/attachment/Issue-Brief-Recent-Medicaid-CHIP-Enrollment-Declines-and-Barriers-to-Maintaining-Coverage

[4] https://www.healthaffairs.org/do/10.1377/hblog20180904.979085/full/

Improving Social Determinants of Health

Arkansas hospitals are not only the backbone of the Arkansas health care system through the delivery of emergency services, inpatient care, and outpatient care, hospitals are also already key components to the health of the communities where they serve. Hospitals fully recognize the importance of social, environmental, and behavioral factors as well as genetic and health care factors that impact a person's health. Arkansas also recognizes that CMS has not typically allowed non-medical services to be reimbursed through Medicaid; therefore, the AHA applauds DHS for seeking funding for hospitals that volunteer to serve as entities – what the waiver defines as Community Bridge Organizations or Life360 Homes – to identify and connect beneficiaries to social services, including integrating these services into their care delivery models, encouraging partnerships with community-based organizations, tracking social needs, and incentivizing a more holistic approach.

The timeline for the implementation of the Life360 HOMEs, coupled with the opaqueness of the ARHOME program development, lack of transparent quality metrics, unknown potential reimbursement, unknown delineated or collaborative responsibilities of the Life360 Home versus the qualified health plan, PASSE managed care plan, etc., makes the proposal lofty and, in the middle of hospitals' continued response to record numbers of very sick patients throughout the pandemic, premature.

The AHA and its members stand ready to work diligently with stakeholders to flesh out Success Life360Homes, Maternity Life360 HOMEs, and Rural Life360 HOMEs as introduced in the waiver application. It will be imperative that start up costs and ongoing payments be satisfactory to not only promote the development of resources, but also to build the critical infrastructure in Arkansas communities to serve patients and communities. Taking on a responsibility of this size without careful planning and stakeholder involvement – especially without soliciting potential beneficiary input – would be daunting under the best circumstances. The planning and implementation timeline must be created in a realistic manner that seeks stakeholder experience and expertise and prioritizes potential beneficiaries' input. We urge DHS not to set implementation dates that are premature and look forward to learning more about specific expected activities and the provision of adequate funding and support.

Evaluation of Life360 HOMEs

We appreciate DHS considering many possible distal outcomes that may be addressable with the Life360 HOMEmodel but are concerned about both the attributability of some the SDOH-related Domain 2 measures and the overall methodological approach. Without specific expected Life360 HOMEactivities, it is difficult to assess to what extent changes those measures, such as change in employment and criminal justice system involvement, could be attributable to the actions of the health care system, leading to concerns about the possibility of spurious findings. Methodologically, there are some issues with comparability between study groups. The most problematic are measures 2A, 2B, and 2C, which propose a pre-post comparison of changes in income with no comparison group. Without a comparison and especially since income generally increases with age – and therefore, many participants will show improvement in these measures regardless of any

programmatic effect – these measures are not useful.[5] For the other Domain 2 measures, difference-in-difference study design alone may not be sufficient to account for differences in the underlying characteristics of the nonrandomly assigned groups, since it will not account for unobserved or time-variant confounders.

The Arkansas Hospital Association and its members are offering these comments in a spirit of collaboration with the goal of successful and timely implementation of these new regulations by DHS, and we stand ready to work with the Department and other stakeholders to address the issues raised in our letter and to ensure the program's overall success for Arkansas's hospitals and, most importantly, the patients and families that our hospitals are so honored to serve.

