



July 12, 2021

Ms. Cindy Gillespie
Secretary
Arkansas Department of Human Services
PO Box 1437, S-295
Little Rock, AR 72203-1437

Ms. Elizabeth Pitman
Director
Arkansas Medicaid
PO Box 1437, S-295
Little Rock, AR 72203-1437

Submitted electronically to ORP@dhs.arkansas.gov

RE: Arkansas's Medicaid Expansion (ARHOME), Section 1115 Waiver Application

Dear Secretary Gillespie:

The Arkansas Hospital Association (AHA) is a membership organization that proudly represents more than one hundred health care facilities and their more than 50,000 employees as they strive to care for all Arkansans. The Association works to support, safeguard, and assist our members in providing safe, high-quality, patient-centered care in a rapidly evolving – and highly regulated – health care environment. The AHA sincerely appreciates the opportunity to comment on the section 1115 demonstration waiver application for Medicaid Expansion – called Arkansas Health and Opportunity for Me (ARHOME) – as proposed by the Arkansas Department of Human Services under the requirements of 42 CFR part 431 subpart G and the application procedures under 42 CFR 431.412(a).

Further, the AHA applauds the outstanding efforts of Governor Asa Hutchinson, your leadership team at the Department of Human Services, the 93rd General Assembly of the Arkansas Legislature, and the long list of stakeholders who worked collaboratively to ensure that Arkansans under 138 percent of the federal poverty level remain eligible to access Arkansas's health care system.



Access to Care

Since Arkansas's 2013 implementation of the Arkansas Health Care Independence Program, known as the Arkansas Private Option, Arkansas has provided premium assistance to support the purchase of coverage from Qualified Health Plans (QHPs) offered in the individual market through the Marketplace by beneficiaries eligible under the expanded adult group described at Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act, which were both (1) childless adults ages 19 through 64 with incomes at or below 138 percent of the federal poverty level (FPL) or (2) parents and other caretakers between the ages of 19 through 64 with incomes between 17 percent and 138 percent of the FPL. The Arkansas Private Option and each subsequent iteration of the program met or exceeded the objectives in Title XIX of promoting continuity of coverage for individuals, improving access to providers, enhancing the continuum of coverage, and furthering quality improvement and delivery system reform initiatives.

Specifically, a Kaiser Family Foundation study found that Arkansas's uninsured rate among non-elderly adults dropped from 27.5 percent to 15.6 percent between 2013 and 2014, which correlated to a 55 percent drop in uncompensated care in Arkansas's hospitals and expanded access to care in community-based settings and specialty care for beneficiaries.¹

Because of the premium assistance model, Arkansas's adult Medicaid Expansion population has not fallen prey to the practices of Medicaid Managed Care companies that limit a patient's access to care by rationing patient services or limiting network providers either through reimbursement rates that do not cover the cost of care or that increase the cost of care delivery due to inefficient administrative processes. Likewise, the premium assistance model has proven much more favorable to providers than traditional Medicaid rates, as Arkansas Medicaid hospital *per diem* inpatient rates have remained stagnant for more than 20 years and hospital fee-for-service outpatient rates were last cut in 1992 and never restored.

Therefore, the AHA enthusiastically supports ARHOME's proposal for the continuation of Qualified Health Plan coverage for Arkansas's Expanded adult population under the premium assistance model.

Onboarding and Ensuring Coverage

Medicaid eligibility is determined by the Department of Human Services in accordance with federal and state laws and regulations. The eligibility determination for Medicaid must remain a distinct process from qualified health plan enrollment or PASSE managed care plan enrollment. Currently, upon being determined Medicaid eligible under the new adult group, all beneficiaries begin their coverage in Medicaid fee for service.

Because the Medicaid eligibility determination is the sole responsibility of DHS, AHA requests that DHS implement the federal requirement for presumptive eligibility detailed in 42 CFR 435.1110. As an alternative, the AHA respectfully requests that DHS reinstitute 90-day retroactive eligibility, which was originally in place as a waiver from presumptive eligibility in the 2013 demonstration waiver. The current demonstration limits retroactive coverage to 30 days prior to the date of application.

¹<https://www.kff.org/medicaid/issue-brief/a-look-at-the-private-option-in-arkansas/>



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.

Streamlining Enrollment and the Member Experience

Once DHS determines a new adult group applicant eligible for Medicaid, individuals who identify themselves as “medically frail” or are subsequently identified as medically frail remain in fee-for-service for their coverage, but individuals who are not medically frail are covered by fee-for-service for a temporary period of time before enrollment into a qualified health plan.

