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June 17, 2016

Dawn Stehle, Division of Medical Services Director
Arkansas Department of Human Services
P. O. Box 1437, Slot S295
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Ms. Stehle:

Arkansas Advocates for Children and Families (AACF) applauds the work to continue the Medicaid expansion program in Arkansas. Because of the great success of the Private Option, Arkansas leads the nation in reducing the number of uninsured adults. Over 250,000 low-income Arkansans now have comprehensive health coverage, many for the first time. Moving forward, the transition to Arkansas Works will safeguard access to coverage for hundreds of thousands of hard-working families.

AACF also appreciates the thoughtful process that allowed stakeholders to have an active voice in shaping the program and offering Governor Hutchinson and legislators important feedback through the Health Reform Legislative Task Force. This demonstrates the commitment from leaders in our state to ensure all Arkansans, including the most vulnerable, have access to care regardless of their income and also a commitment to transparency and public engagement.

There are several concerns that we would like to highlight as the state moves forward with the implementation of Arkansas Works.

Employer Sponsored Insurance (ESI)

Our key concern regarding introducing subsidized ESI as a feature of the Arkansas Works program is the need for careful coordination to ensure the program is easy for enrollees to understand, navigate, and access their full benefits package. Many of the individuals enrolling in ESI have previously had to make contributions through an Independence Account. DHS should ensure these individuals are appropriately informed about changes to their coverage and counseled about how to pay the monthly premium, access doctors in the network, and other key changes. We learned a great deal about the importance of a simple and well-coordinated process from the complicated and costly implementation of the Independence Accounts. Both the necessary resources and time must be allocated to develop the needed IT platform and a coordinated system. For example, DHS should also explore solutions that will not require enrollees to carry two cards, both the ESI card and Arkansas Works

card, to avoid any confusion for providers and enrollees. This approach may be the best option today to ensure wraparound benefits are accessible, but DHS should consider the possibility of rolling out a single card with a special designation for Arkansas Works enrollees in the future.

We also are very concerned about the ability for beneficiaries to access benefits and cost-sharing protections provided as a wraparound to their ESI coverage. We appreciate the state's commitment to ensuring that benefit and cost-sharing protections are made available to beneficiaries. However, research has shown that there are reasons to be concerned about the implementation of premium assistance programs that wrap around employer-sponsored coverage. In particular we wish to clarify that all providers in the employer's network, regardless of whether they participate in the Medicaid program, will be required to charge Medicaid's lower cost-sharing levels and educated on the need to do so. This is important since Medicaid consistently offers enrollees more affordable coverage than ESI.

In addition, accessing services that may not be available under ESI may prove challenging for beneficiaries. Again, it is important to ensure that an ESI participant is not required to go to a Medicaid participating provider for a covered service and that providers who have not previously worked with Medicaid will understand that wraparound services are available and how to bill using a patient's client identification number.

DHS should also articulate how transitions will be managed if an enrollee becomes unemployed and is no longer qualified to be covered by ESI. This will require a seamless transition to a QHP to ensure there are no gaps in coverage.

The state should not seek a waiver to avoid providing non-emergency transportation to enrollees covered through ESI. Research shows that lack of transportation reduces utilization of health care services among low-income people. While many families may rely on alternative methods, like public transportation for their routine travel to and from work, their access to transportation to doctor's appointments may still be limited. In addition, in most parts of the state, public transit is not even available. Non-emergency transportation is a critical benefit that can help to prevent chronic conditions, such as diabetes and cardiovascular disease, from worsening.

The waiver indicates ESI sponsored coverage may be expanded to spouses or dependents of Medicaid-eligible individuals in the future. We strongly recommend DHS maintain the current ARKids First program because it's working for kids and families. The ARKids First program has been hugely successful in reducing rates of uninsured children in our state to under 5 percent and ensuring they receive comprehensive, affordable coverage. We have serious concerns about the likelihood of successfully providing the EPSDT benefit for kids through an ESI wraparound. There is no clear rationale for disrupting coverage for kids. Unless it can be demonstrated that this would be a cost-effective option that does not reduce access to coverage or care, the ARKids program should continue to function as it does today.

90 Day Retroactive Eligibility

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. Health care providers and the state also benefit from retroactive eligibility. Doctors and clinics are not left with unpaid bills for treatment they've provided, and the state has been able to reduce uncompensated care spending. Though the proposal to eliminate retroactive eligibility would create similar enrollment processes for Arkansas Works and insurance carriers, the financial risk of removing retroactive coverage outweighs any potential benefit. It is even more critical because of significant delays families currently experience between the time they complete the application and are successfully enrolled in a health plan. Finally, 90-day retroactive eligibility is essential, since the state has not implemented presumptive eligibility, which would allow individuals in need of care to enroll quickly and avoid the administrative delays that plague our system today.

Premiums for Enrollees

Although the state currently requires some enrollees to make payments to an Independence Account, the proposal to establish fixed monthly contributions (up to $19) would function like premiums. Federal regulations prohibit premiums for individuals earning less than 150% FPL. Also, extensive research shows that even small fees can be a barrier to enrolling in coverage and accessing treatment. Furthermore, enrollees will incur a debt to the state if the premiums are not paid. While this is an improvement from more dangerous proposals to lock individuals out of coverage, it will still create a hardship for many low-income families and depress enrollment.

In addition to the concerns raised above, AACF is proud of the steps our state has taken to continue to improve the health of enrollees. Offering incentive benefits to encourage enrollees to receive preventative care is an important feature of Arkansas Works. With adequate coordination and consumer outreach and education, this is a promising policy to support the health and well-being of Arkansans. We would also strongly encourage the state to engage AACF and organizations with expertise in health literacy to assist with the development and review of enrollee notices and educational materials. Consumer education will be critical to the successful implementation of these policy changes.

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 successful implementation of Arkansas Works.

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.

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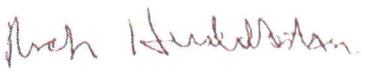
Respectfully,



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Comments and Suggestions on Arkansas Works 1115 Waiver Extension Application

Introduction

As a committed partner to the success of Arkansas Works, Arkansas Blue Cross Blue Shield (ABCBS) appreciates the continued national leadership and extraordinary effort by DHS to design Arkansas Works as described in the waiver extension application. We recognize that the extension application conforms to the CMS requirements for renewal and is not intended to address many of the operational details that will be important to a successful implementation. However, given the importance of this application document and CMS' consideration of this request, we have included several specific program comments and suggestions that we believe are relevant to both this immediate discussion and the long term program planning. We hope these comments will be helpful as you continue to develop Arkansas Works, and are happy to answer any questions you may have. ABCBS appreciates the opportunity to provide this input and we look forward to collaborating with you and other stakeholders in the coming months to continue the success of this important health care program for Arkansans.

