

Section 1115 Demonstration: Arkansas Health Care Independence Program "Private Option" Demonstration

Public Comments

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| <p>Comments from Arkansas Advocates for Children and Families</p> | <p>Public Comments to the Centers for Medicare and Medicaid Services regarding Arkansas’s Health Care Independence Program</p> <p>Dear Secretary Sebelius,</p> <p>Arkansas Advocates for Children and Families is very supportive of the steps Arkansas has taken to cover uninsured adult Arkansans earning less than 138 percent of the federal poverty level through the Health Care Independence Act of 2013, also known as the Private Option. Approval of the state’s 1115 demonstration waiver will help Arkansas move toward improved access to health care coverage for all children and families. We appreciate the opportunity to comment on the proposed waiver.</p> <p>We want to underscore our support of particular features of the waiver proposal in addition to our general support for this unique approach to the Affordable Care Act’s Medicaid expansion for low-income adults and parents.</p> <ul style="list-style-type: none"> • We support the rationale that the Health Care Independence Act will potentially reduce churn for some enrollees as they are able to remain in the same plan when their financial situations move them from Medicaid eligibility to eligibility for premium tax credits and vice versa. • We support the potential for improved access to health care providers achieved by providing low-income enrollees in the demonstration with the same insurance carriers and provider payment rates as higher-income enrollees. • We support a long-term move toward families having the same type of health coverage, provided no additional barriers are put in place for achieving continuous, comprehensive coverage for all family members. • We support retroactive coverage and fee-for-service coverage prior to QHP enrollment for Private Option enrollees. • We support the state’s plan to allow eligibility determinations to be made through either the FFM or the Arkansas Eligibility and Enrollment Framework so that eligibility determinations can be available through multiple pathways, especially for complex families. <p>However, some features of the proposal raise concerns for child and family advocates.</p> <ul style="list-style-type: none"> • Children’s Coverage. ARKids First works well as administered today, and the state should protect its progress in covering Arkansas’s children. Moving children into the demonstration in future years via a waiver revision should not be considered until the “private option” is fully evaluated. The effectiveness of providing wraparound coverage for Medicaid-required benefits and upholding cost-sharing limitations should be examined before children are included in the demonstration. Additionally, moving children to a different coverage source would be a major policy change and should be subject to a transparent public process comparable to new waiver applications. We appreciate the comments in the proposal comments suggesting | <p>2013-09-06 22:13</p> |

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| | <p>that the state will afford the public an opportunity to review and comment on such changes.</p> <ul style="list-style-type: none"> Benefits. Additional clarifications and service wraps are needed to ensure Private Option enrollees receive the full range of Medicaid benefits guaranteed to them by Medicaid statute and regulations. The proposal states the Medicaid agency does not intend to enter into contractual relationships with QHPs. Without a contractual relationship, it is unclear how the state will be able to monitor and oversee the provision of services to “private option” participants by the QHPs. <p>Specifically, we support the stated coverage wraps for EPSDT benefits for 19-20 year-olds, non-emergency transportation, and out-of-network family planning services. Coverage for federally qualified health centers and rural health centers should also be a coverage wrap. However, Arkansas should not be allowed to exclude coverage of visits to the emergency room for non-emergency services for private option enrollees. The proposal states these services are not part of the essential health benefits provided by the QHPs, although the types of services provided in the emergency room are covered by the ABP. The state could impose limited cost-sharing on such services but should not be allowed to exclude coverage altogether.</p> <ul style="list-style-type: none"> Cost-sharing. We support the proposal’s intent not to charge premiums or deductibles. The proposal indicates that a state plan amendment (SPA) will be submitted to describe the Alternative Benefit Plan and the cost-sharing design the state will adopt. We believe this SPA should be made available for public review and comment. Future changes to cost-sharing design should be subject to a transparent public process and adhere to the protections imposed for Medicaid beneficiaries. Additionally, DHS should outline the process for aggregating cost-sharing at the family level and limiting exposure to 5% of family income. The proposal is not clear about whether stated cost-sharing limits apply to a family or an individual. <p>Arkansas proposes to exclude coverage of non-emergency services provided in the emergency room from coverage on the ground these services are not part of the essential health benefits provided by the QHPs. By excluding the services, Arkansas would essentially impose cost-sharing equal to the cost of the visit, which would violate Medicaid rules. The state could impose cost-sharing on such services but should not be allowed to impose cost-sharing outside Medicaid’s limitations for beneficiaries.</p> <ul style="list-style-type: none"> Eligibility and enrollment. We supported the initial draft proposal’s intent to include 12-month continuous coverage for newly eligible adults and are disappointed this feature was removed for the submission to CMS. We encourage inclusion of this provision to help reduce churning and promote better quality care. We also encourage the plan auto-assignment feature to consider past and current health care provider use and full-family coverage in its algorithm and allow a longer period of time for enrollees to change their plan choice. Medically Frail Individuals. The proposal does not provide sufficient information regarding the criteria or the screening tool that will be used to determine whether an individual is “medically frail” and therefore ineligible for the demonstration. The proposal never specifies the definition that will be used to make this determination. | |

