Public Comments Received on Application for ARHOME Section 1115 Demonstration Project and Arkansas Department of Human Services Responses

Summary

On June 13, 2021, the Arkansas Department of Human Services (DHS) released the draft application for the ARHOME Section 1115 Demonstration Project for public comment. During the 30-day public comment period, DHS held two public hearings on the draft application. DHS received 23 timely comments on the draft application. This Section consolidates and summarizes comments in opposition to specific provisions in the applications. The comments of individuals and individual organizations are also included at the end of this Section.

DHS has carefully considered each comment. The DHS responses to the comments are described below. As described in the application, the Medicaid provisions of the Affordable Care Act (ACA) represent a significant change from Medicaid's historical role in providing medical assistance to children, people with disabilities, the elderly and low-income parents with dependent children. In general, the ARHOME proposal is designed to test several hypotheses related to addressing the Social Determinants of Health, especially economic security, the relationship between long-term poverty and the associated increased risk of chronic diseases and premature death, and as to whether individuals will treat and value coverage as insurance and by contributing a share of the cost of coverage.

Retroactive Eligibility

Request to reinstate retroactive eligibility from proposed 30-days to Medicaid requirement of 90-days retroactive coverage. Rational for opposition to 30-day retroactive eligibility include:

- Concerns around continuity of care due to loss of coverage when beneficiary doesn't understand renewal process or does not receive notice.
- Limiting retroactive coverage to one month increases the likelihood of people on Medicaid carrying major medical debt and increase the odds that hospitals will not be compensated for care.
- Concern with no exception for increase length of retroactive coverage for Medically Frail population.
- Rural hospitals often do not have the ability to absorb these uncompensated care costs and may be put at further risk of closing.
- AR Works also included a limit on retroactive coverage, but the state has failed to evaluate its impact. There is no need to test this further and as such, it should be removed from the proposal.
- Requiring implementation of presumptive eligibility or reinstating 90-day retroactive coverage will more aptly enhance hospital discharge coordination options for patient care planning, which can reduce costly repeated hospital admissions and prevent an otherwise-eligible beneficiary to be saddled with large amounts of health care debt that could have been avoided.

DHS Response

The concept of any type of insurance, including health insurance, is to purchase coverage prior to needing coverage. Insurance is designed to protect against a future and unforeseen event. For the new adult eligibility group, the majority of whom have some level of income, including 20% who have income above 100% of the federal poverty level, encouraging them to join the insurance pool prior to incurring medical expenses is important. It is noteworthy that an individual can apply for Medicaid at any time during the year, which provides an individual with an advantage compared to employer coverage or individual coverage through the Marketplace, which limits applications to an open enrollment period.

Under the application, a hospital or another other type of provider will still have 30 days from the date of application to help an individual enroll in order to receive payment from Medicaid retroactively. The provider has the incentive to educate the individual about the importance of enrolling in Medicaid to obtain coverage and seek timely payment from DHS. Uncompensated care has been reduced dramatically since the state adopted the new adult eligibility group in 2014. Overall, providers will be substantially better off financially under ARHOME which continues to use premium assistance to purchase coverage for the majority of enrollees even with this provision.

DHS discontinued the reduction in the retroactive period in March 2019 due to litigation. The policy therefore has not been evaluated as part of AR Works. This provision will be part of the ARHOME evaluation.

Premium, Copay, Cost Share

Oppose increases in cost sharing and premiums. Rationale for opposition to co-payments for individuals at or above 21% FPL include:

