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August 8, 2016

The Honorable Secretary Sylvia Burwell
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: Arkansas Works 1115 Demonstration

Dear Secretary Burwell:

We appreciate the opportunity to comment on Arkansas's proposed Arkansas Works program (AWP) § 1115 Demonstration. The National Health Law Program (NHeLP) protects and advances the health rights of low income and underserved individuals. The oldest non-profit of its kind, NHeLP advocates, educates and litigates at the federal and state level.

Arkansas already has a successful Medicaid expansion which insures about 240,000 individuals. As the state notes in its application, this has contributed to one of the highest reductions of uninsurance in any state.[1] NHeLP recommends that HHS not approve any features of the AWP demonstration that are unauthorized by any federal law and will be harmful to this successful Medicaid expansion and the enrollees who depend upon the coverage. We urge HHS to work with Arkansas to preserve Medicaid expansion without harming current enrollees or jeopardizing enrollees in other states who may be affected by similar proposals. In its review, we urge HHS to zealously enforce its stated policies and the words and intent of § 1115 of the Social Security Act.

A. Existing Enrollees

HHS has approved several Medicaid expansion § 1115 demonstrations that include unprecedented waivers that in many cases negatively impact access to care for consumers and also conflict with the legal requirements for such demonstrations. HHS in some cases likely approved these waivers because, in exchange for the waivers, HHS could secure a Medicaid expansion that would cover thousands of individuals in an unexpanded stated.

[1] Arkansas Works program application, p. 2.

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Applications like Arkansas's, which request modifying coverage for individuals *already* enrolled, create an entirely different cost-benefit analysis. For extensions or amendments to existing Medicaid expansion programs, HHS should set a higher standard for approval. Altering an existing demonstration risks worsening access to care for current enrollees. Moreover, approving such harmful provisions in a state that has already expanded Medicaid could encourage widespread regression of Medicaid standards. Therefore, HHS should not approve any waivers in Arkansas that worsen care for current expansion enrollees, as our discussion below illustrates.

B. Premiums

Arkansas's § 1115 application requests premiums which are not approvable under § 1115. Specifically, the premiums violate three core requirements for § 1115 demonstrations:

- Section 1115 explicitly circumscribes waiver authority in Title XIX to requirements contained in § 1902.[2] Anything outside of § 1902 is not legally waivable through the §1115 demonstration process. §§ 1916 and 1916A are requirements independent of § 1902 and cannot be waived through § 1115.
- A § 1115 demonstration is precisely that, a demonstration. Arkansas's requests for § 1115 authority for premiums is not approvable because they will not test anything, given the well-known results of redundant studies on premiums. For example, the premiums for low-income enrollees that Arkansas seeks to apply with a waiver, have been repeatedly tested and consistently shown to depress enrollment – including for the very populations of adults that is the focus of the Arkansas proposals. *See* David Machledt and Jane Perkins, *Medicaid Cost Sharing and Premiums* (March 2014), available at: http://www.healthlaw.org/publications/browse-all-publications/Medicaid-Premiums-Cost-Sharing#.UzneLoX3IX5.
- Section 1115 demonstrations must also be "likely to assist in promoting the objectives" of the Medicaid. The objective of Medicaid is to furnish health care to low-income individuals. Many of the enhanced premium and cost sharing elements in Arkansas's proposal cannot be approved because they reduce access to care. The Social Security Act, particularly § 1916A, provides states with a great deal of flexibility to impose some premiums on higher income populations. Yet, Arkansas seeks to run past these options to implement a proposal which research has established is harmful to low-income people, and which will clearly result in interrupted care, lost opportunities, and churning.

Given that monthly contributions are not permitted for this population below 150% FPL, *punishments* for non-payment of contributions should also never be approved. We urge

[2] SSA § 1115(a)(1).

HHS to not approve any penalties on consumers who fail to pay premiums, including loss of existing benefits.

As an example, we urge CMS to consider Ohio's *own* finding that over 125,000 individuals would lose coverage in 2018, the year the Healthy Ohio plan would first implement premiums, relative to enrollment without that premium payment enrollment system.[3] Premiums for those living on incomes below 100% FPL would be especially concerning, since they contradict the structure of the ACA and numerous Medicaid cost sharing protections set at 100% FPL, including the prohibition on enforceable cost sharing. We note, however, that, under the law, premiums are equally impermissible for individuals below 150% FPL whether they are mandatory or optional.

Finally, if (against our recommendation) HHS approves premiums, HHS should clarify the limits on how Arkansas can act on the requested "debt to the state." If Arkansas finds other means to punish individuals who carry debt, it would have a similar effect as enforceable premiums. HHS should not allow a state to use other state mechanisms to implement punitive measures that target Medicaid enrollees (i.e., HHS should withholding matching funds if states attempt to do this).

