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October 24, 2021

The Honorable Xavier Becerra, Secretary
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Ave., S.W.
Washington, D.C. 20201

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

Dear Secretary Becerra:

The National Health Law Program (NHeLP) 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 comment on the ARHOME section 1115 application.

As described in detail below, the ARHOME project raises serious legal concerns. The application does not include a sufficient level of detail to allow for meaningful comment on a number of features of the project, including the features that Arkansas claims will address social determinants of health. What is clear from the application is that the State is seeking permission to implement a number of policies – imposing premiums, waiving retroactive coverage, and restricting access to services through various mechanisms – that conflict with the core objective of the Medicaid Act (furnishing medical assistance) and serve no experimental purpose. In fact, the application is explicit that, with these

policies, Arkansas is seeking to further its own alternative objectives for the program, such as improving beneficiary health, moving individuals out of poverty, and saving money. As such, these policies are not approvable under section 1115.

I. Application Deficiencies

The ARHOME application does not allow for a notice and comment process that is “sufficient to ensure a meaningful level of public input.”¹ Arkansas has failed to explain a number of the central features of its proposed project. For example,

- The application indicates that it will offer several different benefit packages: (1) a fee-for-service (FFS) package for medically frail individuals; (2) a distinct FFS package for individuals who do not chose a QHP when they enroll or are deemed “inactive” after they enroll in a QHP; (3) a new package for certain individuals with serious mental illness or substance use disorder who are enrolled in the PASSE program; and (4) QHP coverage for the remainder of the expansion population. However, nowhere does the application explain the specific contents of each of the benefit packages. Of note, it is our understanding that individuals in FFS are limited to six prescriptions per month—a restriction on coverage not mentioned by Arkansas but one that would apparently apply only to this targeted group.
- Arkansas asks for federal funding for three kinds of “community bridge organizations” called Life360 Homes, which it claims will help address social determinants of health. Here too, the application is short on details. Arkansas does not answer critical questions, including: What specific scope of services will the Life360 Homes provide? What is the rationale for having hospitals deliver the services? How will Arkansas determine who is eligible to enroll in one of the Life360 Homes, and what if a person is eligible for multiple Life360 Homes? Can individuals be disenrolled, and if so, what protections will beneficiaries who are subject to disenrollment have?
- In the application, Arkansas proposes to require QHPs to offer incentives to their members for participating in health improvement and economic independence initiatives, but indicates that QHPs will determine the nature of the incentives at a later date (subject to State approval). The application states that the incentives will not be “additional benefits, but rather small rewards.”² But, it also states that one of the “rewards” could be reduced cost sharing, which suggests that Arkansas would permit (or encourage) QHPs to link completion of various health or work activities to access to care.³ In short, the application offers little information about the nature of

¹ 42 U.S.C. § 1315(d)(2)(A), (C); 42 C.F.R. § 431.408(a).

² Ark. Dept. of Human Servs., *Arkansas Health and Opportunity for Me (ARHOME) Section 1115 Demonstration Application 5-6* (2021), <https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ar-arhome-pa.pdf> [hereinafter “Application”].

³ *Id.* at 10.

the health improvement and economic independence initiatives, and the information that it does include is inconsistent.

- Arkansas proposes to keep individuals who do not select a QHP in FFS and to move individuals who are in a QHP and deemed “inactive” into FFS. But, the application does not provide critical details, including: the parameters under which individuals will be kept in or moved into FFS; how long individuals will be forced to remain in FFS; and whether beneficiaries can appeal the State’s decision to move them into FFS. (Presumably, this should be treated as an involuntary Medicaid managed care disenrollment, but that is not clear in the application.)
- Arkansas seeks federal funding “to pay for medical services in an IMD.”⁴ The application provides no further information about that request.⁵

The lack of information makes it difficult – if not impossible – for members of the public to understand and offer meaningful comment on these core elements of the project. As a result, the application should not have been deemed complete.⁶ We ask CMS to require the State to submit an application that adheres to the federal requirements and to provide an additional comment period on that proposal.

We note that the lack of information about the proposed project also makes it impossible for CMS to determine whether Arkansas is conducting a valid experiment under section 1115.

II. HHS Authority Under Section 1115

For the Secretary to approve a project pursuant to section 1115, the project must:

- be an “experimental, pilot or demonstration” project;
- be likely to promote the objectives of the Medicaid Act;
- waive compliance only with requirements in 42 U.S.C. § 1396a; and
- be approved only to the extent and for the period necessary to carry out the experiment.

⁴ Application at 28.

⁵ Regardless of the exact nature of that request, it is not approvable. Because the IMD exclusion lies outside of 42 U.S.C. § 1396a, it cannot be waived under section 1115. See 42 U.S.C. §§ 1396d(a)(31)(B); 1315(a)(1). As described in more detail below, section 1115(a)(2) does not create an independent “expenditure authority” for the Secretary to allow a state to ignore provisions of the Medicaid Act outside of section 1396a. The application also fails to include any evaluation criteria on this issue and generally does not meet the expectations for SMI/SED demonstrations set forth in CMS’s 2018 guidance. See CMS, Dear State Medicaid Director Letter, SMD #18-001 (Nov. 13, 2018) <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf>.

⁶ See 42 C.F.R. § 431.412(a).