- Citing research that even relatively low levels of cost-sharing for low-income populations limit the use of necessary healthcare services. Oppose copay for non-emergency use of ED cite studies decreased utilization of ED services but did not result in cost savings because of subsequent use of more intensive and expensive services.
- The Division's request to impose a $9.40 fee for each "non-emergent" or "inappropriate" use of the emergency department (ED) for those with incomes at and above 21 percent of FPL could increase costs for cancer patients. Imposing this surcharge may dissuade an individual from seeking care from an ED setting – even if the case is medically warranted. Cancer patients undergoing chemotherapy and/or radiation often have adverse drug reactions or other related health problems that require immediate care during evenings or weekends. If primary care settings and other facilities are not available, these patients are often directed to the ED.
- Increased premiums for individuals at and above 100% FPL likely to discourage eligible people from enrolling. Cite study that shows modest increases of a few dollars in premiums resulted in disenrollment, especially among healthy individuals, from the program.
- Higher out-of-pocket costs decrease the likelihood that a lower income person would seek health care including preventive screenings.
- Premiums and cost sharing can be particularly burdensome for a high utilizer of health care services, such as an individual in active cancer treatment or a recent survivor.
- Requiring enrollees to pay up to five percent of household income each quarter could result in many cancer patients and survivors delaying their treatment and could result in them forgoing their treatment or follow-up visits altogether.
- Findings from a Kaiser Family Foundation (KFF) review of the literature show abundant evidence that premiums result in more beneficiaries becoming uninsured, especially those with lower incomes, leading to greater unmet health needs.
- Individuals not enrolling due to premiums does not mean that they somehow "value" insurance less; it likely means they cannot afford the premium. "…[T]hose who become uninsured following premium increases face increased barriers to accessing care, have greater unmet health needs, and face increased financial burdens."

DHS Response

The application describes the importance of individuals sharing a nominal part of the cost of coverage at length, so it does not need to be repeated here. Individuals will determine whether they value insurance coverage as affordable and their relationship with the health care professionals through their willingness to contribute financially.

The provisions on nominal copayments, which are allowable under federal rules, still provide substantial protections for individuals which make coverage affordable. The modest increase in premiums as a percentage of income reflect what is allowable under the Affordable Care Act (ACA) for individuals with income above 100% of the federal level (FPL). Moreover, ARHOME will limit premiums and cost sharing below the levels allowed by the federal Marketplace.

Although commenters cite research on cost sharing in the Medicaid program, there is little research that is directly related to premiums and copayments on the ARHOME population. Previous studies and other state Demonstrations on premiums and cost sharing are significantly different than the ARHOME design.

The premium and copayments will be subject to rigorous evaluation, including through comparison of take-up rates. As described in the application, as many as two-thirds of the uninsured population likely qualify for subsidies through tax credits, through employers, or through Medicaid. Gaining a better understanding of what individuals consider to be affordable is therefore of national significance.

Evaluation

- Concern that proposal does not include an interim evaluation of AR Works so no evaluation data on state's experience and state is asking for comment on new program without ability for public to review current demonstration.
- We appreciate DHS considering many possible distal outcomes that may be addressable with the Life360 HOME model but are concerned about both the attributability of some the SDOH-related Domain 2 measures and the overall methodological approach. Without specific expected Life360 HOME activities, it is difficult to assess to what extent changes those measures, such as change in employment and criminal justice system involvement, could be attributable to the actions of the health care system, leading to concerns about the possibility of spurious findings. Methodologically, there are some issues with comparability between study groups. The most problematic are measures 2A, 2B, and 2C, which propose a pre-post comparison of changes in income with no comparison group. Without a comparison and especially since income generally increases with age – and therefore, many participants will show improvement in these measures regardless of any programmatic effect – these measures are not useful. For the other Domain 2 measures, difference-indifference study design alone may not be sufficient to account for differences in the underlying characteristics of the nonrandomly assigned groups, since it will not account for unobserved or time-variant confounders.

DHS Response

Two evaluations are available to inform public comments. The impact of the use of premium assistance as the central feature of the original waiver was published in 2018. The interim evaluation of ARWorks , which also uses premium assistance, can be accessed on the DHS website Arkansas-Works-Interim-Evaluation-20210630-Final.pdf, where it has been available since June 30, 2021.

We appreciate the comments on the evaluation design of the different populations that will access services through different pathways. We agree with the importance of determining appropriate comparison groups for the evaluation and will work with CMS on the final design of the evaluation. ARHOME includes major changes, such as addressing Social Determinants of Health, accountability of

Qualified Health Plans (QHPs), the use of incentives to participate in health improvement and economic independence initiatives and opportunities as well as the new Life360 HOMEs. In addition, individuals with significant behavioral health needs will be enrolled in the Provider-led Arkansas Shared Savings Entity (PASSE) program. We agree that given these different methods of intervention with the different target populations, using the most appropriate methodologies will be key to conducting the evaluation.

