September 6, 2013

VIA ELECTRONIC SUBMISSION

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

Re: Arkansas Health Care Independence Program ("Private Option") Demonstration

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 provide comments to Arkansas' proposed Health Care Independence Program § 1115 demonstration.

NHeLP recommends that HHS not approve the Arkansas request for section 1115 authority to conduct premium assistance, exactly as requested. Instead, first, we urge HHS to address a number of concerns in the proposal and encourage Arkansas to bring it to a legally approvable form. We urge HHS to work with Arkansas to achieve a Medicaid Expansion that will serve future Medicaid enrollees well, including those inside Arkansas benefiting from this proposal and those in other states who may pursue similar proposals.

Second, we ask that before HHS takes action on this waiver request, it take steps to address its own "stewardship of federal Medicaid resources." GAO, *Medicaid Demonstration Waivers: Approval Process Raises Cost Concerns and Lack of Transparency* at 32 (June 2013). As the GAO recently concluded, "HHS's [budget neutrality] policy is not reflected in its actual practices and, contrary to sound management practices, is not adequately documented….[T]he policy and processes lack transparency regarding criteria." *Id.* We request that HHS zealously enforce its stated policies and the legal limits of Medicaid section 1115 demonstration law, to ensure progress in Arkansas

without opening the door to policies that ignore the fundamental nature of Medicaid as an entitlement program.

A. Introduction: Legal Authority

Arkansas has submitted an application to conduct a section 1115 demonstration program to use individual market premium assistance to implement a Medicaid Expansion. The stated authority to conduct *individual* market premium assistance underlying this application is 42 U.S.C. § 1396d(a). However, the statute and legislative history create serious questions about the validity of this claimed authority. Section 1396d(a) defines "medical assistance" and, for the most part, is a listing of services that can or must be included in this definition. By contrast, Congress has dealt with premium assistance in other, specific provisions of the Act. Congress has authorized states to conduct *group* or *employer* coverage premium assistance, which are unambiguously and carefully detailed in statute at sections 1396e and 1396e-1. Notwithstanding two very recent policies from HHS (in regulatory and sub-regulatory guidance), there is no history of statutory or regulatory guidance for section 1396d(a) authority. Given the uncertainty of the statutory authority and the untested regulatory framework, we believe it is incumbent upon HHS to be extremely cautious and exacting in the approval of any such authority, and even more so for related waivers. HHS should hold tightly to the principles announced in its March 2013 Question and Answer document. And under these circumstances HHS must also be unmistakably clear as to the waiver authorities being granted and their legal limits.

B. Single State Agency

In addition to premium assistance authority concerns, Arkansas's request, as currently written, fails to ensure that the single state Medicaid agency will remain in charge of the Medicaid program for affected populations, as the Medicaid Act requires.[1] The application does not provide the general public or HHS with information and specifics establishing that the single state Medicaid agency will continue to make administrative and policy decisions for the program. By law, the single state Medicaid agency must be in control and accountable for Medicaid coverage. While Arkansas may not formally delegate away Medicaid authority, it in effect surrenders control over the majority of benefits for an entire category of enrollees (and possibly multiple categories in the future). Arkansas will not control many benefits package details, authorization criteria, and provider contracts and terms established by the plan. The application envisions a memorandum of understanding between the Medicaid agency and the private insurance companies. However, the establishment of an MOU relationship between the state and QHPs, as suggested in the proposal,[2] does not resolve the concern that the QHP would act as an independent entity with its own authority, including discretion, contrary to what Medicaid law permits. NHeLP is very supportive of HHS requiring written agreements between the involved entities to satisfy the legal requirement for a single state agency, clearly delineating roles and responsibilities, with the ultimate authority and

[1] 42 U.S.C. § 1396a(a)(5).
[2] Arkansas 1115 Waiver Application, page 49.

responsibility housed in the Medicaid agency. However, the application is sparse on details and the mere presence of an MOU at some point in the future does not satisfy this requirement. HHS should require more of Arkansas as a condition of approval. While assuring consumer protections, this would also address some of the GAO's conclusions that find HHS processes lack the supporting evidence required to justify deviations from historical requirements. GAO, supra. at 32.