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| | <p>Arkansas should confirm that it will treat as “medically frail” all individuals who meet the definition set forth in the Medicaid statute and regulations, not just those who are identified based on an arbitrary predetermined percentage of the population. DHS should also clarify how the choice of an ABP or traditional Medicaid coverage will be presented to medically frail enrollees to help them make an informed decision about coverage. It is disturbing that the hypothesis appears to be that those in the “private option” will have greater access to quality services given that extremely poor parents, children, and medically frail adults will remain in the fee-for-service program. Equal access to quality care for those enrolled in fee-for-service Medicaid should be part of the demonstration’s terms and conditions.</p> <ul style="list-style-type: none"> Accountability and Consumer Protections. The waiver states that the appeals process for the private carrier's QHP will be utilized for Private Option enrollees. DHS should further clarify how guaranteed access to Medicaid protections in the case of inappropriate denials of covered benefits or wrongful termination of coverage will be ensured for Private Option enrollees. Additionally, the lack of formal contractual relationships between the Medicaid agency and QHPs raises questions about the responsibility for carrying out the requirements of the Medicaid program, including reporting, document disclosure, and adherence to federal Medicaid requirements. Regardless of the demonstration, the Arkansas Department of Human Services is the single state agency, and it remains responsible for oversight, monitoring, and ensuring that all beneficiaries receive the benefits and protections afforded by the Medicaid statute. Lastly, data and quality reporting by QHP carriers may not meet Medicaid standards or provide transparency to the public. State agencies and outside groups may thus be unable to analyze fully the effects of the Private Option. <p>The Private Option is an extremely positive development for uninsured adult Arkansans. Concerns should be addressed to maximize the positive impact on the health and wellness of Arkansans. Future proposed changes to this Section 1115 demonstration waiver through amendments should be subject to a public process allowing for public comment that is similar to a new waiver application to ensure ongoing public input for significant changes to Arkansans’ coverage options. If Arkansas commits to providing Private Option enrollees the full protections available to Medicaid beneficiaries, risks to families can be mitigated.</p> <p>Thank you again for the opportunity to comment, and please let us know if you have questions or concerns based on this feedback.</p> <p>Respectfully, Rich Huddleston Executive Director Arkansas Advocates for Children and Families Anna Strong Health Care Policy Director Arkansas Advocates for Children and Families</p> | |

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| <p>Comments from National Health Law Program</p> | <p>Below is an excerpt of the National Health Law Program's comments. Our full comments exceed the space allowed; limited space makes it challenging to fully respond to a proposal which is 60 pages long. Our full comments have been provided to CMS staff and will also be available on our website, at: http://www.healthlaw.org/index.php?option=com_content&view=article&id=501:health-reform-nhelp-comments&catid=51</p> <p>Comments:</p> <p>The National Health Law Program (NHLP) is a public interest law firm working to advance access to quality health care and protect the legal rights of low-income and underserved people. We appreciate the opportunity to provide comments to Arkansas' proposed Health Care Independence Program § 1115 demonstration.</p> <p>NHLP recommends that HHS not approve the Arkansas request for section 1115 authority to conduct premium assistance, exactly as requested. Instead, first, we urge HHS to address a number of concerns in the proposal and encourage Arkansas to bring it to a legally approvable form. We urge HHS to work with Arkansas to achieve a Medicaid Expansion that will serve future Medicaid enrollees well, including those inside Arkansas benefiting from this proposal and those in other states who may pursue similar proposals.</p> <p>Second, we ask that before HHS takes action on this waiver request, it take steps to address its own "stewardship of federal Medicaid resources." GAO, Medicaid Demonstration Waivers: Approval Process Raises Cost Concerns and Lack of Transparency at 32 (June 2013). As the GAO recently concluded, "HHS's [budget neutrality] policy is not reflected in its actual practices and, contrary to sound management practices, is not adequately documented....[T]he policy and processes lack transparency regarding criteria." Id. We request that HHS zealously enforce its stated policies and the legal limits of Medicaid section 1115 demonstration law, to ensure progress in Arkansas without opening the door to policies that ignore the fundamental nature of Medicaid as an entitlement program.</p> <p>A. Introduction: Legal Authority</p> <p>Arkansas has submitted an application to conduct a section 1115 demonstration program to use individual market premium assistance to implement a Medicaid Expansion. The stated authority to conduct individual market premium assistance underlying this application is 42 U.S.C. § 1396d(a). However, the statute and legislative history create serious questions about the validity of this claimed authority. Section 1396d(a) defines "medical assistance" and, for the most part, is a listing of services that can or must be included in this definition. By contrast, Congress has dealt with premium assistance in other, specific provisions of the Act. Congress has authorized states to conduct group or employer coverage premium assistance, which are unambiguously and carefully detailed in statute at sections 1396e and 1396e-1. Notwithstanding two very recent policies from HHS (in regulatory and sub-regulatory guidance), there is no history of statutory or regulatory guidance for section 1396d(a) authority. Given the uncertainty of the statutory authority and the untested regulatory framework, we believe it is incumbent upon HHS to be extremely cautious and exacting in the approval of any such authority, and even more so for related waivers.</p> | <p>2013-09-06 13:28</p> |

