Medicaid Headaches

Progress in Arkansas' program thwarted by bureaucratic snags

Arkansas, one of only 12 Republican-controlled states to expand its Medicaid program under President Barack Obama's health care law, has managed to significantly reduce the number of its residents who are uninsured.

The influential Kaiser Family Foundation found that the state's uninsured rate among non-elderly adults dropped to 15.6 percent in 2014 from 27.5 percent in 2013. In addition, hospitals saw their uncompensated care costs fall 55 percent as more patients received treatment in doctors' offices instead of emergency rooms.

But those accomplishments are now in jeopardy. Thousands have been dropped from the program since June, after delays in a process to reverify their eligibility. And thousands more are at risk.

The state has blamed the delay on problems in switching to an automated verification system. The state Department of Human Services in June began telling beneficiaries whose income changed 10 percent or more since enrollment that their coverage has ended or will end soon unless they provide proof that they are still qualified for benefits. Some of the letters were mailed just days before a 10-day deadline for filing the information and even beneficiaries whose income declined received the letters.

Danny Johnston/AP Photo

MIXED REVIEW: Arkansas Gov. Asa Hutchison pushes to continue the state's Medicaid expansion.

The predictable result: widespread confusion and outrage among beneficiaries and their advocates.

When Arkansas expanded its Medicaid program, it chose a unique system called Private Option, where the state purchases coverage from private insurance providers for the newly qualified beneficiaries — members of households earning up to 38 percent more than the federal poverty level. The program is scheduled to end on Dec. 31.

Under the usual federal rules, Medicaid enrollees are to be sent annually a prefilled verification form that they can update with any changes. And they must have at least 30 days to return the form before the state can revoke coverage. However, those who reapply within 90 days must be reinstated under a streamlined process, which Arkansas provides.

But Arkansas was given a waiver from the 30-day requirement by the federal Centers for Medicare and Medicaid Services to give the state more time carry out its nontraditional renewal process. Beneficiaries were given just 10 days from the date on the letter to return paperwork, pay stubs or other documents verifying their income. Those who don't make the deadline are booted from the program as fast as the state can process them, usually in about 10 days.

Amy Webb, communications director for the Arkansas Department of Human Services says the state has been identifying recipients of the letters by cross-checking income from applications with state tax records and other data.

CMS later amended the exemption to require a full 30 days to provide the documents, according to Webb. She says the state stopped sending the 10-day warning letters Aug. 21 and is in the process of writing new ones with the 30-day time frame. The state doesn't know when it will be ready to send out

the new letters, Webb says.

Even so, more than 339,000 letters with the 10-day deadline have been mailed since June. And some 58,000 Medicaid clients have been dropped from the program, including many for failing to respond in the 10-day time frame that CMS now says was inadequate.

"CMS did not request the state to start the process over for the individuals who already lost coverage and our system currently isn't able to simply turn them back on and start over," Webb says.

Advocates say it's clear that the letters are causing widespread confusion for beneficiaries.

"The state has not been able to break down or parse out how many of those folks [receiving the letters] do still meet the eligibility requirement based on income," says Marquita Little, health policy director for Arkansas Advocates for Children and Families.

Beneficiaries whose coverage has ended now find themselves in the same uninsured boat they thought they escaped when they were enrolled in the plan, Little adds.

Arkansas says that, of the 58,000 beneficiaries whose coverage was halted, 3,200 have been reinstated after providing the data.

Mary Franklin, assistant director for the state's Department of Human Services Division of County Operations, outlined the state's stance on the cutoffs in a July 15 news release: "If people enrolled today get a request for more information and are still eligible and want coverage, it is their responsibility to respond within the time frame allowed."

Built-in Flaws

Little says she had concerns early on about the renewal process. She was worried officials would have difficulties locating beneficiaries due to changing addresses among the low-income population, and would not allow beneficiaries sufficient time to respond. She also says there was insufficient outreach and education about what the renewal process would entail.

The process was made all the more difficult for beneficiaries, she adds, when the Arkansas legislature in February 2014 restricted how the Department of Human Services, Arkansas Insurance Department and Arkansas Department of Health could use funds to promote or advertise Medicaid. The restrictions meant that any kind of education outreach to consumers fell to community organizations.

The Department of Human Services' Webb says that the agency works with insurers and community organizations, and posts information on its website, to get the word out to enrollees.

Tricia Brooks, a senior fellow at the Georgetown University Center for Children and Families, says that it's important for states to verify ongoing Medicaid eligibility annually. However, the state's alternative process to reverify eligibility, rather than implementing a formal renewal, is adding an administrative burden on both the state and current enrollees.

Brooks says that the state is requiring anyone who had a 10 percent increase or decrease in income to provide additional proof of eligibility. But enrollees who did see a decrease in income would still be eligible for Medicaid, she adds.

"The state would be smart to put resources into complying with renewal requirements than this spin-off process that seems to be poorly executed," Brooks says.

According to Brooks, even though beneficiaries who miss the verification deadline can reapply for the program, "it's going to create a bigger administrative mess from a paperwork sense."

Matt Salo, executive director for the National Association of Medicaid Directors, says all states struggle to figure out how to make sure people on the rolls are supposed to be there.

"You want to make sure the process works for people," Salo says. "You don't want to create unnecessary burdens that create negative perceptions of consumers and you don't want to scare people away from something they're entitled to."

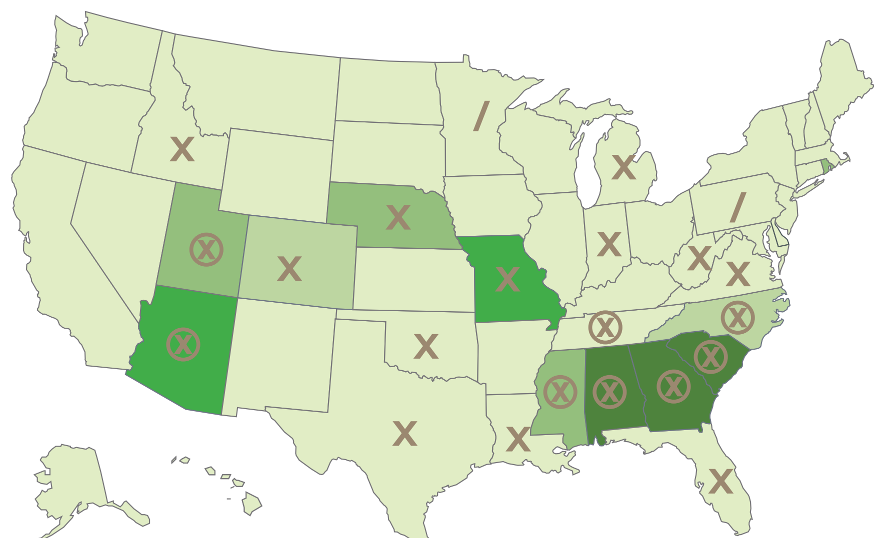
— Marissa Evans

E-Verify: Under-Utilized

A dozen states mandate use of the federal E-Verify system to check the immigration status of state workers and contractors, and only eight require large private businesses to use it. Congress is debating whether to renew E-Verify, which now has about 608,000 registered business users.

Businesses using E-Verify (per 1,000 residents)
Fewer than 1.9
1.9 to 2.5
2.5 to 3.5
6.4 to 7.2
7.2 to 8.8

State mandates for:
/ contractors
X contractors and state employees
Ⓧ contractors, state employees and most businesses



Source: U.S. Citizenship and Immigration Services, National Conference of State Legislatures

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