National Health Law Program

To: Health and Disability Rights Advocates
From: Jane Perkins, National Health Law Program
Date: April 25, 2006

Re: Q&A – State Medicaid Plans

Question: I read the recent Fact Sheet you prepared for the National Disability Rights Network that discussed selected Medicaid provisions of the Deficit Reduction Act of 2005.[1] I noticed that states have the option of whether to implement many of these provisions. Can you explain the process that states use to implement optional Medicaid programs?

Brief answer: Each state has implemented its Medicaid program through a state Medicaid plan. States choosing to exercise an option set forth in the federal Medicaid Act must ordinarily submit a state plan amendment to the U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services (CMS). CMS can approve or deny the amendment. There are steps you can take to participate in the review process on behalf of your clients.

Discussion: Medicaid is joint program administered by the federal and state governments pursuant to the Medicaid Act, 42 U.S.C. § 1396. To receive federal Medicaid funding, each state must have in effect a comprehensive, written state plan for medical assistance that has been submitted to and approved by the Secretary of the U.S. Department of Health and Human Services (HHS). The state Medicaid plan describes the nature and scope of the state's Medicaid program and includes assurances by the state to the federal government that the state Medicaid program will be operated in conformity with the federal Medicaid Act, regulations, and official issuances of HHS. *See* 42 U.S.C. § 1396a(a) (listing required contents of state Medicaid plans), 42 U.S.C. §§ 1396b, 1396c (describing federal funding mechanisms for state Medicaid programs); *see also* 42 C.F.R. § 430.10.

Overview to the state Medicaid plan

The state Medicaid plan is a series of pre-printed documents that states complete to show that they are implementing the basic federal Medicaid rules. In addition, there are individualized attachments and state plan amendments that describe particular characteristics of a state's program. For example, states specify which optional Medicaid services they cover on pre-print

[1] For a discussion of Medicaid provisions of the DRA, *see* Jane Perkins, National Health Law Program, *The Deficit Reduction Act of 2005: Implications for Advocacy* (Apr. 2006) (available from Training and Advocacy Support Center of NDRN).

pages by marking an "X" in the appropriate box accompanying the listing of services. Additional text discussion, on the pre-print, an attachment or state plan amendment will describe particular characteristics of coverage (e.g. any quantitative limits on services for adults). CMS has posted state Medicaid plans and amendments at: http://www.cms.hhs.gov/medicaid/stateplans/.

The state Medicaid plan must be amended whenever necessary to reflect changes in federal statute, regulation, or court decisions and to reflect "material changes" in state law, policy, organization, or operation of the program.[2] According to the Second Circuit Court of Appeals, a change is considered material if "the clear and unequivocal effect of the interpretation is actually to alter the written terms of the plan."[3] States choosing to implement the Medicaid options authorized by the DRA will need to submit a state plan amendment and receive CMS approval because the DRA options will result in material changes to the operation of the state program.

The state plan amendment process

State plan amendments are typically developed by state Medicaid agency employees. Except in the circumstances discussed below, each plan amendment must be submitted to the Governor or his designee for review and comment before it is submitted to CMS.[4] The state Medicaid plan must give the Governor a specific period of time to review the state plan amendment.[5] Any comments from the Governor must be submitted to CMS along with the plan amendment.

As noted, there are exceptions to this submission process. A state plan amendment need not be submitted to the Governor if the Governor's designee is the head of the Medicaid agency. Also, the Governor's review is not required for pre-printed plan amendments that are developed by CMS if they provide "absolutely no options for the State."[6]

Once developed and approved by the Governor (if required), the state plan amendment is

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[2] 42 C.F.R. § 430.12(c). Changes related to advance directive requirements must be submitted as soon as possible, but no later than 60 days from the effective date of the change to state law concerning advance directives. *Id.*

[3] *Concourse Rehab. & Nursing Ctr., Inc. v. DeBuono*, 179 F.3d 38, 46 (2d Cir. 1999). *See generally Oregon Ass'n of Homes for the Aging, Inc. v. State of Oregon*, 5 F.3d 1239 (9th Cir. 1993) (holding state regulation invalid due to state's failure to submit plan amendment).

[4] *See* 42 C.F.R. § 430.12(b)(1).