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| | <p>HHS should hold tightly to the principles announced in its March 2013 Question and Answer document. And under these circumstances HHS must also be unmistakably clear as to the waiver authorities being granted and their legal limits.</p> <p>B. Single State Agency</p> <p>In addition to premium assistance authority concerns, Arkansas’s request, as currently written, fails to ensure that the single state Medicaid agency will remain in charge of the Medicaid program for affected populations, as the Medicaid Act requires. The application does not provide the general public or HHS with information and specifics establishing that the single state Medicaid agency will continue to make administrative and policy decisions for the program. By law, the single state Medicaid agency must be in control and accountable for Medicaid coverage. While Arkansas may not formally delegate away Medicaid authority, it in effect surrenders control over the majority of benefits for an entire category of enrollees (and possibly multiple categories in the future). Arkansas will not control many benefits package details, authorization criteria, and provider contracts and terms established by the plan. The application envisions a memorandum of understanding between the Medicaid agency and the private insurance companies. However, the establishment of an MOU relationship between the state and QHPs, as suggested in the proposal, does not resolve the concern that the QHP would act as an independent entity with its own authority, including discretion, contrary to what Medicaid law permits. NHeLP is very supportive of HHS requiring written agreements between the involved entities to satisfy the legal requirement for a single state agency, clearly delineating roles and responsibilities, with the ultimate authority and responsibility housed in the Medicaid agency. However, the application is sparse on details and the mere presence of an MOU at some point in the future does not satisfy this requirement. HHS should require more of Arkansas as a condition of approval. While assuring consumer protections, this would also address some of the GAO’s conclusions that find HHS processes lack the supporting evidence required to justify deviations from historical requirements. GAO, supra. at 32.</p> | |
| Ensure Program Integrity | <p>Program integrity refers to the proper management of Medicaid to ensure quality, efficiency, and cost effective use of state and federal. Program integrity initiatives work to prevent and detect waste, fraud, and abuse, to increase program transparency and accountability, and to recover improperly used funds.</p> <p>HMS recommends that Arkansas Department of Human Services and the Office of Medicaid Inspector General work with CMS to apply at least the same rigorous program integrity standards to the QHPs as is applied to Medicaid FFS today in order to ensure efficient and proper use of taxpayer funds and access to appropriate care.</p> <p>For example, Arkansas may want to analyze and evaluate QHP’s performance by checking that payments to the QHPs from the MMIS are accurate; payments by the QHPs to their provider networks are billed and paid appropriately and that services provided are necessary and appropriate; and ensuring that QHPs maintain financial solvency. Such analyses will provide valuable, ongoing insight into individual QHP performance, as well as insight</p> | 2013-09-05 13:30 |