C. Notice and Appeals

Although Arkansas' proposal does provide for "notice and appeals," it only requires the process to comply with the QHPs standards, processes, and entities, even when the service is a Medicaid covered service being provided, using Medicaid money (to pay the premium), to a Medicaid enrollee. As written, the waiver request raises serious questions regarding its legality under the Medicaid Act, 42 U.S.C. § 1396a(a)(3), and regulations, 42 C.F.R. part 431.200. The waiver also appears to ignore some of the Constitutional requirements of *Goldberg v. Kelly*, 397 U.S. 254 (1970), which are immutable, minimum requirements that cannot be waived or ignored. As the *Goldberg* Court recognized, the low income status of the adults and parents covered by the waiver means that they have a "brutal need" for public assistance. *Id.* at 261. To comply with the Medicaid Act, the regulations, and the Constitution, the Arkansas waiver program needs to clarify the required content of notices, see *Goldberg*, 397 U.S. at 268-69 ("The opportunity to be heard must be tailored to the capacities and circumstances of those who are to be heard."); 42 C.F.R. 431.200. It must describe the circumstances under which benefits will continue pending appeal, *see Goldberg*, 397 U.S. at 264 ("[O]nly a pre-termination evidentiary hearing provides the recipient with due process"). It cannot, as currently proposed, rest upon a paper review or discretionary testimony (App. at 13); rather, the program must ensure that enrollees are able to be heard through testimony and witnesses by an impartial decision-maker, see Id. at 270 ("It is not enough that a welfare recipients may present his position to the decision maker in writing or second-hand through his caseworker.").

Finally, serious single state agency issues would be raised if the insurance company rather than the single state Medicaid agency made the final decision on appeal. *See*, *e.g.*, *K.C. ex rel. Africa H. v. Shipman*, 716 F.3d 107 (4th Cir. 2013) (holding health plan contractor insurer could not override agency decision and that "[o]ne head chef in the Medicaid kitchen is enough").

Arkansas must be required to allow all enrollees access to the Medicaid appeals system for all Medicaid covered services, without exceptions or unwanted delays. We do not object, or believe it would be legally impermissible, for HHS to allow an *optional* and *additional* plan review process that could operate concurrently to the Medicaid process for Medicaid services. In all such cases, a favorable decision from the Medicaid entity would control, and such decisions could not be delayed because of the plan level process. Unless Medicaid enrollees are guaranteed access to a Medicaid appeals system, we do not believe the § 1115 application is approvable or could be legally implemented.

D. Cost-sharing

We support the commitment to follow all Medicaid cost-sharing requirements as broadly stated in this Arkansas section 1115 application.[3] This feature is in fact a required one, since section 1115 demonstration authority cannot legally waive the requirements of sections 1396o and 1396o-1, or any other such provision lying outside of 42 U.S.C. 1396a.[4] It is unclear what cost-sharing waiver authority the state was initially seeking, but any individual premium assistance proposal must comply in full with sections 1396o and 1396o-1, and related regulation, and this remains true with or without a waiver.[5] We believe this is the intent of the proposed section 1115 waiver, though we note there is ambiguous language which confuses the intent. *See* Arkansas 1115 Waiver Application, page 1, stating that "Private Option beneficiaries will … have cost sharing obligations consistent with both the State Plan and with the cost-sharing rules applicable to individuals with comparable incomes in the Marketplace." We believe this language could only be legal if it is meant to always apply the Medicaid Act protections except where the Marketplace protections for a given service are *more* stringent. Furthermore, we note that the application does not include enough details to confirm how the demonstration will comply with other key Medicaid Act cost-sharing requirements which HHS must ensure remain intact:

- While the application indicates there will be no cost-sharing for individuals below 100% FPL in year one, it indicates that cost-sharing will be added for the 50% to 100% population after year one through an amendment. Those levels of cost-sharing are not specified – and we have concerns that the state will use the amendment process so skirt the full 42 U.S.C. §1396o(f) requirements. The population groups who are being enrolled in this waiver are described in the Medicaid Act and, thus, can no longer be considered "expansion populations." As such, the requirements of §1396o(f) will apply to the State's decision to impose cost sharing over and above that which is already allowed under the Medicaid Act, see §§ 1396o and 1396o-1 (describing states' flexibility to impose nominal cost sharing on individuals below 100% FPL). Any effort by the State to impose cost sharing above the statutorily authorized options and limits must meet the five tightly circumscribed criteria of §1396o(f) and be implemented only after public notice and comment. We urge HHS to clarify with the state that (1) any "amendment" imposing higher cost-sharing is subject to full section 1396o(f) requirements, and (2) HHS will also require the state to meet the full section 1115 transparency requirements (See also Part G below for more details).
- The application indicates that the QHPs will be required to track the cumulative cost-sharing paid by enrollees and comply with the 5% aggregate cap on cost-sharing in law. The application sets the cap at 100% of FPL for individuals above 100% of FPL, which is a sensible administrative approach. However, when/if

[3] See e.g., Arkansas 1115 Waiver Application, pages 11, 15.
[4] See 42 U.S.C. §1315(a)(1).
[5] Waivers could only be permissible following the legal requirements for waivers contained *within* section 1396o.

cost-sharing is established for populations below 100% FPL, no such line at 100% would be acceptable for them. The state would need to draw a lower administrative line for those populations.

