



**SURGEON GENERAL, STATE OF ARKANSAS**  
**JOSEPH W. THOMPSON, MD, MPH**

July 19, 2013

Sydne Harwick  
Legislative Clerk  
Committee on Energy and Commerce  
2125 Rayburn House Office Building  
Washington, DC 20515

Dear Ms. Harwick:

Please find enclosed my responses to the questions for the record regarding my testimony before the U.S. House of Representatives, Committee on Energy and Commerce, Subcommittee on Health hearing on Wednesday, June 12, 2013, entitled "The Need for Medicaid Reform: A State Perspective."

Thank you for the opportunity to testify on this important issue. Please feel free to contact me if additional information is needed.

Best regards,

A handwritten signature in black ink that reads "Joe Thompson MD MPH".

Joseph W. Thompson, MD, MPH  
Surgeon General, State of Arkansas  
Director, Arkansas Center for Health Improvement

cc: Governor Mike Beebe, State of Arkansas  
Arkansas Congressional Delegation  
Arkansas House of Representatives, Speaker of the House  
Arkansas Senate, President Pro Tempore

**Arkansas Surgeon General Joe Thompson’s response to questions related to appearance before the Subcommittee on Health of the US House of Representatives-Committee on Energy and Commerce (June 12, 2013 – “The Need for Medicaid Reform: A State Perspective”)**

- 1. Your state has reached a preliminary agreement with the U.S. Department of Health and Human Services (HHS) to use Medicaid dollars to pay for private coverage sold on the insurance marketplaces that are being created by the ACA, correct?**

The state has reached an agreement with the Secretary of the U.S. Department of Health and Human Services (DHHS) conceptually regarding Arkansas’s planned use of Medicaid dollars for premium assistance to purchase Health Insurance Marketplace (HIM) qualified health plan coverage for those who would have otherwise been eligible for Medicaid expansion under the Patient Protection and Affordable Care Act (PPACA). This concept has been authorized legislatively by the state via the Health Care Independence Act of 2013,<sup>1</sup> also commonly known as the “private option.” The state is currently pursuing an 1115 waiver with DHHS to implement the private option.

- 2. Do you believe your state has enough providers to support coverage of additional beneficiaries?**

Like many other states, Arkansas faces primary and specialty care workforce shortages. The greater issue in Arkansas is the maldistribution of its health care workforce, with urban areas having potentially excess supply and rural areas having critical shortages. Unlike many other states, Arkansas has taken a comprehensive approach to health care system transformation. Rather than pursue coverage expansion for Arkansans in isolation, the state simultaneously engaged in initiatives beginning in 2010 to develop a strategic plan to address workforce issues, optimize the use of health information technology, and transition from a volume-based to an outcome-based payment system using a public-private collaborative approach. Removing the financial barrier to coverage for uninsured Arkansans—some of whom reside in counties where the uninsured rate is near 40 percent—is not an immediate solution to workforce issues. However, providing a paying source for providers is a first step toward stimulating business growth in health care services and should be accompanied by incentives that improve patients’ health care seeking behavior.

- a. Do you believe that, had Arkansas chose to undergo a standard Medicaid expansion under the ACA, there would have been enough providers to support such an expansion?**

Under a traditional Medicaid expansion as contemplated by PPACA, Arkansas would likely not have had enough participating providers to meet demand from an additional 250,000 adult eligibles. Eligibility for Arkansas’s Medicaid program is among the most restrictive in the nation for adults. While the state’s Medicaid program maintains a network of providers who are responsive to the demands of the current Medicaid population—largely comprised of children and the aged, blind and disabled—the state would have had significant difficulty

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<sup>1</sup> Acts 1497 and 1498 of 2013

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building a network to meet the demand of the newly covered population. Building a sufficient network would have required robust recruitment inclusive of increased reimbursement rates approaching that offered in the private insurance market.