Discussing each of these limitations a bit further:

First, the state must propose to conduct an “experimental, pilot, or demonstration” project. This demands a “novel approach” to program administration.⁷ To evaluate whether a proposed project is a valid experiment, the Secretary needs to know what will be tested and how, at the point in time when the project is being approved. In addition, courts have made clear that a project designed to test whether a benefits cut will save money does not satisfy the experimental requirement in section 1115.⁸

Second, the project must promote the Medicaid Act’s objectives. According to Congress, the purpose of Medicaid is to enable states “to furnish[] medical assistance” to individuals “whose income and resources are insufficient to meet the costs of necessary medical services” and to provide “rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care.”⁹ Thus, the “central objective” of the Medicaid Act is “to provide medical assistance,” that is to provide health coverage.¹⁰

Third, the Secretary can only waive provisions set forth in section 1396a of the Medicaid Act. The Secretary cannot waive requirements contained in sections 1396b through 1396w-5.¹¹ Once the Secretary has acted under section 1115(a)(1) to waive compliance with designated provisions in section 1396a, section 1115(a)(2) provides that the costs of “such project” are “regarded as expenditures under the State plan” and, thus, paid for under the same statutory formula that applies for a state’s expenditures under its state plan.¹² Section 1115(a)(2) does not create an independent “expenditure authority” or “requirements not applicable to expenditure authority” for the Secretary to allow a state to ignore provisions of the Medicaid Act outside of section 1396a or to rewrite or modify the provisions in section 1396a or any other provision outside of section 1396a. To the contrary, it is a “clean-up” provision that merely provides the authorization necessary for federal reimbursement of expenditures for a project that has been approved under section 1115(a)(1).

Fourth, section 1115 allows approvals only “to the extent and for the period . . . necessary” to carry out the experiment.¹³ The Secretary cannot use section 1115 to permit states to make long-term policy changes.

⁷ *Beno v. Shalala*, 30 F.3d 1057, 1069 (9th Cir. 1994).

⁸ *Newton Nations v. Betlach*, 660 F.3d 370, 381 (9th Cir. 2011); *Beno v. Shalala*, 30 F.3d 1057, 1069 (9th Cir. 1994).

⁹ 42 U.S.C. § 1396-1; *id.* § 1396d(a) (defining “medical assistance” as provision of, or payment for, specified health care and services).

¹⁰ *Stewart v. Azar*, 366 F. Supp. 3d 125, 138 (D.D.C. 2019); *id.* at 144 (rejecting “promoting health” as an independent objective because the Medicaid Act is “designed . . . to address not health generally but the provision of care to needy populations” through a health insurance program).

¹¹ See 42 U.S.C. § 1315(a)(1).

¹² *Id.* § 1315(a)(2).

¹³ *Id.* § 1315(a); see also *id.* §§ 1315(e)(2), (f)(6) (limiting the extension of “state-wide, comprehensive demonstration projects” to one initial extension of up to 3 years (5 years, for a

As noted above, several features of the ARHOME project exceed one or more of these limitations and harm Medicaid beneficiaries.

III. Premiums

Arkansas seeks permission to impose premiums on beneficiaries with household income above 100% of FPL. The amount of the premiums for 2022 will be \$22.44 per month for individuals with income ranging from 101% to 120% of FPL and \$26.88 per month for individuals with income above 120% of FPL. Individuals who do not pay the premium will go in debt to their QHP.¹⁴

Section 1115 does not give the Secretary authority to allow Arkansas to implement these premiums. The Medicaid Act explicitly prohibits states from charging premiums to individuals with household income below 150% of FPL.¹⁵ These limits exist outside of section 1396a, and as a result, cannot be waived under section 1115. Time and again, Congress has made clear its intent to insulate the substantive limits on premiums and cost-sharing from waiver under section 1115. In 1982, Congress removed the substantive limits on premiums and cost-sharing from section 1396a and transferred them to a new section 1396o, which imposes independent obligations on states.¹⁶ Since then, Congress has made repeated changes to the limits, confirming that changes in the flexibilities available to states to charge premiums must come from Congress, not from HHS.¹⁷

In addition, the premiums are not experimental and conflict with the objectives of the Medicaid Act. While Arkansas is not proposing to terminate coverage when beneficiaries fail to pay, the requirement to pay will deter eligible individuals from enrolling in and keeping their coverage. Redundant research, *conducted over more than two decades*, has shown that premiums serve as a barrier to obtaining and maintaining Medicaid coverage.¹⁸

waiver involving Medicare-Medicaid eligible individuals) and one subsequent extension not to exceed to 3 years (5 years, for Medicare-Medicaid waivers). In 2017, a CMS Informational Bulletin announced the intent “[w]here possible, . . . [to] approve the extension of *routine, successful, non-complex*” section 1115(a) waivers for a period up to 10 years. Ctr. for Medicaid & CHIP Servs., CMS, CMCS Informational Bulletin 3 (Nov. 6, 2017) (emphasis added). The Bulletin should be disregarded because it conflicts with, among other things, section 1115’s limitation of approvals to experimental, pilot, or demonstration projects (not for “routine” projects) and only for the period necessary to carry out the experiment (not to maintain a successful experiment as an ongoing policy).

¹⁴ Application at 12-13.

¹⁵ 42 U.S.C. §§ 1396o(a)(1), (c)(1), 1396o-1(b)(1).

¹⁶ Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248, 96 Stat. 324, 367.

¹⁷ See Omnibus Reconciliation Act of 1987, Pub. L. No. 100-203, § 4101(d)(1), 101 Stat. 1330, 1330-141 to -142 (authorizing premiums on pregnant women and infants with incomes over 150% of FPL); Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6408(d)(3)(B), (C), 103 Stat. 2106, 2269 (codified at 42 U.S.C. § 1396o(d)) (authorizing premiums for certain working individuals with disabilities who have incomes over 150% of FPL); Deficit Reduction Act of 2005, Pub. L. 109-171, § 6041-6043, 120 Stat 6, 81, 85, 86 (2006) (adding 42 U.S.C. § 1396o-1).