- Under law, the 5% limit must be applied on a monthly or quarterly basis. Arkansas notes as much in its responses to comments received.[6] However, earlier in the same application Arkansas writes that "QHPs will monitor Private Option beneficiaries' aggregate amount of copayments to ensure that they do not exceed the *annual* limit." (Emphasis added). HHS must clarify that Arkansas must require QHPs to evaluate this on, at most, a quarterly basis. This includes a method to track the cost-sharing levels, identify and provide notice to individuals who have met their threshold, and ensure that providers understand that these individuals are not liable for the cost-sharing.
- While the application does indicate that "Arkansas will make adjustments to the cost-sharing cap for Private Option enrollees in two adult households," it does not indicate what this adjustment will be. This must be clarified to explicitly indicate that the combined cost-sharing for the entire Medicaid household must never exceed 5% of that household's income.
- Under the proposed demonstration, states would <u>not</u> directly contract with the QHPs, who would in turn contract with providers for a wide range of enrollees, many of whom are <u>not</u> Medicaid enrollees. Under these circumstances, in a demonstration where QHP providers will collect cost-sharing at point of service, it is difficult to understand how Arkansas Medicaid will enforce the requirement for non-enforceable cost-sharing for all individuals below 100% FPL (and some individuals above that limit). Arkansas' application does not address this requirement and how it will be enforced. The application should not be approved unless and until this is clarified.
- Arkansas' application mentions the state will pursue "health savings accounts" (HSA), though no further details are provided. State descriptions of HSAs typically include a monthly "contribution". Such a contribution, if charged regularly without respect to utilization, is in fact merely a premium called by a different name and illegal under Medicaid law for populations below 150% FPL.
- The waiver is confusing regarding cost sharing and coverage associated with non-emergency use of the emergency room (App. at 44).
    - In the comments section, it takes the position that non-ER use of the ER is not a covered service; however, this is not correct. While the state can, under the law, impose a copayment, it does not follow that a service that is otherwise described as an EHB/ABP (e.g., physician visit) is not a covered service because an individual accessed it through an ER. Arkansas has improperly equated the *service* (which is covered) with a policy for the *preferred site* for delivering the service. If the recipient chooses the improper site, Congress has established that the penalty is a copayment, not that it is a non-covered service.
    - Furthermore, the comment section appears to adopt a $20 copayment for non-emergency use of the ER. This would violate the statutory limits for

[6] Arkansas 1115 Waiver Application, page 43.

nominality set out in sections 1396o and 1396o-1 and implemented in the newly finalized federal regulations at 42 C.F.R. § 447.54, which cap the copayment at $8.00 for individuals under 150% FPL.[7] This maximum should be tightly guarded and never waived by HHS. Emergency room copayments have been heavily studied; they would not serve an experimental purpose. Prior research indicates that instituting higher copayments on ER use in the Medicaid context does not effectively reduce expenditures.[8] Furthermore, non-urgent use of the ER is uncommon (only 10% of Medicaid ER visits) and roughly as prevalent in Medicaid as in privately insured populations.[9] There are many valid systemic reasons low-income populations may occasionally need to use an ER on a non-emergent basis. Some Medicaid enrollees are far more likely to face barriers to accessing primary care that lead them to seek out the ER.[10] In some cases, those enrolled in MCOs with weak provider networks go to ERs to obtain access to specialty care that is unavailable through FQHCs or other alternative primary care sites. In addition, primary care providers tell their patients, when in doubt, go to the ER, with many leaving a message to that effect on their office voice mails during off hours. The prudent layperson responds to all these situations by going to the ER to obtain care.