Sincerely,

Bo Ryall
President & CEO, Arkansas Hospital Association

[5] https://www.bls.gov/news.release/wkyeng.t03.htm

Arkansas Community Organizations
Arkansas Community Institute

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July 11, 2021

Ms. Elizabeth Pitman
Director
Division of Medical Services
Arkansas Department of Human Services
P.O. Box 1437, Slot S295
Little Rock, AR 72203-1437

Re: Application for Proposed ARHOME 1115 Demonstration Project

Dear Ms. Pitman:

Arkansas Community Organizations (ACO) and the Arkansas Community Institute (ACI) are two non-profit membership organizations of low-income Arkansans working for policies that improve the health of our communities through greater access to health care and through addressing social determinants of health such as unhealthy housing, harmful judicial policies and racial discrimination. Our organizations supported the Affordable Care Act (ACA) as a step forward in our work to win universal access to affordable, quality health coverage. During the first enrollment period some of our staff worked as navigators to help people enroll in health insurance through the Marketplace. We opposed the 2018 work requirements and assisted national press outlets in finding people harmed by this policy. We are strongly encouraging our members and communities to receive any of the COVID 19 vaccinations available.

We are writing to express our opposition to several provisions of the ARHOME 1115 demonstration project. The project proposes to increase the cost of health coverage and reduce retroactive coverage at a time when the number of COVID 19 cases, hospitalizations and deaths are on the rise and Arkansas state government has a budget surplus of nearly $1 billion. The rise in the Arkansas Works Qualified Health Plan (QHP) enrollment as a result of the pandemic should be something we welcome instead of a reason for capping the number of QHPs. The enrollment increase gives us the assurance that people who lost their jobs and hours of employment have the coverage they need during the pandemic at little or no cost to them.

ACO and ACI oppose the cut in retroactive eligibility from three months to one month. Although Arkansas's Medicaid expansion program has been in existence since 2013, there are still people who do not know about the program in part because the Arkansas legislature cut the health care navigator program and efforts to promote the program by state government. Our organization has been surveying people who have Medicai
d on their experiences with applying and renewing the program. In one rural county we have encountered people who were not aware that they could get health coverage through the program.

The three month retroactive period is especially helpful for new enrollees who have chronic conditions. One of the people we enrolled in the " private option" (as it was known during the first enrollment period) had tumors in her stomach and accumulated several medical bills from previous doctor's visits. The three months of retroactive coverage helped reduce her medical debt while getting the medical care she needed.

Medical debt is problem in Arkansas especially for communities of color as indicated by the Urban Institute's interactive debt map and our own study of household debt in Arkansas here. The three months retroactive eligibility could be very helpful in preventing an increase in the debt burdens experienced by many low-income households.

ACO and ACI oppose the increases in cost sharing and premiums in the ARHOME waiver proposal. Households at 138% of the federal poverty or below are low-income and well below the state median household income of $47,597. The goal of Medicaid is to provide health coverage to people who could not otherwise afford it.

Under the proposed waiver the insurance company would have the responsibility of collecting the increased premium. A person with an income of $13,000 per year is likely struggling to pay rent, utilities and other household costs. The increased premium would be burdensome for a person that already has difficulties paying for necessities such as food, clothing, heating in the winter and shelter. If someone does not pay one or more of the premiums, what actions would the insurance company take to collect it? Would the provider send the unpaid balance to a debt collection company which would likely cause the cost of the unpaid premiums to increase? We oppose charging any premiums for Medicaid funded health insurance for people with incomes between 100% and 138% of the poverty line.

We also oppose the cost sharing or co-pays in the proposed ARHOME waiver and especially the drop to 20% of the federal poverty line that would trigger the co-pays. The proposal would leave it up to the health care provider to collect the co-pay and allow the provider to deny future care due to non-payment. In our opinion it is wrong to impose cost sharing for needed health care and medicine on people who have very little income. Even if a provider continues to see patients if they cannot make the co-pay, the potential for significant medical debt exists.

We are opposed to the proposed ARHOME 1115 Demonstration Project and urge the Centers for Medicare and Medicaid Services to reject it..

