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## VIA ELECTRONIC SUBMISSION

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
P.O. Box 8016  
Baltimore, MD 21244-8016

### Re: Amendments to Arkansas's Health Care Independence Program

Dear Sir/Madam:

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 Arkansas's proposed amendment to its § 1115 Health Care Independence demonstration.

NHeLP recommends that HHS not approve the proposed amendments as requested. The application includes provisions that clearly are not authorized by any law and would set a dangerous precedent that undermines key federal protections in the Medicaid program. We urge HHS to address these problems and require Arkansas to bring the proposals into a legally approvable form. We urge HHS to work with state officials to achieve a Medicaid expansion that will serve future Medicaid enrollees well, including Arkansas residents affected by this proposal and those 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 of the Social Security Act's § 1115.

#### A. Limits of § 1115 Waiver Authority

Section 1115 explicitly circumscribes waiver authority in Title XIX to requirements contained in § 1902.<sup>1</sup> Anything outside of § 1902 is not legally waivable through the § 1115 demonstration process. Arkansas expressly requests waiver of requirements that lie outside

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<sup>1</sup> 42 U.S.C. § 1315(a)(1).

of § 1902. These waiver requests, sometimes explicit and other times necessitated by their objectives, include attempts to skirt requirements in § 1916 and § 1916A. None of these waiver requests are permissible because the substantive requirements rest outside of § 1902 and independently require state compliance. In other words, any reference to the provision in § 1902, which could be waived, does not and cannot also waive the independent, freestanding requirements of these Medicaid Act provisions.

## B. Premiums and Cost Sharing Generally

Arkansas's § 1115 application contains numerous premium and cost sharing features (each discussed below) which are not approvable under § 1115. Specifically, the proposals repeatedly violate four core requirements for § 1115 demonstrations:

- As mentioned above, § 1916 and § 1916A are free-standing requirements lying outside of § 1902, which cannot be waived through § 1115. Even if this were not true, *any* waiver of cost sharing in § 1916 must comply with the waiver requirements of § 1916(f), the *only* legal channel for such waivers. Arkansas attempts to waive cost sharing requirements in § 1916 through § 1115 without following the § 1916(f) requirements. Moreover, section § 1916(f) only applies to cost sharing. Even if Arkansas complies with § 1916(f), the Medicaid prohibitions on premiums for individuals below 150% FPL are still *never* waivable.
- A § 1115 demonstration is precisely that, a demonstration. Arkansas's requests for § 1115 authority regarding premiums and cost sharing are not approvable because, as proposed, and given the well-known results of redundant studies on cost sharing and premiums, they will not test anything new. For example, one of the principal features Arkansas seeks to waive, premiums for low-income enrollees, has already been tested repeatedly and consistently shown to *depress* enrollment – including for the very population of adults that is the focus of the Arkansas proposals. See David Machledt and Jane Perkins, *Medicaid Premiums and Cost Sharing* (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 Act.<sup>2</sup> The objective of Medicaid is to *furnish* health care to certain low-income individuals. Several key premium and cost sharing elements in Arkansas's proposal cannot be approved because they would *reduce* access to care. The Medicaid Act, particularly § 1916A, already provides States like Arkansas with a great deal of flexibility to impose premiums, cost sharing, and similar charges. Yet, the State seeks to go beyond these lawful options to implement even more punitive proposals that research has already established to be harmful to low-income people – policies that will clearly result in interrupted care, lost opportunities, and churning.

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<sup>2</sup> 42 U.S.C. § 1315(a).

- HHS should wait to see the evaluation of current premium assistance program in other states like Iowa, which will implement premiums for individuals over 100% FPL, before approving an expansion of those premiums to individuals with incomes as low as 50% FPL. The potential risks for this extremely low income population are greater.

### C. Required and Optional Premiums (“Contributions”)

Arkansas’s Health Care Independence Program amendment is premised on monthly contributions for expansion eligible individuals above the 50% of the Federal Poverty Level (FPL). The State also requests to impose penalties (in the form of per service copayments) for individuals who do not keep up with their monthly payments. Arkansas’s extreme concern with consumer “skin in the game” ignores the fact that Medicaid’s legal cost sharing system already provides generous flexibility for states to create strong incentives for enrollees to avoid unnecessary care. More important, after decades of research into the subject, the Medicaid Act specifically prohibits some of the features that Arkansas requests.