C. Retroactive Eligibility

Medicaid requires states to provide retroactive coverage for enrollees.[4] Arkansas has requested § 1115 demonstration authority to waive this requirement. This waiver should not be allowed because there is no demonstrative value to the request. The entirely predictable result will be: (1) more low-income individuals experiencing medical debt collections and bankruptcy; (2) more providers – especially safety net hospitals – incurring losses; and (3) more individuals experiencing gaps in coverage when some providers refuse to treat them because the providers know they will not be paid retroactively by Medicaid. This policy has dubious hypothetical benefits and very concrete harms. For these same reasons, the § 1115 demonstration should not be approved because this does not promote the objectives the Medicaid.

D. Freedom of Choice for Family Planning Services and Supplies

The AWP application includes a broad request for waiver of freedom of choice. The Social Security Act specifically requires freedom of choice for family planning services and supplies, even in managed care arrangements.[5] HHS and a number of district and federal circuit courts of appeal have consistently made clear that states must cover family planning services and supplies provided by any qualified provider, including out-of-network providers.[6] Therefore, HHS should clarify that, regardless of any approval of freedom of choice waiver requests in the AWP, individuals remain entitled to obtain out-of-network coverage for family planning services and supplies, regardless of whether

[3] Healthy Arkansas Section 1115 Demonstration Waiver: Summary, available at: http://medicaid.Arkansas.gov/Portals/0/Resources/PublicNotices/HealthyArkansas-Summary.pdf.
[4] SSA §§ 1902(a)(34); 42 C.F.R. § 435.915.
[5] SSA § 1902(a)(23)(B).
[6] *See* CMS, State Medicaid Manual, § 2088.5.

there are available in-network family planning providers. We recommend that any approval include language similar to the language in HHS's freedom of choice waiver in Indiana: "No waiver of freedom of choice is authorized for family planning providers."[7]

E. Transportation

Medicaid requires coverage of NEMT.[8] This is a core Medicaid requirement, applicable to all state plan enrollees. HHS cannot approve the waiver of NEMT requested for ESI enrollees under § 1115 authority. There is no valid experimental purpose to not provide transportation – it is clear that beneficiaries will lose access to care. Furthermore, reducing access to care for poor beneficiaries, including ones in isolated rural communities that lack any public transportation, clearly contradicts the objectives of the Medicaid Act. To the extent HHS has (in our view, illegally) approved such a waiver recently in Iowa and Indiana, we believe that HHS should wait until the analysis of those "demonstrations" is completed before authorizing any more experiments that are dangerous and likely to hurt beneficiaries. The evidence so far suggests that NEMT waivers do not help furnish care to Medicaid recipients and likely exacerbate health care disparities, as the populations most likely to face transportation barriers to accessing care include racial and ethnic minorities, women, and people with disabilities or who have substantial health care needs.[9]

F. Appeals

We continue to be concerned with Medicaid appeals in the current and proposed Arkansas demonstrations. Individuals enrolled in Medicaid should have access to the full Medicaid appeals process – which includes features such as advance notice of denials, air paid pending, and the right to call witnesses, question witnesses, and have an impartial decisionmaker – regardless of whether they are in premium assistance for QHP or ESI coverage. This should be the case for eligibility decisions as well as service decisions. We urge HHS to ensure that all Medicaid enrollees have access the due process protections required by the U.S. Constitution.[10]

G. Work Referrals

We appreciate that Arkansas's demonstration application does not include a work requirement as a condition of eligibility. We urge HHS to ensure that the state does not present the "work referral" to enrollees in a way that confuses enrollees into thinking it is a condition of eligibility and/or otherwise dissuades enrollment in Medicaid.

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[7] Letter from Marilyn Tavenner approving Health Indiana Plan 2.0, 6 (Jan 25., 2015).
[8] *See* 42 C.F.R. § 431.53; CTRS. MEDICARE & MEDICAID SERVS., STATE MEDICAID MANUAL § 2113.
[9] Suzanne Bentler, *et al.*, University of Iowa Public Policy Center, Non-Emergency Medical Transportation and the Iowa Health and Wellness Plan (Mar. 2016).
[10] U.S. Const., amend. XIV, § 1; *Goldberg v. Kelly*, 397 U.S. 254 (1970)

Conclusion

In summary, we have numerous concerns with the legality of Arkansas's § 1115 demonstration application, as proposed. We fully support the use of § 1115 of the Social Security Act to implement true experiments. We strongly object, however, to any efforts to use § 1115 to skirt essential provisions that Congress has placed in the Social Security Act to protect Medicaid beneficiaries and ensure that the program operates in the best interests of the population groups described in the Act. We urge HHS to address our concerns prior to issuing any approval. If you have questions about these comments, please contact Leonardo Cuello (cuello@healthlaw.org). Thank you for consideration of our comments.

Sincerely,

Leonardo D. Cuello