Sincerely,

Neil Sealy

Neil Sealy on behalf of the Arkansas Community Organizations and Arkansas Community Institute
2101 S. Main Street
Little Rock, AR 72206
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From: Anna Strong
To: ORP
Cc: Susan Averitt; Gary Wheeler
Subject: Comments on ARHOME waiver from ARAAP
Date: Monday, July 12, 2021 4:57:50 PM
Attachments: Arkansas Chapter OCA Logo Small.png

[EXTERNAL SENDER]

Dear Ms. Pitman,

The Arkansas Chapter of the American Academy of Pediatrics (ARAAP) is the state's membership organization for pediatricians, representing more than 440 members across Arkansas. On behalf of our members, ARAAP wishes to submit comments on the state's Proposed ARHOME Section 1115 Demonstration Project waiver. Our detailed comments will focus on the Maternal Life360 HOMEs' home visiting services, access to care, and the economic independence provisions of the waiver application. Our comments are rooted in our mission, "to attain optimal physical, mental, and social health and well-being for all children," by improving access to comprehensive health care and social supports that help children and their families thrive.

Broadly, we are supportive of the continuation of health care coverage for non-elderly adults, many of whom are parents or caregivers for the young patients our member pediatricians treat in their clinics and communities. When parents have coverage and access health care, their children do, too. We also generally support the innovative Life360 HOMEs that seek to address a variety of social determinants of health for Arkansas families, though questions remain about implementation details and the process for ensuring access to these across the state.

Maternal Life360 HOMEs. We strongly support this expansion of evidence-based home visiting by up to 5,000 slots to a targeted group of families in Arkansas. Home visiting programs across Arkansas benefit from incredible infrastructure provided by a statewide home visiting network that provides training and technical assistance, evaluation, guidance, start-up support, and ongoing quality improvement work to community-based programs. With support from public and private funding streams, home visiting already reaches children in every county. Evidence-based models currently serve children prenatal to age five. ARHOME's Maternal Life360 HOMEs should build upon and support that infrastructure as birthing hospitals establish programs for ARHOME recipients. The Arkansas Better Chance home visiting programs and Maternal Infant Early Childhood Home Visiting (MIECHV) partnership show the success of this model. **Maternal Life360 HOMEs can launch more effectively with centralized, experienced infrastructure that is not described in the waiver.**

To achieve the stated impacts of lowering infant mortality rates, home visiting programs must be made widely accessible and successfully managed. **Using evidence-based programs, as required in Act 530 of 2021 language, is the best way to ensure outcomes and operations align with program goals.** HomVEE lists programs we recommend exploring here: https://homvee.acf.hhs.gov/HRSA-Models-Eligible-MIECHV-Grantees. One concern we have is that the Strong Start program mentioned in the waiver is not on HomVEE's evidence-based list, nor is it currently in operation in Arkansas. Programs such as Healthy Families America, SafeCare, or Nurse Family Partnership may provide a better fit locally. Maternal Life360 programs could provide services and also refer families to existing longer-term programs in

the state.

Lastly, enrollment must be nimble to meet the needs of the target population. While it is optimal to enroll women in home visiting during pregnancy, **families should be allowed to enroll in Maternal Life360 HOMEs through the end of a child's first year of life**, at minimum, to have maximum benefit on infant mortality and maternal mortality. Health and social factors that impact health outcomes may not arise until after a child is born. Additionally, pediatricians and other primary care providers may recognize "high risk" factors such as maternal depression, unsafe sleep environments, or parental drug use during well-child visits during a child's first year of life. Having the ability to refer families with infants to Maternal Life360 HOMEs from primary care is essential. Some of the most vulnerable pregnant women may not be enrolled in a Qualified Health Plan (QHP) but instead be enrolled in traditional/pregnancy Medicaid or the new PASSE options outlined in the waiver. Allowing women across all expansion coverage options or Pregnancy Medicaid to access the Maternal Life360 HOMEs would broaden the programs' reach and help achieve health outcome goals outlined in the waiver. It would also simplify eligibility from a consumer perspective.