[5] *Id.*

[6] *Id.* at § 430.12(b)(2)(ii).

submitted to the appropriate CMS regional office.[7] The regional office will discuss issues with the state Medicaid agency and consult with the central CMS office. The determination of whether a state plan amendment is approval is based on relevant federal statutes and regulations.[8]

Each CMS Regional Administrator has been delegated authority to *approve* state plan amendments. However, only the CMS Administrator, in consultation with the Secretary of HHS, may *disapprove* a state plan amendment.[9]

When a state submits a plan amendment, CMS has 90 days to approve the amendment, disapprove the amendment, or request additional information.[10] If CMS does not act within this time frame, the state plan amendment is considered approved. If CMS requests additional information, CMS has a second 90-day time frame within which to approve or disapprove the amendment, beginning on the date the requested information is received from the state.[11] Since January 2001, CMS has tracked the time period while it is awaiting receipt of additional information it has requested from a state. If CMS has not received the state's response to the CMS request for additional information within 90 days, it will initiate disapproval action on the amendment.[12]

The effective date of the state plan amendment depends on the subject matter of the amendment. If the plan amendment provides additional services to eligible individuals, increases payment amounts for services already covered by the plan, or makes additional groups eligible, the effective date cannot be earlier than the first day of the quarter in which an "approvable plan" was submitted to the CMS regional office.[13] For plan amendments that change the State's payment method and standards, the effective date cannot be earlier than the first day of the calendar quarter in which an approvable amendment was submitted to CMS.[14] In other situations, the effective date may be a date requested by the state and approved by CMS.[15]

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[7] *See* 42 C.F.R. § 430.14.

[8] *See Id.* at § 430.15(a).

[9] *See Id.* at §§ 430.15(b) and (c).

[10] *See* 42 U.S.C. § 1316(a)(1)

[11] *See* 42 C.F.R. § 430.16(a).

[12] *See* CMS, *Dear State Medicaid Director* (Jan. 2, 2001), *available at* http://www.cms.hhs.gov/smdl/downloads/smd010201.pdf.

[13] 42 C.F.R. §§ 430.20(b)(1).

[14] *Id.* at §§ 430.20(b)(2), 447.256.

[15] 42 C.F.R. § 430.20(b)(3).

Regardless of the effective date of the plan amendment in the State, CMS policy will not provide federal financial participation (FFP) for any state plan amendment until it is approved. In other words, CMS will not advance FFP to a state at the beginning of a quarter for a pending state plan amendment.[16]

If a state plan amendment is disapproved or the state is otherwise dissatisfied with the CMS Administrator's action, the state may obtain an administrative hearing to reconsider the decision. The request for reconsideration must be made within 60 days of receipt of the notice of final determination.[17] Within 30 days after receiving the request for reconsideration, the CMS Administrator is to notify the state of the time and place for the hearing. The hearing is to occur within 60 days of the notice of final determination unless the State and CMS Administrator agree in writing to an earlier or later date.[18] The hearing procedures are set forth at 42 C.F.R. §§ 320.60-430.104 and include requirements for all pleadings, correspondence and exhibits to be publicly available for review and copying[19] and publication of information about the reconsideration in the *Federal Register.*[20] The state and CMS are parties to the hearing. In adition, other individuals and groups may be recognized as parties if they have been injured by the contested issues and their "interest is within the zone of interests to be protected by the governing Federal statute."[21] Any individual or group wishing to participate in the hearing must file a petition with the CMS Docket Clerk, within 15 days of the *Federal Register* notice that concisely states: (1) the petitioner's interest; (2) who will appear for the petitioner; (3) the issues on which the petitioner will participate; and (4) whether the petitioner intends to present witnesses.[22] The presiding officer will act on the petition. In lieu of participating as a party, interested individuals or groups can request permission to file an *amicus curiae* (friend of the court) petition in the case.[23]

Within 60 days of the final determination on reconsideration, a state may file an appeal

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[16] *See* CMS, *Dear State Medicaid Director* (Jan. 2, 2001), *available at* http://www.cms.hhs.gov/smdl/downloads/smd010201.pdf.

[17] *See* 42 U.S.C. § 1316(a)(2).

[18] *Id.* at § 1316(a)(3); 42 C.F.R. § 430.18.

[19] *See* 42 C.F.R. § 430.62.

[20] *Id.* at § 430.74. For an example, *see* 71 *Fed. Reg.* 3853 (Jan. 24, 2006) (Notice of Hearing; Reconsideration of Disapproval of Ohio State Plan Amendments regarding habilitation services).

[21] 42 C.F.R. § 430.76(b).

[22] *Id.*

[23] 42 C.F.R. § 430.76(c).

directly to the appropriate United States circuit court of appeals.[24]

Ten Tips for Successful Advocacy

It is important to learn as much as you can about your state's DRA state plan amendments, as early as possible. Becoming part of "the loop" may require some homework, however. Presently, federal law does not generally require public notice that a state plan amendment is being planned or submitted. Moreover, the state Medicaid agency may undertake its activities without specific legislative authorization. To further complicate the situation, states may develop their plans in secret, through closed door communications with CMS. There are, however, numerous places during the review process where P&A clients may become involved. Listed below are steps you can take to obtain information and monitor activities in your state.