**b. How does your state's plan insure access to a sufficient number of providers?**

In the short term, capacity constraints particularly in rural areas may delay services for non-acute needs (e.g., preventive screening). However, the use of private qualified health plans' provider networks and leveraging the HIM network adequacy requirements will help to mitigate provider access issues. Longer term workforce goals as outlined in the state's health workforce strategic plan—team-based care, optimal use of health information technology, and financing arrangements that will promote patient-centered medical homes, including the use of physician extenders in remote locations—are also underway.

**3. Last year CBO estimated that private insurance plans cost nearly 50 percent more than Medicaid. In Arkansas' own actuarial analysis, it was found that the difference in provider rates between the private market and Medicaid is less than 25%. The report also indicated that there may be actual cost-savings associated with the Medicaid proposal.**

**a. What evidence is there that placing Medicaid beneficiaries into the private insurance marketplace will achieve cost-savings?**

Analysis released from the Arkansas Department of Human Services (DHS) earlier this year shows the estimated financial impact of the private option. The estimates point to several differences in the Arkansas market for which the CBO estimates were unable to account by using national averages for Medicaid costs and national estimates of rate differences between Medicaid and private carriers. As noted, Arkansas analysis showed that the average difference in Arkansas was less than half of that estimated nationwide. Beginning with this Arkansas-specific baseline, the analysis projected a 5 percent reduction in private provider reimbursement rates due to the introduction of 250,000 individuals into the market, generating deflationary price pressure on commercial carrier contracts with providers. Competitive pressure from qualified health plan management and transparent pricing in the Marketplace is estimated to reduce premiums by an additional 5 percent, a reduction that would be shared by premiums for all individuals (e.g., above and below 138% FPL) across the Marketplace, not just plans in which private option eligibles can enroll. Extracting medically frail populations from eligibility for the private option is estimated to further reduce Marketplace premiums. All of these factors—combined with a displaced need to increase provider reimbursement under a traditional expansion—results in an impact that could drive the incremental costs of the private option to zero, or even produce cost savings, depending on thriving competition and strategic qualified health plan management.

**b. Will the "actuarial soundness" certification regulations which apply to Medicaid managed care plans also apply to the exchange plans offered to Medicaid beneficiaries?**

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Actuarial soundness requirements that are applicable to all qualified health plans offered through the HIM will apply to the plans from which private option eligibles will be able to choose.

**c. How will the state address the vast difference in provider rates that will likely occur between Medicaid provider rates and qualified health plan provider rates?**

While private insurer provider rates are greater than those currently provided by Medicaid, the differences in those rates in Arkansas do not appear to be as “vast” as they are in the majority of other states. A traditional Medicaid expansion would have required an increase in provider rates to meet access requirements. A coverage expansion via the private option is expected to produce deflationary pressure on private market rates given the volume of new patients with a paying source and will reduce uncompensated care costs, which is now reflected in an approximate 8 percent hidden surcharge in premiums.

**4. In a recent memo to states from HHS, Secretary Sebelius stated "beneficiaries must remain Medicaid beneficiaries and continue to be entitled to all [Medicaid] benefits and cost-sharing protections." It seems HHS is actually eliminating the benefits the state hoped to achieve through the private insurance market and thus make the state Exchange look more like Medicaid.**

**a. How will the private plans offered to Medicaid beneficiaries in the Exchange compare to Medicaid, in terms of cost-sharing and benefits provided?**

Medicaid cost sharing requirements will be satisfied by all silver level qualified health plans offered to individuals eligible for the private option. Required Medicaid benefits not already covered by qualified health plans—non-emergency transportation, oral and vision care for 19- and 20-year olds—will be “wrapped” for beneficiaries, provided by fee-for-service Medicaid.

**b. Will Medicaid continue to provide wrap-around services for those services that are not covered in the standard set of benefits?**

Yes, fee-for-service Medicaid will provide those services to beneficiaries.

**c. Will these wrap-around benefits include the cost-sharing portion of the plans?**

Private option beneficiaries between 100-138 percent of federal poverty level (FPL) and subsidy-eligible beneficiaries between 139-150 percent FPL will be subject to cost-sharing that complies with Medicaid requirements. Private option eligible beneficiaries under 100 percent of FPL will have no-cost sharing in the first year of the program.