As a Private Option/Arkansas Works participating QHP, a significant small employer health insurance plan and fellow Arkansans committed to the health, economy and citizens in our state, we offer the following comments and suggestions for your consideration.

Improve Enrollment Transitions and Participant Understanding

Challenges with churning are not unique to Arkansas; virtually every Medicaid program in the country has struggled with this problem, and we appreciate the efforts and interest DHS has demonstrated in identifying ways to minimize transitions between health plans, and the continued focus on this issue by including churning in the proposed Arkansas Works evaluation strategy. The success of the HCIP demonstrates how important these new health care options have been for improving access to health care, and we want to do everything possible to support continued success under Arkansas Works.

While we realize some level of churn is inevitable, we believe development of a comprehensive enrollee communication and education campaign and easy-to-understand enrollment materials will be critical to ensure a smooth transition. In addition to the assistance ABCBS and other QHPs can provide, Arkansas is fortunate to have many experienced insurance agents, advocacy representatives, and providers who work with the customers who will participate in Arkansas Works, and can provide valuable assistance with development and distribution of educational materials to ensure Arkansans have access to the information they need. ABCBS is eager to provide our help with this initiative, as well as several other suggestions provided below that we hope will be useful as DHS considers opportunities to minimize churning.

Comments

Like other public plans and as demonstrated in HCIP, Arkansas Works enrollees will continue to experience change that occurs due to income fluctuations as individuals change jobs, experience reductions or increases in hours and pay, seasonal shifts in work, changes in household arrangements and financial support, and other personal circumstances that lead to shifts in coverage, all of which contribute to the current churn between Medicaid, HCIP, and subsidized QHP coverage. With the Arkansas Works premium payment requirements and the new ESI premium subsidy program intially focused on the small group market, additional churn may occur as follows:

- Although we realize that individuals will not be dis-enrolled for non-payment of premiums, some individuals may be confused by the implications of non-payment or "past due notices" and may not complete the reapplication process based on the belief they are no longer eligible for the program. Others could discontinue using their plan if they think coverage is no longer effective. This could be particularly problematic in the small group ESI market as individuals with chronic conditions might not receive treatment they still have access to, resulting in more missed work due to health issues. An effective communication plan will be critical to ensure enrollees understand their coverage has not changed and continue to see their PCP and use their health benefits.
- Some families covered by Arkansas Works will have a mix of coverage types with inconsistent enrollment periods and varying re-determination dates. A family that shares identical qualifying income information could have children in traditional Medicaid, one adult in an Arkansas Works QHP and another in an ESI premium assistance plan. The complexity of navigating these programs and the renewal requirements will be challenging for many and is likely to contribute to temporary episodes of uninsurance as individuals do not understand the varying re-enrollment requirements or fail to meet deadlines for completing the process for three separate programs.

Suggestions

While churning between health plans cannot be entirely eliminated, minimizing the occurrence and the consequences of churning is important to maintain continued coverage and health care, and reduce costs for both the State and QHPs. While the initial structure of the program places specific boundaries around what is acceptable ESI coverage, this will become a more significant issue as Arkansas Works expands beyond the small group market into large group and self-funded group health plans. As both an Arkansas Works participating QHP and a small employer benefit plan for employers who are likely to choose to participate in the new ESI program, we offer the following suggestions for your consideration:

- Work with health plans, the Third Party Administrator (TPA), insurance agents and other stakeholders to develop the State's waiver evaluation strategy related to eligibility information, enrollment communications, and measuring the occurrence and impact of churn on enrollees, DHS, and QHPs and small employer health plans. Include an evaluation of the process, enrollee touchpoints, and administrative costs associated with premium and cost sharing processing, incentives reward tracking and reporting, reconciliation tracking and reporting, and other costs identified by the strategy team. Based on findings, develop targeted strategies to address contributing factors that can be controlled or minimized.
- For individuals enrolled in a QHP who subsequently have access to ESI, allow them to remain in the QHP until the annual re-enrollment period occurs. This will improve the continuity of care by

providing enrollees an adequate time period for the transition, and will reduce costs associated with enrollment changes.

- For families with members in multiple programs (including Medicaid, Arkansas Works and/or ESI premium subsidies), coordinate re-eligibility determinations to create one single renewal period for all family members. While this will require some additional effort by DHS, the long term benefits of improving the process for enrollees, reducing lapses of coverage, and reducing DHS and QHP administrative costs associated with multiple renewals and churn should be worth the effort. Agents can play a valuable role in the area.
- Ensure any premium past-due notifications sent by Arkansas Works or QHPs **clearly state** the individual will not lose coverage and should continue to use his/her health plan benefits. Studies have shown that consumer behavior is driven by people's perceptions of costs and penalties, whether accurate or not[1]. While we do not want to minimize the importance of premium payments and the personal responsibility it encourages, we also want to ensure individuals do not mistakenly believe they have lost coverage or fail to complete re-eligibility forms based on the perception they no longer qualify for coverage, which defeats the entire purpose of Arkansas Works.
- Work with QHPs, the TPA, small groups and agents to track administrative activity and costs associated with transitioning members between the various programs. Based on findings, consider continuous process improvements and enhanced administrative efficiencies to improve enrollment transitions between programs.
- Conduct periodic but regularly scheduled focus groups, stakeholder meetings and/or surveys of individuals who have experienced churn to identify contributing factors and potential solutions.
- Create a working group with QHPs, ESI health plans representatives, insurance agents, small employers and stakeholders to assist DHS in the development of a comprehensive Outreach and Education Program targeted to specific groups, such as employers, employees, agents, current HCIP enrollees and the general public. Use the work group to also identify opportunities to reduce churn and increase ESI uptake.
- Work with QHPs, small employer health insurers, providers and stakeholders to develop a policy to minimize disruptions of care and allow continuity of care for enrollees transitioning from one plan to another.

Eligibility and Enrollment Processes

Enrollment Requirements and Restrictions

Comments

As operational requirements are developed, we encourage DHS to address reconciliation of Arkansas Works enrollment periods and waiting periods under ESI with the requirement to effectuate coverage of new Arkansas Works enrollees beginning on the first day of the month in which a member applies for coverage. Include consideration that most small businesses have under ACA a a waiting period that cannot exceed 90 days from date of employment before an employee is eligible for enrollment. A typical small group employer will have a 60 day waiting period for full time new hires.

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[1] Short PF, K Swartz, N Uberoi, and D Graefe. 2011. Realizing Health Reform's Potential: Maintaining Coverage, Affordability, and Shared Responsibility When Income and Employment Change. New York: The Commonwealth Fund.

