Handout

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Memorandum

DATE	:	February 4, 2014
TO	:	Senator Jonathan Dismang
FROM	:	Matthew Miller, Assistant Director for Legal Services
		Nell Smith, Administrator, Research and Policy Analysis
		Jessica Beel, Staff Attorney
		Isaac Linam, Staff Attorney
SUBJECT	:	Arkansas Health Care Independence Program

Question Presented

You asked that our staff examine whether the "special terms and conditions" of the Arkansas Health Care Independence Program demonstration waiver restricted the state's ability to terminate the program. As part of this request, you authorized our staff to discuss the issue with staff of the Department of Human Services (DHS).

Discussion

From the outset, I should note that our staff examined aspects of this issue in the past and the research was publicly released at a January 16, 2014 meeting of the Senate and House Public Health, Welfare, and Labor Committee. In that memo I noted several times that a definite response to such questions required input from DHS as some of the relevant information is uniquely within their knowledge. Pursuant to your instructions, our staff met with DHS officials and obtained their feedback. We then independently reviewed the information they provided and conducted our own analysis. As a result, some of the information in this memorandum differs from what was provided on January 16, 2014. Any such differences arise from our consideration of facts and information that were unknown or unavailable during preparation of the previous memorandum. That said, I will address the issue in a question-and-answer format:

Do the "special terms and conditions" apply to an early termination of the Arkansas Health Care Independence Program?

As we mentioned in our earlier-released memorandum, the special terms and conditions of the demonstration waiver approved on September 27, 2013 specifically provide for the suspension or termination of the Arkansas Health Care Independence Program demonstration (hereafter "program"). The phase-out process in the demonstration waiver requires roughly 7 and 1/2 months to complete. The "special terms and conditions" appear on their face to represent the entirety of the program and are easily misinterpreted as such. However, the missing piece of the analysis is that when obtaining the demonstration waiver, DHS also amended the Medicaid State Plan to provide coverage for a new adult group consisting of non-pregnant individuals age 19 through 64 with a household income at or below 138% of the federal poverty level. DHS submitted the plan amendment on September 20, 2013 and it was approved on December 10, 2013.

Approval for the plan amendment came after the approval of the demonstration waiver -- while the waiver was approved first, the program would technically not have been able to go forward without the plan amendment. However, given the approval of the waiver the concurrent approval of the plan amendment was not in doubt. This is evidenced by the "Program Description and Objectives" section of the "special terms and conditions" which was issued before the approval of the plan amendments (underlined for emphasis):

> Under the Private Option demonstration, the State will provide premium assistance, to support the purchase by beneficiaries eligible under the new adult group under the state plan of coverage from QHPs offered in the individual market through the Marketplace.

The demonstration waiver operates in tandem with the state plan amendments to provide that the state will offer premium assistance for the newly eligible adult group to purchase insurance offered in the individual market through the Marketplace. While the waiver allows the use of Medicaid funds to provide premium assistance to participants in the program, the eligibility of the participants is determined by the state plan. If those persons are not eligible under the state plan, then providing them premium assistance under the waiver becomes a moot point.

The net result of this analysis is that the termination provisions of the "special terms and conditions" apply to termination of the waiver (which allows for premium assistance) and not the termination of eligibility of persons with a household income at or below 138% of the federal poverty level (which was determined by plan amendment S32). If the state sought to terminate the premium assistance envisioned by the waiver, the 7 and 1/2 month process would apply. This would only end the premium assistance, however -- the state plan

would still provide that persons at or below 138% of FPL were eligible for assistance in some form. An additional amendment to the state plan would still be required.

There is a simpler and more direct route to achieve an early end to the program -- amending the state plan to remove eligibility for the new adult group. This makes the demonstration waiver moot as the persons covered by it would not be eligible for the funds. This method also removes confusion in the state plan about how to treat the newly eligible adult group -- they clearly would not be covered.

Terminating the program by removing eligibility through a plan amendment is also consistent with Arkansas Code § 20-77-2105, which required DHS to submit both federal waiver and State Plan Amendments to implement the program. The law further provides that any State Plan Amendments shall be optional and revoked by the state at its discretion. There is no reference to discretion in revoking waivers.