Under the law, HHS should not approve monthly contributions for any individuals below 150% FPL.<sup>3</sup> According to the Medicaid Act, “any enrollment fee or similar charge” is illegal for this very-low-income population, whether they are called monthly fees, assessments, contributions, or premiums.<sup>4</sup> Arkansas’s “monthly contributions” meet the federal definition of a premium or similar charge. Even if, contrary to the law, HHS considered a waiver of the premium prohibition, it should still not be approvable because, given the well-established studies on the impact of premiums on low-income people, there is no experimental value to premiums nor do they promote the objectives of the Medicaid program, as required by § 1115(a).<sup>5</sup> The impact of any premiums on low-income people is clearly visible from data collected by the Healthy Indiana Program (HIP), a premium-based Medicaid expansion demonstration established in 2008, that found premiums even below \$5 a month to cause lower income individuals to disenroll from health coverage.<sup>6</sup> Based on data published in the 2012 HIP Annual Report, of those beneficiaries required to make a monthly contribution, over 18% of HIP members with incomes between 50-100% FPL were disenrolled or never completed enrollment

<sup>3</sup> See 42 U.S.C. §§ 1396o(a)(1), 1396o-1(b)(1)(A). There are very limited exceptions to this rule, for certain populations, that are not applicable to the Medicaid expansion eligibility group. See, e.g., 42 U.S.C. § 1396o(b)(1), (c), & (d).

<sup>4</sup> 42 U.S.C. § 1396o-1(a)(3)(A); 42 U.S.C. § 1396o(a)(1).

<sup>5</sup> For example, in 2003, Oregon experimented with charging sliding scale premiums (\$6-\$20) and higher copays on some groups in an already existing § 1115 demonstration for families and childless adults below poverty. Nearly *half* the affected demonstration enrollees dropped out within the first nine months after the changes. Bill J. Wright et al., *The Impact of Increased Cost Sharing on Medicaid Enrollees*, 24 Health Affairs 1106, 1110 (2005).

<sup>6</sup> *Healthy Indiana Plan 2.0 1115 Waiver Application*, 28, (2014), <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2.0/in-healthy-indiana-plan-support-20-pa.pdf>.

due to failure to pay their premium in 2012.<sup>7</sup> This occurred despite very strong incentives to pay, including a long waiting list and a 12-month lockout for disenrolled individuals; so one might expect disenrollments to be even higher absent such provisions. Numerous other studies over the last decade have shown that premiums reduce participation, with more severe drop offs at lower income levels.<sup>8</sup> Premiums for those living on incomes below 100% FPL are especially concerning, since they contradict the structure of the ACA and numerous Medicaid cost sharing protections set at 100% FPL. We note that, under the law, premiums are equally impermissible for individuals below 150% FPL whether they are mandatory or optional.

**Recommendation:** Imposing premiums on populations below 150% FPL is not permitted under Medicaid cost sharing statute. Waiving this requirement is not novel and will not promote the objectives of the Medicaid program, as required for § 1115 demonstrations. Therefore, HHS should not approve this proposed amendment.

#### D. Targeted Cost Sharing

The premium proposal is inextricably intertwined with a cost sharing component and must thus be evaluated under § 1916 and § 1916(f). Arkansas proposes to penalize individuals who fail to pay their premiums by imposing per service cost sharing. While the Medicaid statute allows states flexibility to target different cost sharing structures at different groups, it only permits such targeting for groups above 100% FPL.<sup>9</sup> Below 100% FPL, the statute stipulates that targeting cost sharing (including by eligibility group) “shall not apply.”<sup>10</sup> Not only does the Arkansas proposal target cost sharing specifically for expansion eligible adults *below* 100% FPL, but it would target only a subset of individuals in that expansion group (those who fail to pay their premiums). The targeting does not promote the objectives of the Medicaid program. Moreover, HHS

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<sup>7</sup> Indiana’s annual report provides misleading conclusions on nonpayment percentages because it inexplicably includes the 23% of enrollees with no monthly HIP contributions, which artificially inflates the denominator. It also disaggregates individuals who fail to make the first payment from those who fail later during the year to make the total percentage of nonpayers appear smaller. The figure cited here (18.3%) is separately calculated based on tables available in the report. See *Healthy Indiana Plan Demonstration Section 1115 Annual Report: Demonstration Year 5*, 25-31 (2013), [http://www.in.gov/fssa/hip/files/2012\\_HIP\\_Annual\\_Report.pdf](http://www.in.gov/fssa/hip/files/2012_HIP_Annual_Report.pdf).