Access to Care. More than half of children in Arkansas and many individuals with disabilities depend on Medicaid fee-for-service (FFS) coverage to ensure equitable their access to health care. This demonstration seeks to show that individuals with access to private QHP plans have equal or better access to care than individuals with Medicaid FFS access. We respectfully **request that the results of this evaluation be used broadly to ensure that Medicaid FFS rates provide equitable access to health care for all populations served by Arkansas Medicaid**, including pregnant women's Medicaid and ARKids First A and ARKids First B, as enrollees in these categories have no private option for coverage. We also support continued transparency about efforts to ensure that 19- and 20-year-olds are made aware of and have access to full EPSDT benefits in addition to the more limited QHP benefit packages.

Economic Independence Opportunities. We support efforts to help families move toward economic independence. However, the **premium increases and additional copayments outlined in the waiver will diminish access to care for individuals near or below the poverty line, many of whom are families with children.** Research demonstrates that premiums serve as a barrier to obtaining and maintaining Medicaid for those with low incomes. Premiums result in increases in disenrollment, shorter lengths of enrollment, and serve as a deterrent to those eligible from enrolling. A 2015 report shows that "families living in poverty, and particularly in deep poverty, have few resources available after they pay for the most basic necessities, even before other critical expenditures such as health care, childcare, and transportation are taken into account." It concludes that low-income individuals are particularly sensitive to modest or nominal increases in medical out-of-pocket costs, including premiums. This provision of charging premiums for low-income individuals, which has been shown to be a barrier to care, runs counter to the overall theme of this proposal, which is to help people who are living in poverty.

Thank you for the opportunity to submit comments. Arkansas pediatricians look forward to collaborating with Arkansas Medicaid and partners during the rule-development process and implementation of ARHOME.

Anna Strong, MPH, MPS
Executive Director
Arkansas Chapter, American Academy of Pediatrics

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July 9, 2021

Arkansas Children's Response to Request for Public Comment for
Arkansas Health and Opportunity for Me (ARHOME Program)

To: DHS Office of Rule Promulgation
ORP@dhs.arkansas.gov

Arkansas Children's is encouraged by the continuation of coverage for low-income adults through the proposed ARHOME program. Health care coverage for adults positively impacts children's health. Over the years, Arkansas Children's has consistently supported coverage expansion, and the proposed ARHOME program particularly resonates with our organization due to the emphasis on improving maternal and infant health by increasing evidence-based home visiting through Maternal Life 360 HOMEs. Quality home visiting services reduce costly problems, including low-weight births, emergency room visits, and children in the social welfare, mental health, and juvenile justice corrections systems. Home visiting yields powerful short and long-term effects for the families who participate.

As a longtime supporter and contributor to home visiting, Arkansas Children's houses the Arkansas Home Visiting Network (AHVN). The AHVN is a collaborative effort with state agencies, private donors, federal funders, and local implementing agencies to develop, expand, evaluate, and provide leadership to home visiting services throughout our state.

The AHVN facilitates activities among its members to raise public awareness, expand and sustain home visiting services, provide supplemental training, collect and share data, and to share relevant policy and research information. The AHVN currently supports Arkansas children and families through 9 different home visiting models:

- Arkansas Early Head Start
- Family Connects Union County
- Following Baby Back Home
- Healthy Families America
- HIPPY Arkansas
- Nurse-Family Partnership
- Parents as Teachers
- SafeCare Arkansas

Each model serves families prenatally until their children reach kindergarten and is managed by a State Model Lead who is housed at the AHVN. The State Model Lead is responsible for ensuring home visiting sites are in compliance with guidelines established by all funding sources. This goal is achieved by providing technical training on model fidelity requirements, helping

sites solve complex challenges involved with program implementation and recruitment, and financial guidance when appropriate. Model specific training is completed regionally, and all home visiting programs across the state have access to a free annual AHVN Training Conference, annual Winter Institute, and the annual AHVN Leadership Retreat.

The AHVN also provides consultation and technical assistance for new and existing home visiting programs/models in the following areas:

- Continuous Quality Improvement: statewide infrastructure, local program technical assistance, improvement of the continuum of care
- Organizational, Infrastructure, and Leadership Development
- Comprehensive and ongoing training aligned with the key benchmarks established nationally for effective home visitors.
- Ages and Stages Questionnaire (ASQ) Developmental Screening Training (All State Leads & AHVN Trainers are nationally certified ASQ Trainers)
- Disseminate information to each home visiting site directly about new information from our national networks and models
- Directly communicate to all home visiting models across the state through social media such as Facebook, Instagram, Twitter, Pinterest, and YouTube.