¹⁸ Samantha Artiga et al., Kaiser Family Found., *The Effects of Premiums and Cost sharing on Low-Income Populations: Updated Review of Research Findings* (2017),

For example, a 1999 study of low-income health programs in several states found that premiums amounting to 1% of family income reduce enrollment by nearly 15%, while premiums set to 3% of family income cut enrollment in half.¹⁹ In 2003, Oregon experimented with imposing sliding scale premiums (\$6-\$20) and higher cost sharing on some Medicaid enrollees. Research concluded that almost half of the affected individuals dropped out of the Medicaid program within the first six months after the changes.²⁰ Similarly, a 2014 study of Wisconsin Medicaid beneficiaries found that an increase in premiums from \$0 to \$10 reduced the likelihood of individuals remaining enrolled in the program for a full year by 12-15%.²¹ Notably, other changes in premium amounts (for individuals with higher incomes) had no or relatively little effect on enrollment.²² According to the authors, “[t]he implication of these findings is that the premium requirement itself, more so than the specific dollar amount, discourages enrollment.”²³ In addition, the authors found that the results “are not driven by moral hazard in enrollment.”²⁴ In other words, enrollees were not enrolling only when they needed care and then disenrolling to avoid having to pay the premiums.

The Kaiser Family Foundation reviewed research on premiums published between 2017 and 2021 and concluded that recent studies support the earlier research findings that premiums reduce coverage and increase disenrollment.²⁵ In one study included in the review, researchers found that when Michigan increased premiums for expansion adults with income above 100% of FPL by an average of \$3.15 per month, disenrollment increased by 2.3%.²⁶ Put another way, every dollar increase in premiums increased disenrollment by .7%.²⁷

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

¹⁹ Leighton Ku and Teresa Coughlin, *Sliding-Scale Premium Health Insurance Programs: Four States’ Experiences*, 36 INQUIRY 471, 476 (Winter 1999-2000), <https://www.jstor.org/stable/29772862>.

²⁰ Bill J. Wright et al., *The Impact of Increased Cost Sharing on Medicaid Enrollees*, 24 HEALTH AFF. 1106, 1110 (2005), <https://www.healthaffairs.org/doi/10.1377/hlthaff.24.4.1106>.

²¹ Laura Dague, *The Effect of Medicaid Premiums on Enrollment: A Regression Discontinuity Approach*, 37 J. HEALTH ECON. 1, 10 (2014), <https://ccf.georgetown.edu/wp-content/uploads/2012/03/Dague-Premiums.pdf>.

²² *Id.*

²³ *Id.* at 10. Additional research supports this conclusion. See, e.g., Coleman Drake & David M. Anderson, *Terminating Cost-Sharing Reduction Subsidy Payments: The Impact of Marketplace Zero-Dollar Premium Plans on Enrollment*, 39 HEALTH AFF. 41 (2020), <https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.00345>.

²⁴ Dague, *supra* note 21, at 10.

²⁵ Madeline Guth et al., Kaiser Family Found., *Understanding the Impact of Medicaid Premiums & Cost-Sharing: Updated Evidence from the Literature and Section 1115 Waivers* (2021), <https://www.kff.org/medicaid/issue-brief/understanding-the-impact-of-medicaid-premiums-cost-sharing-updated-evidence-from-the-literature-and-section-1115-waivers/>.

²⁶ Betsy Q. Cliff et al., *Adverse Selection in Medicaid: Evidence from Discontinuous Program Rules*, NAT’L BUREAU OF ECON. RSCH. 4 (2021), https://www.nber.org/system/files/working_papers/w28762/w28762.pdf.

²⁷ *Id.*

In sum, imposing premiums on ARHOME beneficiaries has no experimental value; there is nothing new to test here.²⁸ More than two decades of research has concluded that premiums deter and reduce coverage, especially among low-income individuals. And, Congress has recognized as much. In an effort to maximize coverage during the COVID-19 pandemic, Congress eliminated premiums for individuals with income below 150% of FPL who receive coverage through the Marketplace in 2021 and 2022.²⁹

Despite this evidence, Arkansas offers several justifications for its request to charge premiums. The State indicates that the main purpose of the premiums is “to assess whether individuals value coverage as insurance.”³⁰ Whether individuals “value” Medicaid coverage is immaterial under the statute, and virtually impossible to measure experimentally. The purpose of the Medicaid program is to provide medical assistance to individuals whose income is too low to cover the cost of services, regardless of whether those individuals “value” the coverage. What is more, Arkansas is wrong to presume that individuals who do not pay the premium do not “value” their health coverage. There are several other obvious and well-documented reasons why Medicaid beneficiaries fail to pay premiums. Administrative complexity and administrative errors prevent many enrollees from meeting premium requirements.³¹ In other cases, the individuals simply do not have enough money to cover all their necessities—that is one of the reasons they qualify for Medicaid in the first place.³²

The State also suggests that the premiums are proper because “individuals at the same income level in states that did not expand Medicaid to the new adult group who purchase individual insurance coverage through the Marketplace” could face even higher out-of-pocket costs than ARHOME enrollees.³³ Again, Arkansas misunderstands the purpose of the Medicaid program and section 1115. To be approvable, a section 1115 project must promote the core objective of the Medicaid program, which is to provide medical assistance. The relevant baseline for determining if a proposed project will do that is not the absence of coverage (leaving individuals to seek coverage through the Marketplace), but rather coverage that complies with the requirements of the Medicaid Act.³⁴ Here, then, the relevant baseline is Medicaid coverage provided without premiums, and there is no question that the proposal will cause coverage to dip below that baseline. While the level of

²⁸ See Application at 14 (suggesting that “the valuation will consider whether the application of a premium will have an impact on the “take up” rate for new applicants”).

²⁹ American Rescue Plan Act, Pub. L. No. 117-2, § 9661, 135 Stat. 4, 182 (2021).

³⁰ Application at 14.