<sup>8</sup> Samantha Artiga & Molly O’Malley, Kaiser Fam. Found., *Increasing Premiums and Cost Sharing in Medicaid and SCHIP: Recent State Experiences* (2005), <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/increasing-premiums-and-cost-sharing-in-medicaid-and-schip-recent-state-experiences-issue-paper.pdf>; Jill Boylston Herndon et al., *The Effect of Premium Changes on SCHIP Enrollment Duration*, 43 HEALTH SERVICES RES. 458 (2008); Bill J. Wright et al., *The Impact of Increased Cost Sharing on Medicaid Enrollees*, 24 HEALTH AFF. 1106 (2005).

<sup>9</sup> 42 U.S.C. § 1396o-1(a)(1).

<sup>10</sup> 42 U.S.C. § 1396o-1(a)(2)(A). Medicaid statute and regulations create a limited exception allowing targeting copays at any income level for non-preferred drugs and nonemergency use of the ED. See also 42 C.F.R. § 447.52(d).

cannot even consider waiving a Medicaid cost sharing provision unless the Arkansas proposal meets all the conditions laid out in § 1916(f).

In this case, the State’s proposal to apply targeted cost sharing as a penalty for nonpayment of a premium does not meet several of the requirements of §1916(f). It is not limited to two years.<sup>11</sup> It is not “based on a reasonable hypothesis” (or any hypothesis at all) nor is it “designed to test [the hypothesis] in a methodologically sound manner, including the use of control groups.”<sup>12</sup> In fact, the amendment proposal does not appear to include any modifications of the current demonstration evaluation *at all*. Finally, the benefits of using the threat of copayments to push people to pay a “voluntary” premium (described cryptically as promoting “independence and self-sufficiency” and providing “participants with direct information about the cost of health care services and out-of-pocket costs”) clearly do not outweigh the potential risks (facing higher copays that researchers have repeatedly concluded present barriers to health care access and threaten beneficiaries’ financial as well as physical health.)<sup>13</sup>

**Recommendation:** The proposed application of targeted cost sharing as a penalty for nonpayment of a premium is not permitted under Medicaid cost sharing law. HHS has no authority to approve such a proposal, and certainly not if it fails to meet the strict requirements under § 1916(f). This proposed amendment does not satisfy those requirements, does not test a valid hypothesis, and provides no credible evidence that it would promote the objectives of Medicaid. Therefore, HHS may not approve it.

### **E. Cost Sharing in Excess of Medicaid Maximum Limits**

Though studies show that even low copays negatively impact access to necessary care for low income individuals, the Medicaid Act provides States substantial flexibility to customize cost sharing structures to fit their needs. However, Arkansas’s proposed amendment to its premium assistance demonstration includes cost sharing for individuals above 100% FPL that appears to exceed the maximum statutory limits.

The state proposes that individuals above 100% FPL who fall behind on required monthly premiums would be penalized by facing “QHP level” cost sharing at the point-of-service. Providers would be permitted to refuse to perform the service if the individual could not pay. The State’s proposal does not include any details that indicate what the scope of “QHP-level” cost sharing might be, but currently available plans marketed toward “Health Care Independence” beneficiaries include services with cost sharing in excess of the allowable maximums. For example, Ambetter of Arkansas currently markets two sets of plans as options for HCIP beneficiaries. The web-posted

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<sup>11</sup> 42 U.S.C. § 1396o(f)(1).

<sup>12</sup> 42 U.S.C. § 1396o(f)(4).

<sup>13</sup> 42 U.S.C. § 1396o(f)(3). See also Ark. Dep’t Human Servs., Div. Med. Servs., *Arkansas Health Care Independence Program (Private Option): Proposal to Amend Special Terms & Conditions*, 3 (Sept. 15, 2014), <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/ar-private-option-pa.pdf>.

Summaries of Benefits and Coverage (SBC) for these plans include a \$20 copay for ED visits, which exceeds the \$8 statutory maximum.<sup>14</sup> Moreover, Medicaid law limits such copays to nonemergency visits, while the SBC makes no such distinction.<sup>15</sup> These SBCs appear to contradict the State’s claim that: “Currently, individuals with incomes above 100% FPL pay co-payments and co-insurance at the point of service, and those co-payments and co-insurance amounts are consistent with federal Medicaid law.”<sup>16</sup> Other listed services include copays that may well exceed the statutory limit of 10% of the Medicaid agency’s cost for that service, including \$140 daily copays for inpatient stays, \$20 copays for urgent care visits, and cost sharing for maternity care.