Member Incentive Programs

- Oppose inviting private insurers to provide cost-sharing discounts to enrollees who engage in work related activities.
- Oppose discounts for health-improvement activities which have been shown in employer-based coverage settings to disproportionately penalize people who already face systemic barriers to achieving better health.
- Concerns health equity issues associated with wellness incentive programs because of higher rates of chronic health conditions for people of color and increased incidence of food deserts and environmental hazards in low income neighborhoods could lead to wellness programs that can look more like a penalty. The state does not provide a comprehensive list of what behaviors QHPs could offer incentives for but lists annual wellness exams and attending a job fair as examples.
- The health plans would be able to reduce or eliminate beneficiaries' cost-sharing obligations if enrollees participate in the incentives and concerned that this incentive program could be used to discriminate against individuals who use tobacco and have other chronic health conditions and potentially discourage them obtaining coverage. At a minimum, the state should clarify these provisions so that we can more fully comment on their implications.
- We are concerned that giving QHPs complete autonomy to develop incentive programs will result in cherry-picking healthier beneficiaries, especially given the proposed initiative to "hold QHPs accountable" by imposing sanctions on QHPs that fail to "improve the health" of their members.

DHS Response

Many of the comments on the incentive programs reflect misunderstandings about how such incentives will be designed by the QHPs. QHPs will not have "complete autonomy," nor will they be permitted to "cherry pick" beneficiaries. Individuals either pick their own health plans or are auto-assigned by DHS. Individuals cannot be disenrolled by the health plans for not participating in incentive programs.

There is an increasing use of incentives in public and private health plans across the country. DHS has provided a few examples of health and economic incentives a QHP may employ but will allow flexibility to QHPs in choosing incentives that are most effective for their members. The QHPs will be accountable for meeting performance measures. They will be required to provide annual Quality Assessment and Performance Improvement Strategic Plans, which will be reviewed by the new Accountability Oversight Panel. Thus, there will be ample opportunities for further review of how the QHPs use incentives and for public input.

Reassignment Inactive to Medicaid FFS

- Concerns that reassignment could be viewed as a penalty by the beneficiary and wholesale reassignment of beneficiaries without utilization could be detrimental to this balance or risk and result in higher QHP premiums for the program.
- Question about compliance with federal "equal access" requirements particularly when there is objective evidence that access differences between the care deliver strategies exist.

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

DHS Response

As clearly stated, this provision will not be operational in the first year of the Demonstration and will be developed with the opportunity for public comment. The term "inactive" is used to describe an individual who is not utilizing services so concerns about this provision as a penalty or noncompliance with equal access should be alleviated.

Provider Refuse Service After One Non-payment

Rationale for opposing ability for health care provider to refuse service to patient who was unable to make one co-payment includes:

- Concern that this could have the potential to limit access for needed services and could divert those with the inability to pay to safety net providers such as FQHCs.
- This is not allowed under federal regulations for individuals under 100% FPL (42 CFR 447.52(e)(1)). And even if it were permitted under federal law, this practice should not be allowed as it would prevent beneficiaries from receiving necessary medical services.

DHS Response

The policies outlined for copayments are consistent with federal rules for the Medicaid population. More than 20 states require copayments for the adult population in a manner that is consistent with federal rules.

FQHCs typically charged copayments for their uninsured population prior to the ACA. FQHCs and all health care providers have experienced significant financial gains due to the original and current Demonstration. Higher reimbursement rates through the QHPs will most likely result in providers continuing to serve individuals even if they do not make the nominal copayment.

Access to Care

- The ARHOME demonstration proposes for most Medicaid expansion beneficiaries to be covered by Qualified Health Plans (QHPs), while others will be covered by Medicaid fee-for-service (FFS). Accordingly, some providers will be reimbursed by QHPs and others will be reimbursed by the state through FFS. We urge you to consider the loss of meaningful access to care based on this operational structure of beneficiaries being covered by both QHPs and FFS. Additionally, as the share of AR HOME beneficiaries in FFS rises, there will be negative fiscal impacts on all providers due to the low FFS payment rates. This may cause even more access issues in FFS as providers decline to participate.
- Federal Medicaid laws require equal access to care regardless of the delivery system. Therefore, given the statements in the proposal indicating that access to care is better in QHPs than in FFS, DHS has a responsibility to improve access in FFS. This could be done by increasing FFS provider rates, working to add more primary and specialty care providers to the FFS networks, and carefully monitoring access to ensure the measures taken are effective.