³¹ See, e.g., Jake Harper, *Indiana’s Model for Medicaid Could Spread – But It’s Not Working for Everyone*, Ill. Pub. Media, (Jan. 18, 2017), <https://will.illinois.edu/news/story/indianas-model-for-medicaid-could-spread-but-its-not-working-for-everyone>.

³² See, e.g., Madeline Guth, et al., *supra* note 25 (highlighting that available data from evaluations of section 1115 projects with premium requirements indicate that “many enrollees experience confusion over premium policies” and that “many enrollees reported that their premiums were not affordable”).

³³ Application at 14.

³⁴ See *Stewart v. Azar*, 366 F. Supp. 3d 125, 154 (D.D.C. 2019).

out-of-pocket costs that Marketplace enrollees face in non-expansion states is troubling, it does not factor into the equation.³⁵

IV. Cost Sharing

Arkansas states that it is seeking to impose cost sharing up to “the amounts allowable under Medicaid rules.”³⁶ However, the State is in fact seeking to deviate from the federal requirements in several respects.

First, Arkansas suggests that Medicaid providers can refuse to serve an individual after the individual has failed to pay a copay.³⁷ Under federal law, states cannot permit providers to deny services to individuals with income at or below 100% of FPL on account of their inability to pay cost sharing.³⁸

Second, the application indicates that Arkansas could decide to only impose cost sharing requirements on beneficiaries who do not complete health improvement or economic independence initiatives.³⁹ Federal law does not permit any kind of targeted cost sharing for individuals with income below 100% of FPL.⁴⁰

Under 42 U.S.C. § 1396o(f), “under any waiver authority,” the Secretary can only allow Arkansas to deviate from the federal requirements if, after providing notice and comment, they find that five tightly circumscribed criteria are met.⁴¹ Here, Arkansas has not even requested a waiver under section 1396o(f), much less demonstrated that its cost sharing proposal complies with the criteria.

The proposed premiums and cost sharing raise an additional legal and practical concern. While the application states that Arkansas will cap premiums and cost sharing at 5% of income each quarter, the application fails to show that Arkansas will be able to implement that cap.⁴² Under federal regulations, if a state’s premiums or cost sharing policies place beneficiaries at risk of reaching the 5% cap, which the ARHOME scheme does – the state must develop an effective mechanism to track families’ incurred premiums and cost sharing “that does not rely on beneficiary documentation.”⁴³ The state must inform enrollees and

³⁵ Even if it did, the data that Arkansas cites does not account for the recent change in the law, which eliminated premiums for Marketplace enrollees with income below 150% of FPL in 2021 and 2022. See American Rescue Plan Act, Pub. L. No. 117-2, § 9661, 135 Stat. 4, 182 (2021).

³⁶ Application at 12.

³⁷ *Id.* at 13.

³⁸ See 42 U.S.C. §§ 1396o(e), 1396o-1(a)(2)(A), 42 C.F.R. § 447.52(e)(2).

³⁹ Application at 10, 27.

⁴⁰ See 42 U.S.C. § 1396o-1(a)(1), (2)(A); 42 C.F.R. § 447.52.

⁴¹ 42 U.S.C. § 1396o(f)(1)-(5).

⁴² See *Id.* § 1396o-1(a)(2)(B), (b)(1)(B)(ii); 42 C.F.R. § 447.56(f).

⁴³ 42 C.F.R. § 447.56(f)(2).

providers when the aggregate cap is reached and establish a process for enrollees to request a recalculation of their limit due to a change in circumstances.⁴⁴

The ARHOME cost sharing structure is complex – it uses seven narrow income bands and appears to tie some debts to QHPs (premiums for QHP enrollees), some to the State itself (premiums for FFS enrollees), and some (cost sharing) to providers. The State has not come close to making it clear how it will ever be able to track or record individuals' or families' expenses and the amount of their 5% cap in close to real time. Providers often submit claims months after the date of service, meaning that Arkansas will not be able to rely on claims to track incurred cost sharing and notify enrollees when they have reached the 5% cap. Moreover, even a small change in income during a quarter could shift a beneficiary into a lower or higher income band, but the State describes no mechanism for individuals to report such changes or to inform individuals of the amount of their 5% cap. And, the proposal to delay enrollment in QHPs and shift “inactive” individuals back into FFS (discussed below), will make this tracking and calculation even more complex.

For example, imagine Individual A, with an income of 40% FPL (aggregate cap of \$20.96 each quarter), goes to their primary care provider in January for basic lab work and to renew two prescriptions, one of which is non-preferred (\$23.50 in total cost sharing). The PCP and the pharmacy do not submit claims to Individual A's QHP for two months. In February, Individual A's spouse goes to their psychologist, who charges the spouse \$4.70 for the visit, even though the family has already reached the 5% cap. What happens if the psychologist threatens to discontinue services if the spouse does not pay the copay? How will Arkansas inform the psychologist that she cannot bill Individual A's spouse for this cost sharing, when Individual A's claims have not yet been submitted? What happens if Individual A gets a small raise and his income increases in February – will the spouse then owe the psychologist the copay?

The existence of such a complicated premiums and cost sharing structure, under which beneficiaries will routinely exceed the 5% cap, is an administrative disaster in waiting and will only impede beneficiary access to care. Arkansas has not demonstrated that it is prepared to implement such a structure in accordance with federal law, and as a result, its proposal should not be approved. Arkansas can implement cost sharing through a state plan amendment that adheres to federal statutory and regulatory requirements.

V. Retroactive Coverage Waiver

The ARHOME project seeks to “reduce the period for retroactive coverage from 90 days to 30 days prior to eligibility determination.”⁴⁵ CMS should not grant this waiver because it violates section 1115.

⁴⁴ *Id.* § 447.56(f)(3),(4).

