



ROBERT “BO” RYALL
President & CEO

June 15, 2017

Cindy Gillespie
Director
Department of Human Services
PO Box 1437, S-295
Little Rock, AR 72203-1437

Dear Director Gillespie:

The Arkansas Hospital Association (AHA), on behalf of its 100 member organizations and their combined 45,000-plus employees, appreciates the opportunity to comment on the potential impact of proposed waiver amendments to the Arkansas Works Section 1115 demonstration.

As a membership organization with a mission to safeguard hospitals’ operational effectiveness in advancing the health and well-being of their communities, the AHA is a strong proponent of Arkansas Works. The AHA applauds Governor Asa Hutchinson and the Arkansas Legislature for continuing its support of the state’s innovative healthcare coverage expansion.

Arkansas Works (and its predecessor, the Arkansas Private Option) has been instrumental in reducing the state’s uninsured rate and has helped Arkansas hospitals to retain their ability to serve patients throughout our state. As of the end of April 2017, over 320,000 Arkansans received comprehensive health coverage under this program. This program has also significantly contributed to a reduction in the amount of uncompensated care borne by Arkansas’s hospitals. In each full year during which Arkansas Works has been operational, Arkansas hospitals have seen an annual decrease of approximately \$150 million. While this decrease has certainly not eliminated uncompensated care, the reduction has stabilized the financial situation for many of the state’s hospitals.

Additionally, we appreciate the Arkansas Department of Human Services (DHS) stated commitment to furthering the objectives of the Medicaid program by providing continuity of coverage for individuals, improving access to providers, and improving the continuity of care across the continuum of coverage. However, AHA has several concerns with the Arkansas 1115 waiver demonstration amendment request and worries that proposed amendments will not result in improved access to providers or continuity of coverage and care for Arkansas Works enrollees. Further, the proposed waiver amendments will have adverse financial implications for Arkansas’s hospitals.

Retroactive eligibility:

AHA requests that the state’s waiver of §1902(a)(34) be denied. This waiver would allow the state to discontinue providing retroactive eligibility for the demonstration population prior to the first date of the month in which the individual applies for Medicaid coverage.

AHA is concerned that the waiver of retroactive eligibility will result in unanticipated and avoidable gaps in coverage and healthcare debt for Arkansas Works enrollees. History has shown that gaps in coverage can have significant adverse health outcomes for patients with certain conditions. AHA also notes that this change is likely to have a negative impact on access to providers.

Further, the elimination of this provision increases financial risk for hospitals and other providers and punishes hospitals that serve uninsured individuals and leads to an increase in those hospitals' uncompensated care. AHA has requested, but not yet received, data from DHS to determine the amount of retroactive coverage paid to the state's hospitals for Arkansas Works enrollees. We urge DHS not to implement a change without fully examining and being transparent about the impact it will have on hospitals and other providers.

In addition to opposing the waiver of retroactive coverage, AHA notes that the state has not yet implemented the provision allowing for presumptive eligibility determinations by qualified hospitals, as required under current federal law. The AHA encourages DHS to implement presumptive eligibility, but also suggests that, in the alternative, an option would be to put in place an appropriate time-period of at least 60 days of retroactive coverage. This would enhance hospital discharge coordination options for patient care planning, which can reduce costly repeated hospital admissions. Retroactive coverage of at least 60 days or implementation of presumptive eligibility are far superior to the current proposal to waive § 1902(a)(34).

Partial Expansion:

In this waiver amendment request, DHS is asking for a comparability waiver under Section 1902(a)(10)(B) to the extent necessary to allow the state to phase out eligibility for individuals in the newly eligible adult group found at Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act with incomes above 100% of the federal poverty level (FPL). DHS is, in effect, asking CMS to grant a partial Medicaid expansion. Approval of this waiver would require a departure from CMS' prior position, as expressed in sub-regulatory guidance, that partial expansions are not allowable. CMS previously noted that, "Congress directed that the enhanced matching rate be used to expand coverage to 133% of FPL. The law does not provide for a phased-in or partial expansion."¹

AHA is concerned that the proposed partial expansion and planned transition of the approximately 60,000 current Arkansas Works enrollees with incomes above 100% FPL will result in a loss of coverage for a significant number of this population. Affordability of cost-sharing obligations under Marketplace and ESI options is a significant concern for many low-income working Arkansans. Current experience with the institution of premiums for Arkansas Works enrollees with incomes between 100 and 138% of the federal poverty level indicates that approximately 20-25% have paid premiums. Under DHS' proposed changes, any individual who fails to pay premiums for 90 days will lose coverage for the remainder of the plan year.

Consequentially, this proposed waiver will lead to gaps in coverage, churn, and uninsurance for many low-income working Arkansans. This, in turn, will lead to increased insurance premium rates and increased uncompensated care for the state's hospitals. DHS' own estimates indicate that the potential premium impacts due to the partial expansion would range from a 0.8 to a 1.7% premium increase. Additionally,

¹ CMS, December 10, 2012 Frequently Asked Questions on Exchanges, Market Reforms and Medicaid. <https://www.cms.gov/CCIIO/Resources/Files/Downloads/exchanges-faqs-12-10-2012.pdf>

DHS estimates that potential increase in annual uncompensated care costs in 2018 due to the partial expansion would range from an additional \$5 to \$28 million, depending on the percentage of current Arkansas Works enrollees who transition from Arkansas Works to either Marketplace coverage or to ESI.² By DHS' own estimate, that total could climb and range from \$11 million to \$54.5 million in 2020, adding substantially to hospitals' reliance on adequate payments from private insurers to cover the resulting cost shift.

However, it is unlikely that insurers as a group could pay those adequate rates, particularly if the issuers participating in Arkansas's Marketplace do not receive the needed premium increases to cover their own projected losses caused by the partial expansion. The combined effects on hospital finances would range from harsh to devastating.

Instituting Work Requirements as a Condition of Eligibility:

With this amendment request, DHS seeks to institute a work requirement as a condition of eligibility for Arkansas Works enrollees and seeks a waiver of reasonable promptness under Section 1902(a)(3) to allow the state to prohibit re-enrollment for the remainder of the calendar year for enrollees who fail to meet work requirements.

AHA lauds DHS for its interest in promoting work and its desire to enhance economic advancement opportunities among this population. AHA is also appreciative of the Department's recognition of the need for certain populations to be exempt from this requirement. However, AHA continues to have concerns regarding the operationalization of this requirement and its addition as a condition of eligibility for participation in the state's healthcare coverage expansion.

The operationalization of the work requirement is exceedingly complex and may lead to significant enrollee confusion. The duration of exemption is not uniform and varies by exemption type. The complexity of navigating work requirements will require a comprehensive education and outreach plan to minimize gaps in coverage.

Additionally, AHA is concerned about the disenrollment of Arkansas Works enrollees who fail to meet the work requirements. As currently designed, Arkansas Works enrollees who fail to meet the work requirement for any three months during the coverage year will not be eligible for coverage under the program for the remainder of the calendar year. AHA supports DHS' efforts to find multiple pathways for compliance with the work requirement, including employment, job training, education and volunteerism. However, AHA is concerned, given the rurality of the state and existing transportation challenges, that the work requirements will be a barrier to coverage for some non-exempt Arkansas Works enrollees who are willing, but unable to meet these requirements. Additionally, the requirement that non-exempt Arkansas Works enrollees demonstrate monthly compliance via an electronic portal may be a challenge for some enrollees due to lack of internet access. These proposed changes and the fact that failure to meet these requirements will result in the enrollee's loss of coverage for the remainder of the calendar year will likely lead to increases in churn, gaps in coverage, uninsurance and uncompensated care for hospitals and other providers.

² Arkansas Department of Human Services, Arkansas Works 2.0 PowerPoint presentation dated June 6, 2017. The low range of DHS' uncompensated care estimate (increase of \$5.6 M for calendar year 2018) estimates that 5% of the population with incomes between 100-138% FPL do not enroll in Marketplace or employer-sponsored insurance (ESI), while the high range (\$28 M) assumes that 50% do not enroll in other Marketplace or ESI coverage.

Transparency Regarding the Administrative Renewal Process for Impacted Enrollees:

As previously noted, the requested waiver amendments are likely to result in numerous Arkansas Works enrollees experiencing either a termination of Medicaid coverage or a gap in coverage. In order to mitigate the potential negative consequences of the proposed amendments, DHS should provide a detailed explanation of its process for conducting administrative renewals of Arkansas Works enrollees as required under current federal regulations before implementing the changes proposed in this waiver amendment.

Impact on Premiums and Provider Reimbursement Rates:

As previously mentioned, DHS has estimated that the changes proposed in this waiver amendment will likely result in a premium increase of 0.8% to 1.7%. Historically, the issuers participating in Arkansas's Marketplace have reduced provider rates to compensate from inadequate premium increases. AHA is concerned that hospitals will have further reductions in their negotiated rates with issuers if Arkansas Works premiums are adversely impacted by the proposed amendments.

Evaluation hypotheses:

DHS expresses that, with this amendment, the state will "test innovative approaches to promoting personal responsibility and work, encouraging movement up the economic ladder, and facilitating transitions between and among Arkansas Works, ESI, and Marketplace for Arkansas Works enrollees." DHS proposes adding a hypothesis to the evaluation to determine whether work requirements increase the number of Arkansas Works enrollees who are employed.

AHA supports the addition of this hypothesis, but also encourages a more robust study of the impact of the changes proposed in this amendment request. Specifically, if the requested waiver amendments are approved, research questions and hypotheses regarding the impact of the elimination of retroactive coverage, partial expansion, and the imposition of work requirements as a condition of eligibility should be considered as additions to the evaluation design. This would provide valuable information regarding the impact of these changes on the continuity of coverage for individuals, continuity of care across the continuum of coverage, churn, rate of uninsured, enrollee access to providers, uncompensated care and the growth rate of insurance premiums.

Once again, although AHA has significant concerns regarding several of the proposed waivers requested in this amendment request, AHA remains strongly supportive of the healthcare coverage expansion in Arkansas. AHA looks forward to working with DHS develop meaningful improvements that will benefit the State of Arkansas, its hospitals and the patients we jointly serve. We feel confident that DHS and Arkansas hospitals share the goal of creating solutions to ensure that Arkansas's hospitals remain viable and continue to serve efficiently and effectively as the safety net for our healthcare system. Thank you for this opportunity to make our concerns known.

Sincerely,

A handwritten signature in black ink, appearing to read 'Bo Ryall', with a stylized, cursive script.

Bo Ryall

From: David Grigsby <astatered2@gmail.com>
Sent: Friday, June 16, 2017 8:20 AM
To: DHS DMS HCIW
Subject: We can do better for Arkansas!

Dear Official,

As an Arkansas resident and volunteer with the American Heart Association, I am writing to express my concern for the 1115 Demonstration Waiver for the Arkansas Works program.

The Arkansas Works program was a model healthcare program for the rest of the nation. Unfortunately, with these waivers, 60,000 people will lose their insurance. The people that will be most affected are the people that are the most in need, the sick and the working poor.

To treat and prevent heart disease and stroke, it is important to ensure that everyone in Arkansas have access to affordable, quality healthcare. The intent of the 1115 Demonstration Wavier program is to increase access and test innovative approaches to delivering care.

This waiver request imposes multiple hurdles to an individual or family's ability to attain coverage, including:

- Limiting income eligibility to 100 percent of the federal poverty level (FPL), which will cut coverage for thousands of adults including those in serious need of ongoing medical care;
- Disenrolling individuals who may not be able to work, including medically frail patients, and prohibiting re-enrollment until the next year;
- Elimination of the ESI premium assistance program; and
- Elimination of retroactive eligibility for adults and medically frail patients.

Please reconsider this approach to Arkansas Works. Affordable, quality healthcare access is critically important to for all Arkansans. Thank you for your time and consideration.

Regards,
David Grigsby
1696 Fletcher St
Wynne, AR 72396

From: Maria Del Toro <maria-deltoro@live.com>
Sent: Friday, June 16, 2017 8:18 AM
To: DHS DMS HCIW
Subject: We can do better for Arkansas!

Dear Official,

As an Arkansas resident and volunteer with the American Heart Association, I am writing to express my concern for the 1115 Demonstration Waiver for the Arkansas Works program.

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Please reconsider this approach to Arkansas Works. Affordable, quality healthcare access is critically important to for all Arkansans. Thank you for your time and consideration.

Regards,
Maria Del Toro
1505 W Emma Ave
Springdale, AR 72764

From: Margaret Tremwel <mtremwel@wregional.com>
Sent: Friday, June 16, 2017 8:17 AM
To: DHS DMS HCIW
Subject: We can do better for Arkansas!

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Please reconsider this approach to Arkansas Works. Affordable, quality healthcare access is critically important to for all Arkansans. Thank you for your time and consideration.

Regards,
Margaret Tremwel
515 W Skyline Dr
Fayetteville, AR 72701

From: Sam Evans <sevans86@yahoo.com>
Sent: Friday, June 16, 2017 8:16 AM
To: DHS DMS HCIW
Subject: We can do better for Arkansas!

Dear Official,

As an Arkansas resident and volunteer with the American Heart Association, I am writing to express my concern for the 1115 Demonstration Waiver for the Arkansas Works program.

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Please reconsider this approach to Arkansas Works. Affordable, quality healthcare access is critically important to for all Arkansans. Thank you for your time and consideration.

Regards,
Sam Evans
333 Links Dr
Texarkana, AR 71854

From: Cindy Hudlow <cindy.hudlow@heart.org>
Sent: Friday, June 16, 2017 8:15 AM
To: DHS DMS HCIW
Subject: We can do better for Arkansas!

Dear Official,

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Please reconsider this approach to Arkansas Works. Affordable, quality healthcare access is critically important to for all Arkansans. Thank you for your time and consideration.

Regards,
Cindy Hudlow
599 Bordeaux Ave
Springdale, AR 72764

From: Heather Hall <heather.hall@heart.org>
Sent: Friday, June 16, 2017 8:13 AM
To: DHS DMS HCIW
Subject: We can do better for Arkansas!

Dear Official,

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Please reconsider this approach to Arkansas Works. Affordable, quality healthcare access is critically important to for all Arkansans. Thank you for your time and consideration.

Regards,
Heather Hall
3001 Hook Ln
Farmington, AR 72730

From: Deven Daehn <deven.daehn@heart.org>
Sent: Friday, June 16, 2017 8:12 AM
To: DHS DMS HCIW
Subject: We can do better for Arkansas!

Dear Official,

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Please reconsider this approach to Arkansas Works. Affordable, quality healthcare access is critically important to for all Arkansans. Thank you for your time and consideration.

Regards,
Deven Daehn
1453 Prairie View Ave
Elkins, AR 72727

From: rebecca buerke <rebecca.buerke@heart.org>
Sent: Friday, June 16, 2017 8:11 AM
To: DHS DMS HCIW
Subject: We can do better for Arkansas!

Dear Official,

As an Arkansas resident and volunteer with the American Heart Association, I am writing to express my concern for the 1115 Demonstration Waiver for the Arkansas Works program.

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Please reconsider this approach to Arkansas Works. Affordable, quality healthcare access is critically important to for all Arkansans. Thank you for your time and consideration.

Regards,
rebecca buerke
909 W 2nd St
Little Rock, AR 72201

From: Angela Rhodes <vampirefairy999@yahoo.com>
Sent: Thursday, June 15, 2017 11:45 AM
To: DHS DMS HCIW
Subject: We can do better for Arkansas!

Dear Official,

As an Arkansas resident and volunteer with the American Heart Association, I am writing to express my concern for the 1115 Demonstration Waiver for the Arkansas Works program.

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Please reconsider this approach to Arkansas Works. Affordable, quality healthcare access is critically important to for all Arkansans. Thank you for your time and consideration.

Regards,
Angela Rhodes
923 Turtle Creek Dr
Rogers, AR 72756

From: Vanessa Williams <vanessa_bradford@ymail.com>
Sent: Thursday, June 15, 2017 11:44 AM
To: DHS DMS HCIW
Subject: We can do better for Arkansas!

Dear Official,

As an Arkansas resident and volunteer with the American Heart Association, I am writing to express my concern for the 1115 Demonstration Waiver for the Arkansas Works program.

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Please reconsider this approach to Arkansas Works. Affordable, quality healthcare access is critically important to for all Arkansans. Thank you for your time and consideration.

Regards,
Vanessa Williams
116 Hudson St
El Dorado, AR 71730

From: John Blanch <jjblanch@cox.net>
Sent: Thursday, June 15, 2017 11:43 AM
To: DHS DMS HCIW
Subject: We can do better for Arkansas!

Dear Official,

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Regards,
John Blanch
2358 E Ferguson Ave
Fayetteville, AR 72703

From: Robbie holland <robbielashelle@gmail.com>
Sent: Thursday, June 15, 2017 11:42 AM
To: DHS DMS HCIW
Subject: We can do better for Arkansas!

Dear Official,

As an Arkansas resident and volunteer with the American Heart Association, I am writing to express my concern for the 1115 Demonstration Waiver for the Arkansas Works program.

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Please reconsider this approach to Arkansas Works. Affordable, quality healthcare access is critically important to for all Arkansans. Thank you for your time and consideration.

Regards,
Robbie holland
2314 Pleasure Dr
Bryant, AR 72019

From: Leilani Baitlon <lancexec@gmail.com>
Sent: Thursday, June 15, 2017 11:41 AM
To: DHS DMS HCIW
Subject: We can do better for Arkansas!

Dear Official,

As an Arkansas resident and volunteer with the American Heart Association, I am writing to express my concern for the 1115 Demonstration Waiver for the Arkansas Works program.

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Regards,
Leilani Baitlon
30 Nottingham Rd
Little Rock, AR 72205

From: Eileen Joyce <efjoyce@att.net>
Sent: Thursday, June 15, 2017 11:40 AM
To: DHS DMS HCIW
Subject: We can do better for Arkansas!

Dear Official,

As an Arkansas resident and volunteer with the American Heart Association, I am writing to express my concern for the 1115 Demonstration Waiver for the Arkansas Works program.

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Regards,
Eileen Joyce
1308 Cove View Ln
Little Rock, AR 72211

From: Gary Throckmorton <gst7@tcworks.net>
Sent: Thursday, June 15, 2017 11:39 AM
To: DHS DMS HCIW
Subject: We can do better for Arkansas!

Dear Official,

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- Elimination of the ESI premium assistance program; and
- Elimination of retroactive eligibility for adults and medically frail patients.

Please reconsider this approach to Arkansas Works. Affordable, quality healthcare access is critically important to for all Arkansans. Thank you for your time and consideration.