Though not a birthing hospital, as an organization firmly invested in home visiting, Arkansas Children's looks forward to working closely with the Department of Human Services and hospitals to use the already established infrastructure of the AHVN to bring high quality home-visiting services to more families across Arkansas through the ARHOME program.

Sincerely,

Brent Thompson
Executive Vice President
Chief Legal Officer

July 9, 2021

ACHI HEALTH POLICY BOARD

ACHI's Health Policy Board identifies and establishes strategic priorities, provides direction and guidance, and serves as a forum for the exchange of ideas.

Ms. Cindy Gillespie
Secretary, Department of Human Services
PO Box 1437, Slot S201
Little Rock, AR 72203

Dear Secretary Gillespie:

The Arkansas Center for Health Improvement's (ACHI) Health Policy Board appreciates the opportunity to provide comment on the Arkansas Health and Opportunity for Me (ARHOME) demonstration waiver program, the proposed overhaul of Arkansas's Medicaid expansion program known currently as Arkansas Works. Consisting of 21 voting members from across the state who bring diverse perspectives and interests on health, the ACHI Health Policy Board identifies and establishes strategic priorities and provides direction and guidance for the organization. The proposed five-year ARHOME waiver represents a continuation of the state's innovative efforts over the last eight years to provide affordable, quality coverage to low-income Arkansans through the Medicaid program, and we are supportive of that goal, as well as new opportunities to address social needs in target populations through Life360 HOMEs.

First, we are pleased to see that ARHOME—like its predecessor programs—has at its core the premium assistance model, which uses Medicaid funding to purchase individual qualified health plans (QHPs) available on the Health Insurance Marketplace instead of administering coverage through the Medicaid fee-for-service program. The federally required evaluation of the premium assistance model in the Health Care Independence Program showed that Medicaid enrollees in QHPs experienced better access — both perceived and actual — and higher-quality care than enrollees in fee-for-service. The use of premium assistance has also benefitted the individual insurance market in Arkansas by promoting enhanced competition and stabilizing premiums.

Second, we commend the Department of Human Services for incorporating Life360 HOME concept into the waiver proposal to provide more intensive levels of intervention, care coordination, and linkages to community-based services for at-risk populations. The targeted populations for Life360 HOMEs have consistently experienced health disparities and profound social needs that serve as a barrier to improved outcomes. We are hopeful that there will be robust participation in the Life360 HOMEs by both providers and enrollees, and that the Life360 HOMEs will include evidenced-based interventions that have been shown to improve health outcomes.

ACHI
INSPIRING HEALTHY ACTS

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As waiver components continue to evolve from previous iterations and throughout the life of the waiver, we would urge regular compliance monitoring and rigorous state and federal evaluations that carefully assess results against stated objectives to inform both state and national awareness. Opportunities exist to learn from waiver strategies that are successful, as well as those that fall short of expectations or have unintended consequences.

The ACHI Health Policy Board encourages the Centers for Medicare and Medicaid Services to approve the state's waiver proposal request to continue Medicaid expansion coverage in Arkansas. Thank you again for the opportunity to provide comment on the ARHOME proposal.

Sincerely,

Annabelle Imber Tuck, JD
Chair, ACHI Health Policy Board

2021 ACHI Health Policy Board*

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*The statements expressed herein represent the collective observations and opinions of the ACHI Health Policy Board and should not be attributed to any individual board member in their personal or professional capacity.