Suggestions

- Consider if DHS will ask employers and small employer health insurers to disregard the waiting period for enrollment in the ESI for Arkansas Works enrollees. If so, applicable Arkansas Insurance Department regulations may need to be amended.
- If not, DHS could temporarily enroll individuals in fee-for-service Medicaid, or allow the individual to select a QHP. If this is the approach, we again note this practice would contribute to the enrollment transition process previously discussed.

Enrollment of New Small Employers in ESI Premium Assistance

Comments

On page 10, Section II 1. *Implementing a Premium Assistance Program for ESI*, the extension application explains that "In the first year of ESI premium assistance," eligible small employers interested in participating in the ESI premium assistance program will notify the State that their plan meets cost-effectiveness criteria (i.e., the employer covers at least 25% of the premiums) and opt in to participate in the ESI premium assistance program. The State then matches individuals who are eligible for Arkansas Works against a list of participating ESI employers. However, the extension application does not indicate if employers can apply at **any time** during the first year to become participating ESI employers, or if their enrollment is limited to a specific time frame prior to the beginning of the ESI program.

Suggestions

Depending on the answer to this question, the following may apply:

- If an employer is allowed to join at any time, we suggest DHS consider allowing employees who are already enrolled in an Arkansas Works QHP to remain in their QHP until their next re-enrollment date, rather than requiring the individual to switch to the newly available ESI plan immediately.

Employer Disenrollment or Cancellation of Coverage

Comments and Suggestions

We encourage DHS to consider the following plan administration scenarios; we will be happy to collaborate on decisions that are appropriate for an ESI market:

- Once enrolled in the ESI program, can an employer voluntarily withdraw from participation in the ESI premium assistance program? If so, are there any limitations or restrictions?
- If an **employer** fails to remit timely premiums to the insurance carrier, and the policy is cancelled, will the employees participating in ESI automatically be transitioned to the standard Arkansas Works, or with they have to re-apply for Arkansas Works? For purposes of the **incentive benefit**, will employees be penalized for failure of the **employer** to timely remit premium payments?

Enrollee and Employer Education

Comments

As discussed above, implementation of a comprehensive employee and employer education program will be critical to ensure the success of the ESI premium assistance program and minimize the potential for disruptions in benefits. Education materials will have to be developed that meet the needs of both current HCIP enrollees who must understand how their coverage is changing under ESI, as well as new enrollees who have no experience with HCIP or Arkansas Works and may have never had a health insurance plan. Employers and agents will expect a simple, easy and responsive open enrollment and ongoing benefit administration process.

Suggestions

We encourage DHS to consider the following plan administration scenarios and will be glad to work with you to provide additional information on options that are appropriate for an ESI market.

- Enrollees may not be aware of or understand the requirement to present two separate insurance cards when obtaining health services, which will create administrative challenges for providers, enrollees and health plans. In some cases (especially for new patients), providers may refuse to provide services without both cards, delaying enrollees' access to necessary care. In addition to a clear, simple communication program specifically targeted to ESI enrollees, also include a provider education and communications program that instructs them how to handle situations where an enrollee doesn't present both cards. For example, encourage providers to copy both cards during the patient's initial visit so the information is available if the enrollee forgets a card in the future. Provider education will be especially important since some providers in an employer health plan network may not be Medicaid providers.
- Enrollees and the provider community may not understand the concept of "wrap benefits" and may not be aware of services covered under the Arkansas Works ESI plan if they are relying solely on the summary of benefits provided by their employer health plan. Conveying this information in a simple, easy to understand explanation will be critical to ensuring members and providers are aware of the full scope of benefits available to them under Arkansas Works – ESI benefits.
- Enrollees who are transitioning from HCIP to ESI under Arkansas Works may have other family members who will continue to be covered under their current Arkansas Works QHP. These enrollees will need to understand that the change to ESI only impacts their health coverage; other family members will not be affected by the change, and should continue seeing their existing health care providers.
- To assist enrollees transitioning from HCIP to ESI, we recommend developing targeted information materials to help them understand the differences in their new coverage and provide a simple Q&A for questions they are likely to have. The materials should address such things as differences in provider networks, any differences in benefits, and the availability of wrap services. Enrollees will also need access to customer support services from both DHS and the ESI plan support staff who are trained to address the questions individuals will have. These changes can be challenging for individuals who have limited experience with the health care system, particularly those with chronic conditions or individuals who are currently involved in a care plan for a serious illness.
- New education materials and an outreach strategy should also be developed for small business owners. As a small employer health benefit plan provider in Arkansas, ABCBS has extensive

experience working with small businesses owners throughout the state. The majority of these owners wear many hats as small employers, and are usually overwhelmed by the complexities of purchasing a group health benefit plan. We have learned that those who offer insurance do so because they care about their employees and want to do "the right thing," but require a great deal of assistance when selecting a health plan. The added complexity of understanding the implications of the premium assistance plan will require additional time with each small employer, and development of financial proposals tailored to each individual business' individual circumstances. Additionally, we anticipate that most employers will want assistance with explaining the ESI premium assistance to employees they believe may be eligible.

Because of the relationship they have with small employers and their experience working with employee benefit plans, insurance agents bring a valuable perspective to this process and should be included as partners working with DHS, QHPs and the TPA to ensure a coordinated strategy for educating and working with employers and employees.

To facilitate employers' understanding of the program and ensure a consistent, uniform messaging strategy throughout the state, we offer our services to DHS to assist in the development of employer and employee educational materials to ensure the information is clear, written in easily understood terms, and comprehensive in the explanation of how the program works. We have a highly trained, experienced group of agents who specialize in working with small business owners and urge DHS to use our expertise to develop user-friendly materials that sufficiently address the many questions employers and employees will have. Doing so will significantly reduce the volume of questions posed to DHS staff during the roll-out of the new program, will smooth the transition process for enrollees, and will likely increase initial participation in the ESI program.

Additional Provisions/Comments

Cost-Sharing Reductions & Cost Sharing Wraps

Because of the complexities of the cost sharing reconciliation process, we suggest that DHS work with QHPs to discuss the implementation of this important process to identify any concerns or problems and minimize operational issues that may occur. While we understand the concept is very similar to the HCIP process, differences between the two programs may require some modification due to program variations.

Eliminating Retroactive Coverage

On page 14, the application indicates that "individuals will become eligible for Arkansas Works coverage at the point that they apply for coverage under Title XIX." Later, on page 15 under "Waivers", 6th bullet, you request an exemption from the requirement to provide coverage "any time prior to the first day of the month in which an individual applies." Similar information is included in the table on page 17, under the *Use for Waiver/Expenditure Authority for §1902(a)(34*). These two statements appear to conflict; in the first, it appears coverage is effective on the day a person applies; in the second and in the table, it appears the intent is to make coverage effective the first day of the month in which an individual applies. To ensure consistency and avoid any confusion, we suggestion you consider refining the language as appropriate based on your intent.