Regards,
Gary Throckmorton
10 Snowden Cir
Greenbrier, AR 72058

From: marsha stovall <stovallmarsha@yahoo.com>
Sent: Thursday, June 15, 2017 11:38 AM
To: DHS DMS HCIW
Subject: We can do better for Arkansas!

Dear Official,

As an Arkansas resident and volunteer with the American Heart Association, I am writing to express my concern for the 1115 Demonstration Waiver for the Arkansas Works program.

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Please reconsider this approach to Arkansas Works. Affordable, quality healthcare access is critically important to for all Arkansans. Thank you for your time and consideration.

Regards,
marsha stovall
9204 Dollarway Rd
White Hall, AR 71602

From: Christopher Walker <amrak63@outlook.com>
Sent: Thursday, June 15, 2017 11:37 AM
To: DHS DMS HCIW
Subject: We can do better for Arkansas!

Dear Official,

As an Arkansas resident and volunteer with the American Heart Association, I am writing to express my concern for the 1115 Demonstration Waiver for the Arkansas Works program.

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Please reconsider this approach to Arkansas Works. Affordable, quality healthcare access is critically important to for all Arkansans. Thank you for your time and consideration.

Regards,
Christopher Walker
2910 Breckenridge Dr
Benton, AR 72015

From: Veronica Thomas <vcnyar5@yahoo.com>
Sent: Thursday, June 15, 2017 11:36 AM
To: DHS DMS HCIW
Subject: We can do better for Arkansas!

Dear Official,

As an Arkansas resident and volunteer with the American Heart Association, I am writing to express my concern for the 1115 Demonstration Waiver for the Arkansas Works program.

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Please reconsider this approach to Arkansas Works. Affordable, quality healthcare access is critically important to for all Arkansans. Thank you for your time and consideration.

Regards,
Veronica Thomas
520 W Semmes Ave
Osceola, AR 72370

From: Jessica Westerman <jessicawesterman1980@gmail.com>
Sent: Thursday, June 15, 2017 11:35 AM
To: DHS DMS HCIW
Subject: We can do better for Arkansas!

Dear Official,

As an Arkansas resident and volunteer with the American Heart Association, I am writing to express my concern for the 1115 Demonstration Waiver for the Arkansas Works program.

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Please reconsider this approach to Arkansas Works. Affordable, quality healthcare access is critically important to for all Arkansans. Thank you for your time and consideration.

Regards,
Jessica Westerman
1119 Allyson Ave
Bryant, AR 72022

From: Tim Vinsant <tim.vinsant@fmail.com>
Sent: Thursday, June 15, 2017 11:34 AM
To: DHS DMS HCIW
Subject: We can do better for Arkansas!

Dear Official,

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Please reconsider this approach to Arkansas Works. Affordable, quality healthcare access is critically important to for all Arkansans. Thank you for your time and consideration.

Regards,
Tim Vinsant
13111 W Markham St
Little Rock, AR 72211

From: Cheri Carden <cheri.carden@outlook.com>
Sent: Thursday, June 15, 2017 11:33 AM
To: DHS DMS HCIW
Subject: We can do better for Arkansas!

Dear Official,

As an Arkansas resident and volunteer with the American Heart Association, I am writing to express my concern for the 1115 Demonstration Waiver for the Arkansas Works program.

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Please reconsider this approach to Arkansas Works. Affordable, quality healthcare access is critically important to for all Arkansans. Thank you for your time and consideration.

Regards,
Cheri Carden
2913 N Old Wire Rd
Fayetteville, AR 72703

From: Diana Rogers <diana-rogers@hotmail.com>
Sent: Thursday, June 15, 2017 11:32 AM
To: DHS DMS HCIW
Subject: We can do better for Arkansas!

Dear Official,

As an Arkansas resident and volunteer with the American Heart Association, I am writing to express my concern for the 1115 Demonstration Waiver for the Arkansas Works program.

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Please reconsider this approach to Arkansas Works. Affordable, quality healthcare access is critically important to for all Arkansans. Thank you for your time and consideration.

Regards,
Diana Rogers
13686 Stoneridge Rd
Rogers, AR 72756

From: Nancy Deyo <nancy_deyo@yahoo.com>
Sent: Thursday, June 15, 2017 11:31 AM
To: DHS DMS HCIW
Subject: We can do better for Arkansas!

Dear Official,

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Please reconsider this approach to Arkansas Works. Affordable, quality healthcare access is critically important to for all Arkansans. Thank you for your time and consideration.

Regards,
Nancy Deyo
25 S Graham Ave
Fayetteville, AR 72701

From: Michael Berryman <Reviveusohlord@msn.com>
Sent: Thursday, June 15, 2017 11:30 AM
To: DHS DMS HCIW
Subject: We can do better for Arkansas!

Dear Official,

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Please reconsider this approach to Arkansas Works. Affordable, quality healthcare access is critically important to for all Arkansans. Thank you for your time and consideration.

Regards,
Michael Berryman
9092 Highway 242 W
Lexa, AR 72355

From: Jeannie De Meyere <Jdemeyer@harding.edu>
Sent: Thursday, June 15, 2017 11:29 AM
To: DHS DMS HCIW
Subject: We can do better for Arkansas!

Dear Official,

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Regards,
Jeannie De Meyere
1020 Dortch Loop
North Little Rock, AR 72117

From: Robert Parker <parkerm007@sbcglobal.net>
Sent: Thursday, June 15, 2017 11:28 AM
To: DHS DMS HCIW
Subject: We can do better for Arkansas!

Dear Official,

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Please reconsider this approach to Arkansas Works. Affordable, quality healthcare access is critically important to for all Arkansans. Thank you for your time and consideration.

Regards,
Robert Parker
12 Clancy Ct
Little Rock, AR 72223

From: Suzy Fehlig <sfehligh@me.com>
Sent: Thursday, June 15, 2017 11:28 AM
To: DHS DMS HCIW
Subject: We can do better for Arkansas!

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Please reconsider this approach to Arkansas Works. Affordable, quality healthcare access is critically important to for all Arkansans. Thank you for your time and consideration.

Regards,
Suzy Fehlig
300 Shadow Ridge Way
Cave Springs, AR 72718

From: Kelly Warner <kwarn@robbidavisagency.com>
Sent: Thursday, June 15, 2017 11:26 AM
To: DHS DMS HCIW
Subject: We can do better for Arkansas!

Dear Official,

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Please reconsider this approach to Arkansas Works. Affordable, quality healthcare access is critically important to for all Arkansans. Thank you for your time and consideration.

Regards,
Kelly Warner
281 Ross Hollow Rd
Bigelow, AR 72016

From: Steve Day <steveday9119@gmail.com>
Sent: Thursday, June 15, 2017 11:24 AM
To: DHS DMS HCIW
Subject: We can do better for Arkansas!

Dear Official,

As an Arkansas resident and volunteer with the American Heart Association, I am writing to express my concern for the 1115 Demonstration Waiver for the Arkansas Works program.

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Please reconsider this approach to Arkansas Works. Affordable, quality healthcare access is critically important to for all Arkansans. Thank you for your time and consideration.

Regards,
Steve Day
PO Box 881
Mountain Home, AR 72654

From: Kathryn McCollum <kaymccollum@sbcglobal.net>
Sent: Thursday, June 15, 2017 11:23 AM
To: DHS DMS HCIW
Subject: We can do better for Arkansas!

Dear Official,

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Please reconsider this approach to Arkansas Works. Affordable, quality healthcare access is critically important to for all Arkansans. Thank you for your time and consideration.

Regards,
Kathryn McCollum
1600 Dorado Beach Dr
Little Rock, AR 72212

From: Joyce Ramay <joyceramay@yahoo.com>
Sent: Thursday, June 15, 2017 11:22 AM
To: DHS DMS HCIW
Subject: We can do better for Arkansas!

Dear Official,

As an Arkansas resident and volunteer with the American Heart Association, I am writing to express my concern for the 1115 Demonstration Waiver for the Arkansas Works program.

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Regards,
Joyce Ramay
3412 Foxcroft Rd
Little Rock, AR 72227

From: Gale scott <galegscott@gmail.com>
Sent: Thursday, June 15, 2017 11:21 AM
To: DHS DMS HCIW
Subject: We can do better for Arkansas!

Dear Official,

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Please reconsider this approach to Arkansas Works. Affordable, quality healthcare access is critically important to for all Arkansans. Thank you for your time and consideration.

Regards,
Gale scott
14412 Charwick Dr
Little Rock, AR 72212

From: Emily Douglas <ekdjmd@cox.net>
Sent: Thursday, June 15, 2017 11:20 AM
To: DHS DMS HCIW
Subject: We can do better for Arkansas!

Dear Official,

As an Arkansas resident and volunteer with the American Heart Association, I am writing to express my concern for the 1115 Demonstration Waiver for the Arkansas Works program.

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Regards,
Emily Douglas
702 NE Greenwood Way
Bentonville, AR 72712

From: mario palomino <mario.palomino@pepsico.com>
Sent: Thursday, June 15, 2017 11:19 AM
To: DHS DMS HCIW
Subject: We can do better for Arkansas!

Dear Official,

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Regards,
mario palomino
3523 Natchez Trace
Fayetteville, AR 72703

From: Darin Jones <dejones@ualr.edu>
Sent: Thursday, June 15, 2017 11:18 AM
To: DHS DMS HCIW
Subject: We can do better for Arkansas!

Dear Official,

As an Arkansas resident and volunteer with the American Heart Association, I am writing to express my concern for the 1115 Demonstration Waiver for the Arkansas Works program.

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Please reconsider this approach to Arkansas Works. Affordable, quality healthcare access is critically important to for all Arkansans. Thank you for your time and consideration.

Regards,
Darin Jones
74 Valley Estates Cove
Little Rock, AR 72212

From: Matthew Stripling <stripling_07@yahoo.com>
Sent: Thursday, June 15, 2017 11:17 AM
To: DHS DMS HCIW
Subject: We can do better for Arkansas!

Dear Official,

As an Arkansas resident and volunteer with the American Heart Association, I am writing to express my concern for the 1115 Demonstration Waiver for the Arkansas Works program.

The Arkansas Works program was a model healthcare program for the rest of the nation. Unfortunately, with these waivers, 60,000 people will lose their insurance. The people that will be most affected are the people that are the most in need, the sick and the working poor.

To treat and prevent heart disease and stroke, it is important to ensure that everyone in Arkansas have access to affordable, quality healthcare. The intent of the 1115 Demonstration Wavier program is to increase access and test innovative approaches to delivering care.

This waiver request imposes multiple hurdles to an individual or family's ability to attain coverage, including:

- Limiting income eligibility to 100 percent of the federal poverty level (FPL), which will cut coverage for thousands of adults including those in serious need of ongoing medical care;
- Disenrolling individuals who may not be able to work, including medically frail patients, and prohibiting re-enrollment until the next year;
- Elimination of the ESI premium assistance program; and
- Elimination of retroactive eligibility for adults and medically frail patients.

Please reconsider this approach to Arkansas Works. Affordable, quality healthcare access is critically important to for all Arkansans. Thank you for your time and consideration.

Regards,
Matthew Stripling
3908 Lakewood Valley Dr
North Little Rock, AR 72116

From: Holly Holiman <hholiman@gmail.com>
Sent: Thursday, June 15, 2017 11:16 AM
To: DHS DMS HCIW
Subject: We can do better for Arkansas!

Dear Official,

As an Arkansas resident and volunteer with the American Heart Association, I am writing to express my concern for the 1115 Demonstration Waiver for the Arkansas Works program.

The Arkansas Works program was a model healthcare program for the rest of the nation. Unfortunately, with these waivers, 60,000 people will lose their insurance. The people that will be most affected are the people that are the most in need, the sick and the working poor.

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- Elimination of retroactive eligibility for adults and medically frail patients.

Please reconsider this approach to Arkansas Works. Affordable, quality healthcare access is critically important to for all Arkansans. Thank you for your time and consideration.

Regards,
Holly Holiman
16479 Patton Rd
Pea Ridge, AR 72751

From: Ann Mesrobian <mesrobiana@gmail.com>
Sent: Thursday, June 15, 2017 11:15 AM
To: DHS DMS HCIW
Subject: We can do better for Arkansas!

Dear Official,

As an Arkansas resident who votes every election, I am writing to express my concern for the 1115 Demonstration Waiver for the Arkansas Works program.

The Arkansas Works program was a model healthcare program for the rest of the nation. Unfortunately, with these waivers, 60,000 people will lose their insurance. The people that will be most affected are the people that are the most in need, the sick and the working poor.

To treat and prevent heart disease and stroke, it is important to ensure that everyone in Arkansas have access to affordable, quality healthcare. The intent of the 1115 Demonstration Wavier program is to increase access and test innovative approaches to delivering care.

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- Elimination of retroactive eligibility for adults and medically frail patients.

Please reconsider this approach to Arkansas Works. Affordable, quality healthcare access is critically important to for all Arkansans. Thank you for your time and consideration.

Regards,
Ann Mesrobian
19 W Pike St
Fayetteville, AR 72701

From: Sandra Davis <sandrakayedavis@gmail.com>
Sent: Thursday, June 15, 2017 11:15 AM
To: DHS DMS HCIW
Subject: We can do better for Arkansas!

Dear Official,

As an Arkansas resident and volunteer with the American Heart Association, I am writing to express my concern for the 1115 Demonstration Waiver for the Arkansas Works program.

The Arkansas Works program was a model healthcare program for the rest of the nation. Unfortunately, with these waivers, 60,000 people will lose their insurance. The people that will be most affected are the people that are the most in need, the sick and the working poor.

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Please reconsider this approach to Arkansas Works. Affordable, quality healthcare access is critically important to for all Arkansans. Thank you for your time and consideration.

Regards,
Sandra Davis
6 Eagle Shore Dr
Conway, AR 72032

From: Allison Hogue <allison.hogue@heart.org>
Sent: Thursday, June 15, 2017 11:14 AM
To: DHS DMS HCIW
Subject: We can do better for Arkansas!

Dear Official,

As an Arkansas resident and volunteer with the American Heart Association, I am writing to urge that the Department of Human Services oppose the 1115 Demonstration Waiver for the Arkansas Works program.

The Arkansas Works program was a model healthcare program for the rest of the nation. Unfortunately, with these waivers, 60,000 people will lose their insurance. The people that will be most affected are the people that are the most in need, the sick and the working poor.

To treat and prevent heart disease and stroke, it is important to ensure that everyone in Arkansas have access to affordable, quality healthcare. The intent of the 1115 Demonstration Wavier program is to increase access and test innovative approaches to delivering care.

This waiver request imposes multiple hurdles to an individual or family's ability to attain coverage, including:

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- Disenrolling individuals who may not be able to work, including medically frail patients, and prohibiting re-enrollment until the next year;
- Elimination of the ESI premium assistance program; and
- Elimination of retroactive eligibility for adults and medically frail patients.

Please reconsider this approach to Arkansas Works. Affordable, quality healthcare access is critically important to for all Arkansans. Thank you for your time and consideration.

Regards,
Allison Hogue
421 S Richards St
Benton, AR 72015

From: Mitra Rahmani <Mitra.Rahmani@heart.org>
Sent: Thursday, June 15, 2017 11:14 AM
To: DHS DMS HCIW
Subject: We can do better for Arkansas!

Dear Official,

As an Arkansas resident and volunteer with the American Heart Association, I am writing to express my concern for the 1115 Demonstration Waiver for the Arkansas Works program.

The Arkansas Works program was a model healthcare program for the rest of the nation. Unfortunately, with these waivers, 60,000 people will lose their insurance. The people that will be most affected are the people that are the most in need, the sick and the working poor.

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- Elimination of the ESI premium assistance program; and
- Elimination of retroactive eligibility for adults and medically frail patients.

Please reconsider this approach to Arkansas Works. Affordable, quality healthcare access is critically important to for all Arkansans. Thank you for your time and consideration.

Regards,
Mitra Rahmani
13111 W Markham St
Little Rock, AR 72211



American Cancer Society
Cancer Action Network
901 North University
Little Rock, AR 72207
501.603.5212
www.acscan.org/ar

June 15, 2017

Division of Medical Services
Program Development and Quality Services
Arkansas Department of Human Services
P. O. Box 1437 (Slot S295)
Little Rock, AR 72201

Re: Arkansas Works Section 1115 Demonstration

The American Cancer Society Cancer Action Network (ACS CAN) appreciates the opportunity to comment on Arkansas' proposed amendment to the Arkansas Works demonstration waiver. ACS CAN, the nonprofit, nonpartisan advocacy affiliate of the American Cancer Society, supports evidence-based policy and legislative solutions designed to eliminate cancer as a major health problem. As the nation's leading advocate for public policies that are helping to defeat cancer, ACS CAN ensures that cancer patients, survivors, and their families have a voice in public policy matters at all levels of government.

ACS CAN generally supports Arkansas' goal to enhance health outcomes by improving access and the quality of care provided to low-income childless adults through the Arkansas Works program, but we are concerned with many of the proposed amendments, particularly phasing out individuals in the program from 101 to 138 percent of the federal poverty level (FPL). Over 16,000 Arkansans are expected to be diagnosed with cancer this year¹ – many of whom are receiving health care coverage through the Arkansas Works program. It is imperative that low-income Arkansans continue to have access to health care coverage under the Arkansas Works and Traditional Medicaid programs. Further, specific requirements must not create barriers to care for low-income cancer patients, survivors, and those who will be diagnosed with cancer. We urge the Arkansas Department of Human Services ("the Department") to consider our recommendations to ensure that low-income Arkansans continue to have access to quality, affordable, and comprehensive health insurance.

Following are our specific recommendations on the Arkansas Works Demonstration application.

Phase-out of New Adult Group

ACS CAN is deeply concerned with Arkansas' decision to reduce eligibility and eliminate coverage for Arkansas Works enrollees with incomes between 101 to 138 percent of the federal poverty level (FPL). We are particularly concerned that individuals who are medically frail would lose access to affordable coverage as a result of this proposal.

¹ American Cancer Society. *Cancer Facts & Figures 2017*. Atlanta, GA: American Cancer Society; 2017.

Thousands of Arkansas Works enrollees have been designated as medically frail, including Arkansans who are in active cancer treatment or recent cancer survivors. Moving medically frail cancer patients out of Arkansas Works and into a qualified health plan may appear to preserve coverage, but it will result in a significant increase in out-of-pocket cost sharing - even with advance premium tax credits and cost-sharing reduction subsidies - making coverage unaffordable. Individuals enrolled in silver-level plans (even with 94 percent actuarial value and cost-sharing reductions) would be subject to \$854 annual maximum out-of-pocket spending. This would represent seven percent of total household income for an individual earning 101 percent of the FPL. When coupled with the monthly premium of \$13, an individual earning \$12,180 could face total health care expenditures above \$1,000 annually – a sizable portion of their total income.