The ARHOME waiver application further seeks to administratively move beneficiaries among fee-for-service Medicaid (even if not determined medically frail), qualified health plans, and the Provider-Led Arkansas Shared Savings Entity (PASSE) managed care plans. While the AHA applauds the Department of Human Services for seeking stakeholder input prior to implementation of this reassignment and assures that this reassignment process will not occur prior to 2023 and not without approval sought through the state rule-making process, continuity of care is at significant risk.

We are concerned that the proposed cost-sharing increases could cause individuals to drop Medicaid coverage, and we disagree with the premise that premiums are necessary to “assess whether individuals value coverage as insurance.” Medicaid’s primary purpose is to provide access to health care services for low-income individuals, and it is unlikely that reductions in participation due to increased cost-sharing reflect individuals devaluing coverage, rather than the necessity of making painful economic choices among competing priorities. The AHA does appreciate that there is no proposed cost-sharing for inpatient hospital stays, which could have caused adverse effects such as avoidance of addressing serious medical issues.

Similarly, 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.² 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.

² <https://www.startribune.com/disparities-dog-system-to-distribute-disability-services/563636552/>



The application is also silent on the periodicity of coverage for beneficiaries. In keeping with the goal of acclimating individuals with insurance, once a beneficiary is assigned into a qualified health plan, a beneficiary should remain in that plan for a full 12 months to ensure continuity of care and proper evaluation of the plan's quality improvement performance. In addition, an efficient and beneficiary-friendly appeals process must be created to allow a beneficiary who was reassigned into a plan to select the coverage best suited to that beneficiary.

Safeguards to Ensure Continuity of Care

The demonstration waiver application states that churn describes movement of individuals on and off the Medicaid program within a single year and over multiple years. Since March 11, 2020, when the national public health emergency was declared, the churn in the Medicaid program has been minimal, in accordance with federal laws and regulations. Prior to that time, however, beneficiaries were highly susceptible to losing coverage in a number of ways unrelated to their eligibility for Medicaid, such as disenrollment due to returned mail – sometimes due to participants not notifying the state of a move and other times due to problems with the State's records despite a participant reporting a change of address.³ The State's previous experience with work requirements also highlighted the unexpected difficulties that administrative barriers, such as various required reporting, can pose to Medicaid participants, causing many to lose coverage despite continued eligibility.⁴

While a number of required member notices are referenced in the demonstration waiver application, we strongly urge DHS to handle these notices carefully to minimize the risk of participants being inappropriately reassigned to fee-for-service or disenrolled despite continued eligibility. Specifically, we 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.

While outside the scope of comments on this proposed rule, we urge DHS to also use these strategies, as well as *ex parte* renewals that take advantage of all useful data sources to automate renewals, consistent with 42 CFR § 435.916, to avoid administrative disenrollments during the mass redeterminations following the end of the federal Public Health Emergency.

³ <https://files.kff.org/attachment/Issue-Brief-Recent-Medicaid-CHIP-Enrollment-Declines-and-Barriers-to-Maintaining-Coverage>

⁴ <https://www.healthaffairs.org/doi/10.1377/hblog20180904.979085/full/>



Improving Social Determinants of Health

Arkansas hospitals are not only the backbone of the Arkansas health care system through the delivery of emergency services, inpatient care, and outpatient care, hospitals are also already key components to the health of the communities where they serve. Hospitals fully recognize the importance of social, environmental, and behavioral factors as well as genetic and health care factors that impact a person's health. Arkansas also recognizes that CMS has not typically allowed non-medical services to be reimbursed through Medicaid; therefore, the AHA applauds DHS for seeking funding for hospitals that volunteer to serve as entities – what the waiver defines as Community Bridge Organizations or Life360 Homes – to identify and connect beneficiaries to social services, including integrating these services into their care delivery models, encouraging partnerships with community-based organizations, tracking social needs, and incentivizing a more holistic approach.

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.

Evaluation of Life360 HOMEs

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.⁵ For the other Domain 2 measures, difference-in-difference 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.

The Arkansas Hospital Association and its members are offering these comments in a spirit of collaboration with the goal of successful and timely implementation of these new regulations by DHS, and we stand ready to work with the Department and other stakeholders to address the issues raised in our letter and to ensure the program’s overall success for Arkansas’s hospitals and, most importantly, the patients and families that our hospitals are so honored to serve.

Sincerely,



Bo Ryall
President & CEO, Arkansas Hospital Association

⁵ <https://www.bls.gov/news.release/wkyeng.t03.htm>

