
October 19, 2021

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
200 Independence Ave, SW
Washington, DC 20201

**Re: Arkansas Health and Opportunity for Me (ARHOME) Demonstration**

Dear Secretary Becerra:

Thank you for the opportunity to provide comments on the Arkansas Health and Opportunity for Me (ARHOME) demonstration.

The undersigned organizations represent millions of individuals facing serious, acute and chronic health conditions across the country. Our organizations have a unique perspective on what individuals need to prevent disease, cure illness and manage chronic health conditions. The diversity of our groups and the patients and consumers we represent enables us to draw upon a wealth of knowledge and expertise and serve as an invaluable resource regarding any decisions affecting the Medicaid program and the people that it serves. We urge the Department of Health and Human Services (HHS) to make the best use of the recommendations, knowledge and experience our organizations offer here.

The purpose of the Medicaid program is to provide healthcare coverage for low-income individuals and families, and our organizations are committed to ensuring that Arkansas's Medicaid program provides quality and affordable healthcare coverage. Our organizations strongly support Arkansas's continued commitment to Medicaid expansion. Reviews of more than 600 studies examining the impact of Medicaid expansion have found clear evidence that expansion is linked to increased access to coverage, improvements in many health indicators, and economic benefits for states and providers.[1] However, Arkansas's waiver also includes a number of financial and administrative barriers to care for the patients and consumers we represent. We urge you to consider the following comments as you evaluate this application.

Retroactive Eligibility

The ARHOME demonstration would continue to limit retroactive coverage to 30 days for the demonstration population. There are no exemptions, including for medically frail individuals. Our organizations oppose the limitations on retroactive coverage for the demonstration population.

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

Medicaid paperwork can be burdensome and often confusing. A Medicaid enrollee may not have understood or received a notice of Medicaid renewal and only discovered the coverage lapse when picking up a prescription or going to see their doctor. Without retroactive eligibility, Medicaid enrollees could then face substantial out-of-pocket costs at their doctor's office or pharmacy. In Indiana, for example, Medicaid recipients were responsible for an average of $1,561 in medical costs with the elimination of retroactive eligibility.[2]

Health systems could also end up providing more uncompensated care. For example, when Ohio was considering a similar provision in 2016, a consulting firm advised the state that hospitals could accrue as much as $2.5 billion more in uncompensated care as a result of the waiver.[3] Increased uncompensated care costs are especially concerning as safety net hospitals and other providers continue to deal with the COVID-19 pandemic. Additionally, Arkansas currently has 11 rural hospitals that are vulnerable to closure.[4] Limiting retroactive coverage increases the financial hardships to rural hospitals that absorb uncompensated care costs.

Premiums and Cost-sharing

The ARHOME demonstration also increases both premiums and cost-sharing for individuals, creating financial barriers that would make it harder for patients to access the care that they need. Our organizations oppose the changes to premiums and cost-sharing included in the demonstration.

Arkansas proposes to increase premiums for individuals with incomes at or above 100% of the federal poverty line. Premiums will likely discourage eligible people from enrolling in the program. For example, when Oregon implemented a premium in its Medicaid program, with a maximum premium of $20 per month, almost half of enrollees lost coverage.[5] Additional research on Michigan's Medicaid expansion program showed that modest increases of a few dollars in premiums resulted in disenrollment, especially among healthy individuals, from the program.[6] Consequentially, these individuals no longer had access to preventive treatments and early detection for various conditions that are more treatable at an earlier stage. For patients with serious and chronic conditions, a gap in healthcare coverage could mean delays in receiving needed treatments and services that ultimately lead to a worsening of their condition, hospitalizations and other negative outcomes.

The state is also requesting to impose copayments ranging from $5 to $20 on individuals with incomes at or above 21% of the federal poverty line ($225 per month for an individual). Research has shown that even relatively low levels of cost-sharing for low-income populations limit the use of necessary healthcare services.[7]

One of the copays included in the proposal is for non-emergency use of the emergency department. Patients should not be financially penalized for seeking help for any health problem. When people do experience severe symptoms, they should not try to self-diagnose their condition or worry that they cannot afford to seek care. Instead, they must have access to a quick diagnosis and treatment in an emergency department. A study of enrollees in Oregon's Medicaid program demonstrated that implementation of a copay on emergency services resulted in decreased utilization of such services but did not result in cost savings because of subsequent use of more intensive and expensive services.[8] This provides further evidence that copays may lead to inappropriate delays in needed care.