The level of the out-of-pocket maximum would be particularly burdensome for a high-utilizer of health care services, such as an individual in active cancer treatment. That's because cancer patients in active treatment require many services shortly after diagnosis and would end up having to meet the maximum out-of-pocket required over a very short period of time. Having to pay the full cost up front would likely result in many cancer patients delaying their treatment and could result in them forgoing their treatment altogether.

We strongly urge the Department to consider maintaining eligibility for individuals earning between 101 and 138 percent of the FPL in the Medicaid program. Further, we ask the Department to consider providing medically frail individuals, including enrollees in active cancer treatment and recent cancer survivors (who require frequent follow-up care) access to health care coverage under Arkansas Works until they are no longer deemed "medically frail."

Transitioning Coverage & Continuity of Care

Cancer patients undergoing an active course of treatment for a life-threatening health condition need uninterrupted access to the providers and facilities from whom they receive treatment. Disruptions in primary cancer treatment care, as well as longer-term adjuvant therapy, such as hormone therapy, can result in negative health outcomes.

We note that the draft 1115 waiver amendment fails to provide specific provisions to ensure that individuals transitioning from Arkansas Works to QHP coverage, beginning January 1, 2018, can continue to see their health care provider if medically necessary. Failure to consider the care delivery and/or treatment regimen of patients, especially those individuals managing a complex, chronic condition like cancer, could have devastating effects on patients, their families and providers.

As the draft 1115 waiver amendment is finalized, we ask the Department to consider continuity of care provisions that would minimize disruptions in coverage and care for individuals in active treatment for life-threatening illnesses, such as cancer. We urge the state to establish a clearly defined process through which an Arkansas Works enrollee or their physician can inform the Department that they are in active treatment; allowing them to maintain their cancer care treatment regimen and continue to see their providers through the same health care systems through the end of their treatment. This will ensure that the Department's goal of "improving continuity of care across the continuum of coverage" is met.

Incentives Benefits

ACS CAN supports the state of Arkansas' goal of promoting and enhancing health outcomes through the Arkansas Works program. However, the use of punitive outcomes-based programs that penalize enrollees for failing to meet arbitrary health outcomes will not likely generate cost savings or improve the health of low-income Arkansans. **We encourage the Department, to consider implementing a comprehensive, evidence-based participatory incentive program that: provides adequate and comprehensive coverage of preventive services, including tobacco cessation, weight loss and cancer screenings and that emphasizes evidence-based interventions to educate, promote, and encourage patients to participate in prevention, early detection, and wellness programs.** Evidence shows that unhealthy behaviors can be changed or modified by modest incentives, as long as they are combined with adequate medical services and health promotion programs.²

Educating, encouraging, and raising Arkansas Works enrollees' awareness of the benefits, services, and incentive programs will significantly contribute to greater health amongst Arkansas Works enrollees. Providing enrollees educational information about incentive programs and encouraging appropriate utilization of health benefits, specifically primary and preventive care services, will help to reduce the state's cancer burden and associated costs.

Work Requirements & Lockout Period

Work Requirement

The requirement that all adults aged 19-49 must be employed or engaged in specified educational, job training, or job search activities for 80 hours per month to maintain eligibility or enrollment in Arkansas Works does not recognize the unique situation faced by patients with serious illnesses, such as cancer. Many cancer patients in active treatment are often unable to work or require significant work modifications due to multiple physical, cognitive, and psychological effects of their treatment.^{3,4,5} Including a work requirement as a condition of eligibility for coverage, could result in cancer patients being ineligible for the lifesaving cancer treatment services provided through Arkansas Works.

We appreciate the Department including exemption categories, which includes the medically frail, to protect certain populations from the work requirement and its associated lock-out period. **We ask the Department to clarify that cancer patients and recent survivors be included in the definition of medically frail.** With respect to cancer, the definition of medically frail should explicitly include

² Consensus statement of the Health Enhancement Research Organization, American College of Occupational and Environmental Medicine, American Cancer Society and American Cancer Society Cancer Action network, American Diabetes Association, and American Heart Association. Guidance for a reasonably designed, employer-sponsored wellness program using outcomes-based incentives. *JOEM*. 2012; 54(7): 889-96.

³ 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.

⁴ 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.

⁵ 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.

individuals who are currently undergoing active cancer treatment –including chemotherapy, radiation, immunotherapy, and/or related surgical procedures – as well as new cancer survivors who may need additional time following treatment to transition back into the workplace. We also request that the Department clearly define what they mean by “catastrophic event,” as far as it concerns exemption of the work requirements.

Lock-Out Period

We are deeply concerned about the proposed lock-out period for failure to meet the above work requirements for three months during a plan year. **Subjecting enrollees to the proposed lock-out without exception could place a substantial financial burden on enrollees and cause significant disruptions in care, particularly for cancer survivors (who require frequent follow-up visits) and individuals battling cancer.** During the proposed lock-out period, low-income cancer patients or survivors will likely have no access to health care coverage, making it difficult or impossible to continue treatment or pay for their maintenance medication until they can pay all outstanding premiums or the lock-out period expires. For those cancer patients who are mid-treatment, a loss of health care coverage could seriously jeopardize their chance of survival. Being denied access to one’s cancer care team could be a matter of life or death for a cancer patient and the financial toll that the lock-out would have on individuals and their families could be devastating.

In addition to including cancer patients and recent survivors in the medically frail designation, ACS CAN urges the Department to consider implementing a medical or hardship exemption, that would exclude individuals managing complex medical conditions, like cancer, from any lock-out penalties. Additionally, we encourage the Department to allow enrollees and/or their health care providers to proactively attest to any change in their health status that could qualify them for the medical or hardship exemption from the work requirement and associated lock-out period, preventing any unnecessary gaps in coverage.

Retroactive Eligibility

ACS CAN is opposed to policies – like retroactive eligibility – that create any type of time limit on Medicaid eligibility. These policies could place a substantial financial burden on enrollees and cause significant disruptions in care, particularly for individuals battling cancer. As a safety net program, Medicaid allows enrollees to receive coverage retroactively if they did not realize they were eligible for coverage under the program or while they prepare the proper documentation and application to become enrolled in the program. Many uninsured or underinsured individuals who are newly diagnosed with a chronic condition do not receive recommended services and follow-up care because of cost.⁶ In 2015, one in five uninsured adults went without care because of cost.⁷ Waiving retroactive eligibility could delay necessary care in low-income populations and negatively impact patients with complex medical conditions that require frequent follow-up and maintenance visits to help control their disease process.

⁶ 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.

⁷ The Henry J. Kaiser Family Foundation. Key facts about the uninsured population. Published September 29, 2016. Accessed May 2017. <http://kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/>.

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 and Labor Act (EMTALA) requires emergency departments (ED) to stabilize and treat individuals in their emergency room, regardless of their insurance status or ability to pay.⁸ Retroactive eligibility allows hospitals to be reimbursed if the individual treated is eligible for Arkansas Works or Traditional Medicaid coverage. Likewise, Federally Qualified Health Centers (FQHCs) offer services to all persons, regardless of that person's ability to pay or insurance status.⁹ 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' safety net when considering whether to continue with waiving retroactive eligibility in Arkansas Works and the Traditional Medicaid program.

Presumptive Eligibility Determinations

We are concerned that eliminating the presumptive eligibility for qualified hospitals could jeopardize access to stable coverage and critical care. Many low-income, uninsured or underinsured individuals – including cancer patients and survivors^{10,11} – go to the ED for their care.¹² The presumptive eligibility determination allows hospitals to assume patients are Medicaid eligible, preventing the patient from having to pay for services out-of-pocket, ensuring timely access to needed care, and allowing hospitals and providers to be reimbursed for services provided.

This proposal could negatively impact enrollment and prevent the uninsured or underinsured – who may be eligible for Medicaid but have not yet enrolled – from enrolling and participating in the program. By enrolling more of the uninsured through the presumptive eligibility determination process, hospitals are helping the state realize cost-savings by providing low-income Arkansans access to coverage that will contribute to increased utilization of low-cost primary and preventive care services. Similar to waiving the retroactive eligibility provision, waiving presumptive eligibility could negatively impact safety net hospitals that rely on presumptive eligibility determinations to be reimbursed for their services and rely less on charity care.¹³

Conclusion

⁸ Centers for Medicare & Medicaid Services. Emergency medical treatment & labor act (EMTALA). Updated March 2012. Accessed May 2017. <https://www.cms.gov/regulations-and-guidance/legislation/emtala/>.

⁹ National Association of Community Health Centers. Maine health center fact sheet. Published March 2017. Accessed May 2017. http://www.nachc.org/wp-content/uploads/2016/03/ME_17.pdf.

¹⁰ Sadik M, Ozlem K, Huseyin M, AliAyberk, Ahmet S, Ozgur O. Attributes of cancer patients admitted to the emergency department in one year. *World J Emerg Med*. 2014; 5(2):85-90.

¹¹ Zhou Y, Abel GA, Hamilton W, Pritchard-Jones K, Gross CP, Walter MF, et al. Diagnosis of cancer as an emergency: a critical review of current evidence. *Nature Reviews Clinical Oncology*. 2016; 14:45-56. doi:10.1038/nrclinonc.2016.155.

¹² National Center for Health Statistics. *Health, United States, 2015: with special feature on racial and ethnic health disparities*. Hyattsville, MD. 2016. <https://www.cdc.gov/nchs/data/hsr/hsr15.pdf>.

¹³ Brooks T. Health policy brief: hospital presumptive eligibility. *Health Affairs*. January 9, 2014. http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_106.pdf.

We appreciate the opportunity to provide comments on the Arkansas Works Demonstration Project application. The preservation of eligibility and coverage through Arkansas Works remains critically important for many low-income Arkansans who depend on the program for cancer prevention, early detection, diagnostic, and treatment services. Upon further consideration of the policies that will be included in the final waiver application, we ask the Department to weigh the impact such policies may have on 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, and we look forward to working with the Department to ensure that all Arkansans are positioned to win the fight against cancer. If you have any questions, please feel free to contact me at Michael.keck@cancer.org or 501.658.4632.

Sincerely,

A handwritten signature in black ink that reads "Michael Keck". The signature is fluid and cursive, with the first name "Michael" written in a larger, more prominent script than the last name "Keck".

Michael Keck
Arkansas Government Relations Director
American Cancer Society Cancer Action Network

June 15, 2017

Dawn Stehle, Director
Division of Medical Services
Program Development and Quality Assurance
P.O. Box 1437 (Slot S295)
Little Rock, Arkansas 72203-1437
HCIW@Arkansas.gov

RE: ARKANSAS WORKS 1115 DEMONSTRATION WAIVER AMENDED APPLICATION

Dear Director Stehle:

Thank you for the opportunity to Comment on the Arkansas Works 1115 Demonstration Waiver Application Amendment, published for comment on May 19, 2017 at medicaid.state.ar.us.

Human Arc was started in 1984 with the sole purpose of bridging the gap between available government programs and their intended beneficiaries. Human Arc has expanded over the past 33 years to help hospitals and health plans connect their patients and members to governmental programs and community services. We have helped well over a million people in unfortunate circumstances enroll in Medicaid and have helped many millions find food, clothing, shelter, prescriptions and more. Human Arc has 550+ associates serving the low-income, disabled and elderly population for customers across 40 states. We are a for-profit organization financed by the value received by our customers. **We believe our long history of working with the low income population gives our voice credibility.**

We appreciate the intention of Arkansas Works to emphasize personal responsibility, promote work, and enhance program integrity. **Our greatest concerns** with the Arkansas Works 1115 Demonstration Waiver Application Amendment are 1) the elimination of retroactive eligibility and 2) the 100 percent of the federal poverty level (including the 5 percent disregard) enrollment cap for the expansion population.

RECOMMENDATIONS

- We propose that the application process be adjusted to allow for 90-days retroactive coverage from submission of application (as it is in current law - 42 U.S.C. §1396(a)(34)), allowing for provider reimbursement during the 90-day period prior to application if an applicant has medical bills during the current month or prior period.
- We propose that the income limit be sustained at 138 percent of the federal poverty level, as required in TITLE II; Subtitle A; SEC. 2001 of the Patient Protection and Affordable Care Act to be considered Medicaid "expansion" and, therefore, eligible for enhanced federal funding.

Below is a detailed explanation supporting our recommendations.

WAIVER OF RETROACTIVE COVERAGE

The ramifications of the Arkansas Works 1115 Demonstration Waiver Application Amendment, as written, will substantially impact the low-income expansion population of the state, particularly those that are uninsured, eligible for Medicaid and in need of health care services. It will also adversely impact the medical providers trying to serve them. Gaps of time without medical coverage for the low income population that are eligible and applying for Medicaid will be significant. Every day we experience situations where uninsured individuals present at a hospital requiring emergency medical treatment and many times are unable to manage an application process due to mental health issues, lack of capability, illness and a myriad of other reasons. In many cases they are unaware of their eligibility for a Medicaid program.

Retroactive eligibility was first enacted in 1972 to protect persons who are eligible for Medicaid but do not apply for assistance until after they have received care, either because they did not know about the Medicaid eligibility requirements, or because the sudden nature of their illness prevented their applying. The provision was amended in 1973 to provide retroactive coverage for persons who died before eligibility could be claimed.¹ This is codified at 42 U.S.C. §1396(a)(34). The Social Security Program Operations Manual System (POMS) states that “Retroactivity is very important.”² Is it any less important for the Arkansas Works intended beneficiaries? We believe it is important, even critical, for all Medicaid applicants to have access to retroactive Medicaid coverage both for the reasons stated by Congress when it was legislated as well as those we have outlined below.

SUSTAINING THE 138 PERCENT INCOME LIMIT

Reducing Medicaid eligibility for the expansion population from 138 to 100 percent of the federal poverty level would make 60,000 current Arkansas Works enrollees ineligible for coverage. They would be switched instead to regular premium subsidies (and cost-sharing subsidies if they pick Silver plans) for plans purchased in the exchange,³ if they can afford them. Premium assistance and cost-sharing reductions are not guaranteed. Congress could eliminate them at anytime or the judicial system declare them unconstitutional. Coverage does not translate to care if it is unaffordable, which will prove detrimental to the state of Arkansas, medical providers and residents.

IMPACTS

The probable impacts of these changes to Arkansas consumers and medical providers are to drive up the uninsured rate, reduce the financial stability of providers, negatively impact the overall health of this population, and increase consumer debt.

The following comments and rationale will illustrate that the Arkansas Works 1115 Demonstration Waiver Application Amendment **does not meet the following criteria** used by the Center for Medicare and Medicaid Services to determine whether Medicaid program objectives are met relative eliminating retroactive coverage and implementing a 100 percent enrollment cap:

- Increase and strengthen overall coverage of low-income individuals in the state.
- Improve health outcomes for Medicaid and other low-income populations in the state.
- Increase access to, stabilize, and strengthen providers and provider networks available to serve Medicaid and low-income populations in the state.

Negative impact on the overall health of this population

The gap in coverage that will be created by the elimination of retroactive coverage could be devastating to those newly enrolled Arkansas Works recipients who received services prior to their start date. This gap could be substantial, particularly if an individual is denied, requests an appeal which is sustained and eventually overturned. The time frame for application processing could be days to weeks to months or more. Since there is not adequate coverage after a health care emergency, the likelihood of following the intended continuum of care is reduced and health outcomes will be impacted.

Patients' ability to afford medical services decreases significantly depending on how their deductible stacks up to their household income. For patients whose deductibles equalled 5 percent or more of their annual income, 40 percent said they chose not to see a physician, get a medical test or visit a specialist, according to a survey by Commonwealth Fund.⁴ Middle-income individuals appeared more likely to forgo care. This is further confirmed by a RAND study that found lower-income people more likely to defer or avoid care. The RAND study also articulated a potentially hazardous vicious circle: individuals in poorer health tend to be ordered more medical services that can result in comparatively greater financial burden, leading to noncompliance, which in turn sustains adverse health.⁵

Increased medical debt and bankruptcies

A greater number of insured patients have reported difficulty paying medical bills. Workers' wages increased 1.9 percent between April 2014 and April 2015, whereas American's out-of-pocket medical expenses jumped 9 percent from 2014-2015.⁶ Among Americans aged 65 or under who have insurance, 20 percent said they had problems paying medical bills within the past year.⁷ Collection agencies will be pursuing more people; further stressing the financial, physical and mental health of uninsured and underinsured adults.

Medical debts contribute to over half (52 percent) of debt collections actions that appear on consumer credit reports in the United States and contribute to almost half of all bankruptcies in the United States. Uninsured people are more at risk of falling into medical bankruptcy than people with insurance.⁸

Reduced financial stability of medical providers

The Affordable Care Act has lowered the uninsured rate in the U.S., but it has not relieved the financial pressure hospitals experience from providing uncompensated care.⁹ Uncompensated care is the term hospitals use to describe both bad debt, which they define as any bill not paid in full, and charity care, which is provided to uninsured low-income consumers and doesn't even get billed.¹⁰ The Arkansas Works 1115 Demonstration Waiver Application Amendment will increase this financial pressure on hospitals by increasing the number of uninsured, eliminating the medical provider's opportunity to be paid retroactively for services rendered and increasing patient liability by moving up to 60,000 Medicaid beneficiaries to a Qualified Health Plan.

Many hospitals have attributed a jump in bad debt expenses to patients' increasingly unaffordable insurance deductibles. For insured patients, management consulting firm McKinsey & Company estimated the rate of bad debt is increasing at well over 30 percent each year in some hospitals.¹¹

Hospitals and health systems used to collect a majority of healthcare reimbursements from government or commercial payers. With the rise in popularity of high-deductible plans, hospitals are interfacing more than ever with patients to collect on accounts. From 2011 to 2014, the number of consumer payments to healthcare providers increased 193 percent, according to a study from InstaMed.¹² True self-pay patients generally pay 6.06 percent on the dollar, while patients who self-pay after insurance pay 15.51 percent overall, an analysis by Crowe Horwath found.¹³

Providers must have a margin to continue providing care. The Arkansas Works 1115 Demonstration Waiver Application Amendment will not strengthen providers or their networks if they cannot pay their bills. No margin, no mission.

CONCLUSION

Human Arc believes the evidence shows that the bulk of the savings will come at the expense of the low income and uninsured expansion group. The estimated savings are really a shifting of costs to the low income, uninsured and the medical providers that serve them.

To reiterate, our greatest concerns with the Arkansas Works 1115 Demonstration Waiver Application Amendment are the **elimination of retroactive eligibility** and the **100 percent of the federal poverty level (including the 5 percent disregard) enrollment cap** for the expansion population.

