FamiliesUSA
The Voice for Health Care Consumers

September 7, 2013

The Honorable Kathleen Sebelius
United States Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20201

By E-Mail to: Kathleen.Sebelius@hhs.gov

Re: Comments on Section 1115 Waiver related to Arkansas Health Care Independence Program "Private Option" Demonstration

Dear Secretary Sebelius:

Families USA is grateful for the opportunity to comment on the Section 1115 Waiver related to the Arkansas Health Care Independence Act of 2013. We appreciate the work of both CMS and the State of Arkansas in extending access to healthcare to more parents and childless adults through expanded Medicaid eligibility.

We are a national healthcare advocacy organization supporting policy changes that will expand access to affordable healthcare for all Americans; given our mission, we are committed to seeing Arkansas expand Medicaid eligibility. For expanded coverage to be meaningful, benefits must be accessible and appropriate for the population being covered, barriers to care must be minimal, and care provided must be of high quality.

Our comments concern improvements to the state's proposal to ensure the "private option" accomplishes these objectives while meeting federal and state Medicaid requirements. These comments augment and supplement those submitted in the September 6, 2013 letter signed by a number of national advocacy groups, including Families USA.

Identification and treatment of medically-frail individuals

We have several concerns with the proposed identification of medically frail individuals who are exempt from mandatory enrollment in the private option.

- ***Insufficient detail regarding identification of medically-frail individuals***

In its March FAQs, "Medicaid and the Affordable Care Act: Premium Assistance," CMS noted premium assistance demonstrations must be limited to individuals "who must enroll in benchmark coverage and are not described in SSA 1937(a)(2)(B)." CMS further cited the medically frail as an example of an exempt group. The process the state will use to identify such individuals is a critical component of a premium assistance program's eligibility determination mechanism.

As submitted, Arkansas's waiver application lacks sufficient detail regarding how exempt

populations—specifically the medically frail—will be identified to meet the requirements for a complete application outlined in 42 CFR 421.412. That section states that applications will not be considered complete unless they include a comprehensive program description and a background of the proposed health care delivery system, including eligibility requirements.

Although the proposal discusses a process for developing identification mechanisms, it does not provide sufficient detail about either the screening tool questions or how the screening tool will be applied. Stakeholders are therefore unable to assess the tool's effectiveness. Because the proper identification of medically-frail individuals is vital to the protection of vulnerable people and to the success of the demonstration, the content and plan for use of the screening tool should be part of the waiver application. The waiver application should not be considered complete until the state identifies the actual questions to be used and details the process it will use to evaluate responses and identify exempt individuals. These matters should be subject to public comment and appropriate revision before the waiver is approved: they are too central to the waiver's structure to be developed as the waiver program is implemented.

- ***Improperly defining medically-frail based on cost and setting arbitrary limits***

The application states that the screening tool methodology is a combination of individual characteristics and a "weighted scoring algorithm based on applicant responses" that will be "calibrated to identify the top ten percent expected costs among the newly eligible population." This implies that only individuals who are expected to fall within the top ten percent expected costs will be considered medically frail, regardless of other characteristics. This is inconsistent with 42 CFR 440.315(f), which outlines individuals whom states must consider medically frail and exempt from mandatory enrollment in benchmark coverage. That section lists individuals based on their characteristics, not expected medical costs. In fact, many individuals who have medical characteristics that would classify them as medically frail might not fall into the "top ten percent expected costs." Nonetheless, they would be best served with the benefits available through the traditional Medicaid program, and should not be excluded from it.

In addition, while we appreciate the state's clarification that individuals will be able to request a redetermination of their medically frail status (application p. 41), individuals and their providers will need to be made aware of this option in order for it to be meaningful.

Lack of data on budget neutrality

Program costs are critically important. In order to be sustainable, the private option must have costs analogous to traditional Medicaid if it were to serve the expanded population. Furthermore, 42 CFR 435.1015 requires the total cost of purchasing coverage through premium assistance programs, including the costs of administration and wrap-around coverage, be comparable to the expense of providing direct coverage. There is an additional requirement that 1115 waivers be budget neutral. The proposal does not include sufficient information on how Arkansas intends to measure cost comparability and meet the budget neutrality requirement.

- ***Insufficient data for meaningful public comment***

In the application's section on budget neutrality, the state references an actuarial analysis. However, details of that analysis and the assumptions on which it was based are not provided. In the section on evaluation and how cost comparability will be measured (application p. 7), the application merely states "TBD." The lack of detail does not allow for adequate public comment under 42 CFR 431.408.

- ***Concerns expressed by GAO***

In a June 2013 report, the General Accountability Office issued a report expressing concern about the waiver approval and monitoring process, particularly with respect to enforcing budget neutrality.[1] The report noted a lack of transparency in the basis for setting spending limits and lack of public comment in the approval process. While we recognize, and greatly appreciate, that transparency in the approval process has increased recently for new 1115 waivers, Arkansas's application repeats some of the problems noted in the GAO report in the area of cost data. Before final approval, additional information on cost calculations and the comparability analysis should be made available for public comment.