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| | <p>into cost drivers and potential vulnerabilities for each QHP. Specifically appropriate oversight of QHPs will:</p> <ul style="list-style-type: none"> • Prevent/recover improper payments • Control program costs/ rates • Ensure QHP contract/MOU compliance • Improved monitoring of care quality and efficiency • Improved insight into QHP performance and cost drivers • Reduce FWA in State <p>In addition, we encourage Arkansas and CMS to negotiate what percentage of recoveries can be retained by the State verses what must be returned to the federal government so as to incentivize program integrity oversight. Recognizing that in 2014 the federal government contributes 100% funding for the newly eligible population, the state receives no financial benefit for cost recovery and payment integrity activities. States will not pursue assertive program integrity if 100% of the recovered funds must be returned to the federal government, yet the state incurs the administration costs</p> <p>Applying Medicaid RAC activities and other program integrity efforts to this Private Option population further promotes some of the stated goals of the waiver, including discouraging over utilization, reducing fraud, waste and abuse and achieving cost neutrality.</p> | |
| <p>Assess a Premium Assistance Program for Employer Sponsored Coverage (ESI)</p> | <p>CMS and Arkansas may also consider premium assistance not just for QHPs, but also performing a cost-benefit analysis on providing ESI premium assistance for individuals who have access to coverage through their employer. It is conceivable that placing a Private Option member into ESI may be more cost effective than paying premium assistance to a QHP for that same member.</p> <p>Traditionally, premium assistance programs encourage low-income families' participation in private coverage, prevent crowd-out in publicly funded programs, and achieve cost savings by utilizing employer contributions to offset costs. Premium assistance programs use federal and state Medicaid and/or State Children's Health Insurance Program (SCHIP) funds to subsidize the purchase of private health insurance. They may also utilize employer or enrollee contributions to help pay premium costs.</p> <p>Premium assistance programs often generate significant savings for Medicaid while providing beneficiaries access to a larger network of providers and the ability to cover a whole family under the same plan. These programs lower overall healthcare costs by taking advantage of premium dollars employers are willing to contribute toward their eligible employee and dependent premiums-money that is now often "left on the table."</p> <p>Arkansas could leverage its existing Health Insurance Premium Payment Program which began in October 2012 and today provides premium assistance reimbursements for fifty six families with Medicaid recipients suffering from disabling conditions and special needs. Furthermore, we encourage CMS and Arkansas to negotiate the Federal Matching Assistance available to the State to perform ESI premium assistance, recognizing that the federal government will fund the Private Option members at 100%.</p> <p>Implementing an ESI Premium Assistance initiative for the newly eligible population would preserve payer of last resort principles, help to reduce member churn, promote a market based approach, help to rationalize</p> | <p>2013-09-05 13:27</p> |

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| | <p>provider reimbursement across payers, expand provider access, and leverage the Arkansas Health Care Payment Improvement Initiative – further achieving the outcomes stated in the waiver.</p> | |
| <p>Maintain Medicaid as the Payer of Last Resort</p> | <p>By state (§ 20-77-306) and federal law [§1902(a)(25) of the Social Security Act], Medicaid is required to be the payer of last resort; that is, all other available third party resources must be used before the Medicaid program pays for the care of an individual eligible for Medicaid. The identification of other insurance and the recovery of overpayments due to other coverage are known as Third Party Liability (TPL).</p> <p>In CMS guidance or FAQs released in March 2013, Medicaid and the Affordable Care Act: Premium Assistance, it states “that under all these arrangements, beneficiaries remain Medicaid beneficiaries and continue to be entitled to all benefits and cost-sharing protections”. Arkansas’ waiver proposal, intends to use commercial QHPs instead of Medicaid managed care plans, but clearly these Private Option beneficiaries will still gain access to Medicaid Fee for Service (FFS) benefits. For example, the state is proposing Medicaid wrap around benefits to at least include non-emergency medical transportation, EPSTD services and potentially family planning services. Additionally, the waiver is proposing a three months retroactive Medicaid FFS coverage period. The state is also proposing to provide coverage through the FFS Medicaid program from the date an individual is determined eligible for Medicaid until the individual’s enrollment in the QHP becomes effective.</p> <p>Given that both CMS and the State consider these members to be Medicaid, then HMS recommends that the payer of last resort principles apply to ensure a fiscally sustainable, cost-effective program. Maintaining this population as a secondary payer will better position the demonstration for the required cost neutrality – meaning that the cost of covering Private Option beneficiaries will be comparable to what the costs would have been for covering the same expansion group in Arkansas Medicaid fee-for-service (FFS).</p> <p>TPL Models</p> <p>There are several TPL models Arkansas and CMS may explore as detailed in an August 1997 State Medicaid Director letter relating to various TPL structures in a Medicaid managed care environment. Those same models are applicable to the qualified health plans (QHPs) offered through the Arkansas Insurance Marketplace. The models are:</p> <ol style="list-style-type: none"> (1) Exclude or disenroll individuals with known TPL from enrollment in QHPs. (2) Allow individuals with TPL to receive coverage through QHPs with the state retaining TPL responsibilities. (3) Require QHPs to assume TPL responsibilities through a reduction in capitation payments reflecting the amount of projected TPL the plan should recover. (4) Exclude or disenroll individuals with commercial managed care TPL coverage. Allow individuals with non-commercial (ie Medicare) managed care TPL coverage to receive coverage through the QHP with the QHP assuming TPL responsibilities, but the state retaining responsibility for tort and estate recoveries. | <p>2013-09-05 13:25</p> |
| <p>Arkansas Chapter, American College of</p> | <p>Ms. Marilyn Tavenner Administrator</p> | <p>2013-09-04 07:49</p> |