Improving Program Benefit Design

As the participation in Arkansas Works continues to grow, addressing existing benefit structure and plan design requirements that encourage inappropriate use of care or are not cost-effective becomes increasingly important. Based on recent Legislative discussions and the State's increasing focus on Medicaid reform, we strongly recommend that DHS work with participating QHPs to review existing program design provisions to ensure requirements incentivize and reward employees for appropriate, responsible behavior. While there are numerous specific changes that should be addressed, an example is the requirement for enrollees to make co-payments for PCP visits and **no** co-payment requirement for Emergency Room (ER) visits. While the co-payment requirements may seem minor, the message to enrollees is that ER visits are acceptable and encouraged by the absence of a co-pay requirement. We want to increase the use of primary and send the message to enrollees that an ER visit is not a substitute for a visit to your PCP and should only be used for emergency situations.

While we do not want to discourage enrollees from accessing ER services when appropriate, we suggest imposing a small ER co-payment requirement that should be at least equal to, if not more than, PCP co-payment requirements. Ideally, we suggest removing co-payment requirements for all PCP visits as a clear message to enrollees that their first choice for care should be the PCP when appropriate. We also suggest evaluating co-pays for urgent care centers or clinics with extended office hours to ensure co-payment costs are also lower than those for ER services. Along with these changes, we would also like to see an ongoing, collaborative effort between DHS, QHPs, and providers to improve education of enrollees regarding the appropriate utilization of health plan benefits, with a focus on the importance of visiting their PCP.

This is just one obvious benefit design change that is consistent with the Arkansas Works philosophy of improving patient responsibility. ABCBS welcomes the opportunity to provide recommendations for additional plan design changes that we believe will further encourage the appropriate utilization of health care, improve cost effectiveness, and further promote the Arkansas Works goals of emphasizing personal responsibility, promoting work, and enhancing program integrity.

Trend Assumptions

In Section V, you propose an annual cost growth rate of 4.7%, consistent with the current waiver and suggest considering a higher trend assumption based on claims and utilization experience. As the market has evolved, enrollees have become more knowledgeable about getting coverage and how to access care in the system after they are covered. This has increased utilization and among a higher prevalence of individuals with greater health care needs. Arkansas' experience with Medicaid Expansion and Exchanges is similar to most other states and, in fact, had less cost increases to-date.

A trend in the 6-7% range may be more reflective of the market for the next few years. We would be glad to provide additional data and analysis to support this recommendation. Based on our financial experience, MLR, cost trends, and our own future projections, we would welcome the opportunity to meet with DHS and Optumas to discuss this decision prior to submission of the application to CMS.

In addition to medical trend, there are other factors that will drive increases in rates during the proposed waiver period. First, the ACA health insurer fee is scheduled to resume in 2018 and then increase. Second, the period of the initial waiver, 2014-2016, was supported by the federal transitional reinsurance program, which expires in 2017. This suggests a specific change to the 2017 rate levels

would be appropriate. Third, when Medicaid begins to apply quarterly out-of-pocket maximums within this program, cost-sharing reduction payments will have to increase. This increase should be included in the overall budget targets, even though this will not affect Marketplace premiums. Lastly, the State has previously reported that the original demographic composition projected for the initial waiver period ended up understating the Budget Neutral costs. Corrected demographic assumptions should be applied to establish a better 2017 budget neutral calculation."

Workforce Development

While we understand that federal requirements limit the direct linkage of Medicaid programs to work requirements, we believe that there are appropriate ways to effectively align with the "works" part of Arkansas Works. This would include collaborating with state, education and community organizations to support members with employment and career development. We look forward to the opportunity to provide leadership in this area.

Conclusion

As previously stated, we are impressed with Arkansas' innovative leadership and know that DHS understands the challenges of launching such a new program and sincerely appreciate your ongoing engagement with ABCBS and other stakeholders. We realize much of the work on implementation is just beginning, and many important decisions will be made in the days ahead. As the largest health plan in Arkansas, the largest QHP in both the Private Option and the Arkansas Exchange, a leader in the small employer market, and a partner with the State's health care practice and payment transformation programs, Arkansas Blue Cross Blue Shield is committed to supporting the State through this transition period and continuing our partnership in the years ahead. As you continue to develop the operational and go-to-market plans for Arkansas Works, we look forward to working with you to build a successful program and provide critical services to improve the health, workforce and economy for all Arkansans.

Thank you for the opportunity to provide these comments. Please let us know if you have any questions or would like additional information on any of the suggestions or comments.

June 17, 2016

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Program Development and Quality Assurance
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RE: Comments on the Proposed Extension for and Potential Modification to the 1115 Demonstration Waiver for the Health Care Independence Program

Health Management Systems, Inc. (HMS), is pleased to submit comments to the Arkansas Division of Medical Services, for consideration as it gathers information on the proposed extension to the Section 1115 waiver for the Health Care Independence Program known as *Arkansas Works*.

In accordance with guiding principles detailed in the 2016 Arkansas Works Act, HMS recommends several ideas in order to further promote and maximize employer based insurance and enhance program integrity.

Promoting & Maximizing Employer Based Insurance

In the waiver application, the Division describes the enrollment process, which includes a step to identify whether a Title XIX eligible individual is employed by a participating employer for purposes of assessing that individual's eligibility for the mandatory Employer Sponsored Insurance (ESI) Premium Assistance Program. Indeed, this process will help to identify individuals who have access to ESI, but are not currently enrolled in that ESI. However, there is no detail on how to confirm ESI that is self-reported in the application; activity to search for undisclosed ESI at application and throughout the coverage period; or the role of the qualified health plans (QHPs) in ascertaining and maximizing ESI throughout an applicant's coverage period.

Nationally, on average, over 10% of Medicaid members have additional forms of health insurance coverage. While having other health insurance coverage and being on Medicaid is permissible, both federal and state law, §1902(a) (25) of the Social Security Act and Arkansas General Statutes § 20-77-306, respectively, require that Medicaid pay last.

As such, HMS recommends the following additional steps to further promote and maximize ESI throughout various intervals in the Arkansas Works program while ensuring that Medicaid pays last.

Recommendations

1. Electronically validate applicant self-reported health insurance information at the point of enrollment.
2. Electronically search for undisclosed health insurance coverage at the point of applicant enrollment.
3. Ensure ongoing checks for changes to a Medicaid members' other health insurance coverage.

4. Develop a process by which QHPs must routinely leverage ESI when known, and continue to search for unknown ESI throughout the beneficiary's enrollment in the QHP.
5. Make the ESI Premium Assistance Program mandatory for employers.