The State should explain how it resolves these apparent discrepancies at the point-of-service, and how it would ensure that no beneficiary would face cost sharing above Medicaid allowable limits under the proposed system. As with the proposed waiver of targeted cost sharing described above, HHS cannot legally approve a waiver of Medicaid maximum cost sharing limits unless the demonstration meets all the requirements of § 1916(f). It would not be sufficient for the State to later reimburse beneficiaries for amounts above Medicaid limits, as this would constitute an unlawful barrier to care for individuals who may be denied needed services when they cannot afford the cost sharing at the point of service.

Moreover, even if the “QHP-level” cost sharing did not exceed Medicaid maximum limits, the policy effect of imposing such cost sharing is clear. More beneficiaries would forego needed care due to the increasing out-of-pocket costs, which likely would lead to negative health outcomes, such as increased hospitalizations, down the road.

HHS’ prior approval of premiums for state plan beneficiaries between 101-138% FPL already fails to meet the requirement in § 1115 that demonstrations test innovations “likely to assist in promoting the objectives of Title...XIX.”<sup>17</sup> Adding an additional cost sharing barrier that penalizes individuals who fail to keep up with their premiums would create yet another barrier to care for low-income adult beneficiaries.

**Recommendation:** HHS should not approve this amendment to charge enforceable “QHP-level” cost sharing as described. HHS must, at the very least, ensure that no Medicaid beneficiary is ever charged cost sharing for a service in excess of the maximum limit permitted under the law.

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<sup>14</sup> Ambetter of Ark., *Silver Plan 1 Benefits: Plan Brochure for 94% AV Level*, 1 (last visited Oct. 8, 2014), available at <http://api.centene.com/Brochures/62141AR0080004-36.pdf>. See also Ambetter of Ark., *Plan Brochures & Summaries of Benefits and Coverage: Healthcare Independence Program* (last visited Oct. 8, 2014), <http://www.ambetterofarkansas.com/brochures/#hip>.

<sup>15</sup> *Silver Plan 1 Benefits*, *supra* note 13, at 1.

<sup>16</sup> Ark. Dep’t Human Servs., *supra* note 12, at 40 (page 2 of “Summary of Comments and Responses on Proposed Amendment”).

<sup>17</sup> 42 U.S.C. § 1315(a).

## F. Independence Accounts

The State has established no demonstration purpose for introducing “Independence Accounts” (IAs), the individual health expenses accounts administered by a third party administrator (TPA). The State itself admits that IA program “is somewhat complex, but is designed to promote beneficiary accountability.”<sup>18</sup> It does not explain what it means by accountability, but the IA appears to be intended as a mechanism to ensure that beneficiaries pay their cost sharing liabilities. We have a number of concerns about the proposal to introduce an unnecessary additional layer of bureaucracy into the management of Arkansas’ Medicaid expansion demonstration:

- 1) The IA would greatly increase the administrative complexity the Medicaid program by requiring the TPA to track and, in timely fashion, notify beneficiaries *and* providers who is eligible for what level of copays on a monthly basis. This opens the door for confusion, unlawful charges, and added costs due to administrative burden without accomplishing a clear policy goal. We understand that there have been significant challenges with distinguishing private option enrollees from Marketplace enrollees at point-of-service even under the current system, which has resulted in incorrect cost sharing charges. Adding yet another layer will only exacerbate these problems;
- 2) The IA would effectively transfer beneficiaries’ cost sharing liabilities from individual providers to the State. The proposal calls for the TPA – not the provider – to bill beneficiaries for copays and ultimately transfers cost sharing liability to the State.<sup>19</sup> The proposal does not appear to include a mechanism by which providers, at their discretion, can waive copays on a case-by-case basis, contrary to the plain language of § 1916(d)(2).
- 3) The proposed amendment does not include any description of what will happen to funds in the IA should a beneficiary leave the program. This makes it impossible to comment on possible negative impacts of this proposal and generally indicates a lack of thoughtfulness in the proposal design.
- 4) Even if CMS approved the IA, Arkansas’s proposal appears to require only a single notice to beneficiaries to explain how it functions.<sup>20</sup> This would be wholly inadequate for a change even the State acknowledges is “complex.”
- 5) The amendment includes a vague reference to the possibility of applying “additional incentives and consequences” to enrollees after securing approval from CMS.<sup>21</sup> CMS should clarify that any such substantive changes to an

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<sup>18</sup> Arkansas Dep’t of Human Services, *supra* note 12, at 40 (page 2 of “Summary of Comments and Responses on Proposed Amendment”).

