



July 14, 2023

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
200 Independence Ave, SW
Washington, DC 20201

Re: Arkansas Health and Opportunity for Me (ARHOME) 1115 Amendment

Dear Secretary Becerra:

Thank you for the opportunity to provide feedback on Arkansas' ARHOME 1115 Amendment.

The undersigned organizations represent millions of individuals facing serious, acute and chronic health conditions. We have a unique perspective on what individuals and families need to prevent disease, cure illness and manage chronic health conditions. The diversity of our organizations and the populations we serve enable us to draw upon a wealth of knowledge and expertise that is an invaluable resource regarding any decisions affecting the Medicaid program and the people that it serves. We urge the Centers for Medicare and Medicaid Services (CMS) to make the best use of the recommendations, knowledge and experience our organizations offer here.

The purpose of the Medicaid program is to provide healthcare coverage for low-income individuals and families, and our organizations are committed to ensuring that ARHOME provides access to quality and affordable care. We strongly oppose Arkansas' proposal to implement a complex new demonstration

amendment that includes both work requirements and time limits for Medicaid beneficiaries. These requirements will greatly threaten access to and continuity of care for Medicaid patients while creating additional barriers and implementation challenges within the ARHOME program. Our organizations urge CMS to reject this amendment.

Barriers to Care

Arkansas' proposal sets up a tiered coverage structure in which patients have access to different coverage – Qualified Health Plans (QHPs) or Fee-for-Service (FFS) Medicaid – based on their income, length of time in the Medicaid program and compliance with engagement activities. These requirements are not about promoting work but about adding red tape that jeopardizes patients' access to care, and our organization oppose them. The vast majority of those with Medicaid who can work already do so; 91% of those in the Medicaid expansion group nationally are either workers, caregivers, students, or unable to work due to illness.¹ Additional processes to determine patient eligibility and participation in program requirements inherently create opportunities for administrative errors that jeopardize access to care. The detrimental effects that these requirements have on patients are not consistent with the goals of the Medicaid program.

Additionally, all individuals – even those who are working – will ultimately have to comply with new program requirements if they have Medicaid coverage for more than three years. Our organizations oppose time limits on Medicaid coverage. Patients with serious health conditions rely on regular access to their healthcare providers and cannot afford a disruption in their care. Again, this structure is not consistent with the goals of the Medicaid program.

Continuity of Coverage

Arkansas' proposal to transfer patients from QHPs to FFS for failing to participate in state-defined "engagement activities" will disrupt patient care. Enrollees transferred from QHPs to FFS would lose access to their providers and risk interruption of treatment plans, such as previously established prior authorizations for services and medications. This transferring of care will especially affect patients with chronic health conditions that require regular treatment, but that the state has not defined as life-threatening. Research has shown that individuals with disruptions in coverage during a year are more likely to delay care, receive less preventive care, refill prescriptions less often, and have more emergency department visits.² Involuntarily transferring beneficiaries between different plans will jeopardize continuity of patient care and is directly counter to the demonstration's goal to "improve continuity of care."

Challenges of Implementation

Our organizations are also concerned that implementation of the proposed requirements will pose challenges for the program and enrollees alike. The proposal would require significant infrastructure and investment to be implemented as proposed, including enhancing data sources, hiring and training staff, and investing in community resources that address health-related social needs. Arkansas is likely unprepared to implement new infrastructure and a new hiring process to this extent. In addition, Arkansas' previous proposal to impose work requirements was estimated to cost \$26.1 million, and this new proposal may cost as much, if not more, given its complexity. The state's previous proposal also revealed major flaws in the state's ability to use data to identify exemptions and make enrollees aware

of new requirements. Ultimately, before litigation halted the policy, 18,000 patients lost coverage largely due to additional paperwork and bureaucracy, not changes to eligibility.

Arkansas is already in the middle of the unwinding of the COVID-19 continuous coverage requirements, a massive project that has led to alarming coverage losses. As of June 2023, the state had disenrolled 217,000 beneficiaries, 79% of whom lost coverage due to procedural reasons, and not as a result of changes in eligibility.³ Given these deeply concerning numbers, it is unlikely that the state is prepared to undertake a new proposal of this magnitude. Our organizations are concerned that this proposal will increase administrative burden on the program as well as increase bureaucratic red tape for patients.

Lack of Detail

Arkansas's proposal is lacking key details that raise additional concerns about this demonstration. The state does not provide details on how it would determine "engagement" for certain activities like being a parent for a dependent child or an unpaid caregiver. Many of these beneficiaries may have limited time and resources to dedicate to new engagement activities if they are already caregivers. It is further unclear how the state will determine if a beneficiary is "progressing toward improved health and economic independence." The language describing expected progress of enrollees is vague and leaves these decisions to the success coaches or QHPs. Giving this level of discretion to QHPs is particularly concerning, given the financial incentive for QHPs to move patients with chronic conditions and higher healthcare costs from their plans to FFS, and opens the door to discrimination against patients with chronic diseases or other health conditions.

For beneficiaries who are then moved to FFS, there is no defined pathway back to QHP coverage if an individual begins or maintains employment (for those in the higher income groups). Because employment is not considered an engagement activity, it is unclear how these individuals would return to QHP coverage. In addition, beneficiaries would have to affirmatively select a QHP to be reenrolled. Prior to the COVID-19 pandemic, 75% of individuals in the program were auto-assigned to QHPs, according to the state.⁴ Given this, it is likely that reenrollment among those who have become eligible to return to QHPs will be low.

Conclusion

Our organizations remain opposed to work requirements and time limits in all forms, as they are not in line with the goals of the Medicaid program. The ARHOME 1115 amendment threatens the continuity of care for patients, places undue administrative burden on patients and the Medicaid program and lacks critical details. In order to protect access to affordable and quality healthcare for Arkansans, we urge CMS to reject this proposal.

Thank you for the opportunity to provide comments.

Sincerely,

American Cancer Society Cancer Action Network
American Heart Association
American Kidney Fund

American Lung Association
Asthma and Allergy Foundation of America
CancerCare
Child Neurology Foundation
Cystic Fibrosis Foundation
Epilepsy Foundation
Hemophilia Federation of America
Lupus Foundation of America
Lutheran Services in America
March of Dimes
National Hemophilia Foundation
National Multiple Sclerosis Society
National Organization for Rare Disorders
National Patient Advocate Foundation
Pulmonary Hypertension Association
Susan G. Komen
The Leukemia & Lymphoma Society

¹ Guth, Madeline et al. Understanding the Intersection of Medicaid & Work: A Look at What the Data Say. Kaiser Family Foundation. April 24, 2023. Available at: <https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-work-a-look-at-what-the-data-say/>.

² Sugar S, Peters C, De Lew N, Sommers BD. Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the Covid-19 Pandemic. Assistant Secretary for Planning and Evaluation, Office of Healthy Policy. April 12, 2021. Available at: <https://aspe.hhs.gov/sites/default/files/private/pdf/265366/medicaid-churning-ib.pdf>.

³ Medicaid Enrollment and Unwinding Tracker. Kaiser Family Foundation. July 5, 2023. Available at: <https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-and-unwinding-tracker/>.

⁴ Request to Amend the ARHOME Section 1115 Demonstration Project. Department of Human Services, State of Arkansas. June 1, 2023. Available at: <https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ar-arhome-pa-06022023.pdf#page=4>.