Amending the state plan is also simpler from a timing standpoint. 42 C.F.R. § 430.12 provides that state plans are amended to reflect material changes in state law, organization, or policy, or in the State's operation of the Medicaid program. It appears the defunding of the program would constitute a material change that triggers a state plan amendment. 42 C.F.R. § 430.16 covers the timing of state plan amendments - such amendments are considered approved within ninety (90) days of receipt unless CMS sends a written notice of disapproval or requests additional information (in which case the receipt of the additional information restarts the ninety-day period). However, 42 C.F.R. § 430.20 notes that the effective date of this type of plan amendment may be a date requested by the state if CMS approves it.

The following appears to be the simplest manner of ending the program if funding were to hypothetically cease on July 1, 2014. DHS would seemingly be aware of that fact no later than March 26, 2014 (the last possible day of the fiscal session). Their awareness of the lack of funding would prompt the submittal of a state plan amendment to remove eligibility for the new adult group. They would request an effective date of July 1, 2014. The department would also be requesting federal financial participation (FFP) for the quarter beginning July 1, 2014 and ending September 30, 2014 and would request an amount that did not include the persons eligible under the Arkansas Health Care Independence Program (this principle will be explained in greater detail later in this memorandum). The approval of a state plan amendment removing this eligibility makes the demonstration waiver moot, much as repealing a law makes the administrative rules implementing a law moot. If the plan amendment were approved, the persons covered by the demonstration waiver are by definition not eligible for the funds.

Is the State subject to any penalties for an early termination of the Arkansas Health Care Independence Program?

This question presumes that the state either operates contrary to its state plan or that the federal government refuses to allow the state to amend its state plan and terminate the program at the same time the state lacks appropriation to follow the plan in its current form. 42 U.S.C. § 1396c is the relevant section of federal law (underlined for emphasis):

> If the Secretary, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of the State plan approved under this subchapter, finds-
> (1) that the plan has been so changed that it no longer complies with the provisions of section 1396a of this title; or
> (2) that in the administration of the plan there is a failure to comply substantially with any such provision;
>
> the Secretary shall notify such State agency that further payments will not be made to the State (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure), until the Secretary is satisfied that there will no longer be any such failure to comply. Until he is so satisfied he shall make no further payments to such State (or shall limit payments to categories under or parts of the State plan not affected by such failure).

42 C.F.R. § 430.35 provides additional detail:

> a) *Basis for withholding*. CMS withholds payments to the State, in whole or in part, only if, after giving the agency reasonable notice and opportunity for a hearing in accordance with subpart D of this part, the Administrator finds—
>
> (1) That the plan no longer complies with the provisions of section 1902 of the Act; or
>
> (2) That in the administration of the plan there is failure to comply substantially with any of those provisions.

(Hearings under subpart D are generally not called until a reasonable effort has been made to resolve the issues through conferences and discussions. These may be continued even if a date and place have been set for the hearing.)

(b) *Noncompliance of the plan.* A question of noncompliance of a State plan may arise from an unapprovable change in the approved State plan or the failure of the State to change its approved plan to conform to a new Federal requirement for approval of State plans.

(c) *Noncompliance in practice.* A question of noncompliance in practice may arise from the State's failure to actually comply with a Federal requirement, regardless of whether the plan itself complies with that requirement.

(d) *Notice and implementation of withholding.* If the Administrator makes a finding of noncompliance under paragraph (a) of this section, the following rules apply:

(1) The Administrator notifies the State:

(i) That no further payments will be made to the State (or that payments will be made only for those portions or aspects of the program that are not affected by the noncompliance); and

(ii) That the total or partial withholding will continue until the Administrator is satisfied that the State's plan and practice are, and will continue to be, in compliance with Federal requirements.

(2) CMS withholds payments, in whole or in part, until the Administrator is satisfied regarding the State's compliance.

Relevant to this discussion is the holding of National Federal of Independent Business v. Sebellius, 132 S.Ct 2566 (2012), that states cannot be forced to expand Medicaid. Under the Affordable Care Act, states risked the withholding of all Medicaid funds if they failed to expand. The court found such a premise unconstitutional. Key excerpts of that opinion are set out below (citations omitted):

We have upheld Congress's authority to condition the receipt of funds on the States' complying with

restrictions on the use of those funds, because that is the means by which Congress ensures that the funds are spent according to its view of the "general Welfare." Conditions that do not here govern the use of the funds, however, cannot be justified on that basis. When, for example, such conditions take the form of threats to terminate other significant independent grants, the conditions are properly viewed as a means of pressuring the States to accept policy changes.