We believe we have demonstrated that the waiver of retroactive coverage and enrollment cap in the Arkansas Works 1115 Demonstration Waiver Application Amendment do **not meet the criteria used by the Centers for Medicare and Medicaid Services to determine whether Medicaid program objectives are met.**

We recommend that the application process be adjusted to allow for 90-days retroactive coverage from submission of application, allowing for provider reimbursement during this same time period, and retention of the 138 percent federal poverty level for the expansion population.

We are available for consultation at your request. Thank you again for the opportunity to be heard in this Comment process.

Respectfully,

Adam Miller
Chief Executive Officer
Centauri Health Solutions, Inc.
Company
6263 North Scottsdale Road, Suite 185
Scottsdale, AZ 85250
480-418-3443 office
813-500-0379 mobile
Adam.Miller@CentauriHS.com
www.centaurihs.com

Mike Baird
Vice Chairman Advisory Board and Founder
Human Arc, a Centauri Health Solutions
1457 East 40th Street
Cleveland, OH 44103
216-426-3510 office
216-849-8493 mobile
mb@humanarc.com
www.humanarc.com

References

¹ 99 Pa. Commonwealth Ct. 345 (1986), 514 A.2d 204, William Martin, Petitioner v. Commonwealth of Pennsylvania, Department of Public Welfare, Respondent. No. 2351 C.D. 1984. Commonwealth Court of Pennsylvania. Argued March 11, 1986. July 30, 1986.

[https://scholar.google.com/scholar_case?case=8264689460606004823&q=1396a\(34\)&hl=en&as_sdt=6,36percent20-percent20r\[13\]#r\[13\]](https://scholar.google.com/scholar_case?case=8264689460606004823&q=1396a(34)&hl=en&as_sdt=6,36percent20-percent20r[13]#r[13])

² SI 01715.001 Medicaid and the Aged, Blind and Disabled C. 3., Program Operations Manual System (POMS), Social Security Administration, <https://secure.ssa.gov/poms.nsf/lnx/0501715001>

³ Arkansas and the ACA's Medicaid expansion, healthinsurance.org, Louise Norris, May 30, 2017, <https://www.healthinsurance.org/arkansas-medicaid/>

⁴ 21 statistics on high-deductible health plans, Becker's Hospital CFO Report, Brooke Murphy, May 19, 2016, <http://www.beckershospitalreview.com/finance/21-statistics-on-high-deductible-health-plans.html>

⁵ Trouble Ahead For High Deductible Health Plans?, Health Affairs Blog, Ifrad Islam, October 7, 2015, <http://healthaffairs.org/blog/2015/10/07/trouble-ahead-for-high-deductible-health-plans/>

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⁷ Ibid.

⁸ SI 01715.001 Medicaid and the Aged, Blind and Disabled C. 3., Program Operations Manual System (POMS), Social Security Administration, <https://secure.ssa.gov/poms.nsf/lnx/0501715001>

⁹ 21 statistics on high-deductible health plans, Becker's Hospital CFO Report, Brooke Murphy, May 19, 2016, <http://www.beckershospitalreview.com/finance/21-statistics-on-high-deductible-health-plans.html>

¹⁰ Feel like the hospital is shaking you down over that bill? It probably is., Modern Healthcare, Brigid Sweeney, Crain's Chicago Business, March 28, 2017, http://www.modernhealthcare.com/article/20170328/NEWS/170329910?utm_source=modernhealthcare&utm_campaign=dose&utm_medium=email&utm_content=20170328-NEWS-170329910

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¹² Ibid.

¹³ 10 things to know about healthcare collections and patient financial responsibility, Becker's Hospital CFO Report, Morgan Haefner, April 27, 2017, <http://www.beckershospitalreview.com/finance/10-things-to-know-about-healthcare-collections-and-patient-financial-responsibility-2017.html>

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™



Arkansas Chapter

#1 Children's Way, Slot 900

Little Rock, AR 72202-3510

E-mail: aimee.olinghouse@yahoo.com

Arkansas Chapter Executive Committee

President

Chad Rodgers, MD, FAAP
500 S. University Ave. #400
Little Rock, Arkansas 72705
Phone: 501.664.4044
E-mail: drchadinlr@comcast.net

Vice President

Gary Wheeler MD, MPS, FAAP
4815 W. Markham
Little Rock, Arkansas 72205
Phone: 501.661.2000
E-mail: gary.wheeler@arkansas.gov

Secretary/Treasurer

Maya Lopez, MD, FAAP
Dennis Developmental Center
1301 Wolfe Street
Little Rock, Arkansas 72202
501.364.1836
lopezmayal@uams.edu

Chapter Executive Director

Aimee S. Olinghouse

3315 Doral Drive

Little Rock, Arkansas 72212

Cell: 501.831.3057

E-mail: aimee.olinghouse@yahoo.com

June 16, 2017

Dawn Stehle, Director
Division of Medical Services
Program Development and Quality Assurance
PO Box 1437, S-295
Little Rock, AR 72203-1437

Dear Director Stehle,

The American Academy of Pediatrics (AAP) Arkansas Chapter, a nonprofit organization representing [NUMBER HERE] pediatricians from across the state, dedicated to the health, safety and well-being of all Arkansas infants, children, adolescents and young adults, thanks you for the opportunity to provide comments on the Arkansas Department of Human Services proposed amendment to Arkansas Works 1115 Demonstration Waiver.

We write to express our concerns with this proposed waiver amendment, which would make significant changes to Medicaid coverage in Arkansas and create barriers for low-income parents and their families. These changes could ultimately have a negative effect on the health and economy of our state and halt the progress we have made as in decreasing our uninsured rate. In fact, between 2013-2014, Arkansas cut its uninsured rate of non-elderly adults from 27.5% to 15.6%, the second largest decline in the country¹.

Specifically, we are concerned with the following proposed waiver provisions:

- **The work requirement for adults ages 19-49.** This provision would set a very troubling precedent for Medicaid by requiring beneficiaries between the ages of 19-49 to meet work requirements while also providing proof of meeting this requirement electronically every month or be locked out of the program until the following year. The exemption process for this requirement is also extremely onerous, in some cases requiring exempt individuals, such as those caring for a dependent child under the age of 6, to demonstrate they remain exempt every 2 months. Not allowing individuals who fail to meet the work requirement for a cumulative 3-month time period to reenroll until the following year could result in lengthy time periods without access to care or the termi-

¹ <http://www.kff.org/medicaid/issue-brief/a-look-at-the-private-option-in-arkansas/>

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Little Rock, AR 72202-3510

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Arkansas Chapter Executive Committee

President

Chad Rodgers, MD, FAAP
500 S. University Ave. #400
Little Rock, Arkansas 72705
Phone: 501.664.4044
E-mail: drchadinlr@comcast.net

Vice President

Gary Wheeler MD, MPS, FAAP
4815 W. Markham
Little Rock, Arkansas 72205
Phone: 501.661.2000
E-mail: gary.wheeler@arkansas.gov

Secretary/Treasurer

Maya Lopez, MD, FAAP
Dennis Developmental Center
1301 Wolfe Street
Little Rock, Arkansas 72202
501.364.1836
lopezmaya@uams.edu

Chapter Executive Director

Aimee S. Olinghouse

3315 Doral Drive

Little Rock, Arkansas 72212

Cell: 501.831.3057

E-mail: aimee.olinghouse@yahoo.com

nation of an existing course of needed treatment. We are concerned that Medicaid coverage could be punitively denied for those who are unable to meet this requirement.

It is unclear what this provision is attempting to achieve as 8 in 10 Medicaid eligible adults live in working families and almost 60% work themselves.² A study from 2014 showed that only 28% of employees of private firms with low average wages obtain health insurance through their jobs, and 42% are not even eligible for employer sponsored coverage,³ demonstrating that simply being employed does not guarantee these individuals will be able to obtain health insurance.

We are particularly concerned about including 19-20-year-old enrollees in this work requirement. As you know, young adults at this age are only just beginning the transition between school and work, as well as taking on multiple new responsibilities. Due to the administrative burden of the requirement to prove compliance in order to obtain health coverage additional young adults may become uninsured.

The Medicaid program was developed to provide needed coverage to low-income residents—most of whom already work—who cannot afford private insurance. A work requirement punishes those who may be facing family difficulties or otherwise unable to find employment or attend school. Adding a burdensome work requirement counters the purpose Medicaid as a health care lifeline for those most in need.

Additionally, given the excessive amount of confirmation needed to prove compliance with the work requirements, it is likely the administrative burden on the state will be increased, resulting in additional costs that could be used for patient care or system innovation. It is also unclear if all Medicaid beneficiaries in the new adult group would have access to the technology required to provide Arkansas with the needed information to confirm compliance.

- **Decreasing income eligibility from 138% to 100% of the federal poverty level (FPL).** This proposed eligibility change will result in 60,000 Arkansas residents no longer being eligible for Medicaid funded subsidies as well as the protections and wrap-around coverage they current have in their marketplace plans. The stated goal is to enroll these individuals into marketplace plans using federal premium subsidies to reduce costs. Under the Affordable Care Act (ACA), premium payments could be as much as 2%

² <http://kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work>

³ https://meps.ahrq.gov/mepsweb/survey_comp/Insurance.jsp

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Phone: 501.664.4044

E-mail: drchadinlr@comcast.net

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4815 W. Markham

Little Rock, Arkansas 72205

Phone: 501.661.2000

E-mail: gary.wheeler@arkansas.gov

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Maya Lopez, MD, FAAP

Dennis Developmental Center

1301 Wolfe Street

Little Rock, Arkansas 72202

501.364.1836

lopezmaya@uams.edu

Chapter Executive Director

Aimee S. Olinghouse

3315 Doral Drive

Little Rock, Arkansas 72212

Cell: 501.831.3057

E-mail: aimee.olinghouse@yahoo.com

of monthly income for individuals earning between 100-138% of FPL, much higher than what is currently paid each month for Medicaid. There could also be additional costs associated with marketplace plans, such as co-pays, deductibles, and prescription drug costs.

This change may leave low-income parents and other family members without the life-line of Medicaid for needed coverage. Research shows that when parents have health care coverage, they are more likely to go to the doctor, miss less work, and are better able to care for their children. Additionally, when parents have health insurance, children are more likely to be insured. Healthier families lead to healthier children.

- **Eliminating the use of Medicaid dollars to subsidize employer sponsored insurance (ESI).** The proposed waiver would also eliminate the program which provides premium assistance for Medicaid eligible adults to help them purchase ESI when available. Individuals who earn more than 100% of FPL would transition into marketplace plans and potentially receive such premium tax credits. However, under the ACA, if an individual is offered ESI that is considered "affordable" and meets a "minimum value" standard, then individuals will not be eligible for premium tax credits. For a plan to be "affordable" premiums for an individual plan cannot exceed 9.6% of household income, which is much higher than those eligible for Medicaid would be paying under the current program. Elimination of this program would likely result in many of these individuals becoming uninsured, as their ESI would be unaffordable to them.

- **The elimination of retroactive eligibility for the new adult population.** Under the waiver amendment, Medicaid coverage for this population would become effective on the first day of the month an eligible individual applies for coverage. This proposed change could put low-income individuals at risk for medical debt and increase uncompensated care costs for hospitals.

Eliminating retroactive eligibility could deter beneficiaries from seeking needed care for fear they would be responsible for medical bills they cannot afford. This can result in higher medical costs in the long-term as Medicaid beneficiaries could delay seeking care. It could also result in increased rates of uncompensated care as physicians, hospitals, and pharmacies lose money for services they have already provided. Families could be stuck with significant and unaffordable medical bills that would only make it more difficult for them to achieve financial independence, while hospitals and health systems could experience economic challenges that may threaten their existence.

This waiver adds a great deal of complexity to the Medicaid program for eligible benefi-

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Chad Rodgers, MD, FAAP

500 S. University Ave. #400

Little Rock, Arkansas 72705

Phone: 501.664.4044

E-mail: drchadnrlr@comcast.net

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Little Rock, Arkansas 72212

Cell: 501.831.3057

E-mail: aimee.olinghouse@yahoo.com

ciaries as well as the state, with new administrative costs. The excessive amount of additional reporting to the state regarding eligibility would seemingly impact the state budget as new systems are developed and staff are used to track enrollee compliance with proposed work requirements. Additionally, cutting the income eligibility limit will result in 60,000 fewer Medicaid enrollees, hurting the Arkansas' historic gains in reducing the number of uninsured.

Thank you for the opportunity to provide comments on this waiver amendment. We hope the state takes into consideration the thoughts of Arkansas's pediatricians as it considers changes to this request. If you have questions on our concerns, please contact me.

Sincerely,

A handwritten signature in cursive script that reads "Aimee Olinghouse".

Aimee Olinghouse, Executive Director

June 16, 2017

Dawn Stehle
Director
Division of Medical Services
Arkansas Department of Human Services
700 Main Street
Little Rock, AR 72201

Dear Ms. Stehle:

On behalf of the nearly 30 million Americans living with diabetes and the 86 million more with prediabetes, the American Diabetes Association (Association) provides the following comments on the Arkansas Division of Medical Services' proposed amendments to the Arkansas Works 1115 Demonstration Waiver.

Elimination of Medicaid Coverage for those Over 100% of the Federal Poverty Level (FPL)

According to the Centers for Disease Control and Prevention, over 11% of adults in Arkansas have diabetes, and more than 5% have prediabetes.¹ Access to affordable, adequate health coverage is critically important for all people with, and at risk for, diabetes. When people are not able to afford the tools and services necessary to manage their diabetes, they scale back or forego the care they need, potentially leading to costly complications and even death.

Adults with diabetes are disproportionately covered by Medicaid.² For low income individuals, access to Medicaid coverage is essential to managing their health. As a result of inconsistent access to Medicaid across the nation, these low income populations experience great disparities in access to care and health status, which is reflected in geographic, race and ethnic differences in morbidity and mortality from preventable and treatable conditions. For example, a recent study conducted in California found "amputation rates varied tenfold between the highest- and lowest-income neighborhoods in the state."³

Medicaid expansion made available through the Affordable Care Act (ACA) offers promise of significantly reducing these disparities. In Medicaid expansion states, more individuals are being screened for and diagnosed with diabetes than in states that haven't expanded.⁴ **Considering this, the Association has been a consistent supporter of Arkansas's decision to accept federal Medicaid funding to extend eligibility for the program and is opposed to the state's proposal to eliminate eligibility for individuals who earn over \$12,663 per year.** Since 2014, Arkansas had one of the largest drops in uninsurance rates



1 in 11

Americans has
diabetes today.



Every **23 seconds**,
someone in the
United States
is diagnosed
with diabetes.

More than
18,000
youth are
diagnosed with
type 1 diabetes
every year.

in the country.⁵ It would be a great disservice to Arkansas residents if the state made changes that will undo the excellent work the state has done to ensure every resident of Arkansas has access to adequate, affordable health care. A recent report from the Centers for Medicare and Medicaid Services Office of the Actuary recently estimated that of the people who may lose Medicaid eligibility as a result of an end to expansion, “a small fraction” will purchase individual market coverage, but “most” will be uninsured.⁶

While there are subsidies available in the state health insurance exchange for individuals earning 100% to 400% of the FPL, those individuals will be required to pay more out-of-pocket for their care than they may under Medicaid. Research has found low-income adults would spend six times more in out-of-pocket costs under private insurance than if they were enrolled in Medicaid.⁷ Unfortunately, the future of the cost-sharing reduction subsidies is highly uncertain, further jeopardizing the affordability of health insurance through the state exchange.

Alternative to Limiting Medicaid Eligibility

Rather than eliminating coverage for a portion of the Medicaid expansion group, the Association strongly recommends Arkansas consider the coverage of the full expansion population as an opportunity to focus on chronic disease prevention. For example, type 2 diabetes can be prevented or delayed through the National Diabetes Prevention Program (National DPP), an evidence-based lifestyle intervention program proven to have long-term impact. Research shows that even after 10 years, people who completed the program were one-third less likely to develop type 2 diabetes,⁸ providing Arkansas a long-lasting impact for their investment. According to the Centers for Disease Control and Prevention, over 1 million adults in Arkansas have prediabetes or are at risk for developing type 2 diabetes.⁹ If just 16% of those people participate in the National DPP, over 31,000 years with diabetes can be averted, saving the state of Arkansas more than \$40 million over 10 years. Focusing on the Medicaid expansion program as an opportunity to prevent future chronic illnesses will help to improve the health of Arkansans and result in long-term cost savings for the state.

Work Requirements

The Association is deeply concerned by the state’s proposal to institute work requirements as a condition of Medicaid eligibility for those ages 19 – 49. Instituting work requirements is contrary to the goal of the Medicaid program: offering health coverage to those without access to care. Most people on Medicaid who can work, do so. Nearly 8 in 10 non-disabled adults with Medicaid coverage live in working families, and nearly 60% are working themselves. Of those not working, more than one-third reported that illness or disability was the primary reason, 28% reported they were taking care of home or family, and 18% were in school.¹⁰ For people who face major obstacles to employment, harsh Medicaid requirements will not help to overcome them. In addition, research shows work requirements are not likely to have a positive impact on long-term employment.¹¹ Instead, instituting a work requirement would lead to higher uninsured rates and higher emergency room visits by uninsured

Americans who would have been eligible for Medicaid coverage, and increase the administrative burden for the state and its Medicaid managed care plans.^{12,13} **Therefore, the Association recommends the state not implement work requirements.**

Conclusion

The Association continues to support the success Arkansas has had in reducing its uninsurance rates. Scaling back Medicaid eligibility and tying eligibility to work requirements will significantly impact the advances the state has made and leave low-income adults with diabetes and prediabetes without an affordable option for health care. Therefore, we urge the state to not move forward with these proposed changes. Instead, we recommend the state explore opportunities to focus on chronic disease prevention in the Medicaid expansion program, by covering evidence-based programs like the National DPP.

Thank you for the opportunity to provide our input on the Arkansas Works 1115 Demonstration Waiver amendment. If you have any questions, please contact me at vdelagarza@diabetes.org or 512-472-9838, ext. 6017.

Sincerely,



Veronica De La Garza
Director, Arkansas Government Affairs

¹ Centers for Disease Control and Prevention, 2014 National Diabetes Statistics Report, Arkansas. Available at: <https://gis.cdc.gov/grasp/diabetes/DiabetesAtlas.html#>. Note: The CDC also reports over half of Arkansas adults have high blood glucose levels.