DHS Response

Commenters are raising an issue with a provision that has been part of the Demonstration since the original waiver was approved by the Obama Administration. Access to care in the traditional Medicaid program is a significant issue that DHS and the legislature have been addressing. Governor Asa Hutchinson signed Executive Order 19-02, which requires DHS to review Medicaid FFS reimbursement rates at least once every four years, in an effort to ensure reimbursement rates result in robust Medicaid provider networks. Medicaid FFS rates have been increased for key medical professionals including physicians. DHS will continue to monitor the issue of access to care and act accordingly.

Community Bridge Organization/Life360 HOME

Maternal Life360 HOME:

- Maternal Life360 HOME model should build upon and support existing infrastructure as birthing hospitals establish programs. Using evidence-based programs, as required by Act 530 of 2021, is the best way to ensure outcomes and operations align with goals, such as reducing infant and maternal mortality.
- Some of the most vulnerable pregnant women may not be enrolled in a Qualified Health Plan but instead be enrolled in traditional pregnancy Medicaid or the new PASSE options outlined in the waiver. Allowing women across all expansion Medicaid options to access the Maternal Life360 HOMEs would broaden the programs̄ reach and help achieve health outcome goals outlined in the waiver. It would also simplify eligibility from a consumer perspective
- **Maternal Life360 HOMEs can launch more effectively with centralized, experienced infrastructure that is not described in the waiver.** One concern we have is that the Strong Start program mentioned in the waiver is not on HomVEE's evidence-based list, nor is it currently in operation in Arkansas. Programs such as Healthy Families America, SafeCare, or Nurse Family Partnership may provide a better fit locally.
- Maternal Life360 programs could provide services and also refer families to existing longer-term programs in the state.
- While it is optimal to enroll women in home visiting during pregnancy, **families should be allowed to enroll in Maternal Life360 HOMEs through the end of a child's first year of life**, at minimum, to have maximum benefit on infant mortality and maternal mortality. Health and social factors that impact health outcomes may not arise until after a child is born. Additionally, pediatricians and other primary care providers may recognize "high risk" factors such as maternal depression, unsafe sleep environments, or parental drug use during well-child visits during a child's first year of life. Having the ability to refer families with infants to Maternal Life360 HOMEs from primary care is essential.

Life360 HOMEs implementation questions

- How will DHS decide which communities to fund CBOs in?
- Will a beneficiary who meets the criteria for all three Life360 Homes be served by all three at the same time? Or, will their participation be limited based on PMPM guidelines?
- How will hospitals create the infrastructure to support these programs?
- How will traditional PW coverage and the ARHOME models work together?
- Will pregnant women who are served by the Maternal Life360 Home have limits on retroactive coverage and be subject to premiums if their income is above 100% FPL?

- How will you ensure the hospitals and their local partners choose evidence-based home visiting programs, so that families get what they need, and Medicaid achieves the outcomes they are proposing in the waiver?

DHS Response

DHS appreciates the overall support for the concept of the Life360 HOMEs. The questions and comments on funding and the number of Life360 HOMEs will be worked through with CMS. The comments on the Life360 HOMEs address details that go well beyond what is typically described in a waiver application or even the operational design described in the Special Terms and Conditions of an approved waiver. Such details are being developed and will be open to future public discussion. Based on the evaluations of national and state models, DHS acknowledges the need for balance between direction to providers and flexibility for them to make adjustments over time for interventions that are most effective.

The State is currently developing rules for Life360 HOMEs and will work with communities and providers to develop rules that support the implementation of the program. These questions will be answered through this rulemaking process and will be released for public comment at a later date.

Life360 HOMEs:

- The timeline for the implementation of the Life360 HOMEs, coupled with the opaqueness of the ARHOME program development, lack of transparent quality metrics, unknown potential reimbursement, unknown delineated or collaborative responsibilities of the Life360 Home versus the qualified health plan, PASSE managed care plan, etc., makes the proposal lofty and, in the middle of hospitals' continued response to record numbers of very sick patients throughout the pandemic, premature.
- The AHA and its members stand ready to work diligently with stakeholders to flesh out Success Life360Homes, Maternity Life360 HOMEs, and Rural Life360 HOMEs as introduced in the waiver application. It will be imperative that start up costs and ongoing payments be satisfactory to not only promote the development of resources, but also to build the critical infrastructure in Arkansas communities to serve patients and communities.
- Taking on a responsibility of this size without careful planning and stakeholder involvement – especially without soliciting potential beneficiary input – would be daunting under the best circumstances. The planning and implementation timeline must be created in a realistic manner that seeks stakeholder experience and expertise and prioritizes potential beneficiaries' input. We urge DHS not to set implementation dates that are premature and look forward to learning more about specific expected activities and the provision of adequate funding and support.