. . .

In this case, the financial "inducement" Congress has chosen is much more than "relatively mild encouragement"—it is a gun to the head. Section 1396c of the Medicaid Act provides that if a State's Medicaid plan does not comply with the Act's requirements, the Secretary of Health and Human Services may declare that "further payments will not be made to the State." A State that opts out of the Affordable Care Act's expansion in health care coverage thus stands to lose not merely "a relatively small percentage" of its existing Medicaid funding, but *all* of it. Medicaid spending accounts for over 20 percent of the average State's total budget, with federal funds covering 50 to 83 percent of those costs. The Federal Government estimates that it will pay out approximately $3.3 trillion between 2010 and 2019 in order to cover the costs of *pre*-expansion Medicaid. In addition, the States have developed intricate statutory and administrative regimes over the course of many decades to implement their objectives under existing Medicaid. It is easy to see how the *Dole* Court could conclude that the threatened loss of less than half of one percent of South Dakota's budget left that State with a "prerogative" to reject Congress's desired policy, "not merely in theory but in fact." The threatened loss of over 10 percent of a State's overall budget, in contrast, is economic dragooning that leaves the States with no real option but to acquiesce in the Medicaid expansion.

. . .

> Nothing in our opinion precludes Congress from offering funds under the Affordable Care Act to expand the availability of health care, and requiring that States accepting such funds comply with the conditions on their use. What Congress is not free to do is to penalize States that choose not to participate in that new program by taking away their existing Medicaid funding. Section 1396c gives the Secretary of Health and Human Services the authority to do just that. It allows her to withhold *all* "further [Medicaid] payments ... to the State" if she determines that the State is out of compliance with any Medicaid requirement, including those contained in the expansion. 42 U.S.C. § 1396c. In light of the Court's holding, the Secretary cannot apply § 1396c to withdraw existing Medicaid funds for failure to comply with the requirements set out in the expansion.

The wild card in the above analysis is that the State has amended its state plan to include persons eligible for the program, obtained the necessary waivers, and enrolled persons into the program. Is the decision to terminate such an agreement with the federal government the equivalent of choosing not to expand as envisioned by the opinion? A document released by CMS on December 10, 2012 to address "frequently asked questions" suggests the answer is yes:

> ***If a state accepts the expansion, can a state later drop out of the expansion program?*** A. Yes. A state may choose whether and when to expand, and, if a state covers the expansion group, it may decide later to drop the coverage.

While that statement suggests federal cooperation in exiting the program, it is impossible to predict how the scenario would play out. If the state faced reluctance in gaining approval to end the program, it could argue that the logic in NFIB v. Sebellius against penalties would apply -- such an argument would likely center around the idea that refusing to let the state terminate the program is a "gun to the head" forcing the state to participate against its wishes.

Note also that the federal law cited above specifically references either a full withholding of funds or a withholding for the parts of the program associated with noncompliance. Based on my understanding of how federal financial participation (FFP) funds are received, withholding of the specific funds at issue would be impossible. It is my understanding that DHS requests FFP funds in advance of a calendar quarter -- for example, DHS will request funds for the July 1, 2014 - September 30, 2014 quarter a few weeks in advance of July 1. Given the timing of the fiscal session, DHS would be aware of a lack of appropriation when

making future requests and would not request FFP to fund the program if it was not funded in the 2015 fiscal year. The imposition of penalties presumes that the federal government declined a DHS request to amend the state plan and the state then operated counter to the plan -- however, in that case withholding the funds at issue would not be a penalty option as the state would not have requested the funds. If CMS sought to force the state to fund the program, it would need to send the state funds it did not ask for. Thus, the most foreseeable penalty would be a withholding of funds not associated with the program (the outcome frowned upon in NFIB v. Sebellius).

In summary, federal law allows for the withholding of all federal Medicaid funds for noncompliance with a state plan. Whether that is appropriate in this case is impossible to answer conclusively. Recent Supreme Court precedent and CMS publications suggest federal resistance or the imposition of penalties might be inappropriate, but the question would rest with a court.