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| Emergency Physicians | <p>Centers for Medicare and Medicaid Services</p> <p>Dear Ms. Tavenner:</p> <p>On behalf of the Arkansas chapter of the American College of Emergency Physicians and the patients our members serve each day in the state’s emergency departments, I urge CMS to ensure that the state of Arkansas’ Section 1115 waiver application, “Arkansas Health Care Independence Program – (Private Option)- Demonstration,” provides adequate coverage to emergency patients and appropriately defines how the state will determine the non-emergency care contemplated in the application.</p> <p>The waiver application includes a hypothesis stating that “private option beneficiaries will have lower non-emergency use of emergency room services as compared to Medicaid beneficiaries in non-Premium Assistance expansions nationally.”</p> <p>Appendix B of the application lists comments to and responses from the Arkansas Department of Human Services during its public hearings about this waiver application. In a response to a public comment, the state asserts that “Non-emergency use of the emergency room is not a covered benefit under the Alternative Benefit Plan, since non-emergency use of the emergency room is neither an Essential Health Benefit nor a mandated service in the Alternative Benefit Plan. As noted in the waiver application, the State will provide educational materials describing the appropriate use of the emergency room and will notify beneficiaries that non-emergency use of the emergency room is not covered under the Alternative Benefit plan.” However, the state application does not indicate how non-emergency use of the emergency department will be defined.</p> <p>It is critical that if this waiver is approved it is done so with clear direction that the state must follow the prudent layperson standard in determining what constitutes non-emergency use of the emergency department and that such determinations must not be based on a patient’s final diagnosis. The prudent layperson standard provides critical protections to patients so that they are covered if they seek care for a condition they believe may require emergency medical attention even if the issue turns out not to be as serious as the patient believed. Patients must not be put in the position of having to correctly diagnose their own symptoms in order to ensure coverage.</p> <p>Federal law (42 CFR 438.114) and CMS precedent have clearly supported the use of the prudent layperson standard since its passage as part of the Balanced Budget Act of 1997. Most recently, in a rule (CMS -2334-F) adopted July 15th of this year, CMS noted the significance of the prudent layperson standard as it relates to states setting co-payments for non-emergency care delivered in the emergency department. The rule states that the prudent layperson standard makes it “difficult to determine a service as non-emergency just based on CPT code.” In responding to comments on the subject in the final rule, CMS stated that it continues “to believe that the use of diagnosis and procedure codes alone is not an appropriate process for determining non-emergency services, as doing so would not adequately protect beneficiaries legitimately seeking ED services based on the prudent layperson standard, for whom a CPT code assigned after care is provided may indicate a non-emergency condition.”</p> | |

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| | <p>The same logic should clearly apply to the Arkansas demonstration project's stated intent to reduce non-emergency use of the emergency department among the population covered under the proposed "private option" plan. Currently, the waiver application does not describe how the state will define non-emergency care, but in a response to public comment, the application indicates that the financial ramifications for patients deemed to be using the emergency department for non-emergency care could greatly exceed the costs of a co-payment since it states that non-emergency care is not a covered benefit.</p> <p>To ensure that the critical patient protections provided by the prudent layperson standard is afforded to the "private option" population, as it is to those covered by Medicaid managed care programs and private insurers in the state, we urge CMS to require the State to stipulate that it will not base definitions of non-emergency care or related coverage decisions on final diagnoses and that it will abide by the prudent layperson standard in making any such determinations.</p> <p>Respectfully,</p> <p>Darren E. Flamik, MD, FACEP President, Arkansas Chapter of the American College of Emergency Physicians</p> | |