Each of the above listed recommendations are detailed as follows:

1. **Validate Self-Reported Applicant Health Insurance Information**
   Today, as part of the application process, applicants' self-report enrollment in other health insurance coverage, albeit an employer sponsored plan, a spouse's plan, Medicare, COBRA, etc. Self-attestation is routinely accepted by states for its face value. However, in order for the insurance to be meaningful, and it is maximized as early in the process as possible, **HMS recommends such disclosed health insurance information be electronically validated at the point of enrollment.** This will allow Medicaid to be the secondary payer immediately upon consumption of services.

2. **Search for Undisclosed Health Insurance Information at Enrollment**
   Sometimes applicants do not realize they have other health insurance coverage, or they choose not to disclose the other health insurance out of fear of being disqualified for Medicaid. Hence, states including Arkansas, already employ processes to search for undisclosed health insurance coverage on behalf of Medicaid beneficiaries. However, today, there is approximately a lag time between 45-90 days from when an applicant is determined Medicaid eligible before a search is conducted for other health insurance coverage. Consequently, due to this lag time, Medicaid is often forced to seek retrospective recoveries for the most significant and costly consumption period.

   Furthermore, the lag time from the point of enrollment to the identification of, and coordination with, other health insurance coverage does not become any less problematic in the Arkansas Works model. In its waiver application, Arkansas proposes that any Arkansas Works beneficiary who does not select a QHP within 42 days will be auto-assigned a QHP, providing up to 42 days of interim fee-for-service (FFS) coverage.

   For these reasons, **HMS recommends that Arkansas move the prospective identification of other health insurance coverage as close to the point of enrollment as possible.** As an added benefit, the state will be able to reduce the pay and chase activity by validating disclosed coverage at enrollment and searching for undisclosed coverage at enrollment. This is very important because, while highly effective, unfortunately pay and chase efforts do not result in the recovery of all claims that should have been the responsibility of another health insurer.

   In fact, a federal audit report issued in January, 2013 by the Department of Health and Human Services, Office of Inspector General, states that challenges remain in recovery of overpayments due to other health insurance coverage. According to the report, "As of June 30, 2011, 44 States cumulatively reported $4.1 billion that they believe is owed by third parties and is at risk of not being recovered."

3. **Ensure Ongoing Checks for Changes to Other Insurance Coverage**
   Medicaid applicants' access to other health insurance coverage is dynamic. As their economic and employment situations change, so does their access to health insurance coverage, particularly ESI. Therefore, identifying health insurance coverage solely at time of application does not account for a Medicaid member's movement in and out of other health insurance coverage over time. For these

reasons, **HMS encourages the Division to continue to routinely search for changes to a Medicaid members enrollment in other health insurance coverage.**

4. **QHPs Must Play an Active Role in Promoting and Maximizing ESI**
   The current and proposed waiver is silent on the role that QHPs will play in identifying and coordinating with other health insurance coverage for their enrollees.

   Over the past 15 years, states have increasingly relied upon Medicaid Managed Care Organizations (MCOs) to provide services to the Medicaid population. In these instances, Medicaid must still remain the payer of last resort. Arkansas Works role for QHPs can be likened to the usage of MCOs by other states and policies must be in pace to ensure the QHPs are searching for unknown and coordinating with known, other health insurance coverage.

   There are numerous models that Arkansas could elect as detailed in an August, 1997 State Medicaid Director letter and referenced immediately below. All of these models are evident across states today and will be just as important for Arkansas to consider in its Arkansas Works program:

   1. Exclude or dis-enroll individuals with known TPL from enrollment in MCOs (QHPs in Arkansas' case).
   2. Allow individuals with TPL to receive coverage through MCOs (QHPs), with the state retaining TPL responsibility.
   3. Require Medicaid MCOs (QHPs) to assume TPL responsibilities through a reduction in capitation payments reflecting the amount of projected TPL the plan should recover or has historically recovered.
   4. Exclude or dis-enroll individuals with commercial managed care TPL coverage. Allow individuals with noncommercial (i.e., Medicare) managed care TPL coverage to receive Medicaid services through the MCO (QHP), with the MCO (QHP) assuming TPL responsibilities, but the state retaining responsibility for tort and estate recoveries.

   HMS recommends that the Arkansas Division of Medical Services:

   1. Select a model for TPL as described above.
   2. Ensure that clear language identifying the QHP's TPL responsibilities is included in the waiver and MOU between the state and the QHP.
   3. If delegating any TPL responsibilities to the QHPs:
      a. Account for TPL in the capitation rate setting process and ensure proper payment incentives are in place to reflect and maximize QHP TPL efforts.
      b. Require TPL results reporting from the QHPs and detail reporting requirements in the final MOU between the QHP and the state.
      c. Ensure proper oversight by the state through TPL safety net reviews, no sooner than one year from the date of service.

5. **Make the ESI Premium Assistance Program Mandatory for Employers**
   HMS applauds the state of Arkansas for its proposal to include a mandatory ESI Premium Assistance Program as part of this waiver application. This requirement will help to ensure that Arkansas Medicaid will remain the payer of last resort and help to maximize ESI.

   Medicaid agencies implement premium assistance programs to pay for Medicaid beneficiaries' commercial premium contributions when the beneficiaries' annual medical expenses outweigh the

cost of their annual premium contribution. Such programs save states millions each year by appropriately redirecting the health insurance costs to the responsible commercial insurer and maintains Medicaid's payer of last resort status. Beneficiaries frequently find these programs attractive because in many cases, the whole family can receive coverage under the commercial insurance policy, at no additional cost to them or to Medicaid. Additionally, beneficiaries generally have access to more providers because commercial insurers have historically enjoyed greater provider participation than experienced by Medicaid. At the same time, providers also find premium assistance programs attractive because reimbursement rates are generally higher under commercial insurance coverage as compared to Medicaid reimbursement rates.

The most successful premium assistance programs nationally mandate not only beneficiary participation, but also, employer participation. Without a mandate for both, success of the premium assistance program is significantly stymied. An employer mandate in the Arkansas ESI Premium Assistance Program is not a mandate to offer health insurance coverage to employees, rather it is a mandate requiring employers to share health insurance coverage information with the state in order to determine if Medicaid applicants and members have access to ESI, but are not enrolled.

Historical opposition to the employer mandate has been riddled with fallacies. Opponents have alleged that such programs increase costs to employers by shifting the coverage responsibility from Medicaid to the employer, particularly when such programs seek to identify the most costly Medicaid beneficiaries.