VIA EMAIL ORP@dhs.arkansas.gov

July 12, 2021

Elizabeth Pitman, Director
Division of Medical Services
Donaghey Plaza, P.O. Box 1437
Little Rock, AR 72203

RE: ARHOME Section 1115 Demonstration Application

Dear Ms. Pitman:

Hemophilia Federation of America (HFA) and the National Hemophilia Foundation (NHF) are submitting the following comments in response to the proposed extension and amendments to the federal Section 1115 waiver for the Arkansas Health and Opportunity for Me (ARHOME) demonstration.

Who we are
HFA and NHF are non-profit organizations representing individuals with bleeding disorders nationwide. Our missions are to ensure that persons with inherited bleeding disorders such as hemophilia have timely access to quality medical care, therapies, and services, regardless of their financial circumstances or place of residence.

About bleeding disorders
Hemophilia is a rare, genetic bleeding disorder affecting about 20,000 Americans that impairs the ability of blood to clot properly. Without treatment, people with hemophilia bleed internally. This is sometimes due to trauma but also simply as a result of everyday activities. Bleeds can lead to severe joint damage and permanent disability, or even – with respect to bleeds in the head, throat, or abdomen – death. Related conditions include von Willebrand disease (VWD), another inherited bleeding disorder, which is estimated to affect more than three million Americans.

Patients with bleeding disorders have complex, lifelong medical needs. They depend on prescription medications (clotting factor or other new treatments) to treat or avoid painful bleeding episodes that can lead to advanced medical issues. Current treatment is highly effective and allow individuals to lead healthy and productive lives. However, this treatment is also extremely expensive, costing anywhere from $250,000 to $1 million or more per year depending on the severity of the disorder and whether complications such as an inhibitor are present. As a result, low-income individuals and families coping with bleeding disorders are at great risk if they lack affordable health insurance. Medicaid provides essential coverage for this segment of the bleeding disorders population.

Waiver application fails to comport with Medicaid objectives
The purpose of the Medicaid program is to provide healthcare coverage for low-income individuals and families. Medicaid expansion is critical for patients with and at risk of serious, acute and chronic health conditions. Reviews of more than 600 studies examining the impact of Medicaid expansion have found clear evidence that expansion is linked to increased access to coverage, improvements in many health indicators, and economic benefits for states and providers.[i]

Unfortunately, the ARHOME 1115 proposal includes several provisions that do not meet Medicaid's statutory objective to provide healthcare for low-income individuals. Instead, the proposed waiver

includes limitations on retroactive coverage, as well as premiums and cost-sharing that will create financial and administrative barriers for patients. These fail to comport with the purpose and objectives of Medicaid, as detailed below.

Retroactive Eligibility

This proposal would continue to limit retroactive coverage to 30 days for the demonstration population. There are no exemptions, even for medically frail individuals.

Retroactive eligibility in Medicaid prevents gaps in coverage by typically covering individuals for up to 90 days prior to the month of application, assuming the individual is eligible for Medicaid coverage during that time frame. It is common that individuals are unaware they are eligible for Medicaid until a medical event or diagnosis occurs. Retroactive eligibility allows patients who have been diagnosed with a bleeding disorder or other serious condition to begin treatment without being burdened by medical debt prior to their official eligibility determination.

Medicaid paperwork can be burdensome and often confusing. A Medicaid enrollee may not have understood or received a notice of Medicaid renewal and only discovered the coverage lapse when picking up a prescription or going to see their doctor. Without retroactive eligibility, Medicaid enrollees could then face substantial costs at their doctor's office or pharmacy.

Health systems could also end up providing more uncompensated care. For example, when Ohio was considering a similar provision in 2016, a consulting firm advised the state that hospitals could accrue as much as $2.5 billion more in uncompensated care as a result of the waiver.[ii] Increased uncompensated care costs are especially concerning as safety net hospitals and other providers continue to deal with the COVID-19 pandemic. Additionally, Arkansas currently has 11 rural hospitals that are vulnerable to closure.[iii] Limiting retroactive coverage increases the financial hardships to rural hospitals that absorb uncompensated care costs. Our organizations oppose the limitations on retroactive coverage for the demonstration population.