⁴⁵ *Compare* Application at 14, 27 with 42 U.S.C. § 1396a(a)(34).

Numerous states have been granted retroactive coverage waivers since at least the 1990s.⁴⁶ By now, it is abundantly clear that waiving retroactive coverage subverts the objectives of the Medicaid Act because it “by definition, *reduce[s]* coverage” for people not currently enrolled in Medicaid.⁴⁷ Arkansas acknowledges these harmful effects by proposing a partial waiver that exempts some individuals—those who incur medical debts during the 30 days prior to eligibility determination. This raises serious legal questions: A partial waiver modifies, or changes, the wording of 42 U.S.C. § 1396a(a)(34) and § 1396d(a), which extend retroactive coverage for three months prior to the month of application, provided the individual was eligible for Medicaid on the date the needed services were provided. While some other waiver authorities authorize HHS to “waive or modify” Medicaid Act provisions, section 1115 only authorizes the Secretary to “waive” them.⁴⁸

Retroactive coverage is critical for Medicaid beneficiaries. Although Arkansas did not provide an estimate of the number of people who will lose coverage due to this waiver, data from other states quantify the obvious: waiving retroactive coverage produces significant coverage loss. Florida reported that tens of thousands of people needed retroactive coverage in just the SFY 2015-2016 time period—approximately 39,000 non-pregnant adult recipients.⁴⁹ Iowa estimated that waiving retroactive coverage in its Medicaid program would decrease coverage by 3,344 people every month and over 40,000 people every year.⁵⁰ During one 16-month period in New Hampshire, 4,657 individuals in the Medicaid expansion population alone benefited from retroactive coverage, which paid for more than \$5 million in medical expenses.⁵¹ When Indiana received permission to waive retroactive coverage in 2015, CMS required the State to continue to provide some retroactive coverage to parents and caretaker relatives, and almost 14% of that population used the

⁴⁶ See Leonardo Cuello, Georgetown Univ. Health Policy Inst., Ctr. for Children & Families, *Retroactive Coverage Waivers: Coverage Lost and Nothing Learned* (Oct. 4, 2021), <https://ccf.georgetown.edu/2021/10/04/retroactive-coverage-waivers-coverage-lost-and-nothing-learned/> (listing 14 current retroactive coverage waivers); MACPAC, *Medicaid Retroactive Eligibility: Changes Under Section 1115 Waivers* (2019), <https://www.macpac.gov/wp-content/uploads/2019/08/Medicaid-Retroactive-Eligibility-Changes-under-Section-1115-Waivers.pdf> (listing the 30 demonstration projects with a waiver of retroactive coverage as of August 2019 and noting that none of the states “have conducted a formal evaluation of the effects of these policies”). See also Jane Perkins & Catherine McKee, Nat’l Health Law Program, *Medicaid Retroactive Coverage: Stop These Waivers!* 2-3 (2021), <https://healthlaw.org/resource/medicaid-retroactive-coverage-stop-these-waivers/> (describing the history of retroactive waivers).

⁴⁷ *Stewart v. Azar*, 313 F. Supp. 3d 237, 265 (D.D.C. 2019).

⁴⁸ Compare 42 U.S.C. § 1320b-5 (section 1135 “waive or modify” authority during a national emergency) with *id.* § 1315 (section 1115 “waiver” authority for a time-limited experiment).

⁴⁹ Agency for Health Care Admin., Florida Managed Medicaid Assistance Waiver at 6 (Apr. 27, 2018).

⁵⁰ See Iowa Dep’t of Human Servs., *Section 1115 Demonstration Amendment, Iowa Wellness Plan*, at Attachment A (2017), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/ia-wellness-plan-pa4.pdf>.

⁵¹ See N.H. Dep’t of Health & Human Servs., *Retroactive Coverage Waiver Submission* (2015), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nh/health-protection-program/nh-health-protection-program-premium-assistance-retro-cov-waiver-submission-12212015.pdf>.

coverage, with the amount paid averaging \$1,561 per person.⁵² Low-income people cannot afford \$1500 in unexpected medical expenses. They become saddled with crushing medical debt—an outcome that is antithetical to the Biden administration’s focus on shoring up and building up the middle class. That outcome also has a disproportionate impact on people of color. Black households are much more likely to have medical debt than white households (28% to 17%); Hispanic households are also more likely to have medical debt.⁵³

Waiving retroactive coverage also raises uncompensated care costs for hospitals and other safety-net health care providers. When Ohio requested a waiver of retroactive coverage, one report estimated that the waiver would result in roughly \$2.5 billion more in uncompensated costs for hospitals over five years.⁵⁴ Iowa’s waiver was opposed on similar grounds, with the Iowa Hospital Association warning that the waiver would “place a significant financial burden on hospitals and safety-net providers and reduce their ability to serve Medicaid patients . . . translate into increased bad debt and charity care for Iowa’s hospitals and . . . affect the financial stability of Iowa’s hospitals, especially in rural communities.”⁵⁵

Congress required retroactive coverage in order to “protect persons who are eligible for Medicaid but do not apply for assistance until after they have received care, either because they did not know about the Medicaid eligibility requirements or because the sudden nature of their illness prevented their applying.”⁵⁶ There are no grounds for ignoring this congressional intent. While Arkansas suggests that the effects of the waiver “can be mitigated by the provider who can assist the individual to apply for coverage at the time they initially seek medical services,” that is not the case.⁵⁷ As Congress recognized, many people need retroactive coverage after a medical crisis, such as a car accident or a heart attack. That medical crisis can keep individuals from applying for coverage for months.

Arkansas has requested the waiver to “test future beneficiaries’ understanding of fundamental [commercial] insurance concepts which depend on obtaining insurance prior

⁵² Letter from Vikki Wachino, Dir., Ctr. for Medicaid & CHIP Servs., to Tyler Ann McGuffee, Ins. & Healthcare Policy Dir., Office of Governor Michael R. Pence (July 29, 2016), <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>.