First, it's important to note that the employer is already offering health insurance coverage to the Medicaid applicant/beneficiary, but for whatever reason the Medicaid applicant/beneficiary is not enrolled in the ESI. Second, cost effectiveness tests often leverage historical utilization data to ensure it makes financial sense for Medicaid to pay the employee's premium share for the ESI. In the case of Arkansas Works, utilization will not be part of the cost effectiveness test. As a result, any argument of dumping high cost Medicaid beneficiaries back onto the employer is simply not accurate.

Lastly, concerns that by adding these otherwise eligible members onto their ESI will increase costs for the employer should also be rejected. The Affordable Care Act contained numerous rating rules that limit an insurer's ability to increase premium costs for employers and again, these employees, and dual Medicaid beneficiaries, were already entitled to participate in the ESI.

HMS highly recommends that Arkansas mandate employer participation in the ESI Premium Assistance Program. Additionally, should Arkansas maintain a phased in approach to the ESI Premium Assistance Program, **HMS recommends that the state start implementation of the ESI Premium Assistance Program with large employers, rather than small as currently proposed in the draft waiver.** This will help create a more sustainable program, and maximize the savings to the state in the most efficient way possible.

Enhancing Program Integrity

Program Integrity Roles and Responsibilities Given that QHPs are similar to MCOs, and QHP coverage is funded by state and federal taxpayer dollars, **HMS strongly recommends that Arkansas revisit what program integrity looks like in Arkansas Works - what efforts must be conducted to ensure taxpayer dollars are appropriately spent and by whom.**

States and MCOs have struggled with these questions for years and several state and national reports highlight the challenges with program integrity in a managed care environment, which is again directly pertinent and conveys to Arkansas Works use of QHPs. In a December 2011 report by the Department of Health and Human Services Office of Inspector General (OIG), *Medicaid Managed Care: Fraud and Abuse Concerns Remain Despite Safeguards, it* noted the key vulnerability as services billed by providers, but never actually rendered. In this same report, the MCOs and States expressed concerns about provider and beneficiary fraud and abuse, including rendering services that are not medically necessary, upcoding by providers, questionable beneficiary eligibility, and pharmaceutical abuse by beneficiaries.

In June 2014, the Government Accountability Office (GAO) released a report, *Medicaid Program Integrity Increased Oversight Needed to Ensure Integrity of Growing Managed Care Expenditures*, highlighting significant gaps in state and federal efforts to ensure Medicaid managed care program integrity. The report did not detail how states or the federal government should specifically apply program integrity oversight, but rather focused more generally on areas that need more oversight, including a recommendation to require states to audit payments to and by MCOs. The report also recommended that CMS update guidance on MMC program integrity and provide audit tools and assistance to states for this purpose.

In May 2016, CMS released final rules, that in part, provide additional guidance on the roles and responsibilities for program integrity in a Medicaid managed care environment. *Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability* proposes some basic program integrity roles by party. For example, MCOs have to report overpayments to the states within 60 days; states have to screen and enroll all MCO network providers, review the accuracy and completeness of encounter data, and validate medical loss ratio (MLR) annual reports, just to name a few. **HMS recommends that Arkansas leverage the new MCO rules to devise a principled, strategic approach for that includes**:

1. Seeking subject matter expertise to develop a compliant, comprehensive, transparent and collaborative program integrity approach in Arkansas Works.

Oversight in a managed care-like environment is distinctly different than oversight in FFS. Expertise is needed to understand and mitigate against pitfalls and leverage lessons learned from more mature managed care and managed care-like models.

2. Implementing wide-ranging, but coordinated program integrity strategies concurrently with the launch of Arkansas Works.

Many states focus on operations when rolling out Medicaid managed care and Medicaid managed care-like programs, but equal effort should be applied to the administration, including the application of program integrity initiatives. Doing so ensures that the inherent promises of managed care, and in Arkansas' case, QHP coverage, which includes better, more cost effective care, are in fact realized.

At the same time, many states take an initial, narrow approach to program integrity in a managed care environment which hinder these promises. For example, states sometimes hinge program integrity efforts on the timely reporting of encounter data, but do little, if any, analysis of the encounter data or review the analysis done by the MCOs. A broader approach to program integrity that includes substantive contract

compliance, quality measures and ongoing reviews of payments to QHPs and payments by QHPs is highly recommended.

3. Ensuring clear delineation of program integrity responsibilities between the QHPs and state staff and/or state contractors through MOUs and/or statutory and/or regulatory guidance.

There is an appropriate role for each of these entities, but it's imperative for ease of administration and efficiency that the roles and responsibilities be clearly defined, coordinated and results shared. Without this, duplication and provider and payer abrasion is likely. Care to beneficiaries may also be compromised. Furthermore, areas in need of additional oversight may go undetected without clear and transparent roles and responsibilities.

4. Providing adequate remuneration and incentives to all entities responsible for oversight.

Any worthwhile program integrity initiative drives significant return on investment; however, upfront and ongoing resources are required to maintain these efforts. It's important that states recognize these costs and account for them both in terms of ensuring the rightful assignment of these responsibilities, as well as properly remunerating the responsible entity for carrying out assigned responsibilities.

5. Imposing sanctions for noncompliance.

Like many compliance programs, application of both incentives and disincentives is necessary to ensure the assigned responsibilities are completed accurately, and if not, there are tools available to change behavior.

HMS applauds Arkansas for their vision in moving the Medicaid program forward through Arkansas Works. We appreciate the opportunity to submit these comments and look forward to providing any additional information that the Division may need to assist them in this process.

Sincerely,

Joseph E. Giamfortone
Director, State Government Relations

Community Health Centers of Arkansas, Inc.
ARKANSAS PRIMARY CARE ASSOCIATION
Expanding Access to Affordable Quality Health Care

June 16, 2016

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

Dear Ms. Stehle,

On May 18, 2016, the Arkansas Department of Human Services, (DHS), Division of Medical Services (DMS) 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. As providers of primary and preventive care services to nearly 165,000 low income uninsured and underinsured Arkansans, CHCA and its members applaud the State of Arkansas for its passage of the Arkansas Works legislation during the 90th General Assembly.

Under Section II, Changes Requested to the Demonstration, Item 1 "Implementing a Premium Assistance Program for ESI" will require all individuals enrolled in coverage through Employer Sponsored Insured premium assistance to receive two insurance cards – an ESI plan card and an Arkansas Works card. While the concept is commendable, it is the details that taunt us. Since this program appears to be a voluntary based program there is concern as to exactly how this would all work, especially with the issuance of two separate insurance cards. We have found that simplicity works best with our patient population, and anything that reduces confusion is beneficial. DHS has recently struggled with the eligibility and verification system required under existing CMS requirements and we are concerned with adding another "voluntary" set of verifications scenarios to check against. Again, the details of exactly how a dual insurance card system would be implemented greatly concerns us.

