October 30, 2013

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P.O. Box 1437 (Slot S295)

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**Re: Comments to Proposed Rules**

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 a number of Arkansas’ proposed rules for Medicaid Expansion.

**Medicaid Notices** (Documents HCIA 31 – 39)

Numerous of Arkansas Medicaid notices (HCIA 31, 32, 36, 38, 39) include illegal warnings to individuals that “[b]y enrolling in or using this health insurance coverage, you acknowledge that the Health Care Independence Program is not an entitlement.” However, under any construction of the law, Medicaid is and remains an entitlement. Furthermore, no individual could under any circumstances waive that legal fact or the due process and Constitutional grounds upon which it is based (see Goldberg v. Kelly, 397 U.S. 254 (1970)). CMS explicitly maintained and safeguarded this requirement in the March 29, 2013 FAQ, when it stated: “Under all these arrangements [of premium assistance], beneficiaries remain Medicaid beneficiaries and continue to be entitled to all benefits and cost-sharing protections.” Thus, we strongly urge Arkansas to remove the above-quoted language, and any similar language, from all of these notices. We note that failure to do so will not only violate Medicaid’s status as a legal entitlement and the CMS guidelines, it will also provide every individual so notified with the opportunity to challenge the notice as legally insufficient for failure to comply with Medicaid’s due process requirements.

Arkansas’ notices (HCIA 31, 32, 38, 39) also include inaccurate information about coverage of emergency room care and language. This language overstates the limited scope of ER coverage and ignores the state’s required role in supplementing coverage not provided by the Marketplace health care plan. Arkansas is merely repeating the improper premise in its waiver application, namely that “Nonemergency use of the emergency room is not a covered benefit under the Alternative Benefit Plan, since non-emergency use of the emergency room is neither an Essential Health Benefit nor a mandated service in the Alternative Benefit Plan.” (Arkansas 1115 Waiver Application, page 44). As we stated in our comments to the waiver application:

“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.” (NHeLP Comments to Arkansas 1115 Waiver Application, page 5, available at:

<http://www.healthlaw.org/images/stories/NHeLP%20Comments%20to%20Arkansas%201115%20Waiver%20Application%2009.07.2013.pdf>.)

**Alternative Benefits Plan** (Documents HCIA 20-30)

We appreciate that Arkansas has described a process (in document ABP2a) to notify individuals of their ability to request medically frail screening. However, we believe the process described has at least two major problems. First, Arkansas indicates it “will provide notice to individuals who believe they may be exempt.” However, few consumers will know about exemption at all. We therefore recommend that Arkansas provide broad notice to consumers, outreach to consumers, and notice to medical providers. Second, the entire process as described requires numerous affirmative steps by a consumer which will pose a barrier to consumers accessing the process. We recommend a more user-friendly process requiring one simple step for consumers.

We are concerned about the creation of a separate FFS ABP for exempt individuals (documents ABP2a, ABP2c). We ask the State to consider whether this will place an incentive on QHPs to identify or exaggerate exemptions, to pass off responsibility for expensive enrollees, and also complicate cost-effectiveness calculations. Publicly, this may be viewed as a financial boon to the private insurers at the expense of the State. We also are concerned that this may leave a smaller isolated FFS ABP population, which will face access problems.

It is also unclear (from document ABP2a) whether the default assignment of exempt consumers will be into the state plan, with the option to select the FFS ABP, or into the FFS ABP with the option to select the state plan. We recommend that exempt consumers should be placed into the state plan with the option to choose the FFS ABP instead.

We are supportive of the concept of a self-attested questionnaire as part of a system to identify exemption and compliment the State for working with University of Michigan and AHRQ to develop a questionnaire. However, we believe it is not legal for the State to use that questionnaire to merely identify the 10% of most expensive individuals and grant exemptions solely on that basis. While the state might plausibly automatically deem everyone in the top 10% as medically frail, individuals outside the top 10% cannot be automatically excluded. Every individual must be measured by the exemption criteria, and exempted regardless of the cost when they meet those criteria, as required by Social Security Act § 1937(a)(2)(B). We recommend criteria that also include consideration of:

* Functional need for care – increased pain and discomfort, or reduced quality of life and function, without care;
* Potential current and future health complications associated without care – for example, for individuals with HIV, diabetes, etc.;
* Comorbidity which complicates care – for example, serious physical health conditions accompanied by mental health conditions.

We believe many of these issues are addressed in the questionnaire but are rendered meaningless by the 10% threshold.

Document ABP3 correctly identifies the need to wrap around services, but it should be explicitly expanded to include FQHC/RHC services, family planning freedom of choice, and mental health parity, as required under Social Security Act §1937(b).

We are troubled by Arkansas’ plan in document ABP2c “to use the flexibility outlined by the Secretary in the final ABP regulation” and “not have a fee-for-service ABP in place by January of 2014, but will work to establish a fee-for-service ABP to be implemented during 2014.” HHS has offered states no such flexibility. Arkansas may be confusing flexibility with HHS’ statement that it does “not intend to pursue compliance actions … to the extent that states are working toward but have not completed a transition to the new ABPs on January 1, 2014.” (78 Fed. Reg. 42200). HHS’ deferment of compliance – assuming it is even legal – is not the equivalent of an offer of flexibility. Arkansas is still subject to a legal requirement. If the FFS ABP is not available by January 1, 2014, Arkansas should clarify what coverage the individuals eligible for the FFS ABP will receive.

**Conclusion**

 We appreciate the consideration of the above comments. If you have any questions or need any further information, please do not hesitate to contact me (cuello@healthlaw.org).

Sincerely,

Leonardo Cuello

Director, Health Reform