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**d. Under the ACA, the federal government established new provisions to stabilize the cost of insuring beneficiaries through the Exchange: reinsurance, risk corridors, and risk adjustment. Will the Medicaid population enrolled in Exchange health plans be included in these programs?**

- i. If YES - how will these additional costs be distributed to other beneficiaries within the Exchange?**
- ii. If NO- will these provisions be applicable in just the Medicaid pool? If so, how will costs be distributed among Medicaid beneficiaries?**

The risk adjustment, reinsurance, and risk corridor programs will apply to the qualified health plans offered to private option eligible, which are also plans in which subsidy-eligible individuals will be enrolled. The risk pools will not differ; costs will be distributed no differently than they are for other beneficiaries in the HIM.

**e. What flexibilities does Arkansas require from HHS to provide true consumer driven, market-based insurance?**

Flexibility pursued via the proposed 1115 waiver process currently under public comment prior to state submission includes the following requests:

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Use for Waiver	Reason for Waiver Request	Waiver Authority
To enable the State to apply the 5% cap on cost-sharing on an annual, rather than quarterly, basis.	This waiver authority will allow the State to align with how carriers will apply the annual cost-sharing limit for commercial coverage in the individual market.	§ 1902(a)(14)
To permit the State to limit reimbursement for federally qualified health centers (FQHC) and rural health centers (RHC) to the amount the FQHC/RHC negotiated with the QHP carrier, rather than the amount established under the prospective payment system.	This waiver authority will allow the State to limit its financial exposure and align reimbursement to FQHCs/RHCs for Private Option beneficiaries with QHPs' contracted rates.	§ 1902(a)(15)
To permit the State to provide coverage through different delivery systems for different populations of Medicaid beneficiaries. Specifically, to permit the State to provide coverage for Private Option eligible Medicaid beneficiaries through QHPs offered in the individual market. The State is not requesting a waiver of comparability with respect to benefits, eligibility, or cost-sharing.	This waiver authority will allow the State to test using premium assistance to provide coverage for QHPs offered in the individual market through the Marketplace or a subset of Medicaid beneficiaries.	§ 1902(a)(17)
To make premium assistance for QHPs in the Marketplace mandatory for Private Option beneficiaries and to permit the State to limit beneficiaries' freedom of choice among providers to the providers participating in the network of the Private Option beneficiary's QHP.	This waiver authority will allow the State to require that Private Option eligible beneficiaries receive coverage through the Demonstration, and not through the State Plan. This waiver authority will also allow the state to align the network available to Private Option beneficiaries with the network offered to QHP enrollees who are not Medicaid beneficiaries.	§ 1902(a)(23)
To permit the State to limit a Private Option beneficiary to receiving coverage for drugs on the formulary of the Private Option beneficiary's QHP.	This waiver authority will allow the State to align the prescription drug benefit for Private Option beneficiaries with the prescription drug benefit offered to QHP enrollees who are not Medicaid beneficiaries.	§ 1902(a)(54)
To permit the State to require that requests for prior authorization for drugs be addressed within 72 hours, rather than 24 hours. A 72-hour supply of the requested medication will be provided in the event of an emergency.	This waiver authority will allow the State to align prior authorization standards for Private Option beneficiaries with standards in the commercial market.	§ 1902(a)(54)

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- 5. Nearly 10% of Medicaid beneficiaries have third-party coverage, in addition to their Medicaid coverage. In these circumstances, the third party payer is required to pay prior to Medicaid, as Medicaid, by statute, is the "payor of last resort". The Deficit Reduction Act of 2005 worked to ensure Medicaid is the payer of last resort by requiring states to amend their Medicaid programs with certain provisions.**