Item 2 " Instituting Premiums for Arkansas Works Beneficiaries with Incomes above 100% FPL" contain some creativity in the offering of incentive benefits for those that pay timely premiums. We applaud the recognition of healthy behaviors, though for clarification, such should be clearly defined. 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. And, we feel strongly that dental care should be a standard medical care not an "incentive". Many overall health problems can be attributed to oral health and we are concerned that using dental care as an "incentive" is sending absolutely the wrong message about the importance of oral health. If you want to add an incentive, add teeth whitening, or membership to a fitness center.

Under Section III, Waiver 1902(a)(34) "to enable the State not to provide medical coverage to Arkansas Works, beneficiaries for any time prior to the first day of the month in which individual applies" puts an extra burden on the providers that we are sure is unintended. Many of the patients first come to see us without all the proper paperwork for enrollment in insurance coverage, though we work directly with each individual the first time we see them. Medicaid has worked very closely with us and many other providers as we worked through "presumptive eligibility" classification and eventually get proper documentation on our patients. Without such a window of time to get this paperwork done, Medicaid providers will not be able to take patients, and access to care for this patient population will be affected.

And, lastly, under Section III, Waiver 1902(a)(4) insofar as it incorporates 42 CFR 431.53: "To the extent necessary to relieve Arkansas of the requirement to assure transportation to and from medical providers for Arkansas Works beneficiaries enrolled in ESI premium assistance". FQHCs are extremely concerned about the removal of non-emergency transportation as many of our clients rely on this service, especially when it comes to receiving specialty care not available in rural Arkansas. This will create an out of pocket burden on the already struggling class, due to this burden many will stay home and avoid receiving proper care because they cannot afford a trip to the doctor, causing their health to deteriorate and in the long run will cost the state more money. We strongly request this language be removed all together.

Thank you for your attention to our comments. 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,

Mary Leath
Chief Executive Officer

June 16, 2016

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 1115 WAIVER EXTENSION APPLICATION

Dear Director Stehle:

Thank you for the opportunity to Comment on the Arkansas 1115 Waiver Extension Application (Arkansas Works), published for comment on May 18, 2016 at medicaid.state.ar.us.

I started Human Arc 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 32 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 concern** with Arkansas Works is the elimination of retroactive eligibility for the expansion population.

RECOMMENDATION

- 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. Below is a detailed explanation supporting our recommendation.

WAIVER OF RETROACTIVE COVERAGE

The ramifications of the Arkansas Works waiver, 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.

The following comments and rationale will illustrate that the Arkansas 1115 Waiver Extension Application **does not meet the following criteria** used by the Center for Medicare and Medicaid Services to determine whether Medicaid program objectives are met relative to providing retroactive coverage:

- 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.

Gap in coverage

- **Gap could be days to months or more:** 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, due to the delay from the application process the likelihood of following the intended continuum of care is reduced and health outcomes will be impacted.

Medical Debt

- **Collections, bankruptcies:** Lacking insurance coverage puts people at risk of medical debt. In 2014, according to the Kaiser Family Foundation analysis of 2014 Kaiser Survey of Low-Income Americans and the Affordable Care Act nearly a third (32 percent) of uninsured adults said they were carrying medical debt. 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.[3]

- **Stress:** Collection agencies will be pursuing more people; further stressing the financial, physical and mental health of uninsured and underinsured adults.

The following comments and rationale will illustrate that the Arkansas Works 1115 Demonstration Waiver **does not meet the following criterion** used by the Centers for Medicare and Medicaid Services to determine whether Medicaid program objectives are met:

- Increase access to, stabilize, and strengthen providers and provider networks available to serve Medicaid and low-income populations in the state.

Financial

- **Lost reimbursement:** Millions of dollars annually could be lost in Medicaid reimbursement to hospitals alone, not including other medical providers. Lost Medicaid reimbursement de-stabilizes providers by shifting the cost of care back to the hospitals.

- **Increased expenses and write-offs:** Providers will experience an increase in charity care, and bad debt. The elimination of 90-day retroactive eligibility and reimbursement for serving Arkansas Works beneficiaries will add stress to self-pay collections. Providers must have a margin to continue providing care. Arkansas Works 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 uninsured expansion group through the elimination (waiver) of retroactive Medicaid coverage. 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 Program 1115 Demonstration Waiver is the **Waiver of retroactive eligibility.**

We believe we have demonstrated that the waiver of retroactive coverage in the Arkansas Works program 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.

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

Respectfully,

Michael J Baird
Chief Executive Officer
Human Arc
1457 E 40th Street
Cleveland, Ohio 44103
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216.426.3510 direct
216.849.8493 mobile

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=6,36 percent20-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] *Ibid*

Becky Murphy

From: Richard Bing <richbing@sbcglobal.net>
Sent: Friday, May 27, 2016 4:20 PM
To: DHS DMS HCIW
Subject: Private Option Changes Feedback

Amy

I read the article about you not receiving any feedback on the Private Option changes in the paper today. I think that's disappointing because I think the private option and the Affordable Care Act are truly a positive improvement for the country and Arkansas.

Prior to 2014 my wife and I had health insurance through her employment. She left her company in 2013 because of her extreme medical conditions. The high priced Cobra health insurance they made available ran out and we were left without medical insurance. Luckily, the ACA / PO kicked in and we were able to get affordable medical insurance through Healthcare.gov. She currently still obtains her Medical insurance through healthcare.gov. I have turned 65 and I am now on Medicare. She is not 65 yet and will need to be on the Private Option medical insurance for 2+ more years.

I have worked full time since I was 22 years old, after graduating from college. I contributed significantly in taxes and social security for 43 years. She graduated in '84 from Nursing School with a RN degree. She worked as an RN or RN Manager for almost 30 years, again contributing significantly. Unfortunately she had to leave the profession due to arthritis and Crohn's. She is not illegible for SS or retirement yet, but I hope we can survive financially until she turns 65 / 66. We do have income and probably not be legible for a much assistance this year.

- Paying an additional $19 per month is not appreciated. It's just another "gotcha" for people that truly need assistance paying for medical insurance. Most people have contributed substantially and this seemed like an insult.
- Yes, let's ensure that all employers provide medical insurance. I think this was for the smaller employers and they need to realize that if you have a business you've got to plan for this. Take some ownership.
- Have we gotten Wal-Mart and other big companies to belly up to the bar yet and provide medical insurance for all ee's if they want it and quit playing the PT game.
- Dental insurance is a great option. To purchase it your self is expensive too.

My wife and I are truly grateful the Affordable Care Act is up and running. There are changes that need to be done but the overall structure is good. Now, if we could get "all" politicians to earnestly make the changes that need to be made. We are happy too that the state of Arkansas realized the Private Option needed continuing. There would have been a lot of unhappy voters if they had trashed it.