² Kaiser Commission on Medicaid and the Uninsured, The Role of Medicaid for People with Diabetes, November 2012. Available at http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8383_d.pdf

³ Stevens CD, Schriger DL, Raffetto B, et. al, Geographic Clustering of Diabetic Lower-Extremity Amputations in Low-Income Regions of California, 8 Health Affairs 33, August 2014

⁴ Kaufman H., Chen Z., Fonseca V. and McPhaul M., "Surge in Newly Identified Diabetes Among Medicaid Patients in 2014 Within Medicaid Expansion States Under the Affordable Care Act," Diabetes Care, March 2015, <http://care.diabetesjournals.org/content/early/2015/03/19/dc14-2334.full.pdf+html>.

⁵ Dan Winters, Kentucky, Arkansas Post Largest Drops in Uninsured Rates, Gallup-Healthways Well-Being Index, February 2017. Available at <http://www.gallup.com/poll/203501/kentucky-arkansas-post-largest-drops-uninsured-rates.aspx>.

⁶ Paul Spitalnic, Chief Actuary, Estimated Financial Effect of the "American Health Care Act of 2017," Department of Health and Human Services, Centers for Medicare and Medicaid Services, Office of the Actuary, June 2017. Available at: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/AHCA20170613.pdf>.

⁷ Leighton Ku and Matthew Broaddus, “Public and Private Insurance: Stacking Up the Costs,” Health Affairs (web exclusive), June 24, 2008, available at: <http://content.healthaffairs.org/cgi/content/abstract/hlthaff.27.4.w318> and from the authors upon request.

⁸ Diabetes Prevention Program Research Group, 10-Year Follow-Up of Diabetes Incidence and Weight Loss in the Diabetes Prevention Program Outcomes Study, Lancet, November 2009. Available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3135022/>.

⁹ CDC Diabetes Prevention Toolkit: <https://nccd.cdc.gov/Toolkit/DiabetesImpact/Dashboard>.

¹⁰ Garfield R, Rudowitz R and Damico A, Understanding the Intersection of Medicaid and Work, Kaiser Family Foundation, February 2017. Available at:

¹¹ Kaiser Family Foundation, Are Uninsured Adults Who Could Gain Medicaid Coverage Working?, February 2015, available at <http://kff.org/medicaid/fact-sheet/are-uninsured-adults-who-could-gain-medicaid-coverage-working/>.

¹² Rector R, Work Requirements in Medicaid Won’t Work. Here’s a Serious Alternative, Heritage Foundation, March 2017, available at: <http://www.heritage.org/health-care-reform/commentary/work-requirements-medicaid-wont-work-heres-serious-alternative>.

¹³ Katch H, Medicaid Work Requirements Would Limit Health Care Access Without Significantly Boosting Employment, Center on Budget and Policy Priorities, July 2016, available at: <http://www.cbpp.org/research/health/medicaid-work-requirement-would-limit-health-care-access-without-significantly>.

June 16, 2017

Dawn Stehle
Division of Medical Services
Program Development and Quality Assurance
P.O. Box 1437 (Slot S295)
Little Rock, Arkansas 72203-1437

Dear Ms. Stehle:

The American Lung Association in Arkansas appreciates the opportunity to comment on the Arkansas Works 1115 Demonstration Waiver amendment.

Arkansas Works provides a vital service to the poorest residents of Arkansas. Individuals and families depend on Arkansas Works for life-saving treatments. The policies proposed in the waiver application would be especially harmful to lung disease patients who depend on regular access to maintenance medications and patients who have limited financial ability to otherwise have quality and affordable healthcare.

The Lung Association in Arkansas wants all Arkansans to have affordable, quality healthcare, especially low-income residents that depend on Arkansas Works. We encourage you to revise the policies in the proposed waiver prior to submitting it to the Centers for Medicare and Medicaid Services (CMS).

Income Eligibility

Reducing the income eligibility from 138 percent of the federal poverty level (FPL) to 100 percent FPL will harm both Arkansans and the Arkansas Works Program.

By reducing the income eligibility from 138 percent of FPL to 100 percent of FPL will result in the loss of health coverage for many low-income people in Arkansas. According to CMS, Arkansas has enrolled over 278,000 newly eligible individuals into the Medicaid expansion program¹. These patients were likely uninsured prior to the expansion and will return to that status if the income threshold is reduced. For lung disease patients in this group, losing health coverage could have deadly consequences.

Lung disease patients need regular healthcare to breathe and live. Patients with asthma need daily maintenance medications to control their symptoms and reduce inflammation in the airways. Without proper treatment, these patients will have asthma attacks and seek treatment in the emergency department, which drives up premiums for those on private insurance. Lung cancer screenings for individuals at high risk, currently something that is covered for this Medicaid Expansion population, can catch this dread disease early, at a stage where it can be treated. Without health coverage, individuals at high risk will likely forgo this important screening, not catching diseases until it is too late for them to be treated.

¹ Total Medicaid Enrollees – VIII Break Out Report, March-2016, Updated December 2016, Reported on the CMS-64. <https://www.medicaid.gov/medicaid/program-information/downloads/cms-64-enrollment-report-jan-mar-2016.pdf>. Accessed on June 11, 2017.

The Arkansas Works program is an innovative program that has allowed low-income residents to have healthcare through the existing private insurance infrastructure. This policy proposal - reducing the income eligibility for the Arkansas Works program - will result in the loss of funding as the program will no longer qualify for the enhanced FMAP that the newly eligible population receives. Without the enhanced FMAP, the entire program could be threatened. The Lung Association in Arkansas strongly encourages Arkansas to take this proposal out of the 1115 Waiver.

Work Requirements

The proposed waiver would impose a work requirement as a condition for Arkansas Works eligibility. The proposal would require all able-bodied adults to fulfil a community engagement and work requirement in order to receive care.

A work requirement has never been allowed in Medicaid because it is contrary to the goal of the program: to offer health coverage to those without access to care. The state's proposal seeks to solve a problem that does not exist. Most people on Medicaid who can work do so, and for people who face major obstacles to employment, harsh requirements will not help to overcome them. Nearly 8 in 10 non-disabled adults with Medicaid coverage live in working families, and nearly 60 percent are working themselves. Of those not working, more than one-third reported that illness or a disability was the primary reason, 28 percent reported that they were taking care of home or family, and 18 percent were in school.²

Work requirements pose a particular challenge for lung disease patients. Patients living with lung diseases such as COPD or lung cancer often have limited lung function making it difficult to breathe. Imposing a work requirement could prevent these patients from getting the treatment they need. In addition to problems posed for patients, the onerous work requirement will also create an administrative nightmare for the agency. Having to verify enrollees work status or level of community engagement will take staff time and cost money. That money should go towards healthcare costs.

Removal of Non-Emergency Transportation Benefits

The proposed waiver would remove the non-emergency transportation benefit from Arkansas Works enrollees. This change will negatively impact lung disease patients enrolled in Arkansas Works. Non-emergency transportation benefits help patients get to appointments and get the treatments they need.

Lung disease patients often need frequent treatment and appointments with their doctors to maintain a normal life. Lung cancer patients need to get to chemotherapy infusions. Patients with asthma need to keep doctor's appointments to ensure they are on the most appropriate treatment to control the symptoms of the diseases and COPD patients need to go to pulmonary rehabilitation appointments.

Non-emergency transportation benefits allow patients to get to their appointments- keeping them healthy and preventing more expensive disease in the future. For the best health outcomes

² Rachel Garfield, Robin Rudowitz, and Anthony Damico, "Understanding the Intersection of Medicaid and Work," Kaiser Family Foundation, February 2017, <http://kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/>.

for Arkansas residents, the non-emergency transportation benefit helps ensure the appropriate treatment is received at the right time.

The American Lung Association in Arkansas encourages the state to reexamine the 1115 waiver before submitting to CMS. The Arkansas residents on Arkansas Works are disproportionately impacted by lung disease and need quality and affordable healthcare to manage their diseases. The proposed waiver as written would not allow for that.

Thank you for reviewing our comments. We appreciate the opportunity to provide feedback.

Sincerely,

A handwritten signature in black ink, reading "Ashley Lyerly". The signature is fluid and cursive, with the first name "Ashley" and last name "Lyerly" clearly distinguishable.

Ashley Lyerly
Regional Director of Public Policy
American Lung Association in Arkansas



Founded in 1977

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June 16, 2017

Dawn Stehle, Deputy Director and Medical Services Director
Arkansas Department of Human Services
P. O. Box 1437, Slot S295
Little Rock, Arkansas 72203-1437

Mrs. Stehle:

Arkansas Advocates for Children and Families (AACF) is very proud of the progress we've made in our state to ensure every Arkansan has access to health coverage. Because of the great success of the Arkansas Works program, today most adults in Arkansas have comprehensive coverage and improved access to important preventative care. Also, our state economy has benefited from better supporting local health care systems and health professionals, as well as helping to stabilize the state budget.

Moving forward, we are hopeful that state leaders will continue to prioritize keeping coverage affordable and accessible for every family in the state. There are several comments that we would like to submit as the state continues the process of making amendments to the Arkansas Works (Health Care Independence Program demonstration waiver).

Work Requirements

AACF has concerns about the proposal to implement work requirements as a condition of eligibility in the Medicaid expansion program. This policy merely adds a new condition of eligibility that will increase the rate of uninsured Arkansans, add significantly to administrative costs, and will not increase employment levels.

Work requirements are not necessary since [research shows](#) about 75 percent of uninsured adults live in a family with at least one full or part-time worker and over half of individuals work full or part-time. For those individuals not working, about 20 percent report caring for a family member, looking for work, being in school, or being ill or disabled. Medicaid can actually help people obtain and keep a job by helping them stay healthy enough to work, and the best way to encourage work is to make sure the workforce is healthy.

Also, [years of research](#) has shown that these types of work requirements are not effective and can even be counterproductive. One example is the Temporary Assistance for Needy Families (TANF) program after the 1996 welfare reform bill was enacted. Although some people did seek jobs with the help of state-sponsored training and placement programs, these jobs were often low-paying and did not lift families out of poverty long-term. This policy ignores the fact that there are other factors that help sustain long-term

employment more than work requirements, like a strong job market, access to health care, and child care grants/vouchers for working parents.

Finally, Arkansas has a recent history of significant administrative barriers in the Health Care Independence program. In fall 2015, problems with the annual renewal process resulted in many coverage terminations. This issue caused a ripple effect in the broader health care system, resulting in a backlog in traditional Medicaid and ARKids First that was just cleared at the beginning of 2017. Employment verification requirements often cause people who meet the requirements or are exempted to lose coverage and fall off due to the administrative burden and complexity. Due to the added red tape, people who met the mandate may lose coverage inadvertently, which will likely increase churning. Again, the TANF program [provides a good example](#) of notable administrative failures that resulted in recipients who are sanctioned having significantly higher rates of disability (even when exempt from the work requirements). Now that the Arkansas Works program has just reached a stable place, adding more red tape with work requirements may threaten this stability. This may also be a costly policy to implement, like the health savings accounts that were terminated due to the high costs versus minimal benefit.

Regarding the one year lock-out period for lack of compliance, this undermines the goals of the program by creating new barriers to coverage. This provision blocks those from coverage who may most need it due to financial hardship or chronic health conditions. The lock-out provision will only force people to seek care in emergency rooms at an even higher cost.

A more efficient use of funds would be investing in effective career and education programs, such as Arkansas Career Pathways, that provide the resources for individuals to receive the support they need for long-term career advancement. This program provides important resources like tuition assistance, child care, and transportation. The funds put towards setting up unnecessary work requirements could be used to improve outreach and enrollment in this program, as well as growing the program to include even more professions and education institutions

Partial Expansion Model

Today, there is not a mechanism that allows states to implement a partial expansion to 100% of the federal poverty level and still receive an enhanced FMAP for this population. The section 1115 demonstration waiver requires states to provide similar coverage and benefits, which means the state would have to demonstrate the people from 101 – 138% FPL will have comparable coverage.

Although the proposed strategy for implementing this policy involves transitioning people to a marketplace plan or employer-sponsored coverage, it falsely assumes this coverage will be affordable. These health plans may not be affordable for many people because of additional cost-sharing requirements and out-of-pocket costs from deductibles, co-pays, and prescriptions. Many enrollees at this income level are working, but are unable to afford the cost of private health coverage and extensive research shows that even small fees can be a barrier to enrolling in coverage and accessing treatment.

We also know from other states that cut Medicaid enrollment and attempted to transition enrollees to other programs that most people end up without health coverage. For example, in [Rhode Island](#), only about 30 percent of the individuals who were no longer eligible for Medicaid successfully enrolled in another health plan and paid a premium to start their coverage.

Beyond the possible challenges implementing a partial expansion, the future of the insurance marketplace is uncertain due to pending decisions at the federal level. It is possible that the structure and amount of tax credits may change, benefit packages may change, and any number of marketplace features may be different soon. This further underscores the difficulty that the state will have assisting former enrollees with a successful transition to another comparable coverage option.

Administrative Review Process

The application strikes out the administrative review process, which was established by [Social Security Act §1943](#) to promote continuity of care. These federal rules require that a beneficiary who is no longer eligible for Medicaid be checked against other eligibility categories or Marketplace coverage. The state should ensure that a process is established in adherence to this federal regulation for enrollees no longer eligible if the partial expansion policy is implemented.

90 Day Retroactive Eligibility

AACF does not support the request to waive retroactive eligibility, especially without meeting the conditions as required in the current Special Terms and Conditions. Medical emergencies are unpredictable and costly. The 90-day retroactive eligibility policy helps safeguard low-income families from incurring medical debts that they are unable to pay.

As part of the amended waiver request in 2016, Arkansas received conditional approval to eliminate retroactive eligibility for Arkansas Works enrollees contingent on the state coming into compliance with statutory and regulatory requirements related to the determination of eligibility:

- Written assurance from the state that it complies with the reasonable opportunity provisions in Section 1137(d) of the Social Security Act
- CMS receiving written assurance from the state that the state has successfully completed the Arkansas MAGI Backlog Mitigation Plan

DHS has yet to meet all the above conditions, specifically implementation of presumptive eligibility. As such, DHS should be held to these conditions and should not seek elimination of retroactive eligibility until the conditional approval requirements are met.

Presumptive Eligibility

The implementation of presumptive eligibility is even more critical if the state moves forward with the elimination of retroactive eligibility for this population. Today, physicians and hospitals are protected from hundreds of thousands of dollars in unpaid bills for treatment they have provided because of the retroactive eligibility policy. Without this policy, health providers in the state will face great financial risk unless presumptive eligibility is implemented. Health care providers need to have the option to make on-the-spot eligibility determinations to reduce their financial risk and ensure consumers in need of treatment can get immediate care and enroll in coverage. The state should move forward with the development of procedures to ensure hospitals that choose to use presumptive eligibility can take advantage of this option.

Consumer Outreach and Education

DHS should develop a detailed plan for outreach and education as a condition of implementing the requested policy changes. An important concern to acknowledge is the ongoing number of policy

changes that have occurred since the program was implemented in January 2014. The current application is now the third waiver amendment request to make even more changes to the program. Families have been forced to remain abreast of the constant changes even when those changes are poorly communicated due to a lack of outreach.

Families must have access to in-person assistance to help them navigate our complex health care system. If the goal is to successfully transition individuals to other private coverage options, they will need adequate support and guidance to research their coverage options and select a plan that meets their family's health and budget needs. Any notices that enrollees receive should provide information on how to contact the federally funded navigator agency or other community organizations that provide help with enrollment. We also know from [research and surveys](#) in Arkansas, that consumers need of health education materials that are at the appropriate reading levels and that help them understand terms like deductibles and co-pays. The state outreach plan should include plans to work with appropriate agencies to ensure these types of materials are available and accessible.

Program Evaluation

The evaluation section of the state's application should be modified to reflect additional evaluation and performance metrics based on these proposed amendments. In addition to federal waiver evaluation requirements, DHS should evaluate the impact of these changes and collect data on the number of people who became ineligible for Arkansas Works; the number of former enrollees who applied for a QHP or other coverage; the number of enrollees who successfully paid a premium and enrolled in coverage; and the number of former enrollees who did not sign up for coverage. This data should be collected and reported quarterly.

Section 1115 Demonstration Waiver Requirements

While it is important for the state to have the ability to demonstrate innovative approaches through the waiver, the 1115 waiver process should not be used to waive consumer protections that are essential to the Medicaid program. This approach gets it backwards by creating new barriers to coverage rather than achieving the statutory purpose of the Medicaid program—to *provide medical assistance to persons in need and to furnish them with rehabilitation and other services to help them attain or retain capability for independence or self-care*. Also, there is no clear hypothesis outlined for the rollback of coverage to 100% of FPL and other requested provisions. Section 1115 waivers are demonstrations and should include a clear hypothesis.

AACF is proud of the progress in Arkansas to maintain affordable coverage for uninsured adults, and we think it is vitally important to support the continuation of Arkansas Works. However, the state is continuing to make changes at the state level with uncertainty about what Congress will do to change the ACA and Medicaid program federally. Without knowing the federal guardrails, it is premature for the state to move forward with more risky changes to Arkansas Works. These hasty decisions mainly burden Arkansas families by limiting their access to much-needed health care.

We look forward to continuing to work together to ensure all children and families in Arkansas can live healthy, productive lives. Thank you for the opportunity to submit comments on the Arkansas Works demonstration waiver.

Respectfully,



Rich Huddleston
Executive Director
Arkansas Advocates for Children and Families



Marquita Little
Health Care Policy Director
Arkansas Advocates for Children and Families



Arkansas

1701 Centerview Drive, #205 | Little Rock, AR 72211
1-866-554-5379 | Fax: 501-227-7710 | TTY: 1-877-434-7598
aarp.org/ar | aarp@aar.org | twitter: @ARAARP
facebook.com/AARPArkansas

June 16, 2017

Cindy Gillespie
Director
Arkansas Department of Human Services
700 Main St.
Little Rock, Arkansas 72201

Dear Director Gillespie,

AARP is the nation's largest nonprofit, nonpartisan organization dedicated to empowering Americans 50 and older to choose how they live as they age. With nearly 38 million members and offices in every state, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands, AARP works to strengthen communities and advocate for what matters most to families with a focus on health security, financial stability and personal fulfillment. AARP Arkansas, representing over 310,000 members, is Arkansas's largest organization representing the needs, views, desires, and hopes of Arkansas's 50+ population.

We appreciate this opportunity to provide feedback on the 1115 Waiver amendment that would significantly change Arkansas Works. While we agree with the Department of Human Services' (hereinafter, the Department) overall objectives to promote the objectives of Title XIX by "increasing overall coverage of low-income individuals in the state, improving health outcomes for Medicaid and other low-income populations in the state, and increasing access to, stabilizing, and strengthening the availability of providers and provider networks to serve Medicaid and low-income individuals" of Arkansas, we believe that many of the policies proposed in the 1115 Waiver amendment would adversely impact a large number of Arkansas Works recipients. If implemented, AARP believes that this waiver would likely worsen health outcomes, create significant financial hardship for many Arkansas Works beneficiaries in need of coverage, increase administrative costs to the state, and result in increased uncompensated care costs for Arkansas's health providers.