Premiums and Cost-sharing

Arkansas proposes to increase premiums for individuals with incomes at or above 100 percent of the federal poverty line. Premiums will likely discourage eligible people from enrolling in the program. For example, when Oregon implemented a premium in its Medicaid program, with a maximum premium of $20 per month, almost half of enrollees lost coverage.[iv] Additional research on Michigan's Medicaid expansion program showed that modest increases of a few dollars in premiums resulted in disenrollment from the program, especially among healthy individuals.[v] For individuals living with an inherited bleeding disorder, even temporary delays or gaps in coverage can be devastating. Interruptions in coverage and treatment could result in joint- or even life-threatening bleeding episodes, with an intolerably high human toll (as well as higher state spending for care in an ER setting).

The state is also requesting to impose copayments ranging from $5-20 on individuals with incomes at or above 21 percent of the federal poverty line ($225 per month for an individual). Research has shown that even relatively low levels of cost-sharing for low-income populations limit the use of necessary healthcare services.[vi] Additionally, the state includes a copay for non-emergency use of the emergency department. Yet a study of enrollees in Oregon's Medicaid program demonstrated that implementation of a copay on emergency services resulted in decreased utilization of such services but did not result in cost savings because of subsequent use of more intensive and expensive services.[vii] This provides further evidence that copays may lead to inappropriate delays in needed care. Our organizations oppose the cost-sharing and premiums for the low-income population covered under this demonstration.

Evaluation

HFA and NHF are also concerned that this proposal does not include an interim evaluation of Arkansas Works, the state's previous demonstration waiver. Therefore, there is no evaluation data on the state's experience with premiums, limitations on retroactive coverage, and other key provisions included in the current waiver application. This is highly problematic because the state is asking for comment on extending its current demonstration and evidence from an interim evaluation would help our organizations fully comment on the current request.

As result, HFA and NHF strongly recommend that Arkansas revise its waiver application as detailed above, in order to ensure that it meets the objectives of the Medicaid program.

Sincerely,

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[ii] Virgil Dickson, "Ohio Medicaid waiver could cost hospitals $2.5 billion", Modern Healthcare, April 22, 2016. (http://www.modernhealthcare.com/article/20160422/NEWS/160429965)

[iii] https://www.ivantageindex.com/wp-content/uploads/2020/02/CCRH_Vulnerability-Research_FiNAL-02.14.20.pdf

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[v] Cliff, B., et al. Adverse Selection in Medicaid: Evidence from Discontinuous Program Rules. NBER Working Paper No. 28762. National Bureau of Economic Research. May 2021. Accessed at: https://www.nber.org/system/files/working_papers/w28762/w28762.pdf.

[vi] Samantha Artiga, Petry Ubri, and Julia Zur, "The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings," Kaiser Family Foundation, June 2017. Available at: https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/.

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July 12, 2021

Ms. Cindy Gillespie
Secretary, Department of Human Services
PO Box 1437, Slot S201
Little Rock, AR 72203

Dear Secretary Gillespie:

The Arkansas Center for Health Improvement (ACHI) appreciates the opportunity to provide comment on the Arkansas Health and Opportunity for Me (ARHOME) demonstration waiver program, the proposed overhaul of Arkansas's Medicaid expansion program known currently as Arkansas Works. ACHI is an independent, non-partisan health policy organization dedicated to improving the health of Arkansans. The proposed five-year ARHOME waiver represents a continuation of the state's innovative efforts over the last eight years to provide affordable, quality coverage to low-income Arkansans through the Medicaid program, and we are supportive of that goal, as well as new opportunities to address social needs in target populations through Life360 HOMEs.

We are pleased to see that ARHOME — like its predecessor programs — has at its core the premium assistance model, which uses Medicaid funding to purchase individual qualified health plans (QHPs) available on the Health Insurance Marketplace instead of administering coverage through the Medicaid fee-for-service program. The federally required evaluation of the premium assistance model in the Health Care Independence Program showed that Medicaid enrollees in QHPs experienced better perceived and actual access than enrollees in fee-for-service. The use of premium assistance has also benefitted the individual insurance market in Arkansas by promoting enhanced competition and stabilizing premiums.