Overall all insurance price will lower if everyone has insurance. The more in the better. Yes, we do need to address the games that individuals, medical providers, insurance companies, hospitals and state governments play. Better things take time.

Thanks for soliciting feedback

Richard Bingenheimer

501.851.6801

ROBERT "BO" RYALL
President & CEO

June 13, 2016

Ms. Cindy Gillespie, Director
Arkansas Department of Human Services
P. O. Box 1437 (Slot S295)
Little Rock, Arkansas 72203-1437

Dear Ms. Gillespie:

The Arkansas Hospital Association (AHA), on behalf of its 100 member organizations and their combined 45,000-plus employees, expresses its appreciation for the opportunity to comment on the potential impact of proposed regulations that would implement the new Arkansas Works program.

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 strongly supportive of the Arkansas Works program now being developed to continue Arkansas's unique and highly successful approach for providing affordable healthcare coverage for eligible low-income Arkansans. We are confident that Arkansas Works will continue to build and improve upon the successes of the Arkansas Private Option, which has helped Arkansas hospitals to retain their ability to serve patients throughout our state.

Specifically, the AHA applauds Governor Asa Hutchinson and the Arkansas Legislature for engineering Arkansas Works, which promises to maintain access to affordable healthcare for our poorest citizens and to strengthen the qualified health plan premium assistance model by emphasizing personal responsibility, promoting work, and enhancing program integrity. As Arkansas's healthcare system continues to improve and as the uncompensated care absorbed by hospitals is reduced, our hospitals stand a better chance to remain financially viable – even in the face of losing more than $2.5 billion in federal cuts related to Medicare payment cuts that have been implemented nationally through the Affordable Care Act (2010), the Budget Control Act of 2011 (sequestration), two separate Tax Acts in 2012, and various regulation changes.

However, the AHA has two major concerns with the Arkansas 1115 waiver extension application. First, and most importantly, the AHA would request to strike or modify §1902(a)(34) that would prohibit medical coverage to Arkansas Works beneficiaries for any time prior to the first day of the month in which the individual applies.

Unfortunately, the Arkansas Department of Human Services (DHS), Division of Medical Services, has been unable to implement the federal requirement for presumptive eligibility detailed in 42 CFR 435.1110. In practice, in place of presumptive eligibility, the department has allowed a 90-day period of retroactive coverage for beneficiaries who are deemed eligible for Private Option plans during the past two years. Should §1902(a)(34) be implemented, we are concerned that an otherwise-eligible beneficiary will be saddled with large amounts of healthcare debt that could have been avoided.

While the AHA encourages DHS to implement the already federally required provisions of "presumptive eligibility," an option would be to put in place an appropriate time-period of at least 60 days of retroactive

coverage. One of these solutions would not only be more beneficial to the patient, but would also more aptly 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 set forth in §1902(a)(34).

Also, while the AHA applauds the voluntary option for employers to be incentivized to offer insurance to their employees, the AHA has concerns that the current eligibility and enrollment systems within DHS are not able to efficiently perform the tasks that will be required to implement the details included in the proposed waivers. Specifically for the ESI population, the AHA is concerned that the patient experience will be less than ideal – due to cumbersome administrative processes – and will result in poor patient satisfaction scores. For example, it is anticipated that a patient who has selected to keep his employer-sponsored insurance with wrap-around benefits from Medicaid would need multiple healthcare identification cards in order for a healthcare provider to be able to receive appropriate payments for caring for that patient. Once the patient is seen, the provider would have the added burden to discern which bills go to the patient versus Medicaid versus the employer sponsored insurance.

The rise of consumerism is having a major influence on healthcare delivery. As a result, patient satisfaction is becoming very important as a hospital quality measure and is more closely tied to reimbursements from public and private payer groups more than ever before. Because the hospital admissions process, which already is heavily laden with inefficiencies brought about by administrative burdens that actually harm the patient care experience, the AHA requests that DHS help to relieve patients and providers of these burdens at the point of care.

As noted by Secretary Burwell in her letter dated April 5, 2016, addressing the well-documented inadequacies with the existing eligibility determination and enrollment systems would be a step in that direction. Adding additional tasks and functionality to an existing system, as required under the waiver request, is counterproductive to creating a more efficient system, at best. Therefore, the AHA asks that DHS improve its enrollment and eligibility systems with the end-users in mind so that employers are truly incentivized to keep their employees insured.

Arkansas's hospitals, which employ about 45,000 Arkansans with a payroll of about $5 billion, go to great lengths to provide needed services to the people in our state in a high quality, cost effective manner. The AHA and its members look forward to continuing to work with Governor Hutchinson, the legislature, both the government and private sectors, and our patients to improve the health of people, leading to healthier families, healthier hospitals, and stronger communities in Arkansas.

Once again, thank you for this opportunity to make our concerns known.

Sincerely,

Bo Ryall
President/CEO

BR/ae

419 Natural Resources Drive • Little Rock, Arkansas 72205 • (501) 224-7878 • Facsimile (501) 224-0519

Becky Murphy

From: Roland Robinson <rolandr47@yahoo.com>
Sent: Saturday, May 28, 2016 7:04 AM
To: DHS DMS HCIW
Subject: Medicaid Expansion

I fully support Expansion, I'm not in favor of requirements for deductibles or co-pays. I do support strenuous eligibility screening and life skills counseling availability as opposed to mandatory job seeking requirements or registration for employment.
I do favor case management from a strictly medical necessity standpoint.
Thanks

Sent from my iPad

Becky Murphy

From: Skip Estes <skipestes@sbcglobal.net>
Sent: Thursday, June 09, 2016 10:12 PM
To: DHS DMS HCIW
Subject: Private Option

Why should anyone make any comments on the private option or changes to it? It is already a done deal, or that's how it appears. It is absolutely shameful that the option allows for people with a large amount of assets to qualify for Medicaid while others, in particular retired people, cannot qualify, simply because they may have monthly income slightly over the amount which automatically disqualifies them!!! Therefore, you can have a neighbor who has real estate worth several million dollars but who has a monthly income of below the $2,000/monthly qualifying limit alongside a retired person who may have monthly income slightly above the qualifying limit but not much in savings. Isn't it nice that retired people get to pay over $1,200/mo. for healthcare coverage and drugs that requires them to withdraw money from their IRAs just to pay for their health insurance and drugs. Meanwhile, Joe Blow with the real estate qualifies for Medicaid?!?! What about this situation makes it a good deal for people who have worked their entire lives and who finally get to retire, but who have to immediately use their savings to pay for health insurance and drug costs?????