Expansion Coverage Reduction

The Waiver amendment calls for the elimination of Medicaid coverage for covered adults between 100% and 138% of the Federal Poverty Level (FPL). This elimination of Medicaid coverage will require those who want to continue to receive health care coverage to enroll in the Arkansas qualified health plans (QHP) marketplace, which will require new premiums and copays for this low income population. This amendment to coverage could result in stressful financial decisions for individuals and families who are already having trouble making ends meet, thereby making it difficult for these “transitional” enrollees to maintain health coverage while affording other everyday essentials.

AARP is concerned that in addition to being subject to higher out-of-pocket expenditures, beneficiaries within this enrollee group are also likely to be limited to less robust healthcare coverage than is available under standard Medicaid.

The waiver amendment does not indicate whether the Department intends to seek enhanced federal matching funds for this group of beneficiaries. However, it is important to highlight that, to date, the Centers for Medicare & Medicaid Services (CMS) has required states to cover all expansion adults up to 138% FPL in order to receive enhanced federal matching funds.

Work Requirements

Arkansas’s amendment also includes a work requirement for Arkansas Works beneficiaries ages 19 to 49 (allowing for some exemptions) as a condition of eligibility. Beneficiaries who are subject to the work requirements “will be required to demonstrate electronically on a monthly basis that they are meeting them.” AARP is concerned that the waiver amendment to require work, education, job search, and volunteering would not only create Medicaid eligibility requirements beyond the program’s core focus on those “whose income and resources are insufficient to meet the costs of necessary medical services” (42 U.S.C. § 1396-1(1))”, but it would also present an unnecessary barrier to health coverage for a sector of Arkansas’s population. This includes the many individuals who have recurring periods of illness due to chronic and behavioral health conditions who may be determined not to be exempted from the work or education requirements.

Also of significant concern is the lack of detail and clarity on the process for determining how and when an Arkansas Works beneficiary will be assessed for a work or community service exemption. In addition, it will be important to specify how beneficiaries will appeal a determination, or request a new assessment if their work situation changes.

AARP welcomes the inclusion in the list of qualifying exemptions those beneficiaries “caring for an incapacitated person or a dependent child under age 6”. However, without a definition of the term “incapacitated” and without any details as to how the Department plans to assess if a person who is being cared for is incapacitated, we have concerns regarding how this exemption will be applied. We would like confirmation that beneficiaries who are family caregivers, providing critical care for their loved ones with chronic, disabling or serious health conditions will be included in this exemption.

In the event these proposed work requirements are permitted to be imposed as a condition of participation in Arkansas Works, we strongly believe it will be critical to maintain an individual's due process rights and all existing Medicaid protections. Furthermore, we seek assurances that dispute situations will be fairly and expeditiously resolved; that individuals will continue to receive adequate notice of state agency actions and a meaningful opportunity to have unfavorable administrative decisions reviewed with reasonable promptness; that coverage of care will continue pending resolution of the appeal; and that Medicaid applicants and beneficiaries will have the right to request a fair hearing on eligibility determinations and coverage issues.

We are also concerned about the requirement for reporting to be done electronically, without consideration for an individual's lack of computer or Internet access. In addition to creating a hardship for many individuals, this requirement will also saddle the state with new costs and staffing needs to develop a reporting system, verify the accuracy of member reporting, and conduct fact finding hearings. We believe that these and other related administrative actions will be costly and, unfortunately, will drain resources away from other priority initiatives.

Work Requirements Lock-Out

AARP has serious concerns with the proposal's imposition of a lock-out period until the next coverage year for beneficiaries who fail to meet the work requirement for any three-month period. We believe that lock-out periods for low-income beneficiaries with serious health needs would have particularly harsh consequences. For example, an Arkansas Works member with behavioral health needs may lose access to necessary medication. The coverage gaps created by these severe lock out periods will invariably lead to added uncompensated care costs for providers, inability of health plans to manage care over time, and poorer health outcomes for beneficiaries resulting in health conditions that will be more expensive to treat later.

Retroactive Eligibility

We urge the State to reconsider its proposal to "not provide" retroactive eligibility, as set forth under current Medicaid law. Without retroactive coverage, future Arkansas Works members could incur crippling medical debt, which would be exacerbated by their inability to take advantage of the more favorable provider reimbursement rates paid by Medicaid. In addition, lack of retroactive coverage would increase the burden of uncompensated care on providers, and could cause future members to forego needed care, resulting in higher medical costs than would otherwise have been the case had they been covered.

Presumptive Eligibility

AARP is also concerned by the proposed waiver's elimination of hospital presumptive eligibility. We believe that hospital presumptive eligibility is an important tool to help to ensure timely access to care while a final eligibility determination is being made. Indeed, presumptive eligibility may be even more important if eligibility determinations take longer due to more restrictive eligibility criteria.

Conclusion

In sum, we appreciate the opportunity to comment on this amendment, and we encourage the state to carefully reconsider these harmful provisions that will adversely affect many older Arkansans, health care providers and Arkansas's taxpayers. If you have any questions, please Ness Nehus at 501-217-1621.

Sincerely,

A handwritten signature in black ink, appearing to read "Herb", written in a cursive style.

Herb Sanderson
State Director, AARP Arkansas

cc: Ness Nehus



June 18, 2017

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

Dear Director Gillespie,

The Arkansas Department of Human Services, (DHS), Division of Medical Services (DMS) has issued public notice of its intent to submit to the Centers of Medicare and Medicaid Services (CMS) a written application to request approval from the Secretary of the Department of Health and Human Services of the Arkansas Works Waiver which is a Demonstration Waiver under Section 1115 of the Social Security Act.

On behalf of the Community Health Centers of Arkansas, Inc. (CHCA) and our 11 member community health centers (also known as FQHCs) and their over 70 locations, please accept the following comments on the Arkansas Works Proposed Section 1115 Waiver. Federally Qualified Health Centers in Arkansas provide primary and preventive care services to nearly 186,000 low income uninsured and underinsured Arkansans.

We are opposed to the significant changes included in the Department's 1115 waiver application. If these changes are approved and implemented, they will lead to such adverse consequences as: a further loss of health coverage for thousands of Arkansans in need, greater financial fragility among essential health care providers, such as FQHCs, hospitals, and nursing homes, and no marked reduction of inappropriate Emergency Department utilization, or reductions in bad debt and charity care. These policy initiatives are not in keeping with the goals of the Medicaid Program, nor the purpose and intent of the section 1115 Demonstration waivers.

Changes requested under section § 1902(a)(10)(B): To enable the State to phase out demonstration eligibility for individuals with incomes above 100 percent of the FPL, For the low-income Arkansans health centers serve, the expansion of Medicaid coverage to individuals with incomes below 138% of the Federal Poverty Level has literally been a life-saving policy change. To now bring that threshold back down to 100%, it would undo the progress made since 2014, forcing our patients into much more limited coverage or into becoming uninsured. Medicaid expansion has also allowed Arkansas health centers to bolster our capacity and to offer a more comprehensive range of services (like behavioral health and substance abuse services) to our patients. Reversing the Medicaid expansion will mean that those who lose Medicaid coverage will lose access to critical specialty care services, and increasingly will return to seeking care in emergency rooms, ultimately leading to higher costs in uncompensated care and poorer health outcomes.

§ 1902(a)(3): To enable the State to prohibit re-enrollment for the remainder of the calendar year for individuals disenrolled from coverage for failing to meet work requirements. While individuals would be able to re-enroll at Open Enrollment, this creates another obstacle for individuals simply seeking health care. While the federal subsidies will continue to ensure coverage for thousands of Arkansans, the cost of non-Medicaid plans and the loss of coverage will significantly influence the number of uninsured in Arkansas. Particularly as many would not know they have lost coverage until they go to the doctor which then will also up the cost of uncompensated

care in the hospitals. We applaud the recognition of healthy behaviors, placing an additional financial burden on this patient population, even though minor in the eyes of you and I that make well in excess of the federal poverty level, can impact access to medical care to our most vulnerable in need of medical care. When *Arkansas Works* was initially passed it featured several changes to the state's Medicaid expansion, such as: subsidizing coverage offered by an employer, making work training referrals, eliminating 90-day retroactive eligibility and increasing premiums. These changes were meant to reduce the burden of Medicaid expansion on the state's budget, while also providing Arkansans with a sustainable path out of poverty. Adding work requirements to this process will have as great an impact as expected on the working population in Arkansas.

Arkansas's health centers serve on the front lines of a changing health care system. We share your belief that our system can be improved dramatically—specifically toward becoming a more equitable, accessible and affordable one for all patients in need, while driving efficiency and promoting high-quality, high-value care. To that end, we offer the following recommendations to help guide your work on any effort to reform the health care system moving forward.

Recommendations:

1. To provide essential outreach and education services for Arkansas Work enrollees to ensure members can retain coverage and additional needed medical services.
2. To establish clear directions and guidelines for work verification for Arkansas Works enrollees.
Example: How will the State handle specific and unique issues related to the lack of available job opportunities within counties across the state of Arkansas?

Thank you for your attention to our suggestions. Should you need any clarification to any of our comments, please do not hesitate to contact Community Health Centers of Arkansas at 501.492-8384.

Sincerely,

LaShannon Spencer

LaShannon Spencer
Chief Executive Officer

From: Karen Shaw <karen@karenschawrealtor.com>
Sent: Friday, June 16, 2017 10:45 AM
To: DHS DMS HCIW
Subject: We can do better for Arkansas!

Dear Official,

As an Arkansas resident and volunteer with the American Heart Association, I am writing to express my concern for the 1115 Demonstration Waiver for the Arkansas Works program.

The Arkansas Works program was a model healthcare program for the rest of the nation. Unfortunately, with these waivers, 60,000 people will lose their insurance. The people that will be most affected are the people that are the most in need, the sick and the working poor.

To treat and prevent heart disease and stroke, it is important to ensure that everyone in Arkansas have access to affordable, quality healthcare. The intent of the 1115 Demonstration Wavier program is to increase access and test innovative approaches to delivering care.

This waiver request imposes multiple hurdles to an individual or family's ability to attain coverage, including:

- Limiting income eligibility to 100 percent of the federal poverty level (FPL), which will cut coverage for thousands of adults including those in serious need of ongoing medical care;
- Disenrolling individuals who may not be able to work, including medically frail patients, and prohibiting re-enrollment until the next year;
- Elimination of the ESI premium assistance program; and
- Elimination of retroactive eligibility for adults and medically frail patients.

Please reconsider this approach to Arkansas Works. Affordable, quality healthcare access is critically important to for all Arkansans. Thank you for your time and consideration.

Regards,
Karen Shaw
772 Whitfield Rd
Pearcy, AR 71964



June 16, 2017

Division of Medical Services
Program Development and Quality Assurance
P.O. Box 1437 (Slot S295)
Little Rock, Arkansas 72203-1437

Re: Proposal to amend the Arkansas Works 1115 Demonstration waiver

I am writing on behalf of the Center for Law and Social Policy (CLASP). CLASP is a national, nonpartisan, anti-poverty nonprofit advancing policy solutions for low-income people. We work at both the federal and state levels, supporting policy and practice that makes a difference in the lives of people living in conditions of poverty. In particular, these comments draw on CLASP's deep experience with Temporary Assistance for Needy Families (TANF) and the Supplemental Nutrition Assistance Program (SNAP), two programs where many of the policies proposed in this waiver have already been implemented – and been shown to be significant barriers to low-income people getting and retaining benefits. These comments also draw on CLASP's experience in working with six states under the Work Support Strategies project, where these states sought to dramatically improve the delivery of key work support benefits to low-income families, including health coverage, nutrition benefits, and child care subsidies through more effective, streamlined, and integrated approaches. From this work, we learned that reducing unnecessary steps in the application and renewal process both reduced burden on caseworkers and made it easier for families to access and retain the full package of supports that they need to thrive in work and school.

CLASP submits the following comments in response to the 1115 Demonstration Waiver Amendment Application and raises serious concerns about the effects of the waiver, as proposed, on the coverage and health outcomes of low-income Medicaid beneficiaries in Arkansas. This waiver takes a big step backwards in coverage and rolls back important coverage gains. What's more, while the state claims that it seeks to support low-income people in their work and education goals, this waiver proposal makes achieving these goals significantly more difficult.

Medicaid plays a critical role in supporting the health and well-being of low-income adults and children. Many work in low-wage jobs where employer sponsored health care is not offered, or is prohibitively expensive. Others may have health concerns that threaten employment stability, and without Medicaid, would be denied access to the medical supports they need to hold a job, such as access to critical medications.

Our specific comments follow.

Reduction in Eligibility

This proposal reduces Medicaid eligibility for adults—including for medically frail adults. The limit for eligibility is dropped from 133% of the federal poverty level (FPL) to 100% of the FPL. This means that all adults between 101-133% of FPL will lose their access to Medicaid. No explanation is offered for how this will promote the goals of Medicaid; rather, this is simply a shift of costs to the federal government. CLASP strongly opposes this provision, and any reduction in eligibility that will result in more people becoming uninsured or having interruptions in their continuity of care.

This eligibility reduction will result in an increase in the number of low-income individuals who churn between Medicaid, the marketplace and being uninsured. This will have negative health consequences, as changes in coverage often require changes in health care providers, and can lead to interruptions in treatment. In one recent study, even among those who churned with no gap in coverage, 29 percent reported a decrease in their overall quality of care as a result of the transition.¹ This is particularly harmful for those with significant health conditions.

Changes in employment, income and family structure all impact churn. Low-income individuals are more at risk of churning from one type of coverage to another² because low-wage work is increasingly variable in hours and/or seasonal.³ The Affordable Care Act deliberately created an overlap between the eligibility levels for Medicaid and the premium subsidy tax credits in order to reduce the need for consumers to frequently switch between coverage under Medicaid and the Marketplace

As discussed below, the likelihood of people churning on and off coverage is increased by the burdensome administrative requirements included in this proposal. Even people who continue to be eligible will fall through the cracks as the paperwork burden increases.

Work Requirements and Lockout Periods on Medicaid Eligibility

CLASP strongly opposes the work requirements and lock out periods proposed in this waiver amendment that would apply to all adults age 19-49 on ArkansasWorks. This is proposed without any evidence of a problem that this is intended to solve; rather, this proposal is based on a false assumption that people do not wish to work and need to be incentivized to do so. (There is also no basis offered for the arbitrary age limits proposed for this policy.)

We strongly oppose the lock-out periods from Medicaid for recipients who fail to meet the work requirement for three months—consecutive or non-consecutive. These lock-out periods are inconsistent with the goals of Medicaid because they would act as a barrier to access to health insurance, particularly for those with chronic conditions and disabilities, but also for those in areas of high unemployment, or who work the variable and unpredictable hours characteristic of many low-wage jobs. The extremely complex documentation requirements mean that many people who should be exempt --or who are actually working or participating in a qualifying activity -- will be cut off and will have no way to regain health insurance until the following year.

In addition, while the purported goal of this provision is to promote work, the reality is that the proposal makes no commitment to providing work activities to participants. In fact, denying

access to health care makes it less likely that people will be healthy enough to work. This provision would also increase administrative costs of the Medicaid program and reduce the use of preventative and early treatment services, ultimately driving up the costs of care while also leading to worse health outcomes.

The proposal to implement time limits on non-working recipients is based on a false assumption that people do not wish to work and need to be incentivized to do so. A recent Kaiser Family Foundation study found that the overwhelming majority of non-working Medicaid recipients were ill or disabled, attending school, caring for other, or seeking work.⁴ Many Medicaid beneficiaries work, but for low-wage workers, employer-sponsored insurance is often either not offered or is prohibitively expensive. Even if unemployed Medicaid recipients obtain jobs, they are highly likely to continue to need health coverage through Medicaid.

A recent Kaiser Family Foundation (KFF) study found that 35 percent of unemployed adults receiving Medicaid—but who are not receiving Disability/SSI benefits—reported illness or disability as their primary reason for not working.⁵ People with chronic conditions that impact their ability to work but do not qualify them for disability benefits will be at high risk of losing access to care. Chronic conditions are, by definition, not time-limited and often impact individuals for extended periods. While the proposal states that the work requirement will not apply to beneficiaries who are physically or mentally unable to work, the evidence from other programs with similar requirements is that in spite of official exemptions, in practice, individuals with disabilities are often not exempted and are more likely to lose benefits.

For example, even though individuals who were unable to work should have been exempted, one study from Franklin County, OH, found that one third of the individuals referred to a SNAP employment program in order to keep their benefits reported a physical or mental limitation, 25% of whom indicated that the condition limited their daily activities. Additionally, nearly 20% of the individuals had applied for SSI or SSDI within the previous 2 years.⁶

Similarly, repeated studies of TANF programs have found that clients with physical and mental health issues are disproportionately likely to be sanctioned for not completing the work requirements.⁷ Such clients may not understand what is required of them, or may find it difficult to complete paperwork or travel to appointments to be assessed for exemptions. Precisely those who need health care the most will struggle to meet the requirement that exemptions for short-term incapacities and for caregivers be renewed every two months. Simply the burden of understanding the requirements and documenting their exemption is likely to be a challenge to people struggling with an overload of demands on their time and executive functioning capacities. In a survey of Indiana enrollees who failed to pay the required premium, more than half reported confusion about either the payment process or the plan as the primary reason, and another 13 percent indicated that they forgot.⁸ These beneficiaries are highly likely to be locked out of coverage, with severe consequences for their health.

This provision may also affect many people who work, but do not consistently meet the 80 hours of work threshold. Workers in low-wage jobs experience significant fluctuations in number of hours and timing of shifts from week to week.⁹ Many workers are assigned to “call-in shifts”, providing no guarantee of work, but preventing them from scheduling other work or activities.¹⁰

The two industries with the largest numbers of employees covered through Medicaid are restaurant and food services and construction,¹¹ both industries well known for their variable and seasonal hours of employment. Individuals with variable hours of employment may also lose coverage and be locked out if they fail to keep up with the requirement to document their hours of employment.¹² While workers receiving unemployment benefits are not subject to the work requirements, less than 30 percent of unemployed workers in Arkansas receive unemployment insurance.¹³

Access to Medicaid supports work

There is no evidence offered that the threat of Medicaid lock-outs would promote work. Arkansas makes no commitment to provide employment services to beneficiaries subject to the work requirement. In the most recent year for which data are available, less than 2,000 people in the entire state participated in Department of Workforce Services training programs.¹⁴ Providers of welfare-to-work services often report that sanctions or penalties that continue for a fixed period of time make it *harder* to reengage participants, because they cannot lift the sanction by coming into compliance. Many beneficiaries will not understand the new rules until they have already been locked out of coverage.