QHP Incentive Programs

The ARHOME demonstration would allow qualified health plans (QHPs) to design "incentive programs" for enrollees, which could be related to health improvement or economic independence. The state does not provide a comprehensive list of what behaviors QHPs could offer incentives for but lists using preventative care and participating in "increasing employment" as examples. According to the application, health plans would be able to reduce or eliminate beneficiaries' cost-sharing obligations or "maintain coverage for a period of time" after an enrollee's income increases if enrollees participate in the incentives.

Our organizations have serious concerns about this proposal, which appears to be a work-around to imposing work requirements on the demonstration population. Our organizations have repeatedly opposed such requirements,[9] which simply make it harder for patients to access the coverage and care that they need. We strongly support the actions that the Centers for Medicare and Medicaid Services (CMS) have taken over the past year to disapprove work and community engagement requirements, and we urge CMS to similarly reject this attempt to use employment status to determine cost and length of beneficiaries' coverage. For similar reasons, we also believe the state's request to move beneficiaries it deems "inactive" (a status based on participation in selected activities including a "positive response" to an economic independence initiative) from QHP to fee-for-service (FFS) coverage should be rejected.

In addition to our concerns with the employment incentives, our organizations are also concerned about the ambiguity with regard to QHP incentive programs, which leaves broad authority to individual plans to implement such programs. Without clear definitions, health plans might implement wellness programs which allow plans to financially discriminate based on health condition. The conditions typically targeted by wellness programs often occur more frequently in older adults and fall disproportionately on women and some racial and ethnic groups, raising the potential for wellness programs to discriminate based on age and gender and to exacerbate racial health disparities. At a minimum, the state should clarify these provisions and CMS should closely review them to ensure that they cannot be used to in a discriminatory manner.

Limits on QHP Enrollment

Finally, the ARHOME application also requests authority to cap monthly enrollment in QHPs. The proposal would set a monthly maximum enrollment cap at no more than 80% of total expansion enrollment. Once the cap is reached, the state would suspend auto-assignment into QHPs for beneficiaries who do not choose a QHP and instead enroll those individuals in FFS coverage. However, beneficiaries that select a specific QHP would still be enrolled in that plan, regardless of the cap.

Our organizations have concerns about the impact of this proposal on patients' access to care. The state has previously asserted that individuals enrolled in QHPs have better access to provider networks than counterparts enrolled in FFS. Additionally, the state is not proposing to expand the FFS provider

network, but this proposal will likely increase enrollment in the FFS program. This means that both existing and new FFS enrollees could face long wait times to see providers. If this aspect of the proposal moves forward, CMS should require the state to demonstrate how FFS enrollees will have equal access to care as those in QHP coverage and to monitor this issue as part of the demonstration.

Our organizations believe everyone should have access to quality and affordable healthcare coverage. We deeply appreciate Arkansas's efforts to continue Medicaid expansion, but we urge you not to approve provisions in this proposal that would add additional financial and administrative barriers for patients. Thank you for the opportunity to provide comments.

Sincerely,

American Heart Association
American Lung Association
Arthritis Foundation
Cancer*Care*
Cancer Support Community
Cystic Fibrosis Foundation
Epilepsy Foundation
Hemophilia Federation of America
Mended Little Hearts
National Multiple Sclerosis Society
National Organization for Rare Disorders
National Patient Advocate Foundation
Pulmonary Hypertension Association
Susan G. Komen
The AIDS Institute
The Leukemia & Lymphoma Society

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[2] Healthy Indiana Plan 2.0 CMS Redetermination Letter. July 29, 2016. Available at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-lockouts-redetermination-07292016.pdf

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

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

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

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

[7] Samantha Artiga, Petry Ubri, and Julia Zur, "The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings," Kaiser Family Foundation, June 2017. Available at:

https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/.

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

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