E. Cost-effectiveness

Where Congress has unambiguously created authority for premium assistance, in Section 1396e[11] and 1396e-1[12], it has explicitly required premium assistance programs to be cost-effective. Recent regulations implementing section 1396d(a) premium assistance authority create a similar requirement for "comparable" costs.[13] Furthermore, HHS requires section 1115 demonstrations to be "budget neutral." As we have noted, the GAO has published repeated and serious concerns with HHS's failure to enforce its policies regarding cost-effectiveness. See GAO, *Medicaid Demonstration Waivers: Approval Process Raises Cost Concerns and Lack of Transparency* (June 2013) (citing previous reports). HHS, therefore, must (1) not approve a section 1115 application for individual market premium assistance which does not establish that the demonstration will be of similar cost to Medicaid state plan enrollment for the same population and (2)

[7] *See* 42 U.S.C. §§1396o(a)(3) and 1396o-1(e).
[8] Neil T. Wallace et al., *How Effective are Copayments in Reducing Expenditures for Low-Income Adult Medicaid Beneficiaries? Experience from the Oregon Health Plan*, 43 Health Serv. Research 515 (2008).
[9] Anna S. Sommers et al., Ctr. For Studying Health System Change, Research Brief No. 23, *Dispelling Myths About Emergency Department Use: Majority of Medicaid Visits Are For Urgent or More Serious Symptoms* (2012).
[10] Paul T. Cheung et al., *National Study of Barriers to Timely Primary Care and Emergency Department Utilization Among Medicaid Beneficiaries*, 60 Annals of Emergency Medicine 4 (2012).
[11] § 1396e(c)(1)(B)(i).
[12] § 1396e-1(a).
[13] 42 CFR § 435.1015(a)(4).

not approve a section 1115 application that is not inconsistent with HHS's stated policies.

The pending request is problematic on a number of fronts. First, and most importantly, Arkansas' cost model assumes the state would otherwise raise payment rates to private market levels in its fee-for-service program. This assumption is simply unreasonable considering the below-market Medicaid rates paid in Arkansas today, other state Medicaid programs generally, and past expansions of the Medicaid program. The section 1396a(a)(30)(A) requirements which Arkansas cites in the individual market premium assistance context have applied with equal force in all states throughout Medicaid's history, and have never led to full compliance with private market rates by Arkansas or other states. Allowing states to justify section 1396d(a) comparability or section 1115 budget neutrality by reference to rates with no basis in Medicaid reality eviscerates the cost-effectiveness requirement.

In addition, although recent regulations clearly require an adequate accounting of administrative costs,[14] it is unclear from the proposal whether Arkansas' assumptions about costs properly evaluate the administrative costs associated with wrapping around benefits and cost-sharing for such a large number of enrollees, and monitoring and enforcing that wrap-around requirement. In fact, Arkansas sets out *reduction* in administrative costs based on reduced churning as a hypothesis to be tested in this demonstration, without even mentioning the serious administrative costs associated with wrap around in this context.

At the very least, the proposal should clarify any unique circumstances in Arkansas (e.g., extremely low managed care penetration in Medicaid) which make these assumption less unreasonable, and prevent unrealistic calculations from becoming the norm.

F. EPSDT

The EPSDT discussion needs to clarify that the Arkansas program will ensure that all state plan services will be covered as a wraparound service, when needed to "correct or ameliorate" the enrollee's condition. Ensuring EPSDT through a wraparound feature is going to be difficult enough; the approval documents need to set the ground rules clearly.

In this application, Arkansas suggests numerous possibilities for how this demonstration might be expanded or altered in future years – for example, Arkansas contemplates adding children to the demonstration in subsequent years. Given the broad EPSDT services requirement applicable to all Medicaid-eligible children which is not "closely aligned with the benefits available on the Marketplace," children cannot be "the individuals in the new Medicaid *adult* group who must enroll in benchmark coverage" to which HHS has circumscribed premium assistance.[15] (Emphasis added) Moreover,

[14] See 42 CFR § 435.1015(a)(4).
[15] "Medicaid and the Affordable Care Act: Premium Assistance," HHS FAQ, March 2013, page 2.

HHS should clarify that neither EPSDT children nor any other group that is traditionally eligible or §1396u-7 benchmark-exempt can be such new Medicaid adults who can mandatorily enrolled into individual market premium assistance through a waiver.