In fact, because providing access to coverage is an important way to support work, this proposal would likely reduce employment outcomes. A recent report from Ohio found that providing access to affordable health care through Medicaid helps enrollees to seek and maintain employment. More than half of Ohio Medicaid expansion enrollees report that their health coverage has made it easier to continue working, and three-quarters of unemployed Medicaid expansion enrollees looking for work reported that their health coverage made it easier to seek employment.¹⁵ Without the support of Medicaid, health concerns would threaten employment stability.

Time limits would lead to worse health outcomes, higher costs

During the lock-out period, beneficiaries will likely be uninsured. Needed medical services and prescription drugs, including those needed to maintain positive health outcomes, may be deferred or skipped. For a beneficiary who gets “locked-out” in the first quarter of the year, they may be uninsured for as long as 9 months, during which time they will go without needed care. Because people without health coverage are less likely to have regular care, they are more likely to be hospitalized for avoidable health problems and to experience declines in their overall health.¹⁶ And during the lock-out period, these now-uninsured patients present as uncompensated care to emergency departments, with high levels of need and cost—stretching already overburdened hospitals and clinics.

The impact of even short-term gaps in health insurance coverage has been well documented. In a 2003 analysis, researchers from the Urban Institute found that people who are uninsured for less than 6 months are less likely to have a usual source of care that is not an emergency room, more likely to lack confidence in their ability to get care and more likely to have unmet medical or prescription drug needs.¹⁷ A 2006 analysis of Medicaid enrollees in Oregon found that those who lost Medicaid coverage but experienced a coverage gap of fewer than 10 months were less likely to have a primary care visit and more likely to report unmet health care needs and medical debt when compared with those continuously insured.¹⁸

The consequences of disruptions in coverage are even more concerning for consumers with high health needs. A 2008 analysis of Medicaid enrollees in California found that interruptions in Medicaid coverage were associated with a higher risk of hospitalization for conditions such as heart failure, diabetes, and chronic obstructive disorders. In addition to the poorer health outcomes for patients, these avoidable hospitalizations are also costly for the state.¹⁹ Similarly, a separate 2008 study of Medicaid enrollees with diabetes who experienced disruptions in coverage found that the per member per month cost following reenrollment after a coverage gap rose by an average of \$239, and enrollees were more likely to incur inpatient and emergency room expenses following reenrollment compared to the period of time before the enrollee lost coverage.²⁰

When beneficiaries re-enroll in Medicaid after the lock-out period, they will be sicker and have higher health care needs. Studies repeatedly show that the uninsured are less likely than the insured to get preventive care and services for major chronic conditions.²¹ Public programs will end up spending more to bring these beneficiaries back to health.

Monthly determinations and lock-out periods add complexity and administrative costs

Tracking exemptions and participation for every beneficiary would significantly add complexity and cost to the administration of the Medicaid program. Arkansas would need to develop a whole new system to track months, send notices to clients, and determine whether a beneficiary qualified for an exemption that month.

One of the key lessons of the Work Support Strategies initiative is that every time that a client needs to bring in a verification or report a change adds to the administrative burden on caseworkers and increases the likelihood that clients will lose benefits due to failure to meet one of the requirements. In many cases, clients remain eligible and will reapply, which is costly to families who lose benefits as well as to the agencies that have to process additional applications. The WSS states found that that reducing administrative redundancies and barriers used workers' time more efficiently and also helped with federal timeliness requirements.

An administrator in Idaho reported that unnecessary reevaluations resulted in wasting caseworkers' time and confusion for families. A Colorado WSS team member reflecting on their former processes noted "it was crazy-making for us... it was a constant workload for all of us". Adding new complicated requirements to Medicaid eligibility, including determining exemptions and tracking the hours of work, which often vary from month to month, would be a major step in the wrong direction.

Eliminate Retroactive Eligibility

The proposed waiver would eliminate retroactive eligibility prior to the first day of the month that the application is. This will present a major burden to providers and emergency rooms, who will shoulder the burden of uncompensated care for beneficiaries who do not get retroactive eligibility. For example, if a patient presents to the emergency room on the 30th of a month and is found eligible for Medicaid on the 2nd of the following month at discharge, the patient's Medicaid coverage will begin the 1st day of the month—and the entire burden of the emergency room visit will be uncompensated care for the hospital.

Thank you for your consideration of these comments.

If you have any questions, please contact Elizabeth Lower-Basch at elowerbasch@clasp.org or (202) 906-8013.

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¹² Liz Ben-Ishai, "Volatile Job Schedules and Access to Public Benefits," CLASP, September 2015, <http://www.clasp.org/resources-and-publications/publication-1/2015.09.16-Scheduling-Volatility-and-Benefits-FINAL.pdf>.

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¹⁸ Matthew J. Carlson, Jennifer DeVoe, and Bill J. Wright, "Short-Term Impacts of Coverage Loss in a Medicaid Population: Early Results From a Prospective Cohort Study of the Oregon Health Plan," Annals of Family Medicine, 2006, <http://www.annfammed.org/content/4/5/391.short>.

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June 18, 2017

TOLL FREE
1-800-967-9224

TELEPHONE
1-870-972-9224

HELPLINE
1-800-952-9243

www.arlegalaid.org

Arkansas Children's Hospital
1 Children's Way, Slot 695
Little Rock, AR 72202-3500
501-978-6479 – Fax

Harrison
205 W. Stephenson
Harrison, AR 72601
870-741-4255 – Fax

Helena-West Helena
622 Pecan, Stes. 208 & 209
Helena, AR 72342
870-338-9834 – Fax

Jonesboro
714 South Main Street
Jonesboro, AR 72401
870-910-5562 – Fax

Newport
202 Walnut Street
Newport, AR 72112
870-523-9892 – Fax

Springdale
1200 Henryetta
Springdale, AR 72762
479-751-0002 – Fax

West Memphis
310 Mid Continent Plaza
Suite 420
West Memphis, AR 72301
870-732-6373 – Fax

Division of Medical Services
Program Development and Quality Assurance
P.O. Box 1437, Slot S295
Little Rock, AR 72203-1437

Re: Comments on Arkansas Works 1115 Waiver Demonstration

Legal Aid of Arkansas is a nonprofit law firm that represents impoverished Arkansans in civil legal matters. Our mission is to improve the lives of low-income Arkansans by ensuring equal access to justice, regardless of economic or social circumstances. Our clients are residents of thirty-one counties and, with some limited exceptions, have incomes below 125% of the federal poverty level.

Health-related legal issues are one of the many challenges confronting our clients. Clients may face struggles accessing Medicaid or Medicare, securing needed services under either program, or dealing with collection efforts by hospitals or providers who have not been properly reimbursed. Through advocacy and education, we seek to maximize the health and financial stability of our clients. In addition, Legal Aid hosted certified in-person assisters from 2013 to 2016 to facilitate enrollment in Medicaid expansion and insurance through the federally facilitated marketplace. Through these years of on-the-ground enrollment work, we know that hurdles already exist to accessing meaningful care, and we understand how the modifications sought in the proposed 1115 Waiver Amendment would exacerbate those existing hurdles.

We offer these comments to help the Department of Human Services understand the negative impact its proposed modifications will have on our clients.

1. Lowering the income threshold to 100% of the federal poverty level will disproportionately negatively affect working families

Lowering the Arkansas Works income eligibility limit from 138% of the federal poverty level to 100% will cause losses in coverage, despite availability of coverage from the federally facilitated marketplace (healthcare.gov). This change in coverage will cause premium increases for thousands, but will have the most severe consequences for working families. The coverage offered to qualifying beneficiaries at 100% and 101% of the federal poverty level will not be comparable, as mere access could be cost-prohibitive for those at 101% of the poverty level using federally facilitated marketplace or employer-sponsored coverage.



Employer-Sponsored Coverage

Under 26 CFR § 1.36B-2, individuals who have an offer of affordable employer-sponsored coverage that meets the Affordable Care Act's minimum essential coverage and minimum value standards is not eligible for an Advance Premium Tax Credit through the Federal Marketplace. The Affordable Care Act sets specific standards for affordability, minimum essential coverage, and minimum value and penalizes large employers whose sponsored plans do not meet these standards. The current affordability standard for 2017 is 9.69% of household income for the employee-only plan.¹ Therefore, employer-sponsored coverage is considered affordable if the employee-only premiums cost less than 9.69% of total household income. It should be noted that the expected family contributed increases slightly each year, as it was initially 9.56% for plan year 2014.² For a household of four earning \$24,324 per year (101% of the federal poverty level for 2017), they are expected to spend \$2,357 per year or \$196 per month for health insurance for one person. Under the current Arkansas Works plan, that same family would pay a maximum of \$228 per year or \$19 per month for one person. This will cause a tenfold premium increase for working low-income Arkansans.

The Family Glitch Expands

This issue is compounded by a component of the Affordable Care Act known as the family glitch.³ The family glitch is a gap in coverage that spouses and dependents of low-income workers often fall into, and will expand to catch more Arkansans when the income eligibility limit is lowered to 100%. The Affordable Care Act employer coverage mandate requires affordable coverage that meets the minimum value and minimum essential coverage standards for employees, or certain employers may face a penalty. These cost controls only apply to employee-offered coverage, not spouse and dependent coverage. Likewise, the affordability standard built into the Affordable Care Act looks at the cost of *employee-only* coverage as compared to *household* income. If the coverage is affordable for the employee only and is offered to the rest of the household, then that household is ineligible for Advance Premium Tax Credits. We have seen some Legal Aid of Arkansas clients who are expected to pay ten times the cost of employee-only coverage for their children and spouses.

Health care will become inaccessible for the spouses and children of low-income working Arkansans, potentially creating an incentive to work less than full time so as not to be eligible for medical benefits. A low-income working Arkansan with multiple part time jobs earning the same amount as someone with a single full time job will be eligible for more affordable care, either through Arkansas Works or the federally facilitated marketplace.

The only relief for these families is in the form of a potential exemption from the Individual Shared Responsibility Payment. The employee's family members are eligible for an exemption if their annual premiums for the lowest cost family plan is more than 8.16% of their household income. Relief from the Individual Shared Responsibility Payment is not the same thing as access to coverage, which these working families currently have with the income limit set at 138%.

Cost-sharing Reductions Are Not Available for Employer-Sponsored Coverage

The future of cost-sharing reductions is uncertain,⁴ but while in effect they have been a powerful measure to increase access to comprehensive health care for low-income Arkansans. Federally facilitated

¹ See <https://www.healthcare.gov/glossary/affordable-coverage/>.

² See IRS guidance 2014-37 available at <https://www.irs.gov/pub/irs-drop/rp-14-37.pdf>.

³ See generally http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=129; <https://www.centerforhealthjournalism.org/2016/04/27/family-trapped-aca-glaring-family-glitch-life-gets-harder>.

⁴ See generally <http://healthaffairs.org/blog/2017/02/21/parties-ask-court-to-keep-cost-sharing-reduction-payment-litigation-on-hold/>; <http://www.kff.org/health-reform/issue-brief/the-effects-of-ending-the-affordable-care-acts-cost-sharing-reduction-payments/>.

marketplace enrollees with incomes up to 250% of the federal poverty level are eligible for a sliding scale cost-sharing benefit if they select a silver level plan. The cost-sharing reduction will lower premiums, co-pays, and deductibles for those who select it. For an enrollee at 101% of the poverty level, premiums are capped at and the actuarial value of the plan increases to 94%, as opposed to the standard 70% of a silver level plan.⁵ Lowering the income eligibility limit to 100% from 138% will deny low-income working families access to this extra assistance accessing care, as this is another benefit they are excluded from due to their offer of more costly employer-sponsored coverage.

Transitioning to Marketplace Coverage and Administrative Review

Current law requires the state Medicaid agency to assess beneficiaries for all programs for which they may be eligible.⁶ However, we have not seen any of our clients who are denied or terminated from Medicaid based on income or immigration status have their applications timely referred to the federally facilitated marketplace for Advance Premium Tax Credit assistance review. The state agency will be responsible for moving tens of thousands of program enrollees from Arkansas Works to federally facilitated marketplace coverage.

To smooth this transition process with minimal gaps in coverage—beyond the initial transition, and as people continue to move out of Arkansas Works based on elevated income—the state agency must develop a more effective process for moving between the two programs. With the Marketplace’s current policy of coverage start dates the following month (or month after that, if the application is submitted after the 15th day of the month) gaps in coverage are inevitable. Likewise, moving from coverage through the federally facilitated marketplace to Arkansas Works results in gaps in coverage, previously addressed by eligibility for retroactive coverage. The retroactive coverage element of the proposed waiver is discussed in more detail below. One possible solution to these lapse periods is presumptive eligibility, also addressed in more detail below.

The stated purpose in the waiver of moving these individuals to the federally facilitated marketplace is to “at least [double] the size of the population enrolling in QHPs offered through the Marketplace” thereby driving “structural health care system reform and more competitive premium pricing.”⁷ If every current Arkansas Works beneficiary above 100% were to be terminated and told to transition into marketplace coverage, there would be significant losses from employer sponsored coverage, lack of affordability, and added administrative hurdles like delays in obtaining coverage, enrollment limited to Special Enrollment Periods, and the requirement of out-of-pocket advance payments.

This transition is likely to be further disrupted by the proposed elimination of the administrative review process mandated by the Social Security Act. The proposed waiver eliminates the administrative review process whereby the state Medicaid agency is obligated to review beneficiaries who are being terminated from or denied coverage for other Medicaid programs for which they may be eligible. This appears at first glance to be in violation of the Social Security Act because no other measures for smoothing transition between programs is provided.⁸

The proposed waiver claims that lowering the income limit to 100% of the federal poverty level will help address the frequency with which program beneficiaries move between eligibility for state Medicaid and federally facilitated marketplace coverage with subsidies.⁹ This is not a true problem that exists under the

⁵ See generally <http://www.healthreformbeyondthebasics.org/cost-sharing-charges-in-marketplace-health-insurance-plans-part-2/>.

⁶ See Arkansas Medical Services Policy Manual Sec. C-140, available at

<https://ardhs.sharepointsite.net/DHSPolicy/DCOPublishedPolicy/Section%20C-100%20Application%20Process.pdf>. See also Social Security Act § 1943, 42 CFR 435.1200.

⁷ See 1115 Demonstration Waiver, Sec. II, Pg. 7.

⁸ See Social Security Act § 1943, 42 CFR 435.1200.

⁹ See 1115 Demonstration Waiver, Sec. II, Pg. 7.

current system, at least not when eligibility is properly assessed by both entities. The state Medicaid agency and federal marketplace do utilize slightly different methods of the modified adjusted gross income measure because the marketplace looks at annual income, whereas the state Medicaid agency looks at one month slices. However, when applications of both assessment measures would create different outcomes—or someone who moved back and forth between Medicaid and federal marketplace coverage—the marketplace measure trumps. There is only one correct answer for which program an individual is eligible for each year. Further, simply lowering the income limit would not address this if it were truly a problem.

Beneficiaries at 100% and 101% will not see comparable pricing in the plans available to them. Arkansas Works has no copays for beneficiaries below 100% of the poverty level and no deductibles for any program beneficiaries. A beneficiary at 101% of the poverty level enrolling in a silver level marketplace plan with cost-sharing reductions—again, their future is uncertain—would still have \$10 copays, 6% coinsurance obligation, a \$100 after deductible admission fee for inpatient hospital services.¹⁰

Medicaid applicants and beneficiaries are legally entitled to prompt action on their applications, and a minimized burden in obtaining or renewing eligibility for benefits.¹¹ Instead of minimizing that burden, these additional administrative hurdles increase it. Transitioning between programs is inherently disruptive to delivery of services, especially where there exists no planned mechanism to smooth that transition. This sort of disruption is a stated goal that the proposed waiver hopes to avoid, but will actually facilitate.

2. Work Requirement

The state's expressed goal in creating a work requirement is to create household independence and stability through employment. Legal Aid of Arkansas supports this goal of household financial stability through employment, but access to affordable health care is an important element of being able to find stable employment. Untreated medical ailments and disabilities can hinder one's ability to obtain and maintain employment and the medical needs must be addressed first, not after employment is secured—if it can be secured at all with untreated medical conditions.

Effects on Legal Aid of Arkansas Clients

One client's scenario who benefitted from the Health Care Independence Program illustrates this point perfectly. Prior to Medicaid Expansion, she worked part-time as a Certified Nursing Assistant, but she had a chronic shoulder condition that limited her ability to provide caregiving services more than 10 to 20 hours per week. The lifting, pushing, pulling, and other physically-demanding tasks simply rendered her unable to work more and threatened her continued employability. One severe injury, and she would not have been able to work at all. Once she had access to insurance through the HCIP, she was able to obtain treatment for her shoulder and, ultimately, increase her working hours. Unfortunately, under the proposed work requirements, this client and others in similar situations would not be able to obtain insurance in the first place. The requirement for 80 hours of monthly employment or job search activities will exclude individuals like this client who are partially employable but struggle due to chronic health conditions.

Also, the work requirements are likely to disproportionately affect rural communities struggling with higher than average unemployment and poverty rates. Even if the state unemployment rate is low for the moment, several Ozark and Delta counties still face unemployment well above the state's overall rate.¹² Individuals in these counties do not have ready access to stable, formal employment that would meet the work requirements. Also, should the downward trend in unemployment reverse, historical data shows that these

¹⁰ See <http://www.healthreformbeyondthebasics.org/cost-sharing-charges-in-marketplace-health-insurance-plans-part-2/>

¹¹ 42 CFR § 435.1200(a)(3)(i).

¹² <http://www.discover.arkansas.gov/Employment/Unemployment-Rate-Rankings-by-Arkansas-County>

counties are often the hardest hit. Perversely, the work requirements may strike hardest where the need is highest.

Lockout Periods and Prior Notice

When the state of Arkansas implemented its work requirement for Able Bodied Adults Without Dependents in the Supplemental Nutrition Assistance Program on January 1, 2016 it did not make clear to all program beneficiaries that this policy was taking effect or what the long-term consequences would be. In March of 2016, many former SNAP beneficiaries came to Legal Aid of Arkansas without any understanding of why the benefits had terminated, or how long they would be penalized for using benefits for that three month period. They did not know that they could only receive SNAP benefits for three months every thirty-six months unless they met the work requirement or an exemption from it.