⁵³ See Leonardo Cuello, *supra* note 46.

⁵⁴ See, e.g., Virgil Dickson, *Ohio Medicaid Waiver Could Cost Hospitals \$2.5 Billion*, MODERN HEALTHCARE (April 22, 2016), <http://www.modernhealthcare.com/article/20160422/NEWS/160429965>.

⁵⁵ Virgil Dickson, *Hospitals Balk at Iowa’s Proposed \$37 Million Medicaid Cuts*, MODERN HEALTHCARE (Aug. 8, 2017), <http://www.modernhealthcare.com/article/20170808/NEWS/170809906>.

⁵⁶ Staff of S. Comm. on Finance, 92d Cong., Rep. to Accompany H.R. 1 to Amend the Social Security Act, and for other purposes, at 209, H. Rep. No. 92-231, 92d Cong., 2d Sess., reprinted in [1972] U.S. Code Cong. & Ad. News 4989, 5099, <https://bit.ly/2TtPPch>.

⁵⁷ Application at 15.

to the need for services.”⁵⁸ But Congress did not enact Medicaid to prepare low-income individuals for the commercial market. It passed the Medicaid Act to enable states to provide medical assistance. And, Arkansas ignores one of the core purposes of the retroactive coverage provisions—to provide coverage to individuals who do not understand Medicaid.⁵⁹ Notably, Congress has taken a very different approach to encourage prompt Medicaid enrollment. Leaving the retroactive coverage requirement alone, Congress has enacted a variety of measures to encourage prompt Medicaid enrollment—e.g., streamlining eligibility and enrollment and providing additional funding for outreach and enrollment assistance. Congress has it right here, and states should be required to adhere to the Medicaid requirements.

Arkansas’s “evaluation” of the retroactive coverage provides no support for allowing the State to continue to ignore congressional intent.⁶⁰ In fact, the inadequacy of the evaluation reinforces the fact that this policy change is not experimental.

The State hypothesized that its waiver would help reduce gaps in coverage, based on the implausible assumption that people delay signing up for Medicaid because of a policy virtually no low-income individuals know exists. Setting aside issues with the logic of this hypothesis, Arkansas’s interim evaluation, a pre-post analysis comparing coverage gaps from 2015-16 to 2017-2019, found that the share of individuals with gaps in coverage actually increased significantly in the post-treatment period.⁶¹ The evaluators then claim that using this result to assess the effect of the retroactive eligibility waiver is “not recommended” because the pre-post periods do not line up with the application period for the retroactive eligibility waiver.⁶² In other words, the State has set up an “experiment” with a questionable hypothesis and then “tested” that hypotheses with an assessment that its own evaluation indicates is inappropriate to inform the hypothesis. This is not an experiment; it is a mockery. (We note, however, that this fits the pattern: A 2019 MACPAC

⁵⁸ Application at 14.

⁵⁹ The evidence supports this congressional purpose. See Jennifer M. Haley & Erik Wengle, Urban Inst., *Many Uninsured Adults Have Not Tried to Enroll in Medicaid or Marketplace Coverage* (Jan. 2021), <https://urbn.is/3yYuAQ0> (noting problems with understanding and lack of awareness of public programs). See generally Julie L. Judson & Asako S. Moriya, *Medicaid Expansion for Adults had Measurable ‘Welcome Mat’ Effects for Their Children*, 36 HEALTH AFF. 1643, (2017), <https://bit.ly/37SadYG> (noting significant increases in Medicaid coverage for previously eligible but not enrolled children). Alexia Fernandez Campbell, *These 2 Medicaid provisions prevent medical debts from ruining people’s lives*, VOX (July 19, 2017), <https://www.vox.com/policy-and-politics/2017/7/19/15949250/medicaid-medical-bankruptcy> (highlighting the story of a man who did not realize he was eligible for Medicaid until after he faced \$500,000 in medical bills and a family friend informed him that Medicaid may be able to help).

⁶⁰ Ark. Dep’t of Human Servs., *Arkansas Works Program Evaluation for Section 1115 Interim Evaluation Report*, Project No. 11-W-00287/6 (June 30, 2021).

⁶¹ *Id.* at 130.

⁶² *Id.*

report found no credible evaluations of retroactive eligibility waivers even decades after the first such 1115 retroactive eligibility waivers were granted.⁶³)

In short, retroactive coverage promotes access by ensuring that providers can begin needed care immediately, before patients apply for Medicaid. Waiving retroactive coverage is not experimental, and more than three decades of experience confirms that it reduces coverage, harming low-income people.⁶⁴ The waiver not only fails to advance the objectives of the Medicaid program, but it actively undermines the key goals of providing coverage, care, and related financial protection to low-income individuals. CMS should not renew this waiver.

VI. Reducing Enrollment in QHPs

As stated above, the vagueness of the proposal makes meaningful comment difficult, so these comments are based upon the limited information that can be gleaned from the application. Arkansas proposes to enroll beneficiaries in FFS instead of QHPs when they: (1) fail to choose a QHP and the state budget targets indicate a need to suspend auto assignment; or (2) choose a QHP but later become “inactive.” Notably, the application does not indicate how long the State will require these individuals to remain in FFS. The proposal is not approvable, as it is not experimental and does not promote the objectives of the Medicaid Act.

The stated goal of the proposal is largely to save the State money.⁶⁵ But, as discussed above, Congress did not enact Section 1115 to allow states to save money.⁶⁶ That is not a sufficient experimental purpose.