**a. Are you aware of what challenges states continue to face in recovering third-party payments?**

Yes

**b. What impediments prevent third-party payers from following through on their payments?**

I am aware that states, including Arkansas, face challenges when applicants fail to realize that they may have other coverage or do not disclose that they have other coverage in fear that they may be disqualified. Because low-income individuals have constant shifts in employment and family situations, their access to coverage other than Medicaid is dynamic. Even where an applicant may fail to disclose the availability of other coverage, Medicaid's access to enrollment data to cross-check that availability is sometimes lacking due to concerns from third parties—and even other state or federal entities—about releasing information to Medicaid. States also face a litany of challenges related to third parties not responding to filed claims or not processing claims in a timely manner. Regarding pharmacy benefit managers (PBMs), many states face challenges related to PBMs' claims that they lack the authority to reimburse Medicaid directly.

I am also aware that payers face technical challenges with processing Medicaid and Medicaid managed care claims and that, in response, many states have looked to alternative methods of processing those claims. Also, many states lack an enforcement mechanism to incentivize third parties from following through on their payments.

- 6. How does the recent increased use of managed care in Medicaid influence third-party liability issues?**

Unlike many other states, managed care has never been a delivery model Arkansas has used for its Medicaid program. Therefore, we have no first-hand knowledge of how the increased use of managed care may or may not influence third-party liability.

- 7. The dramatic expansion of Medicaid under ACA exacerbates the administration complexity of determining eligibility and tracking enrollees. How would this additional complexity influence the ability of states to ensure third-parties pay what they are responsible for?**

The ACA provides resources to states to improve eligibility and enrollment systems and, for some states, actually makes eligibility determination less burdensome by eliminating asset tests. In Arkansas, the private option leverages the protections guaranteed by the HIM and the efficiencies provided by the private market to better ensure that beneficiaries and the state are getting a product that improves access and quality.

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## **The Honorable Gus Bilirakis**

- 1. Can you talk about your work with states and working with CMS on obtaining an 1115 waiver? Florida took almost two years to get an 1115 Medicaid waiver for a state wide managed care plan. What have other states tried through the waiver process? How was interacting with CMS during this process, and how long did it take for CMS to approve the waiver?**

Arkansas's experience with the US DHHS thus far has been a cordial and collaborative one. DHHS has provided a streamlined template for the waiver application and has been available and responsive to the state's questions and concerns throughout the process. Beginning two weeks after the private option was authorized, state officials began meeting with DHHS officials—both from CMS and the Center for Consumer Information and Insurance Oversight (CCIIO)—on a regular basis to work through the waiver process. We anticipate filing the waiver in early August and expect approval in time for HIM open enrollment. Other states have proposed a variety of 1115 waivers, ranging from block grants to targeted demonstrations for family planning services or delivery models for developmentally disabled populations, but Arkansas's proposed waiver to use premium assistance to purchase private coverage through the Marketplace will be the first of its kind.

- 2. The recent Oregon Medicaid study published in the New England Journal of Medicine seemed to show that individuals on Medicaid did not have better health outcomes than individuals without health insurance. Have you seen the study and what are your thoughts on it?**

This was a short-term but powerful study that had the expected short term results with regard to chronic disease. Chronic diseases develop over time and will require long term efforts and observation to gauge the effectiveness of Medicaid coverage. What is encouraging from the report is the significant increased use of preventive care, screening services and prescription drugs. This would portend more effective management and avoidance of future chronic disease. Overall, results exemplify the need to further study the effects of increased coverage using different delivery models, inclusive of Medicaid. The study's findings on health outcomes in Medicaid—though touted by many as proof that Medicaid is a flawed delivery model on the whole—suffer from significant limitations to jump to such a conclusion. Our health care system is no doubt in need of quality improvement, but this need is not unique to Medicaid. Dissolving the Medicaid program is not a rational solution to poor health outcomes in our health care system; neither is simply providing individuals with financial access to coverage and sending them on their way. A more comprehensive strategy is necessary, one that has a multi-payer approach, ensures adequate access to a quality workforce, and incentivizes providers to deliver more cost-effective, quality care and consumers to seek care in an appropriate manner.

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