If the state Medicaid agency's waiver request is granted and work requirements are implemented, the state agency must be abundantly clear in informing program beneficiaries and potential beneficiaries about the work requirement, exemptions from the requirement, the lockout period, and their appeal rights regarding all of the above. These notices must be much clearer and provided much sooner than they were for the SNAP program. Without the ability to plan ahead regarding their SNAP benefits, Arkansans could go hungry. Without the ability to plan ahead regarding their medical care, they could suffer severe medical and financial hardships or death.

Brevity of Exemption Periods

The brevity of the exemption periods will create an administrative hurdle to accessing and maintaining care. For example, a program beneficiary who is the primary caregiver for an incapacitated person or a child under six years old is exempt, but must recertify that exemption every two months. Comparatively, the Supplemental Nutrition Assistance Program (SNAP)—which has similar work requirements and exemptions—will allow for six or twelve month certification periods for individuals in similar situations. Often clients will come to Legal Aid of Arkansas because their SNAP benefits terminated due to administrative filing failures. Either they did not receive their recertification forms, or said forms were not processed timely and they have to restart the application process. Under the proposed changes in this program, that same individual could be locked out for the remainder of the benefit year because they have not proven their eligibility for the exemption.

Legality of Work Requirements

Finally, work requirements are an illegal condition of eligibility unsupported by federal law. Medicaid is a medical assistance program. States do not have flexibility here, even in the context of a Section 1115 waiver. As you know, Section 1115 waivers require a demonstration that will test a novel hypothesis. Work requirements involve no hypothesis, only additional obstacles to eligibility. Even federal approval of the 1115 waiver is no guarantee that work requirements are lawful.

3. Elimination of 90 Day Retroactive Eligibility

One of the most common initial points of service for new Arkansas Works applicants is the emergency room. One of the goals of the Affordable Care Act was to bring an end to the uninsured using the emergency room as their primary care physician and going there for non-emergency matters. This is occurring with far less frequency since Arkansas expanded Medicaid, but uninsured Arkansans still utilize emergency room both for emergency and non-emergency services. While there, a financial counselor will usually help the patient apply for Arkansas Works. Through retroactive eligibility, this arrangement is beneficial to both the patient and the health care facility. Arkansas saw a 55% drop in uncompensated care after the Medicaid expansion was

implemented.¹³ A large chunk of this substantial drop could be lost if retroactive eligibility is no longer available to program beneficiaries.

When the Medicaid backlog was at its most severe, we had many clients come to Legal Aid of Arkansas whose applications had been delayed because there were several different ones on file from several different emergency room visits. Because of retroactive eligibility, all of those past emergency room visits were covered once his Medicaid application was finally approved. If a patient presents at the emergency on the last day of the month and his or her medical needs are so severe that an application cannot feasibly be completed, then that person and the hospital are both left with uncompensated care, and the high cost of legal debt collection measures to collect on the bill. Retroactive eligibility exists to provide security when emergencies happen. Eliminating that protective measure will deny program beneficiaries and medical providers security that they both desire.

Presumptive Eligibility

Presumptive eligibility is a positive step towards addressing the problems arising from eliminating retroactive eligibility, but to our knowledge no concrete plans have been taken to implement that policy. Once a potential beneficiary has submitted an application, he or she may not know whether they have been approved for up to 45 days. Presumptive eligibility will help that person make important care decisions while their application is processed, and start to access prescription drugs immediately. Provided the presumptive eligibility screening process is thorough, the margin of error should be slight. As hospitals will be performing the bulk of presumptive eligibility assessments, their vested interest in getting paid for care rendered will motivate accurate accounting.

Eliminating retroactive eligibility without putting presumptive eligibility assessment into place would be highly detrimental for program beneficiaries who make their initial application while getting medical care at a hospital.

Applicability to Medically Frail Populations

The waiver specifically excludes the medically frail population from the work requirements in recognition of their limited or nonexistent ability to satisfy that requirement. This indicates that this group is treated in a similar manner to traditional Medicaid populations. However, they are not exempted from the elimination of retroactive eligibility. The medically frail population is, as discussed above, the one most in need of the medical and financial security that comes with the availability of retroactive coverage.

4. The Department is unlikely to be able to meet the administrative burden.

The modifications sought by the Department impose untold administrative burdens that, based on past performance, the Department will be unable to meet.

Historical context is useful here. First, the Department required two years to address a backlog in Medicaid applications. At one point, at least 35,000 Arkansans had been waiting over 45 days for an eligibility determination, with many of those who came to Legal Aid having waited three to six months. Second, snafus upon first year of renewals forced the Department to send out multiple notices with conflicting information and delay renewals by several months. Third, even after some individuals in the eligibility backlog were approved, “technical glitches” prevented their Medicaid from reading as active to providers. Thus, they were denied treatment while DHS attempted to sort out the problem, rendering the eligibility approval less timely and meaningful. Fourth, even recently, DHS has seen a trend of SSI-related Medicaid beneficiaries being terminated

¹³ <http://www.kff.org/medicaid/issue-brief/a-look-at-the-private-option-in-arkansas/>

from eligibility at the end of each month through technical glitches, only to be reinstated weeks later after manual investigation by DHS workers.

These illustrations are not academic. Legal Aid clients, including pregnant women, were denied needed medical treatment. Many have been harassed or sued by debt collectors because providers are unwilling to wait several months for DHS to render the eligibility determination and produce an active Medicaid number that is not subject to glitches. The lawsuits have resulted in judgments and garnishments of working people for services that should have been covered by Medicaid.

The disruptions to Medicaid beneficiaries with long-standing eligibility have been particularly hard on people with mental health conditions. One Legal Aid client had been released from an involuntary hospitalization, had received some medications to treat his schizophrenia, and then had his Medicaid suddenly de-activated due to a glitch. The mental health clinic could offer samples of a different medication for a short while, but, before Medicaid was restored, the client de-compensated and was re-hospitalized.

The work requirements and reductions in eligibility to 100% FPL will exponentially augment situations of shifting eligibility status. People may be eligible for three months without working, then go to work for four months and maintain eligibility, then face a layoff or cut in hours that drops them below the 80-hour threshold and renders them ineligible for one month. Or, clients near 100% FPL may gain or lose a family member and his/her income, may get a few extra hours one week, or have some other change that will bump them from 95% FPL to 105% FPL with all the attendant implications for eligibility and transition.

As mentioned above, DHS has an obligation under federal law to evaluate individuals terminated from Medicaid in one category for eligibility in other categories. Legal Aid has no evidence that DHS has been fulfilling this obligation. The additional shifts engendered by the modifications sought by DHS will only widen the gulf between what DHS is obligated by law to do and what it actually does.

Additional burdens on DHS will include county workers, already under-resources, who are forced to review work-requirement compliance reporting, field more questions from confused clients, and otherwise deal with problems relating to shifting eligibility.

Furthermore, clients will be burdened with increased reporting requirements, guaranteeing that some people will be terminated not due to substantive ineligibility but due to lost or overlooked or unreceived paperwork. Thus, people who qualify will be denied benefits, a development that should concern DHS. And, of course, some clients will altogether fail to secure insurance for some months when terminated from Medicaid, either because they do not know they need independent insurance or have little help accessing it. This will result in coverage gaps that could lead to thousands of dollars in liability for uncovered services.

The increases in shifting eligibility status will also likely be burdensome to the insurers, who will have to parse through increasingly complex periods of eligibility and ineligibility. It will also disrupt the patient-doctor relationships, both in terms of an individual's ability to access care and in terms of possible antagonism between providers' billing departments and patients regarding insurance status and bills.

In light of these administrative burdens, it is hard to see what the state gains by imposing work requirements and lower eligibility caps that will only make an already-complex program even more complex.

Sincerely,

Casey Trzcinski Sherman, Attorney
Legal Aid of Arkansas

1200 Henryetta St.
Springdale, AR 72762

Kevin De Liban, Attorney
Legal Aid of Arkansas
310 Mid-Continent Plaza, Suite 420
West Memphis, AR 72301



Dawn Stehle, Deputy Director for Health and Medicaid
Division of Medical Services
Program Development and Quality Assurance
P.O. Box 1437 (Slot S295)
Little Rock, Arkansas 72203-1437

June 16, 2017

Dear Director Stehle:

NAMI Arkansas appreciates this opportunity to submit comments on the state's proposal to amend the Arkansas Works 1115 Demonstration Waiver. NAMI (the National Alliance on Mental Illness) is the nation's largest grassroots mental health organization providing advocacy, education, support and public awareness. NAMI Arkansas is the state affiliate of NAMI and supports nine local support groups. Together, our mission is to improve the quality of life of people affected by mental illness and to promote recovery.

NAMI Arkansas applauds the state for its commitment to Medicaid expansion. Since the program's implementation, thousands of Arkansans with mental illness have gained access to mental health coverage for the first time. Access to coverage and care is essential to improve functioning, to address extremely challenging symptoms and to stabilize the condition of individuals with mental illness.

While we appreciate the state's commitment to this program, we are concerned that the Arkansas Works proposal makes significant changes to the Medicaid expansion program that causes people with mental illness to lose health coverage and prevents people from getting the care they need. In the proposal, restricting the eligibility to 100% of the federal poverty level (FPL) and the mandated work requirements are of particular concern.

Restricting Coverage to 100% of the FPL

The Arkansas Works proposal restricts program eligibility to individuals and families living at or below 100% of the FPL (including the 5 percent income disregard required for the purposes of determining

income eligibility based on modified adjusted gross income (MAGI) standards). Currently, the program is open to people at or below 138% of the FPL.

Medicaid expansion has been an unqualified success in Arkansas, providing coverage for nearly 300,000 people,ⁱ and dramatically reducing the state's uninsured rate.ⁱⁱ The state estimates that nearly 20% of the Medicaid expansion population in Arkansas is above 100% of the FPL,ⁱⁱⁱ meaning that under the Arkansas Works proposal, nearly 60,000 Arkansans will be at risk of losing Medicaid coverage.

Medicaid provides effective, cost-efficient coverage for people living with mental illness. It opens doors to treatment that keeps people healthy, giving them the opportunity to succeed at work, at school and in the community. By promoting mental health screening, early diagnosis and intervention, Medicaid connects people to care and improves outcomes. Medicaid also covers a variety of research-based intensive services that can save lives and money by keeping people with mental illness out of the hospital, out of jail, and off the street. Nearly one third of the Medicaid expansion population has a mental health or substance use condition and relies on this coverage for treatment and services.^{iv}

NAMI Arkansas urges the state not to pursue its request to restrict the expansion population to 100% of the FPL. While we recognize that people above 100% of the FPL will have options to enroll in private coverage, we also remain concerned about the dramatic cost increases they may encounter. This is especially troubling for people with mental illness, whose out-of-pocket medical costs are typically much higher than for their counterparts.^v In the face of high costs, people with mental illness may be forced to delay or forego care entirely. As noted throughout these comments, comprehensive, consistent mental health care is critical to keep people healthy and promote recovery. Arkansas should maintain Medicaid expansion for people up to 138% of the poverty level, providing access to affordable care.

Work Requirements

The Arkansas Works proposal requires adults between the ages of 19 and 49 to work, attend school or job training, or engage in work-search activities at least 80 hours a month to retain Medicaid eligibility. NAMI Arkansas is concerned that the implementation of mandatory work requirements could cause substantial numbers of people with mental illness to lose health coverage, making it difficult to access mental health care. Instead of mandatory work requirements, NAMI Arkansas urges the state to invest in voluntary, evidence-based supported employment options. We also request that mental illness be added to the list of exemptions for the Arkansas Works Program.^{vi}

Mandatory work requirements should not be included in the Arkansas Works program.

Studies of work requirements in other public benefit programs show that participants faced significant barriers in finding and maintaining employment. Work requirements did not lead to long-term, stable employment and the number of participants living in deep poverty increased.^{vii}

Mental Illnesses such as schizophrenia, bipolar disorder and major depression are chronic conditions with symptoms that fluctuate over time in severity and functional impact. People vary significantly in their capacity to work and the number of hours they are capable of working. Moreover, because of difficulties accessing appropriate care, Medicaid recipients with mental illness may have been out of the workforce for many years, thereby making it more difficult to find and secure employment.

NAMI Arkansas appreciates the state's interest in facilitating employment for people enrolled in the Arkansas Works program. However, mandating work as a condition of participation threatens to do more harm than good. Denying healthcare coverage to a vulnerable population is likely to drive up state costs. People who are dropped from Arkansas Works for failing to secure employment will likely wait to seek care until their conditions are more serious and costly to treat. Without Medicaid coverage, more individuals will experience crises, leading to greater strain on emergency rooms, law enforcement and other systems that disproportionately bear the burden of responding to people in psychiatric crisis.

Implementing and monitoring work requirements is also costly and time-consuming for the state. Determining and tracking exemptions is administratively complex and would create barriers to care.^{viii} Moreover, work requirements will likely accelerate the rate of people cycling on and off Arkansas Works, significantly increasing overall administrative costs. Rather than spending scarce public resources on the high cost of implementing and enforcing mandatory work requirements, NAMI Arkansas urges the state to invest in more cost-effective and less harmful alternatives.

People with mental illness should be added to the Arkansas Works Program Exemptions

Medicaid is the single largest payer of mental health services and supports in the United States. Medicaid coverage provides access to lifesaving treatment including medication, therapy and supports that address serious symptoms associated with mental illness.

Cutting people with mental illness from Medicaid would place unthinkable strain on individuals, families and communities. Such a move would significantly drive up state and local costs in uncompensated emergency and hospital care, criminal justice response, homeless services and more. This would destabilize individuals and lead to unnecessary crises in the lives of people with mental illness and their families. Suicide is at a crisis level and 30-year high^{ix} and research shows that 90% of those that die by suicide have a diagnosable mental illness.^x

NAMI Arkansas therefore urges the state to add people with mental illness to the Arkansas Works Program Exemptions just as it did for the population of people living with substance use disorders. Both populations have experienced well documented crises with major challenges in accessing care, disruptions and delays in care, and costly consequences. Moreover, there is a tremendous overlap between mental illness and substance use disorders, with more than 50% of adults with substance use disorders also experiencing a co-occurring mental illness.^{xi}

Expand investment in research based supported employment programs that help people with mental illness return to work as a cost-effective alternative to mandatory work requirements.

While the clear majority of people with mental illness want to work, many face barriers in finding and keeping employment. People with mental illness are unemployed and underemployed at rates far higher than their peers.^{xii} The good news is that well-researched, evidence-based supported employment programs have been developed that have proven effective for people with mental illness.^{xiii} Yet only a fraction of people with mental illness have access to these programs.^{xiv}

Rather than imposing mandatory work requirements, NAMI Arkansas urges the state to dedicate resources to programs that support long-term employment for people living with mental illness. In the long run, investing in these evidence-based practices will be a far more successful strategy for achieving

employment and independence than arbitrarily cutting people from Medicaid benefits at a time when they need them the most.

Once again, NAMI Arkansas thanks the Division of Medical Services and the Department of Human Services for the opportunity to share our thoughts and concerns about the Arkansas Works 1115 Waiver Demonstration Proposal. We look forward to working with you to ensure that people with serious mental illness get the care they need to lead full and productive lives.

Sincerely,



Kim Arnold
Executive Director
NAMI Arkansas

ⁱ Kaiser Family Foundation, *Fact Sheet: Medicaid in Arkansas*, <http://files.kff.org/attachment/fact-sheet-medicaid-state-AR> (January 2017).

ⁱⁱ Benjamin D. Sommers et al., *Both The 'Private Option' And Traditional Medicaid Expansions Improved Access To Care For Low-Income Adults* 35 *Health Affairs* 96, 96-115 (2016), available at <http://content.healthaffairs.org/content/35/1/96.abstract>.

ⁱⁱⁱ Office of the Governor, *Governor Hutchinson to Seek Changes to Arkansas Works Waiver, Legislation Needed* <http://governor.arkansas.gov/press-releases/detail/governor-hutchinson-to-seek-changes-to-arkansas-works-waiver-legislation-ne> (March 6, 2017).

^{iv} Mir M. Ali et al., Substance Abuse and Mental Health Services Administration, State Participation in the Medicaid Expansion Provision of the Affordable Care Act: Implications for Uninsured Individuals with a Behavioral Health Condition, https://www.samhsa.gov/data/sites/default/files/report_2073/ShortReport-2073.html (November 18, 2015).

^v National Alliance on Mental Illness, *Out-of-Network, Out-of-Pocket, Out-of-Options: The Unfulfilled Promise of Parity*, <https://www.nami.org/About-NAMI/Publications-Reports/Public-Policy-Reports/Out-of-Network-Out-of-Pocket-Out-of-Options-The> (2016).

^{vi} We recognize that Arkansas' plan includes an exemption for individuals who are deemed medically frail. However, we know that identifying these individuals is administratively complex. In addition, diagnosis, prevention and early-intervention for mental health conditions requires that people have access to health coverage well before they would be deemed medically frail.

^{vii} LaDonna Pavetti, Center for Budget and Policy Priorities, *Work Requirements Don't Cut Poverty Evidence Shows*, <http://www.cbpp.org/research/poverty-and-inequality/work-requirements-dont-cut-poverty-evidence-shows> (June 2016).

^{viii} Jane Perkins, Mara Youdelman & Ian McDonald, National Health Law Program, *Work Requirements: Not a Healthy Choice*, http://www.healthlaw.org/publications/browse-all-publications/medicaid-work-requirements-not-a-healthy-choice#.WPUhO_krLcs (March 21, 2017).

^{ix} Information retrieved from the Centers for Disease Control and Prevention: <https://www.cdc.gov/nchs/products/databriefs/db241.htm>

^x U.S. Department of Health and Human Services. (1999). *Mental Health: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institute of Mental Health.

^{xi} Sarah L. Hadden et al., Substance Abuse and Mental Health Services Administration, *Results from the 2014 National Survey on Drug Use and Health: Mental Health Findings*, <https://www.samhsa.gov/data/sites/default/files/NSDUH-FRR1-2014/NSDUH-FRR1-2014.pdf> (September 2015).

^{xii} Alison Luciano & Ellen Meara, *The Employment Status of People with Mental Illness: National survey data from 2009 and 2010*. 65 *Psychiatric Services* 1201,1201-1209 (2014), available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4182106/>.

^{xiii} Examples of successful evidence-based programs include IPS Supported Employment (which places people with mental illness in competitive jobs in the community) and the comprehensive service array in First Episode Psychosis programs (FEP) that includes supported employment. Both these interventions have been shown to improve the employment outcomes of people with mental illness at rates far higher than the national average.

^{xiv} NAMI, *The Road to Recovery: Employment and Mental Illness*, <https://www.nami.org/About-NAMI/Publications-Reports/Public-Policy-Reports/RoadtoRecovery.pdf> (2014)