Forcing individuals into Arkansas’s FFS will reduce their access to care. This is because there are significant disparities between QHPs and FFS. Several state-level comments raised these disparities, and Arkansas itself indicates that QHP members will have better care and access to care compared to FFS beneficiaries.⁶⁷ For example, and as noted above, FFS enrollees are limited to six prescriptions a month.⁶⁸ In addition, as Arkansas acknowledges, provider reimbursement rates are lower in FFS than in QHPs, causing FFS enrollees not to have equal access to care.⁶⁹ The negative impact of the proposal on

⁶³ MACPAC, *Medicaid Retroactive Eligibility: Changes under Section 1115 Waivers*, 3 (Aug. 2019), <https://www.macpac.gov/wp-content/uploads/2019/08/Medicaid-Retroactive-Eligibility-Changes-under-Section-1115-Waivers.pdf>.

⁶⁴ See Harris Meyer, *New Medicaid Barrier: Waivers Ending Retrospective Eligibility Shift Costs to Providers, Patients*, MODERN HEALTHCARE (Feb. 11, 2019).

⁶⁵ See Application at 10, 15.

⁶⁶ *Beno v. Shalala*, 30 F.3d 1057, 1069 (9th Cir. 1994).

⁶⁷ See, e.g., Application at 35 (noting “higher reimbursement rates through the QHPs”), 73 (Arkansas Advocates for Children & Families comments collecting statements from the application regarding QHP compared to FFS beneficiaries).

⁶⁸ See, e.g., Application at 114 (Legal Aid of Arkansas comments at 5).

⁶⁹ See 42 U.S.C. § 1396a(30)(A); Application at 35.

beneficiaries cannot be dismissed on the basis that the differences between FFS and QHPs are pre-existing.⁷⁰

As described below, Arkansas's arguments as to how the two aspects of the (currently opaque) proposal are experimental and align with the objectives of the Medicaid Act are not persuasive.

Disenrolling "Inactive" Beneficiaries to FFS

Arkansas views reassigning "inactive" QHP beneficiaries to FFS as a way to encourage individuals to engage in their own health and "to access economic independence opportunities."⁷¹ The application states that "inactive" will be defined through future rulemaking, but goes on to suggest that the definition will include failure to: select a QHP; use the coverage for a preventive screen or service; use of the coverage for a medical service; complete a health assessment; participate in an health improvement or economic incentive initiative; or take "other such actions."⁷²

Arkansas is wrong to presume that failure to choose a plan or to use coverage for services indicates that individuals are not engaged in their health or do not "value" their coverage. An individual may not have needed health care (including preventive care) during the time period in question (whatever that time period may be). Similarly, they may not have needed or had the time, opportunity, or resources to participate in a health improvement or economic incentive initiative. Many people face time-, travel-, childcare-, or disability-related barriers that limit their ability to participate in such initiatives.⁷³

In response to comments expressing concerns about punishing "inactive" individuals by moving them out of their QHP and into FFS, Arkansas said that individuals deemed "inactive" are not using services, evidently meaning the inferior access to and quality of care in FFS will not harm them.⁷⁴ That dismissive response misses the point. Although individuals may be not be using their coverage at the time the State would determine them

⁷⁰ While commenters expressed concern that these differences harm FFS enrollees, especially individuals with disabilities and complex medical conditions like rare disorders, hemophilia, lung disease, and multiple sclerosis, the State did not respond. Arkansas simply stated that the potential disruption in care between FFS and QHP exists currently. Application at 40.

⁷¹ Application at 15, 6.

⁷² *Id.* at 15.

⁷³ In addition, many people may not even be aware of such initiatives. When Arkansas implemented work requirements, repeated research revealed that a large percentage of beneficiaries had not heard of them. See, e.g., Jessica Greene, *Medicaid Recipients' Early Experience With the Arkansas Medicaid Work Requirement*, HEALTH AFFAIRS BLOG, Sept. 5, 2018, <https://www.healthaffairs.org/doi/10.1377/hblog20180904.979085/full/>; MaryBeth Musumeci et al., Kaiser Family Found., *Medicaid Work Requirements in Arkansas: Experience and Perspectives of Enrollees* (December 2018), <http://files.kff.org/attachment/Issue-Brief-Medicaid-Work-Requirements-in-Arkansas-Experience-and-Perspectives-of-Enrollees>; Benjamin Sommers et al., *Medicaid Work Requirements: Results from the First Year in Arkansas*, 381 N. ENG. J. MED. 1073 (2019), <https://www.nejm.org/doi/full/10.1056/nejmsr1901772>.

⁷⁴ See Application at 34.

inactive, that does not mean they will not need services in the near future. What is more, Arkansas ignores that medically frail individuals receive services on a FFS basis. CMS should not permit Arkansas to create a second-tier program for individuals with chronic conditions or disabilities or for individuals it has deemed “unworthy” of QHP coverage.

Preventing QHP Enrollment Based on Failure to Choose a Plan

Arkansas suggests that suspending auto-enrollment will assess whether individuals “value” Medicaid coverage.⁷⁵ But, as noted above in the context of the State’s premiums proposal, ensuring that individuals “value” their coverage is not an objective of the Medicaid Act. And, Arkansas is wrong to presume that individuals who do not select a QHP at enrollment do not “value” their coverage.

As reflected in the Medicaid managed care regulations, enrollee choice is incredibly important so that individuals have the opportunity to pick a plan that includes their preferred providers and generally has a network that will meet their needs. But choosing a plan at the point of enrollment or during a change period—especially when the differences between the plans may largely be a complicated array of providers that people may not currently need—is not an indicator of valuing health coverage. Picking a health insurance plan is extremely complicated, and many people, regardless of education level, find it difficult to make a choice and often do not change their choice once it is made.⁷⁶ Studies show that people routinely pick plans that are not the most beneficial to them.⁷⁷ In one study, only five percent of people did better at choosing an ideal plan than they would have by choosing a plan at random.⁷⁸ That same study found that if individuals with lower socioeconomic status (and in particular, individuals with less education), are less able to make complex decisions

⁷⁵ *Id.* at 11.