DHS Response

DHS appreciates the overall support for the concept of the Rural Life360 HOMEs. The comments on the Life360 HOMEs are details that go well beyond what is typically described in a waiver application or even the operational design described in the Special Terms and Conditions of an approved waiver. Such details are being developed and will be open to future public discussion.

- Rural Life360 HOME CMHCs and CCBHC Expansion grants provide a foundation that Rural Access Hospitals do not and likely cannot provide.
- CMHCs already have capacity and capability to provide evidence-based practices for the priority population identified for **"Rural Life360 Home**" including access in every rural county and

established telehealth options including connectivity to many rural jails
- CCBHC expansion grants also provide for mobile crisis services and assertive community treatment teams
- Although workforce is a concern for all behavioral health providers, CMHCs have a large cadre of licensed MH and SUD professionals with a passion for assisting the most seriously ill individuals
- CMHCs provide cost-effective treatment alternatives when compared to inpatient settings
- There seems to be a noteworthy absence of analytical data to support the proposed waiver plan to rely on rural hospitals to have appropriate experience or the willingness to develop necessary capacity to effectively provide the envisioned demonstration services
- We suggest the intensive care coordination be implemented by CMHCs
- Access to psychiatric inpatient care is a problem in Arkansas, yet the capacity of rural hospitals to fill this gap with quality care is unproven
- It is unlikely that rural hospitals would be able to provide facilities that meet safety standards required for psychiatric inpatient care without substantial physical modifications and added expense

DHS Response

DHS acknowledges the contributions and roles of the CMHCs. At the same time, the application also describes the need to significantly expand capacity and continue to build out the continuum of care. While the rural hospital will be the "hub" for the Rural Life360 HOME, the program will coordinate services for individuals throughout the community including health care services, and services to address health related social needs. The Rural Life360 HOME will need to work closely with all community providers, including Community Mental Health Centers, to be successful. AR Department of Human Services Division of Aging, Adult, and Behavioral Health Services and Division of Medical Services will work together to ensure that funding streams are aligned to expand behavioral health service provision in rural Arkansas by enhancing existing services and improving access to needed services.

<u>Transition to PASSE</u>

The ARHOME proposal seeks to force Medicaid Expansion beneficiaries with mental health conditions into the Provider-led Arkansas Shared Savings Entities (PASSEs). This is problematic for several reasons. First, there are a host of problems around the Optum-based assessment used to determine entry into the PASSEs and the related determinations for people already subject to it. The assessment is not validated. The assessment has been administered in inappropriate ways for people with mental health conditions already subject to it over the last several years. Mental health providers and clients reported that assessments were often conducted quickly with vague explanations for their purpose in settings and circumstances that did not foster rapport with the person being interviewed. And, the results were not reliable, as many people with chronic mental health conditions were determined to be insufficiently severe to warrant a continuation of services, causing massive disruptions in their care. In one case, such a disruption directly caused the psychiatric hospitalization of one of Legal Aid's clients whose life had previously been stable. Second, the PASSE networks do [not] match existing Medicaid Expansion networks. As a result, placement in a PASSE for mental health conditions also means an upheaval in an individual's treatment for everything else. As described above in Section VI, changes in a person's covered providers and medications brings great disruptions and instability. For people who have serious mental health conditions, such a disruption could be even more difficult to navigate. Moreover, some beneficiaries report having appointments in distant locales or having to wait for months, signs that the PASSE networks are not adequate. Again, such problems may be even more difficult for and disruptive to

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

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

DHS Response

DHS acknowledges the transition from fee-for-service to capitation under the PASSE program has been a challenge for some providers. DHS and its Independent Assessment vendor, Optum, continue to work with providers and beneficiaries to ensure timely and accurate assessments are conducted. Nearly 150,000 Behavioral Health Independent Assessments have been completed since the IA program began. The PASSE program currently serves more than 11,600 adults with serious mental illness out of a total PASSE enrollment of more than 46,000 individuals. DHS estimates that the number of individuals to be transitioned into a PASSE will represent less than one percent of total beneficiaries in the new adult eligibility group.