<sup>19</sup> *Id.* at 18.

<sup>20</sup> *Id.* at 10.

<sup>21</sup> *Id.* at 19.

existing demonstration would be subject to the full § 1115 comment and approval process.

Simply put, Arkansas's proposal to establish IAs does not fulfill the requirements of § 1115 demonstrations. It proposes a new layer of bureaucracy unlikely to promote the objectives of the Medicaid program. The proposal does not include a clear statement of the hypothesis this IA "innovation" would test, nor does it describe any plan or metrics to evaluate the impact of the IAs. In the evaluation section of the proposal, *none* of the twelve potential hypotheses specifically address the IA. Indeed, as noted above, the whole evaluation section appears to be *entirely unchanged* from the currently approved demonstration. This indicates that the proposed amendments are not serious attempts to "innovate," but rather new mechanisms designed to penalize beneficiaries.

**Recommendation:** HHS should not approve the amendment that would establish independence accounts. If HHS does approve IAs in this demonstration, it must at the very least require the State to develop a robust, transparent and methodologically sound evaluation to track the relative impact on enrollees in terms of access to care, disenrollment rates, and relative financial burden and to estimate the added administrative burden of the IA program. The State would also have to develop a satisfactory plan for notifying and educating beneficiaries of their rights and responsibilities with regard to the proposed changes.

### **G. Non-Emergent Medical Transportation (NEMT)**

Medicaid requires coverage of NEMT.<sup>22</sup> This is a core Medicaid requirement, applicable to all state plan enrollees. HHS cannot approve the limits to NEMT requested in the HCIP amendments under § 1115 authority. As of January 1, 2014, individuals below 138% FPL are a state plan population. Thus, Arkansas requires a waiver to institute such limitations, and, as noted above, such waivers can only be approved if they have a valid experimental purpose and promote the objectives of the Medicaid Act. Arkansas' proposal presents no valid experimental purpose to limiting NEMT, because no valid experimental purpose exists. The proposed limit of eight annual travel legs appears completely arbitrary; the state provides no evidence whatsoever to justify this limitation. 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. Indeed, NEMT is one of the key services that tailors Medicaid to meet the unique care needs of the low income populations it serves.

Furthermore, like the Independence Accounts and cost sharing proposals, the State provides no valid hypothesis, no study methodology, no control groups, and no evaluation plan *whatsoever* for this proposal to limit NEMT.

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<sup>22</sup> See 42 C.F.R. § 431.53; CTRS. MEDICARE & MEDICAID SERVS., STATE MEDICAID MANUAL § 2113.

**Recommendation:** To the extent HHS has (in our view, illegally) approved such a waiver recently in Pennsylvania and Iowa, we strongly 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. We expect the evidence to show that NEMT demonstrations do not help furnish care to Medicaid recipients.

#### **H. Freedom of Choice for Family Planning Services and Supplies**

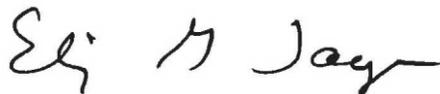
We appreciate that Arkansas will adhere to the requirement to ensure freedom of choice for providers of family planning services and supplies. We recognize and appreciate that HHS has consistently made clear that states must cover family planning services and supplies provided by any qualified provider, including out-of-network providers.<sup>23</sup>

**Recommendation:** We suggest that, as in other recent demonstration proposals, HHS clarify in the text of the demonstration STC that despite any waiver of freedom of choice of providers, individuals remain entitled to obtain out-of-network coverage for family planning services and supplies regardless of whether there are available in-network family planning providers.

#### **Conclusion**

In summary, we have numerous concerns with the legality of Arkansas’s § 1115 demonstration amendment, as proposed. Please know that 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 Medicaid 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 David Machledt ([machledt@healthlaw.org](mailto:machledt@healthlaw.org)) or Jane Perkins ([perkins@healthlaw.org](mailto:perkins@healthlaw.org)). Thank you for consideration of our comments.

Sincerely,



Elizabeth G. Taylor,  
Executive Director

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<sup>23</sup> See CMS, STATE MEDICAID MANUAL, § 2088.5.