⁷⁶ Margot Sanger-Katz, *It’s Not Just You: Picking a Health Insurance Plan is Really Hard*, N.Y. TIMES (Dec. 11, 2020), <https://www.nytimes.com/2020/12/11/upshot/choosing-health-insurance-is-hard.html>; Saurabh Bhargava et al., *Choose to Lose: Health Plan Choices form a Menu with Dominated Options*, Q. J. ECON. 1319, 1323 (Apr. 27, 2017), <https://www.cmu.edu/dietrich/sds/docs/loewenstein/ChoseLose.pdf>.

⁷⁷ See citations in n. 76.

⁷⁸ See Benjamin R. Handel et al., *The Social Determinants of Choice Quality: Evidence from Health Insurance in the Netherlands*, NAT’L BUREAU OF ECON. RSCH. 4 (Sept. 2020), https://www.nber.org/system/files/working_papers/w27785/w27785.pdf; see also Jonathan Gruber et al., *Managing Intelligence: Skilled Experts and AI in Markets for Complex Products*, NAT’L BUREAU OF ECON. RSCH. (Apr. 2020), https://www.nber.org/system/files/working_papers/w27038/w27038.pdf (finding that an algorithm has better outcomes than professionals trained to help people select plans when the decisions are financial). Although the Handel study is based in the Netherlands, the authors explicitly connected the findings to U.S. Marketplace choices. In addition, the findings are relevant to Arkansas’s theories regarding how individuals value and make choices regarding cost-sharing. The study found that individuals with lower education and income chose higher deductible plans, calling into question the theory that people will choose to engage in activities to lower deductibles or cost-sharing. Other studies have found that even when other influences on plan choice are controlled for and the only choices are financial, people make harmful financial choices because health insurance is difficult to understand. See, e.g., Bhargava, *supra* note 76. The same study challenged the standard practice of inferring risk preferences from consumer insurance choices. *Id.*

or have less opportunity to engage with those decisions, then choice-based policies may increase inequality.⁷⁹

In addition, this research shows that plan choice has very little to do with valuing a plan or knowledge of a plan's differences or benefits, but it is highly influenced by peer effects, social and informational networks, and family.⁸⁰ Those researchers found that individuals would likely benefit, and inequality would be decreased, if they were defaulted into a plan and then allowed time to change plans. In addition, other studies show that even those whose profession it is to help others select plans perform worse than an auto-enrollment algorithm.⁸¹ Thus, while Arkansas frames the fact that approximately 80% of QHP enrollees are auto-enrolled as a negative, the failure to choose a QHP could actually be a rational, beneficial decision on the part of beneficiaries.⁸² Not only is there no experimental function in preventing QHP enrollment as a test of valuing coverage, it is contrary to established research finding that people are better off when they do not choose, especially if they have lower socio-economic factors, as Medicaid beneficiaries do simply by their income levels.

VII. Time for Responding to Prior Authorization Requests for Prescriptions

In the application, Arkansas seeks a waiver to allow it to respond to requests for prior authorization of prescription drugs within 72 hours, as opposed to within 24 hours as required under the Medicaid Act.⁸³ The request is not approvable for several reasons.

First, Congress enacted detailed requirements for coverage of outpatient prescription drugs to ensure that beneficiaries have broad and timely access to medically necessary medication. It placed these requirements, including those that govern the use of prior authorization, in section 1396r-8.⁸⁴ Since section 1115 only allows waivers of Medicaid provisions in section 1396a, HHS cannot waive provisions in section 1396r-8.⁸⁵

Second, there is nothing experimental about giving Arkansas extra time to respond to requests for prior authorization. Tellingly, Arkansas does not even propose to evaluate this aspect of the project.⁸⁶ In addition, the waiver is not likely to promote the objectives of the Medicaid Act, as it will simply delay access to care. While the application indicates that Arkansas will permit expedited review (24 hours) in exigent circumstances, it is not clear what would constitute exigent circumstances. And, even under normal circumstances, there is no valid reason for requiring individuals to wait 72 hours to receive medically necessary drugs.

⁷⁹ Handel, *supra* note 78, at 1.

⁸⁰ Handel, *supra* note 78, at 3.

⁸¹ See Gruber, *supra* note 78, at 2.

⁸² Application at 2.

⁸³ Application at 28.

⁸⁴ See 42 U.S.C. § 1396r-8(d)(5)(A).

⁸⁵ *Id.* § 1315(a).

⁸⁶ See Application at 18-26.

VIII. Conclusion

While NHeLP supports the use of section 1115 to implement experimental projects that are likely to promote the objectives of the Medicaid Act, we strongly object to any efforts to use this law to skirt essential provisions that Congress has placed in the Medicaid Act to protect Medicaid beneficiaries and ensure that the program operates in their best interests. As demonstrated above, Arkansas's proposed project is inconsistent with the standards of section 1115.

We have included numerous citations to supporting research, including direct links to the research. We direct CMS to each of the materials we have cited and made available through active links, and we request that the full text of each of the studies and articles cited, along with the full text of our comment, be considered part of the formal administrative record for purposes of the Administrative Procedure Act. If CMS is not planning to consider these materials part of the record as we have requested here, we ask that you notify us and provide us an opportunity to submit copies of the studies and articles into the record.

Thank you for the opportunity to comment on Arkansas's application. If you have further questions, please contact me (mckee@healthlaw.org), Jane Perkins (perkins@healthlaw.org), or Elizabeth Edwards (edwards@healthlaw.org).

Sincerely,



Catherine McKee
Senior Attorney