While we recognize that the proposal to "reassign" beneficiaries who are "inactive" from QHPs to the Medicaid fee-for-service program has some budgetary benefit, the reassignment waiver feature also raises some concerns. First, being reassigned could certainly be viewed as a penalty by the beneficiary. After all, the stigma of Medicaid has been documented and is among the many reasons that Arkansas initially opted for a premium assistance model. Second, as a basic tenet of insurance, the QHPs rely on beneficiaries with low or no utilization to offset high utilization among other beneficiaries. Wholesale reassignment of beneficiaries without utilization could be detrimental to this balance of risk and result in higher QHP premiums for the program. Finally, the reassignment feature — which the waiver proposes to test to understand whether beneficiaries "in a QHP recognize and value the health coverage as insurance above and beyond Medicaid medical assistance" — sparks broader questions about compliance with federal "equal access" requirements, particularly when there is objective evidence that access differences between the care delivery strategies exist. We welcome the opportunity for input into the operationalization of "inactive" beneficiary provisions before the proposed implementation date in 2023, and we hope that the Medicaid reimbursement adequacy review currently underway informs the broader "equal access" questions raised by this proposed feature.

ACHI
INSPIRING HEALTHY ACTS

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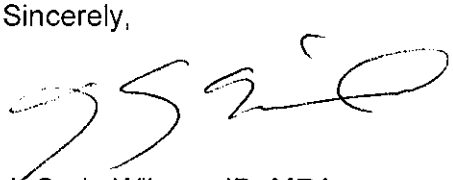
We commend the Department of Human Services for incorporating the Life360 HOME concept into the waiver proposal to provide more intensive levels of intervention, care coordination, and linkages to community-based services for at-risk populations. The targeted populations for Life360 HOMEs have consistently experienced health disparities and profound social needs that serve as a barrier to improved outcomes. We are hopeful that there will be robust participation in the Life360 HOMEs by both providers and enrollees, and that the Life360 HOMEs will include evidenced-based interventions that have been shown to improve health outcomes. We would also invite state officials to explore promising models such as the Following Baby Back Home program developed by the University of Arkansas for Medical Sciences' Department of Pediatrics, which has been shown to prevent three in four infant deaths, improve immunization completion, and increase the completion of needed healthcare utilization among high-risk newborns.

We are also supportive of new quality measurement provisions for the QHPs, which will provide both an opportunity for quality improvement within the ARHOME program and a comparator for QHP performance in the subsidized population above income eligibility levels for Medicaid expansion. As waiver components continue to evolve from previous iterations and throughout the life of the waiver, we would urge regular compliance monitoring and rigorous state and federal evaluations that carefully assess results against stated objectives to inform both state and national awareness. Opportunities exist to learn from waiver strategies that are successful, as well as those that fall short of expectations or have unintended consequences. Regarding the latter, the following waiver provisions merit heightened scrutiny:

- Cost-sharing exposure for individuals with household incomes beginning at 21% of the federal poverty level, or roughly $2,700 annually for a single individual and $5,500 for a household of four. Even relatively small levels of cost-sharing are associated with reduced use of care, including necessary services.
- The ability of providers to refuse service following one instance of non-payment. This could certainly have the potential to limit access for needed services and could divert those with the inability to pay to safety net providers, such as federally qualified health centers, which must provide services without regard to an individual's ability to pay.
- The limit on retroactive eligibility to 30 days. This waiver feature was previously approved by the Centers for Medicare and Medicaid Services and implemented as part of Arkansas Works but was discontinued. The interim evaluation of Arkansas Works was unable to fully assess this waiver feature.

ACHI encourages the Centers for Medicare and Medicaid Services to approve the state's waiver proposal request to continue Medicaid expansion coverage in Arkansas. Thank you again for the opportunity to provide comment on the ARHOME proposal.

Sincerely,



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