Are there any agreements with insurance companies that complicate an early termination of the Arkansas Health Care Independence Program?

The department entered into a "memorandum of understanding" with the insurance companies providing coverage through the program. We had the opportunity to review the memorandum of understanding with Blue Cross Blue Shield and assume that the document mirrors agreements with other insurance companies. The memorandum addresses in plain language the possibility of an early termination:

> 7.2.3 This memorandum of understanding will terminate immediately in the event that statutory authority for the Health Care [I]ndependence Program is repealed by the state; waiver authority for the Health Care Independence Program is revoked by CMS; or funding for the Health Care Independence Program is terminated by either the State or the federal Government.
>
> 7.3 Close-Out Procedures. Upon termination of expiration of this Memorandum of Understanding, Issuer will comply with close-out procedures developed in conjunction with DMS. The close-out procedures will include the following:
>
> 7.3.1 Issuer will promptly account for and repay funds advanced by DMS for coverage of issuer Enrollees for periods subsequent to the effective date of termination. . .
>
> 7.3.3 Issuer will establish an appropriate plan acceptable to and prior approved by DMS and AID for

> the orderly transition of Issuer Enrollees. This plan will include the provision of pertinent information to identified Issuer Enrollees who are: pregnant; currently receiving treatment for a chronic or life threatening condition; prior approved for services or surgery; or whose care is being monitored by a case manager to assist them in making decisions which will promote continuity of care.

This language clearly provides for an early termination of the program.

Does the demonstration waiver incorporate the "triggers" to exit coverage in the Health Care Independence Act of 2013?

The act contained several provisions concerning the implementation of the program:

- The program shall not be implemented if necessary federal approvals are not obtained.
- The program shall terminate within one hundred twenty (120) days of a specified reduction in federal medical assistance percentages (FMAP).
- Any state plan amendments submitted to implement the program shall be optional and able to be revoked by the state at its discretion.
- The program shall not be implemented if DHS is unable to confirm that employers shall not be subject to shared responsibility penalties if employees enroll and obtain coverage through the program.
- The program was to be suspended until the passage of an appropriation for implementation.

The provision on termination within one hundred twenty (120) days of an FMAP reduction is not recited in the special terms and conditions or the state plan, although the special terms and conditions note that the state must submit a modified budget neutrality agreement if there is a reduction or increase in federal financial participation. Neither document envisions an automatic end to the program in this circumstance. However, the absence of that language does not appear to preclude the state taking action if that "trigger" became relevant.

As noted earlier, under federal law state plan amendments are appropriate to address material changes in state law. A reduction in FMAP as seen in the act is arguably a material change, as Arkansas law would at that point require an end of the program. Also as noted earlier, plan amendments are considered approved within ninety (90) days unless other action is taken by CMS. Thus, presumably DHS could obtain a state plan amendment within the one hundred twenty (120) days envisioned to terminate the program as required by the Health Care Independence Act. While one might argue that the matter should have been included in the "special terms and conditions" or state plan, it appears other means exist for the state to comply with that provision. The

timeline for a state plan amendment is also consistent with the one hundred twenty (120) termination period under the Health Care Independence Act.

We are unaware of present state plan amendments or a provision of the state plan that specifically provides that the amendments are optional and able to be revoked at the state's discretion, although this was not discussed with DHS and we might have failed to locate it. The law does not require that this be written into the plan amendment -- a plan amendment would seemingly comply with the law so long as it was by practice optional and revocable. That would be a factual determination.

The provision on confirming that employers are not subject to penalties is likewise not addressed in the state plan or the special term and conditions. DHS states that they confirmed that employers would not be subject to penalties based upon their review of 26 U.S.C. § 4980H (stating that the penalty is triggered when a person obtains a premium tax credit or cost sharing through the exchange, which they state does not occur when a person is enrolled in the program) and 26 U.S.C. § 5000A (stating that coverage under the Medicaid program is minimum essential coverage under the Affordable Care Act). This confirmation was based upon their own review and was not validated by any federal agency. This action is arguably consistent with the Health Care Independence Act of 2013, as it is silent on how DHS was to confirm the penalty issue.