G. Waiver transparency

Arkansas' suggestions about future changes to its proposed section 1115 demonstration raise the concern these changes will be made through section 1115 amendment processes which, according to some interpretations, may not be subject to transparency protections which apply to new section 1115 proposals. The changes suggested by Arkansas are significant, and HHS must require such changes to comply with the full transparency requirements. Any other outcome would violate the intent of section 1115(d) by allowing states to skirt the Congressionally-mandated transparency requirements for section 1115 demonstrations that "impact on eligibility, enrollment, benefits, cost-sharing, or financing with respect to" State Medicaid programs by allowing the state to furtively implement changes through amendments as opposed to applications or renewals.[16]

H. Medical frailty

Arkansas' section 1115 proposal is ambiguous about the proper application of medical frailty. Arkansas indicates that it will apply §1396u-7 medically frail exemptions, but then may attempt to further qualify when they will apply such exemptions.[17] HHS must not approve any section 1115 waiver until it is clear that Arkansas would not limit medical frailty exemptions more than permitted under law.

Arkansas' application states that there will be no comment period for the medically frail definition, though there will be a notice and comment period for a State plan amendment (SPA) on the ABP, and this SPA would include details about medical frailty. The application also says that the will be no appeals process for medical frailty decisions. This raises legal concerns. The Medicaid regulations give the individual the right to apply for the eligibility category of their choice. If an individual wants to apply as medically frail and is denied as medically frail, then their claim for assistance has been denied and appeal rights should attach. We note that in some cases the definition of medically frail is not open to reasonable dispute (e.g., individuals in a drug treatment program), and individuals must have some method to challenge state denials that are patently erroneous in fact or law.

The Arkansas proposal projects that approximately 10% of the new adult population will qualify as medically frail.[18] We understand this number to be an estimate, as opposed to

[16] 42 U.S.C. §1315(d)(1).
[17] See Arkansas 1115 Waiver Application, page 10: "[I]ndividuals determined to be medically frail/have exceptional medical needs *for which coverage through the Marketplace is determined to be impractical, overly complex, or would undermine continuity or effectiveness of care* will not be eligible for the Demonstration." (Emphasis added). It is unclear if the language in italics is intended to narrow the exception or merely describe the population.
[18] Arkansas 1115 Waiver Application, page 10.

a target. HHS should explicitly prohibit the state from applying a 10% standard for medical frailty, as such a standard could otherwise become an impermissible cap.

I. Auto-assignment

Arkansas predicts many enrollees will be auto-assigned into plans,[19] and yet this auto-assignment has only been designed to fairly distribute market share among the QHPs (although future assignment methodologies will factor in things like quality). The auto-assignment process should be in the best interests of beneficiaries, as required by 42 U.S.C. § 1396a(a)(17). Thus, it should account for the enrollee's previous provider history, provider capacity/limits within each plan, and limited English proficiency. It should also account for geographic location/zip code; otherwise the non-emergency transportation wraparound service could be unnecessarily used, generating unnecessary costs.

J. Prior authorization

Arkansas requests waiver of § 1396a(a)(54) to "permit the State to require that requests for prior authorization for drugs be addressed within 72 hours, rather than 24 hours"[20] as is required under section 1396r–8(d)(5)(A). Recent Medicaid regulations confirm that ABP benefit packages are subject to section 1396r–8 requirements for drugs that are covered by the ABP.[21] Although section 1396a does *reference* section 1396r–8, such reference does not change the fact that section 1396r–8 places *independent requirements* on the ABP. The requirements in section 1396r–8 lie outside of section 1396a and are thus not waivable under section 1115 of the Act. Arkansas cannot waive, and must comply with, the section 1396r–8 requirement to respond to prior authorization requests in 24 hours for drugs covered under the ABP which are subject to section 1396r–8. These requirements, set by Congress, are reasonable and necessary, given the importance of commencing and maintaining medication regimens as soon as possible after the prescription is written (whether there is an emergency or not).

K. Hypotheses

A section 1115 demonstration is just that – a demonstration – and it must demonstrate something. The Arkansas proposal is to be commended for at least including hypotheses (eleven of them) to be tested. However, many (eight) of these eleven hypotheses are seriously flawed.