Further expansion of the private option

Arkansas state officials have signaled their intent to move children and parents currently in traditional Medicaid to the private option in later years. Such actions would disrupt the ARKids First program, a major success that has helped reduce the rate of uninsured children to 6% today from 22% in 1997[2] and would represent a major change in the private option program. Such changes should be considered new waiver requests, not amendments, and be subject to all the public notice and comment requirements that apply to new 1115 waivers.

Appeals Process

In its March FAQs, referenced above, CMS was clear that individuals enrolled in Medicaid premium assistance programs "remain Medicaid beneficiaries." As such, they remain entitled to key protections of that program such as the Medicaid fair hearing process. We are extremely concerned about the state's proposal to use the Qualified Health Plan's (QHP's) appeals process and, for external review, a Qualified Independent Review Organization. There is no mention that the QHPs must provide Medicaid protection, such as providing aid pending an appeal. Furthermore, private option enrollees do not have access to the state fair hearing process. The appeals process outlined in the waiver application jeopardizes beneficiaries' procedural rights that are central to the Medicaid program.

The proposal also undermines the state's oversight capacity. The fair hearing process does more

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1 United States Government Accountability Office, *Medicaid Demonstration Waivers: Approval Process Raises Cost Concerns and Lacks Transparency* (Washington: GAO, June 2013), available online at http://www.gao.gov/assets/660/655483.pdf.
2 Anna Strong, *Extending Medicaid Through Private Health Plans: Reactions to Arkansas's Private Option* (Arkansas Advocates for Children, 2013) available online at http://www.aradvocates.org/assets/PDFs/Health/Private-Option-Reaction.pdf

than protect Arkansans; it also provides a means for the state to monitor and evaluate plan performance and practices. Removing the state from the process entirely abrogates Arkansas's responsibility for the Medicaid program, which is not the intent of premium assistance waivers. States implementing premium assistance are still responsible for ensuring beneficiaries enjoy all the protections of the Medicaid program; the fair hearing process is a major provision that cannot be discarded.

State responsibility

The state has indicated that it intends to have an MOU rather than a formal contract with the QHPs. Whatever form the agreement between the state and the QHPs takes, that agreement must clearly delineate the state's and the QHP's responsibilities. Premium assistance does not allow a state to bypass its responsibilities for administering the state's Medicaid program. CMS should ensure that the agreement entered into between the state and the QHPs is sufficiently detailed and binding so as to allow the state to exercise its oversight and enforcement responsibilities, and that the state understands that it retains certain responsibilities, such as enforcing non-discrimination in service delivery and program oversight and monitoring.

Outreach and education

- ***Outreach and education for beneficiaries***

The waiver does not explain how the state will undertake the comprehensive beneficiary outreach and education required to make the demonstration successful. Beneficiaries will need education about matters including benefits and cost-sharing rules, appeals rights, qualification guidelines for traditional Medicaid, and access to wrap-around services. In particular, Medicaid wrap-around coverage will only work if beneficiaries are aware it exists and know how to use it. Anecdotal evidence suggests that in other premium assistance programs, few beneficiaries were aware of the availability of wraparound benefits.[3] The state should articulate an outreach and education strategy prior to approval of the waiver.

- ***Outreach and education for providers***

The private option with Medicaid wraparound will be a new form of coverage to providers and well as patients. The state must therefore also educate providers about benefits available to private option beneficiaries, including those that are atypical for other patients covered by private insurance, such as EPSDT and non-emergency transportation. If providers do not know that a service is covered through a wraparound program, they are much less likely to recommend it to their patients, and the patients are likely to never be aware that the benefit was available to them. Both the private plans and the state need to provide clear, simple, and accessible information and processes for providers to help them assist their patients in obtaining the full range of Medicaid benefits – both those covered by the private option and by the wraparound.

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3 Kaiser Commission on Medicaid and the Uninsured, *Premiums Assistance in Medicaid and CHIP: An Overview of Current Options and Implications of the Affordable Care Act* (Washington: Kaiser Commission on the Uninsured), March 2013, p. 9.

Cost-sharing

We are pleased to note that there will be no cost-sharing for individuals below 100% of the federal poverty line in Year 1. However, we are concerned about the proposed imposition of cost-sharing on individuals with incomes ranging from 50-100% of the poverty line starting in Year 2. We understand this is permissible under Medicaid rules, but we want to emphasize that doing so can have a detrimental impact on enrollees' access to care. If those cost-sharing changes are introduced, to mitigate the harm from these guidelines, enrollees should get periodic notice of their status relative to their cost-sharing maximums.

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Thank you for the opportunity to submit these comments. If you have any questions, please contact Dee Mahan at Families USA: (202) 626-0622 or dmahan@familiesusa.org.

Very truly yours,

Dee Mahan
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Families USA

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