The individuals identified in the waiver application that will be transitioned into a PASSE are first identified as Medically Frail and receive services through FFS. The PASSE program offers a number of services, including Home and Community Based Services (HCBS) and care coordination, for which they are not currently eligible. Newly identified individuals would first meet eligibility for the Medically Frail category before being referred by their Behavioral Health service provider for a Behavioral Health Independent Assessment and potential enrollment in the PASSE program.

The Medically Frail group and the PASSE group are exempt from cost sharing.

<u>Communication to Beneficiaries</u>

- Urge DHS to handle required member notices carefully to minimize the risk of participants being inappropriately reassigned to fee-for-service or disenrolled despite continued eligibility. Specifically ask that DHS allow multiple potential pathways (e.g., in person, by telephone, by accessible 24/7 online option, and by mail) to communicate with beneficiaries and to receive back any needed responses; adopt a reasonable compatibility threshold for inconsistencies between self-attested income and external data sources; accept a reasonable explanation for any inconsistencies rather than requiring paper documentation; proactively identify changes of address using external data sources (e.g., U.S. Postal Service's National Change of Address system, QHP enrollee records, SNAP/TANF enrollment records, and records from other state

agencies); follow up on returned mail and attempt other contact before disenrollment; and allow participants to have at least 30 days to respond to notices or requests for information, consistent with federal rules. These reasonable measures will help ensure that participants do not wrongly lose essential health coverage. In addition, notices and communications from qualified health plans and PASSE managed care plans should meet and exceed the standards of traditional Medicaid communications.

DHS Response

We agree with comments to strengthen and enhance communications with beneficiaries. We believe beneficiary notices, change of address, enrollment records, and other such operational matters are being greatly enhanced as the new Arkansas Integrated Eligibility System (ARIES) is being completed statewide.

Auto Enrollment and Cap on Qualified Health Plan Enrollment

- Limiting auto-enrollment means a beneficiary's transition to QHP coverage will be delayed indefinitely. This adds administrative complexity to the program. A new beneficiary may qualify for Medicaid Expansion, not enroll in a QHP, start receiving care and prescriptions through FFS, later move to a QHP, and then find that doctors or prescriptions covered under FFS are not covered through the QHP.
- Oppose capping monthly enrollment by setting a monthly maximum enrollment cap at no more than 80% of total expansion enrollment and suspending auto-assignment into QHPs for beneficiaries who do not choose a QHP and instead enroll those individuals in fee-for-service (FFS). Urges the state to explain how this proposal will not limit patients' access to care. At a minimum, the state should ensure that capping QHP enrollment and reassignment will not have an adverse effect on access to care for beneficiaries. We request that you provide additional data on this proposal including the race, ethnicity, language and gender of the beneficiaries that will most likely be impacted by this change and moved to FFS.

DHS Response

This provision is a financial "safety valve" which is temporary and will be used only if necessary, to remain with the state budget target. This provision does not affect the individual's right to select his or her own QHP. The suspension of auto-assignment from FFS to a QHP will be administratively simple. It involves only delaying action that DHS takes to make assignment for a short period of time. The potential for disruption in care during the transition from FFS to a QHP that was described in the comment, is a possibility under the program as it exists today as individuals are first enrolled in FFS then moved into a QHP.

To ensure a healthy insurance pool, the resumption of auto-assignment after a period of suspension must be random, therefore it would not be based on race, gender, age, utilization of services or any other characteristic during the FFS period.

SUD Coverage

- We appreciate the Institution for Mental Disease (IMD) Coverage and believe it will improve access for individuals with Substance Use Disorders that require residential care. We ask that

funding for the SUD population include payment for the full continuum of SUD services (e.g. detoxification services, residential treatment and specialized women's services).

DHS Response

We agree such funding for the full continuum of care is important to successful treatment and recovery. Access to the full continuum of care is a challenge in both the private and public sectors. Approval of ARHOME will enhance greater access.