In the first instance, five[22] of the eleven "hypotheses" are not in fact related to the "premium assistance" authority that this demonstration calls into question. There is no evidence that the QHPs individuals will be enrolled into will be a significantly different or

[19] See Arkansas 1115 Waiver Application, page 27.
[20] Arkansas 1115 Waiver Application, page 30.
[21] 42 CFR §440.345(f).
[22] These include the first three "access" hypotheses and the two "quality" hypotheses. See Arkansas 1115 Waiver Application, pages 4-5, 7-8,

novel delivery system as compared to the standard use of health plans (i.e., managed care) in Medicaid. These hypotheses are indistinguishable from familiar managed care hypotheses, and there is nothing "demonstrable" about managed care in Medicaid considering that (1) the Medicaid Act already includes state plan authority to operate managed care, (2) Medicaid managed care is decades old, (3) the majority of current Medicaid enrollees nationally *already* are in managed care, and (4) it is likely that the overwhelming majority of state Medicaid Expansion enrollees will be enrolled through managed care. There is nothing novel about delivery system hypotheses around health plans, and need to demonstrate something already available in the Act, and which has been and is being extensively tested.

Earlier we addressed two[23] of the other hypotheses – those related to reduced administrative costs and comparability of total costs. These hypotheses are simply not tenable in their current formulation. In particular, we note that the cost-effectiveness hypothesis is problematic and that Arkansas attempts to have it both ways: Arkansas assumes that it would need to increase fee-for-service rates to justify its grossly flawed cost-effectiveness calculation, and at the same time, assumes no such rate increase for fee-for-service throughout the other hypotheses (and demonstration discussion) declaring the access virtues of premium assistance. This hypothesis therefore not only fails as a justification, but the false assumptions within it distort the entire proposal. And again, this is the type of section 1115 activity that the GAO has previously and repeatedly criticized. It should not be continued here.

Yet one[24] more hypothesis – predicting lower Marketplace rates – is not valid because, though possibly true in fact, it is not relevant to a Medicaid demonstration evaluation. It deals with impacts to people outside of Medicaid, not Medicaid enrollees.

We do believe that there are three[25] hypotheses that are possible valid bases for this demonstration:

- A premium assistance program *might* demonstrate that there will be fewer gaps in insurance coverage due to reduced churning.
- A premium assistance program *might* demonstrate that there will be enhanced continuity of providers due to reduced eligibility and plan churning. (We note that continuity of plan enrollment should not be a measure of success, since consumers want continuity of *providers*, not insurers, and insurers regularly change their covered providers).
- A premium assistance program *might* demonstrate higher take up rates than similar fee-for-service and managed care programs.

We note, however, that it is not enough for Arkansas to have these (and other) hypotheses written down. This must truly be a demonstration and the hypotheses must

[23] The first two "cost" hypotheses. See Arkansas 1115 Waiver Application, pages 6-7.
[24] The fourth "cost" hypothesis. See Arkansas 1115 Waiver Application, page 8.
[25] The last two "access" hypotheses and the third "cost" hypothesis. See Arkansas 1115 Waiver Application, pages 5-7.

be tested using a well-designed experiment followed by comprehensive analysis. There is not enough described in the current proposal to indicate this will be the case. We note that the analytic data provided by many of these hypotheses will only allow 'apples to oranges' comparisons permitting no clear conclusions to be deduced. For example, the evaluation approaches repeatedly rely on comparisons between very different populations – such as comparing higher-income premium assistance populations (which excludes the medically frail) to lower-income fee-for-service populations (which includes numerous vulnerable categorical groups). CMS must not approve this proposal until Arkansas has clarified the methodology for the demonstration analysis. It is essential to the demonstration function that the demonstrations be valid *and* well-tested. In our view, only three of Arkansas' hypotheses pass the former requirement, and none apparently pass the second. Furthermore, we urge HHS to preserve the character of the demonstration process, in accordance with HHS guidance, by only considering "approving a limited number of premium assistance demonstrations."[26]

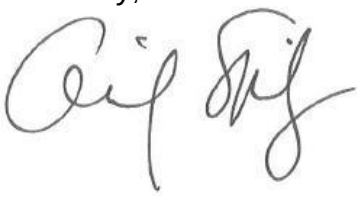
L. Habilitative services

We note that the list of covered benefits does not include any items that are habilitative services.[27] Habilitative services must be covered by the ABP as incorporated through the EHB standard.

Conclusion

In summary, we have numerous concerns with the legality of Arkansas' section 1115 premium assistance demonstration application, as proposed. We urge HHS to address these concerns prior to issuing any approval. If you have questions about these comments, please contact Jane Perkins (perkins@healthlaw.org) or Leonardo Cuello (cuello@healthlaw.org). Thank you for consideration of our comments.

Sincerely,



Emily Spitzer,
Executive Director

[26] "Medicaid and the Affordable Care Act: Premium Assistance," HHS FAQ, March 2013, page 1.
[27] Arkansas 1115 Waiver Application, page 13.