1 *Learn about your state's process for making state plan amendments.* Consulting your state rules, state Medicaid plan, and agency personnel, you will need to find out whether the Governor or a designee reviews state plan amendments. As noted above, the state Medicaid plan must set forth a specified time frame for the Governor's review, and you should learn this as well.

2. *Find out about state plan amendments that are being considered.* Developing helpful contacts within your state Medicaid agency is obviously essential. The developmental disabilities and/or mental health divisions may be involved in the process and be helpful to you. The Medicaid agency may also involve physician, community clinic or hospital associations. Your contacts with these entities can possibly get you early access to information about a state plan amendment.

3. *Make immediate contact with the person in the CMS regional office who has been assigned responsibility for the plan amendment.* This person can provide valuable information about the nature and timing of the CMS review process.

4. *Obtain copies of documents between the state and CMS, including the state plan amendment.* While the government agencies may refuse to provide draft documents, you have a right to obtain copies of final documents. While your contacts may provide you with documents, you may want to file a public records/freedom of information act request early on to obtain information about the state plan amendment.

5. *Review your state statutes to determine whether specific legislative authorization is needed for the change proposed by the state plan amendment.* The National Health Law Program has recently posted a review of state laws on its website, which includes charts showing whether state legislation is needed for Medicaid changes or whether the state Medicaid agency is authorized to make changes without legislative approval. This memorandum should also be

[24] 42 U.S.C. § 1316(a)(3).

consulted.[25]

6. *Request and attend public meetings.* Currently, there is no federal law that generally requires public notice and opportunity to be heard prior to the submission of a state plan amendment. There are some important steps you can take, however. The Medicaid Act requires all states to have a functioning Medical Care Advisory Committee (MCAC) that reviews and comments on Medicaid policy developments and changes. Press for MCAC to meet, take an active role, and hear public comment on state plan amendments to implement DRA options.[26]

Moreover, there are federal and state laws that do require public notice and comment in certain situations:

- While states have been given significant flexibility regarding cost sharing, if a state is going to implement a copayment policy that is not authorized by either 42 U.S.C. §§ 1396o or § 1396oA, it must seek a waiver from the Secretary of HHS which cannot be approved without prior public notice and opportunity to be heard. *See Id.* at § 1396o(f).

- If the proposed change relates to payment rates, the state is required to provide an opportunity for public review and comment. The state must: (1) use a public process for determining rates; (2) publish proposed and final rates, the methodologies underlying the rates, and justifications for the rates; and (3) give interested parties a reasonable opportunity for review and comment. *See* 42 U.S.C. § 1396a(a)(13)(A); 42 C.F.R. § 447.205..

- The state plan amendment may create "rules of general applicability" under your state Administrative Procedure Act. If so, a formal rule making process may be required.

- Some of the home and community-based services options that can be implemented through state plan amendments could result in additional populations and services being recognized. If CMS decides to disapprove a state plan amendment that your clients support, you can participate in the appeal process (assuming that the state decides to contest the denial). You should monitor the *Federal Register* for Notices regarding hearings on reconsiderations of the disapproved state plan

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[25] *See* National Health Law Program and National Association of Community Health Centers, *Role of State Law in Limiting Medicaid Changes* (April 2006), *at* http://www.healthlaw.org *(What's New).*

[26] For additional discussion of MCACs and how to participate in them, *see* Jane Perkins and Sarah Somers, National Health Law Program, *Medical Care Advisory Committees* (Jan. 2005) (available from NDRN and NHeLP).

amendments. The Notice will explain the subject matter of the proposed state plan amendment, the reason for the disapproval, and give information about the timing and conduct of the hearing.

7. *Unilaterally insert your clients into the review process by commenting to your state agency and CMS on the state plan amendment, in writing, at the earliest possible time and regularly when developments occur.* Disability advocates have important issues to raise at all steps in the review process, including at the very earliest stages when only draft proposals are circulating. In addition, advocates should be prepared to provide comments on the state plan amendment that is submitted to CMS. Continue to submit written comments, as appropriate. Make sure that you copy all persons who would be interested in your client's position on this matter, including state and federal policy makers.

8. *Schedule meetings with appropriate agency personnel.* You should be prepared to address your main arguments orally at one or more meetings with the state and to follow up with more extensive written comments. You may also meet with the regional CMS office.

9. *Measure the state plan amendment for compliance with federal Medicaid and civil rights laws, including the Americans with Disabilities Act.* While the Deficit Reduction Act of 2005 has given states unprecedented flexibility, numerous Medicaid Act provisions continue to apply, as do the Americans with Disabilities Act, Title VI of the Civil Rights Act, and, of course, the United States Constitution.

10. *Obtain technical support when needed.* The National Health Law Program and NDRN are available to provide technical support as state Medicaid plan amendments are being considered in your state. Do not hesitate to contact either office for assistance.